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Press Release
Not for release until after the presentation to the BCUHB Board by Donna Ockenden on 12th July 2018.

Headline: The Ockenden report into governance arrangements on Tawel Fan ward prior to closure in December 2013 and current governance arrangements in Older People's Mental Health Care at BCUHB to the current time is published on Thursday 12th July 2018 at 1030hrs.

What is the Ockenden review?
The Ockenden review is an extensive and lengthy review comprising over two and a half years of detailed work, involving consideration of several thousand documents, some previously unpublished and 200 interviews with current and former BCUHB staff and current and recent service user representatives across the six counties of North Wales.

Tawel Fan ward was a 17 bedded ward in the Ablett unit at Ysbyty Glan Clwyd. Prior to its closure it was a ward that was designated for the assessment and treatment of dementia patients. At the time of its closure BCUHB said it was 'currently not assured that Tawel Fan is able to provide an environment of care 24/7 which is consistent [with] safe standards of compassionate care to the most vulnerable patients suffering from advanced dementia.'

The Ockenden review has found that from the birth of BCUHB in October 2009 BCUHB were repeatedly informed that there was very significant cause for concern in the systems, structures and processes of governance underpinning a range of services provided by BCUHB. This included older people's mental health care and older peoples care generally. From as early as 2012 BCUHB had a range of external reviews into itself from multiple organizations. The Ockenden review has found that BCUHB made very limited progress in meeting the recommendations from those reviews over a prolonged period of time. In many cases the recommendations were simply carried forward from review to review.

From early 2013 BCUHB were being told very clearly that their management and investigation of concerns, (serious incidents, complaints and Never Events) was not fit for purpose. This feedback mirrors the feedback from current and recent service user representatives participating in the Ockenden review. Along with other issues, this led to Welsh Government placing BCUHB in 'Special Measures' in June 2015. They remain in 'Special Measures' to this day.

The Ockenden review has found that BCUHB was told repeatedly about the same concerns around medical and nurse staffing, documentation, safeguarding of vulnerable adults, safety issues in estates, staff training and appraisal, bed numbers and bed management. Action plans were frequently developed following external reviews and HIW inspections. But as recently as the end of 2017 actions promised following reviews and inspections in previous years were found not to have been carried

out by BCUHB. Where progress has been made over the last 8 years it has been too slow and is not yet on a sustainable footing.

Multiple external reviews and inspections from 2009 to the current day and current and recent service users often comment positively on the dedication of BCUHBs front line clinical staff. Front line staff within Older Peoples Mental Health spoken to throughout the review consistently reported significant concerns around staffing levels and lack of engagement with the Board and senior management team within mental health and this forms the basis of one of the many recommendations within the Ockenden report.

It is now absolutely essential that BCUHB as an organization led by the BCUHB Board makes the required and necessary progress with the recommendations of the Ockenden report moving forward. The recommendations of the Ockenden report when put in place will improve services for vulnerable older people and will support improvement of the working environment for the many staff involved in delivering frontline clinical care across mental health. The BCUHB Board must now grasp the opportunity that the recommendations of the Ockenden report gives to them and ensure the recommendations are met within the timescales as set out clearly in the report.

In conclusion Donna Ockenden said 'I have reviewed governance across Older Peoples Mental Health from 2009 to the current day. I have found that the systems, structures and processes of governance, management and leadership introduced by the BCUHB Board from 2009 were wholly inappropriate and significantly flawed. The BCUHB Board was alerted to those significant flaws, both internally and externally, for many years before action began to be taken. Where progress has been made, it has been too slow. I hope that this report can help accelerate the pace of improvement that the resident population of BCUHB and their staff deserve.

I presented my report to the BCUHB Board today and heard from Board members their views of the improvements underway. I feel that the Board do now understand the significance of the challenging journey they face and I hope that the recommendations made in my report will assist them to accelerate this journey. '

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