

Abertawe Bro Morgannwg UHB

Following the Bridgend boundary change, Abertawe Bro Morgannwg University Health Board became Swansea Bay University Health Board on 1 April 2019. For the purposes of this report which covers the 2018 – 2019 period we have used the former name of the health board.

In general, our inspections have shown that patients have been treated with dignity and respect and were happy with the healthcare provided. Many service areas have also demonstrated good leadership and management.

There were, however, some areas that required improvement including, record keeping and medicine management in some settings. The management and maintenance of resuscitation equipment must also be up to date, and staff must be appropriately trained in the equipment.

The way serious incidents are investigated is also inconsistent.

Historic governance was scrutinised in detail last year in relation to the health board's handling of the employment and allegations made against Kris Wade. Our review found that the issue of line of sight between the Board and operational services has been a recurrent theme since 2014. The current Board has accepted our recommendations and is maturing with a focus on improvement.

We also made a number of recommendations for all health boards in Wales as noted in our National Reviews section, and in more detail in the full report on our website.

Hospitals

We conducted an inspection at the Neath Port Talbot Minor Injuries Unit and a surgical services inspection at Morriston Hospital

- ✓ Patients were treated with dignity and respect in both hospital inspections
- ✓ Good infection control procedures
- ✓ Good systems in place to promote patient safety
- ✓ Good management of controlled drugs

- ✗ Timely management of trauma and orthopaedic patients
- ✗ Concerns about the management of theatre lists at the unit were expressed by staff
- ✗ Safety checks in theatre need strengthening
- ✗ Concerns over the number of never events
- ✗ Key equipment, resuscitation checks and audit arrangements need to be improved (NPT). These issues have been found in the minor injuries unit on previous visits
- ✗ Risk assessments for blood clots (Morriston)

Mental Health

We inspected the Tawe Clinic at Cefn Coed Hospital

- ✓ Patients were treated with kindness and compassion
- ✓ Information about advocacy was prominently displayed
- ✓ Efforts had been made to make the entrance and outside areas pleasant for patients to use
- ✓ Visible and supportive leadership
- ✓ Good compliance with health board mandatory training
- ✗ No call system for patients in bedrooms
- ✗ Lack of furniture in bedrooms
- ✗ Inadequate checking of emergency equipment
- ✗ Aspects of record keeping need improvement
- ✗ Information about how to raise a concern should be clearly visible
- ✗ Care and treatment plans need to be in line with the Mental Health (Wales) Measure

Dental

We inspected 13 practices

- ✓ Patients reported a friendly, professional and patient-focused service in 10 out of 13 practices
- ✓ Good leadership in 8 of the 13 practices visited
- ✓ Safe use of x-rays in 5 practices
- ✓ A good suite of policies and procedures in five practices
- ✗ Improvements need to be made in clinical record keeping in most practices – recording of medical histories, allergies, health promotion advice, treatment justification, consent and cancer screening.
- ✗ Gaps in staff training in safeguarding, resuscitation training, and fire safety.
- ✗ Improvements needed in the management of equipment including emergency equipment

GP

We inspected three GP surgeries

- ✓ Patients were treated with dignity and respect
- ✓ Surgeries were clean and accessible
- ✓ Evidence of engaged managers and good leadership
- ✗ Provision and checking of emergency equipment in two settings
- ✗ Policies and procedures needed updating in all practices
- ✗ Mandatory training gaps-resuscitation, safeguarding, infection control
- ✗ Website requires updating in two practices
- ✗ Provision of a working hearing loop at two practices

Community Mental Health

We inspected the Neath Port Talbot Community Mental Health Team

- ✓ Dedicated staff
- ✓ Patients treated with dignity and respect
- ✓ Evidence of supportive treatment plans for patients
- ✗ Environmental risks-such as ligature points (the service received an immediate assurance letter in relation to the environmental risks)
- ✗ Poor culture of incident reporting
- ✗ Discord between leaders leading to a poor culture at a senior level