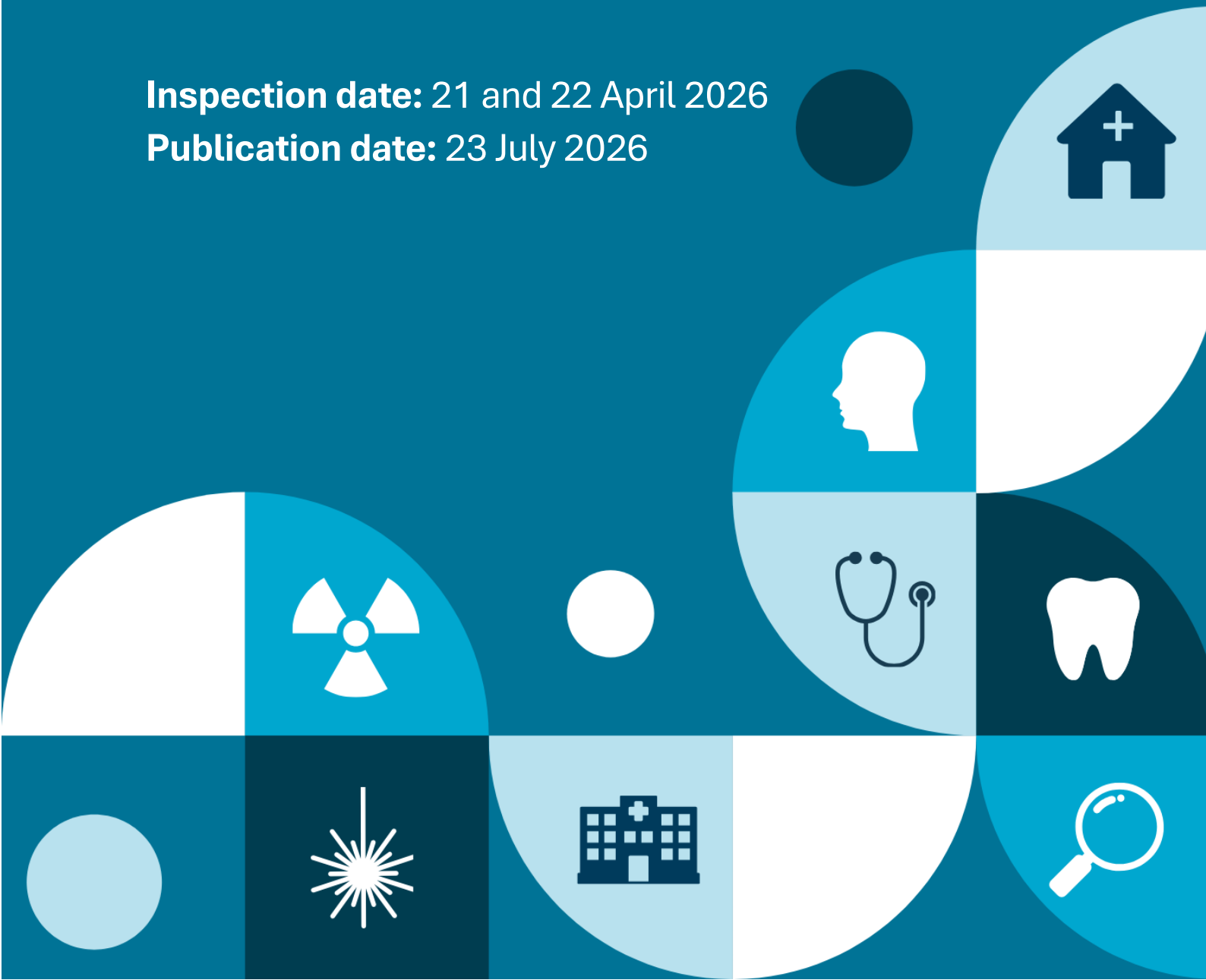
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Ionising Radiation (Medical Exposure) Regulations Inspection Report (Announced)

Radiotherapy Department, Velindre @ Nevill Hall Hospital, Velindre University NHS Trust

Inspection date: 21 and 22 April 2026
Publication date: 23 July 2026



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Digital ISBN 978-1-80853-081-4

Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Values

We place people at the heart of what we do.

We are:

Independent – we are impartial, deciding what work we do and where we do it.

Objective - we are reasoned, fair and evidence driven.

Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find.

Inclusive - we value and encourage equality and diversity through our work.

Proportionate - we are agile and we carry out our work where it matters most.

Our Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

Our Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued, and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection of the Radiotherapy Department at Velindre at Nevill Hall Hospital, Velindre University NHS Trust on 21 and 22 April 2026.

During our inspection we looked at how the department complied with the Regulations and met the Health and Care Quality Standards.

Our team for the inspection comprised of three HIW healthcare inspectors and a Specialist Clinical Officer, Radiotherapy from the Medical Exposures Group (MEG) of the UK Health Security Agency (UKHSA), who acted in an advisory capacity.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Overall, the quality of patient experience within the service was positive. Patient feedback gathered through questionnaires demonstrated consistently high levels of satisfaction. Patients reported that they were treated with dignity and respect, that staff provided clear explanations, and that they were given sufficient information to understand the risks and benefits of their treatment. Feedback also indicated positive experiences in relation to access and flow through the department, including ease of locating the service and being kept informed about waiting times.

Inspectors observed staff interacting with patients in a calm, respectful and professional manner. Communication was clear and compassionate, and patient privacy was consistently maintained. The environment supported dignified care, and staff were attentive to patient needs throughout their time in the department. The service also demonstrated a commitment to supporting patient health and wellbeing, with a wide range of health promotion information available, including materials on physical activity, healthy eating, fatigue management and condition-specific support. Pregnancy and radiation posters were displayed throughout the department to support patient safety.

This is what we recommend the service can improve:

- Ensure communication with patients about eligibility and access arrangements for Velindre@Nevill Hall Radiotherapy Unit is consistently clear and easy to understand.

This is what the service did well:

- Treated patients with dignity, respect and compassion, supported by positive patient feedback and inspection observations
- Provided clear explanations and information to patients, supporting understanding and informed care
- Made a wide range of health promotion and wellbeing information readily available to patients.

Delivery of Safe and Effective Care

Overall summary:

Overall, we found that the service had many arrangements in place to support the safe and effective delivery of radiotherapy, with good compliance with the Ionising Radiation (Medical Exposure) Regulations. The employer had established a structured approach to procedures, protocols and quality assurance, and staff demonstrated awareness of their roles and responsibilities. We found positive practice in relation to patient identification checks, pregnancy enquiries and the management of risk, including effective reporting and review of incidents and near misses through established governance routes. The service also described strong involvement of specialist expertise and effective equipment quality assurance arrangements, supporting safe implementation of new techniques. However, we identified improvements are required to strengthen and consolidate documentation and assurance processes, particularly to ensure that governance arrangements fully include the satellite service. Key gaps included the absence of a ratified clinical audit procedure and limited evidence of a planned programme of clinical audit and IR(ME)R compliance audits at the satellite site. Further work is also required to ensure local dose reference levels and key processes are clearly documented, visible at the point of use, understood by staff and subject to audit.

This is what we recommend the service can improve:

- Implement and ratify a written clinical audit procedure and a planned, multidisciplinary programme of clinical audit that clearly includes the satellite service.
- Strengthen assurance that employer's procedures and protocols reflect current practice across both sites, clearly describe any local variations, and ensure evidence of compliance with written procedures are demonstrated at the satellite site.
- Strengthen arrangements for clinical audit and image optimisation oversight, including ensuring relevant dose reference levels are approved, visible at the point of use, understood by staff and supported by ongoing audit.

This is what the service did well:

- Had structured risk management and incident reporting arrangements, with incidents and learning reviewed through established governance processes.

- Applied clear safety checks in practice, including robust patient identification processes and pregnancy enquiries, with recording within electronic systems.
- Demonstrated a systematic approach to equipment quality assurance and access to specialist advice, supporting safe implementation of new techniques and technologies.

Quality of Management and Leadership

Overall summary:

Overall, the quality of management and leadership within the service was positive. Staff feedback reflected strong confidence in the care provided and pride in the service, with most staff reporting they felt supported by their immediate manager. Leaders and managers were described as visible and accessible, with staff encouraged to raise concerns and contribute to improvement. The service demonstrated an open, learning-focused culture, supported by regular meetings and huddles. Training, competency and professional support were identified as strengths, particularly for radiographers and Medical Physics Experts, with clear role expectations, good induction and mentorship, and access to specialist expertise when required.

This is what we recommend the service can improve:

- Strengthen workforce support arrangements to reduce feelings of isolation and to ensure staff wellbeing, workload and support are monitored during ongoing service change.

This is what the service did well:

- Fostered a positive working environment where staff felt supported by immediate managers and encouraged to raise concerns and contribute to improvement
- Provided strong training, competency and professional support arrangements, including effective induction, mentorship and access to specialist expertise.

3. What we found

Quality of Patient Experience

Patient feedback

Patient feedback was very positive. Responses were received from 43 patients, most of whom (90.7%) completed the questionnaire themselves and had received treatment within the previous two months (95.3%). All respondents agreed or strongly agreed that they were treated with dignity and respect, that staff explained what they were doing, and that they were given enough information to understand the risks and benefits of their treatment. Most patients also reported positive experiences of access and flow through the service, with 97.6% finding the department easy to locate and 100% stating they were told how long they would need to wait.

Patient comments included.

> *"My cancer journey has been a joined-up delivery since the start – I am extremely happy with my care."*

> *"The staff are extremely friendly, polite and professional."*

Person-centred

Health promotion

The service actively supported patient health and wellbeing through the availability of a wide range of health promotion information. This included leaflets on physical activity and cancer, healthy eating, coping with fatigue, pelvic floor exercises, and condition-specific information supplied by organisations such as Macmillan Cancer Support, Prostate Cancer UK and Breast Cancer Now. Pregnancy and radiation posters were displayed throughout the department.

Dignified and respectful care

Patients were treated with dignity and respect throughout their time in the department. Inspectors observed staff communicating with patients using a clear, calm and respectful tone, and noted that privacy was consistently protected. The department benefits from a spacious reception and waiting area, multiple sub-waiting areas within clinical and treatment zones, consultation rooms, a quiet room and dedicated changing facilities.

Doors to clinic and treatment rooms were kept closed during use, staff knocked before entering rooms, and signage clearly indicated when changing rooms were occupied. These arrangements supported patient privacy and dignity. The environment was clean,

well maintained and fit for purpose, with seating suitable for patients with differing mobility needs, including bariatric chairs.

Individualised care

We found that care was delivered in a way that reflected individual patient circumstances. The availability of radiotherapy services locally at Nevill Hall Hospital was viewed positively, supporting patients to access treatment closer to home and reducing travel burden. Inspectors noted that the department layout supported patient independence, with changing rooms and toilet facilities located close to treatment areas to minimise unnecessary movement when patients were prepared for treatment.

We observed staff interacting with patients in a polite, compassionate and respectful manner at all times. Staff took time to explain procedures and respond to individual patient needs, supporting a calm and reassuring experience. Inspectors found that patients were treated as individuals rather than as part of a process, with staff giving patients time to ask questions and respond.

Timely

Timely care

The service demonstrated effective arrangements to support timely care. Inspectors were told that booking processes were well planned and managed, resulting in minimal waiting times for patients and alignment with treatment requirements, such as bladder preparation protocols. Where delays occurred, reception staff and radiographers informed patients promptly, supported by instant messaging systems between clinical and reception teams.

Equitable

Communication and language

Communication with patients was a strength of the service. Inspectors observed staff explaining procedures clearly and reassuring patients throughout their pathway. Information about staff roles, treatment processes and patient preparation was displayed on digital information screens, including walkthrough videos of treatment areas.

All signage within the department was bilingual. Several staff members wore Welsh language identifier lanyards, and inspectors were told that a number of staff and clinical oncologists were Welsh speakers. Translation services were available where required. However, inspectors noted that most patient information leaflets were available in English only, with limited written information available in Welsh, and that

language preference recording was not consistently mandatory.

The employer should strengthen arrangements to ensure patients' language preference is recorded as mandatory within relevant systems and documentation, and that this is completed consistently to support delivery of care in the patient's preferred language.

While most patients (76.2%) stated they would know how to complain if they wished, a smaller proportion indicated they would not, this is consistent with our findings during inspection, where the low visibility of information on how to complain. Information on providing feedback was available via interactive digital screens, tablets and paper forms on request. Inspectors noted that information on complaints procedures and advocacy services was less visible, and that feedback messages rotated quickly on screens, which may limit accessibility for some patients. This highlights an opportunity to further strengthen the visibility and accessibility of complaints information.

The employer should improve the visibility and accessibility of complaints information and advocacy support, ensuring this is clearly signposted in patient areas and available in formats that meet a range of patient needs.

Rights and equality

The environment was designed to be accessible for all patients. Inspectors observed level access throughout the unit, automatic doors, ramp access from car parks and wheelchair availability at the entrance. A dedicated patient car park located immediately next to the unit was identified as particularly positive. Translation services were available through Language Line using mobile translation equipment.

The service demonstrated a clear commitment to respecting patients' rights and promoting equality through accessible facilities, reasonable adjustments and supportive staff behaviours. Inspectors observed good access for disabled patients and arrangements to support patients with sensory or communication needs, including hearing loops and large-print information on request. Staff described reading information aloud for patients who required additional support.

However, inspectors noted a potential perception of inequity for patients who are not currently able to safely access radiotherapy treatment at this site. While this did not reflect differential treatment by staff, it highlights the importance of clear communication with patients about eligibility and access arrangements.

The employer should review and improve communication with communities about eligibility and access to treatment at the satellite site to minimise potential perceptions of inequity.

Delivery of Safe and Effective Care

Compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (as amended)[1]

We found the service demonstrated good compliance with IR(ME)R 2017, with some improvements required to ensure full compliance with the IR(ME) (Amendment) Regulations 2024. We also noted the importance of ensuring the satellite service at Nevill Hall Hospital is fully integrated within the IR(ME)R governance framework.

Employer's duties: establishment of general procedures, protocols and quality assurance programmes

Procedures and protocols

The employer had established written procedures and protocols as required under IR(ME)R 2017. The information provided within the self-assessment form was discussed with the senior management team, and opportunities to strengthen some procedures were identified throughout the inspection.
The IR(ME) (Amendment) Regulations 2024 came into effect on the 1st of October 2024 and require the employer to implement a written procedure for clinical audit (employer's procedure O). At the time of inspection, a written employer's procedure for clinical audit was not in place. The requirement for a written audit procedure had also been identified and recorded as a required action in the department's local IR(ME)R audit activity in March 2025.During inspection the department leads acknowledged the importance of expediting a written audit procedure to meet the requirements of the IR(ME) (Amendment) Regulations 2024 and shared a draft procedure, accompanied by an outline of the approval process and timeframe for ratification and implementation.

The employer must implement a written clinical audit employer's procedure in accordance with the IR(ME) (Amendment) Regulations 2024 requirements.

We reviewed all IR(ME)R 2017 documentation submitted in advance of the inspection and spoke to duty holders and senior management to confirm understanding of processes and practice. The documents provided showed a good understanding of IR(ME)R 2017. However, some ambiguous IR(ME)R terminology was identified on occasion within departmental and health board documentation, for example the role and responsibilities of the IR(ME)R employer cannot be delegated.

The employer should ensure that IR(ME)R terminology is clear and noted correctly within documentation referenced for IR(ME)R purposes.

The service had a structured approach to written employer's procedures and protocols, with documentation reviewed prior to and during the inspection found to be well

[1] As amended by the Ionising Radiation (Medical Exposure) (Amendment) Regulations 2018 and the Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024

organised. Inspectors noted version control and review arrangements, including documents displaying version numbers and review dates. Staff described how updated documentation was communicated and where current versions could be accessed. However, it was noted that Trust wide documentation, such as RTP-IMAG-6 Review of Dose Reference Levels for radiotherapy related imaging, did not accurately reflect local processes at Velindre at Nevill Hall Radiotherapy Unit.
The employer must ensure that Trust wide procedures and protocols:

- **are reflective of current practice across both sites**

- **clearly document and communicate any differences where local processes vary between sites**
- **are supported by arrangements that provide assurance that staff are using the current, approved versions in practice.**

The service described an annual programme of IR(ME)R compliance audits undertaken across the wider radiotherapy service, including an IR(ME)R Amendment Regulations 2024 audit and audits relating to patient identification, dose, and fractionation. Audit actions were described as being recorded and monitored through established governance processes. However, inspectors were not provided with sufficient evidence to demonstrate that IR(ME)R compliance audits had been undertaken at Velindre@Nevill Hall Radiotherapy Unit, or that the audit programme explicitly included the satellite site. This limited assurance of local oversight and mirrors the findings in relation to clinical audit. **The employer must ensure a planned programme of IR(ME)R compliance audits is implemented which clearly includes Velindre@Nevill Hall Radiotherapy Unit, with evidence of completion and governance oversight.**

Referral guidelines

Robust, evidence based clinical protocols have been established by the employer. The "joint protocols" shared consistently demonstrated referral guidelines, including diagnosis and staging investigations, as well as inclusion and exclusion criteria.

A detailed procedure for making, amending and cancelling referrals was shared prior to inspection. Currently the referrer or practitioner are the only individuals who may cancel a submitted referral. The department shared plans to review this process, with access to the cancellation process extended further than referrer or practitioner, to aid administrative processes. The inspection team highlighted that if current processes are updated, the department must ensure the referrer and practitioner are informed of any cancellation.
The electronic patient referral system was reviewed during inspection. Review of patient records identified that the current referral template does not include a section for the referrer to record clinical history/information.

The employer must review and strengthen the referral template to ensure the referrer records sufficient medical data, including relevant clinical history.

Dose reference levels for typical localisation or verification exposures

The IR(ME) (Amendment) Regulations 2024 require the employer to establish, review and make available to the operator, dose reference levels (DoRLs) for typical planning and verification imaging. At the time of inspection DoRLs were not in place for CT planning exposures and CBCT verification imaging at V@NHRU

The inspection found that local dose audits for radiotherapy planning and verification imaging had been undertaken since the department went live in June 2025. Staff confirmed DoRLs for standard planning and verification imaging at V@NHRU were currently under development. However, inspectors were not provided with evidence that DoRLs had been finalised, approved or implemented for routine clinical use at V@NHRU. Although national DoRLs are available, they were not found to be in place in the interim period.

A trust wide DoRL procedure was shared prior to inspection. It was identified during a tour of the department and following discussion with staff, that the procedure did not reflect the department at V@NHRU, for example, inspectors found that CT planning DoRLs were not displayed within the CT planning area. Discussion with staff across disciplines also identified a lack of understanding and awareness regarding DoRLs.

The employer must ensure that Dose Reference Levels for typical CT planning exposures and CBCT verification imaging:

- **are finalised, formally approved and implemented in accordance with local procedure**
- **have clear visibility and accessibility at the point of use**
- **are supported by appropriate staff training to ensure awareness and effective application in clinical practice**
- **are underpinned by ongoing audit and governance arrangements to provide assurance that optimisation requirements under IR(ME)R 2017 (as amended) are being met.**

Medical research

The service stated that Velindre at Nevill Hall Radiotherapy Unit does not currently offer enrolment in clinical trials at Nevill Hall, but that the wider radiotherapy service participates in radiotherapy clinical trials, with patients able to enrol at the main Velindre Cancer Centre in Cardiff.

Entitlement

Entitlement documentation, including corresponding scopes of practice, were reviewed for each duty holder on site. Training and competency records reviewed during the inspection were comprehensive for radiographers and radiotherapy physics staff, providing assurance that these groups were appropriately trained and competent for their roles. Clinical Oncology training and entitlement records were also viewed on site. Entitlement records detail the corresponding scope of practice for referrer and

practitioner IR(ME)R duty holder roles only. Detail pertaining to the operator role and corresponding scope of practice was not recorded. Evidence of training and assessment of competency for operator tasks also needs to be strengthened. It was positive to note work has already begun drafting operator competency records, but these must be implemented for the range of operator tasks required.
The employer must review training and entitlement arrangements for medical staff, to ensure appropriate training, assessment of competency and entitlement is recorded for all tasks undertaken in the operator role.

Patient identification

The service had processes in place for patient identification using full name, address and date of birth, with identification recorded within the system for planning and treatment exposures. Staff on site confirmed each operator independently completes the task of identification, utilising separate primary source information. Both operators independently carry out the task of identification and are responsible for the task they undertake. The documented employer's procedure related to patient identification did not clearly define roles and responsibilities reflective of the clinical practice described.
The employer should review and clarify their Patient Identification Procedure to ensure it clearly defines roles and responsibilities and accurately reflects clinical practice at Velindre@Nevill Hall Radiotherapy Unit.

Individuals of childbearing potential (pregnancy enquiries)

The service described a clear process for establishing pregnancy status in line with IR(ME)R requirements. Pregnancy enquiries are undertaken for all individuals aged 12–55 years, with risks and benefits discussed during consent and documented accordingly. Pregnancy status is re-checked prior to planning CT and first treatment exposures, with completion recorded within the oncology management system. During the inspection, it was confirmed that the operator is ultimately responsible for ensuring pregnancy checks are completed and recorded. Information to support patient awareness is provided during consent and education encounters, with pregnancy and radiation posters displayed within patient areas.

Benefits and risks

The service described that benefits and risks of exposures were discussed at multiple points during the consent and treatment process, during consent this was supported by standardised documentation and confirmation during pre-treatment education. Although the task of communicating benefits and risks is completed and recorded, currently there is not a local procedure describing all methods by which this information is appropriately communicated, how additional support may be accessed when required, or the provision of adequate training in accordance with IR(ME)R Schedule 3 to support this task.
The employer must ensure a documented procedure (employer's procedure l) is in place that clearly describes how benefits and risks are communicated, including

who provides the information, when this occurs, where this is documented and how staff are trained.

Clinical evaluation

The service had a documented employer's procedure in place relating to clinical evaluation, which was reviewed as part of the inspection. Staff were able to describe how clinical evaluation is undertaken across the radiotherapy pathway, including planning, verification and treatment exposures, and how this forms part of routine clinical decision-making. Clinical oncologists described their role in reviewing imaging, treatment delivery and patient progress, with opportunities for review and escalation where concerns were identified.

However, inspectors identified limitations in the clarity and completeness of the documented arrangements for clinical evaluation. While the procedure provided an overarching framework, it did not consistently or clearly describe:

- how clinical evaluation is undertaken for each type of exposure (including planning CT, verification imaging and treatment exposures).
- who is responsible for carrying out clinical evaluation at each stage of the pathway; and
- where and how clinical evaluation is recorded, including within electronic systems.

During staff discussions, a range of responses were provided regarding the timing, responsibility and recording of clinical evaluation, indicating a reliance on professional practice rather than a consistently applied, clearly documented process. This limited assurance that all staff have a shared understanding of their roles and responsibilities under IR(ME)R, and that clinical evaluation is undertaken and recorded in a consistent and auditable manner.

The employer must ensure that the procedure for clinical evaluation is reviewed and strengthened to clearly outline the process for clinical evaluation for each type of exposure, including planning, verification and treatment. This detail should include how clinical evaluation is carried out, where it is recorded and who is carrying out the task. The documented process must subsequently be audited to assess staff understanding and compliance.

Non-medical imaging exposures

The employer's IR(ME)R documentation clearly stated non-medical imaging exposures are not carried out in the radiotherapy department.

Employer's duties - clinical audit

Inspectors identified limitations in the arrangements for clinical audit. At the time of inspection, a written employer's procedure for clinical audit was not in place (other than in draft). The service was unable to provide evidence of a planned programme of clinical audit activity that clearly included Velindre@Nevill Hall Radiotherapy Unit, and no site-specific audit schedule or completed audit examples were available for review. While plans to develop local clinical audit activity were described, these had not yet been implemented, limiting assurance that clinical audit was being used to evaluate and improve practice at the satellite site.

The employer must develop, implement and maintain a planned, multidisciplinary programme of clinical audit that covers the full range of relevant radiotherapy exposures and associated processes across both sites, including Velindre@Nevill Hall Radiotherapy Unit. The programme should specify audit priorities, frequency, sampling, responsible leads and reporting routes, and should demonstrate that findings, learning and actions are reviewed through established governance arrangements.

Employer's duties - accidental or unintended exposures

The service demonstrated a structured approach to managing the risk of accidental or unintended exposures across the radiotherapy pathway. Inspectors reviewed documentation and discussed arrangements with staff, which showed that processes were in place to identify, report and investigate incidents and near misses. Staff were able to describe escalation routes and the use of established reporting systems, with incidents and learning considered through relevant governance and risk management forums.

Inspectors found that the service had undertaken a documented assessment of risk covering the radiotherapy pathway, supported by incident reporting arrangements and the use of recognised taxonomy to support learning and trend analysis. This provided assurance that risks associated with radiotherapeutic practice were being actively considered and reviewed. Inspectors also noted evidence of governance oversight where risks were identified, including escalation to the risk register where appropriate. However, inspectors were not fully assured that arrangements for the management of accidental or unintended exposures were sufficiently clear and consistently documented. While elements of prevention, reporting, investigation and learning were described, these arrangements were spread across multiple documents and processes, rather than being clearly set out within a single, consolidated employer's procedure. This limited assurance that arrangements are applied consistently and are fully understood across all staff groups.

Inspectors also identified that some documentation lacked sufficient clarity regarding the management of clinically significant accidental or unintended exposures, including thresholds for escalation and the recording and monitoring of resulting actions. In

addition, where equipment-related issues had been identified, further clarity was required to demonstrate how learning and risk actions were systematically captured and embedded within governance processes.

The employer must

- **develop a documented overview (employer's procedure K) that clearly describes how the probability and magnitude of accidental or unintended exposures are reduced across the radiotherapy pathway**
- **review and strengthen process related to the identification and management of clinically significant accidental or unintended exposures**
- **ensure that risk actions associated with a recurring equipment malfunction affecting CBCT acquisition are clearly documented, including escalation to and monitoring through the risk register, to provide assurance that risks are effectively managed.**

Duties of practitioner, operator and referrer

Staff demonstrated awareness of their IR(ME)R roles, supported by competency documentation and defined scopes of practice.

Justification of individual exposures

The service described the justification and authorisation processes for each exposure performed at the radiotherapy planning, verification, and treatment stages of the patient's care pathway. During discussion, the senior management team (SMT) explained the local process for justifying and authorising additional planning scans via the 'CT IR(ME)R Authorisation' Physician Orders in ARIA, the corresponding joint protocols shared were discussed, and the SMT acknowledged the detail pertaining to IR(ME)R roles and responsibilities around this process were ambiguous. Subsequent discussion with staff indicated multiple processes for justification and authorisation of additional planning scans dependent on the exposure type, including the use of Authorisation Guidelines. The process for justification and authorisation of additional planning exposures should be reviewed and strengthened to ensure each type of additional exposure is considered, clearly described in local documentation and cascaded to all relevant staff.

The employer must review, clarify and strengthen the documented process for justification and authorisation of additional planning scans to ensure that it:

- **clearly describes the process for additional planning scans outside protocol**
- **defines roles, responsibilities and reflects clinical practice at the satellite site**
- **is supported by appropriate staff training**
- **is subject to a compliance audit to provide assurance of consistent implementation.**

Optimisation

The service described optimisation processes through the Joint Image Optimisation Procedure, including strategies to ensure imaging doses are as low as reasonably practicable (ALARP). This included the requirement for Medical Physics Expert involvement in optimisation of paediatric imaging exposures and for individuals who may be pregnant.

The service also described that radiotherapy treatment plans are individually optimised, including delineation of target volumes and organs at risk to minimise dose to surrounding tissues, with the level of optimisation depending on clinical site and treatment category.

Paediatrics

The service described paediatric optimisation being addressed through documentation including explicit requirement for MPE involvement in paediatric imaging optimisation. At the time of inspection, paediatric patients were not being treated at Velindre @ Nevill Hall Hospital.

Carers or comforters

The self-assessment form and all staff conversations stated that exposures to carers and comforters are not justified for external beam radiotherapy planning and treatment, and that carers and comforters are not allowed to remain with patients during any medical exposures.

Expert advice

The service described significant Medical Physics Expert (MPE) involvement in radiotherapeutic practice, including involvement in new techniques and service developments, protocol establishment and review, and peer review of deviations from protocol.
Staff discussions also indicated that MPEs were accessible for advice when required.

Equipment: general duties of the employer

The service described a structured equipment quality assurance programme, supported by documented QA/QC procedures and schedules (including machine QA schedules and commissioning/decommissioning processes). The service also described maintenance contracts, trend monitoring and mechanisms for reporting faults and removing equipment from clinical use if it cannot be made safe.
Throughout the process inspectors noted a safe and systematic approach to implementing new technologies and techniques, including a contingency approach relating to cross-site CT planning capability.
During the inspection we reviewed the hardware equipment inventory and found this did not include equipment serial numbers, as required by IR(ME)R.

The employer must review and update the hardware equipment inventory to ensure equipment model numbers are included (Reg 15(2)).

Safe

Managing risk and health and safety

We found that the service had governance arrangements in place to identify, manage and escalate risks associated with the delivery of radiotherapy, including those arising from the operation of the satellite service at Nevill Hall Hospital. Risks were considered across the radiotherapy pathway, providing a structured approach to oversight and assurance.

Arrangements were in place for the reporting, investigation and review of radiotherapy-related incidents and near misses through the Once for Wales Datix system. Information from incidents was reviewed through established governance structures, supporting organisational oversight and learning. Staff were able to describe escalation routes and how learning from incidents was shared locally

We found that risks associated with equipment and technology were actively monitored and managed, supported by routine quality assurance activity and clear escalation processes when faults or safety concerns were identified. Where equipment-related issues occurred, these were investigated and actions taken to reduce the likelihood of recurrence.

However, we identified that not all aspects of the risk management framework were fully supported by consolidated written procedures, particularly where processes were described across multiple documents rather than within a single overarching framework. The service recognised this and had identified further work to strengthen documentation and improve clarity and consistency across sites.

Inspectors also found that changes to practice, including the introduction of new technologies and techniques, were implemented in a controlled way. Where changes were being introduced, these were trialled on a limited basis prior to wider implementation, supporting risk management during service development.

The new building presented some challenges for staff and managers, and a structured estates rectification process was in place to address identified issues. The associated risks were being actively managed and mitigated to minimise any potential risk to patients.

Infection prevention and control (IPC) and decontamination

Evidence relating to IPC practices was primarily obtained through observation of the environment and feedback from patients, rather than detailed review of IPC policies or audits within the IR(ME)R inspection scope. As such, no significant risks were identified

in this area, and IPC did not form a focus of improvement actions arising from this inspection.

Safeguarding children and safeguarding vulnerable Adults

Staff we spoke with during the inspection were able to describe how concerns would be escalated appropriately, demonstrating awareness of their responsibilities should safeguarding issues arise. Escalation routes were understood to align with Trust-wide safeguarding arrangements, rather than service-specific processes.

Safeguarding training formed part of the Trust's mandatory training requirements, with compliance monitored through established governance and assurance arrangements. Inspectors found good overall compliance with mandatory training across staff groups, providing assurance that safeguarding training requirements were being overseen at organisational level.

Safeguarding policies and procedures were managed at Trust level, providing a consistent framework to support staff working within the radiotherapy service.

Effective

Patient records

We found that patient identification and documentation processes were clearly defined and consistently applied. Patients were positively identified using multiple identifiers prior to planning and treatment exposures, with checks undertaken by two operators in line with local procedures. These checks were recorded electronically within the ARIA system.

Clinical information, including patient identification, pregnancy status where relevant, and details of exposures, was recorded contemporaneously within electronic systems, supporting continuity of care and auditability. Staff were able to describe clearly where and how records were completed and accessed.

Efficient

Efficient

We found that the service demonstrated efficient use of resources and systems to support timely and effective delivery of radiotherapy, including close integration with the main Velindre Cancer Centre. Shared systems and interoperable equipment supported flexibility in planning and service continuity across sites.

Staff described clear workflows, competency-based role allocation and good access to medical physics expertise, enabling issues to be resolved promptly and supporting efficient decision-making. Training and entitlement records were comprehensive, contributing to safe delegation and efficient working practices.

Quality of Management and Leadership

Staff Feedback

Overall, staff feedback was largely positive, with survey responses indicating strong confidence in the care provided and pride in the service. Most staff (87.5%) agreed or strongly agreed that they would be happy with the standard of care provided by the organisation for themselves or their friends and family, and 87.5% reported feeling supported by their immediate manager. Staff consistently described a positive working environment. Staff comments included

> *"V@NHRU is a lovely, calm environment to work in and a delightful setting… There is a sense of staff wanting to do their best for patients,"*
>
> *"Areas of strong collaboration and teamwork across the sites."*

However, feedback also highlighted areas for improvement. While 79.2% of staff agreed that senior managers are visible, a smaller proportion (58.3%) agreed that communication between senior management and staff is effective. Some staff shared concerns around working within a large physical department with lower numbers of staff around. This is despite the management team's ongoing efforts to engage with staff through regular meetings and forums. These figures suggest that there may be value in reviewing communication processes to ensure that staff receive clear feedback on actions taken in response to their concerns.

The employer should strengthen communication between senior management and staff through regular, structured engagement and clear feedback on actions taken in response to staff concerns.

Leadership

Governance and leadership

Staff reported that leaders and managers were visible and accessible, and that they felt encouraged to raise concerns and contribute to service improvement. Engagement with the inspection process was viewed positively, and staff described an open and learning-focused culture, supported by regular meetings, huddles and opportunities for discussion.

Workforce

Skilled and enabled workforce

Training, competency and professional support were identified as strengths by staff, particularly among radiographers and Medical Physics Experts. Staff described clear role expectations, access to expertise when required, and good induction and mentorship arrangements, which supported confidence in their day-to-day practice.

Staff feedback also reflected the significant period of change and development associated with establishing and embedding the satellite service. Some staff described feeling isolated at times, particularly within a growing service operating across multiple sites. Senior leaders acknowledged this feedback and recognised the importance of ongoing monitoring of staff wellbeing and support, particularly as the service continues to evolve.

The employer should strengthen workforce support arrangements to ensure that managers and staff working at Velindre @ Nevill Hall Radiotherapy Unit are appropriately supported, including in relation to wellbeing and workload, during an extensive period of change.

Overall, staff feedback provided assurance that the service benefits from a committed, skilled and engaged workforce, with leadership demonstrating awareness of the challenges associated with service expansion and a willingness to respond to staff feedback.
Across staff questionnaires, interviews, and leadership sections, common themes include:

- Generally strong training and competency arrangements (especially radiographers and MPEs)
- Clear understanding of IR(ME)R roles among most staff
- Positive MDT working and visible leadership engagement
- Flexibility to ensure appropriate cover.

At the same time, there is a repeated caution about:

- Monitoring staff wellbeing during a period of significant service change
- Addressing feelings of isolation among some staff at the satellite unit.

Culture

People engagement, feedback and learning

Inspectors were informed that patient feedback was collected through electronic feedback systems within the department. Feedback reviewed during the inspection was consistently positive, and staff reported that comments from patients were shared with teams to reinforce good practice.

While mechanisms were in place to capture and respond to feedback, inspectors noted that opportunities remain to strengthen how positive feedback is visibly communicated. Increasing the prominence of favourable patient comments and examples of good practice would further support staff engagement and recognition.

Staff also described regular team meetings and site-based huddles, which provided a forum to share information, reflect on incidents and promote consistent approaches to

care delivery. Inspectors found these arrangements supported communication and collective learning within the service.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to act, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were resolved during inspection			

Appendix B – Immediate improvement plan

Service: **Velindre@Nevill Hall Radiotherapy Unit**

Date of inspection: **20 and 21 April 2026**

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate non-compliance issues				
Findings:					

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role: **Date:**

Appendix C – Improvement plan

Service: **Velindre@Nevill Hall Radiotherapy Unit**

Date of inspection: **21 and 22 April 2026**

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Patients' language preference was not consistently recorded as mandatory within relevant systems and documentation.	The employer should strengthen arrangements to ensure patients' language preference is recorded as mandatory within relevant systems and documentation, and that this is completed consistently to support delivery of care in the patient's preferred language.	Health and Care Quality Standard – Equitable / communication and language	1. All Radiotherapy Request forms in Aria to be updated to ensure the recording of patients' language preference is a mandatory requirement 2. Update will need to be undertaken out of clinical hours (weekend) in line with Varian upgrades scheduled 05/06/26 – 09/09/2026	Helen Payne/ Catherine Pembroke	Due Date 01/08/2026

2.	Complaints information and advocacy support were less visible and may not have been accessible to all patients.	The employer should improve the visibility and accessibility of complaints information and advocacy support, ensuring this is clearly signposted in patient areas and available in formats that meet a range of patient needs.	Health and Care Quality Standard – Equitable / communication and language	1. Timing of bilingual complaints and advocacy support information extended from 10 seconds to 20 seconds and frequency increased on electronic displays 2. Hard copy posters and leaflets for bilingual complaints and advocacy support information to be placed in all waiting areas (in addition to the bilingual leaflets available)	Helen Payne	Completed 11/06/2026 Due Date 01/08/2026

3.	There was a potential perception of inequity for patients who are not currently able to safely access treatment at the satellite site.	The employer should review and improve communication with communities about eligibility and access to treatment at the satellite site to minimise potential perceptions of inequity.	Health and Care Quality Standard – Rights and equality	1. All Radiotherapy Referrers/ Practitioners to be reminded to inform all patients that treatment will be offered at V@NHRU or VCC dependent on the earliest available and clinically appropriate appointment 2. Radiotherapy treatments offered at VCS including VCC and V@NHRU to be added/ updated to Web pages 3. Revised communication to Local Health boards via Llais to be delivered informing of the radiotherapy service offered at VCS which includes V@NHRU and VCC 4. Extension of radiotherapy treatments offered at V@NHRU proposed to VCS	Helen Payne	Due Date 01/09/2026

4.	A written employer's procedure for clinical audit was not in place at the time of inspection.	The employer must implement a written clinical audit employer's procedure in accordance with the IR(ME) (Amendment) Regulations 2024 requirements.	IR(ME) (Amendment) Regulations 2024; employer's procedure O	1. Develop clinical audit procedure – undertaken via Radiotherapy MDT engagement and approval 2. Issue Radiotherapy / Radiotherapy Physics Clinical audit procedure – reporting to Radiation Protection Medical Exposures Operational Group	Helen Payne/ Thomas Rackley/ Samantha Warren	Completed and submitted to HIW 22/05/26 Completed and submitted to HIW 22/05/26

5.	Some documentation used ambiguous or incorrect IR(ME)R terminology.	The employer should ensure that IR(ME)R terminology is clear and noted correctly within documentation referenced for IR(ME)R purposes.	IR(ME)R 2017	1. QS 19 Radiation Safety Policy revision in advance of RPMEOG (23/7/26) 5.1-to be corrected to Chief Executive Appendix 11 - to be corrected to Chief Executive 2. Correction of delegation authority of entitlement to delegation of task 3. Policy to be updated to include reference to Dose reference levels 4. All IR(ME)R operators to demonstrate completion of e IR(ME)R module 5 5. Audit to be undertaken on QS19 to be reported back to RPMEOG	Tony Millin	Due Date 01/10/2026 Due Date 01/10/2026 Due Date 01/10/2026 Due Date 01/06/2027 Due Date 01/12/2026

6.	Trust wide procedures and protocols did not always reflect current practice across both sites or clearly describe local variation.	The employer must ensure that Trust wide procedures and protocols are reflective of current practice across both sites, clearly document and communicate any differences where local processes vary between sites, and are supported by arrangements that provide assurance that staff are using the current, approved versions in practice.	IR(ME)R 2017 – Employer's duties: establishment of general procedures, protocols and quality assurance programmes	1. Update all joint protocols to include reference to V@NHRU 2. As documents are transferred to IDEAGEN in line with planned programme of work the scope of all documents will be updated to reflect all VCS locations where EBRT is delivered	Helen Payne	Due Date 01/07/2027

7.	Inspectors were not provided with sufficient evidence to demonstrate that IR(ME)R compliance audits had been undertaken at Velindre at Nevill Hall Radiotherapy Unit or that the audit programme explicitly included the satellite site.	The employer must ensure a planned programme of IR(ME)R compliance audits is implemented which clearly includes Velindre at Nevill Hall Hospital, with evidence of completion and governance oversight.	IR(ME)R 2017 (as amended)	Review of Audit forms and schedule undertaken Audit forms updated to reference location of audit and type, locations now reflect VCC and V@NHRU, and type of audit includes compliance, regulatory, clinical, other - Audit schedule updated to reference location and type of audit All Audit results, corrective actions and improvements reported to staff and presented to management review	Helen Payne Samantha Warren	<u>Radiotherapy</u> Completed and issued for use 22/05/2026 <u>Radiotherapy Physics</u> Due 01/08/2026

8.	The current referral template did not include a section for the referrer to record sufficient medical data, including relevant clinical history.	The employer must review and strengthen the referral template to ensure the referrer records sufficient medical data, including relevant clinical history.	IR(ME)R 2017 – referral information	1. Review of current process for raising a radiotherapy request, identify most appropriate method for ensuring sufficient medical data / relevant clinical history is included 2. Review supporting procedures to ensure compliance with IR(ME)R and RCR guidelines. 3. Any improvements identified to be communicated to, and training offered to all staff groups 4. Referral to treatment is included in radiotherapy routine Audit schedule -	Catherine Pembroke/ Helen Payne	Due Date 01/09/2026 Due Date 01/10/2026 Due Date 01/12/2026 Due Date 01/04/2027

9.	Dose Reference Levels for typical CT planning exposures and CBCT verification imaging were not in place at the time of inspection and were not clearly visible at the point of use.	The employer must ensure that Dose Reference Levels for typical CT planning exposures and CBCT verification imaging are finalised, formally approved and implemented in accordance with local procedure, have clear visibility and accessibility at the point of use, are supported by appropriate staff training to ensure awareness and effective application in clinical practice, and are underpinned by ongoing audit and governance arrangements to provide assurance that optimisation requirements under IR(ME)R 2017 (as amended) are being met.	IR(ME)R 2017 (as amended); IR(ME) (Amendment) Regulations 2024	1. DRLs to be displayed in the control room 2. MPE to provide training to relevant staff groups on use of DRLs 3. RTP-IMG-6 defines ongoing audit, and we are currently up to date.	Samantha Warren	1. Due Date 30/06/2026 2. Due Date 30/09/2026 3. Complete and issued 14/11/2025

10.	Entitlement records for medical staff did not record operator role detail and evidence of training and assessment of competency for operator tasks needed to be strengthened.	The employer must review training and entitlement arrangements for medical staff, to ensure appropriate training, assessment of competency and entitlement is recorded for all tasks undertaken in the operator role.	IR(ME)R 2017 – entitlement and training	1. Review and update current entitlement documentation to ensure they reflect operator tasks. 2. Review and update appropriate training, assessment of competency for all tasks undertaken as an operator. 3. Review medical staff entitlement records and update to ensure they record operator role detail with evidence of training and assessment of competency	Catherine Pembroke/ Claire Davies/ Maeve Williams Catherine Pembroke	1. Due date 31/12/2026 2. Due Date 31/05/2027 3. Due Date 31/05/2027

11.	The documented Patient Identification Procedure did not clearly define roles and responsibilities reflective of clinical practice at Velindre at Nevill Hall Hospital.	The employer should review and clarify their Patient Identification Procedure to ensure it clearly defines roles and responsibilities and accurately reflects clinical practice at Velindre at Nevill Hall Hospital.	IR(ME)R 2017 – patient identification	Review QPWI 60 Patient Identification to ensure it clearly defines roles and responsibilities and accurately reflects clinical practice – Process in OP setting. – Process at planning CT. – Process at Treatment Delivery. – Process at on-Treatment Review	Helen Payne /Catherine Pembroke	Due Date 30/09/2026
12.	There was not a documented local procedure fully describing how benefits and risks are communicated, including who provides the information, where it is recorded and how staff are trained.	The employer must ensure a documented procedure (employer's procedure I) is in place that clearly describes how benefits and risks are communicated, including who provides the information, when this occurs, where this is documented and how staff are trained.	IR(ME)R 2017; Schedule 3; employer's procedure I	Develop an employer's procedure that clearly describes how benefits and risks are communicated, including who provides the information, when this occurs, where this is documented and how staff are trained.	Catherine Pembroke/ Helen Payne	Due Date 31/12/2026

13.	The documented procedure for clinical evaluation did not clearly describe how clinical evaluation is undertaken for each type of exposure, who is responsible, or where and how it is recorded.	The employer must ensure that the procedure for clinical evaluation is reviewed and strengthened to clearly outline the process for clinical evaluation for each type of exposure, including planning, verification and treatment. This detail should include how clinical evaluation is carried out, where it is recorded and who is carrying out the task. The documented process must subsequently be audited to assess staff understanding and compliance.	IR(ME)R 2017 – clinical evaluation	1. Review of issued document to clearly describe how clinical evaluation is undertaken for each type of exposure and who is responsible and where it is recorded. 2. Update to document template and /questionnaire in ARIA to clearly identify that clinical evaluation has taken place and by whom. 3. Clinical evaluation added to Radiotherapy audit schedule for November 2026	Helen Payne / Samantha Warren/ Catherine Pembroke	Due Date 31/12/2026

14.	The service was unable to provide evidence of a planned, multidisciplinary programme of clinical audit activity that clearly included Velindre at Neville Hall Hospital.	The employer must develop, implement and maintain a planned, multidisciplinary programme of clinical audit that covers the full range of relevant radiotherapy exposures and associated processes across both sites, including Velindre at Neville Hall Hospital. The programme should specify audit priorities, frequency, sampling, responsible leads and reporting routes, and should demonstrate that findings, learning and actions are reviewed through established governance arrangements.	IR(ME)R 2017 (as amended); IR(ME) (Amendment) Regulations 2024	1. Develop clinical audit Schedule – undertaken via Radiotherapy MDT engagement and approval 2. Issue Clinical audit Schedule – reporting to Radiation Protection Medical Exposures Operational Group and informing Trust Clinical Audit Plan	Helen Payne	Completed and submitted to HIW 22/05/26 Completed and submitted to HIW 22/05/26
15.	Arrangements for the management of accidental or unintended exposures were spread across multiple documents and were not clearly set out within a single, consolidated employer's procedure.	The employer must develop a documented overview (employer's procedure K) that clearly describes how the probability and magnitude of accidental or unintended exposures are reduced across the radiotherapy pathway.	IR(ME)R 2017 – accidental or unintended exposures; employer's procedure K	Produce an employer's procedure to meet requirements of Schedule 2 (k).	Helen Payne	Due Date 31/03/2027

16.	Some documentation lacked sufficient clarity regarding the identification and management of clinically significant accidental or unintended exposures.	The employer must review and strengthen process related to the identification and management of clinically significant accidental or unintended exposures.	IR(ME)R 2017 – accidental or unintended exposures	Review and update QPWI 07 to ensure that, - it is clearly documented who is responsible for establishing if a SAUE is clinically significantly. - it is clear where assessment of clinically significant accidental or unintended exposures are documented.	Samantha Warren	Due Date 31/12/2026
17.	Risk actions associated with a recurring equipment malfunction affecting CBCT acquisition were not clearly documented, including escalation to and monitoring through the risk register.	The employer must ensure that risk actions associated with a recurring equipment malfunction affecting CBCT acquisition are clearly documented, including escalation to and monitoring through the risk register, to provide assurance that risks are effectively managed.	IR(ME)R 2017 – accidental or unintended exposures / risk governance	Xi recurring equipment malfunction added to Risk Register	Samantha Warren	Completed 10/06/2026 – Risk register updated.

18.	The process for justification and authorisation of additional planning scans was ambiguous and not clearly described in local documentation for each type of additional exposure.	The employer must review, clarify and strengthen the documented process for justification and authorisation of additional planning scans to ensure that it clearly describes the process for additional planning scans outside protocol, defines roles, responsibilities and reflects clinical practice at the satellite site, is supported by appropriate staff training, and is subject to a compliance audit to provide assurance of consistent implementation.	IR(ME)R 2017 – justification of individual exposures	1. Review and update Joint Clinical Protocols to ensure the process for justification and authorisation of additional planning scans is clearly described. 2. Update document template and /questionnaire in ARIA to align with process for justification and authorisation of additional planning scans. 3. Review and update IR(ME)R appendices to align with process for justification and authorisation of additional planning scans. 4. Staff training update 5. Add next scheduled audit	Helen Payne / Samantha Warren/ Catherine Pembroke	1. Due Date 31/08/2026 2. Due Date 31/08/2026 3. Due Date 31/08/2026 4. Due Date 31/08/2026 5. Due date 30/11/2026

19.	The hardware equipment inventory did not include equipment model numbers.	The employer must review and update the hardware equipment inventory to ensure equipment model numbers are included (Reg 15(2)).	IR(ME)R 2017 Reg 15(2)	1. Add column to inventory for model numbers 2. Obtain model number for manufacturers	Samatha Warren	1. Due Date 30/06/2026 2. Due Date 31/10/2026 (Elekta updated waiting for information from Varian, Siemens to be added)

20.	Communication between senior management and staff was not consistently effective, and staff wanted clearer feedback on actions taken in response to concerns.	The employer should strengthen communication between senior management and staff through regular, structured engagement and clear feedback on actions taken in response to staff concerns.	Health and Care Quality Standard – Leadership / staff engagement	1. Develop V@NHRU staff survey to identify areas for improvement in relation to effectiveness of communication, clarity of feedback and action undertaken in response to concerns 2. Review survey and disseminate results 3. Develop improvement plan in collaboration with staff to ensure method, frequency and clarity of communication is actioned 4. Repeat Radiotherapy Staff survey on an annual basis	Helen Payne / Samantha Warren / Catherine Pembroke	1. Due Date 01/09/2026 2. Due Date 01/10/2026 3. Due Date 01/12/2026 4. Due Date 01/09/2027

21.	Some staff described feeling isolated during a significant period of change and development associated with the satellite service.	The employer should strengthen workforce support arrangements to ensure that managers and staff working at Velindre @ Nevill Hall Hospital are appropriately supported, including in relation to wellbeing and workload, during an extensive period of change.	Health and Care Quality Standard – Workforce / leadership	1. Ensure V@NHRU representative are invited to all change programmes 2. Review all V@NHRU staff job plans to ensure alignment with operational hours to reduce the risk of isolation. Review Work From Home (WFH) and staff rotas to reduce risk of isolation 3. Review and implement improved signposting of established staff support services	Helen Payne/ Samantha Warren/ Catherine Pembroke	1. Due Date 01/07/2026 2. Due Date 31/03/2027 3. Due Date 01/08/2026

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role: **Date:**