Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

First Floor Ward, Velindre Cancer Centre, Cardiff, Velindre NHS Trust

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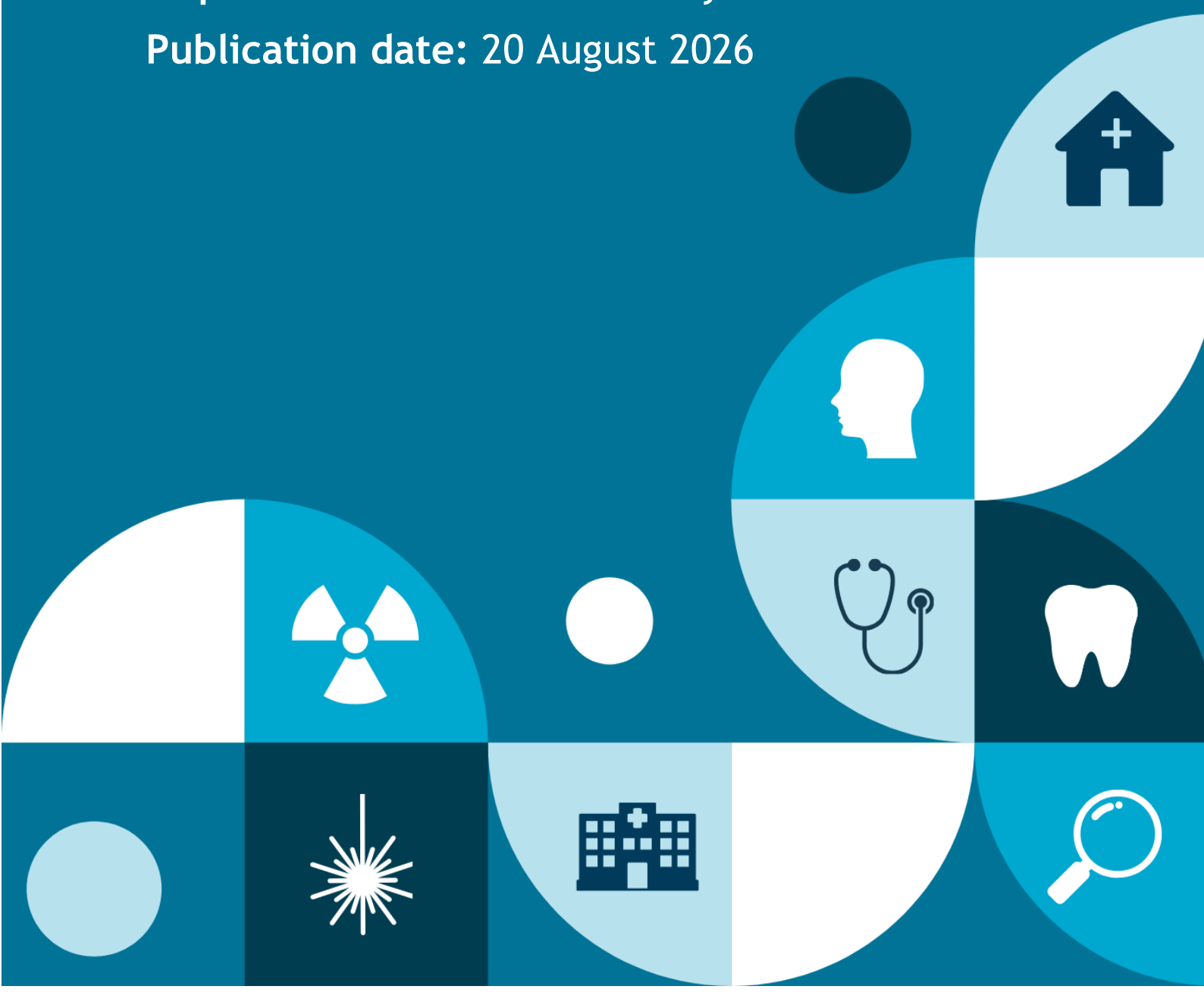

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

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 unannounced inspection of the First Floor Ward, Velindre Cancer Centre Cardiff, Velindre NHS Trust on 19 and 20 May 2026.

Our inspection team comprised two HIW healthcare inspectors, two clinical peer reviewers and a patient experience reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 17 questionnaires were completed by patients or their carers and 13 were completed by staff. Feedback and some of the comments we received appear throughout the report.

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, patients reported a positive experience of care on the first floor ward. Feedback gathered during the inspection and through the HIW patient survey indicated that patients felt safe, well looked after and supported by staff. Patients consistently described staff as kind, caring, approachable and responsive, and we observed compassionate interactions between staff and patients. Survey responses relating to the overall experience of care were highly positive, and although responses about waiting times were slightly lower than other areas, they remained positive overall.

We found care was generally delivered in a person-centred and respectful way. Patients said they were involved in decisions about their care, and staff listened to them and supported them to maintain independence. Families and carers were encouraged to be involved in care, contributing to a holistic approach.

The ward environment was generally clean, well maintained, accessible and easy to navigate, and the availability of equipment such as hoists and mobility aids helped support patients with physical needs. Staff had also completed relevant mandatory training, including equality, diversity and inclusion, mental capacity and deprivation of liberty safeguarding.

However, some areas required improvement. While systems were in place to capture patient feedback, including information from Llais and open communication with staff, feedback mechanisms were not always sufficiently visible or actively used. Patients appeared less likely to raise concerns formally, which meant the service needed to strengthen how it captured, tracked and acted on informal or incidental feedback. Health promotion information was available in some areas, but patient-facing information was not always clearly accessible, tailored to different needs, bilingual or available in suitable formats.

There were also inconsistencies in how individual needs were identified, recorded and responded to. Although staff demonstrated an understanding of patients' preferences, the service did not always clearly show how patients with additional or complex needs were identified and how this information informed care planning.

This is what we recommend the service can improve:

- Ensure patients have clear and accessible information on how to raise concerns and improve the visibility and use of feedback mechanisms
- Strengthen systems to consistently identify and meet patients' individual needs, including those requiring additional support

- Improve the accessibility and availability of patient information, including information tailored to different needs
- Ensure patients receive clear, consistent and coordinated information about their care.

This is what the service did well:

- Provided compassionate, kind and respectful care, with patients reporting positive experiences and feeling safe and well supported
- Supported person-centred care, including involving patients in decisions and encouraging family and carer participation.

Delivery of Safe and Effective Care

Overall summary:

We found that the ward generally provided safe and effective care, with a number of systems and processes in place to support patient safety and quality of care. The environment was generally clean, accessible and suitably equipped, and staff demonstrated good knowledge of key areas of practice. Infection prevention and control arrangements were largely effective, with good hand hygiene practice, accessible PPE, visible cleanliness and strong audit compliance. Safeguarding arrangements were appropriate, and good staff compliance with safeguarding, mental capacity and Deprivation of Liberty Safeguards training.

There was positive evidence in relation to medicines management, blood management, pressure ulcer prevention, and nutrition and hydration. Multidisciplinary working was established, with regular meetings, documented discussions and access to specialist services including palliative care and bereavement support.

However, we identified several areas where improvement was required to strengthen safety and assurance. Bed rails had been used without documented individual risk assessments, although the service told us this was addressed immediately during the inspection. Some environmental maintenance issues required attention from an infection prevention and control perspective, and improvements were needed to ensure hand hygiene products were optimally placed, reusable equipment was clearly identified as clean, and cleaning materials were stored securely. We also found that some equipment safety checks were overdue, and there was no reliable system to identify, track and monitor equipment requiring servicing. Risks were also identified in relation to chemotherapy administration systems, as the system in use was not fully closed.

Some patients did not have appropriate identification or allergy wristbands, oxygen was not routinely prescribed when administered, and the medicines fridge was not locked, although a replacement was undergoing calibration prior to use. The fridge was, however located in a secure treatment room. There was limited evidence that falls risk assessments and ongoing monitoring were consistently completed and documented. Patients did not always receive comprehensive discharge safety-netting information, and there was no consistent visual system to identify patients who needed support with eating and drinking.

Overall, while there was positive evidence to support safe and effective care, the Trust needed to strengthen governance, documentation, equipment oversight, medicines safety and care coordination to ensure consistent and reliable patient safety processes.

Immediate assurances:

During the inspection, we identified an immediate patient safety concern relating to the management, organisation and availability of patient records. This issue was escalated during the inspection, and the Trust provided some assurance that prompt action had been taken to address the risks identified. Further details of the concern and the actions taken by the service are set out in Appendix B.

This is what we recommend the service can improve:

- Strengthen systems for the servicing, maintenance and tracking of medical devices and equipment
- Ensure medicines are managed safely, including secure storage and consistent monitoring of medicines storage
- Improve the consistency of key care processes, including discharge planning, falls risk assessment and monitoring, and the provision of discharge safety-netting information
- Ensure systems are in place to identify and support patients requiring assistance with nutrition and hydration.

This is what the service did well:

- Maintained a clean, accessible environment with appropriate equipment and good infection prevention and control practices
- Demonstrated effective multidisciplinary team working, with access to specialist support and evidence of appropriate care planning and monitoring.

Quality of Management and Leadership

Overall summary:

We found positive evidence of committed and professional teams, with staff describing a supportive team environment and good working relationships across nursing, medical and allied health professional groups. Staff were visible, responsive and engaged at ward level, and staffing levels at the time of the inspection were sufficient to support safe care and a positive patient experience. Training compliance was generally good, and staff demonstrated appropriate knowledge in key areas of practice.

The Trust had established governance, risk management, incident reporting, staff engagement and quality improvement systems in place, supported by a clear strategic approach at corporate level. We also noted significant longer-term service developments, including plans for new cancer centre and satellite centre provision and recent senior leadership appointments. These demonstrated a clear organisational vision and commitment to future service delivery.

However, we identified that organisational systems and improvement processes were not always consistently embedded into day-to-day ward practice. The immediate assurance issue relating to the management and availability of patient records highlighted gaps in governance, risk management and leadership oversight at ward level. This reduced assurance that risks were always being identified, assessed and mitigated effectively. Wider organisational intelligence also identified concerns about staff engagement, communication and leadership visibility during a period of organisational change.

Further improvement was needed to ensure learning from incidents, concerns and risks was clearly communicated, embedded and monitored at ward level. Although systems were in place to support feedback, learning and continuous improvement, there was limited evidence that these consistently resulted in sustained changes in practice.

We found positive evidence in relation to the electronic patient record system, which was easy to navigate and supported accurate, up-to-date nursing records with appropriate access controls. However, digital systems were not fully integrated across all aspects of patient care, and continued reliance on paper medical records contributed to fragmented information and reduced assurance that all relevant information was consistently available at the point of care.

Overall, while the Trust had clear organisational structures and committed ward-level staff, further work was required to strengthen ward-level governance, staff engagement, learning, digital integration and the consistent implementation of improvement activity.

This is what we recommend the service can improve:

- Ensure governance systems are consistently implemented to identify, assess and mitigate risks to patient safety.
- Strengthen the embedding of governance arrangements and organisational processes at ward level to ensure consistent operational oversight.
- Ensure workforce systems provide clear assurance that staff competencies are aligned to service requirements.
- Strengthen arrangements to ensure organisational processes supporting learning and improvement are consistently applied in practice.
- Improve staff engagement and communication to support staff during periods of organisational change.

This is what the service did well:

- Maintained established governance frameworks supported by clear strategic direction and future service planning.
- Demonstrated a positive and collaborative team culture, with staff committed to delivering high quality patient care.

Details of the concerns regarding patient safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient feedback

We found that systems were in place to capture patient feedback, including *Llais* information and open communication between staff and patients. However, visibility and use of feedback mechanisms could be improved. Patients in this service appeared less likely to raise concerns formally.

We also considered patient feedback using the HIW patient feedback survey results for the first-floor ward. These included responses relating to overall experience of care. The survey results demonstrated that patients consistently rated their overall experience of the ward highly.

Overall, the survey findings support our direct observations and the feedback obtained from patients during the inspection, providing assurance that patients reported a positive experience of care on the ward during the reporting period.

This was reflected in comments we received from patients during the inspection, for example:

> *"The staff are so kind and caring, nothing is too much trouble."*
>
> *"I feel safe and well looked after when I'm on the ward."*

The Trust must:

- **Review current systems and processes in place to ensure patients have clear and accessible information on how to raise concerns**
- **Improve the visibility of feedback mechanisms and take proactive steps to capture, track and act on informal and incidental feedback.**

Person-Centred

Health promotion

We found evidence that the service supported aspects of health promotion and patient wellbeing. Information relating to infection prevention and specific conditions was displayed on the ward, and patients had access to appropriate dietary options.

Patients reported that staff listened and adapted care based on their needs, supporting their involvement in their own care. However, patient-facing health promotion information was not always clearly accessible or tailored to different patient needs.

The Trust should ensure health promotion information is clearly accessible and patient-focused and is available in formats suitable for all patients.

Dignified and respectful care

We found that staff treated patients with kindness, compassion and respect. Patients felt listened to and valued, and we observed staff adapting their communication style appropriately.

Patients appeared well cared for, and privacy was generally maintained during care, with appropriate use of curtains and facilities. This was reflected in feedback from patients, who consistently described staff as kind and caring and said they felt well looked after on the ward. The ward had a corridor-style layout with limited separation between bed spaces. However, no privacy or dignity concerns were identified during the inspection.

There was no bath available for patients on the ward due to water safety requirements and associated control measures.

Individualised care

We found that care was generally delivered in a person-centred manner. Patients told us they were involved in decisions about their care and that staff adapted support to meet their individual needs. Staff demonstrated a good understanding of patients' preferences and were able to describe how care was tailored accordingly.

Patients also confirmed that their independence was supported. Staff told us that families and carers were encouraged to be involved where appropriate, helping to support a holistic approach to care. Patients were also positive about the quality and choice of food, and we found that dietary needs were accommodated.

However, individual needs were not always supported consistently. Although person-centred practice was evident, the systems for identifying, recording and responding to patients with additional or complex needs were not always clearly demonstrated.

We also found that inconsistent communication between clinicians affected the delivery of fully individualised care. Some patients did not receive clear or coordinated

information about their care, which reduced their ability to understand and participate in decisions.

Accessible and bilingual patient information was not always available. This limited the service's ability to fully meet the diverse communication and information needs of all patients.

The Trust must ensure that appropriate resources are available to support patients with additional needs. It must also implement clear systems to identify patients who require additional support, and ensure this information informs the planning and delivery of their care.

Timely

Timely care

We found that patients had timely access to care and support. Staff were visible and responsive, and patients reported that requests for assistance were responded to promptly. This was also reflected in the patient survey responses.

However, we found that discharge planning processes were not consistently evident through the review of patient records. This may impact the timely progression of care and patient flow through the service.

The Trust should strengthen discharge planning processes to support timely patient flow and continuity of care.

Equitable

Communicating and language

We found that patients generally felt able to communicate with staff, who were described as approachable and supportive. We observed many examples of sensitive and compassionate communication. Information was also displayed on the ward relating to nursing staff, which supported patients in identifying members of the nursing team.

However, some patients told us that communication with all clinicians was not always consistent. Some patients reported confusion due to input from multiple clinicians, and not all felt they had received sufficient explanation about their care. We also found that the presentation and coordination of patient information could be improved.

The Trust must:

- **Ensure patients receive clear, consistent and coordinated information about their care, including appropriate explanation of diagnosis and treatment**
- **Provide clear information about all staff roles and who is responsible for coordinating patient care.**

Rights and equality

We found that the ward was accessible and easy to navigate, with clear signage for bathrooms and toilets. Patients reported feeling safe in a clean and well-maintained environment.

The environment and availability of equipment, including hoists and mobility aids, supported patients with physical needs and contributed to maintaining independence and safe access to facilities.

We also found that staff had undertaken relevant mandatory training to support the delivery of equitable care, including equality, diversity and inclusion (EDI) training and Deprivation of Liberty Safeguards (DoLS) and mental capacity training. This highlighted that staff were equipped to support patients with diverse needs.

While the ward environment and available equipment supported patients with physical needs, the service could not consistently demonstrate how individual access and communication needs were identified and responded to. For example, accessible and bilingual information was not always available, and arrangements for identifying patients who required additional support were not always clearly evidenced.

The Trust must ensure there are consistent systems and processes in place to identify and meet patients' individual access needs. This includes access to suitable facilities, equipment and communication support, to enable equitable care for all patients.

Delivery of Safe and Effective Care

Safe

Risk management

We found that the ward environment was generally accessible, safe and fit for purpose. Lift access was available and staff had access to equipment to support patients with mobility needs, including profiling beds, hoists and toilet aids. Nurse call bells were observed to be in working order and within easy reach of patients. Rooms were also available to support private conversations with patients and relatives.

The ward environment was generally clean and well maintained. However, we found some maintenance issues, including chipped skirting boards and other areas requiring attention from an infection prevention and control perspective.

We found that bed rails were in use without documented risk assessments. This was fed back to leaders during the inspection, and we were told that bed rail risk assessments were implemented immediately.

The Trust must ensure:

- **Ensure bed rails are only used following appropriate individual risk assessment and clear documentation**
- **Address all environmental maintenance issues that may impact patient safety and infection prevention and control.**

Infection prevention and control (IPC) and decontamination

We found that IPC arrangements were largely effective. Personal protective equipment (PPE) was available across the ward, hand hygiene practice was observed to be good, and staff were able to explain how to access IPC policies. Staff also understood what action to take following a needle stick injury.

The ward environment was visibly clean, with less clutter observed than at the previous inspection. We reviewed high levels of compliance in hand hygiene and IPC audits. There was also adequate provision of single cubicles to support patient isolation, and infection rate information was displayed at ward level.

However, some improvements were required. The positioning of alcohol gel was not always optimal, and not all reusable equipment had clear “I am clean” stickers to indicate it had been decontaminated. We also found the cleaners’ cupboard was unsecured during the inspection; this was raised with staff and resolved during the inspection.

The Trust must ensure:

- **cleaning chemicals and materials are always stored securely**
- **Hand hygiene products are accessible at the point of care**
- **Reusable equipment is clearly identified as clean following decontamination.**

Safeguarding of children and adults

We found that safeguarding arrangements were appropriate. The ward was secured through a locked door system with access controlled by key fob or buzzer.

Staff records showed good compliance with safeguarding training, including Deprivation of Liberty Safeguards (DoLS) and mental capacity training.

Case tracking also showed that where applicable, mental capacity assessments had been completed on admission for the records reviewed. There were no patients subject to DoLS at the time of our inspection.

Blood management

We found positive evidence that blood management systems were in place. The ward had access to a satellite blood fridge supplied through Cardiff and Vale blood bank, and staff described stringent checking processes. Staff involved in transfusion were required to complete annual mandatory training, and an All Wales blood transfusion pathway was in place.

Staff described incident reporting arrangements through Datix and external reporting pathways where required. No transfusion incidents and no Serious Hazards of Transfusion had been reported during the 12 months prior to inspection.

Management of medical devices and equipment

We found that staff knew who to contact regarding faulty equipment and servicing arrangements. Equipment to support patient care was available, including hoists and pressure-relieving equipment.

However, we identified that some equipment safety checks had exceeded the required dates. The ward also did not maintain a reliable record of equipment requiring servicing, which limited assurance that equipment was safe and appropriately maintained.

We also identified risks relating to the management of chemotherapy administration systems. The system in use was not fully closed, increasing the risk of spillage.

The Trust must ensure:

- **All medical devices and equipment are serviced and safety checked within required timescales**
- **A robust system is implemented to identify, track and monitor all equipment requiring servicing**
- **Safe systems are used for the administration of chemotherapy, including closed systems to minimise the risk of spillage**
- **Oversight arrangements are strengthened to ensure equipment checks and monitoring processes are consistently completed and recorded.**

Medicines management

We found several areas of good practice in relation to medicines management. Drug charts reviewed were signed and dated appropriately, patient identifiers were recorded, and reasons for omitted doses were documented. Pharmacy support was available during weekdays, with on-call arrangements available out of hours.

We also reviewed evidence confirming that controlled drugs were appropriately checked and recorded, and we observed good practice during the medicines round.

However, some areas required improvement. Three patients were not wearing identification wristbands on arrival, including one patient who was about to receive chemotherapy, and who also required an allergy band. Oxygen was not routinely prescribed for patients, and one chart reviewed did not include a patient weight where this was required.

Fridge temperature monitoring processes were in place. However, the medicines fridge in use was not locked, although it was located in a locked treatment room. At the time of inspection a new lockable fridge had been procured and was undergoing calibration ahead of use.

The Trust must ensure:

- **Patients have correct identification and allergy wristbands whilst on the ward and prior to medicines administration**
- **Oxygen is prescribed appropriately whenever it is administered**
- **Medicines, including those stored in fridges, are secure at all times**
- **Patient weight is recorded where required.**

Preventing pressure and tissue damage

We found that the service had effective processes in place to assess, monitor and manage the risk of pressure and tissue damage. Patients were consistently assessed for pressure ulcer risk on admission, and appropriate skin assessments were completed and documented in line with identified risks.

Care plans were developed in response to assessed need and were tailored to individual patients. We found ongoing monitoring of pressure areas, with documentation demonstrating that patients were regularly repositioned. There was also evidence that mattresses were selected appropriately according to assessed risk.

In one case, a patient with a grade 2 pressure ulcer had clear evidence of reassessment, repositioning and the use of an appropriate mattress. Our findings also indicated improvement in pressure ulcer care compared with previous inspection activity.

Falls prevention

We found that the ward environment and availability of equipment supported safe patient care. Profiling beds, mobility aids and nurse call bells were available and accessible, which supported patients at risk of falls.

However, limited evidence was available during the inspection to demonstrate that falls risk assessments and ongoing monitoring were consistently completed and documented. This reduced assurance that falls risks were being consistently identified and managed.

The Trust must ensure consistent systems are in place to assess, monitor and manage patients at risk of falls, including clear documentation and appropriate preventative measures.

Effective

Effective care

We found some positive evidence of effective care delivery. Multidisciplinary team (MDT) working was established, with regular MDT meetings taking place and discussions recorded in patient records. Staff were able to access specialist input when required, including palliative care and bereavement services, supporting coordinated care.

However, there was limited evidence that patients consistently received comprehensive discharge safety-netting information. This reduced assurance that patients were always fully supported to manage their ongoing care and recovery after discharge.

The Trust must ensure patients consistently receive appropriate discharge safety-netting information to support ongoing care and recovery.

Nutrition and hydration

We found positive evidence in relation to nutrition and hydration. Nutritional risk assessments were completed on admission, and the All Wales nutrition pathway was in place through the electronic system. Food charts were also available where required.

Meals were described as appetising and were served regularly, and patients were observed being assisted with positioning for meals where required. Snacks and drinks were also available between meals.

However, there was no consistent visual system, such as recognised indicators, to identify patients who needed support with eating and drinking.

The Trust should implement a consistent system to identify patients who need support with eating and drinking, to ensure appropriate assistance.

Patient records

Overall, we found good nursing documentation. Initial assessments and reassessments were timely, accurate and up to date, with clear evidence of multidisciplinary input in patient records.

However, we found significant concerns regarding the management, organisation and availability of medical records. Medical notes were difficult to locate, were not stored securely, and lacked clear systems to support authorship and traceability. Informal documentation processes were also identified, creating a risk of gaps in care.

These concerns presented a risk to patient safety and were raised as an immediate assurance issue during the inspection. Details of the actions taken by the service to address this are provided in **Appendix B.**

Efficient

Efficient care

We found some positive evidence of multidisciplinary working. Weekly MDT meetings took place, discussions were documented in patient records, and staff were able to access specialist services when required, including palliative care and bereavement support.

However, there was limited evidence that tasks and responsibilities were consistently allocated within care processes. This reduced assurance that care delivery was always coordinated efficiently at ward level.

The Trust must ensure roles, responsibilities and tasks are clearly allocated within care processes to support efficient delivery of care.

Quality of Management and Leadership

Staff Feedback

We received 13 staff questionnaire responses as part of the inspection. Overall, ward staff described a positive and supportive team environment, with good working relationships between nursing, medical and allied health professionals. During the inspection, staff were observed to be professional, caring and committed to delivering high-quality patient care. They also appeared engaged in their roles at ward level.

However, wider organisational intelligence identified concerns relating to staff engagement and experience. These included anxiety linked to organisational change, and concerns about communication and leadership visibility. Although these issues were not directly observed at ward level during the inspection, they provide important context and indicate that the impact of organisational initiatives to improve culture and engagement was not yet consistently evident across the service.

The Trust must promptly implement processes to strengthen wider staff engagement and communication. This is to ensure staff feel appropriately supported and can raise concerns, particularly during periods of organisational change.

Leadership

Governance and leadership

We found that established governance frameworks and structured systems were in place, including arrangements for incident reporting, risk management and organisational oversight. These arrangements demonstrated a clear strategic approach to governance at a corporate level.

We were also aware of significant strategic developments within Velindre Cancer Services, which included plans for a new cancer centre, the development of a satellite centre, and recent senior leadership appointments as part of wider organisational transformation. These developments demonstrate a clear long-term vision and commitment to future service delivery.

At ward level, staff were engaged in delivering care; however, we identified variation in how governance arrangements were applied in practice. While systems and processes were clearly established, they were not consistently embedded into day-to-day ward activity.

The immediate assurance issue relating to the management and availability of patient records demonstrated gaps in governance, risk management and leadership oversight. This indicated that systems to identify and mitigate risks were not always effective at ward level. Details of the actions taken by the service to address these concerns are provided in **Appendix B.**

Overall, our findings indicate that while governance structures are well developed at organisational level, further work is required to ensure these are fully embedded and consistently applied in practice, particularly during a period of organisational change.

The Trust must ensure that:

- **Governance systems are implemented and sustained to identify, assess and mitigate risks to patient safety**
- **Ward-level governance and operational oversight is strengthened, particularly during periods of organisational change.**

Workforce

Skilled and enabled workforce

We found that staff generally demonstrated the skills, knowledge and commitment required to deliver care and worked effectively as part of an MDT. Staff were visible, responsive and engaged, and supported patients in a timely and appropriate manner. At the time of inspection, staffing levels were sufficient to support the delivery of safe care and contributed positively to patient experience.

Training compliance was generally good and supported by organisational systems for mandatory training and workforce monitoring. Staff demonstrated appropriate knowledge in key areas of practice, providing assurance that core training arrangements were in place.

However, training and competency were not consistent across all areas of care. Not all ward staff had received training relevant to their role, including specialist training such as chemotherapy administration. This meant that, while overall staffing and core training arrangements provided some assurance, further work was needed to ensure staff competencies were fully aligned to service demand.

The Trust must ensure:

- **All staff complete mandatory and role-specific training required for safe clinical practice, including specialist training relevant to the service**

- **Staff competencies are consistently monitored and aligned to ward level service demand, including specialist areas of practice.**

Culture

People engagement, feedback and learning

We found that organisational systems were in place to support staff engagement, feedback and learning. These included structured arrangements for incident reporting and concerns management, demonstrating a commitment to openness, transparency and continuous improvement.

However, feedback to staff on learning and outcomes from incidents and concerns was not always visible. There was also limited evidence of a consistent process to check whether learning had been understood and applied in practice. This reduced assurance that learning was supporting consistent improvement in care delivery.

The Trust must ensure:

- **Learning from incidents, concerns and risks is consistently translated into improvements in practice**
- **Processes are strengthened to ensure feedback and learning are clearly communicated, embedded and monitored at ward level.**

Information

Information governance and digital technology

We found positive evidence in relation to the electronic patient record system. The system was easy to navigate, and nursing records were overall accurate, up to date and contemporaneous. Access to the system was appropriately controlled, providing assurance that information was protected.

However, digital solutions were not established across all elements of patient care, with continued reliance on paper medical records. This contributed to fragmented information and reduced assurance that all relevant information was consistently accessible at the point of care.

The Trust must improve the integration and use of digital systems across all aspects of patient care to ensure information is complete, accessible and up to date.

Learning, improvement and research

Quality improvement activities

We found that organisational systems to support learning and improvement were in place, including established processes designed to promote continuous improvement. These arrangements demonstrated a clear organisational commitment to improving the quality of care.

However, there was limited evidence that improvement activity was consistently implemented, monitored and evaluated in ward practice. This reduced assurance that improvement initiatives were leading to sustained changes in care delivery and patient outcomes.

The Trust must ensure that

- **Quality improvement activity results in demonstrable and sustained improvements in practice**
- **Processes are strengthened to ensure improvement initiatives are consistently implemented and embedded at ward level.**

Whole-systems approach

Partnership working and development

We found evidence of positive multidisciplinary working, with staff working collaboratively across professional groups to support patient care and decision-making.

However, improvements were needed in coordination of care processes, including discharge planning and communication between teams, as identified in previous sections.

The Trust should strengthen coordination and communication between teams, particularly in relation to discharge planning and patient flow.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, 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 the inspection			

Appendix B – Immediate improvement plan

Service: **First floor ward, Velindre Cancer Centre, Cardiff**

Date of inspection: **19 and 20 May 2026**

Findings	**Missing medical records and interim documentation arrangements** During the inspection, we found that when patient medical records were unavailable there was no formal process in place to create a temporary set of notes. Individual "polly pockets" were used to hold ad hoc documentation for the duration of the patient's admission. On discharge, these were stored within the chemotherapy administration office alongside hundreds of similar records relating to other patients with missing notes. Where the original records were not located, these temporary files remained in storage and were added to during subsequent admissions. This meant there was a significant risk that complete clinical information would not be available at the point of decision making. The absence of a robust and traceable system for managing missing records increased the risk of omission or error in clinical care. Immediate action was therefore required to establish a safe and reliable process, with a very short timescale for the review and reallocation of all individual records stored in the chemotherapy administration office.

	Improvement needed	Standard / Regulation
1.	The service must take immediate action to implement a robust, standardised and fully traceable system for the timely management of missing medical records and all interim clinical documentation. This must include clear arrangements for the prompt creation of a temporary record whenever the main case notes are unavailable, consistent patient identification on all interim documentation, secure storage, oversight and tracking of records, and timely reconciliation to the main record when located. The service must also undertake an immediate and comprehensive review of all individual records currently stored in the chemotherapy administration office and ensure their timely reallocation, reconciliation or incorporation into the appropriate patient record. The service must provide assurance that complete, contemporaneous and accessible clinical information is available to staff at the point	Health and Care Quality Standards 2023 – Safe; Health and Social Care (Quality and Engagement) (Wales) Act 2020; Duty of Candour Procedure (Wales) Regulations 2023.

	of care, that associated risks are identified and managed through governance processes, and that any actual or potential patient harm is considered in line with the Duty of Candour procedure where the threshold is met.	

Service Action:	Responsible officer	Timescale
Following the inspection, immediate actions have been taken to address the risks associated with missing medical records and interim documentation. All actions below are categorised as: • Completed and in operation • In progress • Further actions planned for embedding and monitoring **Actions Completed and Now in Operation** **Immediate cessation of previous process and implementation of revised system; Completed and in operation from 20 May 2026** • Use of "polly pockets" for interim documentation has ceased with immediate effect. • A standardised and traceable process for managing missing medical records and temporary records is now fully implemented and in operational use across Velindre Cancer Centre. **Standard Operating Procedures (SOPs)**	Directorate Manager for Cancer Services	20.05.2026 (SOPs developed Completed) SOPs in use pending full governance sign off 24th June Quality Safety Risk and Experience Board

Developed and implemented in practice from 20 May 2026 • SOP for the management of missing medical records • SOP for the creation and management of temporary medical records These SOPs: • Define requirements for creation, tracking, escalation, reconciliation and governance • Are in active operational use by staff Will undergo formal governance sign-off on 24 June 2026 (Quality, Safety, Risk and Experience Board) *(This does not affect current operational use)*		
Operational flowchart and staff instruction Completed 20 May 2026 and in ongoing use • A clear operational flowchart has been issued to all relevant staff • Staff have received instruction that: o All interim documentation must follow the approved temporary records process o The previous informal arrangements must not be used	Directorate Manager for Cancer Services	20.05.2026 (Completed)
Comprehensive review of stored records (chemotherapy administration office) **In progress – commenced 27 May 2026**; A structured recovery programme is underway to	Directorate Manager for Cancer Services	27.05.2026 (Recovery plan currently

address all stored interim records. **Current position** • The review has commenced and is actively underway • Work is progressing through a four-stage recovery process: 1. Identification and cataloguing – underway 2. Matching and searching – commenced 3. Consolidation – pending completion of stage 2 4. Final reconciliation – planned final stage **Expected completion** • Target completion date: 30 June 2026 **Governance and oversight** • All records are being: o Logged and tracked o Escalated where the main record cannot be located • Any unresolved cases are: o Reported via Datix o Reviewed through Directorate governance arrangements		underway with expectation for completion by 30 June 2026)
Review of Datix incidents and patient harm	Head of Nursing for Acute,	27.05.2026 (Completed,

Completed 27 May 2026 • A targeted review of the Datix incident reporting system has been undertaken, specifically examining: o Missing medical records o Interim documentation issues **Outcome:** • No actual or potential patient harm identified associated with these issues • Therefore, no Duty of Candour thresholds were met **Assurance:** • A clear process is now in place to ensure: o Any future incidents are reported via Datix o Harm is assessed o Duty of Candour is applied where the threshold is met	Inpatients and Palliative Medicine	no harm identified)
Staff briefing and immediate communication **Completed 26 May 2026** • A formal staff briefing was delivered covering: o Inspection findings o New SOPs and processes o Expectations for compliance	Head of Nursing for Acute, Inpatients and Palliative Medicine	26.05.2026 (Completed, we will monitor and spot check actions being implemented)

• Ongoing monitoring and spot checks are in place to ensure adherence		
Immediate action has been taken to address the risks identified during inspection. A standardised, safe and fully traceable system is now implemented and operational, supported by: • Defined SOPs • Staff training and communication • Strengthened governance and incident management The review of all stored records is actively underway, with a defined completion date, and robust oversight arrangements are in place to ensure completion and sustained compliance. No patient harm has been identified, and processes are in place to ensure that any future risks are identified, managed, and escalated in line with Datix and Duty of Candour requirements. We thank the HIW inspection team for identifying these issues and for their constructive challenge, which has supported immediate action and strengthened assurance around patient safety		

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): Kate Hannam

Job role: Director Velindre Cancer Service **Date: 28th May 2026**

Trust Corporate representative:

Gillian Knight

Executive Director of Nursing, Allied Health Professionals and Health Science - 3 June 2026

Appendix C – Improvement plan

Service: First Floor Ward, Velindre Cancer Centre, Cardiff

Date of inspection: 19 and 20 May 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 were not consistently aware of how to raise concerns, and feedback mechanisms were not sufficiently visible or consistently used to capture informal feedback.	The health board must ensure patients have clear and accessible information on how to raise concerns and strengthen the visibility and use of feedback mechanisms, including systems for capturing, tracking and acting on informal and incidental feedback.	Person centred / Culture / Learning, improvement and research	Patients will be given a curated pack on arrival with information detailing how to raise concerns, including information on Call for Concern. Updated patient information and feedback displays will be provided in patient areas. Ward assurance audit to include compliance with display requirements. Ward, directorate and divisional governance minutes will evidence review of patient feedback themes and actions. QR code for patient feedback to be included within take home medications.	Senior Nurse Senior Nurse Senior Nurse Head of Nursing Ward Manager Executive Director of Nursing, AHP's	7th August 2026 7th August 2026 30th August 2026 Already in place prior to inspection. 30th July 2026 Date to be confirmed

				Engagement between the Trust and Shared Services Partnership to explore opportunities to roll out CIVICA experience Wales platform to gather feedback from service users via SMS text messaging.	and Health Scientists	
2.	Health promotion information was not always clearly accessible or tailored to patients' needs.	The health board should ensure health promotion information is accessible, patient-focused and available in appropriate formats.	Person centred / Equitable / Information	Develop and implement a ward-based oncology health promotion improvement programme, aligned to relevant national priorities and the Trust's strategic objectives, to ensure health promotion information is patient-focused, accessible, up to date, and available in a range of appropriate formats. This will be supported through benchmarking and adoption of best practice from other cancer centres.	Ward manager	31st August 2026
3.	Bathing facilities not available (shower facilities remain fully operational)	The health board must address issues with the bath water safety	Person centred / Equitable / Safe	An assessment has confirmed that a bath is required within the inpatient ward, and provision has been incorporated into the design of the new hospital. Through routine water safety tests, the bath has tested positive for legionella since 29th December 2025. New flexible hose is to be connected as identified as a likely source. This is due to be delivered W/C 27th July 2026, process of water testing and if legionella is no longer present, bath will be reinstated.	Head of Nursing	7th August 2026
4.	Systems to identify and meet individual patient needs were not consistently	The health board must ensure resources and systems are in	Person centred / Equitable	WNCR has holistic needs assessments embedded within the system to identify patients' individual needs. A regular audit will be incorporated into the ward audit programme to provide assurance that assessments are	Senior Nurse	7th September 2026

	demonstrated.	place to identify and support patients with additional needs.		completed appropriately, additional needs are accurately identified, and there is documented evidence that appropriate actions have been taken to address those needs. **Audit Criteria:** 1. An assessment is completed within WNCR in accordance with local policy and documentation standards. 2. Any additional physical, psychological, social, communication, cultural, spiritual, or safeguarding needs are clearly identified and documented. 3. Where additional needs are identified, there is evidence of: o Appropriate care planning/interventions. o Referral to relevant services where required. o Communication with the multidisciplinary team and documented within MDT handover. o Ongoing review and evaluation of the interventions provided. 4. Documentation demonstrates that identified needs have been addressed or that a clear rationale is recorded where actions are still		

				pending. Achieve and maintain 95% compliance against the audit criteria by October 2026.		
5.	Discharge planning processes not consistently evidenced.	The health board should strengthen discharge planning processes to support patient flow and continuity of care.	Timely / Efficient / Effective	Daily board rounds now have Estimated Discharge Dates (EDD) set, these are visible on 'at a glance board' and within MDT handover document. Establish a Velindre Cancer Service Patient Flow Framework, informed by the NHS Wales Performance and Improvement Optimal Patient Flow Framework, to drive sustainable improvements in patient experience, flow, capacity management, and operational performance. Handover sheet is now multidisciplinary, therefore has enhanced handover across professional teams and inclusive of discharge planning.	Clinical Lead Graduate Trainee Clinical Lead	11th June 2026 (Completed) 30th October 2026 11th June 2026 (Completed)
6.	Communication with patients not always clear and consistent across clinicians.	The health board must ensure patients receive clear, consistent and coordinated information	Person centred / Information	Continuity in consultant ward cover has been introduced to reduce the number of different doctors involved in patient care, an issue highlighted in the report. This approach provides a consistent clinical lead who coordinates care and communication with the site-specific oncology team, ensuring patients receive clear	General Manager	4th June 2026 (Completed)

		about their care.		and coherent information regarding their treatment and management plan. This will be monitored through patient experience feedback and clinical incidents. A weekend handover sheet has been developed for complex patients; these are situated in the patient's notes for the weekend medical team.	Clinical lead	1st July 2026 (Completed)
7.	Lack of clarity regarding staff roles and care coordination.	The health board should provide clear information about staff roles and coordination responsibilities.	Person centred / Information	Introduce a visible patient information board, identifying the named nurse and responsible consultant for each patient's episode of care. Develop and provide patient information explaining the roles of key members of the multidisciplinary team and how care is coordinated during an inpatient stay. Include confirmation of the patient's named care coordinator and responsible consultant within daily MDT handovers and board rounds. Audit compliance quarterly through patient experience feedback and ward assurance audits. Achieve and maintain 95% compliance against the audit criteria December 2026.	Senior Nurse	31st December 2026
8.	Systems to support equitable access and communication needs not	The health board must ensure systems are in place to identify	Equitable / Person centred	Review and strengthen processes for identifying, recording and responding to patients' access and communication needs, ensuring requirements are documented at admission and that appropriate	Trust Patient Communication Lead	31st August 2026

	consistently applied.	and meet diverse access and communication needs.		information formats and communication support are available and monitored through routine audit, ensuring all is bilingual (Welsh and English) Updated communication to the ward team regarding the availability of language line and "sign line on wheels", this can be utilised for all patients where language or communication needs are identified. Where alternative communication is required, such as language, this will be included within the MDT handover.	Ward Manager Ward Manager	28th July 2026 28th July 2026
9.	Bed rails used without consistent risk assessment.	The health board must ensure bed rails are only used following appropriate risk assessment and documentation.	Safe	Implement the bedrails procedure, including all patients to have a Bed rails risk assessment. Communication to staff around immediate implementation of the procedure and risk assessment. Create an education board on first floor ward around bed rails risk assessment tool. Create an audit plan to ensure compliance. Achieve and maintain 100% compliance against the	Ward Manager	28th May 2026 (Completed)

				audit criteria by 30th October 2026.		
10.	Environmental maintenance issues impacting safety and infection prevention.	The health board should address environmental maintenance issues impacting safety and infection prevention and control.	Safe	An estates review of the ward environment will be undertaken to develop and implement a prioritised workplan with regular monitoring of progress through the Cancer Service governance arrangements escalating any risks or barriers to delivery.	Head of Estates	30th July 2026
11.	Cleaning materials not always stored securely.	The health board must ensure cleaning chemicals and materials are stored securely at all times.	Safe	Cleaning cupboard now has a key, and door is locked when unattended. Spot checks to be incorporated into the monthly cleaning audit, with a target of 100% compliance by 30th July 2026.	Head of Nursing Soft FM manager	20th May 2026 (Completed) 30th July 2026
12.	Equipment not consistently labelled as clean and hand hygiene products not always optimally located.	The health board should ensure equipment is clearly labelled after decontamination and hygiene products are accessible.	Safe	All staff have been reminded about the use of the "I am Clean Stickers" at the "Big 4" and utilisation will be monitored through the monthly environmental audit, and daily ward checks, undertaken by the ward sister.	Senior Nurse	17th July 2026 (Completed)
13.	Equipment servicing checks overdue and	The health board must ensure all	Safe / Leadership	The process will be reinforced whereby clinical staff verify equipment service status before use and	Ward Manager	1st June 2026

	no reliable tracking system in place.	equipment is serviced within timescales and implement a robust tracking system.		promptly report any equipment approaching or exceeding its service due date to the appropriate Clinical Engineering department or service provider. Ward manager has developed an audit to randomly check equipment each month to ensure compliance with service and equipment is in working order. Clinical Engineering will complete the ongoing audit of medical devices across Velindre Cancer Services and implement an enhanced equipment tracking system to strengthen oversight of servicing schedules, maintenance compliance and overdue equipment. Compliance will be monitored through regular reports from the Medical Devices Team and quarterly review through the Medical Devices Management Group (MDMG).	Ward Manager Director of Medical Physics and Clinical Engineering	(Completed) 1st June 2026 (Completed) 6th November 2026
14.	Chemotherapy delivery system not fully closed, increasing risk of	The health board must ensure safe systems are used for	Safe / Effective	Business case has been developed to move from current systems to a closed system for the delivery of chemotherapy. This was prioritised by divisional and	Systemic Therapies Head of Nursing	Completed Prior to Inspection

	spillage.	chemotherapy delivery, including closed systems.		executive teams, and included within the IMTP. Procurement process has included a trial of 3 systems, and one has now been endorsed as clinical system of choice. Executive approval required to proceed with procurement.	Systemic Therapies Head of Nursing Executive Triumvirate	30th June 2026 24th August 2026
15.	Patient identification and allergy wristbands not consistently used.	The health board must ensure patients wear correct identification and allergy wristbands.	Safe	The requirement of and related patient safety impact of allergy wristbands, was communicated to staff as part of the initial feedback session from HIW and we have confirmed this, through an established audit programme. 100% compliance achieved in June 2026 audit. Continue to monitor and maintain compliance.	Ward Manager	26th May 2026 (Completed)
16.	Oxygen not consistently prescribed.	The health board must ensure oxygen is prescribed whenever administered.	Safe / Effective	Communicated to team following the verbal feedback of HIW team, the importance of O2 prescribing and standards required. O2 prescription to be part of the next Druggles. Pharmacy monthly audits include O2 prescription, to utilise MDT meetings to feedback audit results and agree learning. Achieve and maintain 95% compliance against the audit criteria compliance by November 2026.	Head of Nursing Ward Pharmacist Ward pharmacist	26th May 2026 3rd August 2026 14th August 2026

17.	Medicines not always securely stored (including fridge security).	The health board must ensure medicines are stored securely at all times.	Safe	Fridge with no lock has been decommissioned and replaced with Fridge that has a locking mechanism. Medication management audit to monitor compliance with locking the fridge.	Ward Manager Ward Manager	22nd May 2026 (Completed) 22nd May 2026 (Completed)
18.	Patient weight not always recorded where required.	The health board should ensure patient weight is recorded where required.	Effective / Safe	Communicate to all staff about the importance of transcribing weights onto the drug charts. This is already embedded within pharmacy audit. When electronic medical prescribing is rolled out (EPMA), there will be a reporting mechanism to alert to any omission of weights within electronic drug charts. Confirmed with digital clinical team that there will be a function in electronic medical prescribing that doesn't allow prescription of medications without a weight submitted to the electronic drug chart.	Ward Manager Ward Manager Head of Nursing	28th July 2026 1st November 2026 23rd July 2026 (Completed)

19.	Limited evidence of consistent falls risk assessment and monitoring.	The health board should ensure systems are in place to assess, monitor and manage falls risk.	Safe	System in place through audit plan that ensures there is consistent falls risk assessment, care planning and monitoring with a target of 95% compliance by September 2026. Continue with monthly falls panel which reviews all inpatient falls and any falls that occur within Velindre. Continue with monthly reporting through quality and safety governance as a floor to board assurance.	Ward Manager Head of Nursing Head of Nursing	1st June 2026 (Completed) Already in place prior to Inspection. Already in place prior to inspection.
20.	Patients did not consistently receive discharge safety-netting information.	The health board should ensure patients receive appropriate discharge safety-netting information.	Effective / Timely	Patient safety netting will be discussed individually with patients based on their needs and ongoing requirements. This will be strengthened by continuity of care of ward consultant. All patients that receive treatment are given treatment helpline information. Continue to monitor for any patient safety incidents that identify discharge planning as a contributory factor. As part of the ward KPI's that are being developed for	Clinical Lead Head of Nursing Head of Nursing General	11th June 2026 (Completed) Already in place prior to inspection. Already in place prior to inspection. 31st

				the acute transformation programme, we aim to monitor readmission rates, either to Velindre or any Welsh Acute Health Board.	Manager	December 2026.
21.	No consistent system to identify patients requiring assistance with eating and drinking.	The health board should implement a consistent system to identify patients requiring assistance with nutrition and hydration.	Safe / Person centred	Utilise a symbol for patients requiring assistance with nutrition and hydration, this will be used on the 'at a glance board' and within handover document by the 29th August 2026. • Utilise the daily "Big 4" to communicate this improvement and change. • For 8 weeks post initiative, compliance will be monitored to ensure practice is embedded. • This will then be incorporated within the ward audit plan.	Senior Nurse	23rd October 2026
22.	Lack of clear systems for authorship and traceability in records.	The health board should introduce systems to support authorship and traceability in records.	Information	Communication has been shared with all MDT staff members to ensure all notes are replaced in the notes trolley when not in use, this was done as part of staffing briefing following the informal feedback. Lockable notes trolleys have been ordered, ward manager to chase delivery date. To ensure positive change in practice, spot audits are to be completed.	Head of Nursing Ward Manager Senior Nurse	26th May 2026 (Completed) 24th July 2026 22nd July 2026 (Completed)
23.	Lack of clear allocation of roles	The health board should ensure	Efficient / Workforce /	Implement a standardised multidisciplinary board round process with clear allocation of actions,	Ward Manager	December 2026.

	and responsibilities in care processes.	clear allocation of roles and responsibilities to support efficient care delivery.	Leadership	responsible individuals and target completion dates for each patient. Enhance the MDT handover document to clearly identify the lead clinician, named nurse and responsible professional for key actions relating to patient care, discharge planning and escalation. Introduce a daily review of outstanding actions during board rounds to ensure accountability, timely completion and effective coordination of care. Undertake quarterly audits of MDT documentation and board round records to provide assurance that roles, responsibilities and actions are clearly documented and completed within agreed timescales. Achieve and maintain 95% compliance with documentation of allocated responsibilities and action completion by December 2026.	Quality and Safety Lead	December 2026
24.	Some staff identified concerns regarding staff engagement and experience, including anxiety associated with organisational change and concerns regarding communication and senior leadership	The Trust must promptly implement processes to strengthen wider staff engagement and communication. This is to ensure staff feel appropriately	Workforce / Culture / Leadership	Following the Organisational Change Process (OCP), the leadership structure has been strengthened with the appointment of a dedicated Senior Nurse for the First Floor Ward and a Head of Nursing for Acute, Inpatient and Palliative Care. This provides increased visible leadership, clearer lines of accountability and enhanced support for staff during organisational change and future service developments. A monthly ward meeting has been established to	Ward Manager / Senior Nurse	December 2026

	visibility.	supported and can raise concerns, particularly during periods of organisational change.		provide a regular forum for staff to receive service updates, contribute ideas, discuss patient safety learning and openly raise concerns within a supportive environment. Themes and actions arising from these meetings will be monitored through the ward governance structure. Minutes from this are available to support. We will monitor staff engagement and attendance and monitor recurring concerns. We will capture "you said, we did" feedback mechanism for staff To further strengthen staff experience and wellbeing, two Staff Experience Advisors have recently been appointed within the Organisational Development Team. They will work alongside ward leadership teams to support staff engagement, wellbeing and organisational transition as preparations continue for the move to the new Velindre Cancer Centre in April 2027.		
25.	Some staff told us that learning from incidents, concerns and risks was not consistently communicated, embedded and monitored at ward level.	The Trust must ensure: Learning from incidents, concerns and risks is consistently translated into improvements in	Learning, Improvement and Research / Leadership / Culture	Ward staff are routinely invited to participate in Rapid Reviews following incidents and contribute to the development of incident timelines to ensure learning reflects frontline experience. Learning from incidents, concerns and risks is also shared through the monthly ward meeting, providing an opportunity to discuss outcomes, actions and changes to practice. To further strengthen visibility of learning, a ward-based learning board will be developed to display	Head of Nursing / Senior Nurse / Ward Manager	December 2026

		practice Processes are strengthened to ensure feedback and learning are clearly communicated, embedded and monitored at ward level.		recent incidents, themes and resulting improvements in practice. The daily "Big 4" safety briefing will continue to be utilised to reinforce learning and support translation into day-to-day clinical practice. Progress will be monitored through the ward governance framework. We will strengthen assurance by quarterly assessing/asking through ward meetings staff awareness of key learning from incidents		
26.	Not all ward staff had received training relevant to their role, including specialist training such as chemotherapy administration.	The Trust must ensure: All staff complete mandatory and role specific training required for safe clinical practice, including specialist training relevant to the service Staff competencies are consistently monitored and aligned to ward level service	Workforce / Safe / Effective	A training needs analysis is currently being undertaken to identify the proportion of ward staff requiring chemotherapy competency training. In parallel, the Nurse Education Team is completing a benchmarking exercise to determine the appropriate level of chemotherapy-trained staff required to meet current and future service demand. All staff receive mandatory training in the safe handling of chemotherapy on commencement in post with annual updates completed thereafter. Training compliance and chemotherapy competency levels will be recorded and monitored. The completed training needs analysis will be shared with ward leadership, and the proportion of chemotherapy-trained nurses will be routinely reported through workforce and staffing review meetings to provide assurance that workforce competencies remain aligned to service	Head of Nursing / Education Senior Nurse / Senior Nurse / Ward Manager	December 2026

		demand, including specialist areas of practice.		requirements. We will use the recently published ward manager toolkit and support ward senior nurses with a review of competencies aligned to services delivered. https://nhswalesleadershipportal.heiw.wales/ward-managers		
27.	While governance structures are well developed at organisational level, further work is required to ensure these are fully embedded and consistently applied in practice, particularly during a period of organisational change.	The Trust must ensure that: Governance systems are implemented and sustained to identify, assess and mitigate risks to patient safety Ward-level governance and operational oversight is strengthened, particularly during periods of organisational change.	Leadership / Safe / Information	Velindre Cancer Service Divisional Directors have undertaken a comprehensive review of governance and reporting arrangements to strengthen oversight, mitigate risk and further enhance patient safety. Revised governance structures, reporting routes and escalation processes will be shared with the ward team and displayed to provide transparency and demonstrate the “Ward to Board” assurance framework. In addition, the newly appointed Head of Quality and Safety will provide ongoing support, education and guidance to ward teams to further embed governance processes, strengthen safety culture and support continuous quality improvement. We will enhance through our recently appointed quality and safety lead our quality dashboard incorporating patient safety, patient experience, workforce, audit and improvement metrics for monthly review and escalation through divisional governance arrangements.	Head of Nursing	September 2026

28.	Digital solutions were not established across all elements of patient care, with continued reliance on paper medical records.	The Trust must improve the integration and use of digital systems across all aspects of patient care to ensure information is complete, accessible and up to date.	Information / Efficient / Effective	The Trust is progressing a procurement programme to strengthen digital systems across all aspects of inpatient care, supporting improved accessibility, accuracy and real-time availability of patient information. This programme forms part of the wider digital transformation strategy in preparation for the new Velindre Cancer Centre. Implementation will continue in partnership with Digital Services and clinical teams to ensure digital solutions are introduced in a planned and sustainable way, reducing reliance on paper records, improving information sharing across multidisciplinary teams and enhancing patient safety, operational efficiency and clinical decision making. We have a phased implementation plan in progress with digital colleagues prioritising paper-based processes for digitisation, with regular reporting of progress, risks and benefits through governance arrangements.	Head of Nursing	April 2027
29.	There was limited evidence that improvement activity was consistently implemented, monitored and	The Trust must ensure that Quality improvement activity results in demonstrable	Learning, Improvement and Research / Leadership	To ensure quality improvement activity results in sustained improvements in practice, the Nurse Education Team and Acute Nurse Consultant Team will facilitate structured action learning debriefs following quality improvement initiatives. These sessions will support reflection, evaluation of	Nurse Education Team / Acute Nurse Consultant / Head of	December 2026

	evaluated in ward practice	and sustained improvements in practice Processes are strengthened to ensure improvement initiatives are consistently implemented and embedded at ward level.		outcomes and identification of opportunities for further improvement. Existing ward forums, including monthly ward meetings and safety briefings, will be utilised to discuss implementation of improvement initiatives, share learning and demonstrate how changes have been embedded into everyday practice. Progress and sustainability of improvements will be monitored through the ward governance framework to provide ongoing assurance. We will also implement a structured ward quality improvement programme, supported by the Quality Improvement Team, using recognised improvement methodology to deliver and sustain measurable improvements in care. Progress, outcomes and benefits realisation will be monitored through a ward improvement tracker and reported through ward and divisional governance arrangements to provide ongoing assurance of implementation and impact.	Nursing	

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): Emma James

Job role: Director of Nursing, Allied Health Professionals and Healthcare Scientists Date: 31/07/2026