

Pathways of Care Delays

Final Internal Audit Report

2026/27

Hywel Dda University Health Board



Reasonable Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

HDU-2627-17

July - August 2026

24 September 2026

October 2026

Andrew Carruthers, Chief Operating Officer

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Executive Summary

Purpose

To review systems in place for the management of patient discharges including a focus on arrangements implemented after the previous audit reviews.

Overview

The implementation of the Miya patient flow system has streamlined the recording of discharge data and interaction with established platforms such as Welsh Nursing Care Records (WNCR) system and Welsh Patient Administration System (WPAS). The rollout of the Miya system included clear engagement with staff through ward walkarounds and training, whilst a support model was established for staff post rollout.

Internal controls have been embedded with the validation of patient records to ensure all pathways of care delays (POCD) are accurately captured on Miya as part of the census information submitted to Welsh Government. A monthly Regional POCD Validation meeting is also in place to collate and verify the information in conjunction with local authority representatives. Governance arrangements are established with a dedicated West Wales Optimal Flow and Discharge Delivery Group feeding into the Six Goals Programme Workstream Integrated Operational Group. POCD data is regularly reported to the Finance and Performance Committee and Health Board. The Quality Improvement and Service Transformation (QIST) Team continue to provide ongoing support to wards and services.

These internal controls and actions implemented have potentially contributed to the reduction in the number of POCD discharges from 250+ (July 2023) to approximately 200 (July 2026) and total days delayed for POCD discharges from 10k+ (July 2024) to 6k (July 2026).

Three medium priority findings were identified during this review in regards of links to national documents not working in the *Hospital Discharge Guidelines* document, non-attendance of key personnel outlined in national guidance at board round meetings and instances of incomplete patient information on the Miya system.

We have concluded **Reasonable** assurance on this area. Whilst noting the positive implementation of actions and improvements in systems and internal controls since the previous internal audit review, discharge delays remain an ongoing risk for the Health Board with sustained longer-term improvements and actions needed with external stakeholders to address these challenges.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives ¹		Related Findings	Assurance
1	Policies and procedures are in place for discharge management that reflect the requirements of the Welsh Government's <i>Hospital Discharge Guidance</i> and the <i>Discharge to Recover and Assess (D2RA) Pathways Guidance</i>	1	Reasonable
2	Processes and resources support the timely discharge of patients including allocation to a specified D2RA pathway discharge stream and identification of an Expected Discharge Date (EDD) at the point of admission	2 & 3	Reasonable
3	Pathways of care delays are reviewed and analysed to understand the circumstances and actions taken to address areas of poor performance and low/non-compliance	-	Substantial
4	Governance arrangements are established to provide oversight and monitoring of discharge management	-	Substantial

¹ The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Management Actions

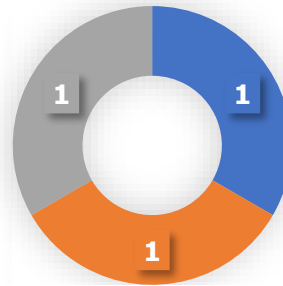


High Priority



Medium Priority

Themes



- Information, Data Quality & Data Accuracy
- Policies & Procedures
- Quality, Safety & Patient Experience

Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Delayed Patients Census - At a Glance

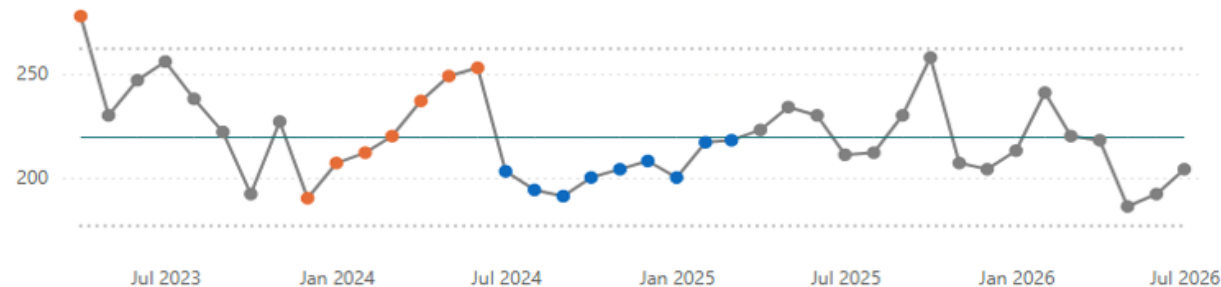
Patient count for delays at census date: 15th July 2026

A patient is defined as a delayed discharge, 48 hours after they have been declared clinically fit to progress to their next stage. This data tracks delayed discharges over time to assess improvement. The SPC chart for the census count of the number of patients delayed is showing usual variation, and that the census count has increased in July. The total days delayed (cumulative) is showing improving variation with a significant reduction in May and July. Whilst the number of delayed patients is still high, the time they are delayed has reduced. However, there is still a system wide issue with discharge delays.

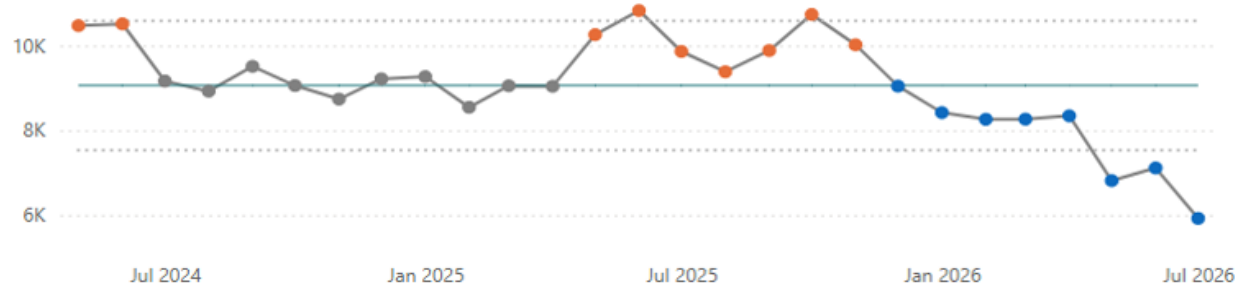
Number of Pathways of Care delayed discharges

Key

- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition



Total days delayed for Pathways of Care delayed discharges



NOTE: This slide provides a snapshot of patients delayed from discharge in one of our hospitals, regardless of their area of residence i.e. **includes** patients living outside of the Hywel Dda area (Carmarthenshire, Ceredigion and Pembrokeshire).

Findings & Agreed Action Plan

Objective 1: Policies and procedures are in place for discharge management that reflect the requirements of the Welsh Government’s <i>Hospital Discharge Guidance</i> and the <i>Discharge to Recover and Assess (D2RA) Pathways Guidance</i>	Reasonable
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Overview / Summary of Observations

The Health Board has an approved *Hospital Discharge Guidelines* document that was published in April 2024 with the aim of supporting staff with ensuring patient discharges are safe, timely and appropriate. The *Hospital Discharge Guidelines* document is an adoption of the Welsh Government (WG) guidelines document that was issued in September 2024 with a subsequent updated version published in January 2025. The WG guidance document is available on the organisation’s dedicated discharge SharePoint site.

The *Hospital Discharge Guidelines* document outlines its aims and objectives, roles and responsibilities, summary of key discharge related information including D2RA pathways guidance and listed supporting documentation. The *Hospital Discharge Guidelines* document also contains a link to the September 2024 WG guidelines document rather than the updated version. However, this link does not work. **[Finding 1]**

Key Findings		Risk & Impact	Agreed Management Action
1	Hospital Discharge Guidelines Document	Staff do not adhere to current guidance impacting on the quality and safety of patient care.	Agreed Action: Review and update the <i>Hospital Discharge Guidance</i> document
	The <i>Hospital Discharge Guidelines</i> document contains a link to the WG guidelines that does not work and is referring to the older version of the guidelines.		Expected Evidence of Implementation: Updated <i>Hospital Discharge Guidance</i> document
		Medium Priority	Officer: Anna Chiffi (Assistant Director of Nursing, Patient Safety & Quality)
Theme: Policies & Procedures		Control Design	Target Implementation Date: 31 January 2027

Objective 2: Processes and resources support the timely discharge of patients including allocation to a specified D2RA pathway discharge stream and identification of an Expected Discharge Date (EDD) at the point of admission	Reasonable
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Overview / Summary of Observations

In 2025, the Health Board replaced the Frontier system with the Miya patient flow system. The introduction of Miya included interactive screens replacing whiteboards in wards that allowed staff to record and view patients’ ‘live’ data with the WNCR and WPAS systems feeding into the Miya system.

The rollout of the Miya system was undertaken by the Digital Project Team with support from the Clinical Informatics Nurse Team who facilitated the training of ward and department staff, whilst day-to-day support continues to be provided by the QIST Team. Clear plans to ensure the

successful implementation of the Miya system were evident in the approach taken by the Digital Project Team including engagement with all staff, creation of digital inclusion support plans, dedicated demonstration days and a support model following the rollout. Discussion with a sample of ward managers at Withybush, Glangwili and Prince Philip Hospitals confirmed that they had received training from the Clinical Informatics Nurse Team during the rollout of the Miya system

A sample of 15 wards at three acute hospital sites confirmed that all interactive screens displayed key elements of the discharge process whilst daily board rounds are undertaken. However, not all key personnel listed in national guidance attend the daily board rounds, including social workers, pharmacists and community representatives. **[Finding 2]**

An output report from the Miya system for the 27 July 2026 was tested to ensure the completeness and accuracy of key information was recorded for listed patients across all acute wards. Whilst testing identified evidence that key data elements listed in national guidance were captured in the Miya system, we noted incompleteness with some elements including reasons for POCD, D2RA pathway, EDD, SORT and Red2Green principles. Discussions with ward managers and the QIST Team noted the root cause for incomplete data was due to either (i) patients' records not updated in real time due to workforce demands on the ward, and/ or (ii) training weaknesses of individuals. Whilst compensatory controls have been implemented to address these issues, including the ongoing support to wards and departments by the QIST Team including additional Miya training and regional POCD validation meetings (see Objective 3 for detailed review) ensures a retrospective check and updating of POCD reasons for patients in the Miya system as part of the census review, challenges around the completeness of data remain. **[Finding 3]**

Key Findings	Risk & Impact	Agreed Management Action
2 Board Round Non-Attendance Of the 15 sampled wards tested, instances of non-attendance at board round meetings by key personnel (as outline in the national guidance) were identified, including Discharge Liaison Nurses, flow coordinators, social workers, pharmacists and community representatives.	Patients' quality and safety of care is impacted due to non-attendance of key personnel at board rounds resulting in increased number of delayed discharges.	Agreed Action: A review of multidisciplinary board round attendance arrangements will be undertaken to identify barriers to attendance and opportunities to strengthen representation from key professional groups, including Discharge Liaison Nurses, Flow Coordinators, Social Workers, Pharmacists and Community Representatives. Expectations regarding attendance will be reinforced through existing governance structures, interprofessional operational standards, and consideration will be given to alternative arrangements where physical attendance is not always possible. Expected Evidence of Implementation: • Review of current board round attendance arrangements completed. • Agreed expectations and attendance requirements communicated to relevant teams. • Board round attendance monitoring mechanism established. Medium Priority Officer: Marilize Preez (Improvement & Transformation Lead)

	Theme: Quality, Safety & Patient Experience	Control Operation	Target Implementation Date: 31 December 2026
3	Completeness of Patient Information Testing identified evidence that key data elements listed in national guidance were captured in the Miya system, we noted incompleteness with some elements including reasons for POCD, D2RA pathway, EDD, SORT and Red2Green principles. Discussions with ward managers and the QIST Team noted the root cause for incomplete data was due to either (i) patients' records are not updated in real time due to workforce demands on the ward, and/ or (ii) training weaknesses of individuals.	The quality and safety of patients is impacted due to incomplete patient records resulting in delayed discharges Medium Priority	Agreed Action: The QIST Team will continue to work with wards and clinical teams to strengthen data quality and compliance with national guidance. This will include targeted training and support, regular review of data quality reports, feedback to ward teams, and reinforcement of expectations regarding the real-time updating of patient records. Opportunities to simplify processes and improve system utilisation will also be explored through existing patient flow governance arrangements. Expected Evidence of Implementation: • Refreshed guidance and training materials issued to ward teams. • Delivery of targeted MIYA training sessions and support. • Regular data quality audits/reports monitoring completion of key data fields, including PoCD reason, D2RA pathway, EDD, SORT and Red2Green. Officer: Marilize Preez (Improvement & Transformation Lead) Target Implementation Date: 31 December 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 3: Pathways of care delays are reviewed and analysed to understand the circumstances and actions taken to address areas of poor performance and low/non-compliance

Substantial

Overview / Summary of Observations

The Health Board have established a POCD validation process to ensure the accuracy and reliability of patient information prior to formal monthly submission of census data to Welsh Government. The validation process has been captured in a standard operating procedure document.

Walkthrough testing of the validation process confirmed (i) circulation of clinically optimised patient lists issued to county representatives, (ii) engagement of counties with local authority representatives, Long Term Care and Allied Health Professional colleagues to corroborate and accurately code discharge delays, (iii) attendance of county representatives at the Regional Validation Meeting following validation of their data, and (iv) submission of validated county cohort master lists to the Regional Validation Chair for submission to the Welsh Government.

To support the delivery of discharge improvement initiatives and POCD reduction, SharePoint sites have been created for the Optimal Hospital & Patient Flow Framework (Policy Goal 5) and Miya system that contains reference to policies, procedures and other supporting documentation that is available to Health Board employees.

The QIST Team present monthly data validation and performance reports to county leads that provides a breakdown of performance positions for D2RA pathway allocations, discharge and deconditioning related data. In addition, the QIST Team also deliver training sessions, facilitate improvement methodologies for targeted areas, and provide on-site implementation support throughout the year to ward and departments.

A weekly report is submitted to the Executive Team that provides a summary of the delayed patient census performance position. A breakdown of reasons for delays by county of residence in the 11 August 2026 weekly report highlighted that many of the delays are due to external parties – see position below. Engagement with local authorities and Regional Partnership Board to identify sustained longer-term improvements to address external-related POCD is currently ongoing.

DELAY REASON	TOTAL PATIENT COUNT	TOTAL DAYS DELAYED
External parties’ delays	145 (71%)	4606 (78%)
Health Board delays	33 (16%)	934 (16%)
Joint delays (Health Board and external parties)	26 (13%)	379 (6%)
TOTAL	204	5919

The rollout of the Miya system combined with the support of the QIST Team and POCD validation process appears to have contributed towards an improved POCD performance position with a reduction in the number of:

1. POCD discharges from 250+ (in July 2023) to approximately 200 (in July 2026)
2. total days delayed for POCD discharges from 10K+ (in July 2024) to approximately 6k (in July 2026) with significant downward trend evident over the past 12 months

The above performance positions were taken from the weekly report submitted to the Executive Team on 11 August 2026 with graphical representation reflected on page 2 of this report.

Objective 4: Governance arrangements are established to provide oversight and monitoring of discharge management

Substantial

Overview / Summary of Observations

A West Wales Optimal Flow and Discharge Delivery Group was formed as part of the Six Goals Urgent Emergency Care Programme (Safe Hospital Care Workstream) responsible for providing strategic oversight, supporting collaborative system improvement across health, social care and partners, with Pathways of Care Delays (POCD) a key element of the group's scope. A draft terms of reference was listed as an item on the group's July 2026 agenda for ratification.

During 2025-26, updates from the West Wales Optimal Flow and Discharge Delivery Group would be included in the highlight reports submitted to the Six Goals Programme Workstream Integrated Operational Group. In addition, a Regional POCD Action Plan 2026-27 was submitted that provided updates on identified actions to address POCD within the organisation.

Oversight of POCD discharge performance positions and supporting narrative were included in integrated performance assurance reports submitted to the Finance and Performance Committee (FPC) and Health Board in 2026, whilst focused papers such as the Performance Deep Dive Alerts and Hospital Flow Process reports were submitted to the FPC in June and April 2026 respectively. Key actions identified in the minutes of the FPC meetings included engagement with local authorities and Regional Partnership Board to identify sustained longer-term improvements to address external-related POCD.

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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Audit and Assurance Services confirm with the Institute of Internal Auditors (IIA's) professional standards and to the Global Internal Audit Standards in the UK Public sector, as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

