

Fast-track hospital end-of-life discharge pathway

Geriatric Medicine Research Collaborative

DOI:

[10.1136/bmjspcare-2021-003183](https://doi.org/10.1136/bmjspcare-2021-003183)

License:

Creative Commons: Attribution-NonCommercial (CC BY-NC)

Document Version

Peer reviewed version

Citation for published version (Harvard):

Geriatric Medicine Research Collaborative 2022, 'Fast-track hospital end-of-life discharge pathway: is it actually fast? National clinical audit', *BMJ Supportive and Palliative Care* . <https://doi.org/10.1136/bmjspcare-2021-003183>

[Link to publication on Research at Birmingham portal](#)

General rights

Unless a licence is specified above, all rights (including copyright and moral rights) in this document are retained by the authors and/or the copyright holders. The express permission of the copyright holder must be obtained for any use of this material other than for purposes permitted by law.

- Users may freely distribute the URL that is used to identify this publication.
- Users may download and/or print one copy of the publication from the University of Birmingham research portal for the purpose of private study or non-commercial research.
- User may use extracts from the document in line with the concept of 'fair dealing' under the Copyright, Designs and Patents Act 1988 (?)
- Users may not further distribute the material nor use it for the purposes of commercial gain.

Where a licence is displayed above, please note the terms and conditions of the licence govern your use of this document.

When citing, please reference the published version.

Take down policy

While the University of Birmingham exercises care and attention in making items available there are rare occasions when an item has been uploaded in error or has been deemed to be commercially or otherwise sensitive.

If you believe that this is the case for this document, please contact UBIRA@lists.bham.ac.uk providing details and we will remove access to the work immediately and investigate.

Is a Fast Track Pathway discharge actually fast?

National audit of Fast Track Pathway discharge from hospital to community setting

Abstract

Background: A fast-track pathway discharge is a method of providing Continuing Health Care for the rapidly deteriorating patient within a short period of time. Once the completed fast track pathway tool has been received by the Commissioning Care Group (CCG) the implementation of resources to allow discharge should not exceed 48 hours.

Methods: We conducted a multi-centre study in England investigating the success of the fast track pathway discharge tool utilising retrospective analysis of patient records for whom fast track pathway discharge pathway paperwork had been submitted between 01/03/19 and 31/03/19.

Results: Seventy-two percent of patients were not discharged within the 48-hour period and there was significant variability in success depending on hospital site. Delays in discharge were most frequently considered to be secondary to delays in sourcing packages of care and nursing home placements. The involvement of specialist discharge nurses in paperwork submission improved the acceptance rate by the CCG. Those patients who died in hospital had a significantly longer admission than those who were discharged (length of stay: 19 (11-28), days to death, 28 (18-42) $p=0.039$). This was entirely accounted for by an increased number of days between admission and the first suggestion of fast track pathway discharge in those who died in hospital (discharged: 9 (5-19), died: 15 (9-33) $p=0.003$).

Conclusions: This study demonstrated an unacceptable delay in the fast track pathway discharge process with significant variation in success of the discharge process at different geographical locations.

Abstract – 240

Text - 2296

Background

In England and Wales, a fast track pathway discharge is a method of providing Continuing Health Care (CHC) for the rapidly deteriorating patient within a short period of time (1). It can be used within the community to arrange social care or in acute care hospital setting to facilitate discharge. Within acute care this mode of discharge is frequently employed to discharge deteriorating and dying patients to their preferred place of care, such as a nursing home or their own home, with ongoing care (CHC) funded by the National Health Service (NHS). The aim of the pathway is to 'identify individuals who need access to NHS Continuing Healthcare quickly with minimal delay' (1). The fast-track pathway tool is completed by an appropriate clinician caring for the patient who determines the individual as eligible. Once the completed fast track pathway tool has been received by the Commissioning Care Group (CCG) it cannot be deemed ineligible and they must immediately action the tool. It is expected that the time period between receipt of a completed fast track pathway tool and implementation of resources should not exceed 48 hours (1).

A 2015-2016 Marie Curie funded analysis of fast track pathway discharges demonstrated widespread poor quality data and audit procedures. The majority of hospitals and CCGs contacted were unable or refused to provide enough data for meaningful interpretation. However, there was evidence to suggest that targets set by the Department of Health and Social Care were not being met. Only two of thirteen NHS trusts were discharging patients within the expected 48 hours. Thirty-two percent of CCGs stated the average wait was more than a week for a fast track pathway discharge (2). The poor adherence to the national guidance suggested in the Marie Curie funded analysis needed to be robustly reviewed in a national audit to confirm the suggested outcomes.

Aims

- 1) Investigate adherence to Department of Health and Social Care target of fast track pathway discharge within 48 hours
- 2) Identify geographical differences in fast track pathway implementation

Methods

We describe a multi-centre study conducted in England. The study was open to all acute care hospitals and data were collected by local staff. The study protocol was disseminated by the Geriatric Medicine Research Collaborative (GeMRC) using established communication channels (3, 4). National guideline documents and data collection proformas were shared via email, social media, and web-based resources. Sites were required to obtain necessary local approvals, and confirm these were in place when registering via REDCap.

All patients aged 18 years and older for whom fast track pathway discharge paperwork had been submitted between 01/03/2019 and 31/03/2019 were eligible for inclusion in the study. Data were collected retrospectively from paper and electronic patient records. Data were collected on demographics, descriptors of the admission and discharge process, and free text that described in the opinion of the auditors why discharges may have been delayed. Anonymised data were submitted directly by the local trust sites via REDCap, which is secure encrypted web-based data management software.

Statistical analysis was performed using IBM SPSS Statistics 26 (Chicago, IL, USA). The statistical significance of demographic descriptives, the breakdown of fast track discharge pathway discharge process and the success of fast track discharge pathway applications were assessed using one sample binomial tests and one sample Chi² test. Significance of differences between length of stay in patients who died in hospital or were discharged were assessed using Mann-Whitney U tests. Free text comments were categorised into groupings according to themes, and a count of these themes was presented.

Results

This study includes data from 347 patient records from 12 different sites throughout England (Supplementary table 1 for full details). Table 1 describes patient demographics. The median age was 81 (IQR 71-89) and there was no significant difference in the proportion of each gender. Patients identified for a fast track pathway discharge were most likely to be under the care of general or geriatric medicine departments. Fifty-four percent of patients were discharged to a 24-hour care facility, and 45.3% of patients were discharged to their own homes with additional care provision. Patients discharged to a 24-hour care facility were on average older than those discharged to their own homes (84 vs. 79; U=10269, p=0.001). The median length of stay in patients who were discharged was 19 days. Of the small proportion of patients that died before being discharged (4.6%), the median days to death was 28 days. The time to death was significantly longer than time to discharge (28 vs. 19; U=3298, p=0.039).

Breakdown of the fast track pathway discharge process

Seventy-two percent of patients were not discharged within the recommended 48 hours from submission of the fast track pathway discharge paperwork. There was significant variability (0 – 60%) in success of discharge within 48 hour across sites ($\chi^2(10)=32.3$, p<0.001) (Supplementary Table 2). Just over half (53.9%) of these delays were considered avoidable by auditors. Table 2 displays reasons given by auditors for delays; the most common reason being a delay in sourcing packages of care and care facility placements.

Table 3 demonstrates the fast track pathway discharge process in detail. Patients were in hospital for a median 9 days (IQR 5-19) before the first suggestion of a fast track pathway discharge. This suggestion was most frequently made by the consultant (46.2%), followed by the registrar, of the parent team (15.4%). Median number of days between suggestion of a fast track pathway discharge and paperwork submission was 2 days (IQR 0-4). Paperwork was most commonly completed by doctors (48.6%). There was no significant difference in the length of time between suggestion and submission when considering which member of the team completed the paperwork ($H(2)=4.650$, $p=0.325$), or which member of the team originally suggested a fast track pathway discharge ($H(2)=4.917$, $p=0.670$).

The majority of fast track pathway discharges were approved on their first submission (93.1%). Of those declined, 70.8% were resubmitted successfully. There was a significant difference in approval rates depending on which member of the team had submitted the paperwork (Discharge Liaison Nurses 3.1% rejected vs. ward nursing staff 14.5% rejected; $\chi^2=9.701$, $p=0.046$) (Supplementary Table 3). The median number of days between submission of paperwork and discharge was 4 days (IQR 2-7). There was no significant difference in time between submission and discharge for patients discharged to 24-hour care facilities (4 days, IQR 2 – 7) and patients discharged home with additional care (4 days, IQR 2 – 6) ($U=8329$, $p=0.194$).

Supplementary Table 4 considers differences in the fast track pathway discharge process between patients who died during admission and those who were discharged. It demonstrates that the significantly longer admissions of those who died is entirely accounted for by an increased number of days between admission and first suggestion of fast track pathway discharge in those who died in hospital (9 vs. 15 days; $U=3424$, $p=0.032$).

Reasons for delay in discharge process as described by auditors

The organisation of 24-hour care facility placements were frequently mentioned as reasons for delay of the discharge process. Specifically, the first choice of facility being unavailable due to lack of capacity, delays in care staff assessing the patient prior to transfer, and delays in the care facility accepting a patient once they were deemed eligible. Auditors specifically mentioned the “delay(s) in care home assessing patient(s)” and “care home being (unable) to accept patient” until a specific date. Additional themes that were noted at three or more sites included patients requiring ongoing medical intervention, patients being ‘out of area’, the discharge process falling over a weekend, family delaying discharge e.g. being uncontactable or needing more time to make a decision, and delay in fast track pathway application being completed, sent, received or approved (Table 4). There were also several themes that were only mentioned for one site, but some of which appeared to be recurring issues for that site with multiple patients affected, e.g. delay in arranging transport.

Discussion

The primary aim of this research was to establish if hospitals were consistently able to discharge patients using a fast track pathway within the recommended 48 hour target. This study has confirmed the findings of the Marie Curie funded analysis (2), and other research that has shown delays to discharge for patients at the end of their life (5-7). Hospitals are regularly failing to hit this target. We have shown that the delay starts even before the fast track pathway application is submitted. Further research needs to be conducted in to the causative and contributing factors. It can be hypothesised that lack of communication (both within the team and with the patient or family), time pressures on staff, and a lack of training might all contribute (8, 9).

Delays in discharge were considered avoidable in over half of cases. By far the commonest cause of delay was sourcing the appropriate care for the patient, whether this was a care package or placement. This is similar to previous research (6, 10). Again, whilst more research needs to be done to investigate the exact reasons for these delays, it can be surmised that this is in part due to lack of availability and a social service sector that is under strain (11).

A small number of fast track pathway discharges were rejected by the CCG. However, the fast track pathway submission cannot be deemed ineligible once submitted. The majority of the rejected fast-track pathway tools were then resubmitted, suggesting the reason for refusal was inaccurately completed paperwork rather than an inappropriate referral. Discharge liaison nurses were the most successful at completing paperwork. This highlights importance of adequate training and experience. Previous research has demonstrated the value of specialist nurses in guiding the discharge process for patients at the end of their life (7).

Patients who died in hospital were inpatients for significantly longer than patients who survived to discharge; this difference in inpatient stay is entirely accounted for by time between admission and first suggestion of fast track pathway discharge. This could represent a failure to identify the dying process, or suggest an acute deterioration during their hospital stay. This study did not sufficiently investigate the difference between these two cohorts of patients to definitively explain these differences and this would be an interesting future direction of study. The National Audit of Care at the End of Life found that the recognition of imminent death in hospital was good (12) but being able to identify patients in the last six months of their life is a more difficult skill. Consultants were the most likely team member to suggest patients required a fast track pathway discharge. This suggests consultants: may be more experienced in recognising the dying process, have more opportunity to recognise the dying patient and/or are more likely to advance management.

There was a significant difference in the success of fast track pathway discharges depending on geographical location. These geographical differences have been previously identified (7). The descriptive data revealed reasons for delays that only occurred at one site, but caused delays for multiple patients at that site. For example, one site appears to have issues with arranging appropriate and timely transport, but this did not appear to be an issue anywhere else. Although, this study is unable to fully explain the reasons for these differences it suggests that any Quality Improvement Project should include discussion between different sites about good and bad practice and potential solutions. The descriptive data highlights other potential causes of delay, some of which appear to be

quite prevalent occurring over multiple sites. An example of this would be discharges that fell over a weekend. This was highlighted in three different sites.

An important contributor to delays were those relating to patients' families. These ranged from the family being uncontactable, there being a delay in re-arranging furniture at home so that the necessary equipment could be delivered, and to the family changing their mind about discharge destination after the process had begun. It is difficult to know how these delays can be avoided, and if indeed they should be. Ultimately the Fast Track Pathway is a tool to ensure patients are discharged in a timely manner to a suitable destination that they and their family are happy with. If the 48 hour deadline puts undue stress on the patient or family then it could be argued that it should be waived.

The limitations within this study are primarily centred on the small number of data submissions from a limited number of sites. This is of particular concern when considering sub-analyses. However, as it is the first study of its kind, it does provide invaluable information on the success and failure of the fast track pathway discharge process in England. It is also important to note that an assumption has been made that when the paperwork was submitted it was also received. As the paperwork is submitted electronically, this is a valid assumption. However, paperwork submitted at 9pm on a Friday may not be physically received by the CCG until Monday at 9am. We acknowledge there may have been some incomplete data upload from individual sites. It is unclear whether the fast track pathway discharge process may have been different within this group of patients for whom identifying notes was not possible.

Conclusion

This study demonstrated a delay in the fast track pathway discharge process with significant variation in success of the discharge process at different geographical locations. Identified factors that may be amenable to change within a hospital setting include: reduction in time between suggestion and submission of paperwork, paperwork completed by specialists (e.g. Discharge Liaison Nurses), and early recognition of the dying process. Increased resources in social care and availability of care facilities, and increased speed of return of acceptance for fast track pathway discharges by the CCG, would also significantly improve the time taken to discharge patients by this process.

Table 1 – Demographics of patients included within this study

Age		81 (71-89)	
Gender	Male	47.3% (164)	p=0.334
	Female	52.7% (183)	
Speciality	Medicine	31.4% (108)	p<0.001
	Geriatrics	35.5% (122)	
	Oncology/Haematology	17.2% (59)	
	Surgery	10.2% (35)	
	Other	5.8% (20)	
Discharge destination	24-hour care facility	54.7% (179)	p=0.097
	Own home with additional care	45.3% (148)	
Death during admission	Yes	4.6% (16)	p<0.001
	No	95.4% (331)	
Days to death during admission		28 (16-42)	p=0.039
Length of Stay		19 (11-28)	

Table 1 – Demographics of patients included within this study.

Data displayed is median and IQR or proportion. Table displays the demographic descriptive data of all patients included within this study. Gender, speciality, discharge destination and death during admission are displayed as proportion of total patients with missing data excluded. One-sample binomial tests (gender, discharge destination and death during admission) and one-sample chi squared tests (speciality) have been used to demonstrate statistical significance. Age, days to death during admission and length of stay are displayed as median with inter-quartile range. Data is not normally distributed. Statistical significance between days to death and length of stay has been tested with an Independent Mann-Whitney U test.

The data in the table describes the patients included within the study as older adults, median age 81, with no significant difference in the proportions of male and females. Proportionally more of the patients were from geriatric wards and there was no statistical difference in the discharge destination; patients were equally likely to be discharged to a care home or receive a package of care at home. A small proportion of patients died during this admission prior to their discharge being arranged. The average length of stay was 19 days and the average time to death as an inpatient was 28 days.

Table 2 – Delays to discharge in the fast track pathway discharge process

Was delay avoidable?	Yes	53.9% (137)
	No	46.1% (117)
Reasons for delay	Delay in approval	7.8% (27)
	Application rejected	4.0% (14)
	Delays in sourcing package of care	17.6% (61)
	Delays in sourcing care placement	19.3% (67)
	Delays with family viewing placement	9.5% (33)
	Change in health needs	7.5% (26)
	Delays in medication provision	0.9% (3)
	Delays in equipment provision	7.8% (27)
	Delays in providing home oxygen	1.2% (4)

Table 3 – Delays to discharge in the fast track discharge process

Data displayed is proportions with raw numbers in brackets.

The data in the table demonstrates that over half of delays in discharge were thought to be avoidable. The reasons for delays are described in the table; the most common reasons were delays in sourcing a package of care and placements.

Table 3 – Breakdown of the fast track pathway discharge process

Fast Track pathway Discharge Suggested	Days between admission and suggestion		9 (5-19)	
	Team member suggested fast track discharge	Consultant	46.2% (135)	p<0.001
		Registrar	15.4 (45)	
		Other doctor	9.2% (27)	
		Nursing staff	6.2% (18)	
		Allied Health Professional	4.1% (12)	
		Alternative specialist	4.1% (12)	
		Multidisciplinary team meeting	6.5% (19)	
		Other	8.2% (24)	
Fast Track Pathway Discharge Paperwork Submission	Days between suggestion and paperwork submission		2 (0-4)	
	Team member completing the paperwork	Medical team	48.6% (157)	p<0.001
		Nursing staff	19.2% (62)	
		Palliative care	0.3% (1)	
		Discharge Liaison Nurse	30.3% (98)	
		Other	1.5% (5)	
Fast Track Pathway Discharge Approval	Approved	Yes	93.1% (323)	p<0.001
		No	6.9% (24)	
	Resubmitted	Yes	70.8% (17)	p=0.066
		No	29.2% (7)	
Fast Track Pathway Discharge	Days between paperwork submission and discharge		4 (2-7)	
	Less than 48 hours	Yes	27.6% (76)	p<0.001
		No	72.4% (199)	
	Days between approval and discharge		3 (1-5)	

Table 2 – Breakdown of fast track discharge process.

Data displayed is median and IQR or proportion. Table displays the breakdown of the fast track discharge process. MDT member suggesting fast track discharge, team member completing the paperwork submission, fast track discharge approval, fast track discharge resubmission and fast track discharge less than 48 hours are displayed as proportion of total patients with missing data excluded. One-sample binomial tests (approval, resubmission and less than 48 hours) and one-sample chi squared tests (MDT member suggesting fast track discharge and team member completing paperwork) have been used to demonstrate statistical significance. Days between admission and suggestion, days between suggestion and submission, days between submission and discharge and days between approval and discharge are displayed as median with inter-quartile range. Data is not normally distributed.

The data in the table describes the fast track discharge process. The patients included within this study were on average in hospital for 9 days before there was a suggestion of a fast track discharge; this suggestion was most frequently made by the consultant of the team. There was on average 2 days between the suggestion of a fast track discharge and the submission of the paperwork; the paperwork was most frequently submitted by the medical team. The majority of fast track submissions were approved. The average number of days between the submission of paperwork and discharge of the patient was 4 days and less than a third of patients were

Table 4 – Reasons for delayed discharge within 48 hours described in auditor free text responses

Theme	Number of sites that mentioned theme	Number of patients affected overall
No beds available at first choice placement	2	3
Delay in care home coming to assess patient	5	6
Delay in a bed becoming available at placement once patient accepted	4	6
Delay in care agency commencing care package	2	2
Patient requiring ongoing medical input	5	7
Patient 'out of area'	3	4
Discharge fell over the weekend	3	5
Family causing delays	4	10
Delays in fast track pathway application being completed, sent or received	3	6
Delays in fast track pathway application being approved	3	4
Delay in providing equipment	1	4
Delay in obtaining transport	1	3
Patient deteriorated prior to discharge	1	3
Medical outlier on an inappropriate ward	1	1

Table 4 - Themes that emerged from thematic analysis of free text – describing reasons for delay in discharge within 48 hours.

Data displayed are themes identified from qualitative analysis of free text along with number of sites affected and number of patients affected. There are 12 sites in total.

Supplementary Table 1 - Details of sites who submitted data

Hospital	Trust	Region
Addenbrookes Hospital Cambridge	Cambridge University Hospitals NHS Foundation Trust	East Anglia
Chesterfield Royal Hospital	Chesterfield Royal Hospital NHS Foundation Trust	Derbyshire
Kingsmill Hospital	Sherwood Forest Hospitals NHS Foundation Trust	Nottinghamshire
Poole General Hospital	University Hospitals Dorset NHS Foundation Trust	Dorset
Queen Elizabeth Hospital Birmingham	University Hospitals Birmingham NHS Foundation Trust	West Midlands
Queen Elizabeth Hospital Gateshead	Gateshead Heath NHS Foundation Trust	Tyne and Wear
Queens Hospital Burton	University Hospitals of Derby and Burton NHS Foundation Trust	Staffordshire
Queen's Medical Centre	Nottingham University NHS Foundation Trust	Nottinghamshire
Royal Derby Hospital	University Hospitals of Derby and Burton NHS Foundation Trust	Derbyshire
Southampton General Hospital	University Hospital Southampton NHS Foundation Trust	Hampshire
University Hospital North Tees	North Tees and Hartlepool NHS Foundation Trust	County Durham
Wolverhampton New Cross	The Royal Wolverhampton NHS Trust	West Midlands

Supplementary Table 2 - Details of success of fast track pathway discharge within 48 hours

Hospital	Number of data submissions	Success of discharge within 48 hours
A	10.7% (37)	2.7% (3)
B	7.5% (26)	31.6% (6)
C	8.4% (29)	37% (10)
D	5.8% (20)	18.2% (2)
E	14.4% (50)	47.5% (19)
F	2.9% (10)	25% (2)
G	0.6% (2)	NA
H	17.9% (62)	20% (19)
I	14.1% (49)	38.8% (19)
J	11.2% (39)	0% (0)
K	4.9% (17)	25% (3)
L	1.7% (6)	60% (3)

Supplementary Table 2 - Details of success of fast track pathway discharge within 48 hours

Data displayed is proportion with raw numbers in brackets.

The data in the table demonstrates a significant difference between the success of discharge within 48 hours at the different local hospital sites. Note the discrepancy between number of data submissions and success of discharge is due to missing data.

Supplementary Table 3 – Success of fast track pathway discharge applications according to the member of team submitting the paperwork

Team Member	Failure rate
Medical team	5.7%
Nursing team	14.5%
Palliative care	0%
Discharge liaison nurse	3.1%
Other	20%

Supplementary Table 3 - Success of fast track Pathway discharge applications according to the member of team submitting the paperwork

Data displayed is proportion of failed applications by each team member. Statistical significance has been tested with a Chi 2 test. $p=0.046$.

The data demonstrates the most successful member of the team at completing fast track discharge paperwork is the palliative care team. However, the data for palliative care team represents only one paperwork submission and should therefore be interpreted with caution. The next most successful member at completing paperwork are the Discharge Liaison Nurses who only had paperwork rejected 3.1% of the time. This is compared to the nursing team who had 14.5% of their applications rejected and other teams members who had 20% of their applications rejected. There were only 5 paperwork submissions by other team members so this should be interpreted with caution.

Supplementary Table 4 – Differences in the fast track pathway discharge process due to inpatient death

	Discharged	Died as inpatient	
Days between admission and either death or discharge	19 (11-28)	28 (16-42)	p=0.039
Days between admission and suggestion	9 (5-19)	15 (9-33)	p=0.032
Days between suggestion and paperwork submission	2 (0-4)	3.5 (1-7)	p=0.510
Days between paperwork submission and approval	1 (0-2)	1 (0.5-2.0)	p=0.357
Days between suggestion and destination decision	5 (3-9)	5 (2-8)	p=0.483
Days between approval and destination decision	0 (0-1)	0 (0-1)	p=0.624
Days between paperwork submission and either death or discharge	4 (2-7)	3.5 (2-7.5)	p=0.839
Days between approval and either death or discharge	3 (1-5)	3 (2-5)	p=0.796

Supplementary Table 4 – Differences in the fast track discharge process due to inpatient death

Data is displayed in median days with IQR. Statistical significance has been tested with Independent Mann-Whitney U tests.

The data demonstrates that there is a significant difference in the time to death and time to discharge (or length of stay). This is accounted for by the increased time between admission and first suggestion of fast track discharge.

1. Department of Health and Social Care (UK). Fast-track pathway tool for NHS continuing healthcare. In: Department of Health and Social Care, editor. www.gov.uk/government/publications/nhs-continuing-healthcare-fast-track-pathway-tool2018.
2. Marie Curie Charity. Making every moment count: the state of fast track discharge in continuing healthcare in England. Marie Curie Charity; 2016.
3. Geriatric Medicine Research Collaborative. Using Social Media and Web-Based Networking in Collaborative Research: Protocol for the Geriatric Medicine Research Collaborative. JMIR Res Protoc. 2018;7(10):e179.
4. Geriatric Medicine Research Collaborative. Growing research in geriatric medicine: a trainee perspective. Age Ageing. 2020;49(5):733-7.
5. Thompson S, Frampton E. Audit of delayed discharges from a specialist palliative care unit. BMJ Supportive and Palliative Care. 2012;2(Suppl 1):A60-A.
6. Scott IA. Preventing the rebound: improving care transition in hospital discharge processes. Aust Health Rev. 2010;34(4):445-51.
7. Venkatasalu MR, Clarke A, Atkinson J. 'Being a conduit' between hospital and home: stakeholders' views and perceptions of a nurse-led Palliative Care Discharge Facilitator Service in an acute hospital setting. J Clin Nurs. 2015;24(11-12):1676-85.
8. Minichiello TM, Auerbach AD, Wachter RM. Caregiver perceptions of the reasons for delayed hospital discharge. Eff Clin Pract. 2001;4(6):250-5.
9. Redwood S, Simmonds B, Fox F, Shaw A, Neubauer K, Purdy S, et al. Consequences of 'conversations not had': insights into failures in communication affecting delays in hospital discharge for older people living with frailty. Journal of Health Services Research & Policy. 2020;25(4):213-9.
10. King's Fund. Delayed transfers of care: a quick guide. <https://www.kingsfund.org.uk/publications/delayed-transfers-care-quick-guide>; 2018.
11. Morse A. Discharging older patients from hospital. <https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf>: National Audit Office; 2016.
12. Healthcare quality improvement partnership. National audit of care at the end of life. 2nd round report. 2020.