The Availability and Supply of Short-Term Care Beds in Long-Term Care Facilities: A Mechanism to Ensure Timely Transfers Out of Hospital for Older Patients in England

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RESEARCH

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MADELINE NAICK

KAREN JONES

*Author affiliations can be found in the back matter of this article

ABSTRACT

Context: At the time of the study, hospitals in England had 24,029 patients who no longer met the criteria to reside (as of 1 April 2022).

Objective: This qualitative study examined the availability of short-term beds in long-term care facilities to support the discharge process, alongside the opportunities and challenges managers faced.

Method: Managers in long-term care facilities were interviewed between October 2021 and April 2022. The framework approach underpinned the analysis, which used thematic analysis.

Findings: Managers perceived that short-term beds enable the transfer of patients from a hospital for assessment and potential rehabilitation before returning home or to a further care setting. Three main themes emerged: supply and demand, service pressure, and the impact of the COVID-19 pandemic.

Limitations: The study was conducted during the COVID-19 pandemic, when the government's guidance to long-term care facilities underwent significant changes. The study was limited to a small sample of managers from long-term care facilities, and therefore, the views may not be representative. Finally, we acknowledge that the preferences among patients and families were not represented in the study, and that the discharge process could not be fully explored.

Implications: This study found that communication and planning within and between health and social care providers are crucial for ensuring the timely discharge of patients into long-term care facilities. These findings are consistent with post-pandemic research (Naick and Jones (in development)), highlighting the potential to inform the government policies focusing on the hospital discharge process.

CORRESPONDING AUTHOR:
Madeline Naick
Research Assistant, Personal Social Services Research Unit, University of Kent, Cornwallis Central, Canterbury, Kent, CT2 7NF, UK
m.s.naick@kent.ac.uk

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INTRODUCTION

Hospital discharge is the final stage of an individual's journey when they leave an acute setting to an environment best suited (for example, back home or to a long-term care facility such as residential care homes or nursing care homes) to meet their ongoing health and care needs (Department of Health and Social Care, 2024). However, delays within the discharge process continue to be a priority for the government in developing policies aimed at reducing the number of older people staying in hospitals, alongside ensuring equal and fair processes.

A delayed hospital discharge is used to describe situations where there is a delay with a patient being discharged from the hospital to home or a further care setting when considered medically fit to do so (NHS England, 2020). The number of people delayed per day is calculated by dividing the total number of delayed days in the month by the number of calendar days (NHS England, 2020). On 1 February 2025, NHS hospitals in England had 22,028 patients who no longer met the 'criteria to reside'. Of these, 8,062 were discharged, leaving 13,966 patients in hospital (NHS England, 2025). A similar number of patients remained in the hospital during the study period. On 1 April 2022, NHS hospitals in England had 24,029 patients who no longer met the 'criteria to reside'. Of these, 10,801 were discharged, leaving 13,228 remaining in the hospital (NHS England, 2022).

It has been extensively documented that delayed transfers of care can impact cognitive impairment, frailty, and a reduction in the ability to perform activities of daily living can harm well-being (e.g. Hinde *et al.*, 2021; Bai *et al.*, 2019; Bo *et al.*, 2016) and presents additional costs to health and social care systems (Maguire, 2023). From a health system perspective, Maguire (2023) estimated that in 2022–23, the direct costs of delayed discharges alone (excluding additional costs from activities such as cancelled operations or staff time spent arranging care packages) were around £1.7 billion at the time of the analysis. Furthermore, inequalities in the discharge process across different localities can also delay the transfer of patients out of the hospital, impacting patients' access to care (Smith *et al.*, 2022).

The Department of Health and Social Care (DHSC) introduced the Discharge to Assess (D2A) model of care in 2020 to expedite patient discharge from the hospital during COVID-19 when the discharge criteria were met (DHSC, 2024; HM Government, 2020). Hospital staff must identify which D2A pathway will support a patient's discharge by carrying out a limited assessment of needs on the ward.

There are four pathways for professionals to consider.

1. Pathway 0 – A patient is discharged home or to a usual place of residence with no new or additional health and/or social care needs.
2. Pathway 1 – A patient is discharged home or to a usual place of residence with new or additional health and/or social care needs.
3. Pathway 2 – A patient is discharged to a community bed-based setting that offers dedicated recovery support. New or additional health and/or social care and support are required in the short term to help the person recover in a community bed-based setting before they are ready to either live independently at home or receive longer-term or ongoing care and support.
4. Pathway 3 – A patient is discharged to a new residential or nursing home setting, who is considered likely to need long-term residential or nursing home care. This pathway should be used only for patients with the highest level of complex needs and in exceptional circumstances, as generally, the aim is not to transfer patients permanently into an long-term care facility (LTCF) for the first time directly following an acute hospital admission (DHSC, 2024; DHSC, 2020; NHS England, 2021).

Pathways 1 and 2 may include reablement and rehabilitation support at home or in an LTCF, which involves providing short-term practical and emotional support to assist patients in recovering and building resilience and independence. The patient can be discharged back home or to a care facility, where a comprehensive health and social care assessment will be conducted to determine whether the individual can continue to reside at home or if a permanent placement in an LTCF is required (DHSC, 2024). LTCFs offer long-term care, respite care, intermediate care, or palliative care. There are two types of facilities with nursing care homes providing personal and nursing care, and residential care homes providing personal care only (Brook *et al.*, 2020). During the COVID-19 pandemic, the discharge assessment initiative assisted with discharge planning upon admission to the hospital. The right discharge destination was identified to provide a safe and timely discharge, offering practical support to promote an individual's independence (HM Government, 2020; DHSC, 2020).

To ensure hospital discharges occur promptly, multidisciplinary teams across the health and social care sectors should collaborate with the person being discharged, alongside their family carers where relevant, to plan for the discharge (DHSC, 2024). A recent policy from the DHSC (2024) has led to the implementation of care transfer hubs to coordinate health and social care, thereby supporting timely hospital discharges. The hubs, physically or virtually, comprise multidisciplinary teams that include representatives from health, social care, housing, and the voluntary and community sectors. They work in an integrated manner to support the planning of complex discharges and to broker the required support through adult social care, intermediate care, and community health services (DHSC, 2024).

Numerous national policies and practice guidelines have been implemented to enhance care coordination during discharge. However, previous research has found the presence of poor discharge coordination, communication and planning factors within the discharge process, leading to a negative impact within the discharge process (Gridley *et al*., 2022; Dossa *et al*., 2021; Leclair *et al*., 2021; Sheehan *et al*., 2021; Fernandez *et al*., 2018).

While there have been studies regarding the post-discharge process from the hospital, the primary focus has been on the perspective of health providers and intermediate care services (Herfjord *et al*., 2014; Abrahamsen *et al*., 2016; Jeffery *et al*., 2023). There has been limited literature exploring the impact of short-term care beds (D2A Pathway 2) on the discharge process from the hospital to an LTCF involving care home managers. This qualitative study explored the barriers and facilitators regarding the effectiveness of the discharge pathway for patients from hospitals to short-term care beds placed in LCTFs.

The qualitative study explored:

- The availability and demand of short-term care beds within an older adult LTCF.
- The perceived impact of short-term care beds on the timely transfer of patients out of the hospital.
- Discharge arrangements and the factors that facilitate or inhibit the process.
- The resident's journey during and after a short-term stay in an LTCF.

METHOD

The Clinical Research Network (CRN) Kent, Surrey and Sussex advertised the study to all CRN local offices in England and the NIHR ENRICH Research Ready Care Home Networks. The networks bring together LTCF staff, residents, and researchers to facilitate the design and delivery of research (nihr.ac.uk). The project was also advertised within the Contact, Help, Advice and Information Network (CHAIN). CHAIN is an online support network for people working in health and social care (chain-network.org.uk). A project flyer included information about the study and details of what participating in the project would involve, alongside contact details of the research team for further information and to express an interest in the study.

An email was sent to each interested LTCF, including an information sheet for the manager, before scheduling an online (MS Teams or Zoom) or telephone interview. Recruitment snowballed across the Clinical Research Network, and other LTCF managers expressed interest in participating. In eleven counties across South East, East and North East England, 14 LTCF managers had expressed an interest in the study, and 14 participated (seven in residential care and seven in nursing care).

The interviews, which lasted between 30 and 45 minutes, took place between October 2021 and April 2022. One researcher, a qualitative researcher with a clinical background, conducted the interviews. Oviedo *et al*. (2021) highlighted the social and psychological benefits of using clinician researchers to conduct interviews during the COVID-19 pandemic. Researchers with a clinical background understand the pressure of services and share a common language, essential when building rapport during interviews.

All interviews were audio-recorded, transcribed verbatim, and analysed using thematic analysis in NVIVO software. The qualitative researcher conducted this analysis.

The semi-structured interview schedules were informed by previous research (Gridley *et al*., 2022) and engagement with colleagues from the Department of Health and Social Care. The schedule included the following areas:

- information on the number of short-term beds within an LTCF and whether the beds are privately or LA-funded (or both);
- the length of time residents' stay;
- the impact of offering short-term care beds on delayed transfers of care;
- factors that facilitate or challenge offering short-term care beds; and
- factors facilitating or challenging the timely transfers of patients out of the hospital into an LTCF.

The emerging themes were presented to DHSC policy colleagues during the first stage of the research, and additional questions were included in the topic guide to capture information on the capacity to offer short-term care beds, recent changes to staffing levels, staff retention, and recruitment of carers. At the time of the study, LTCFs were required to follow pandemic guidance regarding COVID-19, which was also included in the interview questions. Following feedback from interviews, a separate interview schedule was developed for nursing care that included the following additional questions: 1) Impact of COVID-19 on access to therapeutic, physiotherapy, Dietician, Speech and Language (SaLT) and therapy services for residents occupying a short-term care bed and 2) the expectations on LTCF staff and the impact on residents.

At the start of the interview, the researcher reviewed key information from the participant information sheet and checked understanding. There was an opportunity to ask any questions. Verbal informed consent was taken at the time of the interview. Participating LTCFs were provided with a £20 Amazon voucher and a certificate of participation, which they could display. Ethical approval was obtained from the University of Kent's Social Research Ethics Committee (0916).

ANALYSIS

The framework approach was chosen to underpin the analysis, given the small sample size, and to facilitate the development of a robust qualitative data analysis method (Firth and Smith, 2011; Ritchie *et al.*, 2003): the software package NVivo, version 13, assisted data organisation. The framework approach comprises five stages: familiarisation, identification of a thematic framework, indexing, charting, mapping, and interpretation (Heath *et al.*, 2012). The first analysis stage involves familiarising the interview data (Ritchie *et al.*, 2003). An initial coding framework was used to identify and refine the codes (Firth and Smith, 2011). NVIVO version 13 managed the data and assigned codes to categories. A matrix was created for each theme with data charted within that theme. For the final stage, thematic analysis was applied to the data and recurrent and important final themes were identified (Heath *et al.*, 2012). A discussion took place with the project team about the initial codes and final themes to establish the integrity and trustworthiness of the data.

FINDINGS

Long-term care facility description

On average, the 14 LTCFs (e.g., nursing and residential care homes) reported having 42 registered beds, ranging from 14 to 96. Please refer to Table 1 which describes profile of participants, type of LTCF and funder. Four managers reported having beds specifically designated for short-term residents, such as those in respite care. At the same time, the rest did not have dedicated beds but nonetheless accepted short-term residents. Five managers reported that short-term residents privately pay, with three reporting that residents were LA-funded and the rest having a mix of privately and LA-funded residents. Generally, stays were up to one to four weeks, including respite for family carers, rehabilitation, delays with care packages, waiting for a pre-assessment or complete assessment, or a family arrangement from the hospital.

THEMES FROM THE ANALYSIS

The analysis revealed three main themes: supply and demand, service pressure, and the impact of COVID-19.

Theme 1: Supply and Demand

It was identified that short-term beds could be an interim measure to assess care needs and provide time to organise home care packages or adaptations to the home.

> I would say that yes, we have had residents come to us on a Discharged to Assess basis because the social worker was unable to set up a care package for them in the community. (CH 010)

> We've had one who came to us out of the hospital due to needing rehabilitation in a care home. And then when it came to the person actually going back to their own home, they couldn't get a care package in place, and he was with us for another six weeks. (CH 014)

The increased demand and short supply of short-term beds seemed determined by LA's capacity to provide home care packages or timely adaptations to the home.

> ... there's a lot of communication between hospitals and ourselves because there aren't the packages in domiciliary care at the moment, because there's not enough staff. So, we're

CARE HOME ID	LOCALITY	TYPE OF LTCF	CQC RATING	NUMBER OF BEDS
1	Surrey	Nursing	Good	60
2	Surrey	Nursing	Outstanding	96
3	West Sussex	Nursing	Good	31
4	East Sussex	Residential	Good	20
6	Hertfordshire	Nursing	Outstanding	22
7	Hampshire	Residential	Good	24
8	West Midlands	Residential	Good	47
9	Cambridgeshire	Residential	Good	33
10	Cambridgeshire	Residential	Good	36
11	East Anglia	Residential	Good	63
12	Cambridgeshire	Residential	Outstanding	14
13	Northumberland	Nursing	Good	35
14	Sunderland	Nursing	Good	56
15	Tyne and Wear	Nursing	Good	47

Table 1 Profiles of Participants, Long-Term Care Facility, and Funder.

Mean (average) Number of Beds = 41.7 (42).

> finding that there are people who are ready to go home into the community, but because the dom [domiciliary] care is not in place, we're picking up the people coming through at the moment, as a short-term. (CH 004)

> From the hospital point of view, they are fit for discharge, they come to a care home as an interim placement until the housing sorts out a double bedroom on the ground floor, for example. Until that gets sorted, it may take months. (CH 007)

The short-term care beds served as an interim measure for a prompt discharge following the initial assessment on the hospital ward, providing time for a complete assessment of need to be conducted after discharge. Following a comprehensive assessment, residents often transition to a permanent placement due to health concerns and specific needs. While this process aligned with the D2A model regarding not transferring a patient permanently into an LTCF, it reduced the supply of short-term beds for assessment. Affecting access for patients ready to be discharged from hospitals.

> Or in the end they stayed here long-term of the level of need showed that actually, they can't manage to go back in the community, they can't even prove to the level of going back in the community. (CH 007)

However, it could be argued that short-term beds are an effective mechanism for an easier transition for residents to become permanent. Poorer outcomes are dependent on several factors, including the level of function before hospital admission and access to rehabilitation in the LTCF, as some individuals are unable to reach optimal function to return home.

Theme Two: Service Pressure

The theme of 'service pressure' refers to the pressures LTCFs face when offering short-term beds. The D2A model outlines that an initial assessment is carried out on the hospital ward; however, managers perceived the assessments as inadequate, which affects their ability to provide short-term beds.

> It just seemed like the hospitals – and I understand this because I am a nurse and did used to work in them but it just seemed like it was a chuck, anyone out anywhere type scheme to free up beds and some of the assessments of people prior to coming to us were very poor. (CH 011)

The managers highlighted that coordinated information on health and physical conditions was not always current before transferring a patient to the LTCF for a short-term stay.

> …different staff nurses look after these patients in our local hospitals every single day, and so they didn't know these people all that well. …so you'd get all the clinical stuff, how much they weighed, I'd notice they've got a pressure sore perhaps, maybe not, but you know, that was the type of information you could get if you get the clinical information about if they had diabetes, etc., But you weren't getting the bit about them as a person and three-quarters of them were people with memory problems or a diagnosis of dementia and what I'm used to in assessment is getting to know them as a person, getting to know their likes and dislikes. (CH 011)

Timely discharges presented a further challenge for LTCFs, as discharges on weekends can affect the availability of short-term beds with adequate resources, such as GP cover during the weekend.

> I'm always sensible about what I call safe admissions anyway. I will have admissions on a Friday, but I prefer they be here by 4:00 p.m. on a Friday so I can register them at the doctor's office. If not, they're not registered anywhere for the whole weekend, and I don't think hospitals get that, because they've moved from one part of the county to another, they won't be registered on that Friday if they arrive at 8 o'clock at night. Okay, we can call 111, but they won't be under our own GP surgery at that point, so you probably can't get district nursing service over the weekend because they'll only do it on a GP, and it's on their system. (CH 011)

The managers stressed the importance of reviewing paperwork and having up-to-date information on a person's health and physical condition before accepting someone for a short-term stay due to the potential increased level of care required for new residents.

> I think at the hospital. I think because they go through so many stages and so many people are looking after the person's care, and often you don't always get, you know, if they had physio involvement, not always is it all collated in the information that gets sent out to us. (CH 004)

It is acknowledged that one manager perceived the paperwork for short-term beds as a burden.

> I mean, for me personally, the amount of paperwork that goes into a short-term, and by the time you've maybe tried to get the new resident with a doctor, with their own doctor and the amount of time it takes in the community to get a lot of the stuff done, sometimes it's not beneficial

> to care homes to do that. Because by the time you get your paperwork sorted, they're off, then they're going. (CH 004)

Theme 3: Impact of COVID-19

The COVID-19 pandemic significantly impacted the ability of long-term care facilities (LTCFs) to offer short-term beds. This theme provided valuable insights into the challenges faced by the LTCFs during the pandemic, and guided future national government policies when facing a new pandemic. Due to the residual risk of exposure to COVID-19 in hospitals, at the time of the study, the UK Health and Security Agency (2022) guidance stated that a new resident would have to be isolated for 10 days in a room once transferred, which delayed access to rehabilitation when transitioning into a LTCF. Then, the assessment would begin afterwards.

> ... When they then come – hospitals are still classed as a high-risk activity for care home residents, so basically they will then – even though they've got a negative test, they will then have to isolate for ten days. (CH 009)

Managers discussed the impact that isolating in the LTCF had on new residents. Not only were they socially isolated in a new environment from other residents, but due to pandemic-related guidance on services, LTCFs reported a double effect: they had limited access to community reablement services during lockdown. This also reduced the potential for rehabilitation during a critical six-week timeframe immediately following hospital discharge.

> ... he came into care at the time of COVID, when restrictions were very high, that re-enablement wasn't taking place the way it should have, if that makes sense, at the speed to be able to return to the community. The person is now in long-term care, and maybe a year ago, he had a 60/40 chance to do that, a sixty per cent chance of working with us and returning to the community and maybe forty of staying long-term. (CH 007)

Some managers reported a lack of services entering the LTCF during the lockdown and a significant decrease in contact with healthcare professionals visiting the LTCF. This impacted the ability to offer short-term beds, as the required support from healthcare professionals was unavailable to support residents with specific mobility or nutritional needs.

> Because up until probably about a month ago, a speech and language therapist hadn't come into the building at all, and still, the preference is that they do things remotely. Swallowing is quite a difficult thing to assess comfortably via a computer screen. So it has certainly been one of the things that has made us stop and think, actually, can we safely support this discharge if we can't get access to a speech and language therapist for, you know, however many days or weeks the wait might be at the time? (CH 006)

A significant concern for managers was staff availability during the pandemic, particularly in terms of getting sick from COVID-19, refusing to get vaccinated, or facing recruitment problems.

> But I would say due to staff testing positive for COVID, that's most probably had an impact on the home because we've had to pull management resources to support out on the floor. And then, when – and then due to that, and see the workload from taking Discharged to Assess, I made the decision not to accept any more admissions. (CH 010)

Managers also reported a climate of fear among existing staff regarding the safety of vaccines and the compulsory vaccination programme for care workers. A lack of knowledge about COVID-19 and the loss of experienced staff significantly impacted some smaller LTCFs, which could not cover regular care shifts and offer short-term beds.

> ... And ever since we got hit [COVID] and, you know, care homes are not a great place to be, staff are not coming into care. You know, I've got three adverts out at the moment and I've had, what, two people apply for three positions. So, yeah, we're not getting people through. And, obviously, the vaccine has made a significant impact on people's willingness to come into care, as some individuals don't want to receive the double jab. People have left because care homes were among the first to require the double jab. So a lot of them went to the NHS and moved out of working in care homes because they didn't want to have the vaccine. (CH 004)

Managers believed recruitment was made harder because of the requirement that staff be vaccinated. For smaller care homes, recruitment challenges meant that they risked closing.

> Trying to get committed staff now, a lot of us are burnt out because we used – we worked a lot. We are tired. We have been – like last month, we had an outbreak. I managed, in a forty-hour week, to do sixty hours overtime. (CH 009)

Many LTCF managers stepped in to assist with shifts, bridging the gap. The administration's impact on balancing the staffing shortfall during this period is unknown.

DISCUSSION

The number of days patients remain in hospital when they are medically fit to be discharged is an ongoing issue for policymakers and the care sector in England (Smith *et al.*, 2022). Many policies and guidance are coming from the Department of Health and Social Care, such as the D2A model. Despite these policies, patients are remaining in hospitals unnecessarily. On 30 June 2025, NHS hospitals in England had 20,633 patients who no longer met the 'criteria to reside' and 8,961 of these patients were discharged (NHS England, 2025).

The availability of short-term care beds in long-term care facilities (LTCFs) has received considerable attention from the Government as a mechanism to reduce the number of patients staying in hospitals when they are medically fit to leave (NHS England, 2021). This focus is significant, as it directly impacts patients, family caregivers, and the care sector due to delays within the transfer process. The national system of the D2A model, introduced by the DHSC in 2020 during the COVID-19 pandemic, highlights the use of LTCFs for short-term care beds (DHSC, 2020). The managers in the current study believed that short-term care beds within LTCFs can serve as a mechanism for facilitating timely hospital transfers. Indeed, the use of LTCFs with the D2A model is associated with reduced length of stays (Wilson *et al.*, 2023).

The D2A model emphasises that patients should not be transferred permanently into an LTCF for the first time directly following an acute hospital admission (DHSC, 2020). Aligning with this policy, the study highlighted that some patients are being transferred to a short-stay bed with the understanding that there may be a potential requirement for a permanent bed following a complete assessment after discharge. It could be suggested that this mechanism facilitates an easier transition for patients, although it presents challenges for LTCFs. This, in turn, reduces the supply of short-term beds for assessment and access to services for patients ready to be discharged from the hospital. There is an identified risk of patients with reduced function on admission to hospital having poorer outcomes when placed in a short-term care bed or becoming permanent (Abrahamson *et al.*, 2016; Wilson *et al.*, 2023).

The managers outlined several challenges associated with offering short-term care beds to residents and the impact on their recovery and rehabilitation potential during their stay in an LTCF during the COVID-19 pandemic. This was often affected by staffing issues in LTCFs during the pandemic, which were also reported as problematic due to sickness and poor recruitment. This usually meant that managers had to increase their workload and reduce management resources within the facility. The managers discussed the LTCF staff's role in implementing interventions without assessment and input from therapists, which raised concerns about the safety of residents upon discharge during the pandemic.

In the current study, managers perceived that initial hospital assessments were sometimes inadequate for safely transferring patients into their care. They emphasised the importance of having access to patients' records and hospital notes before accepting a patient for transfer to an LTCF for a short-term stay. Some managers reported receiving irrelevant and missing information regarding patients' health and support needs. Inaccurate information subsequently impacts the timing of patient discharge, affects communication across the D2A pathway and decisions to transfer to an appropriate LTCF (Jeffery *et al.*, 2023).

There is clear evidence to suggest that delays in transferring patients from the hospital can exacerbate cognitive impairment, frailty, and the inability to perform activities of daily living (Hinde *et al.*, 2021; Bai *et al.*, 2019; Rojas-Garcia *et al.*, 2018; Bo *et al.*, 2016). For example, Hinde *et al.* (2021) emphasised that broader factors impact the patient pathway. Delayed discharge increases health risks for patients remaining in the hospital and hinders other elective admissions. The long-term impact on patients and family carers has a personal effect and can potentially increase the financial challenges within the health and social care sectors. Evidence suggests that discharging a patient too soon can lead to dissatisfaction and increase the potential for readmission rates (Friebel *et al.*, 2019; Rojas-García *et al.*, 2018). In the current study, the managers expressed concern about the impact of being transferred too early and the need for safe discharges to ensure better outcomes for patients.

The Nuffield Trust (2021) outlined the importance of effective planning and joint working in the discharge process. Aligning with this importance, the challenges found in the current study seem to stem from communication and planning between and within the care sectors, such as hospital staff not sharing up-to-date, key or correct information on a patient's health status with the care home manager (Jeffery *et al.*, 2023). The NHS and local authorities (LAs) working more closely to plan and implement hospital discharge, recovery, and reablement in the community could potentially resolve some of these challenges. Communication and planning improvements could prevent late patient transfers on a Friday afternoon, leaving sufficient time to register each individual with a GP for the weekend**.** Effective communication and multidisciplinary discharge planning between the sectors may also help ensure that the

LTCF receives all the required information to make an informed decision about whether to accept an individual, and that there is a sufficient workforce to support their needs (Herfjord *et al.*, 2014).

During the COVID-19 pandemic, the situation was exacerbated by confusion, conflict, and chaos within departments, resulting in delays in discharges and duplication of work. Staff in both hospital and community settings faced extreme pressure during the first wave of the COVID-19 pandemic, as they managed their daily roles and routines alongside new systems of care and evolving guidance (Healthwatch, 2020; MacLochlainn *et al.*, 2023). However, a forthcoming paper from a separate study (Naick and Jones (in development)) that explored the D2A Pathway 2 after the pandemic found consistent findings with the current research regarding the challenges faced by LTCFs. Both studies could inform the government's policies regarding transferring patients from hospitals to long-term care facilities (LTCFs) and the value of effective communication and planning between and within the care sectors to facilitate discharge.

It is necessary to acknowledge that the study was limited to a small sample of LTCF managers who accepted the invitation to participate; therefore, we cannot gain a representative impression of the views. Furthermore, we acknowledge that the preferences among patients and families were not represented in the study, and that the impact of the discharge process could not be fully explored.

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COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR AFFILIATIONS

Madeline Naick orcid.org/0000-0002-4807-4944
Research Assistant, Personal Social Services Research Unit, University of Kent, Cornwallis Central, Canterbury, Kent, CT2 7NF, UK

Professor Karen Jones orcid.org/0000-0003-0851-8341
Director, Personal Social Services Research Unit, University of Kent, Cornwallis Central, Canterbury, Kent, CT2 7NF, UK

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