Central Bedfordshire Council
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Hospital Discharge Task Force

Final report of the review of performance relating to the pathway for leaving hospital

Security Classification: Not protected

Contents

Summary

At a previous meeting the Social Care, Health and Housing OSC (SCHHOSC) discussed issues relating to hospital discharge, including the importance of looking at the whole pathway and meeting the needs of patients. Members also discussed feedback that some patients were being discharged from hospital inappropriately, either late at night or early in the morning. It was agreed to establish a task force to review performance and report back to the Committee.

The Task Force was constituted byCouncillors Rita Drinkwater (Chairman), Bowater; Mrs S Goodchild, Mrs D Gurney, Mrs A Sparrow; and a representative of Bedfordshire Local Involvement Network and latterly HealthwatchCentral Bedfordshire.

To commence the review the Task Force invited health professionals with experience of hospital discharge to attend a meeting and provide their views. Evidence was received from:-

- Y Aris, Head of Adult Safeguarding in Bedfordshire for Bedfordshire Clinical Commissioning Group
- Dr J Baxter, Clinical Director for Bedfordshire Clinical Commissioning Group
- S Collins, Deputy Chief Operating Officer atBedfordHospital
- Dr B Ella, Clinical Director for Bedfordshire Clinical Commissioning Group
- Dr L Mackenzie, General Practitioner at Wotton Vale Healthy Living Centre
- N Patel, Head of System Redesign for Bedfordshire Clinical Commissioning Group
- S Rees Assistant Director of Adult Social Care at Central Bedfordshire Council
- E Saunders, Assistant Director of Strategic Commissioning at Central Bedfordshire Council
- G Turrell, Acute Quality Manager for NHS Bedfordshire

What was working well?

Attendees were asked to provide evidence of good practice and what they felt was working well in Central Bedfordshire. Positive feedback related to following:-

- the use of the short-stay medical unit;
- practice in relation to the reablement, rapid intervention and fast response teams;
- the use of community matrons;
- the whole range of community and voluntary services that were available, including the good neighbour and village care schemes; and
- improvements at BedfordHospital in relation to the holding of electronic records.

Where could we improve?

Attendees were asked to suggest areas that the task force could consider in more detail by suggesting where improvements could be made. Whilst it was not possible for the task force to cover every aspect that was suggested the Members agreed to focus on two areas:-

1. **Understand performance in relation to hospital discharge from those hospitals that provide a service to Central Bedfordshire residents**

There was anecdotal evidence of poor performance both locally and nationally and Members agreed it was important to understand the evidence of local performance. The Task Force also held a meeting to focus specifically on the performance of BedfordHospital as the hospital with the greatest numbers of patients from Central Bedfordshire.

2. Consider ways of enhancing communication and signposting to service providers.

There were many partners and services operating in Central Beds and there was a need to understand who was responsible for signposting to services and ensuring that relevant partners were talking to one another effectively.

To support the review Members requested information from BedfordHospital and Bedfordshire Clinical Commissioning Group (BCCG) relating to the length of stay in hospital and acute and non-acute delayed transfers of care. Members also met with commissioners to discuss the role of communication and services that could potentially be commissioned to support improved outcomes. The remainder of this report focuses on the two key areas that the Task Force agreed to look into in greater detail.

Next steps

In light of the information received by the task force Members agreed several recommendations regards improvements or further investigation that was required. Due to the complexity of there being several hospitals that discharge patients into Central Bedfordshire Members felt it was necessary both for their recommendations to be taken on board by relevant organisations as well as continued review of performance relating to hospital discharge. It was also noted during the course of the review that several other local authority health scrutiny committees, including Luton Borough Council's had recently undertaken a task force review of performance relating to hospital discharge at the Luton and Dunstable Hospital.

The task force requested that a response be provided to their recommendations by relevant organisations and that HealthwatchCentral Bedfordshire and the CCG be requested to continually review hospital discharge performance and that performance be presented to the SCHHOSC on a quarterly basis. It was also important that HealthwatchCentral Bedfordshire felt able to raise any concerns regards hospital discharge locally with the Committee as necessary.

The recommendations of this task force were endorsed by the Social Care, Health and Housing OSC on 27 January. In agreeing the recommendations the Committee agreed that a progress report be provided by relevant organisations in March 2013. Organisations will be requested to complete Appendix B with a view to updating the Committee on progress in implementing the recommendations of this review.

1.UnderstandingHospital Performance

Performance relating to Excess Bed Days (EBDs)

To understand local performance the task force requested information from Bedfordshire Clinical Commissioning Group relating to hospital discharge experienced by residents of Central Bedfordshire. Table 1 illustrates the data provided by BCCG in relation to the following for the period August 2012 to August 2013:-

No. of spells:	Total number of spells in hospital
Excess bed days:	The total number of EBDs beyond a predicted length of stay after which the hospital incurs an additional cost. Excess bed days is a measure of patients staying longer than a predicted number of days for a particular spell, a hospital will it is a point where the Hospital costs start to incur a daily rate. But is does not mean that they are fit to be discharge (many in this category are very ill).
Total length of stay:	The number of days (LOS) between admission and discharge

The data illustrates the number of residents who experienced a spell in hospital by postcode. However, this method is imperfect with the main anomaly being in the area around Cranfield, which places residents in Bedford Borough. But all along the boundary between the two Local authorities there may be errors in either direction.Luton and Dunstable Hospital delivered the highest number of spells in hospital to patients from Central Bedfordshire (39%). It is worth noting that due to the difficulty of mapping this data this figure may be higher had it included those residents that would appear in the Bedford Borough data. There were a similar number of EBDs at Luton and Dunstable and BedfordHospitals in comparison to the total number of spells.

Concerns/key issues

In discussing the performance data whilst the Task Force raised issues regards the number of EBDs at some hospitals they noted that a faster discharge process did not always mean a trust was more effective than others. Successful performance relied on both quantitative and qualitative outcomes. Therefore the task force highlighted the following concerns:-

1. Whilst the task force had concerns regarding the EBD rate at Stoke Mandeville and the Lister, which accounted for 16% of the number of spells from Central Bedfordshire during this period it was considered more appropriate for other local authorities to review these in more detail. In reaching this conclusion it was noted that several local authorities had recently undertaken reviews of hospital discharge locally. It was however suggested that the Ivel Valley Locality Team should review performance at the Lister in more detail.
2. The BCCG was fairly new in operation and there was a future need to assess its plans for system redesign of acute and emergency care pathways and their impact on the hospital discharge pathway. The BCCGs future plans for acute and emergency care pathways needed to be reviewed further at a future OSC meeting.
3. Whilst the task force were not overly concerned with current performance there was a need to provide ongoing accountability of hospital discharge performance by the OSC, the Locality Teams and HealthwatchCentral Bedfordshire. It may also be

appropriate for other local authorities Overview and Scrutiny Committees to review the performance of trusts where there were high numbers of excess bed days.

Table 1: EBDs for Central Bedfordshire residents by the first 3 digits of the postcode (Aug '12 - Aug '13)	No. of Spells	EBDs	Total LOS
Total all Hospitals	58694	15357	142960
Total Named Hospitals	56688	15118	136794
Luton & Dunstable Hospital Foundation Trust	22757	6898	54537
Bedford Hospital Trust	13394	3764	37157
East & North Hertfordshire Trust	5897	2114	16376
Milton Keynes Hospital Foundation Trust	3136	463	6117
Buckinghamshire Healthcare Trust	3675	745	6000
Cambridge University Hospitals Foundation Trust	1666	246	3521
University College London Hospitals Foundation Trust	934	212	1761
Royal Brompton &HarefieldFoundation Trust	738	128	2925
Oxford Radcliffe Hospitals Trust	688	219	1934
Papworth Hospital Foundation Trust	608	33	2003
Royal Free Hampstead Trust	546	67	949
West Hertfordshire HospitalTrust	525	29	618
Pinehill Hospital	480	1	285
Great Ormond Street Hospitalfor Children Trust	351	4	467
Royal National Orthopaedic HospitalTrust	348	142	1052
Hinchingbrooke Health Care Trust	298	6	268
ClinicentaLtd	295	0	40
Imperial College Healthcare Trust	182	40	595
Northampton General HospitalTrust	170	7	189

Recommendations

1. **That a report be presented to a future meeting of the Social Care, Health and Housing OSC by BCCG to provide greater clarity of its plans for the system redesign of acute and emergency care pathways.**
2. **That the Ivel Valley Locality Team be asked to review performance in relation to hospital discharge at the Lister Hospital and the numbers of delays of discharge for Central Bedfordshire residents.**
3. **report should be sent to other LAs to consider whether a review of performance by scrutiny was necessary.**

Performance relating to delayed transfers of care (DTC)

The task force also received information (table 2) on the reasons for delayed transfers of care (DTCs). DTCs occur when patients are fit to be discharged from hospital but for a reason outside the hospitals control they continue to occupy a bed.Many DTCs are for a short period of time and many are less than the trim point and do not incur any excess bed days, as a result there is no direct relationship between EBDs and DTCs.

The task force also received information on the organisations that caused the delays (table 3) with a view to determining whether there was a particular organisation at the route of a DTC.

Table 2: Reason for delayand number of days of delay for patients of Central Bedfordshire for all NHS providers (Apr - Dec '12)	Patients	Days
Patient or family choice	18	759
Completion of Assessment	25	664
Further non-acute NHS care (including intermediate care, rehabilitation etc…)	24	649
Awaiting residential care home placement	13	415
Public Funding	2	87
Care package in own home	8	143
Awaiting nursing home placement	1	89
Disputes	1	53
Community equipment/adaptations	2	27
Housing – patients not covered by NHS and Community Care Act	2	30
Total:	96	2916

Table 3:Cause of delay incurred by patients of Central Bedfordshire for the period Apr – Dec '12	Patients	Days
NHS	62	1,970
Social Care	18	534
Both	16	412
Total:	96	2916

In discussing the information the Task Force noted that before April 2012, local authority based data was not available, data was only recorded by NHS Provider and PCT / Commissioning Group. Consequently, the quality of date relating to social care delays was questionable due to the processes for checking the accuracy of data. As data quality and reliability improves, the SCHH directorate intends to include "delayed discharges for social care reasons" into its performance scorecard.

Despite the quality of the data it demonstrates that the three principal causes of delay during this period (71%) were patient or family choice (759 days); delays in completing an assessment (664 days); and awaiting further non-acute NHS care (649 days). Whilst the NHS was the cause for 68% of the days of delay there were several delays that were the result of social care reasons (predominantly where patients are awaiting residential care home placements, 343 days) or as a result of both NHS and social care reasons (predominantly due to completion of assessment 355 days).

n light of the performance the task force did not agree any specific recommendations but it did note the difficulty of addressing the number of days of delay as a result of patient/family choice and highlighted the importance of community care and being able to provide services to people in their home where appropriate. Whilst there were delays as a result of patient or family choice the task force felt it was important for patients to have time to consider what they wanted to happen next in the context of long-term care. Patients needed to be provided with the time to make a considered choice before being moved into a care home placement. Engagement with carers throughout this process to ensure that they were confident and supported was also important.

2. Hospital Discharge at Bedford Hospital

In light of the performance information Members invited a representative of Bedford Hospital to attend a meeting to explain their performance. Steve Collins, the Deputy Chief Operating Officer (BH) attended a meeting and outlined the changes and investment at the hospital to address some of the concerns regarding hospital discharge. These included:-

- An SLA between Central Bedfordshire Council and Bedford Borough Council to provide extended hours was agreed in April 2011. This moved the operation of the Social Work Team based at the Hospital to a seven day a week operating model. This was implemented to improve discharge rates and avoid people having unnecessary delays in being able to return home or to a more appropriate form of care.
- Encouraging positive involvement from social care schemes in A&E and hospital discharge.
- Gathering patients who may experience more complex discharges onto one ward, particularly elderly patients so that discharges could be managed more effectively.
- Making courtesy calls to patients once they had been discharged from hospital to check everything was ok.
- Using a Carer Lounge to provide useful and timely information to carers and work with carers early in the hospital discharge pathway.

The task force were also aware that a service level agreement was in place with Bedford Borough Council in order to provide social work teams and extended hours at Bedford hospital. These arrangements were as follows:-

Bedford Hospital Social Work Team

The Hospital Social Work team provides an assessment and care management service to in-patients of Bedford Hospital aged 18 and over. This service is also extended to their families and carers. All patients in need of support are referred for an assessment to assist facilitate a timely hospital discharge. Currently the service operates a seven day a week service.

The Hospital Team contribute to the development of joint policies within the hospital, e.g. The Choice Directive, and assist in times of crisis, e.g. Winter Pressures, ensuring that patients experience an integrated health and social care approach to discharge planning.

This service is offered to patients discharged to both the Bedford Borough Council and Central Bedfordshire areas and is governed by a Service Level Agreement which is hosted by Bedford Borough Council.

Luton and Dunstable Social Work Team

The Hospital Social Work Team which covers the Luton and Dunstable Hospital is operated by Central Bedfordshire Council. Currently the service operates Monday to Friday and the criteria for access to the service is the same as for the Bedford Hospital equivalent. Both teams provide the following interventions:

- The Social Work team will complete an overview and/or Specialist Social Work Assessment.

- Following assessment all eligible patients will be offered a care package, which may consist of domiciliary care, direct payments, residential or nursing care, in order to facilitate a timely discharge.
- Assessments and care planning is offered to both the patients and their carers.
- Professional support is offered to self-funding patients who require assistance with organising appropriate care.
- There is also a requirement to screen for Continuing Health Care and complete Mental Capacity assessments involving an Independent Mental Capacity Assessor (IMCA) if necessary.
- Risk assessments and care plans are completed for all patients and copies are provided to the patients and all relevant care providers.
- Following discharge case files are transferred to the relevant Area Team for review at four or eight weeks. The patient's electronic record is updated using the SWIFT database and file audits are completed before cases are transferred.

Whilst there were several positive aspects of performance it was reported that the majority of delays in hospital discharge occurred during the winter and resulted from delays in obtaining prescriptions and medicines from the hospital pharmacy. There were peaks in the numbers of delays during the year resulting from an outbreak of norovirus. It was also reported that additional pressures could be placed on the hospital as a result of referrals from other hospitals, such as those resulting from the closure of the Surgicentre at the ListerHospital. This had created additional pressure especially as BH had not been adequately notified of the change. Despite the SLA to provide extended hours it was also discussed that the same level of service was not always provided by the hospital at weekends. Having a consistent approach to hospital discharge on Mondays-Fridays and Fridays to Sundays was an areas that the Hospital recognised was in need of improvement.

Although Members were encouraged by the level of investment at BedfordHospital there were concerns regarding aspects of communication. These concerns included the need to ensure that appropriate equipment was available for patients when they were discharged from hospital and the importance of a consistent approach to hospital discharge. There were also concerns relating to the difficulty in obtaining information on patients whilst they were in hospital and the difficulty of obtaining information from various departments that would support an effective discharge from hospital. In light of discussion it was suggested that improvements could be introduced. The Task Force provided the following recommendations in light of their discussion:-

RECOMMENDED that BedfordHospital

1. **employ a person specifically to communicate between the hospital and community healthcare services to support more effective discharges from hospital by ensuring that equipment is available for patients and that appropriate community healthcare needs are met.**
2. **ensure staff fully understand the discharge pathway so that there is a consistent approach and that accurate expected dates of discharge can be provided.**

3. **put appropriate procedures in place to ensure a consistent approach to hospital discharge across the week, including the weekends to ensure that unnecessary delays do not occur just because it is Saturday or Sunday.**
4. **provide one named person who is responsible for an individual patient's entire hospital pathway to ensure that all aspects of that persons care have been considered, including appropriate transport and equipment being available at the other end once they had been discharged.**
5. **provide a single point of contact when discharging patients from hospital and proactively encourage patients to use this single point of contact if they have any issues in the two week period after discharge.**
6. **hold patient information on one central system so that persons need only ring one number in order to obtain any relevant information on that patient.**
7. **seek input from Carers using the Carer Lounge as to whether staff strike the right balance between engaging carers at an early stage and finding the appropriate time to discuss an issue.**

RECOMMENDED that the CCG encourage hospitals from whom it commissions services to standardise hospital discharge forms with a view to creating one familiar form that contained all the necessary information in one place to support effective planning for hospital discharge speeding up the process and making it more efficient.

3. Enhancing communication and signposting

Hospital discharge is a complex process, which is compounded by the complexity of the health system and understanding who is responsible for what. There are many partners delivering different things making it hard to draw them all together, especially when there are several different hospitals that discharge into Central Bedfordshire. The complexity of the process makes it difficult to deliver a common approach for our residents. In light of their discussions the Task Force agreed that there was a need for a 'navigator' to ensure effective communication and signposting to ensure that residents were aware of the services that were available to them. This role would also support effective performance in relation to the hospital discharge pathway.

The Task Force discussed several concerns in relation to communication and signposting, which included:-

- The need to increase the quality of information that is available for patients on the services available locally.
- There is required a more visible interface between the Council, the NHS and community organisations, in particular to encourage discussions between health providers in the north and south of Central Bedfordshire. Members felt that things worked pretty well in the south but that more thought needed to be given to how some of the services (particularly the short-stay medical unit) that have worked so well in the south could be provided in the north to improve the quality and quantity of provision.
- The importance of organisations having a consistent approach to communication so that residents are informed in a consistent manner of the services that are available to them. Organisations should also be mindful of the services that are already delivered by others in the area before agreeing to commission new services.
- The need for better coordination and clarity of the roles of the discharge planning team, rapid intervention team and the district nurses.
- The need to provide district nurses with more advance notice of patients prior to their discharge from hospital. There were often cases where district nurses were not aware of patients up until the point of discharge.
- Hospitals needed to ensure that support for patients didn't stop at the front door when they were discharged to a care home resulting in insufficient information during handover and ultimately a poor quality of care.

In discussing this role the Task Force were informed that the Healthier Communities and Older People Committee were already looking into issues regarding links with community groups in the hospital discharge process. It was also commented that Bedford Hospital had introduced "System One" which aimed to improve communication in relation patient notes and could address some of the concerns of the Task Force. The Task Force also discussed the Joint Community Beds Review (CBR), which it considered would address several of the issues relating to the 'north-south divide'. As this issue was to be considered in detail by the SCHHOSC the Task Force provided a series of specific question to be considered by the

SCHHOSC to provide assurance that the CBR had addressed those issues. These questions are set out in **Appendix A**.

The Task Force agreed the following further recommendations relating to the role of communication and signposting:-

RECOMMENDED that a review be undertaken of the Clinical Navigation Team (CNT)to determine whether it has delivered against its objectives and whether its role remains suitable. In light of this review it should be considered whether the CNT or another appropriate body could be responsible for the following:-

1. **making available a greater quantity and quality of information for patients on the services provided by community organisations and others.**
2. **providing a visible interface for communication between the Council, the NHS and community organisations, particularly to encourage more detailed discussion between providers in the north and south of Central Bedfordshire.**

RECOMMENDED that more effective coordination be undertaken between the discharge planning team, rapid intervention team and the district nurses and that the roles of these teams be considered to provide greater clarity.

RECOMMENDED that hospitals provide district nurses with more advance notice of patients prior to their discharge from hospital, including more detailed information in relation to the needs of that person following their discharge from hospital.

RECOMMENDED that the Care Home Provider Forum discuss issues relating to patient care during discharge from hospital to a care home and whether the handover of information is sufficient.

AppendixA

Interim issues to be raised by the Social Care, Health and Housing OSC in relation to the Joint Community Bed Review:-

Throughout the course of the Task Force review Members have been informed that the Community Bed Review will resolve many of the problems that have been discussed. It is currently envisaged that the Community Bed Review will be presented to the Social Care, Health and Housing Overview and Scrutiny Committee (SCHHOSC) in March 2013. To support the effective challenge of this report it is proposed that the following questions be provided to the SCHHOSC to assist Members with their deliberations:-

1. **Does the Community Bed Review provide evidence of a north/south divide within Central Bedfordshire in terms of the health facilities that are available? If so, how does the Community Bed Review address this divide and what proposals are included for the possible provision of a Short Stay Medical Unit in the north of Central Bedfordshire?**

The Task Force received comments of a perceived north/south divide in terms of the healthcare facilities that were available in Central Bedfordshire. Members were informed that the Community Bed Review (CBR) would identify facilities throughout the area and ascertain if this divide existed. Members were particularly interested to learn if there was evidence of demand for a facility similar to the short-stay medical unit (SMU) at Greenacres within the north of the area to enhance provision.

Members did not consider performance information relating to the short stay medical unit in the south of Central Bedfordshire although anecdotal evidence suggested that the existing SMU had been very effective. It was considered that expanding the number of similar facilities throughout Central Bedfordshire, where it was cost effective, would be positive.

2. **How does the Community Bed Review encourage ongoing planning and communication on a Central Bedfordshire wide basis to ensure that services are available that are appropriate across the whole area.**

The Task Force considered that planning for health services was not undertaken on a region wide basis and that the perceived north/south divide was encouraged by the lack of discussion undertaken in the round. The Task Force were informed that the CBR provided an opportunity to ensure that in the future planning was undertaken on a Central Bedfordshire basis. Commissioning decisions would be taken on the basis of services that were necessary across the whole area. The Committee should ensure there are adequate proposals to ensure commissioning decisions are of a strategic focusing on need across the whole of the area and that discussions involve representatives from across Central Bedfordshire.

3. How does the Community Bed Review identify opportunities to make best use of block-contracts and how will block contracts be used to make potential savings open to service users?

The Task Force raised concerns that some self-funders were not benefitting from the savings that resulted from block contracts. It was commented that the CBR would identify opportunities for using block contracts and would enhance provision where appropriate to pass on savings to service users. The Committee should ensure that opportunities are identified and there are adequate proposals to ensure that service users will benefit from the use of black contracts across Central Bedfordshire,

Although the CCG is new in operation and the System Redesign manager is only recently in post there is a need to understand in more detail the CCGs plans for system redesign for acute and emergency care pathways. This is an issue that can be picked up in more detail with the CCG once there are proposals that the group can review in more detail.

Appendix B

	Recommendation	Lead	Update & comments
1.	CCG be requested to continually review hospital discharge performance and that performance be presented to the SCHHOSC on a quarterly basis	Bedfordshire Clinical Commissioning Group (BCCG)	
2.	That a report be presented to a future meeting of the Social Care, Health and Housing OSC by BCCG to provide greater clarity of its plans for the system redesign of acute and emergency care pathways.	BCCG	
3.	That the Ivel Valley Locality Team be asked to review performance in relation to hospital discharge at the Lister Hospital and the numbers of delays of discharge for Central Bedfordshire residents.	BCCG	
4.	That a report be sent to other LAs to consider whether a review of performance by scrutiny was necessary.	Scrutiny and Policy Manager	
5.	That Bedford Hospital employ a person specifically to communicate between the hospital and community healthcare services to support more effective discharges from hospital by ensuring that equipment is available for patients and that appropriate community healthcare needs are met.	Bedford Hospital	
6.	That Bedford Hospital ensure staff fully understand the discharge pathway so that there is a consistent approach and that accurate expected dates of discharge can be provided.	Bedford Hospital	

	Recommendation	Lead	Update & comments
7.	That Bedford Hospital put appropriate procedures in place to ensure a consistent approach to hospital discharge across the week, including the weekends to ensure that unnecessary delays do not occur just because it is Saturday or Sunday.	Bedford Hospital	
8.	That Bedford Hospital provide one named person who is responsible for an individual patient's entire hospital pathway to ensure that all aspects of that persons care have been considered, including appropriate transport and equipment being available at the other end once they had been discharged.	Bedford Hospital	
9.	That Bedford Hospital provide a single point of contact when discharging patients from hospital and proactively encourage patients to use this single point of contact if they have any issues in the two week period after discharge.	Bedford Hospital	
10.	That Bedford Hospital hold patient information on one central system so that persons need only ring one number in order to obtain any relevant information on that patient.	Bedford Hospital	
11.	That Bedford Hospital seek input from Carers using the Carer Lounge as to whether staff strike the right balance between engaging carers at an early stage and finding the appropriate time to discuss an issue.	Bedford Hospital	

	Recommendation	Lead	Update & comments
12.	That the CCG encourage hospitals from whom it commissions services to standardise hospital discharge forms with a view to creating one familiar form that contained all the necessary information in one place to support effective planning for hospital discharge speeding up the process and making it more efficient.	BCCG	
13.	That a review be undertaken of the Clinical Navigation Team (CNT)to determine whether it has delivered against its objectives and whether its role remains suitable. In light of this review it should be considered whether the CNT or another appropriate body could be responsible for the following:- 1. making available a greater quantity and quality of information for patients on the services provided by community organisations and others. 2. providing a visible interface for communication between the Council, the NHS and community organisations, particularly to encourage more detailed discussion between providers in the north and south of Central Bedfordshire.	Central Bedfordshire Council (CBC)	
14.	RECOMMENDED that more effective coordination be undertaken between the discharge planning team, rapid intervention team and the district nurses and that the roles of these teams be considered to provide greater clarity.	CBC	