HDP10
Ymchwiliad i brosesau ryddhau o'r ysbyty
Inquiry into hospital discharge processes
Ymateb gan Ganolfan Niwrotherapi
Response from Neurotherapy Centre

Please find below comments relating to the Hospital Discharge Process, particularly around discharge and the use of community teams.

Early Discharge

- Knowledge and confidence about the environment, and the skills the individual needs to function safely are key components of a safe and effective discharge. Therapists should be actively engaged with patients from the start of their admission and seen as part of the team to ensure that any necessary community care and support is available, and any assistive equipment for use at home is provided in a timely manner.
- Effective communication between ward and community teams or services is essential to facilitate early discharge. Early conservations with the community resource team (GP, District Nurse and Social Worker) should be considered to enable earlier discharge and subsequent review at home later in the day.
- Thinking about what community support is available in someone's locality should be one of the things staff think about during discharge planning, especially for those with few friends or family living close by.

Successful early discharge (and the avoidance of re-admission) will often be affected by the level of local knowledge of services that the patient is referred onto. Recognition of the preventative and rehabilitative role of the 3rd sector and building strong links and effective referral systems into them, and other local services through the embedded use of DEWIS Cymru would help to speed up the process and improve outcomes. The use of the phrases 'community teams and services' needs to be expanded to routinely incorporate 3rd sector services, but there will need to be an educational drive around this as all too often there is a reliance on NHS services, and poor or little knowledge of services that sit alongside, and compliment these.

There should also be investment in community services which support health outcomes, and a move to embed them into care pathways, so that successful early supported discharge can be achieved, and evidence of service improvement, and patient experience can be gathered.

For many people living with long term conditions, quality of life is a major factor in how well they do, and how long they stay independent and in their own home. There are significant health economics associated with this, and access to ongoing support, close to home can have a major impact on quality of life and decrease the need to access primary and secondary care. It also supports the Carer in their role allowing respite from their caring responsibilities, access to information as and when it is needed, as well as education, employment and peer support which help to decrease the negative impact on mental health that both living with a condition and caring for someone with a long term condition can have.

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