HD 18
Rôl awdurdodau lleol o ran cefnogi'r broses o ryddhau cleifion o'r Ysbyty
The role of local authorities in supporting hospital discharges
Ymateb gan: Alzheimer's Society
Response from: Alzheimer's Society

Local Government and Housing Committee
Welsh Parliament
Cardiff Bay
Cardiff
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Alzheimer's Society Cymru
Gyda'n gilydd, byddwn yn cynnig help a gobaith i bawb sy'n byw gyda dementia
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Friday 28th February 2025

Alzheimer's Society dementia support and partnerships response to the Local Government and Housing Committee inquiry on the role of local authorities in supporting hospital discharge.

Alzheimer's Society welcomes the opportunity to respond to the Senedd Local Government and Housing Committee's inquiry on the role of local authorities in supporting hospital discharge.

Alzheimer's Society is the UK's leading dementia charity, working towards a world where dementia no longer devastates lives. We do this by giving help to those living with dementia today and providing hope for the future. We provide direct dementia support services, fund research, and campaign for change to improve the lives of people living with dementia in Wales, England, and Northern Ireland.

This submission is informed by direct insights and case studies from our delivering our local services. The hospital dementia advisor programme, referenced throughout this submission, demonstrates how early intervention and specialist support can enhance the experiences of people living with dementia in both primary and secondary care.

The effectiveness of local authorities (primarily social services) in supporting safe, timely and efficient discharges from hospital.

A hospital dementia advisor provides non-clinical support to people living with dementia, their families and healthcare professionals. It focuses on offering guidance, resources, and emotional support during hospital stays and transitions back home. the adviser ensures high-quality care by understanding individual needs, offering person-centered support, and helping hospital staff deliver tailored care.

The goal is to empower individuals with dementia to share their views and make informed choices while ensuring access to the services they need. This role involves directly engaging with patients and families and collaborating with healthcare teams to ensure smooth care transitions.

Working in hospitals, the Hospital Dementia Adviser service has identified key gaps in the discharge process, including:

- Delays due to slow social care coordination, with people living with dementia and their carers frequently experiencing extended hospital stays while awaiting care assessments or placement arrangements.

- Lack of integration between hospital discharge teams and local authorities, leading to inefficiencies and communication breakdowns.
- Variable support across different regions, with some local authorities being proactive, while others struggling due to workforce shortages and funding constraints.
- Limited post-discharge support, increasing the risk of hospital readmission for people living with dementia due to inadequate follow-up care.

The Hospital Dementia Adviser role has been crucial in bridging these gaps, advocating for People living with dementia in discharge planning, facilitating smoother transitions, and ensuring hospital teams communicate effectively with social services. However, without better local authority collaboration and investment in social care resources, discharge inefficiencies will persist, impacting both patients, carers and health and social care capacity. Strengthening Hospital Dementia Adviser integration with social services and securing sustainable funding for the role could significantly improve discharge outcomes for people living with dementia.

The main barriers for local authorities in effectively facilitating the discharge of patients with care and support needs including social care capacity and workforce shortages; waits for care assessments (and other assessment related issues); challenges in arranging care home placements or home care packages, and disagreements or legislative barriers affecting discharge decisions.

Local authorities face significant challenges in supporting timely and efficient hospital discharges for people living with dementia. Hospital Dementia Advisers frequently encounter barriers, which impact discharge planning and patient outcomes:

- **Workforce shortages**: Social care teams often lack the capacity to assess and arrange care quickly, leading to prolonged hospital stays.
- **Delays in care assessments**: people living with dementia frequently experience discharge delays due to backlogs in social care assessments and slow decision-making.
- **Challenges in arranging care packages**: Limited availability of home care and care home placements creates bottlenecks, leaving patients in hospital unnecessarily.
- **Disagreements and Bureaucratic Barriers**: Conflicts over funding responsibilities and unclear discharge pathways cause further delays.

Hospital Dementia Advisers play a crucial role in mitigating these challenges by advocating for timely social care involvement, ensuring discharge plans are patient-centred, and bridging communication gaps between hospital teams and local authorities. However, without stronger integration and investment in social care, discharge inefficiencies will persist, placing additional strain on health and social care, people with dementia and their carers.

The variations in hospital discharge practices throughout Wales and the impact on local authority delivery. How to improve consistency, including the identification of best practice and innovative approaches that could be adopted more widely.

To ensure equitable and efficient hospital discharges across Wales, the following best practices should be adopted more widely:

Standardised Discharge Pathways:

- Implement early social care involvement models where local authority teams participate in discharge planning from the point of admission.
- Introduce dedicated dementia discharge coordinators within existing roles in every hospital to streamline communication between hospitals and social services.

Innovative Approaches:

- Hospital at Home models should be expanded, ensuring that home-based care services are available as an alternative to prolonged hospital stays.
- Digital tools, such as risk assessment AI (Brave AI), can help predict and manage high-risk discharges, ensuring social care teams are prepared in advance.

Stronger Hospital Dementia Adviser Involvement in Discharge Planning:

- Expand the Hospital Dementia Adviser role to include formalised advocacy in hospital discharge processes, ensuring social care teams have real-time insights into people living with dementia and their carer needs.
- Increase Hospital Dementia Adviser-led training for hospital discharge teams, promoting dementia-inclusive discharge planning across all hospitals in Wales.

An assessment of current discharge processes and procedures at a local government and national level, including partnership working between the NHS and local authorities, strategies for increasing community capacity, and the effectiveness of Welsh Government support.

Hospital discharge practices vary widely across Wales, with significant inconsistencies in how NHS teams and local authorities coordinate care for people living with dementia. The Hospital Dementia Adviser service has highlighted several gaps and strengths in current discharge systems:

- **Inconsistent social care involvement**: Some hospitals integrate social services early in discharge planning, while others delay engagement until discharge is imminent, causing preventable delays.
- **Variable access to post-discharge support:** Some regions have strong referral pathways to community dementia services, while others lack structured connections between hospital teams and social care.
- **Limited awareness of dementia needs in discharge planning:** Hospital teams often struggle to accommodate the complex care needs of people living with dementia, resulting in inappropriate or unsafe discharges.

Partnership Working Between NHS and Local Authorities

Hospitals with dedicated dementia leads who serve as a single point of contact for Hospital Dementia Advisers demonstrate more efficient coordination between NHS teams and local authorities. For example, at Southmead Hospital in Bristol, Hospital Dementia Advisers are integrated into multiple teams, including discharge planning, social work, and community organisations, ensuring smoother transitions for people living with dementia. However, some hospitals lack a structured approach to collaboration, leading to gaps in care post-discharge and increased readmission risks.

Strategies for Increasing Community Capacity

- **Building Stronger Links Between Hospitals and Community Services**: Hospital Dementia Advisers facilitate referrals to community-based dementia services to support patients post-discharge. In some areas, Hospital Dementia Advisers work with link workers, Age UK, and Carers UK to improve continuity of care.
- **Expanding Hospital-Based Dementia Support:** Information stands, and hospital welcome hubs help underserved communities engage with support services before discharge, improving access to dementia care.

Effectiveness of Welsh Government Support

Welsh Government initiatives aim to improve discharge efficiency, but regional disparities persist.

- Investment in Hospital at Home models and virtual wards has shown promise, but there is limited integration with dementia-specific discharge planning.
- Best practice adoption is inconsistent, with some hospitals benefiting from structured NHS-social care partnerships, while others rely on ad-hoc discharge planning.

Improving Consistency and Best Practice Adoption

To create a more standardised approach to hospital discharge across Wales, the following best practices should be adopted widely:

- Establishing Dementia Leads in Hospitals: Dedicated dementia specialists should act as a bridge between NHS teams, social care, and Hospital Dementia Advisers to improve hospital-community coordination.
- Embedding Hospital Dementia Advisers in Discharge Planning Teams: Hospital Dementia Advisers should be involved at the point of admission to ensure early discharge planning, reducing avoidable delays.
- Strengthening Post-Discharge Referral Pathways: Local authorities and NHS teams should adopt a standardised process for referring people living with dementia and their carers to community dementia support services.
- Expanding Community-Based Dementia Care Options: Welsh Government should scale up Hospital at Home models and ensure they are tailored to the needs of people living with dementia, preventing unnecessary hospital stays.

Thank you for the opportunity to respond to the Committee's consultation. Please get in touch if you have any questions about our insights.

Yours sincerely,

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