falkirk & clackmannanshire carerscentre

Meeting Minutes

Consultations for carers to share their views with external organisations

FOR FALKIRK CARERS

Integrated Discharge and Care at Home Consultation with Claire Chapman, Liz Beattie and Daniel Stoddard from Falkirk's Health and Social Care Partnership.

Held on 28th May 2026

at The Carers Centre, Falkirk

Quick recap

This meeting focused on discussing hospital discharge processes and care at home service redesign in Falkirk. Claire Chapman the Home First Lead presented an integrated discharge service initiative aimed at improving patient discharge from hospital, with plans for single points of contact, clearer communication, and specialized teams for different wards. Participants shared extensive personal experiences about challenges with current discharge processes, including poor communication, lack of Carer recognition, and inadequate support systems. Daniel presented plans to redesign Falkirk's in-house care at home service by moving away from time-and-task focused care to a reablement model, involving 6–8-week periods of support to help people regain independence after hospital discharge or illness. The discussion covered concerns about Carer continuity, staff's payment for travel time, international Carers, and the need for better recognition of unpaid Carers in hospital settings and at home.

NHS Visitors

- Karen Goudie, Executive Nurse Director and Ross McGuffie, Chief Executive and Yvonne Cairns Dementia and Delerium Lead are coming to the centre on Thursday the 18th of June 10am-12 noon, more info and an invite will follow soon! I do hope you can make it on the day!

Daniel (Care at Home lead)

- Share email with Sharlene containing the link to the public consultation on changes to the Care at Home service and ensure information about library events is included (Daniel has provided this and it is attached below).
- Report back on the outcomes of the public consultation to the IJB in September and proceed with implementation of in-house service changes as appropriate.
- Work with staff to shape the new Care at Home service model, ensuring input from people who receive care, family members, and staff.
- Develop and implement a process for regular reviews of care packages, both in-house and with external providers, including clear communication channels for Carers/family to request reviews when needs change.
- Explore and implement career progression for staff, training, and team models (e.g., BERTSOG) to maximize staff experience, support, and job satisfaction within the Care at Home workforce.

Falkirk Health Initiatives Update

Claire Chapman presented on the Home First initiative for Falkirk Health and Social Care Partnership, explaining their work on an integrated discharge service aimed at improving hospital discharge processes across Forth Valley. The presentation covered plans for earlier and clearer discharge planning, better communication through a single point of contact model, and the establishment of specialized teams covering different wards and specialties.

Dementia Identification System Implementation

The discussion also covered the Integrated Discharge Service, which includes a Discharge to Assess model and involves collaboration with GPs and primary care systems. Claire shared positive experiences regarding the new discharge service, noting that it successfully reduced hospital stays and helped patients return to familiar surroundings more quickly.

Hospital Discharge Communication Challenges

Claire led a discussion about hospital discharge processes and communication challenges. Participants shared experiences of poor communication during hospital stays, including lack of information about discharge plans and unclear contact processes. The group discussed the need for better identification of Carers early in the hospitalization process and establishing a single point of contact for discharge information. Claire noted that while there are pathways teams and the Frailty Unit, there are ongoing communication gaps that need to be addressed.

Discharge Process Challenges for Carers

The discussion also covered concerns about the 7-day limit for care packages and the importance of considering individual circumstances, including the impact of routine changes on patients with conditions like dementia. Claire noted that social work teams are already aware of these issues and are working on improvements to the Care at Home framework.

Carer Support and Challenges

Sharlene discussed occupational therapy input and participants shared examples when they have been involved in the person that they care for's rehabilitation. The discussion highlighted concerns about the practical challenges of providing care, including the need for two-person hoists and the difficulty of managing care responsibilities while receiving medical treatment.

Care at Home Service Redesign

Daniel presented plans to redesign the council's in-house care at home service to address resource constraints and growing care needs, we have an aging population and the number of over 65's is likely to double within the next 20 years. Daniel explained the shift from the traditional time-and-task model to a reablement approach, which supports people in improving their functionality over 6-8 weeks after hospital discharge or following a fall. The new model aims to help people maintain independence at home longer while reducing the need for long-term care, though

traditional care will still be available for those who cannot improve or need medication at specific times.

Falkirk In-House Care Service Changes

Daniel discussed changes to the in-house care service in Falkirk. Daniel explained plans to introduce more regular reviews of care, both in-house and independent, through a new assessment and review role that will be separated from operational delivery. The changes include a six-week public consultation starting this week, with information being sent to service users and three events planned at libraries in June (more information is attached below).

Home Care Services Challenges

The discussion focused on challenges in home care services, particularly regarding staffing, wages, and the transition to a reablement model. Participants shared their experiences about caring and discussed the importance of relationships and proper training for paid Carers, noting cultural differences and the need for paid Carers to be paid for travel time. The group explored concerns about attracting younger staff and addressing wage disparities between newer and more experienced staff.

Information from Daniel below

We want you to get involved in the redesign of Falkirk's Care and Support at Home Service. We have proposed some changes which may affect how you receive your care.

We're moving Falkirk Council's Care at Home Team towards a reablement focused service. To do this, we want to expand the team and change the kind of support they provide.

Our proposal is for an expanded Falkirk Council team which does three things:

- **Short-term reablement care:** This will be their main focus. They will support people new to the service or those leaving hospital. They will provide temporary support to help people increase their independence. Following this, people would move to a different local care provider for any long-term support, unless they have complex care needs.

- **Short-term support:** The Falkirk Council team will also provide short term support to help prevent emergency care home placements and hospital admissions.
- **Care at home:** The Falkirk Council team will provide care at home to people who need enhanced support or if their needs cannot be met by other providers. This means most people will receive their ongoing care at home support from other local providers.
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If you currently receive care at home from the Falkirk Council team, these changes may affect how your care is provided.

Most care at home will be provided by another local provider. If you need to change provider, you can choose your own or ask Falkirk Council to arrange a provider for you.

All local providers are held to the same standards as Falkirk Council's own services. If you pay for your care, the cost of care would not change. Falkirk Council's Social Work Adult Services will still manage your care plan.

We are gathering feedback about this proposal until 6 July.

You can share your views by completing our survey. Scan the QR code or visit the link below to access the survey online.

For more information, you can drop-in to your local library to chat to a member of the team on the following dates:

Grangemouth Library	Falkirk Library	Larbert Library
11 June, 2-4pm	16 June, 1-3pm	25 June, 2-4pm

If you need more information or support to share your views, please email integration@falkirk.gov.uk or call 01324 50 60 70.

Take part now

Visit www.falkirkhscp.org/care-at-home-survey or scan the QR code to learn more and complete the survey.

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Carers View and Experiences

- A Carer stated that the person they care for was discharged recently following 8 months in hospital. The Carer stated that they never received any clear messages or information. The cared for person had been in Falkirk Community Hospital, the Carer said, "I asked if we could have a meeting to have a handover, medical update, as we have never had an update since being moved there, plus a discussion about the plan & support moving forward". This Carer stated that they were told "no, they were not a medical ward & to contact their GP once settled at home for a medical update".

- A Carer stated that medical staff at Larbert said that the person that they care for would be discharged to Falkirk hospital, the social worker team said they were going to be discharged to home. This added additional stress onto the Carer.

- A Carer stated that "the initial support was good but when this change to 4 times a day it was not good". This Carer stated that "no one turned up & I had to phone social work to get carers. The person that I care for needs a 2-person hoist to get him out of bed for toileting etc, and I can't do that on my own. I am over 80 yrs old".
- A Carer stated "I can't see how care at home can possibly improve or be sustainable in the future given the numbers Daniel stated. The money just isn't there for now and there'll be even less in the future for Scotland's growing care needs. I don't think anybody has a realistic solution yet".
- A Carer stated "the problem is that those younger paid carers also need to earn a decent wage in order to give their life any comfort whatsoever. Carers are never going to be paid what they're worth, so why would young people want to become a carer?" Daniel explained that they are trying to provide Career progression pathways to entice young people to work in care.

- A Carer stated that "we need to ensure mechanisms are in place for staff (especially new and younger staff) to raise concerns about workplace culture and integration with experienced staff and foster a person-centred approach across all generations of carers".
- A Carer suggested that extended community hospital hours could help alleviate some of the pressures.
- A Carer suggested implementing a national identification system for people with dementia and Alzheimer's, similar to diabetes bracelets, to help medical staff recognize and provide appropriate care.

- A Carer shared their experience when the person that they cared for was discharged home, this Carer stated that "despite safety risks, including the cared for person experiencing multiple fractures within a short period, the person was discharged home", this Carer emphasized the need for "better recognition of dementia by hospitals and called for written justification of discharge decisions, particularly for high-risk patients".
- A Carer shared their experiences and the worry that they had surrounding losing their current care provider due to the person they care for having a longer stay in hospital. This Carer felt like the "clock was ticking" and they wanted the person they care for home so that they didn't lose the package of care they had.
- A Carer spoke about a paid Carer singing and dancing as they came to support the cared for person, we discussed the importance of staff being happy in their role.
- A Carer emphasized the need for better recognition of Carers during hospital stays; this Carer also suggested a point-based system to streamline pathways for different care needs.
- A Carer mentioned the need to visit the person they care for at hospital at mealtimes, to ensure their loved one was eating due to staff shortages.
- Carers spoke about the lack of communication between wards in the hospital and how this often results in Carers having to re tell their story, this causes addition stress and frustration.
- Feedback from HSCP/NHS is important to Carers.
- A Carer shared their experience of being discharged from the ward and having to wait for hours without their medication, this Carer was then asked to leave as the discharge lounge was closing, they left without any medication

and did not receive this until the following day when their child collected this for them, this occurred a few years ago.

- Carers would like one point of contact within hospital settings.
- Carers learned that many paid Carers services are provided by external agencies and not Falkirk Council staff.
- Discussion was had around paid Carers not having time to make fresh meals and one Carer said they were told microwave meals only.
- A Carer asked if a single point of contact would be staff in the hospital, Claire said they would.
- A Carer asked if children wards would be involved, this project surrounds adults only, Claire said that frailty and aging pathways are the first in this test of change.
- A Carer asked if GPs were involved in the new hospital processes, Claire said they are.
- A Carer explained that after the cared for persons discharge, they ended up in a care home, Liz explained that this is why there is the option to have 21 days support at home, to ensure a very robust assessment takes place.
- A Carer asked about reablement, wondering if they could initiate support for themselves, Daniel said that you can.

Comments collated on the day on the flip chart:

1. Were you involved early enough in decisions about discharge?

   Carers Answers

- Home assessments need to be planned properly.
- I didn't agree with the decisions
- Yes
- There needs to be a single point of contact.
- Kept in touch but only after discharge.
- Not asked if I was a Carer.
- There needs to be clearly defined pathways ie home, rehab, care home.

- Was communication clear and consistent, and did you know who to contact?

  Carers Answers

- No
- I knew to contact the ward but not who to contact
- The person I spoke to changed all the time.
- When the initial information is given to admin could the Carers contact details be added too?
- I was told what was happening.

2. Did the discharge plan feel realistic and safe for home?

Carers Answers

- No
- First time yes, then rehab yes, from there on no, I complained and did not receive any feedback.
- Yes, everything was discussed with me.
- Yes received 24hr care at home.
- Discharged after 8 months, meeting not agreed too, social work said one thing and NHS staff said another.
- Concerns were not noted.
- No accountability for care post discharge.
- We need to think about if there is no support available at home.

- Were your capacity, limits and wellbeing properly considered?
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Carers Answers

- Not as a Carer being discharged, nobody asked.
- I was asked if I wanted to take them home, but nobody asked how I was and if I could manage/required support etc.
- I would like to be asked how I was and how I was feeling about them coming home.
- I want to be recognised as a Carer.

3. Was the right support in place after discharge?

Carers Answers

- Initially yes.
- Not for a Carer being discharged themselves.

- No was left for family members, nobody checked.
- Yes, was aware of the 7 days and package of care would be lost so keen to get them home.
- No last visit, 21 day assessment, withdrew right support too early, resulting in a bad fall and a visit to hospital.

4. What is the one change that would most improve discharge for carers?

   Carers Answers

   Be involved from the point of admission
   Be recognised as a Carer.
   Be involved in the whole process.
   Be informed of what support I need to provide when they are coming home.
   Be asked how I am.