## https://www.essex.gov.uk/adult-social-care-and-health/going-and-leaving-hospital

# I’m worried about having enough care post discharge.

The hospital will assess your current care needs and may organise a temporary package called reablement for 6 weeks. This is free of charge. If ongoing care is needed, it will continue until a care provider has been found, or you are helped to find a company for you to self-fund.

# I have a reablement package, but I need more help.

Talk to the company providing your care about your needs, they will liaise with the hospital about increasing your care. Social services will be in contact around week 3-4 of the reablement package, to discuss ongoing needs and support, after this they can also speak to our social prescribing team.

# What happens when my care package runs out?

You will need to arrange your own care once your reablement package runs out if you are self-funding. If you can’t afford to self-fund, it will be arranged by adult social care. This will be discussed when they talk to you 3-4 weeks after discharge. You can contact adult social care through the details below:

Monday to Thursday: 8:45am to 5pm Friday: 8:45am to 4:30pm

Phone: 0345 603 7630 Text: 0345 758 5592 Out of hours telephone: 0345 606 1212

Email: [socialcaredirect@essex.gov.uk](mailto:socialcaredirect@essex.gov.uk) Web: <https://www.essex.gov.uk/adult-social-care-and-health/adult-social-care-contacts>

# Who will take care of my medical needs when I’m discharged?

The hospital will ensure district nurse visits are in place for specific medical needs such as wound care. If the situation changes and a new medical need arises, you will need to speak to the GP for a new district nurse referral.

# I need more equipment than I used to, how can I get this?

The hospital should complete an Occupational Therapy referral to make sure your home is suitable for you post discharge. They will arrange any urgent equipment needed.

If, when you get home, your equipment needs are different than expected, talk to our GPs and we will refer you to the Urgent Care Response Team (UCRT) who will assess you and provide the equipment needed.

The Lions Short Term Appliance Loan Service is a charity based at Saffron Walden Hospital that can provide emergency or brief access to wheelchairs, commodes, walking frames and other equipment for the infirm, temporarily injured or disabled.

The Red Cross can provide wheelchairs for hire from £22 per week.

# I have been discharged for end-of-life care, what help can I get?

The hospital will refer you to Farleigh Hospice before you are discharged. You can call them on 01245 457300 or visit their website <https://www.farleighhospice.org/> . Farleigh will be able to support you with a wide range of needs and should be your first point of contact unless you are acutely unwell.

# I’m out of hospital but I’m getting worse not better.

Book an appointment to speak to a GP to discuss ongoing medical needs. We may refer you to our MDT where the GPs will discuss your care alongside district nurses, social prescribers, and social services.

If you are unable to cope at home despite the support in place, you may need to go back to hospital. If this is within 7 days of your discharge you should call your ward. The details of this will be on your discharge letter.

# Am I eligible for the NHS continuing Care Scheme?

You would usually become eligible for this scheme if you had a significant change in circumstances during your hospital admission. The hospital team would refer you to this programme if they thought it was applicable.

# I’ve been home for a while and I need some help accessing community services/benefits

We can refer you to our social prescribers who can help you find community support groups. They will focus on what matters to you and making your life at home comfortable. Social prescribers are not an urgent service, so it might be up to a week before they see you.

# What do I do if I fall at home after my discharge?

We can refer you to Social Prescribers to discuss telecare that can help keep you safe at home and get you support for falls instead of calling for an ambulance with long wait times.

# What if my family member has gone back into hospital? What do we do?

Keep in contact with the discharge co-ordinator from the ward in hospital. If they are in A&E or in the assessment rooms, liaise with the staff in that area. The Social Prescribing team can help with family liaison if they are prior known to their service. If you do require some assistance after the next discharge home, please contact the surgery as our Social Prescribing may be able to offer some assistance depending on the need.