How to make referrals or contact the Home from Hospital Service

We work closely with the Hospital discharge teams, occupational therapists and social workers to identify eligible patients who can benefit from the service. Clients can be referred into the service through a number of routes:

- Hospital discharge or as part of a period of reablement
- GPs , social services or community health services.
- Integrated health and social care projects
- Self-referral or family referral

By phone: 020 8442 7651
By email: bridge@nhs.net (secure) *to be arranged*
By email: homefromhospital@bridgerenewaltrust.org.uk
In person: Chestnuts Community Centre
280 St Ann's Road
Tottenham
London N15 5BN

The Bridge Renewal Trust
Bridge
Home from Hospital Service

bridge renewal trust
for happy and healthier communities

Practical and emotional support

About our service

The Home from Hospital service provides practical and emotional support to patients aged over 50 years old to return home safely from hospital on discharge. We accompany the patient home and provide up to three home visits for up to four weeks after discharge to prevent unnecessary re-admissions.

Who we can help

We can help people due to be discharged from hospitals who meet the following criteria:

- Resident of Haringey and aged 50 or over
- Requiring discharge from Whittington or North Middlesex Hospitals
- Give consent or have been determined that it is in the patient's best interests to access the service
- Would benefit from practical support at home but not including personal hygiene, domestic cleaning or laundry
- Home and social situation deemed not at risk
- Able to be safe at home alone with this service
- No longer requiring acute medical care
- Money available for basic amenities (food, transport, fuel)
- At risk of hospital admission / readmission if no support is provided
- Worried about returning home and / or live alone and have no apparent support from family or friends

Who we cannot help

- Not Haringey resident
- Children and adults under the age of 50 years
- People with complex needs

What you will get from us

The service encourages patients to regain their independence on returning home, by providing social and practical personalised support including:

- Accompanying patients home following hospital discharge.
- Three home visits and up to four weeks of support after hospital discharge.
- Supporting patients to collect pension / benefits / prescriptions.
- Practical assistance with essential food shopping (non-financial).
- Practical assistance with contacting appropriate services to ensure residents feel safe and well with access to amenities – heating, lighting and hot water.
- Practical assistance with checking and topping up gas/electricity and paying bills (non-financial).
- 'Check and chat service' – telephone calls for the first 4 weeks following discharge from hospital to check how patients are settling back in the community.
- Provision of information and links, signposting and referrals to local community activities and local services.
- Help with making and accessing GP appointments and other health and social care appointments.
- Practical assistance with accumulated posts, completion of forms, letter writing and posting.

What we do <u>not</u> provide

- Personal care
- Financial support
- Support to meet complex needs