West Essex Health and Care Partnership

TOGETHER FOR A HEALTHIER WEST ESSEX

NHS

People at the heart of everything we do

How the Care Coordination Centre (CCC) supports Urgent & Planned Care



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Right care. At the right time. In the right place.

People
Patients, families and carers

Partnership
Working together across services

Better care
Safe, timely and joined-up support

Healthier lives
Supporting people at home for longer

Care Coordination Centre (CCC)

Navigating to the right services, at the **right time**, in the **right place**

Rapid Triage

- Assess and prioritise referrals
- Identify urgency and risk

Multidisciplinary Team (MDT)

- Expert clinical input
- Team collaboration for the best outcome



Coordinate Support Quickly

- Single referral point
- No wrong door

Seamless Referrals

- Link to the right service
- Timely and safe transitions of care

Access to Community Services

- Community Nursing & Therapy
- Mental Health Support
- Social Services
- Reablement & Home 2 Assess
- Urgent Community Response
- Community Hospital
- Voluntary Services

What is the CCC?

8am – 8pm, 7 days a week
Clinical MDT line for real-time advice & support

Single referral and coordination point
"No wrong door"

Admission avoidance, planned care & safe, supported discharge

Always thinking "Home First"

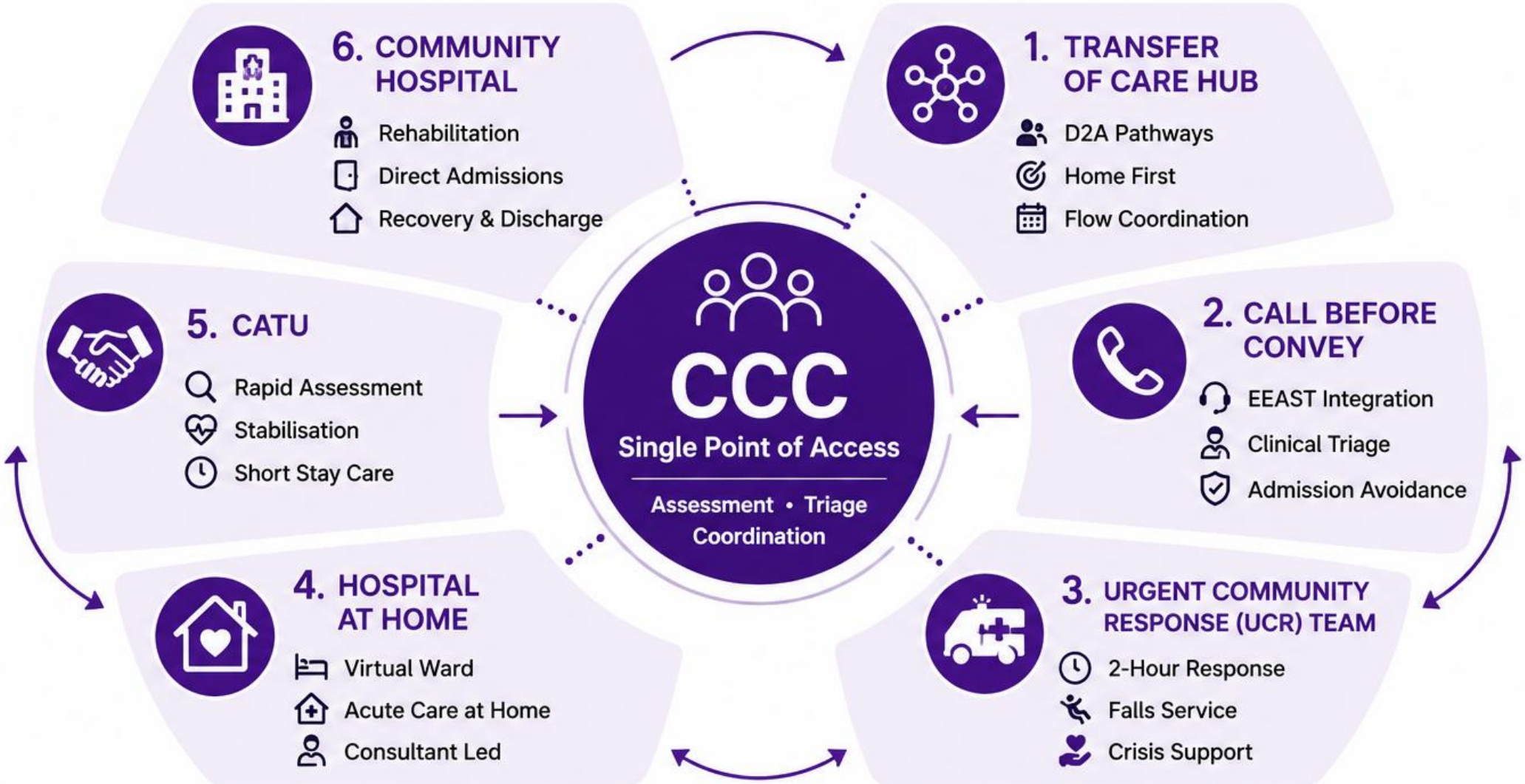
Right person.
Right care.
Brighter futures.

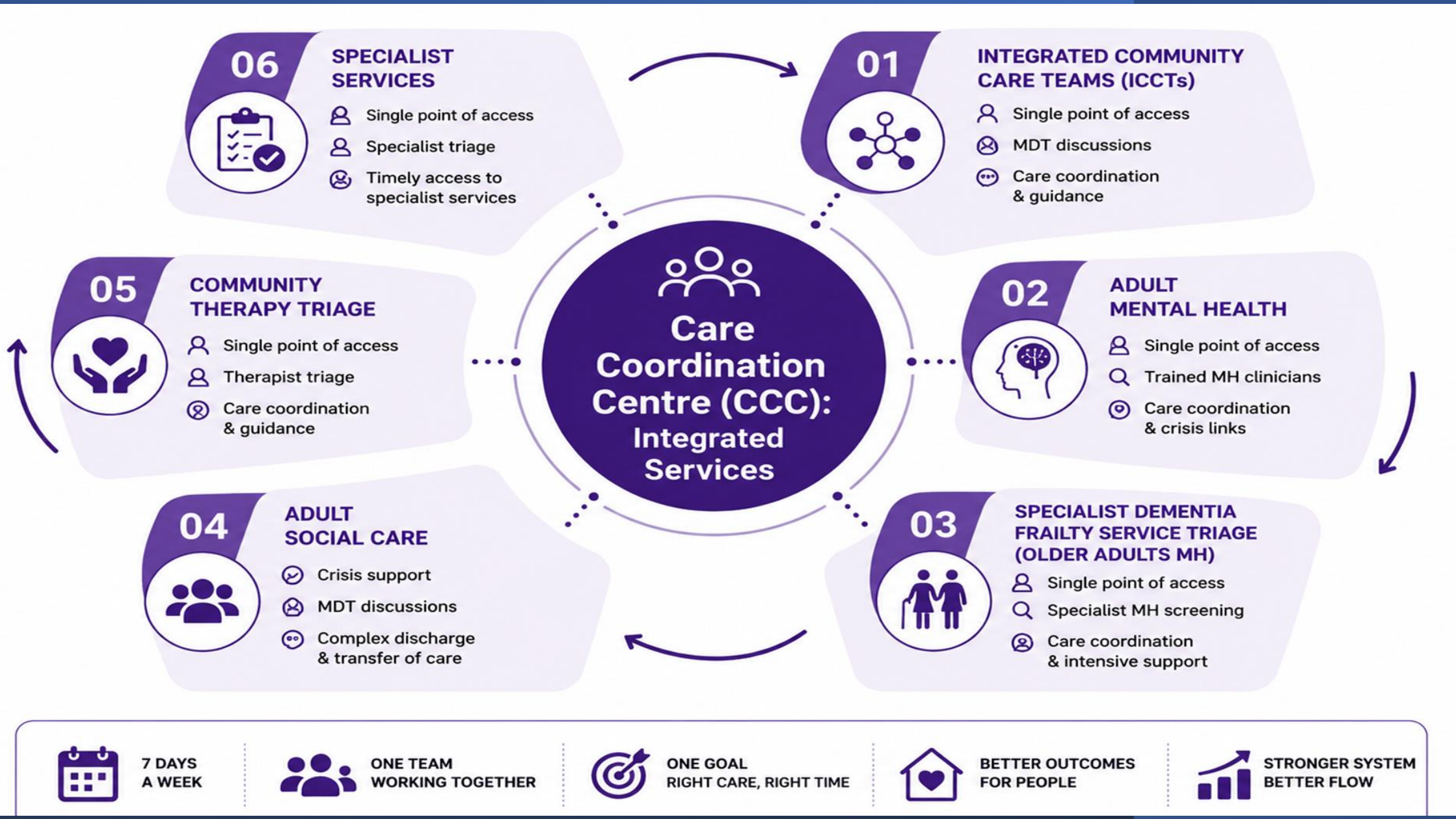
PEOPLE | PARTNERSHIP | BETTER CARE TOGETHER

Stronger Communities Healthier Lives

Care Coordination Centre (CCC)

One Front Door for Urgent Community Care




06
SPECIALIST SERVICES
Single point of access
Specialist triage
Timely access to specialist services
01
INTEGRATED COMMUNITY CARE TEAMS (ICCTs)
Single point of access
MDT discussions
Care coordination & guidance
Care Coordination Centre (CCC): Integrated Services
05
COMMUNITY THERAPY TRIAGE
Single point of access
Therapist triage
Care coordination & guidance
02
ADULT MENTAL HEALTH
Single point of access
Trained MH clinicians
Care coordination & crisis links
04
ADULT SOCIAL CARE
Crisis support
MDT discussions
Complex discharge & transfer of care
03
SPECIALIST DEMENTIA FRAILTY SERVICE TRIAGE (OLDER ADULTS MH)
Single point of access
Specialist MH screening
Care coordination & intensive support
7 DAYS A WEEK
ONE TEAM WORKING TOGETHER
ONE GOAL RIGHT CARE, RIGHT TIME
BETTER OUTCOMES FOR PEOPLE
STRONGER SYSTEM BETTER FLOW

What would you typically do?

Two common scenarios – one coordinated response

Right care. At the right time. In the right place.

Scenario A



Falls + new confusion this morning

- 82-year-old, lives alone
- Found on floor by carer
- More confused than usual
- No obvious injury, but unsure how long they have been down

Scenario B



Breathless + not eating over 3 days

- 76-year-old with COPD and frailty
- Increasing breathlessness
- Poor oral intake and feeling unwell
- Family concerned and requesting support

Same principles. One point of contact.

CCC – Coordinated Response

Rapid triage | Expert advice | Timely, safe care

1 CCC Rapid Triage

- Single point of contact
- Clinical assessment and risk stratification
- Immediate advice and 2-hour response where appropriate

2 Coordinate the right support

- Support at home via GP / community / specialist teams
- UCR / community nursing / therapy teams
- CATU / Hospital at Home
- Main Hospital (if required)

Aim: the **right care**, at the right time, in the right place – supporting safe, timely and effective care for our patients.

People
Patients, families and carers at the centre

Partnership
Working together across services

Better care
Timely, effective and joined-up support

Healthier lives
Keeping people well at home for longer

How to Access Integrated Community Services

One point of contact. The right support. At the right time.

Right care.
At the right time.
In the right place.

1 One route in – Contact the CCC

Single point of contact for all community support, including:

- Integrated Care Teams (ICTs)
- Mental Health
- Specialist Services
- Adult Social Care

2 CCC Clinicians Triage Referrals

Our clinical team will:

- Assess and prioritise
- Send to the right service
- Ensure urgent and same day needs are escalated
- Coordinate routine support

WEST ESSEX CARE COORDINATION CENTRE

3 MDT Support When Needed

We bring the right people together:

- Clinical discussions
- Assessment & care planning
- Guidance and advice
- Fast access to the right care

4 Early Contact Encouraged

Contact the CCC early so we can provide support before issues escalate, working with INT's.

- Proactive support
- Prevent deterioration
- Better outcomes for patients
- Reduced hospital admissions

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People.
Partnership.
Better care together.

Transfer of Care Hub (ToCH)

Coordinating safe, timely and effective transfers of care across West Essex

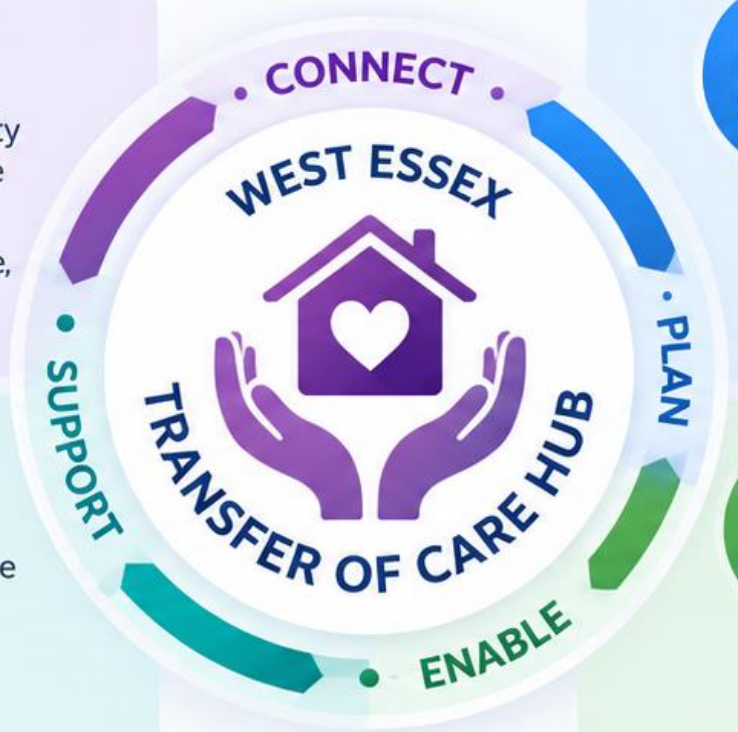
Right person.
Right care.
Right place.
Home first.

We Work Together Beyond the Hospital

- Collaboration across CCC, community teams, adult social care, primary care and the acute hospital.
- Ensuring the right care, in the right place, first time.

Daily Planning to Keep People Safe

- Daily MDT discussions to agree each person's needs for a safe discharge.
- Proactive planning for complex cases and those at risk of delay.
- Involving the person, their family and carers in decisions.



Real-Time Problem Solving

- CCC monitors each person's discharge journey.
- Quickly activates the right services when needs change (e.g. H2A, Reablement, Community Hospital, Complex Bedded Care, Hospital at Home).
- Escalates and removes barriers to keep people moving.

Home First, With the Right Support

- Our aim is always for people to recover in their own home wherever possible.
- Providing the right support to reduce delays and prevent readmission.
- Improving the person's experience, independence and outcomes.

Shorter hospital stays | **Safer, timely discharges** | **More people home, sooner** | **Better experiences** | **Reduced readmissions**

WEST ESSEX CARE COORDINATION

PEOPLE | PARTNERSHIP | HEALTHIER COMMUNITIES

Stronger Communities
Healthier Lives

How to contact the CCC

One number. One email. The right support.

Right care. At the right time. In the right place.

Phone
0300 123 5433
(Option 2)

Email
epunft.carecoordinationcentre.west.2023@nhs.net
For non-urgent queries, information and updates

When to call

1 Urgent (today)

- Acute changes in condition
- New or worsening symptoms
- Risk of harm, falls or unwell and need advice now

Call for immediate advice and support

2 Planned (next few days)

- Support with discharge planning
- Assessment or service referrals
- Equipment or care package queries
- Ongoing care coordination

Call or email

3 Discharge queries (same/next day)

- Queries about today's discharge
- Changes to discharge plans
- Transport or home support arrangements
- Follow-up after discharge

Call for prompt advice

People — Patients, families and carers

Partnership — Working together

Better care — Safe, timely and joined-up

Healthier lives — Supporting people at home