

West Essex Provider Forum How the Care Coordination Centre (CCC) supports Urgent & Planned Care

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Working together
for a healthier future



What is the CCC?



🕒 8am-8pm 7 days per 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”

6. Community Hospital

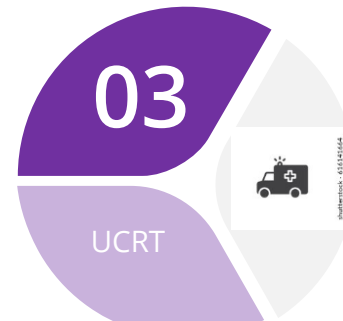
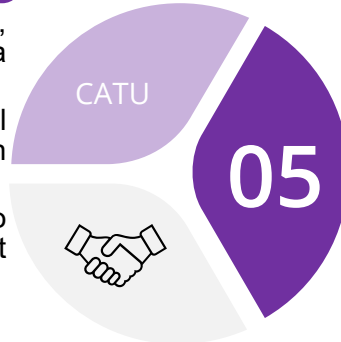
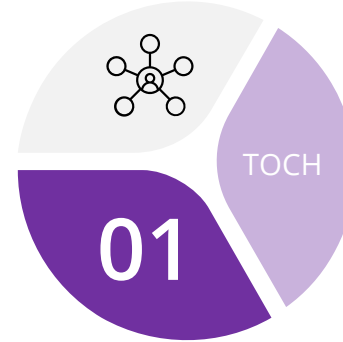
- 4 Wards including Stroke/Neuro.
- Direct admissions.
- Adults requiring additional care and monitoring which is unable to be delivered in their usual place of residence.
- Discharges from Acute.
- Adults with clear medical, nursing or therapy need/goals to participate with rehabilitation programmes.
- Supports 7 days a week discharge, EDD identification for all adults to facilitate discharge planning.

5. Community Assessment & Treatment Unit (CATU)

- Provides urgent short-term assessment, stabilisation and treatment – 8am-8pm 7 days a week.
- The service aims to prevent acute hospital admission and provide urgent intervention in the community.
- Focus on Home First – aim to support adult to their usual place of residence in the shortest amount of time.
- 2 hour to maximum 96 hour LOS.
- Ambulance conveyance direct to CATU following Triage.
- Consultant and ACP led.

4. Hospital at Home

- Personalised, hospital equivalent care at home for adults, 18+.
- Team consists medical consultants, advanced clinical practitioners, senior clinical practitioners, general and mental health nurses, healthcare support workers and administrators.
- Patients are monitored and reviewed daily via MDT board rounds.
- Care is provided either face-to-face care or remotely utilising digital remote monitoring equipment.
- Capability to provide intravenous therapies in the home.



Care Coordination Centre (CCC): Urgent Care

Tel: 0300 123 5433
7 days per week 08:00-21:00

1. Transfer of Care Hub

- West Essex health and social care system linking all relevant services across sectors to aid discharge and recovery and admission avoidance. Operates 7 days a week
- The TOCH is responsible for developing timely and person-centred transfer of care plans based on the principle of 'no place like home'
- It decides which 'Discharge to Assess' pathway each person should be placed on (1, 2 or 3) based on the detailed referral description of the adult received from the acute or community hospital.

2. Access to Stack & Call B4 Convey

- Category 3, 4 and 5 calls are transferred to the CCC for Urgent Community Response where deemed appropriate.
- The calls are assessed and triaged by the CCC clinician to determine if the patient can be safely supported at home or alternatively admitted to a Community inpatient setting) rather than being conveyed to ED for assessment.
- Supports to reduce ambulance handover delays and increase availability of ambulances.
- Operates 7 days a week.

3. Urgent Community Response (UCR) Team

- Standardised service across Epping, Harlow and Uttlesford Districts – 8am-8pm 7 days a week
- Aim to respond in timely manner to people with an urgent physical or mental health and/or social care need, typically assessing needs and providing an appropriate short term intervention within 2 hours.
- **Dedicated 2 hour falls response vehicle** for adults who have had a fall with or without serious injury or require lifting from the floor, either at home or in a care/ residential home

6. Specialist Services

- Single point of access for referrals into Specialist Services
- Referrals screened for appropriate information and forwarded to the appropriate specialist service for triage.
- Liaison with appropriate team for any urgent/same day access referrals received
- Convening of MDT discussions as required
- Access 5 days per week Mon-Fri 09:00-17:00

5. Community Therapy Triage

- Single point of access for referrals for adults requiring routine therapy/rehabilitation services
- Referrals triaged by trained therapist
- Convening of MDT discussions as required
- Access to care coordinating advice and guidance
- Access 5 days a week Mon-Fri 09:00-17:00

4. Adult Social Care

- Support crisis intervention for referrals from EEAST, Rapid Intervention Service, Acute ED, Intensive Support Team, Falls Car, UCR & Virtual Hospital
- Access to care coordinating advice and guidance
- Daily professional lead to support MDT discussions
- Supporting transfer of care function and complex discharge
- Access 7 days per week 08:00 to 18:30 Mon-Sat and 08:00 to 17:00 Sun & BH

1. Integrated Community Care Teams (ICCTs)

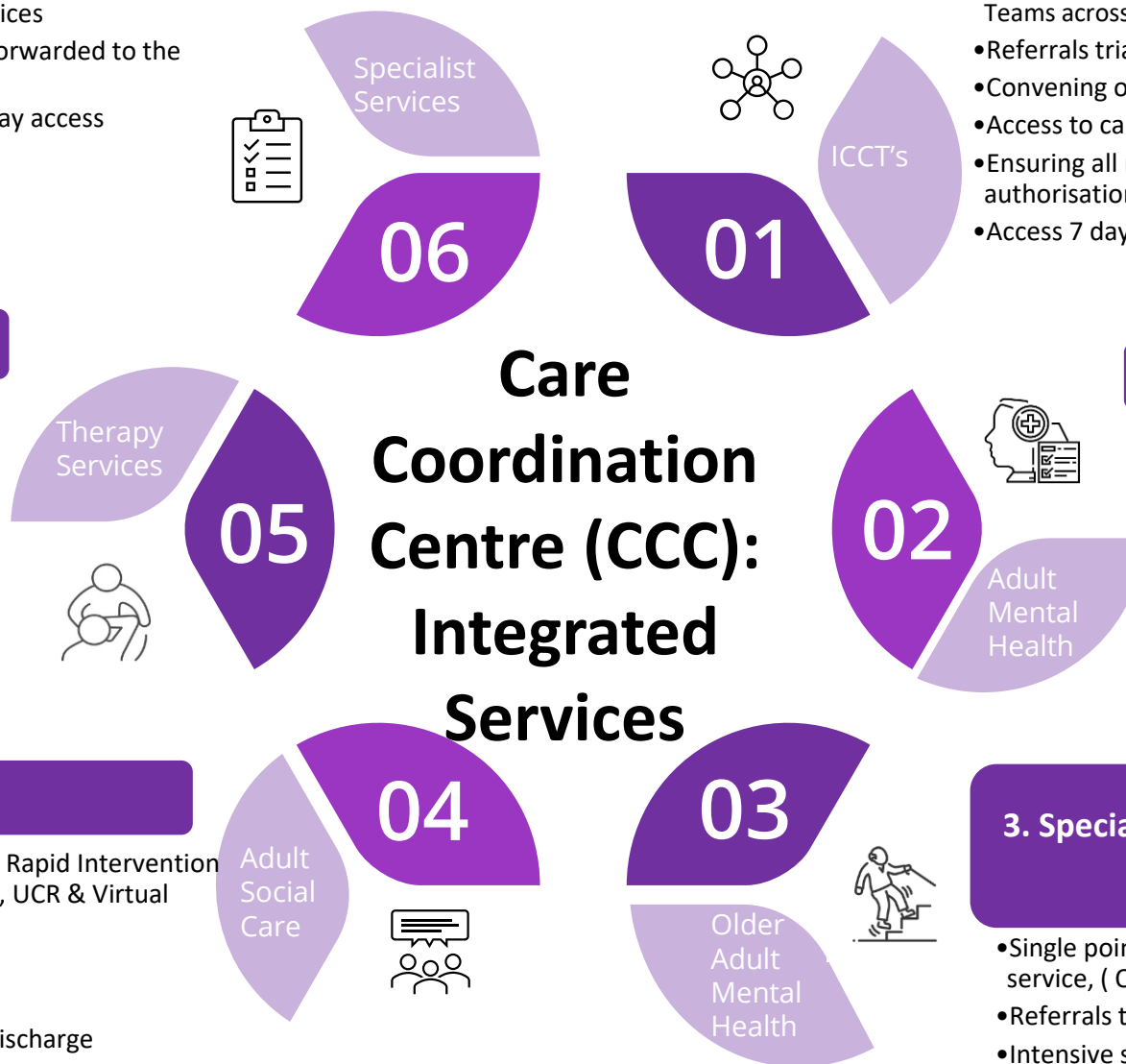
- Single point of access for referrals into the Integrated Community Care Teams across all localities Harlow, Epping and Uttlesford
- Referrals triaged by trained clinicians
- Convening of MDT discussions as required
- Access to care coordinating advice and guidance
- Ensuring all referrals for EOL are prioritised and accurate medication authorisation completed
- Access 7 days per week Mon-Sun 08:00-21:00

2. Adult Mental Health

- Single point of access for referrals for Adult Mental Health
- Referrals triaged by trained MH clinicians
- Convening of MDT discussions as required
- Access to care coordinating advice and guidance
- Links to MH crisis team
- Access 5 days a week Mon-Fri 09:00-17:00

3. Specialist Dementia Frailty Service Triage (Older Adults Mental Health)

- Single point of access for referrals for Specialist Dementia frailty service, (Older Adults Mental health)
- Referrals triaged & screened by trained Older adult MH clinicians
- Intensive support team for UCR (IST)
- Convening of MDT discussions as required
- Access to advice and guidance
- Access 7 days a week 09:00 - 17:00- (Sat & Sun covered by Intensive Support Team)



Tel: 0300 123 5433

7 days per week 08:00-21:00

What would you typically do?

Scenario A
Falls + new confusion this morning

Scenario B
Breathless + not eating over 3 days

CCC- Rapid triage & 2-hour response

Support at home via GP/
community/specialist
team teams, CATU,
Hospital at Home, Main
Hospital

Urgent care — what you get when you call



Clinical triage in minutes



Rapid support
(UCR, CATU, Hospital at Home,)




Guidance for deterioration
or concerns



Admission avoidance —
alternatives to 111/999/A&E

How to Access Integrated Community Services

 **One route in – Contact the CCC**
(ICTs, Mental Health, Specialist Services, Adult Social Care)

 **CCC Clinicians Triage Referrals**
(sent to right service, urgent/same day/routine needs prioritised)



 **MDT support when needed**
(Discussions, A&G, Right care quickly)

 **Early Contact Encouraged**
(CCC activates planned or urgent support before issues escalate working with INT's)

Transfer of Care Hub (ToCH)



We Work Together Beyond the Hospital

CCC, community teams, adult social care to ensure right care, right place, first time



Daily Planning to Keep People Safe

daily MDT discussions to agree each person's needs for a safe discharge



Real-Time Problem Solving

CCC monitors each person's discharge journey and quickly activates services like H2A, Reablement, Community Hospital, Complex Bedded Care or Hospital at Home when needs change.

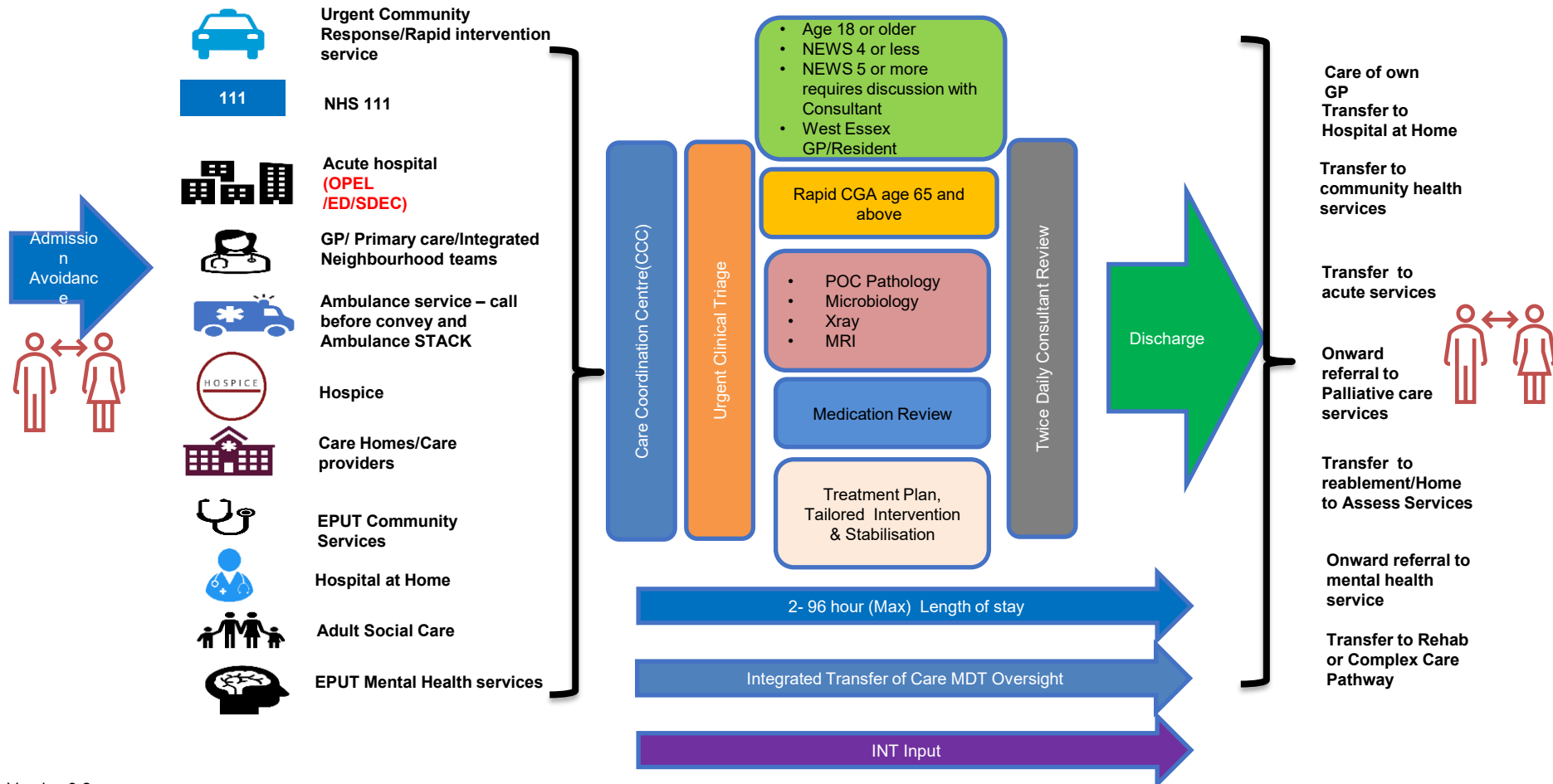


Home First, With the Right Support

The aim is always for people to recover in their own home wherever possible — reducing delays, preventing readmission and improving the person's experience.



West Essex Community & Assessment Unit – CATU, Poplar Ward SMH



What helps us help you

 Contact us early — small concerns prevent big crises and help avoid deterioration

 Share what changes you notice -breathlessness, confusion, falls or “just not themselves”

 Let us know about capacity pressures – telling us early helps us plan and prevent delays

 Make decisions with us, not alone – the CCC is here to share risk and agree the safest plan together

How to contact CCC



Phone: 0300 123 5433 (Option 2)



Email:

epunft.carecoordinationcentre.west.2023@nhs.net

When to call:

Urgent (today)

Planned (next few days)

Discharge queries (same/next day)



Intermediate Care in Essex

West Provider Forum

Jo Rogers
Head of Intermediate Care

April 2026

What is Intermediate Care?

“Intermediate care services provide support for a short time to help you recover and increase your independence.”

They are *“A range of integrated services that promote faster recovery from illness, prevent unnecessary acute hospital admissions and premature admissions to long term care, support timely discharge from hospital and maximise independent living.”*

Paragraph 2.14 of Care Act Statutory Guidance states Reablement should *‘assist a person to maintain or regain the ability to live independently.’*

Intermediate care services are primarily designed to support physical recovery of function and skill. They are often delivered for as little as **1-2 weeks** and they are **non-chargeable**, unlike most other ASC services.

The Council’s Intermediate Care offer consists of a suite of both **home** and **bed based** services which vary slightly between localities.

They are available to people of **all specialisms/cohorts** who are **over the age of 18, ordinarily resident in Essex** and **registered with an Essex GP**. They don’t include the wider range of Intermediate Care services provided locally by the NHS e.g. Virtual Frailty Wards, UCRS, RADS, Community Therapy, Hospital at Home etc.

What is the Intermediate Care Offer in Essex?

Pathway 1 discharges are those to the **person's home** or usual place of residence with **new** or **additional health and/or social care needs**. The following services support this pathway.

- **Reablement** - a short-term, intensive support service in the persons home, which enables Adults to optimise their independence over a short period of time and recover skills and confidence to live at home and maximise their independence. There are two Reablement providers in each locality - ECL and th Additional Reablement Capacity (ARC) provider DeVere.
- **Home to Assess (H2A)** - a short-term support service for those people where reablement potential is unclear and may include a Community Therapy led assessment in the first few days at home.

Pathway 2 discharges are those to a **community bed-based setting which has dedicated recovery support**. **New** or **additional health and/or social care** and support is required in the short-term to help the person recover before they are ready to either live independently at home or receive longer-term or ongoing care and support.

- Bed based intermediate care in Essex includes Recovery to Home Beds and Coastal Beds in Northeast Essex, **Community Hospital beds in MSE** and **West Essex**, and Interim Placements in care homes countywide. Interim placements have little or no dedicated recovery support.

What happens in an Intermediate Care service?



Using a trusted assessor approach a comprehensive review of function and the environment is undertaken. Adult choice is considered, and a personalised, structured care and support plan is written. Enabling approach not doing for



Onward referrals are made, equipment, adaptations and caretech are prescribed if required. IAG and signposting and connections into the community e.g. frontline app



Regular progress reviews are carried out. Care and support is right sized. MDTs are used to discuss progress and problem solve. Therapists are engaged if required



Care Act Intervention (assessment/review) - support plan, QA, SID, RFS and ISP to SPT. Financial assessment. Right support, right time, right place.



Care and support plan is regularly updated as the adult progresses and a written report making future recommendations is shared with ASC (usually within first two weeks)



Adult moves on from IC – if self caring, get a welfare call a week later. Outcomes of the IC service are recorded for MI purposes

Tabletop exercise

- From your perspective as care providers, what do adults and families tell you about their experience of hospital discharge and short-term or step-down care (including intermediate care)? **What do you think would make that experience clearer, smoother, or more person-centred?**
- Thinking about your role in the wider discharge pathway, **what could help services work together more effectively to create capacity and avoid delays into appropriate care and support after hospital discharge?**

