The Rotherham NHS
NHS Foundation Trust

Care Co-ordination Centre

The Care Co-ordination Centre provides the following services:

- **GP Support Service** – Access point for GPs to gain advice and guidance in relation to the range of health care services available within TRFT. The service also provides a referral service, arranges placements and co-ordinates patient transport.
  Navigation service provided also to other health care professionals.
  A community pathway for suspected DVT is also provided.

- **Hospital Discharge** – A follow-up service for patients at risk of hospital re-admission. The service contacts all patients that have been discharged within a 3 day period to ascertain if their condition is stable and that they have integrated back into home life. Appropriate checks are made to ensure patients are receiving effective support packages.

  A community pathway for intravenous therapy at home provided by District Nursing and/or Fast Response Team aimed to reduce length of stay (LOS) and enhance patient experience.

- **Urgent Response Service** – Single point of access for NHS 111 and 999 ambulance service into alternative levels of care. CCC forms part of the YAS Pathfinder Project which supports ambulance crews when patients do not require Emergency Department (ED) services.

- **Acute Oncology Service** - Patients who are referred via the CCC for a healthcare need who are known to the Acute Oncology Service (AOS), have a notification of pathway management / new condition / ongoing healthcare need highlighted for appropriate follow up by the AOS.

- **Oakwood Community Unit** - All referrals for patients who require step up beds are currently taken by the CCC

Supported Discharge Care Pathway and Supporting Case Management

- The CCC hold a register of patients in acute beds, whose medical episode are complete and will proactively liaise with in-patient wards on a daily basis to facilitate discharge and update the register

- Supporting case management function is for patients who have been identified by their GP or by the CCC team (during a repeat admission to hospital), as people who require additional support to allow them to self-manage their long term condition and treatment(s)

- **Discharge to Assess** - The CCC liaise wards to identify patients who have a residual nursing need who are likely to require a decision support tool and facilitate discharge. This ensures that the patient is at their optimum prior to assessment in a more conducive environment.

24/7 & Single Point of Access

- **24/7 Service** – The service will receive out-of-hours calls from patients and health professionals who require access to community health services or have an urgent health need commencing the 31st July 2015.

- **Single Point of Access for Community Nursing Referrals** – The service receives all hospital based referrals for community nursing services

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