

## What if I'm not happy with the care I am getting from the CCT?

Please speak to your GP Practice in the first instance. Alternatively you can also contact CNWL Patient Support Service:

Tel: 0300 013 4799

Email: [feedback.cnwl@nhs.net](mailto:feedback.cnwl@nhs.net)

## How do I contact the CCT?

Your Care Co-ordinator

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You can contact him/her as follows:

Telephone .....

Email .....

## Tell us, we're listening

Our staff want to know how they are doing. Tell us what you think at [www.cnwl.nhs.uk/feedback](http://www.cnwl.nhs.uk/feedback) and then we'll know what we have to do.



This document is also available in other languages, large print, Braille, and audio format upon request. Please email [communications.cnwl@nhs.net](mailto:communications.cnwl@nhs.net)

هذه الوثيقة متاحة أيضاً بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة برايل للمكفوفين وبصيغة سمعية عند الطلب

### Arabic

این مدرک همچین بنا به درخواست به زبانهای دیگر، در چاپ درشت و در فرمت صوتی موجود است.

### Farsi

এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে, ব্রেল এবং অডিও টেপ আকারেও অনুরোধ পাওয়া যায়

### Bengali

Dokumentigaan waxaa xitaa lagu heli karaa luqado kale, daabacad far waa-wayn, farta indhoolaha (Braille) iyo hab dhegaysi ah markii la soo codsado.

### Somali

Mediante solicitação, este documento encontra-se também disponível noutras línguas, num formato de impressão maior, em Braille e em áudio.

### Portuguese

நீங்கள் கேட்டுக்கொண்டால், இந்த ஆவணம் வேறு மொழிகளிலும், பெரிய எழுத்து அச்சிலும் அல்லது ஒலிநாடா வடிவிலும் அளிக்கப்படும்.

### Tamil

Este documento también está disponible y puede solicitarse en otros idiomas, letra grande, braille y formato de audio.

### Spanish

Dokument ten jest na życzenie udostępniany także w innych wersjach językowych, w dużym druku, w alfabecie Braille'a lub w formie audio.

### Polish

આ દસ્તાવેજ વિનંતી કરવાથી બીજી ભાષાઓ, મોટા છાપેલા અક્ષરો અથવા ઓડિઓ રચનામાં પણ મળી રહેશે.

### Gujarati

Be belge istenirse, başka dillerde, iri harflerle, Braille ile (görme engelliler için) ve ses kasetinde de temin edilebilir.

### Turkish

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Stephenson House, 75 Hampstead Road, London NW1 2PL.  
Tel: 020 3214 5700 [www.cnwl.nhs.uk](http://www.cnwl.nhs.uk)

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Foundation Trust  
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# Care Connection Teams Information for patients



The Hillingdon Health and Care Partnership (HHCP) brings together four key care providers to deliver joined-up care for Hillingdon residents aged 65 and over with complex needs. The key partners are: GP Networks, CNWL, The Hillingdon Hospitals NHS Foundation Trust (THH) and H4All.

Care Connection Teams (CCTs) were introduced in April 2017. This leaflet contains answers to some frequently asked questions to help you understand this new way of working so you can get the most out of it.

## Frequently asked questions

### What is a Care Connection Team?

A Care Connection Team (CCT) is made up of a GP, a guided care matron and a care coordinator who work together to make sure that you get the care that you need. The guided care matron is a senior nurse who will be responsible for carrying out an assessment of your health and wellbeing needs and planning your care. The care coordinator will support the CCT by working closely with the guided care matron. You can contact your care coordinator on the number given at the end of this leaflet.

### How does the team work?

We meet regularly to monitor and discuss your needs and look at the best way of helping you. Sometimes we might decide to involve other services to help you, such as hospitals, therapists, social services or H4All (a voluntary organisation which can help patients with social support needs). If so, we will make sure

that everybody involved in your care has the right information and that they are all working together to help you to maintain your health and wellbeing.

### Why am I being cared for by the CCT?

CCTs work with carefully chosen patients aged 65 or over who have one or more long-term conditions, such as diabetes, cardio-vascular disease, chronic obstructive pulmonary disease (COPD), stroke or dementia and who would benefit from accessing services to meet their needs in a joined-up way.

The CCT offers a coordinated approach to managing your condition.

### What are the benefits of being cared for by the CCT?

We want to keep you healthy and to tackle problems as soon as they arise, or to prevent them happening at all. We will treat you in your own home or the place where you usually live. Through regular contact with you and discussions with the professionals involved in your care, we want to make sure that your condition is well managed so that you don't end up having an emergency admission to hospital. You also have the benefit of knowing that while you're in our care, there is someone you can contact about your condition without needing to make an appointment with your GP.

### Will the CCT be responsible for all my health and care needs?

We are responsible for managing your long-term condition. We will coordinate your care for all your health needs even if we don't treat you directly. For example, if you have a fall we will contact the Fall Prevention Team.

### Do I have to give permission for my information to be shared with other services?

We will ask for your consent to treat you. This will include consent to the involvement of other services as necessary, to save having to give separate consent to lots of different professionals. One of the benefits of being in the care of the CCT is the sharing of information between the services involved in your care.

However, if there is a service with which you do not wish to share your information, you have the right to refuse. We will discuss your care with you every step of the way, so you will have the chance to make your wishes clear

on this.

### Will I always be under the care of the CCT from now on?

We expect that most people will be managed by the CCT for up to three months. We will discuss with you at the start what they are trying to achieve. For example, if your condition is unstable at the start of our team's involvement, we will work together to manage your condition until you are stable enough to manage it yourself. Through regular monitoring we will know when you are ready to leave our care and then you will be discharged back to your GP. If you experience a health problem after you have been discharged from our care, you will need to visit your GP as you did before. You may be re-admitted to our care should your condition change in the future or if you develop another long-term condition.

