Better Care in Hull

NHS
Hull Clinical Commissioning Group

Hull City Council

Better Care in Hull has a shared vision **'People in Hull will expect better care and better care will be organised around them'**

Our intention is that local health and social care services will not look the same in five years' time. Health and social care organisational boundaries will be broken down to ensure that care is well co-ordinated across different care settings.

People will have more choice and control to support them to stay in their own home. They will have the resources to self-care and the information to access coordinated care when they need it. People will have a better understanding of their local services because people in Hull will be will be consulted and more involved in the development of health and social care services in their city.

Better transition between services:

"When I moved between services or settings, there was a plan in place for what happened next"

The key aims for Better Care in Hull are:

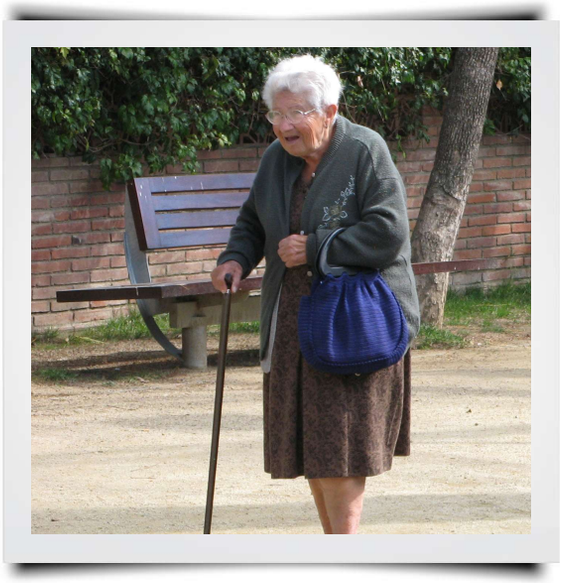
- **Person centred coordinated care and support across health and social care**
- **Reduced emergency department attendances**
- **Reduced emergency and unplanned admissions to hospital**
- **Shared information across health and social care organisations**
- **More people receiving care in their own homes and reduced admissions to care homes**
- **High quality, equitable services across the city, seven days a week**

Our eight Better Care in Hull schemes are:

1	**Prevention and community hubs**	Our community hubs will provide more integrated services across health and social care and could also include services provided by the voluntary sector and community groups. They will differ in each area in order to best meet the needs of the local population and to make best use of the existing resources.
2	**Primary care and self care**	We will support much more proactive management for patients with long term conditions in primary care with a named care coordinator
3	**Falls**	We will develop early support and intervention services across health and social care to reduce the projected level of falls and support people to continue to be active and independent.
4	**Reablement**	We will provide short term support to help people after a period in hospital to learn or re-learn the activities they need for everyday life
5	**Ambulatory care**	A range of services will work together in hospital to enable patients to have their condition rapidly assessed, investigated and treated without being admitted to the hospital ward.
6	**Residential and home care**	We will provide appropriate alternatives to residential care by expanding home care and extra care services and support
7	**Long term conditions & dementia**	We will create a more integrated network of care and support for patients with long term health conditions and their carers
8	**Mental health**	There will be better integration of mental health services between health and social care

Meet Dorothy

Better Care in Hull



Better Care in Hull aims to deliver better co-ordinated care services to meet the needs of local people like Dorothy.

Dorothy (82) lives alone in sheltered housing and has family who live nearby, and a number of friends who support her. Dorothy is getting a bit unsteady on her feet and has had a few falls at home and her family is concerned. Dorothy agrees that she is a bit forgetful at times but she is very much in control and wishes to retain this independence.

Better care planning:

"I know what is in my care plan. I know what to do if things go wrong"

Dorothy has a history of urinary tract infections. Recently she had a fall resulting in a head injury but did not lose consciousness and used her lifeline to raise the alarm. The wardens called for an ambulance and Dorothy was taken to A&E.

Best outcomes for Dorothy	How Better Care services can help get the best outcomes
To get out of hospital as soon as possible and return to her own home	**Assessment and discharge planning** An outcomes based assessment commences on Dorothy's arrival in the frailty area of the ambulatory care unit at Hull Royal Infirmary. She is clinically assessed by a geriatrician and her immediate medical needs are met. Health and social care staff working within this area of the hospital are involved from the early stages to ensure relevant information about Dorothy is available to support her recovery. This will help Dorothy feel more confident that health and social care staff have the latest information about her condition. It also means that if she feels unwell she knows she has a plan in place for her return to home which will be followed up the next day by social care.
To receive regular therapy to continue recovery and be fully independent again.	**Housing and aids** Rapid assessment by a team working in the community is carried out to establish whether Dorothy can go home with rehabilitation. Her housing scheme warden and occupational therapy team are fully involved from the outset to ensure any equipment or adaptations needed are in place, in liaison with the local falls service.
To be in control of her future	**Voluntary sector contribution** Links are made with local voluntary organisations that can provide support and companionship for Dorothy when she returns home. Her GP recommends a 'social prescription' and Dorothy is offered a six week programme of activity based on her interests. It includes some light physical activity, joining a singing group and a lunch club. Dorothy is beginning to feel more confident and that she can manage now and in the future. If she needs help or advice she knows who to ask and that it will be readily at hand.

Contact us:

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Better care in emergencies:

"I could plan ahead and stay in control in emergencies. I had systems in place so that I can get help at an early stage to avoid crisis"

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Hull 2020
Making a better future together