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How do we work to address the stark inequalities that COVID-19 has highlighted?



Hospital discharge

Potential to increase inequalities if we are not careful how this is done.

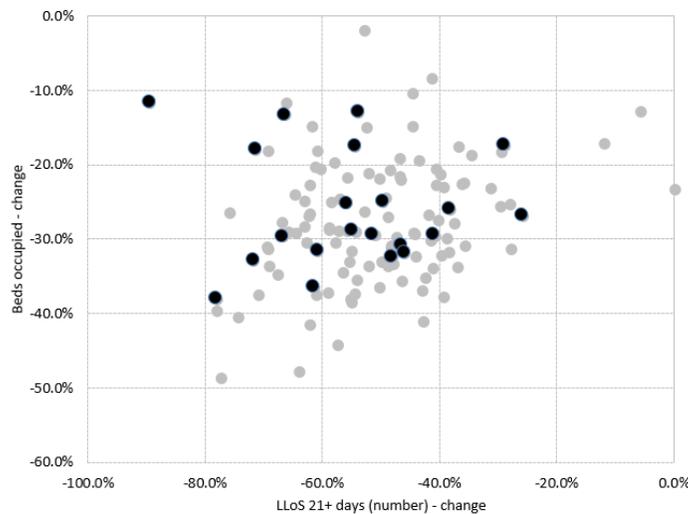
21+ days stayers

All regions have reduced LLOS > 21 days significantly. As at week ending 3 July, the range was **53% - 63%** reduction against their own March 2018 baselines, slightly behind the previous week (53% - 65%). Midlands achieving **61%**, East of England **58%**.

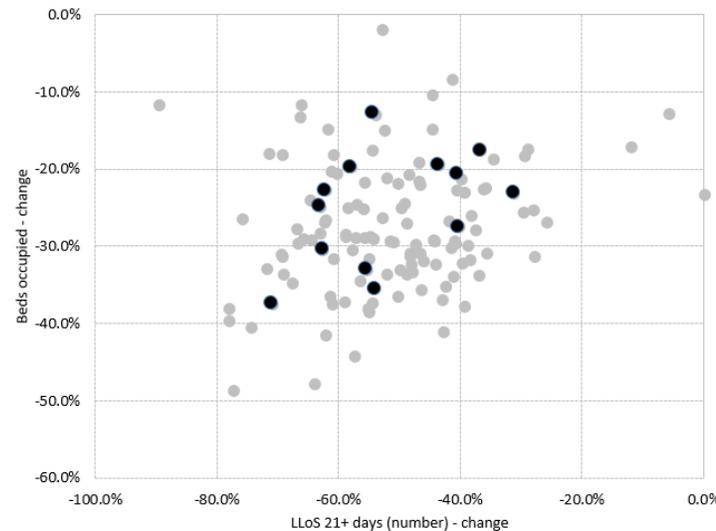
Variation

Significant variation across the country on how regions have been able to implement this model. Regions which were looking and working to implement this prior to the pandemic appear to have been more successful. Charts below for Midlands and East of England show how their trusts (the darker plots) compare to the rest of the country (shown in grey).

Midlands



East of England

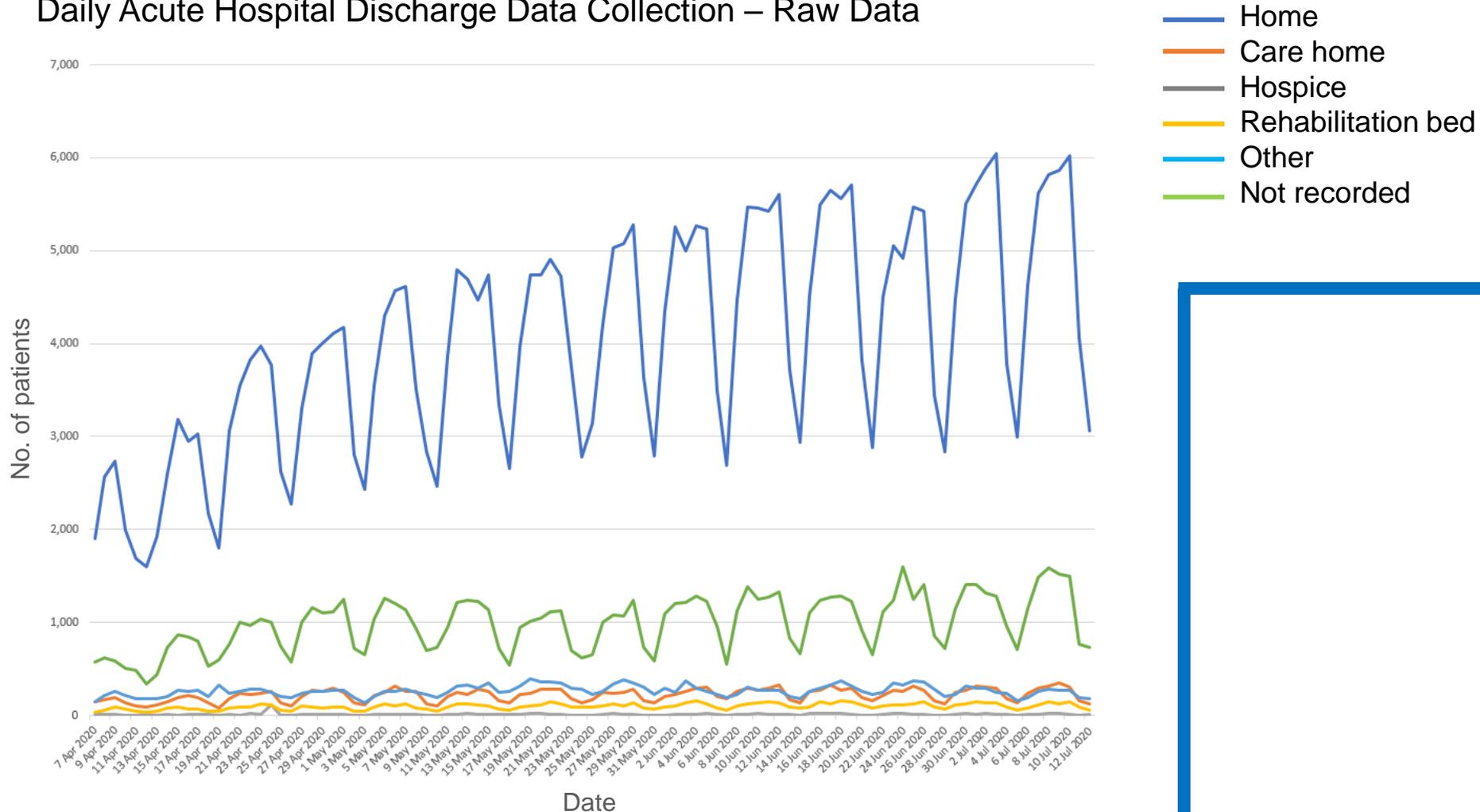




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Daily Acute Hospital Discharge Data Collection – Raw Data





How do we work to address the stark inequalities that COVID-19 has highlighted?



Recommendations from PHE report: **Beyond the data: Understanding the impact of COVID-19 on BAME groups**

-  Mandate comprehensive and quality ethnicity **data collection** and recording.
-  Support community **participatory research**.
-  **Improve access, experiences and outcomes** of commissioned services by BAME communities.
-  Accelerate development of **culturally competent occupational risk assessment tools**.
-  Fund, develop and implement culturally competent **COVID-19 education and prevention campaigns**.
-  Accelerate efforts to target culturally competent **health promotion and disease prevention programmes**.
-  Ensure COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to **create long term sustainable change**.



What areas of personalisation do you feel have accelerated for the better as a result of COVID-19?

NHS



Home First



Enabling safe and timely transfer of patients from secondary care back home in most cases, supporting more people at home, especially those that were shielding

Joint Planning



Enable **cross-system working locally** to ensure appropriate health and care support is provided in the right setting following discharge from hospital; **6 weeks** of funded care delivery.

Personal Health Plans



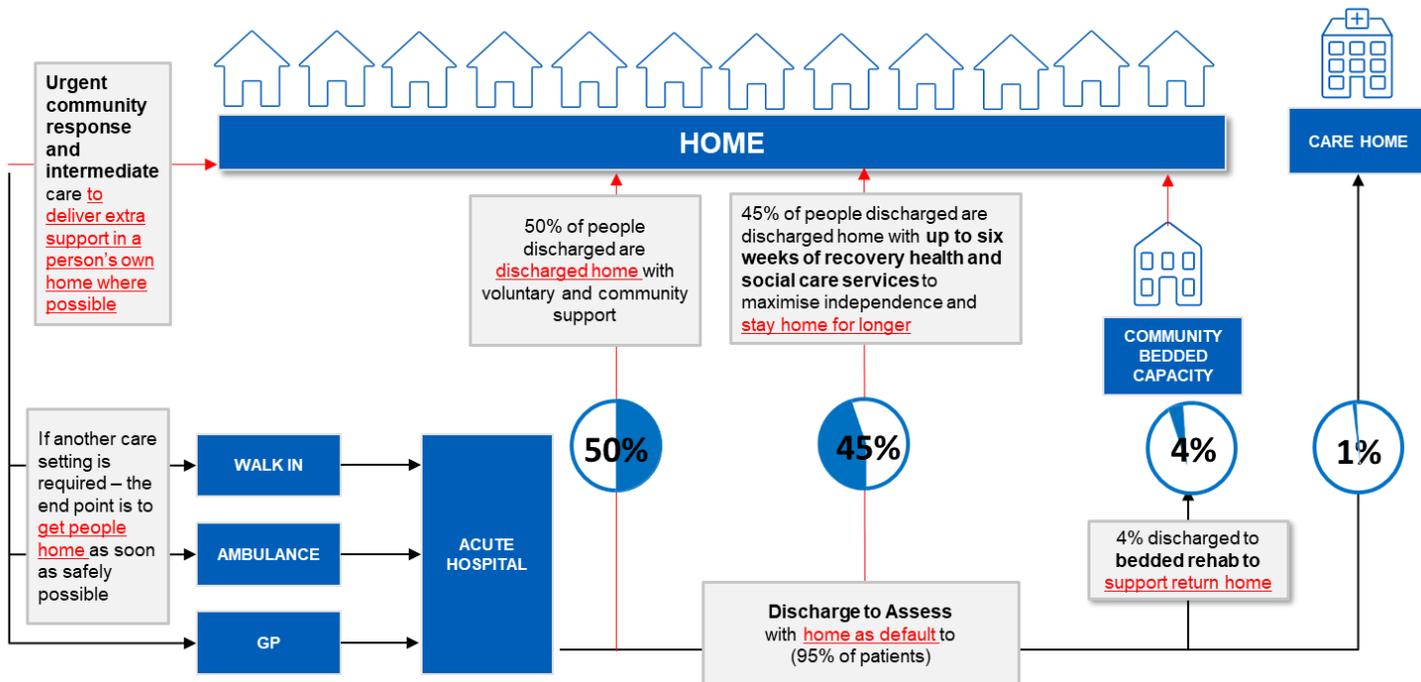
Providing personalised support care plans **proactively**.



How do we effect the change needed to ensure that people can access person centred, person led, co-ordinated care and health support that enables people to live the lives they want to lead in the community?



Home First - Overall aim: to support people to maximise their independence and remain in their own home



Questions welcome

