

Neighbourhood Working

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Neighbourhood working



Place-Based Approach



Neighbourhood Teams



NHS Transformation

Key Principles



Person-centred,
community-
focused care



Multidisciplinary
teams (MDTs)



Prevention
and early
intervention



Integration
across all
care sectors



Reducing
health
inequalities

Strategic Aim – move from:

Hospital → **Community**

Reactive → **Proactive**

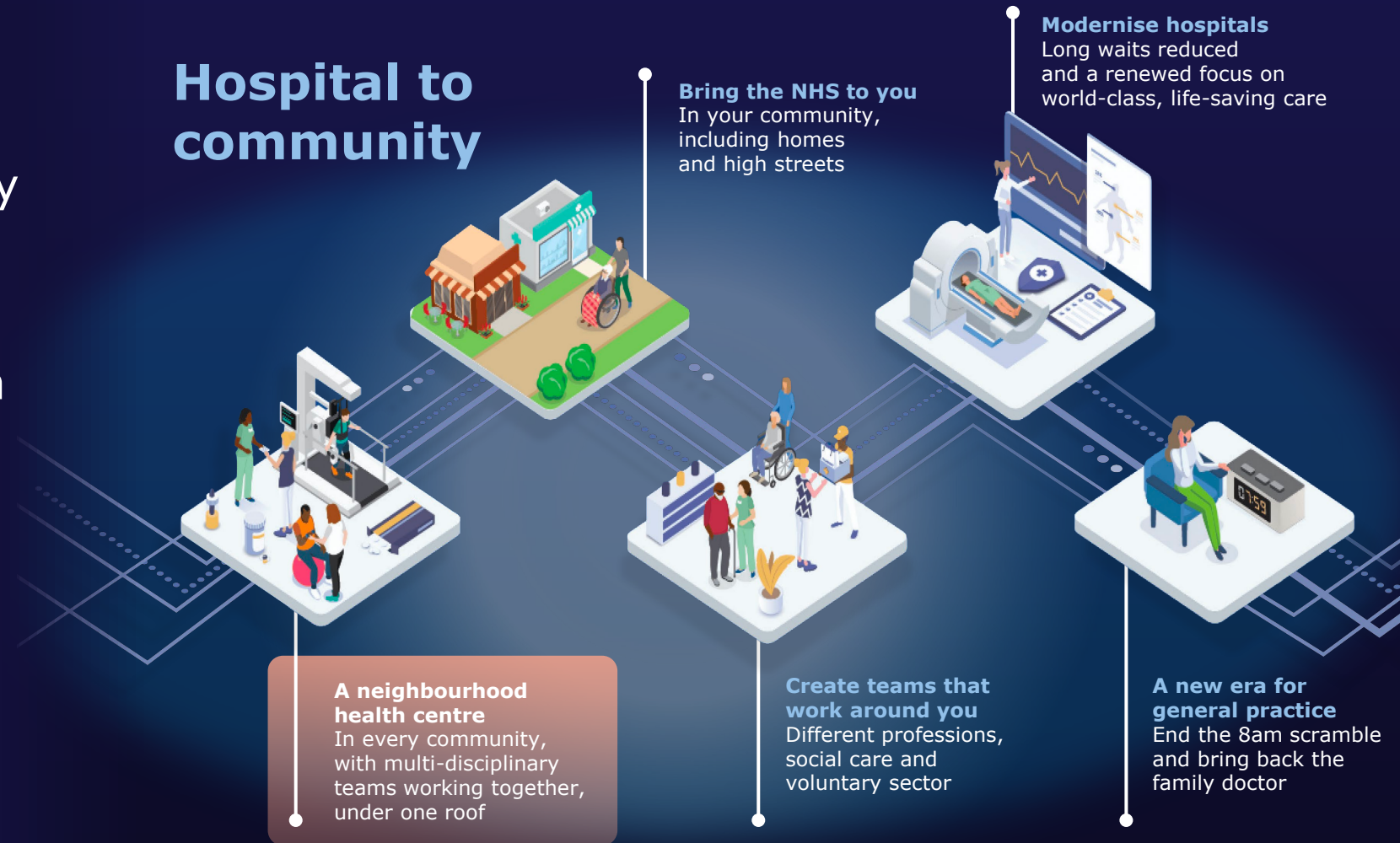
Organisational silos → **Integrated teams**



Neighbourhood working, the NHS 10 years plan



- Establish a **Neighbourhood Health Centre** in every community
- Ensure people with complex needs have an **agreed care plan by 2027**
- Enable shift to **preventative care**



Targets of the Neighbourhood health framework

March 2026



Outpatient referrals

25%

diversion rate through "single points of access" in 10+ specialties by March 2027.



Follow-up Reductions

10%

reduction in secondary care outpatient follow-up appointments by March 2027

Pediatric Access

10%

reduction in acute outpatient appointments for under-16s by March 2029..



Urgent GP Care

90%

of clinically urgent patients to be seen by a GP on the same day by March 2027.

Frailty Support

10%

reduction in non-elective admissions for frailty and housebound patients by March 2029.



End of Life Care

10%

increase in identification and 10% reduction in admissions by March 2029.



Evidence-Based Outcomes

10%

improvement for CVD, diabetes, COPD, mental health conditions, and dementia.

Diabetes Care Processes

10%

increase in patients receiving all eight recommended care-process elements.



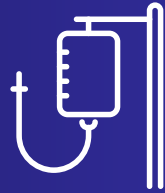
Evidence, 10-year plan



Systems that invested more in community care saw on average...

15%

Lower Non-Elective
Admissions



10%

Lower Ambulance
Conveyance



Lower ED
Attendances



Systematic Review Findings

6% **Reduction
in costs**

6% **Improvement in
outcomes** from
integrated care models



Birmingham & Solihull Community Care Collaborative is pioneering the shift from hospital to community, deploying multidisciplinary teams and implementing a new data-led care model.

Washwood Heath, a new hub in East Birmingham, has seen **A&E attendances fall by over 30% in the last 12 months among targeted patients, and length of hospital stay fall 14%.**

This approach is now being rolled out across Birmingham and Solihull.



Prevention



Key Indicators

- High Intensity Use
- Wrong care setting
- Low engagement with the service
- Low compliance with treatment
- Not following pathway
- Duplicate efforts

What are we doing to help?

Community Integrators



Aiming to create a '**left shift**' in case delivery across Birmingham and Solihull and to deliver **social, community and mental health interventions** to citizens overusing care resources through **Integrated Neighbourhood Teams (INTs)**

The Process



Identify

Citizens who are candidates for intervention



Manage

Each case, from info gathering to discharge



Monitor

Track all cases across the cohort

Each stage is delivered with **HealthShare**

Community Integrators – Built on HealthShare

Manage and Monitor



Case Management (CMT)

Delivered via the **Case Management Tool**, entirely built on **Care Community**.



Information Gathering

Track progress from **Shared Care Record** through triage, onboarding, and discharge.



Health Insight Dashboards

Monitor entire cohorts via **population, key worker, and patient views**.

All components are integrated to **streamline workflow** and **improve citizen outcomes** across Birmingham and Solihull.



Community Integrators CMT

Manage



- Multi-partner care planning
- Built directly in HealthShare
- Single-record care plan
- Gathers data from multiple sources
- Resides in one place – single source of truth
- Allows multiple clinical actors to contribute to one care plan in one place, for **truly integrated case management**

Community Integrators – Building on HealthShare



Identify

Old Model

Incomplete dataset

Limited support

Data silos

New Model - Health Insight

HealthShare foundation, algorithmically driven



Richer dataset

Inject algorithm with a richer dataset from the Shared Care Record.



Smarter identification

Users identify better candidates through filtering.



Streamline workflow

Enabling direct action from dashboard to the CMT to start tracking progress.

Streamlining workflows and enhancing intervention accuracy across the system.

Community Integrators Initial Outcomes, June 2026



Pilot Overview

- 89 residents from 5 Birmingham Neighbourhood Health Centres
- Appropriate community interventions introduced
- Analysis measured service utilization pre & post intervention

Interim results:

19%-48%

reduction in service utilisation

Projected Annual Savings (Extrapolated across 30 INTs)



>22K

GP Attendances

>6K

A&E Visits



~3K

Inpatient Spells

>27K

Inpatient Bed Days





Thank You