



Connect

Providing the **right care** at the **right time** in the **right place**
for the people of Birmingham & Solihull

Newsletter for the Birmingham & Solihull Community Care Collaborative

April 2026

Singapore Health Colleagues Visit Birmingham to Study Neighbourhood Health

Healthcare professionals from the National University Health System, Singapore, recently visited the East Birmingham locality hub in Washwood Heath to learn about the city's innovative approach to creating a neighbourhood health service.

Neighbourhood health is about shifting care closer to home and joining up services across local government, social care, and the voluntary sector.



Stephanie Tham, Senior Assistant Manager at the National University Health System Singapore with Chris Holt, Chief Transformation Officer for BCHC, Nurse Qiwen Ng and Sister Ai Wah from the Community Care Team with Shannie Jennings, Senior Locality Integration Manager for BCHC

Birmingham's ability to weave social prescribing and community partnerships into the medical model offers a powerful blueprint for refining our population health approach.

Stephanie Tham

Senior Assistant Manager, Community Operations, Regional Health System Office, at the National University Health System, Singapore

During their visit the trio visited the care co-ordination centre and the Respiratory Same Day Emergency Care and Heart Failure clinics. They also observed how GPs, social workers, mental health practitioners, social prescribers, clinical health practitioners and voluntary sector partners work as a single, unified team to support residents with more complex needs.

The hosts shared the locality and neighbourhood health model that has been

developed by the Birmingham & Solihull (BSOL) healthcare system and how this is addressing the wider determinants of health, such as housing and social isolation, alongside medical treatment.

Also shared were the governance and data-sharing models that have also been developed that allow multi-organisational teams to coordinate care at a neighbourhood level in real-time.

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Stephanie Tham, Senior Assistant Manager, Community Operations, Regional Health System Office, at the National University Health System, Singapore said: "Learning more about locality hubs across Birmingham and Solihull as well as the work of the integrated neighbourhood teams has been eye-opening. In Singapore, we are working towards delivering integrated health-social care in the community and Birmingham's ability to weave social prescribing and community partnerships into the medical model offers a powerful blueprint for refining our population health approach."

The visitors are taking part in the International Integrated Care Conference, taking place in Birmingham from 13–15 April 2026. Taking place in Birmingham from 13–15 April, the conference brings together more than 1,000 global health and care leaders to share innovations in policy, practice, and the integration of health and social care services.



Alan, aged 91, was having treatment in the heart failure clinic when the Singapore team visited. He commented that he was so busy chatting and laughing with the visitors that his treatment time flew!



New Community In Reach Team Launches at MMUH

A new Community In-Reach Team has officially launched at Midlands Metropolitan University Hospital (MMUH) in West Birmingham to help discharge patients sooner to continue their treatment in the community.

Operating directly within the acute hospital setting, this specialist community focussed team will work side-by-side with ward staff to accelerate safe discharges and ensure patients continue their clinical treatment in the comfort of their own communities.

Alternatives to a hospital stay or sooner hospital discharge include admission to a virtual ward, short term support from the Early

Intervention Community Team and access to a range of other community services designed to help people recover at home.

Lisa Maxfield, Deputy Chief Partnerships Officer at MMUH said: "The in-reach model is proving invaluable in supporting acute hospital staff to deliver timely, patient-centred care. By enabling earlier discharge, patients can continue treatment at home, promoting recovery, independence, and overall wellbeing.

"The West hub team has been working closely with clinicians and discharge trackers to identify patients suitable for community-based pathways. A key strength has been effective information sharing from community input, ensuring

strengthened coordination with district nursing, social care, and mental health services."

Amy Crumpton, Group Manager for the West Locality Hub added: "The model also reviews patients, who have a high number of admissions, to help identify holistic needs and opportunities for a more preventative approach to care. This joined-up approach supports continuity of care and ensures patients receive the right support at the right time. Early data shows the model is already having a meaningful impact on reducing length of stay for patients in West Birmingham. We are excited to be delivering this work with the opportunity to impact patients longer term health outcomes in West Birmingham"

Transforming Community Health Through Social Prescribing

The roll out of the Integrated Neighbourhood Teams is on track with 16 teams now live across Birmingham & Solihull. INTs are made up of different health and social care professionals including nursing and therapy colleagues, mental health professionals, social prescribers, voluntary sector, social care and other council services.

They support people with multiple, often complex, health and care needs, who are receiving care from lots of different parts of health and social care.

In this month's edition of Connect we would like to highlight the role of the social prescriber which is extremely important in today's health service. A social prescriber services as a critical bridge between clinical medicine and community support to address the "wider determinants of health"—factors like loneliness, debt, and housing that doctors cannot treat with medication alone.

The practice has evolved from being in a niche role into a central pillar of the NHS's long-term strategy for prevention and personalised care; so much so that a Social Prescribing Day was launched in 2019.

Over the last 12 months Witton Lodge Community Association (WLCA), one of our INT partners in North Birmingham, has supported almost 400 local residents through social prescribing. Here we learn more from John Faber, WLCA's dedicated social

prescribing link worker, who helps people to take control of their health and wellbeing.

John (picture right) works in conjunction with the Midlands Medical Partnership (MMP) to support GP patients across North Birmingham. John's work helps to ease the pressure on clinical health service providers.

Patients are referred into John – via a social prescription issued by their GP – who will then facilitate an initial phone conversation with them to discuss their situation and needs.

"Social Prescribing is an important and much needed project that connects residents in the north of Birmingham to many non-clinical services," he said.

"This includes advice on social activities & groups, mental health support, benefits advice and housing support. The social prescribing I do helps to take the pressure off local GP surgeries and allows them to put more focus on the medical needs of people.

"We are very proud to be a provider of social prescribing in the north of the city. It allows us to play a key role in delivering positive impacts in peoples lives."

While traditional prescription medicine remains vital, it often falls short of solving the health problems that can be caused by things like loneliness or stress caused by financial or housing issues.

That is why WLCA is happy to lead this transformative approach to healthcare.



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John Faber

WLCA's dedicated social prescribing link worker

The Transformative Benefits of Social Prescribing

Witton Lodge Community Association was proud to support a community engagement event which was held to raise awareness of the benefits of social prescribing.

Link Worker, Sean Thompson-DeWolfe, organised the session at Cotmore Surgery to talk to patients and local residents about alternatives to prescription medicines.

Shane Wedderburn, our Flourishing Communities Service Manager, attended the event to highlight the health and wellbeing activities currently being delivered at the Witton Lakes Eco Hub.

"Shane brought energy to the room during his presentation, moving between groups of patients to discuss the holistic pillars of a healthy life: housing, employment and wellbeing," said Sean.

"He showed how activities at the Eco Hub can positively impact a person's physical and mental health."

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Cotmore Surgery has around 5,000 patients. The session was held to engage with those aged 50 to become more aware of what is available within the local community.

"Social prescribing is about using the local environment you live in and the support systems that are in place," added Sean

"Health doesn't start at the doctor's door, it starts with a safe and comfortable home, a steady job and a community that listens."

Meanwhile, Shane commented: "It was a delight to speak to patients and residents about physical activity, wellbeing programmes and environmental initiatives being delivered at our Hub in Witton Lakes Park."

➔ For more details on the range of activities delivered at Witton Lakes Eco Hub please call 0121 227 3200.



Health doesn't start at the doctor's door, it starts with a safe and comfortable home, a steady job and a community that listens.

Sean Thompson-DeWolfe
Link Worker



North Birmingham Stroke Education Event Success

More than 50 patients and their families are now better equipped to spot stroke symptoms, following a collaborative health and care education event led by Good Hope Hospital.

Invitations were sent to patients who had attended the hospital's emergency department or stroke outpatient clinics over the past few months and were identified as having a transient ischaemic attack (TIA) or 'mini stroke'.

After looking at the clinic letters of these patients, the stroke therapy team noted the most common cardiovascular risk factors included high blood pressure, high cholesterol and atrial fibrillation, a type of heart rhythm problem where the heartbeat is not steady.

The event, held at Sutton Coldfield United Reformed Church, was designed to look at these topics specifically. They were led by Good Hope Hospital's Dr Khaled Darawil, Stroke Consultant, and Professor Sudarshan Ramachandra, Consultant Chemical Pathologist and Professor of Metabolic Medicine.

The event was a collaboration between Good Hope Hospital, Royal Sutton Coldfield Town Council, Birmingham and Solihull Integrated Care Board, The Pioneer Group/Age Connects West Midlands representing Sutton Coldfield Neighbourhood Network Scheme, and voluntary sector partners such as the Stroke Association and Headway.

Caroline Graham, Therapy Lead for Stroke and Neurology at Good Hope Hospital, said: "We know there is a lack of awareness and delays in seeking urgent treatment for stroke, so it's vitally important that people know the signs and symptoms. The Act FAST campaign is a useful aide memoir and was highlighted in the session."

"We also wanted to focus on prevention, a key objective of the NHS 10 Year Health Plan. Colleagues from Birmingham and Solihull's Integrated Care System shared the 'Know Your Numbers' campaign, encouraging patients to get free blood pressure checks at local community pharmacies. We also shared Arrhythmia Alliance's 'Know Your Pulse' initiative to identify atrial fibrillation. People often aren't aware they have high blood pressure or atrial fibrillation and how these conditions, if left untreated, increase the risk of stroke, which is a life-changing event."



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Caroline Graham

Therapy Lead for Stroke and Neurology at Good Hope Hospital

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Stroke is preventable, and various hospital teams attended the session to educate patients about lifestyle changes to help reduce their cardiovascular risk factors, such as healthy eating, reducing alcohol intake, smoking cessation, and physical activity. Teams from Good Hope Hospital included the lipid clinic, alcohol care team, tobacco care team, physiotherapists, and dietitians.

Caroline added: "We brought together some brilliant resources, apps and digital services to help people to self-manage and understand when they need to seek medical advice. Sadly, we are seeing higher numbers of TIA patients attending our stroke clinics at Good Hope Hospital, and seeing younger patients, so education about how to reduce cardiovascular risks plays a vital role."

This integrated health and care approach for local people is part of the Birmingham and Solihull Community Care Collaborative which encourages local health and care partners to work together to provide better joined-up health and care services in our neighbourhoods to meet the needs of our local population.



New Community Service Offers Local Support for Heart, Kidney, and Diabetes Patients

A new community healthcare service has started in South Birmingham, transforming to help people with long-term heart and kidney and diabetes conditions manage their health. Since launching in late February 2026, the service has already helped more than 400 residents, providing hospital-level expertise within a local community setting.

Pharmacists in local GP surgeries are identifying people who need extra support for complex problems and reviewing the medications and treatment plans. Following the review the pharmacists usually work directly with the patient, but also if someone's case is particularly complex it gets reviewed by a team that includes University Hospitals Birmingham (UHB) specialists, local primary care GPs and the pharmacists. So patients get full input without having to go to appointments. Because the service has a group of healthcare professionals with different skills and expertise working together it means there is less duplication and care is more accurate.

There are new treatments now available for these conditions and the teams is working to make sure that patients have those treatments available to them and that specialised care plans are implemented early keeping people well and making it less likely that they will require hospital care,

Professor Paul Cockwell, Consultant Nephrologist at UHB and Medical Director Long Term Conditions and Prevention NHS Birmingham and Solihull (pictured right) said: "This is the first time that hospital based colleagues have joined forces with pharmacists, GPs and other acute and community professionals working in the South Birmingham area to work in this way. This initiative is fundamentally about joining up care that we can bring to the patient in their community as part of the wider national approach to shifting care from hospitals to community."

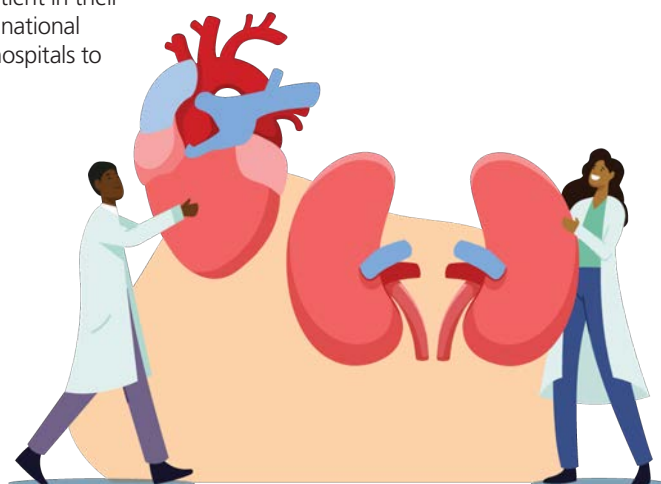


Simone Wilson, Chief Operation Officer for South Doc Services, the GP federation which co-ordinates the service said: "Our service is already transforming lives by improving the quality of care for patients with these often-interlinked conditions. By intervening early through proactive reviews and consultant led MDTs, we

are not only enhancing patient wellbeing but have already successfully prevented unnecessary hospital admissions since our February launch."

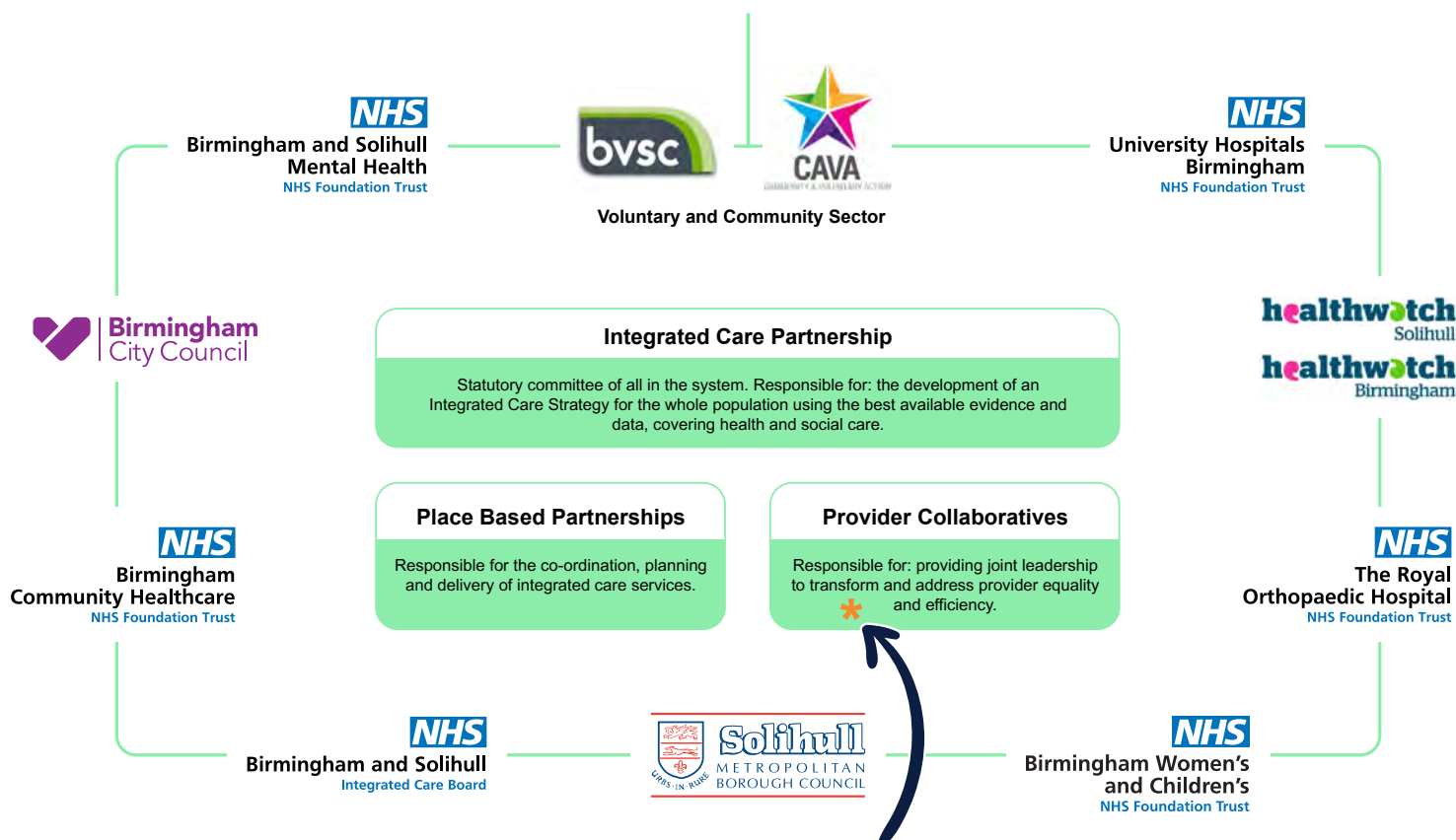
"The long-term vision is to expand this model across the whole of Birmingham and Solihull. The team is also developing robust support for people who are being discharged from hospital with one or more of these conditions and have plans to integrate dedicated mental health specialists into the team. We want to treat the whole person, not just their symptoms."

This initiative is part of the wider Birmingham and Solihull Community Care Collaborative programme of work.



Get in touch

If you have any news or stories you want to share, or you'd like to give a shout out to your team, get in touch with jenny.chatham@nhs.net with a few details. We will do the rest!



* This is where the Community Care Collaborative sits within the wider BSol health and care system.