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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

February 2026



Care Minister visits East Birmingham locality

Patients diagnosed with heart failure in Birmingham and Solihull have been given improved access to essential care through the launch of a brand-new community heart failure service at Washwood Heath Health and Wellbeing Centre (WWH), provided by Heartlands Hospital, part of University Hospitals Birmingham NHS Foundation Trust.

WWH is one of six neighbourhood hubs to open across Birmingham and Solihull as part of the Community Care Collaborative (Collaborative) programme of care. These hubs are part of the government's strategy to provide better integrated localised health and social care service with the aim of shifting care from hospitals into communities, focusing on

prevention and early diagnosis, and using digital technology to better integrate health, social care and voluntary sector support around individuals and families.

The new service will enable patients with heart failure to be monitored and receive routine appointments closer to home with access to specialist heart failure nurses working closely with community nurses and primary care colleagues.

Minister of State for Care, Stephen Kinnock MP, officially opened the heart failure service by cutting a ribbon held by Heartlands Hospital's Director of Operations, Ed Landon, and Heart Failure Advanced Clinical Practitioner, Stewart Black.

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Through our 10 Year Health Plan we are shifting care from hospital to community, bringing it closer to where people live.

Stephen Kinnock
Minister of State for Care



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Ed Landon, Director of Operations, Heartlands Hospital, said: "This new clinic will help us to wrap care around our patients, giving them essential community care, helping improve their quality of care and overall long-term health outcomes.

"This is an exciting extension to the Respiratory Same Day Emergency Care service launched at the Washwood Heath Health and Wellbeing Centre a year ago."

Asgher Khan, aged 55 years-old, from Yardley has intravenous (IV) furosemide daily, which relieves fluid congestion and breathing difficulties in patients with heart failure. He received this treatment at Heartlands Hospital but is now able to go to Washwood Heath. He said: "The service is priceless. I get more of a personal relationship with the team; it's like a VIP service.

"I used to feel quite stressed going into hospital, but at Washwood Heath, once you're done, you can go home. The team make sure you're comfortable, do all the necessary checks, like your blood pressure and weight, and are there to discuss any problems and give reassurance and guidance. It's real one-to-one care. I'm so grateful."

This new clinic will help us to wrap care around our patients, giving them essential community care, helping improve their quality of care and overall long-term health outcomes.

Ed Landon

Director of Operations,
Heartlands Hospital



Minister of State for Care Stephen Kinnock said: "I was delighted to visit Washwood Health and Wellbeing Centre – one of our pioneering neighbourhood health services – and to open the new heart failure clinic.

"Through our 10 Year Health Plan we are shifting care from hospital to community, bringing it closer to where people live. Washwood is leading the way, providing health and care services for the people of Saltley and Birmingham right on their doorstep.

"The new clinic offers patients rapid access to diagnostic appointments, care and support in one place. This will ease pressure on hospitals, while delivering better, more convenient care for patients."

Richard Kirby, Chief Executive, Birmingham Community Healthcare (NHS) Foundation Trust, the organisation appointed to lead the work of the collaborative added: "The addition of the new heart failure clinic to the existing services provided at this neighbourhood hub in East Birmingham marks a great advance in how we are trying to better deliver healthcare more locally for patients. This community-based specialist care is enabling earlier interventions and helping residents manage their health closer to home which is where we know they would prefer to be."

During the visit Mr Kinnock also met colleagues across other areas of the hub, including members of the integrated neighbourhood team, one of 11 now 'live' across the city, with five more due to launch by end of March 2026 and a target of 35 by the end of 2027.

Staff from BCHC and Heartlands Hospital offered an insight into the innovative collaborative use of real-time data in the care co-ordination centre; and colleagues from UHB in the respiratory same-day emergency care service talked to the minister about their first year of operation, in which they have seen over 1,500 patients.

David Melbourne, Chief Executive of NHS Birmingham, the Black Country and Solihull, added: "The East Birmingham Locality Hub is one of 43 initiatives across Birmingham,



the Black Country and Solihull that have been selected to take part in the National Neighbourhood Health Implementation Programme, which is a strong endorsement of the partnership approach we are taking to tackle stark and unjust health inequalities by designing services around communities rather than organisations."

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Richard Kirby

Chief Executive, Birmingham
Community Healthcare (NHS)
Foundation Trust

New North Initiative set to help people with frailty

Around 60 patients a week are being better supported to facilitate safe discharge of patients sooner to their place of residence thus reducing unnecessary hospital stay thanks to a new focus on frailty being delivered by Good Hope Hospital and the North Birmingham Locality hub.

Frailty is a long-term, usually age-related state that results in reduced resilience making them more vulnerable with seemingly minor conditions having a major impact on their lives.

A joint team of Good Hope acute care consultants and North Hub community team now review inpatients with frailty on a daily basis and assess whether they could benefit from a home-first approach by receiving the care they need in the community. Community care can be delivered in a patients' own surroundings or at community-based clinics.

Patients discussed are inpatients that are either aged 80 and over, those who live in care homes and those identified as approaching palliative or end-of-life care.

Zoe Kimbley, Consultant in acute medicine at Good Hope Hospital who is working closely with the hub team, said: "Our department sees on average 15 patients with frailty each day, with more than 14,000 emergency admissions via A&E during 2025 for patients aged 65 and over. priority is to help them return home, or to their usual surroundings, as quickly as possible, where they are more comfortable and will recover sooner."

North Birmingham (encompassing Sutton Coldfield, Kingstanding and Erdington) has a significant and growing population of elderly and frail residents. Data indicates that the northern part of the city has one of the largest concentrations of older residents in Birmingham, with a high proportion of people aged 65 and over, including those aged over 80.

Dr Rahul Dubb of Sutton Coldfield Group Practice and co-lead GP for the North Locality hub added: "The care co-ordination role at the Locality Hub at Stockland Green Health Centre



gives us a real opportunity to glue together hospital based care with that provided in the community and general practice to better tailor health and care services to meet the needs of our north Birmingham population. We know that North Birmingham has a relatively higher proportion of a growing elderly population. Our collaborative working with Good Hope Hospital teams is a key ingredient in helping us provide the very best health and care services we can to ensure that local people live well for longer in their own surroundings.

As part of the continued development of health and care services in North Birmingham, the area is set to welcome the opening of the new Sutton Cottage Hospital which is being

transformed by Birmingham Community Healthcare (NHS) Foundation Trust into a £8.5 million, "one-stop" integrated health hub for older adults in North Birmingham, focusing on specialised care for frailty, dementia, and chronic conditions.

Scheduled to be operational late spring 2026, it will offer multidisciplinary services to provide proactive integrated care in the community, including diagnostics thus reducing hospital admissions.

This new approach enhances existing services delivered in North Birmingham and Good Hope Hospital for patients with frailty.

Services in north Birmingham will continue to be developed by the North Locality Hub.



Amy's Journey to Safer Living

Patients are already feeling the benefits of this new frailty approach between Good Hope Hospital and the North Locality hub. One such patient is Amy. Aged 95 and living alone in her own home, Amy came to the attention of the north hub team. Despite receiving both planned and unplanned district nurse visits, she was regularly being admitted to Good Hope Hospital with injuries from falls—five times during December alone.

During her recent hospital stay, the new frailty multi-disciplinary team, which included Consultants from Good Hope Hospital, GPs and Senior Hub, reviewed Amy's case in detail. Their goal was to see how they could provide better support and care for Amy to prevent the frequent hospital admissions and high intensity community care. After careful consideration the team agreed that she was no longer safe to return to her own home and that she would be safer to transfer to a local nursing home that could meet all of Amy's health and care needs.

In a true Locality partnership collaboration, the North hub Coordinator worked with the North hub social worker and a number of nursing homes to find the best new home for Amy.

During her hospital stay, Amy was reviewed daily at the Frailty MDT. The new community care focussed in reach team based at Good Hope Hospital maintained regular communication with the ward consultants to ensure timely treatment and prevent any avoidable delays to discharge.

Holly Tuite, Service Manager for the North Locality Hub said: "Amy's case was a true collaboration between multiple health and care partners and decisions that were made in a timely way due to the fact that we are all sitting in the same room with a permanent live link to the in-reach team at Good Hope Hospital. Amy's move to a local nursing home was a case of us delivering the right care in the right place and at the right time. Since moving to her new surroundings, Amy is more comfortable and much safer. The intervention successfully halted the cycle of emergency care; she has required zero hospital admissions and no further district nurse interventions.

Without this multi-disciplinary, North Locality hub and Good Hope Hospital partnership intervention, Amy would likely have continued to suffer recurrent falls and hospitalisations, leading to a further decline in her health and wellbeing.



Council Leader Visits Hub to Witness Future of Neighbourhood Care

Councillor John Cotton (pictured), Leader of Birmingham City Council, recently paid a visit to Washwood Heath Health & Wellbeing Centre (WWH) to observe the pioneering work of the Community Care Collaborative (CCC) in transforming local healthcare delivery.

The visit highlights the success of WWH as the definitive pilot site for Birmingham and Solihull's neighbourhood health model. Chosen for its proximity to Heartlands Hospital and its goal to tackle deep-seated health inequalities, WWH successfully shaped the new model of care which was used to mobilise five additional Locality Hubs across Birmingham & Solihull in October 2025.

Locality Hubs—central to the Government's NHS 10-Year Plan—are designed to shift the focus of the health service from hospitals to communities, moving from reactive treatment to proactive prevention and from analogue to digital care.

Commenting on his visit, Councillor Cotton said: "The work being done here at Washwood Heath and the five other recently launched



Locality hubs is a blueprint for the future of the health and wellbeing of our citizens. By bringing leaders from the NHS, the voluntary sector, and the community together, we are ensuring that

residents receive the right care, in the right place, at the right time. This is about more than just healthcare; it's about building a fairer, healthier Birmingham."

Right care, right time: A day in the life of a hub coordinator

Whilst at weekends Duncan lives out his passion for music by playing bass guitar in his band Cattle Hammer, during the week he is very much focussed on his role as Hub Coordinator in the Central Locality Hub.

Based at Moseley Hall Hospital, Duncan plays a pivotal role in supporting the Locality hub team to keep patient flow in and out of hospital moving smoothly. Here he talks about his job and the reasons behind why he enjoys it so much.

I start my day in the hub, usually with a coffee in hand, by attending the morning huddle. This huddle is the most important part of my day—it's where we are updated on what is happening with the patients on our caseload and from that I know what I need to focus on for the day ahead.

There are several key aspects to the Hub Coordinator function. The first is to look after our "Pathway 2" patients. These are the patients who are medically stable enough to leave the acute hospital, such as the Queen Elizabeth Hospital in Birmingham, but aren't quite ready for their own home yet; they need a stay in a community hospital, such as Moseley Hall, to get their strength back. Another is to support patients, who are being discharged from a community hospital, in their journey back to their usual surroundings which include home.

To achieve this, I spend a lot of my time working closely with the hospital Discharge Facilitators. They work directly with specific patients and ward teams to handle the immediate, practical details of going home whereas I manage the overall process and transition. We're like two sides of the same coin, making sure people move smoothly from one bed to the next.



Another crucial part of my day's work is to identify and small but significant hurdles that can stall a discharge, such as missing paperwork or transport issues. This includes checking in with care homes to make sure there aren't any unnecessary delays—like a room not being ready—that keep someone in hospital longer than they need to.

By unblocking these hurdles, I know I'm helping to keep the flow of the system moving. Every time we help a patient move into a community bed, we are freeing up a space in an acute ward for an emergency

patient. When we help a community patient to go home, we open up a bed for someone else to begin their rehab. I know we say it all the time but it really is about getting somebody the right care at the right time and in the right place.

I love my job. It is incredibly rewarding because I get to see the direct impact of my work; when I unblock a delay or settle a family's nerves, I'm not just moving a name on a screen—I'm helping a person get one step closer to home or where they need to be to continue their path to recovery.



How Real-Time Data Kept Javed Safe at Home

For one local patient living in south Birmingham, a routine trip to the bathroom in the middle of the night ended in a nasty fall and a call to 999. Whilst the ambulance crew was able to help him to get back up on his feet and stabilise him after the shock, he did not need to be taken to hospital.

The following morning, the South Locality Hub GP, Dr Immi Gandhi, phoned Javed for a chat to find out how he was feeling and the details around what had happened. It quickly became clear that this wasn't just a one-off accident—it was a safety issue that was likely to happen again as Javed was growing more unsteady on

his feet, always had to get out of bed in the night to use the bathroom, and needed some support to move safely around his house. This would also make sure that he could stay living in his own home and for the family not to have to start looking at other options.

The GP got in touch with the Early Intervention Community Team who called on Javed the following day to check on how he was after his fall and see how it could help him to live more safely at home.

By the end of that same day, the necessary mobility equipment was installed and in place. What started as an emergency call the night before ended with a permanent solution,

giving Javed his independence back and, most importantly, the peace of mind that he could move safely through his own home.

Without the new data approach that is being used in the Locality Hubs across the Birmingham & Solihull system, the fact that Javed had to call an ambulance and was not conveyed to hospital would not have been acted on so quickly across the health and care system. The fact that we now receive this real time data and there is a GP in the care co-ordination centre at the hub to make these types of phone calls means that Javed was made safe to stay living in their own home within 24 hours and hopefully avoiding having to call for an ambulance in the future.

How the West INT Supported James to Live Better at Home

Before the West Integrated Neighbourhood Team (INT) stepped in, 54-year-old James was calling 999 twice a week and missing health and care appointments. Managing diabetes and schizophrenia while living in an inaccessible second-floor flat had become overwhelming. He was also suffering from frequent headaches, blackouts, and other health complications.

Emily, a mental health practitioner from the INT, took the lead on his care. She noticed that James's wheelchair didn't fit easily through his doorframes, making it difficult for him to move around and also to leave his home, which was one reason he struggled to get to his medical appointments.

After Emily's initial assessment the INT coordinated several practical steps to help. Emily arranged for a GP to visit James at home to treat a recurring abscess and organise district nurse support. During the visit, the GP identified signs of glaucoma. The INT arranged an urgent referral for James and the necessary transport to the eye hospital.

The INT also flagged James' flat as unsuitable for a wheelchair user and requested an urgent housing move. They also set up a care package and a pendant alarm for his daily safety. Finally, an immediate review of his prescriptions helped reduce his physical symptoms and hallucinations.

Thanks to this joined-up approach, James hasn't needed an ambulance in over two months. It is a great example of how different professionals working together can significantly improve a patient's quality of life.



INT Citizen Leaflet Refresh

In response to feedback, the Integrated Neighbourhood Teams citizen leaflet has been updated to provide useful information to users of the INT. It answers regularly asked questions such as why the INT is contacting the citizen, how the INT can better support the user's health and wellbeing and the next steps in their care plan. The leaflet has been uploaded to the BCHC website and intranet and has been designed in an accessible format so it can be accessed by all.

→ [For more information](#)

Birmingham and Solihull
Integrated Care System
Caring about healthier lives



Integrated Neighbourhood Teams

Our neighbourhood approach to health and care in Birmingham & Solihull

What are Integrated Neighbourhood Teams?

Integrated Neighbourhood Teams (INTs) are led by your local GP network. They are multi-disciplinary teams that bring together healthcare and social care professionals to support patients, often with complex health and social care needs who use multiple services.

The aim of the INT is to improve your health and wellbeing and reduce unnecessary hospital admissions by adopting a holistic approach to your wellbeing.

We can also help you to be discharged home from hospital sooner if you are admitted.

Who makes up an Integrated Neighbourhood Team?*

GP

INT Co-Ordinator

Mental Health Practitioner

Social Worker

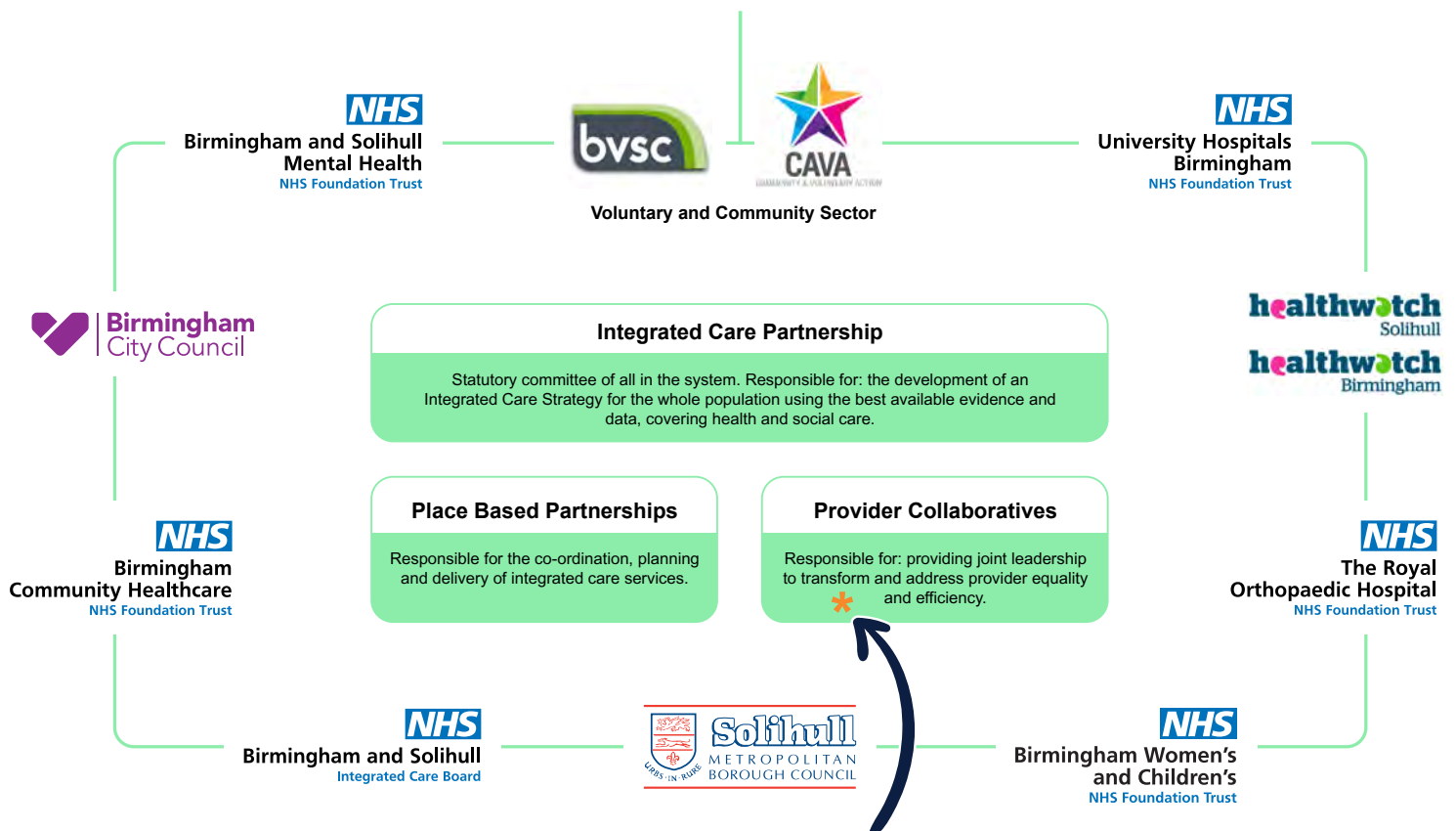
Long Term Condition Practitioner

Social Prescriber – connects people to non-medical support



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.