

BSol CYP Neighbourhood Health

13th October 2026
Partners in Paediatrics



By your side

Neighborhood Health Framework

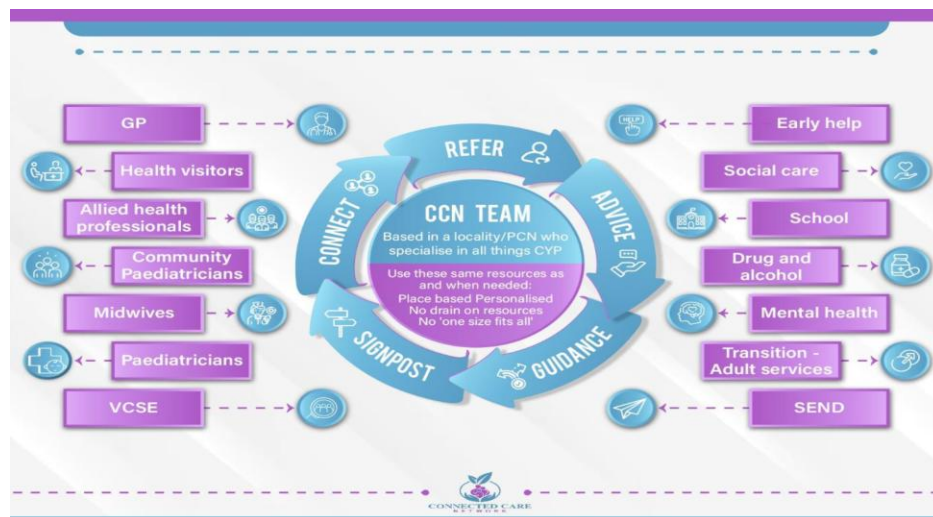
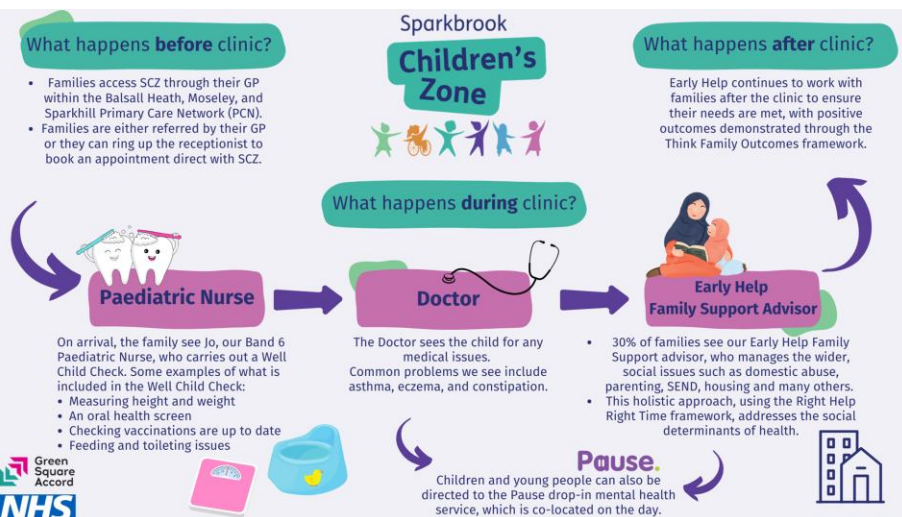
Neighbourhood health framework - GOV.UK

- Children and young people (CYP): GPs will use children and young people INTs to provide timely access to paediatric expertise in the community, alongside wider health and care professionals, including mental health and community services.
- INTs will also help families to manage some conditions at home if clinically appropriate. The evidence base shows that many ED attendances and outpatient appointments are a result of children receiving care in the wrong place. The NHS will address this through the INTs, and we will build this service over time, with every child who needs one having access to an **INT by the 2028 to 2029 financial year**.
- In practice, we expect systems will see a shift in outcomes through the reduction of outpatient appointments, with wider benefits including a reduction in ED attendances and hospital appointments.
- As part of setting up INTs, ICBs and local authorities should work together to consider how these services join up with other children's services - for example, safeguarding, family help and multi-agency child protection teams, Best Start Family hubs, and the 'Experts at Hand' service for children with SEND

- improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care. By March 2029, we aim to:
 - reduce acute outpatient appointments for children under the age of 16 by 10%
 - make substantial progress towards reduction of community waits for children, as part of delivering Medium Term Planning Framework success measures



The journey so far...

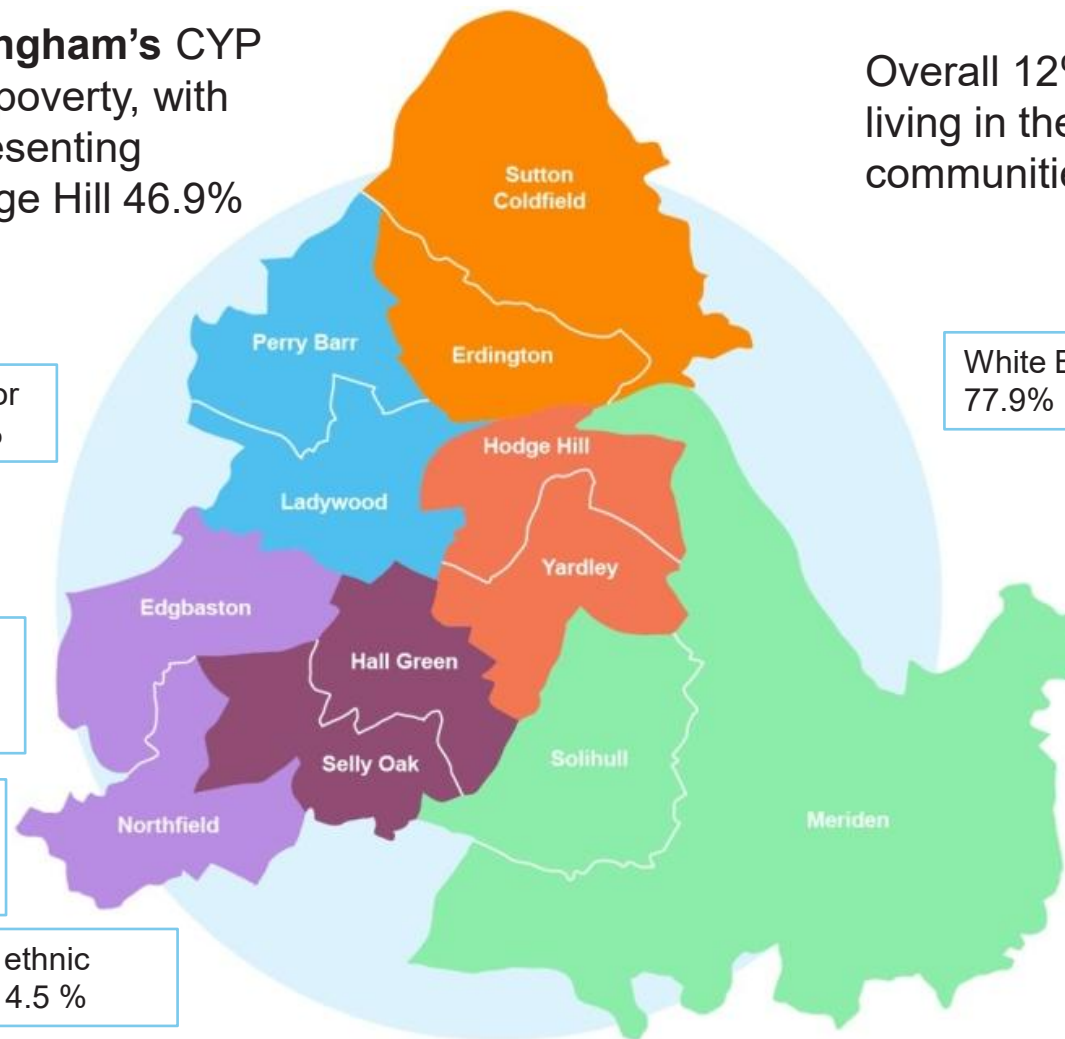


- Local national exemplars.
- Aiming to meet unmet need.
- Created at a time other statutory service offers were in development in both areas.
- Robust evaluation with evidence of effectiveness.
- Yet financially unsustainable as unable to take funding out of the system to support.

Birmingham & Solihull

32.5% of **Birmingham's** CYP live in absolute poverty, with Ladywood representing 53.8% and Hodge Hill 46.9%

Overall 12% of **Solihull's** CYP living in the most deprived communities



Children and Young People Integrated Care

Right support. Brighter futures. Healthier together.



1. Integrated Care Teams in Every Locality

To have a “CYP Integrated Care Team” in every locality across BSol by end March 2027.



2. Reduce Secondary Care Outpatient Appointments

To reduce the number of secondary care outpatient appointments.



3. Include Mental Health

To include mental health in the models.



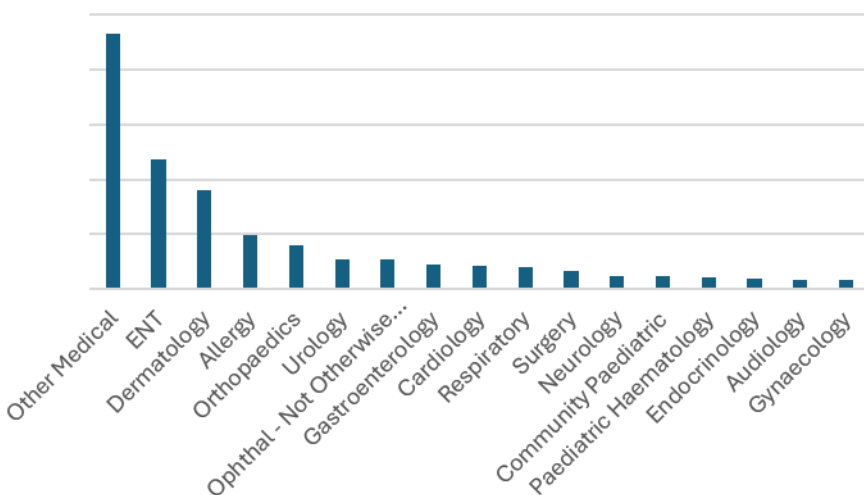
4. Demonstrate Impact on School Attendance

To demonstrate an impact on school attendance.

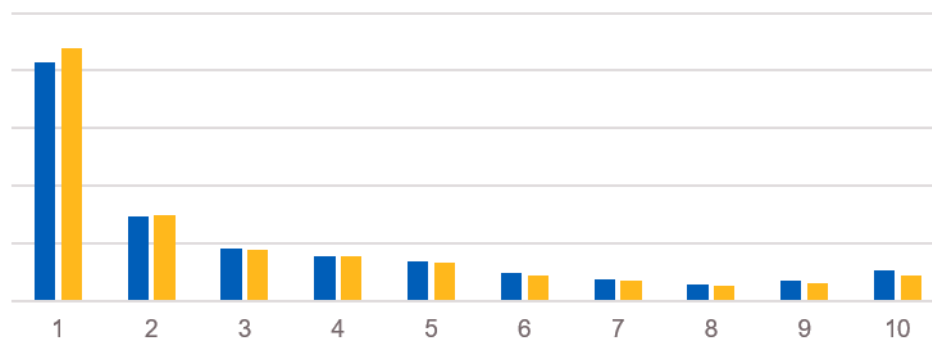
Focus on referrals

- Primary care to secondary care referrals
- BSol Resident referrals <18 years old
- April 2023 to July 2025

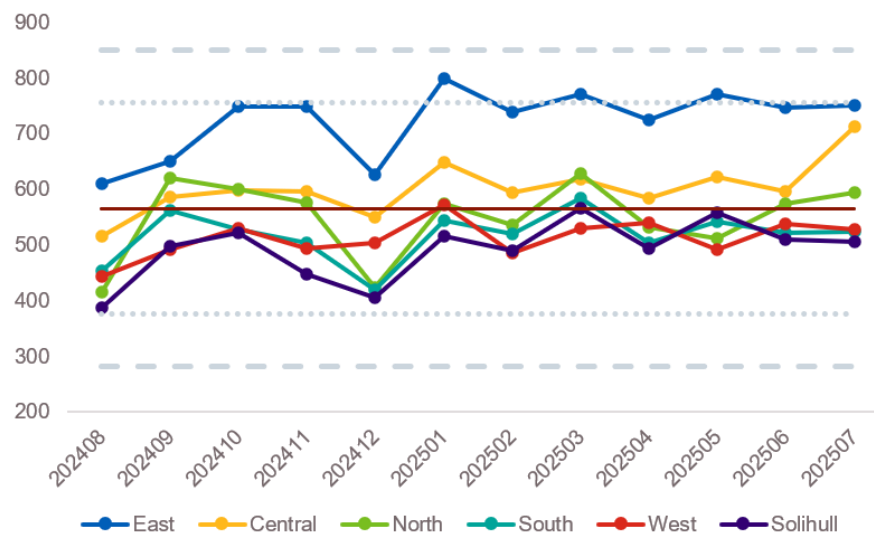
Referrals by Specialty



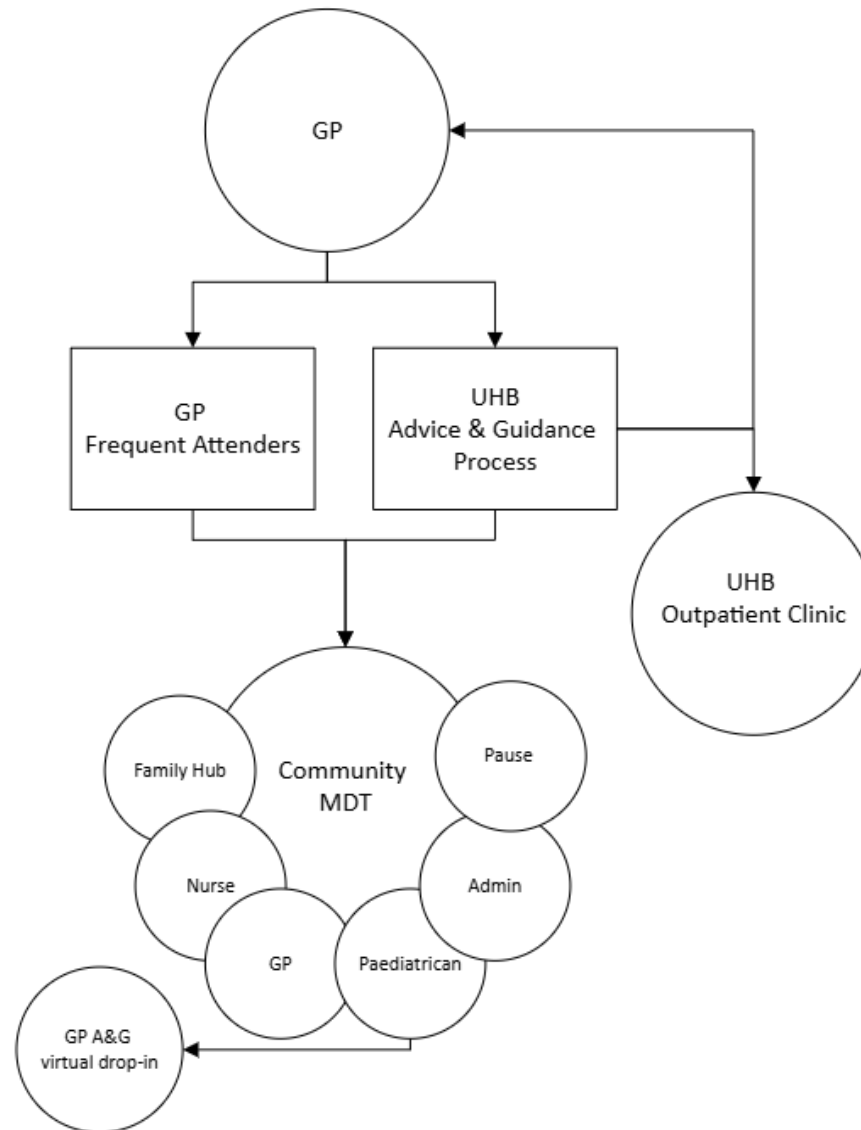
Referrals by IMD



Referrals by Locality



East Locality Model



East Locality Update

April- August 2026



**Birmingham Women's
and Children's**
NHS Foundation Trust

139

Appointments
Scheduled

23

Was
Not Brought

116

Outpatient
Appointment
moved from
hospital to
community

108

CYP Discharged
from OPWL

60

Families
Referred onto
FH Duty Worker

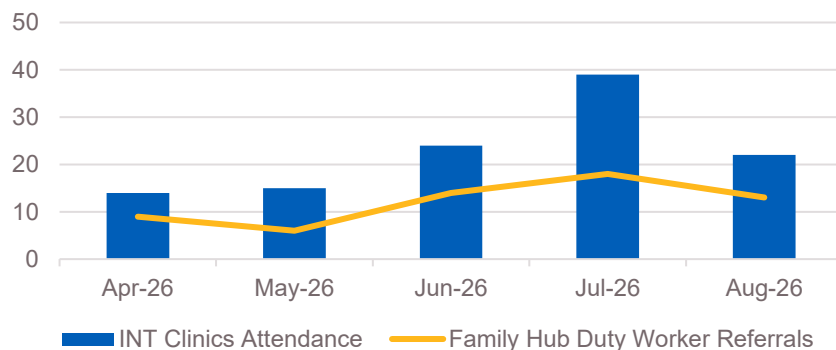
16.5% was not brought

93% discharge rate needing no further secondary care follow up

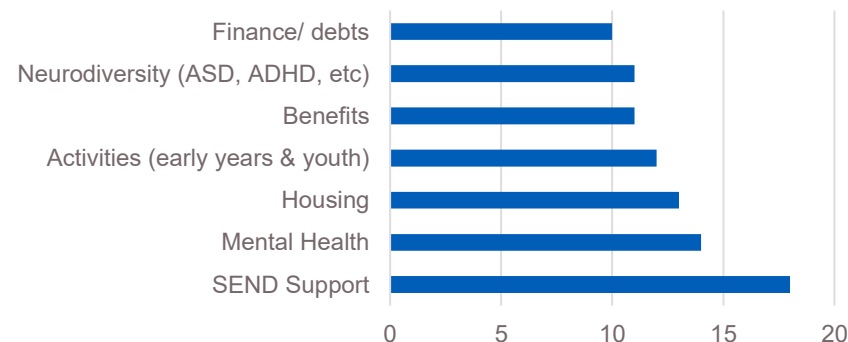
Clinic continues to see **8 CYP a week**, with CYP seeing Nurse, GP & Paediatrician with

52% of families consenting to support from Family Hub.

East INT Attendance & Duty Worker
Referrals



Support Provided by FH Duty Worker
Apr to Aug 2026



Case Study

A Whole-Family Approach to Support Frequent Healthcare Users



**Birmingham Women's
and Children's**
NHS Foundation Trust

Challenge

- Child attended GP >30 times in 18 months
- Family made >60 GP contacts
- Repeated investigations failed to reassure family
- Frequent ED attendance

Intervention

MDT involving:

- Parents & 3 children
- Consultant Paediatrician
- GP
- Referred onto Family Support Worker

Focus shifted from symptoms to whole-family needs.

Impact & Learning

Shared understanding that constipation likely explained symptoms

Identified neurodiversity, sleep and support needs

Improved confidence in management plan

Better coordination across services

Potential reduction in unnecessary healthcare use

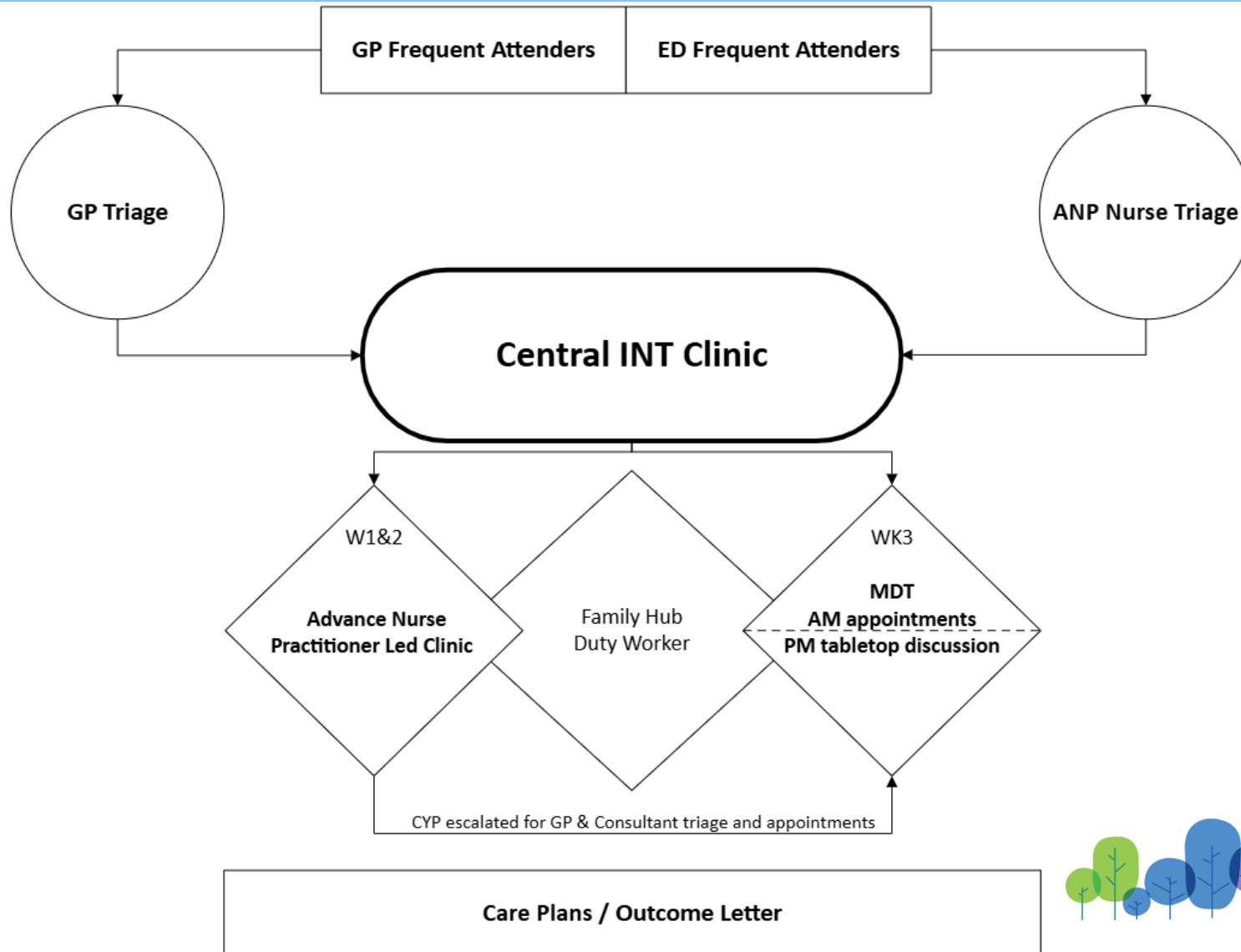
Family feedback:

"Where have you been hiding this clinic? It's been amazing."

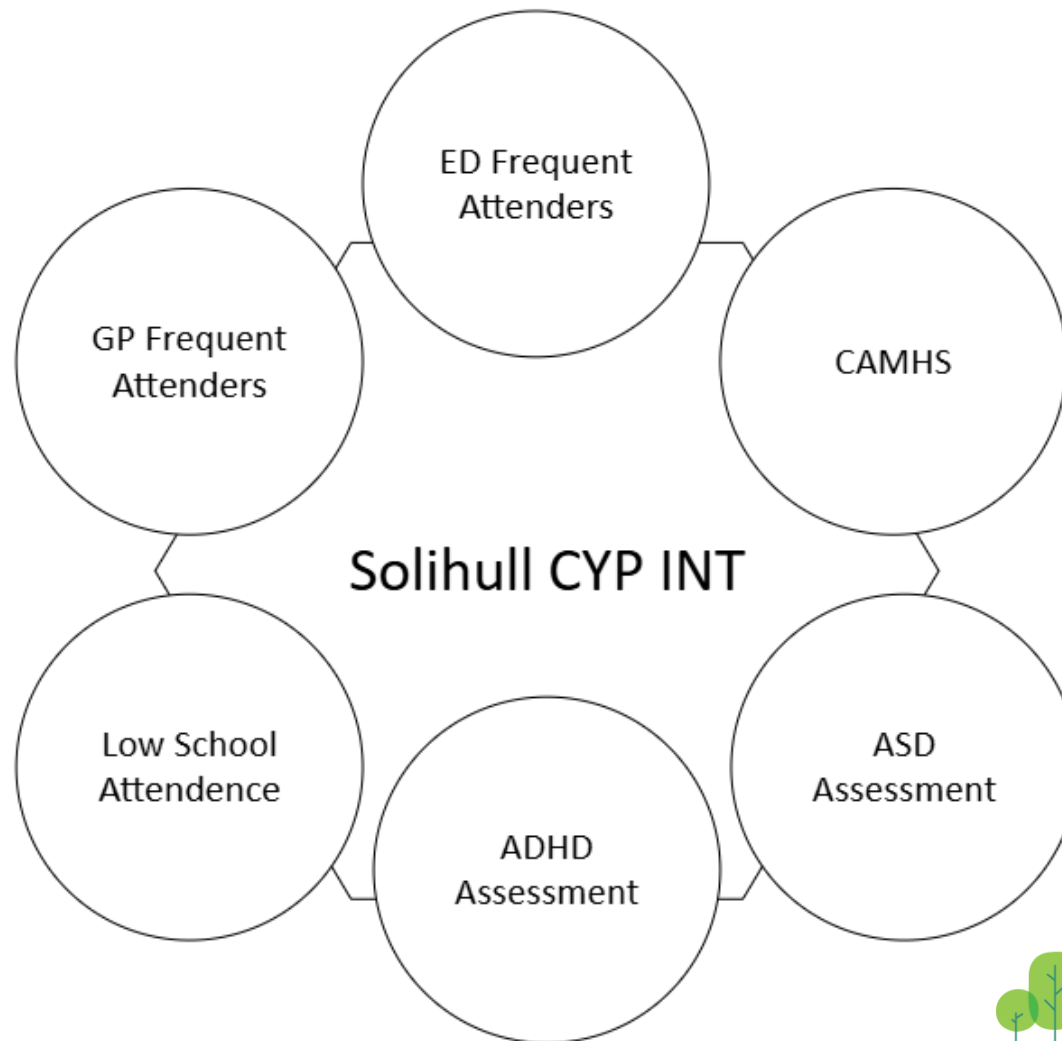
Key Message: A coordinated whole-family approach addresses underlying drivers of high healthcare utilisation and improves patient experience.



Central Model



Solihull Model



Direct Impact

- Secondary Care Outpatient Consultations
- Follow up GP appointments
- School attendance

Patient Family Focussed Outputs

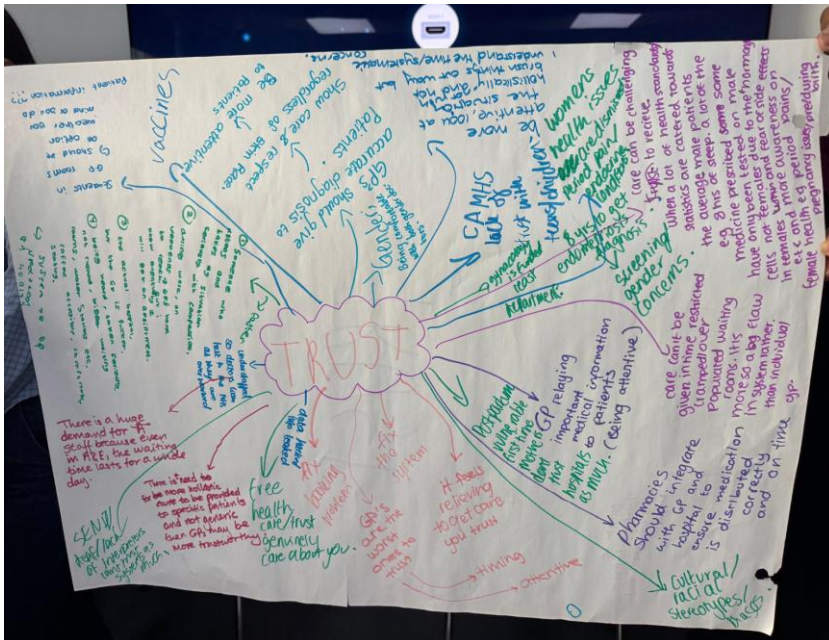
- WNBs
- Patient Reported Outcome Measurements (PROMs) and feedback

Wider Impact

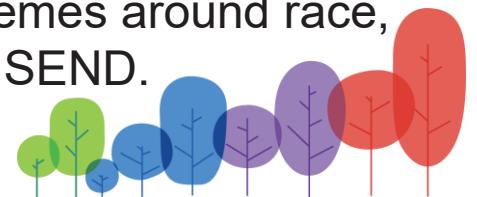
- Reduced ED attendances
- Reduced GP attendances
- Increased school readiness
- Addressing wider determinants of health

Engagement sessions in schools and youth settings across Birmingham, using age-appropriate, interactive activities that encourage participation and honest reflection.

350+ CYP, (age 12 to 19) engaged since January 2026, across school and community settings. Emerging themes include:



- CYP value the NHS
- Frustrated by long waiting times and staff shortages.
- Experiences of feeling dismissed or not listened to.
- Clear desire for more youth voice in shaping services, and opportunity to take an active role in community health improvement.
- Highlighted equity themes around race, gender, religion, and SEND.



Risk Stratification & Frequent Attenders Model

Using data and insight to proactively identify and support CYP most at risk



Academic partnership

Working with MLCSU and Imperial College.



Developing risk stratification model

Using CPRD (GP Research database) to develop a model for CYP.



Model looking for risk factors for CYP high risk of:

- Repeat ED attendances
- Repeat GP consultations
- Emergency admissions without being known to a specialty



Generate risk algorithm at GP practice

Produces a list of high risk CYP for the outcomes above.



Proactive engagement and prevention

Public Health Nurse embedded in BCHC to engage and prevent escalation (Summer 2026).



Review of HISU at Sandwell, BCH & HH

Reviewing existing HISU models across Sandwell, Birmingham Community Healthcare (BCH) and Heartlands Hospitals (HH) to inform alignment and optimisation.

Challenges

No shared platform for all members of the MDT to see clinical information

All patient oversight is currently in secondary care system

Information governance barriers

No uniform clinic booking system

No easy clinical triage system across all sites

Triangulation of datasets between primary & secondary care and education

Tracking progress of CYP is not automated

Barriers to community prescriptions



Next steps



Ongoing implementation & monitoring



Linking in more services/VCSE



Focus on community paediatrics and other specialties



Scaling up –changing the way we provide care as a system



Evaluation-comparing models



Finding sustainable funding models



Thank you



**Birmingham Women's
and Children's**
NHS Foundation Trust

Hayley Durnall - Deputy Chief Strategy Officer and
Public Health Consultant

Hayley.Durnall3@nhs.net

Simarjeet Kaur - CYP INT Programme Manager

Simarjeet.Kaur6@nhs.net

