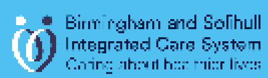
Birmingham and Solihull
Integrated Care System
Caring about healthier lives

What Pharmacy Needs to Know About Integrated Neighbourhood Teams (INTs)

Wednesday 4th March 2026



Session information

- This session will be recorded and shared along with a copy of the slides.
- Certificate of attendance (available on request) if you have joined the webinar but have not registered and would like a certificate, add your email address to the chat.

- We will have a Q&A session at the **end of the presentation**:
  - But please feel free to add questions to the chat as we go along,
  - or put your hand up to ask your question, camera on or off whatever you prefer.

- **Please complete the survey** at the end of the webinar, we welcome and value your feedback to improve future educational sessions we deliver.

Content

5 mins	Welcome and Introductions	**Dr Jeff Aston (Chair)** Chair of the BSol Pharmacy Faculty, Associate Chief Pharmacist: Clinical Services, University Hospitals Birmingham
15 mins	An overview of the introduction and development of Integrated Neighbourhood teams and locality hubs. • What has been delivered so far in BSol, local priorities and next steps.	**Chris Holt**, Chief Transformation Officer, BCHC
20 mins	Primary Care: • How the Bordesley East PCN INT works in practice • Real life case study examples	**Dr Nahmana Khan**, GP Iridium Medical Practice & GP lead for Bordesley East INT **Sadia Safdar,** Lead Training Pharmacist, Iridium Medical Practice, INT Pharmacist
10 mins	How could Community Pharmacy support INTs? Current reality and future possibilities	**Shalia Anwar** BSol ICS Community Pharmacy Clinical Lead
10 mins	Q&A	**ALL speakers and Hamzah Aslam Community Partnership worker** *Occupational Therapy, INTs (East and West District),Adult Social Care and Health Directorate*, *Birmingham City Council*

Introduction

- The Community Care Collaborative is our **system-wide partnership** of Primary Care, community health services, community mental health services, social care and the voluntary and community sector.
- The Collaborative aims to **deliver integrated care in neighbourhoods and localities** to support people to live well in their own homes.
- The Collaborative has worked with partners to **develop integrated neighbourhood teams** and locality hubs.
- At present the model **concentrates on services for adults**. As it develops, it will extend to integrated care for **children and young people**
- **Locality partnerships** will be central to the roll out of the model of care.
- Our **model of care will continue to evolve** as we learn and we expect it to develop further in the light of experience.

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Community Care Collaborative
Right care, right time, right place
for the people of Birmingham and Solihull

Introduction into INT National perspective

- **Integrated Neighbourhood Teams** continue to be one of the most talked-about developments for all systems
- National Planning Guidance recently issued along with **specific Neighbourhood Health guidelines** – with “Neighbourhood multidisciplinary teams” being a key component (e.g. INT’s)
- **Birmingham & Solihull informed the guidance**, and continues to attract national attention in development of the NHS 10yr Plan and Medium Term plans
- Our system faces significant financial pressures – with INT’s being one of the few areas where **investment is being prioritised**

NHSE Neighbourhood Health Service Guidance

NHS and social care working together to prevent people spending unnecessary time in hospital or care homes

Strengthening primary and community based care to enable more people to be supported closer to home or work

Connecting people accessing health and care to wider public services and third sector support, including social care, public health and other local government services

The National Guidance sets out **6 core components** of a Neighbourhood Health Service:

1. Population health management
2. Modern general practice
3. Standardising community services
4. **Neighbourhood multidisciplinary teams (MDTs)**
5. Integrated intermediate care with Home First approach
6. Urgent neighbourhood services

Systems are asked to:

- Standardise the 6 core components of existing practice to achieve greater consistency of approach
- Bring together the different components into an integrated service offer
- Scale up to enable widespread adoption of neighbourhood services
- Evaluate the impact of these actions, ways of working and enablers

Neighbourhood Health: Our Working Definition

Neighourhood health is a way of working that brings together services, professionals and communities to support people's health, wellbeing and independence in the places they live and in ways that make sense to them.

Its purpose is to help people live well at home as part of their communities, with timely, coordinated support that promotes independence, prevents avoidable illness, supports recovery and tackles the wider factors that shape health.

Neighbourhood health is not a single model. It adapts to the needs, assets and priorities of local communities particularly those experiencing the greatest disadvantage. It is underpinned by shared principles:

- taking a whole-person, whole-life approach;
- providing care that is preventative co-ordinated and personalised;
- focusing on early intervention, rehabilitation and recovery;
- bringing together multidisciplinary teams to support individuals and families;
- based in the communities in which people live, bringing teams together to work with people in neighbourhoods and places.

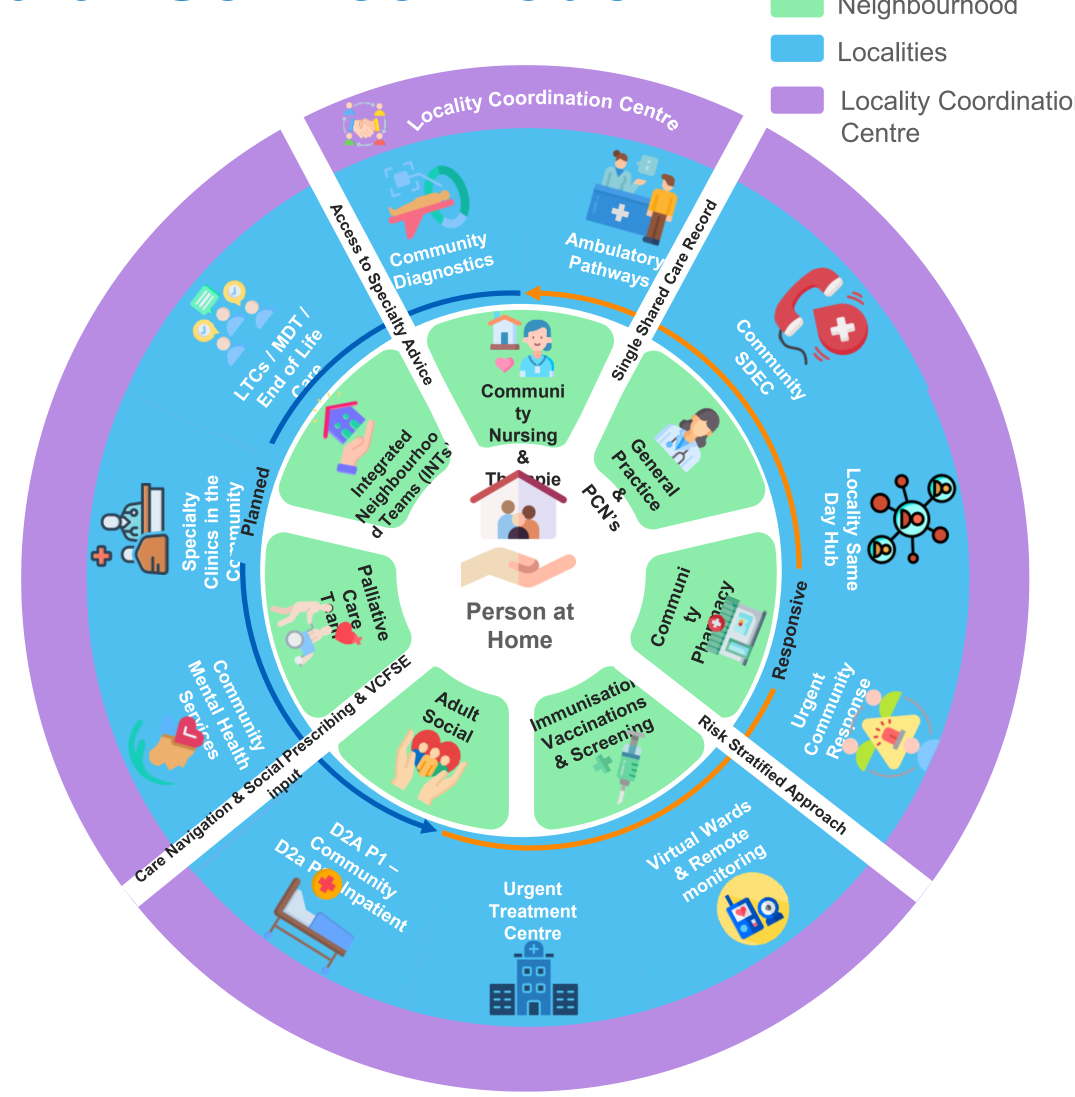
Places, Localities and Neighbourhoods – our footprints

- **One system** (c. 1.4m people).
- **Two places** based on the local authorities (Birmingham & Solihull), each led by a Place Committee.
- **Six localities**: with locality partnerships (c. 300k people).
- **35 neighbourhoods** (c. 30 – 50k people) broadly aligned to PCNs. c. 5 – 6 neighbourhoods in each of the five Birmingham localities and in Solihull.

Our Locality and Neighbourhood Health Service Model

Our approach seeks to:

- Keep people **healthy and independent at home**;
- Focus on the **whole person**: early intervention & prevention
- Provide **co-ordinated care** for people with long-term conditions
- Foster partnerships with **voluntary & community sector**
- Integrate: via **co-located teams**
- Be **digitally enabled**: e.g. single *shared care records*
- Be **data-driven**

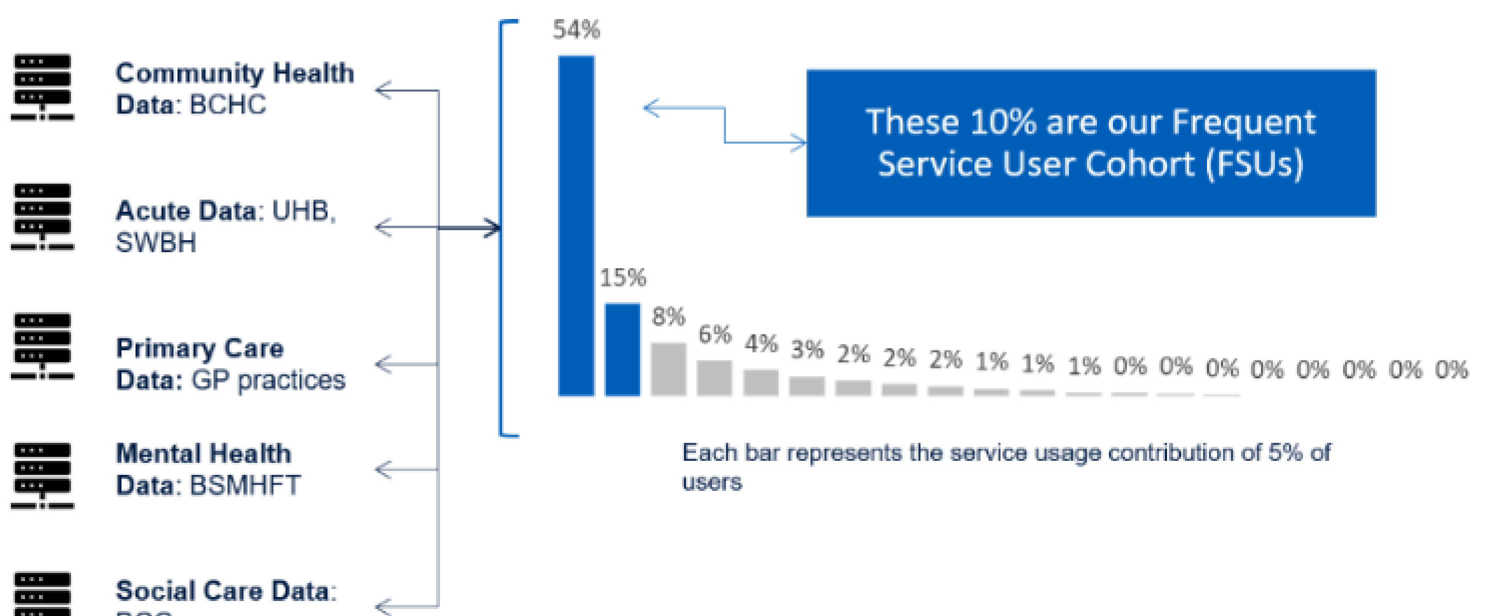


Initial analysis identified the specific cohorts for INTs to focus on

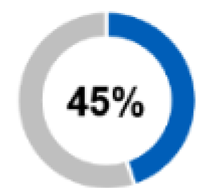
We connected 3 years of Cross-System Data

This told us 10% of people make up 69% of demand on services

We found that 45% had prevention potential



Suitable for INT



45% of people of the cohort could have had their **service usage prevented** through the type of support our INTs can coordinate

*Hospital attendances & admissions, Outpatients appointments, GP appointments, Social care packages

Deep-dives identified the specific interventions needed

Proposed Focus Areas for Intervention Deep Dives

3 of the top 10 interventions would likely be accessed via Social Prescribers, a key intervention referral route for INTs.

Social Prescribing

3 of the top 10 interventions are existing service offerings, which should offer measurable impact.

Medicines Review, Community MH Support, Care Package Reviews

The remaining 4 interventions are either relevant only to a specific sub-cohort, or would only likely achieve impact over a longer period, so will be recommended to INTs but not prioritised for deep dives.

Diabetes Support, Drugs & Alcohol, Long Term Conditions Counselling

Design informed INT development…with dedicated roles

A structured, 'dedicated' team…

INT Co-ordinator: a skilled admin who ensures the appropriate information gathering and smooth running of the INT

Neighbourhood expert: a social prescriber who supports the whole team in building knowledge of available interventions

GP: a named GP for the PCN, who attends both weekly meetings and has delegated responsibility for any clinical decision-making by the INT

Four key workers (OT, social worker, community and mental health staff member): contribute professional perspective about cases, act as key point of contact for specific residents supported by the INT.

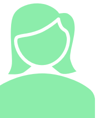
…delivering results in the first year

	Pre-INT	Post-INT	Var (#)	Var (%)
GP Attends	2,623	1,782	-841	-32%
ED Attends	428	362	-66	-15%
Inpatient Spells	90	67	-23	-26%
O/P Spells	1,171	878	-293	-25%
Community Contacts	2,417	2,056	-361	-15%
Mental Health	230	327	+97	+42%

How It Feels – Citizen and Staff Experience

- **Staff Unity and Satisfaction:** Frontline staff report increased job satisfaction and a strong sense of unity working collaboratively within the Locality and INT model.
- **Holistic Citizen Support:** Citizen's report receiving holistic care guided by trusted relationships and 'what matters to you' conversations
- **Addressing Social Determinants:** The locality approach focuses on social determinants of health like housing and mental wellbeing alongside clinical interventions.

"I can access staff and services when I need support."



Kate is 37 years old and has high levels of A&E attendances for a variety of different presentations.

"Joined up services help me get well and stay well."

Margaret is a 91-year-old lady who frequently accessed GP and Acute Hospital services.

"I only have to tell my story once."

Lucy is 41 years old and has accessed Mental Health and A&E services for their diagnosed personality disorders.

Current position & next steps

- 12 teams now 'live' and we remain on track to have 16 by end of March'26.
- A proposal for 2026 roll-out is being agreed with Locality Partnerships
- The plan is to have all 35 INTs live by March 2027.
- We are undertaking a mini evaluation to understand early establishment and impact.
- We need to expand the role within INTs – with a priority on pharmacists

'Putting Place and Neighbourhood approaches at the heart of integrated care'

Dr Nahmana Khan

GP Lead

East Birmingham Integrated Neighbourhood Team (INT)

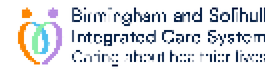
What Pharmacy Needs to Know About INTs

Important Facts

- ❑10% of residents drive 71% of demand across health & social care services.
- ❑Many of these are those ‘revolving door patients’ going in and out of A&E and other services with no management plan put in place
- ❑These individuals often experience a lack of continuity in care, with services assuming that another agency is addressing their needs — resulting in those needs remaining unmet..

AIMS OF INT

- INT bring together multiple health professionals to support people with complex needs to reduce hospital admissions, inappropriate service use and improve well-being.
- This is done in a holistic way so improving well-being in multiple aspects of their lives
- Needs could be social, mental, physical or financial – INT aims to address these all..

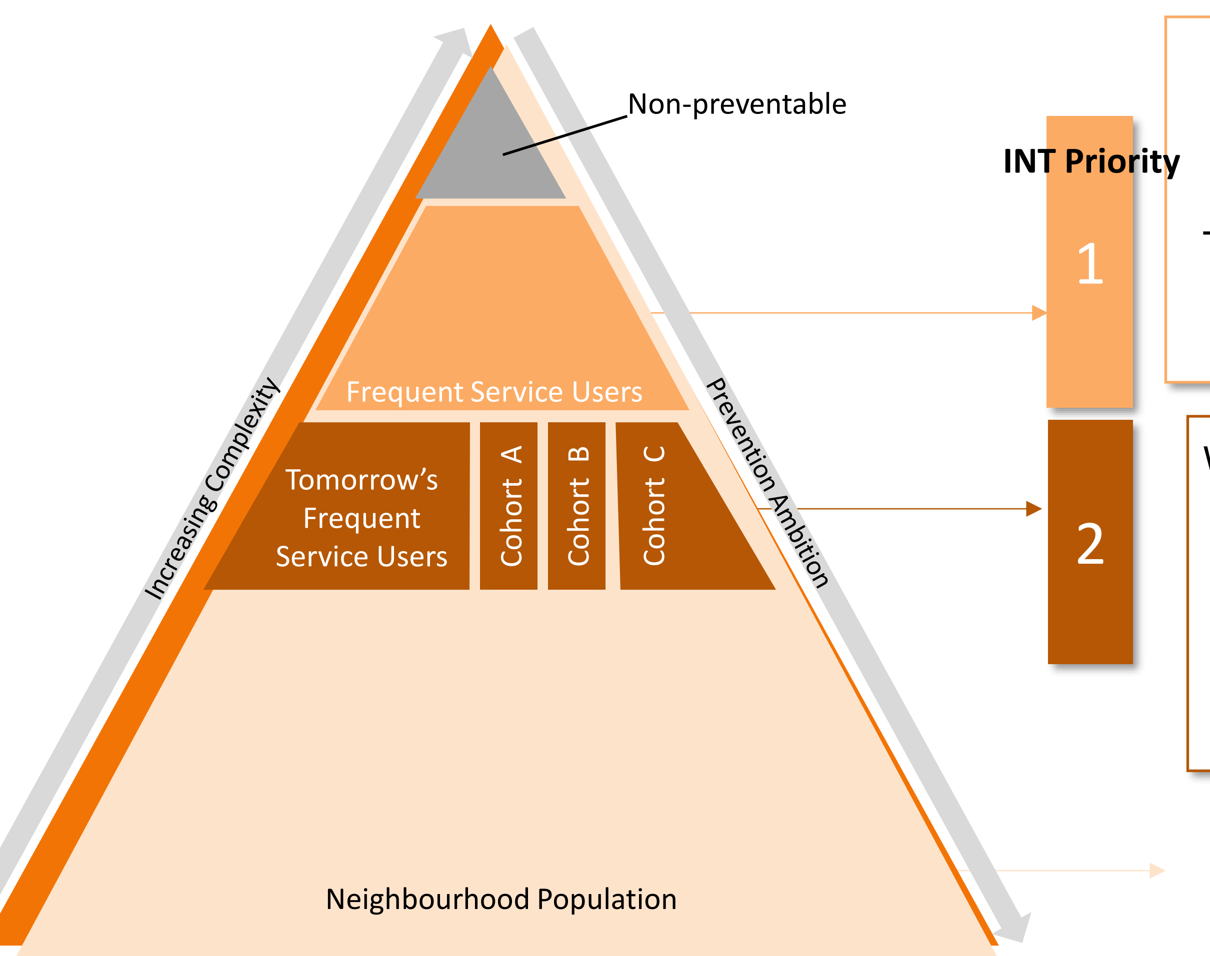


The INT Team… meets on a weekly basis

- ❑Social Worker
- ❑Occupational Therapist
- ❑GP
- ❑Mental Health Worker
- ❑Social Prescriber
- ❑Complex social prescriber
- ❑Community Nurse
- ❑Pharmacist
- ❑INT co-ordinator

Why is neighbourhood working the way forward?

- INT MDT professionals serve their local community & know their population the best..
- Each Birmingham locality has different demographics and so different needs
- East- Cohort that utilises GP services the most are younger women (single mums) & 40 year old + women.
- West - Cohort that utilises GP services the most are those with drug & alcohol abuse.
- Local services need to reflect the needs of the local population..



INT Priority

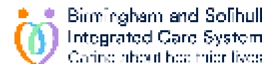
1

Start by preventing escalating need and avoiding inappropriate, persistent, frequent service users of a wide range of our services across primary, secondary and social care.

These are people **the system is failing today**, who will benefit from **holistic support**, and will **relieve system capacity in the short to medium term**

2

With system capacity relieved, our INTs will become the **delivery arm of population health management**. Using data and analytics to predict tomorrow's FSUs at a neighbourhood level, and to identify cohorts of need, for preventative support **before they reach crisis point.**
The benefits of this support will take **longer to materialise but will be larger**



How does it work?

Frontline practitioners have designed our INT operating model

Cohort long-listing

FSU long list identified by analysts using service usage data

Data based triage

Simple rules used to triage out deceased, out of area or underage FSUs by analysts

Early information gathering

'INT Coordinator' to collect simple service use data on an FSU and prepare a 1-2 minute summary

Initial triage meeting 'INT Coordinator' presents summary to the INT members, who make a streaming decision

Urgent action needed if citizen cannot wait for process completion, action agreed

Priority for INT Discussion

Key INT worker assigned, investigation areas agreed

Not suitable for INT if citizen could not benefit sufficiently from INT support / discussion

Holistic Conversation & Investigation

INT key worker investigates priority areas through discussion with the citizen, and (as needed) known professionals

MDT Discussion

INT discuss the person's case, now with expanded information, agree suggested intervention(s) and next steps (continue, cease, pause)

Intervention Conversation

INT key worker shares recommendation with citizen, they agree next steps / priorities together

Warm Handover

INT key worker supports citizen to access preferred intervention(s), engaging with intervention team

Follow up Conversation

INT key worker follows up with citizen to support access and continued empowerment

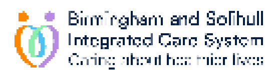
Decision to Cease Support if further INT intervention needed / possible, outcomes of support captured

Decision to Pause Support due to citizen circumstances or availability of right interventions

NEWTON

What does the INT team think?

- Each member of the team feels upskilled through shared learning in team discussions, learning we can take back to our own practice and benefit others
- Feel supported and more empowered to help a citizen confidently with the backing of a team
- Finally feel care is more joined up !!



How are we developing?

- ❑Increasing routes of referral-
- ❑Work Well
- ❑Social Care Champions
- ❑PCN Live referrals
- ❑Referral via A&E Hub- to direct a FSU that INT can help to ‘keep out of A&E’ with the support of an MDT

BULLRING
Integrated Neighbourhood Teams
Birmingham and Solihull
Together, we can support people to live healthier, happier and more independent lives, in the neighbourhood and communities they call home.
STRICTLY PRIVATE AND CONFIDENTIAL
25

PHARMACY & INT COLLABORATION

Conducting Structured Medication Reviews

Following Referrals from Integrated Neighbourhood Teams (INTs)

Sadia Safdar | Lead Training Pharmacist, Iridium Medical Practice | Birmingham & Solihull INT

What is a Structured Medication Review (SMR)?

"An evidence-based and comprehensive review of a patient's medication, taking into consideration all aspects of their health — a shared decision-making conversation led by the patient's individual needs, preferences and circumstances."

Patient-Centred

Both clinician and patient bring their own agenda. When referred via INT, the clinical agenda is pre-identified — focusing the review efficiently.

Evidence-Based

Reviews draw on current clinical guidelines, patient history, secondary care letters and known comorbidities to optimise regimens.

Action-Oriented

Every review ends with an agreed plan — communicated back to the INT for coordinated follow-up across the MDT.

How SMRs Support INT-Referred Patients

1. Optimising Chronic Disease Management
2. Assessing Safe Medication Management
3. Breaking Down Language & Cultural Barriers

Mutual Benefits: Pharmacist & INT

Pharmacist gains from INT work

- Develops holistic, person-centred consultation skills beyond medicines
- Gains visibility of wider social determinants of health affecting patients
- Access to INT's community network — voluntary organisations, social services, housing
- Builds confidence in complex, multimorbid patients
- Strengthened relationships with GP leads, nurses and social workers

INT gains from pharmacist

- Dedicated medicines expert within the MDT — reducing GP burden
- Medicines safety reviewed for highest-risk patients as a priority
- Compliance barriers identified and resolved proactively
- Community pharmacy connections leveraged for patient benefit
- Seamless feedback loop: SMR outcomes inform INT care plans

Work in Progress: Reaching Diverse Communities

Maximising Pharmacy First through culturally appropriate health education

The Challenge

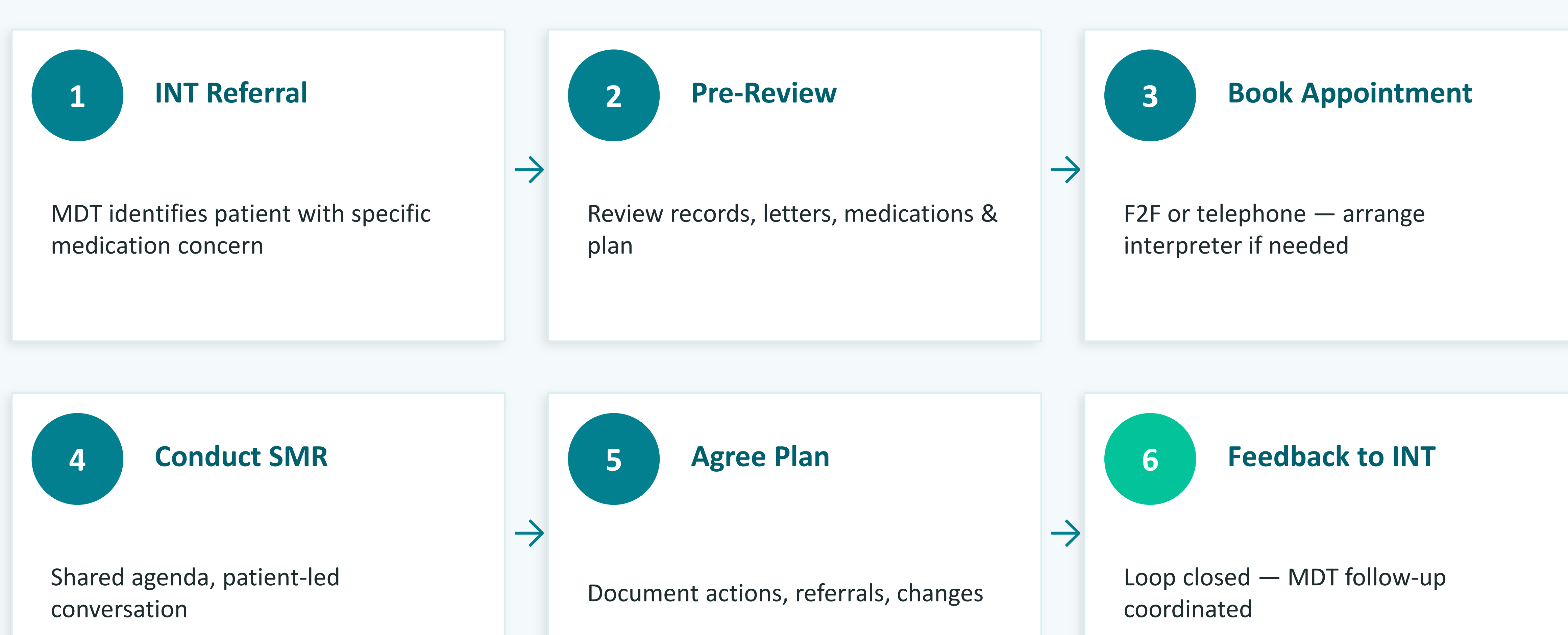
- Many patients from diverse backgrounds are unfamiliar with how the NHS is structured.
- In multiple countries of origin, hospitals are the primary — often only — point of treatment.
- This leads to A&E attendance for minor ailments that could be treated in primary care or pharmacy.
- Language and cultural barriers further reduce uptake of Pharmacy First services.

Our Approach

- Developing multilingual resources explaining how the NHS works and what each service offers.
- Educating communities on appropriate minor ailment management in their own language.
- Partnering with community pharmacies to be the first point of contact for these patients.
- INT-pharmacy collaboration to identify and support patients who repeatedly miss the right pathway.

🤝 *Community pharmacies are key partners — barriers must be overcome together before Pharmacy First can reach its full potential in our population.*

The SMR Process: From INT Referral to Outcome



Multiple SMR sessions may be required — patient need always guides the pace and depth of the review

Case Study — Falls, Fractures & Bone Protection

75F | FSU – OPD Flag

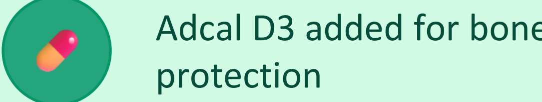
Background

- Referred to INT as FSU with OPD flag
- T&O follow-ups for recurrent fractures:
  - Left distal radius — May 2022
  - Right radius — April 2024
- Both caused by falls

Future Risks

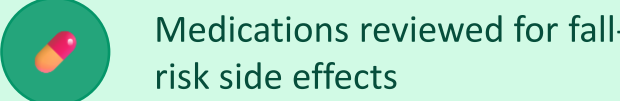
- Further falls and fracture
- Further functional limitation and loss of independence
- Negative impact on mood
- Could end up in care

Pharmacist Outcome


Adcal D3 added for bone protection

Analgesia reviewed and optimised

Referred for DEXA scan to assess bone density


Medications reviewed for fall-risk side effects

What Was Missed

- No exploration of cause of falls
- No assessment of impact on ADLs
- No discussion of prevention

What INT Did

- OT asked to review — assess adaptations
- INT Pharmacist asked to review:
  - Analgesia
  - Medications that could cause falls
  - Bone protection

Key Learning: Recurrent falls in an older patient are never just an orthopaedic issue — the pharmacist's lens on bone protection, analgesics and fall-risk medicines is essential to the MDT response.

Case Study — Mental Health, Compliance & Community Pharmacy Partnership

46F | NHS 111 FSU

Background

- Asthma, Migraine, Bipolar, Paranoid PD, EUPD, Chronic Anxiety, Benign Intracranial Hypertension
- NHS 111 frequent caller & FSU A&E for MH crisis
- Known to CMHT at Small Heath Health Centre
- 3 children; lives with ex-husband; limited contact causes distress
- Brother died in 2016 post-MH discharge — awaiting trauma-based therapy
- INT noted 111 calls were for emergency medication supplies

⚠️ Concerns

- Poor compliance → increased MH crises
- Increased self-harm risk
- Hopelessness and deteriorating mental health

What INT Did

- Referred to INT Pharmacist to explore barriers to medication ordering
- Referred to Social Prescriber for healthy distraction and wellbeing support

What Pharmacist Did

- Thorough assessment revealed patient struggles to call GP — anxiety about explaining herself
- Poor mental health impacts memory — forgets to order medications
- Options explored:
  - Weekly automatic ordering — requires community pharmacy to alert practice if uncollected
  - Priority prescription line access as vulnerable adult ← chosen
- Priority line also provides a regular contact point for crises — direct pathway to Duty GP

💡 *Key Learning: Community pharmacies can play a vital role — proactively alerting the practice when vulnerable patients are not collecting their medications is a simple but potentially life-changing intervention.*

Case Study — Restless Leg Syndrome, Alcohol & Concealed Upper GI Bleed

60M | FSU – GP Flag

Background

- Poor sleep — Restless Leg Syndrome
- Anxiety, Depression, Psychotic Disorder
- Alcohol abuse (140 units/week)
- Barrett's oesophagus
- IHD — MI 2019
- On Aspirin, Escitalopram, Aripiprazole; PPI not controlling symptoms
- INT discussion: alcohol + antipsychotics as possible RLS cause; iron deficiency from upper GI bleed also considered

What INT Did

- Referred to INT Pharmacist to investigate RLS cause and provide patient education

Pharmacist Findings

- Multiple risk factors for upper GI bleed: Aspirin + Escitalopram + inadequate PPI
- Patient disclosed haematemesis the previous week
- Reported 140 units of alcohol per week; educated on contribution to RLS

Outcome

- Reported back to GP — bloods and gastroscopy requested
- GP reinforced alcohol dangers and referred to CGL
- Gastroscopy: significant extension of Barrett's oesophagus found
- Inpatient admission at Park House — now alcohol free
- Alcohol likely the cause of RLS — Ropinirole prescribed but never needed

Key Learning: The pharmacist's review uncovered a life-threatening and undisclosed upper GI bleed. This is exactly the kind of risk that falls through the gaps without a structured, holistic medicines review.

Key Takeaways

- 🔗 INT referrals give pharmacists targeted, high-value SMR opportunities
- 💊 SMRs optimise chronic disease management and identify hidden compliance barriers
- 🛡️ Medicines safety — anticoagulants, GTN, analgesia — assessed and secured
- 🗣️ F2F + interpreter appointments transform engagement with diverse populations
- 📈 The pharmacist-INT relationship is mutually upskilling and community-connecting
- 🌍 Work in progress: multilingual education & Pharmacy First adoption

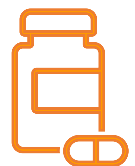
Thank you | Questions welcome | Sadia Safdar — Iridium Medical Practice

NHS Community Pharmacy Services

Shalina Anwar
ICS Community Pharmacy Clinical Lead
Birmingham and Solihull ICB

Community Pharmacy- an introduction

303 NHS community pharmacies in BSol situated in the heart of communities



- uniquely positioned through their accessibility, clinical expertise and trusted relationships with local populations
- frequently serve as the first point of contact for individuals
- play a pivotal role in reducing health inequalities across BSol
- convenient locations, extended opening hours, including evenings and weekends, and strong presence in areas of high deprivation make them highly accessible
- well utilised, and less formal healthcare environments, offering vital support for individuals who may struggle to access, or choose not to engage with other health services

…making the community pharmacy network an invaluable asset within the local health system.

Community pharmacies offer a critical frontline solution

Leveraging Community Pharmacy to deliver Neighbourhood Health Services

Key Outcomes

- ✓ Reduction in non-urgent GP and A&E attendances
- ✓ Improved vaccination uptake
- ✓ Better management of respiratory conditions
- ✓ Increased patient satisfaction and access to care and preventative care
- ✓ Reduction in readmission rates
- ✓ Support system resilience through integrated pharmacy services

BSol Community pharmacies deliver vital, accessible care that eases pressure on GPs and hospitals. Formal integration of existing national pharmacy services into the Neighbourhood Health Service and stronger collaboration with system partners will standardise delivery, expand clinical pathways, and enhance local services, supporting consistent care and advancing system-wide health outcomes

The 2025/26 Community Pharmacy Contractual Framework and pilot initiatives such as the Community Pharmacy IP Pathfinder Programme and the RSV and Pertussis Vaccination Pilot will enhance care across BSol. Tailored to population needs, these services can be embedded into the Neighbourhood Health Service, aligning with system priorities and supporting delivery of key health outcomes

The 10 Year Health Plan redefines community pharmacy as a core component of the Neighbourhood Health Service, expanding its clinical remit to improve access, efficiency, and sustainability. Key policy shifts include independent prescribing, chronic disease management, enhanced prevention, and targeted women's health services, including HPV vaccinations. NHS App integration and Single Patient Record Access will link pharmacies securely to NHS digital systems

Opportunities

- **Include Community Pharmacy in Collaborative Leadership**
  Recognise pharmacies as vital assets in meeting neighbourhood health needs, now and in the future.
- **Integrate National Community Pharmacy Services at No Extra Cost**
  Embed funded services such as the *New Medicine Service* into Neighbourhood Health Services through collaboration, ensuring seamless delivery without an added system cost burden.
- **Increase Utilisation of Key Community Pharmacy Services to Boost Primary Care Access**
  Deploy *Pharmacy First* and the *Pharmacy Contraception Service* to enhance capacity and service effectiveness.
- **Support mobilisation of the *Discharge Medicines Service* to Improve Post-Discharge Care**
  Enable utilisation of *DMS* to enhance continuity of care, reduce readmissions, and align with GIRFT and Red Tape Challenge improvements across care interfaces.
- **Broaden Hypertension Case Finding**
  Promote universal uptake of the *NHS Community Pharmacy Hypertension Case Finding Service* to support early detection and management of heart disease.
- **Increase Utilisation of Vaccination Services via Community Pharmacies**
  Use pharmacy-based services to increase uptake and protect vulnerable populations.
- **Consider the Potential in Community Pharmacy When Making Future Strategic Decisions**
  Factor community pharmacy capabilities into strategic commissioning decisions to meet population health needs such as supporting women's health, men's health, children and young people, planned care, diagnostics, and long-term condition management.

Thank you for listening – any questions?

Thank you to all our speakers, Q&A panel and BSol Training Hub (Stanley Agwuh)

What Pharmacy Needs to Know About Integrated Neighbourhood Teams (INTs) – Fill in form