Coventry Neighbourhood Health Programme

"A National Neighbourhood Health Implementation Programme (NNHIP) early adopter site"

1st April 2026

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Coventry Neighbourhood Health

Content:

1. NHS 10 Year Plan, NHSE National Neighbourhood Guidance and Neighbourhood Health Partnership Framework
2. Background to the National Neighbourhood Health Improvement Programme (NNHIP)
3. The issues we aim to address through this programme – a Population Health Management Approach
4. Our emerging Neighbourhood Health model
5. Implementation progress to date
6. Measuring progress
7. Next steps

Purpose:

1. To provide the Health and Social Care Scrutiny Board with an update on Coventry's National Neighbourhood Implementation Programme

2. To summarise the population health diagnostic, the neighbourhood and Integrated Neighbourhood Team (INT) and Coventry Coordination Hub (CCH) design.

3. To update on progress to date (including Wave One delivery)

3. To outline the key milestones and decisions expected through 2026–2027

Coventry Neighbourhood Health

1. Background

Working together to create healthier neighbourhoods

National Guidance

- **NHS 10-Year Health Plan:** Neighbourhood Health is a central pillar of the government's NHS 10-year plan and NHS England's 2025/26 guidance. It supports the Governments **three shifts**; from hospital to community, from sickness to prevention, and from analogue to digital. It responds to rising multimorbidity, fragmented care, and the need to deliver *more care at or closer to home.*

- Detailed **Neighbourhood Health Guidance from NHSE** is expected to be published in early January 2026, this will detail **6 priority steps** that ICBs need to take before April 2026, working with providers and other partners to lay the foundations for neighbourhood health.

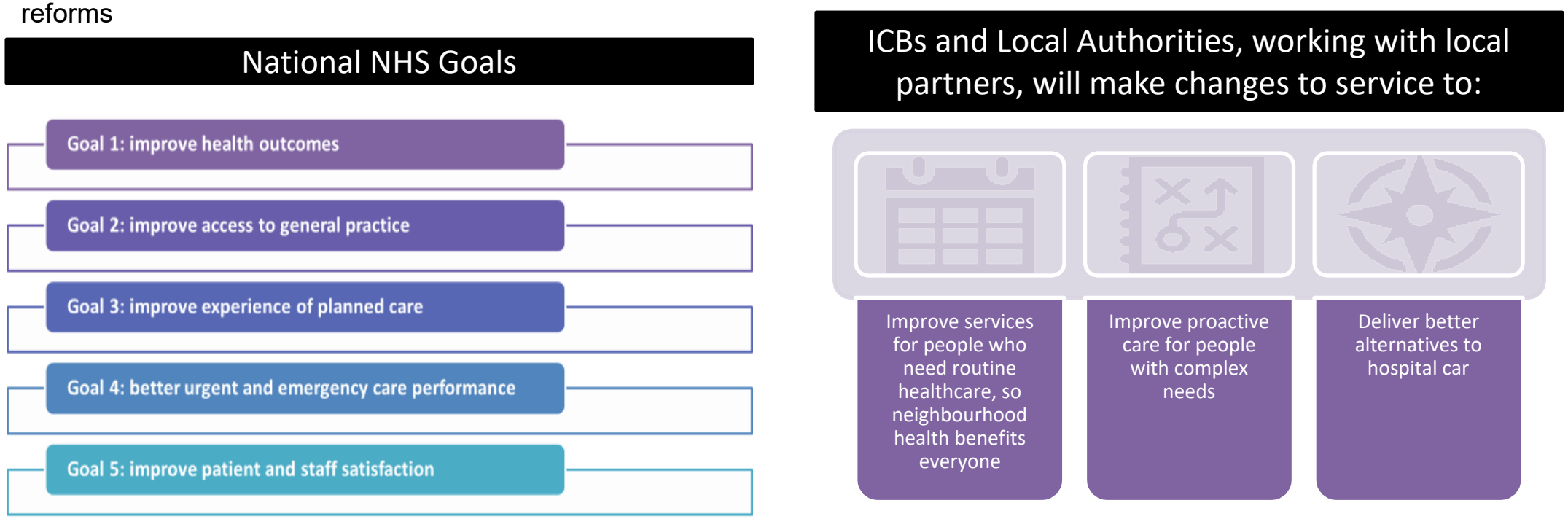
- The **Neighbourhood Health Partnership Framework** is due to be published in January 2026, will ask HWBs to bring partners together to jointly develop strategic neighbourhood health plans by April 2026.

- The **Coventry Care Collaborative** is the delivery vehicle that is leading the development and implementation of the Coventry Neighbourhood Plans using the wider partnership approach. UHCW as the lead provider of the Community Integrator contract are the convenor of the Integrated Neighbourhood Teams.

- **Initial national focus & outcomes:** NHS England's 2025/26 guidance prioritises people with *complex health and social care needs* (c.~7% of the adult population drives 76% of health and social care demand), aiming to *reduce unnecessary time in hospital or care homes*, strengthen continuity/personalisation, and *connect people to wider public services* that support independence.

National Guidance (cont)

- **The Neighbourhood Health Guidance** was released on 17th March 2026, it sets up 5 key goals to be delivered via 3 key reforms



- **How is this being implemented:** The **National Neighbourhood Health Implementation Programme (NNHIP)** is a national *test-learn-grow* effort selecting exemplar Places across England, of which Coventry is one of 43, with enabler workstreams (data/digital, estates, finance, workforce) and an evaluation framework to surface what works and scale it.

- **Alignment with wider reforms:** Neighbourhood Health dovetails with the *Primary Care Access Recovery Plan* (e.g., Pharmacy First, modern general practice access), *Urgent Care Recovery Plan, Elective Care Recovery Plan* and the **Core20PLUS5** inequalities programme—using population health management to target deprived and inclusion groups and priority clinical areas (e.g., hypertension, COPD, SMI, maternity, early cancer diagnosis)

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2. Population Health Management Diagnostic

Rachel Chapman

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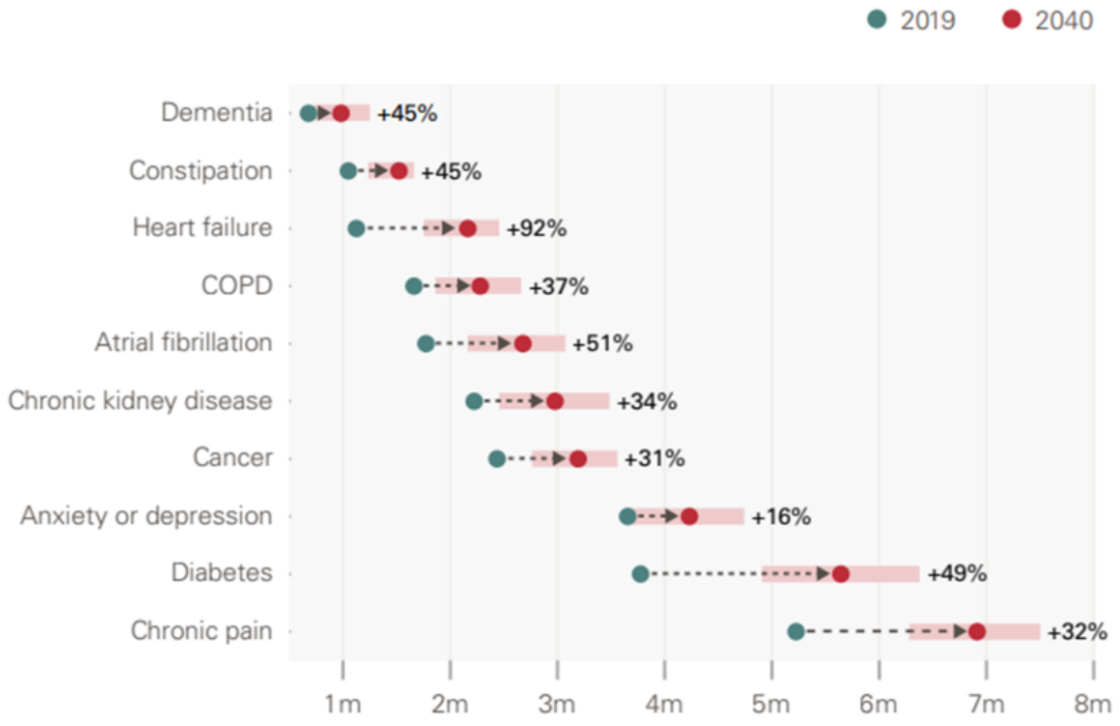
Projections to 2040

Fig. 1:Projected total number of diagnosed cases for the 10 conditions with the highest impact on health care use and mortality among those aged 30 years and older, including demographic changes, England, 2019 and projected for 2040



- Most major conditions projected to increase in prevalence.
  - Largest increase in absolute number: chronic pain and diabetes
  - ≥30% increase in the number of people living with cancer, COPD and chronic kidney disease
  - In most cases, these increases are driven by population ageing rather than a rise in age-specific rates or earlier onset.
- Projected increase in the number of people living with multiple conditions.

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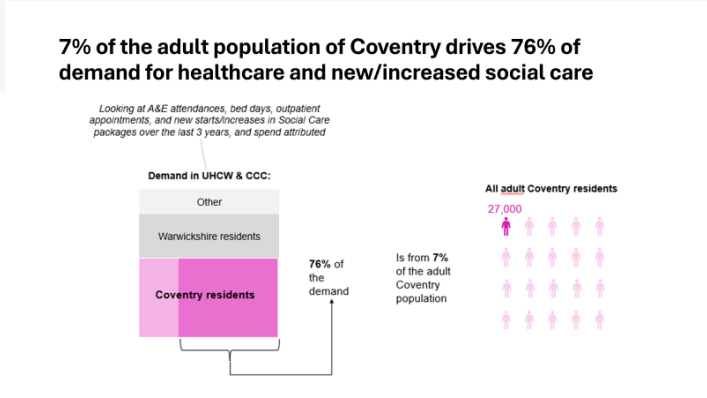
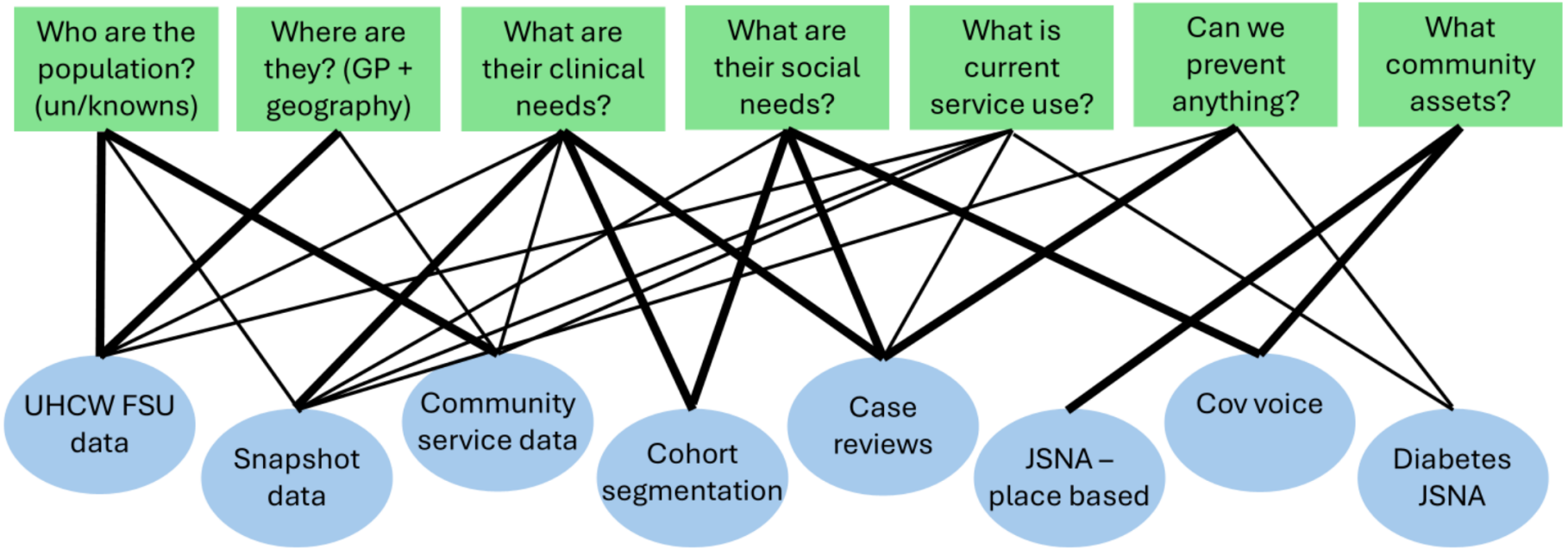
PHM stage 1: gathering information





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The Findings

1. Complexity is an issue at all ages – not just older people
2. Opportunities for proactive care are often missed
3. In order for our workforce to provide personalised care they need the appropriate support structures in place
4. Opportunities for self care and patient activation are often missed
5. Services and partners ‘shift care’ but could ‘share care’
6. A focus on health conditions can mean that the social context of the patient is not appropriately considered
7. A standardised ‘one size fits all’ service delivery does not work for all and does little to reduce health inequalities

Coventry Community Integrator

Working together to create healthier neighbourhoods

Coventry Neighbourhood Health

3. Our emerging Neighbourhood Health Model

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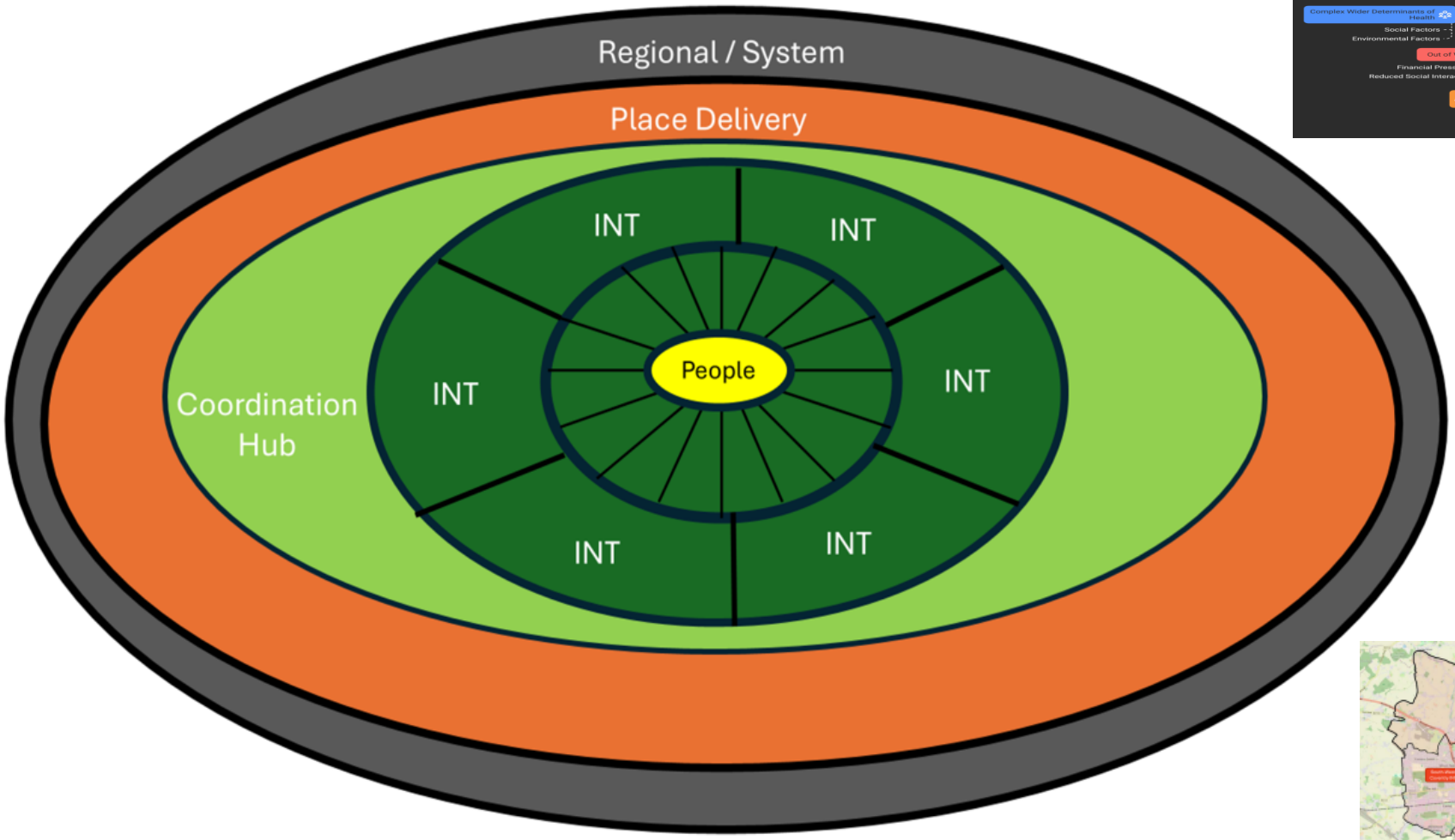
Neighbourhood Health INT Model for Coventry

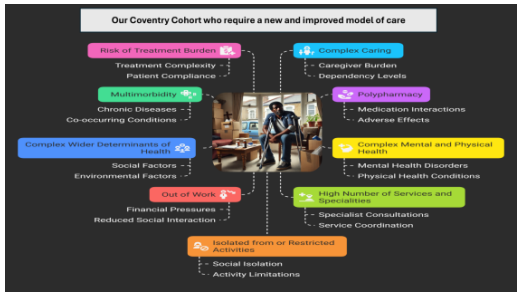
Partnership Designed

Needs Led & Connected

Operationally Enabled

Neighbourhood Delivery





- **One Coventry Community Integrated Urgent Team and place level support**
- **One Coventry Co-ordination Hub**
- **6 Integrated Neighbourhood Teams - aligned practices and care homes**

Coventry Neighbourhood Health

4. Implementation progress to date

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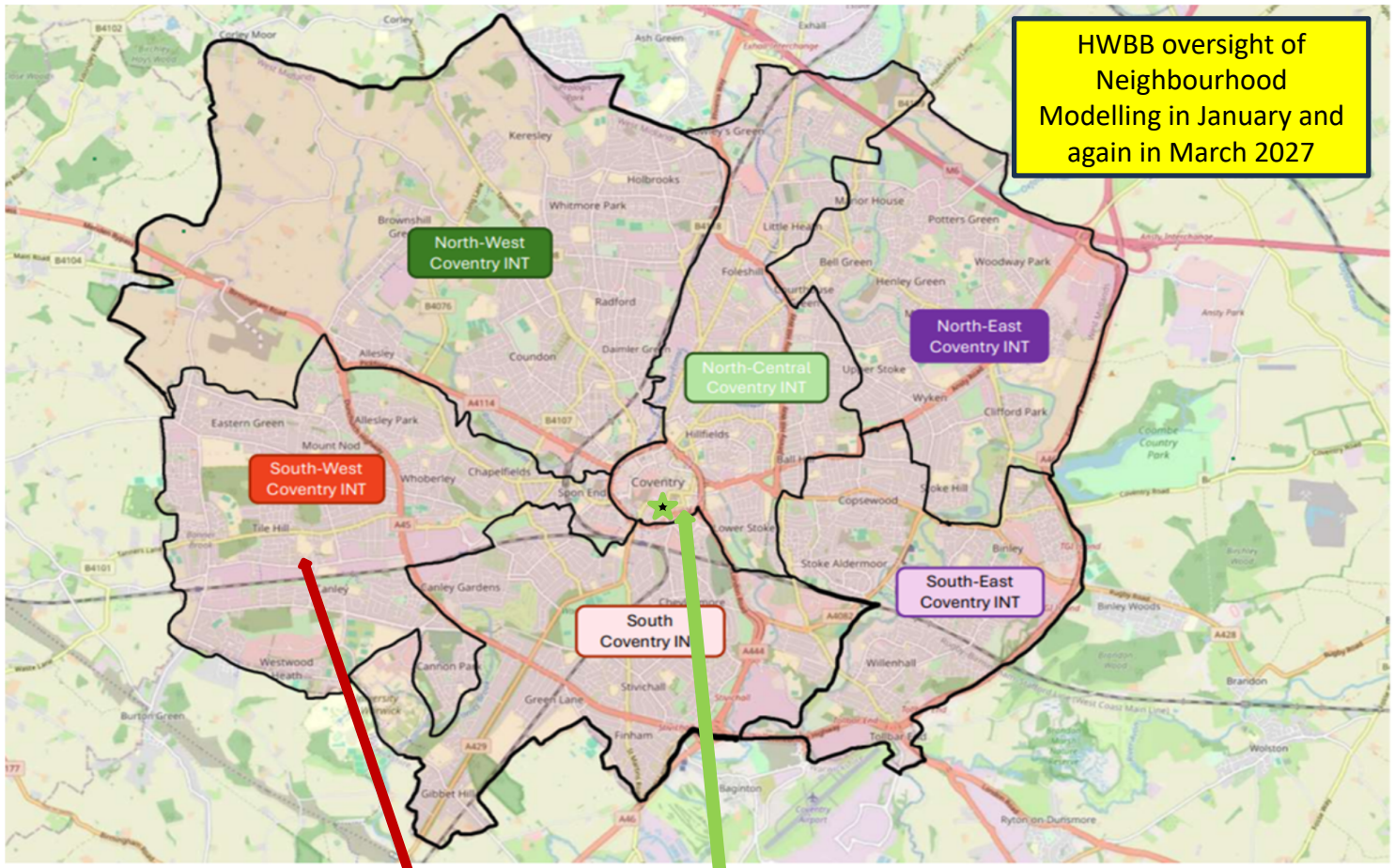
Partnership Co-Design, testing and iterating

Neighbourhood Health INT Model for Coventry

There are **39 Neighbourhoods** recognised in the model.

These neighbourhoods are grouped to create **6 INTs** planned for the city:-

- ✓**North-West Coventry INT**
- ✓**North-Central Coventry INT**
- ✓**South-West Coventry INT**
- ✓**South Coventry INT**
- ✓**North-East Coventry INT**
- ✓**South-East Coventry INT**

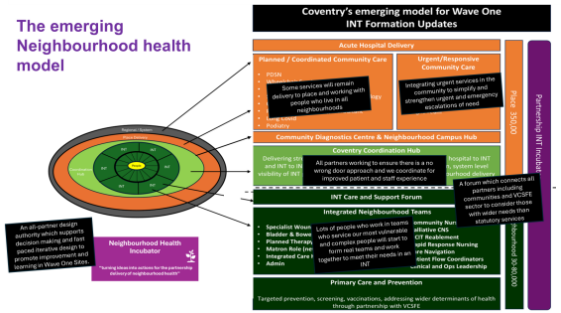


HWBB oversight of Neighbourhood Modelling in January and again in March 2027

Wave One South-West Coventry INT – established 2nd Dec 2025

City Wide Coventry Coordination Hub established 17th Dec 2025

The emerging Neighbourhood health model



Coventry Neighbourhood Health

Coventry Community Integrator

5. Measuring progress

Working together to create healthier neighbourhoods

Emerging Benefits

Measures of system resource use

Metric	Numerator	Denominator
Number of outpatient appointments (new and follow up) per 1,000 patients in the cohort	Number of outpatient appointments (new and follow up) for patients in the cohort	Number of patients in the cohort
Number of emergency admissions per 1,000 patients in the cohort	Number of emergency admissions for patients in the cohort	Number of patients in the cohort
Number of inpatient bed days per 1,000 patients in the cohort	Number of inpatient bed days for patients in the cohort	Number of patients in the cohort
Number of ambulance conveyances per 1,000 patients in the cohort	Number of ambulance conveyances for patients in the cohort	Number of patients in the cohort
Number of A&E attendances per 1,000 patients in the cohort	Number of A&E attendances for patients in the cohort	Number of patients in the cohort
Number of general practice appointments per 1,000 patients in the cohort	Number of general practice appointments for patients in the cohort	Number of patients in the cohort

Neighbourhood Index

Patient reported
- Health confidence and activation
- Named care coordinator
- Personalised support
- Continuity of care
- Involvement in decisions

Care Management
- Vaccination rates
- Multi-disciplinary assessment
- Care plan
- Social prescribing referrals
- Care coordination / no of providers involved in care

Carer's Experience
- Care satisfaction with services provided to care recipient
- Carer needs being met
- Access to support
- Carer's assessment and registration

Care Optimisation
- NEL admission rate
- ACSC admissions
- OP apts out of hospital setting
- PPPY/M trend
- Care home admissions
- Discharge to home
- Length of stay

National Neighbourhood Health Implementation Programme

First submission in March for January 2026 and will report monthly over duration of NNHIP

Case study – INT Care and Support Forum

Context

Person B was identified as a frequent service user with multiple hospital admissions and frequent primary care contact. 117 primary care contacts within last six months and three admissions to hospital in last six months.
Professionals from community services, primary care, voluntary sector and mental health discussed case within Care and Support Forum. Patients voice collected and heard having patient's wishes and goals at centre of discussion. Patients top three priorities were to stop worrying about health, feel comfortable with what she can eat and get new dentures.

Outcome

Full holistic assessment completed
Dental and dietitian support in place.
Care Nav input support with vision, hearing, and outpatient appointments.
Therapy input for showering equipment.
Clinical psychology support with health anxiety/ coping mechanisms.
Son put in touch with carers trust
One contact with primary care since discussed 11.2.26 and no admissions to hospital
Key worker assigned and contact numbers given
Patient feedback to be collected.

Patient Story

Mrs B 69-year-old living with son and current smoker.
Suffers with Chronic Obstructive Pulmonary Disease and recent Heart Attack. Admissions with chest infections. Does not like to leave house due to anxiety and does not attend outpatient appointments due to transport issues and anxiety.
Very low BMI, no fitting dentures and worried since heart attack about what to eat, long standing health anxiety previously had talking therapy but did not find helpful.

Actions: Arranged joint visit with Community Nursing and clinical psychology as not known to any community teams. Concerns around low BMI, skin integrity and anxiety. Full holistic assessment of needs to be undertaken and chase dietitian/dental support

Service Utilisation Reduction
- 117 PC contacts in last 6 months
- Care and Support Forum = 1 appt in the 6 weeks since forum
- **Reduction in GP use by 96%** – noted only short term, need to monitor medium and long term
- If equated to other 38 people discussed, do we have baseline GP appointments for all C&SF attendees??

Case study – INT Care and Support Forum

Context

Mrs T 94-year-old was highlighted as a vulnerable individual who lives alone, with infrequent visits from her friend/cleaner and daughter-in-law. There was evidence of some self-neglect and safeguarding issues. 35 primary care contacts in previous 6 months and no hospital admissions.
The Care & Support Forum provided an opportunity to connect services across and to look at Mrs T as a whole person, coordinating a response accordingly.

Outcome
- ✓ Key worker allocated = Social Prescriber
- ✓ Offered care package but declined
- ✓ Pendent alarm
- ✓ Smoke and CO alarm with heat detectors via telehealth
- ✓ 20 primary care contacts since discussion and two A+E attendances with falls

What we did
- ✓ Reopened safeguarding referral & arranged a joint visit with
  - OT
  - viewed memory clinic referral and referred
  - ial Prescriber to investigate church reconnection
  - anged appointment for hearing aids.
  - anged a safe & well check with the fire-brigade
  - anged a patient experience visit

Patient story

Mrs T felt rather special when a fire engine turned up at her home to check her smoke detectors and carry out a Safe & Well check. She reported feeling safer with a pendant alarm round her neck.

She did not wish to reconnect to the Church at this point, but during the patient experience conversation, she was able to explain that she had a friend who comes round most days, has good neighbours and is perfectly content with her social situation.

She was looking forward to getting her hearing aids, but was a little confused about when her appointment was.

1

Case study – Coventry Coordination Hub

Context

78 year old female care home resident presented with a prolonged history (over 6 weeks) of right leg pain, swelling, warmth, and erythema. Initial management occurred in primary care and urgent care settings, with repeated assessments and treatment for suspected cellulitis despite limited clinical improvement. Diagnostic uncertainty persisted, particularly around exclusion of deep vein thrombosis (DVT). She had 24 GP appointments and two WMAS calls in last 6 months.
The key problem was delayed diagnosis and ineffective treatment escalation due to:
- Repeated antibiotic prescribing without clinical improvement
- Inconsistent clinical assessment and lack of face to face review initially
- Diagnostic uncertainty regarding DVT despite multiple healthcare contacts
- Patient reluctance to attend hospital settings

Outcome
- ✓ Avoidance of unnecessary hospital admission
- ✓ More personalised and coordinated care approach
- ✓ Improved reassurance and engagement despite anxiety about hospital attendance
- ✓ Improved communication across services
- ✓ Greater clarity in escalation pathways
- ✓ Increased confidence in managing complex cases collaboratively
- ✓ Strong multidisciplinary collaboration
- ✓ Effective use of coordination hub
- ✓ Timely escalation and shared decision making
- ✓ Flexibility in care delivery models (e.g. hospital at home)
- ✓ No A&E admissions but reduced (9) primary care contacts

What we did

Multiple GP and Urgent Care (UEC) reviews were undertaken, including Wells scoring for DVT risk.
Several courses of antibiotics were prescribed in line with cellulitis management guidance.
Diagnostic imaging was arranged across multiple hospital sites to rule out DVT.
Ongoing symptoms triggered escalation discussions within the coordination hub
A multidisciplinary approach was initiated, involving GP liaison, nursing teams, and coordination hub staff
The frailty pathway was activated to facilitate assessment and treatment while avoiding unnecessary hospital admission
Consideration of hospital at home pathway for IV antibiotic therapy

Patient Story

Patient suffered from a painful, swollen, and warm leg for over a month. Initially treated for cellulitis, they were prescribed four different courses of oral antibiotics via phone and video consultations, none of which provided relief. The resident underwent several UEC assessments and hospital scans to rule out a DVT, with their symptoms worsening over time. The resident was extremely anxious about their condition but flatly refused standard hospital admission. The Coordination Hub's intervention changed the resident's trajectory by arranging an at home paramedic assessment via the frailty pathway, providing necessary reassurance and bypassing the distress of a traditional hospital admission.

1

Evidence of reduced demand on primary care, increased admission avoidance, especially for those whose wishes are to remain at home.

Increased evidence of what matters to me discussions with personalised plans of care.

Joint working with shared visits and reduced duplication and repetition.

Staff report benefits of co-location and being able to have a discussion rather than make a referral to plan joined up care.

Connections with communities and assets which statutory services report not being aware of or able to connect to increasing.

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Case study – Coventry Coordination Hub

Context

91-year-old gentleman, a resident of a nursing home, was living with advanced frailty and a background of progressive bulbar palsy, requiring a PEG tube for nutrition.
He was admitted to hospital 5 times in last six months due the concerns regarding worsening confusion, reduced mobility, and overall functional decline. During admission, further assessment highlighted increasing care needs and concerns around safety, particularly in relation to his deteriorating physical condition and patient then moved to nursing home.

What we did

Integrated discharge team flagged the patient at the afternoon Coventry Co ordination hub huddle with Community and acute colleagues' presence. Community Care Home team were present in afternoon huddle and they agreed to co ordinate for the patient. CHT supported discussions with GP, nursing home and palliative care team to support care plan in line with patient wishes.

Outcome

The opportunity was for staff in the co ordination hub working between hospital and community and primary care to fulfil patient wishes
The aim was to prevent further admissions for this patient and manage his health care needs in the community at end of his life.
Patient needs were met within the nursing home with support of Community services and Primary care.
Patient had no further readmissions
Patient passed away in the nursing home with support from the palliative team.

Patient story

This reflects a patient whose priority was to spend their final days in the familiarity and comfort of their place.
Through effective multi agency coordination and clear communication, services worked together to honour patients wish.
The patient was supported to die peacefully at nursing home, with appropriate clinical, emotional, and practical support in place.
Their end of life journey was person centred, dignified, and aligned with what mattered most to them.

Case study – Coventry Place Proactive Focus on Care Homes

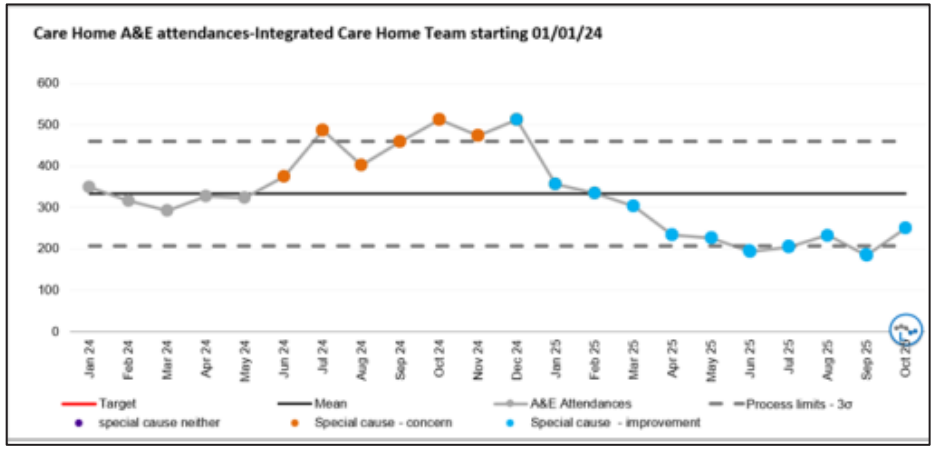
What we did

Integrated Care Home Team: (future delivery with INT)

- Established in January 2025
- Worked with Coventry Homes & UEC to raise awareness of UEC pathways and access
- A&E attendance data review (from March 2025) to reduce further attendances
- Named nurses for each care homes (dedicated teams- continuity)
- Work with district nurses and specialist teams to improve outcomes
- Supports GPs to ensure LTC reviews are up to date, support ward rounds
- No referrals or criteria's
- Support visits to each home on a regular basis
- Proactive and personalised care support

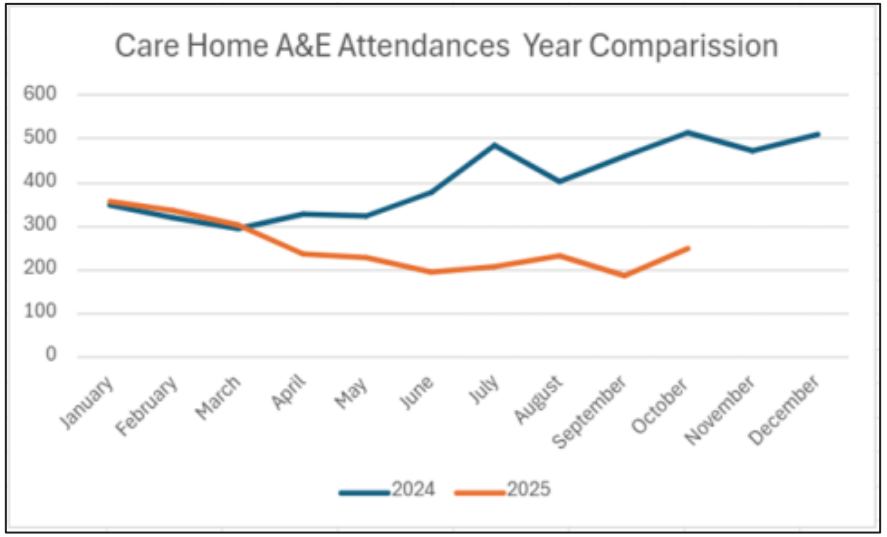
UEC/OCIT: (future delivery with CCH)

- No wrong front door approach, no rejection seeking correct support on behalf of care home.
- Redesigned UEC pathway for care homes



Outcome

The graphs identify that there has been a significant reduction in A&E attendances from Coventry Care Homes in 2025, with a comparisons to 2024 showing from April 2025.

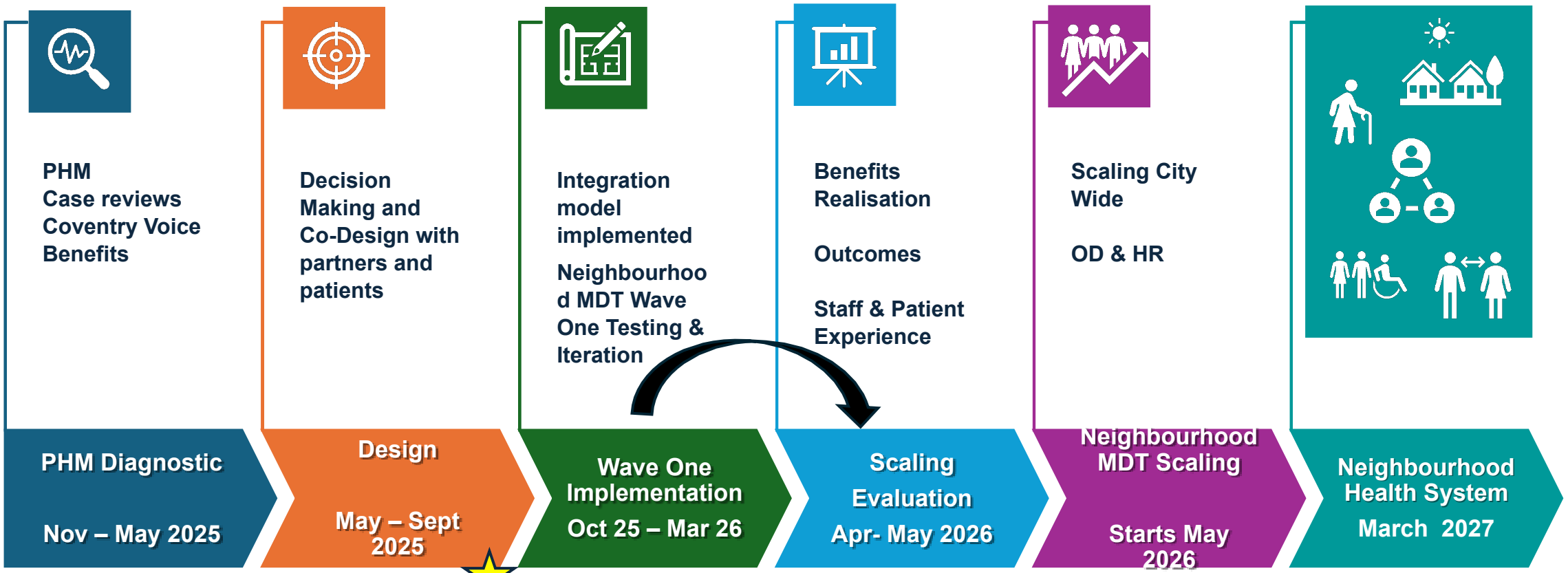


Coventry Community Integrator

6. Next Steps

Working together to create healthier neighbourhoods

Community Integrator Transformation Timeline



National Neighbourhood Health Implementation Programme

September 2025

NNHIP Objectives and Deliverables Oct 2025- Oct 2026

Coventry Community Integrator

Questions and comments

Working together to create healthier neighbourhoods