# Neighbourhood Health Maturity Self-assessment

June 2025

*If you have any enquiries about this pack, please contact the Community Care Team*
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# Neighbourhood Health Maturity Self-assessment

## Briefing

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| **Purpose** | The purpose of this tool is to support your System level self-assessment of your current level of maturity with regards to Neighbourhood Health. It will also be used to support dialogue between yourselves and the Regional Programme in terms of joint actions and support, alongside learning from across the Midlands Region where there is identified good practice. |
| **Scope** | The self-assessment should be carried out at System Level, focusing at either Place and/or Neighbourhood level, and INT/MDT and Service coverage in relation to the total population of the System. For this baseline assessment your responses should focus on the 2 to 4 % of Complex Patients (Adult and CYP) that are at risk of long-term admissions to either Hospital or Care Homes. |
| **Timeline Checkpoints** | Systems are asked to complete a baseline self-assessment, using the criteria set out in this document to determine the current level of maturity, by end-of June 2025 and return via the Midlands Regional ROC by 12:00, on the 24th July 2025.<br>The Self-assessment will be re-run, late Q3/early Q4. |
| **Measuring outcome** | The baseline assessments will be used to agree a programme of support with the Regional Hospital to Community (H2C) Programme, and to assess progress at year-end. |

# Neighbourhood Health Maturity Self-assessment

## Briefing continued

2025/26 Delivery Requirements, as set out in the National Neighbourhood Health Guidelines

- Standardisation and scaling of the initial 6 components

- Agree locally what specific impacts systems will seek to achieve during 2025/26, including as a minimum:
  - improving timely access to general practice and urgent and emergency care
  - preventing long and costly admissions to hospital
  - preventing avoidable long-term admissions to residential or nursing care homes

- Supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations

- NHS England » Neighbourhood health guidelines 2025/26
- NHS England » Guidance on neighbourhood multidisciplinary teams for children and young people
- NHS England » Standardising community health services

# Neighbourhood Health Maturity Self-assessment

## Briefing continued

### Points to note in completing this tool

1. The Maturity Framework is structured to follow the Core Components and Enablers of the Neighbourhood Health Guidance. It is recognised that there maybe some overlap between the statements within the core components and Enablers that have been developed. This is inevitable when viewed via an implementation perspective and should be used to reinforce the co-dependencies between components and outcomes
2. Selection of the self-assessed level of maturity is a judgement, not an absolute decision. Systems will find that they have many elements across the maturity continuum, supported by local evidence. What is important, is that in completing the assessment, systems have a clear view on the actions they need to take to progress implementation, alongside the support that would be beneficial from the Regional Programme. Whilst helpful for your system to acknowledge maturity across the continuum, the focus of year 1 is to fully meet the ‘starting’ maturity for the identified population of 2-4% implementing INT/MDTs
3. Your final ‘judgement’ of maturity in this baseline assessment should be determined in relation to the 2025/26 specific requirements,. The framework will facilitate a wider assessment in future years, following publication of the ’10 Year Plan for Health’
4. When completing the assessment, please outline the local evidence you have used to determine your judgement in relation to Maturity.
5. Prior to submitting your completed assessment, please ensure that it has been moderated across the organisations and functions involved in implementing Neighbourhood Health

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| **Six core components and enablers** | **Starting** | **Progressing** | **Achieving** | **Excelling** | **Local/System Evidence** |
| **Population health management** | • Have one consistent PHM approach and analytical tools in place.<br>• Have information governance, data sharing and processing arrangements in place to ensure that data is shared safely, securely and legally.<br>• Able to segment and risk stratify population data.<br>• All available data can be broken down into neighbourhood and place level | **All the preceding characteristics plus:**<br>• Have a person-level, longitudinal, linked dataset across primary, acute, community and social care encompassing data from:<br>  • General practice and wider primary care<br>  • Community health services<br>  • Mental health<br>  • Acute care<br>  • Social care<br>  • Public health | **All the preceding characteristics plus:**<br>▪ Use advanced analytical tools (*including segmentation to identify inequalities*) and approaches to improve care<br>▪ Have a cross-system intelligence function providing support to all levels of the system. | **All the preceding characteristics plus:**<br>• Apply a single consistent system-wide PHM method to ICB analytics platforms to segment and risk stratify populations, based on complexity and forecasted resource use.<br>• Dataset to have broadened to include data components from: Local or central government including employment, education, safeguarding, *voluntary services* and housing status<br>• Developed multi-disciplinary analytical and improvement teams to ensure a data driven approach to development on interventions, focussing on prevention and reducing health inequalities.<br>• Dataset to have broadened to include data components from:<br>  • Local or central government including employment, education, safeguarding and housing status | **STARTING**<br><br>*Standard word regarding the position of the Systemwide PHM tool needs to be supplied by System Primary Care for inclusion in all place self-assessments.*<br><br>*We can include local workarounds which we are using to get us started whilst awaiting the release of the System PHM tool.*<br><br>This is further supplemented by information tools and dashboards being developed by individual organisations e.g. SWBH Town Dashboard, where we are able to utilise acute information looking at the following data by town: Demographic profile, community contacts, emergency care, elective, out-patients and diagnostics with information about type of patient accessing service and also top intervention or complaint for each area. |

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| **Modern general practice** | ▪ ICB has established a Primary/Secondary Care interface group with a named SRO<br>▪ ICB supporting practices to participate in local and national services to redirect avoidable secondary care patient contact to general practice/community providers<br>▪ All practices have all 3 (Online consultation, Cloud based telephony and walk in) channels available to patients to access general practice and patients are informed of how their enquiry will be managed at the first point of contact<br>▪ ICB has identified practices to participate in the national Practice Level Support programme to implement modern general practice<br>▪ ICB starting developing approaches to reducing unwanted variation across their practices | **All the preceding characteristics plus:**<br>▪ Primary/secondary care interface group meets regularly with participation from primary care and secondary care (clinical and non-clinical)<br>▪ 90% - 100% of practices signed up to participate in local/national services to redirect avoidable secondary care patient contact to general practice/community providers<br>▪ Practices have all 3 channels available to access general practice and are regularly reviewing data regarding patient contacts to improve access and align practice capacity to demand.<br>▪ Practices are promoting self service, self referrals and digital pathways to patients as appropriate. Triage processes and care navigation are in place but may need further development/refinement.<br>▪ Peer Ambassadors have been appointed and are being facilitated by the ICB to support practices<br>▪ ICBs have an understanding of the learning from practices attending the national PLS programme and have started to identify mechanisms to share the learning. | **All the preceding characteristics plus:**<br>▪ Primary/secondary care interface progress resulting in patients being seen in an appropriate setting by primary/secondary care clinicians.<br>▪ Increase in the number of patients using self-referral services, an increase in the use of advice and guidance service by general practice and delivery of EHCH DES specification.<br>▪ All practices working towards modern general practice and have OC open during core hours for both admin and clinical requests. Mature care navigation and triage processes are in place and being maximised for Pharmacy First pathways and digital self service. Continuity of care is a consideration for all appointments<br>▪ GP Dashboard metrics indicate MGP model in place and show improvements over time. HIS patient satisfaction and continuity of care metrics show improvement over time.<br>▪ Peer Ambassadors providing targeted support locally to practices to implement MGP and supporting local development programmes<br>▪ Co-ordinated approach to sharing the learning from practices that have participated in the national PLS programme | **All the preceding characteristics plus:**<br>▪ Cultural shift within acute trusts where primary/secondary care protocols adopted across acute trusts<br>▪ Reducing demand through developing models<br>▪ ICB capturing qualitative information highlighting benefit to patients and primary/secondary care.<br>▪ All practices have implemented all elements of modern general practice as indicated by GP Dashboard metrics. All practices have OC open during core hours for both clinical and admin requests and capture structured information about the patient's presentation, population segmentation and risk stratification of the patient into a single workflow.<br>▪ Mature Peer Ambassador programme providing support to practices to implement MGP<br>▪ Local learning networks.<br>▪ ICB using data and intelligence including patient measures including any local survey work with Health watch/CQC/patient insights, National GPPS/ONS Health Insight Survey Data/Patient complaints information.<br>▪ Staff satisfaction measures through national and local staff survey. | **PROGRESSING**<br>• There is an established primary/secondary care interface group in Sandwell with active workstreams, eg, wound care and maternity. This is supported by a system-wide interface group to progress system wide issues.<br>• All practices in Sandwell Signed up to A&G<br>• 3 channels available in all practices. However, for online consultation there are still 5 practices who are not fully compliant for open during core hours with no limitations. We are working with them to achieve by 1st Oct in line with national contract.<br>• 37 Practices are complying fully with demand and capacity work will the remaining 10 is ongoing.<br>• Some practices have undertaken the programme previously which has been run for a few years in different forms. ICB not identified practices for this tranche however the ICB has encouraged all practices to consider the programme to help them on their MGP journey, noting that the programme is a 12 week commitment starting in September.<br>• Peer Review Ambassadors |

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| **Standardising community health services** | • Local needs, priorities & inequities for Community Health Services for children & adults (CHS) are starting to be identified and understood<br>• The provision of core CHS services across Neighbourhood footprints has been mapped and discussions are taking place regarding commissioning of services to ensure equity of access, and appropriate service provision for the identified demand<br>• Commissioning intentions for Neighbourhood Health services integrates both NHS and Local Authority provision, wider system partners and providers, and the voluntary and third sector<br>• Work is beginning on improving collaboration & joint decision-making to improve outcomes, patient experience & to support the shift of activity from hospital to community<br>• Current commissioning arrangements including contract management frameworks, alongside service provision, is being reviewed to deliver management of patients outside of the acute setting where appropriate, including those with escalating care needs in line with the Neighbourhood Health guidance<br>• The Neighbourhood Health commissioning strategy is in development with the involvement of all system partners<br>• The system is aligning the workforce & financial data against its draft Neighbourhood Health strategy | **All the preceding characteristics plus:**<br>• Population health management analysis is being used to identify demand at a Neighbourhood level alongside opportunities for shifting care to a community setting where appropriate<br>• New outcomes-based service specifications that align with the agreed system strategy are in development<br>• Through the established Neighbourhood based working and integration, improvements in services are being identified and implemented<br>• Work is progressing across health & local authority strategic partners/providers to develop collaboration & joint decision-making to improve outcomes, patient experience & to support the shift of activity from hospital to community<br>• The system has identified and is now actioning any changes to Commissioning arrangements and contracts that are needed to deliver the required service to meet identified demand within it's established neighbourhoods<br>• Neighbourhood Health and performance of wider Community Services are integrated within the overall System Performance Assessment Framework, and are available as a single / shared set of metrics derived from the Federated Data Platform (FDP) | **All the preceding characteristics plus:**<br>• Commissioned services, at Neighbourhood level, are designed meet the locally identified priorities & Health inequities for those populations<br>• Standardised, equitable & accessible integrated community health services (including all documented elements of planned care) are designed, commissioned & delivered effectively, with patients, carers and families, to meet the needs & priorities of their population.<br>• Services at a Neighbourhood level have been integrated across Health and Local Authorities, focused on outcomes, including patient experience, that achieve the shift from Hospital to Community<br>• A cohesive and effective neighbourhood health commissioning strategy is in place, integrating relevant elements across 111, UEC and UCR and recognising the need for services 24/7.<br>• Ongoing Contract Management, underpins provider accountability and shared resources aligned with the agreed outcomes within each defined Neighbourhood<br>• CHS activity workforce & financial data is aligned with Standardising Community Health Services guidance's categorisation of services. | **All the preceding characteristics plus:**<br>• An exemplary neighbourhood health commissioning approach, developed and driven by all strategic partners<br>• Excellent collaborative leadership across health & local authority partners<br>• Effective co-production & proactive work to anticipate & understand the current & future needs of children & adults.<br>• Innovative use of funding<br>• Community health services are seamless & are used as exemplars for other areas, demonstrating clear improvements in outcomes<br>• Community health services provide excellent patient, family/carer & staff experience & outcomes<br>• Core service provision is understood & described in detail, enabling flexibility & innovation. | **STARTING**<br><br>There are established MDT town teams meeting monthly in all 6 towns working well together.<br><br>This is enhanced by embedded voluntary sector partnership working as part of the MDT<br><br>We have a robust home first approach and support people to not be conveyed.<br><br>The PHM data will enable us to develop our approach and we have plans to develop this. |

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| **Neighbour-hood multidisciplinary teams (MDTs)** | • You have developed a model, which has been piloted in at least 1 neighbourhood<br>• The approach has been evaluated following dynamic implementation on a specific cohort of patients based upon Population Health analysis<br>• The INT/MDT includes Local Authority Colleagues, alongside Acute, MH and Primary Care Colleagues, and Third Sector<br>• The holistic care plans are developed to take account of the patient voice, with patients participating in the plan development | **All the preceding characteristics plus:**<br>• There is an agreed, system level expansion plan to achieve 100% of the same INT/MDT approach across the system for the initial cohort<br>• The capability to access the Shared Care Record is in place across the system and all INT/MDT Participants can access this<br>• Plans have been developed to modify the approach for different cohorts, as identified by Neighbourhood Level PHM analysis<br>• Workforce plans to enable staff to move between Care Setting are at an early stage of agreement | **All the preceding characteristics plus:**<br>• Each Neighbourhood has an active INT/MDT<br>• The Neighbourhood Population has been segmented and stratified to identify the cohorts of patients that would benefit from proactive management within the Community/Primary Care setting<br>• All patients have a documented 'Personalised Care and Support Plan'/'Advance Care Plan', accessible via the Shared Care Record<br>• For Palliative and End of Life Care patients the MDT have developed the Advance Care Plan / Respect Plan<br>• Service availability (to deliver the agreed plan) is sufficient to cover a 7 day service | **All the preceding characteristics plus:**<br>• There is a reduction in the utilisation of unscheduled care / A&E Attendances for the target cohorts of patients<br>• There is an increase in the use of Community/Primary Care based Urgent Care<br>• The system has local mechanisms for monitoring achievement of outcomes<br>• The workforce has the capability to utilise remote technologies to support patients in their own home | **STARTING**<br><br>We have established MDTs in our 6 towns across Sandwell across health and social care partners and includes community, MH, LA. Public Health and social prescribers.<br><br>We are now developing the integration of primary care into Town MDTs as part of our next steps in the development of our Sandwell model..<br><br>We have pilots planned to develop our approach with metrics to be captured enabling us to assess the impact of primary care being in the MDT and determine next steps. |

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| **Integrated intermediate care with a 'Home First' approach** | ▪ MDT discharge planning including rehabilitation requirements starts on day of admission<br>▪ Joint decision-making between Health and Social Care at point of discharge<br>▪ Clear information across the whole system on commissioned bedded capacity for Pathway 2 (Community-based rehab)<br>▪ System level criteria is established for discharge Pathway 2 (community-based rehab)<br>• Criteria is established at system level for discharge Pathway 2 beds aligned to national policy and rehab complexity scores (2a, 2b, 2c,2d).<br>• Clear roles and responsibilities established between CTHs and INTs<br>• Evidence of Therapy led provision in intermediate care<br>• Identification of gaps / opportunities for step-up care (based on 'avoidable hospital admission information') | **All the preceding characteristics plus:**<br>• Referral links between Care Transfer Hub (CTH) and Integrated Neighbourhood Teams (INTs)<br>• Clear information across the whole system on commissioned P1 services, that enable a Home First / Intermediate Care approach<br>• Home first approach embedded across acute and community in-patient discharge teams<br>• System level performance assessment framework (PAF) that incorporates the intermediate care framework outcomes (KPIs)<br>• Joint EPR that supports rehabilitation/intermediate care within community settings (specifically the patients own home)<br>• Neighbourhood MDTs to agree 'pull' criteria to support discharge | **All the preceding characteristics plus:**<br>▪ Accurate integrated reporting of intermediate care<br>▪ System level performance framework that identifies all instances where Home First was not achieved (at point of admission or discharge)<br>▪ Case management approach in some areas e.g. complex discharge patient<br>▪ Evidence of increase in step-up activity (with corresponding decrease in acute / step-down provision)<br>▪ Aligned Demand and Capacity across all provision<br>▪ Digital technology are supporting the joined-up provision of IC across health and care | **All the preceding characteristics plus:**<br>▪ Embedded case management approach across integrated teams (including IDTs). INTs safely 'pulling' patients home<br>▪ Ability to evidence and celebrate how the Home First approach is embedded as business as usual (shift from hospital to community)<br>▪ Evidence showing avoidance of long-term admissions jointly between health & social care<br>▪ Evidenced adequate community/Step Up provision commissioned in line with PHM analysis re: demand<br>▪ People discharged to appropriate setting on Discharge Ready Date (through effective discharge planning)<br>▪ Monitoring of outcomes including patient experience (intermediate care) embedded at Neighbourhood, Provider, Commissioner levels | **PROGRESSING**<br><br>We have a mature Integrated Discharge Hub of Health and Social Care workforce.<br><br>We have an integrated reablement facility (Harvest View) to enable step up and step down.<br><br>We have daily capacity meetings informed by data.<br><br>We have a bed matrix across our place with details of bed provision.<br><br>We have therapy led provision across all P1 and P2 pathways.<br><br>We have accessible step-up provision available for health and social care teams.<br><br>We have a range of improvement activity underway including the need to embed automatic and systematic capture of patient experience. |

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| **Urgent neighbour-hood services** | SPoA are in place but require further work to optimise the opportunity and meet minimum specifications including:<br>• one SPoA number for each ICB<br>• Ambulance 'stack' is visible and reviewed (hear and treat)<br>• Call Before Convey in place (see and treat)<br>• UCR provision is aligned with existing demand at a rate of 180 per 100k pop..<br>• Step-Down and step-up VW provision meets national minimum standards<br>• Step-up VW provision is being explored and enhanced to facilitate ED avoidance for identified cohorts of patients (frailty)<br>• SPoA can facilitate referrals from GP, NHS111, care Homes and Ambulance Service as a minimum<br>• SPoA should operate for a minimum 12hrs per day (working towards 24hrs) | **All the preceding characteristics plus:**<br>• Data capture to improve understanding of potential demand across urgent services and how this aligns with existing workforce/skills/capabilities/capacity<br>• Provision of community step-up VW in place, and ED attendance is avoided<br>• Digital enablement is commencing<br>• Communication across all services exploring opportunities to collaborate and integrate<br>• Majority of the minimum requirements for SPoA are being met.<br>• Pathways are being explored through the lens of Frailty to ensure all service provision required is in place, optimised and adds value to the patient.<br>• Reduce the various referral points to streamline access to the most appropriate service at the earliest part of the patient journey including alternatives to ED | **All the preceding characteristics plus:**<br>• Collaboration between the CTH and SPA to align accessible services and streamline access and data collection.<br>• Progressing towards working 24/7<br>• Wide range of health and social care professionals can access the SPoA where triage, streaming, referral is required<br>• SPoA can directly book patients into appropriate services in a timescale that meets their presenting need (same day/next day)<br>• Digital enablement is progressing at pace, with access to SCR, Care Plans, Respect forms, recent clinical records etc, that will aid clinical decision making<br>• Care Homes (with/without nursing) will have streamlined access into SPoA to provide clinical advice and facilitated response from suitable services so that staff avoid calling 999 where not clinically appropriate | **All the preceding characteristics plus:**<br>▪ Mature (potentially combined/integrated) SPA/CTH operating 24/7, and at scale across defined geography with a single access route/number<br>▪ Access to SPA/CTH available to any health and social care professional, and selected patients, where clinically beneficial<br>▪ Ability to triage, coordinate and access all urgent care services to avoid ED attendances or readmissions where clinically safe to do so – regardless of where the patient resides (own home/care home)<br>▪ Aligned D&C across all urgent pathways (acute and community) including as a minimum, UCR, step up/down VW, Medical & Frailty SDEC, UTCs, diagnostics, falls – supported by access to social care, pharmacy, voluntary sector etc<br>▪ The use of robust accurate data to closely monitor service provision, utilisation and access against demand profiles | **PROGRESSING/ACHIEVING**<br><br>We have one SPA for Sandwell where UCR and visible ambulance stack and call before convey is in place.<br><br>Step-down and step-up is in place with virtual wards and can support referrals from multiple partners.<br><br>We have demand and capacity modelling for UCR and Virtual Wards to develop proposed workforce models.<br><br>Community step-up is in place with digital tools and we are developing this further.<br><br>We communicate and work together across our services to develop integration including a frailty focus with some specific workshops. We have some frailty pilots planned with consultant attending our care navigation centre, piloting a GP person in the hub and developing proactive work in care homes.<br><br>We have integrated UCR and SPA |

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| **System Architecture and model of Care** | • System has defined and agreed its Neighbourhoods<br>• System partners have been identified<br>• There is a developed shared vision and outcomes<br>• There are agreed accountability arrangements<br>• There is clear leadership, organisational and clinical, setting the direction | **All the preceding characteristics plus:**<br>• Roles and responsibilities across partners has been identified<br>• There is clear governance arrangements and lines of accountability between Neighbourhood and Place.<br>• There is a clear plan for evaluation and roll out of the Neighbourhood Model<br>• Minimum of 60% of system population is covered by Neighbourhoods where INTs/MDTs are established for Adults and Children in line with Neighbourhood Health guidelines.<br>• INTs are in operation for the specific cohorts (comprising Adults and CYP) as stipulated in the 25/26 Neighbourhood Health Guide requirements. | **All the preceding characteristics plus:**<br>▪ All ICB geography (100%) is operating with a Neighbourhood Health model<br>▪ The system has established collaboration between providers both NHS and non-NHS.<br>▪ There is an embedded improvement approach where learning is being shared and acted upon | **All the preceding characteristics plus:**<br>• There are full integration both horizontally and vertically at their Neighbourhoods.<br>• There is a clear delivery programme for each Neighbourhood.<br>• INTs are in operation for PHM analysis identified demand / patient cohorts (comprising Adults and CYP)<br>• Evaluation is showing benefit to patients and a cohesive and cost-effective model of care. | **STARTING**<br>• Within Sandwell the 6 Towns are recognised by all partners including the residents as the neighbourhoods for the development of INT.<br>• All partners are part of the Sandwell Health & Care Partnership (SHCP) which has clear governance and has set out its vision and priorities which has identified key transformation priorities of Connected Communities and Home First.<br>• Sandwell and West Birmingham Hospital (SWBH) acts as the host for the SHCP.<br>• A draft INT specification is being developed by the ICB system in conjunction with all relevant parties which will support and set out agreed outcomes.<br>• We are continuing to develop our neighbourhood model and have some pilots currently being mobilised to test out our new model |

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| **Workforce** | ▪ There is an established shared vision with defined clear goals for integrated neighbourhood teams, shared with ICBs, Local Authority and local providers<br>▪ The system has built early engagement and buy-in from all professionals across specialties and services<br>▪ Work is progressing on developing a shared culture and set of values that support collaboration and patient-centred care<br>▪ A focused workforce mapping exercise has been started to map existing workforce capacity, skills and capabilities across all partners and providers in a bottom-up approach.<br>▪ Distributed leadership capability is starting to be built across neighbourhood teams<br>▪ There is an agreed approach to ensuring skills and tools are in place for staff to safely work across organisational boundaries in a pilot area.<br>▪ There is multi-professional working with clearly defined roles and shared accountability<br>▪ There is an outline organisation development plan which describes how to bring teams together ahead of service delivery.<br>▪ Establish feedback loops and support continuous learning | **All the preceding characteristics plus:**<br>▪ Staff involved in pilots are engaged and are actively involved in building the local neighbourhood service model to optimise the use of services, including wider primary care, general practice, mental health, community health services, neighbourhood MDTs and social care services.<br>▪ Opportunities for learning are identified to inform roll-out of other MDTs from service delivery evaluations.<br>▪ There is a broader organisational development plan with identified metrics and deliverables<br>▪ Workforce leadership across organisations have a shared vision to inform future expansion plans | **All the preceding characteristics plus:**<br>▪ There is an established shared culture and set of values that support collaboration and patient-centred care across all stakeholders and participants in Neighbourhood MDTs/INTs<br>▪ Workforce leaders across organisations have an agreed joint expansion plan linked to the agreed service delivery model understanding future supply and technology requirements<br>▪ Staff are enabled to utilise skills and tools to safely work across organisational boundaries in each neighbourhood<br>▪ There is joint training and staff rotation for neighbourhood teams in operation | **All the preceding characteristics plus:**<br>▪ Ways of working and integrated processes support learning and continuous improvement.<br>▪ There is a defined workforce model and plan that articulates the future activity shift from hospital and community that fully takes account of population health needs and requirements.<br>▪ There is future years plan for joint training and staff rotation across all services<br>▪ There are identified barriers and opportunities to better enable productive integrated working with a supply training and education plan in development to support delivery | **STARTING**<br>• All partners are part of the Sandwell Health & Care Partnership (SHCP) which has clear governance and has set out its vision and priorities which has identified key transformation priorities of Connected Communities and Home First<br>• Our town team MDTs have been effective in building relationships to develop shared ways of working.<br>• Due to current system financial pressures, it is challenging to develop a workforce plan for the future.<br>• The pilots we have planned for INTs will develop how we work together across organisations with shared tools and processes<br>• We have established feedback loops in services and organisations, but we are developing how this is integrated.<br>• We have explored other local models to understand their learning to build into our model and how we roll-out this model.<br>• Through our Black Country |

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| **Clinical and professional Leadership** | | | | | **Unable to assess without criteria.**<br><br>• Strong clinical and professional leadership within the Sandwell Health & Care Partnership from all partners.<br>• Strong Primary Care Collaborative of all the PCN CD's that are actively part of the governance of the SHCP and are part of the leadership and development of all plans.<br>• Sandwell clinical leads also are key leaders of the Black Country Integrated Care Board and Black Country Primary Care Collaborative |

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| **Six core components and enablers** | **Starting** | **Progressing** | **Achieving** | **Excelling** | **Local/System Evidence** |
| **Digital** | • Integrated neighbourhood teams (INT) to have agreed data sharing agreement that enables shared care planning<br>• Members of the integrated Neighbourhood teams (INTs) to have digitalised records<br>• Robust digital maturity mapping across integrated Neighbourhood teams (INT) to ensure an adequate or minimum level of infrastructure is in place to support cross setting working<br>• The INT/MDT is using minimal data from all participants including primary, community and acute providers as part of care planning<br>• There is retrospective reporting re service utilisation and performance<br>• The INT is using manual processes, e.g. paperwork, phone calls etc in their delivery of services to patients<br>• Patient self-management through assistive technologies is limited, e.g. passive patient portals<br>• Limited/pilot programmes utilising remote monitoring and online consultations for patients | **All the preceding characteristics plus:**<br>• The capability to access the Shared Care Record is in place across the system and all INT/MDT Participants can access this<br>• Digital Capability to co-ordinate care across an integrated neighbourhood team i.e., scheduling, remote consultation<br>• Basic EPR interoperability between providers; beginning to include social determinants data<br>• Basic digital referral systems; limited communication between teams<br>• Self-management, patients receive digital reminders, educational content<br>• Online consultations available as part of INT/MDT support, but not embedded in care pathways<br>• Manual tracking of avoidable admissions; periodic reporting | • **All the preceding characteristics plus:**<br>▪ Integrated Shared care record accessible across settings (primary, acute, community); includes behavioural and social data<br>▪ Predictive models identify patients at risk of admission; alerts for care teams<br>▪ Shared digital care plans with coordinated task management across teams<br>▪ Interactive tools for self-management; remote monitoring/ communication with care teams<br>▪ Remote monitoring for high-risk cohorts with guidelines for follow-up<br>▪ Dashboards showing KPIs: admission rates, response times, care plan adherence<br>▪ Live Data reporting across MDT within INT<br>▪ Regular Data validation process in place<br>▪ Joint model of care implemented across INT that is supported by Digital | • **All the preceding characteristics plus:**<br>• All members of the INT reporting via Federated Data Platform (FDP)<br>• Information regarding care provided by all members of the INT available via NHS APP<br>• Digital infrastructure interoperable and accessible across a patient's pathway within an INT provider<br>• Real-time data exchange; predictive dashboards; full interoperability with regional/national systems<br>• AI-driven dynamic risk scoring; integration of unstructured data (e.g. notes, wearables); outcomes inform prevention strategies<br>• Real-time shared workflows; automatic triggers for care team intervention; performance tracking<br>• Personalised engagement (PEPs, full access to NHS App functionalities, chatbots, virtual care); real-time feedback from patients; equity-aware engagement analytics<br>• Proactive intervention based on continuous data streams (e.g. wearables, home devices); virtual ward<br>• Real-time dashboards with drill-down capabilities; predictive and prescriptive analytics on system-level and patient-level metrics | **STARTING**<br><br>We are developing agreed data sharing agreements across all partners.<br><br>We do not yet have digitised records or an assessment of our digital maturity and are currently using manual processes.<br><br>Patients are directed to self-help tools and information electronically by general practice partners, eg, lifestyle changes.<br><br>We have digital tool in place for Virtual Words (Docobo) and are reviewing the system. |

# Neighbourhood Health Maturity Self-assessment

## System Level Actions and Opportunities

| Actions |
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| Opportunities |
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