Department of Health & Social Care

NHS

Application to take part in the National Neighbourhood Health Implementation Programme

All fields in this document should be completed. THE QUESTIONS AND YOUR ANSWERS CONSTITUTE THE CRITERIA UPON WHICH YOUR APPLICATION WILL BE JUDGED

Applications should be emailed to england.neighbourhoodhealthserviceteam@nhs.net by 8 August 2025.

Place details

1. **Current ICS your Place is part of:** …Black Country ICS……

2. **Full name of the Place on which the project will focus**……. Sandwell…..

(please include details on footprint including population size, local authority alignment and number/configuration of any integrated neighbourhood teams):

Sandwell is a new Borough, made 50 years ago from six towns – Wednesbury, Tipton, West Bromwich, Smethwick, Oldbury and Rowley Regis. With 346,500 residents we have diverse communities proud of their town (neighbourhood) identities.

As a borough we have high-level and widespread deprivation and health inequalities. These are complex and long-standing issues and, despite consistent intervention using data driven approaches, our outcomes remain poor in comparison with other parts of the Black Country and with England as a whole.

This is a consequence of the continued challenge of tackling widening structural inequalities. We are the most deprived Borough in the Black Country and 12th most deprived nationally. This deprivation is evident across the whole Borough where 60% of our Lower Super Output Areas are in the most deprived 20% nationally, with none falling into the 20% least deprived nationally.

The extra-ordinary scale of the local challenge to narrow health inequalities in access and outcome is clear in our high-level outcome data.

- Infant mortality is the 6th highest in the country, and at 7.1 per 100,000 births, significantly higher than our Black Country neighbours, such as Dudley where the rate is 4.1.
- Life expectancy and healthy life expectancy are below average, and life expectancy at birth is the lowest in the Black Country. In 2021-22 males and females in Sandwell had the 143rd and 134th lowest life expectancy out of 151 local authorities in England.
- We have higher premature mortality rates than England and the West Midlands, including preventable deaths under 75 years from cancer, cardiovascular, respiratory and liver diseases.

Despite system and targeted work, smoking and obesity rates have both topped national tables at times in the last few years. We have not yet stemmed the rising tide of future demand, with childhood obesity in year 6 being highest in the country at 31%, and the gap between us and England has widened over the last 10 years.

Our understanding of these challenges, which are both entrenched and newly developing, is deep and has informed our approach for delivering a systemic method to reducing health inequalities and improving our population's health through our Place Board.

Building on Sandwell's history of making things happen, our Place Board brings together investors, businesses, government departments, partners and our residents, ensuring we maximise opportunities and address the root causes of deprivation.

A keystone of the Place Board is our Health and Care Partnership (SHCP), which has already achieved notable success in delivering change at pace, as detailed in this application. We will continue to drive this ambition through the national neighbourhood programme, enabled by a clear financial commitment from our Better Care Fund to support the development of Neighbourhood working.

Strategic Partnership

SHCP brings together partners from across health and care to deliver our vision;

"Our citizens thrive, in vibrant communities, supported by local, joined-up health and care services"

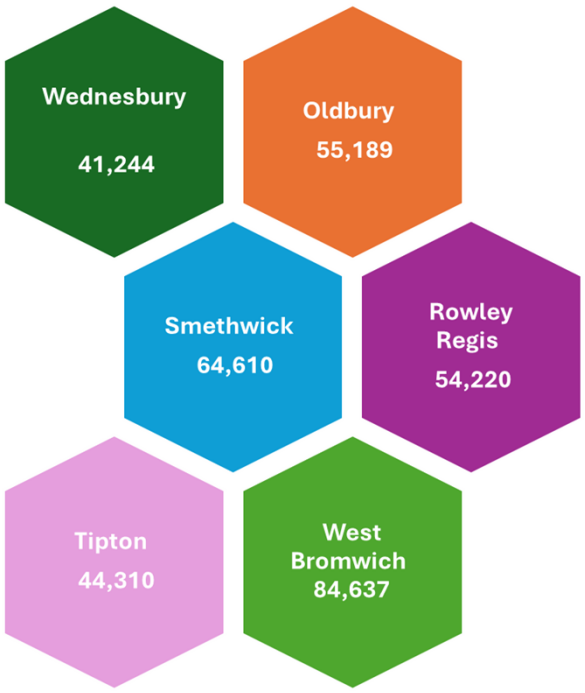
Partners have pledged to collaboratively working together,
with executive and director level representation from:

- Sandwell Primary Care Collaborative – *representing all GPs two PCN CD members are nominated to attend SHCP*
- Sandwell Council (Public Health, Social Care and Housing)
- Sandwell and West Birmingham Trust (SWBT), *Integrated Acute, Community and Primary Care*
- Black Country Healthcare MH/LDA Foundation Trust
- Sandwell Children's Trust
- Sandwell Leisure Trust
- Sandwell Council of Voluntary Organisations (SCVO)
- Healthwatch
- Black Country Integrated Care Board (ICB)

Together, we are committed to aligning services and developing neighbourhood teams around the six towns.

Integrated Neighbourhood Teams (INTs)

Sandwell's 6 towns each has an established INT that has developed over the past 12 months.



Teams include representatives from:

- SWBT Community Matron (*Neighbourhood*
- *Team Clinical Lead*)
- District Nursing Team
- Community Therapies
- Mental Health Services
- Social Care and Social Workers
- Social Prescribers
- Public Health Development Workers

(*linked to voluntary/community sector*)

As part of the Community Mental Health Transformation Programme, Primary Care Mental Health Teams have been established and will form the foundation of mental health support within the integrated neighbourhood teams.

Primary Care Integration

Sandwell has eight Primary Care Networks (PCNs), which are not geographically aligned with the towns, however in a dense urban area neither are individual GP registration patterns. As part of those 8 PCNs we also have a large vertically integrated super practice covering 50,000 registered patients that also spans the borough.

Whilst this adds complexity to our INT development, the Sandwell Primary Care Collaborative, comprising of all eight PCN Clinical Directors, supports the development of a town-based neighbourhood model. We have found that building a model around the towns our residents identify with, has helped bring services and partners together in a meaningful way. It has helped us focus on what works on the ground, rather than getting caught up in organisational boundaries. Our town-based INTs are already showing promise in strengthening day-to-day joint working and improving links with the voluntary and community sector.

Therefore, we have developed a draft Neighbourhood Model which enables primary care to be central to INT working, while not requiring time consuming and complex PCN re-configuration.

Draft Neighbourhood Model: Four Tiers

Strategic partners have agreed a draft model structured around four tiers:

Tier 1: Borough-Wide Hub – Managing complex patients with urgent escalating need
Tier 2: Neighbourhood-Based Professional INTs – Supporting proactive care for complex patients requiring multi-agency input
Tier 3: Neighbourhood-Based Coordination – Locally co-ordinated professionals offer for social prescribing, wellbeing, and non-statutory support

Tier 4: Self-Care and Community Support – Locally co-ordinated public offer for voluntary sector, and digital tools including the support to empower residents' self-care.

Pilots and Initiatives

Pilots are underway for Tier 1 and Tier 2 to clarify operating models and resource requirements. Using a Population Health Management approach and frailty datasets, patient cohorts (severe, moderate, mild) have been identified to guide intervention planning.

Tier 1 Initiative:
The inclusion of a GP and Geriatric Medicine Consultant co-located within the Care Navigation Centre. These clinicians will support Call Before Convey and the Urgent Community Response (UCR) service, enabling a higher level of positive clinical risk and intervention in the community thereby avoiding unnecessary hospital attendance/admission.

Tier 2 Initiatives:

1. Our vertically integrated practice and PCN is piloting a reactive community frailty hub to coordinate care for patients with *severe* frailty following an acute attendance or admission. The hub is GP led with MDT participation from the community team, as well as hot access to geriatric and palliative care consultants.
2. A proactive GP-led town-based MDT is using population health data to identify patients from three different cohorts, and provide them with holistic care planning and support:
    - *Moderate frailty* risk
    - High Intensity Users (HIUs) of GP services
    - HIUs of emergency care

These pilots will enable us to test whether our INT approach is improving outcomes and through ongoing testing and refinement we will then rapidly deploy our model to other patient cohorts, such as those with long term conditions.

3. Neighbourhoods within the Place

(please include whether each neighbourhood has a clinical lead, managerial lead and admin support identified):

The Sandwell Health and Care Partnership has invested in a dedicated team to lead and support our priorities of Connected Communities and Home First.

- The Chief Integration Officer is an executive level position, ensuring the voice of partnership is heard, respected and impactful at Board level across health and care.
- The Deputy Chief Integration Officer works operationally on a day-to-day basis to ensure the successful delivery of the partnership priorities and model and is supported by aligned staffing resource from the Integrated Care Board (ICB).
- Two of the PCN Clinical Directors (CDs) have dedicated paid time to lead the partnership work strategically, and two further CDs specifically lead on our connected community priority.
- The partnership resource has a dedicated senior admin lead, with support from a band 4.

At a town (neighbourhood) level we have leadership from primary care, community services and public health:

- Public health has dedicated town-based development officers working with communities and wider stakeholders to understand local needs and issues
- All eight of the PCN Clinical Directors are actively contributing to the development of our neighbourhood approach, collectively shaping a model that places primary care at its core, whilst bringing valuable insight and leadership to the process.
- Our community team (I-Cares) has identified clinical leads for each town-based INT, and provides the clinical admin to support the INT.

The partnership has now developed to a level of maturity that our neighbourhoods need more dedicated resource locally. We have an agreement that the Better Care Fund will be utilised to introduce specific roles to support the delivery of Neighbourhood Health.

The proposal for this resource will be finalised following the learning from our pilot initiatives over the coming months. Dedicated neighbourhood leads are in place, and a BCF-funded coordination model (clinical, managerial, admin) will be confirmed post-pilot, with interim cover via aligned partner roles.

4. ICB Chief Executive and Local Authority Chief Executive who will act as the co-sponsors:

(full name, title and contact details)

As a requirement of this application, systems will be expected to:

- fund a co-ordination function for each neighbourhood (named clinical lead, managerial and administrative support)
- provide essential backfill for staff and similar expenses (travel, accommodation, venues) to participate in the National Neighbourhood Health Implementation Programme
- provide enabling support to progress Neighbourhood Health e.g. analytical support (see FAQs)
- provide a Neighbourhood Health implementation coach and project lead

Mr Mark Axcell	Mr Shokat Lal
Chief Executive Officer	Chief Executive
Black Country ICB	Sandwell Metropolitan Borough Council
Wolverhampton Civic Centre	Sandwell Council House
St. Peters Square	Freeth Street
Wolverhampton	Oldbury, West Midlands
WV1 1SH	B69 3DE
Email: m.axcell@nhs.net	Email: shokat_lal@sandwell.gov.uk

5. Mayoral combined authorities

If you are in a mayoral combined authority, please confirm that the mayor is aware of and supportive of your proposal.

Mr Richard Parker, Mayor (West Midlands) is aware of and supportive of the Sandwell submission, his signature is included at the end of the submission.

6. Neighbourhood Health implementation coach and project lead:

(full name, current role and contact details)

Each Place will need to supply a person who has existing improvement, collaboration and leadership skills and is able to work with their own initiative (see role description in the FAQs). They will be assigned full time for 12 months to act as the local Place coach, as part of the national network of Neighbourhood Health project leads, supported by the national team.

The Deputy Chief Integration Officer (hosted by SWBT) is designated as the implementation coach and project lead.

This role will be accountable to Sandwell Health and Care Partnership and report directly into the Chief Integration Officer (hosted by SWBT).

Support will be provided by the wider integration team and resources from the partners where appropriate.

Contact
Steve Phillips
Deputy Chief Integration Officer
Sandwell and West Birmingham NHS Trust
Trust Headquarters, Sandwell General Hospital, B71 4HJ
steve.phillips@nhs.net
07484 038958

Place background information

7. Does your Place have a devolved budget from the ICB? If so, how is this organised and what scope of services does it cover? (max 150 words)

The Managing Director for Sandwell (ICB) and the Director of Adult Social Care hold delegated responsibility for overseeing the Better Care Fund pooled budget arrangements. These are managed under a Section 75 agreement through the Joint Partnership Board.

For the financial year 2025/26, total BCF expenditure is £72,021,785. Our local oversight and accountability of services funded by the BCF has enabled us to reshape how care is delivered through the transformation of existing services.
Successful examples of transformation include:

- The development of the Integrated Discharge Hub
- The establishment of Harvest View, a joint health and social care intermediate care facility
- Community Offer Plus provided by the voluntary sector with an investment of £1,261,050 to support prevention

Our collaborative BCF approach has also enabled Sandwell to make strong progress in other key areas of Neighbourhood Health, such as:

- Urgent Neighbourhood Services
- Integration of Intermediate Care through the Home First approach

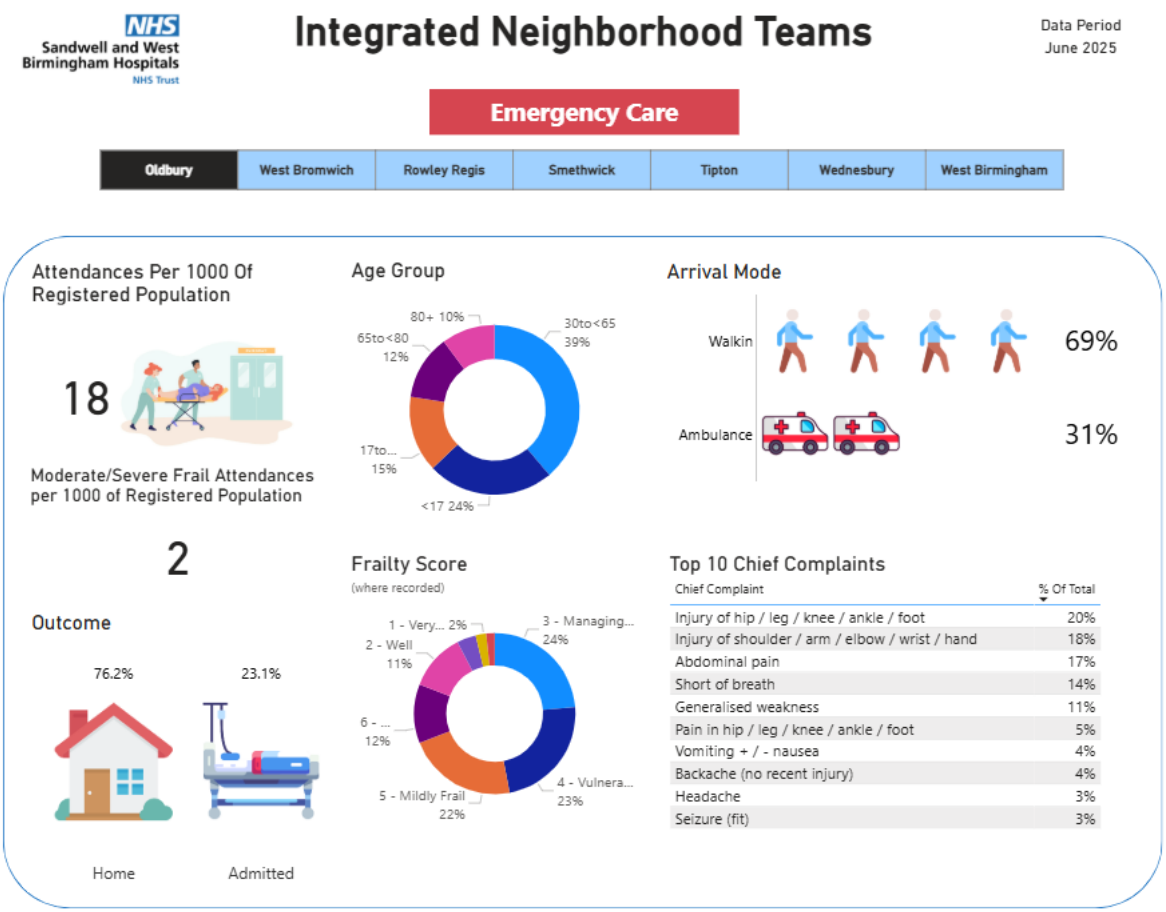
8. Do you have existing data sharing agreements between the constituent statutory organisations in this application, and if so, what do they cover? (max 150 words)

Across the Black Country all GP practices, Trusts and Social Care have signed up to the Shared Care Record, enabling the ICB to develop a strategic population health management tool. Implementation of patient level data is dependent on a S251 agreement.

Locally we have a range of data sharing arrangements in place:

- Ongoing sharing to supporting our integrated services (discharge hub and Harvest View)
- Targeted data sharing to support our pilots
- As an integrated Trust, all data is shared between acute and community services
- All PCNs have a data sharing and processing agreement, with ad-hoc data arrangements for specific services e.g. Targeted Lung Health Checks.

This local approach is supplemented by a range of information tools, for example, the SWBT Town Dashboard, pictured below, includes a demographic profile of each town and all Trust community contacts, emergency care, elective and out-patient activityfor each town.



9. Do you have a risk stratification tool rooted in primary care data that would enable you to identify the adults with multiple long-term conditions and rising risk within the Place that will be the focus of this early work? Please describe (including if you have a section 251 agreement for use of

linked patient level data for population health i.e. for both direct care and secondary use)? (max 150 words)

As noted above, the ICB has developed a strategic population health management tool, with implementation of the patient level element dependent on a S251 agreement.

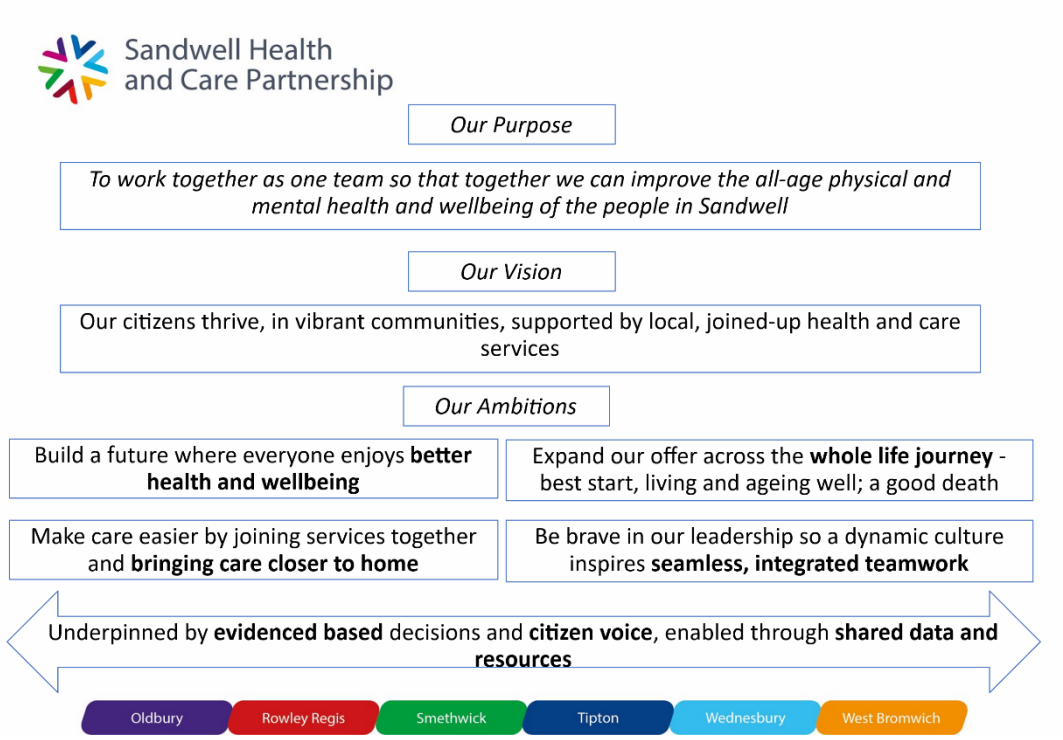
This means a single risk stratification tool is not currently in place, however practices have been supported to risk stratify particular patient cohorts with targeted tools and searches, including diabetes and frailty.

All practices have access to Ardens Manager, which, while not a population risk stratification tool, supports identification and proactive management of patients with poorly controlled conditions enabling prioritisation of vulnerable cohorts.

In addition, a Primary Care dashboard is available at Place level. It provides data on frailty prevalence (chosen cohort) and the interventions received (e.g. personalised care plans). This dashboard is instrumental in developing the right interventions for proactive care and continuity planning.

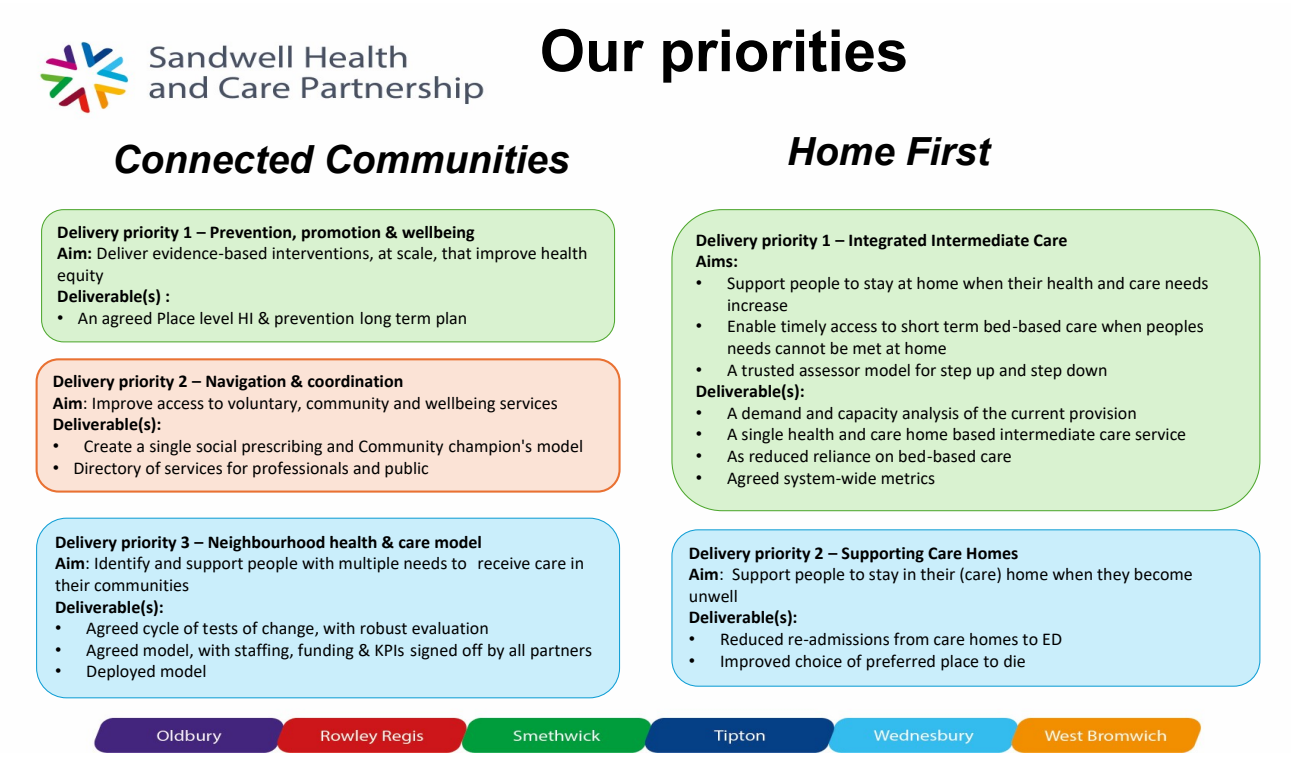
10. Describe any existing forum for CEOs of the different statutory organisations and partners (e.g. VCSE, providers) in your Place that meets regularly to support the implementation of Neighbourhood Health (ways of working, function, responsibilities, frequency). (max 150 words)

The Sandwell Health & Care Partnership (SHCP) is formally established through an Alliance Agreement and hosted within SWBTs governance. The partnership was formed to drive forward integrated ways of working with a shared purpose, vision and ambitions.



The SHCP Board, comprising executives and senior managers from all partner organisations, meets monthly to lead the strategic transformation priorities of ‘Connected Communities’ and ‘Home First’. The Board reports into both the NHS Trust as the formal host and the Health &

Wellbeing Board as the strategic oversight, thereby ensuring alignment with broader system priorities and governance structures.



Your application in local context

Please specify the following on this application form **(strictly no attachments or presentations)**.

11. Describe existing examples of integrated working in your Place or Neighbourhood and the results obtained. (max 500 words)

Sandwell has significantly advanced its Integrated Intermediate Care model as well as its investment into community services to support the closure of hospital beds. Significant progress has been achieved towards integration, facilitated through collaborative strategic management of the Better Care Fund and left shift of resources from the hospital budget into the community budget. A few highlights to note include:

The Integrated Discharge Hub (IDH) consists of co-located health, social care and ICB staff (CHC) working together to co-ordinate and plan safe home-first focused discharges. Needs are pre-empted through an admission checklist ensuring identification at the earliest opportunity thereby reducing delayed discharges. The IDH has also supported more people to be discharged home rather than into a second bed base.

The integrated Home-Based Intermediate Care (HBIC) offer includes community therapy, community care providers and the voluntary sector supporting timely high-quality pathway 1 care. HBIC enabled the closure of 27 community hospital beds, by providing access to rehabilitation and reablement within the patient's home.
Harvest View (HV) a purpose-built health and social intermediate care facility provides 80 beds for step-up and step-down reablement and enhanced assessment. HV has prevented unnecessary hospital attendances by giving direct access to community service step-up as well as

reducing permanent admission to long term care following a hospital admission by providing high quality integrated health and social care support.

Our **Community Offer Plus** which commenced in January 2025, is a collaborative service provided by the third sector working in partnership under a lead provider model. The focus is to support people to live well in their community, support recovery following discharge from bedded care (hospital and community beds), support admission avoidance and support people in crisis within the community.

Our **left shift investment** into community services has included decoupling stroke rehab to provide a dedicated community facility out of the acute environment; creating Epicentre, a nationally recognised acute-medic led service providing higher levels of diagnostics and treatment within the patients home; as well as investment into our care navigation centre and core community services creating one of the broadest offers for an alternative to hospital for GPs and the Ambulance Trust. This has enabled the closure of 90 acute adult hospital beds.

Other examples of working collaboratively across Sandwell include:

Black Country Healthcare FT in partnership with the voluntary and community sector are working in collaboration to deliver new models of care such as Talking Therapies Plus which is designed to reduce the health inequalities gap. They have also partnered with the local authority to deliver welfare rights support for people with a severe mental illness, putting more pounds back into people's pockets.

Sandwell PCNs are working in partnership with Community Services and Public Health to deliver a standardised approach for frailty. Using eFI and the Rockwood Tool there is an agreed model of screening for frailty in the over 65's, which has increased structured medication reviews and proactive falls risk assessments for all frail patients.

12. What do you hope to achieve from being part of the National Neighbourhood Health Implementation Programme? (max 150 words)

We intend to leverage our proven track record in integrated intermediate care to lead the next phase of neighbourhood transformation using a test and learn approach. By embedding robust population health management approaches across our existing neighbourhood infrastructure, we aim to deliver proactive, data-driven prevention and early intervention in communities with deep-rooted inequalities.

This programme provides a pivotal platform to accelerate delivery of our model and scale our ambition. It enables us not only to test and refine innovation at pace but to act as a demonstrator site for national learning. We bring considerable expertise in integrated care design, workforce transformation, and local co-production. We are keen to share and to shape the future of neighbourhood health delivery across the NHS.

Our participation is both a strategic opportunity and a responsibility: to lead, learn, and contribute meaningfully to a sustainable, equitable national model.

13. What will you contribute to the National Neighbourhood Health Implementation Programme that other Places can learn from? Please provide details of the specific interventions that have delivered results. (max 200 words)

Sandwell brings valuable learning to the programme through its experience of delivering integrated care in a complex geography with high levels of deprivation, diversity and inequality.

We bring a proven track record of partnership working and integration evidenced by being the only system nationally to significantly decrease its hospital bed base by redistributing funding to deliver more care in the community.

As outlined above, our strong approach to the integrated commissioning and delivery of our intermediate care services is something we believe others can learn from; by creating joint budgets and teams, we have reduced barriers to co-ordinated step up and step-down capacity thereby supporting more people to stay at home or get home more quickly.

This community first focus means we are one of the few areas to see an actual decrease in attendances and admissions for over 65s and care home residents. Our insight into financial flows, provider collaboration, and workforce models in vertically integrated systems will support national learning. We are committed to sharing tools, operating models, and lessons on aligning incentives, co-management and neighbourhood leadership.

We believe our experience will help shape national thinking on how to deliver neighbourhood health in diverse and dynamic systems.

14. How will you share learning within your System? (max 200 words)

Our system-wide governance is already well established for shared learning, reflection, and strategic innovation. Through the Sandwell Health and Care Partnership—reporting into all partner Boards, the ICB Out of Hospital Board, and the Health and Wellbeing Board—we have a robust platform to embed and disseminate learning at pace.

Our Place Professionals Network functions as a dynamic, multi-disciplinary action learning set. It brings together system leaders, operational managers, and frontline professionals to co-produce solutions and jointly resolve delivery challenges.

Participation in the NNHIP will turbocharge our local improvement and formalise our role as a faculty site, bringing national insights, benchmarking opportunities, and structured external challenge into our Place. We are committed to feeding this learning into our neighbourhoods, supported by our strong communications infrastructure including newsletters, joint staff briefings, professional learning events, communities of practice and system wide innovation showcase as well as supporting other Places within the ICS to adopt tested models and approaches.

15. How will you reach, engage and improve outcomes for the 20% most deprived population as identified by the Index of Multiple Deprivation (IMD)? (max 200 words)

The Health and Well-being Board has recently considered findings of its review by the Local Government Association and is now taking forward an ambitious programme of work. One element of this is to strengthen the JSNA to include a fuller data set with information from partners, including

the VCS, as well as richer information from smaller scale initiatives to inform our decision making in new ways.

We will soon be launching the consultation process to develop our next Joint Health and Well-being Strategy, due at the end of 2025. This will engage our stakeholders and residents in identifying key priorities, and narrowing health inequalities will form a core part of all associated delivery programmes.

Reach into diverse communities is already strong in the Borough, with the Council leading the way, strengthening our integrated approach means health partners can benefit from this in new and exciting ways. A strong evidence base about what works is being built through the recently established and externally funded Health Determinants Research Collaboration (HDRC), based in the Public Health Department at the Council.

16. Please tell us about any other enablers you have implemented or are progressing to support sustaining or scaling neighbourhood working. For example, shared digital patient record, pooling of resources or estates, supporting GPs to work at scale and the development of neighbourhood and multi-neighbourhood providers, left shift of funding, training and development, Neighbourhood Health approaches with other specific population cohorts. We would be grateful if you could provide specific information on any local assets you have already that could support meeting the commitment to have a Neighbourhood Health Centre in every community, as set out in the 10 Year Health Plan. (max 300 words)

Within Sandwell there has been longstanding investment into primary and community care estate that has seen the development of modern health centres within each of the towns. This provides access to a range of clinical and non-clinical spaces to support Neighbourhood Health Centres.

We are digitally mature. All Sandwell services operate an electronic patient record, with Sandwell community services uniquely in the Black Country using a full EPR (SystmOne). All statutory partners across the Black Country are signed up to the Shared Care Record, creating a unified digital infrastructure that enables true multidisciplinary working and seamless care transitions.

Our system is at the forefront of new provider models. SWB is an integrated acute, community and primary care provider, laying the foundations for the development of an integrated health organisation whilst the Sandwell Primary Care Collaborative is developing Nexus—an at-scale general practice provider—creating the foundation for a multi-neighbourhood provider partnership with the Trust.

Our proven track record of managing a multi-million-pound joint delegated budget (BCF) to successfully deliver efficiencies, improvement and integration provides a strong foundation to enable further local delegation. The NHS Trust recognises the value of a left shift of funding having invested significantly into its community services to support the reduction of beds in the new hospital.

17. Please list any other national pilots or initiatives you are involved in. (max 150 words)

The Black Country has been identified as one of the areas to participate in the national Frailty Improvement Collaborative. Detail on the programme has only recently been circulated due to the national team awaiting publication of the 10-year plan. Sandwell will now be working with the collaborative to further drive the innovation in our frailty model, recognised nationally* for its

success in reducing hospital-based care and ensuring high quality and timely care when hospital is necessary.

** Ranked Number 1 nationally for GIRFT Elderly Care Index of Patient Flow*

18. Please identify any particular aspects of Neighbourhood Health (in addition to the initial shared priority of adults with LTCs and risking risk) that you are particularly interested in developing or contributing to (either specific population cohorts, or enabling agendas such as financial flows, digital, workforce, estates, supporting GPs to work at scale and the development of neighbourhood and multi-neighbourhood providers). (max 150 words)

There is a strong modern community estate in Sandwell making us well placed to deliver the national commitment to Neighbourhood Health Centres. The facilities are a mix of NHS Prop Co and CHP, and with the recent suggestions regarding buy-back of estate into local ownership this represents an area to explore nationally.

We are actively shaping the future of contractual partnerships between NHS trusts and general practice at scale. In an urban setting like Sandwell, we believe the Multi-Neighbourhood Provider model is essential. However, new legal mechanisms are urgently needed to enable formal collaboration between NHS Trusts and PCN-led companies.

As an integrated Trust, we have local experience of moving funds between acute, community and primary care – the challenges are not insignificant. We want to lead the redesign of financial flows and productivity measures to remove disincentives for left shift. It's time to industrialise funding alignment across sectors.

Declaration

This is to be completed by all CEOs (or equivalent) and PCN clinical directors in each constituent organisation in your Place.

We collectively agree to:

- endorse this application to join the National Neighbourhood Health Implementation Programme
- support the Place team to deliver the objectives of the programme
- contribute to nationwide learning, sharing and capability building for Neighbourhood Health

We commit to the continued implementation of Neighbourhood Health, including assisting other Places in subsequent phases of the work.

1	Constituent organisation	Sandwell Primary Care Collaborative
	Name and role	Tehmina Rahman, Chair of Sandwell Primary Care Collaborative (on behalf of all PCN CDs)
	Signature	

2	Constituent organisation	Sandwell Metropolitan Borough Council
	Name and role	Shokat Lal, Chief Executive

	Signature	

3	Constituent organisation	Sandwell and West Birmingham NHS Trust
	Name and role	Diane Wake, Chief Executive
	Signature	

4	Constituent organisation	Black Country Healthcare NHS Foundation Trust
	Name and role	Kuli Kaur Wilson, Deputy Chief Executive
	Signature	

5	Constituent organisation	Sandwell Council of Voluntary Organisations
	Name and role	Mark Davis, Chief Executive
	Signature	

6	Constituent organisation	Black Country ICB
	Name and role	Mark Axcell, Chief Executive
	Signature	

6	Constituent organisation	West Midlands Combined Authority
	Name and role	Richard Parker, Mayor
	Signature