South East London Interface Working Maturity Matrix

1. Introduction

The South East London (SEL) maturity matrix is designed to define and measure progress in interface improvement projects, as well as to assess the extent to which the principles outlined in the SEL Interface Consensus document[1] have been embedded in practice. The matrix works alongside the South east London primary and secondary care interface consensus document and is aligned with the priorities of the National Neighbourhood Health Implementation Programme (NNHIP) and other initiatives across South East London that aim to optimise interface working. By providing a structured framework, the tool enables local interface teams within the South East London Integrated Care System (SEL ICB) to identify current strengths, measure adoption of agreed principles, highlight gaps, and prioritise areas for further improvement.

2. Aims and purpose

The purpose of this maturity matrix is to:

- Assess readiness for process improvement across PSCI structures.
- Enable targeted action for operational improvement within local PSCI teams.
- Provide a common framework for evaluating governance, engagement, communication, integration, and sustainability.
- Support strategic planning by aligning local work with national priorities (Red tape challenge, GIRFT), integrators. NNHIP and the SEL neighbourhood development programme.

3. Instruction for use

Scope of Assessment

- In scope: South East London place-based Interface Groups and associated forums

Maturity Levels

- Level 1 - Initial: Ad hoc processes, improvement work not started, guidance is not adopted
- Level 2 - Developing: Some structures and processes in place, early adoption of improvements and guidance

[1] South east London primary and secondary care interface consensus document

- Level 3 - Established: Structures and processes are fully adopted, guidance and improvement projects are now business as usual.

Scoring

- For each dimension, assign a level (1-3) based on evidence from forums, reports, and stakeholder feedback.
- Use qualitative notes to capture context and examples.

Next Steps

- Develop an action plan - Use the identified gaps between current and target maturity levels to plan specific actions for development
- Integrate and monitor progress - Revisit the matrix regularly (e.g., annually) to review improvements, update your assessment, and maintain alignment with the wider system.
- Engage stakeholders - Use the results to support discussion between stakeholders and ensuring a shared understanding of progress and priorities.

Table 1 - Dimensions of access

Dimension	Indicator of maturity	Source/alignment
Governance	Clear, proportionate governance arrangements that define scope, accountability, decision-making authority, and reporting lines for PSCI work.	NHS England, Working Together at Scale[2] (provider collaboratives): *"The 'right' form and governance arrangements should flow from the shared purpose and objectives of the provider collaborative… governance arrangements that are proportionate."*
Leadership and Agency	Named leadership and coordination capacity to own PSCI improvement, manage workstreams, and resolve interface issues.	GIRFT[3] : "All NHS secondary, community and mental health care providers [should] identify an individual or team to act as an 'interface liaison officer' to manage local issues." Integrators: "Building trust, resolving conflicts, and embedding community leadership." INT/Integrators[4]: Building trust, resolving conflicts, and embedding community leadership in INT development.
Engagement/culture	Active, balanced participation from primary and secondary care with a shared improvement culture and mutual accountability.	GIRFT: *"Providers, primary care networks, local medical committees (LMCs) and ICBs to fully participate in local strategic and operational interface groups to resolve local issues."* Integrators: *"Enabling shared learning."* INT/Integrators: Enabling shared learning Facilitating cross-borough dissemination of best practices and scalable integrated models. L&S forum: shared education and cultural alignment opportunities
Integration & Digital	Digital and pathway integration that enables shared working across organisations and settings.	GIRFT: Improve IT by adopting the electronic prescribing service (EPS) in secondary care and increasing access to shared care records. This should include greater interoperability of electronic patient records (EPRs), starting with the sharing of structured medication information. Integrators/INT[5]: Aligning workforce, governance, risk, finance, estates, and digital

[2] Provider Collaboratives guidance
[3] GIRFT – Bridging the Interface Report

[4] Neighbourhoods INT: (NHS England » Neighbourhood health guidelines 2025/26)

[5] Neighbourhood team development: Neighbourhood healthcare maturity matrix | Good Governance

		systems across sectors to operationalise neighbourhood-level integration. Ensuring a standard core community offer across all neighbourhoods that aligns with consistent integration functions. NNHIP[6]: Leveraging technology and data to improve care coordination and outcomes.
Performance monitoring & KPIs	Use of agreed metrics to monitor interface performance, variation, and improvement impact.	GIRFT: "All secondary, community and mental health care providers to continue collecting and collating relevant data for 6-monthly self-assessments… using the GIRFT checklist."
Advice & Guidance (A&G)	Consistent, timely, high-quality use of A&G that supports appropriate referral, facilitates shared care, and meets agreed SEL KPIs for responsiveness, quality, and outcomes.	7.0 South east London primary and secondary care interface consensus document
Clear point of contact	Clear points of contact between primary and secondary care, with defined responsibilities, escalation routes, and response expectations, as set out in SEL RACI matrix for roles and responsibilities across the interface.	3.0-6.0 South east London primary and secondary care interface consensus document
Prescribing	Safe, consistent prescribing across the interface with clear responsibility for initiation, continuation and monitoring; adherence to shared care agreements; and alignment with SEL interface prescribing policy	8.0 South east London primary and secondary care interface consensus document
Communication (Discharge summaries, clinic letters and fit notes)	High-quality, timely clinical communication between care settings (including discharge summaries, clinic letters and fit notes) meeting SEL communication standards for content.	2.0 South east London primary and secondary care interface consensus document
Sustainability and continuous improvement	Capacity to sustain PSCI improvement through workforce planning, funding, learning, and scaling of effective models.	L&S interface objectives: "Evaluate impact and review KPIs; embed shared health promotion agenda; scale successful models." Integrators: "Improving sustainability… offering targeted support to practices or teams under strain."

[6] NNHIP : https://neighbourhood-health.co.uk/about

4. PSCI Maturity matrix

Dimension	Level 1- Initial	Level 2- Developing	Level 3 – Established
Governance	• PSCI activity occurs through ad-hoc forums with no scope or decision-making authority • Governance arrangements are informal	• Purpose and scope for PSCI activity are partially defined • governance arrangements exist but are inconsistently applied • Variable membership and unclear reporting lines.	• Governance arrangements are clearly defined and documented • PSCI forums meet regularly, with agreed membership, delegated authority, and clear reporting into place and system governance structures.
Leadership & Coordination	• No named individual or team is responsible for coordinating PSCI activity or managing interface issues • Escalation is informal and inconsistent.	• Named local leads or teams exist for PSCI, but roles, authority, or coverage of key workstreams are incomplete or inconsistently applied.	• Named PSCI leads or liaison roles are in place with clear authority to coordinate work, manage escalation, resolve interface issues, and oversee all agreed PSCI workstreams captured within the SEL consensus document.
Engagement/ Culture	• Engagement from primary and secondary care is sporadic • Participation is limited and/or unbalanced in representation from both sides of the interface	• More regular engagement is evident, but participation is unbalanced across the interface and dependent on individuals rather than organisational commitment.	• Consistent, balanced engagement from primary and secondary care organisations • Evidence of shared learning, joint problem-solving, and collective ownership of PSCI improvement.

Integration & Digital	• Pathways and systems are fragmented, with limited digital enablement and minimal sharing of information across the interface.	• Shared care protocols and digital tools are implemented in some pathways or services, with partial interoperability or reliance on local workarounds.	• Shared care protocols and interoperable digital systems (e.g. EPS, shared care records) are embedded across the interface.
Performance monitoring & KPIs	• PSCI performance is not routinely measured • data is not collated or used to inform improvement.	• Some PSCI metrics are collected locally or intermittently, but reporting is inconsistent and rarely informs decision-making.	• Agreed PSCI KPIs are routinely collected, reported, and reviewed • data is used to identify variation, support GIRFT self-assessments, and drive continuous improvement.
Advice & Guidance	• A&G is available inconsistently • Response times are unreliable and often outside agreed standards • Poor-quality responses or redirection back to referral is common • Little monitoring or a lack of adoption of the SEL A&G KPIs	• A&G is in regular use across most specialties • Response times and quality are variable but improving • Early adoption of SEL A&G KPIs and feedback mechanisms	• A&G is the standard, embedded route for appropriate clinical queries • All specialties meet agreed SEL A&G KPIs on timeliness and quality • Data is routinely reviewed and informs service redesign and education
Clear point of Contact	• SEL RACI for roles and responsibilities across the interface not implemented • No consistent or reliable mechanism for contact between sectors	• SEL RACI for roles and responsibilities across the interface is partially implemented • Contact mechanisms in place but variably used or understood	• SEL RACI for roles and responsibilities across the interface is fully implemented and understood across organisations

	• Escalation routes and accountability unclear	• Some defined response expectations but not consistently met	• Clear contact points consistently used by primary and secondary care
Prescribing	• Limited adoption of SEL prescribing principles from the consensus document	• Partial adoption of SEL prescribing principles and shared care agreements • Increasing clarity on initiation vs. continuation responsibilities • Shared care arrangements are in place for some medicines/conditions • Ongoing work to reduce inappropriate transfer of workload	• Full adoption of SEL prescribing consensus principles across pathways • Shared care agreements are routinely applied and reviewed • Initiation, continuation and monitoring responsibilities are clear and accepted • Minimal escalation or conflict regarding prescribing responsibility
Communication (Discharge summaries, clinic letters and fit notes)	• Limited adoption of SEL communication standards • Quality and content are inconsistent	• Partial implementation of SEL communication standards • Standardised templates or minimum datasets used inconsistently	• Full adoption of SEL communication standards • Discharge summaries, clinic letters and fit notes are consistently clear on responsibility and timeframes, and all fields in the standards are completed for each letter • Regular audit and feedback cycles sustain compliance with standards

Sustainability	• No plans or resources are in place to sustain PSCI improvement	• Time-limited or non-recurrent support exists for PSCI roles or initiatives, with limited evaluation or scaling of learning.	• PSCI improvement is sustained through recurrent funding, embedded improvement cycles, regular evaluation of impact, and scaling of effective models across SEL.