



Department
of Health &
Social Care



England

National Neighbourhood Health Implementation Programme (NNHIP) - Wave One Summary of Achievement Report

Rotherham Place

25th March 2026

Context

This report summarises the achievements of Rotherham place during wave one of the National Neighbourhood Health Implementation Programme (NNHIP), running between September 2025 and March 2026.

The insights from this report have been combined from the following returns submitted by places during the programme:

- Initial Model Neighbourhood baselining exercise
- Place proformas
- 360° assessment of collaborative behaviours
- February Structured conversation - Maturity Framework

Place Overview - Rotherham

Place	Rotherham	NNHIP Focus (which specific cohort within long term conditions and rising risk are you focussing on?)	Cohort 1 Prevention Patients eligible for the Over 40s Health Check who have not accessed the service, particularly in areas of higher deprivation. Cohort 2 Rising Risk Patients aged 18–39 years with 1 physical long-term condition (Diabetes, Hypertension, Asthma, Cardiovascular disease AND co-existing anxiety and/or depression). Cohort 3 Complex frailty Patients living independently who have 4 or more comorbidities AND 1 or more unplanned hospital admissions
Local Authority	Rotherham Metropolitan Borough Council		
ICB cluster	South Yorkshire ICB		
Region	NE&Y		
National Coach	Siobhan Taylor		
Local Coach	Joanne Martin		
Your Place and its population	rural, urban, 35 IMD rank of average score	NNHIP cohort (#)	<i>Cohort 1 TBC Cohort 2 c.1,230 Cohort 3 c.2,265</i>
		People supported (#)	<i>Work to commence in April 26</i>
		Neighbourhoods (#)	<i>All 6 PCNs</i>

Instructions for completing this document (please delete once completed)

The following slides provide an opportunity to reflect on your achievements, capture challenges, record your next steps and set out the support you need.

Please reflect on your two 360 collaborative assessments (in annex) and the conversations you had with partners at the regional event on celebrating success. Then revisit the KLOES in the maturity framework for each domain, and update slides as follows:

- Slide 5 – This is a summary of your 360 collaborative assessment – please do not edit.
- Slide 6 - This is pre-populated from structured conversation 1. Please update as needed. You will also have been provided with a more detailed summary in the accompanying word document – please add to or correct any of this detail as appropriate.
- Slide 7 - This is pre-populated from structured conversation 1. Please update as needed.
- Slide 8 – This slide refers to the future and is pre-populated wherever possible but will require further input and information.
- Slide 9 – This is a case study. Please complete the template using an example that you think is the most interesting example of progress in your Place.

Collaborative behaviours within the place

Increase of ≥5	
Increase of <5	
Decrease <5	
Decrease of ≥5	

The table below shows the Place-level analysis of the 360° assessment of collaborative behaviours which was conducted in October 2025 and February 2026. Respondents were asked to rate themselves and their places against a series of collaborative behaviours. The results represent the percentage of respondents who agreed or strongly agreed with each of the questions.

Question	Perspective	Cycle: October 2025	Cycle: February 2026	Change from Oct 25 to Feb 26
		33 Responses	24 Responses	
Understanding roles and responsibilities	Self	85%	83%	-2%
	Collective	67%	63%	-4%
Knowing who to collaborate with and when	Self	94%	88%	-6%
	Collective	73%	75%	2%
Treating colleagues and partners with respect	Self	100%	96%	-4%
	Collective	94%	92%	-2%
Trusting colleagues to carry out their roles	Self	97%	92%	-5%
	Collective	88%	88%	0%
Working towards shared priorities	Self	100%	92%	-8%
	Collective	67%	71%	4%
Making decisions in line with priorities	Self	97%	79%	-18%
	Collective	73%	75%	2%
Sharing relevant and timely information	Self	100%	96%	-4%
	Collective	64%	75%	11%
Working together to find solutions	Self	94%	96%	2%
	Collective	76%	79%	3%
Seeking engagement and involvement of communities	Self	88%	92%	4%
	Collective	48%	54%	6%
Supporting and recognising colleagues	Self	97%	100%	3%
	Collective	76%	79%	3%
Seeking and providing feedback	Self	91%	92%	1%
	Collective	67%	83%	17%
Working flexibly to meet need community need	Self	82%	96%	14%
	Collective	64%	67%	3%

Maturity Framework – progress so far: Rotherham Place

Domain	Mobilising			Developing			Maturing			Optimising		
	30%	60%	90%	30%	60%	90%	30%	60%	90%	30%	60%	90%
1. Pop health...	30%	60%	90%	30%	60%	90%	30%	60%	90%	30%	60%	90%
2. New model of care...	30%	60%	90%	30%	60%	90%	30%	60%	90%	30%	60%	90%
3. Community led solutions...	30%	60%	90%	30%	60%	90%	30%	60%	90%	30%	60%	90%
4. Person centred co-man...	30%	60%	90%	30%	60%	90%	30%	60%	90%	30%	60%	90%
5. System integration...	30%	60%	90%	30%	60%	90%	30%	60%	90%	30%	60%	90%

Enabler	Mobilising			Developing			Maturing			Optimising		
	30%	60%	90%	30%	60%	90%	30%	60%	90%	30%	60%	90%
A: Leadership...	30%	60%	90%	30%	60%	90%	30%	60%	90%	30%	60%	90%
B: Digital...	30%	60%	90%	30%	60%	90%	30%	60%	90%	30%	60%	90%
C: Estates...	30%	60%	90%	30%	60%	90%	30%	60%	90%	30%	60%	90%
D: Strategic Commissioning...	30%	60%	90%	30%	60%	90%	30%	60%	90%	30%	60%	90%
E: Workforce...	30%	60%	90%	30%	60%	90%	30%	60%	90%	30%	60%	90%
F: Evaluation...	30%	60%	90%	30%	60%	90%	30%	60%	90%	30%	60%	90%

■ Sep 25
 ■ Feb 26
 ■ Mar 26

Key: % Progress

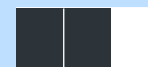
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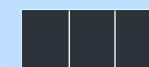
30



60



90



Reflection on your maturity and progress

What have we achieved?

- A shared, system-wide ambition to accelerate integrated working, harness data and intelligence at scale, and transform outcomes for our communities through bold, collaborative action.
- A strengthened governance structure established within the Place Board, reporting to the Health and Wellbeing Board, providing a clear framework for neighbourhood-level working.
- System-wide workshops held to build shared understanding and align priorities across partners.
- Data-sharing and processing agreements developed and formally signed by all Place partners, including all 28 GP practices.
- Population health data reviewed and used to identify priority cohorts for targeted intervention.
- Operational workshops undertaken to refine cohort insights and develop detailed work plans.
- A central insights hub linking consultation data with health, care, and demographic information, with plans to include social care datasets.
- An embedded risk-stratification tool to prioritise working with those in identified cohorts who need it the most.
- Access to the Rotherham record, with progress towards adopting the Yorkshire and Humber Care Record for wider information sharing.

What helped us get there?

Good foundations!

Shared ambition and well established place partnerships over the last 10 years meant that we already had a strong approach to system wider leadership to base neighbourhood discussion's upon.

We also had models of good practice in relation to integrated teams, for example:

- Proactive care models in place with structured monthly MDTs based on risk stratification including social prescribing models delivery by the VCS.
- Vulnerable patients pathway, bringing in partners to discuss this cohort.
- Transfer of Care hub, for admission avoidance and speedy discharge planning across health and social care.
- Integrated mental health community team, including joint funded ARRS roles across primary care and community MH team.

Leaders recognise the need to work together and have open and transparent conversations about issues

One system for community health - SystmOne is used across all Rotherham community services and 27/28 GP practices – this has made data sharing much easier.

Challenges and Barriers

Previously limited data-sharing across partners to be able to truly measure impact. This was overcome by developing and signing data-sharing and processing agreements across all Place partners, including all 28 GP practices.

Difficulty identifying priority cohorts initially. This was overcome by reviewing population health data and embedding risk-stratification tools.

What that means for your Place

This directly relates to the information in SC1 e-from and our key KLOES of successes and barriers.

Emerging outcomes

Leadership & Governance

- A more mature, transparent, and collaborative leadership culture, with cross-organisational discussions now routine.
- Stronger shared accountability, with partners increasingly aligning strategies and decision-making through the Place Board and Strategic Delivery structures.

Integrated, Proactive Care Model

- Shift from reactive to proactive care, evidenced by growing use of risk stratification, MDTs, and anticipatory planning across cohorts.
- More seamless, wrap-around support for residents.
- Earlier identification of unmet need, with targeted health checks and data-driven cohort identification starting to surface hidden demand.

Workforce & Culture

- Increasingly connected, multi-disciplinary working, with teams knowing each other better and responding more quickly to emerging needs.
- Greater trust and autonomy for frontline staff, supported by shared records, digital tools, and clearer pathways.
- Growing capability in whole-person care, integrating physical, mental health, and social determinants across pathways.

What can we learn from work to date?

Data-Led Targeting Strengthens Decision-Making

- We have begun to *properly* use population-health insight to identify priority programme areas, helping us justify targeting resources where they will have the greatest impact, especially in communities with unmet or hidden need.

Integrated MDT Working Creates Smoother, More Coordinated Care

- Testing neighbourhood-based MDT approaches has shown that when primary care, community, acute, mental health, social care and VCS partners operate as one team, duplication reduces and people experience more consistent, whole-person support.

Organisational Development Underpins True Partnership Working

- The programme has reinforced the need for a culture that is open, transparent, and willing to tackle shared issues together, recognising that system-level problems require system-level solutions.

A Test-and-Learn Approach Is Essential for Progress

- We are learning the value of rapidly testing new models, with the freedom to get things wrong at first—knowing that continuous refinement, iteration and honest reflection are the quickest routes to getting things right.

Wider learning and connections

How are you working with the ICB on plans for left shift and committed investment for 2026/27?

- The ICB are a key partner, working with us through joint planning, shared intelligence, and aligned neighbourhood priorities to shape the left-shift model and secure committed investment for 2026/27.

How have you influenced policy or national programmes through the programme – e.g. coproduction work with national programmes, joining the payments work, digital EOI etc

- Proactively sharing learning, challenges, and solutions through our participation in community-of-practice workshops, regional events, and ongoing engagement channels such as the national WhatsApp group. We have contributed to national design and improvement work by collaborating with programme teams. In addition, we have engaged with the national Genomics team to explore how their model could be implemented across Rotherham, providing insight that will inform wider regional and national rollout.

How has the programme supported you to develop NH (communities of practice, events, coaches, networking)(please give examples)

- Provided space and mechanisms to network with others.
- Regional coach support has been invaluable in supporting local coaches, re-affirming NHIP expectations and being able to discuss and resolve programme issues

Next steps

Next Steps

Rapidly Test and Refine Priority Neighbourhood Models

- Continue running short, agile test-and-learn cycles for the Over-40s Health Checks, rising-risk adults, and complex frailty cohorts, using real-time insight and frontline feedback to refine models quickly and effectively.

Continue Embedding a Shared, Open Culture Across Partners

- Strengthen everyday behaviours that promote openness, transparency, and shared issue-resolution — including cross-organisational huddles, shared learning spaces, and joint operational decision-making.

Deepen Community Engagement to Shape Local Delivery

- Work more closely with communities and VCSE partners to co-design, test, and adapt prevention and early-support offers, ensuring they reflect what works most effectively for each neighbourhood.

Review Neighbourhood Guidance and Identify 2026/27 Focus Areas

- Re-examine the neighbourhood health guidance to identify any under-developed components, gaps, or missed opportunities, and agree the priority areas that need strengthening or initiating in 2026/27.

Future Milestones

Develop and Agree a 3-Year Neighbourhood Strategy — and Make It Visible

- Finalise and collectively agree the 3-year neighbourhood strategy, ensuring it is clearly communicated and understood by all staff across Rotherham, as well as the public, so everyone knows what we are doing and why it matters.

What support will you need to deliver your next steps?

- Ongoing access to national communities of practice to share learning, compare models, and build collective capability across systems.
- Continued opportunities to feed real-time insight, challenges, and learning directly into national teams, helping shape policy, guidance, payment models and digital approaches in a way that reflects lived experience.
- Nationally supported “time out” for Place teams to step back from delivery, reflect on learning, plan coherently, and align neighbourhood priorities — ensuring systems have the capacity to implement guidance meaningfully rather than reactively – like the workshops have provided
- Early clarity on expectations, deliverables and any updates to neighbourhood health guidance to enable confident local planning and investment.
- National endorsement of rapid testing, iteration and honest learning — including the freedom to adjust or stop approaches that aren’t working, without performance consequences.
- Access to national datasets, evaluation frameworks and analytical support to help quantify impact, refine priorities and build a strong evidence base.
- Support in developing clear, consistent messaging that helps the public, staff and partners understand what neighbourhood working is and why it matters.

Case study – Rotherham F

New content for SC2 – provide us with an exemplar case study from your area. We are interested in receiving case studies from across the Domains and Enablers of the Maturity Framework so use this as a guide for the aspects we would like to see. This case study does not have to be restricted to things that have happened in the last 6 months or solely through the programme's work, but we would like you to share your most exciting progress and not a repeat of previous case studies that existed before the programme; this could include new phases and progress of a previous example.

Context

Proactive care is personalised and co-ordinated multi-professional support and interventions for people living with complex needs. The specific aims of proactive care are to improve health outcomes and patient experience by:

1. delaying the onset of health deterioration where possible
2. maintaining independent living
3. reducing avoidable exacerbations of ill health, thereby reducing use of unplanned care.

What we did

A collaborative model was developed with the LMC, PCNs, Social Care, Community Health Teams, Mental Health Services, and the voluntary sector to create a flexible proactive care approach. Patients are risk-stratified into one of two pathways: a non-MDT pathway delivered through PCNs, GP practices, and VCS partners; or an MDT pathway, in which a multidisciplinary team—including primary care, social care, mental health, social prescribing, housing, ambulance services and others as required—comes together to develop holistic care plans that address patient needs and reduce unplanned admissions.

Outcome

- Multi-Agency Collaboration
- Comprehensive, Person-Centred Assessment
- Clear Pathway Design and Risk Stratification
- Effective Service Coordination and Navigation
- Access to Commissioned Support Services
- Focus on Preventing Crisis and Unplanned Admissions
- Improvements in Patient Confidence, Independence and Wellbeing
- *The key outcome is that we have been able to use this as a lever to support further development on the NNHIP programme*

Patient story – further details in the attached PDF

Before being part of the proactive care model the patient felt unsafe, isolated, overwhelmed, and stuck.

After proactive care support the patient is

Safer in her home,

More financially stable,

Socially connected,

Actively rebuilding her confidence,

Supported emotionally and practically,

Looking forward to re-joining her community,

More independent thanks to equipment fixes and enabler support

In her own experience, she has moved from crisis to stability, from isolation to connection, and from fear to hope.