National Neighbourhood Health Implementation Programme

Neighbourhood Working in Rotherham: Aligning National Expectations with Local Ambition

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Date 14th November 2025

Purpose

- Provide a shared understanding of the Neighbourhood Working Programme and its alignment with the NNHIP Compact Agreement.
- Review progress to date and the proposed delivery framework
- Provide an overview of the key priorities and tasks for Year 1, with a focus on strengthening the Proactive Care Model and refining the target cohort for rising-risk patients.
- Outline expectations around data development, governance, and reporting arrangements to the Place Leadership Team and Place Board.
- Identify immediate actions, responsibilities, and timelines to support delivery by the end of December 2025.

The NNHIP is a **large-scale change programme,** that will gather and disseminate learning to create exemplars and embed the culture required for delivery.

It will be overseen by a joint DHSC/NHSE Taskforce which reports to the Secretary of State. The Taskforce has four enabler subgroups; workforce, digital/data, funding flows and estates.

The National Neighbourhood Health Implementation Programme (NNHIP) will adopt a test-and-learn approach to support delivery

Initial focus for year one (2025/26)

Supporting progress of NbH

- Working with **one place in each system** (43) during its initial phase
- Building on learning from Places so far and co-producing **evidence-based change components**
- Establishes a **social movement for change** and knowledge spread to other places and population cohorts.

Coaching & building capacity

- **Provide dedicated coaching support and access to subject matter expertise** alongside workshops and networking to **implement change components, enable peer-to-peer learning and development of collaborative improvement and system leadership skills**
- **Build capacity and capability** in places to implement the vision and service model

Informing strategy and policy

- Informing future strategy, policy and development of NH including **identifying barriers and solutions to implementation**
- **Rigorous monitoring of outcome metrics** monthly, with ongoing rapid insights capture and evaluation to test, learn and refine

Components of NNHIP

Culture of change | External expertise | National coaches | Learning workshops and environment | Leadership development Building a social movement/Robust evaluation and monitoring of outcomes

Built on learning from places who have been progressing neighbourhood working across the country and previous programmes

The Programmes collective role is to create the conditions for NbH to flourish

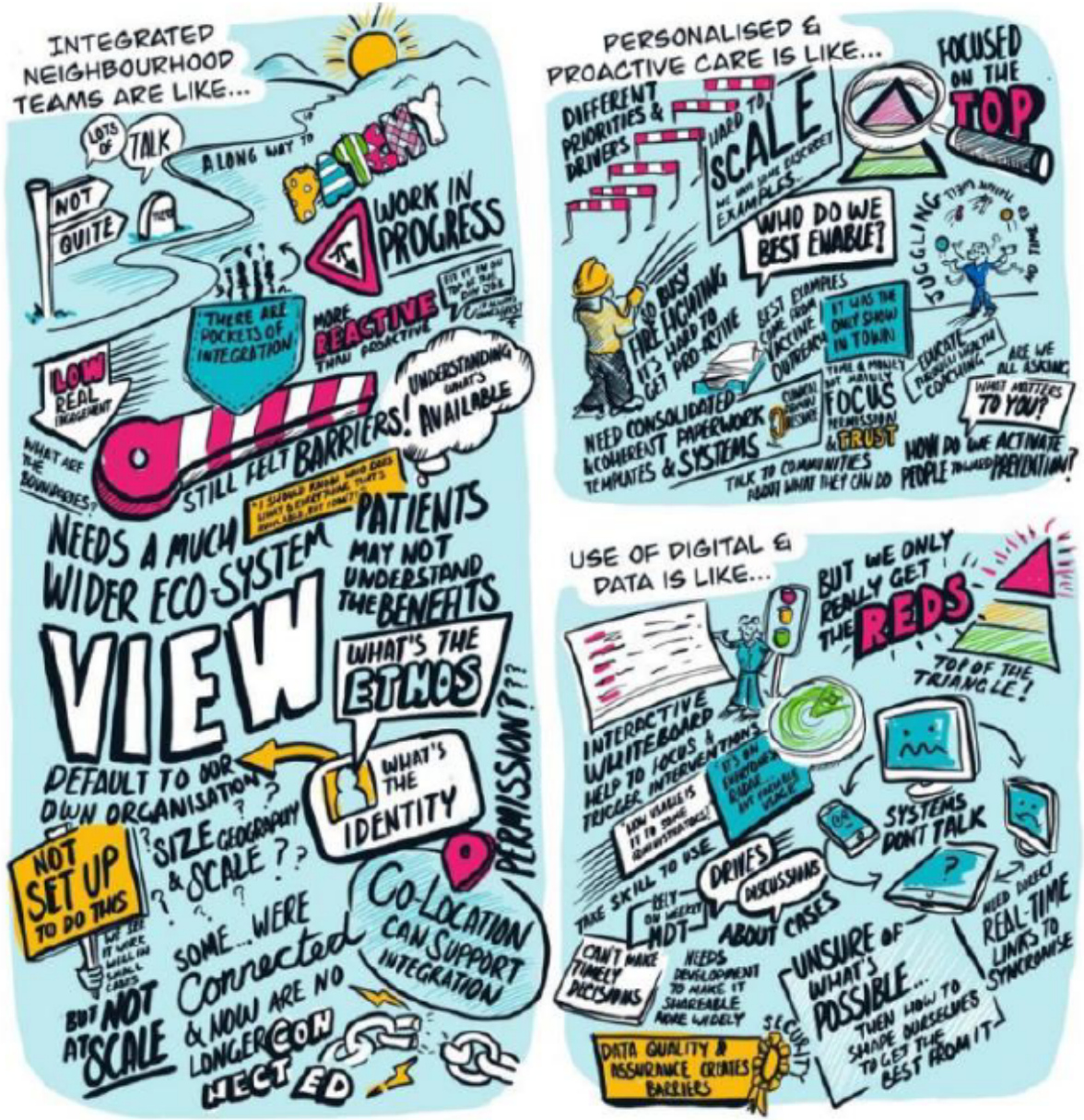
The project

- Building on existing mechanisms
- Focussing on a defined cohort
  - Adults with LTC and rising risk
  - Local prioritisation, existing pilot schemes
  - Most likely to have highest impact
- Refine, adapt, generate new ideas
- Rapid cycle testing driven by data (quants and quals)
- Shared learning

The people

- Working towards a shared purpose
- Building on relationships across the system
- Taking collective action and shared accountability
- Being curious and open-minded
- Not being afraid of ‘failure’
- Being action and delivery focused

Call to action…



This work is more than a programme – it's a social movement powered by collaboration.

Our coaches act as catalysts, helping to create healthier and equitable neighbourhoods. But it's your leadership combined with the wisdom and innovation of the neighbourhood that wi shape the national story.

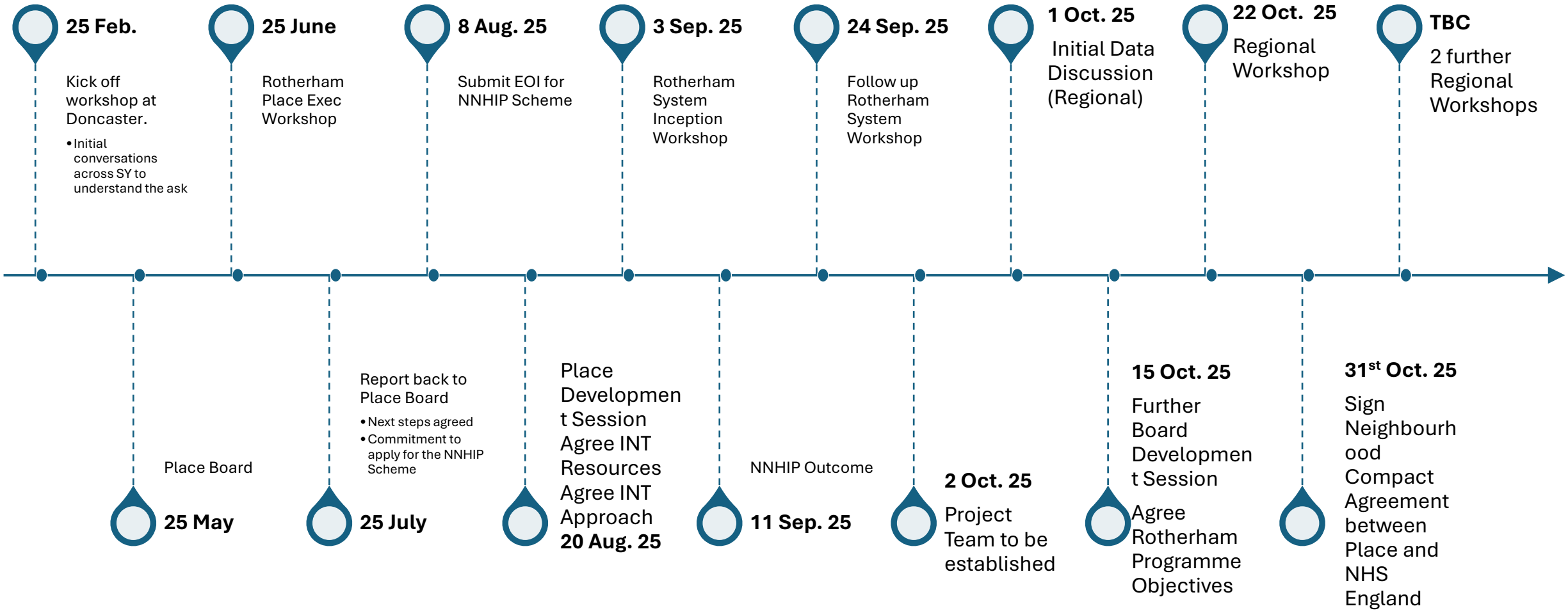
To do this well, we see the following leadership behaviours as especially important in shaping success:

- **Build trust** while also challenging and supporting others.
- **Encourage timely action and decision-making** so progress i optimised.
- **Escalate issues when needed**, ensuring barriers are addressed quickly.
- **Create psychological safety and foster collaboration**, enabling people to bring their best thinking and ideas.

Together, these behaviours will sustain momentum and ensure this movement achieves impact at both local and national levels.

Rotherham's Journey so far.....

Our Neighbourhood Journey so far.....



Context

National milestone

- Rotherham has been successful in joining the National Neighbourhood Health Implementation Programme.

Local foundation

- Two workshops have shaped shared ambitions and early priorities for neighbourhood working in Rotherham.

Partnership appetite:

- Strong commitment from local partners to build on community strengths and existing models.

Programme expectations

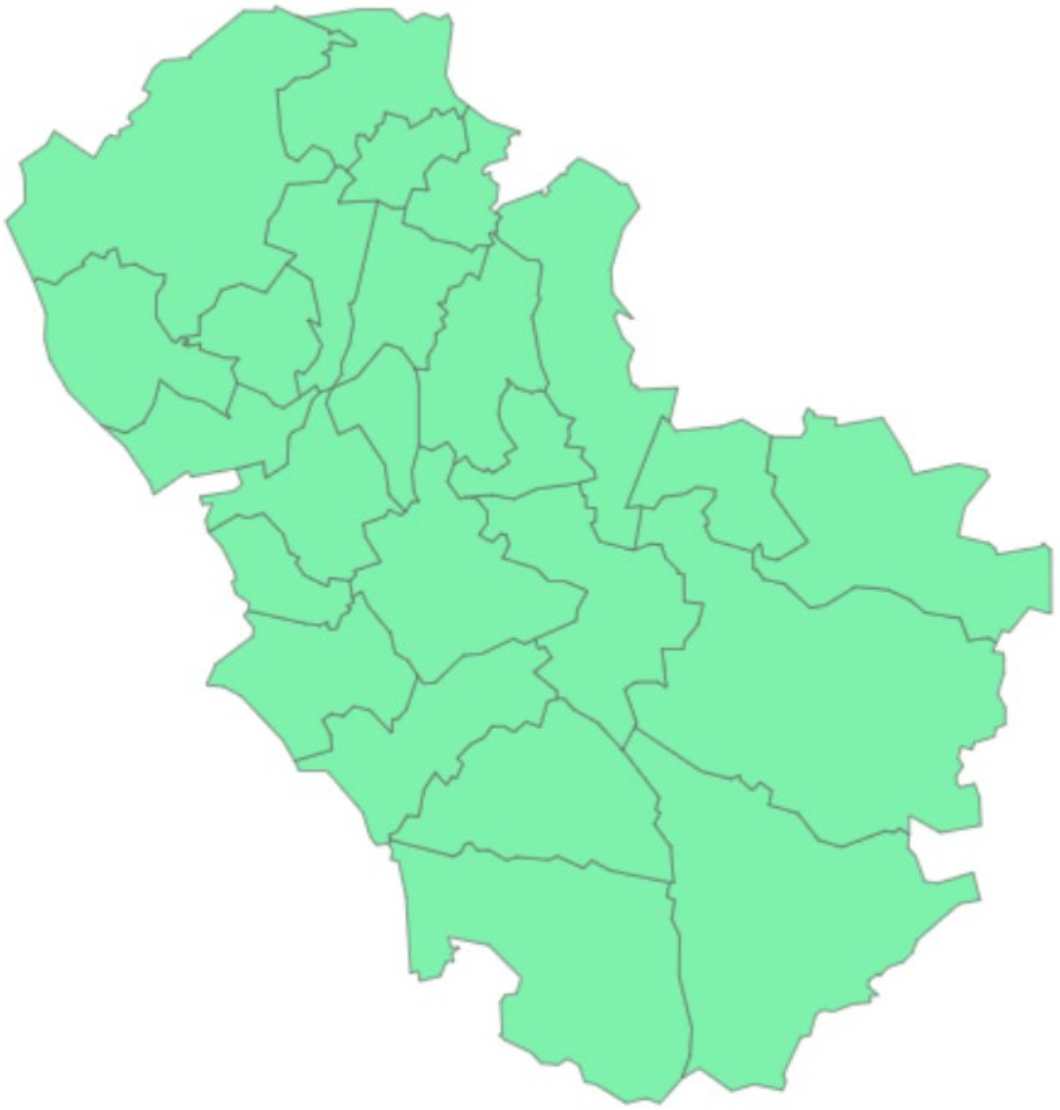
- Clear national milestones, delivery requirements, and support to accelerate progress.

Opportunity:

- Align national asks with local priorities to create a meaningful and sustainable neighbourhood model

Rotherham's Definition of Neighbourhoods

Rotherham's Definition of Neighbourhood



Place based approach to target opportunities based on need

E.G – Could be a need across all of Rotherham or targeted in a specific area where a different approach is needed.

Consistent Universal Services

Everyone gets the same baseline care and support across Rotherham.

Flexible, Targeted Support

Resources can be adapted to meet local needs — no area left behind.

Data + Community Insights

Decisions shaped by both system data and real voices from our communities

Test, Learn, Adapt

Pilot new ideas in neighbourhoods, scale up what works best.

A healthier, fairer Rotherham — built from the neighbourhood up

National ask V Local Ask

National Focus V Local Focus

<u>National Focus</u>

Adults with 2 or more LTC's with rising risk

Or

1 LTC with rising risk with

- Live in deprivation
- Belong to and ethnic minority
- Aged 18 - 40

<u>Local Focus</u>

Prevention

Children

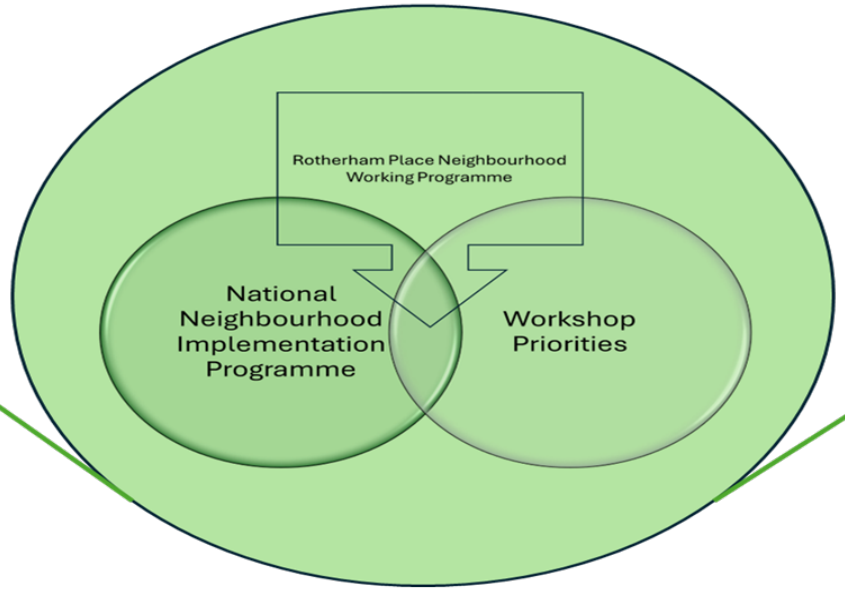
Frailty (EOL)

Back to work

Alignment of Existing Programmes & Enablers

Rotherham Approach to Neighbourhood Working

- **High Impact Areas**
  - Frailty (Proactive Care)
  - UEC
  - Respiratory
  - Diabetes
  - CVC
- Get Moving Rotherham
- Growth Accelerator Programme
- Community Services Review
- Prevention Accelerator Programme
- Weight Management Programme
- Family Hubs
- Focus On Eastwood
- Other Programme areas/ opportunities



- Digital Systems
- Data
- Workforce
- Estates
- Commissioning/ Funding

Enablers

High level focus – next 12 months

Suggested Neighbourhood Programme

National Neighbourhood Programme

Proactive Care - Enhance Current Model

- Meets national cohort request
- Rotherham Place approach based on PCN footprint
- Involves all stakeholder participation
- Baseline established
- Data driven – via Eclipse and judgement

Local Neighbourhood Programme

Place wide:

- Focus on prevention of diabetes and heart health
- Suggest focus on key drivers of LTCs
    - Smoking
    - Obesity
    - Hypertension

Targeted focus

- Eastwood Village

Revised following regional feedback

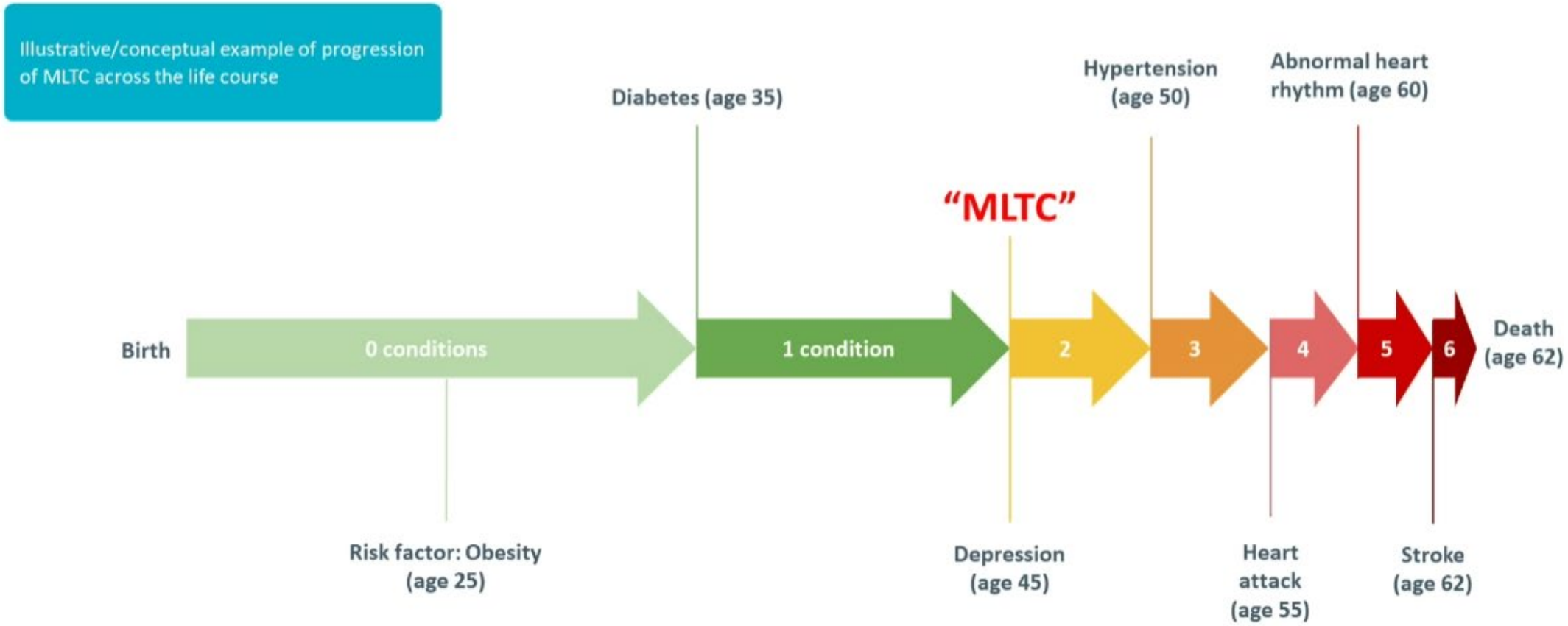
Proactive Care – Prevention

Proactive Care – Rising Risk

Proactive Care - Highly Complex Frailty

Why Proactive Care

Progression of multiple long term conditions (MLTC)



Proactive Care

Case Example – Complex MLTC

- Patricia, age 78
- Lives on her own
- Feels very lonely
- Has anxiety, HF, DM, CHD
- Recent admissions with HF
- Panics with breathlessness
- Has multiple appts
- Takes > 10 medicines
- Feels she has no control

Through neighbourhood health:

- Holistic, whole person care
- Supporting her psychosocial needs
- Care coordination and continuity
- Multidisciplinary input for complexity
- Remote monitoring and feedback
- Personalised single care plan
- Optimising proactive and reactive mx
- Avoiding inappropriate overtreatment
- Supporting her agency and confidence

Outcomes

Supports Left shift Acute to community

- Reduction in ED admissions
- Reduction in ED attendances
- Reduction in appointments to outpatients
- Less handovers

Benefits to the patient

- Feels in control of her health
- Less isolation
- Better continuity of care

Proactive Care

Outcomes

Supports Left shift Acute to community

- Less DNAs
- Reduction in ED admissions
- Reduction in ED attendances

Benefits to the patient

- Feels in control of his health and self managing his condition
- Extended healthy years of life
- Extended life expectancy
- Potential reduction in further LTCs
- Better support for his children
- No longer in debt

Case Example - Rising Risk

- Mark, age 35
- T2D for a few years
- Works on building site
- Irregular eating habits
- Living with obesity
- Struggling with debt
- Young children at home
- Feeling overwhelmed
- No response to appt invite

Through neighbourhood health:

- Proactively identifying and reaching out
- Understanding what matters to him
- Helping him access debt advice
- Supporting his psychological needs
- Clinical reviews outside of core hours
- Early identification of complications
- Addressing his modifiable risk factors
- Empowering self-mx and lifestyle change
- Interventions proven to reduce MLTC risk

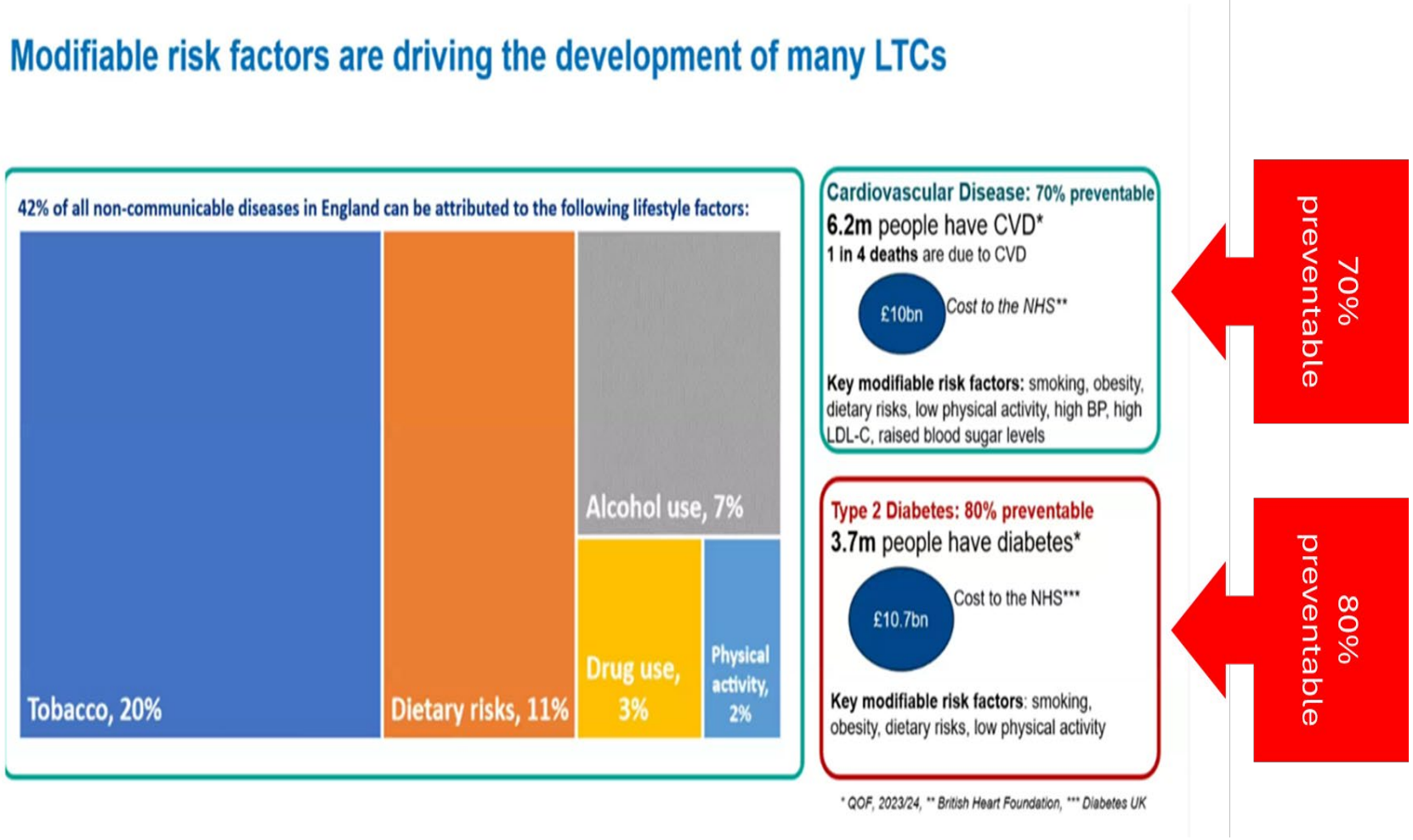
Targeted Prevention

High level Outcomes

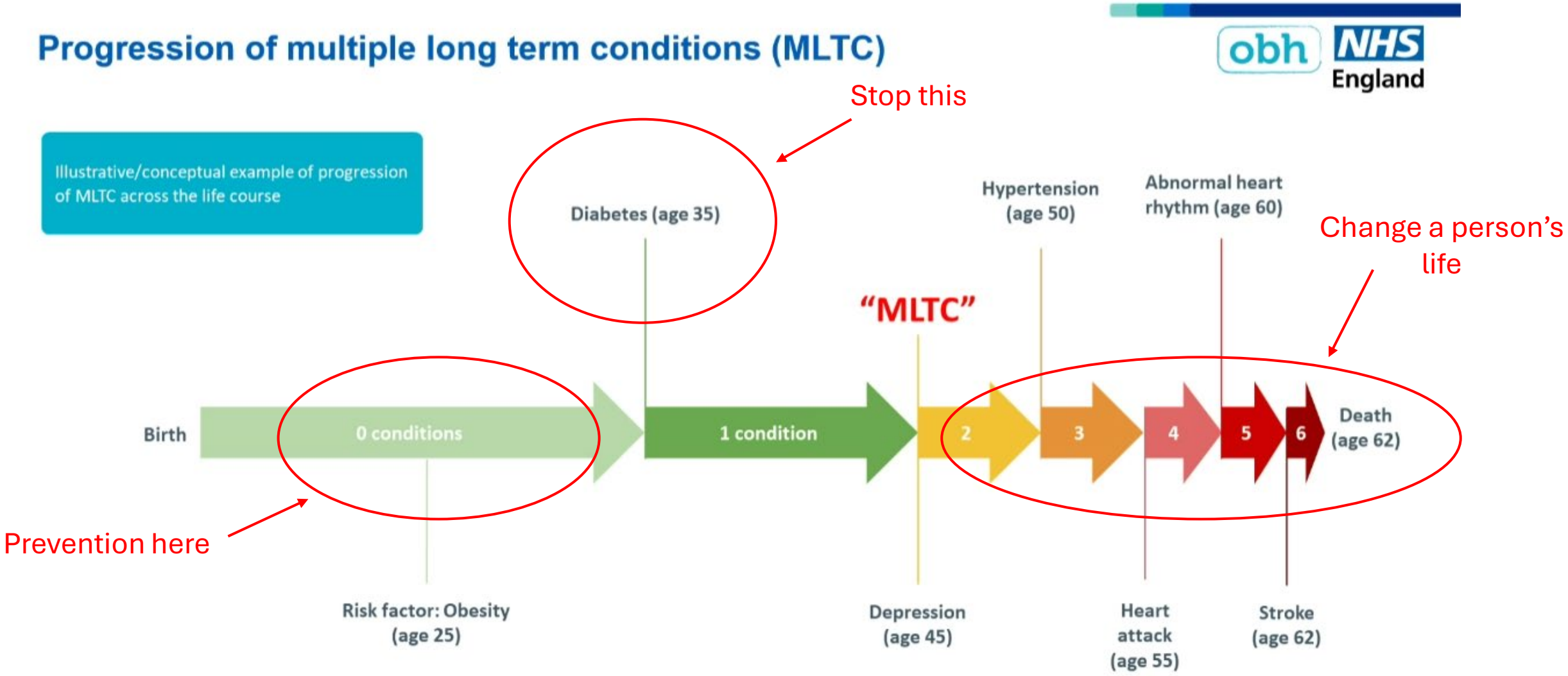
- Preventable conditions
- Prevention will be delivered in the community

(Left shift)

- - Should support a reduction in demand at ED and Acute admissions, outpatient appointments and primary care appointments (over time)

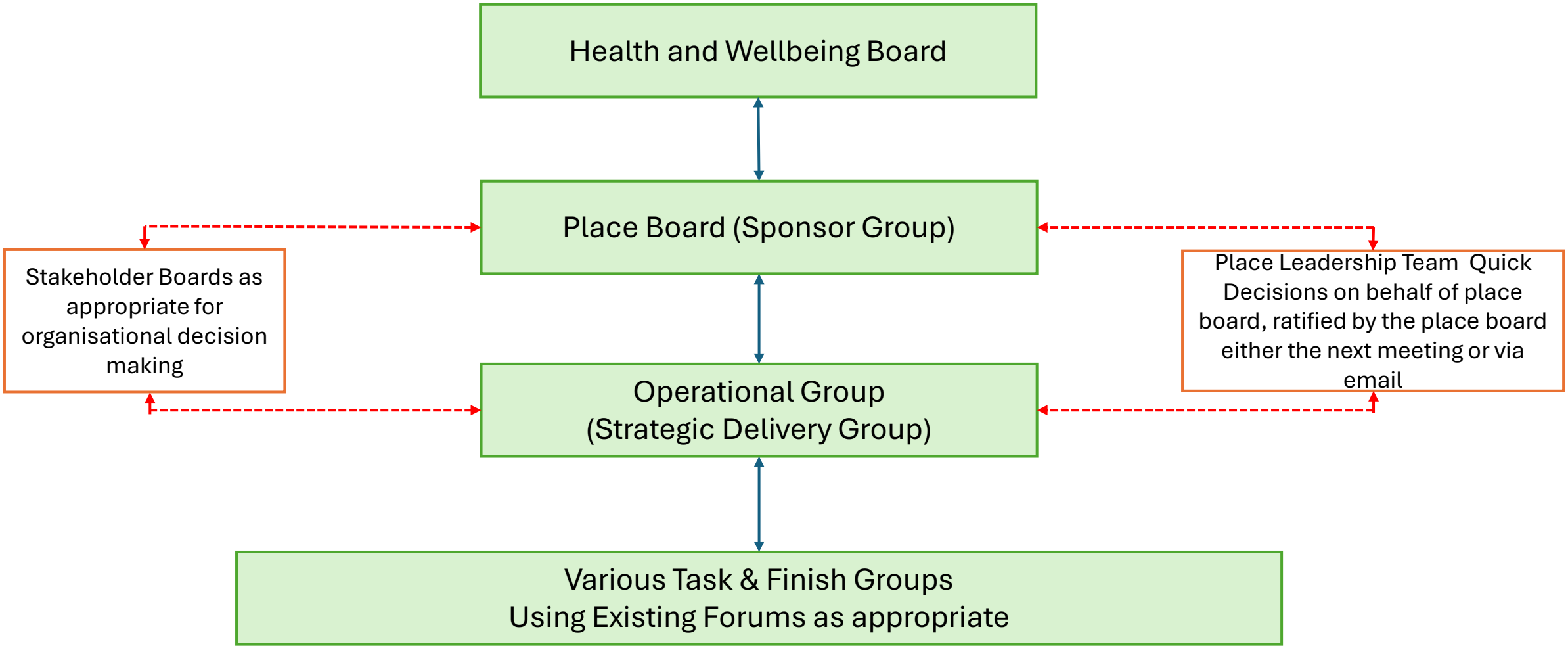


Why Prevention



Governance

Governance Structure



Questions/Comments