National Neighbourhood Health Implementation Pilot

Progress Update – April 2026

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NNHIP Overarching Summary

Representatives from Rotherham attended the second NNHIP event, providing a valuable opportunity to connect with peers, reflected on progress, and shared learning across systems.

A key highlight for was hearing from Minal Bakhai, who shared her seven principles for neighbourhood working, developed through direct engagement with local sites. These principles offer a clear and practical framework to further strengthen Rotherham's neighbourhood approach:

1. **Empower people** – Enable staff and system partners to take ownership and act
2. **Build trust** – Foster credible, meaningful partnerships across organisations
3. **Think system-wide** – Develop a clear neighbourhood model with strong, shared decision-making on priorities and roles
4. **Lead collectively** – Bring leaders together to address shared challenges
5. **Strengthen place** – Ensure the right local structures are in place to support delivery
6. **Commission for impact** – Create commissioning routes that support prevention and a shift towards earlier intervention
7. **Align nationally** – Embed neighbourhood working as business as usual across the system

The event also provided valuable time to pause and recognise progress. Over the past six months, Rotherham has made significant strides in a relatively short period—an achievement that reflects the commitment and collaboration of partners across the system.

Rotherham continues to make strong progress across the programme. Baseline data has been successfully submitted, and data sharing and processing agreements are now in place across partners. This provides a solid foundation for extracting and reporting outcomes to the national team. Partnership working remains a key strength, with continued engagement across system stakeholders to support delivery.

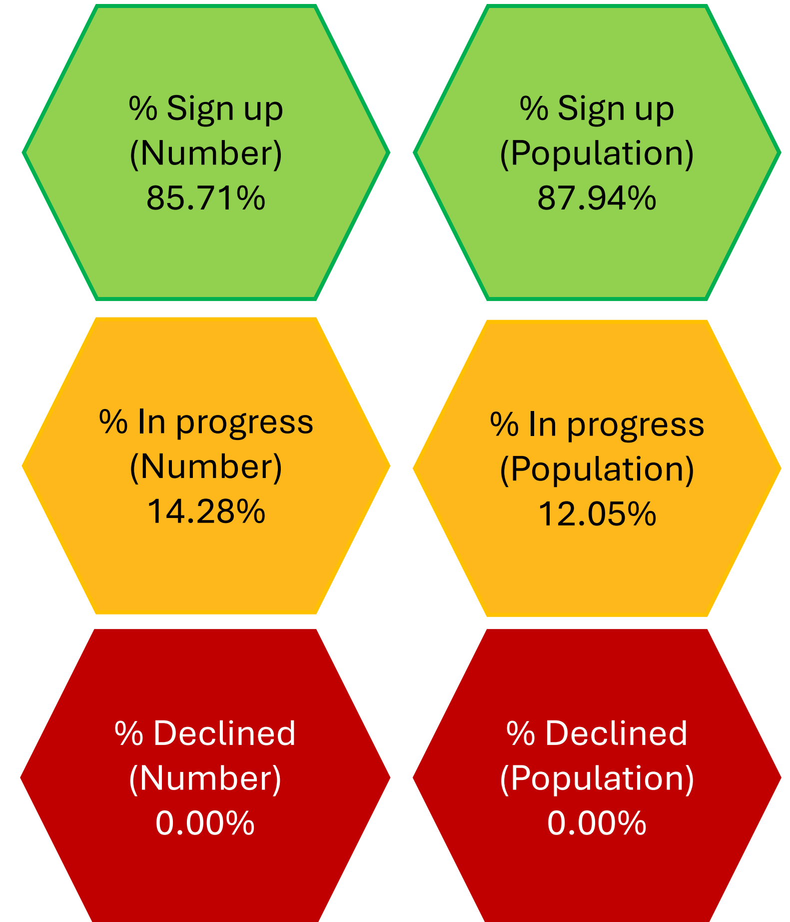
Data Sharing and Processing Agreements Rotherham Place Summary

Place summary - Rotherham	Number of practices	Population Covered
Practices with a completed DSA	24	238,870
Practices with a DSA currently in progress	4	32,734
Practices who have declined sign up	0	-
Practices with no response	0	-
Total	28	271,604

YORK ROAD SURGERY
WOODSTOCK BOWER GROUP PRACTICE
WICKERSLEY HEALTH CENTRE
VILLAGE SURGERY
TREETON MEDICAL CENTRE
THORPE HESLEY SURGERY
SWALLOWNEST HEALTH CENTRE
STAG MEDICAL CENTRE
ST ANN'S MEDICAL CENTRE
SHAKESPEARE ROAD SURGERY
RAWMARSH HEALTH CENTRE
PARKGATE MEDICAL CENTRE
MORTHEN ROAD GROUP PRACTICE
MARKET SURGERY
MANOR FIELD SURGERY

KIVETON PARK MEDICAL PRACTICE
GREENSIDE SURGERY
GREASBROUGH MEDICAL CENTRE
GATEWAY PRIMARY CARE
DINNINGTON GROUP PRACTICE
CROWN STREET SURGERY
CLIFTON MEDICAL CENTRE
BROOM LANE MEDICAL CENTRE (DR PATEL & PARTNERS)
BRINSWORTH MEDICAL CENTRE

THE MAGNA GROUP PRACTICE
HIGH STREET SURGERY
DR RAOLU'S PRACTICE
BLYTH ROAD MEDICAL CENTRE



Cohort 1: Prevention – Over 40s Health Check

Progress within the prevention cohort is well underway, supported by the establishment of a dedicated task and finish group.

This group has been instrumental in:

- Identifying and refining the patient cohort
- Securing system-wide agreement on the approach
- Agreeing baseline and outcome measures (including NNHIP and local priorities)
- Establishing data flows and confirming SNOMED coding for cohort identification
- Developing patient pathways and updating Health Check templates

Delivery elements are also progressing:

- Contracts with Connect Healthcare are being finalised
- Targeted outreach is being enabled through non-attender lists
- Workforce micro-training on behaviour change conversations is underway
- Mobile, workplace, and community Health Check delivery has launched
- Recruitment for a dedicated Health Check role is in progress
- VCSE engagement has commenced, with a focus on IMD1 populations
- Resident focus groups are being undertaken to better understand barriers and motivators

In addition, communications and engagement plans are being implemented, including structured messaging to improve uptake. A directory of services has been updated to support prevention pathways, and a clear patient pathway has been developed.

Evaluation activity is embedded, with early evaluation and a mid-year report planned. PDSA cycles will be used to iteratively refine the approach where required. Overall, work is progressing well, and all partners are aligned and supportive of the delivery plans.

Cohort 2: Rising Risk (18–39 years with 1 physical LTC and Anxiety/Depression)

A task and finish group has also been established for this cohort, with significant progress made against key milestones. The programme is now live across practices from **1 April 2026**.

Cohort Definition & Data

- Patient cohort identified and refined (Nov–Dec 2025)
- System agreement secured via Place Board (Dec 2025)
- Outcome and baseline measures agreed (Feb 2026)
- Data collection methods and SNOMED coding confirmed (March 2026)
- All practices signed up to data sharing agreements (March 2026)
- NNHIP data submitted (March 2026)

Pathway Development

- Patient pathway developed, including risk stratification approach
- Clinical templates revised to support data capture
- Data queries and user guidance developed for practices
- Self-care resources identified and social prescribing offer agreed
- Stakeholder mapping completed, with named leads across PCNs
- Directory of services updated and communicated to practices

Communications & Engagement

- Stakeholder mapping completed
- Briefing documentation developed and disseminated
- Briefings delivered across PCNs, VCSE (VAR), social care, and community services

Pathway Development
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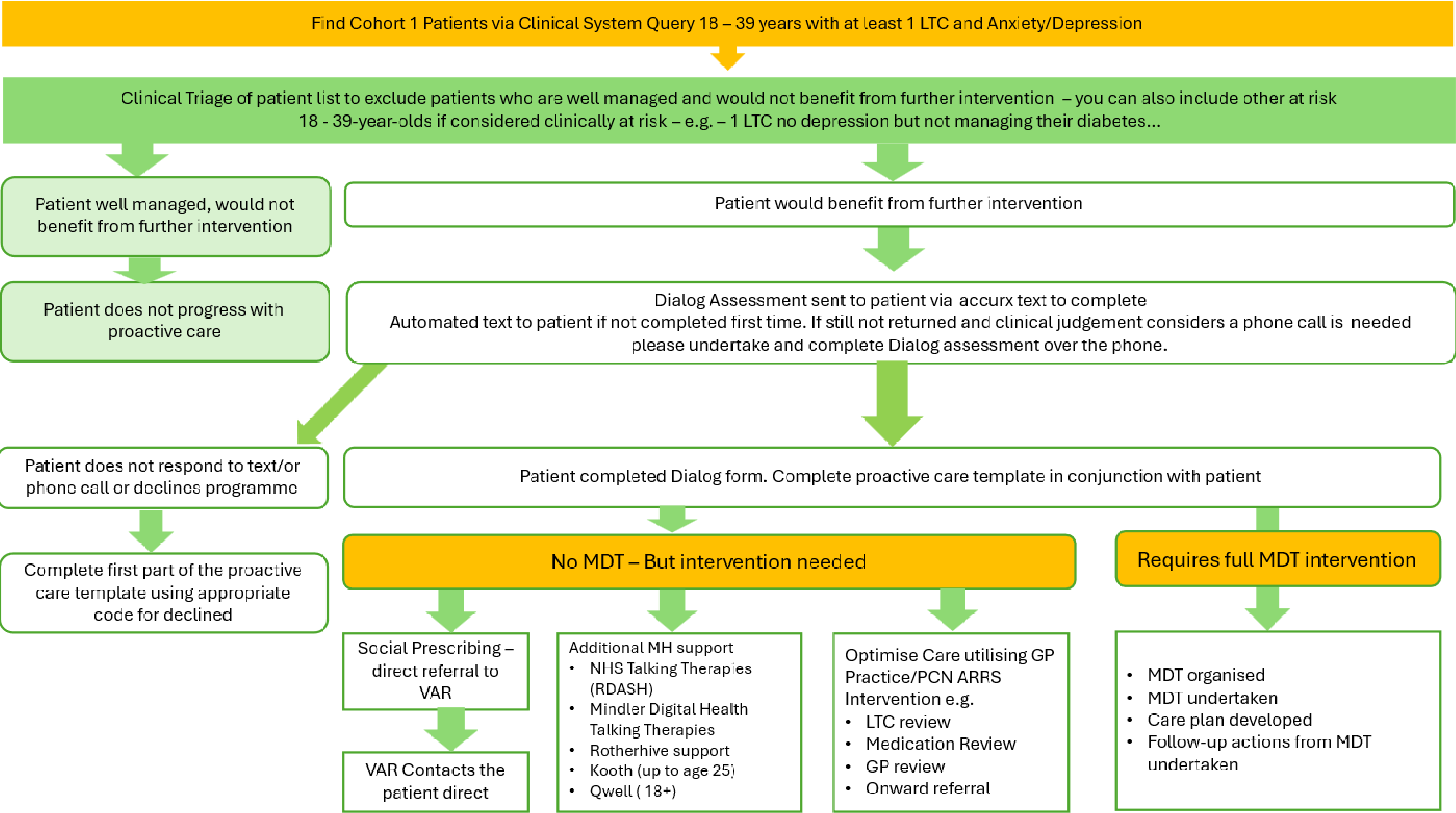
- Training for dialogue-based interventions scheduled
- Go-live readiness confirmed, with all practices prepared to commence from 1 April

Evaluation

- Evaluation plan in development, with completion expected by 30 April 2026

Rising Risk Patient Pathway



Cohort 3: Complex Frailty (4+ LTCs and 1 unplanned attendance/admission in 12mths

Work for the complex frailty cohort is progressing well, with the programme now live across practices from **1 April 2026**. A task and finish group has led delivery across the following areas:

Cohort Definition & Data

- Patient cohort identified and refined
- System agreement secured via Place Board
- Outcome and baseline measures agreed
- Data collection methods and SNOMED coding confirmed Logic model refreshed for the national team Clinical templates revised to support data capture
- NNHIP data submitted

Pathway Development

- Patient pathway developed, including approach to risk stratification
- "My Personal Wishes" embedded within clinical systems
- Data queries developed to support cohort identification and monitoring
- Social prescribing offer agreed for this cohort
- Stakeholder mapping completed across the patient journey
- Named leads identified across Place and PCNs
- Directory of services updated and communicated to practices

Communications & Engagement

- Stakeholder mapping completed
- Briefing documentation developed and shared
- Webinars delivered across PCNs, VCSE (VAR), social care, and planned community services

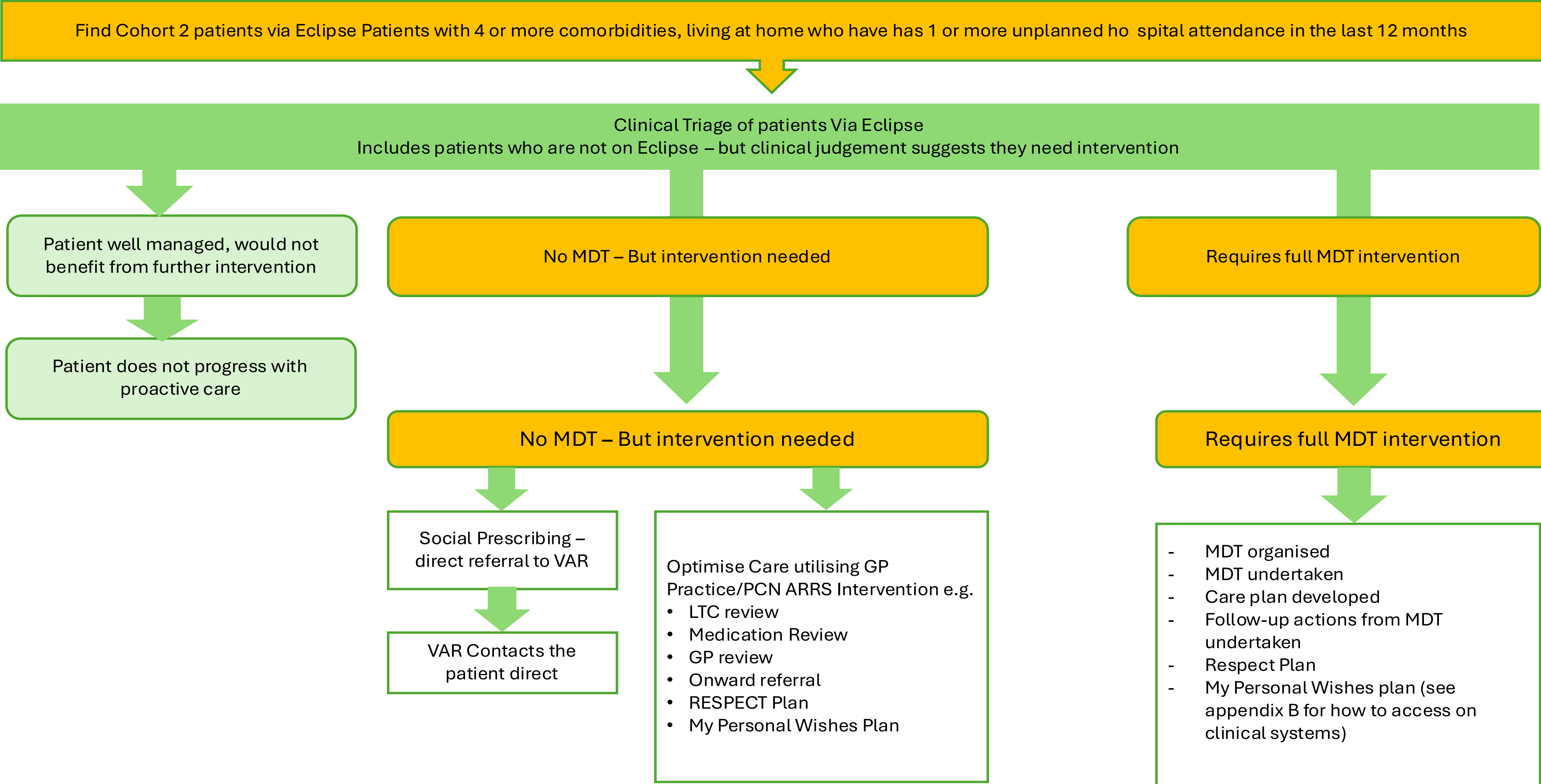
Training & Readiness

- Training for Eclipse system agreed and scheduled
- Training requirements reviewed for My Personal Wishes and RESPECT processes
- Go-live readiness confirmed, with all practices prepared to commence from 1 April

Cohort Definition & Data

- Evaluation plan in development, with completion expected by 30 April 2026

Complex Frailty Patient Pathway



Conclusion and Next Steps

All three cohorts are progressing in line with planned timelines, with Cohorts 2 and 3 now live across practices.

Strong system collaboration, robust data infrastructure, and clear governance arrangements continue to support delivery.

The programme remains on track, with a continued focus on demonstrating measurable outcomes, embedding delivery, and sharing learning with the national team.

Next steps are to build on the 3 cohorts to develop a wider neighbourhood plan in line with national guidance and Rotherham priority areas