

# LPC AGM

## Central East ICB – Developing Neighbourhood Health Pam Green

15 September  
2026



# Management Executive

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Leadership and delivery of strategic objectives, statutory requirements and 10YP implementation

## Neighbourhood Health, Place & Partnerships

Drives local, integrated care by shaping delivery models, fostering collaboration and bringing services closer to communities

## Strategy, Planning & Evaluation

Sets the strategic direction, ensures evidence-based decisions, and evaluates impact to guide scaling or decommissioning

## Population Risk and Clinical Advisory

**Total Quality Management**  
Embeds quality, safety, and continuous improvement consistently across commissioning and delivery

## Utilisation Management

Ensures care is used appropriately, addresses variation, and directs resources to deliver maximum benefit for patients and populations

## Resources

Optimises assets through strong financial, contractual, and procurement discipline to ensure sustainability and transparency

## Organisational Development & Delivery

Builds organisational capability, culture, and performance structures to keep promises and sustain delivery

# Management Executive



**Sarah Stanley**  
Executive Clinical Director  
Total Quality Management  
Deputy CEO



**Dr Fiona Head**  
Executive Clinical Director  
Utilisation Management  
(Medical Director)



**Pól Toner**  
Director of  
Safeguarding/SEND and  
Complex Care



**Kate Vaughton**  
Executive Director for  
Neighbourhood Health,  
Place and Partnership



**Maria Wogan**  
Director for Neighbourhood  
Health, Place and  
Partnership BLMK



**Pam Green**  
Director for Neighbourhood  
Health, Place and  
Partnership C&P



**Ed Knowles**  
Director for Neighbourhood  
Health, Place and  
Partnership Hertfordshire



**Jan Thomas**  
Chief  
Executive  
Officer



**Sarah Griffiths**  
Executive Director for  
Finance, Resources  
and Contracting



**Stacie Coburn**  
Director of Contracts and  
procurement



**Karen Barker**  
Transition Director &  
Executive Director of  
Corporate services



**Tania Marcus**  
Director of People and  
Culture



**Louis Kamfer**  
Executive Director of  
Strategy, planning and  
evaluation

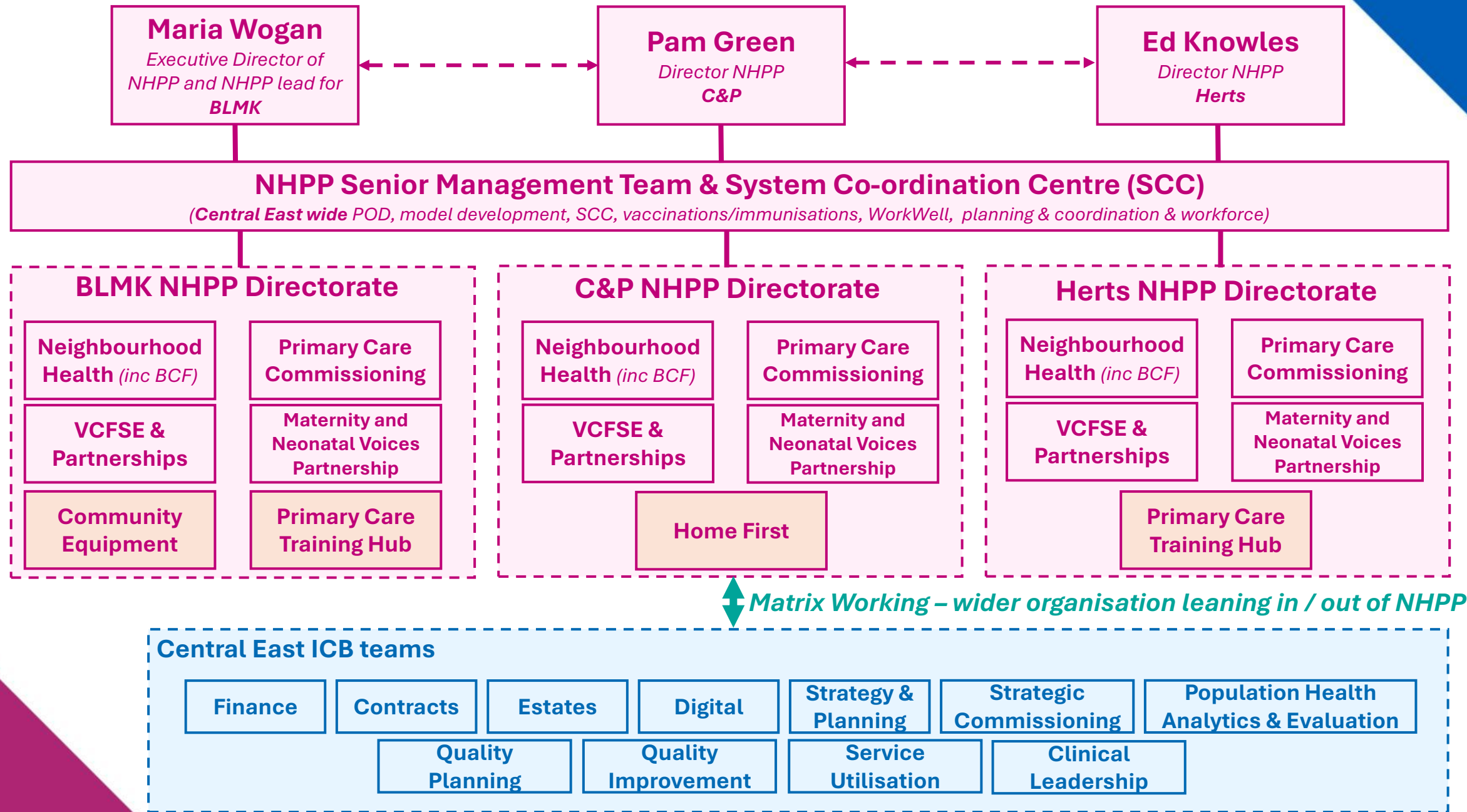


**Andrew Palmer**  
Director of Population  
Health, Analytics and  
evaluation



**Elizabeth Disney**  
Director of Strategic  
Planning and  
Commissioning

# Who we are and what we do



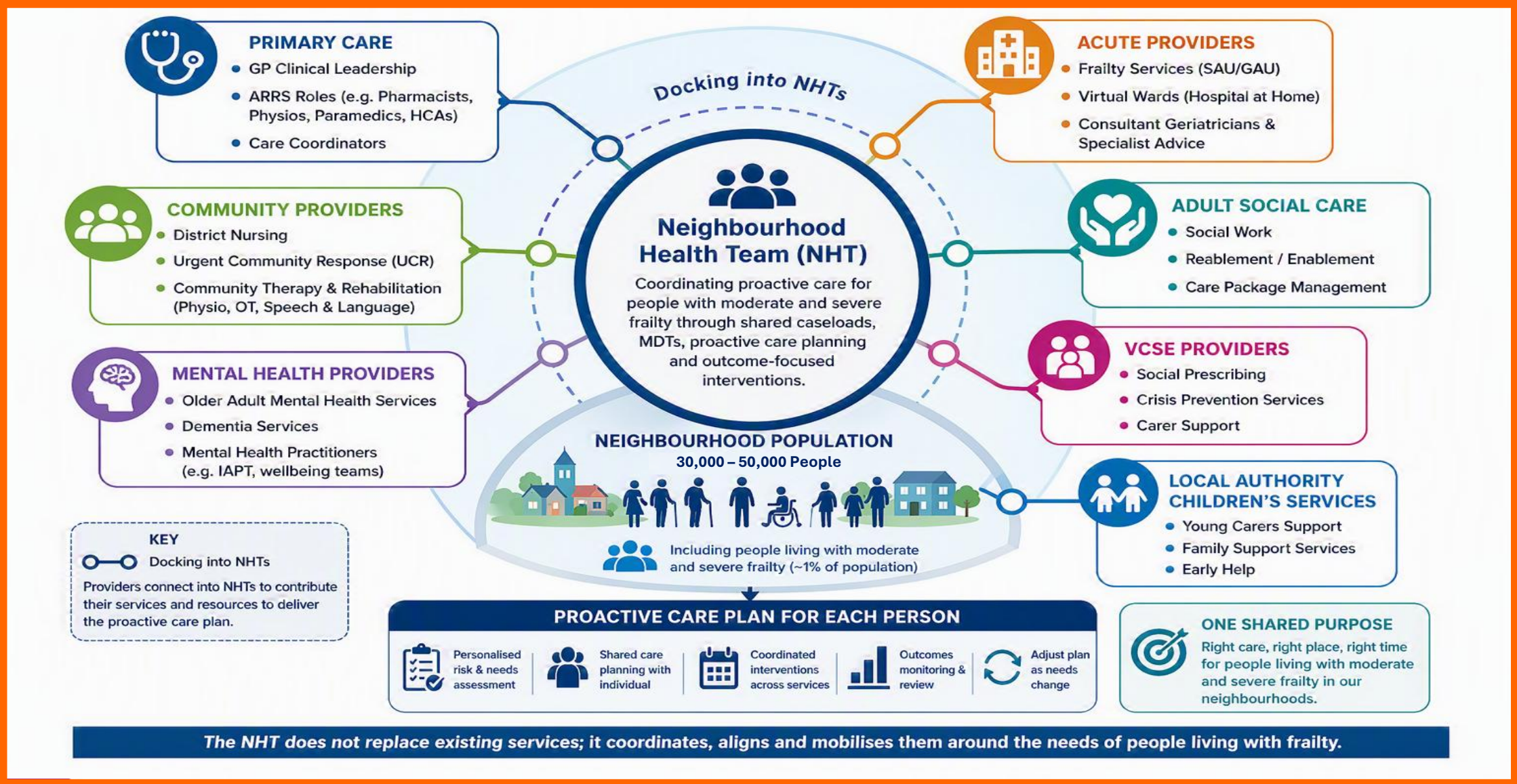
# Who we are and what we do



NHPP is leading C4 NHTs, but with the support from other directorates

# What's been happening?

The Single Neighbourhood / NHT Operational Level – shown at the Conference on 16 July



# What's been happening?

## Neighbourhood Health Requires Two Distinct but Connected Roles

### The Neighbourhood Health Team (NHT)

**Status:** Described in draft NHT/Frailty Specification

**Population:** Typically 30,000-50,000

**Role:** Deliver proactive neighbourhood care and care coordination

**Focus:** People and cohorts

**Contractual Vehicle for 2027/28:** PCN DES /LES Variation (TBC) & contractual commitments for all acute, community and mental health trusts

**Duties include:**

- Identifies and prioritises people at greatest risk
- Delivers proactive, personalised care
- Coordinates multidisciplinary support
- Creates and maintains shared care plans
- Connects health, care and community services
- Responds rapidly to changing needs
- Prevents avoidable hospital use
- Improves outcomes for a defined population

### The Integrator

**Status:** Developing a definition & eligibility criteria

**Population:** Typically 250,000-500,000+

**Role:** Support delivery of neighbourhood health teams and services by coordinating providers, infrastructure, workforce, data and transformation across multiple NHTs

**Focus:** System enablement

**Contractual Vehicle for 2027/28:** TBC – will invite proposals from collaboratives

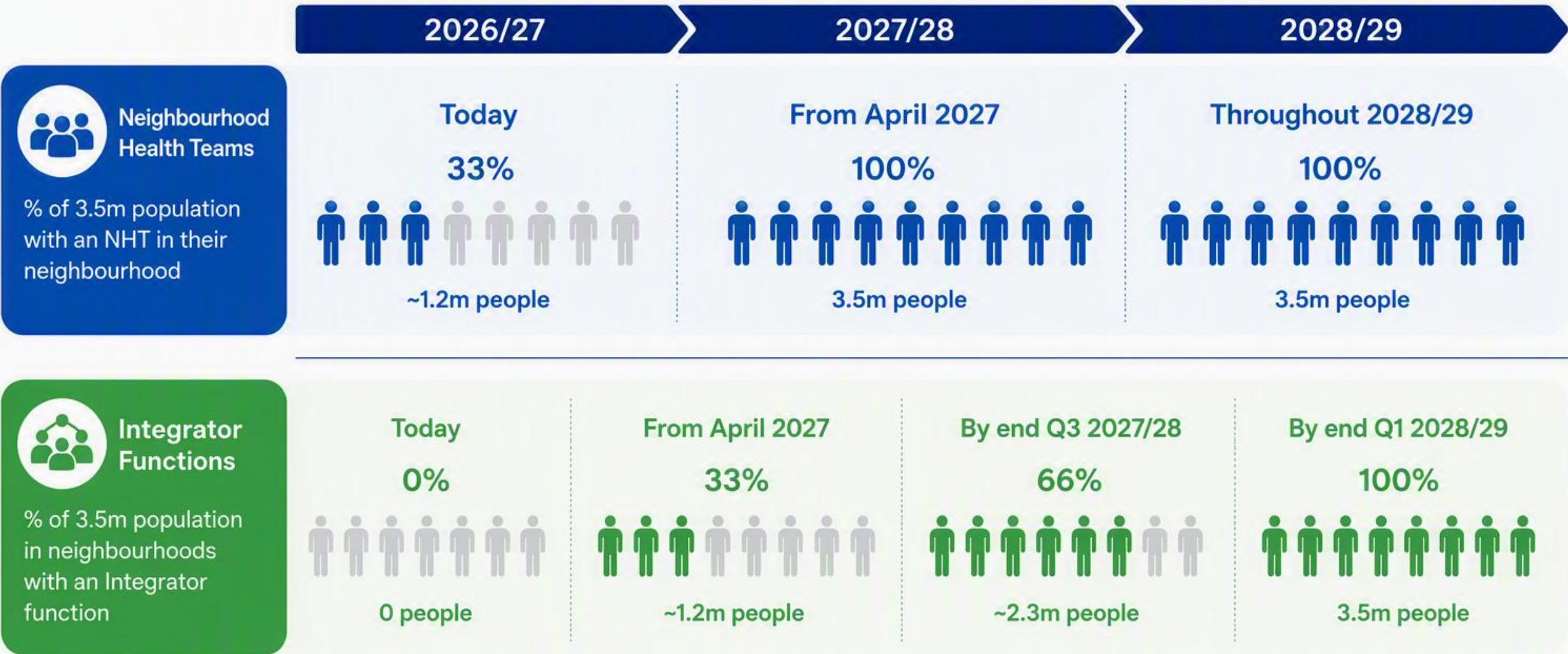
**Duties include:**

- Connects partners around neighbourhood populations
- Coordinates delivery across organisations
- Aligns resources to population outcomes
- Provides data, workforce and improvement infrastructure
- Removes barriers to integrated working
- Supports neighbourhood leadership and maturity
- Drives population health improvement and equity
- Enables the shift from hospital to community care
- Evolves toward greater accountability when systems are ready

# What's been happening?

**Our vision:**  
**Neighbourhood Health Teams (Single Neighbourhoods)**  
33% of the population already benefit from early adopter NHTs. From April 2027, every resident across Central East (3.5m population) will be covered by an operating NHT.

**Integrator Functions (Multi-Neighbourhoods)**  
From April 2027, Wave 1 Integrators are expected to provide coverage for approximately 33% of the population. Coverage will increase to 66% by the end of Q3 2027/28 through Wave 2 expansion, reaching full population coverage (100%) by Q1 2028/29.



## C4 Neighbourhood Health Teams (NHT)

Our aim is to establish a Neighbourhood Health Team in every neighbourhood, applying a **Quality Improvement (QI)** approach, prioritising **people with frailty** as the initial cohort to test and refine the model during 2026/27, to commission Neighbourhood Health Teams from April 2027.

# The landscape we are operating in

## Bedfordshire, Luton & Milton Keynes

- Population size – c1.1m
- No. of PCNs – 25
- No. of GP Practices – 84
- No. Health & Wellbeing Boards – 4
- No. of Place Based Partnerships – 4
- Part of National Programme – No
- No. of Neighbourhoods: 16
  - Bedford Borough – 4
  - Central Bedfordshire – 4
  - Luton – 4
  - Milton Keynes – 4
- Alignment to PCNs:
  - Neighbourhoods are broadly built from PCN footprints, but they are not fully aligned or coterminous

## Cambridgeshire

- Population size – c1m
- No. of PCNs – 22
- No. of GP Practices – 85
- No. Health & Wellbeing Boards – 1
- No. of HCPs – 2
- Part of National Programme – Yes
- No. of Neighbourhoods: 21
  - North Cambridgeshire and Peterborough – 13
  - Cambridgeshire South – 8
- Alignment to PCNs:
  - Alignment to PCNs – Mostly aligned, but not fully, due to deliberate PCN mergers in the south

## Hertfordshire

- Population size – c1.3m
- No. of PCNs – 29
- No. of GP Practices – 97
- No. Health & Wellbeing Boards – 1
- No. of HCPs – 3
- Part of National Programme – Yes
- No. of Neighbourhoods: 10
  - East and North Hertfordshire – 6
  - South & West Hertfordshire – 4
- Alignment to PCNs:
  - ENH is not fully PCN aligned. ENH uses functional neighbourhood footprints; SWH uses district/borough boundaries

# The landscape we are operating in

## C&P

### BLMK

| Place                | Neighbourhood         | Neighbourhood Population Size |
|----------------------|-----------------------|-------------------------------|
| Bedford              | Rural North           | 29,853                        |
|                      | Central East          | 50,733                        |
|                      | Urban East            | 52,890                        |
|                      | Urban/Rural Southwest | 66,022                        |
| Central Bedfordshire | West Mid Beds         | 70,931                        |
|                      | Ivel Valley           | 91,652                        |
|                      | Chiltern Vale         | 83,629                        |
|                      | Leighton Buzzard      | 48,036                        |
| Luton                | North West            | 61,981                        |
|                      | North East            | 60,263                        |
|                      | Central               | 75,039                        |
|                      | South                 | 72,593                        |
| Milton Keynes        | North East            | 61,231                        |
|                      | North West            | 109,468                       |
|                      | Central & East        | 95,312                        |
|                      | South                 | 88,567                        |

| Place | Locality                      | Neighbourhood                  | Neighbourhood Population Size |
|-------|-------------------------------|--------------------------------|-------------------------------|
| North | Huntingdonshire Locality      | A1                             | 48,427                        |
|       |                               | HUNTINGDON                     | 47,472                        |
|       |                               | ST IVES                        | 47,982                        |
|       |                               | ST NEOTS                       | 34,559                        |
|       | Peterborough Locality         | BOROUGHURY AND PASTON          | 47,865                        |
|       |                               | BRETTON PARK HAMPTON           | 33,152                        |
|       |                               | CENTRAL THISTLEMOOR AND THORPE | 59,421                        |
|       |                               | PETERBOROUGH AND EAST PCN      | 60,886                        |
|       |                               | PETERBOROUGH PARTNERSHIPS      | 33,225                        |
|       |                               | SOUTH PETERBOROUGH             | 64,258                        |
|       | Fenland Locality              | FENLAND PCN                    | 31,840                        |
|       |                               | SOUTH FENLAND PCN              | 25,603                        |
|       |                               | WISBECH PCN                    | 50,270                        |
| South | Cambridge City Locality       | CAM MEDICAL PCN                | 51,020                        |
|       |                               | CAMBRIDGE CITY 4 PCN           | 59,266                        |
|       |                               | CAMBRIDGE CITY PCN             | 52,301                        |
|       |                               | CANTAB MEDICAL PRACTICES PCN   | 56,645                        |
|       | South Cambridgeshire Locality | CAMBRIDGE NORTH VILLAGES PCN   | 52,727                        |
|       |                               | GRANTA PCN                     | 58,838                        |
|       |                               | MERIDIAN PCN                   | 53,207                        |
|       | East Cambridgeshire Locality  | EAST CAMBS                     | 90,187                        |

### Herts

| Place                        | Neighbourhood             | Neighbourhood Population Size |
|------------------------------|---------------------------|-------------------------------|
| East and North Hertfordshire | Lower Lea Valley          | 69,521                        |
|                              | North Herts               | 85,856                        |
|                              | Stevenage                 | 82,382                        |
|                              | Stort Valley and Villages | 54,356                        |
|                              | Upper Lea Valley          | 107,790                       |
|                              | Welwyn and Hatfield       | 97,937                        |
| South West Hertfordshire     | Dacorum                   | 128,104                       |
|                              | Hertsmere                 | 94,062                        |
|                              | St Albans & Harpenden     | 131,042                       |
|                              | Watford & Three Rivers    | 141,133                       |

# Key NHPP Definitions

**Neighbourhood** – refers to a defined local geographical area (c.30–50k residents, though larger in some areas) through which integrated care is delivered

**Neighbourhood Health Team (NHT)** - refers to a team of staff who work together across primary, community, acute, mental health and social care with VCSE partners to deliver coordinated, proactive care for a defined population

**Frailty** – refers to people with multi-morbid co-existing conditions alongside age-related problems such as dementia. Issues include falls, impaired mobility, dependence on care, cognitive disorders, incontinence, mood disorders, sensory impairments and polypharmacy

# C4 Neighbourhood Health Teams (NHT)

## What is an NHT?

A team of staff who work together across primary, community, acute, mental health and social care with VCFSE partners to deliver coordinated, proactive care for a defined population

## What do NHTs do day-to-day?

- Proactive case finding using population health intelligence (e.g. frailty cohorts)
- Integrated team working to plan and review care for complex individuals
- Care coordination and navigation to ensure joined-up support
- Holistic, person-centred care planning (health + social + wellbeing needs)
- Rapid response and early intervention to prevent deterioration or admission
- Continuous Quality Improvement (QI) cycles to test, learn and refine delivery
- Strengthen self-management and community resilience

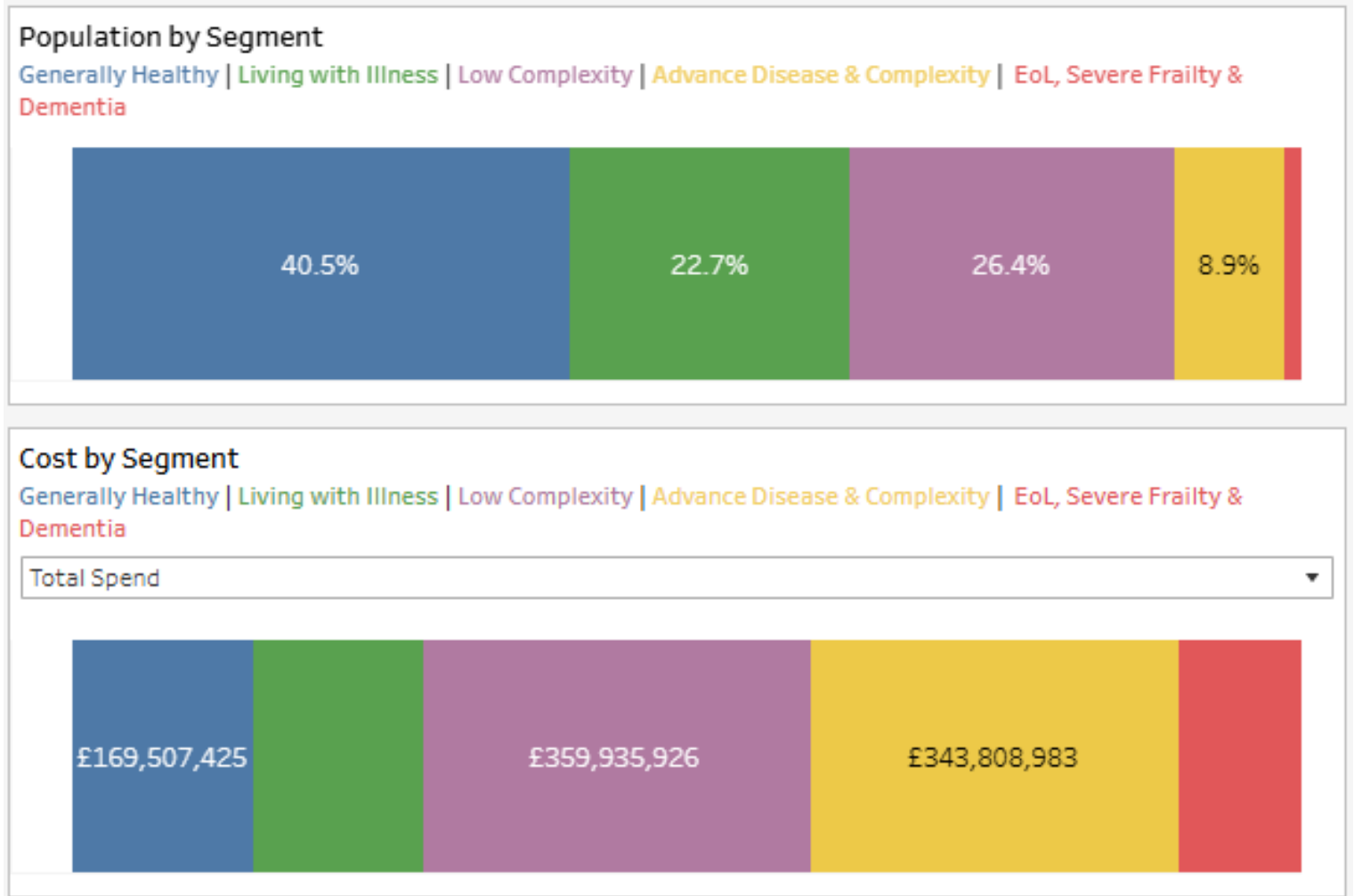
## Who is in an NHT?

- Primary care: GPs, nurses, ARRS roles
- Community services: community nurses, therapists, frailty practitioners
- Adult social care practitioners
- Mental health practitioners
- Voluntary, Community, Faith & Social Enterprise (VCFSE) partners
- Care coordinators / health & wellbeing workers
- Wider specialists aligned as needed (e.g. pharmacists, geriatricians)

# NHTs & Frailty: Understanding population need and health outcomes

## *Prevalence and identification*

- The population of Central East cluster is 3.54m
- 581,000 people aged 65 years and over.
- Approximately 10-11% of the whole population (350-390,000 people) are in a 'complex care need' segment (which includes people living with **Moderate** or **Severe** frailty)
- These cohorts of the population account for approximately 40% of all secondary care spend and have high rates of general practice, community services and social care use



Population segmentation above (HWE segmentation model) showing the proportion of the HWE population in each of the top-level segments, and total secondary care spend for each segment (outpatient, elective inpatient, emergency department and non-elective inpatient)

# NHTs & Frailty: Understanding population need and health outcomes

## Service Utilisation

Applying these figures to the estimated total population living with moderate and severe frailty, the following activity is currently estimated per year for people with **Moderate** or **Severe** frailty across **Central East** (Note: This does not include activity in people with mild frailty)

### The Impact of Frailty: Over 1 Year



**57,248** ED Attendances



**33,952** Non-Elective Admissions



**32,141** Elective Admissions

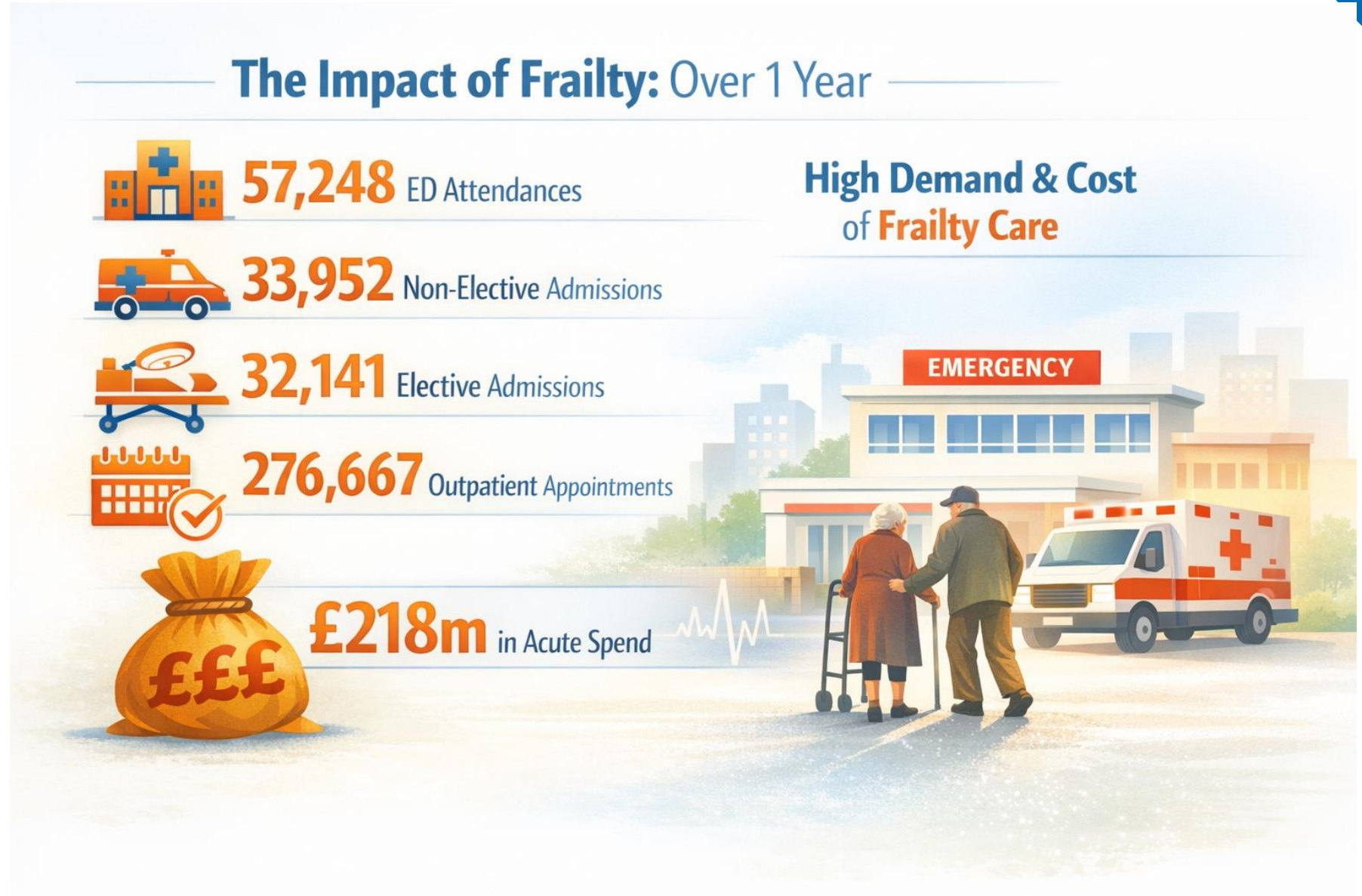


**276,667** Outpatient Appointments

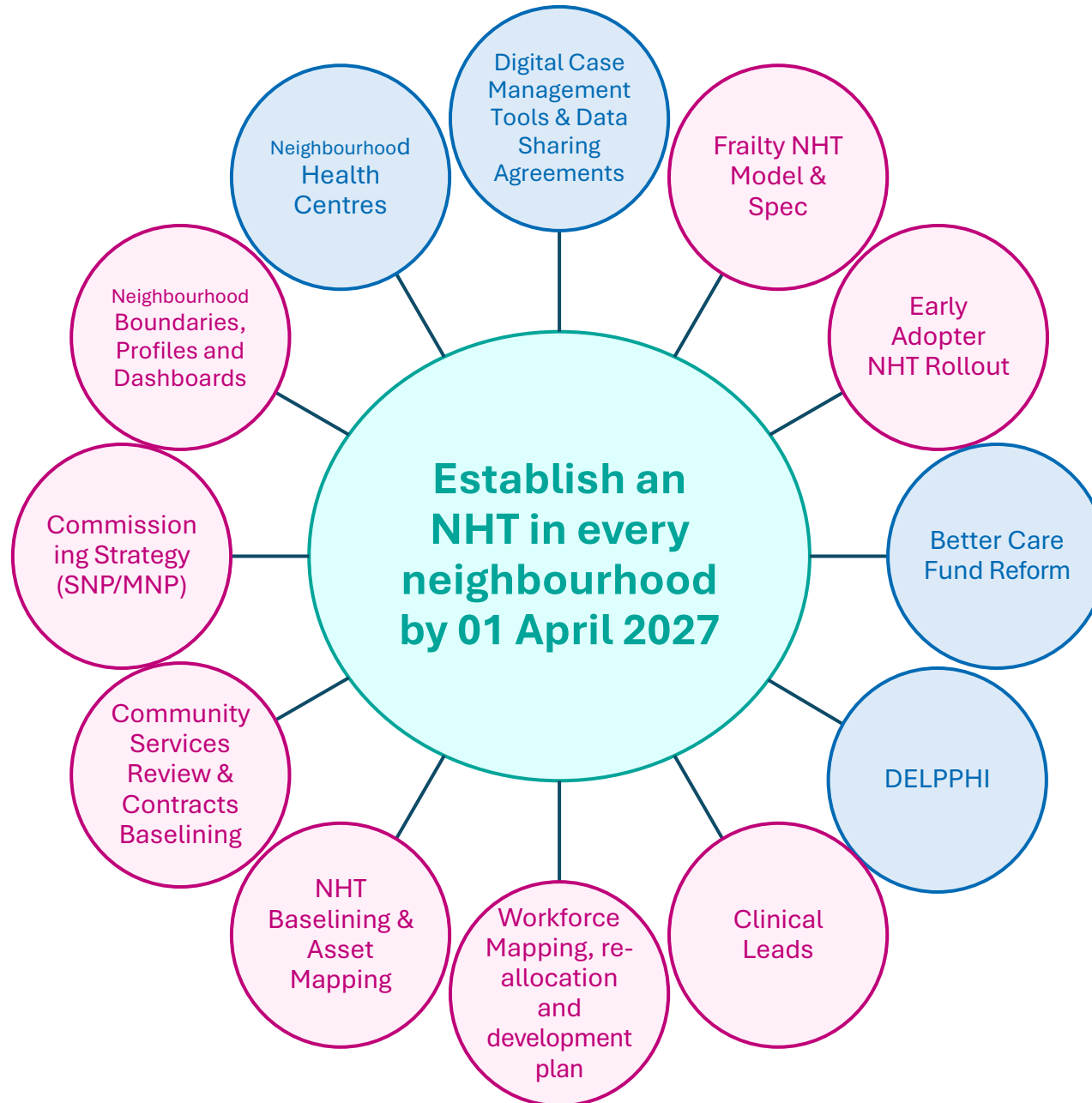
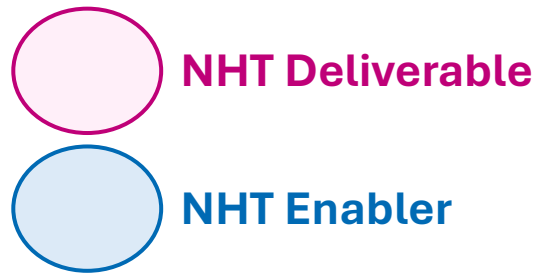


**£218m** in Acute Spend

**High Demand & Cost**  
of **Frailty Care**



# What do we need to deliver and enable to establish NHTs



## Where community pharmacy fits

- **Community pharmacy is a core neighbourhood asset:** accessible, trusted and connected to people who may have limited contact with other services.
- Its role now extends beyond dispensing to clinical care, prevention and medicines support, including Pharmacy First.
- Pharmacy capacity should be built into neighbourhood plans and aligned to local priorities such as cardiovascular disease, frailty, urgent access and prevention.
- The opportunity is broader than increasing service volumes: it is about using pharmacy's full clinical contribution within an integrated model.
- The ICB is considering LPC proposals, including community pharmacy engagement leads, and options to support winter pressures, subject to available funding.

## Integration rather than referral

- Move from simple signposting to genuine, supported transfers of care.
- Build clear pathways, strong PCN–pharmacy relationships, appropriate information sharing and effective professional communication.
- Close the loop so pharmacy interventions and clinical concerns inform patients' wider care.
- Involve pharmacy early in neighbourhood planning—not after services have already been designed.

# What this means for the relationship with the LPC

- Develop the ICB–LPC relationship into a strategic partnership for neighbourhood health and primary care transformation
- Agree what should be coordinated across Central East and where local flexibility is essential.
- Ensure community pharmacy is represented in neighbourhood model development and pathway design.
- Work with the LPC to identify participation barriers, enable contractors and improve consistency.
- Use data jointly to understand variation, underused capacity and opportunities for improvement.
- Focus on smarter use of collective primary care capacity—not simply shifting activity between providers.
- Design pathways together to improve access, prevention and equity, providing the right care closer to home.

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Thank you for listening

Happy to take any questions?

