

Neighbourhoods that Delivery and Don't just Exist

July 2026

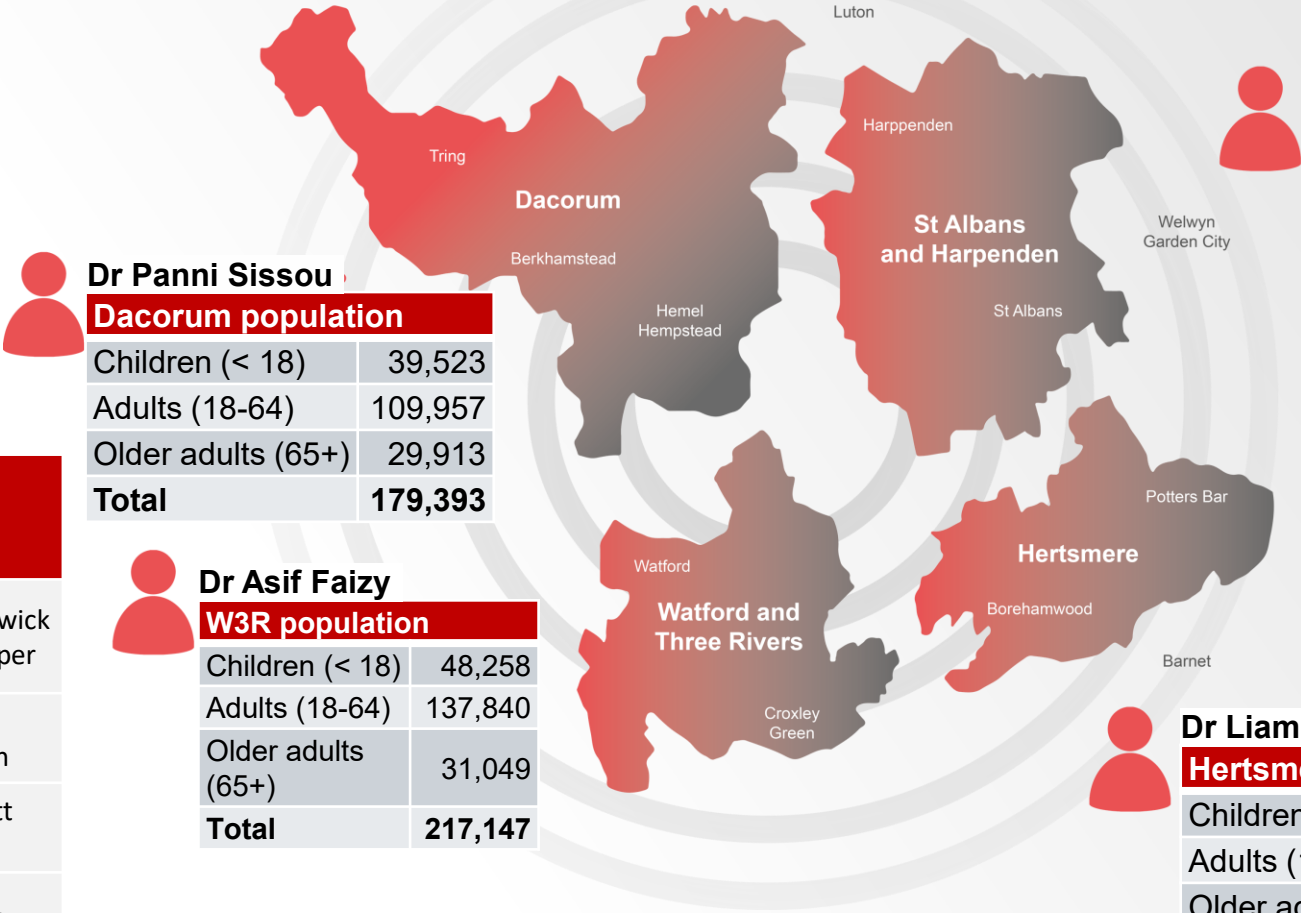
Working together
for a healthier future



SWH HCP has four neighbourhoods representing the **patients registered in the GP practices** residing in each neighbourhood- these neighbourhoods are co-terminus with our district and borough councils

Each neighbourhood is led by a clinical lead, supported by a leadership and management team

Neighbourhood	Neighbourhood Clinical Lead	Integration Lead	Secondary Care Consultant	Community Service Dir/ Mngr
Dacorum	Dr Pani Sissou	Debbie Foster	Sarah Klinger	Leanne Fishwick Frankie Pepper
St Albans & Harpenden	Dr Bethan Rees	Gill Jacobs	Mike Koa-Wing	John Harle Una McCann
Watford & Three Rivers	Dr Asif Faizy	Amanda Burfot	Deepan Vyas	Kevin Barrett Cheryl Ali
Hertsmere	Dr Liam Chapman Dr Anup Shah (<i>dept. clinical lead</i>)	Aimee Venner	Chanpreet Arhi	Louise Ayres Chris MacKay



Dr Panni Sissou
Dacorum population

Children (< 18)	39,523
Adults (18-64)	109,957
Older adults (65+)	29,913
Total	179,393

Dr Asif Faizy
W3R population

Children (< 18)	48,258
Adults (18-64)	137,840
Older adults (65+)	31,049
Total	217,147

Dr Bethan Rees
St&H population

Children (< 18)	35,941
Adults (18-64)	91,802
Older adults (65+)	23,582
Total	151,325

Dr Liam Chapman
Hertsmere population

Children (< 18)	20,169
Adults (18-64)	55,895
Older adults (65+)	16,386
Total	92,450

Defining Our ENH ‘Neighbourhood’

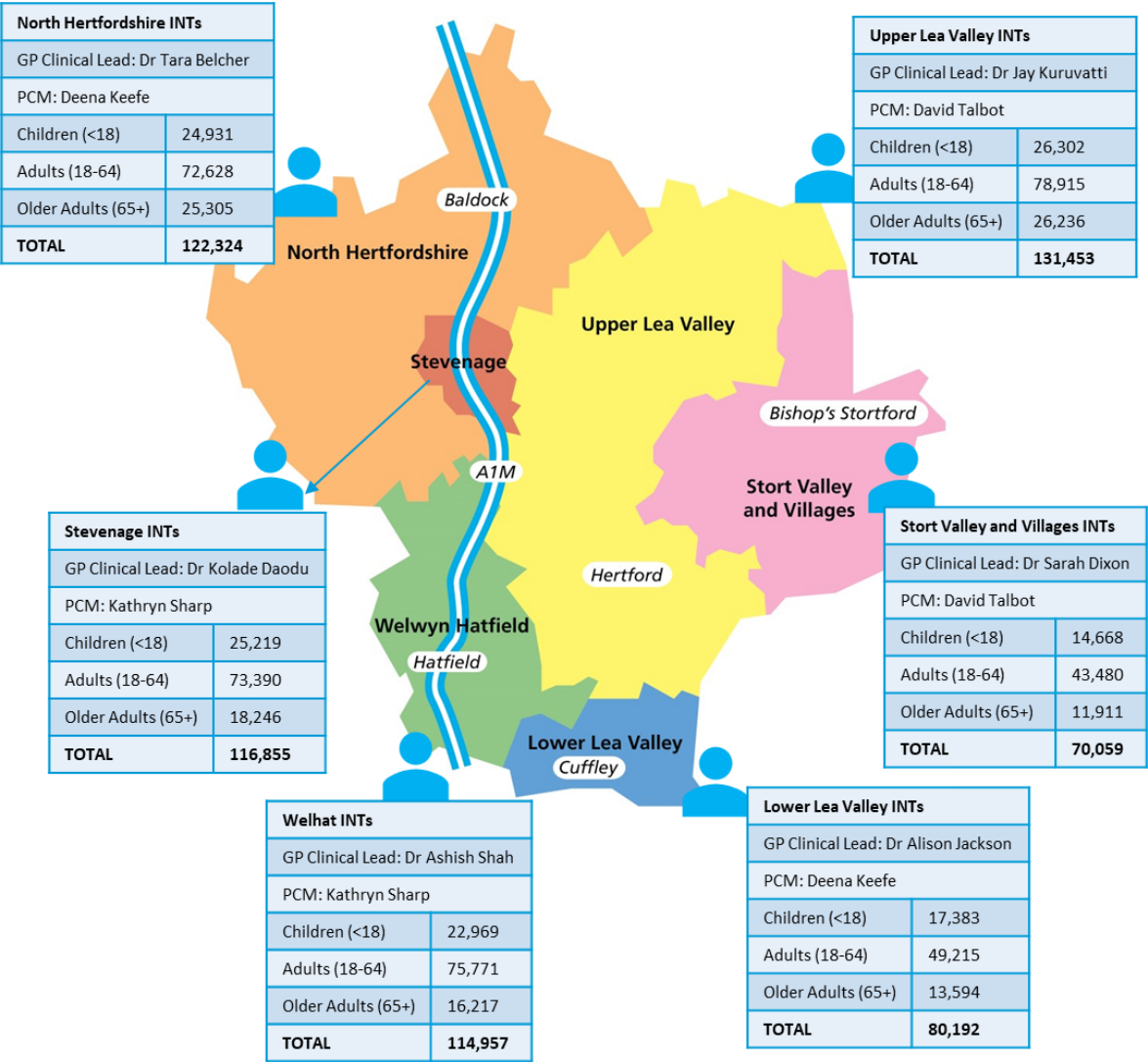
Neighbourhoods in ENH

- Not defined by fixed geography or size — can be a few streets or tens of thousands.
- Shaped by how residents see themselves: local relationships, geography, history, and shared experiences.

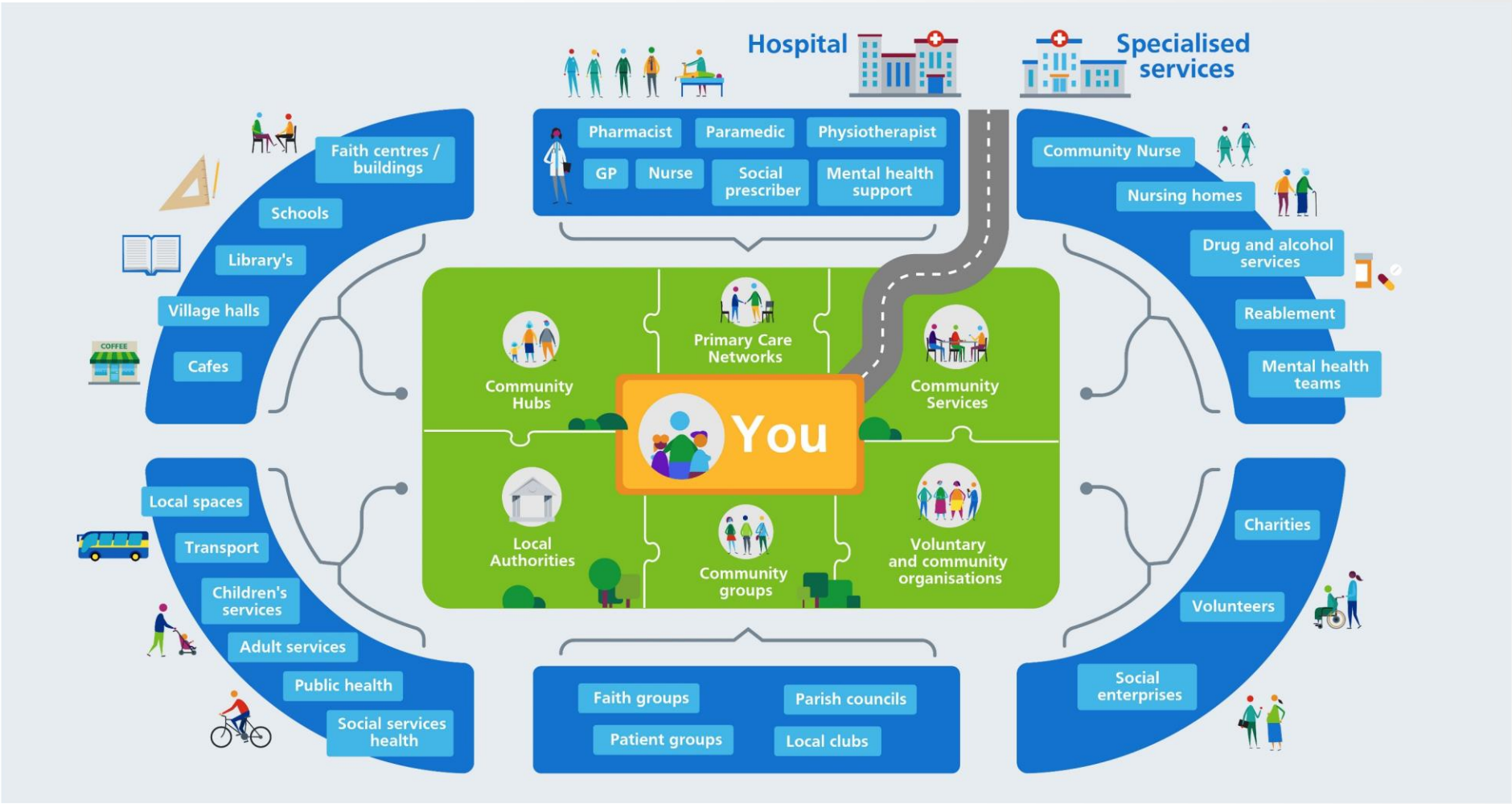
East and North Hertfordshire Health and Care Partnership (ENH HCP) provides health and care services to around 633,000 residents.

The area is divided into six localities, each supported by an Integrated Neighbourhood Team (INT). Together, these localities include 12 Primary Care Networks (PCNs), delivering primary and pharmacy services through 47 GP practices—each serving populations of 30,000 to 50,000 people.

INTs	Primary Care Network	Local and District Council	Acute Trust
Lower Lea Valley	• Broxbourne Alliance • Lea Valley Health	Broxbourne Borough Council	• PAH • Royal Free (Barnet and North Mid)
North Hertfordshire	• Hitchin and Whitwell • Icknield	North Herts District Council (Letchworth Heritage Foundation)	• ENHT • Addenbrookes
Stevenage	• Stevenage North • Stevenage South	Stevenage Borough Council	• ENHT
Stort Valley and Villages	Stort Valley and Villages	East Herts District Council	• PAH
Upper Lea Valley	• Hertford and Rurals • Hoddesdon and Broxbourne • Ware and Rurals	• East Herts District Council • Broxbourne Borough Council • Welwyn Hatfield Borough Council	• PAH • ENHT
Welhat	• Hatfield • Welwyn Garden City	Welwyn Hatfield Borough Council	• ENHT



Actual figures from NHS England Populations Data which can be found at www.digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice
Data referenced June 2025



Strategic objectives and priorities for ENH

Strategic objective 1

Improve the health and wellbeing of our population

- Priority 1** Tackle health inequalities in access, experience, and outcomes.
- Priority 2** Improve outcomes for adults and children and young people.

Strategic objective 2

Transform health, care and wellbeing services to meet local needs and promote independence

- Priority 1** More personalised, preventative, and proactive care.
- Priority 2** Embed use of population health management
- Priority 3** Improved join-up of care for people with physical and mental health needs and learning disabilities

Strategic objective 3

Establish an efficient, effective and sustainable partnership

- Priority 1** Ensure effective collaboration.
- Priority 2** Address wider determinants of health through strong relationships with non-health partners
- Priority 3** Develop an accountable, efficient, effective and inclusive partnership with the right capabilities.



The HCP's priorities for 2026/27 will be consistent with WHTH's clinical strategy and draw on the features of high-functioning systems

Improving access to same day urgent care by taking a system-wide approach to balancing services, including access to general practice

Improving access to specialist opinion and diagnostics when required through joined up working between system partners

Coordination of care

Supporting people with multiple long-term conditions to stay independent for longer, living happier, healthier lives through our proactive care model

Co-ordination of access to and through our system by improving care co-ordination and patient flow

Access

Improving uptake of preventative measures by drawing on the expertise of wider system partners such as public health

Prevention

Improving people's health and wellbeing by influencing the wider determinants of health and aligning our resources to where there is greatest need

➤ Partnerships that have delivered

➤ Partnerships that have not delivered

➤ **What made it successful?**

➤ **What made it fail?**

➤ **What corrective actions can be taken
when a partnership isn't delivering?**