Northern Devon LCP NbH PHM + Evaluation task and finish group meeting

Date: 12 August 2026
Time: 16:00–17:00

Present: Ed Bond, Katherine Allen, Andrea Beacham, Caroline Sanford, Richard Blackwell, Nic Ferreira, Amy Slater

1. Purpose of the meeting

The meeting considered how people should be identified for neighbourhood integrated teams or MDTs, and how the impact of the work should be evaluated. Its aims were to:

- clarify the purpose and scope of the proposed population-identification approach;
- consider whether the existing North Devon population-segmentation methodology could be developed for neighbourhood use;
- consider the current Brave AI offer and learning from other areas;
- distinguish operational cohort identification from system-level performance evaluation; and
- agree the next steps required for a proportionate options appraisal.

2. Main points discussed

A. The operational and evaluation requirements are distinct

The discussion clarified two connected but different requirements. Neighbourhood teams need an operational method that helps them identify a clinically meaningful and actionable cohort. The ICB and system partners also need a method for measuring impact, activity and contractual performance.

The group felt that these requirements should be aligned, but should not be treated as though one tool would automatically meet both needs. A practical model discussed was for local teams to identify the cohort and pass the relevant NHS numbers into the wider evaluation process.

B. The purpose and terminology need to be clear

The group discussed whether the proposed approach was population segmentation, operational planning or risk stratification. Richard Blackwell emphasised that the intended use of the method would determine the relevant governance and regulatory considerations.

A method that supports cohort identification and operational planning is different from a tool that predicts individual clinical risk and changes care. Nic Ferreira considered that the proposed local approach was unlikely to cross the medical-device threshold, subject to the final design and use being clear.

C. Build on the existing North Devon approach

North Devon primary care is already using a population-segmentation approach based on factors including long-term conditions, repeat medicines and appointment activity. Participants described the approach as transparent, understandable and generally clinically recognisable.

The existing approach can be developed while wider decisions are being made. However, the neighbourhood cohort is likely to be narrower than the whole red, higher-use or frailty population. Further work is therefore needed to define the precise population and operational use case.

D. Current data does not yet provide a complete pathway view

The One Devon Dataset brings together primary and secondary care information, but access arrangements, data timeliness and usability have limited its routine use. Acute and community data is not currently available to local teams as a complete, real-time pathway view.

Katherine Allen distinguished the ICB Power BI and financial evaluation work from the operational tool required by neighbourhood teams. Richard Blackwell suggested that a One Devon Dataset use request could provide a route for linking an agreed cohort with wider system data, although this may initially be a snapshot rather than a continuously refreshed solution.

E. Brave AI should be reconsidered using current evidence

The group revisited Brave AI because the product has developed since the earlier North Devon pilot and is being used or considered elsewhere, including Cornwall and Plymouth. Current implementations can use risk, demand and complexity scores and can support more tailored cohort identification.

Potential benefits discussed included the user interface, the ability to refine cohorts and the possibility of identifying people whose needs are increasing but who are not already in the highest-use group. Continuing concerns included transparency, reliance on primary care data and the need to overlay local clinical knowledge and other information.

The group wanted learning from both successful implementations and places where the approach had not worked well. A current demonstration and discussion with the provider would be needed before a recommendation could be made.

F. Implementation involves more than the licence cost

Whichever approach is selected, clinical validation and sense-making will still be required. The meeting also identified information governance, clinical safety, project coordination, MDT review, patient-facing capacity, ongoing maintenance and evaluation as relevant implementation requirements.

An indicative Brave AI figure of approximately 35 pence per head for multiple PCNs was discussed, equating in the meeting discussion to roughly £60,000 for the relevant population. The group noted that the full cost would need to be confirmed and should include implementation and support requirements.

G. Funding remains unresolved

Katherine Allen was clear that any investment in Brave AI should not automatically be assumed to come from the local neighbourhood delivery allocation. The group considered the tool more appropriately framed as enabling infrastructure, but no funding source was identified.

The options appraisal will therefore need to consider the full cost, the opportunity cost and the most appropriate funding route.

H. Two options should be developed in parallel

The emerging direction was to compare two broad routes: build on the existing North Devon segmentation methodology, supported by a One Devon Dataset route where appropriate; or explore Brave AI as an operational cohort-identification tool.

The local approach should continue to develop while further information on Brave AI is gathered. This avoids delaying neighbourhood planning while recognising that a final decision has not yet been made.

3. Actions agreed on 12 August

The meeting agreed that a proportionate appraisal should be developed quickly, using information from the Brave AI provider, current users and the local-method proposal.

No.	Action	Indicative lead from discussion	Position recorded at the meeting
1	Arrange a discussion or demonstration with the Brave AI provider, involving relevant North and East Devon colleagues and appropriate system and data expertise.	Nic Ferreira / Health Innovation South West	To be progressed during September and as soon as practicable.
2	Connect the group with current Brave AI users, including sites with positive experience and sites where the approach has not worked well.	Nic Ferreira / Health Innovation South West	Required to inform the options appraisal.
3	Explore the possibility of shadowing or learning from Plymouth's current Brave AI discussions and implementation.	Caroline Sanford / system colleagues	To be arranged.
4	Clarify the specific neighbourhood cohort and operational use case, including how it relates to the existing red or segmented population.	North Devon neighbourhood leads with Richard Blackwell	Required before the local option can be finalised.

No.	Action	Indicative lead from discussion	Position recorded at the meeting
5	Continue developing the local segmentation option in parallel, including the capacity and support required for sustainable use.	Richard Blackwell with local leads	Agreed so that neighbourhood planning is not delayed.
6	Develop the One Devon Dataset use-request option for linking an identified cohort with wider system data, including the relevant information-governance route.	Richard Blackwell with Ed Bond and relevant data leads	To form part of the local option.
7	Check how the frailty team is currently identifying and stratifying people for frailty and MDT work.	Amy Slater	Follow-up to discussion with the frailty lead.
8	Prepare a proportionate options appraisal comparing the local method and Brave AI.	Local programme team, informed by Richard Blackwell and provider information	To cover purpose, evidence, transparency, data, regulation, IG, implementation, evaluation, cost and funding.

4. Points to resolve through the options appraisal

- What exact outcomes and population should the operational approach support?
- How will each option identify a sufficiently narrow and actionable neighbourhood cohort?
- What data can be included and what important information would remain outside the model?
- How transparent and usable is each method for clinicians and neighbourhood teams?
- What information-governance, clinical-safety and regulatory requirements apply?
- What capacity is required for implementation, validation, maintenance, MDT review and evaluation?
- How will the operational cohort feed the ICB performance and financial evaluation?
- What are the full costs, the appropriate funding source and the opportunity cost?
- How quickly can each option become usable and how can it be sustained?

5. Closing position

No final decision was made on the preferred tool. The meeting closed with agreement to gather the information needed for a balanced comparison while continuing the local-method work in parallel.