Northern Neighbourhood Health Steering Group

Date: 21 July 2026
Time: 08:00–09:30

1. Purpose of the meeting

The meeting regrouped following the Claire Fuller visit and frailty deep dive. Its aims were to:

- agree the next steps for delivering the neighbourhood health model for frailty;
- agree the emerging plan, leads and actions;
- identify service gaps and the potential shape of a funding proposal; and
- clarify where progress would need to be reported.

2. Main points discussed

A. A balanced frailty model is required

There was broad agreement that the Northern plan needs to address several levels of need in parallel:

- immediate reactive care for people in crisis;
- responsive and intermediate care;
- secondary prevention, including fragility fracture prevention;
- proactive care for people with emerging or increasing frailty; and
- longer-term prevention and support for people who are pre-frail.

The group recognised that concentrating only on immediate pressures would fail to reduce future demand, but that longer-term prevention could not replace support for people currently in crisis.

B. Build on existing work rather than start again

The discussion identified existing foundations, including proactive care within primary care, OPIC activity, community services, flow work, Hospital to Home and existing MDT approaches. The group wanted to scale what was already working while identifying the remaining service and infrastructure gaps.

Previously identified gaps included:

- community provision in North Devon;
- community geriatrician input;
- VCSE involvement;
- an end-of-life universal offer;
- the virtual ward interface;

- possible inclusion of UCR; and
- a five-day MDT model drawing on primary care and relevant learning from the Eastern model.

C. Communication and coordination are central

A key theme was the duplication created when community services, primary care, social care, urgent response, virtual wards, the voluntary sector and other services are working with the same person but do not know what the others are doing.

The desired end state was described as integrated community care in which primary care, community services and wider partners work seamlessly around the person. The group felt that improved coordination could reduce duplicate visits and hand-offs, improve patient experience and make better use of existing resources.

D. An integrated MDT was the preferred place to start

The group coalesced around an integrated neighbourhood MDT as an initial practical focus. Further design work was needed to confirm:

- its purpose and functions;
- the population or cohorts it would support;
- core and flexible membership;
- the relationship between proactive and crisis-based care;
- how coordination would work between meetings;
- how it would connect with existing groups and services; and
- how outcomes and benefits would be measured.

The group cautioned against creating a condition-specific or isolated MDT that added another layer. The intention was a person-centred model capable of bringing services together around complex needs.

E. Risk stratification should support action, not delay it

There was support for building on existing patient segmentation and risk-stratification work rather than commissioning a new exercise. The potential contribution of Richard Blackwell and Health Innovation South West was discussed, including using current work as a starting point and ensuring partners accept the methodology and outputs at the outset.

Different routes for identifying people may remain appropriate for different parts of the pathway. Immediate and intermediate-care cohorts may already be known to community services, while proactive-care cases could also be identified through practitioner knowledge and existing population health approaches.

F. Digital tools are enablers, not substitutes for coordination

The Devon and Cornwall Care Record was seen as important infrastructure for shared plans and information. However, members emphasised that a shared record would not by itself coordinate activity or prevent two services responding to the same immediate need.

There were also issues to resolve around:

- Epic integration;
- access rights;
- governance;
- training and mobilisation;
- consistent use of shared plans;
- usability for primary and secondary care; and
- avoiding duplication between different digital products.

The group agreed that neighbourhood digital architecture should be considered through the appropriate digital forum.

G. Resources and funding

Members recognised that the work would need dedicated project management and clinical input, including support for double running while new arrangements were developed. Non-recurrent funding could potentially be used as seed funding, but the plan would need to explain how delivery would become sustainable.

The group also noted the need to distinguish between:

- activities partners could contribute through existing resources;
- genuine new investment requirements; and
- infrastructure or enabling costs such as project support, clinical time, training, digital implementation and evaluation.

H. Measures and evaluation

The proposed model and investments needed to be mapped against the four frailty pillars and relevant outcome measures. Members wanted appropriate metrics for proactive and preventative work, rather than relying solely on immediate acute performance or conventional return-on-investment measures.

The meeting chat included outcome measures across promoting independence and wellbeing, proactive care, integrated intermediate care and frailty-focused hospital care.

I. North and East alignment

There was support for sharing learning and exploring areas where North and East could benefit from working at scale. However, members did not want wider alignment to slow the existing momentum in North or overlook differences in provision, infrastructure and maturity between the two localities.

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3. Actions agreed on 21 July

Katherine Allen summarised six principal actions during the meeting.

No.	Action	Indicative lead from discussion	Position recorded at the meeting
1	Develop the integrated neighbourhood MDT model, including purpose, target population, membership, functions and relationship to existing groups.	Leads to be allocated by Katherine Allen and Ed Bond	Agreed as the preferred starting point.
2	Progress the Health Innovation South West contribution, including use of existing risk-stratification work and evaluation support.	Andrea Beacham to progress the conversation	Funding and acceptance of the methodology needed clarification.
3	Confirm the project management and clinical capacity required to develop and mobilise the model.	Partnership and provider leads	RDUH had indicated that some project management capacity might be available.
4	Support development and mobilisation of the Devon and Cornwall Care Record, including training, access, governance and practical clinical workflows.	Joanne Shill, with relevant primary and secondary care colleagues	Business-case and support requirements to be developed.
5	Map the proposed Northern model, activities and timetable against the frailty pillars and KPIs.	To be allocated	Required to show intended outcomes and the proposed 12-month trajectory.
6	Refer neighbourhood digital architecture and cross-system communication requirements to the relevant digital steering arrangements.	Katherine Allen / Ed Bond to connect with digital leads	Needed to address Epic, primary care systems and possible asynchronous MDT capability.
7	Update the governance map to show the relationship between the MDT, delivery groups, decision-making bodies and financial accountability.	Andrea Beacham with Katherine Allen and Ed Bond	Identified as necessary as the model developed.
8	Establish regular Northern Steering Group meetings and circulate an allocated action list.	Katherine Allen and Ed Bond	Agreed at the end of the meeting.
9	Continue North-led progress while identifying specific opportunities for	Steering Group	Longer-term action rather than a prerequisite for starting.

	North and East alignment and shared learning.		