



Ilfracombe Health & Justice Workshop #3

Workshop Report

Tuesday 16 December 2025, 1pm–4pm
The Candar, High Street, Ilfracombe

Contents

Purpose of the workshop	2
Attendees	2
1. Context	2
2. Formulating the mess: biggest challenges in cross-agency team working	4
3. Ends planning: what success looks like	8
4. Means planning: practical enablers	9
5. Implementation planning: agreeing the Team Around the Person process.....	10
6. Lived experience input and validation	11
7. Completing the Interactive Planning cycle.....	12
8. Wrap up and next steps	12
9. Actions log (captured and inferred from discussion).....	12
Sources used for this write-up	16
Appendix A	16
Devon Integrated Neighbourhood Teams Workshop – 15.12.25	16
Appendix B	21
Workshop #3 Agenda.....	21

Purpose of the workshop

Using a Systems Thinking approach (specifically Interactive Planning methodology):

- Agree the shared vision for a Team Around the Person approach within the Ilfracombe Health & Justice pilot.
- Agree the practical process for delivering Team Around the Person, including membership, information flows and governance requirements.
- Work through Interactive Planning steps to move from current challenges to a viable implementation plan.

Attendees

Name	Role	Organisation
Richard Blackwell	Head of Insights	Health Innovation South West
Libby Smith	Researcher	Health Innovation South West
Lisa Woodward	Stop for Life Engagement Lead	ICE creates
Danielle Meeks	PCN coordinator	Coastal PCN
Rofiat Adeyemi	Reconnect	Devon Partnership Trust
Jake Moore	Community Services Manager	Devon Partnership Trust
Graeme Murray	Probation Service	Probation Service
Richard Preston	Local Sector Inspector	Devon & Cornwall Police
Glenda Jones	Outreach nurse	Royal Devon University Healthcare Trust
Simon Rapsey	Project Manager	Royal Devon University Healthcare Trust
Jenny Smith	Adult Social Care	Devon County Council
Phil Harris	Community Development Lead	Devon Mental Health Alliance
Andrea Beacham	Programme Manager	Royal Devon University Healthcare Trust
Tim Sawyer	Probation Services Officer	Probation Service
Mandi Tydeman	Operational support manager	Royal Devon University Healthcare Trust

1. Context

The group revisited the background of the Health and Justice pilot and the progress from Workshops #1 & #2.

- The pilot is one of four national pilots being described as neighbourhood health pilots by the national lead who has a joint role between NHS England and the MOJ. There is a time-limited funding window (end of March 2026).
- National learning interest was noted and used as a prompt to ensure the operating model and barriers to success are clearly documented.

Scope and boundary

- **Cohort:** people currently on probation within Ilfracombe
- **Geography:** Combe Coastal Practice area (Ilfracombe and surrounding villages)

- **What the “Team Around the Person” includes/excludes** (e.g. coordinated plan & joined up working; not a new clinical service)

Systems Thinking Approach

- A Systems Thinking approach is being used to support the Health & Justice improvement work because it involves people with interdependent needs spanning many services. The ‘failures’ to adequately support individuals in contact with the criminal justice system as described by participants in Workshop 1 are not due to single service failure but more by how multiple agencies, incentives and information flows interact. A systems approach helps make sense of the whole system (Workshop #1), design clearer co-ordination and governance (Workshop #2). Workshop #3 takes us from a shared diagnosis of the challenges of multi-disciplinary team working to an agreed, practical plan for change (using Interactive Planning methodology).
- This workshop was structured around the core stages of Interactive Planning. Participants began by formulating a shared, locally created and owned diagnosis of the current system challenges (“the mess”) for Team Around the Person working in a Health & Justice context, building on Devon-wide learning about Integrated Neighbourhood Teams. The group then moved into Ends Planning to describe an idealised picture of what effective collaboration would look and feel like for people and for professionals if the system were working as intended. From this, participants identified practical enabling components in Means Planning, before translating these into an outline operating model and implementation steps, including MDT arrangements, information governance requirements, and a timebound action log to support delivery within the pilot window.

Interactive Planning stage	Purpose in this workshop	Key outputs captured in this report
1. Formulating the Mess	Establish a shared, locally owned diagnosis of the current system challenges for Team Around the Person working in a Health & Justice context.	Locally created and owned ‘mess’ narrative framed against Devon-wide INT themes. 10-theme mapping table (Devon themes & H&J evidence & what H&J lens adds). Reinforcing-loop framing (interdependencies and ‘solution-sprawl’ highlighted in themes)
2. Ends Planning	Describe an idealised picture of success : what would it be like for people and professionals if the system worked as intended.	Success criteria for people (safety, clarity, fewer handovers, no repeated storytelling, coordinated access). Success criteria for professionals/agencies (clear contacts, efficient sharing/referral, shared ownership, parallel working, tracking). Design principles & measurement intent (early support, legibility, flexible intensity, outcomes/process/balancing measures; “middle layer” cohort noted).

<p>3. Means Planning</p>	<p>Identify practical enabling components that would make the idealised ends achievable day-to-day.</p>	<p>Draft set of enablers/components: holistic assessment/triage; coordination function; weekly MDT case list with pre-reads; short “key story” & action plan shared/updated; live directory of contacts/roles; secure comms approach; transparent handling of thresholds/waiting lists & interim low-threshold offers.</p>
<p>4. Implementation Planning</p>	<p>Translate means into a workable operating model, governance steps, and a practical start plan for the pilot’s MDT.</p>	<p>Operating model outline: weekly MDT agreed in principle; proposed start 1 Feb; preferred day/time guidance; indicative time per case; core membership + call-in agencies. Information governance requirements: process write-up & map to support DPIA/IG sign-off; identify IG leads per org; initial comms via secure email; explore Teams later. Scope/timing decisions: Reconnect eligibility clarification required; entry/exit approach as March funding end approaches. Action log with owners/dates to enable implementation.</p>

2. Formulating the mess: biggest challenges in cross-agency team working

This workshop was framed within the wider Devon-wide programme to progress Integrated Neighbourhood Teams (INT) as part of the Neighbourhood Health vision set out in the NHS 10-Year Plan. On the previous day (15.12.25), the ICB held a Devon-wide workshop which articulated a set of shared themes describing the challenges of integrated neighbourhood working. These themes were made available to participants as a reference point.

Participants were then asked, in groups, to explore the current issues and challenges (“the mess”) associated with working in a joined-up way within a Health & Justice context. They were invited to build on the Devon-wide themes where relevant, while also developing a local, Health & Justice-specific diagnostic to surface additional dynamics and constraints unique to this system.

The resulting Health & Justice “mess” should therefore be understood as a locally created and owned diagnosis of a recognised system problem. While many of the underlying root causes align with the wider Devon-wide findings, this exercise enabled participants to articulate how these issues are experienced in practice within Health & Justice, and to identify context-specific challenges that require focused attention.

Challenges of supporting people with complex needs across multiple agencies: themes from group discussion mapped against the Devon themes

Devon-wide theme	Health & Justice workshop evidence	What the Health & Justice lens adds
1. Fragmentation & lack of alignment across the system	Organisational boundaries and unclear ownership mean no single service reliably holds the whole person over time.	Justice involvement magnifies fragmentation across health, probation, housing, VCSE and place. No single agency has mandate or visibility across the whole journey.
2. Weak end-to-end pathways	Linear processes & serial referrals create bottlenecks and delays. 'Snakes and ladders' effect where pathway-breaks lose progress.	Breakpoints are most visible at justice transitions (e.g. release, recall). Lack of progress increases risk of crisis, breach or reoffending.
3. Inequity of access and outcomes	Responsibility drifts back to individuals via signposting, particularly affecting people with complex needs.	People in contact with the justice system are least able to self-navigate, meaning equal processes generate unequal outcomes.
4. Over-medicalised, reactive model of care	The system is good at crisis response but less effective at keeping people stable once immediate risk reduces or with rising risk.	Crisis responses often involve ED, police or custody, with preventative and relational support dropping away.
5. Failure to support people to stay well at home	Housing instability is a major barrier to engagement and progress.	Housing acts as a keystone dependency in Health & Justice contexts; without it, all other support becomes fragile.
6. Lack of a clear, shared core offer	Systems and language are hard to navigate; too many entry points and thresholds.	Neither professionals nor people experience a coherent Team Around the Person offer.
7. Weak data, information sharing and digital integration	Information does not travel with the person, leading to repeated storytelling and manual workarounds.	Especially pronounced due to risk aversion, consent uncertainty and incompatible systems across justice and health.
8. Disempowering experience for people and families	People are passed between services and required to repeat themselves	Experiences reflect systems designed for administrative convenience rather than human experience.
9. Commissioning and incentives reinforce the problem	Resource scarcity and uneven capacity across areas lead to delays and inconsistent support.	Short-term, siloed commissioning limits shared ownership of outcomes such as post-release stability.
10. Communities are under-used as part of the solution	Limited ability to mobilise community assets despite appetite for relational and parallel working.	VCSE & community organisations hold trust and continuity but are not systematically integrated or resourced.



When viewed against the full set of Devon-wide problem themes, the Health & Justice workshop did not introduce new categories of system failure. Instead, it provided a concentrated illustration of how these issues interact and compound for people with complex needs in contact with multiple agencies. In particular, weaknesses in information flow, commissioning incentives, and the disempowering experience of navigating the system were shown to interact and compound, reinforcing fragmentation and crisis-driven responses.

Reinforcing loops

Whilst 10 distinct themes emerged from both workshops as structural barriers to effective integrated team working, they cannot be dealt with separately; there are reinforcing loops both within themes and between themes.

For example, within Theme 7 (weak data, information sharing and digital integration), the issues reinforce one another: fragmented and incompatible systems, combined with risk-averse information governance, mean professionals lack a shared picture and coordination is held together through patchy and informal channels. This reliance on workarounds increases perceived risk, which further reduces confidence and capability to share information consistently. Between themes, housing instability (Theme 5) and a reactive, crisis-led model of care (Theme 4) form a vicious cycle: unstable housing disrupts engagement and follow-through, driving late crisis responses, and crisis episodes then further undermine housing and stability.

This matters for the next stage because Interactive Planning requires designing for 'the mess' – a set of interdependent conditions - rather than designing fixes for separate issues (ie. a new referral form, a new meeting, a new directory, a new pilot pathway). Piecemeal improvements can result in 'solution sprawl': many small actions that add complexity without shifting outcomes.

Recognising these feedback loops strengthens both Ends Planning and Means Planning. In Ends Planning, it supports an idealised description of what "good" would look like if the system were working as intended – focusing on the conditions that would prevent the loops from forming in the first place (for example, information routinely flowing with the person, shared ownership across agencies, and sustained stability rather than crisis-driven contact). In Means Planning, it provides a practical test for prioritisation: proposed actions should be selected because they are likely to interrupt reinforcing loops and move the system toward the agreed idealised ends, rather than addressing symptoms in isolation.

Problem statements (synthesis of the mess)

Team-working Problem Statement

For people on probation, the agencies involved do not yet operate reliably as a team: ownership is unclear, information does not reliably follow the person, and support is provided through sequential referrals across multiple entry points and thresholds with limited capacity. As a result, people experience repeated handoffs and resets (“snakes and ladders”), responsibility drifts back to the individual via signposting, and instability (especially housing) increases the likelihood of crisis-led responses.

This problem statement sits within the overall pilot problem statement which summarises the overarching problem the Health & Justice pilot is seeking to address:

Health & Justice Pilot Problem Statement

National evidence shows that people on probation often come from underprivileged backgrounds shaped by trauma, poverty, and exclusion, and experience some of the poorest health outcomes in the community. Engagement with local partners has highlighted the perception that services too often “set people up to fail” by not ensuring access to basic needs such as housing, healthcare, and income. Needs in this population are frequently invisible in mainstream health planning because NHS numbers are not consistently captured and data is not linked across agencies. Services work hard but operate in silos, leading to duplication, missed opportunities, and gaps in care. Without systematic assessment, shared data, and coordinated responses, individuals are more likely to cycle between crisis and reoffending, while the wider system bears the cost.

Mess output: A locally owned diagnosis mapped to Devon-wide themes and key reinforcing loops.

‘Mess’ test of success: This diagnosis will be considered “good enough” to design from if it aligns with our lived experience engagement and broadly matches what we hear in the Northern Devon collaborative working questionnaire and from what we see emerging once MDTs begin—so that we can proceed to Ends Planning without reopening the diagnosis at every subsequent decision point.

Actions: Confirmation of diagnosis from Health & Justice stakeholders; Northern Devon collaborative working questionnaire to be added to confirm diagnosis with a larger set of relevant stakeholders.

3. Ends planning: what success looks like

The group discussed what 'ideal' collaboration would look and feel like, from both service user and professional perspectives.

Success for people

- Feel safe, valued and understood.
- Know who is involved and why, with fewer handovers and less confusion.
- Do not have to repeat their story multiple times.
- Support is available when needed and reflects the person's priorities and preferences.
- Where possible, access is simplified through one-stop or coordinated appointments ('same day, same place' was noted as an ideal).

Success for professionals and agencies

- Named points of contact and clear routes to advice and escalation.
- Ability to share information and make referrals efficiently, with shared ownership of follow-up and risk.
- More parallel working and joint problem-solving, rather than sequential referrals.
- Practical ways to track actions and outcomes across agencies.

Design principles and measurement

- Early support and a more legible system, designed around people rather than boundaries.
- Flexible support intensity: 'do for', 'do with' and 'let them do it' depending on the individual's level of empowerment and complexity, with ability to step up and step down over time.
- Measure what matters using a mix of outcome measures, process measures and balancing measures (for example impact on staff capacity and operational pressure).
- A 'middle layer' of people sitting just below statutory thresholds was highlighted as a group who may benefit from coordinated support to stay stable.

'Ends' planning output: Agreed idealised success conditions and draft measures.

'Ends' planning test of success:

Everyone can describe what success looks like for people (validated by lived experience) and professionals in the same way, and we have a small set of agreed success conditions and measures that will let us judge whether the new Team Around the Person approach is working.

Actions: Circulate the draft Ends (what success looks like for people and professionals) to Health & Justice partners for sign-off, agree 6–10 priority success criteria/measures (outcome, process and balancing), and confirm how these will be reviewed once MDTs begin. These don't need to be perfect end state KPIs but rather “signals of success” that would signal we are moving in the right direction.

4. Means planning: practical enablers

Participants suggested concrete steps that would make collaboration easier day to day.

- Start with a holistic needs assessment and triage to clarify priorities and complexity, often initiated through probation.
- A coordination function (Mandi Tydeman -RDUH) to identify the right mix of agencies for each person, and to support follow-up and risk management.
- A shared set list of cases for the weekly MDT, with key needs and background shared in advance.
- A short ‘key story’ and agreed action plan per person, shared with the individual and updated over time.
- A live directory of contacts across organisations, including clarity on roles and referral expectations.
- Secure communications: a secure email group with secure attachments for sharing assessments, action plans and updates, with recipients validated.
- Acknowledgement of waiting lists and thresholds, with transparent communication and interim low-threshold support offers where appropriate.

‘Means’ planning output: list of enabling components (assessment/triage, coordination function, MDT cadence, shared plan, directory, comms)

‘Means’ planning test of success:

The essential enablers for the first iteration of the Team Around the Person model are agreed and in place or scheduled with clear owners and dependencies, so implementation can begin without relying on ad-hoc workarounds. Lived experience engagement validates that the enablers identified are delivered in a way that is helpful and feels safe/accessible/respectful.

Action: Put in place the agreed essential enablers for February start date: (referral & consent process, coordination function, MDT case list process, shared “key story” & action plan template, live directory, secure communications), with owners, sequencing and dependencies (e.g., DPIA/secure email set-up), and an agreed interim low-threshold offer where waiting lists/thresholds prevent progress.

5. Implementation planning: agreeing the Team Around the Person process

The group moved from principles to an outline operating model, focusing on practical MDT arrangements and information governance requirements.

MDT format and membership

- Weekly MDT agreed in principle, with start from 1 February (exact date and meeting invite to be confirmed).
- Thursday afternoons were suggested as the preferred slot; Wednesdays to be avoided; Tuesdays may clash with health checks.
- Indicative scheduling of around 20 minutes per person or case, as a starting point.
- Core membership discussed as health, probation and adult social care, with other agencies brought in when relevant.
- Additional agencies referenced for call-in: housing, police, drug and alcohol services, employment support including DWP or Connect to Work, and VCSE.

Information sharing and governance

- Process documentation and an agreed map required to support DPIA and information governance sign-off.
- Each organisation to identify IG contacts and confirm the appropriate IG route for DPIA and data sharing agreements.
- A pragmatic initial comms approach was preferred: secure email, with a review of Teams options once access constraints are addressed.

Referral scope and pilot timing

- Reconnect pathway eligibility to be clarified and included in documentation (noted as pre-release or within 28 days post-release).
- Concern was noted that actions may remain open as March approaches; weekly MDTs to monitor progress and surface constraints.
- An entrance and exit approach was discussed: clarify expectations for entry into the pilot and what happens if funding ends; suggested approach included no new participants after March if the pilot ends, while continuing MDT support for existing participants where possible within resources.

Implementation planning output: Agreed MDT model, governance requirements, and action owners/timeline.

Implementation planning test of success:

When the Team Around the Person operating model is sufficiently defined and authorised to start safely — i.e., the MDT cadence/time/attendance expectations are confirmed, core membership and call-in routes are agreed, referral scope and entry/exit rules are clear, and the information governance route (including DPIA requirements, IG contacts and interim secure communications) is agreed with a workable timetable

Actions (to complete Implementation planning / start delivery)

Action: Finalise and issue the Team Around the Person process write-up and map (including referral scope, eligibility, entry/exit rules, information flows and controls) for partner sign-off; confirm the weekly MDT slot and circulate invitations; confirm core membership and call-in contacts; establish the agreed interim secure communications approach; and convene a joint IG/DPIA session to agree the governance steps and timeline required to begin MDT operation on the planned start date.

6. Lived experience input and validation

Direct engagement with people on probation has been limited to date due to access constraints and the early stage of recruitment into the pilot. However, lived experience has informed this work through: (i) one direct interview with a person in the target cohort; (ii) indirect insight via VCSE organisations supporting people with lived experience; and (iii) insight from people with similar experiences who are not within the pilot cohort.

As the pilot progresses, lived experience will be used explicitly to validate and refine the Interactive Planning outputs — including the diagnosis of the current system (“the mess”), the description of what ‘good’ looks like (Ends Planning), and the design and implementation of enabling components (Means and Implementation Planning). This will be achieved through two routes: (1) engagement led by probation with people recruited into the pilot; and (2) a Kafka Brigade accountability approach, described below, to deepen understanding of typical service journeys and strengthen multi-agency learning.

Kafka Brigade approach (system accountability and learning)

To strengthen system learning, we will recruit a person with lived experience whose profile reflects common characteristics of the local probation population (derived from triangulated local data), recognising that individual experiences vary. (This does not claim statistical representativeness; it is a structured learning method designed to surface system dynamics). This approach is intended to avoid designing around outliers while still honouring individual narrative detail.

With informed consent and appropriate safeguards, we will document the person’s journey through services in detail (touchpoints, handoffs, barriers, what helped, and what harmed). A multi-agency review will then be held to examine how the system contributed to the experience and to identify concrete changes partners will make, including commitments to reduce unnecessary friction, repeated storytelling, and gaps at transitions.

This work will be carried out using a trauma-informed approach with informed consent, confidentiality, the right to withdraw at any time, and clear boundaries about what will and will not be shared with agencies. Where possible, participants will be supported through a VCSE partner and we will explore appropriate recognition for their time and contribution.

7. Completing the Interactive Planning cycle

To complete the Interactive Planning cycle for the Team Around the Person approach within this pilot, the following additional steps will be undertaken:

- **Resource planning:** confirm minimum viable capacity required for MDT delivery (attendance, coordination and administration) and how this will be provided within the pilot window.
- **Measurement and learning:** agree a small set of outcome, process and balancing measures aligned to the agreed ends, and establish a review cadence (weekly operational oversight via MDT and a monthly learning review).
- **Sequencing and dependencies:** confirm what activity can proceed immediately and what is dependent on DPIA/Information Governance approval, including any interim arrangements.
- **Iteration:** schedule a short redesign point after the first 4–6 MDTs to review early learning, including service user feedback and wider questionnaire findings, and refine the operating model accordingly.

8. Wrap up and next steps

Wider system evidence (Northern Devon questionnaire)

In parallel, a questionnaire has been issued to agencies across Northern Devon to capture perceived barriers and enablers to cross-agency collaboration. Findings will be used to triangulate and refine the ‘mess’ and inform the wider Interactive Planning report, recognising that these insights extend beyond the Health & Justice pilot but are directly relevant to integrated teamworking.

A short learning review will be produced following the initial MDT delivery period, summarising what changed as a result (including refinements to the model, measures, and governance arrangements).

The group confirmed immediate next steps to enable the MDT to start and to complete governance requirements.

9. Actions log (captured and inferred from discussion)

Leads and dates below are based on the meeting notes. Where an owner is marked ‘to confirm’, this should be agreed at the first follow-up.

Action	Owner	By when	Notes
Process design and documentation			
Finalise and circulate the Team Around the Person process write-up and map for partner review.	Simon Rapsey (RDUH)	By early January 2026	Include information flows, escalation points and agency roles.
Confirm Reconnect eligibility rule (pre-release or within 28 days post-release) and reflect in process documentation.	Rofiat Adeyemi (Devon Partnership Trust)	By mid-January 2026	Ensure referral scope is clear.
Finalise referral & consent process (incl. information flows/controls) and confirm entry/exit criteria in one place.	Simon Rapsey (RDUH) / Graeme Murray (Probation Service)	By mid-January 2026	
Agree pilot entry and exit arrangements for March, including expectations if funding ends and how to avoid bringing in new participants late without support.	Simon Rapsey (RDUH) / Graeme Murray (Probation Service)	By February 2026	Confirm what can continue within existing resources.
Analyse Northern Devon collaboration questionnaire findings and confirm/refine the diagnosis ("mess") accordingly.	Andrea Beacham (RDUH) / David Richardson (Devon Partnership Trust)	By mid-Jan 2026	Use as triangulation alongside early MDT learning.
Information governance and comms			
Collate Information Governance contacts for each organisation and schedule a joint IG meeting to agree DPIA requirements and timeline.	Simon Rapsey / Amy Slater (RDUH)	By late January 2026	Aim to complete governance steps before MDT start.
Set up secure email group and agreed approach to secure attachments for sharing assessments, action plans and updates.	Graeme Murray (Probation Service) / Amy Slater (RDUH) with IG contacts	By late January 2026	Review Teams channel feasibility later.
Tools and enablers			

Create and agree templates: “key story” & action plan; set up and maintain the live directory of contacts/roles/referral expectations.	Simon Rapsey (RDUH)	By end of January 2026	
Define the interim low-threshold offer (what happens when thresholds/waiting lists block progress) and how MDT will trigger it.	Simon Rapsey (RDUH) / MDT partners	By end of January 2026	
Confirm and implement the coordination function for Team Around the Person (between-MDT coordination, case tracking, follow-up and risk/action management).	Simon Rapsey / Mandi Tydeman (RDUH)	By late Jan 2026	Define interface with probation referral/triage and admin support requirements.
MDT set-up and operations			
Confirm regular Thursday afternoon MDT slot (avoid Wednesdays) and send calendar invitations for February and March.	Simon Rapsey (RDUH) / Graeme Murray (Probation Service)	By mid-January 2026	Start date discussed: 1 February.
Agree MDT core membership and named points of contact for key agencies; identify call-in contacts for housing, police, drug and alcohol, and employment support.	All partners (to confirm)	By mid-January 2026	Include DWP or Connect to Work.
Measurement and learning			
Agree and document 6–10 priority measures (outcome/process/balancing) and confirm how they will be reviewed (weekly MDT ops + monthly learning review).	Andrea Beacham (RDUH) / Nic Ferreira (HISW)	By end of January 2026	Needs to be ready before MDT start date.
Confirm minimum viable capacity for MDT delivery (attendance, coordination, admin) and what is de-prioritised if needed.	Simon Rapsey (RDUH) / MDT partners	By end of January 2026	

Schedule a redesign/iteration session after 3–4 MDTs and agree inputs (service user feedback, measures, questionnaire findings, constraints).	Simon Rapsey (RDUH) / MDT partners / Nic Ferreira (HISW)	By end of February 2026	Book date end of February now.
Lived experience			
Identify 1–2 probation service users for a facilitated lived-experience session and confirm facilitator and format.	Graeme Murray / Kirsty Frampton (Probation Service)	By February 2026	Service user feedback and identifying Kafka Brigade participants.
Use a trauma-informed approach with consent and clear boundaries on what will/won't be shared; explore appropriate support and recognition for participation.	Graeme Murray (RDUH)	By late Jan 2026	
Embed lived experience in stage completion checks (Mess, Ends, Means), alongside questionnaire findings and early MDT learning.	Simon Rapsey (RDUH) / Kirsty Frampton (Probation)	By late Jan 2026	Confirm diagnosis; refine what “good” looks like; check enablers reduce burden and feel safe
Introduce light-touch feedback once MDTs begin (3-question pulse + brief narrative prompt).	Simon Rapsey (RDUH) / Kirsty Frampton (Probation)	By late Jan 2026	(i) 3-question pulse after contact (e.g., clarity about who is helping, feeling respected, reduced repetition), and (ii) brief narrative prompt (e.g., “What was the hardest part this week?”) to surface barriers and unintended consequences.
Kafka Brigade accountability review: recruit the Kafka Brigade participant, document the service journey, and hold a multi-agency review in which each	Simon Rapsey (RDUH) / Graeme Murray (Probation Service) VCSE partner (to confirm)	By March 2026	Use a trauma-informed approach with consent and clear boundaries on what will/won't be shared; explore appropriate support

agency agrees 1–2 concrete changes; record commitments in the action log and review progress at the redesign/iteration session.			and recognition for participation.
---	--	--	------------------------------------

Sources used for this write-up

- AI-generated summaries from the meeting audio
- Two audio transcript extracts provided from in-person recording.
- Handwritten notes provided by the workshop organiser.
- Key themes of the problem situation noted by the workshop organiser from the Devon Integrated Neighbourhood Teams Workshop – 15.12.25 (Appendix A)

Appendix A

Devon Integrated Neighbourhood Teams Workshop – 15.12.25 Key Themes of the Problem Situation

The themes set out in this appendix were drawn from a Devon-wide Integrated Neighbourhood Teams workshop held on 15.12.25, facilitated using systems-thinking principles aligned with Interactive Planning. Permission was given to collate and reuse these outputs to support subsequent work.

Given the close alignment between Integrated Neighbourhood Teams and a Team Around the Person approach, these themes were shared at the Health & Justice workshop on 16.12.25 as a starting point for discussion. Participants were invited to test, build on, and adapt these themes in the context of Health & Justice, rather than treat them as fixed or complete.

1. Fragmentation & lack of alignment across the system

The system is experienced as **disconnected and siloed**, with poor alignment:

- Between children’s and adults’ services
- Between health, social care, VCSE, housing, education and justice

This results in:

- Disjointed pathways
- Duplication of effort

- Gaps in provision
- People being discharged from one service only to wait for another

Core problem:

The system is organised around organisational boundaries rather than people, families or places.

2. Weak end-to-end pathways

There is no reliable **end-to-end pathway** for people, particularly those with complex or fluctuating needs.

People experience:

- Repeated referrals
- Being passed between services
- No clear ownership of the whole journey
- Crisis responses instead of planned, proactive support

Core problem:

No one is responsible for holding the whole person or family across time.

3. Inequity of access and outcomes

Access to services and outcomes varies significantly depending on:

- Geography (rural / coastal disadvantage)
- Socio-economic position
- Complexity of need
- Ability to navigate the system

This creates:

- Inequalities in access
- Inequitable outcomes
- Disproportionate impact on disadvantaged communities

Core problem:

The system treats equality of provision as fairness, rather than designing for equity of outcome.

4. Over-medicalised, reactive model of care

The prevailing model:

- Prioritises clinical and crisis responses
- Responds late rather than early
- Focuses on deficits and symptoms

This leads to:

- Avoidable hospital admissions

- Inappropriate crisis responses (ED, police, sectioning)
- Failure to address underlying social, emotional and community drivers

Core problem:

The system intervenes too late and in the wrong way, because it undervalues prevention and social determinants.

5. Failure to support people to stay well at home

There is insufficient, poorly coordinated support to:

- Keep people well at home
- Reduce isolation
- Maintain independence
- Support families and carers

Frail people, in particular, experience:

- Preventable deterioration
- Crisis admissions in the last year of life
- Fragmented home-based support

Core problem:

Community-based, preventative and relational support is under-invested and under-connected.

6. Lack of a clear, shared “core offer”

There is no common understanding of:

- What support is available
- At neighbourhood, place and system level
- For different cohorts (children, adults, families, complex needs)

This affects:

- Referrals
- Navigation
- Professional confidence
- Public understanding

Core problem:

The system cannot explain itself clearly to the people it serves.

7. Weak data, information sharing and digital integration

Data and information systems are:

- Fragmented
- Poorly interoperable

- Risk-averse rather than risk-balanced

As a result:

- People must repeat their story
- Professionals lack a shared picture
- Coordination is manual and fragile

Core problem:

Information does not flow with the person.

8. Disempowering experience for people and families

People report feeling:

- Confused
- Passed around
- Not understood as a whole person
- Reduced to diagnoses or service eligibility

This is particularly acute for:

- People with mental health needs
- Families with multiple services involved
- Those with fluctuating or non-standard needs

Core problem:

The system is designed for administrative convenience, not human experience.

9. Commissioning and incentives reinforce the problem

Commissioning is:

- Siloed
- Short-term
- Competitive rather than collaborative

This drives:

- Duplication
- Misaligned incentives
- Lack of shared accountability for outcomes

Core problem:

The way services are commissioned perpetuates fragmentation rather than integration.

10. Communities are under-used as part of the solution

Communities:

- Often understand needs best



one northern devon



- Hold assets and relationships
- Are not sufficiently empowered or resourced

Decision-making is overly centralised, rather than:

- Neighbourhood-led
- Place-based
- Co-produced

Core problem:

The system does not trust or enable communities to shape how needs are met.

In one sentence

We have a fragmented, reactive, inequitable system organised around services rather than people, lacking shared ownership, coherent pathways, and the conditions needed to support wellbeing, prevention and community-led solutions.



one northern devon



Appendix B

Workshop #3 Agenda

Workshop agenda as shared in advance:

1. Welcome and context (10 minutes): purpose of the workshop; recap of previous workshops and Health and Justice pilot.
2. Formulating the mess (30 minutes): review insights and questionnaire themes; group exercise on biggest challenges; cluster themes.
3. Ends planning (40 minutes): prompt on what success looks like; small group discussion; share back; draft success criteria.
4. Means planning (30 minutes): brainstorm practical enablers including IG arrangements, information sharing and forums; prioritise.
5. Agree process for Team Around the Person (30 minutes): review or co-create process draft; confirm IG requirements and next steps.
6. Wrap-up and next steps (10 minutes): summarise decisions and actions; confirm timeline for governance and implementation.