

Trust Executive Board

Date: 15 October 2025

Agenda item: Leave blank

Title: NHSE-funded, RDUH-led Integrated Health & Wellbeing pilot for people on probation in Ilfracombe

Prepared by: Andrea Beacham, Senior Programme Manager for Health Inequalities

Presented by: Andrea Beacham

Action required: *To note that there is a 6-month pilot*

To support the proposed use of the grant funding

To note the required and likely involvement in this pilot from Ilfracombe community teams and ED and to support awareness amongst clinical teams

For noting

1. PURPOSE

To brief the Trust senior leadership team on the Royal Devon's leadership of, and participation in a six-month Health & Justice pilot in Ilfracombe to improve health outcomes for people on probation in Ilfracombe.

Funding of £40,000 has been allocated for a six-month pilot running from 1st October 2025 – 31st March 2026. We are one of four pilots nationally, and they will give us a significant opportunity to influence national policy and practice in a high profile government mission regarding criminal justice.

This pilot is also an opportunity for RDUH to test what is required to enact models of care set out by the Neighbourhood Health Guidelines for Integrated Neighbourhood Teams and receive funding to support the approach. The pilot will require time from RDUH nursing, managerial and BI staff (outlined below and paid for by the pilot), project management from the Partnerships Team and participation in the Team around the Person approach by the clinical team identified in individual health needs assessments. The pilot intervention comprises seven steps that rely on better information sharing between and within the NHS and the Probation Service.

A Neighbourhood Health & Justice implementation toolkit will be created, (which may form the blueprint for other cohorts such as Frailty or Multiple Long-Term Conditions).

2. BACKGROUND

The Health and Justice pilot has been developed with NHS England's Health and Justice Lead, Chandraa Bhattacharya. Ilfracombe is one of four sites across England that has been chosen to test innovative approaches to improving access, experience and outcomes for people on probation. The Ilfracombe proposal has been informed by a series of stakeholder interviews, a multi-agency workshop – the outputs of which can be found [here](#) and a [report commissioned by the Royal Devon](#) about prison-leavers' experience of healthcare.

Of the four pilots, Devon's has the fewest participants (around 50) as the emphasis is on generating learning about the model being tested within a Neighbourhood Health context.

Further detail on policy context, local needs and prior engagement is provided in **Appendix A: Background & Policy Context.**

3. KEY ISSUES

3.1 Poor health and unmet needs

People under supervision of the probation service experience health inequalities linked to complex and inter-related socio-economic disadvantage. They have significant health and social care needs compared to the general population. Around 50% have a diagnosed mental health condition, and they are more likely to suffer from cardiovascular disease, respiratory illness, and cancer. Despite these complex needs, people on probation (who are serving non-custodial sentences), do not have access to the specialist support services that are available to prisoners and prison-leavers and often fall through gaps in service provision.

3.2 Lack of Data Visibility and Integration

People on probation are often invisible to the NHS. Their NHS numbers are not routinely captured, and their probation status (and therefore enhanced risk factors) are not known to public services. There is no shared care planning between agencies, and public services lack the mechanisms to track unmet needs or coordinate responses. This prevents effective population health management and contributes to poor outcomes, including unplanned hospital use and poor continuity of care.

3.3 Rising System Pressures

National policies aimed at reducing the use of prison and promoting community sentences are increasing pressure on probation and wider services in the community.

Without joined-up intervention, this will likely result in increased costs across health, housing, and justice systems.

3.4 Missed Opportunities at Probation Contact Points

Probation appointments represent a critical touchpoint to engage individuals who are otherwise disconnected from services. Currently, there is no systematic way to use these encounters to assess health and wellbeing, develop coordinated support plans, or enable early intervention. This represents a missed opportunity to improve health and reduce reoffending through timely, holistic support.

3.5 Barriers Created by System Complexity

Insights from the Kafka Brigade and Poverty Truth Commission show that fragmented services, rigid processes, poor communication between agencies and lack of local

access are key barriers for people trying to access help. These systemic issues reinforce disadvantage and waste public resources. A new model is needed that improves access, reduces wasted contacts, and holds systems to account for addressing identified needs, rather than responding only to crisis escalation.

4. PROPOSALS

4.1 Aim

This pilot aims to create a new partnership between the NHS and the Probation Service to fill national and local knowledge gaps about the healthcare needs and healthcare utilisation of people on probation. By embedding probation delivery within Ilfracombe and strengthening collaboration across neighbourhood health, justice, and community services, the pilot will generate new insights into this population's health and service use while also testing interventions designed to improve healthcare access, health outcomes, and rehabilitation. Learning will inform improvements, test Neighbourhood Health ways of working, and provide a scalable blueprint for wider system change.

4.2 Objectives

- **To generate new evidence** on the healthcare needs and healthcare utilisation of people on probation in Ilfracombe, addressing gaps in local and national knowledge.
- **To test the feasibility and effectiveness** of embedding probation delivery within a Neighbourhood Health model and using a Team Around the Person (TAP) approach to inform our future Neighbourhood Health MDT.
- **To evaluate specific interventions** — including holistic needs assessments, structured health checks, NHS-number capture, multi-sector data linkage, and the Team Around the Person (TAP) model — in improving access to healthcare, health outcomes, and rehabilitation.
- **To identify system enablers and barriers** to neighbourhood-based collaboration and cross-sector integration and assess their implications for wider service design and delivery.
- **To produce a scalable Neighbourhood Health & Justice blueprint**— capturing adoptable pathways, data-sharing patterns, and workforce practices from the Ilfracombe pilot—to inform local Neighbourhood Health Service development, strengthen health–justice integration, and contribute to ICS and national rollout.

4.3 Pilot design/methods

Participants

The pilot will focus on the 49 individuals currently on probation in Ilfracombe (dynamic cohort, likely to change over the 6 months as people enter or leave probation). All will be offered participation at their probation meetings. Consent will be sought for holistic needs assessment, health check, data sharing, and inclusion in evaluation activities.

Intervention Components

The pilot comprises seven interconnected elements:

1. **Neighbourhood probation delivery** – relocating probation meetings to Ilfracombe as part of the Neighbourhood Health model to reduce barriers, improve engagement, and strengthen integration with local health and community services.
2. **Systemic NHS-number capture** – ensuring consistent identification of participants across health and justice datasets.
3. **Multi-sector data linkage and analysis** – probation and NHS data linked for care coordination and planning; feasibility of using the **Shared Care Record** (direct care) and **One Devon Dataset** (PHM and utilisation mapping) will be tested.
4. **Holistic needs assessment** – structured assessment covering health and criminogenic needs (such as housing, substance use, mental health, and wider determinants which make reoffending more likely) aligned to probation tools (Oasis record system, sentence plans) used to generate multi-agency action plan.
5. **Structured health check** – screening (e.g. blood pressure, BMI, HbA1c, lipids etc), continuity of medication, and vaccination status, with immediate referral as required.
6. **Multi-agency plan** – personalised plan created from the holistic needs assessment:
 - Agreed across NHS, probation, and partners.
 - Identifies priorities, assigns responsibilities, and sets review points.
 - Forms the basis for a TAP Proof-of-Concept (NH MDT precursor) that coordinates actions during the pilot, generates learning to design future Neighbourhood Health MDTs, and can be incorporated once those MDTs are established; progress tracked via the Needs Met Tracker.
 - Aligning TAPs with Neighbourhood Health MDT
7. **Team Around the Person (TAP) Proof of Concept** – multi-agency coordination to ensure tailored, joined-up responses for each participant.

4.4 Evaluation and Learning

The Kafka Brigade model (Appendix K) will be applied to challenge delivery partners on whether services are effectively meeting needs. Evaluation will be mixed-methods:

- **Quantitative:** probation meeting attendance, NHS-number capture, needs assessments completed, health checks delivered, referrals made, follow-up attendance, clinical indicators (e.g. BP, diabetes risk).
- **Qualitative:** lived experience (accessibility, fairness, sense of being “set up to fail”), practitioner reflections (feasibility, barriers, added value of neighbourhood probation), staff experience.
- **Process:** enablers/barriers to IG; feasibility of Shared Care Record and One Devon Dataset; integration of Needs Met Tracker; TAP fidelity and adaptations.

Evaluation Framework

The pilot will use a mixed-methods evaluation to assess feasibility, effectiveness, and system impact across three levels: individual outcomes, system processes and policy.

Anticipated Outcomes

- **Individual:** increased probation engagement, earlier identification of health risks, improved access to treatment, continuity of medication, and stronger rehabilitation support.
- **System:** Proof of concept for a Neighbourhood Health & Justice integration pathway, with a TAP Proof-of-Concept informing and transitioning into Neighbourhood Health MDTs when live. Staff in Probation and NHS have increased awareness of the interrelation between health and criminogenic needs and are able to respond accordingly.
- **Policy:** A tested Neighbourhood Health package (implementation toolkit, IG/DPIA templates, dashboard specification, and workforce training) plus an Neighbourhood health MDT ToR draft and implementation guidance for ICS spread.

5. INDICATIVE COST ALLOCATION

The grant allocation is fairly modest but that doesn't stop NHSE expectations being high. The likely number of people on probation that it is possible to support with £40,000 in 6 months is 50.

To enable partners to both engage in the pilot and create a robust evaluation supporting learning and roll-out we have prioritised the funding to data analysis, personalised care support and funds to overcome access barriers.

It is proposed that RDUH manages the grant funding via the One Northern Devon budget and allocates the resources to the partners/personnel as required.

5.1 Pilot finance breakdown

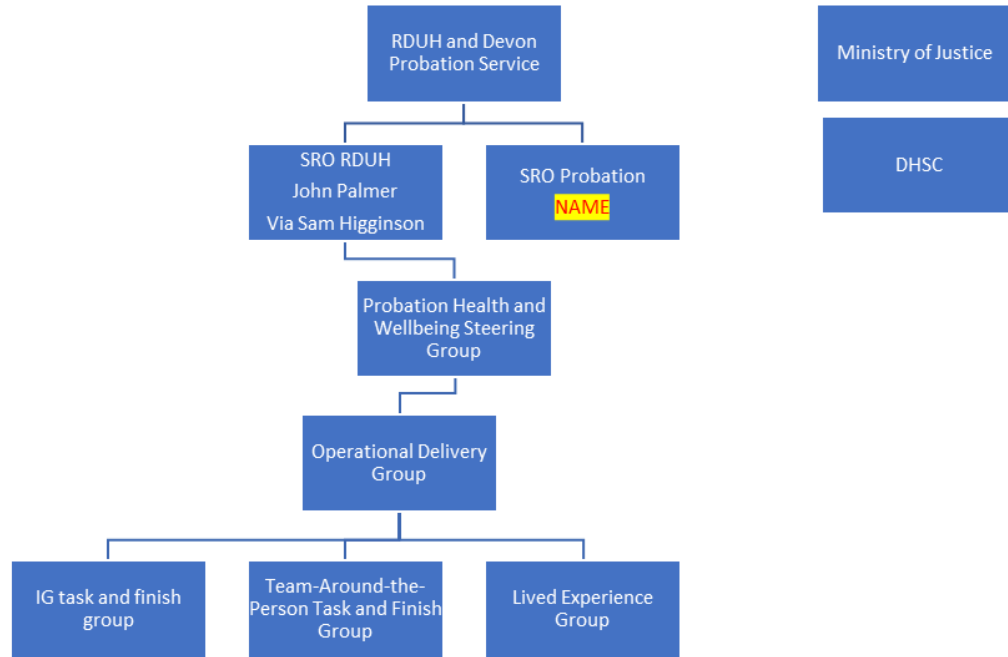
Data analysis & evaluation	Data analyst (RDUH) (B6) To ensure alignment to PHM and risk stratification	0.2 WTE @£200 per day plus evaluation support (as required)	£9,500
Health Needs Assessments	Outreach nurse (RDUH) (B6) Already in post and on a flexi contract which can be uplifted for this pilot	0.2 WTE initially with ability to increase with need (consumable costs included)	£11,000
Team Around the Person (TAP) Co-ordinator	Operations Support Manager (RDUH) (B7) Already in post supporting vaccination team and can do the additional day a week	0.2 WTE initially with ability to increase with need	£8,000
Kafka Brigade model – case finding, case development, individual support, event preparation and management	Experienced Kafka Brigade Facilitator	Flat rate	£8,500
Community venue	Venue for shared health & probation appointments in Ilfracombe.	1 day a week	£1,800
Inclusion support fund/project contingency	Costs involved in supporting the individual to access services or address needs		£1,200
TOTAL (pilot budget)			£40,000

In-kind contributions

Project lead - RDUH	RDUH Partnerships Team	0.2 WTE
Project Manager - RDUH	RDUH Partnerships Team (within workplan)	0.2 WTE
Project lead – Probation Service	Probation Service	0.2 WTE
Project manager - Probation	Probation Service	0.8 WTE
Public health	Outreach Health Checks (covering costs for those not eligible)	N/a

6. GOVERNANCE IMPLICATIONS

6.1 Leadership & Accountability



Lead organisations: NHSE/DHSC, Ministry of Justice, Royal Devon University Healthcare NHS Foundation Trust (RDUH) and Devon Probation Service — co-accountable for delivery, quality and reporting.

Senior Responsible Ownership: John Palmer on behalf of RDUH (John was leading on this before he left and agreed with Sam to continue for continuity) and Louise Arcscott from Devon Probation Service, jointly accountable for the pilot to Chandraa Bhattacharya, NHSE/MOJ.

Decision-making & assurance: Oversight through the Steering Group (monthly). Day-to-day coordination through the Operational Delivery Group.

6.2 Programme Governance Bodies

Steering Group		
Chair: Chandraa Bhattacharya (NHSE/MoJ)	Frequency: Monthly	
Member	Organisation	Organisational role
Chandraa Bhattacharya	NHSE / MoJ	Chair
John Palmer	Royal Devon (RDUH)	
Andrea Beacham	Royal Devon (RDUH) / One Northern Devon (OND)	Senior Programme Manager for Health Inequalities
Louise Arcscott	Devon Probation Service	Head of Devon Probation PDU
Graeme Murray	Devon Probation Service	
Sonja Manton	NHS Devon ICB	Head of Strategy
Justin Varney	Public Health	Member
Ginny Snaith	NHS Devon ICB	Director of Health Inequalities
Lincoln Sargent	Public Health, Torbay Council	Director of Public Health
Steve Brown	Public Health, Devon County Council	Director of Public Health
Scarlet	TBC	Member (TBC)
Adult Social Care representative	Devon County Council (DCC)	Representative (TBC)
VCSE representative	VCSE	Representative (TBC)
<p>Remit: Review progress; manage risks; hold partners to account. Reporting: Monthly reports to OND LCP & to both lead organisations (RDUH & Devon Probation Service).</p>		

Operational Delivery Group		
Chair: TBC	Frequency: Monthly (during pilot)	
Member	Organisation	Organisational role
Andrea Beacham	Royal Devon (RDUH)	Senior Programme Manager for Health Inequalities
Graeme Murray	Devon Probation Service	Project Co-ordinator
Jeanette Courtman	Royal Devon (RDUH)	Lead Member
Mandi Tydeman	Royal Devon (RDUH)	Operations Support Manager
Kelvin Grabbham	Royal Devon (Business Intelligence)	Director of Business Intelligence
Dave Allen	Devon Probation Service (Business Intelligence)	BI – Probation lead
Claire Fisher/Leanne	Encompass/ Lived experience	Chief Exec/client
Keir Duffin	Devon County Council (DCC) – Connect to Work	Connect to Work lead
Debbie Stafford	Devon County Council (DCC) – Connect to Work	Connect to Work lead
Rachel Doherty (rachel.doherty5@nhs.net)	Devon Partnership Trust (DPT) – IN-CS	Liaison & Diversion Manager
Glenda Jones (glenda.jones2@nhs.net)	Royal Devon (RDUH)	Outreach nurse (optional)
Marcela Almond (Marcela.Almond@devon.gov.uk)	Devon County Council (DCC) – Connect to Work	Connect to Work Advisor (optional)
Sabrina Maines-Blatherwick (s.maines-blatherwick@nhs.net)	Coastal Primary Care Network (PCN)	Health Inequalities Lead
<p>Remit: Coordinate operations; resolve issues; track actions; escalate risks to the Steering Group. Reporting: Escalates risks/issues to Steering Group; provides monthly highlight and RAID.</p>		

Information Governance (IG) Task & Finish Group		
Chair: Libby Pickles	Frequency: TBC	
Member	Organisation	Organisational role
Libby Pickles	Devon Probation Service	Probation IG Lead
Ade Bisi Balogun	Royal Devon (RDUH)	RDUH IG Lead
Andrea Beacham	Royal Devon (RDUH)	Programme Manager
Graeme Murray	Devon Probation Service	Project Co-ordinator
Data/Evaluation Lead	TBC	Evaluator (TBC)
<p>Remit: Complete/approve the DPIA; agree consent materials and data-sharing routes; monitor IG compliance. Reporting: Reports to ODG (operational) and SG (assurance).</p>		

6.3 Reporting & Assurance

Operational reporting: Monthly operational dashboard to the Steering Group and onward to One Northern Devon LCP, RDUH, and Devon Probation Service.

Determining the appropriate place for this project to report into will not be known until the pilot commences and the health needs are assessed, i.e. whether the majority of needs are contained within UEC or planned care etc.

The proposal is therefore to request that this pilot reports to the Trust Exec Board until we have established (through the data collection) and agreed in liaison with the operations leadership which is the most relevant division for this work to report to.

Evaluation: End-pilot mixed-methods evaluation with recommendations for spread/adoption.

Escalation: Material risks/issues escalate from Operational Delivery Group → Steering Group → both lead organisations via their SROs, then into standard organisational routes as required.

6. RECOMMENDATIONS

1. To agree that this pilot reports to TEB initially until we have the required healthcare utilisation and needs data.
2. To request that the RDUH leaders of teams operating in Ilfracombe, ED and Outpatients support the pilot by communicating to teams the case for change and why the health needs of these people are important
3. For TEB to agree to receive the evaluation in six months (April/May 2026) and anticipate the requirement to consider the implications of the pilot
4. Support the use of the grant funding to the extension of contracts for the nominated individuals (will require ATRs to be supported)

Operational resourcing (funded within the pilot budget plus in-kind):

- Outreach Nurse/Clinician (RDUH) ~0.2 WTE;
 - TAP Manager (RDUH) ~0.2 WTE;
 - BI Analyst (RDUH) ~0.2 WTE + evaluation support;
 - Programme Lead ~0.2 WTE & Project Manager ~0.2 WTE (RDUH) in-kind contribution
 - Probation staff participation – Project Manager ~0.8 WTE in-kind contribution
5. Confirm wider clinical participation in the Neighbourhood Health MDT: confirm operational links to support the TAP and inform the future Neighbourhood Health MDT design.
 6. Agree that the programme's reporting & accountability lines are adequate: monthly operational reporting to the Steering Group, with onward reporting to One Northern Devon LCP and to RDUH and Devon Probation Service; material risks escalated via SROs into standard organisational routes.

Appendix A: Background & Policy Context.

Key terms

Probation is a form of sentence where a person serves their time in the community instead of prison, either through a community sentence or release from prison on license.

Criminogenic needs are dynamic, offending-related factors, such as substance misuse, housing or pro-criminal attitudes, that increase the risk of criminal behaviour. Addressing these needs is a key aim of the probation service to reduce reoffending and promote rehabilitation.

Alignment with RDUH Health Inequalities Programme

This health and justice pilot proposal forms part of a wider programme of work being led by the RDUH, to reduce health inequalities with a specific focus on Ilfracombe that includes:

- One Ilfracombe Closing the Gap strategy (to tackle Ilfracombe's stark inequalities)
- Coastal Navigator Network (a population health risk stratification approach linked to Neighbourhood Health)
- Ilfracombe Poverty Truth Commission (people with lived experience and service leaders working together to address poverty)
- Neighbourhood Health development which requires design and delivery of tailored models of care for population cohorts underpinned by linked datasets

It is also fully aligned with the RDUH Closing the Gap programme (Epic's compass rose social determinants module) which aims to identify people whose social circumstances are impacting their health and respond accordingly.

Alignment with national policy

The approach aligns with the five principles within the [NHS national framework for action on inclusion health](#):

1. Commit to action on inclusion health
2. Understand the characteristics and needs of people in inclusion health groups
3. Develop the workforce for inclusion health
4. Deliver integrated and accessible services for inclusion health
5. Demonstrate impact and improvement through action on inclusion health

The approach aligns with Neighbourhood Health Guidelines, specifically:

- Focus on sub-cohorts of the 7% of the population who have the most complex health & social care needs and account for 46% of hospital costs
- Support personalisation and continuity of care
- Single electronic health & care record used in real time
- Embrace test and learn approaches and evaluate impact
- Apply PHM methods to design and deliver tailored care models for each population cohort
- Strengthen primary and community based care closer to home or work
- Connecting people to wider public services and third-sector support
- A flexible workforce model built on user-centred approach and joint demand and capacity modelling
- Secondary care support for community clinics, single point of access
- Linked datasets and appropriate data sharing and processing agreements expanding to wider public services over time
- A core team assigned for complex case management with links to an extended specialist team
- Strengthen system alignment to clarify each organisation's contribution and foster joined up delivery

Independent Sentencing Review

The [Independent Sentencing Review](#) (2025) outlines a shift away from short custodial sentences towards greater use of community sentences and suspended orders. While this aims to reduce prison overcrowding, it will place significant *additional* demand on community-based services including Probation and the NHS. This pilot offers a test bed for how a more integrated, preventative and data-driven model could mitigate these pressures and improve outcomes.

Ilfracombe

Ilfracombe is the most deprived town in Devon and ranks within the bottom 20% nationally. Its coastal isolation intensifies structural disadvantage—limited transport options, seasonal employment, underinvestment, and poor access to services—challenges echoed in the [Chief Medical Officer's 2021 report on coastal health](#). These conditions make Ilfracombe a strategically important location to pilot new, integrated approaches for health inclusion groups.

People in contact with the criminal justice system

People in contact with the criminal justice system (CJS) are recognised as a priority inclusion health group under the [Core20PLUS5](#) framework. The population faces multiple, interacting risk factors and in addition, often belong to one or more of the following high-risk groups, multiplying their risk for poor health and chronic disease:

- People living in the most deprived 20% of neighbourhoods
- People with learning disabilities and autistic people
- People experiencing homelessness or rough sleeping
- People with substance dependence
- Sex workers

People on probation

At 240,000, the probation population is approximately three times larger than the prison population (England and Wales as of September 2024). Unlike those in prison, people on probation do not have access to specialist commissioned healthcare and their health needs are often invisible to both the NHS and local authority public health.