Devon Health & Justice Pilot Workshop #2

Friday 19th September 2025, 10:00–12:30

Venue: Lantern Centre, Ilfracombe High Street, EX34 9QB

Co-leads: RDUH & Devon Probation Service

Facilitators: Andrea Beacham, Kirsty Smith, (RDUH) Graeme Murray (Probation Service)

1. Background

At the first multi-stakeholder workshop on 6th June, we discussed how the system of support for people in contact with criminal justice currently works, and we mapped individual service pathways. There was consensus that lack of coherent joined up service resulted in duplication, missed opportunities due to lack of integration and increasing pressure on overstretched services. It also highlighted that there was a lot of will amongst practitioners to address these issues that were preventing them from being able to support people fully.

We've engaged with some individuals with lived experience to confirm their experience is as practitioners described (incl. report from BtheChange).

Since the last workshop we have been given the chance to pilot a more effective approach. It is only a 6-month pilot so initially it will focus on ensuring we have what we need in place to share information and plans between Probation and NHS services. We have established a 7-step process with 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.

7. **Team Around the Person** (TAP) Proof of Concept – multi-agency coordination to ensure tailored, joined-up responses for each participant aligned with Neighbourhood Health INTs

2. Purpose

To agree a practical way of working for the pilot, concentrating on what needs to happen to deliver each of the seven components of the agreed intervention.

3. Viable System Model

Andrea described how often pilots such as this stop when funding ends even if the intervention is shown to be effective often because the pilot is carried out in isolation without all the supporting elements needed to sustain it. We are therefore using an approach that designs from the outset a viable service that includes these elements and builds in the communication channels required to sustain the work. Andrea briefly explained the five parts of the system required:

System 1 — Deliver the work (7 pilot components)

System 2 — Co-ordinate the work (TAP huddles, hand-offs, SOPs)

System 3 — Keep it on track (operational control, KPIs, escalation)

System 3* —Check the truth (assurance/spot-checks, red flags and escalation)

System 4 — Look ahead & adapt (development, external info, population view)

System 5 — Set the guardrails (policy, principles, constraints, approvals)

Workshop participants identified which 'system' their role within the pilot sits in and their hopes for the pilot.

Name	**Organisation / Role**	**VSM system role**	**Hopes for pilot**
Tim Sawyer	Probation Service	S1	Project is worthwhile; open to learning; clarity on how probation fits and how clients move through steps. Better engagement.
Phil Harris	Devon Mental Health Alliance	S3*	Integration with public mental health drop-in including referrals
Libby Smith	Health Innovation South West		Understand the landscape; draw learning for spread and publication.

Dr Sarah Williams	Combe Coastal PCN GP	S1	Outreach/GP interface; clean flow of results into GP record; better served group of people.
Rofiat Adeyemi	DPT (Reconnect)	S1	Co-ordination of services
Ana Paulino	DPT (INCS) liaison and diversion, MH treatment requirements	S1 & S2	Better comms, better referrals
Jake Moore	DPT (CMHT)		Understand pilot and define interface with CMHT; criteria for escalation vs routine paths; better joined-up working, break down barriers
Glenda Jones	RDUH Outreach Nursing	S1	Health check to GP record same day;booking clarity for those who can't self-book. Better comms and feedback. Reduce stigma, improve access, see people sooner/more preventative
Richard Blackwell	Health Innovation South West	S3 & S4	Understand system landscape and develop evaluation that informs future neighbourhood health design. KPI to reduce the number of touchpoints and see if it can be reduced
Lisa Woodward	Stop for Life smoking cessation	S1 & S3	Deeper understanding & insight
Kirsty Frampton	Probation Service Engagement	S2 & S3	Listen to the people of Ilfracombe
Graeme Murray	Probation Service Project Manager	S3	
Bethany Codd	Together Devon Criminal Justice Team Lead	S3	Continuity of care from prison to the community
Kim Willows	Service Lead North Devon Council Housing	S1	Everyone working together. We currently run around trying to get information from everyone to help us assess the need. Earlier assessment. Better understanding from others to make sure a person's expectations are contained. Been doing this job for 20 years and never known a time like this. Private rented accommodation is reducing, reduced top-up.
Katerina Benkanoun	Probation Officer	S1	Want the person to have more confidence.

4. Pilot interventions

4.1 Neighbourhood delivery co-location in Ilfracombe and appointment logistics

Discussion highlights

- Moving probation contact to Ilfracombe was welcomed as removing a major access barrier; co-locating health and probation enables on-the-spot conversations and bookings.
- Housing colleagues explained that they had housing officers available at the Ilfracombe Centre on a Tuesday so this could be combined subject to safeguarding and risk assessments for some clients.
- Drug and alcohol colleagues will try to also be available on the same day.
- Community mental health services have a base at the Ilfracombe Centre but it's unclear at this stage whether/how they could contribute to hub approach as they have a clear referral pathway. Role could be around Advice & Guidance.
- Interest in exploring late sessions for those unable to attend during working hours, subject to staffing and safety arrangements.
- Start with whoever is available in October rather than wait for a perfect arrangement and build as we go

What we agreed

- Target a Tuesday clinic at the Ilfracombe Centre, with two rooms reserved (joint probation meeting and health check). Explore feasibility of late slots; confirm via rota and risk assessment.
- Share contacts and rota across partners so on-the-day handovers are practical.
- Begin in October with a rolling cohort; start with what we can do now and review what we can build in after the first month.

What needs to happen next

- Beth to try to arrange for a D&A worker to be available on the Tuesday
- Graeme to book rooms and arrange risk assessments, liaising with Glenda/Jeanette about health check risk assessments
- Graeme/Amy to arrange further discussions with housing, DWP, DPT and Devon Mind regarding how a co-location in a 'hub' could work with health & probation on a Tuesday

Viable system checks

Deliver the work (7 components)

S2 — Co-ordinate the work (TAP huddles, hand-offs, SOPs)

S3 — Keep it on track (operational control, KPIs, escalation)

S3* —Check the truth (assurance/spot-checks, red flags and escalation)

S4 — Look ahead & adapt (development, external info, population view)

S5 — Set the guardrails (policy, principles, constraints, approvals)

4.2 NHS number capture & 4.3 Multi-sector data linkage

Information sharing, consent and data linkage

Discussion highlights

- NHS number is the preferred identifier; fallback match on name + DOB + postcode.
- Explicit participant consent is required for sharing across probation/NHS; wording should be simple and reusable across partners.
- Separate direct care information (Shared Care Record) from population/evaluation (One Devon) and set minimal, regular cadence for each.
- Nominate an owner and turnaround to fix linkage errors quickly so the cohort becomes visible in clinical systems.

What we agreed

- Capture NHS number and explicit consent at first contact; store the consent outcome and parties covered.
- Use Shared Care Record for direct care coordination; use One Devon for monthly utilisation and cohort insight.
- Track % with NHS# and % linked; nominate an owner to fix match failures within 48 hours.

4.4 Holistic Needs Assessment (HNA) and Health Check — integration and flow

Discussion highlights

- Avoid duplication: OASys/sentence plan fields, housing checks and clinical screening should inform a single short HNA, consent-led and trauma-informed.
- Primary care highlighted a current failure point: health check results are scanned/emailed but follow-up is uneven; need results to land in the GP record the same day and urgent findings to trigger fast-track actions.
- Differentiate between people who can self-book and those who cannot; the latter need on-the-spot booking/warm hand-offs so plans translate into action.
- Sequence: explain the pilot, capture NHS number and consent, then HNA and health check; maintain a plan of record to track actions.

What we agreed

- Design a short HNA aligned to OASys; capture three priority needs with named owners and a two-week first review.
- Define a Health Check bundle (vitals, targeted tests, meds/vax reconciliation, brief health coaching). Results to enter the GP record the same day; urgent findings fast-tracked within 48h.
- Create a simple consent/referral template (adapt Reconnect) that captures consent once and lists the organisations involved.
- Record whether the person will book or needs a warm handover/on-the-spot booking; reflect this in the plan.

4.6 Multi-agency plan, TAP and coordination (System 2)

Discussion highlights

- Desire for a single plan of record showing who is doing what and when, avoiding duplication across systems.
- TAP should be a short, regular huddle with standard agenda (consent check, red flags, priority list, action log), and a same-day summary to those not present.
- Support for a fast-track lane for urgent clinical/safety needs with clear authorisation and booking rules.

What we agreed

- Adopt a shared action log/plan of record; Needs Tracker provides a RAG snapshot for TAP.
- Run a weekly/fortnightly TAP; send a same-day ≤5-bullet summary to the distribution list.
- Define and test the fast-track lane; book urgent slots within 48 hours.

4.7 TAP and coordination (System 2)

3.6 Measures (System 3), red flags and assurance (System 3*)

Discussion highlights

- Preference for a lean KPI set that reflects timeliness, visibility and reliability rather than a long list.
- Assurance should sample real cases monthly to verify that reported greens are true: consent recorded, NHS# verified, SCR opened, Plan ↔ Action Log consistent.

What we agreed

- Pilot KPIs: NHS# capture; consent rate; linkage completeness; HNA ≤28d; Plan ≤14d; Health check ≤14d; first attendance ≤21d; DNA rate; % red unmet needs resolved ≤14d. Each has owner, target, trigger, first lever, and escalation.

- Assurance: check 10 cases/month (or 10%) for NHS# verification, consent evidence, SCR usage at health check, and Plan↔Action Log consistency; fixes within 7 days.

3.7 Principles & constraints (System 5)

Discussion highlights

- Principles: make it easy to attend (local venue, flexible slots, reminders); least paperwork that works; minimum necessary sharing for safety and direct care.
- Trade-offs between access and rehabilitation will arise; an arbitration route and documentation standard are needed.

What we agreed

- Adopt the principles and reference them in the DPIA/ToR; include an arbitration rule (who decides and within what timeframe).

4. Actions, owners, dates

Action	Owner(s)	By when
Book Ilfracombe Centre (2 rooms), confirm Tuesday slot, explore late openings; complete venue risk assessment.	Andrea / NDC Housing	Before go-live planning meeting
Finalize consent wording; submit DPIA(s) with process maps (probation↔NHS).	Andrea + IG leads	This week
Short HNA template aligned to OASys; Plan of Record + action log.	Andrea, Phil, Glenda	This week
Health check results to GP record same day; define urgent ≤48h fast-track process.	Primary care lead + Outreach nurse	Before go-live
Stand up Needs Tracker (RAG + red-flag prompts) and distribution list.	Project team	Before go-live
Nominate linkage owner; implement 48h match-failure fix; set weekly extract + monthly PHM pack.	BI/IG leads	Before go-live
Define TAP cadence, agenda, and same-day summary template; run a dry-run with anonymised cases.	TAP coordinator	Within 2 weeks

5. Risks & mitigations

- IG timing (DPIA approval) may shift October start - Submit complete packs with templates/consent and process maps attached.
- Staffing/late sessions may be hard to cover - Agree rota, back-ups, and risk assessment; start with daytime clinics if needed.
- Data quality for NHS# and linkage - assurance sampling; simple how-to guidance for staff.