Situational Analysis

using data collected between June and March 2026

Ilfracombe Health & Justice Neighbourhood Partnership

Purpose: a structured state of the system analysis for the Ilfracombe Health & Justice partnership, to support design & implementation of a multidisciplinary team model for people on probation in Ilfracombe as a pilot for wider rollout to cohorts with multiple, complex needs across Northern Devon.

1. Purpose of this report

This report provides a structured state of the system analysis for the Ilfracombe Health & Justice partnership. Its purpose is to describe the current situation facing the partnership as it seeks to design and implement a multi-disciplinary team (MDT) model for people on probation in Ilfracombe, bringing together staff from different organisations to provide coordinated support, help people realise their potential, and reduce their risk of poor health. The defined probation cohort is being used as a pilot to test whether this model is viable, effective and scalable for wider cohorts with multiple complex needs across North Devon. [1][2][3]

2. Scope and method

The analysis draws on three groups of source material: local evidence of the current situation; diagnostic materials developed during the Soft Systems Methodology phase; and wider strategic and policy context. The local evidence consistently shows that the issue is not a single-service problem but a system problem. Workshop 3 makes this explicit by stating that failures are not due to a single service failure but arise from how multiple agencies, incentives and information flows interact. [1][2][3][6]

3. Headline assessment

Overall, the partnership can be described as committed but structurally misaligned. There is strong practitioner goodwill, clear appetite for collaboration, and increasing agreement that people on probation in Ilfracombe need a more joined-up response. However, the system remains organised primarily around separate agency mandates, thresholds, data systems, funding arrangements and accountability lines, rather than around the person's end-to-end journey. As a result, what is preached is coordinated, person-centred, trauma-informed and preventative support, while what is often practised is fragmented, threshold-led, administratively cumbersome and dependent on individual work-arounds. [1][2][3][4][5][6]

4. Population and place context

The cohort in scope is not facing a narrow justice problem. The local workshop evidence describes a population commonly affected by early trauma, substance misuse, housing instability, anxiety, shame, transport barriers and weak continuity after release. Lived-experience feedback adds that mental health support, dental access, privacy, consistency of worker, and practical help with housing and benefits are all highly significant to whether support feels usable and trustworthy. [1][4][5]

Ilfracombe's coastal context appears to amplify these difficulties. The coastal inequality data shows that smaller coastal towns tend to have fewer providers, longer waiting times, greater travel barriers, fewer alternatives when services fail, more unstable housing, more fragile employment options, and greater

visibility and stigma in small communities. It also identifies housing, service access, transport, stigma and employment as interacting barriers in coastal justice outcomes. [9][10]

5. Flows of services

The current service landscape is crowded but not reliably integrated. The process maps show multiple agencies involved at once — probation, police, housing, mental health, drug and alcohol services, GPs, DWP, chaplaincy, Reconnect and VCSE support — yet coordination across these pathways is inconsistent and often fragile. Workshop 1 identified too many handover points, serial referrals, late planning, duplication, unclear ownership, and breakdowns in continuity of care after release. [1]

The result is not an absence of service activity but a lack of a dependable end-to-end pathway. Workshop 3 describes this as a snakes and ladders pattern in which progress is repeatedly lost at transition points such as release, recall and movement between services. It also notes that no single service reliably holds the whole person over time, and that justice involvement magnifies fragmentation across health, probation, housing, VCSE and place. [3][8]

In practical terms, this means people are often asked to navigate multiple specialist processes while also coping with unstable housing, trauma, stigma, addiction or poor mental health. Equal processes therefore generate unequal outcomes because the people with the greatest need are least able to self-navigate. [1][3]

6. Flows of information

Information flow is one of the clearest weaknesses in the present system. Local workshop evidence repeatedly refers to information-sharing barriers, uncertainty about what other agencies do, lack of shared systems, poor communication between prison and community settings, and repeated storytelling by the individual. [1][2][3][4]

Workshop 2 is especially revealing because so much of its design work is aimed at fixing these weaknesses: capture NHS number and consent at first contact, use a shared care record for direct care, make the cohort visible in clinical systems, create a short shared HNA, maintain a single plan of record, run regular TAP huddles, and use a lean KPI and assurance set to verify that information is both present and reliable. The fact that these items became core design priorities strongly suggests they are not yet functioning dependably in the current state. [2]

This local diagnosis aligns closely with the Chief Medical Officer's review, which states that people in prison and on probation start from poorer physical and mental health than the general population and still face barriers including gaps in provision, poor data flows, and significant risk points when transitioning into, out of and between prison and probation. [14]

7. Flows of finance, commissioning and resources

For this analysis, finance flows are understood mainly as how funding, commissioning, capacity, incentives and accountability move through the system, rather than the personal finances of individuals. On that basis, the current system appears to be financed and managed largely in organisational silos rather than around a shared pathway.

Workshop evidence points to increased demand, lack of funding and resource, service capacity constraints, and uneven availability of support across agencies. Workshop 3 goes further by identifying resource scarcity and uneven capacity as part of the problem, and explicitly states that short-term, siloed commissioning limits shared ownership of outcomes such as post-release stability. [1][3]

This matters because it means the system rewards agency-level performance more readily than shared outcomes. That diagnosis is reinforced by the national context. The 10 Year Health Plan sets out the need for a shift from hospital to community, analogue to digital, and sickness to prevention, while the Neighbourhood Health Framework says neighbourhood health must include local authority-commissioned services and wider partners, and should focus on prevention, proactive care management and stronger community services. [11][12]

The Independent Sentencing Review adds a justice-system dimension, arguing that sentencing and custody reform should support rehabilitation more successfully and reduce reoffending, and that community alternatives need to be made more effective. [13]

8. Behaviours, practices and culture: preached versus practised

Across the evidence base, the language of the system is strongly relational and person-centred. The partnership speaks about listening to lived experience, reducing stigma, supporting prevention, improving continuity, and working in a joined-up way around the whole person. [1][2][4][5]

However, the experienced reality is more conditional. Workshop 1 describes reluctance to take responsibility unless thresholds are met, limited ownership, bureaucracy, unclear accountability, and processes that look coherent on paper but fail in practice. Lived-experience feedback reinforces that relationships matter greatly, but continuity and privacy are fragile: people value consistent probation officers, discreet local access and practical follow-through, yet are unsettled by repeated retelling, visible probation identity, staff changes, patchy mental health and poor dental access. [1][4][5]

The culture is therefore not simply poor; it is plural and uneven. There are strong relational cultures in some parts of the system, especially VCSE and trusted practitioner relationships, but they sit alongside more formal, compliance-led, threshold-governed and administratively driven ways of working. The main cultural weakness is not lack of goodwill but lack of a shared operating model capable of reconciling those sub-cultures. [2][6]

9. Conflicts affecting performance

The first major conflict is between whole-person need and organisation-specific accountability. People's problems cut across health, probation, housing, benefits, relationships and survival needs, but each organisation remains answerable primarily for its own role, thresholds and statutory duties. This creates a repeated 'not our remit' or 'does not meet threshold' dynamic, even when all parties agree the person needs help. [1][3]

The second conflict is between access and control. The system needs governance, safeguarding and information governance, but the local cohort often needs flexibility, warm handovers, discreet access, quick action and low-friction support. Workshop 2's emphasis on minimum necessary sharing, clear authorisation rules, warm handovers, urgent fast-track routes and arbitration mechanisms shows that the present system has not yet found a satisfactory balance between governance and access. [2]

The third conflict is between repair and reform. Local partners are trying to build a more preventative, neighbourhood-based model while simultaneously operating in a pressured environment of demand growth, constrained resources and financial recovery. Royal Devon's published strategy emphasises collaboration and partnerships, recovering for the future, and innovation; Deloitte's 2026 State of the State characterises the NHS as caught between repair and reform; and Healthwatch's 2026 report highlights persistent access problems, inequalities and delays across core services. [16][17][19]

10. Internal and external trends

Internally, the partnership appears to be moving from shared diagnosis toward practical operating-model design. Workshop 1 established the current-state picture; Workshop 2 began to define specific mechanisms such as co-location, TAP huddles, shared plans, KPI tracking and information governance requirements; Workshop 3 translated these into Interactive Planning outputs and an agreed implementation direction. [1][2][3]

Externally, the strategic environment is favourable to this kind of pilot. The 10 Year Health Plan explicitly says the current NHS is fragmented and hospital-centric and that the Neighbourhood Health Service should bring care into local communities, convene professionals into patient-centred teams and end fragmentation. The Neighbourhood Health Framework says neighbourhood health should organise services around defined populations, include local authority-commissioned services, and work better with public health, adult and children's social care, VCSE organisations and other partners. [11][12]

Devon's Annual Public Health Report adds that alcohol harm is a significant health-inequalities issue locally and notes that Devon's public health grant allocation is among the lowest in the country, with additional treatment funding often confirmed only annually, making longer-term service planning harder. [15]

The wider place context also matters. The Coastal Navigators' Network and related coastal inequality materials position Ilfracombe as part of a broader national coastal challenge marked by employment deprivation, economic inactivity, poor transport, fragile housing, isolation and fragmented access to support. [9][10]

11. What this means for the MDT pilot

Taken together, the evidence suggests that the Ilfracombe pilot is not addressing a marginal service gap. It is testing whether a neighbourhood-level operating model can do four things that the current system struggles to do consistently.

First, hold the whole person across time rather than only dealing with fragments of need. Second, make information travel with the person so that support becomes less dependent on repeated retelling and manual work-arounds. Third, replace serial referral and signposting with warm coordination, shared ownership and practical hand-offs. Fourth, make support more accessible, discreet and relational in a coastal context where visibility, stigma, transport and limited alternatives all matter. [1][2][3][4][5][9]

The pilot therefore makes strategic sense. It is aligned with national policy direction, local public health need, Royal Devon's strategic emphasis on collaboration and recovery, and the justice-system push toward more effective community-based management and rehabilitation. [11][12][13][15][19][20]

12. Conclusion

The current state of the organisation is that of a willing but structurally misaligned health and justice partnership. It serves a cohort with interlocking needs through a system still shaped more by organisational boundaries, thresholds, fragmented information and siloed incentives than by a coherent person-centred pathway. There is strong commitment, important pockets of good relational practice, and growing local clarity about what needs to change. But there is not yet a consistently functioning mechanism that reconciles the different cultures, mandates and information systems involved. The Ilfracombe MDT pilot is therefore best understood not simply as a service innovation, but as a practical test of whether shared intent can be translated into a viable neighbourhood operating model for people on probation and, over time, for a wider population with multiple complex needs. [1][2][3][11][12]

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