NHS
Royal Devon
University Healthcare
NHS Foundation Trust

Probation Service
South West

Ilfracombe Health and Justice Pilot Report: May 2026

1. Highlights

- MOU and funding agreed for project extension until September 2026
- Referrals have now picked up and are starting to flow – 10 people supported up to 30th April 2026
- DPIA and DSA signed off by RDUH and now with partners for comments
- Process for Holistic Needs Assessment finalised including paperwork and recording
- Team Around Person documents finalised
- Successfully recruited and interviewed a Kafka Brigade client – with a second candidate also now identified
- New Kafka CPR date agreed 17th July – absolute priority for all
- Evaluation framework finalised and agreed with Health Innovation SW

2. Data

Data Highlights – provided by Health Innovations South West

2.1 Headline activity; Nov 2025 – 31st March 2026

- People supported: 8

- Follow-ups recorded: 4 (2 weeks: 3/4; 4 weeks: 1/4; second follow-up: 1/4)
- Action plans completed: 2 ("What matters to me" - action plan created: 2/2)
- GP registration: 8
- Primary system barriers: Appointments 4/8; Trust 4/8

2.2 Reach and participant profile

Age:
Mean 44.4, Range 29–59

- <40: 1/8
- 40–49: 5/8
- 50–59: 2/8

Ethnic group:
- White 8/8

Sex:
- Male 7/8
- Female 1/8

Occupation:
- Unemployed 4/8
- Employed 1/8
- Disabled/long-term sick 1/8
- Refused 1/8
- Missing 1/8

Interim interpretation: The interim cohort is predominantly working age, largely male, with a high proportion not in employment.

2.3 Outputs: Access, Need and Barriers

Access to core services:
- Already registered with a GP: 8/8
- Dental registration: where recorded, not registered 4/4 (field incomplete for remaining records)
- Dental problems recorded: 2/8 (e.g., toothache/pain; tooth decay/holes)

Barriers to healthcare use:
- Difficulty getting appointments: 4/8
- No trust in the system: 4/8

The model is reaching people already nominally in the system (GP registered) but who are not effectively using services, facing hidden exclusion (e.g. dental)

Interim interpretation: Barriers split between practical access constraints and trust/system factors.
Access improvements will likely depend on relational engagement (trust-building), active facilitation of access (appointments, navigation)

2.4 Outcomes Signals: Health Status and Risk Identification

Early clinical and risk signals are already visible despite small numbers:

i. Self-Rated Health
- Physical health: good/very good 4/8, fair 3/8, bad 1/8

- Mental health: good 6/8, bad 2/8

ii. Cardiometabolic Risk and Follow-on Actions:
- QRISK recorded: 6/8; range 0.8%–19%
- QRISK ≥10%: 2/6 among recorded
- Diabetes risk: Leicester/DL score 17 noted in 2 cases with follow-on action recorded
- Blood pressure: elevated readings recorded in at least 3/8

iii. Mental Health:
- Suicidal ideation indicated: 0/8

Key: The model is already identifying "hidden high-risk individuals" early. These are people already in contact with services (e.g. GP registered), but risk not actively managed prior to intervention. Even with n=8 people only, the proportion of risk identified is high.

2.5 Health behaviours and engagement (outcomes signals)

- Smoking (n=8): current smokers 5/8; heavy smoking (10+ daily) 4/8; never smoked 3/8
- Engagement with cessation support is mixed, with refusals recorded and limited uptake evidenced at this stage.
- Alcohol/drugs (indicative): alcohol risk concern noted in ≥1 case with refusal of help; drug use concerns noted in 2 cases (historical problems and/or reducing without formal support).

Key: Very high prevalence of behavioural risk factors. Engagement with behaviour change is limited: refusal and low uptake signals readiness to change is variable, trust and timing are critical.

2.6 Person Centred Outcomes (Goal-setting and Action Planning; n=2)

- Action plan created: 2/2
- Priority area identified: Physical health 2/2
- Goals: obtain a dentist due to pain 2/2 housing support (1/2) mental health support (1/2) reduce drug & alcohol use (1/2)

Actions:
- Healthy lifestyle / BMI / weight management discussions
- General prevention/health promotion activity (e.g., routine prevention messages such as immunisation promotion, cancer awareness) appears to have been recorded as completed in several records (based on repeated "Yes" entries in these columns).
- Mobility aids advice recorded: 1 (shower seat) + follow-up planned (4 weeks noted)
- Ongoing support input recorded: 1 (weekly visits from Together Team)
- Mental health escalation need documented: 1

Key: Depth of engagement has been achieved, but conversion to this stage is low currently.

3. Learning and Presenting Issues

3.1 Engagement with probation and referrals into the pilot have proved challenging.

Only a limited number of referrals had been made into the pilot – with the Nurse Practitioner often attending but not able to see any clients There have been a number of factors behind this:

- Some clients have been reluctant to accept the support
- Sometimes there have been no probation appointments booked in Ilfracombe on the pre-agreed days the Nurse Practitioner attends
- The probation Team have explained that they are under significant pressure due to high caseloads and staffing capacity which has meant referrals into the pilot have not been a priority

This has been explored via the Steering Group and action has been taken to attempt to rectify this. The Nurse Practitioner has attended the Barnstaple Office and met with the Probation Officers, and it has been agreed that she can flexibly attend both the Barnstaple and Ilfracombe offices – in an attempt to engage more staff and clients. Underpinning this however is the understanding that the project still needs to be Ilfracombe focussed

3.2 Phase 2 Holistic Assessments and TAP not yet live.

There are a number of factors that have influenced this:

- As yet we have not been able to identify a client who would be suitable for the Phase 2 Holistic Assessments. We've learned that initial engagement by clients with Glenda can be tentative – with an element of trust building needed between Glenda and the client before she is able to discuss the health check offer and the wider holistic assessments and tap offer. Often conversations are developing over a period of time -which is meaning that delivery of both Phase 1 and Phase 2 is not linear. Further discussion is needed to identify how we can work more flexibly to enable the full support offer to be realised.

- Combined with this there are ongoing Information Governance issues with setting up the MDT Team around the Person. All the IG has initially been developed, agreed and signed off by the RDUH, however it still sits with the majority of key partners for their sign off of the Data Sharing Agreement. Despite efforts to push for a conclusion to this the DSA is not fully signed off.

4. Case Study

Due to issues with engagement the scope for full case studies has been limited. However, below is a case study which highlights both the challenges and the benefits of this work:

The Issue:

A lady presented to Nurse Practitioner as having no trust in NHS/GP system. This was due to her feeling that they were patronising because of her situation. She had a history of previous COPD, hospital visits due to recurrent chest infections, was a heroine user, and regular smoker. She explained that she was on medication, but wouldn't engage with the GP practice which meant so relies on family to arrange and collect her medication. In the health check she presented as significantly underweight with a low BMI

The Intervention:

One of the things the lady highlighted that she'd like to address was her low weight. Together with the Nurse Practitioner a diet plan was developed which focussed on increasing weight healthily, including a balanced diet with increasing protein. They also discussed her mental health and the lady described that she was ashamed about her weight. The lady presented as motivated to try the diet plan and to come back and get weighed.

The Outcome:

At a follow-up appointment the lady returned to be weighed and explained how she had found the diet plan really helpful. The weight check showed that she had put on 4lbs which she was very pleased about. She expressed that she was really happy with the support.

Unfortunately however, this was her last probation appointment and she was not due to attend again. She was offered the option to come back and continue to be weighed which she said she would do. However, she did not subsequently return. The Nurse Practitioner has made multiple attempts to contact her but has been unable to. Consequently it is felt that despite some benefits, the full potential for support for this lady has not been realised.