PROCESS EVALUATION OF THE GREATER MANCHESTER INTEGRATED POLICE CUSTODY HEALTHCARE AND WIDER LIAISON AND DIVERSION SERVICE

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REPORT STRUCTURE

This report is structured as follows:

- Summary: background, the service, methodology, findings and recommendations.
- Chapter 1 provides a detailed background and description of the Greater Manchester Integrated Police Custody Healthcare and Wider Liaison and Diversion Service.
- Chapter 2 details the evaluation methodology including the theory of change (ToC) workshop and qualitative data collection and analyses methods.
- Chapter 3 presents the results of the qualitative analysis of data.
- Chapter 4 discusses the conclusions and presents the recommendations of the evaluation.

A revised Theory of Change (ToC) of the Greater Manchester Integrated Police Custody Healthcare and Wider Liaison and Diversion Service is presented in Appendix Three.

SUMMARY

BACKGROUND

This report presents the findings from the process evaluation of the Greater Manchester Integrated Police Custody Healthcare and Wider Liaison and Diversion Service (referred to throughout as "the service"). The Greater Manchester Combined Authority (GMCA) and Greater Manchester Health and Social Care Partnership (GMHSCP) - collectively referred to hereafter as "the commissioners" commissioned the Policy Evaluation and Research Unit (PERU) at Manchester Metropolitan University to undertake this process evaluation of the service in 2019.

The aims were to:

1. Map the processes that existed in custody and at court before and after the service was established.
2. Understand the experience of service users, service staff in custody and court, and staff of partner agencies, with a focus on identifying process improvements for GMP and Her Majesty's Courts and Tribunal Service (HMCTS).
3. Identify the benefits and dis-benefits of the service and barriers and facilitators to the delivery of the service.

It should be noted that the original evaluation that was commissioned in February 2018 comprised an impact and process evaluation. During the extended data scoping phase for the impact evaluation it was agreed by the commissioners and evaluation team that a robust impact evaluation was not possible due to the significant challenges in: accessing health, police national computer and other data; obtaining service user consents to access and use their data; and in identifying a suitable control group. As a consequence, this re-scoped process evaluation was commissioned. All of the fieldwork for this project was undertaken before the COVID-19 lockdown in March 2020.

THE SERVICE

The service is delivered as a partnership between Mitie Care and Custody (Health), the North West Boroughs NHS Foundation Trust (NWBH) and Greater Manchester Community Rehabilitation Company (CRC). It works with individuals in custody, courts and the community to offer support and to respond to their social welfare and health needs which may contribute to their offending. The service delivers a clinical and forensic healthcare response addressing a wide range of health issues and vulnerabilities. It seeks to ensure that people with vulnerabilities who become involved with the criminal justice system are appropriately supported and have their health and care needs met. The service is based at every operational GMP custody suite, in a maximum of 7 suites at any one time, across Greater Manchester.

The service model combines two key services that have historically been commissioned separately; police custody healthcare provision and Liaison and Diversion (L&D). Additionally, a mentoring support service, the Community Service Navigators (CSNs), was also commissioned to run alongside and extend support beyond the custody suites and courts. The aim of the service is to improve the lives of people with vulnerabilities who become involved with the criminal justice system and reduce the chance of future recidivism.

METHODOLOGY

This report is based on data collected through semi-structured interviews and a theory of change workshop. All of this data collection occurred before the first COVID-19 lockdown.

The theory of change (ToC) workshop developed an initial ToC for the service through a structured conversation. Participants included representatives from GMCA; GMP; GHMSCP; HMCTS and the service. A "backwards mapping" approach was taken, beginning with the long-term outcome and working back toward the earliest changes that need to occur. A session was facilitated on each element of the service ToC: final goal; activity; intermediate outcomes; assumptions; evidence; and, enablers. The output of the workshop was an initial ToC and logic model.

A total of 45 Interviews were undertaken between November 2019 and March 2020, with a purposive and ultimately opportune sample of participants including service users, service staff and partner agencies. The service users sampled included representation of the service delivery priority groups, females, veterans and young people (aged under 18). Service staff interviews included frontline staff providing healthcare, liaison diversion provision in custody and at court, and community navigator support; and service managers covering these three elements of the service. Partner agency interviews included representatives from GMP, HMCTS, National Probation Service, a women's centre, a substance misuse service provider, and an Independent Custody Visitor.

Transcripts of the interviews were subject to thematic analysis. This focused on testing the ToC, in accordance with an adapted implementation evaluation research framework[i] that examined the dimensions of: programme fidelity; dosage; quality; responsiveness; reach; service differentiation; and adaptation. Adhering to this framework enabled consistent data analysis and interpretation and has provided actionable findings to inform the further development and improvement of the service.

FINDINGS

The evaluation findings are presented below in response to the three research aims:

1. **Map the processes which existed in custody and at court before and after the service was established.**

The interviewees have experienced the service as being new and innovative.

The interview data confirms that the service has joined together previously separate services and has achieved improvements in the quality of provision through integration and innovation.

The interviewees have experienced a distinct differentiation between what was available before and after the service was established.

The interviewees reported that learning was integrated into ongoing service development and adaptation as a response to reported challenges in the introduction and development of the service. Some challenges inevitably remained and these are reported below.

2. Understand the experience of service users and staff in custody and court and those of partner agencies with a focus on identifying any process improvements for the GMP and HMCTS.

Service user interviewees were mostly positive about the service, particularly in community settings.

Partner agency interviewees reported the service had engaged with the service priority groups (females, veterans and young people aged under 18) and other vulnerable individuals who needed support to access services.

Service and partner agency interviewees reported that the service was being delivered as designed and the level of service received by service users in custodial and community settings was as prescribed by its designers [ii].

Service staff and partner agencies perceived the design of the service to be both practice- and evidence-based.

The service was perceived by agency interviewees to generally be delivering the correct balance of service hours but with some disagreement among interviewees about whether the L&D service hours should be increased.

Partner agency interviewees reported some challenges in court settings in communications with the service and with the availability of service staff.

Some service and partner agency interviewees reported some challenges around programme consistency and continuity, particularly in the transitioning of service users between custody Healthcare Practitioner (HCP) / Liaison and Diversion (L&D) settings and Community Service Navigators (CSN) community settings.

3. Identifying the benefits and dis-benefits of the service and barriers and facilitators to the delivery of the service.

Interviewees reported that the benefits of the service included:

- continuity of the service in a community setting;
- co-location of the service with other services which facilitated reaching service users in need; and
- the knowledge of service staff in accessing responsive services to meet the needs of service users.

The CSN service was particularly well experienced with service user interviewees reporting the considerable impacts and benefits of their engagement with their CSNs.

Interviewees reported that the factors which facilitated the delivery of the service included:

- the separation of the role of service staff from police;
- the embedding of L&D and HCP staff within police custody suites;
- effective, clear and consistent communication;
- 24-hour service provision that maximises service reach;
- team work;
- training and development support;
- management support;
- a strong leadership team;

- established referral pathways and systems;
- multi-agency partnership working;
- dynamic knowledge of L&D and CSN staff of external agencies and services;
- accessibility of community partner agencies for service users;
- good, open and consistent communication with service users; and,
- personal and individually orientated interventions.

The reported dis-benefits of service delivery were related to the accessibility and availability of some L&D court provision.

While interviewees generally reported effective communication with the service, some agency interviewees reported some challenges in communicating with the service. This appeared to be linked to service staff changes arising from recruitment and retention challenges.

Agency interviewees also reported that young people (aged under 18 years) were not frequently accessing the service because they were diverted from the criminal justice system before they reached the custody suite.

Agency interviewees reported the following barriers to service delivery:

- the availability of L&D staff in court;
- HCP and L&D access to individuals who have been arrested where the service staff need to be chaperoned by Civilian Detention Officers (CDOs) in order to engage with the arrestees;
- CSN working hours of 9am to 5pm which does not cater for service users who work; and
- challenges in the integration of the CSN service and the service delivery in the custody suites due to CSNs being unable to access some custody suites.

RECOMMENDATIONS

The strategic and operational recommendations that respond to the evaluation findings are detailed below.

STRATEGIC RECOMMENDATIONS

- Undertake a review of the working hours of L&D police custody provision in relation to demand to explore whether an extension of L&D working hours is required.
- Explore the reported challenges to young people accessing the service in conjunction with YOS to ensure that young people are able to access the service as intended.
- Review the way that Service user feedback is obtained and used to inform the development of the service with specific reference to ensuring that there are young person specific processes as well as processes for service users in custodial as well as community settings to feedback.
- Ensure that all service staff, partners and service users have a common understanding of service functions, including service delivery hours and priority groups.
- Review the KPIs for the service. Some KPIs were viewed as less relevant to the performance of the service, for example the GP KPI, and numbers / proportions of presenting service users seen by each element of the service.

- Review monitoring and evaluation arrangements to ensure the collation of standardised information and outcome data across all areas of the service (including CSN services) towards any refreshed KPIs.
- Explore future outcome evaluation options. It is recommended that this involve mixed methods with considerable planning to overcome some of the experienced challenging in gathering quantitative data from multiple agencies.
- Further research should involve obtaining the experience of service users who do not receive support from the navigators – i.e. obtaining the perspective of the majority of service users who are assisted by the service. This should include their involvement in developing a service specification for future commissioning of the service.

OPERATIONAL RECOMMENDATIONS

- Review L&D delivery at court, with particular consideration to: availability, service offer, points of contact if staff are unavailable and communication.
- Review the CSN caseload management and triage process for providing service user support.
- Review the exit strategy for service users moving on from CSNs to avoid dependency and ensure the individual agency of service users is maximised at exit points.
- Review the needs assessment and review process undertaken by CSNs – currently there is a reliance on secondary assessment data which may change / develop as the service user needs change and the CSN intervention evolves.
- Improve the service feedback loop between service in community settings to custody suites and between community partners to CSN staff.
- Stakeholder feedback process - a once or twice a year meeting between local service staff and the agencies which they signpost clients to may help with providing a feedback loop for service staff – so they can get a sense of the outcome of their work.
- Joint training between HCP and L&D staff in mental health to overcome some identified professional differences and some perceptions regarding knowledge bases. This recommendation is drawn from the qualitative experiences of both service areas.

1. INTRODUCTION

This section describes the Greater Manchester Integrated Police Custody Healthcare and Wider Liaison and Diversion Service as provided by the commissioners.

1.1 BACKGROUND TO THE SERVICE

Police custody healthcare provision has traditionally operated through contractual relationships between local policing bodies and healthcare providers, with the purpose of meeting acute physical and mental healthcare needs of detainees and providing a forensic and legal medical service. The Police and Criminal Evidence Act 1984 (PACE) Code of Practice C sets out the statutory framework for custodial care and the rights and entitlements of a detainee in police custody. Healthcare therefore takes place within the secure estate of a police custody suite/unit. As such, the medical healthcare is ancillary to the role the police have of investigating crime. PACE (1984) places a specific legal responsibility on the Custody officer (usually a Police Sergeant) who is responsible for ensuring the legal process is discharged and has a strict duty of care to all detainees. This will mean their close involvement in decisions to refer for medical assessment and a duty to liaise and confer with Health Care Professionals (HCPs) in order to carry out that duty.

In 2007, Lord Bradley was asked by the Government to consider ways to divert people with mental health problems and other vulnerabilities away from the criminal justice system. The Bradley Review reported in 2009, recommending that the Government should develop and improve Liaison and Diversion Services to help this cohort.

1.2 NATIONAL COMMISSIONING ARRANGEMENTS FOR L&D SERVICES

Following the Bradley Report[iii], NHS England led the roll out of the national L&D programme funded by Treasury. A national specification was developed to support a consistent roll out of the L&D services by 2020. The Greater Manchester Integrated Police Custody Healthcare and Wider Liaison and Diversion Service was developed using this original specification to develop an integrated specification to include the requirements for police custody healthcare.

Liaison and Diversion (L&D) services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. L&D staff can then support people through the early stages of criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required. L&D services aim to improve overall health outcomes for people and to support people in the reduction of re-offending. It also aims to identify vulnerabilities in people earlier on which reduces the likelihood that people will reach a crisis-point and helps to ensure the right support can be put in place from the start.

The NHS England L&D specification was updated in 2019[iv]. The main activities done by L&D services are identification, screening, assessment and referral to other services.

- Identification: Criminal justice agencies working at the Police and Courts stages of the pathway are trained to recognise possible signs of vulnerability in people when they first meet them. They then alert their local L&D service about the person.

- Screening: Once someone is identified as having a potential vulnerability, the L&D practitioner can go through screening questions to identify the need, level of risk and urgency presented. It also helps determine whether further assessment is required.
- Assessment: Using a trauma-informed approach and approved screening and assessment tools an L&D practitioner will undertake a more detailed assessment of the person's vulnerability. This provides more information on a person's needs and also whether they should be referred on for treatment or further support.
- Referral: The L&D practitioner may refer someone to appropriate mainstream health and social care services or other relevant interventions and support services that can help. A person is also supported to attend their first appointment with any new services and the outcomes of referrals are recorded. L&D services will also provide a route to treatment for people whose offending behaviour is linked to their illness or vulnerability.
- Outreach: Multi-disciplinary teams, including support time recovery workers and peer support workers, will work holistically with people in community settings during the currency of any criminal proceedings, including addressing issues such as housing and financial advice.

The police, probation and the judiciary make decisions based on the evidence and information presented to them. L&D services record all information about a person's health needs and, with the person's consent, share these with relevant agencies so they can make informed decisions about case management, sentencing and disposal options.

The roll-out of NHS England commissioned L&D services achieved 100% coverage across England in March 2020.

1.3 THE GREATER MANCHESTER CONTEXT

Police and Crime Commissioners (PCCs) have been elected by the public to hold Chief Constables to account, effectively making the police answerable to the communities they serve. Since May 2017, the Mayor of Greater Manchester has had responsibilities in respect of the governance and budgets relating to Greater Manchester Police and Greater Manchester Fire and Rescue Service. This includes all the functions of a police and crime commissioner. The Mayor has delegated day-to-day responsibility for his delegable powers in respect of policing to the Deputy Mayor (Police and Crime).

The responsibility for commissioning L&D in Greater Manchester sits with what would have been locally known as the Greater Manchester NHSE team prior to May 2017. However, as part of the devolution deal between the Government and Greater Manchester, the Greater Manchester Health and Social Care Partnership (GMHSCP) has been formed to oversee the changes to health and social care locally. Devolution is the decentralisation of public services, meaning those public services are commissioned and run locally rather than nationally. It is the GMHSCP which through devolved budgets including the budget for L&D which holds the commissioning responsibility locally.

A Police Custody Health Needs Assessment (HNA) for Greater Manchester Police (GMP) was undertaken in late 2014. This identified high levels of need amongst custody detainees in Greater Manchester, particularly in terms of mental health and substance misuse. Although the overall numbers of detainees in police custody had been reducing, the vulnerability of the individuals who are detained by GMP appeared to be increasing. Many detainees had multiple and complex needs that are currently unmet within the custody healthcare system, perpetuating the cycle of crime, vulnerability and complex needs.

The findings and recommendations from the HNA were reviewed and accepted by both NHS England in Greater Manchester and the Police and Crime Commissioner (PCC) in Greater Manchester in January 2015. This helped to solidify a shared desire to develop a new system for custody healthcare which integrates physical health, mental health, substance misuse and other vulnerabilities.

This was in line with the national direction of travel on Liaison and Diversion (L&D) and a wider piece of work being coordinated nationally to scope the potential for integration of both Police Custody Healthcare and Liaison and Diversion services.

At this time, it was anticipated that NHS England would become responsible for commissioning police custody healthcare provision thus, would be in a position to commission a single service for both police custody healthcare and L&D.

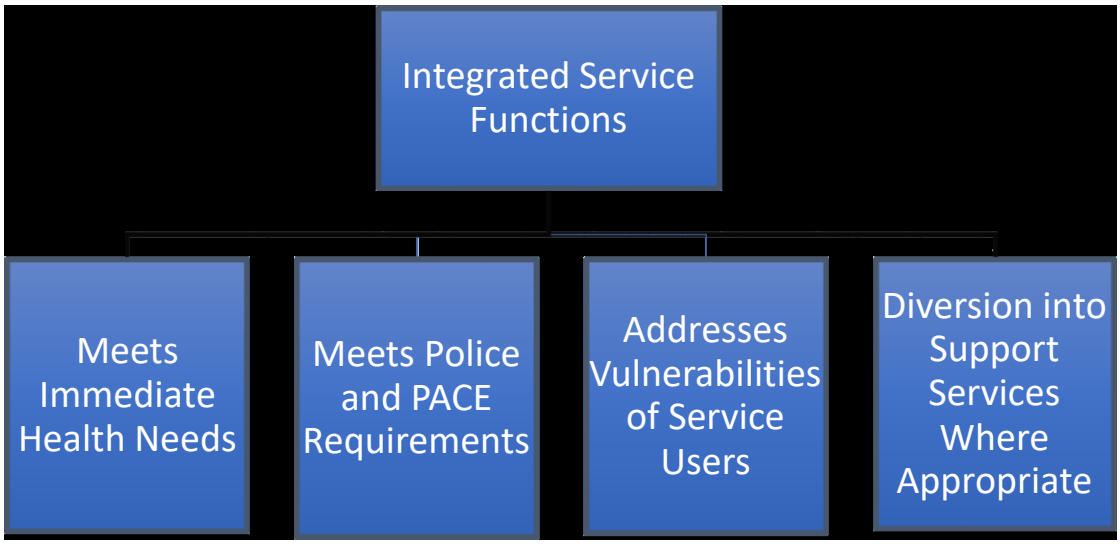
In December 2015 it was announced that the police custody transfer to NHS England nationally would not go ahead and thus the PCC in Greater Manchester and NHS England North West Regional Health and Justice Team (with partners form the devolution team) agreed to come together to co-design and co-commission the same service.

After some scoping work was undertaken in Greater Manchester, it became apparent that there was logic, enthusiasm and clear rationale for a project which sought to procure an integrated custody healthcare and L&D service for Greater Manchester.

1.4 THE DEVELOPMENT OF THE SERVICE - COMMISSIONING ARRANGEMENTS

The two commissioning partners, the Police and Crime Commissioner (PCC) and NHS England in Greater Manchester (via the NHS Commissioning Board) developed a specification for an integrated police custody healthcare and liaison and diversion service. Since the election of the Greater Manchester Mayor in May 2017, these commissioners have been referred to as GMCA and GMHSCP ('the Commissioners'). A Governance Agreement is in place to underpin the joint commissioning arrangements. The following diagram illustrates the requirements of the Commissioners for the service.

Figure One: Requirements of the Commissioners for the service



The Commissioners identified the following service aims:

- Specifically, within the custody environment, the overall aim was to provide medically safe detention, thus reducing deaths in custody and adverse incidents.
- The facilitation of the diversion of individuals, where appropriate, out of the criminal justice system and into health, social care, education and training, or other supportive services.
- Improved access to healthcare and support services for vulnerable individuals and a reduction in health inequalities.
- Liaison between healthcare and support services to deliver a coordinated response, ensuring that the needs of individuals are met.
- To meet the forensic requirements of Greater Manchester Police.

The service is therefore required to provide:

- Police Custody Healthcare.
- Liaison and Diversion in GMP custody suites and Greater Manchester Magistrates Courts.
- Support worker function to assist arrested persons to access support services following their release from custody or court.

A competitive tendering process was undertaken and the contract to deliver the new Greater Manchester Integrated Police Custody Healthcare and Wider Liaison and Diversion Service was awarded to Mitie Care and Custody (Health) Ltd to commence 1st February 2017.

Greater Manchester has been the first site in the country to commission an integrated service bringing together two previously commissioned separate services.

1.5 PREVIOUS SERVICE PROVISION ARRANGEMENTS IN MANCHESTER

Police custody healthcare was provided through a contract whereby GMP would request a Doctor to visit a detainee in a custody suite. Doctors would travel across Greater Manchester often resulting in lengthy delays. Such lengthy delays and the need to ensure a more effective healthcare response was the driver to commission a service which could support GMP in relation to safe detention of detainees. Prior to February 2017, there was no consistent provision of L&D services in Greater Manchester. Some localities had no provision at all and there were several providers delivering L&D. The driver for change was the need to develop a consistent approach in keeping with the national L&D specification within Greater Manchester.

1.6 THE GREATER MANCHESTER INTEGRATED POLICE CUSTODY HEALTHCARE AND WIDER LIAISON AND DIVERSION SERVICE

RESPONSIBILITY

Mitie Care and Custody (Health) Ltd ('the Provider') entered into a contract with the Commissioners to provide the service. The Provider is the lead provider and they submitted their tender on the basis of providing the service with two other organisations; North West Borough Healthcare NHS Foundation Trust (NWBH) and Cheshire and Greater Manchester Community Rehabilitation Company.

These organisations work as partners and refer to themselves as the Greater Manchester Integrated Custody Health and Wider Liaison and Diversion Partnership. The Provider has overall responsibility for the delivery of the service.

The three organisations work together to deliver the service with each organisation having responsibility for specific elements:

- Police Custody Healthcare – Mitie Care and Custody (Health) Ltd.
- Liaison and Diversion – NWBH.
- Community Support Navigators (Support Workers) – Cheshire and Greater Manchester Community Rehabilitation Company.

OPERATIONAL PICTURE

Health Care Professionals ('HCPs') are present in each GMP Custody Suite 24/7 providing physical healthcare in custody and forensic procedures in relation to PACE. A Senior HCP is on duty at all times to provide advice and guidance when required. A Lead Senior HCP is responsible for ensuring the HCPs provide a high-quality clinical service.

HCPs are nurses or paramedics with a minimum of four years' appropriate post-qualifying experience. Where a custody sergeant has concerns for wider vulnerabilities, such referrals are made to the L&D element of the service to screen detainees. These concerns could include mental health, substance misuse, learning disabilities etc. A detainee has the choice to be seen by L&D, as this is a consent-based service and is voluntary whereas fitness assessments are not voluntary. It is a requirement that an HCP carries out assessment of fitness to detain, if judged necessary by a custody officer.

Liaison and Diversion Staff are in all GMP Custody Suites each day of the week. Over the lifetime of the contract the hours or coverage have increased: coverage was from 7am to 5pm in year 1 of the contract; in year 2 coverage was provided 7am to 7pm; and from Y3 it has been 7am to 10pm daily.

There are two types of L&D staff:

- Health, Liaison and Diversion Facilitator (HLDF) who screen detainees for a range of vulnerabilities. Where a Mental Health Act (1983) assessment may be required they will seek advice and guidance from a Senior Liaison and Diversion Practitioner. These staff are 'unqualified' Band 4 NHS staff. Although not 'qualified' they are recruited on the basis of their relevant experience which may have been gained from relevant settings such as community learning disabilities services, child and adult mental health services etc.
- Senior Liaison and Diversion Practitioners who are mainly found in the Greater Manchester magistrates courts but will also cover custody when required. These staff are 'qualified' and come from a range of professional backgrounds for example, social worker, occupational therapists, approved mental health practitioners, mental health nurses. They are employed as Band 6 NHS staff.

There are two Lead Liaison and Diversion Practitioners who are responsible for providing advice and support to other L&D Staff across court and custody. These staff are qualified and employed as Band 7 NHS staff.

The service has an Operational Lead for L&D who has management and service development responsibility.

Liaison and Diversion Practitioners are in all Greater Manchester Magistrates Courts and since September 2019 they are also in the Crown Courts during court opening hours.

There is a Community Support Navigator (CSN) for each local authority area in Greater Manchester. These staff are support workers. There is no requirement for a qualification for these posts and staff are employed due to the relevant experience they have in support work. They provide support to

service users to take up the offers of support from a range of agencies who can provide longer-term support. For example, they might go with the service user to a first appointment to get help with their substance misuse.

A Service Manager, Community Support has responsibility for supervision and management of CSN's. Mitie Care and Custody (Health) Ltd employ a Contract Director for the service.

1.7 THE GREATER MANCHESTER INTEGRATED POLICE CUSTODY HEALTHCARE AND WIDER LIAISON AND DIVERSION SERVICE AIMS

The service aims to deliver a number of key benefits both for service users and for wider systems:

- Benefits for service users include a single, more streamlined holistic triage, screening and assessment process, supported by a continual care pathway into appropriate services.
- Benefits for the wider system include a simplification of interventions provided for service users, particularly while in police custody.

The aim of the service is to improve the lives of people with vulnerabilities who become involved with the criminal justice system and reduce the chance of future recidivism.

2. METHODOLOGY

This process evaluation was developed for the GMCA and GMHSCP (the commissioners) - by the Policy Evaluation and Research Unit (PERU) at Manchester Metropolitan University. The aims of this evaluation were to:

1. Map the processes which existed in custody and at court before and after the service commenced.
2. Understand the qualitative experience of service users and staff in custody and court and those of partner agencies with a focus on identifying: any improvements for Greater Manchester Police, for example in reduction in police time, custody processes; and for Her Majesty's Courts and Tribunal Service (HMCTS) any improvements to court processes.
3. Identify the benefits and dis-benefits of the service and facilitators and barriers to the delivery of the service.

It should be noted that the original evaluation which was commissioned in February 2018 comprised an impact and process evaluation. During the extended data scoping phase for the impact evaluation it was agreed by the commissioners and evaluation team that a robust impact evaluation was not possible due to the significant challenges in: accessing health, police national computer and other data; obtaining service user consents to access and use their data; and in identifying a suitable control group. As a consequence, this re-scoped process evaluation was commissioned.

The framework agreed with the commissioners for this service process evaluation was an adaptation of Humphrey et al's (2016) guidance for undertaking implementation and process evaluations (IPE)[v] , based on the systematic assessment of a large number of programmes. The service process evaluation therefore examined which dimensions of implementation are most crucial in terms of identifying problems and improving performance:

- Fidelity: how far is the service delivery is consistent with design? What are the facilitators and barriers to delivery?
- Dosage: how much service is received by service users, and are there differences? With a specific focus on the deep dive priority groups (see below).
- Quality: how well are the services delivered including how far the services conform to regulatory or professional standards/guidance?
- Responsiveness: how well does the service engage with their users and do they see it as addressing their health and other needs?
- Reach: to what extent do targeted service users come into contact with the service and engage with referral services?
- Service differentiation: to what extent is the service genuinely new and innovative? Does it offer support in ways not previously available and to specific priority groups?
- Adaptation: has the service diverged from its initial design? What is the nature of these adaptations and reasons for them? Are they beneficial or detrimental?

This section sets out the:

- The evaluation methodology including the methods used for data collection and analysis;
- The ethics and research approvals obtained; and
- How the findings should be interpreted

A summary of the research methods and how they address the research requirements is presented in Table 2.1 below.

Table 2.1: Research methods and research requirements

Research aims	ToC workshop	Interviews with service users	Interviews with service staff	Interviews with police court staff, partners
1. Mapping before and after processes	✓	✓	✓	✓
2. Understanding qualitative experience of users, service staff and partners		✓	✓	✓
3. Identifying the benefits and dis-benefits	✓	✓	✓	✓

2.1 THEORY OF CHANGE WORKSHOP

The ToC workshop aimed to develop an initial ToC as a structured conversation in a workshop format. The development of a ToC is a continuous and adaptive process of reflection, and it did not aim to yield a static output. The workshop sought to be part of a staged approach:

- Stage 1: Analyse the context and understand how change happens.
- Stage 2: Develop a programme impact pathway(s), and surface assumptions.
- Stage 3: Assessing the evidence of change and using it to critically reflect on and evaluate change pathways.

A total of 13 participants participated in the ToC workshop including representatives from GMCA, GMP, NHS, HMCTS, and the service.

In advance of the workshop, preparation material including key background service documentation and the principles of a ToC was shared with participants.

Opening discussions analysed the context and how change happens in service and the role of service stakeholders in the change process. A presentation outlined the key elements of the ToC approach. This was followed by facilitated discussion and reflection process on 'how things are now'. These key points were displayed for reference for the remainder of the workshop. Different key stakeholder groups were also identified including current groups and those who could be more involved.

The workshop then moved onto the ToC taking a "backwards mapping" approach, beginning with the long-term outcome and working back toward the earliest changes that need to occur. A session was facilitated on each element of the ToC: final goal; activity; intermediate outcomes; assumptions; evidence; and enablers. Flipchart papers were placed on the walls of the room with Post-it notes and marker pens made available for the group to use. Each of the above ToC elements were headers for a flipchart sheet. Participants wrote down their ideas on Post-its and added them to relevant flipcharts. Once each brainstorm process was completed, the ideas were grouped according to similarities.

Flip charts and Post-it notes were analysed and amalgamated into a digital ToC format and shared with participants and the commissioners. This workshop output is available in Appendix One.

2.2 QUALITATIVE DATA

Table 2.2 below details the participants who were engaged in the evaluation. Details of the sampling criteria are presented in Appendix Two.

Table 2.2: Participants

Stakeholder Groups	Total	Details
Service users	16	Gender: 2 females, 14 males Age: 15 aged 18 and older, one under 18 years Priority service user groups: females, veterans
Service staff	12	Custody suite 1: HCP, L&D practitioner Custody suite 2: HCP, L&D practitioner Custody suite 3: HCP, L&D practitioner Community Support Navigators: Areas 1, 2 and 3 3 Service Managers
Partner Agencies	14	Custody suite 1: Custody Sergeant, Civilian Detention Officer. Custody suite 2: Custody Sergeant Custody suite 3: Custody Sergeant, Civilian Detention Officer. Service providers: Women's Centre; Project Nova; and, a substance misuse service provider Legal advisors: Court 1 and Court 2 Probation Officer: Court 1 and Court 2 Independent Custody Visitor Appropriate Adult
Strategic managers	3	GMCA, GMP Health and GM Health and Social Care Partnership

An interview schedule for each of the stakeholder groups was formulated based on the research framework set out in 1.2 above and agreed with the Commissioners. Interviews were conducted in person and by telephone by three PERU research team members between November 2019 and March 2020. Interviewees were each provided with a research information sheet and all service users were asked to read and sign research consent forms. Most interviews were conducted on a one-to-one basis, with the exception of two service users who had attended an appointment together and preferred to be interviewed together. Interviews were all recorded and transcribed. Transcripts of the interviews were analysed using thematic analysis. Analysis focused on testing the TOC, consistent with the implementation framework set out above, to enable consistent data analysis and interpretation. Analysis aimed to achieve actionable findings to guide improvement and development.

2.3 ETHICAL AND RESEARCH APPROVAL

Ethical approval to undertake this evaluation was gained through the Manchester Metropolitan University ethics committee. Research approval to interview practitioners was gained from Greater Manchester Police, NHS, HMPPS National Research Committee, HMCTS and Cheshire and Greater Manchester Community Rehabilitation Company (CRC). Approval to interview service users was gained from Cheshire and Greater Manchester CRC.

2.4 INTERPRETING THE FINDINGS

Despite the inevitable challenges detailed below, the evaluation has been able to base its findings and conclusions from a wide range of viewpoints from people with a good knowledge of the service and its implementation.

As with other similar qualitative studies, there were some methodological limitations to this study, which need to be considered when interpreting the findings.

The evaluation team was able to interview almost all of the representative stakeholders (as well as some additions) as detailed in the sampling criteria (see Appendix Two). However, those who were interviewed may not have been represented the whole range of views amongst all the service stakeholders.

For example, 11 of the 12 service users who were interviewed were accessed via the Community Support Navigators (CSN) which may have created some sampling bias. The experiences of these individuals are likely to be different to service users who only engaged with the liaison and diversion staff and did not take up the CSN support.

There were difficulties in accessing young service users (i.e. aged under 18), only one young person was able to participate in the evaluation, therefore the experience of young people is limited in this study.

Recruiting services users to participate in evaluations of this nature is always challenging therefore to large extent, the service users who were interviewed were those that the evaluation team were able to access and/or who responded the request to be interviewed. These were individuals who more likely to be engaged with the service, had more exposure to the service and were more likely to view the service positively. That said, the service user interviewees appeared to broadly match the profile of intended service users, i.e. these were individuals with complex needs who had been cycled in and out of the criminal justice service numerous times.

3. THE FINDINGS

This section sets out the detailed findings of this process evaluation. The findings are presented against the service research framework detailed at the beginning of Section 2 under the following themes:

- Fidelity;
- Dosage;
- Quality;
- Responsiveness;
- Reach;
- Service differentiation; and
- Adaptation

These dimensions of programme implementation have been used to identify how the service is working, challenges in delivering the service; and ways in which the delivery of the service can be improved.

The key finding(s) for each of these themed sections are presented at the beginning of each of section.

The facilitators and barriers to implementation and delivery of the service are drawn together separately at the end of this section.

To maintain confidentiality and anonymity, the service staff and partner agency interviewees have not been identified by research ID[vi] numbers or job titles. Service users are less easily identifiable, and their research ID numbers are included against their quotes.

Section 4 concludes this report by drawing together the data findings presented in this section to directly answer the three research aims of the evaluation.

3.1 FIDELITY

This section examines implementation fidelity[vii], i.e. how far the implementation and delivery of the service was consistent with its design.[viii]

KEY FINDING

Interviewees reported that the service as implemented was consistent with its theory and design. The majority of service staff and partners were conversant with the service design and believed it to be a good working approach:

"I think it works pretty well from the model on paper till now" (service staff)

"I think it works exactly… It does what is says on the tin" (service partner).

Staff and partner interviewees reported that the design of all elements of service to be both practice- and evidence-based.

Partners reported that lessons appeared to have been learned from the shortcomings of previous service offers prior to the service and that these have informed the design of the service.

Nevertheless, service and partner interviewees reported that there were some challenges in the way service was delivered which may not have met the original design. This was particularly apparent in the transition between custody HCP / L&D settings and CSN community settings:

> *"The way our model is, it doesn't lend itself very well to the follow-up work. L&D practitioners are based in court and in the police station, and then it's our navigators who are employed by the CRC who are in the community, who don't come into custody or who don't come into courts. The way we'd hoped things would work in custody hasn't panned out as well" (service staff).*

In addition, these interviewees reported that there are challenges in providing the same level of L&D service throughout the day due to the more limited working hours of L&D staff in custody compared to those of the HCP staff:

> *"So, when we developed the model L&D would be there from seven until ten, but at night time the HCPs would basically put the L&D hat on. That hasn't really worked. Quite often, those referrals will be waiting for when L&D come in, in the morning" (service staff).*

> *"…I think personally it's not equitable always overnight as it is during the day" (service staff).*

To address this, some interviewees suggested that the L&D staff should be operating a 24-hour service or extending working hours to 2am to provide workload relief for HCP staff. Others opposed extending L&D hours, regarding this as unnecessary.

Partner interviewees reported variations in service experiences between courts. This appeared to be due to how busy the court was.

Interviewees at one court had a positive experience:

> "*What they do provide us with is very useful so I don't know if it works the way it was planned or not but it is a useful resource. It's a useful partnership I think for both of us and both parties" (service partner).*

At another court, partner agencies were not always able to quickly access L&D staff when needed:

> *"Our express wish is to be able to find information quickly about people's mental health histories and their presenting needs. That doesn't always happen either because of problems with boundaries because we cover a broad geographical area…..either because we can't get access to the L&D staff themselves or we can't get access to the information and they can't get access to it because we're told about the whole information-sharing issue" (service partner).*

Partner interviewees also reported that service consistency at courts appears to have changed over time:

> *"There's been a recent change in that we're sort of seeing a little bit less of them, …. I've kind of lost contact with who the point of contact is. … I would say it started off brilliantly but that kind of connection has probably lessened really…..so many people present with mental health issues and you know for access service to find out …. so helpful to the court…. I wouldn't in any way want to undermine the value of having L&D in the criminal courts" (service partner).*

3.2 DOSAGE

This section on dosage examines the level and frequency of the service received by users and the extent to which the service user priority groups received access to the service.

KEY FINDING
Service, partner and service user interviewees reported that the level of intervention provided by the service was generally appropriate to the presenting needs of service users

Service and partner interviewees reported that initially, the service sought to see all people in custody, but this had been amended:

> *"We had to see 100% between L&D and the HCP but we were finding that the people we needed to see because of vulnerability and had been identified, we were struggling to give them the time that we needed because we had so much pressure to see these other people. It was then changed from mandatory 100% to try and see as many as you can" (service staff).*

To ensure that as many individuals in custody received the service as possible, staff and partner interviewees reported the service conducted 'cell sweeps':

> "*What we'll do is see everybody who is referred and then if we have a quiet period of time where we don't have any referrals we'll go through the custody list and we'll go round and see everybody who hasn't been referred to ourselves or the HCP" (service staff).*

Service user interviewees reported that they were satisfied with the flexibility of the service offered by CSNs in community settings, viewing it to be responsive to their presenting need and allowed them to dip in and out as needed.

Service staff and partners were generally aware of the service priority groups:

> *"Veterans, women, people with learning disabilities, learning difficulties and those charged with indecent images of children. Young people." (service staff).*

However, some service staff (in both custody and community settings) were not as conversant with the priority groups, suggesting that there were *"no priority groups - everyone gets the same service" (service staff).*

3.3 QUALITY

This section on quality examines how well the services are delivered including how far the services conform to regulatory or professional service standards/guidance.

KEY FINDING
Generally, the service has been experienced by service staff, partners and service users as a quality service that adheres to the partnership wide guidelines and standards.

In exploring the regulatory and professional standards of the service, interviewees demonstrated good knowledge of necessary governance and guidance requirements and referenced numerous examples: confidentiality; consent; safeguarding; PACE; NMC and HCPC professional bodies; police framework; information governance; GDPR; Children's Act; Human Rights; partner governance arrangements; and court process.

Most service staff were able to refer to many of these standards, others (a minority) in both custody and community settings were unaware and unable to answer questions regarding standards.

Service and partner interviewees reported that the whole service was considered to be of good quality particularly because of its fidelity and responsiveness and that it provided a service that joined together previously separate services, achieving improvements in the quality of provision through integration.

> *"I think what works well is that we have this myriad of knowledge bases and this pool of people and expertise that we utilise in order to provide quality care. And I think sometimes what can go against us is just frustrations, really, frustrations that we're expecting things that just can't be physically given" (service staff).*

Training and development across all elements of the service was positively referenced:

> *"We do have study days, which are really good. They get speakers in from the external agencies come and chat with us" (service staff).*

Service staff and partner agency interviewees in police stations reported using evidence-based risk, screening and assessment tools including those held in SystmOne and triage assessments and that these had been reviewed to ensure that they met the policies of each agency.

CSN interviewees reported that they relied on the receipt of assessment information in referral forms to guide their interventions for service users. However, regarding their own practice, these interviewees did not report using structured tools or structured review formats to undertake their own assessments or reviews.

3.4 RESPONSIVENESS

This section examines responsiveness - how well does the service engage with their service users and do the service users view the service as addressing their health and other needs?

KEY FINDING
The majority of service user interviewees were positive about their level of participation and engagement in the service, in particular with the provision in community settings.

"I think it's really good. I really do think it's brilliant for people who take the opportunity to listen, yes" (SU1).

CUSTODY SETTINGS

Service user interviews reported that engagement with the service was facilitated by the differentiation of service staff from the police (a view supported by service staff and partner interviews):

> *"Some people won't speak because you're in a police station but when she came in and said, we're nothing to do with the police, we're willing to help you" (SU2).*

The police station environment was regarded by some service and partner interviewees as a facilitator to service user engagement with the service, often because it provided them with time out of their cells:

> *"For detainees - it's a way of getting out of a cell as well but yes, they seem to be on board with it" (service partner).*

For some service users engagement in custody was affected by where in the police station service staff were able to meet with potential service users:

> *"…depends on the situation. If seen in cell, less likely to engage than if spoken to in a separate room. People in cells usually have just woken up" (service staff).*

Interviewees reported differences in service engagement between areas of Greater Manchester and in different custody suites. Some challenges in engagement were also referenced amongst particular groups of service users according to types of offences:

> *"I don't know whether that's because there's quite a lot of gang culture around Salford and people don't want to talk to anyone associated with the police" (service staff).*

Service interviewees also reflected on other facilitators to engagement. Service user engagement with HCPs was felt to be strong on the basis that they met an immediate presenting need:

> *"It's very few will refuse. Very few. Particularly with the healthcare professional because they'll always want something off them" (service partner).*

Service user engagement in custodial settings was also experienced as being assisted by the offer of follow up community support:

> *"Because we've got navigators, they're able to follow those up" (service staff).*

Partners and service users knew that the service offer was not a one-off thing. Other partners reflected on how take up is increasing because the police are more aware of the service and more confident explaining the service to detainees. It was also noted that the police are very positive when explaining about the support on offer.

COURT SETTINGS

Similar challenges to service user engagement were reported by interviewees about courts with the court environment identified as a particular issue:

> *"I think, in general, the staff are good at engaging the individuals who pass through the court, if they have time to spend with them and if they're open to that. A lot of people with mental health difficulties don't want assistance, and then obviously that task is more difficult. So, it's a difficult environment to talk about your mental health. It's a busy court, the cells where probably people are at their most distressed is not a good environment" (service partner).*

Engagement at court when staff were available to meet with service users was generally viewed positively by interviewees:

> "*I think quite positive actually, because I'm quite surprised at how cooperative they can be. even when they often will not engage with the defence solicitor or, you know, L&D can get something" (service partner).*

COMMUNITY SETTINGS

Service user buy-in and engagement was particularly evidenced by service user interviewees in relation to the service community provision – perhaps due to the sample of service user interviewees being drawn from CSN contacts. They reported clear participation and high levels of involvement with the service:

> *"She [CSN] has helped me out with all of my bills. She keeps track of all my appointments and my bills like what need paying. She helped me get a move out of my old house which was a bad place, so I have moved into a lot more of a settled down place. She comes to have meetings with me three days a week, sometimes two or she keeps in contact all the time whilst waiting for my PIP and stuff like that." (SU10).*

"It's helped me with going to the doctor's and asking for medication that I need. And mental health services, kind of, messing me about, not taking things seriously and not getting back in contact, so she's helped me with all that" (SU2).

CSNs were assisting with many aspects of service users lives and helping with complex and changing presenting needs:

> "*On the morning when I was released – I was asked if I needed any help. So, I liaised with them. She advised me what to do and phoned me on a regular basis and I phone her and keep her in the loop side of things…. I was alcohol dependent but I'm now in recovery and not had a drink in ten months" (SU1).*

Some barriers to engagement were reported by interviewees which included a view that service users in employment may not engage as well because the CSN service did not work after 5pm:

> *"I'm out of work. I think it would be harder, a bit harder if I were working" (SU8).*

SERVICE USER CONTRIBUTION

Across custodial and community settings engagement was often considered to be dependent on a SU's level of motivation to engage and make changes in their life, however small. Any level of motivation to make changes was seen as critical to service engagement and in order to maintain engagement a Service user must continue to be motivated:

> *"A lot of people come initially, they want to change, they're full of, you know, I want this, this and this. And then their motivation wanes along the way which, you know, again, is human nature (service staff).*

Many service users were clearly engaged and their buy-in was balanced with encouraged agency – service users were assisted by CSNs and took on responsibility for actions:

> "*She's turned me life around. Not just her, just I have as well like, if I didn't have her help, I wouldn't have done it. I know I wouldn't" (SU5).*

In contrast and importantly, it was also noted that some SU's buy-in had perhaps surpassed such a positive balance, towards a degree of dependency. This was indicated by the continued engagement of service users but their participation and degree of involvement had reduced as they increasingly let the CSN undertake tasks:

> *"She helps me out with any bill and anything there that I need sorting out. I leave it up to (my CSN). I leave it up to my mum and they both discuss it between them. They come down with the mental health and we will sit here in my flat and then we will discuss everything." (SU10).*

However, without knowing the case detail of the service users, it is an observation rather than a conclusion as perhaps their case histories necessitated such reliance and support.

YOUNG PEOPLE

Engagement by the service was not as positively experienced by the interviewed young SU:

> *"You don't really see her. The only person you really see in the police station is the sergeant and then you go to your cell and then whoever comes to get you out in the morning" (SU15).*

This young person was asked further about their engagement with the service:

> *"Yes, it's just been a few times. Sometimes they just bob their head in when you're asleep and that's it. Do you feel like killing yourself? Do you feel like doing this?" (SU15).*

However, the young person did differentiate between service in police stations and service provision in community settings, indicating a better understanding and experience of the CSN services compared to their experience of the service in custody:

> *"You don't want them [service in custody] near you. They're not your mates. They'll never be your mates. They try and be your mates in there. All you want is for them to %^&* off and you stay in your cell. Until they get out, that's the only part that they're any good is when they're getting you out" (SU15).*

FLEXIBILITY

Participant engagement was also evident amongst the priority groups of service users. One Service user reflected on the particular engagement challenges of ex-services personnel and the importance of perseverance and flexibility on the part of the service:

> *"Well, like most ex-squaddies we don't tend to ask for help very often and in fact we don't ask for help at all so when (my CSN) rang me up saying I had been referred in through custody I was a bit…I said I would meet her and I never met her and it went on for a few weeks more but eventually I just went and met her and it was probably the best decision I have made" (SU13).*

3.5 REACH

This section examines reach - the extent to which the target service users came into contact with the service and engaged with services that the service referred them to.

KEY FINDING

Service and partner interviewees generally viewed the service to be effective in accessing their service priority groups and other vulnerable people who needed support to access services.

Service user access to other services was dependent on service staff links and knowledge of agencies which their service users could be referred to.

Service interviewees acknowledged their reliance on the police to ensure the reach of service in custody:

> *"We are a little bit reliant on referrals from the police in custody, but anyone can self-refer but obviously, they would need to know about the service" (service staff).*

In particular, service staff recognised that they were dependent on the police to identify need among detainees and to make a referral to the service.

> *"It depends on what referrals the police have put through and the police being the police, will always put through the people who are the riskiest or the ones that they're most concerned about that's just the way it is. The worry is that there might be someone whose compliant and nice and quiet and they're the ones who are actually the ones that we do need to be worried about, but they're just not flagged to us" (service staff).*

Cell sweeps (referenced earlier) were deployed by service staff to mitigate reliance on police referrals in custody suites, however, service interviewees observed that of cell sweeps would not always be possible at busy times.

Importantly partner interviewees reported that that service take up was increasing because the police were more aware of service and more confident explaining the service to detainees and when they did so the police were very positive when explaining the support on offer.

Consent was also frequently and inevitably considered in relationship to reach, given that potential service users needed to consent to their involvement and their participation is voluntary:

> *"We are a consent-based service. So, if somebody refuses to engage there's nothing we can do" (service staff).*

All interviewed partners wanted to maintain or increase their relationships with service. It was felt that a lot of progress had been made in this area. It was also acknowledged by service and partner interviewees that worker knowledge was as important as established relationships to maintain access and ensure access to any new provision to ensure the reach of necessary services to the service cohort:

> *"It's really difficult because we've got a new worker, so I don't know what her network is, I would like to think that she's linked in with lots of other services. So, she's aware of what's in the community, so when she's talking because I think your L&D worker needs to be very aware of what is going on in this community and how they're linked in, how their pathway is partnership working" (service partner).*

Some access challenges for the service were reported by partner interviewees at one court:

> *"I think they [the service] do a daily visit to the cells, so I think in terms of remand prisoners, they're covered, but in terms of prisoners on bail, that requires the court and probation staff to be in the court or for the L and D team to have been made aware of a potential issue" (service partner).*

Another challenge regarding reach, was highlighted in relation to young people. Some service and partner interviewees reported that young people were not always accessing the service (in both custodial and community settings). In relation to custody this is illustrated by the following observation:

> *"The majority of kids in contact with the youth justice system don't come through custody they're dealt with by your out of court disposal, your contact cards and things like that. They don't bring kids into custody. The kids on the whole that we see through custody are the kids that have offended and offended and offended and eventually they're arrested. It's very rare that it's a child that's never been in trouble before (service staff).*

In community settings it was suggested that there was no targeted youth L&D provision and that this could be developed:

> *"I would keep a youth liaison and diversion in the community as well because like I said, their adult liaison and diversion in the community" (service staff).*

Additionally, that:

> *"I think we missed a trick in terms of engaging with the youth justice teams so we've had to sort of do that retrospectively which has caused some issues" (service partner).*

3.6 SERVICE DIFFERENTIATION

This section examines service differentiation – to what extent is the service genuinely new and innovative and does it offer support in ways not previously available?

KEY FINDING
The exploration of service differentiation reveals that the service was mostly experienced as being new and innovative. The main reason being because it joins up and effectively integrates two previously separate service areas to fill a large gap in provision.

Partner interviewees generally reported that there was little, if any, service offer prior to the service:

> *"I think we provide a good service. I think we provide a good service that wasn't in place five years ago" (service partner)*

> *"I don't know how they survived without it. You know, I remember the bad old days"(service partner).*

Descriptions of medical staff spread thinly across Greater Manchester and long delays in their attendance when needed at a custody suite were common among these interviewees. When asked how the service differs from what went before partner's accounts included:

> *"It's massive. There wasn't any. When I first started we didn't have a nurse at every station it was hit and miss" (service partner).*

> *"I know the problems that we had before that team was in place and sometimes those problems were horrendous, not always but while that team has been there we have not had any" (service partner).*

Partners also suggested that the previous service offers, particularly in custody suites saw a greater focus on medical needs:

> *"…previously referred to a nurse who wouldn't make MH assessments and assessment of vulnerability. Focus was more medical rather than personal as it is now with L&D" (service partner).*

Some stakeholders also reflected about the changing presenting needs of service users. Previously, medical needs were viewed to be more common but newer challenges and needs of service users are also falling under the remit of the L&D service.

> *"I wasn't here before it is a bit hard to say but I think there is definitely a lot of new issues which are societal issues which come in anyway, so the service is needed more" (service staff).*

Service and partner interviewees also reflected on referrals and the access of service users, particularly priority groups, to other services. Partner interviewees commonly described how the service had improved the access of service users to their agencies by referrals from service staff.

> *"There were no referrals – I say no referrals, I've spent hours getting referrals. So yes, it's vastly different." (service partner).*

Service and partner interviewees also reported that the service differentiated itself on the outcomes that is was able to achieve in meeting Service user need:

> "*it's getting a fuller picture of what that individual's needs are, and then being able to refer them on correctly, and follow up, really. Give them that support that they might require to be able to access us in the first place, whereas, I don't think that was there in the beginning" (service partner).*

The introduction of service engendered greater confidence that service users would be supported to access services on their release from the custody suite:

> *"Beforehand, you could just release them and if anything happened we're in the mire a little bit. But now it's all documented and, like I say, if they choose not to follow it up then we've done all we can" (service partner).*

It was evident from the interview data that the service is an integrated service and many stakeholders experienced its differentiation positively based on the integration of the three arms of the service (HCP, L&D and CSN settings). However, it was also evident that integration was challenging:

> *"There's been a lot of criticism about the service from lots of different places and the service is always called the L and D service. So, everything is applied to the L and D service, but it's not the L and D service. It's[the] Integrated Service" (service staff).*

Many stakeholders knew parts of the service well but made less reference to other elements of delivery. For example, considering police station settings and HCP / L&D provision but making no reference to CSN and community setting delivery. When asked whether any changes needed to be made to the service, one service staff highlighted this point:

> *"If we could increase the model to providing a little bit of a follow-up as well" (service staff).*

The interviewed service users also had positive experiences of service differentiation in cases where they had comparisons. There was a common view that previous services lacked the individualised and consistent support that is provided by the service. Examples included:

> *"To be honest, you got a couple of leaflets given" (SU2)*

> *"I can't think of her name now but with them they stood by me a lot but then they just kept passing me onto services and services and they didn't have anything to do with you keeping your appointments" (SU10).*

There were some challenges to the exploration of this question, as many agency interviewees who were interviewed were relatively new members of staff, especially those in community settings, so their knowledge of previous service offers for comparison purposes was limited. However, many mitigated this limited knowledge by supporting the service.

3.7 ADAPTATION

This section examines adaptation: has the service diverged from its initial design? What is the nature of these adaptations and the reasons for them? Are they beneficial or detrimental?

KEY FINDING

Service and partner interviewees reported that the main adaptation to the service has been an increase in the working hours of L&D provision. Originally it operated from 7am to 5pm; in the second year from 7am to 7pm; and currently 7am to 10pm.

These adjustments appeared to respond to feedback and the experience of the service offer in custodial suites and has been positively experienced by most stakeholders as a beneficial adaptation.

(NB It should be noted that the gradual extension of hours was always intended in the contracting of the service)

In addition to the above findings, as reported earlier there was some disagreement among service and partner interviewees as to whether the working hours of the L&D service should adapt again to become a 24-hour service provision.

Other adaptions made by the service and viewed positively by all stakeholders include responding to changing presenting needs:

> *"Any changes in the criminal culture, the things around county lines and stuff like that, you're constantly having to adapt your knowledge and learn new things and change the way that you work and take on board new stuff. The indecent images, the veterans and the women is a new thing that's come in as 100%, that was never 100% and now it is. It's always changing" (service staff).*

Additionally (as noted above) the increasing length of time that service users were supported by CSNs was also reported positively by all interviewees.

Some interviewees reported that the key performance indicators (KPIs) for the service had led to some service adaptations:

> *"I think there is more focus on the community element and outcomes but we're not in a massive position to be able to do much about that, I would think at the moment because everything is so custody loaded and the targets remain unchanged in custody" (service staff).*

Partner interviewees who had encountered some challenges in access to the service (see 3.1) described a changing view of adaptation. The service had initially been well experienced but partner agencies had needed to adapt. When asked how the service differs from what went before one partner reflected how the challenges experienced in accessing service staff in court had led them to undertake some of the role:

> *"it's hard to quantify what that difference is other than personalities…. maybe I use it less because I've got more experience now and I rely on my own interest and assessment a lot more. I totally understand. There's no criticism of the staff but there isn't an administrator sitting in that room, fielding queries and linking people up. I suppose that would be the dream, wouldn't it?" (service partner).*

"I do feel that things have lost a little bit of momentum. Perhaps because of the change in leadership and possibly on our side….I have to say it was really good, which is perhaps why we've noticed it. It's just tapered off a little; however, most importantly they are there, aren't they?" (service partner).

There were again some challenges in exploring this research question, as many stakeholders who were interviewed were relatively new members of staff, so their knowledge of the previous service offers for comparison purposes was limited.

3.7 FACILITATORS AND BARRIERS TO IMPLEMENTATION AND DELIVERY

This section identifies the facilitators and barriers to the implementation and delivery of the service. In part, they reflect some of the findings reported in the sections above.

FACILITATORS

The facilitators are summarised and grouped into the themes below.

Planning and preparation of service development and introduction:

- Some stakeholders in custody settings viewed that a pilot of service delivery had been undertaken prior to the commission of services and this was well experienced.
- Having experienced some challenges in embedding the service in police stations, the lessons learned from this journey itself and achieving embedment was viewed as a facilitator:

Police station setting:

- The separation of service staff role from the police was a facilitator referenced by many stakeholders, especially delivery staff and service users.
- The embedding of the service within police custody suites.
- Good working relationships and communication between the service and the police in custody suites with particular reference to the service relationship with the Custody Sergeant:

"I can imagine if you have a custody team that is difficult or a facilitator who doesn't get on with custody staff or a HCP that's difficult, that can just throw the whole system out. It really is all about communication, so us passing things over to the HCP, the custody staff passing things to us, the custody sergeant that's referred to you is going to re-interviewed in an hour. If you don't have that things get missed and things go wrong" (service staff).

- Police staff reported that the booking system made the referral process a lot simpler and straightforward.

Communication:

- Effective, clear and consistent communication within the whole service and also between the service and partner agencies. There were various communication tools across the service reported by interviewees that included attendance at a daily police custody suite briefing, team meetings, management communication and wider partnership communication channels, particularly via the CSNs.

Service format:

- 24-hour service provision that maximises service reach:

"We're a 24-hour service. If I don't see it [the case] today, then it would be handed over to the night, so there's no reason why they wouldn't be seen" (service staff).

- Good team work, again both within the service and also between the service and partner agencies. Being embedded within custody suites was also viewed to support better teamwork.
- Established referral pathways and systems.
- The dynamic knowledge of L&D and CSN staff of external agencies and services that can be accessed to meet the complex and changing presenting needs of service users.

Management, supervision and training:

- Training and development support to all service staff and management support was also viewed as a facilitator
- A strong leadership team and the willingness of the leadership team to innovate and fund the service.
- The scrutiny of the service by commissioners was seen as both a facilitator and a barrier. It was experienced as more of a barrier in the early days of the partnership formation whilst working through teething problems of integration under considerable scrutiny. However, more recently, now the service is experienced as being more integrated and embedded, high levels of scrutiny are viewed positively.
- Working together as a multi-agency partnership and building relationships with new partners:

"Building relationships with the women's centres, building relationships with [name of provider] and, you know, whatever the substance misuse teams are in Greater Manchester, I think all of those things are enablers for us" (service staff).

Service user attributes:

- Service users who were motivated to change were viewed as critical to the effective delivery of the service which highlights the co-productive nature of this type of provision. In its absence, a lack of motivation by service users was viewed by interviewees as a barrier.

CSN specific enablers that facilitated effective implementation and delivery of this component of service provision:

- CSN role providing a centralised point of continuity and brokerage of services.
- The ability to spend time in a community setting seeing service users face-to-face and building up working relationships with service users.
- Service users referenced the provision of clear, straightforward and correct advice.
- Service users also referenced good, open and consistent communication as a facilitator.
- Service users also viewed the CSN role to be personal and individually orientated and often described genuine warmth and care demonstrated by their CSNs as a facilitator.

Community partners:

- The accessibility of community partner agencies for service users.
- Ensuring that these partner agencies are conversant with contacts in the service and are knowledgeable of service roles and individuals undertaking roles.

BARRIERS

The barriers to implementation are summarised and presented in the themes below.

Custodial environment:

- The lack of readiness of service users to engage with the service in the custodial setting.

"it can be quite difficult for some people sometimes because they're so focussed on why they're here and what's going on, sometimes they don't feel able to fully engage with us or fully commit to a referral here or a referral there because they are so pre-occupied with their arrest" (service staff).

- HCPs who are not trained to update the police systems.
- Ease of access to people who have been arrested. Civilian Detention Officers have to support service staff in accessing people in cells or seeing people outside of their cell.

Service wide information sharing:

- Challenges in information sharing including: accessing information about whether a service user is known to another agency and receipt and sharing of information with third sector organisations.

Legal restrictions:

- During the joint commissioning process having to establish legal precedents to integrate the health and L&D services

Partner-agency working and communication:

- Some clashes of ethos and approach between partner agencies.
- Some partners felt that existing relationships had become barriers and were in the process of strengthening them:

"[it's] just having… Knowing who the point of contact is perhaps occasionally touching base. Ensuring that meetings are arranged when people can attend and any issues" (service partner).

- It was suggested that the service could be more visible and communicate more widely at all levels of partnership agencies.

Staffing, including recruitment and retention:

- Staff retention and recruitment with particular reference to L&D staff both at court and police stations, CSNs and service management.
- Challenges in retention were suggested to be due to both the nature of positions attracting people looking to move up career pathways quickly:

"People do it just as like a stepping-stone. Something on their CV. They don't seem to make a career of it and I don't know why because it's a fabulous job" (service partner).

- A potential lack of support available to frontline staff:

"*People don't feel supported on the frontline" (service partner).*

- Overstretch of the service:

"People have to move from station to station" (service partner).

- Service structure
- Some service staffs feel isolated, (staff in both in police custody suites and in community settings), a view supported by partners:

"I think people still do feel quite isolated at times" (service partner).

KPIs and oversight:

- Some KPIs were viewed to be challenging and restrictive upon service delivery:

"I think the KPIs don't give us the freedom to be a bit more flexible" (service staff).

"There's quite a few KPIs which are drive for service really, not in a good way, some KPIs that have their service credit attached to it" (service staff).

L&D specific barriers:

- Some interviewees suggested that the L&D provision was not a 24-hour service, although this view was contested with by other interviewees.

Specific barriers identified in relation the delivery of the CSN provision:

- A high demand for home visits amongst service users.
- That CSNs are unable to have service users in their car.
- New in post CSNs who do not have knowledge of available provision in an area.
- CSN working hours of 9-5 which does not cater for people who work.
- Some elements of the service were not experienced as being fully integrated, particularly the community element of delivery. In part because of logistical and procedural constraints, particularly that CSNs cannot always access the custody suites.
- CSNs feel isolated, particularly in the absence of regular and frequent meetings.

4. CONCLUSION AND RECOMMENDATIONS

The process evaluation of the service has yielded rich, detailed and constructive information regarding the service. These accounts give clear information about the service, what is working well and what needs review. It is important and detailed information that will assist with any review and revision of service delivery. The rich detail of information that was provided by stakeholders will ensure that the meaning of messages is not lost.

Clearly, the service has been well experienced as an innovative and quality offer by its stakeholders particularly because of its fidelity and its responsiveness and also because it joins together previously separate services, achieving improvements in the quality of provision through integration and innovation.

As with any new service, it has experienced challenges in its development and introduction. Learning has been integrated into ongoing service development and adaptation as the service has embedded its delivery. Some challenges inevitably remain and have been highlighted by the research.

This section concludes the research report firstly by drawing together the findings in order to answer the three main research aims/questions and then moves on to suggest some recommendations in response to the research findings.

4.1 WHAT PROCESSES EXISTED IN CUSTODY AND AT COURT BEFORE THE SERVICE AND THE PROCESSES THAT EXIST NOW THAT THE SERVICE IS IN PLACE.

The evaluation has observed a well experienced differentiation between the previous offer and the current service offer. In general, the service is experienced as being accordant to delivery expectations. There are many positive indicators that the service is new and innovative. These include:

- Perceived good reach of service to specific priority groups.
- That partners consider the service to be new and innovative and much better than what was available prior to its introduction.
- Considered that service offers service users a speedier healthcare offer compared to previous services.

The service combines services that have historically been commissioned separately; police custody healthcare provision and L&D with the additionally of a mentoring support service to run alongside and extend support beyond the custody suites and courts. Prior to the service, elements of service (L&D, HCP were separate and the CSN role (as delivered by the service) did not exist prior to the service. The evaluation has highlighted evidence of the previous service offer, particularly in custodial and court settings. Generally, stakeholders experienced a much-reduced offer with limited availability of specialist healthcare support and L&D knowledge and expertise.

The introduction of the service saw the combination of police custody healthcare, with L&D and CSN functions. The service also introduced integrated ambition and a combined service aim upon its introduction which had previously not been available. The service aims to improve health outcomes for service users in the criminal justice system and to contribute to the reduction of offending and/or escalation of offending behaviours by means of providing a high quality, safe, effective and best value integrated service.

There are many highlighted benefits of the service to its stakeholders:

- The introduction of the service has seemingly contributed to speeding up the delivery of services that were previously separate, both within custodial and community settings settings.

- In custody, stakeholders reference streamlined and expedited process. In police stations the co-location of service enables quicker access to detainees for assessment and intervention, engendering police confidence that detainee's needs are being met and any risks are minimised to enable the police process to proceed more quickly.

- Similarly, in most courts, court stakeholders are able to access information and make referrals to L&D services quickly.

- In the community, service users are seemingly accessing services more quickly because of agreed and established pathways of referral. Pathways from custody to stakeholders in the community and from CSNs to community stakeholders have both been established and expedited.

The evaluation has highlighted an additional and important element of the process of the service, in the importance of the working alliance between service staff and service users, both in a custodial and community setting.

The evidence drawn from the evaluation indicates that this is a new feature and necessary condition that has been brought about by the integration of the three services and the continuity of the service offer from police and court settings into the community.

The evaluation has gone some way to identifying the necessary process of establishing and maintaining such an effective working relationship and its importance in achieving the sought intermediate and longer-term outcomes of the service.

The evaluation has enabled its features to be identified, specific to the service. This has been reflected in suggested amendments to the service ToC (see Appendix 3).

The importance of a developed working relationship was clear within service users accounts of engagement. Amongst many things, it appears to serve to support engagement enabling any service users who had not previously engaged with the service to return to the service. Additionally, it provided motivation for service users to access services and even its brief intensity in a custodial environment enabling initial engagement and setting the scene for continuity into a community setting.

4.2 UNDERSTANDING THE QUALITATIVE EXPERIENCE OF SERVICE USERS AND STAFF IN CUSTODY AND COURT AND THOSE OF PARTNER AGENCIES WITH A FOCUS ON IDENTIFYING: ANY IMPROVEMENTS FOR THE POLICE AND HMCTS

The evaluation has been guided by the principle that only by understanding and measuring whether an intervention has been implemented with fidelity can researchers and practitioners gain a better understanding of how and why an intervention works, and the extent to which outcomes can be improved[ix].

The evaluation has generated rich and detailed qualitative accounts of the experience of SU, staff and partner agencies. This insight will inform and enable onwards service planning and development.

The key findings about the stakeholder experiences of the service are highlighted below:

- Service users were positive about the service and viewed it to be responsive to their needs. Many described it as life changing and essential to their positive progress.

- Partner agencies were positive about the service and viewed it to be an essential and necessary offer to people in Greater Manchester. Some constructive feedback was given from partners regarding communication, availability and staff turnover.

- Many partners viewed the service to be critical, necessary and essential. They would be concerned if the service was significantly changed or reduced, most wanted to see it extended.

- The role of the CSNs was experienced by partners as important with a number of elements – forging relationships with partner agencies to facilitate links and in supporting service users to attend appointments. This was supported by the views of service users .

- Partner agencies viewed that the service was supporting and improving the access of the right cohorts of service users to their agencies.

- Partner agencies considered the service to generally have good uptake engagement. Any sought adaptations were mostly positive, and partners' wishes for development are to expand and extend the service.

- Staff felt supported, well trained and competent in skills and delivery.

- There were good examples of developed practice and adaptations to ensure reach of service e.g. cell sweeps in each custody suite on a daily basis.

Stakeholders experienced the service delivery to have fidelity of form and of function. This means that service is being delivered as it was designed. Staff and partner agencies considered the design of the service to be both practice and evidence based.

Some challenges were identified around consistency, particularly apparent in the transitions between custody HCP / L&D settings and CSN community settings. There were also differences in court settings with experienced challenges in communication and staff availability.

Most stakeholders considered the service to be delivering the correct balance of service hours to service users.

The quality of the service was generally viewed positively, especially by partner agencies. The service was considered to be of good quality particularly because of its fidelity and responsiveness and that it provides a single service that joined together previously separate services, achieving improvements in the quality of provision through integration.

Service users' engagement with the service was mostly a positive experience, particularly in community settings. Service user engagement was also evident amongst the priority groups. Some stakeholders reflected that service users in employment may not engage as well in community settings due to the 9 to 5 operating hours of the CSN provision.

Service user buy-in was evident and there was a great deal of buy-in to CSN activities and support with clear participation and high levels of involvement amongst interviewed service users.

Importantly, the evaluation also found that some service buy-in had perhaps surpassed a positive balance, towards dependency. This was indicated by the continued engagement of service users but their participation and degree of involvement had reduced as they increasingly let the CSN undertake tasks for them.

Unfortunately, engagement was not as positively experienced by the interviewed young SU. In reference to both points, the somewhat biased sample with only one young person able to participate in the research and the remaining service users drawn from a CSN opportunistic sample, may have influenced these findings.

The service was mostly experienced as being a responsive service that was meeting the needs of service users. Importantly, service staff and partners in custody suites were themselves less confident that service user needs were met in community settings because they themselves were receiving limited direct feedback about this. It did not seem that there was a negative view of the work undertaken in community settings, but instead an absence of information, particularly regarding outcomes and that there could be improvements to the feedback loop for service staff working in custody.

The reach of the service was mostly viewed positively with particular regard to both priority groups and also vulnerable people who need support to access services. In summary:

4.3 WHAT ARE THE BENEFITS AND DIS-BENEFITS OF THE SERVICE AND BARRIERS AND FACILITATORS TO THE DELIVERY OF THE SERVICE?

The evaluation has explored the benefits and dis-benefits of the service. The many benefits of the service identified in the evaluation have been presented in answer to research aims 1 and 2 in the sections above.

No disbenefits were identified by interviewees.

The key facilitators to implementation and delivery of the service are:

- The separation of service staff role from the police;
- The co-location of the service within police custody suites and courts;
- Effective, clear and consistent communication within the service and between the service and partners;
- 24-hour service provision that maximises service reach;
- Team work; training and development support; management support; a strong leadership team;
- Established referral pathways and systems;
- Multi-agency partnership working;
- Dynamic knowledge of the L&D and CSN staff of external agencies and services;
- Accessibility of community partner agencies for service users;
- Good, open and consistent communication between the service and service users; and
- Personal and individually orientated interventions for the service users.

The identified barriers to service delivery pertain to the accessibility and availability of the service rather than the quality of provision. These relate to:

- Staff recruitment and retention;
- The availability of L&D staff in court;
- Young people under 18 years old who are considered to not be frequently accessing the service because they are diverted from the criminal justice system before they reach a custody suite;
- Some elements of the service not experienced as being fully integrated, particularly the community element of delivery;
- CSN working hours of 9am to 5pm which does not cater for people who work;
- Access to people who have been arrested / CDO chaperoning.

It is important to unpick the experience of the service in relation to young people a little further. The evaluation has highlighted that stakeholders viewed that young people were not always accessing the service (in both custodial and community settings). There was a view from some interviewees that the service was not commissioned to work with young people, but this was (and is) an integral part of the service offer.

It will be important to ensure that Service user feedback is collected and utilised in any future service review and also in any future recommissioning of the service. Also, given the challenges encountered by the evaluation of accessing and recruiting young people to participate in the evaluation, it is also important that young people are regularly contributing to service feedback loops and that an established process is in place. Young people will likely need different engagement processes to those of adult service users. It is also apparent that adult service users need established engagement processes both in custody settings as well as in CSN supported settings to ensure that their feedback is routinely heard. It is important that service users are involved in the design of any newly commissioned service and these steps will ensure that engagement and participation is routine and accessible.

4.4 FINAL COMMENTS

Programmes such as the service are implemented and delivered in real-world settings with practical issues, politics, and unanticipated developments that can prompt programme innovation and adaptation[x].

This has been particularly evident in exploring and evaluating the service. Importantly, the service has achieved a move away from views of quality in provision where quality work was something which is solely produced by the practitioner and delivered to the user and where the user takes on a passive role. Instead, throughout this review, it has been clear that the interaction between staff and users is enhancing the quality of the service and this is what is assisting the service in achieving its outcomes. It is also important to note that this is a fine balance to maintain.

The evaluation has enabled the identification of changes that have occurred during the initial period of the service and has gathered information that informs the ToC to better understand how the sought outcomes of service can be attributed to the delivered intervention as intended.

It has also given insight into the necessary adaptations of intervention modality which have again been reviewed in relation to the service ToC. This realist process evaluation has moved away from a purely quantitative approach to better understand programme drivers and its ToC.

Mixed-methods approaches to evaluation coupling process and outcome phases have migrated from other disciplines and offer a more rigorous and scientific strategy for determining programme efficacy.

It is suggested that this qualitative study provides a foundation for onwards mixed methods evaluation of outcomes and impact.

The suggested refresh that has been undertaken of the ToC (presented in Appendix three) provides a large amount of information that the service can use to guide the design of any re-commissioning of the service. The ToC is a powerful and evolving tool that will enable the service and commissioners to plan how it will create change. Its use in the design (as well as evaluation) of complex interventions, will increase the likelihood that the service and any revisions will be ultimately effective, sustainable and scalable. It will assist the service and commissioners by:

- Providing a means to identify what needs to happen for service goals to be reached, rather than focusing on current activities too much.
- Ensuring a shared understanding of the service that has been developed collaboratively over the course of the current evaluation. All stakeholders will be able to use the ToC to understand what the goals of the service are and what is necessary to achieve them.
- A powerful tool to demonstrate what the service is doing and what difference it will make.
- Guiding onwards evaluation – it articulates the causal pathways that lead to the sought end goals of the service and consequently, the key things that need to be measured.

There has been considerable insight into the operation of the service which can be fed back to its various stakeholders to aid onwards development and improvement, together with maintaining the evidently good practice identified in this evaluation. The evaluation has also highlighted some gaps in feedback loops that could be improved and makes accordant recommendations.

4.5 RECOMMENDATIONS

The strategic and operational recommendations which respond to the evaluation findings are detailed below.

STRATEGIC RECOMMENDATIONS

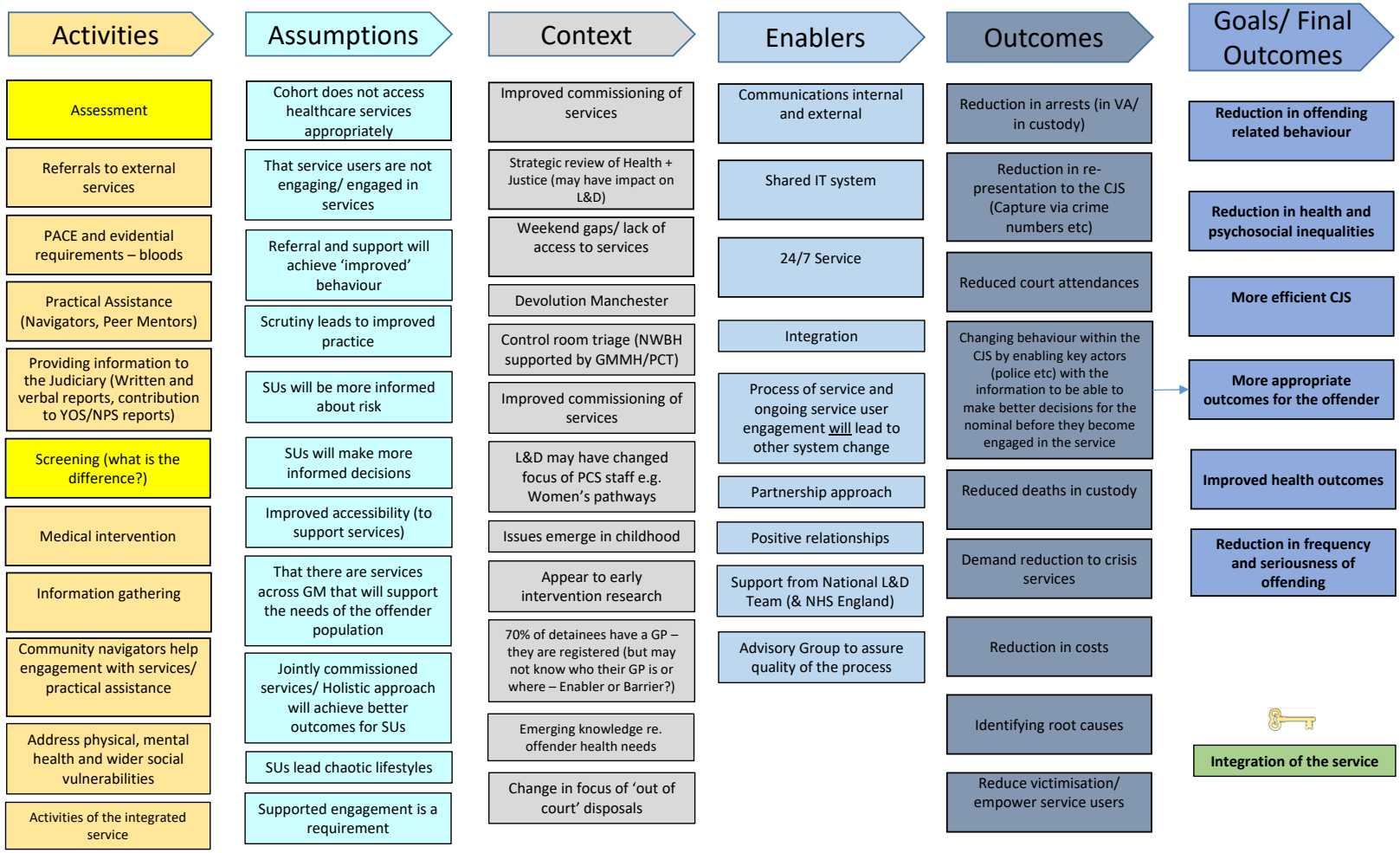
- Undertake a review of the working hours of L&D police custody provision in relation to demand to explore whether an extension of L&D working hours is required.
- Explore the reported challenges to young people accessing the service in conjunction with YOS to ensure that young people are able to access the service as intended.
- Review the way that service user feedback is obtained and used to inform the development of the service with specific reference to ensuring that there are young person specific processes as well as processes for service users in custodial as well as community settings to feedback.
- Ensure that all service staff, partners and service users have a common understanding of service functions, including service delivery hours and priority groups.
- Review the KPIs for the service. Some KPIs were viewed as less relevant to the performance of the service for example the, GP KPI and numbers / proportions of presenting service users seen by each element of the service.
- Review monitoring and evaluation arrangements to ensure the collation of standardised information and outcome data across all areas of the service (including CSN services) towards any refreshed KPIs.
- Explore future outcome evaluation options. It is recommended that this involve mixed methods with considerable planning to overcome some of the experienced challenging in gathering quantitative data from multiple agencies.

- Further research should involve obtaining the experience of service users who do not receive support from the navigators – i.e. obtaining the perspective of the majority of service users who are assisted by the service. This should include their involvement in developing a service specification for future commissioning of the service.

OPERATIONAL RECOMMENDATIONS

- Review L&D delivery at court, with particular consideration to availability, service offer, points of contact if staff are unavailable, and communication.
- Review the CSN caseload management and triage process for providing Service user support.
- Review the exit strategy for service users moving on from CSNs to avoid dependency and ensure the individual agency of service users is maximised at exit points.
- Review the needs assessment and review process undertaken by CSNs: currently there is a reliance on secondary assessment data which may change / develop as the Service user needs change and the CSN intervention evolves.
- Improve the service feedback loop between service in community settings to custody suites and between community partners to CSN staff.
- Stakeholder feedback process: a once or twice a year meeting between local service staff and the agencies which they signpost clients to may help with providing a feedback loop for service staff, so they can get a sense of the outcome of their work.
- Joint training between HCP and L&D staff in mental health to overcome some identified professional differences and also some perceptions regarding knowledge bases. This recommendation is drawn from the qualitative experiences of both of these service areas.

APPENDIX ONE – ORIGINAL THEORY OF CHANGE



APPENDIX TWO – SAMPLING CRITERIA

Interviews were sought with a purposeful sample of participants. In each group, sampling attempted to include:

- ***Service users (SU)***: up to 16 interviews based on: health and social welfare needs; offence type; demographics; first or multiple encounters with the service; services which the service users were referred to; those accessing support through the community navigators; priority service user group; and custody suite/ court attended.
- ***Service staff:*** 12 interviews to include up to 9 frontline staff (providing healthcare, liaison diversion provision in custody and at court and community navigator support) and up to 3 service managers covering the three elements of the service (healthcare, liaison and diversion and Community Support Navigator provision). It was also planned that (where possible) frontline staff and managers would be drawn from the custody suites and courts where the service users were sampled from.
- ***Partner agencies:*** up to 12 staff from agencies involved in facilitating the delivery of the service and partner agencies who are likely to provide services to which service users will have been signposted and/or referred to. Sought partners included: GMP; HMCTS; National Probation Service; Youth Offending Team; women's centres involved in the Greater Manchester Women's Services Alliance; mental health provider; accommodation provider; drugs service provider; and, Independent Custody Visitors.

APPENDIX THREE - THEORY OF CHANGE REVISITED

A ToC is not a static tool. A ToC is a live working document and should be regularly reviewed to ensure it remains relevant and accurately reflects the service and the latest scientific evidence. In order for it to be an effective and useful tool, it should be revised and updated as understanding and knowledge is gained about a service through evidence and observation. The evaluation of service has done just that. It has yielded numerous insights and evidence regarding the service and accordingly, this section revisits and refreshes the initial ToC that was developed as an output of the early ToC workshop (it is available in Appendix One for reference).

ACTIVITIES

Activities refer to the things that the service does or the way the service chooses to deliver day-to-day services.

The activities of the ToC were set out as: assessment; referrals to external services; PACE and evidential requirements, including blood samples; practical assistance (navigators, peer mentors); providing information to the judiciary (written and verbal reports, contribution to YOS / NPS reports); screening; medical intervention; information gathering; CSNs help engagement with services / practical assistance; address physical, mental and wider social vulnerabilities; and, activities of the service. These activities were all apparent in the accounts of interviewed stakeholders.

Also apparent within the evaluation were additional activities that could be included in any revisions to the service ToC. Most of all *'the establishment of a working relationship'* is a necessary activity that has many steps that are undertaken by both parties in order to establish a working alliance and maintain it over the duration of any intervention work. Amongst many things, it appears to serve to support engagement, enable any dropouts to return, encourage motivation for service users to access services and even its brief intensity in a custodial environment enables initial engagement and sets the scene for continuity into a community setting.

Additional activities of 'forums and meetings', particularly regarding oversight and scrutiny were also referenced for example 'high volume users' - a monthly scrutiny meeting to prepare action plans to assist people in reducing their frequency of arrest.

Mention should also be included of partner agency activities that support the activities of the service, which include CDOs accompanying L&D / HCP staff to cells.

ASSUMPTIONS

Assumptions refer to the underlying beliefs about how the service works, the people involved and the context.

The assumptions of the ToC were set out as: cohort does not access healthcare services appropriately; that service users are not engaging/ engaged in services; referral and support will achieve improved behaviour; service users will be more informed about risk; service users will make more informed decisions; Improved accessibility (to support services); that there are services across GM that will support the needs of the population of vulnerable people entering the criminal justice system[xi] and/or at risk of entering the criminal justice system; jointly commissioned services/ holistic approach will achieve better outcomes for service users; service users lead chaotic lifestyles; and, supported engagement is a requirement.

Getting depth and critical thinking on assumptions is widely agreed to be the crux of a theory of change process[xii]. Assumptions are the necessary conditions for change, the '*underlying conditions or resources that need to exist for planned change to occur*'[xiii]. The evaluation highlights an originally proposed assumption that is not perhaps a necessary condition for change. Many service users are not chaotic, especially some of the priority groups and some service users are engaged in services but their attendance may fluctuate and need support. It is suggested that the assumption that SU's lead chaotic lifestyles can be excluded because it does not need to be met for the service outcomes to be achievable.

The evaluation has also highlighted an additional assumption that also incorporates the issue of consent: service users need to be motivated to change in order to engage with the service offer.

Importantly, the service relies on police making referrals to the service. That '*police screen and refer all service users with need*' is suggested as another assumption.

It is important to note the issue that the evaluation has highlighted regarding young people accessing the service and making it clear that young people will access the service on arrest and not at earlier triage and diversion stages (where they will receive YOS services).

CONTEXT

The context of the ToC was set out as: *improved commissioning of services; strategic review of health and justice (may have impact on L&D); weekend gaps/ lack of access to services; devolution Manchester; control room triage (NWBH supported by GMMH/PCT); improved commissioning of services; L&D may have changed focus of PCS staff, e.g. women's pathways; issues emerge in childhood; appear to early intervention research; 70% of detainees have a GP (they are registered but may not know who their GP is or where – enabler or barrier?); emerging knowledge re. the health needs of people entering the criminal justice system; and, change in focus of 'out of court' disposals*.

The evaluation has identified support for all of the above contextual elements. One addition is suggested that reflects the journey that the service has undertaken to date, especially in learning lessons from becoming embedded in police stations.

In answer to the question regarding access to a GP, the evaluation highlights that stakeholders have experienced most service users as having a GP but that they have perhaps become disengaged but are still registered with a practice. It is thus suggested that this could be reviewed to ensure it is a meaningful target.

ENABLERS

The enablers of the ToC were set out as: *communication internal and external; shared IT system; 24/7 service; integration; process of service and ongoing service user engagement will lead to other system change; partnership approach; positive relationships; support from National L&D Team (& NHS England); and, advisory group to assure quality of the process.*

The evaluation findings suggest that '*process of service and ongoing service user engagement will lead to other system change*' is an assumption rather than an enabler. Also apparent within the evaluation, were additional enablers that can be included in any revisions to the service ToC. Most of all '*a developed working relationship between an service practitioner and a* SU'. Amongst many things, it appears to serve to support engagement, enable any dropouts to return, encourage motivation for

service users to access services and even its brief intensity in a custodial environment enables initial engagement and sets the scene for continuity into a community setting.

Other additional suggested enablers are: *the separation of role from police; embedment of the service within police custody suites; effective team work; information sharing agreements; training and development support; management support and a strong leadership team; established referral pathways and systems; scrutiny of the service; motivated staff; police booking system; dynamic knowledge of L&D and CSN staff of external agencies; accessibility of community partner agencies; and, the provision of clear, straightforward and correct advice*. The *'mental health knowledge of L&D staff'* was another identified enabler.

It is also suggested that given the barriers to the service that were identified during the evaluation, that 'enablers' be reworded to 'risks' to ensure the ToC encompasses all necessary elements.

OUTCOMES

The outcomes of the ToC were set out as: reduction in arrests (in VA/ in custody); reduction in representation to the CJS (capture via crime numbers etc.); reduced court attendances; changing behaviour within the CJS by enabling key actors (police etc.) with the information to be able to make better decisions for the nominal before they become engaged in the service; reduced deaths in custody; demand reduction to crisis; reduction in costs; identifying root causes services; and, reduce victimisation/ empower service users.

The evaluation has revealed a number of additional outcomes of the service that could be included in any revisions to the service ToC. Based on the information regarding referrals, these include the improved access of service users to community-based interventions.

GOALS / FINAL OUTCOMES

A final goal is the change you want to see in service users or beneficiaries.

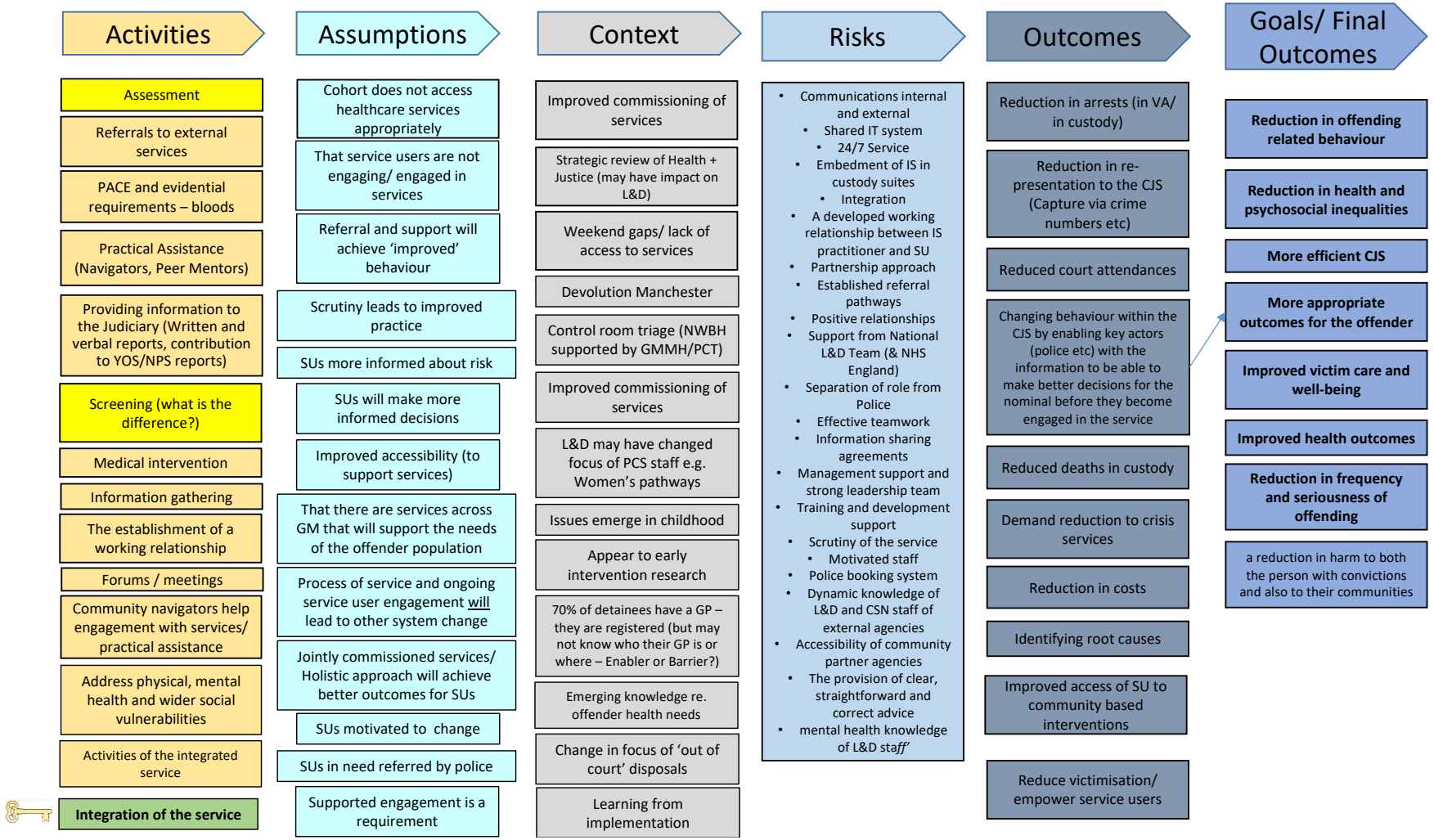
The goals and final outcomes of the ToC were identified as: reduction in offending related behaviour; reduction in health and psychosocial inequalities; more efficient CJS; more appropriate outcomes for the offender; improved health outcomes; and, reduction in frequency and seriousness of offending.

Other additional suggested goals and final outcomes of the service are a reduction in harm to both the person with convictions and also to their communities. Another longer-term outcome of victim care was identified in that by reducing recidivism, 'victim care and well-being improves'.

The final outcome of the ToC is the 'integration of the service'. It is suggested that instead of an outcome, that this is an essential activity that must be completed in order to achieve the sought outcomes of the service.

A refreshed ToC is presented in the Figure Two.

Figure Two: A Refreshed Theory of Change



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[v] Humphrey, N., Lendrum, A., Ashworth, E., Frearson, K., Buck, R., & Kerr, K. (2016). Implementation and process evaluation (IPE) for interventions in educational settings: A synthesis of the literature. London: Education Endowment Foundation

[vi] ID numbers refer to a unique reference number for each participant of the process evaluation.

[vii] For reference, our exploration of fidelity has been guided by the Justice Program Fidelity Scale which is a customisable tool that provides an example of robust and systematic measurement of implementation intensity and modality adherence demonstrated by criminal justice programs. . The scale's accompanying definition of fidelity summarises how it comprises both the structural components of an intervention (e.g., evidence-based nature of modality elements) and therapeutic environment dynamics reflective of the nature and quality of interaction between programme stakeholders.

[viii] Carroll, C., Patterson, M., Wood, S. Booth, A., Rick, J., & Balain, S. (2007). A conceptual framework for implementation fidelity. Implementation Science 2, 40. https://doi.org/10.1186/1748-5908-2-40

[ix] Carroll, C., Patterson, M., Wood, S. Booth, A., Rick, J., & Balain, S. (2007). A conceptual framework for implementation fidelity. Implementation Science 2, 40. https://doi.org/10.1186/1748-5908-2-40

[x] Blakey, C.H., Mayer, J. P., Gottschalk, r. g., Schmitt, N., Davidson, W. S., Roitman, D. B. and Emshoff, J. G. (1987). The fidelity adaption debate: implications for the implantation of public sector social programs. *American Journal of Community Psychology, 15*(3), 253-268.

[x] https://feedbacklabs.org/why-feedback-matters/

[xi] Original version used the term 'offender' – this has been amended to the term 'people entering the criminal justice system.'

[xii] https://www.oxfamblogs.org/fp2p/wp-content/uploads/DFID-ToC-Review_VogelV4.pdf

[xiii] https://english.rvo.nl/sites/default/files/2018/11/FBK_theory_of_change_guidelines_0.pdf