



ENCOMPASS

Supporting What Matters

**Community Flow: North and
East Quarterly Report**

October - December 2025

NHS

Royal Devon
University Healthcare
NHS Foundation Trust

Contents

Sections at a glance

What Is Our Community Flow Programme?	3
Quarterly Highlights	4-5
Stories	6-9
Outputs	10
Outcomes	11
Impact Snapshot	12
Who Have We Reached	14
Insights From the Quarter.....	15-16

*Please note - real names will only be used where consent has been provided.

What Is the Community FLOW Programme?

Encompass Southwest, in partnership with **One Northern Devon** and the **RDUH NHS Foundation Trust**, is delivering a compassionate and joined-up approach to supporting people home from hospital and with re-admissions to hospital. Our **Flow Programme** is at the heart of this, helping services work together around the individual- so that support flows to them, rather than them having to chase it.

One Northern Devon's **Community Flow** aims to provide better access to community support. It aims to ensure closer links between the hospital and the wider support available in communities' this is from volunteers, the wider VCSE sector and the wider 'One Community' partnerships in the six towns and one village in Northern Devon. Our **North** team deliver in **North Devon and Torrington**, whilst our **East** team delivers in the following areas: **Exeter, Tiverton, Cullompton and surrounding villages**.

Community Flow aims to support patients to improve their own health and wellbeing, link them into their communities, help them build sustainable support networks and function as independently as possible. It also aims to enable safer and sustainable discharges, avoid unnecessary readmission and reduce reliance on health and social care services.

Caseworkers apply a **person-centered** approach to working with patients, focusing on the things that are defined by the patient as being important them, within a holistic approach to exploring how they manage their life - encompassing:

- Physical Health
- Emotional health
- Housing/Accommodation
- Family, friends and relationships
- Finance and Income
- Employment and Education
- Community access
- Self-care, diet and nutrition.



FLOW isn't just a service model - it's a shift in mindset about how we offer support. It sees people beyond their symptoms or service labels, recognising that true wellbeing emerges when we understand and respond to the full context of someone's life. It creates space for meaningful change, both for individuals and the systems that support them.

North Quarterly Highlights

Our North team has an FTE Equivalent of 2.8.



136 PATIENTS SUPPORTED THIS QUARTER, INCLUDING **88** NEW PATIENTS

273 people supported in total by Community Flow since April 2025



68 PATIENTS POTENTIALLY AVOIDED FUTURE HOSPITAL RE-ADMISSION



67 PATIENTS POTENTIALLY AVOIDED RE-ADMISSION WITHIN A SIX WEEK PERIOD



53 COUNTS OF SAFER AND MORE SPEEDY HOSPITAL DISCHARGE WERE SUPPORTED



48 PATIENTS WERE DISCHARGED SOLELY DUE TO OUR INTERVENTION



£9,692.79 WORTH OF GRANTS/ FUNDS WERE AQUIRED FOR PATIENTS DURING THIS QUARTER

East Quarterly Highlights

This is the first quarter this project has been active.
Our East team has an FTE equivalent of 2.0.



30 PATIENTS SUPPORTED THIS QUARTER, THEY ARE 30 NEW PATIENTS.

30 people supported in total by Community Flow since October 25.



15 PATIENTS POTENTIALLY AVOIDED FUTURE HOSPITAL RE-ADMISSION



0 PATIENTS POTENTIALLY AVOIDED RE-ADMISSION WITHIN A SIX WEEK PERIOD



3 COUNTS OF SAFER AND MORE SPEEDY HOSPITAL DISCHARGE WERE SUPPORTED



0 PATIENTS WERE DISCHARGED SOLELY DUE TO OUR INTERVENTION



£0 WORTH OF GRANTS/ FUNDS WERE ACQUIRED FOR PATIENTS DURING THIS QUARTER

Yearly Overview

These tables illustrate a selection of quarterly highlights presented on a cumulative basis, primarily relating to hospital discharge interventions, and show how impact builds over time from the start of the financial year (April).

NORTH

Intervention Supported	April-June (Q1)	July- Sept (Q2)	Oct-Dec (Q3)	Jan-Mar (Q4)	Year to Date
Safer and more speedy hospital discharge	29	12	53		94
Potentially avoided future hospital re-admission	73	56	68		197
Potentially avoided re-admission within a six week period	Obtaining	52	67		Obtaining
Discharged solely due to our intervention	22	4	48		74

EAST

Intervention Supported	April-June (Q1- 11 clients)	July- Sept (Q2)	Oct-Dec (Q3)	Jan-Mar (Q4)	Year to Date
Safer and more speedy hospital discharge	N/A	N/A	3		3
Potentially avoided future hospital re-admission	N/A	N/A	15		15
Potentially avoided re-admission within a six week period	N/A	N/A	0		0
Discharged solely due to our intervention	N/A	N/A	0		0

Mr H's Journey- North

Mr. H is a 70 year old gentleman living alone in a rural area. His initial referral came from the Holsworthy Community Team due to increasing loneliness, limited social contact and concerns around his general well being following his most recent discharge from hospital.

On our initial call with the patient, he reported to be feeling lonely and found it difficult to manage day-to-day tasks such as accessing social support and organising his weekly food shopping outside of limited help he was receiving from his son. Mr. H expressed a desire for more regular social interaction and practical help with managing household tasks. He also shared his concerns about finances and difficulty accessing online services due to limited confidence with digital technology. He informed community flow that he does have Wifi in his home however he feels he is paying far too much for it when it hardly ever works. We discussed various options for all of the above issues and decide on the best way to move forward for Mr H, tackling each issue with compassion, efficiency and a view to improve his day-to-day life.

Interventions and support provided

1. Referral to Age UK – Befriending Service

Community flow referred Mr H into Age UK for ongoing befriending support. He now receives regular home visits from a designated volunteer, providing him with meaning social contact and someone to talk to. Mr H has reported looking forward to these visits and feeling significantly less isolated.

2. Full Financial Check through TorrAge

To address financial concerns, Community Flow were able to arrange a benefit review and check with the patient with TorrAge. This ensured that Mr H was receiving all entitlements available to him and helped ease financial worries. He told Community Flow that this referral also increased his confidence with managing his money through the advice and support he ongoingly receives.

3. Support with Food Shopping – Telephone Ordering

Community Flow supported Mr H in helping to set up a Sainsburys Telephone account that allows him to place food orders over the phone. This has given him the flexibility to either have his food shop delivered directly to his home or to create an order that his son can collect for him via click & collect. This has made food shopping more manageable and has ensured he maintains a more consistent diet that suits him.

3. Broadband Support – Transition from Virgin Media to EE

Community Flow were able to assist the patient in switching his broadband provider from Virgin Media to EE after research and identifying that EE offered a stronger, more reliable connection in his rural area. The change has also reduced his monthly costs by over £25, easing that financial pressure. Improved connectivity has enabled Mr H to stay in closer contact with his family and friends who are not local to him, access online services more easily and feel more secure knowing he has a dependable internet connection for every day tasks.

4. Community Connections

Following Mr H expressing his loneliness, Community Flow were able to look into various community events that happen in his local area that he would like to attend. He has now begun attending a weekly coffee and cake morning every week at his local village hall, alongside also attending a community meal every week in a local church. Volunteers come to collect him and bring him home afterwards, enabling him to participate without transport worries. Mr H reports that he has made new friends, feels more socially connected and describes the events as joyful and meaningful.

With Holistic support from community flow, Mr H has experienced significant improvements in his overall well-being, independence and social interactions. Regular befriending visits have reduced his loneliness, while a benefits check has ensured greater financial stability. Practical help with food shopping and transitioning to a more affordable, reliable broadband provider has eased pressures and improved his quality of life. Additionally, reconnecting with his local community through community meals and coffee mornings has brought him a sense of belonging, purpose and new friendships. Together, these interventions have enabled Mr. H to feel more supported, confident and engaged in his day-to-day life.

Mr D's Story- East

D is a 88 year old gentleman who lives alone in a second floor flat (with 2 flights of stairs) in the Exeter area. He was referred to me by an ACM in the UCR Team following a fall which resulted in a broken arm.

He was very independent prior to the fall with all activities and getting out and about. He walked most days down into town to get his food shopping, visit the library, and often got the bus to either Exmouth to see his friend or up onto Dartmoor walking. D is a very private man and chooses to live that way, preferring his own company. He chose prior to fall to sleep on a mattress on the floor and led a very humble simple life, with only a radio for company. Has no internet or computer, and only a basic text/call mobile phone.

Reasons for referral were support with banking and admin, food shopping, social isolation and obtaining his medications.

As he lived close to where I live, and in view of the fact he had very little food I chose to visit him face to face on my initial WMTM contact, as I had capacity to do so. We hit it off straight away and he engaged wonderfully, accepting my support. Being a very private man, he didn't want a lot of fuss and different people in and out, so as I had capacity, lived so close by, and this wasn't a permanent need (only while he had rehab for his arm and equipment installed), we agreed I would do a weekly shop for him until he returned to independence.

He only dealt with cash, so I supported him to get a debit card , to make paying for bills easier if needed, and to save him going to his bank every time he needed money (as the local shop had an ATM).

He needed a new door lock fitted so I obtained one from B&Q and sorted for him.

He wanted to do lots of admin, but as he couldn't access the library I printed off forms and information from the internet, did research for him as well as ordering him a new typewriter ribbon and obtaining stationary.

He was a keen writer and loved reading, so I found him a local writers group which he said he would consider joining once out and about again.

I also custom made him a waterproof cover for his new 4WW which he was delighted with (to buy one he was looking at around £40!).

Working alongside the Community Rehab Team who provided stair rails, a 4WW aid and equipment, an exercise plan, plus their rehab visits, D returned to independence again over the 7 weeks I was involved with him.

On my final visit, D couldn't thank me enough, and at one point started crying, saying "you were an angel sent by God in my hour of need" and thanked me for all my help, and the lovely chats we had. He said he wouldn't have made it without me and the CRT team.

What We Did to Support People

We measure this through **outputs** and **outcomes** - what are these?

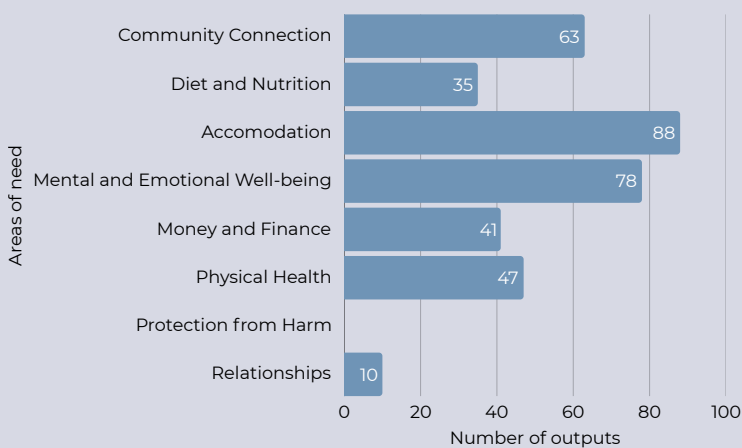
Outputs

These are the practical actions we've taken to support people and help them work towards their goals. For example, under the category of Community Connection, this included actions such as:

- Access to community opportunities and facilities
- New connection to transport services
- New referrals to community groups and activities

North

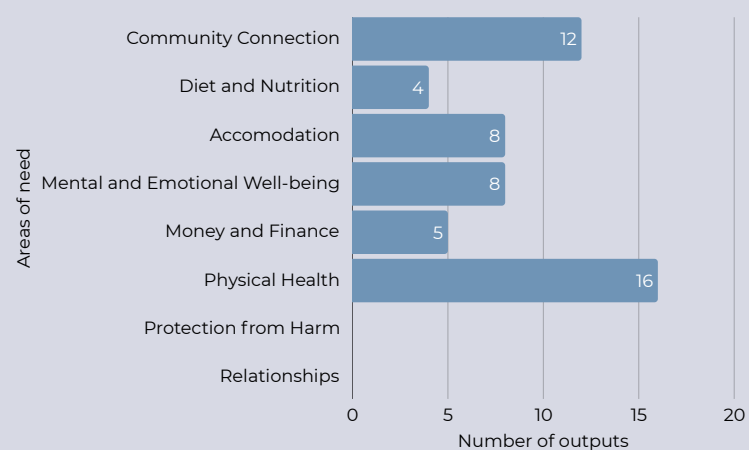
Outputs by area of need



Total = 362

East

Outputs by area of need



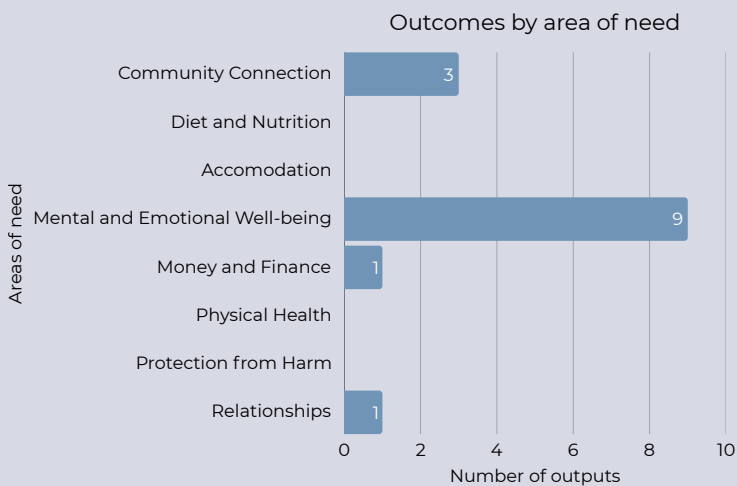
Total = 53

Outcomes

These demonstrate the direct benefits and changes that have emerged from the outputs delivered through caseworker support. For instance, under the category Community Connection, this included results in:

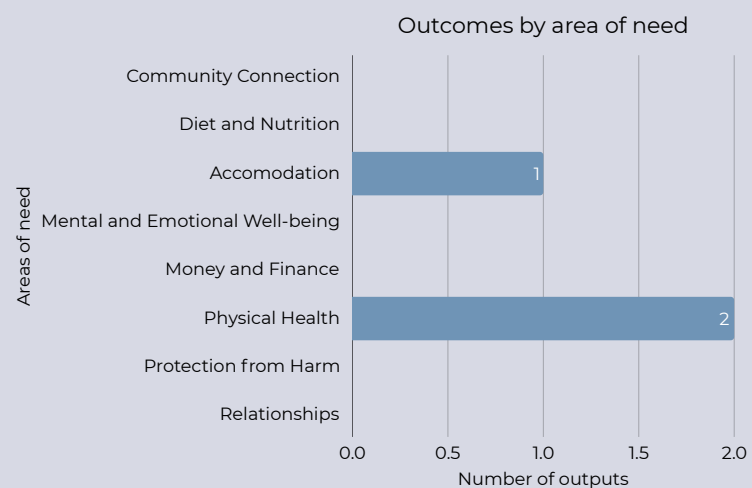
- Client more able to access community facilities and services
- Client reports feeling better connected to local community resources
- Increased independence with travel

North



Total = 14

East



Total = 3

Impact Snapshot

North



50 OF THOSE WE SUPPORT HAVE A CARER



4 OF THOSE THAT WE SUPPORT ARE CARERS



**INBOUND REFERRELS:
BARNSTAPLE: 35
TORRIDGE: 15
BLISS: 22**

East



7 OF THOSE WE SUPPORT HAVE A CARER



0 OF THOSE THAT WE SUPPORT ARE CARERS



**INBOUND REFERRELS:
BLISS: 1
CH&SC TIVERTON & COLLUMPTON: 7
DISCHARGE FACILITATOR: 4
SOCIAL SERVICES ADULT TEAM: 1
CARE-COORDINATOR: 16**

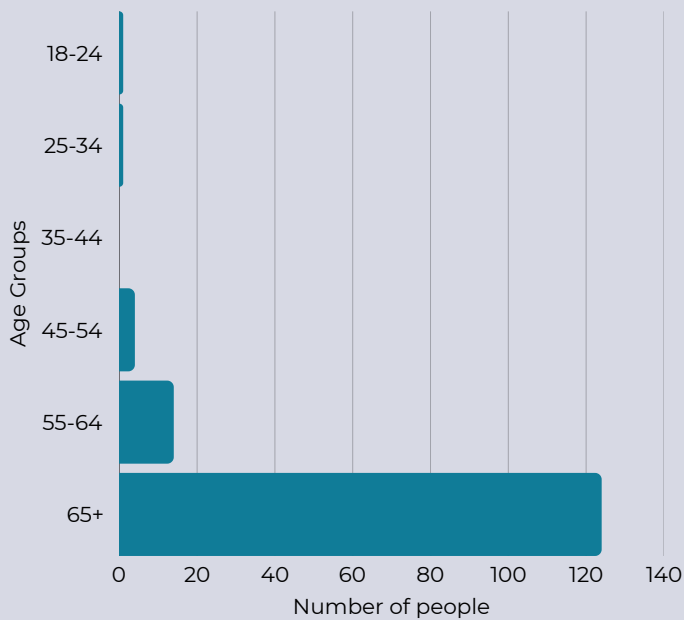
We will be changing this to reflect referral by area for our future reporting

Who Have We Reached?

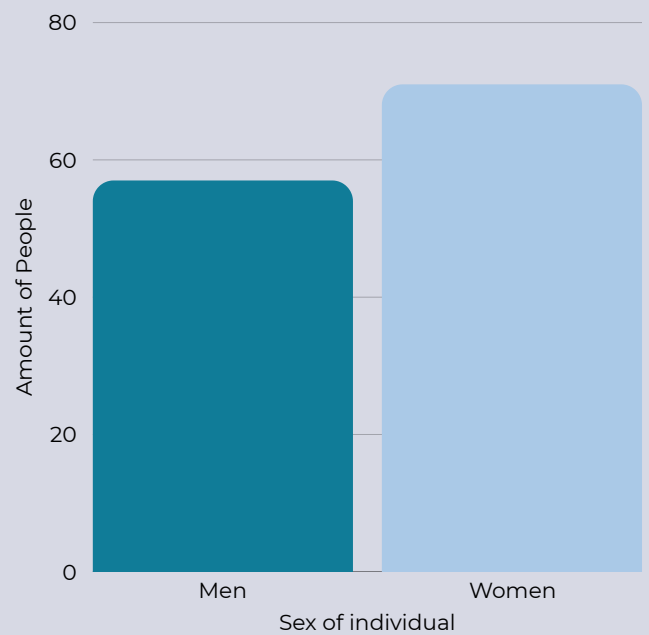
Based on the information we've been able to collect - and that individuals have felt comfortable sharing - the following offers a view of the demographics of the new clients we have supported this quarter:

North

People Supported by Age



People Supported by Sex

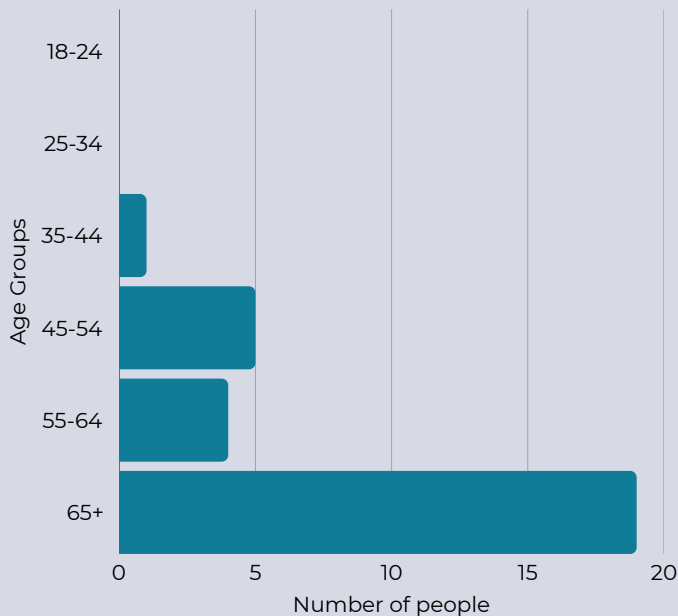


Who Have We Reached?

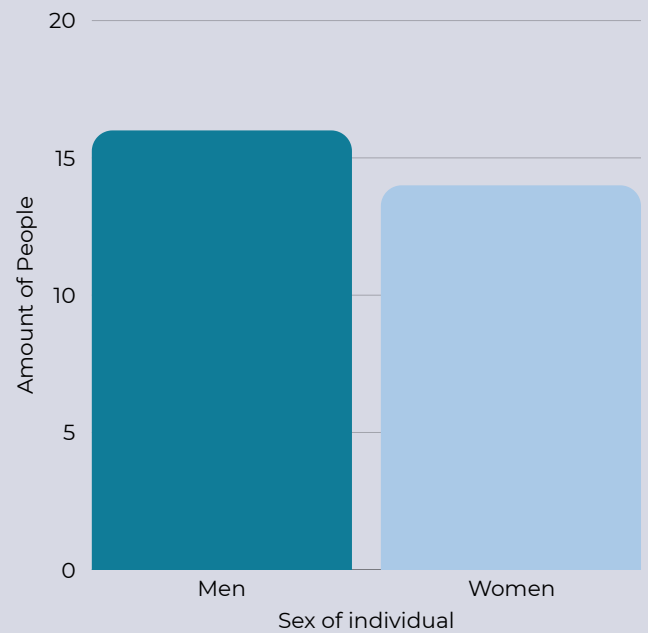
Based on the information we've been able to collect - and that individuals have felt comfortable sharing - the following offers a view of the demographics of the new clients we have supported this quarter:

East

People Supported by Age



People Supported by Sex



Insights from this Quarter

North

What barriers are we experiencing?



Complex and time consuming funding processes- Applications are time-consuming due to: detailed information requirements; expenditure breakdowns, supporting evidence; obtaining documentation. These challenges are compounded when: patients are acutely unwell; patients are still in hospital; there is no family support to assist with gathering information. This delay in funding timelines impacts the speed of hospital discharge; the length of time cases remain open and overall workload management.



Loss of accessible, quicker response funding- The removal of the previously available ICB discharge fund has had a noticeable impact.. While external grants can be successful, they often take multiple quarters to secure and do not meet the need for immediate, flexible funding. This gap increases staff time spent coordinating funding and prolongs patient involvement with the service.



No local connections- There are many patients we work with that have a lack of support networks for individuals we are working with has an impact on their overall health and wellbeing due to myriad of reasons. For instance, there is no one to support them with shopping, taking them to appointments or to pick up prescriptions. Alongside these physical support needs, there is the element of loneliness and isolation.



Patient Transport- Poor transport links makes it difficult for the patients we work with to access local healthcare provisions.

Insights from this Quarter

North

What barriers are we experiencing?



Sanitary conditions- We come across patients who are living in environments deemed too unsanitary for services to meet their needs. This also affects the eligibility for a care package. These issues have an impact on how quickly a patient can be discharged as there are health risks to returning to an unsanitary environment. This leaves us and patients in a difficult position when there are services who are unable to support.



Finances- A lot of the patients we support are living in poverty, this makes access to support services they need more difficult, as well as access to a healthier lifestyle to maintain recovery. Time is a huge barrier here to in relation to grant applications: we have 6 weeks to work with patients, but it can take longer than this to hear back about grant decisions.



Loneliness- there is no longer a befriending service available in Torridge due to Torridge closing. This, alongside issues around transport difficulties, being housebound, as well as a lack of local support networks can leave people isolated and lonely.

Insights from this Quarter

East

Re-occurring patterns of need



Home environment support- De-cluttering and hoarding are frequent reasons for referrals. Clients rarely have the financial means to fund this themselves, which increases reliance on external services.



Digital exclusion- Some clients lack access to computers, the internet and printers, or the ability to leave home independently to access his. This creates barriers to admin tasks, accessing services and completing necessary paperwork. Case workers have had to step in to provide practical support where no alternatives were available.



Enquiries- a proportion of time is spent on enquiries that come through to our caseworkers. This includes contact, admin time, time spent arranging to meet and talking to family. This is work that is not visible in our primary data as they are not opened as 'cases' or classed as a patient supported.

What barriers are we experiencing?



System and Technology- External system access and technical issues limited information sharing and delayed referrals. This also meant to onboarding for staff took longer than normal.



New project- Starting up a project in a new geographic area has meant we have been learning in real time. In some areas, there is also a low awareness of what Encompass does, which means it takes more time to build trust. Caseworkers have suggested the need for promotional material, such as leaflets, to have on hand, especially in areas we have not worked before.



Balancing role boundaries and real world need-caseworkers have had to go above and beyond to meet urgent needs of people, such as offering practical help, where other services could not. This was difficult to categorise within our current outcome frameworks, and raises questions about which work is recognised, recorded and valued.