ENCOMPASS

Supporting What Matters

High Intensity Use (HIU) Flow: North Quarterly Report

October- December 2025

NHS
Royal Devon University Healthcare
NHS Foundation Trust

Contents

Sections at a glance

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

What Is Our High Intensity Use 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 with complex lives. 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.

The **High Intensity Use (HIU) Programme** focuses on people aged 18+ who attend Emergency Departments more than expected- typically more than five times a month or over 20 times a year. Many of these individuals face overlapping challenges that aren't easily addressed by one service alone.

Flow brings together local partners in a 'Team Around The Person' approach, supporting people to identify what really matters to them and take steps towards their own goals. This programme is active across **Northern and Eastern Devon** (and across other locations nationally), and is focused on improving wellbeing and reducing health inequalities.

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.

Quarterly Highlights

38 PEOPLE SUPPORTED, INCLUDING 18 NEW CLIENTS

BELOW NHSE TARGET OF 21*

25% REDUCTION IN NON-ELECTIVE ADMISSIONS TO HOSPITAL

BELOW OUR 40% TARGET- **SEE P11 FOR DETIALS**

86.6% OF PEOPLE REPORTED A POSITIVE EXPERIENCE AT END OF SUPPORT

ABOVE NHSE TARGET OF 80%

100% OF PEOPLE HAVE PROGRESSED IN A GOAL

EXCEEDED NHSE TARGET OF 90%

-4.5% REDUCTION IN EMERGENCY DEPARTMENT ATTENDANCES

BELOW NHSE TARGET of 40%- **SEE P11 FOR DETAILS**

88.8% OF PEOPLE REPORTED REDUCED LONELINESS FOLLOWING SUPPORT

ABOVE NHSE TARGET OF 66%

*Not all of our clients report feeling lonely prior to support.

57.1% SELF-REPORTED IMPROVED WELL-BEING AFTER SUPPORT

Just below our 66% TARGET: 8/14 people were able to complete

We had the equivalent of 2.6 FTE caseworkers working on this project over the last quarter.

See p11 and 12 for full reduction data.

Roger’s Journey

Roger, aged 80, is a devout Christian, who has spent much of his life helping others. He was a talented Carpenter, Railway Engineer and Dress Maker, who has a great sense of humour and a kind, caring nature. Roger shared some of his early experiences with us: his difficult relationship with a mother who expressed he was unwanted, as well as being removed from school at an early age. This affected his literacy levels and meant he had enter the workforce at an early age. These early experiences continue to shape his daily life and confidence now, and contextualise his resilience.

Later in life, after an unhappy marriage ended, Roger shared that his mental health deteriorated, which led to an admittance to a Psychiatric Ward. He shared that he’s ‘never been the same since’. More recently, after moving between flats on the same block, and being unaware that he had to share this with the council, Roger incurred debt. His housing benefit and council tax benefit was consequently stopped. With limited literacy and growing anxiety, these issues became increasingly difficult for him to manage.

Roger had multiple admission to the hospital emergency department due to falls and general ill health, these include: a stroke in 2019, having a pacemaker fitted, being frail (poor mobility), and being Type 2 Diabetic.

At the beginning of support, we asked Roger what matters to him. He said: his health, living independently, his home, being financially independent, his friend, the church, his faith, reducing his loneliness, his career, being involved in the community, and a book that as written about his life. The co-ordination of support with other agencies has been a real strength in order to reach a point where Roger feels more independent, considered, and less lonely.

To support Roger's goals, there were many things we did:

Health and Safety & Daily Living:

- A referral was made to the Adult Social Care Team, in which a care package was allocated. This now includes three carer visits a day to support with personal care, medical administration, meals ad general care. This has supported his general health, as well as reducing loneliness.
- A referral was made to the Occupational Therapy Department, in which he is now better supported with his mobility issues. He now has a walker better suited to his needs when entering his flat and across uneven ground.
- Through a strong relationship built with Roger's Housing Manager, all the safety pull alarms have been fixed in the property.
- Strong communication with Roger's GP was maintained to ensure concerns for Roger's health were shared. A referral has consequently been made to the Falls Team.
- We supported Roger through a minor operation from start to finish, this included reassurance, transport, company at the hospital and ensuring he was home and had everything he needed for recovery.
- We organised Ophthalmic appointments and eye tests for Roger to determine why his vision was so poor. Following tests, it was confirmed that the poor vision was a consequence of the stroke, ongoing issues with his diabetes and low blood pressure.

Financial stability:

- Roger was supported to complete a Housing Benefit Application and he is now in receipt of this, he pays a small amount towards his rental top up, and he is no longer in debt.
- Through liaison with the Council Office, Roger is now exempt from paying Council Tax due to his needs.
- We applied for Disability Living Allowance which has been accepted, this covers the cost of his Care Package, which is a big relief for Roger.

Independence and Empowerment:

- Support to buy an audible watch online. Due to Roger's poor eyesight, he has found it difficult to see the time clearly. This was the first time Roger had ordered anything online, and he was fascinated with the process. This allowed a new sense of independence and learning for Roger.
- Due to hearing difficulties, Roger often missed phone calls, which was a barrier for support. He was supported to get a lanyard that was attached to his phone, which has increased his access to communication.
- We supported him with grocery shopping.

Reducing Isolation and building connection:

- Roger expressed severe loneliness upon the beginning of support. We made a referral to Age Concern to a befriending service, and he now has a visit once a week to chat to someone.
- Roger has been supported by us to attend coffee mornings. Due to mobility, Roger struggled to get there safely independently. Roger has been very grateful for this link back into the community, particularly due to how isolated he had felt for a long, long time.
- Roger has been able to get out the house with his caseworker, Emma, for coffee.

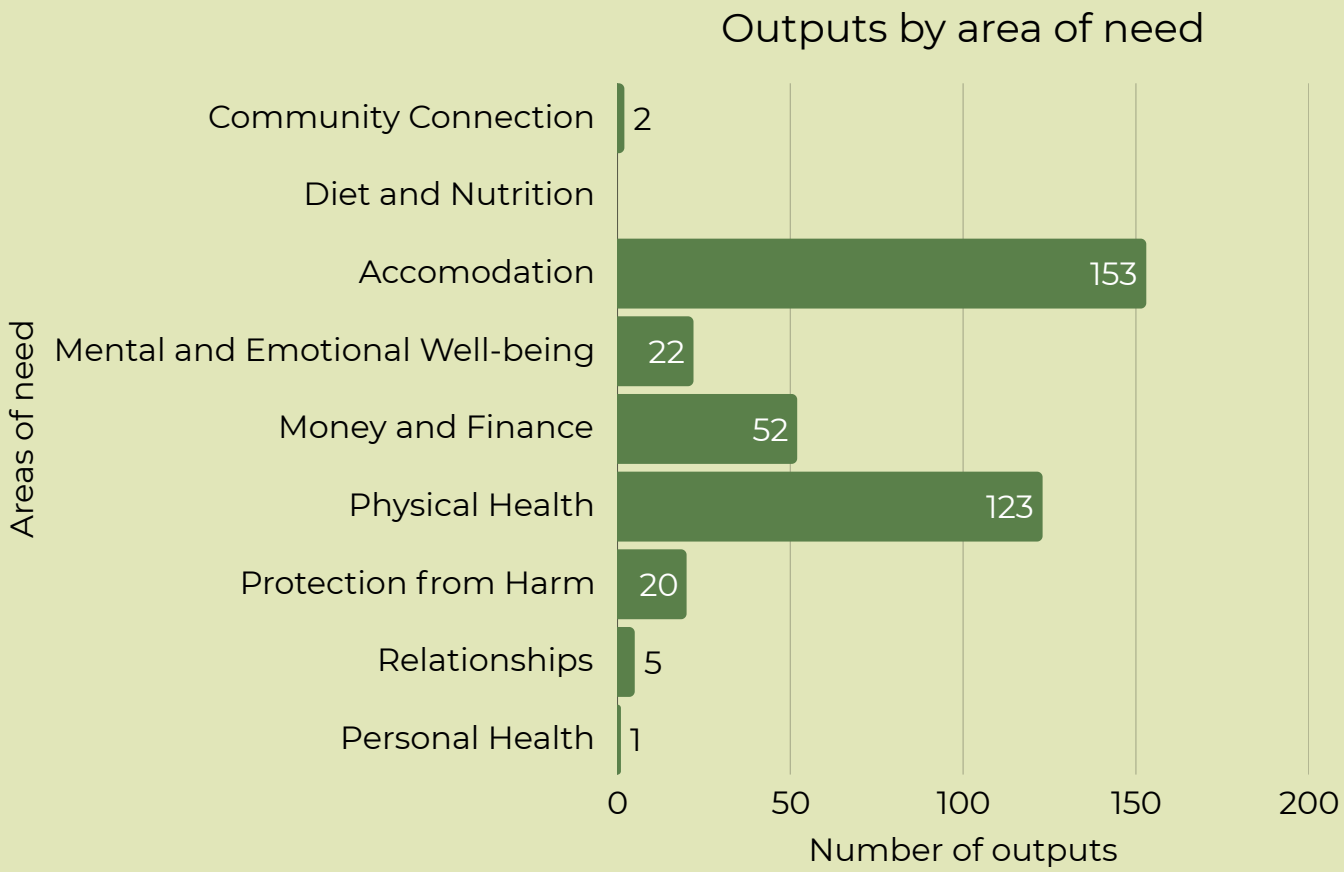
What We Did to Support People

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 **Physical Health** - which had the highest number of outputs - this included support with:

- Accessing external health assessments
- Engaging with their GP appropriately
- Developing self-care skills
- Connecting to drug and alcohol support services



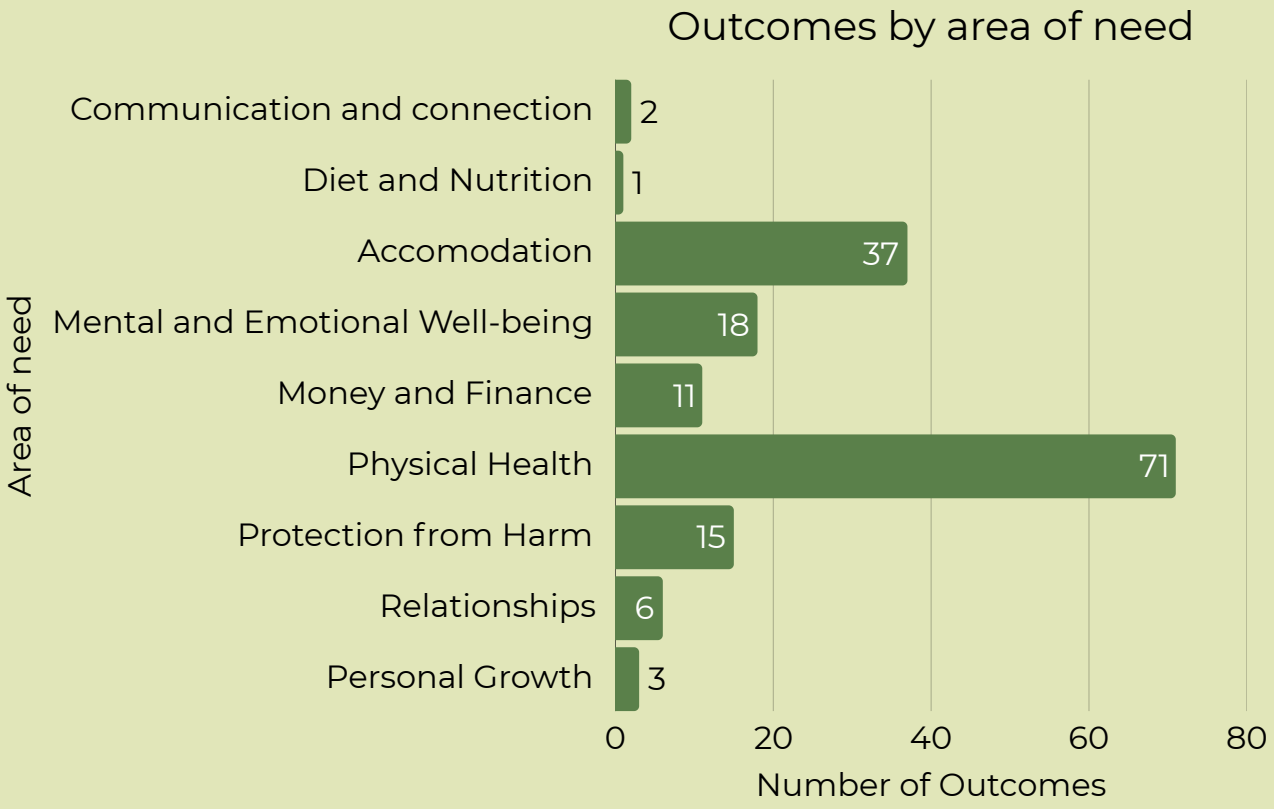
Total = 378

Outcomes

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

- Better management of health conditions
- Reduction in alcohol and/or drug consumption
- The impact of sight loss/deterioration improved

Outcomes are logged upon case closure.



Total = 164

Impact Snapshot

4 WIDER BENEFICIARIES SUPPORTED

911 CONTACTS WERE MADE IN SUPPORT OF CLIENTS

These include direct communication with clients, as well as contact with professionals.

97 GOALS SUPPORTED IN TOTAL

For the 38 people supported this period, there were an average of almost 2 goals per person. These goals are not isolated- they are often interlinked, reflecting the complexity of needs being addressed.

15 PEOPLE ENDED SUPPORT

10 people were closed successfully
2 people disengaged (were not ready for support)
1 person lost their life
1 person moved out of area

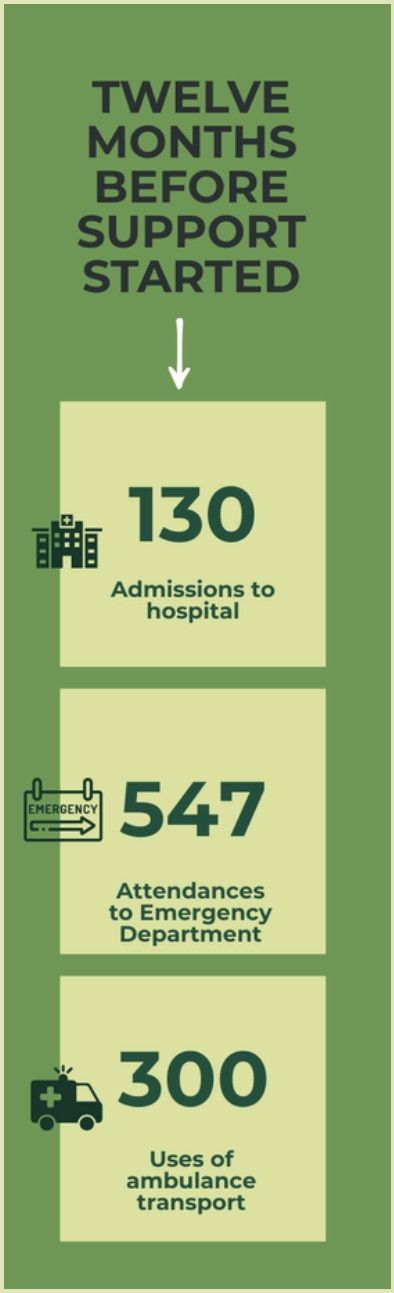
5 PEOPLE DECLINED OUR SUPPORT

How has Our Support Eased Pressure on Services?

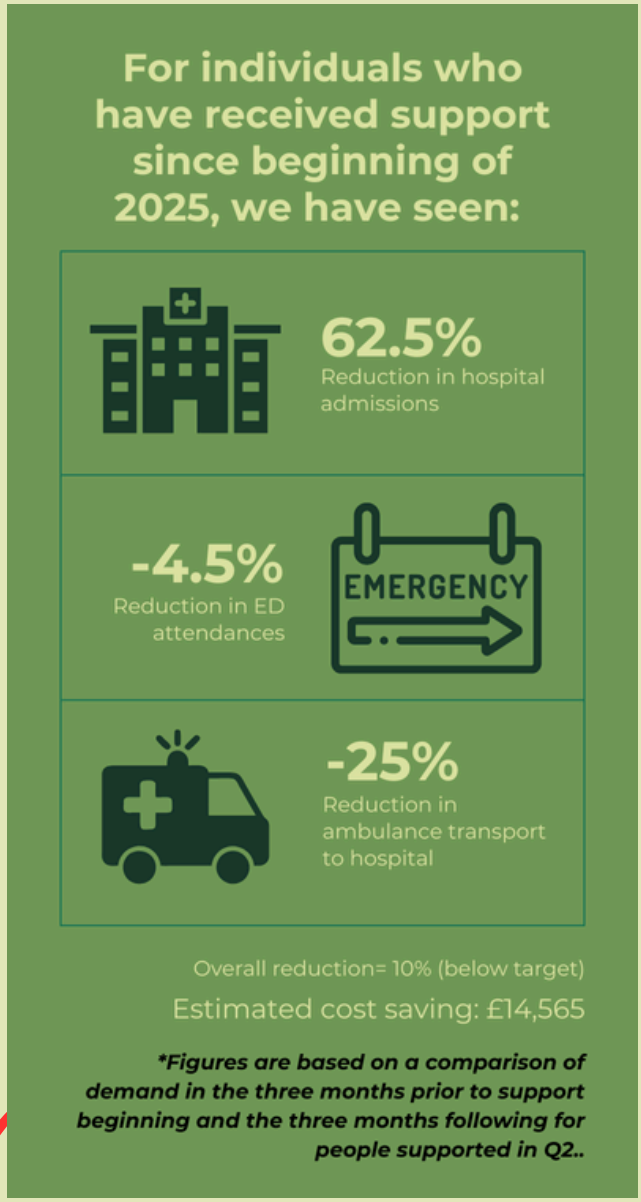
This reduction data will illustrate where there have been changes in how services are used by our clients, as people become more confident to navigate appropriate pathways of support.

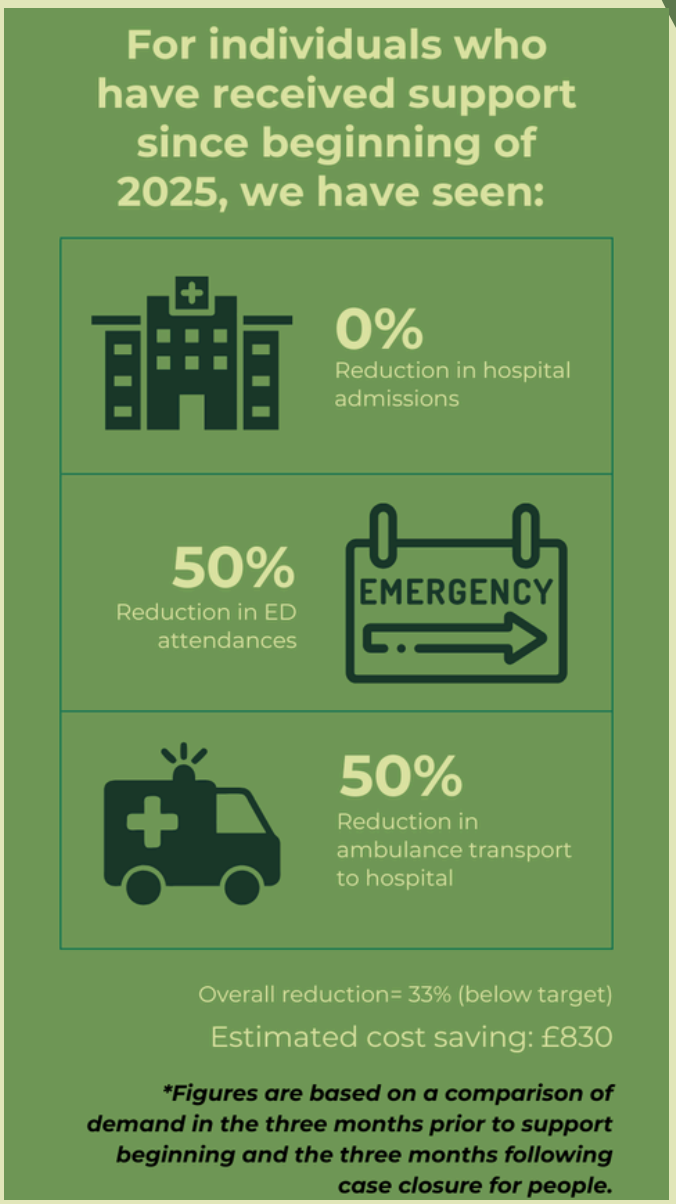
From January to the end of September 2025, we have supported 33 new people. This table shows how often they used emergency services in the previous 12 months before receiving support.

This acts as a reference point for the following page, which illustrates how their service use has reduced - and in which areas - since engaging with us.



Activity Reductions- 3 months



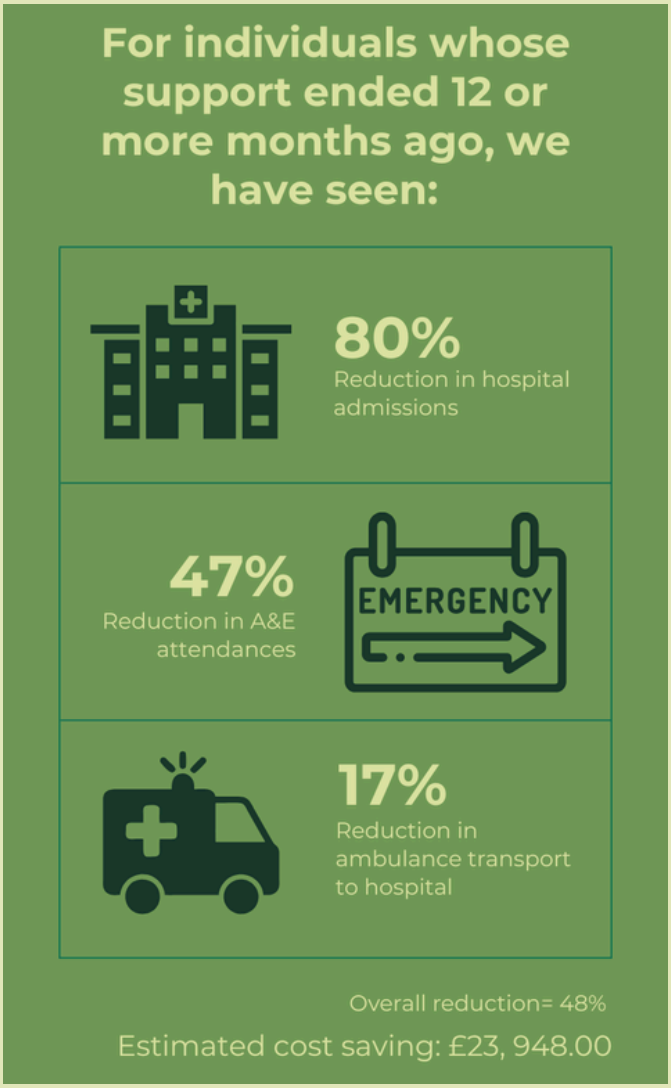


Our three-month figures show an increase in attendances , with results falling into negative figures. This is based on a very small sample size of five individuals (due to disengagement, and a client death), which means the data offers a limited snapshot and can be easily influenced by individual circumstances. In contrast, the 12-month data (on the following page) demonstrates strong progress and highlights more sustainable, longer-term impact, providing a more reliable reflection of outcomes over time.

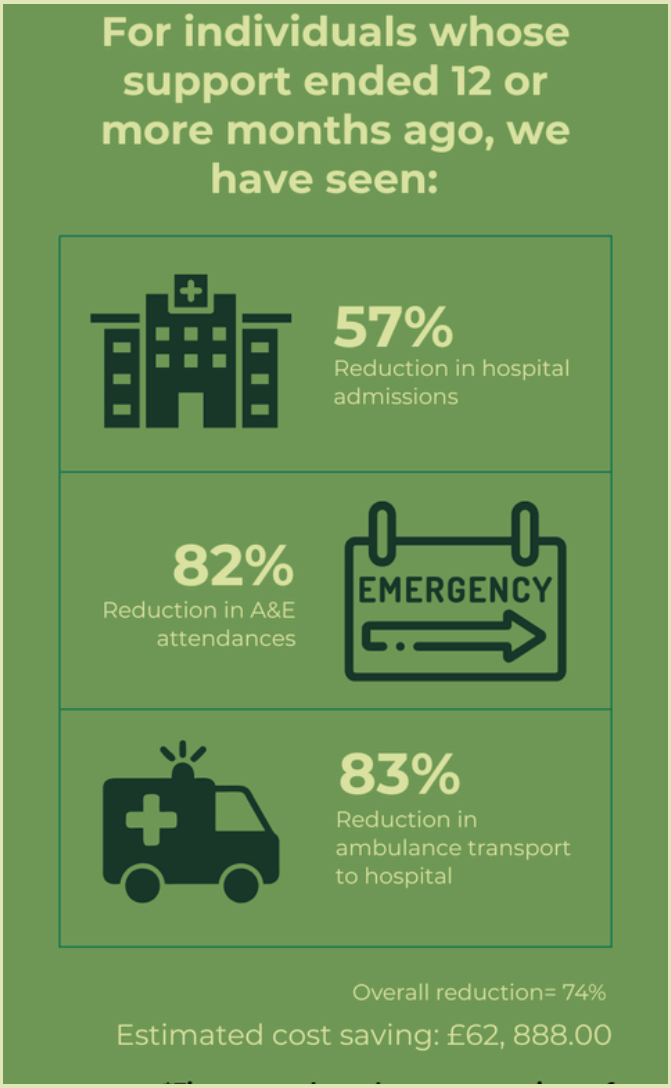
RDUH 2023/2024 cost references as follows:

Average cost of an emergency admission: £3717
Average cost of an attendance to ED £240
Average cost of an ambulance conveyance £539

Activity Reductions- 12 months



12 months prior to start date vs 12 months post stat date



12 months prior to start date vs 12 months post closure date

RDUH 2023/2024 cost references as follows:

Average cost of an emergency admission: £3717
Average cost of an attendance to ED £240
Average cost of an ambulance conveyance £539

Yearly Overview

These tables illustrate the reduction in how services have been used by the people we support on a cumulative basis - showing how this builds over time from the beginning of the financial year (April). Each quarterly percentage reflects those who started support in the previous quarter.

3 months before support started vs. 3 months from support start date (NHSE KPI requirement)

Service	April-June (11 clients)	July- Sept (3 clients)	Oct-Dec (3 clients)	Jan-Mar (Q4)	Year to Date
Emergency Department Attendance	**71%** (from 45 to 13)	**67%** (from 3 to 1)	**-4%** (from 44 to 46)		**21%**
Hospital Admission	**50%** (from 12 to 6)	**52%** (from 27 to 13)	**62.5%** (from 8 to 3)		**40%**
Ambulance Transport	**85%** (from 21 to 3)	**80%** (from 5 to 1)	**-25%** (from 25 to 30)		**22%**

Estimated total saving= **£34, 312.00.** (See RDUH cost reference on p12)

12 months before support started vs. 12 months from support end date (ICB KPI requirement)

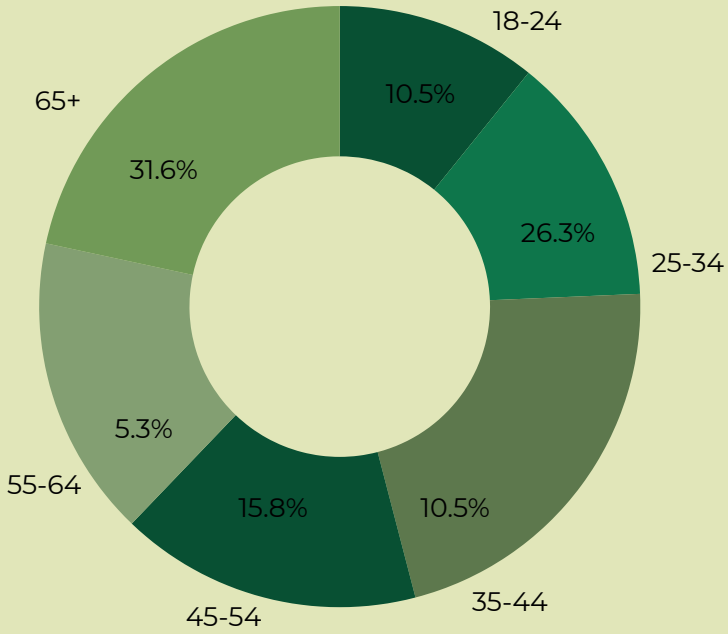
Service	April-June	July- Sept (8 clients)	Oct-Dec (6 clients)	Jan-Mar (Q4)	Year to Date
Emergency Department Attendance	**26%** (393 292)	**70%** (from 27 to 8)	**47%** (from 59-31)		**35%**
Hospital Admission	**20%** (From 54 to 43)	**6%** (from 93 to 87)	**80%** (from 5-1)		**46%**
Ambulance Transport	**44%** (146 to 82)	**63%** (from 51 to 19)	**17%** (from 23-19)		**46%**

Estimated total saving= **£161, 841.00** (See RDUH cost reference on p12)

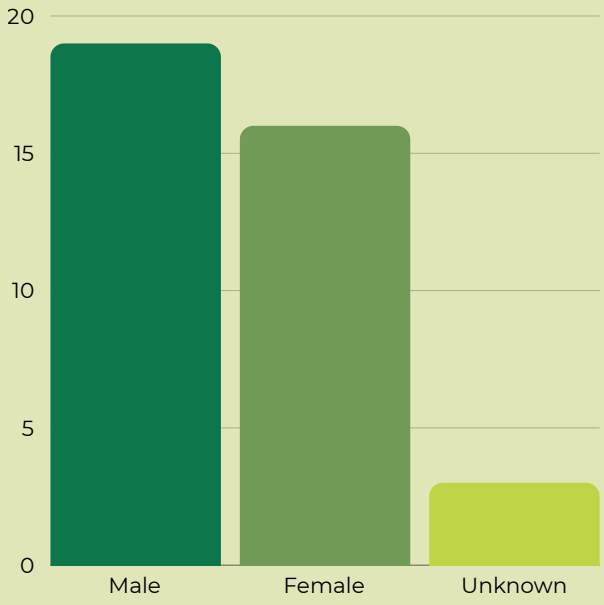
Who Have We Reached?

Based on the information we've been able to collect - and that individuals have felt comfortable sharing - the following offers a partial view of the demographics of the people we support:

People Supported by Age



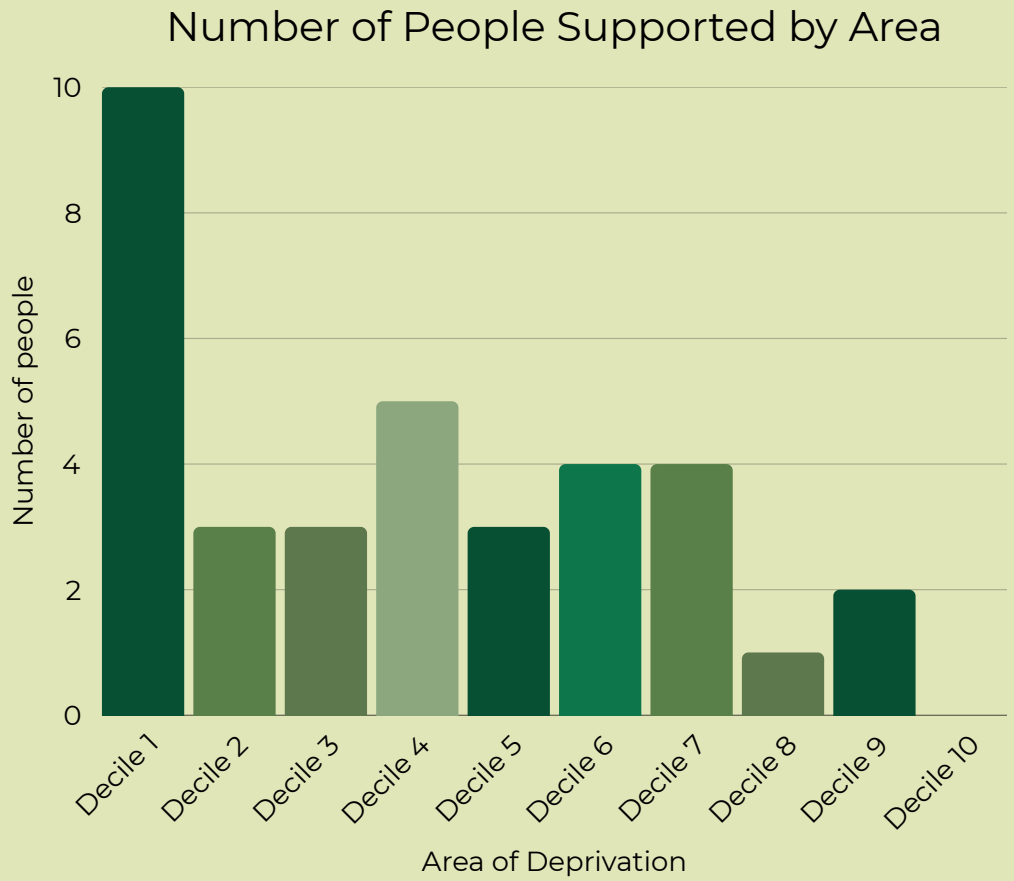
People Supported by Sex



Understanding the Areas We Work Within

This information uses The Index of Multiple Deprivation (IMD)* - a national tool that ranks small areas across England based on levels of deprivation. It helps us understand how the places people live can affect their access to essential resources like income, housing, education, and health. In general, people living in more deprived areas are more likely to face social and economic barriers that can make it harder to live a healthy and stable life.

This bar chart shows the IMD rankings of the areas where the people we support live. Areas are grouped into ten bands called deciles, with Decile 1 being the most deprived 10% of areas in England, and Decile 10 being the least deprived.



29% of the people we supported this quarter live in areas ranked the lowest 10% for deprivation nationally. This reflects the structural inequality many face alongside personal experiences of trauma and disadvantage.

Ministry of Housing, Communities and Local Government (2019).
The English Indices of Deprivation 2019 (IoD2019). London: MHCLG.
Available at: www.gov.uk/government/statistics/english-indices-of-deprivation-2019

Insights from this Quarter

What barriers are we experiencing?

Gaps in specialist support: People with complex or hard-to-diagnose health conditions (like Fibromyalgia) often wait months-up to a year- for specialist input. Without this, their physical and mental health can decline, and they may keep turning to A&E as the only place to get help. Additionally, we have a client who is homeless having to travel to Exeter (an hour away) every day for 20 sessions to access treatment. This geographical barrier has presented multiple challenges.

Digital exclusion in healthcare access: The shift to online GP booking systems has made it harder for people without devices, digital skills, or literacy support to book appointments. For some, this results in calling 999 when other options fail. This has happened at one of our local GP services.

System blind spots around learning needs: People with learning disabilities or difficulties are sometimes unrecognised within health systems, leading to distressing or unsafe situations- for example, not having appropriate advocacy during critical medical conversations. There have also been times where a diagnosis is not known by hospital staff, even though it is in their GP records. This has prevented the Learning Disability Team from being involved when they should be. Additionally, A lack of understanding between terms like learning difficulty and learning disability can create gaps in care. Clearer understanding and consistent flagging are needed across services. As a result, a client was informed that she was in critical condition with Sepsis and final stages of Liver Failure without an appropriate adult or family member with her.

Balancing compassion with system pressures: Caseworkers often hold the tension between holistic, person-centred practice and project pressures to reduce A&E attendance and gather data.

Ethical data collection: At times, it isn't appropriate to collect wellbeing scores or quantitative data. For example, when supporting someone at the end of life, it would not be ethical or compassionate to ask them to rate their wellbeing. This has happened this quarter, alongside disengagement and another client who received sad news about a loved one.

Unrecorded work: a proportion of time is spent responding to enquiries and liaising with professionals or potential clients who may never be formally logged as part of the service. It is imporant to highlgiht this unseen work.

What re-occuring patterns are we seeing?

Unmet need in long-term health conditions: Many people continue using emergency services while waiting for appropriate support, especially as this support is limited for diagnosis that are difficult to diagnose.

Distrust and disbelief: Some individuals with long histories of illness are not always taken seriously by family or professionals, leaving them feeling dismissed or unheard.

Barriers in care settings: People with learning disabilities, trauma, or communication challenges can struggle to advocate for themselves in hospital environments. At times, staff misunderstanding or stigma can further isolate them.

Short-term funding and uncertainty: Time-limited funding creates instability for both staff and clients. Workers may feel anxious about job security, making it harder to plan long-term support or retain skilled team members. Clients can also be affected - conversations about ending support can undermine trust and continuity, and teams may hesitate to open new cases when the project's future is unclear.

Working in this way: What makes our approach unique?

'Holding' people when systems can't: Workers often remain alongside clients while they wait for other services, providing stability and preventing crisis.

Ethical and human approaches: The work sometimes extends beyond usual casework - stepping in when no one else can, at times at crisis point. For example:

- Providing personal care to a bedbound person left without support.
- Removing stockpiled medication to prevent overdose when the system couldn't respond in time.
- Supporting a client with a terminal diagnosis and her family through advocacy and emotional care.

These actions, though beyond formal role descriptions, reflect strong ethics, integrity, and humanity.

Internal collaboration: Keeping cases open and linking clients into other Encompass projects prevents people from feeling abandoned and ensures continuity of care.