Royal Devon University Healthcare NHS Foundation Trust

ENCOMPASS

Northern HIU High Flow Report: Q4 – October - December 2025

1. Highlights

1.1. Quarterly Headlines

- In Q4, the equivalent of 2.0 FTE High Flow case workers have supported 25 clients.
- This includes 6 new clients.
- The target number of new clients per quarter is 19.2 (6.4 per month).
- We are below target regarding new clients being supported, one caseworker started maternity leave in December and focussed on supporting and closing her caseload in the quarter. A new team member started mid-December who is new to our organisation to cover the position and will be undertaking a period of induction and training.
- So far this year High Flow has supported 49 clients. In the 12 months prior to High Flow engagement, these 49 people have:
  - Attended ED **631** times
  - With **123** subsequent non-elective admissions
  - And **211** ambulance conveys

  At an estimated cost of **£722,360**
- For those we have supported, from the date support commenced we have:
  - Reduced ED attendances **60.2 %** (NHSE KPI is 40%)
  - Reduced emergency admissions by **59 %** (NHSE KPI is 40%)
  - Reduced Ambulance conveyances by **62.8%**

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***

2. Data

NB As the programme started in January 2024 the year reporting period is January 2024 – Dec 2024.

2.1 Monthly Data Points:

Metric	Month	Q1	Q2	Q3	Q4	YTD
New Clients Supported in Period	1	23	9	11	6	49
Clients Ending Support	7	7	6	11	12	36
Clients Supported in Period	20	23	25	30	25	49
Closed cases due to disengagement	1	2	2	2	3	9
Number of contacts/interventions with clients	220	629	964	1,158	1,125	3,876
Number of wider beneficiaries	0	4	7	10	3	24
Activity Reduction Cohort	1	23	9	11	6	49
Improved Wellbeing at End of Support	3	0	2	6	6	14
Completed At Least One Goal at End of Support	6	3	2	10	10	25
Case concluded successfully	2	6	3	9	6	24
Clients who declined	1	22	5	11	11	49
Closed cases (other reasons, i.e. moving out of area)	0	3	1	2	2	8
Closed cases due to death	0	0	0	0	0	0

2.2 Patient Usage Data Prior to Support Commencing:

Metric	Month	Q1	Q2	Q3	Q4	YTD
Previous 3 month activity for clients supported in period						
ED Attendances	-	133	57	46	20	**256**
Emergency Admissions	-	11	26	7	7	**51**
Ambulance Conveyances	-	43	21	15	7	**86**
Previous 12 month activity for clients supported in period						
ED Attendances	-	332	112	121	66	**631**
Emergency Admissions	-	29	44	25	25	**123**
Ambulance Conveyances	-	74	52	46	39	**211**

2.3 Activity Reduction Following Support:

Metric	Month	Q1	Q2	Q3	Q4	YTD	Costs savings
3 months before support started vs 3 months from start date of support							
ED Attendances (NHSE KPI 40%)	-	55%	59%	63%	61%	**60.2%** **(256-102)**	**£36,960**
Emergency Admissions (NHSE KPI 40%)	-	52%	59%	65%	58%	**59%** **(51 to 21)**	**£111,510**
Ambulance Conveyances (NHSE KPI 40%)	-	59%	62%	62%	64%	**62.8%** **(86 to 32)**	**£29,106**
NB Please see further information marked * below this table							**Total 3 month Savings** **£177,756**
12 months before support started vs 12 months from start date of support (Data from Jan 2025)							
ED Attendances	-	-	-	-	-	**-**	
Emergency Admissions	-	-	-	-	-	**-**	
Ambulance Conveyances	-	-	-	-	-	-	

* NHSE KPIs only require a comparison of 3 months previous activity vs 3 months post start date activity which is what this data shows – including total cost savings for the 3 month comparisons. However, we are also tracking activity reductions across a 12 month period to evaluate the longer-term impact of the intervention and we will be able to start reporting this from Feb 2025 as 12 months will have passed from the start date of the scheme.

Accordingly, the number of quarters shown in the YTD is 3 as new clients supported in Q4 will not yet have reached 3 months post start date. The YTD number of clients included is 43 – as 6 started in Q4.

Finally, If the 3 months reductions savings is modelled across the whole of the 12 month period – the projected savings would amount to **£710,304**.

Return on Investment

HIU High Flow costs £108,000 per annum for the current service in North Devon.

Even if the figures were modelled to show an ongoing reduction of 50% of the reduction gained from the first 3 months (ie £355,152), the return on investment would be: 1:328, ie for every £1 spent, there is a return of £3.28.

2.4 Process KPIs:

Metric	Month	Q1	Q2	Q3	Q4	YTD
Valid Entry WEMWBS	0.0%	52.2%	100.0%	36.4%	50.0%	57.1%
Valid Exit WEMWBS	50.0%	0.0%	33.3%	54.5%	54.5%	40.0%
Valid Entry Loneliness	0.0%	69.6%	100.0%	54.5%	33.3%	67.3%
Valid Exit Loneliness	50.0%	0.0%	16.7%	18.2%	36.4%	20.0%

2.5 Support Provided to Clients:

Metric	Month	Q1	Q2	Q3	Q4	YTD
Caseworker research undertaken to find solutions for clients.	27	36	55	48	67	206
Caseworker support to meet aspirations.	3	9	13	13	33	68
Continued ongoing contacts with professionals (total number of separate contacts).	87	51	178	457	478	1,164
One-to-one work with clients (per client) number of individual one to one interactions with client.	72	162	399	422	359	1,342
Caseworker support with form filling.	0	5	6	7	14	32
Caseworker support with IT incl. virtual meetings, emails etc.	0	3	11	3	1	18
Team Around the Person meeting conducted.	0	0	0	1	1	2

3. Emerging Needs and Barriers

3.1 Quarterly emerging patterns of need identified by HIU case workers:

The majority of client needs and patterns have been included in previous reports with any additional comments from the quarter included below:

- Mental health continues to represent a significant pattern of need requiring support and interventions from all caseworkers across their caseloads.
- Long Term physical illnesses that are difficult to diagnose and require multiple referrals and tests to try and get answers.
- Addiction
- Financial difficulties resulting from illness relating to both physical and mental ill health and/or financial hardship due to the cost of living.
- Housing continues to be an issue which requires a wide scope of supporting needs, which requires housing and tenancy support, for example:

  - One caseworker in the previous quarter had 6 cases needing housing and tenancy support due to their current accommodation. This reduced to 3 in this quarter due to successful outcomes, the remaining cases require ongoing support, their circumstances include:
  - 1 has a history of being ‘difficult to house’ they are an amputee with additional needs, ex-veteran currently sofa-surfing.
  - 1 has been served an eviction notice who has previously been homeless and rough sleeping, they suffer from epilepsy.

- 1 who's accommodation is compounding their social isolation and is detrimental to their mobility recovery due to its rural location and inaccessibility to the community.

Due to the cost of living, cost of accommodation across all tenures and the supply and demand issue in North Devon the above examples are those which we regularly encounter and support with, where people live in unsuitable or insecure accommodation that impacts further on both physical and mental health. An insight into affordability is the cost of private rented compared to social housing accommodation, a client who was recently supported by High Flow was paying £60 a week rent top-up in the private sector and now pays £4 a week in social housing, this resulted in a substantial improvement to their daily life and wellbeing.

3.2 Quarterly identified barriers/challenges to effective outcomes identified by HIU case workers:

Mental health:
Waiting lists continue to be a problem for clients across services, as this represents a significant pattern of need with clients supported by the project. Clients advise of slipping through the net and a lack of service provision, caseworkers continue to provide support and interventions.

GP appointments and other health services:
All caseworkers continue to report that frequently clients are waiting 4-5 weeks for a face-to-face appointment often to be seen by a locum or part time GP that doesn't always understand the client, this leads to caseworkers and clients repeating their history and problems
Clients experience long waiting lists for other services, including pain.

Other services:
We are experiencing services unable to be flexible and work to client needs, such as closing cases after a short-term period (a few weeks) regardless of recovery, also closing due to 'non-contact', which appears not to take into account client circumstances and need (i.e. mental health/physical health/financial situation). Among these are drug and alcohol and debt advice services.

Housing:
As mentioned in section 3.1 across the project caseload are clients residing in unsuitable or insecure accommodation, which often exacerbates existing mental or physical health and in some cases is the catalyst for this, which can result in both support needs and admittances to ED.

General housing supply represents an ongoing issue, for the more complex cases supported there is insufficient supply of higher needs accommodation as provision is largely for people who have low to medium support needs.

The above examples are among those leading to high levels of complexity requiring cases to remain open for longer than would be anticipated.

Project structure and funding:
Since the project started in January 2024 funding to date has been short-term, initially funded to June, then to October, then to the 2nd week in January 2025. Current funding ends in March 2025. Whilst caseworkers remain fully committed to their clients, at the time of writing this report with 2.5 months remaining are understandably considering their own personal circumstances and securing their own income. Also, as the project has experienced supporting complex, longer-term cases from the ED list are starting to think about exit plans to ensure the clients can be prepared for any project closure by ensuring their goals can be met and equipping them with any tools post project.

New recruitment (refer to section 1.1) involving interviews with team members and an ongoing training and induction period for a new caseworker, which is supported by the HIU team.

Project IT :
At project set-up an interim case and client recording process was introduced taking account of the additional data and information required for HIU reporting and to test that what was being captured was sufficient for

ongoing requirements. This includes various comprehensive excel recording documents which are subsequently linked to reporting software. To extract project data for producing reports relies on documents saving and syncing to update daily what caseworkers are recording in support of client work. In December there was a global issue with the platform used that was not immediately evident, this resulted in the HIU team reviewing all data added for 1 week to identify missing data and readding missing data and information. This involved individual and team meetings to resolve the issue, and several meetings arranged with IT support and the team to ensure the integrity of project data.

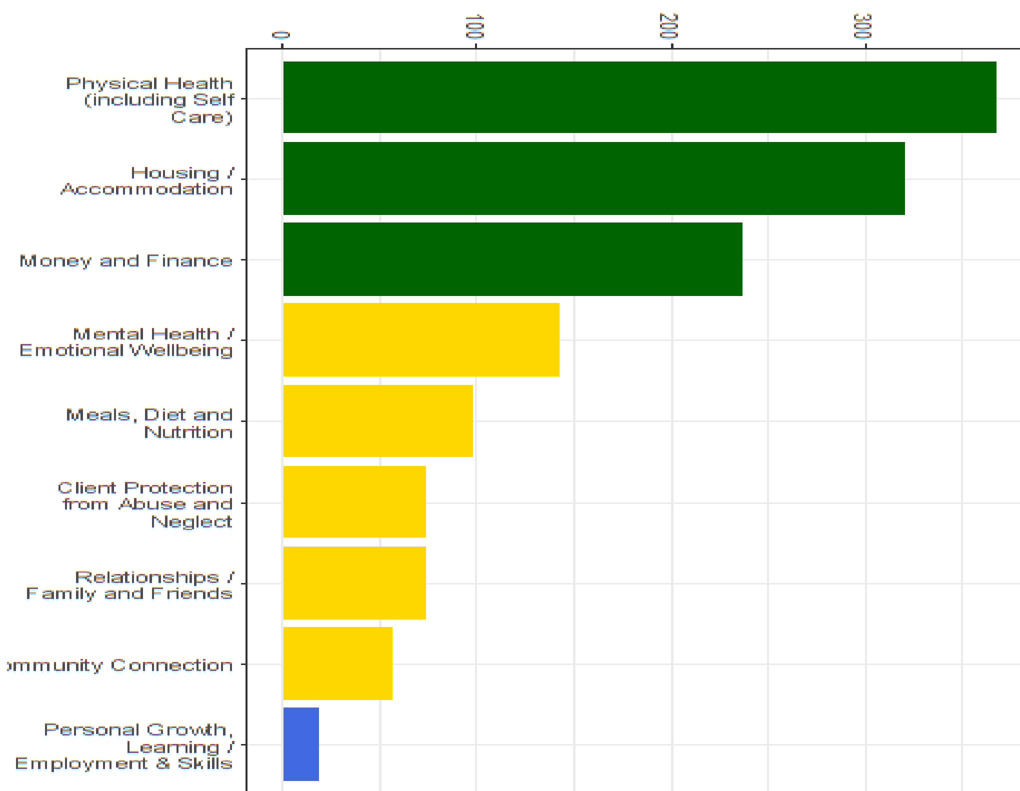
The recruitment and IT matters resulted in fewer new clients than anticipated able to be supported in November and December.

4. Outputs and Outcomes

4.2 Outputs and Outcomes:

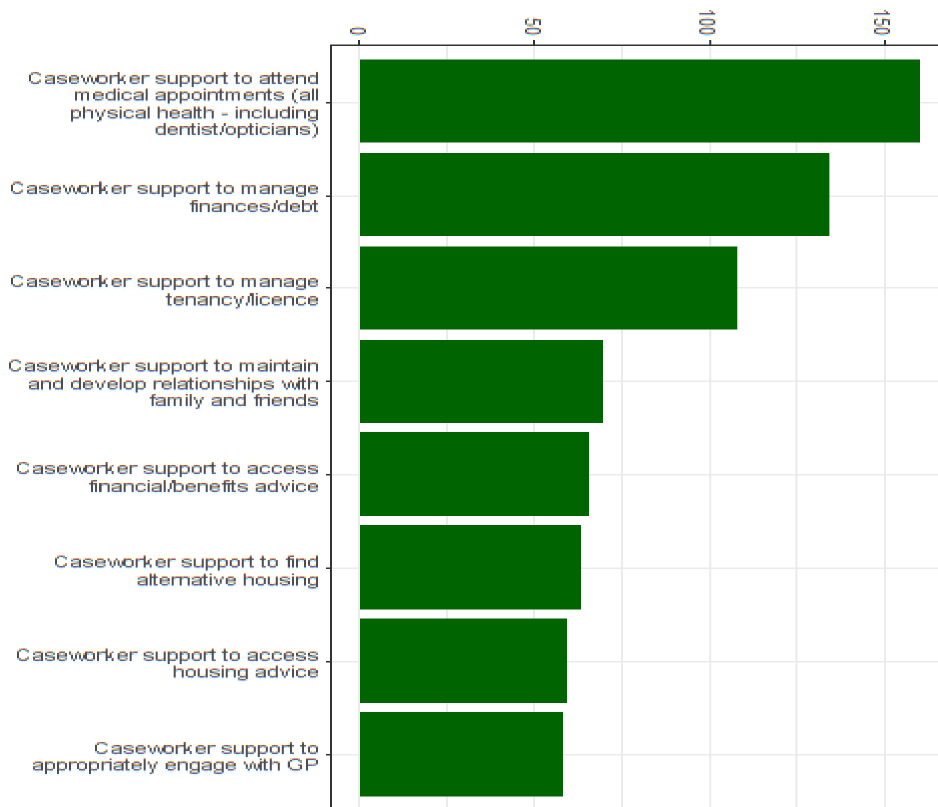
4.2.1 High Flow Caseworker activities with clients based on identified needs

January 24 – Dec 24

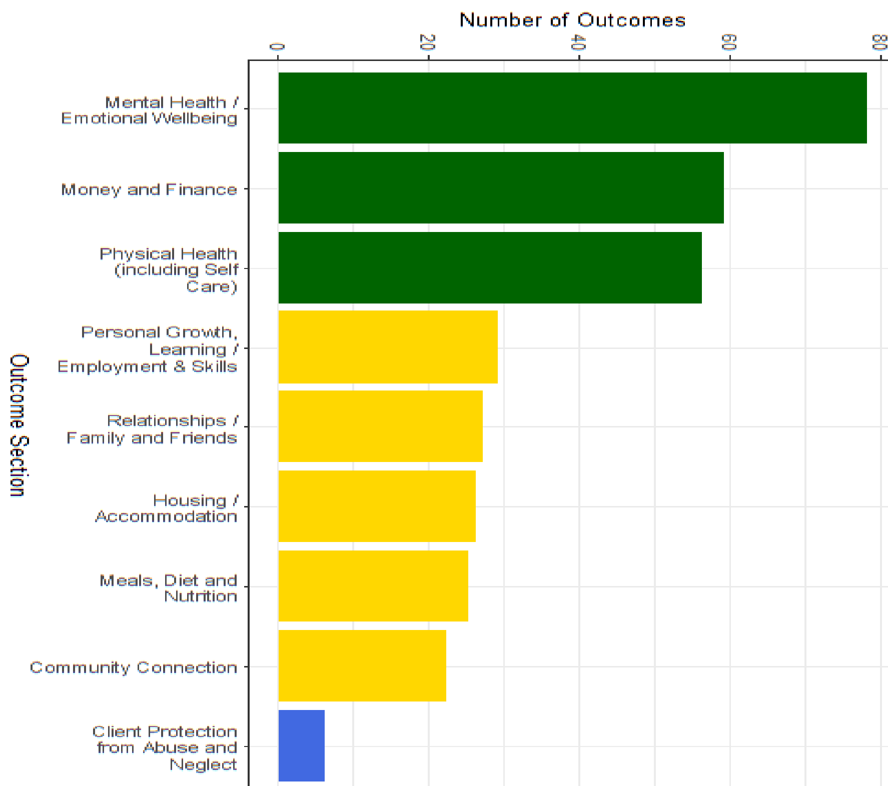


As can be seen from the chart, the main areas of work with clients have been working with them to improve their physical health, their housing and their finances.

Details regarding specific activities within those main areas are detailed in the chart below.

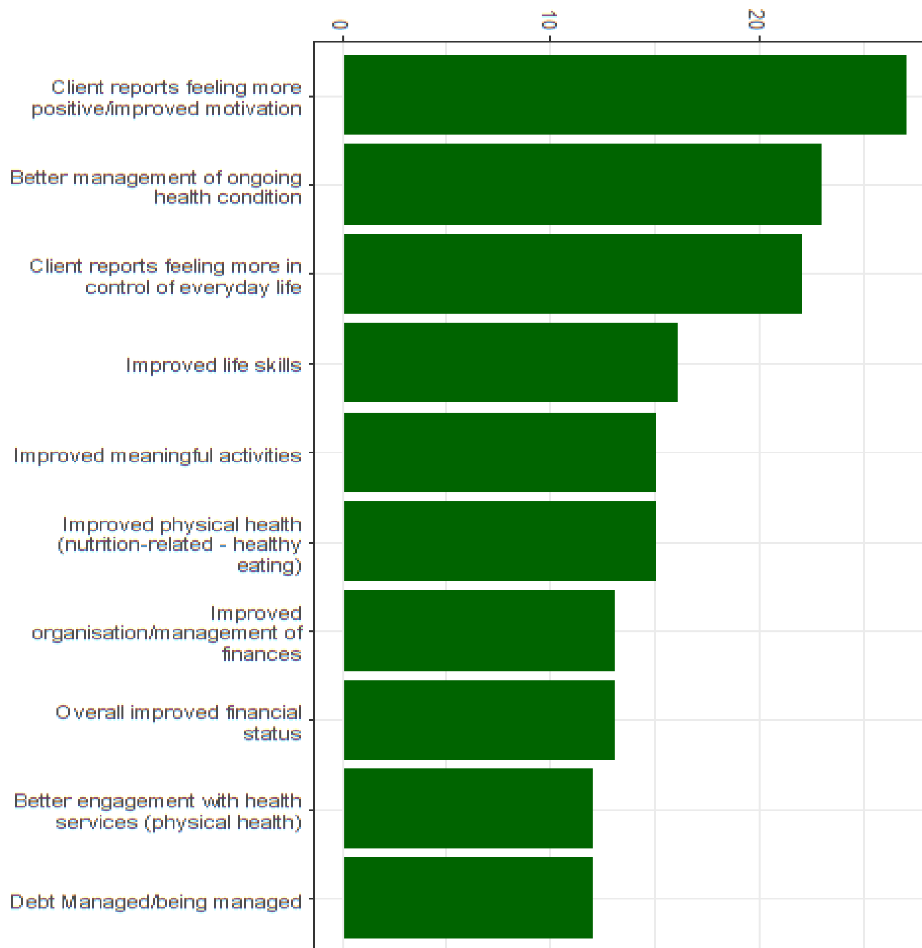


4.2.2 Positive patient outcomes achieved based on needs identified



As can be seen in the above chart – the most impact for patients has been in the areas of mental and emotional wellbeing, money and finance and physical health

The chart below breaks these three areas down into further detail:



5. Case Study

5.1. Case Study

About the client / background:

Stan (name changed) is a 72-year-old gentleman who lives alone in over 50's social housing with warden support on site. Prior to being supported by High Flow he had lived in various accommodation from which he was evicted from including the temporary accommodation that he was placed in when he became homeless, following the council discharging the duty.

After this, he resided in a terrible private let that he referred to as 'The Hovel' which was poorly maintained by the landlord and completely unsuitable for his physical and mental health needs, he also had to pay a rent top up that took half of his pension every week. In addition, he wasn't receiving the full benefit entitlement he was due and struggling to afford essential daily living costs.

Stan suffered from regular episodes of suicidal ideation having lost his daughter who was raped and murdered when she was 14 years old. He self-medicated with alcohol and cannabis in the years that followed. Becoming known across statutory services such as Police, Ambulance, Adult Social Care,

Housing, mental health but non engaging with his GP. A long-term smoker too meant he had respiratory problems and developed COPD and then suffered a heart attack in January 2024.

What mattered to the Client?:

Never becoming homeless again and making his new accommodation into his own personal space. Staying healthy enough to enjoy his newfound life, physically and mentally, along with better management of finances to enable a better way of living and thriving and not just surviving. Having less or no mental health ideation episodes as he moved on with his future day to day.

What did we do?:

- Supported to promote GP engagement by taking him to appointments, getting his medication reviewed on a regular basis and arranging for medication delivery so he didn't have to go and collect it (mobility problems presented a barrier).
- Supported with subsequent hospital appointments that resulted from GP engagement and onward referrals.
- Provided housing support and advocacy by getting him on DHC and a subsequent up band, this resulted in him being offered accommodation in line with his mobility needs which in turn had a really positive impact on his mental health.
- Helped with the logistics of moving and obtaining furniture it initially set up his new home.
- Provided food parcels while money was a struggle.
- Reviewed his finances and maximised income this resulted in awards of Pension Credit and Attendance Allowance in addition to his Housing Benefit and State Pension.
- Set up his first ever Bank Account at the age of 72, he had only had a building society previously and dealt only in cash.
- Spent time listening and chatting and of course having that all important cup of tea on a regular basis and letting him know that he was important.

This case was supported longer-term to resolve all the necessary matters and achieve all his goals to improve his health and wellbeing, the client was also originally carried over from the old High Flow project. The outcome measures below relate to the period for 18 weeks and 2 days when he was supported on the new HIU High Flow as a client in his own right.

Client feedback & did the project work meet their expectations?:

This client stated he is forever grateful for the support that he was given, often commenting that he would not still be here today if he hadn't become involved with High Flow. The project exceeding any expectations that he had.

What have we measured? (e.g. outcomes / outputs / other if applicable):

- **Length of Engagement to date since consent:** 8 weeks, 2 days
- **WEMWBS Score:**. Start 34/70 Finish 55/70 positive difference of +21
- **Outbound referrals:**
  NDDH – 2 x Pathfinders, Reaching for Independence, TDA Drug & Alcohol Services, Cardiology, OPMH, The Moorings, Independent Living Support Officer, Pulmonary Rehab, Fire Safety check.
- **Main Outcomes achieved:**

Significant improvements in all outcome areas: Physical Health, Mental Health / Emotional Wellbeing, Housing, Diet / Nutrition, Relationships, Money / Finances, Personal Growth, Community Connection, Protection from abuse/ neglect.

- **Main Outputs achieved:**

  Physical Health x 34, Money / Finance x 67, Housing x 34, Diet / Nutrition x 8, Mental Health / Wellbeing x 5, Protection from Abuse/ Neglect x 3, Community Connection x 3

- **Goals achieved:**

- Arrange and manage finances in a sustainable, better way.
- Take better physical & mental care of himself.
- Obtain more household items for his new flat.

- **Reductions or changes in ED use:**

- ED attendances -20%
- Non-elective admissions -75%
- Ambulance conveys -56%

What did we learn?

This case was a success as the client placed great value on the relationship with the case worker and was able to trust over a prolonged period. He said he had a feeling of constantly being supported (even when he didn't like the advice/ suggestions as he knew they were made for his best interests). This solid foundation enabled work to be achieve that wouldn't have been possible, in particular around finances and paying bills and rent when he was accommodated, something that other professionals said he would never be able to do. Such relationships can enable sustainable shifts in behaviours and habits longer term.

Quotes and other feedback (from professionals, clients, others involved in support of client)	
Client	*I love my new flat* *I wouldn't still be alive today if it wasn't for you* *We have done so much financial work today; at this rate I will be able to afford to go away … do you fancy a holiday ?!*
Other	*Stan participating in the High Flow programme was a turning point in his engagement with primary care. Prior to him starting work with Katie he was a name I knew from discharge letters only. Following enrolment on the High Flow programme he became someone who was actively engaged in his healthcare.* *Katie supported Stan as a person. He was not seen as an alcoholic and repeated hospital attender (the lens through which we, in healthcare, and other statutory services, are often guilty of viewing individuals in his situation) but a man, who had experienced significant trauma, who was struggling to cope with life. Katie was able to support Stan to address his healthcare needs, but, also, and probably more importantly, the wider things underpinning his health, most significantly his wholly inadequate accommodation.* *In health we often look to measure interventions but cost savings/appointment reductions etc. I think the journey that Katie has walked with Stan is one of the most important journeys she could have walked with him, yet the value is hard to quantify in facts and figures. Stan still has a long journey to make in his recovery, in part due to a high burden of physical health needs. However, through participation in High Flow, I believe that Katie has not only supported Stan with*

	practical solutions, but also demonstrated to Stan his value and worth. For people who have been broken by life, this is the first step to recovery. *Sarah Williams (GP Combe Coastal*

6. Feedback

6.1 Feedback from Clients

“Becky is the best support worker I have ever had”

“I could not have done all of this without you”

“It has been good to know that you were there to talk to if I needed you, thank you”

“It is really lovely here at the new flat - the bedroom doors open onto the outdoor space, and I can lay on the bed in the sunshine”

“We have done so much financial work today, at this rate I will be able to afford to go away … do you fancy a holiday ?!”

“Katie, I felt abandoned and isolated, and you are the only person who has visited me since I got here”

“I love my life now”

“Thank you for today you have been an absolute star”

“Thank you, you are an angel”

“I am doing Sober Oct and so far enjoyed not drinking and happy not to go out!”

“I have loved working with you Katie, you have always made me feel so calm”

“Thank you for meeting me Becky, you are so friendly and you have put me at ease.””

Thank you for visiting me today, I don’t know why I worried and I would like you to visit me again”

“Did you really mean it when you said you could go for a walk with me, no one else has ever said that before, that would mean a lot to me if you can”

“Thank you for helping me out when I get in a mess you know I forget things my mind is all over the place”

“It’s not you that I’m angry with, I like you, thank you for helping me”

“Thanks, Bec I couldn’t have done this without help”

“I’m glad I've done this I can find it hard without help at times I need some support (following work done between letting agent & housing officer”

“I'm going to miss you, thank you for all the support you’ve given me and confidence”

“My head is so busy I just want something to change”

6.2 Feedback from Professionals

“This is amazing news, thank you for passing it on. Just what is needed” (DPT NHS Trust)

“Hi Katie, nice to meet you and hopefully we will work together again soon” (NDC Housing Options Officer)

“Thanks for all your help” (NDH Lettings and Allocations Officer)

“Thank you for all the work you have done with KP I hope you have a nice time off with your lovely new family” (Freedom Centre)

“Thank you for supporting K he is so young and can turn his life around” (Reconnect)

“I would just like to say how nicely this reads and thank you for your work with P” (DPT Social Care Manager)

“Thank you for all you’ve done for K you have done an amazing job it’s been a real team effort a month ago we had no idea what to do with him” (Freedom Centre)

“Thank you for everything with this client good luck on mat leave” (Reconnect)

“D participating in the High Flow programme was a turning point in his engagement with primary care. Prior to him starting work with Katie he was a name I knew from discharge letters only. Following enrolment on the High Flow programme he became someone who was actively engaged in his healthcare.

Katie supported D as a person. He was not seen as an alcoholic and repeated hospital attender (the lens through which we, in healthcare, and other statutory services, are often guilty of viewing individuals in his situation) but a man, who had experienced significant trauma, who was struggling to cope with life. Katie was able to support D to address his healthcare needs, but, also, and probably more importantly, the wider things underpinning his health, most significantly his wholly inadequate accommodation.

In health we often look to measure interventions but cost savings/appointment reductions etc. I think the journey that Katie has walked with D is one of the most important journeys she could have walked with him, yet the value is hard to quantify in facts and figures. D still has a long journey to make in his recovery, in part due to a high burden of physical health needs. However, through participation in High Flow, I believe that Katie has not only supported D with practical solutions, but also demonstrated to D his value and worth. For people who have been broken by life, this is the first step to recovery.

I would whole-heartedly support the ongoing funding for the High Flow programme as a programme that supports the most vulnerable in our society.

It's been lovely working with you Katie, and I mean every word of the above. You have been amazing! Wishing you all the best moving forward, and hoping that our paths cross again at some point” (Dr Sarah Williams Combe Coastal)