St Georges Homelessness Inclusion Team

9-month evaluation report

29th Nov 2021 – 31st August 2022

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pathway
Healthcare for homeless people

NHS
St George's University Hospitals
NHS Foundation Trust

You are an Angel, believe in an Angel

My wings were broken, and I hit the street with a bang.

I shook the dust and said - it's Nothing, Nothing has happened...

And then millions of silver tears flowed.

Thank you

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Executive Summary

People experiencing homelessness have an excess mortality rate 7.9 times (men) and 11.9 times (women) compared to the general population[1]. They also have worse access to health and social care. South West London has high levels of homelessness. For example, 1207 rough sleepers were identified in the boroughs surrounding St Georges between 2021-2022[2].

The Pathway charity has developed a national model of complex care coordination to meet the health, housing and social care needs of people experiencing homelessness when they attend or are admitted to hospital. The St George's pilot of a Pathway model team commenced on 29th Nov 2021. This report outlines how the pilot developed over the first 9 months and summarises headline outcomes. The current team comprises a part time GP, full time nurse, two housing workers, a care navigator, and since April 2022, a part time community nurse.

246 patients were accepted by the team in the first 9 months of the project and supported with health assessments and care coordination. 75% were male, 25% were female. 40.2% were White British, 38.2% Other (including White Other), and 12.2% Black or Asian. 16.3% were known or suspected to have No Recourse to Public funds. 60% of accepted referrals had a local connection to either Wandsworth, Merton or Croydon, although over 20% had a local connection to boroughs outside South West London.

50 (20.3%) patients were rough sleeping at the point of acceptance. Others were sofa surfing, being evicted, or already in a homeless hostel or temporary accommodation. Rough sleeping was reduced from 32% to 7.5% of patients on discharge by the team - a 77% decrease. This represents 39 individuals that were prevented from returning to rough sleeping. Rough sleeping, insecure housing and sofa surfing situations collectively were deceased by 55%. The percentage of patients with Temporary Accommodation placements on discharge increased from less than 1 in 10 on admission, to 1 in 3 on discharge. 14.4% of accepted referrals involved self-discharges (some were referred after the self-discharge). This is very much in line with national rates of self-discharge in inclusion health groups, but reducing self-discharge is an area for focus for future years.

During the 9 months, 95 patients had a Duty to Refer completed, 28 people were newly registered with GPs, and 30 people had address details updated. These all represent improvements in care. Case studies also demonstrate the excellent health and wellbeing impacts of the team.

A proactive care planning audit was undertaken to robustly examine opportunities to improve care. A key positive aspect was that the audit revealed a high level of engagement with patient GPs - audit notes revealed the GP had been identified in 90% of patients and contacted in 94% of these cases. Areas identified in which the team could improve care in the future including supporting mental health needs during admission, and addictions needs post discharge. A 'returned to rough sleeping audit' has also revealed ways that the team can work with the hospital to improve care e.g. around the identification of safeguarding issues, mental capacity assessments and presentations out of hours.

Feedback from patients has been extremely positive. In a set of 20 feedback interviews randomly undertaken with patients who had agreed to be contacted after discharge, team members were universally talked about as kind, helpful and knowledgeable. Patients that rated the team all gave the team a 10/10 or in two cases an 11/10 (!), and all thought that the team should continue.

Quotes included:

'If they hadn't helped me, I'd be on the streets. I had no chance to survive without them.'

'I thought they were outstanding. They went above and beyond the call of duty. They were fantastic, they pushed and pushed. Without them I wouldn't be where I am (a rehab centre).'

'all the advice that the homeless team gave me really worked – as a result I have now had 3 months of treatment and I am in a move-on house for 2 years'

Feedback has also been good from both hospital and community partners.

'Having the Homeless Inclusion Team now has been a great help. They are an excellent team with experience and knowledge that can support discharge coordinators.'
– Discharge Coordinator

You and your team have been incredible so please extend our thanks to them in addition others already mentioned – Drug and Alcohol service

In addition, the St George's team has been recognised pan-London as a centre of excellence; it was chosen as the main team to feature in the London Homelessness Awards application, which the Pathway Partnership Programme collectively won in Oct 2022.

A survey of hospital staff not working in the Pathway team was undertaken. 13 random surveys were filled in by staff, mostly from A&E. 61% said they saw someone experiencing homelessness at least weekly, 77% said they had cared for someone that was discharged to the street. Only 61.5% were aware of the statutory Duty to Refer. This may be because only 23% had had training in inclusion health, while92% said they thought such training would be beneficial. Sadly only 23% said they thought that the health care at St Georges provided to people experiencing homelessness was good, and nobody thought it was excellent. 46.1% though it was poor or very poor. Obviously, this means that hospital staff feel there are opportunities for improvement. The team has had limited capacity to provide teaching to hospital staff this year but would like to do more next year. Where teaching has been undertaken e.g., to GPs in the community with the support of an Expert by Experience – this was received very well, and 62.5% of attendees rated the session as excellent.

Positive secondary care impacts were noted in a data extract looking at the attendance and admission patterns of patients seen by the team. Following first referral to Homelessness Inclusion Team, patients who frequently attended Emergency Department (10+ attendances in the prior year) showed a collective decrease of -65.9% in their Emergency Department attendance rates, and patients who were frequently admitted (4+ admissions in the prior year) showed a collective decrease of -61.2% in their inpatient admission rates. Patients who had been frequently admitted also showed a significant increase in length of stay - this represents care completion and will have contributed to the reduction in attendances and

admissions. As a worked case study example, the team achieved a potential cost saving for one frequently attending and admitted patient of £17,585.

Finally, the team has reviewed the challenges it experienced in the last year, to understand what can be learned and what the future team should look like. Plans have been made e.g. to improve data recording, increase teaching time and produce an advice booklet for patients and staff. However, recommendations have also been made regarding the need for increased staffing levels to improve overall capacity and increase the skill mix in the multidisciplinary team. It is important to note that the team has already been proactive in developing solutions e.g., by developing and bringing in a new triage process, and initiating its own clinical supervision.

Overall, the report reveals a reflective team, with highly skilled staff, that is delivering extremely positive outcomes for many patients, and probable cost reductions to the system. It is hoped that this report will support any future business plan for the team.

1. Aldridge R et al. (2018) Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance misuse disorders in high-income countries: a systematic review and meta-analysis. The Lancet. Vol 391. January 20. pp. 241-250
2. Chain (2022) CHAIN ANNUAL REPORT GREATER LONDON APRIL 2021 - MARCH 2022 https://data.london.gov.uk/dataset/chain-reports

Introduction

The Homelessness Inclusion Team (HIT) started as a 1-year pilot service within St Georges University Hospital on 29th November 2021.

The pilot service was funded by the Office of Health Improvement and Disparities (originally the Department of Health and Social Care) Out of Hospital Care Models (Homelessness) fund[1]. South West London Health and Care Partnership applied to the fund, and received monies to pilot two 'Pathway' type model teams in both St Georges University hospital and Croydon University hospital. Initial funding was provided for a pilot from November 2021 to November 2022. The South West London project is one of 17 sites around the country that received funding as part of a wider £16 million pilot and evaluation project. St Georges received £361,393 as part of this.

It is important to note that St Georges was in a good position to bid for money when the fund was released. This was because A&E Registrar Dr Laura Douglas-Beveridge had already produced a local needs assessment, which argued for a specialist homelessness intervention during 2019-2020. As a result of this assessment, an initial Business Case proposal had already been prepared in May 2020. Huge thanks are due to Laura for her initial work in this area.

The pilot project has been extremely successful, as is highlighted in this report. There is clear evidence of a high need for the service, and impressive outcomes have been achieved.

In line with this, the team's funding has now been generously extended by Southwest London ICS until the end of March 2023. Funding beyond this is also being considered. A Business Case submission is planned to be completed at the end of November 2022, requesting consideration for an extension of funding for the 2023/2024 financial year. As such the follow-on funding required from April 2023 has not yet been confirmed.

This report outlines the nature of the service currently being delivered, how the service has developed, and what the outcomes have been over the first 9 months. It also highlights key challenges, and a vision for the future for the team. The team have all contributed to the production of this report-this is also a huge credit to them when they are so busy.

It is hoped that you enjoy reading this report.

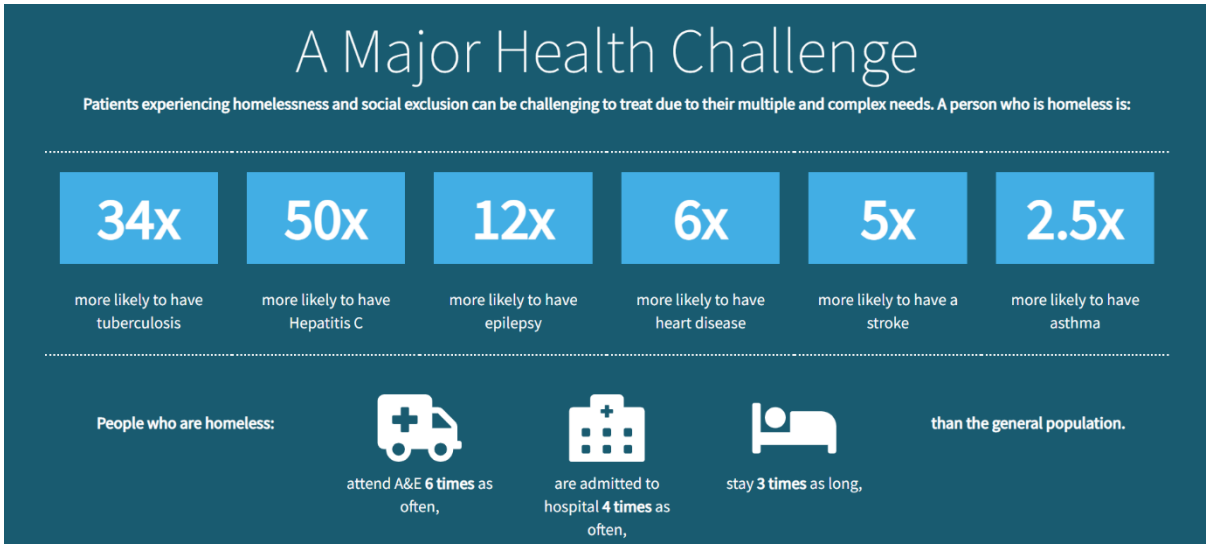
1. https://www.gov.uk/government/news/fund-to-help-end-cycle-of-homelessness-and-hospital-readmissions

Why was a specialist inclusion health service needed in St Georges?

The health issues of health experiencing homelessness

People experiencing homelessness are known to suffer physical health problems at a greater frequency and intensity than the general population during their lifetimes as indicated below, and this results in high hospital usage.

Figure 1: *Health problems and secondary care usage patterns of people experiencing homelessness*



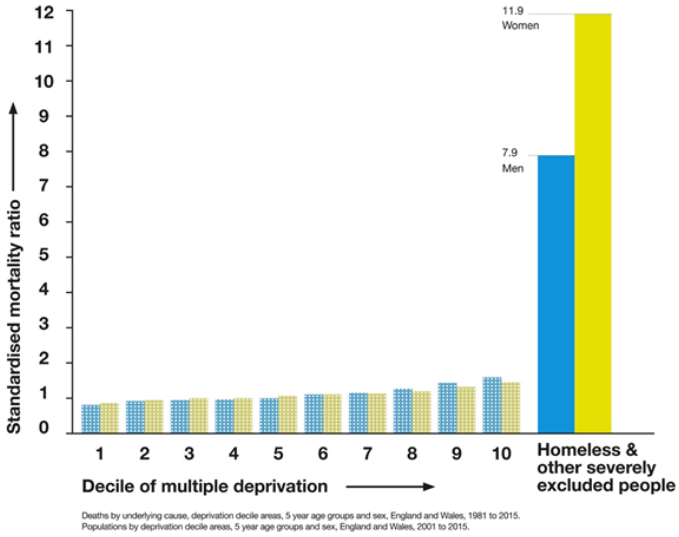
Many of these health problems are preventable. For example, in a study of 600 people experiencing homelessness that died in English hospitals between 2013 and 2017 the biggest killer was cardiovascular disease (30.1%), including strokes and heart attacks. 20.8% of the 600 deaths were caused by cancer. 16.9% were caused by respiratory disease. (Aldridge et al, 2019).

Unfortunately, however, 'tri-morbidity' and complexity often make people experiencing homelessness more difficult to treat. Tri-morbidity is the intersection of physical health, mental health and addictions conditions (Player et al, 2020, Himsworth et al, 2020). People experiencing homelessness have high levels of mental health distress, alcohol and/or drug misuse as well as many physical health issues. For example, in a large survey of people experiencing homelessness reported in 2022 82% of survey respondents reported some form of mental health issue (Homeless Link, 2022), and 6 in 10 people sleeping rough in London were found to have a drug or alcohol problem in 2018 (St Mungos, 2020).

Such complexity can often be exacerbated by communication difficulties. Higher rates of brain injury, psychological trauma, mental ill health, autistic traits, language and literacy challenges, prison and care histories are all present in homeless populations (Andrews and Botting, 2020) making it more difficult for people to engage with services and process information.

As a result of morbidity and complexity, people experiencing homelessness die earlier. Aldridge et al (2018) showed that that all-cause standardised mortality ratios in people experiencing homelessness was 11·86 times higher in females, and 7·88 times in men, than in the general population.

Figure 2: *Standard mortality ratios by decile of deprivation*



Similarly, recent ONS statistics show the average age of death for people identified as homeless in 2020 to be a shocking 45.9 for men and 41.6 for women (ONS, 2021).

Barriers to health care for inclusion health groups

Despite these health issues, many people experiencing homelessness have poorer access to health care. The barriers to access for primary and secondary health care for inclusion health groups are considerable (Gunner, E et al, 2019, Elwell-Sutton, T et al, 2017), and include:

- lack of ID or an address
- language and literacy and cognitive issues
- mental health and addictions
- poverty (e.g. having no credit on one's phone)
- digital exclusion
- practical issues e.g. 'Who will look after my dog?
- lack of trust
- embarrassment
- worries about NHS charging

Patients without identification are frequently wrongly turned away from GP registration (Doctors of the World, 2017, 2018), even though NHSE guidance clearly states that lack of ID should not be a barrier to GP registration.

Homelessness in the St Georges hospital area

St Georges is based in the borough of Wandsworth. Levels of homelessness in Wandsworth and the surrounding boroughs are high.

Figure 3: *Map showing the London Boroughs that surround Wandsworth in South West London*

Numbers of people seen rough sleeping

Annual rough sleeping counts have been affected by the pandemic. However, they are currently higher than pre-pandemic levels, and are predicted to rise further.

Table 1: *Number of individuals seen rough sleeping in Wandsworth and the surrounding boroughs*

	2019/2020	2020/2021	2021/2022
Wandsworth	**203**	**401**	**264**
Lambeth	431	581	438
Croydon	306	322	271
Kingston	124	87	99
Richmond	152	115	61
Merton	92	109	45
Sutton	34	18	29
TOTAL	**1342**	**1633**	**1207**

Source: https://data.london.gov.uk/dataset/chain-reports

Numbers of people presenting to the Local Authority as homeless

Levels of homelessness are also indicated by presentations on account of homelessness at the Local Authority. In Wandsworth alone, nearly 1500 presented to the Local Authority as homeless in 2020/2021 (the last year for which summary data is provided).

Table 2: *Number of individuals presenting as homeless to Local Authorities in the South West area*

	Number of new household presentations for prevention or relief duty 2020/2021	Number of households newly owed a relief duty 2020/2021
Wandsworth	**1,469**	**1,281**
Lambeth	3,254	1,714
Croydon	2,526	1,694
Sutton	993	435
Richmond	390	272
Merton	623	168
Kingston	348	150
TOTAL	**9,603**	**9,249**

Source: https://www.gov.uk/government/collections/homelessness-statistics

Housing issues in Wandsworth

Within Wandsworth there are concerns about the amount of affordable housing, and a recent council plan has been announced to build 1,000 genuinely affordable low-cost rental homes. There are also concerns about a backlog of homelessness cases locally with new housing staff being brought in to try and clear the backlog. As a result, many families remain stuck in temporary accommodation in the borough, with an estimated 3,545 children living in Wandsworth in temporary accommodation with their families in 2021/22.

https://wandsworth.gov.uk/news/july-2022/council-s-new-administration-unveils-raft-of-radical-new-housing-policies/

https://www.independent.co.uk/news/uk/politics/tories-wandsworth-homelessness-prevention-b2148685.html

Evidence for the Pathway team approach

The Pathway charity helps the NHS to create specialist hospital care coordination teams to support people experiencing homelessness whilst they are in hospital.

These teams provide bespoke care plans and high quality care, that supports safe and effectives discharges from the hospital, developed in partnership with in and out-of-hospital partners, which ensure people have the best health, housing and social care support available. Teams are multidisciplinary and include specialist GPs, nurses, allied health professionals, housing experts and care navigators.

Service evaluation and research evidence has shown that the Pathway approach:

- **Improves outcomes for homeless patients.** Better health and care outcomes are achieved during and after discharge [1,2,3,4,5,7,8,9,10,11], and improved housing outcomes are achieved on discharge [3,4,5,7,8,9,10,11]
- **Improves capacity in busy hospitals.** A reduction in A&E attendances [2,4,5,6,8,9], number of re-admissions [2,6,7,8,9] and/or overall bed days[1,6,7,8,9] has been demonstrated in most studies.
- **Is cost effective.** This was demonstrated in one study using Quality Adjusted Life Years [4], and has also been demonstrated by comparing the costs of the team to the reduction in secondary care activity for involved patients.[1,8,9]
- **Meets the statutory Duty to Refer requirements for hospitals.** Teams now ensure the Statutory 'Duty to Refer' which came in in 2018 is met.[10]
- **Is valued by other hospital and community staff and improves integration.** Positive impacts on staff, partners and systems have been demonstrated in all studies [1,3,5,7,8,9,10,11]

1. Hewett N et al. A general practitioner and nurse led approach to improving hospital care for homeless people. Br J Healthc Manag 2012;22(4):225-34.
2. Mpath. A review of the first 6 months of the pilot service. July to December 2013.
3. Homeless Link (2015). Evaluation of the homeless hospital discharge fund. London: Homeless Link.
4. Hewett, N., Buchman, P., Musariri, J., Sargeant, C. et al. (2016). Randomised controlled trial of GP-led in-hospital management of homeless people ('Pathway'). Clinical Medicine, 16(3), 223-229.
5. Dorney-Smith S et al. Integrating health care for homeless people: the experience of the KHP Pathway Homeless Team. Br J Healthc Manag 2016;22(4):225-34.
6. Wyatt L. Positive outcomes for homeless patients in UCLH Pathway programme; British Journal of Healthcare Management 2017 Vol 23 No 8: p367-371
7. Zana Khan, Sophie Koehne, Philip Haine, Samantha Dorney-Smith, (2019) Improving outcomes for homeless inpatients in mental health, Housing, Care and Support, Vol. 22 Issue: 1, pp.77-90.
8. Bristol Service Evaluation of Homeless Support Team (HST) Pilot in Bristol Royal Infirmary. Internal evaluation, presented at Faculty for Homeless and Inclusion Health Conference March 2019 Link: video at bottom of page
9. Gazey A, Wood L, Cumming C, Chapple N, and Vallesi S (2019). Royal Perth Hospital Homelessness Team. A report on the first two and a half years of operation. School of Population and Global Health: University of Western Australia, Perth, Western Australia.
10. Pathway Hull Royal Infirmary Pathway Homeless Health team First year report. October 2019 – September 2020
11. SPCT Inclusion Pathway Homeless Health team First year report July 2021 to June 2022

There are currently 18 'Pathway' model teams around the UK. It was felt that on account of the levels of local homelessness and the prior needs assessment that St Georges would benefit from a Pathway type approach.

Service description

The St Georges Homelessness Inclusion Team (HIT) supports adult patients (18 or over) who are experiencing homelessness (e.g. rough sleeping, living in a night shelter or homeless hostel) or vulnerably housed (e.g. sofa surfing or at risk of eviction), who are inpatients, Emergency Department attenders, or identified as being Emergency Department frequent attenders at St George's University Hospital. Core working hours are Mon – Fri 9am – 5pm.

Staff structure and roles

The team currently has this structure:

Hospital

- 0.6 WTE General Practitioner (Dr Danielle Willams)
- 1 FT Band 7 Nurse Lead (Sharon Stephens)
- 2 FT Band 6 Housing Workers (Alma Kemp and Milly Agnew)
- 1 FT Band 4 Care Navigator (Rhian Clugston)

Community

- 0.7 FT Band 7 Community Nurse (Abigail Pomeroy-Dash) – commenced April 2022

Team activities and interventions that are undertaken for patients

- Befriending and trust building using trauma informed care approaches
- Holistic health assessments (covering e.g. chronic disease, assessment of mental health, addictions, the physical sequelae of addictions, cognition / brain injuries, safeguarding and self-neglect, the assessment of mental capacity, and housing, health and immigration law etc)
- Support to understand and engage with medical treatment
- Complex care planning and discharge liaison
- Referrals to (and support to link into) relevant services such as mental health and addictions services, homeless day centres, primary care services etc
- Housing and benefits support and advice including the provision of skilled advocacy to Homeless Persons units across the UK
- Linking into legal and immigration support – Hodge, Jones and Allen can provide legal advice for homeless patients during their care in hospital, and the team has referral rights to Praxis who provide immigration advice to homeless patients with no recourse to public funds
- Support to obtain birth certificates, passports etc for benefits applications
- Help with GP registration
- Fresh clothes, shoes, and other basics whilst in hospital
- Phones, TV credit, newspapers, juice etc to encourage patients to stay in hospital
- Help to reconnect with loved ones
- Follow up in the community for up to 6 weeks

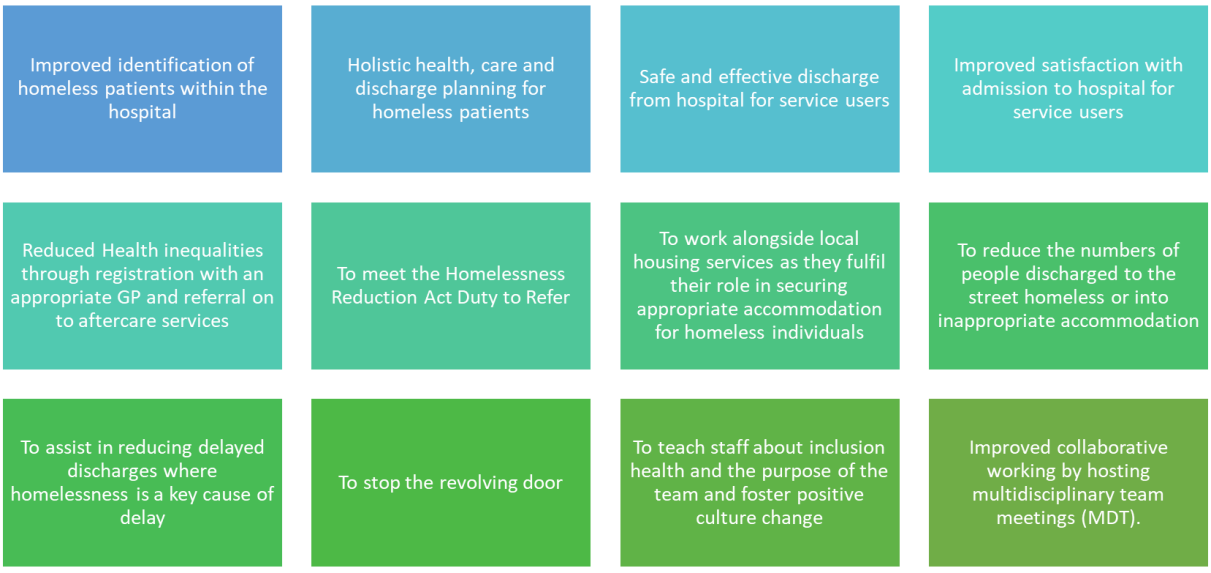
Note that follow-up support is a central part of the support that the team offers for up to 6 weeks post discharge. The team spends about 30% of their time outside the hospital. When patients are given temporary accommodation by the council the team can visit to settle a patient in, and buy plates, cutlery, pans, and bedding to support this as needed. (The team has access to personalisation fund from which it is are able to supply these necessities.) In this way the team are often used as a bridging service when other services don't yet have the ability to take on these patients and/or when floating support services don't exist, but support is needed on discharge.

In addition, other key team roles are that:

- The HIT team links in with other Pathway teams, community homeless nursing teams, GPs, outreach teams, hostel providers and the London Ambulance service to develop care plans for frequent attenders to the Emergency Department.
- The team provides training and advice on homelessness and housing to hospital staff
- The team works on strategic issues. For example, the team is currently working on securing beds in a hotel as a step-down bed. This will enable the team to continue working with some patients for longer and give more time to secure better future placements.

A visual representation of all the team roles in Figure 4.

Figure 4: *Core objectives of the St Georges Homelessness Inclusion Team*



Key Partnerships

The team is integrated well with other hospital and community services that are outlined below. The team has weekly MDTs and invites hospital teams and outside agencies to discuss patients who have complex needs as required.

Hospital partners

- Emergency Department
- Discharge Hub
- Mental Heath – Psych Liaison
- Addictions – Drug and Alcohol (DALT) team
- Safeguarding
- Acute Medical Unit / Short stay wards
- Trauma and Orthopaedics

Community partners

- Addictions services e.g. Wandsworth Community Drug and Alcohol Service, Change Grow Live (Croydon), Westminster Drug Project (Merton), Turning Point
- Homeless Outreach services – e.g. Spear, and others
- Housing Teams – e.g. Wandsworth, Merton, Croydon
- Hodge, Jones and Allen and Praxis
- Trevelyan Group Practice and other friendly GP practices
- Homeless day centres
- CLCH Homeless Health Team
- Pathway

Referral processes

Referrals to the team can initially be made electronically on the hospital system, via email, via phone or face-to-face. Referrals can be made from within and outside the hospital (i.e. partners can refer), and patients can self-refer. However electronic referrals are encouraged from hospital staff, as ultimately all referrals will need to be inputted on the hospital system.

Triage

Due to capacity issues the team has recently developed a triage process.

First a series of triage questions are asked:

Figure 5: *Triage questions on referral*

- What is their current housing and welfare status? (Local Authority/NRPF?)
- Does this person need a Duty to Refer?
- Do they have a GP and are they engaging with them?
- Do they have a complex health presentation?
- Do they have a history of mental health problems?
- Do they have any alcohol or substance misuse issues?
- Do they have any cognition or communication issues?
- Do they have a history of challenging behaviour?
- Are they engaging with services?
- Are there any safeguarding issues (i.e. domestic or gang violence)?
- Do you have any concerns about self-neglect?
- What is the main reason you are referring this patient?

Then the team contacts the referrer where possible to triage and prioritise referrals into the following categories:

Red (high priority) – Patient is currently on the streets, has complex unmet medical issues / safeguarding needs and a history of non-engagement with specialist services in the community.

Amber (medium priority) – Patient is experiencing homelessness /at risk of becoming homeless and/or has potential medical issues / safeguarding needs, and needs some support to engage with services.

Green (low priority) – Pt has accommodation (i.e. is in a hostel) or is at risk of becoming homeless but this is not imminent. Needs help with GP registration or referral to community services or help with a specific issue.

Depending on priority and need patients will then receive:

- **Initial assessment and brief intervention** – this could be advice, guidance or signposting given to a professional or patient. Working time up to 1 day.
- **Holistic assessment and moderate intervention** – this could be support with GP registration, health education, new referrals to relevant teams, liaison and linking patients back in with existing teams, and support with benefits / housing applications. Working time 1 day – 4 weeks
- **Holistic Assessment and full intervention** – this is likely to be for people with complex health needs, and a longer history of homelessness. Care coordination to identify and link patients in with relevant homelessness and other community services, and support engagements as needed e.g. by accompanying patients to initial appointments. Initiation of MDT meetings, and support to settle people into new accommodation. Working time up to 10 weeks.

Personalisation fund

One of the things that has been most valuable to the team (although there were some difficulties in setting it up) has been the personalisation fund of £10,000 that was granted as part of the DHSC bid.

Using this fund, the team has a petty cash system in place of £200 that can be topped up to weekly. The team also utilises the hospital ordering system to acquire stocks of phones and television packages for those patients with extended admissions.

The petty cash fund is currently being used for:

- Toiletries – shower gel, shampoo, toothbrushes, toothpaste, deodorant, combs / brushes, sanitary products, tissues
- Tea / coffees / snacks whilst in hospital and outside hospital
- Shoes / boots / trainers, clothes, underwear, socks, other clothing, coats
- Books, newspapers, puzzle books etc whilst in hospital
- Phone credit
- Birth certificates online
- Transport for patients e.g. taxis, oyster cards, main line train tickets
- Temporary accommodation individual items and welcome packs e.g. quilt and pillow, quilt cover, plates, cutlery, mugs and kettle

If the team had access to a larger petty cash fund and / or a method for larger online bookings in the future, it could utilise the personalisation find more efficiently for patients, in contrast to the current system whereby it is restricted to the £200 a week and the team is thus unable to purchase larger items or orders. Supplies for winter such as sleeping bags and winter clothing are planned.

Case Studies

Four case studies are now presented which exemplify how the team holistically supports patients. Patient names have been changed to ensure anonymity.

Case Study 1

Ali

Ali, a 24-year-old man, presented to the St Georges Homelessness Inclusion Team shortly after the service went live in late November 2021. He had previously been staying with family who had been living in a metal storage container unit in an industrial park, but he and his family had all been evicted prior to his admission.

Ali had a long-term stoma in situ after several surgeries following a gunshot wound in December 2019 and required parenteral (intravenous) nutrition via a Hickman Line (a central venous line directly into his bloodstream). This gentleman also suffered with Post Traumatic

Stress Disorder (PTSD) secondary to the gunshot injury, which caused him to have low mood and anxiety.

Ali had had 33 inpatient admissions from 6 A&E presentations and 30 outpatient appointments in the 2 years prior to being referred to the HIT team. These recurrent admissions were due to infections in his Hickman line, and issues managing his parenteral nutrition, probably exacerbated by his previous living conditions and his low mood. During this time, he had missed other outpatient appointments. On the admission when he met the team, Ali was septic secondary to a severe infection in his Hickman line and had an Acute Kidney Injury secondary to severe dehydration.

As an inpatient, the HIT team was able to support Ali to engage fully with and understand his medical care. This involved the whole team liaising with a variety of hospital teams including medicine, gastroenterology, microbiology, dietetics, and the stoma care team. It also included providing direct emotional support to Ali, as he often struggled with social interaction and engagement due to his PTSD. During this time the team liaised with Ali's family and his GP.

The team Housing Worker then supported Ali with a housing application and liaised with the Local Authority. This included helping Ali to reject the first temporary accommodation offer that was made by the LA (it was on the top floor of a 4-storey building with no lift, no private bathroom, no room for medical equipment and no space to manoeuvre with a drip stand.). The team GP then provided a detailed medical letter outlining the various requirements that would be needed to house Ali safely. He was then offered alternative temporary accommodation in another borough which was suitable.

On discharge the team used its personalisation fund to assist Ali to buy new bedding and other items to ensure his new accommodation was liveable. The team then continued to support Ali after discharge, including helping him to complete his housing benefits application. The team also helped him to re-register with a local GP and understand the local support services available in his new area. Finally, the team referred Ali to a counselling service that deals specially with PTSD and encouraged him to engage with Red Thread (an organisation supporting gang violence victims).

The team worked with Ali for a total of 6 weeks until he was settled and well supported. They continue to have occasional updates on Ali, and are glad to say that he is now doing well in new long term social housing. He is engaging with all the support and health care offered, including attending all of his scheduled outpatient appointments. He has not had any further ED attendances, inpatient admissions or outpatient DNAs since being discharged in Dec 2021 (6 months).

Case Study 2

Alesky

Aleksy is a 44-year-old Polish male, who had been residing in the UK for 20 years. Aleksy was referred to the Homelessness Inclusion Team in January 2022. He had been sleeping rough for the prior month, including over Christmas. Prior to this he had been living in a one-

bedroom property, however a closure order had been made by the police due to his perceived antisocial behaviour.

After trust was built between Alesky and the team, he informed them that a criminal gang had in fact taken over his property for the use of drugs, and they had also been controlling him and taking his benefits. He had also been assaulted by a member of this gang with a glass bottle, resulting in a laceration causing him to lose part of his ear.

When Aleksy presented to St Georges Hospital he had a history of severe headaches, recent falls, amnesia (memory loss), nausea, photophobia (not liking the light), general malaise (feeling generally unwell), and a cough. After several investigations and scans he was diagnosed with a cerebral empyema (an infected area within the brain). This infection continued to expand, and he required surgery. He then underwent a right sided craniotomy (opening of the skull) and removal of the infected area, and as a result required an extended course of intravenous antibiotics. Whilst an inpatient he also developed a right arm Deep Vein Thrombosis (clot) and was commenced on blood thinning medication to treat this. He previously has a medical background of epilepsy, and a right sided brain bleed (or stroke) in 2000 also requiring a craniotomy, leaving him with residual left sided upper and lower limb weakness. He also had a history of cocaine and heroin use and had previously been deemed a vulnerable adult.

As an inpatient the team were able to support Aleksy to engage fully with and understand his medical care. Aleksy would frequently leave the ward for long periods of time, and this would put a strain on his relationship with the ward. The team encouraged him to stay in the ward and were able to support him with this by adding credit to this TV account and visiting him regularly, providing emotional support. The team also reiterated the risks of him being out in the local area, alongside liaising with the ward.

The team worked with multiple teams in and out of the hospital and arranged a Multi-Disciplinary Team meeting to discuss Aleksy's risks on discharge, and how everyone could collectively safeguard against these. This included social services, safeguarding and the police. The team also liaised with his GP regularly.

During this time the team were able to encourage Aleksy to contact his family again, and his parents flew over from Poland to see him. Aleksy had not applied for settled status and due to a gap in claiming his benefits these were then stopped. As a result, it seemed at the time that he actually had No Recourse to Public Funds (NRPF). However, the team then supported him to apply for settled status, and once he received a certificate of application, he was helped to put in an application for Universal Credit and Personal Independence Payment.

The team then attempted to help support Aleksy into stable housing via multiple pathways. First the team attempted to help him access housing through special Coronavirus provisions at the time. However, they were informed that he could not be helped as he has not been verified by outreach as rough sleeping. They then tried to access support via social services. Despite his vulnerability and medical history, the team were advised he did not meet the criteria for support care under the Care Act. They continued to persevere with several different supported housing routes including a referral to Mildmay Hospital. After nearly 7

weeks as an inpatient the team received the news that a space at Mildmay Hospital had become available, where there is a homelessness pathway with specialist housing workers, nursing, social workers and therapists. He was then transferred to their care in late February, in the hope that he would be successfully supported from there.

Three months later he was again referred to the team. He had presented to the Emergency Department having taken an overdose on Co-Codamol in the toilets of a court. Three days earlier he had been discharged, unfortunately back to the streets, from the Mildmay hospital, after they too had struggled to secure him any housing. From here he had been rough sleeping until his re-admission to St George's Hospital.

The team contacted the Local Authority and discovered he had a decision letter which stated that he had not applied for settled status when he in fact did (supported by the team). The team were able to provide evidence of this, and the decision was overturned. As a result, he was then deemed eligible for emergency accommodation, and was offered a one-bedroom flat, which they supported him to move into.

The team has continued to support Aleksy with welfare calls, his medication, his mental health and engaging with his GP. He no longer has feelings of suicidal ideation and has feelings of hope about the future again.

Case study 3

Bernard

Bernard is a 29-year-old male who was referred to the Homelessness Inclusion Team in January 2022 with a history of rough sleeping for the previous 9 months, and long-term intravenous drug use. Bernard also had a history of depression and anxiety with previous suicide attempts, and a history of care refusal and challenging behaviour, following significant childhood trauma.

Bernard had initially presented to St Georges Hospital in January following an injury to his right hand after punching a wall. This then became infected causing an abscess. He had then attempted to drain the infection himself by puncturing the abscess. This led to further infection extending into the tendons of his hand. Over the course of the next 3 months, he required admission three times for a worsening infection. He underwent multiple surgeries including debridement and washout of the wound, a carpal tunnel release (reduction of pressure on a nerve in the wrist), and an extended course of antibiotics. In each case Bernard self-discharged to rough sleeping. Bernard also attended Accident and Emergency a fourth time within 3 months with multiple injection site abscesses. He required further intravenous antibiotics, but unfortunately self-discharged before he could have any treatment in the hospital. In the year prior Bernard had found it difficult to engage with any medical or other care, missing appointments, and not taking treatments and medications.

The team supported Bernard to make a homelessness application to Wandsworth housing in early February 2022. At the time he was rough sleeping on the streets and was offered

emergency temporary accommodation in Croydon. Unfortunately, Bernard said he felt unsafe there as he had previously been threatened with a knife in that area. The team advocated with the Council to ensure that the risk he faced in Croydon was seriously considered, and as a result he was not placed in this area. However, it took several days of discussions to ensure they were able to provide him with safe suitable accommodation elsewhere, during which time he returned to the streets. Bernard was eventually supported to access self-contained accommodation in West Hampstead.

Despite returning rough sleeping during this time Bernard really wanted to engage with drug and alcohol services at this point, but there were some barriers put up from local community teams due to his planned move out of the area. This left Bernard feeling very disappointed in services.

When in West Hampstead, Bernard was initially low in mood about being housed so far away from his previous rough sleeping location of Tooting. However, after some time he was able to recognise this as a positive thing - being away from an area in which he has been easily able to access and use drugs. The team was able to utilise its personalisation fund to help Bernard with support to get to his appointments (e.g. the hand clinic) via taxi and public transport via Oyster card. He was also given a mobile phone to be able to keep in contact, and food packages.

The team were able to support Bernard to register with a GP, and once registered also refer him to Camden Drug and Alcohol Services. After his first appointment he was commenced on a Methadone regime and has since stopped using Heroin. Through his work with the Consultant Psychiatrist here, he was also able to be formally diagnosed with ADHD and personality disorder and commenced on the correct treatment including medication.

The team community nurse enabled Bernard to access his medical care and provided initial support to monitor and clean his injection sites, get ongoing access to antibiotics, and support good compliance with these. Bernard now sees his GP regularly and continues to engage with hand clinic follow up and is due further planned surgery on his hand soon.

During this period the team also supported Bernard with more general welfare calls, and to liaise with his ex-partner. As a result, Bernard is now also back in a constructive relationship with his partner and has weekend access to his 9-year-old daughter. He is also playing Badminton most evenings.

Case study 4

Cezary

A 58-year-old Polish man who was admitted to St Georges was reconnected to Poland, in partnership with an Assessment and Reconnection Worker from St Mungo's, by the team.

This was a 'supported reconnection' to a city in Poland. As part of the reconnection, liaison was undertaken to arrange accommodation, medical care, and support in Poland on his arrival. He was escorted to the airport and supported to get on the plane. At the other end a cab picked him up to take him to a hostel, where he met with a social worker. He was given his own room there to undergo Covid quarantine for 7 days, after which he joined the general

population of the shelter. He is now happily sharing a room with two other people in this hostel and will be able to stay there up to 2 years, with possibility of extension. He already knew the hostel and was pleased to be supported to return.

The St Mungo's worker said

'He wanted to share how impressed he was with the kindness and high level of professionalism of all people who have supported him. He was surprised how quickly he was able to return to Poland with our assistance and expressed his gratitude for the support received. He had asked me to pass on the big THANK YOU to you All ☺'

Team Activity Data

The Homelessness Inclusion Team team collects routine data using a specifically developed 'homeless health template' within the hospital's iClip system. Data collection covers key patient demographics, referral pathways, housing status on admission and discharge, indicators of team activity and discharge outcomes.

Data capture challenges

Data capture has been challenging in this pilot, although it has steadily improved over time. As such all data presented in this report comes with an accuracy caveat as it requires the template to have been filled in within the required time period (which is particularly tricky at the end of any reporting period, as many people will not yet have been discharged). However, any errors will be under-reporting on outcomes, rather than over-reporting.

Data capture is currently via:

- A paper holistic assessment form filled in at bedside. This is then scanned in to iClip and the paper document is filed.
- Summary clinical notes and the care plan are then free texted into the iClip for team and to support hospital staff

- 'Whiteboard' - An Excel spreadsheet supporting MDT processes and team case management stored in the S drive (discharged patients are archived in the S drive)
- An outcome capture template in iClip collects referral data and also outcome data on discharge

Data summary

The following data is taken from the 9-month period from 01/12/2021 to 31/08/2022.

Referrals

- A total of 362 referrals were made to the HIT team during the 9 months (40 per month).
- Of these the team accepted and worked with 246 patients (27 per month). A breakdown of the referral outcomes is presented in Table 3 below.
- Just under half of all referrals came from ED, and just over a third came from inpatient wards. Others came e.g. from the community, outpatients and midwifery. See Table 4 below.
- **Overall St George's HIT team one of the busiest Pathway Partnership teams across the country**

Table 3: *Referral outcomes*

All referral outcomes	Total	%
Accepted patients	**246**	68%
Patient declined / unable to contact	47	13%
Rejected	36	9.9%
Duplicate referral	33	9.1%
Total	362	

Table 4: *Referral sources*

All referral sources	Total	%
Emergency Department	169	46.7%
Inpatient	127	35.1%
Community / Other	66	18.2%

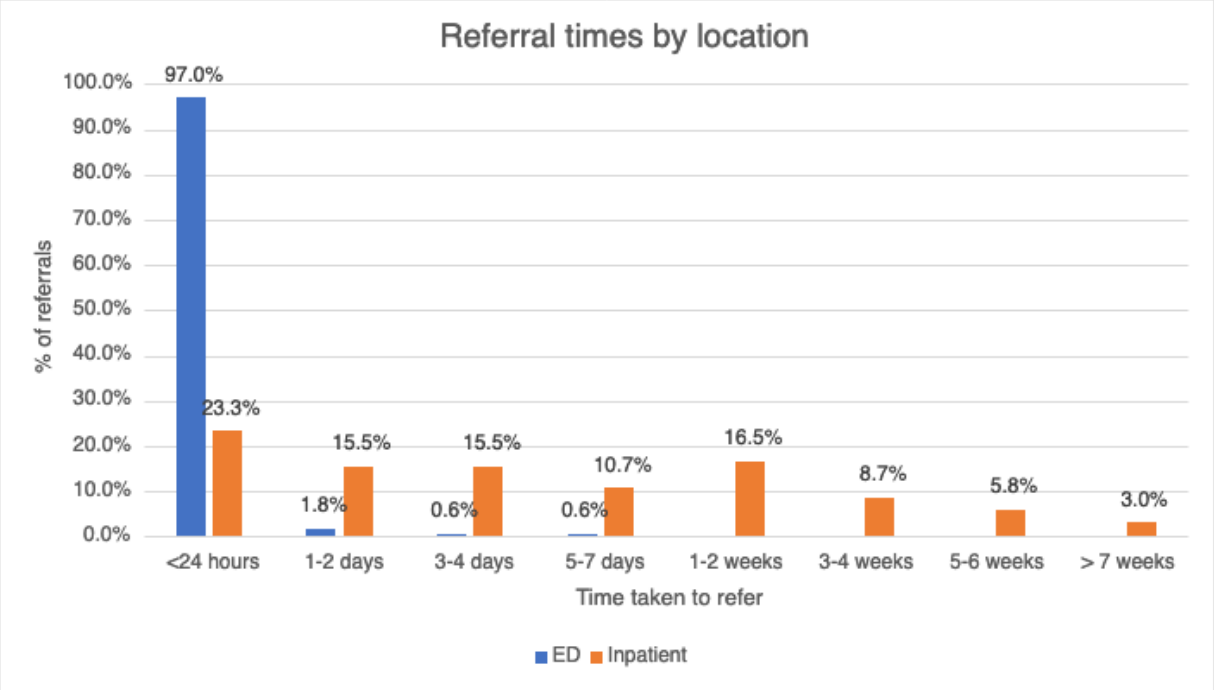
N.B. One reason for mismatch between referrals and patients taken on is that 9.1% of all referrals were duplicate referrals. Whilst the initial acceptance rate of 68% seems low, this counts duplicate referrals and referrals in which the patient declined support or was uncontactable as 'rejected'.

Time of Referrals

99% of all Emergency Department referrals were made within 48 hours of attendance, but only 39% of referrals from Inpatient wards were made within 48 hours of admission. 20% of inpatient referrals took at least 2 weeks from admission for a referral to be made.

Ideally the team should attempt to work with hospital wards to reduce the time taken from admission to referral. 34% of all inpatient referrals took at least a week from admission to be made.

Graph 1: *Time from attendance to referral*



Demographics

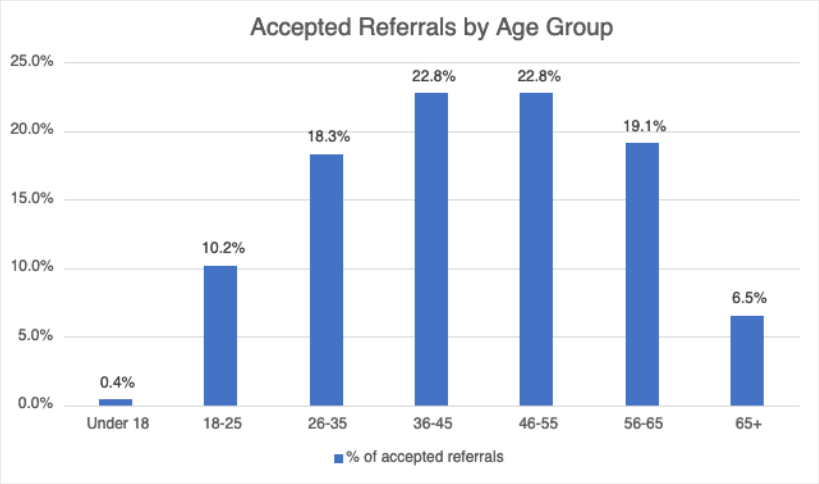
Summary demographics of the accepted referrals were:

- 76% of referrals were male and 25% female (this gender split of accepted referrals is consistent with data cross other Pathway teams)
- 83% of all patients were aged between 26 and 65
- In terms of ethnicity 40.2% were white, 38.2% Other (including White Other), 9.8% black, 2.8% mixed race, 2.4% Asian (ethnicity recording would benefit from improvement)
- 16.3% had known or suspected No Recourse to Public Funds
- 60% of accepted referrals had local connection to either Wandsworth, Merton or Croydon.

Table 5: Gender of accepted referrals

	Total	%
Male	187	76%
Female	59	24%

Graph 2: *Age range of accepted referrals*



Graph 3: *Accepted referrals by ethnicity*

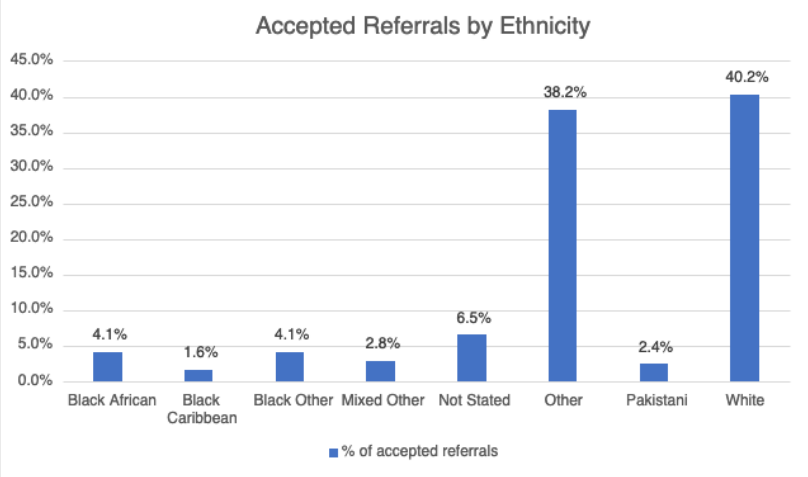
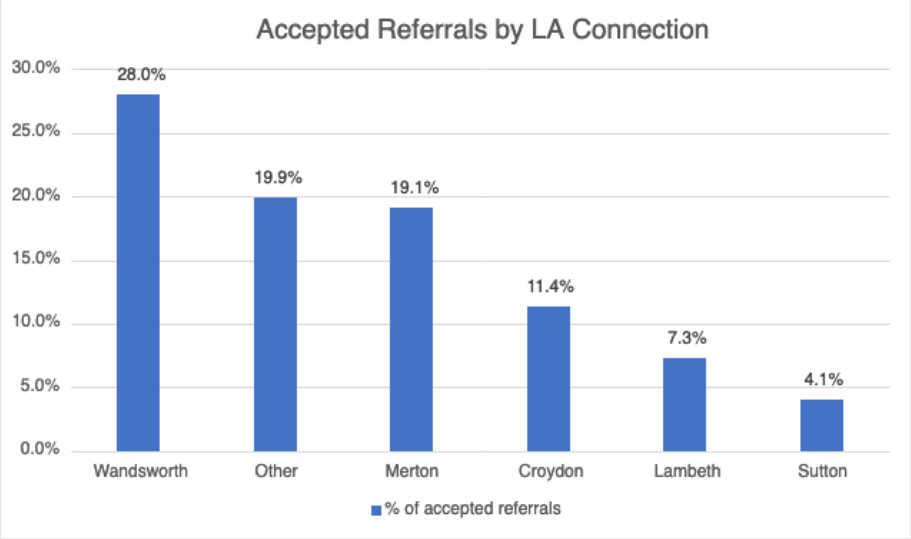


Table 6: *Recourse to public funds status*

Recourse to Public Funds	Total	%
No	26	10.6%
Yes	192	78%
Unknown	28	11.4%

N.B. Of the patients listed as unknown, an estimated 50% of these were 'probable' NRPF cases, but with the team being unable to formally verify this. This gives an estimated 16.3% of all accepted referrals as having No Recourse to Public Funds

Graph 4: *Accepted referrals by local borough connection*



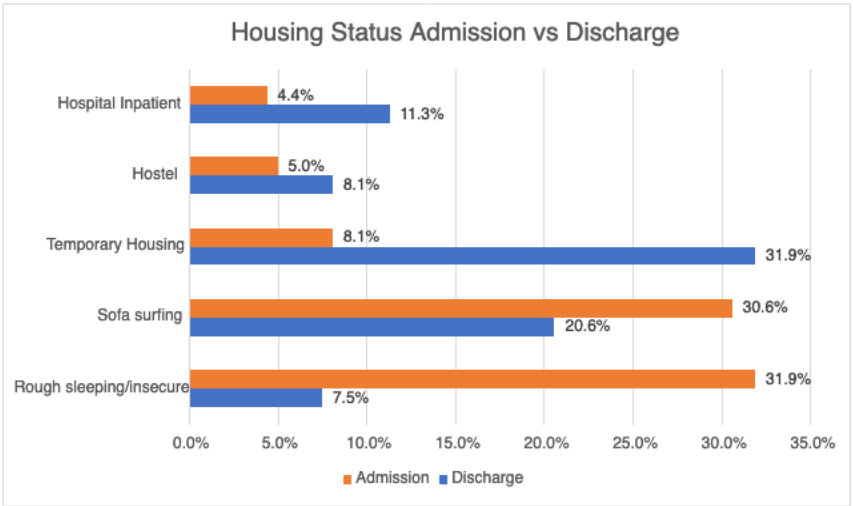
Team Outcome Data

Housing Outcomes

In summary:

- Rough sleeping was reduced from 32% of accepted referrals on admission to 7.5% of accepted referrals on discharge - a 77% decrease. This represents 39 people that were prevented from returning to rough sleeping
- Over 50% of rough sleepers were found TA or hostel placements on discharge
- Rough sleeping, insecure housing and sofa surfing situations collectively were reduced by 55%.
- The percentage of patients with Temporary Accommodation placements on discharge increased from 8.1% to 31.9% (less than 1 in 10 on admission, increased to 1 in 3 on discharge).

Graph 5: *% housing status of accepted referrals on admission and discharge*



Graph 6: *Housing status of rough sleepers on discharge*

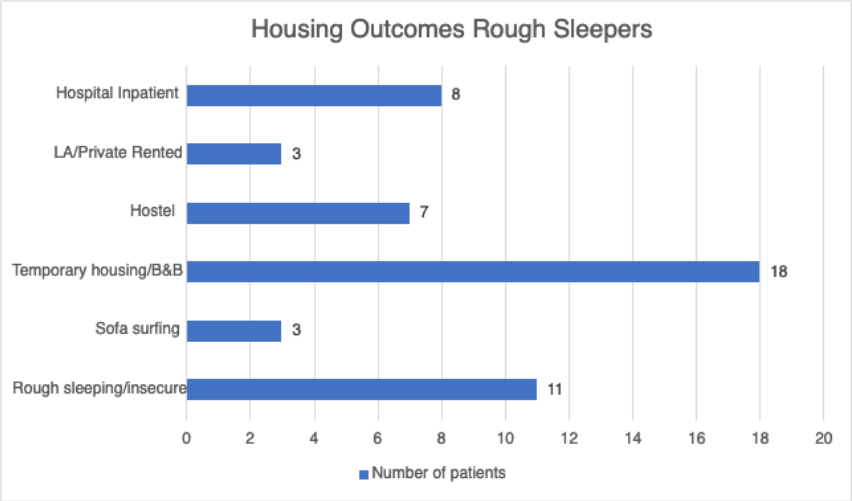


Table 7: *Change in housing status between admission and discharge*

	Admission	Discharge	% Change
Rough sleeping/insecure/sofa surfing	62.5%	28.1%	-55%
Temporary Housing	8.1%	31.9%	+294%

Returned to rough sleeping audit – undertaken October 2022

An audit was also undertaken to take a detailed look at the care of 11 individuals who had returned to rough sleeping (including those who had self-discharged)

Data Selection and Audit Process - All data was pulled from output forms completed by the team, for patients who had been discharged back to rough sleeping from hospital. 12 patients' notes in total were reviewed (one was discharged between August and the time of the audit, undertaken in October)

Results - Factors contributing to patients returning to rough sleeping were mainly noted to be a) patients presenting out of hours b) challenging behaviour, and c) the refusal of interventions. Most of these cases were discharged from the Emergency Department without the team seeing them prior to this.

In 92% (11/12) cases an attempt was made by the team to contact the patient after discharge. 83% (10/12) were able to be contacted and were reviewed by the team. 50% of these patients had repeat attendances with prior scenarios of being discharged to the streets, and 66% of those patients had a history of challenging behaviour. Only 1 patient had NRPF, and in this case that was not deemed to be the main factor that contributed to a return to rough sleeping. In terms of known local connection there was a spread of these patients across a variety of boroughs, but 75% of patients were connected to South London Boroughs (25% had a Wandsworth connection).

A key finding of the audit was:

- 100% of these patients did not have any capacity assessment documented prior to discharge
- 83% of patients also did not have any safeguarding risk consideration documented

This is a key area for further education and training with hospital services and is a clinical safety issue.

Duty to Refer

Almost 85% of all patients seen by the team were identified as being eligible for the Duty to Refer. Of these patients, a 25.3% already had an open application already, or the Duty to Refer process was already being managed by another service. Of the remaining eligible patients, the team documented that they completed the Duty to Refer in 66.9% of cases (although this percentage may be higher due to the data issues mentioned previously).

Table 8: *Duty to Refer outcome data*

Duty to Refer (data available for 226 patients)	**Total**	**%**
Eligible	190	84.1%
Not eligible	36	15.9%
Of those eligible (190)	**Total**	**%**
DTR completed	95	50%
Not completed	47	24.7%
Case already open (so DTR not required)	48	25.3%
Of those eligible and case not already open (142)		
DTR completed	95	66.9%
Not completed	47	33.1%

Note that of the patients identified as 'not eligible' for the Duty to Refer, 22/36 (61.1%) were identified as rough sleeping/insecurely housed or sofa surfing on admission. While it is possible that some of these patients already had cases open and should therefore have been listed as such, it presents a potential opportunity for the team to improve its recording in this area.

GP Registration

In order to improve access to primary care, the team checks that patients are registered with a GP, and that this GP is appropriate (i.e., accessible to the patient).

The team checked 85% of patients' GP registrations – of these, 15% were found to have either not have, or have an inappropriate GP. All were assisted to register or re-register with a new GP.

Table 9: *GP registration outcome data*

GP Registration (data available for 222 patients)	Total	%
Total checked	189	85.1%
Of those checked (189)		
Appropriate	161	85.2%
Inappropriate and assisted to register	28	14.8%

Contact Details

Having the correct contact details on record is an important aspect of patient care, facilitating follow ups, community referrals, appointment booking etc. The team checked contact details for over 90% of accepted referrals. Of these, 30 were found to have incorrect details, all of which were subsequently updated.

Table 10: *Update of contact details outcome data*

Contact Details (data for 229 patients)	Total	%
Total checked	210	91.7%
Correct	162	77.1%
Incorrect and updated	30	14.3%
Details not checked	18	8.6%

Discharges

A key aim of the team is to reduce delayed discharges and self-discharges.

- Under 20% of discharges were recorded as being delayed.
- 14.4% of all discharges were identified as being self-discharges, with 41% of these being from wards. Whilst this is consistent with data from other sites, the team should aspire to reduce the number of self-discharges.

Table 11: *% of delayed discharges and self-discharges*

	Total	%
Delayed Discharge	43/218	19.7%
Self-discharge	31/216	14.4%

Effectiveness of care

The effectiveness of care was measured by undertaking a care plan audit in October 2022. This was a robust audit examining whether everything that could possibly be done had been done for **all** patients.

E.g.

- Physical health – had non-admission health conditions, screening and vaccination status had been reviewed including e.g. dental, optometry etc and had health education been given.
- Mental health – if the person had any form of mental health problem or symptoms, had engagement with mental health services been fully discussed, encouraged, and supported. Had crisis services information been given.
- Addictions – had addictions services been contacted. Had harm reduction advice been given including discussions e.g. on needle exchange and Naxalone.

It is important to note when reviewing the results of this audit that this audit represents less than 10% of all patients seen and was deliberately set randomly for the purposes of care improvement enquiry. The team recognises that they cannot do everything for everyone, but they have endeavoured to try to do as much as possible.

Data Selection and Audit Process - 20 patients were selected at random by choosing every 10th accepted patient from the total list of team referrals. Each patient's notes were reviewed on the hospital iClip system and using the patient 'whiteboard' used by the team in daily meetings. The management of physical health, medications, mental health, and addictions during admission and after discharge were assessed alongside the housing input. Data on GP engagement and the meeting of care and support needs data was also collected.

Results - A full holistic assessment was completed and documented in 55% of patients. Physical health was noted to have been managed thoroughly during the patient's admission in 75% of cases, and medications in 70% of cases. However, this dropped to 35% on discharge for physical health, and 30% for medications. On the bright side though, a GP was identified for 90% of these patients and contacted in 94% of these cases (an extremely positive finding as connecting with primary care providers in the community promotes care post discharge.)

When reviewing mental health interventions this was perceived to be applicable in 13 patient cases. This was noted to have been managed thoroughly in only 10% on admissions, and in 5% discharges. However, in many cases, this was linked to patient engagement, or discharges from Psychiatry services and the team not being able to meet the need themselves. This identifies a potential need for a mental health practitioner on the team.

13 patients had addictions problems (a different 13 patients to the mental health patients - 4 patients had both mental health and addictions problems). 25% of these were noted to be managed thoroughly on admission, and 0% were noted to be managed thoroughly after discharge. A lack of communication with addiction services formed the bulk of how patient discharges could have been improved.

9 patients were rough sleeping on admission. Overall, the audit showed that the team had done everything possible to improve the housing outcome of the patient in 80% of cases

Table 12: *Care Plan audit*

	Physical Health during admission	Physical Health managed on discharge	Medications Managed during admission	Medications managed on discharge	Mental Health managed during admission	Mental Health managed on discharge	Addictions managed on admission	Addictions managed on discharge
Yes – Thorough	75%	35%	70%	30%	10%	5%	25%	0%
Yes - but some missed interventions	10%	20%	0%	0%	15%	10%	15%	20%
No interventions	5%	20%	25%	60%	40%	30%	25%	35%
Yes, but not recorded	0%	5%	0%	0%	0%	5%	0%	0%
Not applicable	10%	20%	5%	10%	35%	50%	35%	35%

Comments –

Whilst these audit results might seem disappointing, it is representative of the volume of work that team is trying to do, and that in many cases the focus of the intervention must be getting someone safely housed.

Also, many of these cases were seen prior to the community nurse being taken on in April 2022. A frequent problem noted in many cases was a lack of patient contact and engagement, particularly post discharge. This often led to a 'no intervention' or 'missed intervention' being recorded after discharge across many areas. Many attempts at patient engagement and contact to community services were noted in some cases, but it is hoped that the addition of a community nurse will go some way towards resolving this. This nurse is now able to help support the engagement and management of patients post discharge and improve these outcomes. In addition, plans for a future bed-based step down will hopefully drive improvements in these areas.

The team is also working to try to build up a picture of services in the community that can continue to try and engage with patients after they are discharged from the team. This has been difficult in some boroughs due to a lack of services or capacity, but is something that can be highlighted at borough level meetings.

Despite all these challenges, we can see that GP engagement is high. After noting a drop in team interventions around physical health and medication management after discharge, utilising the GP contact further could be a way to improve these outcomes in future.

With regards mental health outcomes, only a small percentage of patients were felt to have been managed thoroughly during and after admission. This is something that the team intends to explore with the Liaison Psychiatry team at St Georges Hospital, as well as linking in with the Community Mental Health Team, and other community mental health services to ensure teams are working together as efficiently as possible. A future aim of the team may also be to attempt to secure funding for a mental health worker.

Further engagement with addiction services is also a recommendation of this audit, noting that addiction services had the lowest percentage of cases that were thoroughly managed in the community.

It is important to note that with 80% of patients reviewed, the team had done everything possible to facilitate a safe discharge from a housing perspective which is very positive.

Overall, it is important to note that this was deliberately chosen to be a random set of notes, and that the purpose of the audit is to deep dive and be constructively critical to set improvement targets for the team. Although many patients seen by the team (as will be evidenced by the case studies which were presented previously) have received a truly gold standard service (which would have ticked all the boxes in the audit), this is not possible in all cases, and most of those gold standard cases have not appeared in this audit (which represents less than 10% of the patients seen overall). The team is to be commended for undertaking such a robust audit.

Service Feedback

Patient Feedback

A targeted set of patient interviews being undertaken in September 2022 by a Pathway charity staff member unknown to the patients.

Methodology:

- 20 people were randomly selected from the caseload to interview (A list of 44 people that had consented to be contacted post discharge for feedback was given, and these were the first 20 that were contactable)
- Semi structured brief interviews were undertaken using prompts (interpreters used as needed).
- Core demographics and notes were taken during interviews

Summary demographics of respondents:

- Gender: 12 Male, 8 Female
- Age: 1 in 20s, 4 in 30s, 8 in 40s, 4 in 50s, 1 in 60s, 1 in 70s, 1 did not want to say
- Ethnicity: 7 W British, 6 W Other, 1 W Irish, 2 B British, 2 Asian, 1 Black African, 1 did not want to say
- Language issues: 6 had language issues, telephone interpreter was used in 3 cases
- Length of stay: spanned from a week to 6 months and included two frequent attenders.

Results:

Feedback from these interviews was extremely positive.

Example quotes from different individuals included:

- Everything was good. In fact, everything was very good. Much better than in my country.
- I felt safe and cared for when I left the hospital. People who are homeless really need this team.
- They helped me, sorted me out, they did everything they could. When I had an appointment, they always turned up.
- I thought they were outstanding. They went above and beyond the call of duty. They were fantastic, they pushed and pushed. Without them I wouldn't be where I am (this rehab centre).
- They were amazing. They made sure I had food, everything I needed, they helped me to get housed, they liaised with the council.
- They helped me tremendously. They were a great support to me at a time when I was feeling down and low. They helped me with PIP, which I wouldn't have known about. They knew all the help and support I could get. You have to be a detective to know how to get help. They got me a temporary place, and I'm hoping to be able to move on to somewhere even better.

- If they hadn't helped me, I'd be on the streets. I had no chance to survive without them. They helped me a lot. I can't thank them enough. I've got immigration issues you see, I have to fight for everything.
- Although it was dismal at the time, all the advice that the homeless team gave me really worked – as a result I have now had 3 months of treatment and I am in a move-on house for 2 years. Things are going great. They really made a difference.
- They've been a great support. They reached out to me; I said I needed some help, and they gave it. It was such a relief.

Those that scored the team all scored the team 10/10 with 2 scoring the team 11/10.

Key insights from the interviews:

- Everyone knew they had been seen by the homeless team, and many people remembered names of staff, and/or could describe them very clearly – this indicates the team members clearly identified themselves and their team and built strong relationships with patients
- Team members were universally talked about as kind, helpful and knowledgeable
- Lots of people attributed their current housing status and/or recovery process (e.g. being in housing, or being in rehab) directly to the HIT team
- Lots of people talked about the advice of the team being of value – it would probably be useful to put together an advice booklet
- Lots of people talked difficulties with filling in forms, navigating systems etc, and the valuable help they had received with this
- Everyone thought the service was needed and should continue
- No one specifically said that anything about the team that could or should be improved!
- Most people answered the question 'can you give examples of what the homelessness team did for you?' in a housing, benefits, or subsistence support context. There was little recognition of the team as a health team per se
- There were several examples of people struggling to access primary care post discharge. Obviously, this is a known problem and one of the reasons why the team exists, and the team cannot solve every problem – but one last check on GP access prior to discharging patients may be useful, and it is hoped that the community nurse can have further impact here.

The feedback given by patients on the hospital in general was also very good - much better than is sometimes revealed in these feedback exercises. It is probable that the input of the team and successful discharges are feeding into this wider positive feedback – however St Georges is to be commended in general for seemingly providing a good service across the board.

Patient feedback has also been collected on an ongoing basis.

For example, this was a text that came in to the team:

> Thank u my first night here was great. I felt genuinely 'SAFE' 4 the first time in a long long time… many thanks to the H.I.T Team… I kno u say it's ur job, however if u knew to what degree you've started to restore my faith in humanity U'd understand y I'm saying this so much.

Staff feedback

13 surveys were undertaken with staff using a SurveyMonkey survey promoted via Internal Communications. Although this engagement was low, and 10 out of the 13 responses came from A&E staff it is felt that the results are still useful.

Survey responses:

- How often do you see someone experiencing homelessness? – Every day 1 (7.6%), More than once a week (30.7%), Weekly (23%), Monthly (23%), Less than monthly (7.6%)
- Have you ever had a patient discharged to your care? – 10 yes (77%), 3 no (23%)
- Did you know about the Homelessness Inclusion team prior to taking the survey? 12 yes (92%), 1 no (8%)
- Did you know that you could refer to the team on iClip prior to undertaking the survey? 8 yes (61.5%), 5 no (38.5%)
- Are you aware of the Homelessness Reduction Act – 8 yes (61.5%), 5 no (38.5%)
- Have you ever had any training on homeless and inclusion health – 10 no (77%), 3 yes (23%)
- Do you think you would benefit from some training on homeless and inclusion health 12 yes (92%), 1 no (8%)
- Overall, how well have the health and social care of people experiencing homeless within St Georges hospital been met – Excellent (0%), Good 3 (23%), Satisfactory 4 (30.7%), Poor 5 (38.5%), Very poor 1 (7.6%)
- Only 6 people had referred to the team (5 from A&E). Feedback responses were that the team was Extremely helpful 1, Very helpful 1, Somewhat helpful 3, Not so helpful 1. Although this may seem a bit disappointing this may reflect that fact that staff are expecting the team to be able to house people immediately.

Some challenges with meeting the needs of the client group were brought up in the survey:

- Patient engagement with services post discharge. With ongoing care, their priorities may be different from ours
- Organising follow-up without addresses / phones
- It feels wrong to discharge to street
- Refusal to engage / difficulty with engagement
- That there is nothing we can do for anyone under 18. Age restrictions
- Difficulty getting help out of hours. The majority of homeless patients attend ED out of normal working hours when the HIT are not available
- Can be difficult to get local authorities to be accountable for patients.
- Pressure about discharging them as soon as possible. Other members of MDT - doctors, site management and bed management, not often happy as they are 'blocking the bed'. But an appointment with a housing worker can take a week or so to happen after Duty to Refer is completed. I am not happy with discharging them with just Streetlink when they will go back to street or couch surfing. I struggle with them as they do not have enough support and it also makes me feel sad and frustrated in their behalf.
- They can be ED many hours. I think they often just need food and drink, usually those with drug or alcohol issues

Issues with undertaking the Duty to Refer process were also revealed:

- The form takes too long to do, the website crashed and then it asked for a lot of details regarding the family which I did not have, and the family had a poor grasp of English
- I have referred Duty to Refer but not all patients were able to get temporary housing, some ended with sleeping with friends, and one went back to rough sleeping as appointment time will take a week or so.

A suggestion from one responder was made to think about how the contraception needs of this client group are met.

A spontaneous comment in the survey from a Discharge Coordinator was:

'Having the Homeless Inclusion Team now has been a great help. They are an excellent team with experience and knowledge that can support discharge coordinators.'

Partner feedback

The team has also collected spontaneous feedback provided by partners.

Examples include:

You and your team have been incredible so please extend our thanks to them in addition others already mentioned. Team Manager, Evolve

I want to express my gratitude for the extraordinary amount of collaboration, commitment, and responsiveness across a number of services to rehouse. Head of Clinical Services and Specialist Services for Families

This is an excellent piece of work. Well done all involved in true partnership. Neighbourhoods and Criminal Justice (Strategic) Manager

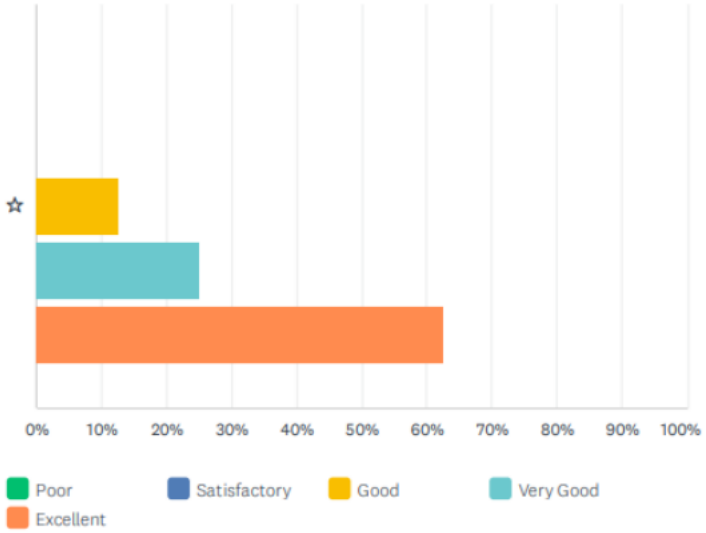
Thanks everyone for your strategic support, and a special thanks for your interpersonal support and or coordination so far for X and his family. Twilight Bay

Teaching feedback

Although the team hasn't been able to do a lot of teaching, some has been undertaken. One example was a half day teaching session for local GPs delivered by the team led by the team GP Danielle in partnership with a Pathway Expert by Experience Jeff.

Feedback was obtained from this session and is presented overleaf.

Graph 7: *Feedback on teaching – Question: Overall, how would you rate this session?*



☆	0.00%	0.00%	12.50%	25.00%	62.50%	
	0	0	2	4	10	16	4.50

#	RESPONSES	DATE
1	It was something I had never had teaching on before and it was very helpful to think more about a vulnerable group of patients and what we can do to help	2/3/2022 10:08 AM
2	Genera discussions about homelessness needs	2/2/2022 9:40 AM
3	Useful insight with the guest speaker	1/27/2022 2:56 PM
4	All of it! Jeff the speaker was very informative and powerful Case studies	1/24/2022 2:49 PM
5	very moving and emotive	1/24/2022 10:28 AM
6	Insight into personal experiences from a previous homeless person. Very well presented to us	1/22/2022 11:04 AM
	us into subgroups as then we are all together, which gives a sense of community and support during the pandemic.	
7	.	1/21/2022 9:42 AM
8	The guest speakers real life experiences	1/20/2022 8:53 PM
9	Case studies	1/20/2022 8:04 PM
10	Personal stories from Jeff	1/20/2022 7:18 PM
11	Very enlightening	1/20/2022 6:11 PM
12	the whole thing was really eye opening and helpful! Especially hearing from Jeff and his lived experience	1/20/2022 5:39 PM
13	The case studies. And hearing the kind gentleman's story	1/20/2022 5:09 PM
14	All new information,, very well organised and presented. Having Jeff's point of view and experience was breathtakingly startling.	1/20/2022 5:08 PM
15	Insight into charities and organisations that I can signpost homeless patients to	1/20/2022 4:52 PM

London Homelessness Awards

The Pathway Partnership Programme won the prestigious London Homelessness Award in 2022. This award is hosted by the London Housing Foundation, but includes the London Councils, Crisis, Shelter, and the London Mayor's office as judges.

The St Georges Homelessness Inclusion Team were seminal to the process of winning the award. They were featured in the application process and were the team that was interviewed as part of the selection process. As a result, the award film that was made, also focuses on the work of St Georges team. Pathway could not have won the award without the team.

To watch the 3 min award film:

https://www.pathway.org.uk/about-us/london-homelessness-awards-2022/

Photo 1: *The Pathway Partnership Programme teams receive the first-place award*

Photo 2: *Housing worker Mille and patient Steven who is featured in the award film*

Secondary Care Usage Impacts

Data was provided by the St George's Business Intelligence team, to assess the secondary care usage of patients seen by the team, and to identify the potential impact the team may have had on secondary care usage.

For each patient with an accepted referral to the HIT team, data was provided on;

- Time/date of every Emergency Department attendance during the period 01/12/20 - 31/08/2022
- Time/date of every Inpatient admission during the period 01/12/20 - 31/08/2022
- Time/date of first referral to Homelessness Inclusion Team (HIT)
- For patients with at least 3 admissions in the year prior to the team going live, length of stay for each admission during the period 01/12/20 - 31/08/2022
- Outpatient appointments attended/DNA during the period 01/12/20 - 31/08/2022

Summary results

- **Following first referral to Homelessness Inclusion Team, patients who frequently attended Emergency Department showed reduced Emergency Department attendance rates**
- **Following first referral to HIT team, patients who were frequently admitted showed reduced Inpatient admission rates**
- **Following first referral to HIT team, patients who were frequently admitted showed an increase in length of stay**

The increase in length of stay is likely attributable to the episodes of care being extended for health reasons and fully completed. Combined with data showing reductions in Emergency Department attendances / Inpatient admissions following referral, the implication is that by spending more time providing patients with high-quality care, the HIT team can reduce the likelihood of the patient needing to come back to hospital. This should ultimately result in less bed days being used, owing to the reduced number of admissions.

Emergency Department Attendance/Inpatient Admission Rates

The data showed 23 patients with at least 10 ED attendances in the period December 2020 to August 2022 and 16 patients with at least 4 admissions in the period December 2020 to August 2022. For each patient, first attendance/admission dates and first referral dates were identified, and an attendance/admission rate was calculated for before and after their first referral.

Rate Before = time between first attendance/admission and first referral (months) / number of attendances/admissions

Rate After = time between first referral and 31/08/2022 (months) / number of attendances/admissions

Table 12: *Reduction in ED attendances and admissions of frequent attenders*

	Average number of ED Attendances / month	Average number of IP Admissions/month
Before first referral	2.97	0.67
After first referral	1.01	0.26
Difference	-1.96	-0.41
% Difference	**-65.9%**	**-61.2%**

Emergency Department Attendances / Inpatient Admissions per patient

The data showed 21 patients with at least 5 ED attendances in the year prior to the team going live. During this period, these patients accounted for 204 attendances, or 9.7 per patient. In the period following the team going live, these same patients accounted for 144 attendances. Multiplying by 1.3 to give a yearly rate, these patients accounted for 192 attendances, or 9.1 per patient.

Following the same method, the data showed 7 patients with at least 10 ED attendances in the year before the team went live. These 7 patients accounted for 119 attendances or 17 per patient. In the period following the team going live, these patients accounted for 80 attendances (60x1.3), or 11.4 per patient.

Table 13: *Reduction in ED attendances per patient*

ED Attendances	At least 5 attendances	At least 10 attendances
Attendances/patient Dec 20-Nov 21	9.7	17
Attendances/patient Dec 21-Nov 22	9.1	11.4
Difference	-0.6	-5.6
% Difference	-6.1%	-32.9%

For IP admissions, there were 20 patients with at least 2 admissions in the year preceding the team going live. Following the method above, this group had 4.1 admissions per patient in the period before the team went live, and 3.7 admissions per patient during the period the team has been live.

6 patients were identified with at least 5 admissions prior to the team going live. These patients had 8 admissions per patient prior to the team going live, and 5.8 admissions per patient during the period the team has been live.

Table 14: *Reduction in Inpatient admissions per patient*

Inpatient admissions	At least 2 admissions	At least 5 admissions
Admissions/patient Dec 20-Nov 21	4.1	8
Admissions/patient Dec 21-Nov 22	3.7	5.8
Difference	-0.4	-2.2
% Difference	-9.7%	-27.5%

Inpatient length of stay

Length of stay data was provided for each admission of patients who were admitted at least 3 times in the year prior to the team going live (11 patients).

Table 15: *Increase in length of stay per patient*

IP Length of Stay	Average Length of Stay (days)
December 2020 – November 2021	4.6
December 2021 – August 2022	11.5
Difference	+6.9
% Difference	+150%

Of these 11 patients, 4 were admitted following their first referral. For these 4 patients, the average Length of Stay prior to their first referral was **8.3 days.** For admissions following their first referral (including the admission at which patients were referred), the average length of stay was **19.3 days.** With a reduction in subsequent attendances and admissions this is hopefully related to the care being fully completed prior to discharge.

Outpatients

The data showed no difference in OP DNA rates in the period prior to the team going live and the period during which the team has been live.

This would be an area for development for next year.

Table 16: *Comparative outpatient attendances and DNAs*

	12/2020-11/2021	12/2021 - 08/2022
Appointments attended	288	400
Appointments DNA	109	161
Total	397	561
DNA %	27.5%	28.7%

Challenges and Opportunities

The team has faced numerous challenges during the pilot period, but this has generated a lot of learning and insights on the opportunities for service development going forward next year. Some of these challenges and related solutions being suggested are highlighted below.

High expectations from hospital staff that the team will be able to house people quickly

Expectations from hospital staff have often been unrealistic, with staff expecting the team to 'house this person today'. Obviously, the team is in the position of advocating with multiple Local Authorities and although there have been many successes, these take time. In terms of housing, the team currently does not have any accommodation itself.

This would be helped by the team being able to deliver more training, and by the team gaining access to some step-down beds.

High patient needs / Lack of floating support services in the community

The team has received many referrals from day 1 and accepts about another 6 patients on to its caseload per week. The original vision of the team was to caseload people for up to 6 weeks post discharge, allowing an ongoing caseload of around 36 for the whole team.

However, the reality in many cases has been that there have not been adequate assertive outreach and/or floating support services to hand over to, and this has been a problem for the team, who have become overloaded at times. As a result of this the caseload of the team has frequently been double what it was originally intended to be.

In response to this the team has started to review patients on the caseload more robustly, and has put a new triage process in place, such that the patients with the greatest need will receive the most support. The team has also started to highlight with commissioners and partners the lack of floating support services, and also to reach out to new voluntary sector support services.

Issues with the clinical recording system

There has been discussion about whether the hospital iClip system is the best clinical recording system for the team. There are reasons for this are that:

- It feels inappropriate to document immigration or other very sensitive information in the hospital system in some cases
- Having a huge amount of social information recorded in iClip may not be helpful to the flow of the clinical record
- Other clinicians may not read the scanned assessments (which is the current way in which the core assessment of the team is stored in the hospital record)
- The hospital team can't communicate directly with GP and community nursing services via the system and/or see their records. Many other Pathway teams document on EMIS or SystmOne for this purpose.
- The outcomes template in iClip still needs work to improve it, and is not coded in most cases (which means it is not adding to national data capture for these clients)

Further work of digital integration and the introduction of a community digital system such as EMIS, could potentially help streamline documentation and improve our record keeping. This could also allow better communication with the community sector further via digital systems. As a result, there is ongoing discussion about other possible recording systems, but also investigation regarding how the iClip system can be utilized.

Data integrity

As the team has been setting up, and the iClip template has been being developed, there have been some opportunities missed to collect the ideal data set, and some concerns over the data quality.

For example, there is a clear opportunity to improve the recording of ethnicity data, by expanding the selection categories within the team's data capture templates. Recording of country of birth would also be helpful. Also 16% of all patients were listed as 'Accommodation unknown' on discharge. There is an opportunity for the team to improve its recording of housing status at discharge. Additionally, patients identified as 'not eligible' for the Duty to Refer, 22/36 (61.1%) were identified as rough sleeping/insecurely housed or sofa surfing on admission. While it is possible that some of these patients already had cases open and should therefore have been listed as such, it presents a potential opportunity for the team to improve its recording in this area. Finally, a key area in which the template in iClip is not currently producing data is in health condition prevalence and adapting it to do this would be a useful improvement.

It is hoped that this can be improved next year.

Lack of capacity / staff

The team is clearly demonstrating multiple improved outcomes for patients alongside financial savings. However, the team has struggled with staff capacity at times, particularly where there has been Annual Leave and sickness. The addition of the 0.6 WTE community nurse from April 2022, and an extra day for the GP (moving from 0.4 WTE to 0.6 WTE) from May 2022 has been welcome, but the team is still at capacity. With 246 referrals in 9 months and an average active case load of 35+ complex patients, there is a need for expansion of the team.

More staff would create more capacity and would also allow for care improvement in some areas. Acquiring administration support could also allow the team to spend more time with patients and with clinical work, as well as strengthening the team's ability to illustrate benefit realisation.

Key areas where more staff would be welcomed are:

- Administrative / data support
- Mental health practitioner (to deliver mental health interventions to these clients), possibly a Mental Health Occupational Therapist
- Social Worker
- Expert by Experience / Homeless Health Peer Advocate

A needs analysis for future staffing is presented below.

Table 17: *Needs analysis for team staff going forward*

Review Questions	GP Lead	Social Worker Band 6	Specialist Nurse Band 7	Housing Officer Band 6	Expert by experience (band 4)	St Georges Personalisation Fund	St Georges Spot purchase beds
• Has this post been filled/how much funds have been used where applicable?	Post filled since Nov '21 All allocated pay budget used	No – no suitable candidates when recruiting	Post filled since Nov '21 All allocated pay budget used	2 x Post filled since Nov '21 All allocated pay budget used	No However we have care navigator with outreach and housing experience	Yes – Annual budget of 10k £6,057.94 funds used to date	Some budget converted into a Band 7 Step Down Nurse
• If not, is it realistic that we will successfully fill this post?	Post will remain in structure Service development – increase sessions from 3 to 4	If budget is increased we will re-advertise for this post	Post will remain in structure	Post will remain in structure	'Expert by experience' role will be challenging to recruit to. The wish is to keep the 'Care navigator' within the structure. However uplift this to a Band 5 role.	Keep fund in non-pay line budget	40k to remain and the Band 7 nurse post to continue. Funds used for step down nurse, 25K, along with invoices expected for block booking.
• If not what other roles could deliver the key added value functions this role is required to deliver?	N/A, post remaining	We would like to recruit if given budget.	N/A, post remaining	N/A, post remaining	N/A, post remaining	N/A	N/A
• If yes, what evidence is there this role is adding value to deliver Pathway objectives?	The reduced revolving door in ED And Improved collaborative working by hosting multidisciplinary team meetings (MDT).	More patients registered with GP	Better experience during hospital stay	Increased awareness of this patient group in hospital	More D2R completed	N/A	N/A
• If limited evidence of the added value it provides to Pathway objectives, how does the post need to change to optimise benefits realisation?	Further admin and data support will strengthen our ability to illustrate benefit realisation	If budget is increased we will re-advertise for this post.	Further admin and data support will strengthen our ability to illustrate benefit realisation	Further admin and data support will strengthen our ability to illustrate benefit realisation	Further admin and data support will strengthen our ability to illustrate benefit realisation	N/A	This has taken longer than expected to secure reasonable step down accommodation, however we are confident that this will be of great value to the service and patients in the coming year.

Time taken to build relationships with hospital services and partner agencies

There is a broad expectation that all Pathway teams will be able to deliver gold standard care immediately e.g. in terms of reducing discharges to the streets. Although this has partly proved to be true in this case, and there have been excellent outcomes for many patients, it is important to note that the success of these teams is based largely on partnership and relationship building with other services, and this takes time.

For example, the team has done a lot of work with the Adult Safeguarding team in the hospital raising the issue of discharges to the street, self-neglect, mental capacity, and the statutory Duty to Refer. However, patients are still being discharged out of hours or during the weekend (sometimes inappropriately, or without the Duty to Refer) despite input and best efforts from the team. The team is trying to influence the knowledge, attitudes, and beliefs of hospital staff , but this will take time. In addition, the huge pressure the hospital staff teams are under to release beds needs to be acknowledged. Culture change will be gradual.

In this first year, the team has focused on building relationships with key support staff e.g. Emergency Department receptionists and security staff. They are found by the team to be key partners in reducing self-discharge when our patients attend ED.

Similarly, it takes time to build relationships with community services. The team works with multiple Local Authorities, addictions services, mental health services, and other Pathway teams, (among other partners) and time is required to maximise the understanding, collaboration and pathways between services.

Partnership working has been a key factor in the work of the team throughout the year, and it will continue to build its networks across South West London going forward. This will include

continuing to be involved in the South West London Steering group and borough level rough sleeper and homeless health meetings. The team will also build on existing pan London networks by reaching out to meet regularly with more boroughs and other Pathways Teams across London.

Delayed referrals

34% of all Inpatient referrals took at least a week from admission to be made. Earlier referral would make it easier for the HIT to respond effectively. It was noted in the data that there have been a high number of duplicate referrals.

The team plans to work next year to further build relationships with hospital staff to ensure earlier referrals with less duplication.

Lack of time for teaching

It seems that hospital staff would welcome teaching, with 92% in the survey saying they would like this, but only 23% having received it.

Ideally the team would like to create the capacity to undertake more teaching.

Burn out

In line with many other Pathway team services the team has raised the issue of burn out amongst staff. The Pathway charity is currently surveying staff to understand the cause of this burnout in order to be better able to support staff.

However, since July 2022 the team has had monthly clinical supervision in place supported by the St Georges Safeguarding Team. This supervision was initiated because of advocacy by the Nurse team lead, who is to be highly commended for this intervention.

No Recourse to Public Funds

As in all the teams, the challenge of meeting the needs of people with no recourse to public funds has been acute. Few options are available for people without recourse to public funds. Therefore, supported reconnection (as in Case 4) can be a very positive intervention.

Lack of time for staff training / staff development

Staff working in Pathway teams need to be experts in their fields and up to date. Further individual and team training opportunities are an area the team wishes to focus on in the future. Ensuring protected time for learning going forward and reviewing the professional development plans from each team member to put in place a training plan, will be key to development of the team.

It would also be good to explore opportunities for posters, and presentations at national conferences on the work undertaken so far, as well as opportunities to get involved in inclusion health research.

Lack of an advice booklet

The team is already planning to complete a booklet with general advice, including a summary of community homeless health and support services across Wandsworth, Merton, and other SW boroughs. This will be helpful for patients, but also helpful for the staff in ED when homeless patients attend out of hours and weekends.

Return on investment

The team has been able to show a return on investment not just financially, but on the health outcomes of patients and quality of life. We can see this from the successes in several case studies and patient feedback.

Financially the main savings will have accrued from the reduced reattendances and admissions in people frequently attending at the hospital. Patients who frequently attended Emergency Department (10+ attendance in the prior year) showed a collective decrease of -65.9% in their Emergency Department attendance rates, and patients who were frequently admitted (4+ attendances in the prior year) showed a collective decrease of -61.2% in their inpatient admission rates. This has been due to the continued support of the team after discharge and facilitated discharges to appropriate accommodation rather than back to the streets. Although length of stay in admission has increased for frequently admitted patients, this is because care is being completed, and this is contributing to the reduction in reattendance and readmission.

An example of the cost savings gained has been calculated from Case Study 1.

Ali had had 33 inpatient admissions from 6 A&E presentations and 30 outpatient appointments in the 2 years prior to being referred to the HIT team. He did not have any further ED attendances, inpatient admissions or outpatient DNAs in the 6 months after accepted and case managed by the team.

Potential cost avoidance:

- Cost of an A&E visit - £182. 6 visits over prior 2 years, therefore expected attendances over 6 months = 1.5. Costs avoided - £273
- Cost of an admission - £2134. 33 admissions over 2 years, therefore expected admissions over 6 months = 8. Cost avoided - £17,072
- Cost of an outpatient DNA - £120. 8 DNAs over 2 years, therefore expected DNAs over 6 months 2. Cost avoided - £240

Total potential cost avoidance: £17,585. This cost avoidance is obviously also associated with much better health management and outcomes.

Cost of team - £311,393 per annum, £233,544.75 for 9 months. The team have seen 246 patients in the first 6 months. This means that the team investment per patient over 6 months is (£233,544.75 / 246) = £949.36 per patient – in this case a very worthy investment!

The aim of the next year will be to further reduce delayed discharges by utilising a bed-based step down for those medically fit patients who may still be waiting on safe suitable accommodation. The team now have confirmed a contract with a local Tooting hotel for this bed based short stay step down unit consisting of a block booking commencing in November. The cost of this room per night is £78 in comparison to £400 per night for a general medical bed, an 80% reduction in costs leading to an approximate saving of up to £117,530 per bed per annum.

Conclusion

It can be clearly seen from this report that the team has been recognised as a successful addition to the hospital within its first year. The team is clearly demonstrating multiple improved outcomes for patients alongside financial savings.

There are also quality improvement opportunities that have been identified, and an aim of the team next year would be to build on this successful foundation and to add additional resources to the service.

It is hoped that the team will be commissioned again going forward.

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