NHS
Mildmay Hospital

Annual Quality Account

April 2023–March 2024

MILDMAY

Transforming Lives

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April 2023–March 2024

Produced by Patricia Nkansah-Asamoah
Admissions Manager

Contents

PART 1

1.1 Introduction

Mildmay Hospital is delighted to present our Quality Account for April 2023 - March 2024. As Mildmay provides healthcare services that are commissioned by NHS England and Integrated Care Boards (ICBs), we are required to publish an annual Quality Account. The reports are published annually by each provider, including the independent sector, and are available to the public.

As stated by Lord Darzi, one of Mildmay's patrons, 'Care provided by the NHS will be high quality if it is safe, effective and with positive patient experience'.

This report highlights the priorities we set out for the year 2023-24, how we performed against set standards and what we hope to achieve in the new financial year.

Our main emphasis was the sustainability of the service in light of dwindling referrals. We set out to develop other step-down services in collaboration with Local Acute Trusts. While we didn't establish a new service in 2022-23, the productive discussions we had during this period paved the way for implementing innovative pathways in the following year.

We have had some positive feedback from our patients and referrers. A homeless representative was present at a recent external meeting with Commissioners of services for homeless people . He had recently met some former Step-Down Homeless Medical Care Pathway patients, and they spoke extremely highly about our service, saying 'Mildmay is the best there is' and one of them said they would no longer be here if it were not for our team.

1.2 Chief Executive's Statement

On behalf of the Board of Trustees and the Executive Team, I am proud to present the 2023-2024 Quality Account for Mildmay Mission Hospital. This account looks at our progress and achievements across the financial year and looks forward to some of our key priorities for patients in 2024 - 2025.

At Mildmay Hospital our focus has been on three pathways. The first provides specialised and individually tailored treatment and rehabilitation for people living with complex or challenging health conditions associated with HIV. The second provides intermediate rehabilitation and care for homeless patients stepped-down from NHS Acute hospitals across London. The third is for rehabilitation and stabilisation treatment for homeless patients from across London who are undergoing detoxification. We strive to accomplish the best possible outcomes and to support individuals to achieve and maintain the greatest possible degree of independence. Our expert team and holistic model of care transform lives.

The 2023 / 2024 financial year was undoubtedly the most challenging since the beginning of the COVID-19 pandemic. With the loss at the end of June of our primary block contract for homeless step-down beds, the charity failed to bring in sufficient patients to break even for the remainder of the year and this at a time when the rest of the NHS was struggling to move patients out of acute beds.

Two rounds of redundancies enabled the charity to cut costs to the point where non-clinical focussed and corporate posts were stripped back to the minimum. This resulted in several less essential tasks, such as the publication of this report, being significantly delayed or even stopped altogether.

By the end of the financial year, the charity was almost at break even, though with significantly fewer reserves. There were ideas for new inpatient pathways but these were still in the negotiation stage. With our bank account showing the lowest funds in recent memory it was perhaps surprising that the money owed to the charity by NHS Commissioners was at its highest level in several years. It was clear that the whole NHS system was under pressure but independent providers such as Mildmay were bearing a disproportionate burden.

From a clinical perspective, the hospital continued to achieve success with patients across all three of the inpatient pathways. Delays to discharges continue to be one of the most challenging areas, but relationships with Local Authority Housing teams helped considerably.

The introduction of Podiatry Services and the mobile Dental Service has benefitted our patients considerably and added to improved outcomes, as has the introduction of the Therapy Dog.

Over the next year, the charity will focus on the introduction of at least two new inpatient pathways. Growing relationships with the North East London Foundation Trust, East London Foundation Trust and the Barts Health NHS Trust will help to stabilise inpatient numbers and therefore the financial stability of the charity.

Having successfully introduced the electronic patient record system over the past few years it is now time to introduce

an electronic staff system covering elements of payroll, pensions and HR. The hope is that we can also introduce and incorporate an electronic staff rota system.

We will continue to work with our referring hospitals to improve patient information before admissions as we work with Local Authority Housing and Community Providers to continually improve discharges.

Despite the challenges the hospital once again demonstrated that patient care could be maintained with significantly lower income levels and patient outcomes remained good. Staffing, whilst continuing to be challenging, never adversely impacted clinical services but allowances were made on the non-clinical side of the organisation.

As I conclude this report patient numbers are once again returning to a more normal level and inpatients for two of the new inpatient pathways have begun arriving.

Geoff Coleman
Chief Executive Officer

1.3 Statement on service quality at Mildmay

Patients are referred for care into Mildmay hospital on three pathways:

1. The first provides specialised and individually tailored treatment and rehabilitation for people living with complex or challenging health conditions associated with HIV.
2. The second provides intermediate rehabilitation and care for homeless patients stepped-down from NHS Acute hospitals across London.
3. The third is for rehabilitation and stabilisation treatment for homeless patients from across London who are undergoing detoxification from drugs and alcohol.

Our patients often have both physical and cognitive impairments, frequently coupled with co-existent psychological ill-health. They may struggle with addiction as an extra co-morbidity. They often live in difficult social circumstances, which make their access to the care that others take for granted very difficult. Through our rehabilitation pathways, which involve nursing, medical and therapeutic interventions working together; as well as social and peer support, patients are invariably discharged in a better state of health so that they may live as independently as possible.

As an integral part of our service delivery, we seek to demonstrate the value of our clinical interventions through measurement by audit and clinical outcome measures. We contribute data to the UK ROC - UK Rehabilitation Outcomes Collaborative to assess the patients on the HIV pathway receiving neuro-rehabilitation, and through this, we can demonstrate the clinical effectiveness of our interventions and cost-effectiveness of our service. We have contributed data to audit the outcomes of the other two pathways helping to demonstrate their clinical effectiveness. We are continually looking at further outcome measures to examine the quality of our clinical services.

We continously seek feedback from patients, their loved ones, our staff and other clinicians; and incorporate recommendations generated from that feedback to try and improve the quality of our services. Our Friends and Family Test shows that 95.8% of the patients surveyed have given positive feedback and all the patients surveyed said that they would recommend our service to a family or friend if they needed it.

Mildmay Hospital provides care and rehabilitation for patients, often at a difficult point in their lives in a modern hospital setting in London. The effectiveness of our interventions, our responsiveness to patient need, and the safety of patients, visitors and staff remain our focus in providing care.

I believe that Mildmay hospital provides and maintains a high-quality service, as evidenced by the above statement.

Dr. Simon Rackstraw FRCP
Medical Director

1.4 About Mildmay

Mildmay was re-established in the 1980s as an HIV charity working to transform the lives of people who are living with and affected by HIV in the UK and East Africa. In 2020 this changed to include intermediate medical care for homeless patients who are referred from NHS Acute hospitals across London.

In the UK, our hospital specialises in rehabilitation, treatment, services and care for patients from both of the above pathways. The primary contract for the homeless pathway is through North East London ICB on behalf of all London ICB's. In addition, there are two further HIV contracts with North West London ICS and Lambeth, Southwark and Lewisham Local Authority. The hospital also accepts spot-purchased referrals from everywhere else in the UK.

HRH Prince Harry's visit to Mildmay at the end of 2015 marked the official opening of our brand new, purpose-built hospital, which replaced earlier buildings. It comprises of 28 en-suite rooms over two wards, each with a communal lounge, kitchen and secure entry/exit system. In the past year, our capacity has increased from 26 to 28 en-suite rooms to meet a growing demand for services.

Our Day Therapy wing ceased in March 2020 and this space has now been used to expand our physiotherapy services to meet the needs of our growing patient numbers. Our ground floor space also incorporates our Occupational Therapy Assessment Centre and treatment rooms. Mildmay has a multidisciplinary, consultant-led approach - with doctors, nurses, speech and language therapy, occupational therapy, clinical psychology, physiotherapy, dietetics, social workers, drug and alcohol worker, housing support workers, chaplaincy and volunteers.

Our Vision

Life in all its fullness for everyone in Mildmay's care

Our Mission

To transform and empower lives through the delivery of quality health services, treatment and care in the UK and Africa.

Our Values

Mildmay's inspiration and values come from our Christian faith. These values, enriched and shared by many people, including those of other faiths and of no religious faith, underpin all our work. We work in a multi-cultural society and are proud of our roots.

Mildmay values the contribution of everyone who works or volunteers for Mildmay, those who use our services, their families, other organisations and funders who work closely with us, and the community, churches and individual supporters who sustain our work.

We are dedicated to upholding:

- Innovation, quality and learning
- Commitment to open communication and respect of individual dignity
- Mildmay places the individual at the very heart of its planning, services and actions
- Development and encouragement of people to their full potential
- Good stewardship of resources.

Registration Details

Mildmay Hospital is registered with the Care Quality Commission and governed by a Board of Trustees who meet with the CEO and senior staff quarterly.

It is a registered company (1921087), a registered charity (292058) and registered with the Care Quality Commission (1-2151037387), location number 1-2311760426)

1.5 Mildmay Inpatient Care and Services

Mildmay Hospital provides rehabilitation for adults with physical, cognitive and psychosocial difficulties. Our multidisciplinary team approach aims to provide patients with positive opportunities aimed to promote independence, build confidence and strengthen abilities. Patients are assessed on an individual basis and we aim to provide patient-centred care. Our patient pathways encourage as much self-management as possible.

Sixty-two per cent of NHS expenditure is spent on long-term care and effective management of those conditions, including HIV and homeless health supports the Acute Trusts to provide quality of care.

The Intermediate rehabilitation beds for the post-detoxification drug and alcohol service are operated by an on-site, skilled, trauma-informed substance misuse team to prepare residents for their ongoing treatment options and deliver intensive preparatory programmes for either full residential rehabilitation or entry into supported or private housing supported by community treatment and wrap-around support.

Summary of the three pathways for inpatient referrals:

Pathway One: HIV Neuro-Cognitive Impairment (HNCI) & Complex Physical Care HIV Admission

AIMS

- To maximise the independence of people living with complex HIV related conditions including neuro cognitive impairment
- To provide assessment and multidisciplinary rehabilitative care to support patients to achieve their maximum potential and regain their independence.
- To provide patients with adherence support
- Symptom control, stabilisation and/or psychological support.
- To prevent acute hospital admission

Pathway Two: Homeless Step-down

AIMS

- To provide a short admission period to support patients who require regular medical and nursing support before returning to independent living
- To provide patients with adherence support

- Symptom control, stabilisation and/or psychological support.
- To reduce the incidence of acute hospital admission
- To provide a safe environment and ongoing nursing, medical and therapy input following an acute hospital admission
- To link patients in with housing teams and access appropriate housing, thus positively impacting on the prevalence of street homelessness in London and its associated morbidity and mortality.

Pathway Three: Stabilisation-Based Intermediate Rehabilitation Beds for Homeless (Post Detox Stabilsation)

AIMS

- Build on the outcomes from IPD and support sustained treatment, engagement and recovery.
- Deliver a safe and supportive intermediate rehabilitation residential setting.
- Provide sufficient varied and skilled clinical and psychological assessment and intervention to maximise positive treatment and recovery outcomes
- To manage different aspects of care for alcohol and/or drug abstinence or stabilisation, associated medical pathology and improving physical and psychological health and wellbeing.
- Participate in a multi-disciplinary partnership with London LAs, IPDs, community substance misuse teams, London Homeless Substance Misuse Enagement Team, rough sleeping teams, housing, specialist general health services (i.e. hepatology, respiratory, alcohol related brain), mental health services, social care services, safeguarding, domestic abuse services and tertiary care to provide a holistic service for people who sleep rough/in hostel accommodation/risk of reurn to the street
- Place service users at the centre of delivering holistic care, promoting health, well-being and life chances
- Raise the aspirations of service users and lower barriers to care to strengthen engagement with treatment by building trust and understanding in the service provided.

PART 2

2.1 Looking Back: Priorities for Improvement 2023-2024

Main Priority - Sustainability

The priority for the 2023-24 financial year was once again about sustainability, the capacity to endure and having the potential for long-term maintenance of relevance and viability. To this end, we had several targets:

1. To continue to provide Neuro-HIV step-down care and rehabilitation services for London and the rest of the UK by maintaining the existing HIV contracts and transferring to a Pan-London contract if possible.

Achievements

• Maintained existing HIV contracts with some ICB's In London

2. To continue to build on the success of the intermediate care for homeless patients stepped down from NHS Acute hospitals across London. The Pan London contract was terminated and replaced with Individually Funded services led by ICBs.

Achievements

• Developed the admissions process across the different ICBs in London

• Developd effective escalation processes with some ICBs to improve the discharge process for complex homeless patients.

3. To continue to provide hospital-based inpatient drug and alcohol stabilisation services post detoxification from an acute centre.

Achievements

• Supported community drug and alcohol teams with discharge planning from admission to acute centres and then to the Mildmay intermediate rehabilitation beds for people with complex needs

• Improve bed management and how bed availability is communicated.

4. To continue to develop our Electronic Patient Record (EPR) to better meet the needs of our patients and other care professionals, improve reporting and meet reporting requirements as per national guidelines

Achievement

• EPR Installation is completed and running live

5. To establish a fourth pathway that will help to ensure the long-term stability of the charity as a whole.

Achievement

• Negotiations with East London Foundation Trust and North East London Foundation Trust with the aim of a pilot step down service in the next financial year.

2.2 Looking Forward: Priorities for Quality Improvement 2024-2025

Priority 1: Sustainability

Identify and develop at least two new in-patient potential step-down services for local acute trusts.

Criteria for success

Have a contract In place for the fourth pathway

Priority 2: Improve delayed discharges

Having set up discharge escalation meetings with NWL homeless leads, we seek to extend this to other ICB.

Criteria for success

Develop escalation meetings with other ICBs s=aside NWL homeless leads

Priority 3: Demonstrating the Safety of staff and patients

Demonstarting the effect of trauma-informed care training and Patient Safety Incident Response Framework (PSIRF) implementation on the safety of patients and staff.

Criteria for Success

Comparing results of staff and patient surveys.

2.3 Statement of Assurance

Mildmay delivers services under NHS contracts following a service specification embedded within that contract. Three care and treatment pathways form part of our service specification:

- HAND Assessment, Rehabilitation and Complex Symptom Control
- Homeless Step-down Care
- Homeless Intermediate rehabilitation for the homeless (Post-Detox Stabilisation)

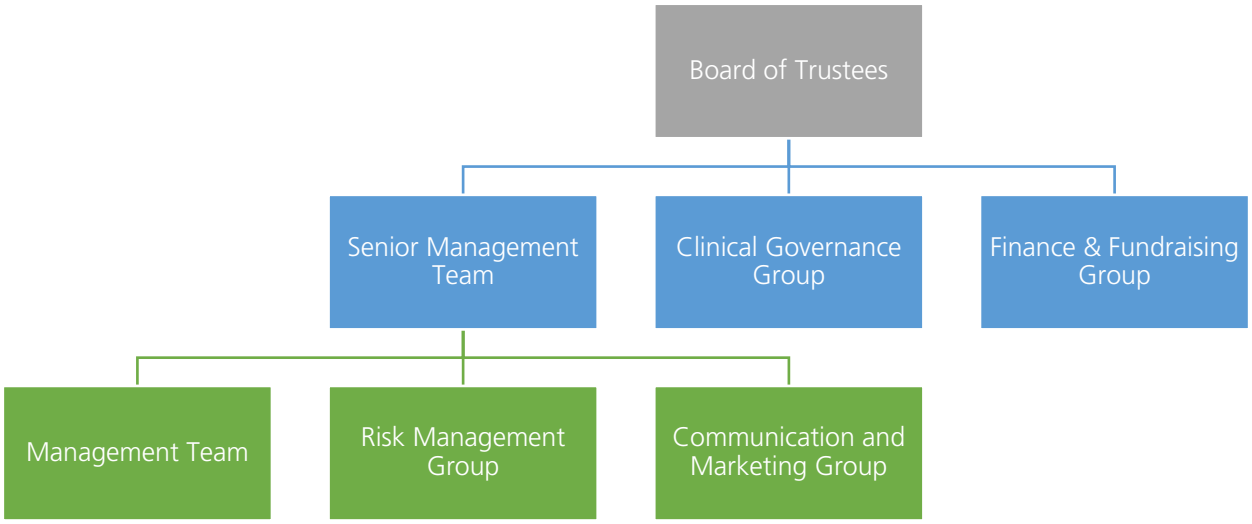
Dr Simon Rackstraw, Mildmay's Medical Director, is a Consultant and a Fellow of the Royal College of Physicians of London and continues to be in demand for knowledge-sharing and information exchange.

During the period, Mildmay submitted Quarterly Performance Reports to NHS commissioners and referring clinical nurse specialists (CNSs) for the HIV and Homeless pathways. We also provided monthly activity and quarterly performance reports to our Drug and Alcohol commissioner.

The Mildmay Management Team met weekly to discuss management and operational issues during the period for prompt action and support.

There are monthly Risk Management and quarterly Clinical Governance committee meetings with oversight from our board to ensure responsiveness to challenges and mitigating risks to promote quality of care.

2.4 Mildmay's Governance Structure



Mildmay Hospital governance model for the Trustee Board

- Voting by the majority of a quorate meeting
- Quorum: 3 for all meetings
- The framework to be reviewed annually

Trustee Board Meeting

Members

Mildmay Trustees

Attendance

Staff by invitation of Trustees

Objectives

To review the Strategy, Performance, Finance, Clinical Governance, Key Risk

Timing

Quarterly

Mildmay Management Team (SMT)

Members: CEO, Medical Director, Head of Finance, Admissions Manager, Estates and Facilities Officer, Head of Human Resources and Matron & Registered Manager

Objectives:

1. Contract Performance
2. Finance & Fundraising
3. Human Resources
4. Operational
5. Estates & Facilities
6. Risks for the main board

Directors will invite attendees as required.

Timing

Weekly

Clinical Governance Group

Members: Trustee (medical) Chair, Trustee (nursing), Trustee (Health Management), Trustee (medical/public health), CEO, Medical Director, Therapies Representative, Matron & Registered Manager

Objectives

1. Oversight of clinical activities
2. Review of risks of service delivery
3. Staffing and compliment
4. Compliance
5. Quality improvement and Quarterly reporting
6. Clinical education and training
7. Clinical policies
8. Information Governance

Timing

Quarterly

Finance & Fundraising Group

Members: Trustees (at least two, one of whom chairs), CEO, Finance Manager, Fundraising Manager

Objectives:

1. Oversight of Finance
2. Oversight of Fundraising activities

Timing

Quarterly

Risk Management Group

Members: CEO (chair), Medical Director, Matron & Registered Manager

Objectives:

1. Identify and manage operational finance, clinical and Information Governance risks as well as review incidents (monthly)

Timing

Monthly

Communications & Marketing Group

Members: CEO (chair), Matron & Registered Manager, Fundraising Manager and others as required, by invitation.

Objectives

Oversight of the following activities:

- Marketing Literature
- Publications
- Events
- Conferences
- Website
- Social Media
-

Timing

Usually monthly

2.5 Review of Services

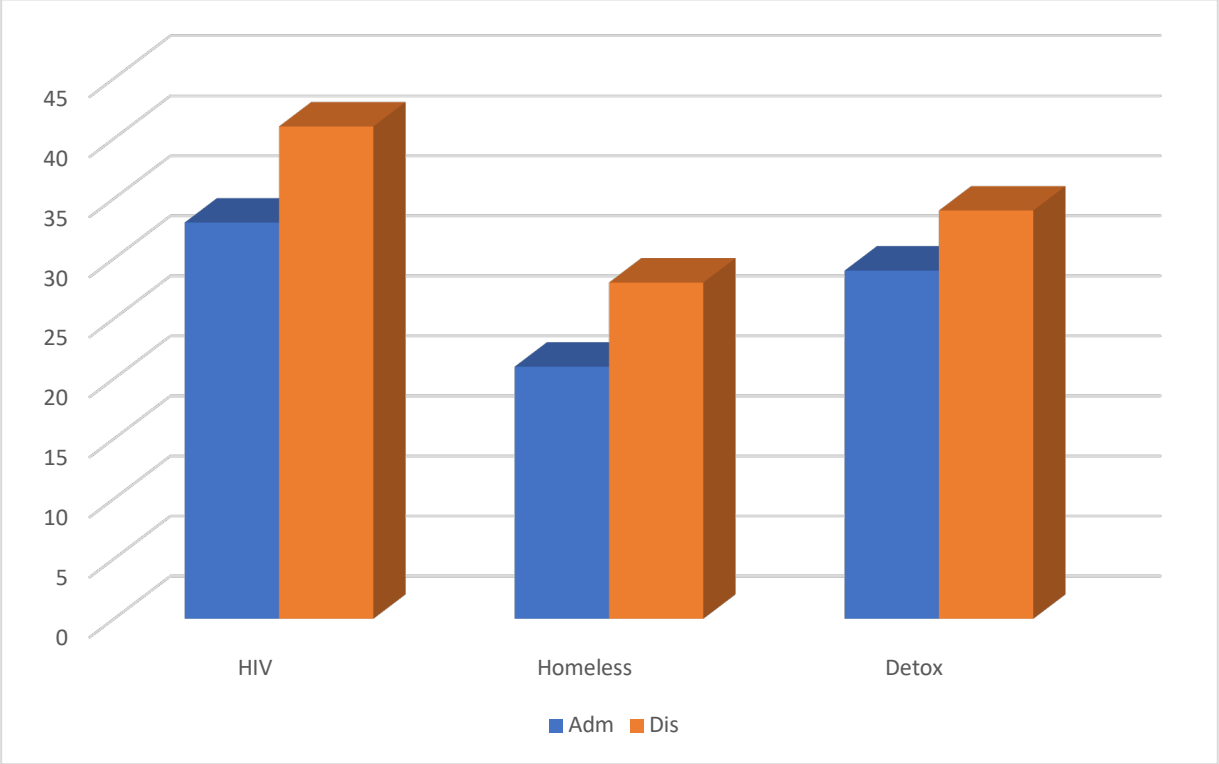
The main change in service delivery over this period was the move from a Pan London contract for the Homeless Step-down medical care to an Individually Funded service led by ICBs.

Referrals are received by email and reviewed by the Mildmay admissions team using the eligibility criteria for homeless step-down care. Some ICBs have other step-down services and will assign patients appropriately.

Mildmay is usually able to accept transfers promptly once funding has been approved. All patients are assessed within 24 hours of admission.

Referrals for homeless step-down care are mostly from hospital homeless pathway teams, complex discharge coordinators and hospital social work teams. They complete a referral form which is sent to us by email at admissions.mildmay@nhs.net.

Admissions versus discharges



For HIV patients:

We had contracts with NEL and NWL ICBs. There is the option for spot purchase for other ICBs both within and outside of London. The main challenge for patients outside London is identifying persons who will approve Individual Funding Requests (IFR).

For Detox patients:

Funding is pan-London. Patients are referred for post-detox stabilisation. They are then discharged back into the community or to a residential rehabilitation setting. Discharge planning is in collaboration with community drug and alcohol teams from before admission.

For Homeless patients:

All homeless funding is spot purchase. There is currently no contract with any ICB for this pathway. We have established good working relations with NWL for this service. All referrals are reviewed by their medical team for funding authorisation. We have developed escalation meetings with some ICBs to discuss patients' clinical progress and barriers to discharge. This is a practice we would replicate with other ICBs.

Best Practice in Discharge Planning NWL ICB

In this financial year, we moved from pan-London funding of homeless step-down medical care to ICB-led funding. Timely discharge based on a 6-week length of stay was identified as one of the challenges in the pan-London Homeless contract. Different ICBs developed various strategies to address this challenge. One effective strategy is Discharge Escalation Meetings with ICB homeless leads. Delayed discharges are either due to clinical or non-clinical reasons. The non-clinical reasons are mainly due to post-care housing.

Discharge escalation meetings with the NWL ICB homeless team started as bi-monthly but are currently weekly.

These meetings focus solely on barriers to discharge and how the ICB can escalate to relevant persons. Actions are assigned and reviewed the following week. In these meetings, extensions of stays are requested and documented. This is done until the patient is discharged.

Weekly updates with NWL help us to escalate problems quickly and Mildmay is made aware of other professionals who will support discharge. We are also linked with other professionals and resources in the community.

Best Practice in communicating bed availability

The post-detoxification stabilisation service is for a block contract of 6 beds. Mildmay sits in the middle of the detoxification pathway where homeless patients or those a risk of homelessness are initially admitted for drug and alcohol detoxification, stabilised at Mildmay Hospital and transferred to inpatient rehabilitation units or back into the community.

Our main referrers are the Addiction Clinical Care Suite unit in Guy's and St Thomas' Hospital. Referrals from other acute centres are considered when we have beds available and patients meet the eligibility criteria. Weekly bed state is sent to ACCS, so they can recommend Mildmay services to eligible patients who have not been referred to Mildmay as part of their care.

Best Practice – Referrers and patients visit before admission

Patients on the detox pathway have the opportunity to work with some staff who have lived experience. They shared some best practices in the drug and alcohol service which we have adopted. Our team visits and participates in team meetings for new referrals. New referrers and patients are encouraged to visit us before they are referred or are admitted to the service.

This sets expectations for the admission and discharge process, community teams know what to expect from Mildmay and share lessons with patients who use our services. This has resulted in good working relations with the Addiction Clinical Care Suite unit in Guy's and St Thomas' Hospital, who are our primary referrers. We also have working relationships with previous community drug and alcohol teams who have used our services like CGL, RESET, VIA etc.

Electronic Patient Records

Capturing, storing and measuring data is necessary for measuring the quality of services. Mildmay uses EMIS for recording and storing patient information. We have access to the Cerna Portal so we can view previous medical records of patients. This improves patient information before admissions.

Mildmay provides data monthly to the UK Rehabilitation Outcomes Collective, UKROC.

Data is processed and analysed by their team in compliance with the UKROC peer group comparison framework. This contributes to the evidencing of the outcomes for HIV Neuro-rehabilitation patients who access Mildmay's services. We receive quarterly reports from UKROC and this is also shared with our commissioners.

Monthly data is submitted to the National Drug Treatment Monitoring System (NDTMS) for the drug and alcohol pathway feeds into the national database. Data is collected to monitor the effectiveness of drug and alcohol treatment services.

Data on patients on the homeless pathway is submitted weekly to the Intermediate Care Community Daily Discharge. This feeds into the national discharge programme database and issues reports on homeless health.

With patient records fully automated, there is immediate access to patient information by health professionals in the team or externally. It allows seamless sharing of information which greatly enhances patient care.

Internal Clinical Audits

Clinical Audits take place in Mildmay Hospital throughout the year and form part of the annual audit cycle programme within our clinical governance framework. The purpose of internal audit is to ensure that practices conform to national standards as well as the regulations and objectives of Mildmay.

The audit report includes the following audits to demonstrate the quality of Mildmay's services:

- MUST (Malnutrition Universal Screening Tool) Analysis
- Medications Audit
- Prescription Chart Audit
- Controlled Drugs
- Hand hygiene/ Infection Control Audit
- Mattress Audit
- Inventory and Disclaimer Audit
- Falls Audit
- Risk Assessments
- ABC charts
- NHS Thermometer (Falls, Urinary Tract Infections, Catheters, VTE assessments, Pressure Ulcers)
- Social Work Audits
- Health and Safety

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Mildmay in this period, that were included during that period to participate in research approved by a research ethics committee was **NIL**.

Mildmay was involved in conducting **NO** clinical research studies on HIV during the reporting period.

NO clinical staff participated in research approved by a research ethics committee at Mildmay during this period.

Care Quality Commission report summary

Mildmay is a registered company (19211087), registered with the Care Quality Commission - 1-2151037387, location number 1-2311760426. The hospital was last inspected in September 2021 and rated 'Good' across all five key areas.

PART 3

3.1 Review of Quality Performance

Mildmay Hospital maintains its monthly data reporting activity and quarterly reports to our commissioners in NEL, NWL ICBs and the City of London.

3.2 Incidents

Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents to learn and improve patient safety.

Mildmay Hospital aims to promote a climate that fosters a just culture. This is at the forefront of our hospital's values and underpins the delivery of all our care pathways, and clinical services as well as any new projects which are implemented within our facility.

Mildmay Hospital encourages and supports incident reporting where any member of staff, volunteer or student feels comfortable and able to report actual occurrences as well as near misses, including any incidents which may harm visitors, staff, students, volunteers or contractors as well as the patients who use our service. We aim to promote a transparent and open culture, balancing high-quality care with staff wellbeing and continuous learning a key part of Mildmay's ethos.

Mildmay implemented PSIRF in November 2023 after training and developing our PSIRF policy and plan. This was approved by our Local ICB; Tower Hamlets and also by the Mildmay board.

183 incidents were reported in 2023-2024 and are summarised below

Incidents	Q1	Q2	Q3	Q4	Total
Falls	13	14	4	2	33
'Near Miss' Falls	4	3	1		8
Missing Patient	3			1	4
Catering	2	1			3
Medication - Controlled Drugs	1	3		1	5
Medication-Other	2		2		4
Theft/Loss of Property	2	0	1	1	4
Maintenance/Estates/Security	10	3	3		16
Substance Misuse/Alcohol	8	9	2	3	22
Confidentiality/ Data	1			1	2
Verbal Aggression	3	3	3	6	15
Physical Aggression	2	2	1		5
Damage to Property	2			1	3
Safeguarding	1			3	3
Smoking	5	5		1	11
Clinical Emergency	1				1
Information Technology	2				2
Admission/Referral	1		1		2
Gym (Stuck In gym corridor)	1				1
Went to gym unsupervised			1		1
Care Plan	4				4
Behaviour - Other	2	11	2	3	18
Self harm	1	1			2

Discharge	2	1	1		4
Visitor		1			1
SLT Incidents		3			3
Accident			1		1
Transport			1		1
Pressure ulcer on admission				2	2
Incident related to Deprivation of Liberty DoLs				2	2
Total number of incidents	73	60	24	26	183

Lessons learned from fall incidents using PSIRF

Insidents were categorised and dealt with differenty before the introduction of PSIRF. One fall was low psychological harm, no physical harm fall for an elderly white (other) male with mobility issues. He was reassured and continued with his physiotherapy programme with no changes. The other fall was a low psychological harm, and low physical harm fall due to a seizure.

The patient was an elderly British male on the drug and alcohol pathway with memory and cognitive issues. He was stabilised by the medical team and continued to work with the substance misuse worker on relapse prevention and psychologist on improving his cognition. Incidents managed using PSIRF takes into account both physical and psychological harm and patients are supported accordingly.

Lessons learned in alcohol misuse using PSIRF

1. The patient is a male of Indian ethnicity who had no psychological harm and no physical harm incident with alcohol. He has a history of alcohol dependence but was referred to the Homeless Pathway. He had no intention to stop drinking when two bottles of brandy were found in his room. These were taken away as per hospital policy, and the patient was given a warning.

He was reviewed by our clinical psychologist but felt embarrassed. He did not want to engage with the substance misuse worker but had to adhere to the hospital policy of not bringing or drinking alcohol on the premises.

2. The patient is a female British who had moderate psychological harm and moderate physical harm incident of intoxication off the hospital premises and self-discharged. She was readmitted after negotiation with her external team.

Within a day of admission, she drank alcohol on the hospital premises and had behavioural issues. She was discharged back to her external drug and alcohol team.

Controlled Drugs Incidents

All incidents relating to Controlled Drugs are reported to the Local Intelligence Network by the Accountable Officer, with practices being reviewed continuously in response to occurrences. Controlled Drugs are audited by the Matron every month.

3.3 Staff Training

Our training programme helps employees learn specific knowledge or skills to improve performance in their current roles. Individual staff members will also do additional training in line with professional responsibilities. Below is the list of mandatory training conducted in the year 2023-2024.

Mandatory training

	Percentage completion
Information Governance	100%
Infection Prevention & Control	100%
Mental Health Awareness	98%
Safeguarding Vulnerable Adults	98%
Safeguarding Vulnerable Children	98%
Violence and Agression	98%
Moving and Handling	100%
Fire safety for Health & Social Care	98%
Food Safety & Hygiene	98%
Health & Safety	98%
Professional Boundaries	98%
Equality and Diversity	98%
Prevent	100%
Basic Life Support	100%

Staff Training and Support (Creating Safety)

Following the implementation of our new post-detoxification stabilisation care, we had increased incidents of challenging behaviour. Almost 40 per cent of incidents were related to challenging behaviour, aggression, smoking inappropriately, and substance misuse.

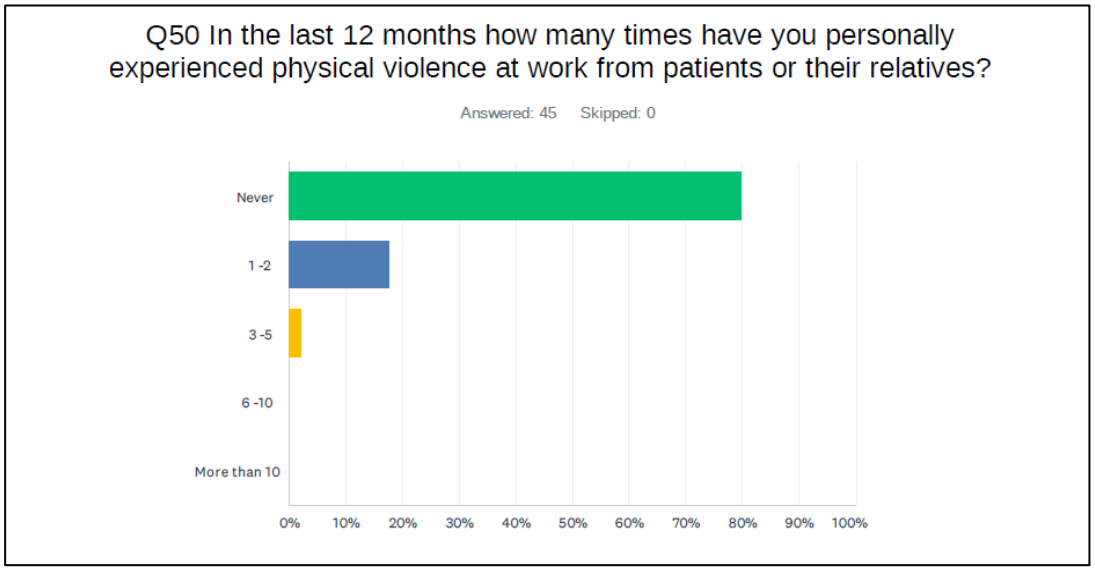
Our priority was to train staff in Trauma Informed Care and managing challenging behaviour. There was a combination of online and face-to-face training. Our clinical psychologist provided Trauma Informed Care training for all frontline staff.

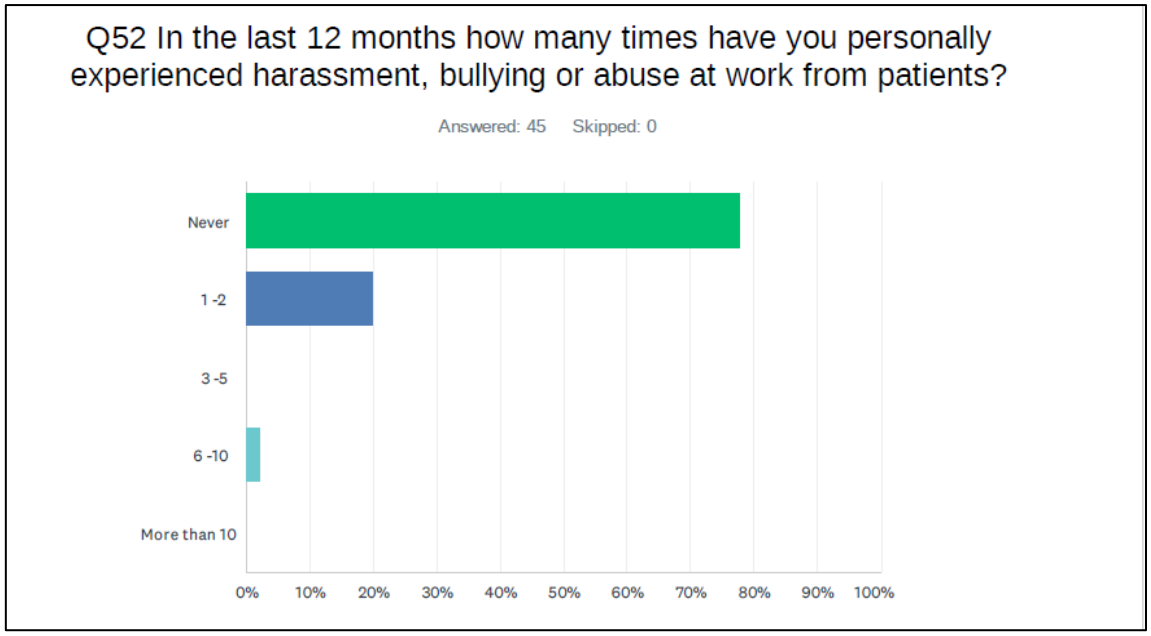
Creating safety for yourself and creating safety in your environment

Following the implementation of our new Staff reported that they were more knowledgeable and confident in knowing when to act and when to keep a distance in the face of challenging behaviour. The next step is to find out how knowledge affects practice and support staff to translate knowledge into practical steps.

Staff Survey

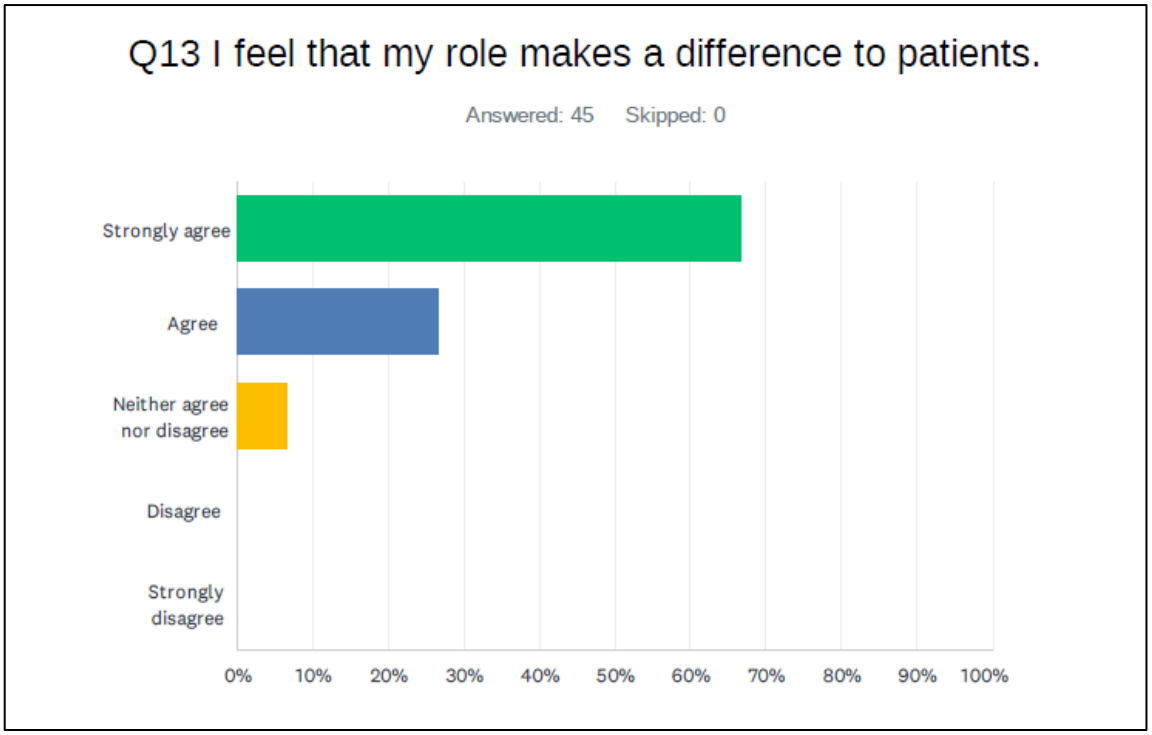
Mildmay conducted an anonymous staff survey on Survey Monkey in December 2023. Questions on experiencing physical violence at work, bullying, abuse and harassment from patients showed these results.



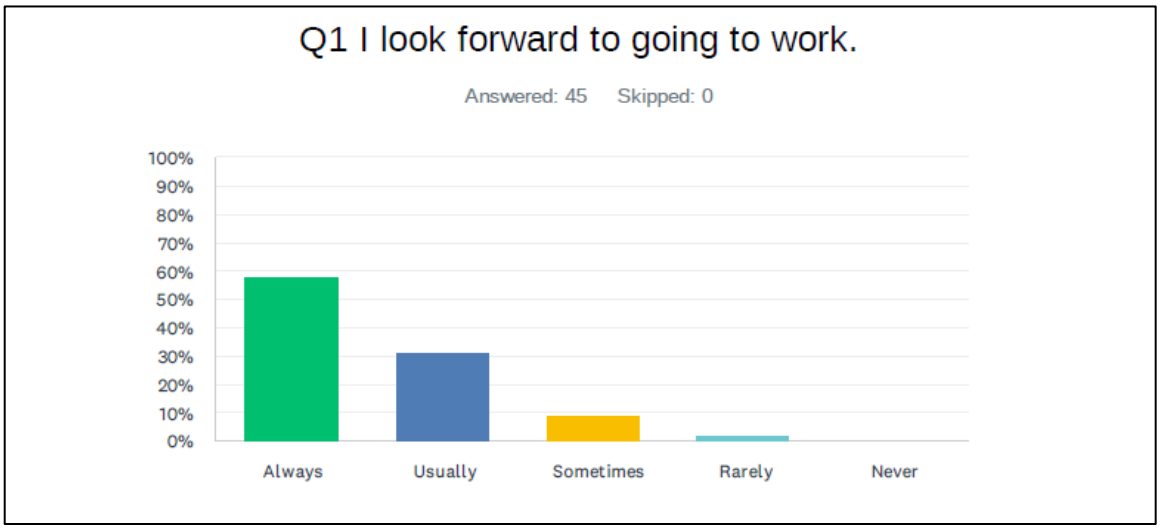


Though the majority of staff had never experienced physical violence, harassment, bullying and abuse from patients in the last 12 months, the few people have to be supported. Training and staff wellbeing clinics run by our clinical psychologist are there to offer such support.

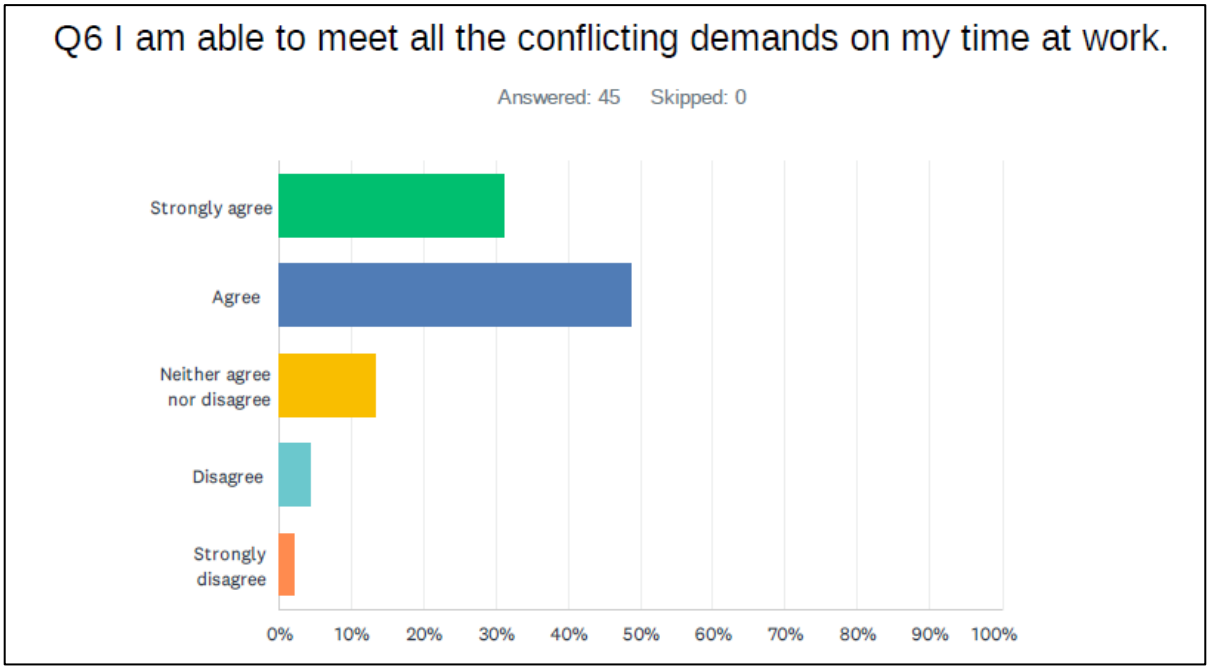
Despite these challenges, staff feel they make a difference to patients.

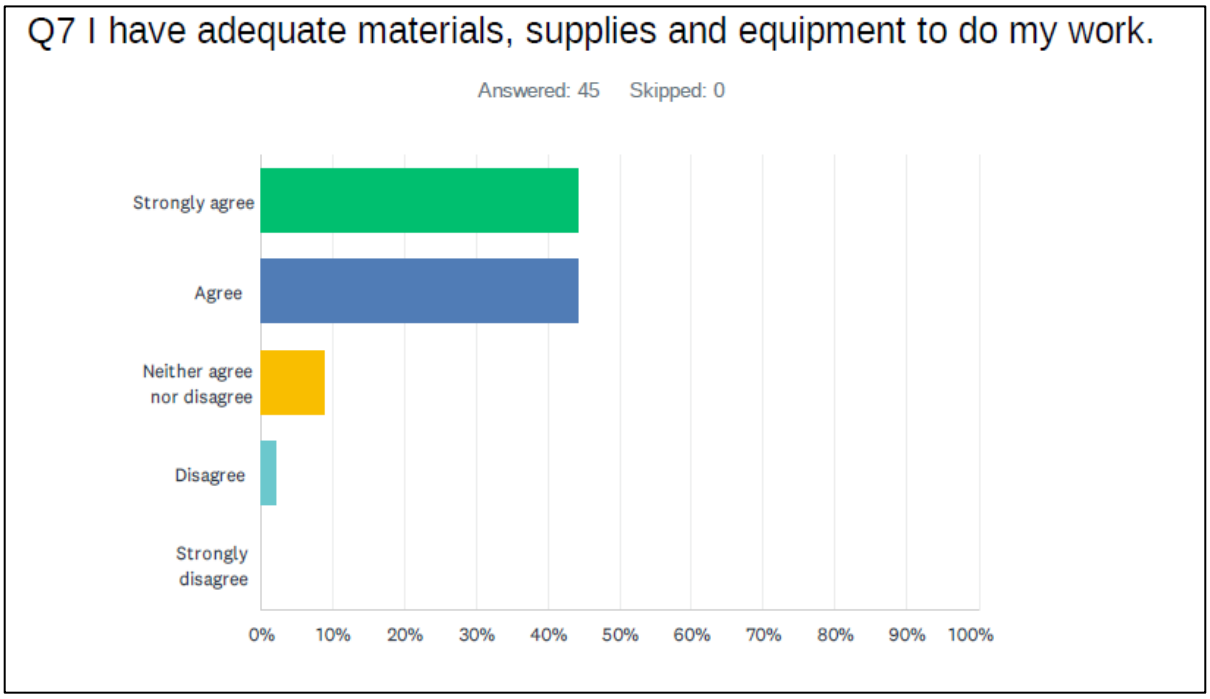


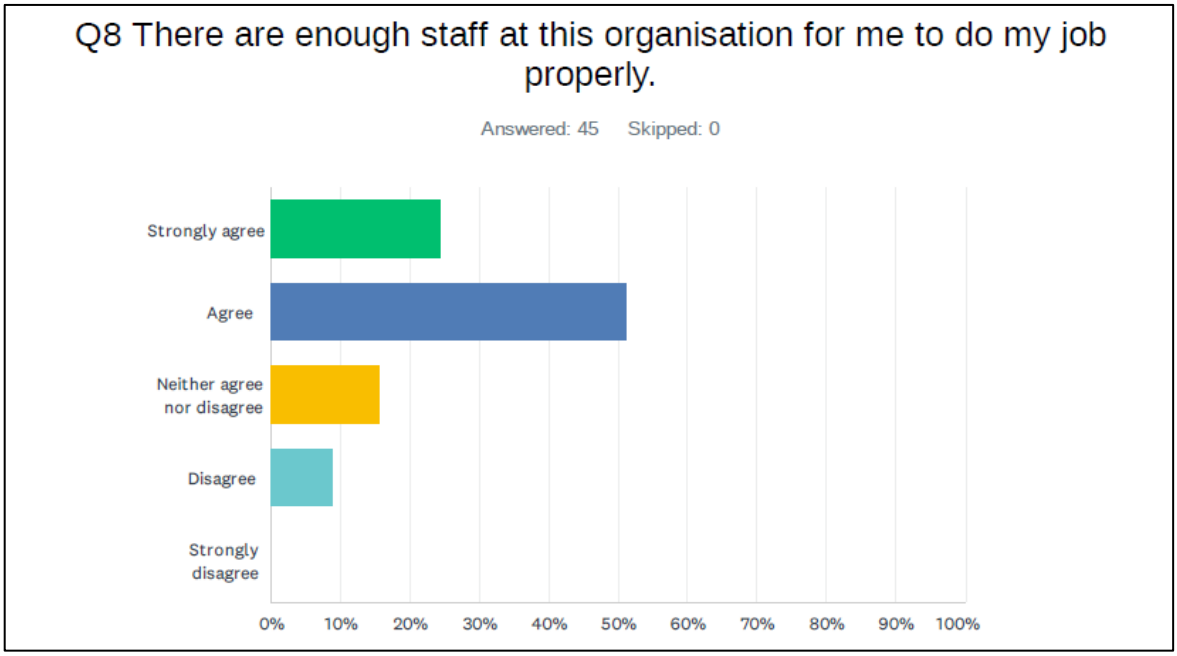
Findings on how staff feel about coming to work and how enthusiastic they are about their work.



Work demands, adequate staffing and adequate supplies.

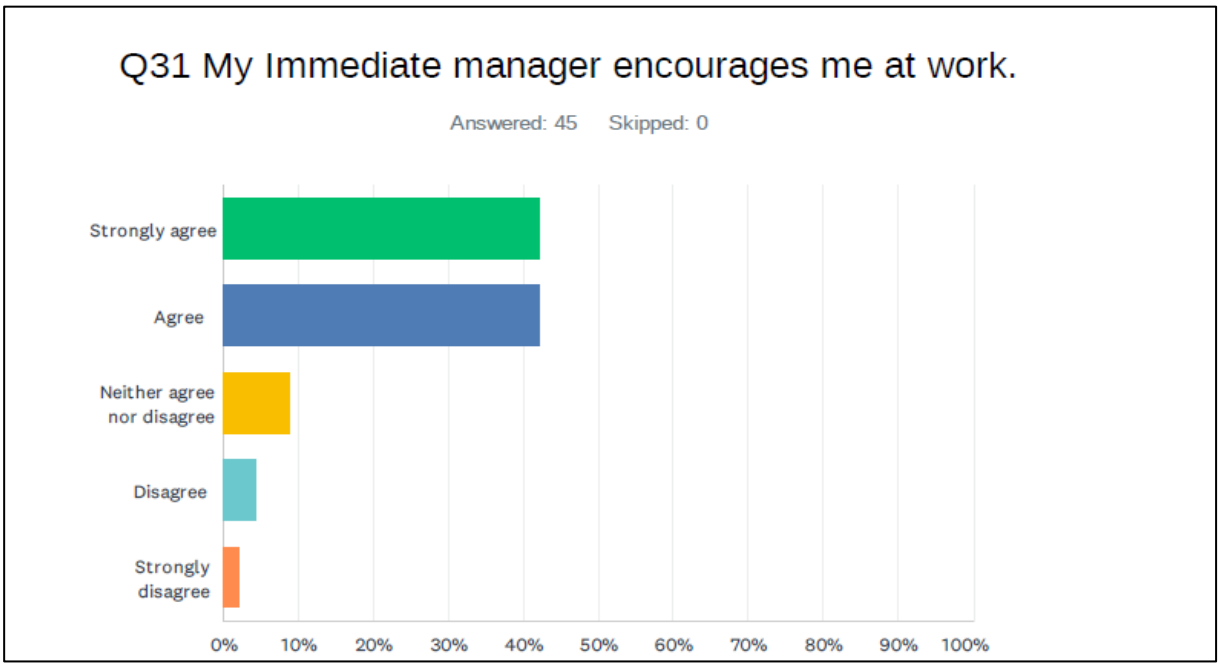


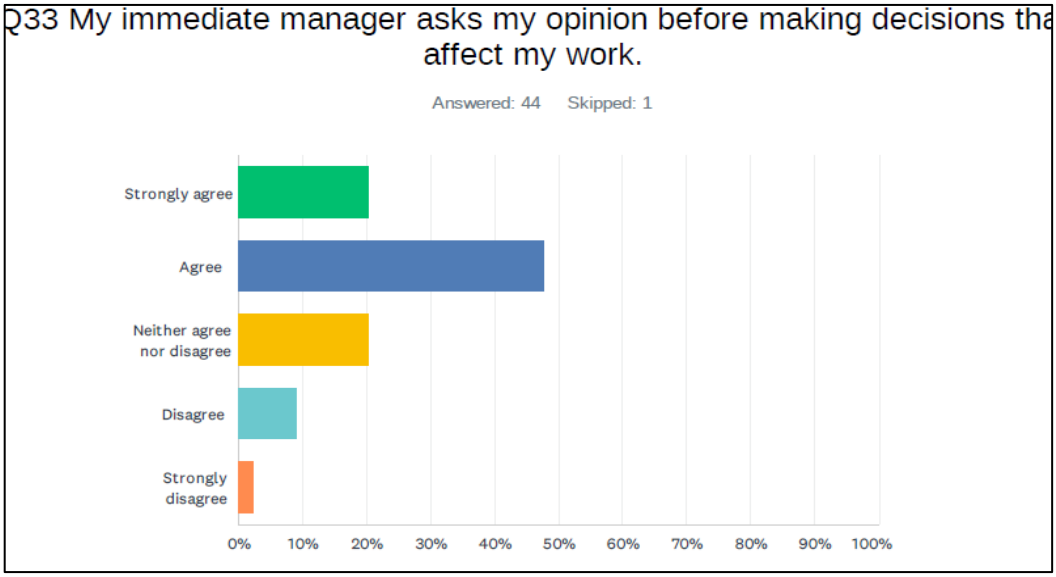


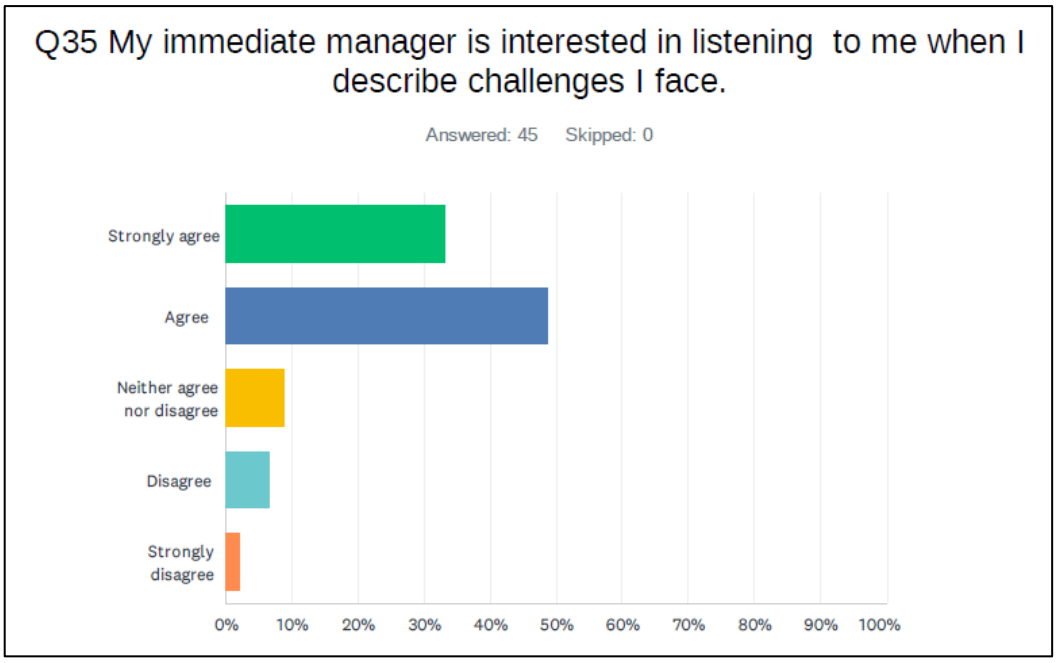


On all three questions, some staff disagreed,that they could meet the demands of their and had enough resources for work.

Empoyee relations – Managers







We are working to maintain effective employee relations with managers. We had an organisational restructure at the beginning of 2024, affecting all departments and reviewing role structures, line management and skill mix. Across all teams, there has been an introduction of middle managers reducing dependency on senior managers. Middle managers are able to react to situations and challenges faced by staff teams as soon as they arise. Middle managers are responsible for supervision, where staff formally have the opportunity to discuss their goals, their learning objectives and any areas they may need to Improve. In addition, staff are encouraged to maintain an active and open dialogue with their line managers at all times, and discuss issues as and when they arise.

Our organisation encourages staff and managers to work together in partnership. We regularly arrange interdepartmental training days, to build and develop a positive working environment and encourage staff to work together and share ideas. This will be measured by mini-surveys across departments which will narrow down our actions going forward.

3.4 Patient Feedback

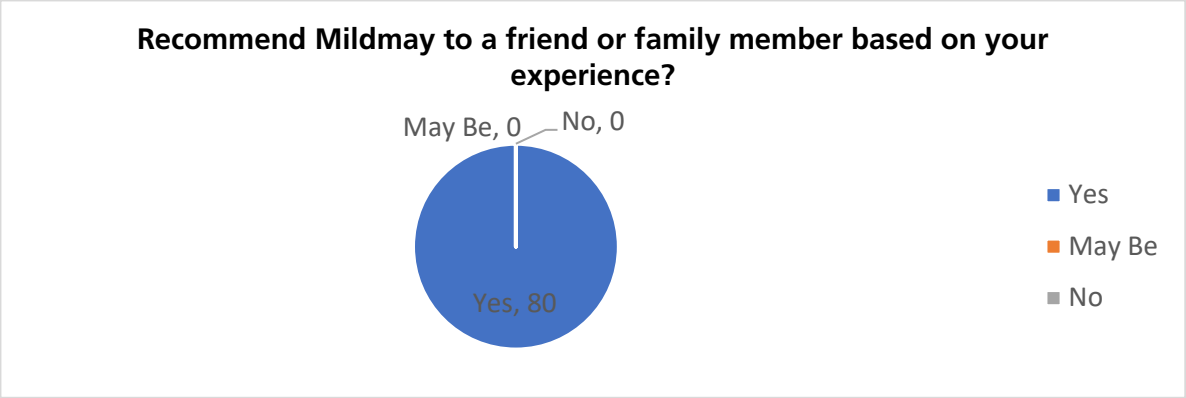
Friends and Family Survey:

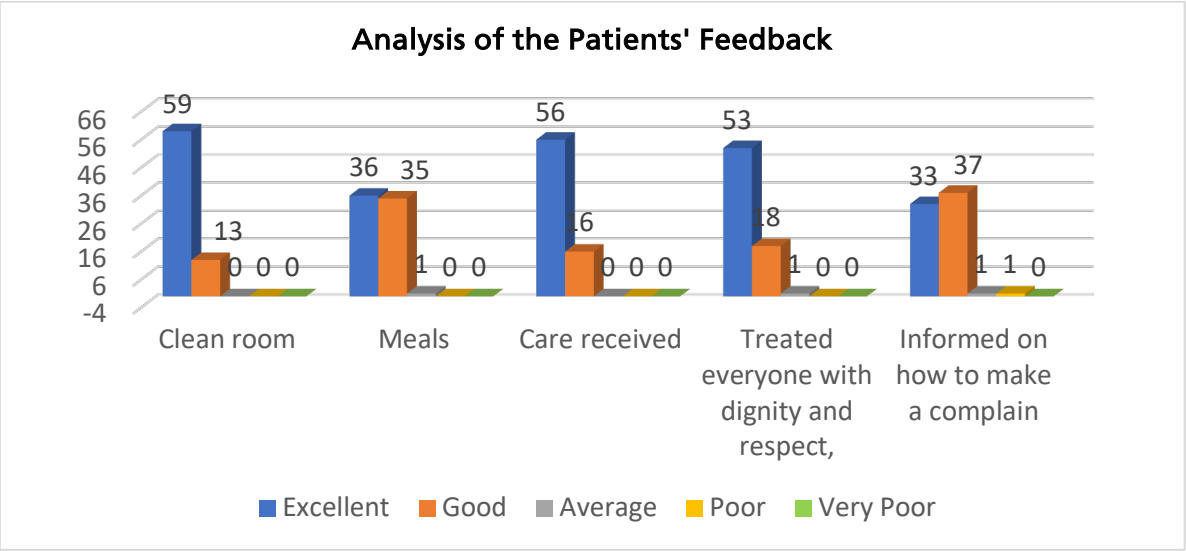
Mildmay places great importance on feedback from people who use our services; patients, referring clinical nurse specialists and other professionals.

In 2023-24, feedback was collected from 80 patients when they were discharged.

On average, we had positive responses (excellent and good) from 97.2% of the patients (excellent and good) and 100% of the patients would happily recommend Mildmay if their friends and family requires the facility.

Based on the analysis of patients feedback, we conducted the the catering survey after volunterring to be a pilot site for new recipies.





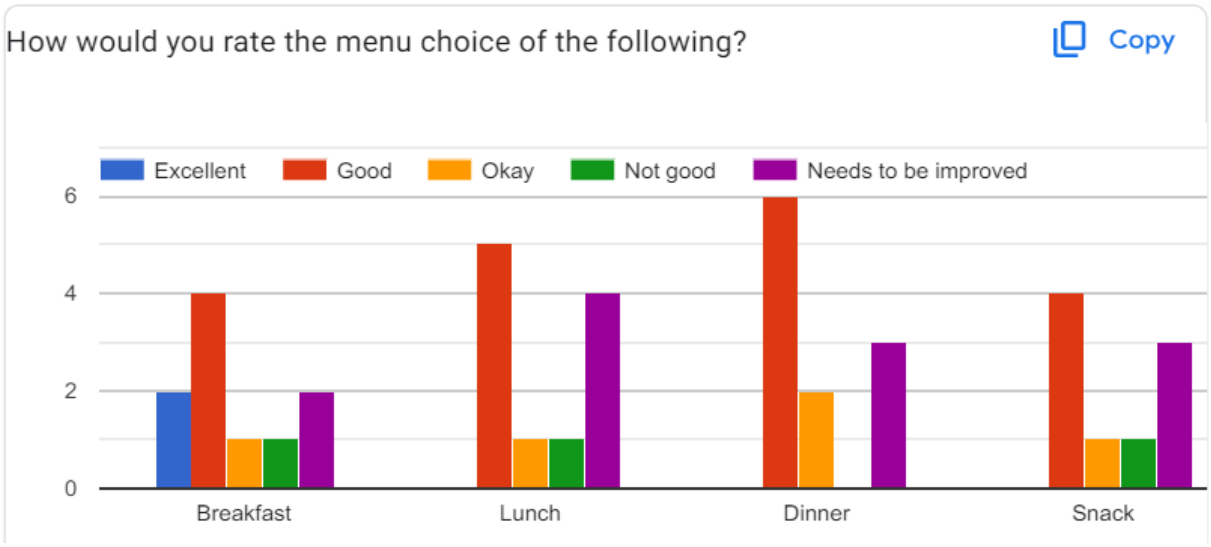
Catering Survey

Mildmay Hospital volunteered to be a pilot site to trial new low carbon emission recipes in the winter hybrid menu; continental style breakfast, cook-fresh lunch model and cook-freeze dinner.

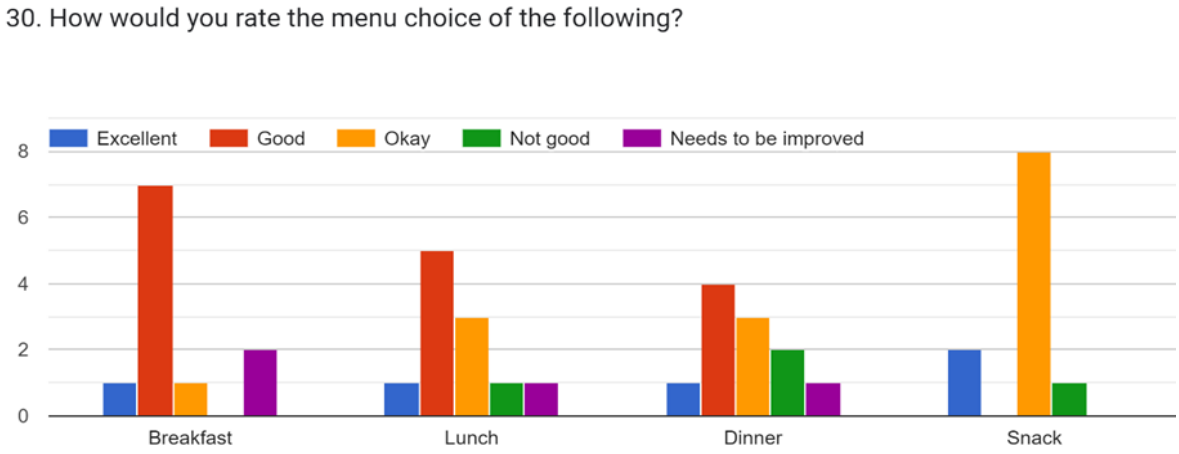
The low carbon emission menu was launched at the end of November 2023 and had more than a 3-week cycle before the first survey results. Final changes were made in February 2024 to the menu after patient feedback, catering skills/equipment, and reflections on food waste. The second survey results reflect this final winter menu.

January and March Results 2024 (Survey with 10-12 participants)

January Survey



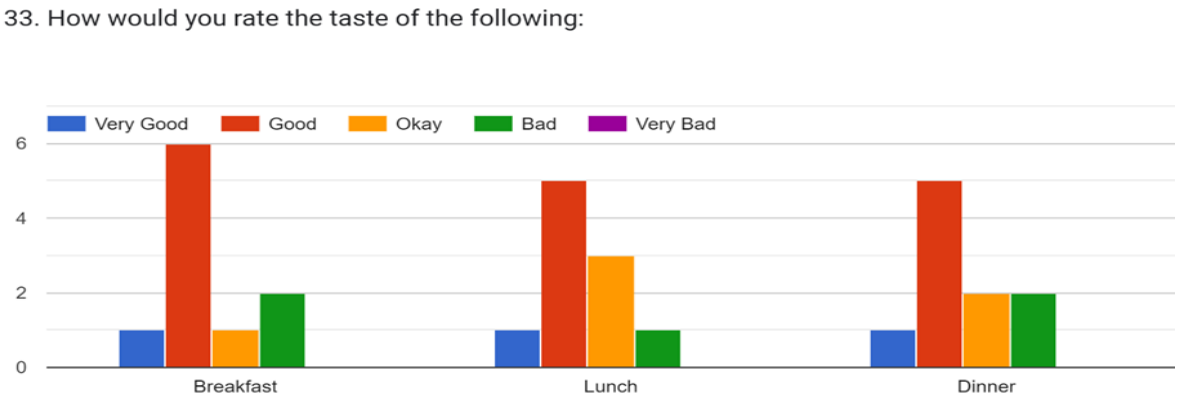
March Survey



Menu choices were improved after the first survey; this was reflected in the March survey. Thirty per cent of menus 'needed to be improved' in the January survey whilst 9% of menus 'needed to be improved' by March.

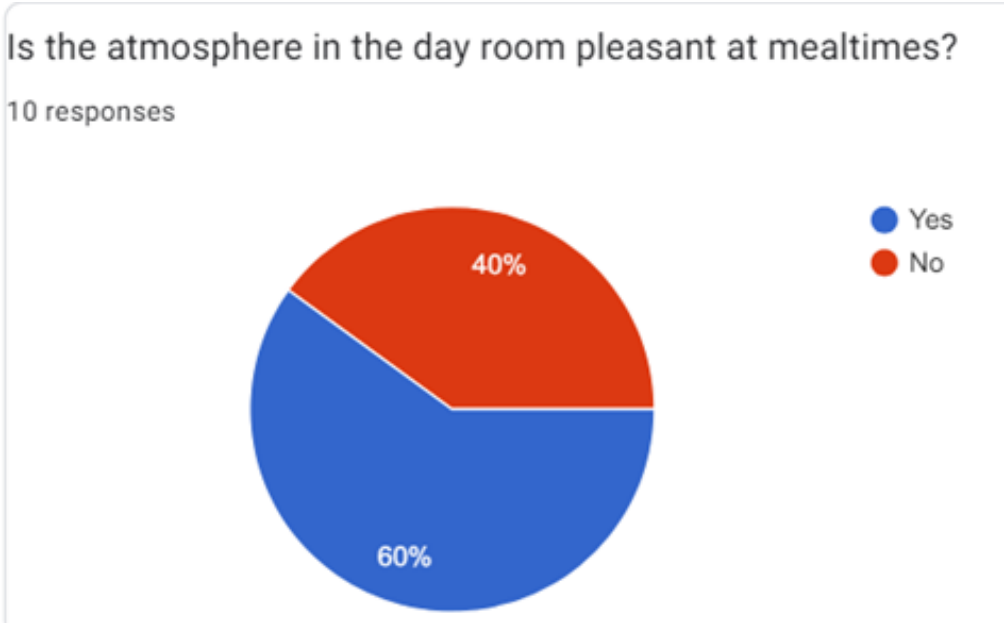
January Survey

March Survey

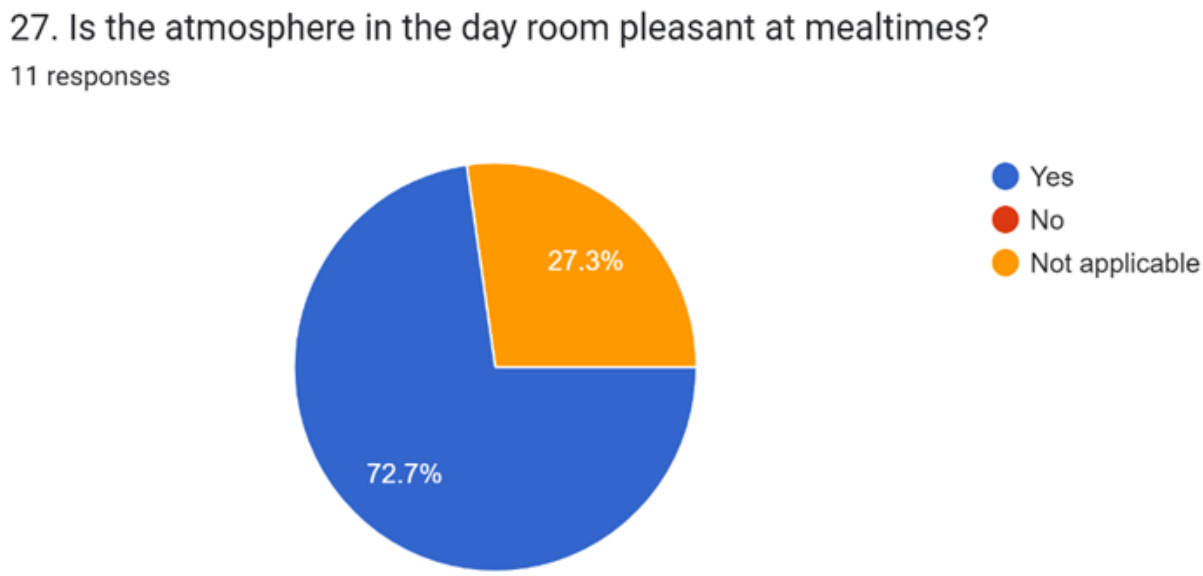


There was not much difference in taste between the January and March surveys; however, no one reported that the food tasted very bad in the March Survey.

January Survey

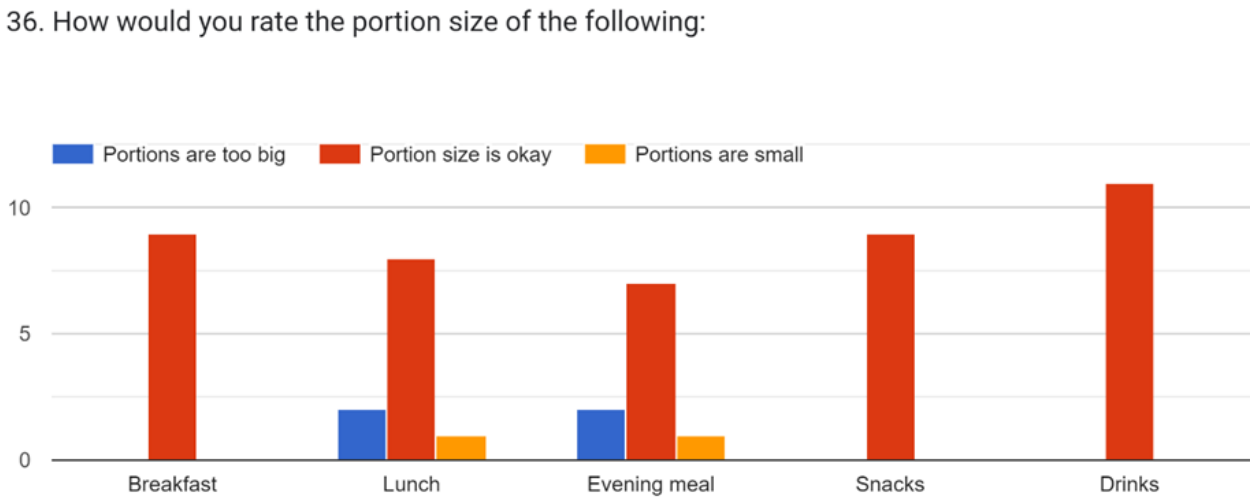


March Survey

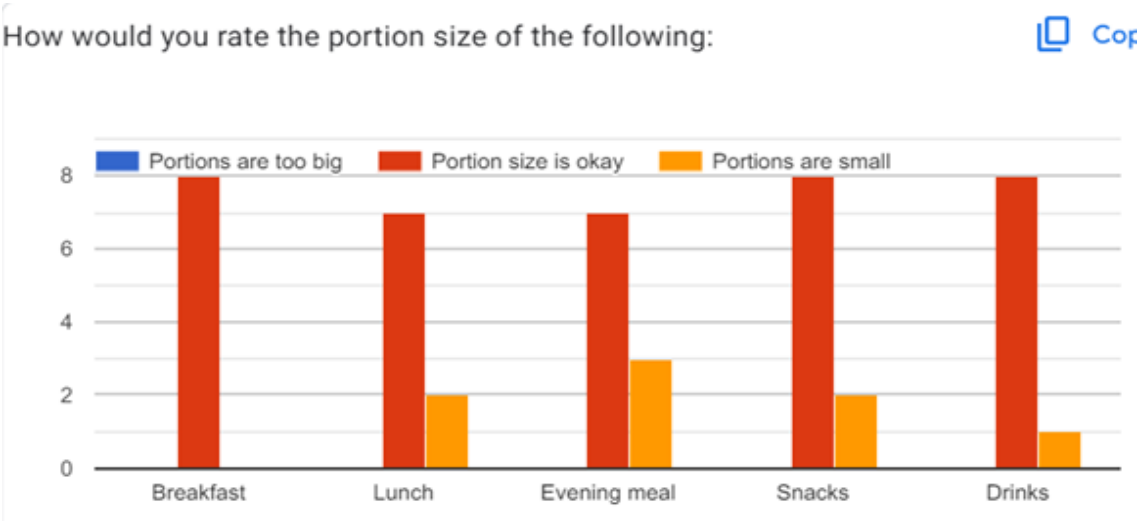


Eating in the day room has improved from 60% to 73%, finding the atmosphere in the room more pleasant. This may reflect the Trauma Informed Group (TIG) work in the day room layout change.

January Survey



March Survey



Some patients reported that food portion sizes were too big in January. By March, all food portion sizes were reported to be okay.

Other findings

Patients wanted more options for breakfast (omelettes, improved egg, beans, mushrooms + more variation), fresh fruit, salads, different meats (lamb, beef, pork, chicken) and more curries at lunch. Patients disliked fish meals, fish in general.

Making more of breakfast at the weekend seems to be of interest to patients and staff advocates.

Long-term patients still want to be offered choices in case they change their minds or fancy something different on the day (if based on food preferences alone).

The survey highlighted that some patients could not follow the food choices on the menu table.

Some patients highlighted that they did not eat specific foods because they did not know if they contained allergens.

Actions for improvement

Ongoing training of staff and catering services to help orientate patients with their food options and choices.

The Speech and Language Therapist and Dietician are compiling a booklet to explain how patients can get their food and what they can have in Mildmay.

Review of when patients select and order their meals (being reviewed at present by the catering steering group with the view to asking for lunch orders on the same day rather than the day before).

Allergens are recorded in an allergens book and communicated to the catering team. This will be extended to all clinical staff. Menus to have allergen information

The introduction of a special/cooked breakfast on a weekend day is being considered for the summer menu.

The new menu introduced colour columns to distinguish the days and help patients follow the menu options per day.

Comments made by patients

- "My stay in this hospital was a memorable one because of your support. I appreciate you all so much."

- "Thank you for the wonderful care you gave to me. I came here very ill but now I am a lot better."

- "I came here very sick, but with excellent doctors and the staff, I am now feeling much better. The nurses are so good; they check up on you all the time with care and help so much."

- "I say all this with great respect for the staff and everything at Mildmay. Wonderful physio/gym and art therapy etc."

3.5 Case Studies

Case Study 1- Detox

Sue was referred for alcohol detox and methadone stabilisation at GSST and then for 12 weeks at Mildmay for further stabilisation and recovery. Her detox started early Feb 2023 at GSST and was then admitted to Mildmay as planned.

While at GSST she had reduced her MTD from 110mgs daily to 100mgs with a view of reducing again if appropriate. She struggled with this reduction and didn't feel able to continue with the reduced dose, so it was assessed to be more beneficial to her to increase it again to 110mg. The rationale was that maintaining abstinence from drug use was the goal and not necessarily detoxing from MTD.

Once her dose had increased again she settled down and reported feeling good. However, during the initial few weeks of her admission, she was in regular contact with a friend who also came to visit her here at Mildmay. After the first two weeks, the agreed external, escorted trips ended. She went out with her friend, and on two occasions she returned to Mildmay after having used heroin. She was given warnings for this as it went against the behaviour agreement that she signed on admission. During this process, she was able to explore what had caused the lapses. She realised that while she was trying to achieve and maintain abstinence from drugs and alcohol, being around a person who was encouraging her to use was likely going to end in being discharged and a full relapse back to daily use would happen. She talked about how building a relationship with her adult children was the main reason for her going through the detox.

She recognised that if she relapsed now, this is not likely to happen as her children have told her they are not willing to invest in her again, only for her to go back to her old lifestyle.

Being supported by the staff at Mildmay she was able to decide to cut ties with this friend and agreed to escorted external trips again for another 2 weeks. This worked well and she was able to settle down again. We agreed that this was a valuable lesson and undergoing this process at Mildmay enabled her to take steps that resulted in her staying in treatment, and working towards her goals.

Also during the initial admission period, her medication was adjusted and changed to allow for her to get better results for her mental health. This was unlikely to have been possible in the community as she needed to be closely monitored for a few weeks.

Towards the end of February, her blood oxygen levels started to drop, which was being monitored by the medical team. She had been diagnosed with COPD. Sue became increasingly drowsy which led to questions about the possibility of her using heroin again. I completed regular urine drug screening to rule this out. This was helpful for both her and Mildmay staff so we could consider other causes quickly. She informed me that she has often been accused of using drugs when in fact she hadn't, so being believed was important to her. This resulted in the development of our therapeutic relationship, which then enabled her to talk about things from her past that she had previously not felt able to.

Sue focussed on her recovery, worked well in 1:1 sessions and attended the Relapse Prevention Group, where she was an active member. She explored her drug-taking history, her thoughts and beliefs regarding her issues with addiction.

At the end of March, her blood oxygen levels were so low that she was admitted to RLH and remained there for 3 weeks. She returned to Mildmay with an NIV (non-invasive ventilation) machine to clear the carbon dioxide from her lungs and was instructed to use it regularly, all night and for some hours during the day. She had also been informed that her COPD was mainly due to smoking drugs and cigarettes from a young age. Sue really did not like to use the NIV machine and only put it on when the nursing staff encouraged her to, so her blood oxygen continued to be low. Over the next few months, she began to realise that she would need to use the machine more often if she wanted any quality of life at all. Even knowing this she still struggled to use the machine as often as required and was not able to stop or reduce smoking cigarettes.

While working with her on her addiction and her health, her external teams were working on where they would place her after discharge. They had originally planned for her to be housed in her flat, living independently. However, this plan needed to change as her need for support had increased. Her teams are now looking at placing her in supported living. This had initially been rejected by her as she felt she had 'earned' the right to have her own front door, after living in hostels for the last 10-plus years. It took some time working with her to be open to the idea that she would need help to do day-to-day tasks. She realised that being on her own would be very difficult, and potentially very lonely as she would not be able to get out much. Working with the external teams every week, we are now looking at her options. The Care Act assessment, CHC checklist and DST form have been completed here at Mildmay which will inform the external housing and social care team of her needs, to house her appropriately.

During the uncertainty and stress of not knowing where Sue would be discharged, she went through a period of smoking crack when she was out of the hospital. Her behaviour was appropriate on her return and was not obviously intoxicated, but she had started borrowing money/cigarettes from other patients. This was soon identified and stopped. All patients are advised that lending and borrowing is not permitted and is now closely monitored. Repaying her debts has been helpful for her and enabled her to get back on track with her recovery. She has acknowledged that recovery has not been easy for her but she continues to explore and learn new skills that she could put into practice after she is discharged.

Case Study 2- Homeless

The patient was a Nigerian National who came to the UK on a student visa in 2012. CN applied for settlement on 20 Mar 2013, but his application was rejected. Unknown to the patient, he did not know the reason(s) why. He was previously homeless, sleeping on buses in London and the Brent area. He also lived in Croydon, working cash in hand as a gardener. He has three siblings living in Nigeria but no contact.

MEDICAL SUMMARY:

CN was admitted to the Mildmay with the following medical issues.

Newly Diagnosed HIV

Right cerebellar subacute infract

Low mood and

Leg pain

IMMIGRATION SUMMARY AND SUPPORT:

He previously made an application to the Home Office, but this was rejected, and he did not know for what reason(s). He was admitted to the Mildmay on 29/3/2022 on the homeless pathway. However, during his housing assessment, it was later established he had limited options due to non-status and was referred to Hackney Migrant Centre for immigration advice. He was given a few appointments to discuss his immigration issues and health to establish what support could be offered to him. A subject of access request was also made to the Home Office, but as advised, could take some time. The Hackney Migrant Centre had to wait about 2 months before his file was received.

The Hackney Migrant Centre was also looking at legal representatives to support CN in making an Article 3 application to the Home Office, after receiving information from Islington Law, based on his mental and physical health, that he does have grounds to make an application.

SOCIAL WORK INVOLVEMENT:

CN was initially assessed by Mildmay to establish whether he had a case to be referred to Brent for a Care Act assessment to be done. He was very guarded with his information and extremely isolated. He was referred to Brent Social Services for a Care Act Assessment to be completed, based on his mental and physical health. However, Brent had advised that CN did not have any care and support needs but gave no feedback to the patient on the outcome. A complaint was made to Brent Social Services to request for a letter to be sent to the patient, but no response was received. Brent Social Services also established that his main last address was not in Brent, therefore CN was not an ordinary resident and had no local connection.

The patient was also offered VRS (voluntary return service) to Nigeria, but the patient declined the offer.

Research was also done to see whether if he returned to Nigeria, he could be provided with HIV care, which was found to be free, but this would depend on other factors, such as his resettlement after so long, stigmatisation, employment and self-management.

HOUSING SUPPORT:

During his time at the Mildmay, the patient was referred to several external agencies who work with people with no recourse, refugees and migrants. However, because his initial application to the Home Office was rejected, some were unable to offer any support and advised him to seek immigration advice. Other services only provided support, but no accommodation. There were also others, who were unable to accept, as he was not eligible for the service.

The patient was spoken to on a few occasions, about VRS and his very limited options in finding accommodation. He was also advised to think about friends he may be able to stay with.

Night shelters were also contacted, but they were not yet available due to the time of year. The Passage in Victoria was also contacted to discuss his situation and whether they were able to assist, but unfortunately, they could not.

DISCHARGE PLANNING:

- Due to the length of time at Mildmay, discharge planning meetings were held with Hackney Migrant Centre, SW and Housing, to establish what other practical solutions we could come up with to support the patient, as he had been referred to several services.
- It was established that due to very limited options, that the Hackney Migrant Centre would look at sourcing hosting schemes and referral to Hackney Night Shelter.
- MDT report was also provided to the Hackney Migrant Centre, to provide clarity on the patient's physical and mental health.
- The Housing worker will continue to look at other services, not already researched.
- Continuing discussions with the patient about his discharge and for him to revisit the options that were offered to him
- To encourage to get out and about due to long spells of isolation.

Case Study 3- HIV

Background

Mr P is a 33-year-old single male, originally born in Northern Spain. He was initially admitted to an Acute Trust in February due to significant leg weakness, which caused difficulty in walking and then transferred to an inpatient Mental Health Unit in March until his admission to Mildmay. Mr P had a severe depressive episode, during which he attempted suicide by hanging. He was diagnosed with HIV in Nov 2018, has been adherent to medication and tries to be mindful of his overall health. Community Health Teams had supported him previously.

At the time of admission to the Mildmay, he no longer experienced suicidal thoughts. However, he was still anxious and had been dealing with ongoing mobility problems for the past 2 years, including tingling sensations below the knees which made him depressed.His mood improved during his admission, with no self-harm thoughts, intent, or plan. Although there were still ongoing mobility issues, he received regular physiotherapy input in addition to input from the multi-disciplinary team.

Physiotherapy

Range of Movement and Strength: Full functional strength and range of motion in the upper limbs bilaterally. For lower limbs, see table below:

LOWER LIMBS	L		R		Assessment Position: Supine		
Range of Movement	Active	Passive	Active	Passive	Strength/5	L	R
Hip Flex 0-140	140	140	140	140	Hip Flex	5	4
Hip Abd 0-30	10	15(tone)	10	15(tone)	Hip Abd	5	4
Hip Ext 0-15					Hip Ext	5	4
Hip IR 0-40	30	30	30	30	Hip IR	5	4
Hip ER 0-45	30	30	30	30	Hip ER	5	4
Knee Ext 0-10	0	0	0	0	Knee Ext	5	4
Knee Flex 0-150	150	150	150	150	Knee Flex	5	4
Ankle DF 0-30	0	0	0	0	Ankle DF	3	2
Ankle PF 0-50	50	50	50	50	Ankle PF	4	4

Ankle Inv 0-30	30	30	30	30	Ankle Inv	2	2
Ankle Ev 0-20	20	20	20	20	Ankle Ev	2	2
Comments: • At rest ankles fall into full inversion. • High medial arches bilateral lower limbs • Big toes flexed at metatarsal-phalangeal joint and extended at interphalangeal joints. Prominent extensor hallucis longus tendon							

Tone: Only lower limbs were assessed as he denied any issues with upper limbs

Increased tone (MAS) bilaterally in:

- Hip flexors MAS 1
- Hip add MAS 3
- Quads MAS 2
- Hamstrings MAS 2
- Gastroc MAS 2

On right lower limb, noted flexor spasms (mild hip and knee flexion) during sensory testing

Pain: No pain reported

Sensation & Proprioception: Reports numbness below knees bilaterally. Able to localise to light touch bilaterally on all lower limb areas expect for toes.

Distal interphalangeal joint (DIP) proprioception impaired bilaterally in the lower limb. Ankle proprioception intact but due to tone, he requires a lot of handling to move the ankle

Coordination: No abnormalities detected during the heel-shin task bilaterally

Functional Activities:

Bed Mobility: Independent, unaided

Transfers (bed, chair, toilet): Independent step-transfer with elbow crutch

Sitting Balance: Independent, unaided

Standing Balance: Able to stand for approximately 30s unaided. Scored 15/28 on the Mini—BESTest showing significant high level balance impairments.

Mobility: Mobilises indoors and outdoors with elbow crutch on the right side. Gait: clears bilat lower limbs during swing phase, attains lower limb extension during stance phase bilaterally. Shifts weight well. Main issue is reduced dorsiflexion during terminal swing resulting in forefoot initial contact in early stance phase.

Falls: Reports that he has had a number of falls over the last year. Reports that his mobility has improved in the last few weeks and is not falling as frequently. Last fall was 1 month ago - lost balance when turning round. No falls since admission to Mildmay

Exercise Tolerance: Able to tolerate hour-long physio sessions. He was able to walk 225m on the 6-minute walk test.

Stairs: Able to ascend and descend 3 flights of stairs with 1 rail. Reciprocal stepping.

Progress with Physiotherapy:

He worked on balance rehab as he showed clear impairments, particularly in anticipatory & reactive postural control domains of the Mini-BESTest. He was independently mobilising with one elbow crutch. He had increased tone in bilateral lower limbs was treated with Baclofen and also has reduced sensation and proprioception in his lower limbs. He has been referred to FES clinic to aid with his gait rehab. He would also benefit from neuro outpatient physiotherapy to work on his range of movement and progressing his mobility and we will refer him for this.

Psychology

Mr P commenced a psychological assessment whilst at the Mildmay; he has expressed a clear interest in seeing a psychologist, the assessment aimed to develop a joint formulation, provide initial recommendations and identify the next steps regarding psychological support post-discharge.

He regularly attended the Mindfulness Group. Additionally, he had several sessions with the Clinical Psychologist working together within an Acceptance & Commitment Therapy model. The work has included introducing Mr P to concepts such as the Choice Point and he has worked on identifying his 'Towards' and 'Away' moves and identifying Values to focus on values-based action. Additionally, he worked on grounding techniques such as Dropping Anchor. He has been proactive in this work and purchased his own copy of The Happiness Trap by Russ Harris to guide his development. A safety plan was also developed with him to support him in the early stages of discharge, which he anticipated would be challenging for him (He has a copy of this plan).

Nursing

On admission, medication was administered on DOT and the patient adhered to all medications. He progressed well and after assessment, he started self-medication from packets without issues. Mr P was discharged with no nursing needs.

Social Work

Mr. P has engaged in an initial social care assessment; a referral will be made for further assessment once he has been transferred into the community. Mr P has low-level care needs. A referral has been made to the housing officer at Mildmay for support with resettlement in the community.

Housing Officer

Working with Lambeth council to source temporary accommodation, a ground floor flat was sourced in Thornton Heath, which is furnished. The patient was discharged to this accommodation.

The patient was discharged safely to his allocated TA. On discharge, a referral was made for psychological therapy to support Mr P in his ongoing recovery. He was also referred for neuro outpatient physiotherapy to work on his range of movement and progress with his mobility.

Case Study 4- HIV

WC is a 49-year-old man. Premorbidly, he was living alone in a house and was in full-time employment as a civil engineer until March 2020. He is separated from his former partner with whom he has two children. He had been looking after them several nights a week and on weekends. He had no known health conditions.

Events leading to admission

WC first presented to an acute centre in April 2020 with rapid functional decline and worsening confusion. His symptoms started in December 2019 with gait abnormalities, followed by reading difficulties and speech impairment. On admission to an acute hospital, he had severely reduced mobility to the point of being bed-bound, cognitive impairment with mutism and severe oropharyngeal dysphagia with minimal oral intake. He was diagnosed with HIV, and an MRI revealed changes consistent with HIV encephalopathy.

During this hospitalisation, ARVs were started and a PEG (Percutaneous Endoscopic Gastrostomy) tube was inserted. As his oral intake improved, the PEG was never used. He was then transferred to a neurorehabilitation unit. Unfortunately, his cognition declined further and he exhibited acute psychotic symptoms and agitation and was transferred back to an acute hospital where he was treated for encephalitis. It was discussed with the infectious disease consultant at the time and this was thought to be a progression of HIV encephalopathy. He was started on anti-psychotics (first Olanzapine which didn't seem to be effective, then Risperidone). During this admission, WC tested positive for COVID-19 on 22 June and suffered from a Staphylococcus aureus infection of the PEG site treated with IV antibiotics. He was admitted to Mildmay Hospital on 07/08/2020 for ongoing monitoring of psychotic symptoms and physical and cognitive rehabilitation.

Progress at Mildmay

Psychiatry

On admission at Mildmay, WC exhibited grandiose delusions, impaired orientation and cognition as well as impaired insight. He was originally on Risperidone 2mg OM 3mg ON, as well as Clonazepam 500mcg TDS. Sodium Valproate was introduced at the beginning of the admission as a mood stabiliser and Clonazepam was stopped.

Unfortunately, after an initial period of improvement, WC developed extrapyramidal side effects with Risperidone, with overall increased tone and shuffling gait. On the advice of our consultant psychiatrist, Risperidone was progressively changed to Olanzapine.

During the switch, WC deteriorated and became bed-bound and aggressive for a couple of weeks, as well as continuously shouting unintelligibly. We ruled out an infectious origin/delirium with a normal urine dip and blood results at baseline. Due to this challenging behaviour, benzodiazepines were re-introduced. Once the titration of Olanzapine was completed, his psychiatric symptoms improved slowly. Sodium Valproate was increased to 500mg ON and 1.5g ON. He is now fully oriented, however still lacks insight into past, present and potential future needs and abilities as some of the grandiose delusions persist.

Nutrition

On arrival, WC had a PEG-J in situ. As his oral intake was meeting his needs, this was deemed superfluous. Extensive efforts were required from the junior medical staff to organise the removal of the PEG-J as this requires an endoscopy procedure to be performed.

As he gained weight throughout the admission, he progressed from a high-energy nutrient-dense diet to a healthy eating diet, and no longer required oral nutrition supplements to meet his needs.

Mobility

On admission, WC was able to mobilise a few steps with the assistance of 1.. During the adjustment of his medication, his mobility deteriorated to the point of not mobilising at all and needing assistance of 2 with chair and bed transfers. He was unable to follow verbal commands and needed a physical demonstration.

Thanks to the improvement of his mental state and ongoing physiotherapy, he is now independent and able to walk > 100 metres without assistance as well as mobilising on the stairs.

Activities of daily living

WC was doubly incontinent on admission and needed full assistance for washing and dressing. He is now continent and fully independent to wash and dress. He continues to have needs at key activity points such as meal preparation and domestic routines.

Discharge planning

WC has much improved in all of the areas described above, however, discharge planning has been extremely challenging due to rapidly changing presentation and needs. The medical team and the MDT had to complete two CHC checklists and forms to correctly assess his needs, as well as constantly liaise with the family to take into account their concerns and expectations. This was a key element of our care and required the extensive experience and expertise of the entire MDT to risk-assess and discharge WC safely and appropriately.

Mildmay Mission Hospital Commissioner's Statement for 2023/24 Quality Account

NHS
North East London

Commissioner's Statement for Mildmay 2023/24 Quality Account

NHS North East London Integrated Commissioning Board is responsible for commissioning health services from Mildmay on behalf of the population of east London.

Thank you for asking us to provide a statement on your 2023/24 Quality Account and priorities for 2024/25.

We welcome Mildmay's intention to develop at least two new inpatient step-down services for local acute Trusts. This work builds on previous quality improvement activity and on important work Mildmay has put into gathering patient and staff feedback to both improve the quality of services and ensure Mildmay provides a positive place to work. We note patient and staff feedback is positive.

We are pleased to see that Mildmay implemented the new NHS Patient Safety Incident Response Framework (PSIRF) in November 2023 and we welcome collaboration to develop PSIRF across the ICB as a new system that will take time to embed and fully develop. We suggest that ethnic recording of people who experience a patient safety event needs further development to enable staff to accurately record ethnicity, rather than nationality, for such patients.

We very much welcome the focus on training staff on trauma-informed care to address behavioral issues and we hope this will enable staff to better manage challenging behavior and feel confident in doing so.

We are grateful to Mildmay for the continued commitment to collaboration and partnership working despite the difficult financial and contractual situation the organisation has faced. We look forward to working together to support and develop our North East London Integrated Care System.

We confirm that we have reviewed the information contained within the Account, and checked this against data sources where these are available to us, and it is accurate.

Overall, we welcome the 2023/24 quality account and look forward to working in partnership with Mildmay over the next year.

Zina Etheridge
Chief Executive Officer
North East London Integrated Care Board

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Annexes

1: Supporting statements

In compliance with the regulations, Mildmay sent copies of our Quality Account to the following stakeholders for comment prior to publication.

- The lead commissioners, commissioners and CNS
- Health Watch
- Mildmay Trust

2: Statement of directors' responsibilities for the quality report

Statement from Geoff Coleman (CEO) and Dr Simon Rackstraw (Medical Director) of Mildmay Mission Hospital is in Part 1 of this report

3: Management Team:

Geoff Coleman
Chief Executive Officer

Dr. Simon Rackstraw
Medical Director

Justine Iwala
Head of Human Resources

Norma Martin
Head of Finance

Teri Milewska
Matron and Registered & Compliance Manager

Miklos Kiss
Fundraising and Communications Manager

Patricia Nkansah-Asamoah
Admissions Manager

Dr Twinkle Shah
Health Analyst and Senior Information Officer

Mildmay began as a charitable institution over 160 years ago.

It has specialised in HIV since the 1980s and continues to deliver quality care and treatment, prevention work, rehabilitation, training, education and health strengthening in the UK and East Africa.

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MILDMAY
Transforming Lives

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