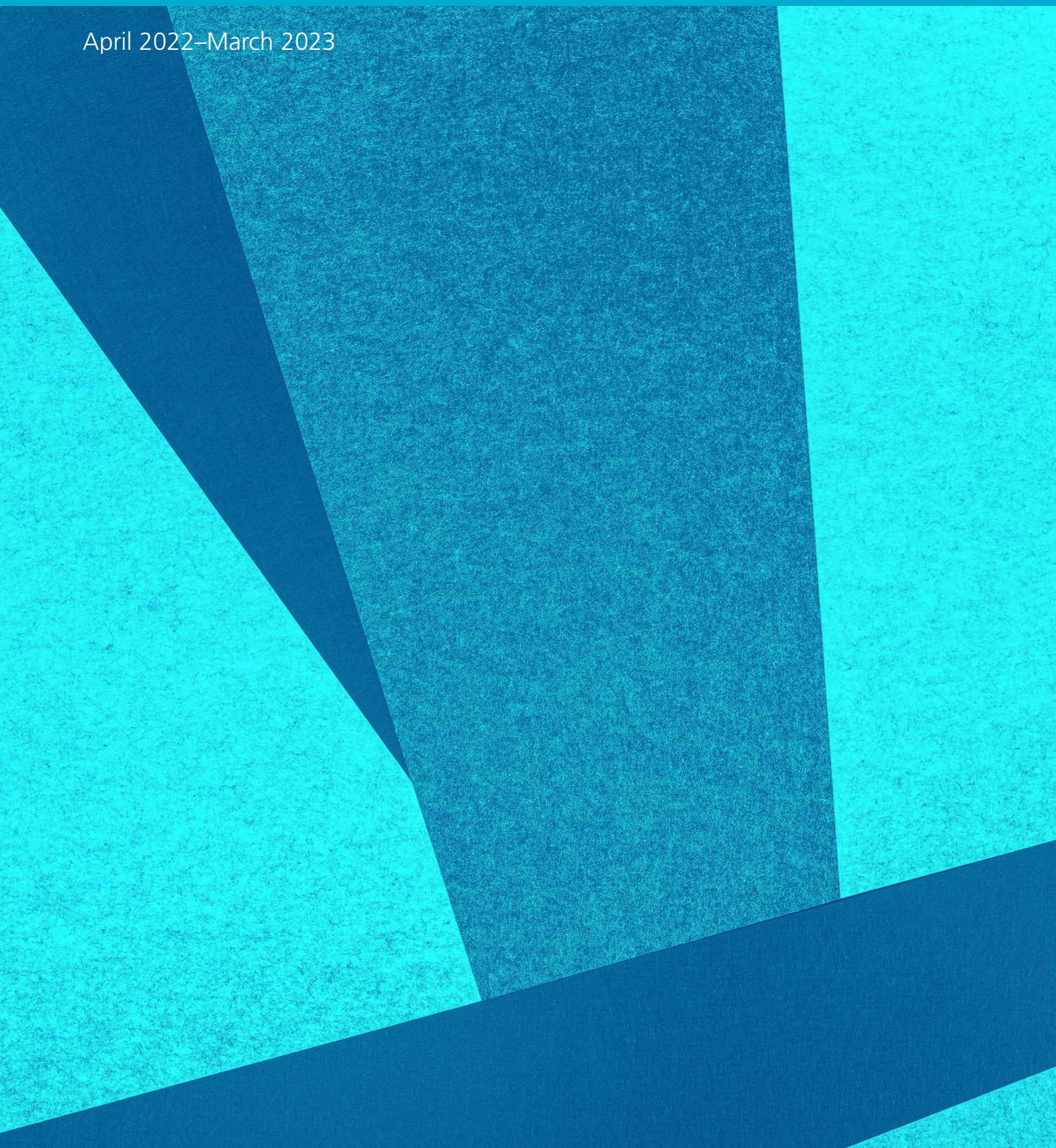
Mildmay Mission Hospital

Annual Quality Account

April 2022–March 2023



MILDMAY

Transforming Lives

Cover image: Scott Webb

Mildmay Mission Hospital

Annual Quality Account

April 2022–March 2023

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PART 1

1.1 Introduction:

A Quality Account is a report about the quality of services offered by a healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. As an organisation that provides healthcare commissioned by NHS England and/or Clinical Commissioning Groups (CCGs), Mildmay is required to publish and annual Quality Account.

The Quality Account is an important way for Mildmay to report on quality and show improvements in the services we deliver to local communities and stakeholders. The quality of the services is measured in the following document by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

Mildmay Mission Hospital
Registered office:
19, Tabernacle Gardens
London E2 7DZ

Company No: 1921087
Charity No: 292058

1.2 Chief Executive Officer's Statement:

Geoff Coleman, MIHM DMS MA MBA
CEO, Mildmay Mission Hospital

On behalf of the Board of Trustees and the Executive Team, I am proud to present the 2022-2023 Quality Account for Mildmay Mission Hospital. This account looks at our progress and achievements across the 2022-2023 financial year and looks forward to some of our key priorities for patients in 2023 - 2024.

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 detox. 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.

At the beginning of 2022, the Charity was beginning to look at a world beyond the Coronavirus pandemic. Whilst there were still restrictions in place the hospital was transitioning into something close to normal operations. That said, there were significant challenges in the form of rising costs for energy and food, and as the income of the hospital for all of the pathways was fixed, this culminated in a significant deficit for the financial year.

In spite of the challenges, the hospital demonstrated that patient care could be maintained amidst significantly higher inpatient admission rates than ever seen before and patient outcomes remained good. Staffing, whilst continuing to be challenging, never adversely impacted services, and whilst most of the NHS continued to see significant vacancies, Mildmay seemed to be solving the nurse recruitment problems seen over recent years.

As we look to the future and the opening of a new fourth pathway, I am immensely proud of the Mildmay team.

Geoff Coleman MIHM DMS MA MBA
Chief Executive Officer

1.3 Statement on service quality at Mildmay

Patients are referred for care to 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 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 to 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 neurorehabilitation, and through this, we can demonstrate the clinical effectiveness of our interventions and the cost-effectiveness of our service. We have contributed data to the formal audit to of the other two pathways demonstrating their clinical effectiveness.

We seek feedback continuously 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, the safety of patients, visitors and staff, and the physical environment all remain our focus in providing care.

Based on the above statement, I believe Mildmay provides and maintains a high-quality service.

Dr Simon Rackstraw
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 workers, 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 roots as a faith-based charity. These values, enriched and shared by many people, including those 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.
- Development and encouragement of people to their full potential.
- Mildmay places the individual at the very heart of its planning, services and actions.
- Good stewardship of resources.

Our Faith:

Mildmay's mission is to reach out to those in greatest need, providing care, love and compassion to the sick and vulnerable. It was set up as a Christian medical mission in response to the cholera epidemic in 1860s London. Mildmay's faith and a strong sense of mission to educate, share knowledge and care for those in greatest need continue to underpin our work.

Our Chaplains:

In keeping with Mildmay Mission Hospital's vision, *"To transform and empower lives through the delivery of quality health services, treatment and care in the UK and Africa,"* the main focus of the chaplaincy team is to offer appropriate religious, spiritual, pastoral, ethical and emotional support to patients, staff, volunteers, and visitors including partners, family and friends. We aim to deliver

services of the highest quality and constantly seek to improve through listening, reflecting, learning and action.

Whilst our hospital's foundation is Christian, we go to great lengths to ensure that we welcome and cater for the needs of persons of all faiths and none. In short, the chaplaincy presence touches all aspects of life at Mildmay, as the spiritual well-being of all individuals is our concern. Our approach is inclusive, ensuring we enjoy key working relationships with all at Mildmay, based on the belief that persons are spiritual though not specifically religious. Networking with faith-based HIV and other relevant organisations, where appropriate, forms helpful links to the chaplaincy and Mildmay.

Registration Details:

Mildmay 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 care for adults with complex physical, cognitive and psychosocial difficulties. We aim to provide positive opportunities to promote independence, build confidence and strengthen abilities. Mildmay offers multidisciplinary assessment and rehabilitation services delivered on an inpatient basis, depending on the needs of the person. 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. Mildmay provides a crucial service within a tough economic climate by providing a cost-effective service for persons living with HIV who have complex health needs.

There are three pathways and the aims for each pathway for Inpatient referrals are:

Pathway One: HIV Neuro-Cognitive Impairment (HNCI), Complex Physical Care, Respite and End of Life Care

AIMS:

- To maximise the independence of people living with complex HIV-related conditions and to provide assessment and multidisciplinary rehabilitative care to support patients to achieve their maximum potential and regain their independence.
- To provide an admission period to support patients who require regular medical and nursing support before returning to independent living
- To provide patients with adherence support
- To support patients with symptom control, stabilisation and/or psychological support.
- To prevent acute hospital admission
- To maintain the ability of patients to live as independently as possible with long-term minimal community support if required.
- To provide expert symptom management, advice, and spiritual, emotional and psychological support to patients who require end-of-life care and their families, friends and carers.
- To provide support after death to families, friends and carers.

Pathway Two: Homeless Specialist Step-Down Care

AIMS

- This specialist medical respite aims to meet the needs of homeless people, prioritising those with complex needs and tri-morbidity, i.e. physical ill-health or injury complicated by a history of mental illness and problems related to substance misuse and possibly COVID-19.
- Patients will be sufficiently recovered to no longer need high-cost acute medical or surgical hospital care but still need a further period of convalescence and community care planning before a safe hospital discharge can be achieved.
- To deliver better care and health outcomes for homeless patients.
- To make more efficient use of available health resources.

Pathway Three: Stabilisation-Based Intermediate Residential Rehabilitation

AIMS

- Pan London contract commissioned by the City of London to support patients who sleep rough, are in hostel accommodation or are at risk of returning to the streets
- Patients are referred to Mildmay as part of the Pan London Substance Misuse Programme pathway of care
- Mildmay works in collaboration with external inpatient detox and community substance misuse care providers, providing ongoing stabilisation, symptom control and ongoing support to patients have recently completed their inpatient Detox
- A multidisciplinary approach providing individualised, person-centred support including group therapy, 1:1 care, rehabilitation, medical, nursing and therapy support

PART 2

2.1 Looking Back: Priorities for Improvement 2022/23

Priority: Sustainability

The challenge for this financial year, as with the previous two, was the lack of long-term NHS contracts. The longest contract is currently eighteen months with the largest of our inpatient contracts being under twelve months. This makes any long-term planning challenging to say the least, and so the priority for this year and looking forward must be sustainability, the capacity to endure and having the potential for long-term maintenance of relevance and viability. To this end, we had several targets:

- To agree on a new strategic plan for the next three to five years
- 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 or transfer to a Pan-London contract if possible.
    - Growing the number of referrals from hospitals across London and the UK.
- To build on the initial successes of the new intermediate care service for homeless patients stepped down from NHS Acute hospitals across London by
    - Continually improving patient outcomes
        - Improve turnaround for inpatient room availability, bringing patients in faster
        - Increased the number of inpatient rooms by two to help bring down the waiting list
        - Appointed Drug and Alcohol Recovery Worker to improve outcomes for patients across all three pathways and assist quicker and more sustained recovery
    - Continually improving the discharge process for patients in terms of both quality and destination
        - Identifying discharge pathways continues to be challenging, however, successes in the identification of specific Local Authority officers have resulted in improvements
- To establish the third pathway, ensuring that it is successful and becomes a part of the hospital's long-term services offering. We achieved this by:
    - Continuing to work with other stakeholders in both the HIV and Homeless sectors to develop the new step-down detox service for homeless patients discharged from Guys and St Thomas'.
    - Continue to collect, analyse and share the results for all aspects of service provision in order that we can continually improve the services that we provide.

- To continue to develop our electronic patient record system (EPR) to meet the needs of our patients better and demonstrate the outcomes that the hospital can achieve.
    - Introduce EMIS to replace the existing PAS System and in-house EPR developed over the past two years.
    - Connect services to NHS Summary Care Record
    - Connect to Royal London Path Labs Service.

2.2 Looking Forward: Priorities for Improvement 2023/24

Priority: Sustainability

The 2023-24 financial year is 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 and a New 3-5 Year Strategic Plan:

- To further develop the new Strategic Plan developed in the last financial year for Mildmay both in the UK and internationally.
- To develop and implement the first Business Plan focussed on achieving the charity's new strategic objectives.
- 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.
    - Growing the number of referrals from hospitals across London and the UK by making referring hospitals aware of this service
- To continue to build on the successes of the new intermediate care service for homeless patients stepped down from NHS Acute hospitals across London by
    - Continually improving patient outcomes
        - Introduce anti-ligature rooms for high-risk patients
        - Develop wound care capability amongst the nursing team
        - Develop trauma-informed care amongst the whole team
    - Continually improving the discharge process for patients in terms of both quality and destination (we will focus on length of stay and lessons learnt from failed discharges)
        - Recruit a second nursing team lead to focus on discharge planning
        - Work with Pathways to develop greater legal support for patients who are NRPF
        - Build on relationships with key Local Authority contracts to eradicate failed discharge events

        - Review MDT to identify if other professionals are needed to speed rehabilitation and reablement time
- To build on the newly established third pathway, ensuring that it is successful and becomes a part of the hospital's long-term services offering. We will do this by:
    - Continuing to develop a long-term relationship with the City of London commissioners.
    - Continue to collect, analyse and share the results for all aspects of service provision in order that we can continually improve the services that we provide.
    - Introduce anti-ligature rooms for high-risk patients
- To establish a fourth pathway that will help to ensure the long-term stability of the charity.
- To continue to develop our electronic patient record system (EPR) to meet the needs of our patients better and demonstrate the outcomes that the hospital can achieve.
    - Manage greater audit capability and risk assessment tools

The biggest challenge, once again, is the sustainability of the hospital. Without long-term contracts, it is challenging to plan beyond the length of the longest contract, which is currently until the end of the financial year.

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:

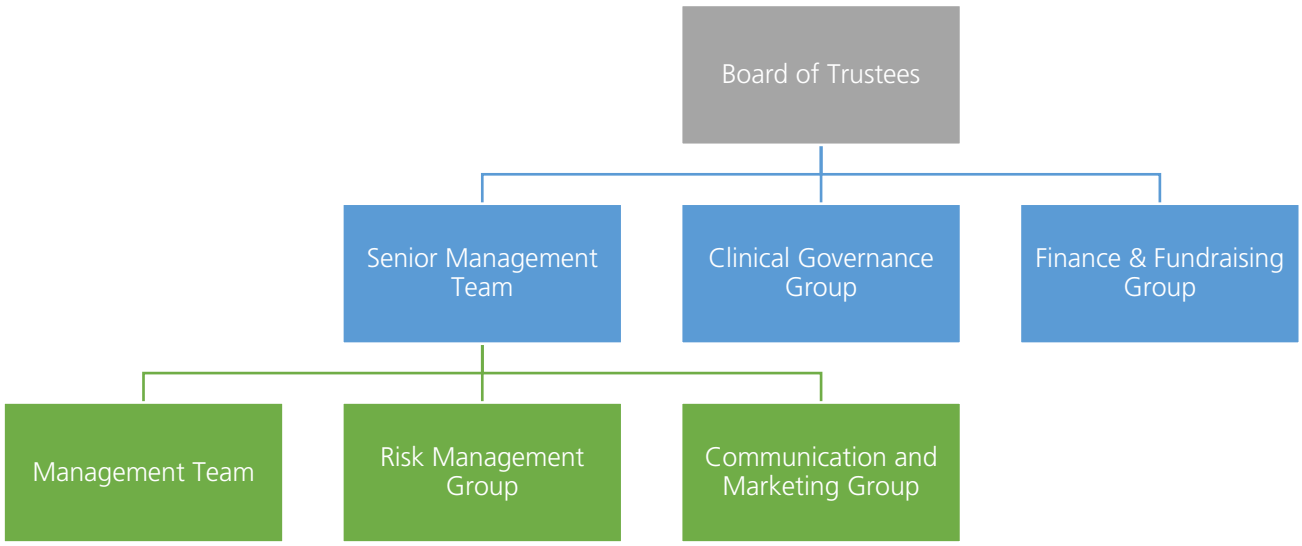
1. HIV Neuro-Cognitive Impairment (HNCI), Complex Physical Care, Respite and End of Life Care
2. Homeless Specialist Step-Down Care
3. Stabilisation-based Intermediate Residential Rehabilitation

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) in the form of a Key Quality Performance Indicator (KPI) table with additional narrative and commentary.

The Mildmay Management Team meets weekly to discuss management and operational issues and to drive forward the business plan. It supports the function of the Risk Management and Clinical Governance committees and ensures that a range of monthly internal audits is undertaken, as well as the quarterly Morbidity and Mortality meeting.

Mildmay's Governance Structure



Mildmay Mission 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
- Meets Quarterly

Mildmay Management Team (MT)

Members: CEO, Medical Director, Clinical Lead Nurse, Finance Manager, Admissions Manager, Human Resources Manager, Registered & Compliance Manager and Fundraising & Communications Manager

Objectives:

1. Contract Performance
2. Marketing & Communications
3. Finance & Fundraising
4. Human Resources
5. Operational
6. Estates & Facilities
7. 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, Clinical Lead Nurse, Therapies Representative, Registered and Compliance 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 educating 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, Clinical Lead Nurse, Estates and Facilities representative, Registered and Compliance Manager

Objectives:

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

Timing: Monthly

Communication & Marketing Group

Members: CEO (chair), Trustees (2), Fundraising & Communications Manager, others as required, by invitation.

Objectives:

1. Oversight of the following activities:
2. Marketing Literature
3. Publications
4. Events
5. Conferences
6. Website
7. Social Media

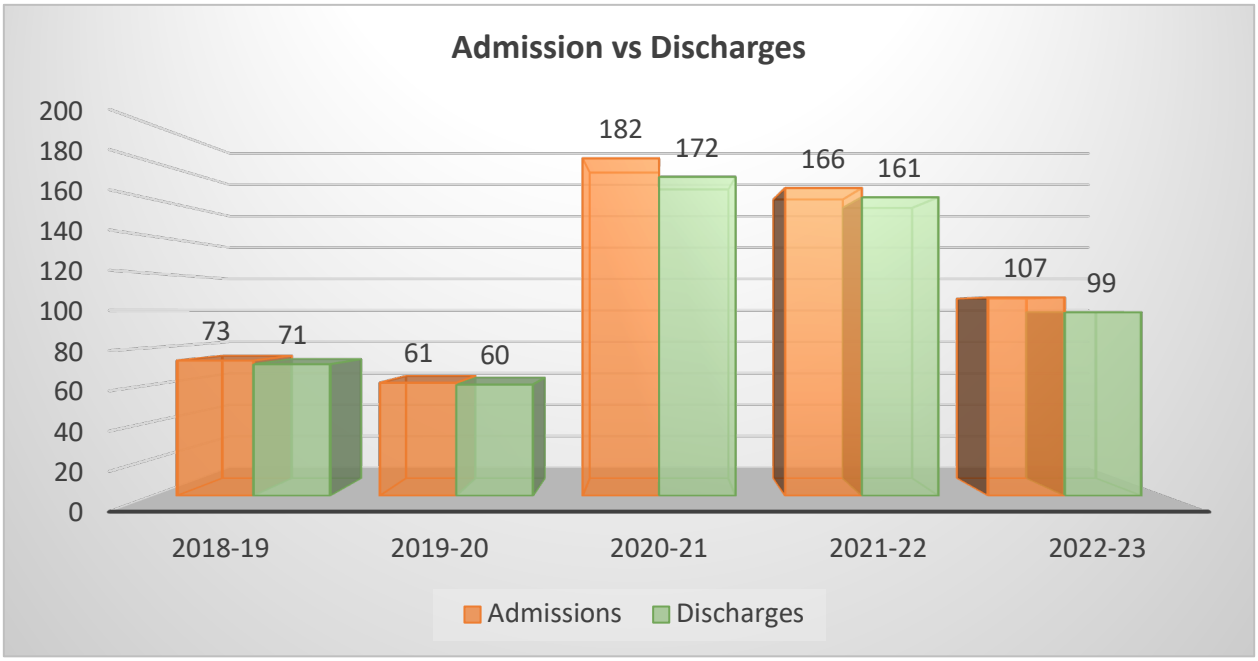
Timing: Monthly

2.3.1 Review of Services

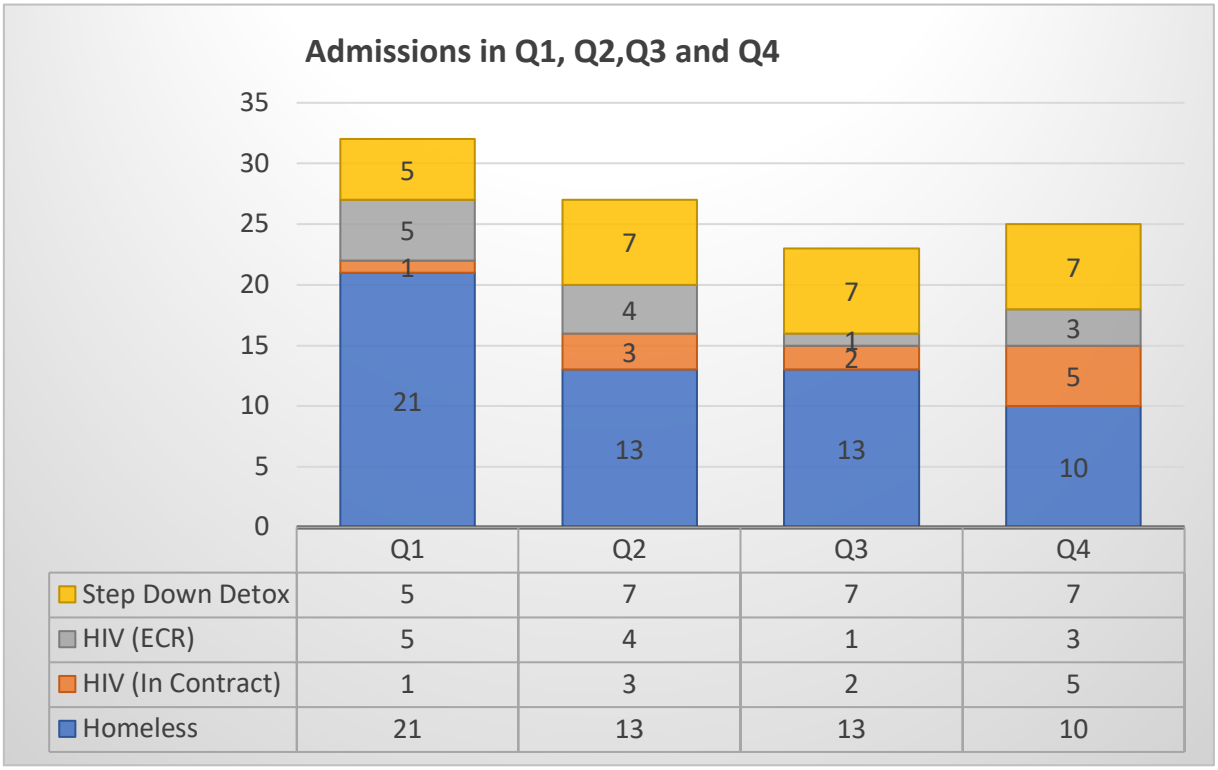
Referrals are received by telephone and email, and all patient-related information must be sent via the secure email account admissions.mildmay@nhs.net.

- Patients are referred under the HIV Pathway by HIV community Clinical Nurse Specialists and HIV specialist medical teams.
- Homeless Pathway teams based at Acute Hospitals refer patients under the Step-Down Homeless Pathway.
- To access the Detox Pathway, patients are referred by community Substance Misuse Teams and must complete their external acute detox before they may be transferred to Mildmay under this pathway.

Admissions versus discharges

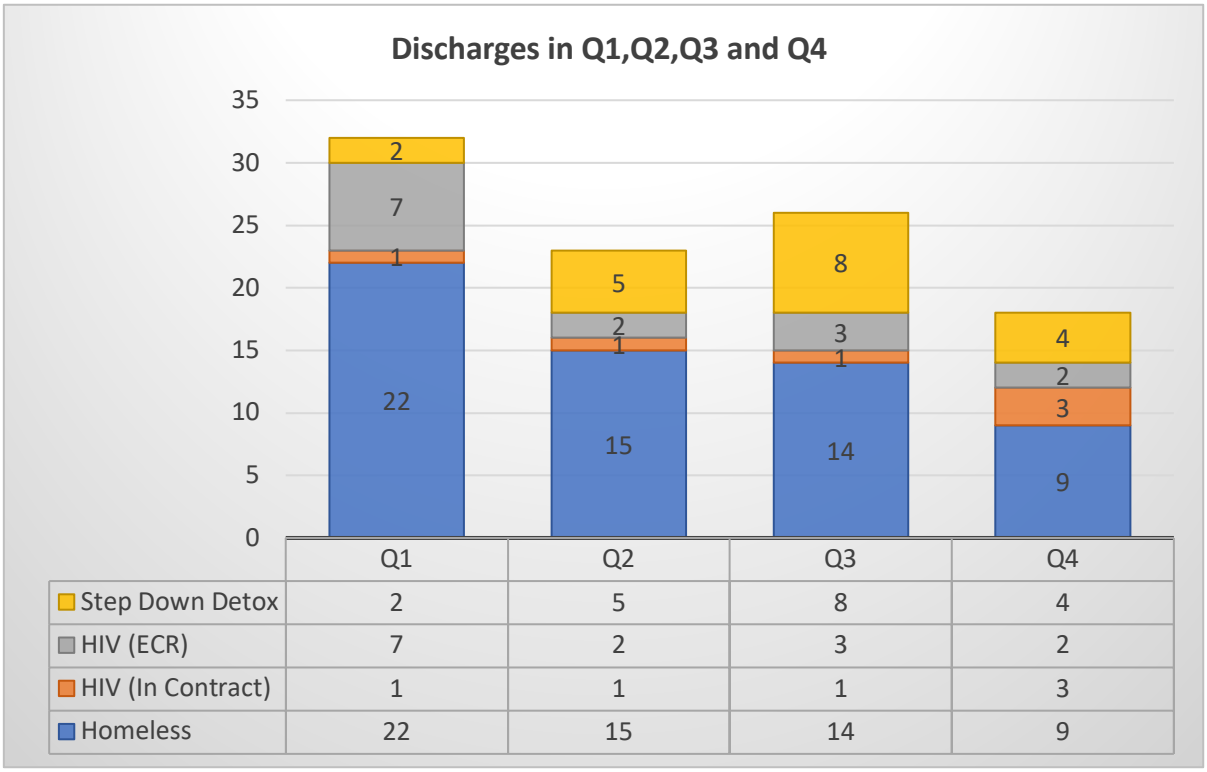


Patients admitted to Mildmay:



	Q1	Q2	Q3	Q4
Step Down Detox	5	7	7	7
HIV (ECR)	5	4	1	3
HIV (In Contract)	1	3	2	5
Homeless	21	13	13	10

Patients discharged from Mildmay:



	Q1	Q2	Q3	Q4
Step Down Detox	2	5	8	4
HIV (ECR)	7	2	3	2
HIV (In Contract)	1	1	1	3
Homeless	22	15	14	9

For HIV patients only:

Services	2018-2019	2019-2020	2020-2021	2021-2022	2022-23
Admissions	73	61	43	40	24
Discharges	71	60	40	37	20

For Homeless patients only:

Services	2020-2021	2021-2022	2022-23
Admissions	134	124	57
Discharges	128	122	60

For Detox patients only:

Services	2022-23
Admissions	26
Discharges	19

Each patient is admitted to a specific programme of care with a defined stay. Bed Management across three defined inpatient programmes can be complex, and the Admissions Manager ensures that as soon as a bed becomes available, the next patient is ready for transfer and admission, if possible that same day but at the very least within twenty-four hours. Discharge plans are begun on admission and progressed throughout the stay. From day one, the focus of the whole team is to progress patients through their recovery, rehabilitation and reablement to the point where they can be safely discharged. The Social Work Team, in particular the Housing Support Officer, will be talking to their established contacts within the home Local Authority to ensure that they have all of the information they need in order to accommodate the patient.

Patients who have reached the desired level of rehabilitation are discharged as soon as a safe transfer can be made. If, for any reason, the patient needs to remain at Mildmay for additional days, permission is sought from the authorising CNS and commissioner.

2.3.2 Funding

Mildmay is a charitable organisation that delivers care for a specific group of NHS patients. As a charity, Mildmay raises a proportion of funds for each bed day through its activities.

ICBs fund approximately 90% of each bed day.

2.3.3 Participation in Clinical Audit

During this period, Mildmay Mission Hospital participated in **0%** of national clinical audits and **0%** of national confidential enquiries, which it was eligible to participate in (none in the previous year).

The national clinical audits and national confidential enquiries that Mildmay was eligible to participate in during the reporting period are as follows: **NIL (0 in the previous year).**

2.3.4 Internal Clinical Audits

Clinical Audits have taken place within 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:

1. Controlled Drugs Audit
2. Discharge Destination Audit
3. Falls Audit
4. Hand Hygiene Audit
5. Health and Safety Audit
6. Infection Prevention and Control Audit
7. Inventory and Disclaimer Audit
8. MUST (Malnutrition Universal Screening Tool) Analysis
9. Mattress Audit
10. Medications Audit
11. NHS Thermometer (Falls, UTI, Catheters, VTE assessments, Pressure Ulcers)
12. Nutrition and Catering Service Audits
13. Prescription Chart Audit
14. Safeguarding Audit
15. Staff Training and Compliance Audit
16. Student Placement Audit
17. Voluntary Services

2.3.5 Participation in Clinical Research

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

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

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

2.3.6 Care Quality Commission report summary

Mildmay is a registered company (1921087), a registered charity (292058), and is registered with the Care Quality Commission (1-2151037387, location number 1-2311760426). The hospital was inspected by the CQC in the last quarter, and Mildmay was rated **'Good' across all five key areas.**

PART 3

3.1 Review of Quality Performance

Mildmay Hospital maintains its monthly Service Data Activity reporting and quarterly Clinical Commissioning Group monitoring template reports.

3.1.1 Incidents

The purpose of incident reporting is to document the facts of adverse occurrences, highlight any potential risks and concerns, learn lessons, change practices, mitigate against further occurrences and encourage transparency and a blame-free working culture.

The incident reports document patient-related occurrences, for example, falls or pressure ulcers. Incident reporting ensures that patient safety, risk management and fulfilment of legal and professional responsibilities is always a priority of the organisation and its staff.

Additionally, it highlights areas in Mildmay's procedures and processes which may require review. Mildmay uses a word-based incident reporting template, located on its shared domain. All incident reports have a 'Lessons Learned' section and an 'Actions' section to ensure that responsibility for making changes is owned by a relevant senior member of the clinical team.

147 incidents were reported in 2022-23, summarised in the table below.

Incidents	Q1	Q2	Q3	Q4
Falls	9	9	9	10
Near Miss Falls	1	1	4	5
Pressure ulcers			1	
Discharge	1	2		
Medication	1	2	2	2
Medication-Controlled Drugs			1	1
Absconscion	1	3	1	
Maintenance/Estates/Security/Catering	4	3	1	
Substance Misuse	1	2	5	1
Missing patient	1	1		
Staff Conduct	1			
Staffing				1
Admission				3
Equipment				1
Safeguarding	1			3
Accident	3			
Infection Control	1		4	
Confidentiality	1	1		
Wound		1	2	

Physical aggression		2		
Verbal aggression			2	1
Gym		1	2	1
Smoking		2	3	1
Information Technology		2	3	
Care Plan		8	3	
Transport			2	
Catering			2	
Theft/Loss of Property				1
Damage to property				1
DoLS				2
Total number of incidents	**26**	**40**	**47**	**34**

Being responsive to incidents is important to the staff at Mildmay. To understand the reason and the necessary measures to be taken when there is a rise in incidents, causes are ascertained, and solutions found and implemented. Solutions may include patient and staff education, monitoring, auditing and reviewing of procedures, protocols and processes.

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. The Clinical Lead Nurse audits controlled Drugs monthly.

Falls

Falls remain the most frequently reported type of incident

Reason for the high number

1. Falls risk is greatly linked with the acuity of patients, and increases, for example, when a patient is confused, at risk of wandering and lacks insight into their abilities.
2. Many patients admitted to the unit have an unsteady gait and in some cases, are unable to mobilise at all. As part of a patient's rehabilitation, goals are set for each patient. For example, a patient may progress from using a rollator frame to a walking stick.
3. The challenges due to the complexity of our patients and the fact that they are in a rehabilitation programme means that sometimes they are at a higher risk of falling.

Prevention measures for falls

1. When patients are identified as being at high risk of falling, or after they have experienced a fall, physiotherapists develop or update individualised mobility care plans.
2. Patients are observed more frequently by the nursing staff, for example, every 15 minutes instead of a minimum of hourly.
3. Patients may need to be transferred to a room closer to the nurse's station so that they can be observed more closely.
4. A 1:1 carer may need to be booked if a patient is at high risk of falling and prone to wandering.

Implementing Physiotherapy recommendations for falls

It is worth noting that a large percentage of falls can be attributed to 'repeat fallers' who have sustained multiple falls over their admission.

We also aim to ensure that all falls receive a medical review.

Our Physiotherapy Team continue to audit falls, with falls prevention and training a key focus.

3.1.2 Complaints

Complaints, comments and compliments are encouraged from patients, their families and anyone who comes into contact with the hospital. There are several ways in which these can be submitted, from verbally to electronically, using the QR code system on notice boards throughout the hospital. There were **three formal complaints** in the year 2022-23, each resolved on a case-by-case basis.

3.1.3 Staff Feedback Procedure

Mildmay has a complaints procedure which staff can also use to raise complaints. This is easily accessed on the intranet.

We also have an incident reporting procedure for staff to alert the Registered Manager of incidents within the Hospital. These are investigated, and recommendations are made.

Feedback is always given to the concerned parties and the Senior Management Team.

Mildmay has a Whistleblowing policy which details how whistleblowing is handled within the organisation and how we ensure staff who whistle blow do not suffer detriment. This policy can be found on the intranet and is introduced to all staff during induction.

Mildmay has a Speak Up Guardian whom staff can approach and raise any issues without fear of negative consequences.

3.1.4 Staff Training

Mildmay employees access different categories of training for continuing education and development to continue to improve their knowledge and understanding. The categories include Mandatory, role-specific and training to support professional development.

Our training programme includes both in-house and online training. In the year 2022/23, the following face-to-face training was available for all staff:

1. Domestic Abuse in homeless settings
2. CPR Training
3. Safeguarding Adults and Children
4. Fire Safety
5. Sex Exploitation Training
6. Anti-Racist Solutions in Healthcare Training.
7. Basic Life Support Training
8. Behaviour that Challenges

All Mildmay employees are registered on the Mildmay online training portal to access training. Whilst it is impossible to have 100% of staff and volunteers always trained in all areas due to staff turnover, the aim is to have greater than 80% of staff training less than a year old.

The following modules are Mandatory to all staff groups:

Mandatory Training

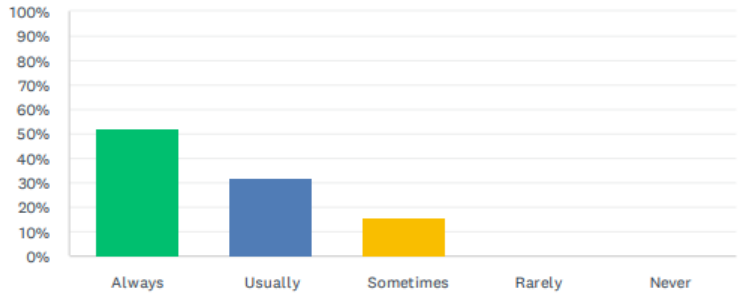
Online Training	% Completion
Preventing Radicalisation	88.4%
Information Prevention & Control	88.4%
Fire Safety	88.4%
Health & Safety	88.4%
Resuscitation	88.4%
Safeguarding Children	88.4%
Safeguarding Adults	89.9%
Equality Diversity and Human Rights	88.4%
Data Security Awareness	89.9%
Conflict Resolution	88.4%
Moving & Handling	88.4%

3.1.5 Staff Survey

An anonymous staff survey was conducted on Survey Monkey in November 2022, with the following results:

Q1 I look forward to going to work.

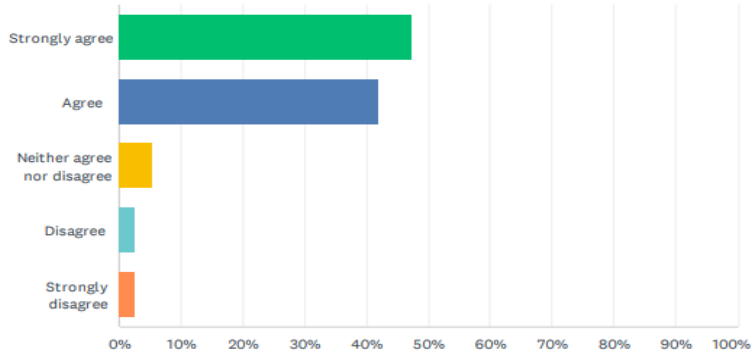
Answered: 44 Skipped: 0



ANSWER CHOICES	RESPONSES	
Always	52.27%	23
Usually	31.82%	14
Sometimes	15.91%	7
Rarely	0.00%	0
Never	0.00%	0
TOTAL		44

Q56 I think that my organisation respects individual differences. (eg cultures, working styles, backgrounds, ideas etc)

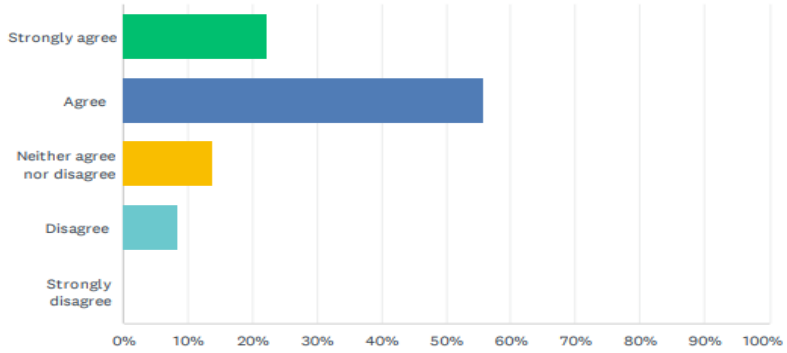
Answered: 38 Skipped: 6



ANSWER CHOICES	RESPONSES	
Strongly agree	47.37%	18
Agree	42.11%	16
Neither agree nor disagree	5.26%	2
Disagree	2.63%	1
Strongly disagree	2.63%	1
TOTAL		38

Q50 My organisation treats staff who are involved in an error, near miss or incidents fairly?

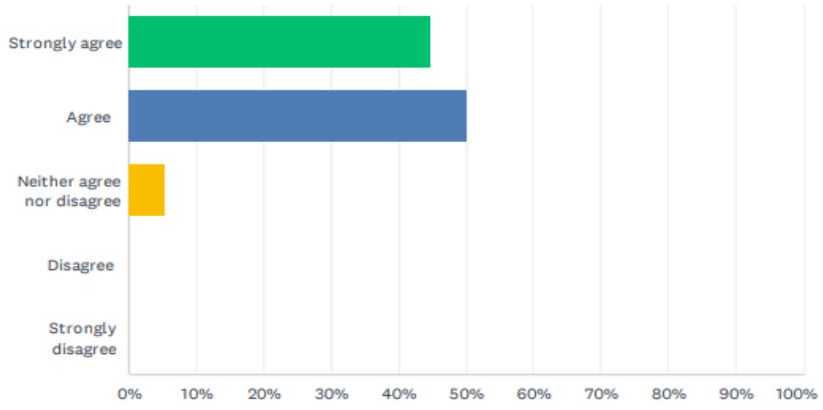
Answered: 36 Skipped: 8



ANSWER CHOICES	RESPONSES	
Strongly agree	22.22%	8
Agree	55.56%	20
Neither agree nor disagree	13.89%	5
Disagree	8.33%	3
Strongly disagree	0.00%	0
TOTAL		36

Q54 I would feel secure raising concerns about unsafe clinical practice.

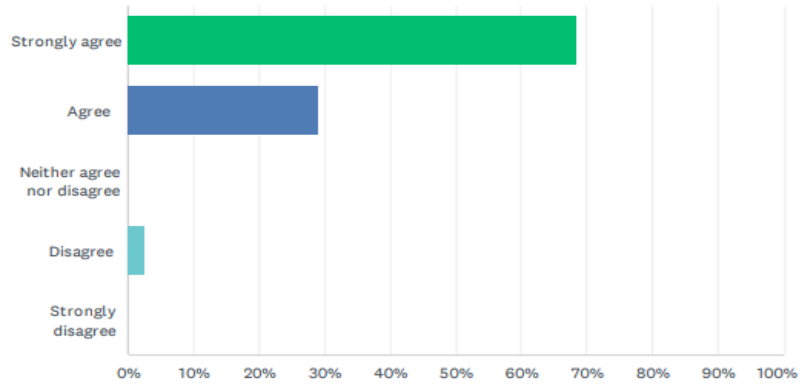
Answered: 38 Skipped: 6



ANSWER CHOICES	RESPONSES	
Strongly agree	44.74%	17
Agree	50.00%	19
Neither agree nor disagree	5.26%	2
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		38

Q63 Care of patients is a top priority for Mildmay.

Answered: 38 Skipped: 6



ANSWER CHOICES	RESPONSES	
Strongly agree	68.42%	26
Agree	28.95%	11
Neither agree nor disagree	0.00%	0
Disagree	2.63%	1
Strongly disagree	0.00%	0
TOTAL		38

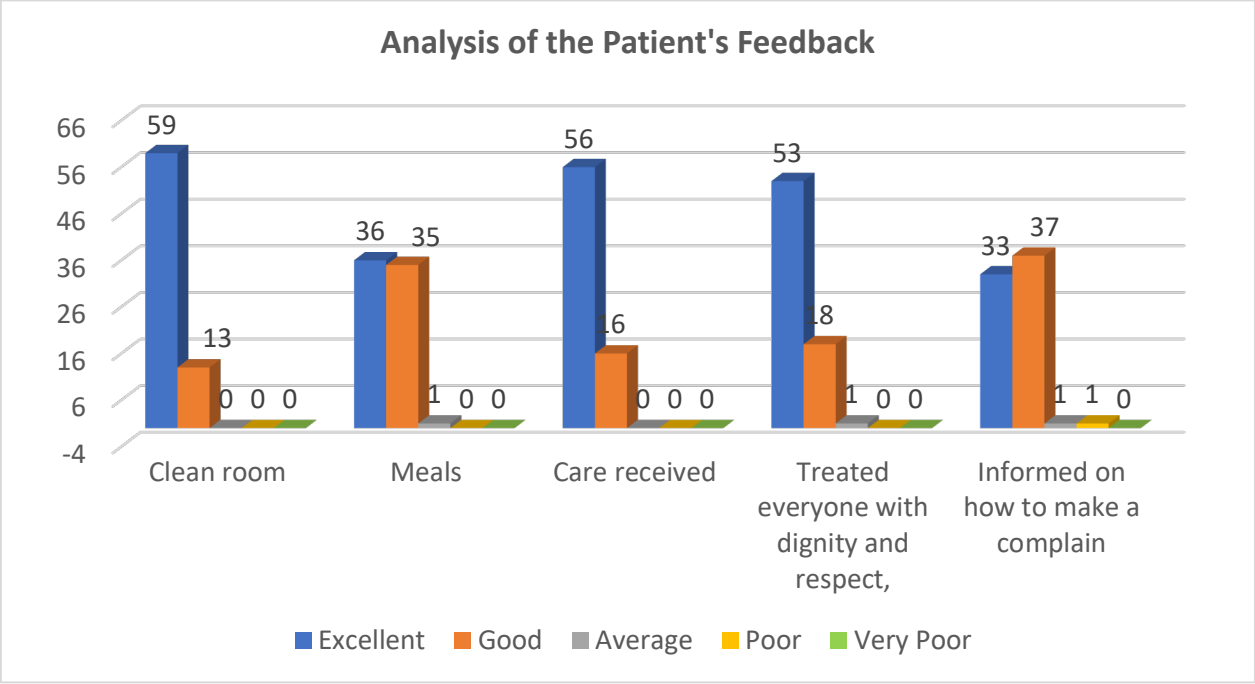
3.2 Feedback from Service Users

Friends and Family Test:

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

In 2022-23, feedback was collected from 72 patients when they were discharged. On average, we had positive responses (excellent and good) from 97.2% of the patients (excellent and good), and 95.8% of the patients would happily recommend Mildmay if their friends and family require the facility.

Analysis of patient feedback



Most feedback is collected in real-time at the bedside before a patient is discharged. Concerns from feedback are dealt with immediately. Compliments are fed back to staff and recorded in monthly dashboards and quarterly reports.

Captured comments:

Ward Patient Comments:

"Thank you. I would like to take this moment to let you know how much you are appreciated. Mildmay is a true angel to me, and I am grateful to you more than words can express.

Few people possess the considerate, unselfish, loving heart that you have and fewer are willing to give so much of themselves. I thank you all for your kindness and for being the wonderful organisation you are. I know I am blessed to have you all in my life."

God bless you"

Staff Quote:

"I have been working at Mildmay as lead physiotherapist for nearly three years and have enjoyed working with a dynamic MDT, diverse patients and an approachable management team. I have developed clinically from a management perspective and personally in the time I have been at Mildmay. It is a unique setting which has a lot to offer patients, staff and the community."

Joanna Keating
Lead Physiotherapist

3.3 Case studies

Case study 1- Homeless patient

By **Kattya Mayre-Chilton**
Specialist Dietitian B7 DT25287

This is a case study I would like to bring to everyone's attention given the special circumstances in which it took place. It not common for the therapist to key work the patients on the homeless pathway but I felt compelled to do so given the patient's predicament and complex dietetic intervention. He is not recognised as a resident in this country, nor his home country, due to a lack of paperwork and a passport.

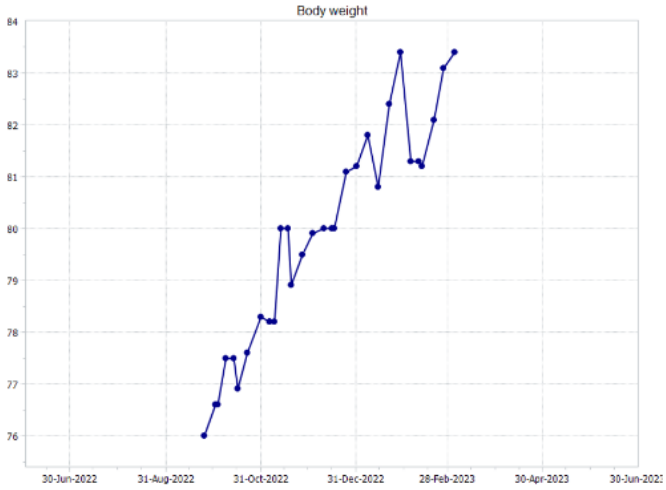
He had no traceable next of kin, and even if he were to return home, we would not know how it would be possible to maintain the necessary level of care given the perilous situation in his native country.

This gentleman, 55 years old from the Union of Soviet Socialist Republics (USSR) era, entered the UK before 1992 as an immigrant smuggled in the back of a truck. He was originally from the Ukraine area of the USSR and had no documents. This was his third admission to Mildmay since 2020. He was referred to dietetic intervention on his third admission when he was transferred after he had a Stroke (left middle cerebral artery (MCA) infarct) with complicating expressive and receptive dysphasia (receptive dysphasia is difficulty in comprehension and expressive dysphasia is difficulty in putting words together to make meaning). He was being fed via a percutaneous endoscopic gastrostomy (PEG) feeding tube (to prevent aspiration pneumonia) due to unsafe swallowing. PEG feed and care and discharge planning require extensive monitoring and handover from the dietitian; for this reason, I volunteered to help the homeless team and key work on his behalf.

This gentleman was always referred through the homeless pathway as he had no immigration status in the UK but cannot go back to the dissolution of the Soviet Union, Ukraine zone, as he has no passport or identification to get a travel pass. Our housing officer explore this during his admission in 2020 and 2021 when the Ukraine embassy would not recognise him as a citizen because he has no passport. She also identified that he had a daughter, but all ways to contact her failed. During his third admission in 2022 and with his complex clinical needs, it was even less likely to be returned to the Ukraine war zone and harder for us to locate his daughter.

This gentleman required long-term enteral feeding via a PEG due to unsafe swallowing and is unlikely to meet his nutritional requirements without this support. The PEG was also used to maintain his hydration and delivery of medication such as his medication to treat seizures (Levetiracetam) twice a day, dispersible aspirin daily; to treat ulcers by slowing down the food transition (Propantheline) three times a day; for elevated cholesterol (Atorvastatin) daily; to help with the sleep hormone Melatonin was given daily and 'when required'.

His weight on admission (Aug 2022) was 77.9kg, height 1.86m with a body mass index (BMI) of 22.5kg/m2 classified in the healthy weight range, malnutrition universal screening tool (MUST) score >2. The following graph shows an upward trend for weight gain. He did have a few troughs when he increased his activity levels or when he had episodes of diarrhoea. On discharge (Feb 2023) his weight was 83.1kg with a BMI of 24.0kg/m2 in the healthy range, MUST >2 because he needed PEG support. He gained 5.2kg (6.25%) during this admission.



His estimated requirements targets were calculated, based on his weight, for energy to be 2337kcal, with protein 78-116g and fluids to meet 2.7L per day.

He was nil by mouth (NBM) with regular mouth care. All his nutrition and hydration were delivered directly to the stomach via the PEG, known as Enteral Nutrition, using tube feeding. The PEG tube insertion was on 14 July 2022. It was a 15FG Freka in diameter with a skin gastric lumen distance of 4cm. There were no reported complications. This is important information to hand over in case the PEG needs replacing.

At the acute hospital, he was started on an overnight feeding regime, and this was continued on transfer to Mildmay. This overnight feeding method is advisable to encourage patients to engage in rehabilitation care during the day. However, night staff found him frequently touching the tube, which raised concerns of the tube getting dislodged (pulling the tube out or displacing it).

His feed was changed to a bolus feed regime, which allowed the administration of 200–400 ml of feed down the PEG over 15–60 minutes at regular intervals. Bolus feeding can be like a normal feeding pattern, more convenient, and allows freedom of movement for the patient. He tolerated the bolus feed concentration and ingredient content.

The established bolus regime feed volume was seven 200ml bottles of Fresubin Energy Fibre 200ml per day (total vol 1400ml/24hrs); with 50ml water flushes (to prevent the tube getting blocked) per and post each bolus delivery (total of 700ml/24hrs). The total provided by the feed was, for Energy 2100kcal; Protein 78.4g and Fluids 2625ml/day.

Any additional water to meet his requirements was given with his medication dilution and flushes. He had seven medication events per day. According to our Tube Feeding Procedure and Drugs - Management Administration of Medicines Procedure, all medications need to be reviewed to enable them to be delivered via an enteral tube to the stomach and checked if they did not react to the feed. Each separate medication was recommended to be dissolved or suspended using 15ml of sterile water. Administration involved the use of 30ml of sterile water for flushes (to prevent the tube from getting blocked) pre and post-each medication (total of 525ml/24hrs).

The staff were trained (Hospital standards) and advised to ensure the patient was always positioned at >40 degrees during feeding and for 30 minutes after feeding stops. Using the appropriate feeding syringe (purple in colour), they feed slowly and gently through the tube, e.g. 250ml over 20 minutes. The prescribed water (50ml) was poured into the syringe and allowed to flow through to flush the feeding tube appropriately.

The PEG stoma site care required daily cleaning by nurses; during this cleaning, any changes to appearance, colour or discharge were noted to indicate any possible infection, and the medical team and the dietitian would be informed if any concerns were raised. We were more vigilant in monitoring this as, due to expressive and receptive dysphasia, he was unable to tell us if he was in pain or discomfort. We used the communication tool developed by our Speech and language therapist (SLT) to help with understanding if he was in pain or not. He could point at pictures to indicate if he was happy or not. We used this to guide us on his possible preferences. Prior to his being discharged (2/3/23), the PEG stoma site looked clean, clear and slightly pink colour, indicating no infection with the established track.

Other stoma site care involved the PEG being advanced and rotated at Mildmay, this takes place every week on Thursdays. This weekly procedure is to prevent Buried Bumper syndrome, whereby holding the visible end of the tube and rotating it 360° (a complete circle) and advancing (pushing) the tube approximately 2-3cm into the stomach and pulling it back to the original position. Prior to him being discharged (2/3/23), there were no issues, and his PEG care was conducted appropriately.

During his admission, he had a couple of episodes of diarrhoea, samples were checked, and they were not infectious. We had to closely monitor his tolerance to the feed concentration, fibre content and rate of delivery until we found a feed and rate which he tolerated. His bowels were opening on average twice per day and loose ~200g, this was normal for him. We started to use the validated King's stool chart for enteral feeding to monitor his bowel habits better.

SLTs worked intensively with him to help with communication and capacity and trialled oral options to improve his quality of life. Some challenges with oral trials with yoghurt or teaspoons of water included coughing and hypersalivation. The nursing team reported that he was not managing oral secretions, and he was not swallowing when given teaspoons of water. This was reviewed by SLT with close liaison with the allocated Independent Mental Capacity Advocate (IMCA) to determine if it was in his best interest to remain NBM.

The physiotherapy team worked intensively with him, and he was able to leave his room and sit by the nurses' desk. There he could interact with everyone on the ward, and he was engaged in looking at newspapers and magazines as well as playing games with staff. On occasion, we got to see a smile.

In coordination with our social worker lead, a referral was completed for an IMCA to be allocated to represent him because he had no family or contact available. Under the Mental Capacity Act 2005, the role of the IMCA is to legally safeguard his interests regarding making decisions about where he wanted to be discharged to and about eating options, risks and quality of life. The IMCA could not see why it was not in the patient's best interest, given the current situation, that he shouldn’t have a nursing care placement. The social worker lead completed a referral for the community social worker allocation. Once one was allocated, we organised a discharge planning meeting, which she attended and conducted a capacity review with him. The team with the

community social worker completed a full discharge decision tool form, and the overall agreement was that the best place for him was a nursing care environment, ideally with some neurorehabilitation to help him continue to improve. The forms were submitted, and the funding borough approved this.

He was reviewed by four nursing homes, one specialised in Neurorehabilitation and the others offering more general care. The funding borough referred and selected the nursing home. Once we received the final approval, we could proceed with planning for discharge and his transfer. This included calls to the nursing home by various members of staff to see what they had in the facility, and what they required for us to send over for a safe discharge.

From a dietetic viewpoint, this included the regime, and they requested a month's feed supply (nine boxes were provided). They were supplied by a different feeding company so to prevent delay I wrote to their GP with appropriate prescription for using Nutricia Fortisip Multi-fibre 200ml bottles which were nutritionally complete, high energy (1.5kcal/ml) with fibre, 7 per day, and recommended that on review that the dietitian may want to reduce bolus to 6 per day as his weight was steadily increasing.

I referred to their community enteral nutrition team, nurses sent any additional equipment and information, doctors completed the discharge summary and medication on discharge and all other therapies involved completed their ongoing referrals. The transfer was booked, and a member of staff accompanied him.

The staff reported that he looked happy when he arrived at the nursing home and was smiling. We conducted a few follow-up calls to ensure all was going well and the funding borough also requested paperwork to support their funding allocation. The nursing home manager reported that he looked happy, had settled and there were no issues raised, we had a safe discharge.

Case study 2-Homeless patient

By Sheila James
Housing Officer

Social background

The patient, TE, is a Jamaican National who came to the UK in 2002 after fleeing a threat to her life. She does not have any status in the UK but has been working with Lewisham Refugee and Migrant Network, which submitted an "indefinite leave to remain" application to the Home Office on 15 July 2022.

She stayed in Birmingham for several months, with a friend, before moving to London. There she sofa-surfed with friends. Both parents are deceased, but she does have siblings and children living in Jamaica and a cousin in London.

Medical summary

TE was admitted to the Mildmay on our Homeless Pathway on the 29 June 2022 with the following issues:

- End-stage renal failure
- Dialysis (3 times a week)
- Type 2 diabetes
- Ischemic heart disease
- Hypertension
- Cataracts

Immigration summary and support

Before TE was admitted to the Mildmay Mission hospital, she was already working with LRMC (Lewisham Refugee & Migrant Centre) to apply for ILR (indefinite leave to remain), which was submitted on 15 July 2022, as they believe that she has a strong case for her ILR to be granted.

Later, she was referred to Lawstop, only when she was referred to Haringey ASC to request for a Care Act, which Haringey did not fulfil. Lawstop became involved to challenge Haringey ASC. Lawstop are continuing to work on TE's case with regard to a Care Act assessment being done.

In November, Lawstop was seeking information from the Royal Free and Queen Elizabeth, following advice from the Barrister. The Barrister also ascertained that Tower Hamlets should be the local authority doing the Care Act assessment, which they have now approached to request for them to complete a Care Act Assessment. Lawstop has given Tower Hamlets ASC until 19/12/22 to provide a substantive response.

The immigration officer at LRMC (Lewisham Refugee and Migrant Centre) is preparing a Schedule 10 application to the Home Office for accommodation.

Social work involvement

When TE was at QEH, a referral was made to Greenwich ASC for a Care Act assessment to be done on 14 July 22, but this was never completed, as Greenwich has also questioned whether TE was of ordinary residence in Greenwich but was not found to be of residence and her case was passed onto Haringey ASC to request for a Care Act assessment, based on her level of care and support needs. However, Haringey ASC could not establish that she was of ordinary residence to Haringey, despite being provided with evidence of her address history. Lawstop then made the decision to challenge Haringey ASC, following letters sent and waiting a response.

Housing support

Whilst at the Mildmay, TE has been supported by referring her to several agencies/organisations in support of people with no recourse, just to name a few:

- **Emmaus community** (not suitable for their service)
- **Housing Justice** (did not hear back)
- **Migrant Help UK** (could not assist, as she did not make an asylum claim - the immigration officer at LRMC, did not feel it was a good idea, as this could complicate her case)

  With Migrant Help UK, her file was created on the 30/11/22 and advised that there is normally a 10-day window, depending on when she would be discharged. Called back on the 2/12/22 and they requested for her Home Office reference number, which was given to them, but unfortunately, this was not a PORT reference number, just her ILR application reference and advised that unless she has made an asylum claim, they were unable to assist her.

- **Your Place** (did not hear back)
- **Martha House** (only accept those who had been granted ILR within 6 months)
- **All people All places** (only accept those who have a local connection to Newham)
- **SJOG** (referrals for those recognised by the Home Office as being trafficked)
- **Hackney Winter Shelter** (not taking any new referrals)
- TE also discussed the possibility of staying with friends and/or family, but this was not an option for her, as she did not have anyone she could stay with.
- A request to Lawstop to ask for them to refer to Hosting Schemes on the 21/10/22

Discharge planning

- Schedule 10 applications by LRMC in process to send to Home Office to request for accommodation
- Lawstop has requested Tower Hamlets local authority to provide a substantive response following a request for Care Act Assessment by 19/12/22.
- The Housing Officer to continue to look at other possible available options for accommodation.

Challenges

- Services stipulations regarding criteria not suitable for
- Lack of resources
- Delayed feedback from services already involved
- Conflicting information regarding address history
- Funding
- Social Services not accepting Duty for Care Act assessment
- Limited accommodation options

Case Study 3-Detox Patient

By **Theresa Hibbert**
Drug and alcohol worker

Lucy– name change

Lucy is a 41yr old woman with a history of crack and heroin use. She was severely underweight and had not been adhering to her HIV treatment. She also had some gynaecological issues and needed a total tooth extraction due to severe decay.

She had been prescribed methadone by the external drug and alcohol service to help her to stop using heroin. As she stopped needing to buy heroin to avoid opiate withdrawal symptoms, this enabled her to stop buying crack as well. She then maintained a drug-free status which enabled her to work towards going to rehab.

To be accepted into rehab, she needed to detox from methadone. The external service organised the funding for her to complete a methadone detox in Guys and St Thomas. It was also agreed that due to Lucy's other health issues, she would benefit from a period here at Mildmay, where she would have the opportunity to stabilise and address some of the other health issues before going to rehab.

I was able to visit Lucy during her detox at GSST to introduce myself and to give her some information regarding her admission to Mildmay. She felt this relieved some of her anxiety about coming to a new place and having someone to meet her that she had met helped with the transition.

On admission to Mildmay Hospital, she was still struggling with some effects of the detox, such as insomnia, and she had some vomiting episodes. She was able to get her circadian rhythm back in the first few weeks, and the vomiting passed in the first days.

Lucy attended the relapse prevention group and 1-1 sessions that supported her in maintaining abstinence from drug use. Initially, she was quiet and didn't feel able to contribute much to the groups. She was concerned about how other people viewed her, but over the weeks, her confidence grew, and she became an active member. She was able to offer insight into some of her own issues, as well as support to other group members with topics that they had struggled with.

Lucy started taking her medication more regularly and attended her appointments at the dentist and gynaecology departments at other hospitals. At first, I attended with her as she didn't feel confident about going on her own, but I stopped going when she felt strong enough and didn't need me to be with her. Her trips out on her own went well with no issues.

Her stay here also provided her with the opportunity to see her daughters regularly to improve her relationship with them. This was important to her as she felt that she would then be able to focus on herself in rehab.

She informed me that had she gone straight to rehab from the detox, she may not have been able to engage from the start, but now she is stronger and feels that she will be able to participate and get the most out of it.

She was discharged from Mildmay with no issues and went in a taxi with her external key worker to rehab as planned.

Case Study 4-Detox case history

By **Theresa Hibbert**
Drug and alcohol worker

Julie – name change

Julie is a 47-year-old woman who has had a history of problematic drinking for many years, which required a medical detox. She had been admitted to Guys & St Thomas Hospital to complete a planned detox, which went well and was completed within the expected time.

Julie was due to go straight to rehab from detox, which was all set up. However, as she had been able to complete the detox seven days ahead of schedule, a referral was made for her to come to Mildmay to stabilise and rest. This was agreed upon, and Julie arrived at Mildmay feeling good about the detox but anxious about coming to a new place.

We talked about what she can expect being here and what is expected of her. This relieved some of the anxiety, and she was able to settle quickly. She agreed not to leave the hospital without an escort as she understood this could put her at risk of relapse.

We went to the shops a few times, and it was the run-up to Christmas, and she wanted to send out cards before going to rehab. These trips went well, and Julie was able to talk through any difficulties she was having while being out of the more secure surroundings of Mildmay.

After seven days, Julie went off to rehab with the accompaniment of her external key worker.

Her worker let me know that Julie got there safely.

Case history 5-HIV case history

By **Josh Pedro**
Physiotherapist

Background

Mr X was admitted to King's College Hospital on 13/5/22 with a 3-week history of confusion. During his admission, he was diagnosed with progressive multifocal leukoencephalopathy (PML) secondary to advanced human immunodeficiency virus (HIV) and started on antiretroviral. Due to worsening symptoms, PML immune reconstitution inflammatory syndrome (IRIS) was suspected, so he was started on steroids. He also had steroid-induced hyperglycaemia, for which he had been started on insulin.

He was admitted to Mildmay on 25/07/22 for specialist neurorehabilitation.

Presentation

On admission, Mr X presented as follows:

- Dense right-sided weakness
- Mild tone in the right upper & lower limb
- Right-sided hemianopia (visual impairment)
- Right-sided neglect
- Doubly incontinent
- Global aphasia (communication impairment)
- Probable apraxia

Level of function on admission

- Not consistently responding when being spoken to. Only spoke in single words or very short phrases, such as "I don't know", and responds more when agitated
- He is unable to call for help or to make his basic needs known
- Would not attend to visual, auditory or sensory stimuli on the right and kept his head rotated to the left. He required regular repositioning of his right side as he was not aware of when his arm fell from the arm of the chair or his leg off the wheelchair footplate.
- Full assistance for all activities of daily living (ADL)
- Incontinent of bladder & bowels
- No movement of the right upper & lower limb was observed

- Assistance of two and a slide sheet for all bed mobility
- Hoist transfer with the assistance of two
- No independent sitting balance. He required a supportive wheelchair. He was always supervised due to his history of falls
- Would climb out of the bed or chair and get himself onto the floor several times a day, mainly when he was agitated, so a mattress was placed on the floor
- Unable to stand, walk or use stairs
- Continence managed with pads

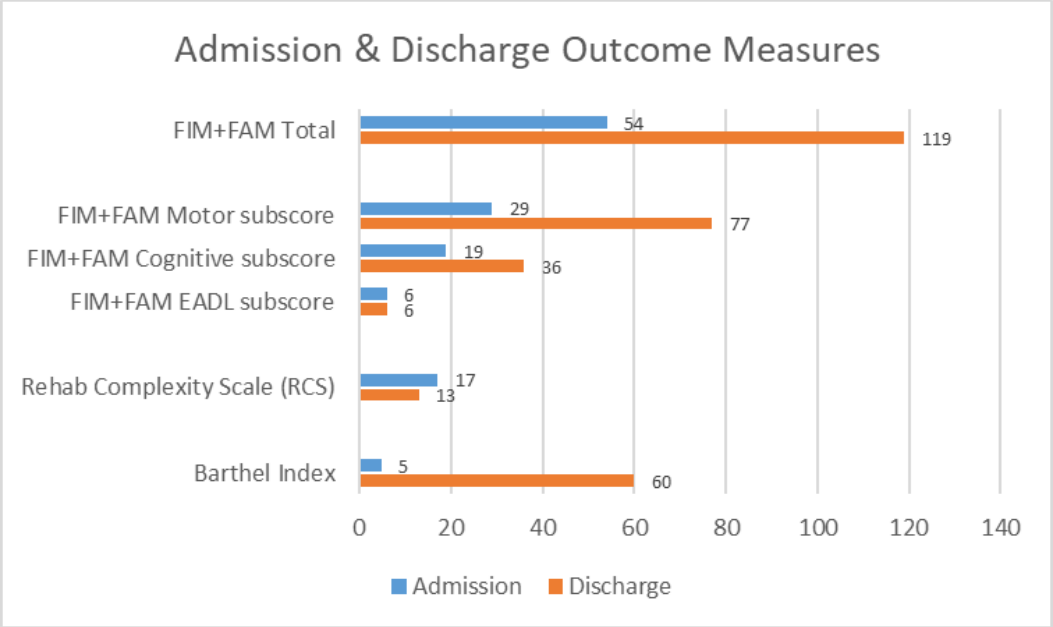
Physiotherapy intervention

- Manual handling assessment & care plan
- Graded seating programme, progressed to standard chair
- Therapy led goal setting
- Graded standing programme in standing frame
- Gait re-education
- Falls management
- Getting up off the floor education & practice
- Bed to chair transfer progression
- Balance rehabilitation (in sitting & standing)
- Strengthening exercises for upper & lower limb
- Cardiovascular exercise
- Sling provided for upper limb support
- Foot splint provided to aid with gait
- Functional rehab: indoor mobility practice, stairs practice, sit-to-stand practice, drinking from a cup, placing hat on head, assisted eating with impaired arm
- Joint working with the multi-disciplinary team
    - Medical team to manage tone & engagement
    - Nursing staff to reduce falls risk & progress mobility & function
    - Dietician to ensure adequate nutritional intake corresponds with increased activity
    - Occupational therapy (OT) to progress functional tasks, particularly using the upper limb, and strategies to assist cognition
    - Speech & Language Therapy (SLT) to assist with communication
    - Social work to establish suitable discharge destinations and to complete Continuing Healthcare (CHC) assessment

Level of function on discharge

- Always responds when spoken to & can have a supported conversation with staff & family
- Able to make his needs known most of the time with prompting
- Attending to the right side sometimes requires prompting
- Can reposition his limbs in the chair independently and no longer requires a sling
- Fully continent of bladder & bowels. Able to use the toilet with the assistance of one
- Able to participate in ADLs with the assistance of one
- He can move his right hand, elbow and shoulder & is progressively requiring less assistance and prompting to use his upper limb in functional tasks. He is now showing antigravity activity in his right hip, knee and ankle and is slowly developing the ability to move his right lower limb voluntarily but still requires a lot of prompting and cueing.
- Independent bed mobility
- Step round transfers with a frame and assistance of one. Occasionally uses a stand aid when he is agitated or fatigued.
- Able to sit upright with back unsupported & sits in a standard armchair or wheelchair
- Mobilises up to 100 metres indoors with a frame and supervision of one
- Able to complete stairs with one rail, on his left side, and assistance of two
- No falls or episodes of getting onto the floor in the last three months
- Can tolerate daily hour-long physiotherapy sessions (mood dependent)

Outcomes of admission to Mildmay



The Functional Independence Measure (FIM) is a global measure of disability and can be scored alone or with the additional 12 items that formulate the Functional Assessment Measure (FAM). The UK FIM+FAM [1] is designed to measure disability in the brain-injured population. It has an ordinal scoring system for all 30 items from 1-7 (1 = complete dependence and seven fully independent). The lower the score, the more dependent the person is. The FIM+FAM scores can be subdivided into Motor, Cognitive and Extended Activities of Daily Living (EADL) sub-scores.

On admission, Mr X's total FIM+FAM score was 54. This improved to 119 on discharge. He showed significant improvements in the motor and cognitive sub-scores, especially the motor sub-score where he became fully continent of bladder & bowels as well as needing reduced assistance transfers, mobility, stairs, washing, dressing and grooming. See Appendix 1 for individual scoring of each domain.

The Rehabilitation Complexity Scale (RCS) [2] provides a simple overall measure of Care, Nursing, Therapy, Medical and Equipment needs and is designed to offer crude banding of complexity. The higher the score, the more care the patient requires. Mr X's RCS score was 17 on admission, reduced to 13 on discharge, reflecting reduced care needs.

The Barthel Index (BI) is an ordinal scale used to measure performance in ADLs. Ten variables describing ADL and mobility are scored, a higher number being a reflection of greater ability to function independently following hospital discharge. Mr X's BI score was 5 on admission and 60 on discharge.

Discharge from Mildmay

Physiotherapy, working as part of the MDT, enabled Mr X to be more independent through rehabilitation and has played a leading role in discharge planning. Mr X is due to be discharged to a residential care home with ongoing community physiotherapy, OT and SLT referrals as he still has ongoing rehab potential.

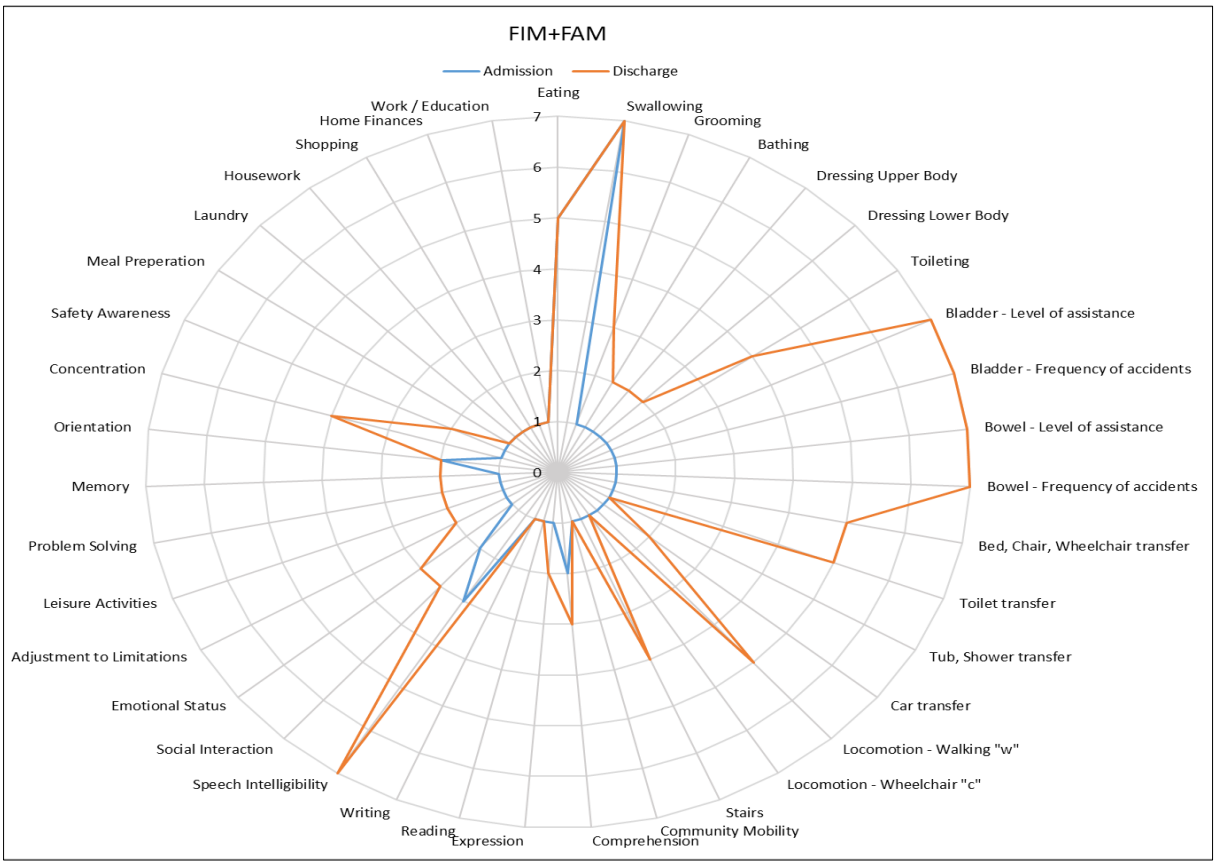
References:

1. FIM FAM - The UK FIM+FAM (Functional Assessment Measure) (kcl.ac.uk)

2.Rehabilitation Complexity Scale Extended - https://www.kcl.ac.uk/cicelysaunders/resources/tools/rcse

Appendices:

1. FIM+FAM radar chart



Case history 6-HIV case history

By **Kattya Mayre-Chilton**
Specialist Dietitian B7 DT25287

MDT discharge planning with PEG nutritional support transferred to another country

- Mrs XX (56-year-old, Portuguese Caucasian female), HIV diagnosed with recent deterioration of HIV neuropathy, AKI on CKD complication and non-compliant with HIV medication. Biochemistry showed elevated Ur-9.8; Cr-313; CRP-6 and low EGFR-14. She was on fluconazole, cyanocobalamin, ondansetron, levetiracetam, Colecalciferol, Dolutegravir, Lamivudine, Prednisolone, ambisome and PRN metoclopramide. She had an established PEG in situ from nutrition only as required. Prior to admission and transfer to rehabilitation, her family were not coping with her care needs. She had children in the UK, parents and extended family all still alive in Portugal.
- On admission her MUST score was 2; weight 62.3 kg; height 1.73 m; BMI 20.8 kg/m^2 in the healthy range. Estimated requirements- for a weight of 64.85 kg: Energy: 25-30 kcal/kg + PAL 1.1 = 1783-2140 kcal; Protein 1.2-1.5 g/kg= 77-97 g; Fluid 35 mls/kg = 2270 mls. She continued with poor oral intake secondary to ongoing nausea and vomiting, Metoclopramide was started. She was transferred on fortisip compact protein 3-4 orally; strawberry/banana oral nutritional support (ONS). If she refuses or declines meals and/or oral ONS, consent was sought to give bolus feed via percutaneous endoscopic gastrostomy (PEG) (4 as bolus with 50 mls water flushes pre/post each bottle). These provided 1200 kcal; 72 g protein; 1200 mls).
- She deteriorated, continued to manage minimal oral intake, estimating a meal per day with assistance and encouragement, for enjoyment and quality of life. She reported that she is not overly hungry. Nutritional support was changed to delivered PEG feed overnight: upgraded to Fresubin Energy Fibre 1200 ml @ 100 ml/hr for 12 hour (with 12 hours rest in the day to allow for oral intake) with 50 ml water flushes pre and post (+/-) each feed bag; this provided 1800 kcal, 67.8 g protein, 1400 ml per day. This required setting up, changing bags and providing water flushed pre and post any tube use. The PEG site care is completed weekly with no issues; cleaning, advancing and rotating.
- Her oral intake remained poor, she required ongoing PEG nutritional support to prevent malnutrition, meet nutritional requirements and hydration as well as maintain her current weight. In addition, her medication could be delivered via the PEG.
- Family and MDT discharge planning meeting focus on medical, physical and social needs, overall prognosis, to agree an appropriate discharge destination and create an action plan to achieve this. She had recurrent Cryptococci meningitis, resulting in irreversible brain scarring. This led to the loss of her sight, problems with her memory, reduced risk awareness (cognitive impairment) and the regular drowsiness. She was at high risk of getting another brain infection which would be difficult to treat due to her poor kidney function as the medication to treat the infection is toxic to the kidneys. She was at high risk of other infection and becoming more unwell very quickly. If she goes off her medication, she is at even more risk. The route of medication is currently via the PEG.

- Family's wishes were for her to travel to Portugal where she can have more family support. MDT consider this as possible but not advisable due to her health vulnerability. However, the MDT worked with the family to realize the plan of transfer. This discharge coordination process was led by her keyworker, the lead physiotherapist.
- From a nutritional perspective to support a PEG discharge can be complex and organizing for abroad we had to imagine all possible events to keep her safe. The follow steps were considered and taken:
- Trial prior the discharge higher energy feed of 2 kcal/ml and reduce volume and time for feed so that its only 1 bag used overnight, to monitor tolerance.

Nutritional support

- Fresubin 2 kcal 900 ml at 100 ml/hr. for 9 hours overnight (15 hrs. rest in the day and encourage oral intake). Plus 50 ml water flushes pre and post (+/-) each feed bag. Provides 1800 kcal, 67.8 g protein, and 1000 ml per day. If she tolerates i.e. no issues with bowels or vomiting, increase rate to 120 ml/hr. for 7:30 hrs. overnight.
- This may help encourage oral intake in the day with assistance due to vision change.
- Trial of bolus feeds if she unable to eat in the day. Using bolus and fluids in the day can help on the travel abroad.
- All above can be addressed by the community dietitian in the UK or handed over to a hospital in Lisbon, Portugal.
- Reach out to hospital and colleagues in Portugal to see what feeds suppliers are used and equipment, to see capacity and availability. Determine if we can change and settle her on any changes while she stable.
- Handover to UK community or Hospital in Portugal:
- The doctors are recommending that the medication is administered via the PEG on discharge. They need to ensure water flushes pre and post each drug to prevent the tube from blocking.
- Provide a guide for water flushed with medication: flush tube with 30 ml sterile water using a 50 ml syringe before any medication.
- Provide details of the PEG, type, how it was placed, dates of insertion and any known complications and rational used.
- Provide PEG feed regime and/or medication for nursing staff to do- they can also help with feed and water flushes?
- Provide a stoma saving device (Enplugs, Corstop) for emergencies.
- PEG site CARE instructions: daily clearing, weekly monitor: advancing and rotating.
- Overnight PEG feed with the head of the bed raised to reduce the risk of aspiration.
- She will require assistance to eat and drink, recommendation for red tray system.
- MDT planning travel: what airport, time of waiting, comfort, form of travel to the airport, wheelchair access, what to suggest of there are delays, aim for shorted travel time, when landing to access hospital on new site as soon as possible.
- The hospital and family called the team to confirm she arrived in Portugal safely. I would commend the keyworker for her amazing coordination to support this discharge.

3.4 Commissioners' Statement for 2022 - 2023 Quality Account

NHS
North East London

Commissioner's Statement for Mildmay 2022/23 Quality Account

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

Thank you for asking us to provide a statement on the 2022/23 Quality Account and priorities for 2023/24.

We welcome Mildmay's intention to continue to work toward improving the quality of discharges and patient outcomes, building on the work carried out in 2022/23 and to refresh its 3–5-year plan to ensure viability and sustainability. We are impressed by the effort Mildmay has put into gathering patient feedback in order to understand patient experience, as well as staff feedback to ensure that Mildmay provides a positive place to work.

We congratulate Mildmay on adapting to the complexity of providing a homeless step-down pathway and a detox pathway for a very vulnerable cohort of people and for the willingness of its staff to work with Inclusion Health and other local health professionals in order to develop processes and build expertise.

We are grateful to Mildmay and its staff for their commitment to collaboration and partnership working that will further 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 2022/23 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

30.06.23

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Appendices

Supporting statements

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

- The lead commissioners, commissioners and CNS
- The Overview & Scrutiny Committee (OSC) of the London Borough of Tower Hamlets or its Health Board.
- Health watch
- Mildmay Trust

Statement of Directors' responsibilities for the Quality Account

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

Management Team

Geoff Coleman
Chief Executive Officer

Dr Simon Rackstraw
Medical Director

Justine Iwala
Head of Human Resources

Norma Martin
Head of Finance

Comfort Sagoe
Clinical Lead Nurse

Teri Milewska
Registered and Compliance Manager

Patricia Nkansah-Asamoah
Admissions Manager

Miklos Kiss
Fundraising and Communications 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.

Mildmay Mission Hospital

Chief Executive Officer: Mr Geoff Coleman MIHM DMS MA MBA

President: The Rt Hon the Lord Fowler

Patrons: Professor the Lord Darzi of Denham, Dame Judi Dench, Sir Cliff Richard, Sir Martyn Lewis CBE

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