Mildmay Mission Hospital

Annual Quality Account

April 2020–March 2021

Annual Quality Account 2020-21

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Introduction

Mildmay Mission Hospital is delighted to present our Quality Account for April 2020-March 2021. As Mildmay provides healthcare services that are commissioned by NHS England and Clinical Commissioning Groups (CCGs), 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.

The Quality Account is an important way for Mildmay to report on the quality and improvements in the services we deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided. This includes information on how how well we are doing, continuously improving the services we provide, and how we respond to checks made by regulators like the Care Quality Commission (CQC).

Every Quality Account will include:

- A signed statement from the most senior manager of the organisation
- Answers to a series of questions all healthcare organisations are required to provide
- A statement from the organisation detailing the quality of the services it provides.

For more information about Quality Accounts, visit the NHS website: bit.ly/2U3jCsC

PART 1
Chief Executive's Statement

On behalf of the Board of Trustees and the Executive Team, I am proud to present the 2020-2021 Quality Account for Mildmay Mission Hospital. This account looks at our progress and achievements across 2020-2021 and looks forward to some of our key priorities for patients in 2021-2022.

At Mildmay Hospital, our focus in the past has been on providing specialised and individually tailored treatment and rehabilitation for people living with complex or challenging health conditions associated with HIV within a supportive, compassionate and caring environment. Over the past year we have also provided step-down care for homeless patients discharged from NHS Acute Trusts across London. 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 2020, the Charity was facing the potential closure of its clinical services in the UK. With a reducing number of HIV patients being granted funding for our HIV services the hospital quickly became unsustainable. All of this quickly changed with the arrival of the COVID-19 pandemic and the hospital was asked to step up and support other NHS services across London.

The first few months were particularly challenging as we treated a new cohort of patients, some of whom had COVID-19 and required isolation. With a large number of clinical staff given redundancy in March, prior to the anticipated closure of the hospital's clinical services, we had to rely heavily on bank and agency staffing. This reduced over the course of the first quarter and more so by then end of the second.

There were many challenges with the new cohort of patients and the first three to six months was a steep learning curve. By the summer with the end of the first peak in the number of COVID patients the situation became more relaxed and the hospital began to settle into a routine. By the autumn it was clear that we were heading into a second peak and the pressure on patient turn-around was intensifying. This reached its peak towards the end of November and was sustained throughout December and much of January before once again beginning to relax.

During the year the homeless step-down contract was extended twice and whilst the charity would have liked to see a long-term contract this was not possible. As we look to the future and the possibility of a third peak just beyond the horizon we still do not know whether the hospital will be financially viable but we hope that we will continue to have a place providing services alongside our NHS colleagues in London.

Geoff Coleman MIHM DMS MA MBA

Chief Executive Officer

Statement on service quality at Mildmay

Patients are referred into Mildmay who are living with HIV infection and other complicating co-morbidities. 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 a rehabilitation pathway which involves nursing, medical and therapeutic interventions, 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, and through this, we can demonstrate the clinical effectiveness of our interventions and cost-effectiveness of our service.

We seek feedback continuously from patients, their loved ones, our staff and other clinicians; and try and incorporate recommendations generated from that feedback to try and improve the quality of our services. Our Friends and Family Test shows that **92% of the patients surveyed have given positive feedback.**

Mildmay Hospital provides care and rehabilitation for patients living with HIV infection, 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 that Mildmay Mission Hospital provides and maintains a high-quality service.

Dr Simon Rackstraw FRCP
Medical Director

About Mildmay

Mildmay is 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 the UK, our hospital specialises in rehabilitation, treatment, services and care for people with severe and complex HIV-related health conditions, including HIV-associated brain impairment. Mildmay delivers services to the NHS through the mechanism of multilateral contracts with some London CCGs (Clinical Commissioning Groups). It 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 26 ensuite rooms over two wards, each with a communal lounge, kitchen, assisted bathrooms and secure entry/exit system.

Our Day Therapy wing includes a large lounge where our music and art therapy sessions take place. It also incorporates our physiotherapy gym and Occupational Therapy Assessment Centre, digital inclusion suite 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, chaplaincy and volunteers.

Please note that In the light of Department of Health & Social Care guidelines relation to the COVID-19 pandemic, Day Therapy Services have been suspended until further notice.

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.

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 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, 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.

Our hospital's foundation is Christian and 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 wellbeing 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 with the chaplaincy and Mildmay.

Registration Details

Mildmay Mission 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).

Mildmay Mission Hospital's services

Mildmay Inpatient Care and Services

Mildmay Mission Hospital has historically provided care and rehabilitation for adults with physical, cognitive and psychosocial concerns associated with living with HIV. 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 are rehabilitated according to their identified needs. Self-management is encouraged as far as practicable.

In response to the pressure on acute beds created by the COVID-19 pandemic, Mildmay developed a new pathway of care, specialising in providing holistic step-down inpatient care to patients who are homeless.

This new pathway of care is available to patients who are HIV-negative, as well as those who are HIV-positive. Homeless patients are referred to Mildmay by acute hospitals across London, once they are medically stable. Patients are then able to access Mildmay's specialist medical, nursing and therapy input as well as receive support from the in-house Social Care and Housing team. The aim of the holistic Homeless Pathway is to provide patients with respite and rehabilitation support with the goal of being rehoused on discharge. In addition, patients are linked in with support services within the community, for example substance misuse, district nurses and mental health services.

The Homeless Step-Down Pathway runs in parallel with the HIV Rehabilitation Pathway. As part of Mildmay's Homeless Step-Down Pathway, several beds have also been reserved for patients who are homeless and need to self-isolate due to a positive or suspected COVID-19 diagnosis.

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: Homeless COVID Care

AIMS

- To accommodate and provide medical and nursing support and isolation facilities to homeless people in London who present with symptoms of COVID-19, have been in contact with COVID-19 or have a confirmed COVID-19 diagnosis.

Day Therapy Service

- This service was suspended due to COVID throughout the reporting year 2020/21.

Supporting Teams

Mildmay has in-house catering (ensuring that individual dietetic requirements are met), a facilities team, a small administration team and a fundraising and communications team.

Admission and Discharge

Admissions are managed by the Admissions Officer supported by an administrator. The Admissions team rapidly responds to referrals, and forwards to the medical team to assess for suitability for the rehabilitation programmes at Mildmay. The team communicates with other health and social care professionals and facilitates for funding to be secured for admission of our HIV patients.

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 by email to admissions.mildmay@nhs.net. Referrals are only accessed for eligibility and suitability as there is block funding in place for this service.

Referrals for COVID care beds are for homeless patients who are either posive for COVID or have COVID like symptoms and need to self isolate. Patients may be referred and admitted under the COVID care pathway 24 hours a day, 7 days a week. The COVID-19 referral mobile telephone number is 07895751370, which is held by the nursing team out of hours. The mobile phone will need to be returned to the Admissions team every morning, Mondays-Fridays.

The designated email account is COVIDcare.mildmay@nhs.net. Our designated COVID-19 mobile number is 07895751370 (formerly 07376185873).

Mildmay employs a discharge nurse and a housing officer who are responsible for ensuring patients are discharged in a timely fashion and a safe manner. All other members of the MDT contribute to discharge planning.

Colleagues from Mildmay's multidisciplinary team

PART 2

Looking Back: Priorities for Improvement 2020/21

Priority 1: Sustainability

Description:

The 2020-21 financial year has been all about sustainability, the capacity to endure and having the potential for long-term maintenance of relevance and viability. To this end we have several targets:

- 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 establish a new step-down care service for homeless patients in London.
- To identify other potential step-down services for local Acute Trusts.
- To re-establish our Day Therapy services to meet the needs of our existing and new cohorts of patients.
- To work with other third sector partners in both the HIV and Homeless sectors to develop the new services and forge long-term relationships.
- To continue to develop our electronic patient record system (EPR) to better meet the needs of our patients and demonstrate the outcomes that the hospital can achieve.
- Consideration should be given to commissioning or developing a database, bespoke to the service, which better supports data capture, analysis and reporting. The service needs to develop a system by which data can be captured from each of the
- practitioners on a real-time basis. This could be done as a group at the weekly multidisciplinary meeting, or—via a shared database—with practitioners entering data in the relevant fields in real time.
- Given the need to be able to reassure commissioners about the service's expertise in
- working with patients with a substance misuse problem, cognitive impairment, and associated challenging behaviour, there needs to be a particular focus on these areas when capturing interventions and outcomes.

Looking Back: Priorities for Quality Improvement 2020/21

During the COVID-19 pandemic, over the course of the year, our priorites changed drastically and we quickly developed a new service, looked at sustainability, provided effective clinical care to our existing cohort of HIV patients in the face of COVID-19 infection, developed a database to start our Electronic Patient Record.

We also supported staff by highlighting infection control and prevention practices, provided adequate PPE, vaccines and testing as well as training in other forms of support for staff and adopted new strategies for ordering and maintaining stock levels. We also aimed to provide a holistic patient experience in the face of the pandemic.

Priority 1: Development of Homeless Pathway in a pandemic

We were given the go-ahead to start a service for people who are homeless just a few days before the hospital was due to close down. We rapidly mobilised ourselves in terms of staffing (some staff had been made redundant) and began the service.

We have gone through several phases to meet the growing needs of London homeless population. We started off with the provision of 12 step-down beds, which were increased to 14. In June 2020, we were requested to demarcate some beds for homeless patients who needed to self-isolate because they were positive for COVID-19 or had symptoms.

For this service we provided daily sitreps, weekly data and quarterly performance reports to West-East London NHS Commissioners for the block homeless step-down contact.

Priority 2: Delivering Effective Clinical Care to HIV cohort in COVID-19 Pandemic (Infection Control and Prevention)

In line with IPC recommendations we continued to deliver effective clinical care to our HIV patients who fall in the category of patients requiring 'shielding' from potential COVID exposure. All HIV positive patients and HIV negative homeless patients were screened for Covid prior to transfer to Mildmay. In the event of COVID positive patients being admitted, they were immediately allocated single rooms in the isolation area on the second floor and later stepped down to HIV or standard step-down homeless rooms after testing negative for COVID. National guidelines are adhered to.

All patients (HIV positive & HIV negative homeless) were screened, daily as a minimum, with a temperature check and COVID symptom check. If any patient was pyrexial >37.7C or had other symptoms compatible with the PHE definition for possible COVID, they were moved to a single room in the isolation area and their room is terminally cleaned according to current PHE COVID guidance.

All 26 rooms on both wards are single occupancy which has positively impacted on transmission rates of Covid within our facility. In the year under review, there was no evidence of nosocomial infection with COVID among our existing Covid negative patients.

Priority 3: Staff Support

Following the implementation of our new homeless service, there has been an increased risk of verbal assault by patients to staff, as has been demonstrated by increased incidents of verbal assaults to staff in the first quarter of the year. Our priority was to train staff in managing challenging behaviour, there was a combination of online and face to face training. We provided monthly sessions with our speak up guardian. During the pandemic, staff had access to additional psychological support, they could book telephone appointments with either our clinical psychologist or one of our chaplains.

Priority 4: Holistic Patient Experience (Visitors Procedure)

In the light of COVID-19, managing patients' visitors became a challenge and we adapted our procedures to reflect national guidelines. A room was designated for visits, as visitors were not allowed on the wards. All visits required booking in advance, with visits at designated times to allow for the room to be sanitised. The procedure has been under continous review and was adapted as the COVID-19 guidelines were updated. We are currently using the seventh version in response to changing COVID guidelines.

We aim to continue facilitating visits where possible; balancing safety, national guidelines and the holistic care of patients.

Priority 5: Development of a database for Homeless Pathway

Over the past eighteen months Mildmay has been developing an electronic patient record system. The vast majority of the work for this has had to be carried out in-house because the two options of either purchasing a ready-made system or being included in an already operational system from one of our partner NHS Trusts was not achievable. Stage one was to replicate our existing Patient Administration System, completed during the summer of 2000. Stage two was to add clinical functionality and was completed by March 2021. We are on the final phase which will be completed by the end of 2021.

Priority 6: Improvement of Food and Food Service

Following our annual PLACE inspection, we identified areas that require improvement within our food service. We aim to continue to improve menu choices and food services at Mildmay and use feedback from our patient survey to develop this aspect of the service. We established a Task and Finish Group to drive through the necessary changes involving a range of clinical and non-clinical professionals, we re-established our a regular forum for discussing ongoing improvements based on concerns from patient feedback and appointed a ward host.

Looking Forward: Priorities for Quality Improvement 2021/22

Priority 1: Documentation of Safeguarding Concerns

Following the audit of our homeless service, it was highlighted that 13 safeguarging issues weren't picked up. However the majoroty of these cases had already been dealt with by referring teams. We plan to implement a new system of acknowledging, documenting and reporting safeguarding issues which have already been dealt with by referring teams. The CCG will be supporting us with learning in evidencing safeguarding issues and set out agreed actions which we can be audited against.

Priority 2: Demonstrating Clinical effectiveness for the Homeless Pathway

We have demonstrated the clinical effectiveness of our HIV services using UKROC-validated measurement indices. This is not yet clearly defined with our new homeless service. There were two audits of our homeless service; one internally and the other externally. One commissioned by the Mildmay and the other by Healthy London Partnership. We aim to develop tools and processes to demonstrate clinical effectiveness in our homeless step-down care using existing NHS key performance indicators like the Discharge to Access. Benchmarking with NHS priorities. Seek benchmarking data from other Discharge to Assess and step-down services (via the Integrated Care System Leads)

Priority 3: Completion of an electronic patient record system

We will continue the work we started in transforming our current patient administration system into an electronic patient record system. We aim to replace all paper based records with the electronic system by the end of 2021 for all of the pathways.

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 COVID Care

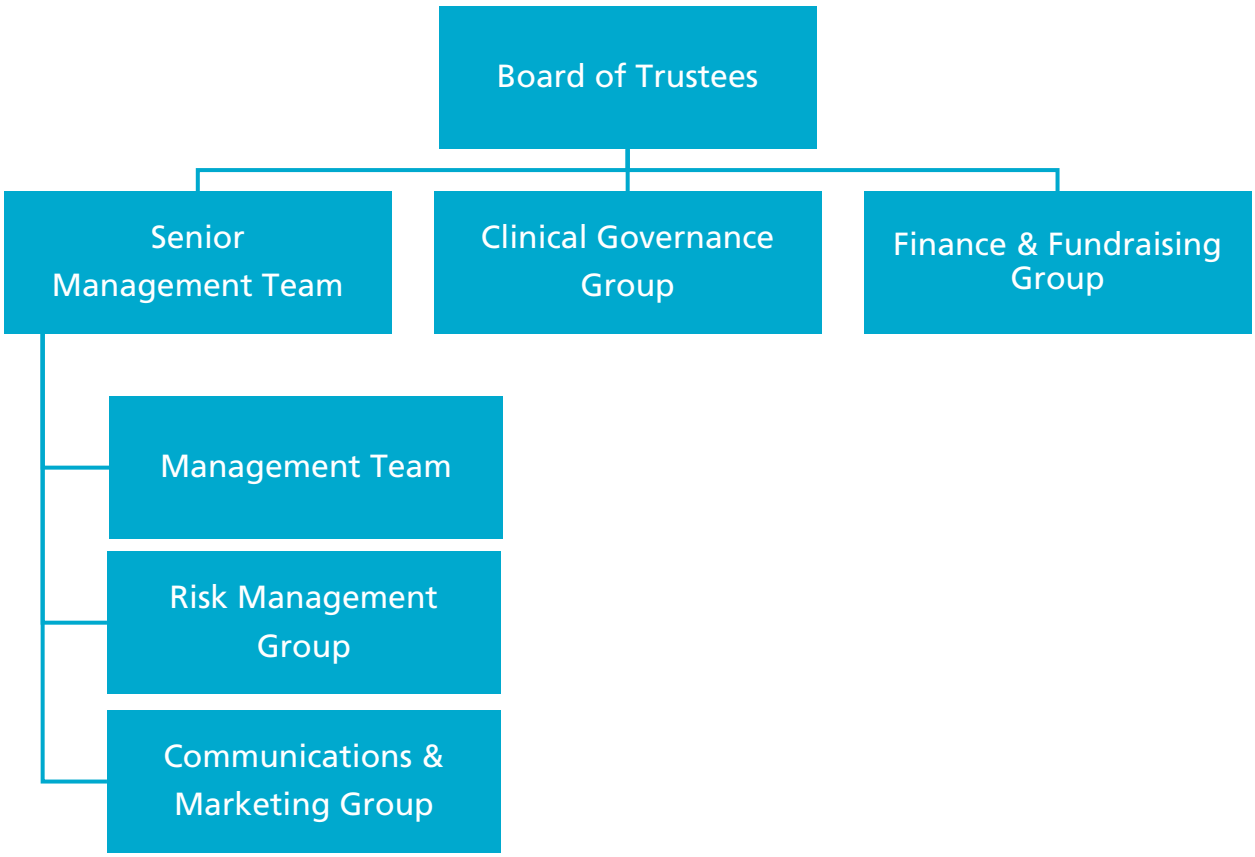
Dr Simon Rackstraw, Mildmay's Medical Director, is a Consultant and a Fellow of the Royal College of Physicians of London, and continues to be in demand for knowledge-sharing and information exchange.

During the period, Mildmay submitted Quarterly Performance Reports to NHS commissioners and referring clinical nurse specialists (CNSs) for the the HIV and Homeless pathways. in the form of a Key Quality Performance Indicator (KPI) table with additional narrative and commentary.

The Mildmay Management Team met daily and then weekly to discuss management and operational issues during the COVID pandemic for prompt action and support.

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

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 Senior Management Team (SMT)

Members: CEO, Medical Director, Head of Finance, Head of Human Resources

Objectives:

1. Contract Performance
2. Marketing & Communications
3. Finance & Fundraising
4. Human Resourcess
5. Operational
6. Risks for the main board

Directors will invite attendees as required.

Timing: Monthly

Mildmay Management Team (SMT)

Members: CEO, Medical Director, Clinical Lead Nurse, Head of Finance, Admissions CNS, Head of Estates and Facilities, Head of Human Resources and Registered 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: Monthly

Clinical Governance Group

Members: Trustee (medical) Chair, Trustee (nursing), Trustee (Health Management), Trustee (medical/public health), CEO, Medical Director Lead Nurse, Therapies Representative, 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 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, Head of Estates and Facilities, 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), Lead Nurse, Day Service Manager, Registered Manager, Fundraising Manager, others as required, by invitation.

Objectives: Oversight of the following activities:

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

Timing: usually monthly

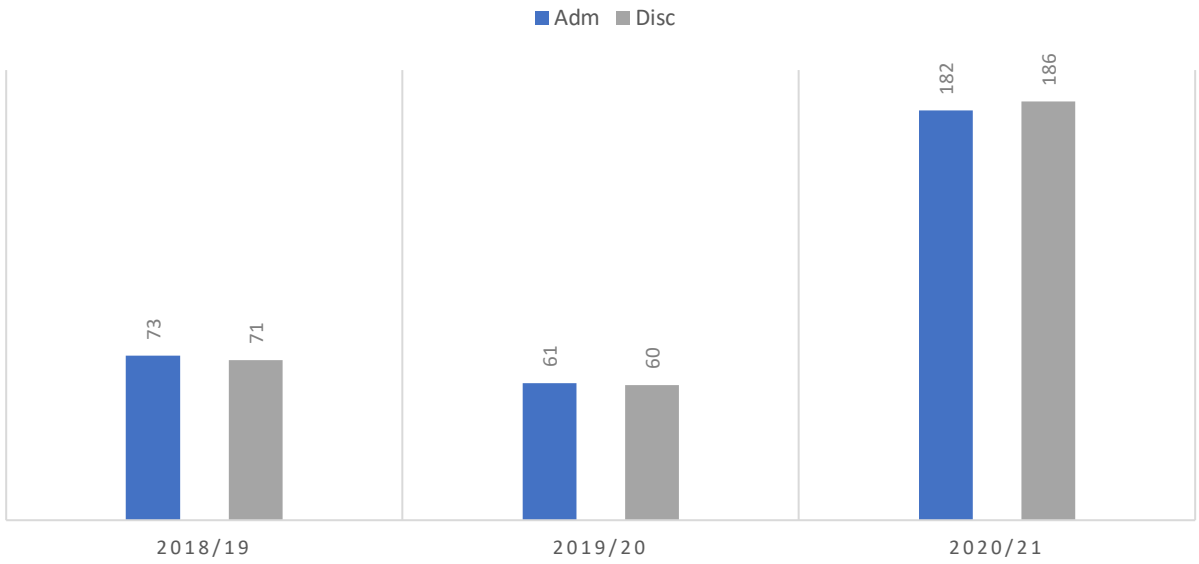
Review of Services

Referrals for HIV are received by telephone or email mostly from Clinical Nurse Specialists (CNS). Mildmay is usually able to accept transfer promptly once funding has been approved. All patients are assessed within 24 hours of admission.

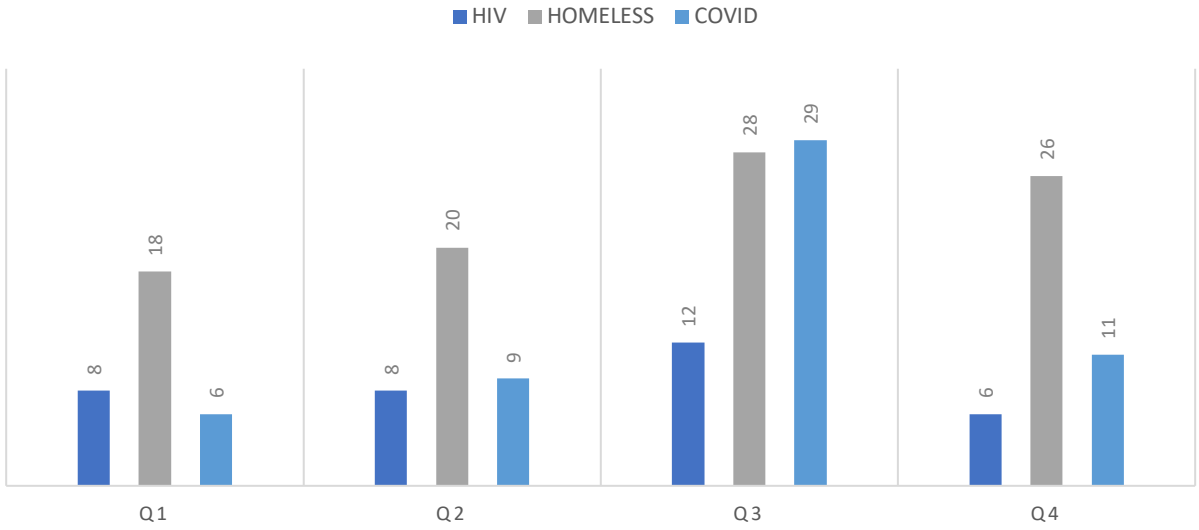
Referrals for homeless step down care are mostly from hospital homeless pathway teams, complex discharge coordinators and hospital social work teams. They complete a referral form which is sent to us by email at admissions.mildmay@nhs.net.

Referrals for Covid care beds are for homeless patients who are either positive for Covid or have Covid-like symptoms and need to isolate. Patients may be referred and admitted under the Covid care pathway 24 hours a day, 7 days a week. The Covid-19 referral mobile telephone is held by the nursing team out of and returned to the Admissions team every morning, Mondays-Fridays. The designated email account is Covidcare.mildmay@nhs.net.

Admissions versus discharges

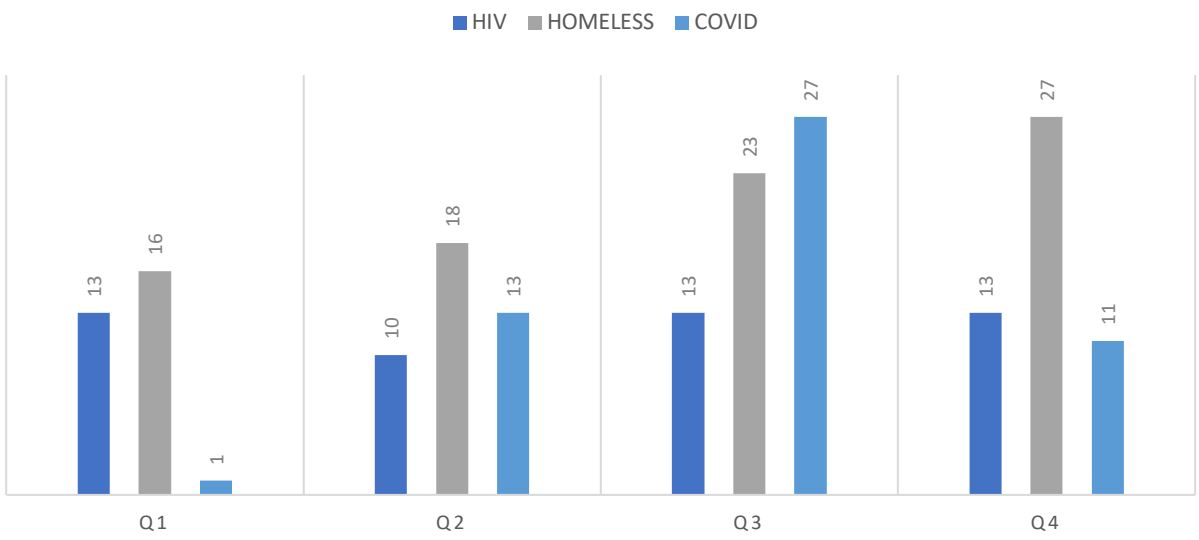


Patients admitted to Mildmay:



Admissions	Q1	Q2	Q3	Q4
HIV	8	8	12	6
Homeless	20	19	28	26
COVID-19	4	11	29	11
Total	**32**	**38**	**69**	**43**

Patients discharged from Mildmay:



Discharges	Q1	Q2	Q3	Q4
HIV	13	10	13	13
Homeless	16	18	23	27
COVID-19	1	13	27	11
Total	**30**	**42**	**63**	**51**

For HIV patients only:

Services	2018-2019	2019-2020	2020-2021
Admissions	73	61	34
Discharges	71	60	49

For Homeless patients only:

Services	2020-2021
Admissions	148
Discharges	137

HIV patients are admitted to a rehabilitation programme that ranges from 6-8 weeks. Discharge plans are begun on admission and progressed throughout the stay. HIV patients who have reached the desired level of rehabilitation are discharged to a safely to the planned destination based on their care needs post rehabilitation. Our homeless step down patients are discharged after 6 weeks, however patients could be discharged earlier or later but majority of discharges are planned. Covid care patiets are discharged afrte their isolation period or could be stepped down to a homeless bed based on their medical needs.

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.

Clinical Commissioning Groups (CCGs) fund approximately 80% of each bed-day.

Participation in External Audit

During this period, our homelss service was audited by the CCGs and the Healthy London Partnership. Results of the audit were shared and lessons learned were implemented.

Internal Audits

The homeless service was audited internally with lessons learned and other strategies implemented.

Internal Clinical Audits

Clinical Audits have taken place in Mildmay Mission 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

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 in HIV during the reporting period.

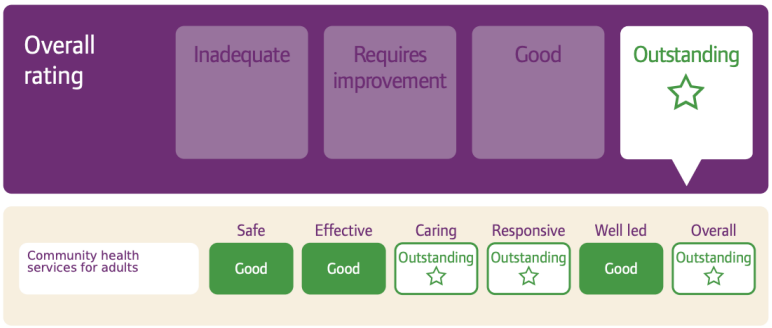
NO clinical staff participated in research approved by a research ethics committee at Mildmay during this period.

Care Quality Commission report summary

Mildmay is registered with the CQC (Care Quality Commission 1-2151037387) to deliver services under two regulated categories:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

Mildmay received an announced CQC inspection on 5th/6th April 2017 and on 31st July 2017, Mildmay was rated as **Outstanding.**



In the summary, elements of care highlighted as Outstanding were as follows:

- support for patients beyond clinical care
- emotional support with personalised spiritual and social support
- an extensive timetable of therapeutic activities
- comprehensive rehabilitation focus aimed at greater independence
- comprehensive volunteer support programme aimed at the main at reducing patient isolation
- Board representation from two HIV positive individuals, including a former service user
- patients involved in their rehabilitation programme.

The relevance of Data Quality

Capturing, storing and measuring data is necessary for measuring the quality of services**.** Mildmay uses i-Care for recording patient information, although it also maintains a paper-based notes system. i-Care meets information governance requirements and is a programme used by a range of health & social care providers, including specific NHS bodies, to provide robust and accurate outcome data.

Mildmay follows the UKROC (UK Rehabilitation Outcomes Collective) data acquisition processes and provides information that is compliant with UKROC peer group comparison frameworks. This contributes to the evidencing of the outcomes for patients who access Mildmay's services.

The Homeless services required that daily Community Discharge Sitrep is submitted to NHSE, daily Sitrep submitted to WEL CCG for Step-down beds and COVID Care beds, Capacity tracker for vacancies with an emphasisi on COVID beds. There are weekly submissions to WEL CCG on patients in Step-down beds and COVID Care data for Healthy London partnership.

Clinical Coding error rate

Mildmay was not subject to the Payment by Results clinical coding audit in 2019/20 by the Audit Commission.

NHS Number & General Medical Practice Code Validity

Mildmay has not submitted records during the reporting period for inclusion in the Hospital Episode Statistics as it is not a requirement of the contract with our commissioners.

All patient-identified information is protected – sent via secure *nhs.net* emails.

Summary hospital-level mortality indication (SHMI)

This indicator, which measures whether mortality associated with hospitalisation was in line with expected levels, does not apply to Mildmay as a tertiary health service provider.

PART 3

Review of Quality Performance

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

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. For example, incidences reported about the measurement of liquid controlled medications resulted in changes to Mildmay's internal medicines management procedures in line with national guidelines. Mildmay uses a word-based incident reporting template, located on its shared domain.

- Recording of incidents (and how they were responded to) will demonstrate the service's effectiveness and formally recording the reasons for any refused referrals will reassure commissioners that the service is not 'cherry picking' in order to work with patients with lower levels of challenging behaviour.

Being responsive to incidents is important to the staff at Mildmay. To understand the cause 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.

117 incidents were reported in 2020-2021, summarised in the table below.

Summary of incidents

	Q1	Q2	Q3	Q4
Falls	-	5	12	6
Near Miss falls	6	1	4	
Pressure Ulcer	3	-	-	
Wounds - other	-	1	-	
Medication	3	1	2	2
Absconscion	5	3	1	
Absconscion/Fall	-	-	1	
Confidentiality	-	1	2	
Maintenance/Estates/Security/Catering issues	-	9	5	5
Substance misuse	-	1	1	2
Smoking	2	5		4
Behaviour	1	1	1	
COVID-19 self-discharge	-	2	-	
Allegation	-	1	-	
Aggression	4	-	1	1
Infection Control	-	-	1	1
Accident	1	-		
Theft/Loss of Property	2	-	1	
Feeding Tube				1
Controlled Drugs				1
Oxygen				1
SLT				3
Total number of incidents	**27**	**31**	**32**	**27**

Falls

Falls continue to be the highest reporting incident and an audit was conducted by our Lead Physiotherapist.

AIMS

- To investigate whether current Falls Policy and Procedures are effective in preventing and managing the falls risk at Mildmay Hospital.
- To investigate whether current Falls Policy and Procedures are being followed by Mildmay staff
- To identify staff training needs

METHOD

Retrospective analysis of all Falls Incident Reports and patient notes from December 2019 - December 2020 (inclusive). Audit tool developed based on Mildmay Slips and Falls Procedure, Mildmay Post Falls Protocol and on previous Mildmay audit results (2016-2018).

RESULTS

Falls Incidence Data:

- 27% incident reports submitted in the specified time period were reporting patient falls (104 incidents in total, with 28 falls incidents)
- Total = 32 falls. The equates to an average of 2.9 falls per 1,000 bed days
- Total number of patients who fell 2019-2020 = 16 patients. 50% of falls were repeat fallers.
- William Ward = 94% of falls, Catherine Ward 6% Falls.
- Severity of falls: Near Miss 6%, No apparent injuries 88%, Minor Injuries 6%.
- No calls to London Ambulance Service (LAS) due to a fall. No falls resulted in acute hospital admissions.
- 75% of falls were unwitnessed

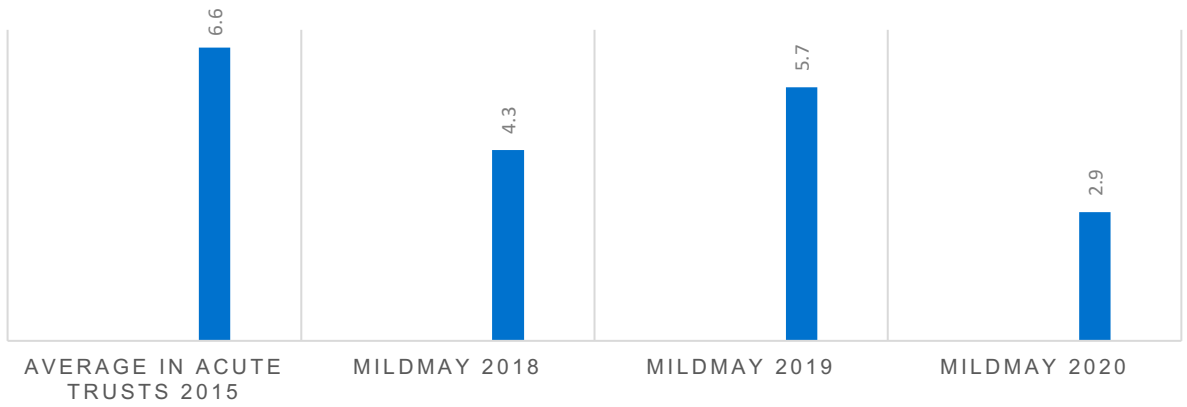


Fig 1: Falls rate per 1,000 beds. Comparing falls rate with national average as per RCP Audit 2015 with falls rates in Mildmay in 2018, 2019 and 2020.

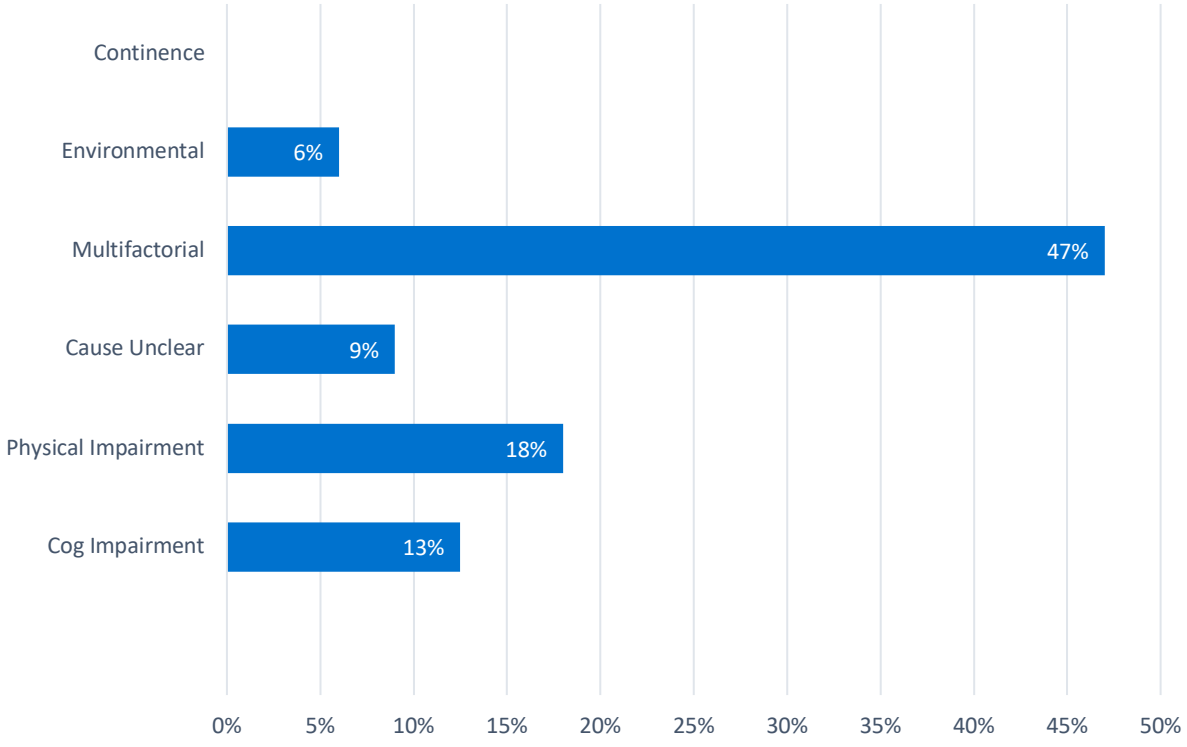


Fig 2: Main Cause of Falls as per MDT Assessment

- Physical Impairment includes balance impairment, lower limb weakness.
- Cog Impairment includes reduced risk awareness, reduced problem solving resulting in impulsive behaviour patient not calling for help.
- Multifactorial includes cognitive, physical and behavioural impairment.

Falls Management Data:

- 100% of falls required no wound care at all.
- 9% patients (n=2) did not have their observations (obs) done, according documentation, immediately after a fall. In 1 case a patient declined for their obs to taken.
- 93% of Post Fall Action Plans implemented – as evidenced in the notes.
- 28% were had observations done 4 hourly post fall
- 18% of patients' families were informed post-fall
- 25% of falls not referred to in physio notes in post-fall physio session.

General observations during Audit:

- Falls not consistently documented in the notes despite an incident report being submitted.
- Falls not consistently documented on the obs chart as post falls obs.

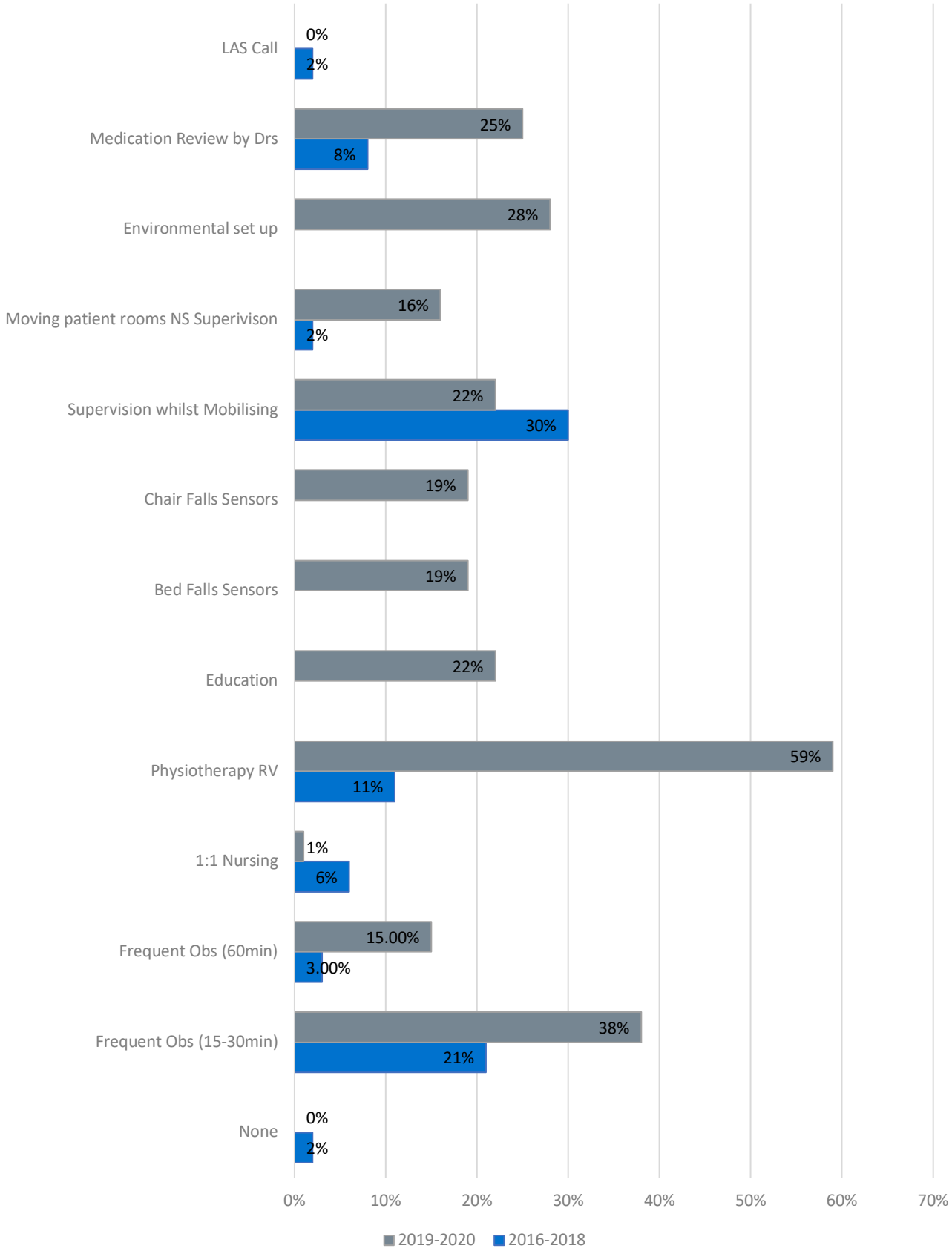


Fig 3: Post Falls Management / Preventative Measures comparing audit data 2016-2018 and 2019-2020

Analysis:

During 2020, Mildmay had a significantly higher number of admissions and the lowest number of falls in several years (see figure 1). In addition to having robust falls management procedures at Mildmay, the development of the homeless and COVID pathways on Catherine Ward is likely to be a factor in this. Patients on these pathways are largely younger, independently mobile and cognitively intact and consequently have a lower risk of falls. Patients on these pathways also had shorter admissions and a higher turnover in comparison to patients on the HIV pathway. However, patients under the homeless pathway have sustained falls; and many of them presented with falls risk factors. There have been a number of amputees and poly-trauma patients admitted under this pathway who are at high risk of falls and have had falls. This is reflected in significantly higher incidence of falls on William Ward (94% of falls), the HIV ward, in comparison to Catherine Ward, the COVID and Homeless pathway ward. Patients on the HIV pathway generally have complex impairments and multiple comorbidities; presenting with physical, cognitive and behavioural impairments is the main cause of falls at Mildmay in 2020 (see figure 2).

The severity of falls occurring over this period were low with 88% of falls having no apparent injuries and only 6% of falls classed as minor injuries. There were no serious falls and no fractures due to a fall. No falls resulted in a LAS call or acute hospital admission.

It was difficult to accurately analyse some of the post fall staff actions due to Mildmay Falls Procedures and Protocols not specifying when hourly and 4 hourly observations should be carried out. 68% of patients had their observations carried out immediately after the fall with no further observations until the next standard observations. It was documented in 91% of falls were highlighted to the medical team immediately post fall, so it may be that frequency of observations were discussed but this was not specifically documented. Neurological observations were not consistent within the notes, obs charts and incident reports. The ACVPU (Alert, Confusion, Voice, Pain, Unresponsive) Scale was used more than Glasgow Coma Scale (GCS). NICE Guidelines for Falls in Older People, 2015 [QS86] state that based on NICE Head Injury Guidelines 2019 [CG176], neurological observations for all patients where head injury has occurred or cannot be excluded (for example, unwitnessed falls) should use GCS. Since 75% of falls occurring at Mildmay were unwitnessed falls, the GCS should have been used more frequently. This has highlighted the need for a review of falls protocols and procedures.

50% of patient falls (n=8 patients) were repeat fallers. All these patients were on the HIV pathway and had combination of physical, cognitive and behavioural impairments. Causes of falls and their management in this group is complex and multifactorial in nature. Falls prevention strategies such as falls sensors, increased nursing observations, environmental set up were used and reviewed in this group of patients. It would be beneficial to carry out regular reviews of whether patient specific falls management strategies are being implemented. This could be in the form of bed sensor and call bell audits.

Only 18% of falls were documented to be reported to patient's families / Next of Kin (NOK). This is a significantly low number and issues with documentation are likely to be a factor. This was previously identified as an issue and in order to improve this, the incident

form was amended to include an "Informing NOK" section in incident forms in July 2020. The absence of this section on the older forms may have skewed the data. It was also noted that there was limited documentation in the notes of discussions with family. This needs to be addressed with all staff members through training and notes audits.

Comparing 2019/2020 and 2016/2018 audit results shows that falls management / preventative measures have improved in some areas. There was a documented increase in medication reviews by the medical team, a higher percentage of patients were moved to rooms closer to the nursing station and more patients had a falls review with physiotherapy post fall. In 2019/2020 there was less requirement for 1:1 supervision and increased 15-30 and 60min nursing observations to check on patients' safety. It is unclear whether the reduced need for 1:1 supervision is due to higher frequency of nursing checks or due to patients having different needs based on individual risk assessments within the 2 cohorts. Based on 2018's audit recommendations, bed and chair sensors were to be purchased. Falls sensors were used in 19% of patients who had fallen (n=3). Falls sensors were used in the repeat fallers group.

This audit demonstrates that Mildmay has an MDT approach in managing falls, where management and prevention strategies includes the medical, nursing and therapy teams. Research has shown that multiple interventions performed by the multidisciplinary team and tailored to the individual patient can reduce falls by 20–30%. (RCP National Falls Audit 2015).

Recommendations:

1 Amend Slips, Trips and Falls Procedures and Post Falls Protocol to define when more regular post falls observations need to be carried out.

2. Amend Slips, Trips and Falls Procedures and Post Falls Protocol to specify the Glasgow Coma Score as the preferred neuro assessment to be carried out as per NICE Guidelines 2013.

3. 2020 Falls Prevention and Management workshops for all staff and presentation of Falls Audit Results.

4. Assigning the responsibility of informing NOK / family of a specific member of the MDT e.g. keyworker or person completing the incident form (to be discussed within the MDT).

5. Development of a guideline as to how to complete a falls incident report to ensure all information is recorded and to ensure staff are aware of varied falls management options.

6. Improving documentation within clinical notes through education and regular notes reviews when incident forms are submitted.

7. Close monitoring of repeat fallers and their management plans to reduce incidence of falls within this group of patients.

8. A review of how and when falls sensors are used.
9. Clear methodology for collecting and analysing audit data is documented to enable more accurate comparisons in future audits.

Audit Limitations:

- It is important to note that differences in case mix appears to have had a big impact on falls rates.
- The difference between previous and current audit results is likely to be impacted by different methodology in collecting data. In the 2016-2018 audit, only data from Falls Incident Reports were included. In the current audit, data form Falls Incident Reports and patient notes were included in audit.
- Data in this audit is derived from incident reports and patient notes. Some falls which were reported via an incident report were not documented in the patient notes which raises concerns regarding accuracy of the notes – it is likely that some actions were carried out but not recorded. This will have an impact on the data.

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

Controlled Drugs Incidents

- Quarterly reports in relation to Controlled Drugs are submitted to the Local Intelligence Network in April 2021.
- Procedures have been reviewed and losses of liquid medications of a volume greater than 5% are reported as an incident, (for example, a loss greater than 5ml in a 100ml bottle of Oramorph would be reported as an incident).
- There are occasionally very small discrepancies whereby the volume of a liquid controlled drug is actually greater than expected. These discrepancies are however too small to be reported as an incident, as per the procedure detailed above i.e. they are less than 5% of the total volume of the liquid medication
- The nursing team are reminded to be vigilant, document accurately and report any losses as soon as they are noted, before they accumulate
- Liquid controlled medications are measured in full on a weekly basis
- Controlled Drugs are audited by the Clinical Lead Nurse and Nursing Team Leader
- In addition, the Registered and Compliance Manager undertakes spot checks of CD registers
- Any discrepancies in tablets always need to be reported as incidents, however there have been no such occurrences noted
- Staff are encouraged to use the same type of enteral syringe whilst measuring liquid medications, in order to maintain consistency and accuracy.
- Monitoring, training & supervision on safe management of controlled drugs is ongoing.
- All non-stock controlled drugs continue to be destroyed as per procedure as soon as possible after the patient has been discharged or after a drug is no longer being prescribed.

Complaints

There were 4 formal complaints in the year 2019-2020.

Complaint 1 (Quarter 1)

Procedures and Practices on the Ward

A complaint/concern was raised by a patient's partner in relation to nursing and therapeutic practices on the ward including access to phone calls/video calls on the ward, Mildmay's visitors procedure and nursing staffing levels.

Management of the Complaint

- An internal investigation took place
- Meetings were held between key members of the Mildmay team and the patient's partner, to discuss the concerns raised in depth
- The external safeguarding team undertook a thorough investigation and meetings were held between all stakeholders
- The multidisciplinary team worked alongside the patient and his partner to improve the patient's care experience at Mildmay. The patient reported feeling more satisfied with his care as the admission progressed.
- There have been significant challenges as a result of the COVID-19 pandemic and the impact that the government guidelines have had on the visitors procedure at Mildmay. The concern/complaint related to the restrictions to visiting, however Mildmay Mission Hospital, like all healthcare organisations has been obliged to significantly restrict visitors. Mildmay has continued to review the visitors procedure in response to changes to government guidelines
- During this period Mildmay's staff attempted to mitigate against the visiting restrictions by facilitating video calls and telephone calls between patients and relatives/partners/friends. The concerns raised by the patient's partner helped to improve these processes for this patient and for others, and facilitating contact between patients and their loved ones remains a priority for Mildmay's team
- There was a higher proportion of agency staff covering nursing shifts in April 2020 as a direct and initial result of the COVID-19 crisis, and an increased number of nursing staff being required due to increased patient numbers. This was later resolved as Mildmay recruited a number of nursing staff into substantive and bank nursing posts
- The investigation highlighted areas which could be improved for example in relation to documentation.

Lessons Learned

The concerns raised helped to improve Mildmay's practices in facilitating contact between patients and their loved ones during the COVID-19 pandemic. It raised awareness of the importance of video calls, telephone calls and other forms of communication during the national lockdown and enabled Mildmay to develop creative ways of facilitating communication. The concerns raised helped to improve communication on the ward within the team and between the team and the patient and his partner/family. The concern/complaint enhanced multidisciplinary team working and promoted the development of a positive working relationship with the patient's partner.

Complaint 2 (Quarter 1)

Procedures and Practices on the Ward

A verbal complaint was raised by a patient and her relative in relation to available equipment, room availability, staff attitudes and general practices on the ward.

Management of the Complaint

- The management team liaised with the patient and her relative to resolve the issues that had been raised
- The patient raised concerns and queries re nursing practices on the ward for example queries in relation to her wound care and catheter. The issues were discussed with the nursing team and resolved
- The patient raised concerns in relation to the communication skills and attitude of some of the nursing staff. This was explored and the relevant staff were spoken to
- The patient complained about the type of food available. The ward staff and catering staff worked alongside the patient to identify alternatives
- The patient progressed well through her rehabilitation and was discharged home.

Lessons Learned

The complaint highlighted the importance of working in partnership with patients and their families to resolve any concerns in as holistic and person centred a way as possible. It highlighted the importance of effective communication within the team

Complaint 3 (Quarter 1)

Admissions Processes

Complaint received from a commissioner re Mildmay's practice of limiting new admissions to a maximum of two per day and our request for acute centres to transfer patients to Mildmay by midday.

Management of the Complaint

- A telephone meeting was held between the commissioner and Mildmay's CEO and Registered Manager
- Mildmay needed to balance the capacity of its team, risk management and safety concerns with flexibility
- Mildmay requests for acute centres to transfer patients early in the day if possible, but will also continue to be flexible and will not turn away any patients who are transferred after this time
- The restriction is in place as Mildmay's SHO's work 9-5pm and require sufficient time to admit a patient, liaise with acute centres, order any required medications etc. This is particularly significant on Fridays prior to a weekend. Quite often, patients have been admitted from a range of acute centres without the correct TTO's, care plans and discharge summaries in place. Our team require time to resolve these issues and need to be able to liaise with external teams, clinics, pharmacies etc while they are still open
- Patients also require sufficient time to be assessed by therapists on admission for example for mobility aides and individual dietary needs
- Admissions are planned in advance and generally the majority of patients are admitted by early afternoon however there are exceptions
- Mildmay has since demonstrated increased flexibility and changed its practices by at times admitting patients under the homeless Covid-Care pathway late in the evenings – however, patients under the Covid-Care isolation pathway often require less medical input than, for example patients under our other pathways and, if admitted late, these patients are then not assessed by the medical team until the following day .

Lessons Learned

The complaint raised important issues around admission processes and the necessity of balancing flexibility with effective risk management.

Complaint 4 (Quarter 2)

Attitude of Therapist

A patient complained about the attitude of one of the therapists prior to a therapy session. The patient became very emotional when discussing issues on the ward. The therapist cancelled the therapy session as he did not feel that it would be appropriate to continue until the patient had calmed down. The patient became very upset by this and accused the therapist of being rude to her. The patient raised a formal verbal complaint.

Management of the Complaint

- The Registered and Compliance Manager investigated the allegations and incident
- It was arranged for an alternative therapist to work with the patient, with immediate effect
- The Registered and Compliance Manager met with the patient and her next of kin
- The therapist's line manager (the Medical Director) and the Registered and Compliance Manager formally met with the therapist to discuss the incident in depth
- Human Resources was informed of the incident
- The Registered and Compliance Manager kept the patient updated as the investigation progressed and apologised to the patient on behalf of Mildmay that she had had this experience
- The Registered and Compliance Manager liaised with the Clinical Lead Nurse re the concerns the patient had raised re issues on the ward.

Outcome

- Following investigation, there was no evidence found that the therapist had been rude or aggressive towards the patient
- The therapist reflected on the incident and the way he had communicated with the patient. He was aware that he should have been more aware of boundaries and the way that he had communicated to the patient that her therapy session should be cancelled i.e. he should have waited until the patient had calmed down before communicating this information to her
- The patient continued to receive psychological support and Psychiatric input throughout the duration of her admission

- The patient continued to access therapy throughout the duration of her admission but chose to see an alternative therapist. This was facilitated for her, as per her wishes.

Lessons Learned

- The therapist utilised the incident as a learning experience and would use this to develop his interpersonal skills
- The Registered and Compliance Manager and Clinical Lead Nurse worked together to manage this patient's care needs and to use this incident to inform best practice.

No formal complaints were received in Quarters 3 and 4.

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 whistleblow do not suffer detriment. This policy can be found on the intranet and is introduced to all staff during induction.

Mildmay Mission Hosptial HIV Patient Risk Assessment For Covid Pandemic

Infection Prevention and Control

Mildmay Hospital received a letter from the Director of Quality & Safety for Waltham Forest, Newham and Tower Hamlets CCG in June 2020 suspending the placement of HIV patients at Mildmay Hospital until adequate assurance is in place that the cohort of COVID-negative HIV patients (many of whom are likely to fall in the category of patients requiring 'shielding' from potential COVID exposure) are not mixed with the non-HIV homeless COVID-positive/negative patients.

Gaps

The placement of the COVID isolation area was not ideal for an isolation area as it was next to a communal area. It was difficult to maintain social distancing in day rooms without close supervision.

Mitigating Actions

COVID-suspected/positive patients' isolation rooms were moved to the other end of the ward (rooms 1-7) next to the back door which was away from the communal areas and staff caring for the patients in isolation can enter and exit by a separate doorway from other staff/patients.

Rooms 1,2,4,& 5 were ring-fenced as COVID isolation rooms and a privacy screen was placed across the corridor in between those rooms. Rooms 1,2,4,&5 were better suited as COVID isolation rooms as they are next to the 'back door' and there was an additional corridor toilet for extra staff hand hygiene facilities.

Advice that communal day rooms should not be used was implemented.

The Homerton University Hospital Infection Prevention & Control team were assured that there were adequate infection, prevention & control measures in place for the segregation of the cohorts of HIV positive patients and HIV negative homeless patients.

A few minor points to improve risk reduction for all patients were noted.

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 the training conducted in the year 2019-2020.

Mandatory training

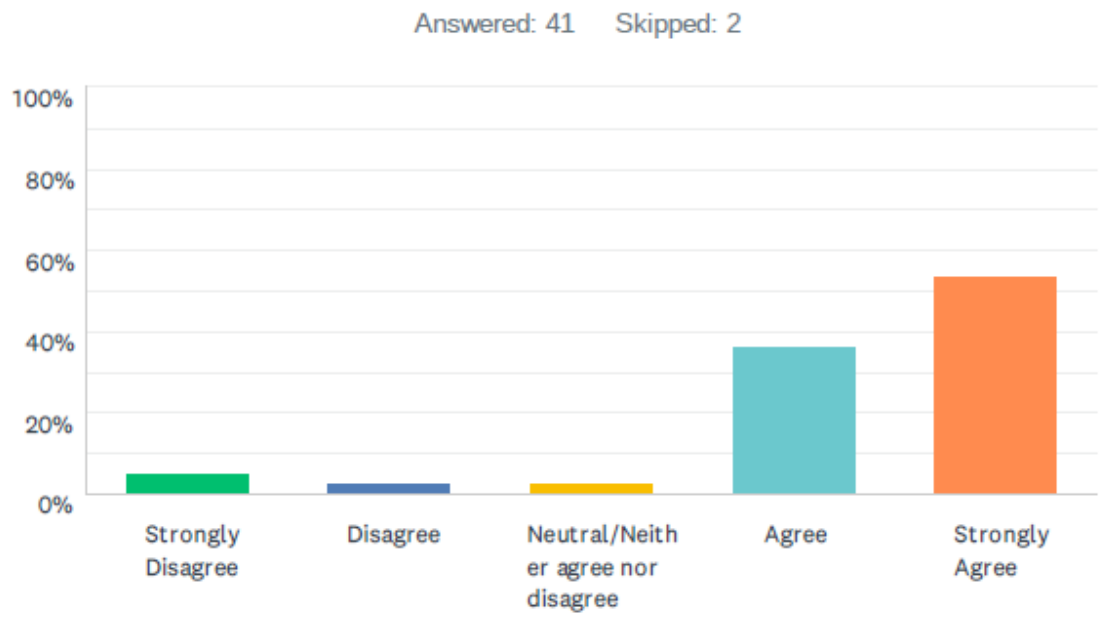
	% of completion
GDPR for Health & Social Care	93.47%
Moving & Handling of People and Objects	93.47%
Handling Violence & Aggression / Managing Behaviour that Challenges	91.30%
Safeguarding Adults	82.60%
Basic Life Support	93.47%
Bullying and Harassment	89.13%
Equality, Diversity and Inclusion	84.78%
Fire safety for Health & Social Care	91.30%
Food Safety & Hygiene	91.30%
Health & Safety Training Level 2	91.30%
Infection Prevention & Control	89.13%
Coping with Stress	91.30%
Communication Skills	91.30%
Complaints Handling	86.95%
Conflict Resolution	89.95%
Consent for Health & Social Care	86.95%
COSHH	91.30%
Countering Bribery & Corruption	89.13%
Dementia Awareness	86.95%
Dignity Privacy and Respect Training	86.95%
Emergency First Aid	91.30%
Information Governance	95.65%

Learning Disability Awareness	86.95%
Lone Working	89.13%
Mental Capacity & DOLs Training	95.65%
Mental Health Awareness	86.95%
Preventing Radicalisation Training	89.13%
Professional Boundaries in Health & Social Care	89.13%
Safe Handling of Medications (clinical)	100%
Safeguarding Children	82.60%
Chaperone for Health & Social Care	89.13%

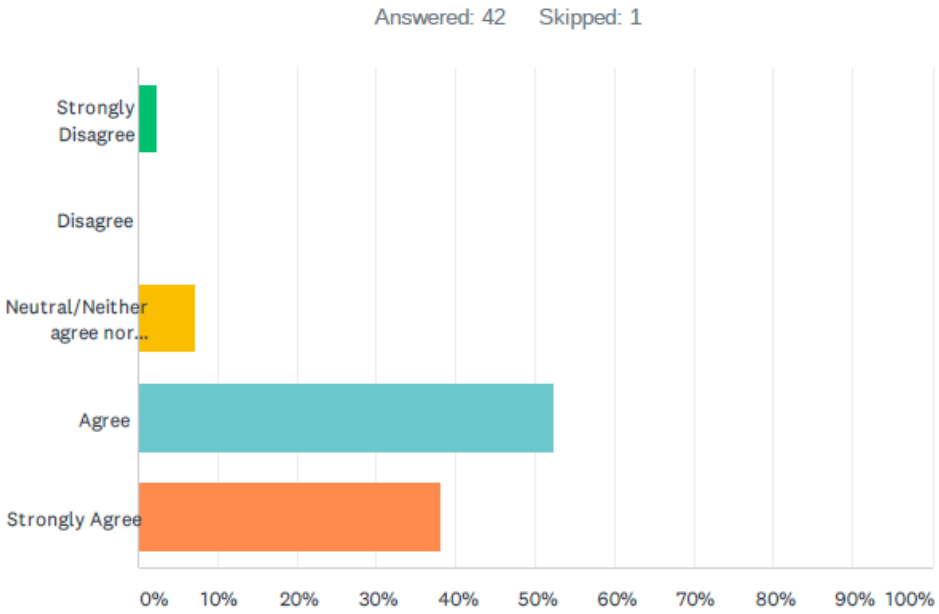
Staff Survey

An anonymous staff survey was conducted on Survey Monkey in April 2021, which gave the following results:

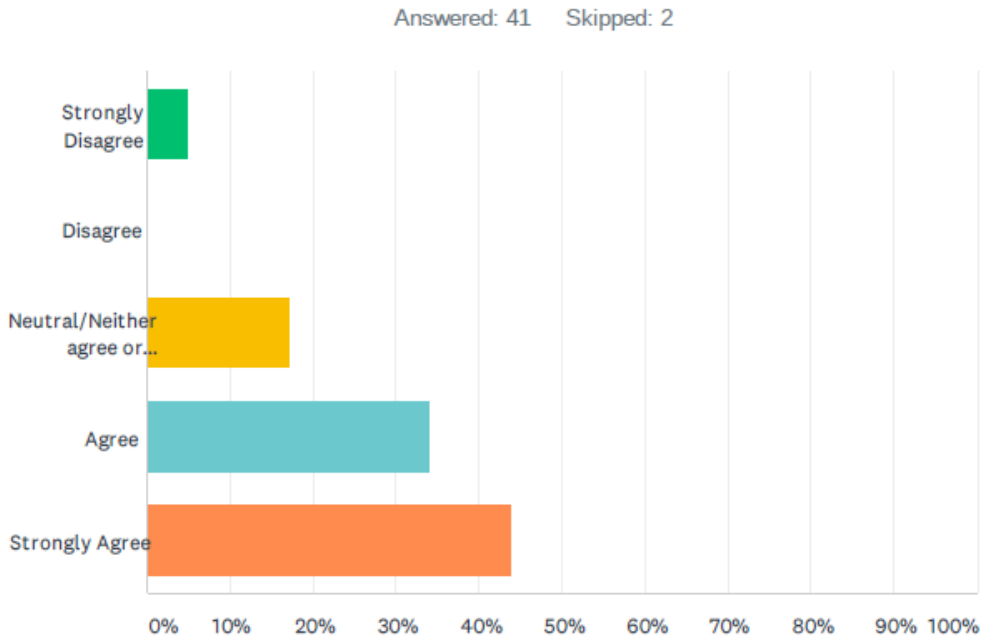
I always know what my work responsibilities are



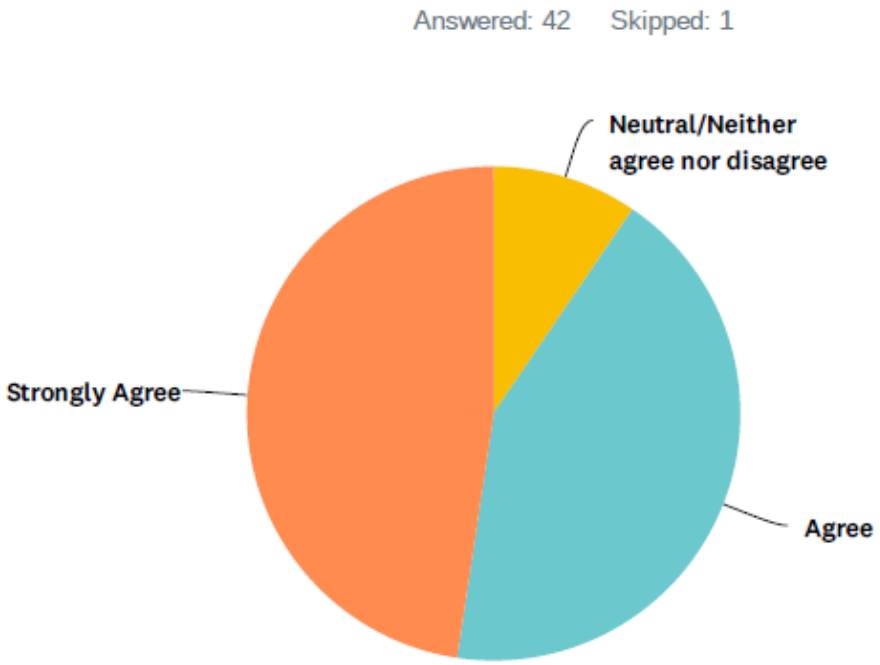
I am able to make suggestions to improve the work of my team



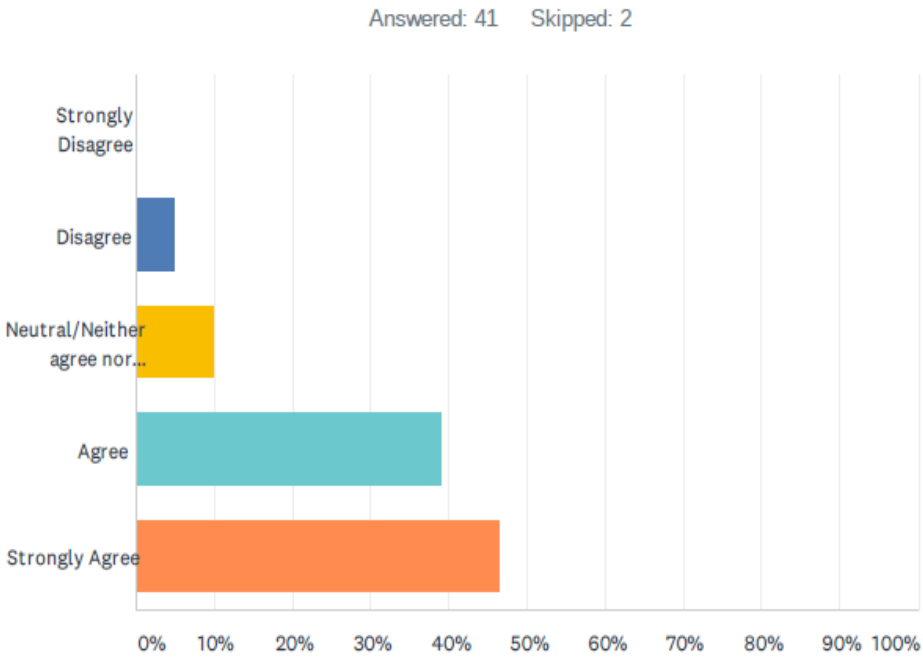
I am satisfied with the support I get from my immediate line manager



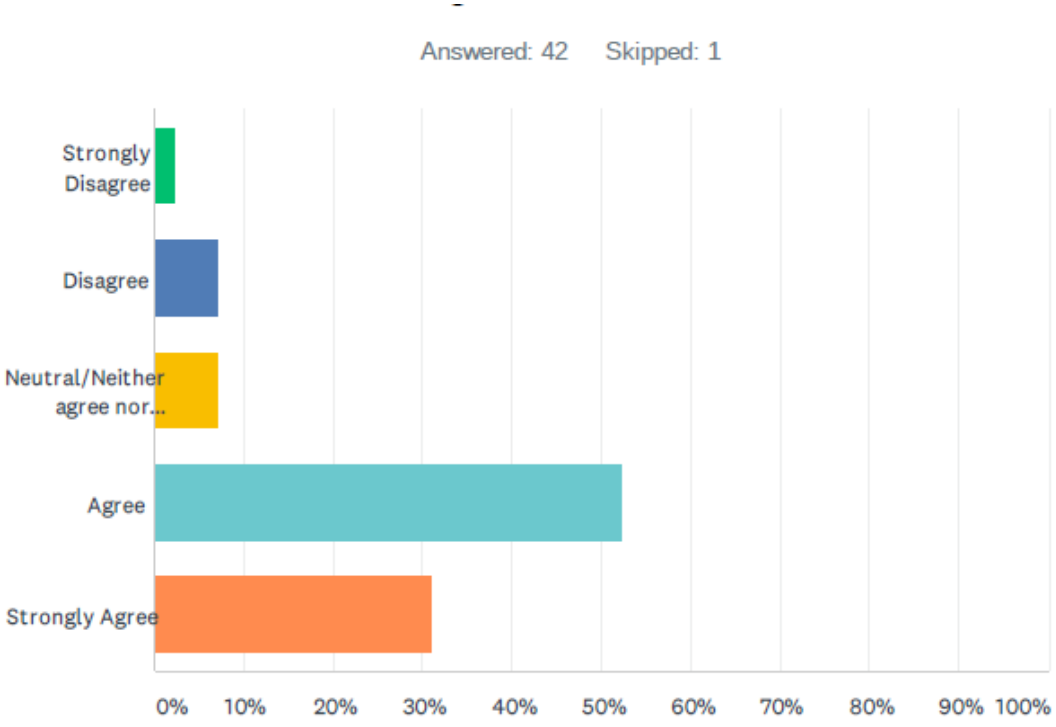
My organisation encourages staff to report errors, near misses or incidents



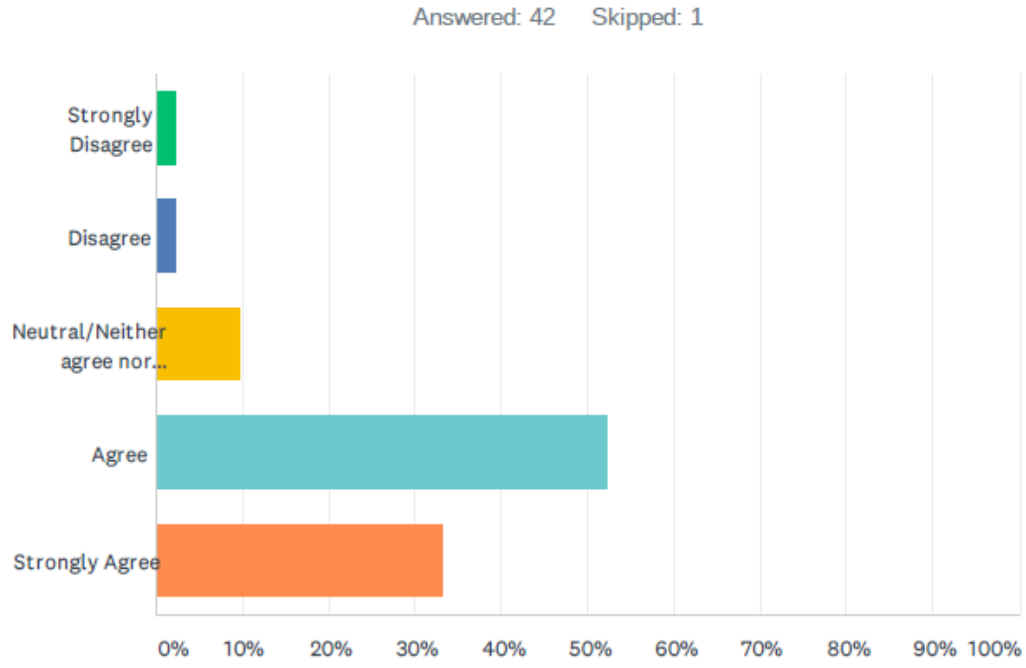
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again



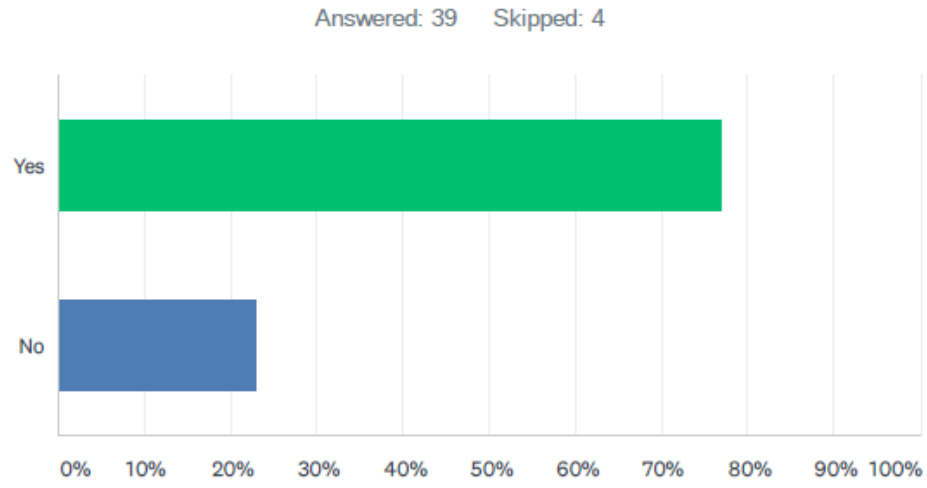
I would feel secure raising concerns about unsafe clinical practice



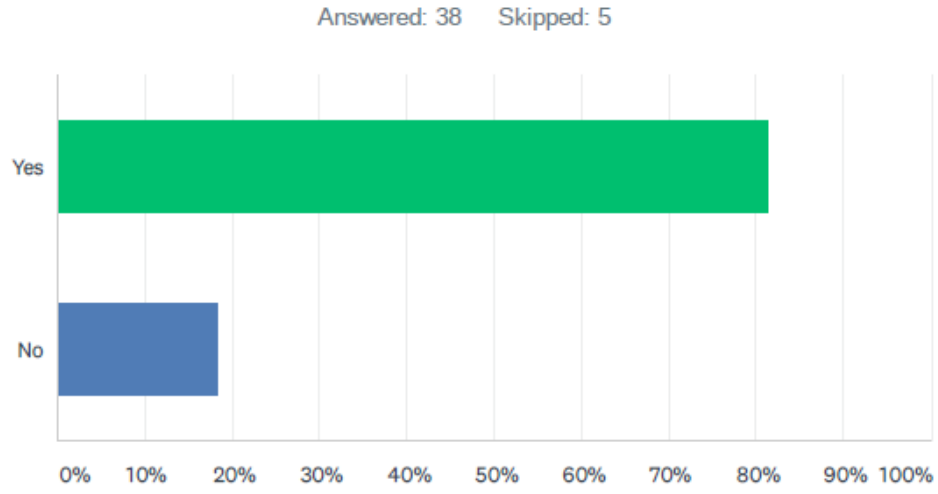
I am confident that my organisation would address my concerns about unsafe clinical practices



If you were working at Mildmay when the homeless service started, were you informed about changes in structure and processes?



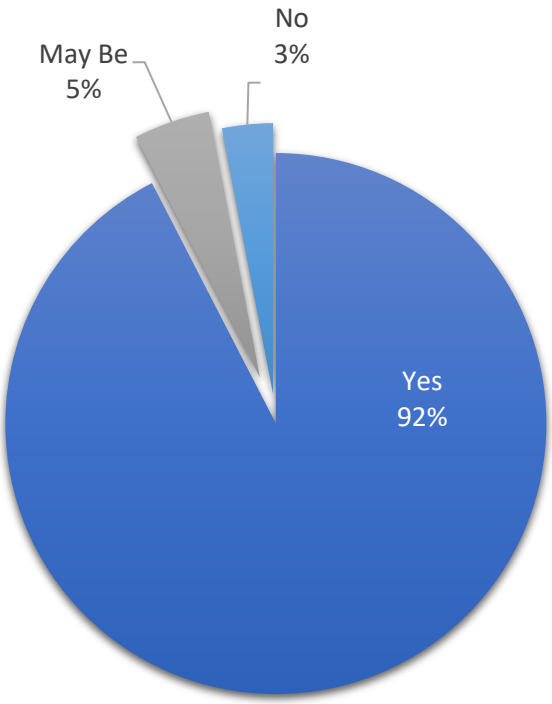
Were there policies and protocols to follow on COVID Care and were these explained at introduction?



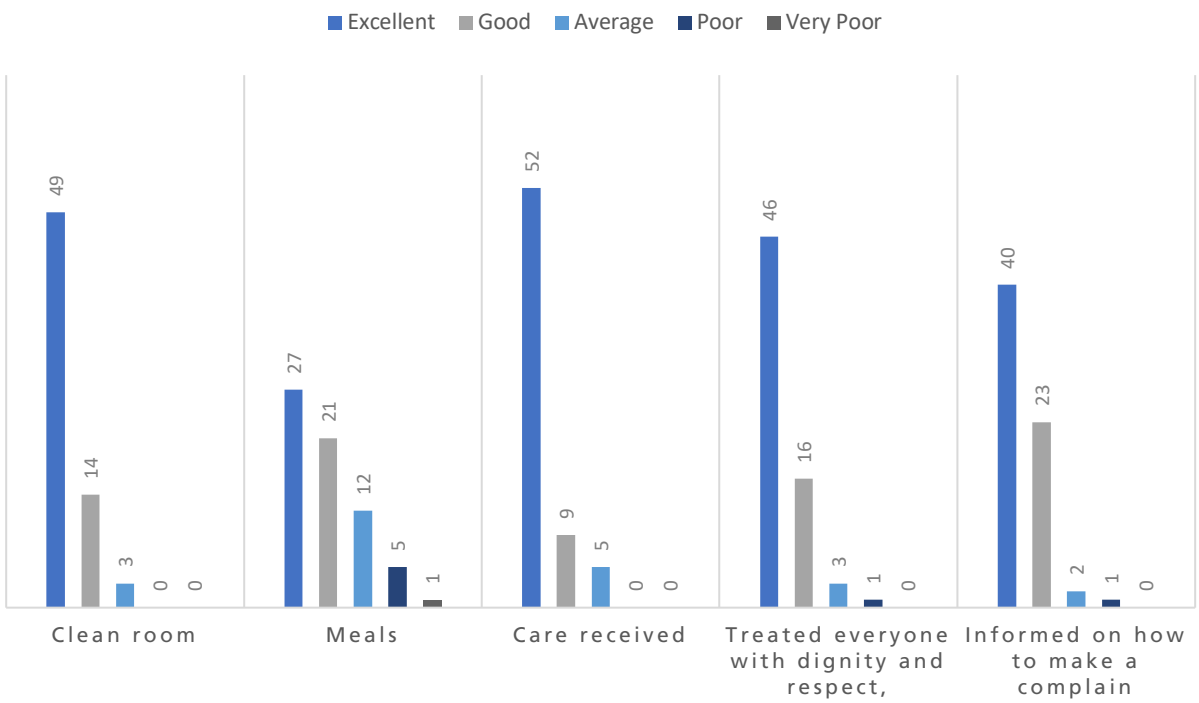
Friends and Family Test:

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

In 2020-2021, feedback was collected from 66 patients when they were discharged. On an average, we had positive responses from 94% of the patients (excellent and good) and 96% of the patients agreed they would recommend Mildmay if their friends and family require it.



Analysis of patient feedback

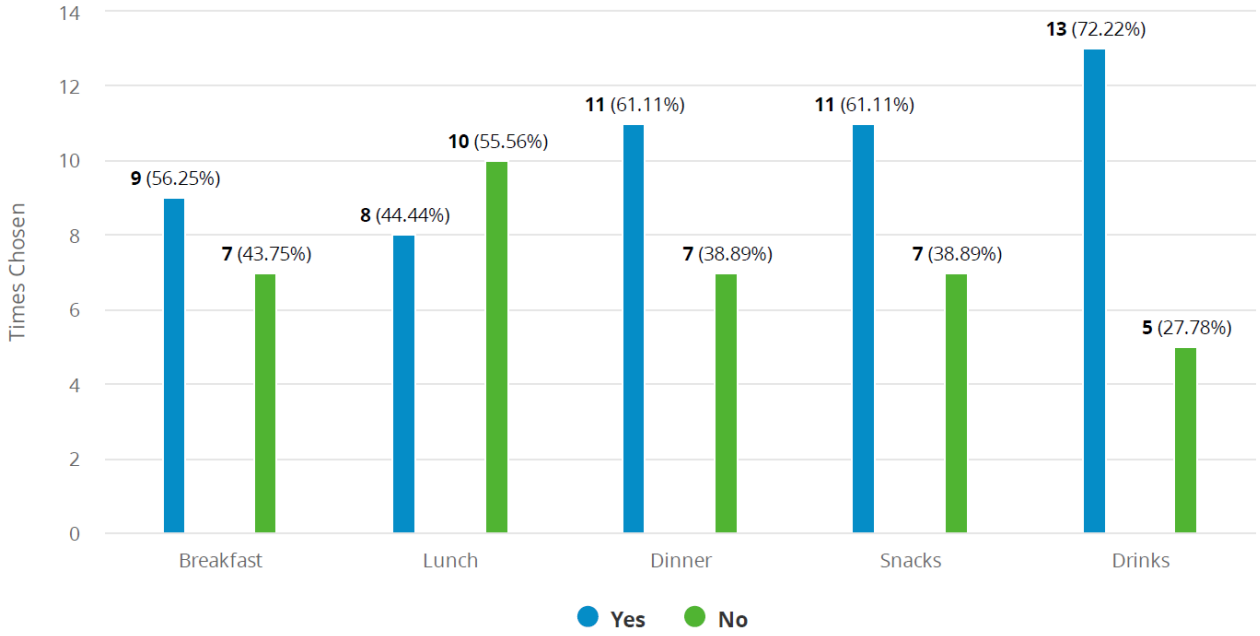


- Most feedback is collected in real-time at the bedside before a patient is discharged. Concerns from feedback are dealt immediately. Compliments are fed back to staff and recorded in monthly dashboards and quarterly reports.
- Approximately**, 94%** of patients gave positive feedback (Excellent and Good) about cleanliness, care received, being treated with dignity and respect and making a complaint.
- **73%** of patients gave positive feedback (Excellent and Good) about food.
- We conducted a catering survey to determine ways to improve foods and food service.

Catering Survey

Regarding hospital meals: Were there enough menu choices?

Number of responses: 18

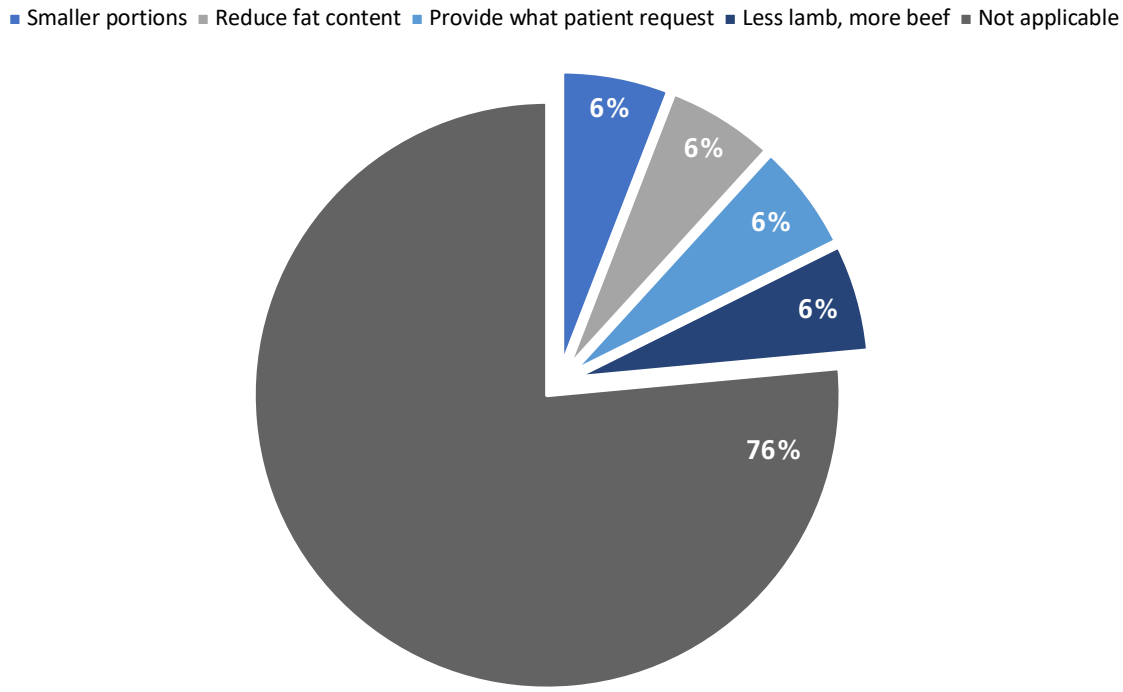


How would you rate your meals?

Number of responses: 18

Suggestions to improve hospital food

Number of responses: 17



Though a lot has been done to improve the food and food service, portion control, reduced fat content and providing what the patient requested will be implemented by the catering team going forward.

Captured comments and case studies

Clinical staff:

"Thank you so much for making this whole rotation at Mildmay so enjoyable. I have loved working with all of you- the team is so friendly and welcoming and I am going to miss everyone. Keep up the good work and all the best. "

GP vocational trainee

"Thank you all for the help and support you have given me over the last 6 weeks. Its been a pleasure to work with you all. Best Wishes."

Student nurse

"Thank you so much for your support during my placement. I am super grateful and saying a big thank you''

Student social worker

Ward patients:

"I thank the management, doctors, nurses for the excellent care you have given me during my stay in your hospital. Mildmay hospital is one of the best hospitals I have ever visited. Staff here are doing an excellent work. I recommend a pay rise for everyone here"

"I would like to thank all of you for your kind support you have given me. Very special thanks to nursing staff and doctors for your friendly support. The dietician, my physiotherapist great job. On behalf of my family and myself, we wish you all the best, and hope you keep on helping those in need''.

"I'll miss everyone- thanking you for everything you've done. I know I have progressed on my journey and that's because of Mildmay staff. Keep up the good work."

''The staff and everybody at Mildmay are professional and showed a lot of empathy and compassion towards me. I am in a better place mentally, physically and emotionally. I am a Christian and I see love in this place''.

Case Studies

Case Study 1

Due to the COVID-19 situation patient X was transferred from acute hospital earlier than would usually be expected. They had been extremely unwell presenting with previously diagnosed HIV but had not engaged with services.

A number of substantial needs were identified as requiring assessment and input from the whole clinical team. These included but were not limited to; adherence support; psychological support, assessment of cognition; assessment and rehabilitation of physical impairment; HIV management; promotion of function and greater independence.

During admission they received input from the following disciplines: medical, nursing, physiotherapy, speech and language therapy, dietitian, occupational therapy, and social work

They had been prescribed antiretroviral therapy and whilst at Mildmay a number of disciplines were involved to work on elements to achieve safe swallowing of medication, and targeted work on developing adherence and understanding of the medication regime.

Success was shown by an improved CD4 count and reduction in viral load

They are currently getting in and out of bed, using their en-suite level shower, and walking indoors with supervision only, and are still improving due to daily physiotherapy and other therapy input. When first at Mildmay an attendant controlled wheelchair was necessary for mobility as they were unable to walk, and were receiving all care from two staff, in bed, on a specialist pressure relieving mattress.

They have also gained greater independence with everyday activities, and are now able to complete some activities independently, that they could not before, and can do some parts of others.

With each session, Patient X quickly engaged in speech therapy despite the range and severity of his needs e.g; severe face/mouth muscles weakness and difficulties with co-ordination resulting in unclear words or sounds, unable to chew and swallow food, unable to safely swallow liquids (risk of choking, chest infection) and facial disfigurement. Cognitive difficulties (e.g. attention and memory) affected language processing and production. Consequently, frequent sessions per day and variety were required to address the range of needs i.e. Swallow rehab: electrical stimulation, facial and throat muscle strengthening, conditioning and retraining with food/liquid; Language Rehab: computer software therapy, speech articulation drills, endless worksheets and then bringing this all together to transition from gesturing/alphabet chart use to being able to produce speech (intelligible enough to enable video calling with loved ones). Patient X embraced novel therapies not widely available in the UK/NHS in addition to the evidence-based practice at Mildmay - the results speak for themselves.

On admission Nil by Mouth with gastrostomy feeding used for nutrition and fluid needs. Oral intake commenced and built up from oral trials to now meeting their full energy and

protein needs orally with a texture modified diet. Gastrostomy tube is only used to make up fluid deficit from oral intake with the aim of meeting full fluid requirements orally.

BMI now weight now within normal range after a 10kg weight gain during admission.

An assessment of their home was completed by Mildmay's occupational therapist as part of identifying whether the person could return home, and what support may be needed to do so, in terms of equipment, and community services. All the clinical team will be liaising with community-based colleagues to ensure information is shared prior to discharge.

Family and others significant to the person have also been involved in the discharge planning process.

Therapist Team

Case Study 2

Medical History

Medical diagnosis: 1) VZV encephalitis with vasculopathy and associated infarct 2) Acute infarct 3) Severe oropharyngeal dysphagia with expressive and receptive aphasia 4) Advanced HIV - CD4 48 5) Reactivated Hepatitis B

The patient was admitted under the Infection and Immunity team at an acute London hospital. Underwent anaesthetic supported MRI head and lumbar puncture, which demonstrated significant active encephalitis and severe vasculitis with thrombo/haemorrhagic events. Further CT angio imaging demonstrated left MCA and right ACA thrombi. After discussion with Neurology and stroke teams, she was commenced on five days methylprednisolone and aspirin (not suitable for IR thrombectomy).

She started to improve on this treatment course, and subsequently began rehabilitation with SLT, physio and occupational therapists (she was not felt suitable for HASU/stroke therapies). She was found to have profound expressive and receptive dysphasia, severe oropharyngeal dysphagia, and right-sided moderate weakness. Due to her ongoing unsafe swallow, a PEG was inserted.

She was noted to have skin changes on the insides of her thighs bilaterally, which were investigated by Dermatology. Skin biopsy was performed which showed plasma cell infiltrates but no evidence of Kaposi's sarcoma. These changes were felt to be consistent with the superficial thrombophlebitis seen on USS Doppler of legs in September 2020. Repeat US Doppler was done whilst she was an inpatient and showed no SVT or DVT. Her case was discussed with haematology who suggested six weeks of treatment dose Tinzaparin due to the ongoing pain and skin changes (this course has now been completed). Dermatology suggested light compression for legs with Tubigrip bandages, then graduated compression stockings if able to tolerate.

The patient's speech and swallow have both improved during her stay at Mildmay and she has been able to tolerate certain thickened foods orally as well as via the PEG.

She was markedly aphasic (both receptive and expressive) on admission; however, her speech has improved somewhat and whilst still aphasic, she is now able to say a few words and communicate slightly better. However, she is very inconsistent in her communication and speaks a bit more around certain favoured staff members. She has been regularly reviewed by the Speech and Language team. She was initially PEG fed but is now tolerating a modified diet orally, although she does need supervision by staff at all times when eating. All medications are administered via the PEG tube by nursing staff.

Social History

The patient is a 51-year-old black African woman, who has lived in the UK for over 15 years. A social care assessment identified the following issues and needs:

Social Isolation, Using home safely e.g. safe use of equipment such as microwave, cooker, taps e.tc, managing her finances, managing activities of daily living, deterioration in her mental health due to noncompliance with her medication and general deterioration in her health / unintentional neglect, lack of insight therefore may be unable to call for support in an emergency, risks of falls especially when her nutrition intake reduces , cognitive impairment which may lead to an inability to verbalise her care needs, Increased risk of wandering, Inability to manage her toileting needs independently, fluctuating needs and capacity therefore a clear assessment of her needs cannot be ascertained as these changes often, choking risk due to ongoing issues with swallowing and oral intake, high risk of unintended significant weight loss.

The patient has a 16 year old son with complex needs. During the patient's admission at Mildmay she was able to attend one of the court hearings with support from a member of social work team, to state her wishes and feelings concerning her son's care and support. The judge was pleased to see that despite her health challenges, she was present (virtually) at court to engage in the process. This was seen as a positive step for the family. The patient's son now has legal representation in place and will be involved in social care processes and procedure where appropriate.

Mental Capacity Assessment and Best Interest Meeting

According to S1 principle 2 of the Mental Capacity Act 2005, an individual is to be assumed to have capacity unless it is established that he does not. 3 capacity assessment were carried out to ascertain the patient's capacity to make a decision on discharge location, sharing information with CCG for CHC Process and litigation capacity. This was carried out and established that the patient lacks capacity therefore we acted under the S1 principle 6 of the Mental Capacity Act to promote the patient's Best Interest: this requires all parties involved in her care and support planning, along with the patient and her Next of kin to meet to discuss what is in her best interests in terms of specific decision such as discharge location. This was well attended by professionals internal and external from Mildmay, and a decision was made that it is in the patient's best interest to discharge her to a care home placement which offers further rehab opportunity.

NHS Continuing Health Care Assessment

Due to complexities in the patient's care and health needs, it was important to have an assessment of her health needs, to decide if a continuing Health Care assessment full assessment is necessary. This process and assessment became a lengthy process due to the complexities in the patient's health needs. The local Commissioning group awarded Funded Nursing Care and Social Services and searched for a suitable long term placement for the patient.

Overall Analysis of case/ Decision on case and recommendation

There have been some challenges both external and internal to her participation and also the range of assessment activities available to her. For example, (necessary NBM, and diet/texture modifications have meant that kitchen assessment options have been inappropriate until recently; the fact that she does not respond verbally to the occupational therapist means it can be difficult to gauge her engagement and understanding of aspects of her care and potential implications when this is discussed with her.

In early January she participated in the preparation of a simple, cold dessert (Angel Delight) under supervision. On this occasion, she did not initiate activity once / when verbally prompted and required verbal and physical cues, plus support to assemble the few items required for the activity. She has however relapsed since then and is currently mainly fed via her PEG.

Physically, when prompted she carried out the activity components but did not do this without input. In the rehabilitation setting, she receives a high level of support and consequently a high degree of oversight. This is protective and reduces risk. – by virtue of the setting/situation and also due to her needs, and presentation. Risks remain however and have been observed even in this setting. For example, she has flooded the en-suite shower-room, and also the area in her bedroom (where there is a sink). Visual cues/signage do not appear to have impacted this as yet.

Regular 30-minute checks by ward staff are in addition to specific support for prompting and monitoring ADLs such as dressing, personal care, and nutrition, and eating and drinking(less than 20% at this present time). She also does not have access to a standard oven on the ward (only a microwave), and it is unlikely that in this setting she would be using it unnoticed or unsupervised, whereas, in the community, this may be more of a possibility.

Mildmay's Occupational Therapist recommends full assistance with all IADLs. If there will be long periods where she is to be left unsupervised then consideration may need to be given to managing kitchen risks, for example by disconnecting gas supply, and only having limited cooking facilities available. She is inconsistent in this setting as to initiation and 'desire' to complete activities. She has ranged from wanting to walk outside (not with OT), to remaining in bed for long periods, and/or not getting dressed.

Telecare may be required (if available in her Borough) for management/alert of wandering; stove/oven use etc. Mildmay staff would need advice/information from her Borough as to what is available. The patient will also benefit from a placement at a neuro nursing placement, to allow her to benefit from a slow stream rehabilitation.

Mildmay's social work team have worked extensively with the patient, her next of kin and her family to ensure that appropriate support and care are in place for the patient when she has been discharged from hospital. It is also key to promote the patient's wellbeing and safety and promote a safe and smooth discharge from hospital. Without a rounded and person-centred approach of working with this patient, her family and other agencies to plan her care and support, there may have been lapses in her care and a risk

Social Work Team

Case Study 3

Patient Q, called this for confidentiality, was a 36-year-old man with a diagnosis of Schizophrenia for about 15 years. The Schizophrenia was being managed on high doses of Clozapine. He was also diagnosed with an Emotionally Unstable Personality Disorder. He was referred to the Mildmay Hospital by the Homeless Team through Homeless Care Pathway.

He had delusional beliefs, and periods of great excitability, anger and frustrations, and periods of deep depression. He had suspected personality disorder and history of behavioural issues. He also had an alcohol habit in excess of 6-8cans /day.

He was referred whilst living in an accommodation-based service (mental health residential setting) where he did not wish to stay. Prior to that he had been in hospital for 2 months where he had had several procedures done on his knee culminating with him having a high knee brace in situ and mobilising on elbow crutches.

While his mental health was not always stable and a risk of suicide was identified, he agreed with his care team that the risk was not necessarily increased by his living in the community. His ability to cope was at risk if he was unwell. His plans were to move on to live independently in the future but expected low level regular support for the time being, and a responsive and increased level of support from time to time when needed.

On the ward, his behaviour was erratic, impulsive, intense and unpredictable. His mood had intense episodes of anxiety, irritability and dysphoria. Several times, especially late at night or early mornings, he would call emergency services to inform them he wanted to harm or kill himself. On several occasions, Ward staff had to deal with concerns expressed by emergency services personnel with regards to his safety. When staff attempted to reassure him, he would become verbally aggressive and would use some explicit racial terms to describe staff. Considering his threats to harm himself and suicidal ideation, his bedroom had had to be stripped and potential risk items removed.

He once attempted to hit a member of staff with one of his crutches. Sometimes he would refuse to take his medication, especially in the mornings. He did not want to be woken up for his medication, and it was unsafe to leave it for him to take it later.

His girlfriend once called the ward, and her input was quite helpful to staff in managing his moods and behaviours. Medical staff eventually adjusted the times he took his medication to accommodate his wishes for uninterrupted sleep.

Being on Clozapine meant he had to have strictly regular blood tests. He was on very high dosage of it. Medical staff ensured he was registered with the Clozapine Patient Monitoring Service (CPMS). In his case, it was every 4 weeks. The patient used to decline to have his bloods taken by a nurse as he preferred Doctors. Sometimes Doctors' schedules meant they will not be able to do bloods on due days. Contingent measures had to be put in place in such situations to ensure bloods were done on time. There were some guidelines to be followed with regards to Clozapine administration: After various inputs from the MDT during his period of admission, he appeared more manageable and was eventually discharged to a place of safety.

Nursing Team (RMN)

Mildmay Mission Hospital 'Mildmay' Commissioners' Statement for 2019/20 Quality Account

NHS NEL CCG (North East London Clinical Commissioning Group) Commissioner Statement for Mildmay Mission Hospital 2020-21 Quality Account

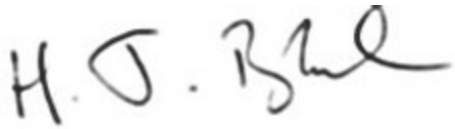
NHS NEL CCG welcomes the opportunity to provide this statement on Mildmay's Quality Account. Mildmay's work has been impacted by the Covid-19 pandemic like no other organisation. From the organisations early beginnings in the 1860's working with Cholera, to its work in the 1980's to the present day working with HIV, Mildmay has been at the forefront of work with infectious diseases that have challenged the way our society works and functions. At a point when Mildmay's future looked uncertain, Mildmay has stepped up and been a pivotal support for London in the Covid-19 pandemic, helping provide the best clinical care to those in the homeless community impacted by the pandemic. This has required Mildmay to change its delivery model and support the implementation of new pathways. We recognise that this brought a number of significant operational and quality challenges, key amongst these the challenge of staffing, as well as a change in clinical priorities. We thank Mildmay for the closer working relationship with commissioners through this period, and hope that this continues through any future challenges.

Review of 2020-2021 and priorities for Improvement 2021-22

As highlighted the pandemic has focused attention in key areas, and Mildmay have prioritised: sustainability; effective care (in particular Infection Prevention and Control); the homeless pathway; and staff support. It is commendable that Mildmay unlike many other health and care provision did not have any outbreak on its inpatient wards, this is clearly a reflection on the robust Infection Prevention and Control measures in place, and reflective of the clinical leadership. In addition throughout this period the positive feedback from staff and patients, along with the high uptake of mandatory training despite the significant changes undertaken is good to see.

In terms of priorities for 2021-22 we welcome the focus on: safeguarding; the clinical effectiveness of the homeless pathway; and the electronic patient record system. Although, as highlighted in the Quality Account, the audit carried out towards the end of 2020-21 highlighted potential gaps in safeguarding practice, the auditors also mentioned that many more safeguarding issues would have been undetected and unaddressed had Mildmay not been part of the pathway, in addition Mildmay was praised for its holistic care. Clearly as Mildmay is serving a highly vulnerable population the focus on safeguarding, as well as the mental health and substance misuse needs of the patients seen by the hospital is particularly welcome.

We confirm that we have reviewed the information contained within the Quality Account and checked this against data sources, where this is available to us, as part of existing quality and performance monitoring discussions. We agree that the account is accurate in relation to the services provided. NEL CCGs and partners will work with closely with Mildmay to support the delivery of these objectives.



Henry Black

Accountable Officer
NHS North East London Clinical Commissioning Group

Annexes

Annex 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
- Mildmay Trust

Annex 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

Annex 3: Management Team:

Geoff Coleman
Chief Executive Officer

Dr. Simon Rackstraw
Medical Director

Comfort Adams
Clinical Lead Nurse

Teri Milewska
Registered and Compliance Manager

Camilla Hawkins
Lead Occupational Therapist and Day Therapy Manager

Justine Iwala
Head of Human Resources

Norma Martin
Head of Finance

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: Dame Judi Dench, Sir Cliff Richard
Registered Office: 19 Tabernacle Gardens, London E2 7DZ, UK
Registered Charity No. 292058
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MILDMAY
Transforming Lives

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