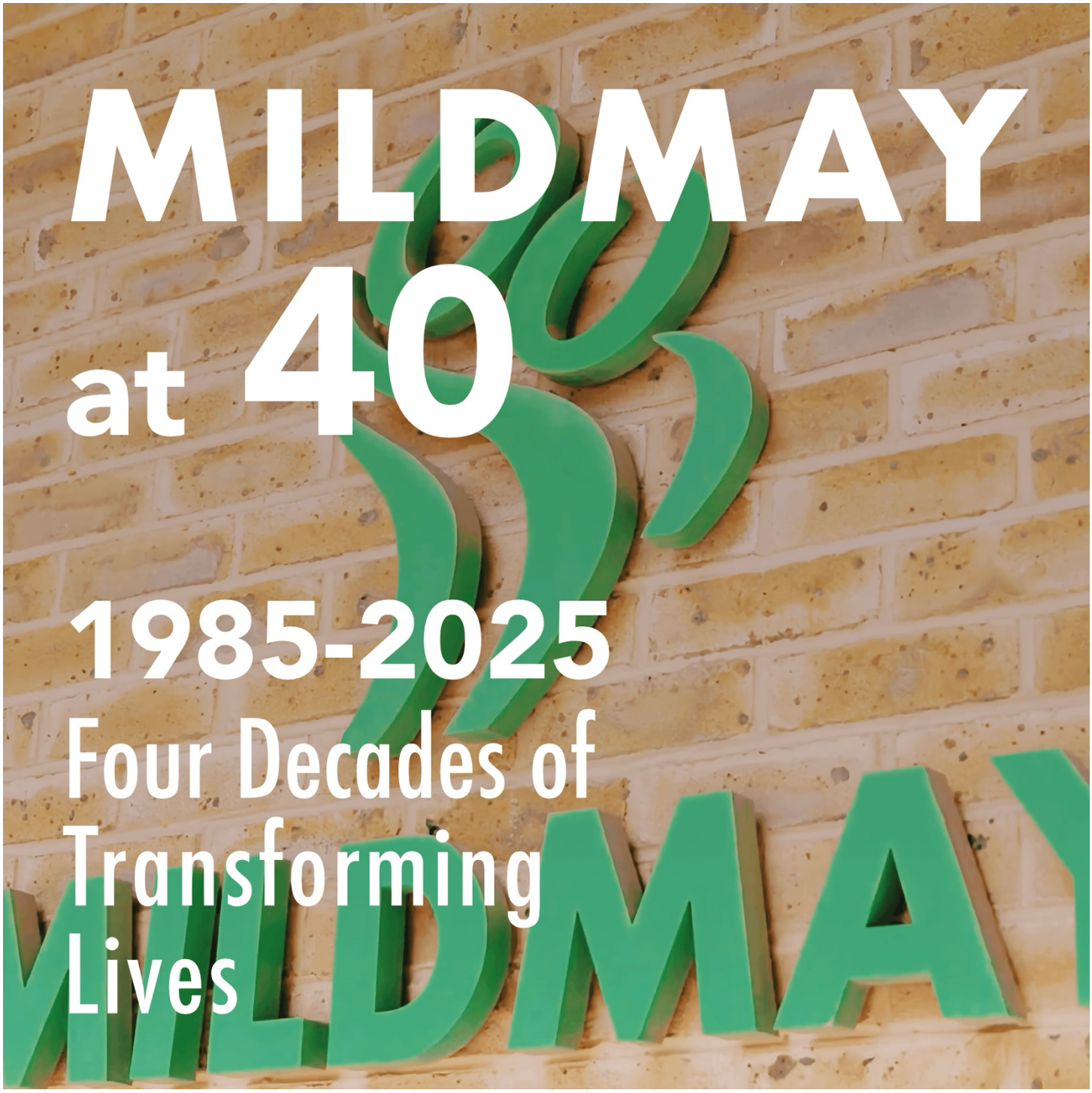
NHS
Mildmay Hospital

# Annual Quality Account

April 2025 – March 2026



MILDMAY

Transforming Lives

**Cover:**

The cover of this Quality Account is adapted from the cover of *Mildmay at 40*, a commemorative book published in 2025 to mark the hospital's 40th anniversary as an independent charitable hospital. The book records Mildmay's history from its reopening in 1985, following closure by the NHS in 1982, and its response to the HIV/AIDS crisis from 1988, through four decades of specialist care.

NHS
Mildmay Hospital

# Annual Quality Account

April 2025 – March 2026

**Produced by Patricia Nkansah-Asamoah**
Admissions Manager
Mildmay Hospital

# Contents

# PART 1

## 1.1 Introduction

We are pleased to present Mildmay's Quality Account for the period April 2025 to March 2026. As a provider of healthcare services commissioned by NHS England and Integrated Care Boards (ICBs), we are required to publish an annual Quality Account, made available to the public alongside those of all other providers, including the independent sector.

As Lord Darzi, one of our patrons, has noted, quality care within the NHS must be safe, effective and deliver a positive patient experience. This report sets out the priorities we identified for 2025–26, how we performed against established standards, and what we aim to achieve in the year ahead.

## 1.2 Chief Executive's Statement

On behalf of the Board of Trustees and the Executive Team, I am proud to present the 2025-2026 Quality Account for Mildmay Hospital. This account looks at our progress and achievements across the financial year and looks forward to some of our key priorities for patients in 2026 - 2027.

Inpatient numbers throughout the year have proved challengingly low. Whilst partner organisations across the NHS have been under incredible pressure Mildmay has operated, for the most part, at between 50% and 75% of its capacity.

The charity's finances for the financial year were incredibly tight and without a pilot project in the last quarter we would have seen the services either closed or transferred to one of our partner NHS Trusts. Remarkably we managed to make it through although we finished the year with no financial reserves.

We are extremely pleased to report that all of our NHS commissioning organisations have managed to get to a position where they are paying for services in less than three months. At the start of the financial year we had a significant number of debts that were more than six months old.

The introduction of the Faster Data Flows Reporting for NHS Commissioners has gone well and this system is now thoroughly embedded.

Recruitment has gone well and over the last year we have seen our lowest vacancy levels ever. Staff retention continues to be superb.

We only had contracts in place with two of our primary commissioners during the financial year. North West London ICB and the City of London. None of the other London ICBs, including our host NEL ICB, are in contract and all chose to utilise the ECR system. This however, no longer gives the charity challenges with NHS Pensions as they have accepted that all of the patients we treat are NHS, even if they are ECRs, and therefore staff are included as members of the NHS Pension Scheme.

The hospital continues to benefit from the mobile Dental Service and Podiatry Service in addition to the regular appearance of the Therapy Dog.

Over the next year, the charity will focus on the introduction of at least one new inpatient pathway. Mildmay will look to continue to grow relationships with local NHS Trusts as well as NHS and Local Authority commissioners.

**Geoff Coleman**
Chief Executive Officer

## 1.3 Statement on service quality at Mildmay

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

1. The first provides specialised and individually tailored treatment and rehabilitation for people living with complex or challenging health conditions associated with HIV.
2. The second provides intermediate rehabilitation and care for homeless patients stepped down from NHS Acute hospitals across London.
3. The third is for rehabilitation and stabilisation treatment for homeless patients from across London who are undergoing detoxification from drugs and alcohol.
4. The fourth is providing intermediate residential care for rough sleepers with drug and alcohol issues. These are patients who do not traditionally engage with local drug and alcohol teams but engage with the London Regional Homeless Engagement and Support Teams (RhEST). This Is to improve patient engagement and provide continuity of care

Our patients often have both physical and cognitive impairments, frequently coupled with co-existent psychological ill-health. They may struggle with addiction as an extra co-morbidity. They often live in difficult social circumstances, which make their access to the care that others take for granted very difficult.

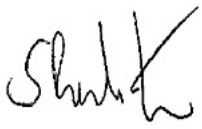
Through our rehabilitation pathways, which involve nursing, medical and therapeutic interventions working together; as well as social and peer support, patients are invariably discharged in a better state of health so that they may live as independently as possible.

As an integral part of our service delivery, we seek to demonstrate the value of our clinical interventions through measurement by audit and clinical outcome measures. We contribute data to the UK ROC - UK Rehabilitation Outcomes Collaborative to assess the patients on the HIV pathway receiving neurorehabilitation, and to National Drug Treatment Monitoring System (NDTMS) for patients undergoing drug and alcohol detoxification rehabilitation. Through these reporting mechanisms, we can demonstrate the clinical effectiveness of our interventions and cost-effectiveness of our service. We have contributed data to audit the outcomes of the other two pathways helping to demonstrate their clinical effectiveness. We are always looking at further outcome measures to examine the quality of our clinical services.

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

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

I believe that Mildmay hospital provides high-quality care, for patients admitted to the hospital as evidenced by the above statement.



**Simon Rackstraw FRCP**
Medical Director

## 1.4 About Mildmay

Mildmay was re-established in 1985 as an independent charitable hospital following closure by the NHS beginning in 1982. In 1988, the hospital began working with people living with and affected by HIV and their families, developing a specialist expertise in HIV-related neurorehabilitation that remains central to its work today. This work has extended to East Africa, where Mildmay supports health programmes in Uganda and beyond. In 2020, Mildmay extended its UK services to include intermediate medical care for patients experiencing homelessness, referred from NHS acute hospitals across London. Services have since expanded further to include post-inpatient detoxification (IPD) stabilisation for rough sleepers, and in the last quarter the hospital piloted a new intermediate residential care pathway for rough sleepers who do not engage with local drug and alcohol services.

Mildmay's hospital specialises in rehabilitation, treatment and inpatient care across all these pathways. HIV services are commissioned under two contracts with North West London and North Central London Integrated Care Boards. The primary homeless pathway contract is held with North East London ICB on behalf of all London ICBs, and a pan-London contract covers post-IPD care. Spot-purchased referrals are accepted from elsewhere in the UK.

The hospital operates from a purpose-built building opened by The Duke of Sussex in 2015, comprising 28 ensuite rooms across two wards, each with a communal lounge, kitchen and secure access. Following the cessation of day services in March 2020, the former day services wing has been repurposed to expand physiotherapy provision. The ground floor also houses an occupational therapy assessment centre and treatment rooms.

Care at Mildmay is consultant-led and multidisciplinary, delivered by a team that includes doctors, nurses, physiotherapists, occupational therapists, speech and language therapists, clinical psychologists, dietitians, social workers, drug and alcohol workers, housing support workers, art therapists, chaplaincy staff and volunteers.

In 2024, the Mayor of London and Transport for London named one of the six London Overground lines the Mildmay line, after Mildmay Hospital, recognising our pioneering role in HIV and AIDS care and support for LGBTQ+ communities.

In 2025, Mildmay marked forty years since its re-establishment as an independent charitable hospital.

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

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

## We are dedicated to upholding:

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

## Registration Details

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

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

## 1.5 Mildmay Inpatient Care and Services

Mildmay Hospital offers specialist rehabilitation for adults living with physical, cognitive, mental and psychosocial challenges.

Our multidisciplinary team delivers personalised, patient-centred care that promotes independence, builds confidence and supports each person's recovery. Every patient is assessed individually, and our tailored care pathways are designed to support self-management wherever possible, helping people regain control and move forward with their lives.

Sixty-two per cent of NHS expenditure is spent on long-term conditions. Mildmay's specialist management of those conditions - including HIV and homeless health - directly supports acute trusts in reducing pressure on inpatient services and delivering high-quality care.

Our intermediate rehabilitation beds for the post-detoxification drug and alcohol pathway are supported by an on-site, trauma-informed substance misuse team. They prepare residents for ongoing treatment through intensive programmes leading to either full residential rehabilitation or entry into supported or private housing with community treatment and wrap-around support.

This provision has been extended to include intermediate residential care for rough sleepers with drug and alcohol dependencies - specifically those supported by the London Regional Homeless Engagement and Support Teams (RhEST), who work with individuals that do not engage with traditional services. Through this pathway, Mildmay provides access to specialist inpatient care for detoxification, stabilisation and preparation for residential rehabilitation.

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

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

### AIMS

- Build on the outcomes from IPD and support sustained treatment, engagement and recovery.
- Deliver a safe and supportive intermediate rehabilitation residential setting.

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

## Pathway Four: Intermediate Care Pathway - rehabilitation for rough sleepers with drug and alcohol issues referred by the London Regional Homeless Engagement and Support Teams (RhEST)

### AIMS

- Address the gaps in specialist inpatient detoxification and stabilisation for rough sleepers who experience the greatest barriers in accessing specialist in-patient substance misuse treatment
- Development of an effective pathway between outreach /homelessness services and intermediate care/ residential treatment services.
- Improvement in health of people experiencing rough sleeping
- Stabilisation of co-existing drug misuse
- Confirming referral and commencement to the next treatment episode which supports ongoing abstinence and recovery
- Support the transfer of care to a rehabilitation facility to undertake a 12 weeks detox programme if accepted

## Neuropsychiatric rehabilitation care for patients referred by the North East London Foundation Trust

There were a small number of neuropsychiatric rehabilitation patients in April that were a spill-over from the previous financial year's contract with the North East London Foundation Trust.

# PART 2

## 2.1 Looking Back: Priorities for Improvement 2025-2026

### Priority 1 - Sustainability

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

#### Criteria for success

Have a contract in place for the fifth pathway

#### Achievements

During 2025–26, we implemented and tested a pathway providing direct access to specialist inpatient intermediate care for people experiencing rough sleeping, with a wide range of health needs including drug and alcohol dependence and significant physical and mental health problems. This operated under a contract running to the end of the financial year, and we are hopeful that this will be renewed on a permanent basis in the next financial year.

### Priority 2: Have signed contracts in place for all London ICBs that use Mildmay services.

Moving away from ECR and spot contracting to cost and volume or block contracts is a priority for Mildmay in the coming financial year. Without formal, signed NHS contracts in place, Mildmay is at a significant disadvantage in a number of areas, including access to NHS pensions.

#### Criteria for success

Have signed contracts for NWL, NEL and NCL ICBs for both HIV and Homeless inpatients.

#### Achievements

We have a signed contract with NWL for HIV and Homeless services and NCL for HIV services. This cannot be deemed a success, however, as the majority of ICBs remain reluctant to enter into formal signed contracts, despite the cost savings this would deliver for them.

### Priority 3: Upgrade IT Assets

As a charity, Mildmay has always sought to minimise IT expenditure while meeting the NHS England Data Security and Protection Toolkit requirements. However, the end of support for Windows 10 and the minimum security standard of TPM 2.0 means the hospital has no choice but to upgrade a significant number of its computers.

#### Criteria for Success

The replacement of 100% of the charity's desktop computers and 50% of the charity's laptop computers.

#### Achievements

Because of the significant financial constraints that the charity found itself under, this project had to be pushed back to the new financial year.

## 2.2 Looking Forward: Priorities for Quality Improvement 2026-2027

### Priority 1: Strategic Plan

2025 was the final year in the charity's Strategic Plan. It is therefore incumbent on the Board of Trustees to agree a new Strategy that will see the charity through the next three to five years.

#### Criteria for success

Have an agreed Strategic Plan for the next three to five years and a Business Plan for the twelve to eighteen months.

### Priority 2: Sustainability

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

#### Criteria for success

Have a contract In place for two new pathways.

### Priority 3: Have signed contracts in place for all London ICBs that use Mildmay services.

Moving away from ECR and Spot contracting to a Cost and Volume or a Block contract must be a priority for this financial year. Not having formal, signed NHS contracts in place gives Mildmay a significant financial challenge.

#### Criteria for success

Have signed contracts for all London ICBs that use Mildmay services.

### Priority 4: Upgrade IT Assets

Upgrade all of the charity's computers to Windows 11, TPM 2.0. Move all of the charity's servers into the cloud.

#### Criteria for Success

The replacement of 100% of the charity's desktop and laptop computers.

## 2.3 Statement of Assurance

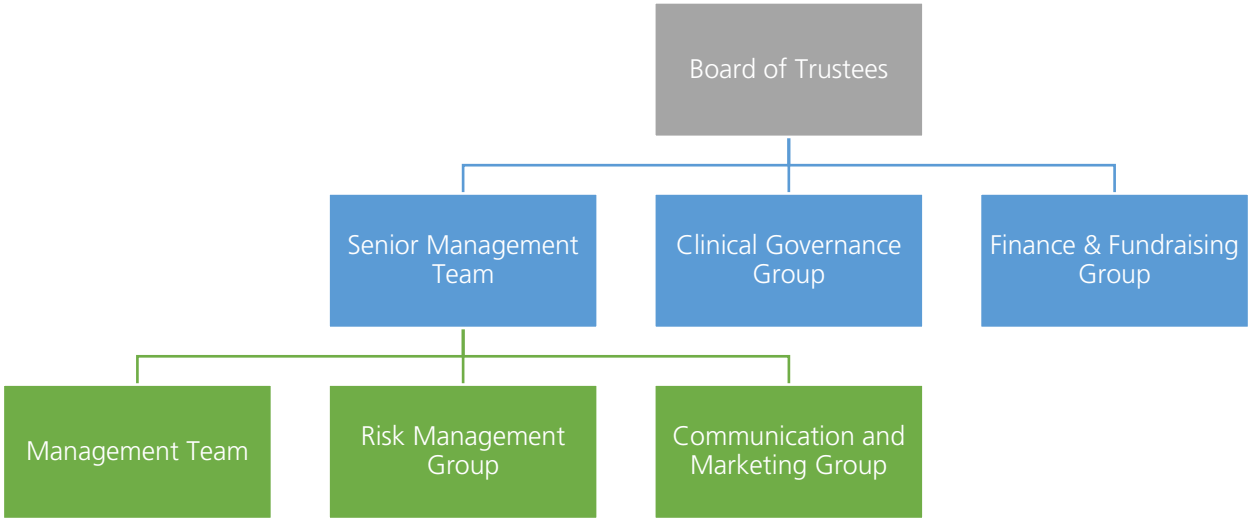
Mildmay Hospital delivers services under NHS contracts following a service specification embedded within that contract. Three **core** care and treatment pathways form the most significant part of our service specification:

- HAND Assessment, Rehabilitation and Complex Symptom Control
- Homeless Step-down Care
- Homeless Intermediate rehabilitation for homeless patients and those at risk of homelessness (Post-Detox Stabilisation)

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

During 2025-26, Mildmay submitted monthly activity and quarterly performance reports to our drug and alcohol commissioner. The Mildmay Management Team met weekly to discuss operational issues and agree prompt action and support. Risk Management Committee meetings were held monthly, with quarterly Clinical Governance Committee meetings and quarterly board meetings providing further oversight, ensuring responsiveness to emerging challenges and risks to ensure quality of care.

## 2.4 Mildmay's Governance Structure



## Mildmay Hospital governance model for the Trustee Board

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

## Trustee Board Meeting

### Members

Mildmay Trustees

### Attendance

Staff by invitation of Trustees

### Objectives

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

### Timing

Quarterly

## Senior Management Team (SMT)

Members: CEO, Medical Director, Finance Manager, Matron & Registered Manager, Admissions Manager, Estates and Facilities Supervisor, Human Resources Manager and Fundraising & Communications Manager

### Objectives:

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

Directors will invite attendees as required.

### Timing

Weekly

## Clinical Governance Group

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

### Objectives

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

### Timing

Quarterly

## Finance & Fundraising Group

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

### Objectives:

1. Oversight of Finance
2. Oversight of Fundraising activities

### Timing

Quarterly

## Risk Management Group

Members: CEO (chair), Medical Director, Matron & Registered Manager, Estates and Facilities Supervisor, Therapies Representative

### 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), Trustee (marketing), Fundraising & Communications Manager and others as required, by invitation.

### Objectives

Oversight of the following activities:

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

### Timing

Monthly

## 2.5 Review of Services

The rough sleeper pathway pilot was designed for people who are sleeping rough or at risk of doing so. It provided a period of stabilisation with the aim of supporting transition into structured inpatient rehabilitation. The pathway was developed to ensure continuity of care for individuals who struggle to engage with traditional drug and alcohol services, whether due to complex physical or mental health needs or challenging social circumstances.

Referrals were received from prisons, hospitals and external drug and alcohol services, and were identified and screened in collaboration with the London RhEST team. All referrals were received by email and reviewed by the Mildmay admissions team with input from the medical team. Only one referral was declined during the pilot. Patients were offered admission with the aim of stabilisation and preparation for inpatient rehabilitation.

### Referral processes - all pathways

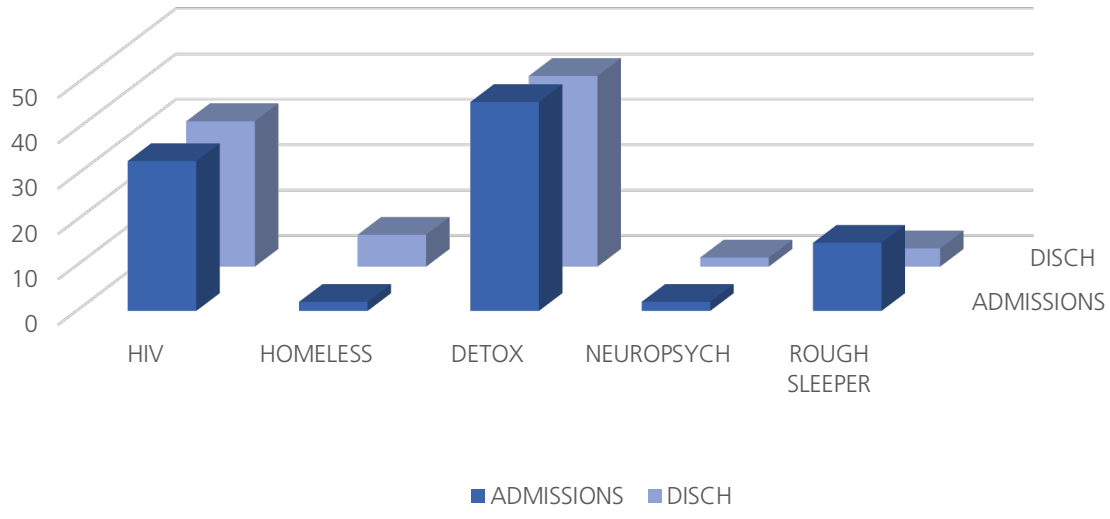
Completed referral forms are emailed to a dedicated email address and reviewed by the admissions team, who assess each referral for appropriateness. HIV referrals come primarily from HIV consultants or clinical nurse specialists in acute centres, with funding from the relevant ICB.

Homeless step-down referrals come mainly from hospital homeless pathway teams, complex discharge coordinators and hospital social work teams.

Post-detox inpatient stabilisation referrals come primarily from local drug and alcohol services, with most patients transferred from the Addictions Suite at Guy's and St Thomas'.

Neuropsych referrals are received from NELFT. Mildmay is ordinarily able to accept transfers promptly once a patient is medically fit and funding has been approved. All patients are assessed within 24 hours of admission.

### Admissions versus discharges 2025-26



## HIV patients:

Mildmay held contracts with North West London and North Central London ICBs. For ICBs without a formal contract, both within and outside London, spot purchasing arrangements are available.

The main challenge for patients referred from outside London is identifying the appropriate individual or team responsible for approving Individual Funding Requests (IFRs).

## Patients experiencing homelessness:

Mildmay held a contract with North West London (NWL) ICB. We continued to work collaboratively with NWL, with all referrals reviewed by their medical team for funding authorisation.

Escalation meetings with NWL ICB were used to discuss patients' clinical progress and identify barriers to discharge, facilitating safe and optimal outcomes for complex discharges.

## Post-Detox patients:

Funding for this service is pan-London. Patients are referred for post-detox stabilisation and, following their stay, are discharged either back into the community or to a residential rehabilitation setting. Discharge planning begins prior to admission and is carried out in close collaboration with community drug and alcohol teams to ensure continuity of care.

## Neuropsychiatric patients:

We provided care for patients referred by the North East London Foundation Trust (NELFT) on a spot purchase basis.

Referrals may include individuals with or without a primary mental health diagnosis, often presenting complex psychosocial needs that require multidisciplinary support to progress toward independent living. This pathway ended in June 2025.

## Rough Sleepers pilot:

Funding for this service was provided by OHID. Referrals were screened by RhEST and reviewed by the Mildmay medical team. Patients were detoxed from alcohol or stabilised on oral substitution therapy, and prepared for inpatient rehabilitation through assessment, medical optimisation, group work and therapeutic interventions including occupational therapy, speech and language therapy, physiotherapy and psychology.

## Best Practice: Streamlining HIV Admission and Funding process for NCL ICB

HIV referrals to Mildmay are reviewed and funded by different health teams across the various ICBs. For NCL ICB, funding is provided through Continuing Healthcare, but this process is not well understood by many of the clinicians who make referrals. To address this, Mildmay delivered HIV education sessions for several clinical teams and the London HIV Forum, focusing on funding applications and the processes used by different ICBs.

A number of NCL clinical teams also received direct support with their funding applications.

As a result, HIV admissions from NCL ICB increased from 3 patients in 2024/25 to 8 in 2025/26. Over the same period, referrals were accepted from 6 London boroughs, compared to 2 in the previous year, ensuring more equitable access to neurocognitive rehabilitation for patients across NCL.

## Best Practice: Review of admission procedure in response to substance misuse incidents

In 2024, substance misuse was identified as a key safety area under PSIRF, with 13 incidents recorded in this category. In response, Mildmay reviewed its admission processes to ensure patients have realistic expectations of the care available to them. Where possible, our Drug and Alcohol Worker now engages with patients prior to admission. Patients sign contracts on admission and are encouraged to engage with external community drug and alcohol support teams. Warning systems and early discharge procedures are in place for patients who continue to breach hospital policy. Security has been increased to 24 hours a day and a new search procedure has been implemented.

Despite these measures, the number of substance misuse incidents rose marginally to 14 in 2025/26. Half of these occurred in the final quarter, during our participation in OHID's pilot supporting patients with a history of homelessness and substance misuse through the Rough Sleepers Pathway, which provided direct access to our inpatient services for this more complex cohort.

Responding to the challenges presented by this pilot has strengthened Mildmay's capacity to provide direct access to inpatient care for complex patients from prisons, hospitals and the community. Notwithstanding the marginal rise in incidents from 13 to 14, there was no impact on the quality of care provided.

## Best Practice in collaborative working with external agencies on the rough sleepers pilot

The contract for the rough sleepers' pilot came into effect in mid-January 2025.This pathway between the Mildmay Hospital and London RhEST overall produced a number of positive outcomes for those experiencing a high level of deprivation. The pilot was mobilised and developed simultaneously which presented a number of challenges. These were resolved with joint planning meetings and regular updates with OHID providing oversight. As part of the process, the team had to define the specific level of alcohol dependence that would make a referral to Mildmay unsuitable. This matter took some time to be resolved. A lead-in period would have allowed the development of more specific guidance around this and other challenges regarding synthetic cannabinoid withdrawal management.

Only 1 person out of the 15 admissions dropped out, which is a high success rate for this group. There were some admissions that progressed very quickly from referral to admission and thus captured a small window of opportunity for successful engagement.

The holistic nature of the Mildmay offer to allow for stabilisation of physical and mental health as well as OST dosage is invaluable for a cohort with high needs who may not be ready for rehab and who are not engaging well with community healthcare. Nearly seventy percent of patients on this pathway went on to inpatient residential rehabilitation.

## Electronic Patient Records

Capturing, storing and analysing data is essential to measuring the quality and effectiveness of our services. At Mildmay, patient information is recorded and securely stored using EMIS, while access to the Cerner Portal enables us to view patients' previous medical records, enhancing the quality of information available prior to admission.

We submit monthly data to the UK Rehabilitation Outcomes Collaborative (UKROC), which is processed and analysed in accordance with the UKROC peer group comparison framework. This helps to evidence the outcomes of our HIV neuro-rehabilitation services. We receive quarterly UKROC reports, which are also shared with our commissioners.

For our drug and alcohol pathway, we submit monthly data to the National Drug Treatment Monitoring System (NDTMS), which feeds into the national database and supports the monitoring and evaluation of treatment effectiveness.

In the homeless pathway, data is submitted weekly to the Intermediate Care Community Daily Discharge system, contributing to the national discharge programme and informing reporting on homeless health outcomes.

With fully electronic patient records, authorised health professionals, both within our team and externally, have immediate access to essential information, significantly enhancing the coordination and quality of patient care.

## Internal Clinical Audits

Clinical audits are conducted throughout the year at Mildmay Hospital as part of our annual audit cycle within the wider clinical governance framework. These internal audits ensure that our practices align with national standards, regulatory requirements, and Mildmay's own clinical objectives.

The audit report includes the following audits, providing evidence of the quality and effectiveness of the care we deliver:

- Bedrails
- Catheter
- Hand Hygiene
- Infection Control
- Inventory and Disclaimer
- Mattress
- Medicines Management
- Malnutrition Universal Screening Tool (MUST) Analysis
- Next of Kin
- Nutrition (MUST scores, feeding tubes, catering service, food waste)
- Prescription Chart
- Pressure Ulcers
- Safeguarding
- Student Placement
- Urinary Tract Infections
- VTE Assessment, Treatment and Prevention
- Waterlow

## Participation in Clinical Research

**NO** patients receiving NHS services provided or sub-contracted by Mildmay during this period were included in research approved by a research ethics committee.

Mildmay conducted **NO** clinical research studies on HIV during the reporting period, and **NO** clinical staff participated in research ethics committee-approved research at Mildmay during this time.

## Care Quality Commission

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

# PART 3

## 3.1 Review of Quality Performance

Mildmay Hospital maintains weekly, monthly and quarterly data reporting activity to our commissioners, including NWL ICB and the City of London.

## 3.2 Incidents

### Patient Safety Incident Response Framework

Mildmay's Patient Safety Incident Response Plan (PSIRP) sets out how the hospital intends to respond to patient safety incidents, highlighting key themes identified through review of incident data, CQC notifications, risk registers, clinical governance reports and audits. The plan is not a fixed set of rules; Mildmay remains flexible and considers the specific circumstances of each incident and the needs of those affected. A total of 95 incidents were reported in 2025–26.

Four key safety areas have been identified as priorities for Mildmay's patient improvement profile.

#### Falls

There is a proportionately high number of falls and near-miss falls in comparison to other incident categories, directly linked to the significant number of patients admitted for rehabilitation who have mobility needs. Falls management was identified as a priority when the first PSIRP was issued in November 2023 and remains a key focus. There has, however, been a noticeable reduction in falls over the past two years - from 22 in 2024 to 16 in 2025 - which may reflect the impact of falls management as a PSIRP priority, alongside the restructure of the therapy team, the introduction of the therapy assistant role and more frequent manual handling training for staff.

The risk of falls can increase temporarily as patients progress through rehabilitation, particularly for those with neurocognitive impairments who may lack insight into their own abilities as their physical strength and mobility begin to improve. To mitigate this, the physiotherapist reviews individual care plans as each patient progresses, and falls are continuously audited and monitored. Falls prevention strategies include specialist equipment such as falls sensors and mobility aids, increased patient observation, one-to-one care, intentional rounding and room allocation based on individual risk - for example, placing high-risk patients closer to the nurses' station. The physiotherapist delivers falls prevention and manual handling training to nursing staff through a range of formats, from formal classroom sessions to ward-based demonstrations for small groups.

Note: although estates and facilities ranked third in the overall incident table, it falls outside the scope of the Patient Safety Incident Response Framework and is not included here.

#### Substance misuse

Incidents related to unprescribed drugs and alcohol remain a key priority, linked to the Post detox Pathway commenced in 2022 and Mildmay's expanding work with patients who have a history of substance misuse.

This affects not only patients under the Post-Detox Recovery Pathway but also a proportion of patients across other pathways, given the demographics of those affected by HIV and homelessness. Following the identification of substance misuse as a key safety area under PSIRF, incidents in this category reduced to 11 in 2024 before stabilising at 14 in 2025.

Mitigations include pre-admission engagement by the Drug and Alcohol Worker wherever possible, to ensure patients have realistic expectations of the care available; individual key working for all patients under the Detox Pathway; and one-to-one therapy alongside a range of group therapies including mindfulness, art therapy, relapse prevention groups and on-site AA meetings. Several other members of the team have significant experience in substance misuse, and detox and substance misuse is a designated link area for the ward manager and one of the healthcare support workers. Patients sign contracts on admission and are encouraged to engage with external community drug and alcohol teams. Warning systems and early discharge are in place for patients who breach hospital policy. Security operates 24 hours a day and a new search procedure has been implemented. Mildmay's reputation in this area has supported further expansion in 2025–26 through participation in OHID's pilot providing direct inpatient access for patients with a history of homelessness and substance misuse.

## Smoking

Smoking has been introduced as a PSIRP safety priority. A significant proportion of patients across all pathways are smokers, and incidents of patients breaching the no-smoking policy - by smoking in rooms or other internal areas - occur regularly. There were 9 smoking-related incidents in 2024 and 5 in 2025. Smoking on the premises breaches the Health Act 2006 and the Health and Safety at Work Act 1974, and increases the risk of fire, endangering patients and staff.

Mitigations include formal and informal warnings and expedited discharge where necessary, alongside a focus on smoking cessation and harm reduction. OHID has encouraged Mildmay to permit vaping on site as a safer alternative to smoking, in line with the government's smoking reduction strategy. Mildmay has secured a budget to provide vapes to patients who may benefit, in addition to prescribed nicotine replacement. Nursing staff are accessing specialist smoking cessation training. Extended security and reception hours now allow patients to use the designated outdoor smoking area at night, reducing the risk of smoking on the wards. No-smoking signage has been increased and the Smoke Free Procedure reviewed. Addressing smoking incidents requires collaborative working across nursing, therapy, and estates and facilities teams.

## Aggressive and challenging behaviour

The continued requirement to support staff following incidents of aggressive or challenging behaviour from patients or relatives remains a priority. Such incidents reflect the complexity of the patient group and the frustrations some patients may experience. In 2025–26, 12 incidents were reported: 6 involving verbal aggression and 6 involving physical violence.

Mitigations include training and support from the clinical psychologist, the embedding of a trauma-informed care approach across all pathways, and ensuring wards are adequately staffed. All staff have completed de-escalation and personal safety training.

Challenging behaviours are documented in ABC charts to identify triggers and patterns, and individualised behavioural management plans are in place. Behavioural agreements are completed on admission, with warning systems and expedited discharge for patients who continue to breach policy. Staff are encouraged to contact the police when necessary. Out-of-hours support includes 24-hour on-call management advice. Further support is available through HR, the Speak Up Guardian, union counselling services, occupational health and the on-site psychologist. The clinical psychologist facilitates routine and post-incident debrief and reflection sessions.

## Missing patients and absconding

There were 6 missing patient and absconding incidents in 2025–26.

Missing patient incidents involve patients who have mental capacity and can access the community independently, but who have not returned to Mildmay at the expected time and cannot be contacted by telephone.

There were 4 such incidents. In each case, staff followed procedures, made multiple attempts to contact the patient, liaised with next of kin and community teams where appropriate, and reported patients to the police as missing persons where their safety and whereabouts could not be confirmed. All four patients eventually returned safely; however, three were discharged earlier than planned due to lack of engagement with the multidisciplinary team and extended periods away from the hospital.

Absconding incidents involving patients subject to Deprivation of Liberty Safeguards who have been assessed as lacking mental capacity, require escort when accessing the community, but have attempted to leave the hospital unsupported. There were 2 such incidents, both involving the same patient. On one occasion the patient was returned to the hospital by police; on the other, staff persuaded the patient to return. One-to-one care was implemented as an additional safeguard.

## 95 incidents were reported in 2025-2026 and are summarised below

| Incidents | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| **Falls** | **4** | **6** | **7** | **5** | **22** |
| **Missing Patient /Absconding** | **0** | **2** | **2** | **2** | **6** |
| Catering | 1 | 1 | 0 | 1 | 3 |
| Medication | 0 | 1 | 0 | 0 | 1 |
| Theft/Loss of Property | 0 | 0 | 1 | 1 | 2 |
| **Maintenance/Estates/Security** | **3** | **2** | **3** | **1** | **9** |
| **Substance Misuse/Alcohol** | **3** | **2** | **2** | **7** | **14** |
| Confidentiality/ Data | 0 | 1 | 2 | 2 | 5 |
| **Verbal Aggression** | **1** | **0** | **2** | **3** | **6** |
| **Physical Aggression** | **1** | **1** | **0** | **4** | **6** |
| Behaviour - other | 0 | 1 | 0 | 0 | 1 |
| Damage to Property | 0 | 0 | 0 | 1 | 1 |
| Potential Safeguarding | 1 | 2 | 0 | 0 | 3 |
| **Smoking** | **2** | **0** | **1** | **4** | **7** |
| Information Technology | 0 | 1 | 0 | 0 | 1 |
| Wound | 1 | 0 | 0 | 1 | 2 |
| Accident | 0 | 0 | 0 | 2 | 2 |
| Pressure ulcer on admission | 1 | 0 | 0 | 1 | 2 |
| Therapy Care Plan | 0 | 0 | 0 | 1 | 1 |
| Medication CD documentation error | 0 | 0 | 0 | 0 | 1 |
| **Total number of incidents** | **18** | **20** | **20** | **36** | **95** |

## Controlled Drugs Incidents

All incidents relating to controlled drugs and their documentation are reported to the Local Intelligence Network by the Accountable Officer, with practices reviewed continuously in response to occurrences.

## 3.3 Staff Training

Mildmay's statutory and mandatory training programme enables staff to work safely and effectively. Staff also have access to CPD training, both internally and externally, supporting them to develop new skills, enhance their knowledge and remain current with best practice. Mildmay fosters a learning culture that promotes continuous.

improvement across teams, with the aim of delivering better quality care for our patients

In 2025–26, all mandatory training was delivered in a classroom-based format, highly interactive and tailored to Mildmay's specific needs. The following mandatory training was completed during the year:

### Statutory and Mandatory Training

| | Percentage completion |
|---|---|
| Information Governance and Data Security Awareness | 100% |
| Infection Prevention & Control | 100% |
| Conflict Resolution | 100% |
| Safeguarding Vulnerable Adults | 100% |
| Safeguarding Vulnerable Children | 100% |
| Moving and Handling | 100% |
| Fire Safety | 100% |
| Health & Safety | 100% |
| Equality, Diversity and Human Rights | 100% |
| Prevent Radicalisation | 100% |
| Resuscitation (Basic Life Support) | 100% |

The following CPD training was delivered in-house by Mildmay staff and external providers:

- End of Life care Training
- Autism Training
- Practice Supervisor and assessor update
- De-escalation and Personal Safety training
- Trauma Informed Practice
- Lead Adult Care – Level 3 for all Healthcare Support Workers (completion in 2027)

## Staff Survey

Mildmay conducted its annual staff survey in January 2026, giving all staff the opportunity to provide feedback across key areas including patient safety, compassionate culture, organisational learning, staff health and wellbeing, and the introduction of new care pathways. The results inform our work to improve staff experience and working conditions, and provide an opportunity to benchmark against other healthcare organisations in support of continuous quality improvement.

### Patient safety

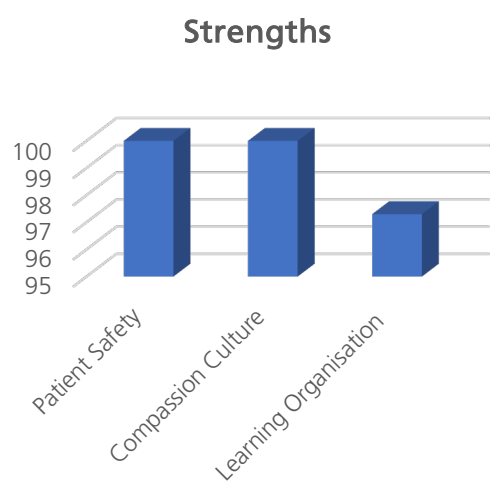
The standout result was in patient safety: 100% of respondents agreed that Mildmay encourages staff to report errors, near misses and incidents; 91.89% confirmed that Mildmay takes action in response; and 91.89% said they receive feedback about changes made following incidents.

### Compassionate culture

Results strongly indicate that staff perceive Mildmay as having a highly compassionate culture, both in patient care and internal support. 100% of respondents confirmed that care of patients is a top priority; 97.3% believed Mildmay would act on concerns raised by patients; and 94.4% would recommend Mildmay as a place to work.

### Learning organisation

97.3% of respondents had received an appraisal and reported that it had helped them improve their performance and agree clear objectives. 97.29% agreed that Mildmay had given them the opportunity to improve their knowledge and skills.




## Areas for improvement

### Safe and healthy staff

A considerable amount of work remains to address harassment, bullying and abuse from patients: 40.54% of respondents reported experiencing harassment, bullying or abuse in the last 12 months, and 16.2% reported experiencing physical violence from patients or their relatives.

### Introduction of new pathways

28% of respondents found the introduction of the Rough Sleepers Pathway stressful, and 11% felt they had not been appropriately trained and supported at its introduction. A further 40% neither agreed nor disagreed on both counts. 30% of respondents reported increased work pressure following the introduction of the Intermediate Care Pathway, with 37.84% indicating they needed additional training to deliver better care within this pathway.

### Summary

Overall, the staff survey results were strongly positive, with patient safety and patient-centred care identified as the primary organisational focus. Staff described Mildmay as a learning organisation with a no-blame culture in which mistakes are analysed for systemic improvement.

The principal challenge identified is supporting staff who experience abuse from patients, which is an inherent risk given the complexity of the current patient cohort.

Mildmay has zero tolerance of abuse and has implemented a range of mitigations: post-incident debriefs to explore the reasons behind aggressive presentations; readily available psychology support; a Speak Up Guardian providing a confidential channel for staff concerns; and 24-hour security to assist with conflict management and de-escalation involving both patients and visitors.

## 3.4 Volunteering at Mildmay

Volunteers make a distinctive contribution to life at Mildmay. They work alongside clinical and administrative staff in a range of roles; supporting patients on the wards, assisting with activities, and helping with day-to-day administration, and bring a quality of presence and attention that enriches the hospital environment in ways that are difficult to measure but easy to recognise.

Mildmay was supported by at least 10 volunteers during 2025-26. We are grateful to all those who give their time to Mildmay, and to the patients whose openness makes volunteering here a meaningful experience.

During 2025-26, we received the following reflection from a long-serving volunteer on the completion of their time with us:

"What struck me most was never one single dramatic moment, but rather the quiet, consistent kindness that exists here every single day. A nurse pausing mid-shift to hold a patient's hand. A porter offering a warm word to someone who looked frightened. A receptionist remembering a name, a face, a small detail that made someone feel seen. These moments happened constantly, almost without anyone noticing and yet to me, as a witness to them, they were extraordinary.

The staff here do not simply do a job. They show up with genuine compassion, day after day, in circumstances that would test anyone. To work alongside them — even in a small capacity — has been one of the greatest honours of my life."

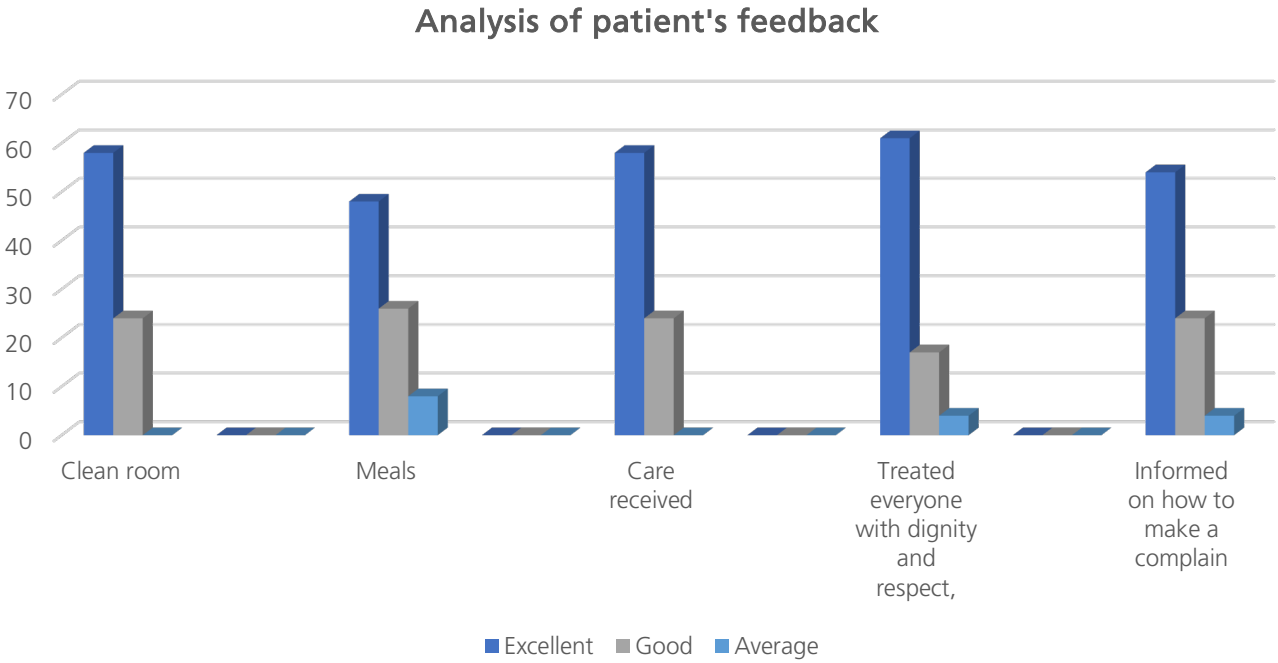
## 3.5 Patient Feedback

### Friends and Family Survey:

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

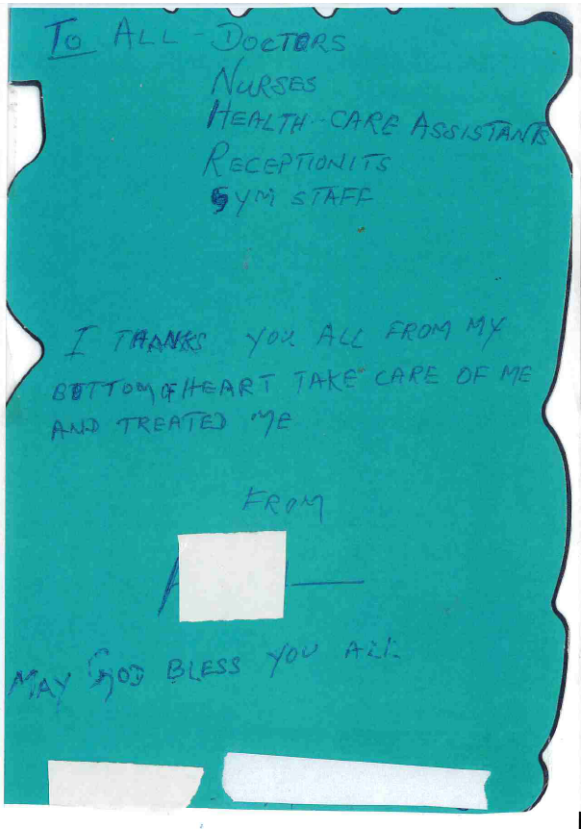
In 2025-26, feedback was collected from 82 patients at the point of discharge.

On average, we had positive responses (excellent and good) from 97.1% of patients, and **100% of patients would happily recommend Mildmay if their friends and family requires the facility.**

## Comments made by patients

- “Very caring and thoughtful, done with total respect.”
- “I found everything perfect. I appreciate all the help I've taken on board at Mildmay”
- “Learned and enjoyed meeting with other patients.”
- "Thanks to all the staff especially physiotherapy, have supported me physically and psychology who have been a mentor to me. I am grateful to the chaplain also for praying with me."
- Mildmay gave me the space to construct a future path utilising the signposts provided. I just want to say a huge THANK YOU!!!!! You have no idea just what you have done for me

## 3.6 Case Studies

### Case Study 1- Post-Detox Stabilisation

Male patient E arrived as planned after an alcohol detox. He had also been smoking heroin and crack on occasions. He previously had a dependent heroin habit which required OST to manage.

Patient E spent a number of years in prison and then on release he became homeless. He had been street homeless for many years in the area where he grew up and where his family still lives. He became entrenched in the homeless life until he started getting older and felt he could no longer use drugs in a way that he needed to be tied to a methadone prescription. He worked hard to stop using drugs but then when his housing was not secured he began drinking heavily. He continued heavy drinking daily, and smoked crack and heroin occasionally for a number of years and continued to be street homeless. During his alcohol dependence time he would become aggressive and violent on the street which became an issue for the local police and council.

More recently he was housed in a hostel where he started engaging with the drug and alcohol service. He worked toward a detox and admission to Mildmay for stabilisation. He had some peripheral neuropathy, some suspected cognitive issues and poor pain management of a back injury.

During his admission, he initially engaged well and joined in with the groups. He was expecting to be housed in the area of London that he is familiar with, however the council would only be able to offer a hostel. The police informed him that if he returned to the area and became violent or aggressive on the street he would be banned from returning. This news was delivered to him by his housing support worker. Patient E took this news very badly and couldn't understand why this was happening. This resulted in him retreating to his room and he rarely left his room for the next few weeks. During this time Mildmay staff worked hard at trying to engage him but he wanted to stay in his room on his own. The substance misuse worker and OT worker continued to go to his room for general motivational work to see if he would engage.

His external team referred him to rehab in Bournemouth where they have a resettlement program, which was thought to be his best option. Patient E could see why they thought of this but did not want to go as he didn't want to acknowledge the situation with his area.

Around 3 weeks before he was due to discharge the substance misuse worker and external housing worker met with patient E to discuss with him his options and the consequences of each option. As the meeting was deliberately arranged in a communal area downstairs, he had to get dressed and leave his room. He explained that when he got dressed he could see how much he had neglected himself by the length of his beard and hair. After the meeting it seemed he recognised that he had limited options and then decided to go to the barbers.

After that day he started engaging again in groups and started talking to the other patients who supported him in his decision to go to rehab. By the time he was discharged his back pain medication had been adjusted and stabilised. Psychology completed a cognitive screening with him and he was reassured that although there was some memory recall difficulties, this would not interfere with him being able to engage at rehab. He prepared for going to rehab and recognised that he had an opportunity for a new start and it was up to him to make the most of it. Throughout his admission he maintained abstinence from drugs and alcohol which he reported was a major achievement for him.

His external key worker reports that he is still there and doing well.

## Case Study 2- The Role of the Multidisciplinary Team in the Management of Progressive Multifocal Leukoencephalopathy

Progressive multifocal leukoencephalopathy (PML) is a rare, but often fatal, demyelinating condition caused by the John Cunningham virus (JCV). This polyomavirus, first isolated in 1971 from a patient named Cunningham, primarily affects immunocompromised individuals, including those living with HIV/AIDS. The disease is associated with severe neurological damage and is typically seen in patients with advanced immunosuppression, such as those undergoing chemotherapy, organ transplant recipients, or those with HIV/AIDS (Mesran et al., 2024). Reactivation of JCV within the central nervous system leads to progressive white matter damage, which can severely impair cognitive, motor, and visual functions (Major et al., 2000). Currently, there is no effective antiviral treatment specifically targeting JCV, and the condition is associated with a high mortality rate (Naro et al., 2022). Approximately 4 to 8 % of patients with advanced HIV disease develop PML (Hou & Major, 2005; McGuire, 2003), and it remains one of the most significant neurological complications in this population.

The patient is a 60-year-old male who presented to an acute care facility with a three-week history of progressive confusion. His social history includes chronic excessive alcohol consumption (15 cans of beer per day), marijuana use, and regular cocaine use. These factors may have further contributed to his compromised immune status. Additionally, his BMI was 17.3, classifying him as underweight, a known risk factor for poor outcomes in HIV (NICE, 2014).

Upon presentation, the patient exhibited several neurological deficits, including confusion, behavioural changes, right-sided neglect, hemianopia, aphasia, and dysarthria. His cognitive impairment and risk of falls led to 1:1 nursing care. Notably, his underweight status was an additional concern, as malnutrition can exacerbate the effects of HIV and impede recovery (NICE, 2014). The patient's complex presentation warranted a comprehensive, multidisciplinary approach to address both the neurological and nutritional aspects of his care.

Initial blood tests confirmed the diagnosis of HIV, with a viral load of 200,022 copies/mL (log 5.3) and a CD4+ count of 59 cells/µL, indicating advanced HIV disease. Brain imaging, including an MRI scan, revealed a confluent white matter lesion in the left parietal lobe and the splenium of the corpus callosum, consistent with PML. The presence of JCV in the cerebrospinal fluid (CSF) further confirmed the diagnosis. Follow-up MRI scans showed increasing white matter signal abnormalities, highlighting disease progression, with oedema implicating the left frontal region.

The patient's cognitive and behavioural changes, including personality shifts, aphasia, and visual-spatial difficulties, were consistent with frontal lobe involvement. After eight weeks of initiating antiretroviral therapy (ART), the patient was diagnosed with PML-IRIS (immune reconstitution inflammatory syndrome), which can occur in HIV patients with low CD4+ counts upon initiating ART. This syndrome is characterised by paradoxical inflammation in response to immune system recovery, further complicating the management of PML (Summers et al., 2019).

The cornerstone of HIV treatment is antiretroviral therapy (ART), which the patient was started on immediately upon diagnosis. His ART regimen included Truvada (Emtricitabine and Tenofovir Disoproxil Fumarate) and Dolutegravir. These medications effectively suppress HIV replication and help restore immune function, thereby preventing further deterioration and improving the patient's CD4+ count from 59 to 114 cells/µL within two months. His viral load decreased from 200,022 to 35 copies/mL, indicating a favourable response to ART.

To address the perilesional oedema associated with PML-IRIS, oral prednisolone was prescribed. Although corticosteroids are often used to reduce inflammation in PML-IRIS, they carry risks, such as

steroid-induced diabetes, which the patient developed. The management of his diabetes involved insulin and metformin therapy. In addition, the patient received Pembrolizumab, an immune checkpoint inhibitor, and Co-Trimoxazole prophylaxis to prevent opportunistic infections.

Managing the patient's polypharmacy regimen was crucial to prevent drug interactions and adverse effects. Close monitoring ensured that the patient did not experience significant drug-related complications (Maher et al., 2014). As a result, he tolerated the treatment well, and his condition gradually improved over several months.

## Multidisciplinary Approach to Care:

The patient's recovery highlighted the importance of a multidisciplinary approach. A collaborative team, including nurses, dietitians, physiotherapists, psychologists, and social workers, played a crucial role in managing the various aspects of his care.

**Nursing Care**: The nursing team provided continuous care, managing medication administration, assisting with activities of daily living, preventing pressure ulcers, and providing 1:1 supervision to mitigate fall risks.

**Nutritional Support**: Given the patient's low BMI, a dietitian developed a personalised nutritional plan, focusing on increasing calorie intake and providing supplements to improve his nutritional status. Over the course of four months, the patient gained weight, and his BMI increased from 17.3 to 24.6 $kg/m^2$, a promising indicator of recovery (NICE, 2014).

**Physiotherapy**: Initially bedbound, the patient was unable to sit or stand independently. Through intensive physiotherapy, he regained functional mobility and balance. After several months, he was able to walk with the assistance of a Zimmer frame, demonstrating significant progress in his physical rehabilitation.

**Psychiatric and Cognitive Support**: The patient also received psychiatric support to address his cognitive impairments and mood disturbances. Quetiapine was prescribed to manage mood fluctuations and speech and language therapy was crucial in improving his ability to communicate, ultimately enhancing his quality of life. Additionally, cognitive therapy was initiated to support his recovery of mental function.

**Occupational Therapy**: This therapy aimed to improve his ability to perform daily tasks independently, such as feeding himself and personal hygiene. Occupational therapists helped improve his upper limb function, which enhanced his independence and overall well-being.

**Social Work**: Social workers ensured that the patient's living situation was safe and assisted with caregiver education, particularly in medication management and fall prevention.

This case study illustrates the complex clinical management of PML in an HIV-positive patient, emphasising the challenges of diagnosing and treating this rare but severe condition. The role of a multidisciplinary team, integrating specialists across nursing, nutrition, rehabilitation, psychiatry, and social work, was crucial in improving the patient’s health and quality of life. This comprehensive approach is essential in managing the multifaceted needs of patients with HIV-associated PML, ultimately leading to better health outcomes and greater patient satisfaction.

## Case Study 3- Physiotherapy Case Study

Patient C presented with **worsening bilateral lower limb pain and numbness**, associated with significant **paraesthesia**. These symptoms had progressively affected her **activities of daily living (ADLs)** and overall mobility. She was admitted to Mildmay in a **wheelchair**, unable to mobilise independently following an in-patient detoxification.

Nerve conduction studies confirmed a **sensory axonal polyneuropathy**, consistent with alcohol-related neuropathy. Physiotherapy assessment revealed **generalised deconditioning**, particularly **poor upper body and core strength and significant lack of balance and co-ordination** attributed to prolonged inactivity and lack of regular exercise.

### Initial Physiotherapy Assessment

#### Subjective Findings:

- Persistent bilateral lower limb pain and numbness
- Fatigue with minimal activity
- Reduced confidence with standing and walking
- Difficulty performing ADLs independently
- Poor balance and co-ordination

#### Objective Findings:

- Reduced lower limb proprioception and altered sensation
- Decreased muscle strength, particularly in proximal lower limb and upper body musculature
- Poor postural control and reduced balance
- Unable to ambulate independently; reliant on wheelchair mobility
- Reduced cardiovascular endurance

#### Functional Limitations:

- Dependent on assistance for transfers
- Unable to mobilise independently
- Reduced tolerance to upright positioning

#### Physiotherapy Problem List

1. Impaired gait and mobility
2. Reduced muscle strength due to deconditioning
3. Sensory deficits affecting balance and proprioception
4. Reduced exercise tolerance and increased fatigue
5. Reduced independence with ADLs

## Physiotherapy Interventions

A structured and progressive physiotherapy programme was implemented, focusing on **functional restoration and independence**.

**Key Interventions Included:**

- **Strengthening programme:**
    - Progressive resistance exercises targeting lower limb, upper body, and core musculature
- **Gait re-education:**
    - Task-specific walking practice
    - Focus on step symmetry, foot placement, and postural alignment
- **Balance and proprioceptive training:**
    - Static and dynamic balance exercises
    - Gradual reduction of external support
- **Functional mobility training:**
    - Sit-to-stand practice
    - Transfer training
- **Graded exercise programme:**
    - Gradual increase in activity duration to improve cardiovascular endurance
- **Education:**
    - Energy conservation techniques
    - Importance of ongoing exercise and physical activity

## Outcomes

Following consistent physiotherapy input, the patient demonstrated **significant functional improvements**:

- Progressed from wheelchair dependence to **independent indoor ambulation**
- Improved lower limb strength and postural stability
- Increased confidence with walking and transfers
- Improved exercise tolerance with reduced fatigue
- Greater independence with ADLs

## Discussion

This case highlights the importance of **individualised physiotherapy intervention** in patients with alcohol-related sensory polyneuropathy. While neurological symptoms contributed to mobility impairment, **general deconditioning played a significant role** in functional limitation. A holistic physiotherapy approach addressing strength, balance, gait, and endurance was crucial in facilitating functional recovery.

## Conclusion

Through targeted physiotherapy intervention, the patient achieved a **substantial improvement in mobility and functional independence**, progressing from wheelchair use to independent indoor ambulation. Ongoing exercise and physical activity were emphasised to maintain gains and prevent further deconditioning.

# 3.7 Operational Research Studies

## Exploration of psychosocial factors associated with advanced HIV presentations of people living with HIV being referred for inpatient rehabilitation

Moodley, Rackstraw

NHS
Mildmay Hospital

### Exploration of psychosocial factors associated with advanced HIV presentations of people living with HIV being referred for inpatient rehabilitation

Divyan Moodley and Simon Rackstraw

#### Objectives:

People living with HIV (PLWH) with advanced disease often present with severe health conditions resulting in extended hospitalisation, in-patient physical rehabilitation and subsequent long-term care needs. These delayed presentations result from late diagnoses or disengagement from HIV care.[1] Psychosocial factors play a significant role in both these key drivers. This paper aims attempts to identify these associated factors and assess their significance.

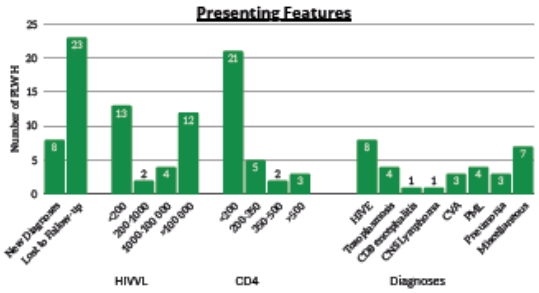
Mildmay Hospital in London specializes in the treatment and rehabilitation of PLWH with complex and severe HIV-related health conditions, providing a setting for understanding the challenges associated with late presentations and their impact on healthcare needs.

#### Method:

A retrospective review was conducted on Mildmay Hospital's database for PLWH referred for in-patient rehabilitation between 01/01/2024 and 01/01/2025.

#### Results:

Thirty-one PLWH were identified with a mean age of 49. Twenty-three (74%) were male while eight (26%) were female.





#### Discussion:

In investigating the factors contributing to these late presentations and/or disengagement with care, internalized stigma, lack of social support, and mental health diagnoses were found to be the most prevalent.

Among the thirty-one patients included in the review, each had at least one factor that may have contributed to their delayed presentation or disengagement from care.

The results highlight the multiple possible associative factors that are contributing to the high risk of morbidity and mortality associated with advanced HIV presentations. Although significant effort is made into addressing stigma within communities, this remains to be a major obstacle to early diagnoses and fully engaged care.

There is also a need for HIV care to incorporate a wider social perspective in its services, addressing psychosocial issues sooner to prevent morbidity at an earlier stage.

#### Conclusion:

In summary, identifying the presence of these psychosocial factors and applying a robust risk stratification system early in the management of PLWH may reduce the risk of disengagement and subsequent deterioration of PLWH. In addition, addressing the same factors at a population level may encourage earlier diagnoses in patients not tested and thereby reducing the incidence of late and severe presentations of PLWH.

#### References:

1.Op de Coul ELM, van Sighem A, Brinkman K, et al
Factors associated with presenting late or with advanced HIV disease in the Netherlands, 1996–2014: results from a national observational cohort
BMJ Open 2016;6:e009088. doi: 10.1136/bmjopen-2015-009088

MILDMAY
Transforming Lives

# Enhancing balance in people living with HIV through physiotherapy

Lotsios


A BERG BALANCE SCALE-BASED ASSESSMENT

**AUTHORS**
Asterios Lotsios Lead Physiotherapist
BSc, MSc, PgDip, PgCert

**ORGANISATION**
Mildmay NHS Hospital

**BACKGROUND**

People living with HIV (PLWH) face challenges such as balance impairments due to neurological and musculoskeletal complications associated with long-term infections and antiretroviral therapy. Balance physiotherapy training is a promising intervention to address these impairments, yet its effectiveness remains underexplored.

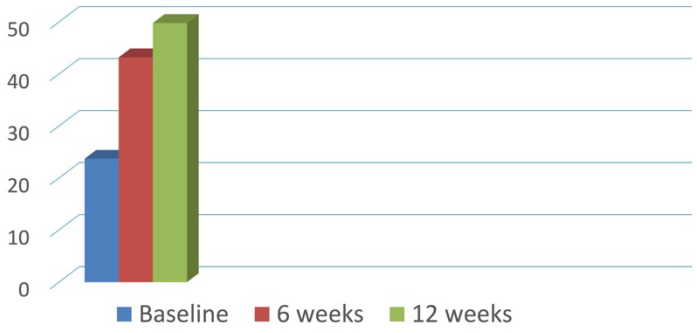
**OBJECTIVE**

This study investigates the impact of a structured balance physiotherapy training program on the balance abilities of PLWH, using the Berg Balance Scale (BBS) as the primary outcome measure.

**METHODS**

A cohort of 25 PLWH that were admitted to Mildmay Hospital for rehabilitation (mean age 45.6 ± 7.2 years) with self-reported or clinically observed balance issues participated in a 12-week physiotherapy program. The program consisted of weekly, 60-minute sessions involving strength, flexibility, and proprioceptive exercises tailored to individual needs.
Participants were assessed using the BBS at baseline, mid-point (6 weeks), and conclusion (12 weeks). The scale, ranging from 0 to 56, evaluates static and dynamic balance through 14 functional tasks, with higher scores indicating better balance.

Berg Balance Scores during Rehab (Scale= 0-56)




**RESULTS**

At baseline, the mean BBS score was 23.7 ± 5.6, reflecting significant balance impairments. Substantial improvements were observed at 6 weeks (mean: 43.2 ± 4.9, $p < 0.05$) and 12 weeks (mean: 49.8 ± 3.6, $p < 0.01$). Key areas of improvement included single-leg stance, turning, sit-to-stand transitions and pivot transfers. None of the participants experienced adverse events, demonstrating the safety of the intervention.

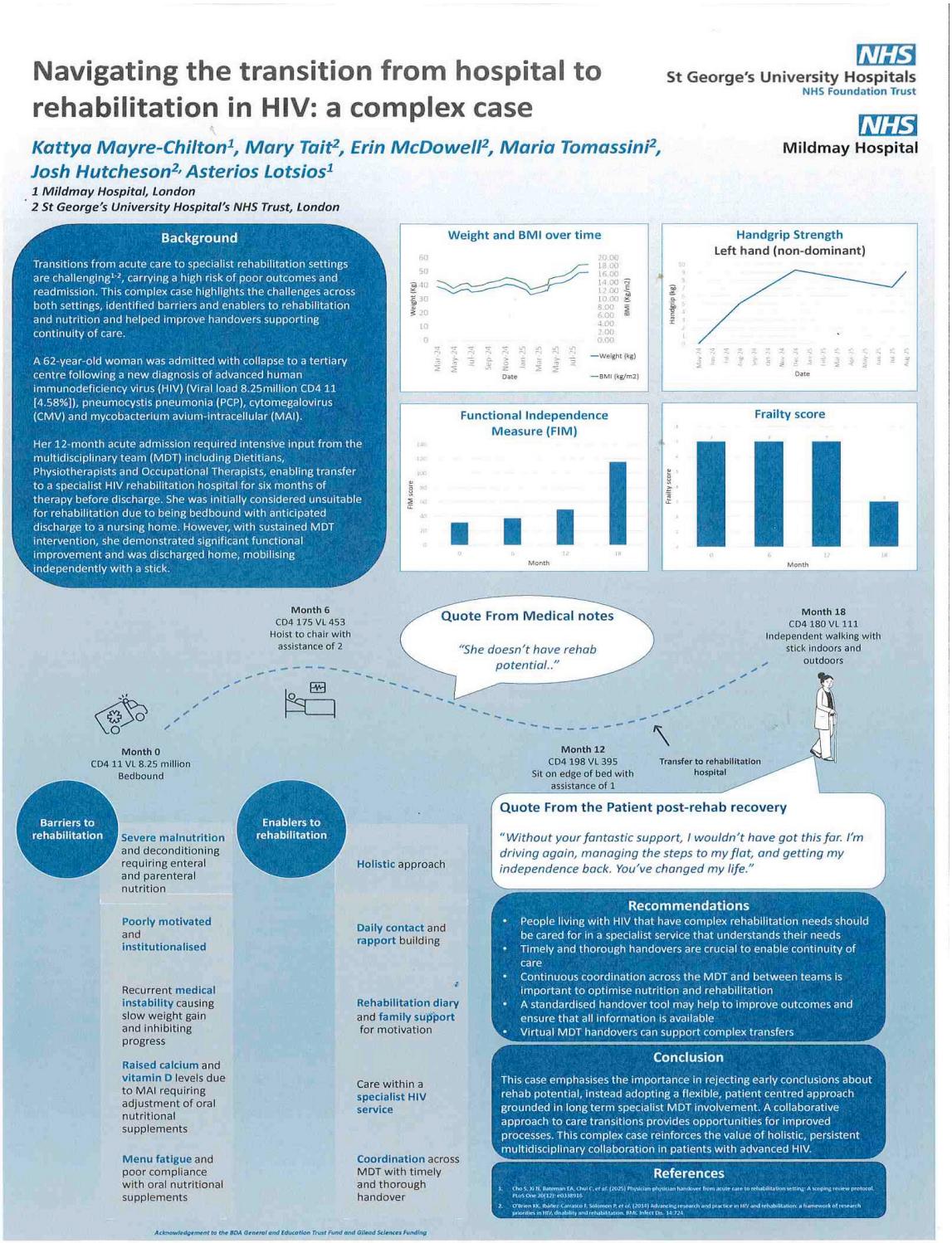
**CONCLUSION**

This study highlights the efficacy of balance physiotherapy training in improving functional balance in PLWH, as evidenced by significant gains in BBS scores over 12 weeks. These findings suggest that tailored physiotherapy programs can enhance quality of life, reduce fall risks in this population and avoid any unnecessary admissions. Future studies with larger samples and long-term follow-ups are warranted to confirm these results and explore mechanisms underlying balance improvements.

Lima, C.A, et. Al 2018 The Berg Balance Scale as a clinical screening tool to predict fall risk in older adults: a systematic review

# Navigating the transition from hospital to rehabilitation in HIV: a complex case

Mayre-Chilton, Tait, McDowell, Tomassini, Hutcheson, Lotsios



# Mildmay Mission Hospital Commissioner's Statement for 2025-26 Quality Account

NHS
North East London

**Commissioner's Statement for Mildmay Hospital Quality Account 2025/26**

NHS North East London Integrated Care Board is the lead commissioner responsible for commissioning health services from Mildmay Hospital on behalf of the population of north east London and wider. Thank you for asking us to provide a statement on Mildmay Hospital's 2025/26 Quality Account and priorities for 2026/27.

We join Mildmay Hospital in celebrating its four decades of work as an independent charitable hospital and acknowledge the continued commitment to compassionate, person-centred care. We welcome the focus within the Quality Account on sustainability, the development of additional inpatient pathways, and the need to strengthen digital infrastructure. We also note the planned development of a new three-to-five-year strategic plan, which will be important in setting out a clear and sustainable future direction for the organisation.

We particularly note the development and testing of the Rough Sleepers pathway, which supports improved access and engagement for people who experience significant barriers to traditional services. This aligns with system priorities to reduce health inequalities and improve outcomes for underserved groups, and we look forward to Mildmay Hospital continuing to strengthen the evidence base for this and any future pathways, including clearer reporting on activity, outcomes, patient experience, impact on discharge and flow, and learning from implementation.

The Quality Account is open about the challenges Mildmay Hospital has faced during 2025/26, including low inpatient occupancy, significant financial pressures, reliance on spot purchasing and ECR arrangements, and the delay to planned IT asset upgrades. These are material areas of risk. The ICB would hope to see robust plans and measurable milestones during 2026/27 to improve service utilisation, complete the required digital infrastructure improvements, and ensure that financial pressures do not adversely affect quality, safety or patient experience.

We are pleased to see that Mildmay Hospital continues to apply the NHS Patient Safety Incident Response Framework and to identify key safety themes. The reduction in falls over time is encouraging. However, the Quality Account also highlights areas requiring continued and strengthened focus, including substance misuse incidents, smoking-related incidents, aggressive and challenging behaviour, missing patients and absconding, and controlled drugs documentation. Moving forward, we hope the organisation can demonstrate sustained learning from these themes, clear actions with timescales, and evidence that mitigations are reducing risk across all pathways.

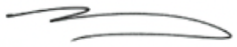
The staff survey results are positive overall, but we are concerned by the reported levels of harassment, bullying, abuse and physical violence experienced by staff from patients or relatives, and by the proportion of staff reporting stress or additional training needs linked to the introduction of new pathways. The ICB welcomes the mitigations described, including trauma-informed practice, debriefing, psychological support, security arrangements and training. We hope to see Mildmay Hospital continue to monitor staff experience closely and to provide assurance that staff are appropriately supported, trained and protected as pathways develop.

We also encourage Mildmay Hospital to ensure future Quality Accounts present performance information as clearly and consistently as possible, including trend data, thresholds or targets where available, and explicit links between identified risks, improvement actions and

outcomes. This will support commissioners, partners, patients and the public to better understand progress and areas where further improvement is required.

We look forward to continuing to work with Mildmay Hospital and partner commissioners during 2026/27 to support quality improvement, sustainability and safe, effective, person-centred care. Subject to the limitations of external review, we confirm that we have reviewed the information contained within the Account and, where possible, checked this against data sources available to us, and are satisfied that it presents a fair reflection of Mildmay Hospital's quality priorities, achievements and challenges over the reporting period.

Overall, NHS North East London Integrated Care Board welcomes Mildmay Hospital's 2025/26 Quality Account and recognises the organisation's commitment to caring for people with complex needs.



Dr. Nnenna Osuji
Chief Executive Officer
North East London Integrated Care Board

# Appendices

## 1: Supporting statements

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

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

## 2: Statement of directors' responsibilities for the quality report

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

## 3: Management Team:

**Geoff Coleman**
Chief Executive Officer

**Dr. Simon Rackstraw**
Medical Director

**Justine Iwala**
Head of Human Resources

**Norma Martin**
Head of Finance

**Teri Milewska**
Matron and Registered Manager

**Patricia Nkansah-Asamoah**
Admissions Manager

**Dr Twinkle Shah**
Health Analyst and Senior Information Officer

**Miklos Kiss**
Fundraising and Communications Manager

Mildmay began as a charitable institution over 160 years ago.

It has specialised in HIV for over 40 years and continues to deliver quality care and treatment, prevention work, rehabilitation, training, education and health strengthening in the UK and East Africa.



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