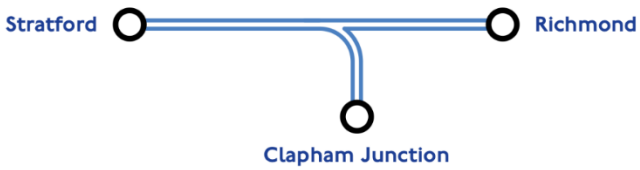
NHS
Mildmay Hospital

Annual Quality Account

April 2024 – March 2025

The Mildmay line



MILDMAY

Transforming Lives

Cover:

The Mildmay line logo represents a profound honour for Mildmay Hospital. It signifies the naming of one of the six London Overground lines after Mildmay, its dedicated staff, and the patients we have served, both past and present. This recognition pays tribute to Mildmay's significant history since 1866, and in particular its pioneering and era-defining work during the HIV/AIDS crisis, which established it as a valued and respected place for the LGBTQ+ community. (https://tfl.gov.uk/modes/london-overground/how-the-names-were-chosen?intcmp=75270)

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Produced by Twinkle Shah
Health analyst and Senior Information Officer
Mildmay Hospital

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PART 1

1.1 Introduction

Mildmay Hospital is delighted to present our Quality Account for April 2024 - March 2025. As Mildmay provides healthcare services that are commissioned by NHS England and Integrated Care Boards (ICBs), we are required to publish an annual Quality Account. The reports are published annually by each provider, including the independent sector, and are available to the public.

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

This report highlights the priorities we set out for the year 2024-25, how we performed against set standards and what we hope to achieve in the new financial year.

Our main focus was, once again, the sustainability of the service in light of dwindling referrals. We set out to develop other step-down services in collaboration with Local Acute Trusts. We did manage to establish a new service in 2024-25 with NELFT. We continue to have discussions with ELFT and Barts NHS Trusts.

Once again we have had extremely positive feedback from both our patients and those hospitals that refer to Mildmay.

Perhaps the highlight of the year was the naming of one of the London Overground routes after the hospital in recognition for the work that it undertook in the 1980s and 90s during the early AIDS crisis. The Mildmay Line will celebrate this work and keep the hospital in the minds of Londoners, the city we call home.

1.2 Chief Executive's Statement

On behalf of the Board of Trustees and the Executive Team, I am proud to present the 2024-2025 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 2025 - 2026.

During the year Mildmay Hospital opened its fourth pathway, to treat Neuro Psychiatric patients referred by the North East London Foundation Trust. Our first pathway to provide specialised and individually tailored treatment and rehabilitation for people living with complex or challenging health conditions associated with HIV continues to see a decline in admissions, though not in the actual number of referrals. The second pathway to provide intermediate rehabilitation and care for homeless patients stepped-down from NHS Acute hospitals across London has seen an increase in the number of referrals. The third pathway to provide rehabilitation and stabilisation treatment for homeless patients from across London who are undergoing detoxification has also seen a slight increase. We strive to accomplish the best possible outcomes and to support individuals to achieve and maintain the greatest possible degree of independence. Our expert team and holistic model of care transform lives.

The 2024 / 2025 financial year was incredibly challenging but remarkably we managed to not have the deficit that we had the previous year when we all but wiped out all of our reserves. The non-payment of debts by NHS Commissioners is at an all time low, which in turn has enabled us to keep our finances in the black. A pilot project over the summer and into the autumn with NELFT to trial the new NeuroPsych pathway also enabled the charity to maintain a relatively positive cashflow for that period.

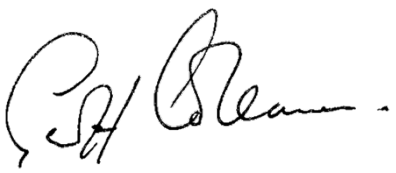
The Electronic HR Project had to be put on hold as the Faster Data Flows Project took priority. This will be a primary focus for our IT Team over coming months as it has been since the autumn.

The hospital began the year with a number of key vacancies in the Therapy team. By the end of March it was clear that we were making significant progress and at the time of writing this report all vacancies in our Therapy team have been filled.

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, managed to sign contracts. This has given the charity significant challenges with NHS Pensions as all Independent Providers are required to have at least 50% of patient income through NHS contracts. The charity is communicating with NHS Pensions to try to resolve this issue before staff are informed that they cannot be 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 new inpatient pathways. Mildmay will look to grow the relationships with the North East London Foundation Trust, East London Foundation Trust and the Barts Health NHS Trust and in particular the North East London ICB



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 for neuropsychiatric rehabilitation care for patients referred by the North East London Foundation Trust.

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 almost 100% 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.

Dr. Simon Rackstraw FRCP
Medical Director

1.4 About Mildmay

Mildmay was re-established in the 1985 as an HIV charity working to transform the lives of people who are living with and affected by HIV in the UK and East Africa. In 2020 this evolved to include intermediate medical care for patients experiencing homelessness who are referred from NHS Acute hospitals across London.

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

Mildmay operates a purpose-built hospital building opened by Prince Harry in 2015, which replaced earlier buildings. It is comprised of 28 ensuite rooms in two wards, each with a communal lounge, kitchen and secure entry/exit system.

Our day services ceased in March 2020 and this wing has now been used to expand our physiotherapy services to meet the needs of our diverse patient cohorts. Our ground floor also incorporates our occupational therapy assessment centre and treatment rooms. Mildmay Hospital has a multidisciplinary, consultant-led approach - with doctors, nurses, speech and language therapy, occupational therapy, clinical psychology, physiotherapy, dietetics, social workers, drug and alcohol worker, housing support workers, chaplaincy, art therapy and volunteers.

In 2024, the Mayor of London and Transport for London named one of the six London Overground lines after our hospital honouring the NHS and acknowledging Mildmay's vital work with HIV/AIDS. In 2025, we celebrate forty years since our re-establishment as a voluntary 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, and psychosocial challenges. Our multidisciplinary team works together to deliver personalised, patient-centred care that promotes independence, builds confidence, and enhances each person's abilities. Every patient is assessed individually, and our tailored pathways are designed to support self-management wherever possible, helping people to regain control and move forward with their recovery. Sixty-two per cent of NHS expenditure is spent on long-term care. The effective management of those conditions, including HIV and homeless Health, directly supports the Acute Trusts in providing high-quality care.

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

The neuropsychiatry rehabilitation offers patients on admission in NEFLT, who do not require an acute psychiatric bed but dealing with complex psychosocial issues that require multi discplianry input the opportunity to receive rehabilitaion and support in a sfae envoronment. We aim to reduce these psychosocial issues and help reduce the frequent use of acute mental health services.

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 Enagement Team, rough sleeping teams, housing, specialist general health services (i.e. hepatology, respiratory, alcohol related brain), mental health services, social care services, safeguarding, domestic abuse services and tertiary care to provide a holistic service for people who sleep rough/in hostel accommodation/risk of reurn to the street
- Place service users at the centre of delivering holistic care, promoting health, well-being and life chances

- Raise the aspirations of service users and lower barriers to care to strengthen engagement with treatment by building trust and understanding in the service provided.

Pathway Four: Neuropsychiatric rehabilitation care for patients referred by the North East London Foundation Trust

AIMS

- Rehabilitation of patients with or without a primary mental health diagnosis in acute mental health beds
- Provide MDT rehabilitation for patients to achieve their goals towards living more independently
- Provide specialised neurocognitive assessments to support discharge planning
- Reduce the need for repeated admissions to acute mental services
- Free up beds in NELFT acute mental health services.

PART 2

2.1 Looking Back: Priorities for Improvement 2024-2025

Priority 1 - Sustainability

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

Criteria for success

Have a contract In place for the fourth pathway

Achievements

We have piloted step-down services for NELFT. We are currently providing services on a spot-purchase basis as we gauge the complexity of patients with whom Mildmay can effectively support NELFT.

Priority 2: Improve delayed discharges

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

Criteria for success

Develop escalation meetings with other ICBs in addition to NWL homeless leads

Achievements

Discharge escalation meeting set up with Newham Unplanned Care Homeless Lead resulting in two out of three patients discharged within the agreed timeframe. The third was a complex discharge.

Priority 3: Demonstrating the Safety of staff and patients

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

Criteria for Success

Comparing results of staff and patient surveys

Achievements

- The initiative has been successful and going forward will continue to be a part of the staff training programme.
- Safety among staff was looked at in the light of staff protection from violence, abuse and threats, support after incidents of challenging behaviour and being empowered to speak up.
- Incidents of physical and verbal aggression from patients do not correlate with staff survey results which could mean that there is the issue of under-reporting among staff.
- Staff have been encouraged to document all challenging behaviour and have been supported by managers following incidents.
- Staff 1:1 supervision will address issues of safety with respect to incidents experienced, documentation and reporting for further support if indicated.
- Staff require continuous training in trauma informed care for embedded learning and specialist support from a mental health practitioner to support staff and patients on the Neuropsych pathway.

2.2 Looking Forward: Priorities for Quality 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.

Priority 2: 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 puts Mildmay at a significant disadvantage when it comes to things like NHS pensions.

Criteria for success

Have signed contracts for NWL, NEL and NCL ICBs for both HIV and Homeless inpatients for this financial year

Priority 3: Upgrade IT Assets

As a charity we have always spent as little as we could on IT whilst meeting all of the criteria to achieve the NHS England Information Authority's success criteria for their Toolkit. Unfortunately with the cessation of Windows 10 and the minimum security standard of TPM 2.0 Mildmay 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.

2.3 Statement of Assurance

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

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

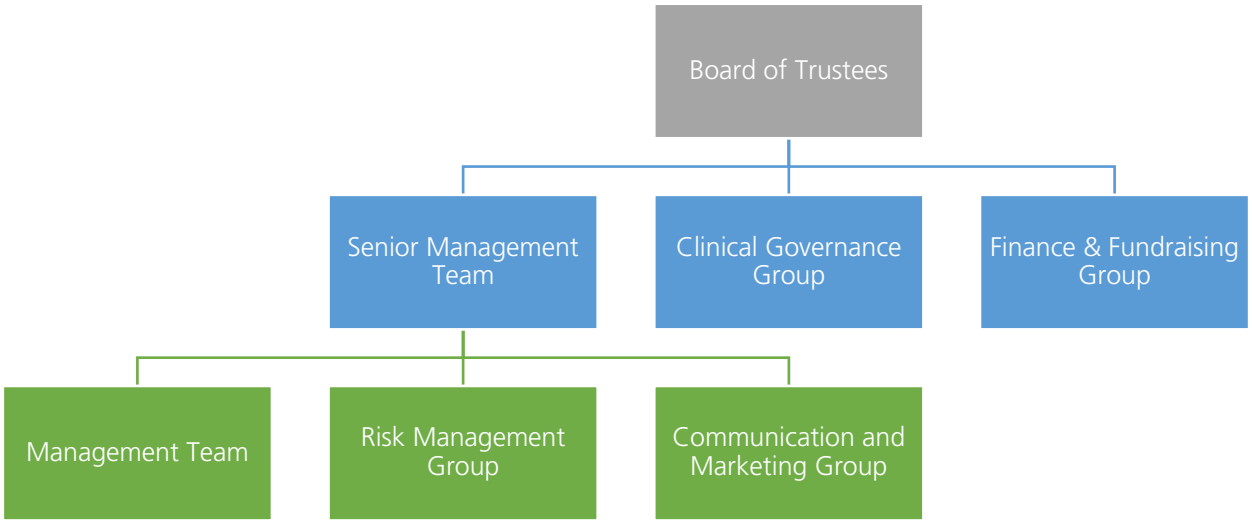
Dr Simon Rackstraw, Mildmay's Medical Director, is a Consultant and a Fellow of the Royal College of Physicians of London and continues to be in demand for knowledge-sharing and information exchange.

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

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

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

2.4 Mildmay's Governance Structure



Mildmay Hospital governance model for the Trustee Board

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

Trustee Board Meeting

Members

Mildmay Trustees

Attendance

Staff by invitation of Trustees

Objectives

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

Timing

Quarterly

Senior Management Team (SMT)

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

- 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 & Comms Manager and others as required, by invitation.

Objectives

Oversight of the following activities:

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

Timing

Usually monthly

2.5 Review of Services

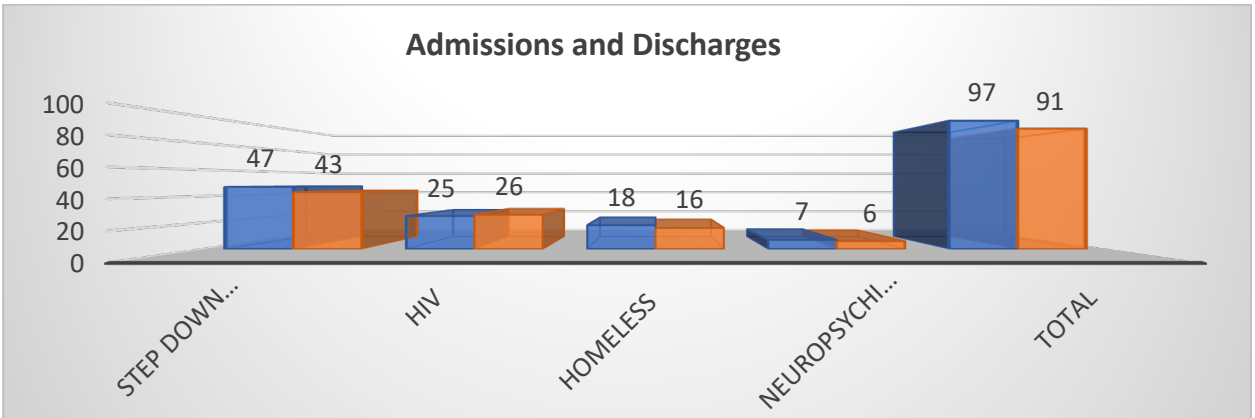
The main change in service delivery over this period was the introduction of the Neuropsychiatry pathway. It has been a learning curve as we gauge patients from North East London Foundation Trust who will be best suited for Mildmay's existing offer such as patients with complex psychosocial issues, those with cognitive impairment and dual diagnosis.

All referrals are received by email and reviewed by the Medical Director and Consultant psychaitrist on this new pathway. Those who will benefit form Mildmay's services ae transferred appropriately.

With our other existing services, Mildmay is usually able to accept transfers promptly once funding has been approved. All patients are assessed within 24 hours of admission.

Referrals for HIV, homeless step-down care and post detoxification stabilisation are mostly from acute hospital HIV consultants, homeless pathway teams, complex discharge coordinators and hospital social work teams. They complete a referral form based on the pathway needed which is sent to us by email at admissions.mildmay@nhs.net.

Admissions versus discharges (from April 2024-March 2025)



	Step down detox	HIV	Homeless	Neuropsychiatric rehabilitation	Total
Admissions	47	25	18	7	97
Discharges	43	26	16	6	91

For HIV patients:

We had a contract with North West London ICB, but not with other London ICBs, including our host ICB, North East London. For ICBs without a formal contract - both within and outside of 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).

For patients experiencing homelessness:

We had a contract with North West London (NWL) ICB, but not with other London ICBs, including our host, North East London (NEL) ICB. We have established strong working relationships with NWL for this service, with all referrals reviewed by their medical team for funding authorisation.

We have also developed escalation meetings with some ICBs to discuss patients' clinical progress and any barriers to discharge — a collaborative and effective approach we would be keen to replicate with other ICBs.

For Post-Detox patients:

Funding for this service is pan-London, with patients referred for post-detox stabilisation. Following their stay, patients 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.

For patients on the neuropsychiatric rehabilitation pathway:

We provide 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.

Our service is particularly suited for patients who would benefit from neurocognitive assessment and assistance with discharge planning.

As a new service, we are collaborating closely with NELFT to streamline the referral process and ensure a seamless transfer of care.

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 Cerna 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.

With fully automated patient records, authorised health professionals - both within our team and externally - have immediate access to essential information. This seamless sharing of data significantly enhances the coordination and quality of patient care.

For our drug and alcohol pathway, we submit monthly data to the National Drug Treatment Monitoring System (NDTMS). This 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, which contributes to the national discharge programme and informs reporting on homeless health outcomes.

We submit the required data to NHS Data Fast Flow on a monthly basis to ensure timely and accurate reporting.

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

Participation in Clinical Research

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

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

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

Care Quality Commission report summary

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

PART 3

3.1 Review of Quality Performance

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

3.2 Incidents

Patient Safety Incident Response Framework

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

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

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

Mildmay implemented PSIRF in November 2023 after training and developing our PSIRF policy and plan. This was approved by NHS NEL ICB and also by the Mildmay board.

Our Patient Safety Incident Response Plan (PSIRP) sets out how Mildmay Hospital intends to respond to patient safety incidents over a period of 12-18 months, highlighting key patient safety incident themes which have emerged following review.

A total of 105 incidents were reported in 2024-25, reduced from 183 in 2023-24

At present, four key safety areas have been identified as a priority for Mildmay's patient improvement profile. This is based on incident report data, MDT input, survey data, patient and external professional feedback and complaints data.

There is a proportionately higher number of falls incidents and near-miss falls, and this is directly linked to the significant number of patients who are admitted for rehabilitation and have mobility needs. As patients progress through their rehabilitation and their mobility and abilities continuously change, for some patients the risk of falls increases for a period of time. This is particularly evident in patients who have neurocognitive impairments and may therefore lack insight into their abilities and level of risk, as their physical mobility and strength starts to improve. To mitigate against the increased risk of falls, the Physiotherapy team reviews care plans and patient's individual needs as each patient progresses, and falls are audited and monitored. Our Physiotherapy team deliver training to the nursing team in relation to falls prevention. The training ranges from formal classroom based sessions, to individualised ward based sessions and demonstrations delivered to small groups. Falls prevention strategies include the use of specialist equipment such as falls sensors and a range of mobility aids, increased monitoring of patients, 1:1 care and intentional roundings and flexibility of room swaps for example allocating patients who are at high risk of falling a room close to the nurses station.

The second identified key area is alcohol related incidents, and this links in directly with the Detox Pathway which was commenced in 2022. In addition, due to the demographics of individuals affected by HIV and homelessness, a proportion of patients under our other care pathways also have a history of alcohol and substance misuse, which impacts on incident data. Effective mitigations put in place during this period included employing a dedicated Drug and Alcohol Worker who supports patients to manage their Detox, and also provides training and support to the multidisciplinary team in relation to this area, as well as adding security roles to our staff team. To prevent alcohol related incidents, patients with a history of alcohol dependence receive input from our Drug and Alcohol Worker, who keyworks all patients under the Detox Care Pathway. 1:1 therapy is available, in addition to a range of group therapies, including Mindfulness and sessions such as Art Therapy, as well as targeted Relapse Prevention groups and AA meetings onsite. We have reviewed admission processes and in order to ensure that patients have realistic expectations of the care that is available to them, our Drug and Alcohol Worker engages with patients pre admission, when possible. Patients sign contracts on admission and are encouraged to engage with external drug and alcohol community support teams. Mildmay utilises warning systems and early discharge if patients continue to breach hospital policy.

The third identified Patient safety incident type is discharge planning, which is often complex due to many of Mildmay's patient's having complex social histories, a history of homelessness and complex medical, physical and cognitive needs. Our Lead Social Worker audits discharge planning, including delayed

discharges. In addition to reviewing audit data, we reviewed discharge related incidents and complaints. Discharge planning is complex and multidisciplinary, and mitigations include designated keyworkers and named nurses for all patients, Discharge Planning Meetings and Review meetings, senior Discharge Co-Ordinator Nurses on each ward and changes to the admissions process to ensure that discharge planning is addressed prior to admission. Patients are strongly encouraged to participate in their own discharge planning processes and to set goals in partnership with multidisciplinary staff. Mildmay's Social Worker provide individualised support in relation to discharge planning and the whole team refers to community services as required well in advance of the discharge date, for example district nurse teams, nutritional support services, community Physiotherapy and equipment resources.

The final identified issue is the need for staff to be adequately supported following incidents involving aggressive or challenging behaviour by patients or their relatives. Such incidents sometimes occur due to the complexity of the patient group, and associated frustrations some of the patients may be experiencing. Mitigations include extensive support and training by the Clinical Psychologist, and introducing a Trauma Informed Care approach across each of the care pathways, as well as ensuring that the wards are well staffed and staff are able to access support when needed. Staff are encouraged to document all challenging behaviours in 'ABC' charts, with the aim of identifying possible triggers and behavioural patterns. Behavioural management plans are individualised. Warning systems are in place, with escalated discharges if patients continue to breach hospital policy. Behavioural agreements are completed on admission. Staff are encouraged to contact the police if necessary, and there is an Out of Hours support system in place for staff, including 24 hour On-Call advice and support from the management team.

105 incidents were reported in 2024-2025 and are summarised below

Incidents	Q1	Q2	Q3	Q4	Total
Falls	7	7	6	1	21
Missing Patient Absconscion	1	2	0	1	4
Catering	2	1	1	0	4
Medication - Controlled Drugs	1	0	4	0	5
Theft/Loss of Property	1	0	0	1	2
Maintenance/Estates/Security	4	1	0	1	6
Substance Misuse/Alcohol	0	5	3	5	13
Confidentiality/ Data	0	1	0	0	1
Verbal Aggression	2	1	1	0	4
Physical Aggression	1	1	1	0	3
Behaviour – sexual inappropriateness	1	0	0	0	1
Behaviour - other	1	3	1	0	5
Damage to Property	1	2	0	1	4
Deprivation of Liberty Safeguards	0	2	0	1	3
Potential Safeguarding	2	0	0	2	4
Smoking	1	6	1	2	10
Equipment	0	1	0	0	1
Clinical Emergency	0	1	0	0	1
Information Technology	0	1	0	0	1
Incident related to Gym	0	1	0	0	1
Patient Death	0	0	1	1	2
Wound	0	1	1	1	3
Sharp Items	0	0	0	2	2
Pressure ulcer	0	2	1	1	4
Total number of incidents	**25**	**39**	**21**	**20**	**105**

Controlled Drugs Incidents

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

3.3 Staff Training

Our Statutory and Mandatory training programme enables our staff to work safely and effectively. Staff also have access to professional CPD training (both internally and externally) which enables them to develop new skills, enhance their knowledge and remain up to date with best-practice. Mildmay fosters a learning culture which promotes continuous improvement across teams, leading to better quality care for our patients. Below is the list of mandatory training conducted in the year 2024-25

Statutory and Mandatory Training

	Percentage completion
Information Governance and Data Security Awareness	100%
Infection Prevention & Control	98.5%
Conflict Resolution	98.5%
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)	98.5%

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

- Sex Expliotation training
- Picc Line training for nurses
- Mildmay Tailored Manual Handling Training
- Mildmay Tailored Fire Training
- ECG placement and Head Injury training.
- Waterlow Training
- Nutrition Training

3.4 Staff Training and Support (Creating Safety)

As highlighted in last year's Quality Account, the focus was to train staff on Trauma informed care to be able to manage patients with challenging behaviour. Regular in-house training was carried out by the Lead Psychologist and her team. This was a success to a great extent as staff are in a better position to manage post detoxification patients. Training will be ongoing in this area to embed learning. The Neuropsychiatric rehabilitation care pathway was introduced in May 2024. Though all pathways have a mental health aspect to them, further training in this area was provided to staff to ensure both staff and patient safety. Feedback from staff regarding this new pathway was gathered in the December 2024 survey. The results reflect that a number of staff were still in a learning process. We have now introduced a Senior Mental Health practitioner within the nursing team to support patients and staff and ensure safety is maintained.

Supporting Staff Wellbeing and Reducing Work-Related Stress

Mildmay recognises the importance of staff wellbeing and has taken a proactive approach to managing and mitigating work-related stress. Several measures have been introduced to foster a supportive, open, and responsive working environment:

A no-blame culture:

We actively promote a culture of openness and learning, where staff feel safe to raise concerns and seek support when challenges arise.

Training and development:

Staff are supported through both mandatory and role-specific training to ensure they are equipped to carry out their duties confidently and effectively, reducing the risk of stress from feeling unprepared.

Inter-professional support and reflective practice:

i. The Psychology Team provides regular Trauma-Informed Practice training, incorporating mindfulness techniques to help staff manage stress.

Open reflective forums are held to review challenging incidents, enabling shared learning and better preparation should similar situations occur in future.

ii. Our Substance Misuse Worker facilitates monthly open sessions where nursing staff can discuss the challenges of supporting detox patients. Feedback from attendees has been positive, with staff reporting that these sessions have helped them feel more confident and supported.

iii. The recent appointment of a Senior Mental Health Nurse has significantly enhanced staff support on the ward. Their ongoing presence provides real-time advice and guidance when responding to mental health-related incidents.

Work-life balance and attendance:

Staff are encouraged to plan and evenly distribute their annual leave throughout the year to avoid burnout and reduce stress-related absenteeism. This is reviewed quarterly to ensure fair and consistent practice across the team.

Supervision and open communication:

Regular 1:1 supervision sessions are held quarterly, giving staff the opportunity to raise any concerns before they escalate. Compliance with this process is monitored on a quarterly basis.

Human Resources support:

The HR team operates an open-door policy, allowing staff to raise concerns confidentially and receive prompt support. This may include referrals for counselling or occupational health, and where necessary, the provision of special leave to help staff manage personal difficulties.

Priority request system for shift workers:

All rostered staff are entitled to submit three 'priority day' requests per 28-day rota cycle. These days are granted without the need for explanation and aim to provide staff with predictable rest days that support their wellbeing.

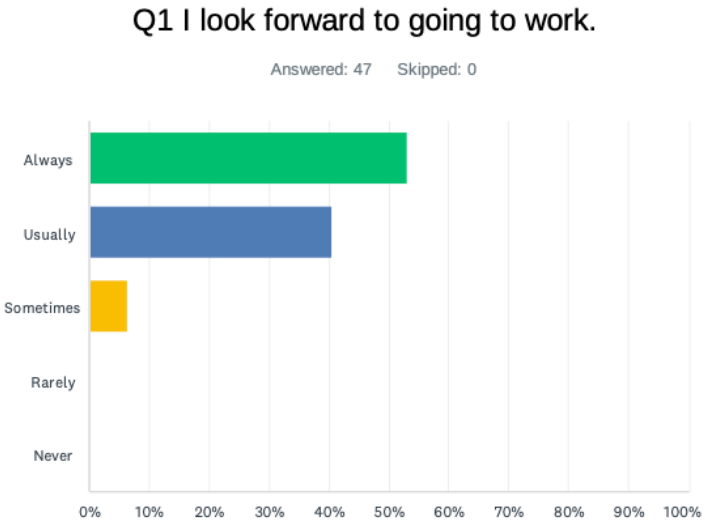
Social connection and morale:

The matron has introduced link roles within the nursing team, including a *Social Events Link Person* who organises staff activities such as meals out, picnics, cable car trips, and bring-and-share events. These opportunities have been well received and have helped strengthen relationships across departments.

Staff Survey

Mildmay conducted the yearly staff survey in December 2024. This gave all staff the opportunity to provide feedback on key areas including staff engagement, work/life balance, and the quality of care we provide to our patients. The results of the staff survey inform our practice in improving staff experiences through improving working conditions. The results also give us the opportunity to benchmark against different healthcare organisations to improve the quality of care we provide to our patients.

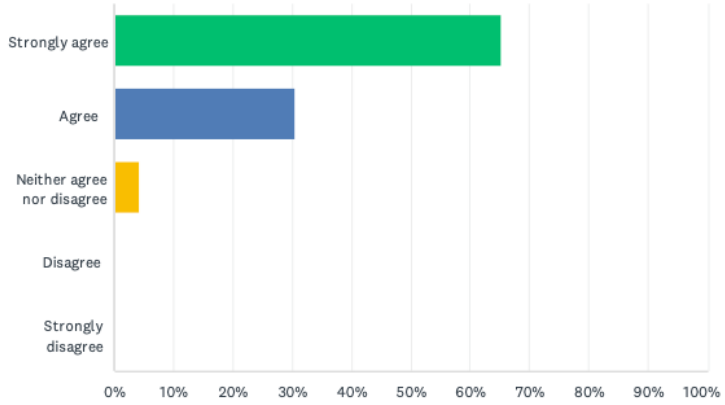
Below is some of the feedback from the staff survey:



ANSWER CHOICES	RESPONSES	
Always	53.19%	25
Usually	40.43%	19
Sometimes	6.38%	3
Rarely	0.00%	0
Never	0.00%	0
TOTAL		47

Q4 I always know what my work responsibilities are.

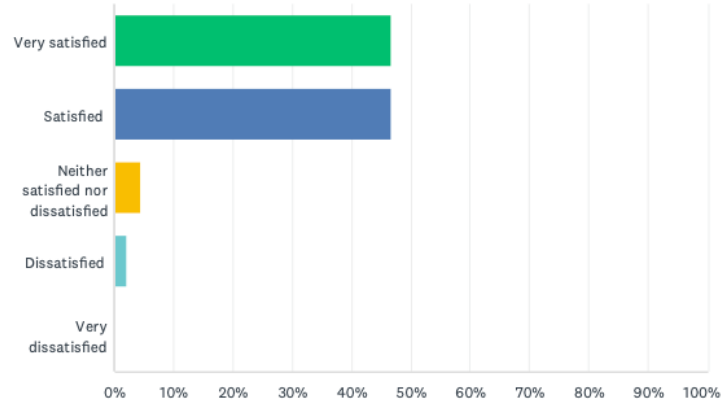
Answered: 46 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strongly agree	65.22%	30
Agree	30.43%	14
Neither agree nor disagree	4.35%	2
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		46

Q12 The opportunities for flexible working patterns.

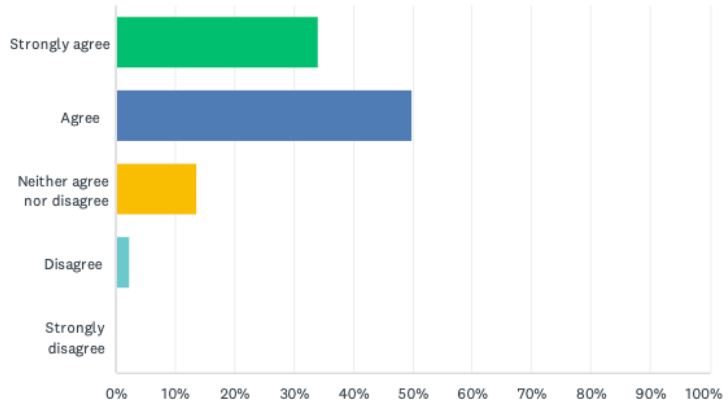
Answered: 45 Skipped: 2



ANSWER CHOICES	RESPONSES	
Very satisfied	46.67%	21
Satisfied	46.67%	21
Neither satisfied nor dissatisfied	4.44%	2
Dissatisfied	2.22%	1
Very dissatisfied	0.00%	0
TOTAL		45

Q21 The team I work in often meets to discuss the team's effectiveness.

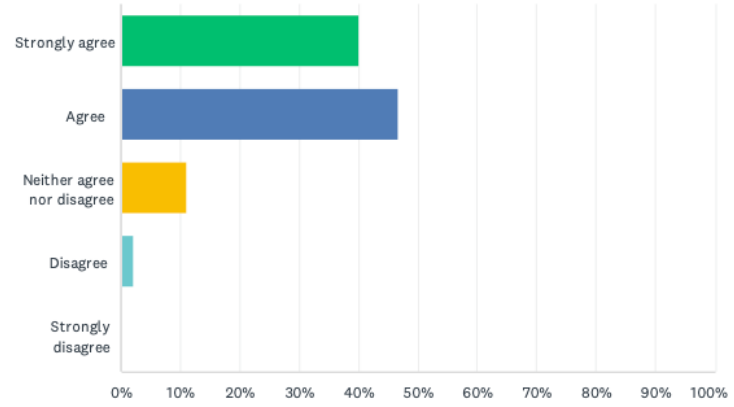
Answered: 44 Skipped: 3



ANSWER CHOICES	RESPONSES	
Strongly agree	34.09%	15
Agree	50.00%	22
Neither agree nor disagree	13.64%	6
Disagree	2.27%	1
Strongly disagree	0.00%	0
TOTAL		44

Q27 Teams within Mildmay work well together to achieve their objectives.

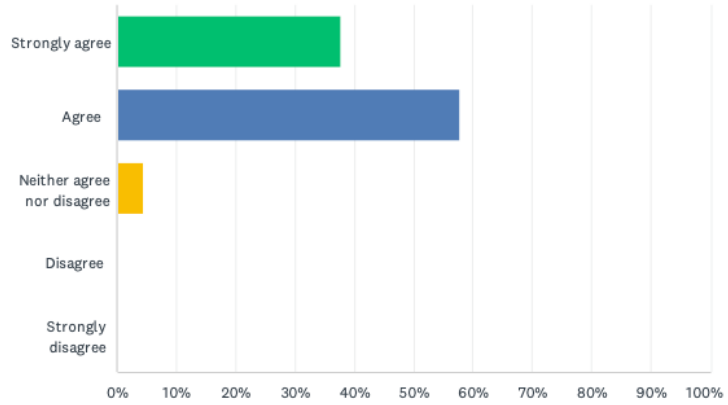
Answered: 45 Skipped: 2



ANSWER CHOICES	RESPONSES	
Strongly agree	40.00%	18
Agree	46.67%	21
Neither agree nor disagree	11.11%	5
Disagree	2.22%	1
Strongly disagree	0.00%	0
TOTAL		45

Q36 My immediate manager takes positive action to help me with any problems I face.

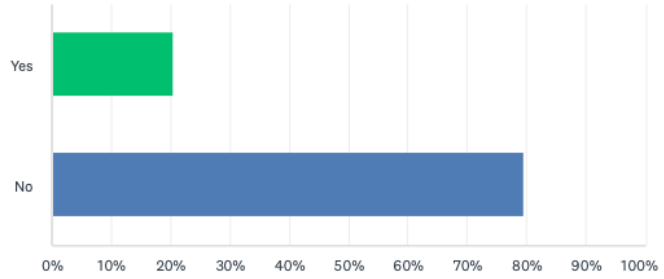
Answered: 45 Skipped: 2



ANSWER CHOICES	RESPONSES	
Strongly agree	37.78%	17
Agree	57.78%	26
Neither agree nor disagree	4.44%	2
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		45

Q41 During the last 12 months have you felt unwell as a result of work related stress?

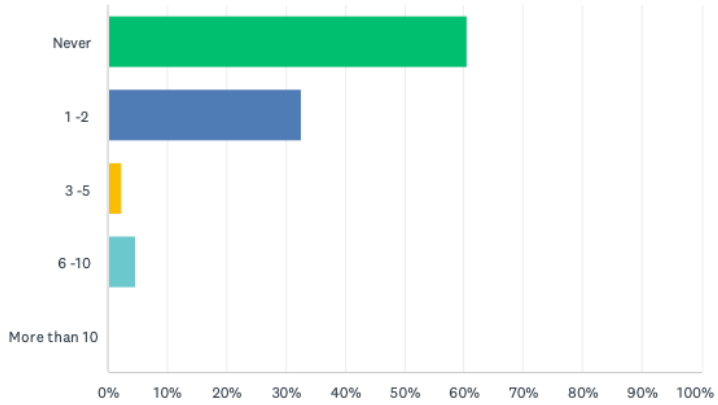
Answered: 44 Skipped: 3



ANSWER CHOICES	RESPONSES	
Yes	20.45%	9
No	79.55%	35
TOTAL		44

Q52 In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients?

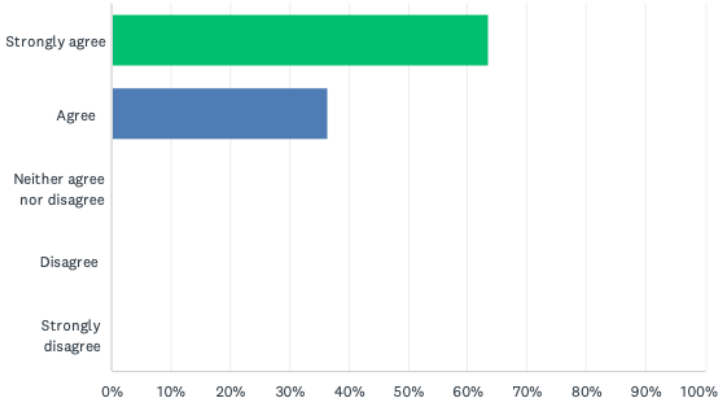
Answered: 43 Skipped: 4



ANSWER CHOICES	RESPONSES	
Never	60.47%	26
1 -2	32.56%	14
3 -5	2.33%	1
6 -10	4.65%	2
More than 10	0.00%	0
TOTAL		43

Q62 My organisation encourages us to report errors, near misses or incidents.

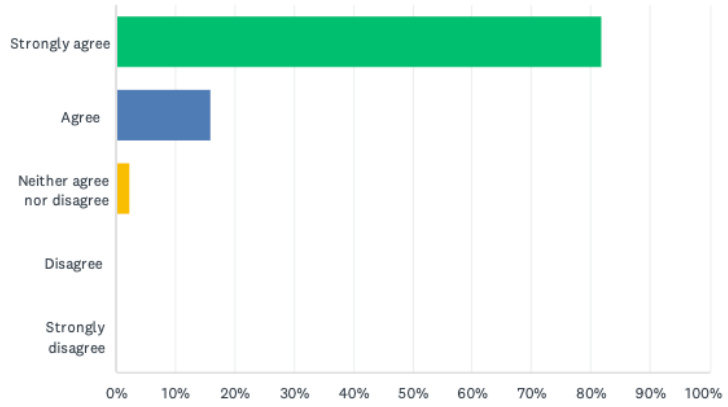
Answered: 44 Skipped: 3



ANSWER CHOICES	RESPONSES	
Strongly agree	63.64%	28
Agree	36.36%	16
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		44

Q74 Care of patients is a top priority for Mildmay.

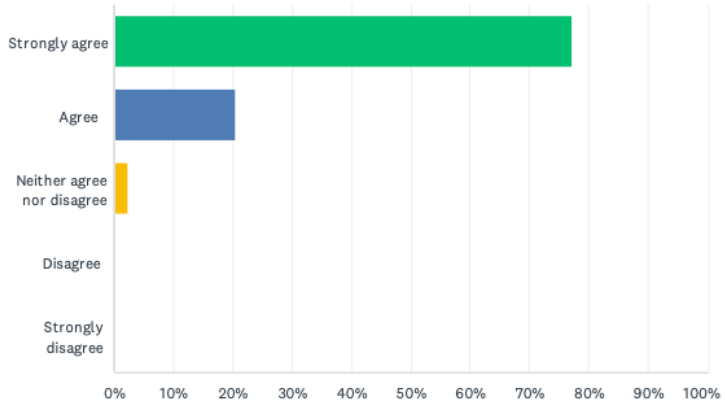
Answered: 44 Skipped: 3



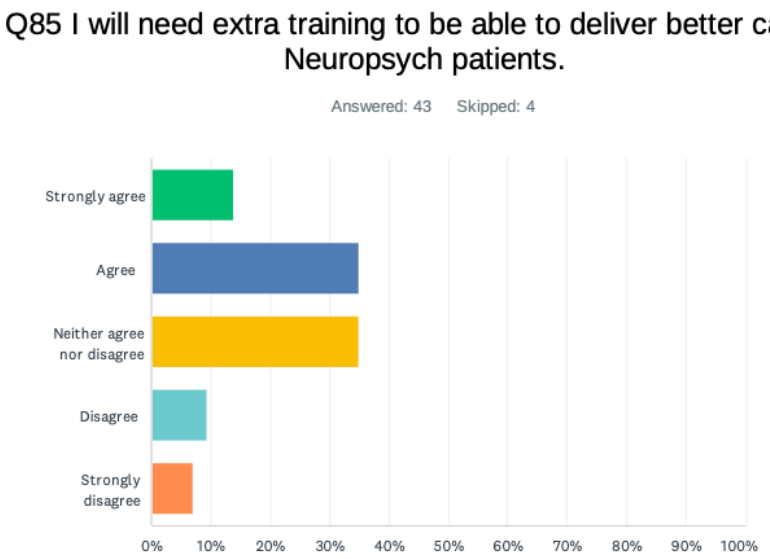
ANSWER CHOICES	RESPONSES	
Strongly agree	81.82%	36
Agree	15.91%	7
Neither agree nor disagree	2.27%	1
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		44

Q75 Mildmay acts on concerns raised by patients.

Answered: 44 Skipped: 3



ANSWER CHOICES	RESPONSES	
Strongly agree	77.27%	34
Agree	20.45%	9
Neither agree nor disagree	2.27%	1
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		44



ANSWER CHOICES	RESPONSES	
Strongly agree	13.95%	6
Agree	34.88%	15
Neither agree nor disagree	34.88%	15
Disagree	9.30%	4
Strongly disagree	6.98%	3
TOTAL		43

Overall the feedback from the staff survey was positive. Our staff feel that Mildmay is a great place to work and patient care is a top priority. The introduction of middle managers within the nursing team has been a great success. Ward managers, the Senior Mental Health Practitioner and the Charge nurse work alongside junior staff providing support on an ongoing basis. Appraisals and supervisions across teams have been efficiently done giving staff an opportunity to discuss their goals, learning objectives and any areas they may need to Improve. The Charge Nurse is responsible for Clinical Skills in the nursing team, identifying gaps and developing skills in the real work environment. We have continued to arrange interdepartmental training days, to build and develop a positive working environment across different teams and encourage staff to work together and share ideas.

The changes implemented over the last year have had positive results including a low staff turnover, decline in sickness absence and improved staff morale.

3.5 Patient Feedback

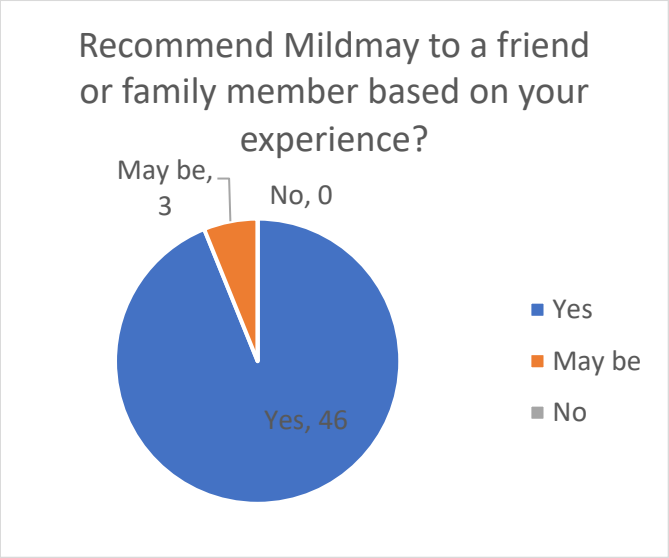
Friends and Family Survey:

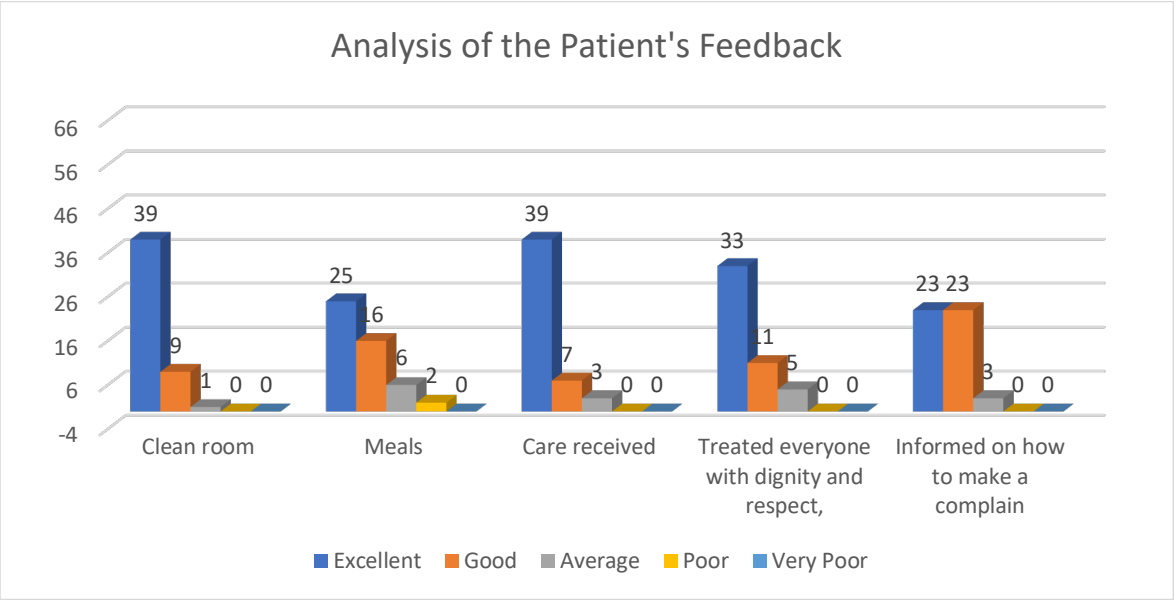
Mildmay places great importance on feedback from patients,

In 2024-25, feedback was collected from 49 patients when they were discharged.

On average, we had positive responses (excellent and good) from 92% of the patients (excellent and good) and 100% of the patients would happily recommend Mildmay if their friends and family requires the facility.

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

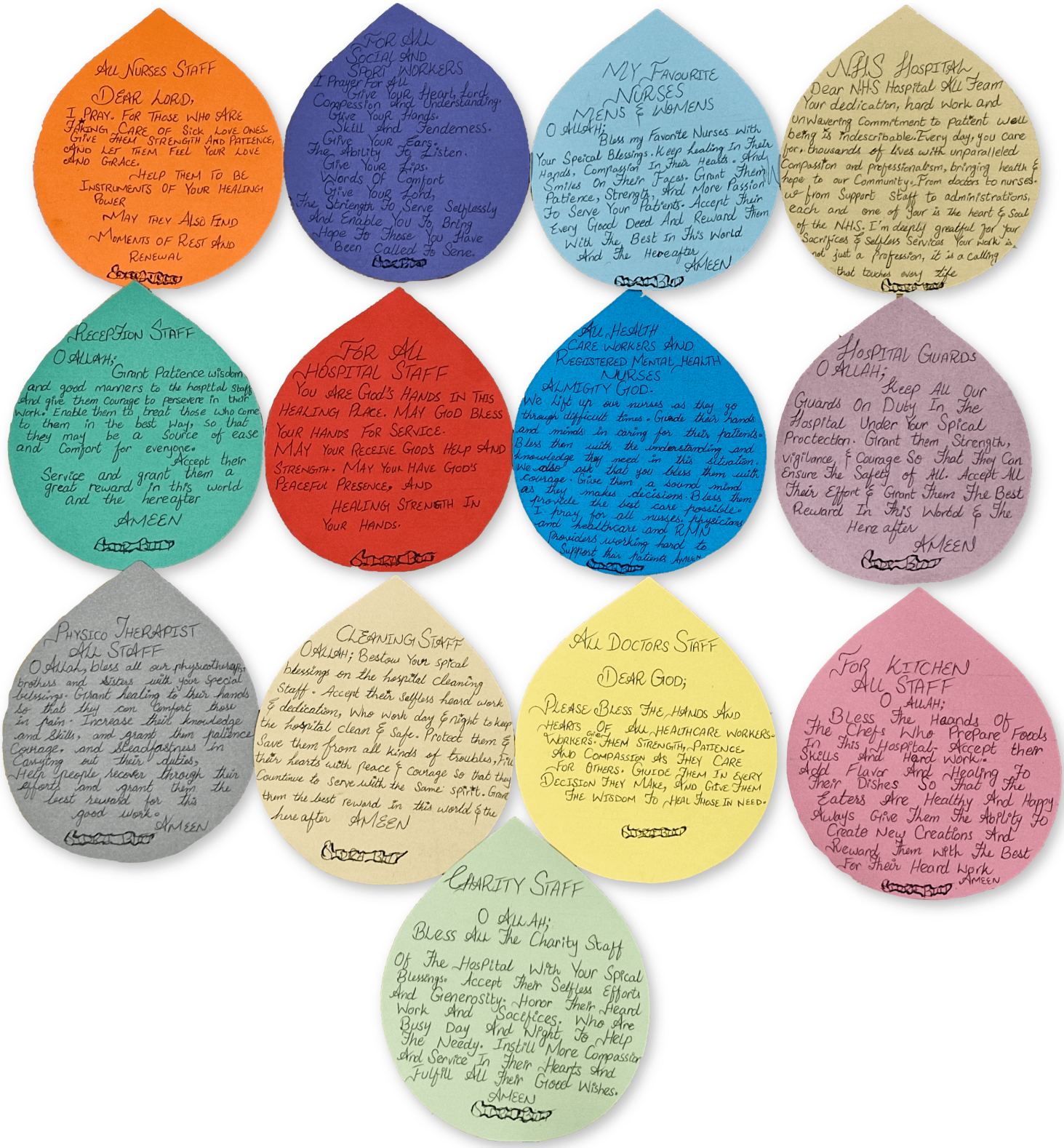




Comments made by patients

- "My stay in this hospital was a memorable one because of your support. I appreciate you all so much."
- "Thank you for the wonderful care you gave to me. I came here very ill but now I am a lot better."
- "I came here very sick, but with excellent doctors and the staff, I am now feeling much better. The nurses are so good; they check up on you all the time with care and help so much."
- "I say all this with great respect for the staff and everything at Mildmay. Wonderful physio/gym and art therapy etc."

Appreciative feedback from patients




THANK YOU
MILD MAY HOSPITAL
All Management Team
All Staff And Doctors
Thank you very much to the management
team at Mild May Mission Hospital
All the Doctors and Nurses and
all staff who took such good
care of me and enabled me
to start my journey towards a
new life again. Thank you
very much to
every one

3.6 Case Studies

Case Study 1:

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

July 2025

Mrs. X (63-year-old, English Caucasian female) was diagnosed with HIV advanced stage C (22.11.2024); with CD4 of 264 (31.12.24), viral load (VL) of 395 (9.1.25). She was started (23/01/25) on DESCOVY (tenofovir alafenamide and emtricitabine) and TIVICAY (dolutegravir) 50mg once a day. Medication review on the 18/03/24 when DESCOVY was increased to twice a day and Dolutegravir 50mg. On the 23/01/25 she was started on Prednisolone (steroid). Medication interaction with food and oral and enteral nutritional supplements were cross-checked using https://www.hiv-druginteractions.org/checker; where DESCOVY showed no food interaction expected where as TIVICAY showed potential interactions with ONS and feeds. Enteral feeds contain polyvalent cations, which can may decrease the concentration of Dolutegravir due to chelation with polyvalent cations. This indicated that the enteral feed needed a break for 6 hours before and 2 hours after taking dolutegravir.

Additional medical and medication:

She had hospital acquired pneumonia (HAP), pneumocystis pneumonia (PCP), cytomegalovirus viremia (CMV), Mycobacterium avium (MAI), Enterococcal bloodstream infection (BSI), Liver function deranged cholestatic pattern, hyponatraemia, hypercalcaemia (resolved), unhealed grade 2 ulcer, chronic diarrhoea, malnutrition and cachexia. On escitalopram, ethambutol, famotidine, fluconazole, folic acid, mirtazapine.

Biochemistry on the 17/03/25 Hb 100L (99) CRP 5 Alb 23L (20) PO^4 0.71L (0.68) Deranged liver function test (LFTs).

Bowels were opening and stools were type 5 (T5) after eating, seems to stimulate bowels. Mainly loose stools through her lst hospital stay.

Family and social background:

Her next of kin was her daughter who was aware of her diagnosis. They lived together in a permanent flat on the 2nd floor with no lift. She has a small family, her ex-husband, mother and sister were all unwell and some also hospitalised. Only support was from her daughter (21 y.o) and who had started a new full-time job.

Transfer to Mildmay:

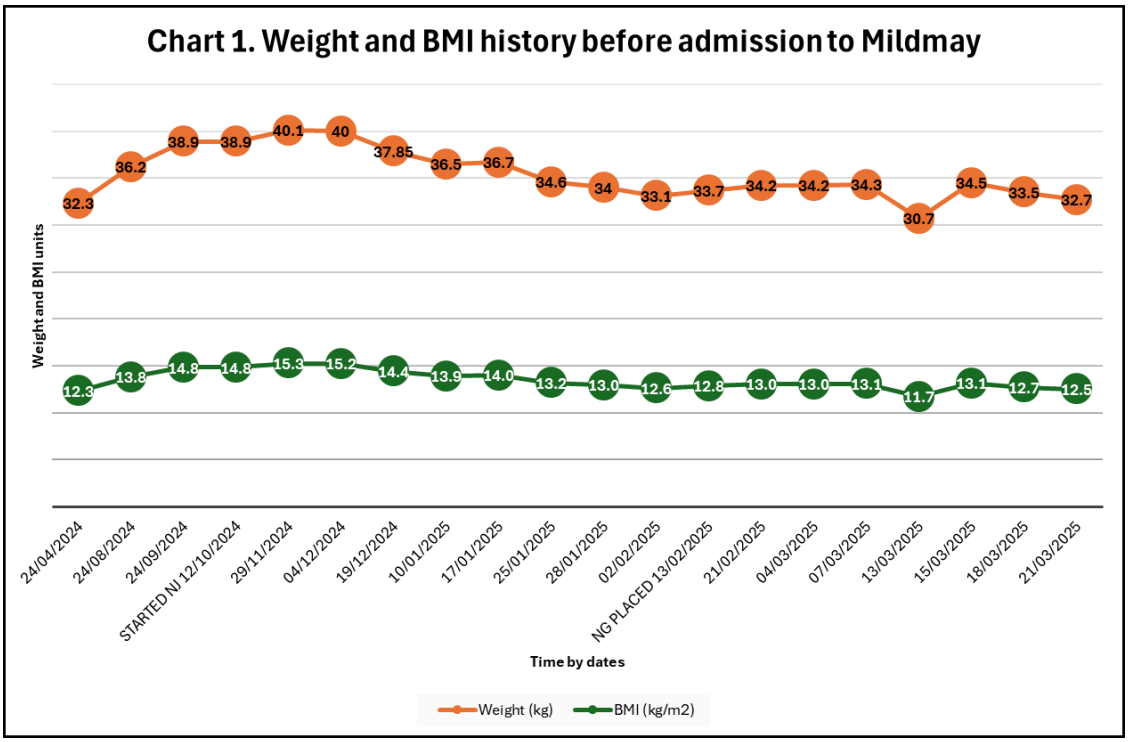
She was transferred after a year admission at an acute hospital for 12 weeks rehabilitation following a recent HIV diagnosis.

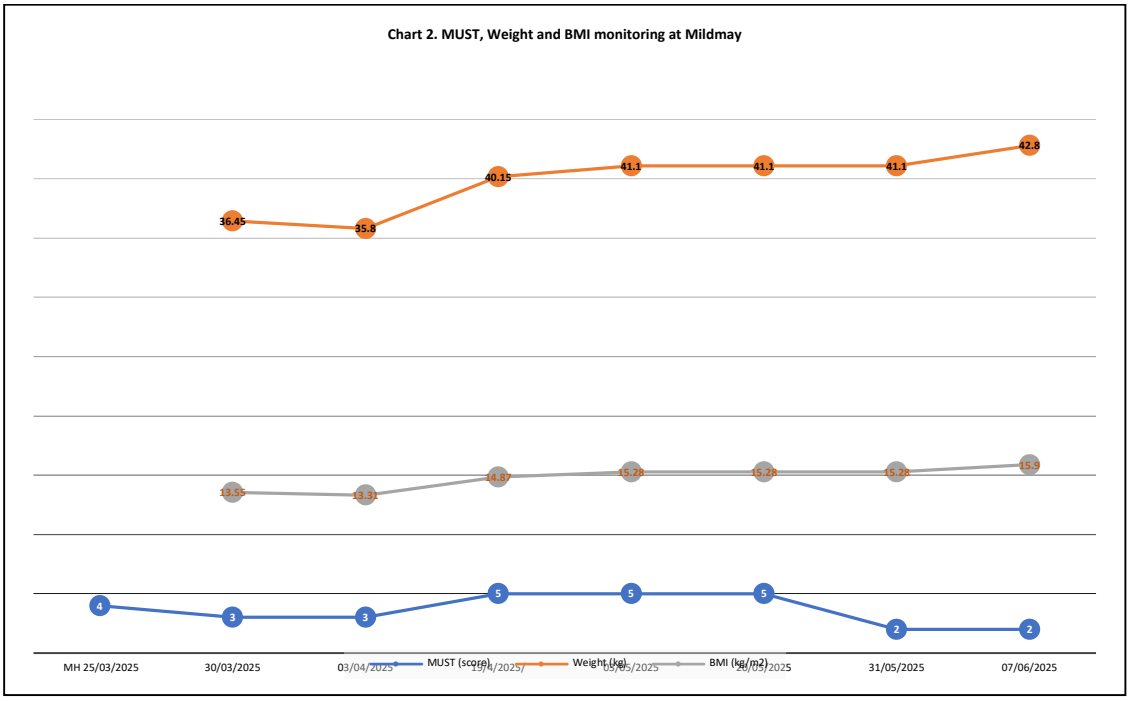
The malnutrition universal screening tool (MUST) score was 4 /6 on admission. She was bed bound, transferred with enteral nutrition nasogastric tube (NGT) in situ.

Anthropometry:

Weight and BMI history can be seen in Chart 1.

On (30/3/25) full assessment her MUST score was 3/6, weight was 36.45kg, height 1.64m, and her BMI was 13.55kg/m^2 classification of seriously underweight and will require long-term nutritional support.





Current (7/6/25) MUST score reduced to 2/6, weight 42.8kg, 15.9kg/m2 classification of seriously underweight, with overall weight gain of 6.35kg (15%) which is significant, over the last 2.5 months.

Estimated requirements:

Her estimated requirements were calculated using PENG (2018) for a person bedbound with a body mass index (BMI) <18.5kg/m2. Using the 36kg weight (25-30kcal/kg + 1.2PAL) provided a range of 1081-1296 kcal/day with1000kcal to gain weight; her energy requirements range from 2081-2296kcal per day. Her protein requirements to replenish 2g/kg came to 72kg and fluids requirements 1080mls per day.

Based on current weight of 42.8kg her energy requirements range from 1284-1540kcal with an addition of 800kcal to gain weight; 2084-2340kcal per day, 85.6g protein, 1284ml per day.

Oral diet:

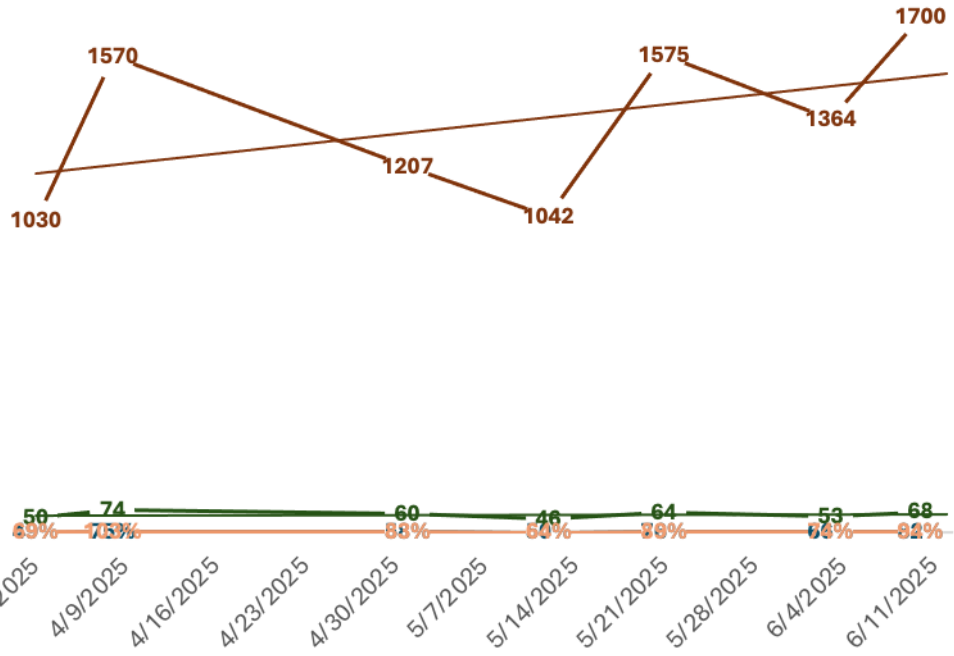
Prior to transfer she was eating well, she liked a cooked breakfast of mushrooms, baked beans with added butter and hash browns; midmorning snack she was having cheese and tomato roll; she was eating all her lunch and dinner. Her intake was estimated to be about 1500-1600kcal/day, 70g of protein.

At Mildmay, she was able to eat orally all food of the International Dysphagia Diet Standardisation Initiative (IDDSI) level 7: regular (cut up food) and fluids IDDSI level 0- thin, recommending a normal diet. Even though she was able to eat, she was not able to meet her requirement on food alone, therefore she was given oral nutritional supplements (ONS) as required and NGT enteral nutritional to support.

On admission, she reported no food allergies only having mild lactose-intolerance and was not avoiding dairy products. She reported that her food dislikes were large chunks of meat - mince is fine and did eat meat, and when she was not sure of the food option, she selected vegetarian. She needs her spaghetti cut and needed supervision during mealtimes, so she was placed on *red tray feeding*, a system in hospital to identify and support patients who are at risk of malnutrition or who need assistance with eating. She reported recently increasing vegetable intake due to dietetic recommendations. She was recommended to eating upright, seat out while eating, be alert and encouraged oral hygiene.

Chart 3 shows the summary of the Food record charts (FRC) weekly average intake. During her stay she did not eat on the 11th of May when she was very unwell. Post recovery the liner forecast for food energy (calories) intake is increasing. The protein projection is flatter. She also reported that she was enjoying the summer menu more.

CHART 3. SHOWS THE ESTIMATED AMOUNT OF CALORIES AND PROTEIN EATEN AND THE % THEY MEET OF THE LOWER LEVEL OF REQUIREMENTS



	4/2/2025	4/8/2025	5/1/2025	5/12/2025	5/21/2025	6/3/2025	6/10/2025
Energy (kcal)	1030	1570	1207	1042	1575	1364	1700
% met	49%	75%	58%	50%	76%	66%	82%
Protein (g)	50	74	60	46	64	53	68
% met	69%	103%	83%	64%	89%	74%	94%

Nutritional interventions and rational:

The handover rational received reported that she had on and off loose stools the whole admission at St Georges and improved prior to transfer to almost verging on constipation whilst given Peptisorb. This is a specialised nutritional formula, primarily used with malabsorption or maldigestion, and is often used for dietary management of disease-related malnutrition. It's a peptide-based formula that contains proteins that have been broken down into smaller peptides, which can be easier for the body to absorb. Previously she was on Vital 1.5kcal but always had loose stools with this. In addition, they stopped prescribing both Cholestyramine and Loperamide. Pancreatic enzyme replacement therapy (PERT) was not trialled because the faecal elastase-1 (FE1) level was >800 ug/g and was considered normal and did not indicate exocrine pancreatic insufficiency (EPI). A scan indicated mildly oedematous pancreas but at the time her stools were formed. This needs further exploration as it is so hard to get her to gain weight despite excess kcals given.

Nutritional support

1. Food: cooked breakfast and extra snacks.
2. ONS Fortisip Plant (Vegan) twice a day (600kcal/24g protein) – patient preferred plant based. To be given as needed (latin "pro re nata," PRN).
3. NGT feed: Peptisorb 500ml @ 83ml/hr for 6 hours 8pm to 2am (stop 6 hours before and 2 hours after the dolutegravir dose) which provided 500kcal, 20g protein and 700mls

- Total provided 1100kcal, 44g protein and 900ml

At Mildmay, on initial assessment the NGT site at left nostril looked very loose and numbers were worn away and the tube had been in place longer than a month, she did well to tolerate this tube. There was no information on transfer about the NGT. Patient consented at St Georges to having the NGT purely for feeding support. In accordance with Mildmay Enteral feeding procedures NGT aspirate pH are checked and signed by 2 nurses before commencing water flushes and feeding. NGT feeding was overnight to allow her to engage with therapy in the day. The nutritional transfer plan was continued and monitored.

We requested NGT information (1/4/25) to ensure it was used safely on site. The NGT was inserted on the 13/2/25, in the left nostril, the brand used was Corflo 30321301 and the nose-ear-xiphoid (NEX) measurement was 91 and centimetres marked at 57. No other details were given, such as: if they have any difficulties in placing it, she uses a nose piercing on the left nostril, she has a previous NJ, etc. This information can help us decide further enteral nutrition procedures as required.

The transfer recommendations were changed on the (3/4/25) post review; when Fortisip Plant was stopped and replaced by NGT feed Survimed 500ml @ 83ml/hr for 6hrs (stop 6hrs before next dolutegravir dose) with water flushes of 100 ml pre and post feed to provide an total energy of 500kcal, protein 20g and fluids 700ml. Survimed is also a peptide-based formula we use at Mildmay. She also started a trial on ONS Vital 1.5kcal three times per day (900kcal, 20.3g protein, 600ml) cafe latte flavour, we recommend to give 100ml, 6 per day (small amounts through the day). The total provided: 900kcal (41%) to meet 1930kcal/day on top of normal food.

Review to see if she was tolerating the NGT (8/4/25) Survimed feed; however, it was stopped at 3AM (300ml @ 100ml/hr for 3hrs) because she did not tolerate it. Vital 1.5kcal, which is lactose free, was prescribed one per day (300kcal, 13.5g protein, 200ml) café latte, but due to nausea this was given in small volumes (50ml) to help her tolerate it and given four times a day with antiemetics. The main aim was to wean off NGT and move to oral intake only.

Patient removed the NGT (1/5/25) and was on ONS Vital 1.5kcal 100ml four times per day only (600kcal, 27g protein, 400ml) cafe latte flavour and cyclizine was increased to help increase oral intake.

Patient deteriorated (8/5/25); she had low potassium, required IV, in addition she was not tolerating the catheter. She was transferred (14/5/25) to acute site and on returning her oral intake declined and need to increase fluids. Cooked breakfast, snacks and fluids she likes (eg Vinto) were offered as well as the normal food service. She continued on Vital 1.5kcal 80ml four times per day (300kcal, 6.8g protein, 200ml) cafe latte, with the aim to increase Vital 1.5kcal to 90ml four times a day and if tolerated 100ml four times a day. Discussion with Speech and language therapist (15/5/25) we agreed to plan for possible further deterioration and explore NGT replacement in case she needs this and to prevent her being placed nil by mouth (NBM). I sought consent for the NGT

placement of its required or she deteriorates once a long weekend, which the patient consented and provided feed regime to staff as a back-up.

On review no issues were raised (22/5/25) about nausea or vomiting the since 16/5/25. In agreement with patient, we decrease Vital 1.5kcal volume to 55ml six time per day (300kcal, 13.5g protein, 200ml) and changed for vanilla flavour. She is not able to tolerate the café latte ONS.

She reports enjoying the summer menu (3/6/25) and continues on Vital 1.5kcal volume to 55ml six time per day (300kcal, 6.8g protein, 200ml) vanilla flavour. She is slowly gaining weight (Chart 2) and she is improving with mobility and activities of daily living.

Impression and future thoughts:

She will need long term oral nutritional support, looking to increase her protein intake and change her ONS in view that her bowels have been normal. We will continue to monitor and plan for discharge.

Key working:

The clinical psychologist and dietitian are co-key workers for this patient. The reason for her admission was for ongoing physical rehabilitation, medical and dietetic optimisation.

The patient's personal goals while at Mildmay:

- To walk and then she can do all the things she is unable to do.
- She wants to be able to go to the toilet and not wear pads – PART ACHIEVING
- Increase her leg strength
- Stop enteral feeding support- ACHIVED

The referral focused on Physical and psychological goals looking at:

- Independent transfers mobilise short distances
- Completing a light meal – PART ACHIEVING
- Independent washing and dressing when appropriate – PART ACHIEVING

Patient has improved and is now able to sit out for more than 2 hours for meals, doing daily physiotherapy, able to wash herself and much more. The commissioners approved a four-week extension, and we hope she will gain abilities to allow her to go home on discharge. The team discharge meeting recommended to request another 4 weeks extension to support further rehabilitation, increase independence and support safe discharge home.

Completed by Kattya Mayre-Chilton
Specialist dietitian B7 (DT 52587)

Case Study 2:

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

Q4 2024/25

Patient A

Patient A was admitted to Mildmay on the detox pathway after a planned admission with GGST. He arrived with a past medical history of:

- Alcohol Dependence
- Alcohol Withdrawal Seizures
- Liver Cirrhosis
- Previous vertebral fractures
- Previous Proximal Femur fracture
- Previous osteomyelitis
- BPH

The events leading to Admission to Mildmay:

In 2020, Patient A sustained a spinal injury after falling while intoxicated and moving furniture, resulting in a broken back. He underwent surgery followed by physiotherapy. During his recovery, he was bitten on the back by a dog, leading to an infection that delayed his healing. In the following year, Patient A accidentally burned his buttocks on a radiator, unaware it was on - an injury requiring surgery and leaving a scar. He did not feel the heat due to lower body numbness combined with intoxication.

Patient A engaged with his local drug and alcohol service, where he began working towards detoxification and rehabilitation. His plan was to detox from alcohol with the Guy's and St Thomas's Substance Misuse Team (GSST), followed by a period of stabilisation at Mildmay. This would allow him to explore his addiction issues and improve his mobility. During his admission, the option of residential rehab was discussed, which he felt would be beneficial. His external team recognised the progress he was making and agreed to fund further rehabilitation.

Although Patient A was able to walk and stand, he was unable to do so for long periods. He increasingly relied on crutches and a wheelchair to mobilise. He also experienced numbness in his feet, which sometimes caused him to place them incorrectly, leading to further falls and injuries.

Motivated by these events, Patient A expressed a desire to stabilise, regain physical strength, and eventually return to work. He was committed to abstaining from alcohol and wanted to be present and stable for his daughter and parents.

During his admission, he developed a cough and worsening shortness of breath. A chest X-ray showed left lower zone consolidation, and a sputum sample grew Haemophilus influenzae. He completed a course of intravenous co-amoxiclav, followed by oral doxycycline. After a respiratory review and lung function tests, he was started on Anoro Ellipta and Salbutamol due to smoking-related lung damage, as he did not meet the diagnostic criteria for COPD.

He was also reviewed by Dermatology for a suspected fungal infection and commenced on Ketoconazole for seborrhoeic dermatitis. Additionally, he was found to be pre-diabetic and received lifestyle advice accordingly.

Progress at Mildmay:

Patient A was an active participant in the Relapse Prevention Groups and engaged well in one-to-one sessions. He was eager to understand the roots of his alcohol addiction and learn strategies for maintaining abstinence. Through exploring his thoughts, feelings, and beliefs, he became more open to change. He prepared thoroughly for his next step into residential rehab, determined to make the most of the opportunity. He was mindful of the support he had received from multiple professionals and teams, and expressed genuine appreciation for the investment made in his future.

During his time at Mildmay, Patient A also engaged positively with our occupational therapists, physiotherapists, nursing, and medical staff. From a nursing perspective, he was prescribed medication via Directly Observed Therapy (DOT) and adhered well. He also self-medicated responsibly from prescribed packets.

He regularly attended the Life Skills Group, where he took part in cooking sessions and discussions on practical topics such as tenancy maintenance, budgeting, communication skills, and how to identify scams. He interacted appropriately with both peers and staff, often contributing helpful advice during group discussions.

Prior to admission, Patient A relied heavily on a wheelchair due to long-standing spinal issues and lower limb weakness. His personal goal was to leave the unit using only a walking stick – a goal he successfully achieved. He worked hard in the gym most days, and when pain levels were high, he focused on flexibility exercises to maintain consistency in his physiotherapy programme.

Patient A achieved his goal of remaining abstinent from alcohol and walked out of Mildmay using only a walking stick. He progressed to a traditional drug and alcohol rehabilitation centre. As Mildmay has previously referred patients to this particular rehab and maintained links with their team, we received an update from his key worker confirming that he completed Stage 1 of the programme and has now advanced to Stage 2. He continues to maintain abstinence and is planning to relocate to the new area, having developed a strong support network and integrated into the local community.

Case Study 3:

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

June 2025

Patient B

Patient B is a 49-year-old man who was admitted after an alcohol detox. He has a long history of alcohol use which resulted in a diagnosis of fatty liver and liver cirrhosis. He has also had a stroke.

His marriage broke down due to his drinking, however his wife has been supportive and has continued to support him in being present for his children. This has been his main motivation for addressing his addiction as he doesn't want to miss out on the relationship he can have with his children, as well as the impact his drinking has had on his health.

He has not had any previous experience of a medical detox and rehabilitation, so felt unsure about what to expect. He decided from the start that he wanted to get as much out of his admission as possible, and that he would attend everything offered to him and learn as much as he can.

He expressed that due to the environment and staff at Mildmay he was able to feel confident about his treatment and trusted to process.

He engaged well with physiotherapy as he wanted to be as mobile as strong and physically able as possible by the time he left. He enjoyed his sessions in the gym and gained the benefit of the physio team. He was able to recognise that improved health and fitness is at odds with heavy alcohol use which added to his resolve to address his addiction.

He was seen by the psychology team and attended Mindfulness groups throughout his admission and engaged well with the content of the sessions.

He was also seen by psychology for a cognitive assessment as towards the end of his admission due to reported difficulties with memory (e.g., names/upcoming appointments) and word-finding in the context of previous stroke and history of high-level of alcohol use. Unfortunately, the outcome of the assessment was inconclusive due to his level of anxiety. It was recommended that Patient B be referred to the Community Neurorehabilitation team by his GP for further assessment and vocational rehab to support return to work, should he continue to experience difficulties with memory and/or word finding when he completes drug and alcohol rehabilitation.

He had no specific Occupational Therapy goals or needs identified on this admission as he was at his baseline level of function and able to manage his daily activities independently. However, he attended our weekly breakfast group and life skills group where he enjoyed cooking and baking something different every session. It was a pleasure to have him in the group sessions and he was always very aware and considerate of the people around him. He gained socialising skills that didn't involve alcohol, which was new to him. To explore his skills around socialising alcohol free, he joined the weekly debate group which was run by the speech and language therapist.

He was concerned about gaining weight during his admission as he gained a new appreciation of tasty food, which he worked on with our dietitian.

Throughout his admission he worked closely with the substance misuse worker who tied all the groups together with him so he was able to see how he was gaining skills and strategies that could help him maintain abstinence from alcohol. During his 1:1 sessions he worked on preparing for rehab as he did not know what to expect and was very anxious about going. There were times during his admission that he was not sure he wanted to go but recognised that it was his anxiety that was driving these thoughts. He worked on stress reducing techniques that he reported to find extremely helpful and intends to continue them in the future.

While he was here his external team worked on referrals to traditional drug and alcohol rehab to follow on from his Mildmay admission.

A rehab was identified and with the support of the substance misuse worker he was able to become familiarise with them by calling and speaking to the staff there twice a week for a few minutes at a time. Also, the substance misuse worker was able to complete some prep for rehab work with Patient B, which helped him to reduce his anxiety about going.

By the time he was discharged, Patient B was keen to move on to rehab and was excited about the next step in his recovery.

Feedback post-discharge from his drug and alcohol tier 4 worker, has confirmed that Patient B has settled well in rehab and is doing very well.

Case Study 4

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

Q1 2025/26

Patient J

Patient J is a 63-year-old woman admitted to Mildmay for rehabilitation following a prolonged hospital stay related to advanced HIV, significant deconditioning, and multiple complications. She presented with generalised muscle weakness, lower limb instability, and cardiorespiratory fatigue that severely impacted her ability to manage activities of daily living. Discharge planning was complex due to her second-floor flat with no lift access.

Reason for Admission:

- Ongoing rehabilitation and medical optimisation post-acute stay
- Referral to physiotherapy for significant mobility loss and functional decline
- Discharge planning complicated by home environment

Medical Background & Factors Affecting Rehab:

- HIV: Initiated on ART (Biktarvy)
- Hypercalcemia: Monitored; likely linked to immobility and nutrition
- Malnutrition & severe weight loss: Muscle wasting, reduced endurance
- HIV-associated myopathy: Suspected cause of progressive weakness
- Cardiorespiratory fatigue: Limiting tolerance to physical activity

MDT Involvement:

- Nutrition support for weight loss and intake
- Physiotherapy for mobility, strength, and fatigue
- OT/social work for discharge planning

Functional Assessment

Baseline (On Admission):

- Bed mobility: Slow, effortful, assistance of two
- Transfers: Dependent, hoist required
- Sit-to-stand: Max assistance of two + bars
- Mobility: Non-ambulatory, wheelchair-bound
- Showering & toileting: Full assistance of two
- Stairs: Unable to attempt

Current Functional Level:

- Bed mobility: Improved, supervision to minimal assistance
- Transfers: Molift → banana board; step transfers practiced
- Sit-to-stand: 1–2 assistants + grab bars
- Indoor mobility: Short distances with parallel bars
- Step navigation: 1–2 steps with handrails & supervision
- Showering/toileting: Carer assistance; trialling aids

Range of Motion (ROM):

- ULs: Full
- LLs: Mildly reduced hips/knees (inactivity)

Strength:

- ULs: 4+/5 bilaterally
- LLs: 3/5; weakness affects sit-to-stand

Tone & Sensation:

- Normal tone, no spasticity
- Sensation intact

Proprioception & Coordination:

- Proprioception functional
- Mild coordination delay LLs (fatigue-related)

Balance:

- Sitting: Independent
- Standing: Assistance of 2; improved with parallel bars

Cardiorespiratory:

- Fatigue with minimal exertion
- ↑ RR on exertion; occasional dizziness

Physiotherapy Assessment Summary:

- Generalized muscle weakness (lower limbs > upper limbs)
- Mild postural kyphosis & poor core stability
- Fatigue & shortness of breath on exertion (improving)
- Requires assistance of two for transfers and mobility
- Improved standing posture & balance with parallel bars
- Functionally dependent for most ADLs; increasing participation
- High fall risk due to deconditioning & lower limb instability

Functional Independence Measure (FIM) / Functional Assessment Measure (FAM)

Current Functional Status: Transfers

- Bed, Chair, Wheelchair: Moderate Assistance (Score 3)
- Toilet: Moderate Assistance (Score 3)
- Tub or shower: Moderate Assistance (Score 3)

Key Areas for Improvement:

- Safe and independent transfers, particularly involving steps (due to knee instability)
- Increased independence with showering and toileting tasks
- Improved endurance and fatigue management to support daily activity levels

Functional Task Performance & Rehab Focus:

- Shower Assessment: Requires two-person assistance
- Step Transfers: Two-person assist due to knee instability
- Rehab Emphasis: Step navigation, lower limb control, and fall prevention strategies
- Fall Prevention: Ongoing focus due to balance issues and lower limb weakness

Rehabilitation Goals:

- Increase independence in step transfers and stair use
- Reduce assistance required for ADLs, particularly self-care
- Enhance endurance and balance for safer mobility and greater function

Goals:

- Improve proximal lower limb strength to support sit-to-stand transitions
- Enhance knee stability and control to reduce risk of buckling during standing tasks
- Mobilise with side-stepping using parallel bars with minimal assistance
- Achieve independent step transfers with minimal support
- Begin negotiating 1–2 steps with assistance in preparation for home stair use

Patient Engagement & Compliance:

- Highly engaged and motivated during all physiotherapy sessions
- Actively participates in daily exercises and functional retraining
- Demonstrates clear understanding of rehabilitation goals and safety strategies

Exercise Interventions:

- Sit-to-stand practice using parallel bars
- Overhead pole breathing exercises for cardiorespiratory endurance
- Side-stepping drills to improve balance and lower limb control
- Static and dynamic weight shifting to enhance postural stability
- Supported stair stepping on low block to simulate 1–2 step height
- TheraBand strengthening exercises targeting gluteal and hamstring muscles
- Seated aerobic leg movements to gradually build endurance
- Core engagement exercises to support posture and stability

Additional Support & Interventions:

Coordinated wheelchair provision for discharge mobility, facilitated garden access to enhance wellbeing, maintained regular MDT communication to track progress, and ensured daily nursing support for ADLs.

Mobility & Strength Training

- Task-specific rehab: sit-to-stand, transfers, and step practice
- Gait re-education and stair negotiation (1–2 steps with rails)
- Fall prevention incorporated through balance training and safe mobility techniques

Fatigue Management

- Pacing & Energy Conservation: Education on task planning, rest breaks, prioritization, and use of aids
- Graded Endurance Training: Progressive low-intensity exercises and ADL-based tasks to improve stamina

Wheelchair & Transfer Training

- Indoor: Building independence with safe wheelchair navigation
- Outdoor: Assistance still required; stair access remains a barrier
- Ongoing transfer practice (bed, toilet, chair)
- Physiotherapy guidance on safe techniques and fall risk minimization in transfers and navigation

MDT & Ongoing Support

- Referral to community physiotherapy for continued rehab
- Input into falls prevention, including education, exercises, and carer support
- Collaboration with OT for home modifications (grab bars, commode chair, raised toilet seat) to reduce environmental risks

Key Achievements Since Admission

- Improved muscle strength and range of motion (ROM)
- Now able to sit out of bed, perform side-stepping, and complete step transfers
- Participating in assisted showers and daily routines
- Increased confidence in mobility and daily function
- Shifted from short-term coping to long-term goal setting and planning

Patient feedback:

"I feel stronger and more independent now that I can mobilise better."

"I can't wait to drive again."

Personal Goal

To regain independence to live with her daughter, travel, and return to meaningful daily activities.

Current Physiotherapy Focus

- Gait training with parallel bars and supported step practice
- Improving balance, core strength, and knee stability
- Controlled sit-to-stand transitions

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- Gait training with parallel bars and supported step practice
- Improving balance, core strength, and knee stability
- Controlled sit-to-stand transitions

Ongoing Goals (Next 1–2 Weeks):

- Strengthen knee control during sit-to-stand (target: 5–7 days)
- Safely manage 1–2 steps with rails and minimal assistance (target: 7–10 days)

Challenges & Barriers

- Limited time before discharge may restrict further physical gains
- Fear of falling due to previous incidents
- Abdominal weight gain impacting balance and self-confidence

Completed by a physiotherapy student under the supervision of Asterios Lotsios, Lead Physiotherapist

3.7 Published Research

Winner, Best Abstract In the Service Evaluation Stream, British Dietetic Association Research Symposium 2024

Service Evaluation of a Low-Carbon Emission Menu in a Rehabilitation Hospital

Ajao, Felemban, Politi, Kindred, Mayre-Chilton

Service evaluation of a low-carbon emission menu in a rehabilitation hospital

Mildmay Hospital NHS

Authors: T M F Ajao[1,2], L Felemban[1,3], U Halai[1], C Turner-Murthy[1], S McLeish[1], A Politi[4], M Kindred[5], K M Mayre-Chilton[6] | **Work Addresses:** [1]King's College London, London, SE1 9NH, UK | [2]Department of Nutrition and Dietetics, Kingston Hospital, Galsworthy Road, London, KT2 7QB, UK | [3]Department of Nutrition and Dietetics, North Middlesex University Hospital, Sterling Way, London, N18 1QX, UK | [4]NHS England, Quarry House, Quarry Hill, Leeds, LS2 7UE, UK | [5]Net Zero Programme, NHS Estates and Facilities, Commercial Directorate, NHS England | [6]Mildmay Mission Hospital, NHS, London, E2 7DZ, UK

Introduction

- NHS food and catering service contributes ~6% to total NHS greenhouse gas emissions[7].
- Mildmay Mission Hospital volunteered to pilot NHS England's new low-carbon emission recipes.

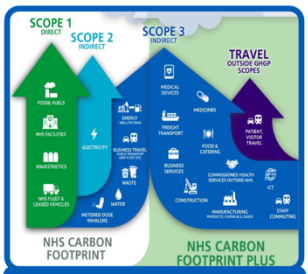

Fig. 1: Summary of NHS net zero targets[6]

Aim Assess the impact of complete low-carbon emissions menu on **a)** food portions and plate waste, **b)** nutritional content of served food, **c)** estimated impact on greenhouse gas emissions, **d)** patient mealtime satisfaction.

Method

1) Development of 3-week cycle menu

2) Audit of 3 patient lunchtimes (*n*=38 meals)

3) Patient survey (*n*=11/16 patients) adapted from PLACE[8]

4) Nutritics v6 analysis of $KgCO_2e$

(7) NHS England (2022). Delivering a 'Net Zero' National Health Service. NHS England. Available from: https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/ [Last Accessed: 28/05/2024]
(8) PLACE (2023). PLACE 2023 September – Ward Food Assessment. NHS Digital. Available from: https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place [Last Accessed: 10/01/2024]

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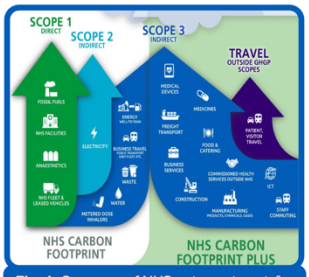

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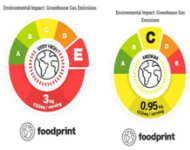

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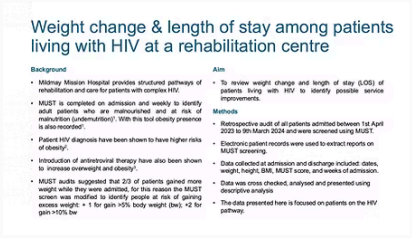
Other Accepted Abstracts in the same stream:

Weight Change and Length of Stay Among Patients Living with HIV at a Rehabilitation Centre

Marion Kyobutungi, Meshonett Appleby, Kattya M Mayre-Chilton; with NOVA students Ana Silva, Beatriz Nogueira, Madalena Fernandes



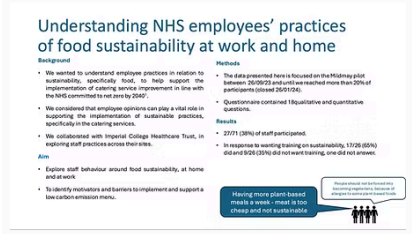
Cross-Sectional Survey on Patient Understanding and Opinions Regarding Sustainability at a Rehabilitation Hospital

By Lara Felemban, Tioluwani Ajao, Kattya M Mayre-Chilton

https://www.mildmay.nhs.uk/_files/ugd/6b3698_5be87faf62114ff99fa2afca94cc5f91.pdf
https://www.mildmay.nhs.uk/_files/ugd/6b3698_ef9e310314d840688393e8f185107f2c.pdf

Understanding NHS Employees' Practices of Food Sustainability at Work and Home

*Presented by Kattya M Mayre-Chilton on **the Streams of Public Health**; in collaboration with Charlotte Turner-Murthy, Urvi Halai*



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Low-carbon emission menu is highly feasible in rehabilitation hospital

Ajao, Felemban, Halai, Turner-Murthy, McLeish, Politi, Kindred, Mayre-Chilton

Low-carbon emission menu is highly feasible in rehabilitation hospital

Authors: T M F Ajao[1], L Felemban[1], U Halai[1], C Turner-Murthy[1], S McLeish[1], A Politi[2], M Kindred[3],K M Mayre-Chilton[4]

[1]King's College London, London, SE1 9NH, UK. | [2]NHS England, Quarry House, Quarry Hill, Leeds, LS2 7UE, UK.
[3]Net Zero Programme, NHS Estates and Facilities, Commercial Directorate, NHS England. | [4]Mildmay Mission Hospital, NHS, London, E2 7DZ, UK.

Introduction

- National Health Service's (NHS) food and catering service contributes ~6% to total NHS greenhouse gas emissions[5].
- NHS England has developed new low carbon emission recipes to support the NHS to achieve net zero by 2040-2045[5].
- Mildmay Mission Hospital volunteered to pilot these new recipes.

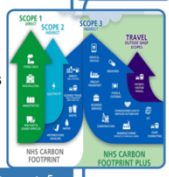


Figure 1: Summary of NHS net zero targets[5]

Objectives

- To assess the impact of a novel whole-menu approach to low carbon emissions on:
  1) food portions and plate waste
  2) nutritional content of served food
  3) estimated impact on greenhouse gas emissions
  4) patient mealtime satisfaction and sustainability awareness

Methods

Patient Population: Adults living with HIV, homeless and/or detoxing.

Cook-Fresh Menu Development

- 3-week cyclical, complete low carbon-emission winter menu.
- Aimed to meet targets for nutritionally vulnerable adults (800kcals, 27g protein per meal)[6].
- Finalised after 2 months of iterative improvements following patient, staff and catering service feedback.

Audit: Conducted over three patient lunchtimes (n=38 meals) with served portions and plate waste after each meal weighed.

Patient Survey: Adapted from Patient-Led Assessments for Care Environment form[7] with additional questions to assess familiarity with sustainability terms. Survey delivered orally (n=11/16 patients).

Effect on Carbon Emissions: Pre-post $KgCO_2e$ analysis of standard menu compared to low-emission menu using Nutritics v6

Results

Served Portions

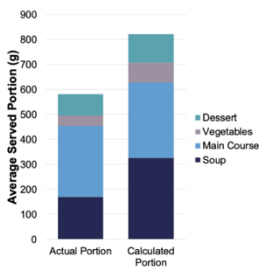


Figure 2: Average served portion (g) stratified by meal component after the launch of the low carbon emission menu.

Meals on average provided 719kcals (89.9% of target), 30g protein (112.6% of target).

Plate Waste

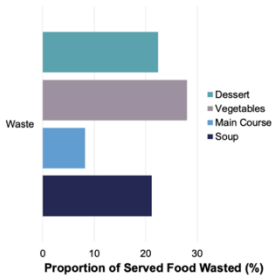


Figure 3: Average proportion (%) of served food that became plate waste stratified by meal component – conducted after launch of low carbon emission menu.

10.1% total plate waste

Impact on Carbon Emissions

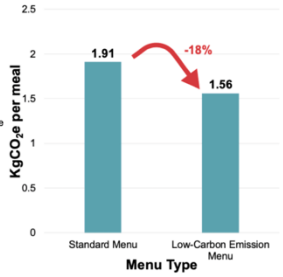


Figure 4: Average carbon footprint ($KgCO_2e$) per meal pre/post launch of the low carbon emission menu.

Patient Satisfaction:

- 64% (7/11) "very satisfied" or "satisfied" with meal taste and appearance.
- 45% (5/11) "satisfied" with meal choice and 45% (5/11) "dissatisfied" or "very dissatisfied" with meal choice.

Patient Awareness:

- 82% (9/11) unaware menu was environmentally friendly.
- 27% (3/11) were somewhat-very passionate about the environment.
- 45-73% (5-8/11) very unfamiliar with terms "sustainable (diet)", "plant-based", "net zero"

Insights and Future Plans

- Results indicate low carbon-emission menu is highly feasible – supporting consistent portions, ability to meet nutritional targets and limited food waste.
- Patient dissatisfaction with meal choice can be complicated by poor menu awareness and poor engagement with sustainability movement.
- Future advances should balance sustainability aims with maintaining adequate patient choice and ensure concomitant patient education/inclusion.
- **Future Plans:** low-carbon emission summer menu; introduce cultural meals, meat-free Mondays, cooked breakfast; scale to larger catering services.

⊕ quantitative menu analysis, patient insights, 18% reduction in carbon emissions ⊖ small sample size, limited applicability to larger hospitals

The presentation of this project was partly funded by the BDA GET fund and King's College London.

References

(5) NHS England (2022). Delivering a 'Net Zero' National Health Service. NHS England. Available: https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/ [Last Accessed: 28/05/2024]
(6) BDA Food Services Specialist Group (2023). The Nutrition and Hydration Digest 3rd Edition. BDA. Available: https://www.bda.uk.com/static/176907a2-f2d8-45bb-8213c581d3ccd7ba/06c5eecf-fa85-4472-948806c5165ed5d9/Nutrition-and-Hydration-Digest-3rd-edition.pdf [Last Accessed: 10/01/2024].
(7) PLACE (2023). PLACE 2023 September – Ward Food Assessment. NHS Digital. Available: https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place [Last Accessed: 10/01/2024]

Other achievements in 2024

- Abstract was accepted for presentation at the **19th International Congress of Nutrition and Dietetics** (ICND2024). This Congress took place from June 12 to 14, 2024, in Toronto, Canada. "**Low-carbon emission menu is highly feasible in rehabilitation hospital**" *T M F Ajao, L Felemban, U Halai, C Turner-Murthy, S McLeish, A Politi, M Kindred, K M Mayre-Chilton*

- BDA press during sustainable September 2024

- NHS England case study

- Article in the *Complete Nutrition* publication: **Implementing Sustainable Dietetic Menus in Practice; The Mildmay Hospital experience,** *C Turner-Murthy, U Halai, S McLeish, T M F Ajao, L Felemban, A Politi, M Kindred, K M Mayre-Chilton.*

Mildmay Hospital Commissioner's Statement for 2024-25 Quality Account

NHS
North East London

Commissioner's Statement for Mildmay Hospital 2024/25 Quality Account

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

Thank you for asking us to provide a statement on your 2024/25 Quality Account and priorities for 2025/26.

We welcome Mildmay Hospital's continued focus on sustainability and on further development of additional inpatient step-down services for local Trusts, work that builds on previous priorities. We welcome the development of the new neuropsychiatry pathway, which will increase choice in north east London. The ongoing improvement work to reduce delayed discharges is crucial to optimise all pathways and reduce length of stay across the board.

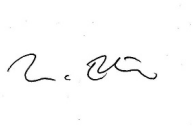
We applaud Mildmay Hospital's continuing efforts to gather patient and staff feedback; to improve the quality of services and ensure Mildmay Hospital provides a positive place to work. We note patient and staff feedback is positive.

We are pleased to see that Mildmay Hospital continues to embed the new NHS Patient Safety Incident Response Framework (PSIRF). We note that there has been a reduction in the number of incidents reported under the new framework, a trend that is often seen initially. We suggest Mildmay Hospital encourage staff to continue to report incidents, further strengthening PSIRF. It is good to see the thematic analysis carried out to identify key safety areas and the focus on addressing those.

We are grateful to Mildmay Hospital for the continued commitment to collaboration and partnership working despite the difficult financial and contractual situation the organisation has faced. We look forward to working together.

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

Overall, we welcome the 2024/25 quality account and look forward to working in partnership with Mildmay Hospital over the next year.



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

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