

Mildmay Mission Hospital







Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Outstanding	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Outstanding	
Are services responsive?	Outstanding	
Are services well-led?	Good	

Overall summary

We found the following areas of outstanding practice:

- The hospital had a clear 'digital inclusion' focus and used information technology in a therapeutic way to help patients improve their cognitive function and problem solving skills.
- Staff provided additional support for patients, beyond clinical care. Staff had a detailed, holistic understanding about their patients' lives and needs. Staff advocated for and ensured the best interest of the patient when liaising with external organisations.
- There was extensive recognition of and provision for the emotional support and wellbeing of patients, with inclusive and personalised spiritual and social support.
- Patients could participate in a comprehensive planned timetable of therapeutic activities, and staff supported them to do so in an inclusive and personalised way.
- The hospital provided comprehensive rehabilitation training and support to help patients maintain or regain independence in their daily lives.

Summary of findings

- There was a comprehensive volunteer support programme to provide one-to-one social time and support to patients to reduce their risk of social isolation.
- The hospital board had representation from two HIV positive individuals, including a former patient. This helped ensure the voice of HIV positive people was included in decision making.
- Patients were involved in service design and staff sought patients' suggestions on how they could better support them and meet their rehabilitation needs.
- The hospital had clearly embedded equalities objectives to improve inclusivity and prevent discrimination. Patients of all faiths and those of no faith were welcomed and treated equally. Staff supported patients of other faiths to practise their faith and had good local links with religious organisations to facilitate support for patients with specific religious and cultural needs.
- The hospital's social work team supported vulnerable patients, some with very wide ranging and complex social, legal and financial needs.
- There were no waiting lists to access services and there were no delays in accepting new patients.
- There was a clearly defined organisational culture at Mildmay Mission Hospital, based on Christian values and the charitable history of the hospital. The whole hospital team demonstrated a strong sense of community to celebrate achievements.

We found the following areas of good practice:

- There was a good overall safety performance across the hospital and effective processes for identifying and managing risks. There were very low levels of reported serious incidents and incidents resulting in harm. Learning from incidents was shared with staff.
- Patient records were comprehensive and clearly documented person-centred care.
- The hospital could evidence positive patient outcomes including improved medication adherence, cognitive function and greater independence.
- Patients' nutrition and hydration needs were managed appropriately. Staff demonstrated a consistent focus in supporting patients to achieve and maintain healthy eating standards.
- There was good multi-disciplinary working between staff within the hospital and with external partners such as social workers.
- Staff adapted their communication and approach for each individual patient. They ensured care and activity sessions were delivered in a relaxed, inclusive and supportive way.
- The hospital had procedures in place to ensure patients experienced a dignified death.
- Patients were routinely involved in their care planning. Staff tailored their clinical approach accordingly so patients could take ownership of their care and work at a pace they felt comfortable with.
- The hospital provided a very comprehensive range of inpatient and day services to support and care for patients living with HIV acquired neuro-cognitive impairment, including those needing complex physiological and psychological support.

However, we also found the following issues that the hospital needs to improve:

- There were a number of nursing vacancies and the hospital was heavily reliant on agency and bank nurses to cover rota gaps.
- Some hospital policies were very out of date and needed to be updated.
- There were isolated examples of do not resuscitate orders (DNAR) not recorded or applied correctly.
- There were some isolated examples of patient records which did not have clearly documented consent forms.
- Some nurses perceived a disconnect between staff groups and felt intimidated by certain individuals in the therapies team. They felt there was limited understanding of what nurses did amongst therapies staff.

Following this inspection, we told the provider that it should make some improvements, even though regulations had not been breached, to help the service improve. These are recorded at the end of the report.

Summary of findings

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Outstanding



Mildmay Mission Hospital

Services we looked at

Community health services for adults

Summary of this inspection

Background to Mildmay Mission Hospital

Mildmay Mission Hospital is a voluntary charitable hospital and rehabilitation unit based in Shoreditch, East London. It is a tertiary healthcare provider of specialist care and rehabilitation for people living with complex HIV-related conditions, particularly HIV Associated Neuro-cognitive Disorder (HAND), also known as HIV-Related Neuro-cognitive Impairment (HNCI) or AIDS Dementia. It is Europe's only centre dedicated to the rehabilitation of people living with HIV related brain injuries.

The hospital is an independent organisation which provides services to patients of the NHS and 20 London clinical commissioning groups (CCGs) as well as CCGs and local authorities in other parts of the UK. Mildmay Mission

Hospital is registered with the Care Quality Commission to deliver services under two regulated categories: diagnostic and screening procedures and treatment of disease, disorder or injury.

The hospital provides inpatient care and day services. There are two inpatient wards: William and Catherine, one with capacity for 14 patients, one with capacity for 12. Facilities for patients include a gymnasium, occupational therapy rehabilitation room, digital inclusion IT suite, garden, clinic rooms and day services activity room.

Mildmay Mission Hospital was last inspected by the CQC in 2013 and the service met all of the core standards of quality and safety inspected.

Our inspection team

Team leader: Max Geraghty, Inspection Manager North East London

The team that inspected the service comprised two CQC inspectors and three specialists including two nurses and a physiotherapist.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive inspection programme of independent healthcare providers.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about Mildmay Mission Hospital. During the inspection visit, the inspection team:

- Visited both wards in the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- Visited the day services areas, including the day services activity room, occupational therapy rehabilitation suite, gym, garden, clinic rooms and digital inclusion IT suite; and observed how staff were caring for patients
- Spoke with six patients who were using the service
- Spoke with the registered manager and manager of the wards

Summary of this inspection

- Spoke with 13 other staff members including the consultant doctor, nurses, allied health professionals, administrators and members of the senior leadership team
- Attended and observed a handover meetings and a multi-disciplinary meeting
- Collected feedback from 10 patients and staff using comment cards
- Looked at 16 care and treatment records of patients
- Carried out specific checks of the medication management on both wards
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as good because:

- There was a good overall safety performance across the hospital and effective processes for identifying and managing risks.
- There were very low levels of reported serious incidents and incidents resulting in harm.
- Learning from incidents was shared with staff.
- All areas of the hospital were clean and maintained to a very high standard.
- Patient records were very comprehensive and clearly documented person-centred care.
- Staff had a good understanding of safeguarding and how to escalate concerns if there were safeguarding risks to patients.
- There were policies and systems to ensure the safe supply, storage, administration and disposal of medicines
- There was sufficient equipment and supplies for staff to safely care for patients, many with complex needs. All equipment was clean and well maintained.

However:

- There were a number of nursing vacancies and the hospital was heavily reliant on agency and bank nurses to cover rota gaps.

Good



Are services effective?

We rated effective as good because:

- Nurses and therapists demonstrated effective evidence based care and treatment in accordance with national guidelines and good practice.
- The hospital could evidence positive patient outcomes including improved medication adherence, cognitive function and greater independence.
- Patients' nutrition and hydration was managed appropriately. Staff demonstrated a consistent focus in supporting patients to achieve and maintain healthy eating standards.
- Patients' pain relief was managed appropriately.
- There was good multi-disciplinary working between staff within the hospital and with external partners such as social workers.
- The hospital had a clear 'digital inclusion' focus and used information technology in a therapeutic way to help patients improve their cognitive function and problem solving skills.
- Staff told us the hospital was a good learning environment.

Good



Summary of this inspection

However:

- Some hospital policies were very out of date and needed to be updated.
- There were isolated examples of do not resuscitate orders (DNAR) not recorded or applied correctly.
- There were some isolated examples of patient records which did not have clearly documented consent forms.

Are services caring?

We rated caring as outstanding because:

- We witnessed many examples of compassionate care during our inspection.
- Staff adapted their communication and approach for each individual patient. They ensured care and activity sessions were delivered in a relaxed, inclusive and supportive way.
- Patients gave us consistently very positive feedback about their experiences of care at the hospital. Patients told us they appreciated the support staff gave them to remain independent.
- Staff provided additional support for patients, beyond clinical care. Staff had a detailed, holistic understanding about their patients' lives and needs.
- Staff advocated for and ensured the best interest of the patient when liaising with external organisations.
- The hospital had procedures in place to ensure patients experienced a dignified death.
- Patients were routinely involved in their care planning. Staff tailored their clinical approach accordingly so patients could take ownership of their care and work at a pace they felt comfortable with.
- There was extensive recognition of and provision for the emotional support and wellbeing of patients, with inclusive and personalised spiritual and social support.

Outstanding



Are services responsive?

We rated responsive as outstanding because:

- The hospital provided a comprehensive range of inpatient and day services to support and care for patients living with HIV acquired neuro-cognitive impairment, including those with complex physiological and psychological support needs.
- Patients could participate in a comprehensive planned timetable of therapeutic activities, and staff supported them to do so in an inclusive and personalised way.

Outstanding



Summary of this inspection

- The hospital provided comprehensive rehabilitation training and support to help patients maintain or regain independence in their daily lives.
- Volunteers befriended patients and provided one-to-one social time to reduce the risk of social isolation.
- The hospital had clearly embedded equalities objectives to improve inclusivity and prevent discrimination. Patients of all faiths and those of no faith were welcomed and treated equally.
- Staff supported patients of other faiths to practise their faith and had good local links with religious organisations to facilitate support for patients with specific religious and cultural needs.
- Staff in the hospital had good access to translation and interpretation support.
- The hospital's social work team supported vulnerable patients, some with very wide ranging and complex social, legal and financial needs.
- There were no waiting lists to access services and there were no delays in accepting new patients.
- There were very few complaints, but all complaints were investigated and follow up action was taken by the hospital's leadership team.

Are services well-led?

We rated well-led as good because:

- Senior leaders had a clear vision for the hospital and plans for developing the service. They had identified their main challenges and opportunities.
- There were effective governance processes in place to ensure the reporting, escalation and review of risk and performance information.
- There was an appropriate record of risks, mitigating actions, updates and ownership of actions.
- There were clear performance indicators in place for the service.
- Staff spoke positively about the leadership structure in the hospital. Clinical staff told us the senior team was visible and approachable.
- The board had representation from two HIV positive individuals, including a former patient. This helped to ensure the voice of HIV positive people was included in decision making.
- There was a clearly defined organisational culture at Mildmay Mission Hospital, based on Christian values and the charitable history of the hospital.

Good








Summary of this inspection

- Staff were proud of their work and the quality of care they provided. The whole hospital team demonstrated a strong sense of community to celebrate achievements.
- Patients were involved in service design and staff sought patients' suggestions on how they could better support them and meet their rehabilitation needs.
- There were opportunities for staff and patients to report concerns and share information directly with the chief executive.

However:

- Most staff felt well supported by their managers and colleagues, but we received isolated comments that some nurses perceived a disconnect between staff groups and felt intimidated by certain individuals in the therapies team. They felt there was limited understanding of what nurses did amongst therapies staff.

Community health services for adults

Safe	Good 
Effective	Good 
Caring	Outstanding 
Responsive	Outstanding 
Well-led	Good 

Are community health services for adults safe?

Good 

Safety performance

- There was a good overall safety performance at Mildmay Mission Hospital in the 12 months preceding our inspection. Staff in the hospital routinely reported against key safety performance indicators, including for pressure ulcers, venous thromboembolism (VTE), falls and urinary tract infection from catheterisation (UTI). This information was collated by the hospital on a monthly basis and reviewed by senior staff in governance meetings (see section on incidents for more information).
- During our inspection we saw the Safety Cross tool (a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care) in use by inpatient wards and day services.
- The hospital had effective systems and processes for identifying and managing risks and there were mitigating actions in place to manage risks (see sections on assessing and responding to patient risk and managing anticipated risks for more information).

Incident reporting, learning and improvement

- The hospital used a paper-based incident reporting system for staff to record issues and concerns. The staff we spoke with told us they felt comfortable to report incidents and concerns and understood the processes

for reporting and investigation. Staff also told us they received feedback from senior staff in response to incidents and learning from incidents was shared with all staff in emails and monthly team meetings.

- In the 12 months preceding our inspection there were no reported never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were no serious incidents requiring investigation (SIRI) in the 12 months preceding our inspection.
- Staff in the hospital measured, monitored and analysed common causes of harm to patients such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm, and venous thromboembolism (VTE) incidence. The hospital used a system of 'safety crosses' to record when harms such as falls, medication errors and pressure ulcers had occurred. Safety Cross posters were displayed on the wards to share this information with patients and visitors; however it was not signed by the responsible individual.
- In the three months before our inspection the hospital reported five falls in the inpatient wards, and none in day services. The multi-disciplinary team (MDT) conducted a falls assessment as part of each patient admission.
- In the three months before our inspection the hospital recorded one grade 3 pressure ulcer. Senior nurses had investigated that this was not due to poor care and there were extenuating circumstances. As a result of cognitive impairment, the patient had kicked the end of



Community health services for adults

the bed until their heel bruised and broke down. Senior nurses sought support from a tissue viability nurse to ensure effective wound care for this patient and to put preventative measures in place. In the same period there was one instance of a patient suffering a moisture lesion. This patient had arrived from an acute hospital with the lesion. We saw evidence of a pressure ulcer audit which had taken place in February 2017.

Duty of Candour

- There was a duty of candour policy and senior staff we spoke with understood their responsibilities in this area. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Hospital documentation recorded no occasions where staff were required to discharge their responsibilities under the duty of candour to inform patients of mistakes.

Safeguarding

- All staff at the hospital were required to complete Safeguarding Adults Level 1 and 2 training. At the time of our inspection 95.5% of staff had completed this mandatory training, meeting the hospital target. The hospital safeguarding lead was trained to Level 3.
- There was a safeguarding policy. Staff we spoke to had a good understanding of how to escalate concerns if they thought there were safeguarding risks to patients.
- CQC received no safeguarding alerts or safeguarding concerns in relation to Mildmay Mission Hospital in the 12 months preceding our inspection.
- Staff demonstrated the ability to intervene on patients' behalf where they had concerns about the behaviour of staff in another organisation. For example, one patient travelling in a taxi organised by the hospital arrived upset after the driver had made inappropriate remarks about HIV, which had frightened them. The day services coordinator (DSC) had contacted the taxi company and ensured the driver was no longer able to provide services to the hospital. In addition this member of staff worked with the patient concerned and hospital colleagues to ensure they were protected and supported.

- The volunteer services leader had adapted the safeguarding policy and whistleblowing policy into a version appropriate for volunteers. This included how to take action when they were worried a patient might be at risk and how to escalate a situation to a member of staff or safeguarding officer. In addition it provided volunteers with information on how to raise concerns confidentially with a senior member of staff.

Medicines

- There were policies and systems to ensure the safe supply, storage, administration and disposal of medicines in accordance with NICE guidance NG5 medicines optimisation: the safe and effective use of medicines. Nurses conducted audits of medicine stocks on a weekly basis.
- Medicines were stored safely in trolleys in secure access treatment rooms on each ward. The trolleys were locked and chained to a wall. Each patient was allocated a space on the trolley for their medications.
- There were systems to ensure the safe use and storage of controlled drugs (CDs). There were locked cupboards within the treatment rooms containing CDs. Nurses had key fobs to access the treatment rooms and the nurse in charge was responsible for the key to the CD cupboard. The hospital used a double prescription process for named patients in receipt of controlled drugs. We checked the hospital's controlled drugs register and all entries were double signed. There was a formal process for the destruction of controlled drugs no longer in use or out of date. However, there were some stocks of CDs in the CD cupboard that were awaiting destruction by the responsible officer.
- We reviewed the minutes of ward meetings which showed that CD register counting inaccuracies had been discussed by nursing staff. This related to a discrepancy in the counting of Methadone (under by 100ml) which had not been reported by a staff member. This was classed as an incident and was reported to NHS England via the quarterly Local Intelligence Network, as per standard procedure. Information submitted by the hospital shortly after our inspection showed an action plan was in place and learning from the incident had been communicated to nursing staff to ensure they dispensed the correct medicine from the correct supply for the correct patient.



Community health services for adults

- Nurses completed medication rounds throughout the day. Some patients required early morning or late evening medication. The main medication rounds were at 10am, 2pm and 6pm.
- Patients' antiretroviral medications were prescribed by the hospital medical director or consultant doctor and supplied by local acute hospitals. There was a reconciliation process on a daily and weekly basis to check stock levels. However, senior nurses told us that the process required nurses to collect the medications from the other acute hospitals, which was not optimal in terms of resource use. Senior nurses were exploring alternative ways to overcome this, such as using a courier service.
- Senior nurses conducted medicines audits on a quarterly basis. The most recent medicines audit from March 2017 included indicators such as: supply and ordering of medicines, ward stock drugs lists, oxygen supplies readily available, and health and safety warnings in place. The audit identified that some staff were not aware of how to order emergency supplies of medication out of hours. The audit also found some storage cupboards were not clean, tidy or secure and containers were not dated on opening. However, the audit was not signed so it was not clear who was responsible for it and there was no action plan to address the areas where there were gaps.
- The medication administration record chart audit in March 2017 also revealed three patients' names were not clear or legible on the record chart. There was a recorded action but it was not clear if this had been completed.
- There were sufficient numbers of nurses trained in intravenous medication administration, but nurses told us this method was not frequently used. Nurses told us patients occasionally required IV antibiotics.
- Patients had access to controlled drugs as required to help manage their pain. We observed two nurses administering methadone to a patient. They stayed with her until she had taken the medicine to ensure it was taken safely and completely.
- Nurses told us most patients did not self-medicate on admission but worked towards self-medicating as part of their discharge plan. Patient's self-administration of medicines was observed by nurses and recorded in notes. Self-medication risk assessments were in place. Nurses told us patients could self-medicate using their own prescription drugs and vitamins, but other

medications use was discouraged. Staff we spoke with were aware of risks associated with patients using illegal drugs and were able to identify unusual behaviours which could indicate usage of such drugs.

- Patients could access complimentary therapy medications such as homeopathy and aromatherapy while in hospital.
- We saw medication fridge temperatures were checked and recorded daily. The records indicated all temperatures were within range but there were some minor gaps in recordings. All medicines within the fridges were within date (for example insulin and eye drops).

Environment and equipment

- Mildmay Mission Hospital was located in a purpose built building which officially opened in September 2014. Senior staff at the hospital had contributed to the design of the building to ensure it met the needs of the service and for patients.
- All of the hospital areas were maintained to a very high standard. There was a bright and welcoming reception area, from which the day services area, chapel, gym and clinical rooms could be accessed. Two inpatient wards: William and Catherine were located on the first and second floors of the building.
- All areas of the hospital were bright, spacious and well organised. There were specific areas within the building for storage, including dedicated spaces for patient records and large equipment, away from clinical areas. There was appropriate secure space for storage of oxygen cylinders.
- There was a secure entry system to the hospital with CCTV and secure windows throughout, to ensure the safety of patients and staff.
- There was an accessible garden with planted areas and seating for patients and visitors. This created a calm and welcoming space for people to use away from clinical areas.
- The hospital was fully accessible throughout, with lifts to each floor, accessible doorways and disabled access toilets on each floor. Many ward rooms were wheelchair accessible with a step free bathroom.
- Staff in the hospital displayed art works which had been created by patients as part of their rehabilitation programme.



Community health services for adults

- There were noticeboards throughout the hospital containing information about activities, hospital performance and achievements. There was a notice board in the reception area with the names and photos of all staff working at the hospital.
- There were fire extinguishers and fire safety equipment at appropriate points throughout the hospital.
- Staff told us they had sufficient equipment and disposable items to do their jobs effectively. Staff told us they could procure or hire specialist equipment for patients if it was needed, for example, wheelchairs, bariatric support and orthotic equipment.
- All equipment had laminated instruction sheets with protocols on how and when to use different equipment. Safety testing stickers were evident on all equipment we looked at, but some information had faded from cleaning products in some instances so details could not be seen.
- There was a well-equipped gym in the hospital with a selection of exercise machines and apparatus.
- Emergency resuscitation trolleys were located in the secure access treatment rooms on each ward. We saw the contents of the trollies were checked daily by nursing staff and were tagged and sealed.
- Staff in the day care unit documented weekly observations of each patient's weight, blood pressure, pulse and adherence to their HIV antiretroviral medicine. We looked at this information for 12 patients for the three months prior to our inspection and found it to be documented consistently.
- We looked at four care plans for patients in the day services unit. Each care plan included a standardised information pack that included the reason for their referral and key clinical contacts, including their consultant and clinical nurse specialist. All of the care plans we reviewed were very detailed and demonstrated person-centred care. Notes recorded extensive descriptions of all interventions, covering complex physical and psychological care. The patients' story of progress, decline, or significant events could be identified easily and it was also easy to follow past events or preventative planning.
- Information on the patient's prescription and history of adherence to anti-retroviral medicine was included in care plans. Planned rehabilitation outcomes were documented and set with the patient at the time of referral. For example, one patient's planned outcomes were to improve mobility and balance through physiotherapy and to reduce loneliness by joining activities groups.

Quality of records

- The hospital used a paper-based records system to record patient notes and interventions. All patient records were stored in secure storage room on site. Paper records were kept for eight years and then archived.
- We reviewed a sample of patients' records and found they were well laid out, tidy, secure, clearly labelled, with chronological multi-disciplinary team (MDT) care documented, referral forms and risk assessment records. All of the records we reviewed were correctly signed and dated. There were a number of records that had lots of paper work in them and were very heavy because patients remained at the hospital for a long time.
- Nurses documented patients' nursing needs every three hours, including positioning, bowel movements, pain, suctioning needs and medication administration. Food record charts and fluid balance charts were completed daily to review patients' hydration and food intake. Patient's observation charts were kept at the nurses' station on the ward or in patient's rooms for easy access.

Cleanliness, infection control and hygiene

- All of the clinical and public areas we inspected in the hospital were visibly clean, tidy and well organised. All areas on William and Catherine wards were visibly clean and tidy. Shower and toilet rooms we inspected were clean and tidy. Dirty utility rooms on each ward were also clean, tidy, and well organised.
- There were hand hygiene points throughout corridors and posters with hand hygiene instructions. Each hand washing sink in clinical areas had a pictorial display of the World Health Organisation's 'Five Moments for Hand Hygiene' guidance.
- We witnessed staff cleaning their hands appropriately. Although hand gel dispensers were available at the entrance to each clinical area and in public areas of the building, we did not see that staff promoted and encouraged people to use them during our observations. For example, when visitors entered the wards or day unit staff did not routinely ask them to disinfect their hands during our observations.



Community health services for adults

- There was a programme of planned infection prevention and control (IPC) audits. This included monthly hand hygiene audits and mattress audits. The most recent hand hygiene audit found good compliance against indicators for use of soap dispensers and alcohol gel, short fingernails, jewellery and routine hand washing.
- There was sufficient protective personal equipment (PPE) including disposable gloves and aprons on wards and at the entrance to side rooms. We observed staff wearing PPE appropriately.
- There was a colour coding system for waste segregation and cleaning products. We saw staff adhered to this system.
- The sharps bins we inspected were not over full and all were within use by date. All of the needle sharps bins in treatment rooms were labelled and secure.
- The hospital used 'I am clean' stickers to indicate when equipment had been cleaned. We saw the stickers were correctly dated and signed on all equipment we inspected.
- A biohazard spill kit was available in the day services unit and the day services coordinator (DSC) and therapy assistants had been trained in its use.

Mandatory training

- Staff at the hospital were required to complete a planned programme of mandatory training on a regular basis. Mandatory training modules included: fire and health and safety, infection control and prevention, manual handling, safeguarding adults, information governance, equality and diversity, food hygiene, basic life support, conflict management, and lone working.
- At the time of our inspection the overall compliance rate for completion of all mandatory training was 95.5% across all staff groups.
- To support access to and completion of mandatory training, senior nurses had consolidated some training modules into set dates for all staff to attend together, instead of multiple training sessions spread across the year. There was additional on-site training for moving and handling, fire safety and infection control, interspersed throughout the year.

Assessing and responding to patient risk

- There was a comprehensive risk assessment tool documented in patients' notes, which was completed monthly by nurses. Patients we spoke with confidently discussed risk assessments that staff had completed

with them to help them avoid harm. For example, one patient used a wheelchair and enjoyed visiting a local community garden. They told us staff had completed a risk assessment with them to help them use their wheelchair safely outside of the hospital to prevent them falling out. We saw this risk assessment was individualised to the patient and had been updated in the previous six months.

- Risk assessments were completed for up to 17 areas depending on each patient's needs and health status. All patients had a risk assessment for falls, medicine adherence and social risks such as vulnerability to abuse in the community, exploitation and socially inappropriate behaviour.
- Staff also completed a psychological risk assessment to monitor patients for depression and anxiety and a sexual health risk assessment to establish if they were at risk as a result of sexual disinhibition or a lack of understanding of safer sex. In all cases each entry was signed, dated and stamped by the recording member of staff.
- The hospital's clinical psychologist completed neuro-psychological assessments of patients, including memory, attention and problem solving skills. The clinical psychologist developed recommendations and strategies for patients to maintain and manage their cognitive ability.
- There were Antecedent-Behaviour-Consequence (ABC) charts on wards for nurses to record patients' behaviours. An ABC Chart is a direct observation tool that can be used to collect information about the events that are occurring within a patient's environment. The clinical psychologist reviewed the ABC charts to analyse behaviour patterns and potential triggers and what staff were doing in response. The clinical psychologist completed behavioural risk assessments and planned interventions for nurses to manage and de-escalate challenging behaviour.
- Risk assessments were completed for newly admitted patients within the first 24 hours of their arrival. The hospital used a 'key worker' approach for consistent monitoring of patients' progress.
- The hospital did not use an early warning score system to record patient's vital signs to alert nurses to any deterioration or potential risks. Senior nurses recognised such a system would be useful.



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- There were established emergency procedures in the day care unit. Staff had equipment to monitor pulse and blood pressure and an emergency call system was in place in all areas of the hospital. This enabled day care staff to obtain help from nurses or doctors on the wards.
 - Senior nurses communicated risks relating to individual patients at morning handover, including their plans for the day, however we found that this was not always recorded on all occasions.
 - Some patients at the hospital were able to go out on their own. Some patients needed a chaperone to support them. Nurses kept in touch with patients while they were out so they could check where they were. There was a missing persons policy and protocol for cases where a patient could not be contacted.
 - The hospital provided weekly travel planning sessions for patients who could travel independently. They also provided training in socially appropriate behaviour.
 - Although the risk assessment tool was thorough, there was no specific provision to update it for an individual's daily outings where risk factors were scored highly for some patients. Planned outings were discussed by the MDT on a weekly basis to identify if a chaperone was needed. The risk assessment tool provided a generalised patient risk assessment including a section on community access and risk factors such as inappropriate spending, risk of absconson, dependence on others to access public transport, orientation/road safety, cognitive impairment and absconding risk. These risk factors were scored on likelihood and severity, but there was no individualised plan for outings, for example: time of departure, time of return, staff mobile number, where they were going to, special considerations, review of patient state on the day and if the outing should go ahead. The staff we spoke to had a good understanding of individualised risk management for outings but it was not documented and therefore could not be audited or reviewed.
- Staffing levels and caseload**
- At the time of our inspection a team of 52 whole time equivalent (WTE) members of staff worked across the hospital. This included a 13% vacancy rate, as of January 2017.
 - There were 9.4 WTE qualified nurses in the hospital staffing establishment and two rehabilitation care assistants (RCA). Nursing shifts were for 12 hours and usually consisted of two nurses and three RCAs to cover 14 patients. At the time of our inspection both RCA positions were vacant and there were two nursing vacancies, however the hospital was awaiting three new RCAs to commence in post.
 - The nursing team used a staff acuity tool to identify staffing needs; however we found the hospital was heavily reliant on bank and agency staff to cover rota gaps. Senior staff told us the hospital usually operated a 14 bedded unit on one ward only. In the three months before our inspection, due to an increase in patient referrals, the second ward was opened to accommodate patient numbers. Of the 466 shifts covered by agency and bank nurses, 360 of them were as a result of having the second ward open. Senior nurses told us when using agency nursing, the hospital requested named nurses who had worked shifts at Mildmay before, and most shifts were filled by nurses who were familiar with the hospital. Information submitted by the hospital highlighted only three occasions in the three months before our inspection when they had not been able to secure agency or bank nurses to cover a shift.
 - In addition to ward staffing, the hospital frequently had student nurses on placement.
 - Senior staff told us the recruitment of qualified nurses and rehabilitation care assistants was ongoing. Advertisements placed in national and trade press had not resulted in any suitable candidates. Nurses told us recruitment was challenging because of workload intensity and the complexity of nursing care at the hospital. Some nursing staff we spoke with were concerned about the sufficiency of staffing to meet the acuity level of patients. There were many patients with specific needs and some who demonstrated challenging behaviours and required intensive supervision.
 - The day services coordinator and two therapy assistants staffed the day care unit from Monday to Friday.
 - The volunteer services lead (VSL) managed a structured system of recruitment and retention for volunteers that included a Disclosure Barring Service background check and confirmed references.
 - Allied health professionals in the hospital reported a manageable workload, despite the increase in patient numbers, and felt they had time to build good relationships with patients. At the time of our inspection the hospital had increased physiotherapy capacity in response to increased demand.



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Managing anticipated risks

- Patients who were referred with a history of violent, abusive or sexually inappropriate behaviour were pre-assessed prior to admission. Staff obtained additional support for these patients from the hospital's medical consultant and part-time psychiatrist, as well as the local safeguarding team.
- Each stairwell landing was equipped with an evacuation chair. This is an item of equipment that can be used by trained staff in an emergency in a vertical evacuation of patients who could not otherwise use stairs. All of the staff we spoke with were confident in the use of evacuation chairs and said they had received training in their use.
- Each part of the hospital had a defined evacuation procedure in place. In the day care unit, the day services coordinator was responsible for coordinating an evacuation and there were multiple exit routes from the unit, all of which had step-free access.
- Staff in the day services unit recognised the risk of falls as significant for patients who had reduced mobility. To mitigate the risk, a member of staff accompanied each patient on a reorientation of the unit whenever furniture was reorganised or any other rearrangement took place. As patients with a visual impairment navigated by learning the layout of the unit, a reorientation helped them to establish a new map of the area and its hazards.

Major incident awareness and training

- The hospital had a detailed business continuity plan, which referenced major incidents. The aim of the plan was to ensure the continued provision and recovery of critical services within Mildmay Hospital, to shorten the period of disruption and limit the impact on the organisation's services. The business continuity plan detailed the different roles of responsibilities of staff, key contacts, strategies to respond to different types of incident, and incident management and recovery checklists.
- The Chief Executive Officer of the hospital told us that in cases of a major incident they would expect to receive appropriate patients transferred out from a nearby acute hospital. However it had been challenging to identify a model major incident policy to suit the needs of a small independent healthcare organisation (as opposed to NHS trusts).

- Staff received training in evacuation as part of their mandatory training in fire safety and moving and handling.

Are community health services for adults effective?

(for example, treatment is effective)

Good



Evidence based care and treatment

- Between September 2016 and December 2016 the day services coordinator (DSC) led a pilot project to establish a benchmarking system for day services. Staff planned to use the results to be able to measure the effectiveness of the service and to find out if the service they provided in their standard operating procedures was working well in practice. As a result of the project, an implementation phase was underway that staff would use to reconfigure elements of the service identified as needing improvement. For example, the pilot project identified a need for more detailed patient reviews to enable staff to more readily track progress and success against rehabilitation goals. The DSC had implemented new paperwork to achieve this and the reconfiguration was due to be completed in July 2017.
- We witnessed a number of examples of evidence-based practice. For example, in response to patient need, some nurses had completed training in tracheostomy and ventilation management. This training was used to ensure nurses had the competency to safely and effectively care for patients who had a tracheostomy, including immediate methods to unblock a tube. There was a focus on early monitoring, including close observation and documentation. A blocked airway was treated as a medical emergency and a doctor called. During our inspection, we saw that tubes were reviewed throughout the day and changed if needed. Nurses were able to demonstrate what equipment was required for this. There was a record of tracheostomy care on a 'tracheostomy passport' document. Tracheostomy nurses visited on a monthly basis to change the tracheostomy tube and check equipment.
- Staff at the hospital could access local policies and procedures on the hospital 'general drive'. Staff



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demonstrated to us how to find different policies on the general drive of the computer network. Policies were reviewed by senior nurses and signed off by the hospital medical director.

- The hospital had link nurses with responsibility for audits and policies in a particular area, for example, infection prevention and control, pressure ulcer care, nutrition and mental health.
- All of the hospital's policies carried a statement on the review date, and these were recorded in a central register. We reviewed a sample of policies, procedures and guidelines and found that most documents were within date and had clearly recorded review dates. However we found some policies were not recorded on the master list and therefore some general policies had not been updated for some time. For example, a number of policies were published in 2004 but there was no evidence they had since been reviewed or updated. This included the adherence protocol/strategy and care pathway and HIV dementia scale and guidance. Within these policies the further reading and statistical examples referred to information from 1997-2000, which was out of date.
- The registered manager of the hospital was responsible for identifying and disseminating new national clinical guidelines, such as those provided by NICE and Royal Colleges. We saw evidence of this in MDT meeting minutes.

Pain relief

- There were appropriate processes in place to ensure patients' pain relief needs were met. Nurses used pain scales to measure a patient's pain intensity. Pain scales and measurements help determine the severity, type, and duration of pain, and are used to make an accurate diagnosis, determine a treatment plan, and evaluate effectiveness of treatment.
- Nurses conducted hourly intentional rounding, 24 hours per day, which included checking for pain and any pain relief requirements. Pain scores and prescribed medication were documented in patient notes.

Nutrition and hydration

- Staff demonstrated a consistent focus in supporting patients to achieve and maintain healthy eating standards. This was part of a multidisciplinary approach to standards of nutrition and hydration. For example, in December 2016 a team of dietetics students had visited

the day unit to complete a scoping exercise about improving nutrition for patients. The exercise identified room for improvement in how the service supported patients to eat healthily. For example, the day care unit lead introduced nutritional label training for patients. This involved using examples of packaged food labelling to help patients make healthier choices, such as by identifying the national colour coding system that identified high or unhealthy levels of sugar, salt and fat. We observed a training session and saw staff delivered it in an easy to understand format that was interactive and encouraged patients to ask questions. The trainer discussed each patient's typical daily diet with them and discussed ingredients labels to help them identify which ingredients were less healthy, such as processed sugars. The trainer encouraged patients to get involved and regularly checked their understanding, including by discussing each person's perceptions such as whether brown sugar was healthier than white sugar.

- The nutrition session we observed included a brainstorming element whereby the trainer encouraged patients to work together to overcome problems such as how to sweeten porridge without adding refined sugar.
- Senior nurses audited completion of food and fluid charts in patient records. The most recent audit in March 2017 identified good compliance with food and fluid intake. 100% of patients were assessed for malnutrition using the malnutrition universal screening tool (MUST).

Technology and telemedicine

- There was a 'Digital Inclusion' IT suite in the hospital which was used to help patients improve their cognitive function, problem solving skills and computer skills. The hospital provided IT training for patients to help them use computers and the Internet safely. This included facilitated sessions where patients learnt to carry out basic tasks such as online shopping and send e-mails to friends. Tasks were targeted based on patient need. For example, some patients had reduced mobility and found it difficult to leave their home regularly. To support them, staff helped them carry out grocery shopping online. IT sessions included a safety element so patients could learn how to protect themselves from exploitation and fraud. This included supervised sessions in using social media and how to maintain appropriate levels of privacy when doing so.



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- The IT suite included modified equipment such as large-format keyboards to help patients with reduced dexterity in their hands or visual impairment.
- The hospital had introduced computer software that was designed to help train and exercise patient's minds to improve cognitive function. Patients accessed this software during facilitated sessions in the hospital's IT suite and once they achieved a minimum level of proficiency and confidence they could progress through the training independently. We spoke with a patient who used this software. They told us they felt it had significantly improved their ability to remember things day-to-day and said they felt it had improved their ability to function generally.

Patient outcomes

- Patients referred to Mildmay Mission Hospital come to the hospital with HIV infection and other co-morbidities. The hospital's medical director told us most patients have both physical and cognitive impairments, often coupled with psychological problems.
- The hospital submitted data to the UK specialist Rehabilitation Outcomes Collaborative (UKROC), which is a national scoring database for collating case episodes for inpatient rehabilitation. Data from 2015/16 showed 85% of patients were able to return to their own homes after interventions by the hospital. This was an increase of 3% over the previous year. The hospital was also able to demonstrate that for patients who required longer-term nursing home placements following their rehabilitation at Mildmay, they had reduced dependency upon other people and improvement in cognitive function.
- In 2015/16 no patients were readmitted to Mildmay Mission Hospital from home within 28 days of being discharged to home.
- Patients we spoke with in the day care unit told us their health had improved and their rehabilitation outcomes were better due to their experiences and support on the unit. For example, one patient said a speech and language therapist had worked with them to help them slow their speech so they could be more easily understood. They said, "I'm very proud of my progress so far. It's made a huge difference with people being able to understand me and being able to communicate". We saw the DSC maintained up to date knowledge of the therapies plan of each individual and worked with

patients throughout their time in the unit to maintain their exercises and rehabilitation strategies. One patient said one of their achievements was being able to make their own cup of coffee, which they had achieved after therapy in the unit.

- The day services team recorded outcome measures including patients' attendance, focus, adherence to antiretroviral medications and their progress. However, the team was not able to collate statistical evidence of longer term outcome measures, for example acute hospital admission avoidance, as it was difficult to determine with certainty that the day services team's input, as part of a range of support that community based patients receive, was the categorical reason for improved outcomes.
- There were many descriptive case study examples which demonstrated the impact of the day services rehabilitation pathway in rehabilitating patients and avoiding admissions to hospital. For example, one case of admission avoidance for a patient with chronic uncontrolled hypertension. The day services team used weekly health clinics to monitor adherence to medications and check other chronic diseases such as hypertension and diabetes. One patient's blood pressure was uncontrolled despite being on anti-hypertensive medication. The patient followed a nutrition curriculum in the Mildmay healthy living session where the patient learnt how to swap sugars and salt in a healthy way. Staff in the day services team also helped the patient get in contact with their GP to change their medication which reduced and stabilised the patient's blood pressure.
- Another day services case study regarded a patient who was admitted as an in-patient in 2015 but was discharged with road safety issues and lack of orientation to place. The patient could easily get lost. The patient had attended day services since March 2016 and had engaged in the community integration programme. This helped the patient plan journeys and use public transport confidently. After one year of training the patient was able to travel independently from home to the hospital and in the local community.
- Therapies staff used goal setting to set targets for patients, for example in daily activities, task analysis and exercise programmes. Goals were identified during the initial assessment or interview questions with the patient on admission to help identify realistic goals and



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manage expectations. Clinicians used a SMART approach and goals were agreed at the weekly MDT meeting. The team developed targets for specific neuro-psychological interventions as required.

- Therapists at the hospital used the Wessex Head Injury Matrix to assess cognitive improvement by patients. They also used Functional Assessment Measures and Functional Independent Measures (FIM and FAM scoring) to assess patients' progress from admission to discharge. Collated data of these measures submitted to UKROC demonstrated overall motor and cognitive improvements for a majority of patients, but improvement for some patients was greater than for others due to several underlying factors.
- The hospital used a key worker approach to provide continuity of assessment. This helped to identify slow progress by ensuring a consistent presence in a patient's care. Senior clinicians felt this system was effective for the long term inpatient setting.
- Staff worked with patients to stabilise adherence to prescribed antiretroviral medicine. This was because gaps in taking the medicine, or not taking them at all, could present serious health risks. Day care unit staff asked each patient about their adherence but relied on them providing accurate information to monitor this. Staff also liaised with community clinical nurse specialists to corroborate the information provided by patients and identify when they might be at risk as a result of inconsistent levels of adherence. A patient we spoke with was positive about the support they had received in the service to maintain medicine adherence. They said "when I first started coming here my HIV was not well controlled but now I am undetectable for the first time".
- The hospital team worked to a 'health positive' ethos that meant they worked with patients to overcome what they thought were limitations of their HIV status. This included supporting them to develop strategies to deal with stigma and discrimination if they were subjected to this. We asked patients about this. One patient said "staff have helped me see how not to be limited by my [HIV] status and how to just get on with my life". Staff also worked with patients to help them understand the nature of their cognitive impairment and develop strategies to reduce anxiety. For example, many patients worried about their anxiety level in the belief that they were responsible for it. Staff talked to these patients and explained how it was part of their cognitive impairment, which helped to reduce their worry about it.
- As a result of the work of the hospital team to promote positive outcomes, patients told us they felt better about the future. One patient said "for the first time in a long time I can contribute to my own goals and life and think about what I want in the future. I think about it positively a lot, which I didn't before the staff here helped me to get more active".
- Clinical nurse specialists based in the community or acute trusts referred patients to the day care unit and identified specific goals and outcomes. For example, common outcome goals included improvements in speech and a reduction in social isolation.
- The multidisciplinary team recorded updates and progress with regards to rehabilitation in day services care plans. For example, we saw in one patient's care plan a physiotherapist had noted when they were able to weight bear and had noted communication with a social worker when the patient had not attended a planned session.
- Activity and therapy groups had defined structures and planned outcomes that staff used to deliver them effectively in line with patient's needs and rehabilitation plans. For example, the music therapy group planned to improve hand-eye coordination, socialisation, vocal ability and range, speech and language skills and encourage positive self-expression. We saw from looking at care plans that staff documented daily updates and observations on patient's participation and progress in each group against the planned strategy.

Competent staff

- The hospital had an appraisal and supervision policy that included the level of support for professional development staff should be offered. This included an annual appraisal and structured developmental review to identify training needs. All staff in the day services unit had undergone an appraisal in the previous 12 months and staff told us they felt this was a supportive and useful process.
- At the time of our inspection 83% of staff had completed their annual appraisal.



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- Therapies staff had access to external supervisors to support their professional reflection and development. Some clinicians had arranged their own supervision arrangements because of the specific nature of their work.
- Nurses told us the hospital was a good learning environment because of the complex nature of the patients they cared for and the variety of physical and psychological conditions they presented.
- There was a central budget for staff to attend conferences and publish research abstracts. We were told that the hospital's clinicians were often invited to present at national and international conferences, because of the specialist nature of their work.
- There was a central budget for staff to access external training, including professional and academic qualifications such as postgraduate certificates and postgraduate degrees. The staff we spoke with who had used this facility told us that the hospital had supported their training and this had enhanced their work.
- Staff at the hospital provided tailored training to other staff. For example various members of the MDT led forums and systemic groups on subjects relevant to the hospital.
- All clinical staff were trained in Basic Life Support. There were no staff with training in Advanced Life Support.
- Mildmay Mission Hospital worked with a number of education and training organisations, including universities to provide placements for students and trainees across professions. At the time of our inspection there was a general practitioner trainee on rotation, student nurses and student allied health professionals and a social work student.
- We attended an internal MDT where students and trainees were present. Clinical staff used the MDT meeting as a teaching and learning environment and there were informal moments of teaching and sharing of learning, for example, a nurse explained how to identify the smell of pseudomonas in sputum.
- Rehabilitation assistants were usually based on the inpatient wards. This team took part in a rotation scheme that enabled them to provide care in the day services unit. This helped to maintain their multidisciplinary skills and provide therapy assistants with clinical support.
- Volunteers undertook a structured induction that included general information about HIV and related neuro-cognitive problems and guidance on how to

effectively support patients. The induction was multidisciplinary and included a training session from the lead physiotherapist on how to support patients safely in gentle exercise and in moving and handling. The volunteer services lead (VSL) met new volunteers during their induction and on their first shift and provided as-needed guidance and supervision as they became more experienced. This included monthly supervision initially reducing to six-monthly supervision.

- All staff and volunteers were invited to a two-weekly education forum that was led by a rotation of specialists and external speakers. Previous trainers had included dieticians, clinical nurse specialists and allied health professionals. Staff could present a topic of case study to share learning at this forum.

Multi-disciplinary working and coordinated care pathways

- Staff worked with multidisciplinary professionals from other organisations to coordinate the care of patients with complex needs, including those with social care needs. For example, when a patient was admitted in an emergency with significant social needs, staff worked with care homes, community psychologists and specialists from the local authority in the patient's home area to secure a social care placement. This was one example of a track record of engaging with social care providers to improve knowledge of HIV and reduce stigma around the condition. For example, staff identified that many care homes would not accept patients under the age of 50 despite the benefits this would deliver for those with neuro-cognitive needs. Staff had identified the reason for this was often that care providers did not have an understanding of HIV and felt they could not provide appropriate care. In response staff worked with local care providers to improve their understanding and increase the opportunities for HIV positive patients to live in care facilities. However, some staff at the hospital felt that they needed to work more closely with professionals in the community to ensure that patient goals were set realistically and outcomes ascertained.
- We attended an internal MDT meeting where we witnessed effective MDT working and information sharing. There was open dialogue between professionals and appropriate challenge and support from all staff at the meeting. Staff were confident to say



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what they thought their patients needed. There was thorough, in depth discussion of each patient in terms of their clinical status, social issues and additional support needs. Clinical discussion included progress/deterioration, pain management, adherence to medications, diet (and weight changes), personal care packages, psychological needs, emotional state and barriers to discharge (such as accommodation needs). All of the staff present had good knowledge of their patients. The physiotherapist provided updates on mobilisation of patients, mobility, goals, body condition (strength/fatigue), pain management, swallowing, continence, equipment and reablement needs, referrals and discharge arrangements. There were updates from the social work team about interactions and interventions with other external agencies such as key workers, housing agencies, police and social work teams. The meeting was also used to discuss patients being admitted the following week.

- There was an open plan office for nursing and therapies staff, which facilitated immediate information sharing and dialogue.
- Therapies staff told us they had access to external support from a network of allied health professionals specialising in the field of HIV rehabilitation, as members of the Rehabilitation in HIV Association.
- There was a team of volunteers at hospital who provided befriending and activities support. The volunteer team also worked in various different roles to provide extra capacity in specific areas. For example, the estates and facilities team had a volunteer on one day per week and volunteers regularly supported the fundraising team. A gardening volunteer was also in post that helped to maintain the garden for patients, staff and visitors. New volunteers undertook training sessions with existing members of the team who had received treatment from the hospital or who could discuss their own experiences with HIV. This helped volunteers who did not have previous experience of working with HIV positive people understand their key needs.
- Chaplaincy formed part of the multi-disciplinary approach at Mildmay Mission Hospital. We found that the chaplain was flexible with timings for different daily activities to support the clinical staff and would move or change activities to fit clinical needs.

Referral, transfer, discharge and transition

- There were clear referral criteria which detailed suitability of patients for admission to the hospital. There was a formal referral form available online and in paper form covering the reason for referral and admission requests by external providers. This recorded behavioural risk factors such as morbidity, speech and swallowing, drug rehabilitation, mobility, personal care assistance needs, physiotherapy needs, evidence of social worker input, cognition in relation to insight and memory deficits, and continence. New referral requests were discussed on a weekly basis by the MDT team to determine if the hospital could effectively care for the patient.
- The hospital admissions lead had developed new forms for referrers to record patients' social work and occupational therapy needs to ensure Mildmay Mission Hospital staff were fully aware of a patient's full range of needs and able to make a full assessment before admission.
- The hospital admissions lead prepared a weekly admissions list and this was shared with all clinical staff by email and discussed in the MDT meeting so that all staff were aware of patients' needs and backgrounds.
- Most referrals to the hospital were from acute hospitals and treatment centres for patients who were acutely unwell. The hospital did not accept self-referrals by patients. The admissions lead was able to provide support by signposting potential patients to apply via their local commissioner such as their GP or treatment centre so funding could be arranged.
- There were no examples of declined referrals in the three months preceding our inspection, but there had been previous cases where the hospital did not have the required resources to safely care for a patient with very specific mental health needs.
- The admissions lead conducted visits to assess patients' suitability for admission. There were immediate meetings with the hospital medical director the day after a visit to determine if a patient could be considered for admission.
- Admissions were also calculated according to safe staffing levels and recognition of manageable nursing workload. However, in the six months before our inspection, the hospital had experienced more admissions and had opened the second ward to accommodate new patients.
- We observed a new patient admission. The patient was given a full introduction to present staff and the



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hospital. The admission interview was very patient centred and focused on the needs of the patient and included planning for MDT input and attendance at sessions. Medical admission note templates were designed specifically for patients with HIV acquired neuro-cognitive impairments. The template included a daily record of review by the doctor and conversation with patient. The record also demonstrated forward planning of patients' anticipated medical needs.

- There were mechanisms in place to ensure appropriate and timely transfer of medical information for patients attending outpatient appointments at other acute hospital whilst they were an inpatient at Mildmay Mission Hospital.
- Clinicians reviewed patients' progress at key points in the duration of their stay to establish if they could be discharged early or need to remain for the full duration of the pathway. Patients could also self-discharge if they wished. There was a focus on goal attainment to demonstrate progress. Hospital staff liaised with referrers about the status and progress of each patient.
- Patient records demonstrated evidence of discharge planning by therapists at an early stage of the pathway. Patients who were discharged were provided with care packages, tasks and exercise programmes they could continue at home.
- The hospital used the decision support tool for NHS continuing care where relevant to record ongoing care needs on discharge to another provider.

Access to information

- All staff had access to computer workstations, which provided access to the hospital 'general drive' and internet.
- Some of the hospital staff had NHS secure email addresses, which enabled them to share information with other agencies and care providers in a secure way. This meant that a number of clinical staff relied on others to send information securely, which they felt was inefficient.
- Some staff had access to an electronic patient record system, for example the social work team used the system to share information with other social workers externally. However, nurses did not routinely access the system. This sometimes led to different information being recorded electronically to that recorded on paper.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Each patient who attended the day services unit had documented evidence of their consent. Where a patient lacked the mental capacity to fully understand the purpose of the day centre, there was evidence a multidisciplinary best interests meeting had taken place that identified the benefits to the patient of taking part in day unit activities. Staff documented in each care plan whether the patient's close relatives and friends were aware of their HIV positive status and whether they had any psychological needs. We saw staff acted on this information, such as by recording when a patient had been referred to a counsellor.
- Of the 16 inpatient notes we reviewed we were not able to find completed consent forms seen in two sets of notes.
- The hospital had a formal policy which documented processes for ensuring correct discharge of provisions of the Mental Capacity Act 2005 were applied clearly and consistently to all patients and clients using Mildmay services.
- Deprivation of Liberty Safeguards (DOLS) applications were recorded in patient's notes where relevant. In the year preceding our inspection the hospital had made 12 DOLS applications. All of the DOLS applications we reviewed were within date, with regular documentation about the patient's level of comprehension.
- Clinicians used the Montreal Cognitive Assessment (MOCA) tool to establish patients' level of comprehension. This assessment was initiated by the hospital physiotherapist. This tool was also used to measure patients' ongoing cognitive progress after initial assessment.
- We found some gaps with the correct application of do not resuscitate orders (DNAR) in patient records. In one record we looked at, the DNAR form had been dated and signed by a doctor. The record confirmed the patient was unable to communicate so the doctor had discussed resuscitation with the patient's family members. This was recorded on the form but the discussion had taken place at another acute care provider. The form appeared to be a copied document and there was no Mildmay Mission Hospital identity to the paper. Consent was signed for the acute care provider episode of care but had not been updated when the patient was transferred to Mildmay Mission



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Hospital. The advance decision was not also recorded. A record of discussion and approval from family was noted but not dated or signed by them and the doctor signature was also not dated. The resuscitation order had been cancelled by scoring through and writing a new date, again with no signature or recorded rationale. This example did not meet national guidelines for appropriate recording of patients' DNAR needs and plans to liaise with family members to make decisions should they need to invoke it.

- The hospital recorded independent mental capacity advocate (IMCA) involvement in resuscitation decisions. This was recorded in patient notes. During our inspection there was one case where an IMCA had liaised between the hospital clinicians and a patient's family members to explain the need for a DNAR order as the patient was at the end of their life. We were told there was divergence of opinion between family and clinical staff but this had been handled sensitively.

Are community health services for adults caring?

Outstanding



Compassionate care

- We witnessed many examples of compassionate care during our inspection. During our observations of group activity sessions in the day care unit we saw staff adapted their communication and manner to each individual. Staff also ensured group activity sessions were delivered in a relaxed and welcoming manner with humour. For example, we observed a nutrition group session that aimed to help patients make healthy diet choices and the trainer ensured each individual was involved and included at an appropriate level. For example they said, "I don't want this [session] to be too complex but it will be enough to help us make some healthy choices". We also witnessed a rehabilitation assistant provide comfort and reassurance to a patient who appeared visibly distressed. We observed that the senior leadership knew the names of patients and greeted them all individually and asked about their wellbeing. We saw that all staff were patient and respectful with all patients they encountered.
- Patients we spoke with gave us consistently positive feedback about their experiences of care at Mildmay Mission Hospital. They felt the hospital team were kind, caring and compassionate. One patient said "I don't think of the staff and volunteers as working here, they are my family. I wouldn't be where I am without them." Another patient said, "I don't have any family nearby and I can get very lonely sometimes. This place has been a lifeline. I know everyone, the nurses, volunteers and physiotherapists very well. We have an excellent relationship". Another patient told us "the service has changed me. I feel a changed man. The spiritual influence has impacted me: transforming my thinking and outlook. The close knit community has helped restore my confidence". Other patients told us nurses were "immensely supportive. One in particular has been a "God send", and "I had become reclusive, the day care services enabled me to develop friendships. That helped me regain my confidence".
- The hospital participated in the 'Friends and Family Test' to seek feedback from patients and their relatives and carers. The Mildmay Mission quality account for 2016/17 demonstrated that 25% of inpatients (22 patients in total) responded to the survey and 18 of those surveyed stated they would recommend the service to a family or friend if they needed it and four said they would not. This was a decrease on the 100% rating achieved in 2015/16. Senior staff reported this was possibly because there were some particularly challenging patients on the wards in the reporting period, which may have impacted on the experience of other patients. It was also noted that some patients did not have the capacity to respond to the survey questions and some patients were discharged to acute hospitals due to their health deteriorating, rather than via planned discharge.
- Volunteers we spoke with were able to explain how they provided compassionate care and the impact on patients. For example, one volunteer had played a board game with a new patient in the day services unit who could not easily speak. The volunteer explained the game through demonstration and some humour and said the patient had relaxed and laughed for the first time in weeks as a result. Volunteers included medical students who were able to develop their skills in compassionate care for patients living with HIV and with neuro-cognitive needs.
- Mildmay Mission Hospital provided additional support for patients, beyond clinical care. We attended a MDT



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meeting where staff discussed what was going on in patients' lives generally, not just their clinical needs. Staff had a detailed, holistic understanding about their patients' lives. We heard of a patient who had a court appearance. Staff were liaising with solicitors to help prepare for the court appearance and explain the patient's level of comprehension and the need for staff to advocate and ensure the best interest of the patient. Another patient was at risk of deportation from the UK because they had overstayed their visa. Social work staff gave an update on their attendance with the patient at a solicitors' office and explained the legal options for leave to remain to ensure the patient's medical needs could be met. Physiotherapy staff planned to order medical equipment for the patient such as a wheelchair, should the patient be deported. The social work team liaised with local charities to obtain funding for wheelchairs and support aids.

- The hospital had procedures in place to ensure patients experienced a dignified death. We were told that staff had cared for one patient who had died in the hospital in the year preceding our inspection. The death was unexpected even though patient had a short life expectancy. The hospital policy stated that deceased patients could remain in place for up to five hours, to ensure family, carers and staff could say their farewells. Spiritual, religious and bereavement support was provided by chaplaincy team or counsellor. Patients bodies were cleaned and prepared using agreed guidelines that took account of their religious and cultural views and personal preferences and family members were included in this aspect of care.
- The hospital chaplaincy team organised 'farewells' for patients who were leaving the hospital after long stays, and also organised memorial services for families and friends of deceased patients. The social work team liaised closely with the chaplaincy team, where involvement with a funeral had been requested. The chaplain recalled an example of a patient who wished to have a humanist funeral ceremony, and to support this the chaplain prepared the funeral with poems, music and songs to reflect the patient's life and personality.

Understanding and involvement of patients and those close to them

- Staff we spoke with recognised that patients may have different acceptance levels about their condition and they tailored their clinical approach accordingly so that

patients could take ownership and work at a pace they felt comfortable with. Senior clinicians told they wanted to normalise patients' acceptance and they are not going beyond their "comfort zone".

- Patients told us they were routinely involved in their care planning. For example, one patient said the physiotherapist had spent time with them and explained the gym equipment and what they were trying to achieve with the patient's care plan. The physiotherapist then encouraged the patients to put together their own exercise plan each week, which they prepared the day before a visit. A patient told us "the work I've done with the physio has been a very proud achievement. He helped me to understand the exercises I need to do and showed me how to put together my own gym plan".
- One patient said staff discussed with them their activity plan for the week and together they identified any extra support they might need as a result of visual impairment.
- Patients told us they appreciated the support staff gave them to remain independent. For example, one patient told us "I like that [the staff] make me do things myself to keep my independent. Like when I ask for a snack and they tell me to make it myself! That's really good because they watch me make it to make sure it's safe but otherwise I'd become lazy". Other patients told us that staff had explained the importance of taking their medications, had demonstrated how to use the washing machine and helped them to look neat and tidy.
- As part of the volunteer induction to the day services unit, the day services coordinator introduced volunteers to each patient and gave them an opportunity to get to know each other. This helped the day services coordinator to plan shifts so that volunteers who got to know patients could provide a consistent service.
- Patients were involved in their referral to the day services unit including in their rehabilitation and activities plan. For example, before agreeing to a programme, patients visited the unit and met with staff and other patients.
- At the MDT meeting we attended staff discussed supporting patients through an external 'newly diagnosed' course they could attend to help them understand their condition and what it meant for their health. Patients could also access telephone advice lines. Clinical staff in the MDT meeting discussed reviewing the hospital induction process and working



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with an external organisation called 'Body and Soul' to help patients and their family members understand the impact of HIV and how to care for patients with HIV positive status.

- Senior nurses told us they made 'contracts' with patients to agree acceptable behaviours and actions and to set clear expectations.

Emotional support

- We found there was extensive recognition of and provision for the emotional support and wellbeing of patients. We attended an MDT meeting where staff discussed and planned patients' needs. There was detailed discussion of patients' emotional and psychological states and specific support needs, for example those patients experiencing disassociation or post-traumatic stress disorder. The MDT meeting was also used as a forum to identify potential solutions to support patients based on their likes and dislikes, such as gardening activities for patients who enjoy being outdoors.
- There was formal counselling support available by a trained counsellor. Members of the chaplaincy team were also able to provide counselling.
- A team of chaplaincy volunteers worked with the chaplain to provide emotional support to patients and their relatives regardless of their faith. There was a clear understanding of the difference between spiritual and religious needs. The chaplaincy team had 'on call' arrangements for any urgent spiritual or emotional support needs, or if a patient was at the end of their life.
- The chaplaincy team planned to re-introduce 'spirituality workshops' and 'spirituality groups' to provide emotional and therapeutic support to patients to help them come to terms with their diagnosis and conditions.
- The chaplaincy team organised morning and lunchtime prayer services each day for patients and staff to sing and pray together. Services were planned to reflect what was going on patients' lives and in society generally, such as incidents patients had seen in the streets. The chaplaincy team sought feedback from patients about their thoughts on the chapel service, but explained that they received more immediate verbal feedback from patients. Patients told us they valued the opportunity to

reflect and the chaplain told us that patients would often leave the chapel singing or laughing and feel that they had found some peace or satisfaction from the service.

- Each afternoon, the chaplain visited patients on the wards or in the day service, and telephoned relatives to listen and offer spiritual and religious support. The chaplain also visited patients who had been admitted to acute hospitals when they were unwell.

Are community health services for adults responsive to people's needs? (for example, to feedback?)

Outstanding



Planning and delivering services which meet people's needs

- Mildmay Mission Hospital provided a comprehensive range of day services, as well as inpatient services to support and care for patients living with HIV acquired neuro-cognitive impairment.
- There was a planned timetable of activity groups provided on a weekly basis and patients could plan to attend these in advance either as part of their rehabilitation care plan or by personal choice. During our inspection there was a breakfast club, yoga class, health clinic, chapel service, healthy living session, singing, horticultural therapy, brain training, film club, and a games evening.
- We observed a music group supported by external musicians who led sing-a-long sessions and performances. Patients could play musical instruments, sing, and were helped to follow a rhythm, conducted at a pace suitable to each patient
- We observed a high level of camaraderie amongst patients in the day services and saw lots of interaction between patients. Staff told us the day services were used to provide opportunities for shared experiences and to provide a safe space for interactions.
- We spoke with patients in the day service, they told us things such as "I look forward to Thursdays to come to the gym to get fit" and "the day care service have empowered me to be able to live more independently in the community".



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- Volunteers were available during the weekend and provided activities to reduce the risk of social isolation on the wards and each patient was offered one-to-one social time. Volunteers provide opportunities for patients to chat and play games. We spoke with a volunteer who supported the film club on the wards. The volunteer helped residents decide which film to watch. Volunteers also helped with the music group, helped patients walk to the garden or access the chapel, and served lunches.
- A team of 50 volunteers provided a befriending service to patients on the wards and in the day care unit. This included spending time one-to-one with patients to reduce social isolation and anxiety and accompanying patients to group activity sessions such as yoga or film club. Volunteers were trained to provide activities that contributed to rehabilitation such as playing a board game that required the patient to use their hands and cognition. Volunteer services were offered on patients' own terms, which meant they could request activities such as going for a walk or to a local park.
- The volunteer services lead was able to match specific volunteers and patients together based on individual need. For example, one volunteer was an Islamic community leader and had worked with a patient who needed support in managing their condition in line with their faith. Another volunteer had been able to provide one-to-one support for a patient who did not speak English but who was fluent in the same language as the volunteer.
- Patients had contributed to the decoration of the day care centre through art projects that displayed activities, groups and outings. This included a display titled 'My journey' that demonstrated the progress some patients had made through their rehabilitation programme. We spoke with an art therapy consultant volunteer who had previously received care at the hospital who explained that art therapy activities were based on literature and case studies to ensure effective interventions in both ward based and day services. The hospital was looking to establish art therapy as a specialist service.
- Staff worked with patients who had concerns about disclosure in relation to their HIV status. For example, where patients had not disclosed this information to friends, family members or their GP, staff discussed their options and helped them to identify the benefit and risks of doing so. Staff were also able to facilitate discussions between patients and relatives where HIV disclosure was a concern. Senior clinical staff recognised that when referring on patients to other services, there was an element of disclosure because of the nature of the hospital, which could only be accessed by HIV positive patients.
- The day services team was investigating the development of an expert patient scheme that meant long-term HIV positive day patients would be trained to visit the inpatient wards and provide one-to-one advice to those who were recently diagnosed. This service would enable patients to speak with those who had lived with the virus and ask questions about disclosure, medicine adherence and other personal issues outside of their clinical relationship with staff.
- The hospital provided occupational therapy support to help inpatients manage their daily tasks, such as practical steps to getting home, how to wash safely in the shower, personal care, and meal preparation. There was also some occupational therapy support for outpatients on the cognitive rehabilitation programme. One patient gave us positive feedback about the occupational therapist and told us the support had helped them to re-establish the dexterity they had lost in their hands.
- As part of the rehabilitation function of the day care unit, the team provided a weekly transport training and orientation session. This involved helping patients to plan a journey within London by using a public transport map and Internet resources. Staff accompanied patients and supervised them buying tickets, planning times and navigating the transport system. This helped patients to increase their independence and to contribute to their overall rehabilitation.
- There was an onsite gym at the hospital with exercise machines and equipment for patients to use. Patients were supervised while using the gym to ensure they exercised safely and correctly, and the hospital physiotherapist devised exercise programmes for patients to follow. Patients with disabilities, such as visual impairment or those using wheelchairs were also provided with opportunities to exercise, with programmes devised accordingly.
- There was an independent exercise group for day service users, and inpatients could also access the gym



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to follow pre-set exercise programmes supervised by the physiotherapist to aid progression. There were gym reassessment appointments every three months to check on progress.

- We witnessed a positive atmosphere in the gym. Staff and patients appeared to be enjoying themselves. Patients were encouraged to check they were using equipment correctly and staff gave them individualised guidance. The patients we spoke with were very positive about the gym and felt that it helped to improve their strength.
- The hospital provided weekly yoga sessions for inpatients, supported by the physiotherapist.
- Music and books were available for patients to use in the canteen and day room.
- Patients in the day care unit told us there was a high of standard of food which was “always delicious” and they looked forward to it.
- There were guidance materials in the hospital kitchen about specific dietary needs, for example, appropriate food for patients with dysphagia, and texture descriptors. There were food products available for patients with dysphagia included puree, mashed and fork mashable.
- We observed breakfast time during our inspection. There was a choice of food and cold drinks available, and nurse assistants supported and encouraged patients to eat independently.

Equality and diversity

- Mildmay Mission Hospital had an equality and diversity programme and action plan in place for 2016-2018. This included clear equalities objectives to improve inclusivity and prevent discrimination. The senior leadership team was responsible for monitoring performance against the action plan.
- The work of Mildmay Mission Hospital was based on Christian values and the charitable history of the hospital. However, hospital documentation, and staff, demonstrated that people of all faiths and those of no faith were welcomed and treated equally.
- The chaplaincy team supported patients of other faiths and had good local links with religious organisations in east London. They supported patients of other faiths to practice their faith, for example by providing prayer mats, religious texts, prayer sheets and other resources.
- The hospital worked with local religious organisations to facilitate support for patients with specific religious and

cultural needs. We heard one example of the chaplain liaising with a local mosque to find a female Muslim speech and language therapist for a female patient to provide religious and spiritual support as well as therapeutic support.

- The chaplain was aware of, and adhered to the end of life rituals of other religion, for example cleansing rituals and involved families and friends in this aspect of care.
- Staff in the hospital had access to translation and interpretation support. Language requirement were identified before patients were admitted to the hospital which meant staff could book an interpreter in advance. Interpreters could attend with day care patients as well as provide daily visits to inpatients on the wards, and interpretation of medication instructions to help with adherence.

Meeting the needs of people in vulnerable circumstances

- The hospital’s social work team provided support for patients with very wide ranging needs. The social work team was involved in supporting patients with immigration and repatriation, housing applications, organising advocacy support and debt management. A social worker told us the key principle of this support was to ensure that all patients’ needs were met and their rights upheld.

Access to the right care at the right time

- The day care unit accepted referrals for patients with a range of health needs. Admissions were planned on the basis of bed availability and the patient's own medical condition at the time (and with the administration/ funding having been confirmed). There were no delays in accepting new patients. There was an average of six working days from referral to admission. Initial assessment occurred on the day of admission and treatment commenced at the point of initial assessment immediately after admission. The hospital did not admit patients at weekends.
- The Mildmay Mission Hospital quality accounts for 2015/16 recorded an inpatient occupancy of 82% for the year. This represented 100 in-patient admissions. Day services had a 76% occupancy in the same period. In terms of sessions this represented 3,262 sessions.



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- Where a patient was unstable on their antiretroviral medicine, the day care unit accepted them as a new patient and asked them to bring their medicine in with them. This enabled staff to work with them on adherence.
- The hospital quality accounts also reported that all suitable patients were discharged on target after they had made sufficient progress in the rehabilitation programme. Each patient's discharge was planned with the relevant support agency being involved. There were isolated cases of delayed discharge due to unavailability of nursing home placements (for the 8% of patients who go on to nursing homes).
- The hospital did not accept privately funded patients and care was provided on referral from an HIV clinical nurse specialist. Although the senior team demonstrated in-depth knowledge of the changing prevalence and social patterns of HIV infection in London, there was not a structured system in place to ensure NHS acute trusts and community providers were kept up to date with details of the hospital's services. For example, senior staff told us patients were often referred following ad-hoc enquiries from doctors. In addition there was not a system in place to track where HIV positive neuro-rehabilitation patients were cared for if they were not referred to the service.
- Volunteers worked in the hospital seven days per week and were flexible in their attendance times based on the needs of patients and activities taking place in the hospital.

Learning from complaints and concerns

- Mildmay Mission Hospital reported three complaints in 12 months preceding our inspection. All of these complaints were upheld and no complaints were referred to the Parliamentary and Health Services Ombudsman (PHSO). All complaints had been responded to within agreed timeframes.
- We reviewed all three complaints and found that appropriate investigation and follow up action had been taken by the hospital's leadership team.
- There was a dedicated complaints email inbox and a patient leaflet to promote the hospital's complaints process.

Are community health services for adults well-led?

Good



Leadership of this service

- Staff spoke positively about the leadership structure in the hospital. One member of staff said "we have quite a unique atmosphere here, I don't think you see it in many other places. The leadership is positive and well-structured". Another staff member told us the flat managerial structure and small team made it easy to access decision makers.
- Clinical staff told us the senior team was visible on the wards and they were approachable.
- To build leadership capacity, the organisation split the director of nursing and registered manager position into two separate posts. As of October 2016 there were two members of staff to cover the two separate roles. Both were ward based, but the registered manager post included protected time for administrative and managerial functions. Both attended the nursing handovers, carried out medicine rounds and provided patient care.
- The board had representation from two HIV positive individuals, including one who had been a former patient. This helped to ensure the voice of HIV positive people was always heard and included in reviews and strategy meetings.
- The organisation supported staff to develop and progress to more senior posts. For example the day services coordinator had joined the organisation as a rehabilitation assistant and progressed to a senior activities coordinator before taking up their current post.
- The volunteer services lead held line management responsibility for volunteers and had implemented a system to encourage long-term service and low levels of turnover. This included regular supervision and contact time and support for each individual to maintain a good work-life balance. In addition the number of volunteers scheduled per shift was managed to ensure volunteers could meet patient need and remain active to ensure they could achieve their aims and goals.
- Volunteers told us they were treated with respect by the permanent team and as part of their induction the VSL



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introduced them individually to clinical staff. This helped volunteers to feel part of the team immediately and empowered them to speak with more senior colleagues if they needed help.

Service vision and strategy

- The Mildmay Mission Hospital vision, values and strategy were documented. Senior leaders of the organisation explained their plans for developing the service. They had identified their main challenges and opportunities as: redesign of day services provision (especially around the faster rehabilitation programme) to improve referral rates, sustaining inpatient occupancy levels, 'settling' the organisation following organisational change in 2016, succession and contingency planning for key staff, and improving administrative functions within the organisation.
- The senior leadership team was cognisant of the changing landscape around HIV care and funding and the organisation's vision and strategy recognised this. Senior staff explained that the niche role of Mildmay Mission Hospital meant that there was a sustained demand for their services. However, there was also recognition of the need to promote and publicise the work they do to clinicians and patients. This was seen as "work in progress", but staff told us there was an appetite for fundraising and promoting the work of the hospital. One member of staff felt that Mildmay Mission Hospital "remains London's best kept secret. We need to move on and spread the news". Senior staff told us there was scope to improve engagement with commissioning bodies in London and beyond to promote services and foster demand.
- The Chief Executive of the hospital explained the organisation's quality priorities as providing improved management support to develop the nursing and rehabilitation assistant team, wider use of electronic systems for medical records and incident reporting, and creating an environment where innovation is encouraged.

Governance, risk management and quality measurement

- There were governance processes to ensure the reporting, escalation and review of risk and performance information. A monthly risk management group met to identify and manage operational, finance, clinical and information governance risks and review

incidents. This reported to a quarterly clinical governance group which had oversight of clinical activity, reviewed risks to service delivery, staffing, compliance, quality improvement, clinical education and training and clinical policies. Information from this group was escalated to the quarterly trustee board.

- We reviewed minutes of governance meetings and found there was clear recording of information, updates and actions.
- We reviewed the hospital's strategic risk register and found there was an appropriate record of risks, mitigating actions, updates and ownership of actions. The risk register contained 35 risks; of which five were rated severe ('red'), three were rated 'amber', 14 were rated 'yellow' and 13 were rated 'white'. The severe rated risks included: ambulance bay misuse, risk of patient absconding, IT disruption (including breach of security), high agency usage, and loss of contracts. There were mitigating actions recorded for each risk.
- There were fortnightly management team meetings which reviewed contract performance and occupancy, financial decision making and modelling, service design, general oversight of operations and risks. This meeting also reported to the trustee board.
- There were clear performance indicators in place for the service. These included: no serious incidents, outstanding infection control audits, 85% of patients discharged to home, review of rehabilitation outcome measures and day service outcomes, above average PLACE scores, agency staff usage at less than 5%, and correct application of duty of candour.
- Governance processes in relation to the volunteer team meant the service was delivered safely and within established protocols. For example, where volunteers worked across teams such as with the fundraising team or chaplaincy, the volunteer services lead (VSL) maintained oversight of their work and continued to provide supervisory support alongside the respective service leads. The local in-charge member of staff for each service area was responsible for volunteers and referred to the volunteer services lead if needed.

Culture within this service

- There was a clearly defined organisational culture at Mildmay Mission Hospital, based on Christian values and the charitable history of the hospital.
- Staff we spoke with were proud of their work and the quality of care they provided. There was common



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feedback from staff who felt they had, for the most part, sufficient time to focus on individual patients, build relationships and understand their personalities and likes and dislikes: “the things that really help people feel cared about”. They felt they had time to care. Staff told us the whole team was involved in this aspect of patient care, including kitchen staff, cleaners and the receptionist.

- There was a clear focus on patient care amongst all the staff we spoke with. Staff gave us examples of the progress some patients were able to make, and the pride they felt when patients met their goals and showed improvement. Many staff told us this is what motivated them and there was passion in the way they spoke about their work to us.
- Clinical staff across grades and professions told us they enjoyed working at the hospital and it was a good place to work with a close knit team. Some established members of staff told us this was the reason why they had stayed working there for many years. There were many staff who had worked at the hospital for more than 10 years.
- Most staff told us they felt well supported by their managers and colleagues. However, in the feedback forms we received, there were some anonymous comments that nurses perceived a disconnect between nursing staff and the therapies team and felt intimidated by certain individuals in the MDT. They felt there was limited understanding of what nurses did amongst therapies staff. However, this was not representative of most of the feedback we received.
- Many staff across grades and professions told us, universally, that the lead chaplain was an integral figure in the organisation, both for staff and patients and was “very important to a lot of people here”. Staff told us they confided in the chaplain and asked the chaplain to say prayers for them.
- Many of the staff we spoke with told us they had a responsibility to normalise HIV and peoples’ understanding and opinions of people living with HIV.

Public engagement

- The day services team regularly asked patients for suggestions on forming new interest groups that would help support them and meet their rehabilitation needs.

For example, some female patients had asked for a women’s group so they could discuss issues and socialise in a way they did not always feel comfortable doing so with male patients.

- In the day services user forum staff discussed with patient what they perceived to be good, or not so good. Staff in the day services told us they wanted patients to “lead us in understanding the things we can change to better quality”.
- There was a suggestions box in the reception for patients, their carers and relatives to submit feedback to the senior leadership team.
- The volunteer services lead (VSL) had designed a survey for patients to identify their opinions of being supported by volunteers and to find out if the range of activities was appropriate. As part of this activity, the VSL also interviewed patients to discuss their experiences. The results of the survey and interviews would be used to make changes to volunteer team services and were due in July 2017.
- A chaplaincy committee panel met quarterly for planning, reflection and support of the chaplaincy volunteer team.
- In 2016 fifty staff, patients and relatives of those cared for by the hospital had written comments that were included in a time capsule buried in the garden. This took place to mark the 150th anniversary of the hospital and was intended to provide information about the service for posterity.
- The Mildmay Mission charity fundraising team managed a comprehensive programme of fundraising and promotion activities. There were a number of high profile supporters of the charity, which senior staff told us helped to raise the profile of the organisation beyond the healthcare arena.

Staff engagement

- There were planned monthly ‘CEO surgery’ meetings to provide opportunities for staff and patients to report concerns and share information directly with the chief executive.
- There were quarterly all-staff ‘unit meetings’ held after the trustee board had taken place to update staff on outcomes of the board meeting, address staff concerns, share information and celebrate achievements.
- The senior leadership team organised an ‘away day’ for clinical staff in response to nurses’ feedback from nurses that they would find this beneficial for team morale and



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interaction with the rest of the MDT. Senior staff told us the away day was productive and highlighted both the things staff enjoy and do well, and some pertinent issues.

- As part of the induction programme, new volunteers met with the chief executive officer to discuss their work and opportunities in the organisation. This was part of a strategy to ensure this team felt engaged with the hospital and felt valued by the senior team. We spoke with a volunteer who said “I think [volunteers] are cared for here, we feel like we’re important and valued”.
- Staff were offered monthly access to a clinical supervisor for emotional support and advice, and this was on demand if required. This service was also offered to volunteers in the event they needed support, such as after a patient death.
- Day services staff did not have a scheduled cycle of meetings but met on an ad-hoc basis when new patients were referred or after events such as an incident.

Innovation, improvement and sustainability

- The whole hospital team demonstrated a strong sense of community to celebrate achievements and mark milestones in the organisation. This took place within an

inclusive culture that involved patients, their relatives, volunteers and the local community. For example, to celebrate the opening of the new hospital garden, an opening ceremony took place that included the planting of a symbolic tree.

- The hospital’s volunteer scheme was a further example of the inclusivity of the service. Two volunteers in post at the time of our inspection had been former patients of the service and a volunteer who was a qualified physiotherapist elsewhere in Europe supported patients in the gym alongside the therapies team. A volunteer awards barbeque had taken place in summer 2016 with certificates issued for high standards of work.
- The VSL was proactive in identifying opportunities to expand and develop the volunteer service. For example, in summer 2016 the service had facilitated a six-month placement of an experienced volunteer from another country who visited to support the hospital’s work. In summer 2017 a volunteer intern was due to take up post who would support the VSL and train in management duties.
- The DSC planned to promote the service to other health organisations to ensure greater awareness of the specialist care they could have access to.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had a clear 'digital inclusion' focus and used information technology in a therapeutic way to help patients improve their cognitive function and problem solving skills.
- Staff provided additional support for patients, beyond clinical care. Staff had a detailed, holistic understanding about their patients' lives and needs. Staff advocated for and ensured the best interest of the patient when liaising with external organisations.
- There was extensive recognition of and provision for the emotional support and well-being of patients, with inclusive and personalised spiritual and social support.
- Patients could participate in a comprehensive planned timetable of therapeutic activities, and staff supported them to do so in an inclusive and personalised way.
- The hospital provided comprehensive rehabilitation training and support to help patients maintain or regain independence in their daily lives.
- There was a comprehensive volunteer support programme to provide one-to-one social time and support to patients to reduce their risk of social isolation.
- The hospital board had representation from two HIV positive individuals, including a former patient. This helped ensure the voice of HIV positive people was included in decision making.
- Patients were involved in service design and staff sought patients' suggestions on how they could better support them and meet their rehabilitation needs.

Areas for improvement

Action the provider SHOULD take to improve

- The hospital should consider introducing an early warning score system to record patient's vital signs to alert nurses to any deterioration or potential risks.
- The hospital should review all policies to identify those which require updating. All policies should be updated on a planned, regular basis.
- The hospital should review all do not resuscitate orders (DNAR) to ensure they are recorded and applied correctly.
- The hospital should ensure all consent forms are correctly documented and clearly signed and dated by patients, their advocates and responsible staff members.
- The hospital should take further steps to improve cohesion between staff groups and provide opportunities for staff to learn about the roles and responsibilities of different staff groups.