Mildmay Mission Hospital

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Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location went down. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse.
- The service was visibly clean and well maintained. Staff managed infection risk well.
- The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff assessed risks to patients and acted on them. They provided effective care and treatment, gave patients enough to eat and drink, and offered pain relief when patients needed it.
- Staff worked well together for the benefit of patients, supported them to make decisions about their care and provided information to enable them to lead healthier lives. They were focused on the needs of patients receiving care.
- Staff treated patients with compassion and kindness and respected their privacy and dignity. Staff provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems. Staff felt respected, supported and valued. The service engaged well with patients and the community and all staff were committed to continually improving services.

However:

- The service used both paper and electronic records and information was not always easy to find in patient care records. This meant staff unfamiliar with the system might not be able to find information about patients' needs promptly.
- Patient risk assessments were not always completed within 48 hours of admission.
- There was an inconsistent approach to care planning. We found a few gaps where patient needs were identified but there was no care plan or insufficient detail. Most care plans did not show evidence of patient involvement.
- Staff did not keep written records of the multidisciplinary team meetings. This increased the risk of important information being lost.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health inpatient services	Good	

Summary of findings

Contents

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 NHS patients from 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 two regulated activities: treatment of disease, disorder or injury and diagnostic and screening procedures. The service has a registered manager.

In March 2020, the hospital opened two new patient pathways in response to the COVID19 global pandemic. The step-down homeless medical care pathway provides step-down care for the homeless population of London, meeting unmet need for specialist medical care following treatment in an acute hospital setting. The step-down COVID-care pathway provides COVID-care beds for people who are homeless.

The hospital formerly provided day services, which were closed due to COVID-19 and were not operating at the time of our visit. There are two inpatient wards: William and Catherine. William Ward has capacity for 14 patients with nine occupied at the time of our visit and Catherine has capacity for 12 patients with 11 beds occupied at the time of the inspection. Wards are mixed gender. Facilities for patients include a gymnasium, occupational therapy rehabilitation room, digital inclusion IT suite, garden room and a chapel with multipurpose faith room.

Mildmay Mission Hospital was last inspected in 2017 and was rated outstanding.

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 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.
- Spoke with eight patients and two carers of patients who were using the services.

Summary of this inspection

- Spoke with the registered manager and 18 other staff members including the medical director, nurses, social worker, occupational therapist, housing officer, physiotherapist, speech and language therapist (SALT), dietitian, domestic and estates staff and members of the senior leadership team.
- Attended and observed a handover meeting and a multidisciplinary team meeting.
- Looked at 10 patient care and treatment records.
- Carried out specific checks of medicines management on both wards.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Outstanding practice

We found the following outstanding practice:

- There was a comprehensive volunteer support programme providing one-to-one social time and support to patients to reduce their risk of social isolation. Although COVID-19 had placed limitations on the recruitment and activities of volunteers, the hospital had adapted the volunteer programme to continue to provide support to patients.
- The hospital was given the go-ahead to provide step-down services for people who are homeless just a few days before it was due to close as it was no longer being commissioned. They quickly mobilised to provide the first pathway of its kind in London.

Areas for improvement

Action the service SHOULD take to improve:

- The provider should ensure that records are stored consistently so that patient information is accessible to all staff including agency staff, promptly.
- The provider should ensure that risk assessments of all patients are completed promptly on admission and that clear care plans or risk management plans are in place to address the risks and needs identified.
- The provider should ensure that care plans are person-centred and demonstrate patient involvement.
- The provider should ensure that discussions and decisions made in the multidisciplinary meeting are recorded in the patients' notes.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Community health inpatient services

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

Are Community health inpatient services safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills training to all staff and made sure everyone completed it.

Staff were required to complete a planned programme of mandatory training. Mandatory training modules included: basic life support, emergency first aid, handling violence and aggression, equality, diversity and inclusion, infection prevention and control, dementia awareness, lone working and mental health awareness.

Bank staff had access to the mandatory training programme. The service also provided bespoke training programmes for students and volunteers. For example, student nurses were given a placement pack which provided information about the hospital environment, patient cohort, learning opportunities and other, useful information.

At the time of our inspection the overall compliance rate for completion of all mandatory training was 87% across all staff groups. Nursing and therapies staff were 100% compliant with mandatory training.

Staff were given extra paid time and more access to computers to help them complete training.

The service had grouped staff together to form a 'bubble'. A 'bubble' included staff who worked together and did not mix with other staff groups. This meant staff could keep up to date with training such as basic life support, which was carried out face to face, during the pandemic.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The hospital had clear and detailed safeguarding policies and procedures in place.

Good

Community health inpatient services

All staff including students and volunteers were expected to complete mandatory training in safeguarding children and adults. Nursing and therapies staff were 100% compliant with safeguarding adults training. The quarterly performance and quality report for Q4 2021 indicated an overall compliance rate of 83% for safeguarding adults and children training. The hospital safeguarding lead was trained to level 3 in safeguarding adults and children.

The service had made safeguarding a priority for quality improvement in 2021/22. Service leads met regularly with the CCG and safeguarding lead at the local authority to monitor safeguarding.

The service used a safeguarding spreadsheet to monitor and track safeguarding concerns to ensure concerns were followed up. This was monitored by the social worker and lead safeguarding nurse who were both available for staff to speak to about any concerns.

Patient records showed safeguarding issues were identified and staff made appropriate safeguarding referrals.

Staff had a good understanding of how to recognise signs of abuse and how to escalate concerns if they thought a patient was at risk of harm.

Cleanliness, infection prevention and control, and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and the premises visibly clean.

Clinical and public areas were visibly clean, bright and well organised. All areas on William and Catherine wards were visibly clean and shower and toilet rooms were clean and tidy. Clinic rooms on both wards were cleaned regularly and well organised.

The hospital had implemented COVID-19 procedures for IPC, staff and visitors at the start of the pandemic.

There were hand hygiene points throughout corridors and posters displaying hand hygiene guidance. There was hand sanitising gel and paper towels available throughout the hospital. Staff carried out monthly handwashing and cleaning audits to ensure staff were compliant with procedures.

Staff wore appropriate personal protective equipment (PPE). The service had large stocks of PPE available for staff and visitors and monitored supplies of this at the monthly management meetings. Staff were trained in donning and doffing procedures.

The service had arrangements in place to nurse COVID-19 positive patients separately. There were dedicated rooms with a privacy screen in place and staff caring for COVID-19 positive patients entered and exited by a separate door. The infection prevention and control (IPC) team from a local NHS trust visited the service and were satisfied the IPC measures in place kept all patients safe.

Staff disposed of waste safely. Staff disposed of sharps and infectious clinical waste in separate bins. This was audited on a regular basis. Cleaning checklists were displayed in toilet areas on the wards.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

Good

Community health inpatient services

All areas of the hospital were maintained to a high standard. The reception area was bright and clean. The ground floor included the chapel, gym and occupational therapy area. Wards were located on the first floor and accessed via a lift. This meant all patient areas were accessible for patients with physical disabilities.

The building had specific areas for storage including dedicated space for patient records and large equipment. There was appropriate storage for oxygen cylinders.

There was a secure entry system with CCTV to ensure the safety of patients and staff. Windows were secured with safety catches throughout the building. Patient call bells were within easy reach of patients.

The hospital had a garden with plants and seating for patients and visitors. This was a welcoming space and we observed patients enjoying it during our visit.

The hospital was fully accessible throughout, with lifts to each floor, accessible doorways and disabled access toilets. All patients had their own bedrooms with ensuite facilities. Many ward rooms had a step free bathroom and were wheelchair accessible.

The environment had clear signage, good lighting, seating and quiet areas available for patients if needed. This was helpful for patients with cognitive impairments.

The hospital facilities team carried out a maintenance audit every week to identify any issues and an electronic data base to track tasks. Tasks were tracked on a database and repairs were carried out promptly.

The service had fire safety policy and procedures in place. Fire extinguishers and fire safety equipment were in place throughout the building. Fire drills were carried out twice annually and fire risk assessments were done once a year and included a review of evacuation plans. The last fire risk assessment highlighted three medium and one high risk remedial actions required which had been addressed by the estates team.

Clinic rooms in both wards were well maintained. Records showed that emergency resuscitation trolleys were checked daily by nursing staff and were sealed with a tag.

Electrical equipment tested. Staff applied stickers to clinical equipment to show it had been calibrated in line with the manufacturer's guidance.

Staff carried out regular checks on the environment and an up to date health and safety risk assessment had been carried out by facilities.

The hospital had a business continuity plan, which was due to be reviewed at the time of our visit. This covered escalation procedures and incident management and recovery.

The wards complied with guidance on eliminating mixed-sex accommodation. Both wards were mixed sex, but bedrooms were single and had ensuite bathroom and toilet facilities.

Assessing and responding to patient risk

The hospital had effective systems and processes in place for identifying and managing patient risks. Staff completed risk assessments for each patient. Staff identified and acted upon patients at risk of deterioration.

The service had recently introduced a new risk assessment tool. This covered up to 17 areas depending on the person's individual needs. The areas covered included falls risk, safeguarding, adherence to medication and physical health.

The service monitored the completion of risk assessments within 48 hours of admission through monthly audits. The most recent audit showed this had improved from eight risk assessments not completed in March 2021 to one risk assessment not completed in May 2021. However, when we reviewed 10 records during the inspection, we found three risk assessments had not been completed within 48 hours of the patient's admission. Progress notes showed patient risks were being discussed and monitored but this was not reflected in the care plan or risk assessment.

Staff completed VTE (venous thromboembolism) assessments for 85% of patients according to the most recent audit from February 2021. The service had an action plan to increase these assessments. Actions included updating junior doctors' induction and using posters as prompts.

There were antecedent-behaviour-consequence (ABC) charts on the ward for nurses to record patients' behaviours. An ABC chart is a direct observation tool that is used to collect information about the events that are occurring within a patient's environment. This can be used to analyse patient behaviour patterns and identify potential triggers and what staff are doing in response. ABC charts were used to support staff manage challenging behaviour, keeping patients safe.

Staff we spoke to had a good understanding of the current patients and their needs and risks and were.

The hospital had introduced the National Early Warning Score (NEWS) track and trigger system. NEWS is a tool used to score a patients' vital signs to identify patients at risk of deterioration, including possible sepsis. We saw this being used to monitor patients who were clinically vulnerable, and concerns highlighted were escalated appropriately.

The hospital had an out of hours procedure with clear escalation protocols

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skills mix, and gave bank and agency staff a full induction.

At the start of March 2020, the hospital was preparing to close, and many permanent staff were made redundant. This meant that when the COVID-19 and homeless pathways first opened there were not enough permanent staff to support this. In the first quarter of the year the service relied heavily on agency and bank staff to ensure the ward was staffed safely. Since then, staffing had improved. Over the last 12 months before our inspection, the hospital has significantly reduced its use of agency staff to fill gaps in the roster.

At the time of our inspection a team of 44 whole time equivalent (WTE) members of staff worked across the hospital. There was an addition 25 WTE staff on the bank (19 nursing staff).

Acuity and risk were standing items on the monthly management meeting agenda and was a factor in deciding how many staff were needed for each shift. Each ward always had one registered general nurse (RGN) and one health care assistant (HCA) per shift and this increased to two RGNs and two HCAs according to patient acuity and bed occupancy. For example, staffing increased on William ward if there were eight patients or more. On Catherine Ward, staffing increased if patients were being nursed in isolated due to COVID-19 or if more than one patient required help with personal care.

Good

Community health inpatient services

Staff told us there were enough staff on a shift to support patients and deliver safe and effective care. However, the staff survey results from April 2021 reported that 63% agreed that there were enough staff for them to do their job properly, although 10% of staff disagreed and 27% neither agreed nor disagreed with this statement.

There was a full-time consultant physician who managed the therapies team. There were two full time junior doctors and a GP on rotation. The service had a service level agreement in place with a local NHS trust for a consultant psychiatrist who visited the hospital one day per week. The service had a doctor on call 24 hours per day and was available to assess patients admitted out of hours on the homeless pathway.

The service had enough therapies and other staff to make sure patients had access to specialist assessments in a timely manner. This included access to physiotherapy, occupational and speech and language therapy, a dietitian, housing officer and social worker. An art therapist worked nine hours per week in the service.

All staff including bank, volunteers and students were expected to complete an induction and mandatory training.

Quality of records

Staff kept detailed records of patients' care and treatment. Records were up to date, stored securely and available to all staff providing care. However, not all records were clear and information was not always stored consistently, which meant it was not always easy for staff to find essential patient information quickly.

The hospital used a combination of paper-based and electronic records to record care and interventions. Paper records included progress notes. Some paper records were stored in patients' own rooms and included wound assessment and management, urinalysis, personal care record, fluid balance and stool charts, Malnutrition Universal Screening Tool (MUST) and National Early Warning Score (NEWS) charts.

Electronic records were stored on the hospital shared drive, which all clinical staff had access to and included MDT reports, continuing health care (CHC) and risk assessments, antecedent behaviour and consequence (ABC) charts.

We reviewed a sample of patients' records and found that information was not always easy to find due to the combination of records being stored in different places. Although, nursing staff were familiar with where to find key information and it was not missing or incomplete, there was a risk that this might impact on patient safety, care and treatment. For example, if a new or agency member of staff was unable to find patient information in a timely manner.

Hospital managers and staff recognised that patient records were an area they wanted to improve. Funding was a barrier to the hospital purchasing a bespoke electronic patient record system and efforts to work with the local NHS trust's patient record system had not been successful. The service was running a quality improvement programme to move more patient record forms onto the shared drive.

Patient records were stored securely within a locked room on the ward, which all clinical staff had a key to access. Patient confidentiality was included in the mandatory training programme for all staff.

Overall, most patient care plans reviewed identified and met patient care needs. We also found detailed information about patient's care and treatment needs in all the progress notes we looked at. However, only two of 10 care plans had evidence of patient involvement and were person-centred. Two care plans lacked enough detail about the treatment plan which meant it was hard to understand what care was needed. For example, one patient had continence issues,

but it was unclear how often staff should check if they required assistance or what continence products should be used. Another patient who had an open wound only had a wound care template care plan that had not been adapted or added to with their individual care needs. One patient on William Ward had an identified care need of neurocognitive impairment but the care plan had not been signed, dated or reviewed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

There were policies and procedures to ensure the safe supply, storage, administration and disposal of medicines in accordance with national guidance. Nurses completed an assessed workbook to ensure they were competent in administering medicines.

Medicine administration records and prescription pads were stored securely in secure access treatment rooms on each ward. Each patient was allocated a shelf in a locked cupboard. During the inspection we observed the medicine fridge keys were left in the door on Catherine Ward. We raised this with the nurse in charge immediately who promptly removed them.

There were systems to ensure the storage of controlled drugs (CDs). CDs were stored securely and accurate records were kept.

We inspected medicine audit records and were assured that staff carried out regular audits to ensure that medicines were stored correctly and documentation completed accurately.

Medicine administration audits were completed quarterly by a senior nurse. The January 2021 audit showed 100% compliance with all areas checked. For example, patient allergies were recorded on their drug charts, medicine names and dosages were legible and the timings of all drugs tally with the frequency prescribed. Medicine administration records were clear and legible.

Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

There was an up to date incident reporting procedure and it was included in the induction programme for new staff, including students and volunteers. The service had implemented an electronic incident reporting log everyone could access to report incidents. Staff told us they felt comfortable to report incidents and concerns and understood the processes for reporting and investigation. Staff received feedback about incidents from senior staff. Learning from incidents was shared with all staff in emails and monthly team meetings.

In the 12 months preceding our inspection there were no serious incidents requiring investigation and 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.

Good

Community health inpatient services

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 service undertook a falls audit for the period December 2019 to December 2020. The total number of falls for that period was 32, below the national average for similar organisations. In the three months before our inspection the hospital recorded 11 falls in the inpatient wards. No falls had resulted in serious injury or admission to an acute hospital. The audit identified falls were not being consistently documented in notes despite incident reports being submitted and a low number of falls were reported to patients' family. There was an action plan to address these concerns.

In the three months before our inspection the hospital recorded one grade 4 pressure ulcer. This was present on admission to the hospital and the patient had a wound care plan in place. Senior nurses sought support from a tissue viability nurse to ensure effective wound care for this patient and to put preventative measures in place including using a pressure relieving mattress.

The new homeless and COVID patient pathways had seen a rise in incidents related to drugs and alcohol on the premises and managing aggressive behaviour. The service had implemented mandatory training to support staff to manage these types of incidents. Detailed learning and actions had been identified in relation to these incidents.

Safety performance

The service had good overall safety performance in the 12 months preceding our inspection. Staff at the hospital routinely reported against key performance indicators, including for pressure ulcers, venous thromboembolism (VTE), falls and urinary tract infections.

The service used the NHS Safety Thermometer to collect this information. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient care and promoting 'harm free' care. This information was collated by the hospital on a monthly basis and reviewed by senior staff in governance meetings.

Records showed that staff used patient safety tools such as Waterlow, falls and VTE assessments. However, two Waterlow assessments were incorrectly completed and this was raised with the registered manager during our visit.

Are Community health inpatient services effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Good

Community health inpatient services

The service followed nationally recognised guidelines such as those produced by the National Institute for Health and Care Excellence in the prevention and management of falls and pressure ulcers. These were audited regularly and reported on in quarterly audit reports. Audits were discussed monthly at risk and management meetings with feedback to the wider team. For example, a recent falls audit showed some improvements were still needed in recording falls properly in patients' notes and observation charts.

The hospital used recognised tools to support the management of physical health. For example, the NHS thermometer is used to measure, monitor and analyse patient care and promote 'harm free care'. This was audited monthly and the data analysed on a quarterly basis. Since the last inspection the hospital had introduced the National Early Warning Score system to improve patient outcomes in recognising and responding to the deteriorating patient. Both tools are recognised as effective patient safety tools for improving safety outcomes in clinically vulnerable patients.

The hospital was the first and only HIV rehabilitation hospital in Europe to specialise in HIV Associated Neurocognitive Disorder (HAND). Staff told us about evidenced-based interventions used to support patients on this pathway. For example, the speech and language therapist carried out neurological dysphasia assessments to develop swallow rehabilitation goals and all MDT members used the Functional Independence and Assessment Measures (FIMFAM) which is a global measure of disability for people with brain injuries.

The hospital provided occupational therapy support to help patients manage their activities of daily living like meal preparation and personal care. These could be done in the occupational therapy suite where patients could also access computers. Staff supported patients to navigate the community and public transport, contributing to their rehabilitation and helping them increase their independence.

There were examples of descriptive case study examples which demonstrated the impact of the rehabilitation pathway. For example, one patient had been admitted with an unsafe swallow and was PEG fed. After a programme of rehabilitation therapy, they were able to tolerate certain thickened food, orally, with staff supervision at all times.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff carried out a risk assessment for each patient in relation to their weight and nutritional needs. Staff documented this in patients' records using the Malnutrition Universal Screening Tool (MUST) to screen patients and identify those who were malnourished, or at risk of malnutrition or obese. The most recent audit of 52 patients found staff had assessed all of them using the MUST.

The service had a dietitian and a speech and language therapist available to support with eating, drinking and swallowing. For example, one patient had a modified diet for dysphagia and the therapist had developed swallow rehabilitation goals with them using the international dysphagia diet standardisation initiative framework (IDDSI). Another patient was admitted with a percutaneous endoscopic gastronomy (PEG) feeding tube but was now able to eat a full diet orally with the PEG no longer needed.

There were guidance materials in the hospital kitchen about specific dietary needs. The dietitian and speech and language therapist worked closely with the chef to ensure there were appropriate food options for patients with dysphagia. The kitchen catered to different religious and cultural dietary requirements. For example, one patient had a halal menu.

Good

Community health inpatient services

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

There were appropriate processes in place to ensure patients' pain relief needs were met. Nurses used pain scales to measure pain severity, type and duration of pain with patients. They developed treatment plans based on the assessments and evaluated the effectiveness of treatment. Patients told us their pain was managed well.

Nurses conducted hourly intentional rounding, which is a standardised protocol for carrying out regular checks to address issues such as positioning, pain, personal needs and placement of items. This meant staff could identify and respond quickly to patient's pain. Pain scores and medication was documented in patients' progress notes.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Patients referred to the hospital had physical and mental health conditions such as HIV and other co-morbidities. The new patient pathways meant there were more patients referred without stable housing and with addiction issues. This meant staff were supporting more patients who had challenging behaviour and had barriers to discharge.

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. Over the year 2019 to 2020 the hospital demonstrated that following a rehabilitation admission, the average cost of a patient's care was reduced by £485 per week. The service also used the Functional Independence Measure and Functional Assessment Measure (FIM FAM), Rehabilitation Complexity Scale Extended (RCS-E) and the Northwick Park Dependency Scale (NPDS) to measure patient outcomes.

The service audited patient discharge destinations under the homeless pathway. Of 22 patients discharged between January and March 2021, all went to some type of accommodation. This meant patients were discharged to more stable accommodation than they were admitted from. Ten patients were discharged within the target period of six weeks and no patients' discharge was delayed more than one week. Barriers to discharge included access to lack of welfare benefits, delays with identification being verified and delays with local councils in finding suitable accommodation.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The hospital had an appraisal and supervision policy that included the level of support for professional development of staff that should be offered. This included annual appraisal and structured developmental review to identify training needs. At the time of our inspection all nursing and therapy staff and most other staff had received an appraisal. This was monitored at the management meetings.

Junior doctors were part of a wider scheme for learning, supervision and appraisal. They had additional support from an educational supervisor as well as clinical supervision and 360-degree feedback.

Therapies staff had access to external supervisors to support their professional development. Some clinicians had arranged their own supervision because of the specific nature of their work. The hospital had agreed to fund some clinical supervision for therapies staff. Therapists also kept up to date with training and were supported to attend conferences specific to their discipline. The hospital participated in UK HIV conferences each year, networking and presenting abstracts.

All staff were expected to complete mandatory training and continual professional development training. This was audited and compliance was very good across all staff groups. The hospital was investigating whether they could access the NHS Education Training programme for free as they already had access to the NHS IT education training programme. Nursing staff were expected to complete a medicines management workbook, which assessed their competency and there was a mentorship programme available for nurses to access.

Staff told us the hospital was a good learning environment. Some staff were supported to complete further education through loans and flexible working arrangements. The hospital supported student placements including nursing , social work, physiotherapy and occupational therapy, dietetic and medical students.

Staff told us they had a good induction programme and they had the right training to be able to do their job effectively. The physiotherapy lead had developed an induction booklet for the therapy assistant, which was specific to their role.

All staff had access to regular supervision. Nursing staff had quarterly supervision and the clinical lead nurse, and the lead occupational therapist had monthly supervision. Supervision was recorded on a spreadsheet for monitoring purposes.

Multidisciplinary team working and coordinated pathways

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

The multidisciplinary team (MDT) included a speech and language, occupational, physio and art therapists. There was also a dietitian, housing officer, social worker and nursing / medical staff. A psychiatrist visited the service weekly to review patients who needed specific mental health support. Patients were able to access timely assessments to support their rehabilitation. This meant patients' discharges were not delayed because they were waiting for a specialist assessment.

The MDT had a daily handover meeting with the nursing team so that any issues could be reviewed immediately if needed. The handover we observed was well attended and included a focused discussion on each patient's immediate needs including physical health, discharge destination, any appointments that day, safeguarding and capacity.

We attended an MDT meeting where we observed effective MDT working and information sharing. There was good communication between the professionals and staff felt comfortable to challenge appropriately and say what treatment they thought a patient needed. The clinical discussion included progress, pain management, medication, personal care needs, safeguarding or risk issues, emotional needs and any barriers to discharge such as housing needs. However, although the meeting discussed each patient's progress and goals there were no written records of the MDT meeting in progress notes.

A housing officer had recently joined the service to support patient discharges for all three patient pathways. The housing officer had a background working with people with HIV who were homeless and had been able to use her local knowledge and connections to benefit patient outcomes. The social worker provided updates about work with partner agencies such as mental health or social work teams.

There was a team of volunteers who provided befriending and activities support. However, the pandemic had limited their actions with patients on wards. Volunteers were able to support with other areas such as estates and facilities, gardening, collecting medication and supporting patients to attend appointments in the community.

The hospital had an admissions officer who was responsible for screening referrals. Each patient pathway had clearly outlined including exclusion criteria. Homeless patients could be admitted 24 hours a day and there was a dedicated phone and email address to support this. Out of hours admission procedures were included in the out of hours procedure and included escalation protocols.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The hospital promoted patient independence in all aspects of their care and treatment. This included supporting patients to administer their own medicines and we observed many patients doing that. To support this some patients who self-administered injectable medications, such as insulin, had a sharps bin in their room to dispose of needles safely. One patient told us he wanted to reduce his pain medication, so his prescription had been changed from being regularly prescribed to him having to ask for it when he needed it. Another patient told us the rehabilitation they had been given was very good.

Staff provided smoking cessation aids to all patients who smoked, including nicotine patches and gum. Staff ensured patients who were isolating with COVID-19 received nicotine replacement therapy, if appropriate.

The hospital monitored patients' weight and body mass index and encouraged referral to the dietitian who could provide education and support for maintaining a healthy diet and weight. Some patients declined to engage with the dietitian, but the team continued to encourage this where it was considered beneficial.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The hospital had policies and processes to support patients who lacked capacity to make decisions about their care and treatment. All staff including volunteers and students were expected to complete training on the Mental Capacity Act and deprivation of liberty safeguards (DoLS) as part of their induction. Compliance with this was 96% at the time of our inspection.

The hospital had a formal policy which documented the process for ensuring the correct discharge of provisions of the Mental Capacity Act 2005 were applied correctly and consistently to all patients.

Good

Community health inpatient services

Staff we spoke to understood when DoLS assessments might be needed and we observed regular discussion about a patient's capacity in the MDT handovers and meetings. We saw clear documentation decision-specific mental capacity assessments in patient's records including best interest decisions and appropriate referrals made to the local authority for DoLS assessments. DoLS authorisations were available in care records.

Do not resuscitate (DNACPR) decisions were recorded in patient records showing evidence of discussion with the patient and their carer or family, where appropriate. The hospital audited do not attempt cardiopulmonary resuscitation (DNACPR) standards on a quarterly basis. Of 37 patients admitted during the period March to April 2021 four patients had DNACPRs in place. All forms had been correctly completed, discussed (either with the patient or their relative) and reviewed by the consultant.

Are Community health inpatient services caring?

Good

Our rating of caring went down. We rated it as good.

Compassionate Care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

The hospital had a chaplaincy service that was part of the multidisciplinary team and the chaplaincy lead would attend MDT handovers. COVID-19 meant chaplains could not visit the ward at the time of our inspection but could still see patients for one to one support in the chapel. The service supported patients unable to leave the ward through phone calls and zoom calls. The chaplains had worked hard during the pandemic to make sure patients still had access to emotional, religious and spiritual support either at the hospital or in their own communities. The chaplaincy lead did regular zoom prayer services, which meant even patients isolating had access to services.

During our visit we observed staff walking and chatting with patients in the communal garden and nursing staff interactions on the ward were respectful and considerate. Patients told us they were happy with the care they were given, telling us staff were very supportive and kind toward then.

Staff told us they would feel confident in raising concerns about disrespectful or abusive behaviour toward patients. Team meeting minutes gave examples of nursing staff raising concerns to management and those concerns being addressed properly leading to improved patient care.

A new call bell system was recently installed, and we read care plans that reminded staff to place the call bell within the patient's reach. We observed staff responding to patients quickly and compassionately. Call bells were placed close to patients who were bedbound meaning they could call for help if they needed to.

During the pandemic patients had all their meals served to them in their own rooms which provided plenty of space to sit and eat comfortably. Patient's nutritional needs were discussed at the MDT meeting and if they needed support at mealtimes this was accounted for in the ward staffing levels.

Good

Community health inpatient services

The hospital obtained patient feedback when they were discharged through a patient survey. In the last quarter before our inspection data was collected from 16 patients who all said they would recommend Mildmay Mission Hospital to their family and friends.

The patient survey looked at five areas including cleanliness, care, being treated with dignity and respect, meals and being informed on how to make a complaint. Patients rated these areas excellent or good. Only one patient described meals as 'average'.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

We observed staff discussing patients' care and treatment with them. This was recorded in the progress notes. Patients did not attend the MDT, but each patient had a key worker who would discuss their care with them before and afterwards. Patients told us they were kept updated on their treatment and they felt involved in their care and treatment. Patients described hospital staff as supportive and responsive.

The hospital encouraged patients to access external advocacy services depending on their needs.

The speech and language therapist worked closely with the MDT to make sure patients with specific communication needs had the right support in place. One carer told us that her relative had improved a lot since her admission and that staff had used picture books to communicate with her.

The hospital had access to translation and interpretation services if needed and also used online translation tools to communicate with patients. The patient information booklet had been translated into eight different languages.

During our visit we observed staff demonstrate good practice in protecting patient confidentiality and information sharing by keeping nursing station doors closed when discussing patients. When staff provided a patient with personal care, this was done in the privacy of their own room with the door closed.

Patient records showed evidence of friends and relatives' involvement in patients' care and treatment and carers told us their relative's key worker would keep them informed and updated on their progress.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff assessed patients' emotional and psychological needs on admission and care plans put in place. Staff supported patients to link to their local religious institution or groups in the community.

Staff were sensitive to the carers' needs. The service provided carers assessments to carers. The visiting policy was updated to ensure it was COVID-19 safe but also meant families could come and see their relatives on the ward. The service offered a visiting booking system and asked visitors to take lateral flow tests in the reception area before meeting with the patient to minimise the risk of infection.

Good

Community health inpatient services

We saw many examples of patients being referred to specialist services or organisations to support them to be safely discharged. This included referring people to their local community mental health services, referring to specialist housing providers and supporting the patient to liaise with the home office.

Are Community health inpatient services responsive?

Good

Our rating of responsive went down. We rated it as good.

Planning and delivery of services which meet people's needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The hospital had 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. The pandemic meant day services needed to close to keep patients and staff safe. The management team kept this under review and were planning to reopen these now that restrictions had eased.

Every patient was allocated a key worker (therapist) and a named nurse when they were admitted. It was their responsibility to make sure the patient was involved in all aspects of their rehabilitation. Discharge planning meetings were held mid-way through admission where progress toward a safe discharge was discussed.

The hospital had delivered a music group, horticultural therapy, digital inclusion, real world skills, discussion-based groups and an HIV-specific service for people to share experiences and learn strategies for managing situations in a stigma-free space. The hospital volunteer service supported the delivery of these groups and activities. The pandemic meant these stopped in order to keep patients, staff and volunteers safe.

The service had worked hard to make sure patients still had access to a range of activities during the pandemic working with therapists and volunteers to devise activities that could be done with patients on a one to one basis instead. For example, the art therapist saw patients and volunteers still supported patients to access the community on a one to one basis.

We observed patients using the garden to interact with staff and each other.

The hospital had employed a housing officer to support patients find suitable and stable accommodation on the homeless and HIV pathway and we observed this was working well, with all patients being discharged to some type of accommodation.

There was an onsite fully equipped gym with exercise machines and equipment for patients to use. Patients were supervised whilst using the gym to make sure they were safe and using the equipment correctly. Patients were given an exercise programme developed by the physiotherapist which met their individual rehabilitation needs. This included patients with physical disabilities for example, patients using wheelchairs.

Patients were encouraged to eat independently and at the time of our inspection meals were served to patients in their rooms. All patient bedrooms had a fridge to store items like milk and snack food. Each ward had its own kitchen where patients could use a microwave and toaster to prepare food in between meals. Patients were also encouraged to wash their own clothes in the laundry room on the ground floor which meant they could maintain or build on their independent living skills.

Meeting the needs of people in vulnerable circumstances

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other service providers.

The homeless and COVID-19 stepdown pathways had been developed in response to the COVID-19 crisis to support the NHS. This pathway addressed a huge unmet need for people who were homeless or rough-sleeping and recuperating from illness or injury or who needed somewhere safe to self-isolate and recover from COVID-19. The pathway had a psychological focus on recovery and planning for a safe discharge. Admissions were open 24 hours a day and patients did not need to be registered with a GP to be admitted.

The hospital social worker provided support for patients with a range of needs supporting them with immigration and repatriation, housing applications, welfare benefits and finances and advocacy.

The hospital had access to interpreter services where needed, including British Sign Language. The hospital had a patient information booklet translated into eight languages. Patients who had communication impairments were supported with a range of different aids. For example, low technology augmentation, assistive texts and word boards. One carer told us their relative had been supported to communicate by using picture books and this had helped their overall rehabilitation. Patient communication needs were detailed in the risk assessment.

The hospital was wheelchair accessible with lift access to the other floors. One patient in a wheelchair was observed using the garden area independently. All rooms had been reviewed to ensure they were Disability Discrimination Act 2005 (DDA) compliant and the works required were mostly minor. The hospital planned to have these works completed by the autumn when there would be less patients.

The hospital digital inclusion suite was wheelchair accessible and had a large type keyboard available for people with visual impairment, or physical / motor function difficulties. This allowed all patients to access the suite, which contained computers, and enabled one to one sessions to continue.

Access to the right care at the right time

People could access the service when they needed it and received the right care promptly.

Each patient pathway had clear admission criteria available on the hospital website. There was an admissions officer who screened referrals during work hours and referrals onto the COVID-19 care and homeless stepdown pathways were accepted 24 hours a day with guidance for staff in the out of hours policy to ensure admissions were safe.

The hospital quality accounts for 2019 /2020 recorded an inpatient occupancy rate of 51%. Staff assessed all patients were assessed within 24 hours of admission.

Good

Community health inpatient services

The hospital quality accounts also reported that patients who reached their desired level of rehabilitation were discharged as soon as a safe transfer could be made. Discharge plans began on admission and progressed throughout the patient stay.

The hospital audit report from January to March 2021 stated 10 of 22 patients were discharged within the target period of six weeks. Most of those who exceeded this target stayed only one or two days past the discharge date. These figures had been impacted by an increase in patients who were homeless or rough-sleepers or who had no recourse to public funds.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons with all staff. The service included patients in the investigation of their complaint.

The hospital had a complaints policy and processes in place. All staff had training in complaints handling, conflict resolution and communication skills as part of their induction and mandatory training. At the time of our inspection compliance with these courses was over 86% for all.

Complaints were recorded and monitored in a complaints log and reported on at the management meetings. Staff dealt with complaints sensitively, listening to feedback, apologising and sharing learning with other staff. For example, one patient complained about how a therapist spoke to her. Although this was not upheld, the therapist reflected on the interactions they had with the patient and how they might change or learn from this. The patient was also supported compassionately during the complaints process and updated regularly on the progress of her complaint.

Patients told us they knew how to make a complaint and that they would feel safe and comfortable doing so. Information was provided by the hospital on how to make a complaint or give feedback.

Staff told us they were given feedback and learning from complaints in team meetings and handovers. Staff survey results showed 73% said they got feedback about changes made in response to complaints made by patients.

Are Community health inpatient services well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership of the service

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Good

Community health inpatient services

The chief executive officer (CEO) and registered manager were both visible on the wards, speaking to patients and staff. The registered manager attended the MDT meeting every week so she would be aware of the patient group and current risks. The leadership team had worked hard to support and develop good relationships between the MDT and nursing team.

Since our previous inspection the hospital had appointed a lead nurse with responsibility for safeguarding. An increase in safeguarding referrals had been identified as a result of the new homeless stepdown pathway. The safeguarding lead was responsible for working with partner agencies and providing information and support to staff to ensure issues were identified quickly and keep patients safe from harm.

Staff spoke positively about the leadership team and said they were approachable and supportive. One staff member told us they could speak up and felt listened to. Another member of staff said the leadership team recognised staff skills. Staff survey results showed most staff looked forward to coming to work and felt valued in their role. This was notable as the hospital had faced a challenging year.

The organisation supported staff to develop and progress. For example, one nurse was being supported through flexible working and financial support to complete their top up degree. Other members of staff told us they had been supported to complete their masters degrees. Staff showed loyalty to the organisation and many having worked there for several years.

Service vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all the relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The Mildmay Mission Hospital's vision and strategy were clearly documented on their website and in their strategic plans. Staff were able to describe the hospital's vision and values and we observed this in their interactions with patients. Patients' told us they felt supported and cared for by the staff to get better and become more independent.

The service had a clear, detailed strategic plan and had developed ideas for a new service pathway to meet the needs of the local population. This meant that despite facing closure, when the pandemic began, it was able to mobilise quickly to provide the stepdown homeless and Covid-19 care pathways to support the NHS manage the crisis.

The service was working with the commissioners to try to make the homeless pathway permanent.

Culture within the service

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was a clearly defined organisational culture at the hospital, based on Christian values and the charitable history of the hospital.

Good

Community health inpatient services

Staff told us they were proud of the work they did and the quality of the care they provided to patients. There was a clear focus on the patient experience. Staff knew the patients well and told us that supporting people and improving lives motivated them.

Staff described good working relationships with each other and described an open, learning culture and felt supported by management when things went wrong. Morale was described as 'good'. Several members of staff described the hospital as being like a family. Staff described themselves as enthusiastic about their job and looking forward to coming to work.

There were systems and processes in place to support staff to speak up if they were concerned about unsafe clinical practice. This included a whistleblowing policy. All staff were able to access this. The hospital had a Speak up Guardian and had set up monthly meetings with staff to provide consistent support. During the COVID-19 crisis staff had access to additional psychological support either with the clinical psychologist or the chaplain.

Staff survey results showed staff felt the organisation would support them to speak up and address any concerns that they had.

Most staff felt the hospital was dedicated to diversity and inclusiveness and at the time of our inspection 12.5% of board members and 37.5% of the management team were from BAME backgrounds.

Governance, risk management & quality measurement

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The hospital had governance processes in place to ensure the reporting, escalation and review of risk and performance information. The service had a risk register which was discussed and reviewed at monthly management and risk management meetings. Risks were rated red, amber and green to help identify priorities. Clear mitigation action plans were in place for each documented risk. This information was reported to the clinical governance group and the board of trustees on a quarterly basis.

The risks identified by the service reflected the risks identified by staff and included infection control, verbal and physical assaults on staff by patients, risk of falls and the impact of COVID-19. The service recognised and mitigated risks appropriately.

All staff could access the incident log and the risk register on the shared drive. Staff were able to describe the main risks to the service and learning was shared through team meetings and handovers.

Managers monitored performance indicators including serious incidents, infection control, rehabilitation outcome measures, agency staff use and duty of candour reporting. Members of the MDT took part in audits which were reported on a quarterly basis with recommendations to address any issues identified. Performance indicators were discussed at the monthly management and risk management meetings to monitor progress and identify any barriers to mitigating issues identified.

The service had a shared drive which all staff could access. Each ward had a nurse's station with computers available for staff to update records and check emails. However, we observed information being stored in different places as the

hospital used paper and electronic records and it was not clear what information was stored where. This was a risk that was not recorded on the risk register. There was a quality improvement project working on migrating paper records over to electronic records. The hospital quality account report 2019 – 2020 indicated this would take two to three years to complete but would help in decision making and to improve patient welfare.

The hospital had clear governance processes in place. The service held monthly risk management and weekly operational management meetings. Both meetings reviewed contract performance, bed occupancy and acuity, staffing issues and general oversight of operations and risk. Quarterly clinical governance meetings were attended by members of the board of trustees and reviewed the risk register, dashboard reports and reports from all directorates. Members of the MDT attended risk management and clinical governance meetings on a rotational basis and were responsible for feeding back any issues to and from frontline staff.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The hospital UKROC data was monitored through the quarterly audit report and demonstrated that the service delivered good outcomes for patients and the wider health and social care system.

The service had a comprehensive audit programme which involved members of the MDT taking responsibility for specific areas. Audit outcomes were fed into a monthly dashboard and quarterly performance and quality report and the quarterly audit reports. The quarterly audit report included learning, actions and recommendations.

Audit data including the quarterly reports was available for staff to access on the shared drive. The clinical lead nurse discussed performance and learning in team meetings.

The registered manager was responsible for submitting notifications and did so in a timely manner. This information was recorded on the incident log. Data was also shared through reports and in person meetings with the board of trustees and the commissioners.

We reviewed minutes of management, risk and clinical governance meetings, the dashboard report for May 2021, the Q4 2021 quarterly performance and quality report and the audit report covering January to March 2021 and found there was clear recording of information, updates and actions.

Engagement

Leaders and staff actively engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to improve services for patients.

The Mildmay Mission Charity fundraising team managed a comprehensive programme of activities they adapted and continued throughout the pandemic. High profile supporters of the charity helped to raise the profile of the organisation.

Good

Community health inpatient services

The hospital collected feedback from patients either through face to face discussions with actions taken immediately or through a patient survey form. The hospital used PLACE (Patient-led Assessments of the Care Environment) to provide motivation for improvement by providing a clear message directly from patients about how the environment or service could be improved. The most recent PLACE inspection identified improvements were needed to be made to the food service. The hospital was working to improve menu choices and the food service overall.

The information officer recently designed a new, user friendly survey form to encourage patient feedback. Data collected from patients in quarter 4 showed high levels of satisfaction in relation to hospital cleanliness, the care received, being treated with dignity and respect and being informed on how to make a complaint. All patients who completed the survey said they would recommend Mildmay to a friend or family member.

Continuous staff support was identified as a service priority for 2020/21 in the quality accounts report 2019 -2020. There had been an increased risk of verbal assault by patients to staff following the implementation of the homeless pathway. The hospital made it a priority to make sure staff were trained in managing challenging behaviour as well as proving other forms of support such as counselling sessions and one to one discussions with the Speak Up Guardian.

The hospital conducted anonymous staff surveys on a quarterly basis. The results of this were reviewed at the management meetings and action plans developed if needed. The survey results for April 2021, completed by 87% of staff, showed most staff were very positive about the service despite the challenging year it had faced. Staff reported enthusiasm for work and thought management recognised their contributions whilst at work.

Innovation, improvement & sustainability

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

The hospital was the first to offer a stepdown pathway for the homeless population of London. The hospital stepped in at the start of the pandemic to alleviate the burden on the NHS and provided rehabilitative healthcare for people who were homeless or sleeping rough and who were recovering from illness or injury. The service also created a COVID- 19 care pathway providing a safe place for up to two patients to self-isolate. The creation of two additional patient pathways meant the hospital continued to stay open and patients requiring HIV related rehabilitation continued to be able to access this.

Staff were passionate about the sense of community the hospital had created, comparing colleagues and patients to a family. The hospital worked with volunteers and employed a volunteer coordinator who supported new volunteers. Volunteers had a broad range of roles including supporting patients to attend appointments in the community and collecting medication from pharmacies. Volunteering had continued throughout the pandemic with processes being adapted in accordance with government guidelines. This had benefitted patients.

The hospital UKROC data was monitored through the quarterly audit report and demonstrated that the service delivered better rehabilitation outcomes patients and cost savings for the wider health and social care system

The hospital had a complaints and incident reporting system processes that supported continuous learning and improvement. This included staff de-briefs and incident reviews.

Good

Community health inpatient services

The service had systems to make sure learning was shared with all staff groups. Staff told us they were updated following incidents and complaints through their team meetings and handovers. We saw evidence of practice changing following concerns raised about Personal Protective Equipment (PPE) by nursing staff in team meetings.

The hospital was committed to quality improvement (QI) and set QI objectives for each coming year. For example, a project to create a patient electronic record system to better meet the needs of patients and demonstrate the outcomes the service could achieve. By March 2021 the project had replicated the existing patient administration system and added clinical functionality. This project was expected to be completed by the end of 2021.

The service carried out annual PLACE (Patient Led Assessments of the Care Environment) inspections. The most recent inspection identified areas for improvement in the food service. A group involving clinical and non-clinical staff had been set up with the specific objective to make the necessary changes required. Progress would be monitored though a regular forum to discuss ongoing improvements based on concerns from patient feedback.