MILDMAY

Transforming the lives of people living with HIV

Mildmay UK Hospital Services and Referral

www.mildmay.org

Registered Charity No: 292058

Our Vision

A world in which everyone living with HIV can have a life in all its fullness.

Our Mission

To respond effectively to HIV and related health issues, through specialised care, treatment, training, education and research.

We aim to deliver services of the highest quality and constantly seek to improve through listening, reflecting, learning and action.

Contents

Introducing Mildmay

Mildmay UK is a charitable HIV hospital that is an NHS service provider, located in East London. We provide treatment, services and care for people with complex HIV associated health conditions and are the only centre in Europe dedicated to rehabilitation of patients living with HIV Associated Neurocognitive Disorder (HAND).

We are a specialist HIV unit and receive funds commissioned by Clinical Commissioning Groups. The majority of our contracts are within the M25 region, but we accept referrals from all over the country.

Mildmay's highly skilled medical and nursing care, treatment and rehabilitation is based on individual need. We combine a range of therapies alongside input from our multi-disciplinary team which provides a holistic model of support.

HRH Prince Harry on his visit to officially open Mildmay Hospital

Our Impact

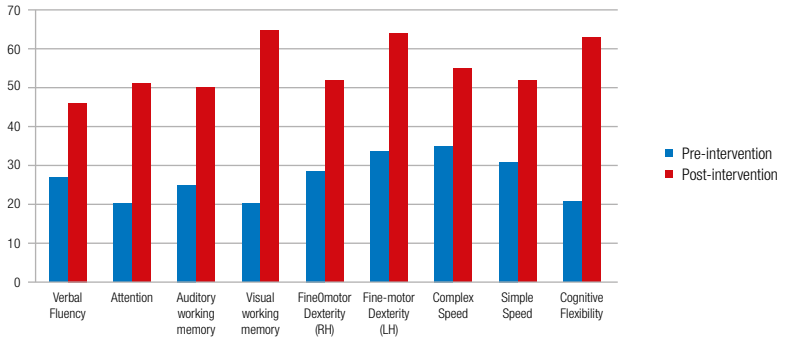
Rehabilitation work in Mildmay's gym

OT assessment

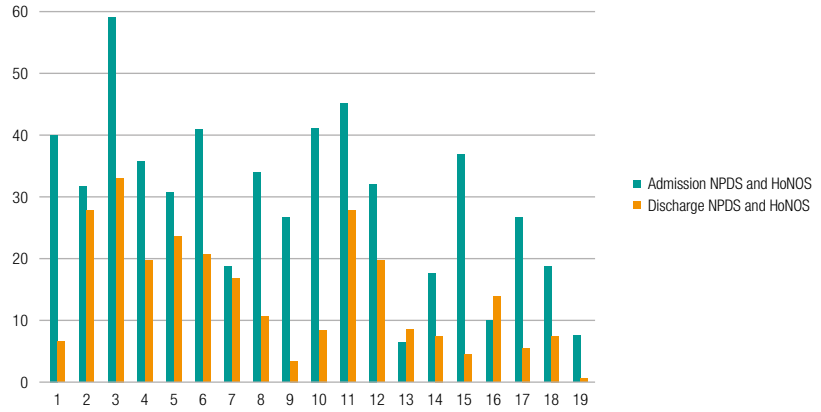
- 80% of patients are able to return to independent living at discharge from Mildmay.
- Working with our multi disciplinary team, patients are encouraged to set their own goals and work towards the rehabilitation outcomes they have identified as being important.
- We work in partnership with organisations and consortia (including NHS and other HIV service providers) to facilitate ongoing excellence in clinical care.
- We provide a safe, confidential and stigma free environment, enabling patients to address and work through many specific issues relating to their HIV diagnosis and treatment. As well as accessing our services, patient recovery is further enriched by the peer support available through informal and formal groups.

There are a number of international studies (example given below) demonstrating an improvement in cognitive abilities of patients diagnosed with HAND pre- and post-Intervention.

S.B. Rourke, T. Sota, S. Rueda, M. Atkinson, Cognitive Rehabilitation (use of cognitive neuro-rehabilitation approaches) in HIV/AIDS, CAHR 2007



Measuring rehabilitation outcomes – Comparison of Admission and Discharge scores (NPDS & HoNOS-ABI combined)



Rackstraw et al. A preliminary investigation of the use of a 'basket' of outcome measures within a rehabilitation service for adults diagnosed with HIV-related neurological disorders. Abstract 5.8, 10th AIDS Impact Conference, Santa Fe, USA; September, 2011

In addition to the above tools which measure 'need' and 'outcome' there are two further tools in use that measure the 'input' provided - Nursing and Therapy dependency scales.

Led by the Medical Director we frequently present at UK and international conferences, where we are able to substantiate the ongoing effectiveness of our service.

Our Multi-Disciplinary Team

Our multi-disciplinary team is led by our Medical Director, Dr. Simon Rackstraw. We combine a range of therapies and disciplines to provide a holistic model of treatment that ensures that patient care is individually tailored and empowers patients to participate in meeting their goals.

Our team consists of:

- HIV liaison psychiatry
- junior medical staff
- nursing (RMN, RGN)
- rehabilitation assistants
- occupational therapy
- physiotherapy
- speech and language therapy
- neuropsychology
- dietetics
- social care
- chaplaincy
- our volunteers

Our Facilities

Our facilities include:

- Twenty six beds in large single rooms, all with en suite facilities
- Two wards across two floors. Each ward has a communal lounge, fully equipped kitchen, assisted bathroom and secure entry/exit system
- Occupational therapy assessment centre – enabling our OT team to assess patient's activities of daily living
- Well-equipped physiotherapy gym
- Day Services centre with treatment rooms, creativity space and lounge
- Digital Inclusion Suite
- Our own in-house catering team and kitchen
- Separate Dining Room
- Newly created tranquil garden space
- Meeting rooms which are also available for hire

Inpatient Services

Mildmay offers a range of Inpatient Services. Medical care is offered 24 hours a day, seven days per week. Inpatients are also able to access additional services offered by our Day Service Unit, including computer training, art, music and horticultural therapy.

All patients are encouraged to be actively involved in their own goal setting. Care plans are formulated on an ongoing basis, taking into account the wishes of the patient and the expectations of the referring clinician.

Mildmay's approach includes a variety of clinical and social assessments and tailored interventions by its multi-disciplinary team.

Day Services

Our integrated team works with clients to develop goal orientated plans which seek to maximise independence, promote the acquisition of skills and build confidence. The programme of activities can strengthen abilities and promote better maintenance of physical, psychological, cognitive and emotional well being within the community. This can lead to improved ability to use and be part of community services, and reduction in incidences of re-admission to hospital due to non-adherence.

A structured pathway of continued rehabilitation enables clients to fulfil and maintain their maximum potential within the community. We provide patients with community based rehabilitation, developing the life skills needed for day-to-day living.

Referrals and Access to Mildmay

You can make a secure referral directly from our website **www.mildmay.org/uk-hospital/**

Or, you can make a referral, or discuss a patients admission with our Admissions Co-ordinator by calling **020 7613 6347** or emailing **admissions@mildmay.org**.

To find out more information or to discuss tariffs for the following Pathways please contact the Admissions Co-ordinator as above.

Admissions to Mildmay

There are three pathways for in-patient care and two pathways for Day Care Services at Mildmay. Across all three pathways there is a strong emphasis on patient involvement. Care is delivered by specialists working as individuals and as a team to ensure the best outcomes. We work with and involve all relevant external agencies and the patients families to ensure that the patients short term goals are met and that their long-term goals are identified and worked towards during admission and then continued after discharge from Mildmay.

In-patient Pathways

Pathway One
Referral for both HIV Associated Neurological Disorders (HAND) and Complex Rehabilitation

- Patients requiring admission for HAND are admitted for a minimum of four weeks. The average length of admission is 12 weeks.
- Patients requiring admission for Complex Rehabilitation are also admitted for a minimum of four weeks. The length of stay is dependent on need and treatment.
- All patients accessing Pathway One have input from all members of our Multi-Disciplinary Team (MDT) as required. This includes: specialist HIV consultant, psychiatrist, medical team, nurses, occupational therapists, physiotherapists, dieticians, speech and language therapist, neuropsychology, social care and chaplains. Our experienced team of volunteers also offer befriending and patient support as appropriate..
- A patient's initial care needs are assessed within the first three days of admission by the relevant disciplines. A key-worker is then appointed from the MDT. Patients care and rehabilitation is planned and implemented with the involvement of the patient and with liaison with the referrer. Continuous assessment and evaluation of the patients short and long-term goals is made by each specialist team and includes weekly MDT meetings led by or specialist HIV consultant.
- All patients in this pathway have Discharge Planning Meetings (DPMs). These are held every three to four weeks with the relevant internal and external staff and carers,to discuss the patient's needs, progress, future needs and discharge options.

Pathway Two
Minor Rehabilitation/Respite

- Patients requiring Minor Rehabilitation/Respite are usually admitted for two weeks but can be admitted for a minimum of one week. Extensions can be granted for longer admission time if there is an identified need.
- Patients in this pathway are usually admitted for psychological support, adherence support, rest and recuperation and symptom control.
- On admission patients are assessed by the medical and nursing team and a named nurse is allocated. If need is identified some patients will be referred on to our MDT, However, the length of the admission for this pathway means that most of the specialist care will be administered by the medical and nursing teams with support from the MDT.
- Patients needs and goals are discussed at the weekly ward rounds and in liaison with the referrer.

Pathway Three
End of Life/Palliative Care

- Patients requiring this pathway will always be allocated the next available bed. This is the only pathway with no fixed time length.
- Patients are assessed by the medical and nursing teams and are allocated a named nurse. Referrals for specialist input by our MDT will come from the nursing and medical assessments to ensure that there is excellent pain and symptom control and treatment.
- Care, needs and input are discussed weekly in the ward rounds.

Day care services

By focussing on health, wellbeing and what each person can do, not what they can't, we enable people to live their lives as fully as possible.

There are two Day Care Pathways

Rehabilitation and Transitional Pathway

- A 12 week rolling programme of rehabilitation.
- Designed to continue improvements in function and mobility. By focussing on health, wellbeing and what each person can do, not what they can't, we enable people to live their lives as fully as possible.
- Our rehabilitation programme Includes group and 1:1 sessions across a programme devised by our specialist multi-disciplinary team and delivered by the Occupational Therapist, Physiotherapist, Social Care, Clinical Psychologist and Rehab Assistants.
- Provides a transitional rehabilitation programme from in-patient to greater independentance at home.

Long-term Support, Maintenance and Admission Avoidance Pathway

- Offers a safe and secure environment to offer activities along with a gentler stream of rehab.
- Includes group and 1:1 sessions across the rehab and activities programme devised by our specialist multi-disciplinary team and delivered by the Occupational Therapist, Physiotherapist, Social Care, Clinical Psychologist and Rehab Assistants.
- Designed to offer regular intervention, observation and assessment to reduce the number of acute centre admissions experienced by vulnerable adults.

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Mildmay UK Hospital Referrals
Tel: 020 7613 6347

Download a referral form at
www.mildmay.org/uk-hospital/

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