This is CNWL
2018-20
www.cnwl.nhs.uk
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In this booklet we set out what we’ve done over the last year and our plans for the coming year. There’s more detail on our website in our Annual Report – www.cnwl.nhs.uk/about-cnwl/planning-performance

Tell us what you think!

Claire Murdoch CBE
Chief Executive
@ClaireCNWL

Professor Dorothy Griffiths OBE, FCGI
Chair
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CNWL is a large community facing Trust, caring for people with a wide range of physical and mental health needs in a variety of settings (hospitals, clinics, schools, homes, prisons) for every age.

We also provide specialised services to communities.

CNWL’s overall CQC rating is “Good” – with outstanding features.

The Trust is ‘outstanding’ for caring and ‘good’ for being safe, effective, well-led and responsive.

Of the 17 licensed services across community and mental health services, all are ‘good’, with two – Sexual Health and Learning Disability services – ‘outstanding’.

We have nearly 7,000 staff providing a range of mental health, community, learning disability, substance misuse, sexual health, dentistry and specialised services to a population of around three million in the South East of England, including in North West London, Surrey, Kent, Milton Keynes and Buckinghamshire, treating over 360,000 people either in the community or as inpatients.

Vision and values

Our vision and values underpin everything we do.

Our vision

Wellbeing for life

We work in partnership with all who use our services to improve their health and wellbeing. Together we look at ways of improving an individual’s quality of life, through high quality health and social care and personal support.

Our values

Compassion

Empowerment

Respect

Partnership
Services in the south of England

Services across London

- Sexual health services (SH)
- Learning disabilities services (LD)
- Addictions (A)
- Community services (adults and children) (Buckinghamshire: dentistry only) (CH)
- Mental health services (MH)
- Eating disorder services (ED)
- Prison healthcare and offender care services (O)
357,222 patients treated in the community

93,534 mental health patients

71,255 adults

10,572 older adults (over 65 years)

8,286 children (under 18 years)

115,696 sexual health patients

906 eating disorder patients

1,019 addictions patients

282 offender care patients

1,214 learning disability patients

71,694 children (under 18 years)

40,606 adults

35,692 older adults (over 65 years)

147,992 physical health patients

71,255 adults

10,572 older adults (over 65 years)

8,286 children (under 18 years)
4,612 patients treated in hospital

- 3,075 mental health inpatients (3,075 adults)
- 3,504 mental health inpatients (3,504 mental health inpatients)
- 27 learning disability patients
- 74 older adults (over 65 years)
- 355 older adults (over 65 years)
- 56 eating disorders patients
- 1025 physical health inpatients (1,025 adults)
- 122 adults
- 903 older adults (over 65 years)
We have **6,982 staff** across a range of disciplines

- **2,202** nursing, midwifery and health visiting staff
- **1,470** scientific, therapeutic and technical staff inc social care staff
- **458** medical and dental staff
- **1,374** healthcare assistants and other support staff
- **55** nursing, midwifery and health visiting learners
- **1,423** administration and estates staff
We have a diverse staff

- 53.77% White or White other
- 13.23% Asian or Asian other
- 22.69% Black or Black other
- 3.17% Mixed or Mixed other
- 3.08% Other Ethnic Group
- 4.2% Registered disabled
- 4.07% Undefined or not stated
- 76.93% Female
- 23.07% Male
Grenfell update

Last year we spoke of the response to the Grenfell fire on the night of 14 June 2017.

During 2018/19 we supported people during the inquiry.

The Grenfell Health and Wellbeing Service has become established and provides care for all those affected by the fire with a range of services including physical health checks, outreach, counselling and specific interventions around trauma. There are listening events so that residents can let us know what works and what else they need. The work and highlights of 2018/19 include virtual reality and wellbeing sessions.

As of June 2019 the Grenfell Health and Wellbeing Service Outreach Team report 16,410 contacts with 114 complex cases currently being case managed by them.

QI update

CNWL is pushing forward with Quality Improvement methodology – QI refers to making healthcare safer, effective, patient centred, timely, efficient and equitable through using a systematic change method and strategies.

More than a quarter of QI projects have service user and carer involvement.

- Active QI projects on Life QI 260
- Completed QI Projects 45
- Staff registered on Life QI 1163
CQC rates CNWL as **Good!**

Are services…

- Safe? **Good**
- Effective? **Good**
- Caring? **Outstanding**
- Responsive? **Good**
- Well led? **Good**
Your Life Line

2:00 Your Life Line receives a call from a daughter anxious at her mother’s distress. The mother has advanced cancer and over the last few days has deteriorated. The daughter thinks her mother is suffering and in pain and wants to call an ambulance to take her to hospital. She is known to both the Hillingdon Palliative Care Service and to Your Life Line. Looking at her notes through Coordinate My Care the team are aware of the mother’s preference to die at home. The team reassure the daughter and suggest that they come and see her and her mother.

2:30 The team arrive at the house. The support worker sits with the daughter and lets her express her fears; the clinical nurse specialist sits with the mother and reassesses her symptoms.

5:30 The mother dies at home, her symptoms controlled with her daughter present.

Single Point of Access

8:00 A service user contacts the Single Point of Access in suicidal crisis. The shift coordinator is a registered mental health nurse and their day began five minutes ago. They have not received a handover before an administrator, who answered the phone, hands them a Post-It note with a name and NHS number. The call is transferred to the shift coordinator as others begin to queue.

The moments that follow reveal several pieces of information. The caller is not currently receiving mental health support. They were recently discharged. They have been drinking heavily. They have taken an overdose. They will not go to hospital. The emergency services have exhausted all available options.

The next hour is spent negotiating, de-escalating and, even, pleading with the caller to enter treatment. Eventually they do.
9:00 A 31 year old female attended for a contraception appointment. During the consultation the mandatory domestic abuse question was asked, “Are you afraid of anyone at home or of any partner?”

Tentatively she responded “yes, possibly”. She disclosed that her partner was controlling. More questions were asked and following this the safeguarding lead called 24 hours later and a “Safe Life” assessment was undertaken.

As there were individuals aged under 18 living in the house a referral to Social Services was made.

9:30 Titration Clinic:
Newly assessed and prepped patients attend the service in a state of ‘physical withdrawal’ from their usual choice of illicit opioid addiction.

While a bit unpleasant, this allows the clinical staff to assess and prescribe a safe substitute such as Buprenorphine or Methadone which will alleviate the withdrawal symptoms within minutes.

This process also ensures that patients are not accidentally given excess opioids on top of what is already in their system. The patient will go on to be reviewed twice before they are stabilised on a therapeutic dose.

9:30 Two health promotion specialists have a booked session at a Drug and Alcohol Service in Islington from 9.30am to 12.30pm. They set up in two places a private and confidential room for consultation and screening and also set up a health promotion table in the main space of the service to engage with clients.

Following the session, staff return to the Mortimer Market Centre to process samples and admin from the session.
Central Criminal Court

Our clinical nurse specialist receives a telephone call to attend the court room. The judge requests a fitness assessment on a defendant who has been charged with murder. He attends the court room at 2pm with his written report following the assessment undertaken in the cells.

The judge requests the clinical nurse specialist contacts the consultant psychiatrist for the team for a further report. He joins the consultant for the assessment and contacts another consultant psychiatrist for a second opinion as requested by the Crown Prosecution Service.

This second opinion takes place and the two consultants produce a joint statement for the court about their findings and the trial continues to a conclusion.

Community Independence Service Rehabilitation Team

Two CIS rehab occupational therapists (OT) meet a patient and her two carers at her home to try out her new hoist and chair.

Since she came out of hospital four weeks ago the patient has been cared for in bed. She has been working on exercises with the CIS rehab physiotherapist and rehab assistant, which have included her rolling from side to side in her bed to build up her core strength. She is now able to participate more actively in her care, as the carers put the sling of the hoist around her.

The OTs show the patient how to use the hand controls of her new hoist and with their close supervision she hoists herself out of bed and into her new riser-recliner arm chair. This is the first time she has sat out of bed in months and as her feet touch the floor she says “this feels strange actually!”. The OTs update the care plan and share it with the carers, if she continues to be able to hoist herself there’s a good chance that Adult Social Care Reablement services can reduce the amount of carers supporting her every day.
10:30 A patient arrives at the service from another establishment. Our on-site pharmacist is told he is currently receiving treatment for Hepatitis C using a specialist medication initiated by hepatology.

The medication is high cost (about £36,000 for a 12 week course) and on the ‘red list’ of drugs only available through the relevant clinic or specific home delivery services. However he has not come with his medication so there is an urgent need to source this medication so the patient can continue their course with as little interruption as possible.

Eventually our pharmacist is able to locate medication and also discovered that the patient had only been with the previous establishment for 24 hours as he was an onward transfer from another establishment.

This establishment is contacted to get details of the prescribing clinic and the specialist nurse is emailed to find out what they need done for care continuation.

Our pharmacist then liaises with local clinicians to request liver function tests and ultrasound as requested by the hepatology team.
10:45 The prison calls a ‘Code Red’ on House Unit Two to attend an incident on the wing where a prisoner has caused self-inflicted injuries to his neck with a razor. A ‘Code Red’ means the Control Room automatically call an ambulance and they are requesting more information.

There is a nurse on the wing already and Hotel One – an emergency care technician – responds from his current location in the prison.

A prison officer brings the wing-based medical emergency bags. Senior healthcare staff arrive to offer support and clinical leadership. Staff on scene finds the prisoner is fully alert.

There is blood on the bed and floor of the cell. He has a large incision on the right side of his neck. It’s gaping and bleeding freely. He is holding a t-shirt to the wound. On examination of the wound, vessels and underlying structures are visible but intact. The prisoner’s observations are stable with no signs of shock.

Decision is taken for the Doctor on site to suture the wound with assistance from the practice nurse in Healthcare. Hotel One informs Control “stand the ambulance down, we can manage this”.

12:00 Staff set up the dining room for lunch, but a patient is unable to eat the meal. Staff and peers gather around the table offer support reminding her of her goals.

She walks out of the dining room and goes back to her bedroom, refusing to come back. Staff check to see how she is as completing meals is non-negotiable.

She is given the option of returning to the dining room to complete the meal or offered a nutrition drink as a supplement or through Naso Gastric Feeding. The patient opts for Naso Gastric Feeding, which is then administered by nursing staff.
14:00 The Home 1st Therapy Team return from a home visit. They are concerned for a patient’s safety. An emergency team meeting is therefore called to discuss options.

It is quickly concluded that the risks of remaining at home remain too high, but there are only two community rehab beds available; one is already earmarked for another patient, the other is in a unit whose staffing levels are such that they may not be able to cope with another patient with high management needs.

It is decided this is the best option for the patient but this means extra staffing needs to be arranged for the unit as well as a specialist mattress sourced, which requires a special out of hours request to be made to the equipment store.

Three hours later, Home 1st is told that the patient is safely on the unit.

15:00 A school nurse has been called into a school in Camden to follow up the wellbeing of one of the pupils who attended A&E after injuring his arm on some broken glass.

She provided emotional support to this pupil a few months after he was involved in an incident between his mother and her partner, which resulted in the police being called.

She is concerned that this injury is connected to this previous incident. She meets up with the pupil in a private space and undertakes a universal screening of his emotional health. The pupil reveals that the fighting has continued between his mother and her partner and the injury was caused while trying to protect her as he was concerned that her partner was likely to hit her.

She contacts the Camden child protection adviser. She also seeks the pupil’s consent to talk to his mother and head of year to make sure that the pupil is helped to feel safe at home and the school know how to support him.
15:30 A GP rings with concerns about an individual who wishes to harm himself.

We explore any support networks from the GP/ social services/ other providers like care providing agencies.

After establishing the actual extent of concerns and urgency, we visit the individual and establish the risks and decide if we can support the individual in their own living environment or we need additional support ranging from social care to hospital admission. Based on information we gather, we visit that same day and put in place a support programme.
16:00 A 15-year-old boy attends A&E after taking an overdose of his dad’s medication with the intent to end his life. He was referred to the Urgent Care team at 5.15pm and was assessed an hour later by a CAMHS practitioner.

The teenager was seen alone initially and his parents joined for the latter part of the assessment. He reported struggling for the past six months since moving to London. He was hearing a negative voice telling him to do things.

He felt life was not worth living, felt unmotivated, and had had poor concentration, poor appetite and poor sleep for the past six months. He denied any issues at school and at home, other than his parents both worked long hours.

While speaking with the CAMHS practitioner he regretted his actions and denied wanting to end his life. His parents agreed they worked long hours and this added to his isolation since they moved to London. Coping strategies and a safety plan was agreed together.

The CAMHS practitioner discussed this plan with the CAMHS medic on duty at 8.25pm and provided a handover to the nurse in charge in A&E so that he could be reviewed by their team prior to discharge home.

An urgent follow up appointment made with the CAMHS Urgent Care Team. A referral was also made to Children’s Services. The boy and his parents were called the next day and an appointment made to be seen the same week for a seven day follow up review.
New referral received from the London Ambulance Service to the team based at St Pancras Hospital, Camden.

This is of an elderly patient who is usually independent but who has had a fall sustaining bruising, no fractures or head injury. She has lost confidence and is in pain – the paramedics feel she needs extra support in the community to avoid an admission to hospital.

The service agrees to see the patient at her house within two hours of receiving the call. On arrival of a physiotherapist a full assessment is completed to identify what support she needs to continue living safely at home to try to avoid an admission.

With the patient, it is agreed she would benefit from a walking frame, a care package morning and evening to help with personal care and meals, and a commode for toileting downstairs to avoid using the stairs all day, which is now too painful.

The GP is contacted and painkillers are prescribed, collected and delivered to the patient. This is all organised the same day – first carer visit and all equipment delivered that evening.

The patient is complaining of dizziness on standing so the rapid response nurse visits and diagnoses postural hypotension – they advise an increase in fluid intake which is passed to the carers – and a temporary hold of water tablets in communication with the GP.

After five days of regular monitoring of pain and mobility, her pain is better controlled, she is more independent with stairs and meals, water tablets are restarted and the care is reduced to once daily and handed over to social services to take over. An onward referral is made to the community rehab team to progress the patient back to mobilising without her frame and make an onward referral to the Camden Falls group once she is ready.
Key issues and risks

These are identified in our corporate risk register – the highest level register of the Trust. We have plans to manage the risks.

- Maintaining and improving quality of services, while managing the financial and workforce challenges. Savings plans are checked for impact; we listen; QI programmes are improving care.

- Workforce: We have a recruitment strategy based around recruitment, retention and redesign.

- Partnership and governance: Legal and regulatory obstacles to partnership; new contracting processes and changes for staff. Growing experience of successful partnership development.

- Financial health and viability: We have a robust financial plan in place.
Income
£508.2m

Expenditure
£519.9m

from...
Clinical Commissioning Groups (CCGs) and NHS England £400.5m
Local authorities £48.4m
Other operating income £42.9m
Other NHS providers £10.6m
Department of Health and Social Care £5m
Non-NHS other £0.7m
NHS other £0.05m

from...
Staff £347.5m
Premises £35.3m
Drug costs £30.3m
Other £14.5m
Net impairments £22.8m
Clinical supplies and services £13.7m
Rentals under operating leases £12.4m
General supplies and services £10m
NHS healthcare services £5.1m
Depreciation on property, plant and equipment £6.4m
Establishment £5.4m
Non NHS healthcare £8.7m
Transport £4.6m
Research and development £3.2m
Our quality priorities for 2018-19

Every year we set priorities for improving service quality. We do this with our partners and in response to feedback.

The Quality Account for 2018-19 set out two quality priorities on ‘patient and carer involvement’ and ‘staff engagement’, using five quality indicators to show these had been achieved.

These two Quality Priorities have run for three years and we reported our annual performance and progress against each priority in our last two quality account reports.

The quality priorities were:

1. Patients and carers feeling involved, supported and taking ownership of the decisions about their care

2. A workforce which is committed, well-trained, well-supported, and above all, engaged.

We achieved our quality priority indicators.

A detailed description of the results and plans to address them are included in the full Quality Account on our website: www.cnwl.nhs.uk/about-cnwl/planning-performance
Quality priority one
Patient and carer involvement

We believe that the best health services are ones that are planned, shaped and delivered by patients, carers and staff working together.

Quality indicator one – Patients report feeling involved in their care or treatment.

Our target was 85% and at year end, 96% of patients told us that they definitely or to some extent involved in their care or treatment, an increase of one percentage point on 2017-18.

Quality indicator two – Patients report their care or treatment helped them achieve what mattered to them.

Our target was 85% and at year end, 96% of patients told us that they definitely or to some extent involved in their care or treatment, an increase of one percentage point on 2017-18.

Achievements

- Patients and carers are overseeing CNWL services through Trust-wide and local governance groups
- Patients and carers are leading the way in making local changes
- Patients and carers are becoming increasingly involved in Quality Improvement (QI)
- Patients and carers are running local social and wellbeing groups
- More service users are being trained to use their experience to inspire and support others
- Patients and carers are helping us recruit compassionate, respectful staff
- Patient and carer stories are being used to influence practice.
Quality priority two
Staff engagement

Staff engagement is central to delivering a quality service. We undertook a number of actions to ensure our staff feel well supported, trained, committed and engaged. To understand whether our actions were having the desired impact, we sought feedback from staff using the Staff Friends and Family test. We also monitored our staff turnover. We have made progress on staff turnover, and note that this improvement has been sustained.

However, our scores on staff recommending CNWL as a place to receive treatment and work remain lower than we would like; albeit that this year we had our highest quarterly scores of the last two years.

Staff engagement, while not one of the Quality Priorities next year, remains of the highest importance for the Trust. We are finalising our new People Strategy and associated actions that will primarily be aimed at improving staff engagement.

Quality indicator one – Staff recommending the Trust as a place to receive treatment.
We set ourselves a target of 70% measured through the Staff Friends and Family Test and the national staff survey. We achieved 68.9% – so have more to do.

Quality indicator two – Staff recommending the Trust as a place to work
We wanted at least 70% of our staff to report that they would recommend the Trust as a place to work. We missed our target, achieving 57.7% compared to 56.6% the previous year. We know we have more to do.

Quality indicator three – Reduce our staff turnover
We wanted to reduce our turnover to 15% and while we did not meet this target we have made progress, with turnover being reduced to 16.6% compared to 16.4% the previous year.
Quality Account priorities 2019-20

We consulted widely with our stakeholders (both with staff and the community) and held a consultation event and agreed to focus on four Quality Priorities for the year ahead:

1. Reducing Falls
2. Improving the Management of the deteriorating patient
3. Reducing violence and aggression for staff and patients
4. Improving the quality of supervision

We also agreed to plan on meeting these priorities over three years to make sure we sustain improvements, while continuing the conversation with our stakeholders so they remain sighted on our progress.
Quality Priority one: Reducing falls

An assessment for all inpatients over 65, which identifies the patient’s individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay.

Year 1
We will use an audit of current falls risk assessment practice to inform a “Falls Risk Assessment” QI programmes.

Year 2
The programme will be managed by the CNWL Falls Board and it will have oversight of the relevant division-specific QI Projects.

The aim of the programme will be to improve completion of Falls Risk Assessment on admission to 85% by March 2021.

The Falls QI programme will aim to improve the quality of interventions delivered to those at risk of falls.

Year 3
The Falls QI programme will extend its remit to include completion of falls risk assessment by CNWL staff working in Integrated Community Services.
Quality Priority 2
Improving the management of deteriorating patient

We want to reduce the risk to patient’s physical health by making sure that a patient’s deteriorating health is identified early and promptly managed.

Year 1
We will roll out NEWS2 – the early warning tool to detect signs of deteriorating physical health and ensure appropriate prompt action is taken. This involves a training programme. We will review and update our policy, procedures and training on emergency responses.

Year 2
We will roll out a revised approach to management of emergency responses and make sure the structure and resources are fit for purpose. We will make sure competencies are in all new job descriptions for staff joining the Trust.

Year 3
We will make sure there is an internal reporting framework to help monitor progress in managing our most unwell patients so we can measure the progress of our three year plan.
Quality Priority 3
Reducing violence and aggression

Incidents of physical assault are the most common type of incidents reported within the Trust. Our priority aligns to the national strategy of reducing incidents of violence against staff and wider patient safety initiatives that reduce the use of restrictive interventions.

We want to reduce incidents of physical assault involving staff and service users (Trustwide) by 30% by 31 March 2022.

Year 1
We will co-produce (at Ward, Service and Trust levels) a vision and a structure and strategy for violence reduction using a Quality Improvement (QI) Approach. We will build capability and capacity for QI for Safety Improvement.

Year 2
- Review progress at early adoption sites.
- Develop spread to other services where improvement is required
- Build capability and capacity for QI for Safety Improvement.

Year 3
- We will review progress of improvement work at Ward and Service levels using the descriptive statistics and tools for measurement like run charts
- We will identify areas of achievement and success
- Build capability and capacity for QI for Safety Improvement.
Quality Priority 4
Improving the quality of supervision

Supervision is an important part of staff support and professional development. It provides an opportunity for staff to reflect on and review their practice, discuss individual cases in depth, change or modify their practice and identify training and continuing development needs. Supervision underpins the very essence of good care.

People who use our services will experience safe, effective treatment and care because all staff are supported to carry out their roles through high-quality supervision.

In Year 1 we will:

• Review and re-issue our Policy Standards for Supervision, providing clear definitions of clinical supervision

• We will clarify individual responsibilities about Supervision and reinforce the importance of reflective learning in improving the quality of care

• We will pilot the use of the CNWL Learning and Development Zone (LDZ) to support managers in recording and tracking supervision

• Concurrently we will re-evaluate current arrangements in all Divisions to identify best practice and any gaps.

• Review current provision of Supervision training and establish a consistent Trust-wide programme.
In Year 2 we will:
- Complete QI supervision projects in each Division. These will be based on a priority set in Year 1
- Hold a Supervision Best Practice Summit to share learning and celebrate best-practice and progress
- Develop supervision to ensure it takes an developmental approach to staff wellbeing
- We will survey staff on their experiences of supervision and use that learning as part of our Year 3 review and continuous improvement.

In Year 3 we will:
- Re-evaluate supervision-arrangements in all Divisions to check that all staff are receiving Supervision, which meets their needs, in line with Trust and professional standards.
Our priority programmes 2019-20

CNWL submitted our one operational year plan to NHS England and NHS Improvement (NHSI) in early April 2019.

CNWL’s objectives remain as in previous plans, Quality, Workforce, Partnership and Development, and Finance and Efficiency.
The context of this plan is:

- Another financially challenging year in 2019-20. Meet our control total – making savings of £15.3m, slightly less than 3% of CNWL’s income.

- The opportunities of the Long Term Plan (LTP) – its commitment to community, mental health and, above all, services for children and young people with ring-fenced funding worth at least £4.5bn across England.

- We will work with our commissioners and with NHS England and NHS Improvement to ensure that the full Mental Health Investment Standards are met.

- Our own ‘forward view for community services’. We set out our plans in an ambitious Community Health Services Strategy 2019-2024.

- A CNWL-wide transformation programme – organisationally and in partnership, developing models in each borough where we work.

- Partnership within our regional systems – the Sustainability and Transformation programmes (STPs) of North West London (NWL) and North Central London (NCL). Also, the Integrated Care System pilot across Bedford, Luton and Milton Keynes (BLMK).
Quality

• We have 300 QI projects underway and have a cohort of QI coaches to embed good practice further.

• We have met all our NHSI targets – supported by Tableau reporting to the front line.

• CNWL was an outlier in restraint and particularly prone restraint in 2017/18. This has improved so that we are now in the middle of the range (National Benchmarking).

• Mental health bed occupancy is at around 95% – from over 100% a year ago – and this is matched by a reduction in patients placed outside the Trust due to lack of beds.

• An inpatient ward for young people with mental health conditions opened in November 2018, reducing the need for young people to travel many miles for their care. During 2019-20, work will continue to develop further services to provide High Intensity Teams to support young people in the community. A unit for young people with a learning disability – Crystal Ward – opened in 2019-20.

• Work to transform sexual health services has shown clinical benefit with more people voluntarily accessing services.

• CNWL’s Club Drug Clinic was praised in the annual report of the International Narcotics Control Board (INCB).

• People who use our services and those who care for them have been involved in our transformation planning and have played a key role in the successful bid for Ealing through the group ‘We Co-Produce’. We have trained more than 75 patients and carers to take part in our recruitment and selection panels.

• Positive feedback from Friends and Family – reaching 95% in community services, and a slightly lower 88% in mental health.
Trust objectives 2019-2020

Workforce

• Our programme to recruit and retain staff has had clear impact in 2018-19. Focus on retention has included a programme to retain band 5 nurses for a year after they qualify. The staff survey, divisional events and back to the floor programmes have given front line staff opportunities to discuss their experience of work at CNWL and what would make it better.

• New roles include nurse apprenticeships and ongoing development of peer workers.

• Agency spend is below the 16% prescribed by NHSE with a rise in both bank and substantive opportunities.

• Equality and Diversity work includes implementing the Workplace Disability Equality Standard; sustaining improvement against our Workforce Race Equality Standard (WRES) metrics; maintaining place in Stonewall’s Top 100 LGBT+ Friendly Employers and strengthening trans awareness.

Finance and efficiency

• As well as coming in on target for our control total, we have addressed the value for money of our corporate services. We now have a number of self-service modules so people can directly access their own data on pay and conditions.

• This includes a review of the culture of corporate services – to ensure that all we do is directed towards the experience of our patients through those who directly provide their care.

• The Trust migrated our mental health records to SystmOne in January 2019.
Partnership and development

- Each borough is engaged in integrated models of care.
- A partnership with West London NHS Trust and others won the contract to provide community services in Ealing. The relationships which underpin this successful bid were developed through providing the Community Independence Service (CIS).
- The investment in ICT is paying off with the move to SystmOne across nearly all community and mental health services bringing about greater sharing and transparency both internally and externally.
Talk to us

Our members help make sure we’re providing the right services for the communities they live in.

We have over 15,000 members whose views are represented by governors.

The Council of Governors meets four times a year and governors also attend a number of additional meetings to contribute to Trust plans.

Our membership includes anyone who:

• Has used our services
• Has cared for someone who has used our services
• Is a member of the public interested in our work
• Works for the Trust.

Breakdown of our membership (March 2019)

2,301
Patients and carers

6,668
Public

6,536
Staff

Tell us, we’re listening

Our staff want to know how they are doing. Tell us what you think at www.cnwl.nhs.uk and then we’ll know what we have to do.