Our Quality Improvement Strategy 2016 - 2019

Delivering improvements in safety and experience for patients, families, carers, volunteers and staff.

A great place to be cared for; a great place to work.
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**Our Vision.**

We will constantly provide the highest possible standards of compassionate care and the very best patient and staff experience. We will listen to and involve our patients, staff and partners.
Foreword from Jackie Daniel, Chief Executive

This time last year I presented our first ever Quality Improvement Plan, setting out our aspirations over the course of the next three years to realise our ambition of making our hospitals great places to be cared for and great places to work.

At that point I described the journey that we had already undertaken in improving standards of care for our patients. The first year of our Quality Improvement Plan was largely focused around addressing the recommendations resulting from the 2014 Care Quality Commission’s Hospital Inspection. 12 months later, our progress has been rigorously assessed through both robust regulatory oversight and by the CQC’s re-inspection. It is pleasing to note that this has recognised the good improvements that we have made, albeit there is still more to do and we will incorporate the revised recommendations within the actions that are set out in our 2016 – 2019 Strategy.

I stated last year that I did not want our Quality Improvement Plan to become just another plan on a shelf, but for it to be a living, breathing document supporting our staff, governors, volunteers and partners to bring to life our ambition. So much has happened over the last year and I applaud all of our staff and partner organisations for the sterling work that has been achieved through working together for patients.

We have learned a great deal about ourselves and about what is important to patients and staff over the last year. When looking back at our quality improvement ambitions over the last year, it is clear that we have delivered a great deal.

It is now time to raise the bar and go further, in line with the achievements made so far. As such, I now present our refreshed Quality Improvement Strategy setting out our agenda for the next three years. The Strategy also describes the measurable outcomes we plan to achieve during 2016-17.

Our progress as an organisation has been built around 5 key strategic pillars that underpin everything that we do:

- **Strategy**
- **Quality & Safety**
- **Engagement**
- **Innovation & Performance**
- **Partnerships**

Our Clinical Service Strategy, Better Care Together, has been recognised as a pioneer for the new national models of care delivery and we have been awarded Vanguard status – we are continuing to work with our collaborative partners across the Bay to develop a radically new model of service configuration towards having a single Accountable Care Organisation providing health and social care to our local populations, delivering more care closer to home. Our joint approach is about delivering high quality, safe, and affordable services to the people of South Cumbria and North Lancashire.

Last year’s Quality Improvement Plan was focused on the immediate priorities arising from the 2014 Care Quality Commission inspection and in setting the baseline from which to develop our longer-term objectives and priorities. Our updated Strategy is just as explicit. All of the “must” and “should” do items arising from our recent CQC re-inspection form part of our Quality Improvement Strategy. It ensures we are clear on the measurable outcomes we expect, to ensure we progress towards becoming an outstanding Trust.

(Continues...)
We have seen significant improvements in organisational culture over the last 12 months, with the adoption of the “Listening into Action” approach a major lever in engaging front-line staff in making patient safety and quality improvements that matter to them. To sustain this momentum moving forward, we are continuing to develop and support further waves of improvement and have adopted the Listening into Action 7-steps process to address our ten biggest clinical safety, quality and service challenges this year.

We have reviewed our leadership structures and roles and responsibilities to incorporate recommendations made in the Morecambe Bay Investigation Report and to reflect updates of professional codes of conduct, regulatory requirements, and our Behaviour Standards Framework that has been developed and written by our staff.

Being in special measures means working with a level of scrutiny that adds pressure at every level of the organisation but it also provides opportunities for support from the wider system and development of relationships with partner organisations, third sector partners, and most importantly, with our staff, patients and wider public.

We will continue to adapt, to learn from our experiences and to improve - our Quality Improvement Strategy reiterates the Trust Board’s commitment to delivering high standards of safe, quality care to our patients, as well as providing a working environment and culture which promotes and welcomes honesty, safety first, openness, and compassion in everything we do.

Jackie Daniel,
Chief Executive.
Having a Behavioural Standards Framework that was created for staff, by staff, gives us all a clear picture of what is expected of us so that we can deliver safe, high quality services, day in, day out, for our patients.

Tom Plant, Service Desk Team Leader

#LeadByExample
Our Vision
We will constantly provide the highest possible standards of compassionate care and the very best patient and staff experience. We will listen to and involve our patients, staff, and partners.

Our Values

Our patients
Our patients will be treated with compassion, dignity, and respect. Their experience is our most important measure of achievement.

Our people
Our staff and volunteers are the ones who make a difference. They understand and share our values and this is reflected in their work.

Our partnerships
Our partnerships make us strong. By investing in them, we will deliver the best possible care to our communities.

Our performance
Our performance drives our organisation. Providing consistently safe, high quality care is how we define ourselves and our success.

Our progress
Our progress will be improved through innovation, education, research, and technology to meet the challenges of the future.
Using Human Factors to understand and improve how we behave and interact with others and the world around us, will help us to continually improve for the benefit of our patients and staff, and make our hospitals as safe as they can be.

Armineh Shahoumain, Learning and Development Specialist (Human Factors)

#LeadByExample
Defining Quality and Quality Governance

Quality

Our definition of quality encompasses three equally important elements:

- Care that is safe
- Care that is clinically effective
- Care that provides a positive experience for patients, their families and our staff

Working with patients and their families to reduce avoidable harm and improve outcomes

Not just in the eyes of clinicians but in the eyes of patients and their families

As evidenced by ‘I Want Great Care’, and Staff Survey and Listening into Action and Big Conversations

Focus on iWantGreatCare

iWantGreatCare lets patients leave meaningful feedback on their care, say thank you, and help the next patient.

- It’s a service that is independent, secure and trusted by patients, doctors and hospitals
- Feedback is provided on doctors, dentists, hospitals, GP practices, medicines, pharmacies, and nursing homes to ensure problems get fixed

For more information see:
www.iwantgreatcare.org/information/about
Quality Governance

Quality Governance is the combination of structures and processes at and below Trust Board level and these include:

- **Quality Governance**
- **Board of Directors**
  - Strategic priorities and objectives
- **Quality Committee**
  - Assurance and Challenge
- **Patient Safety Unit**
  - Rapid Response
  - Weekly Patient Safety Summit
  - Learning from Incidents
- **Audit**
  - Quality Assurance
- **Trust Management Board**
  - Operational Performance
  - Commissioning for Quality & Innovation (CQUIN)
  - Delivering Quality Priorities
- **Leadership Projects**
  - Linking learning to improvement priorities
- **Listening into Action**
  - Coordination of improvement activity

A great place to be cared for; a great place to work.
Using the Listening into Action approach, we were able to work together to make real improvements to the awareness and management of Acute Kidney Injury, and this really will save lives.

Dr Begho Obale, Specialty Doctor

#LeadByExample
Board of Directors:
The Board of Directors has overall responsibility for delivering services and is accountable for operational performance as well as the implementation of strategy and policy.

Quality Committee:
The Quality Committee provides assurance in respect of clinical quality and patient safety, effectiveness and experience through robust reporting and performance monitoring.

Trust Management Board:
The Trust Management Board provides assurance on strategy and risk management performance of the clinical divisions.

Quality Improvement Panel:
The Quality Improvement Panel coordinates improvement activity to ensure that resources are targeted to support key priority areas.

Patient Safety Unit:
Virtual team established to provide a rapid response approach to address urgent quality concerns.

Listening into Action (LiA) waves:
A comprehensive, outcome-oriented approach that engages staff in improving patient safety and experience, as well as staff experience. In addition to schemes developed and led by front-line staff, ‘Big Ticket’ schemes have been identified for large-scale improvements. The approach is supported through training in improvement skills and techniques.

Commissioning for Quality and Innovation (CQUIN) Schemes:
This is a programme of work focusing on delivering key quality outcomes for patients, rather than process outcomes. The delivery of schemes is via teams from across our clinical divisions supported by colleagues in information technology and governance, so that improvements in quality in specified areas of care are fully embedded in a sustainable way.

Audit:
Clinical audit is designed to improve patient outcomes across a wide range of medical and surgical conditions. Its purpose is to engage all healthcare professionals in systematic evaluation of their clinical practice against standards and to support and encourage improvement in the quality of treatment and care. Clinical audit is at the forefront of the Trust’s drive to improve patient care as the results of audit provide an invaluable insight into the quality of care being provided and areas for improvement.

Sign up to safety:
This is a patient safety campaign harnessing the commitment of staff across the NHS in England to make care safer. It is one of a set of national initiatives to help the NHS improve the safety of patient care. Collectively and cumulatively these initiatives aim to nationally reduce avoidable harm by 50% and support the ambition to save 6,000 lives.

Collectively and cumulatively these initiatives aim to nationally reduce avoidable harm by 50% and support the ambition to save 6,000 lives.
What are we trying to accomplish?

Our vision is to constantly provide the highest possible standards of compassionate care and the very best patient and staff experience.

The Quality Improvement Strategy is a rallying call for every single employee, volunteer, and governor to ensure that we deliver excellent care, every time to every patient.

Our aim is to create a culture of continuous improvement and learning which is both patient-centred and safety-focused. To do this, we must create the conditions where we:

- listen to and include the views of our staff and key stakeholders
- fully embed the Trust Values in everything that we do in order to ensure the working environment is conducive to enable continual improvement and innovation
- actively engage with and enable staff to lead and deliver measurable change for improvement
- focus on human factors - how we deliver care as teams
- are open and honest with people when things go wrong

We must also ensure that improvement is seen and understood to be everyone’s business by:

- expecting all teams and staff to be involved in improvement and innovation as part of their everyday business
- local teams regularly discussing lessons learned, innovation and improvement

We must ensure that we create the culture of learning, openness, transparency and candour that the Secretary of State supported in Learning not Blaming, responding to the Freedom to Speak Up Report, the Kirkup Report and the Public Administration Select Committee’s report into clinical incidents.

The outcomes of this plan link closely to those described in the Trust’s Quality Accounts and the Care Quality Commission’s (CQC) domains of safe, effective, caring, responsive, and well-led.

Whilst this Strategy and improvement plan will be delivered through the annual planning round, it is important that we continue to progress the big ticket items that will deliver improved outcomes.

Our current Quality Improvement Plan will continue to run as planned until the end of March 2016 and measurable outcomes for each priority can be found at the end of this document. Our Quality Improvement Strategy will focus on three key improvement outcomes. These are:

Better Care Together

**Better**

- Reducing mortality and harm

**Care**

- Providing reliable care

**Together**

- Improving patient and staff experience
Recognising the human dimensions of improvement

We recognise that at the heart of our approach to quality and safety improvement, there needs to be awareness of the interactions between people, and between people and non-human elements involved in complex systems. This is known as Human Factors.

By having a holistic view of Human Factors and better understanding the interaction between all the elements present in a system, we can improve our organisational culture through better communications and team decision-making, with a positive impact on patient care.

Human Factors is not a stand-alone solution, but rather a broad approach that ensures that people have a better understanding of how people are affected by the teams they work with, the systems they operate, and the environment they work within. It ensures that people know how the combination of the factors affects patient safety and wellbeing so that consistently safe and reliable care can be provided to our patients.

We have appointed a Human Factors Specialist to provide a focus for Human Factors across the Trust and have commenced development of a cadre of staff that have been trained in Insights Discovery, a powerful diagnostic tool designed to support staff to understand both themselves and others in the context of working better together.

As part of our leadership development programme, managers are undertaking a full diagnostics (including Insights Discovery) to support their understanding of their own and others behaviours, and the influence/impact that their behaviours have on others.

Our Behaviour Standards framework was launched in October 2015, setting out the expectations for all staff to take responsibility for their professional behaviour, to work effectively with others, and to challenge and be honest where they feel things are not right. This is a key element in establishing a Human Factors approach.

Other areas where the Human Factors will be adopted will be in supporting root cause analysis and review of clinical incidents through the weekly Patient Safety Summit, through incorporation of human factors into clinical skills training and simulation exercises, and the adoption of Schwartz Rounds (identification of team decision making issues, feelings, and targeting support to make improvements).

Focus on Schwartz Rounds

Around 100 health and care organisations in the UK are contracted to run Schwartz Rounds.

Schwartz Rounds are meetings which provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work.

Research into the effectiveness of Schwartz Rounds shows the positive impact that they have on individuals, teams, patient outcomes, and organisational culture.
The introduction of Human Factors will be through an approach that sees development in three tiers:

- Developing awareness
- Developing knowledge
- Developing expertise

1. **Developing Knowledge**
   - E-learning modules and taught interventions initially targeted at front-line clinical staff.

2. **Developing Expertise**
   - Bespoke, targeted interventions, such as Simulation Based Education (SBE), live coaching within the clinical settings, and virtual learning.

3. **Developing Awareness**
   - General awareness for all staff, through induction, Team Brief and integration in all development programmes.
Working together as a multi-disciplinary team, we have been successful in reducing device related pressure ulcers in a group of patients by 88%. This not only improves the patient’s experience but also means we’ve contributed towards reducing harm in our hospitals.

Claire Rawes, Ward Manager

#LeadByExample
Refining our approach to improvement

All staff at whatever level have a part to play in creating and delivering improvement for our patients and staff, thereby creating ‘a great place to be cared for, a great place to work’. We have developed our approach to growing knowledge and expertise around improvement tools and techniques as well as engaging and empowering staff to improve those things that matter most to them.

To create an improvement culture we want as many staff in different job roles to learn to feel confident in delivering improvement. Clinical and non-clinical staff and colleagues at every level of the organisation should be equally capable of leading change.

We will support our staff to deliver improvement with support from the Improvement Team. This approach will create capacity and capability. Our approach is:

- Common Language
- Engagement
- Support
- Emotional Intelligence
- Improvement Tools and Techniques
- Partnerships
Listening into Action is a proven approach utilised in many successful NHS organisations. Its method is to actively engage with frontline staff to improve the things that matter most to them. It empowers individuals and teams to improve the services they deliver to patients through a simple 7-step methodology.

It’s approach is simple; 7 key simple steps but delivered at pace that identifies and celebrates success however big or small. It can be applied in any setting with any group of staff. Its focus is on delivering the best care we can to our partners by supporting and unblocking frustrations for staff.

Listening into Action works by creating an energy to improve through “Big Conversations”, by supporting teams on their improvement journey and by spreading the approach through the celebration and sharing of achievements.

For the wider organisation the ability to pull staff from all areas to debate a focused piece of work such as creating a learning organisation creates a platform for staff involvement in key issues going forward.

Over the last twelve months, we have developed a model that combines the Listening into Action approach to engagement with training improvement tools and techniques, using the Institute of Health Improvements (IHI) “Model for Improvement”.

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**The IHI Model for Improvement**

**AIM:** What are we trying to accomplish?

**MEASURES:** How will we know if a change is an improvement?

**CHANGE:** What changes can we make that will result in improvement?
This strategy will only be successful if we continue to focus on developing improvement capability throughout our workforce and recognise, reward and celebrate those that are actively engaged in quality improvement activity.

Our aim is to create a resource of staff who have improvement skills and techniques and have applied them successfully. We will continue to provide improvement training for staff at all levels of the organisation.

To this end we intend to continue to provide cohorts of improvement training through Listening into Action schemes and through our Improvement Champions.

Staff involved will receive training through workshops and have an improvement idea to work on and deliver within 20 weeks. This delivers our **Bronze** Improvement Champion.

**Silver** Improvement Champions will be staff who have delivered on bronze and go on to either roll-out their improvement across departments or Divisions, or undertake coaching training to facilitate and support further bronze teams/individuals. They will begin to facilitate action learning sets and deliver improvement tools and technique training.

**Gold** Improvement Champions will be experts in engagement and implementing improvements and be able to manage change across boundaries.

Staff celebrated the improvements they had made at a Pass It On Event on Monday 22 June. They were the first Trust staff to complete their schemes and colleagues about to embark on their improvement work were able to hear about their successes first hand.

The Chief Executive led six Big Conversations with staff in December 2014. Giving staff the opportunity to discuss what frustrates them and gets in their way with making change. A further seven Big Conversations are taking place in Autumn/Winter 2015.
We take the safety of our patients very seriously, and reviewing risks and issues at the four times a day, seven days a week, safety meetings, means that we have started to change the culture to one where the patient is at the heart of everything we do.

Tim Keeler, Clinical Service Manager - Acute and Emergency Medicine
#LeadByExample
Looking back – our progress in 2014/15

During 2014/15 our teams delivered improvements for our patients and colleagues at an improved pace, and the Board of Directors commend front-line teams for the impact that this has had on patient safety, experience, and on staff satisfaction.

Some of these achievements are described below:

Reduction in mortality:
During 2015-16 mortality reduction has been sustained with hospital standardised mortality ratio (HSMR) showing that for 100 patients that die in an average hospital in England, between 80 and 90 die in ours. (See page 26 for an explanation of HSMR).

Reduction in harms:
The Trust has contributed to the national Safety Thermometer database, and during 2015/16 we have maintained low levels of harm. We now deliver between 92-94% harm free care across our services. We have reviewed the impact of continuing to measure falls, pressure ulcers, and infections on our quality outcomes and have decided that whilst we will continue to reduce these, the focus for the next year needs to be on improvements that will have a meaningful impact on our aim of reducing mortality and morbidity. For this reason, we have agreed through Listening into Action that improving outcomes in stroke, sepsis, and acute kidney injury will be the focus for the next year.

Improvement in patient flow and experience:
The Trust has, with support from a national lead on patient pathways, reviewed the flow and alignment of some of our key services across our hospitals. This was fundamental to us achieving the (4-hour) emergency access standard in quarter 2 of the year.

Reduced mortality levels
(See page 26)

We now deliver between 92-94% harm free care across our services.
Accreditation in Gold Standards Framework:
In 2015/16, a second ward in our hospitals achieved accreditation for excellence in quality of care for people nearing the end of life. At the time of accreditation, two of four wards accredited in England were in our hospitals. We aim to achieve accreditation in an additional ward over the next year.

Reduction in complaints:
Whilst we continue to receive and learn from complaints about our services, we are delighted that formal complaints have reduced by 25% and informal Patient Advice Liaison Service (PALS) concerns by 19%. We will continue to work to reduce complaints further over the next year.

Improvement in patient experience:
Last year, over 37,000 patients and relatives have provided feedback through ‘I Want Great Care’. The percent of people who would recommend our services has increased each month along with the number of people who take time to provide feedback. At the time of writing, 93% of people would recommend our services.

Improvements in staff experience:
The results of the national NHS survey in 2014 showed positive improvements towards achieving a normal distribution of scores by March 2017. The Trust’s quarterly pulse surveys taken since then (February, April, July, September 2015) have all illustrated sustained improvements in staff experience, with the most recent survey finding that 89% of staff would recommend UHMB as a place to receive treatment and 81% as a place to work.

Further Reconfiguration of Services
Further improvement in flow was achieved through investment in our estate in a number of areas including the design and development of a Cardiac and Complex Care Unit at our Furness General Hospital site. Further work is planned for the Royal Lancaster Infirmary site which will result in alignment of services for patients who suffer from heart problems, from stroke, and for elderly frail patients who require rapid review and response to ensure they can be cared for in the environment that is best for them. Alignment of services in this way will increase access to specialist beds and reduce the number of beds and specialities in our largest ward (Ward 39). Speedier diagnostics and decisions will support a reduction in mortality and harm events. It will also influence improvements in patient and staff satisfaction.
Improvement Outcome 1: Better

Quality Goal: Reducing harm

Harm is unintended injury resulting from ‘sub-optimal’ clinical care which results in additional monitoring, treatment, or extended stay in hospital. Despite the hard work and good intentions of healthcare professionals, patients are harmed in hospitals every day.

It is our duty and responsibility to protect patients and we are committed to providing harm free care. The Trust is an early adopter of the Sign up to Safety movement which aims to make the NHS the safest healthcare system in the world.

Our priorities for reducing harm in 2015/16 are as follows:
- Improving stroke care and reducing mortality
- Establishment of a specialist elderly frail unit
- Comprehensive utilisation of the Clinical Care Bundle for Acute Kidney Injury (AKI)
- Delivery of the Sepsis 6 interventions

All of these priorities are Listening into Action Big Ticket Items, delivered through a triumvirate of a Clinical (Medical) Lead, Nursing/Allied Health Professional Lead and Management Lead.

Improving outcomes for stroke and for patients who are elderly and frail is dependent upon ensuring that the expertise and the environment are aligned to reduce movement of patients from one part of our hospitals to another, and to bring the decision makers and diagnostic tools closer to the patient.

We will achieve this through: improving our buildings; creating a new integrated stroke unit and a specialist unit for frail elderly patients; and recruiting more specialist clinical staff in these specialties. This will result in timely decisions and seamless pathways of care to ensure continuity for patients when they move from an acute hospital setting to rehabilitation, step down, or home care setting.

Improvement Metrics years 1 to 5 for reducing harm

Focus on Divisional Leadership

We have four clinical divisions:
- Medicine and Emergency Care
- Surgery and Critical Care
- Core Clinical Services
- Women and Children’s

Each of our divisions is led by a “triumvirate”, comprising of a Clinical Director (doctor), Nurse/Midwife and/or an Allied Health Professional and a General Manager.

They are the senior management team responsible for standards of care, safety, and experiences within their areas of responsibility.
Quality Goal: Reviewing leadership roles and accountabilities

In the Care Quality Commission review of 2014, the Trust received a rating of inadequate for the domain of well-led. The 2015 publication of recommendations from the Morecambe Bay Investigation (Kirkup Report) provided further opportunity to review and improve leadership, teamwork and communication across the organisation. We have been working with the University of Lancaster on a leadership programme that supports leadership development of our clinical and management leaders. All of our senior leadership teams have now undertaken this programme, and our middle management and clinical leadership teams will have completed the programme by the end of 2016.

Focus on Lancaster University

We are proud to be working in partnership with Lancaster University on the development of our leaders. The University’s Management School is in the top 1% of business schools worldwide to have triple-accreditation.

Over the last year, leaders and aspiring leaders from across the Trust have been able to take part in an exciting development programme, including lectures and discussions with the likes of the eminent Professor Michael West.

TOP 1%
Lancaster University Management School is in the top 1% of business schools worldwide to have triple-accreditation.

150 COUNTRIES
A truly international community: students and staff come from over 150 countries around the world.

35,000 ALUMNI
LUMS has an alumni network of over 35,000 alumni around the globe.

600 IN-COMPANY PROJECTS
In 2013 over 600 students were involved in consultancy-style projects with real companies as part of their coursework.

200 PHD STUDENTS
LUMS has one of the largest doctoral programmes in business and management in Europe: in 2015, 207 students were registered at LUMS for PhD study.

100 RESEARCH SEMINARS
Each year LUMS hosts around 100 research presentations by visiting academics from around the world.
There have been a number of improvements made to strengthen leadership over the year, one being the development of site based leadership teams to provide support and challenge to divisional management teams and site based service teams. These teams will represent their executive directors on a day to day basis.

During 2015, there has been a review and update of divisional and site leadership structures to ensure alignment with corporate assurance through clear lines of reporting and accountability. The merger of acute and elective medicine divisions to create one management team has supported a more even distribution of professional and managerial support across services.

Clear roles, responsibilities and lines of accountability for divisional and site based management teams have been developed and this is reflected in updated job descriptions for management and front line staff. A reduction in the burden of internal regulation through attendance at all committees has been reduced so that it is targeted and supports clinical leaders spending more time leading clinical services.

**Triumvirate team - accountability from 'the Board to Ward':**

- **Medical Director Chief Operating Officer Executive Chief Nurse**
- **Deputy Medical Director Deputy Chief Operating Officer Deputy Chief Nurse**
- **Clinical Director General Manager Assistant Chief Nurse**
- **Clinical Lead Service Manager Matron**
- **Consultant Physician/Surgeon Assistant Service Manager Ward Sister**
As well as caring for our young patients, it is important that we continue to listen to them and their families and make changes where we need to. As a result of feedback from patients, we’ve improved lots of things, including the menu for children in hospital, which also includes photos and introduced rooms specifically for young people on each ward.

Kerry Little, Clinical Leader / Patient Experience Lead - Children and Young People

#LeadByExample
Quality Goal: Improving documentation

In 2014/15; the Trust successfully submitted a bid for £1.2million from the national Nursing Tech Fund to support the introduction of electronic nursing documentation.

In line with the project plan, four nurses have been seconded to support the IT department in developing e-documents and to provide practical training and support to front line nurses during the pilot and roll-out phases of the project.

On 8th October 2015, ward 6 at Furness General Hospital was the first ward to adapt e-nursing documentation. A project implementation plan is in place and describes the roll-out across all inpatient wards over the next year.

Nurses on adult inpatient wards will complete documentation at the bedside on new mobile computers that have been provided as part of this bid.

Benefits of the system include having secure, legible information with a built-in audit capability to demonstrate high standards of care and areas for improvement.

This system will provide numerous quality outcomes including: a significant reduction of duplication of information; direct link to available guideline or policy; reduction of duplication of documentation/information; improved quality and timeliness of response to incidents or complaints; provision of reminders to staff and managers that interventions or reassessments are due to be updated; link to key performance indicators.

Improvement Metrics
years 1 to 5 for Improving Documentation

<table>
<thead>
<tr>
<th>Year</th>
<th>Reducing Harm</th>
<th>Improving Documentation N/A New Target</th>
<th>Improving Documentation Implemented in All Inpatient Wards</th>
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<tbody>
<tr>
<td>2014-15</td>
<td>92%</td>
<td>N/A New Target</td>
<td></td>
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<tr>
<td>2015-16 to 2016-17</td>
<td>95%</td>
<td>improving documentation implemented in all inpatient wards</td>
<td>improving documentation implemented in all inpatient wards</td>
</tr>
<tr>
<td>2017-18 to 2018-19</td>
<td>98%</td>
<td>improving documentation implemented in all inpatient wards</td>
<td>improving documentation implemented in all inpatient wards</td>
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Quality Goal: Reducing avoidable mortality

Overall mortality at our Trust is measured in two ways across all specialties using two risk adjusted ratio/index: the SHMI (Summary Hospital-level Mortality Indicator) and the HSMR (Hospital Standardised Mortality Ratio). Our goal is to reduce the number of avoidable deaths at our Trust, by reducing the number of patients who die as a result of avoidable harm.

Focus on mortality ratio

The hospital standardised mortality ratio (HSMR) is an important measure to improve patient safety and the quality of care in hospitals. The HSMR attempts to describe the mortality experience of a hospital compared to the rest of the country in a single statistic. The HSMR adjusts for factors that affect in-hospital mortality rates, such as patient age, sex, diagnosis, and admission status. It then compares the actual number of deaths in a hospital with the expected (or predicted) number of deaths. The HSMR provides a starting point to assess mortality rates and identify areas for improvement to help reduce hospital deaths.

The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC). The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures. It includes both deaths occurring in hospital and those occurring up to 30 days post-discharge and adjusts as far as possible for factors outside a hospital’s control that might impact on hospital mortality rates.

The third measure is the crude death count of all Stroke related inpatient discharges. Crude death count relates to the percentage of patients who die in hospital as a result of Stroke as a proportion of all Stroke patients who are discharged. Stroke related deaths are being measured using crude death rates because patient outcomes for Stroke patients is an area that requires improvement.

Our aim is to:

- maintain scores consistently in the ‘statistically as expected’ range, or better, for the HSMR ratio/index measures;
- maintain scores consistently in the ‘statistically as expected’ range, or better, for the SHMI ratio/index measures;
- Reduce the number of crude deaths with a dominant diagnosis of Stroke

These measures will continue to be reported monthly via the Mortality Report to the Quality Committee.

Improvement metrics for mortality

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<th>2014-15</th>
<th>2015-16 to 2016-17</th>
<th>2017-18 to 2018-19</th>
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<tbody>
<tr>
<td>Mortality ratio to be</td>
<td>better than the national average</td>
<td>better than the national average</td>
</tr>
<tr>
<td>92% within expected range</td>
<td>Stroke mortality reduced to 80 or fewer per annum</td>
<td>Stroke mortality reduced to 75 or fewer per annum</td>
</tr>
<tr>
<td>Stroke mortality N/A New Target</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A great place to be cared for; a great place to work.
Improvement Outcome 2: Care

Quality Goal: Deliver effective and reliable care

We recognise that there will be occasions when clinical judgement, based on the requirements of individual patients, will override guidelines. This will be documented on the occasions when this occurs.

Reliability science can help healthcare providers redesign systems to ensure patients receive all the elements of care they need. Healthcare systems are organised differently at the weekends compared to weekdays where there is a lack of access to certain services over the seven day period. This can result in delays to treatment that can contribute to less favourable outcomes for patients.

We are developing plans that will deliver safe, effective and consistent clinical services across seven days, in alignment with plans for the wider NHS, through the following means.

Care Bundles
Care Bundles are ‘best practice’ clinical interventions, with an applied research base, that involve key clinical management steps that have been demonstrated to save patient lives. In effect they are condensed single page versions of clinical guidelines. Some care bundles also advise clinicians on whether to admit to hospital or not.

The Trust will introduce care bundles for key areas of clinical practice as a part of its Quality Improvement Strategy. The initial focus will be on the Listening into Action ‘Big Ticket’ areas:

- Stroke
- Specialist elderly frail unit
- Acute Kidney Injury
- Sepsis

Improvement metrics for care bundles

<table>
<thead>
<tr>
<th>2014-15 Care Bundles</th>
<th>2015-16 to 2016-17 Care Bundles</th>
<th>2017-18 to 2018-19 Care Bundles</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A New Target</td>
<td>Introduction of two of the four Care Bundles</td>
<td>Introduction of the remaining two Care Bundles</td>
</tr>
</tbody>
</table>

2 4 2
Patient Safety Unit

Development of a Patient Safety Unit (PSU) is a key goal for 2016 in order to ensure that quality strategy and plans are clinically led and that resources are deployed to the area of improvement that will be of most benefit to patients and staff. The Patient Safety Unit will consist of senior clinical and support staff who will be under the leadership of the Medical Director and the Executive Chief Nurse. The Unit will provide clinical support and development in response to clinical concerns or themes that are identified through the Patient Safety Summit, internal or external reviews, or through concerns raised by staff or patients. The Patient Safety Unit will be responsible for setting the overall quality strategy and ensuring that resources are aligned to supporting delivery and embedding of quality improvement across all services.
Quality Assurance & Assessment System (QAAS)

In order to support and promote consistent delivery of high standards of care within wards and departments, a ward-level monitoring and accreditation system has been introduced that allows measurement and assessment of the wards and departments against a core framework of standards.

This ensures that quality and safety are delivered and that patients and families are at the heart of care delivery. The outcome of the ward-based assessment will provide accreditation for the Trust’s wards as ‘Exemplar Wards’ assessed as providing excellent care. QAAS will be overseen by the Patient Safety Unit and application for accreditation would be through this route.

**Improvement metrics in Quality Assurance & Assessment**

<table>
<thead>
<tr>
<th>2016-16</th>
<th>2016-17 to 2016-17</th>
<th>2017-18 to 2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieved 2016</td>
<td>10%</td>
<td>50%</td>
</tr>
<tr>
<td>to introduce QAAS process within all inpatient areas</td>
<td>of wards to achieve examplar status</td>
<td>of inpatient wards to achieve examplar status</td>
</tr>
</tbody>
</table>

**Patient Safety Summit**

The introduction of the weekly Patient Safety Summit results in any harm (or near miss) being reviewed by senior doctors, nurses and AHPs within a week of that harm occurring. The story relating to the incident is discussed along with any actions taken and confirmation of individual learning. The Patient Safety Summit considers and promotes wider learning that can be applied across the organisation, and monitors adherence to the duty of candour. This learning is communicated in a number of ways within the organisation and with key stakeholder organisations. Responsibility for sharing learning, outcomes and delivery of recommendations from incidents discussed at the Patient Safety Summit will be through the Patient Safety Unit.

**Improvement metrics in Patient Safety Summit**

<table>
<thead>
<tr>
<th>2014-15 Lessons Learned Bulletins</th>
<th>2015-16 to 2016-17 Lessons Learned Bulletins</th>
<th>2017-18 to 2018-19 Lessons Learned Bulletins</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 General Bulletins per year</td>
<td>12 General Bulletins per year</td>
<td>12 General Bulletins per year</td>
</tr>
<tr>
<td>6 Themed Bulletins per year</td>
<td>6 Themed Bulletins per year</td>
<td>6 Themed Bulletins per year</td>
</tr>
</tbody>
</table>
We were able to go out into the community at a recent event to ask them what was important to them and how they want to see us change and improve in the future. Hearing their feedback, especially around the proposed designs for our new Women and Children’s Unit at FGH, has made a real difference and we can now take their comments and suggestions on board as we move forward.

Gerry Robinson, Maternity Unit Manager

#LeadByExample
Improvement Outcome 3: Together

Quality Goal: Improve patient and family centred care

A positive patient and family experience is of great importance to us. We understand that many of our patients often experience life changing diagnoses and treatments, and it is our ambition to make their experience the best that it can possibly be. In order to do this we also recognise the need for our staff to feel valued and supported.

There is much more that we need to do to improve patient and family care and we ask our patients and their families for their views through the “I Want Great Care” initiative.

The use of “I Want Great Care” will drive quality improvement through a cycle of continuous improvement at ward level, with local actions taken by Matrons and Ward Leaders to address concerns and issues raised through patient feedback in a timely way.

The “I Want Great Care” data is systematically monitored and displayed on all wards and departments involved.

To achieve our aims we will deliver a programme of actions that ensure that our patients and families describe our Trust as their provider of choice based on the quality of their experience. The work we focus on will be based on the guiding principle that all care will be viewed through the eyes of patients and their families.

We will continue to build upon our excellent performance in 2014/15 and we will work towards making year on year improvements from 2015-2019 to achieve a further 5% overall reduction of complaints for every 10,000 patients treated.

**Improvement metrics in improve patient and family centred care**

<table>
<thead>
<tr>
<th>Year</th>
<th>All inpatient areas to deliver I Want Great Care (IWGC)</th>
<th>Inpatient areas to maintain IWGC</th>
<th>Consultant experience feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-15</td>
<td>Achieve 100% of complaints acknowledged within 3 days</td>
<td>Achieve 100% of complaints</td>
<td>Achieve 100% of complaints</td>
</tr>
<tr>
<td></td>
<td>reduce complaints by 5%</td>
<td>acknowledged within 3 days</td>
<td>acknowledged within 3 days</td>
</tr>
<tr>
<td>2015-16 to 2016-17</td>
<td>Achieve 95% of complaints responded to within 35 days</td>
<td>Achieve 95% of complaints</td>
<td>Achieve 95% of complaints</td>
</tr>
<tr>
<td></td>
<td>reduce complaints by 3%</td>
<td>responded to within 35 days</td>
<td>responded to within 35 days</td>
</tr>
<tr>
<td>2017-18 to 2018-19</td>
<td>Achieve 96% of complaints responded to within 35 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>reduce complaints by 2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Partnering with another trust will give both organisations opportunities for learning, mentoring, staff development, and sharing approaches and best practice in terms of governance and risk management. Having a partner like this will help us to ensure that we can continue to learn and improve the services we offer to women and their families.

Dr David Walker, Medical Director

#LeadByExample
Quality Goal:
Improve public engagement

The Trust has focused on improving public engagement over the last year. A number of listening events have taken place with the aim of asking patients and the public for their views and ideas for improving services. Users have been involved in interview panels, reviewing quality of services, and in the design of new facilities. Building on the success of this approach, the Trust aims to increase both scope and depth of public engagement over the coming year.

The Trust aims to ensure that all engagement becomes effortlessly inclusive; this means that we adopt a practice that embraces (and celebrates) diversity at every opportunity.

<table>
<thead>
<tr>
<th>Improvement metrics in Improve Public Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-15 Public Engagement</td>
</tr>
<tr>
<td>Events N/A New Target</td>
</tr>
<tr>
<td>2015-16 to 2016-17 Public Engagement</td>
</tr>
<tr>
<td>Events 6 high quality events per annum</td>
</tr>
<tr>
<td>2017-18 to 2018-19 Public Engagement</td>
</tr>
<tr>
<td>Events 6 high quality events per annum</td>
</tr>
</tbody>
</table>
Quality Goal: Improve staff experience

The delivery of consistently excellent patient experience is reliant upon having an engaged, competent and motivated workforce, unified by a compelling organisational culture built around patient-centred and safety-focused care.

The delivery of this plan is formed around the NHS Constitutional pledge to give every employee the opportunity to be involved in decisions that affect them and the services that they provide, and will continue the drive to give all employees an increased voice on how their organisation can be improved and encourage them to personally take action to achieve this.

It needs to be recognised that cultural change requires time in order to shift the way that people think, act and behave in an organisation, first you have to shift those people’s experience of the organisation. The introduction of the Behaviour Standards Framework is a key step to sustainably shifting employee experience at our Trust, and will be embedded at all stages of the employee lifecycle and reinforced through learning and development interventions.

We are developing a strong network of champions to support improved staff experience. Our Personal, Fair and Diverse Champions support inclusivity and diversity, they are empowered to make a difference, skilled with tools and with resources to share with others and to challenge safely. Our Respect Champions promote respectful and involving workplaces, where everyone is empowered to give their best every day for our patients.

Performance against our ambitions will be measured annually through the NHS Staff Survey, with regular pulse surveys testing in-year changes.

Improvement metrics in Improve staff experience

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2015-16 to 2016-17</th>
<th>2017-18 to 2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve a reduction in Key Result Areas in the Worse Than Average/Worst 20%</td>
<td>Achieve a normal distribution of Key Result Areas</td>
<td>Achieve a normal distribution of Key Result Areas in the Better Than Average/Best 20%</td>
</tr>
</tbody>
</table>

GREAT PLACE TO WORK

Health & Wellbeing
Recruit & Retain
Engage & Involve
Grow & Develop

Achieved 2015

GREAT PLACE TO WORK

A great place to be cared for; a great place to work.
Quality Improvement Strategy 2016 - 2019

Staff feeling valued in their role

- Staff recommending the Trust as a place to work: 81%
- Staff feeling valued in their role: 5%
- Patient safety is Trust priority: 6%

Staff recommending Trust as a place to receive treatment: 90%

- Staff receiving feedback after raising concerns: 9%
- Communication between senior managers and staff: 6%

I'm happy and supported working in my team: 1%

- Staff experiencing bullying or harassment: 5%

Sonipath: The Pulse Survey
September 2015

A great place to be cared for; a great place to work.
The Trust is committed to supporting those who raise a concern, and so encourages and promotes a culture of raising and reporting concerns. As the Freedom to Speak Up Guardian, I am part of that support so that staff, students, trainees, bank staff and volunteers can feel confident speaking out to ensure a safe and high quality service for our patients.

Heather Bruce, Freedom To Speak Up Guardian

#LeadByExample
Measurement and assurance

Robust and ambitious targets will be set for each Local Improvement Team to identify progress and success in achieving this improvement plan. There will be a portfolio of projects for which key performance indicators will be agreed in consultation with clinical leaders. These will be linked to our quality goals.

The proposed dashboard will report on four quadrants of quality. A standard template will be developed which will incorporate benchmark data and trends in order to facilitate clear communication of the information for the Trust Board, staff, governors, and the public.

A dashboard will be developed to enable monitoring at the Local Improvement Team level and provide assurance to the Trust Board through the Quality Assurance Committee.

SAFETY
- Reduced Harms
- Low mortality
- Accreditation of services

EXPERIENCE
- I Want Great Care
- NHS Staff Survey
- Listening Events

OUTCOMES
- Treatment outcomes (upper quartile)
- Length of stay (upper quartile)

IMPROVEMENT
- Improvement Champions
- Recognition & awards for innovation and improvement
Building improvement capacity and capability

This Improvement Plan will only be successful if we continue to focus on developing improvement capability throughout our workforce, and recognise, reward and celebrate those that are actively engaged in quality improvement activity.

We will build on existing organisational structures and expertise to develop skills, build capacity and create opportunities for shared learning across the wider multi-disciplinary team.

**Learning with and from other organisations**
Key to the development of the learning organisation will be developing sustainable long-term partnerships with academic and NHS partners to learn with, and from, other NHS Trusts and international organisations to bring about measurable improvement. This was a specific recommendation made for all NHS organisations, from the Report of the Morecambe Bay Investigation (Kirkup Report).

Specifically we are developing strategic partnerships with:

- Improvement Partners for **maternity services**; these will be formal arrangements that will include shared learning, governance, benchmarking and academic networking.
- Salford Royal NHS Foundation Trust on the **Quality Assurance & Assessment System (QASS)**.
- **Listening into Action** to accelerate employee engagement and involvement.
- Advancing Quality Alliance (AQuA) to build on our membership by accessing training and train the trainer resources to enable key **Improvement Champions** across the organisation to be skilled in improvement science and methodologies.
- Lancaster University to commission flexible and bespoke input to **leadership development**, improvement activities, and action learning sets.
- **Peer Reviews** across like-minded organisations in order to provide independent assurance of quality standards.

**Our partnerships make us strong.**
By investing in them, we will deliver the best possible care to our communities.
Summary

We are fully committed to developing a robust and sustainable process for the continual improvement of the services and care that we provide. We recognise that this can only be achieved with input from our patients, their families, and our staff.

This strategy aims to draw together the different components which are key to delivering safe, effective care and a positive experience for patients and their families. It also provides a clear set of goals which are challenging but crucial for the successful delivery of our vision of providing world class services and getting it right for every patient, every time.

We are aware that leadership and service development are continual processes and that these are influenced by national, regional and local factors. Our learning through recent years has ensured our understanding that all of the people that use, work in or with local health services have an important role to play in the evaluation, development and delivery of continuous improvement in healthcare outcomes and experience for our local population and for our staff.

Our commitment is to ensure that we don’t lose sight of the importance of listening, hearing and working in partnership to ensure that we deliver the most effective health services possible within the resources available to our healthcare economy.
Delivering Our Quality Improvement Plan

Our quality strategy demonstrates a five-year forward view of quality; however, given the pace and breadth of change within the NHS over recent years, it is important to review strategy on a yearly basis to ensure it remains fit for purpose.

The Quality Plan provides a one-year summary of outcomes that are planned to be delivered during year one of the strategy (2016-17).

The outcomes described in the quality plan will be the outcomes that will be used to provide assurance to: the Board of Directors; commissioners; regulators; and to patients and staff, that the improvement goals we set are being achieved.

<table>
<thead>
<tr>
<th>Quality Goal</th>
<th>Outcome</th>
<th>2016-17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing Harm</td>
<td>Patients receiving Harm Free care</td>
<td>96% of Patients</td>
</tr>
<tr>
<td>Reducing Harm</td>
<td>Improving Stroke Care</td>
<td>Care Bundle established and operational</td>
</tr>
<tr>
<td>Reducing Harm, Deliver Effective and Reliable care</td>
<td>Establishment of a specialist elderly frail unit</td>
<td>Specialist Elderly Frail Unit established and operational</td>
</tr>
<tr>
<td>Reducing Harm</td>
<td>Utilisation of the Acute Kidney Injury Clinical Care Bundle</td>
<td>Care Bundle established and operational</td>
</tr>
<tr>
<td>Reducing Harm</td>
<td>Delivery of the Sepsis 6 interventions</td>
<td>Sepsis 6 established and operational</td>
</tr>
<tr>
<td>Leadership Roles</td>
<td>Delivery of Triumvirate Team Accountability from Ward to Board</td>
<td>Triumvirate Team Accountability from Ward to Board established</td>
</tr>
<tr>
<td>Improving Documentation</td>
<td>Delivery of E-Nursing Documentation across all In-Patient Wards</td>
<td>E-Nursing Documentation implemented in all In-Patient Wards</td>
</tr>
<tr>
<td>Reducing Mortality</td>
<td>Reducing the Summary Hospital-level Mortality Indicator (SHMI)</td>
<td>5% better than national average</td>
</tr>
<tr>
<td>Reducing Mortality</td>
<td>Reducing the Hospital Standardised Mortality Ratio (HSMR)</td>
<td>5% better than national average</td>
</tr>
<tr>
<td>Reducing Mortality</td>
<td>Reducing Stroke Mortality</td>
<td>80 Deaths or fewer</td>
</tr>
<tr>
<td>Deliver Effective and Reliable care</td>
<td>Introduction of Care bundles</td>
<td>Two of the four Care Bundles to be established</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Deliver Effective and Reliable care</td>
<td>Development of a Patient Safety Unit</td>
<td>Patient Safety Unit established and operational</td>
</tr>
<tr>
<td>Deliver Effective and Reliable care</td>
<td>Quality Assurance &amp; Assessment System: Accreditation of Inpatient Wards with ‘Exemplar’ Status</td>
<td>5% of Inpatient Wards at Exemplar Standard</td>
</tr>
<tr>
<td>Deliver Effective and Reliable care</td>
<td>Quality Assurance &amp; Assessment System: Accreditation of Outpatient Areas with ‘Exemplar’ Status</td>
<td>Quality Assurance &amp; Assessment System in progress in all Outpatient Areas</td>
</tr>
<tr>
<td>Deliver Effective and Reliable care</td>
<td>Gold Standards Framework: Accreditation of an Additional Ward</td>
<td>1 or more additional Ward achieving standard</td>
</tr>
<tr>
<td>Deliver Effective and Reliable care</td>
<td>Sharing Lessons Learned from Patient Safety Incidents</td>
<td>12 Standard Bulletins and 6 Themed Bulletins per annum</td>
</tr>
<tr>
<td>Improvement in Patient Flow and Experience</td>
<td>Re-alignment of services for acute cardiac/complex medical patients</td>
<td>Acute Complex Coronary Unit to be established and operational</td>
</tr>
<tr>
<td>Improvement in Patient Flow and Experience</td>
<td>Re-alignment of services for Stroke Patients</td>
<td>Integrated stroke unit to be established and operational</td>
</tr>
<tr>
<td>Improvement in Patient Flow and Experience</td>
<td>Reduce number of beds and specialities in Ward 39</td>
<td>Reduction to 32 Beds and 4 Specialities</td>
</tr>
<tr>
<td>Improve Patient and Family centred care</td>
<td>The Trust is described as provider of choice under ‘I Want Great Care’</td>
<td>IWGC introduced in to Consultant experience feedback in at least one speciality</td>
</tr>
<tr>
<td>Improve Patient and Family centred care</td>
<td>Reduce Formal Complaints Improve complaints response timescales</td>
<td>3% Reduction in complaints per 10,000 beds 100% of complaints acknowledged within 3 days 95% of complaints to be responded to within 35 days</td>
</tr>
<tr>
<td>Improve Public Engagement</td>
<td>Increase the scope and depth of public engagement</td>
<td>6 public engagement events</td>
</tr>
<tr>
<td>Improve Staff Experience</td>
<td>Increased voice for staff in how their organisation can be improved</td>
<td>Normal Distribution of Key Result Areas in National Staff Survey</td>
</tr>
</tbody>
</table>
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Date of publication: November 2015
Version: 1.0