

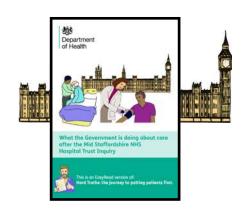


What the Government is doing about care after the Mid Staffordshire NHS Hospital Trust Inquiry



This is an EasyRead version of: **Hard Truths: the journey to putting patients first.**





This EasyRead report is from the Government.



It says:

 what we have done already to make health and social care better



 what else we will be doing to make sure care is kind and safe



 how organisations or staff who do not look after people properly could be punished.



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About this paper





An NHS hospital trust in Mid Staffordshire, or Mid Staffs for short, ran Stafford and Cannock Chase hospitals.



They were unsafe and lots of people suffered who shouldn't have.



Another organisation was asked to run the hospitals for the time being and things have got better.



There have also been problems with care and abuse at other places, like the people with learning disabilities in Winterbourne View.



There have been a lot of people looking into what went wrong, after a Public Inquiry led by Robert Francis.



They have all said there are lots of things wrong with health and social care, not just Mid Staffs, and a lot will need to change to make sure problems like this don't happen again.



The Government has made a lot of changes already.

This EasyRead report is from the Government and says:



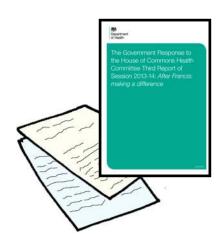
what we have done already



 what else we will be doing to make sure care is kind and safe, and



 how organisations or staff not looking after people properly could be punished.



There is a lot more detail in the other reports and the full version of this paper.



Please see the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry for more details. This can be found on this website:

www.tinyurl.com/HardTruths



Stopping problems happening in the first place





1. Changing the way services work

We want to make sure that what happened at Mid Staffs does not happen again.

This means a big change to make sure:



there is safe care for patients



people are treated as partners



staff are supported to care.



We will make sure that care is safer for patients:

 Every patient will have the names of the doctor and nurse looking after them over their beds.



 Older people getting care at home will have a named doctor looking after them. Other people will have this later on.



 Easy to understand information about how safe each hospital is.



 Telling people if things that should never happen, have happened.



These are things like giving someone too much of a dangerous drug or having an operation in the wrong place.



 Telling all hospitals about any problems with safety so they can all quickly do something about it.



2. Telling the truth

We want care organisations to tell the truth if they have any problems with safety:



We will ask people if NHS trusts should pay costs if they have not told the truth about something unsafe.



 If Parliament agrees, from 2014 every care organisation on CQC's lists will have to tell the truth.



 Staff will also be expected to tell the truth about safety or any mistakes that have been made, even if they are small ones.



If they don't tell the truth they might not be able to carry on doing their job.



3. Listening to patients

Listening to people and patients and doing something about what they say is most important. Patients must be involved at every level of care.



The NHS has a list of the rights we all have and what care we should expect from them. This is called the **NHS Constitution**. You can find the EasyRead version at:

http://tinyurl.com/NHS-ER-CON



The friends and family test has been used in hospitals. This asks patients if they would tell their friends and family they should use that service, or not.



It tells the hospital very quickly if things are wrong.



The friends and family test will also be used in mental health services from December 2014.



People will be able to get support to make their own decisions about their care.



Local Healthwatch speaks up for people using local care services. We are helping them to be as strong as possible.



The CQC is now involving patients in inspections which give hospitals a score.



CQC will listen to what people say to make the way they inspect services better.



Making sure the NHS listens to complaints better, and does something about them. They must not just ignore them.



Having a notice on every ward telling people how they can complain and where to get support.



There will be good information about how many complaints services get.



People who have made complaints will be asked if they are happy with what happened afterwards.



4. Safe staffing

Services need enough staff with the right skills to be safe.



A guide will tell NHS services how many staff they should have at any time and what skills they should have to make sure patients are safe.



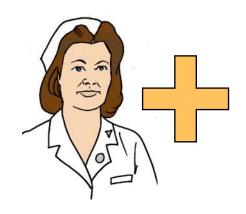
Staffing guides will then be made for other services like mental health, community and learning disability services.



By June 2014, NHS trusts will have to say if they have not always had enough staff on and what they are doing about it.



CQC will check on staffing.



Some trusts have already got more nurses and others plan to.

The numbers of nurses should go up by 3,700 by 2014.



We will be making sure people who want to do nurse training have the right ways of thinking.



Finding out about problems quickly



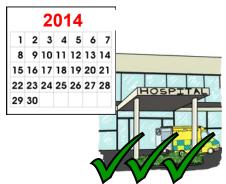
Any problems need to be found out about as quickly as possible, so something can be done about them.



People checking, or inspecting, services will spend more time listening to patients, service users and staff asking them how good care is.



Inspections will be done at night and weekends as well as during the week. More surprise checks will be done.



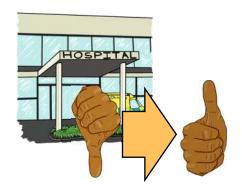
From 2014, the CQC will give hospitals a score saying how good they are.



The scores will be from really good to really bad and will include what patients have said about them.



By the end of 2015 the CQC will have checked and given scores to all main, or acute, hospitals.



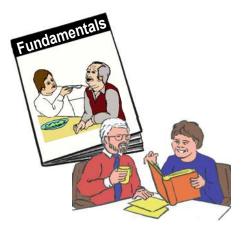
They will also be checking to see if hospitals have been getting better.



Scores for mental health services will be done by October 2014, or January 2015 for private services.



All social care services will have been checked and scored by March 2016.



There will be new rules about how good a service must be. These are called the **Fundamental Standards**.

People will be asked what they think about these easy to understand rules first.

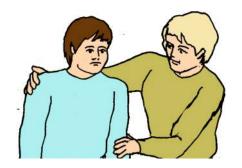


The CQC will be asking services 5 main questions:

1. Are they safe?



2. How good are they at doing what they are meant to be doing?



3. Do they care?



4. Do they change quickly when they need to?



5. Do they have good managers?



There will be other rules that services will have to meet.



The CQC has written EasyRead plans about all this called **Making Services Better, Putting People First**.



We will change the law so CQC is more independent from Government.



Staff will not be paid to be quiet about problems.



Staff will be supported as whistle blowers, telling outside people about any problems.



There will be a friends and family test for staff as well.



The jobs of organisations whose job it is to check services will be made clear so everyone knows who should be doing what.



They must also tell each other what is happening.



New local groups have been set up. These are for local services to talk to each other about any worries they hear about.

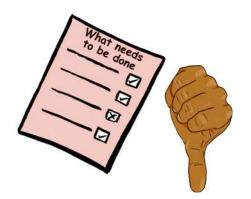
They are called **Quality Surveillance Groups**.



Sorting out problems quickly



When a problem has been found the next thing is to quickly do something about it.



When it is a big problem with a service that is not good enough, there will also be a clear way to do something about it. This is called special measures.





- Very good
- Good
- Needs to get better
- Really bad.



For a hospital to be a foundation trust they will need to be good or really good. In the worst cases someone else will be asked to run a hospital.



Punishing organisations or staff for not looking after people properly



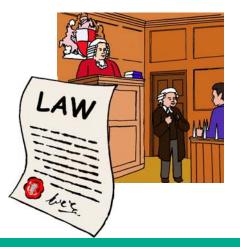
The people who run organisations and the people who work in them will be responsible for care that is not good enough.



There will be a new test to make sure people running trusts are good enough.



Top managers will have to do a good job.



We will make a new law taking staff or organisations who have treated patients really badly to court.



If Parliament agrees, we will make a new law about organisations not giving people wrong information.



There will be a guide to help trusts make care better.



Doctors and nurses will help buy services that make the health of everyone better.



In the end it is the Government that is responsible for the NHS. We will make sure that civil servants and health ministers get to know about and see care services for themselves.



Staff training



Staff who are treated well will treat their patients well.



Involving staff in what is happening at all levels is important and we have asked for a guide to be written on how to do it well.



Important parts of training for staff will be:

good care



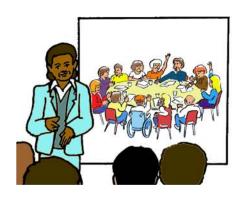
working well together



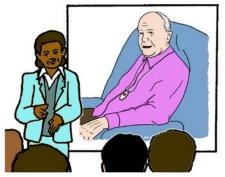
thinking what is best for the person



being safe



listening properly to people.



There will be special training for nurses caring for older people.



Everyone who wants to train as a nurse should have a year as a carer before they start.



Nurses should be checked to make sure they are still good enough to do their jobs properly.



There will be a new Care Certificate for support workers. This will show they have been trained and have the right skills for the job.



Paperwork that is not necessary will be cut down, so people have more time to care.



Making sure managers and leaders know what they are doing and are really good.



And finally



It is the job of everyone in the NHS to make care better.



We have asked trusts to have meetings where they listen to what people have to say.



Lots of them have had these. We want them to carry on so that they can hear what people are worried about and do things about them.



Staff working in health and social care want to give services that are:

safe

doing what they are meant to do



 thinking about what is best for the person



 listening to any worries and knowing they will be sorted out.

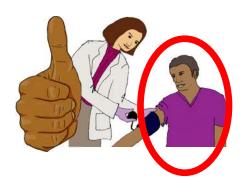


There are 3 main points to remember:

1. Hear what the patient has to say.



2. Speak the truth.



3. Do what is best for the patient.



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