Changing the NHS for the better

Easy read version of:
'Culture change in the NHS: applying the lessons of the Francis Inquiries' Feb 2015
What is this report about? 1.


3. Doing something quickly when things go wrong 16.

4. Making sure staff are well trained and want to do a good job 19.

**Hard words** - These are written in **bold** and explained at the back of this booklet. 23.
What is this report about?

In 2013 a report told us what had happened at Mid Staffs Hospital.

Patients were not cared for properly. Many people died who did not need to.

This report is about what we have done in the NHS since then.

There have been many changes.

We have new ways to check how well:

- hospitals are doing
- **social care** for adults is doing

- staff are doing.

Most patients in NHS hospitals now get good care.

Most people say they feel safe in an NHS hospital.

But this is not good enough.
This report says what still needs to be done.

We want all NHS and social care to be:

- safe

- really good

- kind.
1. Stopping problems happening

To stop unsafe or poor care from now on, we are:

- making it easy for anyone to find out how good health care or social care is

- making sure everyone knows how to be safe in the NHS.

We must learn from our mistakes.
Making it easy for anyone to find out how good health care or social care is

We want the NHS to be honest about how good or poor the care is.

It is now the law that when something goes wrong patients are told quickly.

This will help places to learn from their mistakes.

A lot of hospitals now put the name of a member of staff above the bed.

This is the person in charge of that patient's care.
This is for patients and their families to know who to ask about their care.

We now have a new website called MyNHS.

This shows how good or poor different hospitals are at many things.

MyNHS looks at over 100 different things in a hospital such as:

- how safe it is
• how honest it is

• how the staff feel working there

• what the hospital food is like.

One problem at Mid Staffs hospital was they did not have enough staff on duty.

MyNHS shows how many staff are on duty in wards.
Now we will see if a hospital has problems with not enough staff.

Making sure everyone knows how to be safe in the NHS

The checks that went on in hospitals did not find the unsafe and poor care at Mid Staffs.

We have changed how these checks are done.

The checks are done by the Care Quality Commission (also called the CQC).
The CQC now has new top managers.

The checking teams now have on them:

- experts from hospitals
- hospital staff
- patients.

They look at if the hospital is:

- safe
- really good

- using good managers

- kind

- quick to deal with problems.

We have Sign up to Safety for the NHS.
Over 200 organisations have signed up.

The aim is to make care safer in all the NHS. Sign up to Safety looks at things like:

- helping patients to be safe so they do not fall
- stopping patients getting sores from lying in bed a long time
- working to stop patients getting blood clots in their legs.

We will have an expert team to help hospitals who find this difficult.
Staff need to feel they can tell someone if they are worried about how patients are treated.

The Government asked Sir Robert Francis QC to do a report about how this could be made easier.

This was published on 11 February 2015.

We will carry on finding ways to make the NHS safer and honest.
2. Finding problems quickly

One of the worst things about Mid Staffs hospital was that patients and their families were not listened to when they complained.

This chapter looks at how we are making sure complaints are heard and something is done about them.

The NHS has new ways of telling patients and their families how to complain.

The CQC checks how hospitals deal with complaints.
We now have a Friends and Family Test.

The test asks if they would tell people to use that hospital.

The test is helping hospitals get better at care.

We are looking at NHS *advocacy* services for complaints. We need to know how good they are.

We will finish this in Spring 2015.
The Government is now better at learning how patients and staff feel about their care.

Ministers and civil servants now spend more time in hospitals finding out about care.
3. Doing something quickly when things go wrong

When we saw the problems at Mid Staffs hospital it took too long to sort it out.

No one knew whose job it was to make the care better.

This chapter looks at what we have done about this.

The CQC now does better checks on hospitals.

When a hospital is not good enough they put it in *special measures.*
19 hospitals have been put in special measures over the last year and a half.

We have new rules about good care. These rules are:

- patients and wards need to be clean
- staff must check that patients are eating and drinking. Help must be given to people who need it
- patients must agree to the medicine and care NHS staff give.
Hospitals can do better with help. 6 hospitals have come out of special measures.

There is a new law which makes it against the law to **neglect** patients on purpose.

The CQC can also take services to court who give poor care.
4. Making sure staff are well trained and want to do a good job

The top managers at Mid Staffs hospital did not think about what patients needed.

Other hospitals with good top managers thought about the patients.

This shows how important really good top managers are.

We have looked around the world to see what makes really good top managers.
We need to make sure we have people with the right:

- attitudes
- skills
- training.

We are training some new top managers.
These top managers will lead NHS staff to a future where good care is important.

We must learn to listen to what NHS staff tell us.

The NHS has not been good at listening to staff who see poor care. We must change this.

We must make sure that people coming to work in the NHS have good attitudes.
We need staff who are kind as well as good with medicines.

NHS staff have learnt a lot from Mid Staffs hospital and carry on learning.
Hard words

**Advocacy** is when someone speaks up for you.

**Neglect** is when someone is not looked after properly.

**Social care** is when people have support to live at home. Social care is also day centres and social workers.

**Special measures** - hospitals not giving good care get extra help. They are also watched carefully to make sure they get better.
This paper meets the European EasyRead Standard.

It has been user-checked by the Making It Easier Group of people with learning disabilities.

Artwork includes material from the Inspired EasyRead Collection and cannot be used anywhere else without written permission from Inspired Services.

www.inspired.pics

© Crown Copyright 2015
2902932 March 2015
Prepared by Inspired Services for Williams Lea