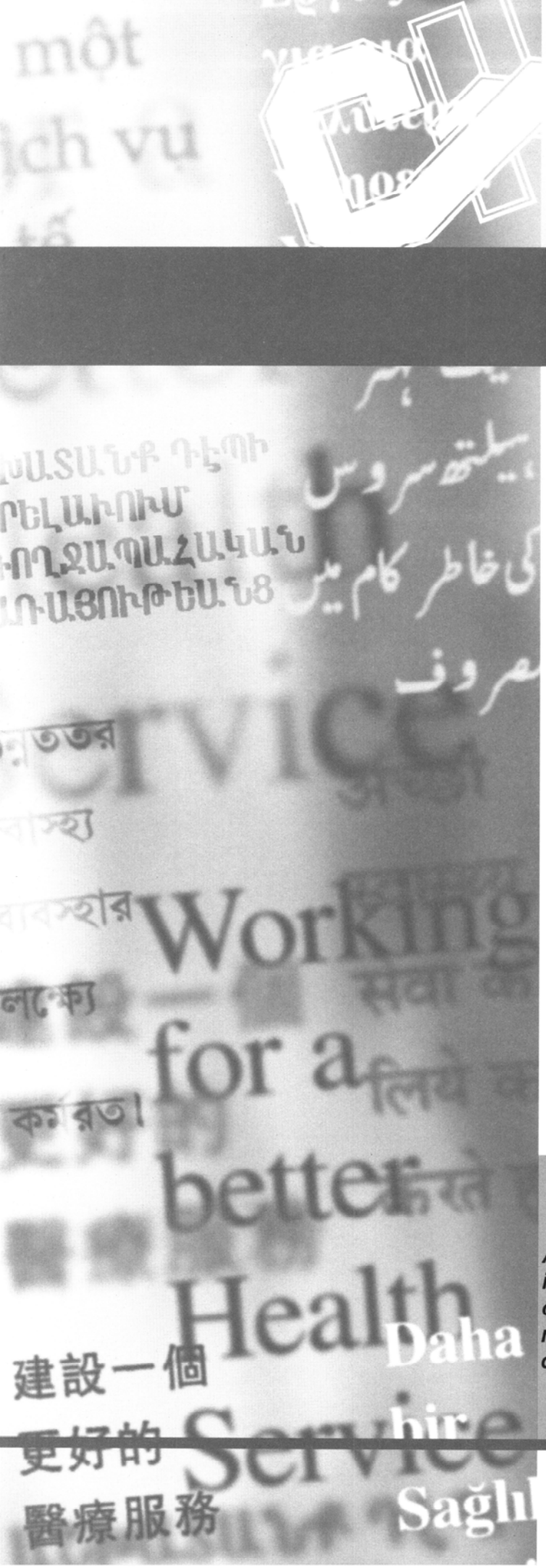

EFFECTIVE VISITING

An overview of the practicalities of lay visiting in the NHS, and an exploration of new challenges facing lay visitors, such as the monitoring of race equality issues and the development of a patient-centred checklist.

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ASSOCIATION OF
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BACKGROUND

This document is an updated version of a briefing produced and then updated for CHCs in London in 1998. It is expected that in 2003 the current CHC statutory right to enter and inspect NHS services will transfer to the new Patients' Forums or equivalent body. The information and advice contained here is still very relevant to any group of people with a statutory remit to visit and inspect an NHS service.

The Greater London Association of CHCs (GLACHC) ran a seminar for CHCs in 1992 about Visiting. It was noted at the time that there was a range of information and guidelines about CHC visiting, that many CHCs have developed their own visiting guidelines and protocols, and effective ways of visiting.

The purpose of this briefing is not only to look at the practicalities of visiting, but to help CHCs explore new visiting challenges, e.g. to GP premises, monitoring race equality issues and developing a patient-centred checklist.

OVERVIEW

The amount of time and resources that a CHC spends on visiting varies depending on a range of locally defined factors including:

CHC work programmes and priorities - some prefer to carry out surveys, hold more public meetings, or to gain views and monitor services in other ways.

The number of provider units in the district which the CHC covers.

The availability of CHC members - in areas where most members are in full time employment it is sometimes difficult to get a team together to carry out a visit.

WHY VISIT?

The purpose of visiting is to observe, listen, ask questions, give praise where praise is due, and offer suggestions for change. First impressions can be important and the guiding question is:

> *"Would I want to be looked after here or would I be happy for someone I care about to be here?"*

Visiting has been a traditional part of CHC activity and CHCs have developed a great deal of knowledge and expertise about local health services through their visiting programmes.

Monitoring local service provision:

Visiting is a useful way for the CHC to gather information to monitor performance standards as published by NHS Trusts as part of their own performance monitoring.

Needs Assessment

A visit might reveal gaps in service provision or shortfalls in the service that are not covered by the contract. Issues of access to a service for particular groups of people or its appropriateness to them might also arise. These can be fed back to the main commissioner – the Primary Care Trust.

Promoting the CHC

Visits are a useful way of publicising the CHC amongst patients, visitors and staff. Visits can raise awareness amongst patients, carers and staff of the complaints procedures. It is useful to distribute leaflets and posters about the work of the CHC, and where it can be contacted, either before or during a visit.

Involving Members

Visiting is a good way of involving the members in the work of the CHC. It is an area of work where one of the most important roles and attributes of a CHC member – that of lay observer- is well used. Members can learn a great deal about services from visits, and visits can be seen as part of a strategy for understanding the shape of overall service provision.

Visits do not necessarily have to take place during the day, but this will depend on the type of service being visited and the reason for the visit. No CHC member should be excluded from visiting because they work certain hours.

There are many reasons why a CHC might want to visit:

- As part of routine inspection and monitoring. Some CHCs have a regular visiting programme to ensure all premises in their area are seen within a year, and that the quality of the service is maintained and improvements made.
- To monitor services whose users are less able to speak for themselves, e.g. -- elderly patients with dementia.
- To identify gaps in services.
- To familiarise the CHC with a newly established service or unit, e.g. a Walk In Centre.
- To collect background information and learn about a service.
- As part of a strategy to monitor a service that is closing, merging, reconfiguring or being consulted on, or under threat of closure.
- As a follow up to complaints received at the CHC or in the media about a particular service.
- As part of a survey or project being carried out by the CHC, e.g. a 24 hour study in an Accident & Emergency department, or a survey of women's experiences of maternity care.
- To specifically monitor access issues e.g. whether the service is culturally sensitive, physical access, access to information, language access, whether staff are trained to care for people with learning difficulties when admitted to hospital.
- Joint visits with other CHCs to visit regional speciality services.
- To monitor the care being received by people who have been discharged into the community.
- To promote public relations- to meet patients, visitors, carers and staff to find out their experience of the service and their views. This helps to demonstrate the interest, concern and commitment of CHCs to the NHS and its users.
- To follow up a previous visit where conditions or circumstances led the CHC to express concern.
- As a way of introducing the CHC to a service, e.g. forming links and building relationships with GPs.
- To build up a picture of local services in order to inform potential users.

VISITING RIGHTS IN THE NHS

The transfer of the statutory right to enter and inspect NHS services and premises will pass to the newly established Patients Forums sometime in 2003 who will have a new power to inspect services commissioned by Primary Care Trusts. Until the actual cessation of CHCs inspection rights are enshrined within The CHC Regulations 1996 (SI No 640) which states: Inspection of premises by Community Health Councils "A council or any member authorised by the Council for the purpose, may enter and inspect any

premises controlled by a relevant Health Authority or relevant NHS Trust at such times and subject to such conditions as may be agreed between the Council and the Health Authority or NHS Trust or, in default of such agreement, as may be determined by the Secretary of State.

No member shall enter –

1. any premises or part of premises used as residential accommodation for officers employed by any Health Authority or NHS Trust, without having first obtained the consent of the officers residing in such accommodation; or

2. premises or parts of premises made available to persons providing general medical services, general dental services, general ophthalmic services, or pharmaceutical services, without having first obtained the consent of those persons."

CHCs do not have a statutory right of access to private hospitals or registered nursing homes. However, where it is in the contract between the provider and the commissioner in premises where NHS patients receive services the CHC may enter and inspect e.g. waiting list initiatives that includes using local private hospital beds for elective surgery. It will be for the CHC and the management of the private facility to agree between them visiting arrangements.

Similarly, when former residents of mental health or learning difficulties institutions are discharged into community homes, the CHC has no right to visit unless their care is being provided by the NHS or funded by the NHS with visiting rights incorporated into the contract. In such circumstances the CHC must respect the fact that they are visiting the individual's home.

It is worth noting that CHCs have increasingly negotiated with GPs, dentists, pharmacists and opticians to gain agreement to visit primary care premises. Also some CHCs have carried out comprehensive programmes of visiting all nursing homes in their districts.

PLANNING A VISIT

If a visit is to be useful, it requires careful planning, well in advance of the actual date of the visit. The following questions need to be considered:

What kind of visit should be planned?

There are many different kinds of visits, and different kinds are appropriate for different circumstances:

Twenty-four hour or extended visits using a rota system of members to cover the visit may be appropriate for services that have peaks and troughs of demand, e.g. A & E departments. Long visits may also be necessary where the CHC wishes to observe the daily routine of a ward. For example, it may be useful to visit a care-of-the-elderly ward early in the morning, at meal times, at times when therapies are taking place, at bedtime and during the night. It may be useful to visit a children's ward when play facilities as well as medical and nursing facilities can be seen.

Visits at particular time – for example at visiting times or a particular consultant's clinic.

Following a patient through the system – a typical patient's path through various aspects of a clinic, e.g. observing waiting times for X-rays and pathology services, blood testing and so on.

Survey of patients' opinions – in outpatients, A & E

Unannounced visits may suit circumstances in which there is reason to believe that the "real" situation would be concealed or altered in some way if the visit was known in advance. However, an unannounced visit may be quite costly in terms of goodwill, and it may be impossible to speak to certain people if a visit is not pre-arranged. It is useful to come to an agreement in principle with the NHS Trust as regards unannounced visiting.

CHC members as part of the local community also use NHS services, as do their relatives, friends and neighbours. The importance of this "intelligence" network should not be underestimated.

Purpose of the Visit

It is important to be clear about the purpose of the visit, which may include talking to patients, to visitors and carers, to staff and simple observation. Often a fresh view from someone who is not part of the service can pick up on things that become invisible to those who are there every day. For example, a CHC visitor may see that the notices on the notice board are out of date, or unavailable in community languages, whereas a member of staff, or even frequent visitor, may have ceased to notice that there was a notice board. Similarly, unpleasant smells may be more evident to an infrequent visitor. CHC visitors may notice that meals or drinks have gone untouched on a care of the elderly ward and the CHC can then discuss whether improvements can be made.

WHO SHOULD GO ON THE VISITS?

Where possible the selection of an appropriate group of members for a visit should be a matter for decision, rather than chance. Some CHCs find it is best to have particular visits as part of the responsibility of a working group/committee, whereas others find it best to convene a group of members for a visit as and when necessary.

It may be important to consider having a mix of people with first hand knowledge of the service, where that is possible, and CHC members with a more general interest. It is also advisable not to have too many people on a visit - between 3 and 4 people is about right.

Users as CHC visitors

It is obviously very important to involve CHC members who are service users on visits wherever possible as their contribution is extremely useful. .

Equality issues

The gender mix of the visiting group should be considered. Mixed groups may often be advantageous, but there may be circumstances where women may be the most appropriate visitors, e.g. on gynaecology wards.

Race and ethnicity should also be taken into account. It is generally useful to have a group with as wide an ethnic mix as possible. Even though, the members of very few CHCs fully reflect the ethnic diversities of their communities, it is necessary to ensure that the needs of black and minority ethnic people are considered. It will be useful to consult in advance of the visit with relevant black organisations in order to be aware of the issues that are of greatest concern to those groups.

If the aim of the visit includes talking to patients and relatives, it may be necessary to consider the availability of interpreting so that members can communicate with a wide range of people.

As services need to be accessible to people with disabilities, it is clearly important that CHC members with disabilities should be fully included in visits. However, the responsibility for considering disability issues does not lie with disabled members, but with all members.

It is important to consider whether some groups are less likely to avail themselves of services because of inappropriate or insensitive services; therefore, to visit with a view to the needs of existing service users only, would be inadequate. So, the Visit will need to look beyond the needs of the people who are currently accessing the service.

Pre-Visit Preparations

Gathering information to inform the Visit

It is important that members are well briefed about any issues or concerns affecting the

service to be visited. For example, has the service been inspected as part of the Commission for Health Improvement (CHI) monitoring? If so, how did the service get mentioned within the CHI report?

The quality and usefulness of information gained on a visit, depends on how well the visit was planned. Before the visit, it is useful for those members who are going to visit to agree what they hope to get out of the visit. It may be possible to allocate particular tasks to individual members. It will certainly be helpful to have access to reports or summaries of reports of previous visits to the service that members are planning to visit. All too often, visits lack continuity, and this can result in wasted effort on the part of the CHC. It will also be helpful to have a profile of the service, information on complaints made about the service and information about media concerns.

It is also generally helpful to be clear well in advance of the visit what the expectations of the CHC are for the visit. This is particularly important if the visit is to include an opportunity to meet with key staff. It is also appropriate to clarify at an early stage whether facilities can be made available to talk to patients and carers in private if needed. In such a case the CHC can ask that posters are displayed announcing the visit.

Practicalities

CHC members should all carry identification, so that people they talk to on the visit can see it.

Leaflets explaining the work of the CHC should be available on and preferably before the visit. Such leaflets should include information on how to contact the CHC after the visit, as some patients will find it easier to talk when they are no longer in hospital. It is also important to remember that staff may have little idea what a CHC is, and they should also have the benefit of an explanatory leaflet.

It is extremely useful to prepare a proforma visit checklist, setting out points to look for and questions to be asked, and exactly who is going to ask which question. If the Commission for Health Improvement (CHI) have undertaken a visit it would be helpful to consider its recommendations and observations.

It should be decided before the visit how the CHC's impressions are to be recorded and written up. Members who take notes should be clear when their notes are required, and it should be agreed who should be responsible for collating the notes and producing a draft report. CHCs vary as to how much this is a task for the staff and/or members.

The exact meeting time and meeting point of the visit should be clear to everyone and adhered to. Decisions should also be made as to what form of transport CHC members and staff will take to the visit. It might be important to use public transport to see how accessible a service is.

Example of a checklist is attached in Appendix One

THE VISIT

- Members should have read the CHC Code of Conduct or whatever code will replace that in future.
- There should be clear agreement of who is leading the visit, who is taking notes, who is speaking to patients and so on.
- Members should always wear identity badges.
- It is important that members introduce themselves to staff, patients and visitors, and they may hand out an appropriate leaflet about the CHC.
- The group should be sensitive to the area/place being visited and the patients in it, for example, a closed psychiatric ward, intensive care unit,

very sick patients and children's wards. Advice should be obtained from staff whether any patients should not be approached in such areas.

- Members should not talk loudly amongst themselves during the visit or hold private discussions unrelated to the visit.

- The group should visit in a spirit of openness and willingness to report good practice as well as problem areas.

- Members should not be afraid to ask questions or seek information from staff.

- At the end of the visit, members of the group should let senior staff know they are leaving.

- Urgent concerns should be reported to the Chief Officer immediately.

FOLLOWING UP A VISIT

- Immediately after the visit, a letter of thanks to the unit concerned is vital.

- It may be necessary at this stage to check factual accuracy with the unit visited.

- All the good work of a visit will be wasted unless follow-up is carefully planned and executed. A comprehensive visit report is essential to successful follow up, although it may be helpful to distil the contents of the report into a brief list of concerns that require a comment from the provider, and a list of issues to raise where appropriate with the commissioners.

- The CHC will also want to make recommendations for action/or improvement which includes a suggested time-scale, and on which a response should be obtained. It is also important to comment on good practice.

- It is sometimes helpful to have a full report for the CHC and for the Primary Care Trust and the provider unit; and a summary report for interested organisations.

- It is important to have a timetable for expected follow-up, arranging post-visit meetings with staff, and follow-up visits to monitor progress, as required.

- The CHC should also be clear about its procedures for dealing with the draft visit report. The appropriate CHC working group could agree the draft first and it is common practice for the full CHC to adopt it as a CHC report, consider the Trust's response, and agree what further action may be necessary.

Influencing change:

Information from visits can inform the CHC's overall work and should be readily available for all CHC staff and members so they can use it in their discussions with local NHS Trusts, Primary Care Trusts and the Strategic Health Authority.

Concerns arising from a visit may form the basis of a campaign, or may serve as a focus for joint work with a relevant voluntary organisation/s or community group/s.

It may be useful to collect a whole year's visit reports into one folder or booklet in order to give a clear impression of CHC views on a range of services. This could be of particular interest to Primary Care Trusts who commission services and Strategic Health Authorities who have a responsibility to performance manage NHS Trusts and PCTs.

Using the Media

Once the CHC has published a final visit report it becomes a public document.

It is important to consider how the press may be involved in the follow up as they may have concerns of their own about a particular service and be looking for snippets from the CHC before the report is public. The Chief Officer and the Chair will

need to carefully consider how and whether to provide information to the press.

SPECIFIC ISSUES

Visiting and Equality issues

The amendment of the Race Relations Act placed a specific duty on NHS institutions to produce a Race Equality Scheme by 31 May 2002 with a legal requirement to prevent race discrimination, to promote race equality and to demonstrate how this will be undertaken and monitored.

It is therefore essential that race and ethnicity issues should be fully integrated into the work of the CHC and it should be clearly recognised that it is the responsibility of all CHC members and staff to ensure that this is the case.

Some CHCs have undertaken visits specifically concentrating on race and ethnicity issues. Others have developed a strategy covering the following:

- Ensuring that CHC staff and members have attended race equality training themselves before challenging NHS staff on this issue!
- Holding a briefing meeting for staff and members to discuss what the CHC hopes to achieve from each visit.
- Obtain a copy of the Trust's Race Equality Scheme, which will outline how it intends to promote race equality and the specific changes and training planned.
- Preparing and distributing a list of ethnicity-specific questions members should ask staff, managers and patients questions such as:
- Are they providing advocacy, interpreting and translation services?
- Do they know about the religious and cultural needs of service users and how to meet them?
- How many of the user representatives are of black and minority ethnic communities, or if the establishment has a policy of involving users in the decision-making process?
- What percentage of black and minority ethnic people use the service? Do the staff and managers know about the minority ethnic communities in their locality?
- Have the staff and managers had race equality training?
- Is ethnic monitoring undertaken and monitored? What changes have been made as a result?
- Is there a real choice as regards single-sex accommodation?
- Do users know and understand what their rights are to e.g. having treatment explained to them so that they can make informed choices?
- Producing and circulating forms containing the relevant questions (including observations to be made on e.g. suitable signposting, information leaflets in minority ethnic languages) to each member on visits to fill in on each visit.
- Holding a meeting after each visit to evaluate the achievements and /or obstacles and lessons learned.
- Establishing a review system to ensure that the strategy is working.
- Ethnically monitoring complaints so that specific race and ethnicity issues can be identified and addressed at a visit.

Visiting GP premises:

The establishment of Primary Care Trusts has meant that more and more CHCs have developed relationships with local GP practices and have been able to make informal visits by invitation to primary care services.

CHCs have expressed the benefits of visiting GP premises as:

- A good way of educating CHC members about GPs and their services.
- Visiting is a way of beginning a dialogue between a CHC and local GPs, getting a two-way flow of information.
- Visits are a way that the CHC can shake off its image as being only about complaints.
- With visits you can "get a foot in the door" with GPs.
- The CHC can build up a useful overview on local primary care provision.
- The CHC can offer a service to GPs to provide "consumer feedback" on their services.
- Visits can be used to find out what local GP concerns are.
  Visits are useful in overcoming GP fears about what the CHC is and does.

Liaison with other agencies

It is important that the intelligence and information gathered by visits is shared with other organisations.

In the new patient and public involvement structures the new Patient Forums or equivalent will be able to send their reports to the Overview & Scrutiny Committees (OSCs), Strategic Health Authorities, CHI, and the National Patient Safety Agency (NPSA) as well as any other person or body the Forums deem appropriate including the media.

CHI inspection visit reports and the Trust's action plans, as a result are useful sources of information on where the CHC should focus their visits.

Appendix One

Below is an example of a visit checklist originally developed by MIND in Brighton & Hove and adopted by Redbridge CHC. It is used when visiting such services as facilities for older people with a mental health problem.

The right to choice in daily life

Movement

- Going outside (in the grounds, escorted and unescorted, out of grounds).
- Getting up and going to bed when you like.
- Requests to go to specific places –are people encouraged to make requests?
- Opportunities to go to different places e.g. shopping, parks, sea, 'outings'.
- Moving residence (it can be very difficult to leave a home that you are dissatisfied with).

Occupation

- Opportunities for: education projects, new skills, requests for learning.
- Regular events (games, groups etc).
- Involvement in domestic tasks and running the home.
- Access to outside groups and events.
- Habitual/historical occupations.
- Entertainment (is it just TV?).

Food

- Choice from a menu/making your own menu.
- Choice for preference (I just fancy...we always had....”
- Cultural choice e.g. halal, kosher food.
- Changing your mind.
- Drinks: frequency and type.
- Availability of snack/fruit.
- Snacks and meals for visitors.

Clothing

- Choice from own clothes.
- Requests for additional clothes.
- Changing clothes at will.
- What is appropriate or not.
- Protection of clothing.

Privacy

- Being alone or in company.
- Seeing visitors.
- Sleeping alone (is it always based on cost?)
- Personal care- help/not help; access to private toilets/bathroom
- A choice of whom helps.
- Sexuality and expression thereof.

Money

- Control of own affairs (is incompetence assumed?).
- 'Pocket money'.
- Access to cash.
- Are people in control of the encashment of pensions books?

Personal belongings

- How limited (does it depend on space or value?)
- Security (locked space., locked rooms)

Medication and other treatments

- Is ongoing informed consent sought and are people told that they have the right to refuse?
- Behaviour and communication i.e. the right to express anger, frustration, sadness.
- Access to other professionals (of privacy) and rights to request a change of professional worker.
- Changing needs.

Risk and Safety

- Dialogue between user and carers re: risky activities, permission to take risks, encouragement to take risks.
- Safety without restraint.
- Containment and control is often a carer's priority; is there permission for care staff to make mistakes.

Environment

- Choice about décor, noise, smell, temperature, space.

Belief

- Spirituality and worship and access to outside bodies.
- How is cultural difference respected?

Communication

- Interpreting services and choice of same sex interpreter and interpreter trained in the needs of this group of people.
- BSL (British Sign Language) interpreting- what about other languages?

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