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Patients' Forums
Visiting and Inspecting Project

Bristol and District Community Health Council

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December 2002

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Aims and Objectives

The new Patients' Forums will have the responsibility to visit and inspect acute, mental health and Primary Care Trust services. Community Health Council (CHC) members currently carry out the duty of visiting acute trust services and mental health services. The new forums will have the added duty of visiting and inspecting services from Primary Care Trusts (PCT's). Therefore it is essential that visiting is carried out in a constructive and appropriate way. Evaluation of the services from visiting and how this is reported back to the trusts must be thorough and purposeful so that areas needing improvement can be identified and addressed. It is also a good opportunity to let trusts and staff know of services that are performing well.

This project was a collaboration between Bristol and District CHC, other CHC's, a Primary Care Trust, an acute trust and lay people. The project aimed to find out what methods are used for visiting at present, how effective these are, how visiting could be performed by the new forums and what evaluation systems need to be in place to ensure that visits are reported back to the trust and to the patients.

This project answers the following:

- What acute trust staff, PCT staff and lay people think of the current system of visiting and how they think this could be improved by forums
- What CHC members think about the current system of visiting and how they think this could be improved
- How the current system of visiting is reported back to the relevant partners e.g. staff, departments and trusts
- How current visiting and inspecting is carried out by CHC members in Bristol and in two neighbouring CHC's

This report will go to the new patients' forums in the Bristol region and possibly further afield, to give them an idea of what has gone before. It also relays how participants felt an effective new system of monitoring can be achieved.

The report will also go to the Department of Health and the Commission for Patient and Public Involvement in Health for their consideration when setting up the new structures.

Executive Summary

- Lay visits to trusts are important to get an independent view from the patients' perspective.
- The lay members carrying out the visits should be representative of the community they serve
- Patients' forums must hold a high profile with the trust and the public
- Extensive and specialised training will be needed to equip lay members with the necessary skills
- Forums must think about the reasons for visiting and choose upon a themed, responsive or systematic approach
- Unannounced visiting could be useful in assessing services, however, it could make for bad relations with trust staff
- Focus of visits should be about talking to patients
- Visiting in Primary Care Trusts could prove difficult - issues around access to private GP practices must be addressed
- Feedback is very important and must go back to the trust at all levels and to the patients/public.
- Patients' forums must have the clout to make change happen
- Forums must work in partnership with other monitoring bodies, other forums, the trust, the community and patients
- Visiting should only be part of the way forums monitor trusts - there are many other methods

Are Lay Visits to Trusts Important?

The majority of participants felt that lay visits to trusts are important. It was felt that lay people could give an independent and neutral view of health services. They also add something to the overall monitoring process that happens within trusts at a patient level.

They give a snapshot report to a trust on a one-day observation and are likely to be important in drawing attention to problems seen by a lay visitor on an ordinary working day.
CHC Member

It is essential that the trust is visited by independent people, who can discuss with the patients and relatives any problems or concerns, and, of course, any ideas for improvement of service.
CHC Member

More involvement of patients the better. If it leads to patients having a bigger voice in the service delivery then yes.
Lay Group

Yes, very important. Visiting needs to be done at a number of levels, some by professionals but also by lay visitors.
Consultant Geriatrician (Acute Trust)

It could be a very powerful thing if it is co-ordinated properly. They could be very powerful if they truly represented the public view.
Medical Directorate (Acute Trust)

...it would be very useful for PCT's to have the patient perspective on these issues and could add more weight to any arguments they might have over getting funding for commissioning services.
Clinical Governance Directorate (PCT)

Good to have a lay perspective. Apart from the National Survey there is no monitoring from the patient's point of view.
Primary Care Manager (PCT)

They are definitely an important thing. It's good that someone completely neutral can look critically at services. They can look at things differently from the patient's point of view.
Practice Manager

Independent external visits to trusts are important ... They (lay people) have a more balanced view of services as seen by local people.
Health Visitor

Some participants, however, didn't see the value in visiting as a single method of monitoring trusts.

I am not certain that visits are important.
CHC Member

Visiting is only one part of monitoring trusts - they cannot cover the full range of issues.
Workshop Participant

Visits are not an end in themselves. The visit is just one technique for understanding the "patient journey". Lots of other ways of gaining patient feedback ...Patients' forums have to be careful not to be limited by the concept of visiting.
Workshop Participant

Visits are a very small and maybe the least valuable part of assessing trusts. Monitoring trusts is more important.
Workshop Participant

Who Should Carry out the Visits?

Participants were very interested in the make-up of the members that would carry out the visiting role. Most people felt that if the membership of the forum was not truly diverse then it could not successfully serve the community.

Most participants want to see a representative sample of the population that can speak on behalf of the community it serves.

Members should be representative of the population. Need to campaign and recruit people appropriately. Will need to convince them that it is in their interests for this to happen. Representation must be better than at present for any kind of credibility.
Medical Directorate (Acute Trust)

You must try to get ethnic minority members to represent themselves and their communities. The forum must be made up of all of the community it is there for.
Lay Group

However, there were questions raised about how true representation would be possible, given the limited capacity of the patients' forum.

Very difficult to represent all people. If there are gaps in representation they must recognise this.
Workshop Participant

How do you get a broad spectrum of people with such a small number?
Workshop Participant

A possible answer to this problem is to have adequate representation of voluntary sector organisations. It was also felt that members of the forum should work within the community and find out the issues that affect different people. They must then act on their behalf asking questions on visits that reflect their issues.

Multi racial link workers that focus on their own communities could be used to find out what their particular health issues are.
Lay Group

..act on behalf of those people in the community who are not represented on the forum by going to a contact point (community leader or users) for consultation before the visit to the service.
Workshop Participant

Most participants were concerned at the number of volunteers required to make up the forums. Some people also felt that the amount of time that members would have to commit to would discriminate against people with little time to spare.

Where will all of these people come from? There is no pool of volunteers.
Workshop Participant

All this is asking a lot of patients' forum members - where and how are the Commission going to find all the lay people willing and able to make the commitment necessary to be part of a patients' forum?
Workshop Participant

It's a lot of work to ask people to commit to and this would discriminate against certain sections of the population.
Lay Group

There is an issue around trying to recruit that many people and the quality of the people you would get...you don't want everyone of a certain type who are all retired or unemployed.
Primary Care Manager (PCT)

There were issues around members having previous medical knowledge or ex-employees of the NHS.

For some it would be beneficial to have some medical knowledge for a broader understanding of the issues.

...professionals can spot some problems that lay people can't.
CHC Member

There is not a problem with having ex-NHS staff...there might be an advantage to having these people as they would have background knowledge of the service.
Medical Directorate (Acute Trust)

Most people however felt that ex-NHS staff could not truly represent a lay view of services.

Lay people with medical backgrounds are not representative of the general public - they should not be included in visits.
CHC Member

...the service will change rapidly and they (ex-NHS staff) may have an outdated view of how services operate and the challenges they face.
Medical Directorate (Acute Trust)

Ex-NHS staff cannot be seen as lay people and should not be allowed to visit.
Clinical Governance Directorate (PCT)

Participants felt that the knowledge and training of forum members would need to be fairly extensive. They also felt that the members would need a sound, unbiased generalist view.

... people who are motivated, unbiased and understanding.
Medical Directorate (Acute Trust)

People who have a lay perspective, from a patient's point of view but also can assimilate information, ask questions and make sense of it all. They will need a range of skills.
Primary Care Manager (PCT)

Patients' Forum Profile

Participants thought it would be important for forums to make sure that they make themselves known. Some felt that trust staff should have an awareness of the significance and function of the forum for them to be effective. The profile of the forums must be raised in public also so that the community is aware of the role of the forum. They must feed back to the public effectively.

You have to make people aware that it will make a difference to them if they are to become involved.
Lay Group

Part of their effectiveness is to disseminate feedback to everyone. Make sure what they see and find is made known.
Lay Group

Forums must be made known to people for credibility.
Practice Manager

Publicity around roles/responsibilities of patients' forums - less than 3% know anything about CHC's.
Workshop Participant

Patients' forums also need to publicise their visiting work to local people/communities, raising profile and work of patients' forums.
Workshop Participant

Forums need to be seen and known to give them credibility - they must do the groundwork with staff and patients to publicise what they are there for.
Workshop Participant

Training

Participants felt that extensive and specialised training would be needed to enable the forum members to carry out their duties properly. It was felt that training is needed for general skills e.g. facilitation, report writing, interviewing etc. as well as learning clinical or medical terms.

Must train people to be able to do the job properly - teach them clinical terms etc.
Lay Group

Should be trained in facilitation skills and report writing.
Medical Directorate (Acute Trust)

How to talk and listen to patients who may be ill, vulnerable and frightened, when it is and is not appropriate to talk to patients, interview and listening skills.
Workshop Participant

Interviewing is a skill and cannot always be taught - some people may be unsuitable.
Workshop Participant

There was also a need for members to have sound background knowledge of the services they would be visiting and how it fits into the overall context of the trust and the NHS. This would also help the members to ask appropriate questions to medical staff and not be intimidated by the situation.

Visitors must have the right support and training so that they are asking the right questions.
Lay Group

There are big training implications for volunteers. If they aren't the right people they may ask inappropriate questions. Need to be taken seriously.
Lay Group

Needs to be training around the structures of organisations, the stratification of control, management structures and knowledge of how the organisation operates.
Lay Group

...many may need communication skills training, especially when dealing with professionals as this could be a barrier for lay people - they need the confidence to ask people what they need to know.
Lay Group

Need to know what they are looking for and have an understanding of practice.
Primary Care Manager (PCT)

Before the Visit

Most participants felt that for the forum members to carry out their role effectively, they must have information about the service area they are monitoring prior to their visit.

The best way to carry out visiting is to have as much information as possible before the visit from the trust. This would leave more time to talk directly to the patients and relatives.
CHC Member

Need hard information before visits e.g. trolley wait statistics, outlyers, bed blockers, cleaning record, delayed/cancelled patients, recent patient surveys, etc, so have proper background to be able to ask useful questions.
CHC Member

Before the visit they should get documents in the public domain, annual plan, CHI review etc. Find out about clinical governance arrangements, HIMP and look at how they are spending their funding.
Lay Group

They need to link closely with the Primary Care directorate as they can provide lots of information and data before the visit.
Primary Care Manager (PCT)

There was also a need for patients and staff to be aware that the forum was going to visit so that they could prepare themselves and any questions or issues they may have to discuss.

Before visits patients could be given some information about the visit taking place and given a card or form to fill in to say either what they feel or to ask for an interview.
CHC Member

They should continue to send out fliers before the visits to display in the wards so that patients and visitors are aware they are coming. This prepares them for the visit.
Medical Directorate (Acute Trust)

...they must do the groundwork with staff and patients to publicise what they are there for.
Workshop Participant

Reasons for Visiting

Participants had mixed views about how the services to be visited should be decided upon.

Some suggested that visiting should be carried out within a structured rolling programme to all areas of the trust at regular intervals. These would be conducted to specific departments/wards within the trust.

There should be a flexible but structured visiting programme. Regular visiting to all parts of the trust.
CHC Member

Perspectives are most useful if they are confined to a particular area e.g, one ward or one department.
Consultant Geriatrician (Acute Trust)

Other participants wanted to see responsive visiting to areas of interest from media intelligence, complaints etc. It was also felt the forum could investigate areas of concern from the trust e.g. PALS or the PCT.

Some visits should reflect either a press article e.g. poor cleaning standards, or a series of complaints received or coming to the notice of PALS.
CHC Member

...ad hoc visits quickly arranged in response to press articles or a combination of similar complaints.
CHC Member

They should look at complaints and issues from PALS and take topics from these e.g. communication.
Medical Directorate (Acute Trust)

Forums need information from PCT's before they visit and then just ask them specific questions about specific issues of concern e.g. why are things below the national average etc.
Primary Care Manager (PCT)

Need to link to PCT priorities to give it some weight - look at the PCT's remit and priorities to concentrate on areas that could be changed.
Director of Primary Care (PCT)

PALS can identify gaps in trust services for visits to occur.
Workshop Participant

It was also felt that forums could undertake themed visiting within trusts to look at particular issues either clinical - diabetes, elderly care etc or general - cleanliness, staff communication.

PCT forums should have a role in suggesting themed visits. They could either carry out visits themselves or ask acute trust forums.
CHC Member

Members could be responsible for an area of interest e.g. one person is responsible for Stroke Services and goes to working groups in the trust. They could also get involved in the community to find out what the issues are for their particular area.
Medical Directorate (Acute Trust)

There will need to be themed visiting, focusing on specific areas e.g. environment of practices, waiting time, confidentiality etc.
Clinical Governance Directorate (PCT)

There were concerns that, as forums would now only cover one trust, there is no point of reference for comparison between trusts and any conclusions could be subjective. It was thought that collaboration between patients' forums would be essential.

Themed visits will be lost - under the present system it is useful to compare like with like. Danger of parochialism?
CHC Member

There needs to be an overall focus on the issues - one overarching group should be established across health boundaries and trusts to get the whole picture.
Lay Group

It would be better to look at the whole picture in a location e.g. over a county to compare services and gain a proper overview. Links between forums are therefore essential. Commission staff could make these links and arrange joint meetings between forums.
Workshop Participant

Unannounced Visiting

There was mixed opinion about the merit of carrying out unannounced visiting in trusts.

Some participants felt that it could be a good way of finding out exactly what happens within services with no time for them to 'prepare' before the visit. They also felt that it was a way of encouraging services to accept that external lay monitoring is part of the culture.

Visit with minimum notice. Especially where there is information from sources such as the media, leading to a feeling that a problem may exist.
CHC Member

Unannounced visiting is paramount - they should have access 24/7 and speak to anyone, anywhere to get snapshots of the services.
Lay Group

There is a value in unannounced visits used far more - within a culture where this is understood.
Workshop participant

Others, however, felt that unannounced visiting would not be of much benefit. They felt that it could make for bad relations with trust staff. There were also issues around confidentiality and patients choosing to be involved in the visits before they happened.

...you don't know if they would change things and you may get a better staff representation if they are aware you are coming. They may be too busy to talk to you otherwise.
Lay Group

It would make for very bad relations expecting spot checks - could be perceived as 'big brother' - there would be no quality from this information.
Lay Group

A good visit should address issues over and above the way things seem to be working on that particular day...they would be perceived as being hostile and staff would not necessarily have the time necessary to engage with the visit.
Consultant Geriatrician (Acute Trust)

It could antagonise already difficult situations. There are also issues around consent from patients - cold calls assume consent, which is blatantly wrong.
Medical Directorate (Acute Trust)

If they are given notice then appropriate staff can be found to show them around and answer questions, they can be told the best time to come so that it is not too busy/quiet.
Operations Manager, Critical Care (Acute Trust)

Some participants felt that an initial visit should be carried out with an unannounced follow-up visit to check that services worked to the same standard as on the original visit and to check if any recommendations from the initial visit had been followed through.

There could be an initial fact finding visit and then over the proceeding month further visits undertaken at random intervals by members.
CHC Member

Meet first with staff then 'drop in' some time during the week (unannounced) to watch and talk to service users.
CHC Member

Might be a useful thing to do as a second layer of visiting. The first visit would happen and recommendations would come out of this. A second unannounced visit could then happen to check that the changes had been made.
Primary Care Manager (PCT)

The Visit

Most participants felt that an overall structure was needed to ensure continuity and standards.

Develop specific protocols for individual visits. This would perhaps give teams a baseline from which to work whilst still allowing free-ranging discussions during the visit.
CHC Member

It would be useful to have a national approach for monitoring trends.
Medical Directorate (Acute Trust)

Main thing is to have basic standards as expectations differ from lay people i.e. some people have low expectations about their healthcare and some are reliant on their practices and use them frequently. It could be subjective as to how people view healthcare.
Health Visitor (PCT)

Structures for visits must be in place so that they are meaningful.
Workshop Participant

All participants felt that the focus of the visits should be about talking to patients about their experiences of care. Some felt that this was important to do in a hospital setting where it was fresh in their minds. Others felt that some patients might not want to discuss the service around staff as they may be fearful of repercussions on their care. It was also felt that the patients interviewed should be representative of the community.

The random chatting to patients doesn't work with staff around etc.
CHC Member

Talk directly to the patients and relatives, although it is possible that patients may feel that they are constrained in expressing views whilst in the hospital environment. It should be made clear that all opinions and experiences collected can only help to improve the services.
CHC Member

The focus should be shifted away from staff views and onto what the patients think and want. This can be done with interviews and surveys etc.
CHC Member

You should talk to the patients, the receivers of the service to see how they would assess the care they receive.
Health Visitor (PCT)

Patients that are questioned during visits need to be representative of the whole.
Clinical Governance Directorate (PCT)

It was felt that there could be communication difficulties when talking to patients because lay people may not know what type of questions to ask. It is also felt that it is a difficult task to talk to patients who may be very ill. There may also be real communication issues around talking to patients who do not speak English or have hearing impairments. Lay people cannot be expected to be adept at communicating in all situations.

There must be established ways of talking to people who do not speak English. There must be translation of any forms or questionnaires so that all can be involved and give their opinions.
Lay Group

Lay people wouldn't know where to begin - there are no obvious questions.
Lay Group

...you must think very carefully about what you ask patients. I don't know how it would work in practice or whether they would listen.
Practice Manager

Must reach people whose first language is not English - some advertising and visiting methods may not work.
Workshop Participant

Participants also felt that it is very important to talk to staff at all levels to gain an overview of what happens within the service and any concerns or issues they would like to raise. Members should not just talk to management within the service.

Always to talk to a variety of staff and not just to get the manager's view - what if the manager is poor or holds a contrary view?
CHC Member

Talk to organisation at all levels from domestics to managers. Broader perspective from every section - users, deliverers and strategists.
Lay Group

You should also talk to practitioners as they may have issues around not being able to provide the total service they would like because of other factors e.g. resources etc. This would be a good way for practitioners to get their point across and put to the trust.
Health Visitor (PCT)

It was also widely held that carers hold a valuable insight into the service that is provided. They can often see through the situation in a way that the patient may be unable to do.

Carers are a good source of information about patients' care and also have valuable experience as volunteers coming from a different perspective.
Lay Group

Lay visits, particularly those looking at the way we work from users' and carers' perspectives are most useful...
Consultant Geriatrician (Acute Trust)

Carers must be listened to as well as patients and staff.
Workshop Participant

All people wanted members to talk to the combination of all of these people to gain a full picture of the service overall.

It is important that the visit includes interviews with clinical staff, non-clinical staff, patients and carers.
Consultant (Acute Trust)

It must be a 360° appraisal of everybody from staff at all levels and all patients.
Primary Care Manager (PCT)

It was generally felt that the forum should be there to look at environmental issues for patients e.g. levels of cleanliness, food etc, as well as structural and clinical arrangements. It was not felt fair to expect a high level of clinical knowledge from members. However, it was felt that it would be better to concentrate on smaller issues that could be changed for patients rather than large organisational arrangements.

Everyone is keen to know of any gaps in services, whether it be cold food or lack of respect, which might be quite normal to people used to hospitals but can be distressing when one is frightened and frail.
CHC Member

Also, irrespective of the primary purpose of the visit, there is a need for comments on perceived levels of cleanliness, house keeping and the catering regime which require close monitoring. This, in effect, means a two tier report: the specific task and general observations.
CHC Member

Root out small problems from patients so that the little things can be fixed - this makes enormous differences when ill e.g. mending broken windows, clean surroundings.
Lay Group

It would be better to focus on small things and get them really right than something about the whole that is superficial.
Primary Care Manager (PCT)

Visiting in Primary Care Trusts

Additional complications arose when talking around the issues of visiting within Primary Care Trusts (PCT's). There has been no lay monitoring within PCT's until patients' forums and some participants thought that this could present problems.

Forums will need to sell visiting to practices so that it is not looked on as yet another monitoring body. Use their ability to gauge patient opinions as a positive thing for the practice - that it would be conducting public involvement work on their behalf so they do not need to use up their time/resources.
Clinical Governance (PCT)

Should go in to look at standards but dress it up differently to other monitoring - should be an element of 'policing' or they will not take it seriously. GP's haven't been subject to monitoring - there has been lots of data collection for clinical governance but no assessed visiting.
Director of Primary Care (PCT)

Idea behind visits is to improve quality of service but GP's are independent practitioners and need to get them on side so that things are done.
Primary Care Manager (PCT)

Practitioners should be receptive of the idea as long as they can say honestly about the situation and highlight areas that need improvement because of lack of resources without fear of being blamed for this.
Health Visitor (PCT)

There are concerns about access into practices within PCT's. Although the visiting within practices will be mandatory, there was confusion over the rights of the forum and whether private practitioners would be receptive to allowing forums to carry out this duty.

There is a real issue about access rights. Practices are mostly not owned physically by the NHS and therefore can refuse entry. The buildings are usually owned by the GP's so they may tell forums that they are not allowed to enter. This is why they will need to sell the idea to them as a positive experience.
Clinical Governance Directorate (PCT)

If government go with a process that means forums must have access then it will be easy. They would have to comply, depending on how it is set up. This is the only way it could work. You could make it voluntary but the PCT are aware of failing practices that aren't doing as much as they could and they wouldn't want to take up an offer of a visit voluntarily.
Primary Care Manager (PCT)

It depends on the agenda but some GP's would probably say no.
Practice Manager

Visiting within a community setting is also an area that may prove complicated. There are issues around patient confidentiality. There are also issues around forum members having the knowledge to assess if the practitioner is doing their job efficiently. There would also be little opportunity to talk to patients privately if out on a home visit with a clinician.

How will the visiting happen with district nursing or CPN's (Community Psychiatric Nurses)? They may have confidentiality issues when visiting patients.
Lay Group

Community visiting will be very difficult to monitor - cannot go out into people's homes with staff and ask about their services. Could ask the people in the practices as they could well have some knowledge about community services.
Director of Primary Care (PCT)

District nursing and health visiting would be a little more difficult to manage. You could go out with health visitors but then there are patient confidentiality issues to take into account. You would have to ask the patients about the service they are getting from the community teams without actually monitoring the way in which individual clinicians operate. It would be very difficult for a lay person to understand if a clinician is acting correctly anyway.
Health Visitor (PCT)

After the Visit

All participants felt that feedback is very important. Feedback should go to the trust at all levels and to patients and the public.

Reporting back structures to the trust must be sound and heard.
Lay Group

Feedback is essential, otherwise the visit serves no purpose. Verbal and written feedback are appropriate. It would be nice if feedback could be provided to staff and managers.
Consultant (Acute Trust)

Feedback should go to anyone who wants it...part of their effectiveness is to disseminate feedback to everyone. Make sure what they see and find is made known.
Lay Group

Feedback should go to the PCT, the practice and the staff.
Director of Primary Care (PCT)

Very important. Have had people in before and got no feedback from it. It is annoying not to know what happened.
Practice Manager

Patients' forums also need to publicise their visiting work to local people/communities, raising profile and work of patients' forums.
Workshop Participants

Participants were divided as to how feedback should go to the various parties. All agreed that there needed to be different feedback mechanisms for different people. Various suggestions for feedback were put forward including traditional written reports. It was also agreed that they should be of a set standard.

A good report should produce a right and proper feedback from the trust. This aspect may require careful monitoring.
CHC Member

Need for standardisation of reports.
CHC Member

The members must understand the framework and use this for every report so they know what they are looking for.
Medical Directorate (Acute Trust)

Report writing was seen by some as too complicated for lay members to undertake and too subjective for a trust to take seriously.

Not all lay people feel comfortable with writing formal reports - can be considerable burden, may put off potential forum visitors. If staff to be involved, at what point should they be brought into the process?
CHC Member

Report writing after (the visit) can be inaccurate and factually incorrect. Should have an original concept of what you want out of the visit and reporting would be easier.
Lay Group

A skilled facilitator will be needed to convey the opinions of the lay people. The report should be as professional as possible so that staff and the trust take it seriously.
Director of Primary Care (PCT)

Participants came up with other ways in which to report back to the trust and to patients. Many thought that verbal reporting to the trusts would be a good way of feeding back information, giving them a chance to discuss the issues raised. Others came up with innovative ideas to get the messages across.

Forums should think about how information is gathered by special methods e.g. video camera, tape recordings etc. to cater to individual forum members' capabilities.
Lay Group

Verbal feedback may be very useful for staff to have an input before the final report is written. May be things that have been missed as cannot capture everything in a 1/2-hour period.
Medical Directorate (Acute Trust)

Feedback to patients could happen through PCT newsletters, websites, and the team brief newsletter for staff.
Clinical Governance (PCT)

There should be different levels of feedback to the Boards and to the practice.
Primary Care Manager (PCT)

Physically come in and then come back and feed back to one person and they can feed back to all - rather than just a written report. There need to be outcomes and recommendations.
Practice Manager

Most participants felt that Board level feedback was essential and, as they are public meetings, the feedback would be in the public domain.

Every Trust should have "visits" as a standard agenda item at Board meetings.
CHC Member

Board meetings are public meetings and they would be fed back at this level.
Lay Group

Feedback should go to the board of the PCT and there should be meetings with practitioners and service managers to make a structured plan with time for implementation and evaluation.
Health Visitor

Look at minutes of board meetings. Non Executive Director will be a lynch pin to talk back to the Chief Executive and the board to tell them of the visiting.
Lay Group

Participants felt that it was very important that feedback and recommendations put to the trust should be acted upon and within an agreed timescale.

Trusts must have to DO something about recommendations made or this is all a waste of time.
Workshop Participant

Timely response from trust required.
Lay Group

There has to be more follow-up and recommendations and actions. Might work better with the forums as they have direct contact with the board, giving more impact.
CHC Member

Non Executive Director puts to board an agenda and areas identified for improvement should be monitored at this level if necessary.
Lay Group

Any recommendations should be implemented by managers. Clinical staff must be aware of this as it allows them to put pressure on managers to implement changes. There may also be changes in clinical practice which can be implemented at a local level.
Consultant (Acute Trust)

There should be an agreed action plan with the trust after the visit.
Medical Directorate (Acute Trust)

All participants felt that a follow-up visit is essential to monitor the trust's progress, with changes that need to be made coming from the recommendations.

Follow-up visits to confirm that promised improvements had actually taken place.
CHC Member

Follow-up visits should then be carried out but allow time for change to happen.
Lay Group

There must then be a follow-up visit to the area to ensure that these changes have happened. There must be a continuity of members going back to the same areas.
Medical Directorate (Acute Trust)

Recommendations made should be followed up. An action plan should be devised with the report and follow-up procedures should be in place.
Operations Manager (Acute Trust)

Follow-up visits must be made to see that changes have been made.
Workshop Participant

Power of Patients' Forums

The influence and power the patients' forums have over the trusts will be a deciding factor in what can realistically be achieved by the forums in the context of visiting. If the forum has little or no power to implement change then the trust could easily not react to calls for action. Participants firstly asked what power the patients' forums would have to make changes.

What powers will patients' forums have?
Lay Group

What sort of "powers" does a patients' forum have to ensure that things happen and so guard against cynicism amongst patients' forum members and wider local community?
Workshop Participant

The participants called for the forums to hold some weight with trusts so that recommendations and calls for change are implemented.

They must have the power to influence change. It will only work if you pull something off that has teeth that produces change. Change should not be quick and superficial, it should be sustainable, positive, slow change.
Lay Group

Needs some teeth to be effective and attractive to practices. If there are recommendations, it will depend on the clout of the forums.
Director of Primary Care (PCT)

Must have the necessary clout to make changes - many voices saying different things may not be heard.
Workshop Participant

Working in Partnership

Participants felt that a great deal of partnership working would have to be undertaken by forums if they were to work effectively.

There should be an ethos of 'all in it together' rather than trying to work against each other.
Director of Primary Care (PCT)

The aim for patients, the forum and trust staff should all be the same. Therefore they would be very useful in highlighting the problems. Partnership working is key - trust, community and patients.
Medical Directorate (Acute Trust)

It was felt that forums would need to work closely with trusts to make sure that they were aware of what they were trying to achieve and also so that they weren't alienating them by coming across as too much of a policing body. It was felt that the experience must be perceived as positive by the trust to ensure their co-operation.

Importance of explaining visits positively to Trust staff - they need to perceive forums as partners in achieving improvement in patient care.
CHC Member

They should work in partnerships with trusts and use PALS to set up the process - this would give added value to the reports and add to the clinical governance agenda and things might actually get done.
Medical Directorate (Acute Trust)

Forums will need to sell visiting to practices so that it is not looked on as yet another monitoring body. Use their ability to gauge patient opinions as a positive thing for the practice.
Clinical Governance Directorate (PCT)

It will need very careful national and local handling. If changes and improvements are to be made then you can't go getting on the wrong side of people.
Primary Care Manager (PCT)

Relationships with the community and community organisations will also be important to forums.

You must link with communities to find out their issues to take back to the trust.
Lay Group

They (members) could also get involved in the community to find out what the issues are for their particular area. This would build a feeling of trust and ownership across the health community.
Medical Directorate (Acute Trust)

Forum must ask communities what issues they face. Training on cultural issues by forums will be very important.
Workshop Participant

Use appropriate community contacts for correct information e.g. the service user. There are resource implications when 'using' community groups for information/help.
Workshop Participant

There will also need to be good links between patients' forums so that there is no overlap in work and also to work across trust boundaries for the patient.

PCT forums could either carry out visits themselves or ask acute trust forums (PCT forums will have acute trust reps). Could visiting be swapped between PCT and acute trust forums?
CHC Member

There is also potential duplication with other forums. As PCT's commission services from hospitals, then acute trust and PCT trust forums could want to monitor the same services. Needs a lot of co-ordination between forums.
Primary Care Manager (PCT)

Links between forums are essential to pick up on problem areas. Commission staff can make links and arrange joint meetings.
Workshop Participant

Working with Existing Monitoring Bodies

There was some concern from participants that the visiting and monitoring carried out by forums may overlap with the work of other monitoring bodies, especially the Commission for Health Improvement (CHI) and clinical governance.

Make sure that monitoring is not duplicated with other systems e.g. CHI, clinical governance etc.
Lay Group

There is a danger of duplication with the work that CHI does.
Primary Care Manager (PCT)

CHI look at whole areas - there is no need to duplicate this work.
Medical Directorate (Acute Trust)

Has to add something over and above what CHI sets out to do. Don't duplicate the existing monitoring by other bodies.
Director of Primary Care (PCT)

Most participants saw a need for forums' visiting to fit within other monitoring structures so that a whole picture can be established.

There should be an overall national strategy for quality control of clinical service. Lay visiting should be part of the overall strategy. They should input to local clinical governance meetings and sit on both national, e.g. CHI, and local monitoring agencies.
Consultant (Acute Trust)

Clinical governance also needs to be closely linked, as does the Board.
Primary Care Manager (PCT)

However, most people felt that the visiting by the independent lay body would be beneficial to services and give a very different view to other monitoring mechanisms.

It would fit in with other monitoring mechanisms because it is an independent, objective assessment of what's going on.
Health Visitor (PCT)

Think it's good to be monitored by however many bodies. You can think things are good but sometimes need an objective view to see the problems. Some staff may not appreciate it but, on the whole, most staff know it is a valuable thing to do.
Practice Manager (PCT)

Consultation Overload

There are real concerns by some participants at over-consultation with the public. If people are repeatedly asked what they want, with little or no action taken, it could lead to cynicism and apathy.

There must be confidence about where the information is going and that it will be acted on. You get consulted over and over again and never see any actual results.
Lay Group

Patients will not want to speak to people unless they see that differences can be made.

You have to make people aware that it will make a difference to them if they are to become involved.
Lay Group

Do not ask people what they want if you are not prepared to give it to them, this makes for cynicism. If you ask questions you must respond to the answers.
Lay Group

Forums could recognise gaps but not necessarily make anything happen. This could be very disillusioning to lay people - shouldn't ask people what they want when you can't deliver.
Clinical Governance Directorate (PCT)

Patients need to feel that their comments will be acted upon. There are ethical issues around asking people what they want and raising expectations if they won't be met.
Health Visitor (PCT)

New Ways of Working

Participants came up with a range of ideas for gaining patient feedback about their care. Visiting, although important, was seen as one of a number of ways to monitor trusts from a patient's perspective.

Patients could be given a card or form to fill in to say either what they feel or to ask for an interview with a member. This could be done in total confidence so that patients feel able to speak without fear of repercussions on their care.
CHC Member

Shadowing patients very helpful, use patient diaries (written and audio) and use video booths.
CHC Member

Regular questionnaire surveys of patient and client satisfaction with various aspects of the service would be helpful. The trust should also have a patients' forum or users' group which lay members should be able to join.
Consultant Geriatrician (Acute Trust)

...get together a range of patients and carers and do a focus session on a topic rather than a whole service area.
Medical Directorate (Acute Trust)

Other ways to engage with patients could include questionnaire, forums, independently facilitated focus groups. Forum should work with the trust to design an audit tool to gather information from patients.
Operations Manager (Acute Trust)

Lots of other ways of gaining patient feedback e.g. user focused monitoring as organised by mental health support groups, knowledge and contacts in local health related voluntary groups, individual patient interviews, patient shadowing, patient held diaries, user focus groups.
Workshop Participant

Should be a built in evaluation of services at a less time consuming level - e.g. comment boxes, questionnaires etc.
Workshop Participant

Current Ways of Working by Community Health Councils

Three Community Health Councils (CHC's) were asked to be involved in this project - Bristol and District (B&D), Bath and Salisbury. An appraisal of the visiting techniques used by each CHC was carried out by talking to staff and reading protocols and previous reports. This section provides an outline of what happens on visits conducted by CHC's. For the purposes of this, 'members' means members of the CHC's who carry out visiting duties.

Who Carries out the Visits?

B&D and Salisbury CHC's members choose to become involved in visiting. There are 16 members from B&D and 15 from Salisbury. All members from Bath CHC are involved in visiting with 21 members carrying out the task. This gives a total of 52 members involved in visiting in the three CHC's sampled.

The gender balance is mostly female with a ratio of 34 women: 18 men.

There are no members involved in visiting from ethnic minorities in any of the CHC's.

The age of most members is 60 years plus. Bath has a member in their late 40's but the rest of the members are retired.

There are four members with physical disabilities.

There is a high proportion of members with previous medical knowledge from either being ex-clinicians or NHS managers - half of all members in Bath and a third in B&D and Salisbury. This averages at approximately just over one third of the total group.

Training

B&D have carried out two training sessions in the last two years. One was held for new members and the other as a refresher course for more experienced members.

Salisbury provide an induction programme for new members which includes training for visiting. Training specifically on visiting is held every 12-18 months. A half day session is run by the chief officer to go through the visiting pro forma and guidelines, and they also practise on wards.

Bath have training as part of their induction process and also hold on-going training sessions.

Reasons for Visiting

In the year from 1st April 2001 to 31st March 2002 B&D conducted 20 visits, Bath 17 and Salisbury carried out 22 visits.

Salisbury has a rolling programme of visiting over a two-year period. B&D carry out themed visiting e.g. care of the elderly services, etc. Bath carries out visits that are decided upon by matters arising from recent intelligence e.g. complaints, media coverage, comments from patients/staff etc. Bath and B&D also carry out visits to areas of concern on an ad hoc basis.

Unannounced Visits

There are no formal arrangements for unannounced visits within trusts by any of the three CHC's. Bath and B&D used to carry out unannounced visiting but found it unproductive. Bath will sometimes 'pop in' to problem areas that have been identified by previous visits. However, this is very informal and not recorded.

Arranging Visits

All CHC's write to the trust requesting a visit to the particular department. Bath asks the trusts when is suitable for them for the members to visit. B&D and Salisbury give the trust a selection of dates and times suitable for the members and the trust chooses one of these. Letters of confirmation are then sent to the members involved and the trust.

Before the Visit

All CHC's appoint 2/3 members to carry out the visit and one of the members is designated as the report writer. Along with the confirmation letter, Salisbury send out any previous report carried out on the department to be visited. Members are also provided with a map.

B&D include with their confirmation letter, a briefing note with key issues to look for on the visit. Background information is requested from the department e.g. staffing levels. This is given to the visiting team to read prior to the visit. Two display notices are given to the trust to put up on notice boards to inform patients and staff of the visit.

Bath members decide whom they want to do the visit with. They may meet up before the visit to discuss what questions they will ask. They are given a report form, contact person's name and a map. Most information from the trust is given to them while they are there or afterwards at their request.

The Visit

Bath members go to reception on the department, noting how easy it is to find. They meet with the contact person and go through the questions on a set form, trying to be relaxed and low key. They will then be taken on a tour of the department where they will talk to other staff and to patients. Staff are not gathered to talk to the members. Members record the information gathered on a set report form. This form will tell them what needs to be asked and also gives them space for general observations or areas of particular interest.

Salisbury also go to the reception and meet with the named person - usually the manager, senior nurse or sister. They talk to all staff on the department. Some visits will include talking to patients but some members don't feel comfortable enough to do this. There is more emphasis on staff input than patients. They work through a checklist of questions about the nature of the service. Members take notes during the visit to write up later.

B&D members are usually escorted by trust management on the visit. They also meet with other staff but do not always have the opportunity to speak with them privately. They also do not always talk to patients.

After the Visit

Bath and Salisbury members will sometimes meet after the visit to discuss what happened and what should be put into the report. B&D members do not meet after the visit.

The report writer from all CHC's then writes up the report/report form and circulates this to the other member(s) for comment/editing. The reports are then sent to the department visited for factual corrections. B&D report is sent to a Visiting Committee for approval and a summary of visits is then reported to the Full Council. Bath and Salisbury reports are sent to the Full Council of the CHC for approval.

Feedback to the Trust

Reports are then sent to the department visited and/or the Trust board, the full CHC council, the Strategic Health Authority (StHA) and the PCT.

Recommendations

Bath recommendations are followed up as action points at council meetings. If big issues arise that may be present in other departments, it may turn into a full project. Action is taken very quickly if necessary. If there is a particular issue of concern, the PCT may be informed and asked to attend a one-off single-issue meeting.

Salisbury members will follow up the recommendations as a matter arising at meetings. Emails are sent to the department as reminders and to get an up-date of changes made. It will not be followed up formally until the next visit in two years time. If it was a serious matter then something would be done to follow up. Members do pop into wards to check up on what's happening.

B&D hold quarterly CHC/Trust liaison meetings to pick up on action points raised to see how they are being addressed.

Changes from Visiting

Salisbury have made mainly peripheral changes, e.g. décor, environment, toilet and washing facilities etc. Sometimes the reports add weight to a broader argument for change.

Bath has made many changes to the trust over the years but sometimes it can take a long time for things to happen. Examples of change are - signposts in hospitals around the trust, re-allocation of space, awareness of soiled linen, senior management involved in some of the problems, getting people consulted on issues e.g. delays or changes to services.

B&D reports are mostly positive and have not always made recommendations for change. However, some visits have called for action and results have included provision of hot food in A&E department, better linen supplies, signage etc.

Visiting in PCT's

Bath and B&D have not carried out any visiting in PCT's.

Salisbury have been conducting visiting in PCT services for the past four years. There are 22 GP practices involved in the project. The visits are conducted in a similar way to trust visiting. Practice managers are written to, seeking their agreement to take part. An agreeable date is then arranged for the visit. A member is assigned to the practice to go and talk to a member of staff.

CHC Staff and Member Opinions on Current Visiting Methods.

CHC Members and staff were asked to think about the way visiting is carried out at present and how it could be improved in the future. Most felt that the current form was an adequate system, providing an in-depth look at the way in which services are run.

Think visits are very good and wouldn't want to lose them.
CHC Staff Member

Wouldn't change it - on the whole, the broad structure is OK.
CHC Staff Member

Yes, I think that this is the best way to carry out visits.
CHC Member

Some felt that there were improvements to be made to the system, mainly around a more in-depth look at the service involved. They mainly felt that members should have more contact with patients and more time should be spent talking with patients and carers. Some felt that the way patients are spoken to in the ward environment was not ideal.

The random chatting to patients doesn't work with staff around etc.
CHC Staff Member

...leave more time to talk directly to the patients and relatives, although it is possible that patients may feel that they are constrained in expressing views whilst in the hospital environment.
CHC Member

Talking to patients can bring about change.
CHC Member

Important to talk to patients at the time of their treatment/hospital stay - patients' perception of their care can change over time.
CHC Member

More time needed on visits to spend with patients/carers.
CHC Member

The focus should be shifted away from staff views and onto what the patients think and want.
CHC Staff Member

Most members and staff felt that it was very important to speak with managers and staff of the service. Some felt, however, that there should be a shift away from seeing only management and include more of the frontline staff.

Tend to be seen by a manager, may be more advantageous to see staff members to be shown around and then talk to the manager later on.
CHC Staff Member

I think that we should speak to more of the front line staff, not the managers.
CHC Member

Some people didn't know what effect, if any, the visiting actually made to services. They felt that trusts often listen to what the members recommend but don't know in practice how much is actually changed.

The written reports do seem to have an effect, although I do wonder if this is cosmetic on occasions.
CHC Member

...the monitoring of effectiveness of change is not often available and sometimes it is difficult to challenge inaction brought about by resource restrictions or prioritisation of other policies, either national or local.
CHC Member

In reality little, if any, actual improvement.
CHC Member

Visits may make CHC members feel good but little evidence they change things and often are regarded by staff as very amateurish.
CHC Member

They felt that the trust should have to respond in a more proactive and defined way so that changes are recommended and followed through.

There has to be more follow-up and recommendations and actions.
CHC Staff Member

Trusts must take visits seriously and respond properly instead of fobbing CHC off.
CHC Member

Need to be assured that improvements have been made, not just promised.
CHC Member

External Opinions of Current Visiting Methods

There was mixed feeling about the way in which visiting by CHC's was perceived at present. Some felt that the current form of visiting was adequate and should only be modified by patients' forums. Some, however, felt that an overhaul of the way in which they worked was needed. They also felt that they needed to be more representative of the community.

Past criticisms of the CHC were around the types of members - they must not replicate the CHC.
Primary Care Manager (PCT)

Need a different beast - people who are motivated, unbiased and understanding.
Medical Directorate (Acute Trust)

Patients' forums will be much closer to trusts than CHC's are (smaller areas to cover) and should be able to develop closer links and reflect local concerns better.
Workshop Participant

Different models of lay visiting - CHC model is not the only or necessarily the best model.
Workshop Participant

There is a danger for CHC members, if appointed to forums, to turn them back into CHC's. However, best practice by CHCs must be taken forward to the forums.
Workshop Participant

Methods

Participants were recruited by writing to contacts already held on a database by Bristol and District CHC. There was also an article in the local voluntary sector newsletter inviting people to get involved.

Participants invited to become involved were:

13 CHC members (13 involved);

56 lay groups (8 involved);

64 acute trust staff (12 involved);

63 PCT staff (10 involved).

Various methods were used during the project. Consultees were always asked to choose their preferred way of involvement with the project. Options included one-to-one interview, telephone interview, questionnaire, facilitated workshop session, group discussion or project involvement to be put as an agenda item at a meeting. People were also asked if they had any other preferable methods that they wished to be used.

All interviews and groups sessions were held at the consultee's place of choosing at a date and time convenient to them. Lay people who were involved were offered re-imbursement for any expenses incurred.

The workshop was held over one day involving two facilitated workshop discussion sessions. The 32 participants were split into three groups with a proportionate number of people from the different sectors.

By the end of the consultation there had been 4 discussion groups, 1 workshop, 12 completed questionnaires and 14 semi-structured interviews.

Sample

19 lay people/voluntary group members and officers from the following groups:

FRIEND- mental health advocacy project
Bristol Racial Equality Council
National Osteoporosis Society
Bristol MIND
Patients' Council, Barrow Hospital
Bristol Older People's Forum
Bristol Lesbian, Gay and Bisexual Forum
Avon Chinese Women's Group

CHC's - Bristol, Bath and Salisbury

6 Staff and 13 Members

PCT Staff

Clinical Governance Manager
PCT Complaints and Incidents Policy Officer
Primary Care Manager
Director of Primary Care and Children's Services
2 Practice Managers
Health Visitor
Community Development Manager
Director of Planning and Partnerships
Vice-Chair and Non Executive Director

Acute Trust Staff

Consultant Geriatrician
Head of Nursing (Medical Directorate)
Lead Nurse (Medical Directorate)
Operations Manager (Medical Directorate)
Consultant Haematologist
Operations Manager (Critical Care Directorate)
Ward Manager (Care of the Elderly)
Head of Nursing (Orthopaedic Centre)
Consumer Involvement Facilitator
PALS Administrator
Clinical Governance Manager (Mental Health Trust)
Lead Nurse (Mental Health Trust)
PALS Manager

Acknowledgements

Bristol and District Community Health Council would like to thank everyone who was involved in this project for their time and support.

Special thanks also to Sheila Page and the members of the Bristol and District Community Health Council for their help and assitance.

Emma Burton

December 2002