Enter & View Workbook

Purpose

The purpose of this workbook is to support authorised representatives in the practicalities of undertaking enter & view visits to providers of health & social care in accordance with Healthwatch policy. It offers an analytic framework for visit planning, conduct and reporting.

Contents   Page

A. Planning the visit

1. What is the rationale for the visit?

    1.1. What is the purpose of the visit?

    1.2. Does it form part of an approved evidence based project?

    1.3. On what information is the visit based?

    1.4. What are the specific objectives of the visit?

    1.5. What are the intended outcomes of the visit?

    1.6. Are visits planned/recently undertaken by others, e.g. CQC, local authority, other Healthwatch?

2. What are the timescales for the visit?

    2.1. Proposed visit dates

    2.2. Agreement with service provider

    2.3. Reporting

    2.4. Sharing

    2.5. Follow-up

3. What is the structure of the visit?

    3.1. Who is leading the visit?

    3.2. Who are the other team members?

    3.3. Is the 'mix' appropriate to the setting to be visited?

    3.4. Have the roles of team members been agreed?

3.5. Are all those visiting authorised representatives?

3.6. Are they conversant with the role of Healthwatch?

3.7. Have they an appropriate understanding of the safeguarding, confidentiality, equality and diversity?

3.8. Do they have an appropriate understanding of the service provided? If not, can this be provided?

3.9. Have the risks of conducting the visit been assessed?

3.10. Has a copy of the provider's guidelines for visitors been obtained?

3.11. Where is the visit to take place, including meeting point?

3.12. What are the names of the contacts and staff being visited

3.13. What relationships have already been established with the service provider?

3.14. What information is required from the service provider?

3.15. When will the visit take place (time & duration)?

3.16. Who/which individuals or groups are to be observed and/or spoken with?

3.17. How will data be gathered e.g. observation, questionnaire, checklist, interview questions?

3.18. Are there special support needs e.g. interpreting, large print information, advocates, private rooms?	
3.19. Will feedback be invited from service users, staff, carers, family members, and/or others participating in the visit?	
3.20. How will feedback on the visit be given to them?	
3.21. What are the formal arrangements for reporting back and sharing information	
3.22. What are the coordinating arrangements with the Project Team, if different from Visiting Team?	
4. How will contact with the service provider be managed?	
4.1. Has a formal letter/email requesting the visit been sent setting out:	
4.1.1. The reason for the visit?	
4.1.2. The evidence on which it is based?	
4.1.3. The specific service to be visited?	
4.1.4. The proposed date and time of the visit?	
4.1.5. Names/groups of those to be met?	
4.1.6. The names of the visiting team members?	
4.1.7. Verification that all are authorised	

representatives and have Disclosure and Barring Checks been completed?

    4.1.8. Contact details for the Host?

    4.1.9. Healthwatch Enter & View Policy?

    4.1.10. The method(s) of data gathering?

    4.1.11. Any special support needs or facilities required?

    4.1.12. Any further information required?

    4.1.13. Details of contact made with local regulator(s)?

    4.1.14. Reporting arrangements at the end of and following the visit?

    4.1.15. Procedure for making last minute cancellations or changes?

4.2. Have these arrangements been formally agreed by the service provider?

5. What information will be provided at the start of the visit?

    5.1.1. Copy of the formal agreement to visit

    5.1.2. Visit plan including:

        5.1.2.1.   Area(s) to be visited

        5.1.2.2.   Name of service provider lead/contact

        5.1.2.3.   Date, time & schedule, including

6.1.2. Place, date and time of the visit

6.1.3. Members of the visiting team

6.1.4. Service provider representatives involved

6.2. Factual account

6.2.1. Description of the visit

6.2.2. Activities undertaken/data gathering method

6.2.3. Numbers of people observed/spoken to and groups (users, carers, staff, public, etc)

6.2.4. Duration of the visit

6.2.5. Specific areas or aspects reviewed

6.2.6. Reception of the visiting team

6.2.7. Any specific issued arising from the visit

6.3. Findings

6.3.1. Specific comment in relation to the rationale for the visit

6.3.2. Any themes emerging from the visit

6.3.3. Appropriate supporting evidence, e.g. anecdotal, observational (respecting confidentiality)

6.3.4. Specific comments on good practice

6.3.5. Specific comments on issues of concern

6.3.6. Limitations (e.g. point in time; participants

involved)

6.4. Recommendations

    6.4.1. Visiting team proposals, including follow-up

    6.4.2. Recommendations from Project Team

    6.4.3. Final recommendations for service provider

7. Sharing

7.1. Identification of stakeholders, e.g. Local Authority, CQC, CCG, Healthwatch England (see Appendix 1)

7.2. Action planning

8. Visit process review

8.1. Summary and discussion of feedback from those visited

8.2. Individual observations on the visit process

8.3. Identification of key learning points and actions

8.4. Feedback to Chief Officer

Appendix: NICE Quality Standard for patient experience in adult NHS services*

No.	Quality statements
1	Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.
2	Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills.
3	Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.
4	Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.
5	Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.
6	Patients are actively involved in shared decision making and supported by healthcare professionals to make fully informed choices about investigations, treatment and care that reflect what is important to them.
7	Patients are made aware that they have the right to choose, accept or decline treatment and these decisions are respected and supported.
8	Patients are made aware that they can ask for a second opinion.
9	Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.
10	Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.
11	Patients experience continuity of care delivered, whenever possible, by the same healthcare professional or team throughout a single episode of care.
12	Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals.
13	Patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care.
14	Patients are made aware of who to contact, how to contact them and when to make contact about their ongoing healthcare needs.

*Excludes mental health, covered by alternative standard

The full document can be downloaded from www.nice.org.uk

Appendix2: Patient stories

Patient stories can be an important component in understanding what has happened to a patient, in conjunction with their perceptions of the health care they have received. Patient stories are gathered by interviewing patients directly, face-to-face or by telephone, to gather their insights on the care they have received.

In PFCC, patient stories complement the shadowing process well. Patient stories can help clarify care experiences where there is not a dynamic pathway or a recognisable journey. They can also work well for particularly sensitive care experiences, such as end-of-life care, where it may not always be appropriate to shadow patients. They can also be used to capture the reflections of family members after the care experience, and can be collected at an appropriate time for the family.

The approach is familiar to health care organisations as most organisations already have in place a mechanism for gathering people's stories, and boards tend to be familiar with the experience of hearing patients' stories.

You can use patient stories to help you understand the patient journey – asking patients to talk you through what happened to them, where, when and with whom. Stories can also be used to explore how patients feel about what happens to them – the impact of particular care 'touchpoints' on them. The resulting stories can have a very powerful impact on staff.

Patient stories can also help the organisation understand how health care fits into the patients' wider life – for example, what happens between episodes of care. This can help illustrate the implications of how things are done, such as the way clinics are organised, or of problems such as delays, poor communication, or the need to chase and follow up health care providers if care is not running smoothly.

Key points

- Identify which sorts of patients you would like to hear from (for example, current or recent) and from where you will draw your sample (perhaps your own records, or from a local support group).
- Think about how you will make contact – by phone or letter – thinking about when and where you would like to talk to the person.
- Provide information about why you are collecting patient stories, and what will happen to those stories once they have been collected.
- Ask for the person's consent to record their story. You might do this by taking detailed notes or making an audio recording for later transcription.
- Depending on the specifics of the care experience, write a loosely structured interview outline to guide the conversation through the care experience. Often a chronological approach works well, with opportunities to revisit significant parts of the process later in the conversation.
- Be flexible enough to allow the patient to talk about the issues they want to talk about, and not be constrained by the interview outline.
- After you have gathered the stories, analyse them in the same way as you do with shadowing evidence, to identify the key themes and generate ideas for improvement.
- Be aware of safeguarding issues and share these with the interviewee. For example, it may not be possible to guarantee the person total anonymity if they raise an issue that you must act upon.
- For each element of the patient's journey you may find it helpful to prompt the person about:

  – how long it took
  – what information they received
  – finding their way around
  – what help they received, and whether they received the help they needed
  – whether their individual needs, for example, with language, mobility, culture or diet, were met
  – who was providing their care

– whether services were responsive, for example, if they were in pain

– how their family was involved

– whether they were dealt with politeness and kindness

– whether their privacy was respected

– what the environment was like

– whether care was well co-ordinated

– how they felt at each stage, what the impact was on them, and which elements had the most positive or negative impact.

Source: The King's Fund, Patient and Family-Centred Care toolkit, 2014 www.kingsfund.org.uk

Related websites:

Institute for Healthcare Improvement – Collecting patient experience stories

NHS Choices – Patients share their experiences

Patient Safety First – Using patient stories

Appendix 3: Shadowing

Shadowing involves witnessing everything the patient experiences, observing and recording each step of the process, and then seeking feedback from the patient at each point. It is an observation technique that provides an opportunity for a third party to experience and record what happens during interactions along a patient's pathway, including what they look and feel like. Its aim is to see the care experience through patients' eyes. It forms a critical part of the PFCC approach.

Shadowing raises staff awareness of the patient experience and the need for change. It helps staff to understand what is working well for patients and their families, and what is not. It can also enable real-time patient feedback, should you choose to work in this way. It might identify issues such as bottlenecks and duplication of effort, as well as elements that are working well and could be replicated.

Ideally, shadowing is carried out by a variety of staff. It is important that senior clinical staff on the team and senior leaders carry out at least some of the shadowing. However, it may also be good for non-health care professionals, such as administrative staff, volunteers or nursing or medical students, or staff from a different care experience who are not familiar with the process to carry out shadowing. They can each bring a different perspective and can view care with a fresh pair of eyes.

There are particular benefits to senior management carrying out the shadowing. By using a mixture of observation and discussion, the process can build up a picture of how the patient moves through the pathway, the speed at which they do so, and the feelings they have about their experience.

> "I felt the shadowing was very powerful. It made me see things that were always in front of me, that on a day-to-day shift you do not notice. I quickly realised it's not the big things that we need to look at – it's the small things that can make such a big difference."

Emma Hughes, Senior Sister/Practice Development Sister, Paediatric Assessment Unit, Walsall Manor Hospital

Key points

- Shadowing is good for understanding processes of care – especially where patients experience a complex pattern of care with multiple exchanges with staff. It identifies the meaning of the care experience and its various elements for patients. It enables staff to check that the things they want to improve are actually the things that patients feel are important.
- Shadowing can be carried out by any individual, including clinical and administrative staff and students. Between them, the shadowers build a picture of what care is like for patients. Everyone involved in PFCC should do some shadowing. It is important that senior leaders do at least some of the shadowing so they can see care for themselves. It should not be delegated to the most junior members of staff.
- Before you start, decide which part of the care experience you want to focus on. Decide where the shadowing will start and finish, how many patients will be shadowed for each element of the experience, and at what time. For example, you might want to shadow patients at different times of day to see the variation in processes that occurs.
- Think about how you will hear back from the shadowers, and plan how you will feed back to the areas or staff involved (both positive and negative issues) in real time.
- Think about what the shadower should focus on: the time waited, the waiting environment, how staff interact with the patient, ease of navigation or the standard of written or verbal information. Give the person doing the shadowing a guiding framework – for an example, see the PFCC Shadowing Field Journal that provides direction but is open to unexpected observations arising.

- Ethical approval is not generally required for service improvement work, but talk to someone on your local research ethics committee in case any local protocols need to be followed in relation to shadowing.
- Decide who will feed back on any examples of poor practice and how.
- Explain shadowing to patients and reassure them that whatever they say to the person doing the shadowing will have no effect on the standard of care they are given. Make sure they give their informed consent, and ask for their contact details if they wish to be updated on progress. Remember, they may be feeling vulnerable or anxious about being involved, or about their health care experience.
- Talk in advance with key staff in the areas in which the shadowing will take place. Make sure they understand its purpose, and emphasise that its aim is to improve quality, not to assess individual performance.
- Design a simple proforma for capturing information, to include: when each activity takes place; patient and shadower reactions to each activity; and further observations.
- Record information under headings such as: environment, printed information, signposting and movement around hospital, waiting time, and verbal communication. A final space could highlight patients' views about what went well and what could have gone better, as well as the shadower's thoughts and feelings about what they saw and heard.
- Prepare a patient information sheet that you can give to patients before and after the shadowing. It should explain the purpose of the shadowing, how it will work and what will happen to the information collected. You can amend the PFCC Shadowing Field Journal to fit your needs.
- At all times, the patient's wellbeing takes precedence over the shadowing. Shadowing should never adversely impact on the care the patient receives, and it will never override the clinical judgement of the person doing the shadowing. If a clinician is the shadower, then their clinical role will override the shadowing role if intervention is required – for example, if a low oxygen saturation has not been noticed, or if a patient is at high risk of falling. Similarly, be compassionate if advocacy is needed – for example, if the patient needs a drink. Speak up for the individual, and record that this was needed.
- If a number of people are going to shadow patients, meet with them as a team to discuss how the process will work and what they will need to do. Allow time to answer questions, and brainstorm what might go wrong and how to respond. A short practice run or role play will give the shadowers some experience and will allow you to tweak the method if necessary.
- After the shadowing, bring the shadowers together to clarify anything you don't understand, probe more deeply, and discuss any emerging themes. Then, gather up the proformas, and provide opportunities for learning for staff in the areas where shadowing has taken place.
- Identify one person to collate, analyse and interpret the data collected and sort the information into themes.
- Bring the team working on the pathway together to discuss the findings and decide how they will feed into both the diagnosis of current practice and the design of your ideal care experience. Remember to identify what works well (and should therefore be retained) as well as what works less well (and should therefore be changed).

Source: The King's Fund: Patient and Family-Centred Care toolkit (www)

Related websites: PFCC Innovation Center – Go Shadow guide

PFCC Innovation Center – Go Shadow field journal

IHI Open School – introduction to shadowing

PFCC Innovation Center – shadowing video

Appendix 4: Checklist for personal conduct

1. Be well prepared and conversant with the visit plan
2. On arrival report to the designated person(s) and produce written authorisation
3. Comply with any instruction given regarding privacy and dignity, health and safety and hygiene
4. Cooperate wi
5. th requests from staff, service users and carers
6. Ensure that it is understood that the Healthwatch cannot deal with individual complaints but that an authorised representative can and should signpost any such requests or disclosures to the appropriate body
7. Maintain confidentiality of verbal and written information, including the identification of individuals, access to records, adherence to protocols concerning disclosure by patients, service users and carers, and whistle-blowing by staff, and care notes concerning findings to be included in the report
8. Be aware of safeguarding obligations
9. Avoid being alone in private with a patient or service user, but remain in communal areas and work in pairs if asked to speak in confidence
10. Avoid entering any non-communal area such as bedrooms or staff quarters
11. Avoid making comments on personal equipment or belongings
12. Do not give opinions or advice on specific care or treatment regimes to patients or service users, their relatives or carers. Any such queries must be referred to the staff in charge
13. Work cooperatively with staff to maintain confidence in services, e.g. avoid making criticisms in front of service users, and save it for the de-brief before leaving and for the written report
14. Adhere to protocols concerning gifts, gratuities and benefits
15. Be as unobtrusive as possible and avoid disrupting routines or service deliver
16. Value people as individuals and respect their wishes, e.g. to leave someone alone if asked to do so
17. Inform the person they have arranged to meet or the most senior person on duty of your departure and give verbal feedback as to the content of the written report
18. Inform the Host of any potential problems or conflict which may arise from the findings
19. Work together after the visit to de-brief and put together evidence based written feedback of your findings to the service visited.

Appendix 5: Useful sources of information

Care Quality Commission: Regulates health & social care services. Checks whether hospitals, care homes, GPs, dentists and services in your home are meeting national standards. Publishes findings, helping people to make choices about the care they receive. www.cqc.org.uk

King's Fund: an independent charity working to improve health and health care in England. Helps to shape policy and practice through research and analysis; develops individuals, teams and organisations; promotes understanding of the health and social care system; and brings people together to learn, share knowledge and debate. www.kingsfund.org.uk

National Institute for Health and Care Excellence: provides national guidance and advice to improve health and social care outcomes for people using the NHS and other public health and social care services by:
- Producing evidence based guidance and advice for health, public health and social care practitioners.
- Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services.
- Providing a range of informational services for commissioners, practitioners and managers across the spectrum of health and social care.

www.nice.org.uk

National Institute for Health Research. NIHR research programmes, Schools for Social Care, Public Health and Primary Care Research and our research Centres, Units and Facilities in the NHS aims to generate innovative new healthcare solutions. They evaluate the effectiveness and impact of new healthcare treatments, find new ways of preventing, identifying and treating ill health, and make this evidence widely available to ensure that decisions about health and social care are being informed by the best possible evidence.www.nihr.ac.uk

Encouraging publication in leading international and national research journals, and supports free and open access to its research publications to ensure that the public and health and care communities benefit from the most up-to-date, peer-reviewed, studies.

Social Care Institute of Excellence: A leading improvement support agency and an independent charity working with adults', families' and children's care and support services across the UK. Also works closely with related services such as health care and housing. Aims to improve the quality of care and support services for adults and children by:
- Identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- Informing, influencing and inspiring the direction of future practice and policy.

Develops a range of freely available resources to help improve the knowledge, skills and practice of care staff and commissioners. Also provide a range of paid-for services including training, consultancy, research and product development. www.scie.org.uk

Appendix 6: Sources

Healthwatch England, Recommended training for Authorised Representatives undertaking 'Enter & View' activity, 2014,

Healthwatch Richmond, Policy for Enter and View and the Recruitment and Selection of Authorised Representatives, 2013

King's Fund, Patient and Family-Centred Care toolkit, 2014

NHS National Centre for Involvement, Code of Conduct relating to Local Involvement Networks' visits to enter and view services, July 2008

Patient and Public Involvement Solutions, LINks Training Pack: Help and Care, 2009