



NHS Greater Glasgow and Clyde

Inequalities Sensitive Practice Initiative

Evaluation Report

Acknowledgements

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We are most grateful to NHS Greater Glasgow & Clyde for giving us the opportunity to work with them. It has been a thoroughly interesting, informative, challenging, and enjoyable experience for us.

We hope sincerely that this report will support NHSGGC and its partners as they seek to develop further inequalities sensitive practice across health and social care services, in the interests of our most vulnerable communities, in Glasgow and throughout Scotland.

Avanté Consulting
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Glossary

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| CAT | Community Addictions Team |
| CtOG | Closing the Opportunity Gap (Scottish Executive) |
| CHCP | Community Health & Care Partnership |
| CHP | Community Health Partnership |
| EQIA | Equality Impact Assessment |
| ICS | Integrated Children's Services |
| ISP | Inequalities sensitive practice |
| ISPI | Inequalities Sensitive Practice Initiative |
| KSF | Knowledge and Skills Framework |
| MCNI | Multiple and Complex Needs Initiative |
| NHSGGC | National Health Service Greater Glasgow & Clyde |
| PACT | Parents & Children Together |
| PCMH | Primary Care Mental Health |
| PHRU | Public Health Research Unit |

Executive Summary

The Inequalities Sensitive Practice Initiative (ISPI) was launched by NHS Greater Glasgow & Clyde (NHSGGC) in 2006, and funded as part of the former Scottish Executive's Multiple and Complex Needs Initiative.

Within the context of health inequalities, ISPI's aim was to identify and illustrate ways of delivering health services which take proper account of individuals' circumstances. With an emphasis on poverty and gender, the Initiative explored how practitioners can support clients to disclose sensitive and difficult issues, such as prostitution and domestic violence, and considered how practitioners and services can respond effectively to these issues. At the same time, managers, planners, and policy makers were encouraged to consider the benefits to be derived from inequalities sensitive practice in terms of performance.

From the beginning, ISPI's focus was upon **practice**. The aim was to encourage practitioners across a range of disciplines to consider and discuss not only **what** they do, but **how** they do it. At the heart of ISPI was the belief that whilst effective partnership working and efficient systems and processes can support inequalities sensitive practice, they are not, in themselves, the solution. ISPI encouraged staff to question the ways in which they respond to an individual's circumstances, to examine personal attitudes and beliefs, and to consider how their current practice and behaviour might not be appropriate in every situation. Staff working in a variety of situations considered how their practice might be improved in order that services can be sensitive to the needs of clients whose health is adversely affected by the circumstances in which they live.

The settings

Four settings were selected for the location of ISPI. Each setting had adopted a model of health and social care which recognised the need to extend beyond the traditional, medical responses to the poor health which can result from inequalities and which acknowledged the significance of poverty and gender. The settings were:

- Maternity Services
- Integrated Children's Services
- Addictions Services
- Primary Care Mental Health Services

Already, these settings had introduced a range of measures designed to address the multiple and complex needs of clients. These included:

- in Addictions Services, the development of a Gender Pilot;
- in Maternity Services, a range of support services delivered to women with complex needs via the Women's Reproductive Health Service;
- in Integrated Children's Services, the establishment of Parent and Child Together (PACT) Teams, designed to provide short-term, intensive support to vulnerable families; and

- in Primary Care Mental Health, the establishment of multi-agency teams whose remit was to provide short-term interventions for people with 'mild to moderate' mental health problems, together with a responsibility to engage with the local communities in order to promote positive mental health.

From the outset, ISPI sought to make the connections between policy and practice. It offered support to the design and piloting of new approaches to service design and delivery, principally within NHSGGC, and involving local authorities and partners from the voluntary and community sectors.

The ISPI Team

Appointed in 2006, the team comprised a Project Co-ordinator, four Setting Leads (one for each of the settings), a Learning and Development Officer, and an Administrative Officer. The Initiative was directed throughout by a Steering Group which included senior representatives of NHSGGC, Glasgow City Council Social Work Services, and the Scottish Government.

Four Setting Implementation Groups were established, with a view to ensuring support and direction at individual setting level. In two of the settings (Maternity Services and Addictions Services), Task Groups were set up, working closely with the Setting Leads.

The evaluation process

In 2007, ISPI commissioned Avanté Consulting as the project evaluators. The Avanté team worked closely with the ISPI team, the Steering Group, and representatives of the Public Health Resource Unit Research and Development team in order that learning could be shared throughout the course of the initiative. The consultants met regularly with stakeholders – the Project Team, staff from individual settings, senior managers, and partner organisations – through individual interviews, focus groups, and workshops. They observed meetings and discussions, and studied relevant minutes, papers, and policy in order to identify the extent to which ISPI was influencing practice, planning and policy development. An electronic and paper-based questionnaire distributed widely across the settings provided feedback on attitudes, awareness, and understanding of inequalities sensitive practice and ISPI.

Through this approach, Avanté consultants developed a comprehensive understanding of the initiative and fulfilled the role of 'critical friend' to the initiative and its staff, whilst at the same time providing objective ongoing evaluation.

What did we learn?

The key ingredients

Inequalities sensitive practice was already evident in many situations, without being 'labelled' as such. Whilst such practice was often attributable to an individual's personal commitment to equalities and inclusion, it was recognised that it was an approach worth defining and replicating. ISPI identified the key ingredients required for inequalities sensitive practice as follows:

- leadership, commitment and enthusiasm;
- recognition of the significance of inequalities sensitive practice throughout the organisational infrastructure;
- a supportive, working environment;
- well-established, well-functioning teams;
- champions of change, offering dedicated, practical support;
- recruitment and selection processes which reflect the values and principles, characteristics and skills required in order to deliver inequalities sensitive practice;
- adequate investment in the development of ISP-related training and support programmes;
- practical illustrations of inequalities sensitive practice (as provided by the ISPI practice descriptors);
- discussion and debate – within a non-threatening environment;
- effective, regular support and supervision for all staff, where principles and practice are considered alongside case management;
- a monitoring and evaluation framework which examines the impact of all of the above, with regard to client support, staff development, and performance management.

What's to be done?

The evaluation report proposes a series of recommendations:

- 1) The significance of inequalities sensitive practice must be embedded throughout the organisational infrastructure - reflected in policy and planning, organisational development, performance management, learning and education, human resources, and the allocation of resources.
- 2) NHSGGC should ensure that corporate services, including the Corporate Inequalities Team, Organisational Development, and Public Health work more collaboratively to ensure clarity of roles and responsibilities in relation to the ongoing development of inequalities sensitive practice.
- 3) The work of the ISPI initiative in relation to learning and development should be remitted to the Learning and Development service located within Organisational Development.
- 4) The role of leaders, throughout the organisation, in the development of ISP should be explored, and reflected in future leadership programmes and performance management.
- 5) The role of 'champions' within services should be explored and defined, with a view to identifying future ISP champions across all NHSGGC settings.
- 6) Strategic and operational managers and any relevant staff should be given dedicated responsibility and authority which will ensure that ISP is reflected in planning and policy.
- 7) Local structures (as described within the main report) should be established in order to further embed a commitment to ISP amongst practitioners. These structures should be led by local managers, involve front-line practitioners and administrators, and include a rolling programme of learning & development activities.
- 8) An understanding of and commitment to ISP must be further developed within the recruitment and selection of all staff employed by NHS GG&C and reflected in future person and job specifications.
- 9) ISP should form a core element of induction activities and mandatory training for all NHS GG&C staff with identified pathways for ongoing equalities training and development.



- 10) Discussions with professional training providers, particularly nurse and social work training institutions, should be initiated in order that inequalities sensitive practice can be reflected in the training of potential future employees.
- 11) The Knowledge and Skills Framework (KSF) system of performance and development planning (currently under-utilised) should be amended to reflect ISP in performance and development planning, and fully utilised across all services.
- 12) Within individual settings, there should be regular opportunities for practitioners to share, question and develop their practice within a safe and supportive environment, individually and collectively, and with access to case studies, practice descriptors and other relevant materials.
- 13) Existing structures should be used to disseminate outputs/resources and share learning from ISPI, and Public Health seminar programmes utilised to articulate and highlight good practice.
- 14) There should be further investment in developing practical illustrations of inequalities sensitive practice such as those provided by the ISPI practice descriptors, DVDs and case studies.
- 15) Regular staff support and supervision should reflect a commitment to reflective practice for all staff.
- 16) Screening, assessment and referral systems within settings should be reviewed to ensure consistency and a commitment to inequalities sensitive practice, using tools such as the Equality Impact Assessment.
- 17) Current data collection systems should be reviewed and enhanced in order to ensure the effective and efficient gathering of client profiling information. Furthermore, the use of data collected from these systems should be reflected in future service planning and design.
- 18) A comprehensive monitoring and evaluation framework should be designed and implemented across NHSGGC, in relation to all of the above recommended actions. This framework should include qualitative and quantitative inequalities indicators which support the measurement of impact upon clients, staff, and overall performance.
- 19) Policy makers, at national and local levels, should ensure that policies take account of the views of managers and practitioners, and that supporting workforce development initiatives are aligned to enable the effective implementation of policy.

Why do we think so?

The recommendations described above are based upon a number of key themes which emerged throughout the initiative, across all of the settings, in individual interviews, focus groups, meetings, and workshops. They include:

- **language and definitions;**
- **inequalities sensitive enquiry;**
- **leaders and champions;**
- **policy and practice; and**
- **learning and development.**

In October 2008, an Action Research Workshop attended by practitioners, team leaders, senior managers, and ISPI staff explored these themes in detail and concluded that they reflect the key 'enablers' to the development of inequalities sensitive practice across mainstream services. At the same time, they highlight barriers to be addressed if staff are to recognise the significance of inequalities sensitive practice, question their values and attitudes, and explore ways in which they might change current practice.

a) Language and definitions

"When we were developing the Gender and Addictions Toolkit prior to ISPI we asked workers what their definition of 'inequalities sensitive practice' was. We were struck by the number of workers that said this meant treating everyone the same. ISPI has managed to get underneath this and been able to evidence that in reality workers do not treat everyone the same, that they do take on board the diversity of our client group and respond differently to each service user. It was clear they struggled to articulate this and also did not badge this under 'inequalities sensitive practice.'"

**Senior Manager,
Addictions Services**

In the initial stages, there was uncertainty amongst practitioners as to the meaning of the phrase 'inequalities sensitive practice'. When invited to give a definition, the most common response was 'a holistic, multi-agency response to the needs of individual clients'. People referred to single shared assessments and referral processes. Rarely did anyone suggest that it might have something to do with their individual practice. However, as a result of the discussion and debate facilitated by ISPI, there has been a gradual raising of awareness and understanding.

Critical of what they described as 'policy speak - the language of academics', by the end of the initiative, staff from all of the settings could describe in their own terms the key characteristics of ISPI.

The absence of a formal definition at the start of the initiative proved helpful, as it prompted the discussion and encouraged practitioners to develop descriptions which were more meaningful and relevant to their working environments.



“Key Characteristics of Inequalities Sensitive Practice

- person centred **and not** service/profession centred
- firmly embedded in a **social model of health**
- have **core, routine** areas of **enquiry**
- empathetically ‘curious’ **and** actively supportive
- firmly embedded in appropriate **pathways of support/care**
- firmly linked to **performance management systems/ data collection sets**
- carried out by **competent practitioners who know and understand the impact of social inequalities on health.**”

Extract from Integrated Children’s Services Setting Report

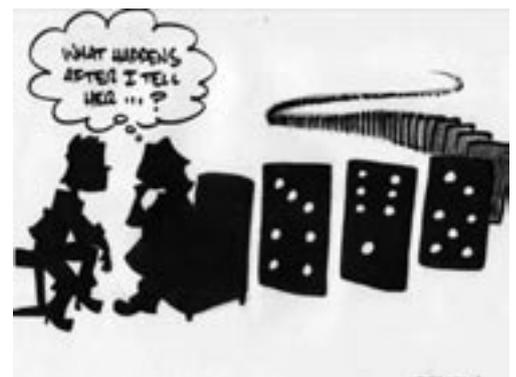
The absence of a formal definition at the start of the initiative proved helpful, as it prompted the discussion and encouraged practitioners to develop descriptions which were more meaningful and relevant to their working environments.

b) Inequalities Sensitive Enquiry

‘Inequalities sensitive enquiry’ was by far the most significant of the themes, highlighted as the key to inequalities sensitive practice. It was widely agreed that it is not possible to design and deliver an appropriate package of support services without an effective and comprehensive assessment of an individual’s circumstances, carried out in a considered way and at the right time. However, there are a number of issues to consider.

What happens if I tell her?

Clients will disclose only when they are ready. They may be fearful of the consequences of disclosure, and may not raise sensitive issues at a first appointment. The practitioner must be able to ‘read the signs’, instil trust in a client, and offer reassurance that support is available. Disclosure requires time, and a relationship between practitioner and client that is based on trust.



“A can of worms”?

Practitioners may be reluctant to pursue sensitive enquiry, concerned that they don’t know how to deal with a particular issue or at times, don’t want to. Awareness raising, training and experience, together with a comprehensive knowledge of other available services, can give staff the confidence and skills to conduct sensitive enquiry. Practical illustrations, such as the DVDs developed by ISPI, offer an excellent means of demonstrating how to explore difficult issues with a client.

Support and supervision

A structured framework for support and supervision provides the opportunity to discuss specific cases including practice review, as well as support for problem-solving, case management and professional development. The active development of this model of support and supervision was highlighted by staff as a crucial element of inequalities sensitive enquiry and service delivery

And it's not just the clients

Individual members of staff may have personal experience of issues such as drug and alcohol abuse or domestic violence. Managers were acutely aware of this, and highlighted the need for support to be available to staff, if required.

c) Leaders and champions

Respondents shared the view that changes in practice are best supported by strong leadership. If inequalities sensitive practice is to be established across mainstream services, there must be clear evidence of commitment and action from senior managers and team leaders across the organisation.

Within the ISPI settings, the enthusiastic engagement of senior managers enabled a comprehensive programme of discussion and training. Attendance at training events was good; ISPI was welcomed as a tool to support development and change. Conversely, without the support of managers, there were serious difficulties in generating interest in the initiative.

There must be leadership and decision-making which reflects a commitment to inequalities sensitive practice in terms of planning, setting targets, identifying priority areas, and allocating resources. In a climate of financial and workload pressures, this requires managers to make challenging decisions on how ISP is supported and resourced against a range of competing organisational priorities.

At the same time, ISPI confirmed the value of 'champions' – practitioners who understand the job and can work alongside their colleagues, but can support and encourage change.

The model of the ISPI Project Lead as 'champion' was vitally important in ensuring that inequalities sensitive practice was a constant feature of service planning and delivery. The Project Team was described by everyone involved in ISPI as bringing passion, drive, and vision to the initiative, and a key underlying contributor to the success of the initiative.



d) Policy and practice



There was a general frustration shared by practitioners, team leaders, and senior managers over the volume of national policies relating to inequalities and wider health initiatives.

Managers and practitioners expressed their frustration at the apparent 'disconnect' between policies and operational issues. There was little sense that policies were influenced by practice and, as a result, were not 'owned' by the field. This led to resentment about additional administrative and

reporting demands which were seen to detract from service delivery.

In particular, staff complained that workforce development initiatives were rarely 'in sync' with the relevant policies.

"Staff and team leaders appear to feel disconnected from the worlds of policy and planning and in some cases feel that their lack of influence in shaping decisions about practice hampers their ability to respond effectively to their service users."

Report from PACT (Parent & Child Together) Teams

Making the connection

Discussions with managers, practitioners, and members of the Corporate Inequalities Team indicated that ISPI provided valuable support in terms of delivering services in response to policies and strategies. Through discussion, training, and example, ISPI helped to connect policy and practice, enabling practitioners to consider how they might change their individual practice in response to policy.

e) Learning and development

Throughout the initiative, training programmes provided the opportunity to raise awareness and understanding of inequalities sensitive practice amongst practitioners. Workshops exploring case studies and practical illustrations have offered the means to examine current practice in a supportive environment. Information sessions enhanced knowledge and understanding of specific issues and of services provided by partner agencies.

Equally important was the multi-agency approach to learning and development which supported the integration of services and effective partnership working. Respondents from health services, social work services, and the voluntary sector confirmed that ISPI encouraged staff to examine together their understanding of equalities/inequalities, the impact upon the health and wellbeing of the individual and their family, and the ways in which their practice can best support clients.

Measuring impact

“When the Project Lead came to our meeting, everyone was completely baffled. It felt a bit condescending. But in terms of trying to measure it, people are fine about it. We have found it quite useful – the training has flushed out some of the concerns I had about health service staff. They clearly don’t have the same opportunity in their training to consider values”.

PACT Team member

Despite efforts to encourage the development of data collection systems, further work needs to be done. In the absence of baseline information and consistent and systematic data gathering, it was difficult to measure progress in terms of staff development, or outcomes for clients as a result of suggested changes in practice.

In interviews and workshops, managers emphasised the need for a business case to be made in relation to inequalities sensitive practice. In order to secure further investment in terms of resources, the impact of inequalities sensitive practice must be demonstrated in terms of effectiveness and efficiency. Practice descriptors which have been developed within each of the settings will provide

the basis for performance indicators and inform the development of an effective, and more consistent monitoring and evaluation framework across different settings.

In conclusion

This relatively small but ambitious project has pursued a series of objectives which sit at the core of a wide range of national and local strategies, policies, and initiatives. When considering the allocation of resources, the emphasis placed currently upon inequalities and health improvement remains small in relation to efficiency and the delivery of clinical services.

Despite its size and scale, ISPI has led to a shift in understanding and awareness amongst the policy makers, planners, and practitioners engaged in its activities. The influence of policy makers involved in ISPI

can be evidenced in recent NHS Greater Glasgow & Clyde policies and strategies; the development of practice descriptors in each of the settings indicates that one year on, not only do managers and practitioners engaged in ISPI have a better understanding of what constitutes inequalities sensitive practice, they have found the means to describe how it can be done; the development of resources such as the DVDs which offer a practical illustration of inequalities sensitive practice will contribute significantly to extending training and learning to a wider audience of NHSGGC staff in the future.



Avanté Consulting
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1.0 Introduction

Tackling health inequalities in Scotland through a social model of health has been a government priority since 1999. There have been numerous policy documents since then, including the White Paper 'Partnership for Care'¹ which proposed radical changes to Scotland's health services in order to improve health in Scotland and, more recently, 'Better Health, Better Care: Action Plan'², published by the Scottish Government in December 2007. This document summarised the key actions aimed at providing better health and care for all the people of Scotland and set the agenda for NHS Scotland around four key themes:

- Health and wellbeing - a comprehensive cross-Government approach to promoting and sustaining health and wellbeing;
- Inequality - targeted action to reduce health inequality;
- Quality - an acceleration of progress towards an NHS that is of the highest quality; and
- Public participation and integration - a new era for public participation and integration in NHS Scotland.

Health and inequalities

Within the wider determinants of health, income deprivation is the best indicator of illness, chronic health problems, disability and premature death.

In 2006/7, 17% of the Scottish population was living in relative low income poverty (before housing costs)³.

In Glasgow City in 2005, 37.8% of the population were income deprived compared to 22.3% in Scotland as a whole⁴. Glasgow has seen more rapid change over the past 25 years than any other UK city and in general

there are increased levels of prosperity. However large areas of the city have not benefited from these changes as the income gap between those who are well-paid and those on the lowest incomes has widened. At the same time the health inequality gap has continued to widen. Although official unemployment figures have reduced a large number of people are economically inactive, deemed too ill or disabled to work. For example in 2004 the number of people aged 16-24 claiming incapacity benefit was almost double the national average (15.68% Glasgow City, 8.9% Scotland). The largest group on incapacity benefit are those with mental health/behavioural issues.

¹ 'Partnership for Care' (2003). Scottish Executive

² 'Better Health, Better Care: Action Plan' (2007). Scottish Government

³ <http://www.scotland.gov.uk/Resource/Doc/226557/0061262.pdf>

⁴ Equality Scheme 2006 – 2009. NHS Greater Glasgow & Clyde

The 2007 Health in Scotland Annual Report⁵ highlighted continuing improvement in much of Scotland's health profile,⁶ supported by national and local initiatives. However, there remains strong evidence that certain communities and groups across the country continue to experience health inequalities, and that the gap is widening. These inequalities are highlighted by the Glasgow Centre for Population Health's 2008 Community Health Profiles and more widely by the Scottish Government's Long-Term Monitoring of Health Inequalities report on headline Indicators published in 2007⁷. Both reflect the ongoing inequalities experienced by individuals and certain communities across Scotland in terms of health and wider social issues, and, together with other supporting evidence, provide a basis for continuing commitment and the need for targeted resources towards tackling health inequalities.

NHS GGC is committed to mainstreaming equality within and across its many functions through a process of integration within its new organisational structures. The organisation has embarked on an attempt to bring about **organisational change** in order to maximise its contribution to addressing the causes and health consequences of the different forms of inequality and discrimination. There is recognition of the challenges which include:

- conflict between medical and social models of health and roles as drivers of change and
- lack of understanding about inequalities in an NHS context

In order that the issues surrounding health inequalities may be properly addressed, NHSGGC has established a Corporate Inequalities Team – the only territorial Board in Scotland to have done so.

The Equality Scheme for the period 2006 – 2009 is the first Equality Scheme to be produced by NHSGGC, in line with the requirements of equalities legislation. The Scheme recognises that “the experience of inequality can be both a pathway to poor health, and a consequence of poor health.” The document acknowledges that “Poverty is gendered. Women are more likely to be poor because they tend to have lower paid jobs, and are more likely to work part-time. They are also more likely to be lone parents (90% of lone parent families are headed by women). Despite progress in recent decades differential access to power and resources continues to keep women in a subordinate and disadvantaged position. The unequal division of domestic labour, family responsibilities and the disproportionate numbers of women living in poverty are evidence of such divergence of opportunity.”

⁵ 'Health in Scotland 2007. Annual Report of the Chief Medical Officer. Scottish Government

⁶ www.gcph.co.uk

⁷ www.scotland.gov.uk/Publications/2008/09/25154901/2

More recently, within NHS GG&C, ten goals have been identified for development of an Inequalities Sensitive Health Service (ISHS). The ISHS:

- 1 Knows and understands its diverse population and the nature of inequality and discrimination it experiences.
- 2 Develops and delivers meaningful engagement with those experiencing inequality and discrimination in order to design services and empower patients.
- 3 Recognises that positive behaviours for health will be more likely to be enacted if strategies for support are specifically designed to take the experience of social class, gender, race, disability, age, sexual orientation and faith into account.
- 4 Understands and removes the obstacles to accessing frontline services and health information.
- 5 Creates services that have the ability to support patients in the context of their lives and gives practitioners support to address the causes as well as the consequences of inequality and discrimination.
- 6 Recruits and retains a workforce that represents, at all levels of the organisation, the diversity of the population.
- 7 Creates a working environment which is responsive to all dimensions of health and social inequalities, and prevents discrimination and prejudice from affecting patient care and staff relations by developing the competency of and support for staff leading and implementing an inequalities sensitive health service.
- 8 Reallocates available resources and manages performance in favour of the elements of an inequalities sensitive health service.
- 9 Procures its goods and services to impact positively on health and social inequality.
- 10 Advocates for and contributes to the implementation of economic and social policy which addresses income inequality, geographic and social class inequality, gender inequality, racism, disability discrimination and homophobia, as pre-requisites for good health.

Within this context ISPI was set up to be one of the tools which will help NHS GG&C, and its partners in the delivery of integrated services, find out what will improve the effectiveness and efficiency of frontline practice and determine what type of planning and policy arrangements are required to facilitate and sustain those practice changes.

Inequalities Sensitive Practice Initiative

In 2005, as part of its commitment to tackling poverty and disadvantage, the Development Department of the former Scottish Executive embarked on a

Multiple and Complex Needs Initiative (MCNI) as one of its contributions to the overall Closing the Opportunities Gap (CtOG) approach. Working across all Executive Departments, the aim of CtOG was to:

- Prevent individuals or families from falling into poverty;
- Provide routes out of poverty for individuals and families; and
- Sustain individuals or families in a lifestyle free from poverty.

The overall aim of the MCNI has been to improve public services for people with multiple and complex needs, with a particular emphasis on increasing the rate of improvement of the health status of people living in the most deprived communities – in order to improve their quality of life, including their employability prospects.⁸

Within the MCNI programme, the Executive funded:

- A literature review on multiple and complex needs (MCN)⁹;
- Fourteen pilot/demonstration projects that aim to explore how services in different settings cater for those with multiple and complex needs;
- An overarching evaluation of the pilot projects that will aim to identify generic programme lessons for improving service delivery.

The Inequalities Sensitive Practice Initiative (ISPI) was one of the fourteen demonstration projects, managed within the Corporate Inequalities Team of NHS Greater Glasgow and Clyde. ISPI's over-arching aim was to support a sustainable shift in practice in four health and social care settings in order to mainstream this approach. The project's operational aim was to identify and establish the mechanisms for extending and integrating the development work into the mainstream delivery of all four settings while also identifying ways of assessing the impact on overall health gain of the recipients of the services.

The settings

Four specific health service settings within NHS Greater Glasgow and Clyde, each at different stages of implementation and in different settings, were selected as the practice areas to support the delivery of ISPI.

⁸ 'Closing the Opportunity Gap' Objectives; Scottish Executive; July 2004

⁹ www.scotland.gov.uk/publications/2007/01/18133343/1

These settings were selected owing to the fact that each had adopted a model of health and social care, which recognised the need to extend beyond the traditional, medical responses to the health consequences of inequality, and acknowledged the relationship with poverty and gender. Furthermore, together, they formed a set of services, likely to be accessed by people facing combinations of problems, which need to be consistent in their response. These settings and services were as follows:

- **Maternity** – the development of the Women’s Reproductive Health Service which uses a model of social obstetrics and public health midwifery in response to the complex nature of the lives of women facing poverty and addictions;
- **Integrated Children’s Services** – the development of PACT teams which uses a social model to address the multiplicity of problems facing families with young children in disadvantaged areas;
- **Community Addiction Teams** – the development of gender sensitive services for people with addictions in order to address the differential needs of women and men;
- **Primary Care Mental Health** – the development of a primary care mental health model which systematically addresses mental health consequences of poverty and gender.

Within this context, ISPI sought to identify and illustrate ways of delivering health services which take proper account of individuals’ circumstances. With an emphasis on poverty and gender, the initiative explored how practitioners can support clients to disclose sensitive and difficult issues, such as prostitution and domestic violence, and considered how practitioners and services can respond effectively to these issues. At the same time, managers, planners, and policy makers were encouraged to consider the benefits to be derived from inequalities sensitive practice in terms of performance.

Implementing ISPI

In order to take forward this initiative in NHSGGC, a team of senior staff was appointed in 2006, to be managed by a Project Co-ordinator. Within the team, there was a ‘Project Lead’ for each setting, each of whom had a sound understanding of poverty and gender issues. All of the team were experienced in organisational systems development in order to build on work carried out within each setting prior to the initiative.

In addition to managing and co-ordinating the work of the team, it was the responsibility of the Project Co-ordinator to ensure that strategic links were established into emerging corporate and setting-specific planning mechanisms.

The ISPI team also included a Learning and Development Officer, whose role was to facilitate training and learning for inequalities sensitive practice and to support a greater understanding of inequalities amongst practitioners, planners and managers in the four settings, and across mainstream learning and education services. The team was been supported by a Project Administrator.

From the outset, ISPI was well supported by NHSGGC's Public Health Resource Unit. The initiative benefited significantly from the information available through the Public Education Resource Library, use of contact databases, input from the Learning and Development team, and the skills and experience of the in-house Research and Evaluation team.

Governance and leadership

The initiative was led by a Steering Group comprised of senior representatives from NHSGG&C, the Corporate Inequalities Team, the Public Health Resource Unit, Women's and Children's Directorate, and Community Health and Social Care Partnerships (encompassing general and children's services planning, addictions services planning, and primary care mental health development). The primary aim of the Steering Group was to assure NHS GG&C, and the Scottish Government that effective governance mechanisms are in place to implement and evaluate ISPI as part of the Multiple and Complex Needs Initiative, whilst providing strategic leadership to the project and ensuring high level links between ISPI and their organisation/ setting.

In addition to the Steering Group, four setting-specific implementation groups (SIGs) were established. During 2008, it was also decided to set up a further implementation group for learning and development. These multi agency groups were intended to provide leadership and guidance, working closely with Project Leads. It was anticipated that, at this level, there would be benefit also in establishing or consolidating links with the voluntary and community sectors.

Within Maternity Services, the SIG was supported by a Working Group, comprised of midwives and other stakeholders. Likewise, within Addictions Services, the SIG was supported by a Task Group consisting of representatives from the Community Addiction Teams across NHSGG&C.

It was envisaged at the start of the initiative that service users might also be given the opportunity to contribute to the initiative. However, it was recognised at an early stage that it was unlikely that ISPI would have any impact upon service users for some considerable time. However, in the meantime, a Service User Survey, conducted by the Project Lead for Maternity Services, has provided valuable 'baseline' information on service users' experiences of maternity services.

Evaluating ISPI

Commissioned shortly after the establishment of the initiative, Avanté carried out an ongoing evaluation. Running concurrently with the initiative, this evaluation sought to inform and influence ISPI's development, in accordance with the eleven questions outlined in the original evaluation brief:

- 1) a What existing evidence of effectiveness is available in relation to inequalities sensitive practice, inequalities sensitive planning and inequalities sensitive policy interventions?*

- b What gaps and patterns exist in relation to these fields and health inequalities?
- 2) To what extent has each setting managed to agree and interpret a definition of inequalities sensitive practice in relation to gender and poverty that has utility for that setting and how was that achieved?
 - 3) What were the factors, both enabling and limiting, that were particular to each setting and/or common to all, that affected this common agreement on inequalities sensitive practice?
 - 4) To what extent has active engagement with staff by ISPI facilitated an understanding of inequalities and inequalities sensitive practice and practice changes?
 - 5) What changes are staff able to demonstrate that reflect an acknowledgement and understanding of the implications of gender and poverty for assessment and management of health presentations?
 - 6) What are the perceptions of service recipients that issues relating to gender and poverty are explored with them?
 - 7) What changes are managers and planners from within each setting able to demonstrate which reflects the aspirations of inequalities sensitive practice both within and across the settings?
 - 8) To what extent are these linked to implementation plans for the key strategic drivers such as the Planning Guidance and the Equality Scheme and concomitantly, to what extent are the key strategic drivers significant in supporting changes within and across the settings?
 - 9) To what extent have the ISPI team, associated steering group and the Corporate Inequalities Team contributed to supporting decision making in favour of inequalities sensitive practice when the demands of other organisational imperatives are dominant eg time constraints, waiting list demands and staff shortages?
 - 10) To what extent has ISPI contributed to the development of inequalities sensitive practice indicators in the four settings?
 - 11) If we want to ensure that inequalities sensitive practice is taken into account in further settings or organisations, what would be the essential ingredients?

An Evidence Briefing, published early in 2008¹⁰, as one of the initial outputs from the evaluation addressed the first question, examining a range of previous initiatives across NHS Greater Glasgow and Clyde, and the United Kingdom.

This final evaluation report sets out the consultants' findings in relation to the remaining questions set out above, focussing particularly upon a number of key themes which have emerged over the course of the past two years.

¹⁰ ISPI (2008). Evidence Briefing Paper 1. NHS Greater Glasgow & Clyde. www.equalitiesinhealth.org

2.0 Evaluation methodology

At the outset, NHS Greater Glasgow and Clyde set out its commitment to ensuring that learning was highlighted and reflected throughout the lifetime of the initiative. In commissioning this evaluation, therefore, NHS GGC sought to adopt an action research process that would inform the initiative as it was rolled out, as well as evaluating its overall impact at its conclusion.

Avanté Consulting was appointed as evaluator of ISPI in April 2007 and worked closely with the Project Team and representatives across each of the four settings.

A qualitative approach

ISPI was founded upon the hypothesis that inequalities sensitive practice is an effective approach which can impact positively on health inequalities. It acknowledged the value of tackling health inequalities through a social model of health. The overall aim of ISPI was to describe and implement ways of delivering health services which take proper account of a client/patient's social and economic circumstances.

Importantly, therefore, ISPI sought to examine ways and means of achieving changes in individual practice, as well as changes in systems and processes. The focus was less on what people do, and more upon how they do it. For this reason, the methodology employed throughout the project was predominantly qualitative rather than quantitative. Through discussion and observation, the evaluation explored with individuals their understanding of inequalities sensitive practice and sought to identify the ways in which their involvement with ISPI may have changed their attitudes and, consequently, their practice.

Size and scale

NHS Greater Glasgow and Clyde is a large organisation employing approximately 44,000 staff. Within this context, ISPI was a relatively small project. However, those involved were representative of individuals working across NHS GG&C and as such there is much to be learned from their experiences.

The evaluation included the following stages:

Stage 1: Desk research and literature review;

Stage 2: Stakeholder Interviews, questionnaires, workshops, focus groups, observations, policy review.

A number of fundamental questions underpinned the evaluation, with regard to all of the agreed ISPI objectives. These questions can be summarised as follows:

- What's working – for whom, in what way, and why?
- What's not working – for whom, in what way, and why?
- What can be done differently in the future, in what areas, for whom and in what way?

In order to achieve the aims and objectives of the evaluation, the following activities were undertaken:

Stage 1: Desk Research and Literature Review

In the first instance, the consultants identified and examined a range of documents relevant to ISPI. The purpose of this stage of the evaluation was:

- a) to develop a detailed understanding of the local plans, policy, and practice that related to the development of inequalities sensitive practice within NHS GGC and their 'fit' with ISPI;
- b) to identify the range of literature relevant to the Multiple and Complex Needs Initiative and the development of inequalities sensitive practice that was available to support the successful implementation of ISPI;
- c) to identify data which provided the baseline for the study, as well as any agreed outcome measures and measuring instruments.

At the same time, a review was conducted of the activities of other organisations, in Scotland, the United Kingdom, and abroad, as well as linking to the national review of projects funded through the Multiple and Complex Needs Initiative.

Stage 2: Stakeholder interviews, questionnaires, focus groups, workshops, observations, policy review, and documentary evidence

Throughout the course of the evaluation, a range of methods was employed to engage with stakeholders. These discussions addressed a range of key questions crossing ISPI objectives, considering policy, planning and practice across a range of stakeholder groups. Opportunities were created for examining progress and sharing learning **within** each of the four specific settings and **across** all four.

Discussions took place:

- with individuals – practitioners, planners, managers, and policy makers;
- with teams; and
- within specific staff groups.

Stakeholders included:

- practitioners – nurses, receptionists, allied health professionals, social workers, etc;
- planners (NHS and local authority);
- managers (NHS and local authority);
- policy makers (NHS and local authority); and
- voluntary sector representatives.

Topic list

Fieldwork was underpinned by a topic list which sought feedback and evidence from respondents on the scale and nature of inequalities sensitive practice. The consultants' activities sought to identify the extent to which the ISPI approach has informed, shaped, and developed practice, planning, and policy. The topics covered are set out in Appendix 1.

(i) One-to-one interviews

Approximately 100 face-to-face and telephone interviews were conducted at regular intervals, with representatives of all key stakeholders, throughout the initiative. In many instances, individuals were interviewed two or three times, in order to consider the impact of ISPI over a period of time and to identify attitudinal and practice change.

(ii) Questionnaire

At the outset, it was intended that a series of regular questionnaires, electronic and paper versions, would be circulated to stakeholders across the four settings, to provide the opportunity for as many staff as possible to participate in the evaluation process. It was envisaged that these questionnaires would provide quantitative data that would assist in identifying emerging themes and in measuring 'distance travelled' in the course of the initiative, and that this information would complement the qualitative data gathered through other methods.

However, it soon became evident that there was no straightforward means of identifying or contacting staff within the four settings that would have supported the regular and consistent circulation of a questionnaire. Instead, a questionnaire (electronic and paper-based) was made available through the Public Health Resource Unit and via the Project Team, inviting interested members of staff to answer a range of questions relating to inequalities sensitive practice. 88 questionnaires were completed and returned, the majority of which were from Maternity Services and Addictions Services. It is likely that this was due to the fact that:

- a paper version of the survey was distributed directly to staff within Maternity Services, together with a letter from the Head of Nursing and Midwifery, encouraging staff to respond;
- Distribution of the questionnaire within Addictions Services was via the Task Group, to individuals directly involved in ISPI activities.

Owing to the fact that it was not possible to determine the number of questionnaires distributed, nor to restrict its circulation to the four settings, the information gathered through the questionnaire was not considered to be of any statistical significance. However, the information provided a general indication of awareness and understanding of health inequalities amongst staff.

The questionnaire and some extracts from the results are included in Appendices 2 and 3.

(iii) Focus Groups

Throughout the initiative, twelve small focus groups (6 – 8 people) were conducted within each of the settings, in order to explore specific issues in detail. These focus groups have served various purposes:

- to consider the impact of ISPI and the benefit of training and learning opportunities;
- to consider the contribution made by the Project Team;
- to identify the barriers and enablers to the ongoing development of ISP;
- to identify changes in awareness, understanding, and practice throughout the course of the initiative.

(iv) Workshops and Corporate Session

Two workshops were held during the initiative. The first, held in January 2008, was a progress review with the Project Team, PHRU and members of the Corporate Inequalities Team, in order to identify key learning points, and to identify issues to be pursued during the second stage of the initiative. This workshop identified a range of 'enablers' and 'inhibitors' to the development of ISP and informed the ongoing work of the Project Team.

The second workshop, held in October 2008, was attended by approximately 50 individuals, including representatives from the four settings, the Corporate Inequalities Team, and the Scottish Government. This workshop provided an opportunity to explore, in a series of groups, the themes emerging from discussions and to consider ways in which the lessons learned during the course of ISPI might be taken forward and applied across all mainstream services.

In January, a corporate workshop session provided the opportunity to share with senior managers the key messages and learning from ISPI, to demonstrate how learning from ISPI can contribute to the 10 goals for an inequalities sensitive health service, and to agree how recommendations from ISPI can be transferred into action.

Graphic illustrations

Data from this workshop was collected in the form of cartoons. These were validated by sharing them with delegates and asking them if they agreed that the cartoons represented a true summary of the discussion. The cartoons are included in this report as evidence to support the findings and conclusions

(v) Observations

The consultants attended a wide range of meetings and discussions between practitioners, policy makers, managers, and members of the ISPI team, primarily to observe, and where appropriate to discuss the extent to which inequalities sensitive practice is influencing planning, decision making, and priority-setting.

(vi) Policy Review

Throughout the project, the consultants worked with the client to identify and review all relevant new policies, strategies and key practice developments in order to identify developments relating to inequalities sensitive practice, and to establish the extent to which these developments have been supported by ISPI.

(vii) Documentary Evidence

Data from minutes of meetings and activity reports were analysed on a regular basis and used as evidence of progress towards Inequalities Sensitive Practice.

Action Research - Working together

Throughout the project, the consultants enjoyed regular contact, formal and informal, with the Project Co-ordinator, Project Team, and ISPI Steering Group. There were regular meetings with the Project Team on a regular basis, and the consultants attended all Steering Group meetings, providing feedback on findings. Project Leads issued invitations to attend a range of events, in an observer capacity.

This approach enabled the establishment of good relationships between the consultants and the ISPI team, enabling the consultants to fulfil the role of 'critical friend'. From the outset, they worked closely with the team in order to consider carefully the methods employed and identify changes in understanding and practice amongst participants. Research informed the development of the project as it progressed and highlighted emerging themes and issues for further exploration - an innovative Action Research approach.

A timeline setting out all of these activities is attached at Appendix 4.

3.0 Findings

ISPI was described as a vehicle to support the delivery of effective services and the implementation of national and local policies, particularly those which focus upon inequalities. Across the four settings, the Project Team sought to assist in the development of integrated services and the implementation of action plans such as the Gender-Based Violence Action Plan and the NHSGG&C over-arching Equality Scheme. It is recognised that, within such a complex environment, it is very difficult to attribute achievements to any one initiative. However, stakeholders reported that the ISPI team made a significant contribution to the development of inequalities sensitive practice across each of the four settings, in a variety of ways.

3.1 Structures and settings

Maternity Services

At the start of ISPI, maternity services in Greater Glasgow & Clyde had developed a range of models of good practice in the care of women and their families who have multiple and complex needs. These included:

- The Women's Reproductive Health Service, based within the Princess Royal Maternity Hospital, which uses a model of social obstetrics and public health midwifery in response to the complex nature of the lives of women facing poverty and addictions;
- Special Needs in Pregnancy Services, developed differently in Clyde from Glasgow with services led by Special Needs in Pregnancy midwives and aligned to local social care services such as drug and alcohol teams. Unlike Glasgow there was no lead obstetrician or in-patient unit.

A number of innovative public health initiatives had been developed in Glasgow in response to identified need including the appointment of a range of specialist Link Midwives, providing support for asylum seekers, refugees, homelessness, and teenage pregnancy. It was recognised, therefore, that there was a need to develop a strategic overview of linked developments in relation to inequalities sensitive practice and the overarching Equalities Scheme.

However, with the extension of the health board boundary to include Clyde along with the re-design of maternity services within Greater Glasgow, the contextual map for the delivery of maternity services was undergoing major change. These changes provided the impetus for the re-design and re-structuring of midwifery services towards the standardisation of midwifery care throughout the health board area. Within this changing arena, ISPI sought to review and build on the good work already established in the maternity service, in order to support a whole system response to the care of women and their families who have multiple and complex needs.

The Pregnancy Pathway Group exists to design and shape future midwifery services. It became apparent at an early stage that the Pregnancy Pathway Group was a key mechanism for channelling issues raised as part of ISPI implementation activity. The Setting Lead, with the support of the Project Lead, assumed responsibility for representing ISPI issues and recommendations for action to the group.

'Life Course Perspective and Whole System Approach'

The ISPI maternity setting adopted a 'life course perspective' in its work, in the recognition that the effects of disadvantage, in all its forms, but particularly in relation to poverty and gender-based violence and abuse, are experienced not just in the immediate and medium term, but often over the whole of the affected individual's life (Itzin, 2006¹¹). It was recognised that systematic multi-agency intervention can reduce risks and secure best outcomes for the future health and wellbeing of both the mother and her infant.

¹¹ Itzin, C (2006). Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse. Great Britain Home Office.

It was agreed, therefore, that ISPI should seek to support the multi-disciplinary maternity service to identify and provide effective interventions to meet the needs of vulnerable women and their families. The setting adopted a task-focussed approach and, in addition to the Setting Implementation Group, established a Maternity Working Group, comprised of representatives of mainstream and specialist midwifery services, specialist obstetric services, addictions services, social work services, child protection and gender-based violence support units, children and families health service, the health service equalities unit and learning and development.

At the outset, service mapping, staff engagement and user engagement were the key focus of the ISPI Maternity work. This work provided a baseline for the development work and identified three long-term goals:

- Inequalities sensitive services and practices;
- Inequalities sensitive practitioners;
- Supportive infrastructure.

A key element of the work within this setting was the User Survey¹², led by the Project Lead, and developed to offer a service user perspective on current maternity care provision. The aim of the survey was to assess the satisfaction of service users who have multiple and complex needs, with the care they received from maternity services and partner agencies while they were pregnant, during childbirth, and in the postnatal period. Sixty women who had had a baby in the previous 3 years, or were currently pregnant, were interviewed. The results provided a valuable snapshot of users' experiences which will inform and influence the design and development of future services.

The final phase of the maternity setting was the development of integrated care pathways and training. This work, undertaken by the Maternity Services Working Group in partnership with other relevant services, represented an important part of the ISPI maternity work programme. It brought together representatives from across the health and social care systems to consider and agree on good practice, paving the way for the development of standards of care and requisite staff competences. The Group completed a series of eight pregnancy pathways which offer guidance in respect of support for vulnerable women and which identify clear quality standards and required competencies. This work is recognised as integral to the work of the Pregnancy Pathways Group and will form the basis for the learning and development programme and subsequent roll-out of training.

Members of the Maternity Services Working Group reported that the opportunity to work together as a multi-disciplinary, task-focussed team was enormously beneficial, in terms of understanding the significance and meaning of inequalities sensitive practice, and of working together in order to produce practical responses to the needs of vulnerable women and their unborn children.

¹² ISPI (2008). Analysis of the Maternity Services User Engagement Survey: Final Report. NHS Greater Glasgow & Clyde. www.equalitiesinhealth.org

“This is the only forum where we all come together and get our teeth into things. We don’t just talk about things we make them happen!”

**ISPI Maternity Group
Member**

Similarly, planners and strategic managers agreed unanimously that the work undertaken by the Maternity Setting has informed and influenced service redesign and workforce development.

Integrated Children’s Services

‘Starting Well’ was a 5-year National Demonstration Project, funded by the Scottish Executive until March 2006 and was moving into a mainstreaming phase. Phase Two – the establishment of Parent and Child Together (PACT) teams - had been developed from existing Social Work Early Years Practice Teams, existing and additional Starting Well health resources (redistributed), and additional SureStart resources agreed with the City of Glasgow Council Education Department.

PACT Teams provide early intervention and additional support to vulnerable families. The teams aim to provide intensive multi agency support on a planned basis for an initial period of three months, after which the family situation is reviewed. Specific support is based on family need and is offered in the family home, and or in centre based settings as required. The PACT teams are multi-agency and multi-disciplinary – providing support from health, social work, education and the voluntary sector.

PACT represents a key service area within Integrated Children’s Services and uses a social model to address the multiplicity of problems faced by families with young children in disadvantaged areas. For these reasons PACT was identified as the main exemplar with which to demonstrate the ISPI process in this setting.

As ISPI got underway, the PACT Teams were at a very early stage of their development. Staff were faced with significant challenges, including the creation of integrated teams (social work, health and voluntary sector) and management arrangements, building links with other agencies eg education, addictions, practicalities such as accommodation and IT, linking with national policy, maintaining relationships with mainstream services/potential referrers, and engagement with service users.

The introduction of ISPI to the PACT Teams proved complicated and difficult, for a variety of reasons. Structures supporting the Teams changed; the Project Lead experienced serious difficulties in securing time to meet with Team Leaders; and accommodation changes led to the Project Lead being isolated from PACT Team staff. It became apparent that, in the midst of establishing new teams, Team Leaders regarded ISPI as ‘yet another initiative’ and had little understanding of what it was seeking to achieve or of how it might support them in establishing integrated, multi-disciplinary teams.

Discussions with Social Work staff during the early stages of ISPI suggested that they saw little added value in ISPI. In their view, inequalities sensitive practice was, and always had been, at the core of social work services.

“When the Project Lead came along to our meeting, we were all a bit baffled. It was a bit condescending – because it was what we’d always done.”

**Social Work Team Leader,
Integrated Children’s Services**

Over time, however, as PACT Teams became better established, there emerged a more enthusiastic response from team members. In order to establish how best to support the newly-formed teams, the Project Lead conducted a simple training needs analysis, using ‘Survey Monkey’. This TNA identified specific learning and training needs within the PACT teams. These emerged as issues relating to employability, poverty, and gender.

In response to the results of the TNA, and with the support of the Setting Lead and the ISPI Learning and Development Officer, a training programme was established. Staff were engaged in the process of producing learning and development tools. Team members took the opportunity to engage in discussion and examination of current practice.

During recent discussions, staff acknowledged the value of the initiative in creating opportunities to explore current practice from a multi-agency perspective, in a non-threatening and supportive environment, thus contributing to the development of integrated, effective multi-disciplinary teams.

More recently, the Setting Lead was in a position to offer strong support to the Project Lead and, in December 2008, a half day workshop was held, the purpose of which was to explore how actions relating to the key learning from the Inequalities Sensitive Practice Initiative (ISPI) can be embedded within the PACT development plan. This workshop was well attended by PACT team members. The Setting Lead and Project Lead were also in a position to emphasise the significance of ISPI and ISP for Integrated Children’s Services in a number of strategic settings.

Addictions Services

Across NHS Greater Glasgow and Clyde, Addiction Services are delivered through integrated Community Addictions Teams (CATS) which bring together professionals from health and social work services. Feedback from stakeholders highlighted the social model underpinning the development and delivery of addiction services within NHS Greater Glasgow and Clyde.

“Within addictions there has been a long standing relationship between poverty and the deployment of services. You just need to look at the communities that we work in, that tells you that our services reflect issues of poverty when they are being developed. But, it’s true, we can always do better in working that right down to the needs of the individual clients.”

Manager, Addictions Services

At the start of ISPI, the effects of inequalities in health had already been considered for practice in the delivery of local addiction services across Greater Glasgow. Inequalities issues had been integrated into CATs service specifications and considered within the Review of Purchased Services since 2004. Multi-agency AAT/ DAT subgroups existed for gender, race, disability and sexuality.

Audits of practice had taken place for race and disability and plans were in place to audit practice as regards LGBT experiences. However, exploratory research with staff in 2003 had indicated a lack of understanding and skills in systematically integrating the implication of gender inequality into practice.

In response to these issues, the Gender and Addictions pilot had been established in order aimed to involve staff in identifying areas of good practice and areas of change through action planning and associated training with mentoring support.

It was agreed, therefore, that in order to support these activities, ISPI should focus on:

- developing and influencing support and planning structures; and
- shaping practice.

Developing and influencing support and planning structures

In line with other settings, the addictions setting established a Steering group and logic model in order to develop activities. The Project Lead also worked with a range of existing equalities groupings within the setting and at CHCP level.

As within the maternity setting, the addictions setting included the establishment and development of a Task Group. This group engaged front line managers from each CAT as local 'champions' to share and cascade learning and practice. It was recognised that these staff members were most likely to be present in the teams on a day to day basis, tasked with daily operational decision-making duties. They would have most opportunity to influence staff through either direct supervision, case conferences or reviews and are expected regularly to assist with managing the daily delivery of the service.

At the outset, therefore, it was important to convey to Task Group members their expected role within ISPI. The Task Group members were regarded as 'early adopters' who had shown willingness to accept the challenges that a gender and poverty perspective demands from addiction practice. They were 'tasked' with responsibility for being the key links to ISPI and expected to eventually influence others and make changes at a practice level.

In order to equip Task Group staff for this challenging role, a set of workshops was arranged, with the support of the ISPI Learning and Development Officer, in order to improve understanding, awareness and knowledge of the ISPI agenda, and to build a supportive network.

From the outset, the Group showed enthusiasm, insight, honesty and a genuine willingness to openly discuss these issues both in relation to addiction services but also in relation to their personal values and attitudes. It was recognised that such personal investment and willingness to discuss issues openly and honestly in a safe environment was key to securing practice change across the service.

“Bringing people together from local teams has given me a place to ask questions without feeling stupid and I now feel more able to go back to my own team and talk about inequalities sensitive practice and encourage others to do likewise.”

Addictions Task Group Member

The Addictions setting recognised that working with an influential staff group and developing the ‘need for ISPI’ was crucial for the longer term sustainability of ISPI.

Despite this, there was a tendency to rely upon the Project Lead for implementation of ISPI, with members of the Task Group assuming a reactive, rather than pro-active role. More recently, however, at a workshop facilitated by the Project Lead and one of the Avante consultants, Task Group members acknowledged their responsibilities in terms of the sustainability of inequalities sensitive practice.

Shaping practice

“If I was being honest, I’d say that I’ve sat back and let the Project Lead get on with things and could have done more. Part of that’s just about time but it’s also about feeling confident to talk about it (ISP) with the rest of the team...I feel more able to do that now, maybe I should have done things a bit earlier but, hey, you cannae go back.”

Task Group Member

Work within the Addictions setting focussed on the development of staff practice through:

- Piloting of routine enquiry for women involved in prostitution within a local CAT;
- A series of information and training workshops on income maximisation and gender issues for Addictions staff;
- The development and piloting of case studies with local CAT teams; creating a model care pathway for women involved in prostitution;
- supporting the distribution and utilisation of a gender toolkit.

Importantly, the Addictions Task Group sought to develop further inequalities sensitive practice at a local level through the establishment of sub groups within individual CATs. These local sub groups encouraged and supported reflective practice across staff teams. Significantly, however, the connections, dialogue, and exchange of learning between the different groupings within the Addictions setting, local sub groups, Task Group, and Setting Implementation Group were limited throughout the period of the initiative. Feedback from task group members in particular highlighted their sense of connections being limited between the task group and the Addictions setting group.

“If you were to ask me what they do, I couldn’t tell you, and that’s probably the same for them.”

Task Group Member

Whilst the setting group agenda included an update on task group activities, this was a limited feature of meetings.

Senior members of the Addictions Service acknowledged that ISPI has made a significant contribution to the ongoing design and development of services, including the re-location of services, and changes to initial assessment procedures.

Primary Care Mental Health

Primary Care Mental Health (PCMH) Teams were established across Greater Glasgow in order to provide short-term interventions to people experiencing mild to moderate mental health problems. At the start of ISPI, as with the PACT teams, these teams were still at a formative stage, and were operating differently in each area. From the outset, however, there was clear recognition of the value of multi-agency working and an acknowledgement that poverty and gender issues had the potential to impact significantly upon an individual's health and wellbeing. The earlier Women's Mental Health project in Bridgeton had offered useful learning in relation to inequalities sensitive practice within mental health services but, at the same time, highlighted the difficulties of mainstreaming such an approach within a service which is based primarily upon clinical intervention.

The South West Primary Care Mental Health Team (Pathways) was established in Spring 2005. In response to the growing body of evidence supporting the implementation of psychological therapies within a 'Stepped Care' framework (NICE Depression Guideline, December 2004), the Pathways Team had opted for a 'Stepped Care' model of service delivery. This model allows therapeutic resources to be utilised to their best advantage, and promotes a matching of client need to the level of service provided. Clients may self-refer to many of the interventions offered, while GPs are still able to make a written assessment for clients who they would like to see receive an individual assessment.

The Project Lead for this Setting was located within the Pathways Team. Given its formative stage, this team was still in the process of identifying systems for undertaking work, and identifying how the skills of its members could be utilised most effectively. This provided an opportunity for ISPI to work with the team, almost from inception, assisting in the integration of an inequalities perspective into both direct client work and community engagement. Work was also underway within the North area, and there was contact with Clydebank and East Glasgow.

During the early stages of ISPI, one of the issues facing the PCMH Project Lead was the lack of leadership stemming from staffing changes and, consequently, a lack of accountability. Priorities for PCMH Teams had been established, but whilst some team members adhered to those priorities, others did not. Teams were operating differently, structures were different, and there was a lack of consistency in terms of working with ISPI. At the same time, the Project Lead became aware that 'Agenda for Change' and corporate re-structuring was having an impact upon staff, who indicated that they were unsettled and de-motivated, and not inclined to participate in ISPI.

At an early stage in the initiative, the Project Lead conducted a session with the Pathways Team which considered the following questions:

1. What does the Pathways Team understand ISP to mean currently?
2. What are the barriers and enablers that exist within the service?
3. What supports might practitioners need to help make practice more inequalities sensitive?

A number of common themes emerged, from interviews, discussions, and the consultants' observations, such as language and what was the 'correct' terminology. It emerged also that ISPI was not yet 'tangible' for practitioners. Detailed discussion and examination of these issues highlighted a willingness amongst practitioners to further develop inequalities sensitive practice.

The location of the Project Lead within a local PCMH team created a strong connection to staff and practice within this area. Over time, and in partnership with the ISPI Learning and Development Officer, the Project Lead facilitated a range of training events which provided opportunity for discussion and debate about the meaning of ISP, and for examination of practice. During the final six months of the initiative, these sessions were extended into other PCMH areas.

In particular, ISPI provided considerable support for the implementation of the Gender-based Violence Action Plan within the PCMH setting. A training needs analysis led by the Corporate Inequalities Team provided an opportunity to look across the PCMH teams and establish what staff had already accessed in terms of training and learning, and what future development needs might be.

During the latter stages of ISPI, work was undertaken in relation to user involvement – a particularly challenging area for Primary Care Mental Health. This work was enthusiastically supported by a voluntary organisation specialising in mental health services, and led to closer joint working between the two organisations.

Within PCMH, as with other settings the Project Lead worked with the local team to consider and review assessment and review processes and recording systems, contributing to changes in initial screening mechanisms. As well as facilitating a range of information and training events, the Project Lead supported the development of practice descriptors.

3.2 Key themes

In the course of the evaluation, a number of key themes emerged, providing an indication of the 'enablers' and 'inhibitors' of inequalities sensitive practice. The themes, summarised below, are offered as the underpinning messages to support the development of ISPI in the future:

- Language and definitions;
- Inequalities sensitive enquiry;
- Leaders and champions;
- Policy v practice;
- An inequalities sensitive NHS; and
- Learning and development.

3.2.1 Language and definitions

“There needs to be a common language, a common understanding. At present, there is a bit of a schism (between NHS and Social Work), which prevents effective practice.”

NHS representative, 2007

Throughout the course of the initiative, a definition of ‘inequalities sensitive practice’ (ISP) proved elusive. From the outset, it was difficult for practitioners to define and understand the term ‘inequalities sensitive practice’. However, respondents agreed that the absence of any formal definition was helpful as this prompted wide-ranging discussions which helped practitioners to make the connection between the rhetoric of policy and the reality of practice.



In the beginning ...

At the start of the evaluation, interviewees were invited to define ‘inequalities sensitive practice’. The most common response was ‘a holistic, multi-agency response to the needs of an individual’. Respondents referred to the value of comprehensive, single shared assessment, and the need to be able to ‘signpost’ an individual to a range of different services. Rarely did they refer to their own individual practice.

The information gathered through the questionnaire indicated that there were mixed views as to the meaning of inequalities, and differing views as to how inequalities might be addressed in terms of health care provision. There was greater awareness of ISPI amongst managers than amongst practitioners, due most likely to the fact that at the time of distribution, it was mainly staff with managerial responsibilities who were involved in the Initiative.

Several months on ...

More recently, however, participants acknowledged that there is more to ISP than multi-agency working. Training programmes, workshops, case studies, and discussions supported individuals to consider – and challenge - the ways in which they themselves currently deliver services. They explored alternative approaches which take heed of the client’s circumstances, and are more likely to result in an appropriate package of care. They acknowledged the need to ensure that their approach to service delivery is non-judgemental and non-discriminatory. There was a clear recognition that inequalities sensitive practice is underpinned by values and principles. In the words of one respondent, it’s about “supporting the spirit of the law’, rather than just the letter of the law.”

“When we were developing the Gender and Addictions Toolkit prior to ISPI we asked workers what their definition of ‘inequalities sensitive practice’ was. We were struck with the number of workers that said this meant treating everyone the same. ISPI has managed to get underneath this and been able to evidence that in reality workers do not treat everyone the same, that they do take on board the diversity of our client group and respond differently to each Service User. It was clear they struggled to articulate this and also did not badge this under ‘inequalities sensitive practice.’”

Senior Manager, Addictions Services

The debates and discussions which took place throughout ISPI were critical in ensuring a shared understanding of ISP. It was widely acknowledged that a pre-determined definition risked being regarded as simply ‘empty rhetoric’, and not internalised within the services.

“I had always recognised that my approach to doing my job was different to that of my colleagues, but often wondered if I was going about things the wrong way. Having been part of ISPI, I know now that I’m getting it right – and I have the confidence to challenge the practice of others when I know it’s wrong.”

Parent and Children Together (PACT) Team Member

Stakeholders believe that a clear definition, presented in plain English and avoiding academic language, will now drive change. This definition must be meaningful for practitioners, focussing on person-centred inclusion. It must “name the game”, stop reinvention, and allow services and practitioners to move forward with clarity. Importantly, respondents are unanimous in insisting, however, that a definition is not in itself enough. Any definition must be accompanied by practical examples and exercises, and the opportunity to develop understanding through training and discussion within teams.

3.2.2 Inequalities Sensitive Enquiry

Of the five themes, ‘inequalities sensitive enquiry’ was the most significant, in terms of discussion, debate, and the importance placed on it by practitioners in the development of inequalities sensitive practice.

Systems and processes

A range of new systems and processes have been introduced across health services in order that wider issues such as gender-based violence and poverty might be addressed. Examples of such developments include work within both Addictions and Primary Care Mental Health Services to develop initial screening tools and single shared assessment systems which better reflect issues of financial inclusion and involvement in prostitution. Within maternity services, there is increased emphasis on the initial interview process or booking visit. Appointment times have been increased to allow 1 hour 15 minutes over 2 visits to allow staff to complete a more comprehensive assessment at point of first contact.

However, in a number of other areas there remain weaknesses in these initial screening, assessment and referral systems, founded, in part, upon a lack of understanding, confidence, and skills amongst practitioners in relation to sensitive enquiry.

Examples of this include inconsistent practice in the 'routine enquiry' process implemented in Maternity Services over seven years ago, and inter-agency issues associated with the Single Shared Assessment. Despite positive feedback about equality and diversity training, practice recommendations are not yet being fully implemented.

“Perhaps there is not a clear enough understanding at strategic and policy levels. It is often regarded as ‘fluffy’ – but if we are to succeed in addressing such complex problems, then it is absolutely essential that staff can get trust, build a relationship, and allow open dialogue with their clients. In a nutshell, that’s what it is about.”

NHS Midwife

Enablers and inhibitors

Practitioners identified a range of issues which enable and inhibit effective sensitive enquiry. These issues relate to:

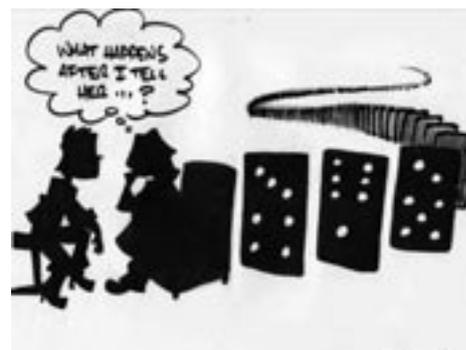
- a) the client;
- b) the practitioner;
- c) partner organisations.

a) The Client

The Multiple and Complex Needs Literature Review states:¹³

“Even when people were aware of services they often experienced difficulties in accessing these because of: low self esteem and low expectations of the ability of services to help them; professionals’ low aspirations for people with multiple and complex needs; and services’ long waiting lists, restricted hours and rigid eligibility criteria that can cause exclusions.”

Throughout ISPI, practitioners and managers shared the view that clients are, in many instances, reluctant to disclose issues such as domestic violence and prostitution, fearful of the consequences. Many are resistant to intervention by statutory services amid concerns that their children may be taken into care; they may incur the anger of a partner or other family members; or be accused of breaking the law. They fear that they may be judged according to their circumstances, and be discriminated against when seeking to access services.



¹³ Rosengard, A; Laing, I; Ridley, J; Hunter, S (2007). A Literature Review on Multiple and Complex Needs. Scottish Executive Social Research

Stakeholders believe that before a client is willing to disclose, they must be given time to establish a trusting relationship with a member of staff, in an accessible, non-threatening, and comfortable environment. Disclosure will take place only when the client is ready to accept help and is confident that good quality support is there. While there are many examples of additional time being allocated to the initial assessment process, ISPI participants concluded that this is rarely the point at which the client has the confidence to disclose.

The Multiple and Complex Needs Literature Review highlights as an element of good practice:

“Enabling access when the service user is ready to engage without lengthy waiting times and enabling easy access to services through: user friendly opening hours; convenience of location; the use of IT and ‘one stop’ service models.”

Recent developments within Addictions Services reflect a commitment to addressing these issues. The location for the delivery of services has been reviewed to make them more accessible, opening hours extended, and a flexible appointments system has been introduced.

Staff across all settings believe that this investment in the early stages of any intervention is likely to give better results and reduce the level of support required at a later stage.

b) The Practitioner

As a result of participating in ISPI training, case studies, and discussions, practitioners confirm that they have a better understanding of the impact of inequalities, in particular, poverty and gender. They appreciate better the need to ensure that the way in which they themselves deliver their service must be sensitive to an individual’s circumstances. However, many also confirmed that there is still reluctance amongst staff to tackle the difficult issues, such as domestic violence and prostitution. Staff are fearful of ‘opening a can of worms’, without knowing how best to respond.

Managers, too, recognised that staff must be able to demonstrate that they have the qualities required to work in a manner that is sensitive to inequalities and that as managers, they have to understand and support staff to operate in this way.

Participants at a stakeholder workshop confirmed that this lack of confidence is due, in most instances, to a lack of skills and knowledge. Whilst many practitioners appreciate the importance of such issues, they do not always know when and how to ask the questions, and how to follow-up on the response. They may not be able to recognise the signs indicating that an individual is ready to talk about a sensitive issue; they may not know enough about additional support services, or have concerns about waiting times for those services.

Throughout the evaluation, respondents emphasised that it is not only clinicians who must deliver their services in an inequalities sensitive manner. Receptionists and administrative staff are often the first point of contact and must also be able to respond sensitively to clients, many of whom may have taken some time to summon the courage to seek help.

Developing the required levels of awareness, understanding, and skills across the entire organisation is widely recognised as a major challenge. The commitment, and ability, of staff to undertake inequalities sensitive enquiry was seen by the majority of stakeholders as being the single most significant requirement to support inequalities sensitive practice.

Support and supervision

The tradition of support and supervision within Social Work offers a model for staff support which is not consistently replicated across health services. Whilst structures are firmly in place within Addictions and Primary Care Mental Health Services, there is inconsistency in other settings, with many respondents indicating that they do not receive any support and supervision. A structured framework for support and supervision provides the opportunity to discuss specific cases including practice review, as well as support for problem-solving, case management and professional development.

The active development of this model of support and supervision was highlighted by staff as crucial in underpinning ISP practice and supporting practitioners to practice in an inequalities sensitive way.

And it's not just the clients ...

Managers across all of the settings were concerned that services must recognise that staff themselves may feel vulnerable and threatened when confronted by issues such as domestic abuse or drug addiction, not least because they may have/have had personal experience of these issues. They emphasised the need for structures to be in place to support staff in order that they too might be helped to disclose and to address any such issues, as well as having responsive and accessible debriefing facilities for resolving issues as and when they are faced during day to day practice.

“The organisation has an awareness that staff might be involved in some of these issues personally, but we need to improve staff support structures – the enquiry aspect of things. There needs to be a greater acceptance of staff that it’s ok to use these internal avenues for support ... there are some supports, but its only once you move further into management that you become aware. The midwife on the ward might not be.”

Senior Midwife

c) Partner Organisations

“As a result of being involved in ISPI, we have been recognised by our partners as being experts in our field, and have been able to make a significant contribution to service design and development.”

Voluntary organisation representative

ISPI has led to a huge raising of awareness and has definitely strengthened partnership working relationships. People involved are now working together regularly as practitioners. There’s more of a ‘robustness’ to it. We understand each other’s remits more – understand the value of what each person takes back. Understand our boundaries, our limitations. Previously, we were too possessive. Some midwives find it difficult to give up a client and refer them to my service.

Member of Maternity Service Working Group

Practitioners indicated that inequalities sensitive enquiry requires confidence in the capacity of partner organisations to respond to the needs of clients. Staff, especially at practitioner and middle management level, must have comprehensive knowledge of the support available from partner organisations in order to make good support and referral decisions.



Straightforward care pathways for all services, supported by effective and efficient referral processes, are critical. At a recent ISPI evaluation workshop, participants confirmed that referrals that lead to a poor experience for the client can damage the client's relationship with the referring agency and impair the likelihood of disclosure and trust.

3.2.3 Leaders and Champions

Strong and effective leadership at all levels was highlighted as a key 'enabler' within ISPI, whilst the lack of leadership was recognised as an 'inhibitor'.

"ISPI is not exactly 'owned' by the Settings. It's not clear to me that they understand their role in driving this initiative forward. They are supportive of the concept – but inclined to leave it to the ISPI Project Lead. With some exceptions, Setting Implementation Groups have not taken ownership ... but what is required is 'leadership' – not just a titular involvement. They haven't understood that there is an active role to be fulfilled."

NHS Senior Manager

Respondents expressed concerns about the apparent lack of leadership from the Setting Implementation Groups (SIGs), established at the outset to lead and direct the initiative. Initially, there was little direction or debate from the SIGS; responsibility for taking forward the work rested with the Project Lead and individual managers. More recently, it appeared that as SIGs, and individual SIG members began to understand the significance of ISP in relation to service delivery, they began to take an interest and demonstrated a commitment to sustaining ISP-related activity beyond the life of the initiative itself.

In reviewing the Addictions Services and Primary Care Mental Health SIGs, and the Addictions Services Task Group with members towards the end of the initiative, members were self critical of the extent to which the groups had taken forward and led on championing ISPI. It was reflected that the Project Lead, in both settings, had often been expected to lead and facilitate developments with limited actions from the wider group membership.

Within the ISPI settings, the enthusiastic engagement of senior managers enabled a comprehensive programme of discussion and training. Attendance at training events was good; ISPI was welcomed as a tool to support development and change. Conversely, without the support of managers, there were difficulties in generating interest in the initiative.

It was agreed by practitioners that at managerial level, there must be leadership and decision-making in terms of planning, setting targets, identifying priority areas, and allocating resources.

Champions

Throughout the discussions, the work of the Project Leads was widely praised. The enormity of the challenge with which they were presented was acknowledged; the enthusiasm and tenacity with which they have tackled that challenge was applauded.



“She has been great, without her it would have been like fog but she was able to make it really simple and clear when she was helping us understand just what all this inequalities sensitive language meant.”

Maternity Setting Working Group Member

“The Project Lead has driven the whole thing, its been her enthusiasm and commitment that has made things happen. She’s supported us to understand things and then helped us to take things forward in our teams.”

Addictions Services Task Group Member

The model of a Project Lead as ‘champion’ was recognised as vitally important in ensuring that ISP was a constant feature of service planning and delivery. Respondents described the Project Team as bringing passion, drive, and vision to the initiative.

Stakeholders within each setting welcomed the practical and flexible approach adopted by the Project Leads. Initial difficulties in explaining exactly what ISPI was all about were gradually overcome by the way in which they engaged participants in discussion, debate, and training – encouraging individuals to identify ways in which clients with multiple and complex needs might be helped – or hindered – by current practice, and ways in which support could be improved in order to take proper account of individual circumstances.

Within the maternity setting, the Project Lead began by facilitating a range of activities which enabled members of the Working Group to understand clearly the meaning of inequalities sensitive practice. Subsequently, she encouraged and supported the Group to apply its understanding to the development of care pathways for a range of vulnerable clients. This approach resulted in a series of inequalities sensitive care pathways which will ‘mirror’ the care pathways being introduced across mainstream services and support the delivery of appropriate and effective care for individuals with multiple and complex needs.

Within Addictions Services and Primary Care Mental Health, Project Leads provided very practical support to a number of working groups and practice development initiatives. These included the development of assessment processes, care pathways and initiatives aimed at tackling prostitution and financial inclusion.

3.2.4 Policy v practice

The Inequalities Sensitive Practice Initiative was intended, from the outset, as a vehicle which would support the delivery of existing national and local policies. The Project Team sought to provide practical support within the four settings, facilitating the development of practice which contributes towards a range of aims and objectives related to inclusion, inequalities, disadvantage, poverty, and health.

Quantity v quality

Throughout the course of ISPI, managers and practitioners have expressed concerns about the volume of policies, strategies, action plans, working groups, and fora which seek to direct and influence their services.

At a recent ISPI evaluation workshop, stakeholders were invited to identify the range of policies, strategies, and action plans which were related to their area of work, and to describe their impact on practice. For many practitioners, whilst they were able to list over 60 policies, strategies, and initiatives, the exercise proved difficult and highlighted the challenge and 'disconnect' between policies and their impact on practice.

Managers expressed their frustration at the apparent 'disconnect' between policies and operational issues. There was little sense that policies are in any way influenced by practice and, as a result, are not 'owned' by the field.



"Staff and team leaders appear to feel disconnected from the worlds of policy and planning and in some cases feel that their lack of influence in shaping decisions about practice hampers their ability to respond effectively to their service users."

Report from PACT Teams

There was a frustration that services are urged to respond to emerging policy whilst at the same time being faced with reduced staffing levels, poor accommodation, increasing demands for record keeping and information, and insufficient administrative support.



It was suggested that this 'disconnect' between policy and planning and the resulting frustration shared by managers inhibits leadership at service delivery level.

Out of time

Respondents expressed particular concern over the fact that national policies which relate to workforce development are rarely aligned with policies which seek to effect change in terms of service design and delivery. There was a concern, therefore, that opportunities to translate policy into practice through workforce development were missed.

Making the connection

Discussions with managers and practitioners indicated that ISPI provided valuable support in terms of delivering services in response to policies and strategies. Through discussion, training, and example, ISPI helped to connect policy and practice and enabled practitioners to consider how they might change their individual practice in response to policy.

3.2.5 Learning and Development

“ISPI has assisted in bridging the gap between policy and practice. The DVD on First Contact/Routine Enquiry is a valuable tool in practice development. It clearly illustrates how crucial the first contact is and that if Addiction Services staff invest some time in ensuring the first contact is positive and that we ask the difficult questions with sensitivity it’s mutually beneficial for both the worker and the service user.”

**Senior Manager,
Addictions Services**

The Project Team included a Learning and Development Officer, whose initial remit was to facilitate training for inequalities sensitive practice development and support greater understanding of inequalities for planners and managers in the ISPI settings. Throughout the initiative, respondents from all four settings were very enthusiastic about the training delivered by the Learning and Development Officer.

It was recognised at an early stage of the initiative that, in the interests of co-ordination and sustainability, it was essential to encourage effective integration between training and learning within ISPI, NHS Greater Glasgow & Clyde’s Learning and Development Service, Public Health Resource Unit, and Scotland-wide NHS training programmes. With this in mind, the Learning and Development Officer succeeded in engaging a range of internal and external stakeholders in the recognition and development of inequalities sensitive practice, including NHSGGC Learning and Education Services, NHS Education for Scotland, and NHS Health Scotland. The Learning and

Development Officer also supported the implementation of initiatives such as ‘Keep Well’ through the provision of training, and regular input to discussions.

The Learning and Development Officer engaged with a number of NHS Greater Glasgow & Clyde-wide initiatives, and developed an Equality Impact Assessment Tool to be applied to all learning and education activities within NHSGGC. This EQIA Tool is designed to ensure that equality issues are properly reflected in all workforce training programmes.

Observation of minutes and papers from relevant learning and education groups indicated that these activities established an awareness and understanding of the need for learning and education programmes to take account of inequalities sensitive practice. However, practice and linkages remain at an early stage of development.

Managers and practitioners recognised the value of the training and learning provided by ISPI and agreed that learning is critical to the development of inequalities sensitive practice. Throughout the initiative, training programmes provided the opportunity to raise awareness and understanding of ISP.

Workshops exploring case studies and practical illustrations provided the means to examine current practice in a supportive environment. Information sessions enhanced knowledge and understanding of specific issues and of services provided by partner agencies.

Responses to the questionnaire confirmed that, whether staff were aware of ISPI or not, there is a demand for formal training on issues relating to health inequalities. 80% of respondents indicated that they would like more formal training on health inequalities issues.

Equally important was the multi-agency approach to learning and development which supported the integration of services and effective partnership working. Respondents from health services, social work services, and the voluntary sector confirmed that ISPI has encouraged staff to examine together their understanding of equalities/inequalities, the impact upon the health and wellbeing of the individual and their family, and the ways in which their practice can best support clients.

“When the Project Lead came to our meeting, everyone was completely baffled. It felt a bit condescending. But in terms of trying to measure it, people are fine about it. We have found it quite useful – the training has flushed out some of the concerns I had about health service staff. They clearly don’t have the same opportunity in their training to consider values”.

PACT Team member

“It was good to have the time to discuss ‘case studies’ with colleagues..... we need more time for peer support.”

PACT Team member

At the same time, however, there was a concern across all settings that this training did not appear to be linked to corporate learning and education activities provided by NHSGG&C.

Medical or social?

The conflict between medical and social models of health as drivers of change was recognised at the outset as a key issue to be addressed by ISPI. Throughout discussions, it was acknowledged by both health and social work representatives that there continues to be a challenge in working between social and medical models of intervention within different settings. Interviewees from all staff groupings, across all the settings, suggested that inequalities sensitive practice is better supported within a social model of care.

Further and higher education

Across all settings, staff emphasised that changes are required in undergraduate training, as well as ongoing professional learning and development in order that inequalities sensitive practice can become synonymous with good practice.

Sharing the learning

Despite their shared objectives, Project Leads worked largely independently of each other. At the evaluation mid term Review Workshop held in January 08, there was clear evidence of opportunities for 'cross-fertilisation' and for comparing and contrasting experiences across the four settings. It was agreed by participants that this could be important if the learning from ISPI is to be of relevance to other mainstream services. However, to date, whilst they contributed to each other's activities in order to support the integration of services, there was limited evidence of the sharing of experiences in terms of developing inequalities sensitive practice.



3.2.6 An inequalities sensitive NHS

There was widespread agreement, across all settings, that inequalities sensitive enquiry requires organisational investment, at all levels, across the entire organisation. It must be reflected in strategic development, planning and performance, learning and education, and human resources, as well as front-line services.

Corporate links

ISPI was located within the Corporate Inequalities Team (CIT) of NHS Greater Glasgow & Clyde. The Head of Health Improvement and Inequalities, the Project Co-ordinator, and the Project Leads sought to promote the concept of inequalities sensitive practice and ISPI itself across all of NHS Greater Glasgow & Clyde's corporate services. The Project Co-ordinator had particular responsibility for ensuring that strategic links were established into both the emerging corporate, and setting-specific planning mechanisms.

In feedback from members of the CIT it was recognised that ISPI provided an important vehicle in linking corporate activities, policies and strategies, with the world of practice. ISPI allowed inequalities practice to be seen as linked to practice in a way that other initiatives had sometimes struggled to achieve.



“ISPI has helped us reach out and be more relevant to the world of practice at a time when practitioners often see us as working in some kind of ivory tower.”

CIT staff member

The increasing references to inequalities sensitive practice across a range of policy documents reflect the impact of their work to date. The Planning and Priorities Guidance 2007-2010, updated for the 2008/09 Planning Round includes a section which sets out the organisation’s approach to tackling inequalities and provides additional guidance to support planning activity across the organisation.

However, whilst membership of the ISPI Steering Group included representatives of a range of corporate services, and social work services, these representatives did not attend meetings on a regular basis. Of all the ISPI settings it was Learning and Development which saw the most developed linkages to corporate functions.

Members of the Corporate Inequalities Team confirmed that ISPI was a very effective vehicle in terms of developing awareness and understanding of inequalities. The initiative developed a range of valuable tools and approaches which will continue to have an impact well into the future. Members of the CIT described ISPI as having ‘brought alive’ inequalities issues, enabling practitioners to transfer knowledge and understanding to practice.

A stable environment

Well-established, stable groups and teams demonstrate the capacity for exploration and development of inequalities sensitive practice. Practitioners who are part of a well-functioning team are familiar with each other’s work, understand their respective roles and responsibilities, and are accustomed to joint working.

Whilst not an established ‘team’, respondents indicated that the multi-disciplinary Maternity Services Working Group provided a productive and supportive environment for its members. Leadership in this setting was provided by the Project Lead; ISPI provided a framework for the team to pursue specific objectives, within an otherwise changing and uncertain environment. Having attended several meetings of the MSWG, it was obvious to us that members were eager to contribute to discussions and benefited from the opportunity to work with colleagues on a range of specific tasks, against a clearly-defined agenda. Meetings generated a sense of energy and enthusiasm, and participants clearly enjoyed working and learning together.

“The structure (MSWG) has been very helpful – there has been a journey, there has been progress, we have looked at the national perspective and then translated that into the local situation. There has been great support for my work – I felt valued – I enjoyed the fact that I had somewhere to report back to. I was reporting to a group that was interested”.

“The selection of the group members and the relevance of us being together was crucial. We have a common cause; we are the advocates for the underdog. I have quite enjoyed the stability in a huge period of change. It has been a good support system, working with peers whom we might have thought were unapproachable. But there’s no hierarchy in the group, and that’s hugely important. We receive lots of information, we have jobs to do – there’s nothing worse than a group which delivers nothing. I’m pleased that we have had tasks and are expected to work for the group”.

Member of the Maternity Services Working Group

Change and uncertainty

The disruption and uncertainty caused by organisational re-structuring, the implementation of ‘Agenda for Change’¹⁴ across the health services, and ‘Single Status’¹⁵ within local authority services, presented challenges for ISPI. In an environment of change and uncertainty, practitioners indicated that they feel under-valued, vulnerable, and threatened. Managers confirmed that staff were less willing/able to respond constructively to examination of their practice during such periods. It was not uncommon for interviewees to suggest that it is unreasonable to expect them to take seriously the development of inequalities sensitive practice, when they feel that the way in which they are being treated in terms of their employment is, in their view, ‘neither equal nor sensitive’.

Making the business case

“The literature presented an overall picture of professionals’ assessments and service users’ options often being constrained by resources and commissioning systems, or by limited vision on the part of service providers”.

The Multiple and Complex Needs Literature Review states:

Managers involved in ISPI believe that the adoption of inequalities sensitive practice can ensure effective care at an early stage, thereby reducing the need for repeated interventions. Senior managers emphasised the relevance of inequalities sensitive practice to HEAT (Health Efficiency Access & Treatment) targets contained within Local Delivery Plans. They suggested that there is an urgent need to present a strong business case, in order that the significance of inequalities sensitive practice can be considered in relation to objectives, targets, and measures.

¹⁴ ‘Agenda for Change’: reform of NHS pay system, supported by NHS Job Evaluation Scheme (JES) and Knowledge and Skills Framework (KSF)

¹⁵ ‘Single Status’: reform of pay scales and harmonisation of conditions of service for local authority staff

3.3 Measuring ISP and ISPI

One of ISPI's key objectives was 'To devise and develop a systematic approach to data collection and effective monitoring systems and to utilise these in the development of practice and to inform establishment of performance indicators and measure impact'.

Staff development

The Interim Evaluation Report, published in December 2007, highlighted the fact that the recording of information relating to staff development was inconsistent and ad-hoc. Systems which were in place were not yet fully implemented. Similarly, data collection systems which existed to gather information about clients were not being applied consistently in every setting. This situation has not changed during 2008.

Outcomes for clients

Respondents confirmed that the collection of data relating to equality issues amongst clients is also inconsistent and ad-hoc. Whilst it was acknowledged that it can be extremely difficult to gather information in a meaningful way, it was recognised also that it was vitally important to identify outcome and outcome indicators for clients in order to establish whether or not changes in practice were making a difference.

"..... further work needs to be done to develop both the practice of routine collection of data relating to equality issues, for example, socio economic situation and employability. A major complicating factor is that data is collected specifically for the child and not for the parent or carer. The weakness in data collection makes it difficult to effectively measure progress in practice or service development, and impedes needs led resource planning."

Extract from Integrated Children's Services Setting Report

Measuring ISPI

Within ISPI, updates provided by each of the ISPI Project Leads provided strong narrative and output information, but failed to provide significant indications of the impact that supported activities have made on practice, planning and policy activities.

Until this situation is addressed, it remains difficult to measure progress either in relation to ISPI or ISP and there can be no clear performance indicators.

4.0 Conclusions

The scale of the task

When assessing its overall impact, it is important to bear in mind the scale of the task within the context of NHS Greater Glasgow and Clyde.

This small but ambitious project pursued a series of objectives which sit at the core of a wide range of national and local strategies, policies, and initiatives. When considering the current allocation of resources, the emphasis placed currently upon inequalities and health improvement remains small in relation to efficiency and the delivery of clinical services.



Despite its size and scale, however, ISPI has led to a shift in understanding and awareness amongst the policy makers, planners, and practitioners engaged in its activities. The influence of policy makers involved in ISPI can be evidenced in recent NHS Greater Glasgow & Clyde policies and strategies; the development of practice descriptors in each of the settings indicates that one year on, not only do managers and practitioners engaged in ISPI have a better understanding of **what** constitutes inequalities sensitive practice, they have found the means to describe **how** it can be done.

Throughout the initiative, whilst exploring emerging themes and issues, careful consideration was given to the original evaluation questions. As indicated in Section 1, the first question was addressed in the Evidence Briefing, published in January 2008.

It was acknowledged at an early stage in the initiative that the question which related to the involvement of service users could not be addressed, as service users were unlikely to experience any significant change in practice during the course of the initiative. However, the Service User Survey, conducted by the Project Lead for the Maternity Services Setting provides valuable information about service users' experiences and offers a baseline against which to monitor and evaluate services in the future.

This section seeks to address the remaining nine questions, as set out in Section 1.

- 2) To what extent has each setting managed to agree and interpret a definition of inequalities sensitive practice in relation to gender and poverty that has utility for that setting and how was that achieved?**
- 3) What were the factors, both enabling and limiting, that were particular to each setting and/or common to all, that affected this common agreement on inequalities sensitive practice?**
- 4) To what extent has active engagement with staff by ISPI facilitated an understanding of inequalities and inequalities sensitive practice and practice changes?**

There is as yet no single definition to which individuals refer within any of the settings. However, the absence of a definition prompted debate and discussion, and encouraged policy makers, planners, and practitioners to explore together the meaning of the phrase. As a result of these discussions, there exists across the ISPI settings a shared understanding of the significance and meaning of inequalities sensitive practice. It would appear that the process of creating/understanding a definition was more valuable than the definition itself.

Of particular value was the opportunity to consider with colleagues from other organisations, in a supportive, non-threatening environment, each other's interpretations of the concept of inequalities sensitive practice, and to examine current practice in the light of those discussions.

Plain English, together with case studies, practice descriptors, training, and opportunities for discussion were responsible for the reaching of a common agreement on inequalities sensitive practice.

However, in order that learning and practice can be properly embedded, there must be leadership, adequate resources, support, and accountability – at all levels.

Leaders and Champions

Strong and effective leadership is critical to the mainstreaming of inequalities sensitive practice. There is a requirement for a cultural change which recognises and values the contribution to be made by inequalities sensitive practice to service delivery, HEAT targets, and, ultimately, patient/client outcomes.

The significance of ISP must be reflected in strategic planning, service design, allocation of resources, and workforce development. It is unrealistic to expect individual practitioners to recognise and respond to the value of inequalities sensitive practice if a commitment to its development is not demonstrated by managers and leaders across the organisation. Staff must be supported and encouraged, through training, development, and support, to examine and adapt their practice.

Changing practice

The process of developing a shared understanding of inequalities sensitive practice was lengthy. Even within the settings, chosen for their recognition of the need to extend beyond traditional, medicalised responses to the health consequences of inequality, there was initial uncertainty as to the exact meaning of the phrase.

Across all of the settings, there is anecdotal evidence to suggest that, as a result of participation in ISPI activities, there has been a general change in attitude amongst staff, greater recognition of the need to address issues such as poverty and gender, and an awareness of additional support services, such as financial inclusion services. It is likely, therefore, that there has been a change in the way practitioners are delivering their services.

Illustrations of practice change are to be found within the Addictions Services, where ISPI supported the development of existing initiatives – the Gender Toolkit, and piloted activities in local CATs to support new practice in responding to the needs of women involved in prostitution and consider financial exclusion issues.

More generally, the development of care pathways, practice descriptors and training materials helped develop staff understanding of ISP, without setting down a singular definition.

5) What changes are staff able to demonstrate that reflect an acknowledgement and understanding of the implications of gender and poverty for assessment and management of health presentations?

Inequalities sensitive enquiry emerged as the most significant issue across all of the settings. It is the key to effective assessment and management of health presentations. It is now widely acknowledged that without an inequalities sensitive approach to assessment and review, the likelihood of identifying and responding to the issues which are impacting upon an individual's health and wellbeing is severely limited. Thereafter, there must be regular sensitive enquiry.

Ongoing review of services should seek to ensure that services initiated at the start of the process are having the desired impact. It is not sufficient simply to ask the questions at the initial assessment - progress must be monitored and the package of care adjusted appropriately.

Through ISPI, practitioners, planners, and policy makers identified a set of generic enablers and inhibitors to inequalities sensitive enquiry, relevant to all mainstream services. Once again, there is anecdotal evidence of attitudinal change amongst individual practitioners, influencing the manner in which they conduct enquiry, deliver their service, and liaise with partner organisations in order to address issues related to poverty and gender. However, in order to ensure capacity to develop inequalities sensitive enquiry, there must be adequate resources. Inequalities sensitive practice can be conducted only within an organisation whose culture and practice recognises the impact of poverty and gender upon health and takes account of inequalities sensitive practice in terms of organisational development and performance management.

There is now widespread recognition of the significance of the value of inequalities sensitive practice amongst those involved in ISPI. However, its delivery is best described in terms of attitude and behaviour – the manner in which a practitioner should ask questions and make assessments. Systems and processes have been amended to include additional time and a range of questions designed to address issues of poverty and gender, but it is acknowledged that the most important issue is the manner in which staff deliver current services. The DVDs, now available as a training tool, provide an effective illustration of an inequalities sensitive approach to the application of systems and processes.

A key output of ISPI has been that through the process of observation, engagement and discussion with team leaders and practitioners, staff have identified the key characteristics of inequalities sensitive practice either present or aspired to. PACT teams have summarised these characterised as follows:

Key Characteristics of Inequalities Sensitive Practice

- person centred **and not** service/profession centred
- firmly embedded in a **social model of health**
- have **core, routine** areas of enquiry
- empathetically 'curious' **and** actively supportive
- firmly embedded in appropriate **pathways of support/care**
- firmly linked to **performance management systems/ data collection sets**
- carried out by **competent practitioners who know and understand the impact of social inequalities on health.**

Extract from ICS Setting Report

Within the Primary Care Mental Health Team in which the ISPI Project Lead is currently located, changes to the initial telephone screening tool reflect an understanding of the impact of poverty and income, and a commitment to addressing such issues.

- 7) What changes are managers and planners from within each setting able to demonstrate which reflects the aspirations of inequalities sensitive practice both within and across the settings?**
- 8) To what extent are these linked to implementation plans for the key strategic drivers such as the Planning Guidance and the Equality Scheme and concomitantly, to what extent are the key strategic drivers significant in supporting changes within and across the settings?**

Changes in assessment processes, intended to create additional time for identification of sensitive issues, flexibility in the delivery of support services, and increased partnership working in order to ensure a more holistic approach reflect a widespread commitment amongst managers and planners to respond to strategic drivers such as the Planning Guidance and the Equality Scheme.

In response to the wider shift towards integrated services, increased partnership working and the establishment of teams such as the PACT Teams and Community Addictions Teams were highlighted as steps towards ensuring a more sensitive, holistic, and effective approach, in response to these key strategic drivers. Within these teams, change is being supported by the integration of services, shared learning, and joint working.

Within maternity services, the appointment of specialist link midwives and the development of pregnancy pathways which take account of inequalities issues are further evidence of change.

At the same time, however, whilst the Planning Guidance and the Equality Scheme are acknowledged as key policy documents, linked to more recent initiatives such as 'Equally Well', attempts to implement change are frustrated by reduced budgets, staff shortages, inadequate accommodation, and poor information gathering systems. Inequalities sensitive practice has become a key feature of policy documents, but its implementation at service level requires adequate resources. There is a tension between delivering services which are inequalities sensitive and services which are meeting current efficiency targets.

A changing environment

The period during which ISPI was piloted was one of significant changes across the whole of NHS GG&C, as well as specific developments within each of the ISPI settings. Changes in delivery structures, new integrated working systems, budgetary pressures and staffing pressures all added to the challenges of developing ISP and winning buy in from practitioners, planners and policy makers faced with many other organisational and professional demands.

Initiatives such as 'Agenda for Change' have created an uncertain environment in which staff can feel unsupported and under-valued. Within such circumstances, managers and planners face difficulties in challenging practice and encouraging attitudinal and cultural change.

9) To what extent have the ISPI team, associated steering group and the Corporate Inequalities Team contributed to supporting decision making in favour of inequalities sensitive practice when the demands of other organisational imperatives are dominant eg time constraints, waiting list demands and staff shortages?

There is evidence now to suggest that the relevance of inequalities sensitive practice to national and local strategies is being recognised at a strategic level.

The following extract from the minutes of the first meeting of the Maternity Strategy Executive Group, which replaced the former Maternity Strategy Implementation Steering Group, indicates that ISPI is now influencing service re-design:

Item 4 Inequalities Sensitive Practice Implementation - Maternity Services

4.1 Work is also underway to develop care pathways, care standards and staff competences through the ISPI Maternity Working Group. The development of practice descriptors to illustrate inequalities sensitive interventions are also in development through the pregnancy pathway work.

4.6 advised that the work programme to redesign the pregnancy pathway had incorporated issues for service improvement emerging from the ISPI work. The pregnancy care pathway had specifically taken on board the needs of vulnerable women during pregnancy ... was now being incorporated into mainstream service provision. It was noted that Lead Midwives with specific service roles dealing with vulnerable women were also already in post. The MSEG noted that a copy of the Women & Children's Directorate Equality action plan had been provided for reference. ... it was reassuring to note .. that the outputs from the work were actively being mainstreamed into service delivery to support and enhance the quality of service to vulnerable women.

Extract from minutes of meeting of MSEG held on 20 August 2008

Within each of the settings, where ISPI Project Leads worked alongside practitioners and managers, there was clear evidence that ISPI was beginning to influence service design and delivery. ISPI was recognised by those directly involved in its activities as having raised awareness, influenced behaviour, and supported practical change, particularly in relation to assessment procedures.

"ISPI has built on developments already underway within Addiction Services for example Gender & Addiction Toolkit and has provided some much needed momentum in developing our work around inequalities."

Senior Manager, Addictions Services

One senior manager within Addictions Services confirmed that ISPI has supported changes in the ways in which clients can access the service. She confirmed that whilst these changes may sometimes mean a slight increase in the time taken to secure an appointment, they ensure that clients receive a service which is tailored to meet their individual needs and therefore more effective. 'Getting it right first time' is recognised as the way to address the 'revolving door syndrome', even if that means longer waiting times in the first instance.

“ISPI has helped to make inequalities something that we consider on a routine basis, we still need to get better at making changes to our practice and that will require all of us to make a commitment to it being a priority over the many other priorities that we have to balance.”

PCMH Team Member

At strategic level, there is evidence within a range of policy documents to suggest that there is a heightened awareness of the value and meaning of inequalities sensitive practice. The activities of the Corporate Inequalities Team, supported by ISPI have succeeded in creating a vision for ‘an inequalities sensitive health service’.

10) To what extent has ISPI contributed to the development of inequalities sensitive practice indicators in the four settings?

By necessity, the focus of ISPI was upon developing an understanding of inequalities sensitive practice and, subsequently, exploring the concept of inequalities sensitive enquiry. At this stage, therefore, there is limited ‘hard’ evidence of its reach and impact.

The potential for practice change, however, is evident within practice descriptors, staff competencies, and training and support materials, such as the Gender Toolkit and ISPI practice DVDs.

It is the consultants’ view that the development of performance indicators should be addressed immediately, both in terms of inequalities sensitive practice and in terms of staff development. The development of practice descriptors, as a means of demonstrating inequalities sensitive practice provide a basis for the identification of specific, measurable, and achievable performance indicators.

Making the case

There is an urgent need to develop a business case for inequalities sensitive practice. It was recognised at an early stage in the initiative that the impact of ISPI upon clients would not be measurable within the life of the project. However, it is clear that the identification of performance indicators, linked to outcomes for clients, are crucial to the development of any business case.

11) If we want to ensure that inequalities sensitive practice is taken into account in further settings or organisations, what would be the essential ingredients?

ISPI sought to define, demonstrate, and develop inequalities sensitive practice, in an effort to improve the support provided to individuals whose health and wellbeing is severely affected by multiple and complex needs. By doing so, this initiative highlighted sharply the issues which affect the inequalities agenda in a wide range of settings. The ingredients required for the promotion and development of inequalities sensitive practice are described as follows:

- leadership, commitment and enthusiasm;
- recognition of the significance of inequalities sensitive practice throughout the organisational infrastructure;
- a supportive, working environment;
- well-established, well-functioning teams;
- champions of change, offering dedicated, practical support;
- recruitment and selection processes which reflect the values and principles, characteristics and skills required in order to deliver inequalities sensitive practice;
- adequate investment in the development of ISP-related training and support programmes;
- practical illustrations of inequalities sensitive practice (as provided by the ISPI practice descriptors);
- discussion and debate – within a non-threatening environment;
- effective, regular support and supervision for all staff, where principles and practice are considered alongside case management;
- a monitoring and evaluation framework which examines the impact of all of the above, with regard to client support, staff development, and performance management.

5.0 Recommendations

Based on the experience of ISPI and the evaluation of its activities, the consultants recommend that the further development of inequalities sensitive practice within its current settings and more widely across NHS GG&C requires the following actions to be taken:

- 1) The significance of inequalities sensitive practice must be embedded throughout the organisational infrastructure - reflected in policy and planning, organisational development, performance management, learning and education, human resources, and the allocation of resources.
- 2) NHSGGC should ensure that corporate services, including the Corporate Inequalities Team, Organisational Development, and Public Health work more collaboratively to ensure clarity of roles and responsibilities in relation to the ongoing development of inequalities sensitive practice.
- 3) The work of the ISPI initiative in relation to learning and development should be remitted to the Learning and Development service located within Organisational Development.
- 4) The role of leaders, throughout the organisation, in the development of ISP should be explored, and reflected in future leadership programmes and performance management.
- 5) The role of 'champions' within services should be explored and defined, with a view to identifying future ISP champions across all NHSGGC settings.
- 6) Strategic and operational managers and any relevant staff should be given dedicated responsibility and authority which will ensure that ISP is reflected in planning and policy.
- 7) Local structures (as described within the main report) should be established in order to further embed a commitment to ISP amongst practitioners. These structures should be led by local managers, involve front-line practitioners and administrators, and include a rolling programme of learning & development activities.
- 8) An understanding of and commitment to ISP must be further developed within the recruitment and selection of all staff employed by NHS GG&C and reflected in future person and job specifications.
- 9) ISP should form a core element of induction activities and mandatory training for all NHS GG&C staff with identified pathways for ongoing equalities training and development.
- 10) Discussions with professional training providers, particularly nurse and social work training institutions, should be initiated in order that inequalities sensitive practice can be reflected in the training of potential future employees.



- 11) The Knowledge and Skills Framework (KSF) system of performance and development planning (currently under-utilised) should be amended to reflect ISP in performance and development planning, and fully utilised across all services.
- 12) Within individual settings, there should be regular opportunities for practitioners to share, question and develop their practice within a safe and supportive environment, individually and collectively, and with access to case studies, practice descriptors and other relevant materials.
- 13) Existing structures should be used to disseminate outputs/resources and share learning from ISPI, and Public Health seminar programmes utilised to articulate and highlight good practice.
- 14) There should be further investment in developing practical illustrations of inequalities sensitive practice such as those provided by the ISPI practice descriptors, DVDs and case studies.
- 15) Regular staff support and supervision should reflect a commitment to reflective practice for all staff.
- 16) Screening, assessment and referral systems within settings should be reviewed to ensure consistency and a commitment to inequalities sensitive practice, using tools such as the Equality Impact Assessment.
- 17) Current data collection systems should be reviewed and enhanced in order to ensure the effective and efficient gathering of client profiling information. Furthermore, the use of data collected from these systems should be reflected in future service planning and design.
- 18) A comprehensive monitoring and evaluation framework should be designed and implemented across NHSGGC, in relation to all of the above recommended actions. This framework should include qualitative and quantitative inequalities indicators which support the measurement of impact upon clients, staff, and overall performance.
- 19) Policy makers, at national and local levels, should ensure that policies take account of the views of managers and practitioners, and that supporting workforce development initiatives are aligned to enable the effective implementation of policy.

In summary

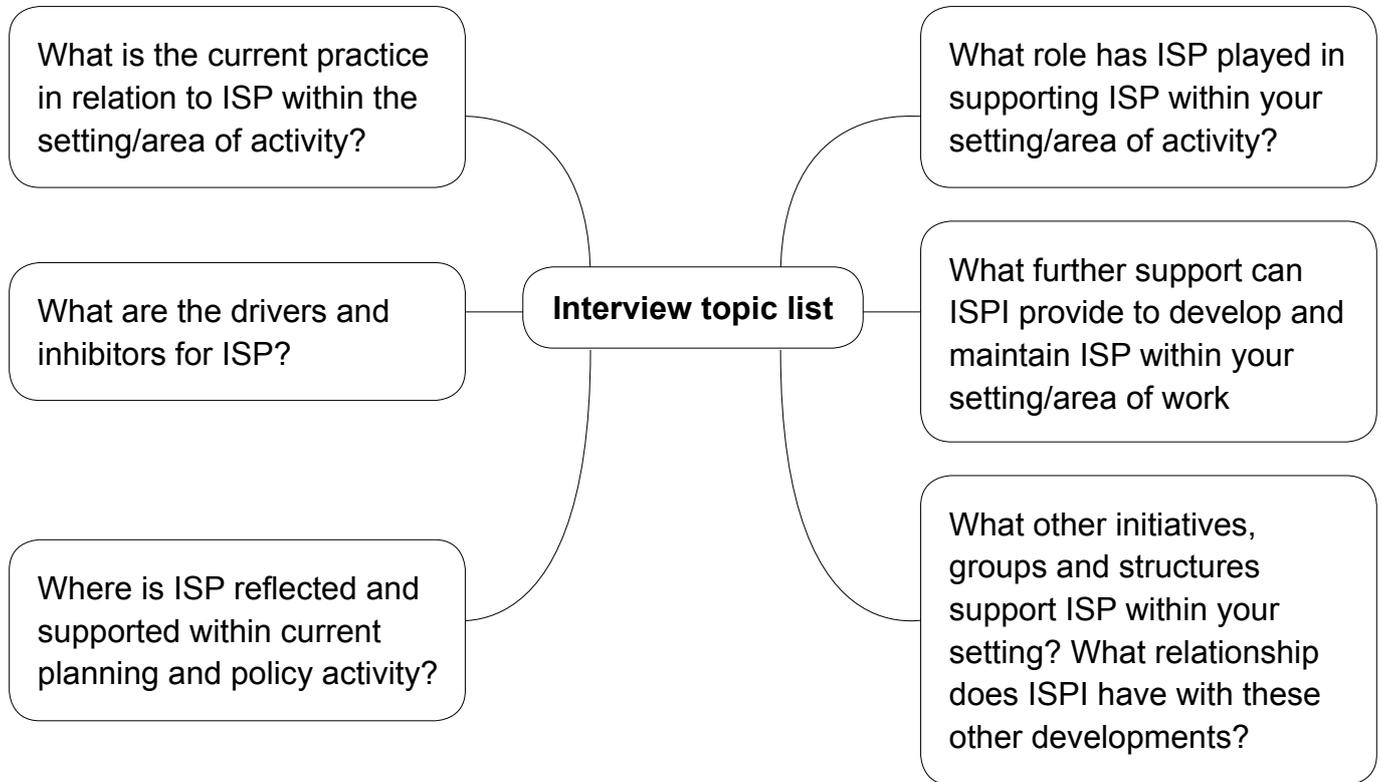
During the past two years, ISPI has identified the means by which inequalities sensitive practice can become the foundation for health and social care services, in the interests of the most vulnerable communities. With leadership and commitment, there is much to be achieved from the lessons learned during the course of this initiative. ISPI has provided a 'road map' towards the development of inequalities sensitive practice. It is for others now to support NHSGG&C to continue this journey.

February 2009

APPENDIX 1

Topic List

Topics covered throughout the consultants' fieldwork are set out in the following diagram:



APPENDIX 2

Questionnaire

QUESTION 1

In which of the following settings do you work? Please tick:

Maternity Services

Integrated Children's Services

Primary Care Mental Health Services

Addictions Services

Learning and Education

QUESTION 2

How long have you worked in this setting?

..... yearsmonths

QUESTION 3

In which area of Greater Glasgow and Clyde are you located?

Community Health & Care Partnership Area (please state which one)

.....

Hospital (please state which one)

.....

QUESTION 4

How would you define your role? (please tick all that are applicable)

'Frontline' care – health/social care

Team leader

Service manager

Senior manager

Policy maker

Planner

Receptionist/administrator/support staff

QUESTION 5

Please describe to us what the word 'inequalities' means to you:

.....

QUESTION 6

To what extent do you think that inequalities should affect the way health and social care services are delivered?

A lot A little Not at all

QUESTION 7

In what ways does your department/service respond to inequalities? Please describe:

.....

QUESTION 8

In what way do you, as an individual member of staff, respond to inequalities?

Please describe:

.....

.....

QUESTION 9

Are there ways in which your awareness and understanding of inequalities has been supported within your department/team?

YES NO NOT SURE

If no/not sure, please go to question 12.

QUESTION 10

Has it been by any of the following methods?

- Briefings and information
 - Policy and strategy documents
 - Group discussion
 - Training events
 - Working with others, sharing good practice
 - Individual learning
 - Others (please describe)
-

QUESTION 11

Have you changed your practice as a result of what you have learned and support you have received?

YES Please describe

NO Can you tell us why not?

QUESTION 12

Do you have a personal training and development plan?

YES NO Not sure

If yes, does it address inequalities issues?

YES NO Not sure

QUESTION 13

Have you ever sought to learn more about inequalities independently?

YES NO

If yes, please tell us how:

QUESTION 14

Have you heard of the Inequalities Sensitive Practice Initiative (ISPI)?

YES NO NOT SURE

If no/not sure, please go to question 17.

QUESTION 15

In what context?

I am a member of the Steering Group/Setting Implementation Group/Working Group
.....

I have attended training delivered by ISPI

I've heard it mentioned at meetings

I've read about it in internal mail/bulletins/newsletters

Other (please describe)

QUESTION 16

Has your involvement with ISPI influenced the way that you work?

YES NO

If yes, in what way?

.....

If no, can you tell us why not?

.....

QUESTION 17

Would you like more support in order to address inequalities issues?

YES NO

If yes, what kind of support would be most helpful? (please number 1 – 6 in order of preference)

Formal training

Guidance/illustrations of best practice

Additional resources (please describe)

More information on other services/agencies

More connections with other services/agencies

Other (please describe)

.....

QUESTION 18

How do you currently share/hear about good practice in other health/social care settings?

At meetings

Through briefings/newsletters

Others

I don't

Thank you for completing this questionnaire. If you have completed the paper version, please return to the following address:

**Alison Cameron
Senior Consultant
Avanté Consulting
CBC House
24 Canning Street
Edinburgh EH3 8EG**

APPENDIX 3

Questionnaire – Extracts from results

Number of questionnaires returned

88 questionnaires were completed and returned. 38 (43%) of respondents described themselves as being located in Addictions Services, 25% in Maternity Services, 24% in Primary Care Mental Health Services, and less than 10% from Integrated Children's Services and Learning and Development.

How long have you worked in this setting?

The longest serving staff were mostly working in Maternity Services – 17 (81%) of the 21 respondents who had worked over 15 years in the same setting were in Maternity Services, and 20 (91%) of the 22 respondents working in Maternity Services had served over 10 years. In the other two frequent settings, a quarter of respondents from Primary Care Mental Health had worked there between 1-2 years, with the same number working in Addictions Services but for the longer timescale of 2-4 years.

How would you define your role?

48 survey participants (55%) defined their role as 'frontline care' in health/social care and voluntary organisations. 35 (40%) of respondents had a role in management, either as a team leader, service or senior manager, policy maker or planner. Of these, 6 people also worked in frontline care. 21 (23%) had support/administration or "other" roles, 3 of which also included policy making or planning. "Other" roles were not identified further in the survey.

Describe what the word inequalities means to you

Respondents shared differing views on the meaning of inequalities, with responses ranging from social inequalities and the impact on the health of individuals and healthcare provision for all, through to workplace inequalities.

They regarded inequalities as the experience of people being treated differently, discriminated against, having barriers to service, lack of opportunity, unfairness and not being equal; and considered whether, in providing a service of equal quality for all, it is sufficient to treat all people the same way.

Respondents were invited to describe in their own terms the meaning of the word 'inequalities'. Comments fell into the following general categories (comments could cover more than one category):

| | Number of comments |
|--|--------------------|
| Barriers / lack of access or opportunities due to factors out of someone's control | 28 |
| Treated differently/different experiences/discrimination | 27 |
| Unfairness | 13 |
| Not equal | 11 |
| Services not adapted to diversity | 9 |
| Disadvantaged | 5 |
| Judgements / prejudices | 4 |
| Pay differences | 4 |
| Staff inequality | 4 |
| Complex interplay between socio-economic-cultural factors and health status | 3 |
| Social divisions | 3 |
| Overlooked | 2 |
| Not treated as individuals | 2 |
| Different information /attitudes | 1 |
| People with multiple needs | 1 |

The following quotes reflect a common theme that emerged from respondents considering the question of what inequalities means for them:

"Inequalities means to me an unfair and unjust treatment of people and a lack of compassion. Experience of inequality has shown stereotyping stigma racism sectarianism ignorance and discrimination as main factors of inequality. Service criteria and funding constraints also impact on inequalities. Within the care field I have seen females individuals with BBV' ethnic minorities and disabled people receiving a care package which is unequal to others."

"A lack of equal treatment for individuality due to systemic limitations."

"Inequalities in the workplace which affect the way in which the service is provided - two main areas - team system - 1) team leaders paid to do more to do same (or less) than team members 2) child care - conditions weighted in favour of women with children - ie parental leave."

To what extent do you think inequalities should affect the way health and social care services are delivered?

48 (54.5%) of respondents indicated that inequalities should affect a lot the way health and social care services are delivered, while about a third said inequalities should not affect delivery at all.

However, this may have reflected a difference in how the question was interpreted, rather than differing opinions on whether inequalities should affect the way services are delivered. For example, someone responding 'not at all' may have meant that services should be available and delivered to all equally, irrespective of which social strata apply, and so inequalities should not affect the way services are delivered. In contrast, someone responding 'a lot' might believe that the way in which people (clients) are advised and made aware of services may need to be tailored to specific sectors of the community in order to encourage them to access services.

Analysis of the responses by respondent' role shows a difference between those in management roles compared to those who are more likely to deal with individuals receiving services (frontline, or administration/receptionist).

32 managers responded to this question. 22 (70%) stated that inequalities should play a large role in the delivery of services, compared to 7 (22%) who stated that inequalities should play no role. The 55 frontline care staff who responded to this question were more evenly split in their opinion. 26 (47%) thought inequalities should affect delivery a lot compared to 24 (44%) thinking inequalities should not affect delivery at all. While worthy of note, these differences in views between roles, are not statistically significant.

In what ways does your department /service respond to inequalities?

Varied responses to this question were assigned to the following themes:

| | Number | % |
|---------------------------------------|--------|------|
| Policy development | 22 | 25.0 |
| Adapt / target service | 21 | 23.9 |
| Links with other services/community | 17 | 19.3 |
| Assess situation/services/feedback | 11 | 12.5 |
| Staff attitude – understanding issues | 9 | 10.2 |

Are there ways in which your awareness and understanding of inequalities has been supported within your department/team?

59 (67%) said there were ways in which their awareness and understanding of inequalities had been supported within their department or team; 11 (12.5%) said it had not.

The most frequent support methods described were working with others and sharing good practice (47/75% of all respondents), training events (46/73%) and individual learning (44/70%). 40 (63.5%) said they were supported by policy and strategy documents, 39 (62%) by briefings and information, and 38 (60%) by group discussion. 8 people (13%) also reported other support, including: informal discussion with like-minded colleagues; personal experience; ‘actually doing things’ and working with clients and colleagues with disabilities, differences and diversity; introducing a structured and directed programme of sharing reading material, to facilitate faster dissemination and learning.

Have you changed your practice as a result of what you have learned and support you have received?

48 (76.2%) respondents said they had changed their practice as a result of what they had learned and support they had received, as described below. 12 (19%) said they had not changed their practices. 8 (66%) of those who had not changed their practice explained that already adhered to good practice and treated people equally, so training reinforced what they already were doing.

Ways in which people have changed their practice as a result of learning and support received

| | Number |
|--|--------|
| Improved understanding / awareness in general to reduce inequalities | 16 |
| Change in personal attitudes and actions | 14 |
| Appropriate planning and policy | 5 |

Responses are illustrated by the following quotes:

“After every training/ viewing/exchange/piece of reading, I have increased awareness, assess my behaviour and responses, and adjust. I also have more awareness when monitoring staff in action.”

In relation to planning and policy, respondents indicated that their practice has changed, illustrated by the following quotes:

“ ... more awareness and knowledge, using framework and language, asking more probing questions in relation to planning and services.”

“ ... by developing a deeper understanding of the issues involved and by ensuring these issues are responded to accordingly ... policy and learning is developed to promote awareness and challenge practice.”

Do you have a personal training and development plan?

52 (59.1%) of respondents had a personal training and development plan, about 30 (34%) confirmed that their plan addressed inequalities issues. 35 (39.8%) of respondents had no personal training and development plan.

Have you heard of the Inequalities Sensitive Practice Initiative (ISPI)?

39 (44.3%) respondents had heard of ISPI. 47 (53.4%) respondents had not. Staff with management-related roles were more likely to have heard of ISPI (66%) compared to respondents in frontline/administrative/support roles (32%). This identifies a significant difference (34%) between the awareness of front-line and managerial roles.

In what context have you heard of ISPI?

39 (36%) respondents who had heard of ISPI had attended training delivered by ISPI. Of this group, 13 (33.3%) were members of the Steering Group/Setting Implementation Group/working group. 12 (30.8%) had heard ISPI mentioned at meetings. (30%). 19 (48.7%) had read about it or gave other reasons.

| In what context have you come across ISPI? | | |
|--|----|------|
| I have attended training delivered by ISPI | 22 | 25.0 |
| I am a member of the Steering Group/Setting Implementation Group/working group | 21 | 23.9 |
| I've heard it mentioned at meetings | 17 | 19.3 |
| I've read about it in internal mail/bulletins/newsletters | 11 | 12.5 |
| Other | 9 | 10.2 |

29 (74.4%) said their involvement with ISPI had influenced the way that they work, while 9 (23.1%) said it had had no influence.

Would you like more support in order to address equalities issues?

71 (80.7%) respondents would like more support in order to address inequalities issues, as summarised below.

The preference listing for support methods was as follows:

Of the 71 respondents that were in favour of further support, 86% indicated formal training and guidance/illustrations of best practice, and 40% rated these two methods as the first and second most important. 56 (78.9%) in favour of further support indicated a desire for more information; 53 (74.6%) indicated that they would like more connections with other services/agencies; such methods were more likely to be rated between second and fourth most important.

Appendix 4

Evaluation Timeline

| ACTIVITY | Jun 07 | Jul 07 | Aug 07 | Sep 07 | Oct 07 | Nov 07 | Dec 07 | Jan 08 | Feb 08 | Mar 08 | Apr 08 | May 08 | Jun 08 | Jul 08 | Aug 08 | Sep 08 | Oct 08 | Nov 08 | Dec 08 | |
|-----------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Desk Research | Yellow | | | | | | | | | | |
| One-to-one Interviews | Green |
| Questionnaires | | | | | | | | | | | | | Yellow | Yellow | Yellow | | | | | |
| Focus groups | | | | | Green |
| Workshops | | | | | | | | Yellow | | | | | | | | | | Yellow | | |
| Observations | | Green |
| Policy review | Yellow |
| Data analysis | Green |

