INEQUALITIES SENSITIVE PRACTICE INITIATIVE: MATTERNITY SETTING

DESCRIBING 'INEQUALITIES SENSITIVE PRACTICE' WORKSHOP REPORT

Introduction

Within NHS Greater Glasgow, it is recognised that measurable health inequalities are the medical (both physical and psychological) consequences of a series of inequalities experienced by people in their everyday lives which relate to socio-economic status, gender, race, faith, age, sexual orientation and disability status or combinations of these factors. The effect of power differentials, discrimination and socialisation acts as a pathway into poor health, can limit access to health and social care and can affect the quality of the response by both individual practitioners and care systems.

The development of **Inequalities Sensitive Practice** is a new construct which aims to describe and implement a form of transaction between practitioner and client/patient which contextualises health and social care presentations. By enabling the client to disclose a range of factors pertinent to poor health and wellbeing, their experiences become legitimised and a more holistic approach to managing poor health or social problems can be identified. The Women's Reproductive Health Service is an example of existing activity where an understanding of the disadvantages experienced by different groups are incorporated into the ways the services and practice has been, or is being, designed.

In order to begin a process of describing this best practice in relation to the delivery of care to pregnant women who have multiple and complex needs and their families, midwives with particular experience of working with women who have a range of social care needs, were invited to participate in one

of two workshops. The workshops, conducted in December 2006 and January 2007, aimed to support practitioners to articulate their views on what constituted good practice and to describe its key characteristics. It was hoped that this process would point towards and benchmark the attributes, knowledge and skills that underpin and contribute to inequalities sensitive practice.

Programme and findings

Each workshop lasted 3 hours and was designed to be interactive. A presentation on the background and aims of the Inequalities Sensitive Practice Initiative provided context to the session. While the content of each workshop was broadly similar, the second session was adapted to allow participants of Workshop 2 to reflect on the discussion and responses recorded from Workshop 1.

Exercises were undertaken to stimulate reflection on practice. In Workshop 1 participants were provided with patient scenarios and asked to identify issues of concern and actions that might follow from this assessment. Participants were asked to suggest how the needs of these patients would best be served without reference to constraints of time, resources, staffing etc i.e. what would best practice look like in an ideal world?

In a second small group exercise, participants from Workshop 1 were invited to consider the knowledge, skills and attributes that underpin inequalities sensitive practice. Participants from Workshop 2 were invited to read through the responses to this exercise and discuss, comment, amend, and add to the list that had been compiled. Participants in Workshop 2 unanimously endorsed the responses of the first workshop group, and went on to expand the discussion and to provide additional issues for consideration. The responses to these exercises are reported below:

1. The values/attributes that underpin inequalities sensitive practice

- **A non-judgmental approach** i.e**.** the ability to recognise and manage one's own prejudices, discriminatory attitudes or assumptions, in order to provide unconditional support and a professional service. Women should not feel judged

because of their social circumstances. In Workshop 2 this topic provoked a discussion around what it means to be non-judgmental. It was agreed that everyone made personal judgments and the requirement should be for individuals to work ethically and professionally and not let personal prejudices get in the way of providing responsive support. While there was agreement on this general principle, some participants felt that sharing core values around equality issues was of fundamental importance. Being self aware and able to separate one's personal and professional views was only part of the picture.

- Empathy: **Acceptance and understanding of an individual's situation and perspective; a non-blaming, inclusive approach.**
- Validation: **Acknowledging and accepting a client's situation and experiences. Listening to and respecting clients' views and validating their experiences may be the only action that is required or even possible for the practitioner. "Don't compound low self esteem by trying to fix/ change too much".**
- Supporting self-efficacy: **Important to recognise and support clients' own capabilities.**
- Honesty: **The need to be open as far as possible with clients especially in relation to child care and protection issues**
- Professional conduct: **The use of professional and respectful language when talking about women who have multiple and complex needs and their families. Disrespectful attitudes and derogatory language is unacceptable. Professional services should not be a barrier to women getting the support and care they need.**
- Realistic expectations: **Workers need to be able to assess a client's readiness to change in order to provide appropriate, stage-based interventions. Clients may not be ready to make a decision or to take action Doing nothing, other than affirming and providing information, is an option. The intervention may plant a seed for action in the future.**

Following this exercise there was discussion around the '**right person'** to undertake inequalities sensitive work. The group

concluded that recruitment processes for student midwives were very important in this respect and felt personal qualities as well as academic abilities should be considered. The following attributes were suggested:

- **Appropriate manner:** The ability to demonstrate sensitivity in different situations
- **Good communication skills** with clients and colleagues at all levels
- **Easy rapport/ friendly/ socially adept**
- **Knowing limitations:** Self-awareness.

2. Knowledge that underpins inequalities sensitive practice

- The social model of health. The rationale behind working in an inequalities sensitive way
- Public health midwifery. Population based health interventions
- Resources and services that are available in local communities and city-wide e.g. local authority facilities, voluntary organisation services
- Child protection and statutory responsibilities/accountability
- **Referral pathways to social care services**

3. Skills that underpin inequalities sensitive practice

- Communication skills: The ability to ask sensitive questions without embarrassment or awkwardness. The ability to communicate at all levels
- Holistic assessment based on history, presentation, probing questions and home situation – not making assumptions based on social status or social circumstances.
- Supporting client resilience
- Managing personal responses to difficult situations
- Supporting self-efficacy in order to nurture skills and responsibilities in relation to parenting
- Motivational interviewing. Skills in asking open questions, reflective listening, affirmation etc.
- Social skills. The ability to get along with people, to establish a rapport and build trusting relationships.

There was a discussion around the natural instinct of midwives to fix everything and to do things for clients rather than support them

to help themselves. It was suggested that practitioners need to be re-trained in this way of working.

Partnership Working

A number of practice issues were raised in Workshop 2 that were felt to be important to the discussion around inequalities sensitive practice. The issues focused on two areas of practice: i) inter-agency working and ii) the practitioner-client interface.

i) Inter-agency working

- **Communication and professional integrity**. There is a responsibility on behalf of the statutory agencies to ensure there is proper de-brief and closure for clients during and after social care interventions.

An example was given of a woman being cared for in her third pregnancy who reported to the midwife that she did not know why her first two children had been taken into care. She reported that the feedback she had received from workers delegated to observe and assess the adequacy of her parenting skills had been positive and encouraging. The outcome had therefore come as a surprise. She was left unaware of the reasons for this decision and uncertain as to what was required of her to be able to keep the baby from her current pregnancy.

The circumstances reported were felt to have implications for current maternity care and raised issues around:

1. The nature and content of social work feedback provided to women
2. The need for clear and honest communication between client and agency and between agencies
3. Responsibility for the care and support of parents in Child Protection cases.

- Clarity of the role, remit and responsibilities of health and social care professionals.

An example was provided of an incident in which a community midwife was left by social services to manage a social care

situation because she was already 'on site' rather than social work undertake a social care assessment process themselves.

It was felt important that health and social care professionals were aware of each other's roles and areas of responsibility, to support integrated and joint working.

- **Involvement and inclusion.** Participants emphasised the need for both service users and frontline workers to be involved and included in discussions and communications

- **Professional conduct:** integrity in the use of information that is shared for joint working purposes.

An example was given of a midwife who reported her concerns around a woman's home situation to social work describing the client's house as filthy. A social worker visiting the household the following day reported to the client that the midwife had said that her house was filthy.

While factually true this kind of intervention was felt to be unhelpful to the continuing provision of maternity care. The language used was felt to be unprofessional and inappropriate to the situation and did not encourage mutual respect and partnership working. Practitioners need to be able to trust other agencies with information shared.

ii). Practitioner-Client Interface

- **Realistic expectations.** Time frames for change processes need to be logical and realistic for clients.
- **Flexibility of practitioner** To provide responsive, client centred care requires a degree of flexibility of practice
- **Practitioner time** is the commodity most valued by service users
- **Home based assessments** are essential to provide environmental and contextual information
- **Important not to make assumptions** about people, particularly on the basis of their initial presentation
- **Open and honest relationship** with client (friendly but professional). Practitioners need to be aware of their professional boundaries i.e. the limits of the support they can

offer and the professional remit of partner disciplines and agencies
- **Advocacy role**. Women may feel oppressed by the involvement of professional agencies. The midwife has a key role in understanding the women's situation and perspective and articulating their point of view

Inequalities Sensitive Practice in the real world

Participants were asked to consider what would need to be in place to allow inequalities sensitive practice to be a core part of mainstream work. Responses included:

- Time. Working in this way can be time intensive. Women should not feel hurried – giving time reflects being valued. Time is required to build trust between the woman and the practitioner which is essential for rapport and sharing.
- Private time i.e. Time alone with a woman to ask confidential and sensitive questions, in order to gain a better understanding of her social circumstances. For example, routine enquiry into gender-based violence can support women to disclose personal concerns.
- Continuity of care. It can take time to establish a trusting, working relationship with a woman. To achieve this it is important that the same midwife, where possible, or midwifery team, provide her ongoing care
- Home visiting early in pregnancy can aid the assessment process. Home visits tend to be less formal, more friendly and provide opportunities to establish rapport and to assess home circumstances
- Staff learning and development. For example, practitioners need to learn how to support people without creating dependency. Staff with a care background may be accustomed to doing things for clients.
- Awareness of own limits in order to prevent 'burn-out'.
- Reflective practice. Opportunities for peer review and case study
- Support/Supervision. To undertake this work midwives need to raise and explore difficult issues with women. Midwives themselves need to receive support and guidance and the opportunity to off-load and reflect on practice without it being viewed as a management issue A system for supervision and support should be considered. One suggestion was that

the supervisor of midwives role could be developed to allow them to provide such support.

- Resources. Quality of care can be compromised where practitioners lack capacity to respond to expressed need. Sensitive questions may not be asked because of where it might lead and the demands that may accompany this. Practitioners need to be well resourced with respect to time, training, personal support and responsive care pathways

Supportive Environment

Participants were asked to consider what structures and systems would be required to enable the multi-disciplinary team to work in an inequalities sensitive way. Responses included:

- Professional Development. Training and professional development to raise awareness, increase knowledge and develop skills
- Pro-active Management. Performance management of care practice through formal management systems of appraisal and support, linked to KSF (Knowledge, Skills Framework) and continuing professional development (CPD).
- Supervision and staff support. A system to provide support, advice and debrief to practitioners who are supporting women with multiple and complex needs and their families e.g. active mentoring, opportunities for supervision, peer support.
- Pre registration student placements in inequalities focused teams e.g. with the Women's Reproductive Health Service
- Service Planning forums to consider how to resource inequalities focused interventions since this way of working is resource intensive.
- Workforce planning. Use of birth rate plus and similar tools to inform workforce planning and capacity issues.
- Training. It was suggested any training developed follow the model of the recent HIV testing training: half-day, mandatory, multi-disciplinary training with use of videos. It was suggested that social workers be asked to contribute to the training.
- Support systems. More resources required to provide support to women and families. It was reported that Inverclyde has support workers/social care assistants who are invaluable and undertake parenting support work.

- Time to listen to clients. Discussion as to who was best to do this job. Some people felt this was the midwives' task. Others felt that social care assistants may be well placed to do this
- Adequate staffing – this way of working demands more resources

End of session reflections

Participants were invited to reflect on the workshop and make any final comments.

- One participant commented that if midwives have dilemmas around whom to talk to for confidential support, how must vulnerable clients feel? Same feelings but magnified as they are much more disempowered.
- Recognising that clients will sometimes try to test you/push you and knowing how to respond.
- It was reported that maternity services staff in Glasgow fear that ISPI is being developed in order to phase out the Women's Reproductive Health Service (WRHS) and everyone will have to take on most complex cases. There may be resistance to participating in ISPI because of this view.

Conclusion

The views and ideas set out above represent the outputs of a brief, focused reflection on practice with 11 midwife practitioners. It provides a basis on which to build a more comprehensive picture of inequalities sensitive practice and the related issues that need to be addressed to support the mainstreaming of this approach.

The report will be used to inform the thinking of the Inequalities Sensitive Practice Initiative and in particular the Maternity Services Working Group.

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