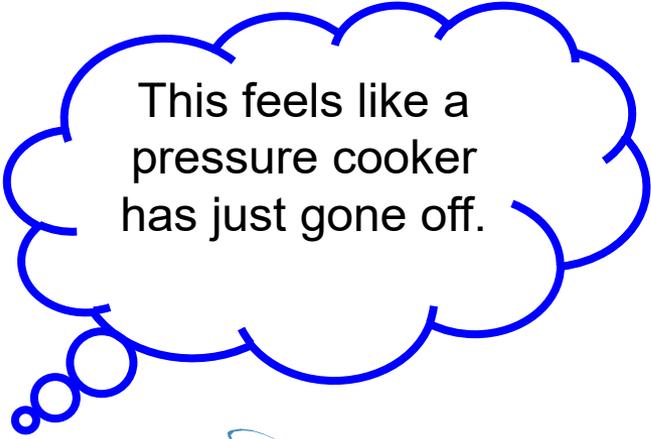
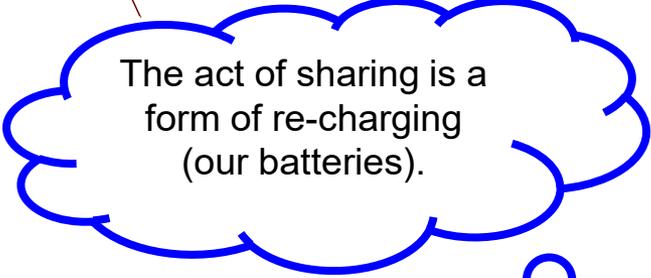


***Caring to Ask - How to embed caring  
conversations into practice across  
North East Glasgow***

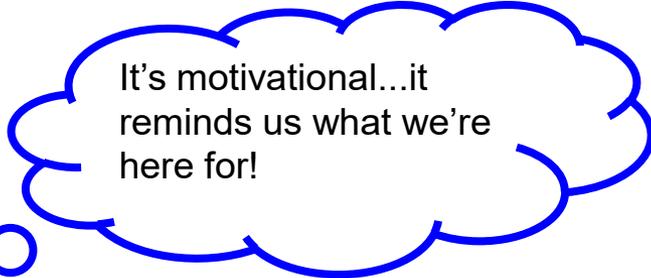
Storyboards from across 3  
settings from ISP practice inquiry  
December 2013



This feels like a pressure cooker has just gone off.



“We need to look after each other so that we can go out and give 100% - we need to understand each other and know our roles”. Lots of (other) things happen to us when we’re out and about – ‘you just deal with it’ but it can become too much. I can tell if people have had a bad visit – we’ve not got time to reflect.



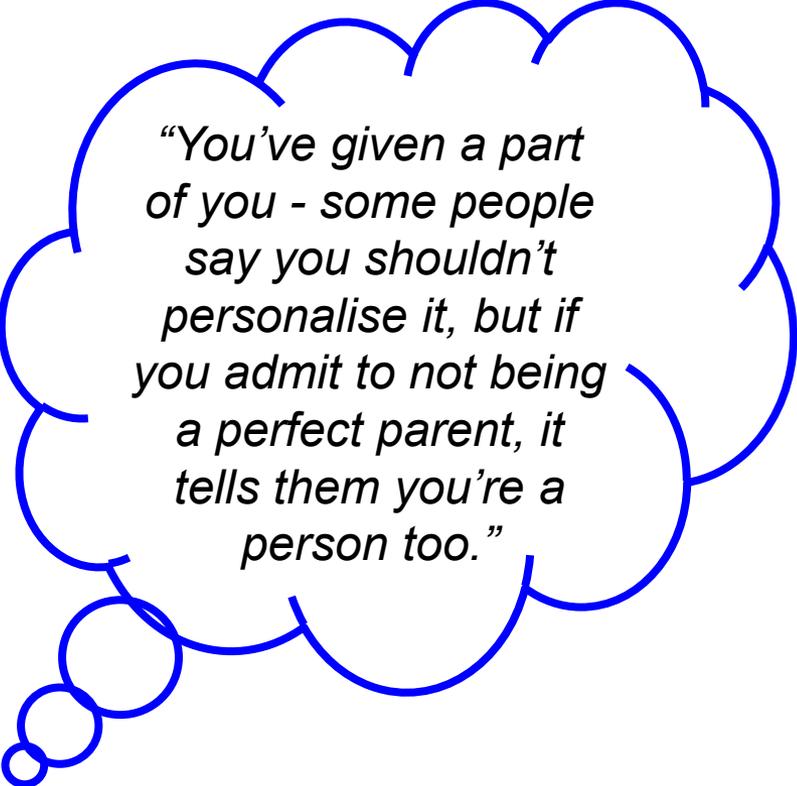
“It’s interesting to hear the stories...

They’re hopeful – show acknowledgement (extraordinary) of our efforts – but they get lost. We should do this more!

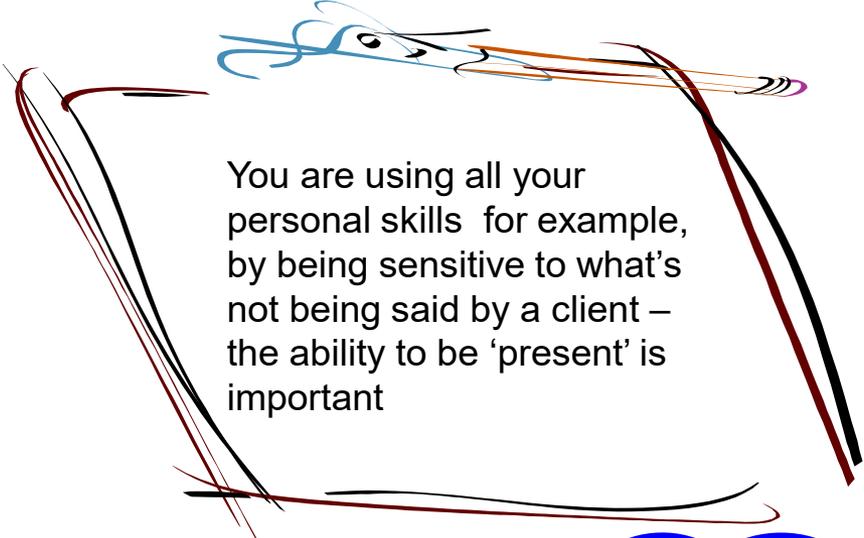
Stories were very powerful – they showed how situations can have a ripple effect from an individual episode to colleagues and families

The act of sharing is a form of re-charging (our batteries).

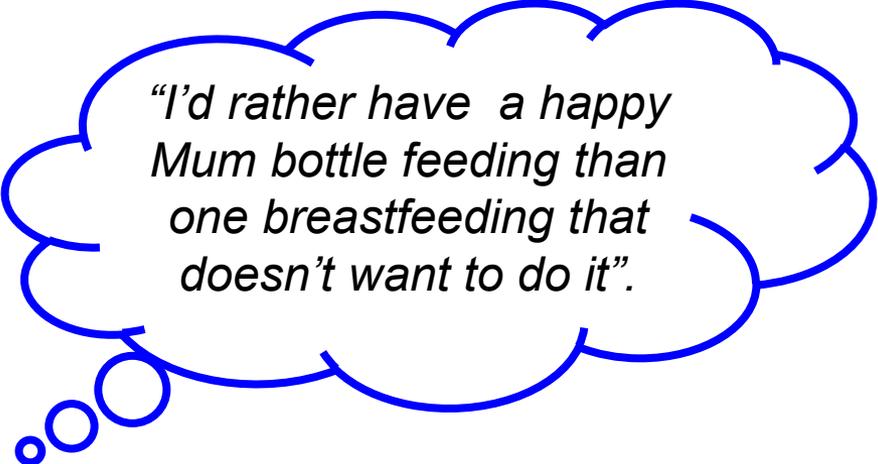
It’s motivational...it reminds us what we’re here for!



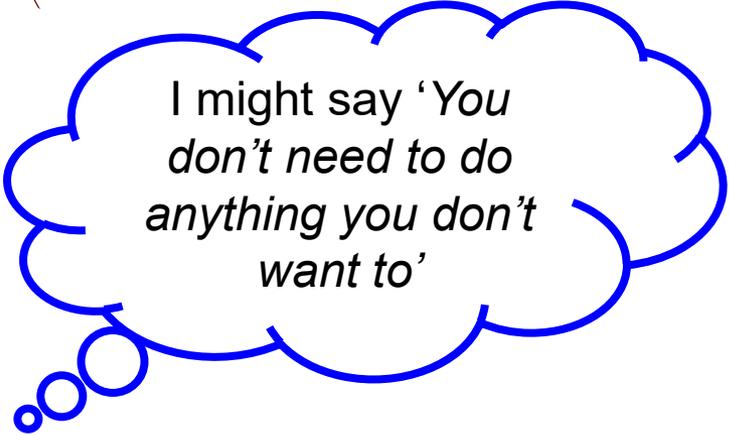
*“You’ve given a part of you - some people say you shouldn’t personalise it, but if you admit to not being a perfect parent, it tells them you’re a person too.”*



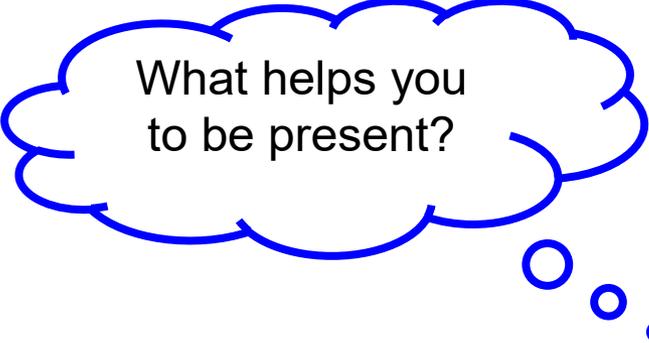
You are using all your personal skills for example, by being sensitive to what’s not being said by a client – the ability to be ‘present’ is important



*“I’d rather have a happy Mum bottle feeding than one breastfeeding that doesn’t want to do it”.*



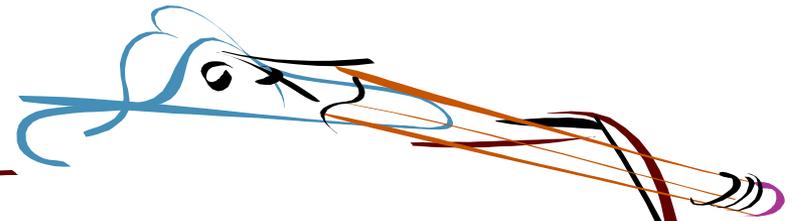
*I might say ‘You don’t need to do anything you don’t want to’*



What helps you to be present?

Some clients were bemused or surprised to be asked.

I said it was part of service improvement



**What works well is....**

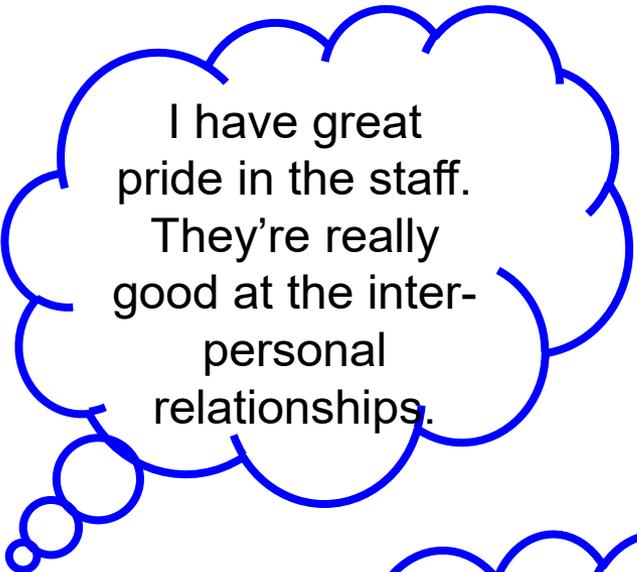
*To be non-judgemental, to have stability*

*For the professional to really want the client to move on – working with acceptance, patience, thinking about readiness to change...*

*Empowering them, - giving people the resources to do things for themselves...*

*Restoring or unlocking their capacity to think and act – not doing for them or to them – but they make the decisions.*

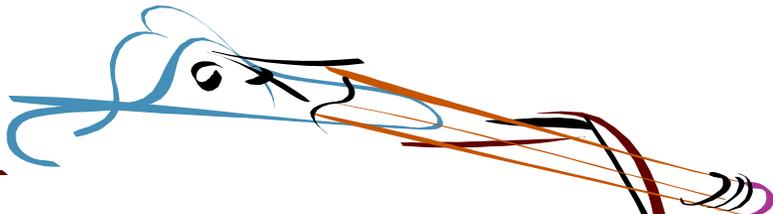
It works well if people know what the service can do.



I have great pride in the staff. They're really good at the interpersonal relationships.



We don't celebrate what we're doing well – as a staff group. I feel both pride and frustration.



***What works well is.....***

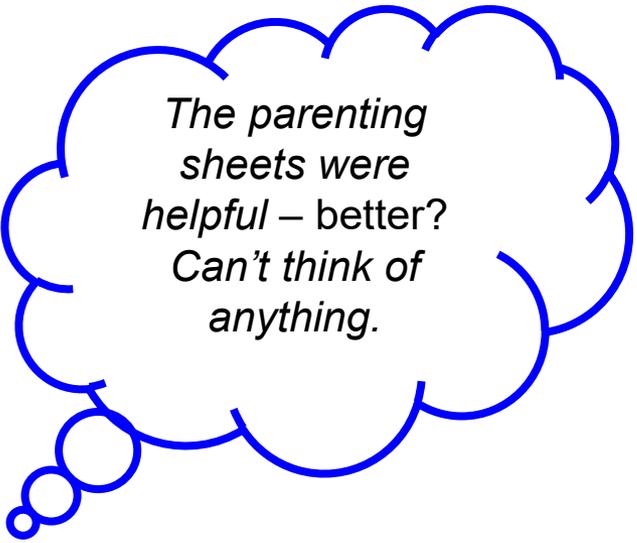
....if we are straight up with people.....and we tell them why we are asking or sharing information.

It's all about trust.

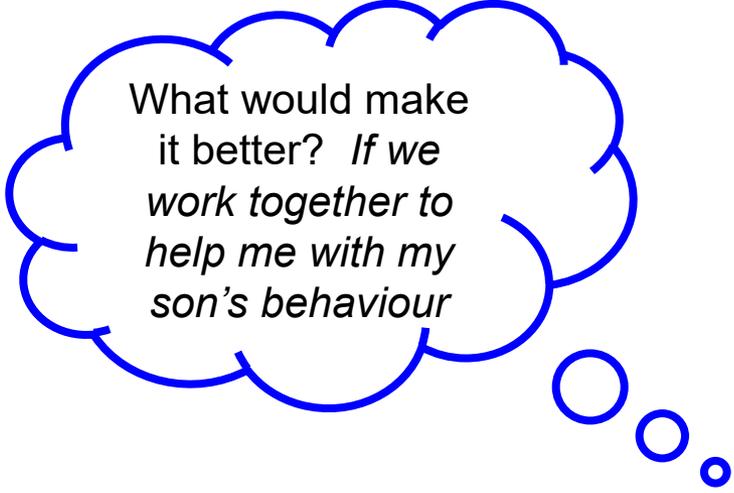
Where we follow things through – completing the circle – not leaving a job unfinished.

Not taking things at face value

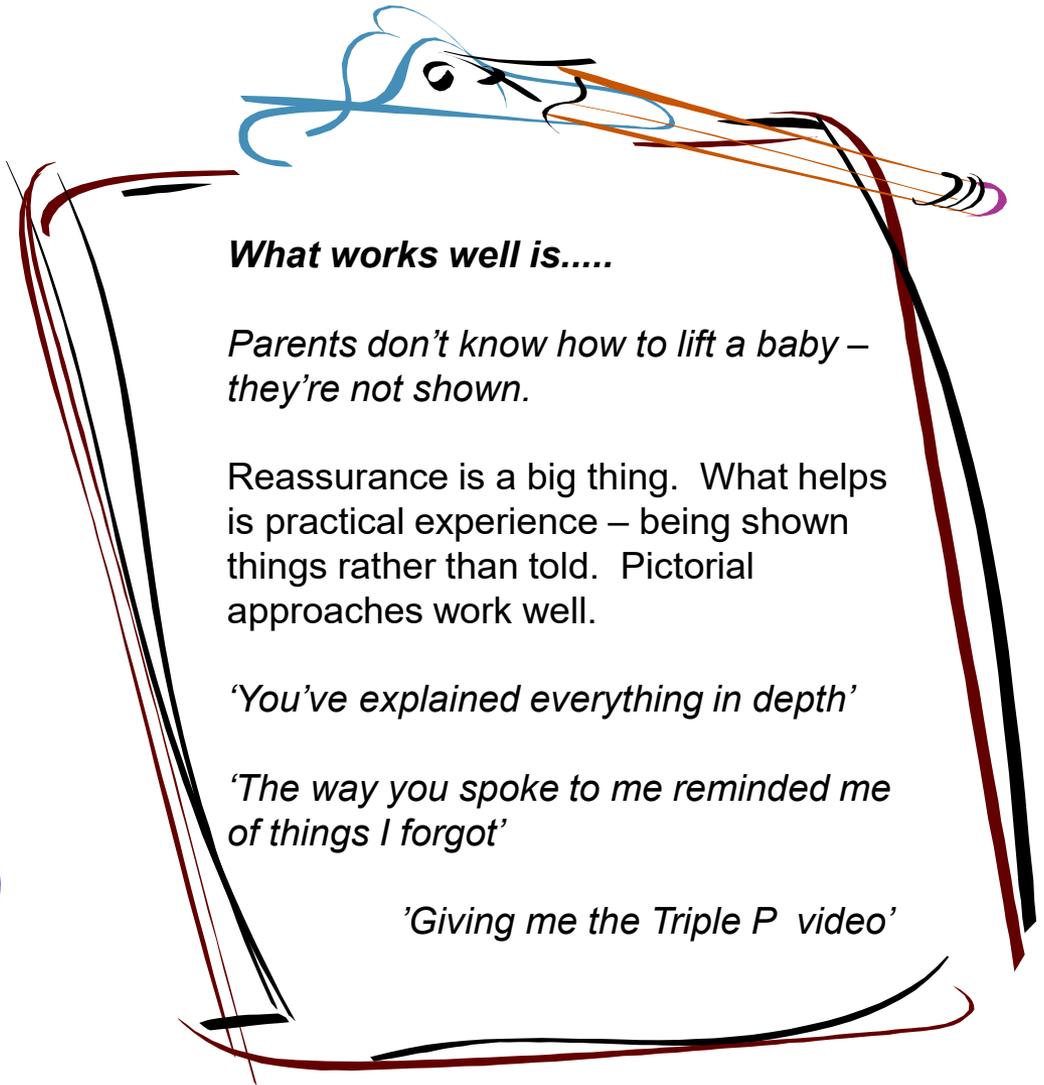
We go the extra mile....you have no lunch, you're exhausted.



*The parenting sheets were helpful – better? Can't think of anything.*



*What would make it better? If we work together to help me with my son's behaviour*



***What works well is.....***

*Parents don't know how to lift a baby – they're not shown.*

Reassurance is a big thing. What helps is practical experience – being shown things rather than told. Pictorial approaches work well.

*'You've explained everything in depth'*

*'The way you spoke to me reminded me of things I forgot'*

*'Giving me the Triple P video'*

*I thought the dad was 'on something' – so I asked him and he went mad at me. I said 'I ask because of your children. I know that you are concerned about your children' – 'I reminded him that I know he can be a good dad'- he eventually said, 'yes it's better that you ask!'..... I could only challenge because of the relationship.*

Mother with post-natal depression. She said to me 'I've got to know you so I don't want to lie to you'. She said yes she had had self-harming thoughts. She's now referred to GP and is being seen. What would make it better?  
Keep listening to me?.....

Mother who'd fled from domestic abuse. For some reason when approached Women's Aid she didn't get support. Was dealt with by a social worker – who found a refuge and said 'we will be in touch' – but were not. She was referred to a refuge in Clydebank without consultation – she has been fighting to stay in her area. When I got in touch and found all this out I was shocked. She said she hadn't thought to contact the health visitor – who are there *'just for the health of the children'* . What would make it better? - to maintain contact with us.

A core family. 2 parents and 3 children. Mother isolated – relationship problems over arguments about parenting. We did Triple P in the evenings that enabled the Dad to be part of it. They appreciated that we found a solution outwith our service hours.

Mother who a few weeks ago took 32 paracetamol. Her partner knew and was there – but then left to do his community service. She is now staying with her mother – social work are involved. She said I'd helped her and her son. She said she'd appreciated me being honest that I was going to talk to the social worker. 'You believed that I could come through this' I supported her when Social Work came to interview her – she said that helped her to be honest with them. What would make it even better? *Just being there for me if I stumble.*

Intensive family. Single parent with a toddler with multiple disabilities – homeless and living in overcrowded conditions with her mother. She is pregnant. Living in poverty and stressed. Recently rehoused close to her mother in a place with a back garden – which is important for the child. I'd given help to find her furniture and other things for the house. She said 'everything had worked well' - *'you've given me help whenever I needed it'*. It had taken time to build up the relationship with this mother.

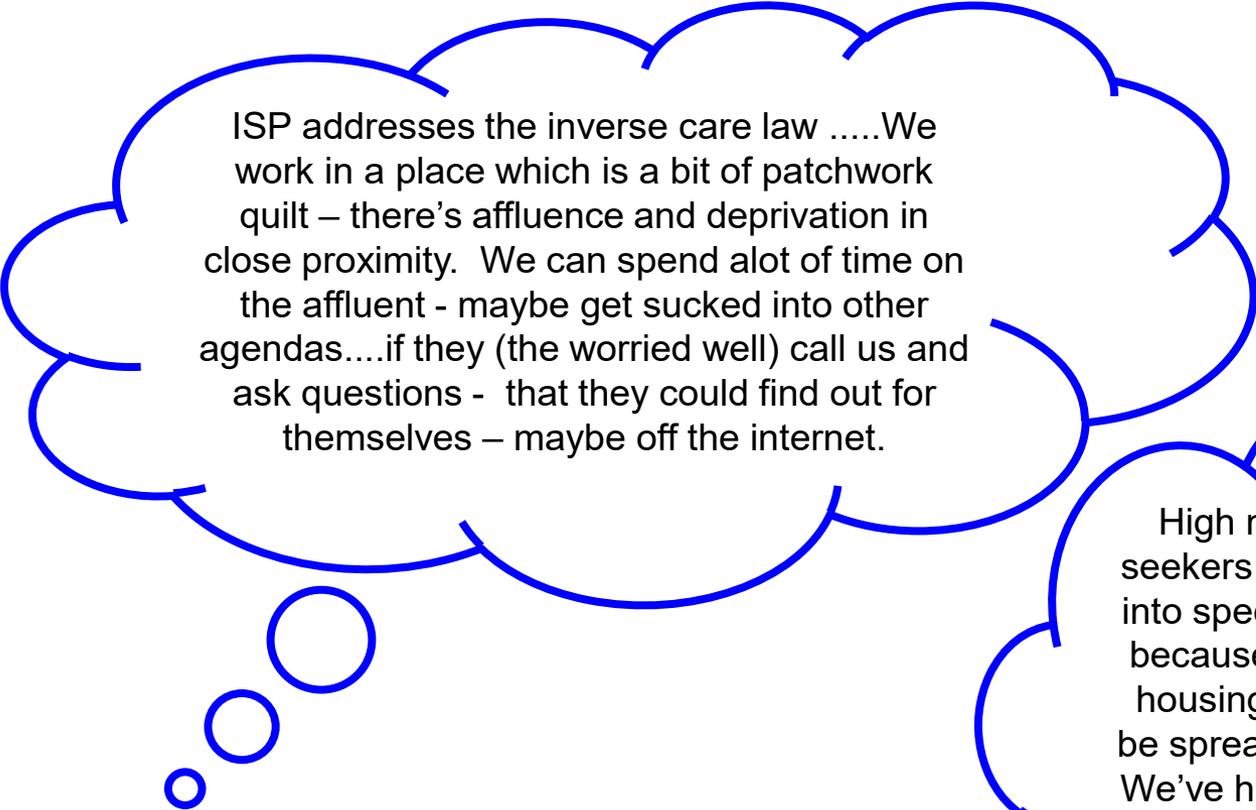
I had a discussion with a colleague about what works well....  
..... When we are supportive as a team, we listen to each other and went the extra mile. *What would make it even better?* We need mutual respect from other professionals – eg social workers, other health professionals. We need to understand each other's roles.

We need to keep the things that are working....

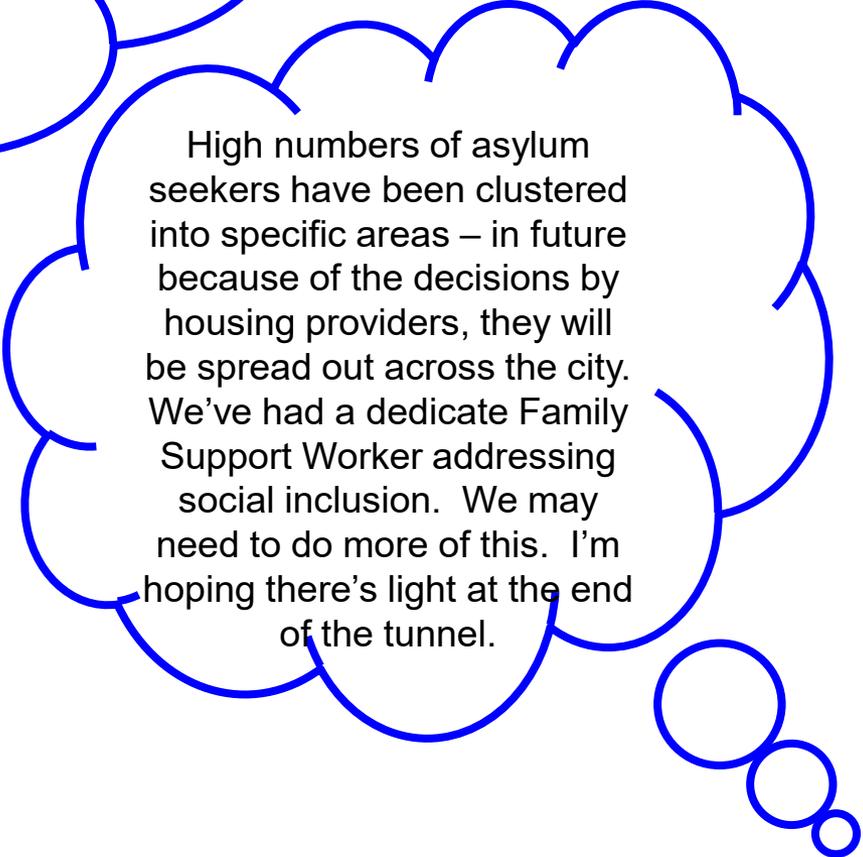
Could Triple P be taken into ante-natal care?

We are not getting it right for every child...

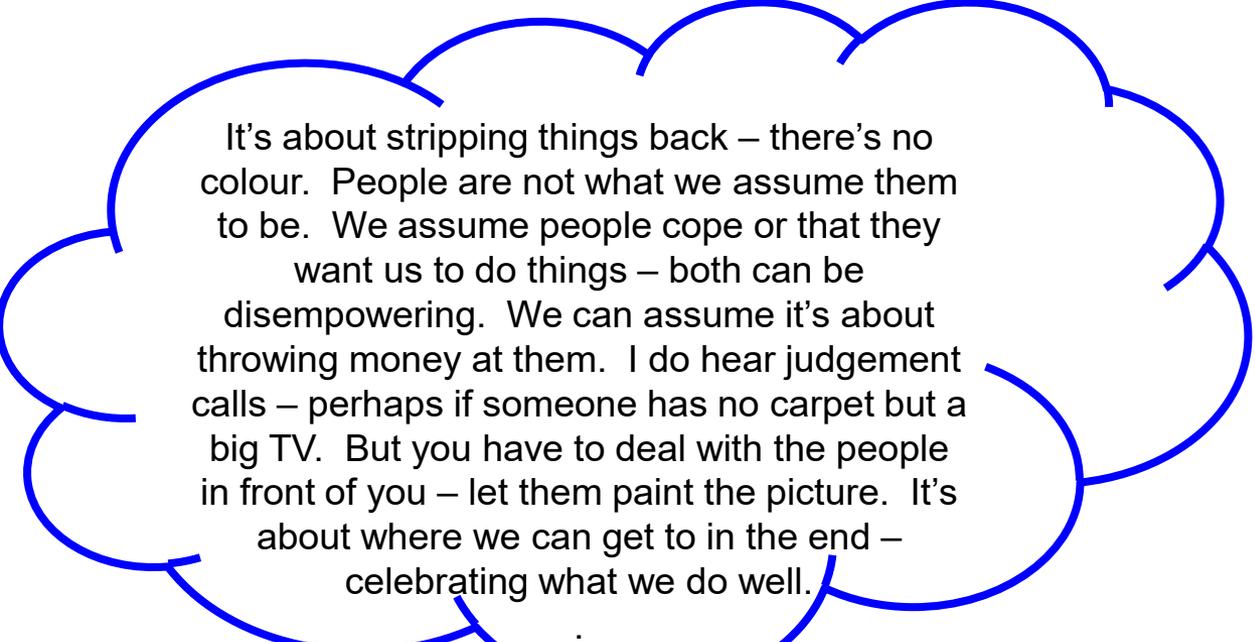




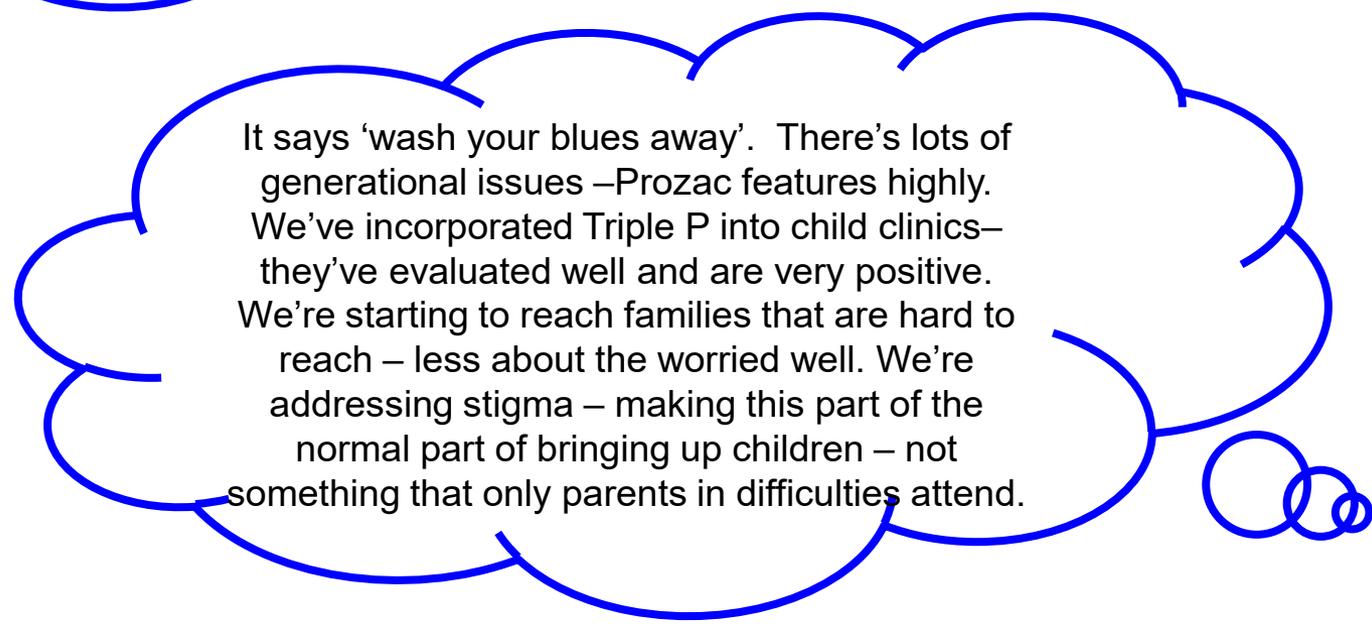
ISP addresses the inverse care law .....We work in a place which is a bit of patchwork quilt – there's affluence and deprivation in close proximity. We can spend a lot of time on the affluent - maybe get sucked into other agendas....if they (the worried well) call us and ask questions - that they could find out for themselves – maybe off the internet.



High numbers of asylum seekers have been clustered into specific areas – in future because of the decisions by housing providers, they will be spread out across the city. We've had a dedicated Family Support Worker addressing social inclusion. We may need to do more of this. I'm hoping there's light at the end of the tunnel.



It's about stripping things back – there's no colour. People are not what we assume them to be. We assume people cope or that they want us to do things – both can be disempowering. We can assume it's about throwing money at them. I do hear judgement calls – perhaps if someone has no carpet but a big TV. But you have to deal with the people in front of you – let them paint the picture. It's about where we can get to in the end – celebrating what we do well.



It says 'wash your blues away'. There's lots of generational issues – Prozac features highly. We've incorporated Triple P into child clinics – they've evaluated well and are very positive. We're starting to reach families that are hard to reach – less about the worried well. We're addressing stigma – making this part of the normal part of bringing up children – not something that only parents in difficulties attend.

It's important to hear the voice of the practitioner – there's a 'hearing gap'

This is about not being embarrassed to ask...finding a way to ask



HELP

...whilst we longer note 'normal for Springburn' – it's important that we don't impose 'middle class' values onto people – in other words, make assumptions about them or judgments – but also not colluding that it's 'OK' .... for example, thinking about GIRFEC...it's hard for staff to get a balance when thinking about the child's needs. How do you maybe say....*'that was good, but is there a park or something...?'*



“I might arrive at an appointment with a big box of leaflets – but I have to respond to the focus and concerns of the family – their focus might be different – it might be breast feeding or the baby’s breathing... rather than my agenda. So I have to be able to adapt and make decisions about what to focus on.



“We used to have Home Makers who did practical stuff with people.”



“We need more team building  
Colleagues need to speak to  
each other more”



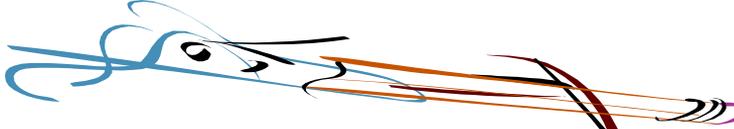
Caseloads do vary – can be  
a big range.....



Staff have the skills –  
they need to be given  
the flexibility to show  
their expertise.....  
(vacancies make that  
difficult)



“Time is the biggest  
issue and frustration”



We use the Edinburgh Post Natal Depression Scale - It could probably be done in 5 mins with an articulate family. I found that because I'd known a mother in the past, she opened up to me – and that took a lot more time.

We need realism about the time it takes – we're under pressure to get in and out again quickly.



“It is more difficult to do Triple P with an interpreter.”



Triple P can't be done in 5 mins.....

It's supposed to be done in 4-6 visits – but if there are literacy problems, or English is their 2<sup>nd</sup> language or they need an interpreter, it could take more like 6-8 visits.

Intensive family – where I've initiated a child protection case conference. Mother has learning difficulties and a premature baby. There's domestic abuse and mental health issues – for the father too. Parents having difficult relationship. She said having someone to talk to worked well; 'I don't think there is anything else you could do'.

*"This group has helped me to improve a relationship with a client. [What helped?] Being here. I think I'm being emphatic, but I'm going in with an agenda – I know what we can offer. Instead, I asked 'how do you see things?' 'What leads you to that conclusion?' This has helped us put things on a better footing."*

I've worked with an African family with 4 children all on the CP register. They didn't want to engage. .... Triple P has been so successful. The children have taken to it so much that they put the dolls to 'time out'! Everybody has been learning a new skill. I've now got them on extension programmes for the summer holidays. She asked me ' Why are you not coming back?' I gave her reassurance that she could do it without me. The interpreter has also seen the whole story....

I think the turning point was coming to their level. Speaking to them as a parent – I gave something of myself – *why would we smack a child when we don't have to?* And she listened to me.....It's now a different house. Their relationships have improved for the whole family unit.

*Definition of Inequalities Sensitive Practice:* a way of working which responds to the life circumstances that affect people's health. Evidence shows that if these issues are not taken into account by the health service, opportunities are missed to improve health and to reduce health inequalities.

ISP takes place when the practitioner: understands the impact of experiences of inequality on a patient's life and health; understands power within the practitioner/ patient relationship and is committed to shifting the balance of power towards the patient; doesn't judge, is empathetic and has good listening skills which supports the individual to tell their story; challenges low expectations and raises the patient's aspirations in a sensitive way, providing alternative options and acting as an advocate when required to do so; is pro-active in ensuring their practice consistently promotes equalities and is non-discriminatory, and takes a person-centred approach.

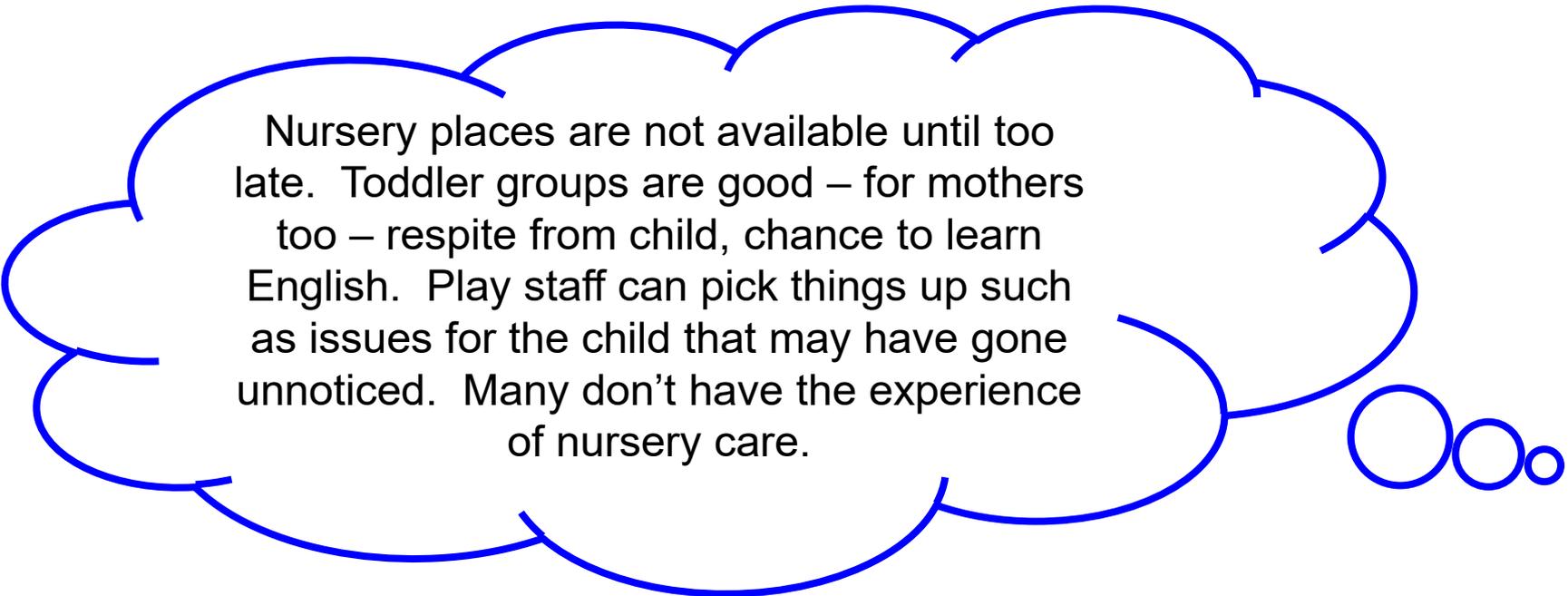
What are we learning about inequalities sensitive practice?

*That's how I do my job!  
It all takes time –  
we need more time*

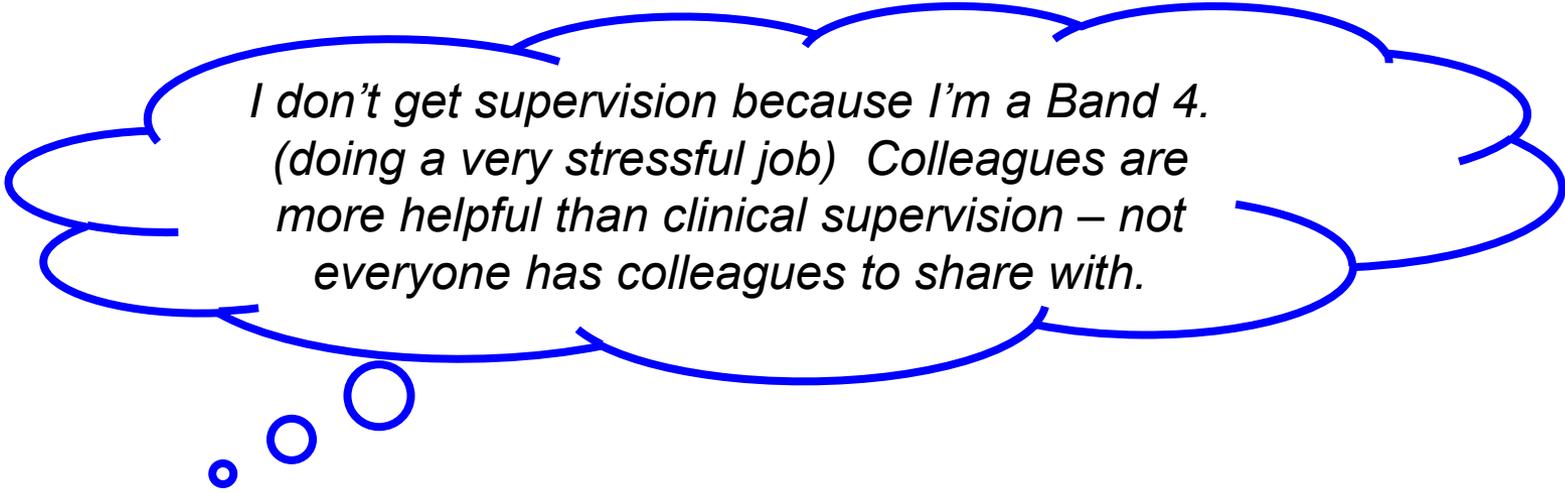
*There are unrealistic  
expectations of us.*

*'No, it's not about 'bottling'  
what I've got.....I'm learning  
from you and from staff'.*

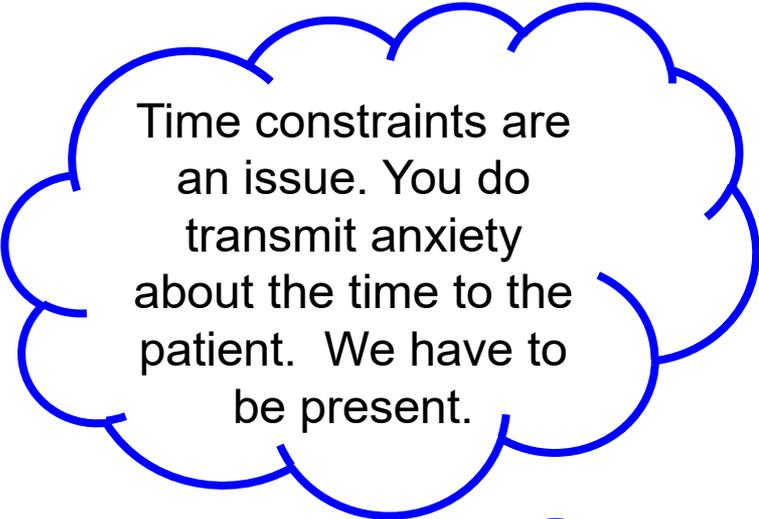
*The disparity of power mentioned in the ISP definition is between practitioners and managers. 'In relation to clients, we won't get across that threshold if we don't yield that power. We're not getting across the threshold with management'*



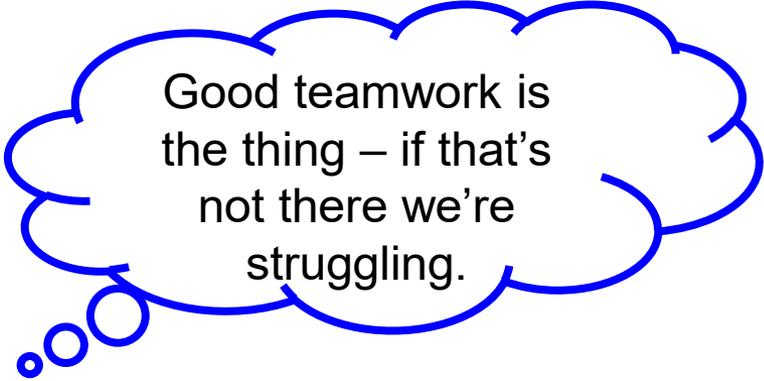
Nursery places are not available until too late. Toddler groups are good – for mothers too – respite from child, chance to learn English. Play staff can pick things up such as issues for the child that may have gone unnoticed. Many don't have the experience of nursery care.



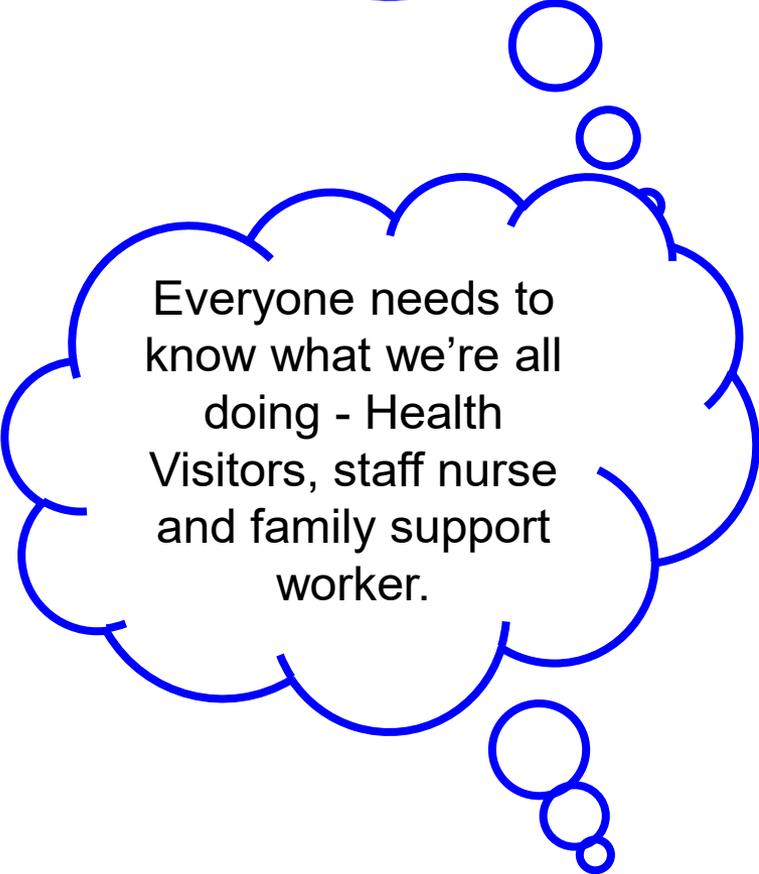
*I don't get supervision because I'm a Band 4. (doing a very stressful job) Colleagues are more helpful than clinical supervision – not everyone has colleagues to share with.*



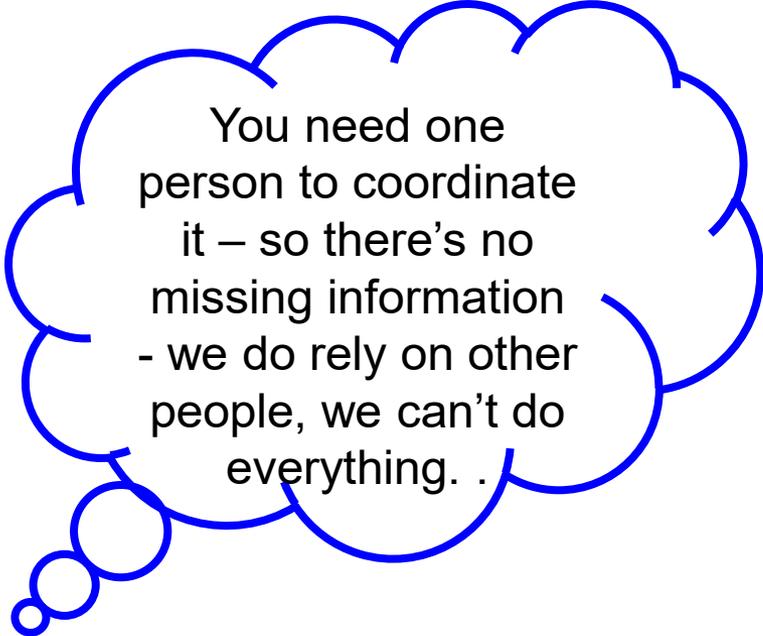
Time constraints are an issue. You do transmit anxiety about the time to the patient. We have to be present.



Good teamwork is the thing – if that's not there we're struggling.



Everyone needs to know what we're all doing - Health Visitors, staff nurse and family support worker.



You need one person to coordinate it – so there's no missing information - we do rely on other people, we can't do everything. .

Young mother of 16 with very bad PND – she was being aggressive towards the baby. There was social work involvement. It was hard for her to admit that she needed help. She said what had worked well was that *the HV had not been judgemental – because of her age and inexperience. She took time to explain to me and my mother why social work were involved.* Referred to PAT. It took time for her to open up and get the information we needed from her. [HV commented- ‘I was surprised that her feedback was positive’]...

The feedback was positive in relation to HV service and most other services.

The only negative remark was about a GP: *'he made me feel that I was wasting his time. He was quite arrogant and not helpful. He didn't reassure me or resolve the problem. It was just kind of 'come back next week if you need to'.....*

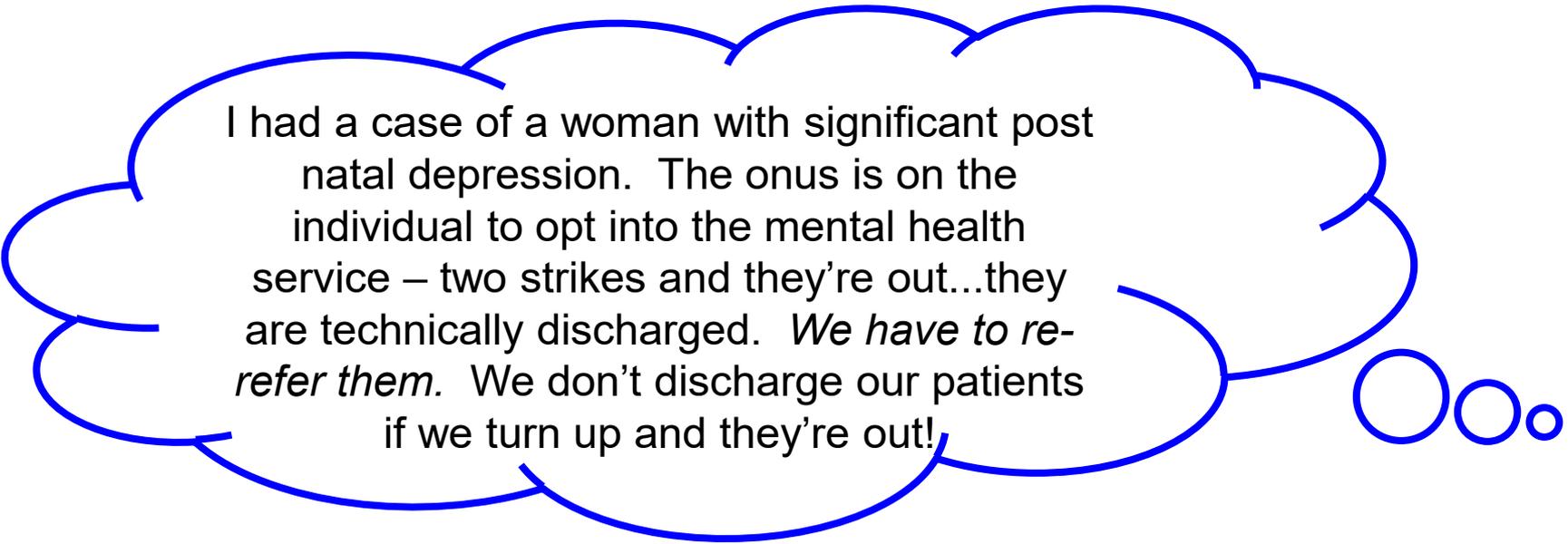
*Sometimes the advice sounds like it come from a book. It would be helpful if you could talk about your own experiences.*

*..... Timing of clinics could be better.*

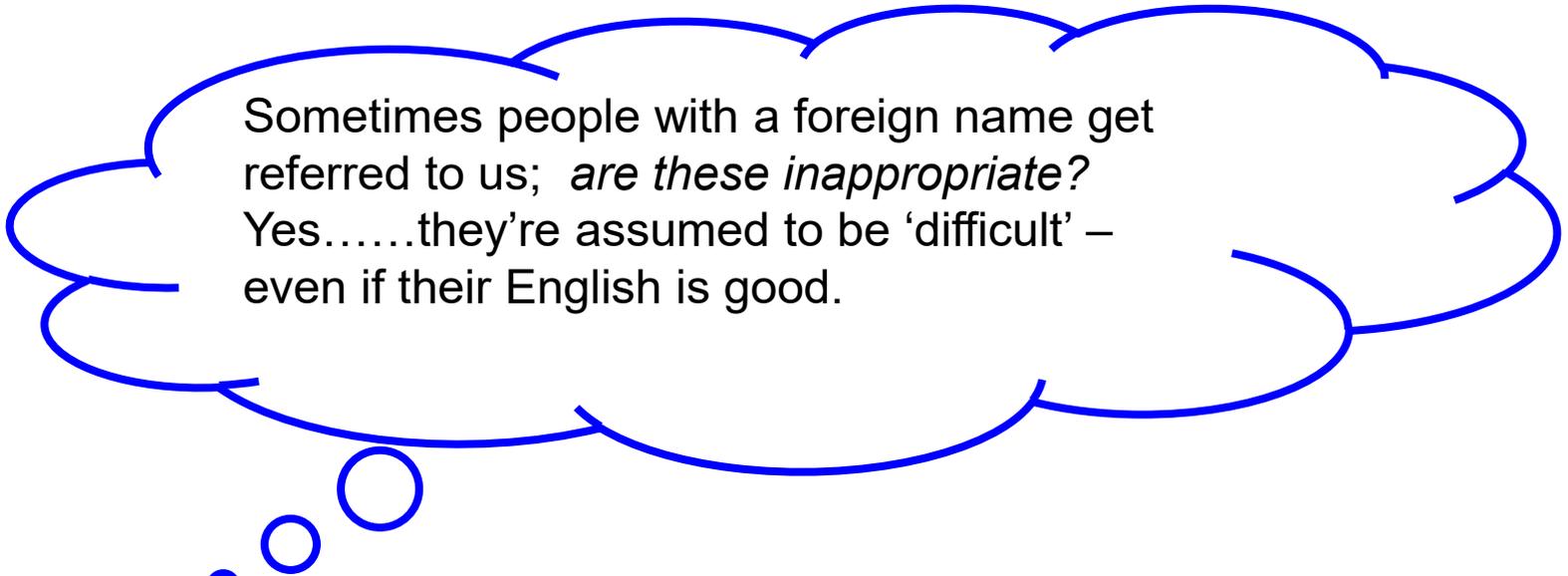
We don't have a receptionist to triage or filter calls. We pick up the phone – it could be anything. We don't have answer machines. We're very obliging..... 'do you ever feel that you are doing other people's jobs?' Yes! The buck always stops with the HV.

*'Inappropriate referrals are just as frustrating for us social workers'.*

Social workers suggested that we're good at building rapport with clients from the outset. Social workers often come in at crisis point.....they also say 'you take lots of referrals' and 'you're willing to do joint visits'



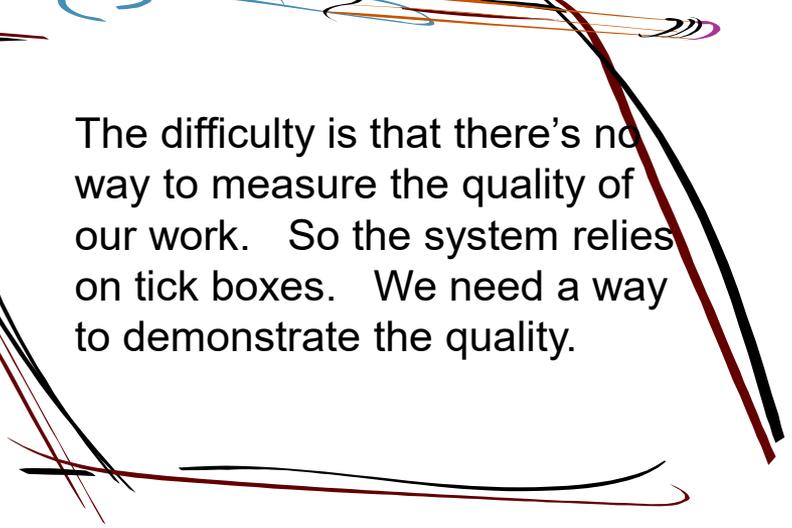
I had a case of a woman with significant post natal depression. The onus is on the individual to opt into the mental health service – two strikes and they're out...they are technically discharged. *We have to re-refer them.* We don't discharge our patients if we turn up and they're out!



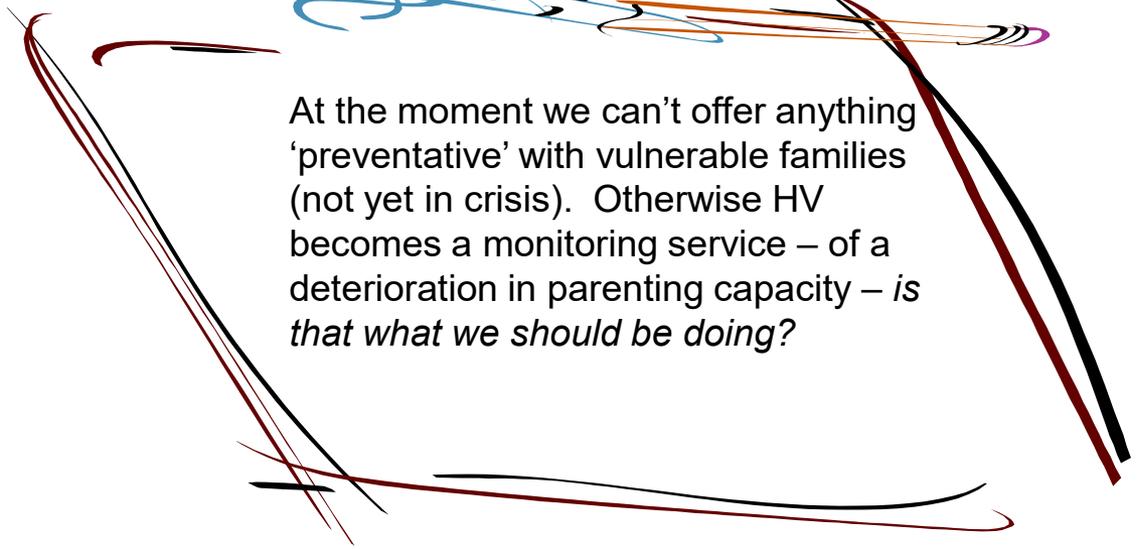
Sometimes people with a foreign name get referred to us; *are these inappropriate?* Yes.....they're assumed to be 'difficult' – even if their English is good.

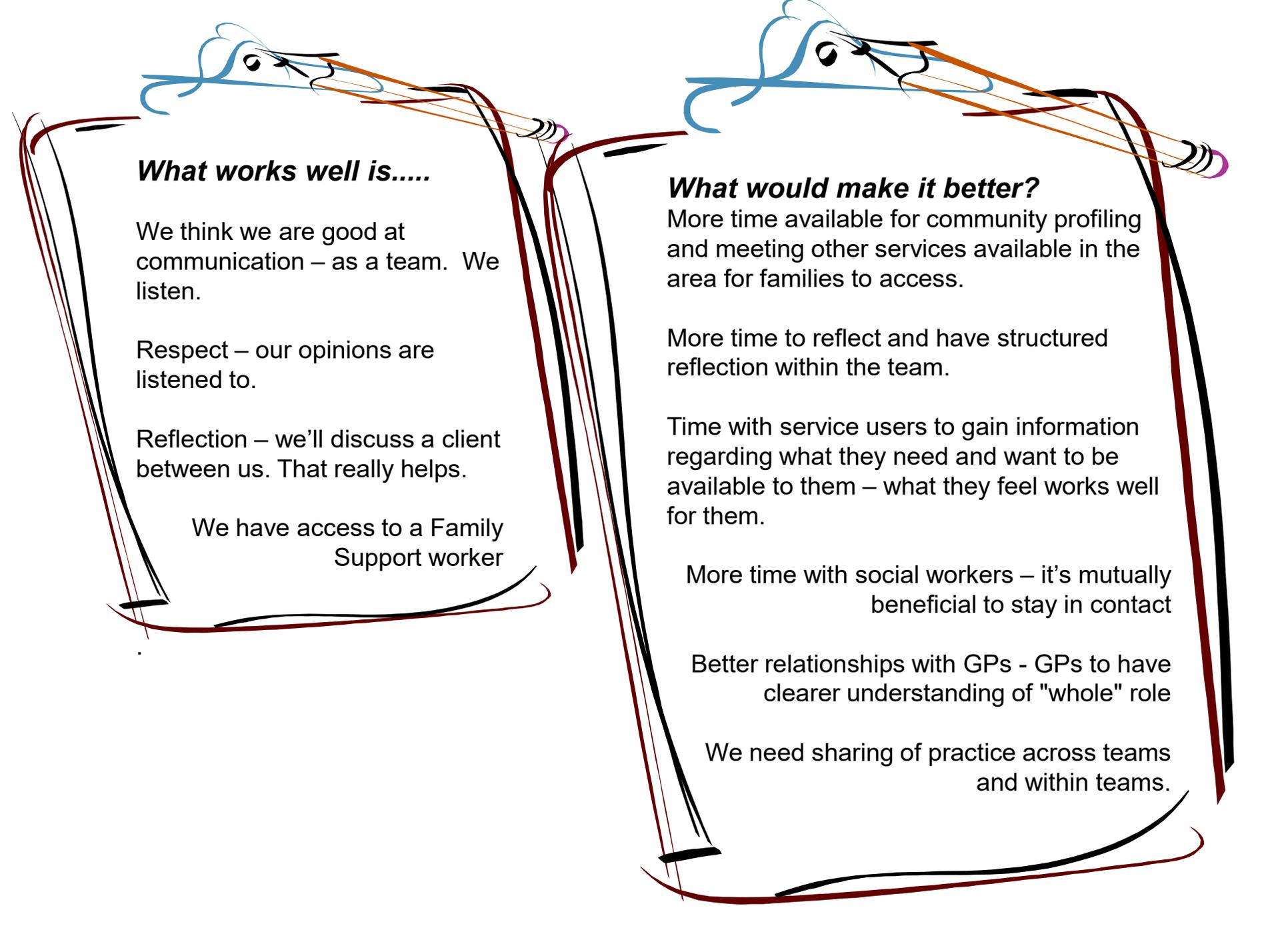


The difficulty is that there's no way to measure the quality of our work. So the system relies on tick boxes. We need a way to demonstrate the quality.



At the moment we can't offer anything 'preventative' with vulnerable families (not yet in crisis). Otherwise HV becomes a monitoring service – of a deterioration in parenting capacity – *is that what we should be doing?*





***What works well is.....***

We think we are good at communication – as a team. We listen.

Respect – our opinions are listened to.

Reflection – we'll discuss a client between us. That really helps.

We have access to a Family Support worker

***What would make it better?***

More time available for community profiling and meeting other services available in the area for families to access.

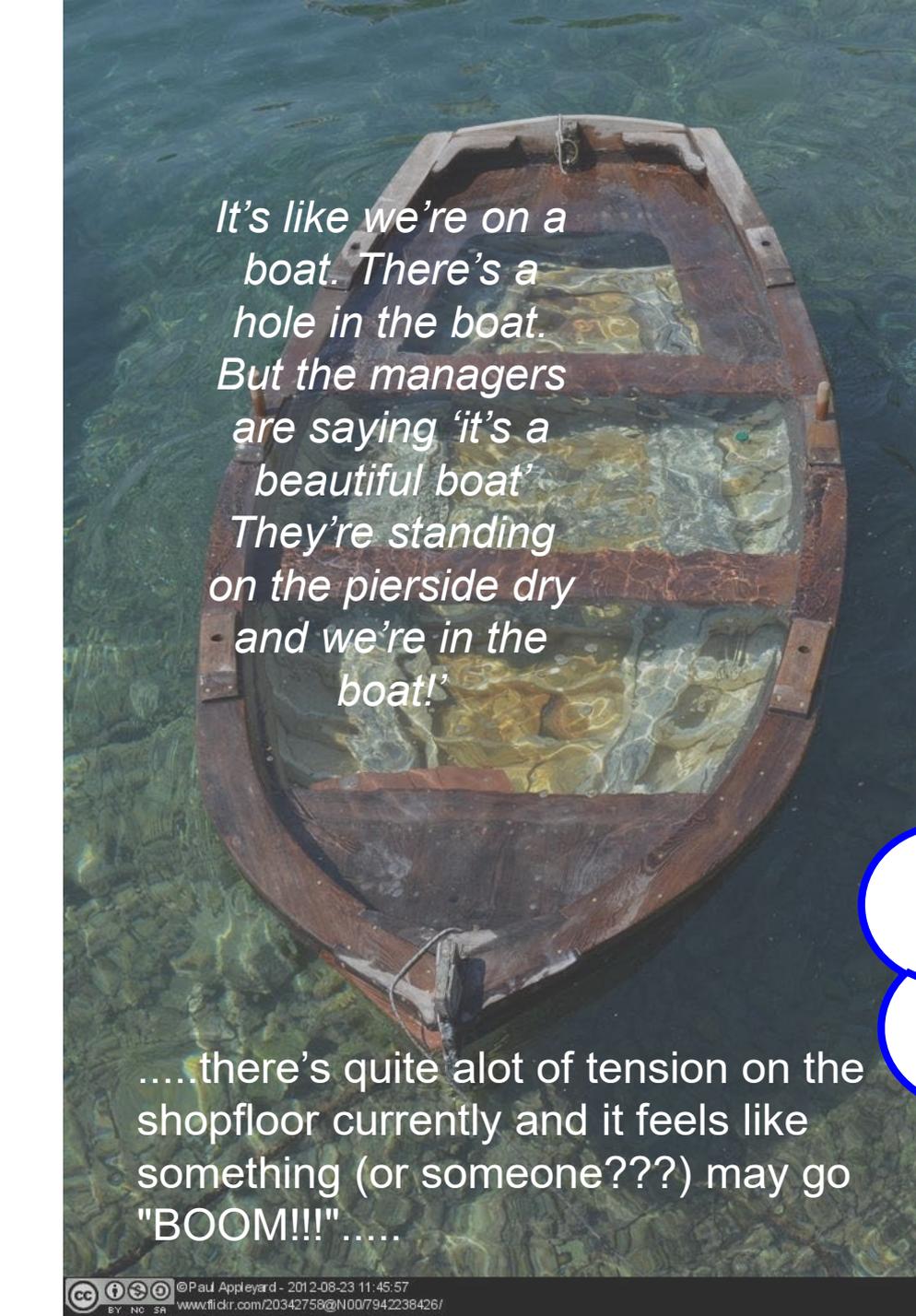
More time to reflect and have structured reflection within the team.

Time with service users to gain information regarding what they need and want to be available to them – what they feel works well for them.

More time with social workers – it's mutually beneficial to stay in contact

Better relationships with GPs - GPs to have clearer understanding of "whole" role

We need sharing of practice across teams and within teams.

A photograph of a wooden boat with a hole in the bottom, floating in water. The boat is viewed from above, and the water is a dark, rippling green. The boat's interior is visible, showing a hole in the bottom that is filled with a yellowish, textured material, possibly a repair or a leak. The boat is surrounded by water, and the overall scene is somewhat somber and cautionary.

*It's like we're on a boat. There's a hole in the boat. But the managers are saying 'it's a beautiful boat' They're standing on the pierside dry and we're in the boat!*

.....there's quite a lot of tension on the shopfloor currently and it feels like something (or someone???) may go "BOOM!!!!" .....

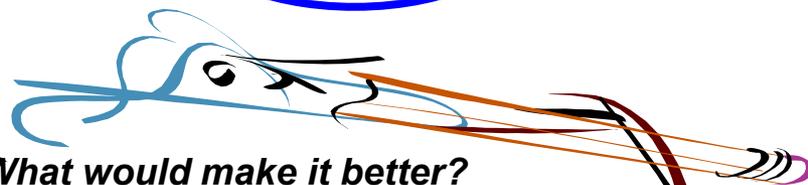
*What support is there to support the quality of what we do?*

If you suggest you're overloaded, they want to look at your time management.

Our practice – our expertise, knowledge and understanding is not valued. Clinical expertise is not valued. We're expected to take on a leadership role – run teams of people.....we will lose our skills.



We have Child Protection supervision, clinical supervision and caseload management - but we *need to share the risk at the service level*- the level of risk is colossal! .....this is not about lone visits but about the complexities of cases.....



**What would make it better?**

Better support from management - "open door" policy, not having to wait for clinical supervision.

Smaller caseload numbers for realistic expectations in order to *"give a service they deserve rather than skimming over"* and give more mutually satisfactory outcomes.

For the organisation on a higher level to have a better understanding of what we are dealing with on a daily basis instead of hitting us with audits.

*'The value of this group is that if nothing else, I know I am not the only one who is thinking these things'*

## What are we learning about inequalities sensitive practice?

.... There is hidden inequality – it's not necessarily about race or gender – it is about poverty.

.... *'The client is not at the centre'*

.... Self-referrals is difficult for those with literacy issues; those with no phone credit or money for bus fares.

....by coming through our system they give up privacy and autonomy and potentially damage their job prospects

There is inequality around how the team is treated within the system and how individuals are treated within the team

We have a flood of inappropriate referrals – people with very complex needs – rather than being an emotional wellbeing & preventative service

People with really chronic problems are being passed around the system because of the squeeze on services. They clog up our service. Used to have to 'self-help workers'.

... They were very clear that they didn't see it as an issue. I'm assuming they're not receiving any complaints?

## **What are we learning about inequalities sensitive practice?**

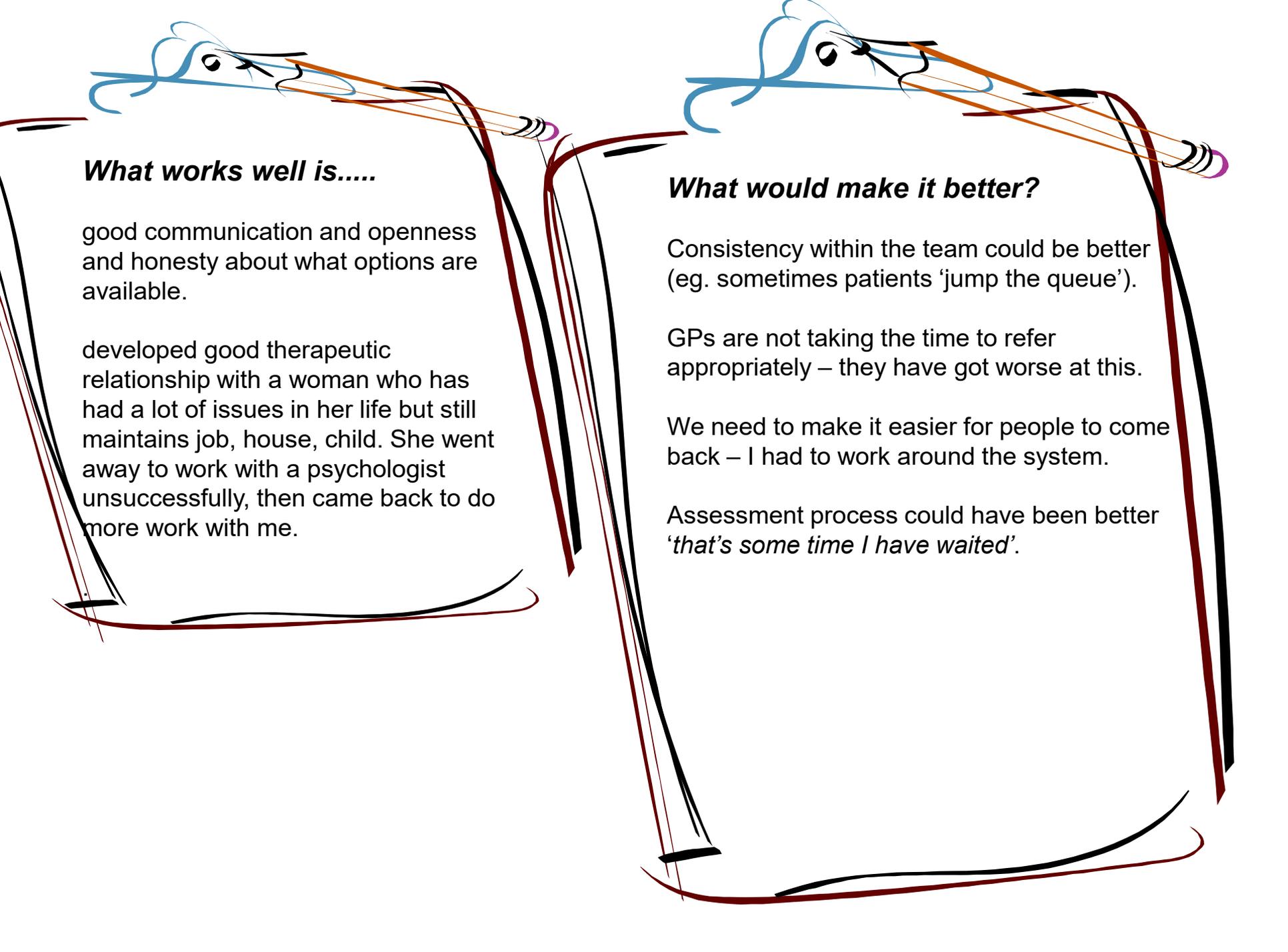
*We don't do home visits....*

Is it possible to give feedback to GPs about inappropriate referrals?

We have asked clients at telephone assessment about disability and what people need to be able to attend. There have been no problems in sorting out people's needs – I have seen them at home due to disabilities. We can do this but we're not really geared up.

It's not visible.

... Another issue is people who work out of hours. We're getting asked for this more and more.



### ***What works well is.....***

good communication and openness and honesty about what options are available.

developed good therapeutic relationship with a woman who has had a lot of issues in her life but still maintains job, house, child. She went away to work with a psychologist unsuccessfully, then came back to do more work with me.

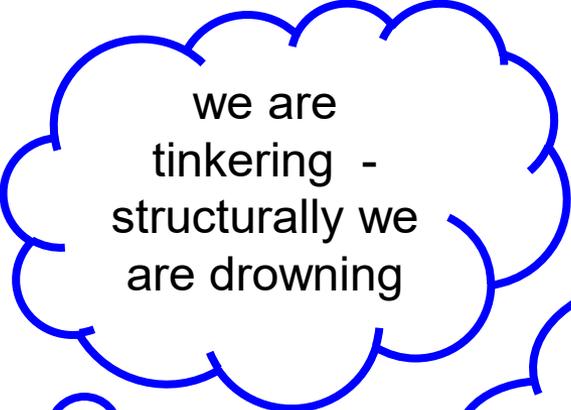
### ***What would make it better?***

Consistency within the team could be better (eg. sometimes patients 'jump the queue').

GPs are not taking the time to refer appropriately – they have got worse at this.

We need to make it easier for people to come back – I had to work around the system.

Assessment process could have been better *'that's some time I have waited'*.



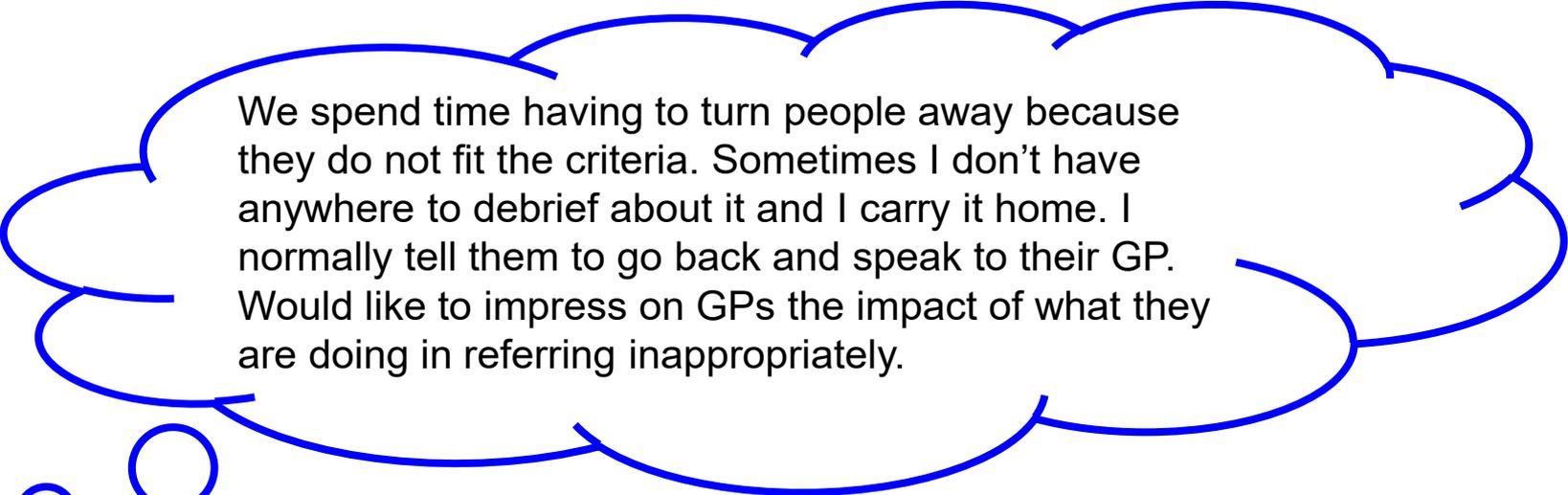
we are  
tinkering -  
structurally we  
are drowning



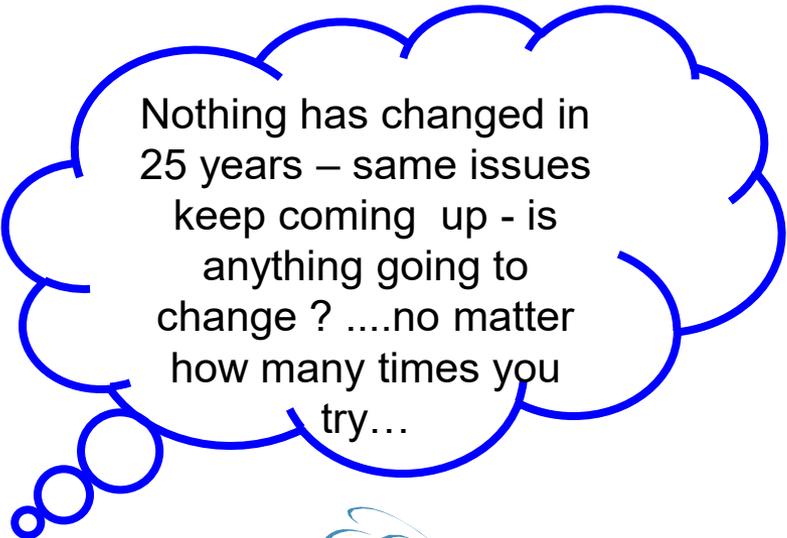
inappropriate  
referrals take  
up so much of  
our time and  
resources



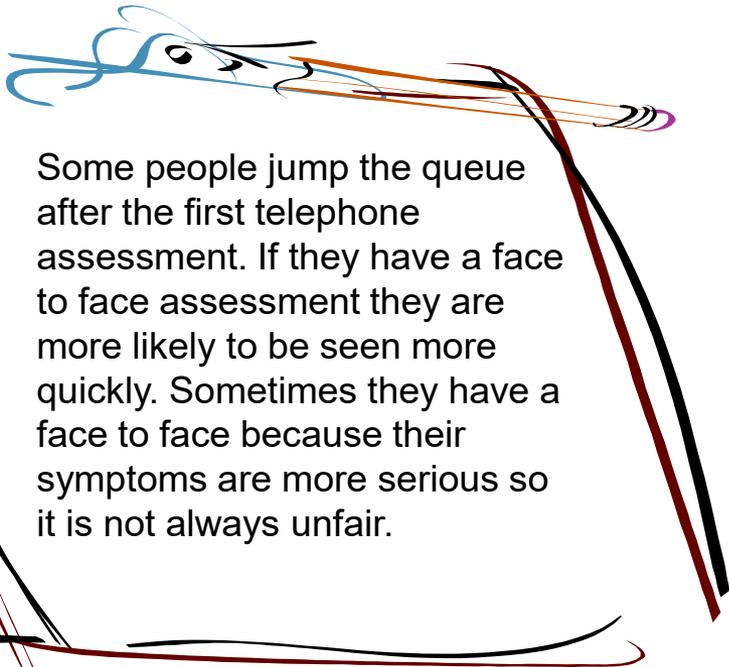
some of our client's  
come with the attitude  
'somehow, someone's  
responsible for fixing  
my problem'



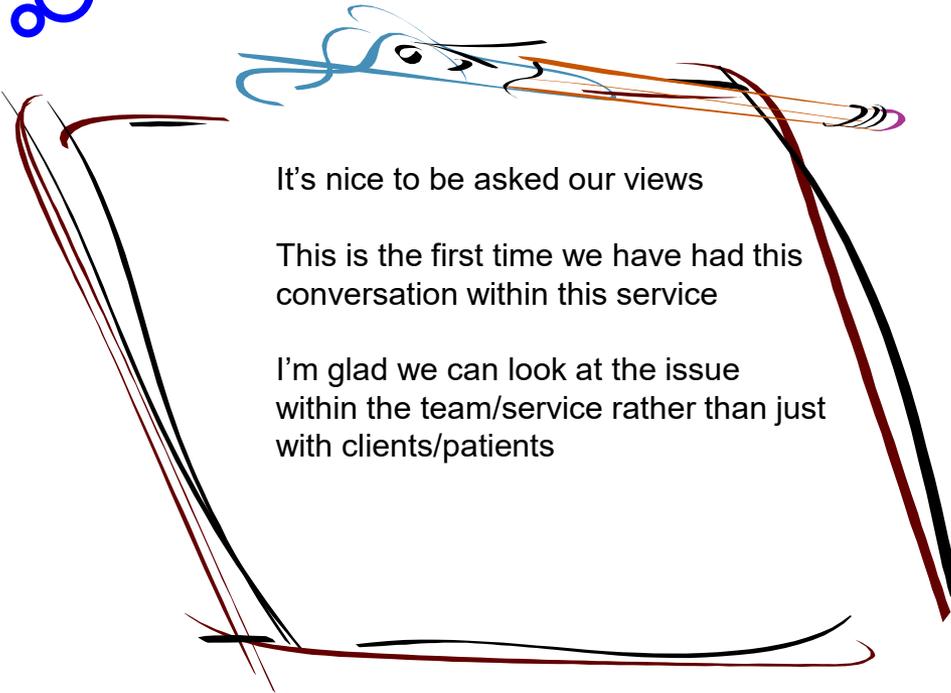
We spend time having to turn people away because they do not fit the criteria. Sometimes I don't have anywhere to debrief about it and I carry it home. I normally tell them to go back and speak to their GP. Would like to impress on GPs the impact of what they are doing in referring inappropriately.



Nothing has changed in 25 years – same issues keep coming up - is anything going to change ? ....no matter how many times you try...



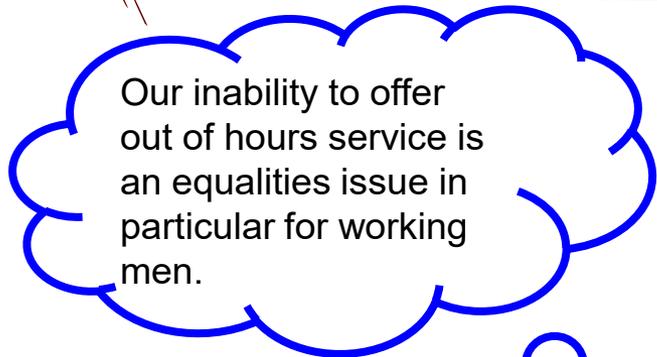
Some people jump the queue after the first telephone assessment. If they have a face to face assessment they are more likely to be seen more quickly. Sometimes they have a face to face because their symptoms are more serious so it is not always unfair.



It's nice to be asked our views

This is the first time we have had this conversation within this service

I'm glad we can look at the issue within the team/service rather than just with clients/patients



Our inability to offer out of hours service is an equalities issue in particular for working men.



The client reported that staff explain things really well.

I had a female patient ...I saw her over a period of several months. During the 6<sup>th</sup> session she disclosed abuse but didn't want the rest of the therapy to focus on that one issue but on the other issues she had been bringing around loss, traumatic bereavement and family issues.

***What works well is.....***

that he was able to offer consistency of appointment time and place

offered a genuine and sensitive presence and a secure relationship - responsive to the client's changing needs

being able to plan/manage caseload and decide number of sessions

Training provided sound basis for the work

Supervision – improving resource for reflection and support

***What could be better....***

greater confidence on part of team member –

(Less?) over-sensitivity to gender issues

Awareness of targets – and therefore looking for cues with which to move bring the treatment to a close – could have passed itself on to client

provision and quality of rooms could have been better

*I had a deaf client who wanted to receive reminders of appointments by text. I couldn't contact him by phone. If he received an appointment and it wasn't suitable he had to come in to the department in person to cancel and rearrange his appointment. When I referred him to Carr Gomm for support he had the same problem. They didn't have a facility for sending out text appointments as they were only just talking about it at the time.*

In my feedback from GPs, we're not getting anything about inequalities. They say that people present with anger management – there's nowhere to refer them to. ....

....Some said that there are issues with telephone assessment –some people don't have credit or are just not good on the phone.

*What could be better....*

A facility to offer text appointments...we now have the technology but it's not working...this would be useful for a number of people and would potentially cut down on the DNAs.

Could admin also have a separate email box?

It's a priority to **have more liaison with GPs** – GPs need a member of staff who they can phone if they have questions about recommending someone to get in touch with us ....



Huge gap between workers and senior managers setting targets. We have no access to them.

*'There is an equality of non-access to the service.'*

There are constant changes in the Lifelink referral process...I don't understand it, don't know them well enough, don't think along the lines of referring to Carrgomm.



GPs raised waiting times as the issue they are concerned about. We think that they think *'inequalities are the least of our worries'*.

We would like clarity of criteria for referral – 'everybody is pushing the boundaries of the service' 'all patients are disadvantaged equally'

4 years ago – there was a rapid cycle change exercise in which they looked at the processes and slimmed it down to cut out inefficiencies – this was good - but in the last 2 years the bureaucracy has crept back up again.

It feels like we're swimming in mud.

Management need to listen to us. They need to be more proactive and take more responsibility for the system that they manage. They need to listen to us about how the system is actually working.



.....nobody has looked at our (criteria) flowchart for 4 years.

GPs don't have any consequences of an inappropriate referral. We 'deal with it' as a team.

I'd like to see management to do more education with GPs – especially as a new group of GPs are coming into the service. They say *'It's very hard to change GPs behaviour'* Management need to tell GPs *they're fouling up the service.*

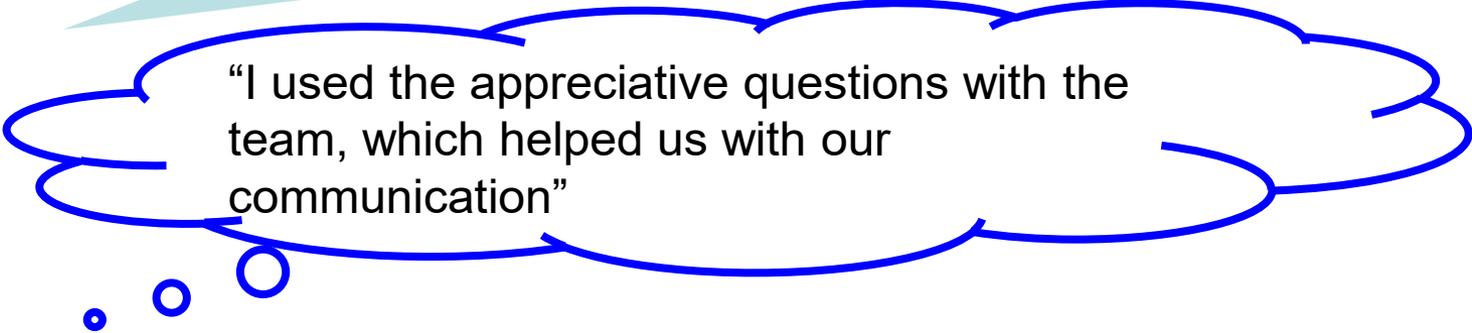
*Even GPs who used to be quite good are giving up and just referring to us.*

Woman who'd just had a baby referred to CMHT by peri-natal services (after the 4 month cut off period). They referred her back to us. This took 4 months – I've only just got round to making a telephone assessment. She's waited 4 months for that. Peri-natal could have phoned to see if she was suitable for CMHT – would have cut out some time. She had been self-harming. Her family were also worried and were trying to help out. This type of scenario is not uncommon.

GPs treat us as a signposting service – they're using us as a triage service. One referral (of someone who had voices in their head arguing about how they should kill themselves ) – the GP said *'I knew they wouldn't be for you'*.

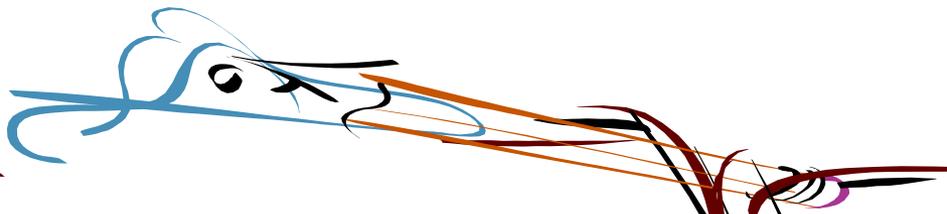
It's a tennis match – referring people around the system. An example of a 'typical' type of issue would be someone with chronic lifelong anxiety or depression who is not suicidal (so not a referral for CMHT) who is economically disadvantaged – perhaps leads a slightly chaotic life, maybe with substance abuse. Could be house-bound. Such a case is far too complex for us.

M asked a patient what was working well for him and he replied, “You asked me!” When she asked what she could do to make things even better he replied, “Keep asking me!”



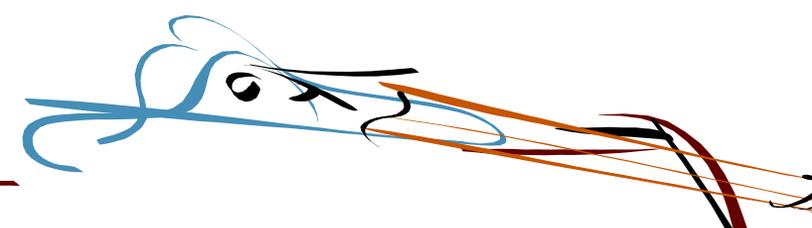
“I used the appreciative questions with the team, which helped us with our communication”

The locum GP gave the patient 3 wee bottles and asked him for samples of his sputum, urine and faeces. He looked at me blankly and I just said “Spit in this, p\*\*\* in this, and s\*\*t in this one please!”



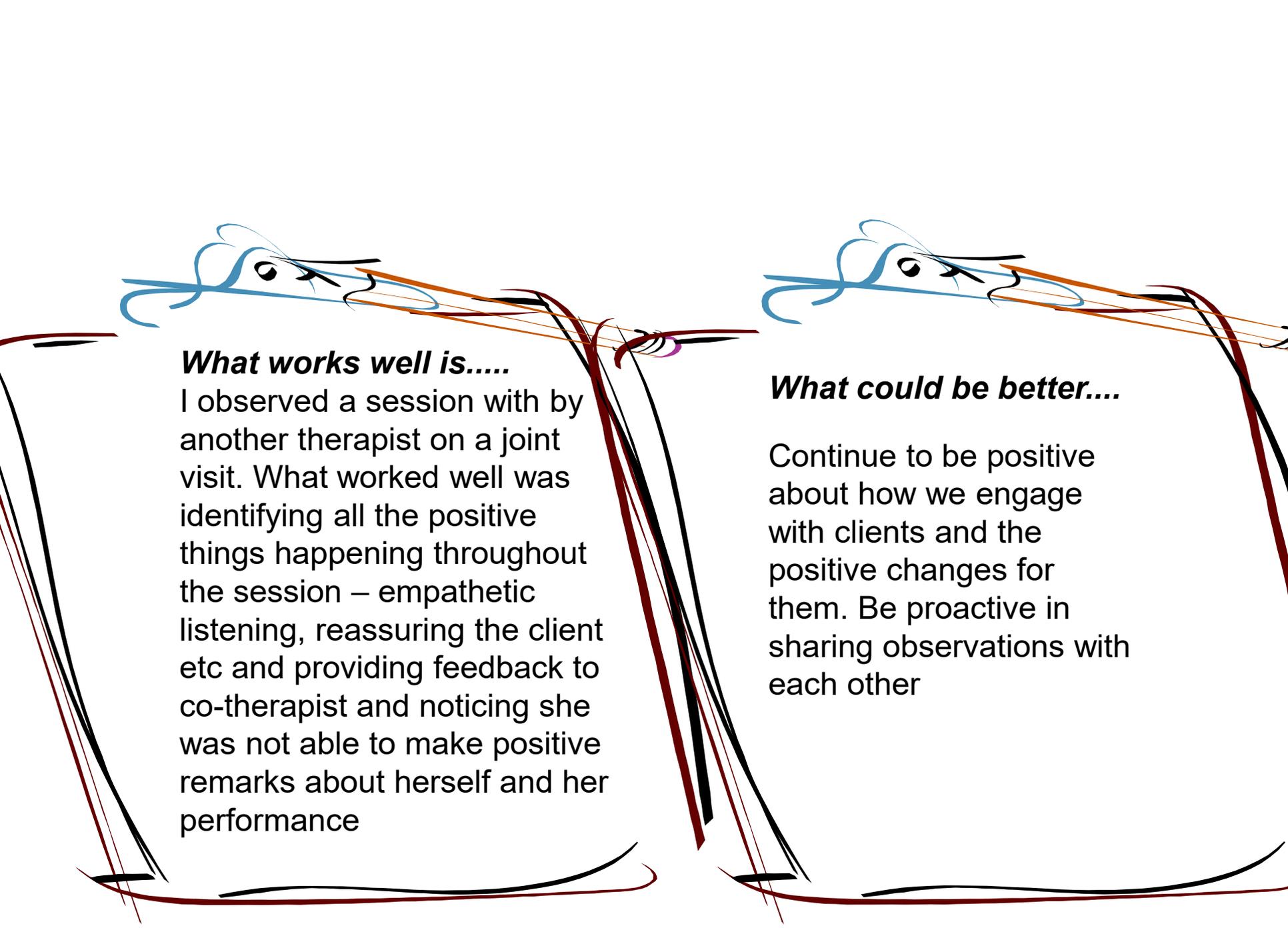
***What works well is.....***

Carrying out comprehensive assessment with client. I explained the whole process and reason for the assessment questions what expectations they had after the assessment. Difficult session as well as the client had suffered a close bereavement



***What could be better....***

Feedback from client on assessment session. When asked if the assessment felt ok the client reported that they had been treated with dignity and respect in relation to the situation and circumstances, felt relaxed and able to talk openly. Finally felt though some positive change was happening

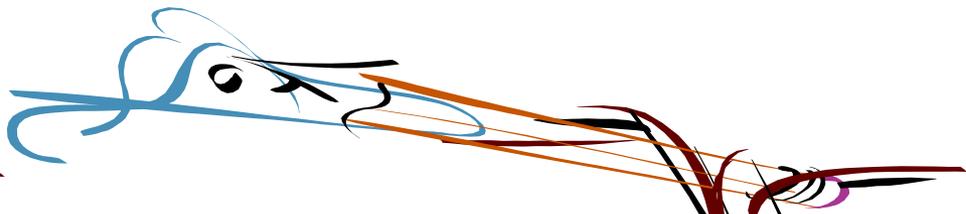


***What works well is.....***

I observed a session with by another therapist on a joint visit. What worked well was identifying all the positive things happening throughout the session – empathetic listening, reassuring the client etc and providing feedback to co-therapist and noticing she was not able to make positive remarks about herself and her performance

***What could be better....***

Continue to be positive about how we engage with clients and the positive changes for them. Be proactive in sharing observations with each other



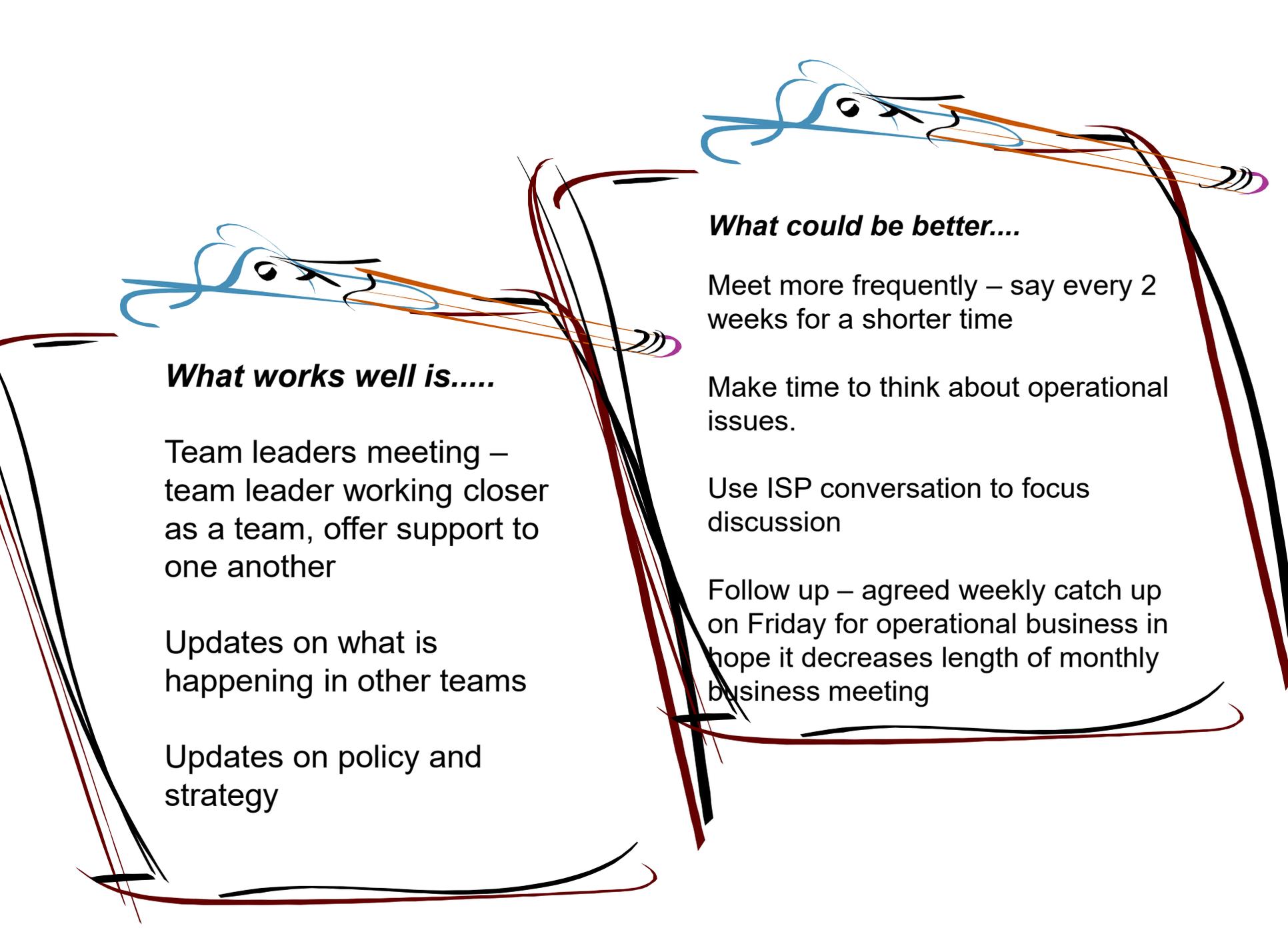
***What works well is.....***

Session with client working on a behaviour activation sheet. When reflecting on the session with the client, the client reports that unless tasks are fully explained and the expectations of the activity she struggles to understand



***What could be better....***

Remember never to make assumptions, fully explain what is required , go through each task and explain what is expected to complete task and reduce any anxieties client has about completing tasks



***What works well is.....***

Team leaders meeting –  
team leader working closer  
as a team, offer support to  
one another

Updates on what is  
happening in other teams

Updates on policy and  
strategy

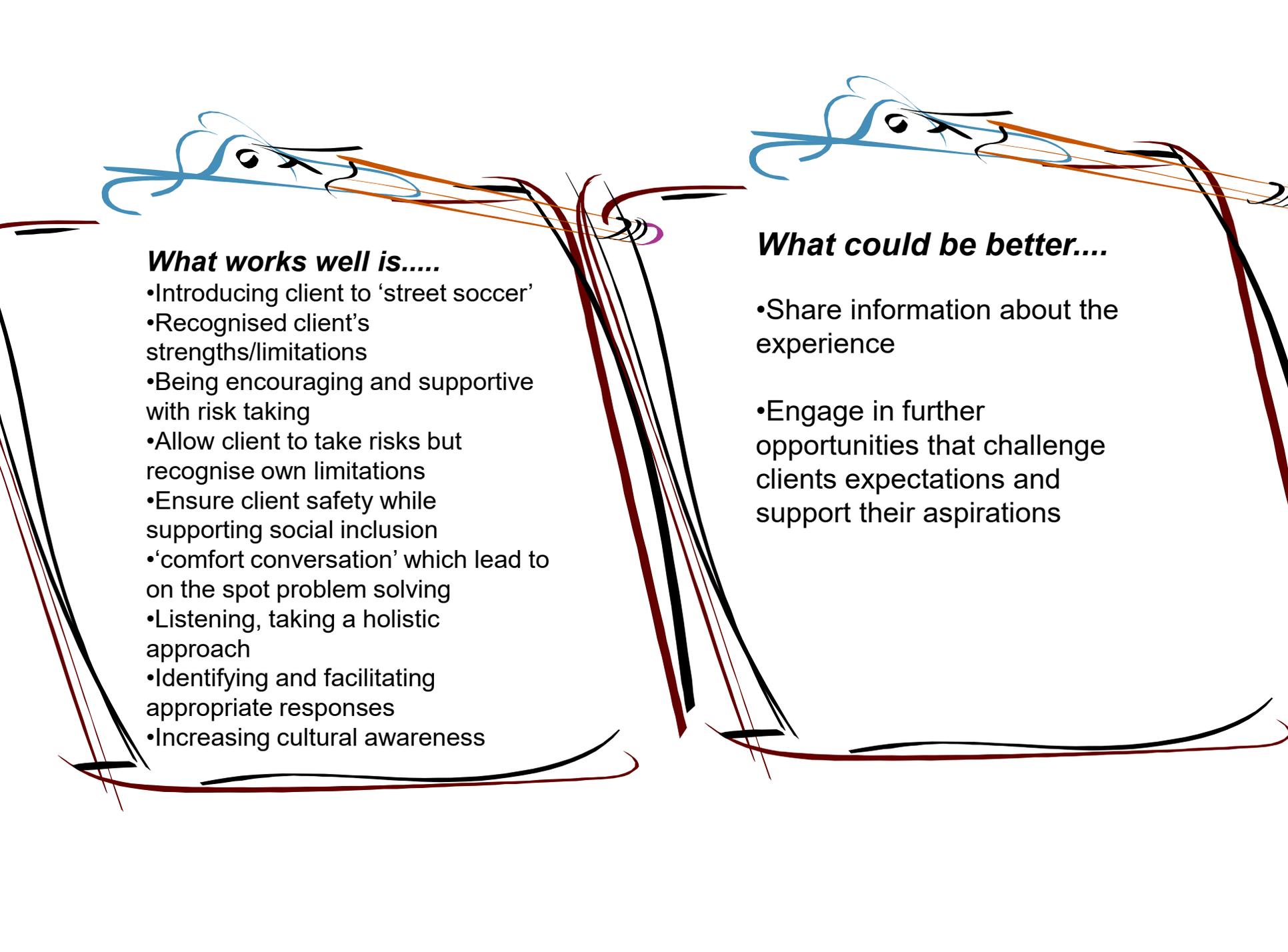
***What could be better....***

Meet more frequently – say every 2  
weeks for a shorter time

Make time to think about operational  
issues.

Use ISP conversation to focus  
discussion

Follow up – agreed weekly catch up  
on Friday for operational business in  
hope it decreases length of monthly  
business meeting

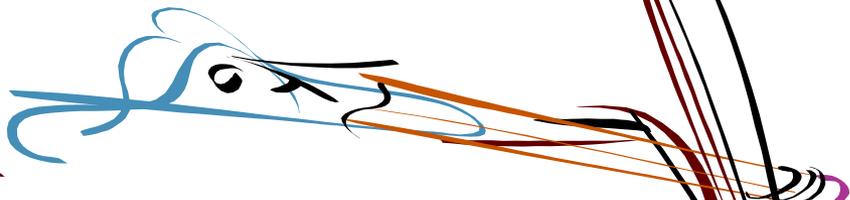


### ***What works well is.....***

- Introducing client to 'street soccer'
- Recognised client's strengths/limitations
- Being encouraging and supportive with risk taking
- Allow client to take risks but recognise own limitations
- Ensure client safety while supporting social inclusion
- 'comfort conversation' which lead to on the spot problem solving
- Listening, taking a holistic approach
- Identifying and facilitating appropriate responses
- Increasing cultural awareness

### ***What could be better....***

- Share information about the experience
- Engage in further opportunities that challenge clients expectations and support their aspirations

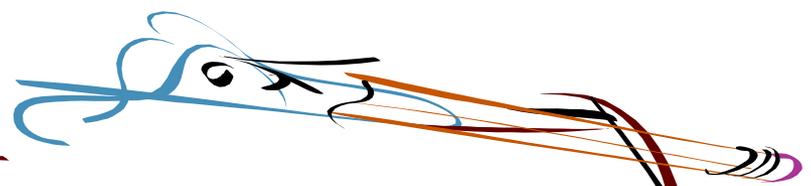
A stylized illustration of a bird's head and neck, drawn with blue, orange, and black lines. The bird is facing right, with its beak pointing towards the right side of the page. The lines are expressive and somewhat abstract, giving it a sketchy appearance.

### ***What works well is.....***

Joint working protocol meeting  
accommodation provider to discuss  
client needs in service which is not  
working

I decided to change format with new  
provider from business agenda to  
asking questions about what is  
working well

The group had no expectations of  
me as they had not met me in the  
past therefor it was easy to do  
Outcome – lots of positive feedback  
about accessibility of services at  
HHS, good responsive relationships  
for team and place to go to ask  
'simple' questions

A stylized illustration of a bird's head and neck, drawn with blue, orange, and black lines. The bird is facing right, with its beak pointing towards the right side of the page. The lines are expressive and somewhat abstract, giving it a sketchy appearance.

### ***What could be better....***

Sexual health training for service /  
project as staff turn over quickly  
and allow project staff to develop  
skills in raising sexual health with  
young people

Share practice with mainstream  
GP; make services easier to  
access e.g. registration process  
for GP

“What inequalities sensitive practice means to me.....

I don't have an image of it”



*“In homelessness we are all individuals. The sun shines brighter when we recognise everyone is not the same.”*



*“The team recognises we are in a period of transition. Caring Conversations was used to enable discussion and more insight was gained into issues/others perspectives. We plan change to benefit clients”*

*“I advocated on a client’s behalf and they are now receiving a better service”*

*“What inequalities sensitive practice means to me.....  
We need to juggle lots of different priorities”*



*“It still feels awkward trying to talk colleagues who are not part of the group using the appreciative questions.....It might actually be easier to talk to service users/patients than we first thought”*

*“Used the appreciative questions with the team which helped us with our communication”*

*“What inequalities sensitive practice means to me..... We need to go slow down to change hearts and minds”*



## ***ISP examples of current practice from addictions and homeless GP service:***

### ***Involving patients***

*Patients who are prescribed opiate substitution therapy have a review of their treatment and care every three months by a medical officer. During this review I ask “how are you finding your current care? What is working well? What should we be doing differently?” This was normal practice in the Young Persons Clinic Homeless Addiction team (I have since moved teams).*

*For patients attending the GP drop in surgery when I am the GP our opening line when patients sit down (after introduction) is ‘What can we do for you today?’*

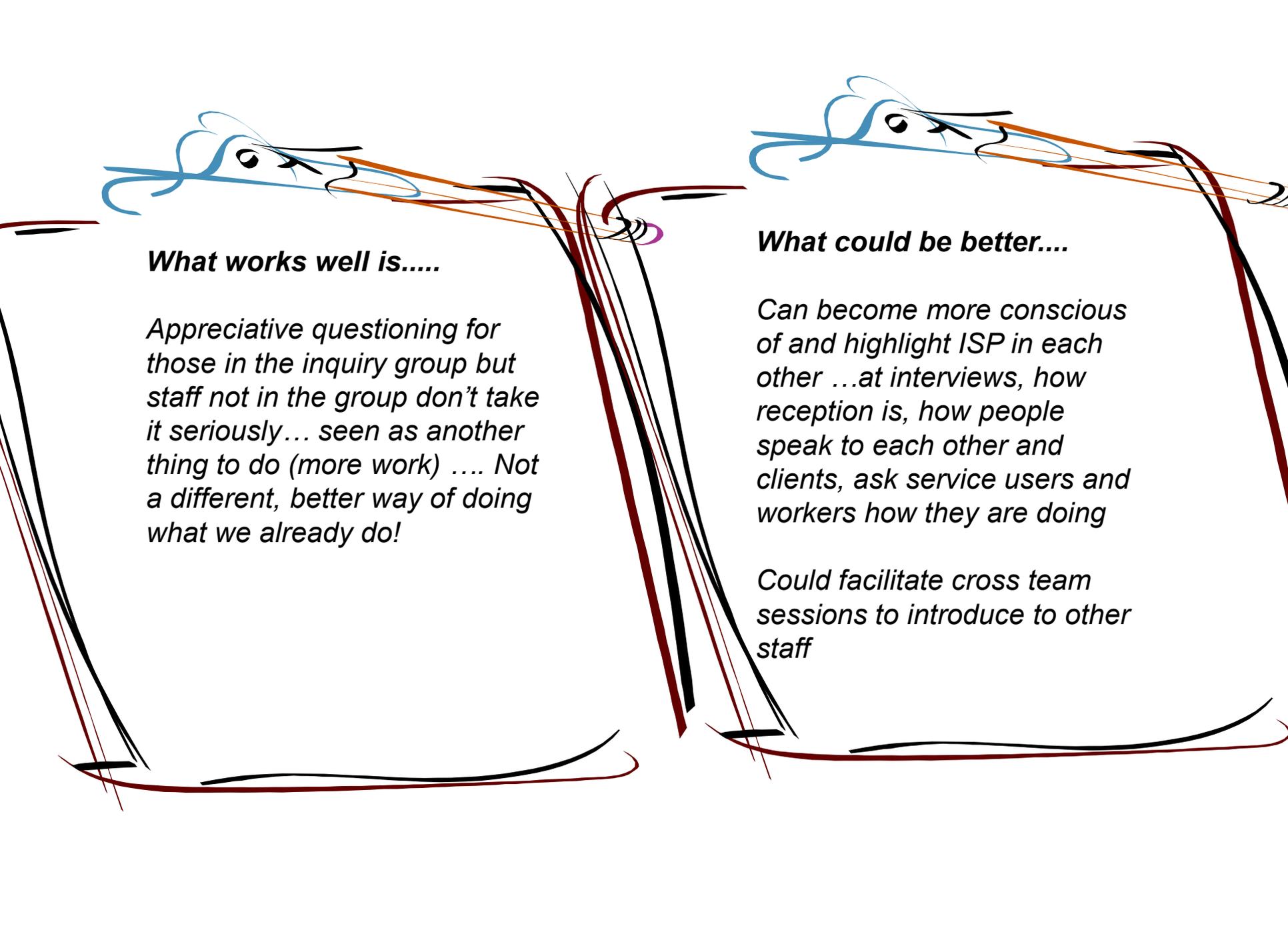
### ***Involving staff***

*It is normal practice in the GP service to thank the team staff each day at the end of surgery for their contribution. This is the healthcare assistant who helps us run the surgery and the reception staff. The GP’s see it as their role to support staff after unusual incidents have happened in the Hunter St reception area. This includes checking out how staff are feeling after a negative incident has occurred and providing positive feedback when staff have handled an aggressive incident or medical emergency well.*

*I spend time talking with reception and healthcare assistant staff when patients have exhibited behaviour that might be unusual or challenging. The purpose of this is to help reframe it psychological terms rather than simply be viewed as negative. This has enabled staff to cope and handle challenging situations more effectively.*

We did a joint visit to a client who had been placed in highly supported accommodation because we were worried that he might start to become dependent on the level of support available – which would take him longer to achieve independent living than was necessary. We were a bit anxious that he would not want to start the domestic activities programme we had designed for him, and on the way there we discussed different approaches we could use to help persuade him. But when we got there the client said, “I’m loving it here and folk are great, but I want to get back to normal as soon as I can” ..... We were delighted, and were really glad we had gone, because we didn’t have to continue with him our caseload.

A client came to us having just been released from Jericho and he had been using, and he said ‘You won’t do anything for me because I have been using’, but I said I would and helped him get accommodation and he is now doing quite well. I have arranged to meet him away from here because he is afraid he will bump into his old cronies and start using again. I am going to ask him ‘what is working well for him and what I can do to make things better’.



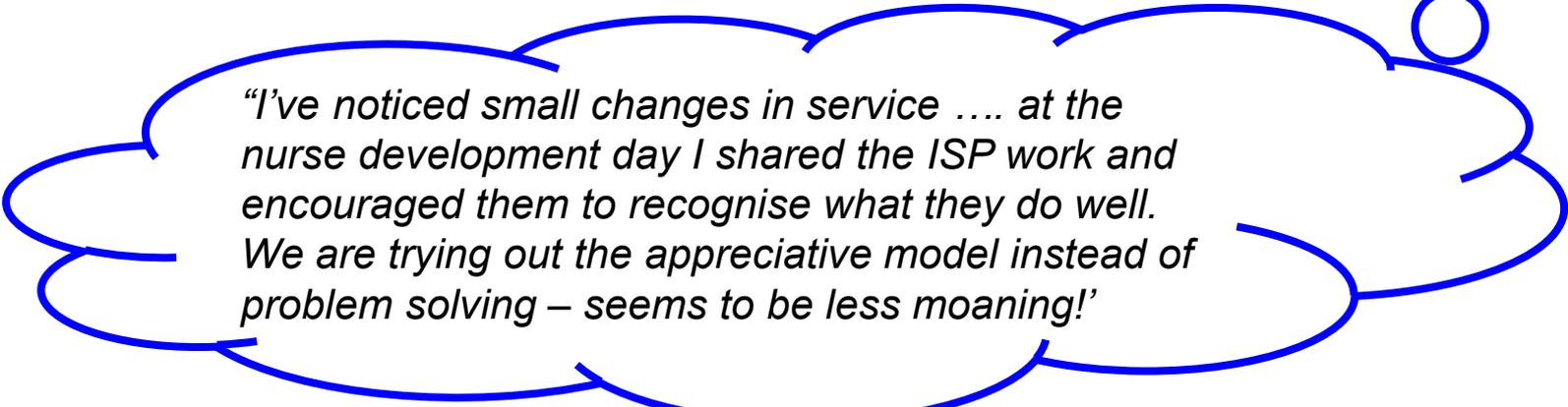
***What works well is.....***

*Appreciative questioning for those in the inquiry group but staff not in the group don't take it seriously... seen as another thing to do (more work) .... Not a different, better way of doing what we already do!*

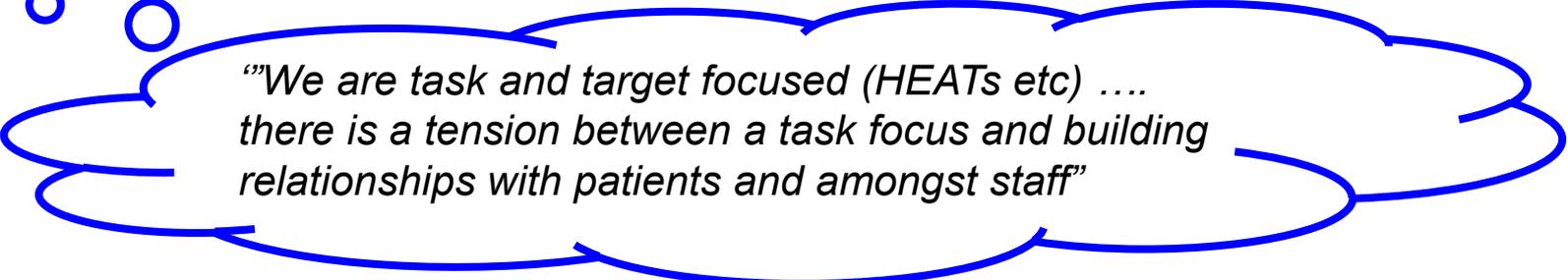
***What could be better....***

*Can become more conscious of and highlight ISP in each other ...at interviews, how reception is, how people speak to each other and clients, ask service users and workers how they are doing*

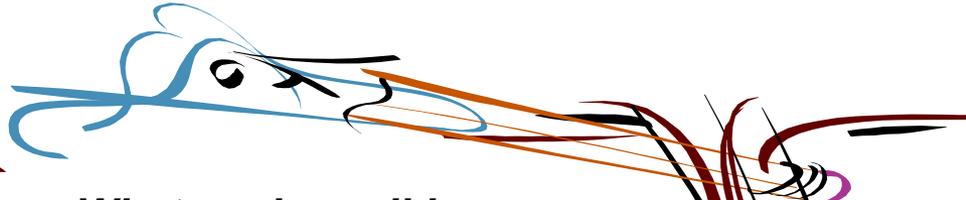
*Could facilitate cross team sessions to introduce to other staff*



*"I've noticed small changes in service .... at the nurse development day I shared the ISP work and encouraged them to recognise what they do well. We are trying out the appreciative model instead of problem solving – seems to be less moaning!"*

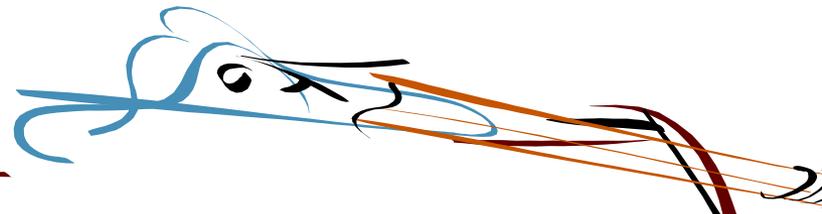


*"We are task and target focused (HEATs etc) .... there is a tension between a task focus and building relationships with patients and amongst staff"*



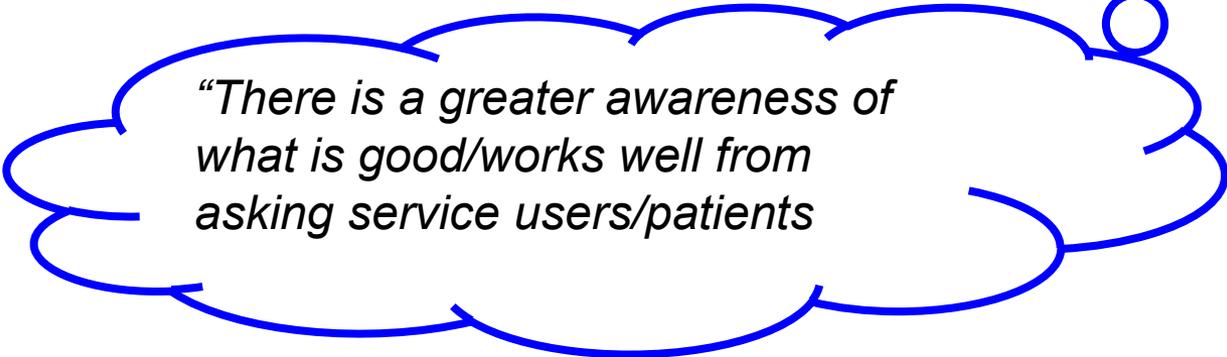
***What works well is.....***

*The inquiry group was the first time the different teams worked together – it broke down barriers*

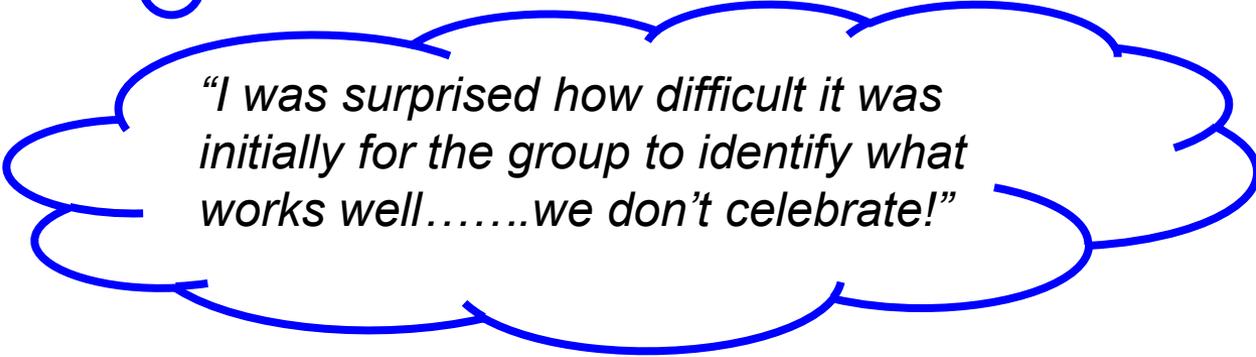


***What could be better....***

*We need a more joined up approach - but we are working on it !*



*“There is a greater awareness of what is good/works well from asking service users/patients*



*“I was surprised how difficult it was initially for the group to identify what works well.....we don't celebrate!”*

•Need to be reflective – seems insurmountable. Is it a question of doing the best we can – is equality achievable or are we just wasting our time?

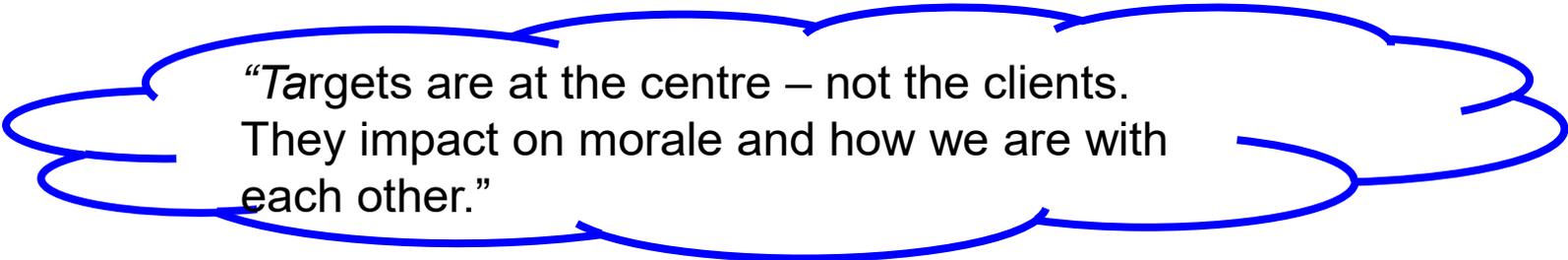
•Is it about really making things better or just 'fixing' things – we need more collaboration with clients?

•Need to be supported to build a thriving culture in dealing with multiply excluded people.

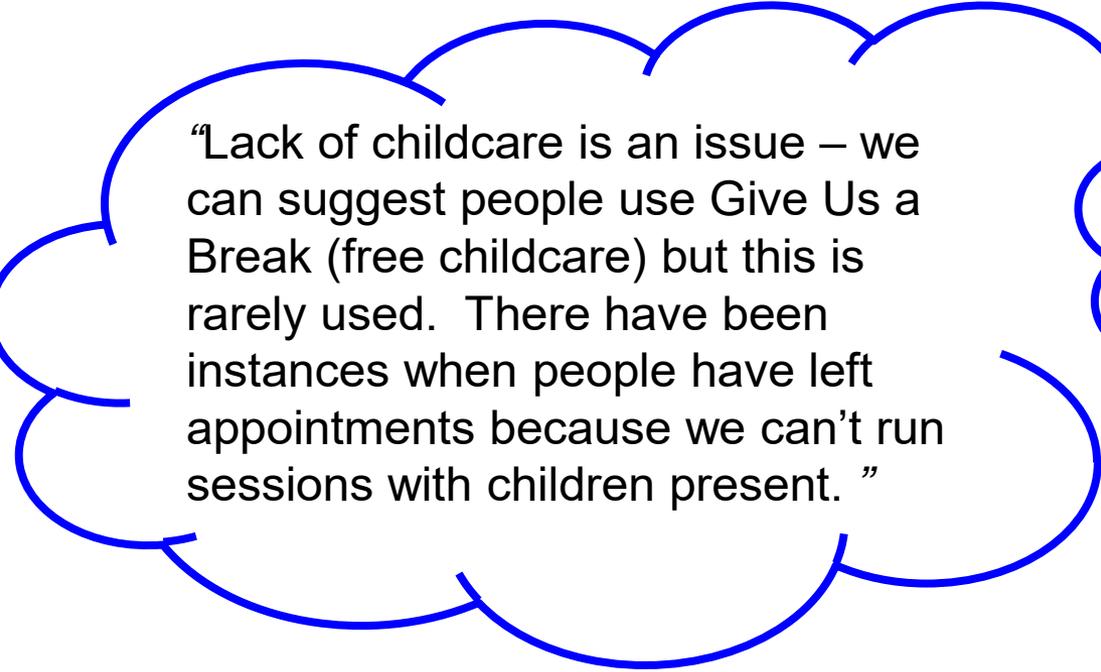
•Making the language and culture of Caring Conversations work is a challenge

•Need tolerance and acceptance - but dealing with conflict/threatening behaviour is an everyday occurrence. Some of this is caused by policy – zero tolerance is problematic

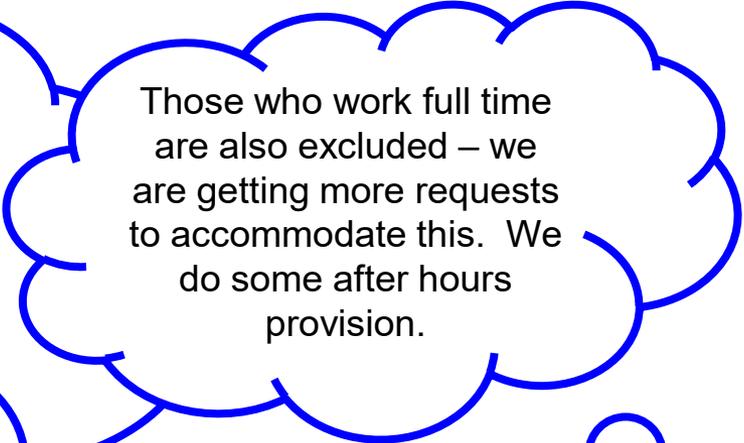
What are we now thinking about inequalities sensitive practice?



*“Targets are at the centre – not the clients. They impact on morale and how we are with each other.”*



“Lack of childcare is an issue – we can suggest people use Give Us a Break (free childcare) but this is rarely used. There have been instances when people have left appointments because we can’t run sessions with children present. ”



Those who work full time are also excluded – we are getting more requests to accommodate this. We do some after hours provision.

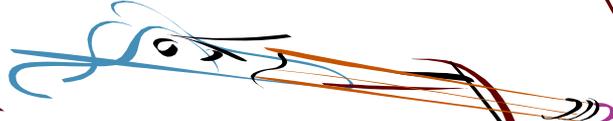




Recent feedback from a GP suggested that we should contact referred people by phone – rather than sending them an ‘opt-in’ letter – which presumably some don’t/can’t read. Maybe he has a point... We’d assumed that people get others to read them for them.

“No doubt more marketing could be done – but we’d be concerned about the volumes it might generate. We’d like to see more clarity about we do do and what we don’t.....GPs are quite muddled up.”

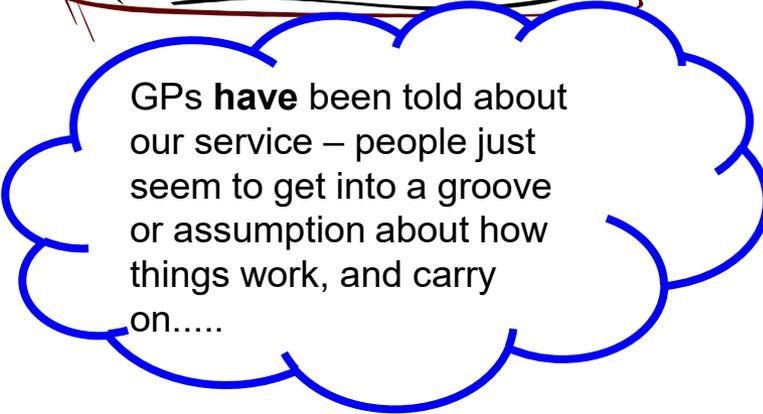




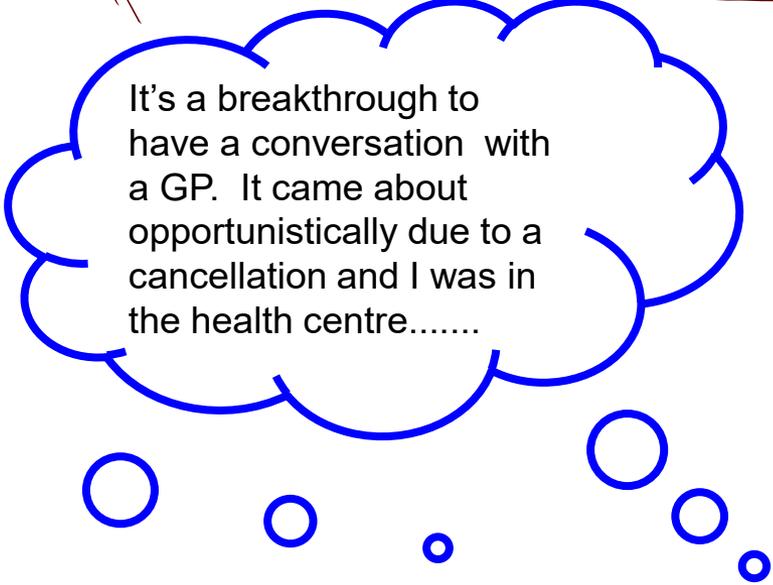
It sounds like this exchange was much more of a dialogue with the GP? – ‘yes, I couldn’t leave him thinking that he wasn’t able to refer!’



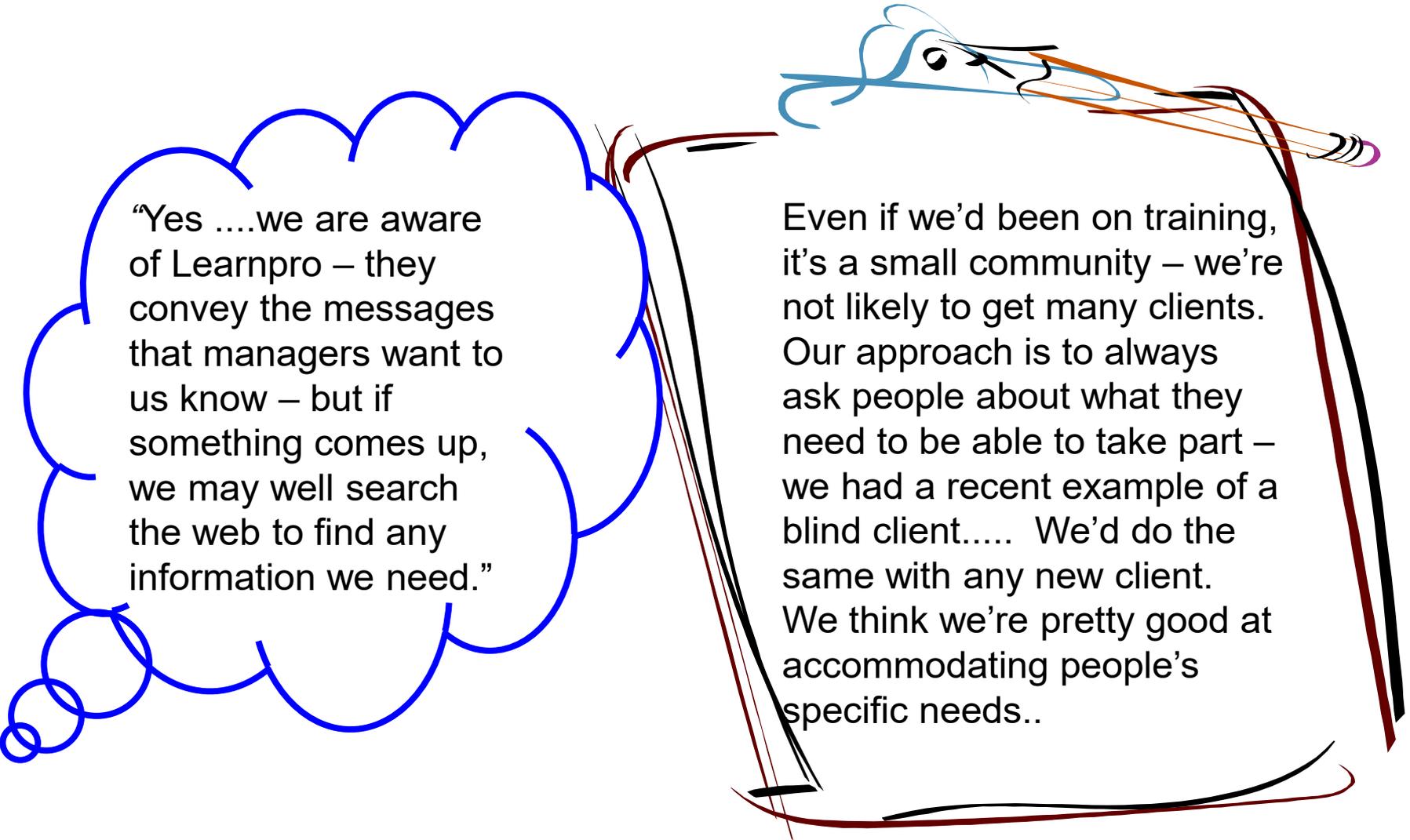
Our leaflets are really for the GP to give to the client – they’re not meant to be left lying around in the surgery – but they are. The content is OK – they are not in different languages, Braille or on DVD.



GPs **have** been told about our service – people just seem to get into a groove or assumption about how things work, and carry on.....

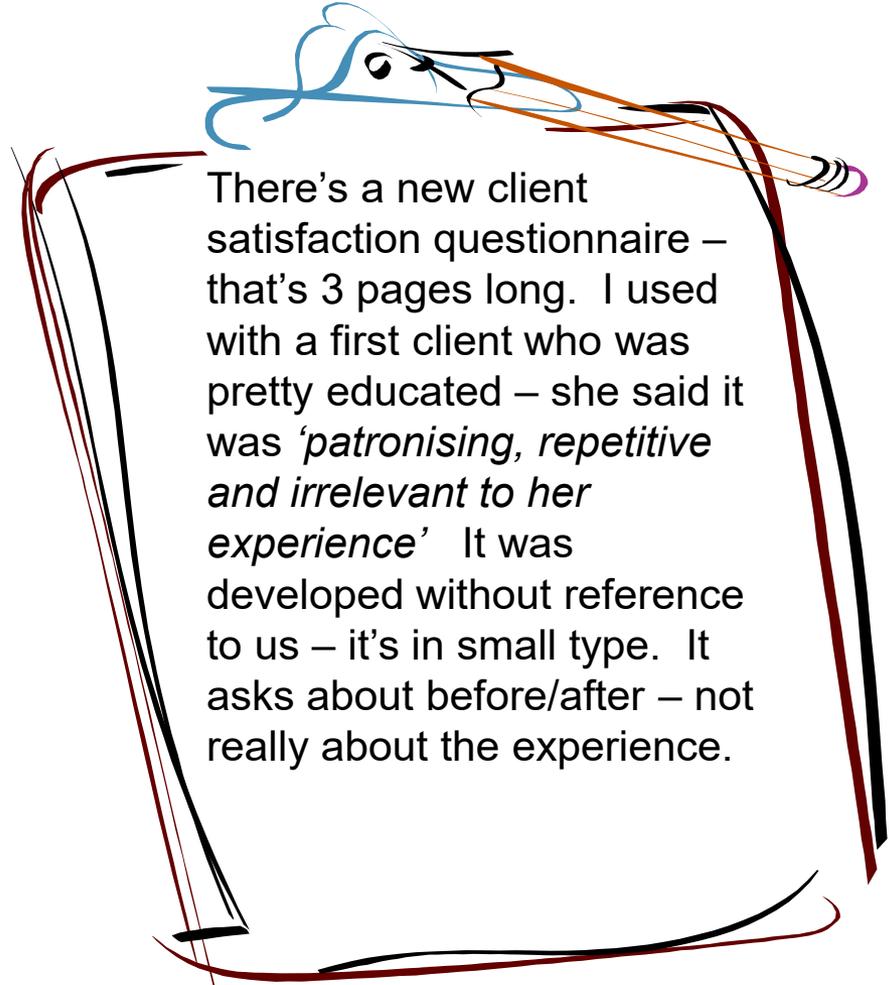


It’s a breakthrough to have a conversation with a GP. It came about opportunistically due to a cancellation and I was in the health centre.....

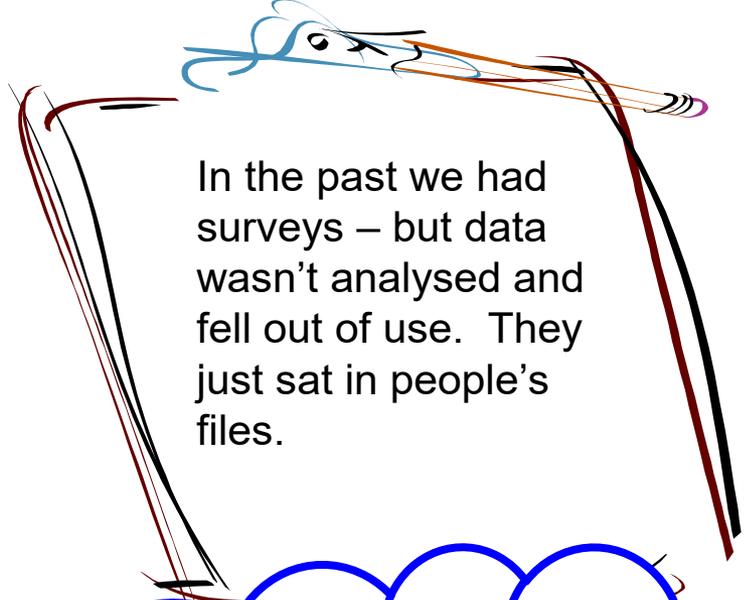


“Yes ....we are aware of Learnpro – they convey the messages that managers want to us know – but if something comes up, we may well search the web to find any information we need.”

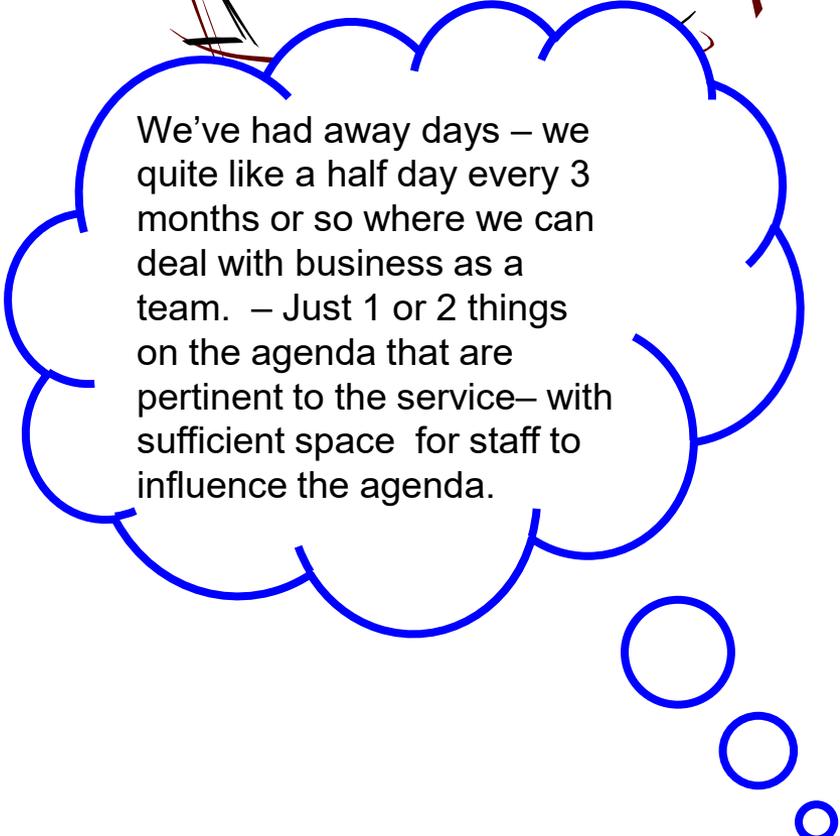
Even if we'd been on training, it's a small community – we're not likely to get many clients. Our approach is to always ask people about what they need to be able to take part – we had a recent example of a blind client..... We'd do the same with any new client. We think we're pretty good at accommodating people's specific needs..



There's a new client satisfaction questionnaire – that's 3 pages long. I used with a first client who was pretty educated – she said it was *'patronising, repetitive and irrelevant to her experience'* It was developed without reference to us – it's in small type. It asks about before/after – not really about the experience.



In the past we had surveys – but data wasn't analysed and fell out of use. They just sat in people's files.



We've had away days – we quite like a half day every 3 months or so where we can deal with business as a team. – Just 1 or 2 things on the agenda that are pertinent to the service– with sufficient space for staff to influence the agenda.

*Definition of Inequalities Sensitive Practice:* a way of working which responds to the life circumstances that affect people's health. Evidence shows that if these issues are not taken into account by the health service, opportunities are missed to improve health and to reduce health inequalities.

ISP takes place when the practitioner: understands the impact of experiences of inequality on a patient's life and health; understands power within the practitioner/ patient relationship and is committed to shifting the balance of power towards the patient; doesn't judge, is empathetic and has good listening skills which supports the individual to tell their story; challenges low expectations and raises the patient's aspirations in a sensitive way, providing alternative options and acting as an advocate when required to do so; is pro-active in ensuring their practice consistently promotes equalities and is non-discriminatory, and takes a person-centred approach.

What are we learning about inequalities sensitive practice?