Equalities In Health

NHS Greater Glasgow and Clyde

Inequalities Sensitive Practice Initiative

NHS Greater Glasgow and Clyde

Evidence Briefing Paper 1

April 2008

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1. Purpose of this Briefing Paper

This paper draws on the evidence briefing, written for the Inequalities Sensitive Practice Initiative (ISPI) by Avanté Consulting, and related documents. It summarises key evidence from the literature which provides information and knowledge supporting an inequalities sensitive practice approach to tackling health inequalities. It is hoped that this evidence briefing will provide useful information for those involved in developing and supporting an Inequalities Sensitive Practice approach at all levels and that it will provide a catalyst for debate amongst practitioners, planners, policy makers and researchers.

2. The Inequalities Sensitive Practice Initiative (ISPI)

The Inequalities Sensitive Practice Initiative (ISPI) is managed within the Corporate Inequalities Team of NHS Greater Glasgow and Clyde (NHSGGC). It is funded by the Scottish Government as part of the Multiple and Complex Needs Initiative, launched in 2006. There are many groups who find it difficult to access the services they need because they experience a range of barriers and discrimination. Examples of these groups are black and minority ethnic groups, migrant workers, asylum seekers, people experiencing homelessness, mental health issues, addictions, domestic abuse, various forms of disability, carers, ex-offenders and their families. Sometimes people are leading chaotic lifestyles. (Rosengard et al 2007)

The Hypothesis

ISPI is founded on the hypothesis that the development of inequalities sensitive practice is an effective approach which can impact positively on health inequalities. It draws on a body of literature that describes practice that has been undertaken / established within NHSGGC, in the UK and across wider European and international settings.

ISPI aims to support a sustainable shift in practice in four health and social care settings in order to mainstream an inequalities approach. It is focussing on four service areas:

a) Maternity
b) Integrated Children's Services
c) Community Addiction Teams
d) Primary Care Mental Health.

3. Poverty, Gender and Health Care - What Evidence is There?

While an abundance of evidence exists on the concept of health inequalities, there is a lack of robust evidence for improved outcomes from interventions (MacIntyre 2007). Scotland's health is worse than many European countries and the gap between the health of the rich and the poor is widening.

> Scotland, and in particular the West of Scotland, has recently been demonstrated to have one of the highest mortality rates in comparison with 20 other similar post industrial sites in Europe and the UK. The rate of improvement is slower than these other areas, in spite of relatively favourable comparisons in terms of wealth, unemployment and educational attainment (Walsh, Taulbut and Hanlon, 2008). In addition, the gap between the health of the top and the bottom of the social scale has widened as more advantaged social groups have experienced greater improvement in their health compared to that of less advantaged groups. This is partly because more affluent groups have higher levels of resources, in terms of finance, time and coping skills, to avail themselves of health promotion advice and preventive services, while the more disadvantaged find it harder to access services and change behaviour. Also, less affluent groups may benefit less from lifestyle changes because they are still exposed to wider health determinants which are detrimental to their health, such as poor working environments, unemployment, and poor housing. (MacIntyre 2007)

Policy and Practice

A Social Model of Health

Tackling health inequalities in Scotland through a social model of health has been a government priority since 1999 and there have been numerous policy documents since then, with the most recent being "Better health, better care" (Scottish Government, 2007). A useful model which explains the ways in which the determinants of health interact to impact on health and wellbeing is described by Dahlgren and Whitehead (1991). A shared understanding of the concept of health inequalities and recognition of the importance of a multi-agency approach are both important for improving health and reducing health inequalities. There is a need to take action in policy and practice on the key inequalities determinants of ethnicity, gender, disability, age, and geography for improving health and wellbeing, but there is an assumption that such actions will automatically tackle inequalities. (Graham and Kelly, 2004)

Gender and Poverty

> *The terms gender and sex can be confusing in the way they are used. In this paper sex is used to describe whether a person is born male or female, and gender is viewed as a social construct, created by social and cultural expectations, norms and stereotyping.*

The WHO policy briefing on gender inequity in health states that "gender inequality damages the health of millions of girls and women across the globe, and can also be harmful to men's health despite the many benefits to men through resources, power and control". (Senn and Ostlin 2007) The report explores the complex issues of gender inequity, its impact on the structural determinants of health, especially economic inequality and poverty. It demonstrates how lack of gender awareness in the delivery of health care systems contributes to gender inequity in health and identifies policy approaches, some of which relate particularly to the delivery of health services, health research and organisational development:

"Unequal, Unfair, Ineffective and Inefficient - Gender Inequity in Health: Why it exists and how we can change it." WHO 2007

Guidance on Policy Approaches

Health Services:

- provide comprehensive and essential health care to meet the differential needs of men and women
- train staff at all levels to understand and apply gender perspectives
- recognise women's contribution to the formal and informal health care systems
- strengthen accountability of health policy makers to gender and health care, incorporating gender into clinical audit and monitoring systems

Health Research:

- Ensure sex and gender are taken into account in all aspects of health research: data collection and analysis and data systems at all levels
- Include women in health studies in appropriate proportions and strengthen women's roles in research committees, funding and advisory bodies
- Broaden the scope of health research to link biomedical and social dimensions including gender

Organisational Development:

- Gender mainstreaming in government and non-government organisations has to be owned institutionally, funded adequately and implemented effectively
- Effective interventions for women's empowerment need to build on and reinforce authentic participation
- Support women's organisations which are critical to ensuring that women have voice and agency and whose access to resources has been declining in recent years

Gender Equality Duty

The introduction of the national policy Gender Equality Duty (GED) in Scotland is a response to the issue of gender blindness which most NHS modernisation policies have demonstrated (Doyal et al, 2003). GED is the law about taking action to prevent sex discrimination for both men and women. It involves:

- The need to raise awareness of gender and its impact on health across organisations
- Staff training and capacity building at all levels
- Engaging with gender based organisations
- Building gender into current equality impact assessment
- Assessing how gender fits with current activity under the Fair For All Initiative
- Focusing on outcomes: schemes and policies are not an end in themselves

Barriers to Implementing Gender Sensitive Care

There may be a significant barrier in implementing gender sensitive care, in terms of understanding the issues and the attitudes and beliefs held by some health care professionals. (Hart and Lockey 2001)

There is a necessity for practitioners to reflect on their own concepts of gender and gender identity and their experience of practice. (Miers, 2002; Hart and Lockey 2001) Gender issues have traditionally been informed by a feminist perspective, but recently the importance of gender analysis taking masculinities into account has been recognised (Doyal et al 2003). Men's health can be a significant entry point for tackling poverty and social exclusion and most services fail to respond to men's needs by addressing their concerns, going to places where they gather, using male workers and skills based training.

Poverty and Povertyism

A recent paper from the Joseph Rowntree Foundation (Killeen 2008) demonstrates how being poor in the United Kingdom can mean being subjected to discrimination on the grounds of poverty. This is described as povertyism and is akin to racism or sexism. Both poverty and discrimination are contrary to the spirit and terms of the Universal Declaration of Human Rights, and the paper argues that the failure to incorporate this into UK law has compounded social attitudes that denigrate people who experience poverty and that undermine popular support for policies to eradicate poverty.

Discrimination on grounds of poverty is also recognised in a recent Scottish Government discussion paper (2008) on tackling poverty, inequality and deprivation. It highlights the gendered nature of poverty and inequality and the need for gendered analysis and approaches. It emphasises the need to tackle both inequality and reduce poverty through economic growth and valuing the contribution of people.

4. Local Policy Development

NHSGGC has embarked on an attempt to bring about institutional change in order to maximise its contribution to addressing the causes and health consequences of the different forms of inequality and discrimination. There is a recognition of the challenges, namely:

- conflict between medical and social models of health and roles as drivers of change
- lack of understanding about inequalities in a health care context
- institutional discrimination
- institutional inertia

A range of measures has been put into place by NHSGGC to support its endeavours to change including:

- A contextual landscape comprising transformational themes, corporate plan, Equality Scheme and antipoverty work
- The new structural framework comprising corporate and federal systems
- **Within this context ISPI has been set up to be one of the tools which will help NHSGGC and its partners in the delivery of integrated services, find out what will improve the effectiveness and efficiency of frontline practice and to determine what type of planning and policy arrangements are required to facilitate and sustain those practice changes**

Within NHSGGC ten goals have been identified for development of the 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.

5. Translating Policy into Practice

The challenge of turning policy into practice is a key theme in the literature, and national policy and strategy documents are often criticised for lacking specific guidance for practitioners. Conversely, a key predictor of whether developments at a local level are mainstreamed is the degree to which they are underpinned by policy.

Elements of good practice are identified in a literature review on multiple and complex needs for the Scottish Government (Rosengard et al 2007):

- providing information in accessible formats that are age, gender and culturally sensitive, and easy to understand
- reaching out to people, including through pro-active and persistent outreach services
- enabling access to services when the service user is ready to engage without lengthy waiting times and through user friendly opening hours, convenience of location, use of IT and one stop models
- easy access points and integrated front line services for people with multiple and complex needs particularly in deprived areas

The Scottish Government has established a Ministerial Task Force on Health Inequalities whose remit tackles these issues and which has to report to Cabinet by summer 2008. The purpose of the Task Force is to achieve measurable outcomes in reducing inequalities through:

- agreeing priorities for cross-cutting government activity
- identify practical measures
- ensure key sectors and organisations that are involved with the Task Force in order to build commitment and support

A number of authors have identified requirements for translating policy into practice: Pettigrew et al (1992), Blackburn (1996), Hart and Lockey (2001), Miers (2002), Hunter and Killoran (2004), Mackenzie and Lawson (2004), and Blamey et al (2006).

Planning

- horizontal planning rather than vertical silos
- co-operative inter-agency networks
- strategic planning and management at local level, with quality and coherent policy, simplicity of goals and key people to lead change

Management

- commitment and strong leadership from managers
- good managerial professional relationships and competency for operating effectively in today's challenging environment
- supportive organisational culture
- taking account of differing perceptions of disadvantage at practitioner level

Practitioners

- clear guidelines for practitioners with consensus on who is a 'disadvantaged' client
- learning from good practice through evaluation and reflective practice
- building a more overt poverty and gender perspective into practice through:
  - profiling and monitoring
  - working for social change
  - team work rather than individualistic approach, involving team training
  - building responsive and integrated support structures

The following barriers to translating policy into practice in public health and primary care have been identified (Gillam and Florin 2002):

- Gaps in knowledge regarding effective interventions
- Partial understanding of the barriers to implementation
- Failure to synthesise existing evidence
- A consistent failure to address the opportunity costs of new or different activities in primary care (increasing public health role means doing less of something else)
- A failure to address adequately, and with all relevant stakeholders, the role of primary care
- Resource constraints

6. The Local Picture - Three Pilot Projects

The Women's Mental Health Demonstration Project (Bridgeton project)

The Women's Mental Health Demonstration Project (WMHP) was developed in 2002 and aimed to develop a social model of care for women presenting within Bridgeton Local Health Care Cooperative with mild to moderate mental health difficulties. Based on best practice guidelines and evidence from across the UK and beyond it aimed to develop and pilot a model of care and to influence wider mainstream policy and practice.

The women were offered the opportunity to be referred to the project worker, who case-worked women largely on an individual basis and provided a range of services tackling a wide range of problems. All those assessed described multiple problems of a psychosocial and social nature. These included:

- difficult relationships with members of their family or with friends
- high levels of sexual, physical and emotional abuse and most women were disclosing to a professional for the first time ever
- low levels of esteem
- high levels of anxiety/depression in relation to their social determinants (for example, housing problems, financial difficulties and issues of personal safety)

The project produced a range of evidence of good practice and practitioner change, through awareness of the social model of health. Good leadership was acknowledged as important for achieving the outcomes. The following recommendations were made in relation to planning and delivery of holistic models of primary care, informed by an understanding of how inequalities shape health outcomes:

- The use of ***monitoring data*** provides potent evidence of the nature of the lives of many women living in vulnerable circumstances. The levels of abuse and inequalities revealed should continue to be used to promote action.
- ***Case-studies*** represent valuable tools for raising awareness and developing good practice. Their use in training and dissemination activities is endorsed.
- More systematic methods such as ***audit and performance management systems*** are required as not all practitioners are amenable to change through training, etc.
- There are ***skills and resource gaps*** in Primary Care Mental Health Teams which relate to a philosophy that may not fit with a social model of health and provision of holistic models of care. These need to be tackled with some urgency.

Clydebank Mental Health Service Pilot

The remit of the pilot was to look at the existing understanding and delivery of gender sensitive service provision within Mental Health Services, and to identify and develop ways of practice that would increase the mainstreaming of gender inequalities responses to mental health and wellbeing. A specific worker was employed as Equality & Mental Health Development Co-ordinator, whose remit was to facilitate a wider understanding and systematic response. The work of the pilot project focussed on gender sensitivity:

- Auditing client and staff perceptions to current approaches in relation to gender sensitivity and views of relevance in Clydebank Mental Health Services.
- Identifying how gender sensitivity is incorporated in service accessibility, assessment, interventions and care pathways.
- Identifying how gender sensitivity is addressed in management, staff support systems and policies.

The evaluation of the project found that:

- Gender has an impact on the likelihood of developing mental illness and specific disorders and on the nature and the experience of the diagnosis. For example, the origins of risk and prevalence of suicide and self harm are different between the sexes.
- Raising awareness and confidence of staff was seen as important because there is a view that treating people as individuals takes gender into account, but this fails to apply an awareness of how gender is relevant to the understanding of and response to mental ill health.

Other recommendations include:

- Choice of sex of worker
- Staff have clear pathways for referral to non-clinical support for domestic abuse, training and role clarification for this and sexual abuse
- Better data recording systems allowing disaggregating by gender
- Further work with managers and staff on perceptions of gender issues
- Continue links with management systems for implementing ISP

Domestic Abuse Link Midwife Project

The demonstration project aimed to provide a dedicated support and advice midwifery service for domestic abuse. It was located within the context of a wider programme of work on gender-based violence within NHS Greater Glasgow and the health care response at policy and operational levels, as well as the recommendations regarding the response of maternity services to domestic abuse.

Three link midwives were appointed to each of the three maternity sites in Glasgow, which provide different models of maternity care. The remit of the link midwives was to:

- support midwives directly in responding to disclosures of abuse
- identify their training and development needs
- provide opportunities for reflective practice
- provide a link into community supports
- assist in the process of introducing change

The evaluation report (Mackenzie and Lawson, 2004) discusses the significance of supporting policy, mainstreaming the role of the midwife, the value of training and support, and the importance of monitoring data. It also highlights the challenges to be faced in changing attitudes and values. The impact on practice and policy was evaluated as:

- Increased the knowledge and confidence of staff and has been instrumental in pushing forward strategic level changes, e.g., a new system of documentation
- Employed an effective staff training model
- Raised issues about clarity of role in connection with domestic abuse
- Positive feedback received from those at a strategic level
- Highlighted the need for a multi-agency approach
- Staff have increased their number of contacts dramatically and have developed broad approaches to dealing with a wide range of problems associated with domestic abuse
- Provided information on the details of appropriate monitoring data collection

7. Summary and Conclusions

The findings from this review of the literature suggest that there is common agreement that the development of inequalities sensitive practice is challenging and that significant cultural and attitudinal change, at organisational and individual level, are needed to develop this kind of approach. In addition, there is a clear indication that effective change requires adequate time and resources.

Levers for successful implementation include:

- Policies which are clear and include practical guidance
- Strategic commitment and effective leadership
- A common purpose and shared understanding of desired outcomes
- Robust evidence linked to approaches presented as 'successful'
- Co-ordinated planning between organisations
- Sufficient resources
- Allocation of realistic time-frames for projects

In summary, successful activity has been supported by strong motivation and commitment on the part of key individuals, clear outcomes, and ongoing evaluation, reflection and learning.

ISPI's key objectives reflect a response to the findings from the literature:

1) To describe the key elements and drivers of each model in light of current stage of development to highlight both the similarities and their setting-specific components.
2) To determine the nature of the policy, organisational and practice enablers and inhibitors which allow for the successful implementation of each of the model developments.
3) To define the appropriate planning frameworks for informing and integrating each model into mainstream service provision.
4) To identify current strengths and weaknesses in current data collection systems for sensitivity to gender and socio-economic status.
5) 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.
6) To utilise the findings of the overall evaluation to inform policy, planning and performance management.

ISPI recognises the following challenges in achieving its objectives:

a) levels of understanding by staff in the service settings
b) motivation for change
c) clarifying the characteristics of leadership and operational change
d) buy-in that inequalities sensitive practice is a standard part of the job and that people are therefore accountable

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