Inequalities Sensitive Practice Initiative
Interim Report - December 2007

Evaluation
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1. Introduction

The Inequalities Sensitive Practice Initiative (ISPI) was established within NHS Greater Glasgow and Clyde in 2006, funded by the former Scottish Executive as part of a programme of work across public sector organisations designed to improve the mainstream response to people experiencing multiple disadvantage. The strategic aim of the initiative is to embed inequality sensitive practice in and across the diverse health and social care settings. The operational aim of the initiative is to identify and establish the mechanisms for extending and integrating the development work into the mainstream delivery of all four systems and to identify ways of assessing the impact on overall health gain of the recipients of the services.

Four specific developments already located with NHS Greater Glasgow and Clyde, each at different stages of implementation and in different settings, were selected as the basis for the initiative. Each of these developments had adopted a model of health and social care which recognised the need to extend beyond the traditional, medicalised responses to the health consequences of inequality, and acknowledged the relationship between poverty and gender. Together, they formed a set of services likely to be accessed by families facing particular combinations of problems and which need to be consistent in their response. These services were as follows:

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

Within the original submission to the Scottish Executive, inequalities sensitive practice is described as

“a new construct in which we will describe and implement a form of transaction between practitioner and client/patient which contextualises health and social care presentations.”

ISPI seeks to support an approach to the delivery of health and social care services which enables the client to disclose a range of factors pertinent to poor health and wellbeing, thus legitimising their individual experiences and resulting in a more holistic approach to managing poor health or social problems.
Implementing ISPI

In order to take forward this initiative, a team of senior staff was appointed in 2006, to be managed by a Project Co-ordinator. Within the team, there is a ‘Project Lead’ for each setting, each of whom have a sound understanding of poverty and gender issues. All of the team are experienced in organisational systems development in order to maximise the further development of work carried out prior to the initiative. In addition to managing and co-ordinating the work of the team, it is the responsibility of the Project Co-ordinator to ensure that strategic links are established into emerging corporate and setting-specific planning mechanisms. In addition, the ISPI team includes a Learning and Development Officer, whose role is to facilitate training and learning for inequalities sensitive practice and to support a greater understanding of inequalities amongst planners and managers in the four settings. The team is supported by a Project Administrator.

The initiative is led by a Steering Group which is comprised of senior representatives from NHSGGC, the Corporate Inequalities Team, Women’s and Children’s Directorate, and Community Health and Social Care Partnerships (encompassing general and children’s services planning, addictions planning, and primary care mental health development). In addition, there are currently four setting-specific steering groups. A decision has yet to be reached as to whether or not there should be a steering group for learning and development. Within Maternity Services, the steering group is further supported by a Working Group, comprised of midwives and other stakeholders, who play a crucial role in supporting the initiative at practitioner level. Within Addictions, the steering group is further supported by a Task Group consisting of representatives from the Community Addiction Teams.

Evaluating ISPI

From the outset, it was recognised that ongoing monitoring and evaluation would be crucial to the success of this project, both to inform further developments within NHSGGC and to provide the tools for replication within other health and social care organisations. It was decided, therefore, to appoint an external consultancy to fulfil this role. Avanté Consulting was appointed as consultants to ISPI in Spring 2007. The evaluation of ISPI is both iterative and formative, thus creating the opportunity for regular reviews of progress as well as assessing the overall impact at the end of the initiative.

This interim report provides a summary of the evaluation process and findings at the end of 2007.
2. Context

In comparison with the rest of Western Europe, Scotland has a poor health record. Furthermore, variations within the country reveal that the area covered by NHS GG&C, particularly Glasgow, has significantly poorer health than the rest of the country and that Britain’s least healthy area is to be found in Glasgow.

**City of Glasgow**

At the same time, the 2006 Scottish Index of Multiple Deprivation confirms that Glasgow City contains almost 33.8% of those areas in the most deprived 15% of data zones (www.scotland.gov.uk).

Community profiles produced recently by the Glasgow Centre for Population Health provide the following statistics (www.gcph.org.uk):

- In North and East Glasgow, life expectancy for men (at birth) is estimated to be 68.1 years, over five years lower than the Scottish average, and has risen by less than a year in the period 1994-98 to 2001-05. Female life expectancy in East Glasgow is approximately three years lower than the Scottish average, whilst in North Glasgow that figure remains at four years.
- In East Glasgow, over 1,960 patients are admitted to hospital annually for alcohol related or attributable causes and there have been over 420 deaths due to alcohol in the last five years.
- An estimated 34% of adults across Glasgow’s five Community Health Care Partnership areas smoke, compared to 27% nationally. 30% of the population are defined to be income deprived.
- The average rate of low birth-weight babies across all areas of Glasgow is 50% above the Scottish average. In East Glasgow, the teenage pregnancy rate is 42% above the national average; in North Glasgow, that figure is 61%.

GCPH statistics provide the following information on communities within the Clyde area:

**Renfrewshire**

- 14.9% of the population are defined to be income deprived.
- Compared to 24% nationally, 25% of women smoke during pregnancy, and 31% of mothers breast feed at six to eight weeks following birth (36% nationally).

**West Dunbartonshire**

- Nearly 18,000 people, 19.7% of the population, are defined to be income deprived and 9,800 adults, 7.0% of the working age population, are employment deprived.
- The rate of low birth-weight babies is 27% above the Scottish average and the infant mortality rate is 80% above the average. The teenage pregnancy rate is 12% higher than the national average.

**Inverclyde**

- Comparing different areas of the community, there is a gap in life expectancy across the neighbourhoods of over 11 years for men and over 13 years for women.
- Over 1,100 patients are admitted to hospital annually for alcohol related or attributable causes and there have been 212 deaths due to alcohol in the last five years. There have been 89 drug related deaths in Inverclyde over the last ten years.
• There were 82 suicides in the period 2001-2005 and there are approximately 370 new in-patient admissions to psychiatric specialties annually.
• The infant mortality rate is 76% above the Scottish average, while the teenage pregnancy rate is 15% above the national average.

The new Scottish Government, elected in May 2007, is establishing its priorities and policies, but Closing the Opportunity Gap (CiOG), introduced by the former Scottish Executive in 2005, continues to influence the development of Scotland’s health services. CiOG’s six key objectives and ten targets are set out in Appendix One.

One of the six key objectives of CiOG was:
• To increase the rate of improvement of the health status of people living in the most deprived communities – in order to improve their quality of life, including their employability prospects.

At the same time, mainstreaming equality has been a government priority since 2000 and the publication of ‘Working Together for Equality’, its Equality Strategy. ‘Mainstreaming equality’ is described in that document as ‘the systematic integration of an equality perspective into the everyday work of government across all departments’. Since then, a raft of policies has addressed issues of inequality and health.

In 2005, the Minister for Health and Community Care launched the paper ‘Delivering for Health 2005’ and gave a commitment to strengthen and enhance primary care services in deprived areas to reduce inequalities by:
• targeting health improvement action and resources at the most disadvantaged areas;
• building capacity in primary care to deliver proactive, preventative care;
• providing early interventions to prevent escalation of health care needs; and
• implementing this approach in up to 5 Community Health Partnerships starting in 2006/07 and a further 7 Community Health Partnerships starting in 2007/2008.

This approach, originally known as Prevention 2010, is now called ‘Keep well’.

Since the Black Report (Department of Health & Social Security, 1980), the increasing gap in British health and life expectancy has been well documented, highlighting the differences experienced by people living in poverty and those living in prosperity. Recent research conducted by R Wilkinson (Impact of Inequality 2005) has developed his previously researched themes on the status of those in poverty to show that income poverty is further compounded by the experience of inequalities in access to services and in the quality of social relations in and between different socio-economic groupings.

Against this backdrop, recent studies have focussed on the concepts of ‘complex’ and ‘multiple’ disadvantages and, consequently, needs. Research carried out by Rankin and Regan (2004) identified the essence of complex needs as implying both breadth of need (more than one need, with multiple needs interconnected) and depth of need (profound, severe, serious or intense needs). These issues are explored further by Ann Rosengard et al in a review conducted as part of the Scotland-wide Multiple and Complex Needs Initiative (A Literature Review on Multiple and Complex Needs, 2007, www.scotland.gov.uk/socialresearch).

Of recent significance is the fact that, following the publication of the Healthier Scotland Cabinet Paper in June 2007, the recently-elected Scottish Government has established a Ministerial Task Force on Health Inequalities, chaired by Public Health Minister Shona Robison. The purpose of the Task Force is to:
In evaluating ISPI, we are seeking to address 13 questions:

1. Where is the current evidence of effective inequalities sensitive practice at operational, planning and policy levels within NHS GG&C?
2. Are there any gaps and emerging patterns that exist in relation to these fields and health inequalities?

3. Is there an agreed definition of inequalities sensitive practice in each of the four priority settings in relation to gender and poverty and, if so, how that definition has been achieved?

4. What are the specific factors that influenced, negatively and positively, the reaching of an agreement on what constitutes inequalities sensitive practice, in each specific setting and across all four?

5. To what extent has the ISPI team contributed to an enhanced understanding of inequalities and inequalities sensitive practice, and practice changes amongst staff in each of the four areas?

6. To what extent can staff evidence change in practice that reflect an understanding and acknowledgement of the significance of gender and poverty issues in relation to the assessment and management of health presentations?

7. To what extent are service users aware that issues relating to poverty and gender are taken into account when accessing health services within each of the four settings?

8. To what extent can managers and planners from within each setting evidence changes that have arisen in response to the aspirations of inequalities sensitive practice, both within and across the settings?

9. To what extent are these changes linked to implementation plans for the key strategic drivers, such as the Planning Guidance and the Equality Scheme?

10. To what extent are these key strategic drivers significant in supporting changes within and across the settings?

11. To what extent has the ISPI team, associated steering group and the Corporate Inequalities Team been successful in supporting staff to prioritise inequalities sensitive practice against other organisational priorities and demands e.g. time constraints, waiting list demands and staff shortages?

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

13. What are the key elements of effective inequalities sensitive practice that are relevant, appropriate, and transferable to other settings and organisations?

The evaluation plan is based upon 4 key elements:

- The shape and size of ISPI overall, as well as its individual settings;
- Contact with staff – intentional, unintentional, and instances where staff are resisting contact;
- Spheres of control and spheres of influence;
- Shifts in awareness and practice.

Each of these elements links to one or more of the key outcomes and at least one of the evaluation questions, as follows:

A. The shape and size of ISPI overall, as well as its individual settings:

By exploring the shape and size of ISPI, we can establish what is happening within the initiative, where, and with whom. This information will guide the consultants in terms of potential informants, and will define the operational structures and stakeholder groups which are supporting the work of ISPI.

Relating to: ISPI Outcome 1
B Contact with staff – intentional, unintentional, and instances where staff are resisting contact:
Throughout the evaluation, the consultants are in touch with a wide range of staff members, across all of the agencies, including those directly involved in ISPI, those not directly ‘targeted’ through ISPI but who, through personal interest or association with colleagues, have become aware of the work of ISPI, and finally, individuals who have been given the opportunity to be involved in ISPI but who have ‘opted out’.

These discussions can determine the extent to which there is an agreed definition of inequalities sensitive practice in the four settings, how it has been achieved, and factors that have influenced (and hindered) that agreement. In addition, they can provide an indication of the extent to which the ISPI team is contributing to an understanding of inequalities and ISP, and help to identify practice changes.

Relating to: ISPI Outcomes 1, 2, and 3; Evaluation questions 3, 4, 5, and 11

C Spheres of control and spheres of influence:
Across the four settings, there are situations where ISPI can be expected to have a direct effect. By studying these situations, we may find gaps and/or emerging patterns. We may also be able to identify those factors which help the development of ISPI and, at the same time, those which hinder its development.

Similarly, there are situations where ISPI may influence behaviour – instances where staff are aware of and interested in the significance of ISP and are seeking to learn from ISPI on a voluntary basis. Once again, these situations will contribute to our understanding of what helps and what hinders the development of ISP.

Relating to: ISPI Outcomes 2, 4, and 5; Evaluation questions 2, 4, 5, 9, 11, and 12

D Shifts in awareness, understanding, and practice
Finally, the evaluation seeks to identify shifts in awareness and understanding of what is meant by ‘inequalities sensitive practice’ and ways in which individuals, teams, and services have changed their practice as a result. At the outset, the evaluation will seek to establish a general ‘baseline’, to establish the point at which staff are entering the initiative. This baseline will provide the means by which impact/progress can be measured throughout the course of the initiative.

Relating to: ISPI Outcome 6 Evaluation questions 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, and 13

Methods
The methods to be employed throughout the evaluation include individual interviews (face to face and telephone), questionnaires, focus groups, workshops, and observations. In addition to this, an evidence briefing has been prepared in order to highlight literature which addresses issues of poverty, gender, and inequality in relation to health, particularly in relation to practice change and development. This evidence briefing will be updated throughout the course of the initiative in order to take account of emerging research.

This first interim report is based upon a series of 46 individual interviews (face-to-face and telephone) with staff across all four settings, at policy, planning, and practice levels, and members of the Steering Group, together with a review of current policy documents, and a literature search. A summary of the interview questions, together with a description of the range of staff interviewed, is provided at Appendix Two.
4. Key Findings

4.1 Shape and Size of ISPI - the ‘starting point’

The evaluation of ISPI began in April 2006, by which time the staff team had been in place for approximately six months, and the Setting Steering Groups had been established. Within the Maternity Services setting, it had been agreed also to establish a Working Group, comprised of midwives and other interested individuals, recognising that they would play a key role in the ongoing development and delivery of ISP.

As indicated in Section 1, the ‘starting point’ for each of the four settings varied significantly, particularly in terms of organisational structures.

Maternity Services

The Maternity Services setting covers all maternity services across NHS Greater Glasgow and Clyde. The achievements of the Women’s Reproductive Health Service (WRHS), an inpatient and community based service for women with the most complex health and social care needs, are widely recognised. There is also a commitment to the mainstreaming of inequalities sensitive practice across the system in order to ensure equity of service.

Interviewees confirmed that the merger between the areas of Glasgow and Clyde has impacted significantly upon the implementation of ISPI, positively and negatively. As well as learning from the approach which has been developed within the WRHS, respondents suggested that there was now the opportunity to consider the different approach which has been pioneered through the ‘SNIP (special needs in pregnancy)’ project in Clyde. At the same time, however, respondents indicated that the re-structuring of services had caused considerable unrest amongst staff and, in some instances, had contributed to a lack of motivation and an unwillingness to engage in what is sometimes viewed as ‘yet another initiative’.

Addictions Services

The Community Addictions Teams (CATs) have been in place for some considerable time. Interviews with Setting Implementation Group representatives indicated that team working across the CATs is well-established and that multi-agency working is now the norm. Inequalities issues have been integrated into CAT service specifications and work is already underway in relation to race, disability, gender, and sexuality.

The Gender Toolkit seeks to involve staff in identifying areas of good practice and areas of change through action planning and associated training. Consequently, there is widespread acknowledgement of the links between inequalities upon health and wellbeing, and the implications for service delivery and practice. Furthermore, there is clear recognition of the value of examining different approaches to service delivery and practice.

The appointment of a member of the CAT staff as Project Lead was acknowledged as a real bonus, as she was in a position to ‘hit the ground running’ and was known to CAT team members.

Integrated Children’s Services

Located within the area of Greater Glasgow, across the five Community Health & Social Care Partnership areas, this setting was at a very different stage in its development. The establishment of ten Parent and Children Together teams was underway; Team Leaders had been appointed, but teams were not yet fully staffed. The creation of integrated teams, therefore, was far from complete. As a result, there were considerable difficulties in launching ISPI. Interviewees indicated that there were practical difficulties in taking ISPI on board, due mainly to the fact that the PACT teams were at that stage too busy getting themselves ‘up and running’. These practical issues appear to have contributed to a general lack of understanding of the aims and objectives of ISPI and, consequently, reluctance on the part of some staff to engage fully with the initiative at the outset. This was
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evidenced by the difficulties in securing the attendance of Team Leaders at workshops and the decision by the Project Lead to restrict the length of any such events simply to try to ensure a better attendance. In order to take account of these issues and progress with the initiative, the Project Lead developed a staged approach to her work, working initially with teams in the East and South areas where the establishment of the new PACT teams was further advanced.

Primary Care Mental Health

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

The Project Lead for this Setting was located within the South West Primary Care Mental Health Team, the first to be established in Spring 2005. Work was also underway within the North area, and there was contact with Clydebank and East Glasgow.

Learning and Development

The shape and size of the learning and development element of the initiative relates to the shape and size of the overall initiative and its individual settings. To date, there has been activity across all of the settings, including a series of workshops within the Maternity Setting within which practitioners were invited to explore the meaning of ISP within maternity services, as well as training events within Integrated Children’s Services, Addictions Services, and, to some extent, Primary Care Mental Health.

Community Health and Care Partnerships

The development of Community Health Care Partnerships/Community Health Partnerships, bringing together a range of statutory and voluntary services across Greater Glasgow and Clyde, were highlighted by interviewees as a very significant opportunity for ISPI. These new structures have acknowledged already the value of multi-agency working. The establishment of the new staff teams will be supported by joint training and service development. Raising awareness of ISP will enable staff to take account of relevant issues within service redesign and will support practice change at a time when staff are ready and willing to adopt new ways of working. Many respondents suggested that currently there is a great deal of enthusiasm amongst health and social work staff for multi-agency working and for the concept of inequalities sensitive practice, supported by the evident ‘buy-in’ at NHS Board level.

4.2 Contact with Staff – intentional and unintentional

At the start of the evaluation process, the consultants sought to speak to a range of staff already engaged in ISPI. It became apparent that, at this stage, those members of staff involved in the initiative included mainly policy makers, managers, and practitioners, all of whom share responsibility for driving the initiative. They included:

- Members of the Steering Group
- Members of the Setting Implementation Groups
- Members of the Maternity Working Group
- Members of the Addictions Task Group
- Members of the Project Team
Inequalities Sensitive Practice Initiative

Maternity Services

The Maternity Services setting is concerned with all maternity services across the entire area of Greater Glasgow and Clyde. Consequently, this setting is attempting to reach a much larger, more diverse group of staff than within the other settings. As a result, the approach which has been adopted within Maternity Services differs significantly from the other three settings.

In addition to the Setting Implementation Group, this setting has established a Working Group, comprised of a range of middle management practitioners across health and social care services. It is widely recognised that each of these individuals has a significant role to play in terms of supporting and developing the concept of inequalities sensitive practice and their effective engagement in ISPI is crucial to its longer-term impact. This group is seeking, in the first instance, to map out the situation regarding inequalities sensitive practice across the maternity services before designing a tailored intervention, to include care pathways, care standards, and learning and development. The Project Lead has also conducted an extensive survey of maternity service users in order to gather baseline information about current services. Whilst this work is underway, the Project Lead has also met with approximately 8 groups of maternity services staff, discussing with them the project and the concept of inequalities sensitive practice. The purpose of these discussions has been to raise awareness and understanding in order that they might engage fully with subsequent ISPI-related activities. Furthermore, these discussions have provided the Project Lead with information which will inform future activities.

Evidence of resistance

It was noted, however, that even within this group of staff, all of whom could be described as having a responsibility for driving this initiative, there were difficulties in securing the co-operation of staff members. Several individuals did not respond to the e-mail and telephone requests to take part in an interview, whilst one individual stated that she was too busy and could not spare the time to speak to the consultants. This suggested that, even amongst the ‘drivers’ of the initiative, there were barriers to involvement.

Addictions Services

To date, contact with staff in Addictions Services has been via the Task Group which is comprised of representatives from thirteen Community Addiction Teams. These representatives include Senior Addiction Workers (Social Work Services) and experienced Nursing Staff (formerly G grade level, now Band 6). These staff are all operating at middle management level, and have been selected on the basis that they have dual management and practice responsibilities. These individuals can play a key role in terms of influencing staff through their daily contact with the teams and, as in Maternity Services, are recognised as the ‘drivers’ for ISPI, both during the project and beyond.

Members of the Task Group have also been identified as individuals who are interested in and committed to the principles of inequalities sensitive practice and therefore ready and willing to engage with ISPI’s work. Not surprisingly, therefore, there is no evidence of resistance within the Addictions Services.

As in the other settings, there is regular contact with the Setting Implementation Group, whose members are operating at strategic and at operational levels across the Addictions Services.

In late 2007, an event was organised for voluntary organisations with a view to raising awareness about the initiative, its aims and objectives. Unfortunately, this event was cancelled due to a very low response rate.

Integrated Children’s Services

As indicated in section 3, contact across the PACT Teams has been difficult to establish. Whilst the Project Lead has sought to establish working relationships with PACT Team Leaders, there were at the outset significant difficulties in engaging with these individuals. As one interviewee explained:
“The PACT teams are very new – I’m not sure how well the team leaders are buying in to this.”

More recently, however, there has been a better response from Team Leaders - contact was becoming more regular and more consistent than at the start of the initiative.

Other members of the PACT Teams have been engaged in ISPI via a training needs analysis which was conducted via an electronic questionnaire. The response rate was high – over 75%.

**Primary Care Mental Health**

As indicated in section 3.1, contact within the Primary Care Mental Health setting has been mainly with staff located within the South West PCMH Team. There has also been some contact with the North team, and initial contacts have been established with staff in Clydebank and East Glasgow. Individuals in contact with ISPI include members of the Setting Implementation Group and the Mental Health Team Leaders. At this stage, the project’s ‘reach’ has not extended beyond these highly-involved individuals.

It is clear that the location of the Project Lead within the South West Team’s office base has been of considerable value in terms of contact.

**Learning and Development**

At the time of writing this report, the Setting Implementation Group for Learning and Development had not been meeting and there was uncertainty as to whether or not there was a need for such a Group. However, it was acknowledged that the re-establishment of a SIG could assist in ensuring better connection and integration with mainstream learning and development services.

In terms of contact with the individual settings, the Learning & Development Project Lead has been working alongside the Project Leads and in contact with the same range of people. It was indicated that, as yet, there had been little or no contact with mainstream learning and development services.

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4.3 Control and Influence

By this stage, the work of the Project Team has being conducted largely through discussion and debate, supported by a range of training workshops. Respondents all emphasised the quality of the training provided by the ISPI team and acknowledged the value of the support provided by Project Leads and the Learning and Development Officer. In addition, there is evidence of the ISPI Project Team, particularly the Project Co-ordinator and, in addition, members of the Steering Group being involved in a wide range of strategic partnership groups, where they have been in a position to raise awareness of the concept of ISP and promote its inclusion in key strategies and policies.

Respondents all acknowledged the importance of inequalities sensitive practice, and were committed to its development across the services. However, as yet, there appeared to be no clear, shared understanding of exactly what constitutes ISP. In the words of one respondent:

“Most people working face to face with children and families have some understanding of the concept. I’m not sure, however, that that’s what they would call it. One of the challenges of the project might be about identifying good practice under that heading – at the moment, they might call it ‘working with vulnerable families’.”

When prompted, only a small number of interviewees were able to offer examples of instances where practice is sensitive to inequalities. However, interviewees confirmed that the activities of the ISPI team have contributed significantly to their awareness and understanding of the concept of ISP and, as a result, have influenced their attitudes, behaviour, and approaches to service design and delivery.
In order for ISPI to exercise any degree of control over service design and delivery, it was suggested by respondents, within each of the settings, that there is a need to establish clear criteria for ISP, based upon a shared definition. One NHS respondent suggested:

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

A similar view, expressed by a representative of Social Work Services was:

“We are talking about terminology, but there is no common currency. We talk a different language about the same thing. We all have very advanced approaches to equalities and inequalities. But what’s clear is that we use equalities, they use inequalities. So I’m not sure what ISP will bring to what we do.”

There was a concern, also, that the concept itself is not sufficiently well understood at strategic and policy levels and that, consequently, it is not given sufficient ‘weight’. As one respondent explained:

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

4.4 Shifts in Awareness, Understanding, and Practice

The funding application document submitted to the Scottish Executive provides the following explanation:

“The development of Inequalities Sensitive Practice is a new construct in which we will describe and implement a form of transaction between practitioner and client/patient which contextualises health and social care presentations.”

It would appear that, at this stage, there is a growing awareness and understanding of this construct, but limited evidence of any real changes in practice.

Describing Inequalities Sensitive Practice

The most frequent responses to this question were based upon the belief that ISP is about tailoring services to the needs of the individual, and ensuring that services are person-centred. When asked to describe ISP, a typical response was:

“It’s about taking a person’s whole life circumstances into account and not making assumptions. Inequalities affect your whole life.”

There was a very clear recognition of the significance of inequalities with regard to health and wellbeing, and widespread commitment to its development. However, as yet, there would appear to be no clear, shared understanding of what constitutes ISP. In the words of two interviewees:

“In order to make an impact, one has to understand the concept – what does it mean for the individual member of staff who could in fact make a difference? Do they understand the concept? Can it inform their practice?”

“In a general sense, the connection between inequalities and health is well understood. But when it comes to practice, there is much less understanding. The practice is poorly understood.”

It was acknowledged by all interviewees, however, that it is vitally important to take account of other circumstances in a person’s life, over and above the issue which has prompted the intervention or referral. All recognised that individual ‘starting points’ vary from person to person and, in addition, emphasised the need to take account of access issues, including language and physical barriers. Many people added that community-based services can offer a more appropriate and sensitive way of reaching people with multiple and complex needs.
**Describing ISPI**

ISPI was described by almost all respondents as a project which is raising awareness and understanding of inequalities and their impact upon health and wellbeing. Respondents appreciated the high quality training, and welcomed the opportunity to participate in stimulating debate and discussion about inequalities sensitive practice. It was suggested that ISPI is highlighting and promoting the value of single shared assessment. However, there was a lack of clarity as to the precise purpose of ISPI and confusion regarding its role in relation to the range of strategies and policies across health and social care services which seek to address equalities/inequalities issues and gender-based violence. Some interviewees voiced concerns about the fact that ISPI is a short-term initiative, another ‘add-on’ and described a general sense of ‘initiative-overload’ across the services. One respondent expressed her concerns:

"The fact that it is called an initiative could be a barrier to its success – everyone is a bit weary of initiatives. There are no barriers to the actual concept – particularly with practitioners, but on the other hand, there could be resistance from people working in more affluent areas who see this as a move towards shifting resources."

Only a few respondents were able to recognise ISPI as a vehicle designed to support the implementation of existing strategies and policies; the majority appeared to see it as yet another strategy.

**Implementing Inequalities Sensitive Practice**

"At a strategic level, every midwife would say they understand the issues of impact on poverty and ill-health on women. Take it down to every day practice, and they struggle to see how they make an impact."

More than half of the interviewees said that inequalities sensitive practice is happening already. However, few individuals were able to describe instances where practice could be seen to be sensitive to inequalities. Rather, interviewees highlighted the benefits of multi-agency working and better ‘sign-posting’ to a range of services. Respondents described the steps being taken to ensure that responses were tailored to suit individual needs, based upon a comprehensive, single shared assessment process. It was recognised, however, that staff must have the confidence to ask the right questions, in a sensitive and appropriate manner. It was acknowledged that such confidence depends upon a reasonable degree of knowledge and understanding of issues such as drug use, homelessness, and poverty, together with an awareness of existing support services.

With regard to gender issues, respondents referred primarily to gender-based violence and, when asked to give examples of good practice, offered examples of gender-specific services, rather than gender-sensitive services.

A small number of respondents did suggest that currently, service delivery models are based predominantly upon middle-class expectations and behaviour and that there is a need to change our perspective.

**Implementing ISPI**

When considering the work of ISPI, a number of interviewees said that, to date, there had been limited opportunity to share knowledge, experience, and practice across the four settings and suggested that there would be merit in more ‘cross-fertilisation’.

The majority of respondents confirmed that they would like more training – in a variety of different formats. It was suggested that there would be benefit in ‘rolling out’ the training into wider teams, integrating ISP training into mainstream training and development programmes, including induction training. It was further suggested that there would be benefits in bringing together staff from each of the four settings for shared learning.
Almost all of the respondents highlighted the need for evidence of good (and bad) practice – in the form of case studies. Many suggested that instances of practice change should be highlighted and asked for ‘process indicators’ to be identified, in order to track progress towards ISP. Suggestions as to what ISPI can do to support the development of good practice included:

“It’s about ensuring that staff are more aware of what they are doing to address inequalities – and where it’s successful – where we can replicate.”

“During the course of the project, let’s make sure that we highlight different ways of working and identify best practice, universally, rather than locally.”

“ISPI can gather information, identify good practice, and present this information – at a time when services are changing.”

Staff involved in policy and planning emphasised the need to keep up the policy debate, in order to shape and influence policy in order to support the ongoing promotion and development of ISP.

Many of those interviewed expressed concerns about the very ambitious ISPI programme and suggested that there would be value in establishing just what might be considered reasonable in terms of targets. It was suggested that it is important to set achievable objectives, given the relatively short time scale of the initiative.

5. Conclusions

One of the key objectives of ISPI is:

“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”.

Based upon this series of interviews, together with the review of policies, strategies, and relevant literature, the ‘enablers’ and ‘inhibitors’ can be summarised as follows:

**What’s ENABLING INEQUALITIES SENSITIVE PRACTICE?**

**Discussion and debate**

It is evident from this round of interviews that staff value highly the opportunity for discussion and debate, facilitated by the ISPI team. All respondents confirmed that these discussions, usually within team meetings or workshops, have heightened their awareness and understanding of the issues surrounding poverty, gender, and health and that they understand more clearly why, in order to be more effective, health and social care services should be delivered in a manner that is sensitive to an individual’s circumstances.

**Training**

All respondents confirmed that training events provided by the ISPI team have been of a high quality and very informative. Once again, they have enabled individuals to understand more clearly the impact of inequalities upon health and wellbeing, and to recognise that they, as providers of services, should adapt the ways in which they deliver those services to take account of inequalities, such as poverty and gender.
Practical Illustrations

Respondents consistently emphasised the value of practical illustrations of inequalities sensitive practice, particularly in relation to poverty and gender. Almost all of the respondents indicated that whilst the majority of staff recognise why practice should be sensitive to inequalities, there is still a lack of knowledge in terms of how to adapt current methods. Many of those interviewed stressed the value of case studies and asked for more to be developed in order to support on-going change.

Champions of change

It is clear that, across the four settings, there are a number of individuals who have recognised that inequalities sensitive practice is not simply about multi-agency working and better signposting. They recognise that it requires a change in one’s own practice and can describe clearly the practical ways in which they have done so. These individuals can play a very significant role in supporting the development of ISP, by demonstrating how it can be done and by supporting and promoting change within their teams and across the services.

Good team working

From our discussions, it was evident that opportunities for the development of inequalities sensitive practice were most often to be found within well-established, integrated teams. Having been in existence for some considerable time, the Community Addictions Teams would appear to be functioning effectively as multi-disciplinary teams and, consequently, to have the capacity and the confidence to review critically their practice from a variety of different perspectives, to share learning and experience, and to ‘take on board’ the need for change.

Dedicated support

Interviewees acknowledged the value of the dedicated support provided by the ISPI team. This support would appear to be particularly effective where the postholder has been appointed from within the team/service, has credibility amongst colleagues, and understands the environment within which s/he is working. In summary, s/he can ‘hit the ground running’.

Commitment and enthusiasm

With very few exceptions, respondents demonstrated a very sincere commitment to the concept of inequalities sensitive practice and a willingness to learn how best to deliver effective and appropriate services. There is an appetite for change and, in many instances, a view that ‘the time is right’, given that there is a significant degree of re-structuring across health and social care services, and a very strong emphasis on multi-disciplinary working.

Leadership

A range of interviewees highlighted the value of clear, strong leadership. There was widespread recognition that the development of inequalities sensitive practice is supported at a very strategic level, locally and nationally. At the same time, respondents emphasised the need for ‘middle management’ to demonstrate a commitment to practice development, and to drive change across teams and services, particularly those which may be new or recently-formed.
**What's INHIBITING INEQUALITIES SENSITIVE PRACTICE?**

**A common language**

There still exists considerable confusion in relation to the terminology which surrounds inequalities and inequalities sensitive practice. The most obvious illustration is to be found between Social Work policies which refer to ‘equalities’ and NHS policies which refer to ‘inequalities’. Similarly, phrases such as ‘accessible services’ mean different things to different people – to some, this means ramps, lifts, and information in different languages, while to others it means behaving in a manner that makes it easier for an individual to approach a service, and to trust a professional.

**What is INEQUALITIES SENSITIVE PRACTICE? And who are ISPI?**

As yet, there is no shared understanding of what constitutes inequalities sensitive practice. As indicated in section 3.4, many people are of the view that it means working with other agencies and disciplines in order to provide an individual with a range of services, to meet their multiple and complex needs. Only some of those interviewed were able to recognise that it is about changing one’s own practice, as well as being better informed about and connected to other services.

Similarly, there would appear to be a common view that the Inequalities Sensitive Practice Initiative is primarily a training project. Despite the fact that the majority of interviewees could be considered as sharing the responsibility for delivering ISPI, it was apparent that the ISPI team are regarded as being the people taking forward the initiative – rather than facilitators of change.

To date, there has been little opportunity for working across the four settings and for the ‘cross-fertilisation’ of knowledge, experience, and debate. Given the clear connections between the four settings and their clients, there would be considerable advantage in facilitating more joint work between the settings.

There is also, in some instances, a sense that ISPI is separate from mainstream activity, particularly in relation to training and development. Many respondents indicated that there would be significant benefit in establishing stronger connections between ISPI activity and mainstream HR/OD services.

**Where’s the evidence?**

The majority of interviewees indicated that, at present, the recording of information about staff training and development, at individual and service levels, is inconsistent and somewhat ad-hoc. Similarly, data collection systems which exist to gather information about clients would appear not to be used consistently in every setting. Consequently, at present, it is difficult, if not impossible, to measure progress either in relation to staff development or service improvement. Until this exists, there can be no clear outcome indicators. Many respondents expressed concerns about the lack of evidence and outcome indicators, either in relation to practice and service delivery, or to client outcomes. The development of a shared understanding of what constitutes inequalities sensitive practice would appear to be essential in order that outcome indicators can be identified, and performance measurement systems established.

**Organisational re-structuring – and insensitive practice?**

The extent to which NHS and Social Work services are being re-structured was considered by some to be an opportunity, but by others to be a barrier. Whilst re-structuring and service re-design were recognised as presenting the opportunity for change, there are clearly many practical issues, such as office re-location and staff recruitment processes, which can significantly affect individuals’ and teams’ capacity and enthusiasm in relation to initiatives such as ISPI. This situation is likely to be compounded by the fact that ISPI is seen by many as ‘another initiative’, likely to make even more demands, rather than a vehicle which can, in fact, support them through change and service re-design.
Lack of infrastructure – lack of leadership and support

Just as the CAT teams, well-established and running smoothly, would appear to provide a robust infrastructure within which to deliver practice change and the implementation of policy, interviewees indicated that, within a range of settings, there is as yet a lack of infrastructure, due once again, to re-structuring and service re-design. Systems are not yet ‘bedded down’, support is not necessarily in place for everyone, individual staff members are ‘feeling their way’ within a new environment. Some respondents indicated that, as yet, there is a lack of strong leadership within their teams, and a need for better integration between agencies and disciplines. Within this fragile environment, staff are unlikely to engage effectively in the critical examination of policy and practice and shared learning that is essential in order to effect change.

Avoidance – yet another strategy?

Finally, there are inevitably those individuals who will resist change and seek ways of avoiding new strategies. In some circumstances, such individuals can undoubtedly create barriers to progress and prevent others from participating.
6. Points to Consider

Having considered carefully the responses of interviewees, the consultants have identified a number of recurring themes, which may merit further consideration. These issues can be summarised as follows:

- the need to establish a shared definition of ‘Inequalities Sensitive Practice’;
- The value of case studies and practical illustrations of ISP;
- having defined ‘ISP’ and identified case studies, the need to identify performance indicators in relation to staff development and changes in practice (preferably building upon those already in existence).
- the need to secure commitment and support at managerial level;
- the need to challenge attitudes and behaviours – at all levels;
- the value of ongoing training and development – but linked to wider training and development functions across health and social work services;
- the value of cross-setting activities;
- the need to make clear that the pursuit of ISPI’s objectives is a shared responsibility which extends far beyond the ISPI Team, and to identify ‘SMART’ objectives, particularly in light of the relatively limited amount of time still available.
Appendix One

Closing the Opportunity Gap (CtOG)

Closing the Opportunity Gap (CtOG) was the result of a cross cabinet review of the Social Justice Strategy (SJS) led by the Minister for Communities. Six CtOG Objectives were announced in July 2004, and ten CtOG Targets were announced in December 2004. The entire strategy was defined by three overarching Aims: poverty prevention, provision of routes out of poverty, and enabling the Scottish population to sustain poverty-free lives.

Closing the opportunity gap: Policy areas, objectives and targets

Each of the six CtOG Objectives correspond to a broader field of policy:

- To increase the chances of sustained employment for vulnerable and disadvantaged groups - in order to lift them permanently out of poverty; (Employability)

- To improve the confidence and skills of the most disadvantaged children and young people - in order to provide them with the greatest chance of avoiding poverty when they leave school; (Pre-school and School Age Education)

- To reduce the vulnerability of low income families to financial exclusion and multiple debts - in order to prevent them becoming over-indebted and/or to lift them out of poverty; (Financial Inclusion)

- To regenerate the most disadvantaged neighbourhoods - in order that people living there can take advantage of job opportunities and improve their quality of life; (Community Regeneration)

- To increase the rate of improvement of the health status of people living in the most deprived communities - in order to improve their quality of life, including their employability prospects; (Health Inequalities) and

- To improve access to high quality services for the most disadvantaged groups and individuals in rural communities - in order to improve their quality of life and enhance their access to opportunity. (Rural Inclusion)
Inequalities Sensitive Practice Initiative

CtOG Objectives were to be achieved through ten specific targets:

A. Reduce the number of workless people dependent on DWP benefits in Glasgow, North & South Lanarkshire, Renfrewshire & Inverclyde, Dundee, and West Dunbartonshire by 2007 and by 2010.

B. Reduce the proportion of 16-19 year olds who are not in education, training or employment by 2008.

C. Public sector and large employers to tackle aspects of in-work poverty by providing employees with the opportunity to develop skills and progress in their career. NHS Scotland will set an example by providing 1000 job opportunities, with support for training and progression once in post, between 2004 and 2006 to people who are currently economically inactive or unemployed.

D. Reduce health inequalities by increasing the rate of improvement for under 75 Coronary Heart Disease mortality and under 75 cancer mortality (1995-2003) for the most deprived communities by 15% by 2008.

E. By 2008, ensure that children and young people who need it have an integrated package of appropriate health, care and education support.

F. Increase the average tariff score of the lowest attaining 20 per cent of S4 pupils by 5% by 2008.

G. By 2007 ensure that at least 50% of all “looked after” young people leaving care have entered education, employment or training.

H. By 2008, improve service delivery in rural areas so that agreed improvements to accessibility and quality are achieved for key services in remote and disadvantaged communities.

J. Promote community regeneration of the most deprived neighbourhoods, through improvements by 2008 in employability, education, health, access to local services, and quality of the local environment.

K. By 2008 increase the availability of appropriate financial services and money advice to disadvantaged communities to reduce their vulnerability to financial exclusion and multiple debts.
Appendix Two

Discussions with interviewees were based upon the following questions:

1. What do you think Inequalities Sensitive Practice is?
2. How might that have an impact on patient health care?
3. What’s needed to have that happen? Training? Public awareness? More integrated services?
4. What role can the Inequalities Sensitive Practice Initiative play in delivering this?
5. What is it doing right now?
6. Where are the opportunities for further development?
7. What are the barriers?
8. What information is being gathered currently that relates to ISP and how?

Interviewees included representatives from the following staff groups:

Steering Group
Setting Implementation Groups
Maternity Working Group
Addictions task Group
Team Leaders
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