

Caring to Ask

How to embed caring conversations into practice across North East Glasgow

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Contents

Executive Summary

This report arises from the recent practice inquiry into *Inequalities Sensitive Practice* (ISP) in the north east sector of the Glasgow Community Health Partnership, in collaboration with the Glasgow Centre for Population Health. It reports on the experience and learning from that inquiry and sets out an approach to build on the initial progress to deepen and extend the reach of approaches to appreciative conversations trialled in three settings during 2013.

The inquiry has brought people together in an exploration of the front line realities of inequalities sensitive practice. It generated fresh and enlarged thinking about assumptions and practices in relation to ISP. Through local small 'tests of change' it has demonstrated both the possibilities and barriers for practice development of this kind. Ultimately it has shown how appreciative and routine feedback can enhance experience for both people using the services and staff and can also act as a route to service improvement and positive health and wellbeing outcomes.

The inquiry has generated a number of recommendations in relation to the further exploration of specific issues directly relevant to ISP. But it went beyond that to suggest that ISP is about more than whether services are providing 'equality of care' to clients, patients or service users, it is also about professional practice, the daily business of how staff interact with the people they work with – their clients and also importantly, with each other. The Glasgow CHP is confident that there is a need to develop this approach to help all staff to retain their positive regard for the people they encounter as patients, clients or service users and other colleagues and partners. This will both improve ultimate health and social outcomes and enhance staff resilience and job satisfaction in the face of considerable and enduring challenges.

This short report highlights the key messages and outlines existing and new resources designed to support the extension of collaborative reflective and appreciative practice across all settings.

1. The National and Local Policy Context

The current policy landscape has many strands that come together to address inequalities and deliver positive outcomes in health and social care. The Ministerial Taskforce on Health Inequalities in Scotland has examined the concepts of 'people and social connectedness' and 'how communities should be partnered in tackling inequalities'; a final report is expected by the end of 2013[1]. At the same time, the National Person-Centred Health and Care Programme aims to bring coherence to a range of initiatives and programmes to challenge all parts of the health and care system to 'put the person at the centre of services', as part of the NHS Healthcare Quality Strategy[2]. This is to be evidenced by 2015 in terms of improvements in the care experience; the staff experience; and co-production.[3]

These developments raise challenges to a sole 'health improvement' model of change and heralds the growing understanding of the vital contribution of communities, the voluntary sector and community planning partners in tackling inequalities and delivering health and wellbeing outcomes.

The Auditor General has suggested that a critical part of reducing inequalities is to 'target a local area, look at what the specific problems are, and build ways of working that improve the situation'.[4] The effectiveness of this approach will depend on the way in which things are done (our emphasis):

> *"... as a society, we need to **co-produce** the outcomes with the individuals concerned. We should do things **with them** rather than doing things to them. Helping people to take control of their lives in that way is a hallmark of the successful Keep Well practices. **We must learn where the good outcomes are and ensure that that practice gets spread**. (Chief Medical Officer) (our emphasis)*

Operationally, these 'wicked' issues present profound challenges to the delivery of inequalities sensitive practice, based on a more person-centred and systemic way of working. There is now clearer recognition that whilst a clear strategic lead is needed to create the right conditions, *'all improvement is local and execution is key, with space to test and implement change'.*

The appreciative caring conversations approach developed here will enable the realisation and embedding of the competencies, skills and behaviours needed to bring a number of local and national policy agendas to fruition. Figure 1 highlights some of these agendas of most direct relevance:[5]

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[1] http://www.scotland.gov.uk/Topics/Health/Healthy-Living/Health-Inequalities/Equally-Well

[2] http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf

[3] http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4015390/Person%20Centred%20Health%20&%20Care%20Programme%20-%20(Item%20CC-2012-07-02).pdf

[4] Scottish Parliament, Public Audit Committee, Wednesday 19 December 2012 http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=7628&mode=pdf

[5] These also include the priorities for public service reform advocated by the Christie Commission http://www.scotland.gov.uk/Publications/2011/06/27154527/2, wider welfare reform http://www.scotpho.org.uk/publications/reports-and-papers/1109-making-a-bad-situation-worse and the priorities of Glasgow CHP http://library.nhsggc.org.uk/mediaAssets/Recruitment/EqualityScheme_Access_Web.pdf and the Glasgow Single Outcome Agreement. http://www.glasgowcpp.org.uk/CHttpHandler.ashx?id=15989&p=0

Figure 1: Selected national and local policy agendas

Facing the Future Together[6]	We take responsibility We put patients first We focus on outcomes We always try to do better We work as one team We treat each other with respect
Francis Report[7]	We will develop more innovative ways of capturing a true reflection of patient experience We will consider the benefits of direct observation of practice and speaking to patients, staff and carers when assessing the standards of healthcare We will enable patients to have clear expectations about the quality of their care and provide feedback
Assets Approaches[8]	Promote self-esteem and ability to cope Focus on strengths and capabilities Encourage people to take control of their own health Defines individuals and communities in terms of the resources needed to stay healthy
Tackling Poverty Framework[9]	People struggling against poverty must be seen as part of the solution Dignity at the heart – deliberate blaming is unacceptable Welfare reform necessitates action now
Workforce 20:20 Vision[10]	Focus on the caring qualities required in staff, more focus on caring behaviours and skills including active listening to patients Commitment to person centred skills Wider skills for looking at families and circumstances – not just treating the person More customer skills, less professional elitism More emphasis on dignity and respect More respectful behaviours needed across the organisation Make greater use of the patients perspective on what it is like to receive care Engage in actual discussion with frontline staff and patients Roles and teams organised around patients needs, not professions

[6] http://www.nhsggc.org.uk/content/default.asp?page=s1885
[7] http://www.midstaffspublicinquiry.com/report
[8] http://www.scotland.gov.uk/Topics/Built-Environment/regeneration/engage/empowerment/newsletter/December10/News/AssetsAllianceScotland and Chief Medical Officer Annual report 2010 http://www.scotland.gov.uk/Resource/0038/00387520.pdf GCPH http://www.gcph.co.uk/work_themes/theme_4_assets_and_resilience/health_improvement_asset_based_approaches
[9] http://www.scotland.gov.uk/Topics/People/welfarereform/tacklingpovertyinscotland
[10] http://www.scotland.gov.uk/Topics/Health/Policy/2020-Vision

2. The nature of inequalities in North East Glasgow

The persistence and pervasive effects of poverty on health outcomes within Glasgow are well documented. Whilst overall health has improved in the past 50 years, deep-seated inequalities in mental health and wellbeing remain within Glasgow and between the city and other parts of Scotland.[11] Deprivation is the key underlying determinant: men in the most deprived areas die 11 years earlier than those in the most affluent; for women the gap is 7.5 years. There are higher rates of heart disease, obesity, diabetes, drug and alcohol misuse, and mental health problems in deprived areas. The profile of inequalities in north east Glasgow largely reflects the pattern in the city as a whole.

Understandings of these patterns and distinctions are of critical importance in the development of both strategic and practitioner responses to combat inequities in health. These trends and patterns are complex and often distinctive, particularly where a number of aspects of inequality interact.[12] In relation to understanding the context for this practice inquiry, it is worth noting:

- The aggregate data reported in the numerous publications can mask differences that are often very local and particular.
- The very scale and 'ordinariness' of poverty across Glasgow may make it much harder for staff to remain sensitive to the particular ways in which its effects are made manifest, and the ways in which it interacts with other factors to undermine people's resilience, capacities and their health and wellbeing.
- There may be significant variations in service and professional performance even within a small locality.
- Strategies to target the worst off on an area basis have not been effective in reaching those most in need and hence have had a mixed impact on inequalities.
- There is a risk of inadvertently widening the health gap without more explicit and targeted efforts to prioritise health inequalities.
- The *Inverse Care Law*[13] might also apply to staff as well as patients, in that resources available to staff, such as support and training may be inversely related to need, given staff working in this sector are in arguably the most demanding setting in the country.

A stock take by the Corporate Inequalities Team published in August 2012 found that in organisational terms the key issues were:

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[11] Audit Scotland, *Health Inequalities in Scotland*, December 2012; Shipton D and Whyte B. Mental Health in Focus: a profile of mental health and wellbeing in Greater Glasgow & Clyde. Glasgow: Glasgow Centre for Population Health, 2011. www.GCPH.co.uk/mentalhealthprofiles; Annual Report of the Chief Medical Officer, http://www.scotland.gov.uk/Resource/0041/00411579.pdf

[12] The Scottish Health Survey, The Glasgow Effect Topic Report, The Scottish Government, Edinburgh 2010; Investigating a 'Glasgow Effect' Why do equally deprived UK cities experience different health outcomes? David Walsh, Neil Bendel, Richard Jones and Phil Hanlon, GCPH, 2010

[13] This refers to the principle that resources tend to be inversely related to the needs of the population.

- Common 'myths' and misunderstandings; for example, a tendency to equate ISP with addressing issues of ethnicity; to think that ISP is not relevant to all posts and the idea that ISP means treating everyone the same.
- The difficulties of a 'training model' to affect frontline attitudes and practices.
- The absence of routine data collection, analysis and use of data, for either local improvement or strategic reporting.
- Despite extensive partnership activity, the failure to maximise the effectiveness of all public services in supporting people most vulnerable in the current climate through local partnership delivery.
- Mixed progress against the 10 Goals and a lack of adequate integration across all levels of the service to deliver whole system change.

It also found some poor patient experience including:

- a lack of awareness or acknowledgement from practitioners of the potential effects of poverty on health and ability to comply with treatment;
- judgmental or dismissive attitudes that compound anxiety and stress;
- failure to ask about their experience of abuse or prejudice and the potential implications that might affect their health;
- experience of culturally insensitive attitudes and persistent negative attitudes, for example, towards issues of sexual orientation.

3. Key insights and messages from the ISP practice inquiry

The Inequalities Sensitive Practice inquiry involved practitioners working in early years, homelessness and primary care mental health settings forming inquiry groups of around 6-8 staff. Each group met 5-6 times between April and August 2013, with a facilitator from the research team.[14] The three groups came together at a larger event held in September 2013 attended by other team members in these three settings, along with operational and strategic managers.

What is inequalities sensitive practice?

The Glasgow Community Health Partnership's definition of ISP describes a person-centred approach and a relationship between practitioners and clients that responds to the life circumstances that affect people's health:[15] This inquiry process brought that definition to life. The practitioners that

[14] These were Cathy Sharp (*Research for Real*), Jo Kennedy (Animate) and Ian McKenzie (Animate). The work has also been supported by Professor Belinda Dewar, Institute of Care and Practice Improvement, University of the West of Scotland.

[15] *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.

took part developed their own understandings of how it related to their practice and offered insights into the real challenges of implementation, given the socio-economic and organisational context in which they work. This section includes selected quotes and images developed through the inquiry process.

A strong message from the inquiry is that inequalities sensitive practice is about more than whether services are providing 'equality of care' to clients, patients or service users. It is also about professional practice, the daily business of how staff interact with the people they work with – their clients and with each other.

Ultimately, inequalities sensitive practice is about attitudes and actions towards people. It involves being non-judgemental, the ability to find strengths in a person or situation, taking time with people to build relationships and trust and being willing to learn *from* people, as well as offer advice and support. Ultimately it is about how staff and managers talk to people and the questions they ask them. It is also about how they listen to people and let them know they have been heard by their actions.

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.

Practical help is really valued by clients and helps to develop the trust and honesty that is necessary to develop positive relationships; it is an important part of person centred or relational practice. Building relationships by being consistent, persistent, and following things through for people to get results is an important source of job satisfaction.

I was working with a single parent with a toddler with multiple disabilities – they were homeless and living in overcrowded conditions with her mother. She is pregnant, living in poverty and stressed. They'd recently been re-housed 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.

The inquiry also illuminated different ways of thinking about types of inequality. Some are easy to see or more readily revealed to a professional, including groups of people with protected characteristics, such as gender, disability, ethnicity or having English as a second language. Others are more hidden and may be due to poverty that is so widespread as to be 'unremarkable';

judgemental attitudes towards young people or service generated inequalities of access, for example due to the volume of inappropriate referrals.

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.

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

What's working well?

The inquiry process revealed that many staff are already practicing in an inequalities sensitive way. There is much good practice under the radar. This has not always been evident either to staff themselves or their wider colleagues; this gap between practice and perception seems to be either because of the understandings of ISP as being solely about people in 'protected categories' or simply that as staff did not routinely ask for feedback they had no evidence about the quality of their work and other people's perceptions of it. It's worth noting that there is also considerable synergy and resonance between the professional ethos of many of the caring professions and this appreciative, strengths based approach to feedback and dialogue.

I had a young mother of 16 with very bad post-natal depression – she was being aggressive towards the baby. There was social work involvement. It was hard for her to admit that she needed help. When I asked her, she said what had worked well was that *I had not been judgemental – because of her age and inexperience. That I'd taken time to explain to her and her mother why social work were involved.* I admit I was surprised that her feedback was positive…

Seeking feedback from people about what is working well was a very powerful way of unlocking this information. This can be a surprising though useful start to a different kind of conversation. Surprise brings learning: by bringing to light the positive things in a situation or relationship, staff and clients can feel more motivated and have a better basis for working together to seek solutions.

Some clients were bemused or surprised to be asked.

I said it was part of service improvement

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

As part of the inquiry, the Primary Care Mental Health Team completed an 'audit' of their existing practice. This was based on requirements of the Equalities legislation and the Equality Impact

Assessment process. It proved to be a valuable process as it highlighted to the team how much they were already doing, as well as identifying some issues for future action. Examples of actions include: calling people who self-refer rather than writing to them because of literacy issues; the crucial role of a working text facility to issue reminders; the need for 'reverse marketing' so that GPs have greater clarity about who the service is for; and the need for better links with external partners, such as social prescribing.

ISP rests on a partnership approach

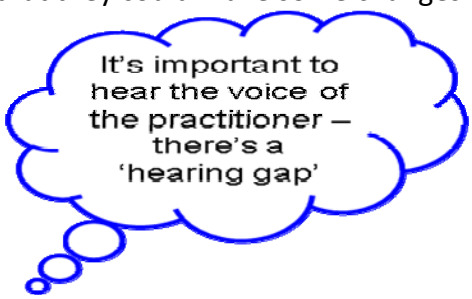
The inquiry also showed that inequalities sensitive practice is about staff knowing their remit, where it ends and where or who to refer people onto for more appropriate or specialist support. In this way, inequalities sensitive practice rests on good partnership working both with people directly and with staff from other professions and agencies.

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.

Front-line practitioners can play an important role in bringing together a range of other professionals and agencies. The inquiry demonstrated that they could *lead change* by talking to other colleagues about their concerns. One example was face to face communication with key partners that proved to be a more effective approach as it enabled a dialogue and a chance to correct misunderstandings, whereas previous formal written communications had elicited no response.

ISP is about staff too

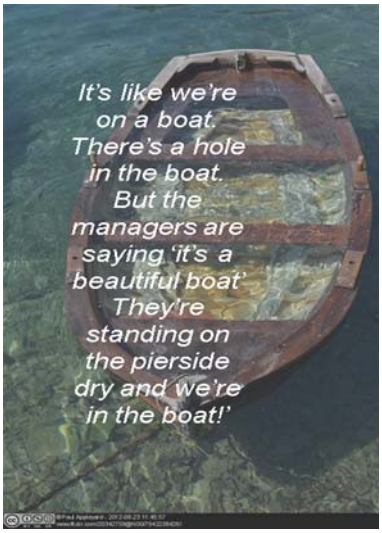
A further important message is that inequalities sensitive practice is also about how staff are treated at work: staff can feel 'done to' and not heard, and, just as for clients, this is disempowering by undermining any sense that they could make some changes for themselves.

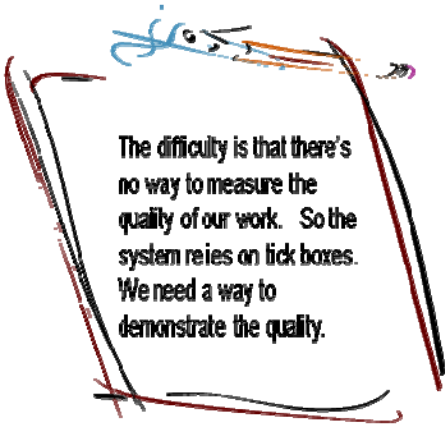


There was a real sense of staff barely coping with the everyday pressures of their work, anxiety about the risks and anger about the real or perceived actions or inactions of managers, other professionals or agencies.

Sharing, reflection and learning

The inquiry process itself demonstrated the value of reflection on and sharing of practice within each setting and across the wider organisation. It revealed that the quality of the work undertaken by practitioners is not being routinely measured: the inquiry was a chance in itself for staff to get validation of the quality of their work and this was highly valued and motivating. Being part of the inquiry gave staff the legitimacy to seek feedback from clients, colleagues and other professionals. Using two simple questions to elicit feedback demonstrated care-in-action and the role of each party in devising solutions.





Bringing these feedback stories to the inquiry process gave participants a chance to reflect and learn from each other. For some this was a motivational and positive process which they saw as linked to wider learning and professional development. The tools used such as images, words to describe emotions and the *7 Cs of Caring Conversations* were found to be useful in different ways; some staff found that they helped to get over a confrontational and adversarial atmosphere.

Within an overall appreciative approach, the inquiry process unfolded differently in the three settings; it had to contend with initial unfamiliarity with the facilitators and lack of clarity about why particular settings or individuals were taking part or even what the inquiry was about. This uncertainty was not always a barrier, but there were also issues of distrust and cynicism about change, weariness with 'initiatives' and an overwhelming workload.

After several cycles of inquiry group meetings and by the cross-setting event held in September 2013, there did seem to be a more widely shared and positive energy across the three settings; participants valued hearing from each other and being able to voice issues directly to operational and strategic managers. The feedback suggests that it is important to 'Keep ISP on the map'.[16]

[16] Display storyboards based on the data from the three inquiry settings were developed for this event. These are available as a PowerPoint presentation on request.

4. What could we do together to make our practice even better?

The simple answer to this question is 'keep asking!' The inquiry had a strong and on-going focus on staying curious, reflection, learning and change, with an emphasis at each stage on what actions could be tested out or proposed for others.

There are a range of generic lessons generated from the three inquiry settings that are broadly concerned with how staff talk to each other and to patients or clients to generate two-way feedback; how the information and insight is used for practice development; and how wider learning can be encouraged and shared through support for collaborative and reflective practice.[17]

Talking to each other to generate two-way feedback

- Use the 7Cs of caring conversations and other tools that support appreciative dialogue both in the relationship with the client and the wider partners. These can help to set the tone of mutual interest and partnership and to craft good questions in the moment. For example:
    - Discuss mutual expectations: for example, ask clients – what are your expectations?
    - Talk about 'we' as 'you and I' rather than the 'service' – challenge the expectation that professionals can 'fix' things alone, for example, ask 'what can each of us do to make things even better?'
    - Think about 'small' steps that are positive; what do you know that works for you?

- Get feedback from clients as a routine activity, whether the relationship is on-going or a one-off encounter.

- Get feedback on behalf of each other. For example, a client could provide feedback about a service when s/he is seeing another practitioner and messages communicated to the relevant services.

- Keep asking – what works well and what can we do together to make it even better?

- Do a bit of self-appraisal every time – even if it isn't possible to get direct feedback from a client.

Using the information and insight

- Integrate patient feedback into work to make it meaningful. This needs to be done in conjunction with a process that allows the feedback to be listened to and acted upon.

- Advocate - on behalf of patients, with management, statutory and voluntary sector services.

[17] These have been distilled into a set of Positive Practice Pointers (see below).

Sharing to learn

- Ensure that the lessons of this inquiry are communicated to the wider staff group, including measures to integrate it into training, presentations and awareness raising approaches.

- Set aside time to talk about ISP to allow people to share ideas – discuss with others, make a plan and audit it, look at whether it is been done before, look at the evidence base again; do this 'top down' and 'bottom up'.

- Implement wider consultation with management and other partners to extend and deepen the inquiry from the original three settings.

- Feedback any specific learning to the Corporate Inequalities Team to consider changes to CIT guidance[18].

- Pay attention to the creation of a positive environment for learning and sharing so that poor practice can be challenged wherever it occurs without invoking defensiveness. The use of the 7C and other tools that are appreciative help to foster this cultural shift and enable staff and managers to facilitate authentic feedback conversations.

Reflective practice as a collaborative and system wide activity

- Protect time for teams to reflect on their practice through both formal and informal networks. This should involve staff at all levels. Ways to enhance collaborative reflective practice include:

- Ensuring that staff have regular feedback about progress.
  - Ensuring that quarterly meetings focus on practitioner experience and allow time for discussion.
  - Run meetings differently to tackle the barriers to speaking up and find ways to encourage greater participation.
  - Bring appreciative inquiry into supervision.
  - Develop shadowing opportunities – for example, between health visitors and social work.
  - Build communications with GPs and other partners – in all settings, to better understand the issues from all sides, supporting better relationships between partners.

[18] http://www.equalitiesinhealth.org/public_html/index.html

Resources to support on-going inquiry

To support this further inquiry, a series of resources has been produced from the ISP inquiry to enable practitioners and managers to embed conversations about the quality of practice into their everyday work.[19,20] These resources include:

- **Positive Practice Pointers (PPPs):** A multi-media set of statements of positive practice in ISP rooted in the learning from this inquiry. This is a flexible tool to prompt further conversations about ISP amongst staff, teams and across settings. Ideally they should be used in conjunction with the learning cycle questions to support facilitated conversations about practice development[21]. They can be used in different ways for example:
  - At regular team meetings
  - In supervision sessions
  - At dedicated/quarterly meetings
  - In an interview process

- **The 7 C's of Caring Conversations** (poster and cards): these are a simple shared evidence-based framework based on seven key attributes important in interactions aimed at supporting learning and action[22]. The 7 Cs are:
  - Be courageous. What would happen if I did something or did nothing?
  - Connect emotionally. How do you feel about what I have said?
  - Be curious. Help me to understand what happened
  - Collaborate. Is there anyone else who could help us with this?
  - Consider other perspectives. What would others say?
  - Compromise. What is the ideal and what would you settle for?
  - Celebrate. What has worked well and why?

- GCPH plan to publish a blog about the inquiry process[23]. This report is available online[24].

[19] See Dewar, B and Sharp, C (2013) Appreciative dialogue for co-facilitation in action research and practice development, International Practice Development Journal 3 (2) [7] http://www.fons.org/library/journal.aspx
[20] Fuller information is in Appendix 1.
[21] The PPPs and learning cycle questions are included in Appendix 1 and are also available on request in digital form.
[22] Dewar B and Nolan M (2013) Caring about caring: Developing a model to implement compassionate relationship centred care in an older people care setting, International Journal of Nursing Studies, DOI: 10:1016\j.ijnurstu2013.01.008 and Dewar B (2013) Cultivating compassionate care, Nursing Standard, 27,34, 48-55
[23] http://www.gcph.co.uk/latest/blogs
[24] http://www.chps.org.uk/content/default.asp?page=s624_4

5. Conclusions and next steps

The practice inquiry has brought people together in an exploration of the practice realities of inequalities sensitive practice. It has generated fresh and enlarged thinking about assumptions and practices in relation to ISP. Through local small 'tests of change' it has demonstrated both the possibilities and barriers for practice development of this kind. Ultimately it has shown how appreciative and routine feedback can enhance experience for both people using the services and staff and can also act as a route to service improvement and positive health and wellbeing outcomes.

Recommendations in relation to inequalities sensitive practice

The inquiry has generated a number of recommendations in relation to the further exploration of specific issues directly relevant to ISP.

1) Within teams and in the wider context, there is a need to more explicitly address the implications of the fact that people who experience poverty are not a 'protected characteristic' in terms of equality legislation, as part of acknowledging the effects of poverty on health and the way in which poverty interacts with other factors to undermine people's resilience, capacities and their health and wellbeing. This impacts at client level, for example, in encounters between patients and GPs or clinicians who may lack 'cultural sensitivity'.

2) Externally there is a need to support better communications and relationships between partners and for some specific approaches to key stakeholders and partners (such as GPs and social work) to ensure that they understand what is available from services and the respective roles and remits of services. There is scope to engage more productively with GPs, by using the GP Forum or LMC/regular information output including new GPs and trainees.

3) Within the Primary Care Mental Health team, there is a need to investigate 'inappropriate referrals' and the way that a 'triage' role for the service has developed to deal with a large volume of clients for whom they are not the appropriate service**.**

4) There is also a need to investigate how staffing levels and the increase in caseloads impacts on ISP across settings.

5) There is a need to develop appropriate ISP indicators that reflect the quality of the work, reported in the GCC quality strategy.

Taking forward the caring conversations process

The inquiry process generated a range of recommendations from front-line practitioners and managers to illuminate and extend the good practice that already exists and reduce the dissonance between policy intentions and on the ground practice and action. The principles of these

recommendations have been accepted by the Senior Management Team who wish to acknowledge existing good practice, support the extension and embedding of the practice inquiry approach and address access to services and wider challenges and barriers to change. The forward approach will build on the commitment, momentum and motivation generated by this practice inquiry to develop and apply the appreciative caring conversations approach across the organisation.

The detail of the forward approach will be developed locally with practitioners, managers and wider teams. The broad principles of this approach are as follows:

- In collaboration with those practitioners involved in the original ISP inquiry groups, forward plans will develop ways to share and continue practice inquiry as part of the core work programme to ensure that the importance of the work is acknowledged and that it is appropriately developed across a wider range of services.

- It will explore opportunities to develop further and deepen inquiries of specific interest to inquiry group members, particularly where it may be possible to engage their team colleagues. Potentially this could support the wider integration of the appreciative caring conversations approach into Releasing Time to Care, internal team development and supervision practice, as well as wider engagement with GPs and external partners, including social work and the third sector.

- It will also explore the potential to connect up the groups involved in the original ISP inquiry across the three settings and including further settings or teams that become involved in this work, to enable them to share experience and learning.

- It will include support for managers to enhance their own professional development to enable them to adopt and support an appreciative caring conversations approach themselves.

- It will develop practical ways to build protected time for collaborative reflective practice for all staff, for example, dedicating time at quarterly meetings to explore these issues and holding dedicated practice development sessions within teams.

- Wider learning could also be supported by developing any opportunities for wider GGC learning events arising from this approach. There are lessons for how business meetings are run to enhance participation and interaction and recognise and build on strengths at all levels.

Specific proposals to take this work forward are:

- **Ongoing Facilitation Support (from Jan/Feb)**: New participants and members of the original inquiry groups are likely to benefit from mentoring or coaching support for wider team facilitation or co-facilitation of continuing inquiry groups. In moving forward it is proposed that there should be an emphasis on co-facilitation and capacity building so that all staff gain in confidence to use this approach without external support. Facilitation support will provide flexible support for 'action learning' for an agreed period of time. It is envisaged that the facilitators will provide a mix of ways to stay connected to the practice settings, through telephone, email and face to face advice and support.

- **Practice Inquiry Re-connector Event (Jan/ Feb):** This will bring together interested practitioners from the original inquiry settings with their colleagues and managers, to re-engage with approach and develop their own ideas for how to take this forward, including specific plans for local inquiries.

- **Resource Package:** There is also scope to produce further resources to support the adoption of the appreciative caring conversations approach in the relationship with the client and wider partners. The use of images and stories has been an important part of the this approach; depending on the interests of those practitioners most involved in taking forward this work, the following ideas may be developed further, using material developed in the original practice inquiry as well as newly emerging material from the next phase.

    - **Good Practice Stories/Digital Stories**: The inquiry generated many stories of practice that could be more widely shared with some editing and attention to presentation. These would be a useful and flexible practice development resource if issued with simple guidance about how to use them.

    - **Conversation Cards:** these would be a revised pack of Envision Cards originally produced by NES[25]. These cards can be used in different ways to help people to talk about their stories, experiences, feelings, thoughts and ideas. They are a flexible resource that has images on one side and positive and negative emotional words on the other[26]; both are useful to prompt discussion and encourage greater participation. A pack could readily be reissued, with relatively minor alterations to their design.

    - **Development of Emotional Touchpoints**: Emotional Touchpoints are a communication tool designed to assist users and carers to express their wishes and views on their care and to participate more fully in their individual care process[27]. This tool has also enabled individuals to participate in service improvement and development by talking about their experiences of care and how it makes them feel. Emotional Touchpoints are used in conjunction with the emotional words (see above). There is already interest within the health visiting team in the idea of developing emotional touchpoints and these could be produced relatively easily.

    - **Podcast:** Ideas for a podcast include modelling a 7Cs conversation with a client.

[25] http://www.nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/resources/publications/valuing-feedback-envision-cards.aspx

[26] http://www.principlesintopractice.net/ToolsandResources/Emotional_touch_Point_Tools.aspx

[27] (2009) Dewar, B, Mackay, R, Smith, S, Pullin, S and Tocher, R Use of emotional touchpoints as a method of tapping into the experience of receiving compassionate care in a hospital setting, *Journal of Research in Nursing* 15(1) 29–41 http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/1003540/JRN%20Emotional%20touchpoint%20article%20Dec09.pdf Accessed 16/11/13

Appendix 1: Inequalities Sensitive Practice Resources
Using the Positive Practice Pointers

This note explains how to use the **Positive Practice Pointers** developed from the Inequalities Sensitive Practice Inquiry, November 2013. This inquiry took place within 3 teams of practitioners working with early years, homeless people and people with mental health issues. The pointers arise directly out of their experience and in many cases reflect their actual words.

The Pointers are a flexible tool to prompt conversations about practice development in relation to Inequalities Sensitive Practice, amongst staff, teams and across settings. The Pointers are available as a PowerPoint presentation on request.

The Pointers can be used in different ways for example:

- At regular team meetings
- In supervision sessions
- At dedicated/quarterly meetings
- In an interview process

The full process described below could take an hour, or more and is therefore suitable for a practice development session with a team. It is also possible to spend 10 minutes at the end of a team meeting or supervision picking a card and reflecting on two simple questions:

- What is working well?
- What could we each do to make it work even better? (in relation to that pointer)

Find a way to enable people to become familiar with the content and images, perhaps through printing them off and having them on display, or setting up a digital photoframe in an office or canteen or simply asking people to review them for themselves.

When you have an opportunity to bring people together to talk about practice, give them a chance to review the full set of pointers. Ideally, spread the full set of Pointers out over a large table and give people time to pick them up, mull over them and discuss informally as they go round.

Then use the following set of questions to structure the group discussion. Follow the order of the stages of **Observe, Reflect, Plan and Act**; check that you have adequately covered each stage before moving on to the next stage. You may wish to allocate an agreed time for each stage depending on how long you have overall.

Learning cycle questions [1]

1. Observe:

a) What interests or excites you?

b) What are you noticing?

2. Reflect:

c) What surprises you?

d) What values and assumptions do you notice (your own and others) and how are they being challenged or affirmed?

e) What does it show about what matters to you and others?

3. Plan:

f) What does it show you about what you need to keep doing and what helps you to do that? What does it show you about what gets in the way of how you'd like things to be?

g) What possibilities for continued or new action do you see (however small)?

4. Act:

h) Is there anything <u>you</u> could do or do more of (tomorrow)?

i) What do others need to keep doing or do differently?

j) What support do you/they need to implement this?

k) What governance structures will you/they report this to?

l) *What will convince <u>you</u> that it's been worthwhile or successful?*

Asking for feedback can feel a bit embarrassing but we find the courage because it's good to know what works well.

Images(without text) kind permission from NHS Education for Scotland

We see inequalities sensitive practice as more than providing equality of care to clients. We stay curious and find a way to ask what people need.

Images(without text) kind permission from NHS Education for Scotland

Taking time to hear the stories that matter to people pays off in the long run. It's just the way we do things round here.

Images(without text) kind permission from NHS Education for Scotland

We are only one expert amongst many. If we connect emotionally with people we find out together what might work.

Images(without text) kind permission from NHS Education for Scotland

We collaborate with other professionals to build trust and relationships so we can work out together what we can each do

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We make it our business to know who else can help our clients.

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Dedicated time for reflection and sharing of experience with colleagues allows us to consider other perspectives

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Our partners know how their actions affect us and when things are not working well we are able to tell them.

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We know the other members of our team, each of our strengths and celebrate what we do well.

Images(without text) kind permission from NHS Education for Scotland

Working in a complex system inevitably involves compromise. Here, each of us knows what really matters most to others so ultimately our services make the impact we all want to see.

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In supervision we focus on 'what is working well?' and 'what we want to do more of to make things even better?'

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Hitting the target can miss the point. Our measures tell us that our work is of high quality and makes a difference to people.

Images(without text) kind permission from NHS Education for Scotland

Being sensitive to inequalities is not the icing on the cake, it is the cake!

Image(without text) kind permission from NHS Education for Scotland