**BALINT GROUP**

**Key philosophies**

1. Nearly all issues which present to clinicians has a psychological element which requires exploration
2. All doctors have feelings during the consultation – these need to be recognised and can be of benefit to patient
3. Doctor has potential for positive therapeutic role in all consultations, not just those with defined disease process

**Characteristics**

* Group members must have clinical contact with patients
* Small Group – 6-10 clinicians plus 2x facilitators
* Best if group similar grade/stage of training
* Meet regularly; every 1-2 weeks
* Sit in circle
* 50mins session
* One group member presents case giving them cause for thought, given rise to; distress, difficulty, puzzlement, surprise
* Group discussion focuses on relationship between presenter & patient, Qs of fact at start but only if have bearing on Dr/Pt relationship

**Objective & Hopes**

* Participants feel listened to, supported and understood when they present cases
* Become more tolerant of ‘difficult’ patients
* Be more empathic to patients’ feelings including negative ones.
* Become more aware of their own feelings in the consultation and be able to use them in reaching a diagnosis
* Allow their natural curiosity about patients as people to emerge
* Gain some insight into why they find some patients particularly difficult or disturbing

**What Balint is not**

* Not for personal therapy – discussion focuses on patient and patient/doctor relationship. Discomfort/distress in doctor acknowledged and worked through in context of needs & problems of patient rather than the doctor
* A Place to solve problems

**Contact**

**SCHWARTZ ROUND**

**Origin**

In 1994 a health attorney called Ken Schwartz was diagnosed with terminal lung cancer. During his treatment he found what mattered to him most as a patient were the simple acts of kindness from his caregivers, he said they made “the unbearable bearable”. Before his death he left a legacy for the establishment of the Schwartz Centre in Boston, to help foster compassion in healthcare.

**Characteristics**

* Multidisciplinary – open to all staff members including non-clinical staff
* No limit on number of attendees
* Monthly
* 1 Hour sessions
* Mixed panel – different at each round
* A Round can either be based on different accounts of a case, or can explore a particular theme e.g. ‘a patient I’ll never forget’
* Panel share their story – emphasis on emotional impact
* Remainder of session – open discussion lead by trained facilitators

**Objective & Hopes**

* Decreased stress,
* Decreased isolation
* Greater understanding and appreciation of colleagues roles and contributions
* Feeling more supported in their work
* Feeling more able to provide compassionate care.

**What Schwartz Rounds are not**

* Not designed as a form of peer supervision and do not fit the traditional model of clinical supervision
* Should not be used as a form of debriefing – if there is a case that has been particularly troubling for staff and the organisation, a certain amount of time will need to pass before it is addressed in a round
* A Place to solve problems

**Contact**

**VALUES BASED REFLECTIVE PRACTICE (VBRP)**

**Origin**

VBRP is a model which has been developed by NHS Scotland to help staff deliver the care they came into the service to provide.

**Characteristics**

* Can be used by anyone working in health and social care
* Suitable for: Reflecting on ordinary everyday experience of providing care, Reviewing clinical care services, Responding to operational proposals, Reflecting on feedback, concerns and complaints
* Regular inter-disciplinary group reflection
* Reflection in action – ward rounds, team meetings etc
* Reflection on action – trained facilitators plus group of practitioners from a team/unit
* Member of staff acts as presents – professional scenario from own practice
* Group responds by naming what they notice or wonder – presenter free to accept or reject
* Key Qs – Needs? Abilities? Values? Voices? You?
* Ends with each group member identifying one professional resonance for own practice

**Objective & Hopes**

* Promote Person-Centred Care
* Create a dialogue between personal and organisational values, attitudes and behaviours
* Enhance staff fulfilment and engagement
* Directly impact on the patient experience
* Influence better clinical outcomes

**What VBRP is not**

* Crisis management
* Critical incident debriefing
* Clinical supervision

**Contact**

<http://www.knowledge.scot.nhs.uk/vbrp.aspx>

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**SPACES FOR LISTENING**

**Origin**

Spaces for Listening (SfL) is a format, based on Nancy Klein’s thinking environment, originated by Brigid Russell and Charlie Jones. In their words, SfL is *‘a simple, lightly-structured process which creates a space in which we each have an equal opportunity to share our thoughts and feelings. It is about starting where we are, and sharing what is going on for each of us. We do not introduce ourselves by our job titles; we all participate as people.’*

**Characteristics**

* Can be used by anyone
* Max 8 attendees (including 2 facilitators)
* Facilitated session in which facilitator is an equal participant
* Do not introduce self by job titles, participate as people
* 50 minutes
* Each participant takes turn in pre-set order; and, in so doing, everyone experiences a level of listening, an equal chance to share, and a spirit of appreciation. participants feel seen and heard. In turn each respond to the following prompts:
* Round 1: How are you, and what’s on your mind?
* Round 2: Any reflections or feelings in the light of Round 1?
* Round 3: Anything to take away, and anything that has resonated, which you have appreciated?

**Objective & Hopes**

* An appreciation for being listened to, and heard, and the power of listening
* A sense of real connection
* The opportunity to pause and have space in the middle of a busy day
* Create the conditions for better conversations in our teams, throughout our organisation and across society

**What Spaces for Listening is not**

* A well being intervention or therapy

**Contact**

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