

Example of how an Exclusion Prevention Group (EPG) could operate in General Practice

What is the rationale for an EPG?

- For those who have experienced the greatest levels of psychological trauma and adversity in their development, one of the most life-limiting consequences can be a severe and enduring difficulty in the relationships they have with care itself.
- Practically, this can severely affect their ability to form and maintain the successful interpersonal relationships that underpin the vast majority of healthcare, and so have an impact on how they both access and receive care.
- This can be thought of as having a 'Relational Injury', in the same way that those who have experienced physical trauma may have a bone or muscle injury. However, the key difference between the two is that a relational injury is typically not as visible as a physical injury.
- Physical injuries can often require services to make adaptations and accommodations to meet the needs of those experiencing them, such that they can access care as easily as those without injury. (e.g. wheelchair ramps, widened doorways, etc.). Those with less visible relational injuries are usually not offered such adaptations and accommodations unless this is specifically recognised and reflected on by the service.
- The central ailment for a person with relational injury is often the limitation their injury leaves them with in terms of being able to both access and make use of care-giving relationships across all settings.
- When people present with traumatic and adverse relational-injury dynamics, these difficulties can be re-enacted in a dysfunctional interaction between ourselves as 'care-givers' and the people we provide a service to as 'care-receivers'. Furthermore, these dynamics may contain elements of the adverse experiences that gave rise to them, and as such do not always evoke positive or sympathetic responses from caregivers. In short; Trauma can be traumatic to be in relation to.
- A person who has experienced relational injury can sometimes act in a way that can ultimately result in their exclusion from services (for example, repeated non-attendance or challenging behaviour).
- General practice teams play a part in the 'relational transaction' between the service and the person using the service, and when working with relational injury there is always a risk of being drawn into interpersonal dynamics that are potentially destructive, punitive and unhelpful to both parties. This can be more likely when services are under pressure and there are high levels of stress.
- Excluding, blaming or other punitive approaches run the risk of perpetuating the relational injury, and at their worst can lead to an exacerbation of the very ailment that brought the person to seek care in the first place, and mean that those in high need of care are unable to access it.
- Adopting this approach improves health outcomes for people with relational injury
- The purpose of an EPG would be to provide a space in which to try and bring an understanding to challenging incidents, produce responses in a thoughtful, trauma informed and care focussed manner, and mitigate the risk of reacting in ways that may worsen the needs of the patient.
- **Being drawn into adverse/traumatic care dynamics can also have a significant impact on the health and wellbeing of clinicians.**

What would be the aims of the EPG?

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More specific aims could include:

- To enable and support a trauma-informed approach that minimises exclusion for patients who have often experienced severe relational injuries.
- To minimise the likelihood of re-enacting the exclusion, trauma, and other adversity that might underpin the presenting difficulties / relationship.
- To discuss incidents that may potentially lead to the exclusion of a patient by all those involved, in a dedicated space away from the time and place of the incident.
- To draw up any management guidelines / contracts of engagement that arise from a better understanding of the incident.
- To discuss individuals who may become at risk of becoming excluded i.e. as a prevention activity.
- To allow colleagues from across the general practice team (and beyond, if appropriate) to discuss and reflect upon situations that challenge the boundaries of the general practice service.
- To provide a setting in which people involved in any incident can discuss the event and reflect upon any issues or emotions that have arisen as a result.
- To feed back into the wider general practice team any issues that arise in relation to suggestions for service development that are highlighted from a review of an incident.
- To minimise the potential for the practice to act in ways that may maintain or exacerbate difficulties for the people who use the service.
- To prevent responses that may be arbitrary, punitive and inconsistent.
- **To support staff wellbeing, recognising that being drawn into adverse dynamics is damaging for them too.**

Who would make up the membership of the EPG?

The EPG would ideally consist of a stable core group comprising practice manager (or deputy), senior receptionist, and a 'lead' clinician (or deputy). Other members of the wider general practice team should be encouraged to attend the group if they have been involved in the incident, or if they know the patient well and would like to offer a continuity perspective. Ideally, the group discussions should be facilitated by someone with expertise in the area of relational dynamics. It may be appropriate also to widen the *ad hoc* membership further to include colleagues from the wider primary care team, such as community pharmacy colleagues.

How often should the EPG meet?

Ideally the core group would prioritise this work and meet on a regular basis to enable the development of consistency of approach and ongoing dialogue. In an Inclusion Health setting, fortnightly meetings would be recommended. In more mainstream settings, the frequency could be monthly in recognition of competing demands and lower prevalence of relational injury dynamics.

What should be the referral process for the EPG?

Patients may be referred for discussion at the EPG for any behaviour that may previously have resulted in their exclusion, for example if they recurrently 'DNA', or if their behaviour is deemed unreasonably challenging. If an incident was deemed to be serious enough to consider a consequence of either suspension or exclusion from the practice, the patient could be suspended from accessing services for a period of time that would allow the exclusion group to meet. The patient should be provided with a letter that would explain the process and inform them of where and how they can gain access to services during the period of suspension.

What is the decision-making process for the EPG?

The EPG would consider the incident and decide upon what is considered an appropriate level of intervention for the practice, avoiding exclusion where possible and reasonable. Any guidelines or behaviour contracts that arise from this would be drawn up by a member of the group to be discussed with the patient at an appointed time. If the outcome is permanent exclusion (being removed from the practice list), then this could be done by letter, or some other non- face-to-face contact means.

Factors that could increase the success of your EPG?

- Buy-in from the whole team (clinical and non-clinical is essential)
- Pre-group training for the whole team on the rationale and theoretical underpinning of the group, for updates for existing staff, and inclusion in induction for all new staff.
- Considering the establishment of an EPG within the context of developing a trauma-informed service may help.
- Referrals need to include adequate levels of information to inform fair and full discussion and decision-making.
- Referrer's attendance should be encouraged at the meeting discussion if possible.
- Regular feedback of decisions to the wider practice team
- Consistency of approach by the wider team to the decision of the EPG
- Regular administrative support for the EPG to enable accurate minutes and preparation of agendas.
- The EPG should ideally take place in the context of patients being made aware of the practice's approach to exclusion prevention for repeated non-attendance or challenging behaviour (e.g. at the point of registration, or on the practice website)
- Any referrals to the EPG for challenging behaviour should be in line with the practice's violence and aggression policies, which should also provide a guide as to when someone's behaviour is deemed severe enough to consider exclusion.
- Sharing learning and examples of good practices with other practices and via Clusters

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