**Practical examples of trauma-informed approaches in a general practice setting**

## ‘Stickability’ of services; aim for ‘low threshold and high-fidelity’ services

***Registration process***

How easy is it for patients to register with your practice? Is it accessible and inclusive? Do you ask for photographic ID and proof of address in a non-stigmatising manner, and still support registration if these are not available?). How are patients with limited literacy supported? Who have English as a second language? In addition to the standard online registration form, what information is collected by the practice to support inclusive care? (eg history of homelessness, need for a interpreter). Could you be more proactive in supporting vulnerable patients to register with a new practice if needed? Sample registration form process and letter shared.

***Approach to continuity of care***

For those patients for whom continuity of care is especially important, do practice processes support this? For example named clinicians, option to pre-book appointments.

***Digital Inclusion***

Recognising the importance of in-person encounters for many patients, including those with a history of psychological trauma, are there ways that your practice could offer choice to patients when booking and attending appointments to minimise digital exclusion?

***Approach to ‘Missingness’***

What is the process within the practice for following up patients who recurrently miss appointments, and are known to have significant medical issues (physical and/or mental health?). Is it coded? Is there proactive follow up from a member of the team to understand why? Could there be a dedicated **patient engagement officer role** created to enable this? (potential reasons considered: ?literacy issues ?insecure postal addresses for appointment letters ?transport issues ?insecure employment, ?poor mental health/low confidence/trust). Can attendance be supported in a different way? Might there be a role for a community link worker?

***Exclusion prevention (registration removal) process***

Have all reasonable mechanisms been tried to ensure that the patient can remain registered with the practice (conversations around challenging behaviour +/- a contract for this behaviour, support for staff). Sample Exclusion prevention Policy shared.

## Recognising and supporting the emotional labour of the jobs we do

***Staff training and support***

Does staff induction include psychological trauma training? Would a buddying scheme with a more experienced staff member be helpful? Is there opportunity for reflective practice sessions and/or ‘de-brief’ sessions after challenging confrontations with patients? Is there discussion at practice meetings and a consistent, fair, equity-informed, exclusion-avoidance approach applied? How do the clinicians care for themselves? Are there opportunities for reflective practice groups, peer support, Balint groups? Are there opportunities for a practice PLT on mechanisms to support wellbeing? (suggested resources: [Communicating effectively with inclusion health populations: 2022 ICCH symposium - ScienceDirect](https://www.sciencedirect.com/science/article/pii/S0738399123003579?via%3Dihub), [National trauma training programme | Turas | Learn (nhs.scot)](https://learn.nes.nhs.scot/37896/national-trauma-training-programme)

## Sensitive signposting/resource sharing

***Best use of existing practice communication channels with patients***

Are these being used to maximal effect, to share helpful information on social and wellbeing support with patients in an easy-access and low-stigma way, and to reassure patients that the practice is connected and supportive? For example having a dedicated ‘social support’ section on practice websites with key links; comfort and signage in the waiting room and patient toilets signalling inclusivity (eg posters for key local services and charities, including LGBTQI, ‘welcome’ poster in different languages). Having a list of ‘text-links; that can be shared with patients. Facilitating sensitive conversations away from the front desk where possible to maintain privacy, with interpreter if needed?

***Making best use of any existing social support roles within the practice***

Is there a joined up referral approach to community link workers, financial inclusion workers? Is there adequate practice support for colleagues in these roles? Are they invited to practice meetings? Coffee breaks? Is there a practice lead or buddy for these colleagues?

***Awareness of resources available to patients***

Is there good awareness of the wider resources and referral pathways that are available to patients with a history of trauma / ACEs, who would like additional support? (including third sector and specialist services). Are these stored somewhere that is easy to locate and update? (eg by the practice health equity lead). Are locums aware of how to locate such resources?

## Practice-based leadership

***Health Equity Lead***

Is there the potential to identify a health-equity lead within the practice? (for example, who could input into the development and improvement of practice processes, network with community groups and share learning with other practices?)

***Inclusivity Mission Statement***

Is there scope to include the practice team in a discussion around creating or updating a mission statement for the practice to include principles of inclusivity, accessibility and equity through relationships of trust and respect?

*“It is more important to know what sort of person has a disease than to know what sort of disease a person has”* Hippocrates

“*Those who have a ‘why’ to live, can bear with almost any ‘how’”* Viktor E. Frankl

## Co-creation of services

Is there the opportunity for the practice to work alongside people with lived experience to plan and evaluate the service they provide?

## Data capture

Is a history of Adverse Childhood Experience captured and coded in the patient’s primary care history? (ensuring appropriate sensitivities are applied when records are shared eg via referrals, KIS). (Useful resource, which acknowledges complexity of current codes! [General practice recording of adverse childhood experiences: a retrospective cohort study of GP records | BJGP Open](https://bjgpopen.org/content/4/1/bjgpopen20X101011/tab-figures-data))

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