Health Innovation
Oxford & Thames Valley

Surrey and Borders Partnership
NHS Foundation Trust

Surrey and Northeast Hampshire

Trauma-informed service

Summary report

End of year one 2023

Introduction

The Trauma-informed Surrey & Northeast (NE) Hampshire Team is a co-produced team comprising of clinical and lived experience expertise. The programme offered is currently the main provider supporting staff and organisations across Surrey & NE Hampshire in their transformation to be trauma-informed via training and consultation. The team also run a co-produced trauma-informed training course for people living in Surrey & NE Hampshire via the local Recovery College. To our knowledge, currently this is the only course of this kind offered in England.

This report forms part of a series, evaluating the implementation of the trauma-informed programme offered by the Trauma-informed Surrey and Northeast (NE) Hampshire Service.

As well as national reference to trauma-informed approaches in the NHS Long Term Plan (NHS, 2019) and Mental Health Implementation Plan (NHS(a), 2019), a local drive for all Surrey and NE Hampshire services to be fully trauma-informed required the locality to consider how this could be most effectively met for organisations across the system.

This report provides a summary of the trauma-informed service activities and evaluations completed in year 1 of the programme. The trauma-informed programme started in 2020 and pilot training was delivered to a limited number of services until March 2022. Year 1 refers to the period of April 2022 to March 2023 as the first year where the trauma-informed service was formally established.

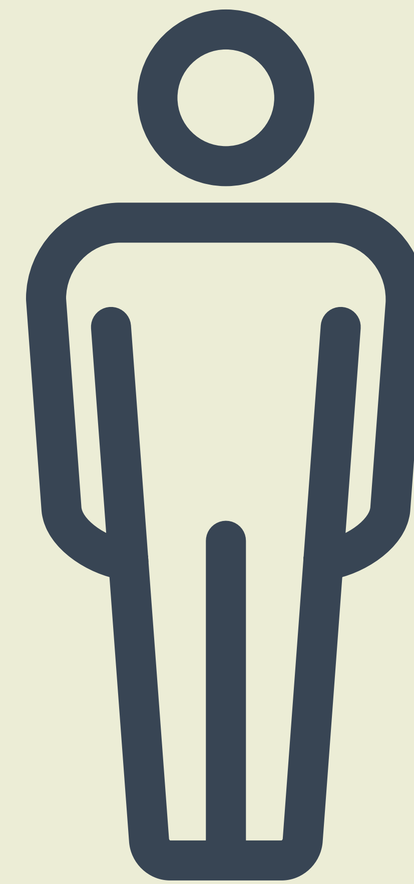
Trauma-informed Staff Training Attendance

Overall training attendance across all workshops was 61% (2257 spaces attended of 3678 spaces allocated). Of those who did not attend workshops 29% did not attend (DNA) and 10% cancelled at short notice (SNC).

A total of 180 workshops ran across 14 different modules, 5 workshops were cancelled.

Workshops

180



A total of 1242 individuals attended training workshops.

Attendance

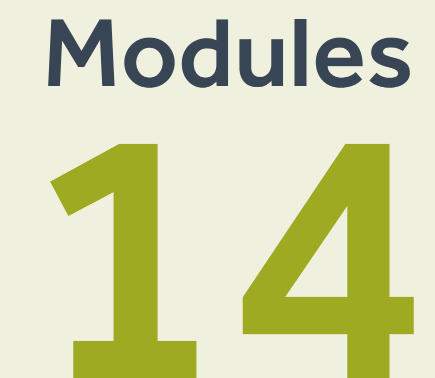
1242

One module ran face to face and provided 2 workshops on the same day: Understanding Trauma and Trauma-informed Care. The rest of the workshops all ran online.

The first year of trauma-informed training workshops began in Q3 2022 and ran to the end of Q1 2023.

Modules

14



Number of participants by sector

Service remits with the highest number of participants were:

435 Mental Health, Drug and Alcohol, Learning Disabilities and Community Services

285 Social Care Services

109 Mental Health Services

Organisations with the highest number of participants attending were:

435

243

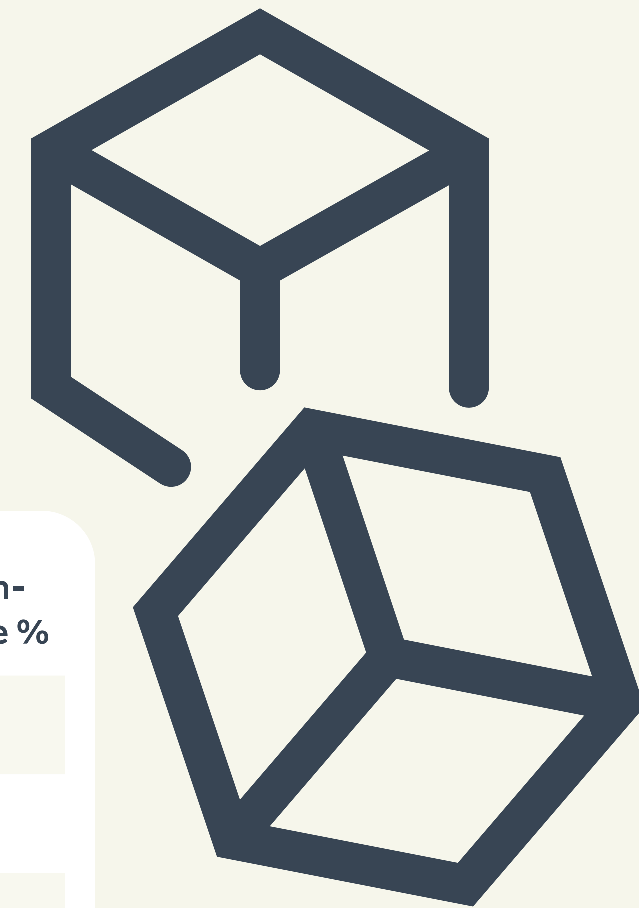
78

NHS sector includes both physical and mental health services, primary care sector includes those who reported working in GP surgeries.

Individual workshops attendance

Module	Number of Workshops	Uptake of spaces (%)	Number Attended	Overall non-attendance %
Understanding Trauma	39	69%	559	57%
Understanding Trauma-Informed Care	36	69%	530	57%
Responding to trauma and avoiding re-traumatisation	21	54%	225	47%
Applying Trauma-Informed Care Principles to ourselves and each other	9	57%	159	49%
Trauma-Informed Care to support refugee and asylum seeker care	14	54%	128	49%
Trauma-informed approaches to Risk Assessment and Management*	10	52%	103	40%
All Interactions Matter*	10	44%	97	41%
Trauma-Informed Supervision *	8	49%	88	43%
Understanding Trauma-Informed Care for Managers	7	40%	73	53%
Leading & Influencing Trauma-informed Change*	9	39%	71	30%
Understanding Trauma & Trauma-informed Care (F2F)**	6	45%	67	28%
Trauma-Informed Care to support Autistic People**	3	74%	59	27%
Being Trauma-Informed with Carers**	4	69%	55	25%
Trauma-Informed Care (TIC) in Primary Care	4	54%	43	44%

*ran from Q2 2022 **ran from Q1 2023



Workshops with the highest uptake of spaces (%)

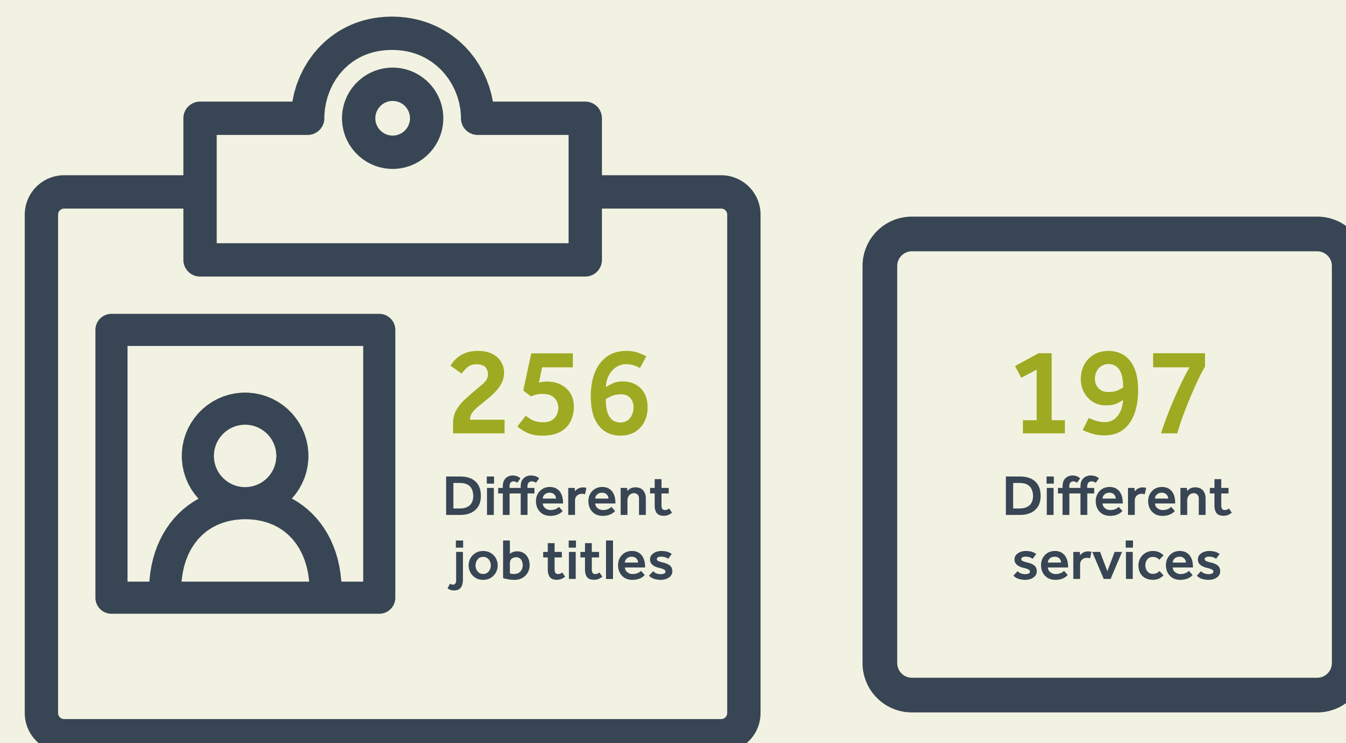
- Trauma-Informed care to support autistic people
- Understanding Trauma-Informed care
- Being Trauma-Informed with carers

- Leading & Influencing Trauma-Informed Change
- Understanding Trauma & Trauma-Informed Care
- All Interactions Matter

Workshops with the lowest uptake of spaces (%)

Attendance by Job Role and Service

Initial analysis of self-reported participant information yielded 256 job titles across 197 services.



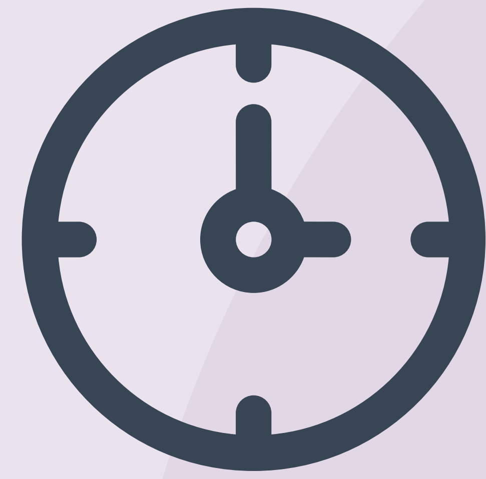
Analysis of the job titles and services worked within for individuals attending training was challenging due to the breadth of workforce accessing training. Job titles varied greatly across organisations and interpretation was required to aggregate these into categories. Additionally, as this field was self-reported by participants when signing up to training it was not always completed or fully completed.

Job Category	Individual Participants	Workshops Attended
Registered Clinician	488	864
Client Facing (Not Registered Clinician)	436	836
Senior Role	236	415
Non-Client Facing	79	140
Unknown	2	2

Job titles were aggregated to produce 52 aggregated job roles and grouped into 4 categories (2 individuals did not supply their job role).

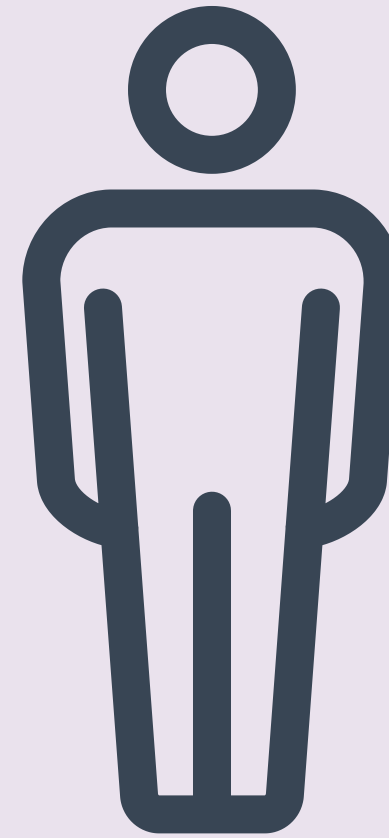
Trauma-informed Staff Training Non-attendance

29%
±Did not attend (DNA)



10%
±Short notice cancellation (SNC)

3%
Rebooking rate after non-attendance

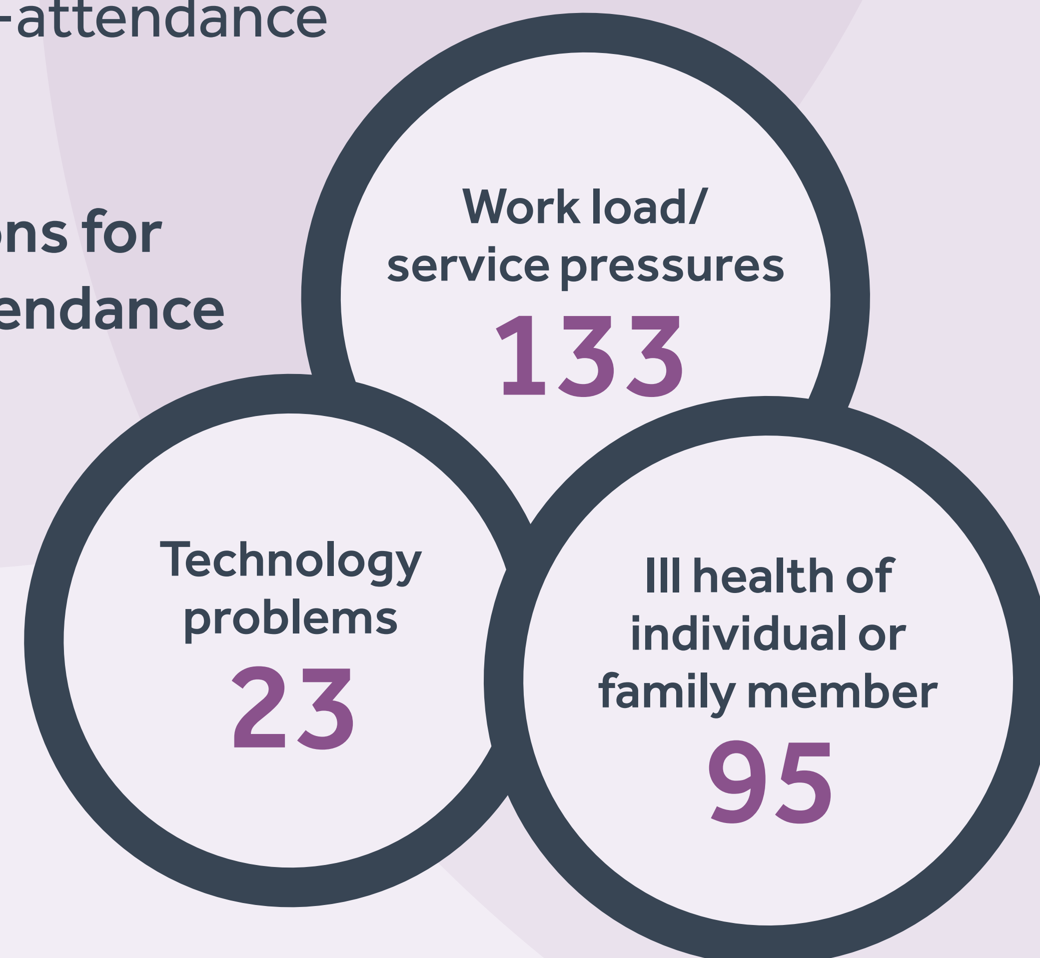


Overall Attendance
61%

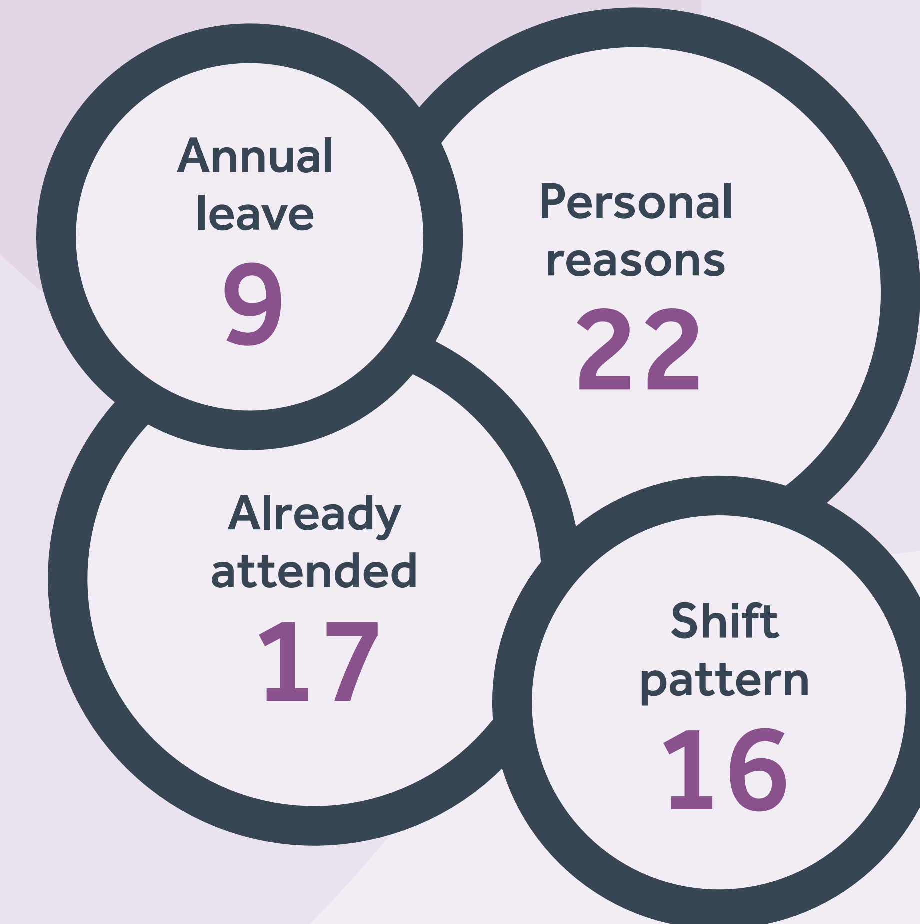
26%
Response rate

A non-attendance questionnaire was sent to all who did not attend a workshop. 371 individuals responded, from 37 organisation (only 234 provided an organisation).

Reasons for non-attendance



Reasons for non-attendance



±SNCs were classified as workshops cancelled with 48 hours or less notice, DNAs were classified as those who did not attend on the day without cancellation.

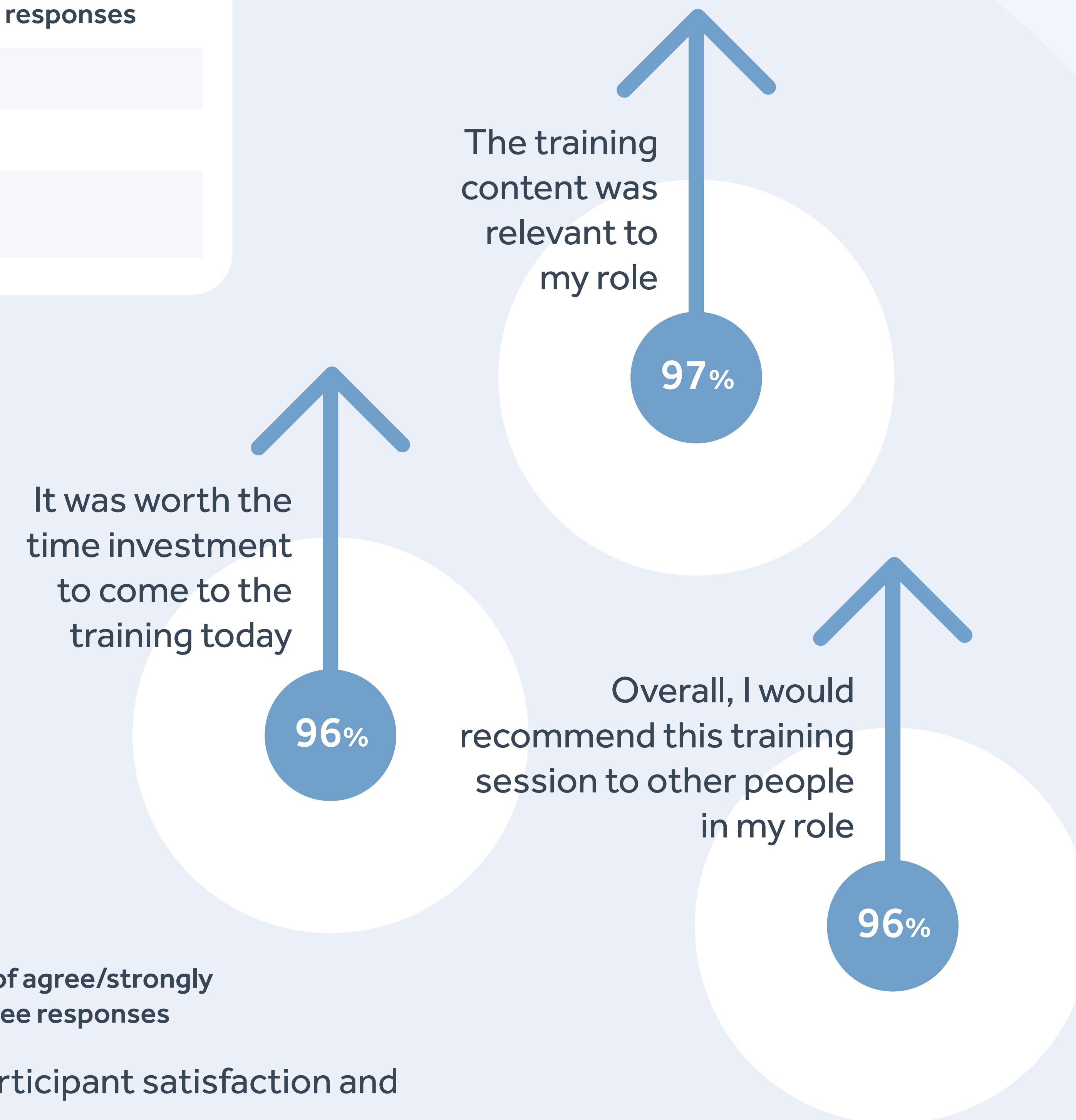
Trauma-informed Staff Training Feedback

Feedback was collected immediately after training via an online form.

Knowledge and Skill

	% of agree/strongly agree responses
I gained new knowledge and skills	95%
I feel that I can apply what I learnt to my work	95%
The methods of delivery used in the training helped my learning	96%

Participant learning scores



% of agree/strongly agree responses

Participant satisfaction and relevance scores

Relevance and Satisfaction

"An excellent and thought provoking session... in a recovery-oriented NHS world, TIC really does give hope that we can work with people in more compassionate and thoughtful ways. Thank you."

"Genuinely one of the best training sessions I have attended. From the moment X [lived experience facilitator] introduced herself, I listened more if I am honest because it is so helpful and reassuring to have someone with lived experience. It helps to make the training seem more relevant and gives authenticity."

"Such training should be rolled out to key training programmes (e.g. medical school, junior doctors, nursing programmes, trust inductions) so that it is not just a voluntary course."

"The training was excellent. I learned so much and it helped give me ideas and clarity."

Specific relevance of the six principles of trauma-informed care was demonstrated through in-session feedback using a digital whiteboard.

Why are these principles important when we are responding to Trauma and Distress?

Safety	Trustworthiness & Transparency	Collaboration & Mutuality	Peer Support	Intersectionality	Empowerment, Voice & Choice
Individuals need to feel safe to share feelings without fear of rejection. Reducing fear and increasing feeling safe supports building trust in relationships where people can open up and connect without shame or blame	Trust is needed to avoid re-traumatisation and doing harm. We don't want to cause more distress or reduce the likelihood of someone accessing support in the future.	Partnership working is not taking the expert stance, working together (not alone), being person-centred will help build rapport, shared language, meet their learning style, learn from each other and from experts in the field. Create a shared goal.	To build relationships and connections that support recovery and staying well.	Everyone is different - so cultural historical and other sensitivities are crucial to manage everyone as a unique individual.	Choice is so important - sometimes services 'do to' rather than 'work with' - for people who may have been violated or disempowered in the past, this is re-traumatising and prevents engagement.
Shared understanding without prejudice or judgement can increase psychological safety, connection, trust, openness, and vulnerability.	So that people are validated in their experience and feel comfortable. To help foster hope for recovery.	Don't do 'to' someone, to be part of the plan, not just a recipient. Always remember the service user is the expert on what they need. Model healthy relationships.	Peer support helps people experiencing issues have hope for the future re: work, relationships, interacting in society.	Observing cultural differences and diversity means that we are being person centred, not stereotyping, or just focussed on their distress. Treat people as individuals without prejudice, who are experiencing their own set of challenges.	We need to be able to empower individuals to be able to start trusting in themselves and recognising that they are worthy.
When someone is distressed, they often feel out of control, we need to offer safety and containment in response. Creating a safe environment prevents someone's arousal levels raising and allows therapeutic healing to occur.	The client needs to feel they can trust the practitioner to feel comfortable, safe, connect and engage in support with services without fear of feeling judged or punished. Builds psychological safety which can help the person regulate themselves.	Collaboration is working together to make people feel less alone whilst also making their own choices and can compensate for traumatic isolation.	Peer support means that you get to work with someone who 'gets' some of the struggles in a deep way - even if the experience is different the compassion is powerful. Learn from others and know we are not alone.	Recognise that people may have traumatic histories - cultural or marginalised groups and people may present trauma differently. This can help understand context of trauma.	People need to be involved in plans that includes their lived expertise i.e., what works for them. Choice and empowerment ensure the person feels valued, listened to, believed, and supported to regain control and build autonomy.
Making sure we risk assess properly to help prevent suicide.	Trust in a person can help people to deescalate more effectively.	Provides the opportunity for individuals to engage more fully in interventions or care plans, gives autonomy for decisions, lessen feelings of coercion which could've been part of their trauma.	Many men (especially who work in public services such as military or police) often find support more accessible.	Understanding someone's history helps understand 'what happened to you?' rather than 'what's wrong with you?'	People with trauma may have experienced times in their life when they did not have a voice or choice and therefore giving this back to someone helps them to challenge filters.
To ensure we are practicing safely and looking after ourselves as practitioners, attending debriefs and having regular supervision, particularly considering vicarious trauma.	Professionals need to break the cycle of previous experience of broken promises and dashed expectations. Remain transparent about processes and what we can and can't provide to manage expectations.	Listen to, be curious, understand what someone wants to achieve not assume we know what is best for them. Provide validation without judgement or blame.	Peer support provides validation and acceptance through normalising the behaviours that develop in response to trauma and reducing shame.	Important to how they have come to understand and interpret their experiences and behaviours. Can inform how we support service users.	What we think is best for someone may not be what they think is best for them.
Building a safety plan with a person, as when a person is distressed, they are not able to engage cognitive function and previous plan can help decision making and make sure their choices and needs are considered.	Trust develops from constant collaboration and mutual respect and authenticity - that trust is the mechanism through which change occurs.	Guides the way we can design our processes, how we start communication with people, the intervention and how we manage and support endings for people.	We should lean on colleagues for support - supporting people with trauma can be overwhelming and distressing so we need to look after ourselves to support our clients. Ensure good reflective practice and spaces to de-brief with skilled colleagues.	Understanding someone's values and why something might be important to them. It's hard to feel understood or safe if you aren't able to recognise and respect my identity and traumas attached to these.	Empowerment supports building resilience and commitment when things get difficult and can promote a healthy culture in teams/services.

What was most helpful?

Applying to real world

Responses frequently referenced the value of being given the opportunity to apply training content to their own roles.

When commenting on applying learning to their own roles and real world work situations, participants often identified other elements of the training sessions that helped this be possible. These are listed below.

"I was able to relate the material to clients that I am currently working with, and it gave me a really good space to take time out of the firefighting nature of my role to reflect."

Theoretical knowledge

Training participants reported many different specific elements of theoretical content that they found helpful. The most frequently referenced theoretical content related to understanding trauma and understanding trauma-informed approaches.

"It was really engaging with simple explanations around what trauma is and how it presents in people."

Skill development

The theme of skill development emerged from participant feedback, with particular emphasis on the 'how to' elements of the training. Training participants valued the rich discussions, often involving lived experience which helped to demonstrate what it means to have a trauma-informed approach.

"Helped me notice the small things that we can do to provide trauma-informed care which can make a big difference to making a client feel safe and supported."

What was most helpful?

Design and delivery

A large proportion of feedback related to the design and delivery of the session. Specifically, the lived experience facilitator and the interactive elements that allowed for multi-agency discussion and sharing of experiences, either in face-to-face groups or virtual breakout rooms.

"The wide range of services within which people attending were from – I thought this enriched discussion and shared learning."

"I found the discussions most helpful, I feel it helped to really understand how to apply trauma-informed care to many different situations."

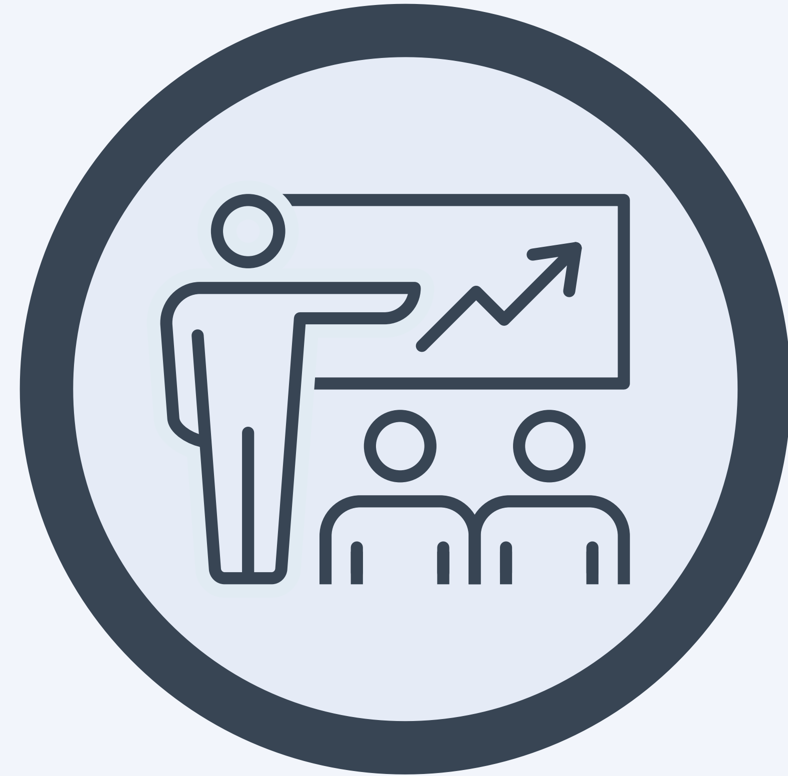
"Professionally, I found the lived experience facilitator's honesty really helpful in demonstrating how even the seemingly small interactions can make a difference."

Materials

There were reflections from multiple training participants regarding the variety, breadth and depth of materials used which included videos, slides, interactive whiteboards, literature, articles and poems. Of all materials, participants most frequently commented on the use of short video clips. Positive comments about the use of videos were given across all training modules.

"The initial video (Trauma-informed care to support autistic people) was very powerful and helped frame and focus the session."

How do you plan to apply learning?



Dissemination and making changes

Training attendees feedback under the theme of dissemination and making changes demonstrated commitment to implement their learning. Participants reported they would share learning with their peers, team and manager, encourage others to attend training and review policies and processes in light of the training they had received.

"I plan to make some posters for the office as reminders for staff."

"I will be discussing trauma at our next team meeting to support my team with understanding its complexity."

"I am going to look at our template, recommend all managers complete this and also consider how we gain feedback from staff as to their experiences."

Attitudes towards interactions

Training attendees frequently described the training as having changed their attitude in terms of how they approach interactions with others. Many of these responses were centred around being mindful of language and the value of every interaction. Responses also referenced the importance of providing choice, being led by those who use services, collaborative and transparent in order to build trusting and compassionate relationships.

"Approach people I work with in a person centred way – what has happened to you, not what is wrong with you."

"I will try and collaborate more with service users and encourage them to be a part of their entire support plan instead of writing it and sending a copy."

How do you plan to apply learning?

Supervision and wellbeing

Many responses related to supervision and wellbeing. These responses referenced trying to be a better role model for their supervisees and incorporate more reflection and space for meaningful wellbeing checks. Practical elements such as more comprehensive reviews of supervision notes and reviewing supervision structure and template documents were also noted.

"Ensure I always have real conversations with those I supervise about how they are."

"I plan to share the wellness action plan with my team and start having better boundaries around working hours."

Confidence in using techniques

Confidence in maintaining a trauma-informed approach was displayed by training participants when they described specific techniques they felt able to take away and implement in their day to day work. The most frequent helpful technique participants intended to use as a result of the training was to ensure they used a trauma-informed lens.

"Using a trauma-focused lens approach to all patient care, avoid any assumptions, take time to learn about background before meeting to avoid re-traumatising."

"Try to understand what service user is trying to communicate by certain behaviours that are traditionally labelled as challenging."

Understanding of behaviour

Many training attendees reported they would now look at reasons behind a person's behaviour as a result of being more aware of the impact of trauma. Being aware of re-traumatisation and taking steps to avoid this was also frequently mentioned.

Exploring barriers

Time

The most frequently referenced barrier to implementing learning was time. These responses recognised time constraints when interacting with people who use services and colleagues, and there was acknowledgement that feeling too busy can lead to forgetting new ways of working.

"Time pressure to 'get things done' which can lead to rushing assessments like this and not giving time and space to make it trauma-informed."

"When things get busy it's easy to revert back to previous ways of thinking and doing."

Resistance

Resistance from other staff was frequently cited as a potential barrier to implementing learning. For some participants, resistance was forged via a lack of understanding, struggles to get "buy-in" from managers and the need to work in a different way such as to have proactive rather than reactive approaches and to keep a trauma-informed focus in practice.

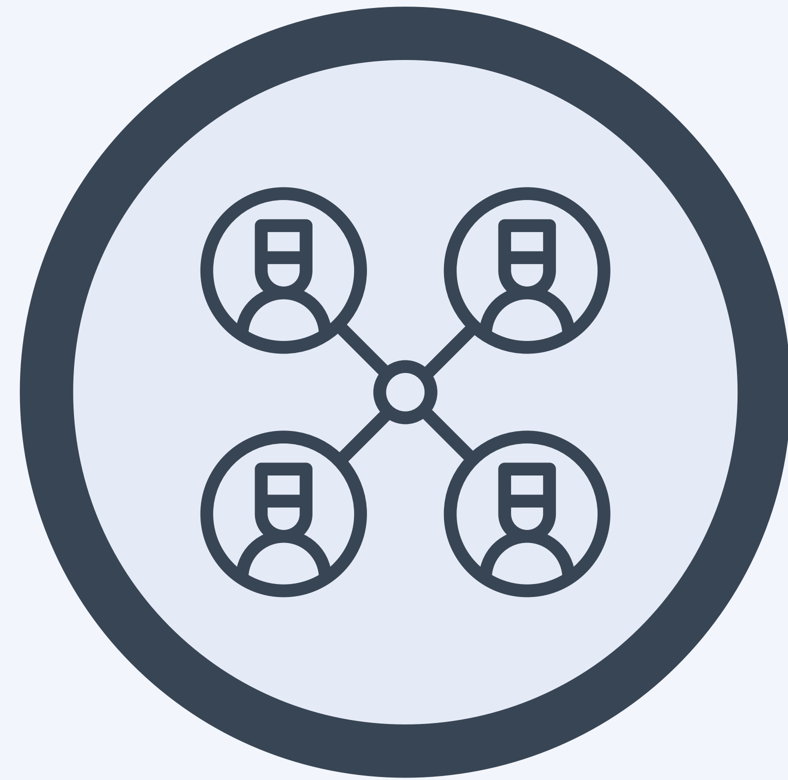
Some participants also expressed challenges in how trauma-informed approaches are viewed across different areas of healthcare.

Other barriers included a lack of engagement from people who use services alongside an individual's experience of trauma.

"Staff attitudes and the belief we have always done it this way so we will continue."

"Attitudes of wider team towards trauma-informed approach. I work in physical healthcare, where some of these ideas might be seen as less of a priority."

Exploring barriers



System barriers

System barriers included organisational pressures across a variety of areas including participants feeling restricted by service policies and processes, as well as financial constraints and competing service pressures such as staffing issues and challenges to offering choice to people who use services.

Consistency of a trauma-informed approach and communication between services were also highlighted as barriers across a number of modules.

Other system barriers included services having a focus on key performance indicators (KPIs) rather than outcomes for people who use services.

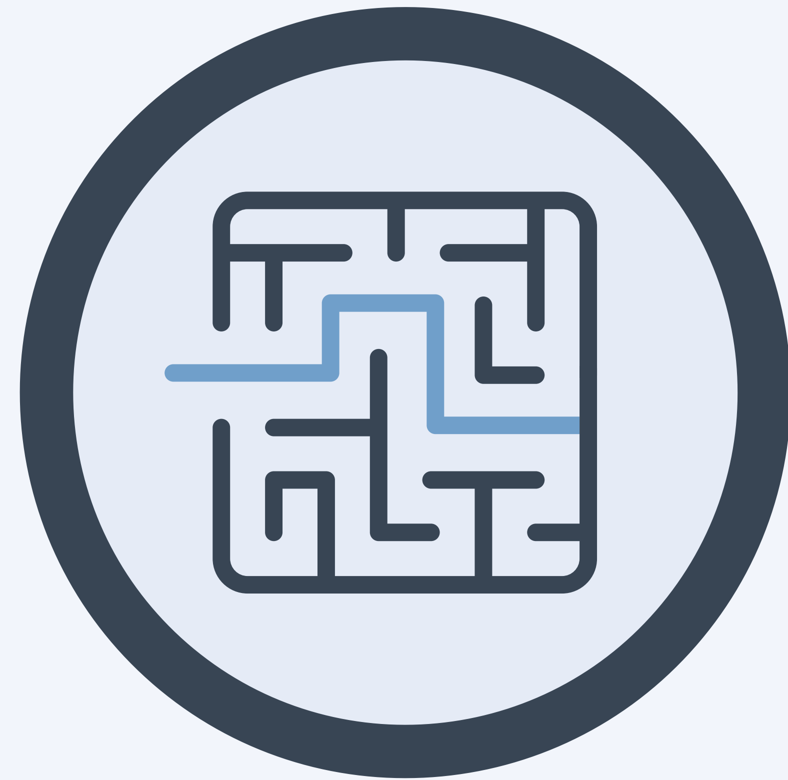
Having the 'head space' for room to think, reflect and adopt a different approach was reported as a barrier to change. This was perceived by participants as different to the barrier of time.

"Boundaries around missed appointments and 'rules' such as 2 DNAs [did not attend] and they are discharged."

"Caseload and financial constraints."

"The turnover of staff, the systems that are set up... cases move on and don't necessarily stay with the same practitioner, resulting in people having to re-tell their story."

Exploring barriers



Personal barriers

Barriers for implementing learning often related to the participants' own personal circumstances or feelings around the training and their work. These included a lack of confidence, fear of offending others or re-traumatisation, compassion fatigue and burn out. Participants also highlighted the need to feel safe, specifically with regards to acknowledging and sharing their own trauma.

Other personal or internal barriers to adopting a trauma-informed approach included personal triggers, unconscious bias, stigma and working with people who use services who evoke strong internal responses.

"Fear of my actions being misunderstood and misunderstanding the actions of others."

"Own personal traumas, which may be triggered and/or cause emotional burn out."

"Remembering everything and feeling confident to change the way I work."

Environment

Some training participants reported their physical working environment as a barrier to implementing learning. This included remote or telephone working as well as the physical space where they may be talking to another person.

"Telephone clinics so I do not have the non-verbal cues from a patient where I used to in a face-to-face appointment."

"Lack of control over the rooms I am allocated to use in GPs and schools."

"Being unable to make physical changes to the working environment such as more visible/ easy escape routes or controlling the presence and noise levels within an office."

What would help overcome barriers?

Perseverance

Many participants reported that overcoming barriers would involve some form of perseverance. This could take the form of integrating trauma-informed approaches into their everyday work, ensuring this is always on their team agenda or raising issues and challenge where appropriate. Within perseverance, training participants also reported the need to build confidence and schedule time to organise, take breaks and review training materials.

"Building this into all frameworks; supervision, sessions, meetings, service reviews, basically making it impossible to forget to focus on this!"

"Making it a priority regardless of the challenges."

"Adapt my supervision sheet so that the principles and 4Rs [realise, recognise, respond, resist re-traumatisation] are always visible and prompting."

"Being transparent and open to have conversations about what might make TIC [trauma-informed care] difficult and how we can overcome these."

What would help overcome barriers?

Service and organisational level changes

Leadership and culture were frequently highlighted both in whiteboard in-session feedback and post training feedback forms as ways to overcome barriers. These included senior leaders attending training, leading by example and role modelling trauma-informed approaches, and explicitly demonstrating buy-in.

A change in culture at both individual and organisational level was suggested, including creating a collective understanding, breaking down bias, empowering people to identify their own responses to trauma, having continual discussions around trauma-informed approaches and placing emphasis on using the trauma-informed lens. Additionally, participants suggested taking feedback from people who use services on board, adopting a strengths-based approach within teams to make the best use of staff expertise, sharing knowledge and experience, supporting staff to remain compassionate and curious and challenging dated viewpoints.

Addressing resourcing issues such as staff shortages and funding cuts, having access to more training, increasing co-production, partnership working with other services and improving service communication were also suggested to overcome these barriers.

The need for easily accessible, funded training was identified for individuals working at all levels and across organisations, not just those providing mental health services, including schools, universities and social care. Ongoing training was also identified as being needed to refresh memories and combat staff turnover.

Improved collaborative working both within and across organisations and trauma-informed policies and guidance were suggested as ways to provide a more consistent approach to people who use services.

"Top down emphasis on its importance so that staff have permission to make time for stepping back and thinking about these issues."

"Speak to managers about the training and encourage them to learn more."

"Improved communication and partnership working with referring teams."

What would help overcome barriers?

Personal development

Incorporating reflective space, being considerate of their own wellbeing and making use of supervision were all referenced within the theme of personal development.

Relationship building

Relationship building skills such as listening, the use of therapeutic contracts, and being mindful of language and transparency were all mentioned by training participants as important factors in overcoming barriers to implementing learning.

Participants emphasised the importance of using trauma-informed approaches with staff and each other, not just people who use services.

What would help overcome barriers?

Working adjustments

Some training participants stated that specific working adjustments would be necessary in order for them to overcome barriers to implementing learning. The most frequently reported of these was either more time or protected time to allow space for incorporating trauma-informed approaches. Other adjustments included smaller caseloads and improved physical working environments.

"Make time to gather history from clinical records; this will help to avoid retraumatising during history taking and afford more time to psych-education and intervention."

"Smaller caseloads and regular supervision."

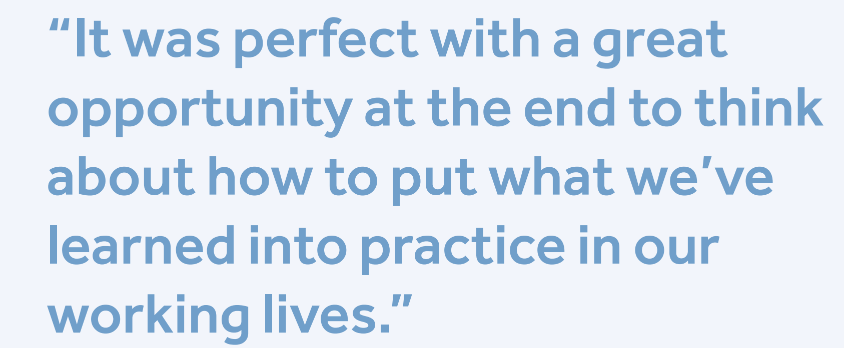
"Factor in more preparation time when having appointments, more time to read through the notes and gain an understanding of where the person is at."

Suggestions for improvement of trauma-informed training programme

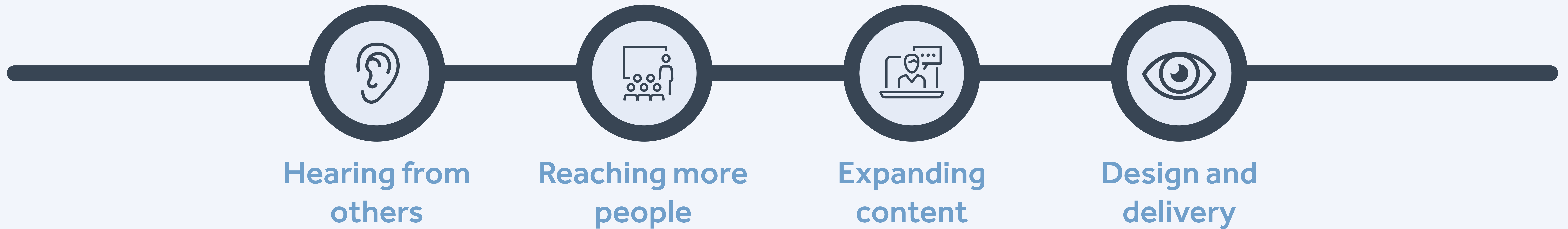
There were no trends across participants who responded disagree or strongly disagree to Likert scale questions. Disagreement responses were received across modules, from individuals working across a number of services from all role types. A small number of participants gave free text answers that related to their disagreement responses.

Training attendees were asked what they thought would improve the training sessions they attended. Responses were grouped into the following themes outlined below.

Of all the training participants that answered this question, almost one third of participants stated there was nothing they would do to improve the training they attended.



> "It was perfect with a great opportunity at the end to think about how to put what we've learned into practice in our working lives."



Trauma-informed Staff Training Follow-up Feedback

In addition to the feedback collected immediately after training, detailed in the previous section, a follow-up survey was sent out to all training participants (1242 individuals) via an online link. The survey sought to understand if/how training participants had implemented the training in practice and was sent 8 – 19 months post training.

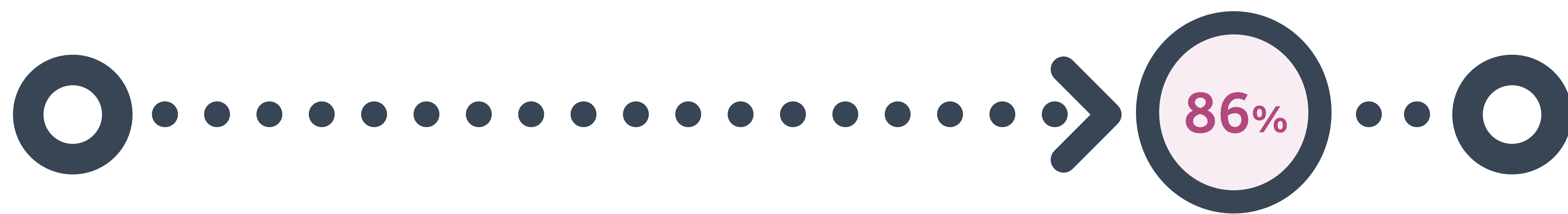
19

Organisations

Frontline Services

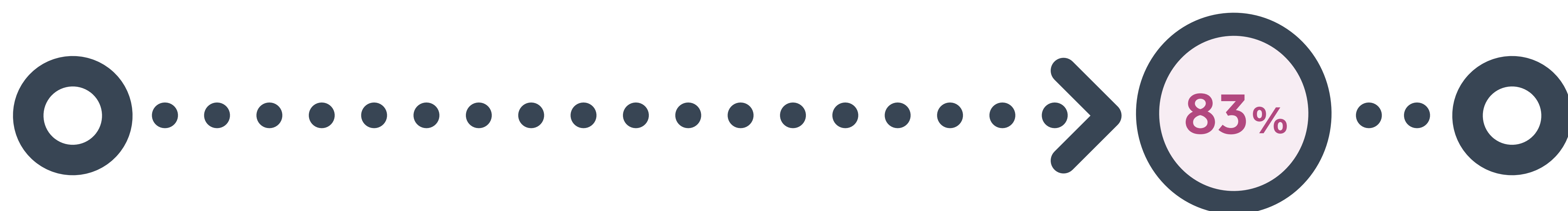
acute hospital care
youth justice
homelessness
domestic abuse support
police
social work
maternity
mental health
primary care
residential care

Confidence to work in a trauma-informed way



86% of participants agreed or strongly agreed that since attending the training they feel more confident about working in a trauma-informed way.

Applying the training

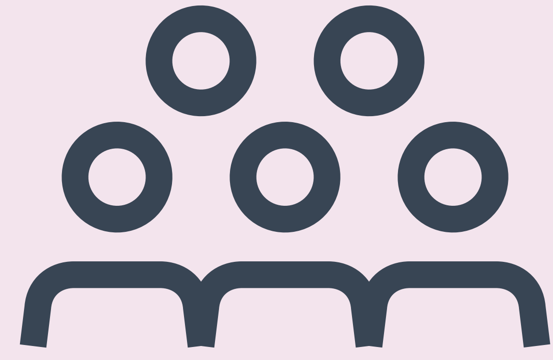


83% of participants agreed or strongly agreed that they have been able to apply the training to their work.

"Gives me **greater confidence** about working sensitively with individuals with trauma history."

"I was able to **share my learning** at a team meeting so my colleagues benefited."

"Boosted my confidence that **I've been doing it right.**"



Team level behaviour change:

Team processes and policy

"Changing structures of meetings and language used."

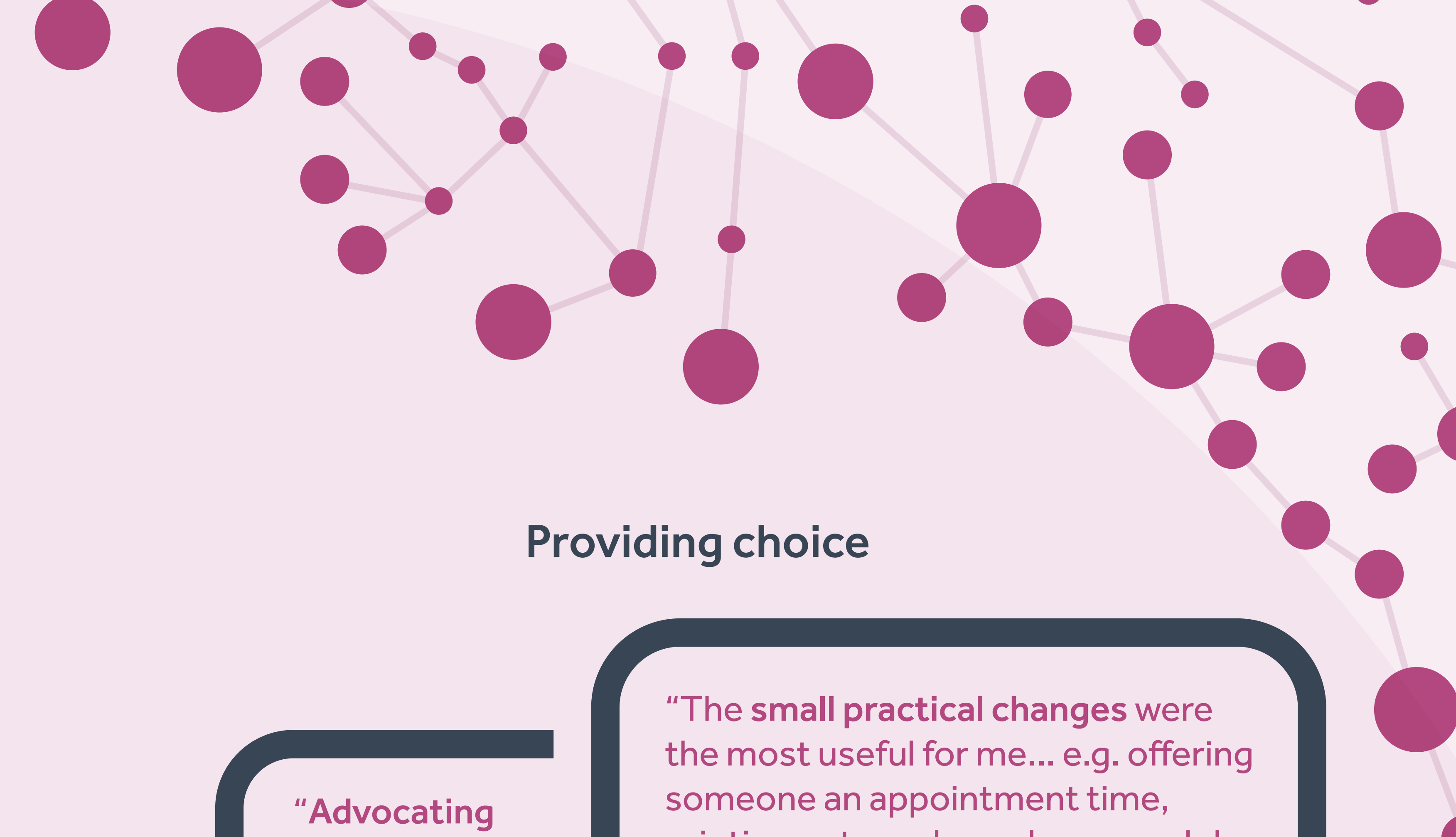
Training

"I have used some of the videos and information slides as part of my training package. It has also been shared at our Safeguarding Group to ensure that those in **leadership** are aware of the impact of trauma when delivering healthcare."

Individual level behaviour change:

Changes in language

"Understanding the theory and language of TIC [trauma-informed care] has given us **tangible ways to articulate** to clinicians what we do and how this helps young people."



Providing choice

"**Advocating for choice** when women are choosing interventions."

"The **small practical changes** were the most useful for me... e.g. offering someone an appointment time, printing out wordsearches or sudoku for people to complete during break times instead of having to 'mingle.'"

Interactions and building relationships

"I have used this training in supervision sessions to support staff and ensure that their wellbeing is good as they work with service users with complex needs and multiple disadvantages."

"I have been able to allow more time to listen to patients and for them to build up a trust and to allow them to express what **makes them feel safe** and have tried to make the environment as safe as possible."

"Support practitioners to consider different approaches with children who have experienced trauma and think about their responses within a **trauma-informed lens** rather than make assumptions."

Knowledge, awareness and attitude

"Understanding more about how to help someone whilst seeking to minimise the effect of reliving the trauma by talking about it."

"Observing my own and others behaviours and responses ensuring they are not triggering for anyone impacted by trauma."

Participant reported impact of training

Sustained awareness and understanding of trauma

"Training delivered to ward staff has meant they are able to understand that past trauma may impact on healthcare delivery, and to consider the environment may risk re-traumatisation."

Increased staff confidence and wellbeing indicators

"Training enabled me to work more sensitively with carers, using trauma as the basis for certain questions, leading to a more tailored type of support."

"Gives me greater confidence about working sensitively with individuals with trauma history, and holding this in mind when considering how people react in the present. what can the service do differently when the person seems to be 'stuck'?"

Improved relationship building with people who use services and staff

"Reduced for some service users and staff having negative encounters and perceive it has improved the quality of interactions with both service users and team members."

"I can apply another perspective to all my patient encounters and consider how some behaviours/communication style/coping strategies can be due to trauma response. I feel that I pause more with my communication to allow patients space to process things."

"Patients are readily coming to find me on the ward as they know that I have the patience and will listen to them."

A shared language and culture

"Helped us to **articulate** and be confident in what we do as youth workers as the principles and practices are aligned."

"Prevented some of the more negative talk about individuals by **reframing behaviour** in line with life experiences."

"Understanding the theory and language of TIC [trauma-informed care] has given us tangible ways to articulate to clinicians what we do and how this helps young people, resulting in **improved referral rates**."

Assessment and engagement skills

"Staff were struggling to manage a complex person who uses our services. Applied the principle to break down the case and formulate a plan than addressed the issues in a trauma-informed way (triangle of care). Staff felt supported, person who uses our service felt validated."

Trauma-informed Recovery College Course

The psychoeducational course "A Trauma-informed Approach to Care" was run by Surrey and Borders NHS Foundation Partnership Trust (SABP) through the Recovery College in September 2022 and in January 2023. The course was run online and comprised of four two and a half hour sessions.

Engaging in future activities

Students were asked if the course had supported them to engage with further activities relating to education, employment and volunteering. Six out of seven students reported that the course had supported them to engage with at least one activity.

Has your time on this course supported you to engage with any of the following?	Number of students who reported engaging
Education	2
Paid employment	2
Voluntary employment	2
Another Recovery College course	3
Volunteer at Recovery College	2

What was helpful about the course?

When asked what they found helpful about the course student responses included comments about the sessions themselves and how they were run:

> Peer support.

> Lots of time for questions and comments welcomed and valued.

> The course was fun and engaging, really interactive with a good balance of education and grounding exercises.

> The TIAC [trauma-informed approach course] course was really amazing, hugely informative and thoroughly well presented. There was an excellent balance of information-input from facilitators and lived experience-input from attendees. There was also a well-held boundary between what were very valuable thoughts/feelings from participants and what could easily have turned into an overload of 'telling my Life story'. This boundary was held with empathy and skill.

As well as comments around the content that was taught and what this meant to them and their view of future service interactions:

> How to care for/help someone with PTSD [post-traumatic stress disorder] and trauma related conditions.

> The people are going to start treating underlying issues and not the stereotypical mental health illness labels. Giving patients safety in their vulnerability, allowing them to form trust which will enable an increased chance of getting to the core problem.

> The major thing that I carry away from this course - other than reassuringly having seen my life reflected in the trauma related content - is HOPE, hope that this approach will be truly taken onboard by clinicians and other mental health services staff to whom it will be presented.

> The information regarding trauma and recognising the effects.

The student who participated in an interview agreed that since they completed the course they have a better understanding of what trauma is and the impact of trauma and that they understand the six principles of trauma-informed care.

They also strongly agreed that since the course they have a better understanding of what to expect from care that is trauma-informed and feel more confident to speak to people supporting them about trauma-informed care and to tell those supporting them what they need.

The student also commented in interview that the course had allowed them to approach services with hope and that they would feel better able to challenge things such as a medical model approach. They also stated that they felt empowered by the fact it is run within their local NHS Trust.

Additional comments

Several students also provided additional comments that advocated for trauma-informed approaches being more widely adopted and training being available to all.

Please make this course is mandatory for all trust staff.

The principles of Trauma-informed Care should be implemented across all NHS services. I've lost count of the times I've felt ignored, not believed and dismissed by hospital consultants, mainly with physical ill-health.

The course gave me a sense of self confidence to keep advocating for myself when interacting with the services but also within my work environment (school) where I believe trauma-informed care should be applied more. Hearing that the course is delivered also to the professionals made me hope that there will be more awareness on what is useful and what may not be helpful when receiving the support and that the approach will be universal across agencies and care related jobs.

I thought I had something wrong with me, so to find out the way I've reacted throughout my life is a response to things that have happened helps me go out with my head held high. It would make a huge difference to people coming into contact with services to understand the connection between life circumstances and how you are." [From interview]

Trauma-informed Staff Action Learning Sets

Action learning sets were piloted to support individuals to embed a trauma-informed approach. There were four groups run from January 2023 to June 2023. Each set had four sessions and group size ranged from four people per group to seven people per group. Three groups consisted of participants from different organisations and services, one group consisted of participants from one organisation.

Rationale for action learning sets

Training alone does not make an organisation (or individual) trauma-informed. Feedback from people who had attended the training programme offered by the service identified that they were finding it difficult to embed a trauma-informed approach.

Action learning sets originated from a recognition that learning comes not just from knowledge but from questioning which can aid thinking and insights. An action learning set is a structured, collaborative, forum to solve real problems using reflection. It consists of a facilitated group of people working either in the same or different organisations that meet regularly to help unpick and finds ways forward with workplace challenges. The Surrey and NE Hampshire trauma-informed service decided to pilot using action learning sets to see if these were a helpful medium to support people embed a trauma-informed approach. The action learning sets offered by the service had a focus on trauma-informed challenges.

In some quotations used within the report action learning sets have been referred to by participants as ALS.

Recruitment

Initially, an email requesting expressions of interest was sent in October 2022 to those who met the criteria of working in a senior role, had previously attended trauma-informed training and were in a position to influence change as a pilot to see if action learning sets were helpful. Following a number of queries from people interested in joining the action learning sets, the invitation was expanded to include any leader, defined not by seniority of role but being in a position to implement and influence change.

Once expressions of interest were sought, they were checked to ensure participants met the eligibility criteria:

The decision was made to have mixed organisation groups to fit in line with a trauma-informed approach which recommends cross sector and across organisation working to foster relationships. There were also a number of people from one service who applied and met the eligibility criteria, and it was agreed to pilot having a group with participants from one service for comparison.

Benefits of participating in the action learning set

Hearing from others

All participants who completed the online questionnaire felt that the action learning set helped the group to reflect upon and resolve emerging issues relating to trauma-informed practice and agreed or strongly agreed that they have a better understanding of the challenges held by others. Nine out of ten participants felt they benefitted from hearing other members of the group think through their chosen issues and valued the opportunity to develop relationships with others.

At interview, hearing from others and the opportunity to reflect with people from different roles and organisations was highlighted by participants.

"I think more than anything it was having time with people who are like minded to really gain support and ... to hold on to hope that things can be different and because we were all in different parts of the Surrey system, there was something quite nice about that as well.... So it was really nice in terms of that thinking from different parts of the system as well about the issues."

[Participant 2, 1 month interview]

A different approach to supporting others

Nine out of ten participants agreed or strongly agreed that the action learning set helped them to support others through asking questions, rather than suggesting solutions. This was reflected as the main theme in free-text responses from participants when asked what they learnt that surprised them.

"I really enjoyed learning about the types of questioning and particularly found the peer consultation powerful."

"How much I want to share my own personal experiences as I think I have some answers- I was surprised by the strength of that pull!"

"The challenge of asking questions that explore the issues rather than giving suggestions for solutions."

"The benefit of asking/ answering questions without a potential solution up my sleeve!"

This was also a prominent theme at both one and three month follow-up interviews for participants.

"I actually grew in in my ability to question and receive questions which I found really interesting."

[Participant 3, 1 month interview]

The right approach

In the online questionnaire responses eight participants responded that they felt action learning sets were the right approach to help them move forward with their chosen issue. One participant responded that they were only able to attend the first session and one participant did not provide an answer.

Responses highlighted the collaborative nature of action learning sets, providing a safe space with a structured approach which supported participants to explore and think about their issues.

The way in which action learning sets were facilitated was highlighted by interview participants as enabling a safe and supportive space to share and reflect.

At interview all participants were extremely positive about the approach of action learning sets.

"I felt safe to share and safe to be vulnerable, safe to get things wrong. And the facilitator was really brilliant at kind of of allowing for that and setting up the ground rules and all the rest of it."
[Participant 5, 1 month interview]

"It's a really good process and I think anybody that's got a service development in their mind should go through it. It think really makes you look at things in a different light. "
[Participant 1, 1 month interview]

Personal development

Participants identified the action learning set as supporting their personal development through looking at issues in different ways, listening more and keeping an open mind and how to explore another's issue.

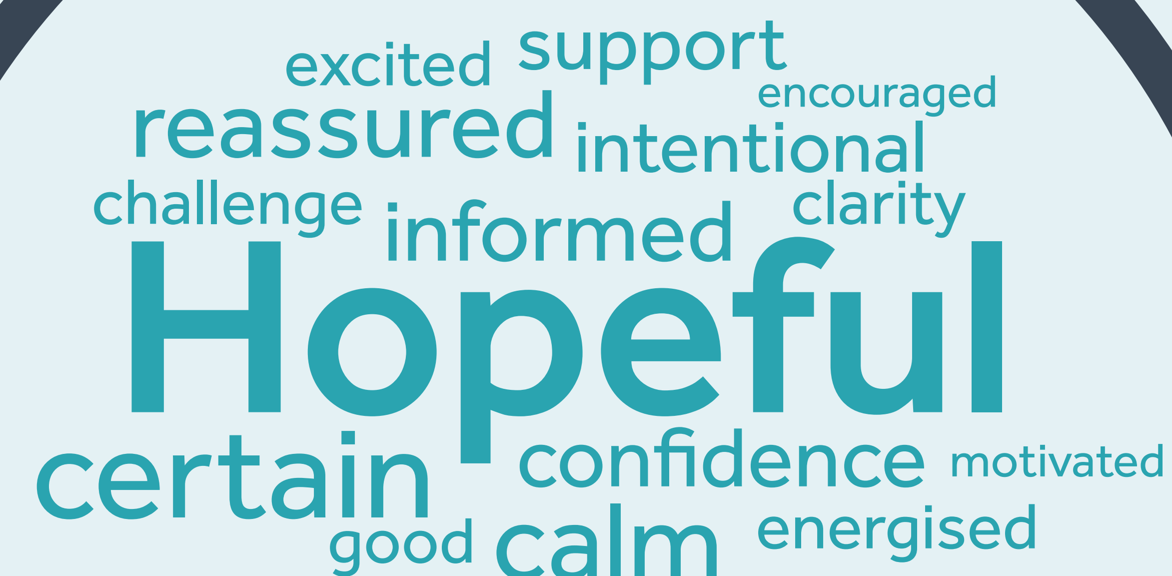
"It has helped support me as I transitioned from one role to another role. The new role comes with far more responsibility and includes building a new service so embedding a TI [trauma-informed] way of working is timely. It also helped me see how ALS [action learning set] can be used to explore another person's issue."

Moving forward with a trauma-informed issue

The online questionnaire asked participants how they were feeling about the issue they brought to the action learning set in three words now the sessions were finished.

Participants also reported that their objectives and ambitions around their trauma-informed issue were much clearer and more focussed after the action learning set.

Eight out of ten participants reported in the online questionnaire that they had taken actions or made progress around their chosen issue since starting the action learning set. This included discussing things with their teams and putting suggestions into practice.



"More focused in the direction I wish to go with this, I feel I can actually proceed without being concerned they are my own beliefs solely."

"Clearer. I do not need to hold all the responsibility for how others respond and engage with what I offer."

"Setting an intention to prioritising listening, posing more considerate questions, reduced preamble, and maintains open / collaborative conversation style."

"Massive progress!! The ALS [action learning set] process has made me think about my role as a trauma-informed leader, how to challenge in a TI [trauma-informed] way and how to build a TI service."

"I have re-kindled and increased my sense of confidence in the power of a like-minded group of colleagues being able to think, reflect and change together, and plan to carry on with this group!"

Impact of progressing a trauma-informed issue

Nine out of ten participants in the online questionnaire gave examples of how addressing the issue around a trauma-informed approach that they brought to the action learning set would impact on people who use services and staff. Answers centred around having better understanding and knowledge to support building a foundation of a trauma-informed approach and supporting others to practice in this way, resulting in better experience of services and improved team working.

"I am hoping it will ensure peer reflective practice is tailored to their needs more appropriately - which I hope will be supportive and have positive impacts for both the staff and the client group they support."

"Immeasurable- each experience like this (and this was a significant one) adds to my ability to influence and change the world (of families and practitioners) for the better."

At interview, all participants highlighted the impact that working in a more trauma-informed way will have on both people who use services and staff. When working with staff, being more trauma-informed was thought to help build psychological safety, allowing staff to feel empowered and confident to come forward and show initiative.

Participants described how being more trauma-informed improves the safety for those who use services as well as improving wellbeing and confidence in services through empowerment and working in collaboration. Participants commented that working in this way can reduce stigma and discrimination and reduce further traumatisation.

"I think that it does impact on patient safety, their welfare, how they would perceive a service based on the assessments that they get, you know it's always been my belief that, you know, one can walk into A&E not having any clue of how to get mental health input or help or support. And it's at that point really that as a liaison team, you can either lose somebody or you can gain their, their confidence and instil some hope. There's a big difference between someone going home and saying., that was absolutely a waste of time, never, ever engaging a mental health service again, pointless. Or them saying do you know what? Still exactly the same but I've got hope now that I can get help."
[Participant 1, 1 month interview]

Measurement

At interview participants were asked if they were measuring the results of progressing their trauma-informed issues. All participants commented that measuring trauma-informed working was challenging and that evidence of working in this way comes from interactions between people.

Some participants reported measuring results in a formal way such as using Commissioning for Quality and Innovation (CQUIN) audits for care quality, designing Patient-reported Experience Measures (PREMs) that include questions around a trauma-informed approach and designing a short questionnaire after staff consultation around service change using questions such as “was consultation useful to you”, “what ingredients made it useful?” and “what has consultation made you think about things?”.

All participants reported informal feedback as measures such as staff reporting a good place to work and teams returning to services for support.

Some participants urged caution in using operational outcome measures as indicators of trauma-informed working. For example, one participant highlighted that staff retention might be used as a measure, but in some cases the right thing, or trauma-informed way, for individuals would be to support them to move on well rather than staying in their roles.

“It’s a tough one to measure... in terms of people’s sort of interactions. We’ve got new staff members and they’re very like, Oh my God, this is such a great place, supportive workplace. It’s not my experience before the other people are jealous. So the narratives that come into discussions, that’s where I think, yeah, it’s good. This is we’ve got this right and now it’s like this is how we operate as a team, so new people coming into that space go ohh right, this is how we’re doing it here, so that that for me is great feedback. “

[Participant 7, 1 month interview]

“What we’ve done is made our own kind of questions and our own measures...we’ve got a kind of outcomes that we like, but we have to tweak it and we do we shape it and sort of make it more meaningful to each piece of work...But the feedback from perhaps the more acute, like the sort of business end of the acute has been does it save us money? Does it retain staff. Does it save us money ...those are the sorts of things that’s hard to demonstrate in an outcome. Particularly if you’re just one ingredient, you’re one part of the ingredient. You’re just measuring one thing when actually the whole system needs to be trauma-informed. So it’s been a challenging thing to try and pin down. Like trying to nail jelly to a wall.”

[Participant 5, 1 month interview]

“I work in what in staff wellbeing. So you know, staff retention. We’re always saying, you know, sometimes a good outcome for that staff member is that they move on and actually they got other experience. So you, I suppose I’m less worried about staff moving on... staff are being supported and their kind of development is being supported and or if they decide from a wellbeing point of view that they want to move on you know that’s a good outcome for some individuals so I’m perhaps looking at it from a different way it depends what you’re trying to measure doesn’t it.”

[Participant 5, 1 month interview]

Challenges and barriers

Overall participants reported in the online questionnaire feeling more confident around addressing barriers to moving their issues forward. They commented that the action learning set had helped them to identify barriers they had not previously considered, and they had learnt skills and techniques to support overcoming barriers.

At interview barriers to progressing with their trauma-informed issue were explored further with participants. Common themes from participants around challenges and barriers included:

Time

Participants highlighted that both the skills they learnt during the action learning set and trauma-informed approaches require time during interactions and decision making. This was seen as a possible challenge particularly in acute settings where interactions often consist of fast-paced conversations and people wanting quick fixes. Also, the time needed to build relationships to work together in a trauma-informed way was raised as a challenge.

However, one participant highlighted that the more people understand and practice the principles of trauma-informed approaches this can actually save time in the long run.

Resistance to change

Staff resistance to change was raised by two participants as a barrier to working in a trauma-informed way. Potentially staff seeing it as "yet another change".

Remote working

Remote working was identified by two participants as a challenge to supporting staff, through a lack of body language and needing to be more explicit about checking in with staff rather than subtle conversations. Although remote working was highlighted as helpful for some staff, it was also thought that meeting in person supported a better dynamic and may help with development of relationships within teams.

Physical environment

Ensuring there is enough physical space for teams to meet in person was raised by one participant as a challenge. For another the physical environment of GP surgery rooms was raised as a barrier to trauma-informed approaches, in relation to florescent light and lack of soft furnishings and arrangement furniture, particularly for autistic individuals.

Lack of consistency across organisations

One participant highlighted that there is a lack of consistency in trauma-informed approaches across services due to differing levels of training and trauma-informed structures within organisations.

Culture

Culture within teams and different settings was spoken about by several participants as a barrier to trauma-informed working. A 'fix it' approach and potentially 'toughened' attitudes towards vicarious trauma and 'not letting things affect me' from staff were highlighted as cultural aspects that would need to be addressed in order for staff to embrace a trauma-informed way of working. Working with those who use services to promote voice and choice and ensure they are involved in decision making may not come naturally to staff particularly in systems that are very hierarchical.

It was also raised that there are many misunderstandings about what a trauma-informed approach encompasses and that it relates only to mental health services.

Workload pressures

One participant reflected that workload pressures can challenge working in a trauma-informed way, as they can become less mindful of things when stress is increased and lose a sense of how they are coming across to the team.

System barriers

One participant highlighted rules across the system are often inflexible as well as lack of time, capacity and inclination. They commented that these were more common among statutory services, where there are strict criteria for people who may not be ready to make changes, and a lack of understanding about the role of third sector organisations as an extension of social care packages.

Power differentials

It was raised by one participant that job title and organisational 'label' can influence how you are listened to and respected by other professionals. They emphasised the need for lived experience and outreach workers to be given the same attention and respect as other professionals.

Access to training

Several participants raised limited access to training as a barrier to trauma-informed working. This was raised to be as a result of shifting eligibility to training and a lack of funding investment. Although some participants had attended a number of training sessions on trauma-informed approaches and felt they could informally add this to their own training, they did not feel confident to deliver the training themselves directly to colleagues and teams.

The need for system support

Organisational or system support and buy in was highlighted by participants as both a barrier and facilitator to adopting trauma-informed approaches. Participants raised that working in a trauma-informed way without this was challenging and that getting buy in can be difficult due to challenges of measuring effect and outcomes.

Where system support was in place this was felt to support a shared vision and ensure that the emphasis remains on hearing the voices of those who use services and caring and fostering 'can do' rather than 'can't do' attitudes.

When discussing working in a trauma-informed way as a system participants raised the need for approaches to be followed through and that training was a starting point rather than the solution.

"It's been delightful working in a place where that is completely embraced. You know, it makes such a difference. It's not about how many people have you seen. It's about what did you do with that person. How did that feel? You know it's about the quality of the relationships that people are building with the people that they're supporting... And I think the emphasis on staff care ... a lot of the reason for the funding and for my post was about the desire not only to hold the frame of trauma-informed care, but just to make sure that the staff felt that they had a container as well."

[Participant 2, 1 month interview]

"Signing up to it and not following it through... maybe it needs to start at the top ... exec level because if they don't do it, it's not going to filter down because they're the ones who are then supervising the next layer. And those are the ones supervising the next layer. So it's not just for clinicians to go for this."

[Participant 6, 1 month interview]

"I've done some training through SABP [Surrey and Borders Partnership NHS Foundation Trust] where they've distilled it to six principles and just having something in a bite sized way where you can do some training around it, but not just training cause I think there isn't much evidence base that just stand alone training does things it's to do with training and then supporting that training with supervision or ongoing sort of peer support or action learning sets or some sort of like minded kind of applied group... but people don't apply it... So you have to kind of live it constantly and just live the complexity and be in it and open minded."

[Participant 5, 1 month interview]

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Health Innovation
Oxford & Thames Valley

NHS
Surrey and Borders Partnership
NHS Foundation Trust

Surrey and Northeast Hampshire

Trauma-informed service

Summary

End of year one 2023

SURREY HEARTLANDS
Health and Care Partnership

Frimley Health and Care

CHANGING FUTURES

SURREY
COUNTY COUNCIL