Evaluation of the Personality Disorder Positive Outcomes Programme (PDPOP)

Year four PDPOP training evaluation report
GP practices and community health teams

September 2024

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TRAINING & VOCATIONAL INITIATIVES IN PERSONALITY DISORDER

NHS Oxford Health NHS Foundation Trust

NHS Health Education England

PDPOP

PDPOP Personality Disorder Positive Outcomes Programme

Health Innovation Oxford & Thames Valley

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PDPOP was conceived and developed by Rob Schafer and Fiona Blyth alongside Gill Attwood and lived experience trainers from Training and Vocational Initiatives in Personality Disorder, part of Oxford Health NHS Foundation Trust. It was launched in 2019 with pilot funding provided by Health Education England (HEE).

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"The lived experience trainers are just such remarkable people and such an incredible resource.

Being able to spend some real time with them I thought was so powerful, and not something I've ever really encountered before...I've done endless diabetes teaching days without a single diabetic person involved. You know, I've done endless mental health stuff, without an actual person with mental health issues being involved.

So many examples of what we do in medical training. You learn about it from people who are "the experts". And they know what they are talking about, but they don't know what it's like to have that condition."

GP Lead

"I will approach complex patients with relationship issues with a different lens, a better understanding, an increased level of compassion and much more knowledge of personality disorder."

Community Nurse

EVALUATION SUMMARY

SUMMARY – BACKGROUND AND OVERVIEW OF THE PDPOP PROGRAMME

Personality Disorder is common, and patients with personality disorder and similar complex needs present frequently to primary care.

Staff frequently report feeling overwhelmed and unprepared to work effectively with this patient group.

To date there is little training available for primary care.

The Personality Disorder Positive Outcomes Programme (PDPOP) was developed in 2019 to support frontline healthcare staff to feel more skilled and confident when working with patients with personality disorder and similar complex emotional needs.

The PDPOP programme is based around a whole team session delivered by two lived experience trainers and two clinical trainers.

The team take the healthcare team on a structured journey to help them deepen their understanding of personality disorder, the patient perspective and how they manage their own reactions.

Local leads or champions in each team receive further support:

- Follow-on modules around specific consultations (GPs)
- The option to shadow a clinician at a homeless medical centre (community health teams)
- Attend the local champions skills symposium (all).

2019-2024

- 39 GP teams trained
- 2 Community Health Teams Trained
- 1069 staff trained
- Covering a patient population of 642,466

This evaluation focuses on year 4 (2023-24)

4 GP surgery teams and 2 community nursing teams, comprising of 102 staff trained.

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SUMMARY – HIGH LEVEL EFFECTS OF THE TRAINING FOR STAFF

Increased confidence

Training participants reported an overall increased confidence in working with patients who may have personality disorder. Participants specifically reported increased confidence around supporting patients and managing their own emotional reactions to patients presenting in crisis with expressions of desperation, self-harm or thoughts of self-harm.

"I think it gives people the confidence that actually the lived experience patients, hearing from them, you know, **they're very clear that they needed boundaries**...It's not a negative thing. It's actually in the person's best interests and it's there to decrease this dependency. So, they've been more independent."
Community Nurse Lead

"I think it just has given me much more awareness of recognising people that may have a personality disorder and being more confident in how I manage them. How I consult with them."
GP Lead

"And I think the other thing, having done the training, we could easily escalate, and we've got a very supportive senior management team in nursing. They'll happily get involved with those patients, write letters to them. But you know, but actually, that's almost a negative approach rather than this approach allows us to almost take control of the team, **give us permission to give boundaries** to a patient because we actually know that actually that might be the best way; rather than escalating it to someone who doesn't know the patient."
Community Nurse

Reduced impact on staff

Training participants reported reduced impacts on staff through better managing their own emotions and feeling less upset or frustrated around challenging interactions, knowing you are not alone in feeling 'rubbish' and not taking things personally.

"[before the training] We would go, "but can they not see that we're tired and that we're seeing them in the rain and we waited half an hour for them to open the door?" I think they [lived experience trainers] were able to rationalise their behaviour during the periods when they were suffering... and you know actually realising that patient at that time can't be empathetic towards the people delivering their care."
Community Nurse

"I think the admin staff ... previously found it very difficult to know how to manage patients with personality disorder. I think because often they're quite emotional or quite distressed on the telephone or when they come to the front desk. **And I think they've been able to stay quite neutral on that rescue/blame seesaw...**and then just kind of you know talking to the patients and kind of gently reminding them that they do have a follow up with their usual GP in a few days' time or kind of in a week's time."
GP Lead

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SUMMARY – HIGH LEVEL EFFECTS OF THE TRAINING FOR STAFF

Recognising and reducing unhelpful dependence

All training participants at interview spoke about steps they have taken since the training to recognise and reduce unhelpful dependency within their services.

"**It's made me aware of seeing people for too long** or keeping them on for that little bit longer. And being more aware of what is actually the best thing for that patient and also what's the best thing for us, our service and our wait list and things like that."
Therapy Team

"I mean, so I hope that they [patients] will be, they'll be **encouraged to take more ownership of their health** and kind of the decisions that they that they are making...And so I think kind of I think it will come gradually and I think it will lead to better doctor / patient relationships because there's less blaming on both sides, less rescuing and kind of more recognition of kind of when you're in kind of in a red zone and kind of in the Blue Zone."
GP Lead

"I am able to maintain **my own sense of self**. I am able to help those patients that develop an attachment to me, to recognise their own skills and resilience and self-management."
Community Nurse

Increased hope

The evaluation found that the training resulted in participants having an increased hope for patients, staff and services.

"I think patients, well, hopefully they're gonna be a bit better understood. So instead of this kind of narrative being, you know, difficult patients or challenging it being, you know they their need is different and how do we meet that. **Now we've got tools to look at how better to support** that person, so hopefully, instead of it being sort of complex or challenging or not getting what they need, we're going to be able to better support them with their needs."
Community Nurse Lead

"Well, so impact for staff is gonna be sort of better morale...when you do have these difficult patients if you like or how it's perceived this sort of difficult situation. How draining that can be, how exhausting it is, how frustrating it is for lots of different reasons, because you want to help and you can't help or...you're now really late with all your other patients and all of these and all of these sort of knock on effect that you get. So, if we can do that better, **that's going to make people feel better 100%**. It's going to make staff feel better. It's going to have a definite, definite impact on that."
Community Nurse Lead

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SUMMARY – HIGH LEVEL FEEDBACK FROM STAFF ABOUT THE TRAINING AND SYMPOSIUM

% OF RESPONDENTS WHO AGREE OR STRONGLY AGREE	100%	100%	95%	98%	100%
QUESTION	I enjoyed the training	The training was useful	There was enough time for discussion	The training was pitched at the right level	I would recommend this training to another healthcare team

"I really like how it's run and especially having the lived experience trainers there that make it so much more interesting because you're listening to people who's been through that. Through that process and giving you all their thoughts about it and how they felt, so that I've never had a training with having real life experience in the training, who can actually answer your questions and you can talk about it actually to them. So that was one of the great thing about the training."
Community Nurse

"The lived experience trainers are just such remarkable people and such an incredible resource. Being able to spend some real time with them I thought was so powerful, and not something I've ever really encountered before...I've done endless diabetes teaching days without a single diabetic person involved. You know, I've done endless mental health stuff, without an actual person with mental health issues being involved. So many examples of what we do in medical training. You learn about it from people who are "the experts". And they know what they are talking about, but they don't know what it's like to have that condition. And I just thought that was incredible."
GP Lead

"Fantastic session. Really helpful, engaging and well delivered. Lived experience trainers really insightful and helpful for learning."
GP
"Good breaks and change of styles, presentations during training. Thankyou!" **Practice Nurse**
"Fantastic training, much needed and wanted!"
Community Nurse
"Excellent course would recommend."
Manager
"Really valuable training the lived experience presenters were amazing and it was the best team training we have had in years."
GP

"It was such a great opportunity for so many different members of the team to get involved. So, the receptionist, medical secretaries, the nurses, we had a really good spread, I think of different team members from across the practice. That was really, really powerful, I think to get some multidisciplinary training. I think it's the first time we've ever done anything like that... So, I think it was a really powerful thing to do that. I thought it was a really great sort of team building thing as well. So not only for just the pure training side of it, but also it really helps spark conversations among the team. I had loads of feedback from the different members of the team that they found it really helpful as well and kind of really helped them to sort of build empathy with patients with personality disorders."
GP Lead

"I felt really inspired. I felt like I had a massive confidence boost in terms of managing the condition and supporting people with personality disorders. That was brilliant. Yeah, I felt really energised. Really energised, really inspired and I think that's what the best teaching can do... It is always so good have that opportunity to kind of step away, talk about something. You don't expect to spend 36 hours talking about something like personality disorders and come away feeling energised. That's just not what you expect. You expect to come away going: "Oh God", you expect to feel kind of drained and hopeless maybe about it all, but I felt the complete opposite. Energised and inspired. It was, yeah. Brilliant."
GP Lead

EVALUATION MAIN REPORT

INTRODUCTION

The Personality Disorder Positive Outcomes Programme (PDPOP) is a training programme that supports frontline healthcare staff to feel more skilled and confident when working with patients with personality disorder and similar complex emotional needs.

Following the successful first three years of delivering the PDPOP training to general practice teams, the programme was expanded to include nursing and allied health professional community teams. As a result, four general practice teams and two community nursing teams (from two NHS Trusts) across the South East of England were trained during year four of the training.

Health Innovation Oxford and Thames Valley was commissioned to conduct an independent evaluation of the third year of PDPOP training delivered in 2022/23. The full evaluation report from year three can be found here. Subsequently, Health Innovation Oxford and Thames Valley were recommissioned to conduct the independent evaluation of year four of the PDPOP training delivered in 2023/24.

BACKGROUND

The previous evaluations outlined the need for PDPOP training in healthcare to meet the needs of individuals who may be diagnosed with personality disorder (González-Ginocchio et al, 2022, Trueman and Williams, 2023). Estimated prevalence of personality disorder in the UK lies at approximately one in 20. However there remains a lack of reliable and up to date data (Mental Health Foundation, 2022), and disagreement regarding the term 'personality disorder' (Foye, et al. 2022).

Up to 24% of consultations in primary care are with patients who would meet the criteria for personality disorder, often presenting in crisis and with greater frequency (Moran et al, 2000). GPs and primary care services have been identified as playing a crucial role in the care of people with personality disorder, often as the first healthcare contact and the route to be referred on to specialised services (Doyle, et al. 2016).

District nursing and community therapy team (community health team) caseloads also include increasing numbers of complex patients with multiple comorbidities of both physical and mental health needs (Marangozov, et al, 2017, Griffiths, 2017).

Supporting patients, particularly those presenting in crisis or emotional distress, is often described as being difficult or complicated, leaving staff demoralised or feeling incompetent, hurt or angry (Aviram et al, 2006). Staff frequently report feeling that they lack the skills to support patients' mental health needs and require training specifically around communication and crisis intervention (Lee and Knight, 2006, Griffiths, 2017).

To address the problems outlined above for general practices and community health teams, the need for system wide training and support has been highlighted (Foye, et al. 2022). In response, the PDPOP seeks to enable more compassionate responses. It aims not only to improve the experiences of those with personality disorder, but to also benefit the wider system around the patients, including staff and other patients. This evaluation seeks to identify evidence of these benefits through changes made in practice as a result of the training and the impact of these changes.

OVERVIEW OF PDPOP TRAINING (1) THE WHOLE TEAM TRAINING

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Training is delivered face to face as either two and a half or four hours for GP practice teams and three hours for community health teams and follows the format below.

1	2	3	4	5	6	7
THE 'AIRING'	**SHARING**	**KEY CONCEPTS**	**BRIEF VIDEO EXAMPLE**	**MANAGING CRISIS CONSULTATION**	**DISCUSSION AND REFLECTION SESSION**	**ACTION PLANNING**
Trainers support the team to take a step back to allow the team to examine the challenges & emotions involved when working with complex patients	Lived Experience Trainers share how they used to present and what was going on for them	Introduced to give a language to help staff describe and understand what is going on for the patients and themselves	To illustrate the concepts in practice	Video & model (Four hour GP version only)	Led by the lived experience trainers, to deepen understanding of the patient experience	Participants generate suggestions for specific improvements the team can make

OVERVIEW OF PDPOP TRAINING (2) KEY TRAINING CONCEPTS

All training centres around four key concepts, © Rob Schafer & Fiona Blyth 2019.

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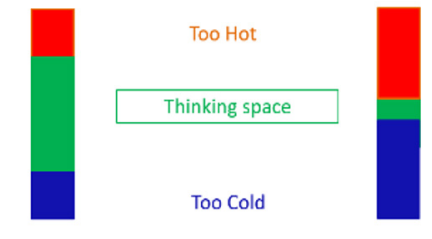
UNMET NEED

An underlying need for example to feel safe, to feel loved that was not met at an earlier time of life, usually childhood. The unmet need can generate strong, difficult emotions and consequent behaviour that may be counter-productive in the present.

TRIGGERS

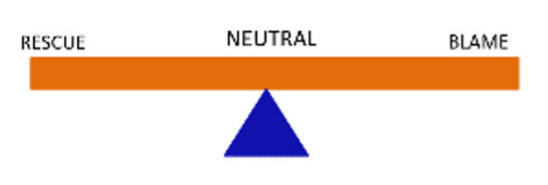
Stimuli that take an individual immediately to a place of danger. The process referred to as 'being triggered', or 'becoming activated'. Triggers can be virtually anything; sights, sounds, smells, behaviours and can be innocuous or non-intentional.

EMOTIONAL THERMOMETER



A way of visualising the emotional state of both patients and staff and how to target the green 'thinking space'. When in the blue or red zones an individual's ability to think and process information and interactions is reduced.

RESCUE-BLAME SEESAW



A key concept to build on the other three that supports staff to recognise patients with unmet need may evoke unhelpful rescuing or blaming behaviour in staff that can cause conflicts within teams.

OVERVIEW OF PDPOP TRAINING (3) THE SKILLS SYMPOSIUM (TWO DAY RESIDENTIAL)

Each year after all the team training has been facilitated, all the local leads and champions are invited to attend a two day residential symposium along with the programme leads and all the lived experience and clinical trainers.

Training team of **eight lived experience trainers** and **ten clinical trainers** working with **all of the local champions**

SHARING THE JOURNEY

Participants and trainers share their experience of taking part in the programme

FURTHER KEY CONCEPTS

Exploring the Personal Agency Pyramid and Consultation Style Triangle

EXPLAINING THE DIAGNOSIS (1)

Personality Disorder Classification Personality Disorder & Neuro-divergence

EXPLAINING THE DIAGNOSIS (2)

Simulated learning (GPs)

ROLE & RECOGNITION

(Community Nurses)

THE CRISIS CONSULTATION

Simulated learning (GPs)

GETTING BEGINNINGS AND ENDING RIGHT

Simulated Learning (Community Nurses)

RESCUE BLAME SEESAW IN PRACTICE

Brief video examples

PUTTING IT ALL TOGETHER

Interactive Complex Case discussion scenarios

LIVED EXPERIENCE LED PLENERY

Lived experience trainers share thoughts and reflections

SELF CARE AND CLOSE

All participants share self care strategies

EVALUATION METHODOLOGY

Health Innovation Oxford and Thames Valley commenced the independent evaluation of year four of the PDPOP training in September 2023. Based on the positive feedback and engagement of the previous year's evaluation there were no design changes to the evaluation.

This report focusses on the experiences and outcomes from the 102 staff who attended PDPOP training between September 2023 and January 2024 from four GP practices and two community health teams across the Southeast of England.

As indicated on the map below (Figure 1.), purple pins represent GP practices trained in years one and two, blue pins represent GP practices trained in year three, dark green pins represent GP practices trained in year four and light green pins represent community health teams.

Figure 1.

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THE NEW WORLD KIRKPATRICK MODEL

The New World Kirkpatrick Model (Kirkpatrick and Kirkpatrick, 2021) was used as a framework for the evaluation. As seen in *Figure 2*. the model provides a framework for evaluating training across four levels: reaction, learning, behaviour and results.

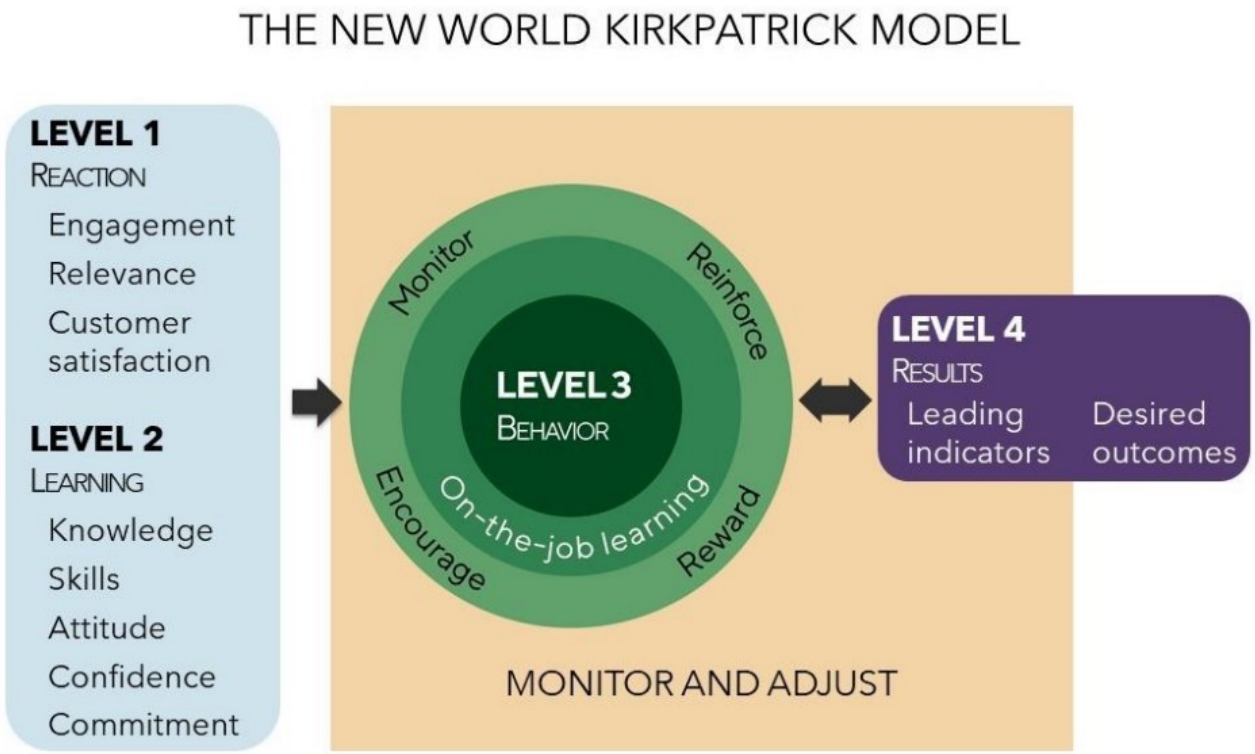

Figure 2. (Kirkpatrick and Kirkpatrick, 2021)

The evaluation consisted of questionnaires made up of Likert item and free-text questions, administered pre and post- training and at follow-up six to eight weeks post-training and semi-structured interviews to evaluate all four levels of the Kirkpatrick Model, full details regarding questionnaires and interviews are given in Appendix A.

OVERVIEW OF PARTICIPATION

RECRUITMENT OF TEAMS

Community health teams were recruited for training through expressions of interest to the PDPOP training lead from senior nursing staff.

GP practices were recruited for PDPOP training through self-sign up. The training was advertised through distribution of flyers sent to Kent, Surrey and Sussex and Hampshire and Isle of Wight GP training hubs, GP training scheme programme directors and assistant directors. Four GP practices and two community health teams completed the training.

TRAINING DELIVERY

Training was delivered in the format of all three versions across the 4 GP practices and two community health teams:

- Two GP practices received two and a half hours face to face training
- Two GP practices received four hours face to face training
- Both community health teams received three hours face to face training

EVALUATION PARTICIPATION

All six teams agreed to take part in the evaluation of the training.

Questionnaires for pre- and post-training were handed out and collected during the face-to-face training sessions by the training team and then handed to the evaluation team. All follow-up questionnaires were accessed online via a link shared with PDPOP leads and practice managers. Detail of missing data can be found in Appendix B.

QUESTIONNAIRES

All six teams completed pre- and post-training questionnaires resulting in 95 matched pre- and post-training questionnaires (93% matched response rate). Responses were matched using the unique identifier provided by participants at the start of each questionnaire.

All six teams completed follow-up questionnaires resulting in 57 follow-up questionnaires (56% response rate) and 49 matched pre-training and follow-up questionnaires (48% matched response rate).

OVERVIEW OF PARTICIPATION
INTERVIEWS

COMMUNITY HEALTH TEAM STAFF

Staff from community health teams were invited to participate in follow-up interviews of up to 30 minutes at approximately six to eight weeks after training. Participants were recruited via emails distributed through team PDPOP champions. Participants were given the option of online interviews via Microsoft Teams (n=7) or face to face at community health team bases (n=6).

13 staff were interviewed at follow-up all from community health team one, there was no participation from community health team two at follow-up interviews. Staff interviewed included district nurses, team management (matrons and team leads), physiotherapy apprentices, tissue viability nurses and rehabilitation assistants.

PDPOP LEADS

PDPOP leads from all four GP practices and both community health teams were invited to participate in an interview at approximately four to six months post-training. All four GP leads, both leads from community health team one and three out of five leads from community health team two participated in interviews.

ATTRIBUTIONS OF QUOTES FROM INTERVIEWS

Due to the small numbers of interviewees at follow-up interviews with community health teams, job roles have been aggregated into categories for quote attribution to support anonymity of participants.

All nursing roles within the community health teams will be referred to as Community Nurse, including mental health nurse, tissue viability nurse, district nurse roles etc.

All therapy roles within the community health teams will be referred to as Therapy Team, including physiotherapists and rehabilitation assistants etc.

PDPOP champions/leads in the community health teams will be referred to as Community Nurse Lead.

PARTICIPANT PROFILE AND DEMOGRAPHICS

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Group size for the teams trained ranged from 11 to 21, with a mean group size of 17 participants (Table 1.). The most represented job roles of those who attended training were GPs (24%) and members of the district nursing teams (24%), followed by receptionists (15%) and admin (12%) (Table 2.). (Community health team one participants included job roles from both district nursing and therapy roles, whereas community health team two included only district nursing roles.) Responses to follow-up questionnaires were proportional to training attendance with regards to job role (Table 3.).

Number of questionnaires received

Practice	Group Size	Pre-training	Post-training	Follow-up
GP 1	17	17	16	7
GP 2	14	14	14	7
GP 3	21	20	20	14
GP 4	20	19	18	11
Community health team 1	19	19	18	13
Community health team 2	11	11	11	5

Table 1. Training group size

Job Role	Total	% of participants
Admin	12	12%
Community Nurses	24	24%
GP	24	24%
Healthcare Assistant	2	2%
Management	9	9%
Mental Health Practioner	1	1%
LD Patient Care Navigator	1	1%
Pharmacist	1	1%
Physiotherapist	3	3%
Practice Nurse	8	8%
Receptionist	15	15%
Social Prescriber	1	1%
Unkown	1	1%

Table 2. Job roles of training participants

Job Role	Total responses
Admin	5
Care Coordinator	1
Community Nurses	12
GP	11
LD Patient Care Navigator	1
Management	6
Mental Health Practioner	1
Physiotherapist	3
Practice Nurse	1
Receptionist	13
Rehab assistant	3

Table 3. Job role of follow-up respondents

FINDINGS

For analysis, Likert item responses have been treated as quantitative data and findings include only matched responses, using participant unique identifiers, for comparisons of pre- and post-training and of pre-training and follow-up. In order to identify if follow-up responses were representative of wider training participants, analysis was undertaken to determine if there were significant differences between the pre-training and post-training Likert item responses of all participants against those of participants who responded to the follow-up questionnaire. There was no significant difference (p=>0.05) between all participant and the follow-up participants responses for all Likert items when comparing pre-training and post-training.

Free-text question responses from all respondents (not just matched responses) for both the post-training and follow-up questionnaires have been included in the analysis.

POST-TRAINING

- 'Please sum up the main thing you have learnt from this training in a sentence'
- 'What (if anything) do you think you might do differently as a result of this training?'
- 'What had the biggest impact for you in the training?'
- 'Any final comments'

FOLLOW-UP

- 'What (if anything) have you been able to apply from the training in your day-to-day work?'
- 'If you can, please give an example of how you have applied the training with a patient (please do not use names or other identifiable details)'
- 'Please share any other thoughts or comments around the training and its effect on you and your team?'

The findings of the evaluation have been structured within the Kirkpatrick Model, the most impactful findings of level 4 results and level 3 behaviour have been included in the main body of the report. Findings for levels 2 learning and level 1 reaction can be found in Appendix C along with the key themes from feedback given about the residential symposium in Appendix D.

The intended purpose of level 4 evaluation is to measure one singular outcome that pertains to the purpose of the organisation undertaking training. However, relating a single training course to a high-level organisational outcome can be problematic, and so results may be measured through leading indicators. Leading indicators are defined as the observations in practice that suggest critical behaviours are on track to have a positive impact (Kirkpatrick and Kirkpatrick, 2021).

Leading indicators were defined by the evaluation team and training leads through the intended results and outcomes of the training prior to training taking place:

- Staff to feel confident and skilled when interacting with patients who may have personality disorder.
- Reduced impact on staff.
- Recognition and reduction of dependency for patients on primary care and community health services and staff.

Level 3 of the evaluation sought to determine the behavioural changes that resulted from PDPOP training through identification of critical behaviours and required drivers. Critical behaviours are specific actions which, if performed consistently in practice, will have the biggest impact on results after training. Required drivers are described as the processes and systems that reinforce and encourage, critical behaviours (Kirkpatrick and Kirkpatrick, 2021).

RESULTS LEVEL 4

Level 4 of the evaluation sought to determine if the training had achieved the desired outcomes by investigating if the predetermined leading indicators were present in practice:

- Staff to feel confident and skilled when interacting with patients who may have personality disorder.
- Reduced impact on staff.
- Recognition and reduction of dependency for patients on primary care and community health services and staff.

Qualitative findings have been reported separately for GP practices and community health teams to enable detailed reporting relevant to the different healthcare settings. The hopes expressed by participants in both settings for the impact of the training is also reported in this section.

Staff to feel confident and skilled when interacting with patients who may have personality disorder

Participant responses to Likert items around confidence demonstrated that the training increased their confidence in dealing with patients presenting in crisis immediately after training and that this confidence was retained at six to eight week follow-up (Table 4).

The questions regarding managing participants' own emotions and how their team responds to patents in crisis were repeated only at follow-up, as participants need to experience these events post-training in order to re-rate their confidence. Participants rated these questions fairly positively pre-training (>50% agree or strongly agree, Table 4), however responses at follow-up show an increased confidence for both these items. There were no significant differences in the responses of GP practice participants and community health team participants to these items.

	% of respondents who agree or strongly agree		
	Pre-training	**Post-training**	**Follow-up**
I would feel confident dealing with a patient presenting in crisis with expressions of desperation, self-harm or thoughts of self-harm.	38%	84%	75%
I can manage my own emotional reactions to patients who present in an emotional crisis.	65%	not asked post training	89%
My team responds effectively to patients who present in an emotional crisis	56%	not asked post-training	94%

Table 4

GP PRACTICE INCREASED CONFIDENCE

At interview GP leads expanded on how a better understanding and awareness of personality disorder has supported them to feel more confident during consultations.

"Yeah, I'm much more aware of it now. But you know, you get a bit more information out before we see them, thanks to the system. And I'm thinking, OK, this one, you know, I need to be extra mindful of my language and plan it a bit. So yeah, I definitely, I think signposting into, you know, internally to myself saying, "look, this is likely to be a crisis consultation. This is what I'm going to probably need to do". I think that's really helpful. You know, more of a road map, if you like."
GP Lead

"I think it just has given me much more awareness of recognising people that may have a personality disorder and being more confident in how I manage them. How I consult with them."
GP Lead

"Remaining neutral feels easier with the confidence from the lived experience trainers input so I understand that this approach is what they identified as most helpful for them."
GP

"I have been able to try and understand PD patients better. I have been more confident in discussing deprescribing. I have been more sympathetic."
GP

GP practice participants reported increased confidence in their free text responses within the follow-up questionnaire.

One GP lead explained that they feel more confident in discussing what their local services provide with patients after discussions with the trainers at the two day symposium.

"I have definitely been positively been affected by it [the training], and feel more confident with PD."
GP

"It has given me confidence in relating to this group of patients and understanding their issues with relating to others. I understand why they appear so chaotic and frustrating to work with. I realise that being compassionate but boundaried with them is very helpful for them. I realise that discussing these patients regularly within the practice team ensures consistency of approach which is also vital for the patients."
Practice Nurse

"I think I came away with a really good understanding of what our local therapy service actually does, and because I've spoken about it a lot with patients, just in passing or kind of you know "this is a website you can look at". But I think I wasn't really able to explain what it is that they actually do to help get people better. So now I feel like I'm more trustworthy when I'm telling patients, they trust the information that I'm telling them about because I actually know what I'm talking about."
GP Lead

COMMUNITY HEALTH TEAM INCREASED CONFIDENCE

Community health team participants reported an overall increased confidence in working with patients who may have personality disorder as a result of the training through learning skills to work in a different way.

"The boundaries, having the confidence to have those discussions to do things a little bit different."
Community Nurse Lead

"And I think that was a big thing that come out that training for me, and I definitely know it would really help our more junior colleagues, that training actually, allowing them the permission to have those conversations, whereas I think the training, sort of, it almost gives you that permission to have that conversation with them."
Community Nurse

"I found the training very useful. I have experience in PD but the team now feel more confident in recognising PD, and avoid the common pitfalls PD may present in the Team dynamic."
Community Nurse

Many participants spoke about confidence through the training 'giving permission' to set boundaries and how this could empower staff.

A number of participants described an increase in confidence around managing when patients are in crisis or distress, through the skills they learnt and knowing where to signpost if they felt further support was needed.

"And I think the other thing, having done the training, we could easily escalate, and we've got a very supportive senior management team in nursing. They'll happily get involved with those patients, write letters to them. But you know, but actually, that's almost a negative approach rather than this approach allows us to almost take control of the team, give us permission to give boundaries to a patient because we actually know that actually that might be the best way; rather than escalating it to someone who doesn't know the patient."
Community Nurse

"I think it gives people the confidence that actually the lived experience patients, hearing from them, you know, they're very clear that they needed boundaries...It's not a negative thing. It's actually in the person's best interests and it's there to decrease this dependency. So, they've been more independent."
Community Nurse Lead

"Yeah, again, I think it was just, I mean we haven't always got all the answers. But it would just help you deal with that moment. With district nursing, you know, you're going into people's homes you don't know what you're gonna be walking into...I think it would help in terms of being able to have those resources. And having those contacts. And knowing how to deal with that and that situation at the time."
Community Nurse

"And I think probably if we had thought that in the past, I certainly would have felt out of my depth to be able to say to that patient there are places that we can signpost you to, and here's some information. But I don't. I don't. I don't feel bad about doing that now. About sort of mentioning talking space or our well-being nurse, our mental health nurse. But I think probably in the past I would have thought "Oh. God, no, no". But I don't feel like that now. So, it's given me more confidence to say "look, what about this", you know."
Therapy Team

REDUCED IMPACT ON STAFF

Responses to the follow-up questionnaire Likert item "I have days where I feel rubbish because of difficult interactions with patients" showed a slight reduction in agreement when compared to pre-training responses (Table 5).

	% of respondents who agree or strongly agree		
	Pre-training	**Post-training**	**Follow-up**
All participants I have days where I feel rubbish because of difficult interactions with patients	55%	not asked post training	47%
GP participants only I have days where I feel rubbish because of difficult interactions with patients	56%	not asked post training	47%
CT participants only I have days where I feel rubbish because of difficult interactions with patients	52%	not asked post-training	46%

Table 5

GP PRACTICE REDUCED IMPACT ON STAFF

"Patient sent in an eConsult that was very negative towards me personally, in terms of not having helped them (despite MANY consults over many years, much time spent supporting patient) I was less upset as I felt better understanding of the situation."
GP

GP practice participants reported reduced impacts on staff through better manging their own emotions and feeling less upset or frustrated around challenging interactions and knowing you are not alone in feeling 'rubbish'.

"I think, being more aware when some patients might be being manipulative when they've got a personality disorder - or not - or they might have a bit of a trait, it's been useful for me, but actually vocalising that a bit more. So, to be more aware of how, you know, a bit more depth of the interaction, being a bit more mindful of it, rather than just feeling annoyed or something."
GP Lead

"Using the models provided to help me ground my own responses to a challenging consultation."
GP

"Increased empathy towards patients with PD and a sense of better control over my emotional reactions to them."
GP

"How they can make you feel, you know, exasperated and quite angry. And they raise a sort of a lot of emotional, you know, a big emotional response, I suppose. And the fact that it's the sort of the same for everybody."
Practice Nurse

"I think it has helped the reception team to feel less frustrated and be more understanding when these patients present themselves."
Manager

REDUCED IMPACT ON STAFF

GP PRACTICE REDUCED IMPACT ON STAFF

One GP Lead spoke at length about the impact that the training had had for the admin and reception staff around managing patients who were distressed and not taking on the distress themselves.

"I think the admin staff [including reception staff], I think they previously found it very difficult to know how to manage patients with personality disorder. I think because often they're quite emotional or quite distressed on the telephone or when they come to the front desk. And I think they've been able to stay quite neutral on that rescue/blame seesaw...and then just kind of you know talking to the patients and kind of gently reminding them that they do have a follow up with their usual GP in a few days' time or kind of in a week's time.

And I think that has been helpful because I think I mean previously they would have maybe taken on that. But the patient's feeling and they can also feel distress themselves and feel like "oh, I need to do something now, I need to kind of help the patient because they're quite distressed" and then perhaps and I suppose ultimately maybe it would not have been good for the patient's clinical journey because they would have booked in with someone else who maybe doesn't know the patient as well and who maybe doesn't know the full story."

GP Lead

"I hope so. I think it definitely does for me, and therefore I'd hope it would for other people that there'll be less of that. Because I think it's given us an understanding that it's not our fault, you know their, their behaviour is to do with them and their personality and you know, we can only do so much. Or not be able to do very much at all. And but that's OK actually."

GP Lead

"Yeah, absolutely, absolutely without question. Yeah, I think, yeah, I think it'll make a massive difference, definitely."

GP Lead

At interview the Likert item around feeling rubbish as a result of difficult interactions with patients was explored. All four GP leads stated that they thought the training would have a positive impact on this.

"I think so. I think it's bound to, because it helps open something up, so that you learn there's a channel of communication, there is a way of describing those behaviours and traits that some people have. So, I think anything that helps us to vocalise about a topic and 'gets it out there' is generally good. I think there is definitely more openness about it."

GP Lead

"Yes, I think it's made me understand why people are the way they are. A little bit more and I think I'm I think probably a bit more tolerant of them and more appreciative of kind of maybe their life circumstances previously that that will have had an impact and kind of the way that they're presenting or the way that they kind of manage their emotions the way that they're coping now, yeah."

GP Lead

"It's been good to keep patients in the green mentalising zone and then also for myself because I appreciate sometimes on duty we have lots and lots of calls for lots you know, physical and mental health conditions. And I think it can be easy to think, 'Oh no, it's that person again, they're just calling about the same thing. They're in distress. Maybe I'll save that till the end and I'll just do these other calls first.'...And then I think I've been able to take like a head on approach. So, I don't, I don't feel as reticent to kind of manage these cases when I'm busy now."

GP Lead

One GP lead gave an example of how the training has made a difference for how they feel while managing duty calls.

COMMUNITY HEALTH TEAM REDUCED IMPACT ON STAFF

CONFIDENCE

For community health team participants there was a strong link between confidence and permission to set boundaries and reduced impact on staff. Examples were given around challenging situations where staff were being made to wait for long periods outside of patient homes, not let in at all or feeling beholden to patients, and how by setting boundaries since the training staff felt more empowered and less helpless in these situations.

"You're not harming your patient by saying "I'm going to leave now." You're helping them. That's a good thing, and actually it helped to complete the visit...They [staff] worry about failure, waiting to get in trouble because you haven't done the wound and then the wound deteriorates or whatever it is that you are there for. So, I think being able to do things different, I thought it's transformational, so that's good...for the patient. And for us going in, being able to go, "OK, I've done my best. I've done the right thing here", and I can walk away knowing that, because I have that knowledge and that experience."
Community Nurse Lead

"I think it's that same thing of understanding that it's not personal against you or anything like that is kind of understanding more about why patients behave in a specific way and what the most useful things you can do to deal with that behaviour."
Community Nurse

"If you go into a patient, you have a really difficult visit and things and you can come out feeling quite deflated and like, it's almost something against you and against your practice and how you've dealt with that situation. When actually like after being on this training, it's knowing that it's not personal, I guess so it's not anything about you."
Community Nurse

NOT TAKING THINGS PERSONALLY

Participants described how the training had enabled them to not take things personally through better understanding and that this impacted on how they felt after difficult interactions.

"Yeah, I think you're still feel rubbish, but you might sit back and think actually this isn't personal to me. It's not personal."
Community Nurse

"It's that understanding that it's not personal, you haven't done it wrong. And it's having more knowledge to be able to have the right conversation to make the right decisions having that confidence and that courage."
Community Nurse Lead

Participants highlighted that they may still feel 'rubbish' after difficult interactions but that the training had supported them to process it better and this could reduce the escalation of situations and reduce the length of time for which they felt 'rubbish'.

"I think from having the training and perhaps putting some answers behind how it made you feel sort of thing. Yes, I'm angry, but I'm not gonna be angry that personally, because this is why they've done that."
Community Nurse

"[Prevent sort of the escalation of situations where people come away feeling rubbish.] I can see how it would. It's... individually that's very rare for me. I can see how you wouldn't get to the stage where it would be as problematic...That you're not gonna get yourself into that. You're not gonna back yourself into that corner, essentially."
Therapy Team

"Some days are just and yeah, you just have bad days. But I think it would be able to make you process it easier. You know, the whole discussing it afterwards and processing and thinking, you know, oh that was rubbish but actually this is why they did that. That's why this happened and you're able to process it and debrief a lot easier."
Community Nurse

COMMUNITY HEALTH TEAM REDUCED IMPACT ON STAFF

"Actually, since we have that understanding you know, like it's OK to feel rubbish because actually there's a difficult patient, just acknowledging that, you probably feel a little bit better, I think."
Community Nurse

"I think we forget that sometimes 'cause we get a lot of pressure from management, go out, get the numbers, you know, get your visits done this and the other. And sometimes we do need to haul ourselves back in, particularly as us, as senior nurses need to pull our teams back in and say let's have some breathing space. Let's you know, let's actually regroup and what is important."
Community Nurse Lead

Some participants reflected that since the training there had been permission to feel 'rubbish' and acknowledgment, and that these support people to feel better.

"Actually, the lightbulb moment came when they [lived experience trainers] started to talk about when they're in their, sort of like, their tunnel of just thinking. They're just thinking about themselves, so it wouldn't matter that they kept somebody, you know a health professional, waiting on their doorstep for 15 minutes in the pouring rain and then decided not to open the door at all. That is how patients are at that moment... So, I really felt that I understood it from their point of view."
Community Nurse Lead

THE POWER OF THE LIVED EXPERIENCE TRAINERS' INSIGHT

A number of participants highlighted that the lived experience trainer insight into how they were feeling and what was happening for them during particular care situations had made a powerful impact on how participants perceived what was happening.

"I think what having the lived experience people there, when they're going through their crisis and then actually saying, you know, I didn't care that you were standing outside for 15 minutes because I just didn't care. And so, it's that understanding that actually they are not thinking straight or you know, they're not doing it deliberately, even though it feels it at the time."
Community Nurse Lead

"[before the training] We would go, "but can they not see that we're tired and that we're seeing them in the rain and we waited half an hour for them to open the door?" I think they [lived experience trainers] were able to rationalise their behaviour during the periods when they were suffering... and you know actually realising that patient at that time can't be empathetic towards the people delivering their care."
Community Nurse

RECOGNITION AND REDUCTION OF DEPENDENCY FOR PATIENTS ON PRIMARY CARE AND COMMUNITY HEALTH SERVICES AND STAFF

Agreement responses to the Likert item "I have patients who I think have become dependent on me in a way that is not helpful for them" were similar throughout the evaluation (Table 6), with small increases in agreement post-training and at follow-up. However, within GP practice and community health team participant free text and interview responses recognising and reducing dependency were large themes.

	% of respondents who agree or strongly agree		
	Pre-training	**Post-training**	**Follow-up**
All participants I have patients who I think have become dependent on me in a way that is not helpful for them	36%	42%	47%
GP participants only I have patients who I think have become dependent on me in a way that is not helpful for them	32%	35%	38%
CT participants only I have patients who I think have become dependent on me in a way that is not helpful for them	45%	55%	53%

Table 6

"So, there were a lot of patients who I think maybe you don't realise that they're dependent because they're presenting. It's not always regularly, but it's enough to think, "oh, you know, you've been here a few times and it's not always about the same thing". So, it's always about slightly different symptoms that kind of never really like draw together... Maybe perhaps I don't understand all. I'm not sure why they consulted about that because it's either not a medical problem or it's something that they knew how to manage themselves. And so, yes, I've been really trying to empower patients to look for information or kind of be able to send them one link so that they can start the journey of looking at health conditions and how to manage it themselves, rather than just sending them lots and lots of different resources."
GP Lead

GP PRACTICE REDUCING DEPENDENCY

"I think I'm much more aware of those patients now and aware when a relationship is starting to become a little bit dependent. And I think I'm much happier in how to separate myself and distance myself a little to try and, you know, tease that apart a little bit, maybe put up some more firm boundaries. So yeah. No, I definitely feel like I would be happier managing that."
GP Lead

"I think we have adopted a strategy of if people if we have patients like that because we have one very much they're named GP service for continuity. Now to put in a more structure ... like I'll see you again in four weeks' time. So that we avoid them calling duty and speaking to different people all the time. I think we've talked more about doing that. I think some people probably always had it 'cause it is a way to. You know, I think it's a recognised way to manage it, but I think we might have more discussion, maybe not in the meetings, but like informally about difficult patients and how we can."
GP Lead

All four GP leads spoke at interview about how they had considered dependency as a result of the training, describing how they began to recognise it and steps taken to reduce this.

"I definitely am more aware of it. But I was aware of it anyway, if that makes sense. Yeah, I was always quite mindful when people start to look like they might be getting dependent. What am I going to do? And it is very difficult because I don't want to hurt anyone's feelings or anything but even if I can't do much about it, I am aware that it's a thing. I think, yeah, probably I'm quite keen to spread it more, you know, use my team, use the team, so if there's something they could see the nurse for ... I'm sort of thinking it's a good idea to manage dependency is to get people looked after across the team."
GP Lead

COMMUNITY HEALTH TEAMS REDUCING DEPENDENCY

"Understanding how allowing a patient to become reliant upon myself as a professional and the service I provide to them is both unhelpful to them and the service."
Community Nurse

"It's made me aware of seeing people for too long or keeping them on for that little bit longer. And being more aware of what is actually the best thing for that patient and also what's the best thing for us, our service and our wait list and things like that."
Therapy Team

A large theme in responses was participants' recognition of dependency and its unhelpfulness to both the patient and the service as a result of the training.

"I think it's that whole thing of like, again hearing from the lived experienced guys that were there explaining why they became dependent on people and why that wasn't helpful, but at the time to them, it seemed really helpful."
Community Nurse

"It's making me more aware, which I didn't know before...because it was there before I even realised it and I didn't know it at the time. But I was actually most probably making it worse for myself and her because she couldn't... If I mentioned discharge, she'd change subject or she'd be ill again. I'd go to the next and she goes, "oh, I've been on the phone to the doctor. I can't possibly do this." So, it's flagged it up to me now. Then you know, you've got to be able to know where to go from there to help that person, because I'm not going to help her by just keep going because she wants me there."
Therapy Team

"Where patients have become partly reliant on me, working in partnership with the DN [district nursing] teams and leadership to try and establish better boundaries and clear goals when completing face-to-face visits."
Community Nurse

"A patient who could not make a decision for themselves without checking in on me. I have successfully got them to make those decisions and decrease their anxiety, improving confidence in themselves."
Community Nurse

Community health team participants provided many examples of applying the training to reduce dependency in both follow-up questionnaire responses and at interview. Empowering patients and setting boundaries were linked with reducing dependency.

"Patient that has become more dependent on our service, able to liaise more effectively with other services to provide addition support and advise."
Community Nurse

"But if you know if you've got that expectation to say, well, we've got a timeline to work towards, then that does help because if you don't set that timeline with them, then it could be forever. I have met a few patients who are in that category and actually I've given them timelines. However, prior to that I didn't, and I've got one that I'm still working with and because I didn't have that boundary with her at the beginning, it's taken a very long time to discharge her."
Community Nurse Lead

COMMUNITY HEALTH TEAMS REDUCING DEPENDENCY

"My colleague, one of my matrons has got that very problem actually. But I think part of the problem is herself as well. That she has a fear of letting go rather than it being just one way from the person she's looking after."
Community Nurse Lead

Participants also discussed at interview their role in creating dependency and this linked to participant's attachment to patients or inclination to want to rescue patients, sometimes contributing to feeling 'rubbish'.

"And yeah, occasionally you do come away feeling rubbish because you don't know where else to go. What else you can do? So, yeah, there have been occasions, and especially when you know, that patient has become particularly fond of you. You've done all you can sort of therapy-wise, and they just don't want you to leave and or you might have got really attached to that patient."
Therapy Team

"I mean that that's quite difficult for us as a service being that most of our patients are elderly. So, we do have people who do things so that we don't discharge them, but then is that based on their personality or is that just loneliness? ... We might be the only people they see from one week to the next, so it's that it's that barrier, isn't it? Working out which is which way it goes.
But if, say, we heal their legs, for example, if we heal their legs and we say they're not coming anymore, they will self-sabotage for us to go back in, but we can't not go in. So, it's just a vicious cycle, isn't it? I mean, you can't refuse to go in."
Community Nurse

Participants also discussed the challenge of loneliness creating dependency on services and how this can potentially impact on discharging patients.

"Someone who has a personality disorder, but then there's an unmet need in maybe older people who are lonely and are getting that need met through health professionals. Yeah, that's interesting and really tough because...they've sabotaged, or they reopened a wound or they've taken their catheter out of something. You can't not go and see that person."
Community Nurse

HOPE FOR THE IMPACT OF THE TRAINING

GP PRACTICES

"I think feeling more confident in managing those that you can't always find a solution. You can't rescue these people and I think also what was amazing about this was that the admin staff came to that training...I think found it really useful because they often bear the brunt of that group. You know, they often tend to be more demanding and more difficult with reception and on the phones... So, I think they also found it really, really valuable."
GP Lead

"I mean, so I hope that they will be, they'll be encouraged to take more ownership of their health and kind of the decisions that they that they are making...And so I think kind of I think it will come gradually and I think it will lead to better doctor / patient relationships because there's less blaming on both sides, less rescuing and kind of more recognition of kind of when you're in kind of in a red zone and kind of in the Blue Zone."
GP Lead

"I think we would now have a team who are much more aware of that type of patient and hopefully how to have more constructive consultations with them. Also, gives us a framework to discuss things amongst colleagues. So that hopefully we can be more constructive and helpful to that to that patient group."
GP Lead

"And so, it's been helpful to know to not feel, for everyone to not feel as alone which I appreciate sounds a bit silly because we always work together all the time but kind of we don't see each other's patients in the consultation. And so, it's kind of been helpful to sort of debrief and kind of download from maybe tricky consultations."
GP Lead

For staff, GP leads identified the impact of the training as not feeling alone and the translation of confidence in supporting patients.

GP leads identified that the impact for patients of the training would be patients feeling more empowered within their care, a better relationship with professionals and receiving better quality care.

"I think for the personality disorder patients, I think it will mean better quality access, because I think it will be, you know with a named GP on a regular basis with a clear plan and a clear way of managing their concerns."
GP Lead

"Yeah, confidence, definitely, I think. Knowing that they can come and talk to me, I think it's been helpful to know that there is a GP lead. I think that's very helpful for members of staff. I think knowing that they don't have to take all the burden on themselves. You know, the reception staff don't have to take all of that decision making on themselves. I think that they feel that they have somebody that they can come and talk to about that, which I think is really powerful."
GP Lead

"I mean for the practice, I hope that it makes everybody more confident in knowing how to manage difficult consultations, whether or not that is with patients with personality disorder or not. And then it kind of strengthens doctor / patient relationships. So that clinical care is better. I think for me, I think it's made me think about the way that I consult, and made me aware of rescuing behaviour in others and what I am thinking about when I rescue people myself."
GP Lead

"And then for our patients who do not have personality disorders, hopefully giving them better access because the system is not quite so preoccupied with this, you know, small group of sort of 30 patients and contacting them every day. We are much more open and much more able to kind of manage problems, as a result."
GP Lead

Better access for other patients was also identified as an impact.

HOPE FOR THE IMPACT OF THE TRAINING

COMMUNITY HEALTH TEAMS

"And I think it will get us talking about it as well as a group. You know, sitting in handovers, you know, actually discussing it and saying, well, I'm not sure about this. What do you think and actually raising those questions, you know, what do you think? We don't do enough of that."
Community Nurse Lead

For staff community health teams identified the impact of better team working through encouraging team members to talk to each other more.

"Service and team I think that that will be more evident, I think that we will all get better at that boundary making and that identifying of challenging behaviour or interactions with patients and I think that that that like sort of dripping effect will help us sort of you know, if you if you save, you know, two hours work on every patient, then eventually you build up a big block of time that you save."
Therapy Team

"Well, so impact for staff is gonna be sort of better morale...when you do have these difficult patients if you like or how it's perceived this sort of difficult situation. How draining that can be, how exhausting it is, how frustrating it is for lots of different reasons, because you want to help and you can't help or...you're now really late with all your other patients and all of these and all of these sort of knock on effect that you get. So, if we can do that better, that's going to make people feel better 100%. It's going to make staff feel better. It's going to have a definite, definite impact on that."
Community Nurse Lead

"I think patients, well, hopefully they're gonna be a bit better understood. So instead of this kind of narrative being, you know, difficult patients or challenging it being, you know they their need is different and how do we meet that. Now we've got tools to look at how better to support that person, so hopefully, instead of it being sort of complex or challenging or not getting what they need, we're going to be able to better support them with their needs."
Community Nurse Lead

Community health team participants identified the impact of the training in practice for patients as a better service as a result of staff having understanding and feeling skilled to better meet the needs of patients.

"So, I think the impact would be more from the patient perspective that actually they would be getting better quality of care because you know we would hopefully have more skills to have better conversations with the patients."
Community Nurse Lead

"Long term for the patient, the patient probably would get a better service because yes, they again with the timeline, they have something to work towards."
Community Nurse Lead

"Someone's now going to the practice nurse. So that's had a huge impact on somebody that we were seeing very regularly for very long visits, we've now got them appointments, they've got now a set time and they're able to go out and that's better for them and their independence. And that's empowering for them. And also, that's better for our service because now we've got more space to see someone else that can't get out and is house bound. So, kind of benefits everyone all around really doesn't it. If we can get it right.
But if you can get out, actually, that's great because you can get a timed appointment and you can take more responsibility for booking it. And when it suits you and all these benefits of that, that sometimes people don't see and they think it's just us wanting to get rid of someone. That's not the case. Actually, that's a better place to meet your need now compared to what we were at the time."
Community Nurse Lead

One participant gave a case study of where they had changed their approach to a patient as a result of the training and the impact that had for the patient and the service.

BEHAVIOUR (LEVEL 3)

Level 3 of the evaluation sought to determine the behavioural changes in practice as results of the training, these are defined in the methodology section as critical behaviours and required drivers. Findings are taken from the follow-up questionnaire responses and interviews with participants. As in the previous section findings have been reported separately for GP practices and community health teams to enable detailed reporting relevant to the different healthcare settings.

GP PRACTICE CRITICAL BEHAVIOURS

In the follow-up questionnaire 33 out of 38 GP practice participants provided examples of what they have been able to apply in their day-to-day work since the training, 27 participants further expanded to provide specific examples where they have applied the training with a patient. At interview all four GP leads described multiple examples of how the training had been applied in practice and changes made because of the training.

Participant responses that evidenced critical behaviours within GP practice staff were the reported individual changes in behaviour made by staff, these fell into two main categories: taking a different approach and applying specific training concepts.

"One thing that really sticks with me is they [lived experience trainers] said if you're dealing with patients like that, think that they're using defence mechanisms that they developed as a child and they haven't been able to emotionally develop into adulthood, and I think that's quite a useful way of thinking about it, and it also gives you a little bit more sympathy for them when people can be quite difficult and it can be frustrating, it's an easier way to have empathy."
GP Lead

One GP lead at interview described how the lived experience trainers' explanation around defence mechanisms had supported them to have more empathy.

"To not judge - it could be a huge challenge for this individual to approach the practice."
Manager

"Speaking to the patient using their name, offer a more private area (if available) for the patient to sit."
Receptionist

"I used it [the training] within challenging situations, demanding for some medication for chest infection, trying to explain regarding it is a viral infection, and placed myself into their shoes and approached from a different angle which helped the patient."
Practice Nurse

"A discussion over a medication request. I listened first to their request rather than starting with declining their request for additional medication."
GP

"I understand how my approach can help these patients. The lived experience trainers said that clear boundaries, being consistent and not giving up with patients is helpful to them."
Manager

A DIFFERENT APPROACH

Taking a different approach included having greater empathy and compassion, taking more time to listen to patients, trying to understand from the patient's point of view and being mindful of how and where to communicate with patients.

"To listen carefully not just to what is being said but also to what is not being said."
Care Coordinator

"We have been keeping calm when certain patients push the boundaries but also trying to understand more the reasons behind their actions."
Manager

"Used phrases to validate the experience of a patient in crisis who was shouting and distressed. Since the training I was more aware of how her past life trauma impacted on her."
GP

GP PRACTICE CRITICAL BEHAVIOURS

"Using the approach where try to get patient to help themselves rather than keep offering them things from me."
GP

"Greater understanding of when to have challenging conversations with patients with PDs - in their 'thinking window'."
GP

"I am working on boundaries. I am recognising that I try to help patients which may be at their detriment (and mine). I am thinking about being more neutral in my approach."
GP

"I have tried to listen and validate patients experiences but then be boundaried in my response. Let them know time is limited, ask them what they would like to achieve from the consultation."
GP

"When a patient kept missing appointments and then requesting an appointment at a different time at very short notice I was clear that the boundaries were kept for this patient. I reiterated the boundaries with the patient and was clear that these were not moved."
Practice Nurse

APPLYING SPECIFIC TRAINING CONCEPTS

Applying specific training concepts centred around empowering patients and remaining neutral using the rescue/blame seesaw and emotional thermometer and setting boundaries within interactions and consultations.

Many participants gave examples of how they are trying to remain neutral with patients by implementing boundaries to better support patients.

"Awareness of trying to get into my thinking zone with patients in crisis by staying calm and using supportive words and encouraging patient to be in their thinking zone and consider how they have coped before in crisis."
GP

"I have set up a clear plan with a patient who calls frequently with health anxiety - he has a telephone appointment with me every 2 weeks and in between we try to avoid him being added to duty. It has given me an opportunity to broach the idea of counselling and CBT with him in a more proactive way."
GP

"Keeping boundaries clear and consistent with one of my frequent attenders who tends to swing between rescue and blame."
GP

"Patient clearly angling for me to solve things e.g. ring secretary, sort out prescriptions. Delegated appropriately to other members of team and gave patient details of who to contact to chase up appts and encouraged them to discuss with support worker."
GP

"I think the concept of being a rescuer or a blamer. And recognising when you're adopting that role and trying not to, trying to stay more neutral, I think that was the main thing that stayed. I think I've got a couple of patients who are quite regular contacts of mine who... probably I was always trying to provide something for them and since we've done the training, I mean, they're quite complicated medically as well, which makes it more difficult, but I think. I've tried to adopt a more neutral approach so that there isn't always something I can do. It's more trying to encourage them in terms of how they might manage things themselves or them recognising that I don't have all the solutions or any solutions for some of them."
GP Lead

"I think having the group session it made me realise I've got one patient who kind of very draining sort of very taxing to deal with. And I think then having the training, I think it made me realise that I definitely am rescuing and I wonder if it's just, by nature, kind of our profession. I guess we want to help people. We kind of want to do something positive for patients and sometimes that does come across as kind of maybe doing things that, maybe, the patient could do themselves with some motivation. So, once I realised this and I kind of take, I've taken a very gradual kind of retreat approach where I rescue less with kind of subsequent consultations."
GP Lead

Two of the GP Leads at interview spoke about how the training had made them recognise their own tendency to rescue patients and steps they have taken to become more neutral.

GP PRACTICE REQUIRED DRIVERS

"Dialogue opened up between me and reception team regarding more challenging patients."
GP

"I have buddied up with a colleague to help me stay on track on clinical days and not give in to saving people!"
GP

Participant responses that evidenced required drivers within GP practice staff were the changes made together that act to reinforce and encourage the training.

"I have buddied up with a colleague to help me stay on track on clinical days and not give in to saving people!"
GP

"I have not dealt with these types of patients recently/ directly, but have been able to coach staff who have."
Manager

"I think since having the training, I think we've been more open about talking about patients with personality disorder and have got the certificate in a frame in the staff room and so it's quite visible and sometimes people talk you know it's acts as a kind of something like a conversation starter sometimes."
GP Lead

"We have got laminated posters up in the reception team area...we've got the two posters up about the balance-scale [rescue-blame seesaw] and about the emotional thermometer. And we've got them in the meeting room upstairs."
GP Lead

"Chatting with the receptionists about the rescue-blame and [emotional] thermometer about interactions, just briefly like, about just trying to be in the middle. And I'll talk about this with colleagues a bit. The emotional thermometer is useful. I think receptionists know what it means. Even the ones who didn't get to do the training."
GP Lead

"I think there has been some change and some shift. And it's helpful because I can kind of go, "hmm, I've noticed this person popping up on duty every day this week and last week and the week before". Here is what's worked for other patients... here's what we've tried with other patients. "Do you want to maybe put something like that in place? I'm going to book them an appointment with you in two weeks' time. Could you talk to them about this?" So, it's often after a prod from me, which I don't mind because at least then we're kind of moving things in the right direction and hopefully the more we talk about it, the wider it will be as a culture thing that we do in our practice, rather than just me doing it."
GP Lead

"So as a part of our clinical meetings, you have a part of a section of time where we can discuss complex clinical cases and it happens to be a lot of them do have a personality disorder and we think about the approach that has been taken and is there anything that we can subtly try to change again like this kind of gradual retreat of rescuing kind of gradually reducing, rescuing less and less or kind of yeah. So that that's been quite helpful."
GP Lead

Continuing to discuss training concepts and support each other

DISPLAYING TRAINING RESOURCES

At interview the GP leads described further changes made as a result of the training that evidenced required drivers for sustained change in practice including displaying training resources and continuing to discuss the training and support each other.

GP PRACTICE REQUIRED DRIVERS

"The rescue-blame seesaw...I think that one mainly and I think it's something we've been able to kind of convey to new incoming clinical staff and to medical students who sit in with us. I think it's a relatively easy concept to describe to other people, and I think it's also made me think, you know, maybe sometimes we rescue people in life... And the emotional thermometer as well, this concept of being in the green mentalizing zone."
GP Lead

"And the other thing I've done, but I haven't actually finished, is that I've printed out a list of all the people on repeat prescription for Diazepam...just so we can be mindful that, possibly, there may be some other ways we can try and help them."
GP Lead

Other changes made at practice level to support the training in practice included reviewing diazepam prescribing and considering how to support patients who frequently contact the surgery.

Two GP leads described at interview how they have been teaching the concepts to new staff and trainees.

"The rescue-blame seesaw. I've used that a lot because I'm a GP trainer as well. So, talking about that rescue-blame seesaw with my trainees has been very helpful. The unmet need as well and kind of by trying to identify that unmet need is a good one, yeah. So, I definitely use the elements of the toolkit quite a lot, pretty much every day, probably. Maybe a lot of it is kind of subconsciously, like you're maybe not going "PDPOP" but definitely incorporating it into my day everyday sort of practice.

I think it helps to be able to put a kind of concept, or a framework on that concept. Because I think a lot of trainees will find themselves quite naturally falling very much into one category or the other. And you know, because when you don't have that experience of kind of recognising your own responses to the patients, I think it can be a really easy trap to fall into. So, it does go down well because I think it also helps to take the shame out of your own response. If that makes sense. So, it kind of helps you to understand that this is something that we all do, especially with this group of patients. That actually recognising that we do it talking about it, addressing it, maybe even, you know, addressing it head on with the patient."
GP Lead

"We have personality disorder protocols, probably a bit of a strong word, but certainly we have more of an awareness of personality disorders as a practice. We have had patients, you know, since, who have been quite challenging and been able to refer back to the personality disorder training. It has been really, really powerful. We've definitely been doing things differently. We've got our list of patients who are our most kind of frequent contactors of the surgery and trying to work on ways to manage them slightly differently, giving them very defined routes into the practice, but without just allowing it to be the kind of free-for-all that it's been in the past."
GP Lead

COMMUNITY HEALTH TEAM CRITICAL BEHAVIOURS

In the follow-up questionnaire 17 out of 19 community health team participants provided examples of what they have been able to apply in their day-to-day work since the training, 15 participants further expanded to provide specific examples where they have applied the training with a patient. At interview all community health staff and leads described multiple examples of how the training had been applied in practice and changes made as a result of the training.

Participant responses that evidenced critical behaviours within community health team staff were the reported individual changes in behaviour made by staff, similarly to GP practice staff these fell into two main categories: taking a different approach and managing expectations and boundary setting.

A DIFFERENT APPROACH

Taking a different approach for community health team participants included having greater empathy and self-awareness, taking more time to listen to patients, changes in communication and sharing mental health resources.

"Being more understanding and aware of other people's emotions and how I respond to them."
Community Nurse

"I have a much better awareness of the patient/professional relationship and how my actions alter or inform that."
Physiotherapist

"Learning to listen more, especially when patient seems a little anxious, taking remarks on board."
Rehabilitation assistant

"I found this training really beneficial in helping me to better understand personality disorders and the most helpful ways to communicate and work with patients who may have personality disorders."
Community Nurse

"And it was just interesting just listening to them [lived experience trainers] in the way that they say, you know, how they reacted to professionals. And actually, the way to word things to get people on board. So, it's made me look at other aspects, actually, of my nursing, you know, how I talk to patients. The way that I word things."
Community Nurse Lead

"I have used some of the advised terminology to discuss two traits I identified with one patient and she has taken the MIND information I gave her to consider her thoughts on how she copes with a potential differing diagnosis than depression."
Community Nurse

At interview some participants also described the change in approach as a shift in attitude around what would have previously been considered 'awkward' or 'disengaged' behaviour and how this had led to further consideration of what might be happening or needed for patients.

"I'd say it's to do with their sort of approach. Maybe to how they feel and the attitudes towards their patients. The ones that can be really what you might describe as classically awkward, I guess actually they're not being awkward for awkward's sake, and you know, if we dig a little bit deeper into what's causing it or you know what's influencing their behaviour in that moment, then we can kind of look at ways around it."
Community Nurse

"I think my nature when I've seen, you know, people that don't want to do what I'm asking them to do is that I then probably categorise them into you know, I don't know. Broad stroke, lazy or you know they don't care or something like that. But the training gave me that little bit more of an insight to step back and say, actually, what are the reasons for that, that I might not have thought about before, you know, I look at actually the way they're interacting with me and the people around them and how they're going about not doing what I'm asking them."
Therapy Team

"I think it's a lot to do with attitudes towards certain patients generally and I'm seeing that with a lot of the district nurses as well. So having done the training and saying that knowledge myself being able to pass that on to my colleagues and say actually let's step back from this situation and think a little bit more about what might be going on with this patient. I think we're all just a little bit more tolerant and perhaps know what the best course of action is to manage those patients."
Community Nurse

"It just makes this question a bit more, rather than "jumping" for me, rather than thinking it's quite difficult, I think it just makes you think a bit longer and a bit think twice and that, like I said, have a bit more patience and try and look at it from a different way to see how you could approach the situation differently, rather what you normally do."
Community Nurse

COMMUNITY HEALTH TEAM CRITICAL BEHAVIOURS

MANAGING EXPECTATIONS AND BOUNDARY SETTING

A DIFFERENT APPROACH

The majority of participant responses within the follow-up questionnaire and at interview around how they have applied the training in practice included managing patient expectations about the service and setting boundaries.

"Set goals for discharge."
Community Nurse

"From outset of assessment with a patient with potential personality disorder provided clear guidance of what the team could provide and not provide, what is expected from them regarding exercises compliance and was positive in how they can actively help themselves (regarding their mobility issue)"
Physiotherapist

"Ensuring boundaries and expectations are managed in terms of not promising a patient a visit or a set time etc."
Community Nurse

"With most patient's now talk about the remit of the team on the initial visit/phone call."
Physiotherapist

"One of the things I took away from the training was to have more well defined boundaries with patients... And I think that's really helped. I think we've gone about patients differently because of it. We tend to communicate more frankly about what everyone is wanting and how we're gonna get there...I think it's just made the whole thing more clear for both patients and staff, and I don't think I've had any push pushback. No, I think people have responded quite well to it. Actually. It's like it's like it's a little more honest."
Therapy Team

Several participants spoke about how it felt to be setting boundaries, describing this as a shift in practice and how at first it can feel counterintuitive.

"I think it's that first time, isn't it? That first conversation, because they're not expecting you to say that and you're not expecting yourself to say it. So, I think once you've said it the first time, it's almost like there's a silence because you like. Ohh. OK."
Community Nurse

"Again, it was mentioned by the lived experience [trainers] in the group that actually you've got to set clear expectations and boundaries. And that is uncomfortable...

As nurses, we're just used to going. Yeah, we'll see you until you know your legs drop off sort of thing. So, it's a very different way for district nursing to interact with patients by setting those clear goals and saying, you know, by at the end of September, we'll have this. And, you know, that's not something that's ingrained in us. So, it's that's going to take some time... because clear expectations is actually, you know, are really important."
Community Nurse Lead

CONCRETE EXAMPLES OF MANAGING EXPECTATIONS AND SETTING BOUNDARIES IN PRACTICE

Preparing patients for discharge.

"I think our big thing is when we are discharging and then things happen because they don't want to be discharged and then we can look at why, you know, not just thinking that they're actually trying to be difficult...

I think we start a lot sooner in the sense of saying to patients you know... Say it's like a wound... "You know your wounds healing really well". And then leaving that conversation then. Now they go. "Well, actually, you know, your wounds doing really well, you know, we'll be looking to discharge you if it keeps continuing to improve like that". So, it's preparing them to say, actually we're discharging you. It's preparing them for that process...

So, it's not just actually being 'dropped on them'. So that they've got time to adapt and if we're finding things are happening, you know we'll branch out now. More to, you know, our community matrons for that extra support, where - before - it was very much like we're going in thinking that every patient is happy to be discharged. Actually, they're not."
Community Nurse Lead

COMMUNITY HEALTH TEAM CRITICAL BEHAVIOURS

CONCRETE EXAMPLES OF MANAGING EXPECTATIONS AND SETTING BOUNDARIES IN PRACTICE

WORKING ACROSS TEAMS

"She [a patient] respected the tissue viability nurse as a lot more than she did the district nursing teams. And so, when we became involved with her care, she only wanted us to care for her wounds, and she would only accept what we'd say as sort of gospel. And if the district nurses said anything different, it became a real problem with that communication.

So, it was kind of explaining to her that actually, unless there's a specific goal that we can achieve in that one visit, because we don't have the capacity to carry out and regular visits, we sort of go in and we assess the situation and give a very detailed care plan. And then it it's down to the district nurses to deliver that care.

So, for that patient, once we've sort of pulled back a little bit in a way and explained that to her that it wasn't possible for us to deliver all that care and that the district nurses would need to do their part of it for her to get the care that she needed, she then was a little bit more open to the district nurses coming in. Whereas before she was, you know, turning them away at the door, not letting them in, only letting them do very specific things with her wounds and her leg and things. So, I think it it's already we've started to see a change in her and more acceptance around you know, people coming in that are not the tissue viability nurse, for example."

Community Nurse

PROMOTING INDEPENDENCE

"So, a patient the district nurse team was seeing her for leg ulcers. And she could have gone to the surgery but chose not to go to the surgery. And there were problems about getting into the property. So, she would sometimes make the nurses wait maybe 20 minutes to half an hour to get in the house. Those sorts of things. And she did very dictate what she wanted, when she wanted it, those sorts of things and following that training, I said, "right, let's go in and we'll have I'll have a chat with her."

So, I agreed with her on that day that we would visit her one day a week and the other day we would make an appointment for her to go to the practice nurse. I also said about that on the days that we visited, we would only wait five minutes and if she didn't respond to us in that 5 minutes, she wouldn't have her visit and she'd have to wait till the next time and so it was very clear.

We made a- I don't want to say it was a - contract, but also it was like "this is what we've agreed today" and we both signed it to say this is what our agreement is, if anything changes, we'll communicate with each other.

And actually, she's now discharged from the district nurse caseload because she enjoyed going out so much that she now managed to go to the practice nurse all the time."

Community Nurse Lead

USING TOOLS AND CORE CONCEPTS IN PRACTICE

Despite being highlighted by community health team participants in the post-training questionnaire, and in contrast to the GP practice participants critical behaviour responses, specific tools and concepts from the training, (unmet need, triggers, the emotional thermometer and rescue-blame seesaw), were not given by community health team participants as examples of how the training had been applied in practice in either the follow-up questionnaire or at interview.

When this was further explored at interview only one participant responded that they had used a specific tool and another reported that they used them as part of their toolkit, but without consciously bringing them to mind.

"I really liked the concept of the rescue blame seesaw, actually. And I think it's one of those things that I have been talking through with my colleagues."
Community Nurse

"Well, I would not definitely have been able to bring up the like, recall those from memory, if I'm being perfectly honest, but I am. I suppose it's one of those things I it's part of my like toolkit now. I don't actively think to myself, you know is it is this person displaying unmet need or what have you. But I am I'm more aware of the things that I might have construed differently but prior to the training."
Therapy Team

"So, I think it's that whole sort of thing of going a bit above and beyond for specific patients that you think, right, they really need my specific support and input in this this way actually that's not quite what they need. It's more to do with, you know, this is the service. This is what we provide, and these are the people who work with, and they're gonna be delivering this care. So, it's really sort of set out what the patients can then expect. And actually, I think that that has definitely worked in a couple of circumstances that we've sort of encountered since then."
Community Nurse

"So, setting like those barriers and things has been really useful so far with the patients I've encountered since that training.

I think it's just hearing their perspective [lived experience trainers] really and their point of view, because I think we, as nurses, tend to think we know what's best for patients and actually hearing that actually, no, you don't. And what maybe you think is the best thing for those patients is not always the best thing. And learning about what made a change for them.

I mean that really hit home with me because I've noticed a few times that I do go a little bit above and beyond for some of my patients where perhaps it's not the right thing to do."
Community Nurse

Other participants reported forgetting about them, or not having used them in practice. However, it became clear as part of the evaluation process that use of the concepts was present in the examples of change participants gave, but without using the terminology, such as not rescuing patients.

COMMUNITY HEALTH TEAM REQUIRED DRIVERS

The main required driver evidenced through community health team participant responses in both follow-up questionnaires and interviews was continuing to discuss the training once back in practice. Participants described this happening in a number of ways, including sharing awareness and using the training to inform discussions about complex cases as well as teaching sessions.

"Sharing awareness of personality disorders and being more able to identify those patients."
Community Nurse

"After the training, you know we were sat in the office and sort of saying Ohh we did this and I thought about this patient and yeah, they're like, oh, yeah, yeah. So, we kind of discuss it within, the team, it does come up in talking about patients and their behaviours."
Community Nurse

"I've run supervision groups and so people do bring patients to the supervision to sort of talk about and think about it [the training] is something that I might bring up."
Community Nurse

"It has been sort of like a drip feed of sessions. And, so, when we have like, as I say, have our handovers that it's, you know, when patients are getting highlighted and it's trying to change staff's perception and the way they work. As I said, you know, it would be things like I would say before, you know, making sure that patients are prepared for what is coming, you know. You know, they have still got the support around them that we can actually then, you know, speak to the GP or speak to other agencies. And while they are still, still under the umbrella of the district nurses, in that sense, so they don't feel abandoned."
Community Nurse Lead

Other participants reported forgetting about them, or not having used them in practice. However, it became clear as part of the evaluation process that use of the concepts was present in the examples of change participants gave, but without using the terminology, such as not rescuing patients.

Participants also described how they have brought the training into supervision sessions and ways in which they have supported staff both within their own teams and others.

"We really wanted the Band 5s to come because you know, they're out and about every day doing the work. But due to capacity, they couldn't. So, I've spent a lot of time with the teams that I've been to since then, you know, talking to them about what the training involved."
Community Nurse Lead

"I mean I've got a good example from recently we've been to see a chap. He's come into our system for the second time and he's presenting in the same way, behaviourally, for want of a better expression, as he did last time. But now we have a different viewpoint on that, and we've discussed that as a, you know, in a two or a three, you know about why that might be. And I think that if we hadn't had that training, we wouldn't have done that."
Therapy Team

"Straight away we got an example that, actually I mentioned this at a countywide meeting, and actually one of the nurses contacted me after said that she has a patient that sounds quite similar, and [we] actually met with her separately. Didn't we? just to kind of talk it through like we're not experts, but this is the kind of stuff that we learned from the day."
Community Nurse

"I think it's changed my practise for the better. I think it's helped me support staff because like I said, I don't see patients day-to-day at all. But it's helped me to be a good leader/manager and to go in and try and get that different perspective and that's been beneficial and the fact that other people have now come to us, actually I think that shows us a depth about that training."
Community Nurse

COMMUNITY HEALTH TEAM REQUIRED DRIVERS

The main required driver evidenced through community health team participant responses in both follow-up questionnaires and interviews was continuing to discuss the training once back in practice. Participants described this happening in a number of ways, including sharing awareness and using the training to inform discussions about complex cases as well as teaching sessions.

"PDPOP champions and I are meeting soon. We've really struggled to get a date when we're all free to look at what we can really do with it. The three of us ... an idea of putting a bit of a MDT group sort of drop in for other professionals because obviously the only the three of us.

How? How we can get that message out there? How we can say we're available to help. We've got a little bit extra training and we can support you.

So, we've got plans to kind of share that a bit further so."
Community Nurse Lead

"Recognising the signs better and referring to MH [mental health] team."
Community Nurse

"I have been able to be aware since the training that one of my patients may have PD, and able to discuss with Mental health nurse who was also involved."
Rehabilitation Assistant

"Discussing with team to think about how patient will respond to involving MH [mental health] team."
Community Nurse

"Have been able to discuss with more with MHN [mental health nurse] on our team for advice as have recognised symptoms."
Rehabilitation Assistant

One community health team lead spoke of plans to create multidisciplinary team (MDT) drop-in sessions.

Another required driver evidenced in one community health team was participants involving the mental health nurse embedded within the team in discussions about patients and referring patients onto mental health services.

CHALLENGES AND FACILITATORS TO THE APPLYING THE TRAINING IN PRACTICE

GP PRACTICE CHALLENGES

"Time is a big barrier. And the lack of meetings. So, reception don't seem to have a team meeting where they discuss difficult cases and things have gone well. Other surgeries I have worked for have done this - a set of meetings - and it was really good to see, and of course you're going to share learning more that way. And when it gets busy maybe the culture is still there of having that together time. I think there's something there about that, but how do you introduce meetings into an already busy surgery when you're not used to them?"

GP Lead

The challenges raised by GP leads at interview to applying the training in practice were consistent with those found in the previous year's evaluation. Highlighting issues that were general challenges faced in primary care and not specific to the PDPOP training including staff turnover, workload, time and capacity restraints, a lack of protected time to meet as a team and a lack of service provision to refer on to.

"I think the immense workload is just a huge barrier really. It's always at a point where every session I do probably generates almost as much work extra as what I'm paid to do... How do you get people learning when they don't even have a lunch break because they haven't got time?"

GP Lead

"And another difficulty we have at this area is we don't have any service for them. There's no sort of personality sort of service, which it sounds like there is in Oxfordshire and Buckinghamshire, where other people were working so. I suppose it's also the concern of giving someone a diagnosis and then doing nothing with it, you know. It's hard because sounds like from all the lived experience trainers going into quite extensive psychological therapy was what they needed and we don't have any ability to offer that."

GP Lead

"And you know, setting aside extra time and energy to then hopefully see a benefit in the long term, it's very hard to kind of stick your head above the parapet, or take a step back. Even just taking a step back and just kind of assessing the situation objectively, like, that can be incredibly difficult. So yeah, time, time and energy are the biggest barriers, I think."

GP Lead

CHALLENGES AND FACILITATORS TO THE APPLYING THE TRAINING IN PRACTICE

COMMUNITY HEALTH TEAM CHALLENGES

Another participant raised workload and capacity as a potential barrier but with the lens of this potentially causing distrust with patients when clear plans could not be given, or appointments were cancelled.

"I think possibly there's challenges around capacity of like the district nurse caseload and things like that in our area at the moment because they can't always, for example, give an idea of how frequently they might be visiting, or they might have to cancel visits, and I think that's causing a real challenge for patients that do have personality disorders already, because they feel like they can't trust the clinicians."

Community Nurse

Many of the community health team participants voiced that they thought the only challenge to applying the training in practice was getting all staff members of the team trained to ensure consistency of working. One participant raised individual confidence of team members as a potential challenge.

"I suppose confidence of the person. Doing that, performing their everyday role, I think that throughout my team, there was definitely quite a spectrum of people who would feel comfortable asking some of the more difficult questions or identifying some of the more subtle and challenging interactions. And so, I would think that unfamiliarity of the of the people putting the training to practise would be a barrier."

Therapy Team

A final challenge raised within community health teams was the potential push back from GPs when raising concerns about personality disorder for a patient.

"I think it is making a difference...I think the bit that we find quite, I would say, a bit frustrating, is when we go to, let's say, a GP. You know, we've been to this patient. We're finding this and this and we think it may be personality disorder and then they look and we get that "well actually what do you expect" you know, more or less...we're not at that stage where we can just go to a GP and say, well, actually, "this is what we found". It's not all the time we have experienced that."

Community Nurse Lead

CHALLENGES AND FACILITATORS TO THE APPLYING THE TRAINING IN PRACTICE

FACILITATORS

Participants from both GP practices and community health teams highlighted more staff attending training and more PDPOP leads in teams as a facilitator to applying the training in practice and overcoming barriers.

"You know more training and being able to have maybe two or three of us in the practice who are leading on it, rather than just one of us. I think that would be helpful."
GP Lead

"I think it's just a matter of linking in with others and really finding out what existing forums are out there for you for the training to be tapped into."
Community Nurse Lead

"I think having people in your area that have also been on the training perhaps so that you can have conversations with others and sort of compare notes if you like. So that when you do come across a patient that's particularly difficult, that may have a personality disorder, someone that you can sort of go to for peer support and almost like the clinical supervision."
Community Nurse

Community health team participants identified the leading indicators of discussing the training as a team, linking in with others and supporting each other as additional facilitators.

"That actually we just get on it and we do the case over we say, you know, they go through each patient on the caseload, but actually given the time and space, so and actually could we address this any differently and maybe even identify patients that could benefit?"
Community Nurse Lead

"And you know, maybe it's something that we could look at as for a link nurse. So, I mean, obviously you have separate sort of mental health nurses, but to perhaps have something like that within the team to have some sort of mental health wellbeing link nurse. Could then keep themselves updated and then relayed back to the team."
Community Nurse

COMMUNITY HEALTH TEAMS VIEWS ON FURTHER TRAINING

As the topic of needing to have more staff trained to implement the training in practice became a prominent theme in the follow-up questionnaire and interviews, this was explored further at interview to gain community health team participant views as to how further training should be facilitated.
Some participants spoke about their preconceptions prior to training that they were unsure what the training would cover and that in some cases this meant they nearly didn't attend.

'Word of mouth' and sharing their experiences of the training was highlighted as being helpful to engaging staff to attend future training sessions.
"And I guess if we were going to do it again, from us going, we'd be able to help the next people by saying "actually, this is what we got out of going".
Community Nurse

"I mean I think the training was brilliant. It was not what I was expecting. In a good way. No, very much and good way."
Community Nurse

"I don't think it was necessarily clear what it was all about. I had another thing in my diary and almost didn't end up attending, but once I ended up going it was great."
Community Nurse Lead

However, there were mixed feelings on how much information should be given beforehand about the training, with some staff feeling others may miss out due to misconceptions and others suggesting a pre-training resource would have been helpful.

"I think that's really difficult because I guess it depends on who's telling you what it was about, because how someone delivers that, it could come across as, "I'm not sure I want to go to that." It doesn't maybe relate to what I do on a day-to-day basis, whereas maybe going in there not knowing. Yeah, it's that bit easier."
Community Nurse

"Like a leaflet... nothing big, but a little snapshot before the training and people can see it and think you know, OK, that seems very interesting. I would [attend], yeah."
Community Nurse Lead

"What would be lovely is to be having our band fives or band fours or threes, even, to be bringing this up and saying actually I've done this training. I think we should do x, y and z and having the confidence to start off those conversations. When they're communicating with patients, just having that extra little bit of confidence. Rather than say "it's not my problem and we need someone above us to sort it out" and to be on a daily basis, identifying patients with extra needs and how we go about addressing them and what we do about it."
Community Nurse Lead

Participants highlighted wanting to see others come back into practice with the same confidence they had gained and that there was, already an appetite from others who wished to attend the training.

"I was in the office the other day I was trying to explain this [the training] and one of our nurse associates was going "And what's that? What's that? That sounds really good, but can I book it?" And it's like "not at the moment". But yeah, already people are sort of interested."
Community Nurse Lead

COMMUNITY HEALTH TEAMS VIEWS ON FURTHER TRAINING

"And I think it gave us when we did the training, we broke up in groups and could discuss specific patients within each group. And actually, I think it really showed that the therapy colleagues have the same patients and the same issues in a different care setting and given tasks."
Community Nurse

"So, I think it would be beneficial as a team, but then I think it would also be beneficial if you're doing it from different areas, you'd get different examples and different things to the table. Yeah, I would probably say do it as a large collection of teams."
Community Nurse

This was further explored with participants as to how training should be delivered, as well as the feasibility of training all staff.
Challenges to getting all staff trained included the size of community health teams and the number of staff who might need to attend training, including new staff joining teams and the financial and workload capacity implications of training multiple staff at one training session.
However, all participants felt the benefits of the training and doing the training with other team members outweighed these potential barriers and that, with enough organisation, future training could be facilitated to ensure all team members received the training.

"Yeah, because we go in to see the patients that the district nurses go to and sometimes the district nurses will come into us and talk about a patient, not talk about them, but mention that "I went to a patient to do dressings, but they're struggling. What do you think?"
Therapy Team

Participants highlighted the value of the training being as a team, or as many as could go, and sessions including both nursing and therapy members of community health teams as well as staff from different localities.

"I think that it gives us a wider understanding, but I think you need a whole team to really to tackle that kind of issue."
Community Nurse

"If you went to like a couple of teams, we could get those together. Perhaps you know "snow plan". So, if we know in advance and so it's an afternoon training like we had."
Community Nurse Lead

"Because you're just standing on the treadmill, and it just needs to stop so that we can give people all the training. I think it was fantastic and it was only about 2-hour training, but I think just talking to the lived experience people was just fantastic really."
Community Nurse Lead

"I think that it gives us a wider understanding, but I think you need a whole team to really to tackle that kind of issue."
Community Nurse

"And actually. some of the patients we discussed, we had more interaction with. So, we all had a slightly different perspective, but we'll talk about the same person, which was really interesting. I think a mix. Different perspectives. Different therapies as well."
Community Nurse Lead

COMMUNITY HEALTH TEAMS VIEWS ON FURTHER TRAINING

"I think I'd like to do it again and maybe then I might take remember different bits of it that I yeah, take away from last time. Yeah, but I definitely would want my team to go. I think it would be really good."
Community Nurse

A number of participants voiced that they would welcome the opportunity to do whole the training again.

"But certainly, that is possible, but we have most areas like Wokingham or Bracknell or Reading or whatever have a monthly forum where they get all the community nursing staff together and that's untrained staff all the way up to band 7 staff... So, you know there are already forums set up that we could tap into."
Community Nurse Lead

One participant suggested using existing forums that bring together staff from different localities as a platform to deliver the training.

Going forward participants felt that the PDPOP training should be mandatory.

"I firmly believe that this should be mandatory. I really do. And I know, like I just said a lot of the Community nurse managers, we are struggling to get all our staff to do mandatory training. Sorry, this is crucial."
Community Nurse Lead

"Just that opportunity to discuss stuff your own experience. Sort of brought our own cases or examples, didn't we? It's just really useful and being able to talk openly about it because I think what you're open about these things, you can then squash them a little bit, can't you?. And I don't know that you know, I could do that in an MDT I think you need that training you need the full experience to get that personally, that's my opinion."
Community Nurse Lead

"It was the lived experience trainers. Yeah, most definitely. Because they were brutally honest and sometimes you need that. Yeah, you just need that...And it's just I think they were brilliant actually, you can hear all the sort of the science and the medical bit behind it and the strategies and these policies and everything. But actually, having people in front of you that live with it... It's really enlightening, very much so."
Community Nurse

"And they were open for us to ask them questions, although you could do videos and interaction with them to go, "but how does that make you feel?" And then ask a few the same question? Actually, it's that dialogue that you're learning as well. So, for me, videos and that wouldn't have been as effective."
Community Nurse Lead

Some participants spoke about a 'train the trainer' style delivery or online or e-learning, however it was felt that this would not have the same results or impact due to limited knowledge and skill and that the whole experience of the training, particularly the lived experience trainers was needed.

SUGGESTIONS

"I think it would be nice to have gone away from the day with some resources or something that I could so present to my own team if you like. So, I'm aware that they probably won't get to go on this training anytime soon, but the fact that I found it so helpful, and I want to be able to pass that knowledge on to them or you know work with them so that they can have better understanding too."
Community Nurse

"If they could have shared the slides. That might have been helpful for just reminders and also some people who couldn't come 'cause they didn't work on that day. And it might be useful if we're talking about something to sort of revisit the concepts. I think it'll be helpful to maybe to have those to share with people and to help facilitate discussions."
GP Lead

"Because you do, you do forget...because you come out of the training and then you think, yes and you can identify things more. But as time goes on you, you start to lose that focus. You tend to focus on some things that you picked up and you engaged with a lot and then the bits that you sort of didn't, you tend to lose that a little bit and you know that could be a lot more helpful in certain situations. So, to have a rolling kind of training in this area will be beneficial, yeah."
Community Nurse Lead

RESOURCES

Participants from both GP practice teams and community health teams suggested having resource packs after the training. Participants commented that these would be helpful for cementation of their own learning, to support others who had not been on the training and act as aids to facilitating discussions.

REFRESHER TRAINING

Refresher training was also highlighted as needed going forward by community health team participants and GP practice leads to support maintaining skills and confidence. Participants agreed that yearly refresher training would be appropriate.

"I do think that I would have liked to know what a personality disorder is at the beginning. I think that I want to know the reason behind it."
Community Nurse

FURTHER CONTENT AROUND PERSONALITY DISORDER

A small number of participants spoke about wanting to know more about the aetiology of personality disorder and the interaction with neurodiversity and other mental health conditions. However, participants acknowledged the time within which training was delivered and the potential impact of delivering too much information.

"I think it would have been interesting to learn more about the interaction of the co-existence of personality disorder with autistic spectrum conditions and with PTSD and with ADHD... I think particularly because as these conditions I mentioned, I think they are becoming more prevalent...and it would just be interesting to know does it affect ... the approach does it affect kind of maybe how you might consult or how the patient might present?"
GP lead

SUGGESTIONS

SIMULATED LEARNING ON USING THE CORE CONCEPTS

Participants from both GP practices and community health teams suggested that simulated learning within the whole team training sessions would be helpful for all staff. The main focus of these discussions at interview was around the use of the core concepts, particularly using the emotional thermometer and rescue-blame seesaw.

"We do quite a lot of simulated learning. I think the whole team would be interested in it. We only trained about six people, but I think it would benefit far more people from the team."
Community Nurse

"I'm just thinking, like, role play for them or role play for us when we're kind of remaining neutral...And maybe, I mean, this is in the realms of being aware of your own self when you are feeling like you're tipping to one side or the other [of the rescue/blame seesaw]. Are there any signs of actually, when you're doing it ... but that may be a bit in-depth, that might be more of a follow-up session or a role play session or something...practical application of how do you actually do it a bit more?.. And more role play, if people are up for doing role play. That kind of way of practising in a safe space."
GP Lead

"But I think when we've had patients that we've struggled with to get the mental health support...they've got huge case load and actually they're dealing with the more severe and actually they probably think the people that we have issues with, who have with mental health disorders that'll be the milder ones, they don't have time to support us, to manage them, maybe because they're not on their radars as a significant risk or harm or anything else, but for us, because we don't deal with it every day and for our staff, it can be alarming and quite hard to figure out the right routes to take. And that's across the system."
Community Nurse

FOLLOW-UP AND SIGNPOSTING

Participants from the community health team suggested that a follow-up by the training team in practice would be helpful to support applying the training, alongside clearer guidance on what was expected of them in terms of cascading the training or sharing with others.

"I seem to remember having some resources, but often you can get sent stuff and you just park it and you don't necessarily naturally go back to it. And I wonder whether it's a little follow up as a little prompt...And also, sometimes we go into training sessions and the expectation is really that we cascade that so I guess we take more of it than they were sharing it. We weren't sure what the plan is for rolling this out or not."
Community Nurse Lead

THE WIDER NEED FOR MENTAL HEALTH SUPPORT IN COMMUNITY MENTAL HEALTH TEAMS

Participants from the community health teams identified the gap in knowledge and support around mental health. Participants described feeling separate from mental health services and how getting support can sometimes be challenging. In teams where there was a mental health nurse embedded this was seen as an invaluable resource.

LIVED EXPERIENCE TRAINER TOP TIPS

At the residential symposium the lived experience trainers were asked for their top tips in working with people with personality disorder as part of the question and answer panel session. Many of these are have been reflected in the examples given in Levels 3 and 4 of the evaluation.

- **Avoid medication - medication delayed my recovery**
- **Remain human**
- **Each patient is unique "If you have met one person with personality disorder...you've met one person with personality disorder"**
- **Validation is a powerful tool**
- **See the person**
- **Compassionate boundaries**
- **Bear in mind the child that learnt that behaviour**
- **I hated boundaries but I needed them**

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APPENDICES - APPENDIX A

QUESTIONNAIRES

Questionnaires were administered pre-training, post-training and at follow-up (six to eight weeks post-training). The questionnaires contained a unique identifier field which enabled matched responses over time and constituted of repeated measure five point Likert items, ranging from strongly disagree to strongly agree, and free-text questions. Analysis of Likert responses was conducted using Microsoft Excel and SPSS where significance testing is indicated. Analysis of free-text responses was conducted using NVivo and thematic framework analysis.

SEMI-STRUCTURED INTERVIEWS

Community health team staff who attended the training were invited to participate in a semi-structured interview at follow-up (six to eight weeks post-training). PDPOP leads from both community health teams and GP practices were invited to participate in a semi-structured interview at four to six months post-training. The latter were conducted up until August 2024.

All interviews were recorded and informed consent was obtained prior to interviews through a Microsoft Forms online consent form. Once transcripts of interviews were verified as accurate, the recordings were deleted, and transcripts were anonymised by being allocated a participant number.

Analysis of all interviews was conducted through transcripts using NVivo and thematic analysis.

APPENDICES - APPENDIX B - MISSING DATA

DEMOGRAPHICS

Participants were asked to complete a unique identifier so their responses could be matched through the evaluation process. They were also asked to select a job role from a predefined list. Only one individual did not select a job role (pre-training).

LIKERT ITEM RESPONSES

There were three individual missing responses to the Likert item ""I have patients who I think have become dependent on me in a way that is not helpful for them". One missing item response was in a pre-training questionnaire and two in post-training questionnaires, there were no missing item responses at follow-up.

FREE-TEXT QUESTION RESPONSES

The questionnaires post-training and at follow-up both included free-text questions.

Post-training missing responses:

- four individuals did not provide a response to the question "What (if anything) do you think you might do differently as a result of this training".
- six individuals did not provide a response to the question "What had the biggest impact for you in the training".

Follow-up missing responses:

- two individuals did not provide a response to the question "What (if anything) have you been able to apply from the training in your day-to-day work?"
- four individuals did not provide a response to the question "If you can, please give an example of how you have applied the training with a patient (please do not use names or other identifiable details)".
- four individuals did not provide a response to the question "Please share any other thoughts or comments around the training and its effect on you and your team?"

APPENDICES - APPENDIX C
REACTION AND LEARNING (LEVELS 1 AND 2)

Levels one and two of the evaluation sought to determine participants' satisfaction, relevance and engagement with the training (level 1), and knowledge, skill, attitude, confidence and commitment as a result of training (level 2). Themes in participant responses across levels 1 and 2 were similar for both GP practice and community health team participants and so are reported together.

SATISFACTION

Participant responses to the five questions relating to relevance and satisfaction in the post-training questionnaire show >95% agreement with the statements. This indicates that the training was highly relevant and that participants were highly satisfied with the training. See Table 7.

Job Role	% of respondents who agree or strongly agree
I enjoyed the training	100%
The training was useful	100%
There was enough time for discussion	95%
The training was pitched at the right level	98%
I would recommend this training to another healthcare team	100%

Table 7

"Fantastic session. Really helpful, engaging and well delivered. Lived experience trainers really insightful and helpful for learning."
GP

"Good breaks and change of styles, presentations during training. Thankyou!"
Practice Nurse

"Excellent course would recommend."
Manager

"Fantastic training, much needed and wanted!"
Community Nurse

"Really valuable training the lived experience presenters were amazing and it was the best team training we have had in years."
GP

APPENDICES - APPENDIX C - REACTION AND LEARNING (LEVELS 1 AND 2)

Job Role	% of respondents who agree or strongly agree		
	Pre-training	Post-training	Follow-up
I have a **good understanding** of what **personality disorder** is	34%	97%	94%
I can **recognise** when a patient **might have a personality disorder**	39%	95%	91%
I have a good understanding of the challenges other staff face when dealing with patients with personality disorder	44%	96%	98%

Table 8

"We all face similar challenges and have very little training on how to deal with them."
Mental Health Practitioner

"Challenges faced by reception staff."
GP

"Recognising that being a rescuer can be a negative thing for the patient."
GP

Responses to the free-text questions also demonstrated a better understanding of the challenges their teams or colleagues face.

Participants also highlighted their learning around the concepts and tools taught.

"Concepts around the rescue/ blame balance really helpful, insight into what is actually helpful support for these patients."
Community Nurse

"Being able to understand a little and recognise traits of personality disorders, recognising some of these in patients understanding the DN [District Nursing] role in this."
Community Nurse

"Understanding what a personality disorder is and how to navigate to the right people and how to have helpful conversations with the patients."
Manager

"My role as a health care professional in regards to nursing a patient with personality disorder. How things I do can help them such as setting boundaries and consistency within the team when looking after patients."
Community Nurse

"To consider what may be underlying the behaviour and kind compassionate boundaries."
GP

Participant free-text responses demonstrated their learning around understanding and recognising personality disorder.

"I have learnt about what personality disorder is and how to spot traits in patients and colleagues alike. I have also learnt a new language that will be used in practice."
Community Nurse

Other themes around knowledge and skills from participant responses included learning around language, considering behaviours, boundary setting and a consistent team approach.

APPENDICES - APPENDIX C

REACTION AND LEARNING (LEVELS 1 AND 2)

ENGAGEMENT

High participant engagement was demonstrated within the PDPOP training sessions through post-training participant free-text responses highlighting the training being interactive and engaging. Engagement was also reflected in the high levels of participation in the evaluation, with 296 free-text responses out of a possible 306 in the post-training questionnaire (not any final comments).

"All of it the training was very informative and will impact the way I assess patients going forward the trainers were very knowledgeable, passionate and engaging, having lived experience speakers was so worthwhile big impact."
Community Nurse

"It was such a great opportunity for so many different members of the team to get involved. So, the receptionist, medical secretaries, the nurses, we had a really good spread, I think of different team members from across the practice. That was really, really powerful, I think to get some multidisciplinary training. I think it's the first time we've ever done anything like that... So, I think it was a really powerful thing to do that. I thought it was a really great sort of team building thing as well. So not only for just the pure training side of it, but also it really helps spark conversations among the team. I had loads of feedback from the different members of the team that they found it really helpful as well and kind of really helped them to sort of build empathy with patients with personality disorders."
GP Lead

"I haven't known really any whole team training other than possibly resuscitation. And people still talk about the training and they say to people who didn't go, "you should have gone. You missed it. You missed out sort of thing." It's definitely something that's stuck in people's heads."
GP Lead

"Discussion with members of team having personality disorder traits - how childhood/ background affect development."
Practice Nurse

"Full team being involved/non clinical team member input. Case presentation."
GP

"Getting all the team together to discuss our most challenging patients."
GP

Participant responses highlighted engagement through the whole team training approach and opportunities for discussion.

APPENDIX C - REACTION AND LEARNING (LEVELS 1 AND 2)

ENGAGEMENT

"Listening to the lived experiences really resonated with how patient may be feeling."
Community Nurse

"The lived experience trainers are just such remarkable people and such an incredible resource. Being able to spend some real time with them I thought was so powerful, and not something I've ever really encountered before...I've done endless diabetes teaching days without a single diabetic person involved. You know, I've done endless mental health stuff, without an actual person with mental health issues being involved. So many examples of what we do in medical training. You learn about it from people who are "the experts". And they know what they are talking about, but they don't know what it's like to have that condition. And I just thought that was incredible."
GP Lead

"Listening to lived experience trainers how they felt, reflected and managing."
Physiotherapist

"Lived experience trainers were so helpful. I could have listened more."
Mental Health Practitioner

As found in the previous year's evaluation, overwhelmingly the participants valued engagement with the lived experience trainers, with 60% of participants referencing this as the biggest impact from the training. Participants described the lived experience trainers as...

"It was good to listen to what they had to say wasn't it and you could really relate to what they were saying to our patients."
Community Nurse

BRAVE
INSIGHTFUL
AMAZING
POSITIVE
BRILLIANT
HELPFUL
EYE-OPENING
IMPACTFUL

"The lived experience discussion was brilliant for understanding."
GP

"Because sometimes there's that fear that I am going to say the wrong thing and offend somebody here. But I want to ask this, but I want to know and so we don't want to be ignorant to it. But we're learning, right? So how do I ask this really honest question and then them being really honest with us actually that's that was so helpful to be able to just be honest."
Community Nurse Lead

APPENDIX C - REACTION AND LEARNING (LEVELS 1 AND 2)

ATTITUDE

Participants' positive responses to the post-training questions showed that they valued the training and felt that it was worthwhile.

Responses also indicated that for a number of participants the training had made a difference to how they view patients and patient behaviour.

THE MAIN THEMES AROUND CHANGES IN ATTITUDES WERE:

Trying not to 'fix' patients.

"What personality disorder is, how to recognise it and to treat everybody with kindness even if they are being rude as it may not be personal."
Receptionist

"I will approach complex patients with relationship issues with a different lens, a better understanding, an increased level of compassion and much more knowledge of personality disorder."
Community Nurse

"To not expect to be able to fix or meet an unmet need for these patients but facilitate them to formulate solutions."
GP

"Recognising these complex patients can't always be "fixed" - but the team need to work consistently and together to deliver care and present expectations from team/patient going forward."
Community Nurse

APPENDIX C - REACTION AND LEARNING (LEVELS 1 AND 2)

ATTITUDE

"Put myself in the patients' shoes, remember what the lived experience trainers told us."
Community Nurse

"More insight/understanding obtained, better aware that there are likely to be numerous difficulties experienced by the Pt, some of which have not yet been recognised/diagnosed. Found the training to be very honest and brave, impact was more relatable hearing it from people having experienced difficulties with MH/Addiction. Personally found it very moving."
Receptionist

Consider the patients' perspective

"After the course it made us all realise how hard it is for the patients too."
Manager

"I understood that even the quite pts have so many silent battles and also the noises pts are trying to be heard."
Practice Nurse

"To be more aware of how certain patients may feel on the inside rather than how they project themselves in the first instance."
Receptionist

"The challenges patients face when consulting and how I can manage my own consultations."
GP

"How our patients with complex emotional needs feel when they are triggered."
GP

"I thoroughly enjoyed and gained a lot of knowledge from this training. The volunteers [lived experience trainers] were inspirational and amazing people. It gives encouragement to dig deeper and have a better understanding of patients situations and lovely to know that, as a team we can help them toward recovery and/or make their day to day living as comfortable as possible."
Receptionist

"People with PD can get better!!!"
GP

Hope

"Take inspiration back to my team and help them to rationalise some of our patient's behaviour."
Community Nurse

"Lived experience trainers - seeing there can be a positive outcome and improving understanding of how it feels for the service user."
Physiotherapist

APPENDIX C - REACTION AND LEARNING (LEVELS 1 AND 2)

RELEVANCE AND COMMITMENT

Participant responses about what they intended to do differently as a result of the training demonstrates the relevance and value of the training and their commitment to apply what they have learnt to their jobs (Kirkpatrick and Kirkpatrick, 2021). The main themes around what participants intended to do differently immediately after the training in post-training responses were changes in communication, a consistent team approach, setting compassionate boundaries and validating and empowering patients.

"Encouraging talking to patients who you think may have a PD."
Community Nurse

"Change my communication with some patients."
Manager

"Explore emotional needs further rather than reaching for prescription."
GP

"Try to take a step back with the team as a MDT to review the team behaviour and agree what care should be given and how."
Community Nurse

"Ensuring the team takes into consideration how through trying to do too much could be harmful."
Community Nurse

Communication

"Be braver in mentioning PD."
GP

"I will discuss training with team I will be more aware that some behaviours may not just be someone being needy or aggressive."
Community Nurse

A consistent team approach

"Talk to the patients more to see if they open up to you."
Community Nurse

"Consider how to raise diagnosis with language."
Manager

"Support the teams to identify and try to manage patients with personality disorder (diagnosed or not) in a way that is helpful for them."
Community Nurse

"Talk about these patients more, make management plans in order for all team to follow the same plan."
GP

APPENDIX C - REACTION AND LEARNING (LEVELS 1 AND 2)

RELEVANCE AND COMMITMENT

"I will put some boundaries in place when dealing with certain patients - discussions within the team so that we all work in the same way."
Receptionist

"Braver, more open boundary setting. Ask the patient what they would wish/ like."
Practice Nurse

"Be clearer in setting compassionate boundaries with patients. This is helpful for them, do not bend over backwards to rescue, try to remain neutral."
Practice Nurse

"Stop rescuing, remember boundaries can be empowering for pt and don't mean I'm not helpful or I'm a failure."
GP

Setting compassionate boundaries

"Ensure and encourage with my team the importance of consistent boundaries. Understanding going above and beyond for all patients is not always useful to them."
Community Nurse

Setting compassionate boundaries was often linked by participants to acknowledging their own tendency to 'rescue' and intentions to stop rescuing patients.

"Use the seesaw, become less of a 'rescuer' where able, try to consider longer term implications of my behaviour."
GP

"Try and remain 'neutral' and not go into rescue mode."
Practice Nurse

"Be clear about what/ service can/cannot provide. Explore clear boundaries."
Community Nurse

"Being more open and reflective of what people may need, but also learning to set better boundaries."
Community Nurse

"Importance of setting boundaries and validating the person as a decision maker."
Physiotherapist

Validating and empowering patients

"Validation for how patient is feeling."
Admin

"Validate the feelings/ experience of the service user."
Community Nurse

"Effective consultations to recognise key points of focus. Allowing the patient to be the main decision maker."
Practice Nurse

"Patient motivated agency is the most powerful tool."
GP

"Validation and acknowledgement of emotions within a consult rather than rescue."
Unknown

APPENDIX C - REACTION AND LEARNING (LEVELS 1 AND 2)

RELEVANCE AND COMMITMENT

Other ways in which participants indicated they would use the training in practice included:

Being more curious

"Be curious about the "why" behind patient behaviours."
GP

"To listen - be curious why somebody might behaving in a particular way."
Physiotherapist

Taking account of their own emotions

"Acknowledging our own emotional responses."
GP

"Think more about where I and my patients and patient's family might be on the mentalisation."

"Reflect on what's going on for me."
Mental Health Practitioner

"Take an extra moment not to let my own emotions affect the situation."
GP

"Regulate my emotions. Try to understand thermometer."
GP

Taking more time to listen

"Learn to listen to patients more. Hear their point of view or expectations."
GP

"Hold back let the patient express themselves until they feel less stressed/calm."
Manager

"Calm, listening, not interrupt patient."
Receptionist

"To be more aware and to listen to patients who may need more time."
Admin

"Hold back, let patient tell you what help they need or what would help them."
GP

APPENDIX C - REACTION AND LEARNING (LEVELS 1 AND 2)

TRAINING RELEVANCE TO COMMUNITY HEALTH TEAMS

As this was the first year that the training had been adapted and delivered to community health teams the relevance of the training was specifically explored with participants from these teams. All participants across district nursing and therapy teams felt that the training was highly relevant to community health teams and for all staff within the teams.

"I think it should be for everyone actually. Not a specific group, all clinical staff, not even just clinical. I think even like the admin 'cause, they could learn, again they get phone calls as well. So yeah, I think it should be rolled out for all bands."
Community Nurse Lead

"And you know, it's kind of this is an area I haven't even thought about and I've been nursing for 30 odd years and actually I'm missing. I'm almost misdiagnosing people, you know, saying you've got depression, but actually they probably haven't or possibly haven't.

So it's very relevant. So, I think it's hugely relevant to all community nursing, not just district nursing."
Community Nurse Lead

Participants all valued the training being face to face, interactive and the lived experience trainers.

"...definitely all levels...I think any grade as well, yeah. And I'm kind of thinking about the therapists, but I can't see why this would be any different for most therapists."
Community Nurse

"Yeah, 100% worthwhile...I think as a team it was, it was really important."
Therapy Team

"I think it's probably more applicable to community teams than perhaps ward based nursing. I mean obviously it's applicable everywhere, but I think even more so in community. I would say to students when they come that as a district nurse, it's very different nursing. When a patient comes to hospital, they're on your territory. When you go to them, you're on their territory and you know mental health and things like that is a lot more. You are a lot more involved in it and you do become their nurse and you, you know, you're visiting them and you can build a different relationship."
Community Nurse

"I did put it in that I liked the fact that it was face-to-face. I think it's really difficult to get it across if it's on teams and I think that's really important as we're going out of the pandemic to get back into face-to-face training."
Community Nurse

"I really like how it's run and especially having the lived experience trainers there that make it so much more interesting because you're listening to people who's been through that. Through that process and giving you all their thoughts about it and how they felt, so that I've never had a training with having real life experience in the training, who can actually answer your questions and you can talk about it actually to them. So that was one of the great thing about the training."
Community Nurse Lead

APPENDIX D

RESIDENTIAL SYMPOSIUM FEEDBACK – KEY THEMES

All four GP leads and seven community health team leads attended the two-day symposium. A feedback form was completed by participants immediately after the symposium and further feedback was sought at interview.

A POSITIVE AND WORTHWHILE EXPERIENCE

"I felt really inspired. I felt like I had a massive confidence boost in terms of managing the condition and supporting people with personality disorders. That was brilliant. Yeah, I felt really energised. Really energised, really inspired and I think that's what the best teaching can do... It is always so good have that opportunity to kind of step away, talk about something. You don't expect to spend 36 hours talking about something like personality disorders and come away feeling energised. That's just not what you expect. You expect to come away going: "Oh God", you expect to feel kind of drained and hopeless maybe about it all, but I felt the complete opposite. Energised and inspired. It was, yeah. Brilliant."
GP Lead

VALUE IN HAVING MORE TIME WITH THE CLINICAL AND LIVED EXPERIENCE TRAINERS

"And I think just having the lived experience people there is it, that's what. What makes it, you know... The NHS talk about involving patients, and I think, compared to how you've involved them on this programme, we've sort of paid a bit of lip service to it really. But I think having them there it just gives a complete. It just makes it real." **Community Nurse Lead**

"Hearing from the lived experience trainers in the nurse group work really made me think about my communication and how this can be received by someone with a personality disorder and the subsequent impact. This really made me reflect and think about what I will do different."
Community Nurse

OPPORTUNITY TO CONNECT AND NETWORK WITH COLLEAGUES

"Meeting people in other roles - can be hard to meet non-GP practice teams normally." **GP Lead**

"It was great. I thought it was really, really good. It was really nice to just be in a room with lots of other professionals with lots of different experience just talking about what we can do better, what we can do different, sharing ideas. I think the mix is really good. I always think a mixture of professionals is great 'cause you can learn so much and it's good to network."
Community Nurse Lead

VALUE OF THE SIMULATED LEARNING

"So I'm the sort of person who really, really hates role play and I'm sure a lot of people have said this as well...I think the examples that the lived experience trainer gave to me. I think they were very realistic and just like how it would be in the surgery, but it was a kind of nice to be in a controlled environment where we could stop the consultation and reflect on what had happened and then kind of move forward. So, yes, I'm glad I did it, yeah."
GP Lead

"Oh, the role play was really helpful. That was good. It was good to have a go at practicing. It was good collaboration, like different people coming together in the group exercises. It's a good example of that working together to try and improve the service."
GP Lead

"I think when you mentioned the word role play, 90% of staff go eek terrifies them, but actually you get so much learning from them and I think the simulated learning's probably for me one of the best ways of learning. And it's actually if people want to learn, I think we need to offer them different ways of learning, because if they know there's going to be an element of role play in it, you'll find a lot of people just back out because of fear. Or not being pressurised to participate if they're feeling uncomfortable."
Community Nurse Lead

REFERENCES

Aviram, R.B., Brodsky, B.S., Stanley, B. (2006). Borderline Personality Disorder, Stigma and Treatment Implications Harvard Review of Psychiatry, 14 (5): 249-256.

Doyle, M.; While, D.; Mok, P.L.H. et al. (2016) Suicide risk in primary care patients diagnosed with a personality disorder: a nested case control study. BMC Family Practice 17: 106. Available from: https://doi.org/10.1186/s12875-016-0479-y [accessed 19.03.2024].

Foye, U.; Stuart, R.; Trevillion, K; et al. (2022) Clinician views on best practice community care for people with complex emotional needs and how it can be achieved: a qualitative study. BMC Psychiatry 22: 72. Available from: https://doi.org/10.1186/s12888-022-03711-x [accessed 19.03.2024].

González-Ginocchio, B., Jones, J., Allen-Curry, N., Hetherington, A., Parry, J. (2022). Evaluation of the Personality Disorder Positive Outcomes Programme (PDPOP). First and second year PDPOP training evaluation report. Skills for Health:Bristol.

Griffiths, J. (2017) "Person-centred communication for emotional support in district nursing: SAGE and THYME model," British journal of community nursing, 22(12), pp. 593–597. Available at: https://doi.org/10.12968/bjcn.2017.22.12.593.

Griffith, R. (2018) "Improved care and support for people in mental health crisis," British Journal of Community Nursing, 23(10), pp. 515–517. Available at: https://doi.org/10.12968/bjcn.2018.23.10.515.

Hoffman, A.N., Lycan, C.E., Robbins, M.E. & Abraham, S.P. (2021). Challenges of living with borderline personality disorder. International journal of science and research methodology, 18 (3): 239-252.

Kirkpatrick J and Kirkpatrick WL, (2021). An Introduction to The New World Kirkpatrick Model. Kirkpatrick Partner:Georgia.

Lee, S. and Knight, D. (2006) "District nurses' involvement in mental health: an exploratory survey," British Journal of Community Nursing, 11(4), pp. 138–142. Available at: https://doi.org/10.12968/bjcn.2006.11.4.20832.

Maslach, C., & Jackson, S. E. (1981). Maslach Burnout Inventory--ES Form (MBI) [Database record]. PsycTESTS.

Marangozov R, Huxley C, Manzoni C, Pike G. Royal College of Nursing employment survey. 2017. Retrieved from: https://www.rcn.org.uk/Professional-Development/publications/pdf-007076

Mental Health Foundation (2022). Personality disorders. Retrieved from: https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/personality-disorders#:~:text=Around%20one%20in%2020%20people,unrecognised%20for%20a%20long%20time.

Moran P., Jenkins R., Tylee A., Blizard R., Mann A. (2000). The prevalence of personality disorder among UK primary care attenders. Acta Psychiatrica Scandinavica, 102 (1):52-7.

National Institute for Health and Care Excellence (2015). Personality disorders: borderline and antisocial. Retrieved from: https://www.nice.org.uk/guidance/qs88/chapter/Quality-statement-4-Pharmacological-interventions.

Papathanasiou C, Stylianidis S. Mental health professionals' attitudes towards patients with borderline personality disorder: The role of disgust. Eur Psychiatry. 2022 Sep 1;65(Suppl 1):S373. doi: 10.1192/j.eurpsy.2022.947. PMCID: PMC9567085.

Pol, S.M., Schug, F., Chakhssi, F. & Westerhof, G.J. (2023). Life stories of patients with personality disorders before and after treatment: Change and stability in agency and communion. Frontiers in Psychiatry, 14. Retrieved from: Frontiers | Life stories of patients with personality disorders before and after treatment: Change and stability in agency and communion (frontiersin.org)

Snowden, P. & Kane, E. (2018) Personality disorder: no longer a diagnosis of exclusion. Psychiatric Bulletin, 27 (11): 401-403.

Trueman, H. and Williams, M. (2023) Year three PDPOP training evaluation report. Retrieved from: https://www.patientsafetyoxford.org/clinical-safety-programmes/mental-health/personality-disorder-positive-outcomes-programme-pdpop/