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Personality Disorder Positive Outcomes Programme (PDPOP)

Year three PDPOP training evaluation report

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Acknowledgements

The authors of this report would like to thank all the GP practice staff who gave their time to the evaluation through questionnaires and interviews to share their learning, experience and examples of application of the training. Their feedback enabled the evaluation to assess the quality and impact of the PDPOP training and define recommendations to improve the training for future cohorts. Additionally, the authors would like to thank the lived-experience and clinical trainers who participated in interviews to share their experience of being a trainer and their hopes for staff and patients through the training. This gave context to the results of the evaluation and allowed for translation into potential patient benefits.

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Notes on navigating this document

We acknowledge that the audience for this report will be broad and that navigating a large document, such as this, can be time-consuming when you are seeking specific information. We recommend that everyone read the executive summary for an overview of the entire evaluation. However, for ease of access and navigation we have provided quick links to key sections of this report and a small number of key results that we think readers will be most interested in based on specific occupation type or role.

Key sections of the report:

- Overview of PDPOP training
- GP staff reaction to training
- GP staff learning
- GP staff behaviour changes after training
- Results of the training in practice
- Potential impacts for patients

Key results:

- Results for reception staff
- Increased staff confidence and reduced staff burn-out indicators
- Shorter and less frequent GP consultations
- Reducing appointments

Executive Summary

Oxford Academic Health Science Network (AHSN) was commissioned to conduct an independent evaluation of the third year of the Personality Disorder Positive Outcomes Programme (PDPOP). PDPOP is a co-produced whole practice approach to training in primary care that aims to help all members of GP teams, including administrative, reception and clinical staff, to feel confident and skilled when interacting with patients who may have personality disorder.

The evaluation consisted of pre- and post-training questionnaires, follow-up questionnaires and semi-structured interviews of practice staff at six to eight weeks, and semi-structured interviews of GP leads at four to six months post-training. Lived-experience and clinical trainers were also interviewed for their experience and hopes for what the training will achieve in practice.

10 GP practices across Southeast England were trained between October 2022 and March 2023. All practices took part in initial pre- and post-training evaluation activities and nine practices took part in six weeks to six month follow-up activities.

The New World Kirkpatrick Model (Kirkpatrick and Kirkpatrick, 2021) was used to evaluate the training across four levels of training evaluation: reaction, learning, behaviour and results.

Reaction (Level 1)

Participants were highly satisfied with the training and found it to be relevant, engaging and useful, with over 90% of participants responding 'agree/strongly agree' to the following statements:

- I enjoyed the training (98%)
- The training was useful (97%)
- There was enough time for discussion (93%)
- The training was pitched at the right level (95%)
- I would recommend this training to another GP practice (97%)

"Thankyou great training, actually relevant to me even though I didn't think it would be."
Admin

"Very informative, I would sit through this again and still find it interesting."
Management

Learning (Level 2)

Initial post-training evaluation demonstrated that participants had gained knowledge about personality disorder and retained this knowledge when followed up after six to eight weeks. At follow-up over 90% of participants responded ‘agree/strongly agree’ to the following statements compared to less than 50% pre-training:

- I have a good understanding of what personality disorder is (94%)
- I can recognise when a patient might have a personality disorder (94%)
- I have a good understanding of the challenges other practice staff face when dealing with patients with personality disorder (96%)

“The types of behaviours that might indicate a person has a personality disorder. How the situation feels from the perspective of the patient with a personality disorder.”
Receptionist

Participants highlighted their learning in the context of:

- Individual needs
- Masking
- Recognising traits of personality disorder
- Importance of the whole team approach
- Four core concepts (unmet need, triggers, emotional thermometer and rescue-blame seesaw)

“I think for many of them it was more thinking along the lines of difficult people, you know, difficult patients. And seeing them in a different light. That not everyone is good at speaking for themselves or explaining what’s wrong.”
GP

“Actively try to maintain a neutral affect and try to temper my desire to rescue a patient.”
GP

A small group of GP and paramedic participants reported that they would have liked a more concrete or solutions-based training, and this is reflected in the recommendations.

Initial post-training demonstrated shifts in participants’ attitude towards patients with personality disorder included acknowledging and trying to understand triggers and greater empathy and compassion.

Increased confidence in managing distress, crisis and participant's own emotions was retained at follow-up:

- Participant confidence of dealing with a patient presenting in crisis with expressions of desperation, self-harm or thoughts of self-harm increased by 45% immediately after training and retained a 40% increase at follow-up.
- Participant confidence to manage their own emotional reactions to patients who present in an emotional crisis increased by 21% at follow-up.
- Participant confidence that their team responds effectively to patients who present in an emotional crisis increased by 29% at follow-up.

"More confidence facing difficult conversations with patients and knowing that it can help them."
Nurse

Behaviour (Level 3)

Evaluation from six weeks post-training to six months post-training demonstrated that participants had applied the training in practice and were carrying out critical behaviours and required drivers through numerous behaviour changes at both individual and team levels including:

- Case discussion meetings
- Identifying and coding patients
- Better use of mental health practitioners
- Application of awareness, recognition and understanding
- Implementing boundaries
- Open conversations about personality disorder
- Structured consultations
- Consideration of medications
- Use of the emotional thermometer and rescue-blame seesaw in practice

Results (Level 4)

Results of these behaviour changes were an overall increase in confidence for staff across practices and roles in working with patients with personality disorder, managing crisis and distress and managing their own emotions. Through increased confidence there was evidence of reduced burn-out indicators for staff through:

- Not taking things personally
- Feeling empowered
- Leaving things at work
- Helping to retrospectively put things into perspective

Although the training did not quantitively show an increase in participants' recognition of patients who are dependent on them in a way that is unhelpful for them [the patient], follow-up questionnaires and interviews revealed evidence of action taken post-training to reduce dependency as a result of the training.

Staff reported that through increased confidence and subsequently reducing staff-burn-out and dependency of patients on primary care they are beginning to see results in practice of:

- Better relationships with patients
- Reduced length and frequency of consultation appointments
- More consistency of working across teams through a shared language

Challenges and barriers

There were a number of challenges to putting the training into practice including staff turnover, time and workload pressures, staff's own internal response to crisis situations and a lack of services and resources to support diagnosed patients. However, in response to the challenge of staff turnover and time and workload pressures the evaluation findings indicate that the training may help to reduce these by lessening staff burn-out and increasing appointment availability through more effective interactions and consultations.

Potential impacts for patients

From the translation of these findings, it can be concluded that in practices that undertake the PDPOP training patients may have a better experience of GP services through a more empathetic and compassionate approach, resulting in fewer triggering instances and the reduction of escalating situations. Patients may also benefit from reduced unhelpful or unnecessary prescribed medications and better consideration of alternative support such as social prescribing, therapy and signposting. Patients may receive better consultations with GPs and face less stigma through educated and open conversations about the diagnosis of personality disorder and feel more contained through a consistent approach across the whole team.

Recommendations

A brief overview of recommendations from the evaluation is presented below.

Training

All participants suggested repeated training, highlighting this as a way to help manage the challenge of turnover of staff, to refresh memories and a way to reflect on what had happened since the initial training. Staff group or role specific training was also suggested.

Resources

Through evaluation activities it became clear that resources were needed to act as required drivers to support the education of new staff and as reminders of the training to support critical behaviours to continue. Resources suggested by participants included written take-away resources and online website resources.

Community of practice

A number of participants from different practices expressed a desire to have a platform/forum/group to exchange ideas, ask questions and problem solve with other practices that have completed the training and to get feedback from the training team. Several GP leads described how the follow-on GP lead meetings had been helpful and supportive and that they would like a similar ongoing forum.

It was felt by participants that a 'community of practice' type of space would provide the right forum.

Recommendations for measuring impact

The evaluation team asked interview participants, lived-experience trainers and clinical trainers what they thought could be measured to demonstrate the impact of the PDPOP training in GP surgeries. The suggestions for potential measures are numerous, however all participants emphasised the difficulty in measuring the less concrete items such as culture, burnout and patient experience. They also urged caution around using a single quantitative measure such as medication, as this could become the single focus and a 'tick box' measure that is not necessarily relevant to all.

Suggested measures fell into three categories: quantitative measures, qualitative measures and measures around follow-up actions and continued meetings after training.

Introduction

The Personality Disorder Positive Outcomes Programme (PDPOP) is a training course aimed at staff working within GP surgeries to help them better understand the condition and to support patients presenting with a personality disorder. PDPOP was conceived and developed by Rob Schafer and Fiona Blyth alongside Gil 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).

The Oxford Academic Health Science Network (AHSN) was commissioned to conduct an independent evaluation of the third year of PDPOP training. This follows the independent evaluation of years one and two conducted by Skills for Health (González-Ginocchio et al, 2022) and aims to build upon these findings and to demonstrate the impact of the training.

The New World Kirkpatrick Model (Kirkpatrick and Kirkpatrick, 2021) was used to evaluate the training across four levels of training evaluation: reaction, learning, behaviour and results.

The main objective of PDPOP training is to help all members of GP teams, including administrative, reception and clinical staff, to feel confident and skilled when interacting with patients who may have personality disorder.

Background

The previous evaluation outlined the need for PDPOP training to meet "a perceived absence of formal training on how to meet the needs of patients who may fall under the label of having a personality disorder, in combination with a recognition that effectively working with this population was a common struggle for staff throughout the chain of health and care" (González-Ginocchio et al, 2022). Additionally, the estimated prevalence of personality disorder (one in 20 (Mental Health Foundation, 2022)), lack of reliable and up to date data and sensitivity regarding the term 'personality disorder' and associated lack of consensus around terminology were discussed.

The case for intervention and system wide training around personality disorder within the context of primary care was made in the previous evaluation report; high prevalence of personality disorder in primary care attenders and inconsistent service availability and provision (González-Ginocchio et al, 2022). Building upon this case for intervention to provide better services for this population is further demonstrated in recent literature, finding that experiences of individuals living with a personality disorder, whether diagnosed by a clinician or not, are varied (Hoffman et al, 2018). However, those with a personality disorder frequently face stigma and experience difficulties when accessing healthcare, where their behaviour is often misunderstood and considered problematic, rude, or disruptive, resulting in punitive responses from staff rather than eliciting empathy, care, and compassion (Pol et al, 2023 and Hoffman et al, 2018).

Recognition that individuals with personality disorders require greater understanding and support from those in healthcare has been present in surrounding literature since the turn of the last century and continues to be highlighted 20 years later (Snowden and Kane, 2003 and Papathanasiou and Stylianidis, 2022).

Staff working within primary care settings frequently encounter individuals presenting with behaviours associated with personality disorders. Supporting such patients, particularly those presenting in crisis or emotional distress, is often described by clinicians as being difficult or complicated, leaving staff demoralised, or feeling incompetent, hurt or angry (Aviram et al, 2006). Individuals with a diagnosis of personality disorder are therefore more likely to face stigma when presenting in a primary care setting in crisis or emotional distress (Aviram et al, 2006).

In response, training such as that of PDPOP that seeks to enable more compassionate responses aims not only to improve the experiences of those with personality disorder but also to benefit the wider community around the GP surgery, including staff and patients. This evaluation seeks to identify evidence of these benefits and ways through which their impact might be measured.

Overview of PDPOP training

PDPOP training is facilitated by lived-experience trainers; individuals with lived-experience of personality disorder, and clinical trainers; individuals with a mixture of clinical backgrounds, including GPs and therapists. All trainers receive initial training for the programme and ongoing supervision, support and training sessions and are paid for the training sessions that they deliver.

The training programme consists of whole team training, followed on with support for lead GPs of a debrief and action planning session with a GP clinical trainer, a follow-on training module and a two day residential symposium at Cumberland Lodge which includes presentations and simulated learning (further details are given in the section 'Residential symposium').

Figure1. Components of PDPOP

Training delivery

Training is delivered to practices face to face for either two and a half hours or four hours. An alternative option of two and a half hours online via Microsoft Teams was offered for this cohort of practices. Training for each version of delivery consisted of the same content and followed the same format, with minor differences detailed in Figure 1.

Training is made up of a mix of small group and whole group discussions, presentations, videos and action planning.

Group discussions include staff discussing patients who evoke strong emotions in the team using a structured framework and time spent with the clinical trainers and lived-experience trainers separately.

Presentations include the lived-experience trainers' presentation 'How I used to present to primary care and what was going on for me', a brief overview of what personality disorder is and the four core concepts: Unmet Need, Triggers, Emotional Thermometer, Rescue Blame Seesaw (see section 'Four core concepts' for further detail).

Videos shown demonstrate how the four core concepts are used in action in two scenarios; one based at reception, and one within a GP crisis consultation.

Action planning at the end of training is a whole group activity where team members write one thing that they think their team already does well when working with this patient group and one suggestion for improvement for the practice PDPOP lead GP to consider.

The differences within the shorter two and a half hour training versions centre around group discussion structure and format. The only content difference is one video (at reception) is shown instead of two. The second video (GP crisis consultation) becomes part of a separate online seminar for the GP lead at a later date as shown in Figure 1.

Four core concepts

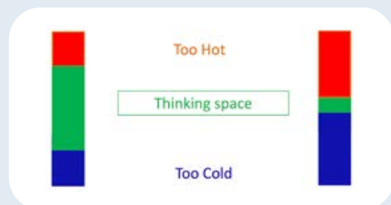
A description of the four core concepts taught within PDPOP training is provided below to allow for understanding and explanation of the findings of the evaluation. These concepts and illustrations are provided with the following copyright attributions ©Rob Schafer & Fiona Blyth 2019.

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.

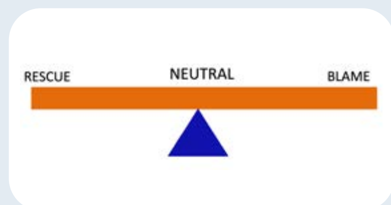
Triggers

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 and thinking about the emotional present of both patients and staff. 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, supports staff to recognise that patients with unmet need may evoke unhelpful rescuing or blaming behaviour in staff that can cause conflicts between approaches within teams.

Residential symposium

The residential symposium takes place over two days at Cumberland Lodge, Windsor, and is more commonly referred to by participants as Cumberland Lodge or the residential training. During the two days GP leads attend, along with all the lived-experience and clinical trainers and the programme training leads. The event includes a number of short presentations, including an initial outline of some of the emerging themes of the evaluation, but is mainly focussed on simulated learning for GP leads.

The simulated learning is facilitated in small groups through scenarios/ case studies of situations that arise in practice; these are then played out between GP leads and the lived-experience trainers. During the scenarios participants have the opportunity to 'pause' for reflection or advice from the rest of the group and receive feedback at the end of the scenario. The aim of the simulated learning is to provide GP leads with the opportunity to practice their learned skills in as close to real-life situations as possible.

Summary of findings from years one and two evaluation

The previous years one and two evaluation of PDPOP training, commissioned by HEE and conducted by Skills for Health evaluated training delivered to 23 practices in the South of England between 2019 and 2021. The evaluation demonstrated that 98.9% of learners found the PDPOP training enjoyable, useful and would recommend it to others. More than 93% of learners agreed/strongly agreed that following the PDPOP training they had a good understanding of what a personality disorder is, can recognise a patient who may have a personality disorder, and have a good understanding of challenges faced by practice staff dealing with this cohort of patients. Furthermore, 74.7% of learners between 2019 and 2021 agreed/strongly agreed they felt confident dealing with a patient presenting in crisis with expressions of desperation, self-harm, or thoughts of self-harm after receiving the PDPOP training.

The lived-experience trainers were identified as one of the main elements to the success of the programme (43.5%) alongside the four core concepts used within the programme (21.7%). Changes made most frequently in the practices who received training in years one and two were:

- Clearer boundaries for patients with personality disorder (50%)
- Improved use of major alerts for patients with personality disorder (47.4%)
- Increasing the involvement of social prescribers with patients with personality disorder (42.1%)
- Management plans for specific patients (36.8%)

The evaluation also presented a series of recommendations. These included:

- Refresher training or follow-up sessions to build on learning, particularly for reception staff where there is often the greatest staff turnover.
- Encourage the use and reproduction of resources such as the four core concepts following the initial training to reinforce learning when staff return to their busy roles.
- Extended time with the lived-experience trainers, including follow-up or refresher sessions.
- Future evaluations should involve independent evaluators from the design phase of the evaluation process and include the opportunity for learners to provide feedback directly to external evaluators, encouraging a more joined-up approach.

Methodology

The Oxford AHSN began the process of designing and implementing the independent evaluation in September 2022. Based on the recommendation of the previous evaluation, design of the year three evaluation began before training commenced, collaboratively with the training team and included opportunities for participants to feedback directly to the independent evaluation team (Oxford AHSN).

This report focusses on the experiences and outcomes from the 386 staff who attended PDPOP training between October 2022 and March 2023 from 10 GP practices across the Southeast of England. As indicated on the map below (Figure 2.), purple dots represent practices trained in years one and two and blue dots represent practices trained in the current year three training year.

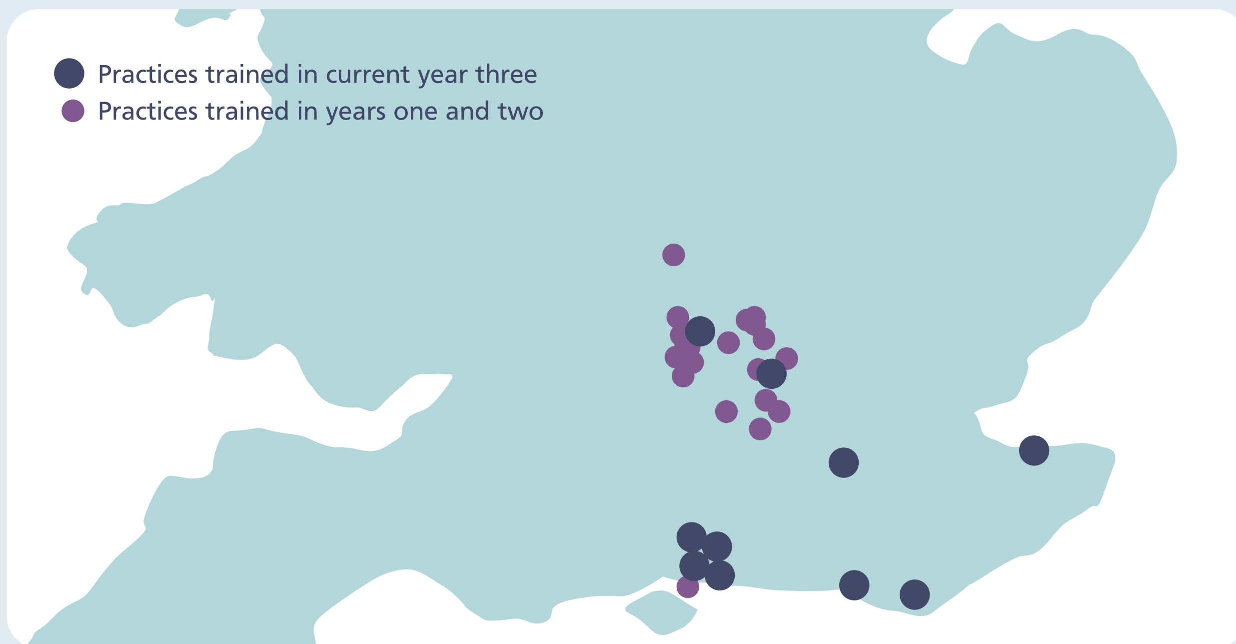


Figure 2.

Defining results and outcome measures

The evaluation team and training leads defined the intended results and outcomes of the training in two parts. Firstly, potential impacts of the training when applied in practice for staff and patients. This was informed by the clinical experience of the training and evaluation team, informal feedback given to the training team and the previous year one and year two evaluations. Two main themes emerged from this discussion; dependency for patients on primary care services and staff and staff burn-out. Secondly, results and outcomes of the training regarding meeting the training main objective; staff to feel confident and skilled when interacting with patients who may have personality disorder.

Staff confidence formed part of the existing evaluation questionnaire through the items:

- I would feel confident dealing with a patient presenting in crisis with expressions of desperation, self-harm or thoughts of self-harm
- I can manage my own emotional reactions to patients who present in an emotional crisis
- My team responds effectively to patients who present in an emotional crisis

These items were also felt to be related to staff burn-out. In order to further evaluate if the training impacted on staff burn-out, use of a formal validated measure such as the Maslach Burnout Inventory (MBI) (Maslach and Jackson, 1981) or the Burnout Assessment Tool (BAT) (Schaufeli et al, 2022) were considered. However, the use of a validated measure was ruled out after consideration of the additional burden of completion on training participants and the tacit nature in which the impact had previously been fed back by previous participants. Therefore, this would be explored further in interviews and through an additional question to the questionnaire:

- I have days where I feel rubbish because of difficult interactions with patients

To determine if the training impacted on dependency for patients on primary care services, it was felt that recognition of dependency was important and therefore this was also explored at interview and a further question added to the questionnaire:

- I have patients who I think have become dependent on me in a way that is not helpful for them

Questionnaires

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. Questionnaires were administered pre-training, post-training and at follow-up six to eight weeks post-training. Analysis of Likert responses was conducted using Microsoft Excel and SPSS where significance testing is indicated. Thematic analysis of free-text responses was conducted using NVivo and thematic framework analysis.

Semi-structured interviews

Practice staff who attended the training were recruited for semi-structured interviews at follow-up (six to eight weeks post-training) and GP leads at four to six months post-training. The latter were conducted up until August 2023. All practice staff and GP lead 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.

Semi-structured interviews were also conducted with lived-experience trainers and clinical trainers to gain further insight into the experience of delivering the training and, at the suggestion of the programme leads, to provide an opportunity to give suggestions and feedback in an anonymous manner. These interviews were not recorded, but detailed contemporaneous notes were taken and then transcribed. A summary of the themes of these interviews was sent to all lived-experience and clinical trainers who participated for sense checking, prior to being shared with the training team in full and then used as appropriate throughout the evaluation report.

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

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 3. the model provides a framework for evaluating training across four levels; reaction, learning, behaviour and results.

Findings for levels one and two, reaction and learning, are based on analysis of the pre, post and follow-up questionnaires. Findings for levels three and four, behaviour and results, are based on follow-up questionnaires and practice staff and GP lead interviews.

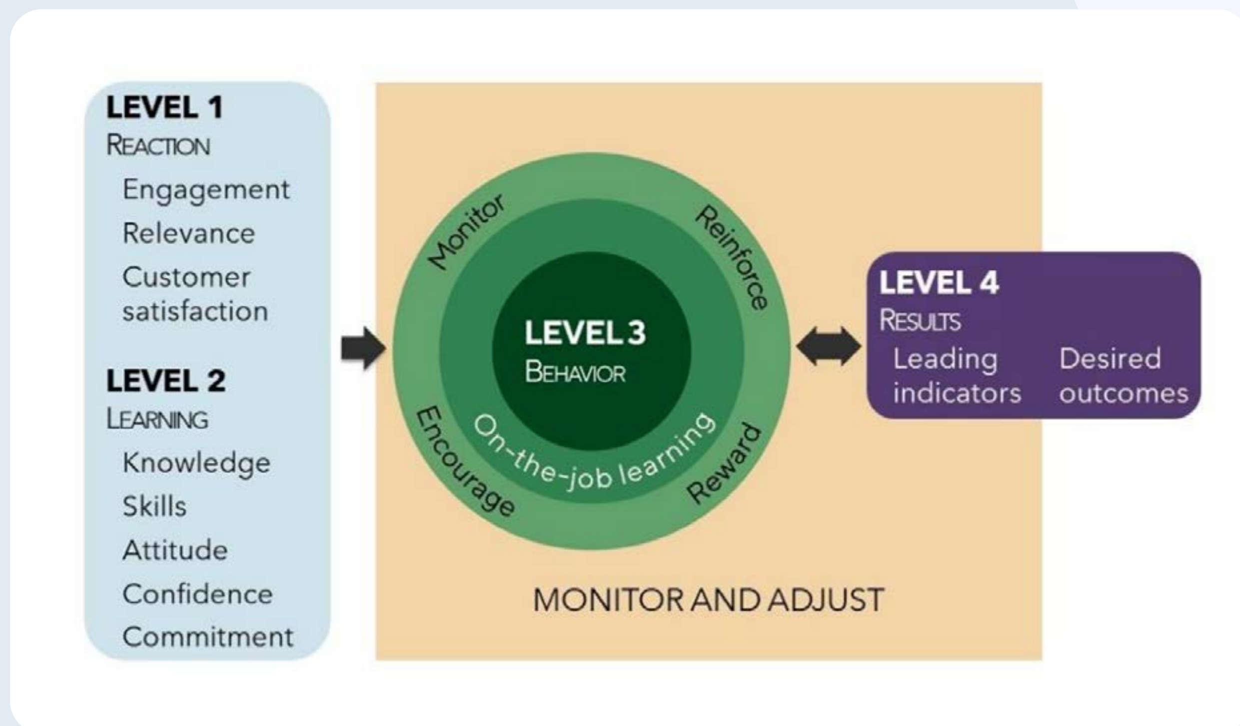


Figure 3. (Kirkpatrick and Kirkpatrick, 2021)

Overview of participation

Recruitment of practices

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.

A total of 10 whole practice places were available for year three training. All places were initially recruited to. One practice withdrew before training due to operational pressures, however, this place was filled through a reserve list of practices who had previously applied for training.

10 GP practices completed the training. One practice withdrew from follow-up activities, including follow-up evaluation, due to the ill health of their GP lead and were unable to nominate an alternative lead.

Training delivery

Training was delivered in the format of all three versions across the 10 practices:

- Two training sessions were delivered online (two and a half hours)
- Three training sessions were delivered face to face over two and a half hours
- Five training sessions were delivered face to face over four hours

Evaluation participation

All 10 practices agreed to take part in the evaluation of the training. Questionnaires for pre- and post-training were either handed out and collected during the face-to-face training sessions by the training team or accessed via a link for Microsoft Forms when training was delivered online. All follow-up questionnaires were accessed online via a link shared with GP leads and practice managers.

Questionnaires

All 10 practices completed pre- and post-training questionnaires resulting in:

- 386 pre-training questionnaires
- 351 post-training questionnaires
- 331 matched pre- and post-training questionnaires (86% matched response rate)

Of the nine practices who continued with follow-up activities, eight practices completed follow-up questionnaires (Figure 4.) resulting in:

- 73 follow-up questionnaires (23% response rate)
- 70 matched pre and follow-up questionnaires (22% matched response)

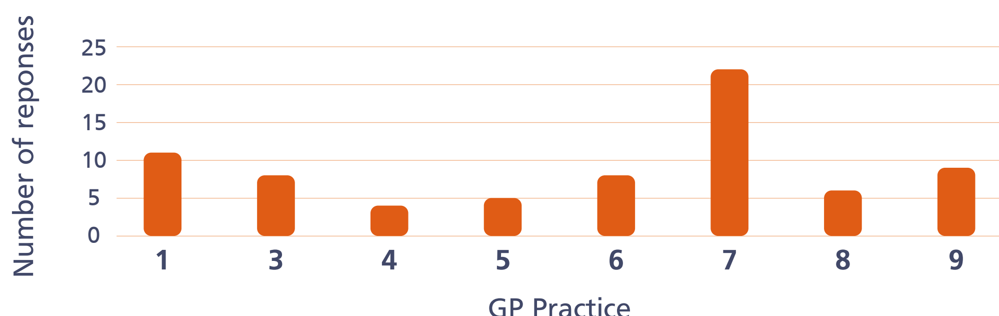


Figure 4. *Practice 2 withdrew from follow-up

Interviews

Practice Staff

Staff from practices 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 GP leads and practice managers. Participants were given the option of online interviews via Microsoft Teams (n=4) or face to face in the practice (n=5).

Nine staff agreed to interviews from four practices. All practices whose staff agreed to interviews had attended face to face training. The staff interviewed came from a variety of roles including GPs, mental health practitioners and medical secretaries. Several interview participants held management roles including operations managers, reception managers and admin managers.

Trainers

Four out of eight lived-experience trainers and six out of nine clinical trainers met with the evaluation team for a 30 minute interview to gather each of their experiences of being a trainer on the programme and an opportunity to give suggestions and feedback to the trainer leads in an anonymous manner.

GP Leads

GP leads from each of the nine practices who continued follow-up activities were invited to participate in an interview at approximately four to six months post-training. Seven of the nine GP leads participated in interviews.

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. There were a small number of missing responses to these questions. Five individuals did not complete a unique identifier (One pre-training, four post-training) and 19 individuals did not select a job role (all post-training).

Likert item responses

There were a very small number of Likert items that were not completed within the pre- and post-training questionnaires. All of these were from paper questionnaires; the online questionnaires made these mandatory fields.

During analysis no trends were found across job roles with regards to missing data. Of the total 18 Likert items pre- and post-training eight questions had missing Likert item responses. The item "I have patients who I think have become dependent on me in a way that is not helpful for them" had the highest number of missing responses, eight pre-training, 15 post-training.

In total there were 21 missing Likert item responses pre-training out of a possible 3,088 and 43 missing Likert item responses post-training out of a possible 3,510. There were 29 individual respondents with missing Likert item responses, the majority had one item missing.

No Likert item responses were missing at follow-up.

A full breakdown of missing Likert item responses can be found in Appendix 1.

Free-text question responses

The questionnaires post-training and at follow-up both included free-text questions. There was a larger number of missing responses to the free-text questions compared to the Likert items. There were 44 missing question responses post-training out of a possible 1,053 questions and 66 missing question responses at follow-up out of a possible 219 questions.

A full break down of missing free-text question responses can be found in Appendix 2.

Participant Profile/Demographics

Practice data

Initial practice data was collected internally by the training lead shortly before or at the time of the whole team training for each practice. Unfortunately, it was not possible to obtain repeated measures to compare to baseline figures within the timeframe of the evaluation. However, this is discussed within the recommendations later in the report.

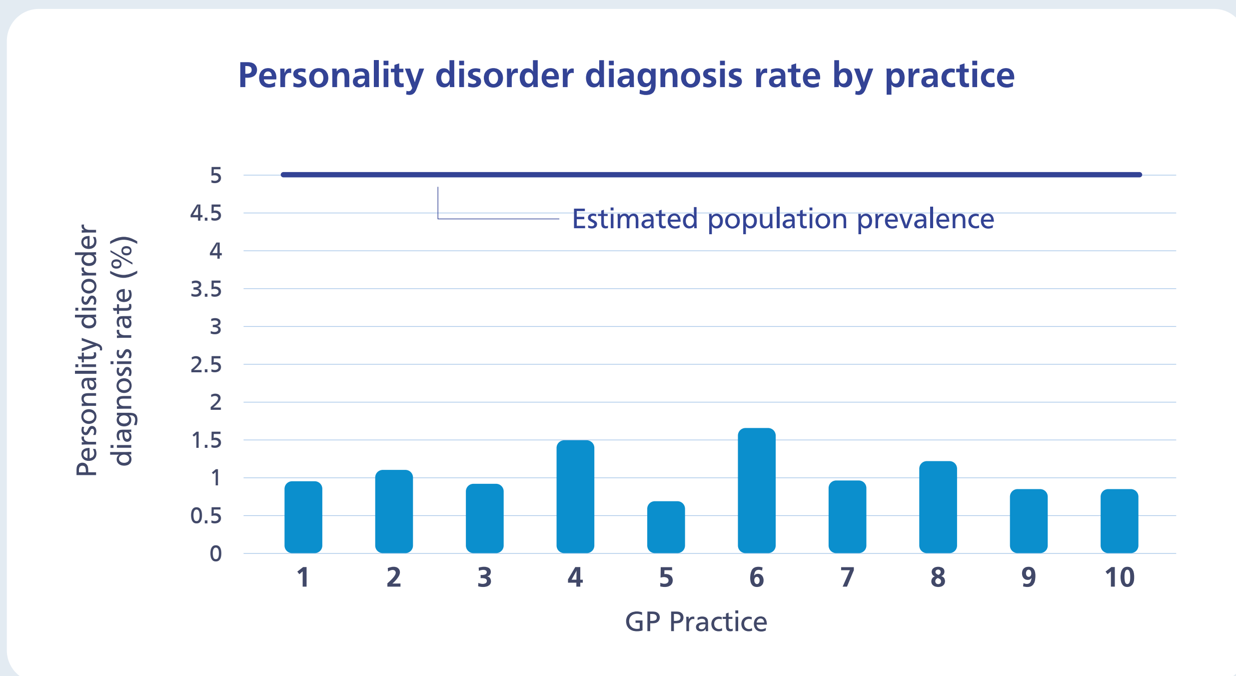


Figure 5.

Figure 5 shows the personality disorder diagnosis rate in each practice. The rates of diagnosis were consistent across practices, ranging from 0.7% to 1.7%. However, these figures indicate underdiagnosis across practices when compared to the estimated population prevalence of 1 in 20 or 5% (Mental Health Foundation, 2022).

Sedative prescribing

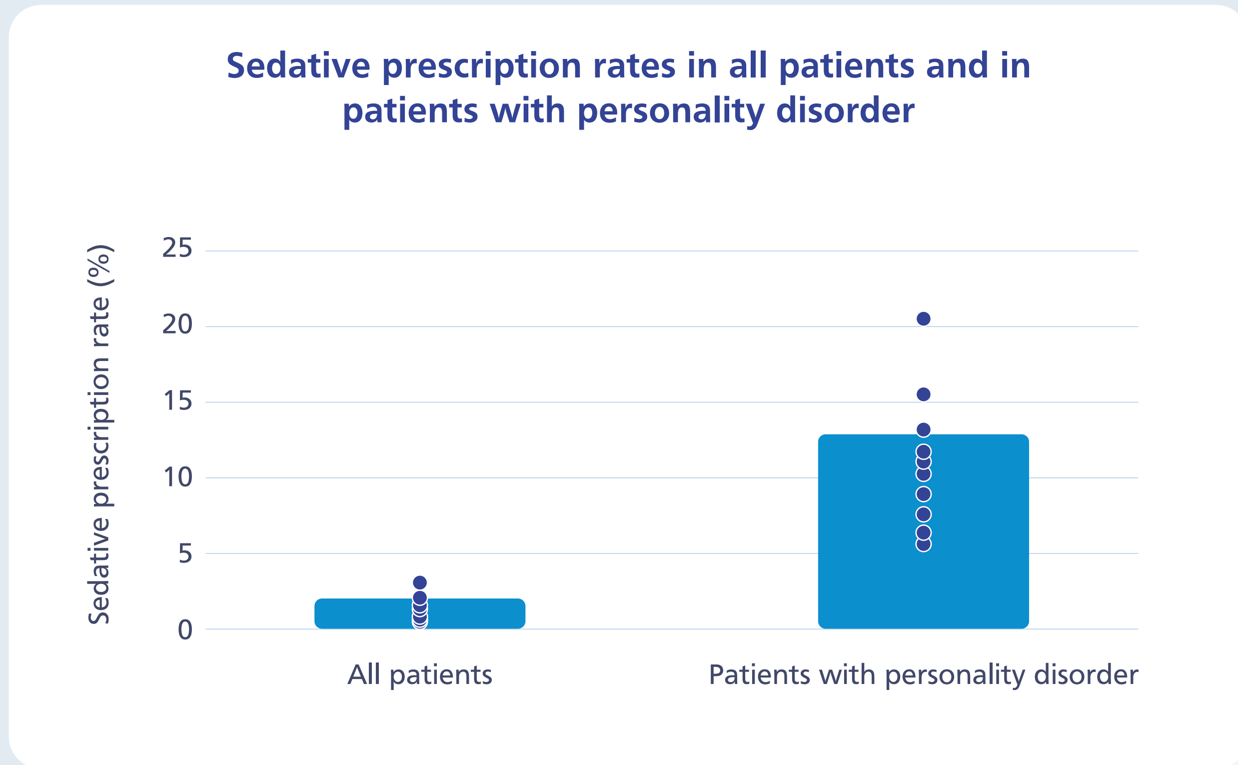


Figure 6. *circles represent individual practices, bars represent patient average based on all patients.

Figure 6 shows rates of sedative prescriptions for all patients and patients with personality disorder. Across all practices patients with personality disorder were shown to have higher rates of sedative prescriptions compared to all practice patients.

Sedatives are a broad range of medications which slow brain activity and include medications such as benzodiazepines that have the potential for addiction.

Sedative prescribing for patients with personality disorder is no longer considered good practice and is only recommended for short term management (~<1 week) of crisis presentations or other co-morbid conditions (National Institute for Health and Care Excellence, 2015).

Frequent attendance

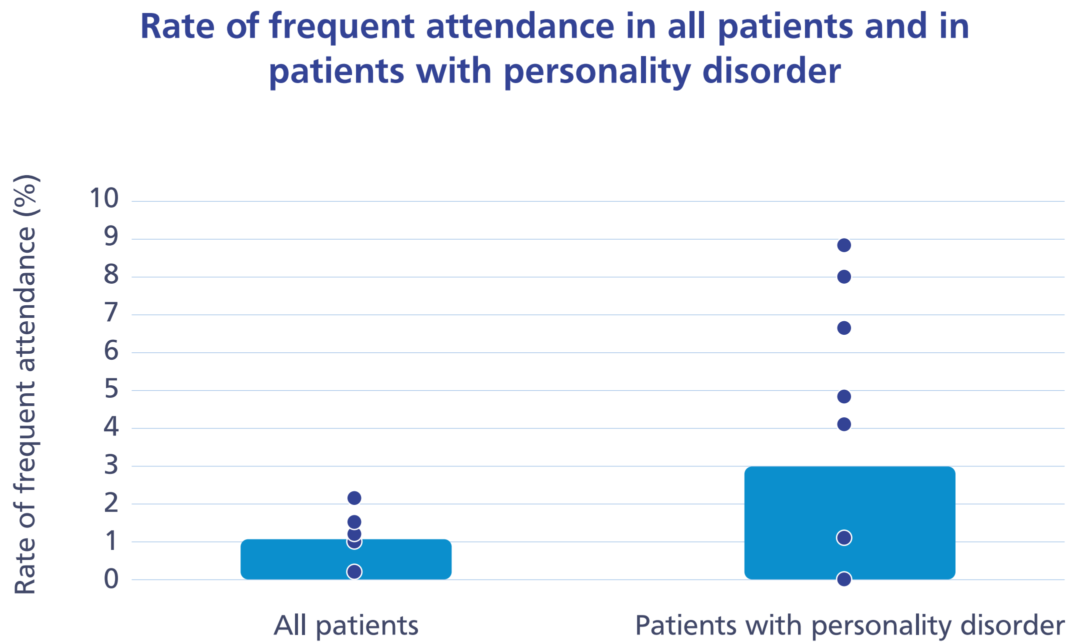


Figure 7. *circles represent individual practices; bars represent patient average based on all patients.

Figure 7 demonstrates that in nine out of ten practices frequent attendance at the practice is higher in patients with personality disorder diagnosis. This confirms previous studies that patients with personality disorder present more frequently to primary care services (Moran et al 2000). Frequent attendance is defined as >10 appointments within the last three months prior to data collection.

Personality disorder diagnosis rate against deprivation index of practices

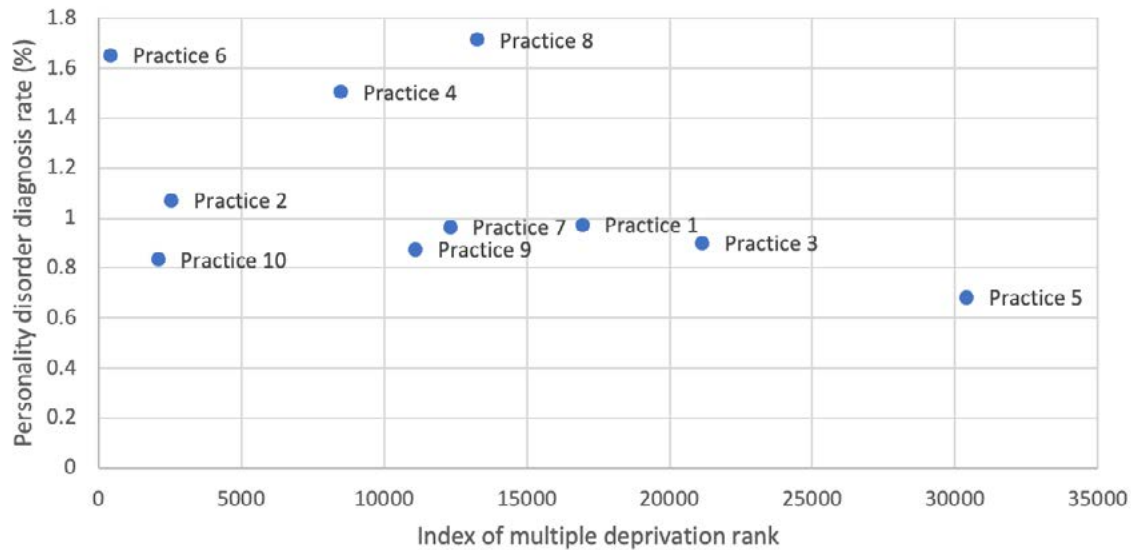


Figure 8.
*The index of multiple deprivation rank runs from 1 most deprived area to 32,844 least deprived area.

Figure 8 displays personality disorder diagnosis rate against the index of multiple deprivation ranking for each practice. The baseline data from the 10 practices shows a weak negative correlation (R^2=0.20) between rates of diagnosis and deprivation rank, suggesting that deprivation is not a strong indicator for higher rates of personality disorder in more deprived locations.

Training group size

Group size for practices varied greatly from 89 participants to 12 participants, with a mean group size of 39 participants, see Table 1.

Table 1.

Job role

Across all practices, the most represented job roles, among those who attended training, were admin (23%) and GP (21%) followed by receptionists (16%) and nurses (13%). Representation of job roles across the 10 practices was similar for GPs, receptionists, nurses, admin, and management staff. There was less representation across practices for social prescribers, mental health practitioners and paramedics.

The job role 'other' was created after participants supplied a role that was not in the predetermined list. A full breakdown of participant job roles can be found in Table 2.

Job Role	Total	% of participants	No. of practices attended from
Admin	87	23%	9
GP	80	21%	10
Receptionist	61	16%	10
Nurse	50	13%	10
Management	27	7%	9
Health Care Assistant	23	6%	7
Pharmacist	19	5%	7
Social Prescriber	14	4%	6
Mental Health Practitioner	12	3%	5
Paramedic	7	2%	5
Other (Physician Associate, Phlebotomist, Student Paramedic, Medical Student, Student GP)	5	1%	4

Table 2.

Responses to follow-up were proportional to training attendance with regards to job role. The largest respondent job roles at follow-up were GP (18), admin and receptionist (17,17).

Job Role	Total
Admin	17
GP	18
Receptionist	17
Nurse	4
Management	6
Health Care Assistant	2
Pharmacist	1
Social Prescriber	3
Mental Health Practitioner	2
Paramedic	2
Did not provide a job role	1

Table 3.

Findings

The findings of the evaluation have been structured within the Kirkpatrick Model. For analysis Likert item responses have been treated as quantitative data and findings include only matched responses for comparisons of pre- and post-training and of pre-training and follow-up.

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.

Free-text questions

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?'

Reaction (Level 1)

Level one of the evaluation sought to determine participants' satisfaction, relevance and engagement with the PDPOP training.

1.0 Satisfaction

Participants' responses to the five questions relating to relevance and satisfaction in the post-training questionnaire shows >90% agreement with the statements. This indicates that the training was highly relevant and that participants were highly satisfied with the training. See Table 4.

Question	% of respondents who agree or strongly agree
I enjoyed the training	98%
The training was useful	97%
There was enough time for discussion	93%
The training was pitched at the right level	95%
I would recommend this training to another GP practice	97%

Table 4.

Participants reflected this within their free-text responses describing the training as very useful, well presented, easy to understand and pitched at an appropriate level. Noting that the training was informative, interactive and engaging.

"Thankyou very informative and interesting, very appropriate for our practice." **Management**

"Very useful as our demographic is diverse." **Receptionist**

A number of participants expressed that they had taken more from the training than they thought they would and some that they would attend the training again.

"Thankyou great training, actually relevant to me even though I didn't think it would be." **Admin**

"Very informative, I would sit through this again and still find it interesting." **Management**

Other participants' final comments were around usefulness of the training and how they would use what they have learnt.

"This IS going to help our patients." **Unknown Role**

"I found this really useful and hope to be able to use these skills to help patients." **GP**

"Thankyou for a very helpful course. I learnt a lot and will take this forward in my private life and work life." **Receptionist**

1.1 Relevance

Participant responses about what they intend to do differently as a result of the training demonstrates the relevance and value of the training in regard to being able to apply what they have learnt to their jobs (Kirkpatrick and Kirkpatrick, 2021).

Themes for these responses included applying awareness and understanding of personality disorder, including being able to recognise symptoms or traits. Participants' awareness, within themselves, of their emotional responses to traits and triggers and awareness of the impact of these responses on patients was also noted.

"Be more aware of PD traits and feelings /reaction it evokes in me." **GP**

"Be more aware of how scenarios like in the video could affect the person dealing with it. By that I mean if the person was 'off' or 'snappy' if spoken to after the event." **Management**

"Be more aware of how I behave with patients and how I can help them to achieve a good outcome from attending the surgery." **Nurse**

Many participants highlighted that they would be more curious with patients about 'what was going on for them' and about their history.

"Be more curious if a patient presents as angry or quick changing emotions." **Nurse**

Others described a change in approach, centring on having more patience. This included listening in a more empathetic way, remaining calm and smiling. Participants also described using a more patient and calm approach to be non-judgemental and more understanding of patients and to not dismiss them.

> "Stay calm, greet with a smile, try and give an understanding response, to not dismiss." **Receptionist**
>
> "We always listen but don't always hear, listen with more empathy." **Admin**
>
> "Remember to stay calm and think carefully to how I might answer a patient's request so as not to let them feel empty." **Unknown Role**
>
> "To be non-judgemental & just listening helps!" **Receptionist**

Many participants' change in approach was to give themselves thinking space, or to take a step back, before speaking or acting, particularly when faced with a patient who was distressed. This was often associated as a step towards helping to remain 'neutral' and to help to remember not to take things personally. Some participants also described thinking space as representing an opportunity to reflect.

> "When I am dealing with someone I may consider a "heartsink" patient, take a moment before speaking to them to focus my mind and choose to be logical rather than taking things personally." **Admin**
>
> "To step back (reflect) rather than trying to fix everything, set boundaries." **Nurse**

The use of specific concepts taught were prevalent within participant responses, including boundary setting, the emotional thermometer and the rescue-blame seesaw.

> "Set clear boundaries so not to rescue the patient, but help as best I can, but within my skill set and to acknowledge my limitations." **Nurse**
>
> "Need to think of being more consistent with boundaries with all patients but in particular the more complex patients." **Social Prescriber**
>
> "Stay balanced more - I will definitely visualise the scales and use the thermometer." **Admin**
>
> "Try to remain in the neutral balance of the see-saw, rather than tending to go to "rescue". Also being aware of the thermometer and "thinking zone"." **GP**

1.2 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. Particularly as over 90% of participants meaningfully completed all three free-text questions (not any final comments) in the post-training questionnaire.

Overwhelmingly the participants valued engagement with the lived-experience trainers, with 225 participants referencing this as the biggest impact from the training. Participants described the lived-experience trainers as:

The opportunity for engagement and discussion with the lived-experience trainers and time to ask questions was identified as impactful by participants.

> "The two [lived-experience trainers] who kindly allowed us to ask questions, I felt I would never have been able to ask normally and I surprised myself of how anxious I was delving into their personal life and I thank them for the courage and help they have both given us today." **Management**

Participants highlighted the impact of the training through the whole practice approach. Commenting on being able to relate to other staff experience as well as hear the experience of those in different roles and be more aware of the challenges others experience.

> "The crucial role of the amazing receptionists and how they deal with such difficult situations and to set clear compassion boundaries." **Nurse**

Participants' responses demonstrated their personal responsibility and program interest through highlighting the positive impact of discussions and brainstorming time as a team. Both within the training and continuing after the training, and how this will have an impact in being able to think about how to support each other and their patients in different and more effective ways.

"Hearing thoughts of my colleagues and their experiences. Working together to come up with strategies to better support each other and patients." **GP**

"Taking time and stepping back to discuss patients as a group. Understanding techniques that could support these patients." **Management**

Learning (Level 2)

Level two of the evaluation sought to determine participants' knowledge, skill, attitude, confidence, and commitment. Knowledge, skill, attitude and confidence are examined in detail below. Commitment is demonstrated throughout this section through participants' responses and examples of their intention to apply the training in practice.

In order to identify if follow-up responses were representative of the wider group of 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 a significant difference (p=0.02) between all participant and follow-up participants' responses for one Likert item asked within the pre-training questionnaire: 'I have days where I feel rubbish because of difficult interactions with patients'. For this item follow-up participants had higher rates of agree/strongly agree responses on average than all participants before training.

There was no significant difference (p=>0.05) between all participant and the follow-up participants' responses for all other pre-training and post-training Likert item responses.

The job role distribution of follow-up responses was proportional of job role distribution of all training participants. There was no significant difference in pre-training and post-training responses of follow-up participant and all participants groups. Therefore, it can be assumed that follow-up responses are representative of all training participants with the exception of one pre-training question as stated above.

2.1 Quantitative evaluation of knowledge and skill

Results of the evaluation questionnaires for the Likert items around knowledge show a significant increase post-training and retained knowledge at follow-up, Table 5.

	% of respondents who agree or strongly agree		
	Pre-training	**Post-training**	**Follow-up**
I have a good understanding of what personality disorder is	44%	95%	94%
I can recognise when a patient might have a personality disorder	46%	90%	94%
I have a good understanding of the challenges other practice staff face when dealing with patients with personality disorder	49%	95%	96%

Table 5.

2.2 Qualitative evaluation of knowledge

Themes among participant responses in the free-text question about the main thing they learnt during the PDPOP training centred around a greater awareness and understanding of what personality disorder is, the 5 traits of personality disorder, personality disorders as a spectrum and different personality types.

> "Understanding different personality traits that make up the spectrum of PDs." **GP**
>
> "What PD is (previously put in the same bracket as depression etc)." **Nurse**

Participants acknowledged that personality disorder is a broad and complex diagnosis and many commented on learning how common they are for the first time during the training.

> "That personality disorders are much more common than I thought." **Social Prescriber**

2.21 Individual needs

In addition to an increased awareness and understanding of personality disorder, participants responded that they had learnt that it is not always obvious when an individual has a personality disorder. They also noted that the way personality disorder presents in individuals is different and that each person will have different needs.

> "Personality disorders can present loudly or very quietly, not always obvious." **Admin**
>
> "The symptoms of personality disorder are not always easy to see initially." **Receptionist**
>
> "A better understanding of what PD is and how it can affect different people in different ways." **Management**
>
> "Understanding PD is different in each individual and presents in many different traits." **Admin**

2.22 Masking

Some participants commented on their learning in the way that patients may present in one manner but that this may not be a true reflection of what they are feeling or experiencing.

"People sometimes hide the feelings and mask them with anger." **Receptionist**

"To hear that most people with personality disorders are very fearful underneath." **Mental Health Practitioner**

2.23 Recognising traits of personality disorder

Participants commented on learning to recognise and identify traits of personality disorder.

"I have learnt how to identify possible traits of personality disorder." **Pharmacist**

"Recognising behaviours that might indicate someone has a PD." **Management**

"The types of behaviours that might indicate a person has a personality disorder. How the situation feels from the perspective of the patient with a personality disorder." **Receptionist**

"I have learned how to identify traits of PD and ways to respond more constructively." **Unknown Role**

2.24 Importance of the whole team approach

Participants also described learning from each other and the importance of a whole team approach.

"Appreciate how the rest of the practice is thinking/feeling. Sometimes you forget due to us not being patient facing." **Admin**

"That even GPs struggle at times with dealing with this condition." **Receptionist**

"Insight into how things can escalate quickly for those that are face to face with patients." **Management**

"Being more aware of both doctor/staff and patient perspectives on personality disorder." **GP**

“Importance of sharing information across the practice, best interest of patients.” **Social Prescriber**

2.3 Qualitative evaluation of skill

Participant responses to the free-text questions demonstrated that they had not only taken away knowledge from the training but also skill. This was notable in their responses regarding what they will do differently after the training.

Participants often stated they would take a different approach after the training, centring around trying to remain neutral when interacting with patients, both in regard to thinking where they are on the emotional thermometer and the rescue-blame seesaw. Responses included being less defensive from the start of consultations and participants bringing themselves and patients back to the ‘green zone’ and avoid ‘rescuing’.

“Think and react differently to patients who are aggressive verbally, straight out the box in a consultation, and try to keep in the neutral zone!” **Nurse**

“Actively try to maintain a neutral affect and try to temper my desire to rescue a patient.” **GP**

Responses also showed participant intentions to use skills and concepts taught in practice, both on an individual level and at a team level:

“I will utilise the emotional thermometer in consultations.” **GP**

“I will listen more openly and more genuinely, recognise my triggers and manage them.” **Management**

“Team approach- discuss patients more. Be boundaried, don’t rescue, share around does not harm.” **GP**

“Remembering unmet need being aware of emotional barometer/rescue blame - all the concepts.” **GP**

2.4 Attitude

Participants showed changes in attitude towards patients, particularly those who may present in a confrontational or aggressive manner. Describing that the training had provided a better understanding of why patients with personality disorder may behave in the ways that they do and acknowledging and trying to understand triggers.

"Understanding there are multiple factors why patients behave in certain ways and try to help and support where we can." **Nurse**

"When dealing with patient with PD who is distressed consider what might have triggered this." **GP**

"Lots to reflect and think about when patients are expressing different emotions and acting in different ways." **Admin**

"Learnt that sometimes patients may appear rude/inconsiderate to others but may be for other reasons or out of their control." **Nurse**

"Understanding the reason why some patients are immediately confrontational when entering the practice." **Receptionist**

"That some people have underlying issues causing their anger/frustration at GP/staff." **Admin**

2.5 Confidence

2.51 Quantitative evaluation of confidence

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 6).

The questions regarding managing participants' own emotions and how their team responds to patients 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 (>60% agree or strongly agree, Table 6), however responses at follow-up show an increased confidence for both 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	33%	78%	73%
I can manage my own emotional reactions to patients who present in an emotional crisis	66%	* not asked post-training	87%
My team responds effectively to patients who present in an emotional crisis	62%	* not asked post-training	91%

Table 6.

2.52 Qualitative evaluation of confidence

Participant free-text responses demonstrated confidence in using the skills they learned during the training:

"I feel better equipped to recognise PD and some concepts to use to help me manage patients better as well as how to discuss the concept of PD with them" **GP**

"I think I could deal with someone with a personality disorder more confidently. After listening to [the lived-experience trainers'] point of view, seeing two sides has help me understand how they are feeling." **Admin**

"Consult more confidently, not aim to cure patient limit medication therapy that is not required." **GP**

"More confidence facing difficult conversations with patients and knowing that it can help them." **Nurse**

For other participants, the training reinforced the participant's confidence in what they were already doing.

"I'm using some good skills already so confidence in what I'm doing." **GP**

Constructive feedback and suggestions for training improvement

Overall, participants viewed the training very favourably, there were a small number of participants who reported that they had not learnt anything and would do nothing differently as a result of the training, including two participants who commented that this was because they were not patient facing.

More time

Suggestions given by participants post-training and at follow-up centred around wanting more time for discussion about putting things into practice or specific training elements, such as consultations. Comments regarding more time came from a range of participants from online and face to face training of both two and a half hours and four hours.

> "I feel that this training was a really good insight into Personality Disorders/traits. I feel that we could have had more time to discuss how to deal with the patients/ideas on outcome." **Social Prescriber**
>
> "Would have liked more time for consultation tips (even role play-eeeeh!)" **GP**

Clinical and non-clinical discussions

Some participants who attended the two and a half hour training suggested that they would have benefited from break-out sessions that differentiated clinical and non-clinical staff, which is a feature of the four hour training session.

> "Great team event - maybe a break out session so non clinical and clinical staff can get some practical training specific to their needs?" **GP**

More concrete solutions

A small number of GP and paramedic participants wanted more concrete information and solutions to use with patients with personality disorder:

"So it was a useful session and I have a greater understanding but personally I found it lacked specific tips/practical solutions to managing these patients." **GP**

"I was slightly disappointed - I was hoping for more clinical information, such as diagnostic criteria for PD, how to differentiate between PD and other mental illnesses, what causes personality disorders, PD from a psychiatric perspective. It felt like a lot of the training was 'try this, but of course it won't work for everyone - for some people this is the worst thing you can do. Basically everyone is unique and there are no particular techniques you can rely on." **Paramedic**

"Maybe more examples of good practice and what helps (and is practical to deliver in GP) would be helpful." **GP**

This was also raised within one of the GP lead interviews where they had received feedback from paramedic staff about the training.

"I've noticed in the paramedics in the acute team there's been some discussion....would have liked is some more concrete can stuff around how we do this better..... So kind of like a masterclass in sort of skills training. Really. But I guess that's, you know, we're all at different stages. So it didn't quite cater to their needs." **GP lead**

Behaviour (Level 3)

Level 3 of the Kirkpatrick model seeks to determine the behavioural changes that result from training. Findings are taken from the follow-up questionnaire responses and interviews of practice staff and GP leads.

Training participants provided an overwhelming number of examples of how they are applying the training in practice, describing changes at both an individual and team level and commenting on observed changes in colleagues' behaviour and practice.

56 out of 73 participants provided examples of what they have been able to apply in their day-to-day work since the training in the follow-up questionnaire, with 21 participants further expanding to provide specific examples where they have applied the training with a patient. Two participants responded that they had not applied anything from the training, one responded that they were in a non-clinical role and one participant responded that they realised they were doing this already.

During the interviews conducted with GP leads and practice staff each gave several examples of how the training has been applied within their practices.

Critical behaviours and required drivers for sustained change

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, monitor, encourage, and reward performance of critical behaviours (Kirkpatrick and Kirkpatrick, 2021).

Throughout the evaluation participants described numerous critical behaviours and required drivers in practice.

In the context of the PDPOP training, critical behaviours are the reported individual changes in behaviour made by staff, such as self-reflection, application of the concepts taught in day-to-day work and changes in thinking and approach to patients. For example;

"I have used some of the tools with patients especially the emotional thermometer. I have also been able to better recognise when a patient is in the red zone and adjust my consulting accordingly." **GP**

"Taking the time to listen to a patient's concerns regarding a health complaint and offering suggestions of ways to help themselves, without 'rescuing' completely." **Nurse**

"Becoming aware of care with follow up, of promoting agency, of encouraging patient to problem solve." **GP**

"I have learned to treat each interaction with a patient as a new event and not let previous interactions colour my opinions/ expectations of patients." **Management**

Required drivers in the context of the PDPOP training are the changes made as a team that act to reinforce and encourage the training such as meeting as a team, revisiting training in conversation, and reminding each other and challenging old behaviours. For example;

"I have heard team members discussing complex patients much more often and considering new ways to approach situations rather than slipping into expressing frustration/anger." **Unknown Role**

"We have the certificate displayed in reception and a patient commented on how good it was to see we are a friendly PD friendly practice :-)" **Receptionist**

"I have a better understanding of personality disorders and how it can affect the patient. As a team we try to remind less tolerant members of staff of the training." **Admin**

"Feel my team are now more empathetic. As a PCN we are also talking about what we can do as a project to test better ways of seeking to support our patients with a Personality Disorder." **Mental Health Practitioner**

Further details of changes as a result of the training, given by participants, are described below in the following structure:

1. Team level changes
2. Practice specific changes
3. Individual level changes
4. GP specific changes in practice
5. Using core concepts in practice

1. Team level changes

At the end of the training sessions participants took part in an exercise to each identify one thing they did well as a practice and one thing they could improve upon. GP leads for each practice took these away and met with the GP clinical trainer within 2 weeks of

the training and formulated an action plan.

All nine practice staff interviewed knew who their lead GP was. These staff were from four practices. Staff from two of these four practices reported that there had not been a formal action plan communicated. Staff from one practice reported no formal changes since the training.

1.1 A process for seeking additional support

One practice introduced a process for reception staff to highlight to clinical staff patients who may need additional support.

> "When they are concerned about a patient that they have contact with being distressed, dysregulated and possibly through the contact having a personality disorder and being kind of flagged up and highlighted to someone that might require additional support, even if they don't have a clear, established diagnosis and the reception staff are quite positive about trying to do that." **Mental Health Practitioner**

1.2 Case discussion meetings

Example One

Participants spoke about continuing to meet as a team after the training to create the action plan and decide on changes together. The multi-disciplinary team meetings include staff from all roles and have continued as regular case meetings where they now discuss the principles of the training in the context of how to best support identified patients as a team in a different way. They identified the benefits as staff in different roles being able to provide consistent approaches to patients and everyone being aware of the plan for patients.

Staff also highlighted how they had revisited cases since the training and adopted different approaches, which was having a positive effect.

> "The feeling of the team was that things were a lot better for all of them. So you know, so we kind of felt that hopefully that shows that it is actually working." **GP lead**

The same practice also reported looking at care plans and using a proforma on paper as a prompt around some of the training concepts.

> "And it's more about the way it's working at the moment it's just a sort of reminder as we're talking about the patients, you know, what do you think the triggers were there? What do you think?" **GP lead**

Example Two

A weekly meeting for admin and reception staff facilitated by the business managers or GPs was introduced in one practice, which was reported to be having a positive effect.

> "It reduces the stress for the staff so they know that there's a place to discuss people and so one of the outcomes was of a regular sort of admin meeting to discuss problems with patients or processes and so on, and create these boundaries and set goals. And it works very well. So I'm very pleased with that." **GP Lead**

1.3 Identifying and coding patients

Example One

One GP lead described how they have implemented a new system for supporting patients with multiple complex needs and patients who regularly attend the surgery. This involves identifying patients and adding a note or code to the electronic patient record, then allocating and confirming a GP lead for the patient, to ensure continuity of care.

They also designed a template in order for the lead GP to review the notes and summarise the patient's needs, including who is involved in their care, what's happening for them and the plan for following up. This allows other GPs to be up to date with patient care when covering and ensures patients do not need to repeat themselves or go over their history again and again.

Example Two

In one practice GPs have been identifying patients with personality disorder after the training and coding patients on the electronic notes system. They suggested that GPs being aware of patient diagnoses and needs before consultations begin offers a beneficial change in practice which can, in turn, support GPs to have a better approach. This was also supported by encouragement for GPs to have open conversations with patients about their diagnosis.

The GP lead for the practice went on to say that encouragement of open conversations went further than those with a diagnosis but also helps GPs to have more confidence with other patients.

"It's the patients that are uncoded that are struggling to give the GPs the confidence to say, hey, let's talk about your regulation, your emotions, how life is going." **GP Lead**

Example Three

One GP lead reported that they are looking at creating a different coding system for staff to recognise patients with complex needs: coding life experiences rather than the diagnosis of personality disorder. They described beginning to make a formulary for coding life experiences and difficulties, such as early history of emotional abuse, interpersonal difficulty, or personal history of self-harm, as a way of reflecting on a person's experience. However, competing priorities and the challenge of working part-time and not being able to attend practice meetings meant that this was taking longer than initially thought.

1.4 The role of mental health practitioners to support patients

Example One

One practice reported that because of a busy time in the surgery and staff changes there had been a delay enacting their action plan. However, they did report employing a mental health worker recently within the surgery as part of the ARRS (additional roles reimbursement scheme) roles. As part of their post-training action plan the mental health worker, together with the lead GP, is looking to identify people with a diagnosis of personality disorder or those who attend the surgery frequently to see if they would benefit from working with the mental health worker to better have their needs met.

Example Two

One GP interviewed (not a GP lead) reported that a change in practice since the training was staff referring more patients to the mental health practitioner within the surgery, commenting that this had reduced the referrals to secondary mental health care and enabled quicker support for patients.

Example Three

One practice reported ongoing work led by the mental health practitioner.

> "Trying to engage with people within an established diagnosis with a clear kind of MDT approach to trying to provide people with consistent support." **Mental Health Practitioner**

However, there were concerns expressed over the limited capacity of only one dedicated mental health worker within the practice and the increased need for these roles to provide the support equivalent of care co-ordinators within community mental health teams (CMHTs). It was reported that the practice is looking to recruit a second primary care mental health worker and that this will help with this change.

Despite these concerns the work was considered important and better for patient care.

> "And I think one of the things that's gonna be important moving forward is consistency. I think people in my role are more likely to be able to offer a consistent therapeutic relationship." **Mental Health Practitioner**

1.5 Part of the conversation

Many staff reported that following on from the training, personality disorder and providing the best care for patients with personality disorder had become part of the conversations taking place between staff in practice. This was described as happening in a number of different ways, including consideration at multi-disciplinary meetings and often more informal conversations over break times.

> "Thing that I would say is that it is now part of the conversation when we have to talk about people in a clinical meeting or MDT, that sort of thing like it's, instead of people not mentioning it at all." **Operations Manager**
>
> "Most of our conversations around this are over coffee often and occasionally different in somebody's room to have a chat about something a debrief at the end of the day almost so it's those kind of 'corridory' type opportunistic conversations where this is happening more than in formal meeting because we just don't have much opportunity for that." **GP lead**

One GP lead described how together with other clinical staff they had begun to meet to discuss patients after the training but that this was challenging to sustain with day-to-day pressures.

> "If we're meeting, it might be three or four of us at lunchtime, and then you know... I'm there, but the person who wants to discuss those difficult issues isn't there and vice versa." **GP lead**

In one practice the GP lead reported that conversations had taken place about how to better support patients who were attending frequently at the surgery or at A&E and how to stop escalation in prescribing medications. They described how the training had supported GPs to feel more confident in having these conversations through better understanding about why this may be happening. Additionally, they highlighted that GPs had reflected on the question as to whether there was something about 'them' as a GP as to why this is happening, as well as the benefits of discussions reassuring them that they were not alone in finding things difficult.

> "But again, the conversations that I think it's easy to have because people will understand where that might be coming from, and also that it's not necessarily, it might say something about them as a GP, but that's OK, you know, if it does, because actually there's reasons why people get pulled into that...... I guess also knowing that you're not the only person and that this this is something other would be finding difficult......The awareness and the permission and you know and sort of feeling empowered and that actually there is support there." **GP lead**

2. Practice specific changes

2.1 Sometimes the intervention is just to sit

Staff in one practice described a change in how they support patients who are distressed or angry. They highlighted that one of the lived-experience trainers had shared how just sitting with them when they were distressed could be really powerful and this had resonated with the team. They described how they had put this into practice. How they had just sat with patients and that they had also observed colleagues, sitting with patients; either in the waiting room or in consultations.

"I think we've always been a compassionate, caring practice but I guess people felt they needed to be doing something, whereas those discussions have highlighted the need for someone to just sometimes just to go with it, just to be with someone for a bit that that meant something to them." **GP Lead**

"Maybe that gets the person into their thinking zone, just giving them that time to be emotional without trying to push it and get something to happen. It just meant that they were... they moved away from the emotion." **GP Lead**

"I have been mindful to be calm and respectful to patients who have presented anxious behaviours. I have sat calmly with them until I can refer them on." **Social Prescriber**

2.2 Reinforcing the training

In one practice the GP lead spoke about the challenge of turnover of staff since the training and how most changes since the training have been around reinforcing, understanding and educating new staff based on the training. Specifically, they spoke about working with new reception staff and supporting better understanding of patients' perspectives and unmet need, particularly when staff may become frustrated or distressed.

"[They've] got an unmet need. We haven't addressed it. You need to understand and just trying to educate on a daily basis.... they're real people who are looking for help and part of your role is to help them from the moment they step through the door." **GP lead**

2.3 Utilising the community garden

In one practice staff spoke about encouraging people to sit in the community garden to wait for their appointments if they can see someone doesn't like sitting in the waiting room. One member of staff described how one patient had been involved in the community garden project and uses the garden to wait for appointments and that this has made a dramatic change to how they interact with staff.

> “They’ll now come in and have a little chat with reception, whereas previously it used to be like 5 words and back out again or making a demand and then leaving. I went downstairs and they were cracking jokes about the football with one of our receptionists, who’s an Arsenal fan and it’s like “This is not the same [person]”.” **Operations manager**

2.4 Reviewing the purpose of the acute hub for patients

The GP lead for one practice spoke about a future planned change of looking at patients and patient needs of those accessing care via their acute hub. (The acute hub is the first line service where patients can access urgent appointments on the same day for problems requiring immediate treatment, staffed by advanced nurse practitioners, nurses, paramedics and practice pharmacists, with GPs available for more complex problems.) The GP lead described how the team had identified this as where people with personality disorder may present in crisis and that this may not be the best route of care to support them, but rather thinking about a care coordinator role.

> “So we’ve kind of thought, could we have like a care coordinator who coordinates our complex patients that might be stuff like palliative care, but it would also be personality disorder so that they’re actually managing some of those people.” **GP lead**

They also spoke about the need to support the staff working in the acute hub service who regularly see patients in crisis.

> “So I think that that impacts on them in terms of it can be quite it’s quite hard work at times and difficult they get some abuse that it can be quite draining and also it’s easy to then kind of get a bit emotionally blunted towards that and start to label and you know, be a bit disparaging.” **GP lead**

3. Individual level changes

3.1 Application of awareness, recognition and understanding

Many participants stated that they have applied their awareness and understanding of personality disorder to their day-to-day work. Including having a better awareness and understanding of people's emotions and expressions and the patients' perspective. This application of understanding was highlighted by participants as not just being applied to face-to-face patient contact but also to telephone calls and patient letters.

"I am more aware of the difficulties encountered by the patients, rather than just thinking that they are rude and aggressive." **Admin**

"I hope that since the training I have been more aware of people's body language and their moods and I have reacted accordingly." **Receptionist**

"Tips on how to communicate better with patients that may have a personality disorder, and a better understanding of how things may be seen from their shoes." **Management**

"Gaining a better understanding of patients point of view, which was because of having people their talking about their own experiences." **Healthcare Assistant**

"I am now better able to understand the link between EUPD and similar patients when considering their propensity to use self-harm in relation to the extreme emotions they can experience." **Mental Health Practitioner**

"Better able to recognise when a patient presenting with PD is in crisis requiring support." **GP**

3.2 Change in approach

Better awareness, recognition and understanding was reported by participants to have led to changes in their approach to interactions with others.

"Offer a smile & friendly welcome, try to help where possible." **Receptionist**

"Recognising situations in which a patient may be displaying signs of personality disorder and how to react to the situation in a positive way." **Nurse**

"Take a moment to think how the patient is feeling and where they are coming from. Also, the trainers mentioned a smile goes a long way which is so true." **Receptionist**

"Better recognition of patients with a personality disorder or emotional issues. Stepping back and looking at the bigger picture." **Healthcare assistant**

3.3 Recognising people as individuals

Participants described how the training and meeting the lived-experience trainers had given them a better understanding and appreciation of people as individuals and how this influenced their approach towards patients.

"So, I deal with the complaints at the surgery and I often am involved in talking to people when they're either really unhappy with this or really like angry with reception or something like that. It gave me a really good perspective and kind of a refresher to consider everybody as individuals and kind of their unique needs. These people probably don't want to be presenting in that way. Or they almost definitely don't want to be presenting in that way. That's not the way they want to be. They're not choosing this. It's, like, infinitely more complex than that. So, I think just kind of re-establishing the idea of kind of meeting every person with the same level of compassion and understanding and just kindness." **Operations Manager**

3.4 Boundaries

Many participants across job roles referenced boundaries in their examples of applying the training with a patient, this was a particularly strong theme in GP responses. The examples centred around providing clearer expectations and structure of the time available within consultations and limiting the interventions offered.

"In suicidal patient declining help, I was boundaried and made an "offer" which was very effective." **GP**

"Been clearer with one of my patients about the length of time we have together in appointments. Helping [them] to remember this in consultations. Initially [they] were really upset by this but have responded more and more positively. I've been quite surprised how easily [they] have allowed me to park topics and direct [them] back to our set aim." **Unknown Role**

"Patient wanted an "emergency mental health appt" as had been in bed all week. She told me her job was awful– but she had a new one. I congratulated her on making the change, and did not arrange follow up." **GP**

"Recognising that someone was feeling overwhelmed and that it was futile to continue the discussion and agree to reschedule for another day to allow time. Also applied it to my own boundaries with someone with PD wanting much longer than their allotted time." **GP**

"Better empathy and clearer limitations to what patients can expect from medical professionals." **GP**

3.5 Talking about personality disorder and diagnosis

Participants spoke about having more conversations about personality disorder with patients. This change was mostly described by GPs and mental health practitioners.

One GP lead reflected on the sharing of one of the clinical trainers who spoke about "taking the leap" of having a conversation about personality disorder with one patient and that this then builds confidence for future conversations and how this had resonated with their colleagues.

"With a clinical session with a patient recently I spent time talking with them constructively about their understanding of their diagnosis, what it felt like for them, and what they wanted to work on terms of their treatment goals."
Mental Health Practitioner

"Setting clear boundaries, sharing more information about PD and treatments with patients." **GP**

Participants also shared that they had had their own reservations about the diagnosis of personality disorder prior to training.

"That despite my own professional and personal concerns about the label and diagnosis of Personality Disorder, I have since been more able to talk positively and constructively with patients who have this diagnosis."
Mental Health Practitioner

Concerns around diagnosis centred around previous experience, often within mental health services, of patients being diagnosed but not being able to access appropriate support and experience of the diagnosis as a form of medical discrimination associated with assumptions about how people will behave.

For one participant they described going into the training with a degree of concern, but that they had found the sharing of the lived-experience trainers experience of a diagnosis really powerful.

"...giving me a different perspective and nonprofessional perspective about the value of the diagnosis. And the way that that's helped people to make changes to their lives." **Mental Health Practitioner**

4. GP specific changes in practice

4.1 Medication

Many GPs and GP leads spoke about a change in the way they viewed medication for patients with personality disorder.

Example 1

One GP lead spoke about taking away a new view of prescribing medication from the training. They described learning around the value of a prescription and that this may represent "care", acknowledgement and validation for someone. Explaining further that if medication is not the answer, this needs to be replaced with another option. This might include a clear and open conversation about the very limited value and potential harms of prescription medication

They also highlighted feeling more confident to not make immediate decisions, particularly around prescribing and being able to have conversations with patients that they will discuss with colleagues and think about the best way forward.

"So, you could be sort of calm and defer decision making about something that could be tricky and ring the patient later. And I think we maybe do that more." **GP lead**

Example 2

An example was given by one of the GP leads of how the training had given them the confidence to have an open conversation with a patient who was prescribed a large amount of medication. They described how at the beginning of the appointment the patient was requesting more medication but that they had had an open conversation about medication and instead created a deprescribing plan.

"And I think that at the start they were wanting more medication, even though they are on quite a bit already. And I managed to turn that around and sort of say, well, and we've came up with a deprescribing plan for them. So that was quite good this week." **GP lead**

Example 3

In one practice, staff commented on a difference in the way GPs were undertaking medication reviews.

> "...been more aware of the treatment for personality disorder as it being more of a therapy thing rather than medication all the time. So I mean, medication reviews and things that come up with people have been on things for a while. It might be a case of looking at it in a different way." **Medical Secretary**

4.2 Structured consultations

A change in the style of consultations was a theme across GPs and GP leads, this centred around taking a more structured approach, focussing on one issue and not trying to 'fix' all problems (even those that may not be health related) and not trying to 'cure' patients. Participants spoke about the impact that this had had, describing consultations as more productive and not feeling like they are failing as a GP.

> "Not coming away feeling that you've achieved nothing, you haven't helped them and the person's probably worse off than where you were before, but you can just pick one route to go down and say okay what you mentioned that let's focus on that." **GP lead**
>
> "Yeah, definitely. It's more productive consultations. I mean, we're not talking great leaps, but nudging in a direction rather than just circling round and round." **GP lead**
>
> "Not being too paternalistic and fix things for people resonated and something for me to work on." **GP**
>
> "One of my patients with strong suspicion of PD is very demanding and calls several times a week, writes letters, offers flowers when [they] wants something out of us I have responded less immediately to [their] queries and offered [them] some time to talk about [their] past issues which has shared another light of our Dr-pt relationship - it has created a safe space with less stress for both of us and emotions can now be expressed and contained into time and space." **GP**

5. Using core concepts in practice

Participants highlighted using specific concepts taught in their day-to-day work and the impact that this has had.

"Be more perceptive of personality traits and consider personality disorder. Having done this, I will be more open to discussing the diagnosis of personality disorder with a view to enabling people to access support to help them manage their condition. Whilst dealing with these patients, I will remain neutral and open, whilst maintaining boundaries and making extra effort to clearly explain both their condition and the procedure for accessing services in a way that will be most beneficial." **GP**

5.1 Rescue-blame seesaw

The rescue-blame seesaw was frequently mentioned by participants in the post-training questionnaires and then continued to be referenced as one of the most impactful elements of the training in follow-up questionnaire responses and interviews.

"Emotional seesaw has been very useful, the image has stuck in my mind ever since the training. We as a team also refer to it quite a lot and discuss how to stay neutral." **Management**

"Recognition that with one patient I have been flipping between blame and rescue and I should try to be somewhere in the middle." **GP**

A significant theme was the recognition of themselves or each other as 'rescuers'. This theme spanned the practices as well as the different staff groups.

In one practice, multiple participants spoke about one member of staff who had been identified as a 'rescuer' by others and themselves.

"I call one of our receptionists a rescuer every day because that's all she does, and I keep saying to her "you're a rescuer. You're a rescuer. You need to get back in that neutral balance." **Practice Manager**

The staff member described as a 'rescuer' by colleagues recognised this was not always helpful for patients or for themselves. They described how they would 'run around' trying to make sure everything was done for everyone, even when this wasn't possible.

All the staff in this practice commented that the rescuing came from having a caring nature and wanting to look after everyone. The staff member who identified as a rescuer stated that this was part of their personality and that it was difficult not to do this, describing a sense of anxiety and worry to make sure patients' needs are met. But that there comes a point where they have reached the limits of what they can do and that they were trying to be more boundaried with patients. The common understanding and appreciation of the rescue-blame seesaw offered staff a new, shared language and way to think and communicate about their behaviours which was relevant to their everyday experiences.

5.2 Emotional thermometer

Participants described keeping the emotional thermometer in mind during interactions and thinking about how to support patients, and themselves, back to 'neutral' if they were stressed or distressed. This was frequently highlighted by GP leads as something they used with patients but also in wider contexts within the team.

> "The emotional scale of going into red and everything becoming completely unhelpful when people are in that emotional state and accepting that and then trying to get people out of that state by not getting into yourself, as it were. So that that was quite useful. And I think when I consulted with patients, if they got hot under the collar, I think. Yeah, just allowing them time to settle." **GP lead**
>
> "The emotional thermometer, which is really helpful for communicating as I say, not just patients with personalities but for all patients and also communicating amongst the team a little bit." **GP lead**
>
> "I think the one I particularly hold on to is the temperature gauge getting somebody right down to think and process." **GP lead**
>
> "I am in the process of making a creative emotional thermometer 'art' work to use with patients. It has been very positive. Thanks." **GP**

5.3 Triggers

Many participants spoke about being able to better recognise triggers for patients and having more conversations with patients around this and as a team.

"I was able to talk about triggers, which is the other thing that I think was portrayed...... And then just helping them realise that you've managed that pattern, and actually you know you have managed that in the past." **GP lead**

An example was given by one GP lead about using the team case discussion meetings that resulted from the training to empower a patient to attend appointments on their own. They went on to say that through the meeting the team had recognised that the parent the patient was attending with was a trigger during appointments, and that since attending they were involved in some voluntary work.

"[The patient] got involved in some of the sign posting to some local voluntary work..... I think it was just the meeting enabled us to recognise. That actually the [parent] was sort of a bit of a trigger for them and actually that relationship and that if we could sort of work with them on their own then that that would help." **GP lead**

Results (Level 4)

The intended purpose of level 4 evaluation within the New World Kirkpatrick Model is to measure one singular outcome, that pertains to the purpose of the organisation undertaking training. However, it is acknowledged that relating a single training to a high-level organisational outcome can be problematic, and so results may be measured through leading indicators. "Leading indicators are defined as short-term observations and measurements that suggest that critical behaviours are on track to create a positive impact on the desired results" (Kirkpatrick and Kirkpatrick, 2021).

Therefore, for the purpose of this evaluation results are defined by leading indicators rather than one overall measure. Leading indicators were defined as outcomes prior to the evaluation as detailed in the methodology section.

Prior to analysis the evaluation sought to determine if the training had impacted on staff confidence and staff burn-out as two separate items. During analysis it became clear that these were intrinsically linked and that increased confidence was the biggest theme amongst participant responses in reducing indicators of staff burn-out such as feeling 'rubbish' after difficult interactions with patients. Therefore, increased staff confidence and reduced staff burn-out indicators are reported as one results section.

Additionally, during analysis it became clear that there were distinctive results for two staff groups, receptionists and GP leads who attended the residential training, therefore each have a dedicated section in the report.

This section of the report will discuss findings in relation to the following leading indicators:

1. Results for receptionist staff
2. The impact of the residential training for GP leads
3. Increased staff confidence and reduced staff burn-out indicators
4. Dependency of patients on primary care services
5. A shared language

1. Results for receptionist staff

Throughout the evaluation process participants from across practices and job roles repeatedly highlighted reception staff as benefitting from the training. Several of the GP leads reported that they had had a lot of positive feedback about the training from reception staff and how they had valued meeting other members of the practice they hadn't met before.

One GP lead described their reception staff as seeming happier and more settled, with fewer problems reported. They indicated that this may be reflected within sickness rates but had not looked into the figures.

1.1 Impact of the lived-experience trainers

Reception staff frequently commented on how powerful hearing the lived-experience trainer stories had been and this had made them reflect on their interactions with patients.

> "It was very interesting and meeting people who spoke with lived-experience is something which will stay in my mind. It makes me feel quite sad that although we treat all our patients respectfully it can come across in a very different way to patients with personality disorder." **Receptionist**

1.2 Improved interactions with patients

Benefits of the training for reception staff centred around self-reported and observed improved interactions with patients, changes in attitudes towards challenging situations and feeling empowered to speak to GPs or colleagues about difficult interactions. Staff commented that the shift was not just in direct interactions but also how difficult interactions are spoken about, describing reception staff as "more mindful of how people are different" **GP** and "it's certainly increased people's empathy" **Mental Health Practitioner**.

One GP lead described how they had needed to provide less support for reception staff since the training as interactions with patients seemed calmer.

> "There's just more of an awareness of back-up if needed, and just the tone just seems a little bit, a little bit calmer." **GP lead**

1.3 Managing difficult interactions

The training was described as benefiting reception staff by helping them to manage when emotional or distressed patients present at the surgery, described as the most challenging part of their day.

> "That would be the thing that they'll find most distressing. It's probably the reason why most quit." **GP lead**

Part of the reason for the improvement was reported by GP leads and receptionists as recognition of what might be happening for patients and not taking things personally.

"I think there is a general sense, I think in reception now that people are not always going to be happy and we're doing the best we can..... That's sort of translation into.... It's not always our fault." **GP lead**

"I can now notice when a person may have a personality disorder and act accordingly. In the past I may have just thought the person was being difficult and argumentative. But now I realise that they may have more complex issues. Understanding when a person might have a personality disorder, rather than just being difficult or rude." **Receptionist**

The impact the training had on reception staff managing difficult interactions with patients was strongly reflected in their own responses to the follow-up questionnaire of how they have applied the training.

"I feel I have a better approach to more challenging patients and can see things from their perspective slightly different." **Receptionist**

"A patient was demanding an appointment with a specific doctor becoming quite aggressive. Rather than matching their tone and volume, I stayed calm and explained that all the appointments had gone, and gave advice on how the patient could get an appointment with that doctor in the near future." **Receptionist**

"With any of my patients I don't fully know their mental health issues I use these practices I use this in everyday situations that arise at work, as you never know how the patient is feeling or what mental health concerns they my have." **Receptionist**

1.4 Better relationships with patients

A number of receptionists reported that this had resulted in better relationships with patients.

"A better relationship with my patients How to manage an emotional state I didn't previously understand." **Receptionist**

"Better relationship with patients and better understanding of their needs." **Receptionist**

1.5 Whole team approach

The whole team approach to training was also highlighted for this staff group. Participants described how reception staff rarely get an opportunity to reflect on why people get emotional, or have a chance to discuss it with other team members because of siloed working within staff groups.

GP leads described reception staff as feeling more empowered to ask for help and come to them about particular patients for the best way forward.

> "So reception not wanting to kind of have that discussion with us, saying look this is really impacting us and now I think they would be much more comfortable to do so. So I think some of that empowerment is really important ......Because they're dealing with a lot of stuff and also a lot of expressed emotion that actually can be very difficult. You feel, it can feel very personal"
> **GP lead**

2. The impact of the residential training for GP leads

Eight out of ten GP leads attended the residential training, six out of seven GP leads interviewed attended the residential training. They highlighted the time spent at Cumberland Lodge as being extremely worthwhile, commenting on the beautiful setting and additional time spent with the lived-experience trainers.

> "I felt like I got deeper into their challenges and difficulties. You know, spending quite a lot of time with them. And was really really useful." **GP lead**
>
> "[The lived-experience trainers] helping other people it like, just even that was just to see it really in that concrete story is really, really important, I think to then be able to offer genuine hope to patients." **GP lead**

One participant commented that they had enjoyed the experience more than they thought they would.

> "I really enjoyed Cumberland Lodge actually more than I thought I was going to when we said we had a day of simulation, I was like, ohh God bring on the coffee. But actually I really enjoyed it. I got a lot out of it." **GP lead**

2.1 Simulated learning

The simulated learning that took place at the residential training was reported by GP leads as the part of the programme that had the biggest impact for them.

"That was the single most useful thing....we had the teaching before ....I was like, it's not a lot of guidance here. I mean, I'm a very tell me point ABC and I will follow. But actually, when it was then brought to the simulation. Yes, you could see why it had to be quite fluid in instruction and then testing out." **GP lead**

"I think the most helpful thing for me was the simulation and actually being able to ask someone like I've asked you the same thing three times. Why are you not hearing it and then them saying, well, I am hearing it." **GP lead**

Some GP leads expressed that they thought participants needed to have attended the residential training to get the most out of the programme.

"I think you needed to have been at the lodge because the training .... I think for many it's distant history. Yes, I take it on board, but would I really I might have dabbled with a few ideas, but I don't think it would have had the impact that it had without the face to face element." **GP lead**

"I feel what you [PDPOP training] took me through was like degree Masters and PhD, consultation skills, certainly when we were sat around in the little groups with the lived-experience trainers that was very memorable and very helpful." **GP lead**

2.11 A safe space

Many GP leads commented on the residential training providing a safe space or environment in which to take part in the simulated learning. This was highlighted as having been essential in order for people to 'throw themselves into' scenarios, particularly for those who felt it was outside their comfort zone.

"I mean, I think it's, it's the opportunity, the safe space and the opportunity to try out ways of saying things, you know, kind of maybe kind of to hone your nuggets." **GP lead**

"Sort of be in terms of your body language and other things too, but also then just the fact that a lot of it isn't actually the specifics of what's said. You know you can pick on that when you're watching and observing but actually what's more important is how it felt for the people who were in that rather than more than just what was said." **GP lead**

2.12 A lot to experience

Although all participants enjoyed the simulated learning, they also spoke about it being challenging and tiring.

"I think you know it's quite a "phwaor" event and you just, I needed a bit of time. I was, you know, it was quite tiring in some ways and quite challenging." **GP lead**

One GP lead spoke about their concern for the lived-experience trainers during the scenarios (this then formed part of the questions for lived-experience trainer interviews).

"I felt a little bit worried that by doing the scenario I brought back up a lot of difficult emotion, difficult experiences of previous experiences and emotions for the lived-experience trainers........But I think it's just that initial raw experience which is almost like it's real and really happening. And that takes a while just to settle I think." **GP lead**

2.2 Key take aways

2.21 Realistic sceanrios

GP leads described the simulated learning as transformational. They valued the opportunity to practice what they had learnt in scenarios with the lived-experience trainers that emulated real-life consultations.

"I enjoyed them. They were very good. We do a lot of simulated learning work with actors and so on - they're incredible and amazing - but to have a lived experience person taking on that role was very unique. And very worthwhile." **GP lead**

One GP lead described how they had 'floundered' in the simulated learning but that was the benefit of it, being able to practise and describing it as a privilege to be able to do that with the lived-experience trainers. They described how the scenarios were realistic and that this was where the benefit came in.

> "You can watch a YouTube video, but it's never, you know, the real thing is what matters. And they were real. You know, they weren't patients, but they were. They were experts by experience. So they knew how to act." **GP lead**

2.22 Feedback

Additionally, the opportunity to gain feedback and to 'pause' to ask questions to peers and trainers was highlighted.

> "It was just testing out your understanding and then applying your new understanding to the situation and you were like I feel more confident now. I know where you're coming from. Um, and just and just having that. The ability to pause and be like, why isn't this working? There's ohh it's not working because you're not asking it in the right way. Ohh OK. How do I ask it in the right way? Right. OK, I'll try that then." **GP lead**
>
> "We're working on our own. The only feedback we would get is in our notes. And so the last time I got that feedback would have been 2005 when I was a GP trainee and otherwise nobody feeds back." **GP lead**

2.23 Reduced fear

One GP lead described how taking part in the simulated learning had reduced their fear of patients reacting negatively during consultations.

> "You know, I've spent the last five minutes desperately trying not to have this massive, you know, explosive conversation. And actually, I was never heading down that way anyway, which was really enlightening. And just. Not being fearful, maybe not being fearful of, of the outbursts and being prepared for the outbursts for which often were never gonna come anyway." **GP lead**

2.24 Observing peers

Other GP leads described how they valued watching others during the scenarios, highlighting the autonomous way in which GPs work. They reflected on how the residential provided opportunities to observe others that would not otherwise happen in practice.

"But you also see what people say and do, you could often take away little nuggets of phrases that people use, things they say that you might not even realise they're saying, and don't necessarily come out in a more didactic type of training. People say lovely things in real interactions, almost real interactions." **GP lead**

"We were working in the same room and I was fascinated because I never ever heard GP sort of - you know - I hardly ever hear them consult." **GP lead**

2.25 Being more open

One GP lead described how they had taken away the approach to be more open and direct with patients.

"Ohh well, I think certainly from the experience with the lived experience is the that they have a sense that you don't mess them around. Just be straight. Be honest. If you don't know, say you don't know. Or tell them how it is. Just be straight. Don't pretend, or whatever, cause they'll see through it." **GP lead**

2.26 Deprescribing

GP leads highlighted deprescribing as a key take-away from the residential training.

"So deprescribing is the other big thing I think that I got from actually got more from that you know on that last day at the residential, I didn't really get that in the in-house training." **GP lead**

2.3 Actions since the residential training

2.31 Shorter and less frequent consultations

For some GP leads the impact of the simulated learning has enabled them to have more focused consultations which has resulted in shorter and less frequent consultation times.

"And it's already making a difference as all of my patients just the change in tack rather than the half an hour appointments I got off the phone in 10 minutes the other day, which is unheard of." **GP lead**

"Yeah, and less frequent..... And just saying, right, we're gonna focus on point A. But we'll do point B next time and next time is going to be then. And I've only got 10 minutes, so we're gonna stick with 10 minutes. And being very clear from the beginning. Lessens the need for them to phone up daily, saying I'm still in a panic, so it's definitely lessened." **GP lead**

2.32 Taking scenarios back to practice

One GP lead described how they wanted to recreate the simulated learning with colleagues.

"The consultation scenarios that we did at Cumberland with my team, I've saved those scenarios and to try - again not one of my strengths - sort of acting role-playing, but I wanted to try to do those with the team and I found this really powerful." **GP lead**

2.33 Residential training for GP trainees

One GP described how they enjoyed the residential and got so much out of it that they have organised for the PDPOP team to run the residential training for their GP trainees later in the year.

"I mean my viewpoint is that we do a lot of communications skills work. But actually, if you can tackle and learn how to deal with PD patients, that's probably the hardest patient. And so everything else will be a lot easier after that. So yes, it's setting the, the barometer high, but it's a good place to get them going and thinking where they need to get to." **GP lead**

3. Increased staff confidence and reduced staff burn-out indicators

As touched upon in the previous section 'Behaviour', increased confidence was indicated as the reason for behaviour change through the application of the training in examples such as discussing and de-prescribing medication and having more open conversations around personality disorder with patients.

This section of the report focusses on increased staff confidence as a specific theme and the resulting impact of this on reduced staff burn-out indicators, such as feeling less 'rubbish' and managing emotional reactions, which are shown to be intrinsically linked.

3.1 Confidence working with patients with personality disorder

Many participants described an overall increase in confidence in working with patients with personality disorder.

> "I think the training has given me more confidence with kind of being able to approach and work with people with personality disorder." **GP lead**
>
> "It's confidence in in dealing with it and having actually just addressing it front on. I've had conversations with non-diagnosed PD patients since and brought up the idea and it's worked very well so it's certainly something to be explored and beneficial for them actually, I think." **GP lead**
>
> "Yes, I would say so. The way I speak with. My patients, more confident. I have a better understanding. More. Able to manage. Patients, I guess, and have tried to influence the rest of the practise to be a little more tolerant and less judgmental with some of our patients, I think." **GP lead**
>
> "I feel it has made me and my team more confident." **Receptionist**
>
> "I feel more confident helping patient with personality disorder" **Receptionist**

3.2 Crisis or distress management

Increased confidence around managing crisis situations and patients presenting in distress, was a common theme during interviews with participants, together with the positive effect the training had on how participants and their colleagues felt after difficult interactions with patients.

This supports the results, in the previous section 'learning' (Table 6).

- Participant confidence of dealing with a patient presenting in crisis with expressions of desperation, self-harm or thoughts of self-harm increased by 45% immediately after training and retained a 40% increase at follow-up.

- Participant confidence to manage their own emotional reactions to patients who present in an emotional crisis increased by 21% at follow-up.
- Participant confidence that their team responds effectively to patients who present in an emotional crisis increased by 29% at follow-up.

Table 7 shows that at six to eight weeks post-training, follow-up participants agreement responses to feeling 'rubbish' because of difficult interactions with patients reduced by 10%. Pre-training responses for follow-up participants only were added to this table due to significantly higher agreement responses in follow-up participants when compared to all participants, discussed previously in the section 'Learning'. As with the questions around confidence discussed earlier in this report, this question was not asked within the post-training questionnaire.

	% of respondents who agree or strongly agree		
	Pre-training all participants	**Pre-training follow-up participants**	**Follow-up**
I have days where I feel rubbish because of difficult interactions with patients	44%	57%	47%

Table 7.

'Participants' responses around increased confidence managing patients in crisis or distress centred around having tools to use to help them feel calmer and to better understanding of emotions.

"I really enjoyed the training and thought the involvement and testimony of people experiencing PD was invaluable. It demystified and took away some fear around how to engage and talk to a person feeling agitated and anxious. The piece of information that stands out for me is to be calm and respectful and to 'not roll your eyes'. It is difficult for us not to react defensively in situations where someone might be/feel threatening and try to diffuse and calm things down as much as possible." **Social Prescriber**

One practice staff described an example about the handover from receptionists about a patient who would regularly call and shout over the phone. Describing the handover before the training as very emotional, with reception staff wanting to ensure that they (the GP) were prepared for an 'angry' call. However, after the training they described the difference in the handover from receptionists about the same patient.

> "So the first time, it was just a big mess of emotions and shouting. But then the second time, that was not the same feel it was. "You know he's struggling. He's having a hard time." You know, they had actually listened to what he said why he was so upset was because he wanted his medication." **GP**

3.21 Managing emotional reactions

Many participants described how feeling more confident to manage crisis and distress also meant being able to better manage their own emotions, through using some of the concepts taught in the training.

> "I might even glance at my little pictures of a seesaw and the thermometer and think okay. Right now they're in the red and there's no point me jumping in as well. It's just giving a framework, I think that when you feel yourself, when it's going down a very emotional sort of route and it's being compassionate but at the same time let's try and steer it back to do some therapeutic work." **GP lead**
>
> "Useful to have better understanding of issues which helps you remain objective, and not so emotionally affected by patient behaviour." **GP**

One GP lead described how the training had given them a better understanding of personality disorder and that this had enabled them to better manage their own emotions when patients presented in crisis.

> "It's the result of people's feelings. You know, it's not deliberate manipulation. For example, you know, people are overwhelmed by their feelings, and they haven't been taught - haven't learnt ways of being able to mentalize, etc. - Then I think that means it's easier to... It becomes sort of less scary and you feel more capable of responding to that distress." **GP lead**

3.22 Reduced referrals to secondary care

Two participants spoke about how increased confidence managing crisis or distress would lessen referrals to secondary care and lead to better relationships with patients.

"Yeah. So I think what this has done is that maybe we as clinicians are getting better at seeing when things don't necessarily needs to go to crisis team or to a secondary mental health care, because what always happens is that we refer and they get rejected because they are not bad enough. Which is an extra blow for the person, isn't it?" **GP**

"It will definitely lessen referrals. The number of referrals to secondary care for mental health alone that get bounced back .... and also for secondary care for physical ailments. I have patients that present physically for mental health problems .... and actually saying do you think maybe your chest pain is because of your anxiety, you know and has this presented before. It should lessen GP attendance because once you get good rapport with someone who understands that you are going to help them and not fob them off." **GP lead**

3.3 The power of the rescue-blame seesaw

Many participants described the impact of learning and applying the rescue-blame seesaw. They spoke about the realisation of being a 'rescuer' and that this had empowered them not to try and solve all patients' problems and that this supports feeling better in their roles and regulating how they feel.

"I don't get pulled into the rescue because I'm a natural rescuer.... Whereas you know this, you're much more regulated to your rescuing. Because you have better understanding that often rescuing is not really, it's not helpful, so making sure you're pushing back a little bit and almost the course has given you permission to push back and say then I'm not gonna take that one from you." **GP Lead**

The impact of this concept in practice on a team was also recognised, particularly when thinking about how different members of the team can be on either end of the seesaw and how this can create 'splits' or divisions in approaches to patients.

"So that bit you know the rescue-blame stuff as well. You know, the way that we can tip into that and the way that different people will evoke those emotions within us. So I think that that you know you can see that particularly when you have the team there and then it becomes explicit that actually so and so thinks about them this way. And another person thinks about them in that way. And then those views may conflict. So I think that for me and for us as a team." **GP Lead**

3.4 Confidence to apply boundaries

GP leads spoke about how the training has made them feel more confident putting boundaries in place with patients, and how to say no to requests that aren't appropriate in a non-inflammatory way. Describing that part of putting in boundaries is being honest about the limitations of what GPs can offer.

"Confidence. Really. With dealing with complex consultations with patients with personality disorder, obviously, but also I'd say any sort of more challenging, consultations, where perhaps needs to be thinking more about boundaries and thinking about patients, unmet needs and things. So yeah I think it's just given me much more confidence actually with those sort of difficult consultations." **GP lead**

3.41 The effect of applying boundaries on GP leads

The result of this was GP leads feeling more positive after consultations, that they were doing a better job and less emotionally affected.

"And then having the training has cemented how you know... Being clear, being firm is the right thing to do. And it's not that we're being bad doctors. And then... because we see the positive effect of it, that enables us to feel better about doing that and continuing to do that to set those boundaries. And you feel more positive because it's the right thing to do and it's having less emotional effect on you as well." GP lead

"I think if you're able to have good boundaries, that means that you aren't left feeling so sort of drained." **GP lead**

"And so I think that it will definitely lead to people feeling, you know, more rewarded and less... Less like they've done something like, you know, they've prescribed something they didn't want to, for example. And because they've been able to manage their boundaries better. Or not run, you know 40 minutes overtime." **GP lead**

3.42 Example of patient impact for applying boundaries

One GP lead gave an example of a patient who had been frequently calling the surgery but not following up with appointments or engaging in their diabetes care. They described how since the training the team had been more consistent with their approach and boundaries and that the patient was now attending appointments and their diabetes was better controlled.

"You know, coming for help and then sort of calling for help and then not ever properly engaging with what was recommended with quite severe diabetes as well. And so they are engaging more now." **GP lead**

3.5 Feeling less 'rubbish'

Participants reflected on how since the training, their increased understanding of personality disorder had led to confidence in being able to not take things personally, feel empowered and leave things at work. This was reported to have had a beneficial effect on how participants felt at work, including feeling less like they were doing things wrong or doing a bad job and feeling more able to help patients. Additionally, participants reported that they felt better about previous interactions with patients that had left them feeling 'rubbish'.

3.51 Not taking things personally

Many participants described experiencing a change in their perception of patients during difficult interactions, resulting in interpreting behaviour as a way of communicating and understanding what might be driving this, rather than taking things personally.

"And you could think actually that wasn't about me. It was about maybe something's going on in their life and I was just the front person that happened to be there at the time." **Practice Manager**

"It is hard not to take it personally sometimes and you think it's going to happen and it ruins your day a bit and you go home and you're thinking about it. But then after that [the training] I did think you gotta think about it from their point how frustrating things can be and the temperature thing and just try and take a step back from it being anything personal." **Medical Secretary**

"I think just generally it makes you think if somebody is being. I don't know difficult or it's not going smoothly. Maybe think why?.... So it makes you sort of stop and think it might not just be a routine you know, moaner, you know there might be something going on in the background, basically." **Practice Manager**

"This training was wonderful and very thought provoking, in a positive way. I feel I have a lot of empathy; however, this training made me realise that coming into contact with a person that displayed aggressive, repetitive or needy traits are to be listened to more in-depth. And could be suffering from personality disorder and asking for help in the only way they know how." **Admin**

3.52 Feeling empowered

Participants described that since the training they have felt more empowered, and this has impacted on how interactions with patients have gone, as well as how they feel in preparation of interactions and afterwards.

"Yeah, definitely. Definitely made a difference because I feel much more empowered to run the conversation rather than be run over by the consultation." **GP lead**

"Significant increase in understandings of these patients / less stress from myself when situations can make me feel powerless, I remind myself that staying the neutral container is what is going to help my patients the most in the long run." **GP**

"We definitely know that we can put things in place to make the management of those people. If they come in in a stressed or kind of vulnerable or sometimes in a quite violent, aggressive state. We can do things, can do preventative things, as well as solving the problem as it happens." **Operations Manager**

"So to be able to steer this person more towards therapy and deprescribing. Um, you feel better about the consultation as well because it feels like a more positive experience. I've come away from it feeling really quite positive and rather than feeling. "Ohh" Whatever that is." **GP lead**

3.53 Leaving things at work

Two participants spoke about how the training and the practice meetings that have followed on from the training have supported them to not take 'work home with them'. They described the importance of having a team where you can talk to each other about things supports not taking work home and enables them to use training and helpfully remind each other of this.

"No, I don't think any of us do [take work home]. We've got to that point now where we have that lovely, you know that meeting and everything and we understand and we don't." **Reception Manager**

"Because, you know, not everybody gets it. And then other people sort of say well, don't you remember they said that in training. Ohh yeah. Didn't think about that. So yeah, we do talk about it." **Medical Secretary**

3.55 Helping retrospectively put things into perspective

Participants often reflected in interview about previous interactions with patients where they had come away feeling 'rubbish', like they were doing things wrong or not good at their jobs, but that the training helped them to have a new perspective on these past experiences.

"You tend to think when someone is like that with you. Ok, I've done something wrong here. What did I do wrong? Because you immediately blame yourself........ How all the years you've been doing the job? Clearly not any good at it anymore I need to go. That rubbish feeling." **Medical Secretary**

One participant reflected on an incident that had happened recently prior to training and that the training had helped to think about why the interaction had happened the way it did.

"That happened about six weeks before we had the training. So it was quite fresh in my mind and it was interesting to sort of hear why they were like it. I think it helped enormously because then you suddenly recognise the traits and the personality." **Medical Secretary**

4. Dependency of patients on primary care services

Table 8 shows the results of pre-training, post-training and follow-up responses to the question; I have patients who I think have become dependent on me in a way that is not helpful for them. Approximately 20% of participants responded in agreement with this question and there was little change at pre and post-training. However, in follow-up questionnaire responses and at interview this was a strong theme with many participants giving examples of action they have taken to reduce this.

	% of respondents who agree or strongly agree		
	Pre-training	**Post-training**	**Follow-up**
I have patients who I think have become dependent on me in a way that is not helpful for them	21%	27%	23%

Table 8.

Participants spoke about the challenges related to providing care that has continuity and builds a relationship whilst ensuring that patients do not become dependent on one individual.

> “Yeah, I think it becomes a problem and people refuse to see other people, you know, then you’ve done them a great disservice. Well, it’s a fine line between. Between forming a therapeutic relationship where you, you know where they feel they can trust you. Umm. And they have the continuity that they need for a while, but it’s then spacing it out and breaking it off. That’s really difficult.” **GP**

Another described how difficult it can be when you are the person that someone is dependent upon.

> “So once they’ve got that, how do you then cut that off? You know, cast them adrift once they’ve got someone. Some people need that one person to focus on and to be there for them. So whether it’s just you listening to them or you’re helping.” **Medical Secretary**

A number of participants in the follow-up questionnaire highlighted recognition and changes around relationships where patients are dependent on them, as well as acknowledging their own limitations both to their patients but also to themselves.

"It has made me a lot more confident in interacting with these patients and also feel more able to try and break the dependency cycle that sometimes develops." **Social Prescriber**

"I recognised that one of my patients had become dependent on me and was being very manipulative. I explained that I think they need more mental health support (more than what I can support them with as a social prescriber) which they did not accept. Prior to the training I felt that I had to carry on calling this patient and supporting them and thought it was my responsibility to make them feel better but now I am able to see that I was not helping them as I was not able to give them what they really need (therapy perhaps)." **Social Prescriber**

4.1 Dependence and rescuing

For some participants, recognising that patients were dependent on them in a way that is unhelpful for them also meant recognising their nature to 'rescue patients'.

One participant who identified as a rescuer described how this has caused patients to come in and ask for them and not want to interact with others at reception, even though they are capable of meeting their needs. They described how they have changed their behaviour since the training and encourage other staff to manage patients' requests rather than them coming to 'sort it out'.

4.2 Reducing appointments

A number of GP leads spoke about examining the way they maintain dependence through regular or follow-up appointments with patients, and that after the training they had made some changes in practice.

Example One

One GP lead spoke about how they had taken away from the training the ideas of promoting independence and personal capability with patients who had become dependent on the surgery.

They went on to say that traditionally, the approach would be to give more regular appointments or schedule appointments at the end of the day so they could run over but that this was not helping patients to be more independent. They described this as an important message that isn't necessarily taught within usual GP training as the focus is on a medical intervention and not so much how to help people help themselves.

Example Two

Recognition of patients who are dependent on the surgery in a way that is unhelpful for them was one of the strongest messages from the training for one GP lead. They spoke about conversations that had continued after the training and how this had started the change through identifying patients and to book in appointments to think about the best way to support them. They also described how this has changed how they book in reviews and has started conversations on why they are working in this way.

> "And so we've said to GPs as a whole that that's not how we should be doing it and we shouldn't be just a rolling programme of reviews. Unless there is a very clear indication to do so. And I think that part of having that conversation together as a group, which we did as a sort of a GP meeting, we then talked about that again. I think getting it out on the table for us all to discuss around those reviews and why we find it difficult sometimes." **GP lead**

Example Three

In another practice staff have begun by identifying patients who regularly attend the surgery with particular needs and are working to reduce this on a case-by-case basis.

> "We've looked at some of those patients who, sort of, have particular demands and explored why they may have the demands. Um, there's always more work. What can be done along that line? But we have started to think about those bits and - at the moment - sort of tackle it as a case-by-case situation." **GP lead**

Example Four

One GP lead spoke about how they had begun to recognise dependency with patients in patterns of having a telephone call and then coming in for face-to-face appointments. They described an example of this after the training where they then realised that there was no need for the patient to come into the surgery as the concern had been resolved over the phone.

> "I don't know how I did it, but I managed to steer away from that and so we didn't make a face-to-face appointment. So where as perhaps in the past I would have done. And you know, there was no need for it. We managed everything that we needed to manage." **GP lead**

"I think it's recognising. Hang on. Why are we why you coming to see me again? You know it's recognising that. It's funny, cause you kind of know it, but you don't. Before I kind of knew it, but I didn't. It didn't sort of recognise. Recognise it in terms of unmet need, perhaps." **GP lead**

Example Five

An example was given by one GP lead of being able to reduce the length of telephone appointments since the training through recognising dependency and using boundaries.

"And it stops you running late because although we've now put in appointment slots for one patient, invariably they'll still run late. You know it's supposed to be 10 minutes. I've spent 45 minutes routinely on a phone call with some because you physically cannot get off the phone. Whereas now you know the times are starting to slow down. So it takes the stress away from my day. I run to time, my patients are less annoyed that I'm an hour behind as usual." **GP lead**

5. A shared language

A prominent theme within the analysis closely linked with increased confidence, reduced staff burn-out and reducing dependency of patients was a shared language among staff and teams. Participants across practices and roles in both follow-up questionnaires and interviews described a shared language within the team to discuss patients, but also support each other as a result of the training.

"It has had a very positive effect on us. It has made everyone more empathetic and understanding. It has also been very helpful in giving us the vocabulary to discuss and manage patients with personality disorder and similar complex emotional issues." **Management**

"You feel like you've got a language and a way to discuss and the awareness between you to kind of then be able to say ohh you know this and this is what's happened." **GP lead**

"Using some of the language around rescue-blame, emotional thermometers and that kind of side of things in terms of .....how do we contain some of the sort of the anxiety and how do we manage some of the behaviours. So, there's definitely been a lot of stuff. I said I think it just helps to have language to describe some of these things." **GP lead**

5.1 Working together

Several participants highlighted the impact of having a shared language and the training as a whole team as being able to work better together.

"I would say that I think there are massive benefits. How beneficial it is for everybody to be working together, regardless of their role or position or anything like that." **Operations Manager**

"It's that sort of joined up team working bit and kind of being able to name and be specific about some of the issues that we're finding and how that impacts us." **GP lead**

"Brought us all together. Reassuring to know we all feel a similar way. Gave us a potential way forward to ensure all on same page re how to handle & ultimately provide best care for these patients." **GP**

"Because it's like a shared knowledge base, people can talk about it a bit more openly, which I think really helps. So, I think the, yeah, the training has given us the information and it's kind of sharing that as a collective has helped." **Operations manager**

5.2 Changes in language in interactions with patients

Participants across practices also highlighted that as a result of the training they had made changes in the language they use with patients.

"I think the reflecting back to the person how they come across in a very calm way. You know, "I can see you are upset. Can we talk a bit more, you know?" **GP**

"I have changed the vocabulary I use when talking to patients to include more phrases like "What can we do to resolve this?", "What would be the ideal outcome?" and "What can I do to make this experience better for you?"" **Management**

Translation of results and behaviour changes as potential impacts for patients

Although the evaluation did not directly engage patients, it is possible to translate these into potential impacts for patients through participant reported behaviour changes, examples of patient changes and the intended impact for patients through the lived-experience, and clinical trainer interviews.

Better experience of GP services

The lived-experience and clinical-trainers all expressed hope that the PDPOP training would improve the experience of individuals accessing GP services. This centred around individuals feeling heard and listened to and subsequently better understood through increased patience and empathy. They also expressed that experiencing better interactions with GP staff, through a more empathetic and compassionate approach, would result in the reduction of escalating situations – or the risk of making them more chaotic – by those providing care being more aware of what may trigger others.

"Amazing what happens when someone is heard and understood." **Lived-experience trainer**

"... [GP staff] being more understanding and knowledgeable about personality disorder and in turn displaying more empathy towards patients." **Clinical trainer**

Evaluation of behaviour changes and results indicate that primary care staff who attended the training have a better understanding of personality disorders, more empathy and compassion and are more confident in managing crisis and distress and their own emotions. Through the training, participants have indicated a profound change in their perception of patients with personality disorders that could lead to better patient experiences of GP services.

"I found the training greatly increased my understanding of PD, and helped me to see beyond the presenting behaviour to the human being." **Management**

"Personality disorder is not always a negative experience. It could just be a challenging or a different experience. Doesn't mean they're gonna come in and be aggressive or anti." **Practice manager**

Additionally, participants described how their own and colleagues' perceptions had changed in a wider context; not just for patients with personality disorder. This indicates the potential for a better experience of GP surgeries which may be enjoyed by a wider group of patients than only those with personality disorder.

"…..looking at people differently, sort of not stereotyping. But if we had an angry man shouting and screaming at the desk asking for an appointment, and we were saying no. And if you had a very upset and vulnerable woman, we would give the appointment to her and not him and now we would treat him the same." **Medical Secretary**

"I think for many of them it was more thinking along the lines of difficult people, you know, difficult patients. And seeing them in a different light. That not everyone is good at speaking for themselves or explaining what's wrong." **GP**

"To be honest with you, I think being able to recognise that people are behaving in the way that they're behaving because of things that are kind of out of their control and not what they want to be doing." **Operations Manager**

Reduction of medication

The evaluation findings suggest an increased confidence among GPs to talk about medication and de-prescribing openly with patients. Considered alongside the examples that participants provided of interactions with patients about medication, this indicates that reductions in the prescribing of unhelpful or unnecessary medications may represent an impact on patients' experience as a result of the training. The findings also reflect the hopes, expressed by the lived-experience trainers when considering the potential benefits of the training, around medication.

The reduction of prescribing medication for individuals with personality disorder was a strong theme across all the lived-experience trainer meetings. It was acknowledged that this may be what individuals are requesting during appointments and can lead to difficult conversations when a GP believes it is in the best interest of the patient not to agree to such requests. It was acknowledged that medication was not necessarily 'fixing' anything and in some cases could be harmful and contribute to an individual's dependency on healthcare services.

In such instances, the prescription was often described by lived-experience trainers as something they would 'be given' or to be 'got out of' the GP, in a symbolic way, rather than being entirely about the medicine itself. Through a better understanding of

personality disorder and how to support individuals the lived-experience trainers hope that medication will not be a go to solution for those attending GP surgeries.

> "...not be reaching straight for the prescription pad and making assumptions about the condition and automatically going to "Depression" or "Bipolar"."
> **Lived-experience trainer**

Open conversations about personality disorder

The lived-experience trainers expressed that the training provides a better understanding of personality disorder for GPs and clinicians and that, in turn, this will enable more open conversations about the diagnosis and how to support people.

They described the benefits for patients as GPs having more hope for patients with personality disorder and knowledge of different treatment pathways and options of support beyond the prescription of medication. They hoped that the training will support opportunities and confidence to discuss "tricky" patients, allowing colleagues to find ways to better support people and to untangle the person (and the personal) from the condition.

> "A diagnosis of personality disorder should be 'a mechanism for change' and not something to be ashamed of." **Lived-experience trainer**

Confidence in discussing personality disorder with patients was a large theme through the evaluation, with many participants across roles providing examples of how they have applied this in practice with positive results for patients.

A consistent approach from GP teams

Both lived-experience and clinical trainers highlighted that the training will support consistency in the approach from staff and in the setting of boundaries, supporting patients to feel more contained and know where they stand with consistent approaches and rules. This was felt to support better engagement and to reduce reliance on services. Specifically, the training elements of the rescue-blame seesaw and the video that addresses how practice teams can 'split'.

Participants highlighted that this was a benefit of the training through the resulting shared language that has allowed them to better communicate within (and across) teams and with patients. The need for a consistent approach was highlighted by participants in interviews. Staff turnover and not all staff being able to attend the

training was identified by some participants as a potential and practical barrier to being able to provide a consistent approach for patients.

Challenges and barriers

Despite overwhelmingly positive feedback about the training, in interviews some participants highlighted there were challenges to putting the training into practice. They frequently expressed that these were general challenges faced in primary care and not specific to the PDPOP training, as outlined below.

Staff turnover

Many participants spoke about staff turnover representing a challenge to the ability of practices to retain changes from training. GP leads spoke about trying to teach and recreate the training with staff, but that it was not a substitute for attending the original training.

> "So that's a bit of a problem really, cause you have staff turnover and you hope, that I suppose that, the stuff you learn will filter down to them through everyone." **GP lead**

Time and workload pressures

Time and workload pressures were often spoken about by participants as a barrier to putting the training into practice. This was discussed both in terms of individually having the time and space to think through the right thing to do with patients but also in terms of time to meet and have discussions as a team.

> "Actually, that there is a will there is a desire to change stuff. So I think barriers would definitely be it's time and I think it's team time as well. It's part of that. So although we have our protected learning once a month as a team, umm there's so many calls on our time for that the stuff that needs to be done and this is the sort of stuff that takes it takes time you know you can't just do it in a sort of 1/2 an hour session and sort it all out." **GP lead**

Competing demands on time and decisions on how to use time was described by one GP lead.

> "I think the challenge is getting the time and trying to just make the case that there is value in using that time rather than seeing patients because ultimately that's the choice, is do we take an hour out of do we lose this many appointments to have this educational session? And that's a bit of a cultural thing as well because, you know, often there's a little bit of pressure for some from managers just appointments, appointments, appointments." **GP lead**

One GP lead spoke about the lack of time for updating records so that everyone could see the right information and a lack of time for thinking space. Describing the challenge and pressures of a 'total triage system' being in place which meant a list of approximately 250 contacts each day to decide what patients need.

> "But when you're going through that list, when you've got that pressure of those numbers to get through as a clinician making decisions. Yeah, just thinking, just thinking more broadly, what's the right thing for this person? What's been happening with them before? How do we go? So, it's difficult to sometimes to translate the perfect sort of situation that we tried to discuss in the training into real life. So, time is a big issue." **GP lead**

Another GP lead described the challenge of time and pressures of the government priority of access over continuity, resulting in GPs only having the time to deal with the immediate day-to-day demands of the surgery.

> "Massive workload means everyone is just totally rushing through everything all the time and it's really hard to be a reflective doctor and you know, be able to use all the skills that are the really good communication skills that are needed as a clinician working with patients with personality disorder." **GP lead**

One participant described how capacity and lack of a duty system or lack of flexibility within the system for people who attend the surgery in crisis.

> "Within primary care, there's no kind of safety net for people that's there. So we're still relying upon just luck in terms of the availability of someone like myself to just to be able to go down towards and respond to people in crisis or referring people back to secondary mental health service."
> **Mental Health Practitioner**

Potential scepticism of staff

One participant spoke about engagement and scepticism of staff prior to the training being a potential barrier but that the training and after-training discussions had "won them over".

> "I think in the end there were one or two sort of sceptical views, but they since have come round and viewed that their original dissatisfaction wasn't dissatisfaction, just dismissiveness. I don't know if they really felt it was relevant to them..... However, a couple of weeks or so, I'm sure they must have had some interactions or something and actually realised they did learn pick up stuff. And some did say "yeah, we got that wrong, it has been helpful"." **GP lead**

Internal response

Two participants spoke about people's internal response to emotionally charged interactions being a potential barrier. Describing how even with all the right training this can 'go out the window', particularly when experiencing multiple consecutive negative interactions.

One participant spoke about internal responses in the context of being on the receiving end of aggression or distressed conversations as well as highlighting the risk of vicarious trauma after listening to what patients have experienced. They described how one way to overcome this was to have a running commentary inside their head of how they felt, so that outwardly they could have a neutral approach, but acknowledged that this was difficult.

> "That could be a barrier cause you know you can only suck up so much, can't you? As a receptionist or doctor or nurse. But if you have that in the back of your mind, that this is how I need to handle myself to help and support that person." **GP**

Staff also described how the residual feelings after emotionally charged interactions and the "non-stop" environment of primary care can mean that there is not time to 'calibrate' afterwards. Which could potentially make it harder to remember and put into practice concepts taught in the training.

> "Umm, I don't even have a little debrief with someone or just with yourself. It's not set up for that. It's just too busy.....to be able to step aside and just take a minute, you know? And maybe have access to someone they can chat with about it would be useful." **GP**

Lack of services and resources

A number of GP leads spoke about how since the training they have been linking in and making connections with other services. Such as PICT (Psychologically Informed Consultations) teams, highlighting that the service was echoing a lot of the things from the PDPOP training and that they would come into practices and that this may help to reinforce some of the messages from the training. GP leads highlighted linking in with other services as key to making further improvements for patients after the training.

> "Well, the next challenge, which is possibly an impossible challenge, but it is... It's one thing getting patients to buy into it, which they can do, but then if you've got no services to offer for treatment. Then it's. It's a bit sort of lands a bit flat and so I've been trying to have conversations with the mental health team as to how they could engage more and the therapies involved." **GP lead**

A lack of service provision for therapy was a large frustration for participants. Participants highlighted the lack of services for patients with personality disorder, describing this as "the NHS burying their heads in the sand" when there is a clear need for services that would relieve pressure on other services and enable patients to access treatment and "make everybody's life better".

> "I think you know if we had a dedicated service like Oxford does it would make a big difference ....you know it's classic, isn't it, with sort of mental health funding, really? If the funding followed then then you know it changes. It [the training] can't be a standalone thing. It has to have that kind of service."
> **GP lead**

Where services were in place, participants described large waiting lists for patients and the need for quicker access to services, describing this as frustrating for both patients and primary care staff.

Several participants expressed that without clear pathways and services it is not clear what to do when someone has a diagnosis of personality disorder.

> "I think they, I imagine, from a GP perspective, it's after you've ... Not necessarily. GP, any kind of clinician, as soon as you say that sort of diagnosis. Or you mentioned that sort of......You attribute that thing to a person. It's then, what do you do afterwards?" **Operations manager**
>
> "It's all very well having all these things in place and training. And it does enrich you. It does give you the tools. Ultimately, there's a lot of. Gaps. Yeah, it seems to me the service is really on its knees. I mean, as we know, right from hospitals to us, yeah. And even out in the community, isn't it? And it is a sorry state." **Medical Secretary**

Participants also attributed the lack of services and resources for patients as a reason they feel 'rubbish'.

> "Regarding the last point above on feeling rubbish due to difficult interactions, I definitely have these days but I would not "blame" it on patients with personality disorder. I usually feel this way due to not having enough resources to support patients with mental health or social needs, and I feel rubbish as I feel I am not able to help the patients and am the person to tell them that there is no support available, which in turn is difficult." **Social Prescriber**

Summary

The evaluation of year three PDPOP training has found that participants were highly satisfied with the training and found it to be relevant, engaging and useful. Initial post-training evaluation demonstrated that participants had greater knowledge about personality disorder in the context of:

- Individual needs
- Masking
- Recognising traits of personality disorder
- Importance of the whole team approach

Initial post-training also demonstrated shifts in participants' attitude towards patients with personality disorder including acknowledging and trying to understand triggers and greater empathy and compassion. Additionally, increased skills and confidence were demonstrated through using the training's core concepts such as the emotional thermometer and the rescue-blame seesaw. As well as increased confidence in managing distress, crisis and participants' own emotions. A small group of GP and paramedic participants reported that they would have liked a more concrete or solutions-based training, and this is reflected in the recommendations.

Evaluation from six weeks post-training to six months post-training through follow-up demonstrated that participants had applied the training through numerous behaviour changes at both individual and team levels including:

- Case discussion meetings
- Identifying and coding patients
- Better use of mental health practitioners
- Application of awareness, recognition and understanding
- Implementing boundaries
- Open conversations about personality disorder
- Structured consultations
- Consideration of medications
- Use of the emotional thermometer and rescue-blame seesaw in practice

Results of these behaviour changes resulted in overall increased confidence for staff across practices and roles in working with patients with personality disorder, managing crisis and distress and managing their own emotions. Through increased confidence there was evidence of reduced burn-out indicators for staff through:

- Not taking things personally
- Feeling empowered
- Leaving things at work
- Helping to retrospectively put things into perspective

Although the training did not quantitively show an increase in participants' recognition of patients who are dependent on them in a way that is unhelpful for them [the patient], follow-up questionnaires and interviews revealed evidence of action taken post-training to reduce dependency as a result of the training. The training resulted in a shared language among staff and this was a strong theme in participant responses during interviews.

There were a number of challenges to putting the training into practice including staff turnover, time and workload pressures, staff's own internal response to crisis situations and a lack of services and resources to support diagnosed patients. However, in response to the challenge of staff turnover and time and workload pressures the evaluation findings indicate that the training may help to reduce these by lessening staff burn-out and increasing appointment availability through more effective interactions and consultations.

From the translation of these findings, it can be concluded that in practices that undertake the PDPOP training patients may have a better experience of GP services through a more empathetic and compassionate approach, resulting in fewer triggering instances and the reduction of escalating situations. Patients may also benefit from reduced unhelpful or unnecessary prescribed medications and better consideration of alternative support such as social prescribing, therapy and signposting. Patients may receive better consultations with GPs and face less stigma through educated and open conversations about the diagnosis of personality disorder and feel more contained through a consistent approach across the whole team.

Recommendations

Training

All participants suggested repeated training, highlighting this as a way to help manage the challenge of turnover of staff, to refresh memories and a way to reflect on what had happened since the initial training. The format of training was suggested in a number of different ways:

- PDPOP as mandatory training on a yearly basis to capture new staff
- A yearly update
- Refresher training after three years
- GP skills master class/ stage two training
- Follow-up training for specific staff groups to focus on the different challenges that each group encounter, e.g., reception team, clinical staff etc.
- Training modules on personality disorder and specific topics such as self-harm, drugs and alcohol and in younger people
- A more concrete, solutions-based training for paramedics and GPs

Wider training provision

Many participants suggested that the training be more widely available and that there would be benefit in this being offered in a range of different settings:

- Training for patients to access
- Training available to the public

Resources

Through evaluation activities it became clear that resources were needed to act as required drivers to support the education of new staff and as reminders of the training to support critical behaviours to continue.

Written resources

Many participants expressed a desire to have written resources to take away from training. A 'top tips' guide to working with people with personality disorder:

- A resource written by the lived-experience trainers with insight into practical points on how to help, that can be shared with staff and patients
- A handbook – a resource to refer to after the training and share with those who weren't able to attend and with new staff
- The core concepts with prompts on how to explain them to others
- References for where to find more information around topics
- A notes resource from the residential training

Website resources

- An FAQs section on the PDPOP website
- Links to practices that have done the training
- Case studies

Visual prompts

- Printed visuals of the core concepts
- More prompts like the mugs given after the residential training
- Prompt messages that can be emailed to staff at intervals after the training such as "Do you remember this from this training?" or "Can you think of an example of this that you've tried this week?"

Community of practice

Several participants from different practices expressed a desire to have a platform/forum/group to exchange ideas, ask questions and problem solve with other practices that have completed the training and to get feedback from the training team. Several GP leads described how the follow-on GP lead meetings had been helpful and supportive and that they would like a similar ongoing forum.

It was felt by participants that a 'community of practice' type of space would provide the right forum.

Recommendations for measuring impact

The evaluation team asked interview participants, lived-experience trainers and clinical trainers what they thought could be measured to demonstrate the impact of the PDPOP training in GP surgeries. The suggestions for potential measures are below, however all participants emphasised the difficulty in measuring the less concrete items such as culture, burnout and patient experience. They also urged caution around using a single quantitative measure such as medication as this could become the single focus and a 'tick box' measure, that is not necessarily relevant to all.

Quantitative measures

- DNA (Did not attend) rates pre and post-training
- Reduction in the number of 'special' or double appointments
- Regular consultations for individual patients and if these reduce after training
- Greater variation in the number of GPs that an individual patient sees (lower dependency)
- Patterns in staff absences and staff sickness rates
- Reception staff turnover rates
- Prescribing and de-prescribing rates, particularly of opiates and including reduction in the number of times a dosage is increased and how much money is saved
- Auditing medications for patients with personality disorder and reviewing longer term medications, such as antidepressants prescribed for over three years
- Rate at which the practice closes on time
- Reduction in hospital admissions or referrals, both physical health hospitals and services and mental health hospitals and services
- Frequent attendance rates at GP surgery and at A&E
- Number of times that situations have escalated (emotionally/shouting)
- Reduction in instances of self-harm (though this is hard to measure or monitor or to attribute to PDPOP)
- Data from social prescribers or greater engagement and take-up of places on courses provided by the third sector (e.g., Recovery College, Oxfordshire MIND etc.)

Qualitative measures

- Patient experience – including sense of agency and responsibility, through a survey to uncover the nuances and meaning of answers
- The experience of newly diagnosed patients about their experience of diagnosis and conversations around this
- Reports of staff burn-out including the use of validated measures
- Gauging the emotional impact of difficult interactions e.g., asking staff about their interactions with patient. How much has it affected you emotionally on a scale of one to 10? How upsetting was it?
- Levels of anxiety reported by staff
- Confidence of staff with challenging interactions
- Asking GPs about the number of 'challenging' patients on their caseloads
- Culture – e.g., a questionnaire to capture how people feel about being part of the PDPOP family
- Complaints, both number and nature

Measures around follow-up actions and continued meetings after training

- The frequency with which professionals get together to talk about challenging cases and who is involved in these meetings
- The number of patients who are brought to the whole practice's attention at the bi-annual meetings to discuss patients. There could be dedicated meetings to look at this caseload, although that would represent (yet) another meeting
- How often the practice meets to review their PDPOP action plan and whether the actions are being taken forward
- Bespoke measures based on the practice action plan
- Does the practice have a PDPOP champion or lead

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Appendix 1

Missing Likert item responses

	Pre-training	Post-training
I have a good understanding of what personality disorder is	1 (GP)	
I can recognise when a patient might have a personality disorder	2 (receptionist)	2 (management, admin)
I would feel confident dealing with a patient presenting in crisis with expressions of desperation, self-harm or thoughts of self harm		1 (job role not given)
I can manage my own emotional reactions to patients who present in an emotional crisis	2 (admin, nurse)	
My team responds effectively to patients who present in an emotional crisis	3 (admin, nurse, healthcare assistant)	
I have patients who I think have become dependent on me in a way that is not helpful for them	8 (management, nurse, admin, healthcare assistant)	15 (admin, management, receptionist, nurse, healthcare assistant, GP, other, not given)
I have days where I feel rubbish because of difficult interactions with patients	4 (admin, nurse, healthcare assistant)	
I would recommend this training to another GP practice		2 (receptionist, healthcare assistant)

Appendix 2

Missing free-text question responses

Pre-training	
Please sum up the main thing you have learnt from this training in a sentence	11 (admin, management, receptionist, nurse, healthcare assistant)
What (if anything) do you think you might do differently as a result of this training?	21 (admin, receptionist, nurse, management, social prescriber, paramedic)
What had the biggest impact for you in the training?	12 (admin, mental health practitioner, GP, management, nurse, paramedic)

Follow-up	
What (if anything) have you been able to apply from the training in your day-to-day work?	14 (GP, management, admin receptionist)
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)	33 (receptionist GP admin nurse, management, pharmacist, healthcare assistant, social prescriber)
Please share any other thoughts or comments around the training and its effect on you and your team?	19 (admin, GP, management, receptionist, pharmacist, paramedic)

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