Kent and Medway
NHS and Social Care Partnership Trust

DEVELOPING SERVICES FOR PEOPLE WITH PERSONALITY DISORDER STRATEGY 2017- 2022

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RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

CONTENT

1. CONTEXT

KMPT provides a range of Mental Health and Social Care services to the people of Kent and Medway. This strategy sets out how we intend to improve our approach to working with people with personality disorders, their carers and families. It has been developed through consultation with people using our services, clinical staff and a range of external partners.

The strategy is set within the framework and principles described in the NHS Five Year Forward View for Mental Health (2016); and consider where services are delivered across Primary and Secondary Care and how we can deliver care integrated with other providers. We also recognise the Department of Health 2009 document 'recognising complexity: Commissioning Guidance for Personality Disorder Services'. This is based on learning from the National Personality Disorder programme. Commissioners called for improved:

- Recognition
- Assessment and Engagement
- Case Management
- Pathway Planning
- Community Services Partnership
- Mental Wellbeing and Pro-Social Behavior
- Recovery and Long-Term Social Functioning

The strategy is mindful of the evidence base, in particular relevant NICE guidance.

I recognise the good work happening in the organisation, for people with these diagnoses, and this strategy builds on this to achieve consistent offer of services across the whole geography of Kent and Medway to people with personality disorders:-

- Reducing inappropriate variation.
- Support Primary Care and Acute Hospitals in working with people with Personality Disorders.
- Improve information and support for family and carers.
- Improve information about personality disorder, its treatment and support available.
- Develop roles which use peoples lived experiences to enhance recovery.
- Improve long term care via SUN projects
- Increase alternatives to hospital admissions and minimize length of stay for those who have an admission, keeping care in the community.
- Support innovation and research
- Prevention of transgenerational mental disorder

Our Trust Vision

Excellent Care, personal to you – Delivering quality through partnership.

The Trust aims to deliver quality services through partnership, creating a dynamic system of care, so people receive the right help, at the right time, in the right setting.

Our Trust Values

Our values describe how we want people to experience us. They are designed to safeguard our practice and help us maintain a course of empathic support, accountability and continuous improvement.

Respect – *we value people as individuals, we treat others as we would like to be treated.*

Open – *we work in a collaborative, transparent way*

Accountable - *we are professional and responsible for our actions*

Working together – *we work together to make a difference for our service users*

Innovative – *we find creative ways to run efficient, high quality services*

Excellence – *we listen and learn to continually improve our knowledge and ways of working*

Our values are at the heart of this strategy and emphasise our passion for people and our respect for their equality and human rights. No person using our services will be excluded because of having a diagnosis of personality disorder.

The need for a Personality Disorder (PD) Strategy

Since the DoH publication, "Personality Disorder: No longer a diagnosis of exclusion" in 2002, signification improvements have been achieved in understanding how best to deliver PD services. We now understand that individuals can recover from many aspects of what is otherwise a debilitating and distressing disorder. There is an emerging evidence base regarding effective management and treatment approaches, nevertheless, staff lack confidence and skills in effective management, and are sometimes overwhelmed or avoidant in the face of complex presentations and unpredictable risk. Approaches which are effective for many forms of mental illness are not necessarily effective for PD, and alternative approaches need to be adopted in order to improve patient experience. PD is associated with significant risks to the individual and to others. In particular, the risks associated with the assessment of chronic and acute suicide risk. Episodes of comorbid mental illness (such as depression) are often missed in those individuals who are already diagnosed with PD.

Principles Underpinning this Strategy

We believe that people with personality disorders can find new ways to improve their health and wellbeing and fulfil their potential as active and equal citizens. Our focus is on recovery and empowering people to live meaningful lives with or without on-going symptoms of their condition.
We aim to:

- Create and sustain a culture of hopefulness that is focused on the pursuit of personal goals and ambitions;
- Support people to take responsibility and maintain a sense of control over their own lives and healthcare needs;
- Open up opportunities for people with personality disorders to build a positive identity and a life beyond illness.

This strategy sets out to ensure that people with personality disorders who use our services and their families are able to access high quality care in a timely and consistent way and within a kind and respectful environment.

2. UNDERSTANDING PERSONALITY DISORDERS

What is Personality Disorder?

PD can be viewed by professionals and patients and their families as a rather controversial diagnosis. However, there is agreement that personality difficulties can best be understood within a bio-psycho-social model. Biology, temperament and quality of care in the early years of life can all influence lifetime wellbeing. We know that growing up in an emotionally secure family with care-givers who are responsive to their children's needs can promote wellbeing, whereas family conflict trauma or poor care can mean children miss out on the benefits of a protective and secure attachment relationship. This in turn can affect the basic building blocks for healthy cognitive, emotional and social development. For some children these experiences negatively influence the way they think about themselves and over time can lead to the development of unhelpful and self-destructive relationship patterns. If this situation continues unchecked it can manifest as personality disorder and may even pass across the generations from parent to child.

Personality disorders are known to emerge in adolescence and continue through into adulthood. People experience significant and ongoing difficulties in their personal, social and occupational functioning which can be highly distressing and stigmatising for all involved. Personality disorders are characterized by longstanding patterns of difficulty across multiple domains of functioning, including cognition (e.g. unusual perceptual experiences, disruptions in the experience of self), emotion (e.g., excessive reactivity or intensity), interpersonal behaviour (e.g., social isolation, high-conflict relationships), and difficulties with impulse control (e.g., repeated engagement in high risk activities). Personality disorder is also associated with poorer long-term physical health outcomes, such as cardiovascular disease, poor nutrition and reduced life expectancy, as well as increased care costs due to frequent

attendance at GP surgeries, accident and emergency departments and acute mental health hospital admissions.

3. PREVALENCE AND SERVICE USAGE

Personality disorder has a prevalence of 5% of the general population, rises to 10% amongst those having GP consultations and estimates suggest that between 30-40% of people attending secondary care mental health community services and 40-60% of those in inpatient services will have personality disorder (coid, et al 2006).

The Personality Disorder Needs Assessment (2016) published by the Kent Public Health Observatory estimated numbers of patients with personality disorder in Kent from applied national prevalence rates to be 66,458 for a specific PD or 86,092 for an unspecified PD, meeting 10 of the criteria but not a specific diagnostic category.

	Mid-2014 Estimated Population	**Estimated Prevalence of Personality Disorder (4.4%)**	**Estimated Prevalence of Unspecified personality disorder (5.7%)**
UK	64,596,800	2,842,259	3,682,018
England	54,316,600	2,389,930	3,096,046
South East	8,873,800	390,447	505,807
Kent	1,510,400	66,458	86,092

Source: Adapted from: Coid et al. 2006-Prevalence and correlates of personality disorder in Great Britain.

The Medway Personality Disorder Needs Assessment (2016) commissioned by Medway CCG in collaboration with Medway Council identified the specific prevalence of personality disorder in Medway.

NHS Choices and NICE guidance prevalence estimates accord with the data provided in the 2007 Household Survey. Extrapolating the national estimated prevalence rates to Medway's population provides the following estimates for antisocial and borderline personality disorders

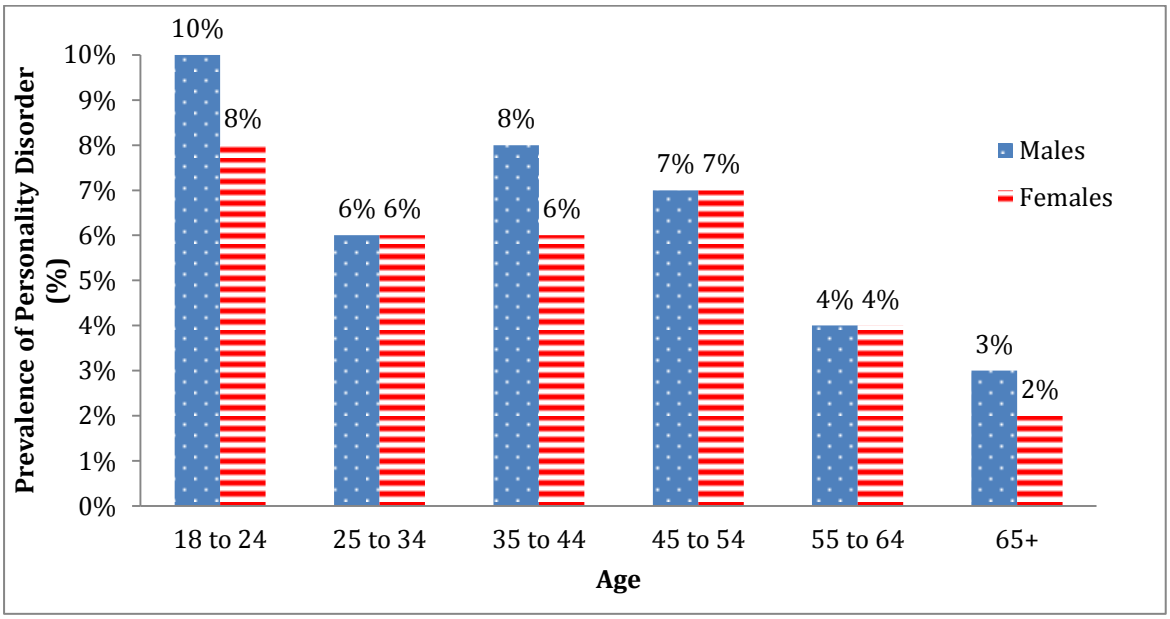
% Prevalence of antisocial and borderline personality disorders in Medway, and estimated number of cases based on 2014 population data

	Male % national	Male no. cases Medway	Female % national	Female no. cases Medway	Total % national	Total no. cases Medway
Antisocial personality disorder	0.6%	612	0.1%	106	0.3%	**718**
Borderline personality disorder	0.3%	306	0.6%	635	0.4%	**941**

Source: Adult Psychiatric Morbidity Survey 2007 and ONS population data 2014

There are many more who might benefit from some help.

Using prevalence data from an Australian survey it predicts that for Kent there is a higher prevalence in younger men and women and males aged 35-44, decreasing with age.



Andrews G, Hall W, Teeson M, Henderson S (1999). The Mental Health of Australians. Canberra: Commonwealth Department of Health and Aged.

Moran et al (2000) estimated 24% of patients accessing Primary Care have P.D. In Kent the trend for admission to Acute Hospital for those with a PD diagnosis recorded is increasing.

There is a marked difference in the rate of admissions by gender with women forming the significant majority of admissions. More research is needed to understand the gender difference.

Emotionally Unstable Personality Disorder (EUPD) or Borderline Personality Disorder (BPD) has the greatest percentage (58%) of admissions in Kent. Unspecified PD makes up 31%. There is a high number of emergency admissions.

Personality Disorder Diagnosis

We know that early identification and signposting to appropriate services can help people with personality disorders and their families to improve their health and wellbeing. Diagnosis is useful to ensure people get the services appropriate to their needs. There are two classification systems that are used to make the diagnosis of Personality Disorder (International Classification of Diseases-ICD and the Diagnostic and Statistical Manual-DSM) and these can be supported by a range of measures and structured interview tools. Broadly speaking, Personality Disorders can be broken down into 3 clusters:

CLUSTER A Odd Eccentric behaviour Bizarre thoughts Socially awkward	CLUSTER B Emotional Erratic Dramatic Relationship Struggles	CLUSTER C Anxious Fearful
Paranoid: Suspicious, distrustful and bears grudges	**Antisocial:** Disregard of other people's rights, lack of remorse, reckless and easily frustrated	**Avoidant:** Sensitive to rejection, low self-esteem and socially inhibited
Schizoid: Detached and prefers isolation	**Borderline:** Mood swings, identity confusion, unstable, intense relationships and impulsive	**Dependent:** Needs others to look after them and lacks self-confidence
Schizotypal: Strange beliefs, poor social skills and eccentric	**Histrionic:** Needs to be noticed, seeks attention and is dramatic	**Obsessive Compulsive/Anankastic:** Controlling, perfectionistic, rigid and preoccupied with detail
	Narcissistic: Has a sense of entitlement, can feel superior to others, and shows disregard and contempt for others	

ICD-11 is expected to be published soon and currently proposes the terminology of personality difficulty, personality disorder, complex personality disorder and severe personality disorder. Domains are proposed:

- Dissocial
- Anankastic
- Emotional Distress

Personality disorder is a broad term that covers many different presentations. It essentially refers to individuals who struggle to manage persistent and pervasive psychological difficulties which cause them and others great distress. We recognise that diagnosis does not give a perfect representation of the difficulties and needs a person experiences and it is not always a straightforward process. A high percentage of individuals diagnosed with one personality disorder can meet the criteria for another and can have additional mental and physical health problems that will need appropriate assessment and treatment (e.g. depression, substance dependency, psychotic disorders). The most commonly diagnosed personality disorders are antisocial personality disorder (ASPD) and borderline personality disorder (BPD). These are the only personality disorders where guidance on treatment and management is given by the National Institute of Clinical and Care Excellence (See NICE guideline 77 and 78).

Accurate data on the number of people diagnosed with personality disorder accessing our service is unavailable as ICD-10 codes have not been routinely employed. However, within the national care cluster framework, people with a personality disorder are most likely to be in cluster 8. Cluster 8 description is of non-psychotic chaotic and challenging disorders. The Trust's information management system for 2015/16 indicates that total bed days used by cluster 8 Adults was 22% acute, 18% PICU. 24% of contacts in Recovery Teams are cluster 8 and 32% of Crisis Home contacts. The total activity varies from 1% in Community Health Health Services for Older People (CMHSOP) to 41.1% (Mental Health Section) of 136 (presentation) (Emergency Police Power) assessments.

Specialist Commissioning at NHS England funds service for individuals diagnosed with personality disorder whose need for security and therapeutic intensity could not be met within the Trust, in specialist inpatient facilities.

4. CURRENT SERVICE DELIVERY

Information about the quality and effectiveness of current service provision for people with personality disorder was gathered from across the Trust stakeholders and from a summary of the key points is presented below:

- A broad range of NICE recommended interventions are available within the Trust but current pathways are unclear and service provision is variable across localities.
- Multiple or inappropriate referrals to different parts of the treatment system can occur.
- Decisions about which therapeutic intervention should be offered is often made by staff in care coordination roles who may not have sufficient knowledge about the most appropriate or effective treatment approaches.
- There is a lack of knowledge and understanding of personality disorders in some services, which can lead to an escalation in risky behaviours and result in crisis and the decision to make an inpatient admission.
- Professional consensus around the best way to deliver services is difficult to achieve
- People using services can experience delays to access appropriate treatment and care.
- People using our services may have to go through multiple assessments to access appropriate treatment and care.
- An individual's readiness to engage in specialist therapy is not well considered at assessment and can lead to high attrition rates or people being rejected from recommended treatments.
- Treatment and care approaches are under resourced.
- Non psychologist trained in delivering psychological interventions can be allocated to provide care coordination.

- Support services for carers and families can be variable across the Trust.
- There is insufficient opportunity for consultation and reflective practice to support staff in managing complex interpersonal dynamics and multiple risk behaviours often associated with personality disorders.
- More support is needed for positive risk taking to enable people to be managed in the community rather than through inappropriate inpatient admissions or costly specialist placements.
- There is a current lack of NICE recommended interventions for people diagnosed with Antisocial Personality Disorder.

It is clear that despite being able to offer a broad range of NICE recommended interventions for people with personality disorder, equity of access and consistent standards of care across the Trust's services have not been fully realised. This strategy is intended to provide a framework to ensure high quality and timely treatment and care is accessible to people with personality disorders who use our services, their carers, and families, integrated with Primary Care and other agencies, statutory, voluntary and private.

5. STRATEGIC AIMS AND OBJECTIVES

Our high-level strategic aims and objectives for the next 5 years are set out below and an implementation plans can be found in appendix 1. Performance will be monitored against the plan on a six monthly basis and wherever possible any barriers to implementation will be identified and addressed through this process. Progress will be reported to the Trust's Executive Assurance Committee.

5.1 A Compassionate and skilled workforce across KMPT, confident and competent in engaging individuals with PD in an informed and responsive manner. Service users can then expect to engage in a sensitive and helpful assessment, with care and crisis planning based on the best evidence to date, and to be offered a flexible package of care when appropriate.

5.2 **Equal Access** This group of people can still experience much prejudice. We want our services to be accessible to people with personality disorders and delivered close to the point of need and consistently across Kent and Medway. We aim to promote social inclusion by ensuring our care packages are age appropriate and sensitive to a range of factors such as people's gender, ability level, sexual orientation, and social, cultural and spiritual needs. We will continue to work hard to engage the most vulnerable in our society and improve access for underrepresented groups, such as those from minority ethnic backgrounds, and lesbian, gay and transsexual people. We will increase recognition of personality disorder by introducing standardised assessment and train our staff in its use so we can offer

treatments consistently and measure outcomes. We will improve access to evidence based psychological therapies and increase access and consistency of our therapeutic communities which offer day treatment services. We will work in partnership with people with personality disorder and their families to ensure good clinical care and shared decision making.

5.3 **Holistic Approach and Prevention** At the heart of our new strategy, we will deliver a psychologically informed care and crisis planning approach which will be based on a holistic needs assessment that takes into consideration the connection between mind and body, family and friends, community and environment. We will work closely with our partners across the statutory, voluntary and independent sectors and local communities to ensure a whole systems approach. Any young person who needs to transfer to our adult services will have a personalised transition plan and be supported through joint meetings between CAMHS and Recovery Teams.

We will ensure effective links are in place with our IAPT and Mother and Infant Mental Health services to promote maternal mental health during pregnancy and after birth and individuals with more significant mental health problems will be offered specialist targeted interventions through our secondary care services. A range of options for intervention will be available, and we will work collaboratively with service users to ensure that the right pathway is identified on an individualised basis.

5.4 **Physical Health** People with personality disorder are at increased-risk of experiencing poor physical and mental health. We will work with our partners to reduce risk factors for health problems and promote healthy lifestyle choices. Our workforce will take a proactive approach by using every contact as an opportunity to check health status and promote wellbeing.

5.5 **Family** The views and needs of children & families of people with a personality disorder will be carefully considered as part of our assessment and psychologically informed care and crisis planning processes. We will provide practical and emotional support to families and carers to help maintain their own health and wellbeing. This may mean working directly with families or navigating them to services offered by partner agencies. We will develop better quality specific information for family and carers and look to develop our family inclusion project to offer specific training and support. We will disseminate information about available treatment and support across our services and within Primary Care.

5.6 **Integrated Care Pathways** Our Personality Disorder services will be based on a model of stepped care. Everyone will receive a psychologically informed assessment, with a PD specific crisis and

care planning approach when this is appropriate. Not all service users will either want to engage in further interventions or will need to do so.

A stepped care model involves:

a) Feedback and signposting for those who do not require secondary care interventions or who do not wish to engage with interventions at this point in time.
b) Psycho-educational support to help with an understanding of the diagnosis and the associated difficulties.
c) Skills based interventions to help manage emotions and behaviours which cause distress.
d) Longer term more intensive interventions, including day care programmes for those.

In the first instance, we will work with our partners to ensure people's basic needs for living are met (e.g. housing, financial, occupational), to reduce risk, and to promote emotional and behavioural stability. For those most in need we will offer a range of targeted, high quality and evidence-based interventions. Service user support will cross tiers of healthcare from primary to specialist. We will consider what local development is required for Tier 4 Inpatient provision. We will improve long term open access community based support. We feel it is important to continue to promote recovery as part of our comprehensive risk assessment and management processes. We acknowledge that most people with personality disorder would prefer to have their needs met out of hospital and we will work with other organisations to deliver accessible and effective crisis advice and liaison services. Our overall goal is to reduce admission to our acute hospitals by providing timely and accessible support and treatment options earlier within the care pathways. Where admission is required we will be clear about the purpose, the agreed length of stay, and any risks that are likely to be increased by the individual being in hospital. At times some of the people we serve may need to rely on others to keep them safe and make decisions for them. We will work with families, carers and partners in other agencies to agree advance plans to keep people safe if they are too ill or lack capacity to direct their own care, reviewed in people's best interests and continually seeking to maintain the individual's dignity and human rights.

5.7 **Consultancy and Training** This strategy is based on strong partnership with Primary Care other agencies in the statutory, voluntary and private sectors. We will use our expertise to provide consultancy, training and advice to help our partners understand the management of personality disorders and ensure greater integration of care. It is essential to reduce unhelpful splitting between agencies that can give rise to poor, uncoordinated responses, especially for those individuals who pose a high risk of harm and suicide. We will offer support to colleagues in Primary Care to ensure support and appropriate referral.

5.8 **Outcome Focused** Our approach will be outcome focused and feedback from people using our services will be used to continually improve quality and safety. We will aim to improve health and wellbeing outcomes, reduce risk and people's reliance on emergency resources,

and promote access to employment, training or vocational activities. Service users will define quality of life for themselves and we will aim to support them in achieving it. This aim will deliver standardised care across KMPT, increased competence in Primary Care, link with the voluntary sector and develop its role in providing support to people with PD, reduce hospital admissions, reduce length of stay, enable recovery and support research to answer outstanding questions.

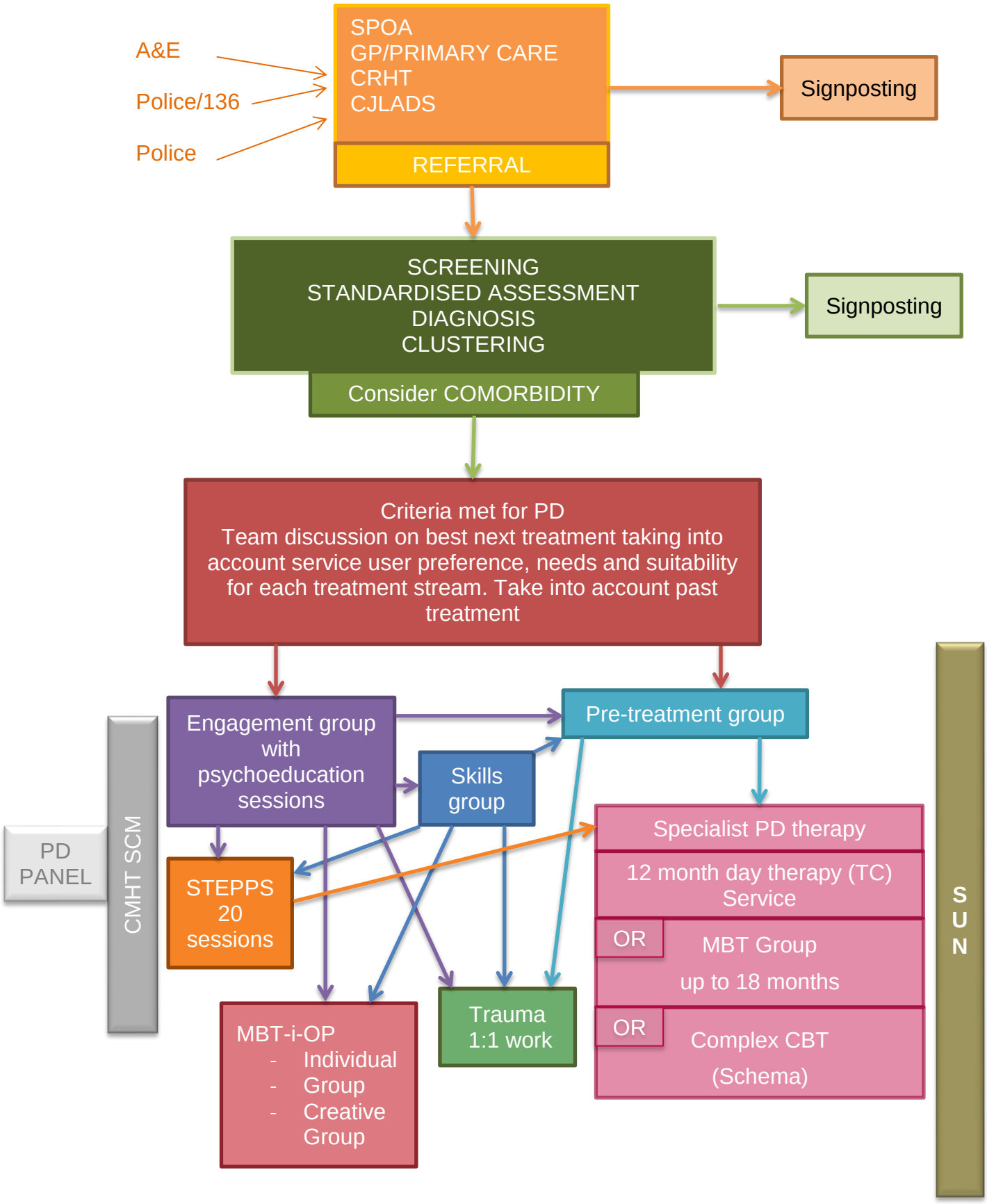
We will measure outcomes as a result of implementing this strategy ensuring our service users are:

- Treated in the right place
- Have easy access to services
- Have options according to their needs and wishes
- Attend more planned contacts with services
- Have fewer unplanned contacts
- Have shorter admissions where this has been avoidable
- Have reduced rates of self harm

By implementing the pathway as shown diagrammatically over leaf and described in stepped care above.

A complete operational model will be set out separately.

Figure 1: Community Pathway for PD



6. WORKFORCE COMPETENCES

We will adopt the competency framework for healthcare professionals working with people with personality disorders developed by Roth and Pilling, (2008). This is shown in figure 3 and includes generic and specific competencies.

- **Blue and orange shading**: Competences in these areas should be demonstrated by all staff providing interventions for people with personality disorders.

- **Green and yellow shading:** Competences in these areas should be demonstrated by healthcare professionals who have had the appropriate training and supervision to carry out the specific interventions.

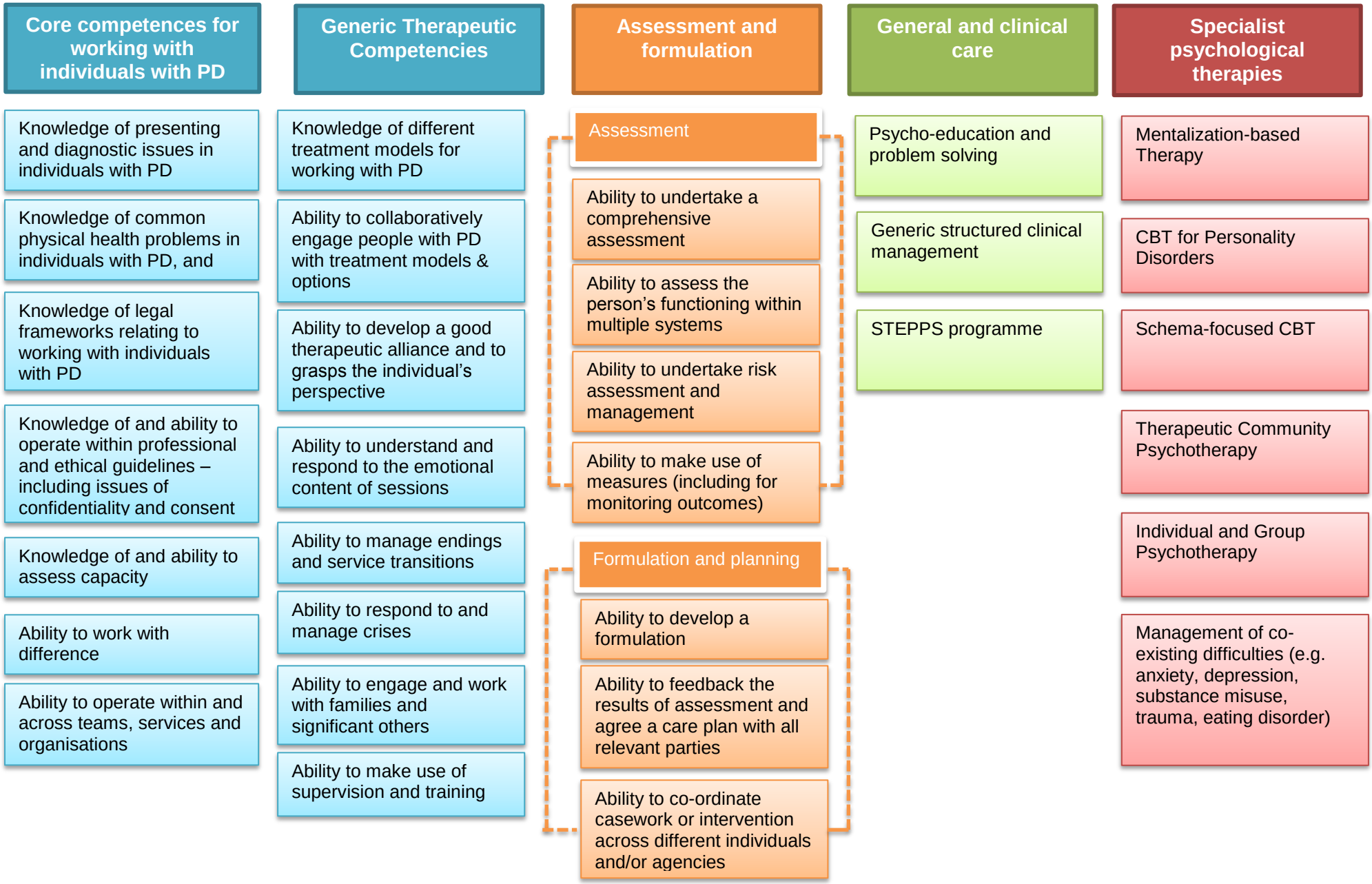
The competency framework will provide the following functions:

6.1 **Clinical Governance:** Monitoring the quality and outcomes of our interventions for people with personality disorder is a key part of our clinical governance activity. Embedding this competency framework will allow us to ensure that interventions are provided in a way that is most likely to bring about real benefits.

6.2 **Supervision:** Supervision and reflective practice are critical when working with people with personality disorders and we are committed to ensuring that our workforce is provided with regular, high quality supervision. The competency framework will be used to improve the quality of supervision by focusing on skills and attitudes that are known to be associated with the delivery of effective treatments and improved practitioner performance.

6.3 **Workforce Development and Training:** The competency framework will be used in staff appraisals and will provide a reference tool for formulating personal development plans and a workforce training curriculum. Effective training is vital to ensuring increased access to well-delivered, safe interventions and to support healthcare professionals who are working with people with highly complex needs.

Figure 3: Competency framework for working with people with Personality Disorder (PD) - (based on Roth and Pilling, 2008)



7. BENEFITS REALISATION

The benefits of implementing this strategy are set out in the following table.

Table 1: Benefits Realisation

Benefits	Commentary
Strategic	Drives forward the Trust's strategic focus on prevention, diagnosis, early intervention, holistic care, and recovery, thereby improving general health and wellbeing of the communities we serve. The Strategy will enable more specialist and recovery focused work at an earlier stage of people's journey into our services. The will prevent people becoming stuck in services as well as decreasing the number of inpatient referrals and the need to commission specialist external services.
People/Services	The care pathways will improve access to evidence-based treatments and care that aims to improve wellbeing and support recovery for people using our services. This includes both mental and physical health improvements. Think family is a key objective of the strategy to encourage more joined up thinking about the needs of the whole family system and not just the person accessing our services. The Personality Disorders Strategy emphasises protective work in the perinatal period to improve health outcomes for children and families.
Quality, Safety and Efficiency	The aim of the Personality Disorder Strategy is to deliver better clinical care in a more timely way and to manage more people within community services. Increasing workforce skills and extending evidence-based interventions will improve the quality and safety of services. We intend to build a culture of reflective practice by developing a robust programme of staff supervision and support using expert practitioners. This will have a positive impact on working practices and staff wellbeing. The pathways include clear step-down options to support people moving out of our services and to reduce re-referral rates. There are also step-up options to ensure appropriate and evidence-based interventions are delivered in a timely way.
Innovation, Business and Research	The Personality Disorder Strategy incorporates innovative ways of working in partnership with a voluntary sector partner. The development of a more coherent and evidence-based approach to working with people with personality disorder may provide future opportunities to increase our market share in this area. There is an opportunity to bid for research funding to address important questions on this patient group.
Reputational	Ensuring an accessible, consistent and effective approach to working with people with personality disorders and their families will produce reputational benefits for the Trust and promote future successes.
Collaborative	Key to our Personality Disorders Strategy is closer working

	with partners in the statutory, voluntary and private sectors. We aim to provide a more integrated approach to care planning and to build on the training we already provide to other organisations in Kent and beyond. One of the essential aims in the strategy is to develop a Service User Network Group with a voluntary sector partner.
Workforce	Adopting the competency framework will make it easier to highlight skill gaps within our workforce and to develop a blended programme of training. We will work with Kent, Surrey and Sussex Health Education England and Canterbury Christchurch University as well as notable academics and trainers to pursue funding opportunities to support a workforce development programme.

8. STRATEGY IMPLEMENTATION MILESTONES

The strategy implementation plan is described in table 2. It is proposed that a project implementation team should be set up to develop a detailed implementation plan and oversee the delivery of the strategy.

The implementation plan will be monitored by the Executive Assurance Committee (EAC) on a six monthly basis.

A risk assessment is included at table 3 and will be further developed with detailed financial plan for business case.

Table 2: Strategy Implementation Plan

2017	MAY	JUNE	JULY	AUGUST	SEPTEMBER
Trust Board Approval					
Form Project Implementation Team					
Gather Baseline Service Data					
Communication Plan					
Project Implementation Plan Report To EAC					
Commissioner Engagement					
Broader Stakeholder Engagement					
Establish Support Group Partnerships					
Develop Training Plan (inc. HEKSS Bid)					
Reallocation of resources					
Deliver Training Plan					
Identify Quality and Outcome Metrics					
Develop Year 1 Evaluation Plan					
Launch					

KEY	
Milestone	
Plan/Design Phase	
Engagement Phase	
Implementation	

9. RISK ANALYSIS

Some of the key risks associated with implementation of the Personality Disorders strategy are described below along with suggested mitigation.

Table 3: Risk Analysis

Risk	Probability	Impact	Action to Reduce/Manage Risk
There is insufficient data to enable full financial modelling and to support a cost-benefit analysis of the redesign proposal at this time.	High	High	Key deliverables for the quarter include a period of intelligence and data gathering to support the implementation plan. Further assurance will go to EAC
Insufficient service information to forecast demand and capacity.	High	High	A more sophisticated demand and capacity analysis us needed for the project implementation plan.
Insufficient understanding of workforce competence	Medium	Medium	We know there are a broad range of specialist competencies within our existing workforce that support delivery of NICE recommended interventions for people with personality disorder. However, the level and location of competencies requires further mapping. As such, a gap analysis will be conducted across WAA services based on the competency framework and findings will inform the workforce redesign and training plan. These details will be included in the project implementation plan.
Failure to secure stakeholder buy-in	Medium	High	A communication plan will be generated and needs to consider the following: 1. There has been significant engagement in the development of this strategy but wider engagement is recommended, especially our Commissioners. Some discussion has already taken place and there are opportunities to build on this going forward. 2. People who use services,

			their carers and families need to be involved in the implementation planning for strategy delivery and have a role in overseeing the progress.
Failure to implement the strategy.	Low	High	The implementation plan and EAC will ensure delivery of the strategy.
Destabilising existing services that are already working well.	Low	Medium	Although there are areas of excellent practice within the Trust, problems with access and consistency are prevalent. The strategy has been developed to build on what works well and improve quality. An effective communication plan will be required to build momentum for change and enthusiasm for the strategy.

10. SUMMARY AND RECOMMENDATIONS

This strategy sets out to ensure that people with personality disorder who use our services and their families are able to access high quality care in a timely way and within a kind and respectful environment. We believe that people with personality disorders can find new ways to improve their health and wellbeing and fulfil their potential as active and equal citizens. Our focus is on recovery and empowering people to live meaningful lives with or without on-going symptoms of their condition. The proposed care pathways offer time limited, evidence-based interventions that are tailored to meet the needs and capacity of the individuals using our services. The strategy supports greater integration between partner agencies, people using services and their families to ensure we are taking a joined up approach to care planning and meeting people's needs. The Executive Board is asked to approve the direction of travel set out in this strategy to enable Working Age Services to move onto the implementation planning phase.

Dr Catherine Kinane
Executive Medical Director

APPENDIX 1 KEY DELIVERABLES

April 2017 – June 2017	May 2017 – April 2018	April 2018 – March 2019
Provide detailed systematic intelligence on current services for people with Personality Disorder accessing WAA services: • Numbers diagnosed • Patient flows • Workforce capacity and competence • Risk management processes • Resource usage – e.g. A&E, Crisis Line, HTT, GPs. • Outcomes • Stakeholder satisfaction	Develop steering group (including internal members, people using services and other key stakeholders) to oversee the implementation of accessible and equitable services for people with personality disorder across the Trust.	Report of year 1 outcomes to the May 2018 Executive Board and recommendations to support service improvement.
Produce detailed implementation plan to take forward the Trust's Personality Disorders strategy	Increase capacity of CMHT workforce to conduct robust assessments, formulations and risk management plans, to provide a range of treatments to a range of PD diagnoses.	Steering group provide continued oversight to ensure integration of the Personality Disorder Strategy in business as usual.
Produce a communication plan to support the Personality Disorder Strategy and take forward key stakeholder engagement events.	In line with national prevalence rates, make diagnosis of personality.	In line with national prevalence rates, make diagnosis of personality.
Resource reallocation to provide sufficient local coverage and to maintain highly specialist provision.	Improve data capture by ensuring diagnosis, care plan and risk is recorded in the electronic patient record of all patients on the personality disorder pathways.	Diagnosis, care plan and risk is recorded in the electronic patient record of all patients on the personality disorder pathways
Develop and deliver workforce training plan. This includes training in generic competencies and NICE recommended therapeutic interventions.	Demonstrate involvement of families in care planning.	Families are involved in the care planning process and support packages are delivered consistently across the CMHT's.
Integrate the Personality Disorder competency framework into ESR to monitor skill development as part of the annual appraisal process.	Develop a consistent approach to psycho-education and structured clinical management groups across the Trust.	Care planning involves other partner agencies to ensure a joined-up and integrated approach tailored to the individual's needs and those of their carers/families.
Develop and implement the Service User Network Group with a voluntary sector	Establish joint planning and intervention processes for delivering coherent and NICE recommended	Outcome evaluation of the Service User Network demonstrates it provides an effective

partners.	interventions for people with a diagnosis of Anti-social Personality Disorder and those diagnosed with other Personality Disorders who have co-morbid difficulties (e.g. substance misuse or eating disorders).	step-down facility that is easy to access and able to manage risk by working in a timely and safe way by working closely with other relevant agencies.
Develop, The App.	Demonstrate integrated pathways with statutory, voluntary and private sector partners to improve the care planning process. This includes closer working with GPs and Primary Care Mental Health Workers	Regular consultation offered to support CRHT staff and those working on inpatient wards with people with highly complex needs. The PD Panel will continue to provide advice about the appropriateness of commissioning external specialist placements. The effectiveness and accessibility of consultations will be evaluated.
Identify quality and outcome metrics and develop year 1 evaluation plan.	Work with voluntary sector partners to deliver the Service User Network group and show clear step-down processes from Trust services to the group.	Reduce the number of admissions of people with a diagnosis of Personality Disorder to the Trust's acute inpatient wards by at least 30% from the previous year. Where admission is required, a clear rationale and discharge plan will be recorded in the electronic patient record.
Launch the Trust's redesigned Personality Disorder Services.	Establish the PD Panel and develop the standard operating procedure to ensure ease of access and effective support for staff working in CRHT/CMHT and inpatient wards with people with complex needs. The consultation group provides advice about the appropriateness of commissioning external specialist placements for individual's on the Trust's Personality Disorders pathways. The effectiveness and accessibility of consultations will be evaluated.	Reduce the average length of stay of people with Personality Disorder admitted to the Trust's inpatient wards by 25% from the previous year's levels. This will be a performance metric for cluster 8 patients.
Develop the care pathways to begin repatriation of people receiving services outside the Trust. Aim to return a targeted number each year.	Ongoing repatriation.	Continue to deliver rolling programme of training via the Learning and Development Plan. This will involve a blended approach of e-learning, taught workshops and external training. Evaluate the impact of training.
	Reduce the number of inpatient admissions to the Trust's acute wards for people with personality	Reduce the number of people with Personality Disorder who require specially

	disorder by at least 20% from the previous year. Where admission is required, a clear rationale and discharge plan will be recorded in the electronic patient record.	commissioned external inpatient or community provision by at least 10% from the previous year. People with highly complex needs may require services commissioned outside of the Trust due to the need for a secure placement offering intensive therapy. Only those meet the national criteria for tier 4 placements will be eligible for NHS England Specialist Commissioning provision.
	Deliver expert consultation via PD Panel to inpatient ward staff working with people with Personality Disorder to reduce the average length of stay by just over 25% (target for all patients is 21 days)	Negotiate reinvestment of savings in the specialist commissioning budget into the Trust's CMHT provision and Service User Network Group.
		Supervision, annual appraisals and professional development plans of staff working with people with personality disorders will include the competency framework and be recorded on ESR.
	Negotiate reinvestment of savings in the specialist commissioning budget into the Trust's CMHT provision and Service User Network Group.	Complete year 2 evaluation of health and wellbeing outcomes, service experience, risk reduction, emergency resource use and access to employment, training and/or vocational activities.
	Deliver rolling programme of training via the Learning and Development Plan. This will involve a blended approach of e-learning, taught workshops and external training for highly specialist therapy skills. Evaluate the impact of training.	
	Supervision, annual appraisals and professional development plans of staff working with people with personality disorders will include the competency framework and be recorded on ESR.	
	Complete year 1 evaluation of health and wellbeing outcomes, service experience, risk reduction, emergency resource use and access to employment, training and/or vocational activities.	

APPENDIX 2 EQUALITY & HUMAN RIGHTS IMPACT ANALYSIS

Title: Developing Services for People with Personality Disorder Strategy 2017-2022
What are the intended outcomes of this work? As set out in the strategy

Sex - Consider and detail (including the source of any evidence) on men and women (potential to link to carers below). No impact
Race - Consider and detail (including the source of any evidence) on different ethnic groups, colour, nationalities, Roma gypsies, Irish travellers, language barriers. No impact
Age - Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare. No impact
Gender reassignment (including transgender) Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and bullying & harassment. No impact
Sexual orientation - Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people. No impact
Religion or belief - Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief. No impact
Pregnancy and maternity - Consider and detail (including the source of any evidence) on working arrangements, part-time working, and infant caring responsibilities. No impact
Carers - Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities No impact
Other identified groups - Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, drug users resident status (migrants) and other groups experiencing disadvantage and barriers to access. No impact

Implementation of the strategy will improve services for Service users and reduce inappropriate variation.

What is the overall impact? Improved service provision
Summary of Analysis Positive impact for Service Users and Carers
Advance equality of opportunity Improve services for all Service Users
Addressing the impact on equalities None identified
Action planning for improvement: The strategy implementation will be monitored including protected characterisation
Objectively Justify[1] decision not to take action to address some of the inequalities identified.

[1] Objective justification
An objective justification allows an employer to discriminate both directly and indirectly on the basis of age. They must, however, show that this discrimination is 'proportionate' and contributes to a 'legitimate' aim.

assessment Plans already under way or in development to address the challenges and priorities identified. Arrangements for continued engagement of stakeholders. Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses) Arrangements for embedding findings of the assessment within the wider system, EDS Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results Arrangements for making information accessible to staff, patients, service users and the public Arrangements to make sure the assessment contributes to reviews of KMPT's strategic equality objectives
For the record Name of person who carried out this assessment: Date Screening was completed 18.05.2017

Equality Impact Assessment Lead:	Signed: 	Date: 18.05.2017
Equality & Diversity Steering Committee	Signed:	Date

Acknowledgments*

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- Lona Lockerbie (Director of Forensic and Specialist Services)
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- Ash Eton Service Users
- PD Service Staff
- Finance
- Performance Team
- Whole Systems Steering Group
- EAC
- CCG representatives
- Quality Committee