Nottingham and Nottinghamshire ICS

Personality Disorders

Clinical and Community Services Strategy

March 2021

This information has been placed in the public domain in order to benefit patients across the country as we believe the experience and approach may be useful for others, however we request that acknowledgement to the work in Nottinghamshire is made and referenced in all materials. This helps us to understand the wider impact benefits of our programme. Please cite 'this work has been informed by the Nottingham and Nottinghamshire ICS' when referencing.

Contents

1. Executive Summary

The Integrated Care System (ICS) ambition across Nottinghamshire is to both increase the duration of people's lives and to improve the quality of those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The aim of the Clinical and Community Services Strategy (CCSS) is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention, delivered in people's homes or in community locations where this is appropriate with a long term view of beyond 5 years.

Each individual is defined by a unique personality made up of attitudes, behaviours, moods and thoughts and the way these traits are expressed when interacting with others and the environment around people all defines an individual's personality. Some characteristics of an individual's personality are inherited and some are shaped by the one's life, events and experiences. Personality disorders (PD) are often developed when certain personality traits become uncompromising.

When long-standing patterns of thinking and acting differ from what most people would consider as normal, this is normally considered as a PD. This uncompromising behaviour can cause distress and may interfere with many aspects of life, including social and work functioning. People with a PD generally also have difficulty in coping and in forming healthy relationships. With some mental health problems the individual will know they have a problem, but are unable to control it, such as anxiety. However, people with a PD are generally not aware of having a problem and so believe they have nothing to control and for this reason they rarely seek treatment.

The NHS Long Term Plan (LTP) makes strong reference to ensuring improvements are made in the integration of health and social care and in particular access to mental health (MH) services. For many people living with long term conditions (LTC) such as diabetes, COPD, sight loss or heart disease, it is crucial to have early and the right timely support to recognise signs of MH alongside the physical health condition and better manage their physical and MH and understand the interplay between the two.

PDs are very complex and often only receive a formal diagnosis in the longer term. This presents issues with how behaviours and traits are perceived by others, again due to the little knowledge and awareness the population have of PDs, this review explores ways in which this can be improved and consequentially how treatments and support for those with a PD can be better accessed.

This PD service review has been undertaken as part of the ICS CCSS work stream. It has been supported by clinical experts and stakeholders in the development of place based service models for the future, to support the long term needs of our existing citizens. The review also focuses on embedding prevention in our population over the next 5-10 years, by shifting our culture from one of illness to one of healthier lifestyles and self-care, but one that recognises the importance to consider MH equally to physical health.

The strategy identifies major stages in the journey of those with a PD and stresses a need to reorganise the way in which these services are delivered, from early access to support through to longer term support for those at highest risk that are living with MH issues. A whole pathway approach in the provision of PD services is crucial in order to maximise the clinical and mental wellness outcome for patients, their quality of life and experience of PD services.

Fundamental themes have been identified along with key transformational opportunities and potential impacts have been developed which include: prevention strategies to promote mental wellbeing, healthy living and independence; improved access & shared communication about patients' past medical history from secondary care settings to community and primary care; appropriate treatments for adults with PD accessible across the ICS; standardise access to services through improved integration between secondary and primary care with a strong focus on both physical and MH care.

A transformational 'Bridge to the Future' highlights current service offers across the ICS and identifies some potential long term next steps that can be taken to achieve the identified opportunities with proposed timelines and the expected outcome for our citizens of Nottinghamshire.

The recommended next steps are vital in keeping the momentum of change in the future offer of improved prevention and better mental wellness for our citizens; providing the right tools for our population to support their wellbeing; providing strong communication links for our staff is vital to enable them to provide the best care for our citizens; the most appropriate models of care in hospital settings, neighbourhood and home need to be provided equitably across the ICS and be provided using best evidence, flexibly and in a patient centred holistic way for them to fulfil their maximum potential throughout their lifetime.

2. Introduction

Background and Purpose	In Nottinghamshire we have made great progress in improving people's health and wellbeing. Today, we can treat diseases and conditions we once thought untreatable. However, our health and care system faces change and this will impact on our services, for example, the growing prevalence of long-term health conditions places new strains on our system. There is inequality evident in both the location of services and in access to services. In some areas, it is easier to access a GP or than in others, or to find things to do to enable citizens to stay active and fit. The ICS ambition across Nottinghamshire is to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The requirement for a CCSS came from the recognition that to achieve this ambition the system has to change as a whole, rather than just in its individual acute, primary care, community and social care elements. It is recognised that only by working together to describe changes in how care is provided across the system, rather than through individual organisations, will we deliver the scale of change required.
The ICS Clinical and Community Services Strategy	The aim of the CCSS is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention. This should be delivered closer to people's homes or in community locations where this enables better prevention, more supported self-care and earlier intervention to support citizens. The Strategy recognises that achieving this change is a long term programme that will be delivered over the next 5 years and beyond. This is also to enable a necessary long term investment in the health and care buildings and infrastructure in the system. An overall CCSS whole life model framework has been developed to focus on the need to support people through their lives from living healthy, supporting people with illness and urgent and emergency care through to end of life care. Citizens can experience different parts of the system at different stages in their lives. With the development of the overall Strategy framework the next phase of work was to review the 20 areas of service across the ICS that collectively form approximately 80% of the volume of clinical work in the ICS. This ensures that overall the Strategy is described as a coherent whole and generates a programme of change for the whole ICS. This review of PD Services provides the opportunity to be such a review and is part of the final phase of work.
NHS Long Term Plan	The NHS LTP is clear that to meet the challenges that face the NHS it will increasingly need to be more joined up and coordinated in its care; More proactive in the services it provides; More differentiated in its support offer to its individuals. The ICS has focused on describing 5 areas of focus for the delivery of the NHS LTP. These requirements are reflected in each of the service reviews that collectively will describe the CCSS **1. Prevention and the wider determinants of health -** More action on and improvements in the upstream prevention of avoidable illness and its exacerbations **2. Proactive care, self management and personalisation -** Improve support to people at risk of and living with single and multiple long term conditions and disabilities through greater proactive care, self-management and personalisation **3. Urgent and emergency care -** Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting **4. Mental health** - Re-shape and transform services and other interventions so they better respond to the MH and care needs of our population **5. Value, resilience and sustainability -** Deliver increased value, resilience and sustainability across the system (including estates)

3. Approach and Scope

Approach	This strategy has been developed through an open and inclusive process which weaves together the expertise of clinicians and care experts with commissioners and citizens in determining the future shape of services across the system. There have been a variety of stakeholder and service user events to develop a clinical and community services model. An extensive system wide piece of work is taking place across a minimum of 20 services. The CCSS Programme Board have reviewed these services against a range of quantitative and qualitative criteria and agreed the final phase of three service reviews. These include ENT and Hearing Services, Personality Disorders and MSK to Elective Orthopaedic services. This document discusses the approach, scope, the key issues and potential transformational opportunities within PD services across the ICS. Health, social care, public health and the voluntary sectors have all been considered through reviewing the current service offer across the ICS. The service review was taken over approximately 10 weeks and there were two workshop held with stakeholders from across the ICS. An evidence review pack was developed which considered national and local best practice to inform the development of potential themes and new models of care where transformational change may take place across the ICS in the future.
Scope	PDs as a service is quite complex with far more breadth than some of the healthcare services reviewed. This review describes key areas of attention that further work can build upon with the respective engagement. The recommendations articulate those areas of focus that were evidenced through the process as areas of significant issue that can be further shaped with the level of detail required. The following focus was agreed in the scope of this review: **In scope:** • Cluster B will be the main focus of the review: ▪ Cluster A – Odd or Eccentric (paranoid, schizoid, schizotypal) ▪ Cluster B – Dramatic, Emotional or Erratic (antisocial, emotionally unstable, histrionic, narcissistic) ▪ Cluster C – Anxious and Fearful (obsessive-compulsive, avoidant, dependent) • Adult services (including transition) • Care and shared care provided or commissioned by health (primary, secondary, tertiary) and social care services • Care and support provided by VCSEs/ 3rd Sector organisations **Not in scope:** • Specialised commissioned services – such as Rampton • Paeds/ (ACEs in scope for early detection)
Engagement	The PD service review has been supported by a tailored PD Steering Group involving stakeholders and clinical experts from across the ICS. They have provided expert advice, guided, confirmed and challenged assumptions throughout the period of review and connected to other workstreams. This group has formed part of the governance process along with the CCSS Programme Board. Two virtual workshops have been held enabling a wide breadth of stakeholders (Psychiatrists, GPs, Psychologists, mental health nurses, allied health professional (AHP), voluntary 3rd sector groups, Heads of Service, Social Care, Public Health, Commissioners and others) to be proactively involved in re-evaluating current service offers across the ICS, in developing potential themes and agreeing transformational change for the future Clinical and Community Services Strategy. In addition a patient focus group was attended, organised by ABBA representatives in collaboration between Opportunity Nottingham Beneficiary Ambassadors, Services for Empowerment and Advocacy (SEA), the CDP Service User Involvement Officer. Citizens that attended included those with lived experience of MH issues. This helps play an active part in the co-design of any future service changes across the ICS.

4. Content

Strategy Development	This Strategy Document consists of five key elements. These have been developed through a process of design and iteration at the workshop and steering group meetings and includes key stakeholders from across the system. The strategy has been developed with reference to the Evidence Review document and the patient focus group that has been held.
Priorities for Change	The work of the Steering Group and the workshop stakeholders identified and confirmed four key areas of focus that need to change in the ICS for PD care. These were based on a review of the current issues facing the ICS and the views of the Steering Group and workshop attendees. Some service user experience has also been incorporated into the development of the strategy.
Proposed Future Care System	Following the initial engagement, at subsequent steering group meetings, attendees started to develop the future care system for PDs to address the Priorities for Change. The future care system is described against two dimensions and aligned to the stepped care model: • **Location** split between - Home (usual place of residence) – Hospital (including both acute and MH) with 24/7 medical presence – Neighbourhood representing all community/primary care and ambulatory care settings • **Urgency** split between - **Emergency/Crisis** requiring a service provided 24/7 to avoid crisis or risk to life – **Urgent** requiring a service 7/7 but not 24/7 to meet urgent care needs – **Planned/Scheduled** reflecting any arrangement where an appointment is agreed between a professional and a citizen The intention of the system model is to focus future care delivery closer to home and also with greater levels of scheduled care to best use the available resources and reduce demand on urgent and emergency care services. The new system to address the Priorities for Change is presented for each location and then summarised overall for the ICS.
Transformation Proposal	The Transformation proposal describes the key initiatives or programmes that are required to deliver this new mode. As described earlier, for PD services, some of these programmes need to be developed in more detail. Namely, • **Priority** – What is the priority of the initiative in the view of the steering group and workshop attendees • **Alignment** – At what level of the system should we aim for a consistent approach for each initiative? This was split into two categories: ▪ Alignment to achieve **consistency** - In most instances this is ICS or Integrated Care Provider (ICP) level where with the greater value is perceived to be in an overall consistent approach. ▪ Alignment for **delivery** of the proposal - There are some instances where the recommendation is for delivery to be at ICP level, alternatively, it is at Primary Care Network (PCN) level where differential delivery would benefit the needs of very local populations • **Enabling Requirements** – What is required to enable each Programme to deliver? This includes workforce, technology, estate or service configuration. There are also requirements of culture or finance and commissioning to allow the system to work together differently • **Benefits and Costs** – Where available, the key benefits of the initiative at system level are summarised
Service Vision	The 'Bridge to the Future' was generated at a further virtual steering group meeting. It summarises the current challenges for the PD system in the ICS now (Priorities for Change), what the ambition is and the outline steps to get there. Progress with the 'Bridge to the Future' and the partnering vision can be returned to with stakeholders as the work develops to review progress.

5. Priorities of Change - Personality Disorders Key Themes

Prevention & Self-help

- Education for non-judgemental practice in validating patients/ Stigma
- Coping mechanisms
- Raising awareness/ Education for all (population, workforce, patients)

Assessment & Understanding of Need

- Early recognition (ACEs)
- Chaotic lifestyles
- Areas of difficulty
  - Substance/alcohol misuse
  - Disordered eating/ Eating disorders/
  - Breakdown (housing/ debt)
- Self-harm/ suicide
- Patient Presentation (including emergency settings)

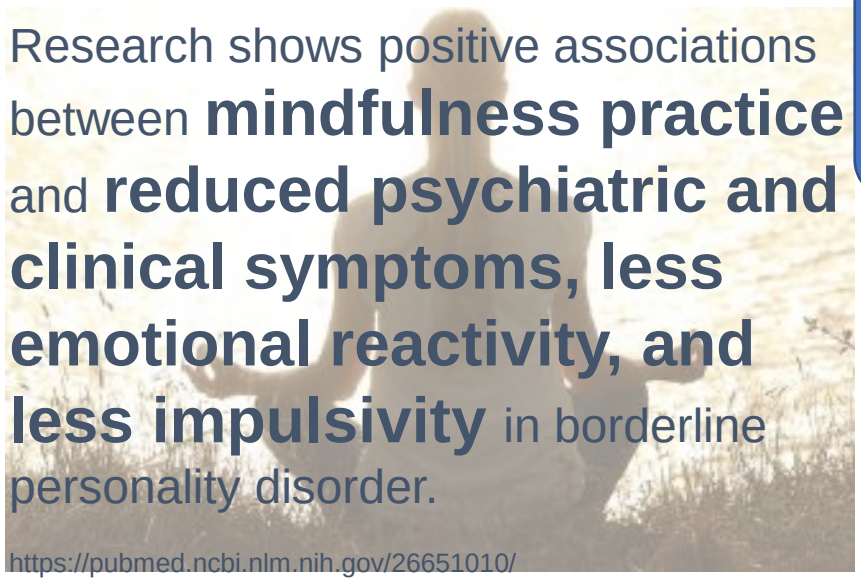
Models of Care

- Emotional instability
- Impulsivity
- Interpersonal difficulties
- Health Inequality, accessibility and inclusivity
- Community provision

Whole System Approach

- Voluntary sector, Criminal Justice and Social Care
- Collaboration/ Integration (MECC principle)
- Quality of Life

Stigma can sometimes come from the professionals themselves whether intended or not MIND



Research shows positive associations between **mindfulness practice** and **reduced psychiatric and clinical symptoms, less emotional reactivity, and less impulsivity** in borderline personality disorder.

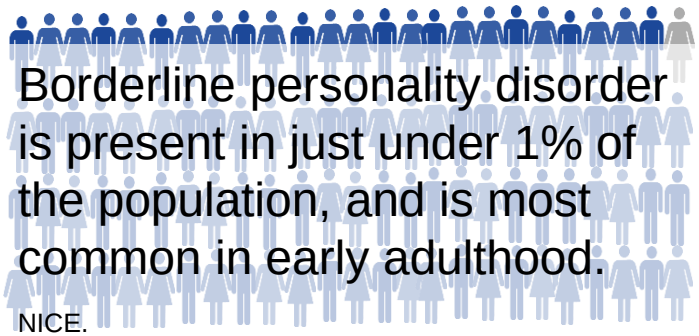
https://pubmed.ncbi.nlm.nih.gov/26651010/

The stigma of being violent and dangerous is the worst for me. I am a caring and empathetic soul who would do anything for the people I love. MIND

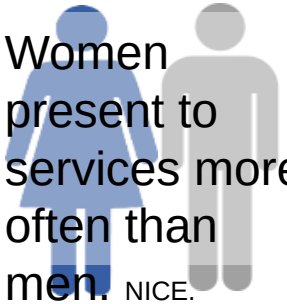
The diagnosis of 'personality disorder' can be controversial because:

- Specialists disagree about how to understand personality disorders
- It doesn't take social context into account enough
- The term itself can be stigmatising

MIND

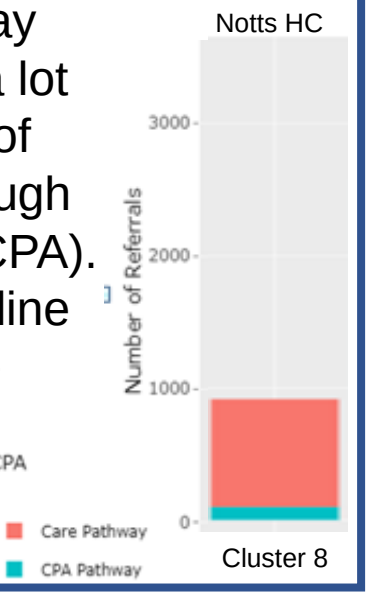


Borderline personality disorder is present in just under 1% of the population, and is most common in early adulthood. NICE.



Women present to services more often than men. NICE.

Having a personality disorder may put you at risk, mean you have a lot of needs, and need a high level of care. You can be supported through the **Care Program Approach** (CPA). The CPA is used to plan and outline the support you need to manage complex needs and your mental health.



Community surveys from Europe and worldwide show high prevalence of rates of

- physical abuse (22.9%),
- emotional abuse(29.1%)
- sexual abuse(9.6%)
- physical neglect (16.3%)
- emotional neglect (18.4%).

This is not accounting for unreported cases.

Mental disorders in individuals with ACEs are thought to develop earlier accompanied by more severe symptomology, increased risk of comorbidity and are less likely to respond to standard treatment

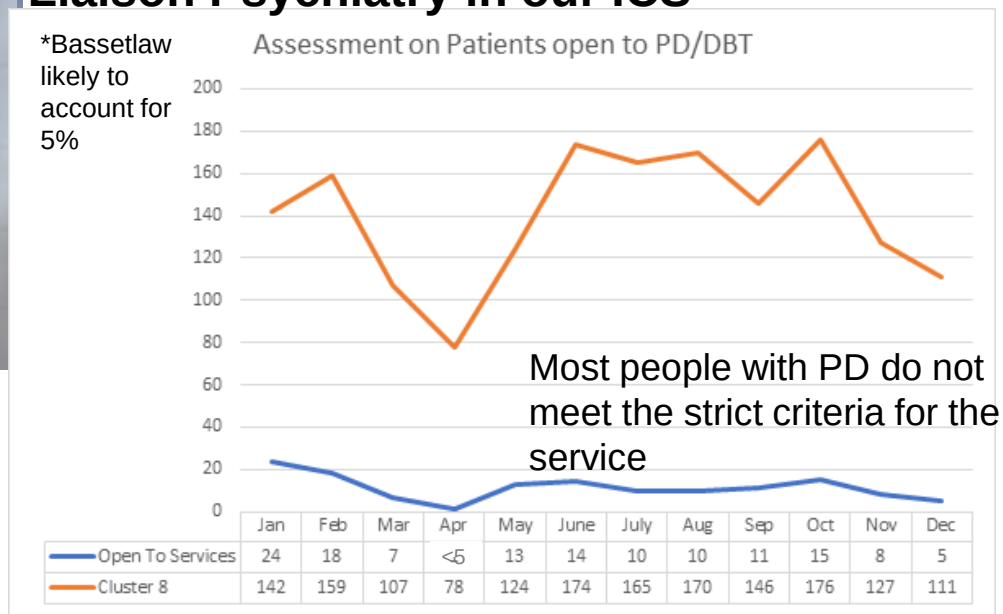
WHO Europe

Obsessive compulsive PD in anorexia nervosa at 22% is far above general population rate of 8%

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3074200/

Liaison Psychiatry in our ICS*

*Bassetlaw likely to account for 5%



	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Open To Services	24	18	7	<5	13	14	10	10	11	15	8	5
Cluster 8	142	159	107	78	124	174	165	170	146	176	127	111

In partnership with Notts Healthcare Trust, Nottinghamshire Mind has developed a Resilience and Stabilisation (R&S) programme that provides information, support and guidance on mental health issues to those referred by LMHT clinicians.

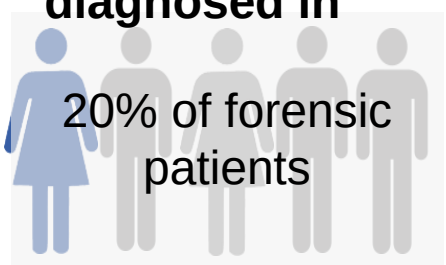
The current level of investment has been extended to now provide a 15-month programme for individuals as follows-

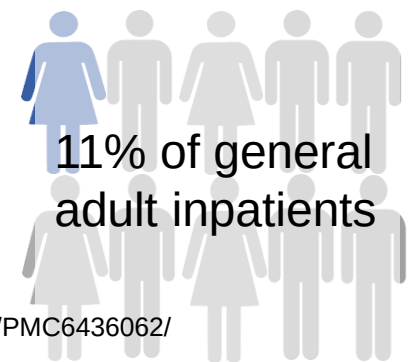
Bassetlaw – 75 referrals
Mansfield – 75 referrals
Newark & Sherwood – 75 referrals
Ashfield – 75 referrals

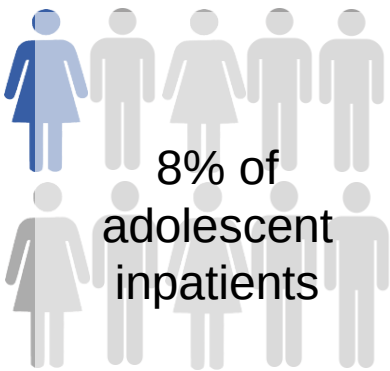
Data per District as of 31st October 2020

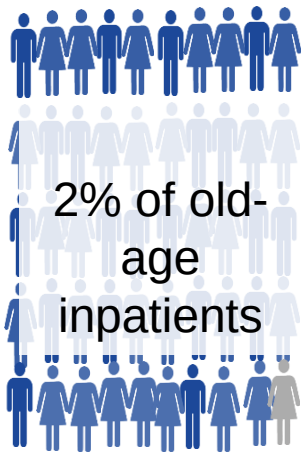
District	Total Referrals to programme	Engaged with programme	Exited from programme	Navigated & Waiting full programme	Awaiting Navigation to programme
Ashfield	75	43	9	11	12
Bassetlaw	132	39	25	18	50
Mansfield	85	42	12	6	25
Newark & Sherwood	88	42	13	10	23
TOTALS	**380**	**166**	**59**	**45**	**110**

Personality Disorder diagnosed in









https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6436062/

5. Priorities for Change

The review identified 4 key areas of focus highlighting potential areas of change which include:

- Prevention and Self-Care (with emphasis on education for non-judgemental practice in validating patients in all settings, coping mechanism to reduce episodes of care need, raising awareness across the ICS population, the workforce and patients);
- Assessment and Understanding of Need (reviewing early recognition amidst chaotic lifestyles, working with people through moments of difficulty including alcohol and substance misuse, disordered eating and eating disorders, preventing breakdown resulting from dents, housing employment issues, looking at suicide and self-harm, and patient presentation);
- Models of Care (reflecting on emotional instability, impulsivity and interpersonal difficulties, assessing health inequalities, accessibility and inclusivity and reviewing what community provision is in place);
- Whole System Approach (involving all partners in the conversation including 3rd sector, criminal justice and social care, collaborative integration highlighting the Make Every Contact Count (MECC) principle and enabling a Quality of Life).

Prevention and Self-Help	Patient feedback suggests PDs have much stronger stigma attached than other mental health disorders. Many resent a diagnosis of PD (*Service user interview, December 2020*), this is however, sometimes a result of the fact that how a clinician comes to the diagnosis of a personality disorder may not necessarily be the patient's experience of how they get their diagnosis and so services need to be mindful about how they word and diagnose and that the diagnosis should be made mindfully and clinically appropriate, rather than as a presentation of difficulties. Public knowledge of PDs is low and people with a PD may be perceived as purposely misbehaving rather than experiencing an illness. People with lived experience reported often having a feeling of being judged in certain situations, causing them to feel devalued or judged as being a lesser person than them, They had noticed people distancing themselves, often making the individuals feel like criminals or trouble-causers. Individuals with PD, sometimes feel judged around care settings by staff that are skilled and specialised to care for their physical health but not their mental health. This is a known concern where 'health provider stigma' is particularly unpleasant for those with borderline disorder and an area where focus is required to address this. Education for the healthcare professionals (HCP) is required, but this links to the entire workforce that has interaction or a duty of care for any person who may present with a personality disorder. That person has the right to have a relationship of trust with the professional or staff member, however, brief, and therefore staff need to engage in a non-judgemental manner and be consistent and reliable in their approach – this was a specific theme that came out from interviewed people with lived experience of substance or alcohol misuse in the ABBA group, how acute hospital staff sometimes called security without even trying to understand the individual's needs. Another patient with chronic severe depression, spoke about how each of the patients with a personality disorder was feeling denounced by that label – so we need to help remove the stigma attached to prevent people from pre-judging Coping mechanisms are often used to help with lifestyle changes including sleep, diet, physical activity and identifying the effective distractions, particularly if someone is thinking about self-harm. Being able to confide in someone and just talk and using mindfulness meditation, which is about relaxation and staying in the present – forgetting about the past and not thinking about the future. Largely early treatments when people show signs of PD, include psychological therapies such as cognitive behavioural approaches. Raising awareness and education is imperative and this could benefit from a three tier approach – educating the population early, and can perhaps even be supporting parents when the child is in the womb for some at risk families, where one or both parents are known to have a personality disorder. A lot needs to be done with social media and the impact this can have from as early as 9-10 years of age – so education in schools early is paramount. Awareness and education of the workforce to understand that there is a responsibility for everyone – so patients become assured of knowing the 'no wrong door' principle works. Finally education of the patients to aid self-management and self-care, which includes coping mechanisms to some degree but also including more specific training such as the Knowledge and Understanding Framework Training.

Assessment and Understanding of Need	The Royal College of Psychiatrists (RCP) encourage diagnosis to be the start of the conversation, but making it more about the formulation and what this means for the individual in terms of the required interventions. Formulation describes the person's experience, which may acknowledge the causation of the problems and provides a shared understanding of the difficulty and then the treatment plan. Formulation is reviewed to help provide sequential progression over time and provides a way for patients to tell their story in their terms, but in a way that is accessible for clinicians. Formulation done particularly well allows the service user to take this to share with their community – their family, friends, employer, and so on. When some people get an initial diagnosis, because they have huge attachment traumas and difficulties with trust they are reluctant to share everything initially, which is one of the reasons it takes time to diagnose. What is then sometimes seen in the first assessment or initial referral, is not what is known a year or two into the relationship where people are sharing more of their experience and trauma. Often the inhibitor of this is that the person holds a lot of shame and guilt about their experiences as one of the sequelae of the abuse they have experienced and this helps understanding of why expectations of getting a diagnosis right much sooner, should not be always be so high because of the clinical needs they have. Therefore, developing an iterative formulation over time with the person, as the relationship builds and changes occur within them and within their environment. Hence, assessment and understanding of needs is a very iterative process, often guided by the pace of the individual. The key to this working well no doubt links to a shared understanding between providers. A study in Manchester had evidence to suggest people with borderline personality disorder were 13 times more likely to report of having childhood trauma, including physical neglect, physical and sexual abuse and emotional neglect. Early recognition or diagnosis can be difficult as it looks at the long term patterns of behaviour and functioning so tends to be diagnosed at the age of 18 or older. Linked to education in the first field, for early recognition the health and social care professionals need to be trained to know how to support and help people showing traits of personality disorder Chaotic lifestyles can often result from the upbringing and principally where the parents also had chaotic lifestyles – setting no boundaries, lacking the skills to parent properly and the child then keeps their needs to themselves to avoid the risk of being let down. This can develop into wanting to cope alone in life often leading to substance or alcohol misuse. Some areas of difficulty include substance and alcohol misuse, which tends to be used as a way of self-medication to deal with the emotions and issues with the personality disorder. The problem is the substance or alcohol misuse makes the situation much worse, even though it is perceived to be a way of coping. People often suffer with disordered eating, which is distinguishable from an eating disorder and is for reasons other than body image or weight and so used as a form of control or punishment or self-harm often linked to social media issues. It is often used to cope with uncomfortable emotions. Not all disordered eaters can be diagnosed with an eating disorder, but those with an eating disorder exhibit disordered eating. When people have a breakdown, this links to more socio-economic issues such as debt, employment issues or housing issues. This can cause a host of problems, and fall into a severe and multiple disadvantaged (SMD) group. Whilst some work is being undertaken to support this cohort, it is something that needs equitable access. Self-Harm and suicide tends to be more prominent in borderline personality disorder. In a national confidential enquiry into suicide and homicide, there was a consistent finding that despite many that died by suicide the majority had long term contact with mental health services, but only 4% with specialist services – of the people that die by suicide, more than half are likely to have suffered from a diagnosed personality disorder and in prisons approximately 60-70% are estimated to satisfy the diagnostic criteria for personality disorder Patient presentation links to the complexity of the area and pathways, particularly with the varying diagnoses of personality disorders. There is variation across general practice in primary care often needing support sooner than it's available. This entanglement of which support is most appropriate and where to go for it becomes more complex because of the time it takes to understand whether it is personality disorder. During this time patients are often bounced between different services and become more and more frustrated.

Models of Care	A number of types of PD are known that exhibit different behaviours. Emotional instability links to changing moods and disturbed patterns of thinking or perception. Impulsivity is where there is a tendency to act without thinking. Interpersonal difficulties refer to problems with interpersonal relationships and difficulties in relating to or bonding with other people. Care provision may differ for each of these and this results in complex pathways because the diagnosis often takes a long time and this can result in patients being passed around different providers with them not meeting certain criteria to be able to access support. Health Inequalities are found with some of the difficulties people have in accessing services that are appropriate to them and accessed in a timely fashion and with the diverse range of presentations such as those above, it is even more difficult to appropriately refer to the right place and often this is where people slip through the gap. The hard to reach groups, such as those of lower socioeconomic status links with higher prevalence of presenting with personality disorders often linked to lower levels of optimism and self-esteem or perceived control. People with lived experience are often not able to access the same services, or even struggle with employment as they are either labelled or seen as a group that will not be stable in the role – as mentioned earlier this is also lack of education of the general population and employers. Community provision needs to improve, not only to provide care and support closer to home, but to enable earlier intervention and reduce the demand and need to go to secondary or specialist care settings. Some pilot work is being done in commissioning crisis cafes to provide a more generic resource, but provide somewhere for people to go to. Haven House and Beacon Lodge are available for people leaving secondary care, but only currently in Nottingham – although people from other areas can access Beacon lodge, this rarely happens. There are relatively new services where the local mental health teams (LMHT) can refer into MIND, or Turning Point, where people who may be on a waiting list, but for whom it is believed that an early intervention may be beneficial – at Turning point it is overseen by a clinical psychologist and assistant psychologist where they help with mindfulness and crisis survival skills. These are currently adapted to COVID so some F2F is happening but also some virtual support is provided. This is an area where feedback has been positive, although the pilot is in its early days of its 6 months duration, and this may be something that can be expanded further across the ICS.
Whole System Approach	People with a personality disorder diagnosis may typically be involved with several different agencies and sectors including social care, housing, criminal justice system and physical healthcare and prisons Although the reference for these people is to their health, there is a real need to ensure mental health teams, psychologist and psychiatrists are able to work with and support these other agencies not directly linked to their health, through evidence based interventions. Collaboration and integration not only links to the previous point, but also in terms of ensuring the right care is available as soon as possible, is vital to outcomes and perhaps the deterioration to higher levels of care need and support as you would go up the stepped care model. Through education and awareness of the workforce, across the ICS there is an opportunity to truly make every contact count (MECC) this may be through very brief interventions or conversation even with physical health professions, but to ensure where need is identified, that the support is available. Collaboration and integration of pathways needs to be seamless across primary care, community care and secondary care, but also include all the other agencies that may be involved with people diagnosed with personality disorders, such as those mentioned above. There are examples above of how the voluntary, community and social enterprise (VCSE) sector are able to support very well and need to be part of the care solution we can provide so integration and close working with these organisations should be maintained. Information flow across providers for data sharing is important for early referral and intervention in subsequent settings. Systems need to interface much better, if working off different platforms. Quality of life for those with mental health issues or personality disorders tend to have one of the greatest reductions. This is linked to their condition or at least the stigma attached to their condition. The quality of life can improve through more integrated support and timely interventions, but there is need to change culturally so that organisations can work off a level playing field to provide care that keeps the patients needs as its focus.

6. Proposed future care system

Home

Planned/Scheduled	Urgent – 24 hours	Emergency/Crisis – 4 hours
Prevention & Self-Care – Education/ Stigma, Coping Mechanisms, Awareness • Education and engagement needs to be available with housing providers to ensure they are able to deal with potential impact on neighbours • Working with individuals early on to prevent need for more intense help/prevent inpatient services etc • Accessible information on living well – wider determinants including housing, employment, financial management support • Education joining up with other services, easily accessible and constructive. Improved engagement from patients with services yields earlier and appropriate support • Intervening early with young people to reduce risk of developing problems downstream • Education strategies considering stigma, including health and social care in schools at appropriate age to prevent stigma – early education for those in probation/ youth offending services – focus on understanding how they have got their and reducing the emphasis on what they have done. Feeling stigmatised makes access to physical health services less likely • In order to prevent deterioration or need for urgent/ crisis care, failed support from IAPTs needs to be followed up Sustainable by: • Improved support and understanding of risks allows earlier intervention • Promotes awareness to support self-care and independence	**Prevention & Self-Care** • Contact phone line for those in crisis, those that live alone without support – ERMS providing iPads to keep people connected • Wrap around care out of hours Sustainable by: • Provides quick response enables earlier intervention and support to avoid crisis services	**Prevention & Self-Care** • Crisis teams – home treatment support and facilitates discharge – all ages • All age out of hours team for transition • EMAS/ Ambulance service – training and education to ensure awareness of mental health alongside physical health needs, especially when they are reaching out for help • Police - Ditto • Suicidality – prevention training and clear access and navigation across the system Sustainable by: • Allows emergency support to be made swiftly, prevents delayed response, helps avoid suicide
Assessment and Understanding of Need – Early recognition, chaotic lifestyles, areas of difficulty, self-harm/ suicide, patient presentation • Social care – Framework moving forward (MH, pick up PD help with housing, money – lots of pressure on these services) – simplify engagement between agencies (healthcare and social care) to ensure workforce are also able to follow clear pathways • Equity of access and support, e.g. resilience of Opportunity Notts – not in county • Substance drug issues, homeless hostels with MH and PD – numbers small, but consistency of engagement with interested professional that can start to build relationships and build trust so they can move forward • New presenters – identify where younger people's behaviour has started – involvement of emergency services – understanding to help with prevention at different levels/stages. Employ coping strategies Sustainable by: • Awareness and appreciation of the need to offer home support with early contact – prevents deterioration and need for specialist/ secondary care.		**Assessment and Understanding of Need** • Crisis helpline – Notts HC and Turning Point • Awareness and access – Samaritans; SMART team (supported accommodation – 24hr phone line) • 999/111 – if not given another number to call, or if in crisis may ring 999. Access points, DoS to highlight where they can access services Sustainable by: • Provides quick response enables earlier intervention and support to avoid crisis services
Models of Care – Borderline PD, Inequalities, community provision • Use of online tools, Recap to help prescribe information – provision of links rather than having to search for them • Access to IAPT from home – simplify rules of referral between GP (PC) and secondary care to ensure no wrong door to access advice and support at different levels, reviewing criteria to consider self-harm risks - IAPT support where risk of self-harm is perceived low, but able to discuss self-harm Sustainable by: • Prevents admissions, speeds up appropriate home support	**Models of Care** • Transition between tiers, e.g. step down to Social Prescribing as secondary prevention with direct access back if required Sustainable by: • Enables smooth flow between services avoiding falling between gaps	**Models of Care** • HCPs to have access to information 24/7 e.g. Rio across all platforms • Suicidality – clear access and navigation across the system Sustainable by: • Clear understanding of patient history, improved and smoother navigation
Whole System Approach – Partner providers, MECC, Quality of Life • Promoting voluntary sector to ensure perception is not one of a lesser service offer – building on existing pilot sites • Social connections to improve quality of life – building on crisis cafes • LTP - Collaborative care planning – all agencies should know what has been agreed – move away from silo working – consider interfaced systems. Complex case discussions with all supporting agencies • Continuity of carer/ assistant with personal independence plans (PIPS) – consistency is key to building relationships • Greater access to psychological informed interventions – supporting home visiting teams Sustainable by: • Provides home support and promotes self-care and awareness for prevention but also enables people to live more independently, reduces care packages • Reduced hospital and social care appointments		

Colour KEY to information source: Steering Group/ Workshop 1 Evidence Document/ Guideline Patient Focus Groups

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6. Proposed future care system

Neighbourhood

Planned/Scheduled

Urgent – 24 hours

Emergency/Crisis – 4 hours

Prevention & Self-Care – Education/ Stigma, Coping Mechanisms, Awareness

- Education of workforce to enable access via multi-agency approach – Knowledge and Understanding Framework (KUF) roll out across ICS
- Working towards 2022 target to have MH in schools (LTP), but ensure this stretches to academies – PH involvement
- LEH for patients with severe mental disorders (many with PD) – aligning across all ICPs – recognise and screen young people with emerging PDs (reduces acute attendance)
- Education of young people and parenting – appetite in schools and asking for help and communication with parents and for parents
- Address self-harm and distress in schools which is higher than perceived
- PC mental health support to develop consistent support to improve help to self-care
- General practice safeguarding meeting looks at younger children, but could follow through (includes education of team to understand transition to young adults with problems)
- Support to care leavers – longer support into adulthood (30yrs)
- Long waits to access IAPTs need to be addressed.
- IAPT providers need to better understand individual needs and consider tailoring psychological support to these needs.

Sustainable by:

- Patients seen earlier reducing risk of deterioration requiring more intense support

Assessment and Understanding of Need – Early recognition, chaotic lifestyles, areas of difficulty, self-harm/ suicide, patient presentation

- Know what is available and being creative with it to consider different needs of different groups – support lines, sanctuaries – understand what can be provided and ensure this is communicated
- Parity of esteem for people presenting – improve education in general practice and community
- Patients reportedly facing further episodes found it difficult to access support as the questions asked for IAPTs only considered the previous two weeks, where their episodes and support needs may have been more irregular.

Sustainable by:

- People recognised for their MH issues alongside physical health needs

Models of Care – Borderline PD, Inequalities, community provision

- Substance misuse services joined pathway with treatment options – gap where people could do better if joined up as numbers high across system
- Improve accommodation – vast majority for older people around cognitive impairment, with no specific accommodation available
- IAPT – standalone sessions coping skills, enabling behaviour change – flexible offer to be accessible
- PC model – PCN level social prescribers (MH) and practical modules to help coping skills etc.
- MDT approach SMD - people moving between develop MDT/ PCN/ICP for more challenging people e.g. criminal justice
- Availability of support for those in PC and psychological services – advice and support

Sustainable by:

- Prevents admissions, speeds up home support as appropriate

Whole System Approach – Partner providers, MECC, Quality of Life

- GP nurses modules for mental health to upskill for MH – encourages PN who are supporting young people – consistency of care
- MECC in housing, probation and development of peer support workers

Sustainable by:

- Collaboration with 3rd sector helps sustain support during waits for treatment/ therapy

Assessment and Understanding of Need

- Assessment as broader need – considers physical when assessing urgent care DPN – not consistently assessing using a measurable tool and not signposting - barriers felt by people accessing support – holistic assessment evidence based tools for more consistent assessment – not keep in acute , or represent
- Short term support as in acute and try to step down – supported accommodation, but lack of robust places to signpost to for wider need and feel supported
- Crisis Teams
- One crisis house – social support and community connections can be lost – level of risk can manage e.g. suicide risk, difficult to get placement in crisis house – can get stuck and then admitted – alternative provision
- Support families and carers what is available – enabling families and carers confident in understanding what is available
- Street triage team/ many present acute care/ED. Early recognition and eye on intergenerational impact

Sustainable by:

- Provides appropriate response in right setting

Models of Care

- Crisis and support with MDT approach in short term and support them in moving out of the system – more of this to reduce acute care and across the life span –
- If over 65 MHSOP aren't getting equivalent service – don't have intervention services developed, crisis support
- Crisis support developing across organisations
- Access to live DoS listing all available services and education for primary care to promote early intervention – understanding available capacity

Sustainable by:

- Prevents admissions, speeds up home support as appropriate

Colour KEY to information source: Steering Group/ Workshop 1 Evidence Document/ Guideline Patient Focus Groups

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6. Proposed future care system

Acute or MH Hospital

Planned/Scheduled	Urgent – 24 hours	Emergency/Crisis – 4 hours
Prevention & Self-Care – Education/ Stigma, Coping Mechanisms, Awareness • ICS workforce to be trained and educated to bridge the gap between mental and physical health needs and identify mental health presentation in physical health settings • Sons of 2/3 of people in prison will be in prison in 20 years' time – ACEs is vital – we have address this and have a long term view – last month 63% prisoners in one month had MH history – 35% substance misuse – 80% of prisoners coming in in January had either or MH/Substance Misuse – very little follow up post prison – how does the world outside prison connect with this – thresholds individual may not be met but collectively they will • Parent mentors consideration for ACEs • Information for carers and families – how can they be supported – vital – education for families is very important to provide support for citizens Sustainable by: • Improves secondary prevention, planning for relapse • Understanding and supporting MH alongside physical health needs	Prevention & Self-Care • Peer mentor availability in an urgent care setting to bridge to more schedule services – crisis café link – citizens can go here in crisis and get mentor support bridging to other support • Access to crisis houses • Build on pilot projects (double impact) - how do we support engagement in care Sustainable by: • Early support provided when relapse is recognised - prevents crisis response	Prevention & Self-Care • Training on how to support citizens presenting but not engaging Sustainable by: • Appropriate recognition of MH needs alongside physical health needs
	Assessment and Understanding of Need • Flexibility in support while responding to drug and alcohol challenges Sustainable by: • Reduces hospital visits, whilst improving safeguarding	Assessment and Understanding of Need • Labels can be applied quickly in ED settings – but just getting a snapshot of their situation – a view strongly expressed by patients! • Quality of DPM referral is better after some follow up – grounding to come back to that first contact- helpful for clinicians as well • Immediacy of support where that immediacy of support can be validated – crisis accessible services out of hours Sustainable by: • Reduces hospital visits, whilst improving safeguarding
	Models of Care • Importance of MDT approach – MDT approach works on the ground level but then is lost higher up • Cluster 8 pathway meeting – allows cases to be discussed for complex presentations – space to think – Trust only – can this be expanded • Access to live DoS listing all available services and education for primary care to promote early intervention – understanding available capacity Sustainable by: • Enable quick response to urgent intervention need .	Models of Care • Risk of suicide to be assessed in emergency cases. • Access to live DoS listing all available services and education for primary care to promote early intervention – understanding available capacity Sustainable by: • May prevent acute admission
Whole System Approach – Partner providers, MECC, Quality of Life • System that understand complexity – housing etc • Peer mentors – could be a key feature Sustainable by: • Effective with wrap around care	Whole System Approach • Address barriers to entry – drugs and alcohol – will not get through the referral process – but if you can engage with the services work in parallel – citizen has to want and be motivated to engage – wavering motivation – flexibility in response • Have to start with basic needs before looking at psychological support – barriers and thresholds do not help Sustainable by: • Enables equity in access for all PD types (including substance, alcohol misuse, suicidality, etc.)	

Colour KEY to information source: Steering Group/ Workshop 1 Evidence Document/ Guideline Patient Focus Groups

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6. Proposed future care system

Availability

Level of Care

	Acute/ MH Hospital	Neighbourhood	Home
4 hours or less / 24/7	• Training on how to support citizens presenting but not engaging – How do we handle this? • Labels can be applied quickly in ED settings – but just getting a snapshot of their situation – a view strongly expressed by patients! • Peer support to help citizens manage their current distress in emergency settings – follow through from one contact to a different one – ongoing assessment that is meaningful • Quality of DPM referral is better after some follow up – grounding to come back to that first contact- helpful for clinicians as well • Immediacy of support where that immediacy of support can be validated – crisis accessible services out of hours – in the • Risk of suicide to be assessed early in emergency cases		• EMAS / Ambulance service – training and education to ensure awareness of mental health alongside physical health needs, especially when they are reaching out for help • Police - Ditto • Awareness of and access to Crisis Response and Home Service including helplines – Notts HC and Turning Point • HCPs to have access to information 24/7 e.g. Rio across all platforms • Suicidality – clear access and navigation across the system • Awareness and access – Samaritans; SMART team (supported accommodation – 24hr phone line) • 999/111 – if not given another number to call, or if in crisis may ring 999. Access points, DoS to highlight where they can access services
Urgent Care/ within 24 hours / 7 days	• Peer mentor availability in an urgent care setting to bridge to more schedule services – crisis café link – citizens can go here in crisis and get mentor support bridging to other support • Access to crisis houses • Build on pilot projects (double impact) - how do we support engagement in care • Flexibility in response while responding to drug and alcohol challenges • Importance of MDT approach – MDT approach works on the ground level but then is lost higher up • Cluster 8 pathway meeting – allows cases to be discussed for complex presentations – space to think – Trust only – can this be expanded • Address barriers to entry – drugs and alcohol – will not get through the referral process – but if you can engage with the services work in parallel – citizen has to want and be motivated to engage – wavering motivation – flexibility in response • Have to start with basic needs before looking at psychological support – barriers and thresholds do not help	• Assessment as broader need – considers physical when assessing urgent care DPN – not consistently assessing using a measurable tool and not signposting - barriers felt by people accessing support – holistic assessment evidence based tools for more consistent assessment – not keep in acute , or represent • Short term support as in acute and try to step down – supported accommodation, but lack of robust places to signpost to for wider need and feel supported • Crisis Teams • One crisis house – social support and community connections can be lost – level of risk can manage e.g. suicide risk, difficult to get placement in crisis house – can get stuck and then admitted – alternative provision • Support families and carers what is available – enabling families and carers confident in understanding what is available • Street triage team/ many present acute care/ED. Early recognition and eye on intergenerational impact • Crisis and support with MDT approach in short term and support them in moving out of the system – more of this to reduce acute care and across the life span – • If over 65 MHSOP aren't getting equivalent service – don't have intervention services developed, crisis support • Crisis support developing across organisations	• Contact phone line for those in crisis, those that live alone without support – ERMS providing iPads to keep people connected • Transition between tiers, e.g. step down to Social Prescribing as secondary prevention with direct access back if required • Access to live DoS listing all available services and education for primary care to promote early intervention – understanding available capacity • Wrap around care out of hours
Scheduled / Appt based	• ICS workforce to be trained and educated to bridge the gap between mental and physical health needs and identify mental health presentation in physical health settings • Sons of 2/3 of people in prison will be in prison in 20 years' time – ACEs is vital – we have address this and have a long term view – last month 63% prisoners in one month had MH history – 35% substance misuse – 80% of prisoners coming in in January had either or MH/Substance Misuse – very little follow up post prison – how does the world outside prison connect with this – thresholds individual may not be met but collectively they will • Follow up to first ED contact – to help bridge to other services • Parent mentors consideration for ACEs • Information for carers and families – how can they be supported – vital – education for families is very important to provide support for citizens	• Education of workforce to enable access via multi-agency approach – Knowledge and Understanding Framework (KUF) roll out across ICS • Working towards 2022 target to have MH in schools (LTP), but ensure this stretches to academies – PH involvement • LEH for patients with severe mental disorders (many with PD) – aligning across all ICPs – recognise and screen young people with emerging PDs (reduces acute attendance) • Education of young people and parenting – appetite in schools and asking for help and communication with parents and for parents • Address self-harm and distress in schools which is higher than perceived • PC mental health support to develop consistent support to improve help to self-care • General practice safeguarding meeting looks at younger children, but could follow through (includes education of team to understand transition to young adults with problems) • Support to care leavers – longer support into adulthood (30yrs) • Know what is available and being creative with it to consider different needs of different groups – support lines, sanctuaries – understand what can be provided and ensure this is communicated • Parity of esteem for people presenting – improve education in general practice and community • Substance misuse services joined pathway with treatment options – gap where people could do better if joined up as numbers high across system • Improve accommodation – vast majority for older people around cognitive impairment, with no specific accommodation available • IAPT – standalone sessions coping skills, enabling behaviour change – flexible offer to be accessible • PC model – PCN level social prescribers (MH) and practical modules to help coping skills etc. • MDT approach SMD - people moving between develop MDT ?PCN/ICP for more challenging people e.g. criminal justice • Availability of support for those in PC and psychological services – advice and support • GP nurses modules for mental health to upskill for MH – encourages PN who are supporting young people – consistency of care • MECC in housing, probation and development of peer support workers	• Education and engagement needs to be available with housing providers to ensure they are able to deal with potential impact on neighbours • Working with individuals early on to prevent need for more intense help/prevent inpatient services etc • Accessible information on living well – wider determinants including housing, employment, financial management support • Education joining up with other services, easily accessible and constructive. Improved engagement from patients with services yields earlier and appropriate support • Intervening early with young people to reduce risk of developing problems downstream • Education strategies considering stigma, including health and social care in schools at appropriate age to prevent stigma – early education for those in probation/ youth offending services – focus on understanding how they have got their and reducing the emphasis on what they have done. Feeling stigmatised makes access to physical health services less likely • Social care – framework moving forward (MH, pick up PD help with housing, money – lots of pressure on these services) – simplify engagement between agencies (healthcare and social care) to ensure workforce are also able to follow clear pathways • Equity of access and support, e.g. resilience of Opportunity Notts – not in county • Substance drug issues, homeless hostels with MH and PD – numbers small, but consistency of engagement with interested professional that can start to build relationships and build trust so they can move forward • New presenters – identify where younger people's behaviour has started – involvement of emergency services – understanding to help with prevention at different levels/stages. Employ coping strategies • Use of online tools, Recap to help prescribe information – provision of links rather than having to search for them • Access to IAPT from home – simplify rules of referral between GP (PC) and secondary care to ensure no wrong door to access advice and support at different levels, reviewing criteria to consider self-harm risks - IAPT support where risk of self-harm is perceived low, but able to discuss self-harm • Promoting voluntary sector to ensure perception is not one of a lesser service offer – building on existing pilot sites • Social connections to improve quality of life – building on crisis cafes • LTP - Collaborative care planning – all agencies should know what has been agreed – move away from silo working – consider interfaced systems. Complex case discussions with all supporting agencies • Continuity of carer/ assistant with personal independence plans (PIPS) – consistency is key to building relationships • Greater access to psychological informed interventions – supporting home visiting teams

Education and training to support prevention and early intervention

High Priority

More recent research has explored potential causes of PDs such as genetics, parenting and peer influences (*What Causes Personality Disorders*). PDs have been associated with childhood traumas and experiences, with links between the number and type of childhood traumas and the development of PDs. Although it is thought PDs cannot be prevented, there is more that can be done to inhibit some of the influences that may trigger the onset of personality traits becoming inflexible and presenting in the longer term as a PD. This includes childhood trauma or adverse childhood events (ACE).

ACEs can include physical abuse and violence, sexual abuse – especially developing borderline PD, where the number and type of traumas linked to the development of PDs (*Pub-Med, Shirley Yen, et al*). Verbal abuse and emotional neglect is also believed to have an impact, where a study found children were three times more likely to as other children to have borderline, narcissistic, obsessive-compulsive or paranoid disorders in adolescence or early adulthood (*Comprehensive Psychiatry, Jan 2001*).

There is currently some very innovative work progressing in the ICS on violence and reduction of ACEs and linked to how this can almost be used to help screen those children at high risk. (*Children and Young People's Service Review - CCSS*) and peer support work through Small Steps Big Changes, especially in the more deprived areas. Improving interaction and support for those parents identified more likely to expose children to these events, can be supported through effective schemes such as parent mentors (parenting courses, *Webster/ Stratten - Incredible years parenting classes* has evidence based and play based teaching). Over two thirds of children that have a father in prison, are likely to end up in prison 20 years later and with a high percentage (nearly 80%) of those in prison believed to have a PD, this is again an area where triggers can be prevented through early support.

It is important that strategies to address these influences are aligned to existing work and to learn from successful pilots and ensure these groups are fully engaged in developing initiatives to raise awareness amongst communities and perhaps less in terms of the individual. It is also imperative to maintain links and to work closely with voluntary, community and social enterprises (VCSE), social care colleagues, 3rd sector and voluntary organisations, housing, employment advisors, etc. who already work to support some of these groups. The sustainability of these VCSEs and 3rd sector organisations is paramount as strong relationships have been built with various communities over the years and without these existing foundations, it would prove a much greater challenge to gain the trust of these communities as well.

Education and awareness for the ICS population can start by having open conversations about MH and PD and should extend to the workforce, to promote MH awareness in all social and physical health settings along with parity of esteem. Existing material such as Knowledge and Understanding Framework (KUF) should be used across the ICS, including those organisations providing secondary support such as housing, debt management, employment to ensure it helps remove stigma and keeps service users engaged.

In order to influence early intervention and support for people with a PD, even though they may not yet have a diagnosis, the level of training and education in primary and community care needs to improve to enable recognition of the signs. Awareness needs to improve across the community setting including more structured education for response teams, such as the police and ambulance crews to ensure an individuals MH capacity is not put aside when responding to an criminal act or attempted suicide.

Through improved engagement and education and support for service users and families through support schemes (e.g. Healthy Families Scheme) coping mechanisms can be established and this can also help improve self-care and management within family structures. This should be a multi-agency approach, which needs providers talking to one another working to a multi-organisational care plan. Through improved self-care and support in primary care, this can help reduce the demand on specialist care in the hospital setting, but requires structure multi-agency working across community providers

Impact & Benefit

- Improve wellness and resilience through preventing triggers leading to development of PD traits
- Reduced emergency presentation in acute setting – crisis response
- Improved support in primary care, enabling better self-care with coping strategies early

Alignment – For education and training supporting early intervention the consistency should be aligned at an ICS level, with delivery aligned to each ICP.

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Multi-agency joined up approach including 3rd sector to provide more **consistent and personalised care**

High Priority

PDs are very complex and often only receive a formal diagnosis in the longer term. This presents issues with how behaviours and traits are perceived by others, due to the little knowledge and awareness the population (and general workforce) have of PDs. Furthermore, because an accurate diagnosis is usually made in the longer term, this makes the care of PDs very intricate. This fundamentally results from the large number of agencies involved in the care of someone with a PD and whether the right service is accessed each time someone needs support. For example, someone with a PD, or developing a PD may choose to indulge in alcohol or substance misuse as a coping mechanism for themselves and as a result of being intoxicated may commit a criminal offence, or hurt themselves. Clearly the intervention that is needed is care for the PD – not be arrested for an offence, or be taken to the hospital for a physical injury. But because, many of these other agencies perform a specific role in response to an action or situation, the individual may not receive the required care.

What further exacerbates the complexity of PDs, is if some initial intervention is not the right one for that type of PD, the patient may no longer be given treatment or support if it is not deemed appropriate – for instance, currently in the ICS, access to IAPT services is withdrawn or withheld for individuals who may be suicidal, even through the individual may benefit from being able to talk to an IAPT provider about this alongside other PD needs. Unfortunately, this is where individuals sometimes get lost in the gaps of service provision, which consequently causes a rapid decline in MH.

The 'no wrong door' phrase was used at a conference by the National Institute of Drug Abuse (NIDA) when describing how providers of care for people with coexisting MH, substance abuse problems as well as physical health disorders find 'no wrong door' when they seek help. This is a powerful ambition, but one that could bring together care professionals in the ICS from social, mental and physical healthcare providers to support people with getting the right care and treatment for MH problems when they need it. A multi-agency approach to providing robust and consistent access across the ICS is needed, where HCPs and Social Care colleagues are fully supported by the MH professionals.

There are some novel treatments and initiatives being developed in which individuals are supported in partnership with 3rd sector organisations involved in community care, developing peer mentors. These are proving particularly useful when urgent support is needed, in places such as crisis cafés. This collaborative working needs to be expanded, not only across the ICS to provide equity in access, but across organisations and health and social care practitioners need to work more towards providing personalised care for patients with a PD. Where evidence is showing the success of some of these initiatives, 3rd sector agencies need to be properly commissioned to allow duplication of these schemes in other parts of the ICS.

Whilst this needs the providers from physical, mental, social care and 3rd sector organisations involved with the main care of those with PD to be working closely together, it also requires support agencies for housing, debt, relationship support, etc., to play a major part in understanding the needs of those with PD and providing input to this to make it truly multi-agency. To make this work, there needs to be an understanding of the cultural shift required for joint working to eradicate barriers and ensure patients are able to access the services that can provide the support they need. For example, ensuring the right referral routes are put in place to support long-term MH conditions, such as PD. Services need to understand one another and by working more closely allow care to be provided outside of organisational boundaries.

Through improved crisis support at an earlier stage and better working with PC/ IAPT moving in and back from SC more easily, this can have a positive impact on the demand currently put on secondary care across the lifespan of someone with PD. With personalised care through collaborative care planning, all agencies should be involved in decision making and an agreed care plan, through complex case discussions.

Impact & Benefit

- More joined up approach, systems talking to each other and breaking down barriers – not got admission and discharge between services. People can get what they need when they need it and not repeating stories and don't feel rejected. More seamless care.
- More thoughtful approach – too quick to identify right service – need conversations with services first to ensure that they are the correct service. Referrals to incorrect service closed elsewhere. What are the difficulties and where is the appropriate place for treatment.
- No wrong door – place based services. Not having to repeat story – patient not passed along different steps and not suitable for any

Alignment – For consistency in joined up approach to provide consistent personalised care, alignment should be at ICS level with delivery aligned at PCN level.

7. Transformation Proposal

Improve MH prevention and support for **Severe and Multiple Disadvantaged** (SMD) individuals through service **access across the ICS**

Medium Priority

Severe Multiple Disadvantage (SMD) refers to people with two or more of the following issues: mental health issues, homelessness, offending and substance misuse. SMD can include other sources of disadvantage, for instance poor physical health, and for women, domestic and sexual abuse - and for Black, Asian and Minority Ethnic (BAME) people, community isolation. Nottingham has the 8th highest prevalence of SMD in England - currently it is estimated that over 5,000 of the City's citizens experience SMD (*Opportunity Nottingham Board, July 2019*).

With around 85% of people facing SMD having experienced childhood trauma, affecting their mental health, there are strong links to the first proposal and in particular progressing work around ACEs. PD is one of the most common diagnoses for those facing SMD. Many of these (around 80%) will have come from sleeping on the streets, with many also known to the criminal justice system.

There is an existing workstream for the Severe and Multiple Disadvantaged (SMD) in the Nottingham City ICP, with a strong partnership building on the Opportunity Nottingham and Everyone initiative. One of the workstreams in this includes a multi-disciplinary team (MDT) to help individuals with complex needs facing SMD, by putting the right things in place to support as persons needs to improve their position, which may be, for instance getting an individual into a sustained housing tenancy. This may involve support from various MDT members, e.g. someone from the Nottinghamshire Healthcare Foundation Trust (NHFT), or from housing, or perhaps the criminal justice team to put various steps in place to support the individual. The partnership includes health, social care, voluntary sector organisations, housing and criminal justice and the MDT makes use of the navigator roles to help with the cases, and whilst current focus is on the most complex individuals, there are plans to progress to the next level down. The purpose of the MDT is to provide 'wrap-around' care to meet the individual's needs.

Many of these individuals are well-known to MH services, but perhaps considered too complex to meet the thresholds to receive treatment due to the lack of flexibility of service provision, for example if an individual misses an appointment with a service, they may be excluded from subsequent appointments or sometimes discharged from services altogether. Another big issue with this group is dual diagnosis where a large cohort have a PD and substance misuse, who are very complex and due to some of the thresholds set and criteria individuals need to meet, they are unable to access services, which is why the support provided by the MDT is so important.

The recommendation is to take the learning of this service, once clearly evaluated to pick up what has worked well, to across the ICS, to avoid inequities across the county. Some of the limitations to overcome including a robust funding platform, (the partnership in Nottingham City is currently looking to secure an additional £4m from the Ministry of Housing, Communities and Local Government (MHCLG)), but also Opportunity Nottingham is local to the city and further collaborations will need to be developed to expand this model across the county.

Discussions about in-reach of some of the multi-disciplinary teams were held in the steering group meetings, for where agencies are struggling in community settings, where attempts to keep people in placements at home, or care homes are struggling to support people require support from these MDTs. There is a recognised risk that this work with SMD may remain city focused and not expand into the county, but this risk needs to be carefully considered in any planning to implement this proposal. This can be justified through detailed articulation of both qualitative and quantitative benefits. This may also need to consider expanding Opportunity Nottingham into the county, or initially taking elements of the scheme that work well and rolling that out. The key point is to replicate the main features.

Impact & Benefit

- Reduce ED attendance
- Prevents individuals bouncing between services
- Reduced crime
- Add the benefits from below – wider social benefits
- Improved access to physical health care
- Reduced suicide risk

Alignment – To strengthen support for SMD people, with an MDT structure in place, this really needs a system-wide approach at ICS level for both consistency and delivery.

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

Targeted approach to **reduce self-harm and suicidality** for those with personality disorders **High Priority**	There is currently work progressing on suicide crisis services in the region for the general population, but this does not breakdown into different mental health disorders. This raises the question about whether the additional risks with personality disorders is fully understood. It is known that with PDs because of potential impulsiveness and dissociation, the risks of suicide and self-harm can be considered to be quite high, however, people that self-harm or have suicidality are sometimes far too easily labelled as having a PD, when this may not be the case at all. It is very important that there is a shared understanding and joined up approach between agencies to ensure individuals are not incorrectly labelled or having their care needs dismissed because they have an assumed label of a PD. People should always be offered an assessment wherever they present for self-harm or suicidality. Across non-MH organisations that respond to self-harm and suicidality (ED, EMAS, Police) there needs to be that inherent trust and support. To help with this, training and education is improving with dedicated roles to support. For example, EMAS have mental health nurses supporting some of the crews, police have street triage. With these similar approaches being taken, there may still be silo working at an organisational level and it would be more effective to develop the cultures to work and support across agencies knowing it is okay to ask for advice. The system, however, needs to have the framework in place to support difficult decisions and risk around self-harm and suicidality. **Impact & Benefit** • Reduction of self-harm and suicidality • Better quality interactions when there are difficult conversations and situations • Psychological informed workforce – improved wellbeing • Validating experience for individual leading to better outcomes **Alignment –** Consistent approaches for reduction of self-harm and suicidality should be at ICS level with the focus to deliver at and ICP level.
Removing barriers to provide equitable access to the appropriate treatments **High Priority**	Certain contracts are set up with thresholds that apply, so a patient not meeting the threshold would not qualify for access to the treatment, e.g. IAPT/ cognitive based therapy (CBT). There are patients that may have had suicidality, but can greatly benefit from CBT, but the IAPT service is not available for patients that have self-harmed or had suicidality. This was found to have some link to a risk averse workforce culture, with a fear factor attached to treating people with suicidality in case they go on to commit suicide. Some would argue this is presenting inequity, perhaps to those that may benefit the most. The system needs to be flexible with the way in which service contracts are set out, to prevent the barriers to access. As described in previous sections, through collaborative and supportive working this flexibility can be effective in providing access to services for all patients where multi-agency approaches to patient care provide sufficient support and advice from clinicians working together to provide the personalised care suited to the individuals needs, rather than a service offer with limits imposed. This hugely prevents patients being bounced around the PD care system, and also improves access at lower tiers of the stepped care model. As a result specialist care in the secondary care setting can focus on the more severe cases with reduced capacity constraints and reduces urgent unplanned care. **Impact & Benefit** • Increased access and intervention • Support for people to not feel alone • Equitable access to evidence based interventions • Reduces morbidity • Increased engagement through enhanced experience - empowered/independence • Improved outcomes through other areas e.g. social function, physical health as well as MH, work, family, criminal justice • Reduce unplanned chaotic care • Reduce admissions • Reduces urgent and unplanned care, have predictable relationship, reduce problem behaviours. **Alignment** – Access to all treatments needs to be equitable across the ICS and so alignment for consistency should be at this level. In terms of delivery the removal of barriers for access should also be managed and aligned at an ICS level.

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7. Transformation Proposal - Summary

Transformation Proposals	Priority (High/ Med/ Low)	Alignment (ICS/ ICP/ PCN)		Workforce	Technology	Estate/ Configuration	Culture	Finance/ Commissioning	Benefits (*Less than £20,000 per QALY is cost effective)
		Consistency	Delivery						

Education and training to support **prevention and early intervention**:
• Early Years
  • Raising awareness of ACEs through effective schemes
  • Parent mentors
  • Support of those children with parents in prison
  • Safeguarding meetings training teams to understand transition to young adults
  • Working to 2022 MH in schools target
• Training and education of workforce
  • Roll out Knowledge and Understanding Framework (KUF) across ICS
  • Primary care education to promote early intervention
  • Training and awareness of workforce that provide secondary support, e.g. housing providers, helping users to remain engaged and removing stigma
• Education and support for service users and families to improve self-care and management
	High	ICS	ICP	• Appropriate skills and experience in schools to act, not just raise awareness
				• Develop skill base across severity range – providing required support earlier – to improve emotional resilience, etc; having access to the required therapies; but also providing the level of skill and training to provide enough low intensity therapy (e.g. teachers)
				• Mindfulness skills in primary schools
				• Training professionals who work with people with PD is vital (e.g. link workers) – many of the 'providers' of PD services are not sufficiently trained in PD
				• Agencies such as housing, police that may come across individuals with PD, need a more specific level of training to approach situations with more understanding and support
				• Trauma informed training offer
				• Workforce capacity for delivery of structured education and training
				• Practice development approach to access training and support
				• Further develop 'Healthy Families' programme. Over-stretched – demand outstrips supply currently.
				• Support for secondary school parents not available across the board.
				• KUF training for IAPT?
					•Use of online tools, Recap to help prescribe information – provision of links rather than having to search for them
					•Practice development online offer
					•Multi-agency approaches – need systems to be talking to each other. One approach to multi-organisational care plan.
							• Build resilience in schools with early education aligned to MH in schools by 2022 – need to eradicate bullying, victimisation, but also support to change those that inflict upon the victims – stop the cause
							• Education of individuals needs to improve so they are aware of what PD means
							• KUF increases ones understanding of a PD, but it does not treat them or equip you with skills to provide that level of support – good for awareness and preparing individuals coming into contact with those with PD, but is just a starting point
							• Cultural buy in and commitment
							• Cultures between PC and specialist services need alignment
							• Transition – challenging part of MH delivery – difficult time to manage – 0-25 agenda should help
							• Different thresholds in different services – boundary issues change. Can discuss with parents to needing consent to do so.
							• How to help and support parents. (experiences are not explored, things aren't spoken about etc, emotions not validated)
								•Healthy families scheme further funding to meet demand.	•Improve wellness and resilience through preventing triggers leading to development of personality disorder traits
									•Reduced emergency presentation in acute setting – crisis response
									•Improved support in primary care, enabling better self-care with coping strategies early

Multi-agency joined up approach including 3rd sector to provide more **consistent and personalised care**: • Effective and appropriate navigation and access through simplified pathways • Peer mentors to support in urgent care settings – crisis café link • Crisis support across organisations with multi-disciplinary approach to help move individuals out of the acute system across the lifespan • simplify engagement between agencies (healthcare and social care) to ensure workforce are also able to follow clear pathways • LTP - Collaborative care planning – all agencies should know what has been agreed – move away from silo working – consider interfaced systems. Complex case discussions with all supporting agencies	High	ICS	PCN	• Peer support to help citizens manage their distress in emergency settings – follow through from contact to contact – ongoing assessment that is progressive • True multi-agency to support those that need support requires more capacity in social care, primary care and many of the other areas that need input – making more effective use of resources through more effective collaboration to make delivery of care more efficient – duplication of interventions needs to be addressed to release the capacity needed • IAPT training for staff working at step 3 with PD, may need some relaxing of IAPT what is delivered – national conversations for training packages • HEE to confirm, but IAPT will need KUF training – education and awareness of how PD develops • Working jointly with 3rd sector. Mental Health Hub (virtual hub) – then can signpost people to voluntary sector etc MH practitioner roles, based in PCN MDT	•HCPs to have access to information 24/7 e.g. Rio across all platforms – centralised access to vital live information – markers to identify current support individuals are accessing •Developing a live DoS •Multi-agency approaches – need systems to be talking to each other. One approach to multi-organisational care plan •F12 help but need to be kept up to date as Services don't know what everyone does and what the boundaries are	•Space for MH practitioners that are being employed – need desk space •Long term plan for Hub and Alliance building	• Physical, mental and social care are all in here, but this should also include areas where support are not commissioned but perhaps supported by 3rd sector (e.g. lottery funding) – so a broader group needs to be considered – is it MDT working or multi-agency providing the care together • Culture to reduce barriers top down • IAPT flow between them and specialist teams need to go via GPs (due to it being PD – not there for step up to stage 4 etc.) IAPT not designed for ensuing MH problems, but don't have referral mechanisms for those with Long term MH conditions - needs reviewing. • Services don't know what everyone does and what the boundaries are and keeping it up to date • Risk thresholds for IAPT – recent self-harm, recent suicidality – IAPT end their involvement, but don't meet LMHT threshold. • PC / IAPT improve with dialogue and SC. (Trent, PTS & Insight) • Self-referral – rather than having to go via GP	• Commissioning - focus on outcomes to enable multi-agency approach • Commissioning for IAPT risk thresholds (recent self-harm/ suicidality) IAPT end their involvement, but don't meet LMHT threshold. • Adapt IAPT thresholds as patients have attachment threshold. More flexible with risk threshold in IAPT. Historical IAPT – not set up for crisis management • Needs to be system led as different providers to improve relationships between PC/IAPT and IAPT/SC. • Manualised approach in IAPT, replicating what prisons previously did – finances around contacts. Move to more formulation approach – treat individual rather than what manual says to do next	•More joined up approach, systems talking to each other and breaking down barriers – not got admission and discharge between services. People can get what they need when they need it and not repeating stories and don't feel rejected. More seamless care. •More thoughtful approach – too quick to identify right service – need conversations with services first to ensure that they are the correct service. Referrals to incorrect service closed elsewhere. What are the difficulties and where is the appropriate place for treatment. •No wrong door – place based services. Not having to repeat story – patient not passed along different steps and not suitable for any.

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7. Transformation Proposal - Summary

Transformation Proposals	Priority (High/ Med/ Low)	Alignment (ICS/ ICP/ PCN)		Workforce	Technology	Estate/ Configuration	Culture	Finance/ Commissioning	Benefits (*Less than £20,000 per QALY is cost effective)
		Consistency	Delivery						
Improve MH prevention and support for **Severe and Multiple Disadvantage** (SMD) individuals through service **access across the ICS**: • Build on Nottingham City model • Develop true MDT approach in each ICP (?) as a partnership of health, housing, social care, voluntary sector, criminal justice • Promote mental health resilience by providing sustained long-term wrap around care for those with most complex needs including substance and alcohol misuse • Presentation at ED – how to best support this – high volume service user post/ frequent attenders	Med	ICS	ICS	•Navigator role and approach needs to be established across the ICS •Presentation at ED – role to support high volume service users (HVSU) is important – some roles have been decommissioned •Need to understand what structure is already in place in the county as there are some organisations specific to city (Opportunity Notts) •Multi agency roles police and EMAS HVSU – working together and diverting from ED •Liaison psychiatrist working together into other services •Opportunity Notts – MDT meeting for chaotic individuals. Development ICP starting with rough sleepers, but now extending to hidden homeless – evaluation and learning. •Flexibility of workforce to work differently – reaching into settings in community	•Flexible use of technology to arrange appointment in the right way for the person •Connections for agencies and the visibility of information	•Currently everything has been done virtually •Services going to the people not the other way round	•Recognition of dual diagnosis for substance misuse •Danger of inequity if not adopted in County •Engage 3rd sector to deliver, but cannot rely on charitable funding longer-term •MDT function is designed to support those with most complex issues – the key parts are to ensure everyone has a navigator – helps navigate all systems to enable them to work together •Geographically models may vary slightly but working with the city teams can help define proposals for county – very important to use all this learning – really important to ensure the right people are around the table – not effective having meetings about an individual's care if the right people are not present •Buy in and authority to make decisions, flexible responses enabled to 'rip up rule book' – organisational buy in and statutory regulation •Equality and mutual respect of experience across agencies •Frequent attenders ED multi-factor considering this and joint working and links across physical and mental health to provide best support	•Sustainable funding models across ICS •Commission support from 3rd Sector where proven to be effective (e.g. crisis cafés) •Outcomes based commissioning •Commissioning of roles where there is inequitable access e.g. HVSU	•Reduce ED attendance •Prevents individuals bouncing between services •Reduced crime •Add the benefits from below – wider social benefits •Improved access to physical health care •Reduced suicide risk
Targeted approach to **reduce self-harm and suicidality** for those with personality disorders: • Parity of esteem – Developing trust between Healthcare Professionals, Police, EMAS/ Ambulance crews, other frequent providers of care with mental health teams • Ensuring those with complex mental health needs are understood and supporting without labelling and stigmatising • Breaking bureaucratic barriers to enable access and support to psychological therapies (CBT)	High	ICS	ICP	•Training and sharing across agencies •How to link and communicate – sharing of expertise and knowledge formulating MDT to manage integrated care plan	•Online packages of training to signpost - built into ESR •Visibility and access to information v supportive in crisis •Virtual connections for MDT •Apps for people to develop individual plans – can include and tailor to access to local services – Stay Alive		•Onwards need may not be suicidal based and so IAPTs can be best options •Culture to work and support across agencies – ok to ask advice •Accountability and understanding of currency around those conversations impact of responsibility, culpability and overcoming this concern •Frameworks to support difficult decisions and risk - offer best practice •Language and support, overcoming fear •Partnership working and leadership support – shared learning •Understanding difficult situations linked to capacity and link to stigma •Acknowledge understanding as whole age		•Reduction of self-harm and suicidality •Better quality interactions when there are difficult conversations and situations •Psychological informed workforce – improved wellbeing •Validating experience for individual leading to better outcomes

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		Consistency	Delivery						
Removing barriers to provide **equitable access** to the **appropriate treatments**: • Identify gaps in service access (e.g. lower tiers in stepped care) to improve provision through early access – GP liaising with IAPTs to allow provision • Review thresholds to allow appropriate referrals for all • Up-line support for Personal Assistants (PAs) need support • Identification, access and stigma • Consistent offer regardless of team/LA the citizen is under (i.e. City/County)	High	ICS	ICS	•IAPT s/ psychological support capacity •Nottingham DBT north Notts – Psychologist and other HCP scoping and adding capacity •Scoping other psychological interventions for all levels of risk •Education for MHSOP to be prepared •Training for AMH services •Roles to span services and professionals - peer support roles connecting with the person •Understand training needs and supported in developing this understanding and opportunity to escalate. •HCA –don't have official body •PAs training and support required. •What support is available for advice without a referral so care can still be provided in the community? Need to refer in to get that support. •Training to reduce stigma, understand these individuals as people rather than something different – needs to be supported down the line, reflective practice. •Awareness of transference. Robust and resilient staff, patient more boundaries in what they can and can't do. Staff response to drug use, self-harm	•Virtual connections to extend mode of delivery to make accessible e.g. structured education management can offer different timing – consider and ensuring this doesn't exclude marginalised groups •Visibility of information and shared systems e.g. development of integrated care plan	•Clinic space to deliver	•Understanding that certain thresholds prevent access to much needed services •Addressing the support that the ones inflicting trauma, or victimising others, in a way to prevent the impact they are having on others •MESOP cultural change for identification and navigating to DBT •Meaningful conversations and inclusion with people service design and delivery – good practice for all proposals •Understanding that certain thresholds prevent access to much needed services •Stigma is huge for this patient group. Loads needs to be changed culturally. Support, supervision, space to be able to talk openly and honestly. •Challenge stigma by looking at source. Training originally was that these are a tricky group of patients. What is current training of student medics etc learning about this cohort of patients. Understand limited training. Training strategy of student medics. Nurses – preceptorship – support healthy work approach. Need to equip students to challenge negative thoughts about this patient group	•PHB to achieve aims and workforce to deliver to this •IAPT info above! •Funding social care – PAs enable citizens to access community. Low paid / minimal training, but empathically provide great service, tuned into patients. Don't get the supervision required to help PAs manage difficult relationships. •Review commissioning of IAPT to include PD •What support is available for advice without a referral so care can still be provided in the community? Need to refer in to get that support.	•Increased access and intervention •Support for people to not feel alone •Equitable access to evidence based interventions •Reduces morbidity •Increased engagement through enhanced experience - empowered/independence •Improved outcomes through other areas e.g. social function, physical health as well as MH, work, family, criminal justice •Reduce unplanned chaotic care •Reduce admissions •Reduces urgent and unplanned care, have predictable relationship, reduce problem behaviours.

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8. Enabling Requirements

Workforce	Enhancing the future health and social care for personality disorder services, requires the following main considerations for workforce: • Existing plans are in place for the roll out of MH trained social prescribers in April 2021, however, with existing challenges in meeting national targets for the provision of IAPT services, the role may be useful in better navigating patients through primary care and community services • Strong involvement from Public Health consultants to lead the prevention agenda, promoting wellness and resilience education in schools from an early age • Widespread training of HCPs to empower them to provide appropriate brief advice and support or signposting/ referring to IAPTs for early identification and response of personality disorders • Maximise resource utilisation through greater engagement with HCPs (make every contact count) offering true parity of esteem with structured education and appropriate accreditation
Technology	The main areas in which technology can effect transformation for personality disorders include: • Digital interfaces and information sharing between organisation should be a clear part of our ambitions going forward. • Developing compatible or interfaced systems that allow access to eSCRs across organisational boundaries • Use of virtual appointments to deliver access to psychological therapies only where appropriate for patients • Ensure all MH services, including 3rd sector organisations are accessible through a Live Director of Services (DoS) • Develop one approach to a multi-agency care plan available electronically – allows accurate record of consent to be seen
Estate	• Maximise opportunities to utilise general practices, health centres and GP practices to provide access to services closer to home where appropriate • Increase presence and access to IAPT services in areas where inequalities exist • Increased service provision in primary and community care settings will require more clinic space to deliver
Culture	• To drive a culture change we need shared and integrated use of workforce across organisations to enable the sharing of resources as there are limited staff groups and expertise, with the introduction of multi-agency approaches this should improve education across the workforce • All ICS partner organisations to be part of the collaborative providers of personality disorders care – parity of esteem • Adopting strengths based, trauma informed, psychologically informed environment approach • Joint working to help people in a different way – liaison between professionals to support person-centred • Partnerships between 3rd sector and organisations to ensure they understand the pathways better and how to refer/ signpost • Cultural change to support prevention – self-care • Workforce to address prevention – everyone's responsibility

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9. Personality Disorder Services Future Vision

'Bridge to the Future'

From…		Phase 1 1st year	Phase 2 2-3 years	Phase 3 5 years +	To…
• Limited awareness and support at early school age • Patients feeling stigmatised in various settings • Changing/ multiple diagnoses of personality disorders • Poor education and coaching to parents/ families in risk of ACEs	Prevention & Self-Help	• PD service providers to work with PH to plan for resource and responsible parties to develop education and training programmes to include specificity jointly defined through providers • Review specific issues (ACEs) and opportunities to address these • Need to include suitable service users at all levels in initiatives for learning • Scope existing material and update to ensure PD is understood – include learning from current successes (Small Steps Big Changes – family mentor scheme, Turning Point, etc.) • Align to Children's Wellbeing pathway	• Retain input from identified service users to test initiatives for learning as they are being implemented • Expand current education initiatives in City to county • Workforce education – system wide to ensure PD is understood and their part in the 'No Wrong Door' approach • Affirm Children's Wellbeing pathway aligns to be PD prevention aware • Improved education and awareness for those with or suspected of developing PD filtering across the system through effective targeted approaches through coordinated joint working	• Routine outcome monitoring • Regular and outcomes focused reviews • All system organisations (incl. 3rd Sector) able to access education and training to fully appreciate PD and parity of esteem approach in all settings across the system • Basic prevention strategies adopted in schools and LEAs across the ICS • Education and training for all-agencies included across all support needs	• Effective schemes raising awareness of ACEs including parent mentors • Robust safeguarding training supporting transition of those with PD in transition • Widespread training offer for workforce in preventing stigma and labelling of those with personality disorders • Equitable access to services supporting wider determinants of personality disorder, such as housing, employment, financial support across the ICS
• Inadequate recognition of MH needs of those with PD in physical health/ emergency settings • Inconsistent assessment of need in primary care • Inequitable access to SMD support across the ICS • Limited understanding of self-harm and suicidality across the workforce	Assessment & Understanding of Need	• Workforce should be recognised as representing the whole system – exploit existing training (e.g. suicide) to enable a culture realisation of parity of esteem – target areas to be defined (e.g. A&E, Police) • Plan to reach ICS-wide workforce education of how PD can present • Plan how to expand MDT for SMD across county – start with what has worked well – plan equitable funding • Plan to expand work on suicide and self-harm to raise awareness further	• Through ICS-wide workforce approach, identify which barriers to access can be removed (e.g. discussing suicide or self-harm with IAPT service providers • Strengthen successful initiatives to duplicate these in other areas • Ensure support is available/ accessible for non-PD service providers eg EMAS • Trial SMD and commission what works well with continuous evaluation • Primary care with improved support to enable early recognition of possible PD • Improved support for suicide/ self harm	• Workforce including appropriate conversations on MH in physical areas of care • SMD - commission for what works for different groups. Who else needs to be in this partnership – what other frequent problems are people presenting with that a multi-agency approach could help. Continue to evaluate and tweak the model • Reduction in suicides through targeted programmes	• Clear understanding and practice of parity of esteem across all service provider • Primary care system that is fully supported with early recognition of PD • Funded SMD services and MDT access across ICS • ICS wide targeted approach for reduced self-harm and suicidality through improved recognition of signs and understanding of need
• Limited service capacity in lower tiers of stepped care model • Uncertainty of who can support • Inadequate access to support for high volume service users (HVSU) • Complex pathways across the ICS	Models of Care	• Identify gaps in lower tiers to define resource/ service needs (long waiting lists to manage) • Scope all PD service providers and details to develop list in a Live DoS • Consider green space work as alternative for those considered at risk (non-medical users) • Scope required HVSU support posts • Identify what diagnoses act as a barrier to accessing services, need to be flexible – plan support needed • Plan specific areas to build flexibility and support to simplify pathways	• 'No Wrong Door' written into service specs – not just IAPT, incl. substance misuse and crisis sanctuary – build good relationships • All providers listed on Live DoS - including increased collaboration and support for 3rd sector groups • Improve presence of and support for HVSU posts • Build collaborative working relationships • Increased access to person-centred IAPT support across ICS	• Improved access to lower tiers of support, providing earlier intervention for reduced burden on secondary care • Improved care and support ICS-wide with gaps in care eradicated for PD • Simplified pathways across organisations and settings, with easy access to 'Who's who' through a Live DoS	• Equitable access to lower tier services supported by appropriate primary care referrals • Live DoS listing all providers and capacity and all 3rd sector organisations • Dedicated support for identified HVSUs • Simplified models of care amid specialist care primary care, community care and 3rd sector
• Barriers to accessing some models of care • Inconsistent access to peer support and local schemes (e.g. crisis cafés) • Incompatible systems between care settings and providers of personality disorder services	Whole System Approach	• Scope and baseline system limitations to design solution e.g. interfacing, single system across providers • Review successes of Crisis cafés to expand in other areas of ICS • Making the system more efficient through improved integration with primary care – define required partners to build multi-agency model and robust structure in lower tiers • Identify gaps to prevent users being denied access – start with plan for existing backlog and inequity of access – detailed first assessment to get people in right treatment at right time	• Interface systems to ensure patient data is readily accessible/ accurate • Improved and expanded access to crisis cafés to support peers (esp. suicidality) • Fill gaps where service offer is a barrier • Continue building multi-agency working to ensure identified gaps are being filled, but approach to patient care is more collaborative • Begin to see system joining up, working around users rather than in silos	• Established peer led model, peer support and peer led monitoring away from crisis sanctuaries • IAPT provision across the ICS matched to demand, across all levels • LA funding for 3rd sector to help collaborate multi-agency support for personality disorders • Fully interfaced systems providing timely and appropriate access to patient data	• Multi-agency input to work through barriers and personalise care provision • True partnership working across professionals and organisations (including 3rd sector) to consistently meet the MH needs of the ICS population • Interoperability of systems to allow visibility of information to support shared-decision making

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

10. Conclusions and Next Steps

Conclusions	The review of Personality Disorder services as part of the development of a Clinical and Community Services Strategy for Nottingham and Nottinghamshire ICS has been undertaken using a co-design model where patients, carers, key stakeholders and voluntary sector groups such as Framework and Opportunity Nottingham, have collaboratively worked together to shape a vision for the future care system. The work has progressed well working remotely and holding virtual meetings. The four key themes for improvement identified are: • Prevention and Self-Care (with emphasis education for non-judgemental practice in validating patients in all settings, coping mechanism to reduce episodes of care need, raising awareness across the ICS population, the workforce and patients); • Assessment and Understanding of Need (reviewing early recognition amidst chaotic lifestyles, working with people through moments of difficulty including alcohol and substance misuse, disordered eating and eating disorders, preventing breakdown resulting from dents, housing employment issues, looking at suicide and self-harm, and patient presentation); • Models of Care (reflecting on emotional instability, impulsivity and interpersonal difficulties, assessing health inequalities, accessibility and inclusivity and reviewing what community provision is in place); • Whole System Approach (involving all partners in the conversation including 3rd sector, criminal justice and social care, collaborative integration highlighting the Make Every Contact Count (MECC) principle and enabling a Quality of Life). The review describes a future care system in optimal care settings and with care provided at different levels of urgency and envisages 4 high priority and 1 medium priority programmes to transform care: • **High -** Education and training to support prevention and early intervention • **High -** Multi-agency approach for consistent personalised care • **Med -** Improved access for Severe and Multiple Disadvantaged (SMD) • **High -** Targeted approach to reduce Self-Harm and Suicidality • **High -** Equitable access to the appropriate treatments To achieve these there are a range of enabling requirements for the ICS across workforce, technology, estate, culture and financial systems. Collectively these initiatives can help transform and provide long term health improvement and sustainability in the area of PD services in the Nottingham and Nottinghamshire ICS.
Next Steps	This strategy sets the future direction of development for PD care in the ICS and it is proposed it will shape future work of the ICS in a number of ways: • The identified priorities and programmes should be used to inform commissioning ICS, ICP and PCN activity • The enabling activities require development and inclusion in the relevant ICS workstreams to inform their work programmes • The impact on estate and configuration changes require inclusion in a programme of pre-consultation business case development alongside the service changes recommended from other reviews, although the impact for PDs is less specific in relation to community hub space • The aggregate impact of the collective suite of service reviews should be used to shape focus of future service provision in acute/ MH and community settings in the ICS

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

11. List of Common Abbreviations

1°, 2° Care	Primary, Secondary Care	EMCA	East Midlands Cancer Alliance	NNU	Neonatal Unit
2WW	Two-week-wait	EMRAD	East Midlands Ambulance Radiography	Notts.	Nottinghamshire
A&E	Accident and Emergency	ENCH	Enhanced Health in Care Homes	NRC	National Rehabilitation Centre
A&G	Advice and Guidance	ENT	Ear, Nose and Throat	NRCP	National Register of Certified Professionals
ACE	Adverse Childhood Experience	EoL	End of Life	NRT	Nicotine Replacement Therapy
ACP	Advanced Care Practitioner	eSCR	Electronic Shared Care Record	NSC	National Screening Committee
ADHD	Attention Deficit Hyperactivity Disorder	ESD	Early Supportive Discharge	NUH	Nottingham University Hospitals
ADVIS	Adult Deaf and Visual Impairment Service	ESDT	Early Supportive Discharge Teams	O_2	Oxygen
AF	Atrial Fibrilation	F2F	Face to Face	OCCCF	Ophthalmic Common Clinical Competency Framework
AI	Artifical Intelligence	FeNO	Frasntonal Exhaled Nitric Oxide	OCT	Optical Coherence Tomography
AID	Accessible Information Standards	FT	Foundation Trust	OOH	Out of Hours
AK	Actinic Keratosis	FTE	Full Time Equivalent	OPA	Outpatient Appointment
AMD	Age-related Macular Degeneration	FU	Follow Up	OPM	Office of Public Management
ANP	Advanced Nurse Practitioner	GA	General Anaesthetic	OTC	Over-the-Counter
App	Application	GBD	Global Burden of Disease	PCN	Primary Care Network
APPG	All Party Parliamentary Group	GOC	General Optical Council	PCP	Personalised Care Plan
ARTP	Association for Respiratory Technology and Physiology	GOS	General Ophthalmic Service	PCR	Patient Care Record
ASC	Autism Spectrum Conditions	GP	General Practitioner	PD	Personality Disorder
AT	Assistive Technology	GPRCC	General Practice Repository for Clinical Care	PH	Public Health
ATAIN	Avoiding Term Admission Into Neonatal units	GPwER	General Practitioner with an Extended Role	PHE	Public Health England
BAD	British Association of Dermatology	GRASP-COPD	Guidance on Risk Assessment on Stroke Prevention for COPD	PHM	Population Health Management
BAME	Black, Asian and Minority Ethnic	H&SC	Health and Social Care	PHO	Public Health Organisations
BB	Better Births	HCP	Healthcare Professional	PID	Project Initiation Document
BCC	Basal Cell Carcinoma	HES	Hospital Episode Statistics	PKB	Patient Knows Best
BEH	Behavioural and Emotional Health	HES	Hospital Eye Service	PN	Practitioner Nurse
BF	Breast Feeding	HL	Hearing Level	PR	Pulmonary Rehabilitation
BFI	Baby Friendly Initiative	HNA	Holistic needs assessment	PSNC	Pharmaceutical Services Negotiating Committee
BLF	British Lung Foundation	HPV	Human Papilloma Virus	PwER	Pharmacist with Extended Role (in skin health)
BMI	Body Mass Index	HV	Health Visitor	QALY	Quality Adjusted Life Years
BMJ	British Medical Journal	IAPT	Improving Access to Psychological Therapies	QIPP	Quality, Innovation, Productivity and Prevention
BP	Blood Pressure	ICP	Integrated Care Partnership	QMC	Queen's Medical Centre
BSG	British Society of Geriatrics	ICS	Integrated Care System	RCEM	The Royal College of Emergency Medicine
BSL	British Sign Language	ICT	Information and Communication Technology	RCN	Royal College of Nursing
BTS	British Thoracic Society	IT	Information Technology	RCOG	Royal College of Obstetricians and Gynaecologists
CAMHS	Child and Adolescent Mental Health Service	IUC	Integrated Urgent Care	RCOphth	Royal College of Ophthalmology
CAS	Clinical Assessment Service	IUT	In-Utero Transfer	RDC	Rapid Diagnostic Centre
CBT	Cognitive Behaviour Therapy	KMH	Kings Mill Hospital	RNIB	Royal National Institute for the Blind
CCG	Clinical Commissioning Group	LD	Learning Disability	RNID	Royal National Institute for the Deaf
CCSS	Clinical and Community Services Strategy	LMHT	Local Mental Health Teams	ROI	Return on Investment
CES	Cranial Electrotherapy Stimulation	LMNS	Local Maternity and Neonatal System	RoSPA	Royal Society for the Prevention of Accidents
CFS	Clinical Frailty Scale	LNU	Local Neonatal Unit	ROVI	Rehabilitation Officer for Visually Impaired
CGA	Clinical Geriatric Assessment	LOC	Local Optical Council	RTT	Request To Treatement
CoC T&F	Continuity of Care Task and Finish	LoS	Length of Stay	RTT	Radiotherapy
CoO	College of Optometrists	LTC	Long Term Conditions	SALT	Speech and Language Therapy
COPD	Chronic Obstructive Pulmonary Disease	LTOT	Long Term Oxygen Therapy	SaToD	Smoking at Time of Delivery
COVID19	Corona Virus Disease 2019	LTP	Long Term Plan	SBLCB	Saving Babies Lives Care Bundle
CPR	Cardio-Pulmonary Rescucitation	LTV	Long Term Ventilation	SC	Social Care
CQUIN	Commissioning for Quality and Innovation	LV	Low Vision	SCC	Squamous Cell Carcinoma
CUES	COVID Urgent Eye-care System	MBCT	Mindfulness Based Cognitive Therapy	SEND	Special Educational Needs and Disabilities
CVD	Cardio Vascular Disease	MDT	Multi-Disciplinary Team	SFH	Sherwood Forest Hospitals
CVI	Certification of Vision Impairment	MECC	Make Every Contact Count	SIGN	Scottish Intercollegiate Guidelines Network
CYP	Children and Young People	$MgSO_4$	Magnesium Sulphate	SLT	Speech and Language Therapy
CYPF	Children, Young People and Families	MH	Mental Healthcare	SPA	Single Point of Access
DASV	Domestic Abuse and Secual Violence	MHCLG	Ministry of Housing, Communities and Local Government	STP	Sustainability and Transformation Partnership
dB	Decibell	Mid Notts.	Mansfield & Ashfield, Newark & Sherwood	TC	Treatment Centre
DNA	Did Not Attend	MMR	Measles, Mumps, Rubella	TIA	Trans-Ischaemic Attack
DoS	Directory of Service	NCGPA	Nottingham City General Practice Alliance	TTO	To Take Out
ECG	Electrocardiogram	NCH	Nottingham City Hospital	TYA	Teenage and Young Adults
ECLO	Eye Clinic Liaison Officer	NGO	Non-Government Organisations	UC	Urgent Care
ECT	Electroconvulsive Therapy	NHFT	Nottinghamshire Healthcare Foundation Trust	UCC	Urgent Care Centre
eCVI	Electronic Certfication of Vision Impairment	NHS	National Health Service	UEC	Urgent and Emergency Care
ED	Emergency Department	NHSE	National Health Service England	UECDI	Urgent and Emergency Care Digital Integration
EFI	Electronic Frailty Index	NHSI	National Health Service Improvement	UTC	Urgent Treatment Centre
ELBG	Ear Lobe Blood Gas	NICE	National Institute for Health and Care Excellence	VCSE	Voluntary, community and social enterprises
EM ODN	East Midlands Operational Delivery Network	NICU	Neonatal Intensive Care Unit	VI	Visual Impairment
EMAS	East Midlands Ambulance Service	NIDA	National Institute of Drug Abuse	WHO	World Health Organisation

12. Data Sources

Data Sources	British Medical Journal Local Data from NUH, SFH, Social Care, CCGs, GPRCC, eHealthscope Mind.org PubMed.gov Children and Young People Service Review – CCSS National Institute for Health and Care Excellence (NICE 2018, Updated Draft), (NICE CG113) NCEPOD Improving the Quality of Healthcare NHS England NHS Health and Social Care Boards NHS Long Term Plan No health without mental health Office of National Statistics Focus Group, 18 Dec 2020 Patient interviews Public Health England World Health Organisation