Using a Strategic Gap Analysis to guide your plans

This has been written by the Strategic Planners in the Transformational Change—Systems team within Healthcare Improvement Scotland. It summarises what a Strategic Gap Analysis is as well as when and how to use it and includes two recent examples of Strategic Gap Analyses we undertook within our improvement programmes

Please note **this document is only 6 pages** – the rest of the pages are two examples of our prior Strategic Gap Analyses in appendices!

A Strategic Gap Analysis is a strategic planning tool used regularly in health and social care planning. It seeks to triangulate evidence from multiple sources to

- Compare the status quo with good practice
- Identify the gaps between the two
- Explore the mechanisms to close the gap to inform future strategy and planning.

This activity can be found within the Analyse stage of the Good Practice Framework for Strategic Planning and the Good Practice Skills for Strategic Planning.

A Strategic Gap Analysis requires other pieces of analysis to be available to inform it

- Analysis of the broader environment (ie the strategic context) to clearly set the parameters for what success looks like – including legislative requirements and policy expectations and the national and local context around infrastructure, funding, assets, challenges and priorities.
- An understanding of the need of the people (ie needs analysis) that this analysis is about (ie target population, patient group, or client group). This should look at the needs of people as its starting point, rather than starting with analysis of existing demand, services and pathways. It looks to understand what drives behaviour and considers how the need of people might change in the future.
- An understanding of what 'good' looks like. Doing this requires bringing together the strategic context, the population need, along with any available evidence and literature on what is considered effective, fair, efficient and accessible care and support for people. This analysis will provide the first of the three sections of the gap analysis.
- An understanding of the way that services are currently provided (the status quo) including current performance and shape of services by triangulating management and performance data, lived experience insight, staff and stakeholder experience, and other relevant sources of insight. This analysis will provide the second of the three sections of the gap analysis.

One of the challenging parts of a Strategic Gap Analysis is ensuring that you have the underpinning analysis available (from the list above) to be able to inform a high quality and useable Strategic Gap Analysis. If you are feeling overwhelmed in trying to understand the gaps, it can be helpful to work

through the above list to see whether you feel like you have sufficient 'answers' from each of these areas first.

Appendix 1 and 2 contain examples of recent Strategic Gap Analyses that we have undertaken as part of our improvement work. They are designed to provide ideas into how you might approach a Strategic Gap Analysis and shouldn't be used as a replacement for local analysis.

Why might you do a Strategic Gap Analysis?

We find Strategic Gap Analyses helpful as a method to bring together a wide range of evidence, thinking and insight and turning it into a concise analysis that clearly identifies the gaps in the system.

Having an evidence based and comprehensive analysis of gaps has helped us to

- Bring stakeholders around a common analysis that facilitates discussions and brings disagreements to the surface
- Identify and agree what areas of change we want to pursue
- Have a robust and clear rationale for our decision making that can be used to build buy in.

Different stakeholders will hold different views on what 'good' looks like. They will also hold different viewpoints on the adequacy of the status quo and differ in their thinking about what the gaps are (and the relative importance of each of the gaps).

It is common that these differing views are not explored explicitly with stakeholders. Which means that when groups of stakeholders are trying to reach a consensus on what services to offer or what changes to make to a service, we end up talking at cross purposes because we haven't arrived at a consistent understanding of where we are aiming to get to.

A concise but comprehensive gap analysis gives stakeholders something to engage with and discuss. It enables them to identify where they disagree, and to work through these disagreements. Hopefully arriving at a shared understanding.

What does a Strategic Gap Analysis look like?

We tend to follow the general structure below

- What does good look like
- What does existing provision look like (status quo)
- What are the gaps between good practice and existing provision.

From our experience of using this kind of analysis, we feel that the process you go through to develop, test, refine and finalise your gap analysis is as important, if not more, than the final output created. You may find that beneficial to conduct initial stakeholder engagement to draw on insights and views, or you may find it helpful to bring an initial draft to stakeholders for engagement. How you approach it will depend on the stakeholder dynamics.

It can be easy to overcomplicate a Strategic Gap Analysis. At its essence it compares good with current to identify gaps between the two. They provide targeted and concise descriptions of what many people may already know. However, they act as a centring document and process to ensure that what we are saying is evidence based, provides reassurance that we have conducted a comprehensive analysis to inform next steps, and act as a mechanism to engage stakeholders, work through disagreements, build a shared vision, and obtain buy in. This makes them a valuable investment as part of planning processes.

The three suggested sections in the Strategic Gap Analysis are described in more detail in the sections below.

1. What does good look like – what do we include?

This section describes what evidence says good looks like – including safety, quality, accessibility, affordability, adaptability, and its ability to effectively meet someone's combination of needs.

It may be that this analysis has already been conducted and you can draw on it for the purposes of your gap analysis. In other cases, you may need to build this as part of your gap analysis.

Describing what good looks like will require you to synthesise evidence from a wide range of sources, including

- Published standards and guidelines
- Recommendations from things like inspections, reports from national bodies
- Feedback, research and insights from people with lived experience
- Literature available that summarises good or effective practice
- Engagement with staff and stakeholders
- Exploring the features of models or services available that seem to be doing well to understand what insights this experience can offer.

Section 1 in each of the two appendices outlines how we bought this together to provide a summary of what we felt good looked like in the context of supporting individuals with a diagnosis of personality disorder and those with mental health and substance use co-occurring need.

2. What existing provision looks like – what do we include?

This section provides an analysis of the 'status quo'. It describes what current services look like. There is no fixed way to break down this analysis. We tend to break these down based on the relevant themes in the topic being explored. Some examples of common ones include leadership, culture, workforce, lived experience, diagnosis, access, care/treatment provided, data, communication, joint working, referral processes, and learning.

Once again, effectively summarises the existing provision requires triangulation of insight from multiple sources including

- A review of existing policies and procedures
- Management and performance data

- Findings from Adverse Event Reviews and other case reviews
- Dialogue with staff
- Feedback/insights from people with lived experience.

One of the common challenges in developing this section is that it can be difficult to disentangle the description of existing provision with an assessment of its adequacy. It is often easier to extract these from each other once you have written both sections 2 and 3. There is no right or wrong way to delineation between sections 2 and 3, provided the end output is appropriately clear for stakeholders to draw meaning from it.

3. What are the gaps between good practice and existing provision

This section analyses the gaps between good practice and existing practice. It needs to be detailed enough to provide a clear sense of what areas need to be explored in any change or improvement. In the examples in the appendices, we kept these simple as a single set of bullet points. For other gap analyses it may make sense to

- Break these down further into themes
- Include detail on potential next steps or suggestions for improvements that could be considering when appraising the options
- Break down each gap to detail the evidence from section 1 and 2 that highlight the gap.

An example in action – excerpt from the Mental Health and Substance Use Gap Analysis

Appendix 2 contains the full Strategic Gap Analysis we conducted to inform a Mental Health and Substance Use Protocol. This section contains an excerpt from this analysis using the theme of 'leadership and culture' in the context of systems that support people with co-occurring mental health and substance use. It covers the summary of good practice, current practice and gaps for just one theme within the analysis to give an example of what the analysis conducted could look like.

A concise summary of this analysis could look as follows.

Good practice	Planned and agreed roles and responsibilities across the whole system that enables flexible responses to mental health and substance use, with a recovery focus
Current practice	Local clinical leadership still sits within condition specific silos rather than joining up mental health and substance use and centres on risk management and immediate safety with a large focus on medical models and treatments to support recovery.
Gap	A system-wide lack of clarity over the roles and responsibilities of staff and services in supporting concurrent need, resulting in debates about where a person's care should sit and people falling between services or not having their whole needs met.

However, the links between do not have to be this explicit and you may want to tease out the areas in more detail. The emphasis within gap analyses should be on identifying gaps between current and existing practice and in particular developing as much insight as possible relating to the drivers and impact of these gaps.

1 Understanding Good Practice - good practice in leadership and culture

This has been informed by research that has gone into the development of the National Mental Health and Substance Use Protocol, including an evidence review and an evaluation of models that support high-level co-occurring mental health and substance use needs.[1]

Good leadership and culture features:

- Clinical messaging that highlights the importance and benefit of collaboration across mental health and substance use services
- Planned and agreed roles and responsibilities across the whole system that enables flexible responses to mental health and substance use, with a recovery focus
- Consistent messaging from senior leaders in relation to 'Everybody's Job' and 'No Wrong Door' to support the provision of integrated care from mental health and substance use services
- Alignment of key drivers for mental health and substance use integration including National Drugs Mission, Suicide Prevention, Mental Health Core Standards and the improving physical health agenda
- A culture of trust across services that supports relationships between staff.

2 Understanding current practice - current practice in leadership and culture

The information informing this analysis came from in-depth engagement with local systems along with various key reports reviewing practice across Scotland.

Current leadership and culture practices features:

- Mental health and substance use are generally not explicitly noted as a linked issue within local strategies
- Local clinical leadership still sits within condition specific silos rather than joining up mental health and substance use and centres on risk management and immediate safety with a large focus on medical models and treatments to support recovery.
- There are implementation challenges that arise from competing hierarchies between medical and social models of care. While there is a clear move to develop and support social models of care, many decisions around pathways, appropriate referrals and access are defined by pre-existing processes and culture that emphasises a primarily medical model.

[1] Care models for coexisting serious mental health and alcohol/drug conditions: the RECO realist evidence synthesis and case study evaluation

3 Understanding gaps - Gap analysis for leadership and culture

Many gaps will emerge and be identified as part of the 'current practice' section. In addition to these, it is important to develop analysis around the impact that not meeting good practice has, along with what might be driving some of those deficits.

- Improvements in supporting concurrent mental health and substance use are not explicitly linked to whole system improvement as highlighted in strategic documents. This is needed to ensure there is sufficient prioritisation and enable clear links to leadership driving HCSP wide change.
- Fragmented leadership approaches result in a system-wide lack of clarity over the roles and responsibilities of staff and services in supporting concurrent need. This causes debates about where a person's care should sit and people falling between services or not having their whole needs met.
- Currently third sector provision sits too separately from statutory provision to provide an adequate response to people with concurrent mental health and substance use need. There needs to be better coordination with third sector services that people with mental health and substance use needs rely on. This will enable sustainable transitions out of statutory services and into communities.

Appendix 1 Personality Disorder Improvement Programme (PDIP) Strategic Gap Analysis

This is a Strategic Gap Analysis conducted by Transformational Change – Systems Unit within the Community Engagement and Transformational Change Directorate in Healthcare Improvement Scotland to inform the proposed Phase 2 of the Personality Disorder Improvement Programme run by the Transformational Change – Mental Health Unit.

Date	January 2023
By	Transformational Change – Systems Unit

Healthcare Improvement Scotland engaged with all the regional NHS Boards and HSCPs across Scotland during 2022 to understand the current services and support available for people with a diagnosis of personality disorder. This note is the Strategic Gap Analysis which compares the status quo with best practice, identifies the gaps in current service provision, and outlines the suggested next steps for phase 2 of this piece of work.

This Strategic Gap Analysis is structured as follows:

1. Outlining the key features of what good practice looks like
2. A summary of existing service delivery across the NHS Boards in Scotland
3. A gap analysis to identify the areas for future development
4. Proposed next steps using the Good Practice Framework for Strategic Planning to identify the key features of Phase 2 from a strategic planning perspective.

The analysis and recommendations within this Strategic Gap Analysis are based on the following evidence sources:

- A literature review of best practice and guidelines concerning treatments for personality disorder undertaken by Healthcare Improvement Scotland
- In-depth interviews with NHS Boards to map their existing personality disorder service provision conducted by Healthcare Improvement Scotland's Strategic Planning Team
- Findings of engagement with those with lived experience of a personality disorder – including individuals with a diagnosis conducted by VOX Scotland and the Scottish Recovery Network – commissioned by Healthcare Improvement Scotland
- Survey and one-to-one interviews with staff working in services that support those with personality disorders conducted by Healthcare Improvement Scotland.

1 What good looks like

Evidence available does not support one single model of delivery over others. Instead, a variety of delivery models are suitable for supporting those with a diagnosis of personality disorder. Within the various models there are a range of key features that are important to ensure that the services and support provided match what we would consider to be good practice. These features are:

1.1 Strong leadership with -

- A clear and coherent strategic plan for how to plan, organise and deliver services
- Buy-in and commitment from senior leadership through to front-line
- A shared understanding of issues, objectives and approaches including a system-wide breadth of focus
- Good communication within and across organisations and services
- Clear and accountable joint governance structures that encompass all the relevant stakeholders and organisations
- Led by those using a collaborative and transparent leadership style that enables distributed leadership, innovation and appropriate risk taking across boundaries.

1.2 Models of care which -

- Are informed by a clear understanding of need and evidenced based approaches
- Contains a stepped match care model which matches severity with appropriate treatment, interventions and support
- Ensures services are embedded in secondary care and that structured clinical assessment and care planning happen here
- Provides access to a range of evidence-based interventions that are right for the person and at the right time2
- Peer support is available and fostered
- Support is available for family and carers
- Medicines are prescribed with care, especially antipsychotic and sedative medicines, and that comorbidity is treated
- Interventions also focus on longer term goals in education and employment
- Transitions and endings are carefully managed with structure and a phased plan

[2] Evidenced interventions for Personality Disorder include (1) those with a diagnosis - Structured Clinical Management (SCM), STEPPS, Dialectical behaviour therapy (DBT), Mentalisation-based therapy (MBT), and Schema-based Therapy, (2) those who may or may not reach full diagnostic criteria for a diagnosis of personality disorder - Emotional Coping Skills, Survive and Thrive and Decider Skills for those who may or may not reach full diagnostic and (3) social and occupational functioning for not 'treatment' support.

- Coordination between different elements and professional groups to ensure access to the right support is enabled no matter where in the system people turn up.
- Services that have strong relationships between staff and patients including consistency, trust, respect and compassion and use trauma informed practices

1.3 Involvement of lived experience which –

- Ensures diagnosis, interventions and ongoing engagement with services have choice by the person as key to the person-centred care for their own care
- Ensuring that those with lived experience can meaningfully input into service design, delivery and review to inform wider service delivery
- Making best use of existing local user, carer and advocacy groups and national representative bodies to provide supported, structured and efficient ways of involving lived experience.

1.4 Adequately trained and supported service staff through –

- Regularly and robustly assessing staff skills, experience and confidence to conduct training needs assessments
- Having a clear, comprehensive and planned out approach to staff training across relevant services
- Provision of high-quality training in specialist therapies, trauma, unconscious bias, and other required skills required for diagnosing, treating and supporting people with a personality disorder
- Consistent and shared view of evidence-based approaches to diagnosis, interventions, treatment, and support for people with a personality disorder
- Putting in place structures and dedicated time to enable staff to implement and further develop their new skills and knowledge
- Putting in place structures that support staff in their wellbeing and safety, performance and development, and contribution to a healthy working culture and environment.

1.5 High quality data including -

- Collecting data that matters, not just what is available, to be able to understand performance, impact, challenges, and improvement opportunities
- Collecting consistent, comprehensive and accurate data that is quantitative and qualitative data from a variety of sources including statutory services, community and third sector services, staff and user engagement

1.5 Adequate and well deployed funding through -

- Robust understanding of budget requirements drawn from high quality analysis
- Clear articulation of current spending
- Adequate resource to meet need that is allocated efficiently to achieve impact

1.6 A focus on learning and sharing by -

- Regularly reflecting on experience to generate and curate learning including identifying enabling factors, barriers and future opportunities to do things differently
- Using data and learning to inform understanding of trends, assessing performance, and informing service improvement
- Establishing, joining and regularly using networks of relevant stakeholders to share learning to inform others.

2 Summary of existing provision in Scotland

This section summarises existing provision across Scotland drawing on evidence and information provided by all the regional NHS boards and HSCPs.

2.1 Leadership and strategic direction –

- Personality disorder is generally not explicitly addressed in mental health strategies and instead is seen as embedded within general mental health services alongside other diagnoses. A small number of Board areas include it within their strategies – for example NHS Lanarkshire. NHS GGC and NHS Grampian have steering groups for Borderline Personality Disorder (BPD) which seek to provide strategic leadership and planning for BPD conditions.
- A number of planned improvements and strategic developments have been delayed by COVID-19 and have yet to resume – for example in NHS Lanarkshire
- Some boards including NHS GGC and NHS Grampian have chosen to focus particular efforts on BPD rather than personality disorders more generally. This appears to be driven by high rates of BPD presentations to acute and unplanned care by those with a diagnosis, or characteristics that would indicate a diagnosis, of BPD
- A number of boards mentioned that they felt that lack of senior buy-in and leadership was limiting the ability of the services to develop and improve pathways for personality disorder.

2.2 Diagnosis

There are a wide variety of views on personality disorder within and between mental health teams in Scotland. Boards report that this can lead to inconsistent diagnosis tools and processes, misdiagnosis, and disagreements over diagnoses made. There is significant overlap with trauma, and it is recognised that those who might attract a diagnosis of personality disorder also may have a range of comorbidities and other presentations (e.g. depression, anxiety, self-harm, substance misuse). Approaches reported included multi-disciplinary and collaborative diagnoses processes, but we noted that many still rely on individual clinical assessment which can vary between clinicians and services.

2.3 Ring fenced resources/specialist teams

All but two boards (NHS GGC and NHS Highland) do not ring fence resources for personality disorder. All support provided to patients are as part of the core mental health services such as the Community Mental Health Team, Multi-disciplinary Teams, Community Psychiatric Nurses and psychological therapies.

- NHS Highland has a specialist service for personality disorder with a stepped care approach where the specialist team provide support for the most acute and complex needs with the earlier steps of the model embedded within the Community Mental Health Team. There are some exceptions for support by the specialist team for example where cognitive impairment makes support by them unsuitable. This team also provides advice, awareness raising and training for professionals across other services who are supporting or engaging with people with a diagnosis of personality disorder.
- NHS GGC has a specialist service for homelessness and personality disorders due to the complex relationship between the two.

NHS Dumfries and Galloway have a virtual team for people with Emotionally Unstable Personality Disorder (EUPD) who provide advice, training and education for other healthcare professionals. NHS Tayside is currently considering developing a specialist clinical team for personality disorders but are waiting on approval to recruit the required staff to resource this.

There are three key drivers for boards' decisions not to have a specialist service including:

- High prevalence of presentations means that it is core business for mental health teams already
- Large variation in presenting issues and need of people with a personality disorder means that it is important that skills are sitting throughout a wide range of services
- Impracticality of having a specialist and ring-fenced team in an area with a small population for the smaller boards

2.4 Integrated Care Pathways

All boards in Scotland support personality disorders across a wide range of health and social care services, with NHS Highland (not including Argyll and Bute) having a specialist personality disorder team to provide care for the most complex cases in their board area. The primary mechanism boards are using for providing for a specific diagnosis, such as personality disorder, across these services is through the development of Integrated Care Pathways for particular diagnoses or needs. The development and use of Integrated Care Pathways is now well advanced across the boards, with most reporting that they do not have them, are still developing them, or that the ones that have been developed aren't fully operational yet.

- Some boards don't currently have an integrated care pathway or are in the stages of developing one for example Argyll and Bute (within NHS Highland), NHS Tayside, NHS Ayrshire and Arran, NHS Lothian and NHS Forth Valley. Those boards operate largely on a case by case

basis for assessing need and onward service referral and may have strong informal links between some services who regularly work together.

- Some boards such as NHS Lanarkshire, NHS Western Isles (pathway relates to BPD only), NHS Grampian, and NHS Borders report that they do have an Integrated Care Pathway in place. However they tended to feel that the pathway isn't well implemented including feelings that their pathway being out of date, that links in the pathway have yet to be formalised or put in place, that the pathway is not well understood so inconsistency remains, that they lack the resourcing and senior buy-in to make them operational, or that it can be hard for some groups to be easily placed in the pathway – for example those who do not meet the criteria for a full diagnosis. NHS GGC has a pathway developed and largely operational for BPD, but other forms of personality disorder care is still done on a case-by-case basis. They also felt that the inpatient parts of their pathway needs further work.

2.4 Care plans

Care plans are used as standard across boards with boards feeling that most people will have a care plan where this is needed. Some limitations in their use that have been identified by boards is that care plans can be focused on presenting problems rather than diagnosis specific, or that care plans may not reflect the complexity of the patient's need. Some boards are starting to implement more sophisticated approaches such as a Care Programme Approach and in NHS GGC they are using an approach they refer to as Coordinated Clinical Care.

2.5 Medical management

Most boards that discussed medical management identified that they aim to use medication sparingly. Some such as NHS Highland and NHS Borders, have guidance, checklists and agreements that are in place to guide its use. However, boards also reported that there is a diverse approach to medical management with some professionals preferring to prescribe medication more than others.

2.6 Interventions offered

There is a large variation in interventions offered for managing and treating personality disorders. Interventions offered are predominately driven by available resourcing to fund, and staff skills to deliver, the intervention. Some boards mentioned that it was more difficult to get buy-in and approval for the more intensive and therefore more costly interventions in the context of the current resourcing constraints and mental health service demand. The most common interventions offered in Scotland include Safety and stabilisation, Decider skills, STEPPS, DBT, MBT, psychotherapy, CBT, Survive and thrive, Group therapy. Some boards noted that finding interventions for young people and older people can be a challenge as some interventions have an age criteria in their board area of 18-64.

2.7 Digital and virtual support

Following the pandemic, boards are increasingly trying to understand how to use virtual and digital methods of engagement within their services. Virtual engagement was noted to help improve

accessibility where distance and transport were barriers to face-to-face engagement, but it was also noted that for a large proportion of people with personality disorder face-to-face support was the most effective as the relationships with staff in one-to-one settings and with peers in group settings were vital components to engagement and success. Boards are generally in the stage of discussing ideas and asking questions rather than having answered the questions around how and when to deploy digital and virtual service options.

2.8 Support for family and carers

Support for family and carers is largely provided through signposting and referral to third sector services and carers groups. NHS Western Isles provides some support on parenting and does relationship and family counselling within some of their services. Particular interventions such as STEPPS and MBT provide sessions where family and carers participate in order to build their knowledge, confidence, and coping skills in supporting someone with a personality disorder. DBT has service materials that guide families with the management of the difficulties of supporting someone with a personality disorder. A number of boards mentioned that they are trying to use the Triangle of Care approach which places carers in partnership with the patient and service as a key partner but note that this can only happen where patients give consent.

2.9 Involving those with lived experience

- Most boards reported intentions or plans to engage more with those with lived experience to inform service improvement, redesign and delivery but weren't in the advanced stages of consistently including lived experience in planning and delivery – for example NHS Lanarkshire are looking at opportunities for co-design and co-delivery staff of training as well as including peer navigators into mental health services. There were a few examples of lived experienced currently being involved including:
    - NHS Highland have recruited a lived experience volunteer to sit within their specialist personality disorder service
    - NHS Tayside report including lived experience individuals in design workshops for their EUPD clinical pathway.
    - NHS GGC have created a service user group within their BPD work which is supported by their BPD steering group but hosted by the Mental Health Network to ensure its independence. This group have produced and contributed content to videos used in staff training and developed leaflets, social media content and other communications materials for those newly diagnosed with personality disorder.
- A number of boards mentioned that they collect patient feedback but noted that they were wanting to do more to analyse and feed findings back into service development.
- A number of boards reported strong ties with third sector organisations, such as the Scottish Recovery Network, as a service delivery partner and getting their involvement in service improvement and development. A few boards mentioned that they drew on these third sector organisations as a way to access existing panels and groups of lived experience.

- Some boards mentioned that they are seeking to involve family and carers more in service design and planning and are trying to use the Triangle of Care approach. This is not currently happening but some boards identified that they hope to be able to do this in the future.

2.10 Data availability and usage

- Data is not systematically and comprehensively captured in a planned way with very few boards identifying management and performance data. Where data is available, diagnosis specific data is not often able to be isolated to understand need and service use around personality disorder. There are some examples of the following data being collected in some boards:
    - Prevalence of diagnosis
    - Patient feedback
    - Management data including wait times, complaints, and disengagement
    - Impact/performance data including audit, evaluation, and clinical outcomes
    - Funding requirements
    - Staff attitudes
    - Staff training and skills
- There are concerns amongst boards about the reliability of the data they hold as differing views on personality disorder can skew diagnostic estimates and intervention data
- A number of boards identified that without a clear Integrated Care Pathway they are unable to develop a robust estimate of the resourcing requirements needed to adequately fund services

2.11 Staff skills, knowledge, and capacity

- All boards mentioned staff skills as a key challenge in providing a wide range of interventions suitable for treating and supporting personality disorder. There are wide spread reports of staff, across specialised and general mental health services, not feeling that they have the confidence to work with people with a personality disorder diagnosis – particularly for more complex presentations, and all the specialist interventions such as DBT require specific training that is not common amongst their staff.
- Those with lived experience reported that they felt that the stigma associated with a diagnosis of personality disorder were regularly present amongst health and social care staff and they felt that they were treated differently once their diagnosis was made or became known to staff. This view was echoed by many of the boards we spoke to. Boards also felt that staff can often feel helpless when it came to personality disorders due to its persistent nature, long timeframes for improvement. They felt that this can often contribute to how staff feel when engaging with patients.
- Most boards as well as those with lived experience also reported that there is a high degree of inconsistency and disagreement in relation to the diagnosis and treatment approaches for personality disorder borne from a lack of common and accurate understanding of the condition, its presentations, underlying drivers (such as trauma), and comorbidities.

- Most boards reported issues with high staff turnover and a challenge to recruit suitable permanent staff when advertising positions. A number of boards, including Tayside and Shetland report relying on locum psychiatry staff as they are unable to fill positions.
- Funding available for staff is limiting the boards desire to provide a wide range of interventions suitable for treating personality disorder. This is resulting in training requests being declined and lack of investment in time spent by staff on coordinating training.
- Boards are struggling to adequately train staff. Almost all boards reported that they do not have a policy and/or plan for training staff in relation to personality disorder. Staff turnover and the creation of specialist teams in other fields of mental health meant that those they do train are unavailable to continue services – particularly specialist services where boards reported that they had to stop interventions like DBT and MBT.
- Trauma related training, most commonly Trauma Informed Practice, was regularly reported by boards as being in place or will be in place for all relevant staff. Where boards reported challenges in getting all staff Trauma Informed Practice training they noted that this was inhibiting their ability to improve their services for personality disorder.

2.12 Funding –

- All boards reported stretched services and limited financial resources contributing directly to a reduction in the range and intensity of support available for personality disorder as well as impacting on timely access for people when they need the support. Many boards reported that they were unable to offer particular specialist interventions that have evidenced positive clinical outcomes for people with a personality disorder, such as STEPPS and DBT, due to funding constraints. Wait times for interventions and to see specialist staff exist across almost all services in all boards in Scotland. Some wait times are within national and local targets, while others can be significantly beyond these – particularly for psychiatrists and psychological therapies. Most boards also mentioned that funding constraints directly impacted the ability to train their staff as it is a challenge to release staff from delivery to participate in training.
- All but two boards (NHS GGC and NHS Highland – excludes Argyll and Bute) do not ring fence funding specifically to personality disorders so support provided is balanced across a wide range of diagnoses and mental health needs where they are consistently seeing an increase in demand and reduction in resources.
- A number of boards mentioned the availability of third sector support for signposting and onward referral has been a challenge across many areas of Scotland. This has been particularly acute where the number of services available from the third sector reduced during the pandemic and hasn't yet reached pre-pandemic levels again.

2.13 Learning and sharing –

- There appear to be very few regular structures in place to learn and share learning to inform service improvement amongst boards and appears to be driven by both a lack of strategic buy in as well as stretched resources and staff. One example of learning and sharing identified by boards

is that the development of the NHS GGC integrated Care Pathway was informed by similar pathways for Learning Disabilities and Older People.

3 Gap analysis

Drawing on a comparative analysis of good services and the existing provision in Scotland the key gaps in, and challenges for, the existing are:

- A lack of shared and accurate understanding of personality disorders across staff, services and organisations leading to inconsistency in diagnosis and treatment
- Limited senior buy in and leadership required to operationalise service improvements
- Under-developed or newly developed Integrated Care Pathways leading to inconsistent treatment and reducing patients ability to access the right support regardless of where they present
- Under resourcing of mental health and other health services limiting the range, intensity, quality and timely access to the services for people with a diagnosis of personality disorder
- Limited access for patients to evidenced based interventions and treatments due to the availability of resources to fund the services and skilled staff to deliver the services
- Limited meaningful involvement from those with lived experience in the design and delivery of services
- Staff turnover and recruitment challenges leading to loss of knowledge and specialist personality disorder skills and a stretched workforce to deliver services. Staff continuity is also of particular importance when supporting people with personality disorder as trusted relationships require constant and reliable engagement over an extended period of time to develop
- Limited opportunity for personality disorder specific training for staff across relevant services due to resourcing constraints and absence of detailed staff training plans which could help with addressing stigma, confidence and skill gaps
- Inconsistent and incomplete data collection and limited use of data to inform future service design and improvement
- Limited opportunities and evidence of learning within services and sharing learning with others to improve services
- Unclear role for digital and virtual service delivery.

It is also worth noting that boards identified a range of contextual factors which were impacting on service delivery including:

- In smaller boards and smaller communities there were reports of issues around patient confidentiality and hesitancy accessing services due to confidentiality concerns by patients
- Dispersed populations in rural areas and poor access to transport (in both rural and urban settings) were both reported by boards to pose accessibility issues, in particular making group work harder

- Remoteness, for example in the Western Isles, can make crisis support more challenging due to the geographical distance and travel between islands required

4 Next steps – advice from the Strategic Gap Analysis to inform the business case for Phase 2 of the Personality Disorder Improvement Programme

Given the findings of the Strategic Gap analysis, we propose a strategic planning approach is taken to design, plan, and deliver an improved set of services for people with a diagnosis of personality disorder. This section outlines the various suggested activities to enable the use of the Good Practice Framework for strategic planning to guide the service improvement process.

The Good Practice Framework for Strategic Planning is made up of five key themes that guide service redesign processes from start to end.

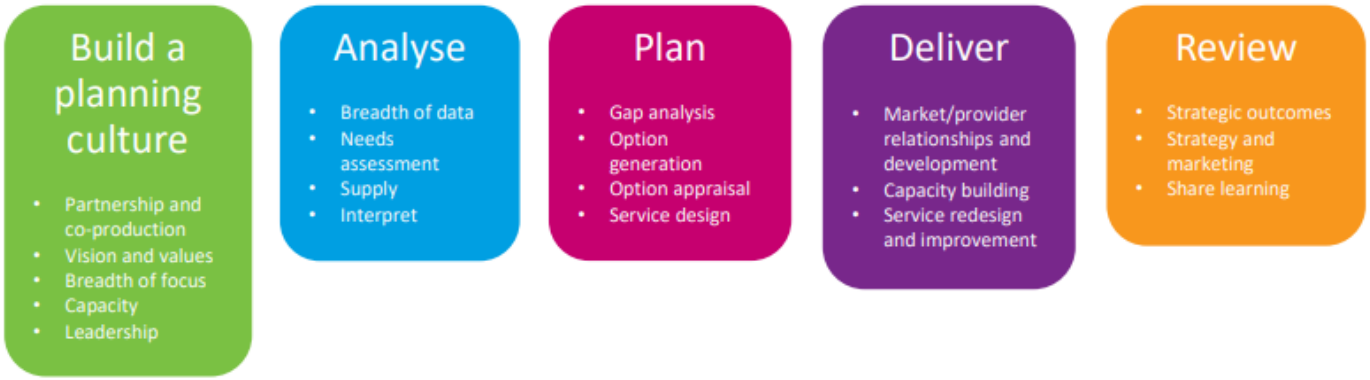

Figure 1 Good Practice Framework for Strategic Planning. (2019). ihub, Healthcare Improvement Scotland. https://www.hisengage.scot/media/2777/strategic-planning-good-practice-framework-final.pdf

Identified gap/challenge	Possible activities for Phase 2
Build a planning culture	
Shared understanding of personality disorders	Combination of leadership and learning and sharing activity
Senior buy-in and leadership	Facilitation of engagement across senior leaders in Scotland to build understanding and buy in
Analyse	Plan
Service development – e.g. Integrated Care Pathways and Interventions for patients	Support boards and HSCPs to further develop their Integrated Care Pathways (or alternative as appropriate) using the Good Practice Framework for Strategic Planning to conduct a needs assessment, option generation, options appraisal, and service design.
	Conduct a forecast quantified impact analysis (e.g. cost benefit analysis) to understand the benefit of better services for people with personality disorders on the reduction in demand for acute, unplanned and other services. (conduct analysis applicable across Scotland with board buy-in and input)
Resourcing of services	Develop cost projections for implementing Integrated Care Pathways (or alternative as appropriate)
	Develop business case for resourcing these changes
Involving lived experience	Developing and implementing an approach for those with lived experience to feed into phase 2 of this work ensuring those with lived experience contribute to the design and implementation of this activity
	Developing a framework, guidance and support for boards and NHS to enable ongoing involvement from lived experience within their service delivery ensuring those with lived experience contribute to the design and implementation of this activity (conduct analysis applicable across Scotland with board buy-in and input)
Role for digital and virtual service delivery	Conduct options generation and options appraisal for the way that digital and virtual services play a role in delivery (conduct analysis applicable across Scotland with board buy-in and input)

Identified gap/challenge	Possible activities for Phase 2
Capacity building	
Staff turnover and recruitment	Identify contribution that the ihub can make to these areas of concern
Staff training	Identify the training needs and put together a case for investing in training required (conduct analysis applicable across Scotland with board buy-in and input)
Review	
Data collection and use	Develop an outcomes framework to measure progress (conduct analysis applicable across Scotland with board buy-in and input)
	Conduct a management and performance data audit and assessment (possibly in two – three case study board areas) to develop recommendations for future data collection (conduct analysis applicable across Scotland with board buy-in and input)
Learning and sharing	Establish and facilitate a network for learning and sharing between boards and HSCPs across Scotland including a focus on: 4. Understanding how personality disorder services operate across the country 5. Engage with different approaches to leadership Understand where the Good Practice Framework for Strategic Planning can support them.

Appendix 2 Mental Health and Substance Use Protocol Programme Strategic Gap Analysis

This is a Strategic Gap Analysis conducted by Transformational Change – Systems Unit and Transformational Change – Mental Health Unit within the Community Engagement and Transformational Change Directorate in Healthcare Improvement Scotland to inform the Mental Health and Substance Use Protocol Programme run by the Transformational Change – Mental Health Unit.

Date	November 2023
By	Transformational Change – Systems Unit Transformational Change – Mental Health Unit

This document includes a Strategic Gap Analysis (SGA) based on the knowledge and evidence gathered during the Mental Health and Substance Use: Improving Our Response programme that finished in March 2024. It is designed to inform the Mental Health and Substance Use Protocol's development by providing insight into the current gaps that the protocol needs to seek to address. The Strategic Gap Analysis will explore what good looks like, then describes existing practice, and finally thematically identifies the disparities between existing and good practice to outline the strategic gaps that the protocol can address.

1 What good looks like

In this section we will outline what good looks like across a number of thematic areas in relation to supportive systems for people with mental health and substance use needs. This has been informed by research that has gone into the development of the National Mental Health and Substance Use Protocol, including an evidence review and an evaluation of models that support high-level co-occurring mental health and substance use needs.[3]

There is a high level of complexity in relation to concurrent mental health and substance use. In addition, evidence clearly shows the beneficial impact of social models of support that are able to respond to complex and changing needs. Current models of care need to be able to adapt to meet a range of needs, outside of medical treatment models, and support positive and sustained life outcomes for people. There is no single model of 'good practice' that can be described. Instead, there

[3] Care models for coexisting serious mental health and alcohol/drug conditions: the RECO realist evidence synthesis and case study evaluation

are various models that include a range of key features that are important to ensure that the services and support provided match what we would consider to be good practice.

The fuller analysis of different models that are appropriate in the context of supporting concurrent mental health and substance use needs can be found within the options appraisal currently under development.

These features of good practice are in relation to leadership and culture within organisations and services, how assessments and access is facilitated, the way that transitions and joint working happens, the communication and information sharing across services, the workforce development, and how lived and living experience is included. These themes are analysed in more detail in the rest of this section.,

1.1 Leadership and culture

Good leadership actively invests in the development of an enabling culture across the various organisations, services and actors relevant to supporting mental health and substance use concurrent need. This is required to bring together historically siloed services and develop a whole system response to mental health and substance use. Without this, technical and operational changes made to processes and services will fail to lead to sustained changed and better outcomes. Strong leadership is centred on holding spaces for collaboration, coordinating change across a broad range of services and sectors; and championing the voices of people with lived and living experience of services and staff. From our experience and the evidence we know that the following matters in supporting this to happen:

- Clear reporting mechanisms that supports the development of shared responsibility at a senior strategic level
- Clinical messaging that highlights the importance and benefit of collaboration across mental health and substance use services
- Planned and agreed roles and responsibilities across the whole system that enables flexible responses to mental health and substance use, with a recovery focus
- Consistent messaging from senior leaders in relation to ‘Everybody’s Job’ and ‘No Wrong Door’ to support the provision of integrated care from mental health and substance use services
- Alignment of key drivers for mental health and substance use integration including National Drugs Mission, Suicide Prevention, Mental Health Core Standards and the improving physical health agenda
- A culture of trust across services that supports relationships between staff

1.2 Assessments and access

There needs to be a clear understanding of a person’s needs across both mental health and substance use, and these should be taken into account together when making decisions on access and support. Doing these in relation to each needs in isolation is not sufficient and leads to poorer access to the right support.

- Joint assessments should be carried out involving multiple service providers to comprehensively understand the individual's needs and determine the most suitable lead service provider.
- Clear designation of the main service responsible for coordinating individual's care, along with the development of a shared care plan involving input from all relevant services.
- Agreement on the specific interventions needed for individuals and where care should be most appropriately delivered, based on the level of presenting need and accessibility considerations. There should be flexibility to adjust interventions and support as circumstances change.
- Specific input on decision making, where there is a question about appropriate services, should be sought from specialists to avoid inappropriate and rejected referrals.
- Building patient choice/preference into decision making.
- Service should jointly agree on the most appropriate assessment and screening tools to be used, ensuring they are reliable, valid, and sensitive to the individual's circumstances. Additionally, clarity on who will administer these tools and how often they will be utilised.
- Transparent communication among services and the service user of assessment outcomes and their implications for accessing various systems of care, fostering trust among services and minimising disputes.
- Clearly documented policies and procedures around referrals, screening, care planning, discharge, and supervision to ensure consistency and accountability in service delivery.
- As per the four-quadrant model, substance use services should also be competent to deal with mild to moderate mental health problems of individuals, and the limitations of such care should be agreed in the local interface protocol.

1.3 Transitions and joint working

Being able to be flexible and respond to changes in a person's needs is essential in supporting people with complex needs, including concurrent mental ill health and substance use. Good practice is centred around how transitions are managed in a planned way, with regards to how need for a transition is identified and how services and the person work together to understand ongoing support where there are transitions out of statutory services. Joint working is also key to flexible service delivery, with good practice being enabled by clear lines of communication across services, shared understanding of a person's needs and the joint service role in meeting those needs.

- Mechanisms in place for emerging needs to be identified and supported or transitioned to the appropriate place within the system of care (e.g. screening tools, multidisciplinary case conferences, seamless referral pathways for transitions, single points of access)
- Effective communication and collaboration channels with emergency departments, primary care providers, drug and alcohol services, hospitals, and specialist treatment centres to facilitate seamless transitions and continuity of care.
- Seamless referral pathways to ensure individuals are transitioned to appropriate care smoothly without the risk of rejected referrals leading to uncertainty about where someone can access support.

- Mechanisms in place for emerging needs to be identified and supported or transitioned to the appropriate place within the system of care (e.g. screening tools, multidisciplinary case meetings, seamless referral pathways for transitions, single points of access)
- Allocate protected time for service providers to build relationships and collaborate effectively. Including staff training to develop skills to support integration and collaborative working.
- Adoption of principles such as “everybody’s job” and “no wrong door” to promote collective responsibility and accessibility to services. Ensuring that these principles are implemented in their true intention rather than just as a requirement to signpost or refer elsewhere.
- Emphasis on holistic care models that prioritise joined up working and prevent individuals from being bounced between services.
- Interface protocols should outline how services will collaborate, share responsibilities, and ensure regular communication when developing or reviewing the person's care plan.

1.4 Communication across services and information sharing

Good communication across services allows for staff to have a fuller picture of a person and their experiences, than single assessments. Information sharing is a core enabler of collaboration, with evidence showing that rapid information sharing can prevent escalation of crisis episodes and facilitate a more joined up response. Within the context of concurrent need, communication and information sharing is central to good care that is responsive to a person’s interlinked needs as a result of substance use and mental ill health.

- Good integration of care needs to be supported by mechanisms that enable effective communication and relationships across services (e.g. joint development days, joint operational meetings at regular intervals, clear points of contact)
- Information governance processes should enable the sharing of information between services (to avoid duplication, to prevent harm and to save people repeating their history again and again)
- Staff should have a clear understanding of when it is appropriate to share information between services, including where they think there might be elevated risks to a person due to specific and emergent circumstances.

1.5 Workforce development

Staff knowledge and skills in support people with concurrent mental health and substance use needs are central to new ways of working that support more joined up, person centred care. Core good practice within workforce development is in supporting staff to have the skills and confidence to address the intersection of both needs, rather than have them in treatment silos. Therefore, underpinning all activity needs to be a focus on staff development that helps develop a workforce with awareness and skills across mental health and substance use, regardless of the service/role in which they sit.

- Opportunities for staff to build awareness, knowledge and skills and relationships across the system (e.g. support and supervision, shadowing, co-occurring conditions networks,

multidisciplinary case conferences, single point of access/integrated referral hubs, joint training, reflective practice, joint significant adverse event reviews)

- Staff have awareness, knowledge and skills (to a level appropriate to their role) to care for people with mental health and substance use needs.
- Training is delivered as part of an overall workforce development that emphasises the need for staff to be able to support people with concurrent needs, and not ad hoc.
- Organisational values challenge stigma and promote and expect positive and compassionate attitudes towards those with co-occurring conditions
- There is a demonstrable commitment to staff well-being (including time to access support and supervision, training, career development opportunities)
- Third sector organisations should be included in workforce development plans.

1.6 Lived and living experience

Engaging with people and having the voices of lived and living experience are key to ensuring good practice from a system planning point of view, as well as service delivery point of view. People have better outcomes when they are involved in setting their own outcomes and in decisions on their care.

- Individuals, carers, families and their loved ones, as well as those organisations that advocate for them, should have
    - clear opportunities to inform the development of local protocols
    - ways to provide feedback on their experiences of services that are used to inform service design, delivery and transformation
- As key delivery partners, community organisations should have access to funding to enable them to provide opportunities and services to enhance community and recovery capital

2 Current practice

In this section we will describe existing provision of support for people with concurrent mental health and substance use support needs. This has been informed by the Mental Health and Substance Use: Improving Our Response programme, which offered bespoke support to five health boards.

There are a range of models of integration that have emerged as a way to better support concurrent need, and there is a lot of ongoing programmes of change looking to improve support. Focal points for improving collaboration are centred on key points of interaction across services such as providing information/ signposting to other services (usually in relation to third sector services); and joint decision making at point of initial referral/identification of joint need. Outside of these formal interactions, a lot of collaboration is driven by peer networks among staff and the provision of additional expertise within a service.

2.1 Leadership and culture

Leadership approaches support the development of high level visions related to whole system support and ensuring holistic responses to needs. However, there is little specificity as to what this means for service delivery and for different cohorts of need. This results in fragmentation of strategy and change, with multiple parallel programmes occurring, that involve similar staff and services. Good leadership is seen in supporting relationship building and providing legitimacy to specific pieces of work, such as the MAT Standards, that are centred on clear clusters of change.

- Mental health and substance use are generally not explicitly noted as a linked issue within local strategies; but are instead addressed individually with mental health sitting within general population wellbeing frames, and substance use being drawn out as a specific are of focus within Alcohol and Drug Partnership leadership and strategy. Where concurrency is noted is mostly under substance use, as a wider consideration around 'holistic' and 'complex' needs.
- In the areas engaged with we have found examples where mental health and substance use were sitting under the same senior manager within the HSCP structure – often accompanied by a range of other responsibilities. This combination has ended up acting as a key facilitator in bringing services around specific programmes of change such as the MAT Standards and the Mental Health and Substance Use Improving Our Response programme.
- As part of the MAT Standards implementation there has been a much stronger focus on operational implementation from leadership around the specific service requirements within the standards, compared to previous change programmes that were built around broader strategic objectives, with leaders taking a more active approach in building relationships and setting direction. This has helped drive improvements, with leaders getting behind operational change and being supportive in overcoming structural barriers around implementation.
- Local clinical leadership still sits within condition specific silos rather than joining up mental health and substance use and centres on risk management and immediate safety with a large focus on medical models and treatments to support recovery. However, in cases of very high risk people with concurrent need there is strong clinical leadership that supports collaboration across service silos.
- While there are strong examples of joint leadership approaches, it is reported that at a whole system level (i.e. beyond mental health and substance use linked services) there remains fragmentation and multiple competing change programmes. This detracts from a singular vision and makes it hard for operational leaders to prioritise their engagement with different strategic change activities.
- There are implementation challenges that arise from competing hierarchies between medical and social models of care. While there is a clear move to develop and support social models of care, many decisions around pathways, appropriate referrals and access are defined by pre-existing processes and culture that emphasises a primarily medical model.

2.2 Assessments and access

Within assessments and determining access to services there is a significant emphasis on managing service risk. Access can therefore be challenging for people with both mental health and substance use needs as thresholds and exclusion criteria in place to support risk in the service can be a barrier to getting joined up support.

- Assessment is clinically led and often single condition specific. Assessments are completed as a way of understanding how a particular service can support an individual rather than the full breadth of need of, and support for, someone.
- Service thresholds act as a barrier to support, as where a person does not meet a service threshold there are few pathways to enable them to find the right level of support.
- There is a significant emphasis on managing service risk within assessments. Within this practice access can be challenging for people with both mental health and substance use needs as thresholds and exclusion criteria in place to support risk in the service can be a barrier to getting joined up support.
- There is a move to integrated referral hubs – such as that seen in Angus. This model is centred on a multi-agency discussion on all incoming referrals through mental health and substance use. Referrals are discussed and allocated to appropriate services, including identifying opportunities where services can work together around concurrent and complex need. This has eliminated rejected referrals in Angus.
    - Dundee have just launched a similar hub, and Perth and Kinross are incorporating the processes and ethos of this into existing multi-disciplinary meetings.
    - In Inverclyde there is a mental health referral hub that supports ensuring people are able to access the right services. Though as it stands, there is limited substance input into these conversations.
- Screening tools are starting to be implemented across services to formalise and standardise conversations – for example, ensuring there are structured conversations to understand levels of substance use within mental health services, and recording these in a way that is easily communicable and understood across all services to inform ongoing decisions and pathways.

2.3 Transitions and joint working

Within the context of concurrent mental health and substance use, transitions and joint working play a significant role in a person's outcomes. Joint working remains either a consequence of multiple crises or ad hoc reactions to specific episodes. In the case of the latter this is reliant on informal relations between staff. Current practice around transitions across services are centred on referral relationships and 'warm handovers' in cases of transitions between statutory services. Where a person is requiring third sector support transitions are done through signposting, often with the help of an advocacy or link worker.

- There are examples of joint working where people have experienced multiple crises. This is done through the Care Programme Approach or where areas have developed specific complex case teams.
    - North Lanarkshire have developed a High Resource User team that supports frequent Emergency Department attendees (a significant proportion of whom have mental health and substance use support needs) and provides interventions with an emphasis on re-direction to, and liaison with, more appropriate services. These services are located within health and social care settings, or in the community, and are tailored to meet the particular needs of the person.
    - Inverclyde have a Community Response Service within the Community Mental Health Team (CMHT) and an Addiction Liaison Team within the Alcohol and Drugs Recovery Service (ADRS) that provide outreach and urgent care services for people, they formulate joint risk assessments and relapse prevention plans
- Where people are open to both CMHT and ADRS services, without a history of multiple crises, there is a generally a lack of joint working, with people getting what can be described as 'parallel care' where people are receiving support from both services, but there is little coordination and communication between the services.
- Where there is a 'mild to moderate' need (in mental health or substance use) in conjunction with a more severe need (in substance use or mental health), there is a focus on the 'primary diagnosis' and people having to find their own support for other 'secondary' needs (and they are often only provided information and signposting to other sources of support)
- There are good pathways and planned transitions where there is a changing need within mental health or substance use that needs escalating or de-escalating. For example, in the form of no-discharge agreements with third sector services that allows for 'step-down' type transitions that can enable re-engagement if necessary. This allows people to progress into community based recovery but with the confidence that they can still access statutory services if required.
- Joint working is often initiated by an individual staff member as a response to a specific need they encounter. This joint working is often enabled through informal, interpersonal relationships with staff from other services rather than as a systematic change in the way the system operates.

2.4 Communication across services and information sharing

Communication and information sharing is regularly highlighted as a barrier to collaboration. The multiple electronic systems means that it is hard to get a full picture of a person. There are few routes of communication that allows third sector staff, seeing a person regularly, can update staff in statutory services. There are increasing instances of joint meetings across services that facilitates information sharing in a way that feeds into decision making.

- Communication tends to be done asynchronously through electronic systems which slows down response times to changes in a person's condition.
- Recording of information is inconsistent; with reliance on free text that results in services not getting the required information to make a decision, and exacerbating issues relating to people having to repeat their stories.

- We have seen many examples of good professional relationships facilitating good joint working. Examples of good practice include informal routes of communication, which tend to be based on interpersonal and individual factors of staff. This approach is subject to risk when people move roles and leads to variation in the care someone receives (dependent on the quality of the professional relationships held by the staff supporting them) as relationships do not exist consistently across services.
- There is very little information sharing with the third sector beyond initial referral (where this is in place)
- There are instances where service level agreements are in place with third sector organisations that allows for accessing and updating of electronic records
- Where there are examples of joint meetings, participants have noted the ease of information sharing through these forums, including third sector organisations.

2.5 Workforce development

There are significant areas of focus regarding working development such as improving trauma informed practice and reducing stigma. There is also a move to include more awareness around mental health and substance use across services, and how concurrent need might impact the required support. However, these are yet to be fully implemented, and there is only early discussions regarding the need to clinical support and supervision across specialisms (e.g. supervision from a substance use specialist for mental health staff).

- Workforce development plans largely centre on the provision of training that can support staff to understand and respond in a person-centred way. Key areas of focus for this are around trauma informed and anti-stigma training. The National Trauma Training Framework offers the key resources underpinning this training, though work is done locally to make it locality and service relevant.
- There is also inclusion of specific training that can be described as 'cross-specialism' where staff within mental health services are training in substance use specific interventions, and vis versa. This has been supported by recent national initiatives around brief interventions and the MAT Standards that specify a need for this.
- Early work is emerging around developing workforce development plans that move beyond formalised training sessions and starts to look at how this is embedded within practice, with space/opportunities for reflective practice. A 2023 *Mental Health Training Needs Assessment* in Tayside noted that:
    - *"For many participants the skill aspect of mental health training may be more important and challenging as they believed rather than only focussing efforts on awareness and knowledge areas, skill development should be supported well to raise worker's confidence in more sensitive topic areas."*
    - A participant said "[we need to be] learning more actively and reflectively with a guide there to help over a period of time."
- The culture around workforce development from service managers and leads is driven by awareness of staffing shortages and anxieties around freeing up staff for training (though there is

a recognition that this is important to do), therefore, plans often focus on mandatory training driven by legislation and local policies.

2.6 Lived experience engagement

Engagement with people with lived and living experience takes place mostly at a strategic level, identifying what people's priorities are and where they would like to see improvements. Engagement centred on the specific design of services, or feedback from experiences is not routinely sought and used to improve or inform service delivery.

- Ongoing engagement also takes place to support strategy reviews or to provide input into particular initiatives. Such engagement is instigated by leadership within the HSCP or ADP but is usually led by Third Sector Interfaces.
- The third sector play a role in elevating voices of lived experience in the forums they attend by relaying the conversations that they have had with people
- There are examples of good outreach engagement around a specific change, for example, in Dundee, the development of an out of hours crisis service was developed with significant input from people with lived experience. A key outcome of this was the development of a service in an open, community and non-clinical setting with few doctors. This was a challenging model to accept by some staff, but the lived experience engagement helped make the case.

3 Gap analysis

- Improvements in supporting concurrent mental health and substance use should be explicitly linked to whole system improvement as highlighted in strategic documents, to ensure there is sufficient prioritisation and enable clear links to leadership driving HCSP wide change.
- There is a system-wide lack of clarity over the roles and responsibilities of staff and services in supporting concurrent need, resulting in debates about where a person's care should sit and people falling between services or not having their whole needs met.
- There are few early intervention or prevention services that can support identified mental health and/or substance needs that don't necessarily meet the thresholds of core services. Such services are required to provide lower level need, but have the capability and connections to identify risk of escalating need and get more support. This should also include links across other services such as housing and social work. Currently third sector provision sits too separately from statutory provision to provide an adequate response to people with concurrent mental health and substance use need. There needs to be better coordination with third sector services that people with mental health and substance use needs rely on. This will enable sustainable transitions out of statutory services and into communities.
- Statutory service staff highlight a lack of knowledge around the third sector service provision, especially outside of commissioned, case holding third sector services (such as recovery cafes), as well as sometimes not feeling confident to signpost due to uncertainty over the quality of services

- There is a lack of coordinated referral assessment when Primary Care are making a referral for someone with concurrent need. This can lead to rejected referrals in cases where mental health services redirect referrals on the basis of substance use, but the identified substance use doesn't meet thresholds for substance use services. This judgement and decision is made without input from substance use staff and can result in another rejected referral and people falling through this gap
- Mild to moderate mental health and substance use tend to be managed within Primary Care and the Third Sector. A significant challenge within this is a lack of agreed definition of 'mild to moderate' and the ability for services to 'hold the risk' of someone with needs outside of their specialism, especially with regards to substance use. This results in a focus on the 'primary diagnosis' and people having to find their own support for other needs. People are provided with information and signposting, but this still leaves a gap with regard to collaboration across services to coordinate care.
- While there is an increase the level of joint decision making, for example, the hubs in Tayside and the outreach services in Inverclyde, there remains a gap around how services support people jointly on an ongoing basis.
- Limited understanding of the way that mental health affects someone's substance use and how someone's substance use affects their mental health. These interplays between mental health and substance use are not currently sufficiently incorporated into care planning.
- There are few mechanisms for phased and flexible transitions between services, in the form of step-up/step-down services where people are able to transition at their own pace
- People with high substance use but moderate mental health needs are not seen as high risk by mental health services due to service specific (risk) assessments and so are often not considered eligible for mental health support that would have a material impact on the high risk nature of their substance use. This is despite strong evidence that suggests that people in this situation are likely to benefit from mental health support, and people with experience of recovery note the increase in mental health needs as drug use decreases.
- Few opportunities for staff networking and relationship building across mental health and substance use, which could work to create staff peer support networks, breakdown clinical silos and build awareness of different service offerings.
- Lack of infrastructure to support information sharing across third sector services means that they are excluded from the information and intelligence required to conduct their services.
- Engagement with people with lived experience needs to be specific and planned, being clear on what the role of the feedback will be, understanding the different roles of engagement, and having agreed mechanisms for influencing change.

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This resource has been developed by Strategic Planners within the Transformational Change - Systems Unit within Healthcare Improvement Scotland. It is designed to

support the Strategic Planning Community of Practice by providing introductions to concepts and topics relevant to Strategic Planners.

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