Greater Glasgow NHS Board

Board Meeting
Tuesday 10th June 2003 **Board Paper No. 2003/42**

DIRECTOR OF PLANNING
AND COMMUNITY CARE

Integrated Addiction Services:- Outcome of Consultation

Recommendation:

The Board approve these proposals to move to an integrated structure for the delivery of addiction services with Glasgow City Council.

1) Background

In considering the outcome of the review of the Methadone programme in June 2002 the Health Board endorsed further work on the development of addiction services and on how integrated management arrangements could be progressed. This report covers that development work, the consultation which followed it and proposals to deliver integrated services and structures.

2) Next Steps

The attached paper

- **reminds us of the context.**
- **restates the case for service integration.**
- **draws together responses to consultation.**
- **addresses the issues raised.**
- **proposes a way forward.**

The case for integration is restated in paragraphs 1.5 and 1.6 of the paper both in terms of the benefits for individual patients but also in terms of our organisational objectives and imperatives.

Responses to consultation indicate these aims are understood and accepted but raise a number of issues which are set out in Section B of the paper. At headline level these included:-

- a number of specific issues, for example around delegation arrangements, which need more detailed development work.

- the need to develop balanced services and structures, not dominated by Health of Social Care models.

- the importance of achieving strong locality accountability but with whole system coherence for specialist addiction services.

- a strong concern that the interfaces between addiction services and other health and social care services were not compromised by the focus on integration.

- the need for clear arrangements and accountability for planning, commissioning and operational management.

The paper responds in some detail to these points and the proposed way forward, outlined in Section C, describes how the next steps can address the issues raised.

A final significant issue is the need to work with our other Local Authorities to agree how we can deliver a similar approach for their areas. We already have agreed integrated community addiction teams with other Authorities and need to build on that platform.

3. Conclusion

These proposals offer the opportunity to

- deliver better services for people with addiction problems.
- meet national and local imperatives and commitments on service integration.
- provide stronger local accountability for addiction services.

Further detailed implementation will be led by the joint general manager – who should be appointed during the summer of 2003 if these proposals are approved.

AN INTEGRATED STRUCTURE FOR ADDICTION SERVICES:
RESPONSES TO CONSULTATION AND
A PROPOSED WAY FORWARD

A BACKGROUND & PURPOSE

1.1 Glasgow City Council and NHS Greater Glasgow issued proposals to integrate the management of addiction services in October 2002.

The consultation process included wide distribution of the attached paper and a series of events and dialogues with staff in Health and the City Council.

The purpose of this paper is to draw together the detailed responses to consultation, address the key issues they raise and propose next steps.

1.2 It is important to restate the context in which these integration proposals were made.

Over the last two years 3 major elements of work have been jointly undertaken by Glasgow City Council (GCC) and the NHS in Greater Glasgow.

The review of the methadone programme highlighted a whole services of issues – three of particular significance:-

- The need for the programme to be jointly organised and managed to ensure that the health service and social work elements were properly co-ordinated. The key objective being to deliver an integrated serve to each client on the programme.
- The need to widen the scope of the programme to include rehabilitation, training and employment.
- Joint ownership of issues arising in communities as a result of concentration of drug users and a collective responsibility to resolve those issues.

1.3 In parallel to the review of the methadone programme Greater Glasgow NHS Board (GGNHSB) began to undertake a process to review and extend the provision of specialist addiction services in the community. This work was partly generated by the alcohol strategy – which highlighted significant variations in service around Glasgow – and partly by the implementation of the review of social work services by GCC. That review put in place an addiction service in each of the 9 social work area teams. The outcome of this work is the concept of specialist community addiction teams (CATs) bringing together health and social care staff in 9 localities under a single team leader. This model has been fully consulted on and is now being implemented. A further outcome is the Primary Care NHS Trust's (PCT) conclusion that there should be a single structure for the management of health addiction services – bringing together current arrangements for the Glasgow Drug problem Service (GDPS) which is managed within primary care, and the Drug & Alcohol Directorate (DAD) which is managed within Mental Health.

A further joint work programme, reviewing purchased services, suggests that a single team commissioning such services would improve efficiency, co-ordination and value for money.

1.4 The results of working together in these three areas, with the context set by the Scottish Executive of moving to integrated services and the local focus on that agenda through the Joint Community Care Committee led to the proposals for integrated

management of addiction services. In addition to these imperatives, set out below are the benefits we believe will flow from an early move to integration.

1.5 The case for change has two distinct dimensions – the benefits for individual patients an integrated service can offer and the potential organisational gains of such an integration.

For individual patients we believe these proposals are a very significant first step to be able to deliver seamless health and social care services to patients with addiction problems. The benefits we see for patients include:

- A single and simple point of access to services.
- Improved co-ordination of care.
- Quicker access to the right services.
- Clearer accountability for care.
- Improved information sharing and communication.
- More holistic, but simpler assessment and care planning.
- A single key worker.
- A culture of collective responsibility.
- Professional time focussed on service users not negotiating barriers.
- Coherent packages of care.

In addition to these benefits to patients we believe that the service developments and changes which have emerged from joint work on community addiction teams, the methadone review and the review of purchased services will make a step change in the range and a quality of help we offer people with addiction problems.

1.6 Turning to the organisational gains we believe these include:-

- A clear, single strand of responsibility for health and social care services with reduced opportunity to buck pass.
- Reduced bureaucracy in decision making.
- A coherent and simple system of care.
- More efficient purchasing and monitoring of contracted out services
- A management structure which reflects and enables us to deliver, - our commitment to provide effective, holistic services to people with addiction problems rather than a uni-agency response.
- A much stronger locality focus ensuring services are responsive to local need.
- With the right approach to financial framework and delegation the opportunity for quicker and more rounded decision making.

B EMERGING THEMES FROM RESPONSES

2.1 This section sets out a number of the main themes emerging from the consultation and responds to them. A more detailed summary of individual responses is shown as Attachment 1.

Many of the responses positively endorsed the proposals, but raised very specific issues, either about a particular element of the consultation paper or about details which are not included in our proposals. Examples of the former include the clinical qualifications of the proposed Clinical Director post, and of the latter, details of budget delegation and clinical/professional accountability mechanisms. This section does not try to respond in detail to all of these points – our proposed way forward, in the concluding section of this paper, will enable these issues – which we believe relate to implementation rather than substantive policy or principle, where there is broad support - to be fully worked through. In addition, some responses focussed on service issues, for example the distinction between services in tiers 3 and 4. A critical purpose of this structure is to create a system of management where those sort of service issues can be raised, debated and resolved with all of the key professional staff able to have an input and with clear and critically, joint, accountability for decision making.

2.2 Although this is a proposal about management structures, structure is not an end in itself. The objective from the start of this process, reflected in our consideration of consultation responses and proposed way forward, is to achieve better service outcomes for patients and clients. The proposals were firmly rooted in joint thinking about service delivery for addictions.

2.3 It is also worth emphasising that, for those patients and clients, a number of other services are critical, including those provided by mental health teams, children's services and primary care. A critical measure of the success of addiction services and their management structure is connecting to those other core services.

2.4 While it is worth noting that the general tenor of responses were positive about a number of aspects of the proposals, there are 7 main themes which emerge from the wide range of carefully considered responses we received. The themes are shown in bold with our commentary below each of them.

2.5 Integrated Management in Principle

While most responses supported integrated management as a way forward, there were some which questioned whether our proposals fully established the case for this approach.

In addition to the macro National and local policy frameworks, including the Joint Committee, which set a direction of integrated structures, there are clear practical issue.

We have already agreed to integrate frontline services following the methadone review and Community Addiction Team development process, based on work thoroughly and critically appraising the right models for service delivery concluding that integration of operational services will benefit patients and service users in a number of ways. The first section of this paper restates the case for change. It is difficult to understand why we would then accept a proposition that would not see those integrated services managed within a single structure, or indeed that we can have appropriate accountability and governance arrangements without such a structure.

2.6 Balance of Health and Social Care

The proposals were criticised by some responsdees from health and social care staff as being too weighted towards a medical model – in the case of social care staff - and too weighted towards a social care model in the case of some health staff.

The proposed structure brings together existing services and service developments, the model of which and specification for, we have already developed together. It will be fundamentally important that the shared accountability element of the integrated structure, i.e. the Executive Team, which will include senior managers from the 3 partners, ensures that the pattern of service delivery is a genuinely integrated and balanced one which reflects the strengths of NHS and social care models. We attach great importance to achieving a positive blend of the different professional perspectives – achieving parity not domination. A programme of culture change and organisational development will be at the heart of implementation. Practical examples of where the integrated approach can strengthen the way we deal with clients include a shared approach to assessment and care management and stronger inter agency child protection arrangements.

2.7 Locality Versus Speciality Management

Responses to this consultation, and other emerging work around service integration, highlight a genuine dilemma about how to deliver on the imperatives:-

- **achieving effective management at local level with real delegated authority.**
- **strong local accountability and service responsibility.**
- **Local leadership across care groups.**
- **city wide systems of specialist care.**
- **links between locality based and more concentrated specialist services.**

This dilemma is not one which is resolvable within a consultation process and structural change for a single service area. Equally, as we have already agreed to implement fully integrated services, identified clear benefits from that change, and require to deliver management arrangements which reflect those service drivers we need to move forward. We have concluded that we can deliver progress for addiction services and our interim solution for community services is outlined in the next section of this paper, but that in parallel a wider process is needed to engage the many stakeholders, including elected members, staff interests, clinical and professional groups and patient and client views, in order to identify the options for a comprehensive way forward for all community based health and social services. It is appropriate that the issues which have arisen from integration processes for particular services should be the basis on which that wider process is built.

The proposals to move forward recognise that Area Management is the pivotal point to deliver cohesive social work services. The diagram below also illustrates the critical interfaces within Health, including mental health and primary care and social work.

<table>
<tr><td colspan="5">JOINT EXECUTIVE GROUP</td></tr>
<tr><td colspan="5">ADDICTION SERVICES</td></tr>
<tr><td rowspan="2">PRIMARY CARE</td><td>CRIMINAL JUSTICE</td><td>CHILDREN AND FAMILIES</td><td>COMMUNITY CARE</td><td rowspan="2">MENTAL HEALTH</td></tr>
<tr><td colspan="3">AREA SOCIAL WORK SERVICES</td></tr>
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2.8 Interfaces with Other Services

A number of points where made here. These included the importance of interfaces with other services, a view that the paper is not adequate in mapping out the relationship of addiction services. A further response highlighted the

critical role of primary care in service provision and planning, this needs to given greater clarity.

A number of these comments indicated an expectation of a very different approach to the one we adopted in setting out these proposals. There is a fundamental point that people with addiction problems are significantly cared for and linked to other services and there must be no fracture between addiction and other key services, particularly the care of children and families. Our aim was not to map out every professional relationship, connection and interface, we know that addiction services are critical to a whole range of other social and health care services as well as child care, including, criminal justice, homelessness, acute hospitals and GPs. These are not proposals to redraw the whole of the health and social care map, nor would our intention or expectation be that they should disrupt the current and developing relationships between different staff and services.

The proposals are about the management of specialist addiction services and we recognise that people with addiction problems are also cared for by a range of other services. We may need to make more explicit the policy objective to achieve better links with these services through this clearer more coherent integrated structure.

Having said that clearly we need to express the importance of service interfaces in conjunction with greater clarity on the limits of this particular process and that there is further dialogue with Children's and families and primary care as central interests. The comments in the preceding section and the interface map reflects that.

2.9 <u>Professional and Managerial Roles</u>

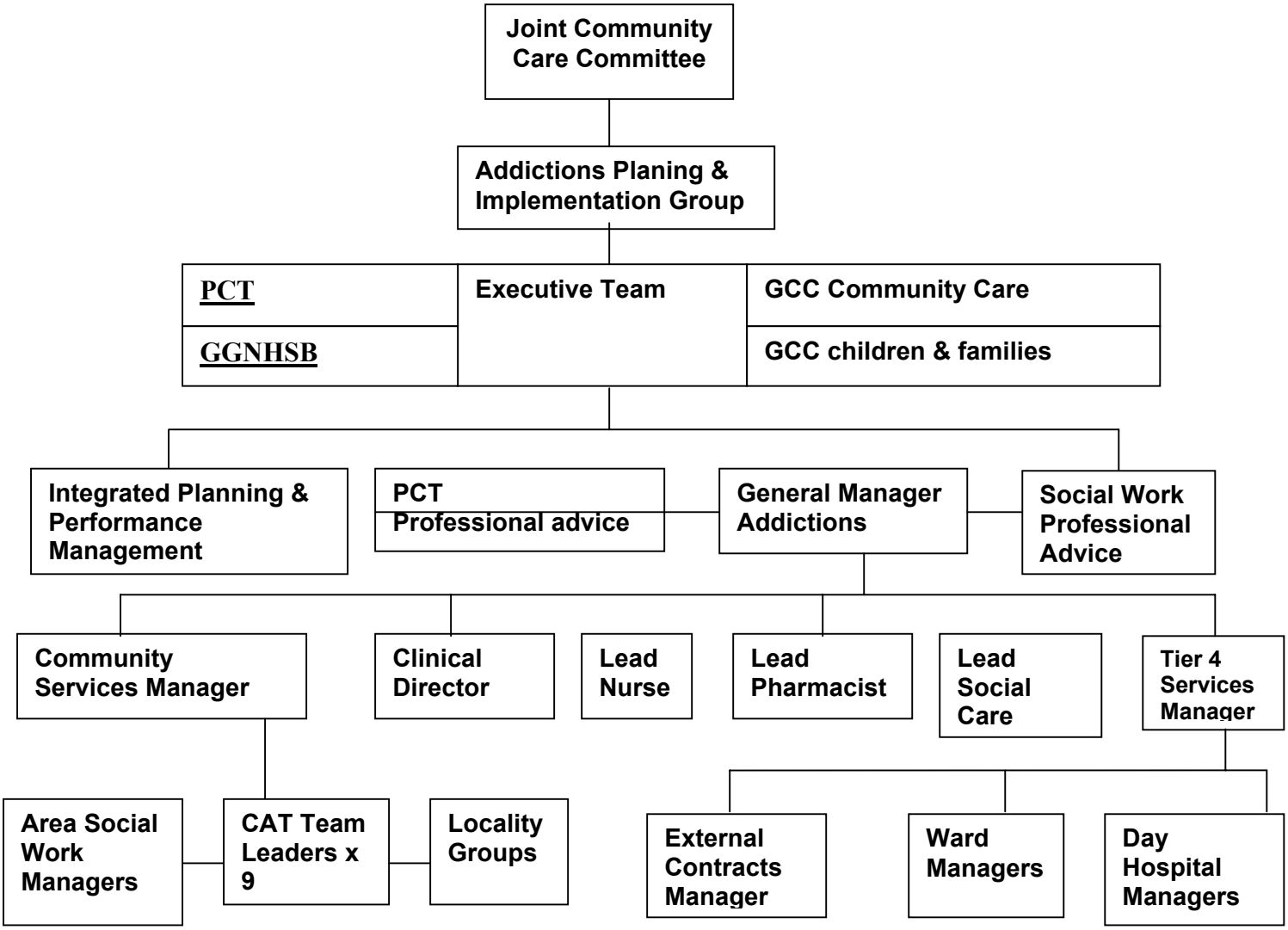
Some commentators, particularly NHS consultant psychiatrists, criticised the structure for being excessively managerially focussed, excluding professional staff from key roles and influence. There was also a suggestion that the structure should have a triumvirate apex. Finally, a number of responses highlighted concerns about governance and clinical and professional accountability.

We put particular effort in developing these proposals into ensuring that the management team was balanced to reflect the main professional groups involved in service delivery, but also recognising the fairly well worn route to good management practise and service outcomes that there needs to be clarity about accountabilities of senior staff. One of the issues where greater clarity may be required is that the structure proposal is influenced by the fact it is designed around organisations which retain separate overall structures, legal duties and accountability routes. This has 2 key outcomes, firstly that a substantial amount of infrastructure in GCC and the NHS will continue to be outside the structure but support it, for example human resources and financial capacity. Secondly, professional support and development will need to be routed into the partner organisations in a way which does not cut across the cohesion of an integrated structure

The feedback on governance and professional accountability is consistent and clear, staff are legitimately concerned to see clarity on these arrangements and we recognise the importance of that detailed work in moving to implement any structural change.

The diagram below illustrates the joint accountability arrangements, recognising there continue to be separate NHS and Local Authority structures. We expect professional leaders within the integrated structure to have formal connections to professional advisers within each organisation.

NHS Greater Glasgow/Glasgow City Council
Proposed Organisational Arrangements – Addictions



2.10 Planning, Commissioning and Operational Management

Our proposals included integrated operational management and policy and planning arrangements operating in 2 strands, accountable to the Joint Executive Group – some responses raised issues about the clarity of responsibilities of those functions, concern about the influence of operational staff on strategy and policy development and how these proposed arrangements would effect current staff roles and responsibilities. One response felt the paper should refer to a whole series of Local and National Strategies. Another was concerned about relationships between other social work centre and planning functions and the proposed structure.

This separation of the functions of policy and planning reflects the current NHS structure – where operational services people are key players in strategy and policy development, but the function is separate and includes an element of accountability and performance management – at arms length from the management of service delivery. However, the term commissioning has a different use in NHS and Local government, we need to explain further roles and responsibilities.

It is also fair to say that there is a partial separation within GCC of these functions as local services are operationally managed by ASW managers with a central policy function. The difference is that central function includes responsibility for direct service commissioning which would be part of NHS operational structures. It is proposed that this direct commissioning of services is part of the General Manager's operational responsibility – that clarity may partly address the issues raised by clarifying the confusion which may exist around the commissioning function. In the NHS, commissioning describes the ranges of activities associated with the macro allocation of resources, managing strategic planning processes, working with operational staff to define and implement positive service change and performance management. The policy reference in the proposed structure related to policy in a strategic sense, not the operational dimensions of the policy and practise development and consistency which are key to the governance of operational services and must lie within the remit of the general manager and professional leaders.

In terms of political interfaces, again as these often focus on operational and frontline issues – the General Manager will be the key player – both locally and across the City Council. In addition, the joint structure brings a single policy and planning function into an accountability to the Executive Group, giving a set of proposals which are cohesive in linking policy, planning, commissioning and operational arrangements but not overloading a single post with all of those responsibilities, which do not require the same skill base or experience.

The NHS White Paper continues to draw a distinction between the strategic responsibilities of Health Boards and operational structures and accountability. This distinction is already partly drawn within Glasgow City and generates the debate outlined in the opening commentary of this section, further aired in paragraph 2.7.

Clearly, as with interfaces with other health and social work services being critical to the operational element of the structure similar effective connections between planning and operational teams will be important.

The diagram below illustrates the proposed split of planning and performance management, operations and functions which need to be shared with all these areas under the accountability to the Executive Team.

Part of the next phase of defining this structure will need to be a wider debate about the final division it's impact on staff and where the shared functions sit – for example research. In addition, we need to work through the implications of this and other integration agendas for our internal budgetary and service planning processes, which remain quite distinct but need to be brought together.

Planning & Performance Management	**Shared Functions**	**Operations**

- Integrated drug and alcohol strategies including community care plan	- Research	- Consistent and coherent service delivery
		  - directly managed
		  - area based
		  - externally commissioned i.e. the service system works for clients

- Overall performance management on key strategic planks linked to priorities and resource allocation	- Health promotion and prevention	- Training - Internal resource allocation and budgeting
- Macro resource planning	- Influence and assess national policy	- Operational links to Primary Care, Criminal Justice and Childrens services
- Needs assessment - Linking addiction planning to wider service strategies	- Board and Committee briefings and papers	- Operational policy application and development
- Link to other Local Authorities		- Supporting community user engagement
- DAT and AAT support		- Service procurement and contract management
JOINT EXECUTIVE TEAM		

A further issue on this theme is influence on strategy and policy development. The point of the structure set out is to reinforce the current commitment to enable clinical, professional and operational staff to be engaged in the process of strategy and policy development – again restating that commitment should reassure people in principle and we need to look at delivering it in practise. There is no question that we need these inputs to get strategy right and strongly grounded in the realities of service delivery.

The final issue about how current staff would migrate into the 2 functions is a legitimate concern and we need to address that as a critical, early part of developing detailed implementation proposals.

2.11 **Relations to Other Local Authorities**

East Renfrewshire legitimately raised the issue of NHS relationships to other Local Authorities.

One benefit of the separation of planning and commissioning capacity from operational management is likely to be the ability to provide from part of that resource the sort of health input we currently require outside Glasgow while aiming to achieve similar operational integration on this model with other Local Authorities.

C CONCLUSION AND WAY FORWARD

3.1 We are persuaded that, the balance of responses, taken with the significant joint work which led to our proposals, and our extant commitment to provide fully integrated operational services, mean that we should move to implement integrated management. Our conclusion is that the best approach to this is incremental implementation, enabling many of the legitimate issues which have been raised, but can only be dealt with by moving to a practical implementation programme, to be addressed. This incremental approach would see the revision and re distribution of the proposals to address the points above, rapidly followed by appointment of a General Manager, to develop detailed implementation proposals.

After the appointment of a General Manager, the key first increment for wider implementation would include finalising the structure and roles of the senior management team, achieving those appointments and moving to develop detailed plans for staff migration, governance and other operational arrangements.

3.2 Dealing with the central concern about the management of addiction services in the community. We propose that, as an interim arrangement, the team leaders of Community Action Teams should be line managed by Area Social Work Managers, but with a strong line of accountability to the Community Services Manager, whose responsibilities will include operational policy and practise development. Pending the appointment of that joint post – the pilot CATs will need to link into health through the Primary Care Division Management Team. Pending the appointment of that joint post – the pilot CAT's will link to health through the Primary Care Division Management Team. Early establishment of the Locality Addiction Groups, which are intended to ensure wider accountability to local interests, will ensure the engagement of other key players from LHCCs and Social Work services.

Attachment 1

RESPONSES TO INTEGRATION ADDICTION SERVICES CONSULTATION

List of respondees and key points raised:

1 Jane Jay, Clinical Director, on behalf of Glasgow Drug Problem Service (GDPS)

- Generally sound.
- Nurses need clear career pathway.
- Clinical Director should be lead physician.
- Questions eligibility for Clinical Director and other roles.
- Questions responsibility for patients and budgets.

2 John Summers on behalf of Psychiatric Advisory Committee

- Needs greater clarity on the services offered in each tier
- Where does comorbidity fit in?
- What is Medical Director/leadership role above Clinical Director post?

3 Alan Fraser on behalf of Addiction Division of Psychiatry

- Clinical Director and lead social work post need greater importance – equivalent to the General Manager.
- Will the Clinical Director be a psychiatrist?

4 GCC Addictions Team, Centre

- Paper is very health orientated, referring to patients throughout and not reflecting the nature of alcohol and drug use, structure does not reflect responses required.
- Key drivers for change too narrow.
- Weak because of lack of profile for children's and criminal justice linkages which are critical.
- Need more detail on planning/policy dimension of proposals which should account through the General Manager, this is bulk of work of central addiction team.
- Commissioning process and rules need clarity.
- Development is separated from operations.
- Other social work centre expertise is key and needs to relate to addictions planning.
- Will policy and planning function do all interfacing with elected members.
- The interface between research and operational staff is valuable.
- How will political and financial accountability be delivered.
- What is role of lead pharmacist?
- Where does responsibility for practise and policy development lie?
- How will commissioning of services relate to the operational management team.
- Formal and informal contract management are vital.
- ASWM need to manage locality services.
- CSM role could be service development and performance management.
- Lead social care post is unclear and confusing.
- How will finance and HR structures operate?

5 Julie Murray, East Renfrewshire Council

- Need local discussion on scope for integrated community service and how it would relate to this structure.

6 Kay Roberts, Area Pharmacy Specialist

- Welcomes pharmacy role, but needs more pharmacy capacity to support community pharmacies – suggests 3 posts to be inserted.

7 Scott Wylie, Consultant Psychiatrist

- Clinical Director post should only be filled by a psychiatrist.
- Questions distinction between tier 4 and 3 services, balance and leadership of nursing staff between those tiers and potential clinical governance issues.
- Field addiction consultants views have been relatively ignored and consultation has been inadequate.

8 Donny Lyons, Medical Advisor for Elderly Services

- Need to explicitly indicate no age barriers to services.

9 Peter Jennow Team Leader, SE Area team.

- Welcomed a number of the statements but concerns about locality management principle
- What will team leader selection process be
- What is purpose of locality groups?
- Social care does not have enough centrality

10 Alison Campbell, Department of Work and Pensions

- Emphatically needs to be part of the integrated approach.

11 Stephen Rhodes, Senior Nurse, Drug and Alcohol Directorate

- Joint General Manager post promotes and enables increased accountability and responsibility.
- Flatter structure should create an open and proactive environment.
- Proposals offer no view of professional accountability structures and mechanisms.
- Total resource to be managed needs clarity – HAT and COMET given as examples of lack of that clarity

12 David Harley, Acting General Manager Specialist Services

- Roles and responsibilities of Executive Team require further detailed consideration
- Operational input into policy and planning is not shown.
- Absence of governance process or structure is a major omission for medical, nursing and social care leads.

13 McLean Currie, LHCC Manager, North Glasgow

a
- Making sense in management terms, but CAT services not detailed enough, particularly on how they will integrate with primary care.
- Is structure top heavy?
- Not impressed, proposals do nothing for service provision in North Glasgow.

b
- Welcomes the proposals
- Drugs must not eclipse alcohol.
- Highlights pressure on the methadone programme

14 Anne Joice Sector AHP N and E Glasgow

- Supports move to joint organisation
- Potential for overlap in some remits
- Need lead AHP

15 Group of GPs Treating Drug Misusers

- Structure excessively managerial and no mention of GPs. The structure of medical input to services is not addressed.
- Does not reflect key role of primary care and its services. Committed GPs have essential roles in planning drug dependency services.

16 Dr P Jauhar – a) Clinical Director b) Personal Response

a
- Healthcare services are marginalized.
- No professional structure suggested reflects importance of general management
- Structure refers to Glasgow District Council but NHS responsibilities are wider.
- Addiction psychiatry is part of general psychiatry.
- Structure is far removed from service delivery and is not designed to reflect clinical and social work service integration.
- Relegates professional input to a flat structure far removed from strategic planning.
- Clinical Director is a lead clinical role.
- Concerns about grading and terms and conditions.
- Proposal does not incorporate serious concerns raised.

B
- Concerns raised by addiction psychiatrists not reflected.
- Top down not bottom up and lacks focus of improving delivery of treatment and care.
- Structure is a series of mangers not acknowledging expertise of senior professionals.
- Clinical Director role is a marginal one – structure should be a triumvirate one.
- Pace of change and structure will disrupt series.

17 Kennedy Roberts, GDPS

- Who has accountability?
- Needs clarity on RMO if patients have no GP.
- Series of questions about HAT and CAT team arrangements.

18 Jill Murray, Chair, PAM Advisory Committee

- Management roles and responsibilities need clarity.
- Lead allied health professions should be included in senior management team.

19 Area Dental Committee

- Disappointed no mention of dentistry.

20 John Owens, Areas Social Work Manager

- Management structure top heavy.
- Where would team leader role be located?
- Should we move to generic addiction workers and is the service model social or medical?

21 Social Work Children, Families and Criminal Justice

- Prospect of considerable gains in improving care but need wider ownership
- Paper should address critical role of addiction in relation to other social care services, picture and language is to health orientated and structure over medical orientated.
- Case for change does not justify the proposed changes and should be broadened
- Paper should articulate a broader strategic approach impression is the main driver is
- the methadone programme.
- Operation of structure difficult to understand
- Reporting mechanisms inadequate for nature of the service joint children's committee should have equal weight.
- See no rationale for separation of planning and policy from operations
- Community service manager proposition is counter to local responsive management structures, the proposals to deliver locality influence are inadequate.
- Should not separate commissioning and contract management function
- Further thought required on social care lead role, it's function and location.
- Recognise huge potential gains for users and families want to engage further with the process.

22 North Area Social Work Staff

- Concerns about grading and other HR issues.
- How would performance be measured?
- CATs must be very strongly locality linked – question role of the community service manager and role of locality addiction group.
- Joint training is a key issue.
- Need to learn form implementation of CAT pilots.

23 Jean Cherry OT Allied Health Professional Committee

- General support for the structure which will improve joint working and provides clear lines of accountability.
- Clarity on reporting mechanisms and governance structures for AHP's is needed.
- Strong professional leadership is required.

24 Stephen Campbell CPN representative Area Nursing Committee

- Well thought out proposals with appropriate clinical supervision mechanisms.
- Interface with existing teams needs clarity.

25 GGNHSB Addictions Team

- Support integrated structure, the absence of which is a significant problem.
- Commissioning arrangements need clarification.
- How will other Local Authorities fit in?
- Links with children and families do not have sufficient profile.
- More detailed review of current policy, planning and commissioning arrangements will be important as part of implementation.
- Need clarity on addictions input to other planning structures.