healthwatch Lincolnshire

Healthwatch Lincolnshire Service Visit Report to:

Lincolnshire Partnership Foundation Trust Drug & Alcohol Recovery Team (DART) November 2015

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Summary

The following report looks at some of our Drug and Alcohol services within Lincolnshire and contains information from 3 enter and view visits undertaken during November 2015. The visits focus on the patient journey, however, with the support of the Lincolnshire Partnership Foundation Trust (Mental Health Trust) and the DART Teams during this programme of work, our report includes engagement and feedback from the staff as well.

The work was carried out to supplement the work we have been conducting around mental health services more generally and although drug and alcohol misuse is not classified as a mental health issue, the service is commissioned by the mental health trust, LPFT, and does often have links in terms of dual diagnosis.

The report identifies key themes which Healthwatch Lincolnshire (HWL) believe should be raised as a matter of importance not only with the Trust and provider, but also where appropriate with other commissioners and providers of related services.

HWL is mindful that factors outside the control of the DART service have an impact on the service provided and consequently the patient experience; where these occur we have included them.

In essence, there were some core themes listed below which came out of the visits and as part of this work we have requested that the Trust comment on the findings in the public interest. Their responses are also included throughout. What is evident is that, the challenges faced are everyone’s business and in order to sustain an effective health and care service for the future, partnership working and assessing lessons learned are key. What must also be recognised is the public recognition of the care and support delivered by frontline staff delivering these services.

Key Themes from the visits and patients spoken to at the time:

The suggestions and recommendations, along with feedback from the Trust can be found on Page 23 onwards and provides a complete picture of the findings.

Thanks goes to the cooperation of the Trust, its staff, our HWL enter and view representatives, patients and carers for their open and constructive contribution to this report.

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Place of Visit:	**DART (Lincoln, Boston, Grantham)**
Address of Provider:	**Units 8 & 9, The Point, Lions Way, Enterprise Park, Sleaford Lincolnshire NG34 8GN**
Service Provided:	**Drug and Alcohol Recovery**
Date:	**November 2015**

1. Background.

This piece of work has been carried out by HWL who has a statutory function to enter and view any publically-funded premises providing health and care services. These visits are carried out with the sole intention of collecting information relating to the quality of services provided and gathering the views of patients, relatives and carers of those people accessing and receiving the services.

In June 2015 research was carried out on behalf of Lincolnshire County Council Public Health to review and inform drug and alcohol consumption and services within Lincolnshire, the 'Substance Misuse Health Needs Assessment'.

The following is taken directly from that report to support the background of our work.

"Lincolnshire is a large county with a population of nearly 725,000 people spread over both rural and urban environments. Estimates indicate there are over 17,000 dependant drinkers and nearly 30,000 high risk drinkers as well as 3000 people dependant on heroin or crack cocaine.

Some of the recommendations and areas for development that came out of that report include the following:

- Consideration needs to be given to the location of future service provision within main urban areas and smaller more rural locations, especially with regard to the most deprived areas of the county.
- Specific provision for dual diagnosis should be considered within any future commissioned model.
- Most drugs are consumed in a domestic environment; consideration should be given to engaging with this difficult to reach group including social media and other engagement campaigns.
- Joint work is required with the Prescribing and Clinical Effectiveness Forum (PACEF) to better understanding prescribing practices within primary care and how these are being used to treat alcohol and drugs dependent patients.

For the full document please refer to Lincolnshire Research Observatory at http://www.research-lincs.org.uk/UI/Documents/Substance-misuse-HNA-Final.pdf

In Lincolnshire there are a number of organisations providing support for people suffering with drug and alcohol problems. Lincolnshire's treatment and recovery service is provided by DART and Addaction and additionally Oasis for Alcohol, all these services provide support, advice and treatment for people over the age of 18 with a drug or alcohol concern. Young Addaction provides support for young people with a drug and/or alcohol problem.

There are other support mechanisms for supporting those in need including:

- **teeninfolincs** is a website for young people with a drug and/or alcohol concerns.
- **Frank** is a 24-hour confidential helpline for young people, parents and carers with questions or concerns about drug and/or alcohol.
- **Re-Solv** is solely dedicated to the prevention of solvent and volatile substance abuse providing education, training and resources.
- **Drinkline helpline** on 0300 123 1110.

In writing our report we look for changes and lessons learned which are fundamental for a service to function effectively and adapt to changes in the environment as well as promoting the work which will be well received by the end user.

In addition to carrying out this work, we have a duty to ensure any information gathered is disseminated to the relevant organisations which have a monitoring and commissioning responsibility. We also have a duty to report to the relevant bodies any cause for concern relating to the safety and care of those in receipt of those services.

2. Methodology

HWL for the purpose of this work, are only focussed on the work provided by DART and the experience of those service users currently accessing support and/or treatment through this service.

HWL authorised representatives were appointed to undertake this piece of work. A questioning framework was produced to enable the representatives to effectively talk with patients, relatives, carers and care-providing staff and to make observations during the visits. The framework is not exhaustive, but does provide a background for directing theme-specific questions – *in this case the 'patient journey'. This included how patients had found themselves within the DART service through to their treatment and their anticipated onward journey.*

The focus of this work was to specifically look how patients used DART and their experience.

We visited 3 sites during the programme of work, Lincoln, Boston and Grantham. This is a Monday to Friday service with no out of hour's provision.

In addition to our focussed piece of work, the visit naturally notes observational perspectives of the provider and where views are expressed by the service user about other elements of care or the environment. These were also recorded.

In the interest of confidentiality we remove the names of those making specific comments although generic comments themselves maybe included within the report feedback.

The Provider.
Lincolnshire's Drug and Alcohol Recovery Team (DART) provides support and treatment for anyone aged 18 or over experiencing problems with drugs and/or alcohol use and is commissioned by Lincolnshire Partnership Foundation Trust (LPFT).

What DART say about their services.

How to access our services.
When an individual recognises that they might have a problem with drink or drugs and feel ready to get help, they can call DART for confidential advice.

There are 3 main teams around the county, but it can also be arranged for alternative venues for visits to clients.

Referrals from other providers could also include the GP, health worker, probation officer or hospital.

When others are concerned about a family member or friend with concerns about someone else, still feel free to give us a call to discuss your concerns and find out how you can help.

The DART teams are open from:	Monday	9 am to 5 pm
	Tuesday	9 am to 7 pm
	Wednesday	9 am to 5 pm
	Thursday	9 am to 7 pm
	Friday	9 am to 5 pm
	Excluding public and bank holidays	

What happens when an individual contacts the team?
Any contact made with the team is confidential. It might just be for advice and find out a bit more about the service or the individual is ready to start the road to recovery.

Everyone who uses DART will receive:

- An assessment carried out by a qualified professional – the assessment will look at why and how drinking or using drugs started, what is being taken or drunk, how often and how it is affecting the individual.
- A personal recovery plan – this will explain how DART can help and how each of the various treatments work and then work with the individual to make a recovery plan which will plan steps from feeling better to overcoming your problems.
- Provide a key worker – throughout the service there will be a named key worker for one-to-one support throughout. They discuss recovery and are there to help with difficult or challenging experiences.
- A crisis plan – for those times when individuals are struggling to cope but still want to avoid resorting back to drugs and alcohol.
- Peer support - opportunities to meet with fellow service users for peer support; to be able to share stories of recovery.

What services are on offer?
No 2 people are the same, so the help and support will vary depending on what works best.

It may include talking things through with someone such as a recovery worker or talking therapies specialist. Helping to learn techniques to avoid unhelpful behaviours and thoughts, or acknowledge and overcome troublesome past experiences.

We may be able to prescribe medication to help gradually reduce reliance on certain types of drugs and other harm reduction advice to prevent catching a serious blood borne virus such as HIV or Hepatitis. We can also offer screening for Hepatitis and provide Hepatitis B Vaccinations.

Support from others
As well as being given a key worker from our team of specialists, there is a wider network of people who have been through the same experiences and offer moral support you need.

The peer support network understands from personal experience how difficult it is to take those initial first steps.

Help with other issues
As we start to understand why the drug and alcohol problem has happened we may identify other factors preventing recovery.

Lack of social networks outside of other drug users, unemployment, boredom, poor housing, family breakdown and loneliness may be major which require assistance to change.

There may be problems with depression, anxiety or maybe even more complex mental health problems that are impacting on a person and as part of local NHS mental health services they can help with these other issues to.

Professional's Information
To fully benefit from our services the person should acknowledge that they need help and support in overcoming their drug or alcohol problem and demonstrate a willingness to recover. The range and intensity of the interventions offered will be determined through the use of objective assessment tools and collaborative discussions with the service user.

What we provide:

- End to end service provision for all drug and alcohol associated treatments and support, including the broadest range of prescribing and psychosocial interventions.
- An experienced team of healthcare professionals specially trained in the provision of treatment, care and recovery for people struggling with drug and alcohol problems.
- A personalised package of care based on individual need, focusing on the range of presenting problems not just the presenting substance.
- Seamless links with local mental health and wellbeing services. As part of LPFT, the team can also look at other contributing mental health problems and work with mental health colleagues.

Local team details below:

Boston
Babbage House, Rear of Boston Borough Council, West Street, Boston PE21 8QR
Tel: 01205 314479
Email: boston.dart@nhs.net

Grantham
Beaconfield Centre, Beacon Lane, Grantham NG31 9DF
Tel: 01476 591233
Email: grantham.dart@nhs.net

Lincoln
Carholme Court, Long Leys Road, Lincoln LN1 1FS
Tel: 01522 597979
Email: lincoln.dart@nhs.net

Recovery is an individual journey.

Acknowledgement.

Following visits to the DART sites, HWL had an opportunity to feedback and outline the findings to a member of the staff team on site at the time. Many thanks to the teams who took time out of their schedule to facilitate the visits but also to listen and contribute to the conversations around the findings. In addition, we would like to thank all the staff at the DART sites who offered an open and honest perspective of their working environment and some of the challenges it faced.

3. Respondents.

Prior to any conversation being held with a service user we introduce HWL and ask permission for any dialogue to continue as we respect that not all service users will want to engage with us in this way.

During the visit we spoke to as many service users who wished and/or had capacity to talk with us. In addition and where we could, we spoke to managerial and operational staff at each site to provide a more holistic view.

A total of 19 service users were spoken with during the visits. In addition we also had 5 staff responses and opportunity to talk with staff team meetings at the Grantham and Boston sites.

These were broken down as follows:

- Boston – 5.
- Lincoln – 8.
- Grantham – 6.

4. Findings from Respondent Experience Survey.

The following provides an overview of the service from a lay-person's perspective and separates the sites for clarity. However, staff feedback, conclusions and recommendations may be duplicated across sites where organisational themes are identified. The culmination of all key findings and recommendations can be found in the table on page 23 onwards.

4.1 Findings for Boston

The following provides the detail of the visit feedback and should be acknowledged that this information was taken at a point in time. If changes have been made since the visit and the provider has commented on them, we will include those within the report for public interest and information.

4.1.1. General Information.

We were told that the service was provided for anyone over the age of 18 requiring support with drug and or alcohol misuse and that that many service users self-referred. However, referrals also came through other routes such as GPs, family members and probation as part of a court order and organisations such as CenterPoint, Framework and from the Church community. Countywide, the service has around 1200 patients in the 'active care' phase of their treatment and beyond that the service provides aftercare of up to one year.

We were told that the team was made up of a visiting Dr and Consultant, recovery nurse, recovery practitioners (key workers), social integration worker and a paid peer advocate.

We were told that generally assessments took place on site and one to one support from a key worker was also provided. Therapies such as CBT (cognitive behaviour therapy) and acupuncture were available on site; peer and support groups take place around the east including Boston and outreach to Skegness, Spalding and Long Sutton. We were told that the majority of service users were white British and that although it is known there is a significant Eastern European community that would benefit from the service, they do not engage.

The team try to work across agencies as much as possible to support the patient this includes involvement in TAC (Team around the Child), Safeguarding and Think Family pathways.

The team and community team can visit and assess a patient before being discharged from hospital and this would include the mental health LPFT wards.

4.1.2. What the Patient said.

We spoke with a variety of service users and a peer advocate during our visit. The responses provided a rich and honest account of the service from their perspective. We sought to understand the journey from access to delivery of core services and then the final stages of recovery and then if relapse occurred, how often and why.

We asked whether service users were new to the service or the circumstances around their attendance.
Those service users we spoke to in the main told us that they had been in and out of services for a significant amount of time - for some for as long as they could remember and some older clients had been in and out of services for 10 - 15 years. They told us in the majority of cases that they had also historically moved between services like Addaction and DART for various reasons but mainly because they felt there was either a clash between the key worker and the client or that they weren't getting the support they felt they needed. This was normally related to prescriptions to support recovery.

Where individuals had gone in and out of the service a number of times, the triggers for relapse tended to occur around family issues or the community which the individual engaged with. In fact across all sites the client group said that access to those actively within the drug and alcohol community had a direct impact on their recovery.

We asked whether service users felt they were assessed quickly enough.
All the clients we spoke to said that whilst they thought assessment could not ever be done quickly enough, they did say that a wait for up to one week had been acceptable, however, we did speak to clients who told us that they had known others where the wait had been too long and had ended in tragic circumstances. The point was made that at the point someone contacts the service, is normally the time they need the help the most and felt there was nothing to bridge the gap whilst waiting for a full assessment.

We asked service users if they felt their information was kept confidentially and safe.
When talking with the client group they consistently referred to their confidentiality agreement and were all able in some detail to tell us what purpose that served in terms of keeping them safe. The clients were also able to tell us they understood that breaches of confidentiality was sometimes required to ensure they were protected and other members of family or the services could be informed to offer additional support.

We asked about key workers, how they were accessed and what their views were of their interactions.
Key workers and nurses were perceived as crucial in the support of the client group. In general the client group felt that recovery was as much to do with the interaction and relationship built with the staff as much as the drive and determination of the individual. We heard mixed experiences with some individuals saying they only met key workers and other staff on the main sites whilst others told us that staff might give them a lift to a meeting if they relied on public transport, or in some cases told us home visits could be arranged. Most felt that their interactions with the key workers were appropriate and were happy with the frequency of visits either weekly or 2-weekly. However, it was also stated that they felt there was not enough time to spend with the workers to add real value.

We asked if service users missed appointments, and what the reasons generally were and what happened as a result.
All clients said they had missed appointments and most said they regularly missed, the main reason given was that they generally 'couldn't be bothered to attend' and in one instance it was felt they were being forced to attend by others rather than their own wish to engage. When clients did not attend appointments they either called in to give a reason or more frequently they were contacted by phone or text to enquire after them on the same day. The clients felt this level of follow up was proportionate and necessary. One client also told us that on one occasion the police had also been contacted by the team to undertake a welfare check.

We asked what their recovery plan meant to them and what they would do in a crisis.
Everyone we spoke with told us that the recovery plan was a useful document as it gave them timelines and targets to achieve. It also allowed them to be more aware of some of the triggers and how they needed to work with them. Everyone told us that the support plans were kept with the key worker and were worked on when they met. A couple felt that their recovery plan wasn't complete but said it was a continual work in progress; others said they felt they were in full control of their recovery plan and had been explained options and given advice; others said their recovery plan felt directed by the key worker. In terms of a 'crisis plan' or what to do if they felt that they were in need of additional support everyone spoken with said they didn't have a physical plan they could refer to but just said they would contact their key worker or family member and in some cases the peer advocate. However, when we discussed what would be the arrangements outside of the normal working hours when the key worker and advocate wouldn't be available they said there was a gap in service or that they didn't know what they would do.

We asked service users what kind of interventions they had come into contact with.
In terms of interventions, those we spoke with had utilised screening and vaccination services. Others had not used family or sessions or had opted out of them by personal choice; those spoken with felt that a need to protect family members from their recovery and personal pride did not want them involving others came up frequently. Whilst one client was aware of other services such as acupuncture and peer support groups, others said they had not be told of other services available and felt no everyone received consistent information.

We asked about peer support groups and for those who had attended what their experience was.
Support groups were perceived by those spoken with as the most beneficial part of their recovery. They said that they felt more engaged with the peer group and its members as they had actual 'live experience' of what an individual was going through rather than the key workers who were paid with no experience. Talking to others in similar situations also helped to share ideas for self-help and built friendships which helped with isolation.

We asked about signposting and other help provided by the service, such as access to welfare and benefit support.
Everyone spoken with had received support in accessing housing and other benefit advice and services. This element was perceived to be excellent and it was acknowledged that the support and guidance in sorting out services was pivotal to

their recovery as being homeless or without financial support could be a trigger or contributing factor to relapse and unwanted behaviours.

We asked what people's long term goals were.
Overwhelmingly those spoken with, with the exception of the peer advocate, did not see a time in the future when they wouldn't be accessing some kind of DART service. Words like, 'comfort blanket' and 'safety net' were used to describe their need to stay part of the service to ensure they didn't misuse again. Some said they would like to be a peer advocate but said they saw that a long way off.

We asked what service users felt was helpful about the service and what could be improved.
Generally clients were happy with the service they now receive, the relationship between the client and key worker was significant and one person told us that it wasn't until they got the right key worker that they started to feel the recovery process could begin. Whilst some were aware of a service user involvement group not many wanted to engage with it and felt the peers and key workers should be sharing their experiences with the staff team. Universally, the issue relating to out of hours care was critical and clients felt more services could be in place out of hours with specialist support around drugs and alcohol. They also felt some kind of helpline/listening service would be useful. It should be noted that services such as FRANK were known about but seldom used by those we spoke to.

4.1.3. **Observations**
Access to the premises.
There is no parking facilities at the premises, however, it is conveniently located near the bus station and public car park.

Are reception/service user/caller conversations confidential?
The visiting team felt the small reception and waiting area was not conducive to confidentiality and although sufficient for a small number of people to wait, there wasn't really adequate space for a wheelchair user and pushchairs would also be challenging to accommodate if there were other people in reception. In terms of meeting rooms these were individual and away from the main reception area which provided a much better facility for one-to-one discussions. The meeting room just off reception, whilst not conducive to confidentiality did provide much needed extra space and a usable room for peer and group meetings without having to go into the main building. Door entry codes were located around the building for added security. Some clients did tell us that it was not always comfortable in the reception area when the behaviour of some clients could be deemed unacceptable. Unacceptable behaviour in the peer group was also reported to occur on occasion.

Does the premises give appropriate access for disabled visitors?
The premises does have ramps up to the building but does not have an automatic door or bell to support access. This was raised at the time of the visit.

Is the premises easy to navigate, signage (different languages, accessible)?
The premises is adequately signposted if you are aware of the service you are looking for. In terms of the interior, although there was no signage in alternative languages, the signage and information available to visitors was plentiful. Signage beyond the main waiting areas was appropriate but not generally accessed by unaccompanied visitors.

Were the premises and facilities clean and in working order?
Yes in the waiting area and meeting room the facility and environment was clean. In other areas of the premises viewed it appeared to be in a good state of repair.

4.1.4. **Common Themes and Conclusions.**
The majority of the following information was shared with the provider directly after the visit. Any which wasn't has emerged as a result of the full service user feedback.

- The relationship between the service user and the key worker seemed to be pivotal to the perceived effectiveness of the service and where the relationship was good, the approach was upbeat. Where the relationship was not so good in the eyes of the service user, they could feel 'done to' rather than fully engaged in the recovery process.

- Comments were received which stated some service users coming from outside Boston were given 9 am appointments which they couldn't or found hard to attend, particularly if relying on public transport. The management said that later appointments and consideration for this should be given to appointment times.

- Peer support groups where they were attended were held in high regard and were seen as perhaps the most important aspect of the service, and from the service users point of view being able to talk with people who have had similar lived experiences was invaluable.

- Wheelchair access from the front door could benefit from a bell.

- The small waiting area is not conducive to confidentiality, however, we were confident the small interview rooms provided adequate facilities.

- Service users told us that waiting for assessment although reasonable was never going to be quick enough as they were often at crisis at the point of referral. We understand that the service is commissioned to be a recovery rather than crisis service but also appreciated that there wasn't anything for the service users between referral and assessment.

- We were told on a number of occasions that clients felt that the key workers relied too heavily on what they were told rather than using their professional training and intuition to gauge a client's needs. We were told that when asked how they were, the client would often say, "I'm fine" and this was taken as reality. When this was discussed with DART they said that the teams should be using tools to work with clients including motivational groups and activities.

- One service user told us that they were not able to work as they wouldn't be able to pick up their medication prescriptions. We queried this with the team who confirmed that access to a 24 hr pharmacy could certainly be arranged within Boston to create greater flexibility for working options.

- Service users felt there was a lack of specialised out of hours pathways and lack of listening/helpline.

4.2 Findings for Grantham

The following provides the detail of the visit feedback and should be acknowledged that this information was taken at a point in time. If changes have been made since the visit and the provider has commented on them, we will include those within the report for public interest and information.

4.2.1. General Information.

We were told that the service was provided for anyone over the age of 18 requiring support with drug and or alcohol misuse and that many service users self-referred into the service. However, other referrals came through other routes including GPs, family members and probation as part of a court order. Countywide, the service has around 1200 patients in the 'active care' phase of their treatment and beyond that the service provided aftercare of up to one year. We were told that at point of referral the aim was to get the client in for assessment within 1 - 2 weeks, however, this contractually could be within 21 days of contact. We were informed that it was not normal for home visits to be carried out but if they did, they would be risk assessed. Generally clients are on a 2 - 4 week appointment cycle unless they DNA and the more complex and vulnerable will remain on 7 day appointment until deemed appropriate to change. We were told that clients have recovery/care plans and these should be reviewed 3 monthly and that only 30% of those clients would take their recovery/care plan with them. We were also told that recovery and key workers could provide basic CBT, access to IAPT services, Time Management in Action and talking therapist support. Clients are also asked to support their plan by undertaking activities in between the sessions.

Screening for BBV (Blood Born Viruses), breath tests, vaccinations are all offered. In terms of prescribing there is a shared arrangement with local GPs, Swingbridge, St Johns, Sheepmarket and Sleaford Medical Group. We previously stated the aftercare was essentially in place for 12 months post discharge and heard that drop outs are most likely to occur around 12 weeks. Grantham felt fortunate that it is co-located within the Mental Health offices with the consultants which enables better communication. The site felt that positive and proactive teams provided a positive and holistic environment, however if it were ever possible, a facility for developing life skills with clients would be beneficial ie cooking, cleaning, budgeting, as there was a clear correlation between chaotic lifestyles and substance misuse. Within the Grantham area the split between drug and alcohol was approximately 40/60%.

4.2.2. What the Patient said.

We spoke with a variety of service users and a peer advocate during our visit and the respondents provided a rich and honest account of the service from their perspective. We sought to understand the journey for users from access through to delivery of core services and then the final stages of recovery and then if relapse occurred, how often and why.

We asked whether service users were new to the service or the circumstances around their attendance.

The people we spoke with had mostly been in and out of the services over a long period of time - one in excess of 10 years. Others, however, were new in service. For those spoken with who had been involved with drug and alcohol services over 5 years, they had accessed and both DART and Addaction and some of their predecessors. Their movement between services was either as a result of an

ineffective relationship between the service and the individual or they had changed post relapse.

We asked whether service users felt they were assessed quickly enough.
In terms of accessing the service there was a mixture of self-referral, GP referral and probation court orders. Everyone spoken with felt the process of referral, first contact and getting an appointment was easy and thought the timelines and waits of 1 - 2 weeks from point of referral was acceptable.

We asked service users if they felt their information was kept confidentially and safe.
The feedback received was that 100% felt their information was kept securely and that the people that accessed the information were trusted and supportive of the process. None of the client group we spoke with were very aware of who was on their own 'confidentiality list' - they seemed to think it was just the key worker and where relevant, a CPN or peer advocate.

We asked about key workers, how they were accessed and what their views were of their interactions.
The people we spoke with spoke highly of their key workers and other staff. They felt safe and secure within that environment. They felt their workers provided enough information to enable them to make informed choices about their recovery. One said they didn't feel bullied into making choices but said they quite often wanted to be provided with next steps. Clients felt that they worked towards plans that were achievable rather than anything where they were set up to fail, timelines were flexible and the steps to change behaviours were small and steady.

We asked if service users missed appointments and what the reasons generally were and what happened as a result.
We were told that clients did miss appointments and where they missed this was generally due to forgetfulness or other appointments or tasks taking priority. Where clients didn't attend they were contacted quickly by the key worker and they felt this provided good levels of support.

We asked what their recovery plan meant to them and what they would do in a crisis.
The recovery/care plan for most offered a means of managing their recovery giving them areas to focus on. When asked about what they would do in a crisis or out of hours the respondents didn't generally know and 2 said "I will have to fend for myself" or "will just have to deal with it or wait".

We asked service users what kind of interventions they had come into contact with.
Services such as screening, vaccinations and CBT had all been accessed on site. A couple said they wouldn't take advantage of family sessions as they felt the family would not want to get involved in the treatment and recovery side. Where family was very involved in the support and care of a loved one this was deemed a very positive experience for the client.

We asked about peer support groups and for those who had attended what their experience was.
When we asked about the peer group those that attended said it was quite uplifting and really beneficial to talk to those that had shared similar experiences. The comments relating to the support groups were around the depleted numbers attending and particularly for the ladies it was quite heavily male focussed although we did understand that other activities such as flower arranging were to be introduced. Feedback from those who had attended was the need to move outside the centre and suggestions were made such as going out regularly for lunch or going on a shopping trip or visit or simply linking them into other groups such as church and social groups. It was important for individuals to start to feel that they were being integrated back into the community. We discussed these themes with the Peer Advocate who said they would take the areas not previously thought of for future consideration.

We asked about signposting and other help provided by the service, such as access to welfare and benefit support.
Most of those spoken with hadn't needed to get any additional support or assistance. However, where they had accessed support around housing and benefits that had really supported the individual take control of their lifestyle.

We asked what people's long term goals were.
With the exception of one, none of those spoken with had been involved in any discussion about the end of the support and care package. For many they viewed it as a continual cycle of help and felt that at the current time they couldn't see when they would stop needing that support even though many of them had been in the services for a number of years.

We asked what service users felt was helpful about the service and what could be improved.
Peer support groups were held in high regard, however it was felt more could be done to increase numbers and possibly by diversifying the type of activities and focus of the group. A couple of individuals also said more regular gatherings may be more beneficial. Some felt education was key and not just the impact or the damage done to the person misusing the substance but also to the families, partners, children and communities as a whole and the support for families could be more formalised.

The issue around getting support and care when you need it was an issue for all. The out of hours pathway was unclear and left gaps for providing care, and whilst it is appreciated DART is not a commissioned crisis service, there is a need for provision.

4.2.3. Observations

Access to the premises.
The premises is well positioned close to the town centre but not within it so provides adequate car parking. What should be highlighted is that the disabled bay is a normal sized space and therefore those needing to fully open doors would struggle to do so within the space. The access to the building is ramped providing support to those with mobility requirements.

Are reception/service user/caller conversations confidential?
The reception area is of a good size with seating available. The reception desk has a screen and therefore access could impact on confidentiality although it was felt that the seating is situated sufficiently far away enough to limit unnecessary breaches of confidentiality. We also noted the use of additional smaller rooms around the reception area should a private room be needed.

Is the premises easy to navigate, signage (different languages, accessible)?
From the front of the building signage is appropriate and easy to see. Once inside the building visitors are escorted around the premises so the need for public signage is limited.

Were the premises and facilities clean and in working order?
The team are based in an old building and are therefore constrained by the structure. Some of the service users did say that they thought the building was drab and dull and despite the efforts to put information on the walls it still felt 'tired' and a bit dingy to the service users. Also noted by the visiting team was the radio playing in reception - it was quite loud and for most of the visit it wasn't tuned in properly which created an audibly challenging environment.

General Observations.
We did note that there was plenty of information available in the reception area and that that in terms of functionality the building did seem to provide appropriate space for all the services to be carried out. The views of the service users were noted, so whilst the building may be old, the internal decoration and furniture could be modernised.

4.2.4. Common Themes and Conclusions.

In general, the feedback surrounding the service provision and the staff was overwhelmingly positive.

We heard that getting the relationship right between the client and the key worker was a key part of starting that recovery journey.

It was felt more could be done to reach out to the wider community that could benefit from the service. We also recognised that from the perspective of DART, the service would not have capacity to cope, nevertheless, this should be considered as part of recommissioning intentions.

It was also felt that more education generally should be delivered into the community about the impact of drug and alcohol misuse on the user, the family, children and loved ones and the community in general. The service told us that they worked with the radio to get messages out to the community, however, we did not ascertain other forms of engagement ie schools, colleges, social media, employers etc.

Out of Hours provision was key for these service users but they didn't know what pathways to utilise. It is appreciated that DART is not commissioned to be an Out of Hours crisis team however during the recommissioning process this could be developed to provide clear pathways. Worth noting is that other services such as FRANK were known about but not regularly used.

4.3 Findings for Lincoln

The following provides the detail of the visit feedback and should be acknowledged that this information was taken at a point in time. If changes have been made since the visit and the provider has commented on them, we will include those within the report for public interest and information.

4.3.1. **General Information.**

We were told that the service was provided for anyone over the age of 18 requiring support with drug and or alcohol misuse and that many service users self-referred into the service. However, referrals also came through other routes such as GPs, family members and probation as part of a court order. Countywide, the service has around 1200 patients in the 'active care' phase of their treatment and beyond that the service provided aftercare of up to one year.

In addition to the Lincoln site there are also outreach workers for Gainsborough, Caistor, Mablethorpe, Horncastle and Louth. Local GPs shared care between Witham and Minster Practice. The Lincoln team has 25 members of staff including 2 specialist recovery nurses, 3 non-medical prescribers, specialist social workers, 5 nurses and recovery practitioner support worker - all with the aim of reintegrating misusers holistically back into the community. Typically we were told recovery practitioners would have a caseload of 30-40 clients. It was felt within the Lincoln area the biggest areas of substance misuse were alcohol and heroin. We were told that the pathways through the system were getting better but there was still room for improvements especially around dual diagnosis and access and integration of mental health services. We also spoke about those cases which were severe and enduring and where deadlines for clients to leave the recovery service and performance by results were no longer a driver.

4.3.2. **What the Patient said.**

We spoke with a variety of service users and a peer advocate during our visit. The respondents provided a rich and honest account of the service from their perspective. We sought to understand the journey for users from access through to delivery of core services and then the final stages of recovery and then if relapse occurred how often and why.

We asked whether service users were new to the service or the circumstances around their attendance.

Predominately the clients spoken with had accessed the service previously and this was the second or third time they had been referred into the service. The clients had in some cases moved providers for various reasons but normally because they felt the relationships built with the other providers was not working for them.

We asked whether service users felt they were assessed quickly enough.

Most clients had self-referred and only 2 were referred via probation and GP services. Referral through to first appointment ranged from 4 weeks to a couple of days and all felt that the time waited was reasonable.

We asked service users if they felt their information was kept confidentially and safe.

All users felt their details are kept confidentially. However, comments were made in relation to the reception area that it was quite an open space in close proximity

to the waiting area. One client told us that they had to shout through the glass to make themselves heard and this had caused embarrassment.

We asked about key workers, how they accessed them and what their views were of their interactions.
The clients that were already in the service said they felt that whilst their existing relationships with their key workers was good, it isn't always the case and the need to match up the right key worker to the right client is very important to the patient journey. In the main, the clients said they felt in control of how they developed their recovery plan and also felt the advice, guidance and experience of the key worker was also really important. Those that were new to the service said they felt involved and engaged in the development of the recovery plan and felt it was progressing at a comfortable speed.

We asked if service users missed appointments, what the reasons generally were and what happened as a result.
Clients spoken with told us that if they had to miss an appointment they generally contacted the service to arrange another appointment or to give a reason. Where this did not happen, clients said that the key worker would normally contact them the same day. One client said they weren't contacted but were instead just checked on when they collected their prescription.

We asked what their recovery plan meant to them and what they would do in a crisis.
The people we spoke to felt the recovery plan provided focus and enabled them to work on recovery in between appointments. Most of the people we spoke to said they had a physical copy of their plan which was not the case at the other sites. However, in terms of what to do in a crisis, generally people were unsure. Some said they would rely on their family, others said they would ring their key worker but seemed unaware that this was not accessible outside normal business hours.

We asked service users what kind of interventions they had come into contact with.
The majority had utilised screening and vaccination services along with talking therapies, although some said they felt the latter wasn't very effective for them as individuals. No one spoken with had felt the need to seek support around other welfare and benefits services such as accommodation or getting back into employment. All spoken with felt that they were currently in a position where they didn't need that level of support, particularly as a number were currently employed.

We asked about peer support groups and for those who had attended what their experience was.
A number of those spoken with had accessed the peer groups and found it useful to speak to people who had been through the same or similar experiences. Others hoped to get involved in the future and a few others felt that the mentors did not meet the needs of the service users. It was felt there was a degree of conflict between some of those accessing the services and those who were post recovery and using their skills and experience to develop not only themselves, but support others.

We asked what people's long term goals were.
The response from clients at the Lincoln site was different from those at the other areas. There was a more timely focus around recovery with some very clear goals in

mind. For those very new into the service they said they didn't really have an idea of timescale but expected that this would be discussed with them over the next few weeks.

We asked what service users felt was helpful about the service and what could be improved.
On the whole the clients expressed a positive experience of the service. They acknowledged that they felt listened to and that this was a recovery service where they expected to make a recovery and leave the service. The clients said they appreciated the suggestions boxes and access to the peer groups which allowed for ideas and suggestions to be made. Out of Hours support was the main area where the clients felt more should be done to make this pathway clear and robust. Another observation which came from the feedback was around the relationship between mental health services and DART - the client group didn't always feel that they were as joined up as they might be. We were told of people being discharged from a service because they hadn't attended a mental health appointment and being sent to A&E rather than being able to access specialist Out of Hours care. Transport for some was also cited as a challenge but for most the positioning of the premises had more positives than negatives.

4.3.3. Observations

Access to the premises.
There is car parking situated around the site and easy drop off access at the front of the building. The site is on one level and is quite spacious in terms of the reception and waiting area and supports disabled access/pushchairs etc. Some respondents felt that the out of town location was ideal. There was a lot of pride amongst those we spoke with and the ability to not have the service in the middle of town provided a little more confidentiality. Others said that they sometimes struggled to get to the site but the positives for clients outweighed the negatives.

Are reception/service user/caller conversations confidential?
The receptionist is seated back from the screen and as a result there may be a need to for an individual to raise their voice to be heard. This was a response echoed by a service user who felt embarrassed that they had to raise their voice to be heard.

Does the premises give appropriate access for disabled visitors?
Single level access and ramps provided good access.

Were the premises and facilities clean and in working order?
All the services viewed provided a clean, fresh and modern environment for those working or visiting the premises.

5. Findings from Staff Experience Survey.

Through a combination of discussion at staff meetings and the receipt of staff feedback forms we received some rich information which provides clarity from a different perspective. The feedback can be categorised into the following areas.

The biggest challenges facing the DART service currently.
There were a number of areas which staff felt impacted on the service and the recommissioning of the service clearly concerned staff in terms of continuity of care and quality of care for those service users within the system. The recommissioning is due to be finalised by April 2016 will full implementation by September 2016 the concerns of the staff need to be acknowledged. Some staff also said they felt unrealistic expectations were placed on the time and capacity to effect change with some of the client group as well as the time and capacity of staff to support.

In addition, staff felt there were not enough trained or authorised staff to carry out specific or specialised tasks which they felt could impact on continuity or quality of care. Staff sickness was highlighted as a concern again in terms of the impact for the client caseloads but also on impact for other team members.

Best aspects/positives about the service.
Very clearly the teams valued each other highly and high morale and team spirit seemed evident and this they felt impacted positively on service users. Staff felt that having client-centred goals, a variety of interactions, ability for the staff and service to be flexible and adaptable and a dedicated staff team were all the key areas of focus for promoting a positive service.

The biggest challenges facing service users.
Without exception there was consensus around the limited access to mental health services and lack of willingness to work with dual diagnosis clients who are not abstinent.

Staff also told us that access to interventions and access to treatments in remote areas could be detrimental to the development and recovery of a client. Also relating to rurality and specifically to the east coast and Skegness, we were told that GPs were a challenge to those working within and using the DART services and that whilst the majority of pharmacists are generally very helpful, occasionally locum pharmacists were not understanding to the client group's needs. The following areas were also cited as challenges or barriers to the service delivering to its potential:

- Access to housing which is available and affordable.
- Lack of jobs.
- Stigma from the general public.
- Client's belief in their own ability to change.
- Continuous cycle of deprivation.

Key areas of benefit for service users.
We were told that having the ability to support a change in lifestyle was crucial to affecting an impact on an otherwise chaotic lifestyle. Abstinence-based interventions, substitute prescribing, needle exchange and general lifestyle advice were all given as benefits clients got from the service.

Whilst it was noted that there is still a general stigma around those who misuse substances, it was felt that it is now generally better and people are more tolerant than they used to be.

Finally in this section, the need to support people to integrate back into a community and access other services and facilities was deemed to be important.

Common reasons service users DNA appointments and anything that can done to reduce DNA?

There were a number of reasons given why service users DNA their appointments and they included:

- Service user's frequently changing phone numbers and addresses demonstrating a chaotic lifestyle.
- Work commitments also had an impact.
- Times given for appointments were also considered a factor. This was also cited by service users as a reason for DNAs as they felt they were unable to get to appointments on time because of distances they need to travel or because the actual time of the appointment didn't work for the individual.
- Relapses.
- Lack of motivation.
- Clashing appointments with Jobcentre Plus. We were told there had been a previous working arrangement to avoid these clashes but this no longer seemed to operate.

A potential opportunity for reducing DNA rates would be scheduling key worker appointments at the same time clients are coming into clinic or picking up prescriptions.

Are the facilities at Boston, Grantham and Lincoln sufficient for the services users at the main sites?

A suggestion that at all sites, tea and coffee should be available all the time not just when the peers are in. We saw at Grantham a variety of refreshments including porridge and soups for clients to use, however, we did not establish whether this was a daily occurrence or whether this was specifically for the peer support group. Generally staff said DART made best use of the space available but did feel that capacity at outreach sites can limit what is offered.

Other suggestions around the availability of internet access for service users was also made so they can be supported with online applications etc.

Services working together.

Generally staff felt that external services worked well together nevertheless greater notice of hospital discharges was cited as one area where it could improve the client experience. Feedback from staff showed a good working relationship with services like family and children and safeguarding. Consistently we heard that access to psychological services and mental health could be radically improved.

Would having HWL collect the views and experiences of your client group as an independent and impartial organisation be useful.

100% said that having HWL engaged and attending outreach and peer sessions and drop-ins would be of benefit.

General Comments

Given the opportunity to meet staff informally prior to the visits at both Grantham and Boston and also receive a number of feedback forms following the visit offered a different perspective on the service specifically around some of its challenges but also some of it shining lights. Overall there were some clear perceived challenges that do or could impact on the services in terms of quality and continuity such as the forthcoming tender process for the service, staff sickness and adequately trained staff. In terms of challenges, there appeared to be some specifics around the support of GPs on the east coast and also the lack of access and support of mental health services. Positives, however, looked internally at the staff teams which worked closely with compassion and dedication. Also noted was where staff felt services worked well together including family and children's and safeguarding teams along with the interest the staff teams had in HWL engaging further with outreach and peer groups sessions which would provide an independent collation of experiences in a confidential manner.

6. General Overview of Observations & Conclusion.

The general findings below are generic and tend to run in themes across all 3 sites although this is not always the case.

- It is clear that the staff are acutely proud of their service and feel there is a real need to offer a clear and specialist pathway for those with substance misuse.
- Staff found that there were gaps in care for service users and particularly around 'shared care prescribing' and there were concerns relating to attitudes of GPs and other professionals towards their client group.
- On the whole, service users were positive about the service they received from their key worker and the service generally, particularly when it came to the provision of advice and support on areas such as housing, benefits and healthy eating. However it was also recognised that for many, recovery did not start until they had found the right key worker. It is acknowledged that marrying up a key worker to a client for an effective relationship could be challenging.

- We noted that service users frequently missed appointments for a whole range of reasons but predominantly, relapse and apathy. Where DNA occurred service users felt that contact by the service was made in a reasonable timeframe and was supportive.
- Peer groups which have been developed seemed to be the most popular and valued part of the service with many feeling that this type of support could be implemented earlier in their treatment programme. There was some negativity towards some of the peer groups which appeared to be at a personal level and as such could be further supported by the positive outcomes of the groups being promoted more widely. Those actually attending the groups said they felt the groups could be more widely advertised and also look more outwardly and use them to integrate the members into the community - for example, setting up a lunch club to work as part of the peer group. These patient suggestions were fed back

to the peer advocate and centre co-ordinator as appropriate but could be relevant for all centres.

- In terms of service user involvement, they generally said that they hoped the peer advocate or the peer groups would represent their views or alternatively their key workers would represent their views in the appropriate channels. We saw service user feedback forms and 'you said, we did' examples during our visit.
- It is acknowledged that DART have a good relationship with local radio and utilise this media format to highlight the services and include patients stories, however, also highlighted was that a larger media campaign could potentially create a demand that could not be met. Given that the vast number of referrals into service appear to be made by the service user themselves suggests there is a growing and more aware population that is recognising the need to address substance misuse issues and capacity for the future recommissioned services need to acknowledge and address this.
- One of the biggest concerns for the staff was the lack of access to mental health services where dual diagnosis exists and although we were told the pathways had improved it was the general feeling that this had much further to go before access and treatment of mental health would positively impact on the service user.
- One of the biggest concerns for service users is the gap in Out of Hours care. The service runs mainly 9 - 5 Monday to Friday, with some late night facility to accommodate working people. However, the majority said that outside of these hours, middle of the night, a weekend or bank holiday they didn't really know what they could do if they felt they needed support or were in crisis except than to rely on themselves or family/friends or A&E to get them through it. There is no specialist support or helpline that is available and OoH care can and does have an impact on the experience of service users. This again under the new recommissioning arrangements will need to be addressed, for example could a specialist worker be linked to the OoH telephone triage system. Whilst there are services such as FRANK nationally, the awareness or use of this was limited.
- The DART teams operate out of the 3 main offices and satellite work was carried out in other towns across the county. The building locations for all were deemed to positive with service users stating that they were away from town centre communities which supported confidentiality and also discouraged those service user communities to congregate. This wasn't as true for Boston which is still central, but was the overall view of Grantham and Lincoln.
- In general, service users felt they were receiving an appropriate level of care and felt the additional services like peer support groups which were highly valued could be improved. We noted that services users felt they were in the service for the long haul with the vast majority not seeing a time when they wouldn't be involved in it one way or another. Interestingly however, the client group for Lincoln seemed to differ in this respect with different expectations for outcome and not seeing themselves forever within a drug and alcohol service and with a greater emphasis on the 'recovery'.

- Generally carers felt that they could ‘cope’ or felt that they just had to get on with it. The sense of personal pride for most of the people we spoke with was evident.

7. Final Recommendations.

In our view the following core observations and recommendations need to be considered by the commissioners and providers of care not only of LPFT but also the relevant commissioning Clinical Commissioning Groups (CCGS). The table below provides the outline of the recommendations and suggestions made and includes the responses in the public interest. It is acknowledged that the items below highlight the areas for development and comment and should in no way detract from the positive feedback and activity described within the report.

Provider Feedback in Response to the Visit. "LPFT DART would like to thank HWL for their courtesy and approachability during their visit to all 3 DART resource centres at Boston, Lincoln and Grantham. We value the suggestions and recommendations which were formulated from the 3 "Enter and View" visits, the staff surveys and staff meetings. It is relevant to note that some of the issues raised such as dual diagnosis and provision out of normal working hours are being integrated in the new countywide service provision for drug and alcohol users which DART are currently tendering for".

Issue Raised	Commentary/Recommendations Related to the Report	Feedback/Commentary/Action in Response	Responsibility
Staff found that there were gaps in care for service users and particularly around 'shared care prescribing' and there were concerns relating to attitudes of GPs and other professionals towards their client group.	Request that DART/LPFT and Commissioners look further into these issues as they relate directly to continuity and quality of care.	DART currently contracts 15 GPs within the county to provide shared care provision. We also have a full time Consultant Psychiatrist, a part-time contracted GP who runs 3 clinics within Boston, Spalding and Skegness offering prescribing, 4 non-medical prescribers and one nurse currently training in this. The drug and alcohol service within Lincolnshire is currently going through an open tender process and shared care provision will be an important part of the proposed new DART model with increased GP numbers working in partnership with Lincolnshire and District Medical Services and Universal Health to expand these numbers. In response to the second part of this issue we continue to provide support and education to	

		professionals within LPFT and wider stakeholders. LPFT work hard to reduce the stigma that others have toward people who experience problem with drug and alcohol use. Both staff and peer mentors offer training sessions around drug and alcohol use to a wide range of diverse groups, for example, student midwifes, university nursing students, to local council workers such as refuge collectors. All shared GPs have supervision with our Consultant Psychiatrist and are trained in RCGP Level 1 or 2 Substance Misuse Certificate.	
On the whole service users were positive about the service they received from their key worker and the service generally, particularly when it came to the provision of advice and support on areas such as housing, benefits and healthy eating. However it was also recognised that for many, recovery did not start until they had found the right key worker. It is acknowledged that marrying up a key worker to a client for an effective relationship could be challenging.	Service users recognised the support given in relation to their wider recovery including housing, life skills, benefits management etc and this was also highlighted by some staff members as a key benefit area for some as once the housing and benefits were sorted their recovery seemed to fall into place. However we also acknowledge the reported lack of suitable and affordable housing and opportunities for work. Opportunity to raise these concerns with Jobcentre Plus, Volunteer Centre and Housing for further discussion around future opportunities.	DART welcome the comments and will continue to work with the service users to build their recovery capital and work in collaboration with the organisations mentioned - Jobcentre Plus, Volunteer Centres and local housing providers. DART is working hard to improve our stakeholder network and increase the access to good quality housing and employment.	

We noted that service users frequently missed appointments for a whole range of reasons but predominantly, relapse and apathy.	The staff team also felt that DNA rates could be improved through scheduling of appointments with the pick-up of prescriptions. In addition some clients travelling from more rural areas could have appointments scheduled that so attendance by public transport wasn't such a challenge, when we spoke to the management team they said that this shouldn't happen but from the client perspective is does.	DART staff arrange appointments for the service users they work with and are able to schedule appointments with prescription pickups dates. We value the comments regarding attendance and lack of regular public transport which is a recognised issue within Lincolnshire. DART management team will revisit this in team meetings reminding staff about being mindful regarding appointments and transport links.	DART Service Management Team
Those actually attending the peer support groups said they felt the groups could be more widely advertised and also look to use them integrate into the community. In terms of service user involvement, they generally said that they hoped the peer advocate or the peer groups would represent their views or alternatively their key workers would represent their views in the appropriate channels.	Building on the feedback and suggestions of the support group users. Consider looking for more engagement as part of the community rather than focussing all meetings around the DART centres, for example set up a lunch club to work as part of the peer group. Please consider utilising HWL as a way of engaging with clients/carers and staff. This can be promoted through HWL for which each group could apply for a small grant to help start up the Hub.	DART have employed 3 Peer Advocates who have worked through their recovery and now support service users/peers within DART. Part of their job role is to build engagement with wider community. DART Lincoln runs an allotment group for service users and peers. We have DART groups running in Skegness, Horncastle, Spalding and Stamford alongside groups which run at the resource sites. All groups are advertised in the reception areas of all resource centres. DART run service users involvement groups which alternative between sites. Each resource site has literature in waiting areas regarding HWL. DART management will liaise with HWL to see how we can work together for the mutual benefit of service users and carers in the future. The challenges for treatment providers to fully manage wider groups outside of its current contract scope are recognised by our commissioners. As such the new treatment system that is currently out to tender is in 2	DART Service Manager

		lots one for treatment and one for the building of a Recovery Community. If successful at tender, DART will support the Lot 2 providers in building these community resilience resources and to link with HWL.	
One of the biggest concerns for the staff was the lack of access to mental health services where dual diagnosis exists and although we were told the pathways had improved it was the generally feeling that this had much further to go before access and treatment of mental health would positively impact on the service user.	HWL request a response from LPFT in relation to these findings and furthermore that the issue of providing mental health and treatment services for someone with a dual diagnosis has been an issue for a long time.	DART continue to work closely with all our mental health teams to ensure that service users who experience dual diagnosis have continuity of care and ease of access with referrals both into DART and from DART into the mental health teams within LPFT. DART workers are able to liaise directly with LPFT Crisis and Home Resolution Team when service users are acutely unwell. The service has access to the clinical systems used by the mental health services and are therefore able to check all referrals to see if they have any dual diagnosis needs. DART attend interface meetings across Lincolnshire on a weekly basis with managers from all mental health services within LPFT to discuss referrals and ensure that they are dealt with by the most appropriate service. DART undertake some joint working with the Community Mental Health Teams and joint care planning is undertaken under the Care Programme Approach for those patients whose care is managed under CPA. DART offer CBT based interventions for low level anxiety and depression and offer very popular countywide groups based around mental well-being. The commissioners of the new drug and alcohol service which DART are tendering for specifically asks for a	DART management, LPFT mental health management teams

		commitment regarding dual diagnosis and our new service model incorporates this.	
One of the biggest concerns for service users is the gap in Out of Hours care, the service runs mainly 9 - 5 Monday to Friday, with some late night facility to accommodate working people. However, the majority said that outside of these hours, middle of the night, a weekend or bank holiday they didn't really know what they could do if they felt they needed support or were in crisis except than to rely on themselves or family/friends or A&E to get them through it. Whilst there are services such as FRANK nationally, the awareness or use of this was limited.	Access to Out of Hours care and support across the county is concerning particularly where individuals in service are not tending to utilise phone or online support. Consider re-education and promotion of online and helpline facilities as well consideration for a specialist support service for out of hours within the new commissioning arrangements.	Currently all service users have a crisis and contingency plan written in collaboration with their key worker within their recovery plan at the start of their treatment episode. This plan has what they would do in a crisis and who they feel they could contact out of normal service hours. The suggestion about re-education of staff about availability of online support and helplines has been noted and during monthly team meetings coordinators will discuss this with staff. Within resource sites DART has literature regarding self- help and mutual aid groups including AA and SMART recovery. The new service model which DART are in the process of tendering for would include more Out of Hours working by DART staff and there is a plan to explore further an out of hours helpline.	DART management team, Commissioners

HWL ask that in addition to the specific recommendations above, that all the observations and recommendations made regarding DART which are directly within the control of LPFT or within the control of other providers or commissioners be considered and acted on in equal measure.

HWL wishes to thank everyone involved in the visit and particularly the respondents, DART Management, staff and HWL authorised representatives. It is acknowledged that if, at any time any patient, family member or carer wishes to talk to HWL relating to compliments, concerns or complaints they can do so in confidence.

Following the report being finalised:

- HWL will submit the report to the Provider.
- HWL will submit the report to CQC.
- HWL will submit the report to LCC or NHS England
- HWL will publish the report on its website and submit to Healthwatch England in the public interest.

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