Lincolnshire Partnership
NHS Foundation Trust

Our ref: SC/DC/HMC/2020

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15 October 2020

Dear Mr Smith

In the matter of Toby Nieland deceased - REGULATION 28 REPORT TO PREVENT FUTURE DEATHS - Response of Lincolnshire Partnership NHS Foundation Trust

The Trust wishes to express, once again its sincere condolences to Mr Toby Nieland's family and loved ones on his untimely death. Owing to the seriousness of the concerns raised by both HM Senior Coroner and the deceased's family at the inquest hearing, the Trust immediately began communicating with its commissioning and provider partners to highlight the matters raised. The Trust is grateful to HM Senior Coroner, Mr Timothy Brennand, for his report of 26 August 2020.

The Clinical Commissioning Group, as the commissioning body, is submitting a coordinated response; this letter will be included as an appendix.

Following consultation with the Trust's Executive Directors, I respond to each of the points raised in Mr Brennand's report as stated below. I have further summarised our actions at the end of this response, with the responsible leads for each action.

1. **The concerns of the immediate family were not communicated to any of the agencies charged with the responsibility of caring for the deceased, nor were their views sought (directly or indirectly) as to the suitability of the deceased's accommodation and/or circumstances and/or pathway of treatment and care.**

   Trust Response:

   The Trust appreciates the importance and benefits of understanding the views of patients' families and carers. It is also recognised that concerted efforts need to be made to support staff to consider the voice of carers. To address this, the Board of Directors and Council of Governors have given a clear message of expectation that carers are seen as a priority and that their needs are considered. The Trust has put in place a range of services that support carers and provide helpful information on a routine basis:-

   - Upon inpatient admission, the Trust provides information to a patient's family and/or carer. The information document is also publically available to view and download from the Trust's website https://www.lpft.nhs.uk/download_file/1876/0

- The Trust offers a dedicated email address for family and carers to communicate with the patient's clinical team. lpft.carers@nhs.net

- A carers' newsletter is produced and circulated on a monthly basis.

- At the time of writing, 93 trust staff are trained in Meriden Behavioural Family therapy and a further 50 staff members are scheduled to receive this specialist training by the end of January 2021. This is a dynamic training programme that educates staff regarding the importance of involving families and carers; it also teaches ways in which family and carers members can be supported.

- The Trust has introduced a dedicated member of staff as a 'Carer Lead' for each of its inpatient units across Lincolnshire. The Carer Lead is available on the ward to patients, families and carers and is identified through the wearing of an orange lanyard.

- The Trust offers specialist individual support to carers and families in times of crisis. The referral for this level of support is received via the patient's clinical team.

- The Trust offers fortnightly education and support groups based in both Lincoln and Boston. During the Covid-19 pandemic, the groups continue to operate temporarily via virtual meetings.

- Dedicated 'Family and Carers' notice boards have been introduced on every inpatient ward offering a wide range of information.

- A smartphone 'WhatsApp' group has been set up to provide another source of information sharing and communication.

- Accreditation under the Triangle of Care initiative, with the Trust having been awarded two stars under this national scheme.

- A Carers Strategy that has been co-produced with carers and with Trust Governors.

- An Executive Director sponsor who has executive oversight and is a member of the Board of Directors.

In cases where explicit consent has not been given by a patient to share their sensitive personal information; the Trust has taken action to remind clinicians that information from families and carers can still be *received*. The Carers Lead for the Trust continues to work with the Divisional Leads; Learning and Development and also the Communications Team to reinforce the message to staff that they can still *receive* information from Carers and Families even when consent is not given from the patient to share information. In Mr Nieland's case it was unfortunate the Trust were not made aware of any concerns held by the family, however there is the clear commitment to learn from this and to consider what needs to be in place to strengthen communication and to actively encourage feedback.

As a provider of specialist mental healthcare, the Trust recognises the role of appropriate accommodation in a patient's recovery, although was not aware of the details of Mr Nieland's accommodation to which he was discharged in 2018.

The Trust recognises the need for appropriate communication between partner agencies to provide collaborative health and social care and support to patients and is committed to continuously reinforce this message to all staff. The Trust now works closely with a number of partners from the Voluntary, Community and Social Enterprise sector in Lincolnshire including Carers First and Everyone, and has developed good working relationships, which have led to identified placement options for patients being discharged from hospital.

The Trust is working with Local Authority, District Councils, Commissioners and NHS England/Improvement on a joint accommodation strategy for those with mental health and social care needs, to ensure the system is working together on more responsive and effective housing solutions for our service users.

2. **Unequivocal evidence established that the deceased suffered from an advanced progressive addiction overlaid with a vulnerable personality amounting to a complex Dual Diagnosis – the significance of which was not appreciated and therefore not managed adequately or appropriately.**

Trust Response:

The term dual diagnosis can be used to cover a broad range of coexisting mental health conditions alongside problems with drug or alcohol use, the common theme being the presence of both drug/alcohol and mental health conditions at the same time. This means that a person's presenting needs can vary significantly. There are recognised challenges in providing effective treatment for this group of patients; most notably, the individuals' willingness and ability to engage.

Due to Mr Nieland's fluctuating mental health needs and the fact that he was deemed to have capacity to make his own life choices, there were times when he was not engaged with mental health services and the Trust was not legally able to enforce any treatment upon him. When Mr Nieland was engaged with the Trust's services, there is evidence that his drug and alcohol issues were being appropriately considered and advice was being given. However, successful treatment for drug and alcohol addiction requires continued engagement, and in Mr Nieland's case unfortunately the Trust was limited in its powers to enforce any treatment.

3. **In any event, even on the basis upon which community care was deemed appropriate, there was an absence of any co-ordination between mental health service provision and addiction services.**

Trust response:

There is evidence from the clinical record that Trust staff believed Mr Nieland was effectively engaging with Addaction (as it was known then) and that he was happy with the support he was receiving. Based upon information available at the time there was

no known need for the Trust to pursue any additional support for his drug and alcohol problems.

Upon reflection, subject to explicit consent, the Trust accepts that it would have been best practice for the Trust to have proactively contacted Addaction to ascertain Mr Nieland's level of engagement as it is evident from the subsequent information provided by Addaction that Mr Nieland was not engaged in the level of structured treatment that the Trust staff believed he was. More proactive contact with Addaction would have identified this mismatch between what Mr Nieland was reporting and his actual level of engagement. In turn, this would have enabled Trust staff to challenge Mr Nieland's claims about his drug and alcohol treatment and provide an opportunity for further encouragement to seek out appropriate support, although it would not have been able to enforce or change any such treatment without Mr Nieland's engagement.

The Trust has in place a policy which provides guidance in cases where patients present with high severity of mental health and substance misuse…

"…*Service users should be engaged with secondary mental health services. This would include Integrated Community Teams, forensic, rehabilitation and acute services. Case management/care coordination would rest with these services with additional support from substance misuse services. This support can include consultation, advice or direct intervention to the service user and their care network*".

The Trust and 'We Are With You' (as Addaction is now called) will work together to ensure the implementation of robust communication systems; agree appropriate information sharing arrangements and ensure alignment of clinical pathways and protocols, with the aim to make collaborative working between the two organisations standard practice. The Trust confirms this is part of its work plan over the next six months, led by the Clinical Director for the Community Services Division working with the Quality lead for the Division.

4. There was an absence of any adequate "Care Programme Approach" (a package of care used to plan mental health care) resulting in no care coordinator being appointed to monitor the deceased within the auspices of an appropriate care plan.

Trust Response:

The Trust has in place a comprehensive clinical care policy which sets out the criteria and process for assessing and putting in place care arrangements. In Mr Nieland's case, following his discharge from inpatient services, in accordance with Trust policy and national guidance, the Trust made arrangements with Mr Nieland to meet with him to assess his needs. It is possible that Mr Nieland could have been placed on a Care Programme Approach, however he did not attend and sadly the opportunity to assess his needs in this regard did not take place. Whilst he was not managed on the Care Programme Approach framework, a lead professional was assigned to Mr Nieland and risk assessment was formulated together with a care plan.

Learning from the death of Mr Nieland, the Trust will strengthen the policy in accordance with the guidance issued by the Department of Health, to ensure where patients identify as having a dual diagnosis, they are provided with an enhanced Care

Programme Approach. Clear guidance will be given to staff regarding procedure in the case of persons with dual diagnosis. The Head of Quality and Safety will lead on the review and strengthening of the policy, working towards the policy update being approved by the Trust's Quality Committee, within the next 6 months.

5. **Inadequate evaluation of the deceased's previous history; his purported non-concordance (repeated assertions of not wanting treatment/support that ought to have been interpreted as an increase in his risk); progression of his complex vulnerabilities; his personal circumstances (reaction to accommodation and relationships); events suggestive of on-going misuse of drugs - all gave rise to missed opportunities to appreciate a series of ascertainable relapse signatures.**

   Trust response:

   Learning from the tragic death of Mr Nieland, the Trust has taken steps to enhance the training offered to staff about assessing risk of suicide to reinforce the complex interplay of factors mentioned above including previous history, accommodation and employment needs, substance and alcohol misuse patterns and relationships. This revised suicide prevention training will be rolled out to all staff commensurate with their role and clinical responsibility, within the next 6-12 months.

   The Divisional leads are working closely with the Learning and Development Lead to develop a time table and identify appropriate staff for training.

6. **The absence of any "assertive outreach" to the deceased when discharged into the community (that is to say, no face to contact, no alternative welfare checks being organised, undue reliance being placed on the informal supervisory role of the landlord or other agencies) gave rise to a total disconnect between patient and healthcare provider, thereby creating a series of missed opportunities to assess the deceased, identify possible relapse signatures and potentially escalate care.**

   Trust response:

   The Trust was informed by the out of area inpatient unit that Mr Nieland had been discharged into the community. In accordance with Trust policy and national guidance, the Trust's Crisis Resolution and Home Treatment Team offered timely follow-up appointments with Mr Nieland to assess his risk and care arrangements. Based upon the information available at the time, a clinical decision to request a police welfare check was not considered necessary. The Trust appreciate the importance the views of family and carers has in formulating appropriate care arrangements for patients. With the benefit of hindsight, it is accepted that the knowledge and concerns of Mr Nieland's family would have better informed assessment of risk. The Trust is continuing to support staff and to emphasise the importance of working and supporting patients to include family and carers in their care. The response under section 1 of this letter outlines the initiatives behind this.

7. **The circumstances of this case evidences a gap in the provision of care to a patient with a Dual Diagnosis in Lincolnshire by reason of there being no dedicated and/or commissioned drug and alcohol recovery team/service.**

Trust response:

The Trust recognises there is currently a commissioning gap in the provision of care to patients identified as having a dual diagnosis. Currently mental health services and substance misuse services are commissioned separately in Lincolnshire with the services provided by two organisations. The Trust is a provider of specialist mental health services and is not commissioned to provide substance misuse services. The local Clinical Commissioning Groups (CCG) and the Local Authority's Public Health department commission 'We Are With You' (formerly 'Addaction') to provide substance misuse services.

Learning from the death of Mr Nieland, as stated above, the Trust commits to the strengthening of its policy in accordance with the guidance issued by the Department of Health, to ensure where patients identify as having a dual diagnosis, they are provided with an enhanced Care Programme Approach which will include working together with 'We Are with You'. Clear guidance will be given to staff regarding policy and procedures in the case of persons with dual diagnosis. Further, the Trust commits to working with its partner agency 'We Are With You', to review and strengthen working arrangements.

Further, as stated above, the Trust and 'We Are With You' commit to working together to ensure the implementation of robust communication systems; agree appropriate information sharing arrangements and ensure alignment of clinical pathways, with the aim to make collaborative working between the two organisations, standard and practice. The Trust confirms this will be part of its work plan within the next six months, led by the Clinical Director for the Community Services Division working with the Quality lead for the Division

8. **The Lincolnshire Partnership NHS Trust document – "Crisis Assessment and Home Team Protocol" (Exhibit reference IJ2) makes no adequate or appropriate provision for a patient with Dual Diagnosis.**

Trust response

The Trust confirms, as stated above, that it will review its clinical policies and protocols relating to dual diagnosis and that it will continue to work with its partner agency, 'We Are With You' to review and strengthen robust communication systems; to agree appropriate information sharing arrangements and ensure alignment of clinical pathways through the use of a jointly agreed protocol. The aim is to make collaborative, integrated working between the two organisations standard practice. This will be part of its work plan within the next six months, led by the Clinical Director for the Community Services Division working with the Quality lead for the Division. The policies and protocols will equally apply to patients being treated within its inpatients and crisis and home treatment services too.

9. **The National Institute for Health and Care Excellence (NICE) Guideline Scope document "Severe mental illness and substance misuse (dual diagnosis): community health and social care services stipulates that there should be a Dual Diagnosis protocol setting out specifically the roles of the mental health provider and the drug and alcohol service provider (no such protocol being in place at the material time) and that whilst it is apparent that some thought has been deployed to re-install a bridge between mental health provision and drug and alcohol services this does not address the needs of a patient suffering from a complex Dual Diagnosis in Lincolnshire due to;**

   a. **The lack of interface between senior or experienced care providers to deal with multi-faceted or nuanced cases.**

   b. **The absence of specialist Dual Diagnosis workers to be deployed in complex cases.**

   c. **The absence of adequate and robust guidance and training, in particular for mental health practitioners to be aware of substance misuse issues and a patient suffering from Dual Diagnosis that impact on appropriate pathways of treatment and care.**

   Trust response:

   Learning from the death of Mr Nieland, as stated above, the Trust is committed to the strengthening of its policies and protocols in accordance with the guidance issued by NICE and the Department of Health, to ensure where patients identify as having a dual diagnosis, they are provided with an enhanced Care Programme Approach which will have joint working with We Are with You', utilising expertise of workers from both services in a collaborative manner. The Trust has already begun conversations with its Commissioning partners and We Are With You, to identify commissioning gaps and ways of ensuring workers with the right skills are deployed in both agencies.

   The Trust is committed to a review of the training provided to staff to ensure they are appropriately equipped with the knowledge and ability to care for patients with dual diagnosis. The Learning and Development Lead is working with Divisional staff to develop the appropriate training package, over the next 6-12 months.

We have summarised below the actions the Trust will take to learn from Mr Nieland's death and enhance services for patients with a complex dual diagnosis presentation: To review internal policies and protocols as well as work together with "We Are With You" to embed care pathways between the two organisations to address gaps in services. (Leads: Clinical Director for Community Division and Quality Lead for the Community Division)

i. To embed care pathways between the Trust and "We Are With You" to address gaps in services. This will also be accompanied by a discussion with the Commissioners to advocate for the right level of investment in the system to meet the needs of people with a dual diagnosis. Leads: Quality Lead for the Community Division and Clinical Director for Community Division – by 31 April 2021.

ii. To review Information sharing arrangements between the Trust and “We Are With You” to remove barriers to information sharing while complying with legal guidance Lead: Trust Caldicott Guardian – by 16 November 2020.

iii. Education and Training: The Trust commits to reviewing and updating its training and competencies programme on offer to ensure a focus on dual diagnosis, including clinical presentations, risk assessment and information sharing. We have recently developed a refreshed suicide prevention training matrix which addresses risk assessment but will work on the other areas. Leads: Learning and Development lead, People Directorate – by 31 October 2021

iv. To reinforce and further embed the important role of carers and family members in providing the right quality care to patients and to support carers in getting involved with their loved ones’ care, including receiving information from carers and sharing information with consent from patients. Lead: Service Manager for Carers and Peer Support – Ongoing

v. To review the Care Programme Approach to ensure the right decisions are made about allocating care coordinators to patients and also to ensure that all patients with a dual diagnosis are allocated a care coordinator. Lead: The Trust Quality and Safety Lead – by 31 April 2021.

vi. To continue to engage with Commissioners and all system partners including primary care, acute care services, and housing partners (not named in the letter but we recognise the importance of all partners in the system) to ensure the services required for patient with dual diagnosis are appropriately funded – clinical, management and leadership and administrative support. Lead: Director of Strategy, Planning and Partnerships - on-going

vii. Promote appropriate data gathering, benchmarking with other services, opportunities for research and learning from Serious Incidents as a system working in an open, collaborative manner. Lead: Medical Director - on-going

Yours sincerely

Acting Chief Executive