Rotherham Doncaster
and South Humber
NHS Foundation Trust

PRIVATE AND CONFIDENTIAL

Chief Executive's Office
Woodfield House
Tickhill Road Site, Tickhill Road, Balby
Doncaster, DN4 8QN
Email: [redacted]

31st October 2024

Ms N J Mundy
Senior Coroner
South Yorkshire (East District)
Coroner's Court and Office
Crown Court, College Road
Doncaster, DN1 3HS

Dear Ma'am,

Re: Regulation 28 Report in relation to the inquest touching upon the death of Carol Ann Guest (D.O.B: 10.11.1948)

Thank you for the issue of your regulation 28 report regarding Carol. As you, and Carol's family would rightly expect, this has been treated with great seriousness and priority inside the Trust. The Board, in public, acknowledged receipt, and myself, [redacted], and our Chief Nurse, [redacted] have led the organisational response relayed here. The Board Quality Committee, now chaired by an experienced GP, will hold us to account to take the actions that I outline.

I should be direct that we do not believe that crisis provision was a relevant factor in what happened to Carol. It is apparent from the attached case summary from [redacted] that there were missed opportunities to refer her to the established older peoples' community team. Having received a referral on March 15th, an appointment was expedited to take place on March 26th. Carol was unaware of both the referral (not issued to her, and the appointment, owing to her death). It is deeply regrettable that relatives who cared for Carol may have been left, in evidence before you, with the impression that crisis services were a primary cause of harm. We will be seeking to meet with family members to hear from them and to share our conclusions with them.

However, accepting the preventive intent of your order to explore crisis service provision, and the possibility of communication weaknesses inside the Trust, and with GP partners, we agree that there is room for improvement. That is the focus of the balance of this response.

What we will be changing?

We have found that our arrangements for accepting crisis referrals for older people are inconsistent within RDaSH, and do not benefit from agreed written protocols. This will change with issue of a new operating protocol to those working clinically on November 7th 2024 – effective immediately.

Local service specifications from commissioning bodies do appear to create age-based parameters for who can access which services. The Trust committed earlier in 2024/25 to remove such externally directed barriers to our services, both for children and young people, and older adults. We are working to a programme to do this by spring 2025, as the changes involved require us to provide additional training to staff.in different presentations and techniques. To be clear, services will still have specialists focusing on particular conditions, but the distinctions between teams will not be driven by age-parameters.

For crisis services, it is apparent that 'out of hours' our teams would routinely see those in greatest need regardless of age. However, during standard daytime hours, calls may be diverted to older people's mental health teams. There then appears to be a further deflection back to general practitioners. **Our guidance protocol will make clear to teams that crisis presentations should be assessed by the team regardless of age or time of day**. This would bring services in Doncaster and Rotherham into line with practice already in our North Lincolnshire services.

We will set out our revised arrangements in writing for those providing the services, but also for local GPs. We will also ensure that, during November, relevant primary care leadership meetings are advised of the changes. That is because we suspect that, over a period of years, pathway changes have been made, and practices have varied knowledge of them. The arrangements will also be clarified in our triage-SPA and to NHS111. This work will be complete before the end of November. In putting this change into place, we will also clarify for local practices, the best routes through which themselves to seek advice, and how to make referrals including urgent referrals. Importantly this will be shared with our communities, carers and patients through all our communication channels.

There is some evidence that dedicated older peoples' crisis services have merit. Whilst we will keep the introduction of such services under review, we have not found a compelling case to create such services and, to do so, would require significant investment from the Integrated Care Board locally. We consider it unlikely that this will occur over the next two years, and as such it is important our existing teams are better able to respond to needs among all adults.

We ourselves are working to invest in training and skills development for teams, with a programme being developed for 2025 to this end, so that we have confidence that differences of presentation and treatment options, are better understood for older adults among those whose recent experience is focused on younger adults. This training support would be a combination of mandated time, and voluntary extended learning. During 2024 the Trust invested in dedicated Learning Half Days, compulsory for all staff, through which to better disseminate knowledge, and to reflect on quality improvements.

Through 2025/26, the Trust is introducing DIALOG/DIALOG+ into our services and replacing the Care Programme Approach (CPA). The intention of this change, adopted by some other mental health providers nationally, is to better support patients and their carers, with plans of care that are outcome focused. **Introducing DIALOG should help us too to have a more accessible**

shared language across the primary/secondary care interface. The change again will break down assumed barriers between teams, pathways, and age-cutoffs. Training began in September 2024 and continues through to April 2026: the teams involved in Carol's referral will be part of this rollout during 2025.

How we will test whether this has been effective?

We understand that simply issuing guidance alone is not sufficient. It will be important to measure the changes outlined, and to test whether they are embedded and understood. To that end, we will make sure that:

- Induction arrangements for our local crisis teams, and wider community mental health teams, take account of what is described in this letter. This month the Trust introduced **new induction arrangements across the organisation**, with a dedicated day for in-team local induction complimented by a much more in-depth institutional induction, taking place in our communities.

- We continue to audit waiting times for care. In September 2023 the Trust adopted a strategy that seeks **from April 2026, to meet an urgent wait time of 48 hours for response, and four weeks for routine care**. During 2024 we believe we have effectively created systems to monitor these commitments, and to begin to move towards them in all our services.

- We are rolling out presently new arrangements to support patient-led booking, and cancellation, of appointments. From spring 2025, we routinely offer **digitally enabled arrangements to support patients to do this** – a change that of course also makes it easier for family members to have delegated access to information about pathways of care. This will also allow us to apply some standards to the pace of triaging referrals and issuing information about appointments. Even where a wait time exceeds our targeted standards, we would want patients to know at any given time what is happening to their referral and to know how to seek help about that.

- The Trust's Equity and Inclusion Group, which I chair, is already auditing the work to replace age-specific policies in our pathways. We will work with clinical audit to consider how best, in **our 2025/26 programme** of audit, evaluation of access for crisis presentations in older adults. This should help us to have a better picture of patterns of demand, through which to further refine services.

- The learning half days, cited above, are mandatory for employees, and from January 2025 attendance will be monitored. It is recognised that some services, such as wards and crisis teams, will struggle to attend – and specific rotational arrangements including paid extra hours – have been put in place mindful of that. I have made arrangements to have **a specific analysis done of attendance** in the Rotherham CMHTs and crisis teams for the coming quarter, such that I can confident colleagues working in those teams have taken up access to the support outlined in this letter.

I should be grateful - should you have chance – if you might indicate whether this response is sufficient and what, if any, future reporting you might require from us. We believe we will be able to evidence material change, over coming months, and would be more than willing to provide an additional report to you – based on the actions above best timed for a year from now – to demonstrate the impact of the changes we have described.

Your sincerely

[redacted]

[redacted]
Chief Executive

For action:
[redacted], Acting Medical Director and consultant psychiatrist (SRO)

[redacted], Chair of quality and safety committee and Chief Nurse

[redacted], Care Group Director
(Doncaster adult mental health and learning disabilities care group)

[redacted], Care Group Director,
(Rotherham adult mental health care group

[redacted], Care Group Director
(North Lincolnshire adult mental health/talking therapies care groups)

For information:
[redacted], non-executive chair of quality committee

Annex A: Trust case clinical summary

1. In considering our response and learning I have briefly summarised the case below.

2. Ms Guest had been diagnosed with mixed anxiety and depression whilst under primary care. The first recorded diagnosis of this was in 2007. She was treated with a several antidepressant medications including citalopram, lofepramine, mirtazapine and fluoxetine which were initiated and monitored by her GP. Her primary care records indicate that she took the medication reliably and had a good response to it.

3. In 2012 she was referred by her GP to Rotherham Talking Therapies for Cognitive Behavioural therapy due to her reporting anxiety and depressive symptoms. On completion of the therapy, she self-rated that her symptoms had significantly improved.

4. From 2014 until early 2024 she was not treated with any medication for her mental health except for brief periods with low dose diazepam.

5. On 8 January 2024 she saw [redacted], Primary Care Mental Health Practitioner, saying she had been struggling with low mood and having broken sleep 6 weeks. It was noted during this appointment that she had no suicidal ideation. Antidepressants and therapy were discussed with Ms Guest requesting time to think through her options. She was given information about how to refer herself to Rotherham Talking Therapies.

6. She attended her GP surgery along with her partner on 1 February 2024 and saw a student at the practice. She was complaining of low mood and anxiety. She also reported a loss of confidence that had been present for some six to eight weeks. She reported sleep problems for 6 weeks, loss of weight despite a normal intake and a loss of energy. She described being anxious about leaving the house. It was identified that she had a number of stressors such as her mother having recently being put in a care home. Ms Guest had previously been a carer for her mother so this led to a big change in routine and loss of role. She had also recently been told that she had macular degeneration after an eye test. Following this appointment she was referred to a Primary Care Mental Health Practitioner.

7. On 2 February 2024 she had a telephone call with a GP, [redacted], where the weight loss was discussed and it was organised for her to have some investigations for this to rule out a physical cause of the weight loss. During this appointment she also expressed concern about the diagnosis of dry age-related macular degeneration for which there is no specific treatment and can lead to sight loss.

8. On 9 February 2024 during a telephone appointment with [redacted], Ms Guest was informed that she had an elevated tumour marker CA19-9 (Carbohydrate antigen 19-9). This can be raised primarily in pancreatic cancer but also other cancers and conditions. A follow-up CT scan of her chest, abdomen and pelvis was requested.

9. This scan was performed on 14 February 2024 and did not show any evidence of malignancy.

10. She saw a Primary Care Mental Health Practitioner, [redacted], on 14 February 2024 and during this appointment she denied suicidal ideation but reported ongoing depressive and anxiety symptoms leading to a request for a GP to prescribe antidepressant being made.

11. Citalopram was started by [redacted] on 15 February 2024 following the request from [redacted].

12. On 20 February there was a telephone call to the Rotherham Crisis Team from [redacted], her daughter-in-law. During the call, it was expressed that Ms Guest was feeling low and guilty. The outcome of the call was for [redacted] to make contact with her GP or Talking Therapies for a referral to the older people's community mental health team to be made.

13. On 23 February 2024 she was seen by [redacted] with [redacted], her daughter-in-law. It was reported that she was not taking the citalopram regularly and that she hadn't noticed any benefit from taking it. The medication was switched from citalopram to mirtazapine and low dose diazepam was prescribed for her to take on as required basis. During this appointment Miss Guest described some symptoms indicating possible delusional beliefs such as someone from British Gas had cancelled "everything" including her pension, and

NHS accounts. Follow up was arranged for 3 weeks time.

14. Citalopram is an SSRI (Selective serotonin reuptake inhibitors) medication and benefits are usually apparent only two to four weeks after commencing treatment. It would be unusual to expect benefits of starting antidepressant medication after only one week. SSRIs can however lead to an initial worsening of anxiety and agitation and so the decision to change to a more sedating antidepressant such as mirtazapine could have been beneficial.

15. NICE recommends that when antidepressants are started that follow up should occur within 2 weeks of starting the medication. NICE also recommends that patients presenting with psychotic depression should be referred to a specialist mental health team.

16. On 8 March 2024 there was a telephone call with [redacted] and [redacted] and concerns were raised that Ms Guest was not taking her medication and that her delusions were getting worse. It was noted in this appointment that an urgent referral to the older people's community mental health team was to be made. This referral was eventually sent on 15 March 2024.

17. The referral was sent as an electronic task to the Single Point of Access. The usual route of urgent referrals would be to contact the Older people's community mental health team duty worker or to speak to the Crisis Team via telephone. Given how this referral was sent it would have been impossible to have responded within a week given that the referral was only sent some 7 days after it was decided to make an urgent referral. In addition, the urgency of the referral is not immediately identified on the document.

18. The referral was triaged on 20 March 2024 (in five days) and it was arranged for an appointment to be made with a psychiatrist. This appointment was to be booked for 26 March 2024. The appointment was not sent out due to the team becoming aware of Ms Guest's tragic passing.

[redacted], Acting Medical Director
27th October 2024