Department of Health & Social Care

[redacted]
Minister of State for Care

39 Victoria Street
London
SW1H 0EU

Our ref: [redacted]

HM Coroner Alison Mutch
1 Mount Tabor Street
Stockport
SK1 3AG

By email: [redacted]

13 January 2025

Dear Ms Mutch

Thank you for the Regulation 28 report of 15th October sent to the Department of Health and Social Care about the death of Mr Stephen Charles Stringer. I am replying as the Minister of State for Care, responsible for primary care and general practice.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Stringer's death and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

The department and practices must be cognizant to the recent changes made to modernise telephone systems, include call routing, and understand that these may not be as clear as they need to be for all patients. This is unacceptable and it must be very clear to all patients what steps are required to access care when they contact their practice.

Call routing enables patients to choose options via their keypad or voice options to enable direct routing to the right person or team. When properly configured, these systems can divert some demand away from phones at busy times, making it easier to get through to someone to book an appointment. However, it is crucial that all triage and appointment systems ensure patients are correctly routed - and if mistakes occur, that these are promptly rectified to connect patients with the right team or person. We want to make sure that patients are able to easily access primary care, and this is not a complex system, we need to do better, so patients can receive the care they deserve. It is deeply upsetting that Mr Stringer was not able to easily access his general practice and his health tragically suffered due to this.

General practices are independent businesses who are contracted by NHS commissioners to perform medical services, and it is the responsibility of the individual practice (provider) to have reliable systems in place to manage interactions with patients. It is essential that clinical issues mistakenly categorized as administrative are identified and appropriately

managed by care navigators. If a practice is unable to effectively monitor its systems to identify and address clinical concerns, a system should be in place to manage this.

We recognise that practices require adequate support to be able to manage these systems. NHS England produced guidance on thishttps://www.england.nhs.uk/long-read/how-to-improve-care-navigation-in-general-practice/ in May 2024. The guidance provides key rules to help guide practices on their role in care navigation. Firstly, clinical requests not allocated by a care navigator (directly over the phone) need to come into a single flow for assessment and all administrative requests must have a clear distribution route within practice and agreed turnaround times. Practices are responsible for tailoring the exact operations and timeframes of this to their own requirements and patient cohorts.

Additionally, the Digital Clinical Strategy published in 2021 outlines NHS England's responsibility and commitment to improve the safety of digital technologies in health and care now and in the future, as well as identifying and promoting the use of digital technologies as solutions to patient safety challenges. The Clinical Safety Standards DCB0129 and DCB 0160 provide the legal framework and best practice to help organisations manage and mitigate risks associated with development and use. NHS England are responsible for ensuring that the Clinical Safety Standards continue to influence safety, and a comprehensive review of both standards is underway and due to complete in 2025 which will involve wide stakeholder engagement.

Patients that are able to see the same practitioner benefit from better health outcomes. We expect that practitioners who have had prior contact with a patient, would recognise the importance of continuity of care and proactively offer this option whenever possible.

It is unacceptable that patients that present with red flag symptoms are consistently missed and misdiagnosed. NICE's NG12 guidance: Overview | Suspected cancer: recognition and referral | Guidance | NICE provides guidance to practitioners on urgent suspected cancer referrals, which clearly identifies 'persistent unexplained hoarseness' as requiring urgent referral. We would expect healthcare professionals to be aware of this guidance, which is of long standing.

A number of national charities highlight a hoarse voice as a potential sign of cancer on their websites (laryngeal or lung cancer being the most common types with this symptom) and there have been a number of local campaigns on this as well. More recently, NHSE has partnered with ASDA to put warnings on mouthcare products such as toothpaste and mouthwash to highlight the possible early signs on head and neck cancer, including hoarseness. https://www.england.nhs.uk/2024/07/nhs-partners-with-asda-to-put-crucial-mouth-cancer-symptoms-on-toothpaste-and-mouthwash/

We understand that NHS General Practices need to be responsive to the needs of their patients. Following contact made by a patient the practice must manage the presenting complaint in a safe and timely way in line with the Health and Social Care Act 2008 Regulations 2014: Regulation 12 Safe care and treatment. The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or

risk of harm. CQC would also expect those working within a service to have the knowledge and skills to use the systems in place, and for there to be sufficient numbers of staff with the right skills employed to meet the needs of those using the service. This is also in accordance with Regulation 12 and Regulation 18: Staffing. Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 requires providers to provide patients with information about their care and treatment options. CQC would expect this to include information on how to access care and treatment. Regulation 17 Good governance requires the provider to ensure they have systems and processes in place to ensure compliance with other requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, including those referenced here.

Additional information was received alongside the coroner's report that has been shared with the Derbyshire ICB. The NHS England Safety Team have been in contact with Derby and Derbyshire Integrated Care Board to understand the clinical safety assurance processes in place and have offered to support future safety training within the ICB and GP community if required.

Yours sincerely,