Department of Health & Social Care

[redacted]
Parliamentary Under-Secretary of State for Public Health and Prevention

39 Victoria Street
London
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Our ref: [redacted]

HM Coroner Samantha Goward
County Hall,
Martineau Lane
Norwich
NR1 2DH

By email: [redacted]

24 March 2025

Dear Ms Goward,

Thank you for the Regulation 28 report of 29th January 2025 sent to the Department of Health and Social Care about the death of Carla Smith. I am replying as the Minister with responsibility for Public Health and Prevention.

Firstly, I would like to say how saddened I was to read of the circumstances of Carla Smith's death, and I offer my sincere condolences to their 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 report raises concerns across two key areas over the care provided by the Trust and its processes:

1) Firstly, significantly long waiting lists for gynaecological referrals, even for those on an urgent pathway. Consultants are left unable to catch up with the backlog and patients may significantly deteriorate while waiting, meaning they can miss out on treatment options.
2) Secondly, that there is no requirement or system in place to monitor the progress of those on a routine or urgent waiting list in the same way there is for those referred until a 28 day wait for suspected cancer. This leaves patients left waiting for excessive periods without requirement for their case to be reviewed.

In preparing this response, my officials have made enquiries with NHS England to ensure we adequately address your concerns.

The Department has acknowledged the coroner's findings regarding the tragic death of Ms Smith from endometrial cancer due to significant delays in her diagnosis and treatment. Recognising the serious risks associated with long waiting times, it has reaffirmed its

commitment to reducing patient wait times and improving access to timely care. A key focus is restoring the 18-week Referral to Treatment standard, ensuring that 92% of patients receive treatment within this timeframe. Addressing the backlog and delays in gynaecology, which have faced increasing demand and performance challenges, is an important part of the overall return to constitutional standards.

To improve access to care, NHS England is supporting the expansion of community-based services, including piloting gynaecology pathways in Community Diagnostic Centres. These efforts aim to bring diagnostic and specialist care closer to patients, reducing pressure on hospitals and speeding up the referral process. Additionally, measures are being implemented to strengthen safeguards between primary and secondary care, including the use of specialist advice and triage services. Pre-referral and post-referral advice mechanisms will provide a safety net for patients awaiting appointments, enabling better communication between GPs and specialists to ensure timely assessments.

The Department is also addressing delays in diagnostic test results, a key factor in this case. The turnaround time for the patient's biopsy results was excessively long, contributing to the cancer's progression from stage 1 to stage 4 before diagnosis. Improving diagnostic reporting times is a priority. The expected turnaround time for histopathology slides is 80% within 7 days and 90% within 10 days. For imaging tests, NHS England published guidance in August 2023 that set out expectations on turnaround times, and an expectation that no test should take longer than 28 days to report. Investments in digital diagnostic transformation, including automated test requesting and result-sharing systems, will help ensure faster and more efficient processing of test results. Enhancements to the NHS App will also allow patients to receive their results more quickly.

Reforms to cancer waiting time standards are being introduced to improve early detection and streamline the diagnostic process. The outdated two-week wait standard is being replaced with a focus on the Faster Diagnosis Standard, ensuring that 75% of patients receive a diagnosis within 28 days. Additional measures include a 62-day standard from referral to treatment and a 31-day standard from decision to treatment. These changes aim to enhance efficiency and provide a clearer framework for monitoring and improving cancer pathways.

The case also highlighted systemic issues in how urgent referrals are processed. While the second GP appropriately referred the patient for further investigation as an urgent referral, the referral was triaged as urgent rather than on the urgent suspected cancer pathway, leading to a four-month delay before further testing. The absence of clear criteria for upgrading cases like this to an urgent suspected cancer pathway contributed to the delay. The original GP should have initiated the referral earlier, specifically on 23 August, rather than waiting until a different GP reviewed the scan on 27 September and made the urgent referral. It is crucial for GPs to adhere to referral guidelines, ensuring timely urgent and USC referrals for postmenopausal bleeding. Further, delays in histopathology reporting meant the biopsy results took several months, significantly impacting the patient's prognosis. The Department recognises the need for improved triage and monitoring of patients on waiting lists to prevent similar outcomes.

To address these challenges, NHS England is expanding elective care reform initiatives, increasing the capacity of Clinical Diagnostic Units to perform more tests such as

hysteroscopies. Digital innovations are also being introduced to improve patient experiences while waiting for care. These steps aim to reduce overall wait times, improve diagnostic turnaround, and ensure that patients with potential cancer symptoms receive urgent attention.

By investing in workforce expansion, digital transformation, and streamlined referral pathways, the Department aims to prevent future delays in cancer diagnosis and treatment. Efforts to improve coordination between primary and secondary care, enhance diagnostic reporting efficiency, and prioritise faster treatment access will be critical in addressing the issues raised by the coroner's report and ensuring better outcomes for patients in the future.

Once again, I would like to extend my deepest sympathies to Ms Smith's family and friends on this tragic case. hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,