

Making rapid diagnostic centres work for people with blood cancer



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Foreword

Diagnosing blood cancer is not easy at the best of times, but the Covid-19 pandemic has presented a challenge like no other. Even before the pandemic, the process of receiving a blood cancer diagnosis was, for far too many people, fraught with delays - with devastating consequences.

For this reason we have been cautiously optimistic about the development of new Rapid Diagnostic Centres (RDCs) for people with non-specific symptoms. For people with undiagnosed blood cancers, which often present with vague symptoms, the prospect of a streamlined pathway to diagnosis could be transformational.

With significantly fewer referrals for suspected cancer during the peak of the pandemic and waiting times for an urgent appointment falling below the standard, it is crucial that the NHS is able to address the cancer backlog. This means that services such as RDCs must be equipped with the tools and resources they need to support the recovery and ensure that no one with blood cancer has to experience an unnecessary delay to receiving a diagnosis.

The NHS has committed to return cancer services back to pre-pandemic levels. But for blood cancer, we know that just going back to how things were isn't good enough. RDCs need to be properly resourced and designed in order to help address the longstanding challenges in diagnosing blood cancers earlier and faster. Now is also the time to test self-referral to RDCs as we seek to ensure people with suspected cancer are seen as soon as possible.

We hope that this report will help Cancer Alliances, hospital trusts and national policymakers to deliver on this vision for RDCs. This is the time to be ambitious.



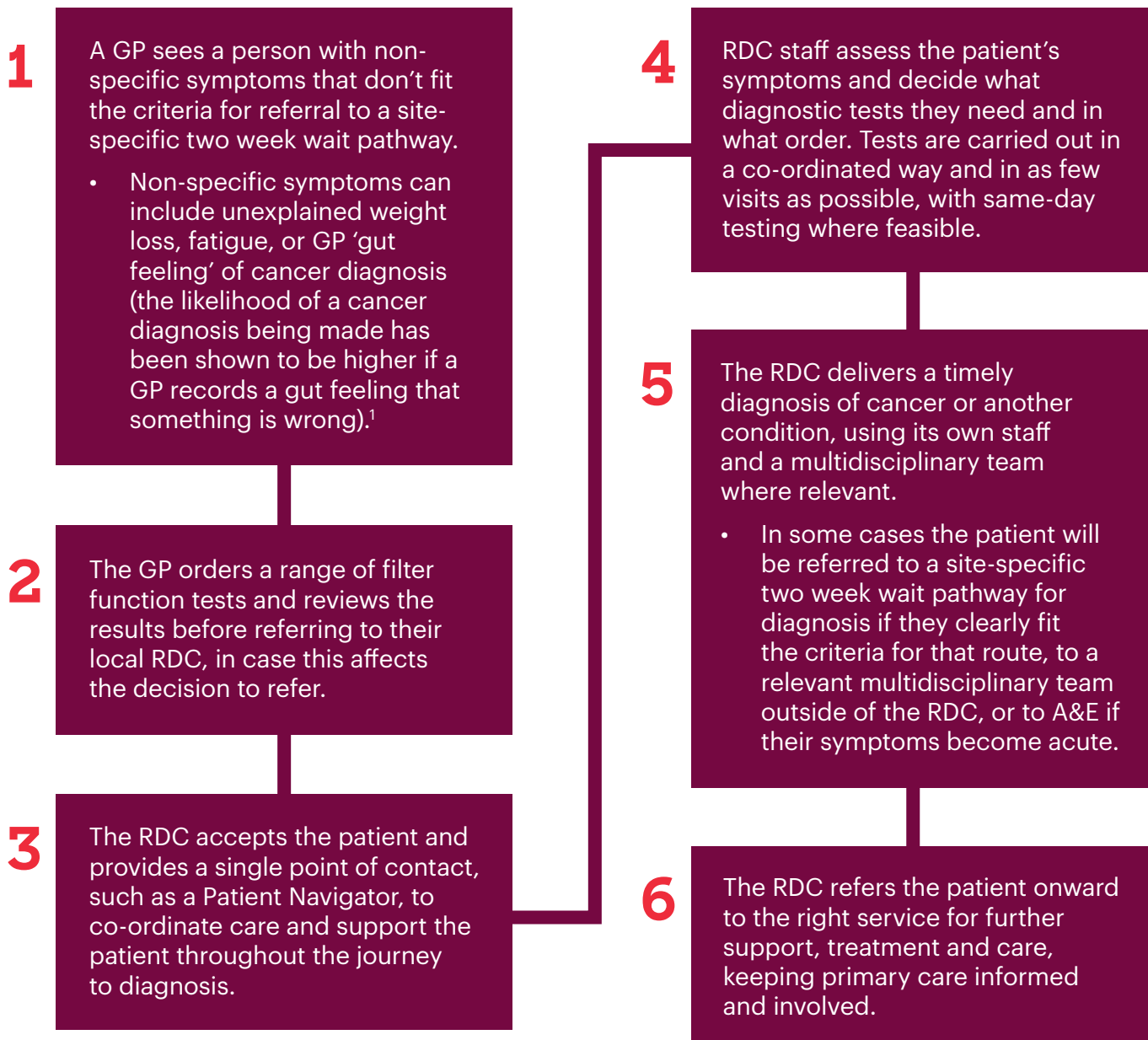
Gemma Peters

**Chief Executive
Blood Cancer UK**

Introduction

Rapid Diagnostic Centres (RDCs) are being rolled out across all Cancer Alliances in England. They aim to provide faster, earlier diagnosis of cancer and other conditions, by connecting patients with non-site specific symptoms with the expertise and tests required for diagnosis in a streamlined pathway.

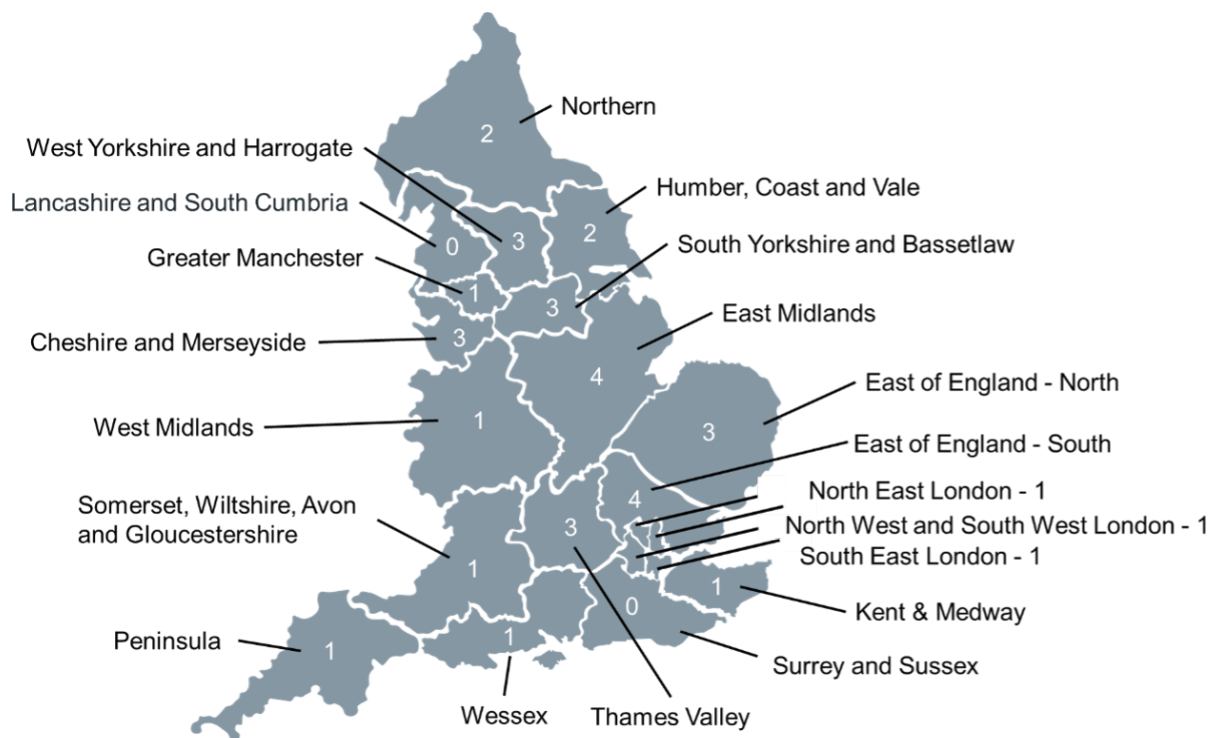
How RDCs for non-site-specific symptoms work*



*This is a general pathway based on NHS England's Vision Specification for RDCs. Individual RDCs may choose to vary this pathway.

1 Friedemann Smith et al, Understanding the role of GPs' gut feelings in diagnosing cancer in primary care: a systematic review and meta-analysis of existing evidence, Br J Gen Pract 2020; DOI: <https://doi.org/10.3399/bjgp20X712301>

Number of non-specific RDCs in each Cancer Alliance (as of October 2020)*



*Map illustrates number of RDCs per Cancer Alliance for non-specific symptoms. Each Cancer Alliance may have additional RDC pathways in place for site patients with site-specific symptoms.

Why are RDCs important for diagnosing blood cancer?

There are significant challenges in diagnosing blood cancer. Many people with undiagnosed blood cancer have symptoms such as unexplained weight loss, fatigue and anaemia, which can be difficult to attribute. Patients with non-specific symptoms are known to wait for 34 days longer on average to receive a diagnosis compared to those people who have specific symptoms of cancer.² Around a third of people with blood cancer see their GP three or more times prior to diagnosis - more than any other type of common cancer.³ And although many blood cancers can't be staged, for those that can such as myeloma, DLBCL (the most common type of non-Hodgkin lymphoma) and Hodgkin lymphoma, the majority of cases are diagnosed at later stages.

Delays to diagnosis can have devastating effects for people with blood cancer. Diagnosis at a later stage in blood cancers such as myeloma, DLBCL and Hodgkin lymphoma are associated with poorer prognosis, with blood cancer patients much more likely to survive for 5 years or more if they are diagnosed at stages one or two.^{4,5,6} Delayed diagnosis can also narrow the treatment options available, cause significant stress and anxiety to patients and their families, and leave patients with a higher risk of developing serious complications.

2 Sewell et al, Rapid cancer diagnosis for patients with vague symptoms: a cost-effectiveness study, Br J Gen Pract. 2020 Mar; 70(692): e186–e192. Published online 2020 Jan 14. doi: 10.3399/bjgp20X708077

3 NHS England and NHS Improvement, National Cancer Patient Experience Survey, available at: <https://www.ncpes.co.uk/2019-national-breakdowns/national-cancer-patient-experience-survey>

4 Cancer Research UK, Myeloma survival statistics, available at: <https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/myeloma/survival>

5 Cancer Research UK, Hodgkin lymphoma survival statistics, available at: <https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/hodgkin-lymphoma/survival>

6 Cancer Research UK, Non-Hodgkin lymphoma: Survival, available at: <https://www.cancerresearchuk.org/about-cancer/non-hodgkin-lymphoma/survival>

Early evidence from pilot RDC models in the UK, Wales and Denmark indicate that RDCs have the potential to diagnose blood cancers more quickly than via other routes. It has been estimated that around 10-15% of cancers diagnosed by RDCs will be blood cancers, most commonly lymphoma, myeloma and leukaemia.⁷ The evidence also shows that RDCs could significantly cut the time to diagnosis, and – although the available data is from a relatively small set of patients – evidence suggests RDCs could potentially diagnose more blood cancers at an early stage compared to normal diagnostic routes.⁸

How RDCs are staffed

In general an RDC will have the following types of staff:

- Senior doctor(s) with ultimate responsibility for the patient's clinical care.
- Clinical Nurse Specialist(s)/ Advanced Practitioner(s).
- Patient Navigator.
- Administrative Support.
- Primary Care Lead/ Champion.

RDCs could be vitally important for patients with an undiagnosed blood cancer who don't fit the criteria for a standard urgent referral for suspected blood cancer. They may also be useful for patients who fit the criteria for more than one site-specific pathway, and who might be at risk of being sent to an inappropriate service. By offering a streamlined hub service and a single point of contact responsible for co-ordinating each patients' care, they could help to prevent people with undiagnosed blood cancer from "bouncing" around the system from one service to another or to and from primary care.

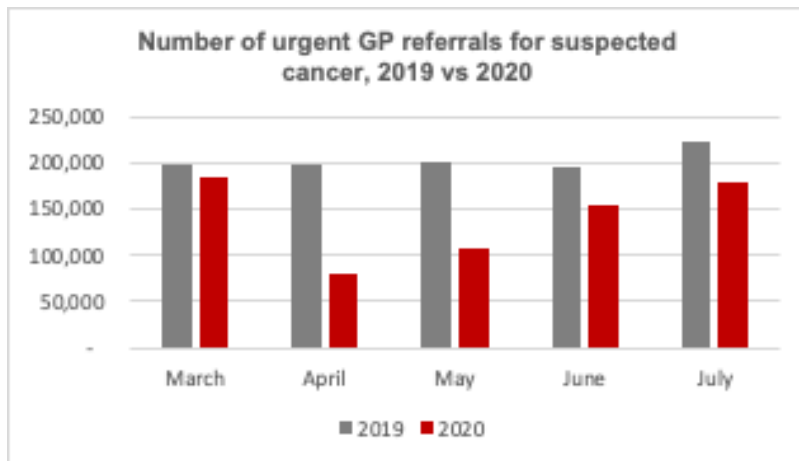
Referrals to cancer services during the Covid-19 pandemic

The pandemic has led to an unprecedented backlog in the number of patients waiting to receive a cancer diagnosis and access vital care. During the first peak of the pandemic in April 2020 there was a 60% decline in the number of patients in England with suspected cancer referred from their GP to a consultant compared to April 2019, and the number of referrals has remained well below the norm in subsequent months.⁹

7 Insights from Blood Cancer UK interview with a clinical member of the NHS England RDC Task and Finish Group

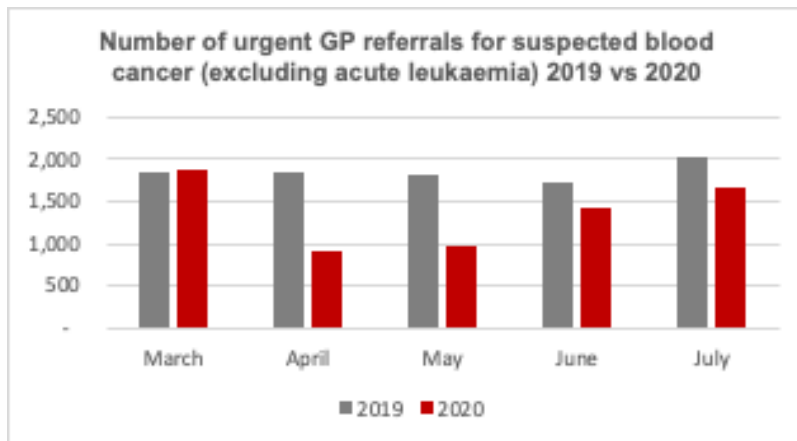
8 Cancer Research UK, Key messages from the evaluation of Multidisciplinary Diagnostic Centres (MDC): a new approach to the diagnosis of cancer, available at: https://www.cancerresearchuk.org/sites/default/files/key_messages_from_the_evaluation_of_the_mdcs.pdf

9 NHS England, NHS England Cancer Waiting Times (Provider Time Series, Oct 2009 – July 2020 with Revisions), available at: <https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/>



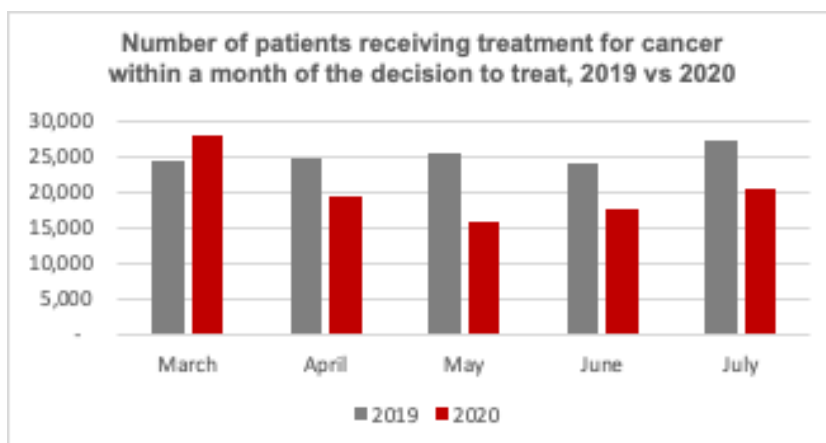
Source: NHS England Cancer Waiting Times (Provider Time Series, Oct 2009 – July 2020)

The number of urgent GP referrals for suspected blood cancer (excluding acute leukaemia) fell by over 50% in March 2020 compared to the previous year and continued to remain below equivalent 2019 levels in all of May, June and July 2020.



Source: NHS England Provider-based Cancer Waiting Times (Provider Time Series, Oct 2009 – July 2020)

The number of patients starting treatment for cancer also fell significantly compared to the same time last year. In May 2020 15,667 patients started treatment within one month of a decision to treat being made, compared to 25,276 in May 2019 – a fall of over a third (38%).⁹



Source: NHS England Cancer Waiting Times (Provider Time Series, Oct 2009 – July 2020)

The impact of this backlog is highly concerning given the importance of access to early diagnosis and treatment for many blood cancers. It is crucial that cancer services can identify and treat people with blood cancer as effectively as possible to mitigate against the effects of delayed presentation and referral during the pandemic.

Why we wrote this report

We recognise that RDCs could be an important tool in the armoury to help address the challenges with diagnosing blood cancer. In the wake of the pandemic having functioning RDCs is more important than ever.

However for the potential of RDCs to be realised it will be important to reflect on their performance so far and assess the early learnings from their response to the pandemic. RDCs will only deliver on their potential for people with undiagnosed blood cancer if they are able to accept patients with common blood cancer symptoms and ensure prompt access to the expertise and diagnostic tools needed to diagnose them.

This report takes stock of what we know about RDC performance so far. At the time of writing, there is little publicly available data to quantify the performance of RDCs in terms of diagnostic conversion rates and times. The findings of this report are therefore based on in-depth interviews with NHS staff at the forefront of delivering and shaping RDCs, including clinicians, Cancer Alliance leads and national policymakers, conducted in June and July 2020. We are grateful to all the individuals who took the time to speak to us and share their invaluable insights. Their names have been listed with permission on page 15.

The policy context for RDCs

NHS ambitions for cancer diagnosis

The NHS Long Term Plan set a target for the health service to diagnose 75% of cancers at stages one or two by 2028.¹⁰ As well as diagnosing more cancers at earlier stages, the NHS is aiming to diagnose cancer faster. The Faster Diagnosis Standard, introduced in April 2020, requires all patients referred on suspicion of cancer to receive a diagnosis or have cancer ruled out within 28 days of being referred.

RDCs are seen by NHS England as key to achieving these targets for earlier and faster cancer diagnosis. Each of the 21 Cancer Alliances in England were asked to establish and begin accepting patients into at least one RDC for non-specific symptoms from January 2020, and for the RDCs to comply with the new 28-day faster diagnosis standard for cancer. Ultimately NHS England intends for all suspected cancer referrals to be made via an RDC.

According to NHS England, RDCs should bring together the latest diagnostic equipment and expertise. They offer patients with vague or non-specific symptoms that could indicate cancer a streamlined route to diagnosis. RDCs should aim to:¹¹

- Deliver earlier and faster cancer diagnosis.
- Reduce unnecessary appointments and tests.
- Deliver a better, personalised diagnostic experience.
- Reduce unwarranted variation in referral for and access to relevant diagnostic tests.

Evidence on RDC efficacy

NHS England is in the process of conducting a national evaluation of RDCs, however the Covid-19 pandemic has delayed the timelines for release of the first evaluation data.

As of July 2020 there were 34 RDCs accepting patients, with a further 58 in development.

Preliminary analysis of these RDCs has indicated that between May and June 2020, RDCs diagnosed 189 cancers.¹² The conversion rate for cancer diagnosis in July was 18%. This is higher than the rate observed in previous trials, which is thought to be due to services re-starting after the first pandemic peak and accepting a backlog of patients.¹² The true rate of cancer diagnoses will need to be evaluated over the longer term.

**Between May and July 2020, RDCs diagnosed 189 cancers.
The cancer diagnostic conversion rate for RDCs in July 2020 was 18%.**

The RDCs being rolled-out across the country are based on ten pilot Multidisciplinary Diagnostic Centre (MDC) sites which were trialled from 2016 to 2018. Analysis of the pilot MDCs found that:¹³

- 8% of patients referred to the MDCs were diagnosed with cancer, and over 50% received a non-cancer diagnosis. The proportion of cancer diagnoses ranged from 4-11% across different MDC sites.¹⁴
- Of the people diagnosed with cancer in the pilot sites, 13% (30 cases) were diagnosed with blood cancer. In comparison around 9% of all cancer cases diagnosed in 2016 were a type of blood cancer.¹⁵ Blood cancers were among the top 5 most common cancer diagnoses made via the MDCs.¹⁴
- A third of the blood cancers diagnosed via the MDCs were diagnosed at stages one or two (although staging information was not available for over 50% of the blood cancers diagnosed).
 - This proportion of blood cancers diagnosed at earlier stages was higher than most other cancers diagnosed, indicating that RDCs could be of particular importance for blood cancers.
- The median length of time between a GP referral and the patient being seen by the MDC was 8 days.
- The median time from GP referral to cancer diagnosis via an MDC was 19 days.
- There was also evidence to suggest that the availability of the MDCs encouraged GPs to refer people with vague symptoms earlier, helping to shorten the time to diagnosis.

Although cost-effectiveness studies of the MDC pilots are still ongoing, evaluation of an RDC pilot established by the Swansea Bay University Health Board (SBUHB) in Neath Port Talbot Hospital found that the RDC was cost-effective in comparison to standard clinical practice, when run near or at full capacity. The RDC was found to cut the average waiting time for diagnosis from 84.2 days in usual care to 5.9 days if the RDC made the diagnosis, or 40.8 days if the RDC arranged further investigations.¹⁶

10 NHS England, The NHS Long Term Plan, available at: <https://www.longtermplan.nhs.uk/publication/nhs-longterm-plan/>

11 NHS England, Rapid Diagnostic Centres Vision and 2019/20 Implementation Specification, available at: <https://www.england.nhs.uk/wp-content/uploads/2019/07/rdc-vision-and-1920-implementation-specification.pdf>

12 NHS Cancer Programme, Monthly RDC Progress Update, October 2020, available at: https://mcusercontent.com/68b588bc5847cde662b4ac613/files/df922f83-4c33-40b1-b966-0cd14d3c6638/For_Information_Monthly_Colleague_Update_on_Rapid_Diagnostic_Centres.pdf

13 Chapman et al, First results from five multidisciplinary diagnostic centre (MDC) projects for non-specific but concerning symptoms, possibly indicative of cancer, British Journal of Cancer, available at: <https://www.nature.com/articles/s41416-020-0947-y>

14 Cancer Research UK, Key messages from the evaluation of Multidisciplinary Diagnostic Centres (MDC): a new approach to the diagnosis of cancer, available at: https://www.cancerresearchuk.org/sites/default/files/key_messages_from_the_evaluation_of_the_mdcs.pdf

15 NCRAS, Routes to Diagnosis yearbook, available at: <https://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence/common-cancerscompared#heading-Zero>

16 Sewell et al, Rapid cancer diagnosis for patients with vague symptoms: a cost-effectiveness study, Br J Gen Pract. 2020 Mar; 70(692): e186–e192. Published online 2020 Jan 14. doi: 10.3399/bjgp20X708077

National specification for RDCs

NHS England has set out a set of core requirements for RDCs, covering aspects such as the minimum referral criteria and staffing requirements.

The specification stipulates that:

- All RDCs should offer patients a single point of contact.
- They should aim to provide same-day assessment and testing wherever possible.
- They should comply with the 28-day faster diagnosis standard.
- RDCs must return a minimum performance dataset for evaluation every quarter.
- Cancer Alliances should engage with primary care networks to support referral into RDCs from primary care.

The specification also requires Cancer Alliances to ensure that by the end of their first year, 20% of cancer patients with non-specific symptoms in their area are diagnosed via an RDC and 50% of GPs are actively referring into RDCs. It estimates that for an average-sized Cancer Alliance 361 people per month will be seen by an RDC, potentially leading to 29 cancer diagnoses.

Core criteria for referral to an RDC

- New, unexplained and persistent:
 - Weight loss.
 - Loss of appetite, fatigue, nausea, malaise, bloating or other constitutional symptom.
 - Vague abdominal pain.
 - Progressive pain, including bone pain.
- GP 'gut feeling' of cancer diagnosis.

Patients should not be referred to an RDC if they:

- Have specific alarm symptoms warranting referral onto a site-specific two week wait pathway (in line with NG12).
- Are too unwell or unable to attend as an outpatient or need acute admission.
- Are likely to have a non-cancer diagnosis suitable for another specialist pathway.
- Are currently being investigated for the same problem by another specialist team.

Community diagnostic hubs

In October 2020, the report by Professor Sir Mike Richards into NHS diagnostic capacity commissioned by NHS was published, recommending significant additional investment in diagnostic infrastructure and workforce.¹⁷ NHS England and Improvement have committed to implementing "community diagnostic hubs", a core recommendation of the review. These community diagnostic hubs will support earlier diagnosis for patients with cancer, and should conform to the RDC service model for patients with suspected cancer.¹⁷

¹⁷ Professor Sir Mike Richards, Diagnostics: Recovery and Renewal, October 2020. Available at: <https://www.england.nhs.uk/wp-content/uploads/2020/10/BM2025Pu-item-5-diagnostics-recovery-and-renewal.pdf>

Findings

1. Covid-19 has slowed progress in the national roll-out of RDCs and introduced uncertainty around funding arrangements

Although NHS England has identified RDCs as vital to the NHS recovery, it is clear that in many areas of the country the pandemic has slowed their development.

Several RDCs either had to pause their planned roll-out of services due to the pandemic or operate at skeleton capacity. In some cases clinical staff were diverted to support the front-line response to Covid-19, while in others RDC services were paused due to a significant drop in referrals. The RDC at Guys and St Thomas' hospital, which has been established for several years, saw the number of referrals fall to just 71 in May 2020, compared to 103 in May 2019 – a 31% decrease.

For some RDCs that were operational before the pandemic, securing access to the full range of diagnostic tests has been challenging. Although common diagnostic tests for blood cancer were largely able to continue, the severe limitations on access to other diagnostics such as endoscopy led to some RDCs being unable to offer a service to patients during the peak of the pandemic.

Where RDCs were not yet operational there have been delays to planned milestones, such as the recruitment of RDC staff, implementation of service level agreements and planned educational activity with primary care.

The pandemic has also delayed the national RDC monitoring and evaluation exercise which had been due to report its first findings early in 2020.

While these impacts are understandable, there is now a need to regain momentum. Some RDC staff are concerned that staffing pressures and low patient footfall may continue to persist over the longer term, and in particular during the winter period. RDC staff are also anticipating a potential surge in the number of patients presenting with multiple non-specific symptoms, whose disease has progressed undetected during the pandemic.

Added to these concerns around capacity has been a lack of clarity over how RDCs will be funded to support the planned recovery beyond 2020. While Cancer Alliances have been asked to accelerate RDC development to support the NHS recovery, RDCs report having received little guidance as to what resources will be available to facilitate this acceleration or to meet the additional expected demand beyond the immediate crisis.

“The Covid-19 pandemic has redirected resources that were previously assured for the development of our rapid diagnostic service over the next few years. We’re having to look for internal bailouts to keep the service going at least until next year. Without long-term assurance of our funding we’re always going to be in a position of uncertainty over our future.”

Carol Taylor

Macmillan Transformation Lead: Cancer Services,
South Tees Hospitals NHS Foundation Trust

Recommendation: RDCs will play a fundamental role in addressing the NHS backlog in diagnoses of blood and other cancers. In order to fully deliver on their potential, NHS England should ensure that Cancer Alliances have sufficient funding to accelerate RDC development and capacity. Cancer Alliances should be provided with clarity over the scale and duration of additional funding for RDCs at the earliest opportunity.

2. There are concerns that RDCs could inadvertently add to specialist care workloads without the appropriate planning and investment

RDCs should help to reduce demand on services such as haematology, by seeing many of those patients who may not be appropriate for investigation in haematology and who ultimately do not receive a blood cancer diagnosis.

“There are patients who may be referred into haematology clinics due to an abnormal blood test but who ultimately receive a diagnosis of a non-blood cancer. These patients would be better served within an RDC where they are more likely to receive a diagnosis and treatment quickly, while also alleviating some of the burden on haematology clinics.”

Professor Derralynn Hughes

Consultant Haematologist, Royal Free London NHS Foundation Trust and Co-clinical Director, NCL Alliance

However in order for RDCs to effectively diagnose cancers it will be vital that they have access to specialist advice. For blood cancer diagnoses this will require access to a haematologist, either as part of the core clinical staff for the RDC, via a multidisciplinary team, or through direct liaison with the haematology department. Developing strong links into existing specialties will be fundamental to the effectiveness of RDCs given that there is no general internal medicine specialty in secondary care within the UK, and RDC clinical leads can be drawn from any relevant specialism.

Types of non-specific symptom RDC clinical leads

NHS England has specified that RDCs can be led by any senior doctor with a general medical background or primary care training. RDCs across the country are currently led by a diverse mix of specialties, including:

- General practitioners.
- Gastroenterologists.
- Medical oncologists.
- Geriatricians.
- Radiologists.
- A&E doctors.

RDCs will also depend on having timely access to diagnostic tests for blood and other cancers, and the expertise to interpret their results. As the initial funding for RDCs does not stretch to procurement of their own diagnostic resource, they will be using existing Trust infrastructure.

While the number of patients being referred to RDCs is currently relatively low, as RDCs ramp up and assess a greater proportion of people with suspected cancer they will require increasing access to specialisms such as haematology from within their host organisation. Given the existing demands on haematology workloads and MDT resources, as well as on diagnostic capacity across the NHS, there are concerns among haematologists that RDCs may inadvertently add demand to services that are already stretched thin without the appropriate level of additional investment in capacity across the system.

“ A sustained focus on rapid diagnostics is vital to enable us to ramp up and meet the anticipated surge in demand following the pandemic. ”

Geraint Jones

South East London Cancer Alliance Lead/Service Lead,
Guy's and St Thomas' NHS Foundation Trust RDC

Recommendation: If RDCs are to achieve the ambition of delivering earlier and faster diagnosis of blood and other cancers, they will need to have rapid access to appropriate expertise and equipment.

NHS England, NHS Improvement and Health Education England (HEE) should ensure that the additional demands on haematology and other cancer specialties from RDCs are accounted for in all workforce planning and transformation activity undertaken as part of the commitments within the People Plan for 2020/21.

Activity to improve workforce data collection at employer, system and national level, as outlined in the NHS People Plan for 2020/21, should include specific data on the developing RDC workforce and this should be used to evaluate what staffing and skills mix within RDCs is optimal to facilitate rapid diagnosis of blood cancer.

The Government should commit to additional long-term investment in cancer diagnostic capacity across the NHS in light of the constraints on access to diagnostics as a result of the pandemic, with specific reference to the recommendations of Professor Sir Mike Richards' recent report on diagnostics.

3. Many RDCs are open to the idea of self-referral but feel unprepared or under-resourced to introduce this in the near future

Many people with blood cancer who experience delayed diagnosis report having had a strong feeling that something was amiss prior to their diagnosis, alongside their persistent but non-specific symptoms.

For these kinds of patients being able to self-refer to an RDC could potentially speed up the time to diagnosis and help to minimise the anxiety, stress and physical deterioration associated with delays in accessing care. NHS England has indicated that self-referral may be evaluated as a potential future addition to the RDC service model, but has no definitive plans or timescales in which to conduct this evaluation.¹⁸

¹⁸ NHS England, The NHS Long Term Plan, available at: <https://www.longtermplan.nhs.uk/publication/nhs-longterm-plan/>

Many RDCs recognise the potential benefits of self-referral, but none of the RDC staff we interviewed felt confident that current capacity could meet any resultant increase in demand. For RDCs to feel confident introducing this model they will need clear, evidence-based criteria for patients to self-score against, as well as assurance that there would not be an unmanageable surge in demand for the service.

Recommendation: NHS England should allocate specific resource for one or more Cancer Alliances to pilot self-referral to RDCs in order to build the evidence base on its efficacy and resource impact as soon as possible.

4. RDC core filter function tests do not include certain tests that could help to diagnose blood cancers

GPs are required to complete a minimum set of filter function tests before referring to an RDC. NHS England has specified a list of core tests, but Cancer Alliances are able to request additional tests at local level. Conducting these tests in primary care can help to remove delays further down the line and support appropriate referral to the RDC or an alternative site-specific pathway.

The nationally-specified filter function tests for primary care do not require a blood film or protein electrophoresis to be conducted before referral (although the latter is recommended as an optional additional test). Blood films are used to support diagnosis for a range of blood cancers, while protein electrophoresis is used to diagnose myeloma – a type of blood cancer that is much more amenable to treatment if caught at an early stage.

While these tests could be ordered by the RDC itself, routinely including them in the core filter function tests might help to speed up the time to diagnosis and, where results are indicative of a potential blood cancer, could enable earlier liaison with haematology or direct referral to the urgent haematology two week wait pathway.

Recommendation: NHS England should evaluate the potential benefits of including electrophoresis and blood films in the core filter function tests for primary care, with a view to mandating them for all RDC referrals if the evidence indicates that people with an undiagnosed blood cancer are more likely to receive an earlier and faster diagnosis when these tests are performed in primary care.

5. "Test-first" RDC models may not be as effective at diagnosing blood cancers

Some RDCs have chosen to use a "test-first" model. In this pathway the RDC performs a full-body CT scan and panel of blood tests on all patients referred to them before the in-person assessment and any potential further investigation is conducted. This model, which was piloted by Oxford University Hospital NHS Trust in the ACE programme, is also being encouraged by NHS England in the wake of the Covid-19 pandemic for its potential to streamline pathways further and minimise contact.

Haematologists have however noted that for certain blood cancers, procedures such as an MRI or bone marrow biopsy would have greater diagnostic utility than a CT scan.

There is a potential risk that patients with undiagnosed blood cancer which is not identified from a CT scan may be discharged back to primary care, or if they are retained within the RDC for further investigation the requirement to perform a CT scan prior to full assessment may introduce an unnecessary and potentially time-consuming additional step.

Recommendation: As part of its formal RDC evaluation process, NHS England/Improvement should evaluate the relative effectiveness in diagnosing blood cancer of RDC models that triage patients based on an initial CT scan, compared to models in which patients are assessed by a healthcare professional prior to testing.

Conclusion

We conclude this report by quoting Professor Peter Johnson, National Clinical Director for Cancer:

**“ I completely accept the challenge that its difficult,
but I don't accept the idea that it shouldn't be done. ”**

We hope that the findings of this report will provide every RDC – established and new – with points for consideration to help them deliver the best possible service for patients with blood cancer and other conditions.

People facing a blood cancer diagnosis have considerable challenges ahead of them. Receiving a timely diagnosis shouldn't be one of them.

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