

The postcode lottery of Cancer Diagnosis: Evaluating RDC rollout across England

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Introduction

Many patients in the UK experience lengthy delays before receiving a diagnosis. It is estimated that around 1 in 6 patients diagnosed with cancer had to visit their GP three or more times before being referred for a proper examination. This problem frequently occurs due to patients' cancer symptoms being vague, such as unexplained weight loss, fatigue or persistent abdominal discomfort, which are serious but non-specific symptoms, meaning they can indicate many different conditions rather than clearly pointing to one type of cancer. As a result, patients frequently fall into what clinicians describe as a "diagnostic limbo". Their symptoms are concerning, but they do not meet the narrow criteria required for specific urgent referral pathways (Erridge et al., 2021).

Even when patients are urgently referred, pathways are not always accurate. Around 13% of individuals, who were referred through urgent cancer pathways, are ultimately diagnosed with a different cancer than the one initially suspected. This illustrates the limitations of the UK's referral systems, which require clinicians to predict cancer based on limited, non-specific symptoms. Historically, these rigid, site-specific referral criteria created a care gap for patients with non-specific presentations. This is a failure in the UK system, where patients must go through repeated GP consultations, multiple sequential referrals, or periods of "watchful waiting," which could prolong diagnostic intervals, increase anxiety, and in some cases allow the disease to progress before detection. This is a huge concern, especially in cancer detection, since around half of all cancers initially present with vague or non-specific symptoms that do not include a single clear red flag sign.

Overall, this structure of the UK referral system is a weakness in the health system; people presented with ambiguous symptoms may struggle to access timely investigation, showing how rigid referral frameworks unintentionally delay cancer diagnosis. The NHS, however, has a long-term plan to address this gap through introducing a new system for such non-specific symptoms.

The role of Rapid Diagnostic Centres in addressing diagnostic gaps

Rapid Diagnostic Centres (RDCs) were established specifically to address this care gap. An RDC is a one-stop, multimodal clinic, generally located in a hospital, to which patients with ambiguous but troubling symptoms can be sent by their GP for rapid assessment. Multiple experts (often general physicians or cancer specialists) and diagnostic services (blood tests, imaging, endoscopy, etc.) are co-located, allowing patients to get a "bundle" of tests and consultations in a single visit. This contrasts with the previous model, in which patients saw a single expert, underwent a single test, and were then sent on their way. RDCs are designed to target people in diagnostic limbo, who do not fulfil the requirements for an Urgent Suspected Cancer route, but have a GP who suspects a cancer diagnosis.

RDCs are transforming diagnostic care, making this both faster and far less stressful for people. A great example is the first centre of its kind in Wales. Over two years, it saw 574 patients and achieved a median of just 12 days from GP referral to a clinic appointment and 34 days to a definitive diagnosis. The impact is substantial; nearly 75% of those who attended received either a new cancer diagnosis or another serious non-cancerous condition (Vasilakis & Forte, 2021). Importantly, for around 27% of patients, RDCs provided reassurance safely, ruling out cancer diagnoses or serious non-cancerous disease. Feedback from those who used RDC services is overwhelmingly positive, with GPs describing the clinic as a "game changer" that has lifted the burden of prolonged diagnoses (White et al., 2025).

More recent data show RDCs' strength in diagnosis. A 2025 study of 860 individuals across London showed a 6% cancer detection rate, and more than a quarter of participants were diagnosed with other significant diseases requiring medical attention. The RDCs have had a major impact at Guy's Hospital, with 92% cancer detected in patients who did not qualify for an urgent referral. Furthermore, Guy's Hospital identified over 180 other significant non-cancerous diseases that have been missed under traditional, scattered referral pathways, underscoring the RCS model's success (Cox et al., 2025; Dolly et al., 2021).

The evidence is significant: the RDC model not only leads to better clinical outcomes but also fully transforms the patient experience. The anxiety of waiting for a diagnosis is often one of the hardest parts of any diagnostic journey; through RDCs, this anxiety is dramatically reduced, and, as a result, patient satisfaction soars. The result is a health care system that is both more humane and more efficient, reducing duplicate tests and the costly fragmentation of care. This also shifts a burden from GPs, who are unable to deliver a diagnosis due to non-specific symptoms, and allows referral to RDCPs without requiring patients to wait for more serious, specific symptoms to develop. This model, first proven in Denmark, where it cut median diagnostic times by over 2 weeks, is now the gold standard recommended by NHS policy and corresponds perfectly with national targets such as the 28-day Faster Diagnosis Standard.

Systematic barriers to nationwide RDC adoption

As much as RDCs seem too good to be true, there is one enormous limitation that threatens their promise to patients: the postcode lottery. Despite the strong evidence and the NHS's own ambition for national coverage by 2024, access to RDCs still depends almost entirely on where the patient lives. Some Integrated Care Systems (ICSs) have fully adopted the idea, incorporating RDCs within their cancer care (NHS England» Evaluation of the Rapid Diagnostic Centres, n.d.). For example, in Greater Manchester, every major trust now hosts an RDC, with 100% pathway coverage achieved as early as March 2022 (Admin, 2024). In parts of London (Northeast, North Central, and Southeast), RDCs are found in hospitals such as Guy's, University College Hospital, and Queen's.

However, as of 2025, some regions and their ICSs still lack a formal RDC model, including across the Midlands, the East of England, and parts of the Southwest. In such areas, patients with identical symptoms are left in the poor system of the NHS and left to wait for answers for an unspecified period. The contrast is staggering: a patient in Salford can expect, on average, 34 days to diagnosis, yet a patient in a rural county without an RDC may wait 84 days or more under standard NHS care. One patient gets an answer, the other is in diagnostic limbo (Vasilakis & Forte, 2021). This geographic variation has real human consequences, the chance of earlier-stage detection and better patient outcomes is determined not by clinical need but by the arbitrary boundary of their local health authority.

Why has this happened? The causes are multiple and systemic. Funding has been inconsistent, with some Cancer Alliances securing early transformation investment while others have received none. This disparity is caused by how funding has historically been allocated, often favouring regions with existing infrastructure and the capacity to rapidly pilot new models of care. Early clinics were thus better positioned to demonstrate success and secure further support, whereas under-resourced regions lagged. Not only that, but diagnostic capacity, particularly CTs and MRI availability, varies; some ICSs cannot absorb the additional demand an RDC would create. These capacity disparities reflect persistent gaps in staff availability, equipment financing, and hospital amenities, suggesting that some areas must overcome substantial practical obstacles before RDC implementation is even possible. And through this all lies a governance gap. Integrated Care Boards, responsible for commissioning, have prioritised RDCs unevenly, with no national mandate strong enough to push for universal adoption. Driven by staff shortages, queues, and financial restrictions, ICSs prioritize current needs over RDC investment.

Policy solutions to the RDC postcode lottery

However, increasing funding alone may not be sufficient. The NHS is already operating under significant financial pressure, and reallocating resources risks diverting funds from other critical services such as emergency care or elective recovery. Furthermore, simply injecting funding into

underperforming regions does not guarantee rapid improvement if workforce shortages and infrastructure limitations persist. The NHS is already facing substantial financial constraints, and reallocating resources risks diverting funds away from other essential services. Simply investing funds into underperforming regions does not mean a quick resolution if labour shortages and infrastructural constraints continue.

Yet the existence of an RDC remains a matter of geographic chance. Yet the very existence of an RDC is a matter of geographic chance. A patient in Salford benefits from a fully embedded clinical care; a patient with identical symptoms in rural Devon or the East Midlands faces the same old diagnostic limbo. The NHS 2024 set target for universal coverage was missed, leaving the diagnostic gap unresolved throughout the UK. It is important to note that this is not a failure of the RCD model itself, but rather a failure of funding and equal distribution. The solution to this postcode lottery is not complex at all. It requires a national mandate backed by adequate investments for ICSs left behind, and a flexible service design to reach every community, not just urban centres. Moreover, a solution also demands expanding workforce training equally to ensure no hub opens without staff to run it.

The question is no longer whether RDCs should exist, as the evidence indicates they should. The question is whether the NHS will complete what it has already started, ensuring that every patient receives appropriate care regardless of their postcode. This is a question of priorities, with one clear answer. However, implementation will need a careful balance of intent and realism, ensuring that improvements are both financially and operationally viable within the limitations of current systems.

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