RM Partners
NW & SW London Cancer Alliance

NHS

Non Site Specific (NSS) Pathway and Rapid Diagnostic Cancer Centres (RDCC) – 28th January 2026

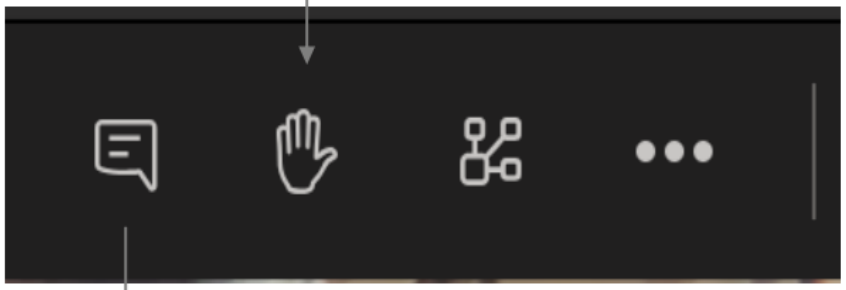
Dr Bina Modi, RMP GP Cancer Lead for Brent and Harrow and GP @ Rapid Diagnostic Centre, Northwick Park Hospital

Dr Charlotte Powell-Tuck NSS RDCC Pathway Group Chair for RM Partners NWL and SWL, GP @ Rapid Diagnostic Cancer Clinic, Kingston Hospital NHS Foundation Trust

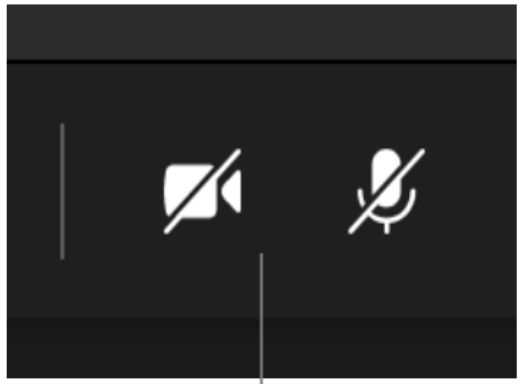
Hosted by The Royal Marsden NHS Foundation Trust

Housekeeping

Hands Up to ask a Question



Chat & Ask Questions



Please make sure your Video & Mic is Off

ALL QUESTIONS TO BE TAKEN AT THE END OF THE PRESENTATION

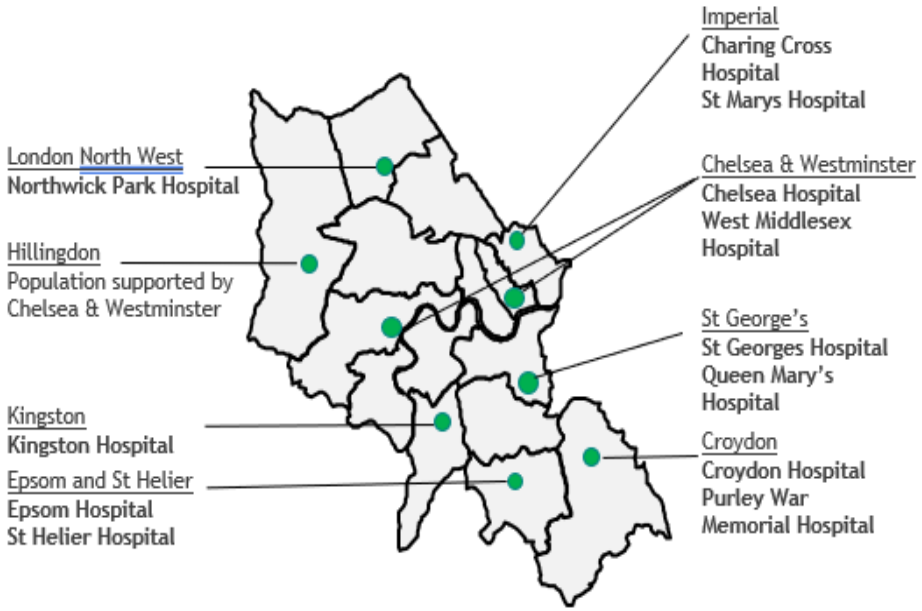
Agenda

Item	Time	Presenter
Introduction	1:00pm	Dr Charlotte Powell Tuck
Background of the RDCCs	1.05pm	Dr Charlotte Powell Tuck
What is a RDCC?	1:05 –1.10pm	Dr Charlotte Powell Tuck
What are common referrals to the RDCCs?		Dr Charlotte Powell Tuck
Who is eligible for referral?		Dr Bina Modi
West London Non Site Specific RDC Referral Form		Dr Bina Modi
Reminder: NICE Guidelines for FIT<10 and Management in Primary Care		Dr Bina Modi
Case Study Discussion	1:10 – 1:40pm	Dr Bina Modi & Dr Charlotte Powell Tuck
Take home messages	1:40pm	All
Questions	1:45 – 2pm	

RM Partners NW & SW London Cancer Alliance NHS

Background of the RDCCs

- Based on multi-diagnostic centres – MDC
- In 2019, NHSE asked all Cancer Alliances to set up at least 1 RDC for NSS symptoms
- 8 RDCs now have been set up **across 7 acute trusts** NWL and SWL



RDCC	Contact details
London North West	lnwh-tr.vaguesymptomsclinic@nhs.net
Imperial	imperial.nssrdccancerclinic@nhs.net
Chelsea and Westminster (Chelsea and Westminster Hospital) Chelsea and Westminster (West Middlesex Hospital)	chelwest.acuteoncology@nhs.net caw-tr.adocwestmid@nhs.net
Kingston	khft.rdcc@nhs.net
Epsom and St Helier	esth.rdc@nhs.net
St George's	stg.rdcc@stgeorges.nhs.uk
Croydon	ch-tr.rdac@nhs.net

What is a RDCC?

- The centres provide better patient and GP experience **with faster access** to relevant tests to **diagnose or exclude cancer** in a cost-effective manner.

- Service specifically designed for GPs to refer patients (aged 18+) who have **non-specific** but **concerning symptoms** of a new cancer, where there is no alternative tumour specific pathway

- **RDCCs aim to see patients meet Faster diagnostic standard (FDS)** – *cancer diagnosed or excluded within 28 days*

THIS SERVICE IS NOT REPLACING EXISTING TUMOUR PATHWAYS

What are common referrals to the RDCCs?

- Unintentional Weight Loss
- Anaemia
- Raised Inflammatory Markers
- Non-specific abdominal pain
- Night Sweats
- Fatigue
- Abnormal Radiology

Who is eligible for referral?

- Patients must meet the criteria:
  - **Over 18** years of age
  - Clinical or radiological **suspicion of cancer**
  - **Does not meet alternative** tumour-specific pathways
  - **Well enough to attend** an outpatient clinic
  - **Aware they may have cancer**

West London Non Site Specific RDC Referral Form

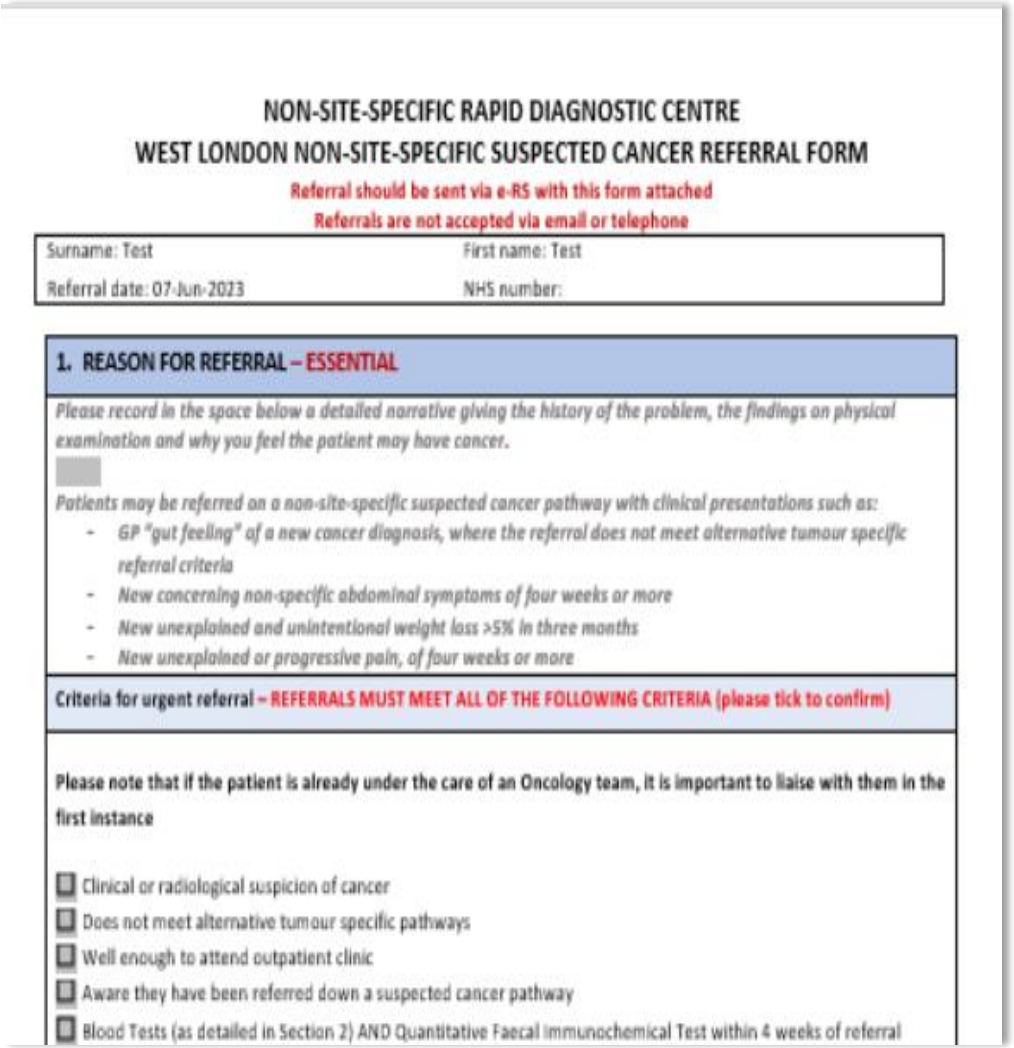
- There is a West London Non Site Specific RDC Referral Form. **The referral form is sat in the Cancer folder within EMIS / S1.**
- You are encouraged to complete the referral form with all relevant details and filter function test results attached:

  1) **Bloods:** FBC, eGFR, LFTs, TFTs, HbA1c, bone profile, CRP, ESR, PSA (men), CA 125 (women), B12/ferritin/folate/iron studies (if anaemic)

  2) **Quantitative Faecal Immunochemical Test (FIT)***

  3) **Chest Xray** (preferable)

- **You can refer via eRS to your local service, using the 2WW dropdown -> non-site-specific**



NON-SITE-SPECIFIC RAPID DIAGNOSTIC CENTRE

WEST LONDON NON-SITE-SPECIFIC SUSPECTED CANCER REFERRAL FORM

Referral should be sent via e-RS with this form attached

Referrals are not accepted via email or telephone

Surname: Test	First name: Test
Referral date: 07-Jun-2023	NHS number:

1. REASON FOR REFERRAL – ESSENTIAL

Please record in the space below a detailed narrative giving the history of the problem, the findings on physical examination and why you feel the patient may have cancer.

Patients may be referred on a non-site-specific suspected cancer pathway with clinical presentations such as:

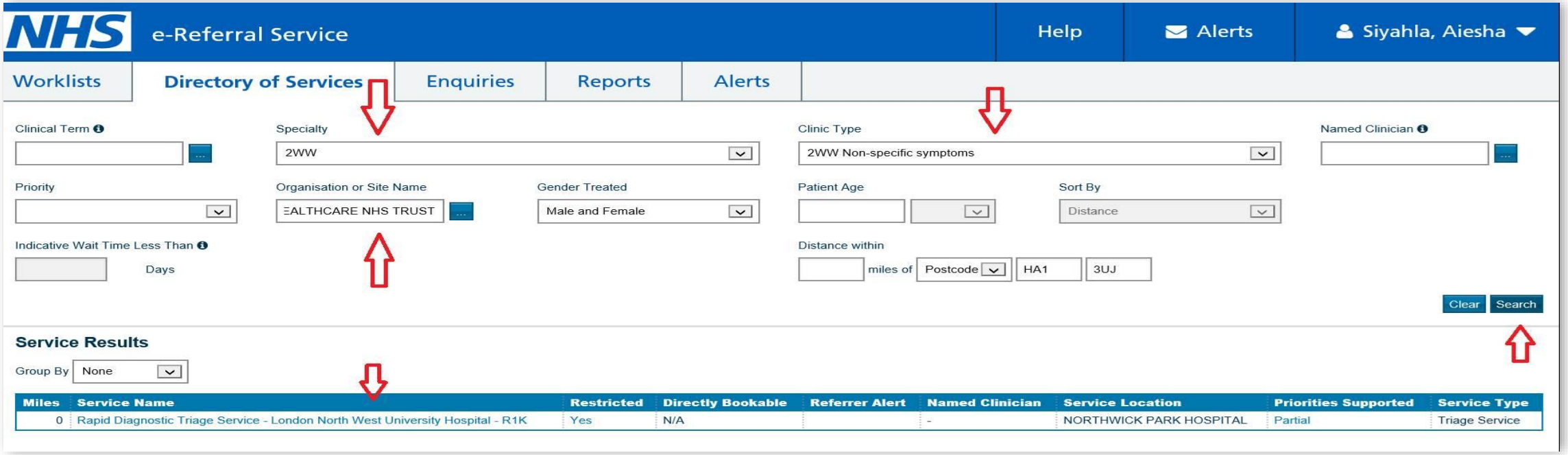
- *GP "gut feeling" of a new cancer diagnosis, where the referral does not meet alternative tumour specific referral criteria*
- *New concerning non-specific abdominal symptoms of four weeks or more*
- *New unexplained and unintentional weight loss >5% in three months*
- *New unexplained or progressive pain, of four weeks or more*

Criteria for urgent referral – REFERRALS MUST MEET ALL OF THE FOLLOWING CRITERIA (please tick to confirm)

Please note that if the patient is already under the care of an Oncology team, it is important to liaise with them in the first instance

- ☐ Clinical or radiological suspicion of cancer
- ☐ Does not meet alternative tumour specific pathways
- ☐ Well enough to attend outpatient clinic
- ☐ Aware they have been referred down a suspected cancer pathway
- ☐ Blood Tests (as detailed in Section 2) AND Quantitative Faecal Immunochemical Test within 4 weeks of referral

How to refer (ERS screenshot)



Reminder: NICE Guidelines for FIT<10 and Management in Primary Care

- NICE[2] recommend safety netting patients who have **not returned a FIT** and those with a **FIT <10 result**

- **Clinically appropriate action for FIT <10 patient:**
  - Reassess and consider repeating FIT (at 4-6 weeks after initial FIT)
  - Advice and guidance
  - Non-specific symptoms (NSS) Urgent Suspected Cancer referral
  - If concerns for lower GI cancer remain (e.g. new onset iron deficiency anaemia) consider USC referral
  - Routine GI pathways

- Safety netting patient verbally and with written material may be helpful e.g

"Your recent stool test showed a very low-risk result. You do not need a hospital referral at this stage. If your symptoms continue or worsen, please contact us again."

1. https://www.nice.org.uk/guidance/dg56/chapter/1-Recommendations
2. NEW Gastrointestinal (GI) Urgent Suspected Cancer (USC) Stratified Pathway Implementation: Guidance for Primary Care – October 2025

Case Studies

Case JS

- 78-year-old lady
- GP referred with 12kg weight loss, fatigue, abdominal pain, diarrhoea, bloating, fever 38C, anaemia
- Recent trip to India- no malaria prophylaxis.
- O/E normal
- Hb 100
- FIT negative
- GP referred to Hillingdon LGI USC but patient says not contacted.
- She would prefer to be seen closer to home.

What would you do next?

1. CTCAP
2. Refer to infectious diseases
3. Colonoscopy
4. Ask the patient to follow up with LGI team at Hillingdon Hospital

Case JS

- IDAR did not accept referral
- She calls for an update – I feel she needs LGI review.
- CT CAP – large mass in ascending colon/ caecum and indeterminate lung nodule
- OGD and Colonoscopy under Hillingdon Hospital – confirm 3cm caecal tumour
- MRI liver – liver metastasis
- Right hemicolectomy, right ureteric stent, chemotherapy, liver resection.

Learning Points

✅ FIT negative bowel cancer! < 0.1% risk if FIT <10 with a normal examination and normal FBC.

✅ Can be challenging to co-ordinate investigations across sites.

Case MM

- 56 year old lady
- GP referral
- 14kg weight loss, fatigue, generalised weakness, reduced appetite, constipation, change in personality, altered gait, SOB
- Symptoms since a flu jab and has viral symptoms again.
- Been to ED - multiple times.
- HTN, T2DM, from Congo
- O/ E Off, inconsistent wide based gait power 4+/5
- Bloods – B12 854, ferritin 258
- FIT negative

What could be the diagnosis?

1. Motor neurone disease
2. Primary brain malignancy
3. Encephalitis
4. TB
5. Post viral syndrome

Case MM

- Bloods – CRP 70
- Plan for CT CAP, OGD, colonoscopy, MRI head, echo
- Referred to medics
- Admitted for CAP and flu + O2 requirement
- Reduced GCS, drowsy, respiratory failure and hypoxia
- Admitted to ITU ? Seizure during sedation holds
- CT CAP – L lower lobe consolidation
- MRI head non specific – minimal raised periventricular FLAIR signal

Case MM

- Reviewed by Neurology, ID, rheumatology- many times.
- Diagnosis of MND – 2 months later
- Home with NIV

Learning Points

✅ Trust your gut instinct – cancer or non cancer

✅ RDC plays a role in identifying both cancer and significant non cancer pathology

Case Study: 85 year old female

Referral Reason

- Unexplained 20% total body weight loss over 2 years
- Drenching night sweats, fever
- Poor appetite but no other GI symptoms

Past Medical History

- Breast Cancer 2015
- Melanoma 2007
- Unexplained PE 2023
- HTN
- Haemorrhoids

Social History

- Lives alone, active playing tennis
- 1-2 glasses of wine daily.

Examination

- Nil significant

Initial Investigations

- Elevated inflammatory Markers CRP 69, ESR 39
- BNP 1027
- Anaemia Hb 100g/l, Plts 768, Ferritin 660.

Differential Diagnosis?

1. Recurrence of cancer
2. Infection
3. Endocarditis
4. Hyperthyroidism
5. Vasculitis
6. Stress

Case Study: 85 year old female

- Investigations Performed:

Investigation	Outcome
CT CAP	9mm pancreatic cyst (likely IPMN)
OGD & Colonoscopy	Diverticulosis only
Bloods	Tumour Markers: CEA, Ca19-9, Ca125, Ca15-3 all normal Vasculitis and autoimmune screen: Normal
PET CT	FDG-avid aorta, carotids, subclavian, femoral → Large Vessel Vasculitis

- MDT conclusion: Cancer excluded → Large Vessel Vasculitis
- Outcome → Patient referred Urgently to Rheumatology (wanted to see within 24hrs), started on steroids.

Learning Points:

- ✅ RDCC identifies both cancer & significant non-cancerous disease
  ✅ PET-CT pivotal when investigations negative but ongoing clinical concern
  ✅ Early liaison with other specialities crucial

Case study: 76 year old male

Referral Reason

- Feeling faint
- Low energy
- 2–3 episodes of epistaxis over several months
- Gut instinct

Past Medical History

- Upper GI bleed 2 months prior (Hb 83 – no source found on scopes)
- Prostate cancer (2016, T3a, radical prostatectomy)
- TIA (2021), CKD, HTN, IHD

•Social History

- Non-smoker, No ETOH

•Examination

- Unremarkable, PS0

Bloods

- Hb 127, Ferritin 20
- CRP, ESR normal, U&E stable
- PSA 0.315 (increased from 0.210)
- Myeloma screen negative

What would you do?

1. Discharge to GP
2. Bloods and CT CAP
3. Refer ENT
4. Refer to Urology

Case study: 76 year old male

Investigation	Outcome
Pathology	No further Hb drop since initial drop February 2025, inflammatory markers normal All tumour markers normal. 5HIAA and metadrenalines normal
OGD/Colonoscopy/ Flexi Sig (Feb–Mar 20250	No clear bleeding source; benign gastric & rectal polyps
CT NCAP (16th May 2025)	Indeterminate high attenuation cystic lesion of small bowel and indeterminate liver lesion.
MRI liver 10.06.2025	Appearances of the 28mm hepatic segment VIII lesion are thought most likely to represent a haemangioma
MRI small bowel 12.06.2025	4.2cm lesion adjacent to jejunum, solid/cystic, enhancement & restricted diffusion
PET Scan (FGD & PSMA) 14.07.2025	**42mm round lesion FDG avid (PSMA negative) suspicious for small bowel origin.** **Mesenteric node and T4 bony lesion PSMA avid** Hepatic lesion seen previously not FDG avid or PSMA avid
CT Guided Biopsy 07.08.2025	Non-diagnostic fibrinoid/necrotic tissue only
Video Capsule Endoscopy 26.08.2025	Normal
Dotatate PET 08.10.2025	• **The left-sided abdominal lesion is not significantly DOTATATE avid** • Focal **uptake seen at the pancreatic tail which is nonspecific** but should be further evaluated. • Right **mesenteric node and T 4 vertebral body marked DOTATATE uptake** although I note this was also **PSMA-avid.**
Surgical excision at Marsden 14.10.2025	Small bowel resection and 2 x mesenteric nodes resected

Case study: 76 year old male

- **DIAGNOSES**
  - Recurrent Oligometastatic (bone) prostate cancer
  - Small bowel GIST
  - Mesenteric nodule paraganglioma x 2 (completely excised)
- **PLAN**
  - **Prostate Cancer:** Hormonal Treatment, SBRT to T4 lytic lesion.
  - **GIST** – Considered low risk (4.3% for aggressive behaviour) for surveillance of this and avidity noted in pancreas.
  - Mesenteric nodule paraganglioma (completely resected)

- **Learning Points:**
  ✅ Non-specific symptoms can mask GI pathology
  ✅ RDCC pathway effective for systematic investigation & cross-specialty collaboration
  ✅ Several investigations sometimes required including a range of different PET scans, and input from multiple teams.
  ✅ Good communication with patient & family maintains engagement through complex pathways and lengthy process.

Case study: 68 year old male

Referral Reason

- Palpable abdominal lump
- 6-week history of bloating, cramps,
- ↓appetite
- 3 kg weight loss

Background

- PMH: anxiety, hypertension, MSM
- Independent, lives alone, retired chartered surveyor.
- FH: niece, aunt & grandmother – bowel cancer [ICE – VERY ANXIOUS HE HAD BOWEL CA]

Examination

- Large, hard, irregular LUQ abdominal mass
- No palpable peripheral lymphadenopathy

Initial investigations

- Ultrasound (09.01.25)
- multiple hypoechoic lesions in liver & spleen
- extensive lymphadenopathy → suggestive of metastatic disease
- unknown primary

Case Study: 68 year old male

Investigations	Outcome
CT CAP (17.01.25):	Extensive disease chest → pelvis, portocaval & retroperitoneal nodes, hepatic & splenic deposits → biopsy advised
Endoscopy (25.01.25):	• OGD – mild reflux oesophagitis + gastric polyp • Colonoscopy – diverticulosis, haemorrhoids, no malignancy
Liver biopsy (31.01.25):	Results from Histology: ***03.02.25*** Poorly differentiated metastatic carcinoma ***11.02.2025*** lesional cells positive for CD45, BCl-2, CD79a findings suggestive of high-grade non-Hodgkins lymphoma ***04.03.2025*** Second Opinion Charing Cross: Diffuse B Large B cell lymphoma, germinal centre subtype.
PET-CT (13.02.25):	• Intensely FDG-avid lymphadenopathy above & below diaphragm, liver/splenic/bony involvement → high-grade lymphoproliferative disorder most likely

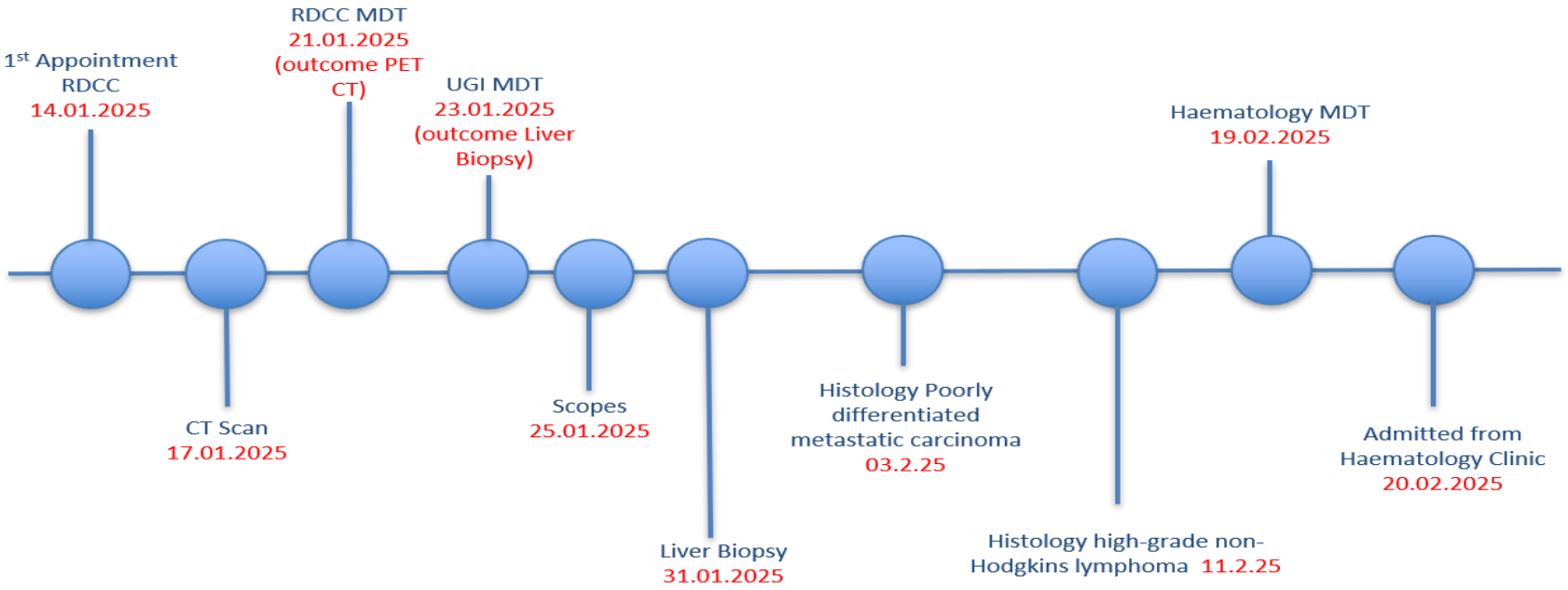
68 year old male

Diagnosis: High-grade B-cell non-Hodgkin lymphoma

Outcome

- Referred Urgently to Haematology for treatment initiation
- Admitted from Haematology Clinic for IV fluids, rasburicase, dexamethasone (tumour lysis prophylaxis)
- Treated with Pola-R-CHP (Polatuzumab/Rituximab/Cyclophosphamide/Doxorubicin/Prednisolone)
- Patient deteriorated whilst awaiting results of investigations/MDTs likely combination of disease and anxiety ++ that led to significant further weight loss.
- Patient subsequently stopped treatment after 2 cycles and opted for palliative care

68 year old male



Learning points

- ✅ Timely investigations critical, diffuse large B-cell lymphoma develops quickly.
- ✅ Role for more psychological support for patients especially those with previous MH issues or trauma on 2WW pathways.
- ✅ Need to advocate for your patient.

Take home messages

Key messages for primary care – Top Tips to support referral

- **Provide important clinical information** e.g. if weight loss is main concern, please outline baseline weight/current weight if available or clothing size change/duration of weight loss or if referral predominantly based on concerning blood/imaging results, please include in clinical information box so easier to see than if amongst all the other investigation results.

- **Consider patient's performance status/frailty**-if housebound/bedbound, is it helpful to investigate for cancer when treatment may not be possible given their level of function?

- **Always include practice email address and bypass number**-saves a lot of valuable time and facilitates good communication with GPs and clinic.

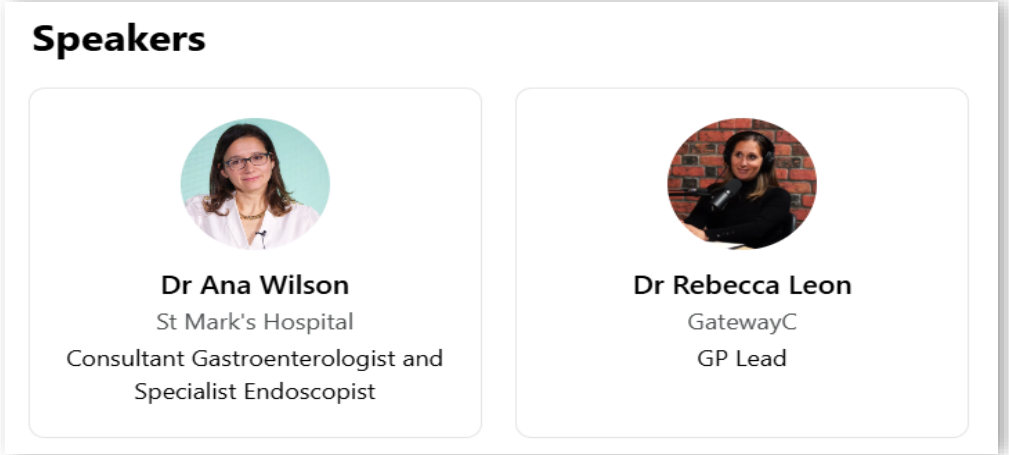
If unsure about referral, please get in touch with the team by email / phone

Upcoming education events of interest

Addressing Systemic Discrimination Development Session			
Date	Time	Location	Booking Link
Wednesday 4th February 2026	09:00 - 13:30	Open Ealing, Unit 14 School Lane, Dickens Yard, London W5 2TD	https://wkf.ms/4nu0SuA
Thursday 5th February 2026	09:00 - 13:30	PCS 160 Falcon Rd, London SW11 2LN	

The sessions will:

- Support Participants to be more aware of systemic discrimination
- Helping participants to explore how they might improve the healthcare experience outcomes for their patients
- Explore the role that participants can play in taking action to reduce inequalities



Lower GI cancer - red flags, FIT and diagnostic challenges in primary care. REGISTER HERE

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