

# Rachel's Pathway (Interim)

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## Preventing fragmented surveillance after diagnosis

### The missing part of the conversation

The NHS 10-Year Plan sets out an important ambition: to integrate data and improve prevention through a single patient record, risk profiling, and predictive care.

But hereditary risk is not only about identification.

Even when a person is diagnosed with cancer, or later found to have a hereditary risk condition, outcomes can still be harmed by fragmented surveillance, unclear responsibility, and disjointed follow-up across hospitals and specialties.

This is where Rachel's Pathway sits.

### What Rachel's Pathway addresses

Rachel's Pathway focuses on what happens after:

- a cancer diagnosis
- a high-risk clinical picture
- or a confirmed hereditary risk finding

It is designed to ensure that the patient receives coordinated, consistent surveillance and follow-up, rather than care being split across multiple services with no single overview.

## Side-by-side: NHS 10-Year Plan vs Rachel's Pathway

Feature	NHS 10-Year Plan (Fit for the Future)	Rachel's Pathway (post-diagnosis / post-risk identification)
Focus	Long-term prevention and risk prediction	Immediate safety and coordination once risk is known
Record	Single Patient Record to support joined-up care	A record alone doesn't coordinate appointments, surveillance, or accountability
Ownership	Does not specify who owns surveillance coordination for hereditary risk patients	Requires a named coordinator / accountable role to ensure follow-up is not fragmented
Surveillance	No defined national surveillance coordination model described	Structured follow-up plan, agreed across specialties
Cross-hospital care	Not addressed in operational detail	Designed specifically to prevent gaps when care spans multiple trusts/services
Timelines	Long-term ambition (years)	Practical and implementable now using existing pathways
Patient experience	More access to records and risk information	A coordinated plan so patients aren't left navigating complex systems alone

### Why this matters: Rachel's experience

Rachel's case shows why identification alone is not enough.

Rachel was diagnosed with breast cancer and received treatment. At the time, it was believed the cancer had been dealt with. However, the cancer later returned and she died six years after her original diagnosis.

In the years between, care and surveillance can become fragmented across hospitals, services, and appointments — especially when hereditary risk is not clearly owned by one accountable pathway.

Rachel's Pathway exists because patients should not be left in a system where the burden of coordination falls on them — or where each service assumes another service is responsible.

### The urgent point

Even if the NHS successfully delivers long-term ambitions by 2035, this will not automatically prevent harm for patients who:

- are diagnosed during the next decade
- have complex clinical histories
- move between services
- or require long-term surveillance and coordinated follow-up

That is why interim safety standards are needed now — both before diagnosis (Rachel’s Rule) and after diagnosis (Rachel’s Pathway).

### What is being asked for

Rachel’s Rule and Rachel’s Pathway together call for two practical interim safety standards:

1. Before diagnosis
  - A minimum, accountable process for hereditary risk recognition using clinical history and red flags — not family history alone.
2. After diagnosis / after risk identification
  - A minimum standard for coordinated surveillance and follow-up, with a named responsible role to prevent fragmentation across services.

Full policy proposals

A comprehensive full Rachel’s Pathway policy proposal is available to read in the Proposal & Policy section of this website.