



Making Every Test Count

Delivering the NHS 10 Year Health Plan through faster, fairer access to in-vitro diagnostics

This report has been developed by Roche Diagnostics UK and Ireland in partnership with the Royal College of Pathologists. This report has been funded solely by Roche Diagnostics.

Foreword

It is often only when people find themselves in the middle of the health system that they realise how much of it depends on something they have never seen. Patients waiting for answers, families trying to navigate uncertainty, and NHS frontline staff working under increasing pressure all experience this reality in different ways. Behind much of the health and care system are the pathologists and laboratory teams who keep it running - often quietly, and without recognition, yet are central to almost every diagnosis.

In Mid Sussex, I see this system from multiple angles. I represent Burgess Hill, home to Roche Diagnostics UK and Ireland, where world-leading innovation is taking place. But I also hear from constituents who are waiting too long for tests, struggling to get timely diagnoses, or managing conditions where small delays make a significant difference. That gap between innovation and experience is one we cannot ignore.

We talk a lot about pressure in the NHS - and rightly so. But too often, we focus on what is visible rather than what lies beneath it. In vitro diagnostics, led by pathologists, is one of those areas: essential to almost every clinical decision, but not always part of the public conversation. When it works well, it prevents a crisis. When it doesn't, the consequences are felt across the entire system.

We are now a year on from the NHS 10 Year Health Plan for England, and its ambition to shift the system towards prevention, digital transformation, and care closer to home remains the right approach. But ambition alone is not enough. The reality is that too many people are still waiting too long for answers, and too many parts of the system are still operating in silos. Across the country, I see the same pattern: services under strain, variation in access, and innovation that does not always reach patients at the pace it should. It is this inconsistency - this postcode lottery - that undermines confidence and, ultimately, outcomes.

That means not just developing new tools, but making sure they are adopted consistently and quickly across the system. At the moment, that is not always happening. Barriers to uptake, variations in infrastructure, and complexity in pathways all contribute to a system in which progress is uneven.

That is why I welcome this work. It brings together the pathology workforce and industry insight to look honestly at what is working, what is not, and what needs to change if we are to deliver a more sustainable, responsive NHS.

If we get this right, the impact is clear: faster diagnosis, better outcomes, and a system that is more focused on prevention than crisis. But most importantly, it means something very simple - people getting answers sooner, at the moment they need them most.

That is a goal worth pursuing.



Alison Bennett is the Liberal Democrat MP for Mid Sussex. She currently undertakes the role of Liberal Democrat Spokesperson (Care and Carers.)



Introduction

A diagnosis is not just a policy target or a system metric - it is a moment that can change a life, shaping everything from the care a person receives to the decisions they and their loved ones make about the future. It can bring relief, uncertainty, or fear. Increasingly, the experience of this moment is shaped by the quality, speed, and accessibility of in vitro diagnostics (IVDs) - the tests performed on samples such as blood, urine, or tissue, either in a laboratory or at home - that influence around 70% of clinical decisions in the NHS, yet account for less than 1% of the total NHS budget.¹ A small increase in funding for this vital area would go a long way.

Whether someone is waiting for answers, starting treatment, or managing a long-term condition, IVDs sit at the heart of their care journey, making them a critical but often undervalued part of healthcare.

A year on from the publication of the NHS 10 Year Health Plan for England, and with the prospect of a new Prime Minister, the question is no longer what needs to change, but how quickly change can be delivered. Its three core shifts - from sickness to prevention, from analogue to digital, and from hospital to community - will not be realised without diagnostics at their core, and without greater ability for systems, data, and pathways to connect and communicate more effectively than they do today.

This is not yet consistently achieved across the health service, but it is increasingly clear that it will be essential to delivering the ambitions set out in national and devolved strategies. While policy frameworks may differ, the direction of travel is clear: towards earlier diagnosis, more personalised care, and services designed around patients' lives, supported by better connected pathways of care.

There are clear signs of progress in recognising the value of IVDs across the system. The recent £237 million investment in community diagnostic services will begin to bring testing closer to patients, improving access and reducing delays.² Advances in digital technology and artificial intelligence are creating new opportunities to connect and interpret diagnostic, genomic, and clinical data, supporting faster, more accurate decision-making and enabling more personalised care. Cancer remains a central priority, with continued focus on early detection, faster diagnosis standards, and the expansion of screening programmes as detailed in the recently published National Cancer Plan.³ Alongside this, regulatory reform and the proposed introduction of an NHS innovator passport for MedTech signal a clear intent to accelerate access to new technologies.⁴

Yet often, the potential of IVDs are not realised in practice, with proven solutions failing to reach patients at the scale and speed that is necessary.

Too many tests that could transform care take years to move from regulatory approval into routine use, and adoption varies widely across the country, creating a postcode lottery where patients' access to the latest advances depends on where they live.

For a system committed to equity, this variation is difficult to justify. Persistent barriers - including fragmented decision-making, complex procurement pathways, workforce pressures, and uneven digital infrastructure - continue to limit the scale and pace of adoption. The result is a disconnect between what is possible and what is delivered in practice, with patients too often waiting longer than necessary for answers that already exist.

This white paper sets out how that gap can be closed. Developed in partnership between the Royal College of Pathologists and Roche Diagnostics UK & Ireland, and informed by a series of expert webinars held between September 2025 and February 2026, it brings together clinical insight, system experience, and the pathology workforce to identify the key barriers to adoption and the actions needed to overcome them.

At a time of heightened political focus and system-wide change, there is a clear opportunity to ensure that IVDs are recognised not as a supporting function, but as a strategic priority. Acting now will be critical to delivering faster diagnosis, improving patient outcomes, and building a more sustainable health system for the future.



1. From hospital to community

The NHS cannot deliver its ambition of shifting care from hospitals into communities if diagnostics remain anchored inside hospital walls. The next phase of healthcare change will depend not simply on moving appointments out of hospitals, but on moving diagnostic capability closer to where people actually live - GP practices, pharmacies, care homes and, increasingly, patients' own homes.

This is about far more than convenience. Earlier access to testing means earlier clinical decisions, faster treatment, fewer avoidable complications and less pressure on overstretched hospitals. In a system under constant strain, diagnostics could become one of the NHS's most powerful tools for prevention and demand management.

Importantly, public attitudes are already shifting. We are entering a period of genuine social readiness for decentralised diagnostics, with 77% of patients willing to self-test at home.⁵ For many, accessibility is no longer seen as a bonus feature of healthcare - it is increasingly viewed as fundamental to receiving timely diagnosis and treatment.

The value of this approach becomes especially clear during the winter respiratory virus season.

Every year, waves of flu, COVID-19 and RSV create enormous operational pressure across the NHS. Faced with diagnostic uncertainty, clinicians are often forced into cautious decision-making of admitting patients for observation, isolating individuals unnecessarily, or prescribing antibiotics while awaiting results that may take days to return. But community-based test and treat models are beginning to show a different way forward.

A powerful example of this shift is the deployment of respiratory point-of-care testing (POCT) for winter viruses. Evaluations led by Dr. David Linden across Yorkshire, Humber, and the North West Coast implemented a test and treat POCT pathway for influenza and COVID-19 in care homes and GP practices. These pilots demonstrated that rapid POCT could cut diagnostic turnaround times from 3 days to just 20 minutes. The impact on care was immediate. Test results changed clinical decision-making in more than a third of cases, reduced antibiotic prescribing by 25%, and resulted in 0 hospital admissions among the tested patient cohort.⁶



Barriers to change

One of the most significant challenges is siloed budgeting. While primary care and community providers may be asked to pay the upfront implementation costs of POCT pathways, the resulting savings - from fewer admissions and empty beds - are enjoyed by secondary care. This means that local organisations are asked to invest for benefits realised elsewhere.

Governance and interoperability also remain major challenges. In many areas, community-generated diagnostic data still cannot flow seamlessly into hospital laboratory systems or national surveillance infrastructure, forcing reliance on fragmented and manual processes. Questions also remain around accountability and oversight, particularly concerning whether hospital pathology services retain governance responsibility for diagnostic devices deployed outside acute settings.

Pathology services form an integral component of Community Diagnostic Centres (CDCs). From monitoring heart disease to checking kidney function or diagnosing diabetes, the centres bring diagnosis and treatment into community settings. These centres are also instrumental in tackling health inequalities, delivering improved access to diagnostic testing, reduced waiting times and earlier diagnosis for patients.

Yet, workforce capacity remains a limiting factor. It is impossible to realise the programme's benefits without adequate staffing to operate CDCs. Currently, CDCs rely on a rotation model due to short staffing. It is unclear how the programme plans to expand the workforce to meet demand and how NHS England's Long Term Workforce Plan will play into this.



Tackling winter pressures on the NHS

Winter pressures on the NHS are frequently intensified by seasonal influenza and COVID-19 cases, which increase hospitalisations and place a significant burden on secondary care services.⁷ Almost 600,000 beds were occupied by patients with COVID-19, flu, RSV, or norovirus over winter 2024/25.⁸

Recent pilot programmes across GP surgeries, care homes (see Figure 1), and Acute Respiratory Infection (ARI) hubs demonstrate that integrating rapid, 20-minute POC testing directly addresses this challenge. These pilots achieved a three-fold win for patients, the NHS budget, and the wider healthcare system:

- The pilots successfully prevented an estimated 17 hospital admissions, 4 deaths, and 1 ICU admission - directly protecting frontline hospital beds when the system needed them most.⁹
- Antibiotic resistance costs the NHS approximately £180 million annually. This new pathway provided immediate diagnostic clarity, driving a 25% reduction in inappropriate antibiotic prescribing.⁹
- Performing the test on-site bypassed the need to send samples to centralised hospital labs, improving turnaround time for results, especially for those in rural settings.⁹

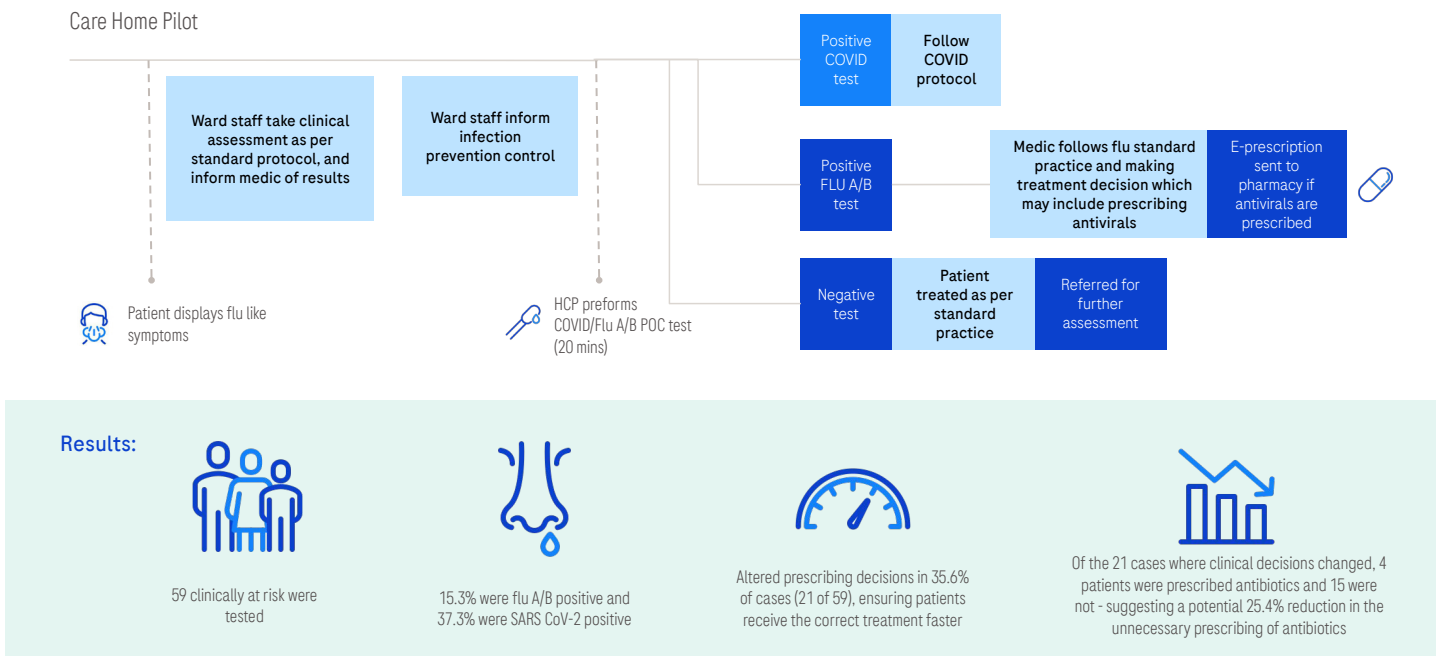


Figure Pathway detailing the collaborative working pilot project between Roche Diagnostics, Roche Products and Health Innovation Yorkshire and Humber. This pathway built a larger evidence base across 21 sites in West Yorkshire. Full case reports of each pathway evidencing these benefits are available on request.

2. From analogue to digital

As the NHS moves from analogue to digital ways of working across diagnostics and care delivery, digital pathology represents one of the most consequential shifts - transforming tissue analysis from a static, slide-based process into a data driven, networked system.

The UK's pathology workforce is facing a critical bottleneck. Nearly half (47%) of all consultants are over the age of 50, and with the average retirement age sitting at 63, the NHS faces a massive wave of retirements over the next decade.¹⁰

Against this backdrop, artificial intelligence (AI) is no longer a luxury. It is a vital tool to keep the system running. By using digital pathology platforms backed by AI, labs can automatically sort routine samples from urgent ones. This allows overstretched pathologists to focus their time and expertise where it matters most: on complex, highrisk cases.

The goal of AI is not to replace human doctors, but to enhance their capabilities. For example, in breast cancer cases, AI can precisely measure specific biomarkers, such as HER2, helping clinicians choose the most effective, tailored immunotherapies for patients. Furthermore, while finding genetic mutations traditionally required slow, expensive molecular testing, AI models can now analyse standard biopsy slides and predict these underlying mutations almost instantly.

Ultimately, the impact of AI goes far beyond just saving time. By reviewing routine slides at lightning speed and spotting critical genetic markers - such as the BAP1 mutation in eye melanomas - directly from standard tissue images, AI is fundamentally reshaping how we diagnose and treat disease.





Barriers to change

Analogue-first infrastructure continues to hold the system back. Many NHS trusts still rely on outdated IT systems and fragmented Laboratory Information Management Systems (LIMS), with limited interoperability across regions. This prevents the seamless sharing of digital workloads and slows the development of networked pathology services.

Data storage and sustainability present an emerging challenge. Digital pathology generates extremely large datasets, and the energy demands associated with long-term storage and AI model training raise important questions about alignment with NHS net zero and carbon reduction commitments.

The skills gap remains a critical constraint. Pathologists and laboratory teams will require structured upskilling in digital informatics, AI interpretation and validation if these tools are to be safely and confidently embedded into routine practice. There is also understandable concern within the workforce about whether AI could displace clinical roles. However, the emerging consensus across pathology and digital health is that AI is more likely to shift the nature of the work than remove it - automating repetitive, low complexity tasks while increasing the demand for specialist clinical judgement in complex cases. In this model, the pathologist's role becomes more focused, not less essential, but only if training,

professional development and workforce planning evolve in step with the technology.

For the digital shift to succeed, we must mandate a 'single sign-on' diagnostic record. This ensures that whether a test is taken in a pharmacy, a CDC, or a hospital, the data follows the patient seamlessly, enabling real-time, multidisciplinary decision-making.

This, and the ambition for the NHS App to be the primary digital front door for all health records, both require major investment in IT interoperability across the health service.

One of the most significant barriers to digital adoption is the fragmented nature of NHS procurement. Proven innovations often take years to move from a successful pilot in one Integrated Care Board (ICB) to routine use nationwide. We welcome the proposed NHS Innovator Passport for MedTech. This mechanism must be used to fast-track validated AI algorithms, bypassing redundant local evidence-gathering and ensuring that patients in every part of the country benefit from the latest advances simultaneously.

Helen's experience of uveal melanoma

In 2019, at her annual check-up with her optician, Helen, 57, was told there was an unusual looking 'bruise' at the back of her left eye. Her optician referred her urgently to the eye clinic at her local hospital. Here they took scans and photographs of the retina and referred her to one of four Ocular Oncology Centres for diagnosis.

At her ocular oncology appointment, after more scans and images of the eye, Helen was diagnosed with uveal melanoma, a very rare malignant melanoma of the choroid in the eye. It affects about 5 in a million of the adult population.¹¹ She had surgery the following day to fit a radioactive plaque, which stayed in place for 5 days, then she returned 6 weeks later to have a biopsy taken of the tumour. The tiny tumour sample was examined for cell type and genetic abnormalities. This histology, along with tumour size, can indicate the risk of spread to other tissues or organs in the body. This aggressive disease has a 50% chance of spread, mostly to the liver, despite successful treatment of the eye.¹¹

Helen was very relieved to receive a good prognosis from her biopsy and is still free of metastatic disease after 7 years.

Patients with uveal melanoma are followed up for many years after treatment and a wealth of data accumulates. Patients can consent for their

data to be available to the Liverpool Ocular Oncology Research Group and their EYE-CAN-AID Bioresource, to improve future patient care.

EYE-CAN-AID is short for Eye Cancer Artificial Intelligence Digital Bioresource, which is an initiative led by Prof. Sarah Coupland, to improve early detection of rare eye cancers.

EYE-CAN-AID is a collaboration between the University of Liverpool, AROTech, NPIC, and Roche Diagnostics, with the latter providing a state-of-the art, high-resolution scanner, for digitising the glass slides of the uveal melanomas for further analysis using AI. It also stores several thousand funduscopy images of the patient's eyes as well as MRI surveillance liver scans, all with the aim of benefiting patients by improving diagnosis and treatment pathways.

EYE-CAN-AID would ultimately like to connect three supra-regional eye cancer centres across NHS England, integrating clinical, radiological, histological, and genetic data of consented patients, creating what would be an invaluable and unique data resource.

Using AI-driven analysis, researchers will develop better diagnostic tools, ensuring faster, more precise, and personalised treatments.





3. From sickness to prevention

The real opportunity for the NHS lies in moving diagnostics upstream - from detecting disease to preventing it altogether. IVDs sit at the centre of this transition, enabling earlier detection, risk stratification and preventative models of care that intervene before disease becomes advanced, complex and costly.

The drive towards cervical cancer elimination illustrates this shift in practice. Recent data highlights that the HPV vaccine has already reduced the risk of death from cervical cancer, and for the first time on record, no women in their early 20s in England died from the disease between 2020 and 2024.¹² The combination of HPV vaccination and accessible cervical screening offers a opportunity to eliminate cervical cancer by 2040.

However, traditional cervical screening uptake has been falling, particularly among younger and more underserved populations.¹³ Developments in cervical screening, such as HPV self-sampling, could change that trajectory by removing some of the most persistent barriers to access - including time, inconvenience, discomfort and, for some patients, previous trauma or anxiety around pelvic examinations. It also offers a more inclusive route into screening for communities that conventional programmes consistently fail to reach.

Research has found that offering a self-sampling kit opportunistically in general practice achieved a 55% return rate, successfully engaging people with a cervix who were either never screened or significantly overdue.¹⁴ This suggests that convenience and autonomy are not peripheral factors, they are central to improving uptake and helping to reduce inequality in preventive care.

A similar example is demonstrated by the Bowel Cancer Screening Programme (BCSP). Expansion of the BCSP, by lowering the screening age from 60 to 50, with the faecal immunochemical test (FIT) offered to individuals aged 50 to 74, aims to detect bowel cancer earlier. The introduction of at-home FIT kits potentially facilitates early detection, and could lead to more individuals being diagnosed at earlier stages, potentially increasing the volume of biopsies and subsequent histopathological examinations.

However, scaling predictive and preventative screening at population level is not without challenges. A shortage of pathologists and other essential diagnostic professionals is a barrier to expanding cancer screening. Effective programmes must ensure timely diagnosis and access to treatment, but each screening test has limitations, highlighting the need for improved methods.

Barriers to change

Public understanding remains a major barrier. Health literacy around screening is often limited, with many patients still mistakenly believing screening is designed to detect existing cancer rather than identify early risk before disease develops.

Operational logistics are another constraint. Large-scale self-sampling programmes require robust systems for distribution, tracking and result integration to ensure kits are returned, samples are valid, and results are seamlessly incorporated into patient records without adding administrative burden to general practice.

Finally, incentive structures in primary care are not always aligned with prevention. Reaching under-screened and marginalised populations is often the most time-intensive aspect of screening programmes, yet current funding and performance frameworks do not consistently reward this additional effort.



Diana's experience of cervical screening

Diana, from Gateshead, had always attended her cervical screening appointments despite finding them uncomfortable. In February 2023, one routine test proved life-changing: her HPV screen identified early stage 1A1 cervical cancer.

Because the cancer was detected at such an early stage, treatment was minimally invasive. Abnormal cells were removed using laser ablation, preventing the need for more extensive intervention. Diana said:

“The staff at the GP surgery, then at the hospital clinic have all been wonderful. I’ve benefitted so much by having this screening - it meant that the cancer wasn’t advanced. It’s not something I’m worried about coming back, because I know it’ll be dealt with early.”

She has since urged others not to delay screening:

“Don’t be put off. If I hadn’t gone when I had, the cancer could have spread. But going when I did meant it has been as straightforward as possible.”

Her experience sits against a backdrop of declining cervical screening uptake nationally. Currently, one third of the eligible population across the UK remains unscreened or overdue for cervical cancer screening.¹⁵



Emma's experience of bowel cancer

After turning 50 in December 2024 and becoming eligible for bowel cancer screening, Emma, from Liverpool, received a FIT test in the post the following month, which she completed and posted off.

"I received a letter inviting me for a telephone conversation with a nurse. They asked if I wanted a colonoscopy, which I then had.

I was diagnosed with stage 2 bowel cancer on 4 February 2025 – World Cancer Day. I’d had no symptoms. I was in utter shock. I had an operation six weeks later to remove my large intestine, part of my small intestine and my appendix, as a tumour was found on that too. There wasn’t a lot I could do. I was in the hands of my consultant, who was amazing.

I’m no longer in treatment, but I am worried every day that my cancer will come back. There’s not a minute that passes by when I don’t think about it. The leaflets provided by Bowel Cancer UK were helpful.”



Calls to action

To transform this vision into reality, we urge policy stakeholders to commit to the following recommendations:

For the Department of Health and Social Care (DHSC):

1. All Pathology Networks must achieve Level 3 Digital Maturity (full digital scanning and reporting) by 2029, to unlock the technology funding promised in the 10 Year Plan.
2. Provide a clear roadmap outlining how mandated funding for NICE-approved technologies will scale to cover diagnostics.
3. Establish a dedicated Pathway Transformation Fund to support local providers in redesigning their services to embed new IVDs into their patient pathways and maximise their benefits.
4. IVDs and the use of AI in pathology should be included in the Innovator Passport scheme to fast-track proven innovations and bypass fragmented local procurement hurdles.

For Regulatory and Health Technology Assessment Bodies (MHRA/NICE):

Review how IVDs are evaluated and standardise the Value Assessment Framework. Assessments should measure total pathway efficiency and long-term savings - such as reduced bed days, avoided isolation costs, and averted antibiotic use - rather than just the upfront cost-per-test.

For NHS England:

1. Mandate a 'single sign-on' diagnostic record. This will allow pathologists to instantly view digital slides across different trust boundaries, ending the postcode lottery of specialist expertise.
2. Reinvest 10% of the savings generated from reduced hospital admissions (achieved through early diagnostic tools, like respiratory POCT) directly back into frontline pathology staffing, infrastructure, and community rollout.

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Roche Diagnostics Limited

Charles Avenue, Burgess Hill, West Sussex, RH15 9RY

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