NICE National Institute for Health and Care Excellence

Putting NICE guidance into practice

Resource impact report:
Haematological cancers: improving outcomes (update) (NG47)

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1 Introduction

1.1 This report looks at the resource impact of implementing NICE's guideline on Haematological cancers: improving outcomes (update) in England.

1.2 The guideline might have resource implications at a local level because of variation in clinical practice across the country. Therefore, we encourage organisations to evaluate their own practices against the recommendations in the NICE guideline and assess costs and savings locally. Some of the resource implications are discussed in this report.

1.3 Haematological cancer services are commissioned by clinical commissioning groups and NHS England. Providers are NHS hospital trusts.

2 Background

2.1 Haematological malignancies are a diverse group of cancers that affect the blood, bone marrow, and lymphatic systems. The main categories are lymphoma, myeloma, leukaemia, myelodysplastic syndromes and myeloproliferative neoplasms, and these vary in prevalence, incidence and survival rates. There are also borderline conditions such as aplastic anaemia and other non-malignant bone marrow failure syndromes (which overlap with hypoplastic myelodysplastic syndrome), and suspected cutaneous lymphomas that need specialised facilities for diagnosis and treatment.

2.2 An estimated 38,000 people per year are diagnosed with haematological cancers in the UK (Haematological Malignancy Research Network).

2.3 Haematological cancers accounted for 8.4% of all cancers (excluding non-melanoma skin cancer) diagnosed in England

between 2001 and 2010 (National Cancer Intelligence Network). In 2013 in the UK there were approximately:

- 12,800 new cases of non-Hodgkin's lymphoma
- 8,600 new cases of leukaemia
- 4,800 new cases of myeloma
- 1,845 new cases of Hodgkin's lymphoma (Cancer Research UK).

2.4 Specialist integrated haematological malignancy diagnostic services (SIHMDS) were recommended in the 2003 NICE guidance on improving outcomes in haematological cancers, and were specified in the Cancer Peer Review Measures for England. Because of slow implementation, additional guidance was issued by the Department of Health in 2012. These recommendations have still not been implemented fully.

3 Recommendations with potential resource impact

Potential areas for additional local costs

Specialist integrated haematological malignancy diagnostic services

3.1 Since the publication of the original NICE guidance on improving outcomes in haematological cancers in 2003, there has been progressive and variable adoption of specialist integrated haematological malignancy diagnostic services (SIHMDS). Production of integrated diagnostic reports is not well established in all centres, and some SIHMDS are co-located while others are networked. The guideline states that integrated reporting is most likely to be achieved through a co-located model (recommendation 1.1.1).

3.2 Health economics modelling by the guideline development centre found that co-located and networked SIHMDS cost £261 and £279

per diagnosis respectively. Both types of SIHMDS were significantly more cost effective than local reporting, because they made fewer incorrect diagnoses. In areas that don't have a SIHMDS, there may be additional capital costs for co-located SIHMDS or set-up costs for an integrated IT reporting system for networked SIHMDS. Capital and set-up costs were not included in the health economics modelling.

3.3 Services may have to make staffing changes to follow the recommendations on SIHMDS. Recommendation 1.1.2 states that SIHMDS should have a formally appointed SIHMDS director who is responsible for the operation of the service, including the design of the diagnostic pathway, resource use and reporting standards. Additional PAs in clinical job plans may be needed to deliver this role. Other staff roles may need to be expanded or reduced, depending on how current services differ from the recommendations in the guideline. This will have to be assessed locally.

Isolation facilities for adults and young people who are at risk of neutropenia

3.4 There may be capital costs from setting up inpatient isolation facilities for adults and young people aged 16 and over if the infrastructure is not in place (recommendations 1.2.3 and 1.2.4). There may also need to be staffing changes as services adapt to having inpatient isolation facilities.

Potential areas for local savings

Restructure of haematology units

3.5 Local haematology units may need to be reorganised to meet the recommendation to provide high-intensity chemotherapy to a minimum of 10 patients per year (recommendation 1.2.2). Some smaller units may need to close and some larger units may need to increase capacity, and there may be some savings from economies

of scale. Nursing and medical staff rotas would need changing, and staff may need to move between organisations.

Providing ambulatory care to reduce length of stay

3.6 The guideline recommends that haematology departments consider ambulatory care for some adults and young people who are having chemotherapy (recommendations 1.2.13–1.2.15). This can be done by giving chemotherapy in a day ward, with patients either staying at home or at accommodation provided by the hospital. Patients would only be admitted as an inpatient when clinically necessary.

3.7 Despite accounting for less than 10% of all cancer diagnoses, haematological cancers cause the highest inpatient bed occupancy of all cancers, and are the most costly to treat (National Cancer Services Analysis Team).

3.8 There may be capital costs from providing the day ward facilities and appropriate local accommodation. The benefit of this would be an improvement in provider productivity by creating additional hospital bed capacity through avoiding inpatient admission and reducing length of stay. The bed day cost of haematological cancer is estimated to be £380 for each bed day saved (averaged NHS Reference Costs 2014/15).

About this resource impact report

This resource impact report accompanies the NICE guideline on Haematological cancers: improving outcomes (update) and should be read in conjunction with it. See terms and conditions on the NICE website.

This report is written in the following context

This report represents the view of NICE, which was arrived at after careful consideration of the available data and through consulting healthcare professionals. The report is an implementation tool and focuses on the recommendations that were considered to have a significant impact on national resource use.

Assumptions used in the report are based on assessment of the national average. Local practice may be different from this, and the impact should be estimated locally.

Implementation of the guidance is the responsibility of local commissioners and providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this resource impact product should be interpreted in a way that would be inconsistent with compliance with those duties.

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