

# Haematological cancers

Quality standard

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This standard is based on NG47, NG52 and NG35.

This standard should be read in conjunction with QS124, QS120 and QS55.

## Quality statements

Statement 1 People with haematological cancer have an integrated report produced by a specialist integrated haematological malignancy diagnostic service (SIHMDS) that is shared with the haemato-oncology multidisciplinary team (MDT).

Statement 2 Young people and adults with specific subtypes of non-Hodgkin lymphoma have staging using fluorodeoxyglucose-positron emission tomography-CT (FDG-PET-CT).

Statement 3 Young people and adults with localised stage 2A follicular lymphoma have local radiotherapy as first-line treatment.

Statement 4 Young people and adults who have completed their treatment for non-Hodgkin lymphoma or myeloma have a discussion about their end-of-treatment summary plan.

# Quality statement 1: Integrated reporting

## Quality statement

People with haematological cancer have an integrated report produced by a specialist integrated haematological malignancy diagnostic service (SIHMDS) that is shared with the haemato-oncology multidisciplinary team (MDT).

## Rationale

An integrated diagnostic report containing all the information relevant to managing a person's condition is important to reduce duplication and avoid any contradictions that may arise when investigations are carried out in separate laboratories. Prompt sharing of integrated reports with the haemato-oncology MDT is vital for making decisions about management and will aid communication and co-working. However, when there is urgent clinical need, SIHMDS should release provisional laboratory reports before the integrated report is produced.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## Structure

Evidence of local arrangements to ensure that people with haematological cancer have an integrated report produced by a SIHMDS, containing all clinical information relevant to management, that is shared with the haemato-oncology MDT.

**Data source:** Local data collection.

## Process

a) Proportion of people with haematological cancer who have an integrated report

produced by a SIHMDS.

Numerator – the number in the denominator who have an integrated report produced by a SIHMDS.

Denominator – the number of people with haematological cancer.

**Data source:** Local data collection.

b) Number of integrated reports produced by a SIHMDS that are shared with the haemato-oncology MDT.

Numerator – the number in the denominator that are shared with the haemato-oncology MDT.

Denominator – the number of SIHMDS integrated reports.

**Data source:** Local data collection.

## **Outcome**

Discontinuation of treatment.

**Data source:** Local data collection.

## **What the quality statement means for different audiences**

**Service providers** (specialist regional centres) ensure that organisations and departments take responsibility for establishing appropriate management structures that oversee laboratory processes and the quality of diagnostic reporting, and audit the production of SIHMDS-validated integrated reports for people with haematological cancers and the sharing of these with the haemato-oncology MDT.

**Healthcare professionals** (such as the SIHMDS director and the SIHMDS haematopathologist) are responsible for reporting standards and overseeing the production of the integrated reports that include all the diagnostic information relevant to

managing haematological cancers. These reports are shared with the haemato-oncology MDT. The haematopathologist establishes the order in which the different results are included in the report and presented to the MDT, and can explain the report.

**Commissioners** ensure that they commission services in which SIHMDS produce validated integrated reports for people with haematological cancers and share them with the relevant haemato-oncology MDT.

**People with blood cancer** have all of their test results and other information about their diagnosis included in a single report that is shared with their specialist team.

## Source guidance

Haematological cancers: improving outcomes. NICE guideline NG47 (2016), recommendations 1.1.2 and 1.1.3

## Definitions of terms used in this quality statement

### Integrated report

A single IT system-generated report summarising all elements of laboratory diagnosis for a specific patient episode, based on available results for haematological cytology, histopathology, immunophenotyping by flow cytometry, cytogenetics, fluorescence in situ hybridisation (FISH) and molecular genetics, in accordance with the current WHO diagnostic classification. A process for validating the report, including double-reporting, and internal audit and cross-checking of results, is recommended before final authorisation. [Adapted from NICE's guideline on haematological cancers, addendum and recommendations 1.1.3, 1.1.4, 1.1.8 and 1.1.9]

### Haemato-oncology MDT

Each haemato-oncology MDT should include sufficient core members for the following people to be present in person or remotely (for example, via video conferencing) at every meeting:

- Haemato-oncologists (either haematologists or some medical oncologists): at least two who specialise in each tumour type being discussed at that meeting (for example,

leukaemia or lymphoma) and at least one from each hospital site contributing to the MDT.

- Haematopathologist: at least one haematopathologist from the SIHMDS should be present to provide the diagnostic information.
- Nurses: at least one clinical nurse specialist, also ward sisters from hospitals that provide high-intensity chemotherapy.
- Palliative care specialist: at least one palliative care specialist (doctor or nurse) who liaises with specialists from other sites. If, because of staff shortages or location, a palliative care specialist cannot regularly attend MDT meetings, the MDT should be able to demonstrate that it reviews patients regularly with such a specialist.
- Support staff: staff to organise team meetings and provide secretarial support.

Teams established to manage people with lymphoma should include the following additional core members, who should be fully and regularly involved in MDT discussions:

- Clinical oncologist: at least one.
- Radiologist: at least one, who liaises with radiologists at other sites.

Teams responsible for managing people with myeloma should include at least one radiologist who liaises with radiologists at other sites and is fully and regularly involved in MDT discussions. Teams that care for people with myeloma should have rapid access to oncologists for palliative radiotherapy, although it is not necessary for clinical oncologists to regularly attend team meetings. [Adapted from [NICE's guideline on haematological cancers](#), recommendations 1.3.9 to 1.3.11]

# Quality statement 2: Staging using FDG-PET-CT

## Quality statement

Young people and adults with specific subtypes of non-Hodgkin lymphoma have staging using fluorodeoxyglucose-positron emission tomography-CT (FDG-PET-CT).

## Rationale

Imaging before treatment is important to define the disease stage and enable appropriate therapy. Metabolic imaging with FDG-PET-CT is more accurate than CT imaging alone for detecting the disease site in several specific histological subtypes of non-Hodgkin lymphoma.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## Structure

Evidence of local arrangements to ensure that young people and adults with specific subtypes of non-Hodgkin lymphoma have staging using FDG-PET-CT.

**Data source:** Local data collection.

## Process

a) Proportion of young people and adults with stage 1 diffuse large B-cell lymphoma who have staging using FDG-PET-CT.

Numerator – the number in the denominator who have staging using FDG-PET-CT.

Denominator – the number of young people and adults with stage 1 diffuse large B-cell lymphoma.

**Data source:** Local data collection.

b) Proportion of young people and adults with stage 1 or localised stage 2 follicular lymphoma for whom radiotherapy would be technically possible who have staging using FDG-PET-CT.

Numerator – the number in the denominator who have staging using FDG-PET-CT.

Denominator – the number of young people and adults with stage 1 or localised stage 2 follicular lymphoma for whom radiotherapy would be technically possible.

**Data source:** Local data collection.

c) Proportion of young people and adults with stage 1 or 2 Burkitt lymphoma with other low-risk features who have staging using FDG-PET-CT.

Numerator – the number in the denominator who have staging using FDG-PET-CT.

Denominator – the number of young people and adults with stage 1 or 2 Burkitt lymphoma with other low-risk features.

**Data source:** Local data collection.

## Outcome

a) Number of young people and adults with specific subtypes of non-Hodgkin lymphoma who have accurate staging.

**Data source:** Local data collection.

b) Treatment appropriate to the subtype of non-Hodgkin lymphoma.

**Data source:** Local data collection.

## What the quality statement means for different audiences

**Service providers** (specialist regional centres) have processes in place to ensure that young people and adults with specific subtypes of non-Hodgkin lymphoma have FDG-PET-CT for staging.

**Healthcare professionals** (such as clinical oncologists) use FDG-PET-CT for accurate staging of specific subtypes of non-Hodgkin lymphoma in young people and adults.

**Commissioners** ensure that they commission services in which young people and adults with specific subtypes of non-Hodgkin lymphoma have FDG-PET-CT for staging.

**Young people and adults with certain types of non-Hodgkin lymphoma** have a special scan called a FDG-PET-CT scan to show where the cancer cells are in the body and confirm the stage of the cancer. FDG-PET-CT scans are particularly useful for people who have been diagnosed with types of lymphoma called large B-cell lymphoma, follicular lymphoma and Burkitt lymphoma.

## Source guidance

Non-Hodgkin lymphoma: diagnosis and management. NICE guideline NG52 (2016), recommendation 1.2.1

## Definitions of terms used in this quality statement

### Young people and adults

16 years and over.

### Specific subtypes of non-Hodgkin lymphoma

FDG-PET-CT imaging should be offered to young people and adults with:

- stage 1 diffuse large B-cell lymphoma

- stage 1 or localised stage 2 follicular lymphoma for whom radiotherapy would be technically possible (if the disease is thought to be encompassable within a radiotherapy field)
- stage 1 or 2 Burkitt lymphoma with other low-risk features.

[Adapted from [NICE's guideline on non-Hodgkin lymphoma: diagnosis and management, recommendation 1.2.1](#)]

# Quality statement 3: First-line treatment for localised stage 2A follicular lymphoma

## Quality statement

Young people and adults with localised stage 2A follicular lymphoma have local radiotherapy as first-line treatment.

## Rationale

Localised radiotherapy is the most effective first treatment for young people and adults with localised stage 2A follicular lymphoma. It has low toxicity and has the potential to cure a minority of young people and adults with this type of lymphoma.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## Structure

Evidence of local arrangements to ensure that young people and adults with localised stage 2A follicular lymphoma have local radiotherapy as first-line treatment.

**Data source:** Local data collection.

## Process

Proportion of young people and adults with localised stage 2A follicular lymphoma who receive local radiotherapy as first-line treatment.

Numerator – the number in the denominator who receive local radiotherapy as first-line treatment.

Denominator – the number of young people and adults with localised stage 2A follicular lymphoma.

**Data source:** [National Radiotherapy Dataset](#) and local data collection.

## Outcome

Survival rates for young people and adults with localised stage 2A follicular lymphoma.

**Data source:** Local data collection.

## What the quality statement means for different audiences

**Service providers** (secondary care NHS hospital trusts) have processes in place to ensure that young people and adults with localised stage 2A follicular lymphoma are referred to radiotherapy services, which provide local radiotherapy for first-line treatment of lymphoma.

**Healthcare professionals** (such as clinical oncologists) perform local radiotherapy as first-line treatment for young people and adults with localised stage 2A follicular lymphoma.

**Commissioners** ensure that they commission services in which young people and adults with localised stage 2A follicular lymphoma have local radiotherapy as first-line treatment for lymphoma.

**Young people and adults with stage 2A follicular lymphoma** in one area of the body ('localised') have radiotherapy focused on that area as their first treatment option.

## Source guidance

[Non-Hodgkin lymphoma: diagnosis and management. NICE guideline NG52 \(2016\), recommendation 1.3.1](#)

## **Definition of terms used in this quality statement**

### **Young people and adults**

16 years and over.

# Quality statement 4: End-of-treatment summary plan

## Quality statement

Young people and adults who have completed their treatment for non-Hodgkin lymphoma or myeloma have a discussion about their end-of-treatment summary plan.

## Rationale

Discussing the end-of-treatment summary plan with a person who has had treatment supports self-management and awareness of signs or symptoms of disease recurrence. It can also alert people to some of the possible late effects of their treatment and possible long-term psychological and emotional problems, such as depression and anxiety, which can occur after treatment.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## Structure

Evidence of local arrangements to ensure that young people and adults who have had treatment for non-Hodgkin lymphoma or myeloma have a discussion about their end-of-treatment summary plan when they complete their treatment.

**Data source:** Local data collection.

## Process

a) Proportion of young people and adults who have completed their treatment for non-Hodgkin lymphoma and who have a discussion about their end-of-treatment summary

plan.

Numerator – the number in the denominator who have a discussion about their end-of-treatment summary plan.

Denominator – the number of young people and adults who have completed their treatment for non-Hodgkin lymphoma.

**Data source:** Local data collection.

b) Proportion of young people and adults who have completed their treatment for myeloma and who have a discussion about their end-of-treatment summary plan.

Numerator – the number in the denominator who have a discussion about their end-of-treatment summary plan.

Denominator – the number of young people and adults who have completed their treatment for myeloma.

**Data source:** Local data collection.

## Outcome

a) Young people and adults with non-Hodgkin lymphoma or myeloma feel supported to self-manage their condition.

**Data source:** Local data collection.

b) Early identification of treatment-related morbidity in young people and adults with non-Hodgkin lymphoma or myeloma.

**Data source:** Local data collection.

## What the quality statement means for different audiences

**Service providers** (specialist regional centres) ensure that processes are in place for

young people and adults with non-Hodgkin lymphoma or myeloma to discuss their end-of-treatment summary plan with a member of their haemato-oncology multidisciplinary team (MDT).

**Healthcare professionals** (such as clinical nurse specialists and other members of the haemato-oncology MDT) have a discussion with young people and adults with non-Hodgkin lymphoma or myeloma about their end-of-treatment summary plan, highlighting personal and general risk factors, including late effects related to their lymphoma subtype, myeloma or its treatment.

**Commissioners** ensure that they commission services in which young people and adults with non-Hodgkin lymphoma or myeloma discuss their end-of-treatment summary plan with a member of their haemato-oncology MDT.

**Young people and adults who have finished their treatment for non-Hodgkin lymphoma or myeloma** discuss their end-of-treatment summary plan with a member of their specialist team. This includes explaining the tests and treatments the person had and whether there may be ongoing side effects or side effects that may appear months or even years after treatment. It also includes how to spot signs that might suggest the cancer is coming back.

## Source guidance

- [Non-Hodgkin lymphoma: diagnosis and management. NICE guideline NG52 \(2016\)](#), recommendations 1.13.1 and 1.14.1
- [Myeloma: diagnosis and management. NICE guideline NG35 \(2016, updated 2018\)](#), recommendation 1.1.1

## Definitions of terms used in this quality statement

### Young people and adults

16 years and over.

## End-of-treatment summary plan

Includes personal and general risk factors, such as late effects related to lymphoma subtype, myeloma and/or its treatment as follows:

- heart damage
- peripheral neuropathy
- cognitive disorders
- second cancers
- infertility
- endocrine (hormonal) problems
- bone and joint damage
- chronic tiredness
- lifestyle factors – exercise, diet and smoking
- inability to do day-to-day tasks.

[Adapted from [NICE's guideline on non-Hodgkin lymphoma](#), full guideline and recommendation 1.14.1]

# Update information

## Minor changes since publication

**June 2026:** Changes have been made to align this quality standard with the update to [NICE's guideline on non-Hodgkin lymphoma: diagnosis and management](#). Source guidance, definitions and links have been updated throughout.

## About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See our [webpage on quality standards advisory committees](#) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard 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 quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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## Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

## Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Bloodwise](#)
- [British Nuclear Medicine Society \(BNMS\)](#)
- [Royal College of General Practitioners \(RCGP\)](#)
- [Royal College of Physicians \(RCP\)](#)
- [Royal College of Pathologists](#)