NICE National Institute for Health and Care Excellence

NICE quality standard

Haematological cancers

Quality standard

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This standard is based on NG47 and NG52.

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

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

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

NICE has developed guidance and a quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services) which should be considered alongside these quality statements.

Other quality standards that should be considered when commissioning or providing haematological cancer services include:

- Suspected cancer (2016) NICE quality standard 124
- Medicines optimisation (2016) NICE quality standard 120
- Cancer services for children and young people (2014) NICE quality standard 55.

A full list of NICE quality standards is available from the quality standards topic library.

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

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 (such as clinical commissioning groups) 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 (2016) NICE guideline NG47, 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, 1.3.10 and 1.3.11]

Quality statement 2: Staging using FDG-PET-CT

Quality statement

Young people and adults with specific subtypes of non-Hodgkin's 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's lymphoma.

Quality measures

Structure

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

Data source: Local data collection.

Process

a) Proportion of young people and adults with stage I 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 I diffuse large B-cell lymphoma.

Data source: Local data collection.

b) Proportion of young people and adults with stage I or localised stage II 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 I or localised stage II follicular lymphoma for whom radiotherapy would be technically possible.

Data source: Local data collection.

c) Proportion of young people and adults with stage I or II 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 I or II 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's lymphoma who have accurate staging.

Data source: Local data collection.

b) Treatment appropriate to the subtype of non-Hodgkin's 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's 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's lymphoma in young people and adults.

Commissioners (clinical commissioning groups) ensure that they commission services in which young people and adults with specific subtypes of non-Hodgkin's lymphoma have FDG-PET-CT for staging.

Young people and adults with certain types of non-Hodgkin's 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's lymphoma: diagnosis and management (2016) NICE guideline NG52, 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's lymphoma

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

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

[Adapted from NICE's guideline on Non-Hodgkin's lymphoma: diagnosis and management recommendation 1.2.1]

Quality statement 3: First-line treatment for localised stage IIA follicular lymphoma

Quality statement

Young people and adults with localised stage IIA 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 IIA 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

Structure

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

Data source: Local data collection.

Process

Proportion of young people and adults with localised stage IIA 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 IIA follicular lymphoma.

Data source:National Radiotherapy Dataset and local data collection.

Outcome

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

Commissioners (clinical commissioning groups) ensure that they commission services in which young people and adults with localised stage IIA 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's lymphoma: diagnosis and management (2016) NICE guideline NG52, 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's 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

Structure

Evidence of local arrangements to ensure that young people and adults who have had treatment for non-Hodgkin's 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's 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's 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's 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's 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's 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's 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 (clinical commissioning groups) ensure that they commission services in which

young people and adults with non-Hodgkin's 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's lymphomaor 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's lymphoma: diagnosis and management (2016) NICE guideline NG52, recommendations 1.9.1, 1.10.1 and 1.11.1
- Myeloma: diagnosis and management (2016) NICE guideline NG35, 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's lymphoma, full guideline and recommendation 1.11.1]

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.

Information about how NICE quality standards are developed is available from the NICE website.

See quality standard advisory committees on the website for details of standing committee 1 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the quality standard's webpage.

This quality standard has been incorporated into the NICE pathway on blood and bone marrow cancers and non-Hodgkin's lymphoma.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

- overall survival of haematological cancers
- treatment-related morbidity of haematological cancers

- quality of life of people with haematological cancers
- patient management of haematological cancers.

It is also expected to support delivery of the Department of Health's outcome frameworks:

- NHS outcomes framework 2016–17
- Public health outcomes framework for England, 2016–19.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact report for the NICE guideline on haematological cancers to help estimate local costs.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and equality assessments 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
- Royal College of General Practitioners (RCGP)
- Royal College of Physicians (RCP)
- Royal College of Pathologists