NATIONAL COLLABORATING CENTRE FOR CANCER (NCC-C)

Haematological Cancers: Improving outcomes

First Guideline Committee (GC) meeting

8th & 9th July 2015

Board Room, NCC-C, Park House, Greyfriars Road, Cardiff

GROUP MEMBERSHIP & ACTION LIST

GC Members	
Dr Fergus Macbeth (FM) (Chair)	Professor John Snowden (JS)
Dr Clare Rowntree (CR)	Dr Christopher Dalley (CD)
Dr Deepak Mannari (DP)	Dr Geoff Shenton (GS)
Mrs Sarah Steele (SS)	Dr Andrew Jack (AJ)
Dr Bhuey Sharma (BS)	Dr Christopher McNamara (CM)
Dr Mike Scott (MS)	Dr Nia Angharad Evans (NE)
Ms Barbara Von Barsewisch (BVB)	John Reeve (JRe)
Ms Marie Waller (MW)	
Alan Chant (AC)	
NCC-C Staff	
John Graham (JG)	Andrew Champion (AC) *(day 2)*
Nathan Bromham (NB)	Matthew Prettyjohns (MP)
Susan O'Connell (SOC)	Stephanie Arnold (SA)
Lianne Gwillim (LG)	Steven Oliver (SO) *(Day 1 & ½ day 2)*
Verity Bellamy (VB) *(Day 1)*	
NICE Staff	
Katie Perryman Ford *(Day 1)*	Laura Sandler *(Day 1)*
James Hall (JH) *(Day 2)*	
Apologies	
Professor John Radford (JRa)	Jonathan Pearce (JP)
Dr Elizabeth Soilleux (ES)	Andrew Champion (AC) *(day 1)*
Katie Perryman Ford *(Day 2)*	

	Action list	**Owner**	**By**
1.	Needs assessment team to consider including 'what barriers exist for not implementing the IOG' within a needs assessment questionnaire.	Verity Bellamy Steven Oliver	On-going
2.	Needs assessment team to provide a summary of the area the needs assessment work will focus on for this update.	Verity Bellamy Steven Oliver	03.09.15
3.	LG to circulate the current version of Improving Outcomes in Haematological Cancers service guidance to the GC.	Lianne Gwillim	07/08/2015
4.	Guideline Committee to review the original guidance to ensure that there are no recommendations within the chapters that are to be removed/kept that relate to the recommendations being updated by the group.	Guideline Committee	28/08/15
5.	SOC to identify any recommendations from Improving outcomes in Children and Young people with Cancer guidance can be referred	Susan O'Connell	03.09.15

	to within the updated Haematological cancer IOG.		
6.	SA to re-check search and sift and check papers for topic A to ensure that children were included.	Stephanie Arnold	17/07/15
7.	SOC to re-check sift for topic A to ensure papers relating to children are included in review.	Susan O'Connell	17/07/15
8.	GS to send SOC a list of names and papers that may need to be included in the evidence review for topic A.	Geoff Shenton	07/08/15
9.	SOC to review the average for discordance rates with the papers identified for topic A and present to the GC at the next meeting.	Susan O'Connell	07/08/15
10.	SOC to remove the paper with the highest rate of discordance from the evidence review for topic A.	Susan O'Connell	17/07/15
11.	SOC to contact subgroup for topic A with any further queries.	Susan O'Connell	
12.	SOC to update evidence review for topic A and present results at the next meeting	Susan O'Connell	
13.	LG to circulate electronic version of the evidence for topic A. (This is for information only).	Lianne Gwillim	07/08/15
14.	AJ to review and update the background for topic A.	Andrew Jack	07/08/15
15.	JS to contact David Barnett regarding using UKNEQAS data source for topic A.	John Snowden	07/08/15
16.	CR to draft the background for topic B.	Clare Rowntree	21/08/15
17.	CR and subgroup to create a table of toxicity for topic B and send to SOC.	Clare Rowntree (lead) Nia Evans John Snowden Christopher Dalley Deepak Mannari	ASAP
18.	SOC to pull information from the Patient Experience Survey and present the results with the evidence for topic B.	Susan O'Connell	On-going
19.	SOC to circulate the revised PICO for topic B.	Susan O'Connell	17/07/15
20.	MP to submit the HE plan for Haematological cancers, improving outcomes to NICE.	Matthew Prettyjohns	ASAP

	Agreed
1.	The GC agreed to remove the paper (Chang et al) with the highest rate of discordance from the evidence review for topic A.
2.	It was agreed that the subgroup for topic A is, Andrew Jack (Lead), Mike Scott, Chris McNamara, Geoff Shenton, Chris Dalley, Elizabeth Sollieux and John Reeve.
3.	The GC agreed the review question, PICO and contacts for topic B.
4.	The GC agreed with the contents of the health economic plan for Haematological cancers, improving outcomes.

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REPORT OF DISCUSSIONS AT THE MEETING

Wednesday 8th July 2015

1.1 Agenda item 1: Introductions and declarations of interest

FM welcomed everyone to the 1st meeting of the Haematological cancers: Improving outcomes guideline committee (GC) meeting and thanked the GC members for volunteering for the group. Each member of the group introduced themselves and gave a background to where they are from and what they do.

Apologies for absence were received from Professor John Radford (JRa), Jonathan Pearce (JP), Dr Elizabeth Soilleux (ES), Andrew Champion (AC) (day 1) and Katie Perryman Ford (Day 2)

FM advised the GC that the meetings are recorded solely to help with writing up of the minutes.

FM gave a brief overview of the NICE conflict of interest policy to the group and noted that some GC members had already declared interests in their applications. These were as follows **(Document 1)**:

- NE declared that she is the lead pharmacist on a CRUK trial management group for AML18, and provides expert pharmacy input, responds to queries. Involved in checking the drug information and dosages were correct in the development of the trial protocol. This interest was categorised as non-personal financial, non-Specific meaning that NE can declare and participate in discussion on all topics because not industry funded.
- NE declared that she is the lead pharmacist and involved in developing the trial protocol for a CRUK trial management group for UKALL14. This interest was categorised as non-personal financial, non-Specific meaning that NE can declare and participate in discussion on all topics because not industry funded.
- MW declared that she received honoraria from Eusa Pharma for giving a lecture on state of the art management of post-BMT complications, psychological late effects of transplantation. This interest was categorised as personal financial, non-specific. Meaning that MW can declare and participate in discussion on all topics as state of the art management of post-BMT complications, psychological late effects of transplantation is not being investigated by the guideline.
- MW declared that she received reimbursement of travelling expenses and subsistence from EBMT UK for helping with the administration of an education study day. This interest was categorised as personal financial, non-specific meaning that MW can declare and participate in discussion on all topics as expenses not beyond a reasonable amount.

- MW declared that she is a member of the EBMT UK nurses group. This interest was categorised as personal Non-financial, non-specific. Meaning that ME can declare and participate in discussions on all topics, due to chair persons action.
- MW declared that she is a committee member of the trust board charity. This interest was categorised as personal non-financial, non-specific. Meaning that MW can declare and participate in discussions on all topics, due to chair person's action.
- GS declared that he is the principal investigator and member of the trial management group for MyeChild 01: Induction: daunoxome v mitoxantrone, Consolidation: Fludarabine/Cytarbine v high dose cyosine arabinoside, SCT conditioning. Funded by the University of Birmingham and the NCRI. This interest was categorised as non-personal financial, specific. Meaning that GS can declare and participate in discussion on all topics because not industry funded.
- GS declared that he is the principal Investigator and Co-investigator for the UK for the InteReALL Sr and HR trial for relapsed acute lymphoblastic leukaemia. Funded by the University of Birmingham and the NCRI. This interest was categorised as, non-personal financial, specific. Meaning that GS can declare and participate in discussion on all topics because not industry funded.
- GS declared that he is the principal Investigator for Blinotunomab for relapsed leukaemia trial. Funded by Amgen. This interest was categorised as, non-personal financial, specific. Meaning that GS can declare and participate in discussions on all topics as no supervisory responsibility on trials.
- GS declared that he is a member of the I=BFM resistant disease working party. This interest was categorised personal as Non-financial, non-specific meaning that GS can declare and participate in discussions on all topics, due to chair person's action.
- GS declared that he is a member of the UKCCSG (UK Children's Cancer Study Group now Children's Cancer and Leukaemia Group (CCLG) Bone Marrow Transplant Committee. This interest was categorised personal as Non-financial, non-specific meaning that GS can declare and participate in discussions on all topics, due to chair person's action.
- GS declared that he is a member of the Medical Research Council (MRC) Childhood Leukaemia Working Group (now CCLG Leukaemia Group. This interest was categorised personal as Non-financial, non-specific meaning that GS can declare and participate in discussions on all topics, due to chair person's action.
- GS declared that he is a member of the Yorkshire and Humber Bone Marrow Transplant Executive. This interest was categorised as personal Non-financial, non-specific meaning that GS can declare and participate in discussions on all topics, due to chair persons.
- GS declared that he is a member of the NCRI Paediatric Leukaemia CSG (ALL and AML subgroups). This interest was categorised as personal Non-financial, non-specific meaning that GS can declare and participate in discussions on all topics, due to chair persons.
- CD declared that he attended an advisory board organised by Novartis for Iron chelation therapy in low risk MBS. This interest was categorised as Personal financial, Non-Specific, meaning that CD can declare and participate in discussion on all topics as Iron chelation therapy in low risk MBS is not being investigated by the guideline
- CD declared that he is Co-signatory for the departmental budget for training and education of department staff. Income is primarily from patient donations (but not Pharma). This interest was categorised as Non-personal financial, Non-specific, meaning that CD can declare and participate in discussion on all topics because not industry funded.
- CD declared that he is a member of the BMT clinical reference group. This interest was categorised as Personal Non-financial, Non-specific, meaning that CD can declare and participate in discussions on all topics, due to chair person's action.

- CD declared that he is a member of the UK MDS executive. This interest was categorised as Personal Non-financial, Non-specific, meaning that CD can declare and participate in discussions on all topics, due to chair person's action.
- CD declared that he is a member of the UK NEQAS Executive for Leukocyte and immunophenotyping. This interest was categorised as Personal Non-financial, Non-specific, meaning that CD can declare and participate in discussions on all topics, due to chair person's action.
- CD declared that he is a member of the MDS, NCRI group for clinical trials. This interest was categorised as Personal Non-financial, Non-specific, meaning that CD can declare and participate in discussions on all topics, due to chair person's action.
- CD declared that he was lead author on a published article for the Journal of Clinical Pathology on Specialist Integrated haematological malignancy diagnostic services: an Activity Based Cost (ABC) analysis of a networked laboratory service model. This interest was categorised as Personal Non-financial, specific, meaning that CD can declare and participate in discussions on all topics, due to chair person's action.
- BVB declared that she attended an advisory board organised by Roche on Subcutaneous administration of Mabtherea feedback from Clinical Nurse Specialists. This interest was categorised as Personal Non-financial, Non-specific. Meaning that BVB can declare and participate in discussion on all topics as Mabtherea feedback is not being investigated by the guideline.
- BVB declared that she is a member of the London Haematological Oncology Nurses Forum. This interest was categorised as Personal Non-financial, Non-specific, meaning that CD can declare and participate in discussions on all topics, due to chair person's action.
- DM declared that he received an honorarium from Celgene for chairing a meeting on the management of myeloma and myelodysplasia. This interest was categorised as Personal financial, Non specific meaning that DM can declare and participate in discussion on all topics as management of myeloma and myelodysplasia is not being investigated by the guideline.
- DM declared that he received an honorarium from Amgen for chairing a meeting on the management of immunothrobocytopenia. This interest was categorised as Personal financial, Non specific, meaning that DM can declare and participate in discussion on all topics as management of immunothrobocytopenia is not being investigated by the guideline.
- CR declared that she received an honorarium from Roche for attending an advisory board on GA101 in CLL. This interest was categorised as Personal financial, Non specific meaning that CR can declare and participate in discussions on all topics as expenses not beyond a reasonable amount.
- CR declared that she received an honorarium from Amgen for attending an advisory board on Blimatumomab in ALL. This interest was categorised as Personal financial, Non specific meaning that CR can declare and participate in discussions on all topics as expenses not beyond a reasonable amount.
- CR declared that she received an honorarium Amgen for giving a lecture on ALL in the elderly at the British Society for Haematology. This interest was categorised as Personal financial, Non specific meaning that CR can declare and participate in discussions on all topics as expenses not beyond a reasonable amount.
- CR declared that she is local PI on MABCUTE trial (randomized study comparing maintenance therapy with subcutaneous rituximab continued until progression with observation only in patients with relapsed or refractory, indolent non-Hodgkin's lymphoma who completed and responded to rituximab-based immunochemotherapy induction and initial 2-year rituximab maintenance therapy administered subcutaneously). Funded by Roche. Trial is closed and in follow-up. No involvement in designing trial protocol. This interest was categorised as Non-personal financial,

specific meaning that DR can declare and participate in discussions on all topics as individual has no supervisory responsibility for the trial.

- CR declared that she is local PI on ECHELON-1 trial (A Randomized, Open-label, Phase 3 Trial of A+AVD Versus ABVD as Frontline Therapy in Patients with Advanced Classical Hodgkin Lymphoma). Funded by Millennium Pharmaceuticals Ltd. No involvement in designing trial protocol. This interest was categorised as non-personal financial, specific meaning that CR can declare and participate in discussions on all topics as individual has no supervisory responsibility for the trial.
- CR declared that she is a member of the trial management group for the UKALL 14 (A randomized trial for adults with newly diagnosed acute lymphoblastic leukaemia). Funded by CTAAC. Involved in designing the trial protocol. This interest was categorised as non-personal financial, specific meaning that CR can declare and participate in discussions on all topics because not industry funded.
- CR declared that she is a member of the trial management group for the UKALL 2011 (United Kingdom National Randomised Trial for Children and Young Adults with Acute Lymphoblastic Leukaemia and Lymphoma 2011). Funded by Leukaemia & Lymphoma Research. Involved in designing the trial protocol. This interest was categorised as non-personal financial, specific meaning that CR can declare and participate in discussions on all topics because not industry funded.
- CR declared that she is a member of the trial management group for the UKALL 60+ (A Phase 2 study for older adults with Acute Lymphoblastic Leukaemia). Funded by CRUK. Involved in designing the trial protocol. This interest was categorised as non-personal financial, specific meaning that CR can declare and participate in discussions on all topics because not industry funded.
- CR declared that she is a member of the Teenage Cancer Trust advisory board. Advises on how to invest in research. This interest was categorised as Personal Non-financial, specific, meaning that CD can declare and participate in discussions on all topics, due to chair person's action.
- CM declared that he is principle investigator for the GALLIUM trial on rituximab versus GA101 in combination with chemotherapy in first-line follicular and marginal zone lymphoma. Funded by NCR and Roche. Advised on setting up the laboratory diagnostics for patients participating in the trial, when the trial protocol was being determined. This interest was categorised as non-personal financial, specific, meaning that CM can declare and participate in discussions on all topics as individual has no supervisory responsibility for the trial.
- CM declared that he is local principle investigator for the PACIFICO trial (Alkylator Combination in Follicular lymphoma Immuno-Chemotherapy for Older patients: a phase III comparison of first-line R-CVP (rituximab, cyclophosphamide, vincristine and prednisone) versus R-FC (rituximab, fludarabine and cyclophosphamide). Funded by CTAAC. This interest was categorised as non-personal financial, specific, meaning that CM can declare and participate in discussions on all topics as individual has no supervisory responsibility for the trial.
- CM declared that he is local principle investigator for the REMoDLB trial (A randomised evaluation to see whether adding bortezomib to standard combination chemotherapy and rituximab (RCHOP) can improve progression free survival in diffuse large B-cell lymphoma with Bortezomib). Funded by Janssen Cilag Ltd. This interest was categorised as non-personal financial, specific, meaning that CM can declare and participate in discussions on all topics as individual has no supervisory responsibility for the trial.
- CM declared that he is local principle investigator for the RATHL trial (a multicentre randomised phase II study to assess response adapted therapy using FDG-PET imaging in patients with newly diagnosed, advanced Hodgkin's lymphoma). Funded by CRUK. This interest was categorised as non-personal financial, non-specific

meaning that CM can declare and participate in discussion on all topics because not industry funded.

- CM declared that he is local principle investigator for the RAPID trial (A randomised Phase III trial to determine the role of FDG-PET Imaging in Clinical Stages IA/IIA Hodgkin's Disease). Funded by Leukaemia and Lymphoma Research. This interest was categorised as non-personal financial, non-specific meaning that CM can declare and participate in discussion on all topics because not industry funded.
- CM declared that he is a medical advisor to the Lymphoma Association. This interest was categorised as personal non-financial, meaning that CM can declare and participate in discussions on all topics as interest is not specific to the content of the guideline
- AJ declared that he is a member of a the trial management group for a Phase III randomised clinical trial comparing rituximab given every 14 days with CHOP given every 21 days (R-CHOP 14 vs21) for patients with newly diagnosed diffuse large B Cell non Hodgkins Lymphoma. Funded by Cancer Research UK and Chugai Pharma Europe Ltd. This interest was categorised as non-personal financial, specific, meaning that AJ can declare and participate in discussions on all topics as no supervisory responsibility on trials.
- AJ declared that he is the principal investigator for a randomised evaluation of molecular targeted therapy with bortezomib in diffuse large B-cell lymphoma (REMoDL-B). Funded by Janssen-Cilag. This interest was categorised as non-personal financial, specific meaning that AJ can declare and participate in discussions on all topics as no supervisory responsibility on trials.
- AJ declared that he is the principal investigator for biomarker development and monoclonal antibodies for the treatment of lymphoma. Funded by Genentech Ltd. This interest was categorised as non-personal financial, specific meaning that AJ can declare and participate in discussions on all topics as no supervisory responsibility on trials.
- AJ declared that he is the principal investigator on a trial to compare remission rates of low grade non Hodgkin's lymphoma with GA101 vrs rituximab. Funded by Experimental Cancer Medicine (ECMC), Genentech Ltd, NCRN and Roche. This interest was categorised as Non-personal financial, specific meaning that AJ can declare and participate in discussions on all topics as no supervisory responsibility on trials.
- AJ declared that he is the principal investigator on the stratification of treatment by molecular and genetic sub-typing for diffuse large B-cell lymphoma. Funded by Leukaemia and lymphoma research. This interest was categorised as non-personal financial, specific meaning that AJ can declare and participate in discussions on all topics as no supervisory responsibility on trials.
- AJ declared that he represents the NCRI on the Lunenburg lymphoma biomarker consortium, the European and North American initiative for the development of biomarkers in clinical trials. This interest was categorised as personal non-financial meaning that AJ can declare and participate in discussions on all topics, due to chair person's action.
- AJ declared that his host Trust is contracted to provide diagnostic services for the GALLIUM trial to Roche. Responsible for supervising staff and ensuring the work is carried out to the required quality in line with the contract. This interest was categorised as non-personal financial, specific meaning that AJ can declare and participate in discussions on all topics as individual has no responsibility for the contract and does not provide any advice or opinion to Roche.
- AJ declared that as head of department was involved in a joint project between Host trust, 14M Genomics and University of York to develop new diagnostics in genomics, ceased involvement when no longer head of department in October 2014. This interest was categorised as Personal financial, Non-Specific meaning that AJ can

declare and participate in discussion on all topics as develop new diagnostics in genomics not being investigated by the guideline.

- SS declared that she volunteers as Treasurer for the Friends of West Suffolk Hospital. Responsible for keeping the books and part of the committee that decides how to spend the fund. Fund only used to support patients and staff of the hospital. This interest was categorised as Non-personal financial, non-Specific meaning that SS can declare and participate in discussions on all topics, due to chair person's action.

The GC were reminded that if they take on any new interests, these must be declared to the NCC-C as soon as they happen so that the necessary action can be taken.

1.2 Agenda item 2: Introduction to NICE and the role of the NICE Guideline Commissioning Manager (Presentation 1) – Katie Perryman-Ford

KPF gave an overview of NICE. KPF is the guideline commissioning manager for this guideline and is responsible for taking the guidance through validation and sign-off, so will attend meetings to help with her understanding of how the guidance is developed.

NOTED:

.1 NICE's is involved in:
- Evidence assessment and interpretation
- Economic evaluation and resource impact assessment
- Pathways, guidance and standards
- Web access for decision support and e-learning.

.2 Clinical guidelines describe the care of individuals by health and social care professionals, are based on the best available evidence of clinical and cost effectiveness, focus on the core management of diseases/conditions in the NHS, and take account of patient perspective.

.3 Guidelines are not intended to replace clinical judgement or as a textbook that covers everything about a particular condition. Neither are they a "wish list".

.4 The process by which clinical guidelines are developed includes the following:
- Topic is referred (this has already happened)
- Scope finalised (following consultation of draft with stakeholders, and for this guideline the areas identified for inclusion were those prioritised by stakeholders)
- Development of the guideline (reviewing evidence and drafting recommendations)
- Consultation of the guideline with registered stakeholders
- Validation of the guideline
- Publication and dissemination.

.5 The guidelines commissioning manager (GCM), overseas the guideline from start to finish, they support the guideline committee and guideline developers with any process issues. A GCM facilitates communication with other NICE guidance producing teams, such as the interventional programme, and technology appraisals, and also external organisations, such as national screening programmes.

.6 NICE has a public sector equality duty, and pays due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not, and foster good relations between persons who share a relevant protected characteristic and persons who do not. This duty came into force in April 2011 and age discrimination from 2012.

.7 When drafting recommendations the following protected characteristics must be taken into consideration:
- Race/ethnicity
- Disability

- Sex and gender
- Gender reassignment
- Sexual orientation
- Religion of belief
- Age
- Pregnancy and maternity.

.8 Several different versions of the guideline will be produced:

- The full guideline – this is written by the GC and will contain all the background, evidence and recommendations. The copyright is owned by the NCC-C.
- The short version, this is a cut down version of the full guideline containing only the recommendations.
- The NICE pathway – this is an electronic summary of all recommendations in a pathway format, it is not therefore a comprehensive pathway.
- Information for the public (IFP) – this is written by NICE and contains all of the guideline recommendations in lay terms.

.9 The support that is available to the GDG throughout the development process is:

- At the NCC-C:
  - The project team
- At NICE:
  - Centre for Clinical practice – contact is KPF
  - Editorial team – help to reword recommendations into NICE style
  - Patient and public involvement team (PPIP) – contact is LS
  - Communication Team
  - Implementation team
- Externally:
  - Stakeholders.

1.3 Agenda item 3: An overview of the development process (Presentation 2) – John Graham

JG gave an overview of how the NCC-C will support the GC in drafting its guidance on melanoma.

NOTED:

.1 The NCC-C is collaboration between a variety of organisations and is hosted by Velindre NHS Trust, in close collaboration with Cardiff University. The Management Board (represented by these organisations) meets quarterly to review progress.

.2 The role of the NCC-C is to develop service guidance and clinical practice guidelines on cancer topics for use in the NHS. The guidelines are based on evidence of clinical effectiveness and cost effectiveness. Guideline are not text books, they focus on what will improve practice.

.3 The current work program of the NCC-C is:

- Currently in development:
  - Melanoma – Publishing July 2015
  - Cancer of the upper aerodigestive track – Publishing in February 2016
  - Myeloma Publishing in February 2015
  - Non-Hodgkins Lymphoma – publishing in July 2016
- Recent Publications:
  - Neutropenic Sepsis Published September 2012
  - Familial Breast Cancer (update) Published June 2013
  - Prostate cancer (update) Published January 2014
  - Referral for suspected caner (update)
  - Bladder Cancer Published February 2015
  - Referral for suspected cancer Published June 2015

.4 An overview of the complete team NCC-C was given and the team working on the guideline was highlighted. The team working on this guideline are:

- Andrew Champion – Project lead
- Lianne Gwillim – Project Manager
- Stephanie Arnold – Information Specialist who carries out the literature searching
- Susan O'Connell –Researcher who reviews the evidence that the information specialist has found
- Matthew Prettyjohns – Health Economist

.5 JG reminded the GC that they must declare all interests to the NCC-C, and gave an overview of the types of interests, which are:

- Personal financial – specific and non specific
- Personal Non-financial - specific and non specific
- Non - Personal financial- specific and non specific

Anything that the GDG think could be a conflict should be declared, especially when relating to a pharmaceutical company or manufacturer. Declarations of interest are reviewed at each meeting. The importance of recording all declarations was stressed and JG advised that if in doubt please contact the NCCC team who will then determine if there are any conflicts of interest to be observed.

.10 JG reminded the group of the GC code of conduct, being accountable for their actions and respectful of all members of the group and their opinions. All discussions and documentation is to remain confidential and should not be disseminated Following today's meeting GC member's names will appear on the NICE website. As such, media and external groups may contact GC members. In this instance **all** contact should be referred to KPF who will pass the enquiry on to the Communications team at NICE to process. GC members should attend all GC meetings. Members who fail to attend on more than three occasions during development of the guideline will be asked to step down.

1.4 Agenda item 4: Timetable for guidance development and housekeeping – (Presentation 2) – Lianne Gwillim

LG gave an overview of the project management side of guideline development and the role of the GC members.

NOTED:

.1 GC paperwork is sent a week before the meeting by email and hardcopies of the papers to be provided at the meeting.

.2 Expenses policy, the key points of this policy are:

- Claims must be submitted to the NCC-C within three months of a GC meeting
- For rail travel the maximum amount the NCC-C will reimburse is for an open standard class ticket. Please take advantage of advanced tickets where possible. For subsistence please note we will not pay for alcohol (same for this evenings meal)
- All claims must be supported by receipts
- This evening's meal must be paid by each GC member and then claimed through the expenses policy. A meal up to the value of £15 can be claimed.

.3 The GC were given an overview of what has happened on the guideline so far:

- Chair and Clinical lead were both appointed in March 2015
- The draft scope was developed in March and June 2015
- Scope went out for stakeholder consultation from 8 November to 5 December 2013.
- Stakeholders consulted on the scope April 2015
- The GC were recruited May 2015

- Comments made by stakeholders were responded to and the scope was revised and returned to NICE in May 2015.
- The final scope was published on the NICE website on 5 February 2015 and is in today's meeting paperwork.

.4 The GC were also informed of keys dates during the guideline development process:

- Committee meeting dates:
  - 8th & 9th July 2015 (Wed & Thurs)
  - 3rd & 4th September 2015(Thurs & Fri)
  - 5th & 6th October 2015 (Mon & Tues)
  - 2nd & 3rd February 2016 (Tues & Wed) Final Meeting
- Submission of draft guideline – 22nd October 2015
- Consultation period – 30th November 2015 – 14th January 2016
- Submission of final guideline –26th February 2016
- Publication of guideline – 25th May 2016

.5 GC members will firstly agree the clinical questions that the guideline will cover, and then spilt into sub-groups to draft backgrounds for each topic, review the appraised evidence and draft recommendations. At the GC meetings the sub-group will present their draft recommendations and the rest of the GC will come to a consensus agreement on what these should be. GC members also help to write the guideline, and assist in responding to stakeholder comments and finally help launch and promote the guideline when published

.6 LG also reminded the group who the contacts for this guideline are.

1.5 Agenda item 5: Patient/Carer involvement in service guidance development (Presentation 4) – presented by Laura Sadler

LS gave an overview of the patient and public involvement programme at NICE.

NOTED:

.1 The Public Involvement Programme (PIP) are a dedicated team at NICE that supports the involvement of users of service, carers and the public across the NICE work programmes. Advises NICE and the collaborating centres on methods for involvement, identifies participants, and provides information training and support to lay people who engage with NICE.

.2 A patient/carer member brings different expertise to the group but everyone has equal status. Groups are based on mutual respect that each member has different perspectives, expertise and experience and that is why they have been recruited.

.3 Patient/Carer members help to:

- refine questions to guide searches for evidence
- Review the evidence
- Prepare guideline recommendations
- Advise on the "information for the Public" (IFP) version of the guideline

.4 During consideration of the evidence summaries and in drafting recommendations, patient and carer members can play a key role in raising issues important for them.

.5 Additional opportunities for patients and carer input to NICE guidelines are through the stakeholder consultation process.

.6 Patient/carer members sometimes have concerns that their involvement is tokenistic, worried if they will be listened to or being heard, lack research skills or training, 'fear of the unknown', worried about the use of qualitative evidence, concerned about time commitments and whether they will have access to papers and admin support. However, the following points can help avoid this:

- Avoiding jargon/explaining technical terms
- Equal status & amicable group working
- Offering a standing agenda item on patient/carer concerns
- Searches for and inclusion of qualitative data

- Dedicated training and support

1.6 Agenda item 6: Service Guidance Methods (Presentation 4) – Nathan Bromham

NB gave an overview of the processes involved in identifying research evidence for clinical guidelines.

NOTED:

1. Service Guidance covers how a service is configured, in terms of equipment and staffing, and also covers location, the setting for delivery, the economies of scale, and geographic variation of NICE guidelines are evidence based.

2. NB informed the GC of the NICE methods for developing service guidance that was updated by NICE in 2014, which involves:
- Scoping
- Developing review questions (In a PICO format, Population, Intervention, Comparison, Outcome)
- Finding the evidence
- Summarising the evidence
- Developing Recommendations

3. When finding evidence a search is performed using the PICO, the information specialist will search for published literature and also registries and audits. Other sources of obtaining evidence are using stakeholders, and using an iterative approach.

4. Once the evidence is found the reviewers will review this and document the study results, and quality and produce evidence statements that the GC can review to make recommendations.

5. When making recommendations, the GC can address or refer to:
- the resources needed for a service
- where patients should be treated or referred
- which staff should deliver the services
- how services should interact and share information

6. Recommendations are underpinned by a comprehensive review of the clinical evidence and also using results from economic models.

7. The GC will also need to document their justification for these recommendations with the linking evidence to recommendations tables.

1.7 Agenda item 7: Health Economics in NICE guidelines (Presentation 5) – Matthew Prettyjohns

MP gave an overview of how health economics are considered in service guidance.

NOTED:

.1 MP informed the GC that the aim of today's presentation is to highlight the need to incorporate economics and the principles of economics within the guidance.

.2 MP explained that the NHS faces a limited budget, but with lots of treatment options we need to decide which ones offer value for money and which ones don't.

.3 A common measure of effectiveness called Quality Adjusted Life Years (QALYs) because a QALY combines both quantity and health-related quality of life (QoL) into a single measure of health gain. The amount of time spent in a health state is weighted by the QoL score attached to that health state.
- QoL is usually scored with "perfect health =1 and death =0"

A QALY can weigh up net effect of treatment for patients and allow a broader comparison between patients groups.

.4 Typical costs used in a model are drug acquisition costs (usually sourced from the BNF), staff costs (e.g. GP visit), cost of medical procedures and cost of time spent in hospital.

These are all direct costs, indirect costs such as productivity lost due to time off work are not considered.

.5 The cost-effectiveness plane was presented to the GC. MP explained that ideally new interventions should be more effective and less costly. In reality, new treatments are often more effective but also more costly. What we don't aim for is new intervention that are less effective and more costly or new interventions that are less costly but also less effective.

.6 To decide if a more effective but more costly intervention is acceptable NICE consider an Incremental Cost Effectiveness Ratio (ICER), which can be compared against a 'willingness to pay' threshold. An ICER is calculated from the cost of alternatives, and the associated QALYs of those alternatives. The threshold is defined in terms of the amount that the payer is willing to pay for one additional QALY. The effectiveness depends on the literature, the evidence, expert views from the GC.

.7 MP informed the GC of the challenges with developing economic models in service guidance. The main challenge is the scale of the problem. There are vast questions covering complex service configurations, figuring out the current service configuration can be challenging and pooled disease areas covering difference conditions also makes matters challenging.

.8 Data limitations when developing a economic model for service guidance, may be that the evidence base is unlikely to be as well developed as that is typically seen in clinical guidelines and source cost data may prove to be challenging and typical sources may not applicable.

.9 In clinical guideline the ideal scenario is to quantify benefits in terms of quality adjusted life years (QALY's). However, it is often not possible to translate service outcomes into QALYs so alternative outcomes may need to be considered.

1.8 Agenda item 8: Needs Assessment – Verity Bellamy & Steven Oliver

Verity Bellamy, Head of Cancer Intelligence, Northern & Yorkshire Knowledge and Intelligence Team, Public Health England and Dr Steven Oliver a Senior Lecturer in Population Health Dept. of Health Sciences, University of York & Hull York Medical School will be carry out the needs assessment work for this guideline. A brief introduction was given and an overview of the areas that can be covered was also given.

NOTED:

.1 The needs assessment will provide background information which supports the need for this guideline. It will hopefully provide epidemiology and service provision data and aims to highlight possible variation and inequalities in the current services in Haematological cancers.

.2 Intention is to look for epidemiological information from 2003 to 2015.

.3 In 2003 regional based registries were set up, these will be helpful to assess cancer registry and HES data.

.4 Will be unable to categorise existing organisations to assist with levels of care.

.5 GC discussion took place on what information would be useful to include in the guideline.

.6 It was noted that the reasons why trusts have not implementing the would be useful information.

ACTION:

.7 Needs assessment team to consider including 'what barriers exist for not implementing the IOG' within a needs assessment questionnaire.

.8 Needs assessment team to provide a summary of the area the needs assessment work will focus on for this update.

1.9 Agenda item 9: Group discussion on scope (Document 3)

JS explained to the GC how the scope was developed and how topics were chosen. The GC had the opportunity to discuss the scope and the topics that will be covered.

NOTED:

.1 The scope was developed based on areas of the original document that needed to be updated, diagnosis and evaluation, organisation of specialist services and facilities necessary for provision of intensive chemotherapy.

.2 Groups that are covered by the scope are:

- All healthcare professionals that provide diagnostic and treatment services to the patient groups below, including clinical and scientific staff in secondary care.
- Adults (over 24 years), young people (16 to 24 years) and children (under 16 years) who are referred to secondary care with suspected haematological cancer.
- The staffing and facilities (levels of care) needed to treat haematological cancers in adults and young people.

.3 The staffing and facilities (levels of care) needed to treat haematological cancers in children (under 16 years) will not be covered in the updated guidance.

.4 The settings that the scope covers are all secondary and tertiary care services that provide NHS care to people with suspected or diagnosed haematological cancers.

.5 The key issues that that scope covers are:

- Providing a diagnostic service for diagnosing and managing haematological cancers for adults, young people and children:
  - Should centralised, integrated diagnostic reporting via Specialist Integrated Haematological Malignancy Diagnostic Services [SIHMDS] be the standard of care for diagnosing haematological cancers in all age groups?
  - What is the most effective way of providing an integrated diagnostic service (for example, co-located laboratory facilities that solely provide haematological cancer diagnosis or networked geographically separate facilities that may also provide other services)?
- The staffing and facilities (levels of care) needed to treat haematological cancers and support adults and young people who are having intensive non-transplant chemotherapy.
  - How should level of care be defined and categorised for people with haematological cancers who are having intensive (non-transplant) chemotherapy, considering:
    - diagnosis
    - comorbidities
    - medicine regimens
    - the management of medicine administration and toxicities?
  - What support facilities are needed at the different levels of care for people with haematological cancers who are having intensive (non-transplant) chemotherapy?

1.10 Agenda item 10: Improving outcomes in Haematological cancers (2003): An overview of original guidance recommendations. (Document 4)

NOTED:

.1 The chapters from the original guideline that will be updated are:

- Chapter 3: Diagnosis and evaluation
- Chapter 4: Organisation of specialist services
- Chapter 5: Treatment (excluding high-dose therapy) – Facilities necessary for provision of intensive chemotherapy

.2 Chapters from the published guideline that <u>will not be</u> <u>updated are:</u>

- Chapter 1: Access to care
- Chapter 2: Patient-centred care
- Chapter 7: Continuing management
- Chapter 8: Palliative care
- Chapter 9: Clinical trials and use of protocols

.3 Chapters from the published guideline that will be removed are:
- Chapter 5:Treatment (excluding high-dose therapy) – Treatment for specific forms of haematological cancer and Management of complications of chemotherapy
- Chapter 6: High-dose therapy

.4 The GC were asked to check the recommendations in the 2003 guidance to ensure that the chapters that are not being updated or are being removed do not contain any recommendations that relate to the areas that are being updated.

ACTION:

.5 LG to circulate the current version of Improving Outcomes in Haematological Cancers service guidance to the GC.

.6 GC to review the original guidance to ensure that there are no recommendations within the chapters that are to be removed/kept that relate to the recommendations being updated by the group.

1.11 Agenda item 11: Additional Best Practice Commissioning Guidance for developing haematology Diagnostic Services

NOTED:

.1 This document was produced by the British Committee for Standards in Haematology (BCSH) Clinical Haematology Task Force in 2009.

.2 This is an updated document to the 1995 guideline on levels of care relating to the provision of facilities for patients with haematological malignancies and severe bone marrow failure.

.3 A survey questionnaire was conducted of all haematologists in the UK and BSCH guideline takes into account these results.

.4 The additional best practice commissioning guidance for developing haematology diagnostic services covers,
- Levels of care
- Intensity and duration of treatment regimen
- Staffing
- Specialist Nurse Training
- Support facilities
- Arrangements for emergency care of patients with chemotherapy related complications

.5 The GC discussed this document and all how the services are currently run. It was noted that time to diagnosis was very important when considering services.

1.12 Agenda item 12: Facilities for the treatment of Adults with Haematological Malignancies – 'Levels of Care'

NOTED:

.1 It was noted that this document was a peer review driven document, and an attempt to re-write the original Haematological Cancers, Improving outcomes guidance in a language that could not be misinterpreted and it is an opinion based guideline.

.2 The guidance was drafted by the National Cancer Action Team (NCAT) and the Royal College of Pathologists to clarify the rationale of the Haematological Cancers, Improving outcomes guidance and by providing practical help in the form of service provision.

.3 It was noted that this document was not any more successful than the original document – however, it was published and promoted better.

.4 The GC discussed this document and also discussed the Improving outcomes in Children and Young people with Cancer guidance, and they felt that some of the recommendations should be cross-referred to in the updated guidance.

ACTION:

.5 SOC to identify any recommendations from Improving outcomes in Children and Young people with Cancer guidance can be referred to within the updated Haematological cancer IOG.

1.13 Agenda item 13: Close of day1

FM thanked the committee for all their input closed day 1 of the meeting.

Day 2 – Wednesday 9th July 2015

1.14 Agenda item 14: Welcome to day 2

FM welcomed the committee to day 2 and a special welcome was given to James Hall the NICE editor.

1.15 Agenda item 15: Group discussion on topic A: Providing a diagnostic service for diagnosing and managing haematological cancers for adults, young people and children (Document 7)

SOC presented a summary of the clinical evidence identified for the topic.

NOTED:

Clinical evidence

.1 The review questions for this topic are:

- A1 - Should integrated diagnostic reporting (via Specialist Integrated Haematological Malignancy Diagnostic Services [SIHMDS]) replace local reporting in the diagnosis of haematological malignancies?
- A2 - What are the effective ways of delivering integrated diagnostic reports (for example, co-located or networked) in the diagnosis of haematological malignancies?

.2 The PICO for these topics are:

PICO Table A1			
Population	**Intervention**	**Comparator**	**Outcomes**
Adults and young people (16 years and older) presenting with suspected haematological malignancies	Integrated diagnostic reporting via the specialist integrated haematological malignancy diagnostic services	Any other reporting	1. Time to diagnosis 2. Diagnostic accuracy 3. Staff satisfaction (e.g. De-skilling of pathologists)/ hematopathologists 4. Health related quality of life 5. Patient satisfaction
PICO Table A2			
Population	**Intervention**	**Comparator**	**Outcomes**
Adults and young people (16 years and older) presenting with suspected haematological malignancies	Co-located integrated diagnostic reporting Networked integrated diagnostic reporting	Each Other	1. Time to diagnosis 2. Diagnostic accuracy 3. Staff satisfaction (e.g. De-skilling of pathologists)/ hematopathologists 4. Health related quality of life Patient satisfaction

.3 The search identified 241 records, from which 159 were excluded and 0 additional records were identified. 82 articles were assessed for eligibility, 63 were then also excluded and 19 articles were included in the evidence review.

.4 A short checklist was used to assess the quality of the included studies and it was judged that the included evidence was of low quality. This was due to the included studies being retrospective case studies. None of the included studies directly compared integrated diagnostic services with other forms of diagnostic services.

.5 All studies that were included had the relevant population with either haematology patients or specific haematology subtypes.

.6 Identified studies broadly compared the rates of discordance in diagnosis of haematological malignancies between initial diagnosis and review diagnosis.

.7 It was unclear in the studies whether the expert pathologist were blinded to the initial diagnosis, this means there is a high risk of bias based on the potential lack of blinding.

.8 The outcomes reported in each study were not specifically listed in the PICO. The outcomes that were reported were considered to be of some use. These outcomes were, diagnostic discordance, change in management and survival.

.9 The evidence reported. 9 retrospective studies of either haematology or lymphoma populations, 2 of which were UK based, reported discordance rates

.10 Discordance rates between initial haematological pathological diagnoses and expert review ranged from 6%-60%.

.11 Revision of lymphoma type was the most common source of discord with discrepancy ranging from 6.5%-23% (2 studies)

.12 Major discrepancies, leading to a change in treatment or management were recorded in 4 retrospective studies

.13 Rate of discordance between an initial diagnosis and review diagnosis ranging from 14.8% to 55%.

.14 One retrospective study compared diagnostic outcomes between specialist haematology laboratories and other commercial laboratories

.15 Patients in the specialist laboratory cohort were more likely to undergo more complex diagnostic testing with 26% of patients undergoing molecular diagnostics compared with 9.3% in community based hospital laboratories.

.16 Patients in the specialist laboratory cohort were 23% more likely to reach a final diagnosis within a 30 day testing period when compared with community based hospital laboratories.

.17 One retrospective study evaluated the value of expert pathology review in terms of survival

.18 No statistically significant difference in 5 year survival between patients with a concordant diagnosis versus a discordant diagnosis (48% versus 53%)

.19 A retrospective study including 25 cases of Burkitt Lymphoma reviewed by 10 pathologists reported a direct correlation between level of experience and diagnosis.

.20 Expert lymphoma pathologists showing marginally higher concordance rates and general pathologists showing the lowest (κ=0.373 versus κ=0.138).

.21 Expert lymphoma pathologists were significantly more likely to make a correct diagnosis compared with both pathologists with experience (OR=3.14; p=0.012) and general pathologists (OR=5.3; p=0.00032).

.22 The GC discussed this evidence and it was queried whether the search included children, SA confirmed that children were not excluded in the initial search but may not have been included when sifting papers. SA and SOC confirmed that they will check the search and will also re-sift to ensure papers relating to children are included, GS also stated that he could send a list of potential papers/articles that may be included to SOC.

.23 The GC commented that they would like to know the average discordance rates in the papers – SOC confirmed that will review the papers and present this to group at the next meeting.

.24 The GC agreed that the paper with the highest rate of discordance should be removed from the review as they felt it was not applicable to the UK setting.

.25 SOC commented that she will update the evidence review based on discussion in todays meeting and will contact the subgroup with any further queries.

.26 The GC discussed the background for this topic and it was agreed that is does need updating, AJ will review and update this.

.27 It was commented that data UKNEQAS may be relevant to this topic and it was agreed that JS would contact David Barnett regarding using this data source.

Health Economic modelling for topic A

.28 MP commented that both clinical questions for topic A could be covered in a three-way cost-effectiveness analysis of the following strategies:

- Local reporting
- SIHMDS – co-located
- SIHMDS – networked

Although it may not be possible (or sensible) to compare the two SIHMDS against each other in this way.

.29 MP suggested that an alternative approach may be to compare SIHMDS against local reporting as one analysis, taking into account the factors that may lead to one choosing a networked or co-located approach as a separate analysis. The example that was given was we could estimate the number of patients required to justify a co-located approach could be estimated. This was done in previous guidance where 2 million figure was estimated

.30 The approach that could be taken for modelling this topic is, a diagnostic model approach, this topics could be treated as a diagnostic decision problem where accuracy data (sensitivity and specificity) drive differences in costs and QALYs. Sensitivity drives QALYs through differences in TPs and FNs (diagnosis delay): Specificity usually has a cost impact, this is not always a big factor but could be in this context, it is often difficult to source data comparing treated and untreated progression rates as most studies wouldn't make such a comparison for ethical reasons.

.31 The other approach would be to create a staging model, the issues with this approach is that it unlikely to be straightforward as typical diagnostic accuracy statistics do not give the full picture. The other issue is not just on whether patient has a haematological malignancy or not but whether the correct haematological malignancy was identified. The GC would need to consider the impact of diagnosing patient with the incorrect haematological malignancy. The model would follow a framework more typically seen in staging economic models. The key issue in this type of model is whether a change in stage actually affects patient management. If management is unaffected then there will be no change in effectiveness (QALYs). Essentially benefits are less tangible and are to do with giving more accurate diagnosis and prognosis.

.32 The key aspects required for analysis is the need for decent data on effectiveness, including accuracy and discrepancy rates, MP hopes it will be possible to model differences based on discrepancy rates and diagnostic accuracy from the evidence review. However, it may be necessary to rely upon non-comparative data.

.33 The ability to translate effectiveness data into cost-effectiveness outcomes is required, this could be done by following approaches typically used in diagnostic and staging type models. MP pointed out that the potential issue here could be identifying whether management will change as a result of change in diagnosis (from one type to another).

.34 Grouping haematological cancers together could cause problems, and average values may need to be used rather than consider them separately.

.35 The costs of the various approaches is usually one of the easier aspects of an analysis but it could be problematic for this topic as some cost data may not be widely available.

.36 MP summarised that there could be difficulties in differentiating between these two approaches on effectiveness grounds.

.37 In cost-effectiveness terms, if the two were equivalent in effectiveness then the cheaper option would be preferred.

.38 Discussion took place on what the question for topic A actually is, it was agreed that the question is local reporting versus Specialist Integrated Haematological Malignancy Diagnostic Services [SIHMDS] in either aspect that it is carried out.

.39 It was commented that the definition of integrated reported should be the same that is n the NCAT report.

.40

ACTION:

.41 SA to re-check search and sift and check papers for topic A to ensure that children were included.

.42 SOC to re-check sift for topic A to ensure papers relating to children are included in review.

.43 GS to send SOC a list of names and papers that may need to be included in the evidence review for topic A.

.44 SOC to review the average for discordance rates with the papers identified for topic A and present to the GC at the next meeting.

.45 SOC to remove the paper with the highest rate of discordance from the evidence review for topic A.

.46 SOC to contact subgroup for topic A with any further queries.

.47 SOC to update evidence review for topic A and present results at the next meeting

.48 LG to circulate electronic version of the evidence for topic A. (This is for information only).

.49 AJ to review and update the background for topic A.

.50 JS to contact David Barnett regarding using UKNEQAS data source for topic A.

AGREED:

.51 The GC agreed to remove the paper with the highest rate of discordance from the evidence review for topic A.

.52 It was agreed that the subgroup for topic A is, Andrew Jack (Lead), Mike Scott, Chris McNamara, Geoff Shenton, Chris Dalley, Elizabeth Sollieux and John Reeve.

1.16 Agenda item 16: The Role of the NICE guideline Editor (Presentation 8)

NOTED:

.1 JH introduced himself and informed the GC that todays presentation will cover, a brief description of the different versions of the guideline, the role of the editor and the main focus is on wording of the recommendations.

.2 NICE produces 2 different versions of the final guideline. These are,

- The NICE pathway which is an online summary of the recommendations, how they fit into the care pathway and how they relate to other NICE guidance on this and related topics
- Information for the public which is a summary of the recommendations for patients, family members and carers and the wider public. This will also be presented in the web format.

.3 NICE pathways aim to bring together all relevant guidance on one topic together into one place. It is laid out as an interactive flowchart so people can clearly see what is covered and navigate directly to the information they want.

.4 NICE pathways provides an easier and more intuitive way to find, access and use NICE guidance. For the first time, you do not need to understand how NICE classifies different types of guidance to view everything NICE has said on a particular topic.

.5 The information for the public version is aimed at patients, their families and carers. It gives an overview of what the recommendations say about the treatment and care

patients should receive (accurate translation of the guidance). It doesn't give a lot of detail about the disease or condition itself. The main principle of the patient version is that it is written very clearly so that people without extensive clinical knowledge can understand it.

.6 The NICE editor is available to help if advice is needed on recommendation wording at any point, and they will attend the final committee meeting during development.

.7 The editor also edits recommendations and other key sections in detail towards end of development (before consultation), and drafts information for the public and works with digital editor on the pathway; these are discussed at the editorial meeting

.8 They also attend the post-consultation meeting to advise on changes to recommendation wording, and edits any updated recommendations and other key sections after meeting.

.9 The NICE editor will also coordinates final steps to publication for all versions

.10 The editor doesn't edit the full guideline, only the short version, with focus on the recommendations.

.11 Towards the end of development the editor will ask for volunteers from the Committee to help with the pathway and 'Information for the public'. This involves attending the editorial meeting and checking final versions leading up to publication. More information will be circulated regarding this at a later stage.

.12 Recommendation in the guideline should:

- be clear, accurate and easy to understand
- focus on what the healthcare professional has to do
- include only the necessary information
- use plain English
- indicate the strength of the recommendation
- acknowledge patient involvement in decision making
- be clearly defined actions and circumstances
- follow NICE's standard advice when referring to drugs, especially in relation to off-label use

.13 Terms used in when writing recommendations are:

- 'Offer' for most interventions, tests and treatments
- 'Take', 'perform', 'do' for simple examinations such as blood pressure
- 'Use' or similar are usually fine for:
- technical details of a procedure the person couldn't be expected to have a view on
- emergency procedure, especially if the person is unconscious
- Usually don't need 'offer' for:
  – 'advise', 'discuss', 'tell'
  – 'refer'
- The term 'must' or 'must not' is only used where there is a legal duty to apply the recommendation.

.14 The term 'offer' (and similar words such as 'refer', 'advise' etc.) is used when the GC are confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective.

.15 The term 'consider' when we are confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective.

.16 The strength of a recommendation depends both on the quality of the evidence and on the balance of benefits and harms. There are degrees of certainty with which a Committee can make a recommendation. This certainty is determined by 3 key things:

- whether there is a legal duty to apply the recommendation (for example to be in line with health and safety legislation)
- the nature and quality of the evidence base (for example the risk of bias in the studies looked at, or the similarity of the patient populations covered)
- the relative benefits and harms of the intervention.

.17 Changes and suggestion will be made by the editor to clarify any ambiguities, simplify language, ensure that the guideline conforms to house style, and so on

.18 The edits should not change the meaning of recommendations

1.17 Agenda item 17: Agreeing the clinical question for topic B: The staging and facilities (levels of care) needed to treat haematological cancers and support adults and young people who are having intensive non-transplant chemotherapy.

Topic B1

NOTED:

.1 The clinical question should be, 'How should level of care be defined and categorised for people with haematological cancers who are having intensive (non-transplant) chemotherapy, defined as regimens that are anticipated to result in >7 days of neutropenia of >0.5 x10^9/L ….. considering:

- Diagnosis
- Comorbidities and frailty
- Medicine Regimens Management of medicine administration and toxicities

.2 The PICO for this topic is:

Population	Intervention	Comparator	Outcomes
Adults and young people (16 years and older) with haematological malignancies and receiving intensive, non-transplant chemotherapy resulting in >7 days of neutropenia of >0.5 x10^9/L	• Location of chemotherapy delivery (Local hospital, Specialist Centres/Units, Home setting, Community Clinics etc) • Level of in-patient isolation i.e. en-suite (NHS building specifications for isolation i.e. HBN4 or higher NHS/ international isolation specifications for immunocompromised patients, e.g HEPA filtration to protect against nosocomial infection. • Ability to effectively isolate other infectious patients to prevent nosocomial transmission of respiratory viral illnesses (e.g. influenza), Clostridium difficile and resistant organisms (VRE, MRSA, stenotrophomonas and others) • Ambulatory care ,permitting treatment from home or hospital apartments/hotels /Access to 24 hour helpline (part of peer review measure) • Staffing (levels, experience, chemo competency (trained) (medical/nursing/other HC Professionals)) • Centre size/specialism (number of patients treated, specialist expertise available (nutrition, psychological, physio-therapy), including on-site transplant expertise/facility in situations	Each Other	• Patient Satisfaction • Quality of Life • Survival Outcomes • Treatment related mortality • Treatment delay • ITU admission rates/discharge • Length of stay • Readmission rates • Infection levels (need for prophylactic anti-fungals, antivirals and antibiotics)

	where subsequent transplant is routinely considered, etc) • Access to ICU		

.3 This lead for this topic is Clare Rowntree (CR) who will draft the background to the topic and the subgroup for this question are Nia Evans (NE), John Snowden (JS), Chris Dalley (CD) and Deepak Mannari (DM).

.4 It was noted that a table showing the toxicity of the regimens would be useful for this topic.

Topic B2

NOTED:

.1 The clinical question should be, Does the level of care affect patient outcome for people with haematological cancers who are having intensive, non-transplant chemotherapy, considering;

- Location
- Staffing levels
- Centre size/specialism
- Level of in-patient isolation
- Ambulatory care
- Prophylactic anti-infective medications

.2 The PICO for this topic is:

Population	Intervention	Comparator	Outcomes
Adults and young people (16 years and older) with haematological malignancies and receiving intensive, non-transplant chemotherapy resulting in >7 days of neutropenia of $\geq 0.5 \times 10^9/L$	• Location of chemotherapy delivery (Local hospital, Specialist Centres/Units, Home setting, Community Clinics etc) • Level of in-patient isolation i.e. en-suite (NHS building specifications for isolation i.e. HBN4 or higher NHS/ international isolation specifications for immunocompromised patients, e.g HEPA filtration to protect against nosocomial infection. • Ability to effectively isolate other infectious patients to prevent nosocomial transmission of respiratory viral illnesses (e.g. influenza), Clostridium difficile and resistant organisms (VRE, MRSA, stenotrophomonas and others) • Ambulatory care ,permitting treatment from home or hospital apartments/hotels /Access to 24 hour helpline (part of peer review measure) • Staffing (levels, experience, chemo competency (trained) (medical/nursing/other HC Professionals)) • Centre size/specialism (number of patients treated, specialist expertise available (nutrition, psychological,	Each Other	• Patient Satisfaction • Quality of Life • Survival Outcomes • Treatment related mortality • Treatment delay • ITU admission rates/discharge • Length of stay • Readmission rates • Infection levels (need for prophylactic anti-fungals, antivirals and antibiotics)

	physio-therapy), including on-site transplant expertise/facility in situations where subsequent transplant is routinely considered, etc) • Access to ICU		

.3 This lead for this topic is Clare Rowntree (CR) who will draft the background to the topic and the subgroup for this question are Nia Evans (NE), John Snowden (JS), Chris Dalley (CD) and Deepak Mannari (DM).

.4 It was noted that a table showing the toxicity of the regimens would be useful for this topic,

.5 The GC agreed that information from the patient experience survey would be of benefit for this topic.

ACTION:

.6 CR to draft the background for topic B.

.7 CR and subgroup to create a table of toxicity for topic B and send to SOC.

.8 SOC to pull information from the Patient Experience Survey and present the results with the evidence for topic B

.9 SOC to circulate the revised PICO for topic B.

AGREED:

.10 The GC agreed the review question, PICO and contacts for topic B.

1.18 Agenda item 18: Health Economics

Health Economic Plan

NOTED:

.1 The health economic plan was presented the GC for review, no queries or comments were made, and the GC were happy for the review to be submitted to NICE.

ACTION:

.2 MP to submit the HE plan for Haematological cancers, improving outcomes to NICE.

AGREED:

.3 The GC agreed with the contents of the health economic plan for Haematological cancers, improving outcomes.

1.19 Agenda item 19: Any other business

NOTED:

.1 No additional business was raised.

1.20 Agenda item 20: Discussion area for next meeting

NOTED:

1. The discussion area for the next meeting will be drafting Recommendations for topics
- A1 & A2
- B1 & B2

1.21 Agenda item 21: Close of Meeting

FM thanked the GC for their input to the meeting. The GC were informed that the next meeting would be on **3rd & 4th September 2015,** starting at 10.45 at the board room, NCCC offices, 2nd Floor Park House, Greyfriars Road, Cardiff, CF10 3AF.