Haematological cancers

NICE quality standard

Draft for consultation

January 2017

This quality standard covers diagnosing and managing haematological cancers in adults and young people (aged 16 years and over). It also covers diagnostic reporting and the organisation of haematological cancer services for children, adults and young people (of all ages). It describes high-quality care in priority areas for improvement.

It is for commissioners, service providers, healthcare professionals, and the public.

This is the draft quality standard for consultation (from 11 January to 7 February 2017). The final quality standard is expected to publish in June 2017.

Quality statements

Statement 1 Young people and adults with haematological cancers have their specialist integrated haematological malignancy diagnostic services (SIHMDS) validated integrated report shared with the relevant haemato-oncology multidisciplinary team (MDT).

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

Statement 3 Young people and adults with localised stage IIA follicular lymphoma are offered first-line local radiotherapy.

Statement 4 Young people and adults with advanced-stage asymptomatic follicular lymphoma are offered rituximab induction therapy[1].

Statement 5 Young people and adults with diffuse large B-cell lymphoma that involves the breast, testis, adrenal gland or kidney, or with 4 or more risk factors for central nervous system relapse, are offered central nervous system-directed prophylactic therapy.

Statement 6 Young people and adults who have been treated for non-Hodgkin's lymphoma have a discussion about their end-of-treatment summary plan when they complete their treatment.

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.

[1] At the time of publication of the source guidance (July 2016) rituximab did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information. The evidence reviewed for the guideline supports the standard monotherapy dosage of 4 doses of 375 mg/m^2 at weekly intervals.

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.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?

Question 3 Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Question 4 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Quality statement 1: Integrated reporting

Quality statement

Young people and adults with haematological cancers have their specialist integrated haematological malignancy diagnostic services (SIHMDS) validated integrated report shared with the relevant haemato-oncology multidisciplinary team (MDT).

Rationale

An integrated report containing all information relevant to managing the patient's condition is important to reduce duplication and avoid potential contradictions that may arise when investigations are carried out in separate laboratories. It is vital that integrated reports are shared promptly with the relevant haemato-oncology MDT when management decisions are being made and before treatment starts. This will aid communication and co-working.

Quality measures

Structure

Evidence of local arrangements to ensure that young people and adults with haematological cancers have their SIHMDS validated integrated report shared with the relevant haemato-oncology multidisciplinary team (MDT).

Data source: Local data collection.

Process

Proportion of young people and adults with haematological cancers who have their SIHMDS validated integrated report shared with the relevant haemato-oncology multidisciplinary team (MDT).

Numerator – the number in the denominator who have their SIHMDS validated integrated report shared with the relevant haemato-oncology multidisciplinary team (MDT).

Denominator – the number of young people and adults with haematological cancers.

Data source: Local data collection.

Outcome

a) Assessment of the extent of the haematological cancers.

Data source: Local data collection.

b) Discontinuation of treatment.

Data source: Local data collection.

c) Effective joint working within the SIHMDS and with relevant healthcare professionals.

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 SIHMDS to produce validated integrated reports for young people and adults with haematological cancers and share them with the relevant haemato-oncology MDT.

Healthcare professionals (such as the SIHMDS director and specialist SIHMDS haematopathologist) produce a validated integrated report that are relevant to managing haematological cancers. These are shared with the appropriate haemato-oncology MDT, and the haematopathologist is available to explain the report. The SIHMDS director's responsibilities include ensuring an overall quality management system is in place, that includes laboratory processes, the quality of diagnostic reporting, auditing, and communication within the SIHMDS and with relevant healthcare professionals.

Commissioners (such as clinical commissioning groups) ensure that they commission services in which SIHMDS produce validated integrated reports for young people and adults with haematological cancers and share them with the relevant haemato-oncology MDT.

People under the care of a haematology specialist team 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

Validated integrated reports

A single IT system-generated report summarising all elements of laboratory diagnosis for a specific patient episode, based on available 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 report validation, including double reporting, and internal audit and cross checking of results, before final authorisation of the report is recommended.

[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 multidisciplinary team (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). 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, 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 patients 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 patients 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 patients with myeloma should have rapid access to oncologists for palliative radiotherapy, although it is not necessary for clinical oncologists to regularly attend team meetings.

[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 diagnosed with specific non-Hodgkin's lymphoma subtypes are offered staging using fluorodeoxyglucose-positron emission tomography-CT (FDG-PET-CT).

Rationale

Pre-treatment staging using imaging 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 disease site detection in several specific non-Hodgkin's lymphoma histological subtypes.

Quality measures

Structure

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

Data source: Local data collection.

Process

a) Proportion of young people and adults diagnosed with stage I diffuse large B-cell lymphoma by clinical and CT criteria who receive staging using FDG-PET-CT.

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

Denominator – the number of young people and adults diagnosed with stage I diffuse large B-cell lymphoma by clinical and CT criteria.

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 receive staging using FDG-PET-CT.

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

Numerator –the number in the denominator who receive 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) Accurate staging of young people and adults diagnosed with specific non-Hodgkin's lymphoma subtypes.

Data source: Local data collection.

b) Appropriate treatment in line with staging for non-Hodgkin's lymphoma subtypes.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (specialist regional centres) ensure that processes are in place so that young people and adults with specific non-Hodgkin's lymphoma subtypes are offered FDG-PET-CT to confirm staging.

Healthcare professionals (such as clinicians) offer FDG-PET-CT to young people and adults with specific non-Hodgkin's lymphoma subtypes to ensure that they are accurately staged.

Commissioners (clinical commissioning groups) ensure that they commission services in which young people and adults with specific non-Hodgkin's lymphoma are offered FDG-PET-CT to confirm staging.

Young people and adults with certain types of non-Hodgkin's lymphoma are offered a scan called a PET-CT scan to show where the cancer cells are in the body and confirm the stage of the cancer. 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 that are stage 1 and sometimes stage 2.

Source guidance

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

Definition of terms used in this quality statement

Specific non-Hodgkin's lymphoma subtypes

FDG‑PET‑CT imaging should be offered to people diagnosed with:

- stage I diffuse large B-cell lymphoma by clinical and CT criteria
- stage I or localised stage II follicular lymphoma for whom radiotherapy would be technically possible
- stage I or II Burkitt lymphoma with other low-risk features.

[Adapted from NICE's guideline on non-Hodgkin's lymphoma, recommendation 1.2.1]

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

Quality statement

Young people and adults with localised stage IIA follicular lymphoma are offered first-line local radiotherapy.

Rationale

Localised radiotherapy is the most effective initial treatment with low toxicity and the potential to cure lymphoma in young people and adults with localised stage IIA follicular lymphoma.

Quality measures

Structure

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

Data source: Local data collection.

Process

Proportion of young people and adults with localised stage IIA follicular lymphoma who receive first-line local radiotherapy.

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

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

Data source: National Cancer Data Repository and ONS merged Minimum Cancer Dataset (1990-2010), 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) ensure that processes are in place so that young people and adults with localised stage IIA follicular lymphoma are referred to radiotherapy services, which provide first-line local radiotherapy for lymphoma.

Healthcare professionals (such as clinical oncologists) offer 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 are offered first-line local radiotherapy for lymphoma.

Young people and adults with stage 2A follicular lymphoma in one area of the body ('localised') are offered 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

Quality statement 4: Rituximab induction therapy

Quality statement

Young people and adults with advanced-stage asymptomatic follicular lymphoma are offered rituximab induction therapy[2].

Rationale

Rituximab induction therapy is the optimal management strategy for advanced-stage asymptomatic follicular lymphoma. This is an active treatment that may lead to fewer patients needing further, more intensive chemotherapy for disease progression than a 'watch and wait' (observation without therapy) approach. An active approach may also help to reduce patient anxiety. At the time of publication of the NICE guideline on non-Hodgkin's lymphoma (July 2016) rituximab did not have a UK marketing authorisation for this indication.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that young people and adults with advanced-stage asymptomatic follicular lymphoma are offered rituximab induction therapy.

Data source: Local data collection.

Process

Proportion of young people and adults with advanced-stage asymptomatic follicular lymphoma who receive rituximab induction therapy.

Numerator – the number in the denominator who receive rituximab induction therapy.

[2] At the time of publication of the source guidance (July 2016) rituximab did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information. The evidence reviewed for the guideline supports the standard monotherapy dosage of 4 doses of 375 mg/m^2 at weekly intervals.

Denominator – the number of young people and adults with advanced-stage asymptomatic follicular lymphoma.

Data source: Local data collection.

Outcome

a) Progression-free survival for people with advanced-stage asymptomatic follicular lymphoma.

Data source: Local data collection.

b) Quality of life for young people and adults with advanced-stage asymptomatic follicular lymphoma.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (specialist regional centres) ensure that processes are in place so that young people and adults with advanced-stage asymptomatic follicular lymphoma are offered rituximab induction therapy, because this may slow progression of their disease and delay starting chemotherapy.

Healthcare professionals (such as clinical specialists) offer rituximab induction therapy to young people and adults with advanced-stage asymptomatic follicular lymphoma, and ensure ongoing monitoring is carried out for those having this treatment.

Commissioners (clinical commissioning groups) ensure that they commission services in which young people and adults with advanced-stage asymptomatic follicular lymphoma are offered rituximab induction therapy.

Young people and adults with advanced-stage (stage 3 or 4) follicular lymphoma without any symptoms are offered rituximab induction therapy. Rituximab is a type of drug that helps the immune system to destroy cancer cells. This means that it helps people stay well for longer, and treatment with chemotherapy can be started later.

Source guidance

Non-Hodgkin's lymphoma: diagnosis and management (2016) NICE guideline NG52 recommendation 1.3.4

Definitions of terms used in this quality statement

Advanced-stage follicular lymphoma

Stages III and IV of follicular lymphoma. In stage III, the lymphoma affects the lymph nodes both above and below the diaphragm (the spleen counts as a lymph node in this definition). In stage IV, the lymphoma is found in organs outside the lymph nodes and spleen, for example, the liver or bone.

[NICE's guideline on non-Hodgkin's lymphoma, Information for public]

Asymptomatic

Without obvious signs or symptoms of disease. Cancer may cause symptoms and warning signs, but, especially in its early stages, cancer may develop and grow without producing any symptoms.

[NICE's guideline on non-Hodgkin's lymphoma, appendix D, glossary]

Rituximab induction therapy

A type of antibody drug that helps the immune system to destroy cancer cells. In non-Hodgkin's lymphoma it is often used together with chemotherapy. Induction therapy is used on its own and given weekly for 4 weeks.

[Adapted from NICE's guideline on non-Hodgkin's lymphoma, Information for public]

Quality statement 5: Central nervous system prophylaxis

Quality statement

Young people and adults with diffuse large B-cell lymphoma that involves the breast, testis, adrenal gland or kidney, or with 4 or more risk factors for central nervous system relapse, are offered central nervous system-directed prophylactic therapy.

Rationale

Central nervous system prophylaxis aims to prevent people with diffuse large B-cell lymphoma having a central nervous system relapse. Central nervous system relapse in these patients occurs infrequently (approximately 5%), but it is a major complication with poor outcomes. The risk of relapse is higher in people with specific extranodal sites involving the breast, testis, adrenal gland and kidneys. In addition, the presence of 4 or 5 specified risk factors can also indicate a high risk of central nervous system relapse.

Quality measures

Structure

Evidence of local arrangements to ensure that young people and adults with diffuse large B-cell lymphoma that involves the breast, testis, adrenal gland or kidney, or with 4 or more risk factors for central nervous system relapse, are offered central nervous-system directed prophylactic therapy.

Data source: Local data collection.

Process

a) Proportion of young people and adults with diffuse large B-cell lymphoma that involves the breast who are offered central nervous system-directed prophylactic therapy.

Numerator – the number in the denominator who receive central nervous system-directed prophylactic therapy.

Denominator – the number of young people and adults with diffuse large B-cell lymphoma that involves the breast.

Data source: National Cancer Data Repository and ONS merged Minimum Cancer Dataset (1990–2010) and Systemic Anti-Cancer Therapy Dataset (Chemotherapy).

b) Proportion of young people and adults with diffuse large B-cell lymphoma that involves the testis who are offered central nervous system-directed prophylactic therapy.

Numerator – the number in the denominator who receive central nervous system-directed prophylactic therapy.

Denominator – the number of young people and adults with diffuse large B-cell lymphoma that involves the testis.

Data source: National Cancer Data Repository and ONS merged Minimum Cancer Dataset (1990–2010) and Systemic Anti-Cancer Therapy Dataset (Chemotherapy).

c) Proportion of young people and adults with diffuse large B-cell lymphoma that involves the adrenal gland who are offered central nervous system-directed prophylactic therapy.

Numerator – the number in the denominator who receive central nervous system-directed prophylactic therapy.

Denominator – the number of young people and adults with diffuse large B-cell lymphoma that involves the adrenal gland.

Data source: National Cancer Data Repository and ONS merged Minimum Cancer Dataset (1990–2010) and Systemic Anti-Cancer Therapy Dataset (Chemotherapy).

d) Proportion of young people and adults with diffuse large B-cell lymphoma that involves the kidney who are offered central nervous system-directed prophylactic therapy.

Numerator – the number in the denominator who receive central nervous system-directed prophylactic therapy.

Denominator – the number of young people and adults with diffuse large B-cell lymphoma that involves the kidney.

Data source: National Cancer Data Repository and ONS merged Minimum Cancer Dataset (1990–2010) and Systemic Anti-Cancer Therapy Dataset (Chemotherapy).

e) Proportion of young people and adults with diffuse large B-cell lymphoma with 4 or more risk factors for central nervous system relapse who are offered central nervous system-directed prophylactic therapy.

Numerator – the number in the denominator who receive central nervous system-directed prophylactic therapy.

Denominator –the number of young people and adults with diffuse large B-cell lymphoma with 4 or 5 risk factors for central nervous system relapse.

Data source: National Cancer Data Repository and ONS merged Minimum Cancer Dataset (1990–2010) and Systemic Anti-Cancer Therapy Dataset (Chemotherapy).

Outcome

a) Central nervous system relapse in young people and adults with diffuse large B-cell lymphoma.

Data source: Local data collection.

b) Proportion of young people and adults with diffuse large B-cell lymphoma and are at risk of CNS relapse have CNS-directed prophylactic therapy.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (specialist regional centres) ensure that processes are in place so young people and adults with diffuse large B-cell lymphoma that involves the breast, testis, adrenal gland or kidney, or 4 or more risk factors for central nervous system relapse are offered directed prophylactic therapy.

Healthcare professionals (such as clinical specialists) offer central nervous system-directed prophylactic therapy to young people and adults with diffuse large B-cell lymphoma that involves the breast, testis, adrenal gland or kidney, or 4 or more risk factors for central nervous system relapse.

Commissioners (NHS England and clinical commissioning groups) ensure that they commission services in which young people and adults with diffuse large B-cell lymphoma that involves the breast, testis, adrenal gland or kidney, or 4 or more risk factors for central nervous system relapse are offered directed prophylactic therapy.

Young people and adults with diffuse large B-cell lymphoma may be at risk of it spreading to their brain and spinal cord. There is more chance of this happening if the lymphoma is in the testicles, breast, adrenal gland or kidney. To lower this risk, an additional type of chemotherapy that can reach the brain is offered. It is also offered to some people whose test results, age and stage and site of lymphoma show that they are at higher risk.

Source guidance

Non-Hodgkin's lymphoma: diagnosis and management (2016) NICE guideline NG52 recommendations 1.6.3 and 1.6.4

Definition of terms used in this quality statement

Risk factors for central nervous system relapse

The following factors are associated with an increased risk of central nervous system relapse in people with diffuse large B-cell lymphoma:

- elevated lactate dehydrogenase (LDH)
- age over 60 years
- poor performance status (ECOG score of 2 or more)
- more than one extranodal site involved
- stage III or IV disease.

[Adapted from NICE's guideline on non-Hodgkin's lymphoma, recommendation 1.6.3]

Equality and diversity considerations

Central nervous system-directed prophylactic therapy means that patients will be exposed to an increase in toxicity, resulting in an increased rate of morbidity. The increased risk of central nervous system disease in older patients specifically with

the toxicity involved in repeat lumbar punctures should be considered and the patient should be involved in these difficult treatment decisions.

Quality statement 6: End-of-treatment summary plan

Quality statement

Young people and adults who have been treated for non-Hodgkin's lymphoma have a discussion about their end-of-treatment summary plan when they complete their treatment.

Rationale

Discussing the end-of-treatment summary plan with the person can help self-management, support people to look out for signs or symptoms of disease recurrence, and alert them to some of the possible late effects of their treatment. The end-of-treatment summary plan should also be sent to the person's GP so that they can also look out for potential signs or symptoms associated with recurrence. It is important that people understand what chemotherapy and radiotherapy they have received and the related physical health problems that can occur after treatment has ended. Young people and adults can also have long-term psychological and emotional problems following treatment, such as depression, anxiety and even post-traumatic stress disorder, which also affect their families and carers.

Quality measures

Structure

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

Data source: Local data collection.

Process

Proportion of young people and adults who have completed their treatment for non-Hodgkin's lymphoma and 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 when they complete their treatment.

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

Data source: Local data collection.

Outcome

a) Young people and adults with non-Hodgkin's lymphoma 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.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (specialist regional centres) ensure that processes are in place so that young people and adults with non-Hodgkin's lymphoma discuss their end-of-treatment summary plan with a member of their haemato-oncology team.

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

Commissioners (NHS England and clinical commissioning groups) ensure that they commission services in which young people and adults with non-Hodgkin's lymphoma discuss their end-of-treatment summary plan with a member of their haemato-oncology team.

Young people and adults who have completed treatment for non-Hodgkin's lymphoma discuss their end-of-treatment summary plan with a member of their haematology specialist team.

Source guidance

Non-Hodgkin's lymphoma: diagnosis and management (2016) NICE guideline NG52, recommendations 1.11.1, 1.10.1 and 1.9.1

Definition of terms used in this quality statement

End-of-treatment summary plan

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

- heart damage
- peripheral neuropathy
- cognitive disorders
- second cancers
- infertility
- 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]

Equality and diversity considerations

The end-of-treatment summary plan should be clearly explained and discussed with the young person or adult (and their family members, carers or care workers, if appropriate). Information provided should be provided in a clear format and in a language suited to the person's needs and preferences.

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.

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
- 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.

ISBN: