NNHLA
National Non-Hodgkin Lymphoma Audit

Local Action Plan for taking on NNHLA State of the Nation Report 2026 Recommendations

The provider should complete the following details to allow for ease of review	
Audit title & aim:	National Non-Hodgkin Lymphoma Audit To assess the process of care and its outcomes in patients with non-Hodgkin Lymphoma
NHS organisation:	
Audit lead:	
Action plan lead: (e.g. MDT lead)	

When making your action plan, make sure to keep the objectives SMART – Specific, Measurable, Assignable, Realistic, Time-related

Key 1 (for the action status)

1. Awaiting plan of action
2. Action in progress
3. Action fully implemented
4. No plan to action recommendation (state reason)
5. Other (provide information)

Key 2 (for the action priority)

High: requires urgent attention (local audit)
Medium: requires prompt action (consider local audit)
Low: requires no immediate action (or local audit)

			Action activities			
No.	**Recommendation**	**Action required?**	**Responsible individual(s)**	**Agreed deadline**	**Status (Key 1)**	**Priority (Key 2)**
1.	Identify patient and tumour factors associated with	Suggested actions: Local (NHS Trusts / Health Boards):				

	emergency presentation, including referrals to hospital in the previous 6-12 months that did not lead to a diagnosis of NHL. The poor survival in this group highlights the need to move these patients urgently through the pathway. Examine the timelines within secondary care for this group, including time to biopsy.	Risk-stratified referral and diagnostic pathways • Local audit of patient and tumour factors associated with emergency presentation and to review prior hospital referrals in the preceding 6–12 months that did not result in an NHL diagnosis. • Review and adjust secondary care referral pathways for cases with high-risk factors for emergency presentation – e.g. review of inconclusive cases – to intercept high-risk patients before deterioration to emergency admission. Improve care pathway after emergency presentation: • Review triage and investigation processes following emergency admission, to improve timeliness of and access to diagnostic tests for patients with suspected NHL. • Review referral pathways from other specialties to Haematology via acute oncology services, to enable faster time to diagnosis/treatment for emergency presentations. • Local audit of timelines from emergency admission to treatment, with learning from trusts where time from emergency presentation to treatment is shorter National (NHS England / Wales Cancer Network / Royal Colleges): Symptom Awareness:				

		• Working alongside patient charities to raise awareness in both clinical and public communities. Risk-stratified referral and diagnostic pathways: • National audit on patient/ tumour factors associated with emergency presentation to develop risk-stratification criteria for secondary care referral and investigation pathway. Improve care pathway after emergency presentation: • Support diagnostic capacity for patients with suspected NHL presenting as an emergency NHS Cancer Programme: Faster Diagnosis Framework Monitor and reduce variation: • Use the NNHLA annual report to monitor emergency presentation rates and survival after emergency presentation at local and national level, and support in-depth audit of challenged trusts to identify areas for improvement.				
2.	Identify opportunities to shorten the longest median time intervals (time from referral to seeing a haematologist and time from diagnosis to starting SACT) within the patient pathway in order to understand system-level delays.	Suggested actions: Integrated Care Systems/Cancer Alliances: to work with and review the following at a trust/health board/hospital level: • Time from referral by other specialties to haematologist, and inter-speciality referral pathways for suspected/confirmed NHL cases				

		• Review opportunities to modernise MDT working and streamline decision-making, to reduce time from diagnosis to starting SACT. • Access to pre-SACT investigations like nuclear medicine renal tests or cardiac tests • Access to chemotherapy units and provision of SACT delivery appointments Monitor and reduce variation: • Use the NNHLA data dashboard to monitor time from referral to start of SACT locally at quarterly basis and learning from trusts where time to treatment is shorter • Use the NNHLA annual report to monitor time from referral to seeing a haematologist and time from diagnosis to starting SACT.				
3.	Identify patient and hospital factors contributing to delays in starting radiotherapy after last administered dose of SACT and explore strategies to reduce inter-provider variation across NHS trusts and health boards. This may include: • ensuring specialist representation at MDT meetings • earlier identification of suitable candidates for radiotherapy through	Suggested actions: Integrated Care Boards/Cancer Alliances: to work with and review the following at a trust/hospital level: • Time from last administered dose of systemic anti-cancer therapy to consolidative radiotherapy. • Access to radiotherapy units and provision of radiotherapy delivery appointments • Effective MDT working with early identification of candidates suitable for consolidative radiotherapy and prompt referral to clinical oncology specialists. • Review process during/ following SACT to identify suitable candidates for radiotherapy				

	timely MDT referral and pre-SACT review by clinical oncologist	early, including any pre-radiotherapy investigations required. Audit above and integrate data collection into departmental meetings or MDT meetings to identify strategies for improvement.				
4.	Identify reasons why individuals with non-Hodgkin lymphoma are not enrolled in clinical trials to ensure equitable access to research opportunities, while also strengthening clinical record-keeping practices to support identification and reduction of participation disparities.	Suggested actions: <u>Enrolment:</u> Local (NHS trusts in England and Health Boards in Wales): • Integrate clinical trial prompts in the multi-disciplinary meeting setting or workflows to ensure regular eligibility screening. Improve visibility and promotion of trials to promote referrals and awareness through training, clear referral pathways and sharing of information/updates. National (NHS England/Wales Cancer Network): • Improved awareness of clinical research trial availability through registries or dashboards, and in partnership with patient charities (e.g. Lymphoma Action, Blood Cancer UK) to embed clinical research as part of routine care. • Work with national research organisations to expand national NHL trial portfolio and address geographic gaps in trial availability. <u>Record keeping:</u> Local: • Ensure research nurses and MDT coordinators receive appropriate training to update trial				

		records with routine audits of trial data completeness to monitor progress. National: • Standardise trial data elements in national datasets and ensure upgraded digital systems (Wales) allow for easy input and extraction of trial participation data. Raise the profile of trial data completeness across the wider multidisciplinary team (MDT) at governance meetings or by sharing data. Local audit of trial enrolment to reduce variation in access to care in a trial setting.				
5.	Monitor rates of severe acute toxicity after SACT for NHL and investigate the reasons underlying toxicity. Encourage the utilisation of appropriate risk stratification tools for severe acute toxicity, for example frailty scoring, and regularly review systems of SACT delivery and safety monitoring to ensure treatment-related adverse effects are minimised.	Suggested actions: Local: • Use risk stratification tools to assess risk of severe acute toxicity and individualise treatment plans, such as dose modification or prophylaxis • Establish a safety monitoring system throughout SACT delivery across cycles, with adjustments made accordingly. • Involve the wider MDT (e.g. clinical nurse specialists, healthcare of older people liaison teams) to support safety monitoring and minimise treatment-related adverse effects • Use the NNHLA annual report to identify trusts with high severe acute toxicity rate after SACT and support local improvement through peer review and cross learning.				

		National (NHS England/NDR/DHCW): • Establish a standardised SACT toxicity risk stratification guidance and safety monitoring expectation. • Support safety monitoring system throughout SACT delivery to enable early detection and management of SACT related toxicity, reducing hospital admission.				

The NNHLA welcome your feedback on this quality improvement template to be used in conjunction with the NNHLA State of the Nation Report 2026 provider level results and quality improvement resources presented on our website.

Please contact the NNHLA if you have any questions related to your results, data collection or service improvement.

References

1. NNHLA State of the Nation Report 2026