NNHLA
National Non-Hodgkin Lymphoma Audit

NATCAN
National Cancer Audit Collaborating Centre

National Non-Hodgkin Lymphoma Audit
State of the Nation Report 2026

An audit of care received by people diagnosed with non-Hodgkin lymphoma between 1 January 2023 and 31 December 2023 in England and 1 January 2024 and 31 December 2024 in Wales.

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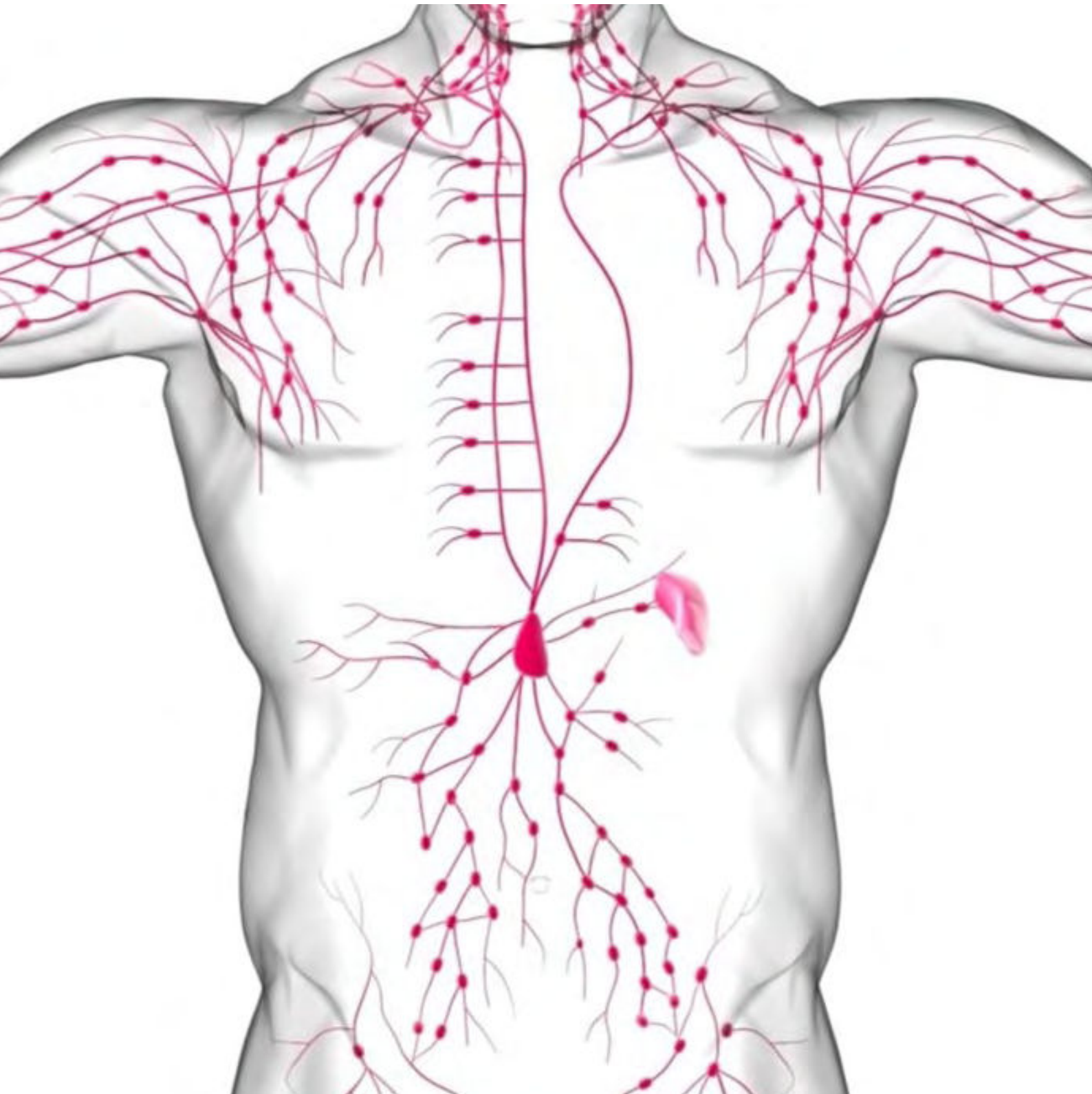

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Royal College of Surgeons of England
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HQIP
Healthcare Quality Improvement Partnership

The National Cancer Audit Collaborating Centre (NATCAN) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Welsh Government as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). NATCAN delivers national audits in bowel, breast (primary and metastatic), kidney, lung, non-Hodgkin lymphoma, oesophago-gastric, ovarian, pancreatic and prostate cancers.

British Society for Haematology
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The British Society for Haematology (BSH) is the professional body for haematologists. It is one of the key partners of the Audit. Registered Charity no. 1005735.

The Royal College of Radiologists

The Royal College of Radiologists is the professional body for clinical radiologists and clinical oncologists. It is one of the key partners of the Audit. Registered Charity no: 211540.

NDRS
NATIONAL DISEASE REGISTRATION SERVICE

This work uses data that have been provided by patients and collected by the NHS as part of their care and support. For patients diagnosed in England, the data are collated, maintained and quality assured by the National Disease Registration Service (NDRS), which is part of NHS England. Access to the data was facilitated by the NHS England Data Access Request Service.

GIG CYMRU NHS WALES
Perfformiad a Gwella
Performance and Improvement

NHS Wales recently implemented Cancer Dataset Forms with the latest implementation date being January 2025. These have been designed to improve the data capture and reporting capabilities of NHS Wales. This implementation has impacted the data quality within NHS Wales. NHS Wales has committed to continue to submit audit data annually until data submissions are sourced exclusively from the new cancer informatics solution. This will be from 2027 onwards that NHS Wales will be able to supply quarterly data using this new integrated, and more accessible digital platform.

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Contents

1. Introduction

The National Non-Hodgkin Lymphoma Audit (NNHLA) is 1 of 10 national cancer audits within the National Cancer Audit Collaborating Centre (NATCAN), which is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government. The aim of NATCAN is to provide regular information on patterns and variation in delivery of cancer care from diagnosis to treatment, using this information to improve access to treatment and facilitate quality improvement (QI) initiatives, with a view to optimising outcomes nationally.

The NNHLA evaluates patterns of care and outcomes for people diagnosed with non-Hodgkin lymphoma (NHL) in England and Wales in line with its Quality Improvement Plan. This sets out the scope, care pathway, 5 QI goals and 11 performance indicators that are used to measure progress against these goals.

The NNHLA assesses current clinical practice against standards set out in national guidelines. It also reports on performance indicators drawn from extensive reviews of existing literature and of UK-specific guidelines relevant to NHL produced by the National Institute for Health and Care Excellence (NICE), NHS England, and the British Society of Haematology (BSH). The work of the audit is also aligned with the UK Blood Cancer Action Plan, published in September 2024, which sets out 17 recommendations on workforce, diagnosis, access to care, clinical trials, access to treatments and data to improve survival from blood cancer, including NHL, in the UK.

This year's report includes people diagnosed with NHL from 1 January 2023 to 31 December 2023 in England, and from 1 January 2024 to 31 December 2024 in Wales. It reports on 9 out of the 11 performance indicators for England and 5 out of the 11 performance indicators for Wales as outlined in the NNHLA QI Plan (Table 1). For the first time, the report provides results for the proportion of people diagnosed with NHL who experienced severe acute toxicity after Systemic Anti-Cancer Therapy (SACT), as well as additional granularity on time from referral to starting treatment, including median time from referral to diagnosis, seeing a haematologist and subsequently starting SACT.

Although the data presented relate to diagnosis up to the end of 2023 in England and 2024 in Wales, the report is being published in September 2026 to allow sufficient follow-up time for the full care pathway to be captured, including definitive treatment and medium-term outcomes. This is particularly important in NHL, where treatment pathways can span many months and sufficient time is therefore needed to ensure that key quality indicators, such as completion of multi-modality treatment and survival outcomes, are accurately recorded and reported (Timeliness of the National Cancer Registration Dataset (NCRD).

The NNHLA derives its indicators using information that is routinely collected by the NHS as part of the care and support given to people diagnosed with NHL, rather than data collected specifically for the Audit. For people diagnosed or treated in England, the data are collated, maintained and quality assured by NHS England's National Disease Registration Service (NDRS). For people diagnosed or treated in Wales, data are provided by NHS Wales Performance and Improvement (P&I), using the Cancer Network Information System Cymru (CaNISC) or Cancer Dataset Form (CDF). For full details of the data and methods used within this report, please see the NNHLA Methodology Supplement.

This report describes the national picture and variation between NHS trusts in England/hospitals in Wales. As this is the third NNHLA State of the Nation report, we present trends over time (longitudinal analysis) using data for England from 2020 to 2023 and Wales from 2022 to 2024. When interpreting the trends, it is important to acknowledge that the data for England begin in 2020, a period that may be considered atypical due to the impact of the COVID-19 pandemic on healthcare delivery, resource allocation and clinical practice.

Further development work and/or additional data is required to report on all 11 indicators for both nations, and in future years the NNHLA will work to align the reporting periods for both England and Wales, as well as providing more timely reporting.

The findings of this report have guided the development of 5 recommendations aimed at improving the quality of care for people with NHL (see Recommendations). These are directed at Cancer Alliances, Integrated Care Boards and NHS trusts/health boards, highlighting priorities for enhancing the treatment pathway, increasing opportunities for people diagnosed with NHL to participate in clinical trials and reducing toxicity after SACT for NHL. It is important to address these factors as they can be associated with poorer patient outcomes and increased variability in care delivery. By targeting these indicators, the recommendations focus on opportunities where improvement is most likely to enhance clinical outcomes, promote consistency across services, and reduce unwarranted variation in care.

An outlier policy has also been carried out to identify providers whose performance, in terms of patient survival, deviates significantly from the expected range. This includes both positive and negative

outliers based on analysis accounting for case-mix and other confounding factors. Identifying these outliers allows for further local investigation into potential drivers of variation, such as differences in clinical practice, resource availability or data quality. This supports targeted improvement efforts where outcomes are poorer than expected and shared learning of best practice where outcomes are better.

The NNHLA also continues to provide quarterly reports to NHS trusts in England in the form of publicly available NNHLA Data Dashboard. The dashboard provides provider-level data quality and performance indicator reports for England every 3 months so that NHS organisations can review their data quality and delivery of care in relation to other NHS trusts, Cancer Alliances and the national average. The aim of the dashboard is to help support NHS trusts track their progress and performance in line with local QI initiatives and to provide the basis for national QI initiatives designed and launched by the Audit.

Additional materials that accompany this report include:

- A methodology supplement with details about the Audit's data sources and methods
- An online glossary that explains technical terms used in this report
- Information about the outlier policy
- Resources to support local monitoring of practice and QI, such as provider-level results on the NNHLA Data Dashboard and downloadable reports and a local action plan template.
- A summary of this report for people living with NHL and for the public is available on the Audit's web pages.

Table 1. NNHLA performance indicators (PIs), accompanying contextual measure and corresponding periods		
Description	**England^**	**Wales#**
Contextualising measure[1]: Proportion of people diagnosed with NHL presenting as an emergency prior to diagnosis.	Yes (01/23-12/23)	Yes (01/24-12/24)
PI 1. Proportion of people diagnosed with NHL discussed at a multidisciplinary team (MDT) meeting within 4 weeks of diagnosis.	Yes (01/23-12/23)	No (data not available)
PI 2. Proportion of people diagnosed with NHL seen by a clinical nurse specialist (CNS).	Yes (01/23-12/23)	Yes (01/24-12/24)
PI 4. Proportion of people with high-grade lymphoma[2] receiving systemic anti-cancer therapy (SACT), who start SACT within 62 days of referral.	Yes (01/23-12/23)	Yes (01/24-12/24)
Median time from referral to starting SACT	Yes (01/23-12/23)	Yes (01/24-12/24)
Median time from referral to diagnosis	Yes (01/23-12/23)	Yes (01/24-12/24)
Median time from diagnosis to starting SACT	Yes (01/23-12/23)	Yes (01/24-12/24)
Median time from referral to seeing a haematologist	Yes (01/23-12/23)	No (data not available)
Median time from seeing a haematologist to starting SACT	Yes (01/23-12/23)	No (data not available)
PI 5. First-line SACT regimens received by people with high-grade lymphoma[2].	Yes (01/23-12/23)	No (data incomplete)
PI 6. Proportion of people diagnosed with NHL with severe acute toxicity within 8 weeks of completing SACT, reported by subtype.	Yes (01/22-12/23)[3]	No (data incomplete)
PI 7. Proportion of people with high-grade lymphoma[2] whose radiotherapy started within 8 weeks of end of first-line SACT.	Yes (01/23-12/23)	No (data incomplete)
PI 8. Proportion of people diagnosed with NHL recorded as receiving radiotherapy, reported by subtype.	Yes (01/23-12/23)	Yes (01/24-12/24)
PI 9. Proportion of people diagnosed with NHL recorded as having received an episode of care that was delivered as part of a clinical trial, reported by subtype.	Yes (01/23-12/23)	No (data not available)
PI 11*+. Overall 1 and 2-year survival of people diagnosed with NHL, reported by grade and subtype.	Yes, 1-year survival (01/22-12/23)[3]; 2-year survival (01/21-12/22)[3]	Yes, 1-year survival (01/23-12/24)[3]; 2-year survival (not enough follow-up)
Further development work needed		
PI 3. Proportion of people diagnosed with Burkitt lymphoma (BL) or diffuse large B-cell lymphoma (DLBCL) undergoing treatment who have MYC testing[4].	No (in development)	No (in development)
PI 10. Time to treatment for relapse of follicular lymphoma, other B-cell lymphomas (incl. chronic lymphocytic leukaemia (CLL), marginal zone lymphoma) and T-cell lymphomas which are not high-grade.	No (in development)	No (in development)

1. A contextual measure is defined within a specific clinical setting or population; in this case, it refers to emergency presentations occurring prior to a non-Hodgkin lymphoma (NHL) diagnosis.

2. High-grade NHL includes Burkitt lymphoma, diffuse large B-cell lymphoma and high-grade T-cell lymphomas.

3. Aggregated 2 years of data used to increase patient volume at trust level.

4. MYC is a gene involved in regulating cell growth and proliferation. Genetic changes affecting MYC can occur in some B-cell lymphomas. Testing for these changes helps guide treatment decisions and outcomes (prognosis) for patients.

* Risk-adjusted indicator + Subject to NATCAN Outlier Policy

^ England data: National Cancer Registration Dataset (NCRD)

Welsh data: Cancer Network Information System Cymru (CaNISC) or Cancer Dataset Form (CDF)

See methodology supplement for the exact definitions of each performance indicator.

2. Infographic

NNHLA
National Non-Hodgkin Lymphoma Audit

Summary of results for people diagnosed with non-Hodgkin lymphoma (NHL) between 1 January 2023 and 31 December 2023 in England and 1 January 2024 and 31 December 2024 in Wales.

Diagnosis and treatment pathway

Diagnoses per year

England
15,911 diagnosed in 2023

Wales
707 diagnosed in 2024

Grade of lymphoma

England 2023
high-grade 50%
low-grade 49%
not classified 1%

Wales 2024
high-grade 47%
low-grade 52%,
not classified 1%

MDT discussion within 4 weeks of diagnosis, where recorded

England 2023
all patients 61%,
high-grade 66%,
low-grade 55%

No data on MDT discussion was provided for Wales

Seen by Clinical Nurse Specialist (CNS), where recorded

England 2023 85%
Wales 2024 95%

43% data completeness in England
80% data completeness in Wales

69 years **Mean age** at diagnosis for both England & Wales

Emergency presentation

England 2023 29%
Wales 2024 29%

Systemic Anti-Cancer Therapy (SACT)

England 2023 **56%**
Wales 2024 **62%**

Proportion of people diagnosed with high-grade lymphoma, who receive SACT within 62 days of referral

Median Time (IQR*)

*Interquartile range

Referral	England: 57 days (50-68 days) Wales: 52 days (40-76 days)		Starting SACT
Referral	England: 17 days Wales: 15 days	Diagnosis	England: 35 days Wales: 33 days	Starting SACT
Referral	England: 36 days	Seeing a haematologist	England: 19 days	Starting SACT

Time of seeing a haematologist not available for Wales

Treatment

Severe acute toxicity

England 2023: **47%**

Proportion of people diagnosed with DLBCL experiencing severe acute toxicity within 8 weeks of completing SACT.

End date for 1st line chemotherapy was not provided for Wales so this indicator could not be measured.

Timing of Radiotherapy delivery

England 2023: **32%**

Proportion of people with high-grade lymphoma whose consolidation radiotherapy started within 8 weeks of end of first line SACT.

End date for 1st line chemotherapy was not provided for Wales so this indicator could not be measured.

Radiotherapy

Proportion of people with NHL receiving radiotherapy within one year of diagnosis

England 2023	Wales 2024
12%	5%
IQR: 8-15%	IQR: 0-7%

Trial Participation

England 2023: less than **3%**

Proportion of people with NHL who were recorded as having received an episode of care that was delivered as part of a clinical trial**

**Note 75% data missing. No data on trial participation for Wales was available

Survival

One-year survival outcomes

	Overall	high-grade	low-grade
England 2023	82%	71%	93%
Wales 2024	84%	73%	94%

Two-year survival outcomes***

***Not available for Wales due to insufficient follow up period

	Overall	high-grade	low-grade
England 2023	75%	64%	86%

Data completeness

	Sex	Ethnicity	Deprivation	Performance Status	Staging (Ann Arbor)	Staging (Binet)	Clinical Nurse Specialist (CNS)	Multi-Disciplinary Team meeting (MDT)
England 2023	100%	95%	100%	56%	65%	36%	43%	73%
Wales 2024	87%	45%	95%	81%	70%	41%	80%	No data on MDT discussion was provided for Wales

3. Recommendations

The following recommendations are developed in collaboration with the NNHLA Clinical Reference Group and based on key findings in this report. The recommendations are intended for healthcare providers and commissioners in England and Wales, including trusts, Cancer Alliances and health boards. The NNHLA local quality improvement action plan contains suggested actions to address the recommendations described below.

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
1. Identify patient and tumour factors associated with 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.	England: Cancer Alliances working with NHS trusts Wales: health boards	**Proportion of people diagnosed with NHL presenting as an emergency prior to diagnosis:** England 2023: 29.4% (IQR*: 26-33%) Wales 2024: 29.0% (IQR: 18-37%) **Survival of people diagnosed with NHL following an emergency presentation:** 1-year survival: England 2023: 59.1% (95% CI+: 58-61%) Wales 2024: 59.5% (95% CI: 53-66%) 2-year survival: England 2022: 51.4% (95% CI: 50-53%) Wales: not enough follow-up	Goal #1: Improving timely diagnosis and treatment.	NHS Cancer Programme: Faster Diagnosis Framework 2022 UK Blood Cancer Action Plan NICE guidance, "Haematological cancers: improving outcomes" (NG47) 2016 National Cancer Plan 2026. (3. A global leader in cancer outcomes by 2035: 'improve and modernise the early detection pathway'; 'reducing the proportion of cancers diagnosed in an emergency setting')
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.	England: Cancer Alliances working with NHS trusts Wales: health boards	**Median time from referral to seeing a haematologist:** England 2023: 36 days (IQR: 29-44 days) Wales 2024: not available **Median time from diagnosis to starting SACT:** England 2023: 35 days (IQR: 29-42 days) Wales 2024: 33 days (IQR: 32-44 days)	Goal #1: Improving timely diagnosis and treatment.	NHS England Cancer Waiting Times Standards (October 2023) UK Blood Cancer Action Plan National Cancer Plan 2026 (2. Driving up NHS cancer performance: 'to meet all cancer waiting time performance by 2029'; 'cut down unnecessary appointments through straight-to-test pathways')
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 timely MDT referral and pre-SACT review by clinical oncologist	England: Cancer Alliances working with NHS trusts Wales: health boards	**Proportion of people with high-grade lymphoma whose radiotherapy started within 8 weeks of end of first-line SACT:** England 2023: 31.5% (IQR: 22-50%) Wales 2024: not available	Goal #1: Improving timely diagnosis and treatment. Goal #5: Reducing variation in NHL management among NHS providers.	Streamlining Multidisciplinary Team Meetings – Guidance for Cancer Alliances (2020) NICE guidance, "Haematological cancers: improving outcomes" (NG47) 2016 Clinical Oncology Workforce Census 2024 National Cancer Plan 2026 (2. Driving up NHS cancer performance: 'harness new technology to speed up access to treatment'; 'improve the effectiveness of multi-disciplinary team working')

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
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.	England: Cancer Alliances working with NHS trusts Wales: health boards	**Proportion of people diagnosed with NHL who were recorded as having received an episode of care that was delivered as part of a clinical trial:** England 2023: 2.6% (IQR: 0-4%) Wales 2024: not available	Goal #1: Improving timely diagnosis and treatment.	UK Blood Cancer Action Plan NIHR (2020) Improving inclusion of under-served groups in clinical research: Guidance from the NIHR-INCLUDE project. UK: NIHR. National Cancer Plan 2026 (5. Delivering world class cancer care through world class research: 'ensure faster set up of clinical trials and more equitable access'; 'NIHR will make research more inclusive, so it reaches more underrepresented communities'; 'Cancer trials will be made more accessible')
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.	England: Cancer Alliances working with NHS trusts Wales: health boards	**Proportion of people diagnosed with NHL with severe acute toxicity within 8 weeks of completing SACT:** England 2023: 47.4% (IQR: 41-54%) Wales 2024: not available	Goal #3: Improving safety and reducing toxicity of NHL therapy.	NICE guidance, "Haematological cancers: improving outcomes" (NG47) 2016 Fox CP, Chaganti S, McIlroy G, Barrington SF, Burton C, Cwynarski K, Eyre TA, Illidge T, Kalakonda N, Kuhnl A, McKay P, Davies AJ. The management of newly diagnosed large B-cell lymphoma: A British Society for Haematology Guideline. Br J Haematol. 2024 Apr;204(4):1178-1192. doi: 10.1111/bjh.19273. Epub 2024 Jan 21. PMID: 38247115; PMCID: PMC7616447.

*IQR: interquartile range according to trust/hospital level results.

+ CI: confidence interval.

^ The clinical recommendation remains consistent with previous year's recommendation, as the performance indicator results continue to support findings from previous reports. There is currently insufficient follow-up time to assess whether improvements have occurred following the publication of previous NNHLA State of the Nation reports.

4. Results for England and Wales

4.1 Characteristics of people diagnosed with NHL

National Cancer Registration data (England) identified 15,911 people diagnosed with NHL in 2023, across 131 English NHS trusts. Data from CaNISC and CDF identified 707 people diagnosed with NHL in Wales in 2024 across 20 Welsh hospitals (Table 2).

In both England and Wales, the mean age at diagnosis was 69 years. A higher proportion of people diagnosed with NHL were male, accounting for 58-60% of cases. The majority were of White British ethnicity (91-98%), although more than half of the data for ethnicity was not recorded for the Wales cohort. A higher percentage of people diagnosed with NHL lived in the least deprived quintiles in England (23%) and Wales (23%). 56% (England) and 81% (Wales) of people had a record of performance status, and of these, 83% (England) and 78% (Wales) were either fully active or restricted in strenuous activity (PS 0-1). 75–85% of people had 0 or 1 comorbidity in England and Wales according to the RCS Charlson comorbidity index. However, drawing any conclusions is difficult as 31-40% of data was missing for this data item. (Table 2 and Supplementary table 1).

Overall, the patient characteristics for England in 2023 and Wales 2024 have not changed compared to State of the Nation report 2025 (for England 2022 and Wales 2023).

4.2 Diagnosis and staging

Key message

Amongst people with staging recorded, more than 2/3 people with NHL presented with advanced stage (3 or 4) disease, except CLL where the majority presented with early-stage disease (Binet A).

There is highly complete recording of subtype based on diagnostic and morphology coding (see Methodology Supplement).

The 3 most common subtypes were large B-cell lymphoma (LBCL), follicular lymphoma (FL) and chronic lymphocytic leukaemia (CLL) in both England and Wales. The incidence of high-grade and low-grade lymphomas was similar in England (around 50%). For Wales, more people were diagnosed with low-grade lymphoma (53%) than high-grade lymphoma (47%). Amongst people with available staging data, 72% (England) and 73% (Wales) presented with advanced stage (3 or 4) disease (Table 2 and Supplementary table 1).

For CLL, the pattern suggested that people in both cohorts were more likely to present at an earlier stage (A), although clear conclusions can't be drawn due to the large volume of missing data (59-64%) (Supplementary table 1).

4.3 Data

Key message

NHS trusts and multidisciplinary teams should ensure key data items are submitted to cancer registries for all people diagnosed with NHL. Attention should be given to documentation of staging, MDT records and CNS involvement in both England and Wales.

Reporting completeness of key data items is crucial to ensure fair comparisons between NHS trusts/health boards and when drawing conclusions regarding the process indicators about healthcare delivery and outcomes (Table 2 and Supplementary table 1).

Data completeness was largely in line with that seen in previous years, ranging from 100% (age, sex and index of multiple deprivation (IMD) quintiles in England, and age groups in Wales) to only around 10% for prognostic indices (the International Prognostic Index for DLBCL (IPI) and the Follicular Lymphoma International Prognostic Index 2 (FLIPI2) was 12% and 9% respectively for England; no data on prognostic indices was available for Wales). Ann Arbor staging completeness remains an issue, recorded in around two-thirds of people (65% in England and 70% in Wales). There was a noticeable improvement in the completeness of Binet staging in Wales for 2024 diagnoses (41%) compared to 2022 (10%) and 2023 (8%) diagnoses. Furthermore, performance status was recorded in less than 60% in England and over 80% in Wales.

Data completeness of MDT discussions was 73% in 2023 in England (stable compared to 2020-2022). Improved record-keeping will allow NNHLA to report more accurately on timely MDT discussion. No data on MDT discussion was provided for Wales. Similar to last year's report, the proportion of people seen by a clinical nurse specialist was recorded in 43% of cases in England in 2023, and in 80% of cases in Wales in 2024.

With regards to treatment delivery, limited data was available on regimen-level SACT and on radiotherapy delivery for Wales. No data on trial participation was available for Wales.

Data completeness should remain a priority for providers, as it will help clinicians and the Audit team to clarify if appropriate care is being delivered and help more accurately prognosticate outcomes for those with NHL.

Table 2. Characteristics of people diagnosed with NHL in England 2023 and Wales 2024.				
	England 2023		**Wales 2024**	
	n	**%**	**n**	**%**
Total	15,911	100	707	100
Age at diagnosis, mean (SD)	69.2 (13.7)		69.0 (13.3)	
Sex				
Female	6,684	42.0	249	40.3
Male	9,227	58.0	369	59.7
Missing (% of total)	0 (0)		89 (12.6)	
IMD quintiles				
1 (most deprived)	2,371	14.9	109	15.5
2	2,829	17.8	128	18.2
3	3,359	21.1	163	23.2
4	3,633	22.8	143	20.4
5 (least deprived)	3,719	23.4	159	22.7
Missing (% of total)	0 (0)		5 (0.7)	
Charlson comorbidity score				
0	5,134	46.7	236	55.1
1	3,097	28.2	127	29.7
2	1,575	14.3	45	10.5
3+	1,183	10.8	20	4.7
Missing (% of total)	4,922 (30.9)		279 (39.5)	
Ann Arbor staging				
Total	12,014	100	550	100
1	1,328	16.9	51	13.2
2	904	11.5	54	13.9
3	1,425	18.2	80	20.7
4	4,187	53.4	202	52.2
Missing (% of total)	4,170 (34.7)		163 (29.6)	
NHL subtype				
Burkitt lymphoma	100	0.6	<5*	*
Chronic lymphocytic leukaemia	3,897	24.5	157	22.2
Follicular lymphoma	2,350	14.8	107	15.1
Large B-cell lymphomas	4,147	26.1	183	25.9
Mantle cell lymphoma	600	3.8	30	4.3
Marginal zone lymphoma	1,234	7.7	51	7.2
NHL, NOS[1]	1,358	8.5	95	13.4
Peripheral T-cell lymphomas	634	4.0	28	4.0
Cutaneous T-cell lymphomas	324	2.0	5–10*	*
Other	1,267	8.0	44	6.2

1. NOS: Not otherwise specified.
*Exact numbers and percentages suppressed to protect patient confidentiality.

Contextualising measure: Proportion of people diagnosed with NHL presenting as an emergency prior to diagnosis.

Key message

29% of people with NHL presented as an emergency; survival was substantially poorer for the people in this group. This finding underpins **Recommendation #1** to identify patient and tumour factors associated with emergency presentation.

Just under 30% of people diagnosed with NHL were either diagnosed through emergency presentation or presented to the emergency department within 28 days prior to diagnosis in both countries, with notable variation between trusts and hospitals (Supplementary table 2). Emergency presentation was more common in high-grade disease affecting over 40% of people diagnosed with NHL, compared to 13-16% in low-grade disease. Supplementary table 3 shows that emergency presentations were more common among older people diagnosed with NHL (aged 80 and over), among ethnic minority groups, and those living in more deprived areas. The highest proportion was seen in high-grade subtypes including Burkitt lymphoma, large B-cell and peripheral T-cell lymphomas.

Survival was substantially poorer in people who presented as an emergency compared to those diagnosed through routine referrals. This pattern was consistent regardless of disease grade, with emergency presenters showing markedly worse survival than those presenting electively in high-grade disease (1-year: 53% vs 85% in England; 54% vs 90% in Wales) and low-grade disease (1-year: 76% vs 95% in England; 77% vs 97% in Wales). The survival gap persisted at 2 years in England (high-grade: 46% vs 77%; low-grade: 66% vs 89%), highlighting the poor prognosis associated with emergency presentation across the full spectrum of NHL. (Supplementary figure 1)

Trends over time: A similar incidence of emergency presentations was observed for England from 2021-2023 (Supplementary figure 4 and Supplementary table 12).

4.4 Diagnosis to treatment pathway

PI 1: Proportion of people diagnosed with NHL discussed at a multidisciplinary team meeting (MDT) within 4 weeks of diagnosis.

Key message

61% of people with NHL in England were discussed at an MDT within 4 weeks of diagnosis, with performance declining over time, indicating the need for action to ensure timely MDT discussion for all newly diagnosed cases, particularly those with high-grade disease.

MDT discussion was recorded for 73% of people diagnosed in England 2023. Where data were complete, 61% of all cases were discussed in an MDT within 4 weeks of diagnosis. People with high-grade lymphoma were more likely to be discussed within this time frame (66%) than those with low-grade disease (55%). There was large variation in practice regarding timing of MDT discussions between trusts (Table 3). Further analysis showed that over 85% of all cases were discussed within 8 weeks of diagnosis, with almost 90% of high-grade cases discussed within this time (Supplementary table 4). No data was available for Wales.

Trends over time: There has been a decline in this indicator in England from 2020 (69%) to 2023 (61%) (Supplementary figure 4 and Supplementary table 12). This may reflect pressures on resources and a reduction in service capacity in the post COVID-19 period.

PI 2: Proportion of people diagnosed with NHL seen by a clinical nurse specialist (CNS).

Key message

43% (England) and 80% (Wales) of people had a record of CNS contact. Where recorded, the majority of people with NHL had contact with a CNS in both England and Wales. Continued effort is needed to ensure people with NHL receive CNS support.

Where CNS information was recorded, 95% of people with NHL were recorded as seen by a CNS in Wales, compared to 85% in England (Table 3). CNS contact was recorded as being higher in the high-grade cases for both England and Wales, with some variation between providers (IQR: 84–100% in England). Greater variation between providers was observed in low-grade cases. Given that there was 43% data completeness for this item in England and 80% data

completeness in Wales, it is difficult to draw definitive conclusions about support provided by CNSs to people diagnosed with NHL.

Trends over time: This indicator has remained stable for England from 2020 to 2023 and for Wales from 2022 to 2024 (Supplementary figure 4 and Supplementary table 12).

PI 4: Proportion of people with high-grade lymphoma receiving systemic anti-cancer therapy (SACT), who start SACT within 62 days of referral.

Key message

56% and 62% of people with high-grade lymphoma started first-line SACT within 62 days of referral in England and Wales respectively. The longest median time intervals within the pathway were from referral to seeing a haematologist (36 days), highlighting opportunities to reduce system-level delays.

This finding forms the basis for **Recommendation #2**.

Around 45% of people with high-grade lymphoma in England and 39% in Wales receiving SACT did not start first-line SACT within the 62-day referral target (Table 3). This figure has increased from 34% in 2020 for England and decreased from 49% in 2022 for Wales (Supplementary figure 4 and Supplementary table 12). There is noticeable variation across NHS providers, indicating possible challenges in the referral process, access to specialist services, and resource distribution that warrant further investigation and improvement locally.

Development work this year has allowed the Audit to explore where in the pathway the longest delays are occurring, with time from referral to seeing a haematologist taking the longest. In England, the median time from referral to seeing a haematologist was 36 days, followed by 19 days from seeing a haematologist to starting the treatment (Table 3). The national median time from referral to receiving a diagnosis was 15-17 days, followed by approximately 1 month from diagnosis to starting the treatment.

Table 3. Indicator results of referral and diagnosis to treatment pathway, England 2023 and Wales 2024.

Performance indicator (PI)	Denominator	England* 2023	Median[1] (IQR[2]) in England 2023	Wales*[3] 2024	Median[1] (IQR[2]) in Wales 2024
PI 1: Proportion of people diagnosed with NHL discussed at a multidisciplinary team meeting (MDT) within 4 weeks of diagnosis	All NHL	61.1%↑	59% (49-71%)	-	
	High-grade lymphoma	66.3%↑	65% (52-77%)	-	
	Low-grade lymphoma	55.1%↑	52% (43-65%)	-	
PI 2: Proportion of people diagnosed with NHL seen by a clinical nurse specialist (CNS)	All NHL	84.9%↑	93% (79-98%)	95.2%↓	100% (91-100%)
	High-grade lymphoma	88.5%↑	96% (84-100%)	97.7%↑	100% (100-100%)
	Low-grade lymphoma	81.2%↑	92% (70-100%)	92.9%↓	99% (86-100%)
PI 4: Proportion of people with high-grade lymphoma receiving SACT, who start SACT within 62 days of referral	High-grade lymphoma	55.7%↑	56% (44-67%)	61.90%↑	50% (40-80%)
Median time from referral to starting SACT	High-grade lymphoma	57 days§	57 days (50-68 days)	52 days§	57 days (40-76 days)
Median time from referral to diagnosis	High-grade lymphoma	17 days§	17 days (13-23 days)	15 days§	18 days (5-24 days)
Median time from diagnosis to starting SACT	High-grade lymphoma	35 days§	35 days (29-42 days)	33 days§	38 days (32-44 days)
Median time from referral to seeing a haematologist	High-grade lymphoma	36 days§	38 days (29-44 days)	-	
Median time from seeing a haematologist to starting SACT	High-grade lymphoma	19 days§	20 days (15-24 days)	-	

* National average reported except for median time measures (where national median reported).

1. Median between trusts in England or hospitals in Wales.

2. Interquartile range.

3. Hyphens indicate where data were not available for Wales.

↑: Increase from previous year. ↓: Decrease from previous year. §: New indicator so no comparator.

4.5 Treatment

PI 5: First-line SACT regimens received by people with high-grade lymphoma.

Key message

The majority of people with high-grade lymphoma received an acceptable first-line SACT regimen, reflecting generally good adherence to recommended treatment pathways.

Separate analysis of SACT regimens was carried out by subtypes among people with high-grade NHL in England (Table 4). Acceptable regimens were delivered to over 80% of patients across all three subtypes: 97% for DLBCL not otherwise specified (NOS), 83% for Burkitt lymphoma and 100% for Peripheral T-cell lymphoma. Little variation was observed across trusts in England, with the majority reporting 100% adherence to acceptable regimens across all subtypes. Data on SACT regimens were not available for Wales.

Further analysis by patient characteristics within the DLBCL NOS cohort is presented in Supplementary table 5. This analysis was limited to DLBCL NOS due to small numbers in other subtypes. Rates were marginally lower in those aged 80 and over and those with poorer performance status (PS 3/4), likely reflecting clinical adjustments to treatment in frailer patients. Lower rates were also observed in people from Black, Mixed and Other ethnic backgrounds, which warrants further investigation to determine whether this reflects differences in disease presentation, comorbidities, or potential inequities in treatment delivery.

Trends over time: Rates of acceptable first-line SACT regimens remained consistently high for DLBCL NOS and Peripheral T-cell lymphoma compared with previous years, with minimal variation between trusts. Fluctuations observed in Burkitt lymphoma over time are likely attributable to small case numbers rather than a meaningful change in practice (Supplementary figure 4 and Supplementary table 12).

PI 6: Proportion of people diagnosed with NHL with severe acute toxicity within 8 weeks of completing SACT, reported by subtype.

Key message

Overall, in England 47% of people with DLBCL NOS undergoing first-line SACT experienced severe acute toxicity within 8 weeks, highlighting the importance of monitoring these rates (**Recommendation #5**).

In England, 47% of people with DLBCL NOS who received an acceptable first-line SACT regimen experienced severe acute toxicity within 8 weeks of completing SACT, defined as a medically significant event requiring overnight hospital admission or blood transfusion in line with Common Terminology Criteria for Adverse Events (CTCAE) grade 3 (Table 4). All cause death during the acute window was also included within this definition. Details can be found in the methodology supplement.

Among those who experienced severe acute toxicity, infection was the most common type reported (64%), followed by haematological (52%) and gastrointestinal complications (38%). Death during treatment occurred in 18% of those who experienced severe acute toxicity (Supplementary figure 2).

Supplementary figure 3 shows risk-adjusted severe acute toxicity at NHS trust level. There were 9 English NHS trusts above the 95% funnel limit, with 2 English NHS trusts above the 99.8% limit.

PI 7: Proportion of people with high-grade lymphoma whose radiotherapy started within 8 weeks of end of first-line SACT.

Key message

Only one third of people with high-grade lymphoma who were due to receive consolidation radiotherapy following first-line SACT started radiotherapy within 8 weeks, with delays worsening over time (44% in 2020 reduced to 32% in 2023); it is important to identify factors that contribute to these delays (**Recommendation #3**).

32% of people in England who underwent consolidation radiotherapy commenced within 8 weeks of completing first-line SACT, rising to 54% within 12 weeks (Table 4 and Supplementary table 6). Consolidation radiotherapy delivery within 8 weeks is considered optimal, with delivery within 12 weeks regarded as an acceptable timeframe. There is considerable variation across NHS trusts (IQR: 22–50%), warranting further investigation of the underlying causes and any geographic patterns. No data was provided on SACT regimens in Wales, so it was not possible to report radiotherapy delivery following SACT.

Trends over time: Comparison between results over time demonstrate a continued reduction in timely delivery of consolidation radiotherapy after first-line SACT, which warrants review by NHS trusts of their assessment and referral pathway for radiotherapy. This proportion in England declined from 44% in 2020 to 32% in 2023 (Supplementary figure 4 and Supplementary table 12).

PI 8: Proportion of people with NHL recorded as receiving radiotherapy, reported by subtype.

Key message

There was substantial variation between providers as well as NHL subtypes in the proportion receiving radiotherapy (with curative, consolidative or palliative intent).

Overall, around 12% people with NHL received radiotherapy (with curative, consolidative or palliative intent) within 1 year of diagnosis in England, compared with approximately 5% recorded in Wales. Due to current difficulties in radiotherapy capture with existing databases in Wales, only limited conclusions can be drawn from the current data provided for Wales; this may explain lower proportions of radiotherapy delivery in Wales compared to England. The most common subtypes receiving radiotherapy were large B-cell lymphoma, follicular lymphoma, marginal zone lymphoma and cutaneous T-cell lymphoma in England; and were large B-cell lymphoma and follicular lymphoma in Wales (Table 4 and Supplementary table 7). A similar pattern by subtype was seen for radiotherapy within 2 years of diagnosis in England (Supplementary tables 7–8).

Further analysis on indications for radiotherapy delivery and future analyses exploring variation in radiotherapy delivery at an NHS trust and hospital level, as well as the structure of radiotherapy referral pathways/tertiary referral centres services, will increase our understanding of differences in care delivery across England and Wales.

Trends over time: There has been no significant change in radiotherapy delivery over time by subtype (England 2020-2023 and Wales 2022-2024) (Supplementary figure 4 and Supplementary table 12).

PI 9: Proportion of people diagnosed with NHL recorded as having received an episode of care that was delivered as part of a clinical trial, reported by subtype.

Key message

Less than 3% of individuals diagnosed with NHL in England in 2023 were recorded as having received an episode of care that was delivered as part of a clinical trial. Reasons why individuals are not enrolled in clinical trials should be identified (**Recommendation #4**).

2.6% of all NHL individuals had a record of having received an episode of care that was delivered as part of a clinical trial in England 2023; this is slightly higher in low-grade cases (3.1%) compared to high-grade cases (2.2%) (Table 4 and Supplementary table 9). No data on trial participation was available for Wales. Record-keeping for trial participation also needs to be improved, with data completeness approximately 25%, varying between 0-78% when reviewed by subtype. Follicular lymphoma and the group 'Other' were the most common subtypes among those who had a record of trial participation (England 2023), while the lowest recorded rates were observed in Burkitt lymphoma, chronic lymphocytic leukaemia, cutaneous T-cell lymphomas, and marginal zone lymphoma.

Although this performance indicator is reported at the Cancer Alliance level due to the small number of trial participants, the overall consistency in low rates suggests that limited record of trial participation is a widespread issue across England.

Trends over time: Overall proportion of people with NHL with recorded clinical trial participation remained around 2-3% in England between 2021 and 2023 (Supplementary figure 4 and Supplementary table 12).

Table 4. Indicator results of treatment, England 2023 and Wales 2024.

Performance indicator (PI)	Denominator	England 2023*	Median[1] (IQR[2]) in England 2023	Wales 2024*[3]	Median[1] (IQR[2]) in Wales 2024
PI 5. First-line systemic anti-cancer therapy (SACT) regimens[4] received by people with high-grade lymphoma (Burkitt lymphoma (BL), diffuse large B-cell lymphoma (DLBCL) or high-grade T-cell lymphoma).	DLBCL, NOS[5]	97.2%→	100% (100-100%)	-	
	Burkitt lymphoma	83.1%↑	100% (100-100%)	-	
	Peripheral T-cell lymphomas, NOS[5]	100%→	100% (100-100%)	-	
PI 6. Proportion of people diagnosed with NHL with severe acute toxicity within 8 weeks completing SACT, reported by subtype.	DLBCL, NOS[5]	47.4%§	48% (41-54%)	-	
PI 7. Proportion of people with high-grade lymphoma whose radiotherapy started within 8 weeks of end of first-line SACT.	High-grade lymphoma	31.5%↓	33% (22-50%)	-	
PI 8. Proportion of people with NHL recorded as receiving radiotherapy, reported by subtype.	All NHL	11.8%→	11% (8-15%)	5.4%↓	3% (0-7%)
PI 9. Proportion of people diagnosed with NHL recorded as having received an episode of care that was delivered as part of a clinical trial, reported by subtype.	All NHL	2.6%↑	0% (0-4%)	-	

* National average reported.

1. Median between trusts in England or hospitals in Wales.

2. Interquartile range.

3. Hyphens indicate where data were not available for Wales.

4. Acceptable regimens were defined as recommended first-line regime as per NICE guidelines or an appropriate adjustment such as anthracycline replacement (see Methodology Supplement for more details).

5. NOS: not otherwise specified.

↑: Increase from previous year. ↓: Decrease from previous year. →: No change from previous year. §: New indicator so no comparator.

4.6 Survival

PI 11: Overall 1 and 2-year survival of people diagnosed with NHL, reported by grade and subtype.

Key messages

1. Overall 1-year survival for all NHL cases was 82-84% in England and Wales; 71-73% for high-grade cases and 93-94% for low-grade cases.
2. Overall 2-year survival for all NHL cases was 75% in England; 64% for high-grade cases and 86% for low-grade cases.

Over 80% of people with NHL survived at least 1 year after diagnosis with this rate lower in England (82%) than in Wales (84%). A similar pattern was noted for 1-year survival in both high-grade (71% in England; 73% in Wales) and low-grade cases (93% in England; 94% in Wales), although 95% confidence intervals did not suggest statistically significant differences between countries (p=0.46 and 0.28 for high and low-grade lymphoma, respectively). Around 75% of NHL cases in England survived 2 years following diagnosis. This rate was 64% in high-grade lymphomas compared with 86% in low-grade lymphomas. (Table 5)

Trends over time: Both 1 and 2-year survival rates either showed small improvement or remained stable over time across subtypes and countries (Supplementary figure 4 and Supplementary table 12). For example, 1-year survival across all people with NHL increased from 79% to 82% in England between 2020 and 2023, and remained stable from 83% to 84% in Wales between 2022 and 2024.

Table 5. Indicator results for overall 1 and 2-year survival in England 2022-23 and Wales 2024.

Performance indicator (PI)	Denominator	England 2023	95% CI[1] in England 2023	Wales 2024[2]	95% CI[1] in Wales 2024
PI 11. Overall 1-year survival of people diagnosed with NHL, reported by grade and subtype.	All NHL	81.7% ↑	81.0-82.3%	83.9% ↑	81.0-86.5%
	High-grade lymphoma	70.9% →	70.0-71.9%	72.8% ↓	67.7-77.5%
	Low-grade lymphoma	92.6% ↑	92.0-93.1%	94.1% →	91.2-96.2%
PI 11. Overall 2-year survival[3] of people diagnosed with NHL, reported by grade and subtype.	All NHL	74.5% ↑	73.8-75.1%	-	
	High-grade lymphoma	63.6% ↑	62.5-64.7%	-	
	Low-grade lymphoma	85.6% ↑	84.8-86.4%	-	

1. 95% confidence interval. 2. Hyphens indicate where there was not enough follow-up time in the data to review patient survival in Wales. 3. Overall 2-year survival was reported for people diagnosed in England 2022 to allow for enough follow-up time. ↑: Increase from previous year. ↓: Decrease from previous year. →: No change from previous year.

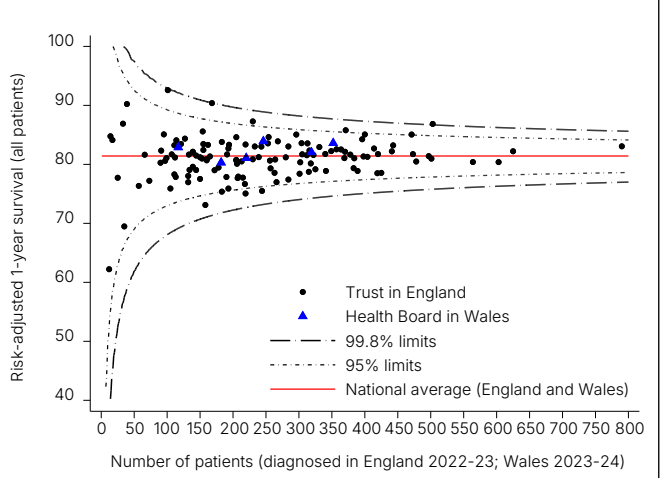
4.7 Outlier analysis

As part of this year's report, an outlier analysis has been carried out for 1-year survival in both England and Wales and 2-year survival in England. Aggregated two years' data were used to increase sample size and statistical power. See Methodology Supplement for risk adjustment process.

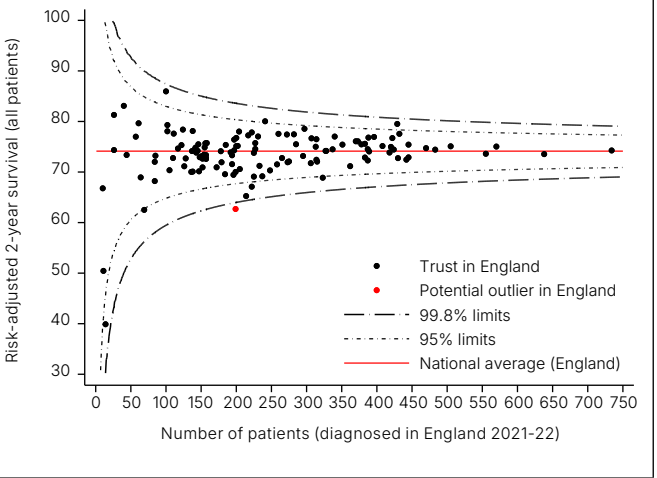
Analysis of overall 1-year survival was performed on a cohort of people diagnosed with NHL in England between 2022 and 2023 and in Wales between 2023 and 2024. After risk adjustment, there was 1 trust in England more than 3 standard deviations (SDs) above the national average considered as a positive potential outlier. There were 3 English trusts between 2 and 3 SDs below the national average, and no NHS trusts/health boards below 3 SDs from the national average (Funnel plot 1a).

Analysis of overall 2-year survival was carried out on a cohort of people diagnosed with NHL in England between 2021 and 2022. After risk adjustment there were 5 English trusts between 2 and 3 SDs below the national average, and 1 trust more than 3 SDs below the national average, considered a potential alarm (Funnel plot 1b). The NATCAN outlier policy was followed for the potential outlier. If trusts remain between 2 and 3 SDs below the national average for 2 consecutive years, they will be considered a potential alarm. The funnel plots demonstrate more variation than expected by chance between NHS trusts/health boards in England and Wales.

Funnel plot 1a. Risk-adjusted 1-year survival for all people diagnosed with NHL in England (2022-23) and Wales (2023-24)



Funnel plot 1b*. Risk-adjusted 2-year survival for all people diagnosed with NHL in England (2021-22)



*England only; Welsh data not included due to insufficient follow-up time.

5. Commentary

This national report provides a comprehensive overview of the patterns of care for individuals diagnosed with non-Hodgkin lymphoma in England in 2023 and Wales in 2024. The report not only presents the most recent data but also offers a commentary on trends observed since the publication of the inaugural State of the Nation report (2024). A longitudinal analysis for all performance indicators (PIs) is included in the Supplementary documents, and detailed results by individual NHS trust/ health board are also provided in Data Tables.

Data considerations:

- Direct comparisons between England and Wales remain challenging due to differences in data collection and reporting periods, especially in the context of the post-COVID-19 pandemic recovery period. These differences may partly explain poorer outcomes in England for some performance indicators.
- Data quality remains a critical concern which has implications for risk adjustment and outlier identification. To emphasize the importance of this issue and support its improvement, NNHLA has launched a quality improvement (QI) initiative in October 2025 to help address these challenges in more depth.
- While improvements of the IT infrastructure in Wales are underway, current limitations have affected the ability to report on some performance indicators for Welsh providers.

Process and outcome observations:

A decline has been observed in several key performance indicators over recent years across England and Wales, highlighting the urgent need for targeted quality improvement at a local level.

Delays to initiating first-line SACT may contribute to poorer outcomes, particularly for people with high-grade disease. By providing additional time measures on the care pathway, this report shows that time from referral to seeing a haematologist and time to starting first-line SACT after diagnosis had the longest delays, highlighting areas to target for quality improvement.

Timely MDT discussions and timely use of consolidation radiotherapy are still important components of the care pathway that need improvement alongside treatment initiation. Addressing these areas may contribute to improved outcomes. An action plan template for NHS trusts/Health boards will be made available on our website to support this work.

The incidence of emergency presentations showed significant impact on patient outcomes including survival rates. There are multi-factorial reasons which will be further interrogated during the course of the audit, such as understanding more about who this group is, the timeliness of care and the treatments received.

1 and 2-year survival has remained stable or improved slightly overall, but variation is seen between providers. This may reflect inequity in care and is monitored via our outlier policy.

Next steps:

Further development work and improvements in data provision in Wales will allow NNHLA to report on more of its 11 indicators for both nations. Reporting on the care and outcomes of people with low-grade NHL is a priority, and work is underway to develop the indicator for time to treatment for relapse in this group.

The NNHLA Data Dashboard continues to provide more timely insights to providers, with a 6-month lag between diagnosis and reporting of data.[1] NNHLA will work to align the reporting periods for England and Wales and provide more timely reporting in its State of the Nation reports.

NNHLA will carry out work to better understand the structure of NHL care, including referral pathways and tertiary referral centre services. This will increase our understanding of differences in care delivery across England and Wales, such as variation in radiotherapy delivery.

Following the launch of the National QI initiative in October 2025, NNHLA has provided continuous and various support to NHS trusts in England including a designated webpage, timely follow-up, training resources and case studies. NNHLA will continue to review data quality to identify any improvements and remaining challenges.

1 The 6-month lag applies to most indicators including the proportion of people discussed in an MDT meeting within 4 weeks of diagnosis, and the proportion of people seen by a CNS. For time to treatment indicators, there is a 15-month lag due to availability of SACT data and follow-up time required.