

COVID-19 Cancer Services Guidance

VERSION 5: Reviewed and reissued 02 February 2022

Te Aho o Te Kahu (Cancer Control Agency) is working closely with clinicians to ensure a nationally consistent approach to cancer and blood services during this challenging time. The priority is to support the continuity of cancer and blood services, whilst taking every effort to ensure safety of staff and patients and preventing the spread of COVID-19.

The following information is included in this update:

- 1) Overall document revision to reflect the change to the COVID-19 Protection Framework (traffic lights).
- 2) Removal of the Hospital Escalation Framework and introduction of Service Disruption Levels.

Approach to cancer and blood services

This guidance was initially developed in 2020 in the context of the elimination strategy. Te Aho o Te Kahu has reviewed this guideline to align with the national COVID-19 Protection Framework (traffic lights).

This guidance is part of whole system planning for cancer care, aligning with endoscopy, radiology, and surgical guidance. The aim is to support the whole of the cancer care pathway to be operating at a consistent level at different hospital capacities.

Whilst the focus is on preserving the delivery of cancer treatment, we also need to be prepared for scenarios where delivery of care may be compromised. The guidance below supports a nationally consistent approach to changes in treatment.

Services should make use of additional general advice on managing haematology and oncology patients during the COVID-19 pandemic, which been developed by New Zealand and Australian cancer and infectious disease specialists¹.

Equitable delivery of care

This guidance reflects the Te Aho o Te Kahu commitment to Te Tiriti o Waitangi in achieving equity for Māori patients. Māori and Pacific peoples experience multiple and disproportionate barriers to accessing cancer diagnoses, treatment, and care. Consequently, these population groups frequently receive diagnosis and treatment at a relatively later stage and have worse cancer-related outcomes. Pandemics can accelerate systemic drivers of inequity, including access to adequate income, shelter and food security. There is good evidence that standardisation of care across treatment pathways reduces inequities².

We recognise that any limitation of services for patients based on survivability of their cancer will disproportionately impact Māori and other priority populations. Therefore, it is recommended that cancer services and DHBs will consider and action the following:

- **Ensure Māori and other priority populations have a prioritised, and well-coordinated diagnostic and treatment pathway.**
- Use this guideline to operationalise equity.

¹ Weinkove, R., McQuilten, Z., Adler, J., Agar, M., Blyth, E., Cheng, A., Conyers, R., Haeusler, G., Hardie, C., Jackson, C. and Lane, S., 2020. Managing haematology and oncology patients during the COVID-19 pandemic: interim consensus guidance. *The Medical Journal of Australia*, 212(10)

² Seneviratne S, Campbell I, Scott N, Shirley R, Lawrenson R. Impact of mammographic screening on ethnic and socioeconomic inequities in breast cancer stage at diagnosis and survival in New Zealand: A cohort study Disease epidemiology - Chronic. *BMC Public Health* 2015;15(1)

- Proactively mitigate the impact of diagnostic and treatment decisions on inequity at all capacity levels.
- As capacity returns, continue to deliver equitable services.

This guidance document fits into a wider framework of activity to mitigate the likely exacerbation of inequities in cancer care in the context of COVID-19.

Multidisciplinary meetings

Multidisciplinary meetings (MDMs) should continue, noting that the form of meetings may change, eg, virtual conferences. Clinical teams may face difficult decisions and if resources are constrained, care may deviate from usual pathways. Many of these pathways were already contributing to inequities. It is recognised that in times of stress biases may be exacerbated, which may impact decision making and increase inequities. These issues should be acknowledged within MDMs.

Where a Māori or Pacific patient's care does not follow the usual treatment pathway, the MDM should consider what can be done to maximise the potential for Māori or Pacific health gain and equity. If this is the case, best practice is to ensure review with a senior Māori or Pacific clinician if available, alternatively seek an opinion from Māori or Pacific health professionals locally.

Treatment provision

The guidance on treatment provision is based on treatment intent and expected risk: benefit ratio of the treatment regimens³. This work has been adapted for the NZ context by cancer clinicians across New Zealand. Considerations include:

- There must be a balance between the risk of cancer not being treated optimally with the risk of illness and spread of COVID-19. This balance of risk may be different in New Zealand to other jurisdictions.
- We must consider the impact decisions will have on Māori and Pacific patients with cancer and comorbidities.
- This guidance does not preclude the need for clinical judgement and clinicians will need to have clear discussion on the risks and benefits of treatment, and treatment preferences with their patients.

Staff, patient and whānau safety

There are concerns regarding the possibility of transmission of COVID-19 between patients, whānau and healthcare staff. The Ministry of Health has provided national guidance around the use of personal protective equipment (PPE) in the context of COVID-19⁴. Infection prevention and control, including hand hygiene, working in teams and meticulous adherence to donning and doffing of PPE, is vital as part of a broad strategy to limit spread of the virus and protect staff, patients and whānau.

Safety also needs to be considered in the context of delayed or deferred treatment. Departments should consider the following:

- Have robust processes to manage wait lists to ensure patient safety is maintained. There must be timely and clear communication with patients/whānau and primary care, including a point of contact for patients and their whānau.
- Departments must have a process to review wait lists to identify those whose clinical situation is becoming more urgent.
- A transparent process to audit referrals that have been declined and sent back to GP (will be reviewed by ethnicity).

³ <https://www.nice.org.uk/covid-19/specialty-guides#cancer>

⁴ <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-information-specific-audiences/covid-19-advice-essential-workers-including-personal-protective-equipment/personal-protective-equipment-use-health-care>

Service Disruption Levels

With the move away from an elimination strategy to manage COVID-19, the National Hospital COVID-19 Escalation Framework has been retired. This reflects the move towards the focus on maintenance of planned health care services meaning each DHB is responsible for prioritisation of services where there are disruptions.

There may be certain circumstances where the DHB may be experiencing disruptions to its overall response while permitting cancer and blood services to continue. This determination is the responsibility of the DHB emergency operations centre in consultation with the cancer and blood services manager.

Conversely, it is possible that cancer and blood services at a hospital may be facing a specific situation that limits their ability to provide care, even if the whole-of-hospital alert level is unaffected and has no need to escalate, e.g., if a radiation therapy service has several staff in self-isolation. It is expected that a unit would aim to redeploy staff within its department to maintain service and/or work with another cancer centre if possible. However, if this is not possible cancer and blood services may be required to change delivery of care. In this case service capacity triggers have been developed to assist cancer and blood services with responding to unit capacity issues.

Level of disruption to cancer and blood services	<i>Examples of triggers which may contribute to service disruption and capacity</i>
No disruption	
Some disruption	Loss of staff through illness, self-isolation, redeployment.
Moderate disruption	As above plus any conversion of facilities to manage patients with COVID-19, ICU capacity, isolation capacity.
Significant disruption	As above plus major occurrences such as a COVID-19 outbreak in the cancer centre or ward.

Note that the factors included above are examples of disruption only. In addition, it is important to consider the expected length of time that the disruption would occur. This is particularly relevant for planning to transfer patients to an alternative location as a short disruption may not warrant transfer.

Process for changing levels

If a blood and cancer service believe they need to move their service up an alert level, two actions are required from the service.

- a. They should notify their own DHB management of this need, and the proposed impact on patients.
- b. They should notify the chair of the relevant national work group (Medical Oncology Work Group MOWG, Haematology Work Group HWG or Radiation Oncology Work Group ROWG). If inequities in service provision are identified, this must be communicated to the relevant national work group and Te Aho o Te Kahu alerted.

The chair of the relevant national work group will also alert Te Aho o Te Kahu to ensure a national picture of service disruption is maintained.

There are regular meetings and clear channels of communication between the key work groups, which will aim to provide support across units if required. Te Aho o Te Kahu will work with cancer and blood services to ensure ongoing consistency and support.

Haematology Service Activity Levels

This document focuses on non-stem cell transplant related treatment and a separate document has been developed outlining an approach to stem cell transplants.

No disruption	Preparation
Some disruption	Consider taking Service Activity Level 5 actions
Moderate disruption	<p>Maintain Service Activity Levels 1, 2, 3, 4 as able.</p> <p>Consider transfer of patients to another facility if likely to be an ongoing period of disruption.</p> <p>Māori and other priority patients, who are likely to have experienced systematic barriers and delays in care, should be prioritised through the pathway and supported to complete treatment.</p>
Significant disruption	<p>Maintain Service Activity Levels 1, 2 and 3a as able</p> <p>Transfer patients to another facility if likely to be an ongoing period of disruption.</p> <p>Māori and other priority patients, who are likely to have experienced systematic barriers and delays in care, should be prioritised through the pathway and supported to complete treatment.</p>

While treatment of people who fall under Service Activity Levels 3 and 4 would be deferred where there is significant disruption to a service there are certain circumstances where people will require urgent treatment. Examples include people who require urgent treatment for hypercalcaemia or renal failure in the context of multiple myeloma. This will be on a case-by-case basis at the discretion of the treating clinician.

Service Activity Level 1

Curative therapy with a high (>50%) chance of success.

- Treatment of Acute Leukaemia
- Treatment of High Grade / Aggressive Lymphomas
- Allogeneic SCT
- Autologous SCT for Relapsed High Grade / Aggressive Lymphomas

Service Activity Level 2

Curative therapy with an intermediate (15- 50%) chance of success.

- Treatment of Acute Leukaemia
- Treatment of High-Grade Lymphomas
- Allogeneic SCT
- Autologous SCT for Relapsed High-Grade / Aggressive Lymphomas

Service Activity Level 3a

Non-curative therapy with a high (>50%) chance of >1 year of life extension.

- Treatment of chronic leukaemia
- Treatment of low-grade lymphomas
- Treatment of multiple myeloma
- Treatment of myeloproliferative disorders

Service Activity Level 3b

Curative therapy with a low (0-15%) chance of success. Non-curative therapy with an intermediate (15-50%) chance of > 1-year life extension.

- Treatment of elderly AML
- Treatment of relapsed haematological malignancy

Service Activity Level 4a

Non-curative therapy with a high (>50%) chance of palliation / temporary tumour control but < 1-year life extension.

- Treatment of relapsed haematological malignancy with multiple prior lines of therapy

Service Activity Level 4b

Non-curative therapy with an intermediate (15-50%) chance of palliation.

- Temporary tumour control and < 1-year life extension.
- Treatment of relapsed haematological malignancy with multiple prior lines of therapy

Service Activity Level 5

Treatments that could be stopped or altered to preserve day unit capacity and minimise spread of COVID-19.

- Stop iron infusions
- Stop venesection for hereditary hemochromatosis where ferritin < 1000
- Stop or extend out to 3 monthly bisphosphonate treatment for myeloma bone disease
- Defer Rituximab maintenance in low grade B cell lymphoma for current time. Some patients with suboptimal response to first line therapy of follicular lymphoma or those with Mantle Cell Lymphoma post ASCT may be considered on a case-by-case basis.
- Clinical review of individual patient transfusion thresholds to minimise blood product administration
- Consider outpatient-based management of low risk non neutropenic / neutropenic sepsis where clinically appropriate.
 - **For Māori, Pacific and other priority populations**, inpatient based management is preferable, due to existing inequities in progression of infection to sepsis. If outpatient-based care deemed more appropriate, must ensure a robust infection monitoring and escalation care plan is in place.
- Look to use Peg-GCSF where appropriate to minimise risk of admission for febrile neutropenia

Medical Oncology Service Activity Levels

Associated with this document is a spreadsheet listing all major regimens for different tumour types and their associated level. This has been developed by the Medical Oncology Work Group and is modelled on UK work from the NHS and informed by similar work from Australia. Of note:

- Not all patients and situations will fit into these categories. There is individual clinician discretion to treat a patient who they feel would derive greater benefit from the treatment than criteria suggest. These discretionary decisions can be made by a clinician in consultation with their Clinical Leader. We recommend a unit-specific peer review process to ensure consistency and fairness within a centre.
- Final decision making remains the responsibility of the unit. If treatment cannot be safely given, then it should be withheld.
- Treatment decisions should be based on clinical benefit, and current resources, not based on compassion (all patients deserve compassion) or patient demands.

- Treatments involving radiotherapy combined with chemotherapy will require discussion with radiation colleagues. In some situations, it may be preferable to proceed with radiotherapy alone than combined chemoradiation.

No disruption	Preparation
Some disruption	Consider taking Service Activity Level 5 actions
Moderate disruption	Maintain Service Activity Levels 1, 2, 3, 4 as able Consider transfer of patients to another facility if likely to be an ongoing period of disruption. Māori and other priority patients, who are likely to have experienced systematic barriers and delays in care, should be prioritised through the pathway and supported to complete treatment.
Significant disruption	Maintain Service Activity Levels 1 and 2; and 3a as able Transfer patients to another facility if likely to be an ongoing period of disruption. Māori and other priority patients, who are likely to have experienced systematic barriers and delays in care, should be prioritised through the pathway and supported to complete treatment.

Service Activity Level 1

- Curative therapy with a high (>50%) chance of success
- Adjuvant (or neo) therapy which adds at least 50% chance of cure to surgery or radiotherapy alone or treatment given at relapse

Service Activity Level 2

- Curative therapy with an intermediate (20- 50%) chance of success
- Adjuvant (or neo) therapy which adds 20 – 50% chance of cure to surgery or radiotherapy alone or treatment given at relapse

Service Activity Level 3a

- Curative therapy of a low chance (10 – 20%) of success
- Adjuvant (or neo) therapy which adds 10 – 20% chance of cure to surgery or radiotherapy alone or treatment given at relapse
- Non-curative therapy with a high (>50%) chance of >1 year of life extension

Service Activity Level 3b

- Curative therapy with a very low (< 10%) chance of success
- Adjuvant (or neo) therapy which adds less than 10% chance of cure to surgery or radiotherapy alone or treatment given at relapse
- Non-curative therapy with an intermediate (15-50%) chance of > 1 year life extension

Service Activity Level 4a

- Non-curative therapy with a high (>50%) chance of palliation / temporary tumour control but < 1 year life extension

Service Activity Level 4b

- Non-curative therapy with an intermediate (15-50%) chance of palliation / temporary tumour control and < 1 year life extension

Service Activity Level 5

Treatments that could be stopped or altered to preserve day unit capacity and minimise spread of COVID-19. Consideration should be given to the following:

- In the context of actual or potential community spread of COVID-19 it is likely that the risk/benefit ratio of some adjuvant therapies becomes negative in this context. Professional consensus within New Zealand is that adjuvant chemotherapy with OS / RFS gain < 5% is unlikely to be favourable for patients. We strongly recommend avoiding commencing these therapies and discussing with patients currently on therapies that the risk/benefit ratio is likely to have changed unfavourably, and strong consideration given to ceasing therapies with these limited benefits.
- Consider outpatient-based management of low risk non neutropenic / neutropenic sepsis where clinically appropriate. **For Māori, Pacific and other priority populations**, inpatient based management is preferable, due to existing inequities in progression of infection to sepsis. If outpatient-based care deemed more appropriate, must ensure a robust infection monitoring and escalation care plan is in place.
- IV therapy should be avoided where there is an oral therapy with broadly comparable health gain outcome
- Therapies with less frequent attendances for example less frequent infusions should be selected where there is an alternative dosing schedule available with minimal therapeutic disadvantage (subject to availability)
- Maintenance therapy of minimal benefit should be discontinued to reduce hospital attendance and reduce chance of nosocomial exposure and spread of COVID-19

Radiation Oncology Service Activity Levels

The Radiation Oncology Work Group (ROWG) endorsed the NHS categorisation of treatments as outlined below. ROWG has also endorsed Appendix 1 of Peter MacCallum Cancer Centre's Clinical Response Plan outlining dose fractionation recommendations⁵.

No disruption	Preparation. Hypofractionation used as clinically indicated.
Some disruption	Hypo-fractionation used as clinically indicated and consider if further opportunities to hypofractionate treatment to increase capacity.
Moderate disruption	Maintain Service Activity Levels 1, 2, 3, 4 as able Consider transfer of patients to another facility if likely to be an ongoing period of disruption. Māori and other priority patients, who are likely to have experienced systematic barriers and delays in care, should be prioritised through the pathway and supported to complete treatment.
Significant disruption	Maintain Service Activity Levels 1 and 2; and 3a as able Transfer patients to another facility if likely to be an ongoing period of disruption Māori and other priority patients, who are likely to have experienced systematic barriers and delays in care, should be prioritised through the pathway and supported to complete treatment.

Service Activity Level 1 – ROWG Category B patients

- Patients with rapidly proliferating tumours currently being treated with radical (chemo)radiotherapy with curative intent where there is little or no scope for compensation of gaps in treatment.
- Patients with tumours in whom combined External Beam Radiotherapy (EBRT) and subsequent brachytherapy is the management plan and the EBRT is already underway.
- Patients with tumours who have not yet started and in whom clinical need determines that treatment should start in line with current cancer waiting times.

Service Activity Level 2 – ROWG Category A patients

- Urgent palliative radiotherapy in patients with malignant spinal cord compression who have useful salvageable neurological function.

Service Activity Level 3 – ROWG Category C Radical patients

- Radical radiotherapy for less aggressive tumours where radiotherapy is the first definitive treatment.
- Post-operative radiotherapy where there is known or potential residual disease following surgery in tumours with aggressive biology.

Service Activity Level 4 – ROWG Category C Palliative patients

- Palliative radiotherapy where alleviation of symptoms would reduce the burden on other healthcare services, such as haemoptysis.

⁵ Peter MacCallum Cancer Centre, Appendix 1 COVID-19 – DRO Clinical Response Plan, March 2020, Victoria Australia

Service Activity Level 5

- Adjuvant radiotherapy where there has been complete resection of disease and there is a <20% risk of recurrence at 10 years, for example most ER positive breast cancer in patients receiving endocrine therapy.
- Radical radiotherapy for prostate cancer in patients receiving neo-adjuvant hormone therapy.