

# COVID-19 Cancer Services Guidance

**VERSION 3:** Reviewed and reissued 18<sup>th</sup> August 2021

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) **Haematology** treatment delivery expectations (page 4)
- 2) **Medical oncology** treatment delivery expectations (page 5)
- 3) **Radiation oncology** treatment delivery expectations (page 7)

## Approach to cancer and blood services

All changes to service delivery should align with the COVID-19 National Hospital Response and follow the directive from local DHBs. 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 specialists<sup>1</sup>.

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.

### Equitable delivery of care

Māori and Pacific peoples experience multiple and disproportionate barriers to accessing cancer diagnoses, treatment and care. Consequently, these population groups are frequently diagnosed and receive treatment at a relatively later stage and have worse cancer-related outcomes. The presence of pandemic 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 inequities<sup>2</sup>.

We recognise that any limitation of services for patients based on survivability of their cancer will disproportionately impact Māori and other priority populations. DHBs should actively mitigate the impact of diagnostic and treatment decisions on inequity at all alert levels. This includes **supporting Māori and other priority populations to have a prioritised, efficient, coordinated and streamlined diagnostic and treatment pathway**. As capacity returns, DHBs should continue to strive for equity.

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.

<sup>1</sup> 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)

<sup>2</sup> 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)

## Multidisciplinary meetings

Multidisciplinary meetings should continue, noting that the form of meetings may change, e.g. 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 multidisciplinary meetings. 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.

## Treatment provision

The guidance on treatment provision is based on treatment intent and expected risk:benefit ratio of the treatment regimens<sup>3</sup>. 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 our most vulnerable cancer patients, Māori and Pacific, and patients with comorbidities.
- This guidance does not preclude the need for clinical judgement and clinicians will need to be having 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-19<sup>4</sup>. 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 for managing 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 for reviewing wait lists to identify those whose clinical situation is becoming more urgent.
- A transparent process for auditing referrals that have been declined and sent back to GP (will be reviewed by ethnicity).

## Triggers to move between levels

The National Hospital Response (NHR) Framework uses colour-coded alert levels to clearly communicate when a whole-of-hospital adjustment to services is required because of an escalation of the COVID-19 situation. Different DHBs may be at different alert levels on the NHR Framework and hospitals can move up or down the alert levels, as needed. **Note:** DHB alert levels are distinct from the Government alert levels (1-4). If a DHB meets the specified trigger criteria to move to a higher alert level on the NHR Framework, then the DHB is likely to require cancer and blood services to respond in line with this. There may be certain circumstances where the DHB escalates its overall response while permitting cancer and blood services to

<sup>3</sup> <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/specialty-guide-acute-treatment-cancer-23-march-2020.pdf>

<sup>4</sup> <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>

continue at a lower level. 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.

	<b>National Hospital Response Framework Triggers</b> <i>Level set by DHB, reflects overall DHB capacity</i>	<b>Cancer and Blood Service Capacity Triggers</b> <i>Triggered by cancer and blood services, reflects service capacity</i>
<b>Green Alert</b>	Managing service delivery as usual with only staffing and facility impact being for training & readiness purposes	Maintaining >75% service capacity
<b>Yellow Alert</b>	Isolation capacity and ICU capacity manageable; some staff absence and some staff redeployment to support response and manage key gaps	Fall to <75% service capacity
<b>Orange Alert</b>	Community transmission/multiple clusters in your community; isolation & ICU capacity impacted; significant staff absence, extensive staff redeployment, gaps not being covered	Fall to <50% service capacity
<b>Red Alert</b>	Community transmission/widespread outbreaks in your community; isolation & ICU at capacity; all available staff redeployed to critical care	Fall to <25% service capacity

## Process for changing levels

If a blood and cancer service believe they need to move their service (but not the whole-of-hospital) up an alert level, two actions are required:

- They should notify their own DHB management of this need, and the proposed impact on patients.
- They should notify the chair of the relevant national working group (MOWG, HWG or ROWG) and alert Te Aho o Te Kahu.

There are regular meetings and clear channels of communication between the key working groups, which will aim to provide support across units if required. Te Aho o Te Kahu is working 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.

<b>Green Alert</b>	Preparation
<b>Yellow Alert</b>	Consider taking Service Activity Level 5 actions
<b>Orange Alert</b>	Maintain Service Activity Levels 1, 2, 3 as able
<b>Red Alert</b>	Maintain Service Activity Levels 1 and 2 as able

Māori and vulnerable patients, who are likely to have experienced systematic barriers and delays in care, should be supported to complete treatment and prioritised through the pathway.

## 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
- 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 Working 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.

<b>Green Alert</b>	Preparation
<b>Yellow Alert</b>	Consider taking Service Activity Level 5 actions
<b>Orange Alert</b>	Maintain Service Activity Levels 1, 2, 3 as able
<b>Red Alert</b>	Maintain Service Activity Levels 1 and 2 as able

Māori and vulnerable patients, who are likely to have experienced systematic barriers and delays in care, should be supported to complete treatment and prioritised through the pathway.

## 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:

- Mortality from COVID in immunosuppressed patients is higher than in non-immunosuppressed patients. In the context of actual or potential community spread of COVID 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.
- 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 Working 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 recommendations<sup>5</sup>.

<b>Green Alert</b>	Preparation
<b>Yellow Alert</b>	Hypo-fractionation as able to increase capacity within units
<b>Orange Alert</b>	Maintain Service Activity Levels 1, 2, 3, 4 as able
<b>Red Alert</b>	Maintain Service Activity Levels 1 and 2 as able

Māori and vulnerable patients, who are likely to have experienced systematic barriers and delays in care, should be supported to complete treatment and prioritised through the pathway.

## 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.

## 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.

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