TE AHO O TE KAHU CANCER CONTROL AGENCY

COVID-19 Adult Cancer Imaging Guidance

VERSION 2: Reviewed and reissued 18th 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.

Approach to cancer imaging

Radiology is a key service in the management of patients with suspected or confirmed cancer and plays a pivotal role in:

- Screening and early detection
- Diagnosis and staging
- Evaluation of response to treatment and monitoring of disease
- Treatment (e.g. ablation, SVC stenting)
- Diagnosis and treatment of complications
- Evaluation of suspected recurrence
- Surveillance of patients treated with radical intent

Radiology is also a key service in the management patients from other acute and planned non-cancer pathways.

Aim of this document

The COVID-19 pandemic has had an initial, and will have an ongoing, impact on the capacity of radiology services. To add to this, many services had pre-existing waitlists and constraints.

The Medical Council of New Zealand provides guidance on safe practice in a resource constrained environment[1]:

- It is important that resources are allocated in a way that is equitable and sustainable, based on need and evidence of benefit.
- Referrals to a service with limited resources should be seen in order of priority and a patient should receive treatment in accordance with their assigned priority.
- Prioritisation systems should be fair, systematic, consistent, evidence-based, equitable, sustainable and transparent.

The aim of this document is to present a framework for:

- Achieving national consistency in acuity assessment for cancer imaging and radiological intervention including for established cancer pathways
- Achieving a common language of priorities for referring and radiology services

[1] **https://www.mcnz.org.nz/assets/standards/ca25302789/Safe-practice-in-an-environment-of-resource-limitation.pdf**

Ongoing of delivery of cancer imaging

Whilst the focus is on preserving the delivery of cancer care, 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 cancer imaging. There must be a balance between risk of illness and spread of COVID-19 with the risk to patients and whānau of cancer not being diagnosed and treated optimally.

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 conditions have been shown to dramatically 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[2].

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. This includes the development of a monitoring framework to drive equity action during the pandemic.

Collaborative approach

System planning

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

In the medium-term, radiology services will need to adapt how they provide their services to imbed processes that represent new normal of practice required to minimise risk of transmission of COVID-19. These may negatively impact capacity. Consideration also needs to be given on how to improve access to primary care for key diagnostics and ensure people are able to progress through the diagnostic pathway.

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 can 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.

[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)

Advice to referring departments

- Include good quality clinical details to inform decision making around imaging. Include the nationally agreed level (as described below).
- Work with your local radiology service to:
    - develop new models of ambulatory care models that combine clinical assessment, diagnostic and/or treatment at a single visit
    - ensure telemedicine is co-ordinated with radiology visits
    - help review and re-prioritise patients on waiting lists to ensure capacity is allocated to those with the greatest need

Advice to radiology departments

- Ensure good processes to support patients attending key radiology appointments, especially Māori and vulnerable groups.
- Ensure good processes to inform patients about realistic time frames and what do if they have concerns or if their condition deteriorates.
- Consider what impact new ways of working might have on your capacity and how you might mitigate this. If there is a gap between demand and capacity, consider options for increasing capacity to manage the gap and any backlog, including via the use of other sites in your network including private providers.
- Have processes for managing wait lists to ensure patient safety is maintained. Determine how you will continually review your waiting lists to identify those whose imaging is becoming more urgent. Review of referrals should be SMO led. Document discussions.
- Work with your referrers to build understanding of your capacity constraints and to get their help with reviewing and re-prioritising patients where required.

Cancer imaging service activity 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).

It is possible that radiology 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 several staff are off or required to self-isolate. It is expected that a unit would aim to redeploy staff within its department to maintain service and/or work with another radiology centre if possible. However, if this is not possible radiology services may be required to change delivery of care.

Green Alert	Business as usual, note some level 5 patients may not be scanned in some DHBs
Yellow Alert	Maintain Service Activity Levels 1, 2, 3 and, if possible 4*
Orange Alert	Maintain Service Activity Levels 1 and 2 and, if possible, 3**
Red Alert	Maintain Service Activity Levels 1 and, if possible, 2

**Consider using community scanners and private sector to maintain capacity and as a "cold" site. **Work with neighbouring DHBs if they are at a lower system level.*

Māori and vulnerable patients, who are likely to have undergone barriers and delays in reaching this point of the cancer pathway, should be supported to complete imaging and may be given increased priority through the pathway.

Service Activity Level 1

Acutes <24 hours

- ED, IP and ambulatory OP and GP
- Includes the adoption of new ambulatory care models that combine clinical assessment, diagnostic and treatment at a single visit.
- Acute interventional procedures including SVC stenting and inpatient biopsies and drainages

Service Activity Level 2

Urgent non deferrable < 2 weeks and essential time sensitive planned imaging

- High suspicion of cancer and other significant pathology
- Sensitive planned follow up case for key agreed high priority pathways e.g assessment post 2 cycles of cytotoxic chemotherapy
- High suspicion of relapse/recurrence/symptomatic progression etc - SOS
- Diagnostic imaging for high priority pathways.
- Key intervention including biopsy and palliative procedures, and high priority vascular access
- This may include Māori and Pacific patients from level 3 given systematic delays in accessing cancer care.

Service Activity Level 3

Non deferrable < 6 weeks and time sensitive non deferrable planned imaging

- Imaging that should be performed within the next 6 weeks
- Lower suspicion of cancer "rule out cancer" and other significant pathology.
- Less sensitive planned follow up case for key agreed medium priority pathways.
- Intervention for medium priority pathways e.g ablation of a liver metastasis in good performance patient
- May include some frail/elderly patients self-postponed or deferred from level 2 or cancers which are less time critical.

Service Activity Level 4

Deferrable, complete within 6-12 weeks. Time sensitive planned imaging that may be deferred if capacity constraints.

- Imaging that should be performed within the next few months
- Intervention that may be deferrable in slowly growing cancers and/or patients with borderline risk and benefits e.g some renal ablations.
- High priority incidentalomas
- Nationally agreed approach to incidental lesions
- Priority cancer surveillance on most suitable patients where there is a good evidence base and NZ national guidance e.g Paediatric Cancer Follow up

Service Activity Level 5

Deferrable low priority

- Low chance of imaging making a health impact or leading to management change.
- Low priority incidentalomas and surveillance.
- Lowest priority, may not happen in some DHBs.

*Incidentalomas – indeterminate lesion that required investigation and often follow up imaging

Surveillance

May include patients who:

- Are susceptible to cancer e.g genetic susceptibility

- Have been treated radically for cancer to look for metachronous tumour or oligo metastatic disease suitable for further radical treatment
- Recurrent disease suitable for palliative treatment

Ministry of Health CT and MR data shows marked variation in demand and the ability to deliver this amongst DHBs. There is significant variation in philosophy and approach amongst wider oncological community and patients as to the risk and benefits. These scans make up to a significant percentage of demand.

The evidence bases for this is varied and may be from expert opinion from other health systems. Much of this work will fall into level 4 and 5 categories at present. This has been identified as key issue to be reviewed to ensure national consistency and best use of resources.