1.1.1

Specialist Medical and Surgical Services

Medical Oncology Services

Tier 2 Service Specification

September 2024

Health New Zealand
Te Whatu Ora

Contents

1. Status

Approved to be used for mandatory nationwide description of services to be provided.

MANDATORY ☑ RECOMMENDED ☒

It is compulsory to use this Specification when purchasing services. No Districts should use a local service specification instead of this mandatory specification.

2. Review History

Review History	Date
First Published on NSFL	October 2004
Review: added new purchase units, waiting times for treatment, sections on Background, and Service Levels refers to the four regional cancer networks.	November 2011
Review: References added/updated including: New Zealand Cancer Plan 2015-2018. Purchase units aligned with latest PU Data Dictionary, MS02013 retired.	February 2018
Content moved to updated Health New Zealand format	September 2024
Consideration for next service specification review	Within the next 5 Years

Note: In September 2024 a small programme of work moved all Service Specifications to Health New Zealand branded templates. No amendments were made to the body text or content of the Service Specification, so references to DHB, Ministry of Health or other pre-2022 reforms vocabulary will still exist. A larger programme of work to review and revise all Service Specifications is planned for late 2024 to early 2025.

Note: Contact the Service Specification Programme Manager, National Health Board Business Unit, to discuss the process and guidance available in developing new or updating and revising existing service specifications. Web site address Nationwide Service Framework Library: Nationwide Service Framework Library – Health New Zealand

3. Introduction

This tier two service specification for Medical Oncology Services (the Service) must be used in conjunction with the tier one Specialist Medical and Surgical Services service specification that contains common content applicable to service delivery for all tiers of service specifications below it. Refer to the tier one service specification headings for generic details on:

- Service Objectives, including Māori health objectives
- Service Users
- Access
- Service Components
- Service Linkages
- Exclusions
- Quality Requirements

This service specification is also linked to the following service specifications:

- Tier two Radiation Oncology Services
- Tier one Services for Children and Young People
- Tier two Paediatric Oncology and Haematology Services
- Tier three Coordination of the Adolescent and Young Adult Service Coordination Service.

3.1 Background

The New Zealand Cancer Plan 2015-2018[1] sets out current cancer-related initiatives and signals potential future initiatives. The Plan has a focus on prevention and early detection and intervention.

The four regional cancer networks promote a collaborative approach to service planning and delivery. They plan and coordinate services at all levels and bring providers and consumer organisations together to ensure co-operation between and integration of services in line with national standards of treatment.

- Northern Cancer Network - Auckland, Waitemata, Counties Manukau, Northland Districts
- Midland Cancer Network - Waikato, Bay of Plenty, Lakes, Tairawhiti Districts
- Central Cancer Network - Taranaki, Whanganui, MidCentral, Hawke's Bay, Wairarapa, Hutt Valley, Capital & Coast Districts
- Southern Cancer Network – Nelson/Marlborough, Canterbury, West Coast. South Canterbury, Southern Districts

4. Service Definition

The Service provides specialist assessment and management of patients with malignant tumours provided in a clinically appropriate facility as close as is practical to the Service User's home.

Surgery, radiation treatment and chemotherapy are the main methods of treatment of cancer. Chemotherapy and surgical services are offered in most hospitals. Other supportive care and ancillary treatments may be provided during treatment.

Six regional oncology centres provide funded medical oncology, radiation oncology and haematology services. These centres are in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin.

[1] www.health.govt.nz/publication/new-zealand-cancer-plan-better-faster-cancer-care-2015-2018

The Service also co-ordinates cancer care related to systemic therapy including cytotoxic chemotherapy, targeted hormonal and molecular therapy or immunotherapy, and aspects of supportive care. Close working relationships and multi-disciplinary meetings with other secondary and tertiary specialities are required to facilitate multi-disciplinary and coordinated management of Service Users.

5. Service objectives

The Service objectives are to provide high quality cancer services that:

- provide advice, chemotherapy treatment or other anti-cancer or supportive therapies to cure or improve cancer free survival rates for long-term control of cancer
- ensure treatment or supported therapies are delivered by methods to ensure maximum safety safely within appropriate time frames and minimise the Service users' risk of complications.

6. Service Users

The Service Users are eligible[2] people with malignant conditions that require advice on management and / or systemic treatment of their condition.

7. Access

7.1 Entry Criteria

All Eligible[3] people whose referral meets the specified referral criteria to a Medical Oncologist. Refer to Appendix One Medical Oncology Prioritisation Criteria, Appendix Two Medical Oncology FSA Prioritisation Criteria.

Access to the Service is by referral to the Service from another medical practitioner or Nurse Practitioner.

7.2 4.2 Exit Criteria

The Service User exits the Service when they:

- are discharged from the Service back to their primary health care practitioner if they have completed their treatment
- they have declined, or are declined treatment
- die, or
- the Service User leaves the area and is transferred to another service.

[2] Eligibility criteria: - Not all people who are referred or present to the Service are eligible for publicly funded services. Refer to website: www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services for more eligibility information

7.3 Waiting Times

7.3.1 For assessment

See Appendix One for Medical Oncology First Specialist Assessment Prioritisation Criteria table.

7.3.2 For Treatment

The Services will ensure that Service Users are treated within the agreed national timeframes for cancer treatment. Refer to the Ministry of Health's Faster Cancer Treatment Health Targets website: www.health.govt.nz/new-zealand-health-system/health-targets/about-health-targets/health-targets-faster-cancer-treatment

See Appendix Three for the Medical Oncology Treatment Booking Priority table.

8. Service Components

8.1 General

Components of a comprehensive medical oncology service include:

- specialist assessment /reassessment of the Service User and their cancer management based on evidence and adequate informed consent delivered in conjunction with other specialists and the GP caring for the Service user.
- consultation and advice on the management of cancer, including specialist advice, follow up and guidance provided to referring clinicians or other specialists
- coordination of care:
  - support services for the Service User and their families: provision of supportive care while the Services User is having chemotherapy treatment including: appropriate access to social work, psychosocial support (counselling) and specialised community nursing care
  - attendance and participation in multi-disciplinary meetings that play a central role in managing patients with cancer
  - management of treatment complications
  - systemic treatment including chemotherapy and hormonal therapies for cure or long term control of cancer and to improve the Service user's cancer free survival. The treatment is based on evidence and /or in clinical trials
  - Palliative treatment including chemotherapy, hormonal therapies and immunotherapy for the control of symptoms caused by cancer to improve the Service user's quality of life.
  - prescription, preparation, and administration of therapy, including cytotoxics, immunotherapy, hormonal therapy, supportive therapy - bisphosphonates, blood products, anti-emetics
  - supervision and review of Service Users receiving chemotherapy treatment
  - Service User education and counselling regarding treatment and self-management during therapy
- referral to other services as appropriate to maximise wellbeing and outcomes for Service Users
- liaison with palliative care and hospice services
- education of medical and nursing staff
- quality assurance activities – review and audit of treatment procedures
- participation in clinical trials to develop the 'standard of careProcesses

8.2 Settings

A consideration in determining the settings for the Service should include (but not be confined to) issues such as cultural appropriateness, accessibility and most effective and efficient use of resources. Services may be provided through in-patient, outreach (visiting) clinics, outpatient settings or other clinically appropriate facility.

The Services will be provided as close as possible to the Service User's area of domicile that meet the clinical needs of the Service User.

8.3 Key Inputs

Appropriately trained, qualified and experienced clinical and support health care professionals, such as:

- medical oncologists
- registrars
- oncology nurses
- multidisciplinary teams
- pharmacists.

Multidisciplinary care involves input and collaboration in a wide variety of areas that include both specialist and shared care services clinical and support staff: The depth of expertise and effective co-ordination of this team is essential to ensure high-quality outcomes.

8.4 Support Services

The following support services are required to be provided as an integral part of the Service:

- pathology and laboratory services
- pharmaceutical services
- diagnostic imaging services
- psycho-social support services
- cancer nurse coordination services
- interpreting services (including NZ Sign Language for the Deaf)
- chaplaincy services.

9. Service Linkages

The Service must be well integrated with other general and specialist services and that there is effective consultation, liaison and referral between services and sub-specialities. Generic service linkages are described in tier one Specialist Medical Surgical Services.

Effective service linkages will be maintained with:

Service Provider	Nature of Linkage	Accountabilities
General Practitioner, Nurse Practitioner or other primary health carers	Referral and consultation	Assessment, treatment and intervention that supports seamless service delivery and continuity of care.
Other Specialists in District Health Boards and in private Services.	Referral and consultation	Obtain expert clinical consultation and referral services that support continuity of care.
Community district nurses and district nursing.	Referral and consultation	Assessment, treatment and intervention that supports seamless service delivery and continuity of care.
Community organisations and services	Facilitate Service access and participation	Provision of information and services that supports seamless service delivery and continuity of care
Palliative Care and Hospice Services	Liaison and consultation	Obtain expert clinical consultation and referral services that support continuity of care.
National Screening programmes	Referral and consultation	Access to assessment, treatment and intervention that supports seamless service delivery and continuity of care.
Social services, home help	Referral and consultation	Assessment and intervention that supports seamless service delivery and continuity of care.
Māori service providers	Facilitate Service access and participation	Liaison as appropriate with local iwi and communities to ensure culturally appropriateness and accessibility to services.
Pacific Peoples service providers	Facilitate Service access and participation	Liaison as appropriate with local communities to ensure culturally appropriateness and accessibility to services.
Community Health Workers, Non Government Organisations and Community Health service providers	Facilitate Service access and participation	Liaison as appropriate that support seamless service delivery and continuity of care.
Providers of support services – including transport and accommodation services	Facilitate Service access and participation	Liaison as appropriate with providers of support services

10. Exclusions

Refer to the tier one Specialist Medical and Surgical service specifications for generic exclusions. In addition this Service excludes:

- the costs of Pharmaceutical Cancer Treatment (PCT) drugs funded from the Pharmaceutical Schedule
- services for children and young people who are eligible for services provided under the Paediatric Oncology and Haematology Service tier two service specification.

11. Quality Requirements

11.1 General

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

The New Zealand Cancer Plan 2015-2018 and the New Zealand Cancer Health Information Strategy[4] should be read to provide guidance to achieve priorities of the Service, such as the delivery of high quality cancer services, and fast cancer treatment.

National Tumour Standards5 are used by the Districts as the benchmarks for high quality care for different types of cancer and help ensure patients receive timely, good quality care along the cancer pathway.

Guidance for Improving Supportive Care for Adults with Cancer in New Zealand6 is a guidance document used to improve the quality of life for people affected by cancer by improving access to and the quality of supportive care.

11.2 Safety and Efficiency

Chemotherapy will only be administered by trained Oncology Nurses who have completed a recognised certification in the administration and handling of cytotoxic preparations.

Access to an appropriate pharmacy service is safe and timely to ensure chemotherapy availability.

[4] www.health.govt.nz/publication/new-zealand-cancer-health-information-strategy
[5] www.health.govt.nz/our-work/diseases-and-conditions/cancer-programme/faster-cancer-treatment-programme/national-tumour-standards
[6] www.health.govt.nz/publication/guidance-improving-supportive-care-adults-cancer-new-zealand

12. Purchase Units

Purchase Units (PU) codes are defined in Health New Zealand's Nationwide Service Framework Purchase Unit Data Dictionary. The following PU code applies to this Service.

PU Code	PU Description	PU Definition	Unit of Measure
M50001	Oncology - Inpatient Services (DRGs)	DRG WIESNZ Discharge. Additional Information is found in the NZ Casemix Framework for Publicly Funded Hospitals which gets updated every year. This excludes the costs of Pharmaceutical Cancer Treatment (PCT)	Cost Weighted Discharge
M50009	Oncology - Blood transfusions	Blood transfusions performed as an outpatient or elective day case in general medicine.	Attendance
M50020	Medical Oncology 1st Attendance	First attendance to medical oncologist or medical officer at registrar level or above or nurse practitioner for specialist assessment. Excludes radiation oncology	Attendance
M50021	Medical Oncology Subsequent Attendance	Follow-up attendances to a medical oncologist or medical officer at registrar level or above or nurse practitioner. Excludes radiation oncology and chemotherapy	Attendance
MS02009	IV Chemotherapy - cancer - Any health specialty	An attendance where the purpose is to receive intravenous chemotherapy treatment for cancer as defined by the Pharmaceutical Cancer Treatment schedule. The specialist may or may not be in attendance. Includes all pharmaceuticals administered during the attendance net of PCT drug cost recovery from Sector Operations. Includes day case treatment excluded from CWDs as per definition of WIESNZ. Excludes treatment not for cancer. Note special PU codes for Haematology and Paediatric Services	Attendance
MS01001	Nurse led Clinics	Assessment, treatment, or education and/or management outpatient clinics led by a nurse specialist not covered under other education management PUCs. This excludes clinics led by a nurse practitioner.	Attendance
MS02001	Blood transfusions – any health specialty	Blood transfusions performed as an outpatient or elective day case regardless of the Health Specialty providing the service, and not provided under any other purchase unit. Additional information is found in the NZ Casemix Framework for Publicly Funded Hospitals which gets updated every year	Attendance

Explanation of the units of measure for the purchase units

Unit of Measure	Unit of Measure Definition
Cost Weighted Discharge	A numerical measure representing the relative cost of treating a patient through to discharge.
Attendance	Number of attendances to a clinic /department/ acute assessment unit or domiciliary

13. Reporting Requirements

Providers report to the New Zealand Cancer Registry[7] is a population-based tumour registry whose primary function is to collect and store cancer incidence data. Cancer incidence is defined as the occurrence of new cancers in a defined population in a specified time period. NZCR provides data for cancer incidence and survival studies, public health research, monitoring screening programmes and policy formulation.

14. Glossary

Not required

[7] www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/new-zealand-cancer-registry-nzcr

15. Appendices

15.1 Appendix One - Medical Oncology Prioritisation Criteria

Statement of Guiding Principles: New Zealand Medical Oncologists believe the following principles must determine access to publicly funded Medical Oncology services. That all patients who wish to receive, and who could potentially benefit from, a Medical Oncology appointment, have the right to see a Medical Oncologist in the New Zealand public health system.

- That no patient, who is medically fit to be seen, should wait more than two weeks from receipt of referral for a Medical Oncology first specialist assessment (FSA).
- That all patients should be kept informed of the status of their referral.
- That all patients accepted for, and who are fit to receive, treatment should commence that treatment within two calendar weeks from the decision to treat.
- That all Medical Oncology services should have the capacity to see FSAs requiring "immediate" assessment (see table below) within 48 hours; and to commence treatment on those patients requiring "immediate" intervention, within 48 hours of the decision to treat.

Where available resources do not permit medical intervention within the two week standard, the Medical Oncology FSA, and Treatment Booking Prioritisation Criteria should be utilised. In all circumstances patients wait times for either an FSA or to commence treatment must not exceed the defined wait time for each Category.

The Prioritisation Criteria are based primarily on the ability of each patient to benefit from intervention, and secondarily on clinical urgency.

15.2 Appendix Two - FSA Prioritisation Criteria

Medical Oncology FSA Prioritisation Criteria

Category	Criteria	Examples
1 **Immediate**- see within 48 hours	• Patients with responsive cancers who are severely symptomatic or in whom there is documented rapid progression; where if not treated quickly will suffer serious morbidity or threat to life	• Burkitt's lymphoma • Choriocarcinoma • Superior vena caval obstruction in diagnosed, chemotherapy responsive, cancers e.g. NHL, small cell lung cancer
2 **Urgent** - see within one week	• All potentially curable cancers, where delay may jeopardise patient outcome • Responsive cancers, with significant symptoms or documented rapid progression requiring urgent intervention • Primary chemo-radiation*	• Advanced germ cell tumour testis/ovary • Aggressive non-Hodgkin's lymphoma • Hodgkin's lymphoma • Small cell lung cancer
3 **Semi-urgent** - see within three weeks	• Known responsive cancers with defined prolongation of life/high chance of palliation • Proven adjuvant therapies, (high/moderate risk) • Adjuvant chemo-radiation*	• Breast cancer • Colorectal cancer (adjuvant/advanced) • Inflammatory breast cancer • Ovarian cancer • Low grade lymphoma (bulky or symptomatic) • Adjuvant NSCLC
4 **Routine** - see within four weeks	• Cancers with known indolent behaviour • Less responsive cancers with limited treatment benefits • Low risk adjuvant treatment (< 5% survival benefit)	• Low grade NHL, low bulk, no symptoms • Palliative chemotherapies of poorly responsive cancers, eg: melanoma, soft tissue sarcoma (non-paediatric), renal cell cancer • Adjuvant stage II colon cancer
5 **Advice only** **-** letter to referrer, no appointment offered	• Straightforward clinical issue, not requiring chemotherapy • No, or poorly defined, treatment options • Very low or unlikely benefit from treatment	

***Some patients prioritised may have their assessment delayed due to the timing of other treatment.

15.3 Appendix Three – Treatment Booking Priority

Medical Oncology Treatment Booking Priority

(Maximum wait times from the decision to treat)

Category	Criteria	Examples
A **Immediate** - within 48 hours	• Responsive cancers with rapidly progressive malignancy or complication of malignancy, where if not treated will suffer serious morbidity or threat to life	• Advanced germ cell tumour testis with evidence of rapid progression, • aggressive non-Hodgkin's lymphomas with severe symptoms of rapid progression • Burkitt's lymphoma • Superior vena caval obstruction in chemotherapy responsive cancers
B **Semi-urgent** - within two weeks*	• All potentially curative cancers • High risk adjuvant therapy • Responsive cancer with evidence of rapid progression, which if not treated promptly may give rise to major complications or worsening of prognosis	• Aggressive non-Hodgkin's lymphoma • Hodgkin's lymphoma • Small cell lung cancer • Undebulked ovarian cancer • Highly node-positive breast cancer
C **Routine** - within four weeks	• All other cases of adjuvant and palliative systemic treatment •	•
D **Combined modality treatment** -Determined by scheduling of the two treatment modalities.	• Combined/concurrent chemotherapy/radiation therapy,	• Eg: cancers of rectum, anus, head and neck, cervix, oesophagus etc.

* Within Category B there may be certain patients who, while not requiring **Immediate** intervention, need to commence treatment before 2 weeks. Such cases, and the necessary time to start of treatment should be identified by the prioritising Medical Oncologist.