Te Whatu Ora
Health New Zealand

17 August 2023

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Your request for Official information, reference: HNZ00023560

Thank you for your email on 26 June 2023, asking for the following which has been considered under the Official Information Act 1982 (the Act).

> *How does the prioritisation of patients who may require chemotherapy work? Please provide me with a general overview of the process. Please provide me with any documentation (including but not limited to processes, policies, frameworks, and criteria) which staff use to prioritise of patients who may require chemotherapy.*

Once a referral is received by the service, the clinician reviews the referral and triages according to a priority of 1-5. When a decision to treat is made, the clinical need determines the priority based on a category score of A = Immediate or Inpatient, B = 7 Days, or C = 28 Days. The decision is made by the medical oncologist based on clinical consideration.

Please also see **Appendix 1. Medical Oncology Prioritisation Criteria**[1]

> *Are criteria used to prioritise patients who may require chemotherapy? If so, please provide me with a full list of the criteria and any documentation that explains how it is to be applied.*

The criteria used to prioritise patients for first specialist appointment are:

Priority	Priority Code	Description
Urgent	P1	Within 48 hours/7 days
Semi urgent	P2	Within 14 days
Routine	P3	Within 28 days
Low priority	P4	>28 days

When a decision to treat is made, the clinical need determines the priority based on a category score of A = Immediate or Inpatient, B = 7 Days or C = 28 Days. The medical oncologist makes the decision based on clinical considerations in line with the guidelines which are referenced in Appendix 1.

[1] This Appendix combines Appendices 1, 2 & 3 to the Ministry of Health publication *Specialist Medical and Surgical Services – Medical Oncology Services Tier Two Specification* https://www.tewhatuora.govt.nz/assets/Our-health-system/National-Service-Framework/Service-specifications/Specialist-medical-services/medical_oncology.docx

Is a scoring system used to prioritise patients? If so, please provide me with a copy of the scoring system and any documentation that explains how it is to be applied.

There is no scoring system used, only the clinical categories as outlined above.

Is there a waitlist for chemotherapy? If so, approximately how long has the average length of the waitlist been in 2023?

Is the waitlist for chemotherapy broken down into risk groups? If so, how many risk groups are there and how is it determined which patients go in which groups?

Is there a prioritisation queue within each risk group? If so, how is the prioritisation queue within each risk group determined?

Is the waitlist for chemotherapy broken down by ethnicity? If so, why?

There is no waitlist for chemotherapy at Te Toka Tumai Auckland.

Is ethnicity used in any way to determine how patients who may require chemotherapy are prioritised, either for appointments or treatment, or otherwise?

Ethnicity does not determine how patients who may require chemotherapy are clinically prioritised for appointments or treatments.

Do schedulers prioritise patients who may require chemotherapy within each risk group? If so, what criteria do they use and how is the criteria used?

Schedulers book patients as per the clinical categories for first specialist appointment and chemotherapy, as identified by clinicians.

How many queues are patients required to be in before undergoing chemotherapy? Is there one queue for an initial appointment and then a second queue for treatment?

There are two potential queues. The first, from referral to being seen by a specialist. The second, between being seen by a specialist and starting chemotherapy. There is no waitlist for chemotherapy at Te Toka Tumai Auckland.

What processes or policies, formal or informal, are in place to reduce inequities between Māori and Pacific peoples who may require chemotherapy and other people who may require chemotherapy?

All patients who identify as Māori are contacted by members of the Āwhinatia te Tangata (cancer support service) before the first specialist appointment to discuss attendance and identify any barriers or support that may be required to enable the patient to attend. Te Toka Tumai has Māori and Pacific navigators who sometimes assist patients in Te Pūriri o Te Ora Regional Cancer and Blood Services.

How is the ethnicity of someone who may require chemotherapy determined? Is it based on self-identification?

All patients seen at Te Toka Tumai have their details and demographics, including ethnicity, registered in the patient management system. The patient provides these details, which are reviewed and updated on subsequent visits, including chemotherapy visits.

How to get in touch

If you have any questions, you can contact us at hnzOIA@health.govt.nz.

If you are not happy with this response, you have the right to make a complaint to the Ombudsman. Information about how to do this is available at www.ombudsman.parliament.nz or by phoning 0800 802 602.

As this information may be of interest to other members of the public, Te Whatu Ora may proactively release a copy of this response on our website. All requester data, including your name and contact details, will be removed prior to release.

Nāku iti noa, nā

Dr Mike Shepherd
Interim Lead - Hospital and Specialist Services
Te Toka Tumai Auckland

Appendix 1

Medical Oncology Prioritisation Criteria

Statement of Guiding Principles: New Zealand Medical Oncologists believe the following principles must determine access to publically 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 defined standard, the Medical Oncology FSA, and Treatment Booking Prioritisation Criteria should be utilised. In no circumstances should patients be required to wait more than four weeks for either an FSA or to commence treatment.

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

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 (high/moderate risk adjuvant; advanced) • Colorectal cancer (adjuvant/advanced) • Undebulked ovarian cancer • Inflammatory breast cancer • Debulked 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	

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.