Report from UKONS 2017 conference workshop:

The Older Person with cancer: How can we Improve Care and Management? An Interactive Workshop

Participants were asked to work in groups to list 3 factors they saw as essential to improving the care and management of older people with cancer in practice. Their responses have been examined and the following categories reflect the priorities of the attendees.

Appropriate Assessment

Most groups viewed some form of assessment to identify needs as essential. The necessary assessment was often described as 'validated' or 'standardised' indicating the need for consistency. Some suggested a 'Comprehensive Geriatric Assessment' or a 'frailty assessment' indicating that the tool would need to be specific to the older patient group to identify need. Others suggested the assessment would need to be 'holistic'. One group suggested that there should be a standardised 'trigger' to signal that CGA should be carried out, such as the presence of 2 or more comorbidities, and another suggested that there should be 1 assessment which incorporates all the necessary factors, acknowledging that incorporating extensive assessment into practice may be time-consuming and onerous for provider and patient. No suggestions were made as to the timing or frequency of assessment, although one group suggested that assessment should be carried out 'across the pathway'. There is ample evidence to suggest that geriatric assessment in various forms can be a useful tool to support decision making and should be incorporated more widely into practice (Kalsi et al 2015, Whittle et al 2017) and is recommended in the Independent Cancer Taskforce (2015) strategy for 2015-2020.

Ways of Working

The majority of groups stressed the importance of collaborative working across specialties (such as geriatric input into oncology practice), within the multidisciplinary team (involving occupational and physiotherapists as part of standard care) and across traditional boundaries such as health and social care, and primary and secondary care. Some suggested making use of existing resources such as Macmillan GPs (Macmillan Cancer Support 2017) in order to achieve this. The importance of communication and knowledge sharing across specialities and along the patient journey (from 'prehabilitation to 'rehabilitation') was stressed, again to encourage a 'holistic' approach. It was suggested by one group that a specific specialist nurse role should be developed for older people with cancer to act as a link between various care teams, and be an advocate for the older person. Specialist nurses in various roles have been trialled such as nurse case managers (Goodwin et al 2003, Jennings-Sanders et al

2005) or nurse navigators (Kuzmarov & Ferrante 2011). Another group stated that ensuring adequate resources and workforce is needed to allow this.

Comments about improving collaborative working were often linked to the need for smooth transitions between elements of the patient pathway, allowing a 'clear pathway for referrals', 'consistency of information provided' and 'appropriate communication at all levels'.

Community Care

A common theme in the comments was the importance of support in the community, away from the acute care setting. It was often stressed that the support needed to be present both before treatment had started, and after treatment had finished, for example in the form of a rehabilitation package on discharge. One group suggested linking in with existing older person's organisations or charities to provide specific services for older people with cancer at home or in the community, an approach trialled by several of the pilot sites in the Macmillan Older People's project (Macmillan Cancer Support 2012). Another suggested a 'Cancer Buddy System' where patients are supported by others in the community who understand the difficulties they may face. Buddying systems are available but tend to be informal. The 'Macmillan Connected' service that fulfilled this function has now been discontinued. Other groups made clear that in addition to providing community services, knowledge of what is available must be widespread and access must be straightforward.

Patients as Agents

Lastly, participants were keen to emphasise that age should not be the primary factor when caring for someone with cancer. Many groups stated that individual preferences should be taken into account when discussing cancer treatments in order to avoid age discrimination. Other comments suggested that the older person with cancer should play an active role in their cancer journey. One group suggested a more widespread use of the Patient Health Treatment summary, completed at the end of cancer treatment and designed to support transition between services and plan for ongoing health needs (Transforming Cancer Services Team 2016). Another suggested greater use of patient-held advanced or anticipatory care planning. A third group suggested greater involvement of older people in research, which is notably lacking in many areas (Marosi & Köller 2016).

References

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