Decision making for the treatment of cancer in older people across the UK

Aim of project

The aim of this project is to build our understanding and evidence base around older patients’ access to cancer treatments. In particular, we want to better understand clinical decision making to treat across the UK and whether decisions are made based on appropriate assessments or whether assumptions based on chronological age are acting as a barrier to access.

This evidence will help to inform Cancer Research UK’s policy positions - allowing us to make recommendations to Government to ensure older people are able to access the best treatment for them.

Overview of cancer outcomes for older people and access to treatment

More than a third of cancer diagnoses occur in people over the age of 75 and cancer survival decreases with age1,2. In England, the lowest five-year survival is seen in 80-99 year-olds even though the survival calculation allows for higher mortality from other causes in the older age groups3.

The proportion of cancers diagnosed in England after an emergency presentation increases with age. 29% of all cancers in those aged 80 - 84 in 2013 were diagnosed after an emergency presentation, compared with 13% of cancers in those aged 50-594. And we know that cancers diagnosed via an emergency presentation are associated with poorer survival outcomes.

Survival rates for several cancer types are lower in the UK compared with other countries and that gap is wider for older people than for younger people5. In the UK, older people have lower breast, lung and colorectal survival at later stages (stages 3 and 4) compared to older people diagnosed at later stages in other countries6,7,8. Stage for stage, survival is typically lower in the UK compared to other countries. For example, around 4 out of 10 (42.2%) older women (70-99 years) in the UK survive their breast cancer for at least 3 years, compared to nearly 6 out of 10 (58.5%) in Sweden or Canada (59.1%). Variation in access to the best treatments is likely to be contributing to these observed international survival differences at a given stage of the disease.

There is a growing body of evidence to suggest that under-treatment of older patients in the UK may be contributing to poor outcomes6,9,10. Surgery contributes to around half of cases where cancer is cured11. However, data from the NCIN has shown that older patients in England are significantly less
likely to receive surgery for their cancer than younger patients – this appears to be a problem for many types of cancer but is particularly acute for breast, kidney and ovarian cancers\textsuperscript{12}.

There is some evidence to suggest that older people are less likely to receive radiotherapy and chemotherapy. Evidence from the Systematic Anti-Cancer Therapy (SACT) dataset has shown older people are less likely to receive chemotherapy or cancer drug treatment\textsuperscript{13}. In 2006, 74\% of patients aged 70 and over with conservatively treated invasive breast cancer had radiotherapy treatment compared to 84\% of those aged under 70\textsuperscript{14}. The National Radiotherapy Dataset and SACT should allow for more detailed analysis of chemotherapy and radiotherapy intervention rates by age in the future.

We also know that older people are less likely to have opportunities to participate in cancer research\textsuperscript{15}, which may limit their access to innovative drugs through trials and means that opportunities to develop the evidence base on how best to treat older people are being missed.

Older patients may be less likely to receive treatment and be enrolled on research studies for a number of reasons, many of which will be completely appropriate. Increasing age can be associated with other clinical factors, such as frailty and co-morbidities: older cancer patients have an average of three other health conditions\textsuperscript{16}, which may reduce the ability of a patient to withstand cancer treatment. It is also important to consider that older patients in the UK may be more likely to choose not to undergo treatment, although there is recent evidence to suggest this is not the case\textsuperscript{17}.

However, we are concerned that additional factors are posing a barrier to older patients accessing treatments and as a result, many older patients are missing out on cancer treatments that they could benefit from.

**Cancer Research UK’s policy development priorities**

Over a third of all cancer diagnoses occur in people over 75 and the UK population is getting older. Improving cancer survival for this group would have a significant impact on overall outcomes. We are therefore eager to identify any barriers that exist to older patients accessing the most clinically effective and appropriate treatment for them.

Treatment decisions should fully consider a patient’s circumstances and condition and should not be made on assumptions based on chronological age, which alone is a poor predictor of treatment tolerance\textsuperscript{18}. Evidence suggests that current assessments of older cancer patients are not fit for purpose and that introducing Comprehensive Geriatric Assessments (CGA) in cancer care could improve outcomes\textsuperscript{19}.

We want to better understand current methods for assessing older patients across the UK and how these are impacting on treatment decisions.

\textsuperscript{12} National Cancer Intelligence Network, Major resections by routes to diagnosis (2006 to 2010; England), 2015
\textsuperscript{13} NCIN, Older people and cancer (version 3.0). 2015, National Cancer Intelligence Network
\textsuperscript{14} NCIN, Breast Cancer in the Elderly – NCIN Data Briefing, September 2010
\textsuperscript{15} NCIN, Older people and cancer (version 3.0). 2015, National Cancer Intelligence Network
\textsuperscript{16} Extermann M et al., Co-morbidity and functional status are independent in older cancer patients. Journal of Clinical Oncology. 1998.
\textsuperscript{17} http://www.macmillan.org.uk/Documents/Campaigns/AttitudesofolderpeoplelivingwithcancerAugust15.pdf
\textsuperscript{18} Gillespie TW et al., Improving clinical outcomes in elderly oncology patients, Journal of Clinical Oncology. 2004.
\textsuperscript{19} Macmillan Cancer Support, The cancer services coming of age: learning from the improving cancer treatment assessment and support for older people project. 2012.
This evidence will enable us to assess the current variation in practice and make recommendations as to how this practice should change to improve decision making and increase older patients’ access to the best treatment available for them. This evidence will also help inform the potential future pilot of a comprehensive care pathway for older patients, as recommended by the Independent Cancer Taskforce in its cancer strategy for England.

### Key Questions

Possible questions include (but are not limited to) the following:

- What assessments are currently carried out on older people? How widely are CGAs carried out? When in the pathway are these assessments carried out and how/why are these triggered?

- Which healthcare professionals carry out assessments of older people? Do they have specific training for assessing older people and feel adequately supported to do so?

- Which individuals are involved in the interpretation of these assessments? Are assessment outputs available for the first multidisciplinary team meeting to inform treatment decisions?

- Which healthcare professionals are present at the MDT meeting to discuss an older person’s treatment? For example, how often are geriatricians present and for which cases is their presence necessary?

- Is there any evidence for how different types of assessments, and models for how these are considered, are impacting on treatment decisions? What does best practice look like and how is this/this could this be spread across the NHS?

- What information is given to older people to support them in considering treatment options? Is it felt that this information is sufficient/could they be supported in other ways?

- Is there reluctance to enter older patients onto clinical trials? If so, what are the barriers?

### Methodology

We welcome proposals on methodology. Examples of methods include:

- Interviews with clinicians (including surgeons, GPs, geriatricians and specialist nurses) across the UK
- Consideration of how to capture patient views
- Online stakeholder surveys

### Product

The product(s) of the research is likely to include:

- An executive summary of key findings
- The methodology and approach to the work
- A full account of all of the research findings

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• Policy recommendations on treatment decision making for older cancer patients

Cancer Research UK will award the project grant to one contracting organisation only; however it may be possible for applicants to sub-contract aspects of the project subject to the approval of Cancer Research UK. This should be discussed at application stage.

Timescale

Informal expressions of interest should be sent to Hollie Chandler (details below) by Friday 27th November – this is so that we can anticipate your application and answer any questions you may have about the project.

A full application giving detailed methodology and budget breakdown should be submitted by Friday 11th December.

The intention is that a decision will be made by Wednesday 23rd December.

The full report should be submitted to Cancer Research UK by the end of May 2016.

Submission

Please send the following to Hollie Chandler, hollie.chandler@cancer.org.uk, 0203 469 5337.

• Proposed approach to project and methodology

• Budget breakdown – we would welcome a suit of options in terms of what is possible

• CVs of staff who will work on the project and a short summary of experience carrying out this type of work

• Information about relevant governance arrangements within your institution.

Or via the following address:
Policy Department, Cancer Research UK, 407 St John St, London EC1V 4AD

Further information

Should you have any questions about this project, please contact Hollie Chandler using the contact details above.