Optimal care pathway for older people with cancer

First edition

Statement of acknowledgement

We acknowledge the Traditional Owners of Country throughout Australia and their continuing connection to the land, sea and community. We pay our respects to them and their cultures and to Elders past, present and emerging.

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This work is available from the Cancer Council website <www.cancer.org.au/OCP>.

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Enquiries about this publication can be sent to <insert email address>

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Welcome and introduction

The *Optimal care pathway for older people with cancer* has been developed to improve care experiences and outcomes for older Australians facing a cancer diagnosis. Cancer is a leading health concern in older people, with this group representing the highest proportion of cancer diagnoses and cancer-related mortality. The complexities of managing cancer in older people are further compounded by age-related comorbidities, variations in physical and cognitive function, and social factors that may influence care needs and outcomes.

While the diagnostic and treatment pathways for cancer remain complex across all age groups, older people face unique challenges that require a person-centred approach. This pathway has been designed around "what matters most" to older people emphasising shared decision-making to ensure that individual values, preferences, and goals are central to their care plan. Rooted in the *4M's framework* – What **M**atters, **M**edication, **M**entation, and **M**obility(Laderman M et al. 2019) – this care pathway highlights the importance of addressing each person's unique circumstances to support quality care provision, safety, and well-being throughout their cancer journey. Optimal care in this population is about balancing effective cancer treatment with the preservation of function, quality of life, and autonomy, while respecting the diverse health goals of older individuals. Addressing *What Matters* encourages healthcare providers to focus on the priorities that are most meaningful to each person.

A cancer diagnosis for an older person can have far-reaching consequences for their physical health, mental well-being, social relationships, and independence. This optimal care pathway is designed to support healthcare providers in delivering tailored, high-quality care that considers the broader context of an older person's life, including their support systems and personal priorities.

The goal of this pathway is to promote and foster age-friendly care across cancer services in Australia. With this approach, we hope to see more environments that respect and respond to the specific needs of older people, enhancing their patient experience and outcomes. Achieving such a transformation will require dedicated change champions – advocates who understand the needs and goals of older people with cancer and are committed to promoting age-appropriate, respectful, and inclusive care across Australia.

Reflective of the distinctive needs of older people, this pathway builds on extensive work in cancer and geriatric care, integrating insights from both fields to guide healthcare providers in delivering personalised, responsive care. Developed by a Multidisciplinary Expert Working Group comprising national leaders in cancer care, this pathway has been informed by input from older people, carers, and community partners, whose perspectives have been invaluable in shaping this initiative.

This optimal care pathway was formally endorsed by the Cancer and Population Screening Committee following advice from Cancer Australia's National Cancer Expert Group (NCEG). Formal endorsement by CAPS Committee acknowledges the importance of this optimal care pathway and the responsibility of the health system to deliver care in an appropriate, culturally safe, responsive and coordinated manner to ensure access and that optimal health outcomes are experienced by all Australians.

We extend our sincere thanks to all who have generously contributed their expertise and experiences to the development of this Optimal Care Pathway.

[signature]
Prof Meera Agar
Co-chair, Older people with
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Intent of the optimal care pathways

Optimal care pathways map seven key steps in cancer care. Each of these steps outlines nationally agreed best practice for the best level of care. While the seven steps appear in a linear model, in practice, patient care does not always occur in this way but depends on the particular situation (e.g. the type of cancer, when and how the cancer is diagnosed, prognosis, management, the patient's decisions and their physiological response to treatment).

The principles underpinning optimal care pathways always put patients at the centre of care throughout their experience and prompt the healthcare system to deliver coordinated care.

The optimal care pathways do not constitute medical advice or replace clinical judgement, and they refer to clinical guidelines and other resources where appropriate.

Figure 1: The optimal care pathway

<insert image>

Optimal care pathway resources

There are three resources for each pathway: an optimal care pathway, a quick reference guide for health professionals and a guide to best cancer care for patients, carers and families.

Optimal care pathways

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This optimal care pathway is designed for **health professionals and health services**. However, **patients and carers** may find useful information in this version to help understand the processes their treating health professionals are following.

This resource aims to:

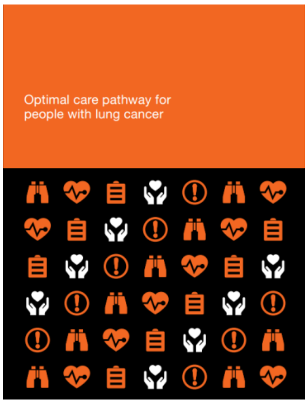
assist health professionals to provide optimal care and support to patients with cancer, their families and carers

provide optimal timeframes for delivering evidence-based care

emphasise the importance of communication and collaboration between health providers and people affected by cancer

assist and inform new health professionals or trainees who are entering the cancer care workforce

provide value to health systems to identify gaps in current cancer services, bring about quality improvement initiatives and improve how services are planned and coordinated.



Adherence to the pathways should be measured wherever possible.

Visit the Cancer Council website <https://www.cancer.org.au/health-professionals/optimal-cancer-care-pathways> to view the optimal care pathways for different cancer types and populations.

Quick reference guides

The quick reference guides are for **health professionals** and **health services**. They provide a summary of each optimal care pathway for health professionals and patients.

<take in image of OCP Quick reference guide front, on right cut into body text>

Optimal care pathway for
people with lung cancer

Quick reference guide

The quick reference guides include:

- optimal timeframes within which tests or procedures should be completed
- checklists with indicators related to recommendations in the optimal care pathway.

Visit the Cancer Council website <https://www.cancer.org.au/health-professionals/optimal-cancer-care-pathways> to view the quick reference guide for this optimal care pathway and for quick reference guides for different cancer types and populations.

Guides to best cancer care

The guides to best cancer care are consumer resources that help patients understand the optimal cancer care that should be provided at each step. Carers, family and friends may also find the guides helpful.

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The guides to best cancer care:

- include optimal timeframes within which tests or procedures should be completed
- include prompt questions to support patients to understand what might happen at each step of their cancer journey and to consider what questions to ask
- provide information to help patients and carers communicate with health professionals
- are available in up to eleven languages for different cancer types and different populations of people, such as this Optimal Care Pathway for Older People with Cancer

Cancer Council

What to expect – Lung cancer

What to expect during each stage of treatment and beyond

Lung cancer support

Call the lung foundation on 1800 654 301 for information about lung cancer and where to go for support and help or visit www.lungfoundation.com.au

Also, qualified cancer nurses at the Cancer Council can answer your questions about the effects of cancer, explain what will happen during treatment and link you to support groups and other community resources. Call the Cancer Council on 13 11 20.

If you need an interpreter, call TIS (the Translating and Interpreting Service) on 13 14 50. For support and advice for carers, call the Carers Association on 1800 242 636.

1. Initial investigations and referral

The following unexplained or persistent (lasting more than three weeks) symptoms of lung cancer include coughing up blood, persistent cough/chest infection, chest/shoulder pain, breathlessness and hoarseness.

Your general practitioner (GP) will assess your symptoms, conduct a physical examination and order a chest x-ray. Your GP should also discuss your needs (including physical, psychological, social and information needs) and recommend sources of reliable information and support.

If lung cancer is suspected, you will be referred to a specialist for further testing. Your GP will provide the specialist with information about your medical history, whether there is a history of cancer in your family, and your test results.

It can be helpful to bring a family member or friend with you to your appointments.

2. Diagnosis and staging

The specialist should discuss your test results and options for further testing. This is to find out whether cancer is present, and if it is, its stage of development and if it has spread.

You may have one or more of these tests:

Computed tomography (CT) scan
Computer technology and x-rays are used to create detailed images of the lungs.

Positron emission tomography (PET) scan
This produces a three-dimensional colour image that may show where cancers are located. A small amount of radioactive material is injected and the whole body is scanned.

Bronchoscopy
A test done under anaesthetic where a flexible tube is used to examine the airways and take tissue samples

Endobronchial ultrasound (EBUS) is a type of bronchoscopy that uses high-frequency sound waves to create an image.

Biopsy
There are several ways to take a small tissue sample (a biopsy) from the lungs to examine under a microscope.

Some people have further tests such as a bone scan.

It can also be helpful to contact lung cancer peer support groups and support groups for carers.

3. Treatment

To ensure you receive the best care, your specialist will arrange for a team of health professionals to review your test results and plan your treatment based on your preferences and needs.

The team will be made up of health professionals who have experience managing and supporting a person with lung cancer. Your specialist will tell you when the team will be discussing your case. Your team should discuss the different treatment options with you including the likely outcomes, expected timeframes, possible side effects, and the risks and benefits. Your doctor may also suggest you consider taking part in a clinical trial. You might want to ask for more time before deciding on your treatment, or ask for a second opinion.

Let your team know about any complementary therapies you are using or thinking about trying.

Some therapies may not be appropriate, depending on your medical treatment.

In some cases, more than one type of treatment will be used to get the best outcome.

The treatment options depend on whether the cancer has spread to both sides of your chest or beyond your lungs.

Lung cancer is often not found until it is advanced because it can grow rapidly and symptoms can be vague.

Visit the Cancer Council's website <https://www.cancer.org.au/cancercareguides > to view the guide to best cancer care for older people with cancer and the guides to best cancer care for different cancer types and populations.

Optimal care pathway for Aboriginal and Torres Strait Islander people with cancer

The *Optimal care pathway for Aboriginal and Torres Strait Islander people with cancer* provides a tool to help reduce disparities and improve outcomes and experiences for Aboriginal and Torres Strait Islander people with cancer. This resource can be used in conjunction with the optimal care pathway for each cancer type.

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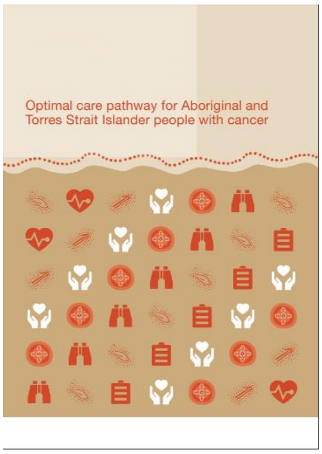

Optimal care pathway for Aboriginal and Torres Strait Islander people with cancer

Visit the Cancer Australia website <https://www.canceraustralia.gov.au/affected-cancer/atsi/resources-health> to view the optimal care pathway for Aboriginal and Torres Strait Islander people.

Scope

Internationally, the definition of "older people" varies, with no universally agreed-upon age. Within the context of this Optimal Care Pathway and Australian healthcare settings, older people with cancer are generally defined as individuals aged 65 years and older. It is important to recognise the considerable heterogeneity within this age group. When we refer to people over 65 years of age with cancer, we are addressing a diverse population that encompasses a wide range of health statuses, functional capacities, comorbidities, and resilience to cancer treatments.

This pathway acknowledges that older people may range from those who are fit and fully independent to those who are frail with complex health needs. Factors such as functional ability, the presence of chronic health conditions, cognitive health, and social support systems can all significantly impact an individual’s cancer journey, influencing decisions around treatment, recovery, and quality of life. Given this variability, this Optimal Care Pathway aims to provide guidance that is adaptable to the unique needs and priorities of each older person, while considering the broader implications of ageing on cancer care.

In recognition of the unique health context for Aboriginal and Torres Strait Islander people, this pathway acknowledges that older age is typically defined as beginning at 50 years for this population. This distinction reflects the increased burden of disease, social determinants of health, and different life expectancies experienced by Aboriginal and Torres Strait Islander people. Healthcare providers are encouraged to refer to the Optimal care pathway for Aboriginal and Torres Strait Islander people with cancer for further guidance on culturally safe and responsive cancer care specific to this population, addressing their unique health needs, cultural values, and priorities.

Principles of the optimal care pathway

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The seven principles of care define appropriate and supportive cancer care that is the right of all patients and those caring for and connected with them.

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Figure 2: The seven principles underpinning the optimal care pathway

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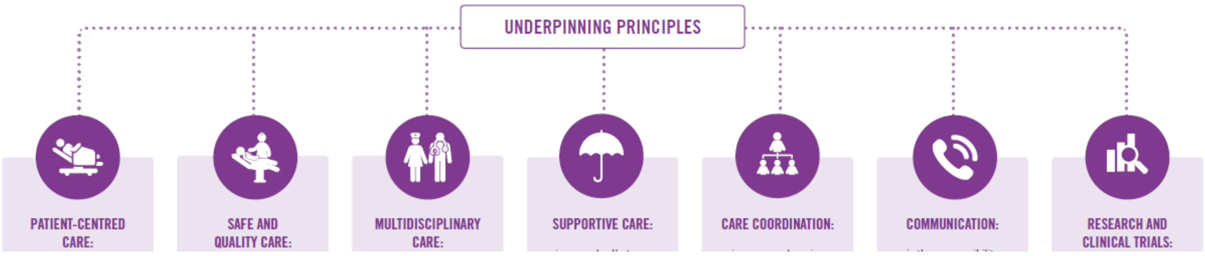

Principle 1: Patient-centred care

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Patient-centred care informs and involves patients in their care and respects and responds to the preferences, needs and values of patients, families and carers.

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Patient-centred care involves older people throughout their care, and respects and aligns care with their preferences, values and goals. Patient-centred care takes into consideration an older person's multidimensional intrinsic capacity (WHO 2017b), and is inclusive of families and carers to the extent an older person wants them to be involved.

Definition of "older" people

In Australia, people aged 65 and above are typically classified as "old" by Australian government organisations, whereas people of Aboriginal and Torres Strait Islander origin are considered "old" from the age of 50 (AIHW 2024b). These age thresholds also determine eligibility for government funded Aged Care Services (DHAC 2024a). The recommended age at which screening or assessment for age-related problems should commence for people with cancer varies between international Oncological Societies. For the purpose of this document, we will use the categories of 65 and older, or 50 and older for Aboriginal and Torres Strait Islander people, when referring to older people with cancer.

It is important to be aware that people in older age groups may not self-identify as "old" (Jurek Ł 2022), often due to negative stereotypes associated with ageing (Kornadt AE et al.

2023). Additionally, older people are very diverse (Lowsky DJ et al. 2014). Whilst some older people are frail with low levels of intrinsic capacity, others maintain intrinsic capacity and remain fit, active, and free of medical issues well into later life (WHO 2017b).

Patient-centred care

Patient-centred care means:

patients are informed and involved in decisions about their cancer and the treatment, post-treatment and recovery program ahead;
patients, their families and carers are provided with access to appropriate and accessible health information, taking into consideration their health literacy and preferred language
treatment recommendations are individualised to a person's multidimensional intrinsic capacities, and aligned with their preferences, values and goals, and are not based on chronological age
alongside management of the primary cancer, other issues are addressed, which can be achieved through geriatric assessment and multidisciplinary management
respect for the cultural and religious beliefs of patients and their families is demonstrated when discussing the diagnosis of cancer
special needs are addressed – for example, the needs of people with disabilities or mental health issues

A patient-centred focus increases the experience and satisfaction of patients, their families and carers, and staff, as well as safety and cost-effectiveness (ACSQHC 2019b).

Advance care planning can contribute to patient-centred care. It provides a process for people to communicate their values, preferences, and goals for their future care in the event that they are not able to communicate these views. This may include appointing a substitute decision maker to make decisions about their future medical care on their behalf should this be needed (DHAC 2022). For more information see Further considerations – Advance care planning.

Family and carer inclusive care

Older people are more likely to rely on family members or carers for support through their cancer treatment than younger people, due to higher rates of multimorbidity, decline in intrinsic capacities and disabilities (Kadambi S et al. 2020). These family members or carers should be proactively integrated into cancer care to the extent they and the older person wants them to be involved. Carers also have informational, practical and psychological support needs which should be addressed (Kadambi S et al. 2020). Older people with cancer may themselves provide care for others. They may need assistance in planning alternate care arrangements. For more information see Further considerations – Carers.

Assumptions cannot be made about the level of support family members are able or willing to provide to older people with cancer. Carers of older people also tend to be older, and they may have their own health or other concerns (Kadambi S et al. 2020). Family members may not be able to support a person for many different reasons. Additionally, healthcare professionals need to be alert to signs of elder abuse which may be subtle and not openly disclosed. Elder abuse can take various forms includes physical abuse, psychological, emotional, sexual or financial abuse, or neglect abuse (ALRC 2016). For more information see Further considerations – Elder abuse.

Age-friendly care

Healthcare services are typically designed to optimise the management of acute illnesses and may not be well organised to care for those older people who have multiple chronic medical conditions, disabilities or psychosocial needs. Age-friendly healthcare has structures, services and environments which are adapted to be accessible and inclusive for older people with varying needs and capacities (Tavares J et al. 2021). A key component of age-friendly healthcare is aligning care with a person's preferences values and goals (Zisberg A et al. 2024). Implementation of age-friendly care can help reduce the risks to older people in hospital environments and maintain a person's intrinsic capacity (WHO 2004).

Evidence-based components of age-friendly clinical care can be summarised as the 4Ms (John A Hartford Foundation 2024):

- What **M**atters most - knowing and aligning care with a person's preferences, values and goals
- **M**entation - preventing, identifying and managing cognitive impairment including dementia, depression and delirium
- **M**edication - using age friendly medications, and minimising unnecessary or potentially inappropriate medications
- **M**obility - maximising older people's safe mobility and function.

Shared care

Shared care is the joint responsibility for planned care agreed between healthcare providers, the patient and any family or carers the patient would like to involve (RACGP 2023). In cancer care, shared care typically refers to care jointly provided by a cancer specialist and a primary care health professional, who is usually a general practitioner but can include nurses and allied health practitioners. Many older people will have a primary care provider with understanding of their medical conditions and multidimensional intrinsic capacities who will be crucial for contributing to their care through the cancer care journey. For older people with complex multimorbidity or geriatric syndromes, care may be shared with secondary care providers such as geriatricians, aged care nurses and palliative care clinicians. Multidisciplinary care is the optimal approach to cancer care for older people (Hamaker M et al. 2022). Shared care may facilitate multidisciplinary assessment and management for older people with cancer. For more information see Further considerations – Transition of health care between services.

Shared care can be delivered throughout the care pathway including during treatment, follow-up care, survivorship care and end-of-life care. Shared care offers several advantages to patients, including the potential for treatment closer to home and more efficient care with less duplication and greater coordination. Evidence comparing shared care and specialised care indicates equivalence in outcomes including recurrence rate, cancer survival and quality of life (Koczwara B et al. 2016).

Telehealth can enable efficient shared care and should be explored for all patients. Patients in some rural or remote locations may access specialists via Medicare Benefit Scheme funded telehealth consultations. General practitioners working in rural or remote locations should be aware of specialist multidisciplinary teams with facilities to reduce the travel burden and costs for patients.

Informed choice and consent

An informed patient has greater confidence and competence to manage their cancer journey.

Health professionals are responsible for enabling patients to make informed choices according to their preferences, values and goals. Patients should be provided with:

- individualised and timely information and guidance about their treatment (see Principle 6: Communication)
- details of their care, including the advantages and disadvantages of each treatment, the associated potential side effects, the likely outcomes on their-functioning, fitness and quality of life, and any financial implications, at each stage of the pathway (ACSQHC 2020).

Health professionals have a legal responsibility to obtain informed consent for all procedures from either the patient or their substitute decision-maker if they are not deemed competent.

Referral choices and informed financial consent

Patients have the right to receive the information they need to be able to make an informed decision on where to be referred for treatment. Treating specialists and practitioners should clearly explain the costs or how to find out the costs of services, tests and treatment options upfront to avoid consumers experiencing ‘bill shock’.

At the time of referral, the patient’s general practitioner or other referring doctor should discuss the different options for referral, waiting periods, expertise, if there are likely to be out-of-pocket costs and the range of services available. This will enable patients to make an informed choice of specialist and health service. Referral decisions influence the care patients receive along the pathway and the direct and indirect costs they and their carers may incur. Different referrals have different costs:

- referral to a public hospital, which may involve some costs
- initial referral to a private specialist with associated costs, with the option of ongoing treatment in a public hospital at any time
- referral to a patient’s choice of practitioner for immediate and ongoing private hospital management with associated costs.

Patients should be made aware that even though public hospital health care is ‘free’ to all Australian citizens and most permanent residents of Australia, there are still associated direct costs such as:

over-the-counter medication and prescriptions
wound dressings
travel costs
parking fees
tests that are not covered by Medicare.

A cancer diagnosis and treatment may affect a patient’s or carer’s income. This is an indirect cost associated with cancer. Social work support is essential to help patients and their families deal with this issue. Patients should be advised not to undergo private care with significant out-of-pocket expenses if financially constrained. Specialists in private practice need to explain costs at the start of each new treatment to acknowledge the cumulative out-of-pocket expenses that patients can incur.

The term ‘financial toxicity’ describes the impact of changed financial circumstances due to cancer and cancer care. It is attributed to increased expenses paid by individuals and families, ongoing out-of-pocket costs and payment for unsubsidised services or medicines, and reduced income. For more information see Further considerations – Financial Toxicity.

For more information on informed financial consent see Cancer Council’s ‘Standard for informed financial consent’ <https://www.cancer.org.au/health-professionals/resources/informed-financial-consent>.

Financial counselling services can provide advice on dealing with financial difficulties. These services can be accessed publicly (via social workers at hospitals, financial counsellors at neighbourhood houses or rural financial aid), privately or through cancer support services such as local charity groups or social work services.

For practical and financial assistance, patients may consider Cancer Council’s financial services https://www.cancer.org.au/about-cancer/patient-support/practical-and-financial-assistance.html>.

SAFE AND QUALITY CARE

Principle 2: Safe and quality care

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Hospitals and health professionals are responsible for providing safe and quality care.

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Professional development in cancer care for older people

Health professionals should have appropriate training and experience to meet the unique needs of older people with cancer. Patients should be referred to an individual practitioner or service with appropriate expertise.

Older people with cancer need to be assured that they are receiving care from health professionals who are aware of ageism and how it can negatively impact care, are knowledgeable and competent to assess for issues which can impact older people with cancer and provide care addressing geriatric domains.

Safe and high-quality care is care provided by appropriately trained and credentialed health professionals who undertake regular quality reviews of their performance, contribute to regular audits of their care and are actively involved in continuing professional development. Hospitals and clinics must have the equipment, staff numbers, policies and procedures in place to support safe and high-quality care for people with cancer. Patients should be offered the safest options for care, which may include using telehealth (Keefe D et al. 2020).

Incorporating geriatric oncology into training programs for health professionals is important for optimal care. Important topics in an education program include (Chapman AE et al. 2021; Extermann M et al. 2021; Kotwal AA et al. 2020; Loh K et al. 2024; Morris L et al. 2022; Solary E et al. 2022)

- Cancer biology, epidemiology and treatment in older people
- Screening and assessment tools and their application
- Providing age-appropriate communication, including educational materials
- Legal and ethical issues relating to older patients and their carers/support/family
- Understand support services available and when to refer
- The 4M’s framework (What Matters, Medication, Mentation and Mobility)(Hodge O et al. 2024)

It is important to educate health professionals about ageism to reduce bias towards older people with cancer. Health professionals should also receive education and training on dignity in the older person, and how to identify and address elder abuse. For more information see Further considerations – Ageism, and Further considerations – Elder abuse.

Hospital quality committees should ensure all health care is informed by evidence, and health professionals and health service managers (including executives) have a responsibility to evaluate and monitor their practice. Optimal care pathways provide a framework to help evaluate and monitor practice over time. Services should be routinely collecting relevant minimum datasets to support benchmarking, quality care and service improvement. Hospital committees and health professional peak bodies should be auditing this process (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2017).

The Australian Council on Health Standards <https://www.achs.org.au/> has created a set of indicators that helps hospitals conform to appropriate standards.

Data-driven quality care

Optimal care pathways outline best practice and by adhering to optimal care pathways service providers are guided to reduce unwarranted variations in care by ensuring patients receive consistent, evidence-based treatment regardless of location or provider. By measuring the performance of a health service against the optimal care pathways, improvements to healthcare systems can be identified to achieve optimal care and drive better and equitable patient outcomes.

Collecting and analysing data relevant to cancer care for older people is necessary to inform evidence-based high-quality care. Older people with cancer are under-represented in clinical trials, and are in fact often excluded from participation (Extermann M et al. 2021; Sedrak MS et al. 2021). To promote data-driven care, health services should where possible conduct and participate in research including and focused on older patients with cancer (Solary E et al. 2022).

Patient-reported experience and outcome measures

Patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs) should be incorporated into routine cancer care.

PREMs are used to obtain patients' views and observations on aspects of healthcare services they have received (AIHW 2018b). Patient experience data is collected for specific services and then relayed to service providers to instigate improvements in patient services (ACSQHC 2019a).

The Australian Hospital Patient Experience Question Set (AHPEQS) is a tool used to assess patient experiences of treatment and care in a private or public hospital. AHPEQS helps to improve the safety and quality of health care by allowing organisations to understand the patient's perspective (ACSQHC 2019a; AIHW 2018b).

PROMs measure aspects of a person's health status such as symptoms, quality of life and needs and are collected directly from patients either online, via a smartphone or through paper-based means.

Collecting PROMs, and then instigating an appropriate clinical response, has been shown to prolong survival, reduce health system use and improve patients' quality of life. While there are many sets of PROMs questions that are relevant to any person with cancer, specific questions can be tailored to particular cancer types, populations or different phases of cancer care.

Health services should ensure well-defined, age-appropriate PREMs and PROMs validated within this cohort are considered to inform optimal care.

Principle 3: Multidisciplinary care

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Multidisciplinary care is an integrated team approach that involves all relevant health professionals discussing all relevant treatment options and making joint recommendations about treatment and supportive care plans, taking into account the personal preferences and goals of the older person with cancer.

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Multidisciplinary care improves patient outcomes. Cancer Australia's 'Principles of multidisciplinary care' provides a flexible definition, allowing services to vary implementation according to cancer type and the service location and context. The principles stipulate:

- a team approach that involves core disciplines that are integral to providing good care, including general practice, with input from other specialties as required
- timely and accessible communication among team members about treatment planning and follow-up plans
- access to the full therapeutic range of treatment and care for all patients, regardless of chronological age, geographical remoteness or size of institution
- care delivery in accordance with nationally agreed standards
- patient and carer involvement in decisions about their care (Cancer Australia 2019b).

Key considerations and components of multidisciplinary cancer care in older people with cancer include:

- teams that meet the needs of the older person at critical time points, including at diagnosis when establishing the treatment plan, during treatment to meet supportive care needs, during survivorship and/or end-of-life care

- considerations of what matters most to the older person with cancer/carer, goals of treatment, tolerance of possible treatment toxicities, polypharmacy, cognition, memory and mood, mobility and falls risk, nutritional and co morbidities and considerations relating to level of independence.

Multidisciplinary meetings, often called MDMs, should be based on the principles outlined above. Governance of MDMs should ensure that team members with expertise in assessment and management of geriatric concerns can actively contribute to treatment decision-making, and the outcome of an MDM decision should include not only the treatment decision but the relevant decisions to respond to geriatric concerns. For people with more complex needs in geriatric domains a tailored MDM including more comprehensive geriatric expertise is recommended.

In many instances the carer of the older person is also an older person themselves with their own individualised health care needs. Consideration needs to be given by the multidisciplinary team (MDT) to the carer's own health and support needs, as their needs as a carer are integral in the approach to optimise outcomes for the older person with cancer.

The possible membership of the MDT is outlined in Appendix E.

For more information on the principles of multidisciplinary care and the benefits of adopting a multidisciplinary approach, see Cancer Australia’s ‘Principles of multidisciplinary care’ <www.canceraustralia.gov.au/clinical-best-practice/multidisciplinary-care/all-about-multidisciplinary-care/principles-multidisciplinary-care>.

SUPPORTIVE CARE

Principle 4: Supportive care

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Supportive care is a vital part of all cancer care. As an integral component of care, it allows for timely identification of and intervention for issues that emerge for the older person with cancer, their families and carers from the effects of a cancer diagnosis and its treatment. Supportive care refers to an integrated field of multidisciplinary services and interventions necessary for people affected by cancer to meet their physical, emotional, functional, psychological, social, information and spiritual needs across the illness pathway (Olver I et al. 2020). Supportive care should begin from the time of diagnosis and continue throughout the cancer pathway. Supportive care underpins delivery of person-centred, quality cancer care.

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Older people are a heterogeneous group who report a broad range of supportive care needs. Most unmet needs are reported in informational and physical domains (Williams GR et al. 2019). In particular, the need to receive more comprehensible information from doctors and nurses and the need for better conversations with doctors are prevalent areas of unmet need for older people (Romito F et al. 2011). The most commonly reported individual needs include: fear of cancer recurrence, financial concerns, not having someone to share worries with, availability of support, and worries of those closest to them. These areas of need are more likely to be reported by people with lower income, who are culturally and linguistically diverse, have several comorbidities and are socially isolated (Fitch MI et al. 2023; Valery PC et al. 2017; Williams GR et al. 2019).

Older people with cancer are diverse, each with unique circumstances, intrinsic capacity, psychosocial needs, and available social support. What matters most to an older person should be central to decisions about supportive care measures, as with other aspects of cancer care (Hodge O et al. 2024). Family and carers should be involved in discussions and decisions to the extent a person wishes.

This is Me tool has been developed as a consumer-generated supportive care resource to help people gather and write down important information to share with their cancer team and articulate what matters most to them (WeCan 2024). See <https://wecan.org.au/oldercan/cancer-diagnosis/this-is-me/

Supportive care needs of family and carers

Families and carers of older people with cancer also experience a range of unmet supportive care needs. Evidence indicates unmet needs are across a complex range of caregiving activities that span managing symptoms and medications, communicating with the treating team and coordinating care, caring for medical equipment, providing personal care, managing household tasks and addressing the older patient’s social and emotional needs (Adashek JJ et al. 2020). These caring requirements can have profound impact on carer’s quality of life and need for supportive care, and carers with poorer mental health, less social support, those caring for frailer patients and living in rural and remote locations, are more likely to experience greater burden of unmet supportive care needs and barriers to accessing the support they require (Johnston EA et al. 2024). The older person with cancer may also have caregiving responsibilities, therefore it is essential to consider how their treatment plan impacts their ability to care for others.

The role of the health professional in Supportive Care

For health professionals, supportive care involves:

- screening and assessing patients and families for their supportive care needs
- providing patients with access to a range of multidisciplinary support services, groups and therapies designed to assist them to live with cancer and its treatment and optimise recovery
- optimising referral pathways to community support organisations (cancer-related non-government, not-for-profit and charities) that provide services to cancer survivors – these address many of the care-navigation, psychosocial and information needs of cancer survivors and those affected by cancer (ACSC 2021).
- being aware of and delivering culturally appropriate care.

All members of the multidisciplinary team have a role in providing supportive care along the care pathway, with special attention at transition points. For more information see Further considerations – Transition of health care between services.

Healthcare professionals should refer to cancer specific Optimal Care Pathways for supportive care considerations of importance to the type of cancer the older person has.

Geriatric Screening and Assessment in Supportive Care

In addition to standard aspects of supportive care for all people with cancer, Geriatric Screening and Assessment can identify unmet needs and guide supportive care interventions for older people. The integration of Geriatric Assessment and Management into cancer care for older people receiving chemotherapy improves communication, physical functioning, and quality of life for older people with cancer, whilst also reducing treatment complications (Hamaker M et al. 2022). Best practice care recommends at a minimum frailty screening and targeted geriatric assessment to identify vulnerabilities or strengths that standard oncology assessments may not capture (Dale W et al. 2023).

Domains which are considered in Geriatric Assessments, align well with many domains of supportive care management, for example, cognition, medication use, co-morbid chronic disease and physical function (See Appendix A)

Geriatric Assessment domains, and considerations if deficits are identified, include:

Cognition – consider treatment decision-making capacity, ensure information provision is appropriate to the person's understanding, consider referral to a cognitive specialist (e.g. geriatrician, neurologist, psychiatrist, occupational therapist)

Comorbid chronic disease – consider consulting with the general practitioner or other involved specialists.

Medication usage – can be optimised by the support of pharmacists, general practitioners, or geriatricians.

Mood – consider refer to mental health supports.

Nutrition – consider referral for dietitian support.

Physical function – consider referral for assessment and management with a physiotherapist or exercise specialist for mobility issues, or occupational therapist of difficulties with activities of daily living

Sensory function – visual/auditory aids are available and utilised, adapt communication and written materials to individual needs.

Social support – consider referrals to a Social Worker, for Aged Care Support Services, and/or transport assistance should be considered

What matters most - commence advance care planning conversations

Refer to Appendix F for a list of Geriatric Domains, for example screening and assessment tools and recommended care.

Health Services

Health services providing care to the older person with cancer should:

clearly identify who has responsibility for undertaking supportive care screening and clear articulation of where supportive care data are reported, discussed and responded to

routinely screen for frailty and assess geriatric domains including falls, functional decline, nutrition status, psychological distress, cognitive function at baseline and during treatment

identify opportunities to strengthen age-friendly care provision and work towards age-friendly healthcare systems to provide care which prioritises what matters most, mentation, medication and mobility (John A Hartford Foundation 2024; WHO 2004). See Principle 1: Person-centred and age-friendly care for further information.

train health professionals in the optimal multidisciplinary care of older people with cancer consider use of patient reported outcome measures to facilitate screening, assessment and patient-driven referrals.

Key review points

The multidisciplinary team should assess the older person with cancer for supportive care needs at these key stages:

initial presentation or diagnosis (first three months)
the beginning of treatment or a new phase of treatment
change in prognosis or poor response to treatment

changes in functional capacity or quality of life

end of treatment
throughout survivorship as any new issues emerge
diagnosis of disease recurrence
change in or development of new symptoms
palliative care
transition to end-of-life care
other time points based on clinical judgement and on patient/carer request.

The multidisciplinary team should determine the need for ongoing referrals to supportive care services. Access can be through hospital-based clinicians, general practice–led chronic disease management plans, team care arrangements and mental health plans. Community services may also be available.

See Appendix A B and C for more information on supportive care domains and the specific needs of people that may arise.

Principle 5: Care coordination

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CARE COORDINATION

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Care coordination is the responsibility of every professional, both clinical and non-clinical, who works with older people with cancer, their families and carers across health and social care sectors.

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Seamless care coordination is essential for older people with cancer and their significant others to successfully navigate the complex health system. Care coordination is a comprehensive approach to achieving continuity of care. It aims to ensure care is delivered in a systematic, connected and timely way that promotes efficiency and reduces the risk of duplication and over-servicing to meet the medical and personal needs of older people and their carers.

Care coordination includes:

proactive and timely communication with patients, their families and carers
treatment plans, survivorship care plans and/or advance care directives
coordinated appointments to ensure timely diagnosis, treatment and survivorship care
appropriate tests and results being available to the treating team so treatment decisions can be made
medical records being available to all members of the treating team and at scheduled appointments
translation or interpreter services arranged if the patient/carer is from a non-English-speaking background or has difficulty communicating due to a physical disability
practical support such as transport, accommodation, advance care planning and financial support
referral and access to supportive care
access to clinical trials
access to telehealth for people in rural and remote areas and for managing vulnerable patients.

Care coordination brings together different health professionals, teams and health services. It also encompasses MDMs, multidisciplinary assessment clinics, supportive care screening and assessment, referral practices, data collection, common protocols, information for patients and individual clinical treatment.

Care coordination should cross the acute and primary care interface and should aim to achieve consistency of care through clear communication, linkages and collaborative integrated care planning.

Care coordination can be facilitated through electronic health record management such as My Health Record. My Health Record is a secure online database that helps with data collection and care coordination (My Health Record 2019).

Formal care coordination through appointed care coordinators plays an important role in managing and supporting patients through the health system. The availability of dedicated care coordinators varies across states and territories according to the complexity of care required and local service capacity and resourcing.

Care coordination for the older person with cancer

Effective care coordination for older people is a comprehensive whole-of-system approach encompassing multiple aspects of care delivery (Victoria CC 2020). Central to this, however, is integration of an older adult care coordinator who can provide continuity in what is often a fragmented and complex healthcare system (Seghers PN et al. 2023). An individualised approach that acknowledges and responds to the competing biopsychosocial factors impacting health and outcomes of older people with cancer is essential, targeting what matters to each person at every step along the cancer pathway (Hodge O et al. 2024). These needs may be distinct to other adult cancer populations and may require a family-focused approach to care (Hodge O et al. 2024). In an era of personalised medicine and increasing complexity of treatment, effective care coordination is essential, especially for older patients who may present with or develop multi-morbidity, requiring involvement of and multiple appointments with several medical teams (Seghers PN et al. 2023). Optimal care coordination for older people provides information, emotional support, empowerment, patient advocacy and consideration of health literacy, with a physical presence at key time points throughout the care continuum (Mollica MA et al. 2021; Seghers PN et al. 2023; Wu J et al. 2023). With the consent of the older person, it is important to ensure inclusion of the patient's primary carers thus facilitating understanding of treatment recommendations and ongoing plans. Cancer care coordination approaches have been proven to proactively orientate patients to resources tailored to their needs, improve patient experiences of care, quality of end-of-life care, and impact appropriate use of health services (Gorin SS et al. 2017). It is considered a critical component of age-friendly cancer services (Hodge O et al. 2024; Mollica MA et al. 2021).

Wherever possible, a care coordinator or a responsible health care professional should be embedded within a dedicated geriatric oncology team or oncology team and have strong links to a geriatric service/geriatric evaluation and management team (GEM), a person's general practitioner and/or aged care provider, as appropriate (Harvey D et al. 2016). With increasing policy focus on, and availability of cancer treatments that enable care at home or in the community, ensuring adequate care and support in the community, aligned with the older person's preferences for place of care, and family or carer capacity to provide care and support, is an important focus of care coordination (Sun V et al. 2021).

Importantly, healthcare providers should develop an integrated person-centred approach to address the needs and preferences of older people while also acknowledging the wide heterogeneity of health and wellbeing within this age group (Seghers PN et al. 2023).

Health services providing cancer care to older people should consider:

- implementing a dedicated, interdisciplinary geriatric oncology service or pathway (where diverse professionals come together to develop a shared plan of care) – or adequate and appropriate access to a geriatrician as a core member of a multidisciplinary team to optimise quality cancer care for older people – impacting patient experience, health outcomes and system costs (Ellis G et al. 2019)

- allocating resources for dedicated geriatric oncology care coordinator roles as part of their strategic and business plans to deliver age-friendly health care (Gorin SS et al. 2017; Harvey D et al. 2016; Hodge O et al. 2024; Mollica MA et al. 2021)

- prioritising these resources at critical time points along the care continuum – with particular attention to early geriatric screening and referral for assessment, screening for elder abuse, supportive care needs and social determinants of health, using validated tools (Mohile SG et al. 2018; Ozluk AA et al. 2023; Venkataramany BS et al. 2022)

- attending to each of the aspects of the 4Ms Model (mentation, medication, mobility and what matters) (Hodge O et al. 2024)

- gathering stakeholder perspectives on institutional barriers to delivery of optimal care for older people (Lynch MP et al. 2021) embedding approaches that include the older person in care and treatment decision-making, as they are able and wish to be involved. Making decisions for or excluding an older person from these discussions may threaten their autonomy and emotional wellbeing and goes against best practice principles of age-friendly care (Hodge O et al. 2024; van der Waal MS et al. 2023)

focusing on the person, functional status and personal preference (what matters most) rather than on the disease or chronological age (Ellis G et al. 2019; Sun V et al. 2021; van der Waal MS et al. 2023).

Hospital/cancer treatment centres must have formal communication systems in place with primary care, community-based service providers and aged care residential facilities for patients who reside in them; and ensure the patient is aware of and consents to these communication channels.

Recognising involvement of other family members, carers and significant others is an important component of care for the older person with cancer (Marcotte J et al. 2019). Although family or significant others provide invaluable support by undertaking multiple tasks along the cancer pathway, evidence suggests that their needs are poorly assessed, resulting in physical and emotional impacts (Marcotte J et al. 2019; van der Waal MS et al. 2023).

Delivery of effective care coordination for older people requires particular attention to streamlining care and communication, identifying availability of and optimising family and/or significant other support networks.

Identify with the patient their available carer support network and capacity of carers to provide ongoing assistance and support throughout the cancer treatment phase and beyond (van der Waal MS et al. 2023).

Provide the patient, family member and carers with names, role delineations and contact numbers for the treating team, including allied health team members.

Reassess at key timepoints any changing needs in care coordination – end of treatment, progressive disease, palliation (Lynch MP et al. 2021; Mohile SG et al. 2018).

Principle 6: Communication

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Everyone employed in the healthcare system is responsible for ensuring the communication needs of older people with cancer and their families and carers are met.

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Good and open communication is a key principle of care for people with cancer. This includes communication with patients and their families and carers, as well as between oncology teams and primary care health professionals. General practitioners should be involved in care from the point of diagnosis, and patients should be encouraged to maintain a relationship with their general practitioner through all stages of cancer care. Communication should be regular and timely.

Age-Inclusive Language

Age-inclusive language refers to communication that avoids stereotypes and promotes respect and dignity for older people. In cancer care, this approach fosters trust, enhances communication, and reduces disparities in access, treatment, and outcomes for older people.

A common example of stigmatising and ageist communication is “elderspeak”, a simplified speech style resembling baby talk, which is patronising and disrespectful (Shaw C et al. 2020). It is essential to avoid using such language and to use respectful, neutral language to foster age-inclusive communication. Words with negative connotations or stereotypes like “elderly” should be replaced with neutral terms like "older people” or "people aged over 65”. Although some may find “senior” acceptable, preferences vary and “older people” or “older adults” is generally regarded as more inclusive (Trucil DE et al. 2021).

In clinical settings, language should be precise yet considerate. For example, “Geriatrics” is an appropriate description of the medical specialty focused on the healthcare of older people but using “geriatric” to describe individuals can be reductive and carries negative connotations. Similarly, “frailty” is a key concept in the care of older people but should be discussed thoughtfully as it may be perceived negatively by some individuals (Durepos P et al. 2022; Hall AJ et al. 2024). To address this, clinicians should educate patients about the medical context of frailty and balance discussions by acknowledging areas of strength and resilience alongside vulnerabilities. This approach ensures comprehensive and respectful dialogues.

Age-inclusive language also involves shifting the focus from chronological age to functional status. For example, describing someone as “managing cancer while maintaining independence” highlights a person’s capabilities rather than framing them solely by chronological age.

Both verbal and written communication should reflect an age-inclusive approach. Patient records, correspondence, and interactions should avoid stereotypes and unnecessary descriptors, focusing instead on clinical relevance and respect for the individual (Kyi K et al. 2023).

Age-inclusive language is vital for creating equitable, person-centred care. By using neutral and respectful language in all aspects of care, healthcare professionals can foster an environment where older people feel valued and receive dignified, high-quality care throughout their cancer journey.

For more information see Further considerations – Ageism.

Enhancing communication

Every person with cancer will have different communication needs, including cultural and language differences. It is important not to make assumptions, but to ask the older person about their communication preferences, including who they would like included in discussions and the extent of that involvement, as well as asking about communication challenges such as hearing or visual impairment or limited literacy. When anyone involved in treatment communicates with patients, they should be truthful and transparent but mindful of cultural sensitivities and the potential psychological impact of the information being communicated.

The incidence of sensory and cognitive deficits increases with age. Older people on average have lower health literacy than their younger counterparts (AIHW 2018a) and less access to and familiarity with digital communications (Borg K et al. 2019; Dykgraaf SH et al. 2022). However, older people are diverse, so communication must be individually tailored. Many older people have high levels of health and digital literacy.

In communicating with older people, healthcare providers should undertake to:

ask about communication preferences including who they would like to be involved in discussions and the extent of that involvement

ensure sensory aids such as glasses and hearing aids are available and used

have access to equipment to enhance communication in clinical settings, for example personal amplifiers

use professionally trained interpreters when communicating with people from culturally diverse backgrounds whose primary spoken language is not English and for people with a hearing impairment (visit the Translating and Interpreting Services website <www.tisnational.gov.au> for more information on interpreter and language services)

avoid relying on family members to act as interpreters except when no other options are available

identify the patient's substitute treatment decision-maker to ensure they are involved in relevant discussions if a person lacks decision-making capacity (see Further considerations – Decision-making capacity)

seek consent before conveying information between health professionals or healthcare teams or with family and carers

empower older people and their family and/or carers to be actively involved in treatment discussions through promoting two-way dialogue, encouraging questions and voicing of concerns

check the patient's and/or their family or carer's understanding by asking the patient and/or their family or carer to say in their own words what has been conveyed ensure information is communicated at a level relevant to the patient’s health literacy and that of their families and carers (ACSQHC 2020), and use tools, diagrams and aids as appropriate (Gilligan T et al. 2017)

provide written resources or links to electronic resources which enhance understanding and provide information about additional supports and services, for written materials use larger fonts and clear printing to maximise legibility

provide appropriate information for people from culturally diverse backgrounds

use culturally sensitive and appropriate forums of communication for people from culturally diverse backgrounds and Aboriginal and Torres Strait Islander people, as appropriate

allow enough time for communication, especially when conveying complex or sensitive information such as an initial diagnosis

provide information on community-based supportive care services and resources to patients and their families and carer

be respectful if a patient seeks a second opinion from another health professional

ensure patients do not have to convey information between areas of care (it is the provider’s and healthcare system’s responsibility to transfer information between areas of care).

Healthcare providers should consider offering patients a question prompt list before a consultation and recordings or written summaries of their consultations afterwards. Question prompt lists are effective in improving communication and the psychological and cognitive outcomes of people with cancer. Recordings or summaries of key consultations improve patients’ recall of information and satisfaction (Hack TF et al. 2013). (Hack et al. 2012). Self-completed resources, like the "This is me” form by OlderCan (WeCan), are completed by the older person and provided to their cancer care team. These should be considered as they can improve communication and understanding of the person’s health, function, social supports and priorities.

Families and carers

Attendance of a family member or carer at clinical appointments is beneficial for many patients, as the family member or carer can provide informational and emotional support. General practitioners and clinicians should encourage and support the involvement of family members and carers by providing an inclusive and supportive consultation environment (Laidsaar-Powell R et al. 2018a). Laidsaar-Powell et al. provide evidence-based guidance on how to support family member or carer involvement in consultations (Laidsaar-Powell R et al. 2018a, 2018b).

However, the level of support family members and carers are able or willing to provide to older people with cancer is variable and no assumptions can be made. Carers of older people also tend to be older, and they may have their own health or other concerns (Kadambi S et al. 2020). Additionally, healthcare professionals need to be alert to older people feeling under pressure to make particular decisions about their cancer treatment, and to signs of elder abuse which may be subtle and not openly disclosed. Elder abuse is common (AIHW 2024a) and can take various forms includes physical abuse, psychological, emotional, sexual or financial abuse, or neglect abuse (ALRC 2016).

For more information see Further considerations – Carers, and Further considerations – Elder abuse.

Surrogate decision makers

For patients with cognitive impairment, capacity to give informed consent to treatment should be considered. If a person lacks capacity to consent to treatment, the person responsible for being their surrogate decision maker should be determined. Legislation differs across States and Territories and healthcare professionals should be aware of their local legislation (O'Neill N et al. 2011). People are assumed to have the capacity to make a decision until assessed as lacking capacity. Decision-making capacity can differ between different decisions and should be considered in relation to the decision in question. Capacity may change over time or fluctuate depending on the environment, or medical issues, so should be reassessed at key time points such as a change in health status or if new concerns are raised (O'Neill N et al. 2011).

People who lack treatment decision-making capacity may still be able to express their preferences, values and goals. They should remain involved in discussions and decisions about their cancer management to the extent they are able to, and efforts taken to maximise their participation, such as using simplified language and images (ALRC 2014b).

For more information see Further considerations – Decision-making capacity.

Communication skills training

Communication skills training programs that use role-play to develop skills and observe patient interactions to provide feedback, should be available to health professionals at every level of practice (Gilligan T et al. 2017).

Communication skills training programs and resources can be found on the following websites:

Australian Commission on Safety and Quality in Healthcare, Communicating for safety resource portal <https://c4sportal.safetyandquality.gov.au>
state and territory Cancer Councils <www.cancer.org.au/about-us/state-and-territory-councils/> for the relevant council
eviQ <https://education.eviq.org.au>
VITAL talk <www.vitaltalk.org>.

Telehealth

Telehealth has become an increasingly acceptable alternative to face-to-face consultations. However, when considering telehealth, the older person’s preferences, their access to and familiarity with digital communication, and any sensory or cognitive issues must be considered (Dykgraaf SH et al. 2022). A face-to-face consultation should be the first option, if it is safe, when delivering critical diagnosis information, a change in therapy or prescribing intensive treatment. If this is not an option, a video consultation should be considered, and the patient should be encouraged to have a support person with them to assist treatment (Keefe D et al. 2020)~~.~~

Principle 7: Research and clinical trials

RESEARCH AND CLINICAL TRIALS

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Research and clinical trials play an important role in establishing the efficacy and safety of diagnostic, prognostic and therapeutic interventions, as well as establishing the role of psychological, supportive care and palliative care interventions (Sjoquist KM et al. 2013).

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Clinical trials are the foundation for improved cancer outcomes, allowing new treatments to be tested, optimising regimens including treatment de-escalation, and offering patients access to potentially more effective therapies than otherwise available to them.

Clinical trials are available for multiple types of cancer and may be a valuable option for people with rare, difficult-to-treat cancers for which there may be limited evidence about how the condition is best treated or managed (Australian Clinical Trials 2015).

Implementation science is key to translating research findings into geriatric oncology practice. It addresses the practical barriers, enablers, and contextual factors that influence the successful adoption of interventions, thereby improving care models (McKenzie GA et al. 2021; Mitchell SA et al. 2017).

In real-world clinical practice, older people with cancer often present with diverse health statuses and comorbidities, yet they remain significantly underrepresented in large prospective randomised studies (Dunn C et al. 2017). Barriers to the enrolment of older people are multifactorial and occur at the system, institution, and individual levels. As such, addressing these challenges and increasing the participation of older people in clinical trials continues to be a key priority for providers and policymakers.

Age alone should never be a criterion for exclusion from clinical trials. However, current eligibility and exclusion criteria often indirectly or directly exclude individuals based on age. To address this, clinical trials should remove upper age limits, include geriatric assessments in the screening process, and increase the availability of trials for older people. Collaboration between oncology teams and geriatric oncology professionals, involving investigators with expertise in geriatric oncology, and providing age-appropriate patient education resources can further improve accessibility. This approach ensures that trial populations better represent the real-world diversity of older people with cancer and generate robust results that inform clinical practice (Goodwin VA et al. 2023).

Clinical trials should incorporate endpoints that are meaningful to older people. This includes designing trials with geriatric-specific measures and outcomes that are particularly relevant to this population (Wildiers H et al. 2013). While overall survival and other survival data are important, additional outcomes that matter to older people should be measured, such as quality of life and impact on specific geriatric domains like cognition, mobility, continence, and clinical frailty. Trials should also include PREMs, PROMs, and, where applicable, carer-reported outcomes to capture the lived experience, quality of life, and treatment impacts (Balitsky AK et al. 2024). Co-design with consumers and patient advocacy groups can enhance trial relevance and participation engagement (Crocker JC et al. 2018). For more information see Further considerations – Co-design.

Treating specialists and multidisciplinary teams should be aware of or search for clinical trials that may be suitable for older people with cancer. The care team should actively support patients in exploring opportunities to participate in research or clinical trials when available and appropriate. Specialists should refer appropriate patients to other treating centres to participate in research or clinical trials at any stage of the care pathway and be willing to discuss the pros and cons of participating in such trials. Many emerging treatments are only available through clinical trials that may require referral to certain trial centres. Any member of the multidisciplinary team can encourage cross-referral between clinical trials centres. Possible ineligibility to participate in a clinical trial should be discussed with the patient. Acknowledge disappointment and offer support in this instance.

Trial staff should receive adequate training to address the specific needs of older participants, mitigate age-related biases, and improve communication. This may include using patient-friendly formats such as large prints, audio recordings, or video materials to assist patients with sensory deficits. Ethical issues in trials with older people, particularly those related to informed consent and minimising potential coercion, require careful consideration, especially with patients with cognitive impairment (Forsat ND et al. 2020).

Health services should strive to implement policies and procedures that facilitate equitable access to clinical trials for all patients, including culturally diverse patients, regional patients and those from Aboriginal or Torres Strait Islander communities (ACSQHC 2022).

Older people may face mobility challenges and logistical barriers that hinder their participation in clinical trials. Therefore, clinical trial locations need to ensure physical access issues are addressed. Additional support, such as transportation assistance and simplified consent processes, can further reduce the burden of participation (Forsat ND et al. 2020).

The use of telehealth technology, such as the Australasian Tele-trial Model, hopes to improve access to trials for patients being treated in rural and regional areas (COSAClinical Oncology Society of Australia (COSA)).

Australian Cancer Trials is a national clinical trials database. It provides information on the latest clinical trials in cancer care, including trials that are recruiting new participants. Search for a trial <www.australiancancertrials.gov.au> via its website.

Education and training

Research and clinical trials provide an opportunity to educate health professionals who are in training about the needs of older people with cancer. Cancer centres may be affiliated with teaching hospitals, universities or research groups to promote higher education or to develop an academic workforce focused on geriatric oncology, leading to more sustainable practice. Specialists should be encouraged to take up and retain active membership to professional societies and organisations dedicated to geriatric oncology that can assist with professional development opportunities.

Further considerations: Supporting the delivery of optimal care for older people with cancer

This section provides further information and guidance about unique concepts in cancer care for older people with cancer. This information is likely to be relevant across all steps in the care pathway.

Age-friendly cancer care

Age-friendly healthcare has structures, services and environments that are adapted to be accessible and inclusive for older people with varying needs and capacities (Tavares J et al. 2021). A key component of age-friendly care is aligning care with a person's values, preferences and goals, thereby respecting the autonomy and needs of older people (Zisberg A et al. 2024). Various age-friendly healthcare frameworks have been developed. Common features include prioritisation of and support for older people across leadership, organisational policies and procedures, communication, care process, as well as the behavioural and physical environment (Zisberg A et al. 2024).

Healthcare services are typically designed to optimise the management of acute illnesses and therefore, may not be well organised to care for older people with multiple chronic medical conditions, disabilities and psychosocial needs. There are risks to older people in hospital environments, including: falls, immobility, pressure areas, malnutrition, delirium, adverse events from medications, and functional decline (Wong KS et al. 2014). Implementation of age-friendly healthcare systems can reduce these risks and maintain a person’s intrinsic capacity (WHO 2004).

Evidence-based age-friendly care can be summarised by the 4Ms framework (John A Hartford Foundation 2024):

> what matters most - knowing and aligning care with a person’s preferences, values and goals
>
> mentation - preventing, identifying and managing cognitive impairment, including dementia, depression and delirium
>
> medication - using age-friendly medications and minimising unnecessary or potentially inappropriate medications
>
> mobility - maximising safe mobility and function in older people.

Carers

Acknowledging that ‘older people’ are a heterogenous and highly variable cohort in their physical and functional capacity, the older person with cancer is more likely to rely on support and practical assistance from carers due to a range of factors which may include reduced mobility, declining functional status, impaired cognition and the presence of other chronic health conditions in addition to the cancer diagnosis. A carer is anyone who provides support or services to the older person. It may be a family member, friend, neighbour or a formal carer from a community-based aged care service provider.

Although the patient remains at the centre of care, it is imperative to involve carers in consultations, assessments and treatment decision-making, according to the wishes of the patient, and always with their consent. Carers are vital in ensuring that decision-making and treatment plans are adequately understood, that they align with the wishes of the patient, and that they are feasible and achievable in the context of the home and family circumstances of the patient (Kadambi S et al. 2020).

Consideration of the capacity of carers to provide ongoing care and support is an essential part of treatment planning, and yet the needs of carers are not always adequately assessed (Marcotte J et al. 2019; Sun V et al. 2021). The role of the carer is paramount in situations where the patient's cognitive capacity is impaired. Careful documentation of the carer's legal decision-making status (Power of Attorney or Guardianship) is required.

Importantly, the primary carer of the older person with cancer may themselves have caregiving responsibilities for other family members and this needs to be explicitly assessed. They may be of an advanced age and have associated chronic health conditions that limit their capacity to provide for the increased care needs of the person with cancer. Optimal care of the older person with cancer is highly dependent on their capacity to be safely cared for in their home and community by those who take on the role of carers.

The significant burden on primary carers, however willing, must not be underestimated (Sun V et al. 2021). Carers need to be provided with information about carer support and respite services, and the availability of financial statutory payments for those who meet eligibility requirements. Capacity of carers to maintain a safe and adequate level of care for the patient must be revisited at critical timepoints in treatment planning, especially at the time of recurrence of cancer, transition to palliation and end-of-life care.

Carer Gateway is an Australian government program providing emotional and practical support and services for carers. Each Australian State and Territory has a service provider. Tailored services can include support in the home, in home respite or residential aged care respite. For further information go to <www.carergateway.gov.au>. Carers can self-refer by calling 1800 422 737, 8am to 5pm Monday to Friday.

Carers Australia is the national peak body for carers: <www.carersaustralia.com.au>. Each Australian state and territory has its own carer's association offering a range of information services and carer support.

Some carers may be eligible for Centrelink payments through Services Australia. Carer Payment is subject to means and asset testing criteria. It may be paid to a person who is providing constant care or a large amount of daily care, roughly equating to a normal working day, such that the carer is unable to engage in paid employment. It is assessed and paid as per an Australian pension. Carer Allowance is a smaller supplementary payment for a person who is providing a lower level of daily care and support. It can be paid to carers who are maintaining paid employment, it is non means tested and does not require the carer to co-habit with the person to whom they are providing care. It is possible to be paid both

Carer Payment and Carer Allowance. For more information go to <www.servicesaustralia.gov.au>.

Aged care services are funded through the Australian government and are administered by local health services and by community non-government organisations. Where an older person with cancer is already receiving services through an aged care provider, their carers should be advised to discuss their changing care needs and investigate the availability of additional services to support the patient and carer. If a patient is not previously known to services, they should contact My Aged Care to request an aged care assessment. This can be initiated by the person with cancer or their carer, via phone on 1800 200 422 (8am to 8pm on weekdays, 10am to 2pm on Saturdays) or by visiting the website <www.myagedcare.gov.au> and applying for an assessment online.

Additional services and resources can be found at OlderCan: https://wecan.org.au/oldercan/

Advance Care Planning

Advance care planning is the process of planning for future health care, in situations where a person was seriously illness and unable to communicate preferences for themselves (ACPA 2024a). It is important to consider this process as a conversation which occurs over time, which may result in preferences being documented in a written document (advance care plan or advance care directive) and/or the appointment of a substitute decision maker (ACPA 2024a). Importantly an advance care plan being communicated with the person's loved ones and treating clinicians will ensure that these preferences and values are understood (ACPA 2024a). A substitute decision maker is a person the older person chooses to make medical decisions on their behalf in the event they are unable to do so for themself. Substitute decision makers have different titles depending on the state or territory in Australia a person lives (ACPA 2024a).

Health professionals from all disciplines have an important role to play in advance care planning conversations, which may include responding to an older person's questions about advance care planning, starting the conversation with the person, and ensuring expressed wishes in an advance care plan are considered in decision-making. Advance care planning conversations should be part of ongoing care for the older person with cancer, well before deterioration in health or crisis situations, and continue into survivorship (O'Caoimh R et al. 2017). The Australian population is diverse, and there are important considerations to ensure that the approach to advance care planning is tailored to an individual's need and is culturally responsive (ACPA 2024a, 2024b).

Formal advance care planning is only legally possible when a person is competent or has decision-making capacity (ACPA 2024a). Equally the timing of when a substitute decision-maker or advance care plan is enacted also depends on an assessment of lack of capacity to make decisions for themselves. Health professionals need to understand approaches to assess capacity and not make judgements about lack of capacity purely based on age (Lin C-P et al. 2018). It is important that all means are explored to support an older person making decisions for themselves before they are deemed a person who lacks capacity. There are a number of elements to consider in relation to decision-making capacity (ACPA 2024a) and it is important that these are specific to the task or decision at hand:

> ability to understand information
>
> the appreciation of the relevance of that information to the situation
>
> the ability to reason or weigh up the risks and benefits
>
> the ability to express a choice,

Evidence points to advance care planning providing the most consistent and positive effects on patient proximal outcomes, including quality of patient–physician communication, treatment preference, decisional conflict and patient–carer congruence in preference, and on documentation of the advance care plan/advance care directive (Malhotra C et al. 2022). Advance care planning should be considered as part of an integrated care plan which also includes supportive and/or palliative care, interdisciplinary support, symptom management and system changes which ensures access to advance care plans at point of care. Advance care planning is not a means on its own to impact the older person's quality of life nor can it ensure end of life preferences are met (Malhotra C et al. 2022).

Refer patients and carers to Advance Care Planning Australia <www.advancecareplanning.org.au> or to the Advance Care Planning National Phone Advisory Service on 1300 208 582.

Ageism

In general terms, ageism refers to how one thinks of, feels about, and acts towards an individual of a different age. Though numerous definitions of this phenomenon exist, this optimal care pathway employs the definition proposed by Thomas Iversen et al, namely that:

> Ageism is defined as negative or positive stereotypes, prejudice and/or discrimination against (or to the advantage of) elderly people on the basis of their chronological age, or on the basis of a perception of them as being 'old' or 'elderly'. Ageism can be implicit or explicit and can be expressed on a micro-, meso- or macro-level (Iversen TN et al. 2009).

This definition highlights a number of key components of ageism. Firstly, it recognises the cognitive, behavioural, and emotional components of ageism, and argues that these experiences can relate not only to an individual's chronological age, but also to their perceived age and stage of life. Secondly, it notes that ageism can be unrecognised / subconscious as well as being intentional / conscious. Finally, it conceptualises the three dominant spaces in which ageism can impact on individuals, namely:

> The 'micro'-level: Otherwise referred to as 'internalised ageism', this involves individuals' self-assessment of their strengths and vulnerabilities, often typified by a devaluation of their personal experiences, health and function.
>
> The 'meso'-level: This refers to interpersonal experiences of ageism and relates to how individuals and groups perceive ageing. It is typically characterised by negative interactions where older individuals are seen to have less intrinsic 'worth' than other individuals.

The ‘macro’-level: This refers to the broader societal and organisational systems that limit the function and power of older individuals. Such systems may include health infrastructure.

Ageism is associated negatively with almost all aspects of an older person’s health, including:

A mortality decrement of 7.5 years (WHO 2021).

Poorer physical health (Allen JO et al. 2022).

Poorer mental health (Allen JO et al. 2022).

Accelerated cognitive decline (Hu RX et al. 2021).

Worse quality of life (Hu RX et al. 2021).

A reduction in access to health care (Hu RX et al. 2021).

With regards to cancer care specifically, ageism is associated with numerous detrimental outcomes. These include:

Lower rates of cancer screening (Yoong K et al. 2005).

Lower rates of histological diagnosis of cancer (Peake MD et al. 2003).

Lower rates of surgical management of cancer (Greener M 2020; Neal D et al. 2022) (Peake MD et al. 2003).

Lower rates of systemic therapy for cancer (Hayes L et al. 2019; Logan K et al. 2022).

Decreased access to clinical trials (Sedrak MS et al. 2021; Townsley CA et al. 2005).

This optimal care pathway pays specific attention to ageism given the pervasive effects it can have on the optimal care of older people with cancer, both from the perspective of the patient and the health-care worker. The authors encourage all clinicians to consider their own ageism when making decisions pertaining to older people with cancer.

Additional information and resources about ageism can be found at https://www.everyagecounts.org.au/

Decision-making capacity

Every adult has a right to make their own decisions and have their decisions respected (ALRC 2014a). However, some people have cognitive impairment which affects their ability to make a particular decision, and this right should be balanced with the need to protect them against harm or from exploitation from others.

Decision-making capacity is the ability to understand and weigh up a decision, various options, and the potential outcomes, and then communicate this decision. In cancer care, decision-making capacity may need to be assessed in relation to the ability to provide informed consent to a medical investigation or treatment, but may also need to be considered in relation to decisions about appointing a Power of Attorney, completing Advance Care documents, or accepting social support services (Capacity Australia 2017).

Whether a person has decision-making capacity is determined according to the law, with different legal tests in relation to decision-making in different areas. These tests vary between different States and Territories of Australia. It is important for clinicians who are assessing a person's decision-making capacity to understand the relevant legislation for their State or Territory (O'Neill N et al. 2011).

People are assumed to have the capacity to make a decision until assessed as lacking capacity. People may have a disability or medical condition affecting their cognition but may retain the capacity to make decisions. Decision-making capacity can differ between different decisions, and should be considered in relation to the decision in question. Capacity may change over time or fluctuate depending on the environment, or medical issues. Capacity cannot be extrapolated from a cognitive testing score (Ganzini L et al. 2005; O'Neill N et al. 2011).

Elder Abuse

The World Health Organization defines elder abuse as "*a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. This type of violence constitutes a violation of human rights and includes physical, sexual, psychological and emotional abuse; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect (World Health Organization (WHO) 2024)."*

In Australia there is increasing community awareness of the incidence of domestic and family violence, and older people should not be assumed to be excluded from these forms of abuse. Any older person with cancer may be currently or historically the victim of abuse, or indeed the perpetrator in an abusive relationship. Evidence of elder abuse may first come to light in the context of the cancer diagnosis, but it may have been present throughout the duration of the relationship with the perpetrator. All members of the older person's treatment team have a duty of care to assess the safety of the patient and of their carers, and to report suspected or disclosed evidence of abuse.

Elder abuse may occur as a result of ignorance or negligence, or it may be intentional, deliberate and malevolent. It may be motivated by greed and may or may not involve criminal conduct (ALRC 2016). Abuse may be perpetrated by family members or by formal carers who provide services to older people in their homes or in residential aged care.

An Australian study of the national prevalence of elder abuse in 2021 (Qu L et al. 2021) identified seven signs that an older person may be experiencing elder abuse:

> Physical – unexplained injuries or signs of punishment or restraint such as bruises, scars and burns

Psychological – verbal insults, threats, humiliation, disrespectful or demeaning language, coercive control, social isolation

Emotional – depression, anxiety or behaviour change

Neglect – preventable health problems, pressure injuries, poor personal hygiene, medication misuse, withholding of food and drink

Abandonment – unsafe home environment, missed appointments

Sexual – non-consensual sexual acts

Financial – fraudulent access to funds, withholding of funds to meet basic care needs, including food, medication, home care services.

The prevalence study identified that one in six (16 per cent) older Australians reported experiencing abuse and that incidents of abuse were most often, but not exclusively inflicted by adult children of the older person. This is consistent with global studies of elder abuse (Yon Y et al. 2017). Consistent with trends in domestic and family violence prevalence in the general community, women were disproportionately represented. It is a hidden and under-reported problem with 61 per cent of those surveyed stating that they did not report the abuse or seek help.

In addition to signs of abuse that are readily observable, oncology teams need to be alert to other more subtle forms of elder abuse. Chemical abuse is the inappropriate underuse or overuse of prescribed medications. Financial abuse may involve the fraudulent use of the patient's banking and pension funds or access to superannuation and insurance payments. This form of abuse may not be easily detected, especially if the primary carer has a legally enacted Power of Attorney or Enduring Guardianship.

A primary carer who is receiving a Carer Payment for the person with cancer may urge continuation of cancer treatment to extend the patient's life, even if it is contrary to the patient's wish, as they may fear loss of income, and sometimes loss of stable housing, should the person with cancer not survive. For the same reasons they may resist recommendations for the patient to move to supported accommodation or residential aged care, thus compromising the care of the patient who can no longer manage safely at home.

Direct but sensitive questioning about suspected abuse is required. Particular care should be exercised with people from priority populations where additional layers of shame and guilt may accompany the disclosure of abuse. While most people are reluctant to acknowledge abuse, older people from migrant populations, those identifying as gender diverse, or in same sex relationships, as well as older people with physical or intellectual disability and those living in rural and remote areas may perceive that there are no other care arrangements or supports for them. For all people there is fear around disclosing abuse, but for the most vulnerable people disclosure of abuse may jeopardise relationships with their carer and put them at further risk of abuse.

Accurate assessment of suspected abuse is particularly complex when the older person with cancer has cognitive impairment, dementia or delirium. Their concerns may be dismissed or minimised. Worryingly, where there is a history of elder abuse, incidents can be amplified in the context of behaviour changes and increased dependency in the relationship as the person with cancer experiences functional and/or cognitive decline. As all forms of abuse are matters of power and control, the perpetrator of the abuse may escalate their actions when the person with cancer is more vulnerable and when declining capacity increases social isolation, making these older people less visible to health professionals.

Whilst “elder abuse” is an acceptable global term for the abuse or exploitation of older people, sensitivity should be exercised when discussing this concept with Aboriginal and Torres Strait Islander people for whom the term “Elder” is revered. The Optimal Care Pathway developed for Aboriginal and Torres Strait Islander people with cancer defines Elder as “someone who has gained recognition as a custodian of knowledge and lore, and who has permission to disclose knowledge and beliefs”.

For further information or to report concerns of abuse, neglect or exploitation of older people contact the national elder abuse phone line, 1800ELDERHelp, 1800 353 374. This is an Australian government service that will connect callers with the service in their state or territory.

Models of care

International guidelines (ASCO, NCCN, ESMO, SIOG) offer different recommended approaches for geriatric oncology models of care based on available resources within a given health system. Notably, recent seminal prospective randomized controlled trials of geriatric assessment and management in people with cancer utilised different models of care and yielded similar outcomes, with benefits in quality of life, reduced toxicity, improved treatment completion rates, improved surgical outcomes, reduced unplanned admissions, and reduced functional decline (Li D et al. 2021; Lund CM et al. 2021; Mohile SG et al. 2021; Soo WK et al. 2022).

The recommended “gold standard” model of care involves a comprehensive multidisciplinary specialist clinic where patients undergo a comprehensive geriatric assessment (CGA) and receive oncologic treatment planning ideally at the same time-point with a geriatrician and medical oncologist working together (or a dual trained geriatric oncologist overseeing all components) (Magnuson A et al. 2014). During this visit the patient also has access to all the supportive and holistic care services they need with appropriate referrals and follow-up made in the same instance.

Understandably, this gold standard model is not practical in all health care systems especially in under resourced areas, non-tertiary level centres, and in regional/remote areas.

Other proposed models include (Chapman AE et al. 2021; Loh K et al. 2024):

Screen and refer model

Patient screened with a validated tool (e.g. G8 or VES-13 available at eviq.org.au) and referred for CGA if they screen positive

If a geriatrician is not available for CGA, the primary care physician, allied health/nursing staff, and/or oncologist will have to perform and oversee the relevant geriatric assessments and management

Geriatrics consultative model

Geriatrician or geriatrics-trained nurse specialist contributes to assessment and management, via referral from a cancer clinic

Self-administered geriatric assessments

Patient completed questionnaires with some variables completed by trained staff

Interpretation of results is required by a trained clinician

No matter the model, if the geriatric assessments can be performed before oncological treatment decisions are made, this has the highest yield for better oncological and geriatric specific outcomes in an older people with cancer.

Cancer referral centres should recognise what model of care is possible within their available resources to cater for the needs of the older person with cancer maximally. This should involve a multi-disciplinary team approach with the goal of: preventing the overtreatment of vulnerable people with cancer of any age; preventing the undertreatment of older fit patients; and meeting all the geriatric supportive care needs of patients, their families and their carers.

There is an urgent need for advancement in implementation studies, education, and training for all clinicians working with older people with cancer in Australia (see Principle 7: Research and clinical trials).

Co-design

The involvement of patients and the public in health care design through participatory action research (PAR) has become an expectation across many countries (Kiss N et al. 2024). Co-design is one approach to PAR and refers to a way of working that enables consumers to become equal partners in improvement activities across health services (ACI 2024). Increasingly recognised as the gold standard for feasible, effective and sustainable health service innovation, co-design is underpinned by a series of core principles:

Change or innovation participants have equal voice.

Planning, designing and delivering services occur with people who have diverse perspectives and experiences of a problem means the final solution will more likely address the problem at hand and meet users' needs.

Participation and engagement occur before the agenda has been set ensuring consumer and clinicians have been involved in defining the problem and designing the solution (ACI 2024).

At its core co-design values lived experience which requires attention to **listening to what matters most** to other people (ACI 2024).

Perhaps nowhere is the adoption of co-design more pressing and potentially impactful than in the design and delivery of care for older people. Data from a survey of 5430 older Australians (Orthia L et al. 2021), 4562 of whom answered a question about what "co-design" means to them, overwhelmingly supported involvement of older people in co-designing aged care services, ensuring that any change introduced to the system, meets the needs of older people. Where older people are engaged in service re-design and innovation, evidence indicates that interventions are more impactful, better meet the needs of older people and have greater clinical utility (Glover J et al. 2023). Importantly, engaging older people in co-design has been shown to raise awareness of engrained and implicit ageism in the health system (Comincioli E et al. 2022).

Transition of health care between services

Transition in care refers to transfer of some or all aspects of a person's care between providers within or across health settings, and may be temporary or longer term (ACSQHS 2024). Data from the Royal Commission into Aged Care Quality and Safety Royal (Royal Commission into Aged Care Quality and Safety 2021) found that people are at higher risk of harm during transitions of care. More than 50 per cent of all medication errors occur when people move from one healthcare setting to another (ACSQHC 2024).

As healthcare and healthcare needs become increasingly complex, especially in the context of cancer, attending to and carefully planning and coordinating transitions in care is essential. This is particularly important for the most vulnerable (older people, people with disability and chronic and complex conditions) who are at greater risk of harm (ACSQHC 2024). Safe transitions in care depend on efficient and effective communication of information between all involved – and in particular the older person and their key carers. The Commission has developed a set of principles to guide safe and high-quality transitions of care:

> Person-centred – transitions of care are based on shared decision-making, informed consent and goals of care.
>
> Multidisciplinary collaboration – there are established systems for collaboration and communication amongst the multidisciplinary team, including the person's regular general practitioner.
>
> Documenting and accessing information – there us an enduring, comprehensive and secure record system to document and access information about the person's previous and ongoing care, at transitions.
>
> Ongoing continuity of care – there is coordination of care, that relies on responsibility and accountability between the treating team, the person, their family/carer, and the receiving service.

These principles should apply wherever health care is received including primary, community, acute, subacute, aged care, and disability care. Further information can be found at: <https://www.safetyandquality.gov.au/our-work/transitions-care/principles-safe-and-high-quality-transitions-care>.

Primary Care engagement

Primary care engagement is crucial for older people with cancer as the general practitioner (GP) often serves as the first point of contact for healthcare services.

This relationship is established even before a cancer diagnosis and continues throughout and after treatment.

Coordination between GPs and local and hospital cancer services is crucial for effective survivorship care as the person with cancer will often attend the GP for supportive care and for help to navigate the health system and treatment plans.

During the cancer care continuum, GPs and other community cancer health professionals play a key role in providing education, counselling, coordinating referrals and information for older people with cancer as well as providing preventative health care.

The older person may have multiple co-morbidities and be prescribed multiple medications.

The GP can put the older person’s entire health information together and oversee and update the health team of changes. This is supported by the GP referral, health assessments, GP Management Plans and Team care arrangements and Home or Domiciliary Medication reviews (DHAC 2024b).

Recall and reminder systems in general practice software can help the GP to remind the older person when important surveillance or treatment timelines are due, for example mammograms or injections to manage osteoporosis.

The older person with cancer may need the GP to assist with supportive measures, for example a referral to My Aged Care, or help to access care by arranging disability car parking permit applications and taxi subsidy applications. The GP and GP nurse are well placed to commence and complete advance care planning discussions with the older person.

GPs can play an important role by uploading from the older person’s electronic medical record, a Health Summary information and Advanced Care plan to My Health Record to facilitate health communication between treating team members (Australian Digital Health Agency 2019).

Efforts to promote a shared care model between cancer services and primary care during active treatment and beyond are essential for comprehensive care. This can be facilitated with the use of cancer survivorship care plans (Green C et al. 2024).

GPs are well-positioned to manage pre-existing comorbidities, treatment-related side effects, and provide psychosocial support and local referral options for older people with cancer.

Barriers to engagement with primary care for older people with cancer include:

lack of an established relationship with a GP perceived lack of knowledge by GP in cancer survivorship care (Hayes BD et al. 2024)

communication challenges between cancer services and primary care (Lisy K et al. 2020),

Strategies to enhance primary care engagement include:

proactively encouraging patients to establish a relationship with a GP (if this has not already occurred)

involving GPs in the healthcare team from diagnosis

inviting the GP to the cancer multidisciplinary team meeting or providing a timely summary to the GP

providing educational updates for GPs on the unique needs of older people with cancer

improving communication channels between cancer services and primary care.

Fostering collaboration between cancer services and primary care is essential for optimising care for older people with cancer. Implementing strategies to facilitate primary care engagement can improve outcomes and quality of life for older people with cancer.

Financial toxicity

Financial toxicity describes the impact of changed financial circumstances due to cancer and cancer care. It is attributed to increased expenses paid by individuals and families, ongoing out-of-pocket costs and payment for unsubsidised services or medicines, and reduced income. Financial toxicity impacts physical, psychological, social, and financial health and is increasingly compared to other toxicities of cancer treatment such as fatigue, pain and nausea. It is experienced by people with cancer worldwide (Carrera P et al. 2024).

Clinical Oncology Society of Australia (COSA) endorsed definition:

“The negative patient-level impact of the cost of cancer. It is the combined impact of direct out-of-pocket costs and indirect costs and the changing financial circumstances of an individual and their household due to cancer, its diagnosis, treatment, survivorship and palliation, causing both physical and psychological harms, affecting decisions which can lead to suboptimal cancer outcomes (Clinical Oncology Society of Australia (COSA) 2022).”

A cancer diagnosis changes people’s lives, and the financial effects can be immediate or realised long after treatment has finished, through palliation and beyond. Diminishing an estate by using superannuation or insurance funds, either to fund living expenses when income is reduced, or to access ‘last resort’ treatment options, can leave family members in debt or in poverty.

Financial toxicity includes two inter-related elements: objective financial burden and subjective financial distress (Carrera PM et al. 2018; Gordon LG et al. 2017b; Zafar SY et al.

2013). Objective financial burden is the measurable out-of-pocket costs related to cancer treatment and its effects, and the nonmedical costs associated with seeking treatment or improving wellbeing. Subjective financial distress is the experiences of individuals and their families, including distress due to erosion of household wealth, loss or reductions in essential and dispensable income, and costs of support and resources needed post-cancer treatment.

Financial toxicity is not solely influenced or predicted by the total out-of-pocket costs paid. Rather it is a function of expenditure and pre-cancer wealth. For some patients, $20 for parking per treatment visit can be the reason they avoid care; while for others, thousands of dollars from their savings or superannuation may be used to go overseas for treatment. The fear of financial implications of cancer care can influence healthcare decisions. Non-adherence to recommended treatment, and trade-offs between essential living expenses, such as food, and treatment costs may lead to poorer health outcomes. Alternatively, the desire to be well or survive can result in significant financial decisions such as the early withdrawal of superannuation or selling a house to pay for care. While changed financial circumstances increases financial toxicity within the first six months of diagnosis, cancer treatment and care can continue for many months or years (Chan R et al. 2022). The impact of financial toxicity is therefore not always immediate, and decisions made at diagnosis can have ongoing implications for physical, psychosocial and financial health and impact the wider family (Chan R et al. 2022; Gordon LG et al. 2017a).

Each component of the health system has a responsibility to address financial toxicity. It is important to prevent, minimise, and manage financial concerns, from diagnosis to survivorship or bereavement, as we do other toxicities (McLoone J et al. 2023). Financial toxicity should not be an acceptable consequence of cancer care in Australia, where healthcare is expected to be effective, accessible, and equitable.

Optimal care pathway

The aim of this optimal care pathway is to help guide system safety and responsiveness to the unique needs of older people diagnosed with cancer. Patient care does not always occur in a linear process but depends on the particular situation (e.g. the type of cancer, when and how the cancer is diagnosed, prognosis, management, patient decisions and the patient's physiological response to the treatment).

This optimal care pathway is intended to complement the cancer-specific optimal care pathways, acting as a tool to identify areas for health services and health professionals to improve the quality and safety of care provided to older people. The information presented at each step is also complemented by the preceding sections in this document regarding principles of care and further considerations.

Visit the Cancer Council website www.cancer.org.au/OCP to view the optimal care pathways for each cancer type (where published).

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Seven steps of the optimal care pathway

Step 1: Prevention and early detection

Step 2: Presentation, initial investigations and referral

Step 3: Diagnosis, staging and treatment planning

Step 4: Treatment

Step 5: Care after initial treatment and recovery

Step 6: Managing recurrent, residual or metastatic disease

Step 7: End-of-life care

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Step 1: Prevention and early detection

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This step outlines recommendations for the prevention and early detection of cancer in older people.

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Evidence shows that not smoking, avoiding or limiting alcohol intake, eating a healthy diet, maintaining a healthy body weight, being physically active, being sun smart and avoiding exposure to oncoviruses or carcinogens may help reduce cancer risk (Cancer Council Australia n.d.).

1.1 Prevention

The prevention of cancer amongst older people requires multifaceted personal and population level interventions throughout life. Decisions about interventions should be guided by discussion regarding opportunities for prevention, alongside assessment of a person’s health status, intrinsic capacities and their values, preferences and goals. Even amongst older people with complex comorbidities, frailty or other life-limiting syndromes, the pursuit of cancer prevention may remain important.

Furthermore, early detection of malignancy in older people can improve care. Cancer screening should be proactively discussed with the older person.

For more information see Further considerations – Age-friendly cancer care, Further considerations – Advance care planning, Further considerations – Ageism, Further considerations – Decision-making capacity, and Further considerations – Primary care engagement.

1.2 Risk factors

Risk factors for malignancy amongst older people

Advancing age is a central risk factor for multiple cancers due to the accumulation of genetic, immune, lifestyle and environmental risks over time. Numerous risk factors for cancer are relevant to people of all ages, including:

- Previous or current smoking
- Previous or current alcohol misuse
- Overweight, obesity and excess body fat
- Physical inactivity
- Poor diet
- Specific infections, including hepatitis B, hepatitis C, human papillomavirus
- Genetic predisposition syndromes
- Certain medications, such as hormonal-replacement therapy (HRT) where there is evidence in some cancers
- Excessive sun exposure

Amongst older people, however, a number of other, less well recognised cancer risk factors have been identified. These should be considered when discussing cancer prevention and screening with older people. These include:

- Frailty (Mak JK et al. 2023)
- A high comorbidity burden (Renzi C et al. 2019)
- Long term use of cancer-predisposing medications (including HRT and proton pump inhibitors)
- Social isolation and loneliness (Kraav S-L et al. 2021)
- Malnutrition (Patini R et al. 2024)

In addition to these risk factors, certain conditions associated with ageing may increase the incidence of cancer through non-biologic pathways. Such conditions include:

- Cognitive decline: this is often due to changes in health seeking behaviour, increasing physical and psychological vulnerability, social isolation, and comorbidity burden
- Frailty: in addition to being a biological risk factor, individuals with frailty are less likely to attend to routine cancer surveillance or health assessment
- Loneliness: older people are at higher risk of loneliness than younger individuals, and this alters health-seeking behaviour.

1.3 Risk reduction

Prevention of malignancy amongst older people

Numerous strategies for cancer prevention across the life span exist within the Australian context. For older people, participation in these interventions remains of importance. Screening interventions, in particular, may remain appropriate for individuals beyond the age cut-offs set by government funded screening programs. Furthermore, individuals within the age limits of screening programs may not be suitable for routine screening if this is in accordance with their wishes and general health. Recognising the impact that ageism has on individuals, healthcare professionals and healthcare systems should be considered when discussing prevention of malignancy.

1.3.1 Risk reduction

Increasing age is associated with a prolonged time from symptomatic presentation to cancer diagnosis (Din NU et al. 2015; Mills S et al. 2023). Critical interventions to address this include:

- Educating older people on the incidence and prevalence of cancer with advancing age
- Educating older people on specific- and generalised- cancer presentation syndromes
- Respecting and valuing symptomatic concerns expressed by older people
- Recognising ageism in health care, and understanding how this can affect patients, carers and health care workers
- Investigating symptomatic concerns through an age-informed lens, but not withholding investigations based purely on biologic age.

This step has highlighted the principles of cancer prevention and early detection for older people with cancer. While many of these themes can be applied to younger individuals, respecting the biological, psychological and sociocultural differences between these groups is critical to address the disproportionate impact that cancer has on older people.

1.3.2 Cancer risk reduction

Everyone should be encouraged to reduce their modifiable risk factors, including taking the following steps.

- Encouraging and managing smoking cessation
- Achieving and maintaining a healthy body weight
- Encouraging and facilitating physical activity
- Limiting alcohol use
- Encouraging healthy eating habits, including intake of wide variety of nutritious foods from the five core food groups
- Reducing ultraviolet exposure
- Completing immunisations
- Pursuing interventions for inherited cancer-predisposition syndromes
- Completing routine cancer screening, including BreastScreen Australia, and National Bowel Cancer Screening Program, the National Cervical Screening Program, and National Lung Cancer Screening Program
- Completing non-routine cancer screening, including skin checks and testing for the early detection of prostate and lung cancer.

Prognostic calculators are available which can be used to estimate a person’s remaining life expectancy. These may be useful in weighing up decisions about extending cancer screening beyond routinely recommended ages.

1.3.3 Smoking

All current smokers should be offered smoking cessation advice and support to quit. Effective strategies to help people quit smoking include:

structured interventions from health professionals

referral to QUITLINE (13 78 48)

individual or group counselling programs, such as those offered by Quit <www.quit.org.au>

nicotine replacement therapy, and other pharmacological agents.

Further information: National Tobacco Strategy 2023-2030 <www.health.gov.au/resources/publications/national-tobacco-strategy-2023-2030>

1.3.4 Immunisation

Health professionals should check the immunisation schedule and advice for the older person and opportunistically encourage uptake by the older person.

1.3.5 Individual assessment

Health professionals are in an ideal position to opportunistically promote and advise on cancer risk-reduction strategies relevant to the individual. Such an assessment should take into account relevant social and cultural factors.

In Australia, opportunities for extended prevention in primary care may be facilitated through General Practitioner Management Plans and Team Care Arrangements and Annual Health Assessments for the older person (DHAC 2024b).

In addition to these interventions, a number of age-informed prevention strategies exist. These include

Extended screening for breast, colorectal and cervical cancer (beyond the age limits of the national screening programs) and other cancers e.g. skin, prostate and lung.

Enrolling older people with impaired mobility into specific strengthening and rehabilitative programs under the guidance of physiotherapy and exercise professionals.

Incorporating nutrition assessment and management of older people.

Implementing regular geriatric assessments and medication reviews.

Identifying and addressing loneliness and social isolation through community engagement.

Regular dental assessment and management.

Such strategies require collaborative decision-making between the person with cancer and healthcare professionals, and must consider the patient's overall health status, preferences and life expectancy. Providers of these interventions should recognise that older patients may de-value their health and experience internalised ageism, both of which can impact on preventative behaviours.

These strategies may additionally prevent or reduce frailty and increase the ability of people to cope with cancer investigations and treatment if they are required.

1.4 Early detection

The timely diagnosis of cancer can reduce both morbidity and mortality, regardless of age. Older people with cancer may present with more advanced disease than younger individuals (Mills S et al. 2023). In addition, the presentation of cancer in older people may be different to that in younger individuals.

Ageing-related physical, psychological and cognitive vulnerabilities may lead to generalised presentation syndromes; such syndromes should raise suspicion for an underlying malignancy.

Age-agnostic presentations of cancer are broad, and may include a palpable lesion, new bleeding, new pain, weight loss, or other local, regional or systemic symptoms.

For older people, additional presentations should be considered; these include:

New or progressive frailty

New or progressive malnutrition

New or progressive cognitive impairment

New or progressive functional decline.

Step 2: Presentation, initial investigations and referral

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This step outlines the process for the general practitioner to initiate the right investigations and refer to the appropriate specialist in a timely manner. The types of investigations the general practitioner undertakes will depend on many factors, including access to diagnostic tests, the availability of medical specialists and patient preferences.

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2.1 Signs and symptoms

Cancers in older individuals may present with a broad array of symptoms and signs. Clinicians should have a low threshold to investigate new symptoms amongst older individuals given the epidemiological correlation between increasing age and malignancy. Furthermore, clinicians should be aware that patients may down-play or under-report symptoms of concern due to internalised ageism, including the assumption that being unwell is a “normal” part of ageing (Allen JO et al. 2022). It is incumbent on all healthcare professionals to dismantle this belief, and to be mindful of how biases may impact on decision-making with regards to symptom evaluation amongst clinicians.

While many signs and symptoms of cancer are shared between younger and older individuals, a more contextual assessment of patient symptomatology is required for older individuals who may be presenting with cancer. This contextual assessment should include:

> Cumulative lifestyle exposures e.g. Smoking pack-year history in an individual presenting with haemoptysis; lifetime alcohol exposure in an individual presenting with an abdominal mass; nutritional history in an individual presenting with fatigue.
>
> Cumulative comorbidity exposures e.g. An individual with advanced diabetes presenting with a non-healing, enlarging lower limb lesion.
>
> Cumulative pharmacological exposures e.g. Length of time on hormone replacement therapy in a person presenting with a breast lesion.
>
> Functional assessment and interpretation e.g. new impairments in mobility in an individual presenting with back pain.

Furthermore, cancer in older individuals may present as a syndrome, often with functional, cognitive, physical or social components (Magnuson A et al. 2019). Critically examining new changes in these domains may reveal clues to an underlying cancer diagnosis. Such syndromes include:

> New or progressive frailty. Frailty represents a multi-faceted syndrome of decreased resilience to stressor events. Cancer may lead to incident frailty, or to progressive frailty. New or worsening frailty may prompt an assessment of an underlying malignancy.
>
> New or progressive cognitive decline. Permutations in cognitive function increase in frequency and severity with increasing age. Cognitive decline may present as an acute confusional state, or as a chronic, typically progressive, state of impaired thought. Both new delirium and new cognitive impairment may be presentations of an underlying malignancy.
>
> New or progressive functional impairment. Individuals with new impairments in basic and instrumental activities of daily living may have an underlying biological precipitant. The metabolic load associated with malignancy may lead to new vulnerabilities in both simple and complex activities, and should prompt clinicians to consider underlying biological processes.
>
> New or progressive social isolation. Older individuals may experience stigma associated with certain medical conditions. Furthermore, older individuals may feel a desire not to ‘burden’ other people with medical issues. These factors, combined with

numerous other social and cultural determinants, may lead to new social withdrawal. In individuals withdrawing from their supports, psychological and physical assessments should be undertaken.

2.1.1 Timeframe for general practitioner consultation

Presenting symptoms should be promptly and clinically triaged by a general practitioner.

2.2 Assessments by the general practitioner

When presented with an older person with new signs or symptoms of concern, general practitioners are recommended to undertake a comprehensive assessment, including:

A thorough medical history. This should ascertain the lifetime exposure to carcinogens (including physical inactivity and overweight / obesity), new or progressive geriatric syndromes (including frailty, social isolation, cognitive impairment and functional deterioration), and physical symptoms. In addition, an assessment of cancer mitigating interventions (including screening and vaccinations) should be undertaken.

A comprehensive physical examination. In addition to a standard examination, practitioners should examine for new or progressive signs of malnutrition or cachexia (including interosseous muscle wasting), new or progressive mobility impairment, and new or progressive cognitive impairment.

A targeted geriatric assessment. This should include an assessment of cognition, mobility, function, nutrition, sensory deficits, and social support.

Malignancy-directed investigations, including:

- Blood tests (with consideration of extended testing to include thyroid function, inflammatory markers, haematinics, and nutritional markers).
- Imaging tests (e.g. ultrasound, chest x-ray, computed tomography (CT) scans).
- Histopathological assessment (e.g. Biopsy). Careful consideration should be taken when the decision is made *not* to pursue a biopsy for older individuals with suspected cancer given the prognostic information provided from a tissue-based diagnosis of cancer.

Clarification of any existing advance care plans and a discussion of the person’s values, preferences and goals.

Older people may wish to have a family member or carer involved in their assessment. If sensory or cognitive deficits are present, communication should be tailored accordingly with consideration of capacity to consent for procedures/tests. Enquiry about social supports and functioning, may reveal practical issues such as transport barriers and carer needs. Older people with limited supports may benefit from early referral for community aged care services.

For more information see Further considerations – Carers, Further considerations – Primary care engagement, and Further considerations – Decision-making capacity.

2.2.1 Timeframe for completing investigations

Older people experience a longer delay in the diagnosis of cancer compared to younger individuals (Din NU et al. 2015). In addition, older people with cancer are more likely to be diagnosed at a later stage (Mills S et al. 2023). As such, a prompt initial assessment is important, with recognition that multiple consultations may be needed in the initial period to capture the aforementioned recommendations.

2.3 Initial referral

Once a cancer diagnosis is confirmed or the results are inconsistent or indeterminate, the general practitioner should refer the patient to an appropriate specialist. Even amongst individuals who may choose not to have interventions for cancer, specialist review is recommended.

Patients should be enabled to make informed decisions about their choice of specialist and health service. General practitioners should make referrals in consultation with the patient after considering the clinical care needed, cost implication (see referral choices and informed financial consent in Principle 1: Patient-centred care), waiting periods, location and facilities, including discussing the patient's preference for health care through the public or the private system.

Referral for suspected or diagnosed cancer should include the following essential information to accurately triage and categorise the level of clinical urgency:
important psychosocial history and relevant medical history
family history, current symptoms, medications and allergies
an assessment of older-age vulnerabilities and strengths
results of current clinical investigations (imaging and pathology reports)
results of all prior relevant investigations
notification if an interpreter service is required.

Many services will reject incomplete referrals, so it is important that referrals comply with all relevant health service criteria.

If access is via online referral, a lack of a hard copy should not delay referral.

The specialist should provide timely communication to the general practitioner about the consultation and should notify the general practitioner if the patient does not attend appointments.

Aboriginal and Torres Strait Islander patients will need a culturally appropriate referral. To view the optimal care pathway for Aboriginal and Torres Strait Islander people with cancer and the corresponding quick reference guide, visit the Cancer Australia website <https://www.canceraustralia.gov.au/affected-cancer/atsi/resources-health>. Download the consumer resources – *Checking for cancer* and *Cancer* from the Cancer Australia website <https://www.canceraustralia.gov.au/affected-cancer/atsi/resources-people>.

2.3.1 Timeframe for referring to a specialist

It is recommended that older individuals with proven or suspected cancer be referred to a cancer clinician within two weeks. Optimal timeframes are provided in cancer specific optimal care pathways, to be used in conjunction with this pathway.

2.3.2 Consider referral to a geriatrician

General practitioners should consider the potential need for a comprehensive geriatric assessment performed by a geriatrician, considering referral to an oncologist and a geriatrician if it is anticipated there is need for geriatric medicine involvement.

Note: if a cancer centre does not have adequate geriatric medicine support, a private or local geriatrician clinic may need to be found. If there are no geriatricians within a health care service, primary care, medical oncology, allied health and nursing clinicians will need to work together to help provide ongoing support for a given patient’s geriatric care needs.

2.4 Support and communication

2.4.1 Supportive care

The patient’s general practitioner should consider an individualised supportive care assessment where appropriate to identify the needs of an individual, their carer and family. Refer to appropriate support services as required. See validated screening tools mentioned in Appendix F.

It is important to note that supportive care needs should be assessed and addressed throughout the entire continuum of care for a cancer diagnosis (Fitch M 2008; Krishnasamy M et al. 2023).

A number of specific needs may arise for older patients at the point of diagnosis. These may include:

- emotional distress and/or anger, anxiety/depression, interpersonal problems and adjustment difficulties
- active physical symptoms (e.g. pain)
- encouragement and support to increase levels of exercise and prevent further functional decline (Cormie P et al. 2018; Hayes SC et al. 2019).
    - clarification of existing services, equipment, and support for the individual and what can be instituted now
    - assistance for carers and support people

For more information refer to the National Institute for Health and Care Excellence 2015 guidelines, *Suspected cancer: recognition and referral*

<www.nice.org.uk/guidance/ng12/chapter/Recommendations-on-patient-support-safety-netting-and-the-diagnostic-process>.

For additional information on supportive care and needs that may arise for different population groups, see Appendices A, B, C and F and Principle 4: Supportive Care.

2.4.2 Communication with patients, carers and families

Communicating with patients, carers and families at the point of cancer diagnosis should be undertaken within the framework of collaborative, patient-directed decision-making. For older people, including and empowering carers throughout the diagnostic process is critical.

The diagnostic clinician should recognise that a cancer diagnosis can have significant psychosocial implications for older people and their support networks. For older people with cognitive vulnerabilities, the explanation of a cancer diagnosis may require numerous visits.

At the point of diagnosis, the primary clinician is responsible for providing clear information to the person and carer regarding the referral process and the expected timeframes for appointments. Special care should be delivered to vulnerable older people, including those from rural / remote areas, those from culturally and linguistically diverse backgrounds, and people from other minority populations. Older, First Nations individuals may require specific input from Aboriginal and Torres Strait Islander health workers. Individuals with cognitive or functional impairment may require formal plans regarding appointment attendance.

Clinicians should consider providing patients with the Cancer Council phone number. Cancer Council nurses are available to act as a point of information and reassurance during the anxious period of awaiting further diagnostic information and specialist consultation. Patients can contact 13 11 20 nationally to speak to a cancer nurse.

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Refer to Principle 6: Communication for more information including communication skills training programs and resources.

Step 3: Diagnosis, staging and treatment planning

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Step 3 outlines the process for confirming the diagnosis and stage of cancer and for planning subsequent treatment. The guiding principle is that interaction between appropriate multidisciplinary team members should determine the treatment plan. The multidisciplinary care of older people with cancer should be guided by an adequate geriatric assessment of the patient in addition to an assessment of the cancer.

A geriatric assessment at the time of care planning is central to the appropriate care of older people with cancer.

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3.1 Specialist diagnostic work-up

The treatment team, after taking a thorough medical history and making a thorough medical examination of the patient, should undertake the following investigations under the guidance of a specialist.

A range of diagnostic tests, assessments and investigations should be completed at this stage of the pathway. The exact recommended diagnostic work-up depends on the type of cancer involved but may include physical examination, blood and imaging tests, and biopsies.

Careful consideration should be made, prior to embarking on potentially invasive tests, of the patients' goals and priorities of care and their likelihood of embarking upon active anticancer treatment.

All patients should be assessed for medical comorbidities, performance status and frailty during the diagnostic work-up.

For more information relevant to cancer specific work-up, refer to the Cancer Council's Clinical Practice Guidelines (Cancer Council 2024a) <https://www.cancer.org.au/health-professionals/clinical-practice-guidelines>

Visit the Cancer Council website (Cancer Council 2024b) < https://www.cancer.org.au/health-professionals/optimal-cancer-care-pathways > to view the optimal care pathways for each cancer type

3.1.1 Timeframe for completing investigations

Timeframes should be informed by evidence-based guidelines and cancer specific optimal care pathways (where available) whilst recognising that shorter timelines for appropriate consultations and treatment can reduce a patient's distress.

Whilst recognising that prompt and efficient diagnosis and staging is preferable in general, in older patients extra time may be required for geriatric screening and/or geriatric assessment and/or obtaining specialist opinions regarding management of comorbidities.

Making the time to facilitate access to a diagnostic work-up and geriatric assessment with patients and family members/carers could optimise this pathway. Telehealth consultations can be considered for patients living remotely, particularly those who may be too frail to travel but are thought likely to benefit from a specialist consultation.

3.1.2 Genetic testing (family risk)

In some cases certain pathological subtypes of cancer or tumour tests (immunohistochemistry or tumour genetic tests) may suggest an underlying inherited cancer predisposition.

Anyone diagnosed with cancer should have a detailed personal and family cancer history taken. Consult relevant guidelines (eviQ Cancer Institute NSW 2024) <https://www.eviq.org.au/cancer-genetics/referral-guidelines> to determine if referral to a familial cancer service is appropriate.

A familial cancer service assessment can determine if genetic testing is appropriate. Genetic testing is likely to be offered when there is at least a 10 per cent chance of finding a causative ‘gene error’ (pathogenic gene variant; previously called a mutation). Usually testing begins with a variant search in a person who has had cancer (a diagnostic genetic test). If a pathogenic gene variant is identified, variant-specific testing is available to relatives to see if they have or have not inherited the familial gene variant (predictive genetic testing).

Medicare funds some genetic tests via a Medicare Benefits Schedule (MBS) item number but most are not. Depending on the personal and family history, the relevant state health system may fund public sector genetic testing.

Pre-test counselling and informed consent is required before any genetic testing. In some states the treating team can offer ‘mainstream’ diagnostic genetic testing, after which referral is made to a familial cancer service if a pathogenic gene variant is identified. The familial cancer service can provide risk management advice, facilitate family risk notification and arrange predictive genetic testing for the family.

Visit the Centre for Genetics Education website (Centre for Genetics Education - NSW Health 2021) <www.genetics.edu.au/individuals-and-families/cancer-in-the-family> for basic information about cancer in a family.

3.1.3 Pharmacogenetics

Pharmacogenetics describes how individual genetic differences can lead to differences in the way certain medicines interact with the body. These interactions can affect the effectiveness of medications and any side effects. Applying pharmacogenetics to treatment planning may help patients to be prescribed the most appropriate treatment at the optimal dose from the beginning of treatment (White C et al. 2022).

For example, routine testing for Dihydropyrimidine dehydrogenase (DPD) mutations is an option for patients commencing chemotherapy with 5-fluorouracil. The Advisory Committee on Medicines (ACM) of the Therapeutic Goods Administration (TGA) advises that DPD testing can be a reasonable clinical choice but need not be mandated. The treating team would consider the value of testing for the individual patient, taking into account test availability and cost and the potential for testing to delay treatment (DHAC and TGA 2022).

3.2 Staging, grading and risk stratification

Staging is the cornerstone of treatment planning and should be clearly documented in the patient's medical record. Staging for many cancers is pathological following surgery because this provides the most accurate information; however, preliminary clinical staging may also be performed using laboratory and imaging tests undertaken during the diagnostic and treatment planning phase.

Details of cancer staging are outlined in each cancer specific optimal care pathway (Cancer Council 2024b).

<insert icon> More information

Visit the Cancer Institute New South Wales website for information about understanding the stages of cancer (Cancer Institute NSW 2024) <www.cancer.nsw.gov.au/understanding-cancer/stages-of-cancer>.

3.3 Performance status

Patient performance status is a central factor in cancer care and should be clearly documented in the patient's medical record.

Performance status should be measured and recorded using an established scale such as the Karnofsky scale or the Eastern Cooperative Oncology Group (ECOG) scale.

Whilst performance status is an important factor in treatment decision-making, it should not be used in isolation. Geriatric assessment improves treatment decision-making and is a better predictor of chemotherapy toxicity than performance status alone (Hurria A et al. 2011)

3.4 Treatment planning

3.4.1 Key considerations beyond treatment recommendations

The delivery of patient-centred care for older people involves the consideration of multiple patient factors that aid treatment decision-making. Many of these factors can be determined as part of an adequate geriatric assessment (Loh K et al. 2024). Important considerations include:

- the patient's overall condition including an assessment of frailty and life expectancy (see Appendix F). Frailty assessment should be used not as a convenient way to withhold potentially effective treatments but rather as a tool to facilitate patient-centred care (Kim DH et al. 2024)

decision-making capacity including a cognitive assessment as appropriate

whether the patient has hearing or vision impairments

determination of patient preferences (e.g. increased survival vs preservation of independence), goals of care and what matters most

an assessment of social supports which may also include the patient’s preferences for family members or carers to be involved in decision-making.

Other factors that are part of optimal care delivery prior to treatment planning include:
discussing the multidisciplinary team approach to care with the patient
appropriate and timely referral to an MDM
consideration of the need to provide care as close to the patient’s home as possible and where necessary a discussion about support with travel and accommodation
use of teleconferencing or videoconferencing as required.

3.4.2 The optimal timing for multidisciplinary team planning

The multidisciplinary team should meet to discuss newly diagnosed patients before definitive treatment so that a treatment plan can be recommended and there can be early preparation for the post-treatment phase. The level of discussion may vary, depending on the patient’s clinical and supportive care factors. Some patients with non-complex cancers may not be discussed by a multidisciplinary team; instead the team may have treatment plan protocols that will be applied if the patient’s case (cancer) meets the criteria. If patients are not discussed at an MDM, they should at least be named on the agenda for noting. The proposed treatment must be recorded in the patient’s medical record and should be recorded in an MDM database where one exists.

Teams may agree on standard treatment protocols for non-complex care, facilitating patient review (by exception) and associated data capture.

Results of all relevant tests and access to images should be available for the MDM. Information about the patient’s concerns, preferences and social and cultural circumstances should also be available.

Multidisciplinary discussion may be facilitated with telehealth technology.

Ideally the results of an older person’s holistic geriatric assessment should be available for consideration during the MDM. If this does not occur, the MDM recommendation should be taken in context of the geriatric assessment and determination of patient priorities, preferences and what matters most.

3.4.3 Responsibilities of the multidisciplinary team

The multidisciplinary team requires administrative support in developing the agenda for the meeting, for collating patient information and to ensure appropriate expertise around the table to create an effective treatment plan for the patient. The MDM has a chair and multiple lead clinicians. Each patient case will be presented by a lead clinician (usually someone who has seen the patient before the MDM). In public hospital settings, the registrar or clinical fellow may take this role. A member of the team records the outcomes of the discussion and treatment plan in the patient history and ensures these details are communicated to the patient's general practitioner. The team should consider the patient's values, beliefs and cultural needs as appropriate to ensure the treatment plan is in line with these.

The responsibilities of the multidisciplinary team are to:

> nominate a team member to be the lead clinician (the lead clinician may change over time depending on the stage of the care pathway and where care is being provided) and identify this person to the patient
>
> nominate a team member to coordinate patient care and identify this person to the patient
>
> develop and document an agreed recommended treatment plan at the multidisciplinary team meeting
>
> circulate the agreed multidisciplinary team treatment plan to relevant team members, including the patient's general practitioner or other primary care provider.

3.4.4 Members of the multidisciplinary team for older people with cancer

The multidisciplinary team should comprise the core disciplines that are integral to providing best practice and relevant expertise for the specific cancer type. Team membership may also vary according to the stage of disease being treated and the individual needs of the patient but should reflect both clinical and psychosocial aspects of care (Victorian Government Department of Human Services 2007). Members with a familiarity with the needs of older people and the ability to respond to the findings of a geriatric assessment will enhance the decision-making process.

Access to multidisciplinary team members with the required expertise may require coordination with specialty centres.

For Aboriginal and Torres Strait Islander patients, it is crucial that the team includes an expert in providing culturally appropriate care to this population. This may be an Aboriginal and/or Torres Strait Islander Health Worker, Health Practitioner or Hospital Liaison Officer.

See Appendix E for a list of team members who may be included in the multidisciplinary team be required for some patients. An Aboriginal and Torres Strait Islander cultural expert should be considered for all patients who identify as Aboriginal or Torres Strait Islander.

3.4.5 Responsibilities of individual team members

The general practitioner who made the referral is responsible for the patient until care is passed to another practitioner who is directly involved in planning the patient's care.

The general practitioner may play a number of roles in all stages of the cancer pathway including diagnosis, referral, treatment, shared follow-up care, post-treatment surveillance, coordination and continuity of care, as well as managing existing health issues and providing information and support to the patient, their family and carer.

A nominated contact person from the multidisciplinary team may be assigned responsibility for coordinating care in this phase. Care coordinators are responsible for ensuring there is continuity throughout the care process and coordination of all necessary care for a particular phase (COSA 2015). The care coordinator may change over the course of the pathway. Effective care coordination is often required to enable older people to negotiate the cancer care ecosystem effectively and should be guided by aspects of the patient's geriatric assessment and individual priorities.

The lead clinician is responsible for overseeing the activity of the team and for implementing treatment within the multidisciplinary setting.

3.4.6 Role of a multidisciplinary team meeting specific for older people with cancer

The optimal management of older people with cancer also involves multidisciplinary supportive care interventions guided by a geriatric assessment. Multidisciplinary teams specific to the needs of older people with cancer may not be cancer specific and could include members with geriatrics expertise in addition to allied health, physiotherapy, exercise physiology, occupational therapy, dietetics, social work, psychology and pharmacy (Dale W et al. 2023).

3.5 Research and clinical trials

Patients should be encouraged to participate in research or clinical trials where available and appropriate. Clinical trials accelerate knowledge gathering and can provide options for cancer patients when other therapies have failed or are yet to be approved. and genomics clinical trials may offer matched therapies not yet available as part of routine care. Clinical trial discussions should be part of the MDM agenda and be documented. Patient age alone should not be used as an exclusion criteria for enrolment on clinical trials. For those who do not meet eligibility criteria, or where a clinical trial is not open, the patient should follow the most recently completed and published 'standard of care' treatment protocol offering the best possible outcome. Enrolment in a clinical trial may involve referral to an external clinical trial centre. Use of telehealth technology may facilitate access to clinical trials.

See Principle 7: Research and clinical trials for more information.

For more information visit <www.australiancancertrials.gov.au>.

3. 6 Support and communication

3.6.1 Supportive care

An individualised clinical assessment is required to assess and meet the needs of people with cancer, their families and carers; referral should be as required. Refer to Step 6.5.1

Supportive care for detailed information about providing supportive care to older people with cancer.

The provision of supportive care specific for older people is important at all parts of the cancer care continuum. The results of a geriatric assessment can be used to effectively guide supportive care interventions according to patient needs and priorities. Appropriate supportive care will vary according to the treatment stage and may include:

- prehabilitation prior to surgery or major procedures
- multidisciplinary interventions during treatment e.g. pharmacological, psychological, physical therapy, aged-care support
- carer support
- rehabilitation
- counselling to support people to understand and adapt to the medical, psychological, familial and reproductive implications of their diagnosis especially if there is a genetic component.

A number of specific challenges and needs may arise for patients at this time:

- assistance for dealing with psychological and emotional distress while adjusting to the diagnosis; treatment phobias; existential concerns; stress; difficulties making treatment decisions; anxiety or depression or both; psychosexual issues; history of sexual abuse; and interpersonal problems
- management of physical symptoms such as pain and fatigue (Australian Adult Cancer Pain Management Guideline Working Party 2019)
- malnutrition or undernutrition, identified using a validated nutrition screening tool such as the MST (note that many patients with a high BMI [obese patients] may also be malnourished (WHO 2018)
- support for families or carers who are distressed with the patient's cancer diagnosis
- support for families/relatives who may be distressed after learning of a genetically linked cancer diagnosis
- specific spiritual needs that may benefit from the involvement of pastoral/spiritual care.

Additionally, palliative care may be required at this stage.

For more information on supportive care and needs that may arise for different population groups, see Appendices A, B and C.

~~3.6.1~~ 3.6.2 Prehabilitation

Cancer prehabilitation uses a multidisciplinary approach combining exercise, nutrition and psychological strategies to prepare patients for the challenges of cancer treatment such as surgery, systemic therapy and radiation therapy. Team members may include anaesthetists, oncologists, surgeons, haematologists, geriatricians, clinical psychologists, exercise physiologists, physiotherapists and dietitians, among others.

Evidence indicates that patients who respond well to prehabilitation may have fewer complications after treatment. For example, those who were exercising before diagnosis and patients who use prehabilitation before starting treatment may improve their physical or psychological outcomes, or both, and this helps patients to function at a higher level throughout their cancer treatment (Cormie P et al. 2017; Silver JK 2015).

For older people with cancer, the multidisciplinary team should consider these specific prehabilitation assessments and interventions for treatment-related complications or major side effects potentially as part of a multidimensional geriatric assessment:

- conducting a physical and psychological assessment to establish a baseline function level
- identifying impairments and providing targeted interventions to improve the patient's function level (Silver JK et al. 2013)
- reviewing the patient's medication to ensure optimisation and to improve adherence to medicine used for comorbid conditions.

Following completion of primary cancer treatment, rehabilitation programs have considerable potential to enhance physical function.

3.6.3 Communication with the patient, family and carers

In discussion with the patient, the lead clinician should undertake the following:

- establish if the patient has a regular or preferred general practitioner and if the patient does not have one, then encourage them to find one

    - provide written information appropriate to the health literacy of the patient about the diagnosis and treatment to the patient and carer and refer the patient to the 'Guide to best cancer care' (consumer optimal care pathway) for their diagnosis as well as to relevant websites and support groups as appropriate

    - provide a treatment care plan including contact details for the treating team and information on when to seek help
- discuss a timeframe for diagnosis and treatment with the patient and carer
- discuss the benefits of multidisciplinary care and gain the patient's consent before presenting their case at an MDM
- provide brief advice and refer to Quitline (13 78 48) for behavioural intervention if the patient currently smokes (or has recently quit), and prescribe smoking cessation pharmacotherapy, if clinically appropriate
- recommend an 'integrated approach' throughout treatment regarding nutrition, exercise and minimal or no alcohol consumption among other considerations
- communicate the benefits of continued engagement with primary care during treatment for managing comorbid disease, health promotion, care coordination and holistic care
- be open to and encourage discussion about the diagnosis, prognosis (if the patient wishes to know) and survivorship and palliative care while clarifying the patient's preferences and needs, personal and cultural beliefs and expectations, and their ability to comprehend the communication

- encourage the patient to participate in advance care planning including considering appointing one or more substitute decision-makers and completing an advance care directive to clearly document their treatment preferences. Each state and territory has different terminology and legislation surrounding advance care directives and substitute decision-makers.

  Communication about options for care may include the topic of voluntary assisted dying (VAD). The details of this will differ depending upon the State or Territory the patient resides in. For more information on VAD see Section 7.4: Voluntary Assisted Dying

3.6.4 Communication with the general practitioner

The lead clinician has these communication responsibilities:

- involving the general practitioner from the point of diagnosis
- ensuring regular and timely communication with the general practitioner about the diagnosis, treatment plan and recommendations from MDMs and inviting them to participate in MDMs (consider using virtual mechanisms)
- supporting the role of general practice both during and after treatment
- discussing shared or team care arrangements with general practitioners or regional cancer specialists, or both, together with the patient.

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Refer to Principle 6: Communication for communication skills training programs and resources.

See Further considerations – Primary care engagement

Step 4: Treatment

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Step 4 addresses the key aspects of care when treating older people with cancer. Visit the Cancer Council website <www.cancer.org/OCP> to view the optimal care pathways for each cancer type.

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Personalised treatment plans

The spectrum of health status for older people with cancer is wide, ranging from those who are fit (median 32 per cent) to those who are pre-frail (median 42 per cent) and frail (median 43 per cent) (Handforth C et al. 2015), depending on the healthcare context. Frailty is associated with increased mortality, post-operative complications and reduced tolerance of chemotherapy (Handforth C et al. 2015). Given the under-representation of older people in clinical trials (Dunn C et al. 2017) the outcomes and toxicities of treatment are less certain, requiring a comprehensive assessment of the person when developing a treatment plan.

Effective treatment planning requires consideration of both cancer and treatment-specific factors (refer to cancer specific optimal care pathway) and person-related factors. Specific considerations for older people include comorbidities, physiological/organ function (e.g., renal, hepatic, and cardiorespiratory), mobility and functional status, cognitive and psychological health, and social support (Soo WK et al. 2023). Personalised treatment plans should account for a person's health status, preferences, values and goals, and multidimensional intrinsic capacity. This may be best achieved through a geriatric assessment to identify vulnerabilities and tailor interventions.

Addressing these factors ensures a personalised approach that prioritises the individual's unique needs rather than relying on chronological age. Clinicians need to be aware of their own potential age biases to ensure that decisions align with the principles of patient-centred care.

A personalised treatment plan may also be informed by genomic testing. Genomics-informed cancer care can improve the experience of people affected by cancer by optimising treatment response and minimising treatment toxicity.

All older people with cancer who are being considered for active treatment should undergo frailty screening using a validated tool, such as the G8(Bellera C et al. 2012)(van Walree et al 2019) or VES-13 (Saliba D et al. 2001). These tools help identify those most likely to benefit from geriatric assessment and management. While screening tools flag potential vulnerabilities, evidence supports the role of geriatric assessment and management in assessing and targeting interventions to key domains such as cognition, comorbid chronic disease, medication usage, mood, nutrition, physical function, sensory function and social support (Chapman AE et al. 2021; Soo WK et al. 2023).

The greatest benefit is seen when geriatric assessment is combined with multidisciplinary interventions (Hamaker M et al. 2022). For patients undergoing chemotherapy, multiple randomised trials have shown improved outcomes with geriatric assessment and management (Disalvo D et al. 2023; Hamaker M et al. 2022). The benefit of geriatric assessment in older people undergoing targeted therapies, radiation therapy (Disalvo D et al. 2023; Giger A-KW et al. 2024) and surgery (Nipp RD et al. 2022) is less certain but also less well studied.

If impairments are identified in geriatric assessment domains, older people should be referred for supportive care interventions from allied health clinicians and/or a geriatric assessment and management with a geriatrician or aged care nurse specialist. A geriatrician may be consulted to assess and aid in decision-making in pre-frail or frail people considering treatments with a significant risk of toxicity or for those considering participation in clinical trials (Hamaker ME et al. 2020). Details are provided below in Section 4.5.1: Supportive Care.

There are various models of geriatric oncology care delivery. These models include a self-administered geriatric assessments, a screen-and-refer model where patients are referred for geriatric assessment and management based on frailty screening results, and a multidisciplinary consultative model where patients requiring geriatric assessment are evaluated by a team that may include nurses, allied health clinicians (occupation therapist, physiotherapist/exercise physiologist, pharmacist, dietitian, speech therapist, social worker, psychologist) and/ or a geriatrician (Chapman AE et al. 2021). Ultimately, the model of care chosen should be adapted to local resources and the specific needs of the patient population (Chapman AE et al. 2021).

Shared decision-making is a fundamental component of geriatric oncology models of care. Older people should be actively involved in decisions about their care, with families and carers involved if the person wishes. Clear communication about treatment options, potential outcomes, and side effects empowers people to make informed decisions that align with their preferences, values, and goals. Find more information in Further considerations – Models of care.

Optimisation of health, functioning and supports of older people

Cognition

Older people with cancer should be screened for cognitive deficits. If issues are identified, a more detailed assessment should be conducted, including obtaining information from family or friends if they consent. Cognitive impairment does not preclude treatment, but the person may require additional supportive measures to enable safe delivery of treatment. It is also associated with an increased risk of cancer-related cognitive decline.

The capacity to give informed consent to treatment should be assessed If cognitive impairment is identified (Caba Y et al. 2021). If a person lacks the capacity to consent to treatment, the person permitted under law to be their substitute decision-maker should be determined. Legislation differs across States and Territories and oncologists should be aware of their local legislation. Additionally, any information should be provided in a suitable format, for example, written information or audio recorded consultations. Involvement of a carer to attend medical appointments should be considered with consent of the older person. Referrals to a cognitive specialist (e.g. geriatrician, neurologist, psychiatrist, neuropsychologist) should be considered for further assessment, diagnosis and management.

Comorbid chronic disease

Older people with cancer have a higher prevalence of comorbidities than those without cancer (Edwards BK et al. 2014). These influence the risk of dying from other causes (Edwards BK et al. 2014). Comorbidities may impact the ability to receive certain cancer treatments, whilst cancer treatments may potentially exacerbate pre-existing comorbidities. Consultation is required with the person’s GP and other specialists involved in their care to optimise management of chronic conditions and assess the safety of planned oncology treatment. Input from a geriatrician may be helpful for those with multiple chronic conditions assessed as being pre-frail or frail.

Medication usage

Polypharmacy is common in older people ranging from 61 to 98 per cent (Herledan C et al. 2023). Unplanned hospitalisations due to adverse drug events occur in 19 to 26 per cent in older people with cancer (Walsh DJ et al. 2024). Medication usage can be reviewed by pharmacists, GPs, or Geriatricians in conjunction with oncologists prior to cancer treatment, with a view to ceasing unnecessary or potentially inappropriate medications. A variety of deprescribing tools such as Beers Criteria, STOPP/START criteria, oncoSTRIP (Systematic Tool to Reduce Inappropriate Prescribing) or OncPal (for those with limited life expectancy) are available (Raju B et al. 2023). See Appendix F.

Mood

Like other subpopulations of people who have experienced cancer, older people with cancer commonly experience changes in mood and elevated levels of distress (Haywood D et al. 2025; Weinberger MI et al. 2011). Fear of cancer progression or reoccurrence is common, and older people with cancer commonly experience a greater risk of developing psychopathology when compared to their aged-matched non-cancer affected peers (Weinberger MI et al. 2011). Screening for distress as well as a more thorough psychological assessment is useful for determining psychosocial supportive care needs for an older person with cancer. If elevated measures of distress or psychopathology are observed, referral to a mental health professional should be considered.

Nutrition

Older people with cancer have a high prevalence of malnutrition (median 54 per cent and severe in 12 per cent) (Hamaker ME et al. 2021). Dietitian referral for nutritional interventions is recommended for these people to improve their physical functioning and quality of life (Liposits G et al. 2023). Use caution with highly emetogenic regimens and use aggressive antiemetic therapy (Dale W et al. 2023).

Physical function

Older people should be assessed for physical function and ability to perform activities of daily living. Weigh the risks and benefits of cancer treatment options, incorporating information about physical performance. Those with impaired mobility or physical function should be assessed by a physiotherapist or exercise physiologist. Physical activity interventions improve lean muscle mass, muscular strength, functional performance and reduce fatigue in older people with cancer (Knowles R et al. 2022). Occupational therapy assessment should be offered to people having difficulties with activities of daily living. People identified as pre-frail or frail may benefit from prehabilitation in order to maintain independence during and after treatment (Guo Y et al. 2022).

Sensory function

Older people with cancer may have visual and/or hearing impairments that go unrecognised, unless specifically asked. Ensure hearing and visual aids are available and utilised. For those with hearing impairment, consider a personal amplifier, speaking slowly and clearly, using written materials, and involving a carer/family member if possible. In-person assessments may be preferable to telehealth. For those with visual impairment, use of large font in written materials and involve a carer if possible. Staff should be made aware so that extra time is allowed and help provided for these people during treatment.

Social support

Assessing social supports is an important consideration in safely prescribing oncology treatment, and lack of adequate support may preclude some treatment options (Dale W et al. 2023). This is particularly important for older people with cancer, as they may be less able to seek help or maintain function in the event of toxicities or complications. Referrals to a Social Worker, for Aged Care Support Services, and/or transport assistance should be considered for those with limited supports (Burhenn PS et al. 2016).

4.1 Treatment intent

Determining the intent of treatment depends on the extent of the cancer and involves a shared decision-making process between the clinician and the older person. Depending on the person's wishes, family and/or carers may be involved. Some people may prefer a family approach to treatment decision-making. The life expectancy of the person and morbidity and mortality risks of treatment need to be estimated to inform decision-making.

The intent of treatment can be defined as one of the following:

curative
anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
symptom palliation.

The treatment intent should be established in a multidisciplinary setting, documented in the patient's medical record and conveyed to the patient and carer as appropriate.

The potential benefits need to be balanced against the morbidity and risks of treatment.

The lead clinician should discuss the advantages and disadvantages of each treatment and associated potential side effects with the older person and their carer or family before informed consent for treatment is obtained. Supportive care services should also be considered during this decision-making process. People should be asked about their use of (current or intended) complementary therapies (see Appendix D). Treatment goals should be regularly reassessed in response to changes with the cancer, tolerance of treatment, and the person's functional status and preferences.

Timeframes for starting treatment should be informed by evidence-based guidelines and cancer specific optimal care pathways (where available). The treatment team should recognise that shorter timeframes for appropriate consultations and treatment can promote a better experience for patients.

4.2 Treatment options

4.2.1 Surgery

Surgery can be a beneficial treatment option for older people with cancer, particularly those with localised tumours, where surgical intervention may improve survival, alleviate symptoms, or enhance quality of life. However, frail older people, particularly those with multimorbidity, reduced performance status, poor nutritional status, or cognitive impairment, are at higher risk for postoperative complications and adverse outcomes. For this reason, surgical planning should consider tailored approaches to optimise outcomes and reduce risks.

Characteristics of Patients Suitable for Surgery

Physiological Resilience: Stable cardiovascular, respiratory, and renal function

Comorbidity Stability: Well-controlled comorbidities with a low risk of exacerbation

Low frailty: Mild to moderate frailty; severe frailty may favour non-surgical options

Functional Independence: Ability to perform daily activities with minimal assistance (e.g. ECOG 0-2)

Cognitive and Social Support: Sufficient cognitive function and reliable support network for recovery

Alignment with Goals of Care: Surgery supports a person's goals, including life extension, symptom relief, or enhanced quality of life.

Timeframe for Starting Surgery

Elective Cancer Surgery: Aim to perform surgery within 4-6 weeks of assessment, allowing time for any necessary preoperative optimisation, including prehabilitation and comorbidity management. This timeframe may be adjusted based on a person's readiness as evaluated by the multidisciplinary team.

Urgent Surgery: For cases with an imminent risk (e.g. obstruction, bleeding), surgery should be planned within 1-2 weeks, balancing urgency with timely preoperative assessments to optimise a person's readiness.

Prehabilitation for frail patients: For frail patients requiring prehabilitation, surgery may be scheduled within 6-8 weeks, contingent on achieving successful readiness through prehabilitation

Pre-operative assessment and Prehabilitation

Preoperative assessment, including geriatric assessment and prehabilitation, can optimise surgical outcomes for older people with cancer, particularly those with frailty or multiple comorbidities (Guo Y et al. 2022). Prehabilitation is most effective when started early, ideally allowing 4–8 weeks before surgery, with a multidisciplinary team coordinating, monitoring, and adjusting the plan as needed.

Key components include:

Standard Preoperative Assessment: Routine preoperative assessments include evaluating cardiovascular, respiratory, renal, and overall functional status, reviewing current medications, and assessing anaesthesia risk.

Geriatric Assessment: This assesses comorbidities and medications, functional status, nutrition, cognition, mood and social support. This assessment aids in surgical planning and identifies prehabilitation or supportive care needs.

Prehabilitation: For older people with identified deficits or reduced physiological reserves, prehabilitation can improve surgical readiness and enhance postoperative recovery. This approach includes targeted exercise, nutritional interventions, and cognitive and psychological support (Guo Y et al. 2022).

Formal cardiopulmonary exercise testing (CPET) can be useful as a tool to evaluate risk and help direct the management of patients who are considering surgery. Early testing can provide identification of patients who are at high risk of poor outcomes from major surgery.

When tailoring patient-specific care for older people, several additional clinical appointments are often required to discern the risk-benefit equation for the individual patient. The use of surgical risk calculators such as the American College of Surgeons NSQIP calculator may be useful for quantifying risk (ACS 2023).

Surgical Approach and Techniques

Minimally Invasive Surgery: When feasible, minimally invasive surgery such as laparoscopic or robotic-assisted surgery is preferred as it can reduce surgical stress, lower complication rates, and shorten recovery times. This is particularly advantageous for older people with frailty or comorbidities.

Open Surgery: When tumour location, size, or patient-specific factors make minimally invasive surgery impractical, open surgery may be necessary. The decision should be carefully weighed against the patient's health status and recovery capacity.

Recovery and Rehabilitation

Enhanced Recovery After Surgery (ERAS) protocols, including optimised pain management, early mobilisation, and nutritional support, should be integrated with surgical approaches to promote recovery and reduce postoperative complications.

Rehabilitation can support recovery in older people after cancer surgery, particularly those with recovery potential. Multidisciplinary assessments can help evaluate physical reserves, functional status, and recovery goals. For people with good recovery potential, a personalised rehabilitation plan including physical therapy to enhance mobility, occupational therapy to aid daily activities, and nutritional support can promote strength, independence, and quality of life. For frail people, rehabilitation focuses on maintaining mobility, preventing complications, and enhancing comfort. Realistic goal setting with input from a multidisciplinary team ensures safe, individualised recovery.

4.2.2 Radiation therapy

Radiation therapy is a highly effective, localised non-invasive cancer treatment suitable for many older people with cancer. Radiation therapy represents a particularly attractive treatment option for those older people in whom surgery or systemic therapies are not recommended due to the high risk of toxicities or due to a person's preference. Radiation therapy typically involves daily treatments on an outpatient basis. Recent advances in planning and treatment technologies have allowed shorter fractionation schedules (hypofractionation) and stereotactic ablative body radiotherapy (1-8 treatments) across a number of cancer types. These advances have significantly improved the efficacy of radiation therapy, whilst reducing side effects and the physical and psychosocial burden of prolonged treatment courses.

Older people with cancer who are fit should be offered standard of care treatment. Radiation therapy is well tolerated in older people with similar outcomes and treatment completion rates compared to younger cohorts. However, treatment modifications should be considered in those who are pre-frail or frail. This can include using radiation therapy instead of surgery for some cancers such as early-stage lung cancer or localised prostate cancer. The use of sequential systemic therapy and radiation therapy instead of concurrent treatment (Simone CB, 2nd et al. 2023), changing to less toxic systemic therapy (Dickstein DR et al. 2023; Simone CB, 2nd et al. 2023), omitting systemic therapy and treating with radiation therapy alone, and shortening fractionation schemes should be considered where possible.

If treatment is being given with palliative intent, consideration should be given to whether medical therapy alone may have equivalent palliative benefits (Mulvenna P et al. 2016) and whether the person is likely to live long enough to benefit from the treatment. A variety of survival prediction tools are available to estimate prognosis(Pobar I et al. 2021).

Older people are also a specific group where radiation therapy can sometimes be omitted without any adverse effects on clinical outcomes such as in patients with low-risk breast cancer (Hughes KS et al. 2013; Kunkler IH et al. 2015; Whelan TJ et al. 2023) and prostate cancer(Donovan JL et al. 2016; Hamdy FC et al. 2016; Hamdy FC et al. 2023). Overtreatment of people with low-risk cancers should be avoided.

4.2.3 Systemic therapy

Systemic anti-cancer therapies play a pivotal role in the management of numerous malignancies. Anti-cancer therapies can be divided into five categories: chemotherapy (cytotoxic agents), immunotherapy, hormonal therapies, targeted therapies, and emerging therapies (including cellular therapies). Each of these modalities presents distinct mechanisms of action, toxicities, and therapeutic considerations, which may require adaptation when treating older people, particularly those who are pre-frail or frail. Modified approaches may be required for each of these modalities when administered to an older person with cancer, taking into account the person's health, function and social supports.

A thorough assessment of the expected benefits and risks of systemic anti-cancer therapy should be considered, given the interplay between biological ageing, functional ageing, malignancy and anti-cancer therapy. In particular, age-related vulnerabilities should be assessed to inform treatment options. This can be achieved through geriatric assessment and management of any identified issues. For patients undergoing chemotherapy, geriatric assessment and management reduces high grade treatment toxicities, increases treatment completion rates, reduces hospitalisations and improves quality of life (Disalvo D et al. 2023; Hamaker M et al. 2022).

Several systemic anti-cancer therapies may lead to incident or progressive geriatric syndromes, and these should be proactively assessed and managed throughout the patient's illness. Regular reassessment allows clinicians to adapt treatment plans, mitigate risks, and address evolving needs during systemic therapy.

Decisions regarding the administration of systemic anti-cancer therapies in older people should be guided by a collaborative, patient-centred approach. Key considerations include a person's organ function, comorbidities, and age-related vulnerabilities such as falls, cognitive impairment, or frailty. Clinicians should also evaluate whether the cancer is curable, the extent to which the cancer influences life expectancy, and the likelihood of therapy contributing to progressive vulnerabilities.

For people who are frail, pre-frail or at risk of treatment toxicity, consider upfront dose reduction with subsequent adjustments based on tolerance, use of alternative drugs or single-agent therapy, sequential rather than concurrent treatment with radiation therapy, and modifications to supportive care medications to enhance tolerability. Validated tools utilising geriatric assessment variables can be used to predict chemotherapy toxicity in older people. These tools are more sensitive than other surrogate markers of frailty such as performance status, however have only been validated in patients receiving cytotoxic chemotherapy, not immunotherapy or targeted therapy (Extermann M et al. 2012; Hurria A et al. 2016).

4.3. Geriatric medicine and aged care

Timely referrals to geriatric medicine teams and aged care services are essential to optimise care for older people with cancer. These teams provide specialised expertise to address the challenges of ageing, and comorbidities, ensuring treatment aligns with patient goals and supports functional independence and quality of life.

Older people with cancer often experience challenges related to ageing, frailty, and multimorbidity that can affect treatment tolerance and outcomes. Referral to specialist geriatric medicine teams offers significant benefits (Viray P et al. 2023), including:

- comprehensive assessment to identify and address vulnerabilities, such as frailty, functional decline, cognitive impairment, and polypharmacy
- optimisation of comorbidities to support cancer treatment and minimise the risk of adverse events
- personalised interventions to support functional independence, including rehabilitation, falls prevention, and management of geriatric syndromes
- coordination of hospital and community-based supportive services, including allied health, aged care, and palliative care services
- support for shared decision-making to ensure treatment aligns with the patient’s overall health, goals of care, and life expectancy
- advance care planning to prioritise ‘What Matters’ to patients and their families.

Referral to geriatric medicine teams should be considered for older people at any stage of the cancer pathway, particularly when:

- there are concerns about frailty, cognitive impairment, or functional decline
- there are multiple comorbidities or complex medication regimens that may impact treatment decisions or safety
- there is uncertainty regarding the risks and benefits of treatment
- additional support is required to maintain independence or address age-related vulnerabilities.

Geriatric medicine plays an essential role within the multidisciplinary team, working collaboratively with oncologists, primary care providers, and allied health professionals to deliver integrated, patient-centred care (Soo WK et al. 2023).

Aged care services provide practical, social, and functional support for older people. These services include: in-home support for daily activities such as personal hygiene, meal preparation, and mobility; respite care for carer relief; community programs like transport assistance and social networks; specialised equipment and home modifications for safety and independence; and residential care facilities providing 24/7 care.

Geriatric medicine and aged care are integral components of the optimal care pathway for older people with cancer, complementing cancer care by addressing multidimensional needs, particularly for frail individuals or those with multiple health concerns.

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See Step 3.6 Supportive care and Step 4.3 Palliative care for strategies to address multidimensional needs.

See Resource list for geriatric oncology resources for health professionals

4.3 Palliative care

Early referral to palliative care can improve the quality of life for people with cancer and in some cases may be associated with survival benefits (Haines IE 2011; Temel JS et al. 2010; Zimmermann C et al. 2014). This is particularly true for cancers with poor prognosis.

The lead clinician should ensure people receive timely and appropriate referrals to palliative care services. Referral should be based on need rather than prognosis. Emphasise the value of palliative care in improving symptom management and quality of life to patients and their carers.

The ‘Dying to Talk’ resource may help health professionals when initiating discussions with patients about future care needs (see ‘More information’). Ensure that carers and families receive information, support and guidance about their role in palliative care (PCA 2018).

Older people with cancer, with support from their family or carer and treating team, should be encouraged to consider appointing a substitute decision-maker and to complete an advance care directive.

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For more information see Further considerations – Advance care planning, Further considerations – Decision-making capacity, and Step 7 End-of-life care

These online resources are useful:

Advance Care Planning Australia <www.advancecareplanning.org.au>
Care Search <www.caresearch.com.au/Caresearch/>
Dying to Talk <www.dyingtotalk.org.au>
the Palliative Care resource kit <www.health.gov.au/health-topics/palliative-care>
Palliative Care Australia (for patients and carers) <www.palliativecare.org.au>.

4.4 Research and clinical trials

The treatment team should support the older person with cancer to participate in research and clinical trials where available and appropriate. This includes interventions of cancer treatment, and supportive care interventions.

For more information visit the Cancer Australia website

<www.australiancancertrials.gov.au>.

See Principle 7: Research and clinical trials

4.5 Support and communication

4.5.1 Supportive care

Supportive care needs should be assessed and addressed throughout the entire continuum of care for a cancer diagnosis (Krishnasamy, Hyatt. Fitch 2008).

Specific challenges and needs that may arise during treatment include:

- assistance for dealing with emotional and psychological issues, including body image concerns, fatigue, quitting smoking, traumatic experiences, existential anxiety, treatment phobias, anxiety/depression, interpersonal problems and sexuality concerns
- potential isolation from normal support networks, particularly for rural patients who are staying away from home for treatment
- management of physical symptoms or pain
- decline in mobility or functional status as a result of treatment

    - assistance with maintaining mobility or function as a result of treatment.

Early involvement of general practitioners may lead to improved cancer survivorship care following acute treatment. General practitioners can address many supportive care needs through good communication and clear guidance from the specialist team (Emery 2014).

Patients, carers and families may have these additional issues and needs:

- financial issues related to loss of income (through reduced capacity to work or loss of work – for older people this may impact their carer) and additional expenses as a result of illness or treatment
- advance care planning, which may involve appointing a substitute decision-maker and completing an advance care directive
- legal issues (e.g. completing a will) or making an insurance, superannuation or social security claim on the basis of terminal illness or permanent disability.

Cancer Council's 13 11 20 information and support line can assist with information and referral to local support services.

For more information on supportive care and needs that may arise for different population groups, see Appendices A, B and C.

See Further considerations – Advance care planning

4.5.2 Rehabilitation

Rehabilitation may be required at any point of the care pathway. If it is required before treatment, it is referred to as prehabilitation (see section 3.6.1).

All members of the multidisciplinary team have an important role in promoting rehabilitation.

Team members may include occupational therapists, speech pathologists, dietitians, social workers, psychologists, physiotherapists, exercise physiologists and rehabilitation specialists.

To maximise the safety and therapeutic effect of exercise for older people with cancer, all team members should recommend that people with cancer work towards achieving, and then maintaining, recommended levels of exercise and physical activity as per relevant guidelines. Exercise should be prescribed and delivered under the direction of an accredited exercise physiologist or physiotherapist with experience in cancer care (Vardy et al. 2019). The focus of intervention from these health professionals is tailoring evidence-based exercise recommendations to the older person's needs and abilities, with a focus on the patient transitioning to ongoing self-managed exercise, as appropriate.

Other issues that may need to be dealt with include managing cancer-related fatigue, improving or maintaining physical activity, achieving or maintaining independence in daily tasks, optimising nutritional intake, and ongoing adjustment to cancer and its sequelae. Referrals to dietitians, psychosocial support, and community support organisations can help in managing these issues.

4.5.3 Communication with patients, carers and families

Communicating with patients, carers and families during treatment should be undertaken within the framework of collaborative, patient-directed decision-making. For older people, including and empowering carers throughout the treatment process is critical.

The lead or nominated clinician should take responsibility for these tasks:

- discussing treatment options with patients and carers, including the treatment intent and expected outcomes, and providing a written version of the plan and any referrals
- providing patients and carers with information about the possible side effects of treatment, managing symptoms between active treatments, how to access care, self-management strategies and emergency contacts
- encouraging patients to use question prompt lists and audio recordings, and to have a support person present to aid informed decision-making
- initiating a discussion about advance care planning and involving carers or family if the patient wishes.

4.5.4 Communication with the general practitioner

The general practitioner plays an important role in coordinating care for older people, including helping to manage side effects and other comorbidities, and offering support when patients have questions or worries. For most patients, simultaneous care provided by their general practitioner is very important.

The lead clinician, in discussion with the patient's general practitioner, should consider these points:

- the general practitioner's role in symptom management, supportive care and referral to local services
- using a chronic disease management plan and mental health care management plan

how to ensure regular and timely two-way communication about:
  the treatment plan, including intent and potential side effects
  supportive and palliative care requirements
  the patient’s prognosis and their understanding of this
  enrolment in research or clinical trials
  changes in treatment or medications
  the presence of an advance care directive or appointment of a substitute decision-maker
  recommendations from the multidisciplinary team.

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Refer to Principle 6: Communication

See Further considerations – Primary care management

Step 5: Care after initial treatment and recovery

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The term ‘cancer survivor’ describes a person living with cancer, from the point of diagnosis until the end of life. Survivorship care in Australia has traditionally been provided to patients who have completed active treatment and are in the post-treatment phase. But there is now a shift to provide survivorship care and services from the point of diagnosis to improve cancer-related outcomes.

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Following completion of active cancer treatment people affected by cancer often face issues that are different from those experienced during active treatment and may include a range of issues, as well as unmet needs, that affect their quality of life (Lisy K et al. 2019; Tan S et al. 2019). Emotional and psychological issues include distress, anxiety, depression, cognitive changes and fear of cancer recurrence are commonly reported by cancer survivors (Lisy K et al. 2019; Vardy JL et al. 2019). People who have or have had cancer may experience challenges in physical functioning, relationships, finances, physical health, psychological health, and cognitive functioning (Corbett T et al. 2019). Late effects may occur months or years later and are dependent on the type of cancer treatment.

When compared to age matched, non-cancer affected peers, older people with cancer often experience long-term burden including; reduced life expectancy, greater rates of hospitalisation, as well as poorer physical health, psychosocial health, cognitive functioning, and overall quality of life (Bagayogo F et al. 2020; Castelo-Loureiro A et al. 2023; Depoorter V et al. 2023).

Four essential components of survivorship care are described (Stovall E et al. 2005):

  the prevention of recurrent and new cancers, as well as late effects

- surveillance for cancer recurrence or second cancers, and screening and assessment for medical and psychosocial late effects
- interventions to deal with the consequences of cancer and cancer treatments (including managing symptoms, distress and practical issues)
- coordination of care between all providers to ensure the patient's needs are met.

5.1 Transitioning from active treatment

The transition from active treatment to post-treatment care is critical to long-term health. In some cases, people will need ongoing, hospital-based care, and in other cases a shared follow-up care arrangement with their general practitioner or primary care provider may be appropriate. This will vary depending on the type and stage of cancer and needs to be planned.

Shared follow-up care involves the joint participation of specialists and general practitioners in the planned delivery of follow-up and survivorship care. A shared care plan is developed that outlines the responsibilities of members of the care team, the follow-up schedule, triggers for review, plans for rapid access into each setting and agreement regarding format, frequency and triggers for communication.

After completing initial treatment, a designated member of the multidisciplinary team (most commonly nursing or medical staff involved in the patient's care) should provide the patient with a needs assessment and treatment summary and develop a survivorship care plan in conjunction with the patient. This should include a comprehensive list of issues identified by all members of the multidisciplinary team involved in the patient's care including Aboriginal Health Officers and ACCHO controlled health services where indicated, and by the patient. A discussion about Advance Care Planning (ACP) should also be considered at this time, if this has not yet occurred. ACP provides a process for people to communicate their views, preferences and goals for their future care if they are not able to communicate their views. This may include appointing a substitute decision maker to make decisions about their future medical care on their behalf should this be needed (DHAC 2022).

Treatment summaries and survivorship care plans are key resources for the patient, their carers, and their healthcare providers and can be used to improve communication and care coordination

The **treatment summary** should cover, but is not limited to:

- the diagnostic tests performed and results
- diagnosis including stage, prognostic or severity score
- tumour characteristics
- treatment received (types and dates)
- current toxicities (severity, management and expected outcomes)
- interventions and treatment plans from other health providers
- potential long-term and late effects of treatment
- supportive care services provided

- medication changes

follow-up schedule
contact information for key healthcare providers.

Refer to cancer specific Optimal Care Pathways for details relevant to specific cancer types.

For older people, following completion of a course of cancer treatment, rehabilitation or allied health interventions should be considered for those with physical or cognitive decline. The need for referral for additional community-based services and supports should also be assessed.

If cessation of treatment is due to inability to tolerate treatment-related morbidity or side-effects, or progressive disease, early referral to palliative care is desirable and should be discussed with the person and their family or carers.

5.1.1 Rehabilitation

Rehabilitation may be useful for older people at any point of the cancer care pathway from the pre-treatment phase (often referred to as prehabilitation) through to disease-free survival or progressive disease (Cormie P et al. 2017). Rehabilitation interventions should be considered for older people with cancer following active treatment. Rehabilitation can address deficits resulting from deconditioning following surgery and other active anti-cancer treatments, complications from cancer, or side effects of cancer treatments (Balducci L et al. 2013).

Rehabilitation aims to improve function, enabling a person to live to their fullest potential, using a multidisciplinary approach (Stott DJ et al. 2017). Rehabilitation is typically goal-based, focusing on interventions which work towards achieving a person’s own goals (Levack WM et al. 2015). Healthcare professionals and the person work together to plan the rehabilitation program. Geriatric assessment can provide a multidomain assessment, identify domains of deficits, to inform rehabilitation planning.

Rehabilitation can be conducted in a variety of settings depending on a person’s needs and available services, including: inpatient, outpatient, community based, and in the home. It may be provided through primary care pathways with a General Practitioner Management Plan and Team Care Arrangements, or within secondary care cancer, rehabilitation, or aged care services.

5.1.2 Cancer-Related Cognitive Impairment

Older people have a higher incidence of Cancer Related Cognitive Impairment (CRCI) than younger adults (Bray VJ et al. 2017). They may also have a range of unmet needs resulting from their CRCI (Haywood D et al. 2025; Haywood D et al. 2024b). For older people with CRCI, their cognition, physical and psychosocial functioning, and unmet needs should be monitored. Those with CRCI may benefit from interventions including physical exercise, mindfulness interventions, functional rehabilitation, cognitive behavioural therapy and training, and cognitive rehabilitation and training (Oldacres L et al. 2023; Pergolotti M et al. 2020). If symptoms are not improving or are worsening, and particularly if impacting on their functioning, referral to a healthcare professional with expertise in cognitive disorders, such as a geriatrician, neurologist or psychiatrist should be considered.

5.2 Follow-up care

Whilst post-treatment care should be evidence-based and consistent with guidelines, it must also align with a person’s preferences, values and goals, and take into account their intrinsic capacity and remaining life expectancy. Older people should be actively involved in follow-up care planning, with inclusion of family and carers to the extent a person wishes.

Refer to cancer specific Optimal Care Pathways for issues relevant to specific cancer types.

Responsibility for follow-up care should be agreed between the lead clinician, the person’s general practitioner, relevant members of the multidisciplinary team (including any relevant care coordinator), Aboriginal and/or Torres Strait Islander health workers and ACCHO controlled health services where indicated, and the person and their family or carers, if appropriate.

Care in the post-treatment phase is driven by predicted risks (e.g. the risk of recurrence, developing late effects of treatment and psychological issues) as well as individual clinical and supportive care needs, preferences and goals. Not all people will require ongoing tests or clinical review.

Strategies to assist older people affected by cancer following completion of active cancer treatment include, and can be documented in a follow-up or survivorship care plan:

a discussion with older people about their values, preferences, goals and definition of living well, to ensure health services are working towards their goals

providing resources about healthy lifestyle choices, including optimal nutrition and exercise to prevent and manage frailty, malnutrition/sarcopenia, and optimise mobility and bone health (COSA 2018; Hayes SC et al. 2019)

information about relevant available services, and how they can be accessed

offering referral pathways to social and emotional wellbeing services and mental health services.

A follow-up or survivorship care plan should include, but is not limited to:
required medical follow-up (e.g. surveillance for cancer spread, recurrence or secondary cancers, screening and assessment for medical and psychosocial effects) with explicit care goals
care plans from other health professionals to manage the consequences of the cancer and treatment, including rehabilitation recommendations, and referrals made to other agencies such as for community aged care services
potential barriers to the follow-up plan (such as transport and cost issues) and strategies or referrals to support services to address these

instructions on how to gain rapid re-entry to specialist medical services for suspected recurrence.

For people with cancer being managed, rather than cured, the plan should address:

- the role of follow-up for people, for example, to evaluate tumour control, monitor and manage symptoms from the tumour and treatment, and provide psychological support
- how they will be retained within the multidisciplinary team management framework.

In particular circumstances, follow-up care can safely and effectively be provided:

- in the primary care setting
- by other suitably trained staff (for example, nurse-led follow-up) (Monterosso L et al. 2019)
- in a non-face-to-face setting (e.g. by telehealth).

General practitioners (including nurses) can:
- connect patients to local community services and programs
- manage long-term and late effects
- manage comorbidities
- provide wellbeing information and advice to promote self-management
- screen for cancer and non-cancerous conditions.

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For further information on cancer survivorship is available from:

- Clinical Oncology Society of Australia Model of Survivorship care at <https://www.cosa.org.au/groups/survivorship/resources/>
- Cancer Australia Principles of Cancer Survivorship at <https://canceraustralia.gov.au/publications-and-resources/cancer-australia-publications/principles-cancer-survivorship>

Templates and other resources to help with developing treatment summaries and survivorship care plans are available from these organisations:
- Australian Cancer Survivorship Centre
- Cancer Australia – Principles of Cancer Survivorship
- Cancer Council Australia and states and territories
- Clinical Oncology Society of Australia – Model of Survivorship Care
- eviQ – Cancer survivorship: introductory course
- mycareplan.org.au
- South Australian Cancer Service – Statewide Survivorship Framework resources
- American Society of Clinical Oncology – guidelines.

5.2.1 Preventing recurrence

Not smoking, eating a healthy diet, being sun smart, avoiding or limiting alcohol intake, being physically active and maintaining a healthy body weight may help reduce the risk of primary recurrence or a second primary cancer.

Encourage and support all cancer survivors to reduce modifiable risk factors for recurrence as well as other chronic diseases. Ongoing coordination of care between providers should also deal with any comorbidities, particularly ongoing complex and life-threatening comorbid conditions.

5.3 Carer needs

Carers have unique health, information and psychosocial needs separate to those of the person with cancer. The impact of caring for a person with cancer can affect the quality of life and physical, psychological and social wellbeing of family carers, who are at risk of psychological distress, anxiety and depression) and frequently delay their own care in default to their caring duties (Sun V et al. 2021). Carers of older people also tend to be older, and they may have their own health or other concerns (Kadambi S et al. 2020). Family members and carers should be provided with information and access to support services extending into the follow-up care phase (Sun V et al. 2021).

5.3 Research and clinical trials

Support older cancer survivors to participate in research or clinical trials where they are available and appropriate.

For more information visit the Cancer Australia website <www.australiancancertrials.gov.au>.

See Principle 7: Research and clinical trials

5.4 Support and communication

5.4.1 Supportive care

An individualised clinical assessment is required to assess and meet the needs of people with cancer, their families and carers; referral should be as required.

See Principle 4: Supportive care for detailed information about providing supportive care to older people affected by cancer.

5.4.2 Communication with older people with cancer and their families and carers

In addition to the key points outlined in the Principle 6: Communication, be aware the term ‘survivor’ may not sit comfortably with the person. Communication should be individualised to a person’s health literacy, and cultural and language preferences. Family and carers should be involved to the extent a person wishes.

The lead clinician (themselves or by delegation) should take responsibility for these tasks:

- explaining the model of post-treatment care and the roles of health professionals involved in post-treatment care including the role of primary care
- explaining the treatment summary
- discussing the development of a shared follow-up care plan
- discussing how to manage any of the physical, psychological or emotional issues identified
- providing information on the signs and symptoms of recurrent disease
- providing contact details of the care team involved
- providing clear information about the role of advance care planning.

5.4.4 Communication with the general practitioner

The lead clinician should ensure regular, timely, two-way communication with the general practitioner or primary care provider regarding:

- the person's progress
- the follow-up care plan
- potential late effects and management strategies
- supportive care requirements

    - recommendations from the multidisciplinary team
- any shared care arrangements
- a process for rapid re-entry to medical services for patients with suspected recurrence

<insert icon> More information

Refer to Principle 6: Communication for communication skills training programs and resources.

Refer to Further considerations – Primary care engagement, and Further considerations – Model of care

Step 6: Managing recurrent, residual or metastatic disease

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People who present with recurrent, residual or metastatic disease should be managed by a multidisciplinary team and offered timely referral to appropriate physical, practical and emotional support.

<end text box>

Step 6 is concerned with managing recurrent or local residual and metastatic disease. The likelihood of recurrence depends on many factors usually related to the type of cancer, the stage of cancer at presentation and the effectiveness of treatment. Some cancers cannot be eradicated even with the best initial treatment. But controlling disease and disease-related symptoms is often possible, depending on the clinical situation.

For an overview of treatment decision-making refer to Step 4: Treatment which addresses the specific aspects of developing personalised treatment plans for the older person with cancer. In addition to considering the choice of treatment modalities and treatment intent, Step 4 covers the nuances of managing concerns and conditions which may co-exist alongside the cancer diagnosis, such as cognitive impairment, functional decline, frailty, suitability of the home environment, social support and carer capacity.

6.1 Signs and symptoms of metastatic disease

Some people will have metastatic disease on initial presentation. Others may present with symptoms of recurrent disease or have symptoms related to persistent disease after a previous cancer diagnosis.

Signs and symptoms will depend on the type of cancer as well as the location of residual/recurrent or metastatic disease. They may be discovered by the older person with cancer or their carer or through routine surveillance in the post-treatment period. For older people with multimorbidity signs and symptoms may have contributors from a range of medical conditions including metastatic cancer, so worsening of existing symptoms may also be a presentation.

6.2 Managing metastatic disease

Managing metastatic disease is complex and should therefore involve all the appropriate specialties in a multidisciplinary team including palliative care where appropriate. From the time of diagnosis, the team should offer patients appropriate psychosocial care, supportive care, advance care planning and symptom-related interventions as part of their routine care. The approach should be personalised to meet the patient’s individual needs, values and preferences~~.~~

The principles to guide potential treatment options are outlined in Step 4: Treatment.

When progression of disease is confirmed an initial discussion should occur to determine the degree to which the older person wishes for further investigation focusing on understanding what matters most for them (Hodge O et al. 2024; van der Waal MS et al. 2023).

As at initial cancer diagnosis effective treatment planning requires consideration of cancer and treatment-specific factors (refer to cancer specific Optimal Care Pathway) and person-related factors (Refer to Step 4: Treatment). Access to the best available therapies, including clinical trials, as well as treatment overseen by a multidisciplinary team, are crucial to achieving the best outcomes for anyone with metastatic disease (Mohile SG et al. 2018). A multidisciplinary team should also develop personalised treatment plans that account for a person’s health status, preferences, values and goals, and multidimensional intrinsic capacity. This is best achieved through geriatric assessment to tailor interventions including timely referral to appropriate physical, practical and emotional support (Dale W et al. 2023) (Ozluk AA et al. 2023) (Refer to Step 4 Treatment).

Older people with metastatic cancer need care that addresses both their cancer and the challenges that come with ageing, such as having multiple health conditions, frailty, and difficulty with daily activities (Seghers PN et al. 2023). Symptoms of recurrent or metastatic disease can be harder to recognise or made worse by existing health problems. Additionally, older people are more vulnerable to treatment side effects. To provide optimal care, a comprehensive assessment of their overall health and needs is essential and should involve the expertise of geriatric medicine specialists.

The older person should be actively involved in decisions about their care, with families and carers involved if the person wishes (Sun V et al. 2021). In the setting of progressive or metastatic disease the team should offer older people with cancer appropriate psychosocial care, supportive care, palliative care, advance care planning and symptom-related interventions as part of their routine care. The full complement of supportive care measures as described throughout the optimal care pathway and in Appendices A, B and C should be offered to assist patients and their families and carers to cope. These measures should be updated as the patient's circumstances change.

Survivorship care should be considered and offered at an early stage. Many people live with advanced and recurrent cancer for many months or years. As survival is improving in many patients, including older people with cancer, survivorship issues should be considered ~~as~~ part of routine care. Older people face unique survivorship challenges, such as managing the interplay between cancer-related symptoms, age-related comorbidities, and functional decline, which require tailored interventions to maintain their quality of life and independence (Fitch MI et al. 2022; Seghers PN et al. 2023). Health professionals should therefore be ready to change and adapt treatment strategies according to disease status, prior treatment tolerance and toxicities and the patient's quality of life, in addition to the older patient's priorities, ~~and~~ life plans and preferences for treatment (van der Waal MS et al. 2023).

As older people with cancer approach the end of life, care should transition from curative or life-prolonging interventions to focus on comfort, dignity, and quality of life. This transition often involves de-escalating treatments that no longer align with the individual's goals of care to provide meaningful benefit. This includes stopping anticancer therapies, deprescribing unnecessary medications, and reducing burdensome interventions where appropriate. Decision-making should involve clear communication about prognosis, treatment burdens, and patient goals.

6.3 Multidisciplinary team

Managing metastatic disease in the older person with cancer should involve all the appropriate specialties in a multidisciplinary team including geriatric medicine and palliative care (Ellis G et al. 2019). Older people with relapsed or refractory disease should be offered referral to a tertiary cancer centre with experience and expertise in managing cancer in the older person.

If there is an indication that a patient's cancer has returned, care should be provided under the guidance of a treating specialist. Each patient should be evaluated to determine if referral to the original multidisciplinary team is necessary and if this is the preference of the patient and their carer.

6.4 Treatment

Treatment will depend on the type of cancer, location, extent of recurrent or residual disease, previous management, geriatric assessment findings (including how concerns in geriatric domains have changed since diagnosis) and the preference of the older person with cancer and/or their carers (Hodge O et al. 2024). (Refer Step 4: Treatment).

The potential goals of treatment should be discussed, respecting the person's cultural values. Wherever possible, written information should be provided, taking account of individual language and health literacy needs.

In discussing treatment options in the metastatic setting specific considerations for the older person with cancer include:

- interventions which can optimise health, functioning and supports of the older person (see Step 4.1 Treatment intent, and Step 4.2 Treatment options)
- anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- symptom palliation incorporating palliative care involvement for all older people with recurrent or metastatic disease
- decisions about clinical trial availability (these may not be available onsite).

Regular reassessment of goals of treatment should occur based on tolerance, side effects, and patient preferences. Open and candid communication with the older person and their carers should be maintained at all times.

6.5 Support and communication

6.5.1 Supportive care

In addition to the principles identified in Principle 4: Supportive care, a number of specific considerations and needs may arise at this time for older people:

- assessment should proactively consider future needs and the likely trajectory for increasing care and support, enabling care planning to be proactive and preventative rather than reactive
- assistance for dealing with emotional and psychological distress resulting from fear of death or dying, existential concerns, anticipatory grief, communicating wishes to loved ones and interpersonal relationship problems
- potential isolation from normal support networks, particularly for rural patients who are staying away from home for treatment
- cognitive changes, either pre-existing or as a result of treatment and disease progression, such as altered memory, attention and concentration

where cognitive impairment is established, carers must be included in all discussions about treatment, anticipated side-effects and prognosis

completion of an advance care directive where one is not already in place

financial issues as a result of disease recurrence which may need consideration of gaining early access to superannuation and insurance

legal issues (completing a Will, Power of Attorney or Enduring Guardian, care of dependants), making an insurance, superannuation or Centrelink claim on the basis of terminal illness or permanent disability

consideration of Centrelink claim for a carer

management of physical symptoms including those symptoms associated with concomitant chronic health conditions

decline in mobility or functional status as a result of recurrent disease and treatments. Referral to physiotherapy or occupational therapy may be required.

6.5.2 Communication with patients, carers and families

The lead clinician should ensure there is adequate discussion with the older person and carers about the diagnosis and recommended treatment, including treatment intent and possible outcomes, likely adverse effects and the supportive care options available.

Supporting the older person at this time point includes eliciting their values and being candid about prognosis, treatment intent, benefits, risks and uncertainties. Information is sensitively provided in appropriate language and within a supportive environment.

<insert icon> More information

Refer to Principle 6: Communication for communication skills training programs and resources.

6.5.3 Rehabilitation

Rehabilitation may be required at any point of the metastatic care pathway, from preparing for treatment through to palliative care. Issues that may need to be dealt with include managing cancer-related fatigue, improving physical endurance, achieving independence in daily tasks, returning to work and ongoing adjustment to cancer and its sequelae.

Exercise is a safe and effective intervention that improves the physical and emotional health and wellbeing of people with cancer. Exercise should be embedded as part of standard practice in cancer care and be viewed as an adjunct therapy that helps counteract the adverse effects of cancer and its treatment (Wilk M et al. 2020).

6.6. Geriatric medicine and aged care

Referral to geriatric medicine teams and aged care services are essential for optimising care for older people with cancer. These teams provide expertise to address the challenges of cancer, ageing, and comorbidities, ensuring treatment aligns with patient goals and supports functional independence and quality of life.

Geriatric medicine and aged care services offer numerous benefits for older people with cancer, including those with recurrent, residual, or metastatic disease. Specialist geriatric medicine teams have an important role in assessing frailty, comorbidities, and functional capacities to guide decisions on treatment de-escalation and goals of care. In cases of worsening frailty or limited prognosis, shifting the focus to comfort and quality of life may be appropriate.

Geriatric medicine and aged care services facilitate care transitions and adaptive care planning that meet the evolving health and support the physical, emotional, and practical needs of older people. Collaboration with palliative care teams is essential to ensure integrated support for symptom management, advance care planning, and end-of-life discussions.

The lead clinician should ensure timely and appropriate referral to geriatric medicine or aged care services. The referral should be based on the older person's need and potential for benefit, rather than prognosis alone.

<insert icon> More information

See section 4.3 'Geriatric medicine and aged care' for more information about their role in the cancer care pathway.

See section X.X 'Supportive care' and section X.X "Palliative care" section for strategies to address multidimensional needs.

See Further considerations – Transitions of healthcare

See Resource list for geriatric oncology resources for health professionals

6.6 Advance care planning

Advance care planning is important for all patients with a cancer diagnosis but especially those with advanced disease. Patients should be encouraged to think and talk about their healthcare values and preferences with family or carers, appoint a substitute decision-maker and consider developing an advance care directive to convey their preferences for future health care in the event they become unable to communicate their wishes.

<insert icon> More information

Refer to Further considerations – Advance care planning for more information and links to resources.

Refer patients and carers to Advance Care Planning Australia <www.advancecareplanning.org.au> or to the Advance Care Planning National Phone Advisory Service on 1300 208 582.

6.7 Palliative care

Early referral to palliative care can improve the quality of life for people with cancer, reduce physical and psychological symptom burden, enhance prognostic awareness, reduce unnecessary health care use and in some cases may be associated with survival benefits (Haines IE 2011; Petrillo LA et al. 2024; Temel JS et al. 2010; Zimmermann C et al. 2014). The treatment team should emphasise the value of palliative care in improving symptom management and quality of life to patients and their carers.

The lead clinician should ensure timely and appropriate referral to palliative care services. Referral to palliative care services should be based on the patient's need and potential for benefit, not prognosis.

<insert icon> More information

Refer to Step 7: End-of-life care for more detailed information and links to resources.

6.8 Research and clinical trials

The treatment team should support the older person with cancer to participate in research and clinical trials where available and appropriate. This includes cancer treatment interventions and supportive care interventions.

For more information visit the Cancer Australia website <www.australiancancertrials.gov.au>

See Principle 7: Research and clinical trials for more information.

Step 7: End-of-life care

<start text box>

Step 7 is concerned with maintaining the person's quality of life and meeting their health, and supportive, cultural and spiritual care needs as they approach the end of life, as well as the needs of their family and carers.

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Some patients with advanced cancer will reach a time when active treatment is no longer appropriate. For older people with comorbidities, it should be recognised that these conditions (for which ongoing treatment may also no longer be appropriate) may significantly contribute to prognosis and end of life needs (González-González AI et al. 2020).

The team needs to share the principles of a palliative approach to care when making decisions with the older person with cancer and their family or carer. End-of-life care is appropriate when the patient's symptoms are increasing and functional status is declining. For many older people this will continue palliative care which commenced concurrently during cancer treatment for locally advanced or metastatic disease, to improve symptoms and quality of life.

7.1 Multidisciplinary palliative care

Shared decision-making should guide end-of-life planning for the older person with cancer including involvement of the multidisciplinary team (Edwards M et al. 2023; Rabben J et al. 2024). It is essential to use a Health Care Interpreter when the person is not proficient in English language. If not already organised, a referral to palliative care services (Iupati S et al. 2023; Johnson MJ et al. 2024; Oluyase AO et al. 2021) should be considered at this stage, with the general practitioner's engagement. This may include inpatient palliative unit access (as required).

The multidisciplinary team may consider seeking additional expertise from these professionals:

- care coordinator/navigator
- clinical psychologist
- clinical nurse specialist or practitioner
- social worker
- palliative medicine specialist
- pain specialist
- pastoral care or spiritual ~~carer~~ advisor
- bereavement counsellor
- therapists, such as music or art
- cultural expert

- Elders and Aboriginal and Torres Strait Islander health professionals

- Health care interpreter

- Speech pathologist

- Dietician

- Wound care specialist.

The team might also recommend that patients access these services:

- home and community-based care (including community based aged care services)
- specialist community palliative care workers
- community nursing

- residential aged care.

If not already in place, the older person should be encouraged to develop an advance care plan (Goswami P 2023; Lin C-P et al. 2019) and consider appointment of a substitute decision maker if they are unable to make decisions for themselves (see Further considerations - Advance care planning). The multidisciplinary care team should identify who will act as the lead health professional and communicate with the older person and their identified carer/family who they wish to support these conversations.

As end of life approaches these discussions should address:

- the person's needs and preferences regarding the cultural and spiritual aspects of care, including requirements close to and following death
- the most appropriate place for care with understanding of the person's preferred place of care and preferred place of death and the support needed for the patient, their family and carers (Pinto S et al. 2024)
- Goals of care should specifically discuss the cessation of anti-cancer therapies, role of investigations, invasive interventions (parenteral fluids, antibiotics), and role of hospitalisation.

The treatment team should identify who is the appropriate person to provide care in partnership with the older person and identified carer; and also ensure that carers and families receive the information, support and guidance about their role according to their needs and wishes (PCA 2018). This includes information about what to do after death particularly if care is at home, including processes to make funeral arrangements.

<insert icon> More information

The treatment team can refer patients and carers to these resources:

- Palliative Care Australia <www.palliativecare.org.au>
- Advance Care Planning Australia <www.advancecareplanning.org.au> or to Advance Care Planning Australia's National Advisory Service on 1300 208 582.
- What matters most for older Australians <https://palliativecare.org.au/campaign/what-matters-most-for-older-australians/>
- Caresearch <https://www.caresearch.com.au/Community> The community centre is for everyone, particularly those directly affected by the need for palliative care. A place to learn about end of life and what you can do for yourself or the person you care for.
- What to do when someone dies <https://www.servicesaustralia.gov.au/what-to-do-when-someone-dies?context=60101>

7.2 Research and clinical trials

Clinical trials may help improve palliative care and in managing a patient's symptoms of advanced cancer (Cancer Council Victoria 2019). The treatment team should support the person with cancer to participate in research and clinical trials where available and appropriate.

For more information visit the Cancer Australia website <www.australiancancertrials.gov.au>.

See Principle 7: Research and clinical trials

See the Resource list for additional clinical trial databases.

7.3 Support and communication

7.3.1 Supportive care

An individualised clinical assessment is required to assess and meet the needs of older people with cancer at end of life, and this should include screening followed by subsequent assessment for physical, psychosocial, spiritual and existential needs supported by validated tools (ACI 2024). Assessment should include proactive identification of future issues which may occur as end-of-life approaches (for example increasing physical care needs, potential symptoms, carer distress).

A specific needs assessment for carer(s) should also be undertaken and regularly re-evaluated, with tailored support provided. The carer of an older person may also have health issues of their own so encouragement to seek appropriate health care (through their general practitioner and/or specialists) may be also required. Assessment of the presence of anticipatory grief and of risk of prolonged grief disorder should be undertaken and a plan for ongoing support into bereavement put in place.

Specific needs associated with end-of-life care for older people may include the following:

Psychological needs

Assistance for dealing with emotional, psychological and existential distress including from anticipatory grief, fear of death or dying, anxiety/depression and interpersonal problems.

Comorbid mental health conditions.

Physical needs

Management of current and potential future physical symptoms including pain, nausea and vomiting, breathlessness, fatigue, constipation, insomnia, cognitive changes and symptoms of delirium (e.g. confusion, perceptual disturbances, agitation).

Medication review and consideration of deprescribing of medications which are not offering benefits, causing adverse effects or contributing to quality of life. Adverse effects from medication interactions and changes in medication pharmacokinetics due to weight loss, renal and/or hepatic function can be common.

Current and future needs related to decline in mobility or functional status, which may impact the person's location of care, ability to transition between care settings (hospital to home) and/or require additional equipment or care supports for personal care (a referral to physiotherapy, occupational therapy or social work may be needed), and access to specialised equipment (hospital bed, shower chair, hoist)).

Change in ability to swallow safely, which may require adjustment in route of essential medications and also lead to risk of aspiration.

Reduced appetite and oral intake may require a response to the distress this can cause the person and their carer(s) but also require discussion about goals of oral intake to support quality of life.

Social and practical needs

Support for current activities of daily living and instrumental activities of daily living.

Putting plans in place for anticipated needs for future deterioration.

Support may be needed to facilitate the appointment of a substitute decision-maker and completion of an advance care plan.

Guidance on how to approach legal issues (completing a will, care of dependents) and making an insurance, superannuation or social security claim on the basis of terminal illness or permanent disability.

Recognition that the carer's needs for support and assistance may increase due to the additional burden of care if planning for death at home. Carers should be directed to community-based services to access available practical support, respite care and/or financial support.

Education and information about medications and their administration (including subcutaneous route is relevant); and planning for required prescriptions and adequate supply.

Arranging a funeral.

Spiritual care

Older people with cancer and their carer(s)/families should have access to spiritual support appropriate to their needs throughout the cancer journey.

These services and resources can help:

referral to 13 11 20 for Cancer Council Australia's Pro Bono Program for free legal, financial, small business accounting and workplace assistance (subject to a means test)

Sad news sorry business (Queensland Health 2015) for the specific needs of Aboriginal and Torres Strait Islander people.

Caring at home caring@home aims to increase access to quality and timely end-of-life care for patients who choose to be cared for, and die at home, if possible.< https://www.caringathomeproject.com.au/>

Carer Gateway Australia https://www.carergateway.gov.au/

Carer payment https://www.servicesaustralia.gov.au/carer-payment

For more information on supportive care and needs that may arise for different population groups, see Appendices A, B and C.

7.3.2 Communication with patients, carers and families

Communication around end-of-life care (Engel M et al. 2023; Pointon S et al. 2024; Pusa S et al. 2024) should:

take into account the person's preferred language for communication, and use a health care interpreter

be open to and encouraging discussion with the person about the expected disease course (Nahm SH et al. 2024) (which may include discussion of comorbidities other than the underlying cancer), considering the person's personal and cultural beliefs and expectations

discuss palliative care options, including inpatient and community-based services as well as care at home and/or dying at home and subsequent arrangements

provide the person and carer with an introduction to the palliative care service and what to expect. Where possible if this can be personalised with joint clinical consultation/phone call or introduction by name to the specific clinician this can facilitate the referral and its acceptance.

be supported by written and other accessible format information about the palliative and end of life plan

Consider ways of delivering virtual care successfully as part of palliative care when required.

7.3.3 Communication with the general practitioner

The lead clinician should discuss end-of-life care planning to ensure the person's needs and goals are met in the appropriate environment. The patient's general practitioner should be kept fully informed and involved in major developments in the patient's illness trajectory.

<insert icon> More information

For support with communication skills and training programs, see these sources:

Communication at end of life <https://www.palliaged.com.au/Practice-Centre/Improving-Practice/Communication-at-End-of-Life>

Virtual care palliative care resources
https://aci.health.nsw.gov.au/networks/palliative-care/resources/virtual

The waiting room revolution https://www.waitingroomrevolution.com

Sad news sorry business
<www.health.qld.gov.au/__data/assets/pdf_file/0023/151736/sorry_business.pdf>
Principle 6: Communication
Further considerations – Primary care engagement

7.4 Voluntary assisted dying

A person who has advanced cancer who meets strict criteria can request access to voluntary assisted dying. It must be voluntary and requested by the person themselves.

As voluntary assisted dying is legislated by state and territory governments, it is essential to know the law and rules around this choice in the State or Territory where the patient lives. Contact your State's health department for the latest voluntary assisted dying information relevant to your State.

<insert icon> More information

https://www.eldac.com.au/Our-Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview

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Our thanks to the following health professionals, consumer representatives, stakeholders and organisations consulted in developing this optimal care pathway.

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PHN's
Murrumbidgee PHN
Nepean Blue Mountains PHN
South Western Sydney PHN
Western NSW PHN
Western Sydney PHN
Central and Eastern Sydney PHN
Hunter New England and Central Coast PHN
North Coast PHN
Northern Sydney PHN
South Eastern NSW PHN
Eastern Melbourne PHN
Murray PHN
North Western Melbourne PHN
Gippsland PHN
Western Victoria PHN
South Eastern Melbourne PHN
Darling Downs and West Moreton PHN
Brisbane North PHN
Brisbane South PHN
Central Queensland, Wide Bay, Sunshine

Coast PHN
Gold Coast PHN
Northern Queensland PHN
Western Queensland PHN
Adelaide PHN
Country SA PHN
Perth North PHN
Country WA PHN
Perth South PHN
Tasmania PHN
ACT PHN
Northern Territory PHN

Health services/systems (state level)
NSW Health
Dept. of Health Victoria
WA Health
QLD Health
NT Health
ACT Health
SA Health

Dept. of Health Tasmania
Local Health Districts

Aboriginal and Torres Strait Islander Organisations

Aboriginal Health and Medical Research Council (AH&MRC)

Australian Indigenous Doctors Association (AIDA)

Indigenous Allied Health Australia

National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners

Professional colleges and societies

Advance Care Planning Australia

Allied Health Professions Australia

Australasian Chapter of Palliative Medicine, Royal Australia College of Physicians

Australian and New Zealand Society for Geriatric Medicine

Australian and New Zealand Society of Palliative Care

Australian Association of Gerontology (AAG)

Australian Cancer Survivorship Centre

Australian College of Nursing

Australian Medical Association

Australian Private Hospitals Association

Australian Society of Anaesthetists

Australian Society of Medical Imaging and Radiation Therapy

Cancer Nurses Society of Australia

Clinical Oncology Society of Australia

Council of the Ageing (COTA)

International Society of Geriatric Oncology (SIOG)

Interventional Radiology Society of Australasia

Medical Oncology Group of Australia

Oncology Social Workers Australia and New Zealand

Private Cancer Physicians of Australia (PCPA)

Royal Australasian College of Physicians

Royal Australasian College of Surgeons

Royal Australian and New Zealand College of Radiologists

Royal Australian College of General Practitioners

Royal College of Pathologists of Australasia

Society of Hospital Pharmacists of Australia (SHPA)

Cancer Cooperative Trials Groups

Australasian Gastro-Intestinal Trials Group (AGITG)

Australasian Leukaemia & Lymphoma Group (ALLG)

Australia and New Zealand Sarcoma Association (ANZSA)

Australian and New Zealand Children's Haematology and Oncology Group (ANZCHOG)

Australian and New Zealand Urogenital and Prostate Cancer Trials Group (ANZUP)

Australia New Zealand Gynaecological Oncology Group (ANZGOG)

Breast Cancer Trials (BCT)

Cancer Symptom Trials (CST)

Cooperative Trials Group for Neuro-Oncology (COGNO)

Melanoma and Skin Cancer Trials (MASC Trials)

Primary Care Collaborative Cancer Clinical Trials Group (PC4)

Psycho-oncology Cooperative Research Group (PoCoG)

Thoracic Oncology Group Australasia (TOGA)

TransTasman Radiation Oncology Group (TROG).

Aged care service providers

Calvary Healthcare

Consumer Representatives & Organisations

Can Assist

Cancer Voices Australia

CarerHelp

Older Persons Advocacy Network (OPAN)

Dementia Australia

Advocacy Groups

Bowel Cancer Australia

Breast Cancer Network Australia

Cancer Council Australia (and State and Territory bodies)

Leukaemia Foundation

Lung Foundation Australia

McGrath Foundation

National Breast Cancer Foundation

Ovarian Cancer Australia

Prostate Cancer Foundation Australia

Rare Cancers Australia

Appendix A: Supportive care domains

Supportive care in cancer refers to the following domains:

the physical domain, which includes a wide range of physical symptoms that may be acute, relatively short lived or ongoing, requiring continuing interventions or rehabilitation

the psychological domain, which includes a range of issues related to the patient’s mental health wellbeing and personal relationships

the emotional domain, which includes a range of responses to stressful life events, including anger, despair, fear or hopelessness

the social domain, which includes a range of social and practical issues that will affect the patient, carer and family such as the need for emotional support, maintaining social networks and financial concerns and access to practical support services such as transport and domestic assistance to optimise independent functioning in the community

the information domain, which includes access to information at the appropriate literacy level and in community languages, about cancer and its treatment, recovery and survivorship support services and the health system overall

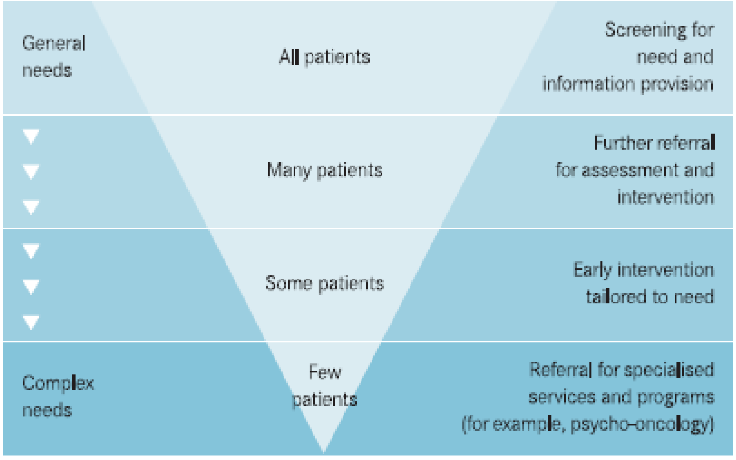
the practical domain, which includes focus on day-to-day activities such as managing finances, childcare, housekeeping or legal affairs

the spiritual domain, which focuses on the patient’s changing sense of self and challenges to their underlying beliefs and existential concerns~~.~~

Fitch’s (2008) model of supportive care (Figure A1) recognises the variety and level of intervention required at each critical point as well as the need to be specific to the individual (Fitch M 2008). The tiered approach to supportive care recognises that all patients should have opportunity for supportive care needs screening and provision of information; many will require further assessment and intervention; some will need tailored, early intervention, while few patients will need referral for specialised support such as psycho-oncology. The model targets the type and level of intervention required to meet an older person’s supportive care needs.

Figure A1: Fitch’s tiered approach to supportive care

Figure 1: The tiered approach



Appendix B: Psychological needs

Older people who have had a cancer diagnosis may have a range of psychological supportive care needs. Psychological distress, fear of cancer recurrence and progression, and psychological challenges resulting from cancer-related cognitive impairment are common in older people who have had a cancer diagnosis (Haywood D et al. 2024a; Haywood D et al. 2024b; Lee A 2023).

Consider a referral to a psychologist, psychiatrist, pastoral/spiritual care practitioner, social worker, specialist nurse or a relevant community-based program if the patient has these issues:

- displaying emotional cues such as tearfulness, distress that requires specialist intervention, avoidance or withdrawal
- being preoccupied with or dwelling on thoughts about cancer and death
- displaying fears about the treatment process or the changed goals of their treatment
- displaying excessive fears about cancer progression or recurrence
- worrying about loss associated with their daily function, dependence on others and loss of dignity
- becoming isolated from family and friends and withdrawing from company and activities that they previously enjoyed
- feeling hopeless and helpless about the effect that cancer is having on their life and the disruption to their life plans
- struggling to communicate with family and loved ones about the implications of their cancer diagnosis and treatment
- experiencing changes in sexual intimacy, libido and function
- struggling with the diagnosis of metastatic or advanced disease
- having difficulties quitting smoking (refer to Quitline on 13 7848) or with other drug and alcohol use
- having difficulties transitioning to palliative care.

Additional considerations that may arise for the multidisciplinary team include:

- support for the carer – encourage referrals to psychosocial support from a social worker, psychologist or general practitioner
- referral to an exercise physiologist or physiotherapist as a therapeutic approach to prevent and manage psychological health
- referral to wellness-after-cancer programs to provide support, information and offer strategies.

Appendix C: Special population groups

The burden of cancer is not evenly spread across Australia. People experiencing socioeconomic disadvantage, Aboriginal and Torres Strait Islander communities, culturally diverse communities, people living with a disability, people with chronic mental health or psychiatric concerns and those who live in regional and rural areas of Australia have poorer cancer outcomes.

Aboriginal and Torres Strait Islander people

Cancer is the third leading cause of burden of disease for Aboriginal and Torres Strait Islander people. While Australia's cancer survival rates are among the best in the world, Aboriginal and Torres Strait Islander people continue to experience a different pattern of cancer incidence and significant disparities in cancer outcomes compared with non-Indigenous Australians.

For Aboriginal and Torres Strait Islander people, health and connection to land, culture, community and identity are intrinsically linked. Health encompasses a whole-of-life view and includes a cyclical concept of life–death–life.

The distinct epidemiology of cancer among Aboriginal and Torres Strait Islander people, and unique connection to culture, highlight the need for a specific optimal care pathway for Aboriginal and Torres Strait Islander people with cancer. Ensuring this pathway is culturally safe and supportive is vital to tackling the disparities for Aboriginal and Torres Strait Islander people.

Published in 2018, the *Optimal care pathway for Aboriginal and Torres Strait Islander people with cancer* provides guidance to health practitioners and service planners on optimal care for Aboriginal and Torres Strait Islander people with cancer across the cancer continuum.

In addition to the key principles underpinning cancer-specific pathways, these are the key concepts that are fundamental to Aboriginal and Torres Strait Islander health:
providing a holistic approach to health and wellbeing
providing a culturally appropriate and culturally safe service
acknowledging the diversity of Aboriginal and Torres Strait Islander peoples
understanding the social determinants and cultural determinants of health (Cancer Australia 2015).

To view the *Optimal care pathway for Aboriginal and Torres Strait Islander people with cancer*, visit the Cancer Australia website <https://www.canceraustralia.gov.au/affected-cancer/atsi/resources-health>. To view the consumer resources – *Checking for cancer* and *Cancer*, visit the Cancer Australia website <https://www.canceraustralia.gov.au/affected-cancer/atsi/resources-people>.

Culturally diverse communities

For people from culturally diverse backgrounds in Australia, a cancer diagnosis can come with additional complexities, particularly when English proficiency is poor. In many languages there is not a direct translation of the word ‘cancer’, which can make communicating vital information difficult. Perceptions of cancer and related issues can differ greatly in people from culturally diverse backgrounds and this can affect their understanding and decision-making after a cancer diagnosis. In addition to different cultural beliefs, when English language is limited there is potential for miscommunication of important information and advice, which can lead to increased stress and anxiety for patients.

A professionally trained interpreter (not a family member or friend) should be made available when communicating with people with limited English proficiency. Navigation of the Australian healthcare system can pose problems for those with a non-Anglo culture, and members of the treatment teams should pay particular attention to supporting these patients.

The Australian Cancer Survivorship Centre has developed a glossary of more than 700 cancer terms in nine different languages. The multilingual glossary has been designed as a resource for professional translators, interpreters and bilingual health professionals working in the cancer field. The glossary is a unique tool that enables language professionals with access to accurate, consistent and culturally appropriate terminology.

Visit the Peter Mac website <www.petermac.org/multilingualglossary> to see the glossary.

People with disabilities

Disability, which can be physical, intellectual or psychological, may have existed before the cancer diagnosis or may be new in onset (occurring due to the cancer treatment or incidentally). Adjusting to life with a disability adds another challenge to cancer care and survivorship.

Several barriers prevent people with disabilities from accessing timely and effective health care (AIHW 2017):
physical limitations
competing health needs
the trauma of undergoing invasive procedures
potential barriers associated with obtaining informed consent
failure to provide assistance with communication
lack of information
discriminatory attitudes among healthcare staff.

In caring for people with disabilities and a cancer diagnosis, the Australian Institute of Health and Welfare disability flag should be used at the point of admittance to correctly identify and meet the additional requirements of a person with disability. Facilities should actively consider access requirements, and health practitioners should make reasonable adjustments where required.

Patients aged between seven and 65 years who have a permanent or significant disability may be eligible for support or funding through the National Disability Insurance Scheme (National Disability Insurance Agency 2018). More information can be found on the NDIS website <www.ndis.gov.au>.

Patients aged 65 years or older (50 years or older for Aboriginal or Torres Strait Islander people) may be eligible for subsidised support and services through aged care services. An application to determine eligibility can be completed online over the phone. More information can be found at the My Aged Care website <www.myagedcare.gov.au>.

<insert icon> More information

‘Talking End of Life’ is a resource that shows how to teach people with intellectual disability about end of life. It is designed for disability support workers but is also helpful for others including families, health professionals and educators.

To view the resource, visit the Talking End of Life website <www.caresearch.com.au/tel/tabid/4881/Default.aspx>.

People experiencing socioeconomic disadvantage

In general, people from lower socioeconomic groups are at greater risk of poor health, have higher rates of illness, disability and death, and live shorter lives than those from higher socioeconomic groups (AIHW 2016). People experiencing socioeconomic disadvantage are less likely to participate in screening programs, more likely to be obese, less likely to exercise and much more likely to smoke, which are all risk factors for cancer. In 2010–2014 age-standardised cancer incidence rates were higher in the lowest socioeconomic areas compared with the highest socioeconomic areas for all cancers combined (Cancer Australia 2019a).

Socioeconomic status and low health literacy are closely correlated. Therefore, effective communication with patients and carers is particularly important given the prevalence of low health literacy in Australia (estimated at 60 per cent of Australian adults) (ACSQHC 2014).

Consideration should be taken for people with cancer experiencing socioeconomic disadvantage to reduce their risk of being underserved for health care.

People with chronic mental health or psychiatric concerns

A diagnosis of cancer may present additional challenges to people who have pre-existing chronic mental health or psychiatric concerns, resulting in exacerbation of their mental health symptoms. This may include heightened anxiety, worsening depression or thoughts of self-harm.

As poor adjustment and coping can affect treatment decisions, people who are known to have a mental health diagnosis need psychosocial assessment in the oncology setting to formulate a plan for ongoing support throughout treatment.

Psychosocial support can assist with challenges in communicating with health professionals, enhance understanding of the treatment journey, ensure capacity for consent to treatment options and improve compliance with treatment requests. A referral for psychosocial support from a health professional to the psycho-oncology team can ensure these patients are provided with targeted interventions or referrals to community-based services that may mitigate problems associated with the impacts of social isolation that frequently accompany chronic mental ill-health.

Many patients with chronic mental health problems may be well known to external service providers. Psycho-oncology health professionals can form meaningful partnerships with existing service providers to optimise patient care throughout treatment and beyond.

Drug use disorders fall within the area of mental health conditions. People who are opiate dependent may have specific and individual requirements regarding pain management and their own preference for type of opiate prescribed or used.

Sexually and gender diverse groups

People who identify as sexually or gender diverse may have unique needs following a cancer diagnosis. Sexually or gender diverse identities include (but are not limited to) people who identify as lesbian, gay, bisexual or transgender, collectively ‘LGBT’. There is no universally agreed upon initialism to describe this community, with other terms such as queer/questioning (Q), intersex (I), asexual (A) and pansexual (P) often included, as well as a plus symbol (+) indicating inclusivity of other identities not explicitly mentioned.

Sexual orientation and gender identity are relevant across the entire spectrum of cancer care, from prevention to survivorship and end-of-life care. LGBT people are less likely to participate in cancer screening, and some segments of the LGBT community exhibit elevated rates of specific cancer risk factors – for example, higher rates of smoking and alcohol use. Regarding treatment, there may be unique factors relevant to LGBT people that may affect decision-making. Additionally, the LGBT population experiences higher rates of anxiety, depression and stressful life circumstances, and may be at risk of inferior psychosocial outcomes following a cancer diagnosis. LGBT people are also more likely to be estranged from their families of origin, and for older people, less likely to have adult children who may provide support and care.

Barriers to care for LGBT people include past negative interactions with healthcare systems, experiences or fear of discrimination and harassment in healthcare settings, assumptions of cisgender/heterosexual identity, lack of recognition or exclusion of same-sex partners from care, and a lack of relevant supportive care and information resources.

To provide safe and appropriate care for LGBT people with cancer, healthcare providers should:

- display environmental cues to show an inclusive and safe setting for LGBT patients
- avoid assumptions about the sexual orientation or gender identity of patients and their partners
- facilitate positive disclosure of sexual orientation or gender identity

include same-sex/gender partners and families of choice in care
be aware of relevant supportive care and information resources
provide non-judgemental, patient-centred care.

Appendix D: Complementary therapies

Complementary therapies may be used together with conventional medical treatments to support and enhance quality of life and wellbeing. They do not aim to cure the patient's cancer. Instead, they are used to help control symptoms such as pain and fatigue (Cancer Australia 2019b).

The lead clinician or health professional involved in the patient's care should discuss the patient's use (or intended use) of complementary therapies not prescribed by the multidisciplinary team to assess safety and efficacy and to identify any potential toxicity or drug interactions.

The lead clinician should seek a comprehensive list of all complementary and alternative medicines being taken and explore the patient's reason for using these therapies and the evidence base. A transparent and honest discussion that is free from judgement should be encouraged.

While some complementary therapies are supported by strong evidence, others are not. For such therapies, the lead clinician should discuss their potential benefits and use them alongside conventional therapies (NHMRC 2014).

If the patient expresses an interest in using complementary therapies, the lead clinician should consider referring patients to health providers within the multidisciplinary team who have expertise in the field of complementary and alternative therapies (e.g. a clinical pharmacist, dietitian or psychologist) to assist them to reach an informed decision. Costs of such approaches should be part of the discussion with the patient and considered in the context of evidence of benefit.

The lead clinician should assure patients who use complementary therapies that they can still access a multidisciplinary team review and encourage full disclosure about therapies being used.

<insert icon> More information

See the Clinical Oncology Society of Australia's position statement *Use of complementary and alternative medicine by cancer patients*. <www.cosa.org.au/media/1133/cosa_cam-position-statement_final_new-logo.pdf

Appendix E: Members of the multidisciplinary team for older people with cancer

The multidisciplinary team (MDT) may include the following members (in alphabetical order):

Aboriginal health practitioner

Anaesthetist

Bereavement counsellor

Cancer Nurse

Care coordinator/navigator

Dietitian

Exercise Physiologist

General Practitioner (GP)

Geriatrician

Geriatric nurse

Health care interpreter

Medical Oncologist

Nurse practitioner

Occupational Therapist

Other Specialist Physicians (e.g., Cardiologists, Nephrologists)

Other nurses (e.g. community health, inpatient care, aged care)

Palliative Care Specialist

Palliative Care Nurse

Pharmacist

Physiotherapist

Psychologist

Radiation Oncologist

Residential or home aged care staff

Social Worker

Surgeon

Speech pathologist

Spiritual/pastoral care provider

Wound care specialist

Core members of the MDT undertaking cancer treatment decision-making will align with cancer specific Optimal Care Pathway recommendations.

The core members for a geriatric oncology specific multidisciplinary team (Gómez-Moreno C et al. 2022) should be tailored to the identified geriatric domains and may vary throughout the cancer journey.

Appendix F: Geriatric domains

Commonly screened/assessed geriatric domains, examples of measures/tools that apply to the domain and recommended care if a deficit or unmet need is identified.

Domain	Measure/Tool	Recommendations if impairments found[1,2]
Mobility/ performance	Physical Function Objective tests • Timed Up and Go (TUG)[3] • Gait-speed[4] • Short physical performance battery[5] Self reported • Falls	• Refer for individualised physical activity interventions (exercise) by a physiotherapist or exercise specialist. Consider strength and balance training. • Gait/assistive device evaluation • Assess falls risk factors and environment modifications (e.g. footwear, syncope, medications, home environment) • Consider prehabilitation / rehabilitation
Functional status	Self reported • Activities of Daily Living (Katz)[6] • Instrumental Activities of Daily Living (Lawton)[7]	• Consider treatment modification to reduce toxicity. • Occupational therapist intervention to support independence and modifications for ADLs and iADLs
Nutrition status / weight loss / sarcopenia	• Mini Nutritional Assessment (MNA)[8] • Malnutrition Screening Tool (MST)[9] • G8[10] screening tool contains MNA questions	• Dietitian referral to support nutrition interventions (e.g. nutrition counselling, high protein high energy diets or oral nutrition supplementation) • Address barriers to oral intake (e.g. physical symptoms, oral health, psychological, financial or food access barriers) • Practical supports for access to food (e.g. meal preparation, grocery shopping assistance)
Social support Social Activity Interference	• Medical Outcomes Study Social Support Survey (MOS-SSS)[11,12]	• Referral to Social Worker to assess supports available • Assist access to community support services (e.g. transport, financial, medication management, shopping/meal preparation)
Medication usage	• Beers Criteria[13] • STOPP/START[14] criteria • OncoSTRIP[15] • OncPal[16]	• Medication review by a Pharmacist, GP or Geriatrician to optimise medication management and reduce the risk of drug related problems eg unnecessary or potentially inappropriate medications • Assess for potential drug interactions. • Deprescribing especially in context of palliative care.
Psychological Health	• Distress Thermometer[17] • PROMIS Anxiety 4-item[18,19] • Geriatric Depression Score (GDS-5)[20]	• Refer to mental health supports (e.g. CBT) • Consider pharmacotherapy for severe, persistent anxiety or depression
Comorbidity	• Charlson Comorbidity[21] Index • CIRS-G[22,23]	• Collaborate with GPs/Geriatricians/other specialists to optimise management and assess treatment safety

	• OARS[24]	• Input of a geriatrician may be helpful for those with multiple chronic conditions assessed as being pre-frail or frail
Cognitive Function	• Mini-Cog[25] • Mini-Mental State Examination (MMSE)[26] • Montreal Cognitive Assessment (MoCA)[27] • Kimberly Indigenous Cognitive Assessment Tool (KICA)[28]	• Consider the impact of mood (depression), delirium (acute brain failure), brain injury or intellectual disability on cognition to ensure appropriate assessment and care can be provided • If cognitive impairment is identified, consider capacity for consent, supports required during treatment and the impact of cancer-related cognitive impairment • Consider referral to a geriatrician, neuropsychology, and/or occupational therapist for further diagnosis and assessment • Information should be provided in a suitable format, considering sensory impairments and health and overall literacy i.e. simple terms, written instructions and involving carers/family where possible and appropriate
Sensory & language	Hearing Vision Language Literacy	• Ensure access to vision/hearing aids • Use strategies to support understanding including use of personal voice amplifiers or written materials with large text • Proactively involve carers/family in consultations with consent of the patient • Provide written materials which are at the appropriate reading level • Involve a healthcare interpreter if impaired language and/or simple English/pictorial resources to support understanding
Life expectancy Frailty assessment tools	Web-based calculators • ePrognosis.org Lee[29]-Schonberg[30] Index • eFrailty.org eg Clinical Frailty Index[31]	• ePrognosis.org Estimates of life expectancy (in the absence of cancer) can assist with decision-making especially in relation to adjuvant therapy. • eFrailty.org Frailty assessment is crucial for providing individualized treatment and prognosis at the personal level
Chemotherapy toxicity	CARG chemotherapy toxicity calculator[32]	• www.mycarg.org A validated tool for predicting the toxicity of chemotherapy. More accurate than simply using performance status (Not used for immunotherapy or targeted therapy toxicity).

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Resource list

For older people with cancer ~~patients~~, families and carers

Advance Care Planning Australia

Advance Care Planning Australia provides national advance care planning resources for individuals, families, health professional and service providers. Resources include a national advisory service, information resources, a legal forms hub and education modules.

Telephone: 1300 208 582
Website <www.advancecareplanning.org.au>

Australian Cancer Survivorship Centre

The Australian Cancer Survivorship Centre has developed information resources and events to help people move from initial treatment to post treatment and beyond, including those receiving maintenance treatments. While they do not provide clinical advice, they connect with a range of providers to enable improved care.

Telephone: (03) 8559 6220
Website <www.petermac.org/cancersurvivorship>

Australian Commission on Safety and Quality in Health Care

The Australian Commission on Safety and Quality in Health Care has developed a resource for patients and carers explaining the coordination of care that patients should receive from their health service during cancer treatment. The resource is called *What to expect when receiving medication for cancer care* <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/what-expect-when-receiving-medication-cancer-care>.

Beyond Blue

Beyond Blue provides information about depression, anxiety and related disorders, as well as about available treatment and support services.

Telephone: 1300 22 4636
Website <www.beyondblue.org.au>

Cancer Council's Cancer Information and Support Service

Cancer Council 13 11 20 is a confidential telephone support service available to anyone affected by cancer. This service acts as a gateway to evidence-based documented, practical and emotional support available through Cancer Council services and other community organisations. Calls will be answered by a nurse or other oncology professional who can provide information relevant to a patient's or carer's situation. Health professionals can also access this service.

Telephone: 13 11 20 – Monday to Friday, 9.00am to 5.00pm (some states have extended hours)

Website www.cancer.org.au/about-us/state-and-territory-councils/

Cancer Council Australia: Caring for Someone with Cancer
<https://www.cancer.org.au/assets/pdf/caring-for-someone-with-cancer-booklet>

Cancer Council's Cancer Connect

Cancer Connect is a free and confidential telephone peer support service that connects someone who has cancer with a specially trained volunteer who has had a similar cancer experience.

A Connect volunteer can listen with understanding and share their experiences and ways of coping. They can provide practical information, emotional support and hope. Many people newly diagnosed with cancer find this one-to-one support very beneficial.

For more information on Cancer Connect call Cancer Council on 13 11 20.

Carers Australia

Carers Australia provides a range of information and supports to carers, such as NDIS, Aged Care and advanced care planning.

Website <https://www.carersaustralia.com.au/>

Website https://www.carersaustralia.com.au/support-for-carers/carer-gateway/

Clinical trial information

For a collection of clinical trials available in Australia see the following sources of information:
Australian clinical trials <www.australianclinicaltrials.gov.au>
Australian New Zealand Clinical Trials Registry <www.anzctr.org.au>
ClinicalTrials.gov <www.clinicaltrials.gov>.

CanEAT pathway

A guide to optimal cancer nutrition for people with cancer, carers and health professionals.
Website <https://education.eviq.org.au/courses/supportive-care/malnutrition-in-cancer>
Website <https://patients.cancer.nsw.gov.au/coping-with-cancer/physical-wellbeing/eating-well>

Elder Abuse

Contact the national elder abuse phone line, 1800ELDERHelp, 1800 353 374. This is an Australian government service that will connect callers with the service in their state or territory.

Phone: 1800 353 374

Website: https://www.betterhealth.vic.gov.au/health/servicesandsupport/elder-abuse

Guides to best cancer care

The short guides help patients, carers and families understand the optimal cancer care that should be provided at each step. They include optimal timeframes within which tests or procedures should be completed, prompt lists to support patients to understand what might happen at each step of their cancer journey and to consider what questions to ask, and provide information to help patients and carers communicate with health professionals.

The guides are located on an interactive web portal, with downloadable PDFs available in multiple languages.
Website <www.cancercareguides.org.au>

Best cancer care guides are available for Aboriginal and Torres Strait Islander people:
Checking for cancer – what to expect
<https://www.canceraustralia.gov.au/sites/default/files/publications/checking-cancer-what-expect/pdf/checking_for_cancer_what_to_expect.pdf>

Cancer – what to expect
<https://www.canceraustralia.gov.au/sites/default/files/publications/cancer-what-expect/pdf/cancer_what_to_expect.pdf>

Look Good, Feel Better

A free national community service program, run by the Cancer Patients Foundation, dedicated to teaching people with cancer how to manage the appearance-related side effects caused by treatment for any type of cancer.
Telephone: 1800 650 960
Website <https://lgfb.org.au>

My Aged Care

My Aged Care provides information about aged care services for people who need some help around the house or want to look into aged care homes. People can find information, refer themselves or a family member, find aged care providers and manage their services through the website or telephone number.

Telephone:1800200422

Website www.myagedcare.gov.au

National Seniors Australia

This is not cancer related but is a fantastic resource for people who may be worried about/have questions about money, bills, concessions, retirement, thinking about aged care/residential care, ageism, elder abuse, healthcare access and affordability, etc.

Website https://nationalseniors.com.au/

OlderCan

OlderCan resources provide advice and support to help older people make decisions about treatment and care, and to make sure that their GP and cancer team are aware of information that is important to an older person with cancer.

OlderCan’s This is ME resource can be used to share important information with the GP and cancer team. <wecan.org.au/oldercan/cancer-diagnosis/this-is-me/ >

Website <https://wecan.org.au/oldercan/>

Palliative Care Australia

Palliative Care Australia (PCA) is the national peak body for palliative care. PCA believes high quality palliative care should be available and accessible to people living with a life-limiting illness when and where they need it. PCA supports the health, aged care and community sector workforce who all have a role in providing palliative care to people with a life-limiting illness and supporting carers and loved ones.

Website for patients: <https://palliativecare.org.au/im-a-patient/>

Website for carers: <https://palliativecare.org.au/im-a-carer/>

Quitline

Quitline is a confidential, evidence-based telephone counselling service. Highly trained Quitline counsellors use behaviour change techniques and motivational interviewing over multiple calls to help people plan, make and sustain a quit attempt.

Quitline is a culturally inclusive service for all, and Aboriginal counsellors are also available. Health professionals can refer patients to Quitline online or via fax.
Telephone: 13 7848
Website <www.quit.org.au> or the relevant website in your state or territory.

For health providers

Australian Cancer Survivorship Centre

The Australian Cancer Survivorship Centre provides expertise in survivorship care, information, support and education. Its purpose is to support and enable optimal survivorship care.
Telephone: (03) 8559 6220
Website <www.petermac.org/cancersurvivorship>

Australian Commission on Safety and Quality in Health Care

The Australian Commission on Safety and Quality in Health Care has developed a guide for clinicians containing evidence-based strategies to support clinicians to understand and fulfil their responsibilities to cancer patients people with cancer. This guide is particularly relevant to steps 3 to 6 of the optimal care pathway. The guide is titled *NSQHS Standards user guide for medication management in cancer care for clinicians* <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-user-guide-medication-management-cancer-care-clinicians>.

Cancer Australia

Optimal Care Pathways and Quick Reference Guides for different cancer types are available for health professionals and health services

Website: https://www.canceraustralia.gov.au/optimal-cancer-care-pathways

An Optimal Care Pathway for Aboriginal and Torres Strait Islander people with cancer is also available:

Optimal care pathway for Aboriginal and Torres Strait Islander people with cancer

<https://www.canceraustralia.gov.au/sites/default/files/publications/Create%20CA%20Publications/pdf/CA-OCP-Aboriginal-and-Torres-Strait-Islander-people-with-cancer-FINAL.pdf>

Optimal care pathway for Aboriginal and Torres Strait Islander people with cancer - quick reference guide

<https://www.canceraustralia.gov.au/sites/default/files/publications/Create%20CA%20Publications/pdf/CA_QRG_Aboriginal_and_Torres_Strait_Islander_people_with_cancer_%20FINAL.pdf>

Cancer Council Australia

Information on prevention, research, treatment and support provided by Australia’s peak independent cancer authority.
Website <www.cancer.org.au>

CanEAT pathway

A guide to optimal cancer nutrition for people with cancer, carers and health professionals.
Website <https://education.eviq.org.au/courses/supportive-care/malnutrition-in-cancer>
Website <https://patients.cancer.nsw.gov.au/coping-with-cancer/physical-wellbeing/eating-well>.

Capacity Australia

Capacity Australia promotes autonomy of decision-making and is a group of dedicated experts with experience in capacity, guardianship, disability, mental health and old age psychiatry.

Website: <https://capacityaustralia.org.au/resources/>

ELDAC – End of Life Directions for Aged Care

ELDAC provides information, guidance, and resources for all aged care staff to support palliative care and advance care planning including:

Website: https://www.eldac.com.au/Our-Toolkits/End-of-Life-Law/Substitute-Decision-Making/Factsheet

Website: www.eldac.com.au/Our-Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview

EveryAGE Counts

EveryAGE Counts is an advocacy campaign aimed at tackling ageism against older Australians. Its purpose is to positively change thinking about ageing, to re-imagine getting older and to set the foundations for current and future generations to age well.

Website: https://www.everyagecounts.org.au/

eviQ

A clinical information resource providing health professionals with current evidence-based, peer-maintained, best practice cancer treatment protocols and information relevant to the Australian clinical environment.

- Website <www.eviq.org.au>

Geriatric 8 (G8) screening tool https://www.eviq.org.au/clinical-resources/assessment-tools/4402-geriatric-8-g8-screening-tool

Vulnerable Elders Survey-13 (VES-13) https://www.eviq.org.au/clinical-resources/assessment-tools/4403-vulnerable-elders-survey-13-ves-13

National Health and Medical Research Council

Information on clinical practice guidelines, cancer prevention and treatment.
Website <www.nhmrc.gov.au>

National Seniors Australia

National Seniors Australia provides links and resources with advice about how to help with concerns older people may raise or disclose when asked what matters to them, including money, bills, concessions, retirement, thinking about aged care/residential care, ageism, elder abuse, healthcare access and affordability.

Website https://nationalseniors.com.au/

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Website https://wecan.org.au/oldercan/

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Health professionals: https://palliativecare.org.au/im-a-health-professional/

Service providers: https://palliativecare.org.au/service-provider/

SIOG – International Society of Geriatric Oncology

Educational Resources for health professionals on a broad range of topics in geriatric oncology

Website: <siog.org/educational-resources/>

WHO ICOPE guidelines

The WHO ICOPE Guidelines provide a useful resource for clinicians who want to know more detailed guidelines about the assessment of and interventions for declines in intrinsic capacity in older people.

Integrated care for older people (ICOPE): guidance for person-centred assessment and pathways in primary care <https://www.who.int/publications/i/item/WHO-FWC-ALC-19.1>

Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity <www.who.int/publications/i/item/9789241550109>

Glossary

advance care directive – a voluntary person-led document that outlines an individual’s values, ~~and~~ preferences, and goals for future health and medical treatment decisions, including their preferred outcomes and care. It is completed and signed by a competent person. It is recognised through specific legislation (statutory) or common law (non-statutory). An advance care directive can also appoint substitute decision-maker(s) who can make decisions about health or personal care on the individual’s behalf if they lose decision-making capacity. An advance care directive~~s~~ focuses on future healthcare and personal care decisions and does not extend to financial matters. It takes effect when an individual loses the capacity to make decisions themselves.

advance care planning – the process of discussing and documenting a person’s values, beliefs and preferences for health and personal care to guide decision-making if they lose the capacity to make or communicate them. It may involve conversations with healthcare providers, family members and substitute decision-makers to ensure the individual’s wishes are understood and respected.

ageism – negative or positive stereotypes, prejudice and/or discrimination against (or to the benefit of) older people on the basis of their chronological age, or on the basis of a perception of them as being ‘old’ or ‘elderly’. Older individuals may experience self-directed ageism (so-called ‘internalised ageism’), ageism within interpersonal relationships, or institutional ageism.

age-friendly – environments, communities, organisations, or healthcare systems that are accessible, inclusive, and supportive of the needs and preferences of older people

alternative therapy – a treatment or practice used in place of conventional medical treatment.

care coordinator – a professional responsible for organising and managing a patient’s healthcare activities across multiple providers to ensure effective and efficient delivery of services. The care coordinator may change over time depending on the patient’s stage in the care pathway, the care setting and the services required.

chemotherapy – systemic anti-cancer therapy using cytotoxic (toxic to cells) medicines

co-design – brings professionals and end-users together to design new services, resources and policies.

cognitive impairment - problems with a person's ability to think, learn, remember, and/or make decisions

complementary therapy – a supportive treatment used in conjunction with conventional medical treatment. These treatments may improve wellbeing and quality of life and help people deal with the side effects of cancer.

Comprehensive geriatric assessment – a multidimensional, multidisciplinary process that identifies medical, social, and functional needs and develops an integrated/coordinated care plan to meet those needs (Parker SG et al. 2018). It builds on geriatric assessment by combining assessment, either by a multidisciplinary team or a single clinician with geriatric expertise, with the management of assessed needs through a multidisciplinary approach

COSA – the Clinical Oncology Society of Australia, the national oncology community bringing together multidisciplinary health professionals across all cancers to advance care and improve outcomes.

end-of-life care – includes physical, spiritual and psychosocial assessment, and care and treatment, delivered by health professionals and ancillary staff. It also includes support of families and carers and care of the patient’s body after their death.

financial toxicity – The negative patient-level impact of the cost of cancer. It is the combined impact of direct out-of-pocket costs and indirect costs and the changing financial circumstances of an individual and their household due to cancer, its diagnosis, treatment, survivorship and palliation, causing both physical and psychological harms, affecting decisions which can lead to suboptimal cancer outcomes (COSA 2022).

frailty – a clinically identifiable state of reduced physiological reserve and increased vulnerability to poorer health and functional outcomes. Frailty becomes more common as people age (Kim DH et al. 2024).

frailty screening tool – a brief questionnaire and/or clinical measure designed to quickly identify people who may be frail or at risk of frailty. Examples include the Vulnerable Elder Survey-13 (Saliba D et al. 2001) and the G-8 (Bellera C et al. 2012) both commonly used in cancer care.

Functional impairment – the reduced ability or inability to perform essential daily tasks. These tasks include basic activities of daily living (ADL), such as bathing, dressing, and toileting, and instrumental activities of daily living (IADL), such as managing finances, using transportation, and preparing meals.

geriatric assessment - a multidimensional assessment of an older person's health across various domains, typically including medical, physical, functional, cognitive, psychological, nutritional, and social factors.

geriatric syndrome – a multifactorial clinical condition that results from underlying states of health vulnerability. Examples include incontinence, falls, pressure ulcers, functional decline, and delirium. These syndromes are more common as people age and can impact quality of life and disability.

health literacy – the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and to take appropriate action**.**

immunotherapy – a type of cancer treatment that helps the body's immune system to fight cancer. Immunotherapy can boost the immune system to work better against cancer or remove barriers to the immune system attacking the cancer.

indicator – a documentable or measurable piece of information regarding a recommendation in the optimal care pathway.

informed financial consent – the provision of cost information to patients, including notification of likely out-of-pocket expenses (gaps), by all relevant service providers, preferably in writing, before admission to hospital or treatment (Commonwealth Department of Health 2017)

intrinsic capacity – the combination of a person's physical and mental capacities (WHO 2017a). These include abilities such as walking, thinking, seeing, hearing, and remembering.

lead clinician – the clinician nominated as responsible overseeing and coordinating a patient's care. The lead clinician may change over time depending on the stage of the care pathway and the setting where care is being provided.

metastatic disease – cancer that has spread from the part of the body where it started (the primary site) to other parts of the body.

multidisciplinary care – an integrated team approach to health care in which medical and allied health providers consider all relevant treatment options and collaboratively develop an individual treatment plan for each patient.

multidisciplinary team – comprises the core disciplines that are integral to providing good care. The team is flexible in approach, reflects the patient's clinical and psychosocial needs and has processes to facilitate good communication.

multidisciplinary team meeting – a meeting of health professionals from one or more clinical disciplines who together make decisions about recommended treatment of patients.

multimorbidity – the coexistence of two or more chronic conditions in the same individual (WHO 2017a)

older person – the definition of an older person varies from country to country. In Australia, the Australian Institute of Health and Welfare defines an older person as someone who is 65 years or older, except for older Indigenous Australians, who are defined as being 50 or older.

optimal care pathway – a framework outlining the key principles and practices required at each stage of the care pathway to guide the delivery of consistent, safe, high-quality and evidence-based care for all people affected by cancer.

performance status – a clinical measure of patient's level of functioning in terms of their ability to care for themself, daily activity, and physical ability (walking, working, etc) (ECOG-ACRIN Cancer Research Group) (reference: https://ecog-acrin.org/resources/ecog-performance-status/)

polypharmacy – the use of five or more medications at the same time

primary care health professional – in most cases this is a general practitioner but may also include general practice nurses, community nurses, nurse practitioners, allied health professionals, midwives, pharmacists, dentists and Aboriginal health workers.

spiritual care – the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.

substitute decision-maker – a person permitted under the law to make decisions on behalf of someone who does not have competence or capacity.

supportive care – care and support that aims to improve the quality of life of people living with cancer, cancer survivors and their family and carers and particular forms of care that supplement clinical treatment modalities.

survivorship – an individual is considered a cancer survivor from the time of diagnosis, and throughout their life; the term includes individuals receiving initial or maintenance treatment, in recovery or in the post-treatment phase.

survivorship care plan – a formal, written document that provides details of a person's cancer diagnosis and treatment, potential late and long-term effects arising from the cancer and its treatment, recommended follow-up, surveillance, and strategies to remain well.

targeted therapy – a medicine that blocks the growth and spread of cancer by interfering with specific molecules.

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