

Dear Editor and reviewers,

Many thanks for taking the time to review this paper. We have tried to address all points as summarised as below. Many thanks for reconsidering.

Yours faithfully

Dr Tania Kalsi

Reviewer 1. Reviewer's code: 03867417

Comment 1: "the authors did not explain how the questionnaire was elaborated, the internal and external validity. The number of patients is enough to validate a questionnaire however this does not eliminate the need for pilot study to check whether the questionnaire has formulation issues."

Response: The questionnaire was internally but not externally validated. We have updated the manuscript to address these points.

In the methods, we have revised to:

"Questionnaire validity was evaluated using a panel of experts (members of the UK Geriatric Oncology Expert Reference Group supported by Macmillan Cancer Support). This expert group included representatives from multiple relevant specialities (medical, clinical and acute oncology, geriatric medicine, surgery, general practitioners (GPs), health & social care researchers) and multiple professions (doctors, nurses, therapists, researchers) and older patients representatives. The panel reviewed the questionnaires readability, content and clarity of words. The content of the questionnaire was iteratively revised accordingly prior to dissemination. "

In the discussion, we have reflected on the need to externally validate this questionnaire with:

"The questionnaire was only internally validated, therefore it would benefit from external validation to exclude problems with the survey design."

Comment 2: "The statistical analysis might benefit from some correlations using uni- and multi-variate analysis."

Response: We described differences between assessment methods favoured by professionals in:

"Clinical history-taking and performance status were favoured assessment methods regardless of profession (table 3). Scoring tools were used far less and were favoured by nurses more than doctors, $p < 0.0001$.

30.5-44.3% of respondents did not use structured methods for assessment or assessment tools to evaluate patient factors such as comorbidities, function, falls or social background. Nurses were significantly more likely to use a structured assessment approach than doctors ($p < 0.001$ for all domains except medications review (0.046))."

Multivariate analysis could not be performed as only basic data on respondents was collected. Therefore, we have included a reflection on this in the discussion:

"We only collected basic data on the background of respondents. Future work should consider collecting more baseline characteristics of respondents to allow for multivariate analysis of factors associated with different assessment preferences."

Comment 3: "Although the authors are native English speakers, I believe that the article would benefit from a review by an English proficient expert in medical writing."

Response: We took this comment on board and had the manuscript reviewed by an English proficient physician familiar with medical writing. We have made a number of changes throughout.

Reviewer 2. Reviewer's code: 00123524

Comment 1. The most important methodological problem that I identify relates to the denominator of the proportions that were calculated and used for inferences. Although the authors did not describe it clearly, It seems that they used the total number of respondents of the survey as the most common denominator of their calculated proportions. It is essential that they describe it clearly when the denominator refers to the total number of respondents, a subgroup of those respondents and, most importantly, to the health services to which they belong. It is easy to understand that from a public health perspective it is much more relevant to understand how many of the health services have geriatricians, social health workers, occupational therapists and others providing care to older patients with cancer together with oncologists than to understand how many providers are able to refer patients to those types of professionals. Of course, there are instances when healthcare providers in general represent the inferential target, and in those cases the denominator should be the total number or respondents. Of course, to provide data related to healthcare services the authors will have to reanalyze their data, as it is possible that more than one healthcare professional from the same service answered the survey. To analyze data related to health services, authors will have to categorize the different kinds of services (e.g. general hospitals, ambulatory clinics, specialty cancer center, etc) for their inferences to make sense. They will also devise a mechanism to solve discordances in the report of different professionals that work in the same health service. If there is a national registry of healthcare units specialized in the care of patients with cancer, then the authors should provide the estimate of how many of those centres participated in the survey through the answers of their employees.

Response: Under every table there is an explanation of the denominator used. E.g. "Table 1. represents % of those who responded excluding non-response". This was mainly the denominator used. There was occasions where this was not possible, mainly related to the results of table 4. This is clearly labelled on table

4. However, we take on board that this information was not easy to find, therefore we have added an explanation in the methods:

“The denominator for percentages was mainly the percentage of those who responded (i.e. excluding non-responders). Where different, the denominator has been described.”

This also changes the following in the results:

“Table 4 describes which specific tools are being used, and also explores potential interest in using existing tools in the future. The denominator for percentages was the total sample.”

We agree with the reviewer that from a public health perspective it is much more relevant to understand how many of the health services have e.g geriatricians. However, assessment methods will also vary between individuals even within the same institution. The survey was not designed as a survey of health services but a survey of clinical practice of individuals with the purpose of identifying differences in clinical practice, experiences and views. Reporting the respondent’s place of work was not an obligatory question for this reason. Therefore a re-analysis as per the reviewer’s suggestion by institution is not possible with this data. We wished to evaluate access to services in terms of respondent’s knowledge (as if they perceive it not to exist, then it either doesn't or they never access it to be unaware of its existence). So discordance in knowledge of access to other services from respondents within the same institution was not something we wished to mitigate against. However, we take the comments on board, and have made some adjustments to give better clarity in the discussion.

“Access to key multidisciplinary team members was variable highlighting the lottery of use of supporting services across the UK. The survey was designed to scope clinical practice of individuals, including their access of these services rather than describe supporting service existence from a public health perspective. It is possible that more services exist than respondents were aware of and therefore did not access. Future work should focus on local service mapping to better link up existing services to avoid duplication given the workforce implications for developing new services^[25].”

Comment 2: “P.11, 1st paragraph: “90% were non-geriatricians, so the survey achieved the primary target of approaching cancer services health care professionals. Relevant disciplines were also sufficiently well represented (medical and clinical oncology, surgery, nursing and therapies) for generalisability across cancer care pathways”. The fact that 90% of survey respondents were not geriatricians does not seem to me to represent evidence that the survey achieved its goal of reflecting the reality of cancer services or providers. I also disagree with the statement that all relevant disciplines were sufficiently well represented. What is the basis for such an interpretation of a survey that was not able to describe any estimate of the total population size or response rates of healthcare professionals being targeted.”

Response: We have removed those sentences and replaced with

“It was completed by professionals working in cancer services with sufficient representation from different groups (medical and clinical oncology, surgery, nursing and therapies) to gain a sense of views and clinical practice.”

Comment 3: “It was disappointing to notice that the whole manuscript does not address the important question of how many cancer services have access or are integrated with palliative care, since there are international recommendations that patients with cancer be referred early on during their treatments to palliative care. This is even more relevant because the UK is the number 1 country in the quality of death index of The Economist journal.”

Response: We agree on the importance of palliative care in achieving holistic care. Access to palliative care was included within table 5 around multidisciplinary access. This demonstrated 78.7% had urgent access to palliative care and 19.2% had routine access. To make this result more visible, we have added more of a reflection of this in the results and discussion.

Results: *“Table 5 summarises urgent access to supporting services. Most had urgent access to palliative care (78.5%) but only a minority had urgent access available to other key professionals such as geriatricians, social workers, old age psychiatry input or to specialist older people nurses.”*

Discussion: *“Reassuringly, almost all respondents reported access to palliative care services, the vast majority having urgent access demonstrating feasibility of early collaborative working with other services.”*

Comment 5: The conclusion that “There is an appetite for national level change...” does not seem justified by the data that were presented. The conclusion that “National pathways standardising assessment methods are much needed to improve consistency to comprehensive assessment of older people with cancer across NHS services” is also problematic because it requires evidence that standardized approaches are better than non-standardized approaches, which seem to be preferred by professionals, and about which the study did not provide any comparisons. I recommend the authors to reframe their conclusions in light of more important gaps in the care of older patients with cancer.

Response: We have reframed our conclusions to focus towards the content of our results

" There is variability in assessment methods for older people with cancer across the UK and variation in perceived access to supporting services. Clinical history taking was preferred to scoring systems. Fostering closer links with geriatricians appears supported."

Comment 5. The authors used the PRISMA checklist to assess the quality of their report. However PRISMA is intended only for systematic reviews. They should have used the STROBE checklist instead.

Response: Agree. PRISMA was only used as was an essential document requested by the journal by the online submission software. It was not a checklist we wished to submit. We had used STROBE to guide writing of the manuscript.

Comment 6. Minor comments: It is not needed to describe which statistical software was used in the abstract. It is considered a waist of precious word space.

Response: Agree. Have removed.

Reviewer 3: Reviewer's code:02544416

No revisions requested