NIHR | Southampton Biomedical Research Centre

NHS Wessex Cancer Alliance

Prehabilitation and Rehabilitation in Cancer Conference

Wessex

3rd July 2025,

Axis Centre Chilworth, Southampton

Agenda

Time	Topic/Activity	Lead
9:15am	**Welcome** **The Vision of the Wessex Cancer Alliance**	Dr Jane Winter Sally Rickard
9:45am	**State of the Nation**	Prof. Peter Johnson
10:00am	**The new 'Prehabilitation in cancer: Clinical and Implementation Guidance.'**	June Davis, Prof. Mike Grocott
11:15am	Refreshment break	
11:30am	**Prehabilitation and the Future of NHS**	Prof. Ramani Moonesinghe
12:00pm	**Examples of delivery across Wessex**	
1:00pm	Lunch	
1:45pm	**Facilitated round table discussions**	ALL
3:30pm	**Table feedback**	ALL
4:00pm	**Close**	

Prehabilitation in people with cancer: Clinical and implementation guidelines

June Davis, Lead Allied Health Professional and Nursing,
Macmillan Cancer Support

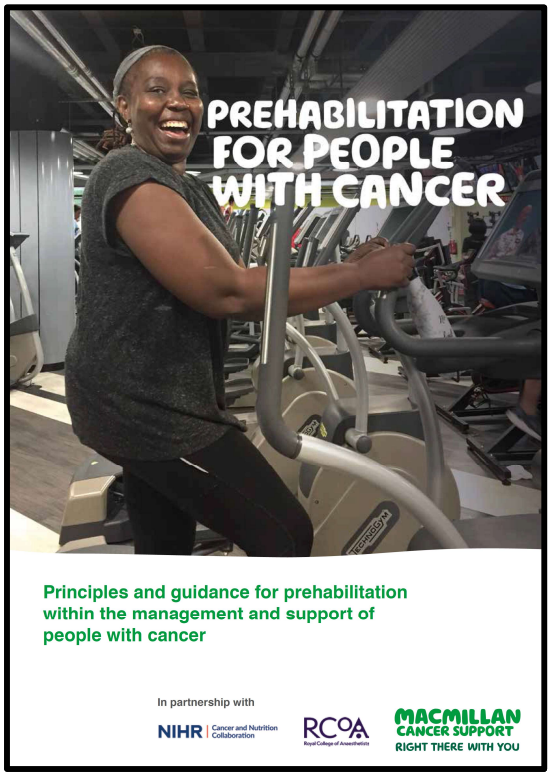
Professor Mike Grocott, Consultant Anaesthetist,
University Hospitals Southampton
Director, NIHR Southampton Biomedical Research Centre

Co-chairs guideline development group

Thursday 3rd July

Guidance to guidelines

- 2018-19 Principles & guidance
- 2024-25 Guideline development
  - Wider stakeholder group
  - Definitions and conceptual framework
  - Evidence based guideline development
  - Six working groups (from three)



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2024-25 Guideline development

- Sponsors
  - Macmillan Cancer Support
  - NIHR Cancer Nutrition Collaborative
  - Centre for Perioperative Care (Royal College of Anaesthetists (RCoA))
  - NIHR Southampton Biomedical Research Centre
  - World Cancer Research Fund

2024-25 Guideline development

- Steering group
  - Chairs
  - Working group leads
- Working groups
  1. Exercise & activity (Denehy, Jack)
  2. Nutrition (Gillis, Parmar)
  3. Psychology (Foster, Webb-Peploe,Grimmett)
  4. Behavior change (Copeland, Avery)
  5. Implementation (Moore, Levett)
  6. Health economics & business cases (Ludbrook, Merchant)

- Working groups
  - Co-chairs
  - Multidisciplinary and multispecialty
  - International (inc. 4 nations of UK)
  - NHS England on Implementation & Health Economics
  - 10-12 members

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2024-25 Guideline development

Project phase (January 2024 – October 2025)	Project progress
Definitions	Complete
Formulate questions	Complete
First phase consultation (definitions and questions) (87 responses)	Complete
Question refinement	Complete
Evidence synthesis	Complete
Formulate statements and recommendations	Complete
Second phase consultation (statements and recommendations) (107 responses)	Complete
Launch, document development, BMJ oncology papers & dissemination	In progress

Evidence synthesis

- Main search = 9465 papers

  The purpose of the search was to identify **randomized controlled trials, systematic reviews, and economic evaluations related to the prehabilitation strategies in adult patients recently diagnosed with, or immediately prior to a diagnosis of, cancer.**

  The search logic was conceptualized in two parts:

  1.Cancer and Prehabilitation and Methodological Filters. Date limit: None

  2.Cancer and Types of Prehabilitation AND Methodological Filters. Date limit: 2018-2024

  Phase 1: Covidence abstract screening (double-review)

  Phase 2: Thematic group screening

- Implementation search = 9410 papers

Prehabilitation agreed definition

- Developed by review steering group and working groups
- Consultation and wider stakeholder engagement via MS forms (87 responses)
- Refined and finalised by review steering group

"Prehabilitation is a needs-based multi-modal intervention, before and during cancer treatment, to optimise physical, nutritional and psychological status, enhance readiness for and tolerance of treatments and improve recovery and/or quality of life.

Prehabilitation involves screening before needs-based assessment, enabling individualised prescription of exercise, nutrition and psychological interventions supported by behaviour change techniques."

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Definitions

- **‘Universal prehabilitation’** is the provision of expert advice on exercise, nutrition and psychological support, along with behaviour change advice, to all individuals before cancer treatment.
  - ‘Universal prehabilitation’ (e.g. surgery school) is the foundation of prehabilitation and may involve screening.
  - It should be noted that generic lifestyle advice alone does not constitute universal prehabilitation.
- **‘Targeted prehabilitation’** is assessed and prescribed by a registered healthcare professional with relevant competencies and may be delivered by un-registered or non-healthcare professionals.
- **‘Specialist prehabilitation’** is assessed, prescribed and delivered by registered healthcare professionals.

The following are specifically excluded from prehabilitation: medical management of long-term conditions (e.g. anaemia management, diabetes management), rehabilitation, and geriatric medical management of frailty. These are related but distinct activities.

2024-25 Post Evidence Review

- Vast amount of literature that is closely related
- Fewer ‘prehab’ studies = before/during treatment
- MANY of these are pilot/feasibility studies (+/- RCT)
- VERY few adequately powered RCTs
- VERY VERY few exploring interactions or comparing approaches

- **Overall – not an example of an efficient/economical research effort**

- Few areas amenable to meta-analysis
- Evidence interpreted via expert consensus
- GRADE to aid interpretation

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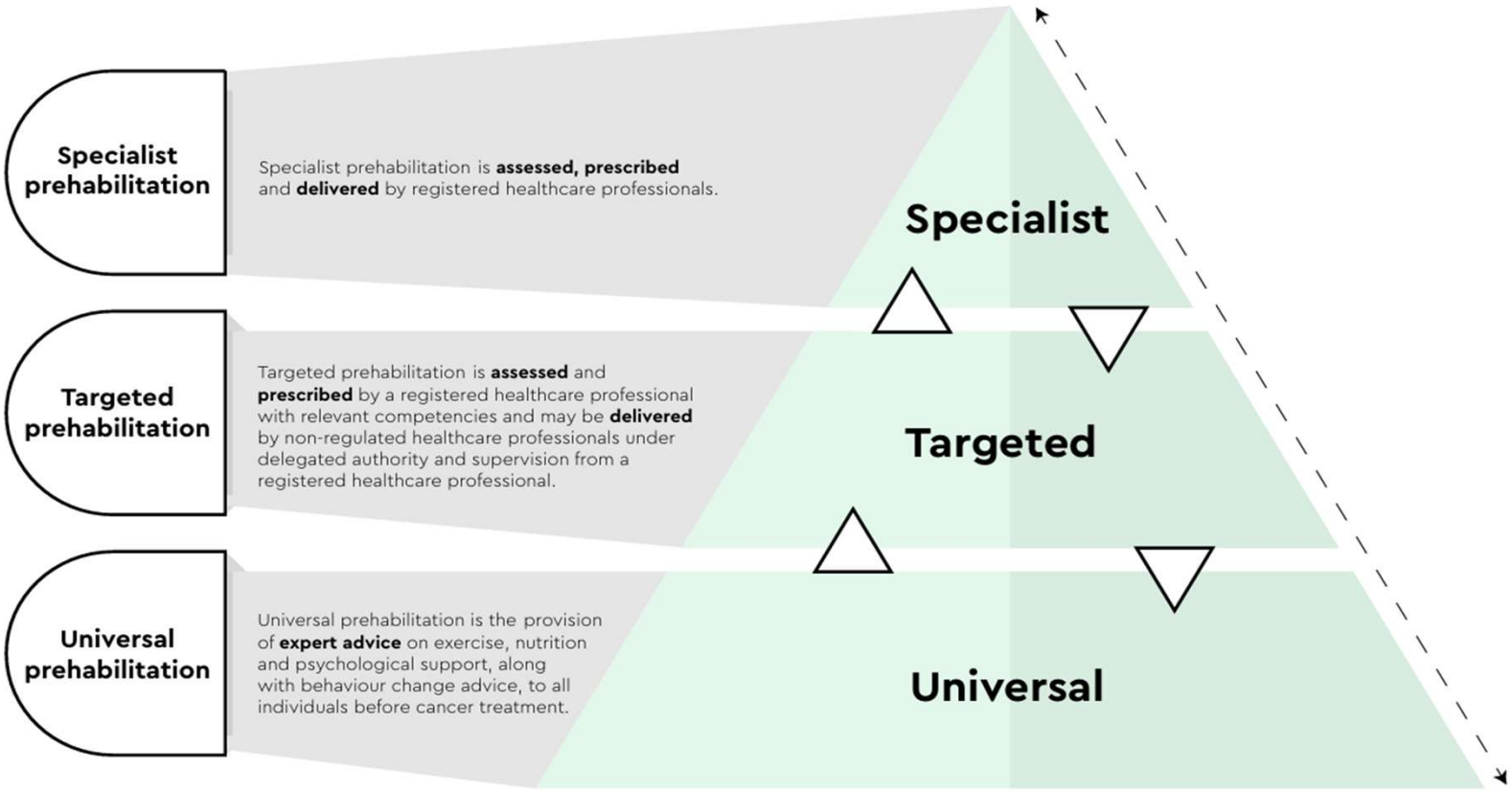

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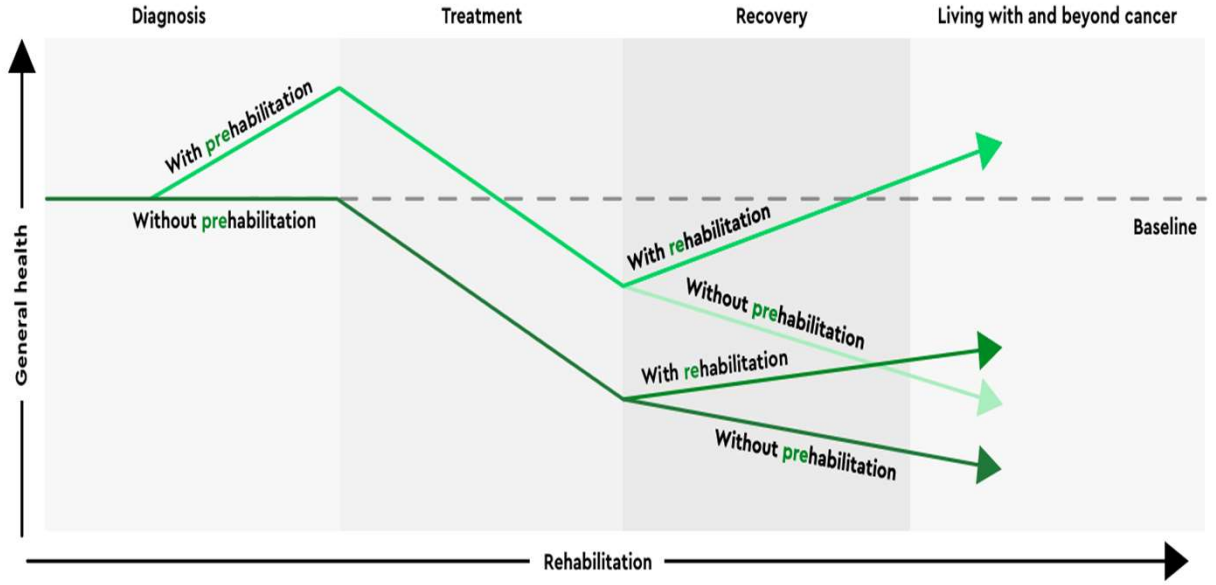
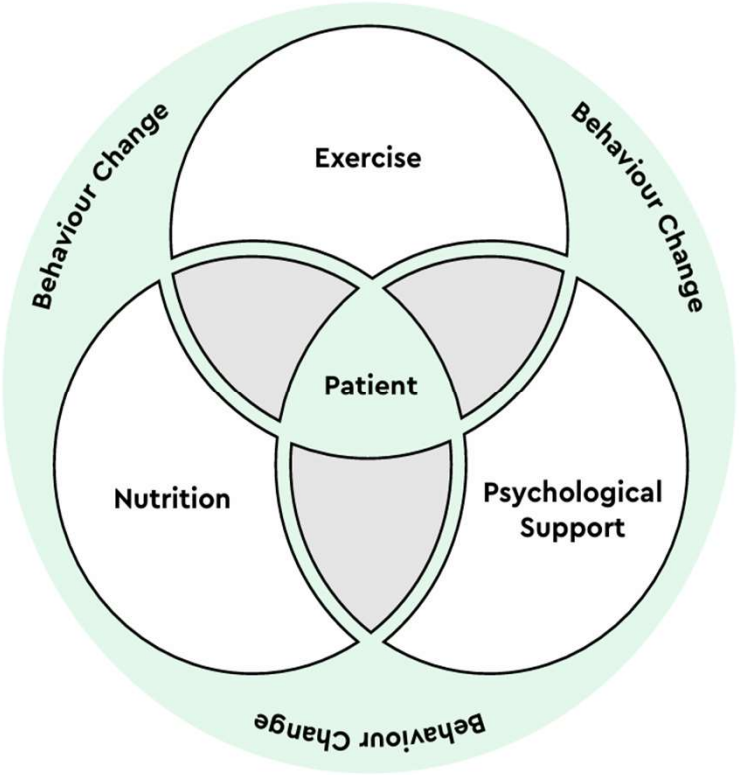

Diagnosis
Treatment
Recovery
Living with and beyond cancer
With prehabilitation
Without prehabilitation
With rehabilitation
Without prehabilitation
With rehabilitation
Without prehabilitation
Baseline
General health
Rehabilitation


Behaviour Change
Exercise
Behaviour Change
Patient
Nutrition
Psychological Support
Behaviour Change

Prehabilitation in cancer draft statements and recommendations and use of the GRADE(Grading of Recommendations, Assessment, Development and Evaluations system)

Statements

- These have been produced based on consensus and the evidence available.
- They are contextual statements, which may inform/explain subsequent recommendations.
- Quality of evidence using the GRADE system is used High quality
  - High quality
  - Moderate quality
  - Low quality
  - Very low quality

Recommendations

- These have been based on the evidence available.
- Both the quality of evidence and the strength of recommendation are included for each recommendation.

Good Practice Point (GPP)

- Recommended best practice based on the accumulated and combined clinical experience of the guideline development group.

Quality of evidence

High quality	⊕⊕⊕⊕ or A
Moderate quality	⊕⊕⊕◯ or B
Low quality	⊕⊕◯◯ or C
Very low quality	⊕◯◯◯ or D

Strength of recommendation

Strong recommendation for using an intervention	↑ ↑ or 1
Weak recommendation for using an intervention	↑ ? or 2
Weak recommendation against using an intervention	↓ ? or 2
Strong recommendation against using an intervention	↓ ↓ or 1

Box 2 | Quality of evidence and definitions

High quality— Further research is very unlikely to change our confidence in the estimate of effect

Moderate quality— Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate

Low quality— Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate

Very low quality— Any estimate of effect is very uncertain

Statements and recommendations – Topics

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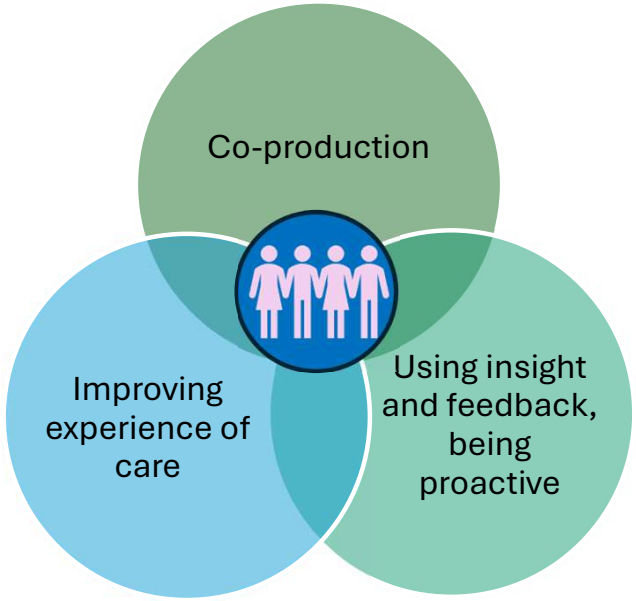
At the heart……Patient engagement

Prehabilitation services should be **co-designed** and **developed** with the patients voice firmly at the centre.



Health Inequalities

	Statements	Quality of evidence
1.	Cancer type and sociodemographic characteristics influence uptake to and engagement with behaviour change and psychological interventions during cancer prehabilitation.	Moderate
2.	People with pre-existing and/or a history of mental health difficulties and people with disabilities were often excluded from studies, or their inclusion was not specified.	Moderate

	Recommendation	Quality of evidence	Strength of recommendation
1.	We recommend that health inequalities should be considered in the design, delivery and implementation of prehabilitation services and the associated interventions to avoid exclusion.	High	Strong

Prehabilitation implementation

	Recommendations	Quality of evidence	Strength of recommendation
1.	We recommend that prehabilitation, as a complex intervention, should be designed, implemented and evaluated using established theoretical models and conceptual frameworks incorporating behaviour change techniques.	GPP	Strong
2.	We recommend that an implementation science approach is used in the development and evaluation of prehabilitation services (evaluation should include acceptability, adherence, adoption, penetration, health outcomes and financial sustainability).	High	Strong
3.	We recommend that prehabilitation is integrated into existing cancer care pathways and aligns with existing services providing integrated care to avoid duplication.	GPP	Strong
4.	We recommend that prehabilitation service design is based on the characteristics of the population served e.g. geographical location, patient characteristics, requirement for social support, clinically complex patients, digital readiness, and socioeconomic status.	Low	Strong
5.	When integrating technology into cancer prehabilitation, clinicians and service designers must actively consider digital literacy, accessibility, language, socioeconomic status, and cultural appropriateness to promote equity of access and reduce health disparities	Low	Strong

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Prehabilitation implementation

	Recommendations	Quality of evidence	Strength of recommendation
6.	We recommend that a standardised reporting structure integrated with existing clinical governance structures is used for adverse events during prehabilitation.	GPP	Strong
7.	We recommend that prehabilitation services address both the facilitators and barriers to implementation during service design.	Moderate	Strong
8.	We recommend that outcomes from prehabilitation services should be standardised and collected nationally to understand the impact on patient-based and cancer outcomes (short and long-term).	GPP	Strong
9.	We recommend that effective delivery of behaviour change interventions can be delivered during face-to-face sessions, telephone calls, digital platforms, or a combination of these modes, considering patient preferences, limitations and digital literacy.	Moderate	Strong
10.	We recommend multimodal interventions with behaviour change techniques that combine nutrition, exercise and psychological support to enhance functional outcomes.	Moderate (Exercise and Nutrition) Low (behaviour change and psychology)	Strong

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Barriers and facilitators to prehabilitation for patients

BARRIERS	FACILITATORS
Accessibility of information	Provision of prehabilitation information which is accessible to multiple ethnic groups and degrees of health literacy
Lack of knowledge on benefits of prehabilitation	Provision of individualised information on the benefits of prehabilitation ensuring information is patient centric and avoids overwhelming patients
Physical incapability to carry out standard prehabilitation intervention	Tailoring prehabilitation to the patient's abilities and needs can help overcome the physical barriers to participation in prehabilitation
Lack of time to undertake prehabilitation interventions	Provision of tailor made prehabilitation intervention which can be home/community based
Lack of social support	Provision of group peer and social support. Role of community based prehabilitation ensure involvement of caregivers and social support.
Reduced emotional wellbeing and self-efficacy	Utilisation of 'teachable moment", focus on short term lifestyle changes patients, behaviour change methodology

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Barriers and facilitators to prehabilitation for health care

BARRIERS	FACILITATORS
Lack of time	Releasing time to educate and refer patients to prehabilitation pathways or provide guidance
Lack of prehabilitation resource	Provision of prehabilitation resources which are easily accessible for both healthcare professionals and patients. Provision of adequate prehab staff.
Lack of confidence/ knowledge in prehabilitation	Provision of a staff educational prehabilitation programme to improve knowledge, confidence and subsequent referral to prehabilitation services
Patient information overload	Provision of easily accessed, individualised information to provide tailor made, patient centric information on prehabilitation.
Lack of prehabilitation pathway	Provision of a easily accessed, interdisciplinary prehabilitation pathway incorporated into standard care allowing sufficient time for provision of prehabilitation intervention.
Lack of communication between different teams	Provision of effective and efficient communication among teams including the provision of named individuals to facilitate interdisciplinary working.

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Health Economics

	Statements	Quality of evidence
1.	Most of the published health economic studies of prehabilitation interventions demonstrate consistent trends towards improved clinical outcomes and decreased healthcare costs. However, these studies are of generally of low and very low methodological quality with wide variations in populations, interventions, outcomes and costs measured. Therefore because of these limitations, it is not possible to make a strong recommendation on the health economic value of prehabilitation. As further evidence becomes available this may change.	Low
2.	In the absence of high-quality health economic evidence, business or service evaluations/analyses performed at a local level can be used to help inform decision making on the funding and implementation of prehabilitation. Service evaluations known to the writing group have findings that align with the published literature trends towards decreased healthcare costs and improved clinical outcomes. Service evaluations alongside the published literature, should be considered by institutions introducing prehabilitation services. Caution should be used considering variability in local populations, demographics and context for delivery of interventions as the service evaluations may not be transferable and generalisable.	Low

Health Economics

	Recommendations	Quality of evidence	Strength of recommendation
1.	Formal economic evaluations should be incorporated into clinical studies* of prehabilitation. High quality data on endpoints relevant to outcomes, value and costs from a range of stakeholders' perspectives should be included in study protocols, with formal economic evaluations that include sensitivity analyses, measures of uncertainty, and adhere to the Consolidated Health Economic Evaluation Reporting Standards (CHEERS). Research groups are encouraged to publish economic data from completed prehabilitation studies, whether the outcomes are positive or negative. *Clinical trials/studies and service evaluations.	Low	Strong
2.	Local analysis of outcomes and costs should guide the decisions of healthcare institutions or regions on the value of introducing or continuing prehabilitation programmes.	Low	Weak
3.	Institutions should consider introducing and subsequently evaluating prehabilitation in scenarios where their patient populations, proposed intervention model, and economic environment are similar to that reported in the favourable health economic literature or service evaluations. The current body of peer-reviewed published health economic evidence for prehabilitation demonstrates trends towards improved outcomes and decreased costs. However, published clinical studies and economic analyses are in general of low and very low quality. In this circumstance, business or service evaluations/analyses in specific institutions can provide a useful guide to decision making on prehabilitation, but the transferability of findings must be considered carefully, especially related to factors such as patient population, intervention type, and local resources and costs.	Low	Strong

Lifestyle/Behaviour change

	Statements	Quality of evidence
1.	Behaviour change interventions in cancer prehabilitation positively impact health behaviours including physical activity, diet, smoking, and adherence to structured exercise programmes that improve patient outcomes before, during, and after cancer treatment.	Moderate
2.	Behaviour change interventions in cancer prehabilitation are designed to improve adherence to interventions such as exercise, nutrition and psychological support, to improve resilience to treatment, reduce complications and improve health.	Moderate
3.	Behaviour change interventions in cancer prehabilitation should be designed using behaviour change theory, and include behavioural goal setting, action planning, problem solving, self-monitoring, provision of feedback, and review of behavioural goals, for each target behaviour.	Moderate
4.	Behaviour change techniques in cancer prehabilitation can modify health behaviours and improve adherence to intervention components	Moderate
5.	Behaviour change interventions in cancer prehabilitation involve structured strategies designed to support individuals to adopt and maintain health behaviours, including improved nutrition, smoking cessation, alcohol reduction and abstinence, increased physical activity and adherence to structured exercise programmes, before and during cancer treatment.	Low
6.	Behaviour change interventions in cancer prehabilitation predominantly focus on the application of specific behaviour change techniques.	Moderate
7.	The most frequently applied behaviour change techniques in cancer prehabilitation are providing instruction on how to perform a behaviour, demonstration of the behaviour, goal setting, action planning, problem solving, self-monitoring, receipt of feedback, and review of behavioural goals.	Moderate

Screening, assessment and personalised support

	Recommendations	Quality of evidence	Strength of recommendation
1.	We recommend that prehabilitation is personalised through screening and needs based assessment using validated tools to inform specific health/lifestyle behaviours, behaviour change, nutrition, exercise and psychological support intervention components.	GPP	Strong
2.	We recommend repeat screening to inform needs-based assessment for patients on prolonged oncological pathways or when entering new cancer pathways.	GPP	Strong

Group Education

	Recommendation	Quality of evidence	Strength of recommendation
1.	We recommend that all patients having major cancer treatment should be offered group education where the elements of prehabilitation are explained e.g. surgery school	High	Strong

Digital/technology

	Statements	Quality of evidence
1.	Technology in cancer prehabilitation refers to the digital tools, wearable devices, telehealth platforms, mobile apps, and other innovations used to support remote monitoring, personalisation of interventions, patient education, self-management, collection of outcome data and communication between patients, healthcare and exercise professionals during the prehabilitation period.	Moderate
2.	Technological interventions and adjuncts used during prehabilitation support health behaviour change and may improve physical function outcomes.	Very low
3.	Technological interventions and adjuncts are feasible and acceptable when integrated into cancer prehabilitation programmes.	Low
4.	Digital literacy, language barriers and cultural differences can limit patient access to technology during prehabilitation however language barriers can also be overcome by digital support.	Low

	Recommendations	Quality of evidence	Strength of recommendation
1.	Technology should be incorporated into cancer prehabilitation to support health behaviour change, intervention delivery, and patient engagement and adherence.	Low	Weak
2.	Technological interventions and adjuncts should be implemented by individuals with appropriate expertise CHECK WORDING HERE	Low	Strong
3.	When integrating technology into cancer prehabilitation, clinicians, exercise professionals and service designers must actively consider digital literacy, accessibility, language, socioeconomic status, and cultural appropriateness to promote equity of access and reduce health disparities.	Low	Strong

Workforce

	Recommendation	Quality of evidence	Strength of recommendation
1.	We recommend that prehabilitation leadership at a hospital and regional level supports local quality assurance, efficiency of provision and operational oversight.	GPP	Strong
2.	We recommend that cancer prehabilitation is multidisciplinary and that all members of the cancer workforce are trained in the principles of prehabilitation, understand the provision of local prehabilitation services and be able to direct patients to these services.	GPP	Strong

Nutrition

	Statements	Quality of evidence
1.	There are many effective nutritional interventions but insufficient evidence to recommend a single superior one-size-fits-all approach	GPP
2.	Evidence supporting routine micronutrient supplementation in patients without deficiencies is limited.	Low

Nutrition

	Recommendations	Quality of evidence	Strength of recommendation
1.	We recommend that all patients have access to nutrition education resources, such as web-based tools, surgery schools, group classes, or booklets, that provide evidence-based nutrition information relevant to all patients with cancer	Moderate	Strong
2.	We recommend that all patients be screened for nutrition-related issues using a validated tool at the earliest opportunity and before initiating cancer treatment.	Moderate	Strong
3.	We recommend that patients identified as at elevated risk through nutrition screening receive a comprehensive assessment by a registered dietitian/nutritionist* to diagnose any nutrition-related conditions and determine their severity. (* this is to reflect the use of nutritionists outside of the UK)	Moderate	Strong
4.	We recommend needs based and individualised treatment plans as per the prehabilitation triangle.	GPP	Strong
5.	We recommend that nutrition interventions target the aetiology of the nutrition diagnosis.	GPP	Strong

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Nutrition

	Recommendations	Quality of evidence	Strength of recommendation
6.	We recommend nutrition counselling be provided by a registered dietitian/nutritionist*. (* this is to reflect the use of nutritionists outside of the UK)	Moderate	Strong
7.	We recommend counselling is personalised to the individual's needs and conditions, centered on shared goals, incorporate behaviour change strategies, and include nutrition support interventions when appropriate	Moderate	Strong
8.	We recommend that nutrition treatment plans prioritise the oral route to meet the nutrition prescription and requirements using strategies such as individualised counselling and oral nutritional supplements.	High	Strong
9.	We recommend that patients unable to meet 50-60% of their energy and protein requirements through oral intake be assessed for enteral or parenteral nutrition.	Low	Strong
10.	We do not recommend the routine use of intentional weight loss interventions for patients preparing for or undergoing acute cancer treatment.	GPP	Weak
11.	We recommend that patients with malnutrition or those following restrictive diets be assessed for micronutrient deficiencies and receive targeted supplementation.	High	Strong
12.	We recommend that the frequency of monitoring and evaluation plans be based on the comprehensive assessment, identified nutrition diagnosis, and patient-specific factors.	Moderate	Strong
13.	We recommend that nutrition interventions be combined with exercise in patients undergoing surgery to improve perioperative outcomes	Moderate	Strong

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Psychology

	Statements	Quality of evidence
1.	Pre-existing psychosocial factors can predict future psychological challenges, engagement with and adherence to/tolerance of cancer treatment.	High
2.	Few interventions in the reviewed studies reflect clinical practice. There was also a lack of screening and/or assessment of psychological status to inform personalisation of psychological interventions.	High
3.	Further high quality research is urgently needed to test psychological interventions that reflect clinical practice.	High

Psychology

	Recommendations	Quality of evidence	Strength of recommendation
1.	We recommend all staff working with people affected by cancer are able to communicate compassionately, recognise and respond to psychological distress and facilitate access to universal psychological support resources. Psychosocial Support - Transformation Partners in Health and Care	GPP	Strong
2	We recommend healthcare professionals conducting screening for psychological difficulties are appropriately trained and have colleagues to whom they can escalate concerns.	GPP	Strong
3.	We recommend screening to identify psychological need using validated/standardised measures alongside an understanding of the patient's context (See Table 1), as these measures alone are inadequate.	High	Strong
4.	We recommend that prehabilitation services include the systematic early detection of pre-existing mental health difficulties and risk factors which may interact with cancer treatments.	Moderate	Strong
5.	We recommend patients identified as requiring psychological support now or in the future, are assessed by a healthcare professional with sufficient expertise and training. This assessment can include further psychometric assessments in addition to clinical interview.	GPP	Strong

Psychology

	Recommendations	Quality of evidence	Strength of recommendation
6.	We recommend health care professionals assessing patients' needs have access to specialist psycho-oncology services for advice and consultation as there is no agreed algorithm for onward management.	GPP	Strong
7.	We recommend embedded specialist psycho-oncology services are provided: • For patients with clinically significant difficulties • Where psychological factors have a significant impact on access to and tolerance of cancer treatment • For the oversight of targeted interventions and the escalation of concerns • For appropriate workforce training and supervision • For the integration of a stratified approach	GPP	Strong
8.	We recommend providing evidenced-based psychological interventions for patients presenting with clinically significant psychological difficulties during the prehabilitation period.	High	Strong
9.	We [illegible] psychological interventions are theoretically informed, target [illegible] gical difficulties	GPP	Strong

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Psychology (Table 1)

Factors	Examples
Previous and current mental health difficulties	Previous diagnoses or contact with mental health professionals e.g. for Depression, PTSD, Severe Mental Illness, Eating Disorders
Psychosocial support	loneliness Impact on family and friends
Personal psychological vulnerabilities	Self-efficacy Illness perceptions Coping response to previous adversity
Engagement with healthcare	Prior aversive experiences in healthcare settings Low engagement with exercise / diet changes
Cognitive difficulties	Dementia, learning disabilities, neurodevelopmental conditions where relevant to cancer treatment
Financial concerns	Impact on employment In receipt of benefits
Wider social context including diversity and inequalities	see statement health inequity.

Exercise

	Statements	Quality of evidence
1.	Behaviour change techniques should be employed to promote adherence to all exercise interventions.	Low
2.	The duration of exercise interventions should be a minimum of 2 weeks, with interventions greater than 4 weeks more effective. Duration should be optimised based on time available between decision for treatment and procedure.	Low in surgery and surgery +/- neoadjuvant therapy Moderate in setting of adjuvant chemotherapy
3.	Low intensity exercise programmes with individualised progression remain beneficial in patients unable to participate at moderate-vigorous intensity.	Low
4.	Serious adverse events during aerobic and strength exercises are rare.	High
5.	Further high quality research is needed to understand the mechanisms of benefit of aerobic and strength exercise throughout the cancer treatment pathway	Low

Exercise

	Recommendations	Quality of evidence	Strength of recommendation
1.	We recommend that all patients with cancer should be screened and risk stratified for physical function and exercise capacity using validated assessment tools at the earliest opportunity and before initiating cancer treatment.	GPP	Strong
2.	We recommend that all exercises be individualised to achieve the most effective outcomes for patients.	Moderate	Strong
3.	We recommend that patients identified as having reduced physical function through screening undergo a comprehensive assessment using validated tools by a trained health professional to guide individualised exercise prescription.	Low	Strong
4.	We recommend that a combination of aerobic and strength exercise be prescribed to patients undergoing surgery to increase physical function and exercise capacity and improve perioperative outcomes.	Moderate	Strong
5.	We recommend that the aerobic exercise component be performed at moderate to high intensity where appropriate (including high intensity interval training).	Moderate	Strong
6.	We recommend that exercise be combined with nutrition interventions in patients undergoing surgery to improve perioperative outcomes.	Moderate	Strong
7.	We recommend inspiratory muscle training, in combination with aerobic and strength exercises for patients having lung cancer surgery to improve perioperative outcomes.	Moderate	Strong

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Exercise

	Recommendations	Quality of evidence	Strength of recommendation
8.	We recommend that all patients receive structured education on the benefits of respiratory exercises prior to surgery to improve perioperative outcomes.	Moderate	Strong
9.	We recommend that patients undergoing adjuvant or neoadjuvant treatment for cancer receive a combination of aerobic and strength exercise delivered early in the treatment pathway to improve patient-centred and clinical outcomes.	High (adjuvant) Moderate (neoadjuvant)	Strong
10.	We recommend that exercise programmes are supervised either face to face, or digitally to promote engagement, adherence, and safety.	Moderate	Strong
11.	We recommend that exercise programmes include structured patient education on the benefits of exercise throughout the cancer care continuum.	Low	Moderate

How will you implement the prehabilitation in cancer guidelines?

Theme	Description (align to action plan)
Service Enhancement & Expansion	Plans to grow or improve prehab services based on guidance.
Multidisciplinary Integration	Recognition of the need for fuller MDT inclusion (e.g., psychology, OT, dietetics).
Business Cases & Funding	Using the guidance to support business cases and secure resources.
Equity & National Consistency	Desire for consistent national standards and inclusion across all regions.
Behaviour Change & Psychology	Emphasis on embedding behaviour change strategies and mental health support.
Standardisation & Outcomes	Need for unified tools, outcome measures, and models of care.
Existing Implementation	Several teams already have established or partially implemented services.
Stakeholder Engagement	Collaborating with charities, alliances, and boards to adapt and implement.
Barriers to Implementation	Challenges include workforce, time, funding, and IT infrastructure.
Training & Education	Need to educate and train MDT staff on prehab practices and tools.
Continuous Improvement & Research	Commitment to audit, feedback, and research-led service evolution.

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Action plan

1. Recommendations, statements and good practice points

- Follow the statements, recommendations and good practice points in these guidelines when designing and developing prehabilitation services for people with cancer.

2. Prehabilitation screening tool

- Develop a standardised validated prehabilitation screening tool that encompasses screening metrics for exercise, nutrition, psychological support and behaviour change.

3. Health Foundation Q Community Prehabilitation Community of Practice

- Continue to grow and develop the online Q community Prehabilitation Community of Practice Prehabilitation in perioperative care special interest group | Macmillan Cancer Support

4. Enhance the capacity, capability and confidence of the workforce

- Develop a multiprofessional prehabilitation curriculum framework to include core capabilities in practice (CiPs) for all levels of practice in line with the Aspirant Cancer Career and Education Framework (ACCEND) along with an education framework.
- Aspirant Cancer Career and Education Development programme | NHS England | Workforce, training and education

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5. Prehabilitation implementation

- Healthcare service providers should test, evaluate and review services locally to increase the local evidence base.

6. Quality improvement and quality assurance

- Develop a quality improvement and quality assurance framework and advocate for the inclusion of prehabilitation in national cancer registries.

7. Outcome measures

- Pursue the development of a standardised outcome measures for prehabilitation.

8. Research

- Using the research questions identified through the development of this guidance, pursue a relevant and contemporary prehabilitation research agenda in partnership with relevant stakeholders including National Institute for Health Research (NIHR) and Cancer Research UK (CRUK)

MACMILLAN CANCER SUPPORT

NIHR | Southampton Biomedical Research Centre

World Cancer Research Fund International

NIHR | Cancer and Nutrition Collaboration

Centre for Perioperative Care

Next steps

- Present at events in Sheffield (1/7) and Southampton (3/7)
- Evidence Based Perioperative Medicine Conference (EBPOM) 8th July
- Q community Webinar on 29th July
- Other UK events in planning
- Complete summary document (including a workforce matrix) and publish by August 2025 (to be accessed via Macmillan website)
- Complete 7 x peer reviewed papers for BMJ oncology by Autumn 2025 (open access)
  - Summary paper – context, methodology, statements, recommendations
  - Prehabilitation implementation
  - Health economics
  - Behaviour change and technology
  - Psychology
  - Nutrition
  - Exercise
- Present at World
  25

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World Cancer Research Fund International
NIHR | Cancer and Nutrition Collaboration
Centre for Perioperative Care

Thank you for listening

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mike.grocott@soton.ac.uk

Prehabilitation – how it fits into the future of the NHS

Ramani Moonesinghe

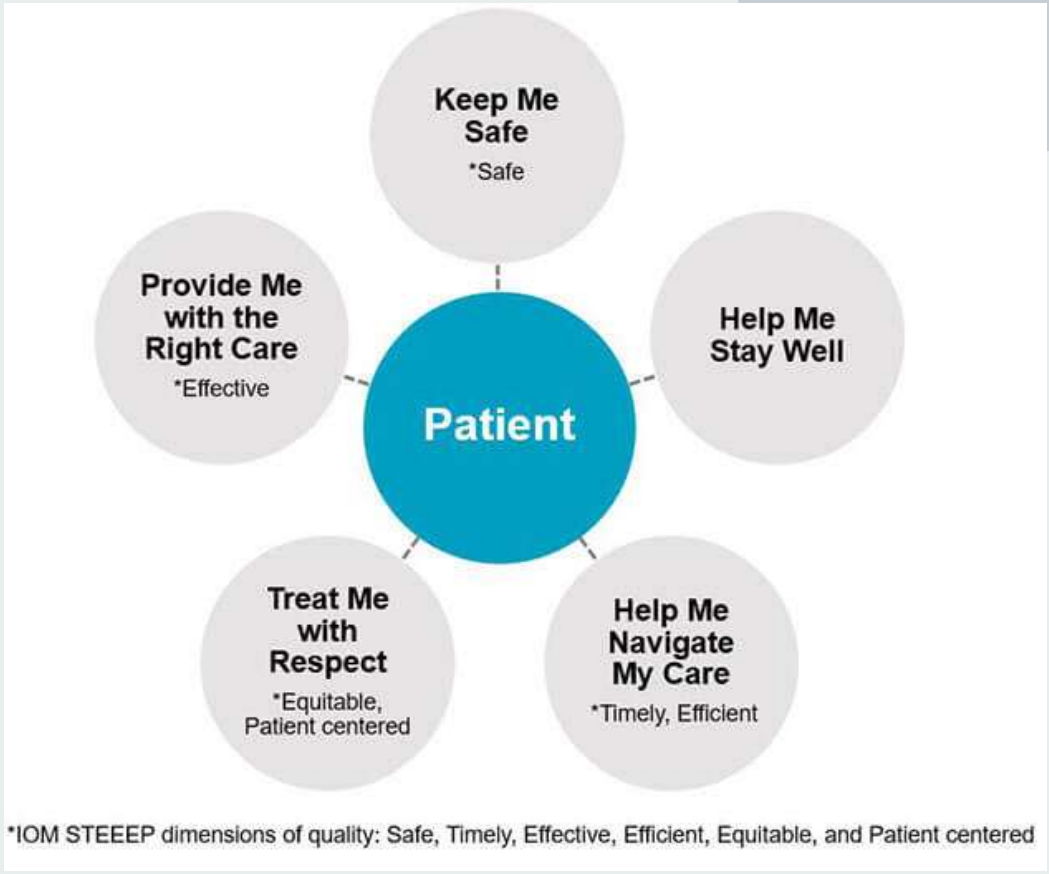
Interim National Director of Patient Safety, NHS England

National Clinical Director for Perioperative and Critical Care, NHS England

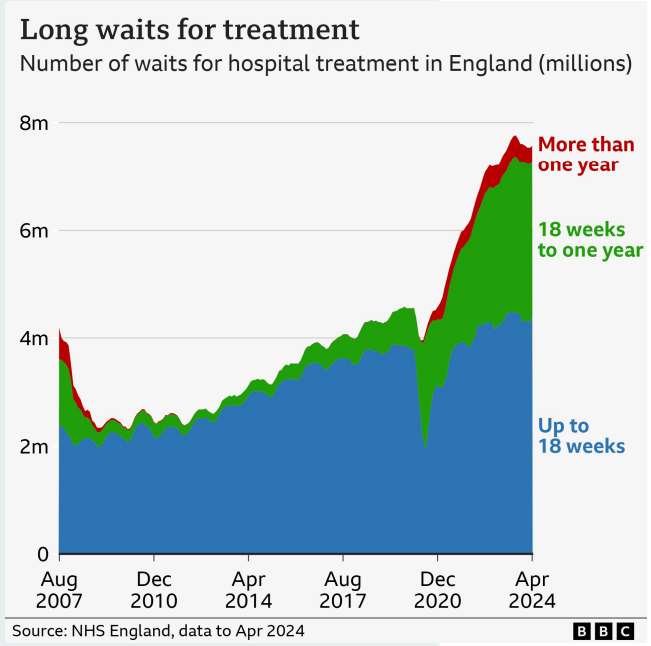
Professor and Hon Consultant, UCL and UCLH

Overview

- It’s a big day for all of us!
- A few highlights of what is to come
- Grounded in our existing commitments – including to prehabilitation
- Thinking about opportunities for the future



*IOM STEEEP dimensions of quality: Safe, Timely, Effective, Efficient, Equitable, and Patient centered



The NHSE national Perioperative Care programme has four overarching priorities:

1. **Improve quality and experience of patient care**
2. **Reduce the size of the elective waiting list**
3. **Accelerate return to the referral-to-treatment (RTT) standard**
4. **Contribute to interfacing agendas:**
   - Prevention
   - Health inequalities
   - Environmental sustainability
   - Blood management

Strategic Objectives

1. Contribute to a reduction in the overall size of the elective waiting list

- Reducing on the day cancellations for avoidable clinical reasons
- Helping to maximise use of day case and elective hubs
- Helping to better plan use of critical care capacity
- Supporting effective shared decision – making conversations and regular touch points with patients

2. Improve post operative outcomes for all patients and narrow the ethnic and income differentials in outcomes

- Empowering patients through improved patient information and use of surgery schools
- Embedding screening and optimisation pathways as standard
- Embedding post surgery drinking, eating and mobilisation as standard

3. Strengthen the resilience and capacity of the perioperative care workforce

- Providing specific e - learning to complement clinical and on the job training for people in key roles
- Redesigning aspects of the perioperative pathway to encourage more time for patients who need the most help to prepare for surgery
- Supporting work to look at processes in the perioperative pathway and opportunities for efficiency

Coming soon...

Toolkits

Surgery School

“Surgery schools are defined as an education and behaviour change intervention delivered by healthcare professionals to groups of patients and their family, friends and carers which aims to prepare them for major surgery.”

Randomised controlled trials suggest that attendance at surgery school can result in:

- Shorter lengths of hospital stay
- Lower levels of preoperative anxiety
- Lower levels of self-reported postoperative pain
- Improved postoperative quality of life

DrEaMing

“Drinking, Eating and Mobilising within 24 hours of Surgery”

- Improved short- and long-term patient outcomes
- Faster functional recovery and reduced deconditioning
- Lower risk of complications like deep vein thrombosis and muscle atrophy
- Enhanced physiological benefits, supporting healing and haemostasis
- Improved psychological well-being, reducing pain perception and promoting faster healing
- Reduced emergency re-admissions within 30d

Surgery school at a Glance

Imogen Fecher-Jones

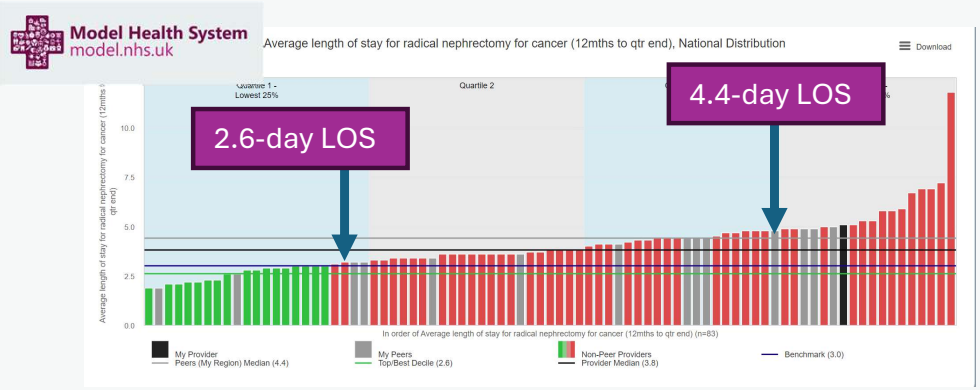
Educational components

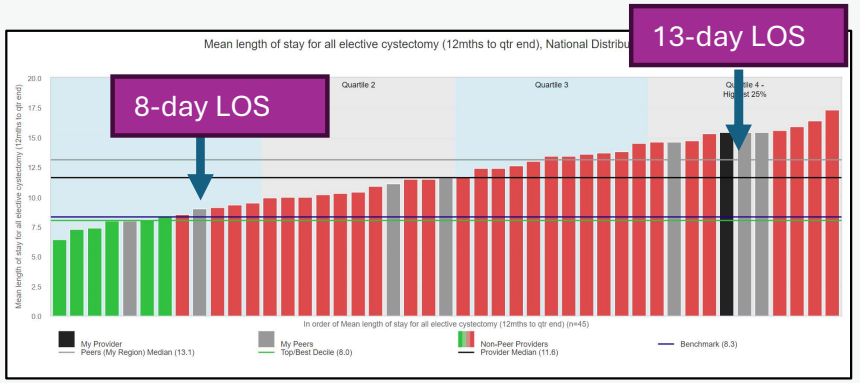
Building a Partnership Through Expectation Setting	Postoperative Complications	Optimising Health Conditions	Prehabilitation	Physical Activity	Nutrition	Psych preparation	Smoking and Alcohol Cessation	Enhanced Recovery	Pain Management
• What to expect throughout the surgical pathway and recovery phase	• Common complications • Activities to reduce risk	• Impact on recovery • Tips for preoperative optimisation	• What it is and how it works • The impact of lifestyle on surgical outcomes	• Increase physical activity • Reduce sedentary time • Moderate to high intensity aerobic exercise • Strength training	• Eating well • Reducing the risk of malnutrition • Postoperative nutrition	• Preparing for a challenge • Normalise anxiety • Well-being activities • When to seek help	• Impact of smoking and alcohol on recovery • Signposting to support to quit	• What it is • How it works • Importance of DrEaMing • What patients can do	• What to expect • Types of pain • Impact on lungs • Managing pain • Non-pharmacological approaches

Perioperative Quality Initiative Surgery School Group 2024

Improving productivity by reducing length of hospital stay

Better implementation of enhanced recovery: Drinking, Eating and Mobilising within 24h of surgery → (DrEaMing)





PQIP
Perioperative Quality Improvement Programme

1st PQIP report | Research published & CQUIN Y1 | CQUIN Y2

Highest risk surgery	2016-18	2018-19	2019-21	2021-23	2023-24
% compliance	54	60	66	67	69

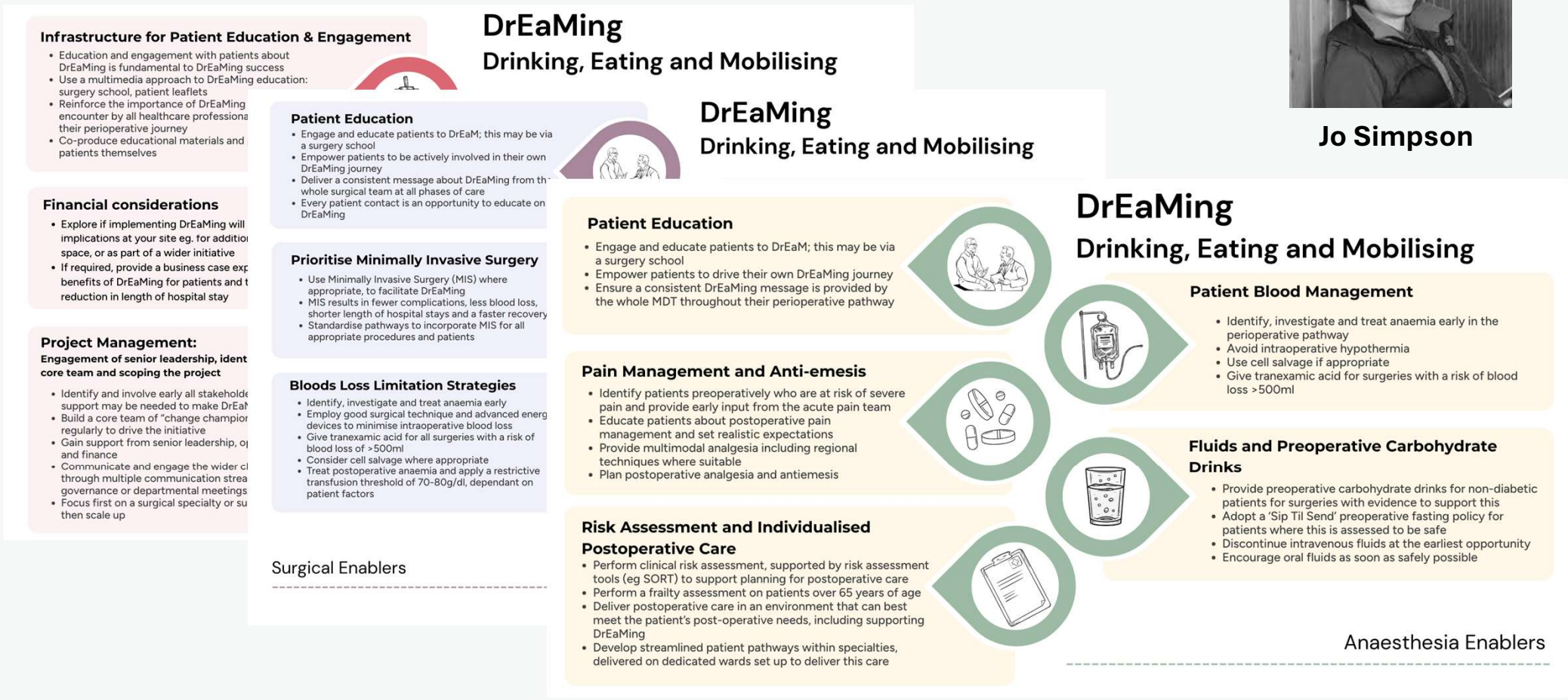
Hospitals with the highest compliance (>80%) have 25% reduction in <u>median</u> LOS e.g. after bowel resection 6-day LOS instead of 8 day

DrEaMing less likely if the patient is:

- Frail
- Unfit:
  - long-term conditions e.g. diabetes
  - Fitness/activity
- Anaemic before surgery
- Goes to ICU rather than enhanced care

DrEaMing toolkit

Jo Simpson



The wider context

Elective Reform Plan

January 2025

The Elective Reform Plan commits to the following perioperative care actions:

1. Asking providers to give patients a date for their routine (non-cancer) procedure only once they have been confirmed by pre-assessment as fit to proceed.

2. From April 2025, establishing an acceptable maximum number for each system of short notice cancellations due to clinical reasons. Providers are required to review their current level of cancellations and ensure these are reported to NHS England.

3. Closely monitoring productivity metrics, including length of stay and short notice cancellations, and raise with providers where these metrics are out of step with similar providers.

4. Extending the Digital Weight Management Programme to people waiting for knee and hip replacements in 2025/26

5. Working through Cancer Alliances to support improvements in prehabilitation for people about to undergo cancer treatment.

Wider still...

The 10-year plan

The 10-year plan

In 1948 a Labour government founded the NHS. My job now is to make it fit for the future

Wes Streeting

Our 10-year plan, backed by an extra £29bn, will transform the service through AI and neighbourhood care – and hand power back to patients

Wes Streeting is secretary of state for health and social care

What does this mean for cancer?

- **Hospital to community:**
    - easier to access cancer screening, diagnostic and treatment services in patients' local areas
    - more choice for people on how and where they access these services.
- **Analogue to digital:**
    - ensure the NHS is able to harness the power of technological innovation to improve the prevention, diagnosis and treatment of all cancers.
- **Sickness to prevention:**
    - enable the NHS to identify those who are at greatest risk of developing cancer earlier and make it easier for everyone to access screening services.

What does this mean for prehabilitation?

Opportunity

- Ctrl+F not useful!
- Putting patients at the centre of health and healthcare
- The three strategic shifts
- Consider the wider agenda
- Think about how prehab fits in as I take you through the next few slides…

Sickness to prevention

Reducing avoidab

- ***Return to work:***
  - Impact on t
  - Complicati
- ***Obesity and nut***
  - Food taxes
  - Specialist c
- ***Exercise and activity:***
  - “national campaign” to get people to move more

Analogue to Digital

Embedding technology into prehab pathways

- ***NHS App:***
    - **“**front door to the NHS”
    - the tool to organise care around patient needs, choices and schedules.
    - 24/7 AI-enabled advice
    - ‘Health Store’ to enable patients to access approved health apps to manage or treat their conditions, enabling innovative SMEs to work more collaboratively with the NHS and regulators.
- ***AI:***
    - New regulatory frameworks for AI and software as a medical device by 2026
    - significant investments in AI infrastructure**.**
- ***Wearables:***
    - By 2035 wearables will be standard in preventative, chronic and post-acute treatment, with data connected to the NHS App and integrated with Single Patient Record

Hospital to community

The Neighbourhood Health Service

- ***A GP led Neighbourhood Health Service:***
    - with new GP contracts to create single and multi-neighbourhood providers (beginning next year) and multiprofessional neighbourhood teams organised around groups with most need

- ***Care closer to the community*** and on the high street:
    - Neighbourhood Health Centres in every community;
    - pharmacy offering more clinical services and prevention (over the course of the plan);
    - focus on prevention through genomics technologies, diagnostics and predictive analytics

- ***Redesigning outpatient and diagnostic services:***
    - 'advice and guidance' in more specialities to reduce need for patients to travel for appointments
    - expanding the use of AI-enabled digital diagnostic tools across specialties

Reflections on how to position yourselves:

- **Speak their language**
- **Outputs not inputs**
- **What do they want to hear?**
  - Does your proposal fit with the three strategic shifts?
  - Will it improve headline statistics?
  - Will it make the NHS more productive?
  - Will it make the country more productive?

NHS
Hampshire Hospitals
NHS Foundation Trust

Development of a Macmillan Rehabilitation Assistant Practitioner

Katy Rolling, Rehab Assistant Practitioner
Emily Mean, Haematology Physio
Sarah Sharp, Oncology Dietitian

Vision

- Initial vision for role
- Macmillan Wellbeing and Supportive Care Lead applied for funding
- 2 years funding secured
- Good response to advert and competitive interview process

First year in post

- Experience prior to this role
- Training, training, training …
- Shadowing
- Competencies
- Clear boundaries for the role

Established role

- Haematology Exercise Class
- Frailty Project
- Manages Wellbeing and Supportive Care web pages
- Holistic assessment for patients on the Haematology ward
- Own Dietetic case load
- Triages Dietetic referrals for Winchester case load
- Involved in roll out of ‘Eating Well with Cancer’ website
- Onward referrals and signposting

Challenges

- Securing substantive funding
- Lack of Oncology Physio
- Management structure
- Working cross site and lack of a desk!

What now

- Cascade training:
  - Frailty
  - Universal nutritional advice
- OT apprenticeship
- Succession planning

NHS
Hampshire Hospitals
NHS Foundation Trust

Thank you!

Any Questions?

Cancer Care in Primary Care – Role of Cancer Care Co- Ordinator

- Nonclinical Cancer Champion
- Supporting with cancer care reviews by contacting diagnosed patients and offering holistic needs and frailty assessments, signposting and referring to other services.
- Supporting practices with cancer related projects, audits, searches etc
- Sharing cancer related information with clinicians within PCN.
- Supporting Cancer Prevention, Awareness or Screening uptake Campaigns
- Facebook content – linked with national campaigns and supporting Wessex Cancer Alliance Campaigns
- Ordering and distributing leaflets to practices
- C the signs dashboard
- Cancer Peer Support Group

Cancer Peer Support Group

at East Wat Clinic, every 2nd Monday of the month 6pm-7:30pm for patients diagnosed or affected by cancer registered within our PCN. This group is FREE no booking required and is run by Cancer Care Co-Ordinator & Social Prescribers employed by PCN.

Referring/signposting patients:

Wessex Cancer Support -Bournemouth Cancer Support Centre - Their services include counselling, support groups, complementary therapies, and practical support.

Macmillan -Information and support for cancer patients

CAN-EMPOWER- site for emotional and psychological support

BH live Bournemouth & Poole – Health and Wellbeing Activities – Rehabilitation programme

Help & Care – Health & Wellbeing coaching, HOPE programme

Live Well Dorset – stop smoking, stay active, weight management

Chill Therapy Bournemouth – see swimming courses

Rising Voices Wessex- A community choir for people living with and beyond cancer, support group

Other peer support groups run by our Social Prescribing Team at East Way Clinic for example: Living Mindfully, Friendship Group, Walking, Bereavement Support

Cancer Peer Support Group – case study

- Mrs L was signposted to our Cancer Peer Support Group by GP. She was very anxious and distressed about her recent cancer diagnosis. She just started her chemotherapy. She attended with her partner.

- The Cancer Care Co-Ordinator offered her a follow up support phone call the next day. During the phone conversation the Cancer Care Coordinator did the holistic needs and frailty assessment. The Cancer Care Coordinator and the patient made a personalized care plan taking into consideration what matters the most to patient at that time. She was referred to the Wessex Cancer Support Centre for further assessment and counselling. She was also signposted to another local group 'Living mindfully' to learn some relaxation techniques. Patient was also signposted to the Macmillan Support.

- This patient continued attending monthly Cancer Peer Support Group. She has finished her treatment. She has signed up with her husband for the HOPE programme after the tester session during our monthly group. She was also referred for cancer rehabilitation programme to BH live.

- We were able actively and in timely manner to signpost this patient for the support that she needed the most. She is now working on increasing her physical activity as she would like to go for long walks again .

Trusted Assessor Presentation 3rd July 2025

Wessex Prehabilitation and Rehabilitation in Cancer Conference

Karen Glover- DCH Trusted Assessor

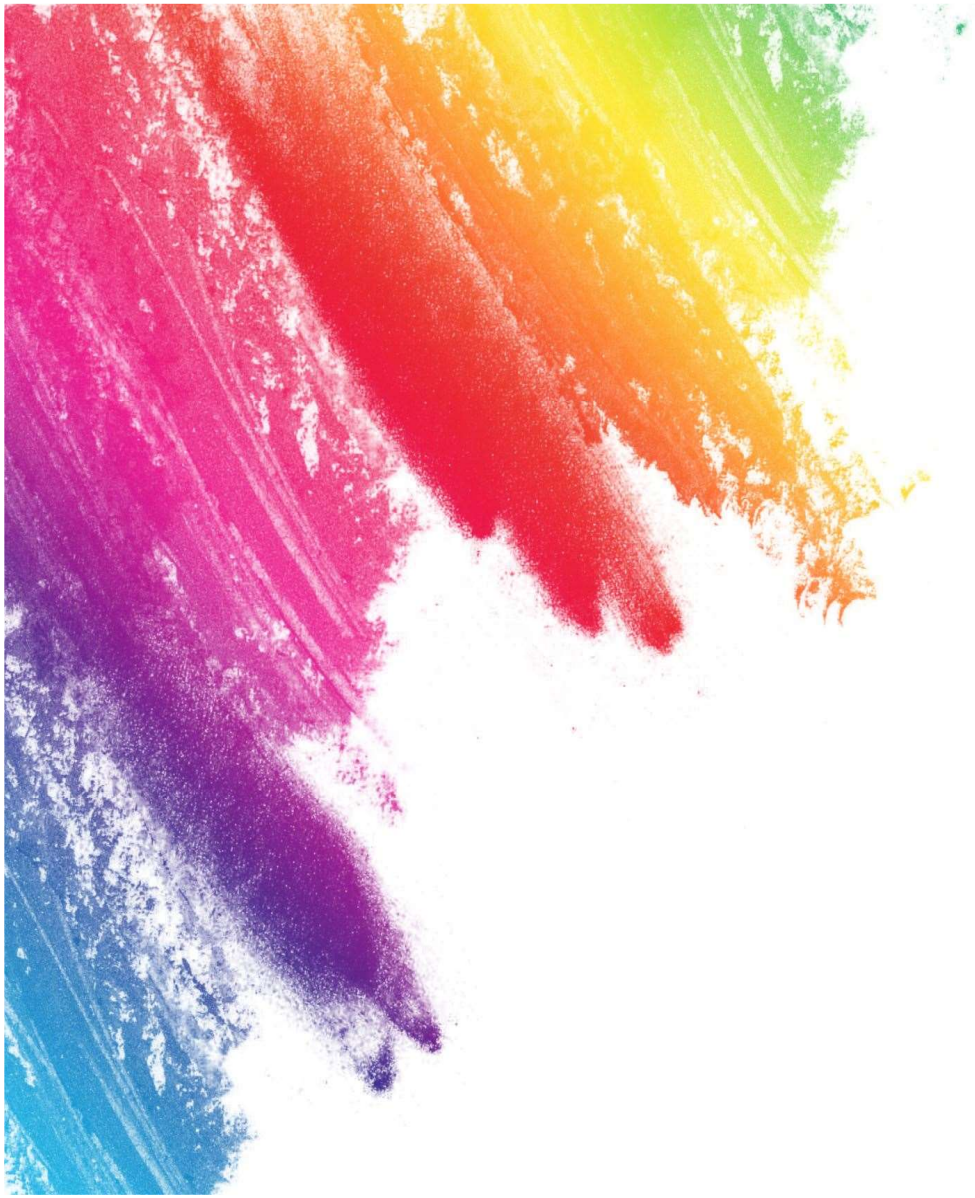

DORSET CARE
ASSOCIATION
www.dorsetcare.co

Trusted Assessor Initiative

➡ National initiative designed to reduce delays in discharges from hospitals. The underlying principal of the approach is to promote safe and timely discharge from NHS trusts to adult social care services.

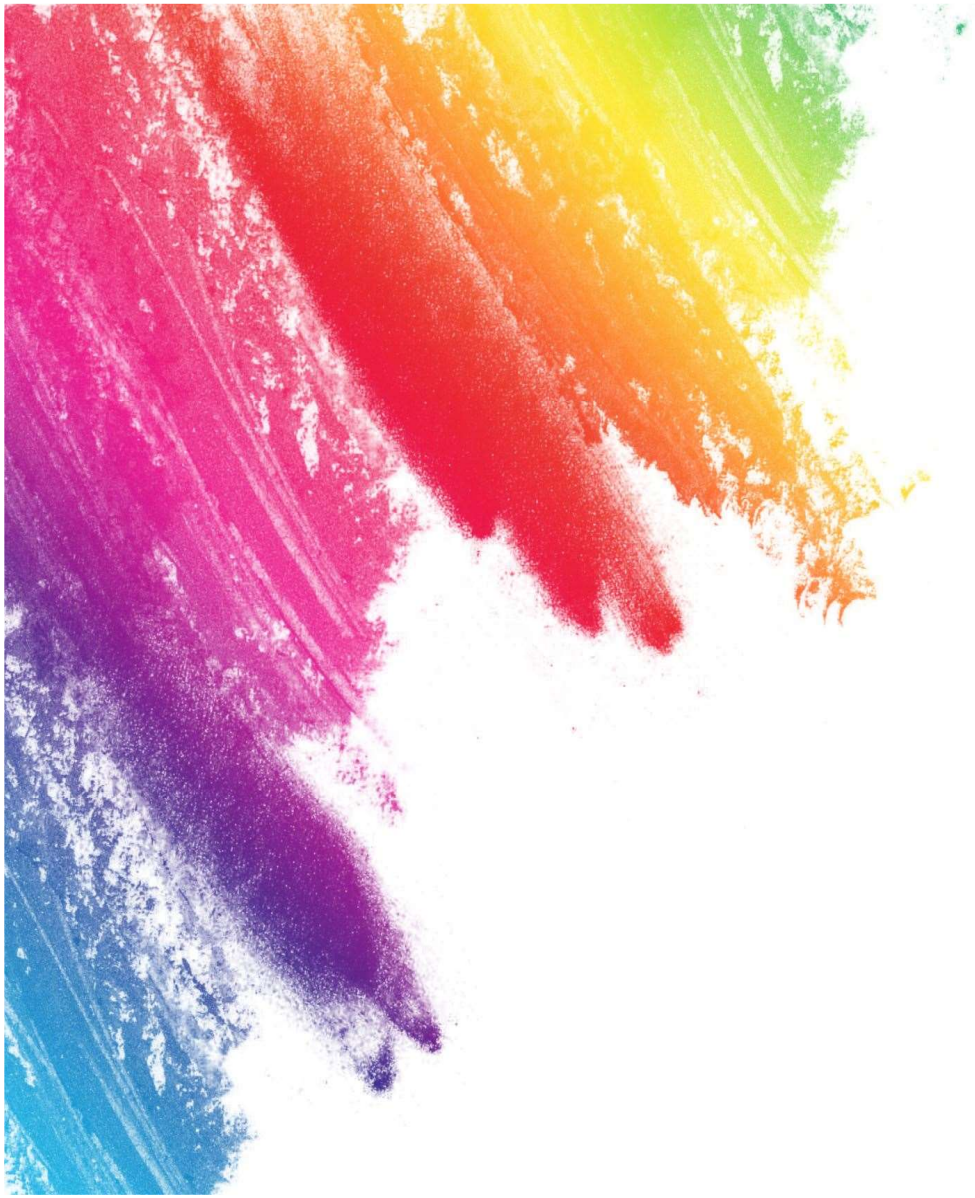
➡ Trusted Assessor is a qualified, skilled, knowledgeable and experienced individual who carries out health and social care assessments and formulate plans on behalf of adult social care providers.

CQC Guidelines



Role of a Trusted Assessor

- Professional, independent and free service for care providers
- Assessment completed within 24hrs from referral
- Reduction in delayed discharges
- Multiple site coverage including Community Hospitals
- Overview of discharge process



Trusted Assessor and Collaboration In Frailty and Oncology

- Trusted assessors provide comprehensive holistic written assessments in collaboration with the wider MDT
- Trusted assessors visit care providers and have awareness of the environment (capacity/limitations).
- Trusted assessors use their knowledge/experience to guide other professionals to ensure safe discharge with reduced risk of re-admission.
- Trusted assessors visit patients daily and provide updates to care providers. including mobility/transfers abilities.

Role of a Trusted Assessor and other professionals supporting people who are frail who have Cancer.

Roles of Health Professionals and Organisations

Oncologists diagnose and treat cancer while adjusting plans to minimize strain on frail patients. They ensure ongoing monitoring and collaboration.

- Tailored treatment plans
- Adjustments for frailty
- Care coordination

Physiotherapists focus on mobility and strength, while Occupational Therapists assist with daily activities and home adaptations.

- Rehab exercises
- Mobility training
- Home safety adaptations

Hospices provide palliative care focused on comfort and quality of life, offering pain management and emotional support.

- Symptom control
- Emotional and spiritual support
- End-of-life care

Dietitians help cancer patients with frailty manage nutrition, adjusting plans for appetite loss, nausea, and weight loss.

- Nutritional assessments
- Personalised meal plans
- Support managing side effects

Pharmacists ensure safe medication use, reviewing prescriptions and educating patient's about proper use.

- Medication reviews
- Safe dosage adjustments
- Patient education

Macmillan Nurses support cancer patients with frailty, managing symptoms, coordinating care, and providing emotional support. They guide patients and families through treatment options.

- Symptom management
- Emotional support
- Care coordination

Supporting individuals with both cancer and frailty requires a collaborative, multidisciplinary approach. Healthcare professionals and organisations work together to provide holistic care, addressing physical symptoms, emotional support, and healthcare navigation.

SCAN ME

Voluntary Organisations

citizens advice

Citizen's Advice supports cancer patients in navigating benefits, rights, and financial concerns.

- Benefit claims
- Financial support
- Legal rights

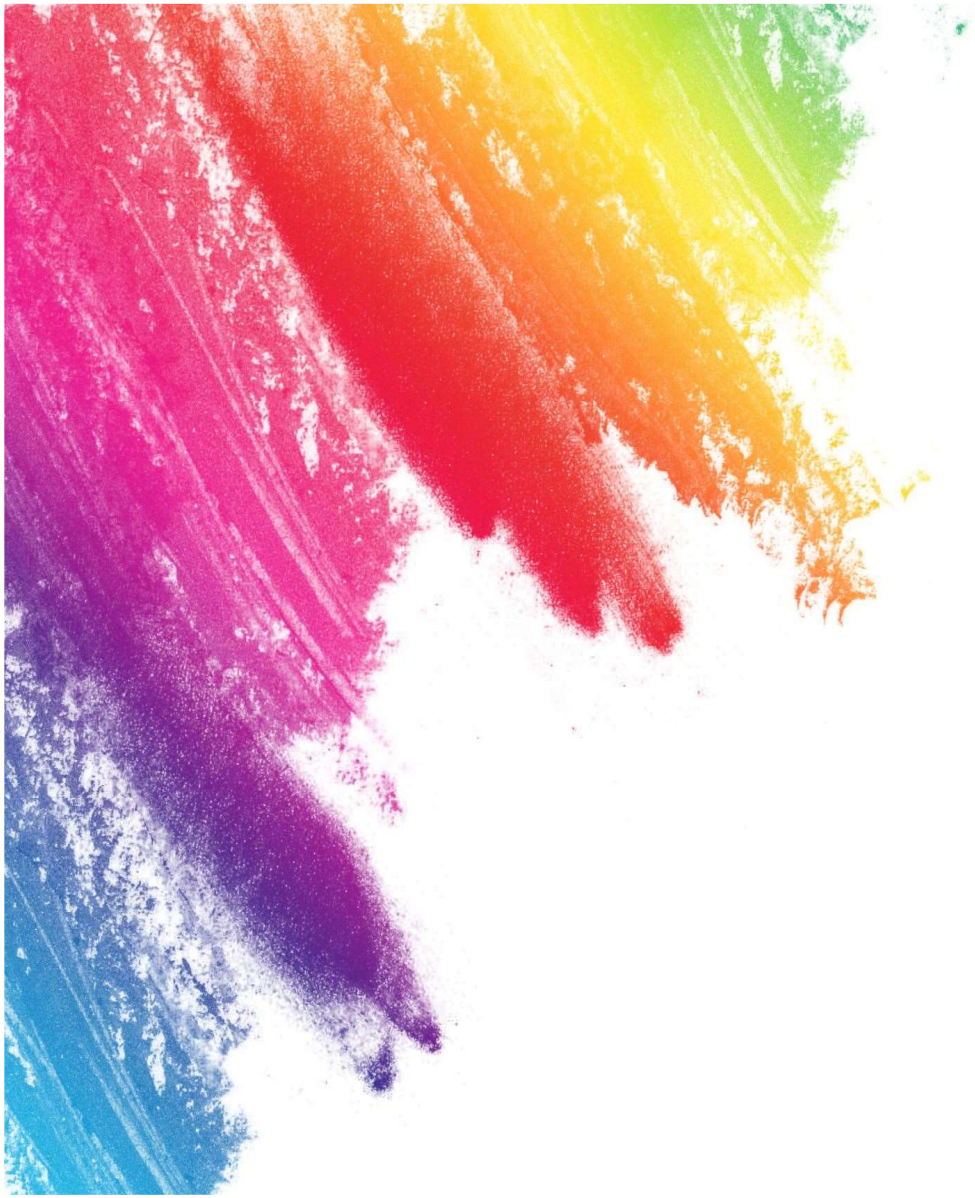
Age UK offers social, practical, and emotional support for older cancer patients and their caregivers.

- Social support
- Caregiver guidance
- Practical help

Macmillan Cancer Support- Offer comprehensive assistance for cancer patients including:

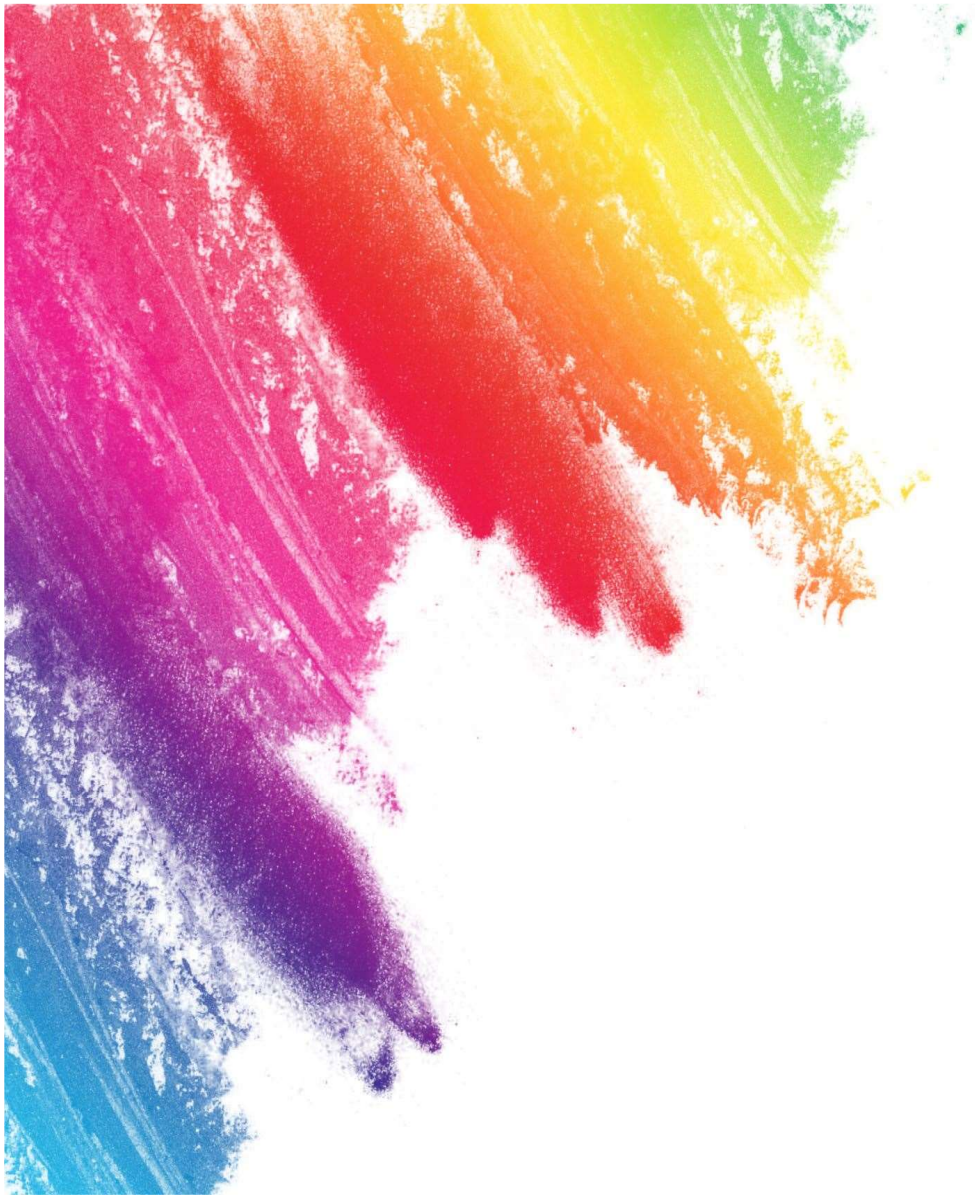
-Emotional support
-Practical support
-Financial support

Role of a Trusted Assessor: Is to Conduct holistic assessments to identify risks and ensures smooth transitions across care pathways, addressing: Physical, Emotional and Social needs.



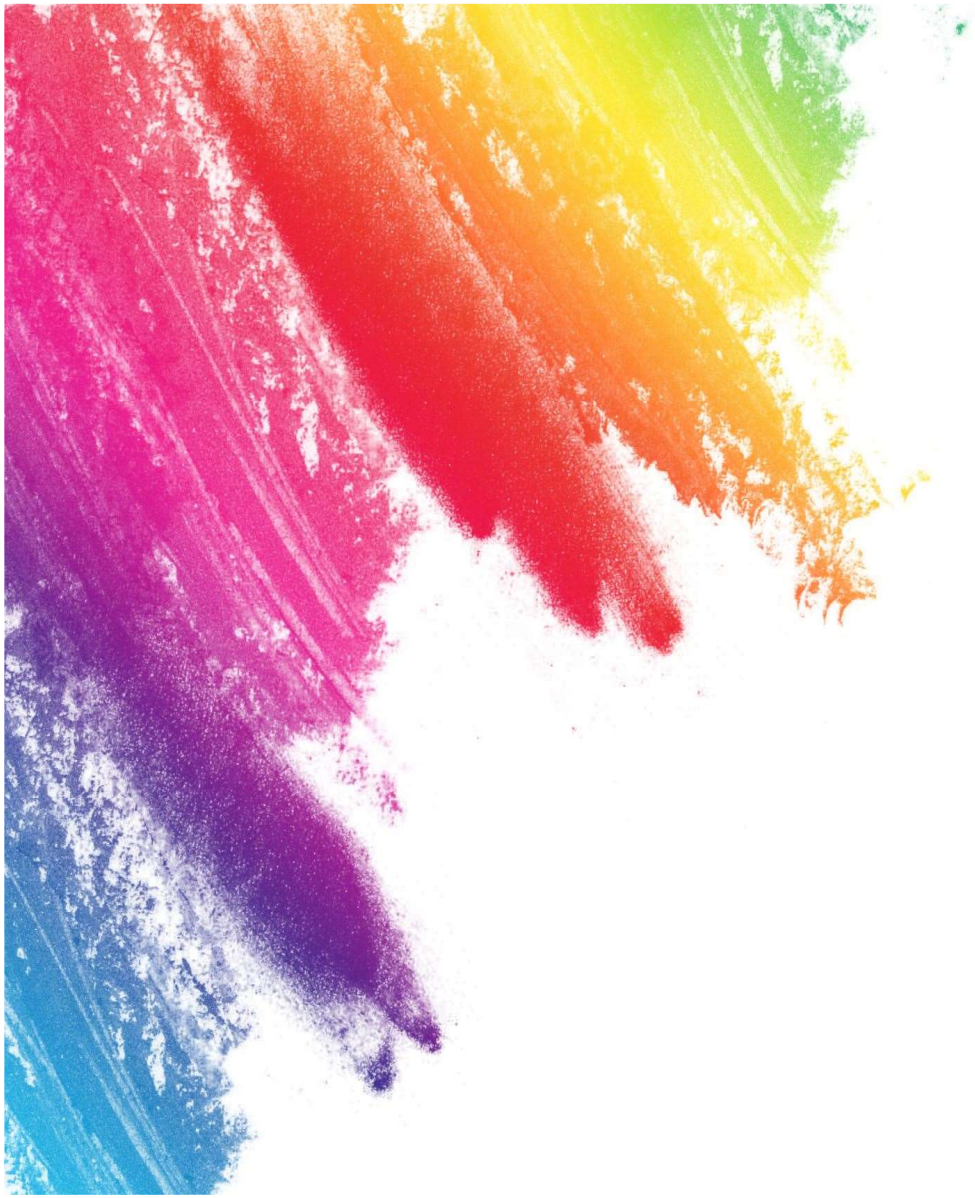
Practical Steps for Effective Collaboration

- ➡ Direct line of communication between MDT and TA's
- ➡ Regular TA updates from care provider to re discharge limitations/expectations.
- ➡ Joint assessment where feasible
- ➡ Establish feedback process for continuous improvement



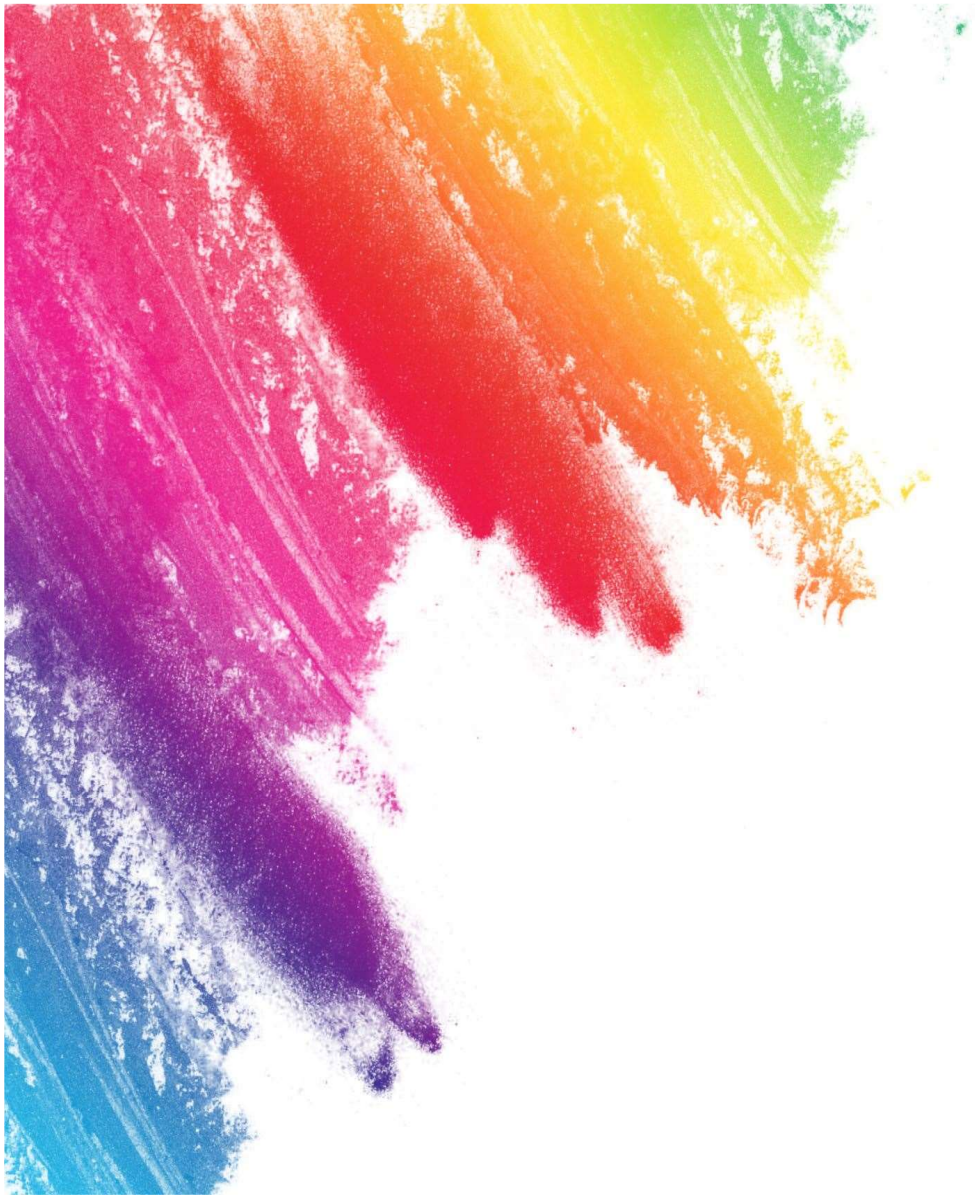
Benefits of Collaboration

- ➡ Faster, smoother discharge experience.
- ➡ Person Centered Care
- ➡ Enhanced support for care providers i.e. M&H plans/specific guidance
- ➡ Effective collaborating with Community Teams



TA's Achievements

- ➡ Effective collaboration with 135 Care Providers across Dorset
- ➡ Since 2021 over 3000 assessments completed without single failed discharge
- ➡ TA expertise sought by Mental Health Team, Brokerage, Care Allocation Team and Social Services
- ➡ Expansion of TA service to UHD Hospitals
- ➡ TA Service recognised as essential service by ICS.



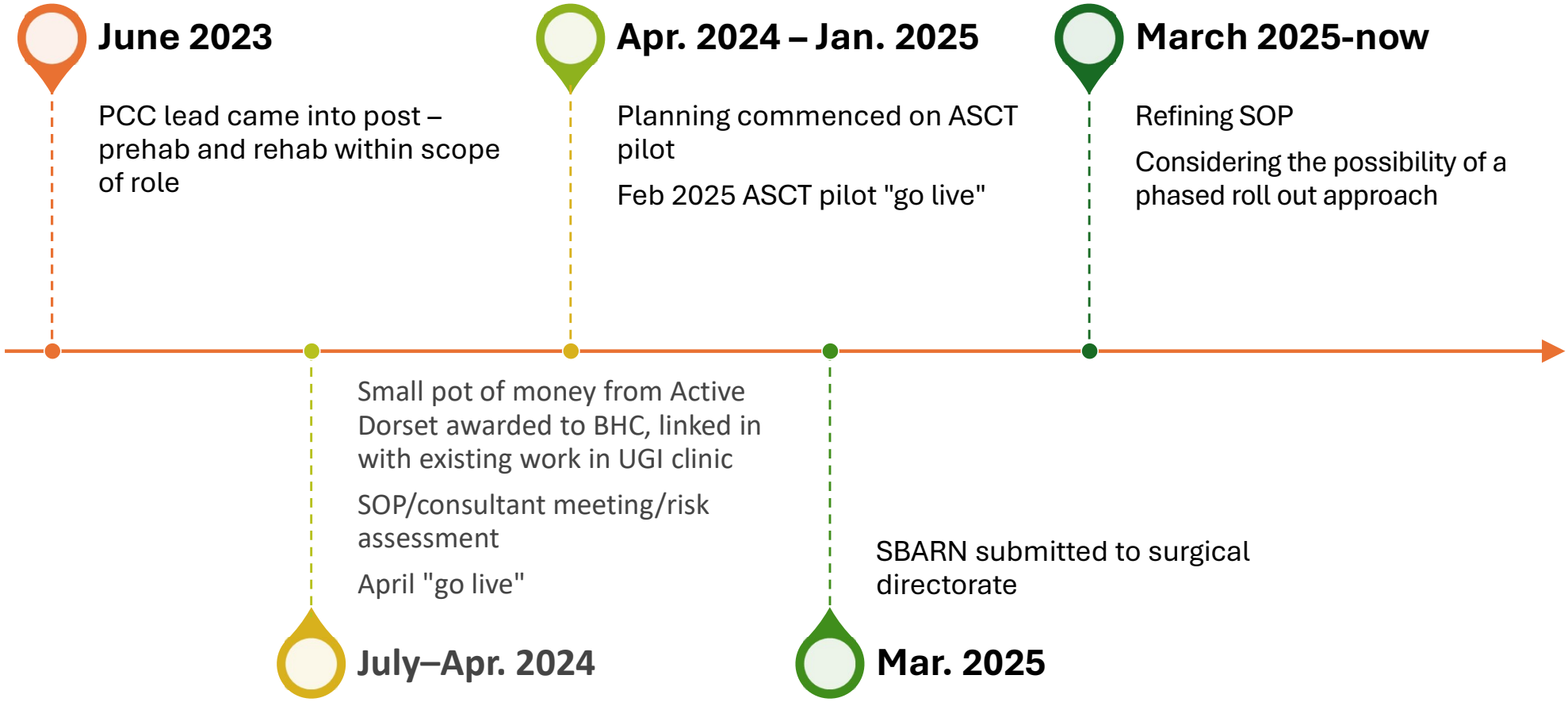
Q&A and Discussion

Prehabilitation at UHD: the start of a journey

Claire Smith – Lead Cancer Nurse

Anna McHillier – Personalised Cancer Care Lead UHD

Timeline


June 2023
PCC lead came into post – prehab and rehab within scope of role
July–Apr. 2024
Small pot of money from Active Dorset awarded to BHC, linked in with existing work in UGI clinic
SOP/consultant meeting/risk assessment
April "go live"
Apr. 2024 – Jan. 2025
Planning commenced on ASCT pilot
Feb 2025 ASCT pilot "go live"
Mar. 2025
SBARN submitted to surgical directorate
March 2025-now
Refining SOP
Considering the possibility of a phased roll out approach

Reality

- Key stakeholder engagement internally – anaesthetists, surgeons perioperative medicine, AHPs
- Bench marking against existing services nationally – University Hospitals Bristol and Weston, UHS, Northampton, Royal Berkshire
- Key Stakeholder engagement and networking externally – June, WCA – Teresa, HEIs
- Learning – Advances in Cancer Care model, reading around, attending prehab/perioperative medicine webinars, attending WCA AHP symposiums
- SBARN writing/rewriting/shared and reviewed

Current Approach – still crystalising

- Phase 1
  - Establish a surgery school and universal intervention
    - Ensure evidence-based screening and assessment tools in place to allow for stratification
    - Explore and source an app – consider use of current universal tools

- Phase 2
  - Targeted and specialist input
    - Analyse tumour site numbers
      - Project level of specialist input
      - Understand internal capacity and required uplift.
    - Discussing "prehab map" for Dorset
      - Consider more providers becoming CanRehab trained

- Phase 3
  - Consolidate engagement for all and close working with INT's
  - Explore funding possibilities – Secondary care? ICB? INT?

Navigation

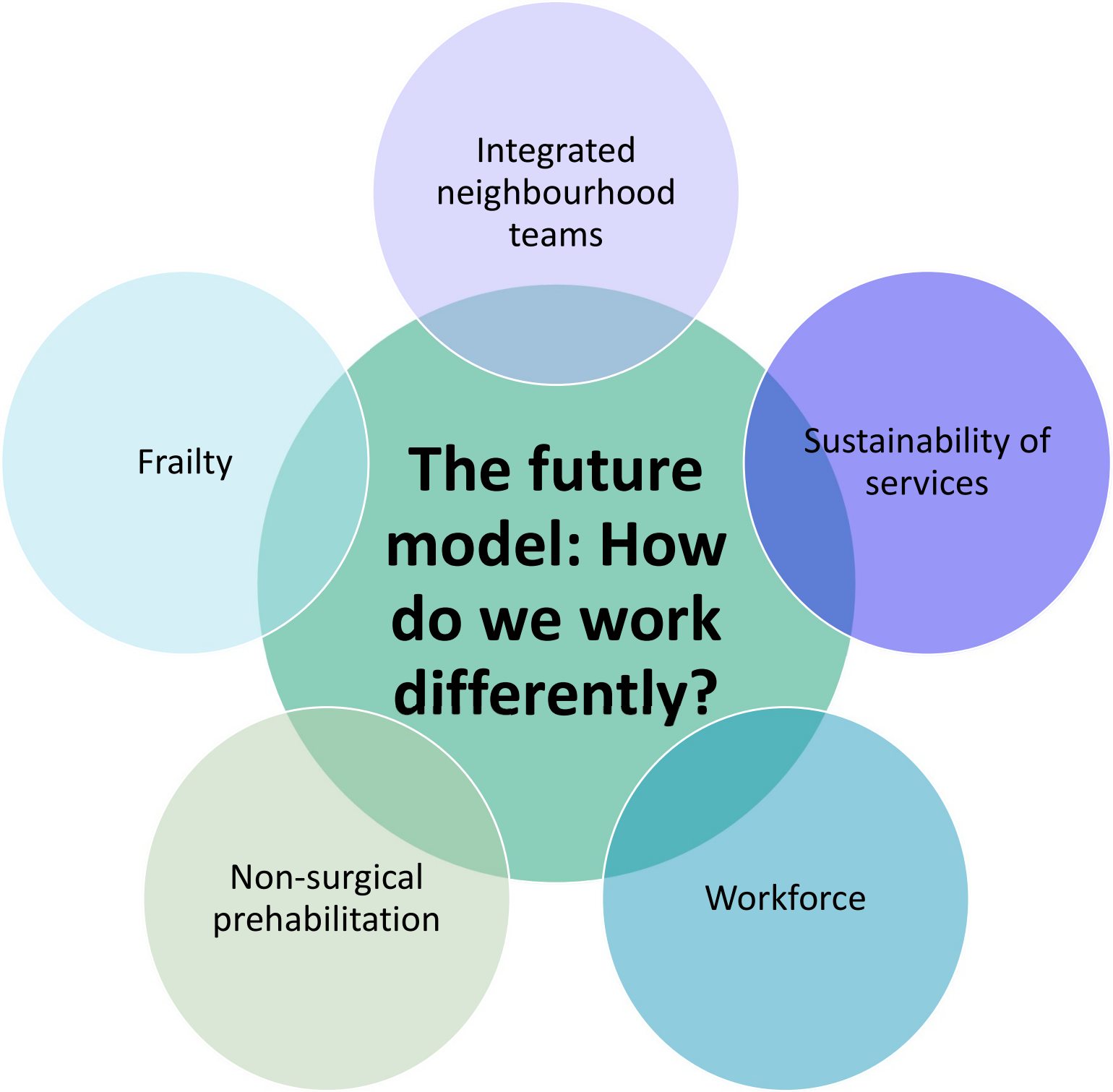
Support roles

Care plans

Learning Points

- Key stakeholder engagement and socialising the idea
  - It is SUCH A GOOD IDEA it is hard to say no to
- Opportunistic
- Tenacity

- Have we reached a tipping point at UHD?
  - Hopefully yes!
  - And well timed as will be supported by the national guidance


Integrated neighbourhood teams
Frailty
The future model: How do we work differently?
Sustainability of services
Non-surgical prehabilitation
Workforce

WCA Prehabilitation and Rehabilitation in Cancer: Toolkit and Service Improvement Tool

For support on design, implementation and delivery of prehabilitation and rehabilitation services across Wessex (and beyond).

This will shortly be updated to reflect the updated guidance.

Please contact Abi Desouza abi.Desouza@wca.uhs.nhs.uk for any queries on the toolkit and SI tool.

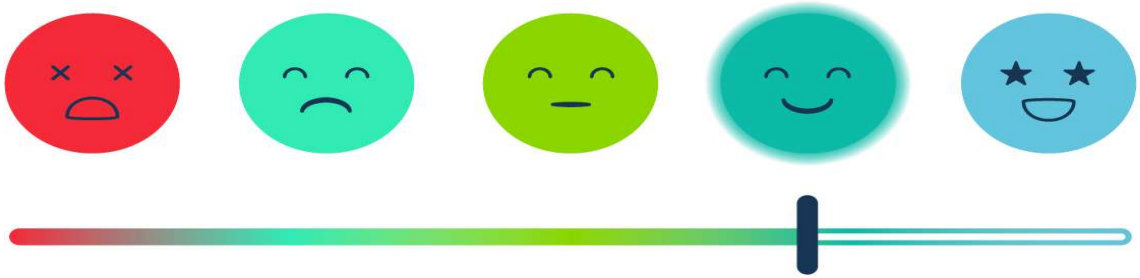
Service Improvement Tool

This service improvement tool will support health and care staff who are designing, developing and delivering prehabilitation and rehabilitation for people with cancer. This includes Cancer Alliances, Integrated Care Boards, cancer care teams, primary care teams, healthcare provider organisations, generic community rehabilitation services, commissioners, third sector organisations and education and research institutions.

In order to share, learn and work together, it is worth checking whether prehabilitation services are being delivered, or are being set up, across different teams in the organisations in which you work, e.g. perioperative medicine teams, cancer clinical teams, general surgery.

We recommend downloading a PDF copy of the questions to plan and coordinate your responses. Completed service improvement tools will be seen by the WCA team and used to measure progress and status of prehabilitation/rehabilitation across Wessex.

COMPLETE THE SERVICE IMPROVEMENT TOOL



Before you go, let us know……

NIHR | Southampton Biomedical Research Centre

NHS Wessex Cancer Alliance

Prehabilitation and Rehabilitation in Cancer Conference

Wessex 03.07.2025

Thank you for your attendance and participation in todays conference.