

Cancer Prehabilitation in Scotland: Report on Survey Findings



HEALTH AND SOCIAL CARE

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Glossary of Abbreviations and Terminology

Abbreviation / Term	Definition
AHP	Allied Health Professional AHPs encompass 14 health professions: Art Therapists, Diagnostic Radiographers, Dietitians, Dramatherapists, Music Therapists, Occupational Therapists, Orthoptists, Paramedics, Physiotherapists, Podiatrists, Prosthetists and Orthotists, Speech and Language Therapists and Therapeutic Radiographers.
CPISG	Cancer Prehabilitation Implementation Steering Group
HSCP	Health and Social Care Partnerships – bring together Local Authorities and local NHS Health Boards to plan and deliver integrated adult community health.
ICJ	Improving the Cancer Journey See TCC below.
MDT	Multidisciplinary team. A team of health professionals who work together to plan an individual's cancer treatment.
NCA	North Cancer Alliance Covers the following NHS Health Boards: Grampian, Highland, Orkney, Shetland, Tayside, Western Isles.
NHS Health Boards	NHS Scotland has 14 territorial Health Boards, which cover specific geographical areas. They are responsible for the protection and improvement of their population's health, and for the delivery of frontline healthcare services.
Primary care	Primary health care is the first point of contact with the NHS. It includes community-based services provided by, for example, GPs, community nurses, pharmacists; and by allied health professionals such as physiotherapists and speech and language therapists.
SCAN	South East Scotland Cancer Network Covers the following NHS Health Boards: Borders, Dumfries & Galloway, Fife, Lothian.
Secondary care	Mainly hospital-based health care provision, including emergency care (via Accident & Emergency), outpatient departments and elective treatments.
SG	Scottish Government
TCC	Transforming Cancer Care, a partnership between the Scottish Government and Macmillan Cancer Support.

	As part of this programme, community-based 'Improving the Cancer Journey' (ICJ) services provide people recently diagnosed with cancer with access to a key support worker. The support worker will support individualised holistic needs assessment and care planning.
Tertiary Care	Specialist health services for people with a condition requiring high levels of expertise and support services.
WoSCAN	West of Scotland Cancer Network Covers the following NHS Health Boards: Ayrshire & Arran, Forth Valley, Greater Glasgow & Clyde, Lanarkshire.

Executive Summary

This report summarises the findings from a survey undertaken in 2022 about cancer prehabilitation and rehabilitation services in Scotland. Its findings were analysed by Scottish Government (SG) analysts, on behalf of Scotland's Cancer Prehabilitation Implementation Steering Group (CPISG). Its purpose was to support CPISG to re-assess the current and planned prehabilitation position within Scotland, in order to understand awareness of the eight [Key Principles for Implementing Cancer Prehabilitation across Scotland](#) ('Key Principles') and deliver its objective of effective national roll-out of prehabilitation services.

For the purposes of the survey the following definitions were provided to respondents:

Prehabilitation “constitutes nutrition, physical activity/exercise and psychological support and the associated interventions delivered before definitive cancer treatment. You may consider individual services or multi-modal programmes.”

Rehabilitation “constitutes nutrition, physical activity/exercise and psychological support and the associated interventions delivered after definitive cancer treatment. Rehabilitation is proactive and personalised.”

There were 187 respondents to the 2022 survey, compared with 295 to a similar survey in 2019. Around three quarters of respondents were employed by the NHS in secondary or tertiary care. Nearly three quarters were Allied Health Professionals (AHPs), Physicians (secondary or tertiary care) or Nurses.

Survey findings have been summarised thematically as shown below.

Attitudes and Awareness

Nearly all respondents attached high importance to prehabilitation, with just over half viewing it as a crucial component of care before treatment, similar to the 2019 survey. Findings were similar for rehabilitation. Around two fifths had high or very high awareness of the 'Key Principles'. A similar proportion had low awareness or were not aware at all. Respondents with prehabilitation services in their local area were more likely to have high awareness.

Service Availability and Resourcing

Local prehabilitation activities were offered in half of survey respondents' areas, with findings similar for rehabilitation. Around two thirds of respondents with either a local prehabilitation or a local rehabilitation service in place had both services, while the remaining third had one service.

There was a small numerical and large percentage increase in the availability of local prehabilitation services compared with 2019. This could either reflect that those with greater awareness or interest in prehabilitation were more likely to participate in the 2022 survey, or an actual increase in the availability or awareness of local services. Following the start of the COVID-19 pandemic, many local services were scaled back or stopped, or their progress was slowed. However in 2022, services were

reported to be resuming or increasing, and new services were starting. During the pandemic many services switched from face to face to phone or video appointments. This experience informed the resumption of some services in hybrid / blended delivery modes. This was viewed as a positive development, but with recognition that while video appointments increased access for some groups they were not appropriate for others.

With regard to staff delivering prehabilitation activities, nurses, dietitians and physiotherapists were most often mentioned. Compared with 2019, there were notable increases in mentions of dietitians, clinical psychologists, counsellors and fitness instructors. One fifth of responses mentioned staff from all three prehabilitation modes; in most cases a nurse and other staff were involved too.

Staffing barriers to supporting prehabilitation included staff shortages, heavy workload and pressures on existing staff. Compared with 2019, there was a considerable increase in local services with temporary funding and a decrease in permanent funding. The need for designated staffing and dedicated and permanent funding to develop sustainable prehabilitation services was emphasised. Around one quarter of survey respondents said that there were local plans to introduce or add to local prehabilitation activities; two thirds did not know.

Service Delivery and Pathways

Respondents were asked how far local service delivery was underpinned by the 'Key Principles'. The highest level of agreement was for the principle that activities are multi-modal (around three fifths). Agreement was at around half for four of the other principles (prehabilitation starts as early as possible; runs in parallel with usual decision-making processes; is part of the rehabilitation continuum; and that screening is recorded by the cancer multidisciplinary team). Agreement was less than a quarter for the remaining three principles (screening, co-produced personalised care plans and validated tools used for assessment; care planning; and outcomes measurement).

Three fifths of respondents with local services either referred to or provided prehabilitation services, with similar findings for rehabilitation services. Poor timeliness of referrals was highlighted as a key issue, with referrals not made automatically or made late. The need for earlier screening, identification and offer of prehabilitation was emphasised, as well as appropriate referral to universal, targeted and specialist services. It was suggested that the Single Point of Contact approach, pathway navigators and cancer support workers could support this process.

Of those with local services, nearly three quarters stated that services screened or triaged for one or more of the three prehabilitation modes. Only one fifth said that services screened for all three modes, compared with the three fifths who agreed that this key principle underpinned local services. Although some suggested that multi-modal interventions were relatively common, others commented that existing interventions did not involve all three modes or that these were not linked to each other. Various approaches to screening were reported for each mode.

Around half of respondents with local prehabilitation services agreed that these services were part of the rehabilitation continuum. However, most of this group did not describe how this continuum worked in practice, so the extent to which their patients moved along a seamless pathway was not clear. Some third sector respondents whose organisations provided both prehabilitation and rehabilitation did describe service delivery throughout the cancer journey. The need for improvement in this area was acknowledged.

The need for senior-level leadership and buy-in for prehabilitation in principle was highlighted, to set the tone for less senior staff. Such leadership could also support service availability and resourcing if it led to the provision of longer-term funding and sustainable staffing. As in 2019, the need for consistent prehabilitation programmes was highlighted, with suggestions to develop a formalised prehabilitation intervention and guidance to support a consistent local offer.

Access to Services

The need to maximise patient access to services was emphasised, as was the need to improve equity of access. It was suggested that both hospital-based and community-based services were needed, to facilitate access at initial referral and during interventions. Specific patient groups at risk of inequitable access included those living in remote and rural areas and on islands, patients in under-served tumour groups and people experiencing socio-economic inequalities. The potential impact of service delivery mode on equity of access was also highlighted.

Communication and Collaboration

Among respondents with local services, multidisciplinary team (MDT) involvement was viewed as an important enabler of an effective pathway. However, there were mixed experiences of MDT engagement. Some described prehabilitation services integrated within or working closely with the MDT, while others commented on services not being part of or linked into the MDT. The need for improved MDT awareness and understanding of the benefits of prehabilitation was highlighted, as well as for improved communication between service providers.

NHS respondents with local services highlighted partnership working with third sector projects, such as the Maggie's pilot projects and Macmillan/ICJ projects, as a potential enabler of effective prehabilitation. However, awareness of these projects and working relationships with them varied, with some stating or implying that local prehabilitation was something separate undertaken by third sector organisations such as Maggie's. The need for improved links with third sector services was highlighted.

Monitoring, Evaluation and Outcome Measurement

Many respondents with local services were uncertain about whether and how monitoring data about patient uptake, adherence and experience was captured. Monitoring processes mentioned included recording patient referrals, uptake, and attendance, and feedback forms or questionnaires. Around one third stated that outcome measures were used to determine the effectiveness of prehabilitation

activities. They highlighted a range of measures used, including objective measures of muscle strength and body mass index (BMI); patient-reported outcome measures; and service-level outcomes. The need for better monitoring, evaluation and outcome measurement, to demonstrate the benefits of prehabilitation, was acknowledged. This could help make the case for long-term funding and sustainable staffing.

1 Background

This analysis reports on findings from a survey about cancer prehabilitation and rehabilitation services which was undertaken by the Scottish Government (SG) on behalf of Scotland's Cancer Prehabilitation Implementation Steering Group (CPISG). In 2019, Macmillan Cancer Support published new guidance on [Prehabilitation for People with Cancer](#). This outlined the principles of prehabilitation and offered advice on how this could be achieved in practice. A Prehabilitation Short Life Working Group was then established in Scotland. The group initiated a survey of prehabilitation services in Scotland, which was undertaken in November-December 2019, before the onset of the COVID-19 pandemic. In September 2020, the group published a report on [Prehabilitation Services in Scotland for People with Cancer](#), which included the survey findings. This work informed a commitment in the [Scottish Government's Action Plan for Cancer Services](#) published in December 2020, to implement a programme of prehabilitation work in Scotland.

CPISG was convened and tasked with developing and supporting effective national roll-out of cancer prehabilitation across Scotland. (See Appendix B for CPISG membership). To date CPISG have developed several outputs including, in April 2022, publication of the eight [Key Principles for Implementing Cancer Prehabilitation across Scotland](#), based on the Macmillan principles. CPISG are also supporting a pilot prehabilitation programme being delivered by [Maggie's](#) centres across the country. However, to deliver their objective of effective national roll-out, it was considered important for CPISG to re-assess the current and planned prehabilitation position within Scotland, to help inform the incorporation of evaluation findings into everyday practice. This survey aimed to support that objective, and to help CPISG to identify future requirements, thereby also informing Scotland's new Cancer Strategy which is expected in Spring 2023.

The survey whose findings are reported below built on the 2019 survey, repeating some of its questions. It added new questions to seek, among other things, an understanding of the impact of the COVID-19 pandemic on prehabilitation in Scotland. Some comparisons with 2019 findings are shown but it is important to note their limitations. Respondents to the 2019 and 2022 surveys were not necessarily the same people; and perceptions of what constitutes prehabilitation could differ between the two surveys.

For the purposes of the survey the following definitions were provided to respondents:

Prehabilitation “constitutes nutrition, physical activity/exercise and psychological support and the associated interventions delivered before definitive cancer treatment. You may consider individual services or multi-modal programmes.”

Rehabilitation “constitutes nutrition, physical activity/exercise and psychological support and the associated interventions delivered after definitive cancer treatment. Rehabilitation is proactive and personalised.”

2 Method

The survey questionnaire used the 2019 questions as a starting point. It added questions about awareness of the newly-published 'Key Principles' and the extent to which they underpinned local services. Other new questions explored specific aspects of service delivery, including changes since the start of the COVID-19 pandemic; potential changes in local pathways to support prehabilitation; and monitoring and outcome measurement. CPISG members helped develop and reviewed the survey questions.

An online survey was created by SG analysts on the Questback platform for which SG has licences. An online link to the survey was distributed by the SG policy team to key stakeholders working across Scotland with a request to cascade it more widely. The survey was open from 6 July until 9 August 2022 and initial invitations were sent to members of the CPISG and its three subgroups. Basic respondent characteristics were monitored each week and reminder e-mails were sent out to all initial recipients at timed intervals to increase the response rate. Specific members were also targeted if they represented a group from whom responses were limited.

SG analysts analysed the survey responses and wrote this report. The report covers the main findings from this survey, and includes some comparisons with findings from the 2019 survey, though as noted in Section 1 above there are some limitations to these comparisons. Interim findings were shared with CPISG members but they were not involved in the survey analysis or report-writing.

3 Breakdown of Respondents

The 2019 questions asking for information about respondents were repeated in this survey. Key findings are shown in table 1.

Table 1: Breakdown of Respondents

Key Points	
Number of Responses	187 (compared with 295 in 2019 survey)
Employing Organisation	77% of respondents worked for the NHS in secondary or tertiary care. The remainder worked for a Health and Social Care Partnership, a Third Sector organisation, a Local Authority or for the NHS in primary care.
Place of Work	66% of respondents worked in Acute Care (this includes NHS secondary and tertiary care). The remainder worked in Community Care, Third Sector organisations and Local Authority settings.
Job Title / Role	71% of respondents were Allied Health Professionals (AHPs), Physicians (Tertiary or Secondary Care) or Nurses. Most of the remainder were Macmillan / Improving the Cancer Journey (ICJ) staff; in Psychological Support roles; Executive Leads / Service Managers; Physicians (Primary Care) or Exercise Specialists.
Health Board location	Responses were received from 13 of the 14 territorial NHS Health Boards. Four Boards accounted for 65% of responses: NHS Greater Glasgow and Clyde, Grampian, Lothian, and Highland.
Cancer Network	Responses broke down as follows: West of Scotland Cancer Network (WoSCAN) – 43% of responses. North Cancer Alliance (NCA) – 32%. South East Scotland Cancer Network (SCAN) – 25%.

See Appendix A: Breakdown of Respondents for more details.

4 Prehabilitation Findings

4.1 Attitudes and Awareness

This theme discusses attitudes among all survey respondents about the importance of prehabilitation; and their awareness of the 'Key Principles' for Cancer Prehabilitation.

4.1.1 Importance of Prehabilitation

Respondents were asked about the importance of prehabilitation interventions for people about to undergo cancer treatment. 154 out of 187 potential respondents (82% of the sample) answered this question, with findings shown in table 2.

Table 2: Importance of Prehabilitation

Importance of Prehabilitation	number of responses	% of responses to this question	% of survey respondents
1 = Not Important At All	0	0%	0%
2	1	1%	1%
3	9	6%	5%
4	54	35%	29%
5 = Crucial	90	58%	48%
No Response	33		18%
Total Responses to this Question	154	100%	100%

Of those who answered the question, 94% selected 4 or 5, indicating that they attached high importance to prehabilitation. This finding was similar for all three cancer networks. 58% of those respondents selected 5, 'crucial', similar to the equivalent 2019 findings (47%). 18% of survey respondents did not answer this question, implying that they did not know.

4.1.2 Awareness of the 'Key Principles for Implementing Cancer Prehabilitation in Scotland'

Respondents were asked to rate their awareness of the 'Key Principles', published in April 2022. All 187 survey respondents answered this question.

- 41% of respondents selected 4 or 5 (high awareness).
- 21% of respondents selected 3 (medium awareness).
- 38% of respondents selected 2 or 1 (low awareness or not aware at all).

There was some variation among the cancer networks. For the SCAN and WoSCAN networks, over 40% of respondents selected 4 or 5 (high awareness), whereas for the NCA this figure was 33%.

Respondents with services in their local area (see Section 4.2) were more likely to have high awareness of the ‘Key Principles’.

The extent to which respondents considered that the eight principles underpinned local service delivery is discussed under the themes below.

4.2 Service Availability and Resourcing

This theme discusses the availability of local prehabilitation services, changes since the start of the COVID-19 pandemic and plans to introduce new services. It also covers the key resourcing issues of staffing and funding.

4.2.1 Availability of Local Prehabilitation Activities

Respondents were asked whether any cancer prehabilitation activities were being offered in their local area.

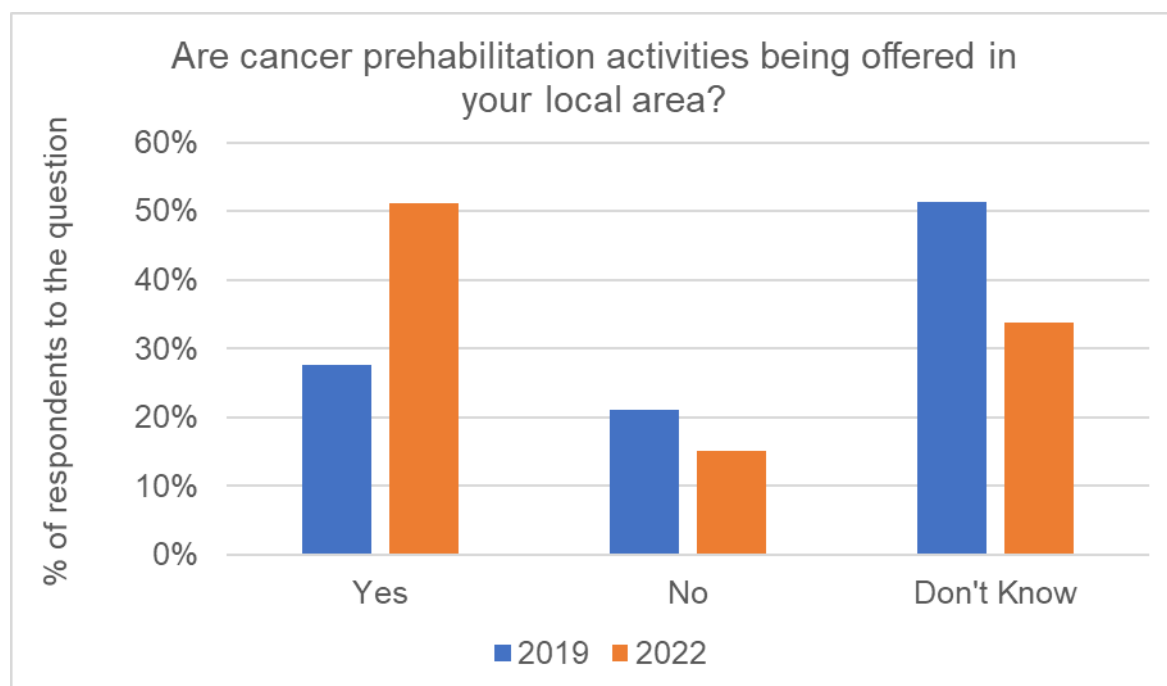
186 out of 187 survey respondents answered this question. Around half said that prehabilitation activities were offered in their local area, as shown in Table 3.

Table 3: Availability of local prehabilitation activities

Prehabilitation Activities offered in local area?	Number of Responses	% of Responses to this Question
Yes	95	51%
No	28	15%
Don't Know	63	34%
Total	186	100%

The same question was asked in the 2019 survey. 2022 findings show a small numerical and large percentage increase in the offer of local activities. Comparisons are shown in Chart 1 below.

Chart 1: Availability of local prehabilitation activities – 2019 and 2022 compared



The lower percentage of those answering ‘Don’t know’ in the 2022 survey could indicate a survey bias, with those aware of or interested in prehabilitation more likely to participate. An alternative explanation is that results might indicate an increase in awareness and/or availability of prehabilitation services since 2019. As noted in Section 1, there are limitations on comparisons between the 2019 and 2022 survey findings.

A breakdown by cancer network is shown in Table 4. WoSCAN respondents reported more local services than the other networks in both 2019 and 2022, with the NCA showing the biggest increase (numerical and percentage) in respondents with local services.

Table 4: Availability of local prehabilitation activities by cancer network

Number Responding 'Yes' to this Question by Cancer Network		
Cancer Network	2019	2022
NCA	6	23
SCAN	23	19
WoSCAN	49	53
Total	78	95

Respondents with locally available prehabilitation services (n = 95) were asked further questions about the availability and resourcing of those services.

4.2.2 Changes since the start of COVID-19

Respondents with local prehabilitation services were asked about changes in local activities since the start of the Covid-19 pandemic. 85 out of 95 potential respondents answered this question.

Many respondents discussed how a number of services were stopped completely, scaled back, or their progress was slowed due to the pandemic. However, they also mentioned how these activities were now resuming or increasing. Some new services were highlighted as positive developments even if they were starting on a small scale or as pilot projects. Examples of new services included:

- A new service for lung cancer patients, which was delayed by the pandemic.
- A new dietitian post for gynaecological cancers.
- Funded psychological support allocated to Maggie's who deliver it to urology patients.
- A funded dedicated physiotherapy service.
- A new small-scale service for people with advanced lung cancer.
- A new link with a local authority leisure service to establish a pathway.

4.2.3 Delivery Mode

Following the onset of the COVID-19 pandemic, many services switched from face to face to phone or video appointments as appropriate. This experience informed the resumption of some services in hybrid / blended delivery modes. Respondents commented positively that the use of video increased access for some groups, for example those living in remote or rural areas. However, it was also acknowledged that video is not appropriate for others, such as some older people, those who are digitally excluded, or people whose suitability for exercise programmes needs to be assessed in person. Respondents believed that face to face services would still be needed for some groups such as these.

4.2.4 Staffing

Respondents were asked what staff or volunteers were involved in the delivery of prehabilitation activities in their local area. 90 out of 95 potential respondents answered as shown in Table 5.

Table 5: Staff involved in delivery of local prehabilitation activities

Staff / Volunteer Role	% of Respondents to this Question who selected this option
Nurse	61%
Dietitian	51%
Physiotherapist	47%
Clinical Psychologist	32%
Fitness Instructor (Local Authority/Move More etc.)	28%
Occupational Therapist	20%
Volunteer/Buddy/Peer Supporter	19%
Counsellor	13%
NHS Technical Instructor/Support Worker	8%

Nurses, dietitians, and physiotherapists were the staff roles most likely to be identified by respondents as involved in the delivery of activities.

Compared with 2019, the most notable increases were in the proportion of respondents selecting:

- Dietitian (from 30% in 2019 to 51%).
- Clinical Psychologist (from 11% in 2019 to 32%).
- Counsellor (from 2.5% in 2019 to 13%).
- Fitness Instructor (from 20% in 2019 to 28%).

There was a smaller increase in mentions of Physiotherapist (from 43% in 2019 to 47%).

Of 'Other' roles, Maggie's staff were mentioned most frequently.

Involvement of staff delivering all three prehabilitation modes was reported by 19% of respondents, as shown in Table 6. Many also responded that a nurse and other staff were involved too.

Table 6: Staff delivering the three prehabilitation modes

Prehabilitation Modes	% of Respondents to this Question
Physical Fitness: Physiotherapist and/or Fitness Instructor	65%
Nutrition: Dietitian	51%
Psychological Support: Clinical Psychologist and/or Counsellor	35%
Responses showing staff from all 3 modes	19%

Qualitative findings from open questions highlighted staffing as a major theme. Staff shortages, heavy workload, and pressures on existing staff; and challenges in attracting and retaining staff, both in general and for temporary prehabilitation projects, were cited as barriers to supporting prehabilitation. Some respondents suggested that designated staffing for prehabilitation work was needed.

Respondents also mentioned pressures on broader health services, such as long waiting lists and insufficient clinical space, which made services difficult for people to access. Services were said to be reactive and focused on crisis management, rather than on prevention and prehabilitation.

4.2.5 Funding

Respondents were asked what type of funding their prehabilitation activities received. 94 out of 95 potential respondents answered that question as shown in Table 7.

Table 7: Type of funding for local prehabilitation activities

Type of Funding	Number of Responses	% of Responses to this Question
Permanent funding	2	2%
Temporary funding	37	39%
I don't know about funding	40	43%
No funding	15	16%
Total	94	100%

Compared with the 2019 findings, the percentage of permanent funding shows a notable decrease, down from 16% to 2% (2 responses). Review of those 2 responses showed that, in both cases, the permanent funding was for specific services which were not part of a comprehensive prehabilitation programme.

There has been a considerable increase in temporary funding (from 17.5% in 2019 to 39%). 65% of respondents with temporary funding stated that it was expected to end in 2022 or 2023 or had ended already.

The proportions with no funding and who did not know were similar to those in 2019.

Funding and resources, including staffing, were strong interrelated themes in response to open questions in this survey, as also reflected in the 2019 survey. Respondents discussed the need for dedicated and permanent funding to develop sustainable prehabilitation services.

Potential influences on future resourcing of prehabilitation, both funding and staffing, could include senior leadership and buy-in for prehabilitation (discussed in Section 4.3), and the availability of evidence about the outcomes of prehabilitation (see Section 4.6).

4.2.6 Introduction of New Prehabilitation Activities

All survey respondents were asked about plans to introduce or add to local prehabilitation activities. 27% of those who answered this question said there were such plans but two thirds did not know. Details are shown in Table 8.

Table 8: Plans to introduce or add to local prehabilitation activities

Plans to introduce / add to local activities?	Number of Responses	% of Responses to this Question
Yes	50	27%
No	12	7%
Don't Know	122	66%
Total Responses to this Question	184	100%

There was some variation across cancer networks. NCA respondents were most likely to be aware of plans to introduce or add to local activities (31%), with SCAN respondents least likely (23%). The proportion for WoSCAN was 27%.

4.3 Service Delivery and Pathways

Respondents with locally available prehabilitation services (n = 95) reflected on specific aspects of prehabilitation service delivery in their area, where improvement could enhance the future effectiveness of local services. Some of the 'Key Principles' are used to frame the discussion about those findings.

4.3.1 Local Delivery underpinned by 'Key Principles for Implementing Cancer Prehabilitation'

Respondents were presented with a series of statements about the eight 'Key Principles' and asked to what extent they agreed that each principle underpinned the delivery of prehabilitation activities in their local area. For each statement, 94 or 95 out of 95 potential respondents answered the question.

The highest level of agreement was with the statement "Prehabilitation activities are multi-modal including exercise/activity, nutrition and psychological support", with 61% of respondents agreeing (including strong agreement).

About half of respondents agreed with the 4 statements below.

- "Prehabilitation activities start as early as possible and in advance of any cancer treatment" (46% agreed).
- "Prehabilitation activities run in parallel with usual decision-making processes so it does not have an adverse effect on cancer waiting times nor delay the start of treatment" (55% agreed).

- “Prehabilitation activities are part of the rehabilitation continuum” (45% agreed).
- “Completion of prehabilitation screening should be recorded at cancer multidisciplinary team alongside performance status” (47% agreed)”.

Three statements had fairly low levels of agreement. These were:

- “All patients are screened to determine the level of prehabilitation required (universal, targeted, specialist)” (23% agreed).
- “All patients (receiving universal, targeted and specialist interventions) have a co-produced personalised prehabilitation care plan” (21% agreed).
- “Validated tools are used for individualised assessment, care planning and outcomes measurement when patients are receiving targeted and specialist interventions” (16% agreed).

Some of these principles are used to frame the discussion below about specific aspects of service delivery.

4.3.2 Referrals

Respondents were asked if they personally referred people to prehabilitation activities and how routinely they did so. 95 out of 95 potential respondents answered, with a breakdown of responses in Table 9.

Table 9: Referral to prehabilitation activities

Referral to Prehabilitation Activities?	Number of Responses	% of Responses to this Question
Yes	35	37%
No	38	40%
I provide prehabilitation services	22	23%
Total Responses to this Question	95	100%

60% of respondents reported that they either referred to or provided prehabilitation services. These findings are similar to the 2019 survey (which included a ‘not applicable’ response option).

34 out of 35 potential respondents (those who answered Yes) also answered the follow-up question about how routinely they refer people.

- 41% selected 4 or 5 (more likely to or always refer).
- 38% selected 3 (medium likelihood of referring).
- 21% selected 1 or 2 (less likely to refer).

Qualitative findings from the open questions highlighted the timeliness of referrals as a key issue, which had already emerged in the 2019 survey. This links to the ‘Key

Principles' that "Prehabilitation activities start as early as possible and in advance of any cancer treatment;" and that "Prehabilitation activities run in parallel with usual decision-making processes, so it does not have an adverse effect on cancer waiting times nor delay the start of treatment."

While it was acknowledged that waiting lists offered an opportunity for prehabilitation interventions, more commonly respondents commented that referrals were not made automatically or were made late. Since treatment should not be delayed and taking into account waiting time targets, this meant that there was often insufficient time to provide prehabilitation interventions before treatment. The need for earlier screening, identification and offer of prehabilitation was highlighted, as well as appropriate referral to universal, targeted and specialist services.

Respondents were asked to share their thoughts on how local pathways could be changed to support prehabilitation. Some stated that prehabilitation services were integrated in patient pathways, with staff routinely screening and referring or signposting patients to appropriate services. Others reported that their local services were not working in this way, with comments that referrals were not always timely. It was suggested that the Single Point of Contact approach, pathway navigators and cancer support workers could support this process.

4.3.3 Screening, assessment and care planning

Respondents were asked if their local prehabilitation service was screening or triaging patients for perceived risk associated with each of the three modes of Nutrition, Physical Activity and Psychological Need. This links to the 'Key Principles' that "All patients are screened to determine the level of prehabilitation required (universal, targeted, specialist);" that "Validated tools are used for individualised assessment, care planning and outcomes measurement when patients are receiving targeted and specialist interventions; and that "All patients (receiving universal, targeted and specialist interventions) have a co-produced personalised prehabilitation care plan."

Of the 95 respondents with local services, 71% responded that their service screened for one or more of the three modes. For each separate mode, just under half of respondents indicated that patients were screened or triaged. Details are shown in Table 10.

Table 10: Screening or triaging patients by prehabilitation mode

Screening or triaging patients for perceived risk associated with:	% responding 'Yes'
Nutrition	44%
Physical Activity / Exercise	46%
Psychological Need	43%
Any mode (n = 67 respondents)	71%
None of the modes (n = 28 respondents)	29%

A breakdown of the 67 respondents whose service was screening for any of the three modes is shown in Table 11. Half of those respondents said that their local service was screening for all three modes, representing 22% of respondents with local services.

Table 11: Screening or triaging patients by number of prehabilitation modes

Service screening for:	Number of Respondents	% of Total	% of respondents with a local service
all 3 modes	21	50%	22%
2 modes	16	31%	17%
1 mode	30	19%	31%
Total	67	100%	71%

In response to open questions, respondents highlighted the need for the involvement of all three modes in prehabilitation services. This links to the 'Key Principle' that "Prehabilitation activities are multi-modal including exercise/activity, nutrition and psychological support." Although responses to some questions suggested that multi-modal interventions were relatively common, some respondents commented that existing interventions did not involve all three modes or that these were not linked to each other.

Respondents whose service was undertaking screening were invited to describe how it was doing this; they responded as follows.

Nutrition. Common approaches to screening included using MUST (Malnutrition Universal Screening Tool), or assessments of weight or appetite change. Less common tools mentioned included the 'Eat Well Age Well' tool for non-clinicians and a frailty screening tool. Respondents reported that screening most often took place through an assessment but that this could be over the phone or during a discussion. Professions highlighted as involved in the screening included Clinical Nurse

Specialists, GPs, Physiotherapists and Dietitians. Referrals mostly went to community or specialist dietitians for onward treatment.

Physical Activity / Exercise. Many responses mentioned consultations or assessments as a means of undertaking physical activity screening. These often included validated tools or objective measures, such as the DASI (Duke Activity Status Index) functional capacity calculator, BMI (Body Mass Index), frailty scores. Clinical Nurse Specialists and Physiotherapists were commonly mentioned as carrying out the screening although other professions were also noted, including Consultants, GPs, and Occupational Therapists. The outcome of screening often involved referral to a physical activity service, which might be provided by the third sector (e.g., [Move More](#)) or a local authority.

Psychological Need. Screening processes were described for low mood, anxiety or depression, or for support needs. These were typically undertaken using a clinical assessment or health needs assessment, involving tools like the EQ-5D (Health-Related Quality of Life). However, a couple of responses mentioned that screening for psychological support is part of a broader, holistic assessment of support needs. More conversational or informal assessments were noted by a few respondents.

In many examples given, respondents used the terms screening and assessment interchangeably, although they are different processes with different purposes. No detail was provided about care planning.

4.3.4 Rehabilitation Continuum

This sub-theme links to the 'Key Principle' that "Prehabilitation activities are part of the rehabilitation continuum." 62 respondents had both local prehabilitation and rehabilitation services, representing around two thirds of respondents with either local service. Analysis of responses from this group showed that around half agreed that this principle underpinned their local services. However most did not describe how their local continuum worked in practice, so the extent to which their patients moved along a seamless pathway was not clear. This could be because of respondents' limited awareness or because the survey did not ask about the rehabilitation continuum explicitly. Some responses suggested that a continuum was in place to some extent, but in some cases this applied only to one prehabilitation mode. A few respondents who did describe service delivery throughout the cancer journey were mainly from third sector organisations which provided both prehabilitation and rehabilitation services. Some respondents highlighted the need for improvement in this area.

4.3.5 Leadership and Management

Leadership and management were mentioned in relation to how local pathways could be changed to support prehabilitation. Some respondents discussed the need for senior-level leadership and buy-in for prehabilitation in principle, setting the tone for less senior staff. This issue could also link to the service availability and resourcing theme (see Section 4.2), if senior-level buy-in led to the provision of longer-term funding and sustainable staffing.

Other respondents emphasised the need for local management and co-ordination of the practical aspects of service delivery.

4.3.6 Consistent Programmes and Guidance

Some respondents highlighted the need for consistent programmes and guidance, in line with the 2019 survey. A few respondents suggested developing a formalised prehabilitation intervention and guidance for a consistent local offer by all prehabilitation services.

While many of the above themes show similarities with findings from the 2019 survey, they also reflect challenges in the NHS and cancer services landscape which have arisen since then. Particular challenges arising from and following the COVID-19 pandemic include broader pressure on health services including staff shortages and long waiting lists, as discussed in Section 4.2.

4.4 Access to Services

Respondents with local prehabilitation services (n = 95) discussed the location of and access to prehabilitation services; and the need for equitable access to services.

4.4.1 Access to Services

Location of intervention: it was suggested both that services should be based in hospitals to facilitate patient access at initial referral, and that services should be available in community facilities which would be more accessible to patients receiving interventions. The need to address geographical inequalities was also mentioned in the context of the location of interventions and availability of transport.

Patient access: some respondents commented on the general need to improve access to services for patients and their families, by increasing their awareness about prehabilitation and by making access easier and more flexible.

4.4.2 Equity and Inequalities

Respondents commented on the challenge of providing services across remote and rural areas, and for island residents. The need to provide equitable services for all tumour groups was also highlighted. Respondents also thought socio-economic inequalities needed to be addressed, in terms of the likelihood of people engaging with services and the affordability of some services, such as exercise sessions.

As discussed in Section 4.2, some respondents highlighted the need to consider the potential impact of service delivery mode on equity of access. They noted that video consultations are not appropriate for some groups, such as people who are digitally excluded, who might also be experiencing other inequalities.

4.5 Communication and Collaboration

Respondents with local prehabilitation services (n = 95) reflected on communication and collaboration between services, including with regard to their local MDT and with local third sector projects.

4.5.1 Multidisciplinary Team (MDT) Engagement

This sub-theme links to the 'Key Principle' that "Completion of prehabilitation screening should be recorded at multidisciplinary team alongside performance status." Findings which contributed included responses to a question about how closely staff providing prehabilitation worked within the care team and patient pathway, for example in an MDT.

Around 40% of respondents to this question explicitly mentioned or alluded to the MDT, though not specifically to MDT meetings. Around half of those discussed prehabilitation services integrated within the local MDT or working closely with it. The other half commented on services not being part of the MDT and not linked into it.

Some respondents described MDT involvement as an important enabler of an effective pathway. Respondents cited the need for improved MDT awareness and understanding of prehabilitation; improved communication between service providers; and improved MDT links with third sector services. A few respondents commented that their local MDT was not comprehensive in terms of including all key professions and all three prehabilitation modes.

Where prehabilitation falls outside MDTs or is spread across services, there were some positive comments about communication and collaboration, but others that there was need for improvement. Respondents reflected on the need for improved communication among staff, including between primary and secondary care and with third sector and local authority service providers. The importance of improving staff understanding of the benefits of prehabilitation was also highlighted. They also mentioned the need for improved communication with patients, including about how prehabilitation could benefit them.

4.5.2 Collaboration with Third Sector Organisations

Several respondents mentioned specific third sector projects, mainly the Maggie's pilot projects and Macmillan/ICJ projects. NHS respondents in particular highlighted partnership working with such projects as a potential enabler of effective prehabilitation. However awareness of these projects and working relationships with them varied. While a few respondents mentioned a close working relationship, most suggested a more distant working relationship. They stated or implied that local prehabilitation was something separate undertaken by Maggie's and that the MDT was not involved.

4.6 Monitoring, Evaluation and Outcome Measurement

Respondents with local prehabilitation services (n = 95) were asked how patient uptake, adherence and experience were monitored; and how patient outcome measures were used to determine the effectiveness of those services.

4.6.1 Monitoring and Evaluation

Many respondents were uncertain about whether and how monitoring was undertaken. Monitoring processes mentioned included recording patient referrals, uptake and attendance; and feedback forms or questionnaires.

Patient uptake. Monitoring processes described often involved recording patient referrals and uptake on a database (e.g., a spreadsheet or software system). A couple of responses mentioned monitoring demographic information and patient impact or outcomes. Few mentioned how the data were used. Some responses highlighted regular reporting of the data, which appeared to be for local monitoring purposes.

Patient adherence. There was a lot of uncertainty about whether patient adherence was monitored within local programmes. Several respondents reported on activities which were stand-alone sessions and so this was not applicable. Others commented that monitoring was undertaken by Maggie's projects. Where data were recorded this was primarily in the form of statistics such as attendance figures. A few respondents mentioned more qualitative information such as feedback or diary information being used.

Patient experience. Many respondents were unsure about whether or how patient experience was monitored. For those that did provide information, feedback forms or a questionnaire or survey was a common approach. These were offered at the end of an intervention, at a specific point (e.g., after surgery), or at multiple points. A few mentioned collecting information informally. Case studies, stories and focus groups were also mentioned but less often as ways of monitoring patient experience.

4.6.2 Outcome Measurement

This links to the 'Key Principle' that "Validated tools are used for individualised assessment, care planning and outcomes measurement when patients are receiving targeted and specialist interventions."

Respondents were asked if outcome measures were being used to determine the effectiveness of their prehabilitation activities. 90 out of 95 potential respondents answered, as shown in Table 12.

Table 12: Use of outcome measures to determine the effectiveness of prehabilitation activities

Use of Outcome Measures?	Number of Responses	% of Responses to this Question
Yes	33	35%
No	14	15%
Don't know	41	43%
Not applicable	7	7%
Total Responses to the Question	95	100%

The proportion answering 'Yes' (35%) was lower than the 2019 finding (55%).

Respondents highlighted a wide range of measures, similar to those mentioned in the 2019 survey. They included objective measures such as of muscle strength and Body Mass Index (BMI); patient-reported outcome measures and service-level outcomes. Some measures mentioned by respondents would be regarded as process measures or screening tools.

For Physical Activity / Fitness, the most frequent mentions were of Sit to Stand assessments, measures of grip strength and the self-reported GLTEQ (Godin Leisure-Time Exercise Questionnaire).

For Nutrition, measures mentioned included oral nutritional supplement usage, feed usage and dietetic care duration.

For Psychological Status, several measures were mentioned by one or two respondents. CORE-10 (Clinical Outcomes in Routine Evaluation) and MYCAW (Measure Yourself: Concerns & Wellbeing) were each mentioned twice. Patient-reported outcome measures such as the multi-dimensional EQ-5D (Health-Related Quality of Life) were also mentioned, as was patient feedback on satisfaction with services and on quality of life.

Some respondents acknowledged the general need for better monitoring, evaluation, and outcome measurement to demonstrate the benefits of prehabilitation. Outcome measurement could link to the service availability and resourcing theme (Section 4.2). Evidence that prehabilitation leads to positive outcomes could help make the case for longer-term funding and sustainable staffing.

4.7 Prehabilitation 'Key Principles': Summary of Findings

This section discusses, for each of the 'Key Principles', findings from the survey question about the extent to which the principle underpinned delivery of local prehabilitation activities. This question was available to all survey respondents, with and without local services. This section also draws on relevant qualitative findings derived from responses to open questions by respondents with local services.

4.7.1 Prehabilitation should start as early as possible and in advance of any cancer treatment

Around half of respondents agreed or strongly agreed that this principle underpinned local activities. However many respondents commented that broader system pressures and staffing shortages could delay the start of prehabilitation.

4.7.2 Prehabilitation should run in parallel with usual decision-making processes, so it does not have an adverse effect on cancer waiting times nor delay the start of treatment

Around half of respondents agreed or strongly agreed that this principle underpinned local services. Several respondents commented that referrals were not made automatically or were made late, which meant that there was often insufficient time to provide prehabilitation interventions before treatment.

4.7.3 Prehabilitation should be part of the rehabilitation continuum

Around half of respondents agreed or strongly agreed that this was the case in their local area. However most respondents with local services did not describe how their local continuum worked in practice, so it was not clear whether it worked seamlessly for patients. Some respondents highlighted the need for improvement in this area.

4.7.4 Prehabilitation should be multi-modal including exercise/activity, nutrition, and psychological support

There were mixed findings on this issue. Around 60% of all respondents agreed or strongly agreed that this was happening in their local area. It appeared that this situation had improved since 2019, with increased involvement of staff groups which delivered the three prehabilitation modes.

Of the 95 respondents with local prehabilitation services, 71% responded that their local service screened for one or more of the three modes. Of those respondents, half said their service was screening for all three modes, which represented 22% of respondents with local services. Some qualitative findings suggested that existing services did not involve all three modes or that these were not linked to each other.

4.7.5 All patients should be screened to determine the level of prehabilitation required (universal, targeted, specialist)

Only a minority of respondents (23%) agreed or strongly agreed that this principle underpinned local services. Respondents acknowledged the importance of early screening and identification of patient needs.

4.7.6 Completion of prehabilitation screening should be recorded at MDT alongside performance status

Around half of respondents agreed or strongly agreed that prehabilitation screening was recorded at their local MDT. Respondents highlighted the MDT as an important

enabler of effective prehabilitation services, but there were mixed views on the extent to which such services were integrated or working closely with local MDTs.

4.7.7 Targeted and specialist interventions demand the use of validated tools for individualised assessment, care planning and outcomes measurement

Only 16% of respondents agreed or strongly agreed that this principle underpinned local services.

4.7.8 All patients should have a co-produced personalised prehabilitation care plan

Only a fifth of respondents agreed or strongly agreed that this principle was a reality for local patients.

5 Rehabilitation Findings

5.1 Attitudes and Awareness

5.1.1 Importance of Rehabilitation

172 out of 187 potential respondents answered this question, which was also asked in 2019. Details are shown in Table 13.

Table 13: Importance of rehabilitation

Importance of Rehabilitation	number of responses	% of responses to this question	% of survey respondents
1 = Not Important At All	0	0%	0%
2	0	0%	0%
3	8	5%	4%
4	58	34%	31%
5 = Crucial	106	62%	57%
No Response	15		8%
Total Responses to this Question	172	100%	100%

Of those who answered the question, 95% selected 4 or 5, indicating that they attached high importance to rehabilitation. Findings were similar for all the cancer networks. 62% of those respondents selected 5, 'crucial', similar to the 2019 finding for this question. 8% of survey respondents did not answer this question, implying that they did not know.

Of all survey respondents, more attached high importance to rehabilitation (88%) compared with prehabilitation (77%). This could reflect their greater experience of rehabilitation, and their awareness of barriers which would need to be addressed to support effective prehabilitation, as discussed earlier.

5.2 Service Availability and Resourcing

5.2.1 Availability of Local Rehabilitation Activities

Respondents were asked whether any cancer rehabilitation activities were being offered in their local area. 186 out of 187 survey respondents answered, with details shown in Table 14.

Table 14: Availability of local rehabilitation activities

Rehabilitation Activities offered in local area?	Number of Responses	% of Responses to this Question
Yes	98	53%
No	26	14%
Don't Know	62	33%
Total responses to this Question	186	100%

These findings are similar to those from the question about local prehabilitation activities. 62 respondents answered 'yes' to both questions, representing around two thirds of 'yes' respondents to each question.

There was some variation among the cancer networks. WoSCAN had the highest proportion of respondents selecting 'yes' to this question (58%) and NCA the lowest (45%). The proportion for SCAN was 53%.

Respondents with locally available rehabilitation services (n = 98) were asked further questions about those services. They discussed a range of rehabilitation services available from the NHS, third sector organisations and local authority leisure centres. Some respondents highlighted challenges relating to staffing and funding, the sub-themes discussed in Section 4.2.

5.3 Service Delivery and Pathways

5.3.1 Referrals

Respondents were asked if they personally referred people to rehabilitation activities and how routinely they did so. This question was also asked in the 2019 survey. All 98 potential respondents answered it, as shown in Table 15.

Table 15: Referral to rehabilitation activities

Referral to Rehabilitation Activities?	Number of Responses	% of Responses to this Question
Yes	47	48%
No	31	32%
I provide rehabilitation services	20	20%
Total responses to this Question	98	100%

48% of respondents referred to rehabilitation services, similar to the 2019 finding of 47%. The proportion who provided services, at 20%, was higher compared with the 2019 finding of 14%.

All 47 respondents who answered Yes answered the follow-up question about how routinely they referred people.

- 40% selected 4 or 5 (more likely to or always refer).
- 47% selected 3 (medium likelihood of referring).
- 13% selected 1 or 2 (less likely to refer).

Qualitative findings highlighted the need for routine and timely referral to rehabilitation services, similar to the prehabilitation findings discussed in Section 4.3.

5.3.2 Rehabilitation Continuum

This sub-theme links to the prehabilitation 'Key Principle' that "Prehabilitation activities are part of the rehabilitation continuum." As discussed in Section 4.3, around half of respondents with local prehabilitation and rehabilitation services in place agreed that this principle underpinned them. However most did not describe how their continuum worked in practice. Therefore, the extent to which their patients moved along a seamless pathway from prehabilitation to treatment and then rehabilitation was generally not clear. However some third sector providers of both prehabilitation and rehabilitation did describe service delivery through the whole cancer journey.

5.4 Access to Services

As discussed in Section 4.4, the location of services and the need to consider geographical inequalities were also mentioned in relation to rehabilitation services.

6 Conclusion

This survey showed very high recognition amongst respondents of the importance of both prehabilitation and rehabilitation in improving people's experience of cancer treatment and outcomes. This suggests an appetite in principle to develop and improve local prehabilitation services. Knowledge and understanding of what this would involve in practice appeared lower, as reflected by only two fifths of respondents with high awareness of the 'Key Principles'. There would be value in further promotion of these principles to those who would be involved in future commissioning, planning or delivery of local prehabilitation services.

At the time of the survey around half of respondents had local prehabilitation services. During the COVID-19 pandemic, services had been scaled back or stopped but were now resuming or starting. The pandemic experience of delivering some services via phone or video had informed the resumption of some services using blended delivery modes. This approach offers an opportunity to improve people's access to services, but with the recognition that video appointments are not appropriate for everyone.

Staffing and funding for prehabilitation, and broader pressures on health services, were identified as key barriers to developing and sustaining prehabilitation services. Since 2019 there has been a notable decrease in permanent funding and increase in temporary funding for services. The need for designated staffing across roles and for dedicated and permanent funding was emphasised in the survey. Respondents indicated that such resourcing was necessary to enable staff to dedicate time to prehabilitation. While the broader environment is challenging, these issues would need to be considered if current or future prehabilitation services are to attract and retain staff and become part of core services.

Survey respondents identified improvements needed in prehabilitation service delivery and pathways. The need for timelier referral, earlier patient screening, identification and offer of prehabilitation, and appropriate referral to universal, targeted and specialist services, were all emphasised. It was acknowledged that interventions needed to include and better link together all three prehabilitation modes. The need for prehabilitation to be part of a seamless patient pathway through to rehabilitation was highlighted. Some respondents commented that guidance for local services would be useful. This view may be linked to low levels of awareness of the principles of prehabilitation, which further promotion would address. However, this finding might also suggest that sharing good practice on how to implement and deliver prehabilitation could help embed the principles in practice. National guidance could be developed to set out the core elements and characteristics of local services, and how to integrate multimodal interventions, in order to alert staff to these issues and support local service development and delivery. These improvements could also be supported through the Single Point of Contact approach, pathway navigators and cancer support workers.

The need for senior leadership buy-in and support for local prehabilitation in principle was highlighted. This would set the tone for their staff and encourage them to integrate prehabilitation into local pathways. It could also inform local discussions

about the provision of more secure and sustainable long-term staffing and funding for services.

Survey respondents identified some specific patient groups at risk of inequitable access to services. These included people living in remote and rural areas and on islands, those in tumour groups without prehabilitation services, and those experiencing socio-economic inequalities. Local services should address potential barriers to access for people in those groups, and ensure that the mode of service delivery maximises their access and promotes the inclusion of all.

MDT engagement, good communication between service providers and collaborative partnership working with third sector projects were all viewed as important enablers of effective prehabilitation services. Any future national guidance could specify in more detail the different staff roles and organisations which should be involved in local prehabilitation services, including third sector initiatives such as those delivered by Maggie's and Macmillan Cancer Support. This would support the suggestion above to develop further guidance for service development and implementation.

The survey showed that awareness of local prehabilitation service monitoring was limited, and that local services used a variety of approaches to measure outcomes. More systematic monitoring and outcome measurement could generate evidence of the benefits of prehabilitation for patients, help engage local service providers and patients themselves, and make the case for investment in local services. National guidance could include advice and templates for local monitoring and outcome measurement. With the aim to roll out prehabilitation across Scotland, consideration of the development of a national core dataset would be useful to support monitoring and evaluation of prehabilitation services and their impact on patient outcomes.

7 Appendices

Appendix A: Breakdown of Respondents

Table 16: Employing Organisation

Organisation Category	Number of Respondents	% of Respondents
NHS Board (secondary or tertiary care)	144	77%
Health & Social Care Partnership	16	9%
Third Sector organisation (including hospices)	15	8%
Local Authority	5	3%
NHS (primary care)	5	3%
not stated	2	1%
Total Respondents	187	100%

Table 17: Place of Work

Place of Work category	Number of Respondents	% of Respondents
Acute care*	124	66%
Community care**	40	21%
Third Sector organisation (including hospices)	14	7%
Local Authority setting	7	4%
not stated	2	1%
Total Respondents	187	100%

* Acute Care includes: NHS Tertiary Care, NHS Secondary Care

** Community Care includes: Primary Care, Health Centres, Health and Social Care Partnerships, Macmillan / ICJ staff.

Table 18: Job Title or Role

Job Title / Role Category	Number of Respondents	% of Respondents
Allied Health Professional	50	27%
Physician - Tertiary/Secondary Care	44	24%
Nurse	38	20%
Macmillan ICJ Staff	14	7%
Psychological Support	12	6%
Executive lead / service manager	10	5%
Physician - Primary Care	7	4%
Exercise specialist	5	3%
Other	4	2%
not stated	3	2%
Total Respondents	187	100%

Table 19: NHS Health Board Location (of place of work)

NHS Health Board	Number of Respondents	% of Respondents
NHS Ayrshire and Arran	11	6%
NHS Borders	5	3%
NHS Dumfries and Galloway	8	4%
NHS Fife	11	6%
NHS Forth Valley	4	2%
NHS Grampian	27	14%
NHS Greater Glasgow and Clyde	50	27%
NHS Highland	22	12%
NHS Lanarkshire	15	8%
NHS Lothian	23	12%
NHS Orkney	1	1%
NHS Shetland	0	0%
NHS Tayside	9	5%
NHS Western Isles	1	1%
Total Respondents	187	100%

Table 20: Cancer Network (of place of work)

Cancer Network	Number of Respondents	% of Respondents
North Cancer Alliance	60	32%
South East Scotland Cancer Network	47	25%
West of Scotland Cancer Network	80	43%
Total Respondents	187	100%

Appendix B: Cancer Prehabilitation Implementation Steering Group (CPISG) Membership

CPISG is a group of experts brought together at the request of the Scottish Government to feed into the national governance structure for cancer. Its membership over the course of the development and distribution of the survey is shown below.

Name	Job Title / Role
Annie Anderson	Emerita Professor, University of Dundee (CHAIR)
Alison Allan	Prehab Pilot Lead & Centre Head Fife, Maggie's
Alison Rowell	Quality and Service Improvement Manager, West of Scotland Cancer Network
Amy Anderson	Project Co-ordinator for Prehabilitation, North Cancer Alliance
Bette Locke	AHP Professional Advisor (Rehabilitation), Chief Nursing Officer's Directorate, Scottish Government (until September 2022)
Chrissie Lane	Consultant Nurse, NHS Highland, Scottish Lead Cancer/Cancer Nurse Consultant Group Representative
David McDonald	Head of Programmes, Modernising Patient Pathways Programme, Centre for Sustainable Delivery. Chair of Digital Sub-group.
Dawn Crosby	Head of Devolved Nations, Pancreatic Cancer UK, Less Survivable Cancers Taskforce Representative
Debbie Provan	Clinical Advisor, Cancer Policy, Scottish Government (Chair of Nutrition Subgroup)
Eilidh Carmichael	Policy Manager, Cancer Policy, Scottish Government (Secretariat)
Gillian Hailstones	Director of Care Services, Beatson Cancer Charity (Co-Chair of Psychological Subgroup)
Gordon McLean	Strategic Partnership Manager, Macmillan Cancer Support
Helen Moffat	Consultant Clinical Psychologist for Oncology and Palliative Care, NHS Grampian (Co-Chair of Psychological Subgroup)
Iain Philips	Consultant Clinical Oncologist, NHS Lothian
Laura McGarrity	Consultant Anaesthetist, NHS Ayrshire and Arran & Centre for Perioperative Care Representative
Lorna Porteous	GP Lead for Cancer and Palliative Care, NHS Lothian & Co-Chair of Scottish Primary Care Cancer Group

Name	Job Title / Role
Myra McAdam	Macmillan Clinical Lead for Living With Cancer, West of Scotland Cancer Network
Rob Murray	Chief Executive Officer, Cancer Support Scotland, Scottish Cancer Coalition Representative (until January 2023)
Sarah Beard	Business Development Director, Maggie's
Susan Moug	Consultant General and Colorectal Surgeon, NHS Greater Glasgow and Clyde

Appendix C: Survey Questionnaire

About You

Q1. Please tell us about your:

Organisation
Place of Work
Job Title/Role

(all free text response options)

Q2. In which Health Board area is your place of work located?
(the 14 NHS Territorial Boards were listed as response options)

Prehabilitation

For the purposes of this survey, prehabilitation constitutes nutrition, physical activity/exercise and psychological support and the associated interventions delivered before definitive cancer treatment. Prehabilitation is proactive and personalised.

Q3. The 'Key Principles for Implementing Cancer Prehabilitation in Scotland' were published in April 2022.

How would you describe your awareness of the Key Principles?

Scale of 1-5: Not aware at all Very aware

Q4. Are any cancer prehabilitation activities being offered in your local area (intervention before definitive treatment)?

Yes
No
Don't Know

Q5. To what extent do the following statements, reflecting the 'Key Principles for Implementing Cancer Prehabilitation in Scotland', underpin the delivery of prehabilitation activities in your local area?

Scale shown for all statements: 1 = strongly disagree 5 = strongly agree
+ Don't Know

- a. Prehabilitation activities start as early as possible and in advance of any cancer treatment
- b. Prehabilitation activities run in parallel with usual decision making processes so it does not have an adverse effect on cancer waiting times nor delay the start of treatment
- c. Prehabilitation activities are part of the rehabilitation continuum

- d. Prehabilitation activities are multi-modal including exercise/activity, nutrition and psychological support
- e. All patients are screened to determine the level of prehabilitation required (universal, targeted, specialist)
- f. Completion of prehabilitation screening should be recorded at cancer multidisciplinary team meetings alongside performance status
- g. All patients (receiving universal, targeted and specialist interventions) have a co-produced personalised prehabilitation care plan
- h. Validated tools are used for individualised assessment, care planning and outcomes measurement when patients are receiving targeted and specialist interventions

Q6. What staff or volunteers are involved in the delivery of your prehabilitation activities in your local area? Please select all that apply.

- Nurse
- Physiotherapist
- Dietitian
- Occupational Therapist
- Clinical Psychologist
- Counsellor
- NHS Technical Instructor/Support worker
- Fitness Instructor (Local Authority/Move More etc.)
- Volunteer/Buddy/Peer Supporter
- Other (please describe)
- Don't Know

Q7. How closely do staff providing prehabilitation work within the care team and patient pathway (for instance, in a multidisciplinary team, or with prehab being a core part of a patient pathway/clinical management guideline)?

Free text response.

Q8. How are the following aspects of your prehabilitation activities monitored?

Q8a. Patient uptake (e.g. of patients referred, who joins the programme).

Q8b. Patient adherence (e.g. number of sessions attended by patients).

Q8c. Patient experience (e.g. patient feedback on the programme).

Free text response for each.

Q9. Are outcome measures being used to determine the effectiveness of your prehabilitation activities?

- Yes
- No
- Don't know
- Not applicable

Q9a. What outcome measures are being used?

Free text response.

Q10. Do your prehabilitation activities have:

- Permanent funding
- Temporary funding (If temporary, when is funding expected to cease?)
- I don't know about funding
- No funding
- Other (please describe)

Q11. Do you personally refer people to prehabilitation activities?

- Yes
- No
- I provide prehabilitation services

Q11a. How routinely would you refer people to prehabilitation activities?

Sliding Scale shown: 1 = never 5 = always

Q12. Is your service screening or triaging patients for perceived risk associated with: Nutrition?

Yes / No / Don't know

Q12a. Please describe how your service is doing this.

Free text response.

Q13. Is your service screening or triaging patients for perceived risk associated with: Physical activity/exercise?

Yes / No / Don't know

Q13a. Please describe how your service is doing this.

Free text response.

Q14. Is your service screening or triaging patients for perceived risk associated with: Psychological need?

Yes / No / Don't know

Q14a. Please describe how your service is doing this.

Free text response.

Q15. How have prehabilitation activities offered in your local area changed since the start of the COVID-19 pandemic? (You may wish to comment on activities that have decreased; plans to increase activities that were cancelled / scaled back; new activities started or planned; delivery mode e.g. digital/face-to-face).

Free text response.

Q16. Are there any plans to introduce or add to the prehabilitation activities in your local area?

Yes

No

Don't know

Q17. Please share your thoughts on how local pathways could be changed to support prehabilitation and optimise patients for treatment, including while they are on waiting lists (you may wish to comment on local barriers and/or enablers to prehabilitation, including leadership, staffing and multi-disciplinary team (MDT) involvement).

Free text response.

Q18. Do you have any other comments on the prehabilitation activities offered in your local area? You may wish to comment on referral/access route, inclusion/exclusion criteria including patient group and planned treatment type, screening and assessment process, location and duration of intervention.

Free text response.

Q19. How important do you think prehabilitation interventions are for people about to undergo cancer treatment?

Sliding Scale shown: 1 - not important at all; 5 - crucial

Rehabilitation

For the purposes of this survey, rehabilitation constitutes nutrition, physical activity/exercise and psychological support and the associated interventions delivered after definitive cancer treatment. Rehabilitation is proactive and personalised.

Q20. Are any cancer rehabilitation activities being offered in your local area (i.e. interventions following treatment)?

Yes
No
Don't know

Q21. Please describe the cancer rehabilitation activities offered in your local area. You may wish to comment on referral/access route, inclusion/exclusion criteria including patient group and treatment type, screening and assessment process, location and duration of intervention.

Free text response.

Q22. Do you personally refer people to rehabilitation activities?

Yes
No
I provide rehabilitation services

Q22a. How routinely would you refer people for rehabilitation activities?

Sliding Scale shown: 1 = never 5 = always

Q23. How important do you think rehabilitation interventions are for people who have undergone cancer treatment?

Sliding Scale shown: 1 - not important at all; 5 - crucial

Additional Comments

Q24. If you have any additional views or comments on prehabilitation or rehabilitation please use the field below to share them.

Free text response.



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This document is also available from our website at www.gov.scot.
ISBN: 978-1-80525-691-5

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for
the Scottish Government
by APS Group Scotland
PPDAS1270642 (04/23)
Published by
the Scottish Government,
April 2023



Social Research series
ISSN 2045-6964
ISBN 978-1-80525-691-5

Web Publication
www.gov.scot/socialresearch

PPDAS1270642 (04/23)