

Cancer Prehabilitation in Scotland: Report on 2025 survey findings



HEALTH AND SOCIAL CARE

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Glossary

Acute Care: Care for medical, surgical, and mental health that require hospital facilities.

AHP: Allied Health Professional. AHPs encompass 14 health professions: Art Therapists, Diagnostic Radiographers, Dietitians, Drama Therapists, Music Therapists, Occupational Therapists, Orthoptists, Paramedics, Physiotherapists, Podiatrists, Prosthetists, Orthotists, Speech and Language Therapists and Therapeutic Radiographers.

Assessment: A detailed evaluation of (prehabilitation) need using validated tools to inform the prescription of targeted or specialist interventions.

Community Care: Clinical care delivered close to home and supports individuals to remain in their homes and communities.

CNS: Clinical Nurse Specialist.

CPOG: Cancer Prehabilitation Oversight Group. Convened to further develop a 'Once for Scotland' approach to multi-modal prehabilitation.

HNA: Holistic Needs Assessment. A process to identify the needs and concerns of an individual and develop a Personalised Care and Support Plan.

HSCP: Health and Social Care Partnership which brings together Local Authorities and local NHS Boards to plan and deliver integrated adult community health.

ICJ: Improving the Cancer Journey. These services are part of a partnership programme between Macmillan Cancer Support and Scottish Government. 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.

MDT: Multidisciplinary Team. A team of different health professionals who work together to plan and deliver an individual's (cancer) treatment.

Multi-modal (prehab): More than one mode of (pre-treatment) intervention to help improve a patient's physical, nutritional, and mental status.

NCA: North Cancer Alliance. Covers the following NHS Boards: Grampian, Highland, Orkney, Shetland, Tayside, Western Isles.

NIHR: National Institute of Health and Care Research.

NHS Boards: NHS Scotland has 14 territorial NHS 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 AHPs such as Physiotherapists and Speech and Language Therapists.

RCoA: Royal College of Anaesthetists.

SCAN: South East Scotland Cancer Network. Covers the following NHS 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.

Tertiary Care: Specialist health services for people with a condition requiring high levels of expertise and support services.

Third Sector: The Third Sector includes charities, social enterprises and community groups which deliver essential services.

Triage / screening: Process of identifying (prehabilitation) need.

WoSCAN: West of Scotland Cancer Network. Covers the following NHS Boards: Ayrshire & Arran, Forth Valley, Greater Glasgow & Clyde, Lanarkshire.

1. Executive summary

This report summarises the findings from a survey undertaken in Spring 2025 about the views of professionals working in cancer prehabilitation and rehabilitation services in Scotland. Its findings were analysed and reported by Scottish Government (SG) social researchers, on behalf of Scotland's Cancer Prehabilitation Oversight Group (CPOG).

The survey had two purposes: first, to understand progress toward achieving the long-term ambition of "Best Preparation for Treatment" ('Pre-treatment') outlined in the Cancer Strategy for Scotland 2023 – 2033. This ambition is that every person diagnosed with cancer in Scotland is provided with timely, effective and individualised care to best prepare them for treatment. Second, to help shape future actions in the current and future Cancer Action Plans, by identifying what new or continuing actions may be needed to realise this ambition for people with cancer.

The online survey included closed and open questions about prehabilitation as a core component of preparation for treatment, and rehabilitation as part of the continuum of care. A survey link was emailed by members of CPOG to their professional networks in cancer prehabilitation. 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."

A total of 302 staff responded to the survey, compared with 187 respondents to the survey in 2022. 71% were employed by an NHS Board. The large majority were Allied Health Professionals (AHPs), Physicians (secondary or tertiary care), or Nurses. There were contributions from all 14 NHS Health Boards and all 3 Cancer Network Areas but not in a representative way, with 40% of respondents from West of Scotland Cancer Network (40%), followed by South East Cancer Network (35%) and North Cancer Alliance (24%).

The sampling approach was convenience sampling. This means we cannot be certain of the representativeness of views across professions or networks since some groups or areas may be over- or under-represented due to the accessibility of the sample. The report acknowledges limitations in comparing groups and survey years, as some variation is expected due to the convenience sampling approach used in 2019, 2022 and in this survey.

Survey findings have been summarised thematically as presented below, and comparisons have been made with the [analysis reported in 2023](#) to understand progress since 2022 towards embedding the eight [Key Principles for Implementing Cancer Prehabilitation across Scotland](#) ('**Key Principles**') in practice.

Attitudes and awareness

Most respondents attached high importance to prehabilitation, with 60% rating it as a crucial component of care before cancer treatment. Two fifths (41%) indicated a high awareness of the eight 'Key Principles', with a similar proportion (38%) indicating low or no awareness of these principles. There were no clear differences in ratings of importance of preparation for treatment and awareness of the Key Principles of prehabilitation observed between the 2022 and 2025 surveys. Respondents emphasised the benefits of prehabilitation for patient outcomes and expressed the need to continue to raise awareness amongst staff of different professions about what prehabilitation entails, what activities are available locally, and how to access them.

Service availability and resourcing

Half of respondents (50%) indicated that prehabilitation activities were offered in their local area. A wide range of professionals were identified as contributing to the delivery of prehabilitation. Most commonly these were Nurses, Dietitians and Physiotherapists. A quarter of respondents (25%) indicated plans to introduce or add to local prehabilitation activities in their local area. These results are unchanged from the previous survey.

Respondents described a mixed picture of progress in service development over the last 18 months, with some areas expanding prehabilitation activities, while others scaled them back. Some attributed changes in local prehabilitation activities to reliance on temporary funding. Just over a quarter of respondents (27%) reported receiving temporary funding, much of which was expected to end within the year. Respondents emphasised the desire for sustainable funding models, including resource to be able to deliver a full range of prehabilitation modes, dedicated staff capacity to deliver prehabilitation, and for targeted and specialist prehabilitation where there are gaps in provision.

Service delivery and pathways

Agreement with statements about the extent to which delivery is underpinned by the Key Principles of prehabilitation has increased between 2022 and 2025. The highest level of agreement was for the statement that activities are multi-modal (69%). Agreement was around two thirds that, in local service delivery: prehabilitation starts as early as possible (64%); runs in parallel with usual decision-making processes (66%), and; is part of the rehabilitation continuum (64%). Fewer than half agreed with statements about: using screening to determine interventions (32%); recording screening by the cancer multidisciplinary team (MDT) (46%), and; using validated tools for assessment and outcomes measurement (34%). Around a quarter of respondents (26%) agreed that all patients have co-produced personalised care plans.

In line with 2022, three fifths (63%) of respondents with local services either referred to or provided prehabilitation services. Timeliness of referrals was highlighted as an issue. Some suggested that automated referrals could improve

early screening and timely onward referral. Some also suggested that coordinator roles or prehabilitation clinics (already in place in some areas) could improve local care pathways and collaboration and help reduce unnecessary burden for people.

Of those with local activities, two thirds (66%) indicated screening or triaging for at least one mode of prehabilitation support in their area. This figure is comparable with 71% in 2022. Perceived nutritional risk was the mode most likely to be screened for. Across all three modes of prehabilitation, a variety of screening methods were described, ranging from tools-based and routinised measures, to methods with a greater emphasis on discussion and professional judgement.

Access to services

The availability of locally accessible services, and appointments that are aligned with patient needs and activities delivered through appropriate modes, were seen as enablers of prehabilitation. Some groups were identified as having inequitable access to prehabilitation, such as people with Stage 1 or Stage 2 cancers, those with co-morbidities, those receiving palliative care, and service offerings varying by cancer diagnoses or treatment types. While video consultations were reported to enable remote connections for prehabilitation, people living in remote and rural areas and those at risk of digital exclusion were noted as groups with barriers to access.

Communication and collaboration

There were three main ways of working described by respondents: close working within an MDT, variable relationships within an MDT, and areas where prehabilitation is delivered by a range of separate services. Across these differences in structure of care teams delivering activities, many respondents described positive relationships and collaboration to deliver prehabilitation and support patients. Respondents also emphasised the need for better collaboration and coordination across different organisations, specifically the NHS and Third Sector. These improvements were seen as essential to ensuring patients receive early, appropriate and joined up pre-treatment care.

Monitoring, evaluation and outcome measurement

As in 2022, many respondents in 2025 were uncertain about whether and how monitoring was undertaken. Recording patient referrals, uptake and attendance, and feedback forms or questionnaires were common responses. A third of respondents (34%) reported using outcome measures to determine the effectiveness of interventions, including a variety of standardised measures and subjective questionnaires, such as quality-of-life measures, tests of functional outcomes, and assessment of post-operative complications. Some felt that better systems, aligned with current IT infrastructure, are needed to monitor patient progress and record patient outcomes.

Learning resources

Around one fifth of respondents (19%) reported using the national prehabilitation website, [Prehab and Me](#). This was largely for their own development or to signpost patients to information to inform and engage them in prehabilitation. Lack of awareness was the primary barrier to using the website. Respondents had varying levels of awareness of other frameworks and e-learning resources related to prehabilitation, with the Enhanced Recovery After Surgery (ERAS) in Scotland module on TURAS being the most widely recognised e-learning resource (by 42% respondents). Linking to existing online resources about prehabilitation and integrating prehabilitation into online health and care training programmes, were suggested as ways to enhance local pathways.

Rehabilitation

Around one in three respondents (33%) reported cancer rehabilitation activities in their local area in 2025, which is down from over half of respondents (53%) reporting rehabilitation activities in 2022. A quarter of respondents (26%) rated their awareness of the [Once for Scotland approach to Rehabilitation](#) as high, suggesting the importance of increasing awareness. Most respondents agreed that local cancer rehabilitation services are realistic and meaningful to the individual, and delivered by a flexible and skilled workforce, in accordance with the 'Once for Scotland' principles. Ease of access to rehabilitation services and integration across services, sectors and agencies were highlighted as areas for improvement.

Key findings and recommendations

Overall, 2025 survey findings reaffirm support for prehabilitation amongst staff, and a stronger perception that the 'Key Principles for Implementing Cancer Prehabilitation across Scotland' underpin delivery of local prehabilitation activities. Awareness of the Key Principles, the availability of prehabilitation activities locally, and the accessibility of activities show few changes from 2022. However, there have been examples of local service improvements over the past 18 months, for example, in reaching patients with a wider variety of cancer types, trialling screening tools, and developing leadership roles to embed prehabilitation in ways of working.

To further advance the adoption of prehabilitation across Scotland, several actions are recommended from the analysis. Namely, continued awareness-raising, establishing forums to share learning from pilot projects and partnerships, providing support to co-design services to improve access, providing guidance on using data to measure outcomes and demonstrate impact, and integration with rehabilitation along the continuum of care. Areas for follow-up conversations with staff to gain further insights are highlighted. These include perspectives on: multi-modal staffing, screening practices, funding models, and the prehabilitation-rehabilitation continuum.

2. Background

This analysis reports on findings from a survey about cancer prehabilitation and rehabilitation services which was undertaken by the SG on behalf of Scotland's CPOG. The aim of the survey was to understand, from a staff perspective, what actions are needed to support the implementation of cancer prehabilitation across Scotland and reduce unwarranted variation.

Cancer prehabilitation is the process of [preparing for cancer treatment and for life afterwards](#). The main goal of prehabilitation is to [help people with cancer recover more quickly from surgery, chemotherapy and radiotherapy, and improve their long-term health](#). It specifically includes support and advice around exercise/activity, nutrition and psychological wellbeing, and should be integral to the care of all people with a cancer diagnosis to improve quality of life, maximise treatment rates and minimise the side effects of treatment.

Following the publication of the [Cancer Strategy 2023 to 2033](#) and [Cancer Action Plan 2023 to 2026](#), CPOG was convened to support the delivery of the strategy's ambition that 'Every person diagnosed with cancer in Scotland is provided with timely, effective and individualised care to best prepare them for treatment'. In December 2024, CPOG commissioned a survey to evaluate progress on Actions 47 – 51 in the Cancer Strategy, and to identify any future requirements for the second Cancer Action Plan.

The online survey was built on earlier surveys issued in 2019 and 2022. It similarly included open and closed questions, which focused on implementation of the [Key Principles for Implementing Cancer Prehabilitation across Scotland](#), derived from guidance published in 2019 by Macmillan, National Institute of Health and Care Research (NIHR) and the Royal College of Anaesthetists (RCOA). It sought the views of prehabilitation staff on their awareness of prehabilitation principles, activities offered in their local area, and potential ways to improve local pathways to optimise patients for treatment. While referenced for comparison throughout the report, full results from the previous 2022 survey can be found on the SG website: [Cancer prehabilitation survey: findings report](#).

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.”

3. Method

SG analysts, policy officials and CPOG members developed the survey questionnaire (attached as Appendix B) based on the 2022 survey. It similarly included open and closed questions and was distributed online. It introduced questions about workforce learning and awareness of the six principles of good rehabilitation. An additional question for Senior Leaders and Service Managers sought details on the ways in which they are embedding prehabilitation in ways of working. One question was revised to better capture the current period, and response categories for employment were introduced to support respondents in completing it more easily.

SG analysts created the survey on Microsoft Forms, following an internal ethical review and a data protection impact assessment. A link to the online survey was distributed by the SG policy team to CPOG members with a request to cascade it more widely amongst professional networks. The survey was live from 24 February until 14 April 2025. Basic respondent characteristics were monitored each week and reminder e-mails sent out to all initial recipients to increase the response rate.

SG social researchers analysed the survey responses and authored this report. Responses to closed questions were analysed descriptively, with frequency distribution tables in Microsoft Excel used to count the number of occurrences in each category. Open text responses were analysed using a qualitative thematic approach in Microsoft Excel. The data were coded using existing codes from 2022 and new ones to match emerging themes and then grouped together for the discussion of findings. Please note that in some tables percentages have been rounded and may not total to 100%.

Sampling and considerations for findings

This report covers the main findings from this survey and includes some comparisons with findings from earlier surveys. There are some limitations to these comparisons, including a larger, and occupationally different, group of respondents to 2022. Any differences observed between surveys may reflect variations in the individuals who responded, rather than actual changes over time. This limitation is acknowledged and explained within the report where relevant to the analysis. The survey design relies on non-probability (convenience) sampling due to its objective to target a specialised population, i.e. people working in the field of prehabilitation in Scotland. Due to this approach it might be expected that those responding have a stronger interest in prehabilitation compared to those who have not responded. In addition, where findings from this survey are broken down by professional group or Cancer Network Area, they refer to differences in the sample which may be influenced by the survey design. As such, we cannot be certain of the representativeness of views across professions or networks since some groups or areas may be over- or under-represented due to convenience or accessibility of the sample. Consequently, where conclusions are tentative or further evidence may be necessary either to contribute deeper understanding or to determine relevant next steps for policy development and/ or delivery, this is highlighted in the discussion.

4. Breakdown of respondents

The survey asked respondents about their employment and place of work. Key findings are shown in Table 1. A total of 302 responses were received.

Table 1: Breakdown of respondents

Key points	
Number of responses	302 (compared with 189 in 2022 survey).
Employing organisation	71% of respondents worked for an NHS Board. The remainder worked for a Health and Social Care Partnership (HSCP), a Third Sector organisation, a Local Authority, or for the NHS in primary care.
Place of work	68% of respondents worked in Acute Care settings. The remainder worked in Community Care, Third Sector organisations and Local Authority settings.
Job title / Role	79% of respondents were Allied Health Professionals (AHPs), Nurses or Physicians (Secondary or Tertiary Care). Most of the remainder were Macmillan / Improving the Cancer Journey (ICJ) staff; Physicians (Primary Care); NHS Technical Instructors, Pharmacists; Project / Improvement Managers; in Psychological Support roles; and Senior Leads / Service Managers.
NHS Board location	Responses were received from respondents working in all 14 of the territorial NHS Boards. Four NHS Boards accounted for 60% of all responses: NHS Greater Glasgow & Clyde, NHS Lothian, NHS Ayrshire & Arran, and NHS Dumfries & Galloway.
Cancer Network	Responses were received across all three regional networks in the following proportions: West of Scotland Cancer Network (WoSCAN) – 40%. North Cancer Alliance (NCA) – 24%. South East Scotland Cancer Network (SCAN) – 36%.

See Appendix A: Breakdown of Respondents for more details on place of work, and job roles/ titles.

5. Prehabilitation findings

Attitudes and awareness

This section presents attitudes among all survey respondents about the importance of prehabilitation; and their awareness of the 'Key Principles' for cancer prehabilitation.

Importance of prehabilitation

Respondents were asked about the importance of prehabilitation interventions for people about to undergo cancer treatment. 292 out of 302 potential respondents (97% 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
1 = Not important at all	0	0%
2	3	1%
3	27	9%
4	87	30%
5 = Crucial	175	60%
Total responses to this question	292	100%

Of those who answered the question, 90% attached high importance to prehabilitation (selected 4 or 5). 60% of those respondents rated it as 'crucial', similar to the equivalent 2022 findings (58%). There was slight variation between Cancer Network Areas. Prehabilitation was most likely to be rated as 'crucial' by SCAN (63%), followed by WoSCAN (60%) and NCA (54%) respondents.

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. 299 out of 302 respondents answered this question, of which:

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

These figures are unchanged from 2022 findings. There was limited variation between Cancer Networks, with 43% reporting high awareness (selecting 4 or 5) in WoSCAN, 40% in SCAN and 38% in NCA.

Service availability and resourcing

This section considers the availability of local prehabilitation services, changes to services in the last 18 months, and plans to introduce new prehabilitation services. It also considers the issues of staffing and funding.

Availability of local prehabilitation activities

Respondents were asked whether any cancer prehabilitation activities were being offered in their local area. All 302 respondents answered this question. Half (50%) indicated that prehabilitation activities were offered in their local area, as shown in Table 3, which is consistent with that reported in 2022 (51%). Just over one third (36%) did not know, which is also in line with 2022 results (34%).

Table 3: Availability of local prehabilitation activities

Prehabilitation activities offered in local area?	Number of responses	% of responses to this question
Yes	152	50%
No	40	13%
Don't know	110	36%
Total responses to this question	302	100%

A breakdown by Cancer Network for those who provided this information (n = 299) is shown in Table 4. As in previous years, WoSCAN respondents were more likely to report local activities than the other networks. SCAN shows the biggest increase (numerical and percentage) in respondents reporting local activities since 2022. Due to sampling limitations, caution should be exercised in interpreting this slight variation in the number reporting activities being offered in their networks.

Table 4: Availability of local prehabilitation activities by Cancer Network

Number reporting that local prehabilitation activities were available, by Cancer Network			
Cancer Network	2019	2022	2025
NCA	6	23	33
SCAN	23	19	53
WoSCAN	49	53	64
Total responses to this question	78	95	150

Respondents with locally available prehabilitation services (n = 152) were asked further questions about the availability and resourcing of those services.

Changes in the last 18 months

In 2022, respondents were asked about changes to local prehabilitation activities since the onset of the COVID-19 pandemic. From this, it was found that there was an initial scaling back of many prehabilitation activities, followed by a resumption of

them in blended or hybrid mode (including telephone or video service delivery). The 2025 survey included a similar question covering the past 18 months (i.e. since Autumn 2023) to track change over time. 115 out of a potential 152 responded.

Responses in 2025 presented a mixed picture. Many respondents mentioned time-limited or pilot projects coming to an end and the need for investment to provide long-term services. Some referenced scaling back activities due to changes to funding or staff resource. Several mentioned local prehabilitation activities having ceased in the last 18 months or having moved from interventions for specific cancer types to a more universal offering. However, there were also many examples of new or expanded services provided, some of which were supported by temporary funding. These included but were not limited to:

- Expanding local prehabilitation to include people with a wider range of cancer types
- New digital services
- Expanded from trial to a substantive prehabilitation service
- A new formal pathway for cancer prehabilitation
- New courses and interventions for people with cancer
- New promotional materials developed
- Pilot of screening tools
- Undertaking a test of change
- New Clinical Exercise Physiologist role.

A few respondents commented that improved local understanding of prehabilitation among staff has led to more referrals. This suggests that, despite limited statistical evidence of change in awareness about prehabilitation, there has been a shift in a few local areas and the instrumental effect of this on practice.

Delivery mode

As in 2022, respondents described the changing modes of delivering prehabilitation services, particularly now being able to offer phone and video support options. These developments were related to increased accessibility for people living in remote and rural areas. They were also seen as beneficial to teams working in one place yet covering a large area. However, it was acknowledged that these modes are not appropriate to everyone, and digital exclusion can act as barrier for some, underscoring the importance of co-designing services and offering choice.

Responses indicated that changes were not always towards greater digitisation. One respondent mentioned a Digital Prehab app, which had ceased after funding ended. Another described now having greater capacity for face-to-face support, from what was primarily telephone support. This highlights the ongoing funding that sustainable digital solutions require, as well as the continued value of in-person interactions in prehabilitation.

Staffing

Respondents were asked what staff or volunteers were involved in the delivery of prehabilitation activities in their local area. 150 out of 152 potential respondents answered this, with their responses shown in Table 5.

Table 5: Staff involved in delivery of local prehabilitation activities

Staff / Volunteer role (Select all that apply)	% of respondents selecting this role 2022 (n = 90)	% of respondents selecting this role 2025 (n = 150)
Nurse	61%	51%
Dietitian	51%	50%
Physiotherapist	47%	35%
Clinical Psychologist	32%	11%
Fitness Instructor (Local Authority/Move More etc.)	28%	23%
Occupational Therapist	20%	7%
Volunteer/Buddy/Peer Supporter	19%	19%
Counsellor	13%	8%
NHS Technical Instructor/Support Worker	8%	4%
Don't Know	7%	19%

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

Compared with 2022, there were decreases in the proportions of respondents selecting:

- Clinical Psychologist (from 32% in 2022 to 11% in 2025)
- Occupational Therapist (from 20% in 2022 to 7% in 2025)
- NHS Technical Instructor/ Support Worker (from 8% to 4% in 2025).

There were also decreases in the proportions (albeit smaller) selecting Counsellors, Physiotherapists, Nurses and Fitness Instructors compared to 2022. Alongside this, more respondents selected 'Don't Know'. [Maggie's Centre](#) staff and Speech and Language Therapists were the most frequently mentioned roles in 'Other'. Palliative Care Consultants, Radiographers and Third Sector staff were also referenced by a few respondents.

Variability in results to this question across 2019, 2022, and 2025 surveys suggests that comparisons may reflect the sample of professionals who responded and their awareness of available services, rather than actual changes in service delivery. It is worth noting that more respondents here referred to prehabilitation (n=41) than provided prehabilitation services (n=20), which may explain some of the uncertainty about the specific staff composition following referral.

Involvement of staff delivering all three prehabilitation modes was reported by 9% of respondents with local prehabilitation activities, as shown in Table 6. This is a decrease from 19% in 2022 and appears to be driven by fewer respondents selecting physical fitness (17% reduction) and psychological support (26% reduction) roles compared to 2022. Open text responses highlighted two cases where psychological/emotional support has ceased in the last 18 months. However, no general pattern emerged of a decline in physical fitness roles in open text responses. Further follow-up conversations would be useful here to understand a full picture of workforce composition and change over time.

Table 6: Staff delivering the three prehabilitation modes

Prehabilitation modes	% of respondents selecting this role (n = 150)
Physical Fitness: Physiotherapist and/or Fitness Instructor	49%
Nutrition: Dietitian	50%
Psychological Support: Clinical Psychologist and/or Counsellor	17%
Responses showing staff from all 3 modes	9%

Qualitative responses from open text questions identified insecure funding for staff as a major theme, as discussed in [Funding](#) below. One respondent described undertaking a visit to another clinic to give insight into the prehabilitation team they would ideally like to build with additional funding. Respondents emphasised the importance of dedicated funding to support staff to deliver a full complement of prehabilitation modes, specific specialist staff to fill gaps in their local area, and to ensure staff capacity beyond ad hoc delivery. This suggests a strong and common concern around staffing and service sustainability, as well as individual areas sharing learning about how to scale up prehabilitation activities.

Funding

Respondents were asked what type of funding their prehabilitation activities received. 146 out of 152 for whom this question applied responded. Respondents could select multiple options and were invited to provide additional details about temporary funding. Nine respondents selected more than one type of funding category, and these were coded to the most appropriate response category. Where 'temporary funding' was selected alongside 'no funding', this was coded as 'temporary funding', and when 'permanent funding' was selected alongside 'temporary funding' this was coded as 'permanent funding' to show the presence of at least some of this type of funding. This suggests that the funding situation is complex, and the categories outlined in Table 7 describe the funding of some but not all prehabilitation activities locally.

Table 7: Type of funding for local prehabilitation activities

Types of funding	Number of responses	% of responses to this question
Permanent funding	20	14%
Temporary funding	39	27%
I don't know about funding	63	43%
No funding	19	13%
Other	5	3%
Total responses to this question	146	100%

Compared to the 2022 survey, a greater proportion of respondents selected permanent funding in 2025 (14%, up from 2%). This figure is more closely aligned with that reported in 2019 (16%). Some respondents added that permanent funding in their area applies only to specific cancers or types of service, rather than all prehabilitation activities. For example, one respondent described permanent funding for rehabilitation services, temporary funding for prehabilitation sessions, and local leisure services that are self-funded by the patient/participant.

The proportion of respondents selecting temporary funding decreased from 39% in 2022 to 27% in 2025. Respondents expanded that in many cases temporary funding had stopped, was stopping later this year, or they were unsure of the end date. In 'Other', respondents noted that their prehabilitation service was offered within an existing permanently funded rehabilitation service. In 2025, over two fifths (43%) were unsure about the type of funding in their local area, and 13% described no funding, which is similar to responses in these categories in 2022.

The data above suggest that there has been fluctuation around the funding of prehabilitation activities over the past six years, as well as uncertainty and possible variations in respondents' interpretations of terms 'permanent' or 'temporary'. In 2025, a greater proportion of respondents selecting permanent funding compared to 2022 may indicate that prehabilitation is being integrated into services, even if this applies to specific cancer or treatment types, rather than all people with cancer, as respondents highlighted. Further insights from follow-up conversations with staff would be helpful to understand these reported changes given the lack of a clear picture and the need for caution when comparing responses across years due to the differences in the sample of staff respondents.

As in 2019 and 2022, funding and resources, including staffing, were strong interrelated themes in response to open text questions in the 2025 survey. Respondents discussed the need for dedicated and permanent funding to develop sustainable prehabilitation services. Several respondents discussed the need for permanent funding to extend pilots and continue offering prehabilitation. Respondents noted that funding for staff could enable earlier intervention or allow prehabilitation services to be offered to those preparing for any cancer treatment.

Additionally, a few respondents acknowledged the cost of offering prehabilitation services and noted that if prehabilitation activities are provided or expanded, these must displace something else. Further follow up would be helpful here to understand the resource allocation trade-offs that local areas face and whether any learning can be shared around how to provide continuity of care as pilot projects come to an end.

Introduction of new prehabilitation activities

All survey respondents were asked about plans to introduce or add to local prehabilitation activities. A quarter of those who responded (25%) indicated there were plans to introduce new activities, however the majority (64%) were unsure. These proportions are similar to 2022 survey results. 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	73	25%
No	33	11%
Don't know	185	64%
Total responses to this question	291	100%

There was some variation across Cancer Networks. In 2025, SCAN respondents were most likely to be aware of plans to introduce or add to local activities (32%), compared to WoSCAN (22%) and NCA (21%). In 2022, SCAN respondents were the least likely to be aware of plans to introduce or add activities. This may indicate that prehabilitation activity has increased since 2022 in this Cancer Network.

Service delivery and pathways

Respondents with locally available prehabilitation services reflected on prehabilitation service delivery and where improvement could enhance the effectiveness of local services.

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, 151 or 152 out of 152 potential respondents answered the question.

The highest level of agreement was with the statement that “Prehabilitation activities are multi-modal including exercise/activity, nutrition and psychological support”, with 69% of respondents agreeing (including strong agreement). This finding showed an increase in positive responses since the 2022 survey (61%).

Over half of respondents in 2025 agreed with the three statements below, with levels of agreement higher than those reported in 2022 for each statement:

- “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” (66% agreed, up from 55%).
- “Prehabilitation activities start as early as possible and in advance of any cancer treatment” (64% agreed, up from 46%).
- “Prehabilitation activities are part of the rehabilitation continuum” (64% agreed, up from 45%).

The increase in proportion of respondents agreeing with the above statements suggests stronger alignment with, and adoption of, those specific Key Principles of prehabilitation implementation in local delivery, compared to 2022 respondents.

Just under half of respondents (46%) in 2025 agreed that “Completion of prehabilitation screening should be recorded at cancer multidisciplinary team meetings alongside performance status”, similar to 2022 (47%).

Although higher than the previous survey, the following three statements received less agreement than others regarding implementation:

- “Validated tools are used for individualised assessment, care planning and outcomes measurement when patients are receiving targeted and specialist interventions” (34% agreed, up from 16%).
- “All patients are screened to determine the level of prehabilitation required (universal, targeted, specialist)” (32% agreed, up from 23%).
- “All patients (receiving universal, targeted and specialist interventions) have a co-produced personalised prehabilitation care plan” (26% agreed, up from 21%).

Lower levels of agreement for these statements suggests that screening for appropriate level of intervention, the use of validated tools with patients receiving targeted or specialist interventions, and co-produced personalised care plans could be considered as areas of ongoing action to support prehabilitation activities. It may also reflect gains in the use of validated tools for assessment, care planning and outcomes measurement compared to the previous survey in 2022.

Referrals

Respondents were asked if they personally referred people to prehabilitation activities, and how routinely they did so. 146 out of 152 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	61	42%
No	55	38%
I provide prehabilitation services	30	21%
Total responses to this question	146	100%

63% of respondents in 2025 reported that they either referred to or provided prehabilitation services, a figure broadly consistent with 60% reported in 2022.

All 61 respondents (those who answered Yes) answered the follow-up question about how routinely they refer people.

- 57% selected 4 or 5 (more likely to or always refer)
- 34% selected 3 (medium likelihood of referring)
- 8% selected 1 or 2 (less likely to refer).

Compared to 2022, the proportion reporting greater routineness of referral in 2025 (selecting 4 or 5) increased from 41% to 57%. Meanwhile, the proportion reporting a lower likelihood to refer (selecting 1 or 2) declined from 21% to 8%. This implies a positive development towards embedding prehabilitation into the patient pathway. However, it should be noted that the sample of respondents to this question for both years is smaller compared to the overall survey sample, which means there is less certainty in the extent of the magnitude of this change over time.

On the other hand, low referral numbers were raised by a few in response to open text questions, with these respondents feeling that this contributed to low service uptake. Comments highlighted the need to encourage staff to refer to services, raise awareness of the benefits of prehabilitation, and be mindful of patient burden in scheduling appointments. The challenge of referrals taking place across large geographical areas was also noted, along with the importance of having local services and staff familiar with them.

Timeliness of referrals remained a key theme from 2022. There was general agreement that prehabilitation should be started at the first suspicion or diagnosis of cancer to prepare patients for treatment. In addition, that prehabilitation should not delay first definitive treatment. In some areas, prehabilitation services were integrated in patient pathways, with staff routinely screening and referring or signposting people to appropriate services. Others, however, felt that this was not happening in their area, that the burden for staff of referring to multiple support systems was time consuming, or that in some cases people were starting prehabilitation too late to benefit fully from interventions and improve their clinical state.

When asked how local pathways could be improved to support prehabilitation, three common ideas emerged: dedicated funding for staff involved in prehabilitation, greater multi-disciplinary team (MDT) involvement, and better coordination of care.

Regarding coordination, respondents described investigating automated referrals to avoid any delays in starting prehabilitation, while others highlighted the benefit of a prehabilitation coordinator role. A coordinator or single point of contact was described as someone to work closely with the MDT to identify, screen, triage and refer. This role, already available in some areas, was seen to have potential to reduce the administrative burden, improve collaboration and the timeliness of referrals. In addition, a few respondents mentioned using temporary funding to establish or explore the development of prehabilitation clinics, aiming to create a more connected and coordinated service.

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 intervention. Of the 152 respondents with local prehabilitation activities, 144 to 145 answered questions about their modes of screening or triaging patients for perceived risk.

Around two thirds (66%) reported that their service screened for at least one mode, as shown in Table 10. The most reported mode of screening was for perceived nutritional risk. This contrasts with previous survey results where the proportions reporting screening were similar across all three modes. As mentioned above, due to sampling limitations, caution should be exercised when comparing responses between years given the differences in the sample of staff respondents.

Table 10: Screening or triaging patients by prehabilitation mode

Screening or triaging patients for perceived risk associated with:	% reporting screening/triaging in 2022	% reporting screening/triaging in 2025
Nutrition	44%	53%
Physical Activity / Exercise	46%	38%
Psychological Need	43%	32%
Any mode	71% (n = 67 respondents)	66% (n = 96 respondents)
None of the modes	29% (n = 28 respondents)	33% (n = 48 respondents)

A breakdown of the 96 respondents whose service was screening for any of the three modes is shown in Table 11. While overall the proportion screening for one or more modes in 2025 is similar to 2022, the proportion screening for all three is lower (29%, down from 50%), and screening for one mode was the most common response. These data may suggest that screening or triaging to determine what level of intervention is required is more consistent across Scotland for some modes

of prehabilitation (nutrition) than others (physical activity or psychological need). A lower level of psychological screening reported here compared to other modes is supported by a few open text references to an absence of psychological support services to refer to, or a universal support offered. However, no clear pattern emerged in open text responses of one mode that was consistently lacking. As noted above, findings may reflect a different occupational profile of respondents between years and their awareness of practice and should therefore be interpreted with caution. Follow-up conversations with staff are recommended for more conclusive insights.

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	28	29%	19%
2 modes	26	27%	18%
1 mode	42	44%	29%
Total responses to this question	96	100%	66%

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

Nutrition: Tools such as the Malnutrition Universal Screening Tool (MUST) and Patient-Generated Subjective Global Assessment (PG-SGA) were commonly described. In some cases, different tools were used for different cancer types due to perceived variation in their sensitivity. Other approaches to screening included discussions around risks or concerns with swallowing, weight / weight loss or appetite changes. Some respondents described a multi-pronged approach. Members of an MDT such as the Clinical Nurse Specialist (CNS), Consultant or Prehabilitation Coordinator were referenced as being involved in the referral process. Referrals mostly went to community or specialist Dietitians for onward treatment. Despite screening and referral taking place, referral to community dietetic services suggests the timeline for intervention may not be optimal and the intervention may be delivered as a single mode rather than as part of multi-modal prehabilitation.

Physical Activity / Exercise: Validated tools or objective measures to assess functional capacity such the Duke Activity Status Index (DASI), frailty scores, grip strength and Sit to Stand Test were mentioned. Several respondents mentioned patient discussions or visits as a means of undertaking physical activity screening, which included the review of clinical notes. CNSs and Physiotherapists were the primary professionals noted to carry out screening for physical activity and exercise. General open or holistic discussions were also referenced as a route to identify perceived risk. Few details were provided about the onward referral route.

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 Holistic Needs Assessment (HNA), involving tools like the EuroQol 5-Dimension (EQ-5D) health-related quality of life questionnaire. However, a couple of respondents mentioned identifying psychological need as part of a broader conversation about feelings and signposting to services. Screening, where highlighted, was primarily conducted by a Consultant, Nurse or ICJ staff. Where available, onward referrals ranged from in-house programmes and counselling services, to signposting to universal emotional support services.

In many examples given, respondents used the terms screening and assessment interchangeably, although these are different processes with different purposes. Across all three modes of screening, approaches varied from being standardised, for example a routine part of MDT discussions, to more unstructured, for example prompted by risks or concerns identified in consultations. Regarding consultations, elsewhere in open text responses it was acknowledged that sensitive conversations about lifestyle factors require adequate time, as these discussions could be interpreted as judgemental if not approached with care.

Leadership and management

Respondents who identified as Senior Leaders or Service Managers (n=13) were asked about the ways in which they are actively engaged in or leading local activities to see cancer prehabilitation embedded in ways of working and/or pathways of care.

Several highlighted their role in strategic support for project teams in developing and implementing prehabilitation services. Primarily this involved having leadership roles in steering groups and working groups. One respondent mentioned focussing on sustainability, specifically securing recurring funding to deliver prehabilitation for cancer and non-cancer pathways via business cases. Another referenced identifying inequalities and gaps for service planning.

A few Senior Leaders or Service Managers mentioned supporting staff to integrate prehabilitation into specific cancer care pathways or establishing a prehabilitation pathway locally. Cross-sector collaboration was also highlighted, with partnerships involving organisations such as Maggie's, Macmillan, Apple Clinic, and NHS Boards. In open text questions, wider respondents described the need for broad level leadership and buy in from managers to engage staff from multiple professions in prehabilitation.

Access to services

Understanding of prehabilitation

Many open text responses focused on the need to improve an understanding of prehabilitation amongst people with cancer, staff, and the public. Some felt that people did not become aware of prehabilitation until well after their diagnosis, and

that promotional activities and broader public health education could enable healthy living and optimise treatment outcomes. Respondents provided practical suggestions of how to do so, such as staff training, hospital newsletters, or creating an easy summary of prehabilitation resources available. Greater awareness of the benefits of prehabilitation was widely seen as critical for early referral and patient engagement in activities.

Equity and inequalities

Several respondents with services in their local area highlighted inequity in access to prehabilitation services. This was most common in descriptions of services or prehabilitation activities specific to some cancers and not others. While some respondents described expanding prehabilitation services to a wider range of cancers/ cancer types over the past 18 months, prehabilitation services were often described as cancer-specific, linked to funding arrangements. Other groups with perceived barriers to access included people with Stage 1 and Stage 2 cancers, people receiving non-surgical treatment, and those receiving palliative care.

As reported in 2022, socio-economic and geographical barriers to access continued to be highlighted in 2025. One respondent noted that some people with cancer do not own a smart phone. A few mentioned people having to pay for physical activity programmes and affordability as a barrier. Transport issues for people living in rural areas making it difficult to access in-person appointments, particularly those who have co-morbidities, were also raised. Responses highlighted the need for local services and co-ordinated appointments to reduce travel time for patients already facing appointments at different sites. These findings emphasise factors to consider in inclusive service design, particularly when considering digital developments.

Workforce learning

All respondents were asked about their use of the national prehabilitation website, [Prehab and Me – Prehabilitation for Scotland](#), for their own learning or to access resources to support patients. Around one fifth (19%) reported using the website, while a majority reported not doing so, as shown in Table 12.

Table 12: Use of the website for own learning or as a resource to support patients

Utilise the website?	Number of responses	% of responses to this question
Yes	57	19%
No	241	81%
Total responses to this question	298	100%

When considered by Cancer Network, a higher proportion of respondents in NCA (24%) reported using the website compared with WoSCAN (19%) and SCAN (16%).

When considered by professional groups, Nurses represented the group most likely to report using the website (32%), compared to Physicians (15%), AHPs (13%) and other professionals (19%). Other professionals include Project/ Improvement Managers, Senior Leaders/ Service Managers, and Counsellors/ Psychologists, listed in Annex A.

Uses of Prehab and Me website

55 out of 57 respondents who reported using the national prehabilitation website responded to a follow-up question about the way in which they make use of the website. Signposting patients to information to improve their understanding and engagement was the most common use (75%), followed by learning more about prehabilitation and how to support patients to prepare for the future (47%). This highlights the website’s role in both patient education and staff development amongst users.

Table 13: Specific uses of the Prehab and Me website

Response statements about uses of website (Select all that apply)	% respondents selecting this statement (n = 55)
Signpost patients to information that will help them understand and engage in prehabilitation	75%
Help answer specific questions the patient has about elements of prehabilitation or their suitability for prehabilitation	15%
Help patients learn what additional support is available to them	40%
Help a patient set their own prehabilitation goals	13%
Learn more about prehabilitation and how they can support patients to prepare for what lies ahead	47%
Find out what education and training is available to develop their knowledge and skills in prehabilitation	27%
Access the Key Principles for Implementing Cancer Prehabilitation to guide their work or the development / delivery of their prehabilitation service	31%
Access the Frameworks (nutrition, physical activity and psychological support) that guide their work or the development / delivery of their prehabilitation service	31%
Other	5%

‘Other’ responses included use of the website to signpost patients to patient groups, and to teach staff and students about cancer prehabilitation and rehabilitation.

All 302 respondents were asked why they did not make use of the website. 247 responded, including 12 who had previously indicated that they do use the website.

Lack of awareness of the website was the most common response (81%), as shown in Table 14. In addition, 14% selected that they did not have sufficient time in a consultation to discuss the website.

Table 14: Specific reasons for not using Prehab and Me website

Responses statements about reasons for not using the website (Select all that apply)	Number of respondents	% respondents selecting this statement (n = 247)
I wasn't aware of the website	201	81%
I don't have enough time in a consultation to discuss the website	34	14%
I don't think it's useful or contains the right information	6	2%
I don't have a local website	8	3%
Other	27	11%

'Other' reasons included that the website is not applicable to their role or the patient group they interact with most closely, low IT literacy amongst patient groups, a wish to personalise information and resources for patients, and use of local resources.

Other online learning resources

All respondents were presented with a range of learning resources related to prehabilitation and asked to indicate whether they were aware of each. Awareness levels, from most to least commonly known, were as follows:

- 42% reported awareness of [Enhanced Recover After Surgery \(ERAS\) in Scotland TURAS pages](#)
- 26% reported awareness of [NHS Scotland Nutrition Framework Education and Training Grid \(Appendix 3\)](#)
- 21% reported awareness of [NHS Scotland Psychological Therapies and Support Framework Education and Training Grid \(Appendix 3\)](#)
- 18% reported awareness of [The Nursing, Midwifery and Health Professions \(NMaHP\) Perioperative Education and Development site](#)
- 17% reported awareness of [Prehab, Rehab and Personalised Care Programme \(PROsPer\) \(NHS England e-learning for health site\)](#)
- 12% reported awareness of [Moving Medicine Scotland](#)
- 4% reported awareness of [Actify](#)
- 3% reported awareness of [Perioperative Medicine in Action \(UCL short course\)](#)

These responses highlight varied levels of awareness of relevant learning resources available, with some resources being more commonly known than others. It is important to note that this reflects awareness rather than the actual use of resources. Results do not indicate whether the resources are being actively used in practice. This could be explored in future surveys.

When describing ways in which local pathways could be improved to optimise patients for treatment, respondents gave a range of suggestions for how to build knowledge, skills and competencies of staff surrounding prehabilitation. These included making links with recognised free online platforms, utilising existing resources such as podcasts, self-help tools and motivational content, pop-up and information events (particularly in remote areas), and integrating prehabilitation into training programmes within professional and vocational training programmes.

Communication and collaboration

Respondents with local prehabilitation activities reflected on communication and collaboration between services, including interactions within local MDTs and local Third Sector organisations. 137 out of a possible 152 respondents with locally available prehabilitation activities provided details.

Multidisciplinary Team (MDT) engagement

Approximately a third (34%) of respondents who provided details on working relationships described close working between staff providing prehabilitation, either as part of an MDT, or with prehabilitation as a core part of the patient pathway after diagnosis. The same proportion (34%) alluded to more variable levels of involvement, for example, noting that some key professions were part of the MDT and not others, or that prehabilitation was delivered by a separate service outside the core clinical team.

As in previous survey results, involvement of the MDT was seen as a key enabler of effective and early prehabilitation. When asked how local pathways could be improved to better support prehabilitation, some suggested more joint MDTs for specific cancer pathways and that prehabilitation should be a regular topic of discussion at meetings. Respondents emphasised the importance of liaising with other staff to identify and refer people with cancer to timely support. One respondent proposed adding a section to the MDT proforma as a useful prompt. Several also highlighted the value of a dedicated coordinator role to facilitate collaboration across services. Coordination of care where targeted or specialist support is needed was additionally seen as important to minimise the number of visits people must make and avoid overwhelming them (see [Referrals](#)).

Where prehabilitation falls outside MDTs or is spread across services, there were some positive comments about communication and collaboration, but also other comments that highlighted a 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 staff awareness and understanding of the benefits of prehabilitation for good engagement in MDTs was also highlighted.

Collaboration with Third Sector organisations

Several respondents mentioned collaboration with specific Third Sector organisations, mainly the Maggie's universal prehabilitation workshops and

Macmillan ICJ. NHS respondents highlighted partnership working with such services as a potential enabler of effective prehabilitation. Respondents highlighted the contribution of Third Sector organisations offering universal emotional, practical and social support before and after treatment.

However, awareness of these services and working relationships with them varied. While some respondents mentioned a close working relationship, others suggested a more distant working relationship. Those latter respondents stated or implied that local prehabilitation was something separately undertaken by Maggie's and that the MDT was not involved. This finding may also explain the level of uncertainty amongst respondents about which specific staff were involved in delivering prehabilitation, as described in [Staffing](#). Feedback mechanisms from referrals were suggested as a way in which collaboration could improve local pathways to support prehabilitation. Given the variation in relationships described in responses, there also may be opportunities to share learning from experiences where collaboration between sectors is reported to be effective.

Monitoring, evaluation and outcome measurement

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

Monitoring and evaluation

Many respondents were uncertain about whether and how monitoring was undertaken. Several explained this was due to monitoring not being part of their role. Monitoring processes mentioned included recording patient referrals, uptake and attendance, and feedback forms or questionnaires.

Patient uptake. Some respondents described monitoring uptake as a shared team responsibility or this being led by a coordinator. Others reported using tools such as spreadsheets or TRAK software to log referrals. A few mentioned conducting audits, and one referred to a process evaluation. Several responses included comments on current levels of patient uptake, although these did not include details on how estimates were derived.

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. Where data were recorded, this was primarily in the form of statistics such as attendance figures. A few respondents mentioned monitoring via a digital platform where individuals can upload their activity. More qualitative information such as interviews, follow-up phone calls or journals were also mentioned.

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 was a common approach. A few mentioned using standardised tools to assess health and quality of life alongside local service satisfaction questionnaires. Monitoring was inferred at various points: at the end of intervention, before surgery, or at specific points throughout a year. Others described gathering more unstructured or informal feedback. Several responses gave accounts of positive patient experiences without citing specific data or metrics.

Outcome measurement

Respondents were asked if outcome measures were used to determine the effectiveness of their prehabilitation activities. 149 out of 152 potential respondents answered. The proportion answering 'Yes' (34%) in 2025 was similar to 2022 (35%). Just under half (44%) indicated that they did not know, as shown in Table 15.

Table 15: Use of outcome measures to determine the effectiveness of prehabilitation activities

Use of outcome measures?	Number of responses	% of responses to this question
Yes	51	34%
No	20	13%
Don't know	66	44%
Not applicable	12	8%
Total responses to the question	149	100%

Respondents described a range of outcome measures, many of which mirrored the measures reported in 2022. The measures consisted of a blend of validated patient-reported and clinical measures. There were references to using multiple measures, having multiple assessment points, and in one case using a national data base to systematically compare patient outcomes. Measures such as feedback or satisfaction surveys were referenced, although these do not constitute standardised outcome measures.

For Physical Activity / Fitness, the most frequent measures mentioned were functional measures such as Sit to Stand assessments, measures of grip strength, and measures of respiratory or cardiovascular health, such as the Six Minute Walk, Cardiopulmonary Exercise Testing (CPET) and Tidal Volume.

For Nutrition, measures mentioned included oral nutritional supplement usage, weight before and after surgery, and measures of nutrition risk such as via the Patient-Generated Subjective Global Assessment (PG-SGA).

For Psychological Status, patient-reported experience measures were described, such as EuroQol 5-Dimension (EQ-5D) health-related quality of life questionnaire and Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS).

Robust outcome measurement was acknowledged as important. Clinical outcome measures, such as length of hospital stay, post-operative complications, and readmissions, were reported. One respondent mentioned re-screening baseline risk indicators and re-testing functional outcomes, emphasising the importance of aligning processes with current IT systems to effectively evaluate outcomes. Another noted that a process evaluation is currently underway in their area. A test of change was also mentioned locally. Outcome measurement could link to the [service availability and resourcing theme](#). Evidence that prehabilitation leads to positive outcomes could help make the case for longer-term funding and sustainable staffing.

6. Rehabilitation findings

This section presents staff awareness of the national approach for good rehabilitation, and perspectives on rehabilitation pathways and delivery.

Awareness

All respondents were asked to rate their awareness of the [Once for Scotland Approach to Rehabilitation](#) published in June 2022. This was a new question in the 2025 survey. 297 responded, of which:

- 26% of respondents selected 4 or 5 (high awareness)
- 25% of respondents selected 3 (medium awareness)
- 48% of respondents selected 2 or 1 (low awareness or not aware at all).

Awareness varied only slightly by Cancer Network, with a higher proportion of respondents reporting high awareness in NCA (29%) and WoSCAN (27%), than in SCAN (21%). Due to the sampling limitations, caution should be exercised in interpreting this slight variation in awareness between the different networks.

Nurses and AHPs were slightly more likely to indicate high awareness (34% and 30% respectively) compared to Physicians and respondents in other professional groups (both 21%). Again, this slight difference should be interpreted with caution.

Service availability

Respondents were asked whether any cancer rehabilitation activities were being offered in their local area. 300 out of 302 survey respondents answered, with details shown in Table 16.

Table 16: Availability of local rehabilitation activities

Rehabilitation activities offered in local area?	Number of responses	% of responses to this question
Yes	98	33%
No	30	10%
Don't Know	172	57%
Total responses to this question	300	100%

Around one in three respondents (33%) reported that there were cancer rehabilitation activities being offered in their local area in 2025. This is a decrease from 53% reported in 2022, with a corresponding increase in the proportion of people selecting 'Don't Know', from 33% to 57%. This could suggest greater uncertainty around, or less awareness of, local rehabilitation activities amongst 2025 survey respondents compared to 2022, although any comparison across years should be interpreted with caution due to differences in the sample of staff respondents.

There was little variation in the likelihood of reporting local rehabilitation activities between Cancer Networks (all between 31% and 34%). Having both prehabilitation and rehabilitation activities locally was reported by 67 respondents, representing 22% of the overall sample.

Respondents with local rehabilitation activities were asked further questions about those services. 86 of a potential 98 individuals responded. They discussed a range of rehabilitation services available from NHS Boards, Third Sector organisations and Local Authority leisure centres. Some services were described as resembling the prehabilitation pathway or forming part of standard post-operative care. Most offerings were physical activity-based, though other forms of support, such as dietary, physiological, emotional support and financial advice, were also mentioned. Delivery was primarily in-person through clinics or drop-in centres, with some examples of online or telephone-based support provided.

Service delivery and pathways

Local delivery underpinned by a Once for Scotland approach

Respondents were presented with the [Six principles of Good Rehabilitation](#) and asked about the extent to which each principle underpinned the delivery of rehabilitation activities in their local area. 95 out of a potential of 98 respondents evaluated these statements.

As shown below, a majority agreed that local services are realistic and meaningful to the individual, and that they are delivered by a flexible and skilled workforce. Statements about the integration and ease of access to services for every individual received more disagreement:

- 49% agreed that their local services are easy to access for every individual, while 25% disagreed;
- 44% agreed that services are provided at the right time, while 18% disagreed;
- 59% agreed that services are realistic and meaningful to the individual, while 9% disagreed;
- 44% agreed that services are integrated, while 24% disagreed;
- 40% agreed that services are innovative and ambitious, while 15% disagreed;
- 53% agreed that services are delivered by a flexible and skilled workforce, while 12% disagreed.

Rehabilitation continuum

As discussed in [Service delivery and pathways](#), around two thirds of respondents (64%) agreed that local delivery of prehabilitation activities is underpinned by the principle that they are part of the rehabilitation continuum. In open text responses, however, few provided details of how this continuum worked in practice. One

respondent described the benefits of meeting patients and becoming a 'familiar face' before surgery so that individuals are comfortable with contacting them afterwards with any further questions. Some Third Sector providers of both prehabilitation and rehabilitation also described service delivery through the whole cancer journey. The need to integrate both prehabilitation and rehabilitation into standard cancer care along the full pathway was emphasised in responses. The importance of effective ways of informing staff about pathways and rehabilitation resources available was also highlighted.

7. Discussion and recommendations

This analysis provides insights that can be considered by CPOG and delivery partners to shape further programme development and implementation of prehabilitation activities. Discussion and recommendations have been set out around five key themes. Implications for progress are considered in relation to relevant Actions in the Cancer Action Plan, and areas for follow-up conversations with staff are highlighted where further insights and analysis would be beneficial.

Further action to increase awareness

Awareness of the 'Key Principles' of prehabilitation remains uneven, with two fifths reporting high levels of awareness (41%) and a similar proportion (38%) reporting low awareness. Some respondents described successful awareness-raising activities having taken place recently in their local area, and the positive impact these activities have had on prehabilitation referrals. Overall results suggest that further action is needed to raise awareness of what the Key Principles of prehabilitation constitute, and the value of prehabilitation – ensuring this is understood across all professional groups – to deliver a consistent message to people with cancer so that they receive support earlier in their cancer journey. In light of these findings, further work with NHS Education for Scotland would be beneficial to support Action 51 to ensure educational tools that support the development and delivery of high quality prehabilitation services are available and accessible to all.

Relatedly, the use of the Prehab and Me website was reported by around one in five respondents (19%), with a lack of awareness being the primary barrier. Those who did use the website found it valuable both for signposting to patients and for using for their own professional learning. More promotion of this resource is recommended across professional groups and Cancer Networks.

Respondents suggested including prehabilitation in professional or vocational online training programmes, which could present a mechanism for boosting awareness of existing online resources and the nutrition and psychological support Frameworks. While the 2025 survey suggests there is more nutrition screening and dietetic involvement compared with 2022, and follow-up conversations with staff are recommended for more conclusive insights about the modes of support being offered, further awareness-raising would support Action 49 to improve understanding of the role of nutritional care and to aid implementation of the Nutrition Framework to assess nutritional needs. Similarly, further work to increase awareness and promote resources amongst staff working with people affected by cancer would support progress with Action 106 to implement and apply the Psychological Therapies and Support Framework in practice. In turn, sharing relevant training and educational resources will support Action 51 to ensure appropriate tools are available and accessible to all staff to support the development and delivery of high quality prehabilitation services. It is advised that future surveys ask about the actual use of resources as well as awareness.

Respondents in this survey expressed a desire to know what local prehabilitation activities are available and how to access them. Uncertainty around workforce composition also highlights the need to ensure potential referrers understand the make-up of prehabilitation services and who is delivering them. With a strategic shift in the SG's [Service Renewal Framework](#) to greater provision of health and social care in community settings, staying up to date with what activities are available locally and where they are located may become even more important as health services may be increasingly delivered outside of hospitals. Respondents proposed ways of disseminating information, such as hospital newsletters and emails, talks, workshops and team meetings. Extending dissemination beyond organisational boundaries, including the Third Sector, will be relevant in the context of Service Renewal, to increase awareness and signposting to services across sectors, and to support collaboration and coordination of prehabilitation activities.

Learning from pilot projects and partnerships

The overall coverage of prehabilitation activities reported by respondents in 2025 remains similar to 2022. To reduce unwarranted variation in access to prehabilitation nationally, there is a clear need to expand coverage to achieve the goal of nationwide coverage of universal prehabilitation (Action 48) and to deliver targeted and specialist interventions also. Respondents highlighted concerns about insecure funding and existing pressures on the cancer care workforce. It may be valuable to share learning from areas where collaboration is working well to deliver multi-modal prehabilitation, including timely screening and referral. This could include sharing learning about how MDTs are structured, how care is coordinated, as well as how cross-sector partnerships are built and sustained. It could also include sharing learning between Senior Leaders/ Service Managers about the ways in which they are actively embedding and scaling up prehabilitation in pathways of care, an effort that would require senior buy-in and leadership, a key enabler highlighted in the 2023 report. Cross-sector collaboration was highlighted positively in the 2025 survey, reflecting progress towards Actions 48 and 50 in terms of providers working together to deliver a universal programme of activities similar to the offer in Maggie's Centres.

Service integration and partnership for prehabilitation is echoed by [Giles and Commins \(2019\)](#) who suggest collaboration at a local level and peer support capacity as ways in which prehabilitation can be delivered in the context of a stretched NHS workforce. Respondents here suggested introducing or strengthening MDTs, automatic referrals, coordinator roles and prehabilitation clinics as operational examples of staff working together to provide timely pre-treatment interventions, in ways that do not place additional burden on people who have recently been diagnosed with cancer. Establishing a forum where delivery partners can share learning from pilot projects would be beneficial to foster collaboration and partnership working across services to support wider adoption of prehabilitation. While local learning around sustainability is valuable, particularly from areas where projects have been scaled up successfully, it may be appropriate to review any assumptions relating to investment that underpin activities to deliver

nationwide coverage. Consideration of this issue is important when non-recurring funding presents a substantial barrier to progress to expand services.

Actions to improve access to prehabilitation

While video consultations were acknowledged to enable more remote connections, accessibility was a key issue in survey responses. Similar groups were identified as facing specific barriers to accessing prehabilitation as in 2022, including people living in remote and rural areas, and those without a smart phone, with low literacy, or with comorbidities. This finding likely reflects systemic inequalities in healthcare. It also suggests that a 'one size fits all' mode of prehabilitation delivery is unlikely to meet the needs of people with cancer, and that maintaining universal access while also addressing specific access needs may be most appropriate. A form of [proportional universalism](#) is already in place through the targeting of prehabilitation via screening, however, targeting of resources should be considered in the commissioning of activities with the wider determinants of health and cancer prevention in mind.

While the proportion of respondents reporting permanent funding was higher than 2022, 14% up from 2%, respondents emphasised that the funding landscape for prehabilitation is complex, with different types of funding at times linked to specific cancers. People with Stage 1 or Stage 2 cancers, receiving non-surgical treatment and those receiving palliative care were highlighted as facing inequity of care due to the scope of prehabilitation activities in some areas. This implies that it may be beneficial to provide NHS Boards with guidance on aligning resources to support more equitable implementation across cancers, cancer stages, and care or treatment types, or to consider whether there should be prioritisation.

One in four respondents (25%) indicated local plans to introduce or expand prehabilitation activities. Support to expand prehabilitation activities may be necessary if equitable access across Scotland remains an ambition of the second Cancer Action Plan. Ensuring sustainable funding models are in place to support activities will be important if the offer of prehabilitation is to be expanded without unwarranted variation across areas and groups. Some respondents also described moving to digital technologies for offering support, while others mentioned increased capacity for face-to-face support. [Stewart et al. 2025](#) note that consulting with patients in the design and delivery of prehabilitation is key to providing truly person-centred care. This includes assessing digital exclusion and how to mitigate this for vulnerable groups when offering community-based or digital care.

In line with the [Service Renewal Framework](#), knowledge, tools and resources are needed to support digital inclusion, with an emphasis on innovation and a 'digital first' mindset for service development. Respondents highlighted interpersonal factors that are important for engaging people in prehabilitation, including ensuring conversations about lifestyle are sensitive so as not to be perceived as 'blaming' the person with cancer. They also emphasised avoiding overwhelming people with too much information at diagnosis, or overburdening by appointments, especially for those living at a distance from services. Therefore, consideration should be

given to how inclusion and person-centredness will be central to new prehabilitation activities, particularly those using digital technologies.

Evidencing impact on patient outcomes

Responses continue to highlight a variety of approaches to monitoring and outcome measurement. One in three respondents with local prehabilitation activities reported using outcome measurements, a level which is unchanged from 2022, and findings reflected a general uncertainty about how monitoring was undertaken. Regarding positive developments, there was an increase in the proportion agreeing that local prehabilitation activities use validated tools for individual assessment, care planning and outcomes measurement in 2025, compared to 2022. In addition, a few respondents described digital recording of outcomes, tests of change, audit or process evaluation underway in their local area. Further progress in this area would support Action 50 to embed successful prehabilitation approaches in management guidelines and pathways of care, whilst also evidencing impact of outcomes.

A community of practice or knowledge sharing activities specifically around evidencing impact are recommended to share good practice and strengthen robust approaches to measurement, which may contribute to demonstrating value and cost effectiveness ([Sout et al. 2022](#)). Guidance around collecting experience data, given the uncertainty in survey responses around this aspect of measurement, would also be advised to drive improvements in services. These recommendations build on those presented in the 2023 report, highlighting national guidance on the measurement of outcomes, and core dataset to support monitoring and evaluation.

Integration with rehabilitation

In light of responses emphasising the need to integrate prehabilitation and rehabilitation more fully along the continuum of care, it is recommended that this finding is tabled for discussion at the National Rehabilitation Network meeting to agree on any required actions. This would include identifying and sharing good practice, in particular to inform staff about pathways and resources available, and identifying where any improvements may be needed to support progress with Actions 70, 71 and 72 in relation to rehabilitation services.

Follow-up conversations with staff

There were some areas within survey results that showed an unclear or slightly contradictory picture. For example, unlike previous survey findings which indicate that physical activity is the most common component of prehabilitation in Scotland (Provan et al. 2022), this survey suggests that screening and staffing for nutritional support is presently more common practice compared to the other two modes. Given the limitations around comparison over survey years due to sampling, it would be useful to explore any underlying reasons for these patterns of response: whether the levels of psychological and physical activity interventions or screening are declining, or to what extent this shift in response reflects changes in the

occupational profile of respondents and their awareness of practice (and their knowledge of different parts of the system) between surveys.

In-depth exploration of perspectives on multi-modal staffing and screening practices would be beneficial to understand progress relating to Actions 49 and 106 to implement nutritional and psychological support, and to provide further insights into any barriers or enablers to embedding these Frameworks more fully in cancer pathways. Follow-up conversations would also bring additional insights in relation to funding models, including consideration of resource allocation trade-offs and learning around how to sustain activities as pilot projects come to an end. Additionally, follow-up conversations would be beneficial to explore the integration of prehabilitation and rehabilitation services in more depth.

For future surveys, it would be informative to ask staff about their use (as well as awareness) of specific professional frameworks related to prehabilitation, for example, the Nutrition Framework and the Psychological Therapies and Support Framework, in addition to the resources that they use in practice, including the Prehab and Me website. This would help build a picture of current forms of skills development and support needed to build competence and capacity to deliver multi-modal prehabilitation.

8. Conclusion

This survey analysis reaffirms strong support for prehabilitation amongst staff, with a majority of respondents perceiving it as playing a crucial role in preparing patients for treatment. This maintained support was reflected in the high level of response to this survey, which gathered input from 302 staff, reporting on activities in all 14 territorial NHS Boards. These staff worked across a range of settings and roles, including in: Acute care, Community care, Local Authorities, and the Third Sector.

In the national adoption of prehabilitation, findings present a mixed view of progress. In 2025, there is a stronger sense that service delivery is underpinned by the eight [Key Principles for Implementing Cancer Prehabilitation across Scotland](#) compared to responses in 2022. This may reflect that staff are knowledgeable about prehabilitation and feel more confident in applying the key underpinning principles to their area of practice. Responses highlighted areas of service development and expansion: for example, reaching new cancer types, trialling screening tools, and developing leadership roles to embed prehabilitation in ways of working. The analysis also highlighted new or expanded services being provided and an increase in the proportion of respondents reporting permanent funding to support prehabilitation activities. These findings indicate positive developments towards embedding prehabilitation into pathways. Although the extent of progress may be limited when findings indicate ongoing challenges with timeliness in referrals, unequal access across cancers and treatment types, and continuing reliance on temporary funding for many activities, reflecting barriers reported in 2023.

Overall, the coverage of prehabilitation services locally reported was in line with 2022, which indicates modest change in the availability of local prehabilitation services. Similar issues around accessibility were also described. Many reported temporary funding coming to an end and were concerned about the impact this would have on the capacity to provide timely and equitable care. Funding and workforce capacity were recurring concerns with calls for sustainable investment and strategic workforce planning to address local gaps in particular modes of prehabilitation support. Key barriers to progress reported in 2023 around staffing and funding therefore continue to be reported in 2025, impacting the goal to ensure nationwide coverage of face-to-face universal prehabilitation across Scotland.

Recommendations from these findings for the second Cancer Action Plan include further awareness-raising activities amongst staff networks on online resources about prehabilitation to advance knowledge, skills and understanding of prehabilitation. In addition, facilitating opportunities to share learning from pilot projects around partnership and collaboration in delivery, and sharing guidance and/or developing communities of practice about co-designing activities for improved access, scaling of services, and measuring outcomes effectively. These enablers reflect recommendations in the 2023 report, including national guidance on outcome measurement, and minimum datasets for monitoring and evaluation. Follow-up conversations with prehabilitation staff are recommended for more conclusive insights on how to embed multi-modal prehabilitation in cancer pathways.

9. Appendices

Appendix A: Breakdown of respondents

Please note: Percentages in some tables may not total 100% due to rounding.

Table 17: Employing organisation

Organisation category	Number of respondents	% of respondents
Health & Social Care Partnership	32	11%
Local Authority	10	3%
NHS Board	213	71%
NHS Primary Care	27	9%
Third Sector	19	6%
Other	1	-
Total respondents	302	100%

Table 18: Place of work

Place of work category	Number of respondents	% of respondents
Acute care	206	68%
Community care	58	19%
Local Authority	12	4%
Third Sector	18	6%
More than one	4	1%
Other	3	1%
Not stated	1	-
Total respondents	302	100%

Table 19: Cancer Network (of place of work)

Cancer Network	Number of respondents	% of respondents
North Cancer Alliance	71	24%
South East Scotland Cancer Network	107	35%
West of Scotland Cancer Network	121	40%
Not stated	3	1%
Total respondents	302	100%

Table 20: NHS Board location (of place of work)

NHS Board	Number of respondents	% of respondents
NHS Ayrshire & Arran	32	11%
NHS Borders	8	3%
NHS Dumfries & Galloway	33	11%
NHS Fife	13	4%
NHS Forth Valley	11	4%
NHS Grampian	29	10%
NHS Greater Glasgow & Clyde	63	21%
NHS Highland	12	4%
NHS Lanarkshire	15	5%
NHS Lothian	53	18%
NHS Orkney	2	1%
NHS Shetland	2	1%
NHS Tayside	24	8%
NHS Western Isles	2	1%
Not stated	3	1%
Total respondents	302	100%

Table 21: Job title or Role

Job Title / Role category	Number of respondents	% of respondents
Allied Health Professional (Other)	4	1%
Dietitian	29	10%
Exercise Specialist	1	-
Macmillan/ICJ Staff	14	5%
NHS Technical Instructor/ Support Worker	5	2%
Nurse	63	21%
Occupational Therapist	12	4%
Pharmacist	6	2%
Physician - Primary Care	15	5%
Physician - Tertiary/Secondary Care	72	24%
Physiotherapist	32	11%
Project/ Improvement Manager	16	5%
Psychologist/ Counsellor	3	1%
Radiographer	6	2%
Senior Leader/ Service Manager	13	4%
Speech and Language Therapist	7	2%
Other	4	1%
Total respondents	302	100%

Appendix B: Survey questionnaire

About You

Q1. Please tell us about your:

Organisation:

Health & Social Care Partnership
Local Authority
NHS Board
NHS Primary care
Third Sector
Other (please describe)

Q2: Place of Work:

Acute Care
Community Care
Local Authority
Third Sector
Other (please describe)

Q3: Job Title/Role:

Dietitian
Exercise Specialist
Macmillan Improving the Cancer Journey
Nurse
Occupational Therapist
Physician – Primary Care
Physician – Secondary/ Tertiary care
Physiotherapist
Psychologist/ Counsellor
Radiographer
Senior Leader/ Service Manager
Speech and Language Therapist
Project/ Improvement Manager
Other (please describe)

Q4: As a Senior Leader/Service Manager, are you actively engaged in or leading local activities that will see cancer prehabilitation embedded in ways of working and/or pathways of care?

Yes / No

Q5: If yes, please provide details
(free text response options)

Q6: 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.

Q7. 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

Q8: Are any cancer prehabilitation activities being offered in your local area (intervention before definitive treatment)?

Yes / No / Don't Know

Q9: 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

Q10: 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
Don't Know
Other (please describe)

Q11: 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.

Q12: How are the following aspects of your prehabilitation activities monitored?
Patient uptake (e.g. of patients referred, who joins the programme).

Q13: Patient adherence (e.g. number of sessions attended by patients).

Q14: Patient experience (e.g. patient feedback on the programme).
Free text response for each.

Q15: Are outcome measures being used to determine the effectiveness of your prehabilitation activities?
Yes / No / Don't know / Not applicable

Q16: What outcome measures are being used?
Free text response.

Q17: 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)

Q18: Do you personally refer people to prehabilitation activities?
Yes / No / I provide prehabilitation services

Q19: How routinely would you refer people to prehabilitation activities?
Sliding Scale shown: 1 = never 5 = always

Q20: Is your service screening or triaging patients for perceived risk associated with: Nutrition?
Yes / No / Don't know

Q21: Please describe how your service is doing this.
Free text response.

Q22: Is your service screening or triaging patients for perceived risk associated with: Physical activity/exercise?

Yes / No / Don't know

Q23: Please describe how your service is doing this.
Free text response.

Q24: Is your service screening or triaging patients for perceived risk associated with: Psychological need?
Yes / No / Don't know

Q25: Please describe how your service is doing this.
Free text response.

Q26: How have prehabilitation activities offered in your local area changed in the last 18 months? (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.

Q27: 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.

Q28: Are there any plans to introduce or add to the prehabilitation activities in your local area?
Yes
No
Don't know

Q29: 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 multidisciplinary team (MDT) involvement).
Free text response.

Q30: 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

Learning resources

Q31: Do you utilise the national prehabilitation website - [Prehab and Me – Prehabilitation for Scotland](#) either for your own learning/access to resources or to support patients?

Yes / No

Q32: In what way do you make use of this website? I use it to...(select all that apply)

Signpost patients to information that will help them understand and engage in prehab

To help answer specific questions the patient has about elements of prehab/suitability for prehab

To help patients learn what additional support is available to them

To help a patient set their own prehab goals

To learn more about prehab and how I can support patients to prepare for what lies ahead

Find out what education and training is available to develop my knowledge and skills in prehabilitation

Access the Key Principles for Implementing Cancer Prehabilitation to guide my work/prehab service

Access the Frameworks (nutrition, physical activity and psychological support) that guide my work/prehab service

Other

Q33: Why do you not make use of the website? Please select all that apply.

We have a local website

I don't think it's useful/contains the right information

I wasn't aware of the website

I don't have enough time in a consultation to discuss the website

Other

Q34: The following are designed to help improve knowledge, skills and competencies in prehabilitation. Please indicate those you are aware of.

[Prehab, Rehab and Personalised Care Programme \(PROsPer\)](#)

[The Nursing, Midwifery and Health Professions \(NMaHP\) Perioperative Education and Development site](#)

[Enhanced Recover After Surgery \(ERAS\) in Scotland TURAS pages](#)

[Perioperative Medicine in Action](#)

[Nutrition Framework Education and Training Grid \(Appendix 3\)](#)

[Psychological Therapies and Support Framework Education and Training Grid \(Appendix 3\)](#)

[Actify](#)

[Homepage - Moving Medicine Scotland](#)

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.

Q35. Scottish Government published the Once for Scotland Approach to rehabilitation in June 2022, based on six principles of good rehabilitation.

How would you describe your awareness of the principles?

1 = Not at all aware, 5 = Very aware

Q36: Are any cancer rehabilitation activities being offered in your local area (i.e. interventions following treatment)?

Yes / No / Don't know

Q37: 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.

Q38: To what extent do the following statements, reflecting the 'Six Principles of Good Rehabilitation', underpin the delivery of cancer rehab activities in your local area?

Scaled for strongly disagree to strongly agree options + Don't Know

Easy to access for every individual

Provided at the right time

Realistic and meaningful to the individual

Integrated

Innovative and ambitious

Delivered by a flexible and skilled workforce

Additional Comments

Q39: If you have any additional views or comments on prehabilitation or rehabilitation please use the field below to share them.

Free text response

Q40: Would you be willing to take part in a follow-up online focus group (lasting no more than 60 minutes) to discuss prehabilitation in more detail? This would be carried out no later than Spring 2026.

Yes / No

Q41: To enable us to contact you for the focus group, please provide your contact details below. Please note that not everyone who volunteers will be invited to participate and your personal information will not be used for any other purpose. A Privacy Notice outlining how your information will be used can be found here:

<https://www.prehab.nhs.scot/cancer-prehabilitation-survey-2025-privacy-notice/>

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