

Prehabilitation for people with cancer

Clinical and implementation guidelines
October 2025

These guidelines are dedicated to the memory of Della Ogunleye, whose life and work left an indelible mark on those who knew her. Della's courage and grace with her cancer experience continues to inspire us. Della was a wonderful ambassador for prehabilitation for people with cancer. We hope this work will stand as a tribute to Della's enduring impact.



Contents

Foreword	4
Context	6
England	7
Northern Ireland	8
Scotland	8
Wales	8
Definitions	9
Methodology	11
Statements and Recommendations	13
Workforce	24
Action Plan	28
Acknowledgements	30



Foreword

Five years on from the publication of the first national guidance on prehabilitation for people with cancer, we are delighted to support the publication of the updated **'Prehabilitation for people with cancer: clinical and implementation guidelines.'**

These guidelines have been developed through a partnership between Macmillan Cancer Support, NHS England, the Centre for Perioperative Care (CPOC), World Cancer Research Fund (WCRF), the National Institute for Health Research (NIHR) Cancer and Nutrition Collaboration, and the NIHR Southampton Biomedical Research Centre.

Informed by experts from across the UK and around the world, it builds on a systematic review of the available literature about prehabilitation before and during cancer treatment, which has increased substantially since the original guidance was published.

People with cancer have told us how much they value prehabilitation, which encourages them to take control of their health and wellbeing, and to choose activities that they can do that will fit into their lives. **"I think when you get that cancer diagnosis you are left floundering and with prehabilitation the support you get gives you focus and a little bit of control back in your life."**

The aims of these guidelines are to see prehabilitation widely adopted to benefit patients' preparation for and recovery from cancer treatment, as well as to improve their experience of care and sense of control.

This document offers consensus statements and recommendations across six key areas which should be considered together to spread understanding of the importance of prehabilitation for people with cancer.

- Prehabilitation Implementation
- Health Economics and Business Cases
- Behaviour Change and Technology
- Nutrition
- Psychology
- Exercise

Specific statements and recommendations are included about health inequalities; screening, assessment, personalised interventions and support, group education, and workforce.

Importantly, there is now also an agreed definition of prehabilitation:

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

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

These guidelines include important information for provider organisations to help them develop prehabilitation for the population they serve, considering factors such as geographical location, patient characteristics, the requirement for supervision, patient complexity, digital readiness and socioeconomic deprivation.

Effective implementation will see prehabilitation integrated into existing cancer care pathways, encompassing community, primary and secondary care. The timing of this publication is particularly welcome, supporting NHS England's commitment to work through the Cancer Alliances to implement prehabilitation.

We look forward to seeing the guidelines being taken forward with patients, professionals, charities, healthcare providers, commissioners and policy makers, to deliver the benefits of prehabilitation for people with cancer and for the NHS as a whole.



Gemma Peters
Chief Executive
Macmillan Cancer
Support



Professor Peter Johnson
National Clinical
Director for
Cancer,
NHS England



Professor Ramani Moonesinghe
National Clinical
Director,
Perioperative and
Critical Care,
NHS England

Context

'In 2020, an estimated 18 million people worldwide were diagnosed with cancer and almost 10 million people died of cancer. Projections suggest that more than 30 million people may be diagnosed with cancer in 2040, a 67% increase in 20 years, with almost 16 million deaths, a 60% increase.'¹

Macmillan Cancer Support estimates that there are 3.5 million people living with cancer in the UK, an increase from around 3 million in 2020. This number will continue to grow². The UK figure is projected to rise by over 1 million per decade to 4 million people living with cancer in the UK by 2030 and 5.3 million by 2040³. This increase is partly due to the UK's growing and ageing population but also due to improvements in cancer diagnosis and treatment.

Macmillan has worked with hundreds of patients, healthcare professionals, system leaders, innovators and commercial healthcare providers to discuss the likely future healthcare experience of people with cancer⁴. The work produced a volume of useful evidence of trends in science, digital technologies and demographics and multiple different drivers for change were articulated. Amongst this data there were three key themes which seemed constant throughout:

- Innovation will never stop
- People with cancer will increasingly wish to be informed and involved about all aspects of their care
- The workforce will be ever stretched but necessarily resourceful

These three themes dovetail when considering prehabilitation in cancer care.

Prehabilitation offers people with cancer opportunities to develop autonomy over their future health. It embraces digital innovation and requires new approaches to workforce deployment. Prehabilitation services should be **co-designed** and **developed** with the patients' voice firmly at the centre.

All of the conversations highlighted inequity of experience as a blight on our services and emphasised that striving for more equitable experience for all communities should be a guiding principle for service development. Prehabilitation services are currently a stark example of those inequities with service provision ranging from the outstanding to the non-existent across the UK.

In workshops held by Macmillan with people affected by cancer, they shared much of the optimism of healthcare professionals about new therapies, but also said that they wanted **"a personalised experience not just a precision treatment"**. They also said that they wanted **"all the help and assistance to live life to the full after diagnosis."**

Embracing prehabilitation will help us meet these aims.



1. International Agency for Research on Cancer. Cancer Tomorrow: a tool that predicts the future cancer incidence and mortality burden worldwide from the current estimates in 2018 up until 2040. Lyon: International Agency for Research on Cancer, 2018

2. Analysis based on time-limited cancer prevalence published for each nation in the UK. The relationship to complete cancer prevalence is derived from 2013 complete prevalence (Macmillan-NCRAS Cancer Prevalence Project). This is projected forwards using the UK growth rates in Maddams et al. (2012). This includes all people who have ever had a cancer diagnosis, some people in this group may no longer consider themselves to be living with cancer. For more information see: Macmillan Cancer Support. Cancer prevalence. Note that the diameter and distance of the circles in the presented diagram are approximate representations of these data for complete cancer prevalence.

3. Analysis based on observed cancer prevalence published for each nation in the UK. The relationship to complete cancer prevalence is derived from 2013 complete prevalence (<http://www.ncin.org.uk/view?rid=3415>). This is projected forwards using the UK growth rates in <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3461160/>, resulting in an estimated 2.5 million in 2015, 3 million in 2020 and 3.5 million people in 2025 living with cancer in the UK. This includes all people who have ever had a cancer diagnosis, some people in this group may no longer consider themselves to be living with cancer. For a more detailed explanation of the methods, please visit Office for National Statistics.

4. Shaping the future of cancer care

England

Prehabilitation was specifically mentioned in the NHS England elective recovery plan in early 2025⁵.

Each of the 20 Cancer Alliances in England brings together the key organisations in their area to coordinate cancer care and to improve outcomes for patients with cancer locally. The NHS England cancer alliance planning support pack for 2025/2026 includes specific reference to prehabilitation.

The 10-Year Health Plan for England⁶ sets out the three strategic shifts:

1. Hospital to Community
2. Analogue to Digital
3. Sickness to Prevention

Table 1 sets out what these shifts mean for cancer and prehabilitation.

Table 1 - The 10 year health plan and what the three strategic shifts mean for cancer and prehabilitation.

	Hospital to Community	Analogue to Digital	Sickness to Prevention
What these shifts mean for cancer	Easier to access cancer screening. Diagnostic and treatment services in patients' local areas.	Ensure the NHS is able to harness the power of technological innovation to improve prevention, diagnosis and treatment for all patients.	Enable the NHS to identify those who are at greatest risk of developing cancer and make it easier for everyone to access screening services.
What these shifts mean for prehabilitation	A GP-led neighbourhood health service: With new GP contracts to create single and multi-neighbourhood providers beginning in 2026 and multi-professional neighbourhood teams organised around groups with most need. Care closer to the community and on the high street: Neighbourhood health centres in every community. Pharmacy offering clinical services and prevention. Focus on prevention through genomic technologies, diagnostics and predictive analytics. Support people to be active participants in their own care by ensuring people with complex needs have an agreed care plan by 2027. Redesigning outpatient and diagnostic services: Advice and guidance in more specialities to reduce the need for patients to travel to appointments. Expanding the use of AI-enabled digital diagnostic tools across specialities.	Embedding technology into prehabilitation pathways: NHS App: Front door to the NHS. The tool to organise patients' care around needs, choices and schedules. 24/7 AI-enabled advice. Health store to enable patients to access approved health apps to manage or treat their conditions, enabling Small to Medium sized Enterprises (SMEs) to work more collaboratively with the NHS and regulators. Artificial Intelligence: New regulatory frameworks for software and AI as medical devices by 2026. Significant investments in AI infrastructure. Wearables: By 2035, wearables will be standard in preventative, chronic and post-acute treatment with data connected to the NHS App and integrated with the single patient record.	Return to work: Impact on economy. Complications and return to baseline fitness. Exercise and activity: National campaign to get people to move more.

Cancer waiting times in England

Whilst prehabilitation should be an essential part of the treatment pathway for people diagnosed with cancer, it is not considered a 'definitive treatment' as regards cancer waiting times. Although the time available for implementing prehabilitation will vary from patient to patient and could impact on time to treatment, it should not be considered an intervention to 'stop the clock' or, in and of itself, be classed as 'active monitoring'⁷. Timing of prehabilitation and definitive treatment are a matter for clinical judgement, weighing the likely benefits and harms of each approach.

Northern Ireland

The Cancer Strategy for Northern Ireland (NI)⁸ includes action 17 which states the need "to develop and implement prehabilitation and rehabilitation services on a regional basis for all those who would benefit from it."

The Minister of Health for NI committed investment to the voluntary sector to support the intention of the Cancer Strategy actions. Macmillan Cancer Support received funding to enable the identification of an equitable prehabilitation model for Northern Ireland. An evaluation report of this model was published in 2025⁹.

Scotland

In Scotland, the 10-year vision¹⁰ states that every person diagnosed with cancer is provided with timely, effective and individualised care to best prepare them for treatment. This begins with prehabilitation and holistic needs assessment and continues throughout the individual's pathway of care, including appropriate follow up.

The Scottish Government cancer action plan 2023-2026¹¹ informed by the Scottish Cancer Strategy¹² includes prehabilitation under preparation for treatment with tangible plans for delivery.

Key principles for implementing prehabilitation in cancer were published in 2022¹³ along with a psychological therapies and support framework¹⁴ and a nutrition framework¹⁵ have been published.

Realistic Medicine¹⁶ is at the centre of the Scottish Government's Chief Medical Officer's annual report¹⁷. It is framed as the importance of having an honest and open dialogue with people about their needs and to support them in a way that is helpful to them and their families. Value Based Healthcare (VBH)¹⁸ has been adopted in Scotland. Prehabilitation is an obvious and intentional example of delivering value-based healthcare.

Wales

The importance of access to prehabilitation for cancer patients in Wales is intrinsic within a number of national strategic documents and clinical pathway guidance. The National Optimal Pathways (NOPs, Wales Cancer Network)¹⁹ have prehabilitation embedded as a central aspect of person-centred care and describe the pathway from a suspected diagnosis onwards. The Welsh Government's programme to transform and modernise planned care and reduce waiting lists²⁰ explicitly endorses access to prehabilitation to overcome risks while people await their surgery, and through which reduce demands on primary and secondary care. The Cancer Improvement Plan²¹ highlights the importance of cancer prehabilitation and its integration as standard into all cancer pathways.

5. Microsoft Word - PRN01789 Reforming elective care for patients published 6 January 2025

6. assets.publishing.service.gov.uk/media/6866387fe6557c544c74db7a/fit-for-the-future-10-year-health-plan-for-england.pdf

7. National Cancer Waiting Times Monitoring Dataset

8. NI Cancer Strategy 22-32

9. <https://www.macmillan.org.uk/dfsmedia/1a6f23537f7f4519bb0cf14c45b2a629/22217-10061/macmillan-ni-prehab-evaluation-report>

10. Cancer strategy 2023 to 2033 - gov.scot (www.gov.scot)

11. Cancer action plan 2023 to 2026 - gov.scot (www.gov.scot)

12. Cancer strategy 2023 to 2033 - gov.scot (www.gov.scot)

13. Key Principles – Prehabilitation for Scotland (nhs.scot)

14. Psychological Framework – Prehabilitation for Scotland (nhs.scot)

15. Nutrition Framework – Prehabilitation for Scotland (nhs.scot)

16. About – Realistic Medicine

17. Chief Medical Officer's annual report 2024-2025: Realistic Medicine - Critical Connections - gov.scot

18. Delivering Value Based Health & Care: A Vision For Scotland (www.gov.scot)

19. Suspected Cancer Pathway - NHS Wales Executive

20. Transforming and modernising planned care and reducing NHS waiting lists | GOV.WALES

21. performanceandimprovement.nhs.wales/functions/networks-and-planning/cancer/cancer-improvement-plan-docs/full-plan/

Definitions

Definition of prehabilitation

The following definition of prehabilitation was agreed by the steering group after working group and stakeholder consultation.

"Prehabilitation is a needs-based multimodal intervention, before and during cancer treatment. The aim of prehabilitation is to optimise physical, nutritional and psychological status, enhance readiness for and tolerance of treatments, and improve recovery and/or quality of life. Prehabilitation involves screening before needs-based assessment, enabling individualised prescription of exercise, nutrition and psychological interventions supported by behaviour change techniques".

Universal, targeted and specialist prehabilitation were defined as:

'Universal prehabilitation' is the provision of expert advice on exercise, nutrition and psychological support, along with behaviour change advice, to all individuals before cancer treatment. 'Universal prehabilitation' (e.g. surgery school) is the foundation of prehabilitation and may involve screening. Generic lifestyle advice alone does not constitute universal prehabilitation.

'Targeted prehabilitation' is assessed and prescribed by a registered healthcare professional with relevant competencies and may be delivered by un-registered or non-healthcare professionals.

'Specialist prehabilitation' is assessed, prescribed and delivered by registered healthcare professionals.

- Universal, targeted and specialist prehabilitation interventions will be needs-based for each domain (exercise, nutrition, psychology) and will incur different levels of cost (tariff).
- The term multimodal encompasses unimodal interventions and combinations of interventions.

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



Figures 1, 2 and 3 show the levels of prehabilitation, patient benefits of prehabilitation and rehabilitation, and key elements of prehabilitation.

Figure 1 – Levels of prehabilitation

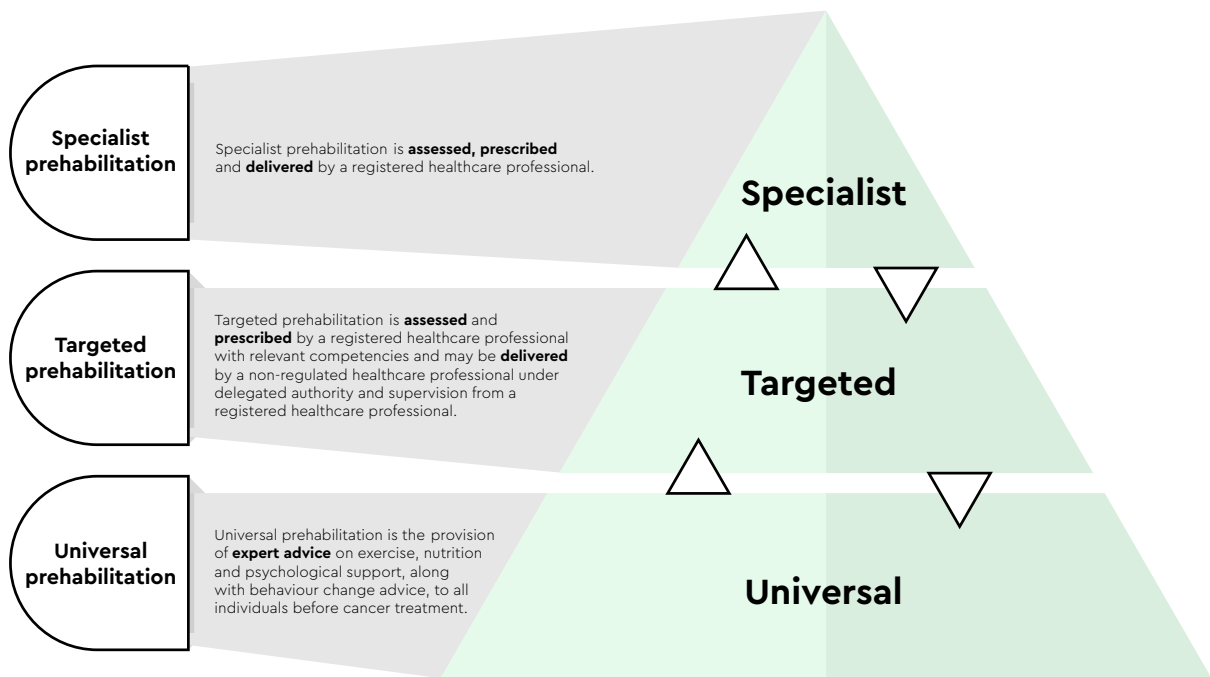


Figure 2 – Patient benefits of prehabilitation and rehabilitation

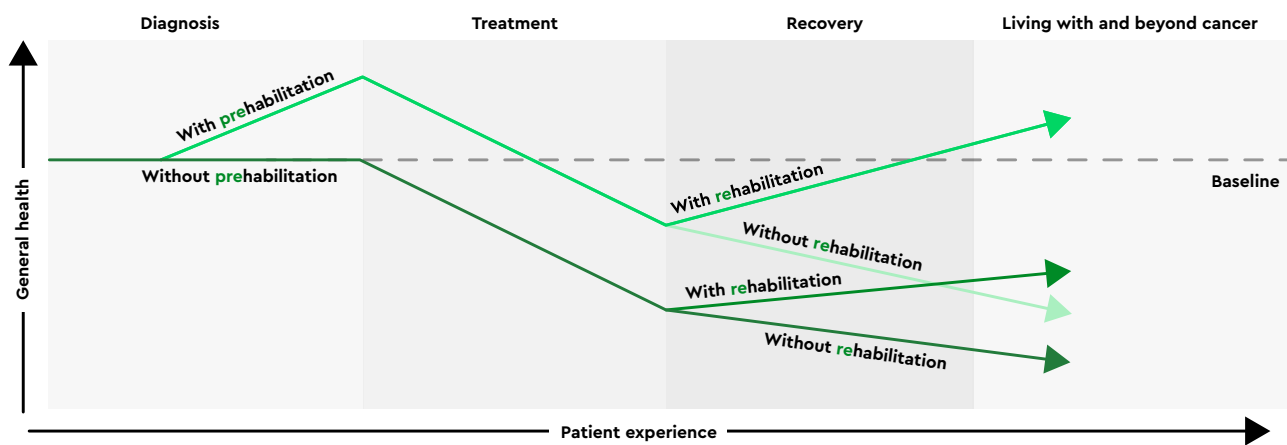
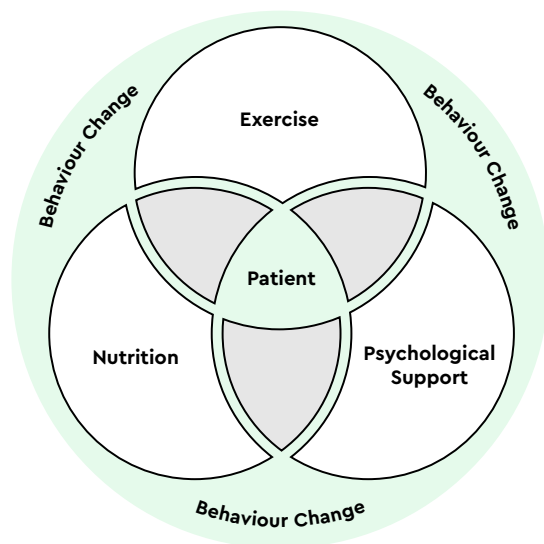


Figure 3 – Key elements of prehabilitation



Methodology

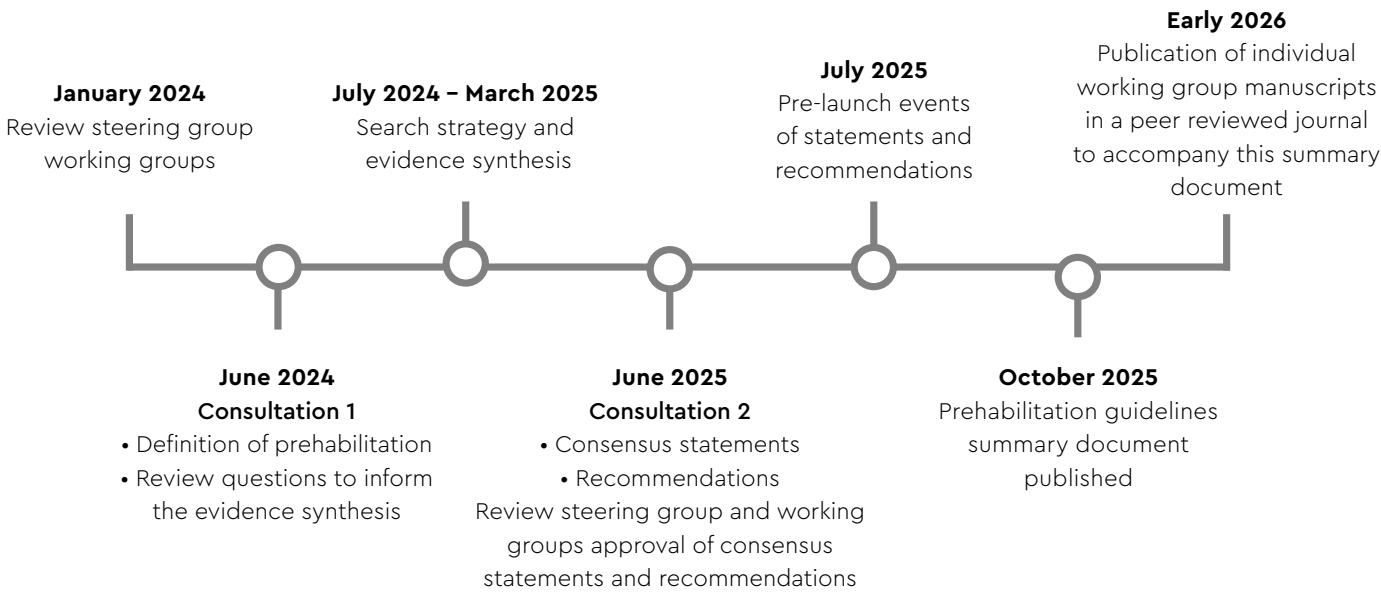
These guidelines were developed through a formal consensus process informed by comprehensive evidence synthesis. The project scope and ambition was to develop clinical and implementation guidelines about prehabilitation for people with cancer, building on the 2019 "Principles and guidance for prehabilitation for people with cancer" guidance document. The aims were to develop definitions, consensus statements, and recommendations, as well as identify questions for further research across six working groups:

- 1. Prehabilitation Implementation
- 2. Health Economics and Business Case
- 3. Behaviour Change and Technology
- 4. Nutrition
- 5. Psychology
- 6. Exercise

Each working group was led by two/three experts and comprised 10-15 diverse members from multidisciplinary backgrounds (e.g. oncologist, dietitian, anaesthetist, exercise physiologist, psychologist, surgeon). All working groups had patient representation, international representation and input from across the four nations of the UK. The Implementation and Health Economics/Business Cases working groups also had representatives from NHS England.

The steering group comprised the guideline co-chairs with working group chairs and two patient representatives. The steering group initially formulated the questions and definitions, and these were sent to stakeholders for initial consultation (93 responses). The definitions and questions were refined-based on this feedback and then each working group used the outputs from the evidence synthesis to inform the development of consensus statements and recommendations, which were iteratively refined and integrated by the steering group and working groups before the second consultation (107 responses). Following consultation, statements and recommendations were refined, agreed and categorised into eleven key topics. We used a modified version of the GRADE approach to describe evidence quality for all statement and recommendations, and strength of recommendations where relevant. In addition, research questions were identified by working groups. Final statements and recommendations were approved by all members of the steering group.

Timeline



Modified GRADE (Grading of Recommendations, Assessment, Development and Evaluations) system

Evidence Quality (Statements and Recommendations)

- **High quality:** further research is unlikely to change the recommendation
- **Moderate quality:** further research is likely to have an important impact on the recommendation
- **Low quality:** further research is very likely to have an important impact on the recommendation
- **Very low quality:** based on available research, any recommendation is very uncertain
- **Good Practice Point (GPP):** recommended best practice based on the accumulated and combined clinical experience of the guideline development group (there is no relevant evidence and/or there is low likelihood of evidence being produced)

Strength of Recommendation (Recommendations only)

Strong recommendations:

- **For patients** — the majority of individuals in your situation would want the recommended course of action and only a small proportion would not request discussion if the intervention were not offered.
- **For clinicians** — most patients should receive the recommended course of action.
- **For policymakers** — the recommendation can be adopted as a policy in most situations.

Weak recommendations:

- **For patients** — the majority of individuals in your situation would want the recommended course of action, but many would not.
- **For clinicians** — you should recognise that different choices will be appropriate for different patients and that you must help each patient to arrive at a management decision consistent with his or her values and preferences.
- **For policymakers** — policy making will require substantial debate and involvement of many stakeholders.



Statements and Recommendations

These guidelines offer consensus statements and recommendations across eleven key topics:

- Health Inequalities
- Prehabilitation Implementation
- Health Economics
- Lifestyle/Behaviour Change
- Screening, Assessment, Personalised Support
- Group Education
- Digital/Technology
- Workforce
- Nutrition
- Psychology
- Exercise

The statements and recommendations for each topic are set out below.

Health Inequalities

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

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

Prehabilitation Implementation

Recommendations	Quality of evidence	Strength of recommendation
1. We recommend that prehabilitation, as a complex intervention, should be designed, implemented and evaluated using established theoretical models and conceptual frameworks incorporating behaviour change techniques.	GPP	Strong
2. We recommend that an implementation science approach is used in the development and evaluation of prehabilitation services (evaluation should include acceptability, adherence, adoption, penetration, health outcomes and financial sustainability).	High	Strong
3. We recommend that prehabilitation is integrated into existing cancer care pathways and aligns with existing services providing integrated care to avoid duplication.	GPP	Strong
4. We recommend that prehabilitation service design is based on the characteristics of the population served e.g. geographical location, patient characteristics, requirement for social support, clinically complex patients, digital readiness and socioeconomic status.	Low	Strong
5. When integrating technology into cancer prehabilitation, clinicians and service designers must actively consider digital literacy, accessibility, language, socioeconomic status and cultural appropriateness to promote equity of access and reduce health disparities.	Low	Strong
6. We recommend that a standardised reporting structure integrated with existing clinical governance structures is used for adverse events during prehabilitation.	GPP	Strong
7. We recommend that prehabilitation services address both the facilitators and barriers to implementation during service design. (Figure 4 and Figure 5)	Moderate	Strong
8. We recommend that outcomes from prehabilitation services should be standardised and collected nationally to understand the impact on patient-based and cancer outcomes (short and long-term).	GPP	Strong
9. We recommend that effective delivery of behaviour change interventions can be delivered during face-to-face sessions, telephone calls, digital platforms, or a combination of these modes, considering patient preferences, limitations and digital literacy.	Moderate	Strong
10. We recommend multimodal interventions with behaviour change techniques that combine nutrition, exercise and psychological support to enhance functional outcomes.	Moderate (exercise and nutrition) Low (behaviour change and psychology)	Strong

Health Economics

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

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

Lifestyle/Behaviour Change

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

Screening, Assessment and Personalised Support

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

Group Education

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

Digital/Technology

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

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

Workforce

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

Nutrition

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

Recommendations	Quality of evidence	Strength of recommendation
1. We recommend that all patients have access to nutrition education resources, such as web-based tools, surgery schools, group classes or booklets, that provide evidence-based nutrition information relevant to all patients with cancer.	Moderate	Strong
2. We recommend that all patients be screened for nutrition-related issues using a validated tool at the earliest opportunity and before initiating cancer treatment.	Moderate	Strong
3. We recommend that patients identified as at elevated risk through nutrition screening receive a comprehensive assessment by a registered dietitian/nutritionist* to diagnose any nutrition-related conditions and determine their severity.	Moderate	Strong
4. We recommend needs-based and individualised treatment plans as per the prehabilitation triangle.	GPP	Strong
5. We recommend that nutrition assessments result in a documented diagnosis, and that interventions directly address the underlying aetiology.	GPP	Strong
6. We recommend nutrition counselling be provided by a registered dietitian/nutritionist*.	Moderate	Strong
7. We recommend counselling is personalised to the individual's needs and conditions, centered on shared goals, incorporate behaviour change strategies and include nutrition support interventions when appropriate.	Moderate	Strong
8. We recommend that nutrition treatment plans prioritise the oral route to meet the nutrition prescription and requirements using strategies such as individualised counselling and oral nutritional supplements.	High	Strong
9. We recommend that patients unable to meet 50-60% of their energy and protein requirements through oral intake be assessed for enteral or parenteral nutrition.	Low	Strong
10. We do not recommend the routine use of intentional weight loss interventions for patients preparing for or undergoing acute cancer treatment.	GPP	Weak
11. We recommend that patients with malnutrition or those following restrictive diets be assessed for micronutrient deficiencies and receive targeted supplementation.	High	Strong
12. We recommend that the frequency of monitoring and evaluation plans be based on the comprehensive assessment, identified nutrition diagnosis and patient-specific factors.	Moderate	Strong

*To reflect the use of registered nutritionists in countries where registered dietitians do not exist. In the UK and countries with registered dietitians, they should deliver these recommendations.

Psychology

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

Recommendations	Quality of evidence	Strength of recommendation
1. We recommend all staff working with people affected by cancer are able to communicate compassionately, recognise and respond to psychological distress and facilitate access to universal psychological support resources. <u>Psychosocial Support - Transformation Partners in Health and Care</u>	GPP	Strong
2. We recommend healthcare professionals conducting screening for psychological difficulties are appropriately trained and have colleagues to whom they can escalate concerns.	GPP	Strong
3. We recommend screening to identify psychological need using validated/standardised measures alongside an understanding of the patient's context (See Table 2), as these measures alone are inadequate.	High	Strong
4. We recommend that prehabilitation services include the systematic early detection of pre-existing mental health difficulties and risk factors which may interact with cancer treatments.	Moderate	Strong
5. We recommend patients identified as requiring psychological support, now or in the future, are assessed by a healthcare professional with sufficient expertise and training. This assessment can include further psychometric assessments in addition to clinical interview.	GPP	Strong
6. We recommend healthcare professionals assessing patients' needs have access to specialist psycho-oncology services for advice and consultation as there is no agreed algorithm for onward management.	GPP	Strong
7. We recommend embedded specialist psycho-oncology services are provided: • For patients with clinically significant difficulties. • Where psychological factors have a significant impact on access to and tolerance of cancer treatment. • For the oversight of targeted interventions and the escalation of concerns. • For appropriate workforce training and supervision. • For the integration of a stratified approach.	GPP	Strong
8. We recommend providing evidenced-based psychological interventions for patients presenting with clinically significant psychological difficulties during the prehabilitation period.	High	Strong
9. We recommend psychological interventions are theory-informed, target causes of psychological morbidity and support patients to manage psychological difficulties	GPP	Strong

Table 2 - Understanding the patients context

Factors	Examples
Previous and current mental health difficulties	Previous diagnoses or contact with mental health professionals e.g. for depression, Post Traumatic Stress Disorder (PTSD), severe mental illness, eating disorders.
Social support	Loneliness Impact on family and friends
Personal psychological vulnerabilities	Self-efficacy Illness perceptions Coping response to previous adversity
Engagement with healthcare	Prior aversive experiences in healthcare settings Low engagement with exercise/diet changes
Cognitive abilities	Dementia, learning disabilities, neurodevelopmental conditions where relevant to cancer treatment
Financial concerns	Impact on employment In receipt of benefits
Wider social context including diversity and inequalities	See statements on health inequalities

Exercise

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

Recommendations	Quality of evidence	Strength of recommendation
1. We recommend that all patients with cancer should be screened and risk stratified for physical function and exercise capacity using validated assessment tools at the earliest opportunity and before initiating cancer treatment.	GPP	Strong
2. We recommend that all exercises be individualised to achieve the most effective outcomes for patients.	Moderate	Strong
3. We recommend that patients identified as having reduced physical function through screening undergo a comprehensive assessment using validated tools by a trained health professional to guide individualised exercise prescription.	Low	Strong
4. We recommend that a combination of aerobic and strength exercise be prescribed to patients undergoing surgery to increase physical function and exercise capacity and improve perioperative outcomes.	Moderate	Strong
5. We recommend that the aerobic exercise component be performed at moderate to high intensity where appropriate (including high intensity interval training).	Moderate	Strong
6. We recommend that exercise be combined with nutrition interventions in patients undergoing surgery to improve perioperative outcomes.	Moderate	Strong
7. We recommend inspiratory muscle training, in combination with aerobic and strength exercises for patients having lung cancer surgery to improve perioperative outcomes.	Moderate	Strong
8. We recommend that all patients receive structured education on the benefits of respiratory exercises prior to surgery to improve perioperative outcomes.	Moderate	Strong
9. We recommend that patients undergoing adjuvant or neoadjuvant treatment for cancer receive a combination of aerobic and strength exercise delivered early in the treatment pathway to improve patient-centred and clinical outcomes.	High (adjuvant) Moderate (neoadjuvant)	Strong
10. We recommend that exercise programmes are supervised either face to face, or digitally to promote engagement, adherence and safety.	Moderate	Strong
11. We recommend that exercise programmes include structured patient education on the benefits of exercise throughout the cancer care continuum.	Low	Moderate

Figure 4 - Barriers and facilitators to prehabilitation for patients

Barriers	Facilitators
Accessibility of information 	Provision of prehabilitation information which is accessible to all groups in the population, in line with NHS standards. ²²
Lack of knowledge on benefits of prehabilitation 	Provision of individualised information on the benefits of prehabilitation ensuring information is patient centric and avoids overwhelming patients.
Physical incapability to carry out standard prehabilitation intervention 	Tailoring prehabilitation to the patient's abilities and needs can help to overcome the physical barriers to participation in prehabilitation.
Lack of time to undertake prehabilitation interventions 	Provision to tailor-made prehabilitation intervention which can be home/community based and supported virtually.
Lack of social support 	Provision of group peer and social support. Role of community-based prehabilitation enables involvement of caregivers and social support.
Heightened emotional distress and/or low self-efficacy 	Assessment of person's concerns and context, developing a shared understanding and plan to support the management of distress & enhance self-efficacy.

22. <https://www.england.nhs.uk/publication/accessible-information-standard/>

Figure 5 - Barriers and facilitators to prehabilitation for health care professionals

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

Workforce

Prehabilitation involves many different roles across multidisciplinary teams to design, deliver and support people with cancer, with different levels of needs and complexity.

The prehabilitation workforce matrix, as set out below, provides a guide to the different roles that can deliver universal, targeted and specialist support across exercise, nutrition and psychology and includes reference to the Aspirant Cancer Career and Education Development (ACCEND)²³ programme levels of practice that these roles (where applicable) should operate at, in order to support people with cancer.

23. ACCEND Framework | NHS England | Workforce, training and education

Exercise

Professional roles that can support prehabilitation interventions at different levels of practice (where applicable)					
Universal	Level of practice	Targeted	Level of practice	Specialist	Level of practice
Allied Health Support Worker e.g. Therapy Assistant, Rehabilitation Assistant (1)	Supportive, assistive				
Anaesthetist	Medical, resident - consultant roles				
Cancer Care Coordinator	Supportive				
Cancer Support Worker	Supportive				
Clinical Exercise Physiologist	Registered, enhanced, advanced	Clinical Exercise Physiologist	Registered, enhanced, advanced	Clinical Exercise Physiologist	Enhanced, advanced
Cancer Nurse	Registered, enhanced, advanced, consultant				
Dietitian	Registered, enhanced, advanced, consultant				
Exercise Instructor	Assistive				
Specialist Exercise Instructor (2)	Assistive, enhanced	Specialist Exercise Instructor	Enhanced		
GP	Medical, resident - consultant roles				
Health and Wellbeing Coach	Supportive				
Occupational Therapist	Registered, enhanced, advanced, consultant	Occupational Therapist (3)	Registered, enhanced, advanced		
Oncologist	Medical, resident - consultant roles				
Paramedic	Registered, enhanced, advanced, consultant				
Pathway Navigator	Supportive				
Pharmacist	Registered, enhanced, advanced, consultant				
Physician	Medical, resident - consultant roles				
Physiotherapist	Registered, enhanced, advanced, consultant	Physiotherapist	Registered, enhanced, advanced, consultant	Physiotherapist	Enhanced, advanced, consultant
Public Health Registrar/Consultant	Supportive				
Social Prescriber	Supportive				
Speech and Language Therapist	Registered, enhanced, advanced, consultant				
Surgeon	Medical, resident - consultant roles				
Therapeutic Radiographer	Registered, enhanced, advanced, consultant				

Nutrition

Professional roles that can support prehabilitation interventions at different levels of practice (where applicable)					
Universal	Level of practice	Targeted	Level of practice	Specialist	Level of practice
Allied Health Support Worker e.g. Therapy Assistant, Rehabilitation Assistant (1)	Supportive, assistive				
Anaesthetist	Medical, resident - consultant roles				
Cancer Care Coordinator	Supportive				
Cancer Nurse	Registered, enhanced, advanced, consultant	Clinical Nurse Specialist (potentially monitor/review but not initial prescription)	Advanced, consultant		
Cancer Support Worker	Supportive				
Dietitian	Registered, enhanced, advanced, consultant	Dietitian	Registered, enhanced, advanced, consultant	Dietitian	Registered, enhanced, advanced, consultant
GP	Medical, resident - consultant roles				
Health and Wellbeing Coach	Supportive				
Occupational Therapist	Registered, enhanced, advanced, consultant	Occupational Therapist (would contribute to assessment and interventions in collaboration with Dietitians)	Enhanced, advanced, consultant		
Oncologist	Medical, resident - consultant roles				
Paramedic	Registered, enhanced, advanced, consultant				
Pathway Navigator	Assistive				
Pharmacist	Registered, enhanced, advanced, consultant	Pharmacist (potentially monitor/review but not initial prescription)	Registered		
Physician	Medical, resident - consultant roles				
Physiotherapist	Registered, enhanced, advanced, consultant				
Public Health Registrar/Consultant	Supportive				
Social Prescriber	Supportive				
Specialist Exercise Instructor (2)	Supportive, assistive				
Speech and Language Therapist	Registered, enhanced, advanced, consultant	Speech and Language Therapist (would contribute to assessment and interventions in collaboration with Dietitians)	Enhanced		
Surgeon	Medical, resident - consultant roles				
Therapeutic Radiographer	Registered, enhanced, advanced, consultant				

Psychological Support

Professional roles that can support prehabilitation interventions at different levels of practice (where applicable)					
Universal	Level of practice	Targeted	Level of practice	Specialist	Level of practice
Allied Health Support Worker e.g. Therapy Assistant, Rehabilitation Assistant (1)	Supportive, assistive				
Anaesthetist	Medical, resident - consultant roles				
Assistant Psychologist	Supportive, assistive	Assistant Psychologist	Assistive		
Cancer Care Coordinator	Supportive				
Cancer Nurse	Registered, enhanced, advanced, consultant	Clinical Nurse Specialist	Enhanced, advanced, consultant		
Cancer Support Worker	Supportive				
Clinical Psychologist	Registered, enhanced, advanced, consultant	Clinical Psychologist	Enhanced, advanced	Clinical Psychologist	Advanced, consultant
Cognitive Behavioural Therapist	Registered, enhanced	Cognitive Behavioural Therapist	Registered, enhanced	Cognitive Behavioural Therapist	Registered, enhanced
Counselling Psychologist	Registered, enhanced, advanced, consultant	Counselling Psychologist	Enhanced, advanced	Counselling Psychologist	Advanced, consultant
Counsellor	Registered, enhanced	Counsellor	Registered, enhanced	Counsellor	Registered, enhanced
Clinical Nurse Specialist	Registered, enhanced, advanced, consultant	Clinical Nurse Specialist	Enhanced, advanced		
Dietitian	Registered, enhanced, advanced, consultant	Dietitian	Enhanced, advanced, consultant		
GP	Medical, resident - consultant roles				
Health Psychologist	Registered, enhanced, advanced, consultant	Health Psychologist	Enhanced, advanced		
Health and Wellbeing Coach	Supportive				
Nurse - other e.g. working in Primary Care, Acute Oncology)	Registered, enhanced, advanced, consultant				
Occupational Therapist	Registered, enhanced, advanced, consultant	Occupational Therapist	Enhanced, advanced, consultant		
Oncologist	Medical, resident - consultant roles				
Paramedic	Registered, enhanced, advanced, consultant				
Pathway Navigator	Supportive				
Pharmacist	Registered, enhanced, advanced, consultant	Pharmacist	Enhanced, advanced, consultant		
Physician	Medical, resident - consultant roles				
Physiotherapist	Registered, enhanced, advanced, consultant	Physiotherapist	Enhanced, advanced, consultant		
Psychiatrist	Registered, enhanced, advanced, consultant	Psychiatrist	Enhanced, advanced	Psychiatrist	Advanced, consultant
Psychotherapist	Registered, enhanced	Psychotherapist	Registered, enhanced	Psychotherapist	Registered, enhanced
Psychological Wellbeing Practitioner (PWP)	Supportive, assistive	Psychological Wellbeing Practitioner (PWP)	Enhanced		
Public Health Registrar/Consultant	Supportive				
Social Prescriber	Supportive				

Specialist Exercise Instructor (2)	Supportive, assistive				
Speech and Language Therapist	Registered, enhanced, advanced, consultant	Speech and Language Therapist	Enhanced, advanced, consultant		
Surgeon	Medical, resident - consultant roles				
Therapeutic Radiographer	Registered, enhanced, advanced, consultant	Therapeutic Radiographer	Enhanced, advanced, consultant		

Key to psychological support:

Roles identified in existing guidance as level 2 (targeted)

Level 4 roles sufficient for psycho-oncology

Notes

Caveats for roles providing psychological support:

- The extent to which professional roles are able to provide targeted interventions is contingent on undertaking training and supervision of psychological skills equivalent to level 2 psychological skills (NICE²⁴) in a UK context.
- Training and supervision of psychological interventions should be with the oversight of level 4 roles.²⁵
- There may be instances in which roles contribute to components of interventions that are in a successive level, with appropriate oversight.
- Specialist psychological interventions can be provided by level 3 & 4 roles, but level 3 roles alone are insufficient for the provision of specialist interventions/psycho-oncology services (as per NICE²⁴ & Macmillan/Transforming Cancer Services Team (TCST) frameworks.²⁶
- Level 4 psychologists work to competencies in cancer.²⁷
- The above list is not exhaustive; there will be rarer roles (e.g. psycho-oncology nurses, family therapists) & newer roles (e.g. clinical associate psychologists) that are not represented.

1) Allied Health Support Worker e.g. therapy assistant, rehabilitation assistant could have the opportunity to have a higher level of practice as long as they have relevant competencies/capabilities and have necessary clinical supervision from AHPs and medical/nursing staff.

2) Specialist Exercise Instructors could have a higher level of practice where they are either a graduate from a relevant degree course (such as a BSc (Hons) Sport and Exercise Science) and/or have relevant continued professional development qualifications/competencies e.g. Level 4 exercise qualifications. This allows them to prescribe and supervise/deliver exercise to people with cancer.

3) Occupational Therapists would be required to have further qualifications/competencies to enable evidence-based delivery of exercise prehabilitation at these levels. Level 4 exercise qualification - cancer rehabilitation or an equivalent qualification would be required.

4) Level 4 (doctoral) roles are necessary for specialist services with expertise in complex mental health, MDT leadership, research and educational skills with clinical governance oversight across stratified assessments, interventions & pathway development.

24. <https://www.nice.org.uk/guidance/csg4/resources/improving-supportive-and-palliative-care-for-adults-with-cancer-pdf-773375005>

25. Level 2 Psychological Skills Training and Supervision: Competencies and guidance for facilitators.

<https://acpuk.org.uk/member-networks/level-2-psychological-skills-training-and-supervision/>

26. <https://www.transformationpartners.nhs.uk/wp-content/uploads/2020/02/Business-case-for-Integrated-Cancer-Psychosocial-Support-Final-.pdf>

27. <https://www.bps.org.uk/guideline/competency-framework-practitioner-psychologists-working-adult-cancer-care>

Action plan

The following is an action plan for service providers, funders and researchers that has been identified as a result of the development of these guidelines.

Action	Description	Responsibility/ownership of actions
1. Follow and implement the recommendations in these guidelines when designing, developing and delivering prehabilitation services for people with cancer.	Healthcare service providers should test, evaluate and review services locally to increase the local evidence base. Progress the opportunities for services to learn from each other and share successful business cases for prehabilitation services.	Healthcare service providers Cancer alliances (England) Cancer networks (devolved nations) Cancer charities Organisations with responsibility for commissioning healthcare services
2. Continue to build the Health Foundation Q Community Prehabilitation Community of Practice. (In progress)	Continue to grow and develop the online Q community Prehabilitation Community of Practice ²⁸ through activities including regular webinars, blogs, journal article reviews and sharing experiences and link local and regional communities of practice to this national endeavour.	Centre for Perioperative Care Macmillan Cancer Support Cancer Alliances Representatives from Northern Ireland, Scotland and Wales
3. Develop an integrated prehabilitation screening tool.	Develop a standardised validated prehabilitation screening tool that encompasses screening metrics for exercise, nutrition, psychological support and behaviour change.	Collaboration between: Researchers Academic Institutions, Royal Colleges and professional bodies, cancer charities, cancer alliances and cancer networks
4. Enhance the capacity, capability and confidence of the workforce.	Develop a multiprofessional prehabilitation curriculum framework to include core capabilities in practice (CiPs) for all levels of practice in line with the Aspirant Cancer Career and Education Framework (ACCEND) ²⁹ along with an education framework. The CiPs will include leading, developing, designing, screening, assessment and the provision of interventions to people with cancer. These CiPs for each level of practice may be incorporated into credit bearing and non-credit bearing continuing professional development (CPD) opportunities and guide workplace-based learning. Practitioners may develop their knowledge, skills, confidence and evidence their capability through a range of opportunities including: • Workplace-based learning and reflection • CPD events • eLearning/online learning resources • University accredited modules and programmes	Collaboration between: NHS England ACCEND programme Macmillan Cancer Support Higher Education Institutions Cancer Alliances Cancer Networks Royal colleges and professional bodies

Action plan

Action	Description	Responsibility/ownership of actions
5. Develop a quality improvement and quality assurance framework.	Develop a quality improvement and quality assurance framework and advocate for the inclusion of prehabilitation in national cancer registries.	National Cancer Registration and Analysis Service (NCRAS) Healthcare Quality Improvement Partnership (HQIP) Researchers Academic Institutions Healthcare service providers
6. Standardise outcome measures. (In progress)	Pursue the development of a set of standardised outcome measures for prehabilitation.	National Prehabilitation Collaborative
7. Drive the prehabilitation research agenda. (In progress)	Using the research questions identified through the development of these guidelines, pursue a relevant and contemporary prehabilitation research agenda in partnership with relevant stakeholders.	National Institute for Health Research Cancer Research UK NIHR Biomedical Research Centres Academic Institutions
8. Develop exemplar business cases to support the health economic case for prehabilitation.	Healthcare service providers should be encouraged to develop and share exemplar prehabilitation business cases across the UK and internationally.	Healthcare service providers Cancer Alliances Cancer Networks Organisations with responsibility for commissioning healthcare services

Acknowledgements

Participant	Role in Prehabilitation guideline development	Job Role(s)	Organisation(s)
June Davis	Co-chair	Lead Allied Health Professional and Nursing Advisor	Macmillan Cancer Support
		Director	Allied Health Solutions
Mike Grocott	Co-chair	Professor of Anaesthesia and Critical Care	University of Southampton
		Director	National Institute for Health and Care Research's (NIHR) Southampton Biomedical Research Centre
Denny Levett	Co-chair Prehabilitation Implementation group	Professor of Perioperative Medicine and Critical Care	University Hospital Southampton NHS Foundation Trust
John Moore	Co-chair Prehabilitation Implementation group	Consultant in Anaesthesia and Critical Care Deputy Medical Director Clinical and Scientific Services	Manchester University Hospitals NHS Foundation Trust
		Hon Senior Lecturer	Manchester Metropolitan University and University of Manchester
Zoe Merchant	Co-chair Health Economics and Business Cases group	AHP Clinical Lead – Greater Manchester Prehab4Cancer and Recovery Programme	GM Cancer Alliance
		GM Targeted Lung Health Check Programme Manager	Manchester University NHS Foundation Trust
Guy Ludbrook	Co-chair Health Economics and Business Cases group	Professor of Anaesthesia	Royal Adelaide Hospital and Adelaide University
Rob Copeland	Co-chair Behaviour Change and Technology group	Director – Advanced Wellbeing Research Centre	Sheffield Hallam University
Leah Avery	Co-chair Behaviour Change and Technology group	Professor of Applied Health Psychology	Teesside University
Liam Humphreys	Co-chair Behaviour Change and Technology group	Senior Research Fellow – (Exercise Oncology)	Sheffield Hallam University
Chelsia Gillis	Co-chair Nutrition group	Assistant Professor, Registered Dietitian	McGill University
Krishna Kholia Parmar	Co-chair Nutrition group	Macmillan Specialist Dietitian and Prehabilitation Project Lead	University Hospitals Birmingham NHS Foundation Trust
		Chair of the BDA Prehabilitation sub-group	British Dietetic Association (BDA)

Acknowledgements

Participant	Role in Prehabilitation guideline development	Job Role(s)	Organisation(s)
Linda Denehy	Co-chair Exercise group	Professor	Department of Physiotherapy; The University of Melbourne, Australia
		Professor	Centre for Health Services Research in Cancer; Peter MacCallum Cancer Centre, Melbourne, Australia
		Honorary Professor	Sir Peter MacCallum Department of Oncology, The University of Melbourne, Australia
		Honorary Professor	School of Medicine, Dentistry and Biomedical Sciences; Queens University, Belfast, UK
Sandy Jack	Co-chair Exercise group	Professor of Prehabilitation Medicine	Clinical Experimental Sciences, Faculty of Medicine, University of Southampton
Chloe Grimmett	Co-chair Psychology group	Associate Professor	University of Southampton
Claire Foster	Co-chair Psychology group	Professor of Psychosocial Oncology	University of Southampton
		Co-Director	Centre for Psychosocial Research in Cancer: CentRIC
Hilly Webb-Peploe	Co-chair Psychology group	Consultant Clinical Psychologist	Gloucestershire Hospitals NHS Foundation Trust

Publication date: October 2025. Review date: 2030.

Please cite this document as Macmillan Cancer Support (2025) Prehabilitation for people with cancer: clinical and implementation guidelines. Prehabilitation resources for healthcare professionals | Macmillan Cancer Support

Macmillan Cancer Support, registered charity in England and Wales (261017), Scotland (SC039907) and the Isle of Man (604). Also operating in Northern Ireland. MAC19939_Digital Guide