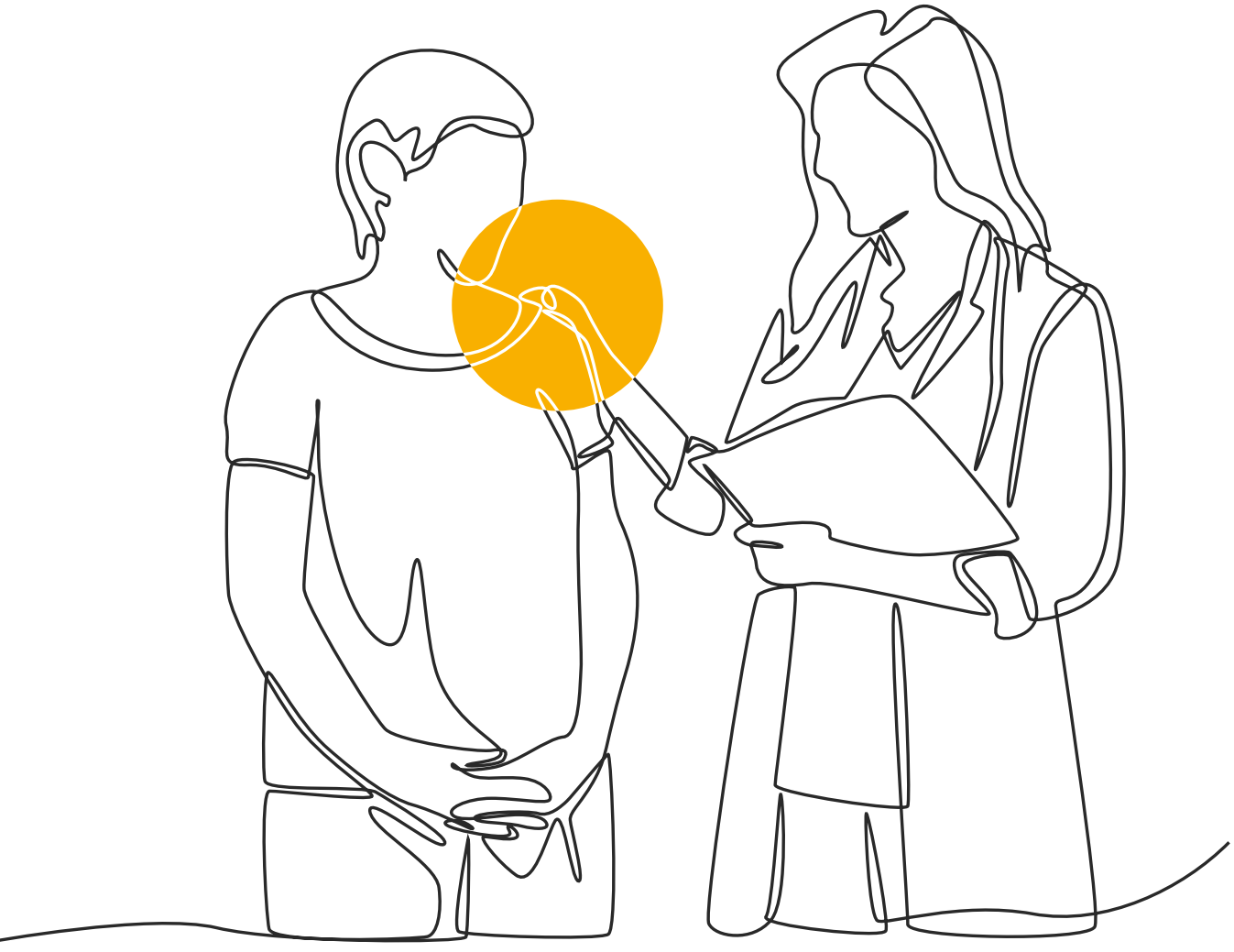
Earlier support, better outcomes:

The case for cancer prehabilitation



Cancer: Project Zero is a non-promotional campaign funded, initiated and developed by AstraZeneca UK, designed for UK healthcare professionals, health system leaders, patient organisations, government representatives and media.

Document Number: GB-78553
Date of Preparation: October 2026

AstraZeneca
CANCER : PROJECT ZERO

AstraZeneca

Cancer treatment does not begin and end with the treatment itself. Increasingly, prehabilitation is recognised as an intrinsic part of cancer care, bringing together physical, nutritional and psychological support to prepare people for treatment, build resilience and support recovery.

This importance is now reflected at a national policy level: the 2026 National Cancer Plan for England commits to a national, digital-first prehabilitation offer, alongside consistent quality standards for prehabilitation and rehabilitation, with support delivered increasingly at home, in community settings and through the NHS App and other digital channels.[1] However, while the direction of travel is clear, the route to getting there is not. There is no single model for how prehabilitation should be delivered, and both the availability and configuration of services vary considerably across the UK.

> This essay offers complementary perspectives on the challenges and opportunities for embedding prehabilitation consistently within cancer care pathways.

Tessa Renouf is an experienced oncology nurse and cancer-care leader with expertise in Systemic Anti-Cancer Therapy (SACT), prehabilitation and service development, and is the SACT Nursing Clinical Advisor at Macmillan Cancer Support. Tessa outlines the key principles underpinning prehabilitation and why it matters for patients, healthcare providers and policymakers.

Karen Livesey is Director of One Wirral CIC and Chair of Wirral's Core20PLUS5 Action Group. She works across health and community partnerships to tackle health inequalities, strengthen local collaboration and improve access and outcomes for underserved communities across Wirral. Karen builds on Tessa's insights by exploring how prehabilitation can be delivered locally and embedded sustainably within cancer pathways.

Katie Lyon is Macmillan Cancer Support's National Improvement Advisor (Scotland) for Cancer Prehabilitation at the National Centre for Sustainable Delivery. She works to support the development and implementation of cancer prehabilitation across Scotland, helping to embed consistent approaches to screening and assessment within cancer pathways, ensuring standardised tools can support greater consistency while enabling services to respond to local needs.

Together, their perspectives highlight the importance of moving towards universal, equitable access to prehabilitation services across the UK.

Prehabilitation: An Integral Component of Contemporary Cancer Care

AUTHOR:

Tessa Renouf — Nursing Clinical Advisor for SACT, Macmillan Cancer Support; Clinical Matron, The Royal Marsden NHS Foundation Trust



The growing number of cancer diagnoses represents a significant health challenge across the UK. More than 420,000 people are diagnosed with cancer each year, which amounts to 1,160 diagnoses every day.[2,3] The number of people diagnosed has increased by approximately 19% over the last decade and is expected to continue rising as the UK population grows and ages.[3,4,5] This will place increasing demand on cancer services.

Alongside the growing number of cancer diagnoses, the number of people living with and beyond cancer continues to grow. Macmillan Cancer Support estimates that almost 3.5 million people are living with cancer in the UK, up from around 3 million in 2020.[3]

A cancer diagnosis can involve multiple rounds of treatment, which can significantly affect a person's physical and mental wellbeing. Supporting patients at every stage of the cancer care pathway is therefore essential to help maintain their independence and quality of life.

Prehabilitation includes physical, nutritional and psychological interventions delivered alone or in combination as part of a multimodal approach.

It improves patients' functional and psychological capacity, helping to improve their readiness for, tolerance of and recovery from cancer treatment.[6,7,8]

By improving physiological function, prehabilitation strengthens the body's resilience to cancer treatments.[9] A review of 24 small studies of prehabilitation during neoadjuvant chemotherapy could be associated with benefits including improvements in treatment response and completion, quality of life and fitness, with eight studies reporting improvements in fitness levels.[10] It can also empower patients by fostering a sense of control, supporting psychological wellbeing, enhancing the overall treatment experience and encouraging longer-term behavioural change.[11,12]

For healthcare services, prehabilitation can make better use of available capacity by improving patient flow, freeing up critical care beds, shortening hospital stays and reducing unplanned hospital readmissions.[13] Evaluations of prehabilitation programmes have shown significant improvements in patient outcomes and more efficient use of healthcare resources, with the Greater Manchester Prehab4Cancer programme reporting a 1.5-day reduction in hospital length of stay among colorectal patients who completed prehabilitation.[14,15,16] Separately, analysis of 1,934 patient-level data from five NHS pilot sites estimated that, if similar effects were achieved across all patients with cancer cared for by the NHS in England, average length of stay could fall by 0.12 days per hospital stay, potentially freeing up around 374,845 hospital bed days annually.[17]

From 2024 to 2025, Macmillan worked with NHS England and other partners to update the 2019 *Principles and guidance for prehabilitation for people with cancer.*[4] Developed through a formal consensus process and comprehensive review of the evidence, the updated guide provides detailed clinical and implementation guidance to support the delivery of prehabilitation for people with cancer.

The guidance recommends that this support begins as early as possible following diagnosis and continues, where needed, throughout cancer treatment.

> The guidelines also recommend that prehabilitation services should be available and accessible to all people diagnosed with cancer and embedded as a routine part of cancer care.

This would support equitable access, regardless of tumour type, treatment modality, age, socioeconomic status, ethnicity or geographical location.

These recommendations align closely with the National Cancer Plan for England's ambition to embed prehabilitation within cancer care.[1]

Investment in prehabilitation services therefore aligns with national policy, supports earlier intervention following diagnosis and responds to the increasing number of people living with and beyond cancer. Prehabilitation offers an opportunity to improve patient outcomes and experience while supporting the delivery of high-quality, personalised cancer care closer to home. However, the configuration of prehabilitation services across the UK remains highly variable,[18,19] which risks further widening existing health inequities.[20]

Standardised screening of patients is a critical first step towards reducing this variation and ensuring more consistent, equitable access to personalised prehabilitation.



> Prehabilitation is a needs-based multi-modal intervention, before and during cancer treatment. Its aim 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 and needs-based assessment, enabling individualised prescription of exercise, nutrition and psychological interventions supported by behaviour change techniques.[4]

SCREENING

Macmillan Cancer Support guidance recommends personalising prehabilitation through screening and needs-based assessment, using validated tools that are widely applicable and simple to use, while remaining sensitive enough to trigger a detailed assessment across exercise, nutrition and psychological domains.[4] This assessment can then inform tailored interventions, including support for behaviour change, healthy lifestyles, nutrition, exercise and psychological wellbeing.

Timing is critical to the screening process.

> Screening to inform needs-based assessment should occur as early as possible in the cancer pathway, with repeat screening for people on prolonged oncology pathways or at key transition points in their care.

For example, patients may receive SACT in multiple rounds, which may have a cumulative effect, contributing to functional decline and changing their support needs. The need for repeat screening is particularly important as treatment progresses. For example, in one retrospective study on 183 Australian haematology patients receiving high-dose chemotherapy before stem cell transplantation, multimodal prehabilitation was found to improve functional exercise capacity, lower-limb strength and function, grip strength, physical activity and symptoms including fatigue and breathlessness.[6] This reinforces the importance of reassessment of prehabilitation needs throughout treatment.[4,16]

Screening can be completed by patients themselves or carried out by registered healthcare professionals. It can also be undertaken by appropriately trained, unregistered healthcare staff under delegated authority.[13] Patients can be scored on a Red, Amber, Green (RAG) rating for each prehabilitation domain corresponding to the intervention. Low risk or "Green" patients would be prescribed universal interventions, while patients who screen as "Amber or Red" (at risk) should receive expert, specialist assessment and interventions. This ensures that the prehabilitation intervention is specifically tailored to their care while identifying their specific deficit and employing a personalised prescription of care.[16]

Nationally, there is no standardisation of screening tools, although research is presently being undertaken in this area in the form of a large, international Delphi consensus study.[21] This aims to develop, validate and implement a simple, online, self-reported risk-stratification tool to identify modifiable physical, nutritional and psychological factors, enabling targeted and tailored prehabilitation interventions. In line with the Government's National Cancer Plan for England, digital screening tools are also being developed to support more consistent identification of patient need.[1] For future services, the key challenge will be to create greater consistency in how need is identified, while retaining enough flexibility to tailor support to individual patients and local pathways.



WORKFORCE

Effective prehabilitation requires a collaborative, interdisciplinary effort that balances the patient's individual needs and values with the timing and urgency of treatment.[22] Cancer is often treated with multiple lines of therapy, each with its own effects and challenges to patients and caregivers.[23] Although prehabilitation has its foundations in pre- and peri-surgical care, it can be applied across other cancer treatments.

This incorporates a broader range of health professionals into the interdisciplinary team in order to provide patient-centric, multi-modal prehabilitation.[16] Indeed, the Macmillan guidelines specifically recommend that cancer prehabilitation is multidisciplinary and that all members of the cancer workforce are trained in prehabilitation principles, understand local provision and can signpost patients to these services, ensuring patients are supported throughout the cancer pathway.[4] Delivering prehabilitation therefore requires different professionals to work together across the cancer pathway, including dietitians, physiotherapists, psychologists, support workers and cancer nurses.

Central to multi-modal prehabilitation is the role of the nursing workforce, which is integral to delivering joined-up, personalised care.[4,16] In a survey of 415 clinical nurse specialists and advanced nurse practitioners, 89% reported routinely giving prehabilitation advice, but 60% identified a lack of guidance and referral processes and 61% identified time as a barrier.[11] Guidance also appears to support onward referral: 73% of nurses provided with guidance on physical activity referred patients to another healthcare professional, compared with 59% of those without guidance.[11]

This is particularly relevant given the role nurses can play throughout the prehabilitation process, from screening and referral through to assessment, intervention and reassessment. Their regular contact with patients can also help them identify changing needs, support patients and families, and make use of "teachable moments" throughout treatment.[11] Incorporating the Making Every Contact Count (MECC) approach enables health workers to engage patients in constructive conversations about optimising health and is endorsed by the National Institute for Health and Care Excellence (NICE) and NHS England.[24] If prehabilitation is to become a routine part of cancer care, this capability cannot sit only within specialist teams. The wider cancer workforce will need the skills, confidence and knowledge of local services to identify need and connect patients to appropriate support.

The opportunity now is to translate the growing evidence and ambition for prehabilitation into consistent practice. That means combining equitable access with effective screening and a workforce equipped to deliver personalised support, so that prehabilitation can become routine rather than dependent on local provision or individual referral pathways.

National Case Study: A Once for Scotland Approach to Cancer Prehabilitation Screening

AUTHOR:

Katie Lyon, Macmillan National Improvement Advisor (Scotland) – Cancer Prehabilitation, National Centre for Sustainable Delivery and NHS Senior Physiotherapist



Scotland is taking a national approach to cancer prehabilitation screening, recognising that screening is the critical first stage of the prehabilitation pathway.

Effective screening enables services to identify an individual's level of need at the earliest opportunity and ensure they receive the right support from the right people, whether through community-based services provided by third sector and leisure partners, or interventions delivered within secondary care.

> Prior to this work, there was significant variation in how prehabilitation screening was being undertaken across Scotland.

Different tools and processes were being used, and in some areas, screening was not taking place routinely. This variation created inequity in access to support and presented challenges for sustainable service delivery and national evaluation.

To address this, a national screening pathway and toolkit were developed through collaboration with NHS boards, regional cancer networks, clinicians and partners. The national approach promotes the use of the same validated screening tools across Scotland, with the aim of reducing unwarranted variation, improving consistency and supporting a sustainable model for cancer prehabilitation delivery.

A range of resources have been developed to support implementation, including guidance, training materials and digital solutions to facilitate screening and referral processes. Importantly, while the national approach standardises what is measured, local teams retain flexibility to design delivery models and referral pathways that best meet the needs of their patient groups and existing services. This seeks to combine greater national consistency with local ownership. With national rollout having begun in March 2026, it is too early to assess the impact of the approach. As implementation progresses, an important test will be whether it increases the reach and consistency of screening, supports appropriate onward referral and helps reduce inequity in access to prehabilitation.

The experience offers an important lesson for wider prehabilitation delivery: which is that greater national consistency does not require a single delivery model. Common standards and tools can help reduce unwarranted variation while still allowing local systems to design services around their populations and existing infrastructure.

Stronger Together: Why Community Partnerships Matter in Prehabilitation

AUTHOR:

One Wirral CIC



No single organisation can meet every need of someone preparing for cancer treatment. Clinical expertise, community support and practical help all play an important role.

The challenge is bringing these strengths together, so patients experience one joined-up pathway rather than a series of disconnected services.

For more than five years, we've been proud to deliver the Wirral Cancer Prehabilitation Service as a core part of the local cancer pathway. From the outset, our purpose has been clear: to help people feel stronger, more confident and better equipped for their treatment or surgery ahead.

As a Voluntary, Community, Faith and Social Enterprise (VCFSE) rooted in Wirral's neighbourhoods, our work naturally starts close to home. We deliver cancer prehabilitation classes in community leisure centres and other familiar local spaces. Our long standing partnership with Wirral University Teaching Hospital NHS Foundation Trust means we can blend that community connection with strong clinical oversight.

We regularly attend tumour group meetings to maintain relationships with clinical teams and reinforce referral pathways. More recently, we have begun receiving multidisciplinary team (MDT) lists, with clinical teams removing patients who are not appropriate before sharing them. Supported by robust Information Governance arrangements aligned with NHS requirements, this helps ensure eligible patients are not missed.

Developing the pathway has also taught us the importance of consistent messaging. Every professional involved in a patient's journey should understand what prehabilitation is, why it matters and the difference it can make. When clinicians, nurses, allied health professionals and community partners all talk positively about prehabilitation, patients see it as a routine part of preparing for treatment rather than an optional extra. That consistency builds confidence, increases engagement and helps embed prehabilitation as part of the treatment pathway from diagnosis onwards.

Making referrals easy is only part of the solution. We aim to contact patients within 48 hours because early conversations build confidence and allow us to develop a personalised plan based on what matters most to them.

One of the biggest lessons we've learned is that barriers to participation are often not clinical. Transport costs, caring responsibilities, confidence or anxiety following a cancer diagnosis can all prevent people from engaging with prehabilitation. Identifying these challenges early allows us to work with local partners to find practical solutions. We support people across all cancer pathways, surgical and non-surgical because cancer doesn't give anyone a choice. You don't choose where you get cancer, so we don't choose who we support. From day one, we designed this service to be inclusive, making sure every person has the chance to feel stronger, more confident and more prepared for whatever treatment lies ahead.

To keep things fair and accessible, the service runs on an opt out basis. More than 4,000 people have been referred to us. Everyone starts with a personalised assessment, followed by a plan shaped around their needs, whether that's structured physical activity, nutrition support, mental wellbeing advice, behaviour change coaching or digital support. Using a mix of community venues and hybrid options means we can adapt delivery to individual circumstances and reduce barriers to participation.

Community Interest Companies and the wider third sector bring strengths that complement NHS services. Their flexibility, local knowledge and established community relationships allow them to respond quickly and personalise support.

Our experience has highlighted five practical lessons that any organisation developing community partnerships could adopt:

Be visible: Attend MDTs and clinical meetings regularly. Familiarity builds trust and confidence in your service.

Keep referrals simple: Continually review referral processes to reduce administration and minimise the risk of eligible patients being missed.

Respond quickly: Early contact reassures patients, builds engagement and allows personalised support to begin as soon as possible.

Look beyond clinical needs: Ask about transport, finances, clothing, caring responsibilities or confidence. Addressing these barriers can be just as important as clinical interventions.

Speak with one voice: Every partner should consistently explain the benefits of prehabilitation so patients understand it is a routine part of preparing for treatment, not an additional service sitting outside the pathway.

STRONGER TOGETHER: WHY COMMUNITY PARTNERSHIPS MATTER IN PREHABILITATION

Supporting people through cancer treatment is too complex for any one organisation to achieve alone. By working across organisational boundaries, we can provide care that is more personalised, accessible and responsive to what matters most to patients. The difference this service makes comes through most clearly when people talk about it themselves.



One Wirral's prehabilitation service continues to demonstrate strong outcomes for people affected by cancer. Evaluation data shows that up to 98% of participants increased or maintained their physical activity levels, up to 98% reported reduced or maintained fatigue, and up to 99% reported improved or maintained mental wellbeing.[25] The service has also demonstrated system-wide benefits, including a 5% reduction in length of stay for colorectal and urological cancer patients, fewer post-operative complications in colorectal cancer patients and reduced 30-day readmissions from 9.9% to 7.9%.[25]

It takes time to build trust, but when organisations invest in those relationships and focus on shared goals rather than organisational boundaries, patients can receive more seamless support across the pathway. Prehabilitation isn't an add-on to cancer treatment, it is part of cancer treatment; embedding it as part of routine care requires community partnerships that connect clinical pathways with support closer to home.

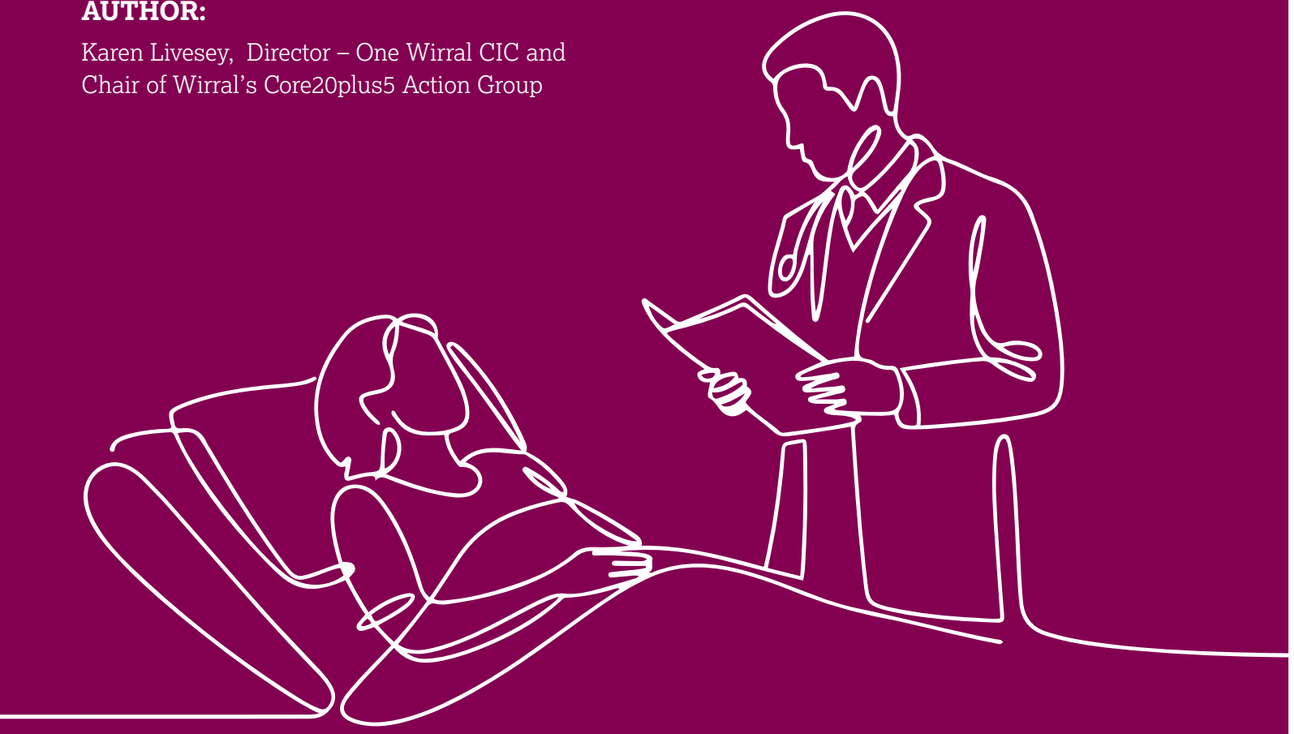
One woman, recovering from major kidney cancer surgery, shared:

> When I first started, it was a struggle, but after nearly twelve weeks, I can feel a massive improvement. The classes helped me regain confidence, take back control, and feel mentally lighter every time I leave.

Making the Case for Prehabilitation: Measuring What Matters

AUTHOR:

Karen Livesey, Director – One Wirral CIC and
Chair of Wirral's Core20plus5 Action Group



As Simon Sinek famously said, "Start with why." That advice has never felt more relevant than it does today.

In the current financial climate, securing investment feels harder than ever. Every service is important, every department has competing priorities, and every business case needs to demonstrate value. Making the case for cancer prehabilitation has been no exception. Fortunately, we've been incredibly well supported by colleagues across Wirral University Teaching Hospital NHS Foundation Trust, who continue to champion prehabilitation and rehabilitation for people living with cancer. We've also received valuable support from Cheshire and Merseyside ICB, despite the difficult funding decisions they face.

But when we talk about our "why", whose why are we talking about?

Is it the patient's? The NHS's?

The reality is that it's both. Patients want better outcomes, improved wellbeing and the confidence to face treatment. Commissioners need evidence that investment improves outcomes, reduces complications and makes better use of limited resources. Developing a successful business case means finding the balance between these perspectives rather than seeing them as competing priorities.

DECIDE WHAT SUCCESS LOOKS LIKE

Before collecting any data, it's worth asking one simple question: what are you trying to prove?

If you don't know what success looks like, you'll almost certainly collect too much information, or the wrong information.

For us, success isn't just about whether patients enjoy the service.

We need to understand whether prehabilitation improves physical and mental wellbeing, reduces frailty and malnutrition, supports healthier behaviours and ultimately improves healthcare outcomes.

That means selecting measures that are meaningful rather than simply measuring everything because we can.

CHOOSE MEASURES THAT ADD VALUE

Collecting clinical data is one of the biggest challenges for any service. You need measures that are clinically meaningful while remaining practical to deliver in routine care.

Our current measures include:

- Short Warwick and Edinburgh Mental Wellbeing Scale (SWEMWBS)
- Clinical Frailty Score (CFS)
- Malnutrition Universal Screening Tool (MUST)
- General Practice Physical Activity Questionnaire (GPPAQ)

Like many teams, we've debated whether we should also measure grip strength or use the sit-to-stand test. Both have their advantages, but many of our patients progress to surgery very quickly.

For a community-based service, introducing additional physical testing didn't feel proportionate given the extra time, equipment, venues and staffing required.

One lesson we've learnt is that every measure comes with a cost, not just financially, but in patient experience and staff workload.

Always ask yourself:

- Will this information change what we do?
- Is it useful for patients?
- Is it useful for commissioners?
- Is the benefit worth the additional burden?

If the answer isn't clear, it may not be the right measure.

DON'T LOSE SIGHT OF THE PATIENT EXPERIENCE

Measurement is essential, but too many questionnaires can quickly become overwhelming.

Assessments, scales and questionnaires can damage rapport if they're delivered as a tick-box exercise. Our team has developed the skills to incorporate outcome measures naturally into conversations, helping patients understand why we're asking these questions.

We've found that when patients understand that the data helps secure and improve the service for future patients, they're usually very willing to participate.

MEASURE OUTCOMES THAT MATTER TO THE SYSTEM

Alongside patient-reported outcomes, we also monitor healthcare utilisation.

We compare hospital length of stay against baseline data collected before the service was introduced and monitor critical care bed utilisation following surgery. These outcomes help demonstrate the wider value of prehabilitation beyond individual patient experience.

However, understanding the impact for patients who don't undergo surgery has always been more challenging.

Ideally, we'd like to understand whether prehabilitation influences wider NHS utilisation, such as GP appointments, emergency admissions or other healthcare contacts. Historically this has been difficult because the data simply wasn't available across organisational boundaries, but things are improving!

THE FUTURE IS BETTER DATA

The development of secure data environments is beginning to change what's possible.

As data becomes more connected across primary care, secondary care and potentially mental health and social care, we'll be able to build a much richer picture of each patient's journey.

This will help us answer much bigger questions:

- Does prehabilitation reduce overall NHS utilisation?
- Does it improve long-term health behaviours?
- Does it reduce inequalities?
- Does it improve outcomes beyond cancer treatment itself?

These are the questions that commissioners increasingly want answered, and the answers will help shape future services.

Measuring success isn't about collecting as much data as possible. It's about collecting the right data.

Good outcome measurement should improve patient care, support service development and provide the evidence needed to sustain and grow cancer prehabilitation. As healthcare continues to evolve, our measures should evolve too, ensuring we continue to demonstrate not just that prehabilitation works, but why it matters.

MAKING THE CASE FOR PREHABILITATION: MEASURING WHAT

PERSONALISING PREHABILITATION THROUGH FRAILTY ASSESSMENT

AstraZeneca partnered with **Macmillan Cancer Support,** the **National Forum of Geriatric Oncology (NFOG),** the **Royal College of Radiologists (RCR)** and the **International Society of Geriatric Oncology (SIOG)** to develop an Astrazeneca initiated and funded UK consensus framework that recognises frailty screening as a vital first step in personalising prehabilitation and is designed to empower HCPs, including those working in settings without dedicated frailty services.

Routine frailty assessment using the Rockwood Clinical Frailty Scale helps identify the physical, nutritional and psychological factors that influence a patient's ability to tolerate treatment. Combined with a Holistic Needs Assessment, it enables healthcare professionals to tailor prehabilitation interventions while identifying patients who require broader support beyond prehabilitation alone.

The framework provides practical recommendations that can be implemented across routine cancer care today, including adopting routine frailty screening, appointing local frailty champions and strengthening links with existing community and optimisation services. By empowering all healthcare professionals, not only specialist geriatric teams, to identify and manage frailty, it supports more equitable access to personalised prehabilitation and wider supportive care.

Building on the framework, AstraZeneca is partnering with Cheshire & Merseyside Cancer Alliance to implement and evaluate the Cheshire and Merseyside Frailty in Cancer Assessment and Management Guidance across cancer pathways. This pathway approach aims to embed proactive screening, assessment and management of patients living with frailty throughout their cancer journey, recognising their individual needs and supporting better experiences and outcomes.

The programme will generate evidence on how frailty-attuned cancer care can help patients receive the right support and intervention, from the right people, at the right time and in the right place, while supporting more sustainable cancer services and reducing pressure on the wider healthcare system.

TURNING AMBITION INTO ROUTINE CARE

The ambition is clear: tailored prehabilitation should be a routine part of every cancer patient's care pathway, not an opportunity available only to some. Realising that ambition means moving beyond pockets of good practice and embedding support earlier in the pathway, starting as soon as possible after diagnosis and adapting as patients' needs change.

It also means tackling unwarranted variation. Where someone lives, their tumour type or the services available locally should not determine whether they can benefit from prehabilitation.

Delivering this will require action across the cancer system: consistent screening and needs assessment; a workforce equipped to embed prehabilitation throughout cancer pathways; flexible local and community delivery; and standardised collection of patient and system outcomes to demonstrate value, support improvement and sustain investment.

The examples explored in this essay show that national consistency and local flexibility are not competing objectives. Scotland's approach shows how common tools can support greater consistency while allowing local adaptation; One Wirral shows how strong clinical-community partnerships can make services more accessible and responsive; and robust measurement is essential to demonstrate value to patients, commissioners and the wider system.

The National Cancer Plan provides an important opportunity to turn this ambition into practice, but delivery must learn from and scale approaches already working across the country, so that earlier, personalised and equitable prehabilitation becomes a routine part of cancer care.

REFERENCES

1. Department of Health and Social Care, NHS England 2026. The National Cancer Plan for England: delivering world class cancer care [Internet]. London: Department of Health and Social Care;. Available from: https://www.gov.uk/government/publications/national-cancer-plan-for-england . Accessed August 2026.
2. World Cancer Research Fund. UK cancer statistics [Internet]. London: World Cancer Research Fund; 2026. Available from: https://www.wcrf.org/preventing-cancer/cancer-statistics/uk-cancer-statistics/. Accessed August 2026.
3. Macmillan Cancer Support. Cancer statistics in the UK [Internet]. 2025. Available from: https://www.macmillan.org.uk/about-us/what-we-do/research/cancer-statistics-fact-sheet. Accessed August 2026.
4. Macmillan Cancer Support. Prehabilitation for people with cancer: clinical and implementation guidelines [Internet]. Macmillan Cancer Support; 2025. Available from: https://www.macmillan.org.uk/dfsmedia/1a6f23537f7f4519bb0cf14c45b2a629/22869-10061/prehabilitation-for-people-with-cancer-clinical-and-implementation-guidelines. Accessed September 2026.
5. Cancer Research UK. Along the cancer pathway [Internet]. 2026. Available from: https://www.cancerresearchuk.org/health-professional/our-reports-and-publications/along-the-cancer-pathway. Accessed August 2026.
6. Crowe J, Francis JJ, Edbrooke L, et al. Impact of an allied health prehabilitation ser- vice for haematologic patients receiving high-dose chemotherapy in a large cancer centre. Supportive Care Cancer. 2022;30(2):1841–1852
7. Bates A, West MA, Jack S. Framework for prehabilitation services. Br J Surg. 2020;107(2):e11-e14. doi:10.1002/bjs.11426.
8. West MA, Astin R, Moyses HE, Cave J, White D, Levett DZH, et al. Exercise prehabilitation may lead to augmented tumor regression following neoadjuvant chemoradiotherapy in locally advanced rectal cancer. Acta Oncol. 2019;58(5):588-595. doi:10.1080/0284186X.2019.1566775.
9. Treanor C, Kyaw T, Donnelly M. An international review and meta-analysis of prehabilitation compared to usual care for cancer patients. J Cancer Surviv. 2018;12(1):64-73. doi:10.1007/s11764-017-0645-9.
10. Renouf T, Martin R. Benefits of prehabilitation in patients receiving neoadjuvant chemotherapy. Cancer Nursing Practice. 2023;22(2):29-34. doi:10.7748/cnp.2022.e1818.
11. Renouf T, Barlow R, Patel T. Barriers and facilitators to giving prehabilitation advice by clinical nurse specialists and advanced nurse practitioners in oncology patients. Support Care Cancer. 2024;32(3):158. doi:10.1007/s00520-023-08273-6.
12. Levett DZH, Grimmett C. Psychological factors, prehabilitation and surgical outcomes: evidence and future directions. Anaesthesia. 2019;74(Suppl 1):36-42. doi:10.1111/anae.14507.
13. Davis JF, van Rooijen SJ, Grimmett C, West MA. From theory to practice: an international approach to establishing prehabilitation programmes. Curr Anesthesiol Rep. 2022;12(1):129-137. doi:10.1007/s40140-022-00516-2.
14. NHS South, Central and West Commissioning Support Unit. Prehab4Cancer evaluation [Internet]. Greater Manchester Cancer; 2021. Available from: https://www.prehab4cancer.co.uk/wp-content/uploads/2022/01/GM_Prehab4Cancer_Evaluation_Report_Final-003.pdf. Accessed August 2026.
15. Kudiersky N, Rosenthal K, Frith G, Phillips G, Keen C, Barratt S, et al. A service evaluation of the Active Together multi-modal cancer prehabilitation and rehabilitation service. medRxiv [Preprint]. 2025. doi:10.1101/2025.08.20.25334050.
16. Renouf T, Bates A, Davis JF, Jack S. Prehabilitation. An interdisciplinary patient-centric conceptual framework. Seminars in Oncology Nursing. 2022;38:151329. doi:10.1016/j.soncn.2022.151329.
17. Bristol Myers Squibb, Macmillan Cancer Support. Understanding and advancing the adoption of prehabilitation in NHS cancer care. 2025. Available from: https://www.macmillan.org.uk/dfsmedia/1a6f23537f7f4519bb0cf14c45b2a629/22839-10061/bristol-myers-squibb-macmillan-prehabilitation-report
18. Stewart H, Zhang X, Hirst Y, Wareing L, Ashmore L, Gaffney C, et al. Prehabilitation before cancer surgery in the UK National Health Service: what services exist, and how do they address health inequalities? PLoS One. 2026;21(5):e0336005. doi:10.1371/journal.pone.0336005.
19. Pufulete M, Coyle V, Provan D, Shaw C, Kunzmann P, Bowrey DJ, et al. Prehabilitation provision and practice in the UK: a freedom of information survey. Br J Anaesth. 2024;132(4):815-819. doi: 10.1016/j.bja.2024.01.013.
20. Hadley C, Zhang X, Stewart H, Stanley S, Kulikowski C, Partridge A, et al. Addressing inequities in the design and delivery of prehabilitation in the UK: case studies of challenges, complexities and good practice. Anaesthesia. 2026. doi:10.1111/anae.70286.
21. Parkington T, Humphreys LJ, West M, Myers A, Keen C, Denehy L, et al. Development of a core screening, assessment and outcome set for cancer prehabilitation: an international Delphi consensus study protocol. BMJ Open. 2026;16(5):e116442. doi:10.1136/bmjopen-2026-116442
22. Sherrer M, Simmons JW, Dobyns JB. Preoperative risk stratification: identifying modifiable risks for optimization. Curr Anesthesiol Rep. 2022;12(1):10-25. doi:10.1007/s40140-022-00519-z.
23. Santa Mina D, van Rooijen SJ, Minnella EM, Alibhai SMH, Brahmbhatt P, Dalton SO, et al. Multiphasic prehabilitation across the cancer continuum: a narrative review and conceptual framework. Front Oncol. 2021;10:598425. doi:10.3389/fonc.2020.598425.
24. Public Health England, NHS England, Health Education England. Making Every Contact Count (MECC): implementation guide [Internet]. London: Public Health England; 2018. Available from: https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources. Accessed August 2026.
25. Cheshire & Merseyside Cancer Alliance. One Wirral Prehabilitation Service: Evaluation of Year One, July 2021 to June 2022. Cheshire & Merseyside Cancer Alliance; 2022. Unpublished report. Accessed October 2026.

Cancer: Project Zero is a non-promotional campaign funded, initiated and developed by AstraZeneca UK, designed for UK healthcare professionals, health system leaders, patient organisations, government representatives and media.

Document Number: GB-78553
Date of Preparation: October 2026

AstraZeneca
CANCER : PROJECT ZERO