JCR'S COMMENTARY The Role of Exercise in Cancer Rehabilitation

COMMENTARY

Professor Anna Campbell MBE
Room 2B42, Sighthill Campus
Edinburgh Napier University
Edinburgh EH11 4BN

The authors provide excellent examples of local, regional, and national interventions that have been successfully implemented in their respective countries. Here in the UK, the charity Macmillan Cancer Care provided funding to design, establish and assess a national program. I was involved from its inception to the evaluation of this UK-wide service called MoveMore. This evidence-based service delivers tailored, behaviour change support to help people living with cancer (PLWC) to become more active or maintain a level of physical activity, depending on their stage of the cancer journey. The pathway is comprised of four components: raising awareness and generating referrals to the program; a behaviour change intervention; a physical activity offers and finally, on-going behaviour change support for up to one year. Some important findings from the mixed methods evaluation of MoveMore (from 2014-2018) are worth highlighting in consideration with the expert panel's webinar discussions. The reader is referred to the summary of this evaluation, which can be located online at *https://www.macmillan.org.uk/assets/evaluation-of-macmillan-physical-activity-behaviour-change-care-pathway-2018.pdf.* As with Quist's observation, the MoveMore teams also found that generating referrals from hospital-based oncology teams to the community-based program were more difficult and time consuming than anticipated. The evaluation showed that the more successful MoveMore programs manage to gain the trust of the referring healthcare professionals, establish an ongoing two-way communication concerning referred participants and provide a referral pathway which is quick and easy to administrate e.g., an electronic record system linking NHS services to local social/community services.

The MoveMore program also tries to address the issues (mentioned by Stuiver) of the "hard to reach" group of PLWC who, for a number of reasons, do not for participate in clinical exercise trials. We were also aware that PLWC have diverse exercise preferences and that one size does not fit all. Therefore, the MoveMore pathway includes an initial behaviour change intervention delivered by a practitioner with motivational interviewing (MI) training. From our evaluation, when this MI component is completed thoroughly and is of a high quality, the service users find it to be a positive and useful experience which helps improve adherence to their physical activity options. However, the evaluation showed that most MoveMore services tend to modify the use of MI and include alternative informal support where required, based around an "open-door" policy. Nevertheless, the informal support also appears to reassure service users that they can raise issues if and when they wished.

Rather than prescribing a standard gym or circuit session, the aim of the MoveMore service is to offer access to a wide range of physical activities. The evaluation demonstrated that the best offers are those based on the wishes of the service user and that take into account local facilities and services and provide activities at a variety of times and locations easily accessed by public transport. We found that the MoveMore services based in municipal settings are best able to help direct participants to a wide range of exercise opportunities and make the transition from free sessions to continued structured exercise more straightforward.

The national MoveMore Program uses a standard validated assessment questionnaire and the analysis of the evaluation of 14 sites and ~1000 service users showed that most users of the service maintained or increased their (self-reported) levels of physical activity following engagement with the service and those who provided data at follow up points had small but statistically significant improvements in health-related quality of life and fatigue.

In the webinar Stout talks about the importance of triage and functional screening as an integral part of cancer rehabilitation. Indeed, triage provides an understanding of the complexity of a patient's health status, guides clinical decision on individual exercise recommendations and defines the risk for exercise-related

© 2021 by the authors; licensee Edisciences, Siracusa, Italy. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution License *(https://creativecommons.org/licenses/by-nc/4.0/deed.en).*

J Cancer Rehabil 2021; 4: 103-104 | DOI 10.48252/JCR22

complications. In addition, standard functional and physical activity assessments provide a baseline point from which we can reassess the individual throughout the continuum of care and identify if/when changes occur. The issue, not discussed in the webinar, is the development of the appropriate workforce to undertake these various roles of the service. No one group of professionals can triage, assess, provide advice, and deliver physical activity and exercise interventions to every person living with and beyond a cancer diagnosis. We are trying to address this workforce issue in the UK by matching the PLWC to the appropriate interventions. These interventions are categorised into 3 groups: specialist, targeted or universal, based on triage and baseline assessments undertaken by physiotherapists, health care professionals or cancer trained clinical exercise scientists. The specialist and targeted interventions are often delivered by physiotherapists; targeted interventions are also able to be delivered by clinical exercise physiologists or appropriately trained cancer exercise fitness instructors; and volunteers, support workers, fitness instructors/personal trainers and rehabilitation/therapy assistants often support people in the universal category. There are few validated training pathways for preparing fitness instructors or volunteers to safely and effectively provide exercise programming to the cancer population in the community setting. One exception is here in the UK, where a structured pathway to gaining a qualification as a cancer exercise fitness instructor is available, with all courses on the pathway validated and quality controlled by an overarching awarding body (the Chartered Institute for the Management of Sport and Physical Activity [CIMSPA]; cimspa.co.uk). For example, the training company CanRehab established in 2015 has provided cancer exercise training for >1000 fitness instructors internationally. A prerequisite to obtaining this certification is to hold a nationally accredited personal trainer/exercise referral qualification, attend a 4–6-day training course, complete a cancer client case study submission, and pass (>70%) a practical and written examination. Crucially, this qualification (although not a clinically registered award) is endorsed by medical and allied health care professionals and has helped develop the link, trust and referral pathways between the oncology and community settings. In addition, most volunteers working with clients with cancer in the UK go through a standard core cancer awareness training program provided by Macmillan. I believe it is beneficial to develop and promote cancer exercise training, assessment and certification equivalent to the CanRehab award in the other countries in order to take advantage of this large and invaluable workforce and to provide a service to as many PLWC as possible. As mentioned by Schmitz, the development of an international register of all known exercise oncology programs will be an excellent resource.

As the webinar experts state, we have an unprecedented opportunity in oncology to commence rehabilitation at the point of cancer diagnosis. The importance of prehabilitation is becoming increasingly recognised within cancer care with emerging evidence of improved cardiorespiratory fitness, reducing post treatment complication and reducing length of stay in hospital, enhancing recovery following treatment and providing a teachable moment to promote. In 2017 Macmillan developed a strategic "Evidence and Insight Review" on cancer prehabilitation in collaboration with internal and external stakeholders. I was part of this group and it was agreed that prehabilitation should be incorporated into routine cancer care. We developed principles and guidance for prehabilitation within the management and support of people with cancer in partnership with the Royal College of Anaesthetists and the National Institute for Health Research Cancer and Nutrition Collaboration. These guidelines are now being implemented throughout UK (*https://www.macmillan.org.uk/_images/prehabilitation-in-cancer-care_tcm9-341789.pdf*).

In response to COVID-19 in March 2020, we very quickly designed and developed a pilot service and a clinical trial called SafeFit *https://safefit.nhs.uk/* a virtual home-based multimodal supervised offer where any person in the UK with a cancer diagnosis is able to self-refer through a dedicated NHS web site. Following an initial assessment and screening by health care professionals, the intervention is provided by CanRehab cancer exercise specialists who are given further training in good clinical practice, nutrition, psychological support and behaviour change before starting to provide the offer to participants over a 6-month period.

Finally, from our experiences of establishing community-based programmes in the UK, for a successful program I would recommend the following: the first step is active support from a multidisciplinary group of stakeholders including oncologists, anaesthetists, surgeons, geriatricians, allied health professionals, nurses, psychologists, clinical exercise scientists, clinical academics, fitness instructors' and most importantly, the patient's voice. Secondly ensure you have the appropriate workforce trained and available for the various tasks of the service. Also develop a business case ensuring you have the sponsorship and support from the executive/senior level health care teams and finally work with these leaders and clinical academics to develop and undertake an implementation evaluation to justify sustainability of the service.

JOURNAL JCR Journal of Cancer Rehabilitation OPEN ACCESS

Submit your next manuscript to Journal of Cancer Rehabilitation
www.edisciences.org/journal-of-cancer-rehabilitation
and take full advantage of:
- Convenient online submission
- Special incentive for early-career and young investigators
- Thorough peer review
- No space constraints or color figure charges
- Immediate publication on acceptance
- Inclusion in CNKI
- Research which is freely available for redistribution
- Support in preparing your article, including:
  - English language editing
  - Translation with editing
  - Artwork preparation
  - Plagiarism check
  - Research communication assistance

For information and communication contact us at:
jcr@journalofcancerrehabilitation.org