



British Society of
Rehabilitation Medicine

Promoting quality through
education and standards

Cancer Rehabilitation

BSRM Position Paper



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Evidence Evaluation

Evidence to underpin the recommendations in the position statement is assimilated using a pragmatic approach to consensus and grading of recommendations developed by Turner-Stokes et al 2016. The method uses a simplified version of the GRADE method, incorporating the typology of evidence that was developed for the UK National Service Framework for Long Term Conditions, which includes a broad church of research design and expert opinion.

Foreword

‘Cancer Rehabilitation’ is one of a series of papers prepared by the British Society of Rehabilitation Medicine (BSRM) that describe how the specialty can play a role in rehabilitation for people with various conditions. The impetus for this series was the enthusiasm of members to apply their skills and knowledge across a number of conditions (as occurs internationally) and from a realisation of a lack of awareness across the healthcare system in how Rehabilitation Medicine as a specialty can contribute towards safe, effective and efficient patient care. The conditions most likely to benefit from Rehabilitation Medicine input are also changing as treatment evolves. This position paper on Cancer Rehabilitation is a prime example of that with the increasing number of cancer survivors with complex ongoing needs.

The aim of these position papers is to give a succinct descriptions of which patient groups may benefit from rehabilitation, how Rehabilitation Medicine specialists can play a role in this and how this can be implemented in terms of working relationships, clinical practice, training and commissioning.

Margaret Phillips

Chair of BSRM Research & Clinical Standards Sub-committee
November 2019

Background

What is Cancer Rehabilitation?

Advances in the treatment of cancer mean that an ever-greater number of people are surviving serious diagnoses and living with the long-term consequences of cancer and some of the persistent side effects that curative treatments may engender. By 2030 there will be four million people living with the effects of cancer in the UK¹. The concept of rehabilitation as means of mitigating impairment and restoring function after acute neurological and orthopaedic illness is well recognised throughout the health service. There is already good evidence for the benefits of focussed rehabilitation in the management of cardiac² and pulmonary³ illnesses.

Rehabilitation is recognised as a key theme within the NHS England Cancer Taskforce recommendations⁴. It enables patients to make the most of their lives by maximising the outcomes of their treatment and minimising the consequences of treatment and symptoms such as fatigue, breathlessness and lymphoedema. The need for rehabilitation starts at the point of diagnosis by helping patients prepare for treatment ('prehabilitation') and discharge home. It can help patients get well and stay well and addresses the practical problems caused by the disease and treatment, helps patients become as independent as possible and minimise the impact on carers and support services.

Cancer and its treatment may cause impairments in a number of different physiological systems concurrently. There are specific issues around the areas of nutrition and pain as well as the psychological effects of surviving a life-threatening illness. The reablement needs of this patient group are, by definition, complex and require a nuanced holistic approach to maximise their opportunities for participation on a lifelong basis⁵.

There are a range of clinical issues that may be experienced by survivors of cancer. These may be relatively straightforward (pain and deconditioning following a single surgical intervention for an abdominal tumour, for example) to extremely complex (the motor, sensory and neuropsychological effects of treatment for a brain tumour) and may involve impairments within a number of domains including communication, continence, swallowing and fatigue⁶. These varying needs and impairments may require the input of different members of the MDT in a range of clinical settings from the post-acute inpatient phase through to a return to engagement in family life and employment.

Oncologists are typically focussed on the diagnosis and treatment of the primary tumour while palliative care has developed as a specialty that effectively meets the needs of patients (often with a cancer diagnosis) who are nearing the end of their life through a multi-disciplinary problem-based approach. For patients who are left with significant impairments but who are likely to survive for the longer term there is not, currently (within the UK), a medical specialty whose responsibility it is to meet their complex needs. We would suggest that the training and experience of rehabilitation physicians working with the wider multidisciplinary team places them in an ideal position to take on this role as they currently do for patients with neurological problems, musculo-skeletal disease and limb loss.

Evidence

For the European Union population (ie, in the 27 European Union member states), the estimated number of cancer survivors was 17.8 million in 2008 compared with 2.5 million new cases and 1.2 million deaths. More than half of European cancer patients diagnosed with one of the common forms of cancers today will be alive after 5 years⁷. Patients in hospices nearing the end of life are able to engage in functional goal setting in the same way as patients in other rehabilitation settings⁸. There is evidence for the effectiveness of medical multidisciplinary rehabilitation in improving outcomes for cancer survivors both within an inpatient and outpatient setting⁵. A Cochrane review of multidimensional rehabilitation programs for cancer survivors supported the effectiveness of time-limited issue-focussed interventions⁹. Even for patients with advanced cancer who are not in the "survivorship" group, Rehabilitation has been shown to meet their needs in a cost effective manner¹⁰. A significant number of people with cancer will have unmet ongoing needs with 22% reporting "moderate to severe" problems with their mobility and carrying out usual activities¹¹. There is good evidence for the value of rehabilitation interventions in improving fatigue and upper limb function in cancer survivors¹².

Which patients need Cancer Rehabilitation?

Cancer rehabilitation can be considered to occur across the patient journey. While some oncology patients' needs may be met through simple supportive measures or self-management¹³, the rehabilitation needs of other individuals may be complex and require a nuanced holistic approach including specialist support to maximise their opportunities for participation and to maintain their quality of life. These may include (but are not limited to)

- Tumours of the central or peripheral nervous system - Access to rehabilitation services may be limited by exclusion criteria based on diagnosis rather than clinical need. Spinal Cord Injury units, for example, may refuse admission to an individual with a cord injury secondary to local or metastatic malignancy even where life expectancy may be many years. There is a clinical judgement to be made as to the appropriateness of rehabilitation interventions at different stages in cancer diagnosis and treatment. Comorbidity, frailty and life expectancy are important considerations in making these decisions so that interventions are applied at appropriate and effective points. These are decisions that a rehabilitation medicine specialist would be well placed to lead on.
- Prolonged chemotherapeutic regimes with deconditioning, postural and nutritional issues – These patients are not traditionally seen as requiring specialist rehabilitation input even though their cancer and its' treatment may have produced complex impairments that are best addressed through the holistic MDT approach that rehabilitation medicine can provide. Although the BSRM guidelines on the interface between rehabilitation medicine, palliative care and neurology¹⁴ make specific reference to neurological disease, there is scope for substantial improvement in quality of life through engagement of rehabilitation medicine physicians in looking after complex patients without primary neurological problems.
- Tumours requiring amputation of a limb/part of a limb - Needs should be met by amputee services, but can require clinical judgement as to the timing and appropriateness of any intervention in the context of the disease process.
- Radiotherapy regimes resulting in fibrotic change in soft tissue or neurological injury – These needs may require input from both musculo-skeletal and neurological rehabilitation services.
- Complex issues around vocational needs - Vocational rehabilitation as a model is currently predominantly applied to the sphere of acquired neurological disease, but the complex needs of younger cancer survivors mean that the interventions used to facilitate engagement in activities, including employment, could equally well be applied to them¹⁵. Rehabilitation medicine physicians have a role in optimising health to ensure participation is maximised. The American Cancer Society has advocated for the role of rehabilitation medicine in the management of specific impairments for cancer survivors¹⁶.

Problems and solutions

Issues for Cancer Rehabilitation

Problems

- There are an increasing number of people surviving cancer for longer periods of time, but with, sometimes, complex and chronic health needs acquired as the result of the consequences of cancer and associated treatments.
- Existing oncology and palliative care services are not set up to meet this need.
- There are limited dedicated allied health professionals who are involved with the care of people living with cancer.
- As well as poorer longer-term health outcomes, cancer survivors currently have reduced rates of return to employment.

Solutions

- That existing inpatient and outpatient neurorehabilitation services commit to meeting the needs of patients with impairments secondary to cancer or its treatment where it is clinically appropriate to do so rather than solely on the basis of diagnostic category. This already occurs in NHS Lothian with comparable outcomes between patients with and without cancer diagnoses.
- That Rehabilitation Medicine physicians work with oncology and palliative care services to meet the needs of cancer survivors with complex needs regardless of aetiology within local networks by becoming involved with oncology MDTs or through an inreach service or a similar model. Such a model is currently active in Manchester (neuro-oncology MDT).
- That rehabilitation medicine physicians become involved with cancer alliances and third sector organisations to provide a strategic and appropriate plan for the assessment and management of people with complex needs who have been treated for cancer.
- That vocational rehabilitation services are available to cancer survivors with complex needs where a return to employment or employment-related-activity is a realistic goal.
- That Rehabilitation Medicine physicians involve appropriate AHPs and equipment services to form a needs-based MDT to meet the complex needs of cancer survivors in an expedient and equitable manner.

Recommendations for the Role of Rehabilitation Medicine in Cancer Rehabilitation?

- That existing specialist rehabilitation services do not exclude patients with a diagnosis of cancer purely on the basis of diagnostic category.
- That cancer networks involve Rehabilitation Medicine physicians in the management of patients with complex needs both within prehabilitation and post-treatment rehabilitation.
- That rehabilitation physicians are involved with oncology multidisciplinary meetings in order to improve patient outcomes.
- That vocational rehabilitation services are equipped to meet the needs of cancer survivors with complex vocational requirements.

- That specialists in Rehabilitation Medicine work with different teams towards a common goal of developing a biopsychosocial model of care utilising holistic approaches with a focus on enablement and putting patients' goals at the heart of care delivery.

Implications for implementation

Training needs

Many of the skills of Rehabilitation Medicine are transferrable to the meeting the complex needs of patients surviving cancer through a goal-based MDT approach. Focussed attachments to palliative care services, completion of learning modules and attendance at tailored short course could provide the appropriate knowledge of different symptom management approaches in oncology. Exposure to basic cancer treatment strategies and pathways may be garnered through attendance at existing oncology MDTs.

Commissioning pathways and service models for Cancer Rehabilitation

Modelling as to the impact on existing rehabilitation services taking on the needs of cancer survivors with appropriate consideration given to medical oversight and AHP/nursing skill mix are needed. There are mechanisms in place through UKROC for inpatient services to capture this complexity and therefore plan appropriate levels of staffing and experience.

It is unlikely that standalone clinical jobs for physicians in cancer rehabilitation are sustainable or appropriate and it would be more clinically and logistically realistic to look at expanding existing roles within local networks. This would ideally involve modifications to job plans incorporating programmed activities inreaching to inpatient oncology and palliative care services as well as involvement with existing MDTs that are involved in the care and treatment planning of patients with cancer¹⁷. As for palliative care in many parts of the country, this may involve 3rd sector or charitable elements to a funding model.

Vocational rehabilitation services are being developed for different diagnostic groups and a parallel service for cancer survivors with vocational needs could be developed within this context.

BSRM Core standards for Cancer Rehabilitation

1. Standards / recommendations – Service Development		Grade of evidence	Strength of recommendation
1.1	Patients who develop functional or cognitive impairments or symptoms (including issues around communication, continence, swallowing and fatigue) as a consequence of cancer or the treatment of cancer should have access to a specialist in rehabilitation medicine who can initiate or refer for appropriate ongoing treatment strategies	RC	Strong
1.2	Cancer alliances involved in the oversight of delivery of services should involve specialists in Rehabilitation Medicine in designing and maintaining appropriate services to meet the longer-term needs of cancer survivors	RC	Strong
1.3	Rehabilitation services should work with local oncology and palliative care services to identify and develop opportunities for joint governance and training opportunities	RC	Strong
2. Standards / recommendations – Service Provision			
2.1	Existing specialist rehabilitation services should have explicit criteria for involvement with patients who develop functional impairment or symptoms as a consequence of cancer or the treatment of cancer where this is clinically appropriate	RC	Strong
2.2	Existing specialist vocational rehabilitation services should have explicit criteria for involvement with patients who develop functional or cognitive impairment or symptoms as a consequence of cancer or the treatment of cancer where this is clinically appropriate	RC	Strong

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