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Original Article

Physiotherapy and Physical Activity: A cross-sectional survey exploring physical activity promotion, knowledge of physical activity guidelines and the physical activity habits of UK physiotherapists.

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ABSTRACT

Objective

Physical inactivity is a public health priority and embedding promotion of physical activity (PA) within healthcare systems is an important lever for change. Many factors influence PA promotion in routine healthcare practice, these include the PA habits of healthcare professionals and also their knowledge of the PA guidelines. Little is known about the extent to which PA is currently promoted in physiotherapy practice or the factors that influence it.

Methods

Following ethical approval a cross-sectional survey of UK physiotherapists was conducted. Findings were analysed and reported in accordance with STROBE guidelines.

Results

There were 522 respondents, 514 of whom were physiotherapists. Seventy seven percent of respondents routinely discussed PA with patients and 68% routinely delivered Brief Interventions. Assessment of PA status was not routine practice neither was signposting to further sources of PA support. Only 16% of respondents correctly answered questions about the content of the PA guidelines. Only 38% of respondents met current PA recommendations. Clinicians' PA levels were not associated with PA promotion activity.

Conclusion

Despite the promising finding that some form of PA promotion is integrated into most respondents' practice, we report a poor understanding of Brief Interventions and poor knowledge of the PA guidelines. Additionally, the majority of respondents were not sufficiently active to meet current PA recommendations.

TEXT BOX 1: What are the new findings?

In this study;

1. Discussions about PA were integrated into the majority of physiotherapy contacts.
2. Brief Interventions may not be carried out optimally;
 - PA status of patients was not routinely assessed.
 - Although 60% of physiotherapists knew that 150 minutes of moderate PA per week is recommended, only 16% of physiotherapists successfully answered all 3 questions relating to the PA guidelines.
 - Physiotherapists did not routinely signpost to further sources of PA support.
3. The majority of physiotherapists were not sufficiently active to meet the current PA guideline for adults.

TEXT BOX 2: How might it impact on clinical practice in the near future?

To maximise the potential impact of physiotherapy on physical inactivity we recommend:

- Further efforts to disseminate the current PA guidelines.
- Targeted knowledge translation of Brief Interventions for PA in a physiotherapy context.

BACKGROUND

Physical inactivity, defined as achieving less than 30 minutes physical activity per week¹, has a significant impact on morbidity and mortality which leads to economic burden on healthcare systems and wider society.^{2,3} Inactive people spend 38% more days in hospital and use significantly more healthcare resources than active people.⁴ Accordingly, there is national and international guidance on how physical activity (PA) can be promoted.⁵⁻⁷

Many factors influence PA at population level and meaningful change requires sustained efforts across multiple systems.⁸ Healthcare is one such system and integrating PA promotion into healthcare is one of the seven "best investments" for reducing PI.⁹

Every healthcare contact is an opportunity to positively influence a patient's health and this is often done pragmatically, through Brief Interventions. Brief Interventions for physical activity can be delivered in routine health care consultations, they have the potential to reach a large proportion of the adult population and have been shown to be cost effective.^{10,11} Clinical guidance recommends the use of Brief Interventions in routine clinical contacts and this forms part of a wider Making Every Contact Count approach which is now embedded within National Health Service (NHS) delivery in the UK.^{12,13}

Physiotherapists are well-placed to promote PA. There are over 51,000 physiotherapists registered in the UK working across health and social care, often supporting people with long term conditions.¹⁴ In 2015-16 there were over 5 million physiotherapy outpatient contacts;¹⁵ a large proportion of patients accessing outpatient physiotherapy services are either overweight or obese, have multiple comorbid health conditions and are physically inactive.¹⁶

Little is known about the extent to which PA promotion is currently integrated into physiotherapy practice. Several studies suggest that levels of PA promotion in physiotherapy practice are low.¹⁷⁻²¹ One study from Republic of Ireland presented more positive findings²² and we identified no UK studies in a 2016 scoping review.²³

Delivering Brief Interventions for PA requires healthcare professionals to have knowledge of PA guidelines. Specifically, healthcare professionals must ascertain whether a patient is in a risk category and know how to make evidence based recommendations. The first UK-wide PA Guidelines were published in 2011;⁵ these were updated and formatted into an infographic in 2015.²⁴

Previous studies suggest PA guidelines are insufficiently taught in undergraduate medical curricula and there is lack of knowledge of them among final year medical students.²⁵⁻²⁷ A survey of physiotherapists in the Republic of Ireland reported that

only 51% of participants were able to accurately state the current PA guidelines.¹⁷ No studies have been identified that explore knowledge of PA guidelines amongst UK physiotherapists.

A healthy and productive NHS workforce is critical to the sustainability of the NHS and PA is an important means of improving workforce health.²⁸ NHS organisations are encouraged to support employees to be more physically active^{29,30} yet little is known about the PA habits of the physiotherapy workforce. In addition, PA habits are a consistent and independent correlate of PA promotion in other healthcare professions.³¹ There is preliminary evidence that this relationship also extends to physiotherapists,^{18,21,32} but this has not been explored in the UK.

Hence, the aim of this study was to explore PA promotion in routine physiotherapy practice in the UK. Specific objectives were to;

1. Understand the frequency with which physiotherapists;
 - (i) initiate conversations about PA,
 - (ii) formally assess PA status,
 - (iii) deliver Brief Interventions for PA,
 - (iv) signpost patients to other PA services.
2. Assess physiotherapists' knowledge of the PA guidelines.
3. Measure the PA habits of physiotherapists and evaluate whether this is associated with PA promotion in clinical practice.

METHODS

Ethics

Ethical approval was granted from the Health & Wellbeing Faculty Ethics Committee at Sheffield Hallam University (reference 2015-16/HWB-HSC-21). The approval was for a broader survey of allied health professionals' engagement with public health practice. The specific PA questions were included with prior consent of all parties with the intention of separate analysis and publication.

Design

A cross-sectional, survey was undertaken.

Survey Tool

A survey tool was developed using Survey Monkey software. Following a pilot (48 physiotherapists), a small number of minor changes were made to the wording of questions. All questions were closed with finite answer options; this was agreed in view of the anticipated volume of responses (survey questions can be seen in supplementary file 1). The questions were designed specifically for this survey with

the exception of measurement of clinicians' PA habits; a validated, single-item question was used to gather this information.³³ The full survey was approved by representatives from Public Health England and the Chartered Society of Physiotherapy.

Procedure

The survey was live in May 2016 and was available for 3 weeks; this was determined by the need to avoid periods of political sensitivity. The survey was promoted widely on social media and through the Chartered Society of Physiotherapy's member networks. To meet the eligibility criteria respondents were asked to confirm that they were physiotherapists in the UK and had current patient contact.

Analysis

All returned surveys were included in the analysis regardless of missing data; consequently, the number of total responses for each survey item is varied. A decision was made to include the pilot data in analysis as only minor changes had been made to the survey following the pilot. All responses were exported into IBM SPSS v24 and analysed using descriptive statistics. Associations between variables were assessed using chi-squared test.

Reporting is in line with the STrengthening the Reporting of OBservational studies in Epidemiology (STROBE) statement for cross-sectional studies.³⁴

FINDINGS

Participant Characteristics

There were 522 responses to the survey; the physiotherapy population is estimated to be 51,000¹⁴, the sample is therefore approximately 1% of the estimated population.

Eighty nine percent (n=463) of the sample were qualified physiotherapists, 10% (n=51) were student physiotherapists and 1.5% (n=8) were support workers. Ninety three percent were from England and all 4 nations were represented (Scotland 3%, Wales 3% and Northern Ireland 1%).

Respondents reported a range of years of experience (see Figure 1). The majority of respondents worked in the NHS (92%) and respondents worked across a range of settings (see Figure 2).

Figure 1: Years of Experience of Survey Respondents.

Figure 2: Healthcare Setting in which Respondents Work.

Only findings from qualified physiotherapists and student physiotherapists are reported hereafter, they are reported together as "physiotherapists" in line with the aims of the study. Full results are available in supplementary file 2.

Current Practice

Participants were asked to estimate the frequency with which they carried out a number of specific actions related to PA promotion in pre-defined categories in line with previous similar cross-sectional surveys.²² The questions were worded such that it was clear that the question related to situations in which there was a *clear* indication to promote PA. Findings are presented in Table 1.

Table 1. Frequency with which Respondents act on Physical Inactivity when there is a clear indication to do so.

	Never		Sometimes		Usually		Always	
	Count	%	Count	%	Count	%	Count	%
Do you initiate conversations about PA?	0	0%	11	2.4%	95	21%	347	76.6%
Do you assess PA status?	96	21.2%	63	14%	113	24.9%	181	40%
Do you deliver brief interventions for PA?	13	2.9%	26	5.7%	106	23.4%	308	68%
Do you signpost to other PA support?	18	4%	83	18.3%	152	33.6%	200	44.2%

Knowledge of Physical Activity Guidelines

Eighty eight percent of respondents (n=382) reported that they were aware of the existence of PA guidelines. Knowledge of 3 specific aspects of the recommendations is detailed in Table 2. Only 16% (n=83) of respondents answered all 3 questions correctly.

Table 2. Table showing correct answers to PAG questions.

PAG Questions	Number of correct responses	Percentage of respondents who answered correctly
Q: How many minutes of moderate intensity	240	60%

physical activity is recommended per week for adults? A: 150		
Q: How many minutes of vigorous intensity physical activity is recommended per week for adults? A: 75	122	33%
Q: On how many days per week is it recommended that adults undertake strength training? A: 2	121	32%

Physical Activity Habits of Physiotherapists

The median number of sufficiently active days (that is, days on which respondents achieved at least 30 minutes of moderate PA³³) was 4. The proportion of respondents who achieved the recommended 5x 30 minutes of moderate intensity PA over a week was 38% (n=149).

The frequency with which respondents delivered Brief Interventions was not associated with years of experience (chi squared p=0.429) nor was it associated with physiotherapists' own PA habits (chi squared p=0.078).

DISCUSSION

The vast majority of respondents integrated some form of discussion about PA with their patients. However, levels of PA are not routinely assessed and Brief Interventions are not routinely delivered. Knowledge of all 3 elements of the PA Guidelines is poor and therefore when Brief Interventions *are* delivered they may not be based on the best available evidence. The majority of respondents do not themselves do sufficient PA to confer optimal health benefits although this was not associated with the likelihood of them promoting PA in practice.

How does this fit with Previous Research?

There is no existing evidence on the extent to which PA promotion is integrated into physiotherapy practice in the UK. As physiotherapists in other countries provide even lower levels of PA promotion,¹⁷⁻²¹ our findings may reflect the growing awareness of PA as a major public health issue in the UK over time.

We find it encouraging that 68% of respondents report routinely delivering Brief Interventions for PA. This does, however raise questions about why the other 32%

do not. Barriers to delivering Brief Interventions for PA in a UK physiotherapy context have not been explored; related literature suggests that barriers may include (i) lack of time, (ii) lack of belief in the effectiveness of brief interventions, (iii) perceived lack of knowledge, and (iv) a sense that it is not acceptable to patients.^{21,22,35,36}

Only 40% of respondents reported that they routinely used some form of measurement tool to assess patients' levels of PA and thus identify inactive patients, inline with earlier findings.¹⁷ Conversely, O'Donoghue et al (2014) found that 76% of physiotherapists always assessed PA levels.²² The discrepancy between these studies may relate to the definition of "assessment"; this term could be interpreted as use of either a formal or informal approach to assessment.

Formal assessment would involve use of a measurement tool; current clinical guidance recommends the use of the General Practice Physical Activity Questionnaire to assess physical activity levels in routine practice.^{37,38} However, such measures take time to complete and interpret and therefore may not be practical in a busy clinical setting.

The alternative is to use informal approaches which although quicker, are likely to be insufficient to accurately measure PA levels and inadequate as a baseline from which to measure change. Some may argue that formal assessment is unnecessary and beyond the scope of routine practice, however delivering Brief Interventions indiscriminately regardless of risk has cost implications for services that could be avoided with a more targeted approach.³⁹

As many as 56% of respondents did not routinely direct patients to further sources of support for PA, even when there was a clear indication to do so. In other areas of health promotion, uptake of further support has been shown to be enhanced when onwards referral is facilitated by the system following a Brief Intervention, for example, by making a forward referral at that time, rather than leaving it to patients to initiate further action themselves.^{40,41}

Despite 88% of respondents being aware of the current Chief Medical Officers' PA guidelines only 16% answered the 3 specific questions correctly. This extends evidence from other professions which highlighted a lack of curriculum content and a lack of knowledge among students.²⁵⁻²⁷ It adds weight to the recent assertion by Reid et al (2017) that that basic knowledge of the PA guidelines, and their components, remains consistently low across health professionals.⁴²

Only 38% of respondents achieved the recommended 5x30mins of moderate PA. This finding must be interpreted with caution due to the limitations inherent with any single-item, self-report measure.^{43,44} The measure used in this study excludes the incidental PA that occurs through occupation or housework for example. It therefore does not reflect the most recent iteration of the PA guidelines which promote the accumulation of 150 minutes moderate PA in bouts of 10 minutes or more through

any means.⁵ In contrast to findings from other studies, physiotherapists' own PA levels were not associated with their PA promotion activity in our study.^{18,21,32}

Suggestions for Enhancing Clinical Practice

Knowledge of all 3 elements of the PA guidelines is limited and this raises questions about the content, quality and specificity of the Brief Interventions that are delivered in clinical practice. Additionally, assessment of PA status and signposting could be considered to be integral components of a Brief Intervention yet these were delivered far less frequently. In practice, despite the number of PA measurement tools available it is difficult to identify a tool that is sufficiently rigorous yet retains clinical utility in a physiotherapy setting. Consensus on the level of assessment of PA status that is appropriate and feasible may help improve the consistency of practice in this area. It may require a physiotherapy led consensus statement on PA Brief Interventions to resonate more fully with the physiotherapy community than one led by physicians or public health experts.

The expectation that physiotherapists will signpost patients to further sources of PA support requires more investigation and mechanisms that could facilitate the sharing of PA information across sectors need to be explored.

Physiotherapists' understanding of Brief Interventions warrants further exploration as do the barriers to delivering them in the context of UK physiotherapy practice. In addition, further work is required to explore why the Guideline specifics of training intensity and strength training are not reaching frontline clinicians. Effective dissemination of this information is required across the future and current physiotherapy workforce.

The majority of respondents to this survey were insufficiently active to have a clear health benefit. The physical activity levels of the NHS workforce are an important consideration as part of a broader workforce wellbeing agenda. Thus further investigation of the PA levels of the physiotherapy workforce, using more robust, direct measurement techniques is warranted.

Strengths and Limitations

This is the first cross-sectional survey that explores current practice in relation to PA promotion in physiotherapy practice, knowledge of PA guidelines and PA habits of physiotherapists. It has generated a preliminary picture which can inform practice developments and future research.

The UK PA guidelines contain several important messages and not all of these were tested. There are also specific PA guidelines for early years, children and older adults; only the adult guidelines were considered in this study.

The non-probability (self-selected) sampling strategy means that care must be taken when interpreting findings. The survey may have been subject to self-selection bias, with engaged physiotherapists responding more readily than those who do not have an interest in this area. This could have led to an over representation of the extent to which PA is currently promoted for example. However, in addition to budget constraints, it would be challenging to obtain a national random sample of UK physiotherapists due to a lack of availability of essential demographic data, and thus an inability to define the population.

CONCLUSION

We identified positive findings in that *most* respondents integrate discussions about PA into *most* of their patient contacts. Further investigation is needed relating to the lack of formal assessment of PA status, relatively poor knowledge of specific elements of the PA Guidelines and a lack of consistent signposting to further PA support. Physiotherapists are ideally placed to contribute to the global efforts to reduce inactivity.

COMPETING INTERESTS

None

CONTRIBUTORSHIP

This study was lead by Anna Lowe under the supervision of Dr Siannadh McLean and Dr Chris Littlewood. Dr Karen Kilner contributed to the data analysis and interpretation. All members of the team were active in preparing and revising the manuscript.

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ETHICAL APPROVAL

Ethical Approval was granted by Sheffield Hallam University, Faculty of Health & Wellbeing Ethics Committee.

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