Everybody Active, Every Day
Chartered Society of Physiotherapy
Consultation response

To: Public Health England (PHE)

By email: physicalactivity@phe.gov.uk

The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the UK's 52,000 chartered physiotherapists, physiotherapy students and support workers.

The CSP welcomes the opportunity to respond to the consultation on 'Everybody Active, Every Day'.

Our response is focussed on the areas in which we feel we can most effectively contribute to the debate. We would be pleased to supply additional information on any of the points raised in our response at a later stage.

The contribution of physiotherapy

Physiotherapy enables people to move and function as well as they can, maximising quality of life, physical and mental health and well-being. With a focus on quality and productivity, it puts meeting patient and population needs, and optimising clinical outcomes and the patient experience, at the centre of all it does.

As an adaptable, engaged workforce, physiotherapists have the skills to address healthcare priorities, meet individual needs, and to develop and deliver integrated services in clinically and cost-effective ways.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists work with children, those of working age and older people; across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self management and promote independence, and help prevent episodes of ill health and disability developing into chronic conditions. Physiotherapy supports people across a wide range of areas including musculoskeletal disorders (MSD); many long-term conditions, such as stroke, MS and Parkinson's disease; cardiac and respiratory rehabilitation; children's disabilities; cancer; women's health; continence; mental health; falls prevention.

Physiotherapy delivers high-quality, innovative services in accessible, responsive, timely ways. It is founded on an increasingly strong evidence base, an evolving scope of practice, clinical leadership and person-centred professionalism.

General Comments

The CSP welcomes the introduction of this document and fully supports the case for greater emphasis on physical activity and an evidenced based implementation framework to ensure services and resources are appropriately and effectively allocated.

1. Is there recently published evidence not included in the documents that should be?

Additional evidence has been reported to us by expert CSP members, therefore if you would like further details/clarification, please get in touch with us, and we can arrange for this to be collated;

1.1 It would be helpful for the document to provide more physiological evidence for how exercise and physical activity can improve cardiovascular disease (CVD), cancer, mental health and wellbeing. There is available evidence that exercise profoundly impacts on mental health, secondary to the anxiolytic nature of exercise.

1.2 The document highlights the social benefits of physical activity and there is available evidence to support improved social inclusion and peer support to sustain service users in a course of planned exercise. This may be through 'buddying programmes' or 'planned lead walks' for example.

1.3 In the 'Quick Snapshot' on page 9, no mention is made of CVDs, which are consistently identified as leading causes of mortality and morbidity and are priorities for PHE. Primary and secondary risk studies for CVD could therefore be referenced.

2. Are there any additional actions that PHE, as a system leader, could enable to support you and your organisation to implement Everybody Active, Every Day?

2.1 It may be helpful when describing 'one-to-one interventions' to include case studies of best practice, in order to inform others how this can be achieved.

2.2 There could be greater promotion of 'Exercise on Referral schemes' as a safe way in which to support those with medical conditions to become more active. Furthermore, embedding behavioural change within these schemes may lead to an improvement in current outcomes.

2.3 When discussing adequate training for healthcare providers, it is equally important to acknowledge that necessary resources are allocated to ensure optimal patient benefit.

2.4 It would be beneficial to place greater emphasis on person-centered, attainable goals. A guideline stating 30-minutes of sustained exercise without further explanation may put off those who lack confidence or have other barriers to exercise.

2.5 Key groups, for example people with learning difficulties, mental health conditions, older people and physical functional impairment, with significantly reduced life expectancy related to life style choices, inherent diagnoses and lack of social inclusion, could be more clearly identified, as these are the groups who can benefit most from a multi-factorial approach to physical activity.

2.6 These groups need to have more targeted support to ensure that;

2.6.1 The environment adaptation is appropriate to need

2.6.2 There are screening processes in place to ensure that people do not end up with injuries secondary to the underlying vulnerabilities inherent in these groups, such as degenerative joint disease, biomechanical anomalies related to posture, gait and balance.

2.6.3 There is support available to help people who are anxious about starting physical activity. For example, encouraging social network connections to accompany people and help initiate relationships with staff in centres that can supervise and support the vulnerable groups in persisting with their course of health improvement.

2.6.4 Outcome data from Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) suggests an increased uptake and longevity in a physical activity programme with a 'buddying support' element to the programme.

2.7 These vulnerable groups are especially harder to engage in physical activity, when activities of daily living are already a struggle and challenge. Additional 1:1 support is required to enable engagement and reassurance/support.

2.8 Practicalities need to be addressed and highlighted. There are simple ways to increase physical activity which do not require additional resources, such as the following:

2.8.1 Getting off the bus a stop earlier than needed

2.8.2 Using the stairs instead of lifts

2.9 It will be beneficial to acknowledge that pain may be a barrier to sustaining a programme of increased physical activity. Secondary to the patho-physiology, there is an inherently lower threshold and greater likely hood of inflammatory conditions (increased cytokines, secondary to chronic stress) in certain groups. These groups need to have an effective route to access neuro-musculoskeletal pathways of treatment to encourage persistence. Further consideration is needed to adapt the programmes to accommodate underlying vulnerabilities, review alternatives or develop strategies to protect from further injury. Rapid access to treatment will enable people to feel safe as they develop their cardiovascular endurance and conditioning. Pain untreated can cause secondary problems but more seriously can significantly reduce their functional ability to do their activities of daily living. For some people in the general population, with underlying conditions such spinal disc pathology or inflammatory arthritis conditions, will need further tailoring of their programmes, which will ensure the underlying conditions are not exacerbated. Physiotherapists have the expert knowledge and skills to be able to manage this population.

2.10 Greater emphasis should be given on the benefits of exercise to support people in smoking cessation. It would be beneficial l to link the smoking cessation campaign messages with the physical activity advice.

2.11 Little specific detail is provided on how expertise and leadership will be developed in Allied Health Professionals (AHPs). It would be beneficial to acknowledge the importance of expertise in exercise and physical activity, which many physiotherapists have and can provide.

3. Is there any additional information or guidance that might support on-going work to embed sustained action to address physical activity?

3.1 It is important to consider the barriers to physical activity and exercise for those with pre-existing conditions or disabilities. This group of people requires appropriate professional support from health-professionals when embarking on physical activity or exercise. Healthcare professionals, including physiotherapists, are experts in this area. Being able to assess a person's exercise capacity, taking into consideration their health problems, is vital when enabling them to become physically active. By using behaviour change, motivational interviewing techniques and expert patho-physiolological knowledge, physiotherapists can help people break down barriers, allay their fears, and support them to exercise safely and effectively.

3.2 Public Health often concentrates (rightly) on prevention – but there is little mention of secondary prevention (except some involvement of the National Centre for Sports and Exercise Medicine p21). This is an area where AHPs are extremely active and possess expertise. For example, physiotherapists routinely utilise exercise interventions and behavioural change into general rehabilitation treatments following diagnosis or episodes of acute care for many diseases.

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Yours sincerely,

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The Chartered Society of Physiotherapy
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For further information on anything contained in this response or any aspect of the Chartered Society of Physiotherapy's work, please contact:

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