Identifying priorities for physiotherapy research in the UK : The James Lind Alliance Physiotherapy Priority Setting Partnership

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2 **Identifying Priorities for Physiotherapy Research in the UK: the James Lind Alliance Physiotherapy**

3 **Priority Setting Partnership**

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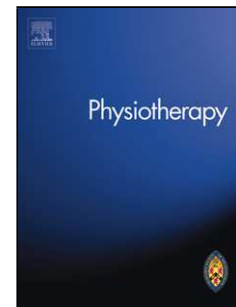
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54   facilitators in the final prioritisation workshop.

55

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57   their time and enthusiasm.

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79   **ABSTRACT**

80   **Objectives:**

81   To identify unanswered questions for physiotherapy research and help set and prioritise the top 10

82   generic research priorities for the UK physiotherapy profession; updating previous clinical condition-

83   specific priorities to include patient and carer perspectives, and reflect changes in physiotherapy

84   practice, service provision and new technologies.

85

86   **Design:**

87   The James Lind Alliance (JLA) Priority Setting Partnership (PSP) methodology was adopted, utilising

88   evidence review, survey and consensus methods.

89

90   **Participants:**

91   Anyone with experience and/or an interest in UK physiotherapy: patients, carers, members of the

92   public, physiotherapists, student physiotherapists, other healthcare professionals, researchers,

93   educators, service providers, commissioners and policy makers.

94

95   **Results:**

96   Five hundred and ten respondents (50% patients, carers or members of the public) identified 2152

97   questions (termed "uncertainties"). Sixty-five indicative questions were developed from the

98   uncertainties using peer reviewed thematic analysis. These were ranked in a second national survey

99   (1,020 responses (62% were complete)). The top 25 questions were reviewed in a final prioritisation

100   workshop using an adapted nominal group technique. The top 10 research priorities focused on

101   optimisation (top priority); access; effectiveness; patient and carer knowledge, experiences, needs

102   and expectations; supporting patient engagement and self-management; diagnosis and prediction.

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104 **Conclusions:**

105 This study is currently the UK's most inclusive consultation exercise to identify patients'and

106 healthcare professionals'priorities for physiotherapy research. The exercise deliberately sought to

107 capture generic issues relevant to all specialisms within physiotherapy. The research priorities

108 identified a range of gaps in existing evidence to inform physiotherapy policy and practice. The

109 results will assist research commissioning bodies and inform funding decisions and strategy.

110 **(Word count 248/ 250)**

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131 **Identifying Priorities for Physiotherapy Research in the UK: the James Lind Alliance Physiotherapy**

132 **Priority Setting Partnership**

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134 **Key messages**

135 • The paper identifies ranked research priorities for physiotherapy research in the UK.

136 • Describes the James Lind Alliance's (JLA) transparent methods and process for priority setting,

137   designed to engage with key stakeholders in physiotherapy research, in particular clinicians,

138   patients, their carers and members of the public.

139 • This is one of the first attempts at profession-wide priority setting using JLA methods. It has a

140   broader scope than previous PSPs, many of which are disease-specific or treatment focused (with

141   some containing specific priorities relevant to physiotherapy).

142 • The study assists in setting the UK physiotherapy research agenda for the medium term and

143   informs funders of stakeholders' opinions, and researchers of the context and wider priorities.

144 • Impact of this approach to priority setting requires evaluation

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146 **Key Words**

147 Physiotherapy, research priorities, co-production, consensus

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149 **Purpose**

150 Physiotherapy, like all healthcare professions, needs to extend and update its evidence base to

151 underpin clinical practice and demonstrate its role and value in contemporary healthcare. This

152 project aimed to identify research priorities for the UK physiotherapy profession that engage

153 research funders and researchers to develop the evidence in areas that matter most to patients,

154 carers and clinicians and that are relevant to healthcare policy. Research priorities for the

155 physiotherapy profession in the UK were last set in 2010[1] . We set out to update these priorities in

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156   order to include views of patients and carers, reflect changes in physiotherapy practice, service

157   provision and new technologies. In contrast to previous priority setting which identified speciality-

158   and condition-specifice priorities, our approach was to analyse all suggested priorities together and

159   investigate the feasibility of identifying priorities relevant to all areas of physiotherapy. The James

160   Lind Alliance (JLA) is a non-profit-making initiative, bringing multiple stakeholders together in Priority

161   Setting Partnerships (PSPs) (2). These partnerships identify and prioritise "uncertainties", or

162   "unanswered questions", about the effects of treatments and areas of healthcare that patients,

163   carers and clinicians agree are the most important. PSPs aim to address what has been described as

164   the mismatch between the treatments that patients and clinicians wish to see evaluated and the

165   treatments being evaluated by researchers (3-5). In 2017 the Chartered Society of Physiotherapy

166   (CSP) engaged with the James Lind Alliance (JLA) to establish a Physiotherapy Priority Setting

167   Partnership (PSP) to identify generic research priorities for the physiotherapy profession in the UK.

168

169   **Objectives**

170   The study had the following objectives:

171   •   To work together with a wide range of stakeholders including clinicians, researchers, patients

172   and carers, funders, educators, support workers, students, service providers, commissioners and

173   policy makers in the UK to identify and agree the most important uncertainties about

174   physiotherapy.

175   •   To agree by consensus with patients, carers and clinicians a ranked list of uncertainties for

176   physiotherapy research, including the top ten uncertainties.

177   •   To publicise the results and process of the PSP.

178   •   To provide the results to research commissioning bodies in a way that helps inform

179   physiotherapy research strategies and funding decisions.

180

181   **Methods**

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182 *Design*

183 The project was managed by a research team at the Chartered Society of Physiotherapy (CSP), the

184 professional body for physiotherapists in the UK and led by a multi-stakeholder steering group. A

185 formal report and appendices are available online (6).

186

187 The study was initiated with an awareness meeting in January 2017 to promote the PSP to key

188 stakeholders, identify steering group members and partner organisations, discuss the scope of the

189 PSP and seek advice for engaging with the community.   The steering group was responsible for

190 agreeing the initial scope of the project, publicising the PSP, overseeing the collection and analysis of

191 the priorities, dissemination of results and taking the final priorities to research funders. A senior JLA

192 adviser (KC) chaired the steering group, advised on methodology and facilitated the final priority-

193 setting workshop.

194

195 Partner organisations provided ongoing support to the PSP by promoting the project, encouraging

196 their members to take part in each stage and disseminating the findings. The PSP was supported by

197 43 partner organisations - 15 universities, 10 CSP professional networks, 8 patient groups, 5 Trusts

198 and commissioning groups, 4 research networks and one policy group (6: page 30).

199

200 The multi-stage JLA methodology 7) was used (Figure 1).   In line with JLAprinciples, patients and

201 carers were involved in the study not only as participants in the surveys and final workshop but also

202 as members of the PSP steering group and as representatives of patient groups. Patients and carers

203 were included in each stage of the study and engaged with decision-making, recruiting patients,

204 reviewing and agreeing indicative questions, ranking of questions and disseminating results.

205

206 **FIGURE 1 – to be inserted approximately at this location**

207 Participants

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208   As the PSP aimed to be inclusive, anyone living in the UK with an interest in physiotherapy was

209   eligible to participate in the identification of uncertainties (Stage 1, Figure 1). Examples included:

210   patients and/or carers who had experienced previous physiotherapy provision, members of the

211   public, patients, carers, clinicians, researchers, research funders, educators, students, service

212   providers, commissioners and policy makers. In line with JLA principles, only patients, carers and

213   clinicians participated in the prioritisation stages (Stages 3 and 4, Figure 1).

214

215   Scope

216   Preliminary discussions and workshops were undertaken amongst lead CSP staff in Practice and

217   Development, Policy and relevant CSP committees in relation to the scope of the project. Early

218   feedback on the scope from the initial awareness meeting informed the Steering Group's discussions

219   on the scope.   A broad scope encompassing physiotherapy for any injury, illness or disability, in any

220   setting for people of all ages was agreed with four key areas of focus - interventions, self-

221   management, prevention and service delivery

222

223   The 4 stages are outlined below (see Figure 1):

224

225   **Stage 1**

226   *Literature searches to identify uncertainties*

227   As part of the scoping for the project, literature searches for two policy themes identified by the

228   steering group as being relevant were undertaken (by RS) – search strategies are available in the PSP

229   online report(6: appendices 1 and 2):

230   i.   Developing and sharing models of good practice for reducing the burden on secondary care.

231   ii.   Promoting good practice in primary care for people with multiple morbidities.

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233   *Initial Survey*

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234   The online questionnaire was developed in SurveyMonkey™ and piloted by the steering group. The

235   survey was open from May to July 2017. The questionnaire (available (8)) took approximately 15

236   minutes to complete, and was also available as a paper version. Four questions in relation to the

237   areas of focus within the scope (interventions, self-management, prevention and service delivery)

238   were included:

239   1) "What question(s) do you have about physiotherapy to help people recover and get back to their

240   usual activities?

241   2) "What question(s) do you have about physiotherapy to help people manage their condition(s)

242   themselves?"

243   3) "What question(s) do you have about physiotherapy to help people to improve their health and

244   prevent disease and injury?"

245   4) "What question(s) do you have about how physiotherapy services are accessed and delivered?"

246

247   Questions could relate to any type of physiotherapy service; for any injury, illness, condition or

248   disability; for people of any age. Demographic data was also requested.

249

250   A website was established to advertise the partnership and the online survey. Participants were

251   recruited using convenience and purposive sampling in line with the JLA's inclusive approach (7).

252   The partner organisations, steering group members and in the CSP promoted the survey through a

253   range of advertisements to members in online and paper publications e.g. the professional magazine

254   *Frontline*, social media, through professional and patient networks and in clinical settings.

255   Interim demographic data about participants was provided to the Steering Committee in order to

256   identify any groups that were felt to be under-represented. Targeted strategies were used to reach

257   these groups and encourage participation.

258

259   **Stage 2**

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260   *Data analysis and verification of uncertainties*

261   Survey responses were analysed using Thematic Analysis (9); individual responses were coded with

262   similar codes being grouped together into themes. Indicative questions were created to represent

263   similarly coded responses within the themes. RS acted as primary analyst, coding the questions,

264   creating initial themes and identifying the indicative questions for review. During initial coding and

265   theme development, JW, BON, BF and AL second coded approximately a third of the data to enhance

266   consistency. GR peer reviewed all coded responses, themes and indicative questions. At regular

267   intervals, data coding, theme development and indicative questions were discussed by the steering

268   committee to refine the analysis. The steering group reviewed the indicative questions, to confirm

269   that the final question set reflected the intent of the initial submitted questions.

270

271   Each indicative question was then checked against the existing evidence for physiotherapy. The

272   literature, including Ovid (Pubmed), EBSCO (CINHAL), PEDro, NICE Evidence and Cochrane databases

273   was searched by RS with assistance from the CSP's library and information service. A question was

274   considered to have been addressed if it had been included in a recent (within 5 years) systematic

275   review that concluded there was sufficient evidence to answer the question. Full search strategy

276   details are in the PSP report (6: appendix 3)

277

278   **Stage 3**

279   *Interim Prioritisation*

280   A second national online survey populated with the indicative questions identified from stage 2 was

281   open from November to December 2017. The survey was targeted to eligible participants (patients,

282   carers and clinicians) following the same strategy used to promote the initial survey. In addition,

283   participants from Stage 1 who had indicated they were willing to take part in in this stage were

284   contacted.   Participants were invited to select and then rank their top ten questions. The questions

285   were presented in a random order to each participant to reduce the risk of bias.

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287 *Analysis*

288 The results of the ranking by patients and clinicians were collated, thereby giving equal weighting to

289 clinicians and patients, to form a ranked list of the indicative questions.

290

291 **Stage 4**

292 *Final prioritisation workshop*

293 The top 25 questions from the interim prioritisation were taken forward to a final prioritisation

294 workshop, a consensus meeting held London in February 2018. Thirty participants (15

295 physiotherapists, 12 patients and 3 carers) were recruited through partner organisations and

296 networks to take part.   We aimed to include a diverse group in terms of their professional

297 backgrounds, experience of health conditions, age and representation across the countries in the UK.

298 A small number of steering group members and a representative from the National Institute for

299 Health Research (NIHR) attended as non-participatory observers at the workshop.

300

301 Participants were divided into three equal-sized groups with a mix of physiotherapists, patients and

302 carers. The groups were asked to rank the questions using an adapted nominal group technique (10)

303 and guided discussion facilitated by three independent JLA advisors. The rankings were collated; the

304 groups were then mixed and asked to rank the questions a second time. The aggregate ranking from

305 the small group exercises was then discussed by the whole group to agree the final order of

306 questions including the top ten priorities.

307

308 **Results**

309 **Stage 1 – Identifying uncertainties**

310 A total of 645 responses were submitted, of which 135 did not contain questions and were excluded,

311 Out of the 510 included participants, 174 (34.1%) had received physiotherapy as a patient; 44 (8.6%)

12

312   identified themselves as carers; 36 (7.1%) members of the public with an interest in physiotherapy;

313   19 responses (3.7%) had been completed on behalf of someone else. Two hundred and thirty four

314   (45.9%) identified themselves as physiotherapists working in clinical practice (categories were not

315   mutually exclusive).

316

317   The majority (75%) of respondents were female and the mean age was 47 years (range 9 to 88).

318   Most respondents lived across the UK (England (77%); Northern Ireland (10%); Scotland (5%); Wales

319   (4.5%); Other (3.5%). Respondents described their ethnicity as: White (91%); Asian/Asian British (1%);

320   Black/Black British (1%); Mixed/multiple ethnic groups (0.5%); Chinese or other ethnic group (0.5%)

321   or preferred not to say (4.5%).

322   For full details about respondents see the final report (6: Tables 1-4, pages 16-17)

323

324   The 510 responses contained 2091 uncertainties. No additional uncertainties were identified from

325   the literature searches.

326

327   **Stage 2 – Analysis and Verifying uncertainties**

328   The submitted uncertainties were collated and refined resulting in 2,152 uncertainties. This is

329   because when some of the uncertainties were analysed they were composed of more than one

330   uncertainty.   Of these 2,152 uncertainties, 35 were considered out of scope. Following coding and

331   theming, 15 broad themes emerged. Similarly coded uncertainties were developed into indicative

332   questions producing 65 questions. The mean number of uncertainties underpinning an indicative

333   question was 33 (standard deviation (SD) 48, range 1-255).

334

335   The secondary care search identified systematic reviews relevant for 8 of the indicative questions.

336   Fifteen additional searches were undertaken which identified systematic reviews for a further 33

337   indicative questions (6: appendix 3). All of the systematic reviews showed that uncertainty existed.

13

338   Therefore, 41 of the 65 indicative questions were verified as uncertainties. The remaining 24

339   questions were discussed with the steering group and considered unlikely to have relevant

340   systematic review evidence in their topics. Considering the available literature and the broad scope

341   of each of the questions, the steering group agreed that all of the indicative questions were

342   unanswered.

343

344   **Stage 3 – Interim prioritisation**

345   There were 1,020 responses to the survey, 636 (62%) were complete and could be used in the

346   analyses; participant categories were not mutually exclusive: 490 (77%) identified themselves as

347   physiotherapists working in clinical practice, others as patients (n = 68 (10.7%)), carers (n = 14 (2.2%))

348   and members of the public (n = 6 (1%)).

349

350   Respondents' mean age was 41.9 years (range 17 to 87); most described themselves as female (81%).

351   Respondents lived in England (62%); Northern Ireland (25%); Scotland (7%); Wales (3%); Other (3%)

352   and described their ethnicity as: White (94%); Asian/Asian British (1.7%); Black/Black British (0.2%);

353   Mixed/multiple ethnic groups (1.4%); Chinese or other ethnic group (0.5%) or preferred not to say

354   (2.5%). For full details (6: Table 5 page 19, appendix 4)

355

356   *Ranking of questions*

357   The separate rankings from the patient/carer and clinician groups were weighted equally and

358   combined to form a ranked list of the top 25 uncertainties to take forward to the workshop in Stage

359   4. For the combined list of the 25 priorities taken forward, as well as the ranked list from the patient

360   and clinician groups, see the Physiotherapy PSP final report (6: Table 6 page 20).

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362   **Stage 4 – Final prioritisation**

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363   The final top ten priorities (see Table 1 below) fall within six themes: optimisation of physiotherapy

364   (top ranked question, underpinned by 18 uncertainties); access (three questions); effectiveness

365   (three questions); patient and carer knowledge, experiences, needs and expectations; supporting

366   patient engagement and self-management; diagnosis and prediction. The number of uncertainties

367   underpinning each of the top ten questions ranged from 3 – 255.

368

369   **Table 1 – to be inserted approximately at this location**

370

371   **Discussion**

372   Our study identified a ranked list of uncertainties relating to physiotherapy in the UK that includes

373   the top ten research questions. These uncertainties reflect the ambitious aim of the project to

374   develop priorities for a profession which covers diverse specialisms delivered in multiple settings and

375   potentially serves all groups in society across the life course. In addition, they address the key

376   elements within the scope of interventions, self-management, prevention and service delivery and

377   are relevant for contemporary healthcare and policy in the UK. The themes of the top 3 priorities are

378   optimisation, effectiveness and access.

379

380   With patients, carers and members of the public forming half of the participants in the initial survey

381   and equal weighting being given to them in the priority setting compared to clinicians, the

382   methodology we used allowed patients and the public to contribute to setting the physiotherapy

383   research agenda. The process was carefully monitored and overseen by the steering group

384   consisting of multiple diverse stakeholders with a range of expertise and the independent JLA.   The

385   new priorities reflect moves to improve impact by wider stakeholder engagement, attempts to

386   embed collaborative patient engagement in the coproduction of research ((11, 12) and a shift in

387   thinking away from expert-led research agendas (13).

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15

389 The well-established JLA methodology and philosophy add strength to the resulting top 10. A recent

390 systematic rapid review considered this type of methodology to be "robust, strategic and aimed to

391 promote equity in patient voices" (14).

392

393 Our approach to identifying broad generic priorities differs from the speciality- and condition-

394 focused approach of the previous UK physiotherapy priority setting project (1). A significant strength

395 of this approach was the removal of potential bias from overrepresentation of participants with a

396 specific condition or area of expertise. It also allowed participants to fully engage with all of the

397 priorities. The priorities not only focus on physiotherapy interventions but how services are

398 delivered, self-management and prevention. Importantly, the priorities can be widely adapted and

399 adopted by researchers and interpreted by research commissioners. Another advantage is that

400 generic priorities are less fixed and prescriptive, allowing for the inclusion of new technologies or

401 innovations.

402

403 Further work needs to be undertaken by researchers with relevant stakeholders to develop the

404 priorities into specific research questions. They can be interpreted alongside other condition- and

405 speciality-specific priorities and research recommendations. However, it is also important that

406 researchers address the urgent need for evidence about physiotherapy for people with multiple

407 physical and mental health conditions. Impact of this approach to setting the profession's research

408 priorities requires evaluation in terms of influencing research funding and uptake and development

409 of the priorities by researchers.

410

411 Previous JLA PSP's have typically been single condition- or issue-focused, many including

412 recommendations for research into physiotherapy related to specific conditions, for example, stroke,

413 multiple sclerosis, scoliosis and urinary incontinence (15). More recently, the scope of some PSPs has

414 broadened to include a wide range of conditions (for example, 'multiple conditions in later life'), as

16

415   well as care settings (for example, 'intensive care') (16). The physiotherapy PSP was the first

416   profession specific PSP. Recently, an adult social work PSP has identified their top 10 priorities and

417   an occupational therapy PSP is underway (15).

418

419   The traditional purpose of JLA PSPs is to identify uncertainties about treatment effects. It is apparent

420   from the scope and emerging priorities of more recent PSPs, for example, the palliative and end of

421   life care PSP (15), that, how treatment and care are delivered is also important to patients, carers

422   and clinicians. Expanding the scope of PSPs to encompass service delivery also identifies

423   uncertainties relevant to healthcare policy. The JLA regularly reviews its principles and methodology.

424   The physiotherapy PSP has the broadest scope to date and the methods we used to address the

425   associated challenges is informing discussions about developing JLA approaches (2).

426

427   A limitation of this study is the low response from across the physiotherapy profession (with CSP

428   membership of approximately 57000) despite wide publicity. The exception to this is Northern Irish

429   respondents who demonstrated relatively high levels of engagement. The sampling method used in

430   the last CSP priority setting exercise (1) was fundamentally different to the approach used in the

431   current project and therefore we have no comparative data in relation to our response rate. Further

432   work is needed to understand factors affecting physiotherapists' engagement with research priority

433   setting. However, appropriate representation from all key stakeholder and demographic groups is

434   probably of more relevance than response rate in this type of large population study.

435

436   The proportion of patients, carers and members of the public declined markedly (50% to 14%) in the

437   second survey although this would have been attenuated by the equal weighting given to the

438   clinician and patient groups in the aggregated ranking. Participants in the workshop were selected

439   with a view to gaining broad representation, within the constraints of feasibility and resources.

440

17

441   As a whole the participants predominantly described themselves as White; with males, members of

442   Black, Asian and minority ethnic (BAME) groups and those in young and old age groups being under-

443   represented. The questionnaire was available in a variety of formats to try to improve accessibility

444   e.g. paper-based, Welsh language, but the impact of these on response rates is unclear and may not

445   have accommodated the communication needs of all potential participants e.g. those with visual

446   impairment or without English as their first language. Responses could be made by proxy, and a small

447   number of participants took this option. Targeted strategies used to engage with networks for older

448   and younger participants and BAME groups had limited success.

449

450   Underrepresentation of BAME groups is a recognised limitation of many of the JLA PSPs (2). Effective

451   strategies have been suggested by the Type 2 Diabetes PSP (16). Previous disease-specific PSPs have

452   had some success with enhanced models of engagement with people with complex health needs

453   ("assisted involvement")(17). Further work on identifying and evaluating methodologies to improve

454   engagement and participation among professional groups and populations which are labelled "hard-

455   to-reach" (18,19,20) should be considered. Limited feasibility and resource limitations have been

456   identified as challenges to engagement with all relevant stakeholders (14) and are likely to have

457   played a part in our study. Some models of engagement may be more feasible in PSPs with a

458   narrower scope.

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460

461   Observers in the final workshop noted the subtle realignment of priorities during discussions in each

462   group session which progressively led to agreement on the final ranking of the priorities. This is a key

463   component of the JLA methodology that might be further researched to better understand and

464   potentially enhance the steps in the consensus building process.

465

466   **Conclusion**

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467 This study provides an opportunity for patients and carers, as well as clinicians and other

468 stakeholders, to influence and guide the physiotherapy profession's research agenda in the UK. A

469 focussed approach was used to agree the top ten physiotherapy research priorities out of 65

470 identified uncertainties. Using the JLA's established methods provided a unique perspective on the

471 wide scope of physiotherapy practice in the UK and co-produced a prioritised list of generic research

472 themes that encompass clinical practice, self-management, prevention and service delivery. These

473 are flexible and can be further refined to produce specific research questions that are highly relevant

474 to clinicians and patients. It is important that the impact of this approach to priority setting is

475 evaluated.

476

477 **Implications**

478 The results will directly inform, guide and influence physiotherapy research funding, commissioning

479 and decisions to produce evidence that matters to clinicians and patients. Other professional groups

480 may be interested in our methodological approach to priority setting across a wide scope of practice.

481 Common challenges around maximising engagement and representation of professional groups,

482 patients and public should be tackled in future research.

483 Word count approx. 3,500

484

485 **Conflict of Interest:** The authors disclose no conflicts of interest.

486

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FIGURE 1

Overview of the 4 key stages of the James Lind Alliance methodology as applied to the

Physiotherapy Priority Setting Partnership

Stage 1
- Identifying uncertainties - national online survey and broad literature reviews
- May - July 2017

Stage 2
- Thematic analysis of uncertainties to develop iterative questions
- Literature reiews to verify uncertainties unanswered
- June - October 2017

Stage 3
- Interim prioritisation - national online survey
- Analysis to produce ranked list of indictive questions
- November - December 2017

Stage 4
- Final prioritisation workshop - top 25 questions reviewed
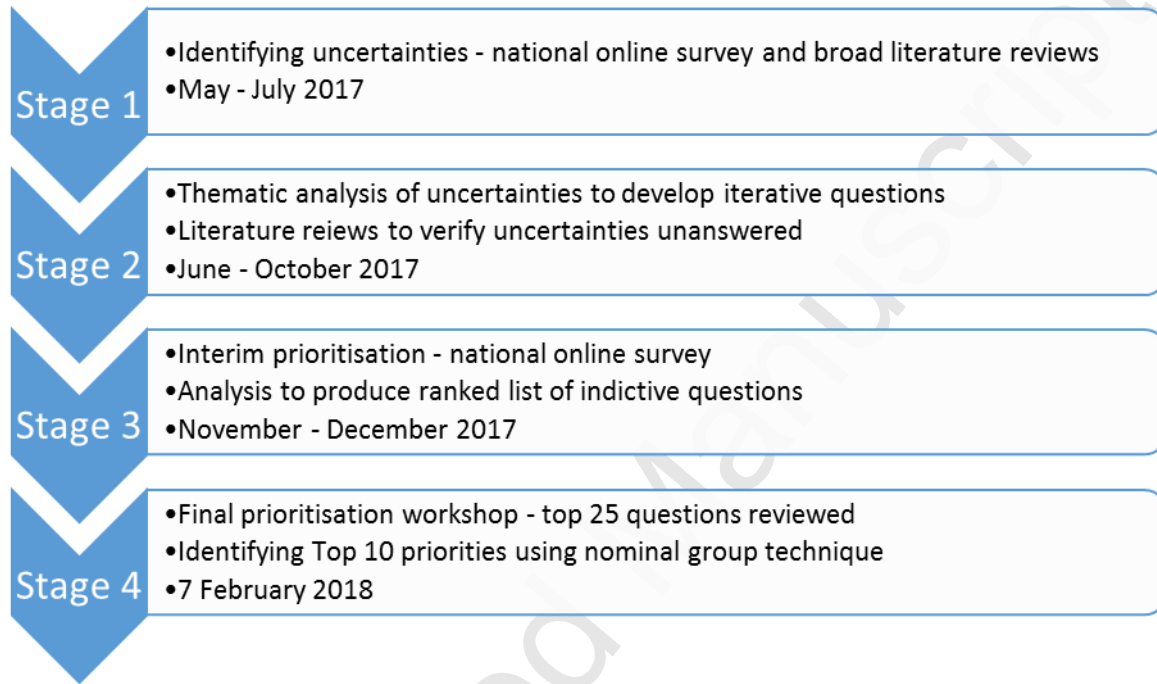- Identifying Top 10 priorities using nominal group technique
- 7 February 2018

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Table 1 Physiotherapy priorities – Top ten priorities after final workshop

Rank	Priorities	Theme	Number of uncertainties
1	When health problems are developing, at what point is physiotherapy most/least effective for improving patient results compared to no physiotherapy? *What factors affect this?*	Optimisation	18
2	When used by physiotherapists, what methods are effective in helping patients to make health changes, engage with treatment, check their progress, or manage their health after discharge?	Effectiveness	190
3	What are the best ways to deliver physiotherapy services to meet patients' needs and improve outcomes for patients and services?	Access	255
4	To stop health problems occurring or worsening, what physiotherapy treatments, advice or approaches are safe and effective? *Where more than one treatment/approach works, which work best and in what dose?*	Effectiveness	34
5	What are patients' expectations regarding recovery, how do these compare to physiotherapists' views and, where recovery is not possible, how is this managed?	Patient & Carer knowledge, experiences, needs and expectations	15
6	How does waiting for physiotherapy affect patient and service outcomes?	Access	17
7	What parts of physiotherapy treatments cause behaviour change or physical improvement?	Effectiveness	3
8	What approaches are effective for enabling parents, relations or carers to support physiotherapy treatment or to help patients to manage their own health problem?	Supporting patient engagement and self-management	24
9	How is patient progress and/or the results of physiotherapy treatment measured? *How is service performance measured and checked?*	Diagnosis and prediction	11
10	How can access to physiotherapy be improved for groups who have reduced access?	Access	22

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