

## Debate & Analysis

# Putting function first:

redesigning the primary care management of long-term conditions

### FUNCTIONAL DECLINE AND LONG-TERM CONDITIONS

Long-term conditions comprise the biggest burden on the NHS, involving more than half of all GP consultations, 65% of out-patient visits, and 70% of inpatient bed days.<sup>1</sup> Their prevalence rises with age, affecting 50% of people by the age of 50 years and 80% by the age of 65 years. As older people accumulate more long-term conditions, they become increasingly frail and are at higher risk of falls, disability, admission to hospital, and the need for long-term care. In order to address this burden, a revolution is needed in their primary care management.

Physical capability, or 'physical functioning', describes an individual's capacity to undertake physical tasks of everyday living. Care and support are needed when a person is no longer able to manage tasks such as washing, dressing, and feeding. Indeed, failure to get to the toilet on time is a frequent reason for admission to residential care.<sup>2</sup> Maintaining physical function is one of the most important factors for quality of life among older adults and a central goal for all people with long-term conditions. Physical inactivity is one of the strongest predictors of physical disability in older people, and physically active people have better levels of physical and psychosocial functioning.

Although normal ageing leads to a decline in physical fitness, this decline is much worse if a person has a sedentary occupation or lifestyle. However, the detrimental effects of prolonged sitting on mortality can be ameliorated by 60–75 minutes of moderate-intensity physical activity per day, such as brisk walking.<sup>3</sup> This is much more than the minimum physical activity recommendation of 30 minutes' moderate-intensity physical activity on 5 days per week, which over half of the UK adult population do not meet. Indeed, a quarter are classified as 'inactive', participating in less than 30 minutes' physical activity per week. There is an inverse association of physical activity with age and with multimorbidity.

So, the drastic decline in physical functioning that many older people experience is not an inevitable part of ageing. The National Institute for Health and Care Excellence (NICE) has issued guidelines for the prevention of frailty, disability, and dementia in mid-life<sup>4</sup> and recommend that

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campaigns should promote the message that: sustained ill health in old age is not inevitable; the risk and severity of dementia, disability, and frailty may be reduced; the earlier in life that healthy changes are made the better; and that health gains can be made by changing behaviours, even in mid-life. How can these recommendations be incorporated into the routine primary care management of long-term conditions?

### PRIMARY CARE ASSESSMENT OF PHYSICAL FUNCTION

The NICE guidelines for the clinical assessment and management of multimorbidity recommend that functional assessments should be used in primary care to assess frailty, including gait speed, the 'Timed Up and Go' test, and self-reported health status.<sup>5</sup> These assessments could form part of the routine management of long-term conditions. However, once those at risk of frailty are identified, how should they be treated?

The variation in physical function that exists among people as they age was acknowledged in the *Start Active, Stay Active* report from the four UK home countries' chief medical officers on physical activity for health.<sup>6</sup> The report described three groups.

- Those who are already active, either through daily walking, an active job, and/or engaging in regular recreational or sporting activity. This group may benefit from increasing their general activity or introducing an additional activity to improve particular aspects of fitness or function, as well as sustaining their current activity levels.
- Those whose function is declining due

to low levels of activity and too much sedentary time, who may have lost muscle strength, or are overweight but otherwise remain reasonably healthy. This group has the most to gain in terms of reversing loss of function and preventing disease.

- Those who are frail or have very low physical or cognitive function, perhaps as a result of chronic disease such as arthritis, dementia, or very old age. This group requires a therapeutic approach (for example, falls prevention programmes), and many will be in residential care.

This report identified primary care as having an important role in promoting physical activity and linking health care with local community-based opportunities. Exercise referral schemes were designed for this purpose. However, the effectiveness of these schemes is limited by low rates of recruitment and retention.<sup>7</sup> Not all eligible patients are offered a referral by their primary care clinician, and others dislike gym-based exercise. The 'Motivate 2 Move' website (<https://gpcpd.walesdeanery.org/index.php/welcome-to-motivate-2-move>) aims to provide health professionals with the tools and information to motivate and educate patients about the health benefits of physical activity, but is difficult to implement with the current pressures on time and workforce in the UK NHS. International examples include the 'Exercise is Medicine' movement in the US,<sup>8</sup> a global health initiative managed by the American College of Sports Medicine that aims to include physical activity when designing treatment plans, including referral to evidence-based

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*“A better way to reduce functional decline [is by] routine assessment of physical function with a patient-centred, tailored intervention ...”*

exercise programmes and qualified exercise professionals. An adaptation of the ‘Chronic Care Model’ from Canada has incorporated routine assessment of physical function as the ‘sixth vital sign’. This builds on other components of the model including: practice organisation; self-management support, which empowers patients to manage their own health; and community resources linking patients to peer support, care coordination, and community-based interventions.<sup>9</sup>

### **THERAPISTS WORKING IN PRIMARY CARE**

Many general medical services previously performed by GPs are being performed by other professions, not only advanced nurse practitioners and pharmacists, but also physiotherapists and occupational therapists.<sup>10</sup> As well as role substitution, the different mix of skills provides an opportunity to add value to patient care. In particular, physiotherapists and occupational therapists place less emphasis on a medical model of illness, which focuses on the diagnosis and categorisation of disease according to the International Classification of Diseases (ICD-10), and more emphasis on a functional approach, using the International Classification of Functioning, Disability and Health.<sup>11</sup> Concentrating on functional limitations, such as whether people can perform activities of daily living, has the potential to improve care for people with long-term conditions by shifting the culture of primary care away from a reactive, disease-focused, fragmented model towards one that is more proactive, ‘whole person’, and preventive.

### **CONCLUSION**

Physical activity benefits physical and psychosocial functioning, with insufficient physical activity levels most apparent in

those with many long-term conditions. Most people with long-term conditions have regular contact with primary care. Primary care interventions to increase physical activity are only used in a limited way in the UK NHS. A better way to reduce functional decline by promoting physical activity, particularly in those with multimorbidity, is needed. Routine assessment of physical function with a patient-centred, tailored intervention might address this. Role substitution of primary healthcare services by non-medical health professionals has been proposed as a cost-effective alternative to GPs. Substitution with physiotherapists and occupational therapists also provides an opportunity for testing different models of care. Stakeholder co-production will be needed to address the challenge of how to incorporate these into the routine primary care management of long-term conditions, weaken the social norms associated with getting older, and strengthen the idea that physical activity and independent functioning go hand in hand.

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