Transforming primary care for today's challenges, looking to the future, and planning for a better tomorrow

Is primary care best equipped to manage today's health challenges let alone looking into the future? Are simply more general practitioners the answer? Can we as a profession have an impact on the social determinants of health that seem to control so many health outcomes? In this article we review the current evidence and explore a primary care network-based initiative that aims to transform primary care for today's challenges, shape it for the future, and plan for a better tomorrow.

Clinical case scenario 1.

Sam is a 42-year-old gentleman who attended his GP due to lower back pain. During his assessment his blood pressure and weight were recorded at 149/97 and 97kg (body mass index (BMI) 34) respectively. Once the history and examination were completed, 10 minutes had passed as the clinician had to address the presenting complaint of lower back pain. The patient was asked to complete 7-days of home blood pressure readings and submit them to the practice. Following which he was diagnosed with his average readings were still high and was diagnosed with stage 1 hypertension. The GP contacted him to explain the diagnosis, the importance of keeping blood pressure low to reduce the risk of complications like strokes and outline the medications that would help to lower the blood pressure. Sam wanted to explain that he was struggling with stress at work currently, and this had led to him becoming more sedentary, eating more fast food, and gaining weight. He was unsure if this could be contributing to the elevated blood pressure, but given the GP did not raise it, he suspects it is unlikely to have had a major impact. The GP decided against highlighting lifestyle options due to a lack of time and did not feel Sam was likely motivated to make a change as he did not seek help in this area. The GP was also worried it would be perceived as blaming the patient for their recent diagnosis.

Primary care is in crisis. With an ever-increasing workload and staffing shortages both waiting times and practitioner burnout is rising (Lawson 2023). The cause of this is multi-factorial: increasing numbers and complexity, a relative fall in funding, an aging population and increasing comorbidity (Baird et al., 2016). This crisis has been further heightened by the COVID-19 pandemic (Jefferson et al., 2022). A major contributing factor is rising non-communicable diseases as a consequence of changing lifestyles (Pinto et al., 2020). Increasingly sedentary behaviour, consumption of calorie-dense ultra-processed foods and several other risk factors are occurring because of industrialisation, urbanisation, population growth and trading in harmful substances (Pinto et al., 2020, Peters et al., 2019, Srour & Touvie 2021). A clear marker of this is the obesity crisis, with 68.6% of men and 59% of women currently overweight or obese in the UK (NHS digital 2022). Obesity, alongside osteopenia/porosis and sarcopenia has been described as a disease triad, termed osteosarcopenic obesity (OSO) as outlined in figure 1 (Ilich et al., 2014). Adipose deposition centrally, as well as in muscles and bone results in reduced bone density and muscles mass (Ilich et al., 2014, Angel 1978).

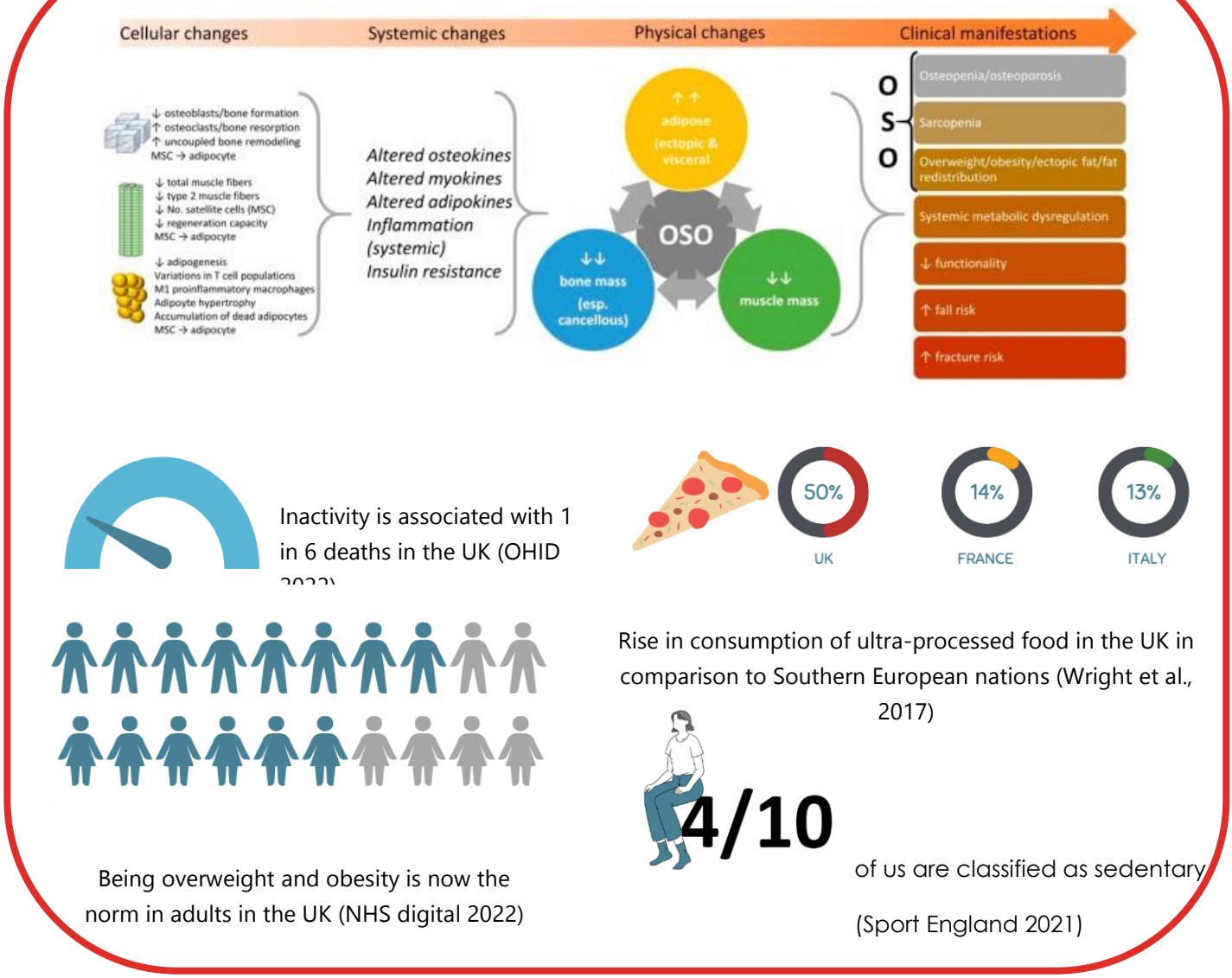

Figure 1. OSO: Cellular changes, systemic changes, physical changes and resultant clinical manifestations and the growing impact of the OSO crisis on our society's health. Source: Kelly et al., 2019, (NHS digital 2022, Sport England 2021, OHID 2022, Wright et al., 2017)

Consequently, this leads to worsened physical and mental health, increased all-cause mortality and notably in our primary care populations increased falls and accelerated aging (Frantzides et al., 2023, Deschenes 2004).

We live in obesogenic environments, with clusters of fast food, tobacco, and alcohol outlets and a lack of healthy food choices, physical activity establishments or green or blue spaces, influencing individual choices. These however are not evenly distributed, with obesogenic factors being more prevalent in areas of social deprivation, correlating with high levels of obesity and multimorbidity (NHS digital 2022).

The current model of primary care is resulting in downstream complications of lifestyle being managed and treated but not prevented. Despite recurrent calls for increasing provision of disease prevention a number of barriers exists: (a) time restrictions and volume of demand, (b) a perceived lack of patient interest, possibly an extension of consultations being driven by patient symptoms rather than preventative health measures, (c) lack of healthcare professional training and confidence and (d) lack of financial provision (Blaine et al., 2020, Leese et al., 2023).

However, with the evolving crisis in primary care, necessity is the mother of ingenuity. The introduction of Primary Care Networks (PCNs) in 2019 offers potential for reimagination of preventative medicine in primary care. The services delivered by PCNs were designed to support the goals of the NHS Long Term Plan (NHS 2019), with the provision of funding for additional roles to create bespoke multi-disciplinary teams (Additional Roles Reimbursement Scheme (ARRS)). Thus, PCNs can employ such roles as social prescribers, health and wellbeing coaches, dieticians, and pharmacists. These roles can bring with them expertise in nutrition, physical activity and behaviour change as well as connections with community physical activity providers which can be used to great effect to implement management of patients through movement.

This article looks to outline a potential model for primary care delivery to help combat the growing issues related to OSO syndrome. It was designed and implemented in the Leamington North and South PCNs and has been running since 2020.

The health empowerment model

The aim of the model is fourfold.

- Provide a more effective platform for clinicians to accomplish patient lifestyle behaviour change through group care and community support.
    - Education on evidenced based lifestyle measures.
    - Develop skills around making habit changes.
- Identify those with the greatest clinical and social need.
- Minimal financial burden to the PCN.
- Increase staff wellbeing and job satisfaction.

Patient identification

Identifying your target population is key. At Leamington PCN we had several different referral options to identify patients with high clinical and social need. Figure 2 illustrates the four main referral pathways into the service.

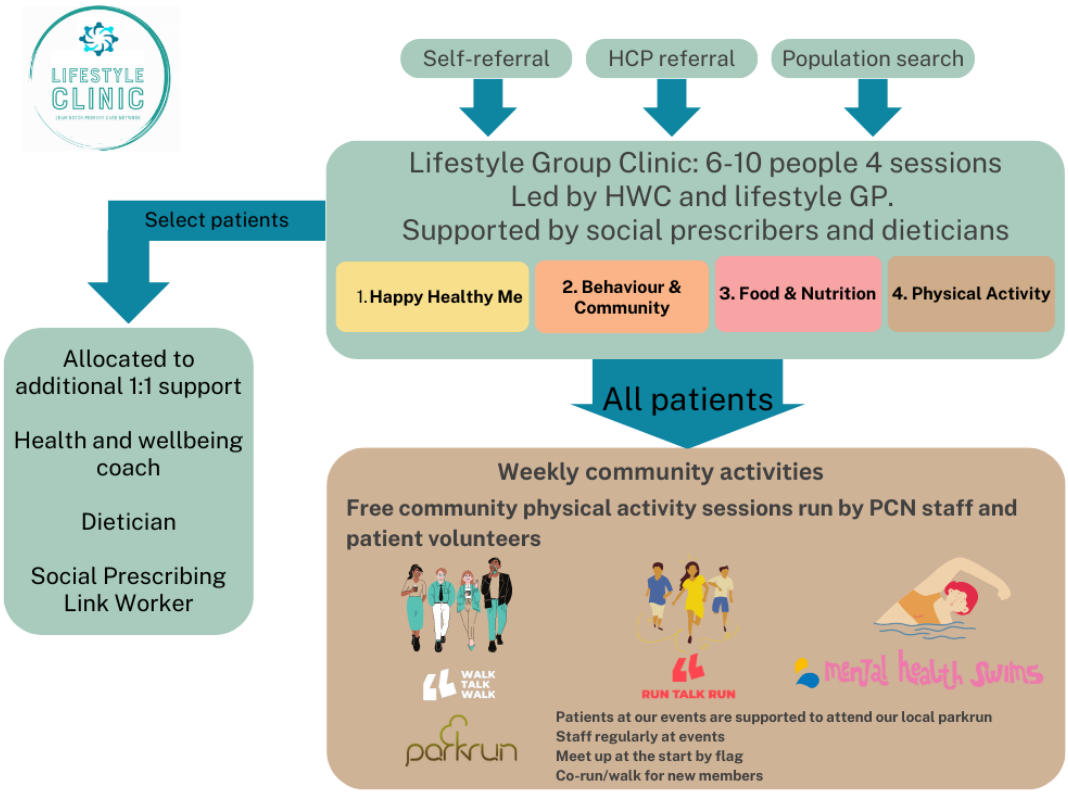

Figure 2. Patient journey through the Leamington PCN lifestyle service.

Self-referral

Self-referral through practice websites helped identify the most motivated and to remove the barrier of patients needing to arrange an appointment before gaining access to the service.

Clinician referral

If a patient is identified from a consultation, lab result or clinic letter they are offered a referral to the service. Attempting to achieve the needed behaviour change into a tight consultation is near impossible, but looking to get the patient to sign up to the lifestyle group clinics is a more achievable task.

Social prescribing referral

Social prescribing referrals are prioritized to identify and support patients from lower socio-economic backgrounds. They are supported to attend the sessions and the content is designed to support lifestyle changes on a very limited budget. Information is provided on how to access food banks, free physical activity providers and community support.

Population search

To further identify patients with the highest clinical and social need, we run searches on our clinical system. A care coordinator or clinician then contacts the patients to discuss the service and gain consent. Approximately 50-60% of patients contacted took up the offer.

An important aspect when signposting patients to any lifestyle intervention whether within primary care, the fitness sector or community groups is to track progress by entering specific

SNOMED codes which can then be searched periodically. There are many potential codes, so agreement must be reached. The Social Prescribing Information Standard was introduced to enable the sharing and recording of information for the whole patient's journey. Having nationally established lifestyle codes embedded through clinical system templates allows staff to easily select relevant codes (Table 1; for extended code list see supplementary file 1).

Activity	Code title	SNOMED CT Identifier (SCTID)
Advice during consultations	Exercises education, guidance, and counseling	410289001
Leaflet/SMS	Patient given written advice on benefits of physical activity	429778002
Walking group	Referral to physical activity program	390893007
Running group	Physical activity target strenuous exercise	408579009
Swim group	Group exercise programme	401167006
Signposted to parkrun	Signposting to community exercise group	1083201000000102
Group lifestyle clinic	Self-help group support	276049006
Individual lifestyle appointment	Lifestyle assessment	443781008

Table 1: Lists the codes used at the Leamington PCN.

Average attendance at the first session was 84% and by the fourth session retention is about 58-81%. Group sizes are between 8-12 and over the last 12 months, we supported over 700 patient contacts across the various lifestyle offerings.

The four-session group clinics

The four group clinics are one hour long and held face to face at a central practice meeting room. They combine education, interactive activities and facilitated discussion.

Session 1: Happy, healthy me (led by GP and health and wellbeing coach)

In session one we spend time discovering who our patients are what matters to them and give them space to outline their health journey and motivations for change. We also outline who we are and look to build confidence and trust. Motivational interviewing techniques are employed to structure the session. A key component is identifying barriers and potential opportunities for behaviour change to shape the upcoming sessions. The structure of the four sessions is outlined and patients are given a workbook with useful information and related content. This includes a 7-day food and mood diary which they return during session two. It is often a very reflective practice for patients and gives them a better appreciation of their behaviour around nutrition.

Session 2: Behaviour, community, and hurdles (led by social prescriber)

In this session, we explore how our behaviours are influenced by our environment and vice versa. Understanding how we think can help us learn to avoid the many pitfalls that result in us straying from a new lifestyle intervention. We discuss the science of behaviour change as outlined in the capability, opportunity, and motivation (COM-B) model (Wilmott et al., 2021) and equip patients with a funded mobile application designed to log identified lifestyle changes and support patients achieve them. We facilitate the group to create their first goal, with a focus on making small, meaningful goals rather than large aspirational ones which often lead to failure. The importance of joining a community like our free fitness club is discussed to help maintain motivation, gain confidence, and overcome hurdles. Many of the hurdles identified are related to social determinants. This is tackled through accessing grant funding and developing mutually beneficial relationships with providers to help patients from low socio-economic backgrounds access healthy food, digital solutions, and physical activity offerings either free or at vastly reduced cost. The fitness club, run by the PCN supports patients to access other community events like parkrun, through promotion and education during the sessions, and then accompanying patients at the event. Collaboration with our local parkrun through the parkrun practice initiative was crucial to achieve this relationship.

Session 3: Nutrition NOT Diet! (led by dietician)

One of the activities is getting patients to tell us the first thing that comes into their head on the mention of the word 'food'. Many have negative thoughts or emotions towards it. But food is not something to be feared. It is crucial for our survival and health. The right foods can help protect and improve our health. However, the wrong foods can have a substantial impact on quality of life, energy levels and mood. In this session we explore their thoughts around nutrition and help debunk some myths while explaining why we can so often have an unhealthy attitude towards what we eat secondary to the food environment we live in. A large chunk of our patient population at the group clinics lives in the more deprived areas of Leamington where there are limited options to buy affordable healthy food, and many are on means-tested benefits with a restricted budget. We highlight local initiatives who support healthy eating like the Lillington pantry to help them access nutritious food at a vastly reduced cost.

Session 4: Physical activity (Led by health and wellbeing coach)

Here, we delve into the crucial role that physical activity plays in promoting both physical and mental well-being. A recurring theme among our patients is their perception of physical activity, often viewing it as a beneficial yet burdensome task, marked by discomfort and strenuous effort. Many individuals express a sense of inability to engage in more active lifestyles, citing constraints such as time limitations, physical or mental health obstacles, or past advisories from healthcare professionals deeming it unsafe. However, it is imperative to note that the consensus statement on risk, as articulated by Reid et al. in 2022, highlights that only a limited number of cases warrant caution against physical activity.

We aim to reshape the mindset around physical activity to enjoyable movement, by emphasizing the joy, fun, and opportunities for connecting with nature and loved ones. In our sessions, we explore various forms of movement and encourage participants to identify personalized approaches to staying active.

As part of our long-term support strategy, we prioritize establishing therapeutic communities for patients with limited social networks. This involves organizing group activities through our

fitness club and collaborating with local events like parkrun. Additionally, we cultivate partnerships with various community entities, including ecotherapy, dance, and art groups, providing diverse options for patients. Our association with the local active partnership not only offers support but also guides us to relevant opportunities, ensuring a holistic and community-driven approach.

Tackling health inequalities through active communities

Leamington, akin to numerous towns in England, exhibits varying degrees of deprivation, with a small enclave of pronounced deprivation in North Leamington and a more extensive area in the South. Statistics indicate that individuals residing in the most deprived areas of England typically experience the lowest life expectancy, while conversely, life expectancy tends to be higher on average in areas with lower levels of deprivation. Almost half of the observed gap in life expectancy between the most and least deprived areas in England can be attributed to excess deaths from heart disease, stroke, and cancer (Public Health England, 2017). The more deprived areas also show a heightened prevalence of various behavioral risk factors.

Moreover, communities grappling with socio-economic challenges, face an increased risk of mental health problems due to their prevailing circumstances. A considerable portion of our patient demographic faces social isolation, a recognized independent risk factor for chronic health conditions (Christiansen et al., 2021).

Fitness organizations naturally draw individuals facing fewer obstacles, inadvertently excluding, or intimidating many in our community from participating in physical activities, thereby exacerbating health inequalities. It is well-documented that these marginalized groups stand to gain the most from reducing sedentary behavior and increasing physical activity (Sport England, 2022).

Recognising the need to address this disparity, we have established and supported several accessible physical activity groups to break down barriers and provide inclusivity. Some of our ongoing programs include:

- Monday evening Walk Talk Walk/Run Talk Run group from a North Leamington GP practice.
- Thursday morning Walk Talk Walk group from a South Leamington GP practice.
- Bi-monthly Swim Together group at the centrally located Leamington Spa Leisure Centre.
- Leamington parkrun events: patients accompanied to our local event to spectate, volunteer, walk or jog.

The Walk Talk Walk/Run Talk Run initiative is dedicated to dismantling the barriers that mental illnesses and loneliness can impose on individuals seeking physical activity. By integrating movement with mental health and community support, our groups offer a unique space where participants, under the guidance of consistent leaders, find solace and safety to freely discuss their mental health. This initiative also allows individuals to progress from a walking group to a walking/jogging group and eventually to a running group (up to 5km), accommodating varying fitness levels and enabling personal growth.

We identified that some patients attending our Lifestyle Clinics perceived walking as unfeasible due to pain, joint issues, or concerns about keeping pace. Recognizing swimming as a preferable alternative, we collaborated with external organisations such as Mental Health Swims, Swim England, and Everyone Active to establish the 'Swim Together' group. This initiative, mirroring the ethos of our walk and run groups, provides individuals with long-term conditions the opportunity to access guided swimming sessions for free, thus directly addressing health inequalities and enhancing both mental and physical well-being.

Our partnership with the local parkrun extends the spectrum of opportunities for patients and staff, offering avenues for volunteering, fostering connections, instilling a sense of achievement, and promoting increased activity levels. All our physical activity groups are facilitated by professionals, including GPs, Social Prescribers, and Health and Wellbeing Coaches, who not only lead sessions but also provide ongoing support, linking attendees to additional health and wellbeing opportunities in the community for sustained benefits. Moreover, our leaders are trained in group facilitation and are certified Mental Health First Aiders.

This approach aligns with the recently published policy paper by the Department of Culture, Media, and Sport, which advocates for an ambitious strategy to enhance nationwide physical activity. Emphasizing collaboration within the government and with various stakeholders, the strategy focuses on fostering activity rather than just sport. This initiative stands as a testament to our commitment to promoting holistic well-being and fostering a more active and connected community (DCMS 2023).

What do patients want?

For any patient contact to be successful, three things are required.

Engagement

The patient needs to feel listened to. The group setting of lifestyle clinics gives patients a platform where they can speak and share experiences with others. Use of language can help change perspectives. For example, reframing ‘exercise’ to ‘movement’.

Education

There often is not enough time in a GP consultation to empower the individual about lifestyle modification, so other avenues are needed for this. The group lifestyle clinics serve to offer some education from the health professional running it. However, a large focus is for patients to engage in discussion and reflection and be inspired by lived experiences of others.

Evolution

Patients benefit from support in making changes and being part of a community. Group lifestyle clinics can be an entry point into this, while also offering further continuous groups for maintenance, e.g., walking groups, swim groups, and parkrun. By providing these additional activities we build a foundation for our patients which supports what we are discussing in our groups. If appropriate, patients are also able to access up to six one-to-one health coaching sessions (over a period of 6 months) which gives them the opportunity to further explore their individual situation, create new insights and behaviour changes that they may not have been able to achieve on their own.

No two patient journeys are the same, each has their own set of circumstances to navigate and Case study 2 outlines how one patient has navigated hers so far.

Clinical Case scenario 2.

Linda is a patient suffering with obesity and has gradually become more anxious about going out due to her size and self-esteem. Referred by her GP, she attends all four Lifestyle Clinic sessions, learning some new information and enjoyed meeting others in a similar situation. When contacted by the Health and Wellbeing Coach a few weeks later, Linda explains that she still wants to change, and knows what she needs to do, but faces barriers in her life to implementing change. Linda is offered further support in the form of one-to-one health coaching, looking to address her weight - she doesn't feel ready to tackle food but is keen to include movement in her life. Walking is difficult but swimming appeals. However, the idea of going to our PCN Swim Together group is daunting. Through health coaching, Linda addresses her barriers and eventually, through her own ideas and actions, feels ready to attend one of our swim sessions. Linda enjoys it and starts investigating other aquatic activities, now feeling that physical activity is becoming more established in her life. Consequently, she has gained confidence in herself, and is ready to tackle other aspects of her lifestyle, including food.

Impact of the PCN lifestyle service

We collected anonymous feedback from 142 patients who attended the four lifestyle clinic sessions (figure 3). There was a stark improvement in people's mental health with 98% agreeing that the sessions had a positive impact on their mental health. It has been widely demonstrated in the literature that there is a positive link between the aspects covered in the sessions of physical activity, improved nutrition, social connection, and mental health.

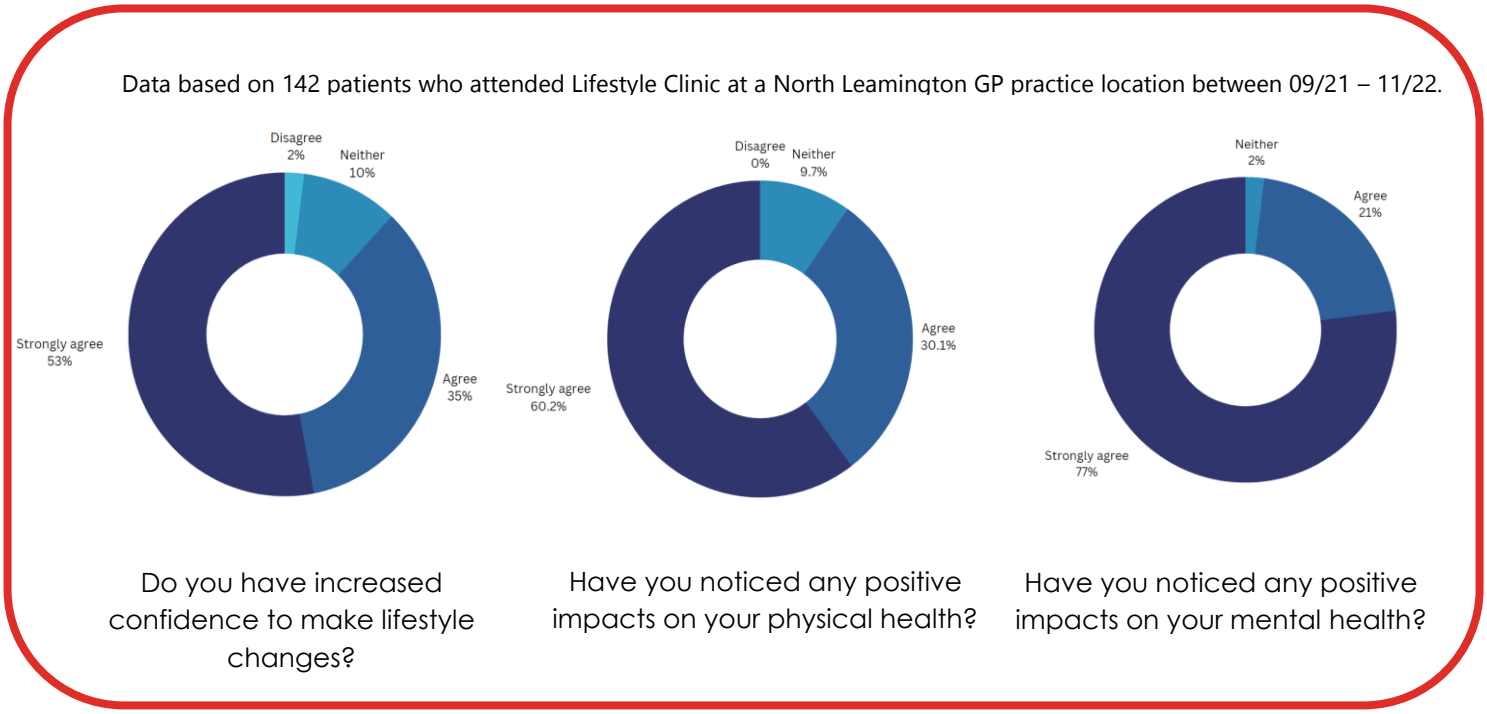

Figure 3. Patient survey results outlining perceived benefits from attending the service.

90.2% reported a positive impact on their physical health and the exercise groups offered as part of the sessions of either a walk, jog or run in conjunction with self-made dietary changes explored in the nutrition session were aimed at improving physical health. Not all participants felt able to engage in increased movement or make nutritional changes and 9.7% reported no change to their physical health.

78% reported feeling increased confidence to make lifestyle changes. Only 2% disagreed that they felt increased confidence to make lifestyle changes. Though still very much an improvement these scores may be lower as confidence is rooted in core beliefs and therefore changes can be harder to implement and take longer to become apparent.

The improvements in mental health were corroborated by the personal wellbeing scores, taken 12 weeks after the last session as shown in figure 4 This showed on average a 2-point reduction in feelings of anxiety, and an increase in 4 points of life satisfaction and happiness as well as a 2-point increase in feelings of being worthwhile. Participants formed social connections with each other and as well as meeting at the sessions they also continued to attend the exercise groups and meet independently of the group. An 85-year longitudinal study at Harvard University found that positive relationships were the biggest indicator of happiness, over perceived indicators of happiness of wealth and career success (Waldinger & Schulz 2023).

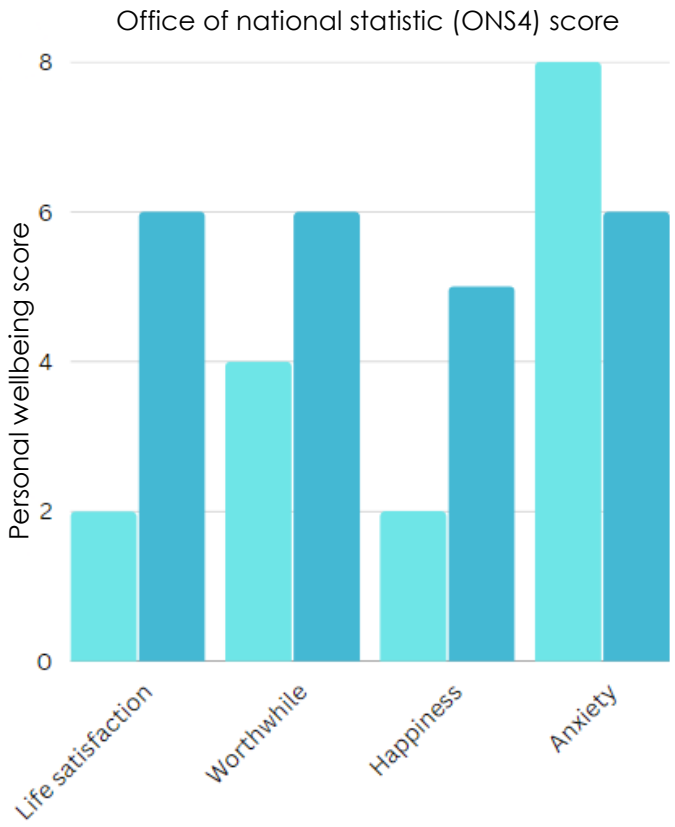

Figure 4. Personal wellbeing score taken at baseline and 12 weeks post session 4.

Patient and staff perspectives

Benefits include better utlisation of staff time, patient satisfaction, holistic healthcare, cost effective delivery of personalised care and community integration.

It is necessary to employ key ARRS roles (social prescribers, dieticians, and health and wellbeing coaches) for their expertise and to help deliver the service. Figure 5 outlines some staff experiences delivering the sessions. Administrative support from care coordinators is required to manage clinics and communicate with patients in addition to the creation and maintenance of a booking system. The primary care network will need to restructure staff clinics to allow time for group activities which often need to be out of core hours to accommodate patients in employment struggling to access daytime sessions.

Furthermore, training may be required for some staff to build confidence and competence in lifestyle medicine delivery. There are two appropriate courses 1) Red Whale Lifestyle Medicine 2) British Society of Lifestyle Medicine Core Accreditation.

Figure 5. Patient and staff feedback taken within July 2020 and August 2023

It's not just about the patients

While addressing the needs of patients is a key priority, so too is addressing the health and wellbeing of primary care staff. The workforce in primary care is currently under high pressure which means many are often reaching levels of burn out, impacting their own physical and mental health (Hall et al., 2019).

The parkrun practice initiative was established in 2018 and is a collaboration between parkrun UK and the RCGP to promote the health and wellbeing of staff and patients. parkrun is a free, community event where you can walk, jog, run, volunteer, or spectate. parkrun is 5km and takes place every Saturday morning. junior parkrun is 2k, dedicated to 4–14-year-olds and their families, every Sunday morning.

Primary care staff who have engaged with the initiative value the importance of teamwork for boosting their morale and mitigating burnout (Galetta-Williams et al., 2020), leading to positive effects on morale and participation (Fleming et al., 2020). The process of signing up is light touch and can be led by any member of staff.

GP practices across the UK are encouraged to develop close links with their local parkrun to become parkrun practices.

Another project to help both staff and patients is the Active Practice Charter (APC). GP practices can sign up to the APC, and receive APC status by achieving five simple, self-declared criteria:

Further information can be found in the supplementary file 2.

This sounds good in theory, but what about convincing my PCN?

Look to create a compelling business case for ARRS roles to support lifestyle projects, leveraging health and wellbeing coaches, dieticians, social prescribers, and care coordinators. Emphasize the benefits of group care, focusing on cost-effectiveness, staff development, and increased patient engagement. Start with small-scale initiatives aligned with the Active Practice Charter and parkrun practice for quick, cost-effective wins, fostering a cultural shift within the PCN. Secure external funding from sources like local councils, active partnerships, and sport legacy funding. Measure outcomes against PCN Key Performance Indicators to demonstrate positive impacts and target achievements.

Conclusion

We need to look beyond purely treating disease, much of which is driven by factors such as environmental, social deprivation, unhealthy consumption patterns and lifestyles, and instead look towards prevention and maintenance of good health in our patients and staff. Through primary care teamwork and PCN collaboration, implementation of interventions such as these can start to shift this model of care to one centered around wellness and doing our bit to combat the obesogenic environment.

Key points

- Osteosarcopenic obesity strains primary care resources, which is largely related to lifestyle factors influenced by both environmental, social and personal factors but Implementing lifestyle interventions within the current framework is challenging.
- A personalised strategy utilizing ARRS staff involves delivering lifestyle education, establishing therapeutic communities, and offering supported interventions such as physical activity groups.
- Identify and leverage community social prescribing assets, utilizing initiatives and resources like the parkrun practice or "We Are Undefeatable" to support professionals to guide patients toward inspiration and support in adopting daily activities.
- Recognise the importance of staff health and wellbeing, enabling them to be powerful role models.

- Addressing significant health inequalities in practice populations requires a targeted approach to ensure those in need receive and are encouraged to access support.

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