Centrum för klinisk forskning och utbildning

Handläggare
Ingela Marklund

Datum
2020-03-02

Diarienummer

Datum och tid	Torsdag 20-12-10 kl. 13.00- 15.00
Plats	Digitalt möte via TEAMS
Deltagare:	Eva Eliasson, Maria Klässbo, Regin Dahl, Tyra Thorn-Andersson, Ulrica Sälgeback, Mia Måseide, Marie Hildén och Ingela Marklund

1) **Val av sekreterare tillika ordförande till nästa möte.**
   Ingela Marklund

2) **Minnesanteckningar från föregående möte.**
   Gicks igenom och lades till handlingarna

3) **E-post Listan**
   Regin Dahl har tagit över administrationen och gjort utskick för 2 kurser samt skickat ut för uppdatering av adress/kontaktuppgifter. Får ca 40 felmeddelande om felaktiga adresser och det har även tillkommit några nya till listan. Fungerar bra,

4) **Karriärutvecklingsmodellen**
   Mia Måseide informerar om arbetet med karriärutvecklingsmodellen där hon ingår i en arbetsgrupp som leds av Eva Lindqvist Österberg från HR. modellen är utvecklad i Stockholm och har anpassats till Värmland.
   Några möten har varit under hösten och efter nyår kommer det att bjudas in till workshops. Därefter kommer cheferna få ett kommunikationsmaterial för spridning av information till alla medarbetarna. Målet är att vid medarbetarsamtalen under våren 2021 ska karriärutvecklingsmodellen användas.
   Eva LÖ har omvärlds spanat och bland annat har Ingela fått ge synpunkter på steg 5 och 6.

5) **Rapporter**
   - Astma KOL- rådet (Eva Jonasson)
     Fokus den senaste tiden har legat på Vårdförlopp KOL steg 1 har fastställts efter revidering. Vårdförloppet beskriver konkret vem som gör vad. Målet med KOL steg 1 är att öka antal patienter som i tid får diagnos och snabbt sätta in åtgärder. Fysioterapeuten är en viktig del av teamet runt patienten. Planeras nu fortsatt arbete med vårdförlopp KOL steg 2 där målet är att patienter med KOL erbjuds behandlingsinsatser, utvärdering och uppföljning enligt de riktlinjer som gäller.

De har fått information från Kunskapscentrum, Anna Frödin verksamhetschef deltog och berättade om hur man arbetar och planerar framåt. Astma KOL rådet kommer inte att finnas kvar, fortsatt arbete kommer att ske inom kunskapsstyrningen, område Lung- och Allergisjukdomar via LAG. Oklart om hur det kommer att se ut just nu.

Andningsteam planeras att starta i början av nästa år bestående av läkare sjuksköterska och fysioterapeut. Teamet ska stödja de verksamheter och patienter som vårdas i hemmet med svårare lungsjukdomar. Detta presenterades av Taivo Kipper öl lungmottagningen och kunskapsbärare lungsjukdomar.
Finns nu en nationell mall för certifiering av KOL- mottagningar, där fysioterapi finns med, bilaga1.

- Diabetesrådet (Linus Svartvik, CSK)
  Ingen information vid detta möte från Linus.

- Cancerrehabilitering (Eva Eliasson)
  Arvika kommer att arrangera utbildning till lymfterapeut v 2-4 2021 med deltagare från hela länet, vilket kommer öka kompetensen inom de palliativa teamen.

- Fysisk aktivitet i sjukdomsprevention och sjukdomsbehandling (Ulrika Sälgeback)
  En uppdatering av FYSS kommer att komma men inte klart när.

  Levnadsvanor: Ulrika är sakkunnig i processen med levnadsvanor inom kunskapsstyrningen och de har kommit uppdaterade rekommendationer från WHO om fysisk aktivitet, se länk, https://www.who.int/health-topics/physical-activity#tab=tab_1
  YFA, Yrkesförening för fysisk aktivitet, håller parallellt på med att ta fram riktlinjer för Sverige som är ute på remiss.
  Medan Nationellt programområde (NPO) för levnadsvanor har tagit fram ett vårdprogram som är på gång ut på remiss.

6) **Övriga frågor:**
   Maria Klässbo:
   Ny forskningschef Maria EH Larsson börjar 1 februari. Hon är sjukgymnast, docent och kommer närmast från en tjänst som regionområdeschef för forskning, utveckling och utbildning inom primärvård i Region Västra Götaland.

   Forum Värmland 2020, 16 februari blir helt digitalt i år och vi hoppas fysioterapeuter får möjlighet att delta.

Kurs EvidensBaserad Praktik, EBP 2021. En bra kurs där man får möjlighet att fördjupa sig inom sitt område och söka evidens för sina kliniska frågeställningar.

Artikel. Maria delar även en artikel om fysisk aktivitet vid långvarigt stillasittande som nyligen publicerats, bilaga 2

Gruppens uppdrag och DL mejllista.
DL-listan får vara som den är och 1 gång/år skickas inbjudan ut till samtliga som finns i listan Regin hanterar för att visa på möjligheten att delta i utvecklingsgruppens möten.

Utvecklingsgruppensmöten ses som ett informationsforum där det delges professionsspecifik information över organisationsgränser i syfte att erbjuda patienterna en evidensbaserad vård av hög kvalitet.

Forskningsmottagning. Regionen har fått medel från Vetenskapsrådet i en nationell satsning på covid-19 forskning. Ingela har i uppdrag att bygga upp en forskningsmottagning på CSK och två forskningssjuksköterskor är rekryterade. Värmland är med i en stor multicenterstudie med Umeå Universitet som ansvarig forskningshuvudman där patienter med covid-19 som varit inneliggande på CSK kommer att följas upp 6 månader efter utskrivning och sedan årligen i 5 år. Handlar till stor del om insamling av prover för biobankning. Forskningsmottagningen kommer att finnas i lokaler på Infektionsmottagning 2.

Nästa möte 24 mars klockan 10-12 via teams.

Certifiering av astma-, allergi- och KOL-mottagning

Ett nationellt stöd i att certifiera och kvalitetssäkra astma-, allergi- och KOL-mottagningar inom primärvård

Nationell arbetsgrupp för astma, KOL och luftvägsallergi
Kontaktuppgifter: kunskapsstyrningvard.se/NPOlungallergi

Nationellt system för kunskapsstyrning Hälso- och sjukvård
SVERIGES REGIONER I SAMVERKAN

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1. Om dokumentet

Dokumentet är utformat av den nationella arbetsgruppen (NAG) astma, KOL och luftvägsallergi och är giltigt från och med 2020-03-01.

Certifierade astma-, allergi- och KOL-mottagningar inom primärvården är ett sätt att skapa en vård som baseras på bästa tillgängliga kunskap och utförs av kvalificerad personal tillsammans med delaktiga patienter. Certifierande mottagningar har funnits i Region Skåne sedan 2014 och har inneburit en konstant kvalitetssäkring och utveckling av verksamheten. Detta till förmån för patienter, medarbetare, ledare och chefer och samhället i stort i och med att verksamheterna även blivit mer kostnadseffektiva.

Den nationella arbetsgruppen för astma, KOL och luftvägsallergi, har tagit fram detta dokument med syfte att sprida kunskap och ett nationellt gemensamt stöd i att certifiera astma-, allergi- och KOL-mottagningar inom primärvården i hela landet. Förhoppningen är att det ska bidra till en god och jämlik vård. Dokumentet är inspirerat av Skånemodellen och i det framgår vad och hur en verksamhet behöver göra för att certifieras enligt en nationellt gemensam standard. Själva certifieringsprocessen utförs av regionerna själva och detta dokument är ett stöd i deras arbete.

Historiskt har benämningen astma/KOL-mottagningar använts men mottagningarna innefattar även patienter med allergier; därav namnskiftet till astma-, allergi- och KOL-mottagningar. Under 2020 har även en nationell arbetsgrupp för matallergi bildats. Målsättning är att även dessa patienter omhändertas vid astma-, allergi- och KOL-mottagningar, när vården är aktuell på primärvårdsnivå och när bra kunskapsstöd har utvecklats.

2. Uppdrag

Uppdraget att skapa en nationell certifiering för primärvårdens astma-, allergi- och KOL-mottagningar gavs av Nationellt programområdet (NPO) för lung- och allergisjukdomar i Nationellt system för kunskapsstyrning hälso- och sjukvård, Sveriges regioner i samverkan.

Under 2020 implementeras ett personcentrerarat sammanhållet vårdförlopp för KOL. Målet med SVF KOL är en mer jämlik och tillgänglig vård där patienten är mer delaktig. Den nationella certifieringen är ett stöd för regionerna att effektivt implementera SVF KOL och kommer ge patienter med astma, allergi och KOL en mer jämlik vård.

3. Patientperspektiv

Patientorganisationerna, Astma- och allergiförbundet och Riksförbundet HjärtLung, ser certifieringsmodellen som en möjlighet att åstadkomma jämlik vård. En nationell, evidensbaserad modell för certifiering är av stor vikt för att patienten ska få rätt utredning, diagnos och behandling. Certifieringen kan även bidra till en ökad möjlighet till fast vårdkontakt och kontinuerlig uppföljning. På så sätt skapar vi trygghet för alla personer med astma-, allergi- eller KOL-diagnos.

4. Bakgrund

Astma, allergi och KOL är folksjukdomar som orsakar försämrad livskvalitet för individen och stora kostnader för samhället (1,2,3). I Sverige är prevalensen av astma bland barn och vuxna cirka tio procent och vid KOL åtta till tio procent. Femton till 50 procent av Sveriges befolkning har någon typ av allergi och prevalensen är högst bland unga vuxna.

Patienterna tas huvudsakligen omhand i primärvården men de med svårare sjukdom bör behandlas och följas inom den specialiserade vården. Det finns stora problem med framför allt underdiagnostik men också feldiagnostik, vilket leder till under- och överbehandling. Detta innebär att många personer är utan en effektiv behandling med sämre livskvalitet som följd.

Korrekt diagnos möjliggör rätt behandling och en regelbunden uppföljning av sjukdomsförloppet vilket är av största vikt för att motverka försämringsperioder med sjukdomsprogression som följd. Det finns studier som visar att astma/KOL-mottagningar leder till minskade samhällskostnader, framförallt genom minskade läkemedelskostnader, färre akuta besök och kortare sjukhusinläggningar [4]. Vidare visar studier att patienter som går på astma/KOL-mottagningar i primärvården blir bättre på egenvård och får bättre livskvalitet och fysisk kapacitet samt minskad ångest jämfört med patienter i primärvården som inte erbjuds vård genom astma/KOL-mottagning [5].

Socialstyrelsens riktlinjer och utvärdering 2018

Den nationella certifieringen stödjer sig på Socialstyrelsens (SoS) riktlinjer och centrala rekommendationer för astma och KOL [1]. Rekommendationerna bedöms innebära ekonomiska konsekvenser på en rad områden. På kort sikt kan kostnadsökningar förväntas, främst när det gäller ökade frekvensutredningar och återbesök. På längre sikt bedöms rekommendationerna leda till stora kostnadsbesparingar eftersom fler personer med astma eller KOL upptäcks och behandlas i en tidigare fas av sjukdomen. Åtgärderna avser också ge en ökad sjukdomskontroll och färre exacerbationer, vilket kan innebära besparingar för hälso- och sjukvården i form av färre akutbesök och sjukhusinläggningar.

Under 2018 har SoS utvärderat vården av astma och KOL [6] utifrån framtagna indikatorer och målvärden [7]. Utredningen visade varierande genomslagskraft av de rekommenderade åtgärderna. Exempelvis har användandet av symtomformulären ACT och CAT ökat men överlag finns det fortfarande stora brister i implementering av de nationella riktlinjerna. Viktiga förbättringsområden är diagnostik, rökslutarstöd, patientutbildning, allergiutredning, skriftliga behandlingsplaner, uppföljning och återbesök. Dessutom brister det i möjligheter till fortbildning av personal, tillgång till en specialutbildad astma-, allergi- och KOL-sjuksköterska samt en gemensam syn på processen för en god vård. Viktiga aspekter i förbättringsarbetet är en välfungerande astma-, allergi- och KOL-mottagning och användning av Luftvägsregistret för kvalitetsutveckling [1,6].

Luftvägsregistret

Luftvägsregistret är kvalitetsregistret för diagnoserna astma och KOL. Registret syftar till att förbättra vårdkvaliteten genom att visualisera hur vårdgivaren i praktiken diagnostiserar och behandlar patienter med dessa sjukdomar.

Registrets variabler är harmoniserade med Socialstyrelsens indikatorer vilket gör att registret kan visa hur väl given vård och behandling korrelerar med gällande riktlinjer. Genom registrering i Luftvägsregistret bereds grunden för kvalitetsutveckling på den enskilda mottagningen men även på regional och nationell nivå.

Det övergripande målet för registret är att säkerställa likvärdig vård i landet som även kan ge möjlighet till forskning som leder till ökad kunskap och förbättring av behandling. För den enskilda enheten och patienten fungerar registret som ett arbetsinstrument ”on-line”, som innefattar funktioner som checklista och egen patientprofil (https://lvr.registercentrum.se/).

5. Syfte

Syftet med certifieringen är att säkerställa en evidensbaserad, högkvalitativ och jämlik astma-, allergi- och KOL-vård på nationell, regional och lokal nivå.

6. Certifieringsprocessen

En certifiering innebär ett kontinuerligt förbättringsarbete av verksamheten och syftar till att skapa förtroende och tillit till nytta för patienten. Certifieringen kan också ge många positiva effekter på verksamheten genom att en tydlig struktur skapas.

Certifieringen säkerställs via årliga kvalitetskontroller inom regionerna. Triangelrevisionen är en beprövad metod som kan användas av regionerna för kvalitetskontroller (https://www.vgregion.se/halsa-och-vard/vardgivarwebben/utveckling--uppfoljning/utbildning/webbutbildningar/triangelrevision/).

Det åligger varje certifierad astma-, allergi- och KOL-mottagning att omgående meddela den ansvariga i regionen om de av något skäl inte längre uppfyller kraven. För de enheter som inte uppfyller kraven kommer certifieringen att dras tillbaka. Det finns möjlighet att få tillbaka certifieringen om kraven uppfylls igen.

Certifieringskrav

Certifieringskraven utgår från att utredning samt vård- och behandling ges i enlighet med Socialstyrelsens nationella riktlinjer [1] samt läkemedelsverkets behandlingsrekommendationer för astma och KOL [2,3]. Certifieringskraven beskrivs i tabell 1 på nästa sida.

Tabell 1. Certifieringskrav för astma-, allergi- och KOL-mottagning

	Verksamhetsansvarig allmänläkare	Astma, allergi och KOL-sjuksköterska	Fysioterapeut
6.1 **Kompetens**	Specialist i allmänmedicin	Utbildning minst 15 högskolepoäng (hp) inom astma, allergi och KOL	Utbildning minst 7,5 hp inom astma, allergi och KOL rekommenderas
Fortbildning	Två dagar per år och profession, gärna i team		
6.2 **Interprofessionell samverkan**	Arbetsterapeut, dietist, kurator/psykolog, diplomerad tobaksavvänjare		
6.3 **Tidsaspekt**	Verksamhetsansvar, 2 timmar/vecka	Tidsbeställd mottagning och telefonrådgivning, 4,8 h/vecka per 1000 listade patienter*	Tidsbeställd mottagning 1,3 h/vecka per 1000 listade patienter**
6.4 **Nationellt spirometrikörkort**	Krav	Krav	Rekommenderas
6.5 **Utrustning**	Spirometri, FEV_1/FEV_6-mätare, PEF-mätare, pulsoximeter, spacer, nebuliserings-utrustning, syrgas, in vitrotest och/eller pricktest för påvisande av specifikt IgE. Informations- och undervisningsmaterial		
6.6 **Luftvägsregistret**	Kontinuerlig inmatning, minst månadsvis Analys av egen statistik minst var sjätte månad		

*Om enheten i dagsläget inte kan uppnå målet 4,8 timmar/vecka/1000 listade patienter kan en åtgärdsplan redovisas. Exempel på acceptabel plan:

- År 1: 3,3 timmar/vecka/1000 listade patienter
- År 2: 4,8 timmar/vecka/1000 listade patienter

**Om enheten i dagsläget inte kan uppnå målet 1,3 timmar/vecka/1000 listade patienter kan en åtgärdsplan redovisas: Exempel på acceptabel plan:

- År 1: 0,5 timmar/vecka/1000 listade patienter
- År 2: 1,0 timme/vecka/1000 listade patienter
- År 3: 1,3 timmar/vecka/per 1000 listade patienter

6.1 Kompetens

Sjuksköterska

För astma-, allergi- och KOL-sjuksköterskan krävs kompletterande utbildning på minst 15 högskolepoäng på avancerad nivå. En hög kompetens utvecklar det självständiga arbetet som sjuksköterskan utför och ger möjlighet till utveckling av omvårdnad [8]. Sjuksköterskan ska ha schemalagd tidsbeställd mottagning med organiserad telefonrådgivning och ansvar för barn och vuxna. Astma-, allergi- och KOL-sjuksköterskeföreningen har utarbetad en kompetensbeskrivning för sjuksköterskan med specialisering inom astma, allergi och KOL som utgår från sex kärnkompetenser; personcentrerad vård, samverkan i team, evidensbaserad vård, förbättringskunskap och kvalitetsutveckling, säker vård samt informatik [9].

Specialist i allmänmedicin

Som verksamhetsansvarig ska den ansvarige läkaren ha kontinuerlig fortbildning inom ämnesområdena astma, allergi och KOL. Läkaren ska vara ett stöd för sjuksköterskan och fysioterapeuten men också för övriga patientansvariga läkare på enheten. Läkaren ska tillsammans med sjuksköterskan ha regelbunden dialog med ledningspersoner vid enheten för att stämma av att tillräckliga resurser för astma-, allergi-, och KOL-mottagningen finns. Läkaren bör även etablera kontakt med den lokala lung- och allergimottagningen inom specialiserad sjukvård för att förenkla konsultationer och öppna för nätverkande och fortbildningar. Läkaren bör verka för intern fortbildning för övriga medarbetare [8,10].

Fysioterapeut

För fysioterapeuten rekommenderas utbildning på minst 7,5 högskolepoäng inom området astma, allergi och KOL samt nationell spirometriutbildning. Fysisk aktivitet och andningsteknik är centralt i vården av personer med astma och KOL, liksom olika tester av fysisk kapacitet. Detta gör att även fysioterapeuten bör ha tidsbeställd mottagning.

6.2 Interprofessionell samverkan

Det interprofessionella teamet runt patienten med astma, allergi och KOL kan bestå av olika professioner utifrån sjukdomens svårighetsgrad och patientens behov.

Tabell 2 och 3 beskriver kortfattat arbetsuppgifter för olika professioner som är kärnkompetenserna i teamet; specialist i allmänmedicin, astma-, allergi- och KOL-sjuksköterska, fysioterapeut, arbetsterapeut, dietist, psykolog och kurator [11]. Biomedicinska analytiker och undersköterskor är viktiga i teamet då dessa professioner ofta utför spirometriundersökningar.

Den nationella arbetsgruppen för astma, KOL och luftvägsallergi har utarbetat kunskapsstöd om interprofessionell samverkan, förslag på samverkansrutiner och exempel på arbetsbeskrivningar. Kunskapsstöden finns på Sveriges Kommuner och Regioners webbutik för nedladdning [12].

Diplomerad tobaksavvänjare

Vid en astma-, allergi- och KOL-mottagning ska det finnas en diplomerad tobaksavvänjare. Alla som röker ska erbjudas rökslutarstöd av utbildad personal som kan ge patienten kvalificerad rådgivning och motivation till rökstopp [13]. Många gånger erbjuder inte hälso- och sjukvården stöd till rökstopp [14], trots att detta är en av de viktigaste åtgärderna vid astma och den absolut viktigaste åtgärden vid KOL. Även föräldrar till barn med astma bör erbjudas stöd att sluta röka.

Tabell 2. Arbetsuppgifter vid astma, allergi och KOL för läkare, sjuksköterskor och fysioterapeuter i primärvården. Beroende på utbildning och kompetens kan vissa yrkesgrupper utföra andra arbetsuppgifter [11, 12].

Allmänläkare	Sjuksköterska	Fysioterapeut
Bedöma symtom, utreda, tolka resultat	Organisera astma/KOL-mottagning	Mäta/bedöma fysisk kapacitet/aktivitet och andningsteknik
Fastställa diagnos, ordinera lämplig behandling	Undersökningar vid utredning av misstänkt astma, allergi och KOL	Planera, genomföra och utvärdera träning i stabil sjukdomsfas och efter exacerbation
Upprätta en behandlingsplan	Upprätta/följa upp behandlingsplanen tillsammans med patienten. Uppföljning av symtom och behandling	Individanpassa fysisk aktivitet/träning och andningsteknik
Uppföljning av läkemedelsbehandling	Övergripande planeringsansvar för patientutbildning och stöd till egenvård	Uppföljning av fysisk kapacitet/aktivitet, andningsteknik
Utreda och behandla eventuell samsjuklighet	Rökslutarstöd (kan vara organiserat på annat sätt)	Medverka i patientutbildning och stöd till egenvård
Remittera till annan specialist vid behov	Introduktion/utbildning till annan personal	Introduktion/utbildning till annan personal

Tabell 3. Arbetsuppgifter vid astma/KOL för arbetsterapeut, dietist, kurator och psykolog i primärvården.
Beroende på utbildning och kompetens kan vissa yrkesgrupper utföra andra arbetsuppgifter [11, 12].

Arbetsterapeut	Dietist	Psykolog	Kurator
Bedömning av ADL	Bedömning av nutritionsstatus och energibehov	Bedömning av ångest, depression, oro och svårighet att acceptera kronisk sjukdom	Psykosocial utredning
Råd om energi-besparande arbetsmetoder	Nutritionsbehandling inklusive skriftlig plan för nutrition	Kristerapi inklusive olika copingstrategier	Vägledning om samhällets stöd och resurser vid ohälsa
Utprovning och förskrivning av hjälpmedel	Utvärdering av nutritionsbehandling	Stödsamtal	Stödsamtal
Bostadsanpassning	Nutritionsundervisning vid olika sjukdomstillstånd	Behandling av ångest och depression	Stöd vid ensamhets-problematik, social isolering och existentiella frågor
	Födoämnesallergier		Kontakter med Försäkringskassan, Socialtjänsten etc

6.3 Krav på avsatt tid

För att kunna uppnå god vård i enlighet med SoS centrala rekommendationer krävs enligt beräkningar sjuksköterskетid 4,8 timmar och för fysioterapeut 1,3 timmar/vecka/1 000 listade patienter. Verksamhetsansvarig läkare bör ha avsatt tid 2 timmar/vecka [8,10].

6.4 Nationellt spirometrikörkort

Syftet med Nationellt spirometrikörkort är att kvalitetssäkra lungfunktionsmätningar. Detta innefattar allt från patientinformation, undersökningsprocedur till tolkning av spirometriresultat. Utbildningen riktar sig främst till läkare, sjuksköterskor och fysioterapeuter i primärvård och pedagogiken baseras på interprofessionellt lärande.

Varje profession har sitt ansvarsområde gällande spirometrikunskap men alla ska ha en god generell kunskap om undersökningen. Sjuksköterskan eller fysioterapeuten ansvarar för rätt genomförd undersökning och läkaren ansvarar för rätt tolkning av resultatet.

Utbildningen är framtagen och uppdateras regelbundet av Nätverket för astma-, allergi- och KOL-intresserade allmänläkare (NAAKA), Astma-, allergi- och KOL-sjuksköterskeföreningen (ASTA) och Svensk förening för klinisk fysiologi och är granskad av Svensk lungmedicinsk förening (SLMF) och Svenska föreningen för allergologi (SFFA).

6.5 Utrustning

Kravställd utrustning finns specificerad i tabell 1.

6.6 Kvalitetsuppföljning

För kvalitetsuppföljning och utveckling av vården ska varje enhet registrera i Luftvägsregistret.

7. 1177/vårdguiden

För att synliggöra mottagningarna för personer med astma, allergi och KOL, bör de särskilt benämnas på 1177/vårdguiden som certifierade astma-, allergi och KOL-mottagningar.

8. Referenser

1. Socialstyrelsen. Nationella riktlinjer för vård vid astma och KOL. Stöd för styrning och ledning, 2015 [Hämtad 191105]

2. Läkemedelsverket. Läkemedelsbehandling vid astma - behandlingsrekommendation. 2015 [Hämtad 191105]

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7. Socialstyrelsen. Vård vid astma och KOL. Målnivåer för indikatorer. 2015 [Hämtad 191105]

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9. ASTA. Kompetensbeskrivning för legitimerad sjuksköterska med inriktning mot astma/allergi/KOL. 2016.

10. Zakrission A-B, Jagorstrand B, Kull I. Beräkning av tid för astma/KOL-mottagningar i primärvård. Utifrån Socialstyrelsens riktlinjer från 2015 – Hur har det gått till? Lung & Allergiforum. 2018;4:27-30

11. Escuder Miquel L, Emtner M, Stallberg B, Zakrisson A. Interprofessionell samverkan for astma-KOL. Allmänmedicin. Tidskrift for svensk förening for allmänmedicin. 2018;39(1):38

12. Nationell arbetsgrupp för astma och KOL. Sveriges kommuner och landsting. Interprofessionell samverkan vid astma och/eller KOL. 2018. [Hämtad 191105]

13. Socialstyrelsen. Nationella riktlinjer för prevention och behandling vid ohälsosamma levnadsvanor. Stöd för styrning och ledning. 2018 [Hämtad 191105]

14. Tunsäter A, Ekberg-Jansson A, Ullman A, et al. Luftvägsregistret årsrapport 2018. [Hämtad 191105]

9. Länkar

Luftvägsregistret
https://lvr.registercentrum.se/

Patientorganisation: Astma- och Allergiförbundet
https://astmaoallergiforbundet.se/

Patientorganisation: Riksförbundet HjärtLung
https://www.hjart-lung.se/

Kunskapsstöd, Nationellt programområde för lung- och allergisjukdomar
http://kunskapsstyrningvard.se/NPOlungallergi

10. Bilaga. Checklista för certifieringen

Checklista för astma-, allergi- och KOL-mottagning	✖
Specialistsjuksköterska	
Vidareutbildad i astma-, allergi och KOL. 15 högskolepoäng	
4,8 timmar/vecka/1000 listade patienter*	
Schemalagd tidsbeställd mottagning	
Spirometrikörkort	
Specialist i allmänmedicin	
2 timmar/vecka för verksamhetsansvar	
Spirometrikörkort	
Fysioterapeut	
1,3 timmar/vecka/1000 listade patienter*	
Tidsbeställd mottagning	
Interprofessionell samverkan	
Arbetsterapeut	
Dietist	
Kurator/psykolog	
Fortbildning	
Teamet fortbildas två dagar/år	
Rekommenderad utrustning	
Enligt tabell 1 i certifieringsdokumentet	
Kvalitetsuppföljning	
Luftvägsregistret	

*Om enheten i dagsläget inte uppnår tidskraven ska en åtgärdsplan enligt tabell 1 redovisas.

OPEN ACCESS

Joint associations of accelero-meter measured physical activity and sedentary time with all-cause mortality: a harmonised meta-analysis in more than 44 000 middle-aged and older individuals

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ABSTRACT

Objectives To examine the joint associations of accelerometer-measured physical activity and sedentary time with all-cause mortality.

Methods We conducted a harmonised meta-analysis including nine prospective cohort studies from four countries. 44 370 men and women were followed for 4.0 to 14.5 years during which 3451 participants died (7.8% mortality rate). Associations between different combinations of moderate-to-vigorous intensity physical activity (MVPA) and sedentary time were analysed at study level using Cox proportional hazards regression analysis and summarised using random effects meta-analysis.

Results Across cohorts, the average time spent sedentary ranged from 8.5 hours/day to 10.5 hours/day and 8 min/day to 35 min/day for MVPA. Compared with the referent group (highest physical activity/lowest sedentary time), the risk of death increased with lower levels of MVPA and greater amounts of sedentary time. Among those in the highest third of MVPA, the risk of death was not statistically different from the referent for those in the middle (16%; 95% CI 0.87% to 1.54%) and highest (40%; 95% CI 0.87% to 2.26%) thirds of sedentary time. Those in the lowest third of MVPA had a greater risk of death in all combinations with sedentary time; 65% (95% CI 1.25% to 2.19%), 65% (95% CI 1.24% to 2.21%) and 263% (95% CI 1.93% to 3.57%), respectively.

Conclusion Higher sedentary time is associated with higher mortality in less active individuals when measured by accelerometry. About 30–40 min of MVPA per day attenuate the association between sedentary time and risk of death, which is lower than previous estimates from self-reported data.

INTRODUCTION

Low levels of physical activity and high amounts of sedentary time are associated with higher risks for morbidity and mortality.[1–6] Some previous meta-analyses concluded that the associations between sedentary behaviours and morbidity and mortality are independent of physical activity.[2 3] In contrast, other large-scale, meta-analyses and cohort studies examining the joint associations between physical activity and sedentary behaviours suggest that high levels of physical activity attenuate or even eliminate the associations between sitting time with all-cause and cardiovascular disease mortality.[4–6] However, the amount of time in moderate-to-vigorous-intensity physical activity (MVPA) that was needed to eliminate the risk of mortality associated with sitting time varied between studies.[4 6]

Previous studies relied on self-reported exposure data for assessing the joint associations between physical activity and sedentary behaviours with mortality.[4–6] Self-reported assessment of physical activity and sedentary behaviours is prone to misclassification and socialdesirability bias, likely underestimates sedentary time, and has limited validity for estimating both light-intensity and total amount of physical activity.[7 8] Furthermore, the potential impact of these biases may be compounded when combining information from two self-reported behaviours. For example, a previous meta-analysis comprising more than one million adults suggested that 60–75 min of daily MVPA was needed to eliminate the increased risk of death associated with sitting time,[4] whereas others concluded that physical activity equivalent to meeting the current recommendations of 150–300 min of MVPA per week effectively attenuated the association between sitting and risk of death.[6] Thus, the amount of physical activity needed to attenuate or even eliminate the higher risk of death associated with sedentary behaviours remains unclear.

The aim of this study was to examine the associations between different combinations (nine mutually exclusive groups) of physical activity and sedentary time with all-cause mortality using more precise accelerometer-derived measures. First, we examined the joint associations of total physical activity or time spent in MVPA (min/day) and different combinations of sedentary time with all-cause mortality. As a secondary aim, we examined whether the association between sedentary time and all-cause mortality differed across strata of total

physical activity or time spent in MVPA, to understand whether the associations between sedentary time and mortality differ by levels of physical activity. We used data from nine prospective cohort studies from four countries that were harmonised at study level and thereafter meta-analysed.

METHODS

Studies

Nine studies identified from a systematic review were included (see online supplemental materials). Study selection, data extraction and bias assessment are described in online supplemental materials. Details of participants, case ascertainment, accelerometer device and covariates of the included studies are described in online supplemental table 1.[9–17] Three of the studies were nationally representative samples of adults in Norway,[17] Sweden[12] and USA.[15] Since our previous publication,[1] where we examined the associations between sedentary time and different intensities of physical activity and mortality separately, we have updated mortality data from the National Health and Nutrition Examination Survey (NHANES) providing a median follow-up period of 10.5 years, during which 1065 participants died (previously, 6.5 years and 492 deaths). The sample weights and the complex survey design of the NHANES were accounted for prior to analyses.[15]

Harmonisation of exposure data

When combining data across different studies, data harmonisation enhances the validity of findings since different studies used different research methods (eg, assessment of what constitutes valid wear; determination of physical activity intensity, etc). The harmonisation process included reprocessing all individual accelerometer data and thereafter reanalysing individual study data according to a standardised protocol (available on request) by the participating study teams. Seven studies assessed physical activity and sedentary time with a version of the Actigraph accelerometer[9 10 12–14 17 18] and two with an Actical accelerometer.[10 16] We extracted data from the vertical axis in 60 s epochs for harmonisation purposes. Non-wear time was defined as ≥90 consecutive minutes of zero counts per minute (CPM), allowing for up to 2 min of non-zero counts if the interruption was preceded or followed by ≥30 min of zero CPM.[18] We included all participants who recorded at least 10 hours of wear time per day for four or more days. Total physical activity was defined by total counts per day/wear time per day in minutes (CPM). Sedentary time was defined as time spent at ≤100 CPM[19 20] and MVPA as ≥1952 CPM[21] and ≥1535[22] for studies using the Actigraph and Actical accelerometers, respectively.

Analyses

All participating studies first categorised their participants into thirds for total physical activity (CPM), time spent in MVPA and sedentary time. To control for individual differences in wear time, sedentary time and time spent in MVPA were expressed as a percentage of total daily wear time before creating the tertiles. Individual studies thereafter performed joint analyses of total physical activity (CPM) combined with daily sedentary time expressed as percentage of wear time, and daily MVPA (% wear time) combined with daily sedentary time (% wear time) in relation to all-cause mortality. Participants who were both most physically active (ie, top third) and least sedentary (ie, bottom third) formed the referent group. Effect sizes were estimated using Cox proportional hazards regression analyses with 95% CIs. Analyses were restricted to those aged ≥40 years. Study specific analyses were harmonised according to various levels of adjustment. Model 1 (crude model) was adjusted for age and sex (when applicable); model 2 (model 1+ adjustment for socioeconomic status and body mass index (BMI)) and model 3 (model 2+ adjustment for covariates included in each study's published final multivariable-adjusted model (all cohorts, except one,[10] adjusted for smoking and presence of prevalent diseases or self-reported poor health; see online supplemental table 1 for details). In our final model (model 4), we excluded all deaths within the first 2 years of follow-up and analysed the data with the same adjustment as for model 3.

In stratified analyses (stratification by total physical activity and MVPA), we assessed whether the dose–response association between sedentary time and all-cause mortality differed between groups with different levels of physical activity, always using those least sedentary (bottom third) as the referent. These analyses were performed using the same models (1–4) of adjustment as described above for the joint association analyses.

Individual study summary data were meta-analysed with a DerSimonian and Laird random effects model yielding eight pooled HRs with 95% CIs for joint association analyses. We assessed heterogeneity by I^2 statistics.

Participant and study-level characteristics may modify associations between physical activity, sedentary time and mortality. As analyses were performed separately for each study, we were only able to examine study-level characteristics. To examine the generalisability, we conducted subgroup analyses repeating the multivariable adjusted, joint analyses by categorising individual studies into studies based on national samples (Activity Behaviour Change (ABC), Sweden; Norwegian National Physical Activity Survey (NNPAS), Norway; NHANES, USA) and non-national samples (British Regional Heart Study, UK; European Prospective Investigation into Cancer and Nutrition, Norfolk, UK; Framingham Heart Study, USA; The REasons for Geographic and Racial Differences in Stroke, US; Walking Away from Type 2 Diabetes, UK; Women's Health Study, USA).

In sensitivity analysis, we excluded one study at a time and repeated all analyses; the findings were unchanged (data not shown). We also reanalysed our data and estimated summary HRs across studies with the fixed effects inverse variance method, and the main findings were unchanged (data not shown). Further, we examined whether unmeasured or residual confounding may have biased or 'explained away' our findings by estimating the E-value for the joint association between sedentary time, MVPA and mortality[23] according to model 4.

Patient and public involvement

No patients were involved in the planning, design or research idea for this systematic review. Nor were they involved in the analyses or data collection for the work. We did not evaluate whether the individual studies included in the review had any patient involvement.

RESULTS

In total, 44 370 participants (69.7% women; mean age 65.8 years, SD 8.6 years) were available for meta-analysis of the joint and stratified associations between physical activity and sedentary time with all-cause mortality. They were followed for 4.0–14.5 years (median 6.0 years; 266 220 person years), during which 3451 (7.8%) participants died.

Table 1 summarises the characteristics of the participants by study. Participants from the three nationally representative samples (ABC, NHANES and NNPAS) were younger and

Table 1 Descriptive characteristics of participants

Study	WAT2D		REGARDS		ABC		BRHS
	Men (n=411)	Women (n=243)	Men (n=3580)	Women (n=4282)	Men (n=371)	Women (n=463)	Men (n=1412)
Age (year)	64.4 (7.0)	62.3 (8.8)	69.9 (8.4)	68.2 (8.7)	53.1 (10.5)	52.6 (10.1)	78.4 (4.6)
Height (m)	1.74 (0.07)	1.60 (0.06)	1.78 (0.07)	1.63 (0.07)	1.79 (0.06)	1.66 (0.06)	1.71 (0.07)
Weight (kg)	93.6 (16.2)	87.0 (17.0)	89.6 (16.5)	77.1 (17.8)	83.3 (10.6)	69.8 (11.7)	79.7 (12.6)
BMI (kg/m^2)	30.8 (4.7)	34.0 (5.8)	28.3 (4.7)	28.9 (6.3)	25.9 (3.0)	25.4 (3.9)	27.1 (3.8)
Normal-weight (%)	7.3	3.7	23.7	29	41.4	55.2	29
Overweight (%)	40.4	21.4	47.1	33.9	49.7	32.3	51.2
Obese (%)	52.3	74.9	29.2	37.1	8.8	12.5	19.8
Wear time (min/day)	852 (216)	843 (209)	850 (282)	846 (268)	909 (211)	881 (213)	844 (246)
Mean counts (CPM)	318 (147)	258 (116)	103 (78)	84 (64)	358 (89)	341 (211)	186 (80)
Sedentary (hours/day)	9.6 (1.5)	8.7 (1.5)	11.5 (1.4)	11.6 (1.4)	8.7 (1.7)	8.4 (1.6)	10.2 (1.4)
Sedentary (%)	63	62	81.2	82	57.6	57.5	72.3
MVPA (min/day)	32.0 (26.6)	19.1 (17.3)	9.8 (14.9)	6.6 (11.6)	35.5 (30.0)	30.5 (30.6)	15.6 (17.6)
MVPA (%)	3.8	2.2	1.1	0.8	3.9	3.5	1.8

Study	WHS	FHS		NHANES		NNPAS		EPIC-NORFOLK	
	Women (n=16 738)	Men (n=1225)	Women (n=1396)	Men (n=1977)	Women (n=2001)	Men (n=1243)	Women (n=1371)	Men (n=3432)	Women (n=4225)
Age (year)	72.0 (5.7)	64.7 (9.6)	64.6 (9.1)	57.1 (12.5)	58.3 (12.2)	57.2 (10.8)	55.8 (11.0)	71.1 (7.6)	69.7 (7.5)
Height (m)	1.64 (0.1)	1.75 (0.07)	1.61 (0.06)	1.76 (0.08)	1.62 (0.07)	1.79 (0.06)	1.66 (0.06)	1.74 (0.07)	1.61 (0.06)
Weight (kg)	70.7 (14.2)	88.7 (15.7)	71.2 (15.8)	88.8 (18.8)	75.4 (18.6)	84.8 (12.4)	69.6 (12.0)	82.1 (12.7)	68.8 (12.7)
BMI	26.2 (5.0)	29.0 (4.6)	27.6 (5.8)	28.6 (5.5)	28.7 (6.7)	26.3 (3.4)	25.1 (4.2)	27.2 (3.7)	26.7 (4.7)
Normal weight (%)	46.3	16.9	35.7	22.3	25.5	28.5	56.4	27.9	40.6
Overweight (%)	34.2	47.7	35.9	44.7	31.1	48.9	32.2	53.1	39.4
Obese (%)	19.5	35.4	28.4	33	34.4	12.6	11.4	18.9	20
Wear time (min/day)	900 (260)	884 (288)	875 (290)	864 (232)	850 (231)	910 (247)	905 (239)	856 (61)	843 (58)
Mean counts (CPM)	198 (95)	148 (144)	129 (106)	309 (162)	259 (123)	330 (150)	325 (136)	247 (127)	237 (108)
Sedentary (hours/day)	9.9 (1.6)	11.2 (1.5)	11.3 (1.4)	8.5 (2.1)	8.4 (1.8)	9.6 (1.5)	9.1 (1.4)	9.7 (1.3)	9.2 (1.3)
Sedentary (%)	65.8	76.3	77.6	59.2	59	63.4	60.4	68	65.2
MVPA (min/day)	14.8 (16.8)	16.9 (23.3)	13.9 (19.7)	25.6 (24.7)	15.5 (16.6)	36.9 (26.4)	33.5 (23.5)	33.7 (26.9)	27.3 (21.7)
MVPA (%)	1.6	1.9	1.6	3	1.8	4.1	3.7	3.9	3.2

Data are mean (SD).

BMI, body mass index; BRHS, British Regional Heart Study; CPM, counts per minute; EPIC, European Prospective Investigation into Cancer; FHS, Framingham Heart Study; MVPA, moderate-to-vigorous intensity physical activity; NHANES, National Health and Nutrition Examination Survey; NNPAS, Norwegian National Physical Activity Survey; REGARDS, The REasons for Geographic and Racial Differences in Stroke; WAT2D, Walking Away from Type 2 Diabetes; WHS, Women's Health Study.

generally more active and spent less time sedentary compared with participants from the remaining studies. Across all cohorts, time spent sedentary, expressed as percentage of daily wear time varied between 57.5% and 82.0% in the least and most sedentary cohorts, respectively. Time spent in MVPA (% of daily wear time) varied fourfold between cohorts from 0.8% to 3.9%. Online supplemental table 2 shows the study specific medians (IQR) of total physical activity, sedentary time and MVPA by tertiles.

Joint associations: total physical activity and sedentary time

In multivariable-adjusted models (age, sex when applicable, socioeconomic position, BMI, smoking, presence of prevalent diseases or self-reported poor health, and other putative confounding factors displayed in online supplemental table 1) and excluding deaths within the first 2 years (figure 1) we observed that compared with the referent group (highest total physical activity/lowest sedentary time), the risk of all-cause mortality increased with lower levels of physical activity and greater amounts of sedentary time. Among those in the highest tertile of total activity, those in the middle and lowest tertiles of sedentary time experienced a 20% (95% CI 0.94% to 1.53%) and 88% (95% CI 0.92% to 3.84%) greater risk of death, compared with the referent group. However, these joint associations were not statistically different from the referent. As level of total physical activity decreased, the risk of death associated with greater amounts of sedentary time increased significantly. In the middle tertile of physical activity, the relative risks of mortality were 38% (95% CI 1.13% to 1.70%), 34% (95% CI 1.06% to 1.70%) and 44% (95% CI% 0.99 to 2.10%) greater across increasing tertiles of sedentary time. In the least active third, the risks were 260% (1.46% to 4.63%), 148% (95% CI 1.21% to 1.81%) and 240% (95% CI 1.85% to 3.13%) greater, respectively, across tertiles of sedentary time. Some effect estimates for extreme groups (eg, low total physical activity in combination with low sedentary time) had wide 95% CI due to small numbers. The HRs for the crude association and other less adjusted models (models 1–3) are shown in online supplemental figures 1–3.

Joint associations: MVPA and sedentary time

In multivariable-adjusted models (age, sex when applicable, socioeconomic position, BMI, smoking, presence of prevalent diseases or self-reported poor health and other putative confounding factors displayed in online supplemental table 1)

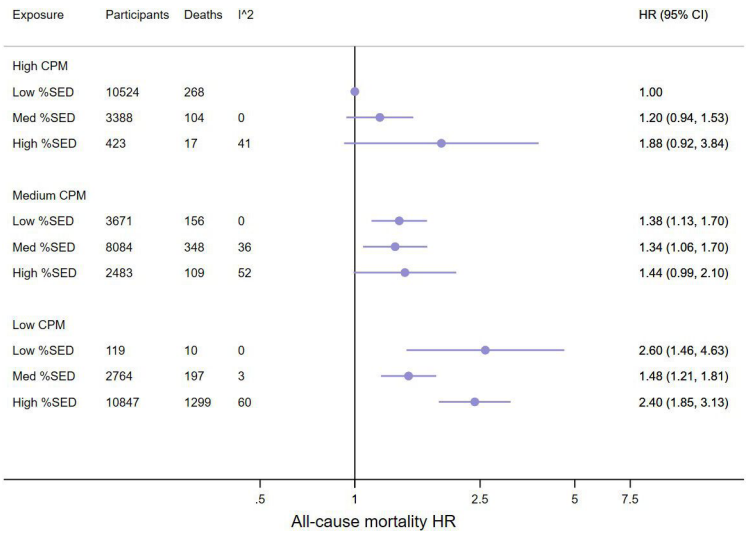

Figure 1 The joint association between total physical activity and sedentary time and all-cause mortality. Analyses are adjusted for age, sex when applicable, socioeconomic position, BMI, smoking, presence of prevalent diseases or self-reported poor health, and other putative confounding factors displayed in online supplemental table 1, and additionally excluding deaths within 2 years (n=42 203; 2508 deaths). Data are HRs and 95% CIs. Sedentary time is expressed as percentage of daily wear time. The median amount of total physical activity (CPM), and time (min/day) spent sedentary across tertiles were 138 CPM, 251 CPM and 396 CPM; and 8.5, 9.4 and 10.7 hours/day, respectively (see online supplemental table 2 for additional information). BMI, body mass index; CPM, counts per minute.

and excluding deaths within the first 2 years (model 4; figure 2) we observed similar patterns of associations as for total physical activity. Among those in the highest tertile of MVPA, the risk of death was not statistically different from the referent for those in the middle (16%; 95% CI 0.87% to 1.54%) and highest (40%; 95% CI 0.87% to 2.26%) tertiles of sedentary time. Similarly, as levels of MVPA decreased the risk of death increased. In the middle tertile of MVPA, the relative risks of death were 5% (95% CI 0.83% to 1.33%), 31% (95% CI 1.02% to 1.67%) and 68% (95% CI 1.22% to 2.30%) greater across increasing tertiles of sedentary time compared with the referent. Those in the lowest third of MVPA had an increased risk of death in all combinations with sedentary time; 65% (95% CI 1.25% to 2.19%), 65% (95% CI 1.24% to 2.21%) and 263% (95% CI 1.93% to 3.57%), respectively. The HRs for the crude association and other less adjusted models (models 1–3) are shown in online supplemental figures 4–6.

In subgroup analyses, we examined the joint associations between time in MVPA and sedentary time with all-cause mortality separately in the nationally representative samples (n=5977, 933 deaths) and in the remaining non-national cohorts (n=36 226, 2141 deaths) (figure 3A,B). In both sub-groups, the shape of the dose–response patterns was similar to our primary analyses. However, in the nationally representative cohorts, the

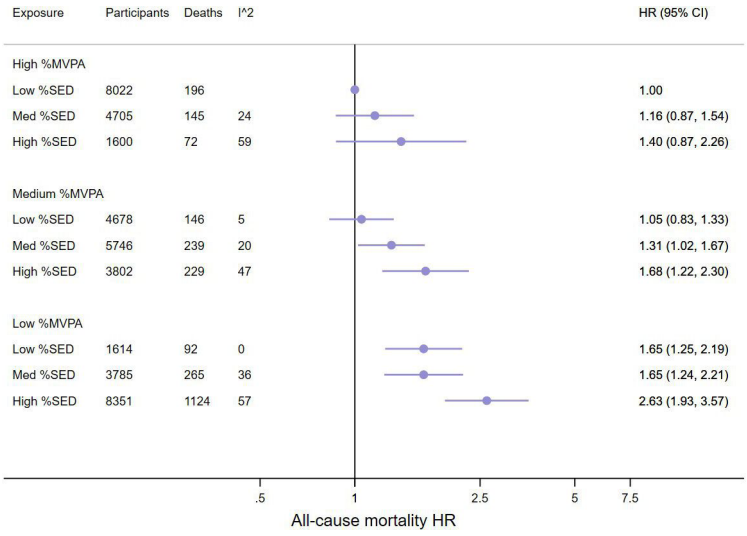

Figure 2 The joint association between moderate-to-vigorous-intensity physical activity (MVPA) and sedentary time and all-cause mortality. Analyses are adjusted for age, sex when applicable, socioeconomic position, BMI, smoking, presence of prevalent diseases or self-reported poor health, other putative confounding factors displayed in online supplemental table 1, and additionally excluding deaths within 2 years (n=42 203; 2508 deaths). Data are HRs and 95% CIs. sedentary time and MVPA are expressed as percentage of daily wear time. The median amount of time (min/d) spent sedentary and in mvpA (min/day) across tertiles were 8.5, 9.5 and 10.7 hours/day; and 2.3, 11.2 and 34.3 min/day, respectively (see online supplemental table 2 for additional information). BMI, body mass index.

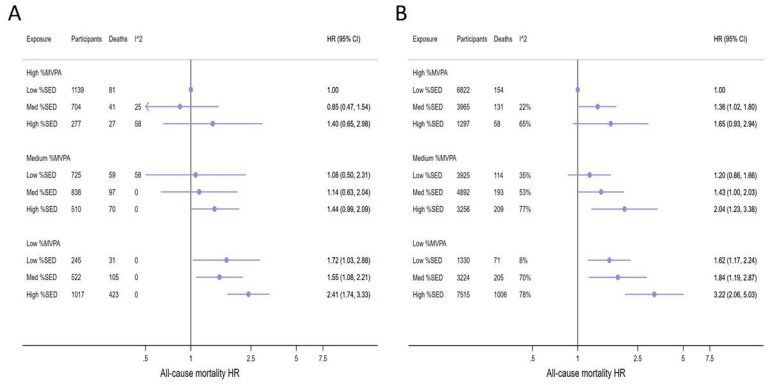

Figure 3 The joint association between moderate-to-vigorous-intensity physical activity (MVPA) and sedentary time (SED) and all-cause mortality categorised by national (A) and non-national cohorts (B). Data are adjusted for age, sex, BMI, socioeconomic position, smoking, presence of prevalent diseases or self-reported poor health and other putative confounding factors according to online supplemental table 1. Data are HRs and 95% CIs. Sedentary time and MVPA are expressed as percentage of daily wear time. The median amount of time (min/day) spent sedentary and in mvpA (min/day) across tertiles were 7.1, 8.6 and 10.2 hours/day; and 10.6, 27.0 and 52.2, min/day, respectively for the National cohorts (figure 3a) and 8.9, 10.1 and 11.3 hours/day; and 1.4, 9.5 and 29.7 min/day, respectively, for the non-national cohorts (figure 3B) (see online supplemental table 2 for additional information). BMI, body mass index.

95% CI overlapped 1 for all combinations between MVPA and sedentary time in the two most active tertiles and the risk of death was only statistically significantly higher for those in the lowest tertile of MVPA (figure 3A).

Stratified analyses physical activity and sedentary time

We thereafter examined the associations between sedentary time and all-cause mortality in strata of total physical activity or time spent in MVPA using the low sedentary third as the referent to examine whether the association between sedentary time and mortality was different in different strata of physical activity (table 2). The direction of results mirrored those of the joint analysis but with all confidence intervals crossing unity for total physical activity (CPM) combined with sedentary time, an observation consistent in crude and multivariable-adjusted models. However, the highest tertile of sedentary time was consistently associated with higher risk of death within each stratum of time spent in MVPA (min/day) and HRs were similar across strata. In the final model (model 4) the risk of death was not statistically different across sedentary tertiles in the high MVPA tertile despite similar effect sizes as those from models 1–3. In some of these groups, including the referent groups, numbers of participants and of cases were low.

Online supplemental table 3 shows the calculated E-values for all combinations for the joint association between MVPA and sedentary time and all-cause mortality, which were >2 for all combinations with the lowest tertile for MVPA or highest tertile for sedentary time. This suggests that any uncontrolled or residual confounding would have to at least double the risk of mortality to fully explain our observed associations for any combination of low MVPA or high sedentary time compared with the referent.

DISCUSSION

Our results, obtained from a harmonised meta-analysis of accelerometer measured physical activity and sedentary time in more than 44 000 middle-aged and older men and women, indicate that physical activity and sedentary time can be combined differently to reduce the risk of premature death. The association between sedentary time and higher risk of death appears attenuated, although not completely eliminated, in those in the highest third of time spent in MVPA. In contrast, those with low physical activity (lowest third) had a higher risk of premature death, with the greatest risk of death occurring in those with the highest sedentary time. In stratified analyses, the risk of death was higher by increasing levels of time spent sedentary across strata for time in MVPA, whereas the role of total physical activity in modulating risk of death with high sedentary time was less clear.

Comparison with previous studies

These results provide a unique contribution because previous studies examining the joint associations between physical activity and sedentary time and mortality have assessed physical activity and sedentary behaviours by self-report.[4 6] A previous meta-analysis suggested that between 60 and 75 min per day of leisure time physical activity of moderate intensity was needed to eliminate the risk of mortality associated with sitting time.[4] While the pattern of associations is generally similar when comparing our findings with self-report,[4–6] we were able to quantify the amount of time spent in MVPA needed to attenuate the risk of premature death associated with sedentary time.

Our joint analysis results suggest that about 30–40 min (median of medians=34 min; IQR: 26–48 min) of MVPA per day (online supplemental table 2) attenuated the risk of death in our most conservative model. Those with as little as 11 min per day of MVPA in combination with 'low' sedentary time (ie, <8.5 hours per day) did not differ in risk compared with the referent group (ie, highest third of MVPA in combination with lowest third for sedentary time). This finding may suggest that relatively low levels of MVPA, lower than the current recommendations,[24–26] reduces the risk of death if combined with low levels of sedentary time. In contrast, in the lowest third of MVPA comprising those who accumulated about 2 min of MVPA per day on average, all combinations with sedentary time (ie, 8.5–10.7 hours per day) were associated with a higher risk of premature death with point estimates all higher than all combinations of sedentary time in the high MVPA category.

Subgroup analyses that categorised studies into national (ABC, NHANES, NNPAS) and non-national samples indicated that sedentary time was associated with higher risk of death in the low active third, (average MVPA of about 11 min per day of MVPA) in the national cohorts only. Compared with the

Table 2 Meta-analysis for the associations between sedentary time (% of daily wear time) and all-cause mortality by levels of total physical activity (CPM) and time spent in moderate-to-vigorous-intensity physical activity (MVPA; % of daily wear time) (n=44 370; 3451 (model 1); n=42 420; 3137 (model 2); n=42 203; 3074 (model 3); n=42 303; 2508 (model 4)) (n in each cell refers to number of participants and deaths)

	Low sedentary	Medium sedentary	High sedentary
Model 1*			
Total PA (CPM)			
Low PA	1 (Ref) (n=122; 10)	0.65 (0.36 to 1.18) (n=2890; 252)	1.02 (0.58 to 1.78) (n=11 719; 1906)
Medium PA	1 (Ref) (n=3810; 186)	0.97 (0.95 to 1.26) (n=8413; 457)	1.10 (0.71 to 1.70) (n=2589; 145)
High PA	1 (Ref) (n=10 889; 348)	1.13 (0.90 to 1.41) (n=3509; 128)	1.55 (0.86 to 2.77) (n=429; 19)
MVPA			
Low PA	1 (Ref) (n=1666; 109)	0.91 (0.73 to 1.14) (n=3973; 345)	**1.73 (1.32 to 2.27) (n=9102; 1669)**
Medium PA	1 (Ref) (n=4860; 184)	1.08 (0.90 to 1.29) (n=5970; 309)	**1.50 (1.24 to 1.82) (n=3979; 304)**
High PA	1 (Ref) (n=8295; 251)	1.18 (0.90 to 1.56) (n=4869; 183)	**1.61 (1.05 to 2.46) (n=1656; 97)**
Model 2†			
Total PA (CPM)			
Low PA	1 (Ref) (n=113; 10)	0.65 (0.36 to 1.18) (n=2738; 231)	1.04 (0.58 to 1.85) (n=11 102; 1689)
Medium PA	1 (Ref) (n=3645; 175)	1.00 (0.74 to 1.34) (n=8100; 430)	1.08 (0.84 to 1.38) (n=2466; 132)
High PA	1 (Ref) (n=10 484; 329)	1.20 (0.94 to 1.53) (n=3368; 125)	1.71 (0.94 to 3.10) (n=404; 16)
MVPA			
Low PA	1 (Ref) (n=1582; 103)	0.98 (0.78 to 1.23) (n=3774; 319)	**1.86 (1.44 to 2.39) (n=8606; 1471)**
Medium PA	1 (Ref) (n=4671; 174)	1.18 (0.95 to 1.45) (n=5751; 293)	**1.57 (1.28 to 1.91) (n=3787; 281)**
High PA	1 (Ref) (n=7989; 237)	**1.31 (1.03 to 1.65) (n=4678; 174)**	**1.71 (1.14 to 2.59) (n=1579; 85)**
Model 3‡			
Total PA (CPM)			
Low PA	1 (Ref) (n=112; 10)	0.69 (0.37 to 1.26) (n=2719; 225)	1.01 (0.56 to 1.85) (n=11 012; 1644)
Medium PA	1 (Ref) (n=3628; 173)	1.06 (0.78 to 1.46) (8068; 424)	1.21 (0.86 to 1.72) (2456; 132)
High PA	1 (Ref) (n=10 446; 327)	1.19 (0.94 to 1.52) (n=3358; 123)	1.80 (0.87 to 3.74) (n=404; 16)
MVPA			
Low PA	1 (Ref) (n=1575; 102)	0.98 (0.77 to 1.25) (n=3746; 310)	**1.72 (1.29 to 2.29) (n=8532; 1428)**
Medium PA	1 (Ref) (n=4650; 173)	1.15 (0.89 to 1.49) (n=5730; 290)	**1.51 (1.23 to 1.86) (n=3766; 279)**
High PA	1 (Ref) (n=7961; 235)	1.20 (0.85 to 1.69) (n=4669; 172)	**1.75 (1.07 to 2.87) (n=1574; 85)**
Model 4§			
Total PA (CPM)			
Low PA	1 (Ref) (n=119; 10)	0.58 (0.33 to 1.01) (n=2764; 197)	1.13 (0.68 to 1.94) (n=10 847; 1299)
Medium PA	1 (Ref) (n=3671; 156)	0.99 (0.72 to 1.35) (n=8084; 348)	1.05 (0.75 to 1.47) (n=2483; 109)
High PA	1 (Ref) (n=10 524; 268)	1.22 (0.93 to 1.58) (n=3388; 104)	2.27 (0.91 to 5.67) (n=423; 17)
MVPA			
Low PA	1 (Ref) (n=1614; 92)	0.92 (0.70 to 1.20) (n=3785; 265)	**1.56 (1.09 to 2.21) (n=8351; 1129)**
Medium PA	1 (Ref) (n=4678; n=146)	1.19 (0.85 to 1.66) (n=5746; 239)	**1.49 (1.14 to 1.94) (n=3675; 229)**
High PA	1 (Ref) (n=8022; 196)	1.17 (0.83 to 1.65) (n=4705; 145)	1.67 (0.98 to 2.84) (n=1600; 72)

*Adjusted for age and sex (when applicable).
†Adjusted for age, sex (when applicable), socioeconomic status and BMI.
‡Adjusted for adjusted for age, sex (when applicable), socioeconomic status, BMI and additional covariates described in online supplemental table 1.
§Model three and excluding deaths within 2 years; boldface indicates significant association (p<0.05).
BMI, body mass index; CPM, counts per minute; MVPA, moderate-to-vigorous intensity physical activity; PA, physical activity.

non-national cohorts that accumulated about 2 min of MVPA in the least active third, the national cohorts included younger and more active individuals with a longer period of follow-up. How these characteristics may modulate the association between sedentary time and mortality requires further scrutiny when longer follow-up data are available.

Our results also indicate that the amount of MVPA needed to attenuate the risk associated with sedentary time may be lower than previously suggested using self-reported data.[4] However, this is likely explained in part by differences between self-reported and accelerometer measured physical activity and sedentary behaviour. Self-reported physical activity usually only assesses specific domains, such as leisure time and recreational physical activity accumulated in bouts or categorised into specific time blocks (self-report studies typically ask about activities that last at least 10 min in duration, in keeping with previous physical activity guidelines; this 10 min minimum duration has now been removed in the most recent guidelines,[24–26]) whereas accelerometer measures capture more movement across multiple domains.

The recently updated physical activity guidelines from the UK, the USA and WHO[24–26] recommend that adults should participate in physical activity for 150–300 minutes of at least moderate intensity every week. They also state that people should move more and sit less throughout the day and that any activity is better than none.[24–26] The new guidelines from WHO[26] also acknowledge the emerging evidence on the interaction between sedentary behaviour and MVPA and states that adults should aim to do more than recommended levels of MVPA to reduce the detrimental effects of high sedentary time.[26] The results from this study, where physical activity and sedentary time were

measured by accelerometry, suggest that accumulating time in MVPA equivalent to the upper level of the 150–300 min per week recommendation may be sufficient to attenuate the detrimental association between sedentary time and risk of premature death. Evidence is also accumulating on the beneficial effect of total physical activity[1 9 27] and light intensity physical activity for longevity.[1 28] In joint analyses of sedentary time and total physical activity (which includes light, moderate and vigorous intensities), we observed a higher risk of death for higher amounts of time spent sedentary in all combinations with total physical activity. However, the risk was not statistically different from the referent in the most active third of total physical activity (figure 1). In line with current physical activity recommendations,[24–26] reducing sedentary time must increase total physical activity (since time in a day is finite) and thus likely reduce the risk of premature death. However, because of uncertainty in effect estimates for some cross-combinations of total activity and sedentary time, more work is needed to determine the interplay between total activity and sedentary time in relation to mortality.

The cohorts included in our meta-analyses accumulated approximately 16 min in MVPA per day. Although not directly comparable, this is lower than population-based estimates in Swedish and Norwegian men and women aged 60–85 years[16 29] and comparable to US men, but higher than in US women aged 60–75 years.[29] Further, time spent sedentary was almost 10 hours per day and considerably higher than comparable population-based estimates from the USA with a younger age structure.[30] Thus, the associations observed between combinations of physical activity and sedentary time with mortality may not be generalisable to younger and more active populations, nor to low-income and middle-income countries.

Strengths and limitations

To our knowledge, this is the first meta-analysis examining the joint associations between physical activity, sedentary time and all-cause mortality using accelerometer measured exposure variables. Accelerometer measured physical activity has higher precision which reduces random error as compared with self-report and, importantly, minimises bias due to correlated cognitive biases in self-reported physical activity and sedentary behaviours. Additional strengths of this study include harmonisation of exposure data and study specific analyses according to a standardised protocol reducing heterogeneity due to different data reduction and data cleaning procedures. We were able to control for many potential confounders in our final model and estimated the E-value as an indicator of the potential impact of unmeasured or residual confounding.[23] An uncontrolled confounder must be associated with both the exposure combination (physical activity and sedentary time) and mortality in the order of at least two to bias or negate the observed associations for those combinations including either the lowest third of MVPA or highest third of sedentary time (E-values between 2.1 and 4.63; lower CI 1.61 to 3.2; online supplemental table 3). To put this in context, the HR for all-cause mortality comparing never vs current smokers was 2.26 and 1.34 in the NHANES and NNPAS data sets, respectively. While we cannot rule out residual confounding, uncontrolled confounding would have to be as large in magnitude as smoking to distort our results. Finally, in our most conservative model, we excluded deaths within the first 2 years to reduce the risk of reverse causation bias. However, follow-up time was short (median 5.5 years) in some of the cohorts which may have a substantial impact on observed associations.[31 32]

Limitations of our study include its observational design. We cannot rule out reverse causation bias from prevalent medical conditions or subclinical disease despite the results excluding deaths within the first 2 years supporting our conclusion. We adjusted our analyses for several covariates including smoking and pre-existing illness or self-reported poor health in our final model but cannot exclude the possibility of residual or unmeasured confounding or other biases. Our sample included middle-aged and older individuals who were at least 40 years at baseline, and it is unclear if the results are generalisable to younger populations. Some of the groups in our analyses had low numbers of individuals and deaths making the point estimates uncertain. Low number of individuals and cases in some of the referent groups in our stratified analyses for total physical activity also makes these associations less reliable. Two different accelerometers were used by the included cohorts and these have only moderate agreement on total sedentary time for the applied cut-points,[33] suggesting they assess sedentary time slightly differently. We reanalysed our data excluding one study at a time to examine if the results were influenced by a specific study and the results were not materially altered. Sedentary time estimated from movement-based cut-points may include non-sedentary behaviours such as standing. However, in the older participants, when movement was not registered over long periods, they were likely to be sedentary rather than standing with little movement. Errors in estimating MVPA and sedentary time are not completely uncorrelated as they are measured from the same device, for instance, failure to correctly identify non-wear time would increase sedentary time and subsequently lower our measure of total physical activity and MVPA in percent of wear-time. Finally, exposure variables were only measured once and change in behaviours between baseline and follow-up may have affected our results. However, accelerometer measured physical activity and sedentary time show good stability (Intra-class correlation 0.70–0.83) over two to 3 years in a 70-year-old women.[34]

CONCLUSION

Higher sedentary time is associated with higher mortality in less active individuals when measured by accelerometry. About

Key messages

What are the findings?

- Moderate-to-vigorous-intensity physical activity and sedentary time as measured by accelerometry can be combined differently to reduce the risk of premature death.
- High amounts of sedentary time (>10.7 hours per day) is associated with higher risk of mortality, especially in those with low or very low levels of moderate-to-vigorous intensity physical activity.
- In active individuals doing about 30–40 min of moderate-to-vigorous-intensity physical activity, the association between high sedentary time and risk of death is not significantly different from those with low amounts sedentary time.

How might it impact on clinical practice in the future?

- Our work may inform the development of future recommendations for physical activity and sedentary time by WHO and other public health authorities.
- Individuals who currently must spend large amounts of time sedentary due to work and transportation should aim to achieve the upper recommended level of 150–300 min of moderate-to-vigorous-intensity physical activity per week.

30–40 min of MVPA per day attenuate the association between sedentary time and risk of death, which is lower than previous estimates from self-reported data.

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