Addressing Frailty in Primary Care: Outcomes from a 12-week functional strength programme

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Down and North Down & Ards GP Federations / SEHSCT

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Background & Rationale

- Frailty = ↑ vulnerability, ↓ reserve
- 29% prevalence NI (*NICOLA*) vs 15% ROI (*TILDA*)
- Early intervention could delay/reverse decline

Frailty Syndromes

- Pain
- Strength
- Opioids or falls risk meds
- BMI
- Smoking
- Cognition
- Mental Health
- Nutrition & Water
- Poly Pharmacy
- Alcohol
- Loneliness

Clinical Frailty Scale

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging. Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Inspiring Minds

Role of First Contact Physiotherapists

- Direct access in primary care
- Skilled in functional testing & exercise
- Ideal to bridge screening → action
- What specific training did we have??

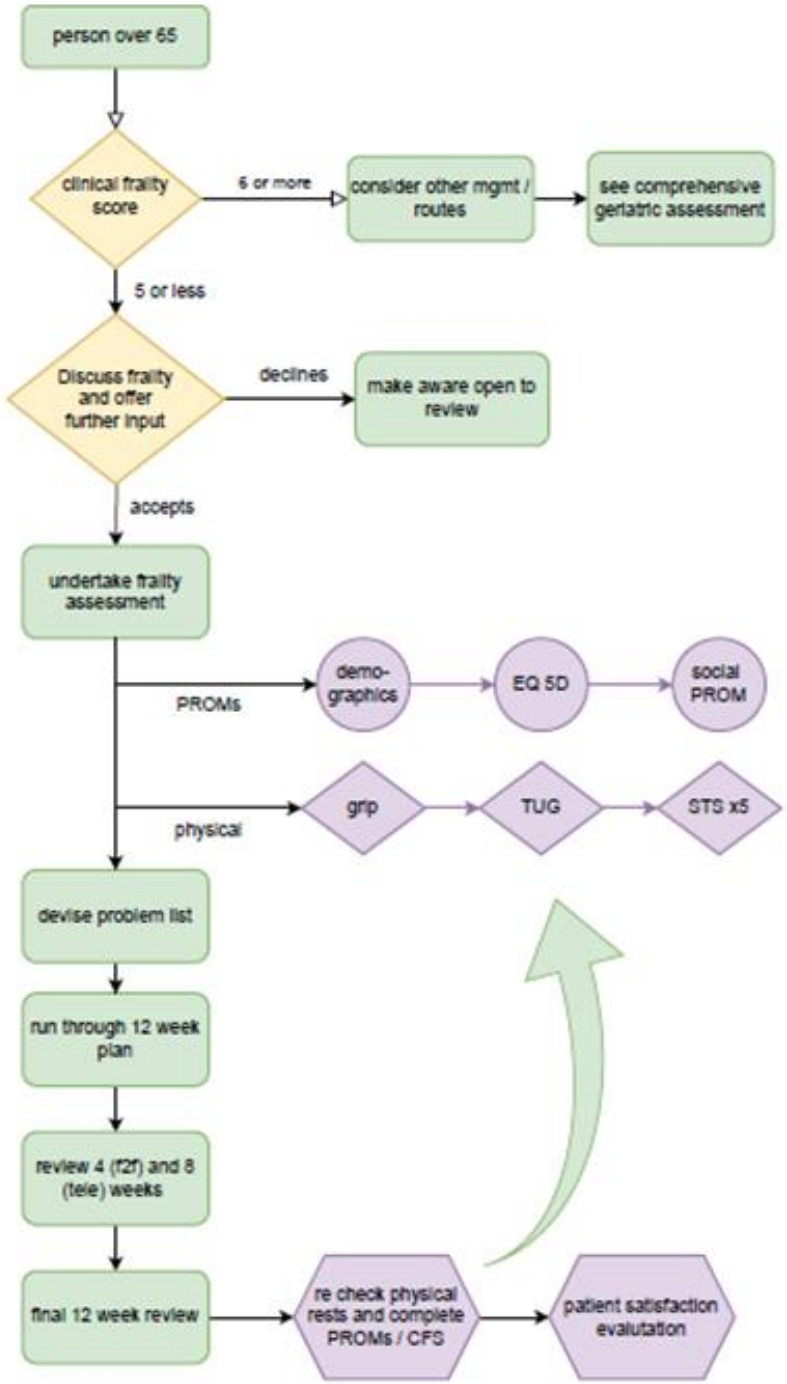
Study Aim

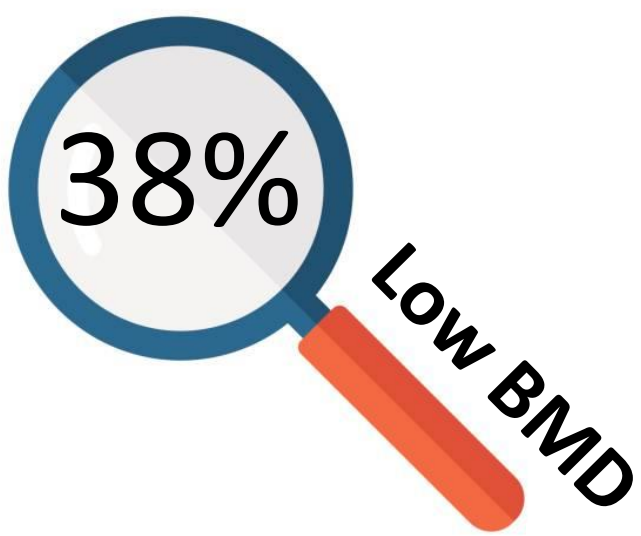
Our aim was simple –

test whether a 12-week, FCP-led functional strength programme for identified mildly frail older adults was feasible, safe, and beneficial in real-world primary care

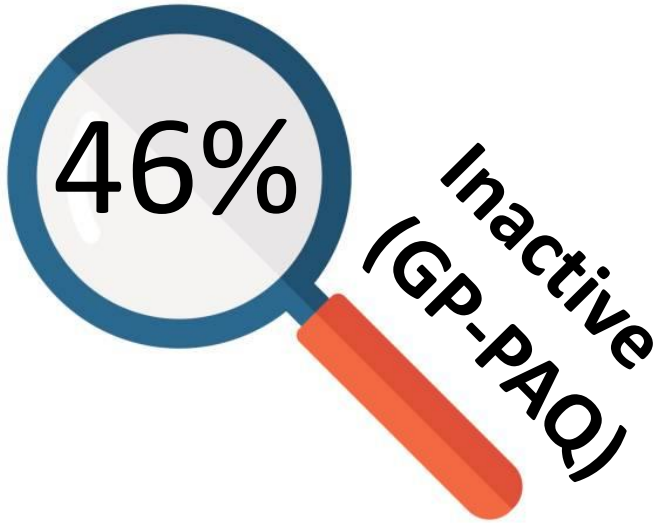
Methods: Design & Participants

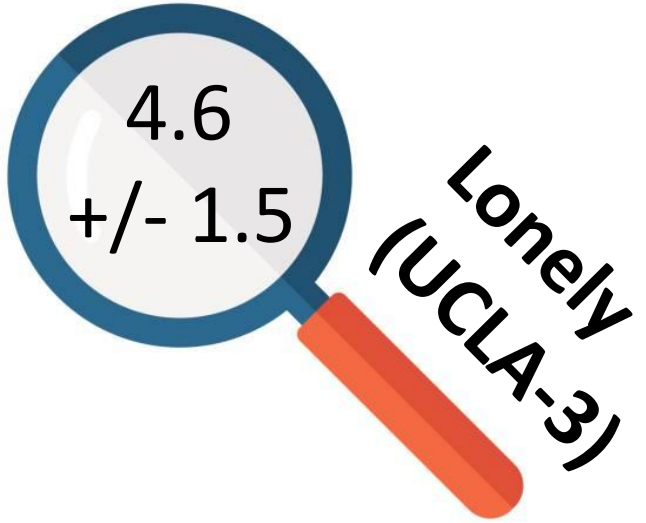
- Direct access in primary care – coming with an MSK issue
- Skilled in functional testing & exercise
- Ideal to bridge screening → action


person over 65
clinical frailty score
6 or more
consider other mgmt / routes
see comprehensive geriatric assessment
5 or less
Discuss frailty and offer further input
declines
make aware open to review
accepts
undertake frailty assessment
PROMs
demo-graphics
EQ 5D
social PROM
physical
grip
TUG
STS x5
devise problem list
run through 12 week plan
review 4 (f2f) and 8 (tele) weeks
final 12 week review
re check physical rests and complete PROMs / CFS
patient satisfaction evalutation



Of note...













Methods: Intervention

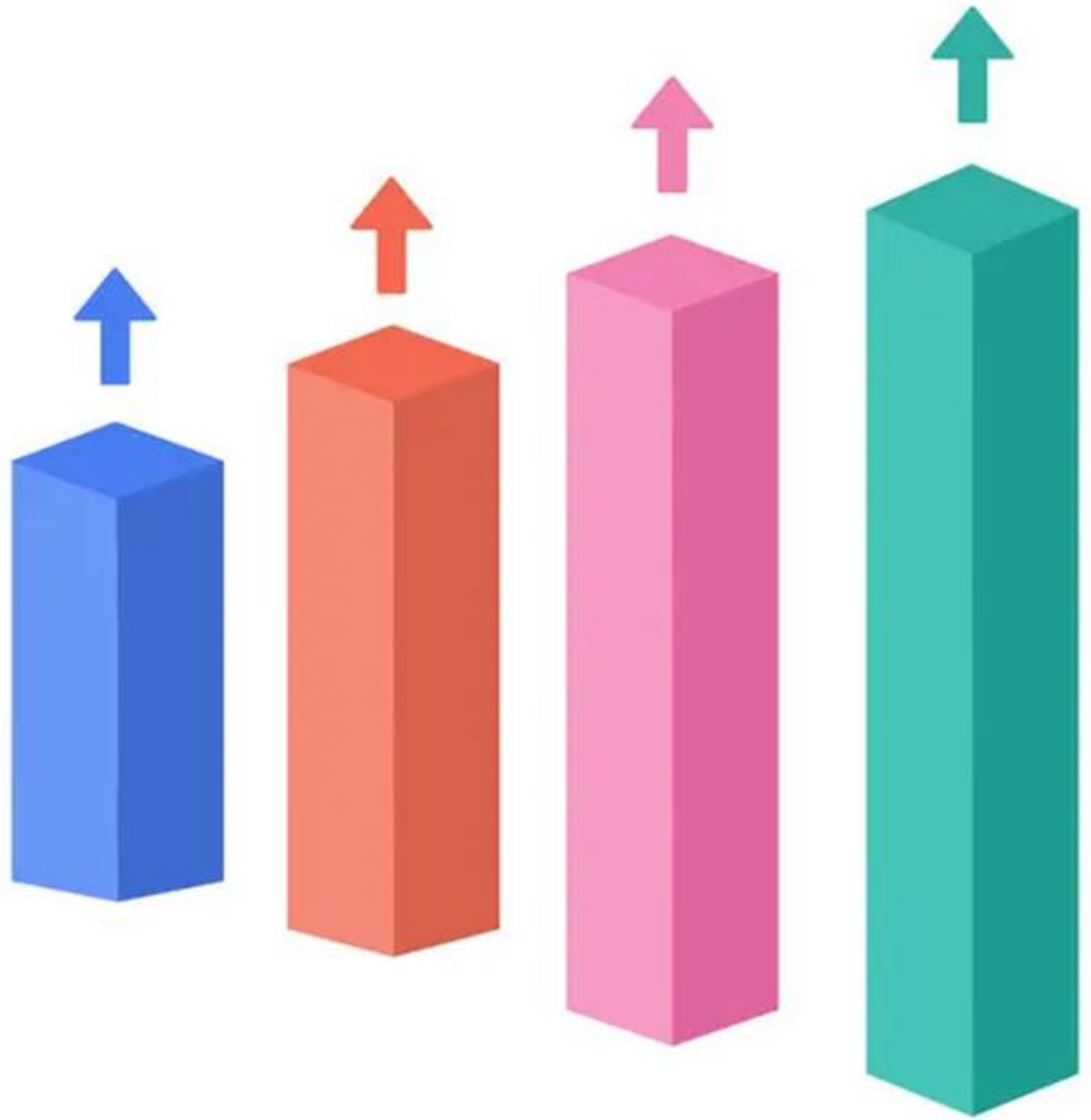
- 6 functional strength exercises
- 2×/week, 12 weeks
- Reviews at weeks 4 & 8

Methods: Outcome Measures

- Primary: 5xSTS, TUG, Grip strength
- Secondary: EQ-5D-5L, Adherence
- Safety monitoring

Results: Participant Profile

- Mean age 74.5 (±6.9)
- 62% CFS 4
- Adherence: 92% median



Results: Primary Outcomes

- 5xSTS: –4.17s (p=0.006)
- TUG: –1.17s (p=0.048)
- Grip +1.33 kg (NS)

Results: Secondary Outcomes

- EQ-5D Index +0.123 (p=0.050)
- No adverse events

Discussion:
Key Points

- Clinically meaningful functional gains
- Safe & high adherence
- Fits within existing FCP capacity

Strengths & Limitations

- Strengths: Real-world delivery, validated tests, high adherence and +ve feedback
- Limits: Small sample, no control group, short follow-up timeframe.

Conclusions & Next Steps

- FCP can participate in frailty management
- Utilise tech – future projects?
- Wider discussions with services particularly the wider frailty network and create/maximise links

Acknowledgements

Thank you...
Questions?

Useful resources