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EDITORIAL

Acute care for frail older people: time to get back to basics?

Readers of *Age and Ageing* will be well aware that systematic reviews reporting on >6500 patients in 13 well-conducted RCTs have demonstrated that comprehensive geriatric assessment (CGA) improves outcomes for older people [1]. The evidence that CGA is effective in older people in a range of settings, including acute care is now well established [2, 3]. However, most acute medical units (AMUs) in England and Wales continue to operate an integrated approach [4], with a variety of physicians contributing to the care of frail older people.

In the current economic climate, new forms of team working which improve efficiency without adversely affecting mortality or re-admission rates are to be welcomed. This is an area of research which in which studies are often 'small-scale, without rigorous study design or the ability to generalise to other settings' [5], and which attempts to demonstrate approaches by which clinical teams can manage, and evidence, changes in practice to improve clinical service delivery.

The paper from Silvester *et al.* describes the use of a clinical microsystems approach to improving the flow of emergency geriatric medicine patients in a single NHS acute hospital trust. Changes in daily bed occupancy were used to measure the impact of the changes. Mortality and readmission rates were also measured. Importantly, the changes in the processes of care they describe included changes in the setting for assessment (the patient's home, or a dedicated 'Frailty Unit') and the processes by which patients were reviewed by senior medical staff ('Seven Day Working'). The intention was clearly to enhance the provision of appropriate and CGA.

While questions remain such as who benefits most or what form of CGA is most effective, the concept of a service that specifically targets frail older people is attractive, and receives support from the construction of frailty as an accumulation of deficits which is associated with the typical clinical presentations that Geriatricians recognise as the bread and butter of their specialty. However, many of the randomised controlled trials which have shown the benefit of CGA were without operational definitions of frailty to inform the selection of participants, so cannot be said to have been 'frailty intervention' trials.

So what do we need to do to ensure frail older people get a better deal in acute care settings? While the development of AMUs are a substantial improvement on the 'safari ward rounds' of the last century [6], the needs of frail older people still need to be addressed.

It is clear that hospitals must adapt to the growing numbers of frail older people who will be accessing acute care. Acute Frailty Units (AFUs) hold significant promise, especially in light of the concerns about the relative ineffectiveness of geriatric liaison services [7, 8]. While AFUs on their own are insufficient to address all the issues pertaining to the care of frail older people in the acute care context, they can act as a significant hub of good practice and focused effort; the Future Hospital Commission [9] report lays out a blue-print for the more generalist approach that is required to care for the increasing number of older people that will be encountered in all settings.

While some of the larger UK centres may be able to operate AFUs already, creating a dual service for acute medicine and frailty medicine (i.e. high volume – low intensity versus low volume – high intensity work) may not be rapidly achievable in all settings. This issue of critical mass will not be addressed sufficiently by workforce changes alone, but will require service reconfiguration along the lines of stroke services. Establishing robust communication mechanisms that allow clinicians to discuss individual patients to weigh up the pros and cons of transfer into acute care, as well as the 'knowledge transfer' that clinical discussions can bring, will be key.

Nearly 60 years ago, Marjory Warren fought to bring the benefits of acute care to frail older people; the intervening period has seen the principles of geriatric medicine becoming more and more mainstream. Despite these fantastic achievements, the best outcomes for frail older people in the acute care context are still delivered by dedicated services—the time to rediscover geriatric medicine has come!

Key points

- Many UK AMUs run an integrated system, yet there is a robust evidence base to support the care of frail older people in acute care within dedicated services that deliver CGA.
- How UK services can be configured to deliver high quality acute care for frail older people remains a challenge.

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Conflicts of interest

None declared.

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