Letters to the Editor

Front door geriatrics has much to offer

The systematic review by Lowthian *et al.* has been interpreted by your editor that 'the sensible conclusion is that we do not need a geriatrician at the front door of accident and emergency'. The commentary by Dr Conroy reached a more measured conclusion. For geriatricians engaged in this front door service, the Lowthian review misses the point regarding the main rationale behind the service: namely to reduce admissions. It would indeed be wonderful if brief comprehensive geriatric assessment in the Emergency Department, combined with community-based follow up, led to reduced mortality and functional decline in those discharge by comparison with a more conventional service within the ED and without organised follow up. Most community interventions have struggled to demonstrate effectiveness in the context of frailty, and so this was not a surprise.

The point missed by Lowthian *et al.* is that the service exists principally to identify patients for whom admission is not essential, and where the perceived risks of admission may well outweigh the potential benefits. Those not currently practicing clinicians may not realise that many older people with non-specific frailty presentations are admitted because of concern about a blood test such as an abnormal CRP, troponin T or acute kidney injury. For many of these patients an experienced geriatrician can safely manage a proportion of these patients without admission. This saves hospital admissions and the associated risks. The crucial test of course is whether this can be done without adversely impacting on mortality or early hospital re-admission, and still achieving patient satisfaction. Audits of these services are providing a growing body of positive evidence. A key outcome indicator is the proportion of over 85s presenting to the ED who are then admitted. This figure can be reduced by experienced physicians with positive risk-taking. To achieve significant impact on the hospital system requires the service to be scaled up to a 7-day service which of course needs investment. The apparently negative message from this paper will do nothing to encourage investment from Hospital Trusts.

Conflict of interest

None declared.

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Re: Front door geriatrics has much to offer

We appreciate Dr Donald's comments in response to our systematic review and meta-analysis on Emergency Department (ED) community transition strategies.

Our review sought to examine care models implemented to support safe transition to the community from ED. Measurement of effectiveness of these interventions was limited by the reported outcomes, which focused predominantly on subsequent risk of unplanned return to hospital, rather than patient health outcomes. As such, our review does not negate the evidence that shows positive effects of comprehensive geriatric assessment (CGA) in the inpatient setting on subsequent patient outcomes [1]. As with inpatient-delivered CGA, a key aspect for the ED setting is direct linkage with community-based services to ensure seamless integration of care and support, especially in the immediate post-ED period of heightened vulnerability.

We agree that one of the aims of emergency care should be to avoid admission where clinically appropriate. This would not only reduce the risk of negative clinical consequences for patients, but also have health system benefits [2]. Impact of CGA on admission rates from ED is certainly worthy of investigation. Appropriately designed trials that assess effectiveness alongside the implementation strategy would help inform service providers and funders of appropriate resourcing of such services.

Conflict of interest

None declared.

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References

1. Ellis G *et al.* Comprehensive geriatric assessment for older adults admitted to hospital: meta-analysis of RCTs. BMJ 2011; 343: d36553.
2. Arendts G, Lowthian J. Demography is destiny: an agenda for geriatric emergency medicine in Australasia. EMA 2013; 25: 271–8.

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