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ACUTE PERSPECTIVE

David Oliver: "Considerably transformed"—changing the narrative on admitting older patients

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I knelt by the patient's bed. Admitted four days earlier when acutely unwell, confused, and immobile, he was now improving.

"How are you today?"

"Doctor, I must say, I'm considerably transformed and substantially restored. I almost feel ready to go home."

Right now, in the language used to describe acute care, admission is relentlessly portrayed as a bad thing for adults, especially older ones.[1-3] It suggests that they'd always want to stay at home or get home sooner—though this barely considers the patients who welcome admission or a slightly longer stay, or the family members providing care, who are often stressed, burnt out, and unsupported.[4 5] This narrative says that inpatients risk hospital acquired infection, deconditioning, delirium, poor nutrition, depersonalisation, iatrogenic harm, and the perils of bed rest. There are data to support such arguments.[6-9] But many of these patients have progressive, long term conditions or frailty, are on a downward trajectory, and would do as badly, or worse, at home or in community settings.[10-12]

The rhetoric is meaningless unless you look at the counterfactual—what would have happened if the patient hadn't come in. And, despite frequent reports suggesting that many inpatients have needs that don't require acute hospital beds,[4 5 13] we know from reports on intermediate care, community services, primary care, and district nursing that adequate capacity in those services is hypothetical, not actual, so audits of bed use[14] can mislead.

The "hospital bad/home good" narrative, which makes it a thought crime to make a pragmatic clinical decision to admit patients, is disingenuous. The real drive behind it is that the UK is one of the lowest for beds per 1000 population among developed OECD nations,[15] and England has fewer still.[16] Our hospitals are far too full, and we've not only closed too many beds[17] but have put increasing numbers out of action for days or weeks because of stranded patients who can't transfer to under-resourced community services.[13 18] The problem is not that people shouldn't be admitted or can't benefit from admission—it's that they stay too long.

We should care about research evidence as much as ideology and policy pushes. Systematic review and meta-analysis of multidisciplinary, specialist led, comprehensive geriatric assessment of frail older people in hospital has repeatedly shown benefits lasting for months after patients leave.[19] The comparable evidence for this assessment in community settings, including "hospital at home" models, is less convincing.[20-22] Meanwhile, major research reviews led by the Nuffield Trust of integrated community models and approaches have shown no consistent evidence for reducing admissions or bed use or the associated costs.[23 24]

Most adults admitted acutely to hospital are older people, usually with multiple long term conditions including frailty, compounded by acute illness—making them our core customers. We need to stop presenting their presence in hospital as a threat that's overwhelming the service.

Let's be more honest about all of this. Of course, we want more older people to remain in their own homes and return there. And admission—especially if prolonged beyond the point where it adds value—can lead to risks and make it harder to return home. But we need to stop badmouthing hospitals and using very selective evidence to condemn their use just because we have a perennial bed crisis.

Many patients are "considerably transformed and substantially restored" after admission. They and their families are glad of it in the short term, and very frequently in our system the alternatives just aren't there.

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