community settings, we established an 'acute frailty unit' (AFU) within one AMU.[2–5]

Patients in the AFU have access to all usual care (including the MDT), but have an increased nursing ratio, and some specialist geriatric input. Despite limited resources, we have been able to show some clinically important trends toward improved process outcomes compared to historical controls (also frail older people):

- increased discharge rates (AFU 9% *v* 5% AMU) odds ratio 1.4 (0.8–2.3), p=0.17
- mean difference in length of stay for AFU patients −0.5 days, p=0.6
- equivalent 90-day readmission rates (historical control 36% (32–47%), AFU 36% (29–56%)).

While these data lack sufficient precision, or indeed the robustness of a controlled trial, they do point to potentially useful new ways of addressing acute care of frail older people.

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Alcohol and hospital readmission (3)

Shalchi *et al* are to be congratulated on their paper on hospital readmission rates (*Clin Med* October 2009 pp 426–30). This concentrated on the medical factors which might have influenced readmission and thus contrasts with previous work which derives from the same catchment area and the same hospital, albeit 20 years earlier.[1] Their definition of 'readmission' was within a period of two weeks, whereas we reported on readmissions up to three years. Our sample was limited to those aged 75 or more. Our objective was to assess the effects of a social service run 'care attendant' scheme in which the health concepts of rehabilitation – a planned withdrawal of support – were melded with the need for care. The service was provided by Harrow Social Services trained care attendants incorporating the rehabilitation ethos.[2]

Like Shalchi *et al*, we found that common medical diagnoses at the initial episode were cardiorespiratory, but that readmission was reduced in the care attendant group. Likewise, older patients were more likely to be readmitted as emergencies. Those patients whose original admission was an emergency were more likely to be readmitted as an emergency. Emergency admissions were significantly more likely for elderly patients living alone.

Shalchi *et al* did not detail the nature of the social support post discharge. However, specific care assistant (as currently named) support targeted at frail elderly emergency admissions, particularly if living alone, would probably be cost effective as our scheme saved money by reducing readmissions even though the scheme provided potential support for many who were not at risk. Care assistants could check that medication was taken appropriately, for example.

Although the scheme was reproduced elsewhere, it was withdrawn by Harrow Social Services at the end of the controlled trial as the savings accrued to the NHS while the investment was made by Harrow Social Services (the monies in fact being spent on other community care projects needing care attendants in the borough).[3,4]

The lessons learned then were that:

1 Hospital and social services had to have trusting relationships.
2 Joint funding across health and social services was appropriate (utilised by the community-based hospital discharge scheme[2] and the care attendants supporting younger people[4]).
3 Social support after discharge utilised the rehabilitation approach – facilitating optimal independence at home thus reducing readmissions.

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In response – additional support to high-risk patients can reduce hospital readmissions

We have been heartened by the response to our article, particularly the letters published above. These emphasise our conclusions, highlight further areas of concern and provide solutions for their management.

The term 'readmission' is poorly defined.[1] Whereas we limited our readmissions to a period of up to 14 days, Woodard and Conroy considered all patients readmitted within 30 days, and Frank felt three years was a suitable time period.

Nevertheless, it is clear from our data, as well as those cited by our colleagues in response, that readmission is more likely in