

Reply

SIR—In response to Ms Henry's comments, I offer the following.

The National Falls Collaborative (NFC) is clearly stated as having set up the 'Sloppy Slipper Campaign' in the reference cited in my original editorial. The NFC may wish to take forward any inaccuracies with the author of the original article to ensure that others are not misled.

Evaluation of any new approach to clinical care should be subject to rigorous external peer review before widespread adoption can be recommended. The Healthy Communities Collaborative (HCC) has much to commend it and there are lessons for us all to learn from it. Ms Henry comments on the number of third parties who have written about the HCC and NFC, and specifically mentions the rigour to which Collaboratives are subject in terms of measurement. However, in the absence of any external peer-reviewed report of the methodology, results and conclusions, third party interpretation is perhaps an inevitability. Rather than await an invitation to publish, I would suggest that these Collaboratives submit their data to one of a number of appropriate peer-reviewed journals which support the widespread dissemination of improvement methodologies.

JACQUELINE C. T. CLOSE
 Department of Health Care of the Elderly,
 King's College Hospital, London, UK
 Email: Jacqueline.close@kcl.ac.uk

doi:10.1093/ageing/afi165

Older people's use of Accident & Emergency services

Sir—We read with interest Downing and Wilson's [1] study of Accident & Emergency (A&E) use by older people, particularly their conclusions regarding the importance of cardiac conditions. We believe that the authors' method of aggregating diagnostic codes into condition groups may overestimate cardiac conditions, but underestimate the potential for reduction of avoidable attendances. The authors report that the most commonly occurring condition was pain in the chest and throat, categorised as a cardiac condition. However, this symptom is categorised within the ICD-10 [2] in the R-chapter (signs, symptoms and abnormal laboratory findings), sometimes known as ill-defined conditions. This group of codes are essentially symptom related, but do not indicate specific diagnoses; the large number of attendances for pain in the chest and throat should not therefore be categorised as cardiac conditions. We note that, as far as we can ascertain without information on the codes themselves, five of the top 20 diagnoses reported would fall within the R-chapter (pain in chest and throat, syncope and collapse, abnormalities of breathing, abdominal pain, urinary retention). This is an important finding given that, since 1992, the R-codes have accounted for around half the reported growth in emergency admissions in the over-75s

Table 1. Incidence of R-coded admissions in an emergency medical setting, 2001

	Acute trust admissions to medicine and care of the elderly (aged over 65) in 2001
Total admissions	394
R-coded episodes/admissions	116 (29.4%)
Of which, presenting problem by system	
Cardiovascular	26 (22.4%)
Respiratory	7 (6%)
GI	8 (6.9%)
Skin	2 (1.7%)
Musculoskeletal/nervous	2 (1.7%)
Urinary/renal	—
Cognitive/behavioural	11 (9.5%)
Nutrition	1 (0.9%)
Immune	1 (0.9%)
Other	57 (49.1%)

[3, 4]. There is speculation that such admissions might be prevented by appropriate targeting of services for older people prior to admission [4]. However, little is known about the underlying causes of such episodes, complicating the provision of services. Classifying attendances of this type as cardiac or respiratory conditions underplays the complexity of these patients' needs and may result in inappropriate deployment of services. As Rozzini and Trabucchi [5] suggest, it is exactly this type of complex presentation that requires the distinctive skills of the geriatrician, but which can be difficult to classify and may be seen as inappropriate for admission to acute hospital. We are currently investigating the problem of R-coded admissions in emergency medical and geriatric settings; pilot findings confirm that these diagnoses are common (Table 1). Our data suggest that national Hospital Episodes Statistics R-code rates of 3% of all hospital episodes may under-emphasise rates in emergency settings; rates in our trust's emergency medical settings are considerably higher. We also note that the most common admission route is via A&E (58%). Questions remain about whether, and in what ways, symptom-related admissions differ from more specific presentations and this is an important area for future research. Clarity about diagnostic coding in research relating to emergency admissions would be valuable in elucidating the scale of this problem, and in identifying avenues for further investigation; misclassifying admissions of this type may be detrimental for both research and clinical management.

BRONAGH WALSH¹, HELEN ROBERTS²

¹School of Nursing & Midwifery, University of Southampton, Highfield, Southampton. SO17 1BJ, UK
 Email: B.M.Walsh@soton.ac.uk

²University Geriatrics, University of Southampton, Southampton, UK

1. Downing A, Wilson R. Older people's use of Accident & Emergency services. *Age Ageing* 2005; 34: 24–30.

Letters to the Editor

2. World Health Organisation. International Statistical Classification of Diseases and Related Health Problems 10th Revision Volume 1, 2 & 3. Geneva: WHO.
3. Department of Health. Shaping the Future NHS: Long Term Planning for Hospitals and Related Services. London: Department of Health, 2000.
4. Department of Health. The NHS Plan. London: Department of Health, 2000.
5. Rozzini R, Trabucchi M. Geriatric wards in acute hospitals. *Age Ageing* 2005; 34: 195.

doi:10.1093/ageing/afi150

Reply

SIR—Walsh and Roberts raise an interesting point in their letter. This highlights one of the many problems with routinely collected data. There is no information available which relates to the actual symptoms that a patient presents to the Emergency Department (ED) with. This information is collected by the staff in the department but it does not form part of the Commissioning Data Set (CDS) [1]. Whilst the R codes used in the ICD-10 [2] coding system do provide some information about the presenting symptoms, this is not the standard diagnostic coding frame used within the CDS. The CDS system is a much less detailed system consisting of 39 broad categories with some subcategories. For example, one of the categories is ‘respiratory conditions’, with simple subcategories of ‘asthma’ and ‘non-asthma’. In the West Midlands, the A&E Surveillance Centre has been collecting the CDS for five years now and has had a unique insight into the variations in coding employed by the hospitals. Out of 18 hospitals that submitted data to the centre, nine used the CDS scheme, six used a locally constructed scheme and three used ICD-10. As the ICD-10 system provides much more information, these hospitals were chosen for analysis in our article.

We agree that the analysis presented in our paper [3] may have overestimated the importance of certain conditions and underestimated the potential for reduction of avoidable attendances. However, the aim of our paper was to describe the attendance patterns of older people and compare these with a younger age group. The aim was not to look at the appropriateness or potential preventability of attendances. When the R-chapter diagnoses are treated as a separate category, they account for 20% of attendances in the over-65s (compared to 10% in the under-65s). However, the pattern of conditions seen does not alter substantially, with cardiac, respiratory and gastrointestinal conditions remaining the most common medical reasons for attendance in the over-65s.

The authors suggest that symptom-related admissions may be preventable by appropriate targeting of services prior to admission, but that little is known about the underlying causes of such admissions. This comes back to the importance of collecting data which can be used for research purposes. If researchers wish to attempt multi-department studies of ED attendance, a comparable system must be found. This may improve now that the Department of Health has mandated the CDS and is collecting this

information centrally. However, the data in their current state cannot provide detailed information relating to presenting conditions.

A. DOWNING¹, R. C. WILSON²

¹Research Fellow, Centre for Epidemiology & Biostatistics, University of Leeds, Leeds, UK

Email: a.downing@leeds.ac.uk

²Public Health Information Specialist, South Birmingham PCT, Birmingham, UK

1. NHS Data Model and Dictionary Service. NHS Data Dictionary. Accident and Emergency Attendance CDS Type. <http://www.nhs.uk/datastandards/pages/dd/index.asp> Last updated 28/04/05. Last accessed 8 June 2005.
2. World Health Organisation. International Statistical Classification of Diseases and Related Health Problems 10th Revision. Geneva: WHO.
3. Downing A, Wilson R. Older people's use of Accident & Emergency services. *Age Ageing* 2005; 34: 24–30.

doi:10.1093/ageing/afi151

Liaison psychiatry for older people—an overlooked opportunity

SIR—Anderson and Holmes [1] draw attention to one of the major issues affecting older people in the general hospital: the prevention, detection and treatment of mental health disorders. They criticise the consultation method of tackling this problem and propose a liaison service solution. The question I pose is ‘Will liaison old age psychiatry be enough even if the necessary staff can be recruited and retained?’ The size and importance of the problem are such that solutions are required now. Liaison may very well be part of the solution, but this may also fail unless the professional and administrative staff of the acute hospital really take on board that the management of mental problems in older people is their responsibility. Staff in the general wards can start by making sure all patients are hydrated and fed!

PETER CROME

Keele University, Staffordshire, UK

Email: p.crome@keele.ac.uk

1. Anderson D, Holmes J. Liaison psychiatry for older people—an overlooked opportunity. *Age Ageing* 2005; 34: 205–7.

doi:10.1093/ageing/afi166

Reply

SIR—We agree entirely with Professor Crome's comments. Liaison psychiatry is only part of the solution to a huge problem that requires genuine whole-system thinking. We suggest that liaison psychiatry is a necessary means of achieving the position of responsibility and ownership to which he rightly refers. The prevalent