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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 to look at the appropriateness or potential preventability compare these with a younger age group. The aim was not to describe the attendance patterns of older people and avoidable attendances. However, the aim of our paper was to examine the extent to which 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.

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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!

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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