LETTER:
SMART WORKING IN OLD AGE PSYCHIATRY

Dr Prasanna N. de Silva,
Consultant in Old Age Psychiatry, Whitby
prasannadesilva@nhs.net

Reading Alistair Burns update in Old Age Psychiatrist\(^1\) made me wonder if the proverbial pendulum might be swinging too far towards integration with Primary Care.

The Whitby old age service has had a 20 year history of working closely with the 6 general practices in the area, but still finds difficulty providing a memory clinic service due to logistic issues pertaining to the acute hospitals. In particular, it is difficult and time consuming to arrange routine brain imaging, and to access ongoing medical out-patient activity (for example about patients being treated for Parkinsonism or cardiac problems).

It is my opinion that the ideal Memory Clinic service should be sited in acute hospitals next to the radiology department. This would allow a 'one stop shop' where the patient could receive psychometrics, imaging, ECG, blood testing and information on diagnosis within the day, with medication provided via the hospital pharmacy. The clinic could also assess patients in the acute hospital with cognitive deficits which continue after a period of delirium.

I think this type of service is essential for the rapid through flow expected with the new NHS requirements on early diagnosis. Access to benefits advice and referral to carer’s resources could be arranged by the clinic, as well as follow up by General Practitioner or Community Mental Health Team (CMHT) (usually following a 3 month trial of treatment). In the near future dementia diagnostics might well include ultrasound guided cerebro-spinal fluid sampling\(^2\) which would need an acute setting.

The drawback of this kind of rapid assessment would be the lack of ‘pre diagnostic support’ which many CMHT memory services provide, perhaps


mostly for people with less severe symptoms. However, a degree of support would be part of the initial (nurse led) assessment prior to scanning etc.

The other area Whitby has developed over the recent years is application of SBARD as the format for documentation and handover - including telephone consultations and Care Programme Approach (CPA) meetings. SBARD stands for Situation, Background, Assessment, Risk management and Decision (or treatment / follow up plan). SBARD has been recommended by the NHS innovations agency for safe, high quality and succinct communication.\(^3\) I have found this system extremely helpful in describing multi morbidity without ending up in a 3 side letter. CPA meetings are much shorter and the feedback we have received from patients and carers is that the structured discussion is easier to digest. Certainly it stops the much dreaded circular and repetitive discussions.

Finally, the ‘elephant in the room’ in acute hospital care is the inadequate triaging of older people attending Accident and Emergency (A and E) units. It is essential that a combined geriatric / psychogeriatric, rapid response service is integral at A and E, with access to imaging and rapid community support, as an alternative to admission.

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\(^3\) De Silva, P.N. Applying SBARD in letters, reports and documents in Old Age Psychiatry. *Progress in Neurology and Psychiatry* (2013) 17: 10-12  