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Heart failure – what the general physician needs to know

Editor – The summary paper from the British Society for Heart Failure 7th meeting highlights some important aspects for the general physician with respect to heart failure management.[1] With respect to diagnosis, however, I would make one comment regarding the use of brain natriuretic peptide (BNP) and NT-proBNP in ruling out heart failure. While it is agreed that natriuretic peptide measurement is very helpful in ruling this out in the majority patients, it is important to bear in mind that in obese patients BNP and NT-proBNP levels are significantly reduced by mechanisms yet to be fully explained.[2] This raises questions about the utility of BNP and NT-proBNP in obese patients in heart failure; further studies are warranted here.

In the meantime, in obese patients where there remains a high clinical suspicion of heart failure, it is recommended that echocardiography is undertaken where the BNP or NT-proBNP level is normal, accepting the fact that echocardiographic views may be suboptimal in the context of an increased body mass index (BMI). Indeed, I have encountered several such cases of echocardiographic proven left ventricular systolic dysfunction in obese patients presenting with acute symptoms of heart failure and with normal NT-proBNP levels. Interestingly, our trust protocol suggests proceeding to echocardiography if clinically heart failure is still strongly suspected after a normal NT-proBNP level and the observations above would appear to support that approach. In an ever-increasing epidemic of increasing BMI in patients due to a variety of factors, it is likely this situation may become more frequent. ■

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Embedding comprehensive geriatric assessment in the emergency assessment unit: the impact of the COPE zone

Editor – I read with interest Taylor *et al*'s article in the February edition of *Clinical Medicine*, Embedding comprehensive geriatric assessment in the emergency assessment unit: the impact of the COPE zone (*Clin Med* 2016;16:19–24).

Their conclusion states 'services can be improved without major investment.' May I say that absolutely no assessment on the impact of community services, additional work for GPs, carer stresses, district nurse time or impact on social services was attempted? While Dr Taylor's trust did not have any major investment to deliver the new unit, what was the cost to the community services?

One geriatrician cannot run a service 365 days a year so there would be cost implications in this alone for their trust. Additionally, comprehensive geriatric assessment requires knowledgeable experienced staff in elderly care. To deliver such a team often means pulling them away from something else equally valuable within the trust.

We need to be careful not to throw the baby out with the bath water running to deliver a frailty friendly front door without robust research evidence. In my elderly care service we are trying to run six wards with six consultants – on three sites, 7 days a week, including orthogeriatrics and surgical referrals, as well internal holiday cover. We already have the highest number of inpatients patients per consultant.

More investment in elderly community services and hospital elderly care is required as well as innovative ways of working. Established hospital elderly care departments should not be put at risk to deliver fashionable trends based on blunt figures such as numbers discharged from the acute medical unit and hospital length of stay. These parameters are not surrogate markers for quality elderly care traditionally delivered within the hospital. ■

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Response

Editor – We thank the correspondent for their letter regarding our recent article *Embedding comprehensive geriatric assessment in the emergency assessment unit: the impact of the COPE zone*.[1] Care of frail older people admitted non-electively to hospital remains variable across the country, as highlighted in the recently published *Older people in the acute setting* NHS benchmarking report (available at www.nhsbenchmarking.nhs.uk/projects/network-projects.php#14). The COPE zone was developed from an established geriatrician in-reaching model. The job plans of pre-existing geriatricians and therapy staff were simply reconfigured, therefore the unit worked from the advantage of already having the team in post. Our data did not show any difference in observed outcomes for older people not admitted to the COPE zone, and the authors do not feel this service change led to any reduction in quality of service elsewhere. It is fair to say that there is a nationwide issue with financial constraints, workforce limitations and overworked staff as highlighted by the Royal College of Physicians special report *Hospitals on the edge? The time for*

action, published in 2012. The correspondent is correct to highlight the potential implications on community services by promoting rapid discharge form hospital, an issue which has not yet been audited at Salford Royal Foundation Trust. We also agree with the correspondent's concern that length of stay and discharge rates should not be the primary objective of any hospital service. The main aim of the COPE zone is to improve the quality of care for older people admitted to hospital by providing timely multidisciplinary comprehensive geriatric assessment, an outcome which has been better achieved by this service redevelopment strategy. The British Geriatric Society states that 'geriatricians have a responsibility to engage in the acute medical care of older people through participation, development of innovative services, and education'.[2] Bringing geriatrician input earlier into the patient journey is a core priority backed by national guidance.[2,3] ■

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Editor – We read Taylor *et al's* article (*Clin Med* 2016;16:19–24) with keen interest. The article mentions, that at the time of writing, the authors were unaware of similar service configurations in the UK.

Musgrove Park Hospital, Taunton opened up an Older Persons Assessment and Liaison (OPAL) unit in November 2015. Our unit appears similar to the COPE zone. OPAL is a 12-bedded unit within a 51-bedded acute medical admissions unit (AMU). We have a comparable multidisciplinary team structure and twice daily board rounds. We identify patients aged over 75 years for the unit who have markers of frailty. We agree with the authors that it is difficult to create validated basic screening tools and current practice often relies on clinical discretion. Frail older patients who are transferred to a non-OPAL bed are also referred and assessed by our team. We have analysed our data for the first 2 months of working and found similar direct discharge home percentages from OPAL to the article data. Interestingly, post OPAL commencement, our average length of stay of patients treated in an OPAL unit bed reduced from 9.7 to 5.8 days in the over 75-year-olds. We note that, unlike the article, we had no formal daily geriatrician input to AMU prior to OPAL initiation. In line with the COPE zone, we currently provide a 5-day service but plan to expand to a 7-day service.

We think that this shows that the benefits are reproducible and would encourage other hospitals to consider such a service. ■

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Response

Editor – We thank the correspondents for their letter regarding our recent article *Embedding comprehensive geriatric assessment in the emergency assessment unit: the impact of the COPE zone*.[1] We share the correspondents' enthusiasm for service development projects aimed at improving the care of frail older people admitted to hospital through timely multidisciplinary team input and comprehensive geriatric assessment (CGA). The discrepancies in care received by older people under traditional hospital systems are well documented. The move towards bringing CGA to the 'front door' is backed by guidance published by the both the Royal College of Physicians and the British Geriatric Society.[2,3] It is encouraging to see similar positive results in other hospitals. ■

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