Diabetes and renal disease: who does what?

Editor – Jones *et al* (*Clin Med* October 2013 pp 460–4) provide a revealing analysis of the distribution of patients with diabetes and kidney disease across the health service. They show that applying traditional referral guidelines which use arbitrary estimated glomerular filtration rate (eGFR) criteria leads to patients who should be managed in primary care remaining under nephrologists and vice versa, with concerning evidence of ageism. They highlight that the rate of progression of eGFR should be intrinsic to the decision to refer the patient, but worry that this will overload the nephrology service.

We have operated an integrated diabetes kidney service for nearly 10 years based upon identifying those patients whose eGFR is declining.[1] It uses a database of diabetes patients to produce a weekly report listing those whose eGFR has been measured in the previous week. An eGFR graph is drawn for each patient and those with a declining trend are reviewed in the diabetes renal clinic by a nephrologist. Once assessed, diagnosed, educated and treated, patients with a stable eGFR are returned to primary or general diabetes care. Those likely to need dialysis or a transplant within the next 12 months are transferred to a multidisciplinary renal clinic.

As patients' eGFR results, wherever they originate, are monitored via the weekly report, they are never completely 'discharged' from specialist care. By having a safe exit route from the clinic, the number of patients attending the clinic in person is greatly reduced. Currently, an average of 85 patients per week are reviewed virtually by their eGFR graph. The clinic capacity that has been freed up is used to see more referrals at an earlier stage of CKD. The new to follow up ratio is now 1:1. Seeing patients at an earlier stage in disease progression helps prevent loss of renal function. The number of patients starting dialysis since the system was introduced has declined.[1]

This system has now been incorporated into the clinical chemistry service to include all patients in the community.[2] This avoids the need for a separate diabetes database and should be possible in all NHS pathology laboratories.

HUGH C RAYNER
Consultant Nephrologist

Heart of England NHS Foundation Trust

References

1 Rayner HC, Hollingworth L, Higgins R, Dodds S. Systematic kidney disease management in a population with diabetes mellitus: turning the tide of kidney failure. *BMJ Qual Saf* 2011;20:903–10.
2 Kennedy DM, Chatha K, Rayner HC. Laboratory database population surveillance to improve detection of progressive chronic kidney disease. *J Ren Care* 2013;39(Suppl 2):23–9.

Diabetes and renal disease: who does what?

Editor – Jones *et al* criticise the current guidelines for referral of patients with diabetes (DM) and chronic kidney disease (CKD) to nephrology clinics (*Clin Med* October 2013 pp 460–4). They have provided their evidence on 26,759 patients aged between 68 and 81 years with declining renal function that was based on estimated glomerular filtration rate (eGFR). However, it must be understood that eGFR of <60ml/min is very commonly seen in healthy older people[1] and this is erroneously categorised as having CKD. It is well recognised that about 25% of the population aged over 70 years do have an eGFR consistent with stage 3 CKD or worse.[2] In the geriatric age group, and without evidence of proteinuria/haematuria, an eGFR around 60ml/min should be considered as normal. In such patients a diagnosis of CKD should not be offered.

RASHEED AHMAD
Consultant nephrologist

Buckinghamshire, UK

References

1 Roderick PJ, Atkins RJ, Smeeth L, *et al*. Detecting chronic kidney disease in older people; what are the implications*? Age Ageing* 2008;37:179–86.
2 Stevens PE, O'Donoghhue DJ, de Lusignan S, *et al*. Chronic kidney disease management in the United Kingdom: NEOERICA project results. *Kidney Int* 2007;72:92–9.

Neurology: still in first gear

Editor – The Francis and Future Hospital Commission reports add to neurology's woes, eloquently summarised by Richard Langton-Hewer and met with diplomacy by the Association of British Neurologists (ABN) (*Clin Med* October 2013 pp 440–2 and *Clin Med* October 2013 pp 443). Part-time consultants, an aging population, the desire for specialist care in the community and the acknowledgement that stroke, dementia, fatigue, pain syndromes and adult learning disability are also neurological illnesses contribute further pressures. For availability of consultant-led neurological expertise in all admitting hospitals 24 hours per day, 7 days per week (which seems appropriate given the rapidity with which neurological knowledge and treatment is advancing) and if neurologists are to take a share in acute medicine, then expansion of neurology is inevitable. An additional 200 consultants would allow, with redistribution, one per 70,000 population (as suggested by the Royal College of Physicians [RCP]/ABN working party in 2011)[1] and an additional 800 consultants would bring the rest of the UK into line with the one per 40,000 population in London.[2]

Prof Langton-Hewer calls for evidence to guide service delivery. The specialty was battered by the National Audit Office (NAO), whose report commented that there was variation (by primary care trust [PCT]) in acute admission with neurological illness that could not be due to chance.[3] The method used to justify this statement was to compare emergency admissions for three illnesses (multiple sclerosis, motor neurone disease and Parkinson's disease) with routine admissions for the same conditions. However, the admission figures used by the NAO show no correlation with the availability, by PCT, of new and follow-up appointments or follow-up to new ratio in neurology.[4] Hence, either the availability of neurology appointments has no effect on acute admission or the figures used by the NAO were not representative of anything relevant. With knowledge of the many factors behind acute and chronic neurological admission, the latter seems more likely. Certainly no decision on neurology consultant staffing should be based on such evidence. In addition, illnesses and treatments change so rapidly, even in neurology, that by the time evidence appears it is out of date.

If we acknowledge that neurology consultant expansion must happen, how can we achieve this in austere times? There will be a

reduction in bed use, when patients are seen on the day rather than waiting for a visiting neurologist. There may be fewer unnecessary investigations and fewer missed neurological diagnoses. Neurology will need to investigate and manage patients promptly and cost effectively; for example, over £70 million per year could be saved by cost-effective prescribing in a single neurological disease.[5] While neurology has never been integrated with general medicine, there would be a responsibility, in time, for neurologists to take part in acute medicine, as the Future Hospital Commission suggests. Equally, general and acute physicians would need to welcome the early involvement and support the expansion of neurology.

After many years of 'making do', is it fair that neurological patients must wait for more evidence before there is equitably distributed specialist-led acute and chronic care in neurology? In 1996 the RCP called for a neurological consultant to be based in every district general hospital[6] but, despite the expansion described by the ABN presidents, that is still a long way off. A start for the ABN and RCP would be to block new consultant neurology posts in London.

PAUL MORRISH
Neurologist, Gloucestershire

References

1 Royal College of Physicians, Association of British Neurologists. *Local adult neurology services for the next decade.* Report of a working party. London: RCP, 2011. www.rcplondon.ac.uk/sites/default/files/documents/local-adult-neurology-services.pdf [Accessed 3 December 2013].
2 Federation of the Royal Colleges of Physicians of the United Kingdom. *Census of consultant physicians in the UK 2011.* Specialty report: neurology. London: RCP, 2013. www.rcplondon.ac.uk/sites/default/files/2011_census_-_neurology_report.pdf [Accessed 3 December 2013].
3 National Audit Office. *Services for people with neurological conditions.* London: The Stationery Office, 2011. www.neural.org.uk/store/assets/files/244/original/NAO-report-Services-for-people-with-neurological-conditions.pdf [Accessed 3 December 2013].
4 Morrish P. What is happening to English neurology: an update. *Clin Med* 2011;11:101–2.
5 Morrish P. Prescribing in Parkinson's disease: a story of hope and adverse events. *Pract Neurol* 2012;12:335–40.
6 Royal College of Physicians. *The district general hospital as a resource for the provision of neurological services.* Report of a working party. London RCP, 1996.

Clinical Medicine 2014 Vol 14, No 1: 94–6

Clinical and scientific letters

OVERVIEW

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Blood tests over the weekend – who looks at them?

Doing routine bloods over the weekend is still common practice in many hospitals but has very little value unless they are acted upon. Also, as a cost-saving measure, many hospitals have no, or very limited, phlebotomy services over the weekend. So inevitably this job is carried out by the already-stretched on-call team, giving them even less time to admit and review ill patients.

We carried out an audit on seven medical wards (with the exception of medical admission unit) over 2 separate weekends. We reviewed the handover sheets and the medical records to look for specific action plans for patients who had their bloods taken over the weekend.

During the initial audit, 67 investigations were performed, of which only 47 were planned; the rest were carried out either following a review or to determine warfarin dose. Of the 47 investigations that were planned only 5 were handed over with an action plan. It was impossible to determine how many of these results were checked and acted upon, as there was very little documentation in patients' medical records. Most of the investigations were carried out to monitor electrolytes, sepsis and international normalised ratio (INR). Some planned investigations like haematinics and alpha fetoprotein do not get processed over the weekend and could have been done after the weekend.

We presented the initial results at our departmental meeting and introduced a structured handover sheet that informed the on-call team about the investigations requested over the weekend, why they were requested and what to do with the results. The audit was repeated after 4 months. During the second audit, 39 out of 44 investigations were planned, of which 21 had a proper handover. Even though there was an improvement in handover and a reduction in unplanned investigations, the documentation on what action had been taken was still impossible to find.

This audit highlights the issues over the weekend when the hospital is run by the on-call team with very limited resources. In the current system, many hospitals rely on laboratory staff to flag up abnormal results and inform the nursing or the medical staff. No investigation should be undertaken without an action plan. A structured handover system can address some of the issues, but not all. Limited phlebotomy services increases the burden on junior doctors over the weekend, where the staffing levels are already critical.

The Royal College of Physicians and NHS Improvement documents recommend a high quality care sustainable 24 hours per day, 7 days per week.[1,2] However, this cannot be achieved solely by re-organising the medical rota when other support services are being rationed due to financial reasons.