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.

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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Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section.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.

Table 1. Sequential use of biologics in PsA.

	First line biologic	Second line biologic	Third line biologic	Fourth line biologic
Patients (n)	548	94	18	1
Reasons for switching (n)	–	Inefficacy: Secondary: 41 Primary: 27 Adverse events: 20 NR: 6	Inefficacy Secondary: 3 Primary: 15	Inefficacy Primary: 1
Biological drug (n)				
Adalimumab	350	46	5	–
Etanercept	186	36	2	–
Infliximab	11	6	7	–
Golimumab	1	3	2	–
Certolizumab pegol	–	1	–	–
Rituximab	–	2	1	–
Tocilizumab	–	–	–	1
Ustekinumab	–	–	1	–
Outcome of switching (%)				
Adequate response to 2nd biologic	–	52	–	–
Adequate response to third/fourth line biologic	–	8	–	–
Awaiting follow up*	–	2	–	–
Adverse events	–	19	–	–
Inadequate response	–	19	–	–

NR = not recorded; PsA = psoriatic arthritis.
*Awaiting assessment of disease activity after switching at time of survey.

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Effectiveness of switching between biologics in psoriatic arthritis- results of a large regional survey

The outlook of chronic inflammatory conditions such as rheumatoid arthritis (RA), spondyloarthritis, psoriasis and inflammatory bowel disease has been revolutionised by the use of tumour necrosis factor inhibitors (TNFi). In the management of moderate to severe psoriatic arthritis (PsA), infliximab, etanercept and adalimumab were approved by The National Institute of Health and Care Excellence (NICE) by August 2007, followed by golimumab in April 2011. Although NICE permits the use of sequential biologics in RA, it states that, at present, there is 'insufficient data to make a recommendation on the sequential use of TNF inhibitors in psoriatic arthritis'[1] Increasingly, PsA patients who fail on first line TNFi therapy due to inefficacy or adverse effects are left with no further therapeutic options due to their local care provider strictly adhering to NICE guidance. There have been no randomised controlled trials of switching between TNFis in PsA and until recently there has been limited evidence to support this practice.

We conducted a regional survey in the north-west of England of PsA patients who started biologic therapy between August 2007 and June 2012. The aims were to assess compliance with current NICE guidance with regards to sequential TNFi use and the effectiveness of switching biologics. Every centre in the region participated; most sites included all eligible patients, representing an accurate reflection of current practice.

We collected data on 548 patients with PsA across 18 sites in the region. Median age was 49 years (interquartile range[IQR]