Author’s response to reviews

Title: Do virtual renal clinics improve access to kidney care? A preliminary impact evaluation of a virtual clinic in east London

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Author’s response to reviews:

Dear Jing Zhang

BNEP-D-19-00566R3

Do virtual renal clinics improve access to kidney care? an impact evaluation of a virtual clinic in east London.

Editorial Query: We request that a point-by-point response letter accompanies your revised manuscript. This letter must provide a detailed response to each reviewer/editorial point raised, describing what amendments have been made to the manuscript text and where these can be found (e.g. Methods section, line 12, page 5). If you disagree with any comments raised, please provide a detailed rebuttal to help explain and justify your decision.

Authors Response: The detailed responses by the authors to the editorial comments are included below, and I have detailed page and line numbers to indicate where changes have been made.
2. Conference abstract

We notice that the abstract of this manuscript has been published before:

This is correct, a similar abstract was presented at the Society for Academic Primary Care conference in July 2019. Following your suggestion I have extensively rephrased the abstract of this report in order to minimise any overlap.

In the report abstract the background paragraph has been completely rewritten as follows (L34-41):

'Early identification of people with CKD in primary care, particularly those with risk factors such as diabetes and hypertension, enables proactive management and referral to specialist services for progressive disease.

The 2019 NHS Long Term Plan endorses the development of digitally-enabled services to replace the ‘unsustainable’ growth of the traditional out-patient model of care.

Shared views of the complete health data available in the primary care electronic health record (EHR) can bridge the divide between primary and secondary care, and offers a practical solution to widen timely access to specialist advice.’

The results paragraph has been changed to include further referral details (L50-52)

‘Prior to the start of the service the general nephrology referral rate was 0.8/1,000 GP registered population, this rose to 2.5/1,000 registered patients by the second year of the service.’
3. Textual overlap

We note that the current submission contains some textual overlap with other previously published works, in particular:

“https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fbjgp.org%2Fcontent%2F69%2F684%2Fe454%26amp;data=02%7C01%7C%7C677c4166de944f11572008d783752ea0%7C569df091b01340e386e5b9e25814%7C0%7C0%7C637122411626919068%26amp;sdata=akhRtXrC2JjVEioREqXT4nMn03MloHy6tRzZZiFTpls%3D%26amp;reserved=0”

This overlap mainly exists in the Background (P3), Methods (P5), Discussion (P12-13).

While we understand that you may wish to express some of the same ideas contained in these publications, please be aware that we cannot condone the use of text from previously published work. Please re-phrase these sections to minimise overlap.

The background section on Page 3 has been re-phrased. The first paragraph (where there was most overlap) has been rewritten as follows: (line 69-73)

‘In the adult UK population the estimated prevalence of Chronic Kidney Disease (CKD) stages 3-5 is 5-6% (1). Identification and coding of CKD in primary care provides a case register which can be used to support the active management of blood pressure, cardiovascular risk and safer prescribing. A register also enables regular review of CKD and specialist referral where there is diagnostic uncertainty or evidence of progressive disease.’

In the methods section on Page 5/6

It is more difficult to rewrite the factual description of the components of the community kidney service, but sections have been rephrased to minimise any textual overlap. (Lines 177-80)

2) 'A package of IT tools: these enable practices to identify patients who require diagnostic coding, would benefit from better blood pressure control, or an offer of statins to decrease the risk of cardiovascular disease. They also include monthly practice alerts to identify patients with a falling estimated glomerular filtration rate (eGFR).’
Additional changes have been made at Lines 184-6

‘Extra clinical support by specialist renal nurses, with a focus on CKD management, was offered to practice teams which had the lowest rates of CKD coding.’

In the Discussion section the strengths and limitations paragraph has been rephrased to reduce textual overlap as follows: (Page 12, Lines 350-352)

‘A strength of this project is that all general practices across four contiguous CCGs took part. Hence this evaluation examines the application of a complex service change to whole health economies, rather than just selected practices.’

Further re-phrasing has been done at Page 13 Lines 359-64

‘The programme evaluation was pragmatic, and allowed for some variation in the way the intervention was implemented in each of the four CCGs. Identifying contextual differences between CCGs in clinical leadership, and in their approach to incentivising change in their constituent practices is important for the success of scaling up complex interventions such as this. Differences in context can affect the process of implementation and contribute to differences in speed of diffusion across differing geographical areas.’

Further editor comments (27/12)

1. I have altered the Consent for publication statement, which now reads:
   ‘Not applicable’

2. The availability of data and materials section has been altered to read:
   ‘The datasets generated and/or analysed during the current study are available from the corresponding author on reasonable request.’
Sally Hull

on behalf of the authors