

the pre-eminent approach in the field and deserves a mention.

PAUL GRANT

Specialist registrar in endocrinology
Kings College Hospital, London

ERRATUM

Letters to the editor: *Clinical Medicine*, December 2010, pp 637–8

Please note the authors of the letter 'NHS research governance procedures' were Peter Selby, director and John Sitzia, acting chief operating officer from the National Institute for Health Research Clinical Research Network. The title of the next letter should not have the title 'National Institute for Health Research Clinical research Network'

Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section.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

A survey of new to follow-up ratios in rheumatology outpatients departments

Practice Based Commissioning (PBC) and Payment by Results (PBR) have introduced perverse incentives for clinicians to work in ways that are not always in the best interests of the patient. PBC may lead to patients who would benefit from a specialist opinion not being referred on cost-saving grounds, or being referred to alternative providers (including private companies) who lack the training and expertise of established specialty multidisciplinary teams. PBR increases income by focusing on new, rather than follow-up, patients (higher tariff earnings for the former compared with the latter) with up to a 13% increase in income if the consultant sees predominantly new patients.^{1,2} This has led to some colleagues being asked to lower new to follow-up ratios or having to work to fixed ratios which are usually lower (n = more new, less follow-ups) than those currently being achieved by the unit. Other pressures on new to follow-up ratios include the 18-week pathway and the perception that many follow-up visits are unnecessary and tie up clinical time.

The British Society for Rheumatology (BSR) clinical affairs committee was contacted by a number of colleagues expressing concern about new to follow-up ratios being imposed upon. In order to determine the size of the problem, and whether any recommendations could emerge from this, the committee embarked on a survey to collect data on new to follow-up ratios and whether

colleagues had been pressurised to reduce these figures in favour of new patients.

The survey was sent to all consultant rheumatologists both electronically and by post in October 2007 with a reminder sent out in January 2008. It included a diary function in which rheumatologists recorded their clinics and how many new and follow-up patients were seen in each. Only 96 responses were received from a possible 545. The median number of years that consultant respondents had been in post was 10 years (range 0.5–29). The median population served per unit was 330,000 (range 110,000–1,000,000). In total, 93% knew their new to follow-up ratio, which was a median of 3.6:1 (range 1–8). Of respondents, 79.6% were pure rheumatologists without a commitment to another discipline. The median number of consultant-led clinics was four (range 2–7).

The survey asked about annual figures of new and follow-up patients and a new to follow-up ratio (3.3:1) was calculated based on these figures. The reported ratio and the calculated ratio were then compared using linear regression. There was a wide variation with only 30% of the variance in the reported ratio being explained by the calculated ratio. Figure 1 shows that for some colleagues there was a large discrepancy between the new to follow-up ratio that they had reported for their unit and the number calculated for the ratio based on the number of new and follow-up patients listed in the diary. Part of this discrepancy could have been accounted for by differences in practice, and by interpretation of what constituted a follow-up (for example disease-modifying antirheumatic drug (DMARD) monitoring was counted as a follow-up appointment in 24.7% of responses).

Of the respondents, 34.5% had been asked to work to a set new to follow-up ratio. This was a median of 3.1 (range 1.3–4). In total, 17.5% of respondents reported that their unit or hospital would incur a financial penalty if they did not reduce their ratios. These data were presented at the Standards Audit and Guidelines Working Group meeting held at the BSR annual general meeting (AGM) in Liverpool. The data sparked a debate over two main points: