Demand Management and Follow Up Ratios in Dermatology - August 2009

Nationally in the last year, referrals to hospital dermatology departments have increased on average by over 10%. To contain demand, PCTs around the country are increasingly imposing arbitrary limits on the number of follow up visits they will pay for. Surrey PCT successfully imposed a 75% centile target for their acute hospitals, and other PCTs appear to be following suit. This figure is a statistic and not based on any audit of appropriate clinical practice. Between 2007/2008, 25% of provider units appear to have achieved a New:Follow up ratio of 1:1.5 or less and some PCTs are expecting their local dermatology services to achieve a follow up ratio less than or equal to this.

Unfortunately the DH's definition[1] of Follow Up is not specific and leaves room for significant variation across the country; in dermatology and for many other specialties. As a result Trusts have been left to work out ways of agreeing this as a workable definition, and managing these follow up ratio demands. This is made even more difficult when PCTs, Private providers and even on occasion B.A.D members are seeing the 'easy' cases in the community leaving Acute Trusts to see the more difficult cases which are likely to require a higher follow up ratio.

While most departments may have a lower follow up ratio for benign lesions (where most patient's referred to the 2 week cancer clinics are reassured and discharged), those patients referred with inflammatory skin diseases and skin cancer are likely to have a much increased follow up ratio (e.g. 1:6 for psoriatics in a recent study).

As a result departments across the country have adopted a number of strategies to address this such as:-

- Specifically negotiating a higher rate with the PCT where longer term dermatology skin treatments can be justified, such as for psoriasis above
- Recording specialised dermatology skin treatments separately from routine dermatology outpatient visits and nurse led treatments e.g. phototherapy visits, dressings, iontophoresis; such that they do not affect the New:Follow up ratio; and in some instances negotiating separate tariffs for these services.
- Recording a series of phototherapy visits as a 'course' rather than multiple follow up visits.
- Arguing successfully, that their case mix is significantly more complex than the average community dermatology service; or that recent changes in NICE, BAD or other professional body advice has mandated increased monitoring of patients (e.g. Biologics and Roaccutane treatments)
- Agreeing a shift to telephone follow up consultations at lower rates

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1 http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Commissioningspecialisedservices/Specialisedservicesdefinition/DH_4001701

- Agreeing to an increase in the use of email consultations for new cases for which some charge full tariff and some lower rates
- Designating some dermatology clinics in the acute hospital setting as 'community dermatology clinics', thereby removing them from the activity count completely. These are paid for at lower rates and patients are sometimes seen by nurses, GPSIs or GPs)
- Maintaining an aggressive discharge policy helps enormously. If patients are discharged after, for instance phototherapy, then if any further intervention is subsequently needed, this will be as a new patient. Shared care practices help too, sharing melanoma and SCC and second line agent follow up will halve follow up numbers. In addition, early discharge for most conditions, suggesting the patient seeks re-referral if needed will help. At the moment, the re-referred new appointment is likely to be quicker with 18 week rule than finding a follow up slot.
- Recording phototherapy under its own code and not as a follow up – hopefully this will be possible with the new HRG. Surgery must also not be coded as a follow up.
- Using a specialist nurse manned helpline for most patients that might otherwise be given a routine follow up appointment. If the patient comes back to dermatology clinic after 6 months then most PCTs agree they can be counted as a new patient. There is now a mechanism for charging for these telephone based consultations with patients.
- Producing data regarding the follow up case-mix for those PCTs applying pressure regarding follow up numbers. If the PCTs can see that follow ups are complex and therefore justified then they may agree a higher ratio as mentioned above for complex psoriatic patients. For example; in one Acute Trust there were a significant number of actinic keratoses follow up patients. A seminar on efudix and related therapies with a representative from every practice in attendance made no difference and the PCT therefore accepted that secondary care had 'tried its best'.