

Interactive State of the Nation Report Psoriasis

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Wilmington
Healthcare

Foreword

Psoriasis is an immune-mediated inflammatory disease that affects the skin. One in four patients develop psoriatic arthritis, an inflammatory condition that affects the joints. Psoriasis can be a minor irritation for some people, but for others it impacts considerably on their quality of life, employment, productivity, and income.

GPs are the first person most patients see about their skin problems, yet many GPs receive little formal dermatology training and some medical schools have removed this specialty from their curriculum altogether. Consequently, dermatology has a comparatively high number of referrals to specialist care, particularly for diagnosis, and there is significant variation in access to psoriasis services across England. Many people also spend years cycling through ineffective treatments before being prescribed the most appropriate treatment. These issues have been exacerbated by the COVID-19 pandemic, which has resulted in reduced workforce, lengthy waiting lists and large backlogs.

Ensuring patients are seen by the right person in the right place and at the right time is a goal of the NHS. A report published by NHS England in September 2022, 'Referral optimisation for people with skin conditions', sets out the key principles of referral optimisation to enable local systems to embed personalised care for patients, strengthen primary care management, and streamline collaboration between generalists and specialists. These are all key to ensuring that patients with skin conditions receive care individualised to their needs and provided by the right person in the right place the first time.

One positive outcome of COVID-19 is that it forced the NHS to accelerate innovations, and several new models of care that have revolutionised ways of working have emerged during the pandemic. For example, the use of teledermatology and other technologies by multidisciplinary teams has allowed specialist care to be provided closer to patients. The shift towards integrated care systems also provides opportunities to develop new collaborative ways of working through partnerships and to implement disease interventions across the system rather than just at a local level.

As an organisation focused on supporting people with psoriasis, it is imperative for the Psoriasis Association, as well as clinicians and patients, to understand how current challenges within the NHS impact on patients' access to timely and appropriate care. This report, developed by Wilmington Healthcare and funded by Bristol Myers Squibb, was commissioned to review current issues with delivery of care in the context of policy and best practice. In addition to the waiting lists and backlogs, it highlights long-term intrinsic concerns such as:

- insufficient staffing of the dermatology workforce in the long term
- lack of sufficient skilled expertise within the workforce
- health inequalities and variation in access to services
- a need for specialist care to be initiated or managed in primary care.

The findings in this report clearly demonstrate that the current system, with the pressures it faces, is not equipped to provide the best possible care for patients with psoriasis and that there is an urgent need for change. The report provides recommendations in line with recent policies and guidance, as well as presenting a number of best practice examples. We hope that the findings and recommendations will encourage systems to review local practices to ask difficult questions – such as 'Where, how and by whom are our psoriasis patients best managed?' and 'How can we develop our psoriasis services to meet our population needs?' – that inspire the introduction of innovative ways of working.

There is a clear need for change and the need is now.

Nick Evans
Chair of Trustees
The Psoriasis Association



Executive summary

This report outlines the current issues in delivering psoriasis care in England in the context of policy and best practice. We emphasise the need for change in the current care pathway, highlighting pinch points on the system and exploring examples of new pathways and models of working in the healthcare landscape, which ultimately can be used to drive improvements in patient outcomes.

Psoriasis can considerably impact quality of life through its symptoms, treatment-related issues and associated effects on mental wellbeing. Socioeconomic impacts of the disease are also significant. Defining an improved care pathway would support benefits to the wider economy as well as relieve patients who are frustrated by the lack of progress in the care of their disease.

Challenges in diagnosis for psoriasis patients are well-documented and stem from a lack of GP training and education in dermatology. As a result, dermatology has a comparatively high number of referrals to specialist care, specifically for diagnosis. To deliver better care across settings, providers should seek to optimise the training and function of the whole dermatology multidisciplinary team and utilise solutions such as screening tools, rapid access to advice and guidance for clinicians, shared learning, and digital adoption.

One of the most significant challenges facing dermatology is shortfalls in the workforce and the consequential limitations on access to services for patients. These shortages have the greatest impact on people with non-cancerous chronic skin diseases who may face longer waits because the NHS prioritises resources to meet cancer targets. While patient numbers are slowly returning to pre-COVID levels, the shortfall in access to psoriasis services has created a significant backlog. Our analysis displays the prioritisation of skin cancer referrals, with an elective recovery of numbers of melanoma dermatology outpatients to above pre-COVID averages, but a slower recovery in psoriasis dermatology outpatient numbers.

Mechanisms to support the workforce shortage includes developing the roles and dermatology experience of primary care and hospital pharmacists, encouraging a greater use of teledermatology services, and developing the use of best practice areas such as superclinics, extended primary care roles and integrated services.

Health inequalities and associated variation in access to psoriasis services in England emerges as a key theme of this report. Waiting times for patients to access psoriasis services varies significantly across ICSs in England. Waiting time inequalities in ethnicity and deprivation were exacerbated during the COVID-19 pandemic with less variation across white communities. While some waiting times have started to recover since the onset of the pandemic, these have primarily been for patients in the least deprived areas.

We hope that this report provides in-depth insights into the current psoriasis treatment landscape in the NHS in England and highlights opportunities where dermatology services can develop in the new integrated system.



How to use this tool

This interactive tool on psoriasis reviews the current issues in delivering care in the context of policy and best practice.

The tool focusses on two psoriasis pathways:

HOW TO USE THIS TOOL

Best practice case studies

By drilling into the links you can explore each of these issues, best practice and policy affecting psoriasis care.

The topics covered include:

Introduction Page 2

Current care pathway Page 8

Possible future care pathway Page 9

Diagnosis Page 10

Access to services Page 17

Access to treatment Page 29

Policies, priorities & guidance Page 42

Resources Page 48

About psoriasis

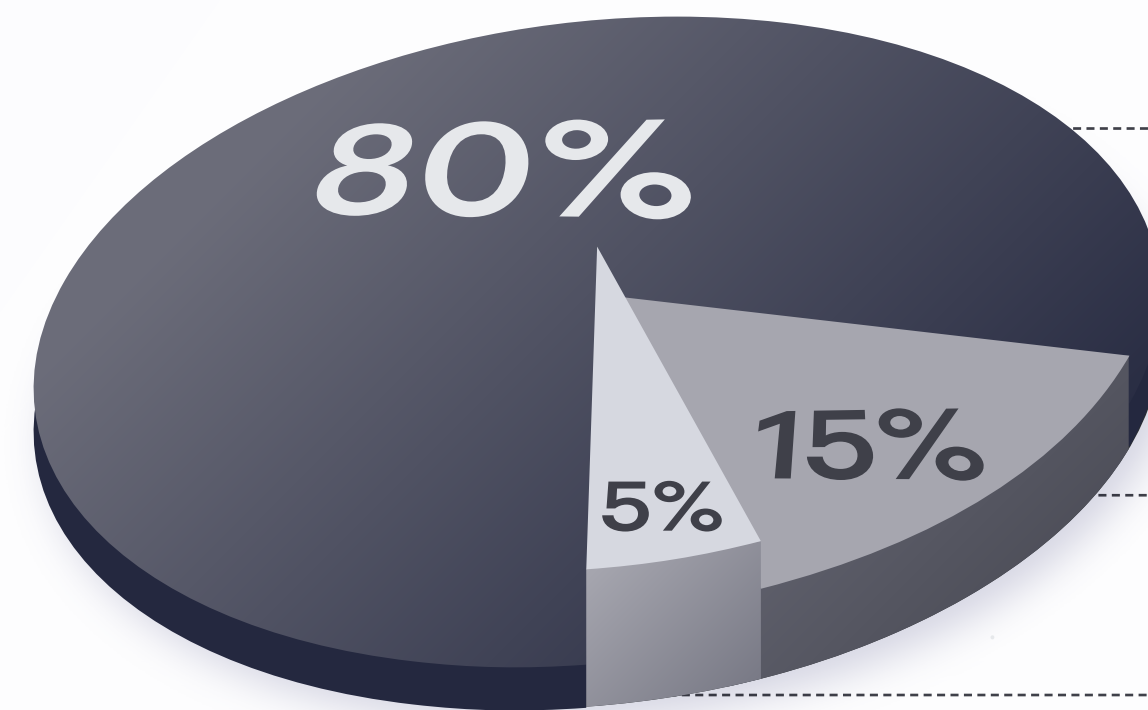
Psoriasis (PsO) is an immune-mediated inflammatory disease that affects the skin and in 1 in 4 patients leads to an inflammatory condition, psoriatic arthritis, which affects the joints¹. Psoriasis occurs when the immune system sends faulty signals that cause the skin cells to grow too quickly. Symptoms are characterised by thick red scaling skin that can cause itching.

Psoriasis is associated with an increased risk of obesity, fatty liver disease, inflammatory bowel disease, cardiovascular disease, lymphoma and non-melanoma skin cancer^{2,3,4}. Although psoriasis is a chronic condition, it can be controlled and go into remission, often temporarily and sometimes permanently¹.

ABOUT PSORIASIS



Frequency of psoriasis types¹



Mild psoriasis (<3% of the body⁵)

- Typically, mild psoriasis may not be visually obvious or noticeable. People will still have a few patches and will need to be treated, but the condition can generally be well controlled¹.

Moderate psoriasis (3–10% of the body⁵)

- More widespread but, again, can usually be controlled with self-management under the supervision of a GP or nurse¹.

Severe psoriasis (>10% of the body⁵)

- When psoriasis becomes severe, large areas of the body are affected; the condition becomes difficult to self-manage or no longer responds to treatment¹.
- At this stage, referral to secondary care at a local hospital outpatient department, or in extreme cases, an inpatient stay may be required to provide optimum care and monitoring¹.

1 in 4

patients develop psoriatic arthritis¹

90%

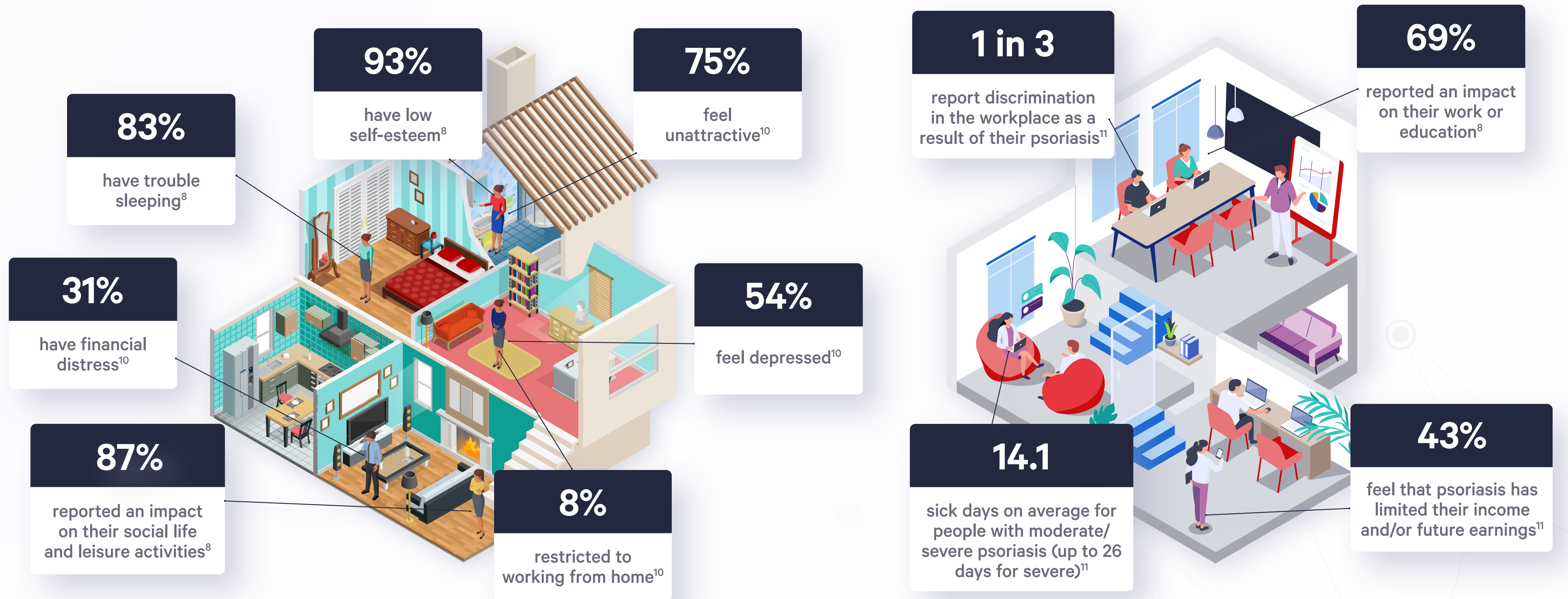
of patients have plaque psoriasis⁶

Impact on life

Although psoriasis can be a minor irritation for some people, for others it can considerably impact quality of life, employment, productivity and income^{7,8}. These harms can result from the impact of the symptoms of psoriasis,

treatment-related issues, the potential emergence of psoriatic arthritis, as well as the social stigma or embarrassment of living with a highly visible skin disease⁹.

IMPACT ON LIFE



Socioeconomic impact



1.1 million

In the UK around 1.1 million people are affected by psoriasis with a prevalence estimated to be around 1.7%¹²



4 million

Total working days lost per year in the UK¹¹



£50 million

Boost to the UK economy from a 10% reduction in sickness absence for people with psoriasis¹¹



£61 million

Out of work benefits for people with a skin disease in 2013/14¹¹



£26 billion

Estimated cost to employers of sickness absence and reduced work productivity as a result of mental health issues, which are particularly prevalent in people with psoriasis¹¹



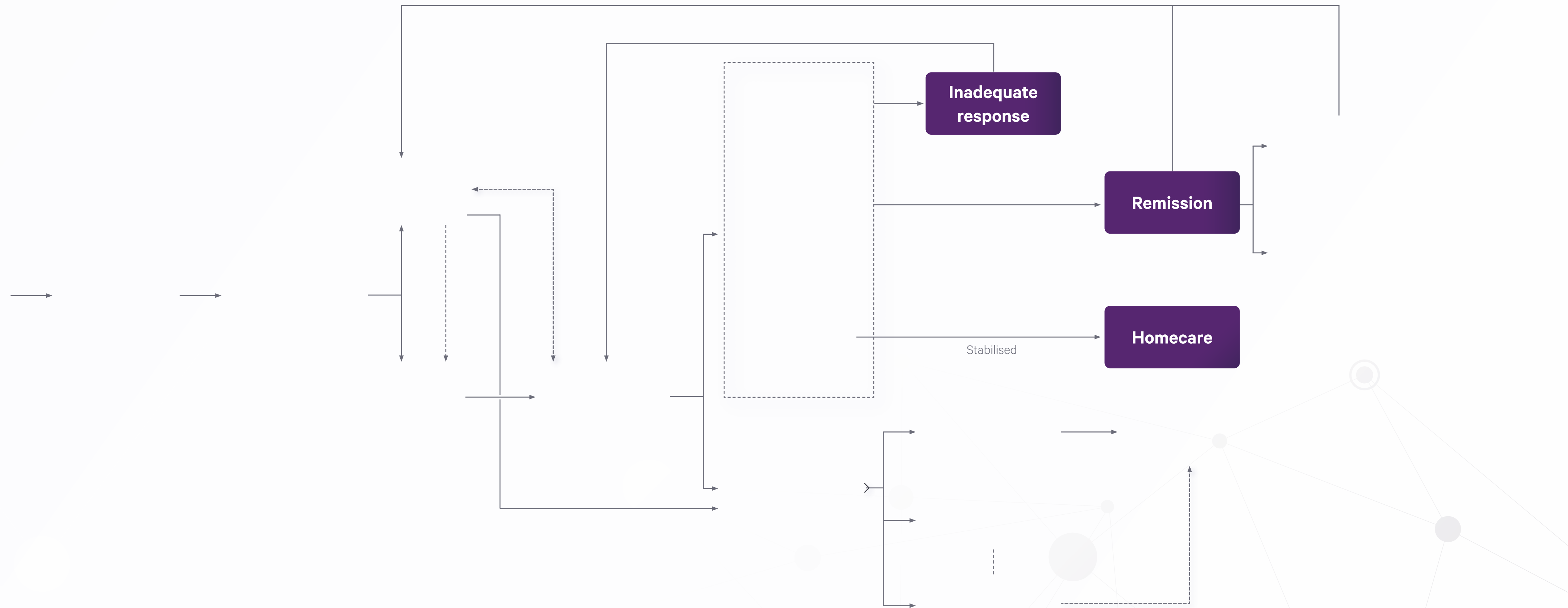
£1.07 billion

Total estimated cost of absenteeism and presenteeism from people with psoriasis¹¹

SOCIOECONOMIC IMPACT

Current care pathway*

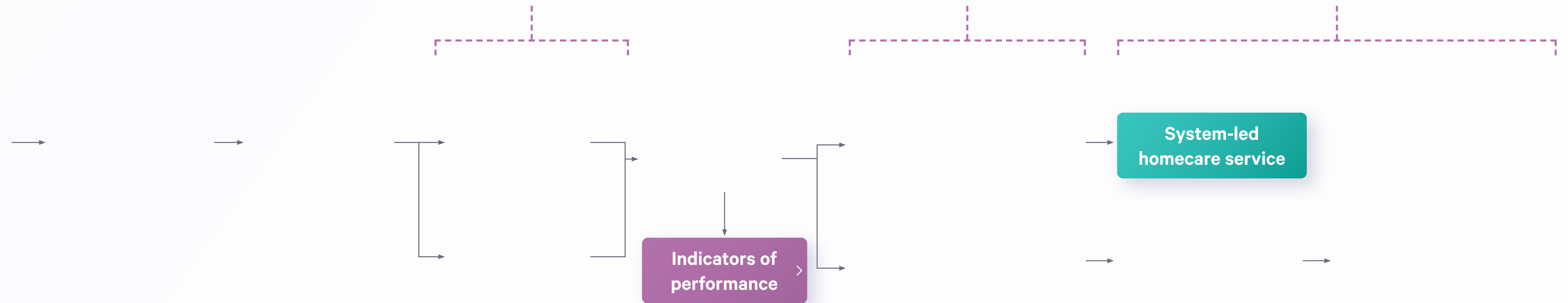
This care pathway indicates current pinch points and issues. **Select the boxes to reveal more information.**



*This pathway has been created based on a number of current practices and examples

Possible future care pathway

Select the boxes to reveal more information.



PIFU, patient-initiated follow up

Diagnosing psoriasis

GPs are the first person most patients see with their skin problems. Around 75% of all NHS consultations for skin problems take place in GP surgeries¹³. Yet many GPs receive little formal dermatology training beyond one to two weeks as part of their five-year medical school course¹³. Some medical schools have even removed dermatology from their curriculum altogether¹³.

Only a small proportion of the three-year specialist GP training programmes offer dermatology as a three-month training option¹³. The GIRFT questionnaire identified just 80 trainee GPs (38 WTE) in dermatology units¹³. Given there are around 3,500 GP training posts, this suggests that less than 10% of GP trainee posts involve secondary care dermatology¹³.

Consequently dermatology has a comparatively high number of referrals to specialist care, particularly for diagnosis. A survey of more than 1,500 Psoriasis Association members found that, whilst 70% of referrals to specialist care were made on the initiative of the GP, 30% of respondents had requested referral through their GP¹⁵.

Patients requesting referral to a specialist may also reflect a lack of confidence in primary care capacity, due to the lack of GP training and education in dermatology. This is supported by the finding that between 31% and 59% of new dermatology referrals are for diagnosis¹⁶.

Current challenges at diagnosis:

- **54%** of psoriasis patients not given enough information by GP or a specialist in secondary care¹⁵.
- **74%** of patients not offered different treatment options¹⁵.
- **10%** were given contact details of support organisations¹⁵.

Immediate solutions to manage inappropriate referrals would be utilising:

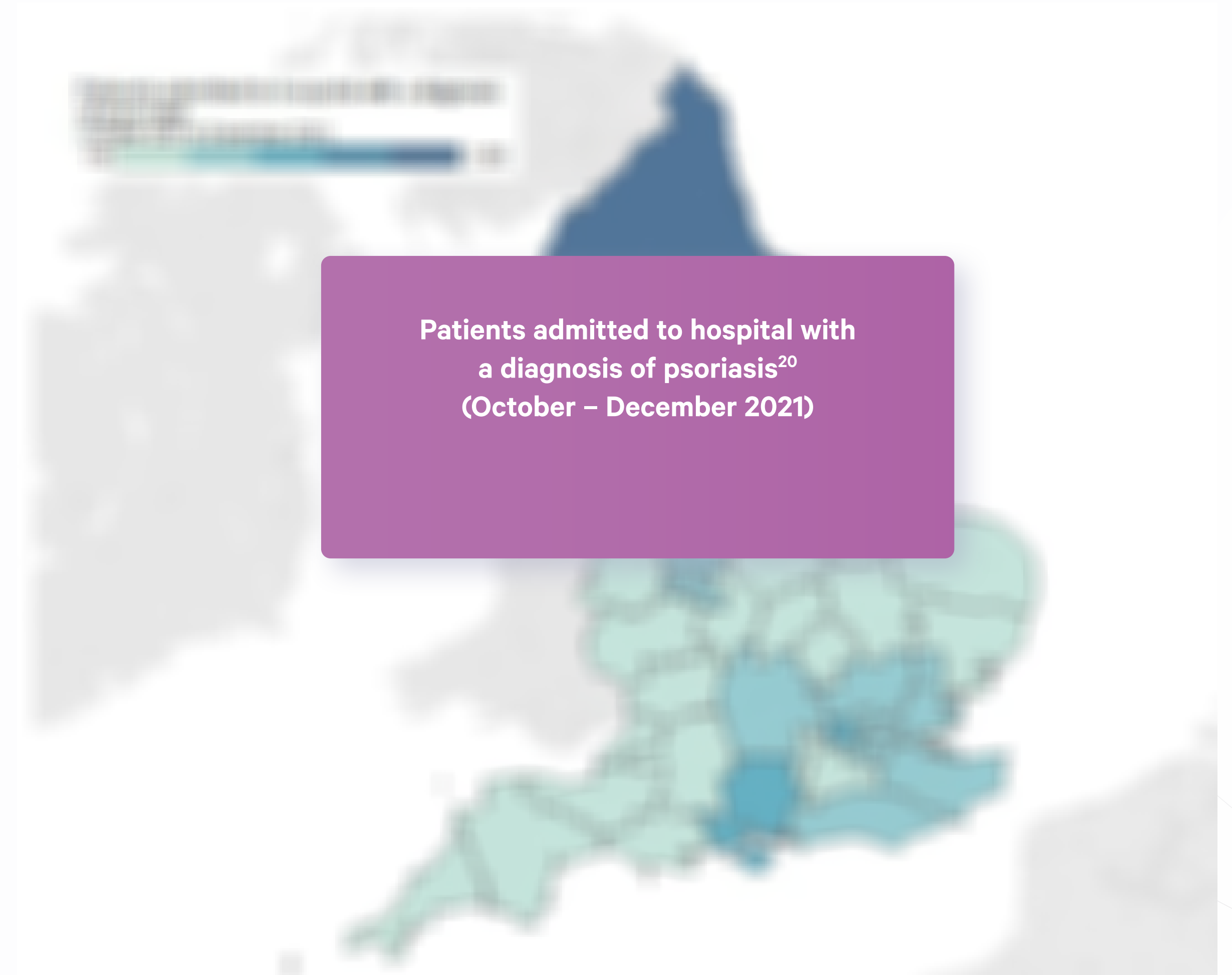
- Screening tools
- Shared learning opportunities and establishing GP champions
- Advice and guidance and teledermatology.

Longer term solutions on training primary care teams are detailed in the GIRFT report¹³.



Psoriasis admissions by ICS

The number of patients admitted to hospital with a diagnosis of psoriasis varies significantly by ICS. In the period between October and December 2021, a higher number of admissions are clustered in the north/north west of England, ranging from a minimum of 135 patients in Cambridge and Peterborough ICS to a maximum of 1,350 patients in North East and North Cumbria ICS²⁰.



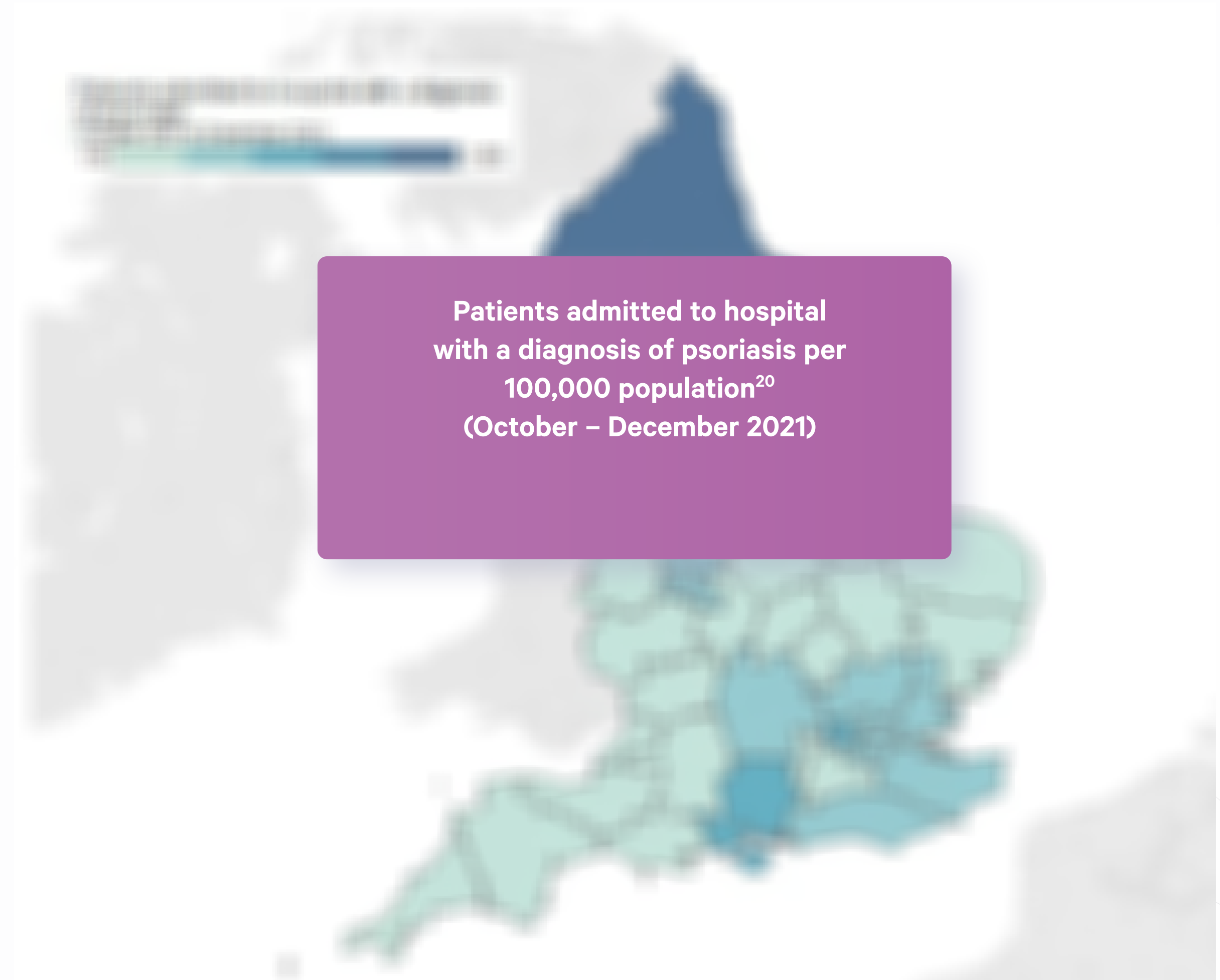
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Psoriasis admissions per 100,000 population by ICS

ADMISSIONS PER 100,000 POPULATION BY ICS

Where patient numbers are normalised per 100,000 population, the patients admitted to hospital with a diagnosis of psoriasis shows much less variation between ICSs (compared to **absolute numbers of patients per ICS**).

In the period between October and December 2021, patient numbers per 100,000 population ranged from 14 patients in Cambridge and Peterborough ICS to 48 patients in Healthier Lancashire & South Cumbria²⁰. The ICSs with the highest figures are clustered in the North/North West of England and those with the lowest figures are in the South surrounding London²⁰.



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GIRFT recommendations on diagnosis

Optimise the training and function of the whole dermatology multidisciplinary team to deliver better care across settings and reduce locum costs. Develop a clinic structure to support this¹³.

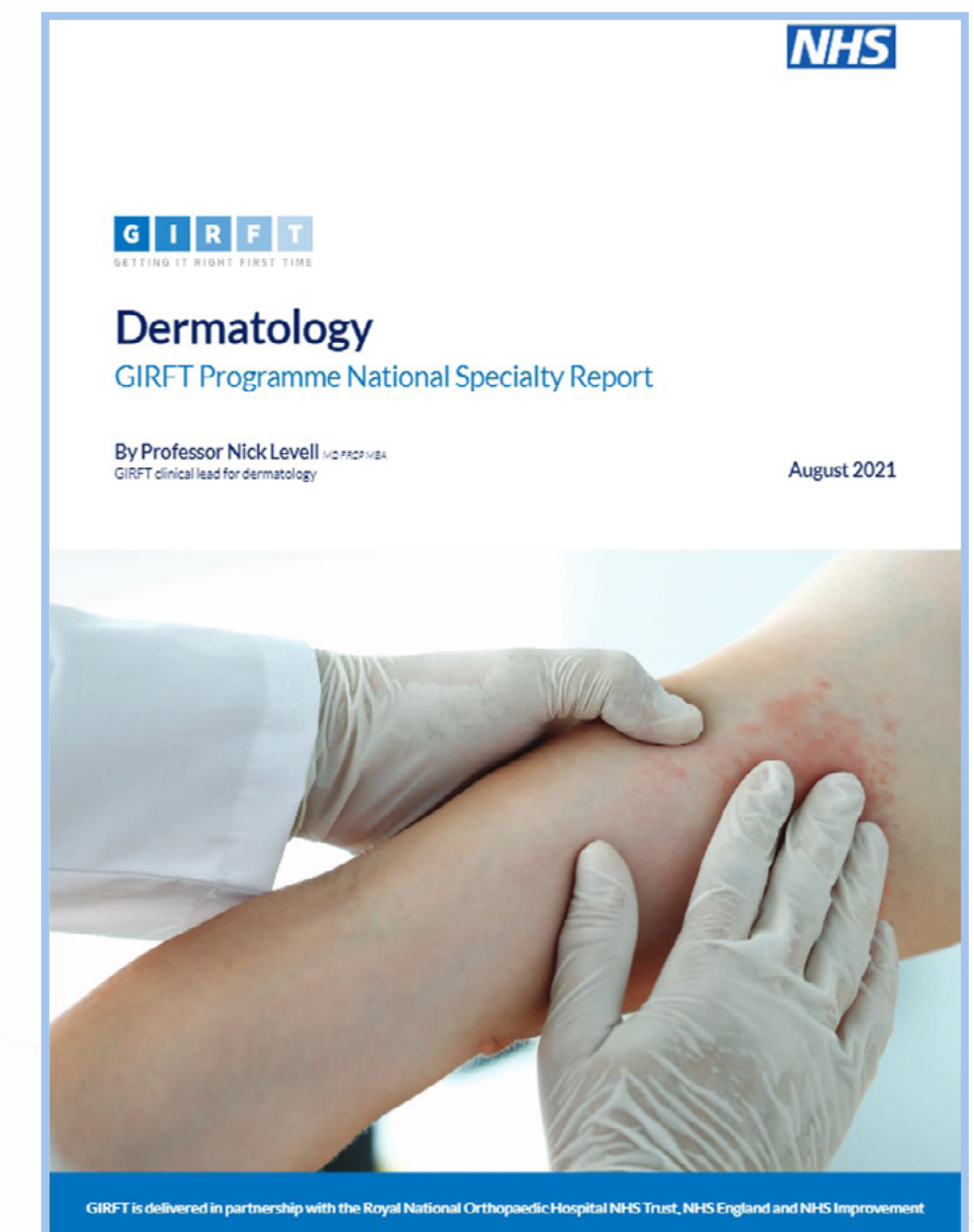
Optimising training:

- Include dermatology in training schemes for GPs and other primary care staff to improve evidence-based patient care and reduce unnecessary referrals¹³.
- Include dermatology training that meets the BAD curriculum in all medical school courses so that all GPs have basic dermatology skills¹³.
- Improve undergraduate dermatology training for pharmacists, so that community pharmacists are able to manage common skin conditions such as eczema, acne, fungal infections and warts in line with current evidence-based dermatology national guidelines¹³.

Use of technology:

- Review teledermatology services to inform trust-level investment and resourcing decisions¹³.
- Assess teledermatology services based on the points described in the GIRFT report when considering whether to invest¹³.

- Trusts/CCGs to publish research and learning from teledermatology services so that others can learn lessons and share best practice. The FutureNHS Collaboration Platform is set up for this¹³.
- Offer patients the electronic referral system (e-RS) Advice and Guidance Service¹³.
- Include time spent providing advice and guidance and teletriage in the job plans for dermatologists¹³.
- Support services keen to innovate in this area¹³.
- Prepare teledermatology services and other clinical services for the introduction of artificial intelligence (AI) and machine learning¹³.



Diagnosis solutions and best practice (1)

DIAGNOSIS SOLUTIONS

Screening tools

The Primary Care Dermatology Society pathway signposts⁵³ to the Psoriasis Epidemiology Screening Tool²⁴ (PEST) as a validated screening tool for psoriatic arthritis, though practitioners should be aware that this does not screen for axial psoriatic arthritis⁵⁴.

Rapid access to advice and guidance

An advice and guidance service enables one clinician to seek advice from another, usually a specialist. For example: this could be about a patient's diagnosis, treatment plan and ongoing management; or it could be for clarification of test results and referral pathways. There are several methods of obtaining advice and guidance. For example, the Consultant Connect telemedicine service enables GPs to actively request advice from identified specialists²⁵. Anecdotally, GPwERs are expected to provide advice and support to other local practitioners to help manage conditions within their expertise. Teledermatology enables GPs to share an image of the affected skin area securely with a specialist clinician (such as a GPwER or dermatology consultant) for advice and review.

Shared learning²⁶

If learning and knowledge around the appropriate treatment of dermatological conditions is shared between practitioners (including GPs, consultants, nurses and pharmacists) and GPwERs are utilised to their full advantage, then:

- Patients should be able to access the care they need earlier and have a better experience of support to manage their condition within a primary and community care setting.
- Primary care clinicians should build their knowledge, confidence and expertise in dermatology, meaning referrals are made into secondary care only when necessary. Improved communication builds trust between practitioners and improves patient management across care settings. Secondary care specialists should spend more time seeing those patients who need their expertise.
- As clinicians in primary care become more confident and proficient at dealing with dermatological conditions and pathways include GPwER services, the number of unnecessary referrals to secondary care should decrease and variation in the quality of referrals and prescribing should improve.

Diagnosis solutions and best practice (2)

Training

- The Primary Care Dermatology Society signposts to a range of dermatology training programmes for qualified GPs²⁷.
- The British Association of Dermatologists has an educational workstream with the Royal College of General Practitioners for GPwERs²⁸.
- However, these programmes mostly reach GPs who already have some interest and expertise in dermatology.

Teledermatology

The growing facilities for accessing advice and guidance using remotely evaluated photographs offers significant support to reducing inappropriate referrals. Examples of teledermatology services refer to lesion diagnosis by clinician, while AI will augment to future teledermatology services^{29,13}. However, digital technologies used to improve the diagnosis and treatment of psoriasis can be divided into three main areas; mobile phone applications (Apps), teledermatology and AI²¹.

Diagnosis and treatment: Tele dermatology in psoriasis

There is wide variation in access to tele dermatology¹³.

- 30% of trusts said their local tele dermatology services are adequately and safely integrated with their services
- 52% of trusts said their local tele dermatology services are not adequately and safely integrated with their services
- 18% of the 117 departments who responded to the GIRFT questionnaire had no local tele dermatology service at all.

Digital technologies used to improve the diagnosis and treatment of psoriasis can be divided into three main areas; mobile phone applications (Apps), tele dermatology and AI.

There is growing evidence to suggest tele dermatology is a useful alternative to in-person clinic visits. Remote Psoriasis Area and Severity Index (PASI) assessments can be comparable to in-person assessments^{30,31}. In addition to monitoring, tele dermatology can help improve adherence by providing reminders. Improved communication between doctors and patients results in better treatment outcomes. Tele dermatology can facilitate more frequent consultations²¹.

Digital medicine for single lesions is relatively straightforward whereas the assessment of a patient with psoriasis requires examination of wider areas. Images of the scalp can often be poor and induration and scaling can also be hard to assess accurately remotely. Where limitations include poor image quality and inadequate history this can lead to inefficiencies²¹.



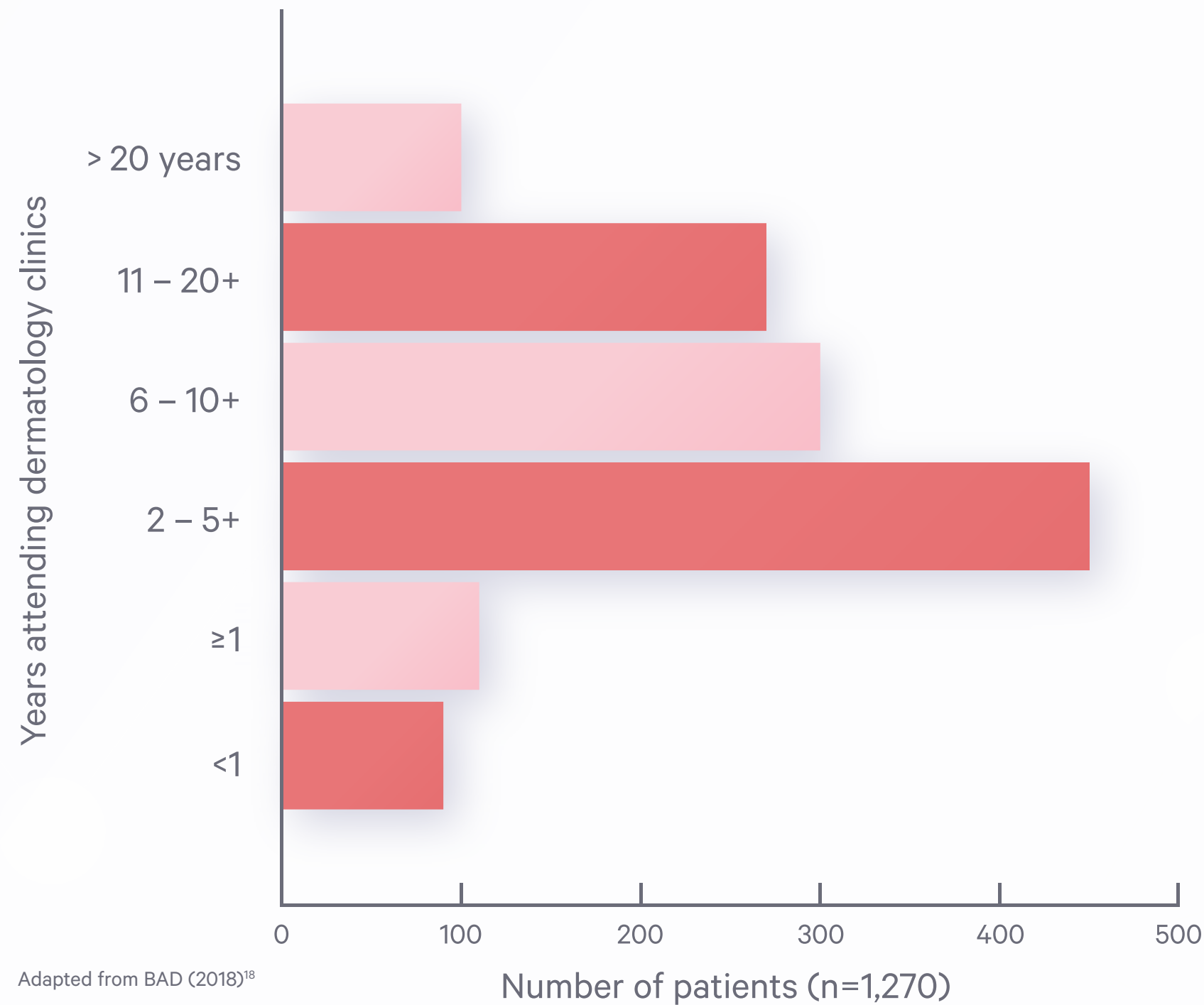
**DIAGNOSIS & TREATMENT:
TELEDERMATOLOGY
IN PSORIASIS**

How do patients access psoriasis services?

Since the start of the pandemic there have been examples of access to specialists supported by remote or virtual clinics, using technology. This has allowed patients to be seen by other dermatology specialist healthcare professionals and referred to dermatology consultants when needed.

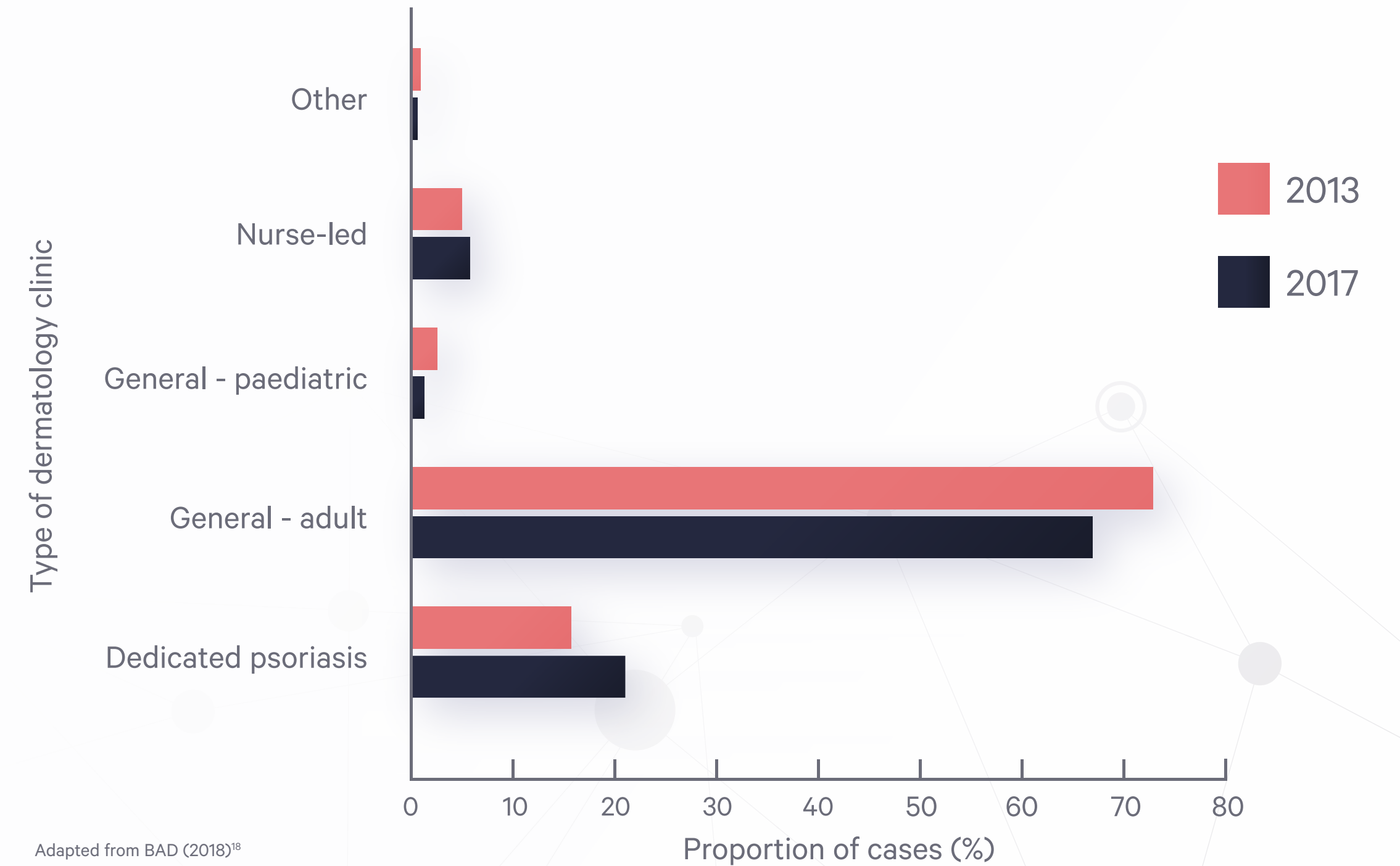
The majority of psoriasis patients have attended psoriasis clinics for two to five years¹⁸.

Numbers of patients with lengths of time attending dermatology clinics¹⁸



Psoriasis patients are usually seen in general dermatology clinics though there are increasing numbers of specific and nurse-led clinics¹⁸.

Proportion of patients seen in each type of dermatology clinic in 2013 and 2017¹⁸



Access to services: Workforce

Shortages in workforce have long been recognised¹⁶. The APPG on skin identified a 28% understaffing in specialists in 2019³².

Shortfalls in the consultant dermatology workforce also mean that some consultants find themselves working single-handed¹³. It is generally poor practice for consultants to work in isolation from other consultants; it means there is no opportunity to discuss new practice or to review each other's practice, which are both essential to protecting patients¹³.

There is considerable variation in the number of dermatology consultants working in trusts, with the six largest trusts (by number of consultants) combined having nearly as many consultants as the smallest 70 trusts combined¹³.

Smaller trusts find it difficult to attract and retain staff due to the workforce shortage. This means they have to rely on high-cost consultant locums, often employed through locum agencies. Many of these expensive locums may not be on the specialist register¹³.

The impact of this is significant:

- Skin cancer referrals are prioritised over patients with often debilitating inflammatory skin disease¹³. Only 15% of departments report equity of access for patients with any skin condition. Not all departments offer urgent access to dermatology services seven-days-a-week²².
- Priority is given to new patients, rather than follow ups. Follow up patients often require attendance for the monitoring of systemic agents²².

GIRFT identified impact on¹³:

- Phototherapy for psoriasis and eczema
- Biological therapy for severe psoriasis
- Emergency care for dermatology
- Psychodermatology for mental health problems relating to skin.

Workforce shortages have had the greatest impact on people with distressing and disabling skin disorders that are non-cancerous¹³. This is because the NHS prioritises resources to meet cancer targets, including skin cancers¹³. Hospitals are asked to make sure that staff focus on seeing people with skin cancers quickly which, if there are shortages of staff, means longer waits for people with non-cancerous but serious skin diseases¹³.

Clinical team: Compensating the shortfall

In order to maximise the workforce, most departments rely on specialised nurses for efficient service delivery²².

89% report nurse-led clinics supported by a dermatology consultant for the assessment of new or follow-up referrals²². Some of these consultations are face-to-face, others are by telephone²².

75% of dermatology outpatient departments report that nurses, under consultant supervision, monitor high-cost drugs such as biological therapies for eczema and psoriasis²².

There are approximately 1,000 specialist nurses working in ratios to consultants from 4.5:1 in Lancashire and South Cumbria to 1:1 in London¹³. There is wide variation in the roles and competencies of specialist nurses and in the way units utilise the skills of their specialist nurses¹³.

There are 226 GPs working in dermatology clinics¹³.

Developing the dermatology expertise of pharmacists, potentially to consultant pharmacists, offers another way to meet the increasing dermatology workload, as does exploring the potential for hospital pharmacists to help with the management of patients on systemic medications, including biologics¹³.

CLINICAL TEAM:
COMPENSATING THE
SHORTFALL

Workforce heatmap: vacant whole time equivalent (WTE) consultant posts (to nearest 0.5 WTE) as a rate per 100,000 population¹³



Data source: GIRFT questionnaire, 2018 and 2019.

SUPERCLINICS

Superclinics

Superclinics are a proven model that may enable working to full efficiency¹³. The concept of a superclinic is to maximise the expertise of the most experienced team members for the benefit of the highest number of patients¹³. The consultant leading the clinic has very few, or no, patients on their own clinic list, but instead sees most of their subordinates' patients¹³. Team members may include junior doctors or nurses¹³.

These superclinics could operate in a virtual context through hub and spoke models. Appropriate networks and hub and spoke services could support the development of integrated care systems (ICS), with specialists in a tertiary centre providing advice and support to colleagues in secondary, primary and community care. However, workforce issues would need to be addressed to ensure feasibility of any new models of working.

Best practice: Extended primary care roles¹³

BEST PRACTICE

EXTENDED PRIMARY CARE ROLES

Dr Tim Cunliffe, GP with extended roles (GPwER) Middlesbrough Specialist Skin Service (MISSS)

Dr Tim Cunliffe is the lead GPwER (formerly GPwSI) working in the Middlesbrough Specialist Skin Service (MISSS), an established community dermatology team. The MISSS is based in a purpose-built centre in the community with modern consulting and operating facilities. The team is well integrated with secondary care dermatology and plastic surgery services, and sits in the same directorate as dermatology at South Tees Hospitals NHS Foundation Trust.

As a GPwER with considerable expertise and experience in dermatology, Dr Cunliffe is able to work closely with colleagues in dermatology and plastic surgery secondary care, bringing appropriate patients into the department for investigation and treatment.

This joined-up approach helps to provide a seamless pathway for patients and avoids unnecessary appointments. It also benefits from the checks and balances, and shared knowledge of up-to-date practice that comes from both parties working closely together. These are essential in helping clinicians remain safe and competent, and in ensuring that primary and secondary care providers work together effectively.

Dr Cunliffe has trained another GPwER, and is the process of training three more, which will help to ensure the sustainability of the service.

Secondary care dermatology clinic in a primary care setting North Devon District Hospital/Litchdon Medical Centre

North Devon District Hospital's secondary care dermatology service is run single-handedly by dermatology consultant Dr Karen Davies from a local GP surgery, Litchdon Medical Centre in Barnstaple. The service provides a full range of secondary care services, with some clinics at the hospital. Patients must be referred by their GP.

Dr Davies is supported by a team of GPwERs in dermatology, providing those doctors with further training and experience. The department also provides dermatology training to medical students as well as postgraduate training to specialty registrars.

Dermatology consultants from Exeter visit to support the service.

Although this service is very dependent on a single consultant and will require recruitment to be sustainable in the longer term, it shows how a good service can be provided to a rural population in the face of shortages in the consultant workforce.

Best practice: Integrated services³³

BEST PRACTICE

INTEGRATED SERVICES

Health Innovation Manchester: Psoriasis Rapid Access Clinic (P-RAC)

The P-RAC clinic runs in a community practice in Salford with patients who have recently been diagnosed with psoriasis. Care is delivered by a specialist team including a dermatology consultant, a health psychologist and a dermatology nurse.

The model promotes early intervention and management of psoriasis with:

- Increased self-care
- Increased adherence to medication
- Early referral to hospital services for those most at risk
- Increased understanding of cardiovascular risk factors in this population
- Prevention of serious comorbidities
- Reduced absenteeism

Best practice: Superclinics¹³

BEST PRACTICE

SUPERCLINICS

Leeds Teaching Hospitals NHS Trust

Leeds' superclinic and advanced nurse practitioners (ANPs) are key to ensuring the trust sees dermatology patients in an effective, timely, safe and patient-centred manner.

Each Wednesday, consultant dermatologist Dr Walayat Hussain and colleagues run the superclinic, bringing together the expertise and skills of allied health professionals. Dr Hussain takes a supervisory role, working with consultant colleagues from plastic surgery, dermatology registrars, nursing staff and physician associates. Working with these health professionals, in particular those from plastic surgery, means patients can be managed appropriately in a single clinic appointment, without the need for a further hospital visit.

ANPs in the clinic have the training and expertise to both clinically assess patients and perform skin surgery, while bringing nursing skills and competencies to the team.

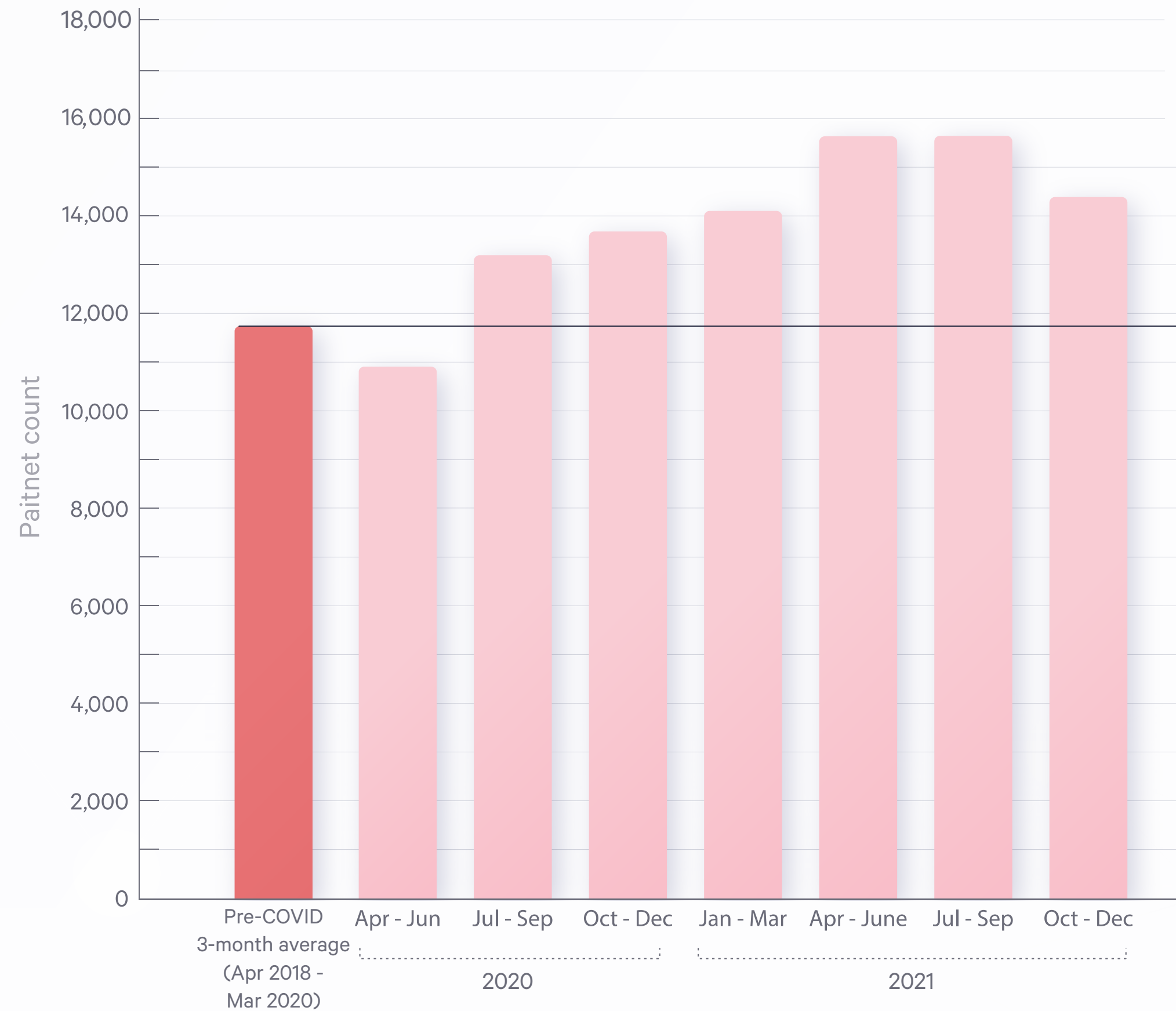
The superclinic model increases the efficiency of the skin cancer pathway, as fewer unnecessary diagnostic procedures are requested by junior staff members. In addition, far fewer patients are brought back for follow-up. There is a further benefit in staff retention; nurse practitioners and physician associates trained to work in the superclinic have very high levels of job satisfaction.

Leeds reports that the superclinic approach has seen a marked improvement in patient flow, with selected patients receiving treatment on their first appointment as a one-stop service. Analysis by the trust's performance team, based on validated metrics, show that the clinic is 30% more efficient than traditional models.

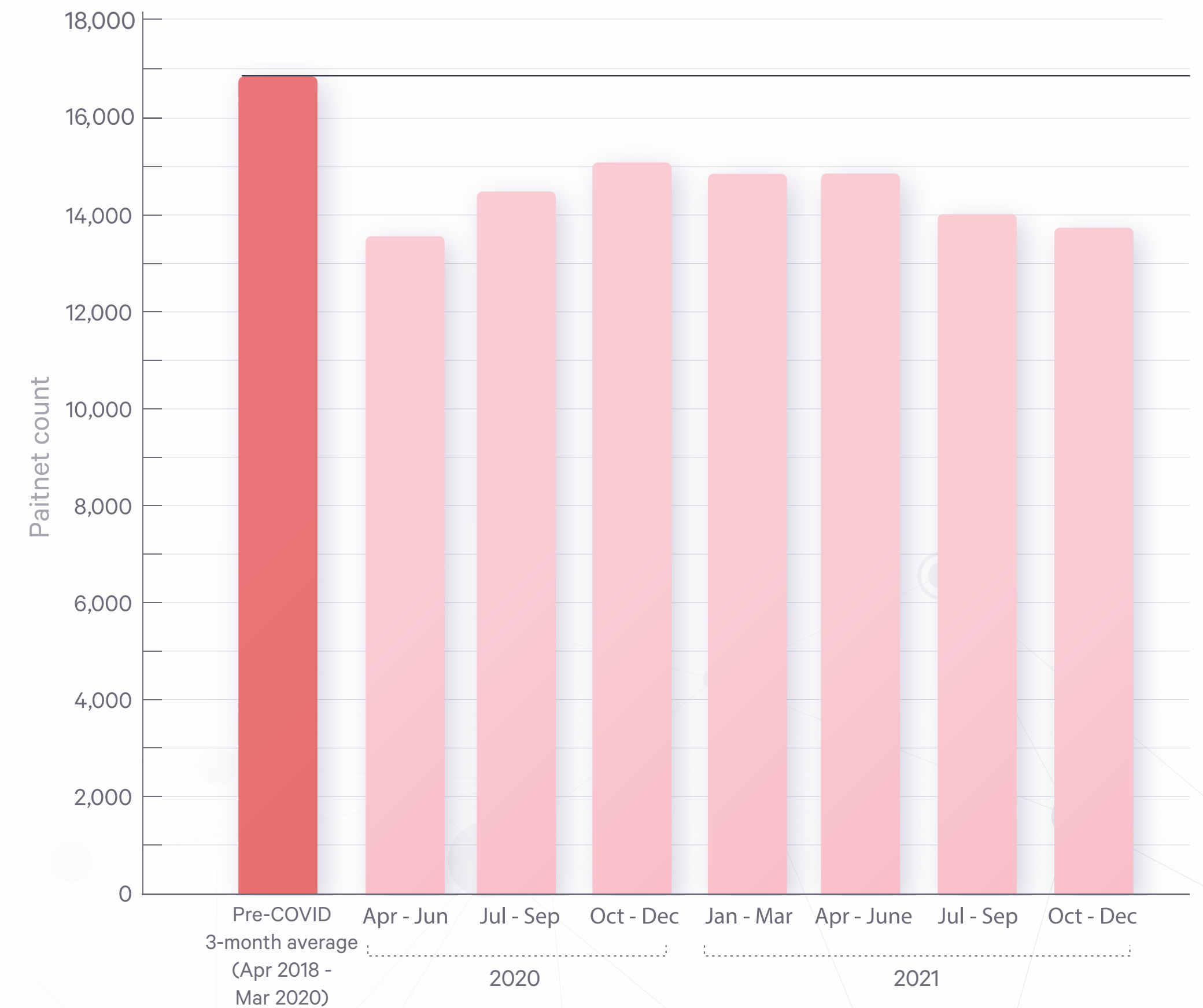
Access to service and elective recovery

Analysis shows long waits for people with non-cancerous but distressing and disabling skin diseases, because the NHS prioritises resources to meet cancer targets¹³.

Number of patients seen in dermatology outpatients: Melanoma²⁰



Number of patients seen in dermatology outpatients: Psoriasis²⁰



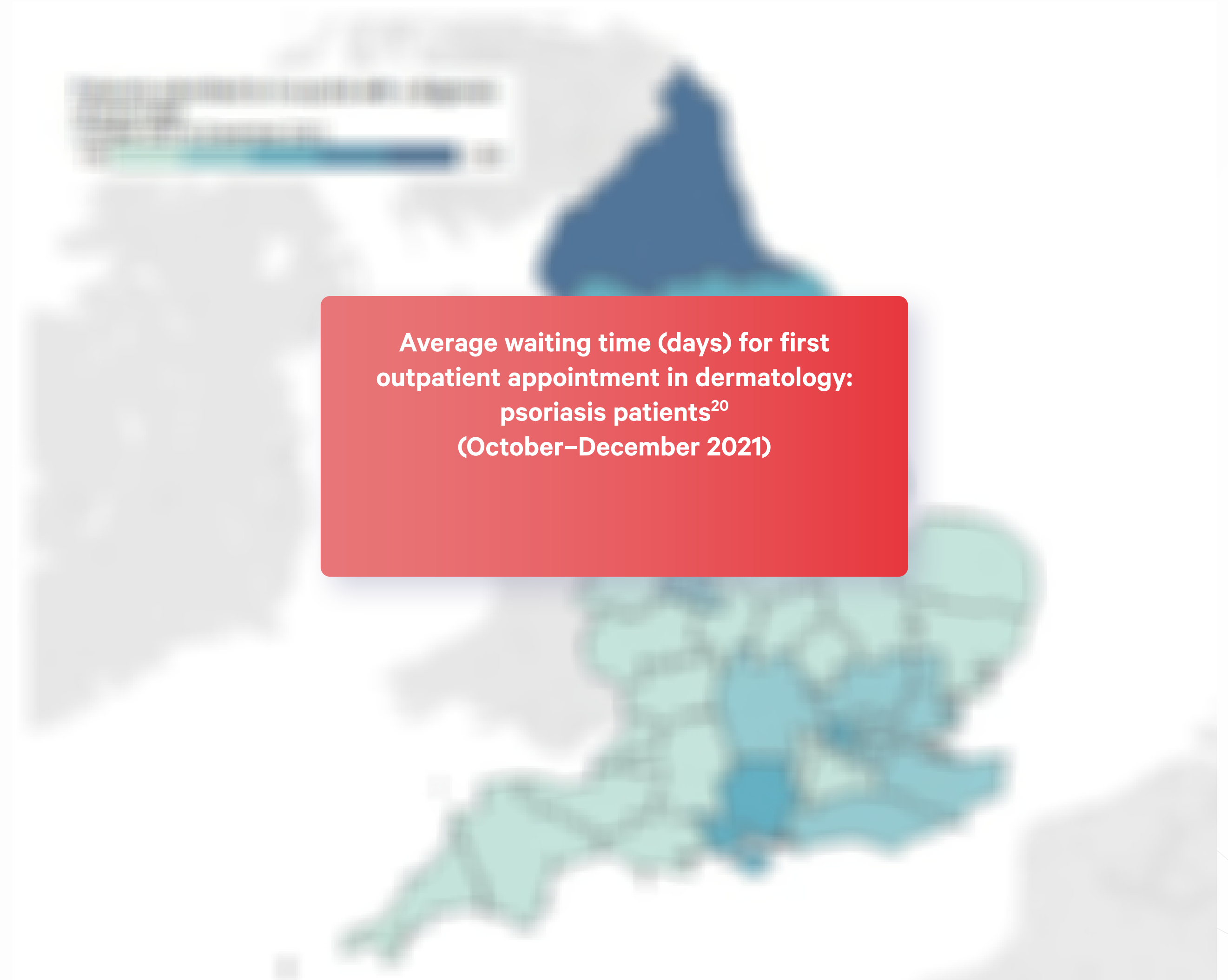
ACCESS TO SERVICE & ELECTIVE RECOVERY

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Variation in access

There is significant variation in access to psoriasis services across England. The wait for a first outpatient appointment in dermatology for psoriasis patients between October and December 2021, ranged from 32 days in Cornwall and the Isles of Scilly ICS to 237 days in Herefordshire and Worcestershire²⁰.

VARIATION IN ACCESS

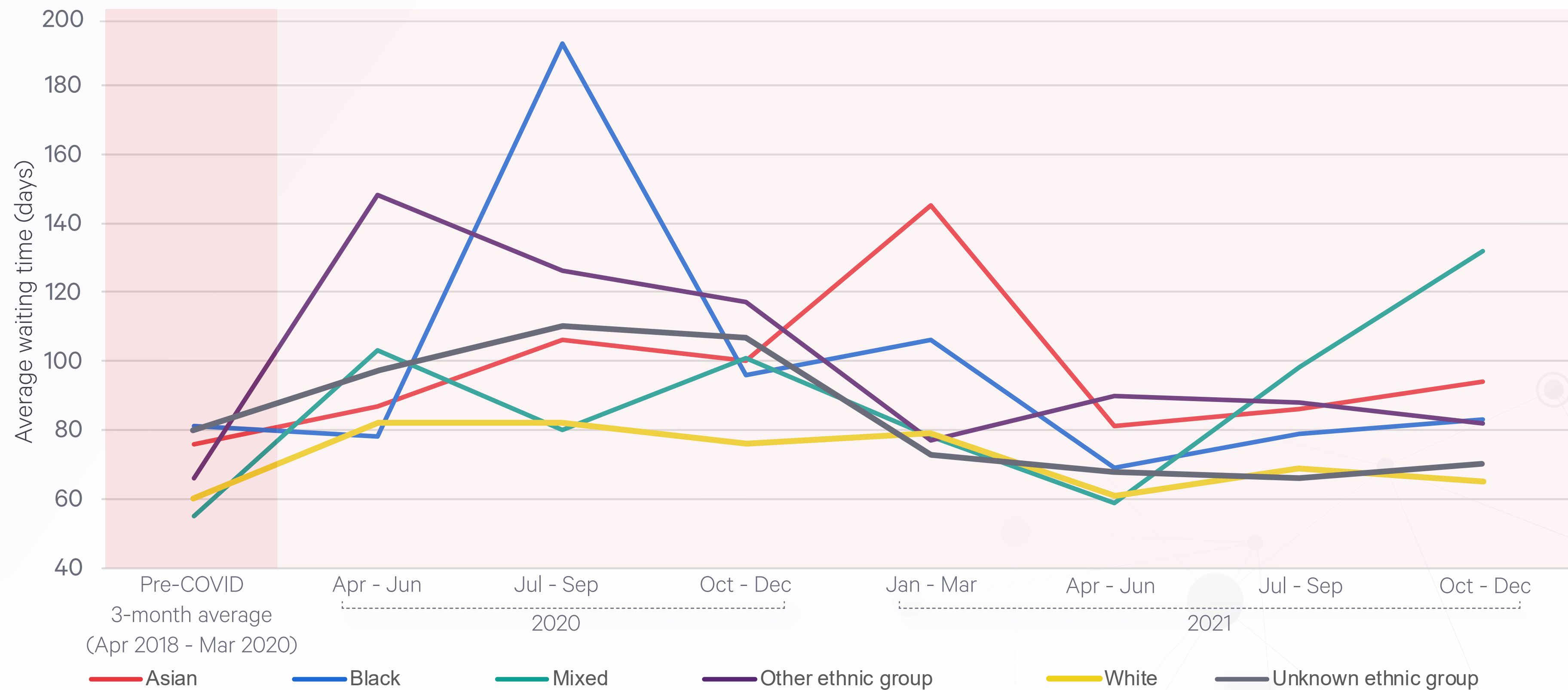


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Waiting time inequalities: Ethnicity

Inequalities in waiting times for a first outpatient appointment for psoriasis before during and after COVID-19 highlights variation across all ethnicities, with less deviation across white communities²⁰. The peaks often coincide with the lockdown, and particularly affect the black, Asian and other ethnic groups²⁰.

Average waiting time for first outpatient appointment in dermatology for psoriasis patients split by broad ethnicity²⁰



WAITING TIME INEQUALITIES

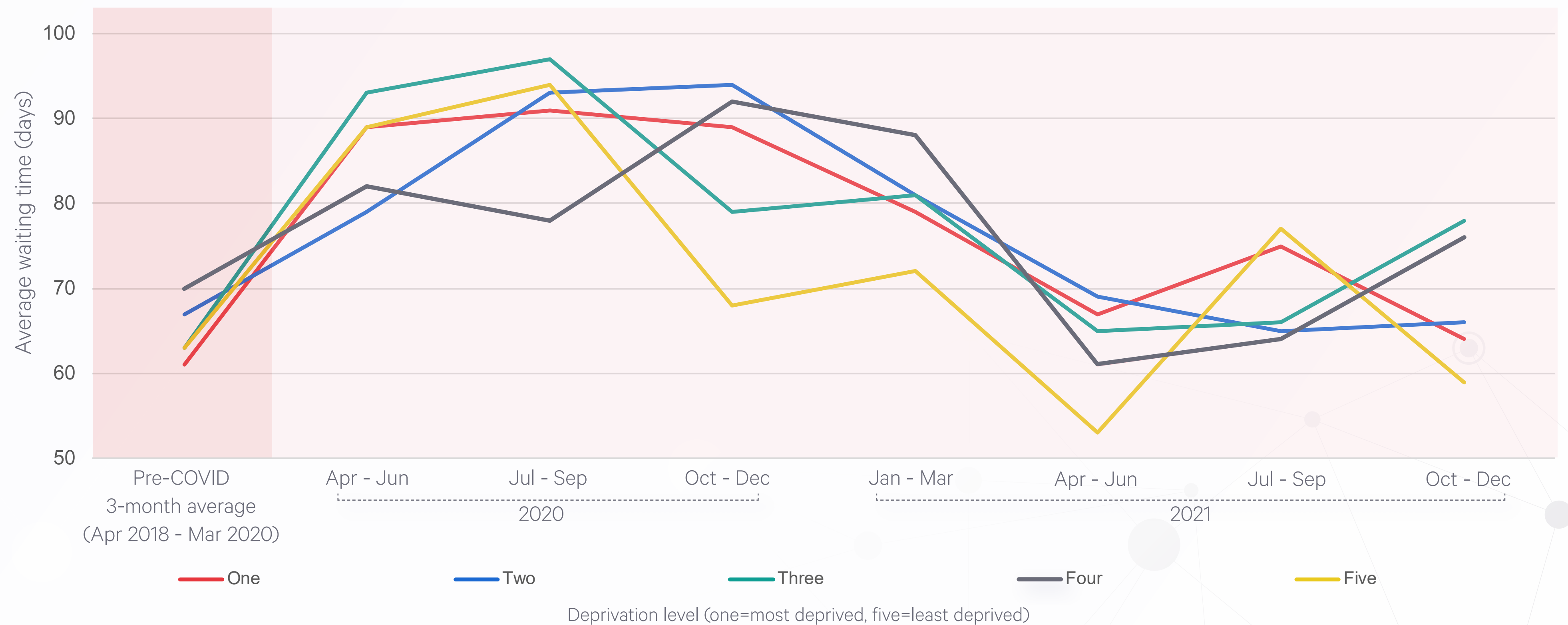
ETHNICITY

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Waiting time inequalities: Deprivation

Waiting times increased across all deprivation categories for a first outpatient appointment for psoriasis at the beginning of the pandemic, most stabilising a year later²⁰. The least deprived patients' waiting times recovered more quickly than every other group²⁰.

Average waiting time for first outpatient appointment in dermatology for psoriasis patients split by deprivation quintile²⁰



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Dermatology services provided in private settings

Over the past few years private healthcare providers in the community have been bidding to provide care to NHS patients.

These services are set up to provide routine and non-cancerous skin reviews in private healthcare settings, allowing specialist care, particularly with biologics, to occur in the secondary or specialist care settings.

For example, some dermatology services commissioned in Bassetlaw and South Warwickshire have been commenced by community provider HealthHarmonie - HealthHarmonie³⁴.

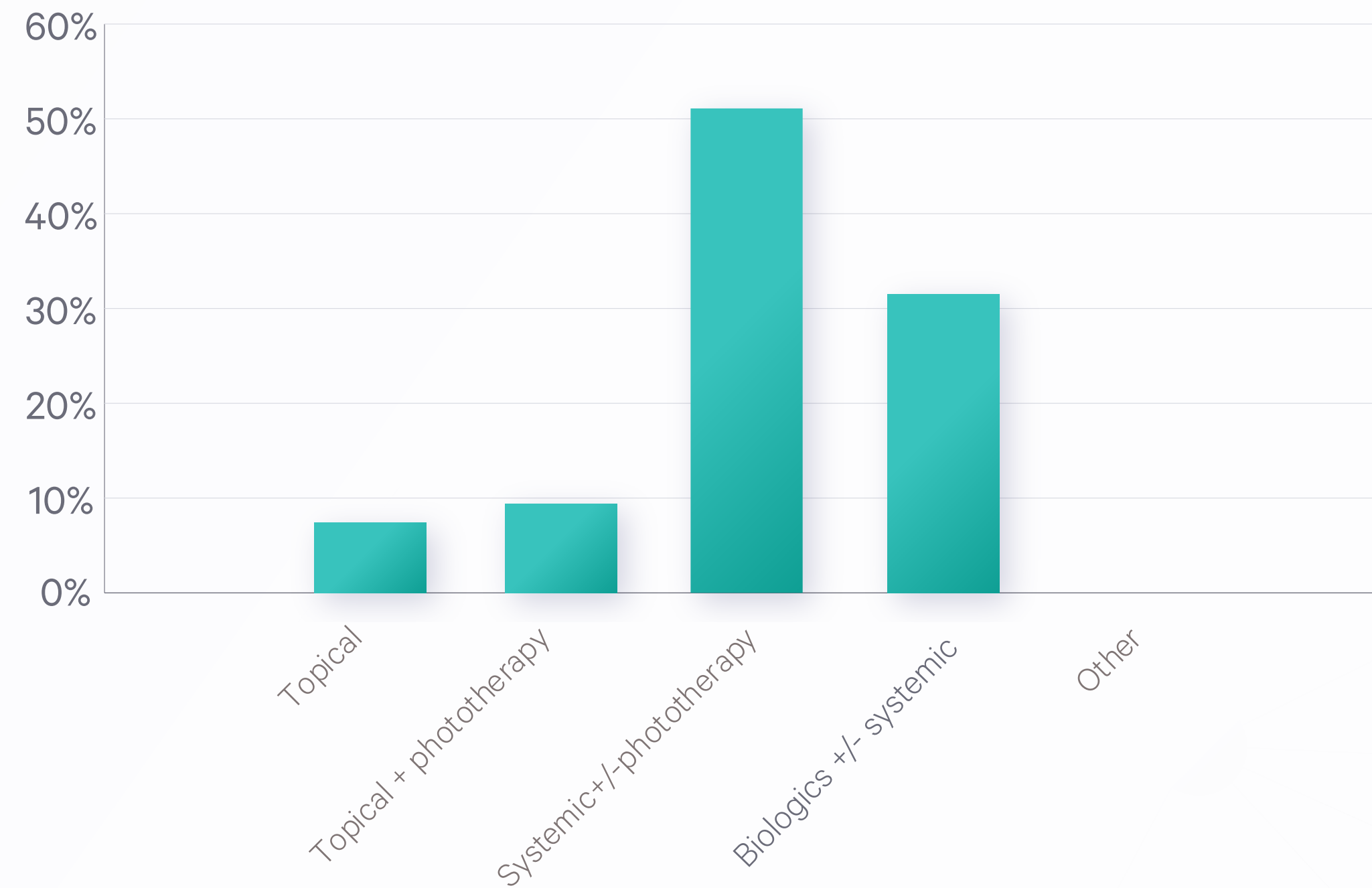
Going forward in the new NHS, there could potentially be opportunities for these private centres, with the correct governance infrastructure, to administer more complex treatments.

PRIVATE DERMATOLOGY
SERVICES

Access to treatment

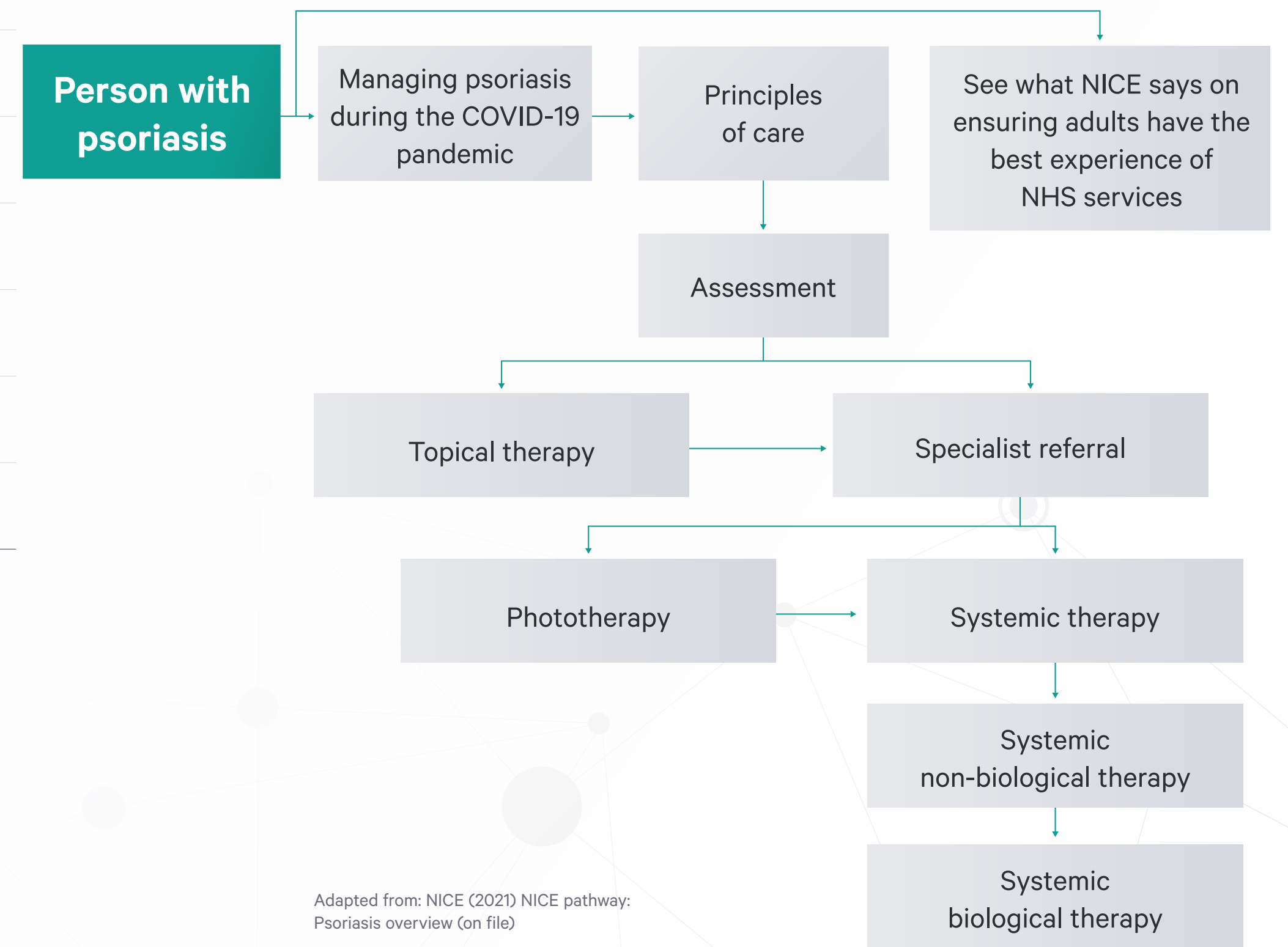
Many people spend years cycling through ineffective treatments for their conditions before being prescribed the most appropriate drug treatments. Consultants at Salford Royal NHS Foundation Trust explained that people with severe psoriasis generally wait a decade before they are prescribed a systemic drug and 12 to 14 years before they are prescribed a biologic drug¹⁷.

Treatment modality in 2017¹⁸



Adapted from BAD (2018)¹⁸

Psoriasis overview: NICE pathway³⁵



Adapted from: NICE (2021) NICE pathway: Psoriasis overview (on file)

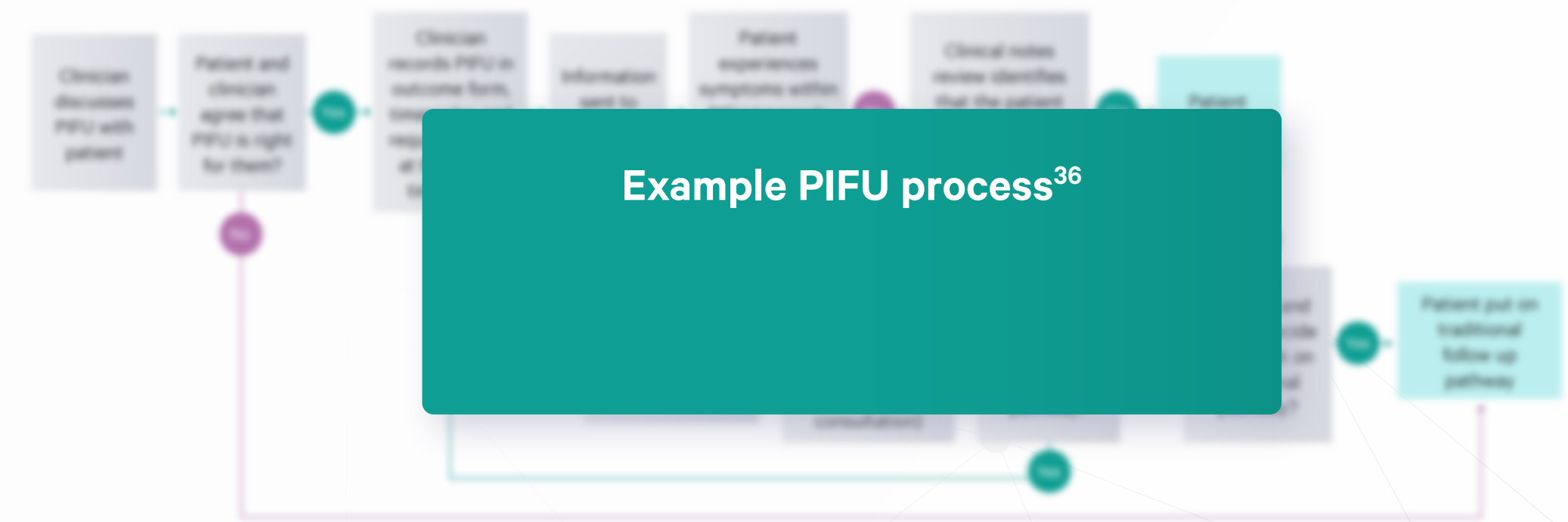
Access to treatment and follow up

Treatment and assessment regimes for psoriasis follow NHS clinical guidance 153⁴, with specialists initiating care treatments such as phototherapy +/- systemic biologic treatments.

Once the psoriasis treatment is initiated and controlled, the follow ups or long-term management is determined by the consultant or link nurse follow up. The aim is to move to a patient-initiated follow up (PIFU) when a patient (or their carer) can initiate their follow-up appointments as and when required, e.g. when symptoms or circumstances change³⁶.

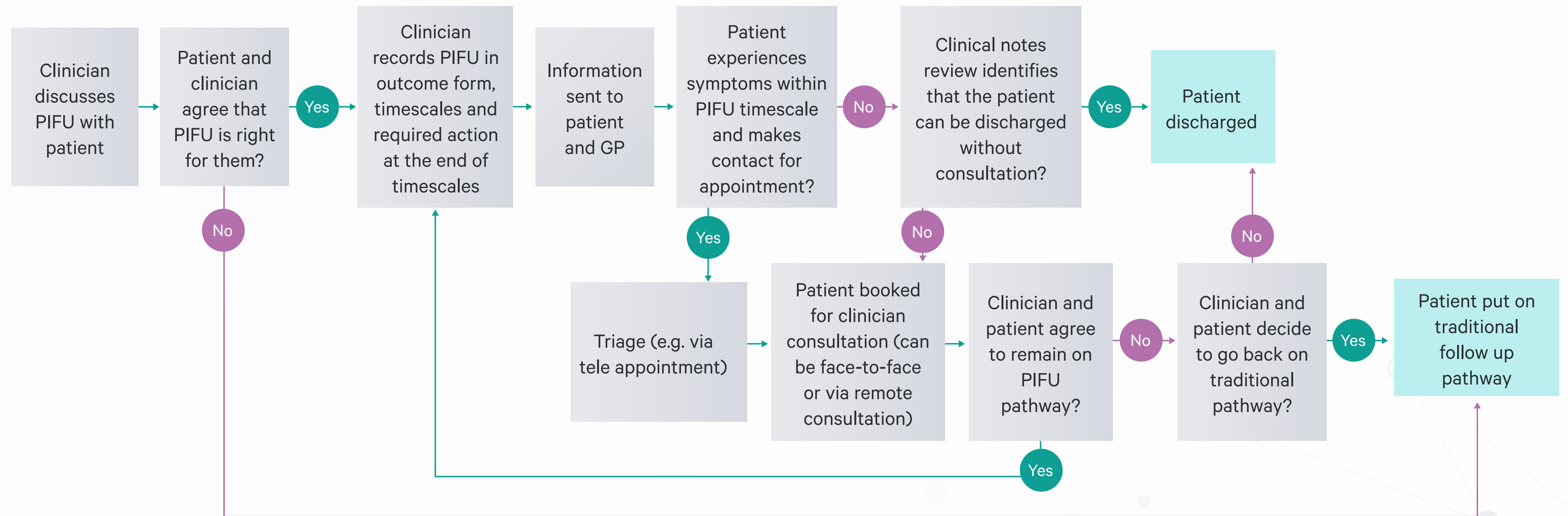
Specific groups of patients such as psoriasis have access to a PIFU specialist where the condition³⁶:

- Flares unpredictably
- Requires prompt access
- Able to self-manage
- Written flare plans provided
- No further treatment options in primary care
- Post phototherapy or after cessation of systemic therapy.



Access to treatment and follow up

Example PIFU process³⁶



Adapted from British Association of Dermatologists (2021) Setting up Patient Initiated Follow-Up (PIFU) services for people with skin conditions. Available at: <https://cdn.bad.org.uk/uploads/2022/04/07153547/Setting-up-patient-initiated-follow-ups-for-people-with-skin-conditions-1.pdf>

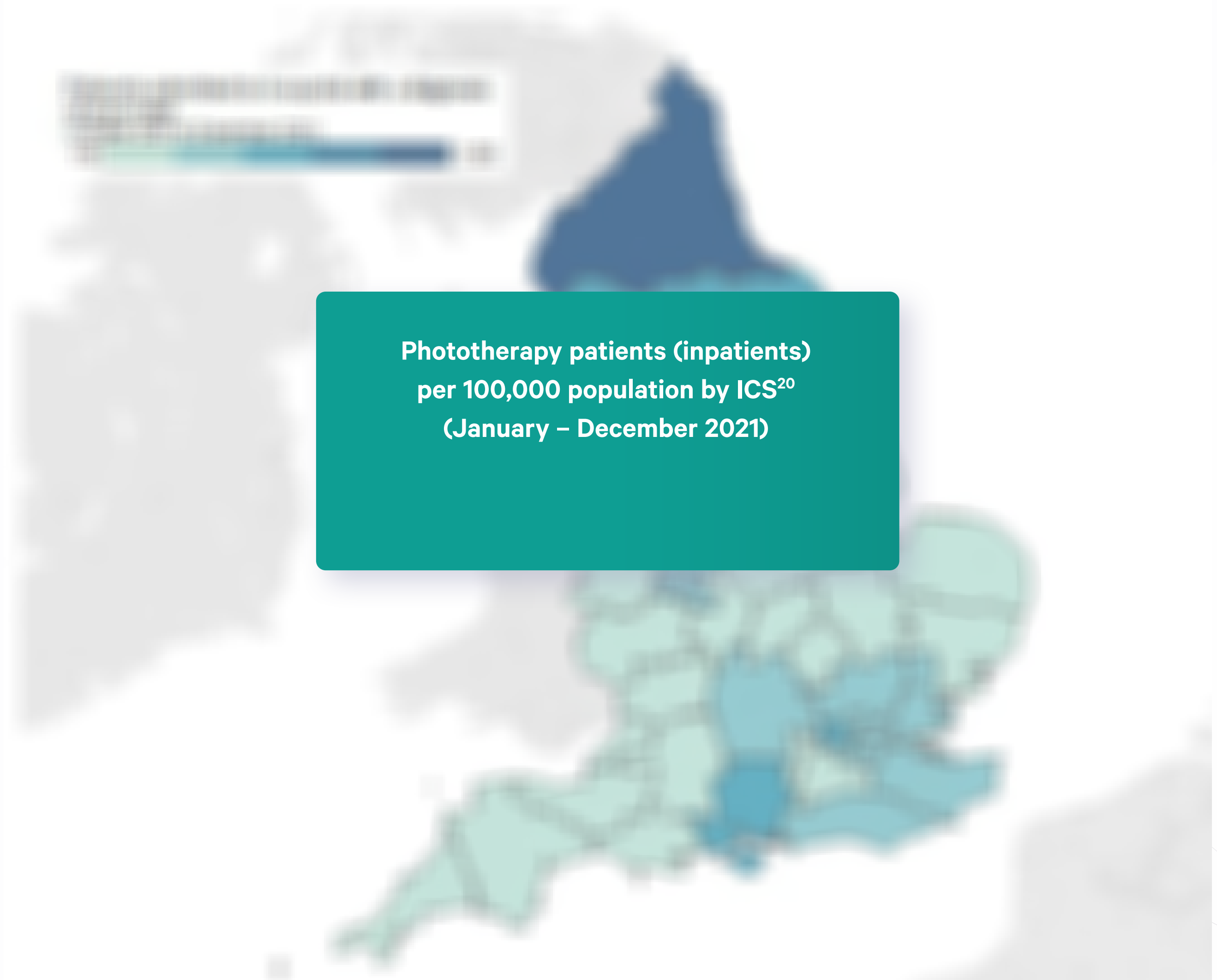
Phototherapy service

There is wide variation in the level of phototherapy use¹³, resulting in considerable variation in access between ICSs²⁰.

As phototherapy is significantly less expensive per patient per year than biologics treatment, using the treatments appropriately could release significant funds¹³.

Phototherapy occurs earlier in the treatment pathways for psoriasis and eczema, so it is reasonable to expect that reduced access to phototherapy is likely to progress some patients to biologics (more expensive) or systemic drugs (less safe)¹³.

In rural areas patients may need to travel far and frequently for phototherapy. Some home-based models have been initiated.



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Best practice: Providing home phototherapy services¹³

BEST PRACTICE: HOME PHOTOTHERAPY

Leeds Teaching Hospitals NHS Trust

Dr Victoria Goulden, consultant dermatologist at Leeds Teaching Hospitals, has successfully piloted the use of remote phototherapy services at home. The pilot is designed to improve access to treatment for patients whose circumstances make regular hospital attendance difficult, such as distance from the hospital, or work and care responsibilities. It is based on a similar service provided by Ninewells Hospital, NHS Tayside.

Leeds' home phototherapy service mainly focuses on treating patients with psoriasis and eczema. It has achieved outcomes similar to those achieved with hospital phototherapy, with similarly low levels of adverse effects including symptomatic erythema. All patients have expressed high levels of satisfaction with the service and would choose home phototherapy again.

The uptake of home phototherapy in England has been low. Dr Goulden highlights the importance of carefully selecting patients who are able to manage this complex treatment. Patients are provided with training and supported remotely, but are closely monitored by the clinical team following clear local governance arrangements to minimise any potential risks.

The home phototherapy team includes a consultant dermatologist, phototherapy nurse practitioner and medical physics practitioner. Dr Goulden noted that development of national clinical guidelines and a governance framework would “encourage the development of home phototherapy in the UK.”



Biologic therapies

There has been a significant increase in the use of biologics therapy³⁷.

While systemic treatments such as methotrexate and cyclosporins are initiated by specialists, they have a number of interactions and require significant monitoring:

- Methotrexate 2-3 monthly - Methotrexate - FBC, renal and liver function tests³⁸.
- Cyclosporin – therapeutic drug monitoring, serum creatinine, urea, potassium, magnesium, lipids and blood pressure³⁹.

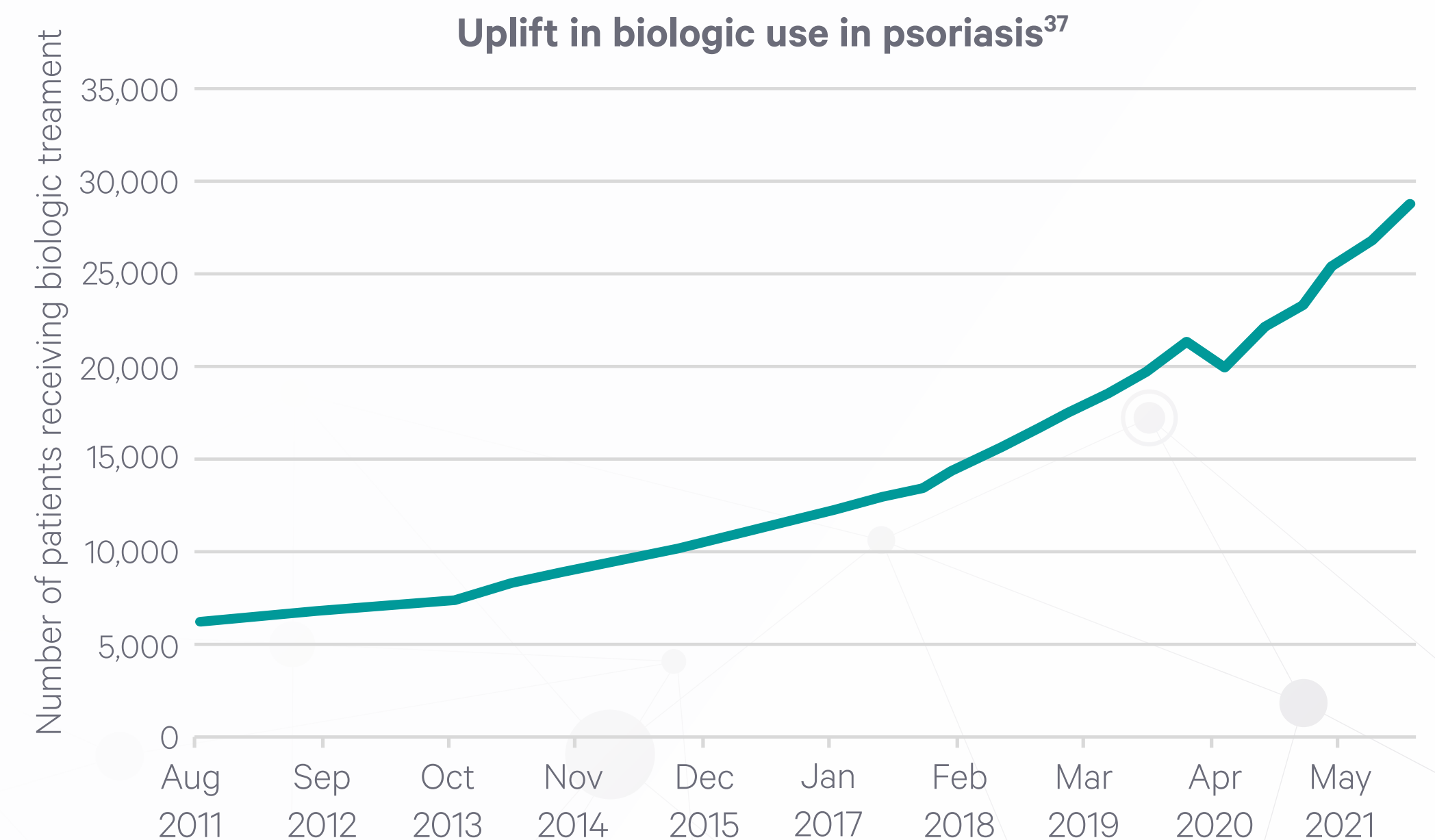
To support workload and manage care closer to home GPs frequently manage shared care protocols, for drug monitoring¹³.

In the past, it was normal for dermatology departments to have wards full of people having treatment for psoriasis, eczema and other conditions. Thanks to biologics, those numbers have greatly reduced over the last 15 years¹³.

BIOLOGIC THERAPIES

75% of dermatology outpatient departments report that nurses, under consultant supervision, monitor high-cost drugs such as biological therapies for eczema and psoriasis²². However, there are limited numbers of specialist nurses with the capability to deliver these services.

GIRFT has recommended that specialist pharmacists in hospital could also support biologic management¹³.



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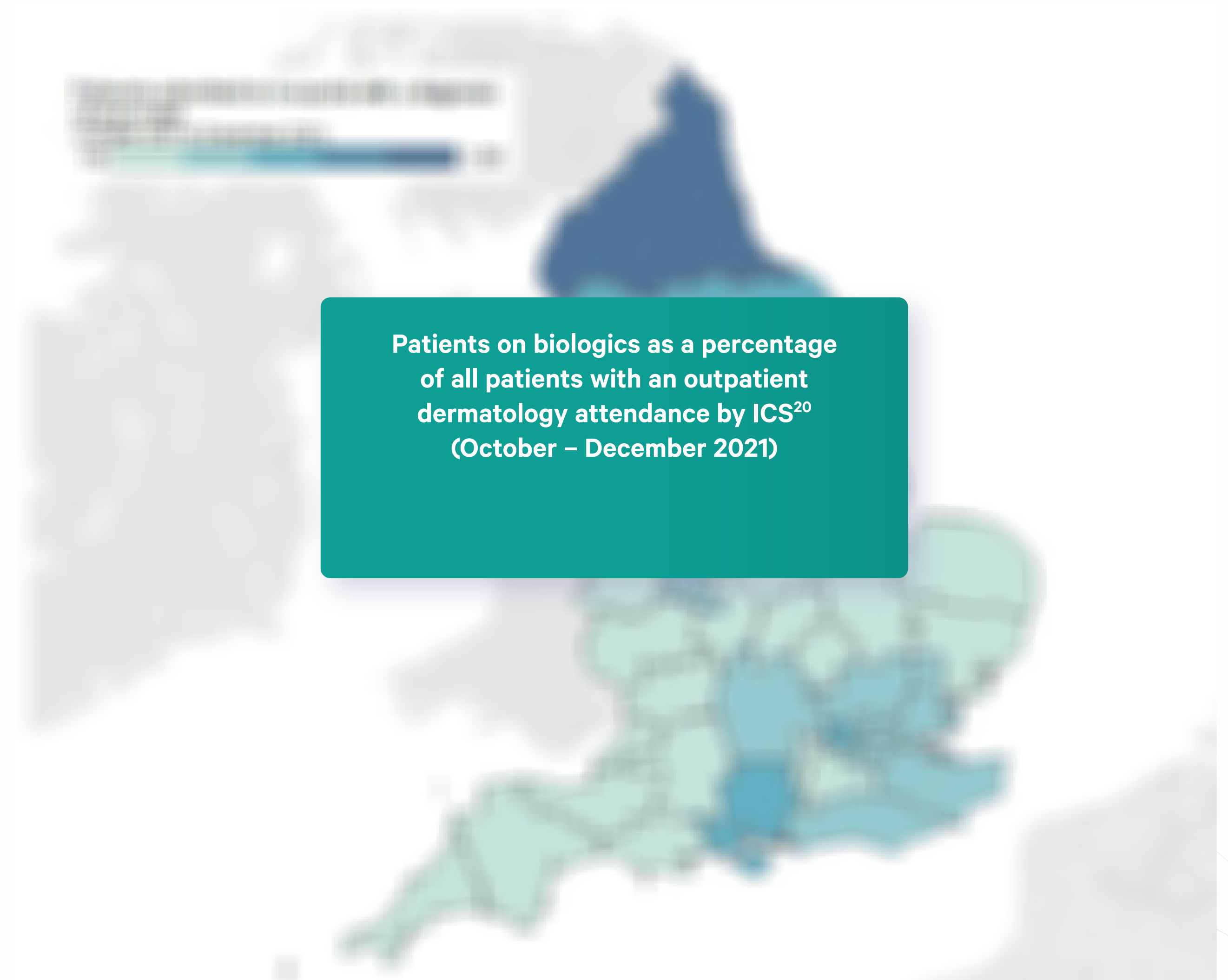
Uptake of biologics

Despite NICE⁴ and British Association of Dermatologists⁴⁰ guidance, there is wide variation in the uptake of biologics for psoriasis.

There are a number of causes for the variation in uptake of biologics¹³:

- Variation in how CCGs are interpreting NICE guidance
- Variation in clinicians' readiness to use newer drugs
- Influence of marketing by the pharmaceutical industry
- Variation in patients' readiness to use newer drugs
- Wide range of choices creates confusion
- Administrative burden strengthens inertia
- Anticipating future cost reductions
- Variation in CCG understanding of special interest consultant roles.

UPTAKE OF BIOLOGICS



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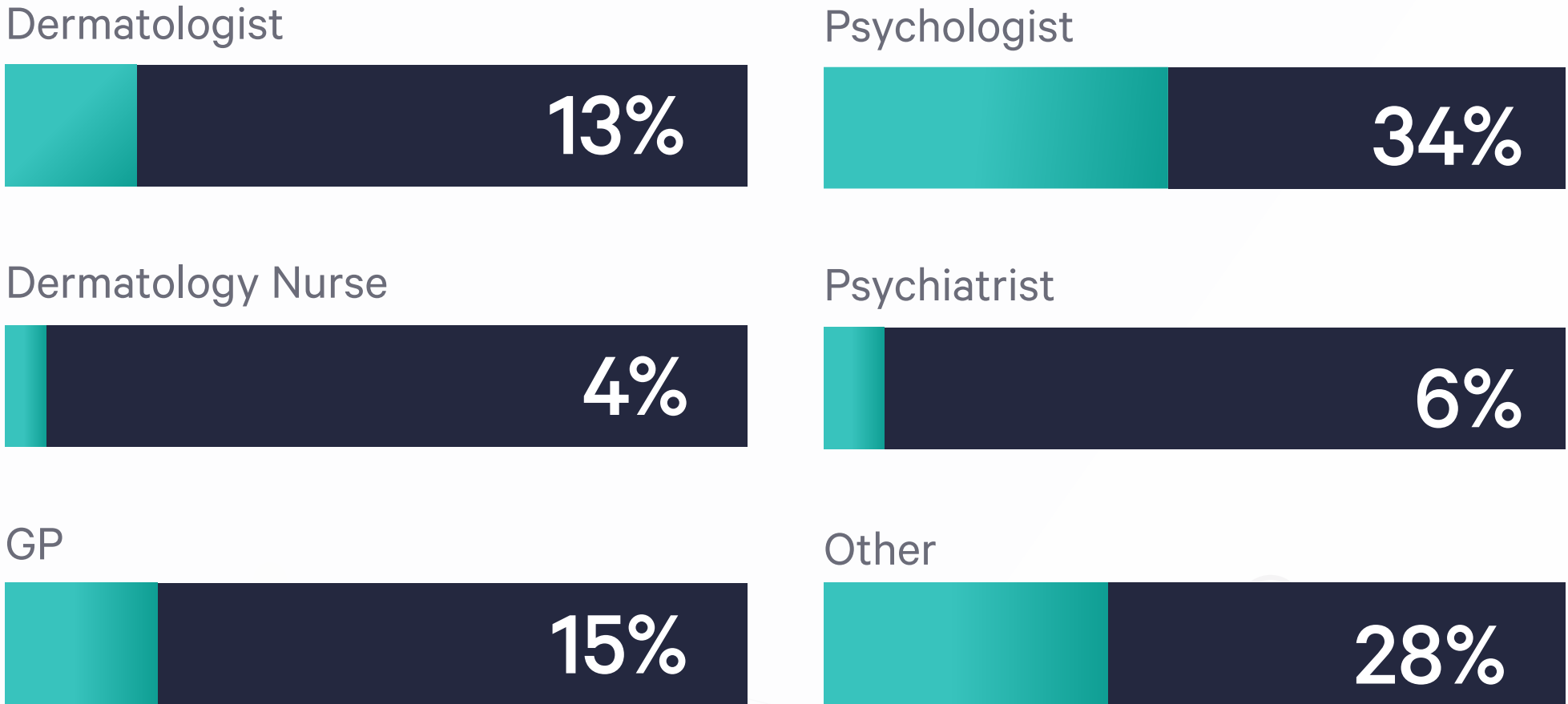
Psychology and mental health in psoriasis

The APPG on Skin (APPGS) highlighted that access to specialist mental health support for people with skin disease is limited throughout the UK⁸. Despite a growing need for such services, 98% of skin disease patients report that their condition affects their emotional and psychological wellbeing, yet only 18% have received some form of psychological support⁸. The majority of support is through the GP dermatology specialist or specialist nurse⁸. Audit indicated 24% of cases had psychologist support and 89% cases had nurse-led support¹⁸.

There is wide variation in access to psychodermatology; there are currently just 11 dermatologists running psychodermatology clinics in nine trusts¹³. This is particularly worrying since the COVID-19 pandemic has exacerbated mental health distress in a skin community that was known to already experience significant appearance-related distress⁸. The NHS Mental Health Implementation plan 2019/20-2023/24²³ sets out plans to improve dedicated provision for groups with specific needs such as psoriasis.

Healthcare professionals treating skin patients

Percentage of survey respondents who have received psychological support in relation to their skin condition⁸



Adapted from All-Party Parliamentary Group on Skin (2020)⁸

Best practice: Psychodermatology service¹³ (1)

Guy's and St Thomas' NHS Foundation Trust

Guy's and St Thomas' psychodermatology service has grown from a two-session per week secondment in 2013 to three full-time psychologists.

Psychologists are assigned to a number of secondary and tertiary clinics. In most clinics the psychologists are available to see patients on the same day as their visit to see other dermatology staff. They are also available to see patients for psychological therapy in their own clinics.

The psychology service has clear referral criteria that distinguish it from primary care psychology and community mental health teams. Dermatology staff follow the referral pathway for liaison psychiatry for diagnostic assessment of mental health, medication reviews and recommendations, and if there is elevated patient risk related to mental health. The pathway provides for same-day assessment where risk is deemed particularly high and for less urgent assessment for low risk referrals. Treatment sessions are limited to 12 plus a one-month follow-up to keep the service viable.

Embedding psychologists in multidisciplinary teams provides the wider team with access to expertise on mental health and the emotional aspects of living with a skin condition. It also supports access to psychology for those patients who may not realise or believe their problem is primarily psychological rather than dermatological.

The service applies a stepped-care approach in line with NICE guidance for the management of depression in people with long-term physical health problems and the BAD's minimum standards for psychodermatology services.

Routine screening by the service has identified a high percentage of previously unrecognised psychological morbidity.

Guy's and St Thomas' psoriasis and eczema service was awarded the British Medical Journal Dermatology Team of the Year (2016) for its entry Holistic Care for Skin Disease, which featured data from their psychodermatology service.

Training resource

Psoriasis Association's 'PsoWell' training programme for dermatology specialists and psychologists⁴¹

PSYCHODERMATOLOGY
SERVICE

BEST PRACTICE (1)

Best practice: Psychodermatology service¹³ (2)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

In October 2019, Dr Stephanie Ball and Dr Soraia Sousa established a new psychodermatology service in Newcastle, serving the north-east of England and Cumbria. Previously, there was no psychodermatology service in the region. This meant patients with complex psychological needs were seen in a general dermatology clinic where appointment times are not sufficient to deal with psychological issues.

The Newcastle service is based on a similar service set up in Lothian, Scotland by psychiatry trainee Dr Catriona Howes, supervised by Dr Wotjek Wojcik, with Dr Ball.

Clinical governance

The service is led jointly by a senior trainee doctor in dermatology and a senior trainee doctor in psychiatry.

The trainees see patients together, while supervision is provided by a consultant dermatologist and a consultant liaison psychiatrist who can be called upon for advice. The consultant liaison psychiatrist also provides formal supervision sessions for both trainees to mitigate any clinical governance issues.

Using a trainee-led model capitalises on the greater flexibility of trainee timetables versus the fixed job plans of the consultant body. It also provides valuable training opportunities for the trainees involved.

Promising Early results

Early results show few cancellations and no non-attendances. Anecdotal evidence shows that patients have been very grateful for the time spent listening to their histories, and for the thorough follow-up letters they receive. These letters include a personal formulation of the patient's problems, set out a plan of action, and often signpost further useful apps and workshops. Patients also appreciate having two perspectives and a joint formulation from the two clinicians present.

New patients have one-hour appointment slots, while follow-up appointments are 30 minutes. As the service is new, referrals currently come from other dermatologists in the region rather than directly from primary care. Conditions seen include delusional infestation, dermatitis artefacta and body dysmorphic disorder, along with skin picking disorder, trichotillomania and mood and anxiety disorders secondary to a chronic dermatological diagnosis, such as eczema and hidradenitis suppurativa.

The service has required very little initial investment other than a large room for the clinic and some administrative support.

PSYCHODERMATOLOGY
SERVICE

BEST PRACTICE (2)

Comorbidity

Psoriasis is generally seen as a dermatological problem but it is actually an under-recognised multi-faceted disease in which psoriatic arthritis and other complex comorbidities can develop. Anecdotally, patients are frequently referred to specialist services far too late in the disease course and by the time treatment starts, they have often developed a range of comorbidities, such as cardio-metabolic disease, obesity, diabetes and depression, which can have a negative impact on treatment outcomes and quality of life⁴⁵.

As we make the transition to new models of care in the form of ICSs and PCNs, the health and care sector must now work collaboratively⁵⁵ to ensure psoriasis and psoriatic arthritis have a place in local priority-setting discussions to enable high-quality service planning.



5.8-30%

of patients with psoriasis suffer from psoriatic arthritis which can further deteriorate quality of life by affecting physical function^{42,43}.



2.9 x

Psoriasis patients have a 2.9-times higher risk of developing Crohn's disease, when compared with the general population².



+6.2%

Psoriasis patients have a 6.2% increased risk for the development of major cardiovascular events within 10 years⁴⁴.

Metabolic syndrome as a whole and its individual components (high blood pressure, diabetes, obesity) have been associated with psoriasis⁴⁵.

COMORBIDITY

Best practice: Integrated psoriasis service

While dermatologists are competent in the management of psoriatic skin disease, many are not sufficiently familiar with the diagnosis, treatment, and referral criteria of co-existent psoriatic arthritis⁴⁶.

Developing the concept of early psoriatic arthritis detection and management within the dermatology clinic needs to be a service priority to improve outcomes and facilitate early combined intervention with rheumatology⁴⁶.

The opportunity to pool imaging and nursing resources also confers an economic advantage, and in addition to the savings made from combining two 'new' appointments with specialists, there are also those associated with the reduction in the overall cost of caring for patients with debilitating joint disease⁴⁶.

With an ever-expanding armamentarium of therapies emerging with efficacy in both psoriasis and psoriatic arthritis, close liaison between dermatologists and rheumatologists is important⁴⁶.

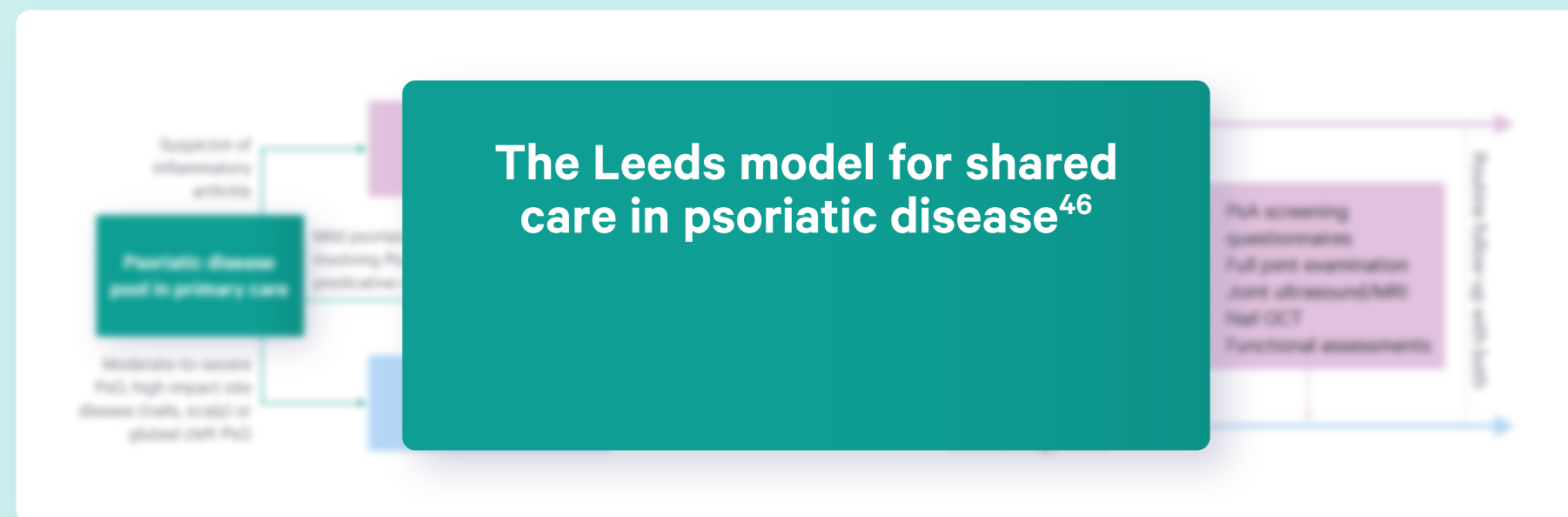
The Combined Psoriatic Service⁴⁷

The Combined Psoriatic Arthritis and Psoriasis Clinic in Leeds was one of the first combined services to be set up in the UK. In a weekly clinic, consultant rheumatologists and dermatologists work together to create personalised treatment regimes aimed at improving the physical condition and quality of life of people affected by psoriatic arthritis and skin psoriasis. The clinic is a tertiary referral hub that benefits from the combined efforts of rheumatology and dermatology specialist nurses, junior doctors and allied health professionals. The service has national and international recognition and regularly hosts clinicians and other allied health professionals in a dedicated educational programme.

The Combined Rheumatology and Gastroenterology clinic⁴⁷

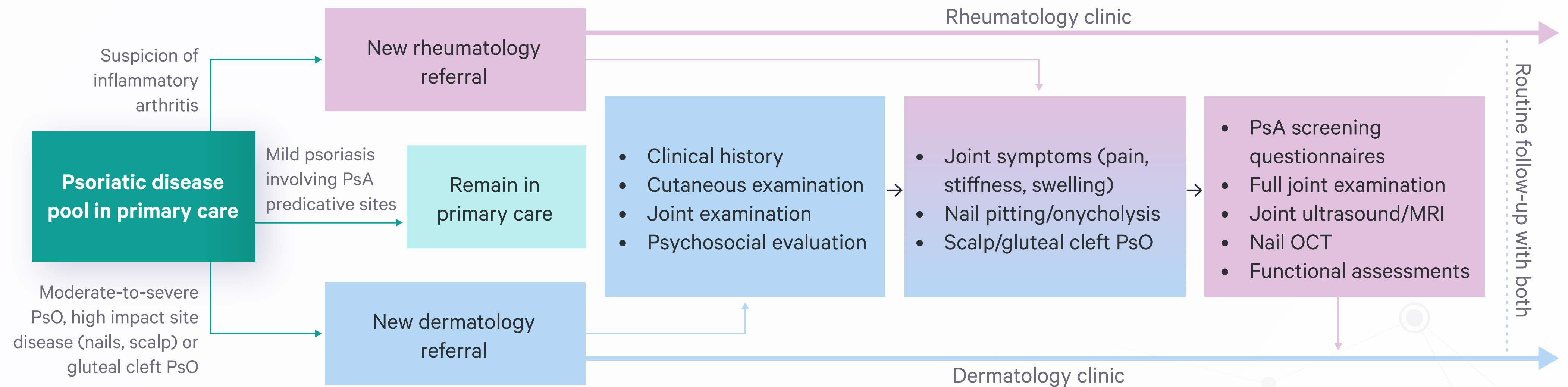
The Combined Rheumatology and Gastroenterology clinic is a bi-monthly clinical service where patients affected by both inflammatory bowel and joint conditions can be simultaneously reviewed by a consultant rheumatologist and a consultant gastroenterologist. This allows prompt management and timely initiation of treatment, avoiding unnecessary cross-service referrals. Patient satisfaction with these combined clinics is very high.

INTEGRATED
PSORIASIS SERVICE







Best practice: Integrated psoriasis service

The Leeds model for shared care in psoriatic disease⁴⁶



MRI, magnetic resonance imaging; OCT, optical coherence tomography.
Adapted from: Savage L, Tinazzi I, Zabotti A, et al. Defining Pre-Clinical Psoriatic Arthritis in an Integrated Dermato-Rheumatology Environment. J Clin Med. 2020 Oct 12;9(10):3262.

2022/23 priorities and operational planning guidance

	Priorities	Impact on psoriasis services
 <p>Invest in workforce</p>	<p>Invest in our workforce – with more people (for example, the additional roles in primary care, expansion of mental health and community services, and tackling substantive gaps in acute care) and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care⁴⁸.</p>	<p>The GIRFT dermatology report¹³ and APPG 2019 audit³² clearly state the need to develop workforce. Until this is managed considering new ways of working psoriasis services to deliver effective care with new integrated roles and technology will be necessary and a priority.</p>
 <p>Reduce waiting times</p>	<p>Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards⁴⁸.</p>	<p>Backlog and waiting times for melanoma, psoriasis and dermatology as a whole indicate a need to focus services. While cancer is the priority, there are many patients suffering with severe psoriasis. Developing new models of care with practitioners with extended role (specialist nurses, hospital pharmacists and GPs) may free up dermatology consultants to manage cancer while managing the psoriasis service issues.</p>
 <p>Population health management</p>	<p>Continue to develop our approach to population health management, prevent ill health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities⁴⁸.</p>	<p>Managing services around patient cohort care priorities may support some of the access issues identified.</p>
 <p>Digital technologies</p>	<p>Exploit the potential of digital technologies to transform the delivery of care and patient outcomes⁴⁸.</p>	<p>Sharing data, records and photographs has been shown to support psoriasis services within integrated working.</p>

Integration

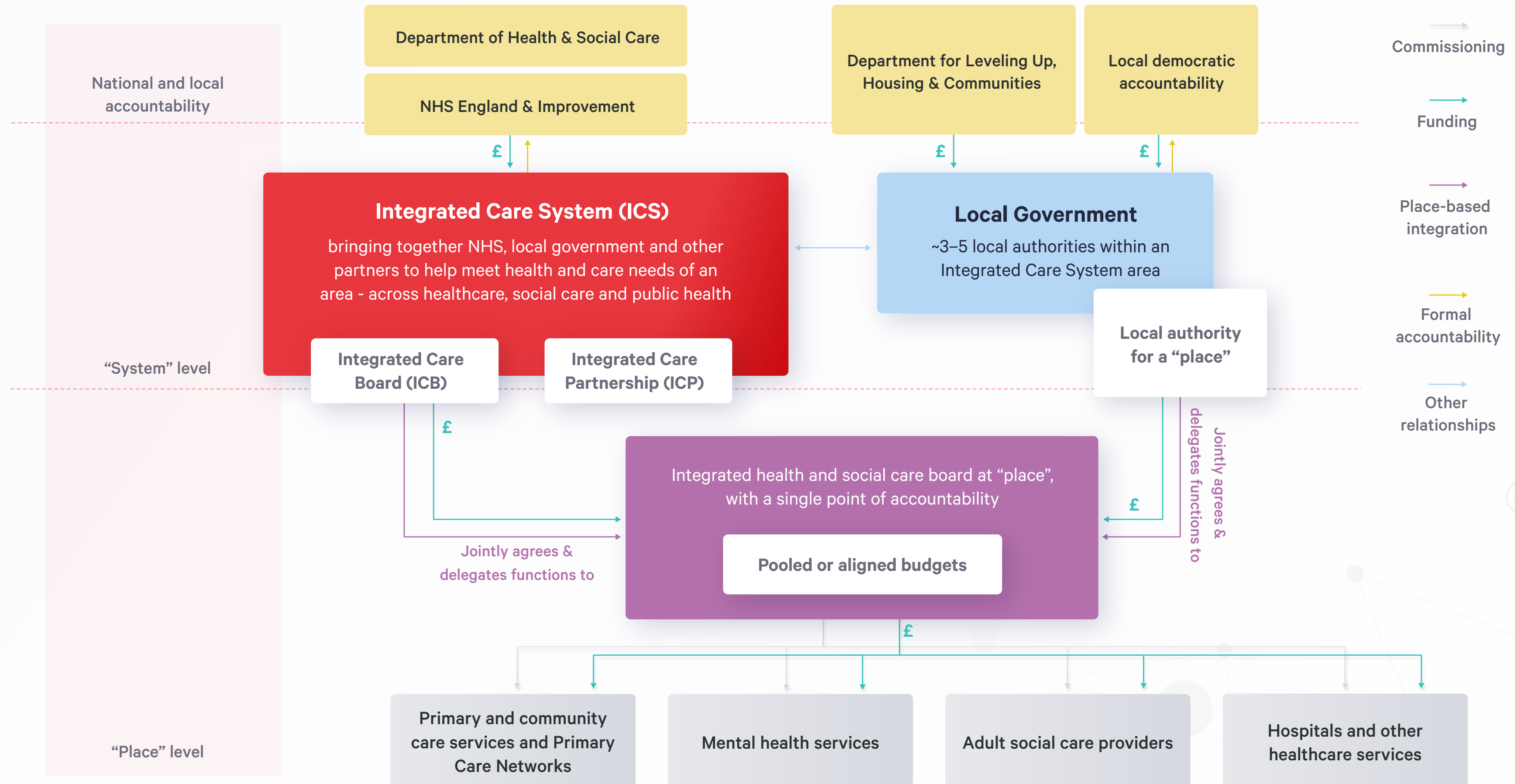
With the recent legislation of ICSs, there has been a move towards collaborative service development. This has been facilitated by financial changes that, while allowing for activity payments for elective recovery, fix the focus on payments supporting the development of new models of care. These aligned incentive contracts allow for multiple providers under a single contract to deliver care as a place-based partnership⁵⁵.

The mechanisms now in place meet some of the issues identified within The King's Fund report¹⁶, i.e. moving from short term tactical cost reduction of commissioning isolated services, to new models of care focussing on a collaborative patient-centred approach. This means that GPwER and community dermatology services can more easily be integrated within a holistic care pathway, with clinical supervision from the specialist team.



Integration

Health and social care integration: joining up care for people, places and populations⁴⁹



Adapted from: Department of Health & Social Care (2022) Joining up care for people, places and populations. Available at: <https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations>

Service priorities: Dermatology – GIRFT programme national specialty report¹³

SERVICE PRIORITIES:
DERMATOLOGY

The 2021 GIRFT Dermatology report recommends a number of mechanisms to support the current workforce shortage:

- More efficient use of NHS resources can be achieved by encouraging the uptake of digital technology including reviewing teledermatology and increasing professional advice and guidance services.
- Improving the training and function of a consultant led multidisciplinary team to improve patient care and reduce locum costs.
- Develop the use of superclinics as a model to allow safe supervision of a multidisciplinary workforce.
- Training dermatology nurses as specialist nurses and nurse consultants, as well as better training opportunities for GPs and pharmacists, who are often the first point of contact for patients.
- Appropriate networks and hub and spoke services could support the development of ICSs, with specialists in a tertiary centre providing advice and support to colleagues in secondary, primary and community care. Workforce issues would need to be addressed to ensure feasibility of any new models of working.



Referral optimisation for people with skin conditions⁵⁰

Ensuring that patients are seen in the right place, at the right time is a goal of the NHS.

Patients with long-term skin conditions can find outpatient referral systems and processes inflexible and ineffective. The rapid access two-week pathway for skin cancer patients takes priority in most specialist dermatology departments, which has an inevitable impact on access to services for other patients.

This has led to an inequity of access to care for people with inflammatory skin conditions such as psoriasis, who can wait a long time to be seen, despite their condition having a significant impact on their quality of life.

An NHS England report released in September 2022, *Referral optimisation for people with skin conditions*⁵⁰, sets out the key principles of referral optimisation to enable local systems to embed personalised care, strengthen primary care management and streamline collaboration between generalists and specialists. All of which is key to ensuring that patients receive care that is personalised to their needs, provided by the right person, in the right place, first time.

The report highlights five key principles which support a system-wide approach to referral optimisation:

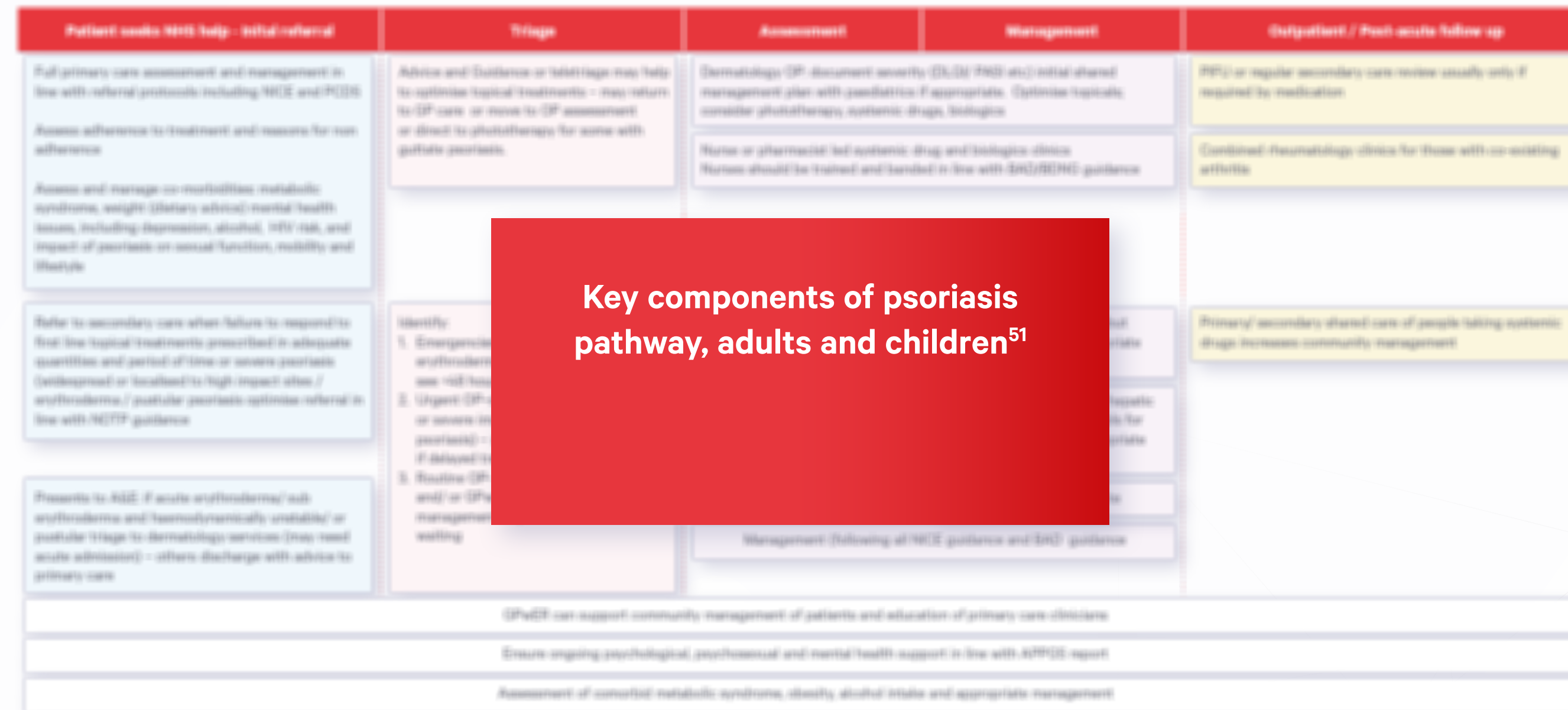
- **Principle 1: Supported self-care**
Equipping patients with the knowledge, skills and confidence to live more independently.
- **Principle 2: Strengthening primary care management**
Practices/PCNs with the capability to provide more care closer to home.
- **Principle 3: Pre-referral specialist advice and guidance**
Streamline systems for closer collaboration between generalists and specialists.
- **Principle 4: Post-referral specialist advice and triage**
Effective systems to connect patients with the right specialist, first time.
- **Principle 5: Monitoring and evaluation of specialist advice services advice and triage**
Highlight good practice, support benchmarking and inform opportunities for system improvement.

Potential integrated care service structure

GIRFT guidelines for psoriasis services⁵¹ identify all elements in a psoriasis pathway from identification and initial management in general practice through to specialist management in a secondary care dermatology service and post-acute follow up.

- The role of GPwER, mental health screening and associated comorbidities monitoring are identified to provide a holistic service.
- The roles of digital technology, patient education, self-management and patient experience data using validated rating scales are highlighted.

POTENTIAL INTEGRATED CARE SERVICE STRUCTURE



Potential integrated care service structure

Key components of psoriasis pathway, adults and children⁵¹

POTENTIAL INTEGRATED CARE SERVICE STRUCTURE

Patient seeks NHS help - Referral	Triage	Assessment	Management	Outpatient/Post-acute follow up
<p>Full primary care assessment and management in line with referral protocols including NICE and Primary Care Dermatology Society</p> <p>Assess adherence to treatment and reasons for non adherence.</p> <p>Assess and manage comorbidities: metabolic syndrome, weight (dietary advice), mental health issues including depression, alcohol, HIV risk, and impact of psoriasis on sexual function, mobility and lifestyle.</p>	<p>Advice and guidance or teletriage may help to optimise topical treatments – may return to GP care or move to outpatient assessment or direct to phototherapy for some with guttate psoriasis.</p>	<p>Dermatology outpatient: document severity (DLQI/PASI etc) initial shared management plan with paediatrics if appropriate. Optimise topicals; consider phototherapy, systemic drugs, biologics.</p> <p>Nurse- or pharmacist-led systemic drug and biologics clinics Nurses should be trained and banded in line with guidance from the British Association of Dermatologists and British Dermatological Nursing Group.</p>	<p>PIFU or regular secondary care review usually only if required by medication.</p> <p>Combined rheumatology clinics for those with co-existing arthritis.</p>	
<p>Refer to secondary care when failure to respond to first line topical treatments prescribed in adequate quantities and period of time, or severe psoriasis (widespread or localised to high impact sites/erythroderma/pustular psoriasis) optimise referral in line with National Outpatient Transformation Programme guidance.</p>	<p>Identify:</p> <ol style="list-style-type: none"> 1. Emergencies (pustular or erythrodermic) may need admission – see <48 hours. 2. Urgent outpatient – sub-erythrodermic/severe or severe impact on patient (eg guttate psoriasis) – may progress to emergency if treatment delayed. 3. Routine outpatient – advice and guidance and/or GPwER advice may optimise management or prevent referral when waiting. 	<p>Emergency outpatient in larger departments same day assessment urgent issues.</p>	<p>Inpatient: rarely necessary but requires nurses with appropriate skills.</p> <p>Gastroenterology input for hepatic issues (non-alcoholic steatohepatitis) with protocols for Fibroscan referral for appropriate people.</p> <p>Dietary referral if appropriate.</p>	<p>Primary/secondary shared care of people taking systemic drugs increases community management.</p>
<p>Presents to A&E: if acute erythroderma/sub erythroderma and haemodynamically unstable/or pustular triage to dermatology services (may need acute admission) – others discharge with advice to primary care.</p>			<p>Management (following all NICE guidance and BAD guidance).</p>	
<p>GPwER can support community management of patients and education of primary care clinicians.</p>				
<p>Ensure ongoing psychological, psychosexual and mental health support in line with APPG skin report.</p>				
<p>Assessment of comorbid metabolic syndrome, obesity, alcohol intake and appropriate management.</p>				

Adapted from: GIRFT (2022) Key components of psoriasis pathway, adults and children. Available at: https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2022/06/Dermatology_2022-06-22_Pathway_Psoriasis-clinician.pdf

Resources

- [GIRFT \(2021\) Dermatology GIRFT Programme National Specialty Report](#)
- [All Party Parliamentary Group on Skin \(2019\) Audit of UK Dermatology Coverage](#)
- [BAD \(2018\) The assessment and management of patients with psoriasis – Where are we since the last audit? - A national clinical re-audit by the British Association of Dermatologists based on NICE clinical guidelines and audit standards](#)
- [The King's Fund \(2015\) How can dermatology services meet current and future patient needs, while ensuring quality of care is not compromised and access is equitable across the UK?](#)
- [NICE \(2012\) Psoriasis: assessment and management. Clinical guideline \[CG153\]](#)
- [Elective Care Transformation Programme \(2019\) Transforming elective care services: dermatology](#)
- [GIRFT \(2021\) GIRFT recommendations address dermatology workforce shortages and call for wider use of technology](#)
- [GIRFT \(2022\) Key components of psoriasis pathway, adults and children](#)

References

1. The Psoriasis and Psoriatic Arthritis Alliance. What is psoriasis? Available at: <https://www.papaa.org/learn-about-psoriasis-and-psoriatic-arthritis/just-diagnosed/what-is-psoriasis/>. Accessed February 2023.
2. Gulliver W. Long-term prognosis in patients with psoriasis. *Br J Dermatol*. 2008;159:2–9.
3. Prussick R, et al. Nonalcoholic Fatty Liver Disease and Psoriasis What a Dermatologist Needs to Know. *Clin Aesthet Dermatol*. 2015 Mar; 8(3): 43–45.
4. NICE (2012) Psoriasis assessment and management. Clinical guideline [CG153]. Available at: <https://www.nice.org.uk/guidance/cg153/resources/psoriasis-assessment-andmanagement-pdf-35109629621701>. Accessed February 2023.
5. Psoriasis Speaks. Psoriasis severity and location. Available at: <https://www.psoriasis.com/about-psoriasis/psoriasis-severity>. Accessed February 2023.
6. Griffiths C, Barker J. Pathogenesis and clinical features of psoriasis. *Lancet* 2007; 370: 263-271.
7. Psoriasis Association & LEO Pharma (2019) Wake Up to Psoriasis. Available <https://psoriasis.qualitycarebyleo.com/-/media/gdm/give-nothing/gntp/uk-mat-25880-leo-pharma-wake-up-to-psoriasis-report.pdf>. Accessed February 2023.
8. All-Party Parliamentary Group on Skin (2020) Mental Health and Skin Disease. Available at: www.appgs.co.uk/wp-content/uploads/2020/09/Mental_Health_and_Skin_Disease2020.pdf. Accessed February 2023.
9. Dalgard FJ, et al. Stigmatisation and body image impairment in dermatological patients: protocol for an observational multicentre study in 16 European countries. *BMJ Open*. 2018;8(12).
10. Krueger G, et al. The impact of psoriasis on quality of life: results of a 1998 National Psoriasis Foundation patient-membership survey. *Arch Dermatol*. 2001; 137:280-284.
11. The Work Foundation (2016) The impact of long term conditions on employment and the wider UK economy. Available at: <https://englishbulletin.adapt.it/the-impact-of-long-term-conditions-on-employment-and-the-wider-uk-economy/>. Accessed February 2023.
12. University of Manchester (2019) New figures show Psoriasis affects around 1.1 million people in UK. Available at: <https://www.manchester.ac.uk/discover/news/new-figures-show-psoriasis-affects-around-11-million-people-in-uk/>. Accessed February 2023.
13. GIRFT (2021) Dermatology GIRFT Programme National Specialty Report. Available at: <https://www.gettingitrightfirsttime.co.uk/medical-specialties/dermatology/>. Accessed February 2023.
14. Storm A, et al. A prospective study of patient adherence to topical treatments: 95% of patients underdose. *J Am Acad Dermatol*. 2008; 59(6):975-980.
15. Nash AS, et al Psoriasis today: experiences of healthcare and impact on quality of life in a major UK cohort. *Prim Health Care Res Dev*. 2015 Jul;16(4):415-23.

REFERENCES

REFERENCES (2)

16. The King's Fund (2014) How can dermatology services meet current and future patient needs, while ensuring quality of care is not compromised and access is equitable across the UK? Available at: https://kingsfund.blogs.com/health_management/2015/05/how-can-dermatology-services-meet-current-and-future-patient-needs-while-ensuring-that-quality-of-ca.html. Accessed February 2023.
17. The King's Fund (2021) Innovation in treatment for people with rarer or less well-recognised long-term conditions. Available at: <https://www.kingsfund.org.uk/publications/innovation-treatment-rarer-long-term-conditions>. Accessed February 2023.
18. BAD (2018) The assessment and management of patients with psoriasis – Where are we since the last audit? A national clinical re-audit by the British Association of Dermatologists based on NICE clinical guidelines and audit standards. Available at: <https://cdn.bad.org.uk/uploads/2021/12/29200148/Psoriasis-clinical-re-audit-2017-interim-report.pdf>. Accessed February 2023.
19. NHS (2019) The NHS Long Term Plan. Available at: www.longtermplan.nhs.uk. Accessed February 2023.
20. Secondary care data is taken from the English Hospital Episode Statistics (HES) database produced by NHS Digital, Copyright © 2022, the Health and Social Care Information Centre. Re-used with the permission of the Health and Social Care Information Centre. All rights reserved.
21. Havelin A & Hampton P. Telemedicine and e-Health in the Management of Psoriasis: Improving Patient Outcomes – A Narrative Review. *Psoriasis (Auckl)* 2022 Mar 16;12:15-24.
22. British Association of Dermatologists (2019) Delivering care and training a sustainable multi-specialty and multi-professional workforce: An audit of UK dermatology outpatient departments against the 16 principles of the Royal College of Physicians' report. Available at: <https://www.skinhealthinfo.org.uk/wp-content/uploads/2019/12/BAD-RCP-OUTPATIENT-EXECUTIVE-SUMMARY-002-1.pdf>. Accessed February 2023.
23. NHS England & NHS Improvement (2019) NHS Mental Health Implementation Plan 2019/20 – 2023/24. Available at: <https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/>. Accessed February 2023.
24. Ibrahim GH, et al. Evaluation of an existing screening tool for psoriatic arthritis in people with psoriasis and the development of a new instrument: the Psoriasis Epidemiology Screening Tool (PEST) questionnaire. *Clin Exp Rheumatol.* 2009;27(3):469-74.
25. NHS Oxfordshire CCG (2020) GP uses Photo Advice & Guidance for Teledermatology to monitor patient. Available at: <https://www.consultantconnect.org.uk/wp-content/uploads/2020/08/Dr-Chris-Phillips-New-Artwork.pdf>. Accessed February 2023.
26. Elective Care Transformation Programme (2019) Transforming elective care services: dermatology. Available at: <https://www.england.nhs.uk/wp-content/uploads/2019/01/dermatology-elective-care-handbook-v1.pdf>. Accessed February 2023.
27. Primary Care Dermatology Society. Diploma in dermatology. Available at: <https://www.pcds.org.uk/diploma-in-dermatology>. Accessed February 2023.

REFERENCES

REFERENCES (3)

28. British Association of Dermatologists. Dermatology Education for GPs. Available at: <https://www.bad.org.uk/education-training/gps/>. Accessed February 2023.
29. NHS England Transformation Directorate. Use of a teledermatology platform to reduce dermatology referrals to secondary care. Available at: <https://transform.england.nhs.uk/key-tools-and-info/digital-playbooks/dermatology-digital-playbook/use-of-a-teledermatology-platform-to-reduce-dermatology-referrals-to-secondary-care/>. Accessed February 2023.
30. Singh P, et al. Tele-assessment of psoriasis area and severity index: a study of the accuracy of digital image capture: tele-PASI accuracy study. *Australas J Dermatol*. 2011;52(4):259–263.
31. Koller S, et al. Teledermatological monitoring of psoriasis patients on biologic therapy. *Acta Derm Venereol*. 2011;91(6):680–685.
32. All Party Parliamentary Group on Skin (2019) Audit of UK Dermatology Coverage. Available at: <https://www.appgs.co.uk/publication/2019-audit-of-uk-dermatology-coverage/>. Accessed February 2023.
33. Health Innovation Manchester (2018) Launch of specialist psoriasis clinic gives patients rapid access to treatment and support. Available at: <https://healthinnovationmanchester.com/news/launch-of-specialist-psoriasis-clinic-gives-patients-rapid-access-to-treatment-and-support/>. Accessed February 2023.
34. HealthHarmonie. Bassetlaw and South Warwickshire Community Dermatology. Available at: <https://www.healthharmonie.com/post/bassetlaw-and-south-warwickshire-community-dermatology>. Accessed February 2023.
35. NICE (2021) NICE pathway: Psoriasis overview (on file).
36. British Association of Dermatologists (2021) Setting up Patient Initiated Follow-Up (PIFU) services for people with skin conditions. Available at: <https://cdn.bad.org.uk/uploads/2022/04/07153547/Setting-up-patient-initiated-follow-ups-for-people-with-skin-conditions-1.pdf>. Accessed February 2023.
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38. British National Formulary online. Methotrexate. Available at: <https://bnf.nice.org.uk/drugs/methotrexate/>. Accessed February 2023.
39. British National Formulary online. Ciclosporin. Available at: <https://bnf.nice.org.uk/drugs/ciclosporin/>. Accessed February 2023.
40. Smith CH, et al. British Association of Dermatologists guidelines for biologic therapy for psoriasis 2020: a rapid update. *Br J Dermatol*. 2020 Oct;183(4):628–637.
41. Psoriasis Association (2020) PsoWell Training Course. Available at: www.psoriasis-association.org.uk/psowell. Accessed February 2023.
42. Prey S, et al. Assessment of risk of psoriatic arthritis in patients with plaque psoriasis: A systematic review of the literature. *J Eur Acad Dermatol Venereol*. 2010;24(Suppl. 2):31–35.

REFERENCES

REFERENCES (4)

43. Henes JC, et al. High prevalence of psoriatic arthritis in dermatological patients with psoriasis: A cross-sectional study. *Rheumatol. Int.* 2014;34:227–234.
44. Mehta NN, et al. Attributable Risk Estimate of Severe Psoriasis on Major Cardiovascular Events. *Am J Med.* 2011 Aug; 124(8): 775.e1–775.e6.
45. de Fátima Santos Paim de Oliveira M, et al. Psoriasis: classical and emerging comorbidities. *An Bras Dermatol.* Jan-Feb 2015;90(1):9-20.
46. Savage L, et al. Defining Pre-Clinical Psoriatic Arthritis in an Integrated Dermato-Rheumatology Environment. *J Clin Med.* 2020 Oct 12;9(10):3262.
47. The Leeds Teaching Hospitals NHS Trust. Specialist Spondyloarthritis Service. About Us. Available at: <https://www.leedsth.nhs.uk/a-z-of-services/rheumatology/specialist-spondyloarthritis-service/about-us/>. Accessed February 2023.
48. NHS England and NHS Improvement (2021) 2022/23 priorities and operational planning guidance. Available at: <https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf>. Accessed February 2023.
49. Department of Health & Social Care (2022) Joining up care for people, places and populations. Available at: <https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations>. Accessed February 2023.
50. NHS England (2022) Referral optimisation for people with skin conditions Ensuring patients are seen in the right place, at the right time. Available at: <https://www.england.nhs.uk/wp-content/uploads/2022/09/B1149-referral-optimisation-for-people-with-skin-conditions.pdf>. Accessed February 2023.
51. GIRFT (2022) Key components of psoriasis pathway, adults and children. Available at: https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2022/06/Dermatology_2022-06-22_Pathway_Psoriasis-clinician.pdf. Accessed February 2023.
52. Royal Free London NHS Foundation Trust. Psoriatic arthritis clinic. Available at: <https://www.royalfree.nhs.uk/services/services-a-z/rheumatology/psoriatic-arthritis-clinic/>. Accessed February 2023.
53. Primary Care Dermatology Society. Psoriasis: psoriatic arthritis. Available at: <https://www.pcds.org.uk/clinical-guidance/psoriatic-arthropathy>. Accessed February 2023.
54. Ganatra B, et al. Use of a validated screening tool for psoriatic arthritis in dermatology clinics. *BMJ Open Quality.* 2015;4.
55. NHS England (2021) Working together at scale: guidance on provider collaboratives. Available at: <https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf>. Accessed February 2023.
56. NHS East and North Hertfordshire Clinical Commissioning Group (2018) First-line biologic agents for treating moderate to severe plaque psoriasis, NICE TAs 103, 134, 146, 180, 350, 442, 511, 521, 574, 575, 596, 723 and local agreements December 2018 (updated March 2022). Available at: [https://www.enhertscg.nhs.uk/sites/default/files/content_files/Prescribing/Commissioning_Contracting_HCD/Psoriasis/First%20line%20biologics%20for%20psoriasis%20proforma.docx](https://www.enhertscg.nhs.uk/sites/default/files/content_files/Prescribing_Commissioning_Contracting_HCD/Psoriasis/First%20line%20biologics%20for%20psoriasis%20proforma.docx). Accessed February 2023.

Abbreviations

AI	Artificial intelligence	NICE	National Institute of Health and Care Excellence
ANP	Advanced nurse practitioner	OCT	Optical coherence tomography
APPG	All-Party Parliamentary Group	PASI	Psoriasis Area and Severity Index
BAD	British Association of Dermatologists	PCN	Primary care network
CVD	Cardiovascular disease	PEST	Psoriasis Epidemiology Screening Tool
DLQI	Dermatology Life Quality Index	PIFU	Patient-initiated follow up
GIRFT	Getting It Right First Time	PsA	Psoriatic arthritis
GPwER	GP with extended role	PsO	Psoriasis
IBD	Inflammatory bowel disease	WTE	Whole time equivalent
ICB	Integrated Care Board		
ICP	Integrated Care Partnership		
ICS	Integrated care system		
MDT	Multidisciplinary team		
MRI	Magnetic resonance imaging		

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