

Psoriasis: Integrated care pathway



Wilmington
Healthcare



Introduction



Foreword

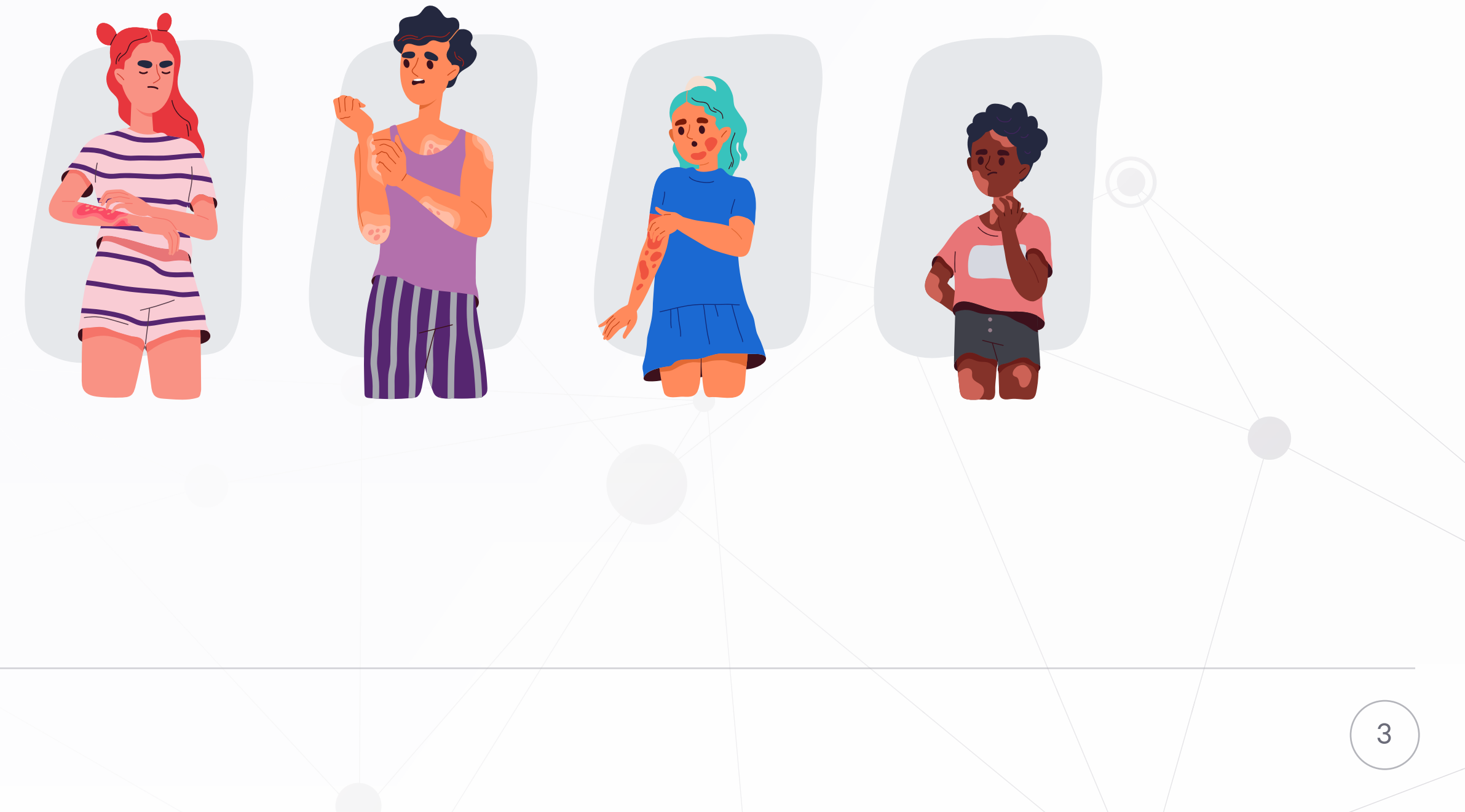
Psoriasis is a chronic inflammatory multisystem condition that can affect the skin, scalp, nails and joints, and is associated with an increased risk of cardiovascular and psychological co-morbidities. For many people, psoriasis impacts considerably on quality of life and can affect employment, productivity and income.

There are many barriers to the provision of optimal care for people with psoriasis and the need for urgent change is evident. GPs are the often the first clinician patients see about skin problems, but few receive formal dermatology training and some medical schools have removed this speciality from their curriculum altogether. This can result in suboptimal management in Primary Care and delays in referral. These issues have been exacerbated by lengthy waiting lists and COVID-19 pandemic associated backlogs.

The need for change is echoed by NHS England, which recognises that changes to the psoriasis pathway are necessary to improve care of patients and optimise the use of resources. NHS England has taken steps to improve care through the publication of strategies and guidance aimed at helping NHS organisations achieve these objectives. These publications include referral optimisation for people with skin conditions, clinical prioritisation of the dermatology non-admitted (outpatient) waiting list: framework to aid elective recovery, and the development of a dermatology redesign optimal patient pathway.

This document, developed by Wilmington Healthcare and funded by Bristol Myers Squibb, sets out an optimal integrated care pathway for psoriasis based on the consensus of an expert group in the dermatology space, input from stakeholders involved at all stages of the pathway and follows the principles of NHS England's dermatology outpatient redesign optimal pathway.

This integrated care pathway is divided into four sections: presentation and diagnosis, primary care management, speciality management, and long-term management. Recommendations for healthcare providers are detailed at each step of the pathway, and from this, we hope that local services will be encouraged to review current practice and introduce innovative ways of working to meet the needs of patients with psoriasis.



Foreword (continued)

To those involved in integrated care, we advocate teamwork across all interfaces of the NHS, to help streamline care for people with psoriasis. Important aspects include that people are seen in the right place and by the most appropriate healthcare professional at the first visit, and that those with most urgent needs are fast-tracked to be seen promptly in secondary care.

Key actions recommended are:

- Ensuring earlier access to healthcare professionals with a good understanding of psoriasis including diagnosis and management
- A better understanding of when and where to refer, and the level of priority (routine or urgent) of any given referral
- Give greater consideration to the possibility of some second-line therapies being commenced in the community by appropriately trained healthcare providers who work in an integrated fashion with secondary care dermatology departments
- Create access to specialist prescribing and specialist nurses in monitoring teams to provide governance framework and support for monitoring care outside of secondary care settings.



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The challenge

Psoriasis is an immune-mediated inflammatory disease of the skin.¹ One in four patients with psoriasis also develop psoriatic arthritis.¹ These conditions can be minor irritations for some people, but for others they impact considerably on quality of life, employment, productivity and income.^{2,3}

GPs are the first clinician most patients see about skin problems, but few receive formal dermatology training and some medical school curriculums exclude this specialty.

Dermatology thus has a high rate of referrals to specialist care, particularly for diagnosis, and patients often spend years cycling through ineffective therapies before receiving appropriate treatment.

These issues have been exacerbated by the reduced workforce, lengthy waiting lists and large backlogs due to COVID-19.

A previous report by Wilmington Healthcare highlighted long-term intrinsic concerns.⁴



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



Need for specialist care to be initiated or managed in primary care

The current pathway is not providing the best possible care for patients with psoriasis and there is an urgent need for change.

NHS England dermatology strategy

NHS England recognises that changes to the psoriasis pathway are needed to improve care of patients and optimise use of resources. It has published strategies and guidance that aim to help NHS organisations achieve these objectives.

In September 2022, NHS England published [Referral optimisation for people with skin conditions](#),⁵ which sets out key principles of referral optimisation for people with skin conditions. The aims are to:

- enable local systems to embed personalised care
- strengthen primary care management
- streamline collaboration between generalists and specialists.

In August 2023, NHS England published [Clinical prioritisation of the dermatology non-admitted \(outpatient\) waiting list: framework to aid elective recovery](#).⁶ This aims to support systems and trusts with clinical prioritisation of routine dermatology outpatient waiting lists to reduce the number of long-waiting patients, which is a key priority supporting delivery of the NHS elective recovery plan.

The approach of the clinical prioritisation framework encourages differentiation between:⁶

- long-wait patients whose skin condition has deteriorated while waiting and need to be seen urgently
- long-wait patients whose skin condition has resolved and no longer require a consultation.

Aims of dermatology recovery approach:⁶

- Ensure only patients who require an appointment remain on the waiting list
- Prioritise patients for outpatient appointments appropriately
- Update patients on the waiting list about their options and support mutually agreed decisions about next steps
- Manage clinical risk effectively and improve clinical outcomes
- Prioritise high risk patients or those with potentially cancerous lesions on elective pathways based on appropriate validation steps

How to use this document

Our integrated care pathway is used as a menu system for this document.

The pathway is divided into four sections, which are colour coded throughout the document:

1 Presentation and diagnosis

3 Primary care management

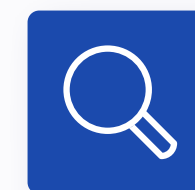
2 Specialty management

4 Long-term management

[Appendix 1](#) contains a list of references used in this document.

The contributors are included in [Appendix 2](#).

Each section provides a bulleted list of actions for the stage of the pathway.



Use the magnifying glass to view larger images.



Click on the 'plus' button for more detail



NHS England dermatology outpatient redesign optimal pathway⁷

In support of its dermatology strategy, NHS England has developed a redesigned dermatology outpatient optimal pathway.⁷

Multiple guidelines on NHS-recommended interventions to redesign the dermatology outpatient pathway that supports patients with psoriasis have been published.


Integrated care pathway for psoriasis

This document sets out an integrated care pathway for psoriasis based on NHS England's dermatology outpatient redesign optimal pathway,⁷ research, consensus of expert groups, and input from stakeholders involved at all stage of the pathway in line with recommended best practice for the management of psoriasis and recent policies and guidance.

Our integrated care pathway for psoriasis follows the principles of NHS England's dermatology outpatient redesign optimal pathway⁷ but focuses on:

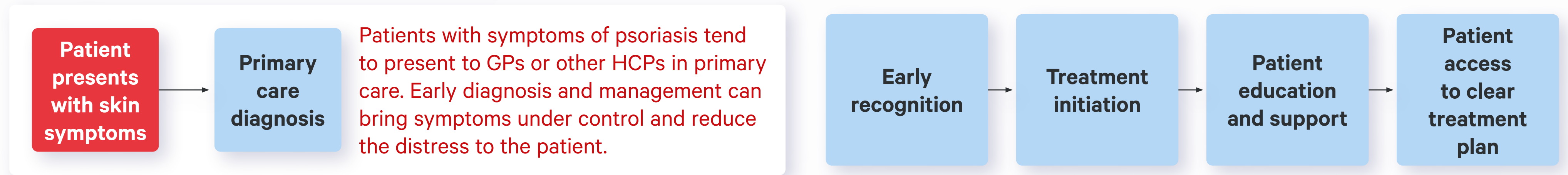
- supporting primary care to maintain diagnosis and treatment in the community under specialist supervision/guidance where possible
- supporting GPs with extended roles (GPwERs) and community specialist nurses (CSNs) to escalate or deescalate treatments in intermediate/community care clinics
- freeing up capacity for secondary care dermatology to focus on patients with psoriasis who have more complex needs
- diagnosing psoriatic arthritis early and directing affected patients to rheumatology
- ensuring supportive therapies such as mental health interventions are available.

We hope that this document will encourage systems to review local practices and introduce innovative ways of working to meet the needs of patients with psoriasis.

A photograph of two women in a professional setting. On the left, a woman in a white lab coat is seen in profile, facing right. On the right, a woman with long dark hair, wearing a dark blazer, is seated at a desk with her hands clasped, looking towards the woman in the lab coat. The desk has a computer monitor and keyboard. The background is bright and slightly blurred. The entire image has a semi-transparent red overlay with a white geometric pattern of lines and dots.

Presentation and Diagnosis

Presentation and diagnosis of psoriasis



Patients should be assessed for:

-  Disease severity
-  Impact of disease on physical, psychological and social wellbeing
-  Psoriatic arthritis
-  Comorbidities

- Psoriasis is typically diagnosed based on the appearance of the skin.¹² However, psoriasis in darker skin types can present diagnostic challenges due to less conspicuous erythema.¹³
 - Patients present with thick red dry scaly skin that can cause itching.^{1,12}

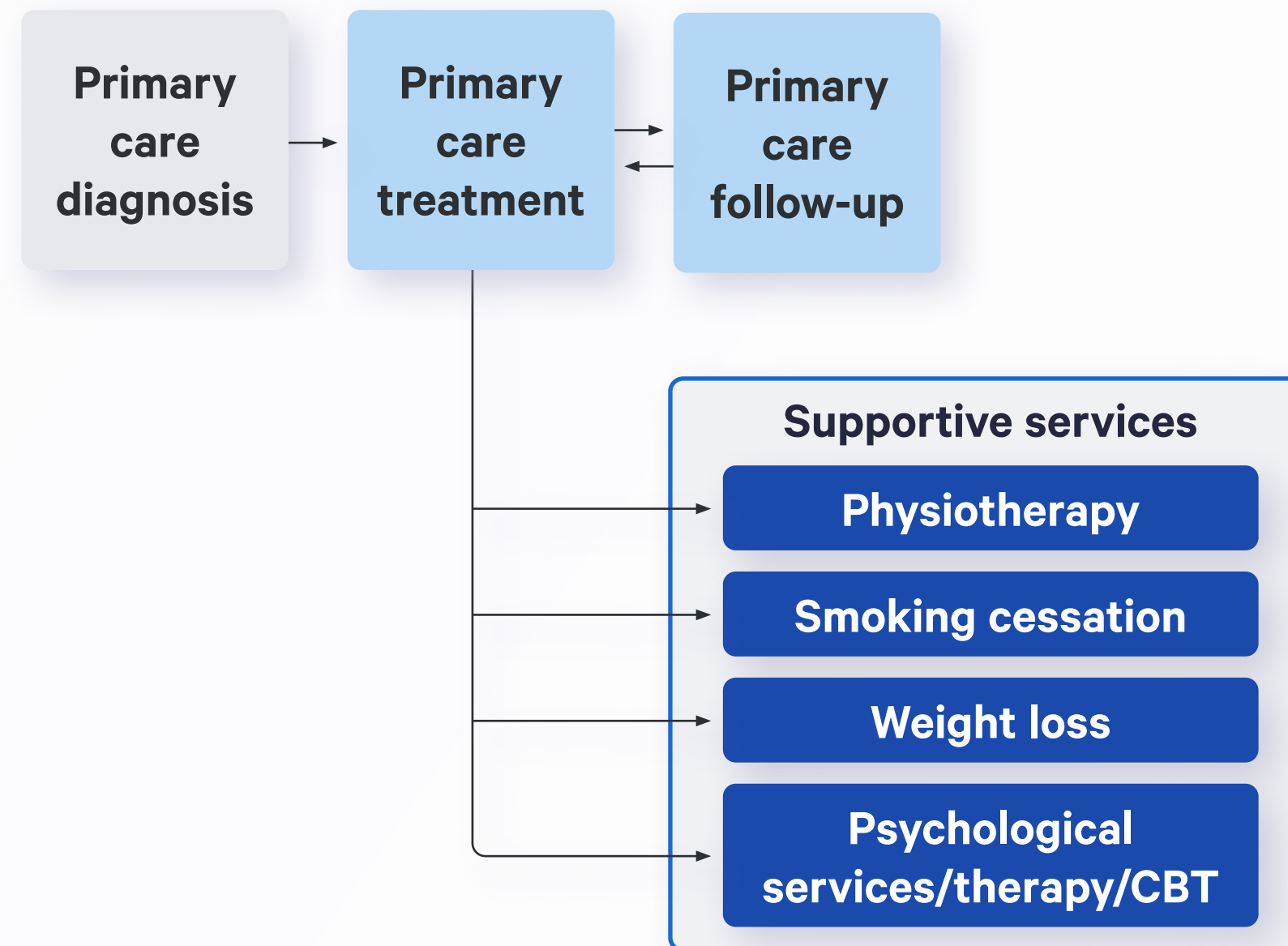




Primary care management

Primary care management

Most patients are diagnosed and start treatment in primary care.



Primary care providers need access to additional support services to provide care for patients and to manage them in primary care.

The Primary Care Dermatology Society (PCDS) have developed a treatment pathway on how patients should be managed in treated on primary care to avoid or delay their need for secondary care/specialist intervention.¹⁴

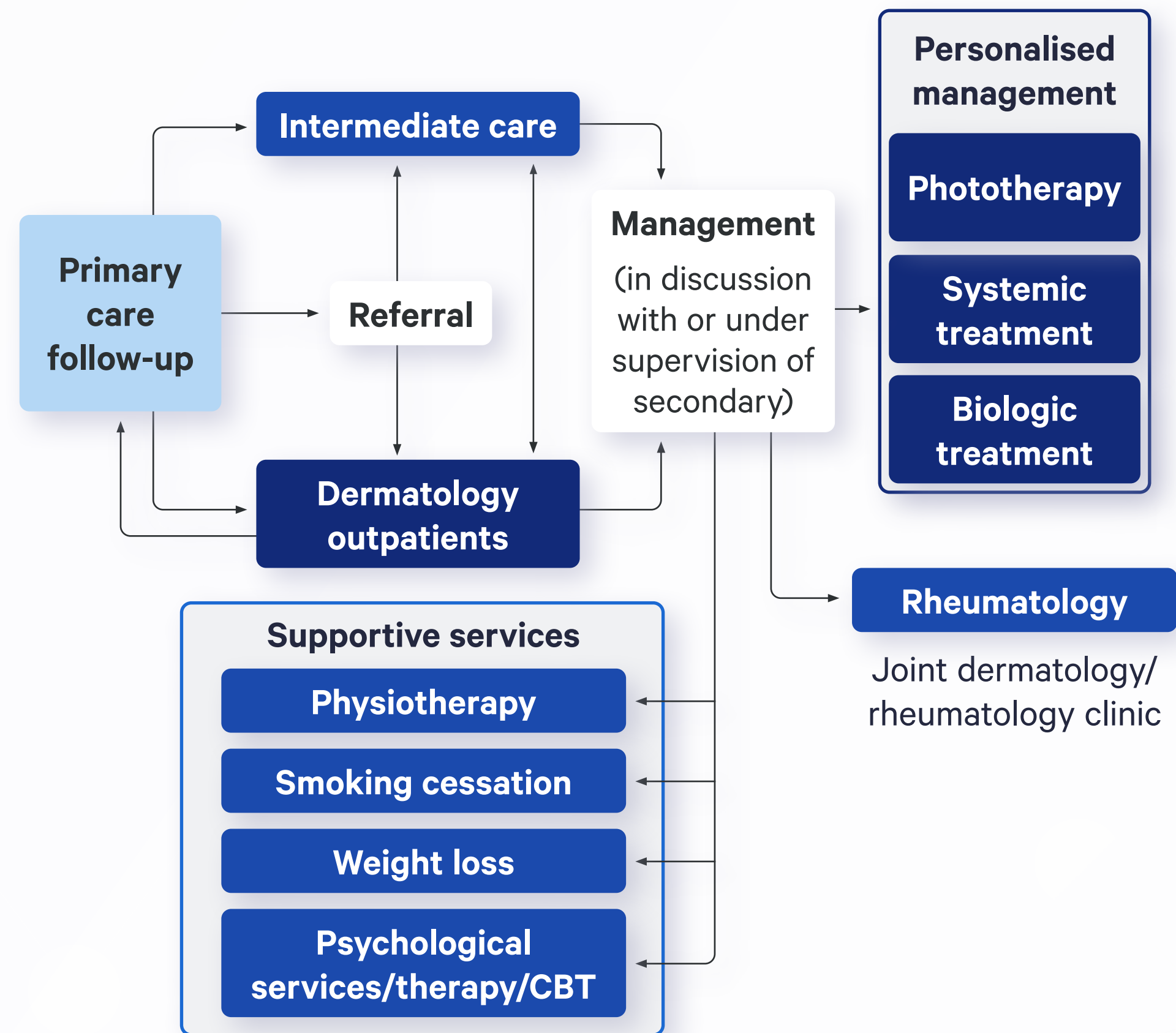
The key needs in primary care include:

- Access to specialist advice – use technology like teledermatology to support such access
- Specialist-led treatment plans that can be continued in primary care
- Ability to escalate and de-escalate treatment as needed
- Support services available in primary care to cover complexities and comorbidities.

Specialty management in intermediate or secondary care


Specialty management

Some patients with psoriasis require care beyond the expertise of primary care and therefore require access to intermediate/secondary care.



- Patients with psoriasis often have a number of comorbidities and complexities that require access to other multidisciplinary teams.
- Specialty services set up in secondary or intermediate care could run alongside other specialty and comorbidity clinics to address inflammatory disease, cardiovascular disease, etc.
- A future aspiration is the integration of community services with local secondary care dermatology services, for example providing direct access from community clinics to phototherapy services or a possible role for second-line therapies such as acitretin and methotrexate.

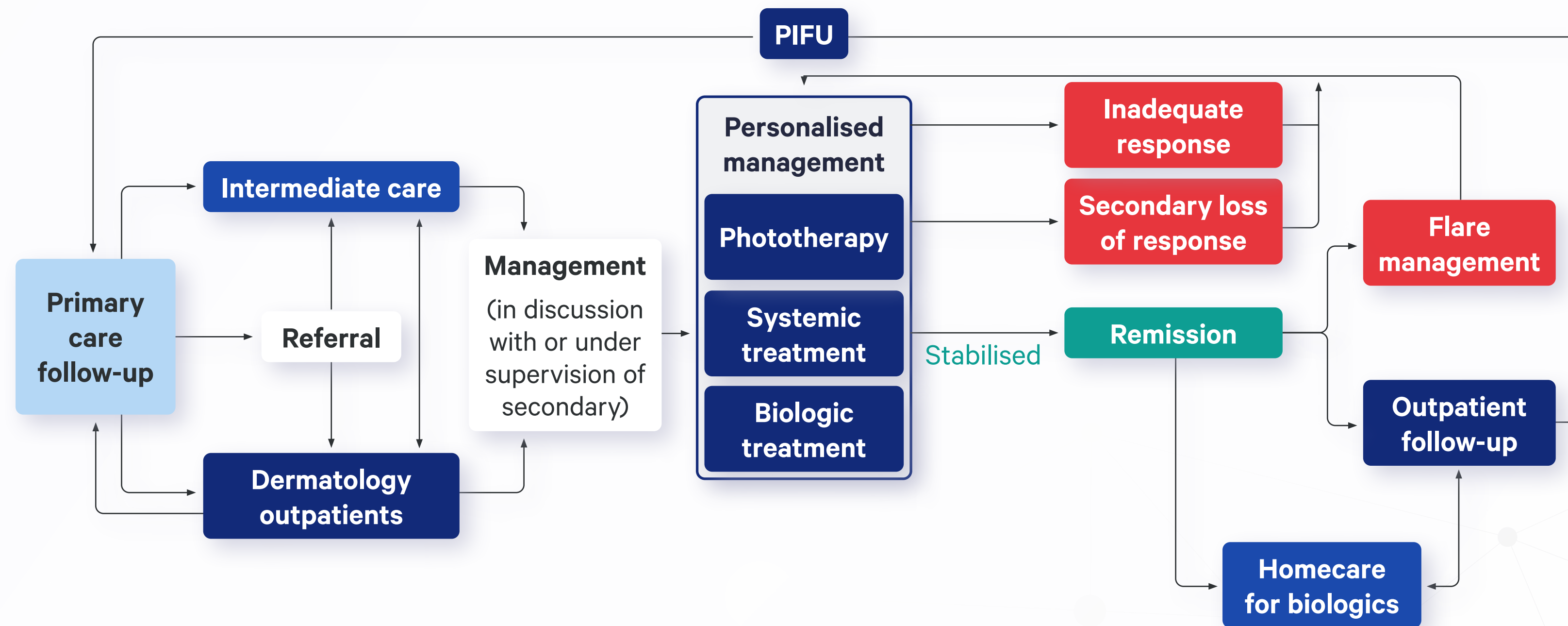
CBT, cognitive behavioural therapy.



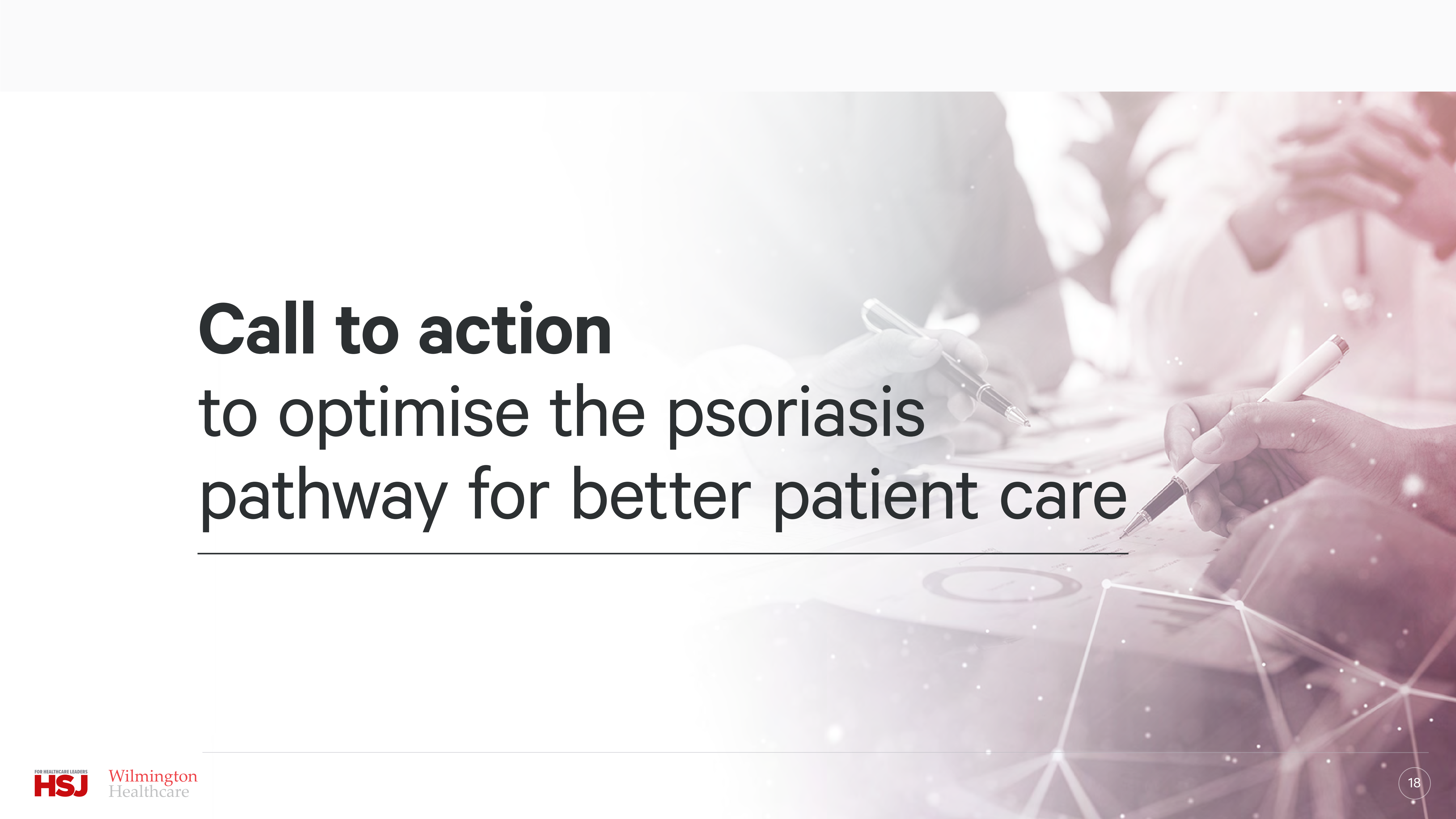
Long-term management in primary care with support from intermediate or secondary care

Long-term management

Long-term management of psoriasis needs to be undertaken in primary care with access and support from intermediate or secondary care and patient initiating and accessing support as needed.



PIFU, patient initiated follow-up



Call to action to optimise the psoriasis pathway for better patient care

Call to action to optimise the psoriasis pathway for better patient care

To allow secondary care to focus on urgent dermatology care and skin cancer referrals, the following actions need to be taken.

Appendices



Appendix 1: References

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13. Alexis A, Blackcloud P. Psoriasis in Skin of Color: Epidemiology, Genetics, Clinical Presentation, and Treatment Nuances. *J Clin Aesthet Dermatol.* 2014;7(11):16–24.
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Appendix 2: Contributors

The optimal pathway described in this document has been developed based on the consensus of an expert group combined with insights gained from interviews with stakeholders involved at all stages of the pathway.

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