NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Psoriasis

Output: Prioritised quality improvement areas for development.

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Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for a NICE quality standard on psoriasis.

It provides the Committee with a basis for discussion when prioritising quality improvement areas for developing the draft quality standard statements and measures. The draft quality standard will be the subject of public consultation.

Key development source(s)

Unless otherwise stated, the key development source referenced in this briefing paper as follows:

> Psoriasis: the assessment and management of psoriasis. NICE clinical guideline 153 (2012).

Where relevant, guideline recommendations from the key development source are presented alongside each of the suggested areas for quality improvement within the main body of the report.

2 Overview

2.1 Focus of quality standard

The focus of this quality standard is the assessment and management of psoriasis in children, young people and adults.

2.2 Definition

Psoriasis is an inflammatory skin disease that typically follows a relapsing and remitting course. Plaque psoriasis, the most common form of the condition (affecting 90% of people with psoriasis), is characterised by well-delineated red, scaly plaques that vary in extent from a few patches to generalised involvement. Other types of psoriasis include guttate psoriasis and pustular (localised or generalised) forms. Psoriasis can result in significant functional, psychological, and social morbidity.

2.3 Incidence and prevalence

The prevalence of psoriasis is estimated to be around 1.3-2.2% in the UK, with the greatest prevalence being in white people. Men and women are equally affected. Psoriasis can occur at any age, although is uncommon in children (0.71%) and the majority of cases occur before 35 years. Psoriasis is associated with joint disease in a significant proportion of patients (reported in one study at 13.8%).

2.4 Management

The significant impact of psoriasis on wellbeing suffered by affected individuals, underlines the need for prompt, effective treatment, and long-term disease control. A wide variety of treatment options are available. Some are expensive and some are accessed only in specialist care; all require monitoring. The use of emollients in psoriasis is important but is already widespread, so the treatment pathway in NICE clinical guideline 153 begins with active topical therapies.

NICE clinical guideline 153 describes established topical treatments as first-line therapy (such as vitamin D and vitamin D analogues, dithranol and tar preparations and corticosteroids). Second-line therapy includes the phototherapies (broad- or narrow-band ultraviolet B light and psoralen plus UVA light (PUVA) and systemic non-biological agents such as ciclosporin, methotrexate and acitretin. Third-line therapy refers to systemic biological therapies such as the tumour necrosis factor antagonists adalimumab, etanercept and infliximab, and the monoclonal antibody ustekinumab that targets interleukin-12 (IL-12) and IL-23.

For most people, psoriasis is managed in primary care, with specialist referral being needed at some point for up to 60% of people. Supra-specialist (level 4) tertiary care is required in the very small minority with especially complex, treatment resistant and/or rare manifestations of psoriasis. Ongoing supervision of those on systemic therapy occurs in specialist settings, sometimes with shared care arrangements for drug monitoring in primary care. Delivery of care in all specialist settings largely follows the traditional model of outpatient consultations with daycare/inpatient admission for more severe disease.

A recent UK audit in the adult population demonstrated wide variations in practice, and in particular, access to specialist treatments (including biological therapy), appropriate drug monitoring, specialist nurse support and psychological services.

See appendix 1 for the key priorities for implementation recommendations from NICE clinical guideline 153.

2.5 National Outcome Frameworks

The table below shows the indicators from the frameworks that the quality standard could contribute to:

NHS Outcomes Framework	Domain 2: Enhancing quality of life for people with long-term conditions.	2 Health related quality of life for people with long term conditions. 2.1 Proportion of people feeling supported to manage their condition.

	Domain 4: Ensuring that people have a positive experience of care	4a Patient experience of primary care. 4ai GP services. 4b Patient experience of hospital care. 4.1 Patient experience of outpatient services.

3 Summary of suggestions

3.1 Responses

In total eleven stakeholders submitted suggestions for quality improvement as part of the 2-week engagement exercise (18/10/12 – 01/11/12). Suggestions were also provided by specialist committee members.

Table 1 Summary of suggested quality improvement areas

Stakeholders were asked to suggest up to 5 areas for quality improvement. These have been merged and summarised in the table below for further consideration by the Committee (incorporating stakeholder and specialist committee member suggestions).

The full detail of the suggestions is provided in appendix 2 for information.

Suggested area for improvement	**Stakeholder (see table 2 for abbreviations)**
Access to services • Access to multidisciplinary services, phototherapy services, community support (specialist nurses) and "re-access" to dermatology specialists when needed. • Shorter waiting times for specialist opinion.	BAD, Wirral CCG, Psoriasis Association, Lilly UK, Janssen, SCM
Use of biological therapy • Early initiation, monitoring, offering alternatives.	Abbott, Janssen.
Assessing disease severity and response to treatment • Treatment goals, routine measurement, recording and assessing of disease severity to assess response to treatment and further treatment decisions.	BAD, Psoriasis Association, Lilly UK, Abbott, MSD, Janssen, SCM
Assessment of co-morbidities • Screening for co-morbidities, identification of risk factors for cardiovascular disease, lifestyle behavioural change support and taking co-morbidities into account during ongoing management.	BAD, Celgene, BPS, Lilly UK, LEO, Abbott, SCM
Quality of life/psychological support • Routine measurement of the impact of the disease on wellbeing, psychological assessment and support.	BAD, Psoriasis Association, BPS, Central North West London FT, Lilly UK, Abbott, SCM
Diagnosis of psoriatic arthritis • Annual screening and early diagnosis.	BAD, Celgene, Abbott, SCM

Additional areas

Additional suggestions provided in appendix 2 but not included in the above table are noted below. General statements cannot be developed so these need further discussion by the Committee to determine focus and suitability.

- Patient education, medicines adherence and shared decision-making (Celgene, Psoriasis Association, Lilly UK, LEO).
- Training to enable psychological assessment (BPS).
- Use of Patient Reported Outcome Measures, Patient Reported Experience Measures and local audits (Abbott, Janssen).

Table 2 Stakeholder details (abbreviations)

The details of stakeholder organisations who submitted suggestions are provided in the table below.

Abbreviation	Full name
Abbott	Abbott Laboratories
BAD	British Association of Dermatologists
BPS	British Psychological Society
Celgene	Celgene
Central North West London FT	Central North West London Foundation Trust
Janssen	Janssen-Cilag Ltd.
LEO	LEO Laboratories Ltd.
Lilly UK	Lilly UK
MSD	Merck Sharp and Dohme Ltd.
Psoriasis Association	The Psoriasis Association
SCM	Specialist Committee Member
Wirral CCG	Wirral Clinical Commissioning Group

4 Suggested improvement area: access to services

4.1 Summary of suggestions

Stakeholders highlighted the need for access to a dermatology specialist if psoriasis is impacting their physical, psychological or social wellbeing.

The importance of “re-access” to specialist care is considered important given the relapsing nature of psoriasis and the fact that some treatments are only suitable for intermittent use.

It was also highlighted that many patients delay accessing care until the problem is a significant issue and that a long waiting time for a specialist opinion can then cause further distress. Given the distressing nature of the disease better access to support in the community could also be of benefit to patients, for example, access to specialist nurses.

As people with psoriasis may require access to several different healthcare professionals working in different specialties (rheumatology, dermatology, psychology), stakeholders highlighted the need for good communication to make appropriate management decisions. It was suggested that a multidisciplinary team approach would facilitate this.

4.2 Selected recommendations from development source

Recommendations from the development source relating to the suggested improvement areas have been provisionally selected and are presented below to inform the Committee in their discussions.

Assessment tools for disease severity and impact and when to refer for specialist care

NICE CG153 Recommendation 1.2.1.10 (KPI)

> Following assessment in a non-specialist setting, refer people for dermatology specialist advice if:
>
> - There is diagnostic uncertainty **or**
> - Any type of psoriasis is severe or extensive, for example more than 10% of the body surface is affected **or**
> - Any type of psoriasis cannot be controlled with topical therapy **or**
> - Acute guttate psoriasis requires phototherapy (see recommendation 1.4.1.1) **or**

- Nail disease has a major functional or cosmetic impact **or**
- Any type of psoriasis is having a major impact on a person's physical, psychological or social wellbeing.

Identification of comorbidities

NICE CG153 Recommendation 1.2.3.3

> For people with multiple comorbidities and/or multimorbidities and any type of psoriasis needing second- or third-line therapy, ensure multidisciplinary working and communication between specialties and, if needed, interdisciplinary team working (for example when both skin and joints are significantly affected).

4.3 Current UK practice

Access to services

Stakeholders drew attention to the study reviewed as part of NICE clinical guideline 153 development showing wide variation in practice in the UK, and in particular, variations in access to specialist treatments (including biological therapy), appropriate drug monitoring, specialist nurse support and psychological services.

Another study documented in the NICE clinical guideline 153 reported that several participants whose psoriasis was severe or poorly controlled found that obtaining a specialist dermatology referral from their GP was unexpectedly difficult.

Phototherapy

A 2008 audit of the provision of care for psoriasis patients[1] showed that 20% of dermatology units did not have dedicated dermatology specialist nurses. Most units provided phototherapy but waiting times for treatment varied. Patients with inflammatory skin diseases were waiting a median of 10 weeks for routine appointments. 23% of units offered multidisciplinary clinics with rheumatologists for the management of patients with psoriasis and psoriatic arthritis. In terms of phototherapy, narrow-band UVB phototherapy was available in 92% of units, broad-band UVB phototherapy in 26% of units and photochemotherapy (PUVA) in 90% of units.

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[1] British Association of Dermatologists and Royal College of Physicians (2008) UK audit of provision of care for psoriasis patients

5 Suggested improvement area: use of biological therapy

5.1 *Summary of suggestions*

Stakeholders highlighted that appropriate use of biological therapy to treat moderate to severe psoriasis could mitigate the impact of the disease in terms of quality of life as well as treatment of the physical symptoms, and that early initiation of treatment is also important in enabling patients to regain a good quality of life.

It was also highlighted that the offer of an alternative biologic drug was important to ensure optimal treatment for patients, and achievement of treatment goals.

5.2 *Selected recommendations from development source*

Recommendations from the development source relating to the suggested improvement areas have been provisionally selected and are presented below to inform the Committee in their discussions.

Systemic biological therapy

The GDG did not review evidence for any aspect of the use of a first biological agent because guidance on this is already available in the existing NICE technology appraisals (TAs).

NICE CG153 Recommendations 1.5.3.3 to 1.5.3.11 are replicated from the relevant TAs and are listed here in alphabetical order by drug.

<u>NICE CG153 Recommendation 1.5.3.1</u>

Biological agents for psoriasis should be initiated and supervised only by specialist physicians experienced in the diagnosis and treatment of psoriasis.

<u>NICE CG153 Recommendation 1.5.3.2</u>

If a person has both psoriasis and psoriatic arthritis, take into account both conditions before initiating or making changes to biological therapy and manage their treatment in consultation with a rheumatologist (see also Etanercept, infliximab and adalimumab for the treatment of psoriatic arthritis [NICE technology appraisal guidance 199] and Golimumab for the treatment of psoriatic arthritis [NICE technology appraisal guidance 220]).

<u>NICE CG153 Recommendation 1.5.3.3</u>

When using the DLQI, healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties that could affect the response to the DLQI and make any adjustments they consider appropriate.

Adalimumab

The recommendations in this section are from Adalimumab for the treatment of adults with psoriasis (NICE technology appraisal guidance 146).

NICE CG153 Recommendation 1.5.3.4

Adalimumab is recommended as a treatment option for adults with plaque psoriasis for whom anti-tumour necrosis factor (TNF) treatment is being considered and when the following criteria are both met.

- The disease is severe as defined by a total PASI of 10 or more and a DLQI or more than 10.
- The psoriasis has not responded to standard systemic therapies including ciclosporin, methotrexate and PUVA; or the person is intolerant of, or has a contraindication to, these treatments.

NICE CG153 Recommendation 1.5.3.5

Adalimumab should be discontinued in people whose psoriasis has not responded adequately at 16 weeks. An adequate response is defined as either:

- A 75% reduction in the PASI score (PASI 75) form when treatment started **or**
- A 50% reduction in the PASI score (PASI 50) and a 5-point reduction in DLQI from start of treatment.

Etanercept

The recommendations in this section are from Etanercept and efalizumab for the treatment of adults with psoriasis (NICE technology appraisal guidance 103).

NICE CG153 Recommendation 1.5.3.6

Etanercept, within its licensed indications, administered at a dose not exceeding 25 mg twice weekly is recommended for the treatment of adults with plaque psoriasis only when the following criteria are met.

- The disease is severe as defined by a total PASI of 10 or more and a DLQI of more than 10.

- The psoriasis has failed to respond to standard systemic therapies including cyclosporine, methotrexate and PUVA; or the person is intolerant to, or has a contraindication to, these treatments.

NICE CG153 Recommendation 1.5.3.7

Etanercept treatment should be discontinued in patients whose psoriasis has not responded adequately at 12 weeks. Further treatment cycles are not recommended in these patients. An adequate response is defined as either:

- A 75% reduction in the PASI score from when treatment started (PASI 75) **or**
- A 50% reduction in the PASI score (PASI 50) and a 5-point reduction in DLQI from when treatment started.

Infliximab

The recommendations in this section are from Infliximab for the treatment of adults with psoriasis (NICE technology appraisal guidance 134).

NICE CG153 Recommendation 1.5.3.8

Infliximab, within its licensed indications, is recommended as a treatment option for adults with plaque psoriasis only when the following criteria are met.

- The disease is very severe as defined by a total PASI of 20 or more and a DLQI of more than 18.
- The psoriasis has failed to respond to standard systemic therapies such as ciclosporin, methotrexate or PUVA, or the person is intolerant to or has a contraindication to these treatments.

NICE CG153 Recommendation 1.5.3.9

Infliximab treatment should be continued beyond 10 weeks only in people whose psoriasis has shown an adequate response to treatment within 10 weeks. An adequate response is defined as either:

- A 75% reduction in the PASI score from when treatment started (PASI 75) **or**
- A 50% reduction in the PASI score (PASI 50) and a 5-pointreduction in the DLQI from when treatment started.

Ustekinumab

The recommendations in this section are from Ustekinumab for the treatment of adults with moderate to severe psoriasis (NICE technology appraisal guidance 180).

NICE CG153 Recommendation 1.5.3.10

Ustekinumab is recommended as a treatment option for adults with plaque psoriasis when the following criteria are met.

- The disease is severe, as defined by a total PASI score of 10 or more and a DLQI score of more than 10.
- The psoriasis has not responded to standard systemic therapies, including ciclosporin, methotrexate and PUVA, or the person is intolerant of or has a contraindication to these treatments.
- The manufacturer provides the 90 mg dose (two 45 mg vials) for people who weigh more than 100 kg at the same total cost as for a single 45 mg vial.

NICE CG153 Recommendation 1.5.3.11

Ustekinumab treatment should be stopped inpeople whose psoriasis has not responded adequately by 16 weeks after starting treatment. An adequate response is defined as either:

- A 75% reduction in the PASI score (PASI 75) from when treatment started or
- A 50% reduction in the PASI score (PASI 50) and a 5-point reduction in the DLQI score from when treatment started.

Changing to an alternative biological drug

NICE CG153 Recommendation 1.5.3.12 (KPI)

Consider changing to an alternative biological drug in adults if:

- The psoriasis does not respond adequately to a first biological drug as defined in NICE technology appraisals (at 10 weeks after starting treatment for infliximab, 12 weeks for etanercept, and 16 weeks for adalimumab and ustekinumab; primary failure) **or**
- The psoriasis initially responds adequately but subsequently loses this response, (secondary failure) **or**
- The first biological drug cannot be tolerated or becomes contraindicated.

NICE CG153 Recommendation 1.5.3.13

For adults in whom there is an inadequate response to a second biological drug, seek supra-specialist advice from a clinician with expertise in biological therapy.

5.3 Current UK practice

There are wide variations in access to specialist treatments according to stakeholders’ knowledge and experience. No published reports were highlighted by respondents, but it was suggested that recent market research data by a pharmacology company indicates that fewer than 7,000 patients actually receive a biologic therapy in the UK, suggesting that many patients with moderate to severe psoriasis may not be receiving an appropriate NICE-recommended treatment.

Stakeholders also commented from their experience that some psoriasis patients are receiving suboptimal care after a first biologic drug has failed.

A 2008 audit of the provision of care for psoriasis patients[2] showed that 73% of dermatology units prescribed biologic therapies for psoriasis with a median of 5 patients receiving these agents in the year. 64% of the units delivering biologics had nurses trained in the use of biologics, and 71% had facilities to deliver outpatient infusions of infliximab, usually shared with other specialities. 98% of prescribing units said they adhered to BAD and 94% to NICE guidelines.

A focussed literature search identified published study of UK current practice relating to the suggested area for quality improvement. An audit of patients treated with biologics for psoriasis since the issue of technology appraisals (TA103, TA134 and TA146) in 7 dermatology units between November 2008 and March 2009[3] showed that compliance with national guidance was entirely appropriate in terms of therapy initiation; however, the requirement to discontinue etanercept in responders was rarely followed. Similarly, discontinuation of biologicals in non-responders was not routine practice.

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[2] British Association of Dermatologists and Royal College of Physicians (2008) UK audit of provision of care for psoriasis patients

[3] Bewley, A (2011) Current application of NICE guidance in the management of patients with severe psoriasis: a clinical audit

6 Suggested improvement area: assessing disease severity and response to treatment

6.1 *Summary of suggestions*

It was suggested that many people with psoriasis receive less than optimal treatment, and that a treatment goal of complete clearance of skin symptoms is central to the management of people with psoriasis, facilitated by regular outcome measurements such as the Psoriasis Area and Severity Index (PASI) and Dermatology Life Quality Index (DLQI), as recommended in NICE clinical guideline 153. The assessment of severity and impact of psoriasis enables the evaluation of the efficacy of interventions. Stakeholders highlighted that progression from first-line treatments to second-line therapy, and referral to secondary care is also determined by disease severity and response to treatment.

6.2 *Selected recommendations from development source*

Recommendations from the development source relating to the suggested improvement areas have been provisionally selected and are presented below to inform the Committee in their discussions.

Assessment tools for disease severity and impact and when to refer for specialist care

NICE CG 153 Recommendation 1.2.1.1 (KPI)

> For people with any type of psoriasis assess:
>
> - Disease severity
> - The impact of disease on physical, psychological and social wellbeing
> - Whether they have psoriatic arthritis
> - The presence of comorbidities.

NICE CG153 Recommendation 1.2.1.2

> Assess the severity and impact of any type of psoriasis:
>
> - At first presentation
> - Before referral for specialist advice and at each referral point in the treatment pathway
> - To evaluate the efficacy of interventions.

NICE CG153 Recommendation 1.2.1.3

> When assessing the disease severity in any healthcare setting, record:
>
> - The results of a static Physician's Global Assessment (classified as clear, nearly clear, mild, moderate, severe or very severe)
> - The patient's assessment of current disease severity, for example, using the static Patient's Global Assessment (classified as clear, nearly clear, mild, moderate, severe or very severe)
> - The body surface area affected
> - Any involvement of nails, high-impact and difficult-to-treat sites (for example, the face scalp, palms, soles, flexures and genitals)
> - Any systemic upset such as fever and malaise, which are common in unstable forms of psoriasis such as erythroderma or generalised pustular psoriasis.

NICE CG153 Recommendation 1.2.1.4

> In specialist settings, use a validated tool to assess severity of psoriasis, for example the Psoriasis Area and Severity Index (PASI) (in addition to the assessments indicated in recommendation 1.2.1.3).

NICE CG153 Recommendation 1.2.1.6

> Use the Nail Psoriasis Severity Index to assess nail disease in specialist settings:
>
> - If there is a major functional or cosmetic impact **or**
> - Before and after treatment is initiated specifically for nail disease.

6.3 Current UK practice

Stakeholders drew attention to the importance of effective use of standardised disease severity assessments in ensuring appropriate biological therapy initiation. A sub-analysis conducted on patients in the UK long-term observational study to monitor the safety of biologics (British Association of Dermatologists Biologic Interventions Register – set up in 2007) showed that psoriasis patients were initiated on biologic treatment with a mean disease severity higher than that recommended by NICE, and it was hypothesised that this could be due to a lack of regular, standardised disease assessment.

Stakeholders highlighted new survey results from The Psoriasis Association which revealed that only 32% of their members reported ever having had their disease severity measured. A recent retrospective chart review also suggested that treatment centres that perform PASI assessment routinely have a more progressive approach to treatment (proportion of patients receiving only one line of treatment higher in centres not using PASI assessment).

The British Association of Dermatologists' 2008 audit of the provision of dermatology services in secondary care for people with psoriasis[4] found that documentation of the physical severity of psoriasis was poor, with a physical assessment using the Psoriasis Area and Severity Index inadequately or never recorded in 79% of outpatient records.

With the introduction of biological therapies in 2005 the British Association of Dermatologists Guidelines Group and NICE recommended use of formal tools to assess disease severity and impact to assess patients with plaque psoriasis being considered for biological therapy and to establish treatment efficacy. Largely as a result of this, dermatologists and nursing staff in specialist practice are trained in the use and interpretation of PASI and DLQI, and whilst the standard assessment for patients requiring biological therapy mandates PASI and DLQI assessment, this has led to the more widespread use of these tools for those requiring phototherapy or systemic therapy. In primary care and non-specialist settings, assessment of psoriasis generally follows the traditional history and skin examination with little use of formal assessment tools.

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[4] British Association of Dermatologists and Royal College of Physicians (2008) UK audit of provision of care for psoriasis patients

7 Suggested improvement area: assessment of comorbidities

7.1 Summary of suggestions

Stakeholders highlighted the studies that show people with psoriasis are at greater risk of cardiovascular disease, are more likely to engage in unhealthy lifestyle behaviours, and encounter barriers to engaging with health protective behaviours (for example, social avoidance due to appearance concerns).

Stakeholders noted the higher incidence of a number of conditions in people with psoriasis and suggested that the cumulative effect of these burdens requires a holistic approach to care for people with psoriasis to ensure that any additional support needs are identified. Stakeholders highlighted the importance of a proactive approach to the identification of risk factors, particularly in non-specialist settings, to ensure appropriate and timely intervention and subsequent reduction in morbidity and mortality associated with psoriasis.

7.2 Selected recommendations from development source

Recommendations from the development source relating to the suggested improvement area have been provisionally selected and are presented below to inform the Committee in their discussions.

Identification of comorbidities

NICE CG153 Recommendation 1.2.3.1

> Offer adults with severe psoriasis of any type a cardiovascular risk assessment at presentation using a validated risk estimation tool. Offer further assessment of cardiovascular risk every 5 years, or more frequently if indicated following assessment. For further information see Lipid modification (NICE clinical guideline 67).

NICE CG153 Recommendation 1.2.3.2 (KPI)

> Discuss risk factors for cardiovascular comorbidities with people who have any type of psoriasis (and their families or carers where appropriate). Where appropriate offer preventative advice, healthy lifestyle information and support for behavioural change tailored to meet the needs of the individual in line with the following NICE guidance:
>
> - Lipid modification (NICE clinical guideline 67)
> - Obesity (NICE clinical guideline 43)

- Preventing type 2 diabetes: population and community interventions (NICE public health guidance 35)
- Prevention of cardiovascular disease (NICE public health guidance 25)
- Alcohol-use disorders: preventing harmful drinking (NICE public health guidance 24)
- Smoking cessation services (NICE public health guidance 10)
- Four commonly used methods to increase physical activity (NICE public health guidance 2)
- Promoting physical activity in the workplace (NICE public health guidance 13)
- Promoting physical activity for children and young people (NICE public health guidance 17).

NICE CG153 Recommendation 1.2.3.3

> For people with multiple comorbidities and/or multimorbidities and any type of psoriasis needing second- or third-line therapy, ensure multidisciplinary working and communication between specialties and, if needed, interdisciplinary team working (for example when both skin and joints are significantly affected).

NICE CG153 Recommendation 1.2.3.4

> Be aware that psoriasis of any type, especially if severe, is a risk factor for venous thromboembolism in adults, and:
>
> - Explain this risk to adults with any type of psoriasis
> - Offer advice on how to minimise the risk (for example, during hospital admission, surgery, or periods of immobility)
> - Manage the risk in line with Venous thromboembolism: reducing the risk (NICE clinical guideline 92).

NICE CG153 Recommendation 1.2.3.5

> Assess whether people with any type of psoriasis are depressed when assessing disease severity and impact, and when escalating therapy. If appropriate offer information, advice and support in line with Depression in adults with a chronic physical health problem (NICE clinical guideline 91) and Depression in children and young people (NICE clinical guideline 28).

7.3 Current UK practice

NICE Clinical Guideline 153 notes that assessment for cardiovascular disease in specialist/dermatology care is not routine and current practice in dermatology is thought to be variable, therefore a recommendation about assessment for cardiovascular disease would apply to secondary and primary care. The evidence on depression, and GDG experience, indicated the need to always consider depression when assessing patients with psoriasis.

8 Suggested improvement area: quality of life/psychological support

8.1 Summary of suggestions

Stakeholders highlighted the major impact of psoriasis on patients' wellbeing, due to the effect of living with a highly visible, stigmatising skin disease. Many patients report problems with their quality of life, and some report major psychological distress. Stakeholders suggested that the psychosocial impact of the disease is often not measured objectively and not recognised, and that even when issues are identified, many patients do not receive appropriate psychological intervention.

8.2 Selected recommendations from development source

Recommendations from the development source relating to the suggested improvement area have been provisionally selected and are presented below to inform the Committee in their discussions.

Assessment tools for disease severity and impact and when to refer for specialist care

NICE CG153 Recommendation 1.2.1.7

> Assess the impact of any type of psoriasis on physical, psychological and social wellbeing by asking:
>
> - What aspects of their daily living are affected by the person's psoriasis
> - How the person is coping with their skin condition and any treatments they are using
> - If they need further advice or support
> - If their psoriasis has an impact on their mood
> - If their psoriasis causes them distress (be aware the patient may have levels of distress and not be clinically depressed)
> - If their condition has any impact on their family or carers.
>
> Ask children and young people age-appropriate questions.

NICE CG153 Recommendation 1.2.1.8

In specialist settings, and if practical in non-specialist settings, use a validated tool to assess the impact of any type of psoriasis on physical, psychological and social wellbeing, for example the:

- Dermatology Life Quality Index (DLQI) for adults **or**
- Children's Dermatology Life Quality Index (CDLQI) for children and young people.

NICE CG153 Recommendation 1.2.1.10 (KPI)

Following assessment in a non-specialist setting, refer people for dermatology specialist advice if:

- There is diagnostic uncertainty **or**
- Any type of psoriasis is severe or extensive, for example more than 10% of the body surface is affected **or**
- Any type of psoriasis cannot be controlled with topical therapy **or**
- Acute guttate psoriasis requires phototherapy (see recommendation 1.4.1.1) **or**
- Nail disease has a major functional or cosmetic impact **or**
- Any type of psoriasis is having a major impact on a person's physical, psychological or social wellbeing.

8.3 Current UK practice

Stakeholders highlighted findings from the British Association of Dermatologists' 2008 audit of the provision of dermatology services in secondary care for people with psoriasis[5] found that documentation of the impact of the disease on quality of life was poor, with a Quality of Life score inadequately or never recorded in outpatient records in 81% of units. Only 2% of units always recorded a quality of life score in outpatient records. The audit also showed that clinical psychology services were available in 40% of dermatology units.

Stakeholders highlighted publications that described the complexity of psoriasis and the need for services to recognise it as a long term condition and in particular the link between the condition and psychological distress. A British Journal of General

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[5] British Association of Dermatologists and Royal College of Physicians (2008) UK audit of provision of care for psoriasis patients

Practice editorial[6], for example, suggested few specialist psychological services for patients with dermatological conditions are available in the UK and opportunities for referral to specialist centres are limited by low recognition of patient need, while a nationwide survey of patient experience undertaken by the Psoriasis Association of its membership in 2009 concluded that there was a significant disparity between the emotional distress experienced and the available support.[7] The 2012 report See Psoriasis: Look Deeper, produced collaboratively by the Psoriasis Association and Mental Health Foundation[8], revealed that some people with psoriasis feel that their GP regards psoriasis as a minor skin complaint and is dismissive of the emotional aspects. This is supported by a study of the recognition of need in healthcare consultations for people with psoriasis published in 2012[9] which found that practitioners were perceived as lacking empathy with the effects of psoriasis and failing to manage it as a long-term condition. This perceived lack of support resulted in some participants withdrawing from conventional health service providers and seeking alternative sources of help.

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[6] Cordingley L, Nelson PA, Griffiths CEM, Chew-Graham CA (2012) Beyond skin: the need for a new approach to the management of psoriasis in primary care

[7] The Psoriasis Association (2009) Membership Survey (submitted 31/10/2012 to NICE team)

[8] The Psoriasis Association and Mental Health Foundation (2012) See Psoriasis: Look Deeper

[9] Nelson, PA, Chew-Graham, CA, Griffiths, CEM, Cordingley, L (2012) Recognition of need in health care consultations: a qualitative study of people with psoriasis

9 Suggested improvement area: diagnosis of psoriatic arthritis

9.1 Summary of suggestions

Stakeholders highlighted that psoriatic arthritis is a joint disease that could benefit from earlier diagnosis and treatment, noting that late diagnosis and treatment can lead to poorer long term outcomes such as damage to joints and patients' functional abilities. It was also noted that there is a prevalence of undiagnosed psoriatic arthritis, and that annual screening for the condition could help to identify patients before joint damage occurs.

9.2 Selected recommendations from development source

Recommendations from the development source relating to the suggested improvement area have been provisionally selected and are presented below to inform the Committee in their discussions.

Assessment and referral for psoriatic arthritis

NICE CG153 Recommendation 1.2.2.1

> Offer annual assessment for psoriatic arthritis to people with any type of psoriasis. Assessment is especially important within the first 10 years of onset of psoriasis.

NICE CG153 Recommendation 1.2.2.2

> Use a validated tool to assess adults for psoriatic arthritis in primary care and specialist settings, for example the Psoriasis Epidemiological Screening Tool (PEST). Be aware that the PEST does not detect axial arthritis or inflammatory back pain.

NICE CG153 Recommendation 1.2.2.3 (KPI)

> As soon as psoriatic arthritis is suspected, refer the person to a rheumatologist for assessment and advice about planning their care.

9.3 Current UK practice

Expert opinion suggests that routine screening for psoriatic arthritis is not current practice.

Appendix 1 Key priorities for implementation recommendations (CG153)

Assessment tools for disease severity and impact and when to refer for specialist care

- For people with any type of psoriasis assess:
    - Disease severity
    - The impact of disease on physical, psychological and social wellbeing
    - Whether they have psoriatic arthritis
    - The presence of comorbidities.
- Following assessment in a non-specialist setting, refer people for dermatology specialist advice if:
    - There is diagnostic uncertainty **or**
    - Any type of psoriasis is severe or extensive, for example more than 10% of the body surface area is affected **or**
    - Any type of psoriasis cannot be controlled with topical therapy **or**
    - Acute guttate psoriasis requires phototherapy (see recommendation 1.4.1.1) **or**
    - Nail disease has a major functional or cosmetic impact **or**
    - Any type of psoriasis is having a major impact on a person's physical, psychological or social wellbeing.

Assessment and referral for psoriatic arthritis

- As soon as psoriatic arthritis is suspected, refer the person to a rheumatologist for assessment and advice about planning their care.

Identification of comorbidities

- Discuss risk factors for cardiovascular comorbidities with people who have any type of psoriasis (and their families or carers when appropriate). Where appropriate offer preventative advice, healthy lifestyle information and support for behavioural change tailored to meet the needs of the individual in line with the following NICE guidance:
    - Lipid modification (NICE clinical guideline 67)

  - Obesity (NICE clinical guideline 43)
  - Preventing type 2 diabetes: population and community interventions (NICE public health guidance 35)
  - Prevention of cardiovascular disease (NICE public health guidance 25)
  - Alcohol-use disorders: preventing harmful drinking (NICE public health guidance 24)
  - Smoking cessation services (NICE public health guidance 10)
  - Four commonly used methods to increase physical activity (NICE public health guidance 2)
  - Promoting physical activity in the workplace (NICE public health guidance 13)
  - Promoting physical activity for children and young people (NICE public health guidance 17).

Topical therapy: general recommendations

- Offer practical support and advice about the use and application of topical treatments. Advice should be provided by healthcare professionals who are trained and competent in the use of topical therapies. Support people to adhere to treatment in line with Medicines adherence (NICE clinical guideline 76).

Topical therapy: topical treatment of psoriasis affecting the trunk and limbs

- Offer a potent corticosteroid applied once daily plus vitamin D or a vitamin D analogue applied once daily (applied separately, one in the morning and the other in the evening) for up to 4 weeks as initial treatment for adults with trunk or limb psoriasis).

Phototherapy (broad- or narrow-band ultraviolet B light)

- Offer narrowband ultraviolet B (UVB) phototherapy to people with plaque or guttate-pattern psoriasis that cannot be controlled with topical treatments alone. Treatment with narrowband UVB phototherapy can be given 3 or 2 times a week depending on patient preference. Tell people receiving narrowband UVB that a response may be achieved more quickly with treatment 3 times a week.

Systemic non-biological therapy

- Offer systemic non-biological therapy to people with any type of psoriasis if:

    - It cannot be controlled with topic therapy **and**
    - It has a significant impact on physical, psychological or social wellbeing **and**
    - One or more of the following apply:
        - Psoriasis is extensive (for example, more than 10% of body surface area affected or a Psoriasis Area and Severity Index (PASI) score of more than 10) **or**
        - Psoriasis is localised and associated with significant functional impairment and/or high levels of distress (for example severe nail disease or involvement at high-impact sites) **or**
        - Phototherapy has been ineffective, cannot be used or has resulted in rapid relapse (rapid relapse is defined as greater than 50% of baseline disease severity within 3 months).

Choice of drugs (systemic non-biological therapy

- Offer methotrexate as the first choice of systemic agent for people with psoriasis who fulfil the criteria for systemic therapy (see previous recommendation 1.5.2.1) except in the circumstances described in recommendations 1.5.2.4 and 1.5.2.12.

Changing to an alternative biological drug (systemic biological therapy)

- Consider changing to an alternative biological drug in adults if:
    - The psoriasis does not respond adequately to a first biological drug as defined in NICE technology appraisals (at 10 weeks after starting treatment for infliximab, 12 weeks for etanercept, and 16 weeks for adalimumab and ustekinumab; primary failure) **or**
    - The psoriasis initially responds adequately but subsequently loses this response, (secondary failure) **or**
    - The first biological drug cannot be tolerated or becomes contraindicated.

Appendix 2 Suggestions from stakeholder engagement exercise

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
001	Lilly UK	• Referral to a dermatology specialist should be available to all patients if any type of psoriasis is having a major impact on a person's physical, psychological or social wellbeing.	Psoriasis is an inflammatory skin disease that has a major impact on functional, psychological, and social dimensions. The patient experience of living with psoriasis in the recent Psoriasis CG powerfully conveys the invidious nature of the disease and how this may vary from individual to individual. As such it is essential for all patients to have access to specialist treatment, if psoriasis is impacting their physical, psychological or social wellbeing.	A study highlighted in the recent Psoriasis CG demonstrated: "wide variations in practice in the UK, and in particular, variations in access to specialist treatments (including biological therapy), appropriate drug monitoring, specialist nurse support and psychological services" which are not readily available to all psoriasis patients.	Psoriasis. The Assessment and management of psoriasis. October 2012. NICE Clinical Guideline 153. Eedy DJ, Griffiths CE, Chalmers RJ et al. (2009) Care of patients with psoriasis: an audit of U.K. services in secondary care. British Journal of Dermatology. 160: 557–64
002	Lilly UK	Assessment and treatment of patients with psoriasis should consider the impact on physical, psychological and social wellbeing. Particular care should be paid to the management of psoriasis at 'difficult-to-treat sites' (face, flexures, genitalia, scalp, palms and soles). Ongoing management is required on	Symptoms related to the skin, problems related to treatments, psoriatic arthritis, and the effect of living with a highly visible, stigmatising skin disease all contribute to the major impact of psoriasis on patients. Three out of four patients describe it as a 'problem' or 'significant problem' impacting their quality of life (Dubertret et al. 2006), approximately 1 in 3	The recent Psoriasis CG highlights that in the UK the broad impact of psoriasis on patients is often not appreciated and reports that even when correctly identified, less than a third of people with psoriasis receive appropriate psychological intervention. 'Difficult-to-treat sites' should be a particular area of focus as they are frequently highlighted throughout the Psoriasis CG as a flag for close consideration of treatment options and, in the British Association of Dermatologists (BAD) guidelines for biologic	Dubertret L, Mrowietz U, Ranki A, et al. EUROPSO Patient Survey Group. European patient perspectives on the impact of psoriasis: the EUROPSO patient membership survey. Br J Dermatol 2006;155(4):729–36 Richards HL, Fortune DG,

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		every aspect of the disease.	patients experience major psychological distress (Richards et al. 2001), 10% contemplate suicide (Kurd et al. 2010). 'Difficult-to-treat sites' (face, flexures, genitalia, scalp, palms and soles) have especially high impact, may result in functional impairment, require particular care in assessing treatment options and may be resistant to treatment. Ongoing assessment of psoriasis and the response to treatment is important as patients differ greatly in their response to different treatments at different stages of their disease.	interventions for psoriasis 2009 (Smith et al 2009), may be considered as 'exceptional circumstances'.	Weidmann A, Sweeney SK, Griffiths CE. The contribution of perceptions of stigmatisation to disability in patients with psoriasis. Journal of Psychosomatic Research. 2001; 50(1):10-15 Kurd SK, Troxel AB, Crits-Christoph P, Gelfand JM. The risk of depression, anxiety, and suicidality in patients with psoriasis: a population-based cohort study. Arch Dermatol 2010;146(8):891–5 Psoriasis. The Assessment and management of psoriasis. October 2012. NICE Clinical Guideline 153. Smith CH et al. British Association of Dermatologists (BAD) guidelines for biologic

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					interventions for psoriasis 2009. British Journal of Dermatology 2009;161:987–
003	Lilly UK	Identify risk factors and screen for markers of cardiovascular comorbidities with people who have any type of psoriasis. Where appropriate offer preventative advice, healthy lifestyle information and support for behavioural change tailored to meet the needs of the individual in line with the relevant NICE guidance around lipids, diabetes, obesity cardiovascular disease, smoking and physical activity.	In addition to the psychological impact of psoriasis and psoriatic arthritis, studies suggest that people with psoriasis are also at greater risk of cardiovascular disease and that the risk increases with increased psoriasis severity. For example, psoriasis is associated with increased risk of atrial fibrillation and stroke (Ahlehoff et al. 2012), myocardial infarction (Gelfand et al. 2006) and cardiovascular risk factors associated with metabolic syndrome (Neimann et al. 2006).	This is a key area for quality improvement because as well as being at higher risk of cardiac events, some treatments are iatrogenic, as highlighted in the Psoriasis CG.	Ahlehoff O, Gislason GH, Jørgensen CH, et al. Psoriasis and risk of atrial fibrillation and ischemic stroke: A Danish nationwide cohort study. Eur Heart J 2012;33(16):2054-2064 Gelfand, J, Neimann, A, Shin, D, Wang, X, ; Margolis, D, ; Troxel, A, Risk of myocardial infarction in patients with psoriasis . JAMA. 2006;296(14):1735-1741. Neimann AL, Shin DB, Wang X, Margolis DJ, Troxel AB, et al. (2006) Prevalence of cardiovascular risk factors in patients with psoriasis. J Am Acad Dermatol 55: 829–835.

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					Psoriasis. The Assessment and management of psoriasis. October 2012. NICE Clinical Guideline 153.
004	Lilly UK	- Psoriasis treatment goals should aim to achieve complete clearance of skin symptoms.	The recent European consensus paper (Mrowietz et al 2011) highlights that even though a number of treatments are available to patients with psoriasis, many patients do not receive the optimal care to clear skin symptoms and to improve health-related quality of life (HRQOL). Many patients with psoriasis are left on less than optimal treatments. A goal of complete clearance of skin symptoms will drive improvements in patient care by ensuring that if the current treatment regimen is not achieving adequate outcomes after a given amount of time, the options available to patients as per the NICE guidance are reconsidered and treatment adapted.	We believe NICE guidance acts to encourage aspirational, world class standards of care. The goals of treatment must be considered central in the treatment of patients with psoriasis, and this is reflected in the recent Psoriasis Clinical Guideline (CG). In this CG, all the recommendations on treatment are derived from an evidence base that considered outcomes PASI 75, PASI 90, clear/nearly clear as well as patient-reported outcome measures and quality of life (DLQI). Having a goal of achieving complete clearance of skin symptoms will serve to ensure patients are fully assessed and monitored and treatment is managed - altered as necessary - to reach this goal.	Mrowietz U, Kragballe K, Reich K, et al. Definition of treatment goals for moderate to severe psoriasis: a European consensus. Arch Dermatol Res 2011;303(1):1-10.2.

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005	Lilly UK	- Treatment and care should take into account patients' needs and preferences. People with psoriasis should have the opportunity to make informed decisions about their care and treatment, should understand the goals of treatment and be aligned with the healthcare professional in terms of expectations of treatment.	Psoriasis is a chronic disease that will require significant self management by patients. As detailed in the Psoriasis CG effective self management relies on several points: "patients have sufficient understanding of their condition and the treatment prescribed; positive attitudes to self-managing – including belief in their ability to manage and the motivation to do so consistently, as well as the skills to self-manage". In addition satisfaction and adherence to treatment for psoriasis is commonly very low (Pathirana et al. 2009). An understanding of what treatment is trying to achieve is central to self management and adherence and also affects the psychological impact of psoriasis.	There is a move in NHS England towards a consideration of patient experience, and more patient engagement and self management. Due to the nature of psoriasis - for example it is a chronic condition that requires a significant amount of time from patients to manage their treatment - better patient experiences, engagement and self management would lead to improved patient outcomes. Better inclusion of individual patient needs and preferences and joint decision making, as well as clear expectations of treatment may further facilitate improved self management and may lessen the impact on the psychological aspects of the disease.	Psoriasis. The Assessment and management of psoriasis. October 2012. NICE Clinical Guideline 153. Pathirana et al. European Dermal Forum. European S3-Guidelines on the systemic treatment of psoriasis vulgaris. 2009
006	Central North West London Foundation Trust	- Mindfulness training as an adjunct to medical intervention	There is evidence that meditation may aid healing, perhaps through anti-inflammatory processes activated by the brain changes. See Kabat-Zinn et al. Psychosomatic Medicine September 1, 1998 vol. 60 no. 5	Integrated care emphasises the role of brain and mind in physical symptoms and recovery. It is important for all healthcare delivery to consider the ways in patients can learn to influence their long-term conditions by psychological as well as by clinical means.	Please see article cited in earlier section

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			625-632 . This study has been replicated by Dr Robles at UCLA and is in press.		
007	British Psychological Society	• Develop care pathways for psychological management that are fully integrated with management of physical aspects of psoriasis	There is good evidence that people with psoriasis experience higher levels of psychological distress than the general population, (NICE CG153) the majority of which is currently undetected in both secondary and primary care (Richards et al., 2004; Nelson et al., 2012). Integrated approaches which combine psychological and physical assessment and management are more acceptable to patients. Furthermore it provides a holistic approach to patient care which leads to improved physical as well as psychological outcomes.	Periodic integrated reviews of psychological and physical functioning should occur in primary as well as secondary care services. (Cordingley et al., 2012) There is strong evidence of the accumulated psychosocial burden over the life course of people with psoriasis as most live with the condition for most of their adult lives (Kimball et al., 2010). Components of assessment should include mood, illness beliefs and coping behaviours (Fortune et al., 2002a; 2000) as all of these impact on self-management and physical outcomes as well as quality of life. Integrated services which combine physical and psychological assessments and enable easy access to psychological input are highly valued by patients with psoriasis and more likely to be utilised (Fortune et al., 2002b). Integrated clinics are viewed as more targeted and less stigmatizing than referral to specialist mental health services in the result is that, in the vast majority of cases, referral to separate mental health services are not appropriate. Practitioner psychologists specializing in physical health are working in integrated services are able	The NICE guideline for management of psoriasis CG153 (October 2012) http://www.nice.org.uk/CG153 Cordingley L, Nelson PA, Griffiths CEM, Chew-Graham CA: Beyond skin: the need for a new approach to the management of psoriasis in primary care. British Journal of General Practice. (62), 568-569. Fortune, D.G., Richards, H.L., Main, C.J. & Griffiths, C.E.M. (2000). Pathological Worrying, Illness Perceptions and Disease Severity in Patients with Psoriasis. British Journal of Health Psychology, 5, 71-82. Fortune DG, Richards HL, Griffiths CEM, Main CJ. (2002a). "Psychological stress, distress and

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				to provide psychological supervision and training of medical and nursing staff as well as direct patient services.	disability in patients with psoriasis: Consensus and variation in the contribution of illness perceptions, coping and alexithymia." British Journal of Clinical Psychology 41(2): 157-174. Fortune DG, Richards HL, Kirby B, Bowcock S, Main CJ, Griffiths CEM. (2002b)A cognitive-behavioural symptom management programme as an adjunct in psoriasis therapy. Britishr Journal of Dermatology; 146: 458–465. Kimball, A. B., U. Gieler, et al. (2010).
008	British Psychological Society	- Routine and repeated psychological assessment of impact of psoriasis upon young people during adolescence	The new NICE guidance (CG153) states that “Care of young people in transition between paediatric and adult services should be planned and managed according to the best practice guidance described in the Department of Health's “Transition: getting it right for young people.” Adult and paediatric healthcare teams should work jointly to provide	The majority of individuals are diagnosed with psoriasis in young adulthood, with 25% being diagnosed before the age of 18 years (Lebwohl, 2003). There is specific psychosocial impact of psoriasis amongst young people and the provision of appropriate psychosocial support to meet their individual needs, particularly in relation to concerns around altered appearance/ disfigurement which can be especially challenging during adolescence. New	The new NICE guideline for management of psoriasis CG153 (October 2012) http://www.nice.org.uk/CG153 Anstey A, McAteer H, Kamath N, Percival F. (2012) Extending psychosocial assessment of patients with psoriasis in the UK, using a self-rated,

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			assessment and services to young people with psoriasis. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.”	evidence shows that this has major impact upon educational achievements and aspirations (Anstey et al, 2012) which have lifelong consequences.	web-based survey. Clinical and Experimental Dermatology; 37(7):735-40. Lebwohl M. (2003). Psoriasis. Lancet, 61(9364), 1197-204.
009	British Psychological Society	- Assess the need for and offer tailored lifestyle behaviour change support for people with psoriasis at point of diagnosis and regularly at follow-up appointments in primary, secondary and tertiary care	There is strong evidence that people with psoriasis are more likely to engage in unhealthy lifestyle behaviours and be overweight. In relation to the latter, weight loss increases efficacy of systemic treatments. Furthermore, there is evidence that there are specific barriers to engaging with some health protective behaviours especially physical activity. These include social anxiety and social avoidance due to appearance concerns. The new NICE guideline for management of psoriasis (October 2012) now reads “ ‘Discuss risk factors for cardiovascular comorbidities with people who have any type of psoriasis (and their families or	People with psoriasis are more likely to smoke (Favato, 2008; Naldi & Mercuri, 2009), drink more alcohol (Kirby et al., 2008) and do less physical exercise and more likely to be overweight (Herron et al., 2005; Lebwohl & Callen, 2006). Whilst offering advice and healthy lifestyle information is important, however, this is not sufficient for behavioural change. Offering support for behavioural change, such as referral to smoking cessation services, is the minimum for those assessed as needing this intervention. (NICE PH6) People with psoriasis do not currently receive lifestyle behaviour change support as part of psoriasis management. The majority are not aware of the associations (neither direct nor indirect) between psoriasis and lifestyles in relation to their health.	The NICE guideline for management of psoriasis CG153 (October 2012) http://www.nice.org.uk/CG153 NICE (PH6 Behaviour Change: Guidance2007).. http://guidance.nice.org.uk/PH6/Guidance/pdf/English. Favato, G. (2008). High Incidence of Smoking Habit in Psoriatic Patients. The American Journal of Medicine, 121(4), e17. Ginsburg, I.H. & Link, B.G. (1993). Psychosocial Consequences of Rejection and Stigma Feelings in Psoriasis Patients. International Journal of Dermatology, 32, 587-91. Herron, M.D.,

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			carers). Where appropriate offer preventative advice, healthy lifestyle information and to support lifestyle behavioural change tailored to meet the needs of the individual in line with the following NICE guidance…'		Hinckley, M., Hoffman, M.S., Papenfuss, J., Hansen, C.B., Callis, K.P. et al. (2005). Impact of Obesity and Smoking on Psoriasis Presentation and Management. Archives of Dermatology, 141(12), 1527-34. Kirby, B., Richards, H.L., Mason, D.L., Fortune, D.G., Main, C.J. & Griffiths, C.E.M. (2008). Alcohol Consumption and Psychological Distress in Patients with Psoriasis. British Journal of Dermatology, 158(1), 138-40. Lebwohl, M. & Callen, J.P. (2006). Obesity, Smoking, and Psoriasis. Journal of the American Medical
010	British Psychological Society	• Ensure minimum standards of skill mix and training standards of staff to ensure that services are able to undertake psychosocial	NICE CG153 states that "The following recommendations have been identified as priorities for implementation. Assessment tools for disease severity and impact and when to refer for specialist	There are high levels of distress in people with psoriasis. Furthermore, psychological distress is not related to psoriasis severity (Fortune et al., 2000) nor are practitioners currently able to effectively assess distress in secondary (Richardson et al., 2004) or	The new NICE guideline for management of psoriasis CG153 (October 2012) http://www.nice.org.uk/CG153 Fortune, D.G.,

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		assessment.	care: For people with any type of psoriasis assess: … the impact of disease on physical, psychological and social wellbeing Following assessment in a non-specialist setting, refer people for dermatology specialist advice if: … any type of psoriasis is having a major impact on a person's physical, psychological or social wellbeing."	primary care (Nelson et al., 2012).	Richards, H.L., Main, C.J. & Griffiths, C.E.M. (2000). Pathological Worrying, Illness Perceptions and Disease Severity in Patients with Psoriasis. British Journal of Health Psychology, 5, 71-82. Nelson P, Chew-Graham, C., Griffiths, C.E.M., Cordingley, L. Recognising distress in health care consultations: a qualitative study of people with psoriasis. British Journal of Dermatology, 2012, ePrint available ahead of publication) Richards HL, Fortune DG, Weidmann A, Sweeney SKT, Griffiths CEM.(2004) Detection of psychological distress in patients with psoriasis: low consensus between dermatologist and patient. British Journal of Dermatology; 151 (6):1227-33.
011	The	• Assessing and recording	The NICE Guideline on	The Audit carried out by the British	CG54

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	Psoriasis Association	of disease severity	management of psoriasis recommends anyone with any type of psoriasis should be assessed for disease severity and impact on physical, psychological and social well-being	Association of Dermatologists into the services in secondary care in the United Kingdom with a focus on the care of people with psoriasis found a Quality of Life Score was inadequately or never recorded in outpatient records in 81% of units, and the most common physical assessment (Psoriasis Area and Severity Index – PASI) was inadequately or never recorded in 79% of outpatient records. The NICE Guideline on management of psoriasis recommends the assessment of severity and impact of any type of psoriasis to evaluate the efficacy of interventions – it is therefore important to record the severity in order to be capable of evaluating the treatment efficacy. The NICE pathway for psoriasis also states that if a person has more than 10% of their body surface area affected by psoriasis they should be referred to a dermatologist – therefore assessing the skin fully is of paramount importance. Being able to record this gives a reference point in time for both physician and patient.	Please see:- • the Audit Of The Provision Of Dermatology Services In Secondary Care In The United Kingdom With A Focus On The Care Of People With Psoriasis - http://www.bad.org.uk/Portals/_Bad/Audits/BAD%20Psoriasis%20Audit%2018.02.08.pdf • NICE Guideline on the Management of Psoriasis - http://www.nice.org.uk/nicemedia/live/13938/61192/61192.pdf • NICE pathway, specialist referral - http://pathways.nice.org.uk/pathways/psoriasis#content=view-node%3Anodes-specialist-referral
012	The Psoriasis Association	• Patient Information / Better communication	Studies have indicated difficulties in patients being able to adhere to all treatments for psoriasis (topical (Feldman et al, 2008),	Topical treatments are perceived negatively by many patients. They are deemed to be sticky, messy, difficult and time consuming, to the extent that they are viewed as	Please see:-• Bhosle, M.J., Feldman, S.R., Camacho, F.T., Whitmire, J., Nahata, M.C. & Balkrishnan, R.

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			phototherapy (Evers et al., 2010), oral therapy (Zaghloul & Goodfield, 2004) and biologic therapy (Bhosle et al.,2006) yet the Psoriasis Association 2009 Membership Survey found that 56% were not given sufficient information about treatments that were available.	“stressful”, “difficult to maintain”, and “a bigger nuisance than the condition”. Despite this, 74% were not offered any different treatment options even though the NICE pathway for psoriasis advises when offering treatments for psoriasis the healthcare professional should:-• ensure the treatment strategy is developed to meet the person's health goals so that the impact of their condition is minimised and use relevant assessment tools to ensure these goals are met (bold added by contributor)• take into account the age and individual circumstances of the person, disease phenotype, severity and impact, co-existing psoriatic arthritis, comorbidities and previous treatment history (bold added by contributor)• discuss the importance of adherence to treatment for optimising outcomes (bold added by contributor)If patients are not given good quality information then they are not equipped to make an informed choice about their treatments, the options available to them and the relevance of adhering to the treatments.	(2006). Medication Adherence and Health Care Costs Associated with Biologics in Medicaid-Enrolled Patients with Psoriasis. Journal of Dermatological Treatment, 17, 294-301.• Evers, A.W., Kleinpenning, M.M., Smits, T., Boezeman, J., van de Kerkhof, P.C., Kraaimaat, F.W. & Gerritsen,M.J.(2010) Treatment Nonadherence and Long-Term Effects of Narrowband UV-B Therapy in Patients with Psoriasis. Archive of Dermatology, 146, 198-9.• Feldman, S.R., Horn, E.J., Balkrishnan, R., Basra, M.K., Finlay, A.Y., McCoy, D., Menter, A. & van de Kerkhof, P.C.M. (2008) Psoriasis: Improving adherence to topical therapy. Journal of the American Academy of Dermatology, 59 (6), 1009-1016.• Zaghloul S.S. &

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					Goodfield, M.J.D. (2004). Objective Assessment of Compliance with Psoriasis Treatment. Archives of Dermatology, 140, 408-14.• Psoriasis Association 2009 Membership Survey (attached)
013	The Psoriasis Association	• Potential for Psychological Support	The Health Care Needs Assessment of Skin Conditions in the UK (Schofield et al, 2009) observed that the psychosocial impact of psoriasis, due to the stigma associated with a visible skin disease is significant and often is not measured objectively. Nearly half of all respondents of a UK web-based survey into quality of life and psoriasis (n = 1760) agreed that even if their psoriasis disappeared tomorrow, they would continue to live with the long-term effects that the condition has had on their life. Seventy percent avoided or limited social activities, 60% said psoriasis had prevented them from pursuing an intimate relationship and 24% for an	Despite the NICE pathway for psoriasis advising that people with any type of psoriasis should be assessed for the impact the disease is having on their physical, psychological and social well-being, and the known psychological impact of skin diseases – access to liaison psychiatric consultation services for patients with dermatological conditions is extremely limited and dedicated psychodermatology services are unacceptably scarce (Mizara et al, 2012). The Audit carried out by the BAD found 56% of dermatology departments lacked a clinical psychology service willing to accept adult dermatology patients and 59% lacked psychological services for children.	Please see:- • the Audit Of The Provision Of Dermatology Services In Secondary Care In The United Kingdom With A Focus On The Care Of People With Psoriasis - http://www.bad.org.uk/Portals/_Bad/Audits/BAD%20Psoriasis%20Audit%2018.02.08.pdf • Anstey, A., McAteer, H., Kamath, N. & Percival, F. (2012). Extending psychosocial assessment of patients with psoriasis in the UK, using a self-rated, web-based survey. Clinical and Experimental Dermatology, 37, 735-740.

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			intimate relationship to end (Anstey et al, 2012)		• Mizara, A., Papadopoulos, L. & McBride, S. R. (2012). Core beliefs and psychological distress in patients with psoriasis and atopic eczema attending secondary care: the roles of schemas in chronic skin disease. British Journal of Dermatology, 166 (5), 986-993 • Schofield, J., Grindley, D. & Williams, H (2009). Skin Conditions in the UK: a Health Care Needs Assessment. Nottingham, Centre of Evidence Based Dermatology.
014	The Psoriasis Association	• Re-Access to Care	Given the relapsing nature of psoriasis and that some treatments are only suitable for intermittent use, provision should be made for patients to re-access secondary care when required (SIGN Guideline 121).	Nurse-led clinics for psoriasis should be considered for re-access for patients with recurrent psoriasis in order to avoid unnecessary delays in accessing services and treatments.	Please see:- • SIGN Guideline 121: Diagnosis and Management of Psoriasis and Psoriatic Arthritis in Adults - http://www.sign.ac.uk/guidelines/fulltext/121/contents.html
015	Wirral	• Care nearer to home in	Many patients find it difficult to		

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	Clinical Commissioning group	the community	travel to their local hospital and Dermatology can be delivered outside of hospital		
016	Wirral Clinical Commissioning group	• Shorter wait times for specialist opinion	Many patients delay coming for assistance until the problem is a significant issue to them and find it distressing to wait for 2-3 months for an appointment. In acute guttate psoriasis there is often a significant wait time for phototherapy which is unacceptable.		
017	Wirral Clinical Commissioning group	• Improved access to practical physical & psychosocial support in the community setting eg specialist nurses	This is a distressing condition which would benefit from more support in the community from specialist nurses & counsellors.		
018	Wirral Clinical Commissioning group	• Improved access to phototherapy			
019	Celgene Ltd.	• Management of psoriasis in patients should take into consideration existing co-morbidities	A patient with psoriasis needs a holistic approach to their disease management and this may include using services and therapeutic interventions that would help resolve more than the skin symptoms. Conditions such	The cumulative effect of the psychological, social and physical burden borne by patients with psoriasis is considerable.Physicians treating psoriasis often fail to look for signs and symptoms of co-existing conditions. It is therefore important that treating professionals are	1. Psoriasis: The assessment and management of psoriasis Issued: October 2012NICE clinical guideline 1532. Eedy DJ, Griffiths CE, Chalmers RJ, Ormerod

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			as cardio vascular disease, diabetes, obesity, depression, hypertension, hyperlipidaemia, elements of metabolic syndrome are frequently reported as co morbidities in psoriasis patients. The incidence of diabetes, hypertension, obesity, hyperlipidaemia, myocardial infarction, atherosclerosis,peripheral vascular disease and stroke is higher in psoriasis patients compared to non-psoriasis patients. Studies have also suggested the risk of mortality from CVD to be significantly higher for patients with psoriasis compared to an unexposed cohort. The psychological burden of psoriasis on patients and their families is immense with studies again indicating that the risk of mental illness such as depression is significantly higher in patients with psoriasis (mild and severe) compared to an unexposed cohort.	adequately trained and made aware of the need. Patients presenting may be requiring additional support (e.g. psychological) to cope with their condition, and services should be developed to adequately meet such needs.NICE clinical guidelines recently published state that early and proactive identification of possible comorbidities, including depression, diabetes and/or cardiovascular conditions, was likely to represent good value for NHS resources. Early identification and intervention, where appropriate, could improve patients' quality of life in the short and longer term at a modest additional cost. Multi-disciplinary teams could assist. It is important that a holistic approach be adopted lest there is a risk that the condition is under/ sub-optimally treated resulting in poor patient outcomes.	AD, Smith CH, Barker JN et al. Care of patients with psoriasis: an audit of U.K. services in secondary care. British Journal of Dermatology. 2009;160(3):557-5643. Menter A, Griffiths CEM. Current and future management of psoriasis. Lancet 2007; 21;370: 272-844. Mehta NN, Yu Y, Pinnelas R, Krishnamoorthy P, Shin DB, Troxel AB et al. Attributable riskestimate of severe psoriasis on major cardiovascular events. American Journal of Medicine.2011; 124(8):7755. Ahlehoff O, Gislason GH, Charlot M, Jorgensen CH, Lindhardsen J, Olesen JB et al. Psoriasis isassociated with clinically significant cardiovascular risk: A Danish nationwide cohort study.Journal of Internal Medicine. 2011;

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					270(2):147-1576. Kurd SK, Troxel AB, Crits-Christoph P, Gelfand JM. The risk of depression, anxiety, andsuicidality in patients with psoriasis: a population-based cohort
020	Celgene Ltd.	• Earlier diagnosis of Psoriatic Arthritis (PSA)	PSA is joint disease that could benefit from earlier diagnosis and treatment Late diagnosis and treatment could lead to irreversible damage to the joints thus reducing a patient's functional abilities with consequent poor long-term outcomes. Moreover severity is associated with an increase in risk of mortality. The Gladman et al., 2011 study followed 1077 patients with new onset (n=436) and established (n=641) PsA and compared the rate of progression of clinical damage in a multivariate analysis. They found that the relative rate of joint damage progression (>2 years vs	Evidence shows that patients treated within two years of diagnosis have fewer complications compared to those who go untreated for more than two years. PSA is a potentially serious condition and therefore earlier diagnosis and treatment can help reduce joint complications and aid in better prognosis. Studies show that there is a large prevalence of undiagnosed PSA amongst psoriasis patients, with most diagnoses picked up during routine attendance at psoriasis clinics. Newer treatment options (including those in development) have shown be promising and may help reduce the burden of PSA morbidity, functional disability and mortality. Given the burden associated with PSA the risk of co-existence of PSA in psoriasis	1. Gladman DD, Thavaneswaran A, Chandran V, Cook RJ. Do patients with psoriatic arthritis who present early fare better than those presenting later in the disease? Annals of the Rheumatic Diseases. 2011; 70(12):2152-2154 2. How Can Psoriatic Arthritis Be Diagnosed Early?; Haddad A, Chandran V; Current Rheumatology Reports (May 2012) 3. Psoriasis: The assessment and management of psoriasis Issued: October 2012

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			<2 years disease duration at first visit) was 1.38 (1.08-1.77); p=0.01. This demonstrates a significantly greater rate of clinical damage progression in those referred late in the disease duration compared to early.	patients should always be assessed and treated appropriately.	NICE clinical guideline 153 4. Sokoll KB, Helliwell PS. Comparison of disability and quality of life in rheumatoid and psoriatic arthritis. Journal of Rheumatology. 2001; 28(8):1842-1846
021	Celgene Ltd.	• Educating patients / care providers	Psoriatic disease has multiple levels of impact on a patient - with symptoms of disease (itching, pain, bleeding, scaling), mood disorders, anxiety and depression, all significantly compromising the quality of life and also leading to reduced work productivity.	Appropriate management of all symptoms is key to improving psychological and social integration which may lead to increased productivity and improved quality of life. Newer therapies in development like the small molecules may aid patients and care-givers with simplifying treatment regimens (oral vs. sub-cutaneous, IV), simplifying pre-treatment work ups and post-treatment monitoring.	1. British Association of Dermatologists. Quality standards for dermatology: providing the right care for people with skin conditions. London: British Association of Dermatologists, 2011 2. British Association of Dermatologists and Primary Care Dermatology Society. Recommendations for the initial management of psoriasis. London: British Association of Dermatologists 3. Nevitt GJ, Hutchinson PE. Psoriasis in the community: prevalence,

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					severity and patients' beliefs and attitudes towards the disease. British Journal of Dermatology. 1996; 135(4):533-537
022	Celgene Ltd.	• Education of physicians in the non-specialist setting to identify disease and risk-factors for co-morbid conditions.	Patients initially present in non-specialist setting and therefore the disease can be unrecognised, under diagnosed and undertreated for a long period of time.	Physicians and HCPs in non-specialist settings are often unaware of or inadequately trained to treat the condition and neither are they encouraged to refer patients early on. Promoting a more proactive behaviour may help reduce the burden of the disease with appropriate and timely management leading to disease modification and reduction in morbidity and mortality associated with psoriatic disease.	1. Richards HL, Fortune DG, Weidmann A, Sweeney SK, Griffiths CE. The contribution of perceptions of stigmatisation to disability in patients with psoriasis. Journal of Psychosomatic Research. 2001; 50(1):10-15 2. Psoriasis: The assessment and management of psoriasis Issued: October 2012 NICE clinical guideline 153
023	British Association of Dermatologists	• Routine measurement of psoriasis severity –PASI score by dermatologists and an estimation of surface area affected and degree of	The management of psoriasis is largely governed by the extent and severity of the disease. For example, people with < 3% body surface area (3 palms worth) of psoriasis can usually be managed	It is rare in primary care for an objective measurement of disease severity to be made, and even in secondary care measurement of severity such as using a PASI score may not be routine. Assessment of response to treatment allowing escalation	Please view guidelines for the management of psoriasis which include recommendations for treatment escalation and referral to secondary care.

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		inflammation (mild/moderate/severe) by general practitioners	with topical (cream) treatments whereas patients with > 10% surface area or PASI ≥ 10 may be eligible for a biologic treatment. Measurement of severity enables the response to treatments to be evaluated (e.g. PASI 75 (75% improvement in PASI score) indicated a good response to therapy. Progression from first-line treatments to second-line therapy, and referral to secondary care is determined by disease severity and response to treatment.	of therapies if necessary, or referral to secondary care may not occur. People with psoriasis therefore may endure an unnecessarily high severity of disease which has a considerable life impact.	Psoriasis. The assessment and management of psoriasis NICE clinical guideline 153. http://Guidance.nice.org.uk/cg153 Diagnosis and management of psoriasis and psoriatic arthritis in adults. Oct 2010 www.sign.ac.uk British Association of Dermatologists' guidelines for biologic interventions for psoriasis 2009. Smith CH et al.Br J Dermatol. 2009 Nov;161(5):987-1019.
024	British Association of Dermatologists	- Routine measurement of impact of psoriasis or psychological co-morbidity using a validated tool, e.g. DLQI (Dermatology Life Quality Index) in secondary care and annual screening for anxiety and depression in primary and	In keeping with other major long-term conditions, psoriasis has a considerable functional, psychological and social impact. Psoriasis is a highly visible, disfiguring skin condition, which impacts relationships, employment, earning potential, quality of life and self-esteem. Unsurprisingly, a third of people with psoriasis experience major	The impact of psoriasis is under-recognised by patients and healthcare professionals. Patients with psoriasis are often alexithymic (unable to talk about their emotions), hence it is often difficult for health professionals to pick up on distress. The routine use of validated measurement tools such as DLQI, HADS and PHQ-9 would ensure the impact of psoriasis is addressed and appropriate referrals made. Without these measures distress is often unrecognised and people	Please view evidence on psychological impact of psoriasis, alexithymia in psoriasis and under-recognition of distress by healthcare professionals in people with psoriasis. The contribution of perceptions of stigmatisation to disability in patients with psoriasis.

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		secondary care again using a validated tool such as HADS (Hospital Anxiety and Depression Score), Patient Health Questionnaire (PHQ-9)	psychological distress (anxiety and/or depression), which is often missed by healthcare professionals.	do not receive appropriate interventions.	Richards HLet al J Psychosom Res. 2001 Jan;50(1):11-5 Alexithymia in patients with psoriasis: clinical correlates and psychometric properties of the Toronto Alexithymia Scale-20. Richards HL, et al. J Psychosom Res. 2005 Detection of psychological distress in patients with psoriasis: low consensus between dermatologist and patient. Richards HL, et al Br J Dermatol. 2004 Dec;151(6):1227-33
025	British Association of Dermatologists	- Annual screening for psoriatic arthritis with a screening tool such as PEST (Psoriasis Epidemiology Screening Tool) questionnaire in secondary care, or asking about joint pain/swelling/stiffness in primary care	25-40% of people with psoriasis have co-existent psoriatic arthritis. Early treatment of psoriatic arthritis prevents permanent joint damage. Guidelines recommend immediate referral to a rheumatologist if psoriatic arthritis is suspected. Annual screening with a questionnaire such as PEST would identify people	Although annual screening for psoriatic arthritis, preferably using a questionnaire tool such as PEST questionnaire is recommended in guidelines, this is not routinely performed and many patients will have established arthritis and joint damage before treatment is instituted. Since psoriatic arthritis usually occurs after psoriasis (mean 10-year lag), even though patients may be asked about joint symptoms on an initial	Please see evidence below for prevalence of psoriatic arthritis, evidence for benefits of early intervention and use of the PEST tool. The prevalence of psoriatic arthritis in people with psoriasis. Ibrahim G et al. Arthritis

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			requiring referral to a rheumatologist.	consultation, they may subsequently develop psoriatic arthritis and without annual screening this may be missed.	Rheum. 2009 Oct 15;61(10):1373-8. Do patients with psoriatic arthritis who present early fare better than those presenting later in the disease? Gladman DD et al Ann Rheum Dis. 2011 Dec;70(12):2152-4 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. Ibrahim GH, et al Clin Exp Rheumatol. 2009 May-Jun;27(3):469-74.
026	British Association of Dermatologists	• Screening for co-morbid conditions both in primary and secondary care –screening every 2 years for: - alcohol intake	Severe psoriasis is likely to be related to cardiovascular disease and all severities of psoriasis are associated with increased risk factors for cardiovascular disease. Risk factors include obesity, type 2 diabetes mellitus, metabolic	Assessing cardiovascular risk in patients with severe psoriasis and identifying risk factors in all patients with psoriasis enables preventative advice, healthy lifestyle information and support for behavioural change to be instituted. It also allows for interventions such as lipid lowering agents	Please see references below for evidence of increased risk factors in patients with psoriasis and increased cardiovascular disease in severe psoriasis.

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		- smoking history - blood pressure - body mass index - waist circumference - pulse - fasting lipids - fasting glucose	syndrome, excess alcohol intake, smoking and hyperlipidaemia.	or anti-hypertensives to be introduced if necessary.	Incidence of risk factors for myocardial infarction and other vascular diseases in patients with psoriasis. Kaye JA, Li L, Jick SS. Br J Dermatol. 2008 Sep;159(4):895-902 Prevalence of metabolic syndrome in patients with psoriasis: a population-based study in the United Kingdom. Langan SM et al J Invest Dermatol. 2012 Mar;132(3 Pt 1):556-62 Risk of myocardial infarction in patients with psoriasis. Gelfand JM, et al JAMA. 2006 Oct 11;296(14):1735-41.
027	British Association of Dermatologists	• Commissioning of multi-disciplinary services to manage moderate-to-severe psoriasis, or mild psoriasis with significant co-morbidity such as severe distress.	Psoriasis is a complex systemic condition with multiple co-morbidities. People with psoriasis may require access to several different healthcare professionals, hence good communication between healthcare professionals, such as within a multi-disciplinary	At present, only a minority of patients attending supra-specialist (level 4, tertiary) centres have access to multi-disciplinary services. There are wide variations in access to specialist treatments (e.g. biologics), drug monitoring, specialist nurse support, psychological services and rheumatologists. The provision of	Please find evidence below for provision of dermatological services and psycho-dermatology services British Association of Dermatologists. Quality standards for dermatology:

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			team, is essential to make appropriate management decisions. At present, the specialties involved with managing psoriasis (rheumatology, dermatology, psychology) are often under different management and income streams which can be a significant barrier to forming multi-disciplinary services. Combining or linking a patient pathway for patients with psoriasis and psoriatic arthritis may reduce duplication of tests etc. and number of hospital visits for patients.	psychological services within dermatology has reduced over the last 8 years, despite recommendations that it be increased. At present, only 4% of dermatology units have counselling available within departments. The commissioning of multi-disciplinary services, with clearly defined care pathways, will help ensure appropriate screening and monitoring of patients as well as adherence to guidelines. Care pathways can be patchy around the UK (e.g. methotrexate) and this is a major reason why certain drugs are not used optimally.	providing the right care for people with skin conditions. London: British Association of Dermatologists, 2011 Available from: http://www.bad.org.uk/Portals/_Bad/Quality%20Standards/Dermatology%20Standards%20FINAL%20-%20July%202011.pdf
028	LEO Pharma	- People with psoriasis should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professional.	There is good evidence that taking patients' needs and preferences into account when choosing treatment improves treatment outcomes.Patient engagement is recommended within the NICE Psoriasis guideline, the NICE Medicines Adherence guideline and the SIGN Psoriasis guideline.	Evidence suggests that making assumptions about patient preference should be avoided and that patients should be given the opportunity to be involved in making decisions about prescribed medicines. Treatment decisions not 'agreed' by the patient are likely to lead to an increased risk of non-adherence.Patient adherence is seen as one of the biggest issues in psoriasis treatment. Up to 40% of patients are estimated to be non-adherent with their treatment regimes and are	Please see the NICE Psoriasis Guideline (CG153), the NICE Medicines Adherence Guideline (CG76), the SIGN Psoriasis Guideline (CG121) and Richards HL et al. J Eur Acad Dermatol Venereol 2006; 20:370-379 for supporting information

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				therefore not receiving maximum clinical benefit from their treatment or value from the prescription charge they may have paid. The NHS also incurs a cost from non-adherence in that the medicine that has not been utilised appropriately is wasted and a non-adherent patient is likely to attend for another HCP consultation because their disease is not being adequately controlled.	
029	LEO Pharma	• Psoriasis is associated with physical, psychological and metabolic comorbidities.It is important that comorbidities associated with psoriasis should be thoroughly assessed by healthcare professionals and discussed with patients.	Assessment and treatment of patients with psoriasis should go beyond just the symptoms related to the skin.	Psoriasis for many people results in profound functional, psychological and social morbidity, with consequent reduced levels of employment and income. It is therefore important that assessment and treatment goes beyond just the symptoms related to the skin.	Please see the NICE Psoriasis Guideline (CG153), the NICE Medicines Adherence Guideline (CG76), the SIGN Psoriasis Guideline (CG121) and Aldeen T et al. British Journal of Nursing, 2011, Vol 20, No 18 for supporting information
030	Abbott Laboratories	• Appropriate assessment of quality of life and psychological impact of patients with psoriasis	Evidence shows that people with skin conditions such as psoriasis benefit from psychological interventions[i]. As recommended in the recent NICE clinical guidelines on psoriasis, there should be an assessment of the psychological impact of the	The recent See Psoriasis: Look Deeper report revealed that psoriasis can have an enormous psychological impact on patients' lives. Approximately one third of people living with psoriasis experience depression and anxiety, with up to 1 in 10 psoriasis patients contemplating suicide1. As stated in the recent NICE clinical guidelines on	The NICE clinical guidelines on psoriasis highlight the importance of the psychological effects of psoriasis on patients2. A 2010 report, 'Body and Soul: Exploring the connection between

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			disease in primary care[ii].	psoriasis, it is vital that GPs and other healthcare professionals recognise these possible consequences when they first see their patients, and that they routinely assess the impact that the disease is having on their daily lives2.	physical and mental health conditions', highlighted the connection between physical and mental health conditions. Having a chronic physical condition can have considerable impact on an individual's mental wellbeing, affecting their psychological resilience, confidence and self-esteem . Most researchers agree that the relationship between physical and mental health is bi-directional, meaning that physical health influences mental health and mental health influences physical health. Results from a randomised controlled trial suggest that appropriate intervention with biologics in patients with moderate to severe psoriasis reduces symptoms of depression as well as improving health-related quality of life .

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031	Abbott Laboratories	- Identification of co-morbidities	The NICE clinical guidelines for psoriasis list a number of comorbidities that occur in psoriasis and highlight why this is important2:Firstly, co-morbid conditions add to the complexity of treatment and may adversely impact on the side effect profile or efficacy of therapies used to treat psoriasis. Equally, some of the treatments used in psoriasis may adversely impact on associated comorbidities such as ciclosporin which, as example, can lead to both hypertension and hyperlipidaemia. Secondly, if people with psoriasis are at significantly increased risk of certain comorbidities, there is the opportunity to devise pathways of care that encompass all aspects of patients' health that would be beneficial in terms of improved awareness, earlier treatment of modifiable risk factors, convenience and time, and also, healthcare resource.' Section 7.4 page 150.	The NICE clinical guidelines on psoriasis recommend discussing risk factors for cardiovascular co-morbidities with patients who suffer from psoriasis as a key recommendation for implementation2. It is vital that appropriate preventative advice, healthy lifestyle information and support for behavioural change is offered to patients in primary care	There is limited audit data on how common identification of co-morbidities is in UK clinical practice2. 'Assessment for cardiovascular disease in specialist / dermatology care is not routine and current practice in dermatology is thought to be variable, therefore a recommendation about assessment for cardiovascular disease would apply to secondary and primary care.' Section 7.4.9 Page 209. 'The evidence on depression, and GDG experience, indicated the need to always consider depression when assessing patients with psoriasis.' Section 7.4.9 Page 209.

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032	Abbott Laboratories	- Early referral	There should be referral pathways with emphasis placed on early referral of appropriate patients. Initiation of biologic therapies in eligible patients should happen at the earliest opportunity.	Early referral of patients with severe psoriasis and appropriate initiation of biologic therapies treats the physical conditions of psoriasis as well as improving patients' quality of life. If the hypothesis of cumulative life course impairment is proven in psoriasis then early referral could mitigate the impact of psoriasis in altering the course of patient's lives	Warren et al5. outlined the theory of cumulative life course impairment and cases demonstrating the effect of psoriasis in 'influencing major life-changing decisions and altering the course of patients' lives, preventing patients from attaining their life goals, pursuing their chosen career, gaining a desired educational level, developing social relationships, gaining full pleasure from family life or having children'
033	Abbott Laboratories	- Assessment of disease impact using standardised tools	Effective use of disease impact assessments should be encouraged in order to plan appropriate care for patients and monitor clinical efficacy. The Psoriasis Area and Severity Index (PASI) and the Dermatology Life Quality Index (DLQI) should be used as Gold standard measures in the assessment of disease severity and quality of life in	The NICE clinical guidelines on psoriasis state that a validated tool to assess severity of psoriasis, e.g. the Psoriasis Area and Severity Index (PASI) should be used in specialist settings2. Abbott considers there to be great variation in UK clinical practice regarding the use of the DLQI to assess quality of life in psoriasis patients, which may contribute towards a delay in initiating effective treatments in eligible patients.	The NICE clinical guidelines on psoriasis recommend using validated tools to assess the severity of psoriasis2. From a United Kingdom long-term prospective observational study to monitor the safety of biologics; The British Association of

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			psoriasis patients in all patients once referred to secondary care at regular intervals. The Dermatology Life Quality Index (DLQI) should be used early to inform appropriate planning of care in psoriasis.		Dermatologists Biologics Interventions Register (BADBIR), a sub-analysis of patients initiated on adalimumab was undertaken. It was observed that psoriasis patients were initiated on adalimumab treatment with a mean disease severity higher than that recommended by NICE. It was observed that at initiation the mean (SD) score for PASI was 16 (8), and for DLQI was 15 (9) . It was observed that the mean PASI, mean DLQI are considerably higher than the eligibility criteria for biologics (10 for both PASI and DLQI) and that the mean duration of psoriasis symptoms was 23 years at time of initiation of adalimumab. It is hypothesised that this may be due to a lack of regular standardised disease assessment. It is

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					unknown how long these patients had symptoms before being referred to secondary care
034	Abbott Laboratories	- Monitoring of treatments	Regular monitoring of patients for efficacy using standardised tools (as above) should be conducted and monitoring of toxicity to ensure informed risk-benefit decisions can be made by patients and clinicians.	To ensure the patient has access to the full range of treatments appropriate for their level of disease severity taking into account the risk of toxicity and not inappropriately remain on ineffective treatments despite high levels of disease severity.	BADBIR registry data may be available in the future regarding time on ciclosporin, to assess whether ciclosporin is being used beyond the one-year maximum time period recommended in the NICE clinical guideline other than for exceptional cases.
035	Abbott Laboratories	- Associated psoriatic arthritis	An estimated 5-7% of people with psoriasis also have psoriatic arthritis (PsA), this figure can increase to approximately 40% in people who have severe psoriasis and in 70% of these people psoriasis precedes the arthritis (7). It is important to encourage joint working between rheumatologists and dermatologists to ensure early identification. and referral of patients with/or at risk of developing psoriatic arthritis from	The NICE clinical guidelines on psoriasis advise that all patients with psoriasis should be assessed for psoriatic arthritis on an annual basis2. There is a recognised need to establish a multidisciplinary approach to managing a psoriasis patient involving rheumatologists and psychiatrists if necessary.	

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			primary care to specialist rheumatologist care. http://www.psoriasis-association.org.uk/arthritis.html,		
036	Abbott Laboratories	• Patient choice and pathways	Patient information and awareness of local services and treatments available is vital to ensuring better health outcomes. Monitoring of how psoriasis is affecting patients' lives should take place through Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs).	Patient choice and empowerment is one of the key tenets of the Government's NHS reforms. There needs to be better awareness amongst psoriasis sufferers of the local services available to them, how to access these services alongside information on success rates and treatment options. There also needs to be awareness and understanding of managing psoriasis between primary and secondary care and the patient pathway. Patients should be clear on their potential treatment journey and should be able to understand / converse with medical staff	
037	MSD	• There should be more emphasis on the treatment goals biologics in Psoriasis		The European Consensus (a goal orientated algorithm) states that the ultimate treatment goal of any psoriasis treatment should be to achieve complete clearance of the skin. We suggest that a Psoriasis Area Severity Index (PASI) 90 score is a good measure of complete clearance.	Mrowietz U, Kragballe K, Reich K et al. Definition of treatment goals for moderate to severe psoriasis: a European consensus. Arch Dermatol Res, (2011) 303:1–10
038	MSD	• For patients with nail involvement, more emphasis should be put		The Delphi consensus states that the overall goals in patients with moderate to severe psoriasis with nail disease should be to	Langley R, Saurat J, Reich K, on behalf of the Nail Psoriasis Delphi Expert

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		on the treatment goals.		maximise the effectiveness of treatment and patients' QoL while minimising side effects.	Panel. Recommendations for the treatment of nail psoriasis in patients with moderate to severe psoriasis: a dermatology expert group consensus. JEADV, 2012 Mar;26(3):373-81
039	Janssen	- Systematic assessment and measurement of disease area and severity of psoriasis	The significant impact of psoriasis on patients' wellbeing underlines the need for prompt, effective treatment, and long-term disease control. Treatments available for psoriasis are varied highlighting the need for a full and comprehensive assessment of the patient and severity of the condition. Yet there is good evidence that shows the severity of psoriasis is not being adequately assessed. Treatment decisions should be based on a full assessment, using tools such as PASI (Psoriasis Area and Severity Index).	There is a lack of consistency in the clinical management (diagnosis and treatment) of psoriasis across the UK. New survey results from The Psoriasis Association revealed that only 32% of patients ever have their disease severity measured. (1) Without regular and systematic assessment of disease area and severity, patients with psoriasis are at risk of receiving suboptimal and unequal care. A recent retrospective chart review investigated whether routine measurement of PASI had an impact on treatment pathways, comparing treatment centres which perform PASI assessment routinely ('PASI centres') against those which don't ('non-PASI centres'). The results indicate that PASI centres have a more progressive approach to treatment of plaque psoriasis than non-PASI centres. For example, the proportion of patients receiving only one line of treatment during the study	(1) Press release from The Psoriasis Association - forthcoming. (2) A multi-centre study to describe treatment pathways and outcomes in patients with plaque psoriasis in secondary care in the UK. Abstract under development

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				period (up to 3 years) was significantly higher in non-PASI centres (66%, 31/47) than in PASI centres (35%, 24/69). (2)	
040	Janssen	• Appropriate and timely referral of patients with moderate to severe psoriasis to secondary care	Even though most people with psoriasis are managed in primary care, specialist referral is actually required in up to 60% at some point in their disease course.(3) n order to manage the condition as well as other factors that affect the patient's quality of life, it is essential that patients with moderate to severe psoriasis receive appropriate care in the specialist setting without undue delay.	A recently published paper on a UK-based qualitative study reported that "several participants whose psoriasis was severe or poorly controlled found that obtaining a specialist dermatology referral from their GP was unexpectedly difficult." (4)	(3) Psoriasis: Assessment and management of psoriasis. Clinical Guideline - Methods, evidence and recommendations, National Clinical Guideline Centre, 2012 (page 17). (4) Nelson P.A. et al., Recognition of need in health care consultations: a qualitative study of people with Psoriasis, Br J Dermatol. 2012 http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2133.2012.11217.x/abstract
041	Janssen	• Appropriate use of biologic drugs for treatment of moderate to severe plaque psoriasis	In order to ensure patients are able to regain a good quality of life, those who have been fully assessed and diagnosed with moderate to severe plaque psoriasis should receive an appropriate NICE-recommended biologic therapy without undue	According to the biologic drugs commissioning guide by NICE, "the proportion of prevalent patients eligible for treatment with a biologic drug is estimated to be around 3% or 18,000 people." (4). However, recent market research data indicate that fewer than 7,000 patients actually receive a biologic therapy in the UK,	4) NICE, Biologic drugs for the treatment of inflammatory disease in rheumatology, dermatology and gastroenterology:http://www.nice.org.uk/usingguidance/commissioningguides/bi

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			delay	suggesting that many patients with moderate to severe psoriasis are not receiving an appropriate NICE-recommended treatment. (5)	ologicaltherapies/home.jsp. (5) Market research data, Sep 2012
042	Janssen	- Changing to an alternative biologic drug when a first biologic drug has failed	This is one of the 'key priorities for implementation' in the NICE clinical guideline for psoriasis (CG153) (6). The full guideline states "compared to best supportive care, a second line biological therapy is likely to be cost effective" (7).	We understand from our engagements with NHS customers that some psoriasis patients are receiving suboptimal care after a first biologic drug has failed. This understanding is consistent with a statement in the full guidance; "this is an area in which there is variation in practice across the UK" (8)	(6) Psoriasis - The assessment and management of psoriasis, NICE clinical guideline 153, 2012. (7) Psoriasis: Assessment and management of psoriasis. Clinical Guideline - Methods, evidence and recommendations, National Clinical Guideline Centre, 2012 (page 696). (8) As above (page 656)
043	Janssen	- Local audits of real world data for treatment of psoriasis	In order to monitor whether quality of care is indeed improving, it is essential to capture and analyse relevant local data for management of psoriasis.	Without effective local audits, it is difficult to establish whether quality improvements have in fact been delivered. For example, do the patients who are eligible for a biologic therapy actually receive one? Or, are the stopping rules for biologic therapies (per NICE TA guidance) properly implemented	To our knowledge, there is limited amount of relevant local audit data available.
044	SCM	Disease severity assessment	Rarely undertaken in community. Significant to decision to onward referral. In	No information provided	No information provided

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			secondary care robust disease severity tools used in clinical practice will aid treatment decision making		
		Psoriatic arthritis screening tool	Important to screen for psoriatic arthritis as earlier diagnosis and treatment results in better treatment outcome and long term prognosis. No tools are currently used outside specialist (rheumatological) setting	No information provided	No information provided
		Cardiovascular assessment in severe psoriasis	Higher risk of CV disease and complications in severe psoriasis. Early detection and treatment through screening will improve clinical outcomes	No information provided	No information provided
		Disease impact and mood assessment	Undetected depression and anxiety secondary to psoriasis may impair a person’s ability to work and maintain social contact / relationships.	No information provided	No information provided
		Timely referral to specialist	Delay in onward referral may result in physical, social and psychological hardship for the person with psoriasis and their	No information provided	No information provided

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			family		