

National Institute for Health and Clinical Excellence

NICE Quality Standards Consultation – Psoriasis

Closing date: 5pm – 26 March 2013

Organisation	British Association of Dermatologists (BAD)
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Please note: comments submitted on the draft quality standard are published on the NICE website.	
Would your organisation like to express an interest in endorsing this quality standard? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
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Please provide comments on the draft quality standard on the form below, putting each new comment in a new row. When feeding back, please note the section you are commenting on (for example, section 1 Introduction). If commenting on a specific quality statement, please indicate the particular sub-section (for example, statement, measure or audience descriptor). If your comment relates to the standard as a whole then please put ~~general~~

In order to guide your comments, please refer to the general points for consideration on the NICE website as well as the specific questions detailed within the quality standard.

Please add rows as necessary.

Section	Comments
e.g. Section 1 Introduction or quality statement 1 (measure)	e.g. Comment about quality statement 1.
Introduction	The quality standards contain dermatologists-endorsed comments and suggestions including a person-centered and integrated approach to provision of care and acknowledgement that commissioners should take standards of care into consideration when designing services is particularly helpful. Further clarification of integrated to include multi-disciplinary teams including access to allied specialists such as nurses, rheumatologists, psychologists, phototherapists, GPs, etc. in addition to a dermatologist when indicated would enable the development of services to address the wider needs of patients with psoriasis. However, these quality standards need to include equitable access to NICE-approved treatments which is where resources should be focused.
Quality Statement 1	The assessment of disease severity is essential to assess baseline severity, response to treatment and identify patients particularly at risk of co-morbidities, or who would benefit from escalation of therapies. Within secondary care, it should be standard to measure PASI at baseline and at 3 and 6 months and 3 to 6 monthly thereafter. The baseline measurements would act as a useful audit tool for appropriateness of referral. In primary care, an estimate of percentage (%) surface area affected, together with the degree of inflammation (mild/moderate/severe) should be the minimum expected assessment performed at baseline, and to assess efficacy of treatment. It should be noted that sites such as face, scalp, hands/feet and genitals may have considerable functional and

Section	Comments
	psychological impact life despite affecting a relatively low % area, or PASI, and therefore need special consideration which is recognised by NICE.
Quality statement 2	We would recommend the title as Quality of life and Psychological impact . Quality of life does not necessarily equate to psychological distress. Consideration of psychological and social wellbeing as well as physical severity is to be commended. DLQI assessment should be obligatory and carried out in conjunction with an assessment of disease severity, both in primary and secondary care, to get a full understanding of the impact of disease. Since DLQI does not measure psychological distress and patients with psoriasis experience high rates of anxiety and depression, a baseline and then an annual measurement of distress using a validated measure such as the Hospital Anxiety and Distress Scale is recommended. If these factors are assessed there needs to be adequate service provision to manage patients with psoriasis and psychological disease. A multi-disciplinary or integrated service is important as this is very under-resourced and a poorly recognised aspect of care.
Quality statement 3	There needs to be an audit of where, when and why there are delays in patients receiving NICE approved treatments. Many patients have never been fully examined by their GP and some remain for years with severe disease and poor quality of life when they are compliant with NICE-approved therapies. The barriers to equitable care need to be known and acted upon. Many patients are reluctant to be discharged from secondary care as they fear they will not be re-referred when necessary. Referral criteria to secondary care should not only be based on physical severity, but also quality of life impact, e.g. DLQI>6 or HADS >8 as in SIGN guidance. This is alluded to in the comment any type of psoriasis that is having a major impact on a person's physical, psychological or social wellbeing ; however, an exact measure would be helpful. Psoriasis tends to wax and wane . provision for quick access to a dermatology specialist without having to go back to the GP should be catered for within the commissioning of psoriasis services.
Quality statement 4	Psoriasis is not just associated with cardiovascular disease but multiple co-morbidities . NAFLD and NASH in particular are very common in this sub-group of patients and there are significant consequences for treatment toxicity and disease outcomes. Obesity, diabetes, arthritis, hypertension, anxiety and depression are also associated with psoriasis. It is important to screen for these conditions and also have pathways in place to manage them, as many of the risk factors such as obesity, smoking and alcohol consumption can be modified. As

Section	Comments
	well as screening, services should include the ability to address and manage these lifestyle issues within the broader multi-disciplinary team, which may span primary and secondary care.
Quality statement 5	The importance of screening for psoriatic arthritis is now well accepted. It is also important that patients are not only screened for the presence of psoriatic arthritis, but receive early referral to an appropriate specialist for treatment, again preferably within the same multi-disciplinary team. Yearly screening is an ideal but this should not divert resources away from treatment of severe skin disease.
Quality statement 6	This statement should include screening <u>and</u> monitoring, not just the latter. There should be equitable access for standard drugs such as methotrexate. Intrinsic to the provision of specialist services should be the safe screening and monitoring of patients on systemic medications in line with national guidelines (NICE, BAD, SIGN). Pathways including access to drug monitoring nurses/clinics and shared care with GPs, again preferably within a broad multi-disciplinary team, should be part of the commissioning process.

Closing date: Please forward this electronically by 5pm on **26 March 2013** at the very latest to QSconsultations@nice.org.uk

PLEASE NOTE: The Institute reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion of the Institute, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.