

## **APPGS – Psoriasis Guidelines Implementation**

### **June 10<sup>th</sup> 2014**

The APPGS meeting on 10<sup>th</sup> June discussed the implementation and uptake of NICE guidelines and quality standards for psoriasis following reports that implementation is very poor in some areas of the country.

Panel members were given 5 minutes to present, with the discussion then opened to all attendees. Dr Sandy McBride represented the British Association of Dermatologists (BAD) as did Dr Tabi Leslie as an APPGS member; Dr Tak Cheung attended as an observer. There were short presentations by BDNG, Psoriasis Association, NHS England, HSCIC, Herts Valley CCG and NICE representatives.

#### Guidelines Content

- There was general agreement that guidelines were welcomed and appropriate. Screening for co-morbidities and assessment of impact and disease severity were thought to be particularly helpful; also long-term disease management.
- Simplified treatment guidance for GPs was highlighted as a need – present guidance was thought to be very long and complex. A4 sheet of guidance, APPs and link with GP computer system were all discussed. Existing patient pathway online was highlighted by the NICE representative as already addressing some of these issues.

#### Evidence that guidelines are not being implemented

- Some examples of good practice around the country and of NICE guidance having a very positive impact on patient care and services.
- Poor PASI, DLQI and PEST scoring assessments  
*[BAD interim psoriasis national audit report was referred to; 60%, 57% and 10% compliance, respectively].*

#### Barriers to Implementation

Several barriers to implementation were discussed:

- Psoriasis is presently not widely recognised as a long-term condition and therefore services are not set up to manage it as such. It needs to be recognised as a common and chronic inflammatory disorder causing serious morbidity, especially amongst primary care professionals. It should not be dismissed as "just a cosmetic skin condition" and can be associated with psoriatic arthritis and cardiovascular disease needs.
- Limited time in primary and secondary care in each consultation.
- Pressure on GPs not to refer  
*[Note: if the guidelines were properly followed the expectation would be that the vast majority of patients would not need referral – it is about expediting referral of patients who need referral, i.e. to access treatments not available in primary care].*
- Lack of training for nurses, GPs and medical students in dermatology.
- Better triage needed by appropriately trained healthcare professionals.

- Lack of psychological support for psoriasis patients [*BAD interim psoriasis audit report was referred to; the level of support has more than halved in the last 6-7 years*]. Patients with psoriasis can suffer from mood disorders and this needs to be recognised and treated appropriately.
- No dermatology QOFF.
- Guidelines too long for GPs to read – very poor knowledge of guidelines by GPs reported by BDNG representative. It is very rare that GPs are aware of them.
- Poor patient awareness of guidelines, so not aware of what they can and should expect.  
[*Note: interestingly NHS Choices information is not entirely consistent with the guidelines. <http://www.nhs.uk/Conditions/Psoriasis/Pages/Treatment.aspx>*].
- Poor shared care agreement with GPs  
[*Note: Patients need to be reviewed both in primary and secondary care at appropriate intervals after a treatment is started to ensure this treatment is working as one would do with other chronic conditions such as hypertension and diabetes*].
- Most people with psoriasis lie in primary care, where there is little awareness of guidelines, and, although there are examples of good care, most experience is not so good.
- 2-week wait pathways for skin cancer have diverted attention and funding away from inflammatory skin conditions which often have a big impact on patient lives.

#### Suggestions for a way forward

There was no consensus as to how to move forward to narrow the gulf between the guidelines and implementation.

- Several people felt that the GP is the best person to manage the patient and should remain central to the care of people with psoriasis. There was a concern that GPs would be de-skilled by e.g. setting up assessment units for people with psoriasis run by nurses or GPwSIs.
- Others felt that GPs are not aware of guidance and too overwhelmed to have time to commit to patients with psoriasis. Patients with moderate-to-severe psoriasis or suspected psoriatic arthritis need rapid access to secondary care or a specialist with knowledge about systemic treatments.
- A long-term disease management strategy was talked about – akin to diabetes and asthma. Whilst this model would address many issues there was a concern that the holistic GP-led approach would be lost.
- There was discussion about how people living in rural areas with poor transport links would best be served. It was felt local GPs would be best to address their needs.
- Annual 30-minute appointment for all people with psoriasis to have total skin examination, screening and review of treatment was thought to be a good aim by most. Discrepancy in opinion as to who should perform this, or how to go about implementing it.
- National audits in primary and secondary care in psoriasis patients to ensure "quality" care, e.g. recording of PASI and DLQI scores.

- Need the development of QOFF rewards for provision of "quality" care in psoriasis patients.

#### Discussion surrounding incentives for implementing guidelines

- In September HSCIC will be looking into developing outcome indicators for psoriasis, mapped to the NHS Outcomes Framework 2013/4, as part of the Clinical Commissioning Group Outcome Indicator Set (CCGOIS) programme (the consultation for which the BAD participated in last year, which featured outcome indicators for "cancers")
  - Outcome indicators would be to support local responsibility and accountability, not national.
  - Often take years to collect – sometimes need to use proxy measures such as time thrombolysis in stroke pathways.
- Quality Premiums are key incentives based on a smaller number of variables. There is a financial premium for these. Only 6-7 measures e.g. avoidable emergency admission and reduction in premature mortality.
  - Felt unlikely to be relevant to dermatology and psoriasis specifically.

Apart from the HSCIC plan there were no other explicit action points from the meeting, although all parties were invited to submit a report to the APPGS.

#### The BAD's perspective

As the BAD's psoriasis audit (interim) report was referred to, we would like to put in a caveat that it was a 'baseline' national audit conducted very soon after the publication of the NICE guidelines and therefore would not currently be the most appropriate indicator for uptake of the guidelines. A re-audit is planned for 2016 to ascertain any improvements in the uptake of and compliance with NICE guidelines and standards.

The 'pathway of care' for patients with psoriasis is explicit in the guideline and easily accessible at <http://pathways.nice.org.uk/pathways/psoriasis/psoriasis-overview>. There is always a gap between awareness and implementation so understanding barriers from every perspective (primary/secondary/tertiary) would be helpful – lack of awareness is not necessarily the main or only issue. Getting decent information on what's actually happening would be helpful in knowing where best to expend efforts.

Getting the management of psoriasis right will have benefits beyond psoriasis – the principles laid out are germane to most chronic skin disease. This point could also be emphasised, i.e. psoriasis is a focus, but lessons or pathways developed are generic and therefore with added value (hence worth the investment in terms of time, staff and costs). Assessing the needs of patients with psoriasis is not difficult and co-morbidities and psychological or social burden is a 'generic' issue, so GPs may be well placed to do it; if they don't, further 'de-skilling' in skin disease (if that is possible) is also a risk. Providing timely access to appropriate interventions will depend on the configuration of local services, but it is explicit in the NICE recommendations that phototherapy and systemic therapy require specialist input and facilities. The key is to have a referral pathway (back and forth) that ensures timely access to *appropriate treatments* that is agreed across the various providers and the configuration of this

will vary from region to region. If in place, it will be cost-effective. The pathway, outcome indicator set, and the national specialised service (when fully developed) all provide a framework against which service delivery should be commissioned and then the quality measured.

At the very least, the next step should be a commitment to meeting or agreeing on an action plan involving all relevant groups as a collective aim.

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