AN AUDIT OF THE PROVISION OF DERMATOLOGY SERVICES IN SECONDARY CARE IN THE UNITED KINGDOM WITH A FOCUS ON THE CARE OF PEOPLE WITH PSORIASIS

COMMISSIONED BY THE BRITISH ASSOCIATION OF DERMATOLOGISTS

AND CONDUCTED BY

THE BRITISH ASSOCIATION OF DERMATOLOGISTS AND THE CLINICAL EFFECTIVENESS AND EVALUATION UNIT, ROYAL COLLEGE OF PHYSICIANS CLINICAL STANDARDS DEPARTMENT

JANUARY 2008

Report authors

David Eedy, British Association of Dermatologists

Susan Burge, British Association of Dermatologists

Jonathan Potter, Programme Director, Clinical Effectiveness and Evaluation Unit, Royal College of Physicians

Jane Ingham, Director of Clinical Standards, Royal College of Physicians

Derek Lowe, Medical Statistician, Clinical Effectiveness and Evaluation Unit, Royal College of Physicians

Acknowledgements

We wish to thank all those who have participated in this audit. We recognise that those giving up their valuable time will inevitably have done so on top of a heavy workload. This audit would clearly not be possible without their support. We are equally grateful to colleagues for their valuable and constructive comments.

We are also indebted to the following hospitals that agreed to pilot the audit:

Aberdeen: NHS Grampian Trusts, A.D. Ormerod
Craigavon Area Hospital Group Trust: D.J. Eedy
London: Guys and St Thomas' NHS Foundation Trust: J.N.W.N. Barker, C.H. Smith
Manchester: Salford Royal Foundation Trust, C.E.M. Griffiths, R.J.G. Chalmers
Oxford Radcliffe Hospitals NHS Trust: S Burge.

CONTENTS Page

EXECUTIVE SUMMARY

This audit was designed to examine the staffing and facilities in Dermatology Departments (units) in the United Kingdom (UK) with a focus on the provision of care for patients with psoriasis. Standards were derived from recommendations of the British Association of Dermatologists (BAD) as well as evidence-based guidance for the management of, and use of biologic therapies in, patients with psoriasis.

Staffing

The BAD recommends that there should be one Whole Time Equivalent (WTE) dermatology consultant post per 100,000 of the population and that no consultant should work in isolation. These standards are being achieved in many parts of the UK (on average one dermatologist covers a population of 107,000); however 11 units have consultants who work in relative isolation. Clinical networks should be developed so that all consultants work within teams and have the support of colleagues.

Dermatology departments see large numbers of outpatients with new:review ratios that depend on case-mix as well as requirements for training. Most Trusts cannot provide diagnostic data on outpatients -a deficiency that should be addressed. Diagnostic data facilitate effective management and help clinicians to research, audit and improve standards of care. Data indicate that most people with inflammatory skin diseases who are referred routinely will have been seen and treatment begun within 12 weeks of referral. Urgent referrals should be seen within 2 weeks but not all units meet this standard.

Dermatology Nurses

Specialist dermatology nurses provide effective care and enhance self-management, but 20% of units still do not have dedicated dermatology specialist nurses to support and educate patients with chronic inflammatory skin diseases - a striking shortfall.

Inpatient Facilities and Emergency Dermatology

The need for dermatology admissions appears to have reduced, but some adults and children with chronic diseases such as psoriasis or emergencies such as skin failure may still require inpatient care under the supervision of a dermatologist. The arrangements for such care will vary depending on local circumstances. Showering or bathing facilities are essential for care of patients with skin diseases - it is disappointing that such basic facilities were perceived to be inadequate in one third of units. This combined with the general lack of nurses trained to care for patients with skin problems (only 40% of nurses caring for dermatology inpatients have had dermatological training) is of concern.

Many units no longer provide 24 hour on-call for dermatology emergencies, but arrangements should be in place to ensure that patients with urgent dermatological problems are seen by a dermatologist within 24 hours of admission and that specialist registrars are trained in emergency dermatology.

Outpatient Facilities and Day Care

Outpatient management, including day care and phototherapy, is increasingly important to replace inpatient care, but one quarter of units were unable to offer day care treatments by trained dermatology nurses and over one third of pharmacies could not easily provide

preparations such as coal tar for topical treatment. Each Trust should provide a dedicated dermatology outpatient area, with trained dermatology nursing staff, and facilities to apply topical therapy. Clinical psychology services (available in 40% of units) should be much more widely available to help children and adults with chronic skin problems cope with the cumulative psychological, social and physical burden.

Most units provided phototherapy but waiting times for treatment should not exceed 2weeks and units should offer more flexible access "out-of-hours". The ultraviolet (UV) output of phototherapy machines must be monitored by a medical physicist

Services for patients with chronic diseases should be flexible but in 37% of units patients could not self-refer. The potential for expanding such direct access should be explored, but the efficiency of self referral back to nurse or doctor led clinics services should be evaluated.

Paediatric dermatology facilities should be enhanced- 40% of units had no dedicated area for young persons and 64% of specialist outpatient services had no paediatric trained nurses.

Biologic therapy

Biologic therapies seem likely to play an increasingly important part in the treatment of chronic inflammatory skin diseases such as psoriasis. Thirty-nine percent of units prescribing biologics for psoriasis stated that prescribing was restricted for financial reasons.

Record keeping

Documentation of the physical severity of psoriasis and the impact on quality of life was poor and might be improved with the use of standardised proformas. Better record keeping will facilitate clinical audit and raise standards of care. Clinical photographs are invaluable to record extent of disease and monitor progress but medical photography services were not available in one-quarter of units.

Communication

Clinic letters (with a copy to the patient) should be sent to GPs within a week of clinic visits (and discharge summaries within a week of discharge). Units should have adequate resources to achieve these standards. Integrated care pathways and protocols should be agreed across all sectors to ensure that care is standardised and of high quality wherever it is delivered.

MAIN AUDIT RECOMMENDATIONS

The audit demonstrates unacceptably large variations in the quality of service provided in hospitals around the UK. Local services will require specialist input (nursing and medical) in initiation, supervision and management, whether provided in hospital settings or in the community. Services must be resourced to meet required standards.

Dermatology specialist nurses should be available in all units to support the care of both outpatients and in patients with skin diseases.
Clinical psychology services should be much more widely available for dermatology patients.
Resources will be required to support prescribing of new therapies such as the biologics which are likely to play an increasingly important part in the treatment of chronic inflammatory skin diseases Resources should be invested in outpatient data collection (case mix) to improve the management of dermatology services.

KEY FINDINGS.

This audit was designed to examine the staffing and facilities in UK dermatology units with a focus on the provision of care for patients with psoriasis. Standards were derived from recommendations of the BAD as well as evidence-based guidance for the management of patients with psoriasis and the use of biological therapies in the management of psoriasis.

Staffing infrastructure.

The BAD recommends that there should be one Whole Time Equivalent (WTE) dermatology consultant post per 100,000 of the population and that no consultant should work in isolation. These standards are being achieved in many parts of the UK (on average one dermatologist covers a population of 107,000); however 11 units have consultants who appear to work in relative isolation.

Key Message
Some consultant dermatologists still work in isolation. Clinical networks should be developed so that all consultants work within teams and have the support of colleagues.

Specialist dermatological nurses enhance patient care, but provision of specialist nurses was variable with a median of 1.5 WTE per dermatology unit. Disappointingly one in five departments had no specialist nurses.

Key Message
20% of units do not have dermatology specialist nurses to support and educate patients with chronic inflammatory skin diseases, thus enhancing self-management. This shortfall should be addressed.

A consultant dermatologist should be available to advise on the emergency care of patients with acute dermatological problems, but only 68% of units provided formal on call, and of those, only 72% (47% overall) provided 24-hour on-call advice. 55% of the 42 hospitals with specialist registrars provided 24-hour on-call. Trainees must learn how to manage acute dermatological problems and on-call experience is an important part of the curriculum.

Key Message
Although many units do not provide 24 hour on-call for dermatology emergencies, arrangements should be in place to ensure that patients with urgent dermatological problems are seen by a dermatologist within 24 hours of admission and that specialist registrars are trained in emergency dermatology

Patient referrals.

Dermatology departments see large numbers of outpatients. The median ratio of new:review patients was 1:1.70. Only one quarter of units collected diagnostic data on outpatients and half of these were unable to supply details about the number of attendances for psoriasis. The median ratio of new:review psoriasis patients was 1:4. Patients with inflammatory skin diseases were waiting a median of 10 weeks for routine appointments.

Key Messages
Resources should be invested in data collection to improve the management of outpatient services. Without diagnostic data to monitor case mix, units cannot manage services efficiently and will have difficulty improving standards of care by audit. Data suggest that it

will be difficult for centres dealing predominantly with chronic inflammatory diseases, such as psoriasis, to reduce the number follow ups and indeed specialist units may have to monitor more patients as new systemic therapies such as the biologics are introduced.

The NHS Improvement Plan (2004) states that patients should wait no more than 18 weeks from the time of referral to a hospital consultant to the start of treatment. Most dermatology patients start treatment at the first outpatient visit ie within 10 weeks of referral. Units should probably aim to see routine referrals within 6-8 weeks so that treatment of patients requiring procedures or investigations is also achieved within 18 weeks. However urgent referrals should be seen within 2 weeks and not all units meet this standard.

Departmental infrastructure and resources.

(a) Adult Inpatient beds

Seventy eight units stated that they admitted patients with psoriasis. Of these, 45 units admitted a median of 60 patients per annum to dedicated dermatology beds. Forty two units admitted a median of 10 patients per annum to general medical beds. Units reported admitting a median of 33 patients per year with psoriasis. The median amongst units for the average length of stay was 14 days, the median for maximum stay being 31 days.

Seventy-six per cent (74) of units reported they had access to adult dedicated dermatology beds and these units had a median of 5 beds. Two beds were provided per 96,834 to 152,229 of the adult population approaching the recommended standard of two dedicated beds per 100,000 population Of the 56 units with a specified number of dermatology beds, only 43% (24) were in dedicated dermatology wards, while another 9% (5) were in combined dermatology/rheumatology units. The others were on general medical wards, where beds were not necessarily protected for the use of dermatology patients. Of the 18 units with access to an unspecified number of beds, two indicated that beds were provided ‘as required in an emergency’ (this may have applied to other units).

Dermatologists supervised the care of in-patients in 92% (52) of the 56 dermatology units with a specified number of dedicated beds and in 39% (7) of the 18 units with access to an unspecified number of beds. Other admissions were supervised by a general physician with the backup of a consultant dermatologist.

In 41% of units topical treatments were applied by nurses who had no dermatology training or by the patients themselves. Specialist dermatology nurses were available in most units (89%) to advise on the care of adult patients on other wards. In these units only 68% had associated bathing and showering facilities for adults.

(b) Paediatric Inpatients

Seventy-five percent (73) of dermatology units reported having beds for paediatric dermatology patients, usually on medical wards (unprotected 90%, protected 10%). Eighty-seven percent of units with paediatric beds had adequate bathing and showering facilities for children.

Specialist nurses were available in 82% of units to advise on the care of children on other wards.

Key messages
Although the need to admit dermatology patients may be decreasing as units provide more ambulatory care, some patients with chronic diseases such as psoriasis or urgent problems such as skin failure will still require inpatient care under the supervision of a dermatologist. The arrangements for such care will vary depending on local circumstances. Patients must have access to baths or showers- it is disappointing that such basic facilities were perceived to be inadequate in one third of units. It is also worrying that only 40% of units had nurses trained in dermatology caring for dermatology inpatients. Also it is not good practice to expect in-patients to apply their own treatments.

Outpatient Services

Most (70%) units held outpatient clinics in an area dedicated to dermatology and 60% of units had access to an outpatient area dedicated to paediatrics.

Key Message
All units should have dedicated facilities for dermatology clinics and should ensure that children are seen in a child-friendly environment.

Dermatologists worked with trained dermatology nurses in 88% of units and had access to dermatology nurse specialists in 80% of units. 74% of units offered clinic rooms in which to apply topical treatments. Clinical psychology services were available for adults and children in only around 40% of units.

Key Message
A minority of dermatologists do not have the support of dermatology nurses in outpatient clinics. Nurses need space in which to educate and treat patients but a quarter of units do not have access to adequate outpatient facilities for treatment. The cumulative effect of the psychological, social and physical burden borne by patients with chronic skin diseases, such as psoriasis, is considerable and clinical psychology services should be much more widely available for dermatology patients.

Nurse-led clinics were available for patients with psoriasis in 60% of units and paediatrically trained nurses provided services in 36% of units.
Services for patients with chronic diseases should be flexible and centred on the needs of patients but in 37% of units patients could not self-refer to either a doctor or a nurse-led clinic. However in 75% of units a psoriasis patient could telephone a nurse for advice.

Key Messages
The potential of expanding direct access should be explored, but such services need to be evaluated.

Twenty-one percent (21) of units held clinics dedicated to patients with psoriasis and 23% offered multidisciplinary clinics with rheumatologists for the management of patients with psoriasis and psoriatic arthritis. Clinics for monitoring patients on systemic drugs (nurse-led or doctor-led) were provided by 45% of units but 8% of units did not provide patients with drug monitoring cards. Some shared-care protocols were available for GPs when patients were on methotrexate (60%), ciclosporin (35%) and acitretin (12%).

Key messages
It seems surprising that more units do not provide specialist clinics to monitor patients with psoriasis or those taking systemic drugs but it is likely that these services will be rolled out more widely as biologics are introduced. Follow-ups can be reduced if GPs agree to share care.

Day-care for psoriasis

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. Phototherapy was delivered by dermatology nurses in 93% while in 11% it was delivered by physiotherapists (some units used both). Bath and topical hand/ foot phototherapy were available in 71% and 92% of units respectively. Phototherapy was offered early (7am to 9am) in 63% and late (5pm to 9pm) in 34% of units. General practitioners could not refer directly for phototherapy in most units.

Sixty-nine per cent of phototherapy units were supervised by a named consultant and all units recorded cumulative doses in the medical records. In 95% of units, a medical physicist monitored the UV output of the phototherapy equipment.

The median number of courses of narrow-band UVB phototherapy and PUVA given over the financial year was 158 and 25 respectively, with a median total of 3,410 attendances per unit in the year, but many units were unable to provide this information. The average waiting time (units' own estimate) for either form of phototherapy was two weeks, but there was wide variation with 20% of units stating an average of more than 4 weeks for UVB and 11% more than 4 weeks for PUVA.

Key messages
Narrow-band UVB has replaced broad band UVB in most units. Waiting times for treatment should not exceed 2 weeks and more units should offer out-of-hours access to UVB phototherapy and PUVA. It is mandatory that the UV output of phototherapy machines is monitored by a medical physicist- the safety of patients is compromised in those units (5%) without such arrangements.

Outpatient topical therapy with dithranol or coal tar is provided in many units (short-contact dithranol - 63%; long contact dithranol - 45%; coal tar - 54%) Scalp treatments were provided in 74% of units. Thirty-eight percent of units stated they would consider using more crude coal tar and 46% more dithranol if facilities were staffed by trained nurses. Over one third of pharmacies could not readily provide coal tar or dithranol preparations.

Key messages
"Old fashioned" treatments such as dithranol or tar are safe, effective and relatively cheap, albeit messy. Coal tar and dithranol still have a place in the management of some patients with psoriasis- both outpatients and inpatients - but units should invest in trained nurses and pharmacies to apply and supply the treatments respectively. Scalp psoriasis is particularly problematic for some patients, but a quarter of units denied patients the opportunity of outpatient scalp treatment.

Biologic Therapies

Seventy-three percent of dermatology units prescribed biologic therapies for psoriasis with a median of 5 patients receiving these agents in the year. Four sites had more than 20 patients receiving biologic therapy. Ninety-eight per cent of prescribing units said they adhered to BAD and 94% to NICE guidelines. Only one unit adhered to neither. Thirty-nine percent of prescribing units stated that prescribing was restricted by financial constraints. Sixty-four percent of the units delivering biologics had nurses trained in the use of biologics. Seventy-one percent of units had facilities to deliver outpatient infusions of infliximab, usually shared with other specialities.

Key message

Biologic therapies seem likely to play an increasingly important part in the treatment of chronic inflammatory skin diseases such as psoriasis and resources will be required to support this therapy.

Record Keeping

Record keeping on the severity (physical and psychological) of a patient's psoriasis was poor. Only 2% of units always recorded a quality of life score in outpatient records and 39% never recorded such a score. Similar results (2% always and 45% never) were seen for inpatient records. Only 10% of units always recorded a global assessment (mild/moderate/severe), and in 12% of units this was never routinely recorded. Inpatient documentation levels (13% always and 15% never) were similar. The Psoriasis Area and Severity Index (PASI), a measure of the physical severity of psoriasis, was documented even less frequently. Seventy-seven percent of units had access to medical photography.

Key Messages

Documentation of the physical severity of psoriasis and the impact on quality of life was poor. Without accurate record keeping it is difficult to audit management and raise standards of care – record keeping might be improved with standardised proformas. Photographs that document the extent of skin disease may play an important part in the medical record and units should have access to medical photography services.

Communication and Education

About one-third of units did not meet the 7-day standard for either outpatient letters (39%) or discharge summaries (33%). Only 40% of units sent the patient a letter after the consultation and only 32% provided patients with a written treatment plan. Sixty-seven per cent of units offered GPs protocols for referral. Guidelines for dithranol treatment were available to GPs from 27% and for scalp treatment from 32% of units. All units provided patients with information about psoriasis and most (93%) offered written information about treatments.

Key Message

Clinic letters (with a copy to the patient) should be sent to GPs within a week of the clinic appointment and summaries sent out within a week of discharge. Most patients will appreciate a written treatment plan. Units should have adequate resources to achieve these standards.

INTRODUCTION

Psoriasis is a chronic, recurrent disease that affects between 1% and 3% of the population.[1] Traditional topical therapies (dithranol, tar preparations, vitamin D_3 analogues and topical steroids) are effective in the treatment of mild to moderate disease.[2,3] Patients with moderate to severe disease (approximately one-quarter of all patients with chronic plaque psoriasis) usually require phototherapy or systemic agents to achieve clearance. [2,3]

Therapies currently widely used for treating moderate to severe psoriasis include broadband UVB and narrowband (TLO1) UVB, PUVA, ciclosporin, methotrexate, hydroxycarbamide, fumarates and oral retinoid therapy.[2,3,4] In general, these more aggressive therapies have proven to be highly effective in the treatment of psoriasis.[4] As there is no standard therapeutic approach, the benefits and risks of therapy must be weighed carefully for each patient, treatment individualized and the impact of systemic treatment monitored.[2,3,4]
Advances in our understanding of the pathophysiology of psoriasis in the last two decades have underscored the importance of the immune system in the development and maintenance of plaques of psoriasis.[1,4] This knowledge, together with the biotechnological revolution has led to the development of new immunomodulatory agents known as the" biologics", examples of which include etanercept, efalizumab and infliximab. In addition to significantly reducing the physical severity of psoriasis, evidence from large randomized, controlled trials demonstrates that biologic therapies improve multiple facets of quality of life.[4,5,6.]

Despite advances in the management of severe psoriasis, inpatient treatment is still required for some patients with psoriasis. However, data for England show the number of dermatology inpatient admissions, excluding day cases, has fallen year on year since 1998[7], presumably paralleled by a reduction in dedicated dermatology beds. New drugs and changes in clinical practice may also account for this decline.[8] However, the median length of stay for inpatient psoriatic patients has remained fairly stable at around 14 days. [8]

The cumulative effect of the psychological, social and physical burden borne by patients with psoriasis is considerable. Indeed the emotional impact of psoriasis is such that as many as 10% of patients, contemplate suicide, especially those of younger age; many more are dissatisfied with their treatment and seek more aggressive therapies.[4,5] Recognition of the importance of incorporating the psychosocial impact of psoriasis into any holistic assessment of disease severity has led to the development of instruments, which complement measurement of disease extent and severity by assessing its impact on psychosocial functioning and quality of life. Both types of instrument should be used to assess the appropriateness of disease-modifying drugs as well as response to treatment. The most widely used tool for assessing psoriasis severity is the PASI, but a range of measures of disease severity and quality of life impairment have been developed and include Psoriasis Index of Quality of Life (PSORIQoL), Dermatology Index of Disease Severity (DIDS) and self-administered PASI (SAPASI). [5,9,10,11]

Until recently most chronic skin disease has been managed either by GPs or in secondary care by specialist dermatologists with access to day-care and in-patient services. The Government's initiative to provide 'Care Closer to Home' is changing the way such services are delivered.[12] The care for patients with psoriasis is also changing with the advent of more effective treatments such as the biologics. We require data about the structure and delivery of services in secondary care so as to: i) identify and tackle variations in standards and; ii) monitor the impact of healthcare reforms.

This audit was commissioned to assess the staffing and facilities in Dermatology Departments (units) in the United Kingdom (UK) with a focus on the provision of care for patients with psoriasis.

METHODS

The audit was carried out by the BAD in collaboration with the Clinical Evaluation and Effectiveness Unit of the Royal College of Physicians (London).

Standards

Standards were derived from guidelines of the BAD on the staffing and facilities required to run a dermatology service[13] and the care of patients with psoriasis[14,15] including the provision of phototherapy services[16] and the use of biological therapies.[4,5,6.] A questionnaire (Appendix 1) informed by these standards was agreed by a panel of experts in 2006 (Appendix 2).

Piloting

The audit was piloted in five sites: Aberdeen, Craigavon, London, Manchester and Oxford during October 2006. The audit questions were finalised by the expert panel and the lead clinicians in the pilot sites. The questionnaire was transferred to a web-based collection database and again piloted before being activated.

Recruitment

The audit was conducted in all regions of the UK. Data were sought from all acute hospital Trusts providing dermatology services. Lead consultant dermatologists for each dermatology unit were identified from the database held by the BAD.

For most Trusts the "unit" was defined as the Trust; otherwise there were "units" within a Trust each offering a distinct service. One hundred and fifty-four units were asked to provide information to the audit and of these 100 submitted data, a response rate of 65%. The numbers submitting data for each country were: England 86; Scotland 8; Wales 3; and Northern Ireland 3. Participating units are listed in Appendix 3.

Data Collection

Responses, after several reminders, were received from February to August 2007. Data were collected using a modification of the Royal College of Physicians' web collection tool, with lead dermatologists having a URL link to the data collection system. Those wishing to submit data on paper did so by post. Eighty-nine responses came via the web-tool and 11 on paper.

The web-tool was of a basic format, with limited internal consistency checking. One particular limitation was that missing numerical data (beds & patient numbers) were exported as 'zero'. However, there were few variables for which a valid zero was possible. Difficulties in interpretation are discussed as they arise in this report.

Presentation of audit results

Results for your unit are shown alongside the aggregated national results. Categorical data are summarised as percentages with numerator and denominator shown. Numerical results are summarised by the median and interquartile range (IQR) of the units. Missing data for individual units will show in the report as blank table cells and at a national level the denominators will vary according to how much missing data there is.

RESULTS

STAFFING

- The Royal College of Physicians and the NHS Workforce Review Team state that one consultant dermatologist is needed per 85,000 of the population with traditional referral patterns, but patterns of service delivery are changing with the shift of care to the community and at present the BAD advises a standard of one WTE consultant dermatologist post per 100,000 of the population.

	National audit (100)		
	Median	Inter-quartile Range	N of sites
WTE consultant staffing	2.8	2.0 to 4.0	98

The response to the catchment question was not uniform. Some units gave Trust catchments and others gave catchments at hospital level, whilst a few others gave overlapping catchments to reflect tertiary workloads. In analysis it was decided to apply Hospital Episode Statistics (HES) derived Trust catchment populations to each unit, supplemented for Scotland and Northern Ireland by a practical consideration of what catchments units had stated and of estimates made during the National 2003 COPD audit. HES catchments were split between units making up a Trust. The aim was to obtain a national population served by the audit participants without double counting. Using this method the total catchment population obtained was 33,264,800 from 98 units which represents 55% of the total UK estimated resident population of 60,587,000 for mid 2006. WTE consultant staffing was known for these 98 units, the total was 311.8, which is equivalent to 0.94 per 100,000 population, or 1 WTE consultant post per 107,000 population.

- Ideally, no consultant dermatologist should work alone: units should be large enough to employ at least two consultants, who should meet regularly with colleagues in surrounding units for audit, CME and CPD. Does your department contain more than one consultant and what support staff do you have[18]?

18/98 sites had fewer than 2.0 WTE consultants, 11 of these less than or equal to 1.0 WTE.

- Dedicated dermatology nurses are essential to any service. In main units they may take on specialist areas as well as using their core skills in outpatient clinics, day treatment units and inpatient units. Do specialist dermatologist nurses exist in your department[13]?

	National audit (100)		
	Median	Inter-quartile Range	N of sites
Specialist Dermatology Nurse WTE	1.5	0.8 to 2.5	100

Assuming Units who did not answer this question had no specialist dermatology nurses, 19/96 sites (i.e. one in five) had no Specialist Dermatology Nurse whilst 8 had less than 1.0 WTE post.

ON CALL SUPPORT

- Ideally a consultant dermatologist should be on call on a 24 hour basis to provide care for dermatological emergencies and provide cover and teaching to on call trainees. Is this provided in your Trust[13]?

	National Audit (100)	
	%Yes	N
2.1 Do consultant staff provide on-call access to dermatological advice?	68	67/99
2.2 If yes (to 2.1), is this 24hr on call?	72	47/65

- Is on call supported by other staff (Associate Specialists, Staff Grades, SpRs, SHOs[13]? As part of the training programme it is considered good practice for Specialist Registrars to be on call and is a mandatory part of their training[13]. Is this being adhered to in your Trust?

	National Audit (100)	
	%Yes	N
2.3 Do you have on-call for:		
Associate Specialists?	2	2
Staff grade?	-	0
Specialist registrars?	42	42
SHOs?	10	10
On call for ANY of the above	47	47
Is this a 24 hour on call	59	27/46

Of 42 hospitals with specialist registrars available to be on-call 55% (23/42) provided this 24 hour on-call service.

PATIENTS AND BEDS IN LAST FINANCIAL YEAR

Patients

	National audit (100)		
	Median	Inter-quartile Range	N of sites
3.1 How many **total** new patients attended your outpatient department in the last financial year (April 2005 to March 2006)?	4924	3349-7038	94
3.2 How many **total** review patients attended your outpatient department in the last financial year (April 2005 to March 2006)?	8318	5560-8319	92

	National audit (100)		
	Median	Inter-quartile Range	N of sites
3.3 Do you know how many new **psoriasis** patients attended your outpatient department in the last financial year?	264	120-500	31
3.4 How many **psoriasis** review patients attended your outpatient department in the last financial year?	801	263-1475	24
3.5a How many if any of these were new (tertiary) patients?	50	20-120	7
3.5b How many if any of these were review (tertiary) patients?	212	24-955	5

The ratio of total review to total new patients was computed for each of the 91 units with both data available – the median ratio of review to new patients was 1.70, IQR 1.30 – 2.20.

It is clear from the above table that most units were unable to state how many new or review psoriasis patients they had seen in the last financial year. For those 22 units that had both data available – the median ratio of review to new patients was 3.0, IQR 2.0 – 3.9

Dermatology beds

- 3.6 (a) All dermatologists should have admitting rights to a dedicated inpatient dermatology unit staffed by trained dermatology specialist nurses. Ideally this should be to dedicated dermatology beds, serviced by an on-call consultant dermatologist and supported by junior dermatology team[13]. Does this occur in your Trust?

- 3.6 (b) In certain cases Dermatological beds provided in general medical wards are satisfactory if there are suitable facilities for bathing and treatment, and if patients receive their care from specialist dermatology nurses[13]. Does this exist in your Trust?

- Teaching hospitals need dedicated inpatient dermatology units to manage the tertiary referral of patients with complex diseases, and also to train undergraduates and specialist registrars. Does this exist in your teaching hospital Trust?

	National audit (100)		
	Median	Inter-quartile Range	N of sites
3.6a How many dermatology patients (total) were admitted TO DEDICATED DERMATOLOGY BEDS under the care of dermatology in the last financial year (either to your Trust or to dedicated dermatology beds elsewhere)?	60	12-166	45
3.6b How many dermatology patients (total) were admitted TO GENERAL MEDICAL BEDS under the care of dermatology in the last financial year (either to your Trust or to dedicated dermatology beds elsewhere)?	10	5-19	42

The above table summary applies only to those units who stated they admitted patients.

In all there were 78 sites who submitted information to the effect that they admitted patients either to dedicated dermatology beds or to general medical beds, or to both. Thus, it is assumed for these 78 units that in 33 (78-45) no patients were admitted to dedicated beds and that in 36 units (78-42) no patients were admitted to general medical beds. For the other 22 units it is assumed that either no patients were admitted to either type of bed or the information was not available.

OUTPATIENT REFERRALS, APPOINTMENTS AND COMMUNICATIONS

Letter triage

- All referral letters should be triaged by a dermatologist[14]. In your Trust are these letters being triaged by a Consultant Dermatologist, by a General Practitioner's with a specialist interest GPSI or someone else trained in dermatology? If your letter triage is being done by someone not trained in dermatology this would be against the Audit standard?

	National Audit (100)	
	%Yes	N
4.1 Are referral letters triaged/prioritised by a consultant dermatologist?	77	74/96
4.2 If NO to 4.1, are referral letters triaged/prioritised by a GPSI or someone else with some knowledge of skin disease?	84	15/18
4.3 If NO to 4.1 and 4.2 are referral letters triaged/prioritised by someone without knowledge of skin disease?	100	3/3

Communication.

- Outpatient letters should be sent to the referring doctor with advice and a treatment plan within 7 days of the patient being seen[14,17]. Is this standard being achieved in your Trust?

- Discharge letters should be should be sent to the referring doctor with advice and a treatment plan within 7 days of the patient being discharged from an inpatient episode[14,17]. Is this standard being achieved in your Trust?

	National Audit (100)	
	%Yes	N
4.4 Are outpatient treatment / advice / consultation letters sent within 7days?	61	59/96
4.5 Are ward discharge summaries sent within 7 days?	67	61/91

WAITING TIMES

- The NHS Improvement Plan states that patients should wait no more than 18 weeks from the time of referral to a hospital consultant to the start of treatment [12]. This period includes any delays in waiting for tests or receiving the results. Most dermatology patients will not have to wait for the results of tests and will start treatment once they have attended the outpatient clinic. Urgent referrals should be seen within 2 weeks. How long do patients with inflammatory skin diseases (dermatoses) wait for an outpatient appointment in your Trust?

5. INFLAMMATORY DISEASES I.E. NOT SKIN CANCER	National audit (100) Median	Inter-quartile Range	N of sites
5.1 What is the average waiting time for a new routine appointment (weeks)?	10	8-12	98
5.2 For psoriasis:	10	7-11	94
5.3 For other dermatoses:	10	7-11	91
5.4 What is the average waiting time for a new urgent appointment (weeks)?	2	2-4	95

There were a small number of zeros stated in the responses, which can be either missing data or zero waiting time. The table above assumes the former.

INPATIENT FACILITIES.

Dedicated adult beds

- All adult dermatology patients should have access to dedicated inpatient beds[13]. Does this facility exist in your Trust?

	National Audit (100) %Yes	N
6.1 Are adult beds available to your department in your own trust?	76	74/98

Three-quarters of units said they had access to dedicated inpatient beds.

- The preferred requirement is two dedicated dermatology beds per 100,000 population[13]. Is this being provided at your Trust?

Units with access to dedicated inpatient beds:	National audit (74 with access) Median	Inter-quartile Range
6.1(a) How many adult beds are available to your department in your own trust?	5	2-6

Having stated they had access to dedicated inpatient beds, 16 of the 74 units then indicated they had no dedicated beds or gave no answer. Twenty sites had 2-4 beds, 24 had 5-9 beds and 12 had ten or more beds. In addition 1 site said ‘as required’ and 1 site said ‘emergencies

only'. The 16 units without beds perhaps don't have any specific number of dedicated beds but were able to call upon a bed if required on demand. For the 56 who had 2 or more beds stated then the median number of beds was 6, IQR 4-8.

It is difficult to get a totally satisfactory national estimate of dedicated beds per adult catchment population because of the uncertainty about the number of beds for some units and the proportion of the audit population that is adult. For the UK as a whole 81.0% of the 2006 UK resident population were 16 years or older (http://www.statistics.gov.uk/pdfdir/popest0807.pdf -- last accessed 29th December 2007).

In those 56 units with dedicated beds there was a total of 354 dedicated beds for the 17,139,598 adult population (= 81% of HES derived 21,159,997 total), i.e. 2 beds per 96,834.

For the audit as a whole assuming no dedicated beds for the other units gives a total of 354 beds for the 26,944,488 adult population covered (=81% of 33,264,800 total), i.e. 2 beds per 152,229.

Supervision of dedicated adult beds

- Are the dedicated beds being supervised by a consultant dermatologist from the unit's own Trust? If not, are they being supervised by a consultant dermatologist from another Trust or by a general physician and supported by a consultant dermatologist?
- If none of these; are they being supervised by a general physician (this is not recommended by the BAD[13]) ?

	National Audit (56 with a stated number of dedicated adult beds)	
	%Yes	N
6.2 Are they under the supervision of		
(a) Their own consultant dermatologist?	93	52
(b) Consultant dermatologist from another trust?		1
(c) General physician with consultant dermatology backup		7
(d) General physician?		0

Ninety-three percent (52) of the 56 units with dedicated beds had these supervised by their own consultant dermatologist, 1 (of 52) jointly supervised with a consultant from another Trust and 3 (of 52) jointly with a general physician. The four units with dedicated beds not run by their own consultant dermatologist had them supervised by a general physician with consultant dermatologist backup. None of the units were supervised only by a general physician without any consultant dermatologist backup.

Of the other 18 units with access to dedicated beds but with no number stated, 7 units said these were under the supervision of their own consultant dermatologist and 11 by a general physician with consultant dermatologist backup.

Location of dedicated adult beds

∞ All dermatologists should have admitting rights to a dedicated inpatient dermatology unit staffed by trained specialist nurses. Dedicated inpatient beds, some with facilities for reverse barrier nursing, are also required for patients with severe and life-threatening skin conditions. Another option of care is that dermatology inpatient care is delivered in a combined joint dermatology / rheumatology unit. Dermatology beds in general medical wards are satisfactory only if there are suitable facilities for bathing and treatment, and if patients receive their care from specialist dermatology nurses. This is less ideal than a specific dermatology inpatient unit. Where are the beds located in your Trust?

	National Audit (56 with a stated number of dedicated adult beds)	
	%Yes	N
6.3 Are they in a:		
(a) Dermatology ward	43	24*
(b) Rheumatology/dermatology unit	16	9
(c) Medical ward – protected	23	13
(d) Medical ward – unprotected	29	16

Note that a blank response was taken as NO and that multiple responses were possible.

*3 units answered Yes to both a) and b) above and 1 unit to a), b) and c).

Other than the 24 units with adult beds located in a dermatology ward, 5 units stated beds were only in a joint dermatology / rheumatology only, 11 only in a protected medical ward only, 15 only in an unprotected medical ward and one in protected and unprotected medical ward settings.

Of the other 18 units with access to dedicated beds but with no number stated: 2 units stated these beds were available on a dermatology ward and 16 on an unprotected medical ward.

Paediatric beds

∞ Dedicated dermatology beds for children are prefered[13]. Another option of care is that dermatology inpatient care is delivered in a combined joint paediatric dermatology / rheumatology unit. Dermatological beds in general medical wards are satisfactory only if there are suitable facilities for bathing and treatment, and if patients receive their care from specialist dermatology nurses. This is less ideal than a specific paediatric dermatology inpatient unit. What exists in your Trust?

∞ Some Trusts provide dedicated dermatology beds only during the working week. Beds must be available for ill patients 7 days a week[13]. If you have a 5 day week dermatology unit, do beds exist for children and adults at the weekend?

	National Audit (100)	
	%Yes	N
6.4 Are paediatric beds available for psoriasis in your trust?	75	73/97

62 units stated they had both adult and paediatric beds available, 12 adult only and 11 paediatric only.

	National audit (73 with access)	
	Median	Inter-quartile Range
6.4 How many paediatric beds are available for psoriasis in your trust?	0	0-2

Having stated they had paediatric beds available, 43 of the 73 units then indicated they had no beds or gave no answer. 22 sites had 1-4 beds, 3 had 5-9 beds and 1 had ten or more beds. In addition 2 sites said ‘as required’, 1 site said ‘unrestricted’ and 1 site said ‘ad-hoc’. The 43 units with no stated number of beds perhaps don’t have any specific number but were able to call upon a bed if required on demand. For the 26 who stated they had 1 or more beds then the median number of beds was 2, IQR 2-4.

Location of available paediatric beds

If Q6.4 =YES (paediatric beds available for psoriasis in trust)	National Audit (73 with beds available)	
	%Yes	N
(a) Dermatology ward	-	0/69
(b) Rheumatology/dermatology	1	1/69
(c) Medical ward - protected	10	7/69
(d) Medical ward - unprotected	90	62/69

Paediatric beds were predominantly unprotected in medical wards. None were in dermatology wards.

Of the 26 units who stated they had one or more beds, 1 had beds available on a joint rheumatology ward, 4 protected on a medical ward and 21 unprotected on a medical ward.

If Q6.4 =YES (paediatric beds available for psoriasis in trust)	National Audit (73 with beds available)	
	%Yes	N
Q6.5 Do these beds have associated adequate bathing and showering		
(a) for adults	68	48/71
(b) for children	87	61/70

46 units had adequate bathing and showering facilities for both adults and children, 15 for children only, and 2 for adults only. 10 units either had neither (7) or did not respond (3).

If Q6.4 =YES (paediatric beds available for psoriasis in trust)	National Audit (73 with beds available)	
	%Yes	N
Q6.6Are they available only during the working week, i.e. must patients go home or be transferred elsewhere at weekends?		
a) for adults	14	9/66
b) for children	1	1/68

1 unit had working week facilities for both adults and children, 8 for adults only. It is assumed therefore that most units had weekend facilities as well as week day facilities.

DERMATOLOGY NURSES

- Dedicated dermatology nurses are essential to any service. In main units they may specialise as well as using their core skills in outpatient clinics, day treatment units and inpatient units. It is essential that experienced dermatology nurses look after dermatology patients to ensure that they receive effective and sympathetic care[13]. These treatment standards apply to the care of adults and children. Patient self-application is not recommended and care by untrained dermatology nurses falls below standard. What is the situation in your Trust?

	National Audit (100)	
	%Yes	N
6.7 Which of the following do dermatology in-patients receive care from most of the time?		
(a) Specialist dermatology nurses	34	30/87
(b) Applied by nurses trained in dermatology	40	35/87
(c) Applied by nurses untrained in dermatology	37	32/87
(d) Patient self applies	28	24/87

Multiple responses were given. In 34% of units (30/87) a specialist dermatology nurse was giving treatment for most of the time. In a further 25% (24/87) treatment was being applied most of the time by trained nurses. Thus in 41% (36/87) care was being applied most of the time only by nurses untrained in dermatology or by the patients themselves.

	National Audit (100)	
	%Yes	N
6.8 Are your specialist dermatology nurses available to give advice on the care of in-patients who develop skin problems on other wards?		
(a) For adults?	89	79/89
(b) For children	82	73/89

OUTPATIENT FACILITIES

- The minimum should be a defined set of rooms where the dermatology clinic is always held[13]. This should include trained dermatology nurses, led by a dermatology specialist nurse, with rooms for treatment application and education. Access to a medical photographer should be available at all times[13]. There should also be an identified paediatric area, or access to a paediatric department for paediatric dermatology clinics. Do these facilitates exist in your Trust?

	National Audit	
	%Yes	N
7.1 In your outpatient clinic do you have access to:		
(a) A dedicated dermatology outpatient area?	70	68/97
(b) Trained dermatology nurses	88	85/97
(c) A dermatology nurse specialist?	80	76/95
(d) Rooms with facilities for applying topical treatments?	74	71/96
(e) Medical photography services?	77	75/97
(f) Access to a paediatric outpatient area	60	58/96

SPECIALIST OUTPATIENT CLINICS

- Good practice for the complex psoriasis patient includes the provision of dedicated clinics for psoriasis patients.
- Good practice for patients with psoriatic arthritis is for them to be managed in joint clinics with rheumatologists. Such combined clinics can offer patients the benefits of extra expertise and 'one-stop' facilities[13].
- A number of systemic treatments for psoriasis require monitoring of various blood and physiological parameters[4].
- Psoriasis produces stress and psychological disturbance in many adults and children, some of whom can benefit from psychological help.
- Dermatology nurses have the potential to underpin long-term condition management, improve the quality of life of patients with chronic skin disease and promote a pattern of integrated service delivery across sectors[18].

Does your Trust offer or have access to some or all of the above services?

	National Audit (100)	
	%Yes	N
7.2 Specialist Outpatient Clinics / Services. Do you offer or have access to:		
(a) Dedicated clinics for patients with psoriasis?	21	21/98
(b) Multidisciplinary clinics run jointly by rheumatologists and dermatologists to discuss the management of patients with psoriasis and psoriatic arthritis?	23	23/98
(c) Systemic drug monitoring clinics?	45	43/95
i) Run by consultant		20
ii) Run by nurses		33
iii) Run by trainee staff		7
iv) Run by associate specialist / staff grade		4
(d) A clinical psychology service willing to accept dermatology patients for:		
i) Children	41	38/93
ii) adults	44	39/88
(e) Nurse-led clinics for patients with psoriasis?	60	58/96
(f) Paediatrically-trained dermatology nurses?	36	35/96

Only 21% (21) of units had outpatient clinics dedicated to psoriasis, and 6 of these also ran a clinic jointly with rheumatologists. A further 17% (17) ran a clinic jointly with rheumatologists.

Systemic disease clinics were consultant led in 20/43 and 12 of these also ran nurse-led clinics. A further 21 also ran nurse-led clinics. 2 of the 4 run by associate specialist or staff grade were also run by a consultant, another also by a nurse and 1 by an associate specialist or staff grade only

- A flexible appointment system is considered good practice, allowing patients with flare of their psoriasis to be seen at short notice, instead of waiting until their next scheduled review appointment[14].

Does your Trust offer this, and if yes is it through doctor or nurse led clinics?

	National Audit (100)	
	%Yes	N
7.3 Can patients' self-refer (SOS appointment) to clinic?		
(a) Doctor based clinic	46	45/97
(b) Nurse led clinic	55	52/94

In 36 units patients could self-refer to both doctor and nurse led clinics, in 9 only to doctor led clinics, in 16 only to nurse led clinics and in 36 to neither, unknown for 3 units.

DAY-CARE CENTRES FOR PSORIASIS.

∞ Broad band UVB radiation in the waveband 290-320 nm, or narrow band UVB 311nm are an effective treatment of plaque psoriasis resistant to topical therapy and should be delivered by day care centres by dermatology units[14,16]. Broad-band UVB, narrow band UVB, PUVA, bath-PUVA and topical hand/foot PUVA should be available. Which of these are provided by your Trust?

∞ With decreasing bed numbers day care topical therapy should be available for chronic psoriasis patients[14]. Which treatments are available in your Trust?

	National Audit (100)	
	%Yes	N
8.1 In your day–care unit do you offer:		
(a) Broad-band UVB?	26	24/94
(b) Narrow-band UVB (TL01)?	92	89/97
(c) PUVA?	90	86/96
d) Bath-PUVA?	71	66/93
(e) Topical (hand/foot) PUVA?	92	88/96
(f) Dithranol treatment outpatients – short-contact i.e. washed off?	63	60/95
(g) Dithranol treatment outpatients – long- contact?	45	42/94
(h) Tar treatment for outpatients (day-care)?	54	51/95
(i) Scalp treatment outpatients (day-care)?	74	70/95
(j) Education about how to apply treatments?	92	88/96

∞ Phototherapy units are increasingly run by specialist nurses who take responsibility for the day to day supervision of the delivery of care, monitoring of patient responses and the assessment of side effects[14,16]. Does your Trust provide dermatology day-care staffed by trained dermatology nurses?

∞ Access should be provided during the daytime, but also after hours and at weekends[14]. For patient convenience, is this offered out of hours by your Trust?

∞ Within main units, dermatology nurses run day treatment units, supervising on-going management in chronic diseases such as psoriasis[14]. Such management includes out-patient topical therapies (8.4) Are these provided in your Trust?

All phototherapy should be administered according to the following guidelines:

• A senior clinician, usually a consultant, with adequate training and a continuing interest in phototherapy and/or photochemotherapy should supervise the service

• An individual patient's course of therapy should be supervised by an adequately trained person (e.g. a doctor, nurse or physiotherapist)

• All phototherapy equipment should be adequately maintained and regularly calibrated by a defined medical physics service

- Accurate records of the dosage and number of treatments, for each patient, must be maintained

- Neither UVB nor PUVA should be used as permanent maintenance therapy unless alternative topical therapies have proved ineffective

Are these guidelines being adhered to in your Trust[14,16]?

	National Audit (100)	
	%Yes	N
8.2 Do you have a day-care unit staffed by trained dermatology nurses?	74	72/97
8.3 During what hours do you offer out-patients phototherapy (UVB or PUVA):		
(a) 7.00am-9.00am (= pre-work)?	63	60/95
(b) 9.00am-12.00 (= mornings)?	96	91/95
(c) 12.00-5.00 (= afternoons)?	87	82/94
(d) 5.00pm-9.00pm (= evenings)?	34	32/93
8.4 During what hours do you offer out-patients topical treatments		
(a) 7.00am-9.00am (= pre-work)?	35	31/88
(b) 9.00am-12.00 (= mornings)?	74	67/90
(c) 12.00-5.00 (= afternoons)?	71	64/90
(d) 5.00pm-9.00pm (= evenings)?	26	22/86
8.5 Is the phototherapy unit supervised by a named consultant?	69	66/95
8.6 Are cumulative doses of UVR recorded in medical records?	100	95/95
8.7 Does a medical physicist monitor UV output of units?	95	90/95
8.8 Is phototherapy run by dermatology nurses*	93	88/95
8.9 Is phototherapy run by physiotherapists*	11	10/94

***** run by both for 3 sites

	National audit (100)		
	Median	Inter-quartile Range	N of sites
8.10 What is average waiting time for phototherapy (weeks)?			
(a) UVB (broad-band or narrow-band)	2	1-4	97
(b) PUVA	2	0-3	97

The average wait for UVB phototherapy was 4 weeks for 14 units and longer than 4 weeks for 19 units. The average wait for PUVA was 3 weeks for 11 units, 4 weeks for 8 units and longer for 11.

	National Audit (100)	
	%Yes	N
8.11 Can a GP or GPSI refer directly for treatment with UVB/PUVA?	18	17/93

	National audit (100)		
	Median	Inter-quartile Range	N of sites
8.12 No. of courses of narrow-band UVB (TLO1) given for psoriasis over last financial year (April to March):	158	97-251	52
8.13 No. of courses of broad-band UVB given for psoriasis Total number of attendances over last financial year	58	10-174	10
8.14 No. of courses of PUVA given for psoriasis over last financial year	25	15-55	47
8.15 Total number of attendances over last financial year	3410	1644-6105	54
8.16 How many patients "did not attend" / failed to complete a course of UVB/PUVA over last financial year?	12	6-27	31
8.17 How many patients with palmoplantar pustulosis attended over last financial year			
(a) for topical PUVA	13	6-21	38
(b) for systemic PUVA?	5	2-10	15
8.18 How many dermatology patients attended for any type day-care medical treatment e.g. tar, topical steroids, dithranol, scalp treatment (excluding phototherapy, wound care or surgery)?	486	48-1850	40
8.19 How many patients with psoriasis attended for day care treatment (excluding phototherapy)? Total number of attendances over last financial year	84	18-270	29

28 units stated both the total number of patients attending for day-care treatment (Q8.18) and the number of psoriasis patients doing so (Q8.19). For these units the median number of total patients was 332 and the median number of psoriasis patients was 92. The median ratio of 'total' to 'psoriasis' patients was 2.2, Inter-Quartile range 1.5-7.0

	National Audit (100)	
	%Yes	N
8.20 Can patients' self-refer (SOS appointment) to the day care centre for treatment when their psoriasis flares	24	21/86

BIOLOGIC THERAPIES

- Biologic therapies were licensed in 2004 in the UK for patients with moderate to severe psoriasis. These new treatments are relatively expensive and long-term toxicity is uncertain. Strict guidelines have been developed to ensure that this new class of therapy is introduced in a systematic and planned way to achieve the greatest possible benefit to people with psoriasis and to facilitate safe and effective prescribing as advised by the BAD[6].

- The guideline group sought to provide useful, evidence-based guidance based on systematic review of available literature, but acknowledges that additional funding may be required to implement the recommendations fully.

- With additional training a nurse may take responsibility for a number of the tasks outlined in the patient pathway including screening, treatment administration, patient education, prescription coordination for home drug delivery, patient support, monitoring and data collection, e.g. PASI.

	National Audit (100)	
	%Yes	N
9.1 Do you prescribe biological interventions? If no, proceed to question 10	73	73/97
If YES to Q9.1 (Do you prescribe biological interventions), do you adhere to:		
9.2 BAD guidelines	98	64/65
9.3 NICE guidelines	94	63/67
9.5 Are you restricted in prescribing these agents because of lack of resources?	39	28/71
9.6 If yes (9.5), is this based on financial restriction?	100	28/28
9.7 Is your resource hospital based (e.g. day care facilities)?	69	40/58
9.8 Availability to receive finance for the drugs through PCT / Health care commissioning?	91	52/57
9.9 Do you have a nurse trained in the assessment and administration of biologicals to aid you in your unit?	64	45/70
9.10 Do you have facilities for outpatient infusions e.g. for Infliximab?	71	50/70
9.11 Are these facilities shared with other medical specialties e.g. rheumatology, gastroenterology?	57	36/63

	National audit (73 units prescribing biologicals)		
	Median	Inter-quartile Range	N of sites
9.4 No. of patients with psoriasis who received biologicals in last financial year?	5	3-8	61

61 units prescribed biologic therapies to between 1 and 79 patients (total 545) in the year. Thirty-nine percent of these (215) were from 4 units who prescribed biologic therapies to 20 or more patients.

OUTPATIENT ACTIVITY DATA FOR THE LAST FINANCIAL YEAR

	National Audit (100)	
	%Yes	N
10.1 Do you collect diagnostic data on outpatients?	23	23/98

Data for last financial year	National audit (23)		
	Median	Inter-quartile Range	N of sites
If YES to 10.1 (collects diagnostic data on outpatients):			
(a) No. of new patient clinic attendances for psoriasis	212	112-362	18
(b) No. of review patient clinic attendances for psoriasis	969	693-1396	12
(c) No. of patients admitted with psoriasis?	33	3-75	12
(d) Average length of stay of an in-patient with psoriasis?	14	13-15	14
(e) Maximum length of stay of an in-patient with psoriasis?	31	21-40	11

Many of the units could not supply these data. For the 12 units with data for both new and review attendances the median ratio of review to new was 4.0.

	National Audit (100)	
	%Yes	N
10.3 If you had the inpatient or day case facilities staffed by trained nurses would you use more crude coal tar?	38	29/77
10.4 If you had the inpatient or day case facilities staffed by trained nurses would you use more topical dithranol?	46	36/78

RECORD KEEPING

- Components involved in the assessment of severity should include the patient's disability (as measured by tools such as the Dermatology Life Quality index (DLQI)), the need for treatment, an objective assessment of extent and severity of disease (as assessed by PASI score or body surface area affected). Management should take patients' views into account. It is helpful to record the patient's view of the most upsetting aspect of their psoriasis[9,10,11].

	National Audit (100)	
	%Yes	N
11.1 Is a Quality of life score recorded e.g. DLQI? (a) In outpatient records?		93
Always recorded	2	2
Well recorded	3	3
Reasonably recorded	14	13
Not adequately recorded	42	39
Never recorded	39	36
11.1 Is a Quality of life score recorded e.g. DLQI? (b) In inpatient records?		88
Always recorded	2	2
Well recorded	1	1
Reasonably recorded	9	8
Not adequately recorded	42	37
Never recorded	45	40

	National Audit (100)	
	%Yes	N
11.2 Is a global assessment (mild/moderate/severe) of psoriasis recorded? (a) In outpatient records?		93
Always recorded	10	9
Well recorded	23	21
Reasonably recorded	31	29
Not adequately recorded	25	23
Never recorded	12	11
11.2 Is a global assessment (mild/moderate/severe) of psoriasis recorded? (b) In inpatient records?		88
Always recorded	13	11
Well recorded	20	18
Reasonably recorded	32	28
Not adequately recorded	20	18
Never recorded	15	13

	National Audit (100)	
	%Yes	N
11.3 Is the PASI recorded? (a) In outpatient records?		92
Always recorded	2	2
Well recorded	3	3
Reasonably recorded	15	14
Not adequately recorded	42	39
Never recorded	37	34
11.3 Is the PASI recorded? (b) In inpatient records?		87
Always recorded	3	3
Well recorded	5	4
Reasonably recorded	10	9
Not adequately recorded	37	32
Never recorded	44	39

EDUCATION, SELF MANAGEMENT & MONITORING

- Most patients with mild or moderate plaque psoriasis can be treated in primary care using topical therapies. Guidelines are in place for the support of primary care in the treatment of psoriasis[14,17]. Are such documents made available to the primary care team?

- NHS reforms require that more monitoring of chronic disease and monitoring of drug treatments are carried out in primary care. Are these being carried out in your locality?

	National Audit (100)	
	%Yes	N
12.1 Information for GPs. Do GPs have access to:		
(a) Protocols for referral of patients with psoriasis?	67	64/95
(b) Treatment guidelines for applying dithranol?	27	26/95
(c) Treatment guidelines for scalp applications?	32	30/95
(d) Shared-care protocols for patients taking acitretin?	12	11/93
(e) Shared-care protocols for patients taking methotrexate?	60	57/95
(f) Shared-care protocols for patients taking ciclosporin?	35	33/93

- Good quality information for patients helps with decision making, compliance and effective therapy. Are the following therapies being supplied by your Trust or are they locally available?
- The risks and benefits of systemic therapy should be clearly explained to the patient, both verbally and in writing. In addition to the patient information leaflet on this web-site the BAD have produced a hand held patient information leaflet for methotrexate that complies with the National Patient Safety Agency directives for safe use of this of therapy and a hand held patient record to facilitate patient monitoring[14,17]. Are these sources of information and monitoring being utilised in your Trust?

	National Audit (100)	
	%Yes	N
12.2 Do you offer patients:		
(a) Written information or booklets about psoriasis?	100	96/96
(b) Access to electronic information in the outpatient unit e.g. interactive computer programme about psoriasis?	17	16/96
(c) Written information about treatments and their use?	93	87/94
(d) A drug monitoring booklet or card?	92	87/95
(e) A written personal treatment plan?	32	30/95
(f) A letter after the consultation or a copy of the letter sent to the doctor?	40	37/93
(g) Access, free of charge, to a local psoriasis patient support group?	26	24/94
(h) Can patients telephone a specialist dermatology nurse for advice?	75	71/95

PHARMACY

- A pharmacy service should be able to meet the needs identified in the dermatology unit[14]. Does your unit provide the following services?

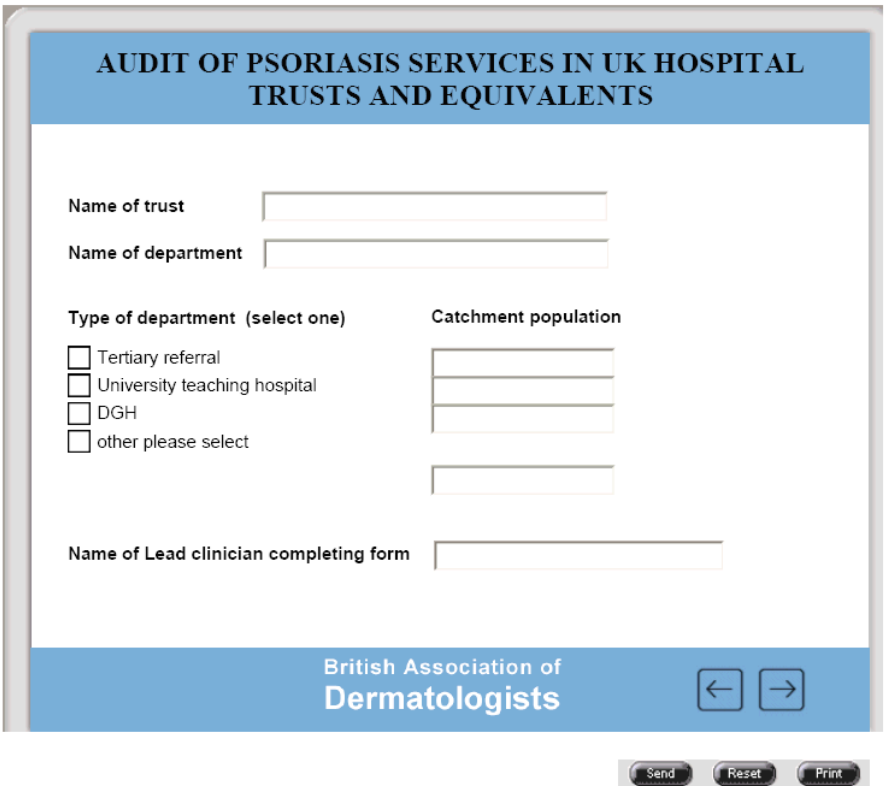
	National Audit (100)	
	%Yes	N
13 Pharmacy Provision:		
(a) Is your pharmacy quickly and readily willing to prepare or obtain dithranol in Lassar's paste (or equivalent) for treatment of in-patients?	62	56/91
(b) Is your pharmacy quickly and readily willing to prepare or obtain tar preparations for the treatment of in-patients?	66	58/88

REFERENCES

1. Griffiths CEM, Barker J.N.W.N. Pathogenesis and clinical features of psoriasis. *Lancet* 2007; 21; 370: 263-71.
2. Griffiths, CEM, Clark CM, Chalmers RJG, *et al.* Systematic review of treatments for severe psoriasis. Health Technology Assessment 2000; Vol. 4: No. 40 1-125. (Available at: http://www.ncchta.org/fullmono/mon440.pdf -- last accessed 29th December 2007).
3. Naldi L, Griffiths CEM. Traditional therapies in the management of moderate to severe chronic plaque psoriasis: an assessment of the benefits and risks. *Br J Dermatol* 2005;152: 597-615.
4. Menter A, Griffiths CEM. Current and future management of psoriasis. *Lancet* 2007; 21; 370: 272-84.
5. van de Kerkhof PC, Mrowietz U, Segaert S, Kragballe K. Comparative efficacy of topical antipsoriatic treatments, systemic treatment and biologics: is severity assessment beyond Psoriasis Area and Severity Index a necessity? *Br J Dermatol* 2007; 156: 771-2.
6. Smith CH, Anstey AV, Barker JN, Burden AD., *et al.* British Association of Dermatologists guidelines for use of biological interventions in psoriasis 2005. *Br J Dermatol* 2005; 153: 486-97.
7. Department of Health. Hospital Episode Statistics England (1998-2005). Available at: http://www.hesonline.nhs.uk?Ease?servlet?contentServer?siteID+1937&categoryID+2003 (last accessed 29th December 2007)
8. Woods AL, Rutter KJ, Gardner LS, *et al.* Inpatient management of psoriasis: a multicentre service review to establish national admission standards. *Br J Dermatol* 2008; in press.
9. McKenna SP, Cook SA, Whalley D., *et al.* Development of the PSORIQoL, a psoriasis-specific measure of quality of life designed for use in clinical practice and trials. *Br J Dermatol* 2003; 149: 323-31.10
10. Kirby B, Fortune DG, Bhushan M., *et al.* The Salford Psoriasis Index: an holistic measure of psoriasis severity. *Br J Dermatol.* 2000; 142: 728-32.
11. Hahn HB, Chuang TY. Using the Dermatology Index of Disease Severity (DIDS) to assess the responsiveness of dermatitis. *Clin Exp Dermatol.* 2006; 31: 19-22.
12. The NHS improvement plan: putting people at the heart of public services. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084516 (last accessed 29th December 2007).
13. Staffing and Facilities for Dermatological Units, British Association of Dermatologists, November 2006,: http://www.bad.org.uk/healthcare/service/Staffing_and_Facilities_for_Dermatological_Units_Nov_2006.pdf (last accessed 29th December 2007).

14. Psoriasis guidelines, 2006, British Association *of Dermatologi*sts http://www.bad.org.uk/healthcare/guidelines/psorintro.asp (last accessed *29th Decembe*r 2007).
15. Guidelines for management of patients with psoriasis. Workshop of the Research Unit of the Royal College of Physicians of London; Department of Dermatology, University of Glasgow; British Association of Dermatologists. *Brit Med J* 1991; 303: 829-35.
16. Taylor DK, Anstey AV, Coleman AJ, *et al.* Guidelines for dosimetry and calibration in ultraviolet radiation therapy: a report of a British Photodermatology Group workshop. *Br J Dermatol* 2002; 146: 755-63.
17. Burge, S. Recertification in the medical specialties: a way forward. Clin Med. 2007; 7: 232-4.
18. Models of Integrated Service Delivery in Dermatology Workforce Group Date: January 2007 http://www.bad.org.uk/healthcare/service/Service_Models_Final_(February_2007).pdf

APPENDIX 1. Questionnaire used for data collection



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

Name of trust

Name of department

Type of department (select one)

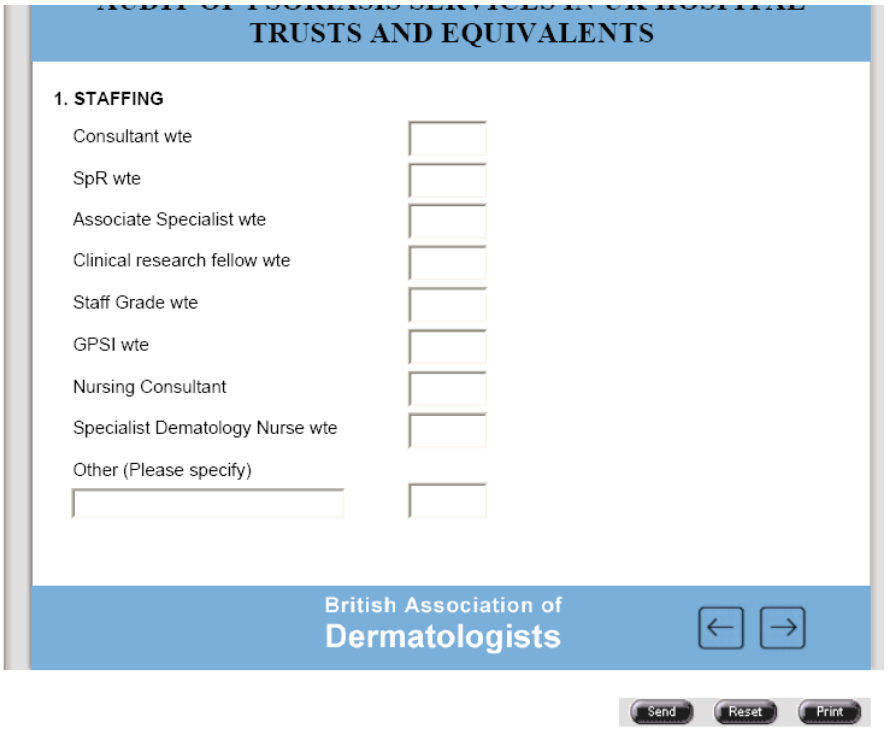
- Tertiary referral
- University teaching hospital
- DGH
- other please select

Catchment population

Name of Lead clinician completing form

British Association of Dermatologists

Send Reset Print



TRUSTS AND EQUIVALENTS

1. STAFFING

Consultant wte

SpR wte

Associate Specialist wte

Clinical research fellow wte

Staff Grade wte

GPSI wte

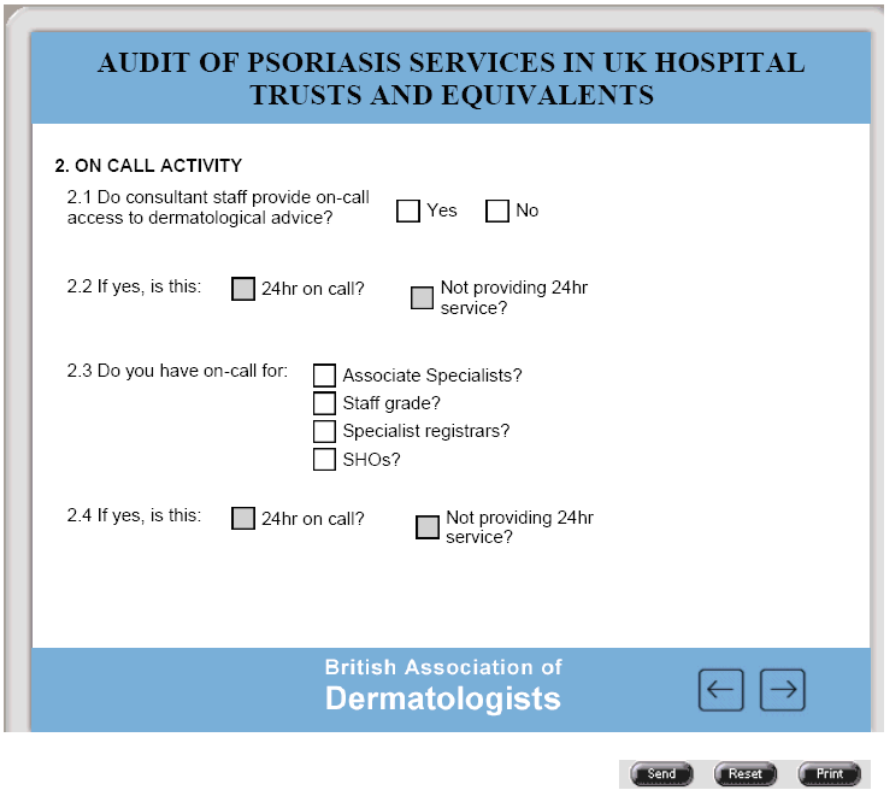
Nursing Consultant

Specialist Dematology Nurse wte

Other (Please specify)

British Association of Dermatologists

Send Reset Print



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

2. ON CALL ACTIVITY

2.1 Do consultant staff provide on-call access to dermatological advice? Yes No

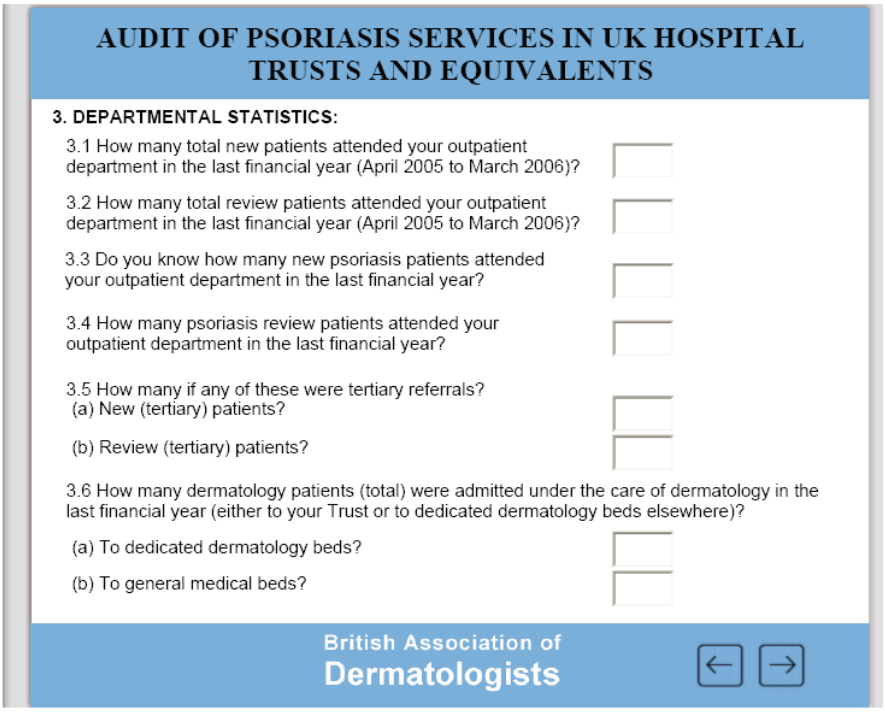
2.2 If yes, is this: 24hr on call? Not providing 24hr service?

2.3 Do you have on-call for: Associate Specialists? Staff grade? Specialist registrars? SHOs?

2.4 If yes, is this: 24hr on call? Not providing 24hr service?

British Association of Dermatologists

Send Reset Print



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

3. DEPARTMENTAL STATISTICS:

3.1 How many total new patients attended your outpatient department in the last financial year (April 2005 to March 2006)?

3.2 How many total review patients attended your outpatient department in the last financial year (April 2005 to March 2006)?

3.3 Do you know how many new psoriasis patients attended your outpatient department in the last financial year?

3.4 How many psoriasis review patients attended your outpatient department in the last financial year?

3.5 How many if any of these were tertiary referrals?
(a) New (tertiary) patients?

(b) Review (tertiary) patients?

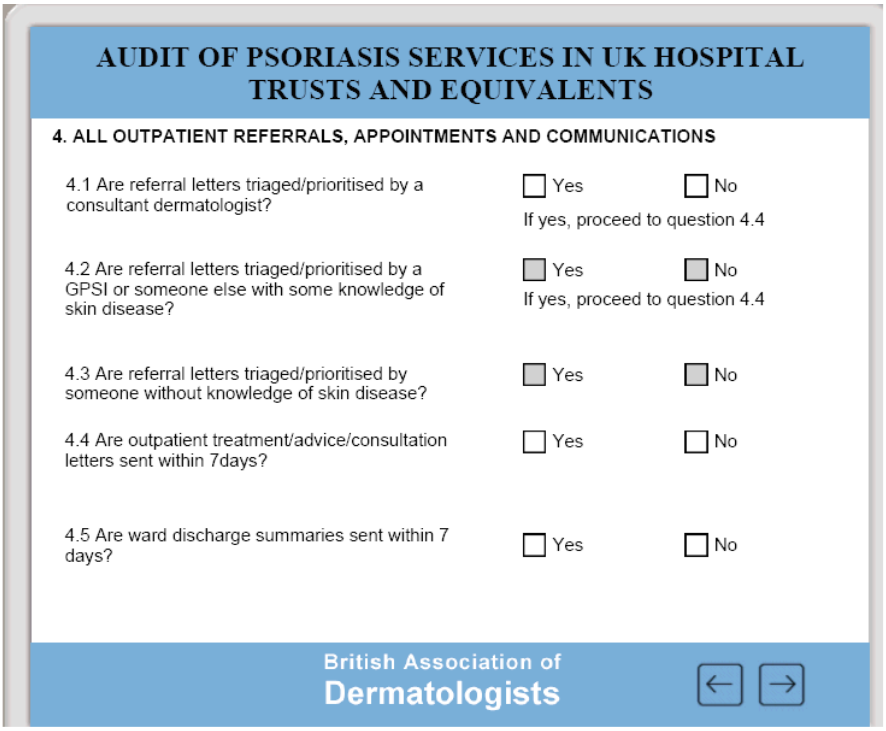
3.6 How many dermatology patients (total) were admitted under the care of dermatology in the last financial year (either to your Trust or to dedicated dermatology beds elsewhere)?

(a) To dedicated dermatology beds?

(b) To general medical beds?

British Association of Dermatologists

Send Reset Print



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

4. ALL OUTPATIENT REFERRALS, APPOINTMENTS AND COMMUNICATIONS

4.1 Are referral letters triaged/prioritised by a consultant dermatologist? ☐ Yes ☐ No
If yes, proceed to question 4.4

4.2 Are referral letters triaged/prioritised by a GPSI or someone else with some knowledge of skin disease? ☐ Yes ☐ No
If yes, proceed to question 4.4

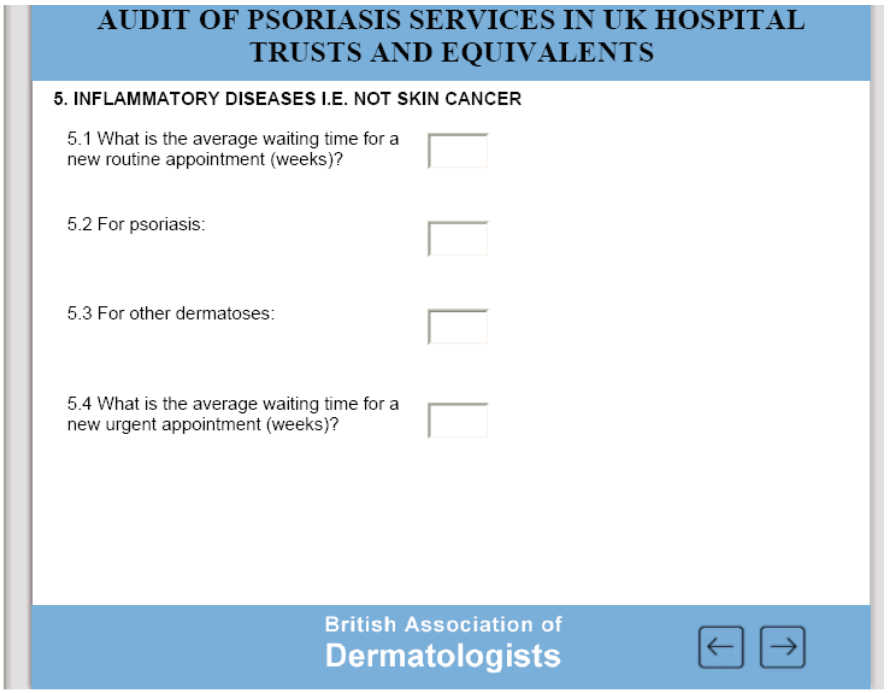
4.3 Are referral letters triaged/prioritised by someone without knowledge of skin disease? ☐ Yes ☐ No

4.4 Are outpatient treatment/advice/consultation letters sent within 7days? ☐ Yes ☐ No

4.5 Are ward discharge summaries sent within 7 days? ☐ Yes ☐ No

British Association of Dermatologists

Send Reset Print



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

5. INFLAMMATORY DISEASES I.E. NOT SKIN CANCER

5.1 What is the average waiting time for a new routine appointment (weeks)?

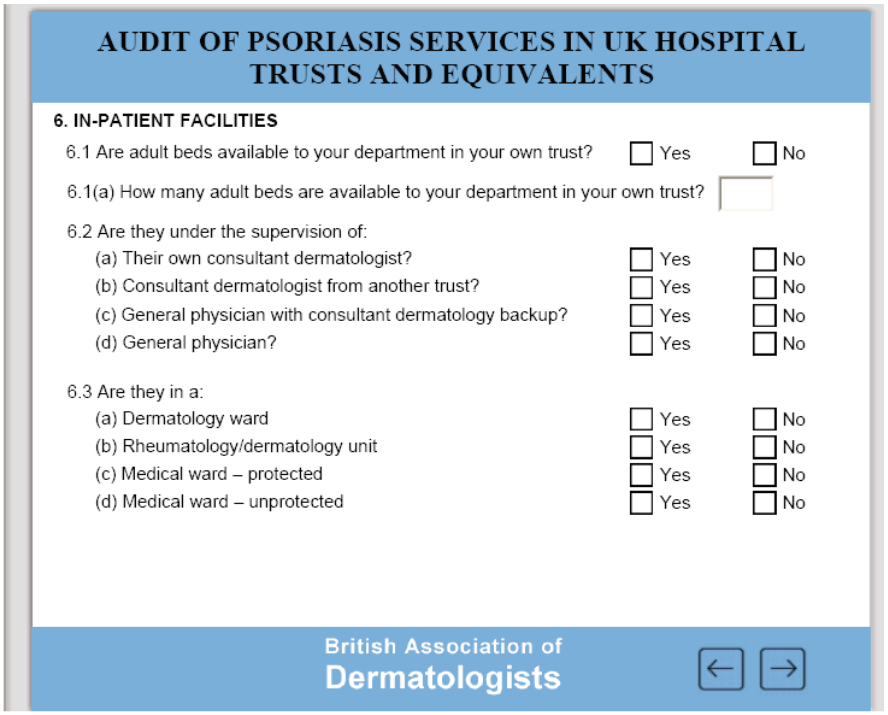
5.2 For psoriasis:

5.3 For other dermatoses:

5.4 What is the average waiting time for a new urgent appointment (weeks)?

British Association of Dermatologists

Send Reset Print



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

6. IN-PATIENT FACILITIES

6.1 Are adult beds available to your department in your own trust? Yes No

6.1(a) How many adult beds are available to your department in your own trust?

6.2 Are they under the supervision of:

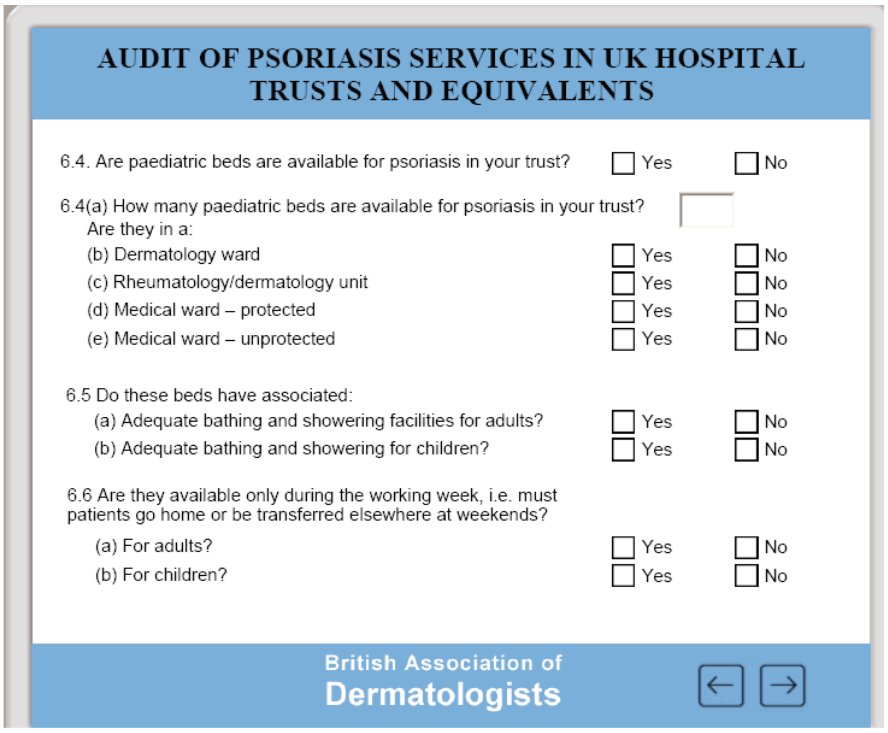
(a) Their own consultant dermatologist? Yes No
(b) Consultant dermatologist from another trust? Yes No
(c) General physician with consultant dermatology backup? Yes No
(d) General physician? Yes No

6.3 Are they in a:

(a) Dermatology ward Yes No
(b) Rheumatology/dermatology unit Yes No
(c) Medical ward – protected Yes No
(d) Medical ward – unprotected Yes No

British Association of Dermatologists

Send Reset Print



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

6.4. Are paediatric beds are available for psoriasis in your trust? ☐ Yes ☐ No

6.4(a) How many paediatric beds are available for psoriasis in your trust?

Are they in a:

(b) Dermatology ward ☐ Yes ☐ No

(c) Rheumatology/dermatology unit ☐ Yes ☐ No

(d) Medical ward – protected ☐ Yes ☐ No

(e) Medical ward – unprotected ☐ Yes ☐ No

6.5 Do these beds have associated:

(a) Adequate bathing and showering facilities for adults? ☐ Yes ☐ No

(b) Adequate bathing and showering for children? ☐ Yes ☐ No

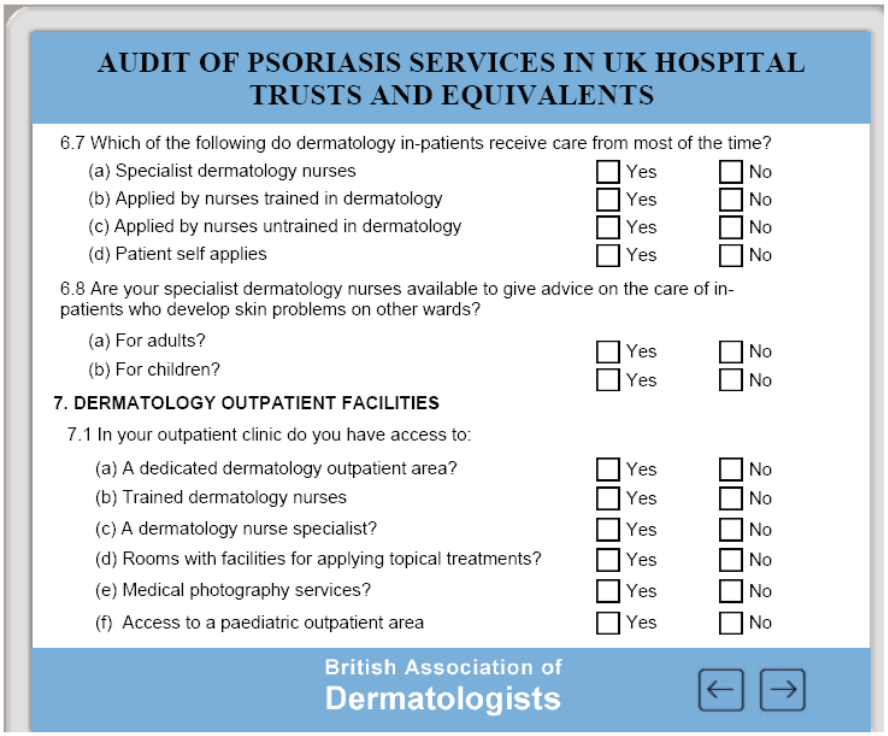
6.6 Are they available only during the working week, i.e. must patients go home or be transferred elsewhere at weekends?

(a) For adults? ☐ Yes ☐ No

(b) For children? ☐ Yes ☐ No

British Association of Dermatologists

Send Reset Print



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

6.7 Which of the following do dermatology in-patients receive care from most of the time?

(a) Specialist dermatology nurses ☐ Yes ☐ No

(b) Applied by nurses trained in dermatology ☐ Yes ☐ No

(c) Applied by nurses untrained in dermatology ☐ Yes ☐ No

(d) Patient self applies ☐ Yes ☐ No

6.8 Are your specialist dermatology nurses available to give advice on the care of in-patients who develop skin problems on other wards?

(a) For adults? ☐ Yes ☐ No

(b) For children? ☐ Yes ☐ No

7. DERMATOLOGY OUTPATIENT FACILITIES

7.1 In your outpatient clinic do you have access to:

(a) A dedicated dermatology outpatient area? ☐ Yes ☐ No

(b) Trained dermatology nurses ☐ Yes ☐ No

(c) A dermatology nurse specialist? ☐ Yes ☐ No

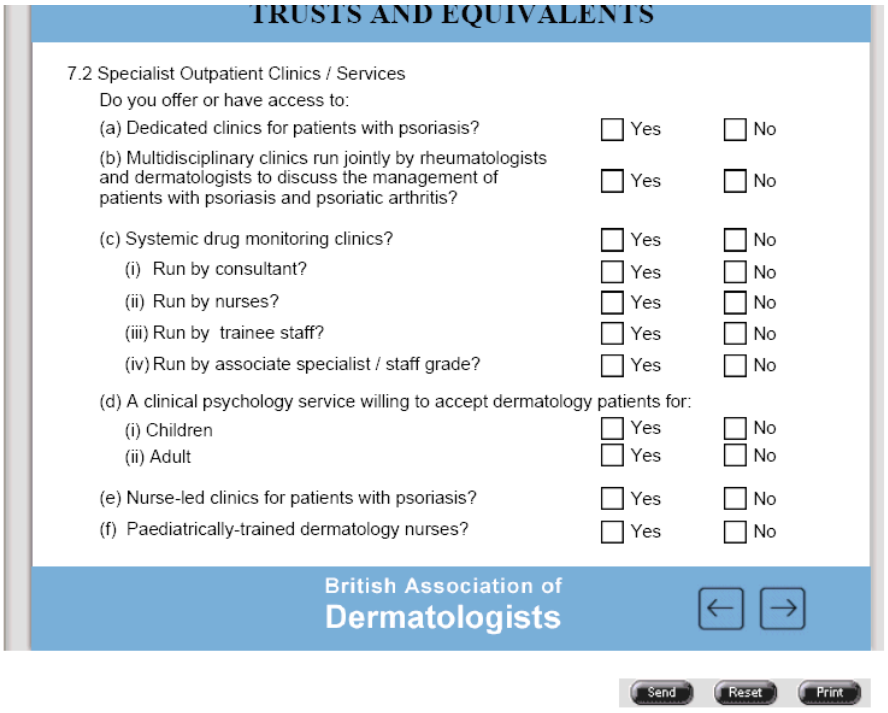
(d) Rooms with facilities for applying topical treatments? ☐ Yes ☐ No

(e) Medical photography services? ☐ Yes ☐ No

(f) Access to a paediatric outpatient area ☐ Yes ☐ No

British Association of Dermatologists

Send Reset Print



TRUSTS AND EQUIVALENTS

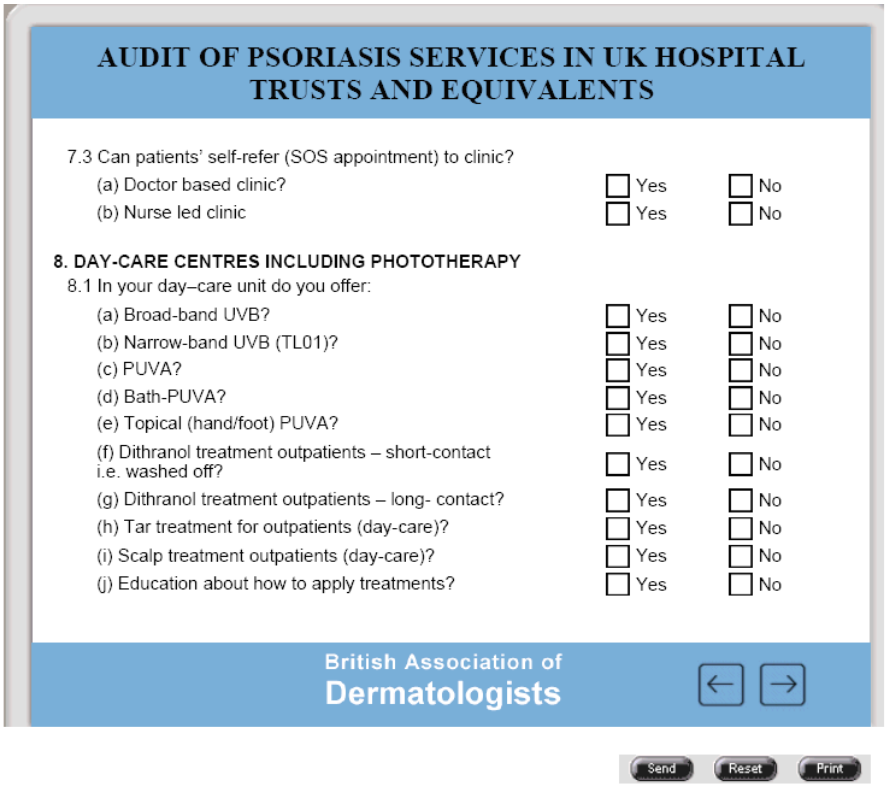
7.2 Specialist Outpatient Clinics / Services

Do you offer or have access to:

(a) Dedicated clinics for patients with psoriasis?	☐ Yes	☐ No
(b) Multidisciplinary clinics run jointly by rheumatologists and dermatologists to discuss the management of patients with psoriasis and psoriatic arthritis?	☐ Yes	☐ No
(c) Systemic drug monitoring clinics?	☐ Yes	☐ No
(i) Run by consultant?	☐ Yes	☐ No
(ii) Run by nurses?	☐ Yes	☐ No
(iii) Run by trainee staff?	☐ Yes	☐ No
(iv) Run by associate specialist / staff grade?	☐ Yes	☐ No
(d) A clinical psychology service willing to accept dermatology patients for:		
(i) Children	☐ Yes	☐ No
(ii) Adult	☐ Yes	☐ No
(e) Nurse-led clinics for patients with psoriasis?	☐ Yes	☐ No
(f) Paediatrically-trained dermatology nurses?	☐ Yes	☐ No

British Association of Dermatologists

Send Reset Print



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

7.3 Can patients' self-refer (SOS appointment) to clinic?

(a) Doctor based clinic?	☐ Yes	☐ No
(b) Nurse led clinic	☐ Yes	☐ No

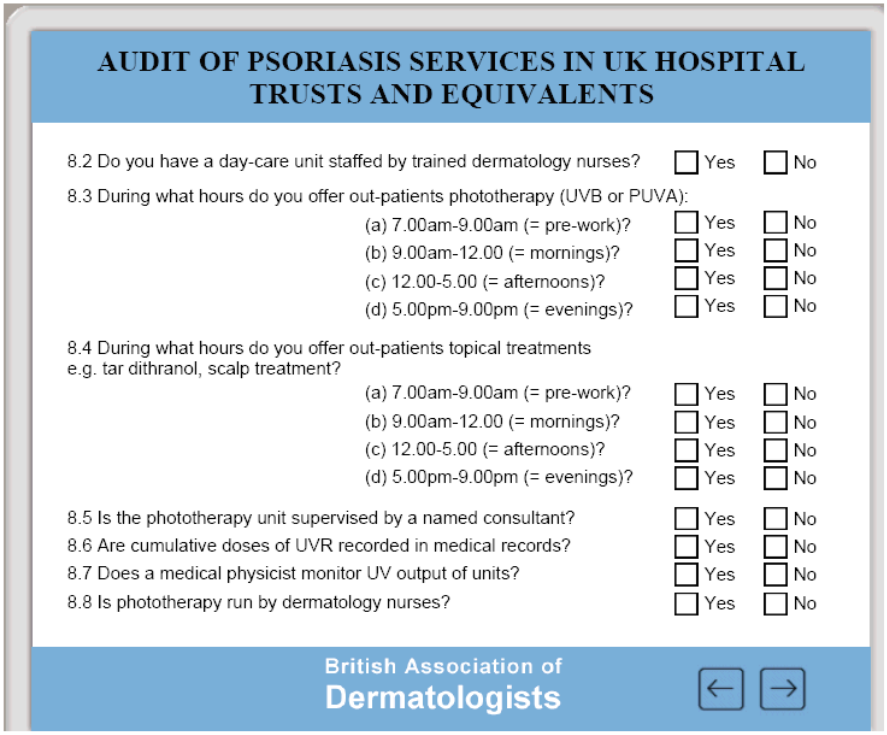
8. DAY-CARE CENTRES INCLUDING PHOTOTHERAPY

8.1 In your day–care unit do you offer:

(a) Broad-band UVB?	☐ Yes	☐ No
(b) Narrow-band UVB (TL01)?	☐ Yes	☐ No
(c) PUVA?	☐ Yes	☐ No
(d) Bath-PUVA?	☐ Yes	☐ No
(e) Topical (hand/foot) PUVA?	☐ Yes	☐ No
(f) Dithranol treatment outpatients – short-contact i.e. washed off?	☐ Yes	☐ No
(g) Dithranol treatment outpatients – long- contact?	☐ Yes	☐ No
(h) Tar treatment for outpatients (day-care)?	☐ Yes	☐ No
(i) Scalp treatment outpatients (day-care)?	☐ Yes	☐ No
(j) Education about how to apply treatments?	☐ Yes	☐ No

British Association of Dermatologists

Send Reset Print



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

8.2 Do you have a day-care unit staffed by trained dermatology nurses? ☐ Yes ☐ No

8.3 During what hours do you offer out-patients phototherapy (UVB or PUVA):

(a) 7.00am-9.00am (= pre-work)? ☐ Yes ☐ No
(b) 9.00am-12.00 (= mornings)? ☐ Yes ☐ No
(c) 12.00-5.00 (= afternoons)? ☐ Yes ☐ No
(d) 5.00pm-9.00pm (= evenings)? ☐ Yes ☐ No

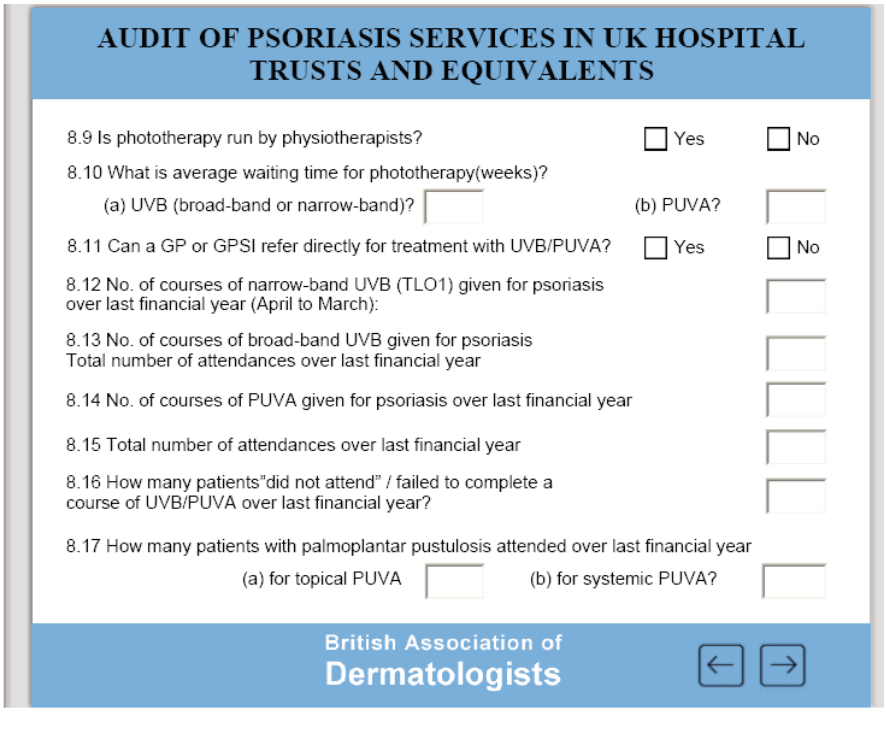
8.4 During what hours do you offer out-patients topical treatments e.g. tar dithranol, scalp treatment?

(a) 7.00am-9.00am (= pre-work)? ☐ Yes ☐ No
(b) 9.00am-12.00 (= mornings)? ☐ Yes ☐ No
(c) 12.00-5.00 (= afternoons)? ☐ Yes ☐ No
(d) 5.00pm-9.00pm (= evenings)? ☐ Yes ☐ No

8.5 Is the phototherapy unit supervised by a named consultant? ☐ Yes ☐ No
8.6 Are cumulative doses of UVR recorded in medical records? ☐ Yes ☐ No
8.7 Does a medical physicist monitor UV output of units? ☐ Yes ☐ No
8.8 Is phototherapy run by dermatology nurses? ☐ Yes ☐ No

British Association of Dermatologists

Send Reset Print



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

8.9 Is phototherapy run by physiotherapists? ☐ Yes ☐ No

8.10 What is average waiting time for phototherapy(weeks)?

(a) UVB (broad-band or narrow-band)? (b) PUVA?

8.11 Can a GP or GPSI refer directly for treatment with UVB/PUVA? ☐ Yes ☐ No

8.12 No. of courses of narrow-band UVB (TLO1) given for psoriasis over last financial year (April to March):

8.13 No. of courses of broad-band UVB given for psoriasis Total number of attendances over last financial year

8.14 No. of courses of PUVA given for psoriasis over last financial year

8.15 Total number of attendances over last financial year

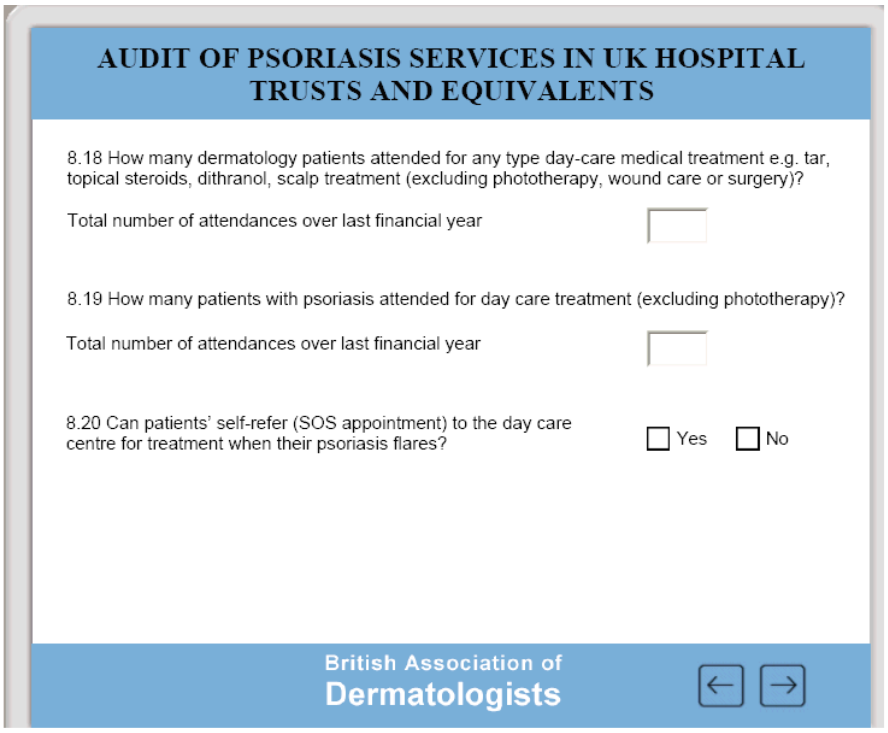
8.16 How many patients"did not attend" / failed to complete a course of UVB/PUVA over last financial year?

8.17 How many patients with palmoplantar pustulosis attended over last financial year

(a) for topical PUVA (b) for systemic PUVA?

British Association of Dermatologists

Send Reset Print



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

8.18 How many dermatology patients attended for any type day-care medical treatment e.g. tar, topical steroids, dithranol, scalp treatment (excluding phototherapy, wound care or surgery)?

Total number of attendances over last financial year

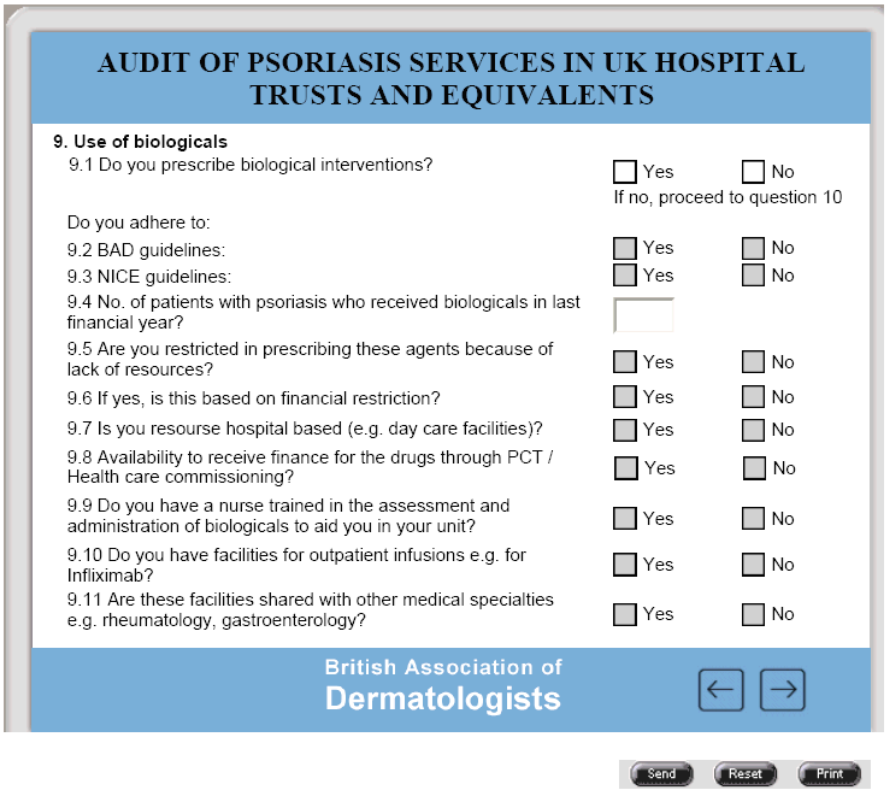
8.19 How many patients with psoriasis attended for day care treatment (excluding phototherapy)?

Total number of attendances over last financial year

8.20 Can patients' self-refer (SOS appointment) to the day care centre for treatment when their psoriasis flares? ☐ Yes ☐ No

British Association of Dermatologists

Send Reset Print



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

9. Use of biologicals

9.1 Do you prescribe biological interventions? ☐ Yes ☐ No
If no, proceed to question 10

Do you adhere to:

9.2 BAD guidelines: ☐ Yes ☐ No

9.3 NICE guidelines: ☐ Yes ☐ No

9.4 No. of patients with psoriasis who received biologicals in last financial year?

9.5 Are you restricted in prescribing these agents because of lack of resources? ☐ Yes ☐ No

9.6 If yes, is this based on financial restriction? ☐ Yes ☐ No

9.7 Is you resourse hospital based (e.g. day care facilities)? ☐ Yes ☐ No

9.8 Availability to receive finance for the drugs through PCT / Health care commissioning? ☐ Yes ☐ No

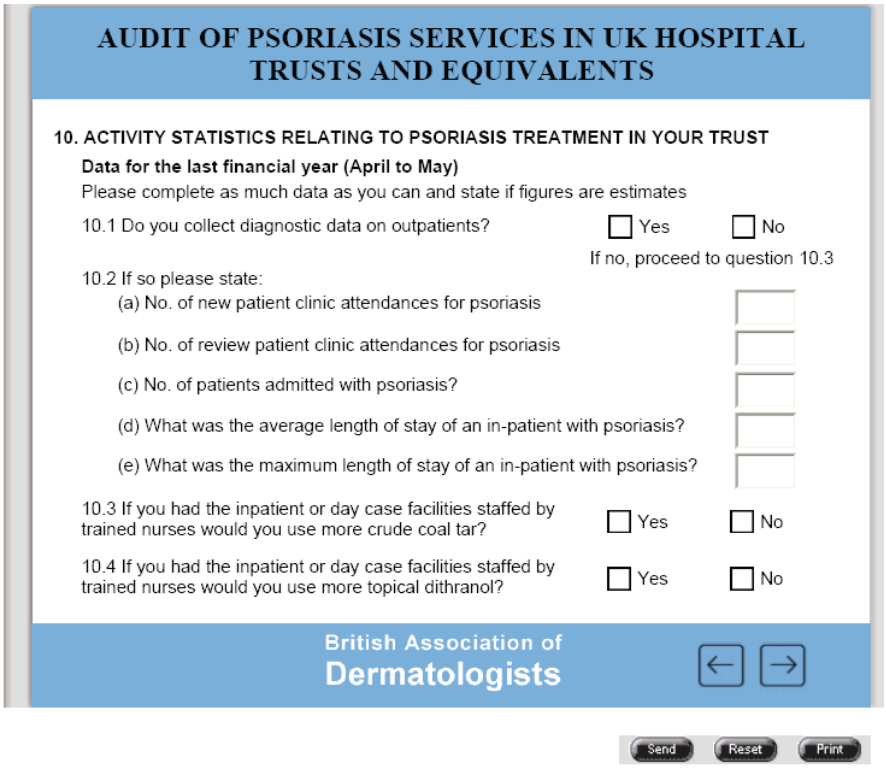
9.9 Do you have a nurse trained in the assessment and administration of biologicals to aid you in your unit? ☐ Yes ☐ No

9.10 Do you have facilities for outpatient infusions e.g. for Infliximab? ☐ Yes ☐ No

9.11 Are these facilities shared with other medical specialties e.g. rheumatology, gastroenterology? ☐ Yes ☐ No

British Association of Dermatologists

Send Reset Print



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

10. ACTIVITY STATISTICS RELATING TO PSORIASIS TREATMENT IN YOUR TRUST

Data for the last financial year (April to May)

Please complete as much data as you can and state if figures are estimates

10.1 Do you collect diagnostic data on outpatients? ☐ Yes ☐ No

If no, proceed to question 10.3

10.2 If so please state:

(a) No. of new patient clinic attendances for psoriasis

(b) No. of review patient clinic attendances for psoriasis

(c) No. of patients admitted with psoriasis?

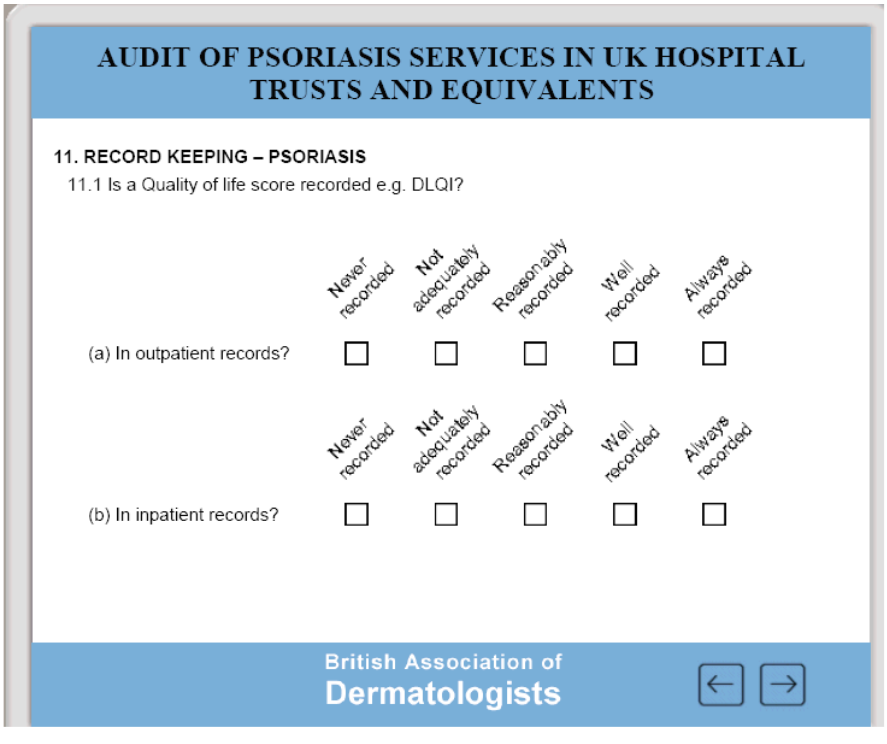
(d) What was the average length of stay of an in-patient with psoriasis?

(e) What was the maximum length of stay of an in-patient with psoriasis?

10.3 If you had the inpatient or day case facilities staffed by trained nurses would you use more crude coal tar? ☐ Yes ☐ No

10.4 If you had the inpatient or day case facilities staffed by trained nurses would you use more topical dithranol? ☐ Yes ☐ No

British Association of Dermatologists



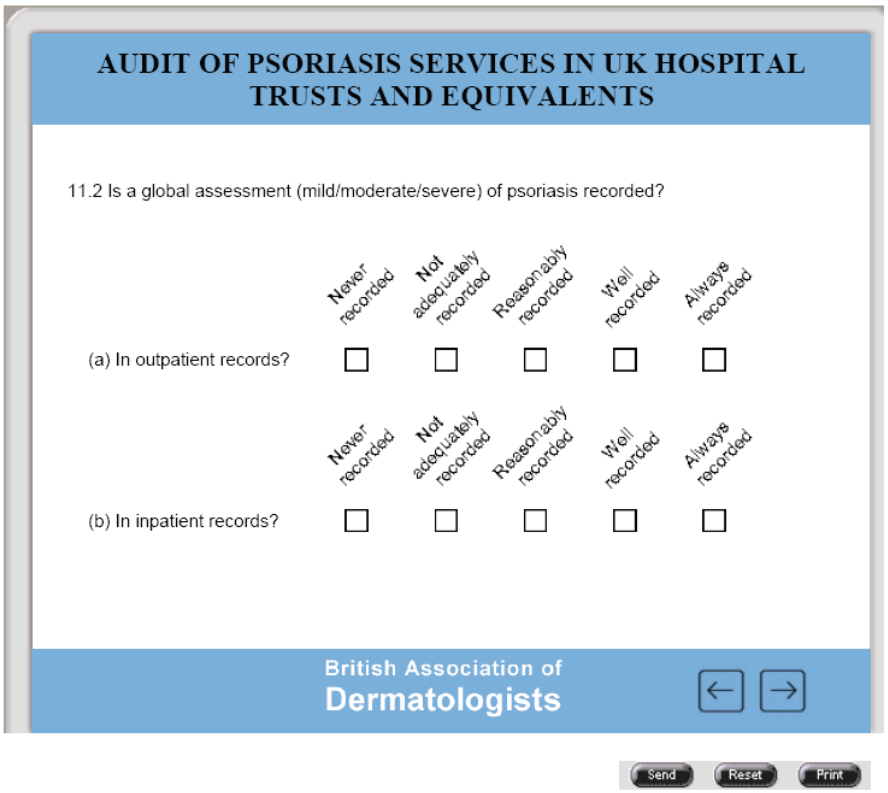
AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

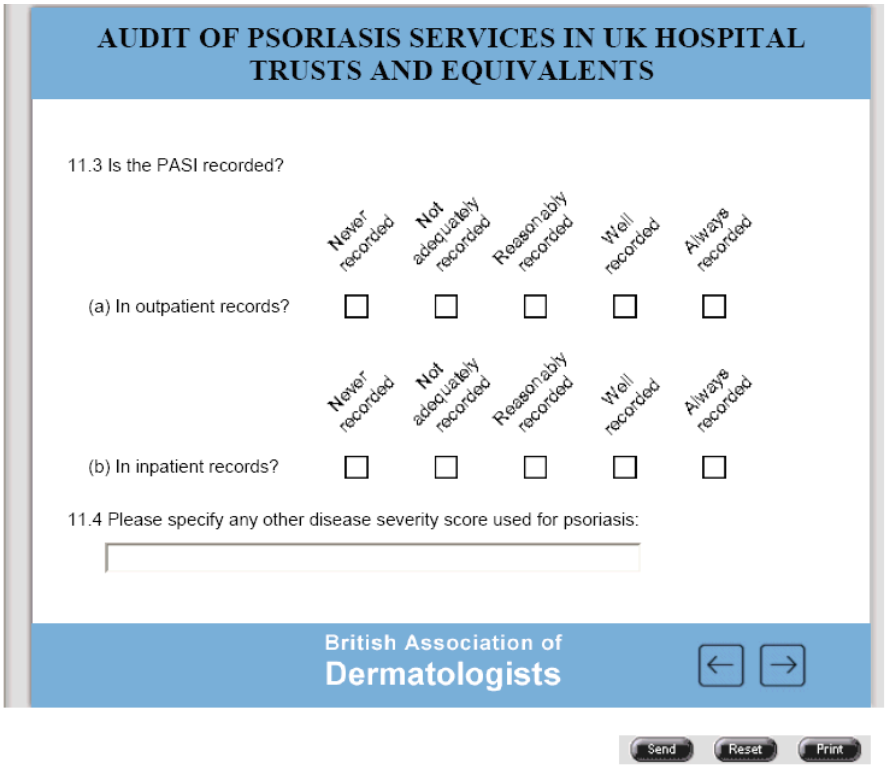
11. RECORD KEEPING – PSORIASIS

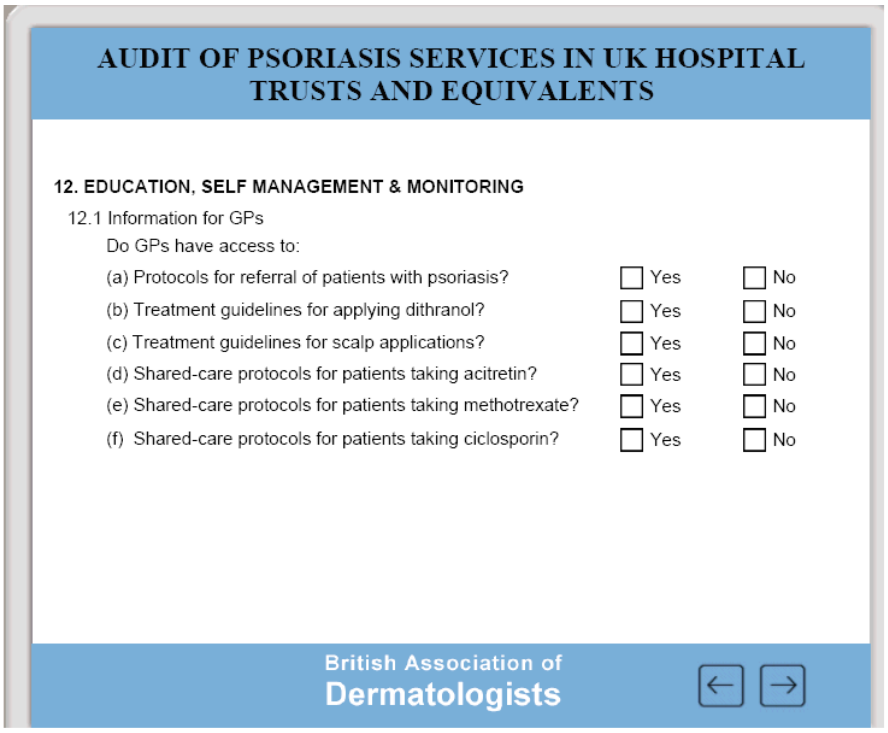
11.1 Is a Quality of life score recorded e.g. DLQI?

	Never recorded	Not adequately recorded	Reasonably recorded	Well recorded	Always recorded
(a) In outpatient records?	☐	☐	☐	☐	☐
(b) In inpatient records?	☐	☐	☐	☐	☐

British Association of Dermatologists


AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS
11.2 Is a global assessment (mild/moderate/severe) of psoriasis recorded?
Never recorded
Not adequately recorded
Reasonably recorded
Well recorded
Always recorded
(a) In outpatient records?
(b) In inpatient records?
British Association of Dermatologists
Send
Reset
Print


AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS
11.3 Is the PASI recorded?
Never recorded
Not adequately recorded
Reasonably recorded
Well recorded
Always recorded
(a) In outpatient records?
(b) In inpatient records?
11.4 Please specify any other disease severity score used for psoriasis:
British Association of Dermatologists
Send
Reset
Print



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

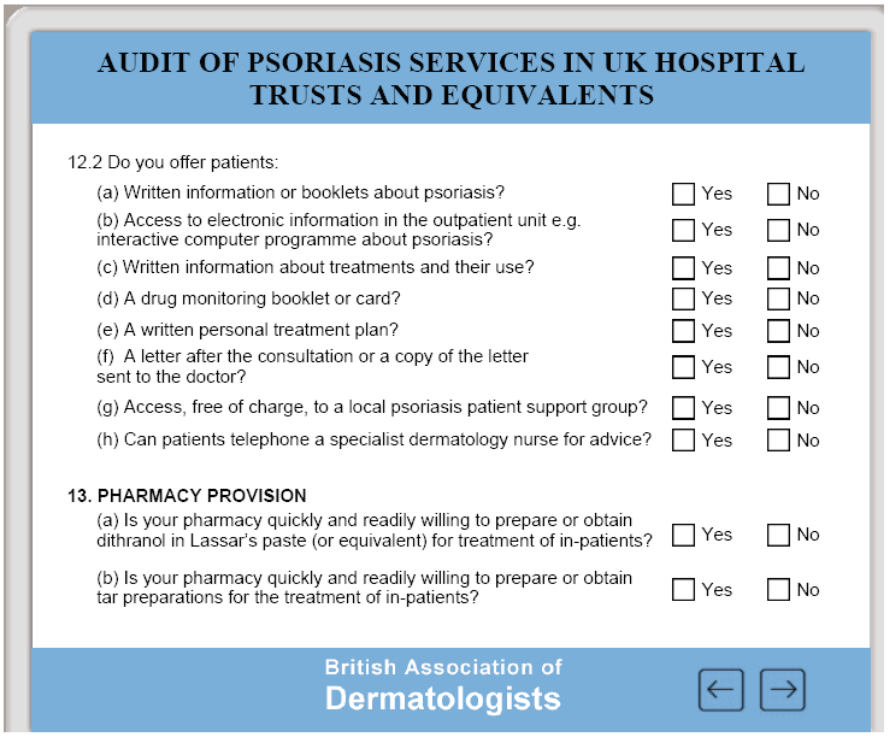
12. EDUCATION, SELF MANAGEMENT & MONITORING

12.1 Information for GPs

Do GPs have access to:

(a) Protocols for referral of patients with psoriasis?	☐ Yes	☐ No
(b) Treatment guidelines for applying dithranol?	☐ Yes	☐ No
(c) Treatment guidelines for scalp applications?	☐ Yes	☐ No
(d) Shared-care protocols for patients taking acitretin?	☐ Yes	☐ No
(e) Shared-care protocols for patients taking methotrexate?	☐ Yes	☐ No
(f) Shared-care protocols for patients taking ciclosporin?	☐ Yes	☐ No

British Association of Dermatologists



AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS

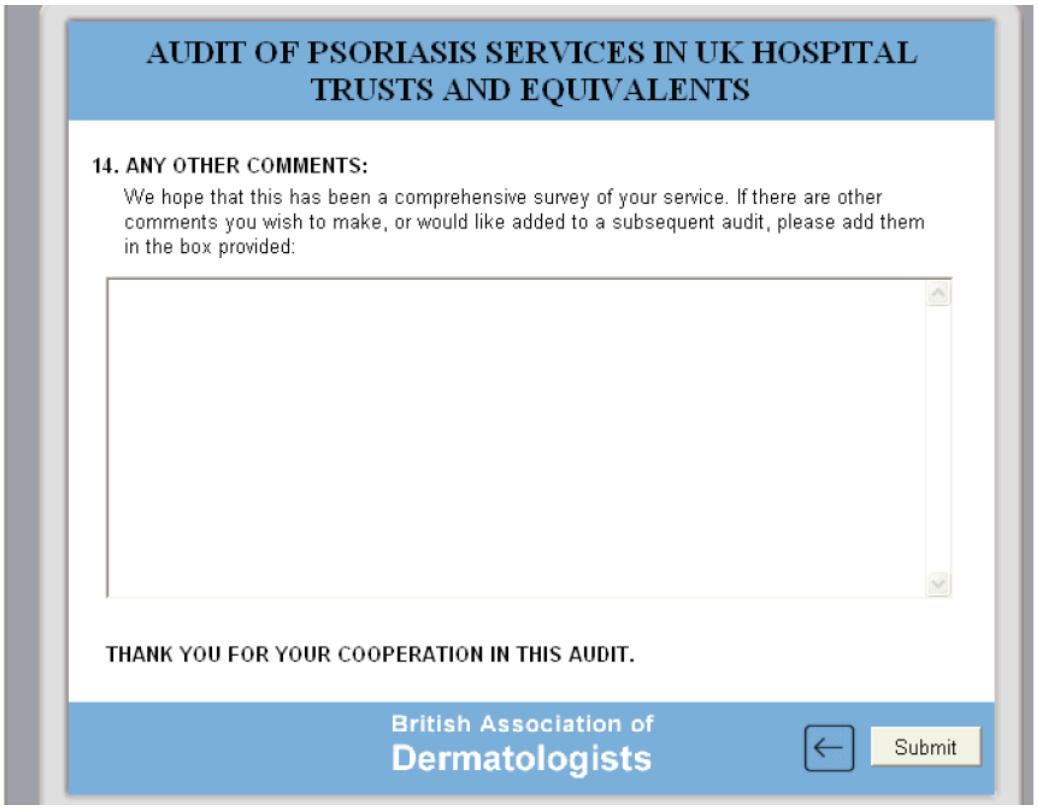
12.2 Do you offer patients:

(a) Written information or booklets about psoriasis?	☐ Yes	☐ No
(b) Access to electronic information in the outpatient unit e.g. interactive computer programme about psoriasis?	☐ Yes	☐ No
(c) Written information about treatments and their use?	☐ Yes	☐ No
(d) A drug monitoring booklet or card?	☐ Yes	☐ No
(e) A written personal treatment plan?	☐ Yes	☐ No
(f) A letter after the consultation or a copy of the letter sent to the doctor?	☐ Yes	☐ No
(g) Access, free of charge, to a local psoriasis patient support group?	☐ Yes	☐ No
(h) Can patients telephone a specialist dermatology nurse for advice?	☐ Yes	☐ No

13. PHARMACY PROVISION

(a) Is your pharmacy quickly and readily willing to prepare or obtain dithranol in Lassar's paste (or equivalent) for treatment of in-patients?	☐ Yes	☐ No
(b) Is your pharmacy quickly and readily willing to prepare or obtain tar preparations for the treatment of in-patients?	☐ Yes	☐ No

British Association of Dermatologists


AUDIT OF PSORIASIS SERVICES IN UK HOSPITAL TRUSTS AND EQUIVALENTS
14. ANY OTHER COMMENTS:
We hope that this has been a comprehensive survey of your service. If there are other comments you wish to make, or would like added to a subsequent audit, please add them in the box provided:
THANK YOU FOR YOUR COOPERATION IN THIS AUDIT.
British Association of Dermatologists
Submit

APPENDIX 2.

PANEL OF ADVISORS FOR THE AUDIT:

C.H. Smith,
J.N.W.N. Barker
A.D. Burden
R.J.G. Chalmers
C.E.M. Griffiths
N.J. Reynolds
A.D. Ormerod
Dr Tim Mitchell (on behalf of Primary Care Dermatology Society)
The Therapy, Audit and Guidelines Committee, British Association of Dermatologists.
The Psoriasis Association
Skin Care Campaign
The Psoriasis and Psoriatic Arthritis Alliance

APPENDIX 3. Hospitals participating in the Audit

Addenbrookes Hospital, Cambridge University Hospitals Foundation Trust
Alan Lyell Dept, Greater Glasgow Health Board
Barking, Havering & Redbrdge NHS Trust
Barnsley Hospital NHS Foundation Trust
Barts and the London NHS Trust
Bedford Hospital NHS Trust
Birmingham Children's Hospital Foundation
Bolton Hospitals NHS Trust
Bradford NHSTHT
Brighton and Sussex University Hospitals NHS Trust
Bro Morgannwg NHS Trust
Bromley Hospitals NHS Trust
Buckinghamshire Hospitals NHS Trust
Burton Hospital NHS Trust
Central Manchester and Manchester Children's NHS Trust
Countess of Chester NS Foundation Trust
County Durham & Darlington NHS Foundation Trust
Craigavon Area Hospital Group Trust
Derby Hospitals NHS Foundation Trust
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Dumfries and Galloway Health Board
East & North Hertfordshire Trust
East Cheshire NHS Trust
East Kent Hospitals NHS Trust
East Lancashire Hospital NHS Trust
Essex Rivers NHS Healthcare Trust
George Eliot Hospital NHS Trust
Guys and St Thomas' NHS Foundation Trust
Gwent Healthcare NHS Trust
Heatherwood and Wexham Park NHS Foundation Trust
Hereford Hospital NHS Trust
Highland Acute Hospitals NHS Trust Inverness
Hillingdon NHS Trust
Hinchingbrooke Hospital NHS Trust
Hull & East Yorkshire Hospitals NHS Trust
Ipswich Hospital NHS Trust
Kettering General NHS Trust
Kings College Hospital NHS Foundation Trust
Kingston Hospital NHS Trust
Lancashire Teaching Hospitals Foundation Trust
Leeds Teaching Hospitals NHS Trust
Mayday Healthcare NHS Trust
Mid Staffordshire General Hospitals NHS Trust
Mid Yorks NHS Trust
Milton Keynes General Hospital NHS Trust
NHS Ayrshire & Arran
NHS Forth Valley
NHS Grampian
NHS Greater Glasgow and Clyde
NHS Greater Glasgow, Clyde Southern General and Victoria
NHS Tayside

Norfolk and Norwich University Hospital NHS Trust
North Cumbria Acute Hospitals NHS Trust
North West Wales NHS Trust
Northampton General Hospital NHS Trust
Northern Trust
Nottingham University Hospitals NHS Trust
NUT Hospitals NHS Trust
Oxford Radcliffe Hospitals NHS Trust
Pennine Acute Hospitals NHS Trust
Pennine Acute NHS Trust
Rotherham NHS Foundation Trust
Royal Berkshire NHS Foundation Trust
Royal Bournemouth and Christchurch NHS Trust Foundation
Royal Hospitals Trust
Royal Surrey County Hospital NHS Trust
Royal United Hospital NHS Trust Bath
Royal West Sussex NHS Trust
Salford Royal Foundation Trust
Sandwell and West Birmingham Hospitals NHS Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Shrewsbury & Telford Hospital NHS Trust
South Devon Healthcare Trust
South Tees NHS Trust
South Warwickshire General Hospital NHS Trust
St Albans & Hemel Hempstead , West Hertfordshire Hospitals Trust
St Helens and Knowsley NHS Trust
Sunderland Teaching Primary Care Trust
Surrey and Sussex Health Care Trust
Swansea NHS Trust
Swindon and Marlborough NHS Trust
Tameside and Glossop NHS Trust
Taunton & Somerset NHS Trust
The Lewisham Hospital NHS Trust
The Royal Cornwall Hospitals NHS Trust
The Royal Devon and Exeter NHS Foundation Trust
United Bristol Healthcare Trust
United Lincolnshire Hospitals NHS Trust
University Hospital of North Staffordshire NHS Trust
University Hospital Coventry and Warwickshire NHS Trust
University Hospitals Birmingham Foundation Trust
University Hospitals of Leicester NHS Trust
Walsall Hospitals NHS Trust
West Middlesex University Hospital Trust
West Suffolk Hospital NHS Trust
Weston Area NHS Trust
Whipps Cross University NHS Trust
Wirral University Teaching Hospital NHS Foundation
Wrightington Wigan and Leigh NHS Trust
York Hospitals NHS Trust