NICE support for commissioning for psoriasis

August 2013

1 Introduction

Implementing the recommendations from NICE guidance and other NICE-accredited guidance is the best way to support improvements in the quality of care or services, in line with the statements and measures that comprise the NICE quality standards. This report:

- highlights the areas of care in the quality standard that have potential implications for commissioners
- considers the cost of implementing the changes needed to achieve the quality standard at a local level
- identifies where potential cost savings can be made
- directs commissioners and service providers to a package of support tools that can help them implement NICE guidance and redesign services.

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. They draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. For more information see NICE quality standards.

NHS England’s CCG outcomes indicator set is part of a systematic approach to promoting quality improvement. The outcomes indicator set provides CCGs and health and wellbeing boards with comparative information on the quality of health services commissioned by CCGs and the associated health outcomes. The set includes indicators derived from NICE quality standards. By commissioning services in line with the quality standards, commissioners
can contribute to improvements in health outcomes, especially in relation to enhancing quality of life for people with long-term conditions and patient experience.

Commissioners can use the quality standards to improve services by including quality statements and measures in the service specification of the standard contract and establishing key performance indicators as part of the tendering process. They can also encourage improvements in provider performance by using quality standard measures in association with incentive payments such as Using the commissioning for quality and innovation (CQUIN) payment framework. NICE quality standards provide a baseline against which improvements can be measured and rewarded, enabling commissioners to address gaps in service provision, support best practice and encourage evidence-based care.

This report on the psoriasis quality standard should be read alongside:

- Psoriasis. NICE quality standard 40 (2013)
- Psoriasis: the assessment and management of psoriasis. NICE clinical guideline 153 (2012)
- Biologic drugs for the treatment of inflammatory disease in rheumatology, dermatology and gastroenterology. NICE support for commissioning (2010).

2 Overview of psoriasis

Psoriasis is an inflammatory skin disease that most commonly presents as red, scaly plaques on the skin. These may vary in extent from a few patches to generalised skin and associated joint involvement. The disease typically follows a relapsing and remitting course, and can result in significant functional, psychological and social morbidity.

Prompt, effective treatment and long-term disease control are important. Symptoms, problems related to treatments, psoriatic arthritis, and the effect of living with a highly visible, stigmatising skin disease impact on wellbeing, with
consequent reduced levels of employment and income. Even people with less severe psoriasis state that it has a major effect on their life.

A variety of treatment options are available:

- **First-line treatments** are topical therapies, such as corticosteroids, vitamin D and vitamin D analogues, dithranol and tar preparations. These can be prescribed in primary care.
- **Second-line therapy** includes phototherapies (broad or narrow-band ultraviolet B light [UVB] and psoralen plus UVA light [PUVA]) and systemic non-biological agents such as ciclosporin, methotrexate and acitretin. These are usually prescribed by specialist dermatologists.
- **Third-line therapy** is systemic biological therapies such as adalimumab, etanercept, infliximab and ustekinumab. These are usually prescribed by specialist dermatologists in secondary or tertiary care settings.
- **Best supportive care** can include a range of the above therapies. Because the condition is relapsing and remitting, the treatments recommended by specialists (mainly in tertiary care) may change based on the progress of the symptoms.

Most psoriasis is managed in primary care, with specialist referral to dermatology needed at some point for up to 60% of people (see section 4.2). Specialist tertiary care is needed in the very small minority of people with especially complex, treatment-resistant or rare forms of psoriasis.

People receiving systemic therapy need ongoing supervision in specialist settings, sometimes with shared care arrangements for drug monitoring in primary care. A [2008 UK audit](#) in the adult population found wide variations in practice, particularly in relation to access to specialist treatments (including phototherapy and biological therapy), appropriate drug monitoring, specialist nurse support and psychological services.

### 2.1 Epidemiology of psoriasis

The prevalence of psoriasis is estimated to be around 1.3–2.2% in the UK. Men and women are equally affected. Psoriasis can occur at any age,
although is uncommon in children (prevalence 0.71%) and the majority of
cases occur before the age of 35. The severity of the condition can vary within
and between people and is not always easy to classify:

- Mild psoriasis (around 80% of people with psoriasis) involves a few patches
  that may need treatment. These are not likely to cause substantial
  problems and can be easily controlled by good adherence to treatment.
- Moderate psoriasis (around 15% of people with psoriasis) involves more
  skin and the condition is widespread. It can usually be controlled with self-
  management and appropriate levels of support from a GP, a GP with
  specialist interest, or dermatology nurse specialist.
- Severe psoriasis (around 5% of people with psoriasis) involves large areas
  of skin covered with psoriasis and the condition becomes difficult to self-
  manage or no longer responds to treatment. At this stage, referral to
  specialist dermatologists may be needed to provide optimal care and
  monitoring\(^1\). In some cases a patient may need to be admitted to tertiary
  care as a medical emergency.

Psoriasis is associated with a range of comorbidities including the following:

- Joint involvement. Psoriatic arthritis is present in a significant proportion of
  people (reported in 1 study at 13.8\(^2\)).
- Depression. The prevalence of depression and suicide are higher than for
  other long-term conditions but are not predicted by psoriasis severity.
- A high incidence of lifestyle behaviours, such as smoking, alcohol-use
  disorders and obesity that can increase the risk of cardiovascular disease.
  The link between psoriasis and cardiovascular disease is not well
  understood.

\(^1\) Psoriasis and Psoriatic Arthritis Alliance (2013) What is psoriasis?
  with psoriasis. Arthritis and Rheumatism 61:1373–8
3 Commissioning and resource implications

The cost of meeting the quality standard for psoriasis depends on current local practice and the progress organisations have made in implementing NICE and NICE-accredited guidance.

Most psoriasis is managed in primary care. Some moderate to severe psoriasis, or psoriasis with comorbidities, may be managed by community- or hospital-based dermatology services.

CCGs are responsible for commissioning community and hospital-based dermatology, and for managing the quality of referrals between primary and secondary care. CCGs may wish to consider commissioning services for people with psoriasis alongside other non-cancerous skin conditions such as eczema and acne, and as part of their broader dermatology commissioning plans. CCGs may wish to work with public health partners within local authorities when commissioning cardiovascular risk assessments.

A small minority of people with very severe psoriasis, or psoriasis that is not responding to treatment, may be seen in tertiary dermatology centres. Specialised commissioning arrangements should be in place for this.

Table 1 summarises the commissioning and resource implications for commissioners working towards achieving this quality standard. See section 4 for more detail on commissioning and resource implications.
<table>
<thead>
<tr>
<th>Quality improvement area</th>
<th>Commissioning implications</th>
<th>Estimated resource impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment (quality statements 1 and 2)</td>
<td>Commissioners should ask local dermatology services to support education programmes to improve GPs’ ability to make appropriate assessment of disease severity and the impact of the condition on physical, social and psychological wellbeing. This should also improve treatment, monitoring and referrals. CCGs should nominate a lead dermatology commissioner.</td>
<td>Improving education of healthcare professionals is likely to increase the appropriateness of referrals to dermatology services. Improving assessment and the diagnostic process could reasonably be expected to lead to a cost saving.</td>
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<tr>
<td>Referring to specialist services (quality statement 3)</td>
<td>Commissioners should ensure that their dermatology services are as accessible as possible to people with psoriasis, bearing in mind local geography and demography.</td>
<td>Up to 60% of people with psoriasis will at some point need to be referred to a dermatology specialist. Additional costs may be incurred in commissioning specialist services where there is not already sufficient capacity in place or to improve access to treatments recommended by NICE.</td>
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<td>Identification and assessment of comorbidities (quality statements 4 and 5)</td>
<td>Commissioners should ensure that their dermatology services can offer people with newly diagnosed severe psoriasis a cardiovascular risk assessment as soon as possible after the diagnosis, and then at least every 5 years. Commissioners need to ensure good links between their dermatology and rheumatology services for people with associated joint disease.</td>
<td>Additional investment may be needed to extend provision of cardiovascular risk assessments to include people with severe psoriasis who are not covered by the NHS Health Check programme. These additional reviews of risk factors for cardiovascular disease may result in savings from a decrease in the number of cardiovascular disease-related events. Earlier identification of psoriatic arthritis is likely to increase demand for early stage treatments.</td>
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<tr>
<td>Monitoring systemic therapy (quality statement 6)</td>
<td>Commissioners should ensure there is a locally agreed protocol for monitoring systemic therapy that incorporates national accredited drug guidelines and policy.</td>
<td>Appropriate monitoring is a core-responsibility of dermatology service providers, which may include primary or community services. This is not anticipated to involve any additional resource impact.</td>
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4 Commissioning implications and cost impact

This section considers the commissioning implications and potential resource impact of implementing the recommendations to achieve the NICE quality standard for psoriasis.

4.1 Assessment

Quality statement 1: Assessing disease severity
People with psoriasis are offered an assessment of disease severity at diagnosis and when response to treatment is assessed.

Quality statement 2: Assessing impact of disease
People with psoriasis are offered an assessment of the impact of the disease on physical, psychological and social wellbeing at diagnosis and when response to treatment is assessed.

Almost all people with psoriasis will first present to a GP, so GPs need to have the knowledge and skills to diagnose psoriasis, and to assess both the severity of the condition and the impact on the person's physical, psychological and social wellbeing. This is important to ensure that they can provide optimal management of the condition.

Commissioners may wish to ask their local dermatology services to support education programmes to raise GP awareness of the following:

- Tools to assess disease severity (such as the Physician's and Patient's Global Assessment).
- The importance of assessing the impact of the condition on physical, psychological and social wellbeing, in order to determine optimum treatment strategies.
• Tools for assessing physical, psychological and social wellbeing (such as the Dermatology Life Quality Index [DLQI] or Children’s Dermatology Life Quality Index).

• Monitoring and management of first-line treatments. Adherence rates for first line topical treatments are low, with rates of between 21–66%. Some people may benefit from additional input from dermatology specialist nurses who can advise on optimal use of topical treatments.

CCGs should nominate a lead dermatology commissioner to champion GP education and monitor improvements in assessment, diagnosis, management and appropriate referral of people with skin conditions. Improving education of healthcare professionals is likely to increase the appropriateness of referrals to dermatology services and could reasonably be expected to incur a cost saving.

4.2 **Referring to specialist services**

**Quality statement 3: Referring to specialist services**

People with psoriasis are referred for assessment by a dermatology specialist if indicated.

The relapsing and remitting course of psoriasis and poor treatment adherence mean that up to 60% of people with psoriasis may at some point experience a flare-up or other complication that affects their physical, psychological and social wellbeing sufficiently for them to need referral to a dermatology specialist.

Commissioners should ensure that their dermatology services are as accessible as possible to people with psoriasis, bearing in mind local geography and the fact that around 70% of people with psoriasis are of

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working age (aged 18–64). Access to phototherapies may be needed 2–3 times a week over a period of several months and some infused systemic therapies take many hours to administer. Therefore commissioners may wish to consider:

- commissioning community-based dermatology, for example triage, treatment and monitoring of people with mild to moderate psoriasis by dermatology specialist nurses or GP with special interest
- extending the availability of phototherapy and dermatology clinics to evenings and weekends
- improving access to home phototherapy for people who are unable to travel to phototherapy centres, for example because of distance, working or caring commitments
- commissioning services that train people to self-administer phototherapy in outpatient settings.

Commissioners should also ensure their dermatology pathway includes access to a range of other dedicated support. For example, this should include:

- psychological interventions and support, tailored to the needs of people with long-term skin conditions and provided by trained healthcare professionals advice
- education and skill development so dermatology specialists can offer education and self-management training to people with psoriasis.

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4 Data extracted from IMS disease analyser. IMS collects data from a sample of GP practice systems. Around 100 are currently delivering data and the database has about 2.7 million patient records, around 0.88 million of which were registered for the whole of the study year. These records are anonymised and are available for analysis via a tool called Disease Analyzer. The sample includes practices from England, Wales, Scotland and Northern Ireland and has a representative UK sample by age and sex. As in any observational database, data entered by panel doctors may be incomplete.

Additional costs may be incurred in commissioning dermatology services that do not already have sufficient capacity in place, or if services are not appropriately accessible.

4.3  Identification and assessment of comorbidities

Quality statement 4: Assessing cardiovascular risk
Adults with severe psoriasis are offered a cardiovascular risk assessment at diagnosis and at least once every 5 years.

Quality statement 5: Assessing for psoriatic arthritis
People with psoriasis having treatment are offered an annual assessment for psoriatic arthritis.

Commissioners should ensure that their dermatology services offer (or refer people to a service that can offer) people with newly diagnosed severe psoriasis a cardiovascular risk assessment as soon as possible after the diagnosis, and then at least every 5 years.

CCG commissioners may wish to work closely with public health partners in local authorities when commissioning cardiovascular risk assessments. They could ask that cardiovascular risk assessments are commissioned as part of the NHS Health Check. They should ask local authority commissioners to specify that adults with severe psoriasis who are younger than 40 are also offered a cardiovascular risk assessment that takes into account their increased risk of cardiovascular disease. Reviewing risk factors for cardiovascular disease at initial assessment and on a 5-yearly basis may result in savings from a decrease in the number of cardiovascular disease-related events.

Commissioners need to ensure that there are good links between their dermatology and rheumatology services so that psoriatic arthritis can be identified and managed early to prevent functional impairment and disability,
and optimise treatment regimens for both conditions. A number of areas operate joint dermatology and rheumatology clinics to assist this.

Assessment for psoriatic arthritis should be undertaken using a validated tool, such as the Psoriasis Epidemiological Screening Tool (PEST). This can be completed without any clinical oversight, so the additional costs are expected to be negligible. However, earlier identification of the condition is likely to increase demand for early-stage treatments. Examples include additional prescribing costs for treatments that can delay exacerbation of the condition (such as non-steroidal anti-inflammatory drugs [NSAIDs] and disease modifying anti-rheumatic drugs [DMARDs]), as well as additional rheumatology outpatient attendances.

Commissioners can find detailed information on commissioning services to assess cardiovascular disease risk in the NICE support for commissioning on integrated commissioning for the prevention of cardiovascular disease.

Commissioners can find case studies of joint rheumatology and dermatology clinics in the NICE support for commissioning on biologic drugs for the treatment of inflammatory conditions in rheumatology, dermatology and gastroenterology.

4.4 Monitoring systemic therapy

Quality statement 6: Monitoring systemic therapy
People with psoriasis receiving systemic therapy are monitored in accordance with locally agreed protocols.

Commissioners should ensure the following:

- There is a locally agreed protocol for monitoring systemic therapy, which incorporates national accredited drug guidelines and policy.
• Where shared care arrangements are in place for monitoring, the competencies and roles and responsibilities of healthcare professionals are clearly outlined.

• Dermatology services retain responsibility for initial prescribing of systemic therapy. However, aspects of supervision and monitoring may be delegated to healthcare professionals in primary or community-based settings as an alternative to outpatient monitoring. If this is done, shared-care arrangements should be formalised.

Commissioners may find the [NICE support for commissioning on biologic drugs for the treatment of inflammatory conditions in rheumatology, dermatology and gastroenterology](#) useful.

5 Other useful resources

5.1 Useful resources

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

5.2 NICE implementation support

• [Psoriasis: the assessment and management of psoriasis](#) NICE baseline assessment tool (2012)

• [Psoriasis: the assessment and management of psoriasis](#) NICE clinical audit tool (2012)

• [Psoriasis: the assessment and management of psoriasis](#) NICE costing report (2012)

• [Psoriasis: the assessment and management of psoriasis](#) NICE costing template (2012)

5.3 NICE pathways

• [Psoriasis](#) (2012)