Key components of psoriasis pathway, adults and children

Dermatology v1 (Clinician)

This is an overview of the key components needed to develop effective dermatology pathways and aims to help commissioners, managers and clinicians to see the overall shape of secondary care services for specific diseases or presentations. There are some examples (shaded blue) which may improve quality or efficiency. They do not provide detailed guidance on disease management or referral criteria (see www.bad.org.uk).

Patient seeks NHS help - Initial Referral	Triage	Assessment	Management	Outpatient / Post-acute follow up
Full primary care assessment and management in line with referral protocols including NICE and PCDS Assess adherence to treatment and reasons for non adherence Assess and manage co-morbidities: metabolic syndrome, weight (dietary advice) mental health issues, including depression, alcohol, HIV risk, and impact of psoriasis on sexual function, mobility and lifestyle	Advice and Guidance or teletriage may help to optimise topical treatments – may return to GP care or move to OP assessment or direct to phototherapy for some with guttate psoriasis. See Teledermatology Roadmap	Dermatology OP: document severity (DLQI/ PASI etc) initial shared management plan with paediatrics if appropriate. Optimise topicals; consider phototherapy, systemic drugs, biologics		PIFU or regular secondary care review usually only if required by medication
		Nurse or pharmacist led systemic drug and biologics clinics Nurses should be trained and banded in line with BAD/BDNG guidance		Combined rheumatology clinics for those with co-existing arthritis
Refer to secondary care when failure to respond to first line topical treatments prescribed in adequate quantities and period of time or severe psoriasis (widespread or localised to high impact sites / erythroderma/ pustular psoriasis optimise referral in line with NOTP guidance	Identify: (1) Emergencies (pustular or erythrodermic) may need admission – see <48 hours (2) Urgent OP–sub erythrodermic/ severe or severe impact on patient (eg guttate psoriasis) – may progress to emergency if delayed treatment (3) Routine OP- advice and guidance and/ or GPwER advice may optimise management or prevent referral when waiting	Emergency OP in larger departments same day assessment urgent issues	Inpatient: rarely necessary but requires nurses with appropriate skills Gastroenterology input for hepatic issues (NASH) with protocols for Fibroscan referral for appropriate people Dietary referral if appropriate	Primary/ secondary shared care of people taking systemic drugs increases community management Optimise follow up arrangements
Presents to A&E: if acute erythroderma/ sub erythroderma **and** haemodynamically unstable/ or pustular triage to dermatology services (may need acute admission) – others discharge with advice to primary care		Management (following all NICE guidance and BAD guidance		

GPwER can support community management of patients and education of primary care clinicians

Ensure ongoing psychological, psychosexual and mental health support in line with APPGS report

Assessment of comorbid metabolic syndrome, obesity, alcohol intake and appropriate management

Invest in education: GP education packages	Regional plans required for safe and funded management of rare out of hours emergencies –not required on site in every hospital		Phototherapy clinic and service should meet BAD service standards Consider home phototherapy (Leeds/ Scotland model) Salford model (in larger departments): MDT psoriasis clinics – all around care	Medicine monitoring: review biologics use compared to national norms and explore reasons for variance
Monitor A&G + teletriage + total referral numbers to ensure that these do not escalate rapidly. A&G should be used to educate and improve primary care treatment of common conditions and not to shift care to secondary care		Super-clinics (multiple practitioners, nurses, junior doctors and GPwERs supervised by consultant without own list who sees nearly all patients) increases outpatient efficiency by reducing follow ups and ensuring all patients get consultant direct opinion		Remote telephone/video clinics – follow up safety monitoring – reduce unnecessary attendance increase community management

Appropriate use of digital technology throughout the pathway to improve patient experience rather than as an end in itself: see the dermatology digital playbook

Clinician should encourage self-management and patient education using online resources – from assessment of treatment adherence to living with a long-term condition

Collect patient reported data and participate in relevant NIHR studies such as BADBIR Clinical research units usually have better outcomes

Follow national specialist society (BAD/ BAPRAS etc) guidelines; NICE guidelines including audit and training recommendations