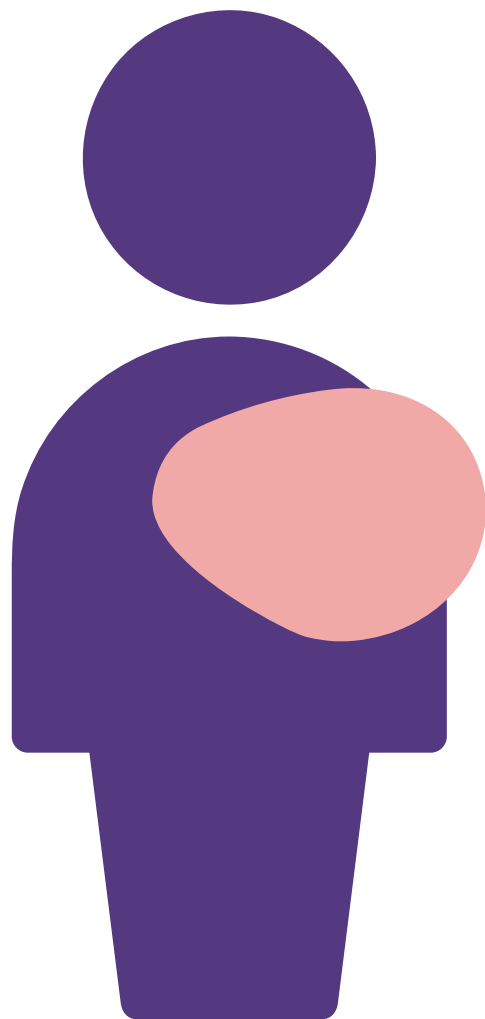




Transforming care for people with psoriasis: delivering outcomes they deserve



A policy position paper from Psoriasis UK®

Published October 2026. Psoriasis UK® • Charity no. 1180666 / SC049563
Psoriasis UK and the Psoriasis UK logo are registered trademarks of Psoriasis UK

Contents

Executive Summary

The problems.....	4
Recommendations.....	5
Defining Rapid Access to Care.....	6
Our Approach	7

SECTION 1

Why Care for People with Psoriasis Needs to Change.....	8
---	---

SECTION 2

Where Current Psoriasis Care Falls Short	12
--	----

SECTION 3

The Patient-Defined Principles of Rapid Access to Care.....	16
---	----

SECTION 4

Measuring Success Differently.....	26
------------------------------------	----

SECTION 5

Initiating Local Discussion and Action.....	28
---	----

SECTION 6

Call to Action	30
----------------------	----

References.....	32
-----------------	----



Supported by:



UCB has provided support for this project but has not contributed to the content of the clinical consensus statement.

Endorsed by:



**BRITISH ASSOCIATION
OF DERMATOLOGISTS**
HEALTHY SKIN FOR ALL



BDNG
BRITISH
DERMATOLOGICAL
NURSING GROUP



PCDS
PRIMARY CARE DERMATOLOGY SOCIETY



GIRFT
GETTING IT RIGHT FIRST TIME

The problems

- 1 > **UK psoriasis care is failing many patients**, despite the availability of safe, effective and affordable treatments supported by robust long-term evidence of safety and efficacy
- 2 > **Therapeutic advances have outpaced the systems designed to deliver them**, meaning many patients do not gain timely access to highly effective treatments that can dramatically improve their lives
- 3 > **Outdated National Institute for Health and Care Excellence (NICE) guidance and a step-ladder approach to treatment lead to delays** in people with psoriasis receiving effective treatments and results in overall higher costs to the health care system
- 4 > **Primary care often feels like a ‘waiting room’ for specialist help** for people with psoriasis, with a lack of access to diagnosis, treatment optimisation and timely review of treatment efficacy
- 5 > **Care pathways are fragmented, inconsistent and often focused on episodic access** rather than lifelong management
- 6 > **Patients experience delays, uncertainty, poor continuity** and wide geographical variation in the quality of, and access to, care
- 7 > **Psoriasis causes itch, pain and sore skin** but also affects far more than the skin, impacting mental health, relationships, employment, self-confidence and quality of life, yet these impacts are often overlooked
- 8 > **The systemic effects of psoriasis including metabolic syndrome and arthritis are important**; too often they are not screened for and managed in primary care

Recommendations

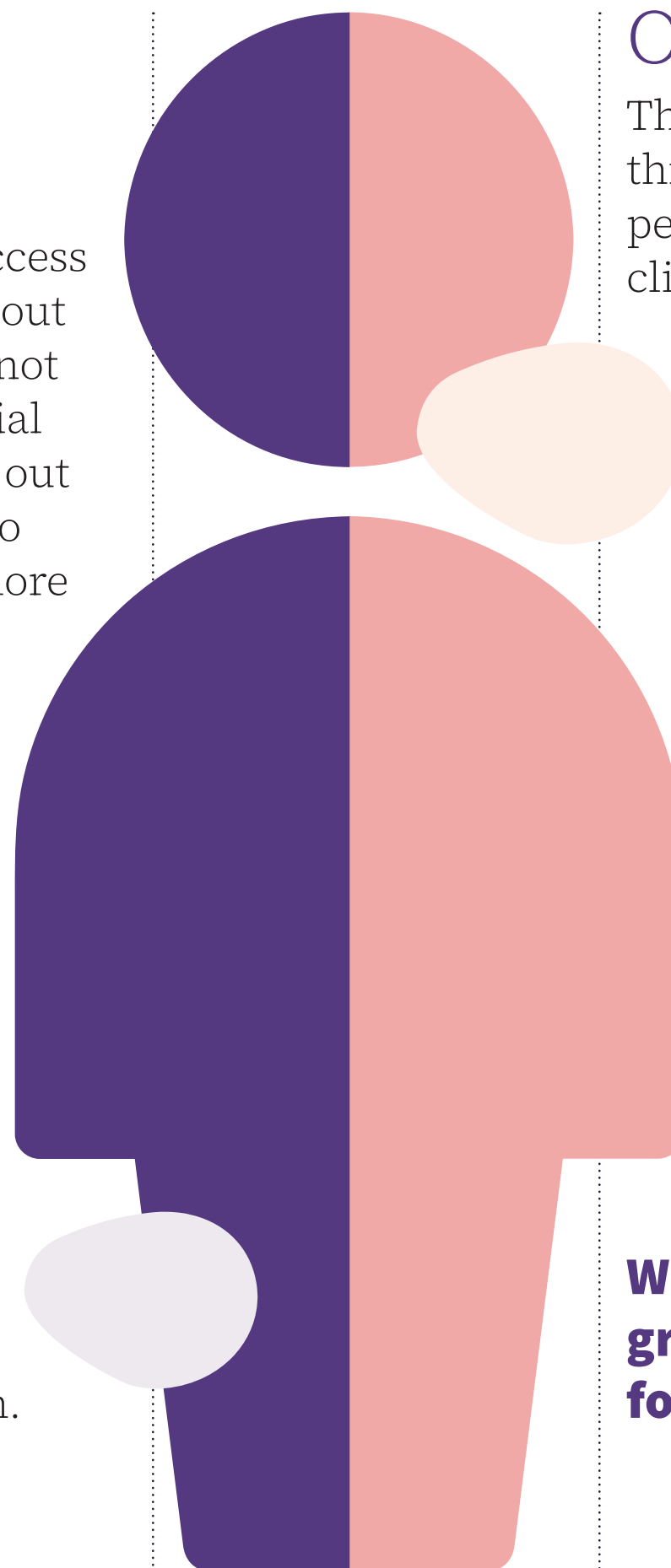
- 1 > **People with psoriasis should expect a prompt diagnosis to be made in primary care by suitably trained healthcare professionals**, an appropriate management plan initiated and response to treatment evaluated, optimised and modified as necessary
- 2 > **Improving care requires a shift from simply increasing access to creating coordinated, continuous pathways** that deliver timely expertise, proactive, ongoing management and improved outcomes across primary, intermediate and secondary care
- 3 > **Improving speed to treatment is important, but rapid access should also include timely review**, appropriate and timely access to highly effective treatments and rapid re-entry to specialist care and treatment optimisation whenever clinical need changes
- 4 > **Personalised treatment and a negotiated ‘treat-to-target’ approach should be at the centre of optimising care** and facilitating appropriate and timely access to systemic treatments such as biological therapies, with NICE guidance updated accordingly and not acting as a barrier to appropriate care
- 5 > **Psychological wellbeing should be recognised as a core component of routine psoriasis care**, with patients signposted or referred to appropriate support according to clinical need
- 6 > **The NHS 10-Year Health Plan offers opportunities to redesign services using neighbourhood-based models of care**, embrace new digital technologies where appropriate and personalise care

Early intervention with modern therapies has transformed what is possible for people living with psoriasis. The challenge now is to ensure that care pathways can deliver these outcomes consistently, equitably and at scale. This requires a shift from focusing on access alone to providing a coordinated, continuous care pathway across the patient journey, ensuring that patients are seen by the right professional, at the right time, from their first point of contact.

Defining Rapid Access to Care

Psoriasis UK believes rapid access should mean timely access to the right expertise throughout the course of the condition – not simply rapid access to an initial appointment. This paper sets out patient-defined frameworks to reset expectations, support more consistent commissioning, and democratise psoriasis care, while aligning with existing National Health Service (NHS) priorities.

When it comes to designing the perfect framework for psoriasis care, there is no single one-size-fits-all approach that will work for all NHS Trusts across the UK. Instead, this paper outlines key principles and provides examples of best practice frameworks for consideration.



Our Approach

This position paper has been developed through a UK-wide steering group involving people living with psoriasis, dermatology clinicians, primary care professionals, specialist nurses, pharmacists, and led by Psoriasis UK. The recommendations were informed by qualitative insight from more than 220 people living with psoriasis alongside current clinical guidance and published evidence.

We are delighted that the document is supported and co-badged by the NHS England programme Getting It Right First Time (GIRFT), the British Association of Dermatologists (BAD), the British Dermatological Nursing Group (BDNG) and the Primary Care Dermatology Society (PCDS).

We would like to thank the steering group and the psoriasis community for shaping this position paper.

Why Care for People with Psoriasis Needs to Change



“It didn’t feel like very much time or care was given to explaining my options – when I asked about methotrexate... to explain the side effects...I was told to ‘just Google it’.”

Person living with psoriasis

About psoriasis

- Psoriasis is a long-term, immune-mediated inflammatory skin condition, with lifelong fluctuations in severity and complexity. The patches on the skin are often associated with itching, pain and soreness.

- Psoriasis affects many systems throughout the body – primarily manifesting as inflamed plaques of skin* – and can lead to a range of associated conditions, including psoriatic arthritis, metabolic syndrome and mental health challenges.¹
- In the UK, approximately 1–3% of the population is estimated to have psoriasis with onset generally occurring between 15–30 and 50–60 years of age, although it can begin at any age.^{1–3}
- Psoriasis can have a profound impact on mental wellbeing, self-confidence, relationships, employment and quality of life.

Why care needs to be reset

Whilst many patients living with psoriasis must manage the condition across their lifetime, care pathways are often designed as if the condition were short term, static, or episodic. This mismatch creates significant burden for patients, inefficiencies for services and delays in early access to effective, safe, life-changing treatments.

Traditional classifications of psoriasis severity and therapeutic approaches no longer reflect patient needs:

- Labels such as ‘mild, moderate and severe’ are outdated; it’s much more important to assess whether topical treatments are effective after an adequate trial, and use this as a measure of severity.
- Too often, the impact of psoriasis in high-impact body sites (e.g., face, scalp, palms and soles, or intimate areas), the psychological burden of disease, or the cumulative effect of recurrent flares is not taken into account.

- Traditional ‘step-ladder’ treatment approaches are out-of-date and may delay access to effective or advanced therapies (including biologics); this standardised approach needs to be replaced by more personalised treatment decisions based on individual patient needs and disease burden.

Across the UK, there is significant variability in access to, and quality of, primary and specialist care – and in resulting outcomes – driven not by patient need but by where they live, local commissioning and service design.[†] Variable escalation thresholds, rigid gatekeeping models, and poorly defined follow-up arrangements often result in unintended harm, delaying effective treatment and driving avoidable service use.⁴

The result is a system that often meets its own process requirements while failing to deliver meaningful outcomes for patients.

*This position paper focuses on plaque psoriasis while recognising that other forms of psoriasis may require different management strategies.

[†] Primary care: first point of contact; secondary care: specialist services.

What Patients Say is Failing in Practice

Insights from more than
220 people living with psoriasis
collected by Psoriasis UK in 2025.



**While effective treatments exist,
many patients continue to
experience barriers to getting the
right care at the right time.**

*“What a wealth of treatments we’ve
got, yet the patient experience is so far
behind.”* Consultant Dermatologist

The five most common challenges patients report:

1

**Delayed or obstructed
access to specialist care**

2

**Seen but not managed meaning
assessment without timely
treatment optimisation**

3

**Long waits, uncertainty between
appointments, lack of continuity
of care and changing decisions**

4

**Psychological factors and quality
of life impact left unaddressed**

5

**Limited patient understanding of
rights and expectations of care**

**Psoriasis care is limited not by
treatments, but by how care is
organised.**

Where Current Psoriasis Care Falls Short:

Exploring the Patient Perspective

1 Delayed or obstructed access to specialist care

- › Many patients require multiple GP visits before referral; there are variable skills in recognising and managing psoriasis in primary care.

“I live in constant fear of being discharged back to my GP.”

Person living with psoriasis

- › Referral guidance varies across healthcare communities and is inconsistently implemented.
- › Capacity pressures in dermatology and rheumatology services cause delays, which may allow disease to progress and increase the burden on patients and services.
- › Patients often struggle to re-enter specialist care once discharged.
- › Although there are national guidelines that recommend referral of all children and young people with psoriasis to specialist care at presentation, and annual assessment for psoriatic arthritis using validated screening tools,⁵ implementation remains inconsistent.

ONLY 37%

of survey respondents said securing a referral to a specialist worked well within their experience of psoriasis care

2 Seen but not managed meaning assessment without timely treatment optimisation

- › Despite reaching specialist care, many patients report delays to treatment optimisation when therapeutic goals are not achieved.
- › Reviews and treatment escalation are not always timely.
- › Psychological wellbeing is often overlooked despite its impact on outcomes and quality of life.

“You’ve been seen, but you haven’t been managed. There’s no point in seeing people and not getting them better.”

Dermatology specialist

3 Long waits, uncertainty between appointments, lack of continuity of care and changing decisions⁶

- › Patients describe fragmented care across multiple clinicians and services, with limited continuity and poor communication.
- › Inconsistent clinical advice and unclear follow-up arrangements leave many patients feeling responsible for coordinating appointments, monitoring their condition and driving treatment reviews themselves.
- › Many patients undergo repeated assessments and multiple follow-up appointments without meaningful improvement in psoriasis control.

“I’ve had really good consultations where the care has been very collaborative, shared decision making...you feel empowered. I made a plan with one clinician and then saw someone else who said, ‘well, I don’t agree with that.’”

Person living with psoriasis



**ONLY
30%**

of survey respondents said follow-up appointments worked well within their experience of psoriasis care.

4 Psychological factors and quality of life impact left unaddressed¹

- › People living with psoriasis have higher rates of anxiety and depression than the general population, yet patients tell us that psychological wellbeing is not consistently discussed as part of routine care.
- › Psychological factors including psychological distress, barriers to treatment adherence, stigma and treatment burden, regularly go unrecognised despite their impact on outcomes.
- › Addressing these unmet needs requires a more holistic approach to care, with earlier recognition of psychological needs.

“There was no appreciation of the psychological impact at GP level at all.”

Person living with psoriasis

“There was no indication of how long I should be going between appointments.”

Person living with psoriasis

5 Limited patient understanding of rights and expectations of care

- › Patients lack clarity on what they should expect from their care, including when they should be reviewed, who is responsible for ongoing management and how they can re-access specialist services if their condition deteriorates.
- › Although national guidance exists (including NICE⁵ and BAD⁷), it is not routinely communicated to patients, resulting in uncertainty about standards of care and available support.

Taken together, these failures demonstrate that: Rapid access is not speed to a first appointment; it means timely access to tailored expertise throughout the care pathway.

The Patient-Defined Principles of Rapid Access to Care

Rapid access is often misunderstood as speed alone. Patients define it differently.

From a patient perspective, the key principles of rapid access to care are:

1

Timely access to the right expertise

2

Personalised treatment and treat-to-target approach, with clearly agreed objectives rather than assessment alone

3

Continuous, planned care with clear escalation and rapid re-entry back into services when needs change

4

Integrated psychological and holistic support – psychological wellbeing routinely considered alongside physical health

5

Defined patient rights and expectations of care



1

Timely access to the right expertise

✓ **What good care looks like:** Patients have timely access to appropriately trained healthcare professionals at diagnosis and when their condition changes or deteriorates.

- Primary care teams have access to education, referral guidance, rapid specialist advice and triage to the appropriate service through the Advice & Guidance (A&G).⁸
- The most specialist expertise is focused on complex decision-making, while suitably trained healthcare professionals (including pharmacists and advanced care practitioners) support ongoing monitoring and management.
- Digital tools support timely assessment but do not replace clinical judgement.

2

Personalised treatment and treat-to-target approach, with clearly agreed objectives rather than assessment alone

✓ **What good care looks like:** Care should be organised around achieving and maintaining meaningful psoriasis control throughout the lifetime of the condition.

- Treatment goals are agreed jointly between patients and clinicians.
- Treatment is reviewed regularly and adjusted where agreed goals are not achieved.
- Decisions reflect what matters most to the individual, including quality of life, employment, relationships and psychological wellbeing.
- Care remains proactive rather than reactive.

3

Continuous, planned care with clear escalation and rapid re-entry back into services when needs change

✔ **What good care looks like:** Patients understand what to expect throughout their care.

- › Follow-up arrangements, monitoring and clinical responsibility are clearly defined.
- › Patients know who to contact if treatment becomes ineffective.
- › Rapid routes back into specialist care exist following deterioration or flare using A&G⁸ services to speed up access.
- › Digital and non-digital routes are both available.

“What matters is being linked to a specialist service when escalation is needed.” Specialist nurse

4

Integrated psychological and holistic support – psychological wellbeing routinely considered alongside physical health

✔ **What good care looks like:** Psoriasis care should recognise the impact of the condition on mental wellbeing, relationships, employment and quality of life.

- › Discussions around psychological wellbeing and the impact of psoriasis on daily life should be routine.
- › Where additional needs are identified, patients should be managed using a stepped care approach, with timely signposting or referral to the most appropriate level of local support, including peer support, self-management resources, social prescribing, NHS Talking Therapies, or specialist psychodermatology services where appropriate.
- › Better recognition of psychological need helps improve treatment adherence, patient experiences and overall outcomes while supporting more efficient use of healthcare resources.

5

Defined patient rights and expectations of care

✔ **What good care looks like:** Patients should be informed, supported and empowered to play an active role in decisions about their care.

- › Clear information about psoriasis, treatment options and expected outcomes.
- › Shared decision-making and agreed treatment goals.
- › Information tailored to individual needs and preferences.
- › Understanding of what good psoriasis care should look like and when additional support may be needed.
- › Access to trusted information, resources and patient support services.

Rethinking Roles Whilst Maintaining High Standards

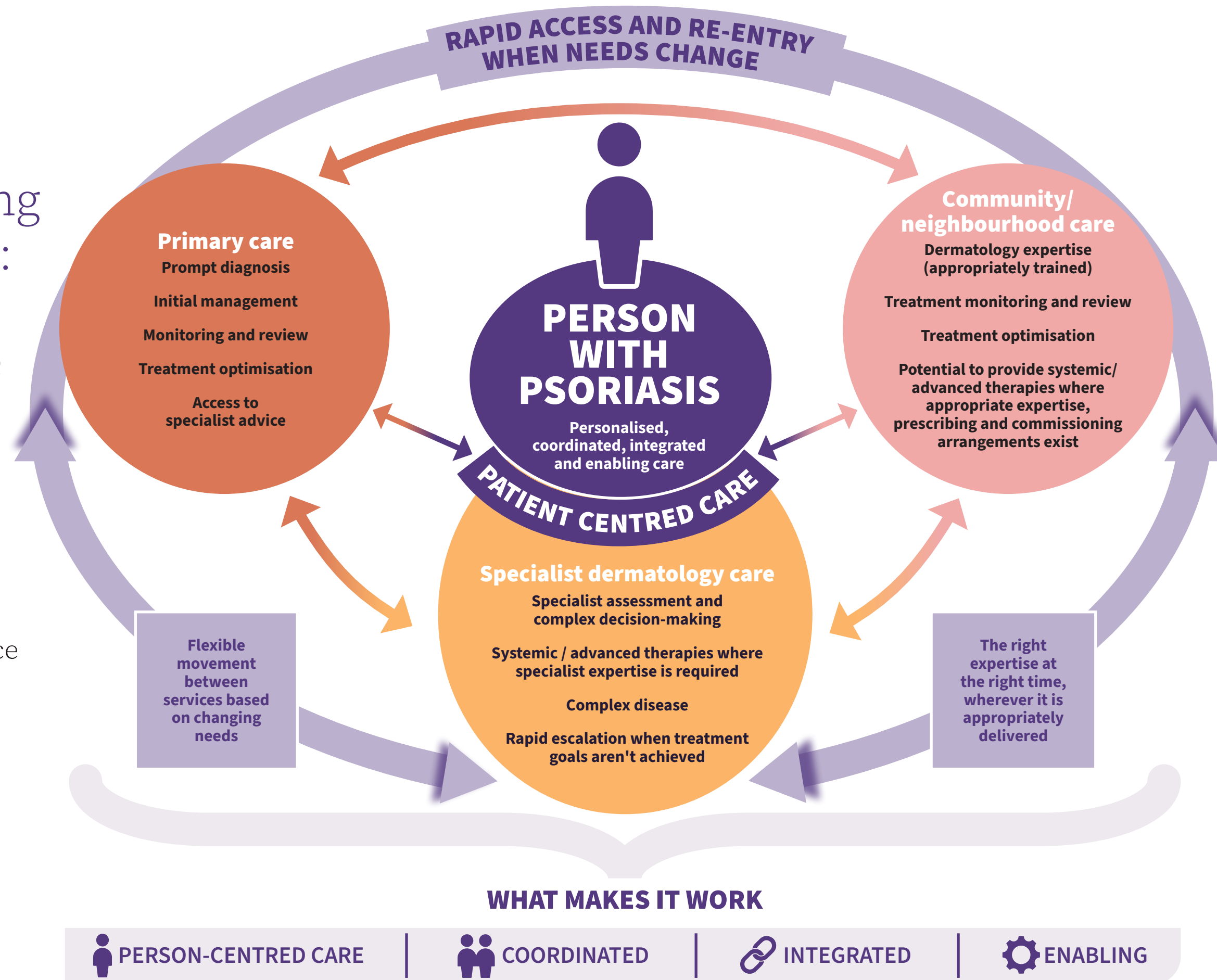
Improving access is about organising expertise more effectively so patients receive the right care from the right professional at the right time, supported by rapid access to specialist advice when needed.



Three illustrative frameworks demonstrating best practice: link with levels of care

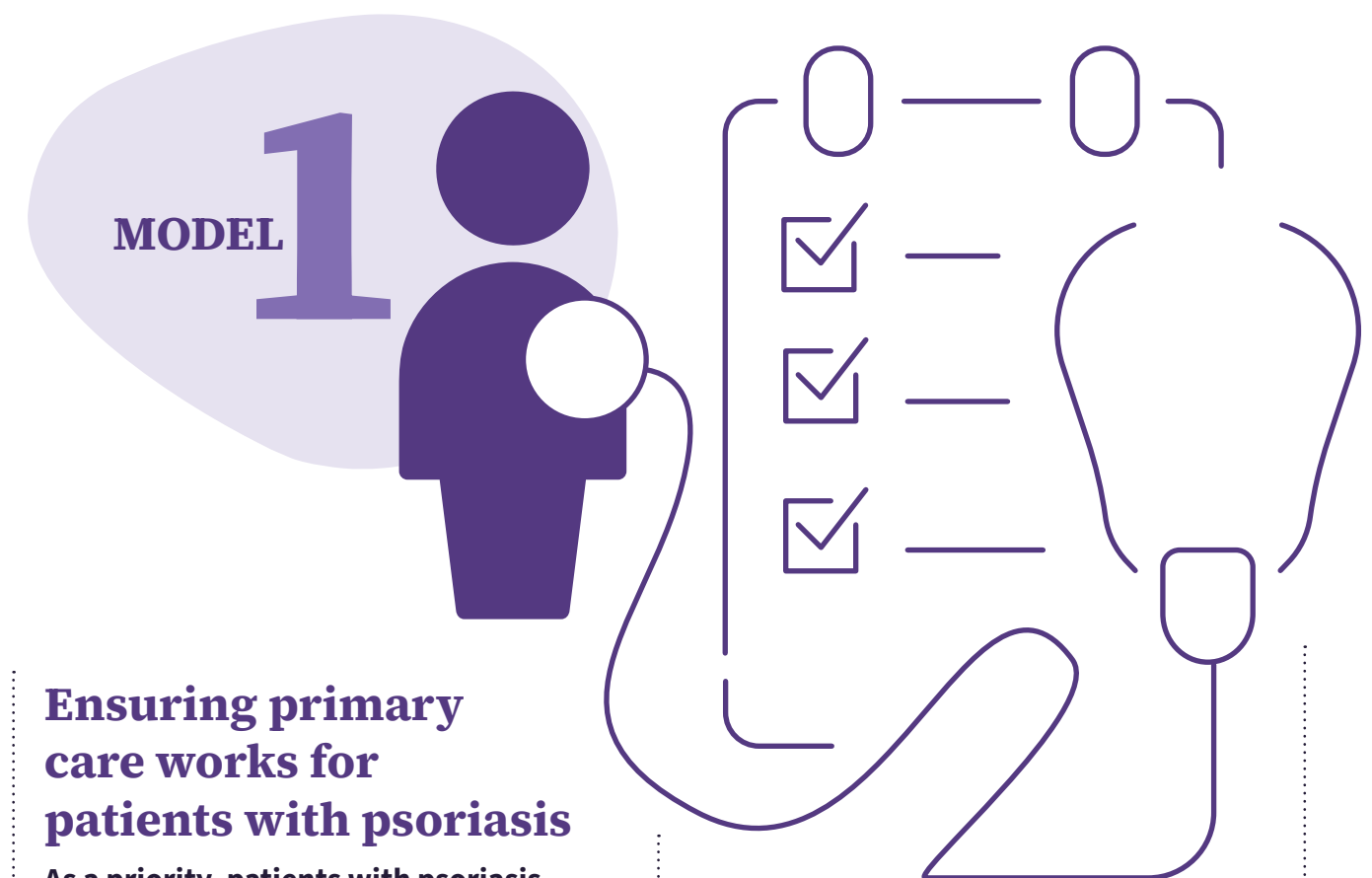
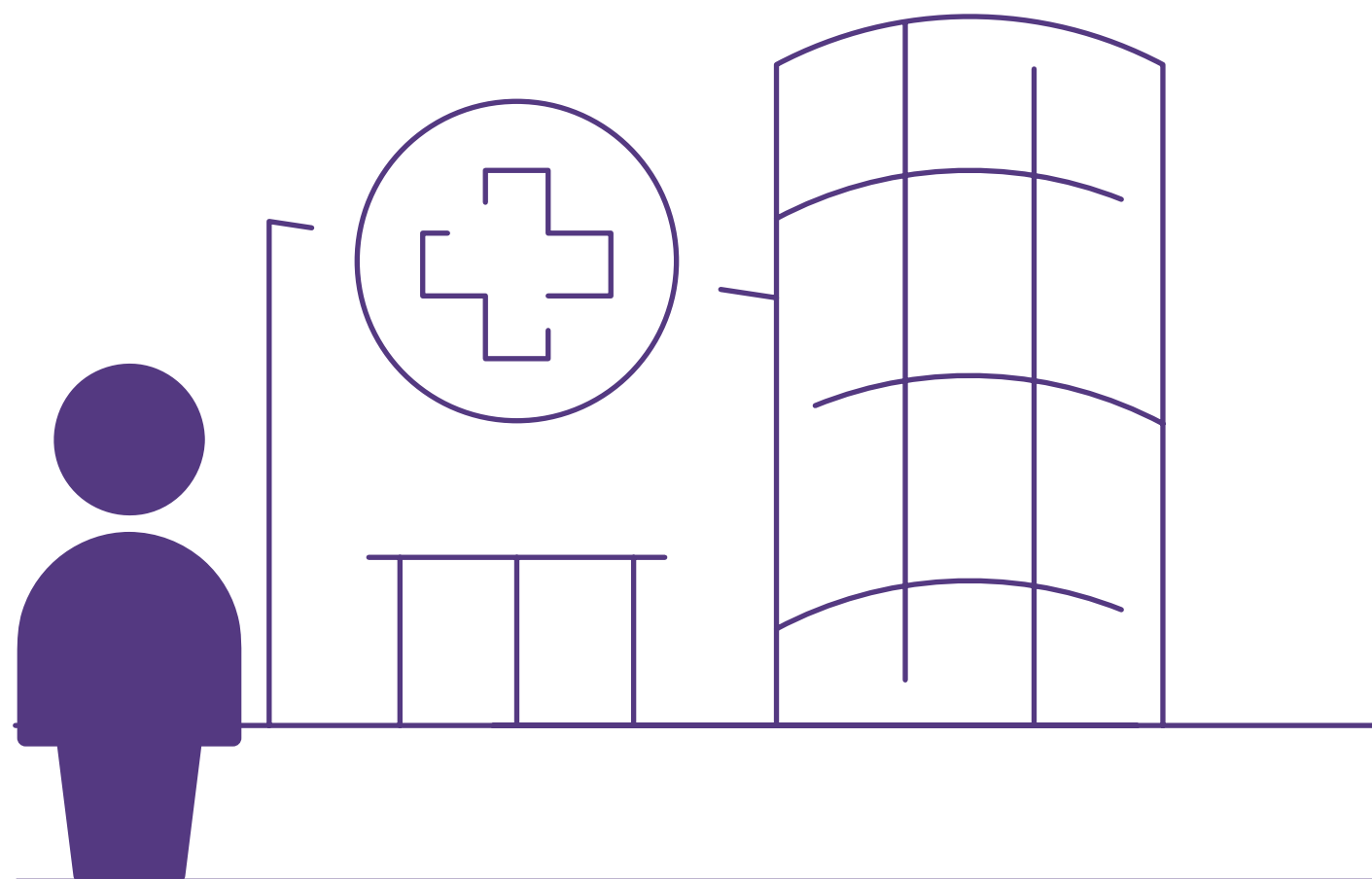
Frameworks for implementing best practice require an understanding of levels of care in order to ensure that people are seen by the right person in the right place first time.

All levels of care can be delivered in community settings, including specialist services, where the relevant skills and expertise are available. Most importantly, integration should improve access to community services rather than introduce additional barriers.



The following examples illustrate how the Patient-Defined Principles of Rapid Access to Care can be delivered in different NHS settings.

Local systems may adopt one or more of these models, or develop alternative approaches meeting the same patient-defined principles.



Ensuring primary care works for patients with psoriasis

As a priority, patients with psoriasis should receive an accurate diagnosis of their skin condition to help them understand and manage it effectively.

- › **Primary care clinicians should be supported** through education, practical decision-support tools and referral guidance to improve confidence in diagnosing, managing and seeking specialist advice for people with psoriasis.
- › **Where diagnostic uncertainty exists, treatment advice or referral for specialist care is needed**, primary care clinicians should have rapid access to specialist advice through A&G.⁸
- › **Clear referral pathways should ensure timely access to specialist assessment** for patients who require it, including patients experiencing flares, those who have not responded to optimised topical treatment, individuals with diagnostic uncertainty or high-impact disease, and people requiring re-access to specialist care.
- › **Specialists reviewing A&G requests should be expected to provide treatment advice** and arrange appointments where appropriate.
- › **Children and young people with psoriasis should be referred to specialist services** in accordance with NICE guidance.
- › **Mental health and quality-of-life impact should be assessed routinely**, with signposting to appropriate support services where needed.
- › **Following discharge from specialist care, patients and primary care clinicians should have clear arrangements** for rapid re-access to specialist services through A&G,⁸ Patient Initiated Follow Up (PIFU),⁹ or other local pathways.

MODEL 2

Rapid access to specialist care in the community for triage and management

The emphasis in the NHS plan on the development of neighbourhood services provides an opportunity to deliver new models of community services for people with psoriasis. These should be led by and/or integrated with local specialist services to enable timely access to appropriate treatment escalation without unnecessary delays in the care pathway.



Community clinics can have a variety of roles depending on the healthcare professionals delivering the care. Examples of services that could be provided include:

- › **Prompt assessment for newly diagnosed patients** to ensure that people with psoriasis receive appropriate support and resources, and that topical treatment has been optimised.
- › Where additional treatments are needed there are two possible models of community service:
 - **Use clearly established direct links with the local specialist service** to ensure a rapid specialist assessment with a view to prompt treatment escalation where appropriate.
 - Where appropriate clinical expertise, prescribing arrangements and commissioning pathways are in place, **provide access to appropriate systemic and advanced therapies**, including biological therapies, within the community service, supporting the treat-to-target approach.
- › **Provision of planned follow-up** and ongoing monitoring using face-to-face, remote consultations, or digital tools such as apps.
- › **A specific care pathway** for those experiencing flares or deterioration, enabling timely re-access to specialist expertise without requiring a new referral through the routine pathway.

MODEL 3

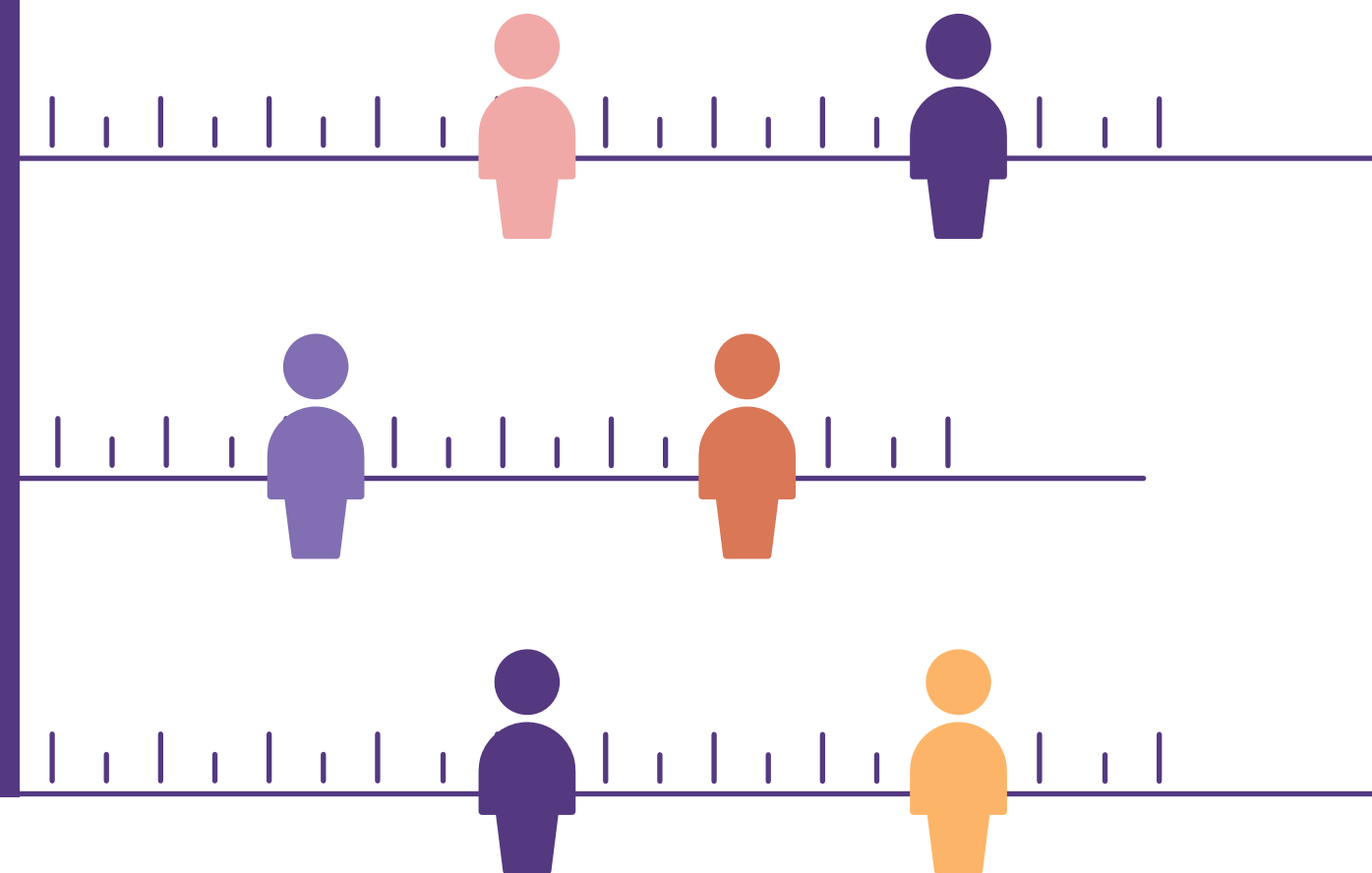
Direct access to specialist expertise: using digital innovation

- › **Patients with a clinician-confirmed diagnosis of psoriasis complete a digital self-assessment** covering disease severity (including in high-impact areas or widespread psoriasis on their body), comorbidities, quality of life and lifestyle data. Secure images of their psoriasis are uploaded which can then be reviewed by the local service.
- › **Patients identified through the digital tool** as having high-impact psoriasis, psoriasis that has not responded to optimised topical treatment or signs of disease destabilisation are flagged for expedited referral to a specialist face-to-face dermatology clinic for further assessment.
- › Once their condition has stabilised, **patients can continue to self-monitor using the digital tool**, with ongoing support from the local clinical service. Digital pathways should complement, rather than replace, traditional routes of access to care.



Measuring Success Differently

Successful psoriasis care should be measured by patient outcomes rather than process measures alone. Meeting waiting time targets is not sufficient if patients continue to experience poor disease control, fragmented care, unmet psychological needs or avoidable deterioration between appointments.



Measures that reflect true value must be prioritised:

1

Timely access to specialist care

- › Early access to appropriate expertise, rapid referral, and clear escalation routes – reducing delays, urgent referrals and unplanned re-entries to care.

2

Timely personalised treatment mapped to patient expectations and agreed outcomes

- › Prompt initiation and ongoing optimisation of treatment, ensuring care progresses beyond assessment to achieve and maintain meaningful control of their condition.

3

Stable control of condition within a continuous care pathway

- › Sustained management over time, supported by proactive follow-up, clear clinical ownership and defined next steps – minimising unplanned reattendances and reducing vulnerability in care.

4

Psychological wellbeing and quality of life

- › Routine assessment of mental health and quality of life outcomes, with integrated support and demonstrable improvements over time.
- › Outcomes should be measured using validated clinical and patient-reported measures rather than inferred solely through quality-of-life scores.

5

Patient confidence, autonomy and experience of care

- › Patient-reported improvements in understanding, trust and sense of control.
- › Greater confidence in navigating care pathways, accessing support when needed and understanding what standard of care should be expected.



A standardised core set of clinician- and patient-reported outcomes is needed to reflect these priorities. These outcomes should be routinely measured through clinician and patient surveys to provide clear insight into how psoriasis care is performing outside of standard metrics, while supporting greater consistency, accountability, and confidence across services.

Initiating Local Discussion and Action

This paper is intended to support local discussions about how psoriasis services can better reflect the Patient-Defined Principles of Rapid Access to Care. Recognising that there is no single model suitable for every NHS organisation, the principles and illustrative frameworks outlined are intended to help local systems review existing pathways, identify opportunities for improvement and agree priorities for service redesign.

Starting the Conversation Locally

This paper offers a structured foundation for representatives across the healthcare system to:

Review current pathways:

Assess how psoriasis services are currently organised, including access to expertise, continuity of care, follow-up and escalation routes.

Consider whether local services provide:

- › A clearly defined psoriasis care pathway from diagnosis through to long-term management.
- › Clear arrangements for follow-up, monitoring, escalation and rapid re-entry to care.
- › A shared understanding of roles and responsibilities across primary, community and specialist care.

Identify variation and gaps:

Where care may be inconsistent, fragmented or difficult to navigate, and how this impacts outcomes, confidence, and service use.

Consider:

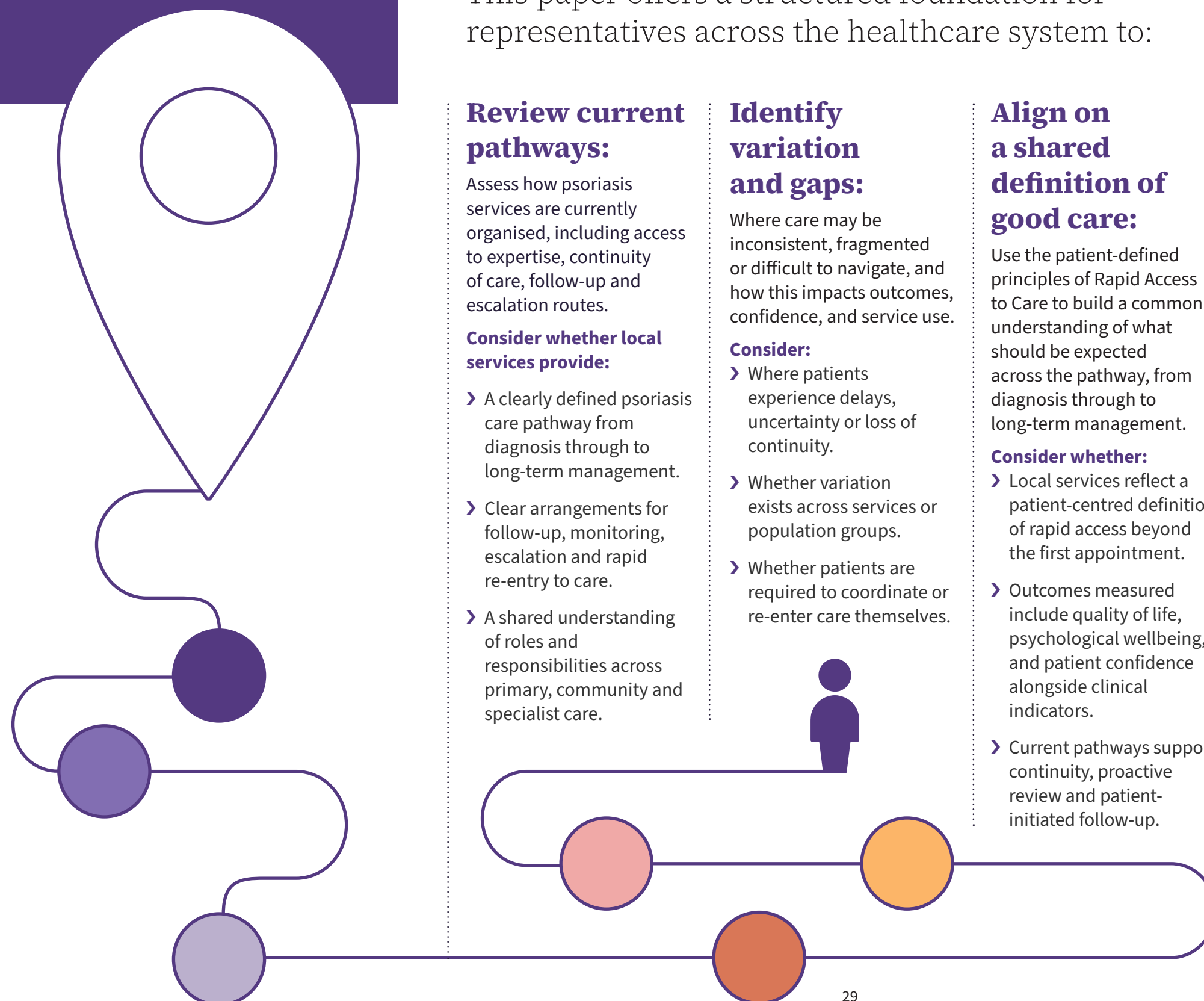
- › Where patients experience delays, uncertainty or loss of continuity.
- › Whether variation exists across services or population groups.
- › Whether patients are required to coordinate or re-enter care themselves.

Align on a shared definition of good care:

Use the patient-defined principles of Rapid Access to Care to build a common understanding of what should be expected across the pathway, from diagnosis through to long-term management.

Consider whether:

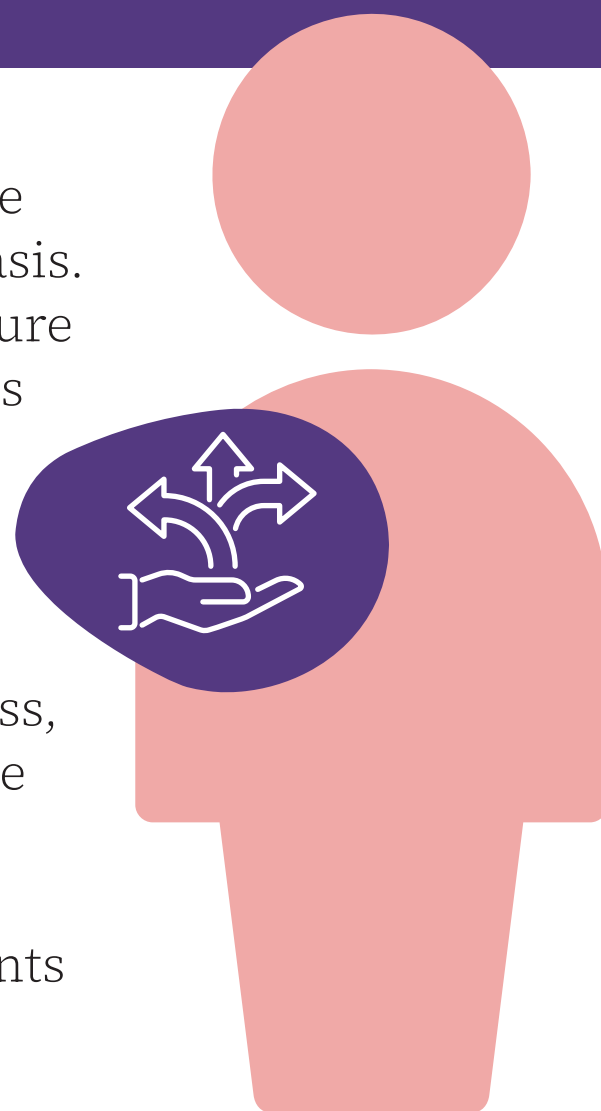
- › Local services reflect a patient-centred definition of rapid access beyond the first appointment.
- › Outcomes measured include quality of life, psychological wellbeing, and patient confidence alongside clinical indicators.
- › Current pathways support continuity, proactive review and patient-initiated follow-up.



Call to Action

People living with psoriasis should be able to access timely, coordinated care whenever their needs change – not only when they are first diagnosed.

Effective treatments have transformed what is possible for people living with psoriasis. The next challenge is to ensure that every person, regardless of where they live, can access care that delivers those benefits throughout their lives. By organising services around timely access, continuity, personalised care and rapid re-entry when needs change, the NHS can improve outcomes for patients while making better use of specialist expertise.

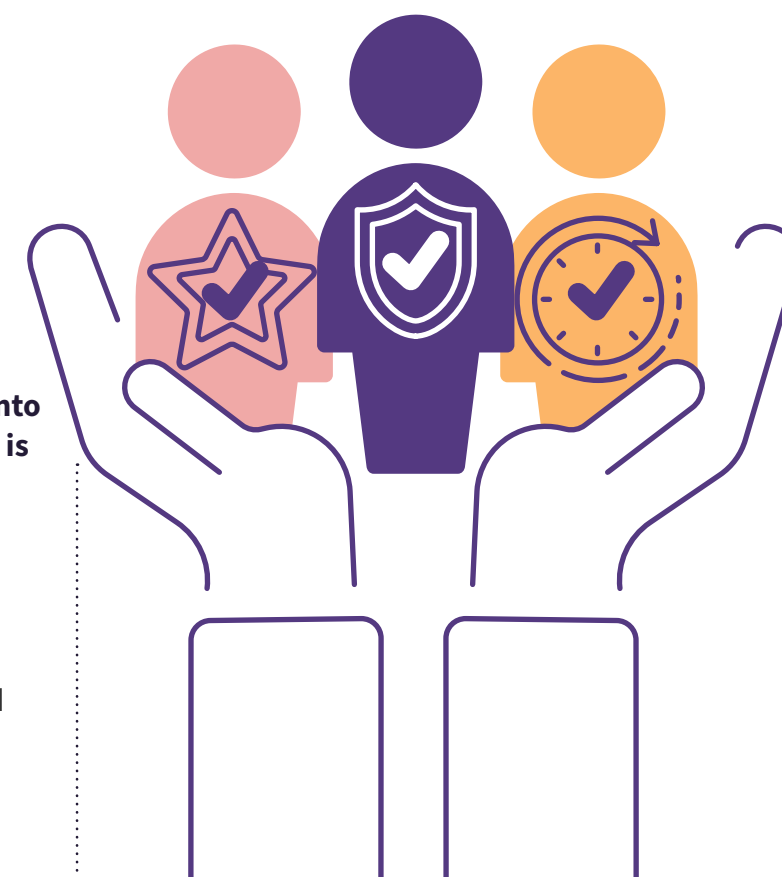


This paper sets out the patient-defined principles needed to achieve that ambition. Psoriasis UK calls on NHS organisations and healthcare professionals to turn these principles into practical changes in how psoriasis care is organised and delivered:

- › **Commissioners and system leaders** should commission psoriasis services as coordinated pathways, with clear arrangements for timely assessment, treatment optimisation, escalation and rapid re-entry to specialist care when needs change.
- › **Clinicians and service leaders** should develop and adopt models of care that improve continuity, support shared decision-making and provide timely access to the right level of expertise.
- › **Healthcare professionals** should measure outcomes that matter to patients – including disease control, quality of life, treatment goals and experience of care – not only disease activity and measures that are easiest to count.
- › **All those involved in planning and delivering psoriasis care** should work across organisational and professional boundaries to ensure that patients do not face unnecessary delays, repeated assessments or gaps in care when their needs change.

GIRFT: next steps

GIRFT is planning future work to improve the assessment and management of psoriasis, including the development of updated guidance



Rapid access is not simply about faster appointments. It is about timely access to the right expertise and the right treatment, at the right time, with the ability to move between levels of care as needs change.

References

1. Chakith MRS, et al. PeerJ. 2025;13:e19325;
2. Parisi R, et al. J. Invest Dermatol. 2013; 133(2):p377–385;
3. Kimmel GW and Lebwohl M. Evidence-Based Psoriasis. 2018:1–16;
4. Local Government Association. Place and health: Bridging the gap in health inequalities. 2025. Available at: <https://www.local.gov.uk/publications/place-and-health-bridging-gap-health-inequalities>;
5. National Institute for Health and Care Excellence (NICE). Psoriasis: assessment and management. 2012. Available at: <https://www.nice.org.uk/guidance/cg153/chapter/Recommendations>;
6. Canteenwala Z, et al. Cureus. 2025;17(10):e94590;
7. British Association of Dermatologists. Psoriasis – an overview. Available at: <https://www.bad.org.uk/pils/psoriasis-an-overview>;
8. NHS England. Referral optimisation for people with skin conditions. Available at: <https://www.england.nhs.uk/wp-content/uploads/2022/09/B1149-referral-optimisation-for-people-with-skin-conditions.pdf>;
9. NHS England. Implementing patient initiated follow-up (PIFU) in dermatology services. Available at: <https://www.england.nhs.uk/long-read/implementing-patient-initiated-follow-up-pifu-in-dermatology-services/>; (All links accessed July 2026).

