Key components of eczema 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 adult and child)Assess adherence to treatment and reasons for non adherence. Provide written management Plan. Ensure adequate quantities prescribed. Assess and manage complications and associated conditions including secondary infection, asthma, allergies, mental health issues including depression, lymphoedema (stasis eczema), HIV (seborrhoeic eczema)	Advice and Guidance or teletriage may help to optimise topical treatments (eg calciuneurin inhibitor use) – may return to GP care or move to OP assessment. See Teledermatology Roadmap	Dermatology OP: initial shared management plan with paediatric input if appropriate. Optimise topicals including calcineurin inhibitors, consider phototherapy, systemic drugs and biologics following NICE guidance. Offer written action plan to support shared decision making		Combined dermatology/ paediatric clinics may support some children with more complex eczema
		Nurse or pharmacist led systemic drug and biologics clinics Nurses should be trained and banded in line with BAD/BDNG guidance		PIFU or regular review not usually necessary unless on systemic drugs
Refer to secondary care when failure to respond adequately to first line topical treatments prescribed in adequate quantities for adequate period of time or severe eczema / erythroderma. Optimise referral in line with NOTP guidance	Identify (1) Emergencies see < 48 hrs - such as acute erythrodermic eczema - may need admission (2) Urgent OP– such as sub erythrodermic eczema or severe impact of disease – may progress to emergency if delayed treatment (3) Routine OP- whilst waiting advice and guidance dialogue or GPwER advice may optimise management or enable cancellation of referral	Emergency OP in larger departments same day assessment urgent issues	Inpatient: rarely necessary but requires nurses with appropriate skills	Primary/ secondary shared care of people taking systemic drugs increase community management
		Identify early related issues such as allergy, asthma, alcohol, sexual function, mental health problems	Nurse led paediatric and adult clinics educate to improve, understanding + adherence to topical treatment and bandage / wet wraps	Liaison with school nurses when appropriate
Presents to A&E: if acute erythroderma/ sub erythroderma and haemodynamically unstable / or eczema herpeticum then triage to dermatology services (may need acute admission) – others discharge to primary care with advice			Involve allergy services if needed particularly for children	Optimise follow up arrangements

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

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

Support mental health, psychological wellbeing in patients and carers in line with APPGS advice, when appropriate with psychology and mental health services

	Regional plans required for safe and funded management of rare out of hours emergencies –not required on site in every hospital	Patch testing for contact allergy should meet BAD service standards	Phototherapy clinic and service should meet BAD service standards	Medicine monitoring: review biologics use compared to national norms and explore reasons for variance
			Consider home phototherapy (Leeds/ Scotland model)	
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		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

Clinicians should encourage self-management and patient education open days in community and secondary care – from assessment of treatment adherence (including addressing any concerns about topical steroids) to living with a long-term condition;

Collect patient reported data and participate in relevant NIHR studies such as A-STAR. Clinical research units usually have better outcomes

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