

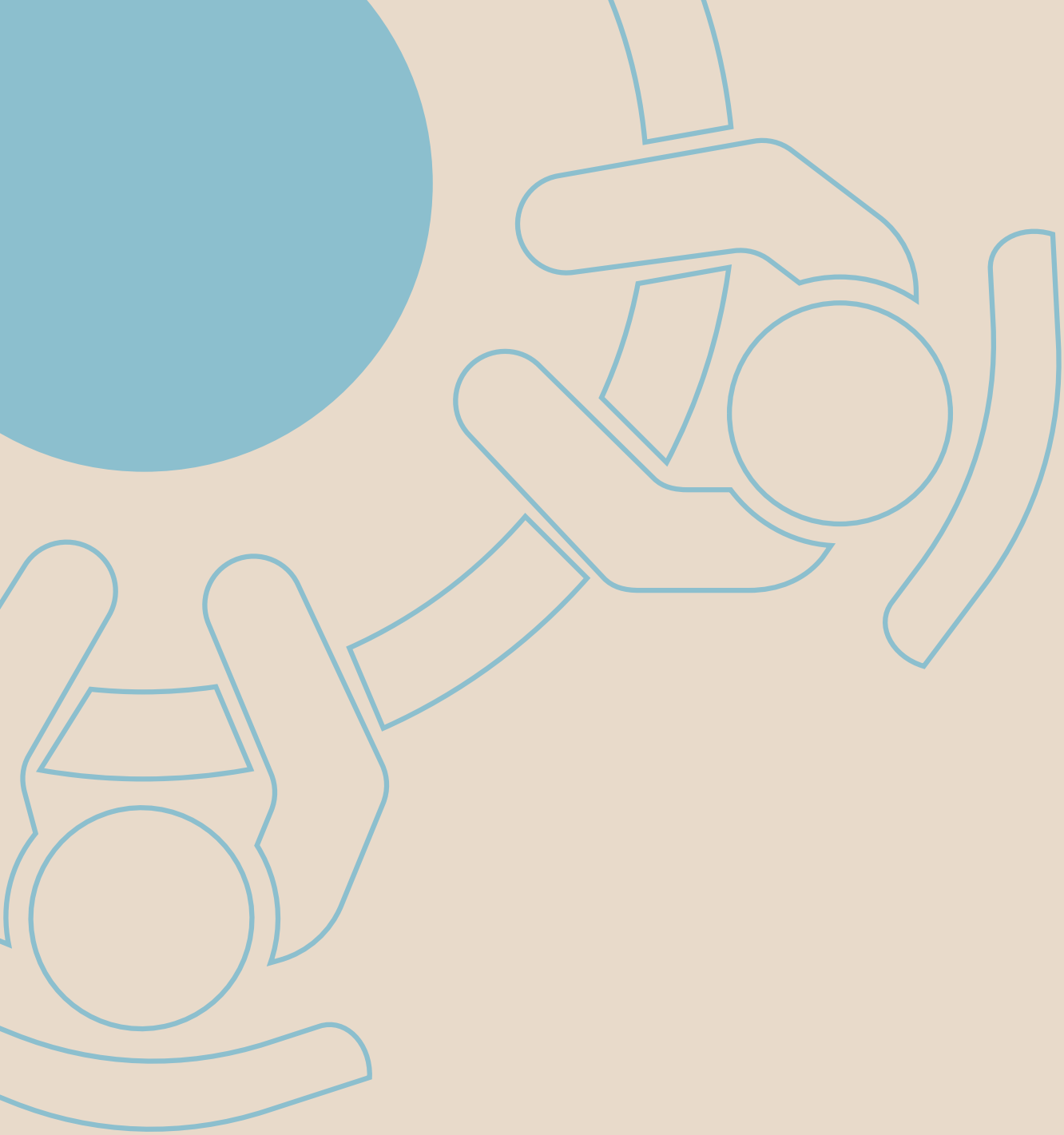
THE PHARMACIST

VIRTUAL ROUND TABLE

# EMOLLIENTS ACROSS NHS PATHWAYS

## EMBEDDING PREVENTION AND GETTING THE BASICS RIGHT

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## BACKGROUND TO THE PROJECT

In August 2026, five UK-based healthcare professionals (HCPs) – a community pharmacist, a dermatology pharmacist, a consultant dermatologist and two general practitioners (GPs) – met virtually to discuss the role of emollients across NHS care pathways. The conversation focused on how patients access emollients across prescription, over-the-counter (OTC) and Pharmacy First routes; the evidence base for emollient selection, including the role of oatmeal as an active ingredient; and how alignment between dermatology, general practice and community pharmacy could be improved.

The Advisers first examined the current practice landscape, including variation in access, switching and substitution behaviours, and the influence of social media on patient expectations. Discussion then turned to evidence-based emollient selection in a prevention-focused model, the clinical and consumer positioning of oatmeal-containing emollients, and the points at which NHS pathways break down. Finally, the Advisers identified practical, high-impact actions that could be implemented locally to improve alignment between dermatology and pharmacy.

The opinions and recommendations of the Advisers are summarised herein.

## EXECUTIVE SUMMARY

Despite their central place in dermatological care, and their prominence at the pharmacy counter, across the NHS emollients are often treated as an optional extra rather than as core, preventative therapy. The Advisers agreed that this misperception, held by prescribers and patients alike, drives a cascade of familiar problems: quantities prescribed that are too small to be clinically meaningful, patients who are never shown how to apply their emollient, inappropriate switching and substitution, and advice that varies from one care setting to the next.

Community pharmacy emerged not merely as an under-used asset but as the natural coordinator of preventative emollient care, and an opportunity to improve understanding and adherence amongst patients. It is the most accessible and most frequently visited point of contact in the NHS; three of the seven Pharmacy First gateway conditions are dermatological; and every newly registered pharmacist is now a prescriber (as of September 2026). The infrastructure for pharmacy to lead is already in place — what is missing is the formal embedding of emollient care within it, and consistent awareness of the wider care pathway across the profession.

The Advisers also recognised a marked shift in patient behaviour. Patients now arrive ingredient-'literate', shaped by social media, and increasingly sceptical of "chemical" products. This represents both a challenge and an opportunity for HCPs to own the evidence around ingredients such as colloidal oatmeal, which was felt to be well liked by patients yet under-specified in adult clinical practice.

The overriding conclusion was that improving emollient care does not require new science: it requires getting the basics right, consistently, at every point of the patient journey.

## PARTICIPANTS



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**Abbreviations**
**BAD** British Association of Dermatologists
**GP** general practitioner
**HCP** healthcare professional
**NHS** National Health Service
**OTC** Over-the-counter
**PCDS** Primary Care Dermatology Society

**References**
**1** Ridd MJ, Santer M, MacNeill SJ, et al. Effectiveness and safety of lotion, cream, gel, and ointment emollients for childhood eczema: a pragmatic, randomised, phase 4, superiority trial. Lancet Child Adolesc Health 2022;6(8):522–532.
**2** Le Roux E, Edwards PJ, Sanderson E, Barnes RK, Ridd MJ. The content and conduct of GP consultations for dermatology problems: a cross-sectional study. Br J Gen Pract 2020;70(699):e723–e730.

## EMOLLIENTS ARE A CORE THERAPY TREATED AS AN ADJUNCT

### Fragmented pathways produce highly variable advice

It was emphasised early in the discussion that emollients sit at the base of the therapeutic pyramid. Even at the specialist end of the pathway, moisturisation remains the critical foundation on which all other treatment is built, yet because emollients are not perceived as "being prescribed like a drug", their importance is routinely minimised.

> Moisturisers can be critical to the skin, more so than any other specialist medication I can throw on top.
>
> An Adviser on the importance of emollients at the base of the therapeutic pyramid

This perception is reinforced by the system itself. NHS prescribing of emollients was described as heavily cost-driven, with a long-standing message that products for dry skin can be self-funded – a message that was felt to have inadvertently signalled that emollients are unimportant, while leaving pharmacists, and their teams, without clear guidance on what to advise in the self-care setting.

However, it was emphasised that access and acceptability are not the same for every patient. The Advisers noted that the cost of self-funded emollients can create a particular barrier for people on lower incomes, while cultural preferences, personal expectations and individual physical characteristics may shift perspectives, not least skin tone, which may or may not be reflected by product imagery, reinforcing the need for advice that is both clinically sound and tailored to the individual.

The discussion continued with dermatology waiting lists which, as long as they are, mean almost every patient reaching secondary care has already received advice from somewhere else – a pharmacist, a pharmacy counter assistant, an allied health professional, or in some cases non-medical avenues such as social media. The advice received was described as highly variable, ranging from sensible to actively harmful, including patients advised to use minimal moisturiser or to start emollients only once a course of topical steroid had finished. Consistency in at least the basic messages – how much, how often, and why – was considered essential, because patients become confused and lose confidence when each setting tells them something different.



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### Under-prescribing and poor technique undermine treatment before it starts

The Advisers focused repeatedly on two basic failures within emollient-based treatment provision. The first is quantity: patients are commonly prescribed a single small tube (~30g) with no repeat prescription, yet for some patients, quantities of 500g per week may be required. It was noted that GPs are often taken aback by the quantity of emollients patients will need, and that under-supplied patients run out, stop treatment, and are left repeatedly chasing prescriptions – an avoidable source of frustration and waste.

The second is technique. Just as inhaler technique cannot be assumed in asthma, it should not be assumed that patients know how to apply an emollient. Advisers described anecdotal cases of patients vigorously rubbing emollients on their skin, causing more harm than good. Practical guidance including how much emollient to apply, how to store and decant products safely, and tips such as keeping a small pot to hand at work or in a bag were felt to make a tangible difference to adherence, with one Adviser's centre having developed a patient education video for precisely this purpose.

### Any emollient is better than none, but we can do better

The Advisers agreed that a long-standing maxim, 'the best emollient is the one the patient will actually use', still holds in a prevention-oriented NHS. An emollient that is too greasy, marks clothing or feels unpleasant will simply not be used, however clinically appropriate, and any emollient is better than none.

However, 'acceptability' was increasingly seen as the floor rather than the ceiling. A growing evidence base around individual ingredients and formulations now allows a more tailored conversation, e.g. is the target the skin barrier, itching, or maintenance between flare-ups? Many patients benefit from a small repertoire of two or three formulations or consistencies, varied by disease severity, season and lifestyle, rather than a single product.

## OATMEAL: LIKED BY PATIENTS BUT UNDER-UTILISED IN ADULT PRACTICE

### The "natural" positioning is an open door, if HCPs own the evidence

The Advisers agreed that oatmeal-containing emollients occupy an unusual position: they are highly visible and well liked in the consumer space, yet rarely deliberately selected in adult clinical practice. In paediatric settings, colloidal oatmeal products were reported to be the most requested branded emollients, driven by parents' preference for ingredients perceived as natural, soothing and time-proven. In adult practice, by contrast, oatmeal was considered under-utilised, even at a time when growing numbers of patients are actively refusing paraffin- and petrolatum-based products.

> The benefit of colloidal oatmeal over certain other ingredients includes its anti-itch properties. It is soothing, it is a humectant, and it offers barrier support.
>
> Expert comment on ingredient-led emollient selection

Oatmeal-containing products already sit on NHS formularies in some areas, and no conflict was identified between NHS prescribing guidance and OTC positioning. The gap, it was felt, lies in how formularies present products: emollients have traditionally been grouped simply as creams, ointments and lotions, with little emphasis on ingredients or their properties, leaving prescribers to work by trial and error.

> Instead of just blindly going through the emollient list on the formulary, hoping you'll hit something that works, it could become a more tailored decision.
>
> An Adviser on ingredient-led emollient selection

There was also discussion of credibility. Increasingly, patients receive ingredient advice second- or third-hand (including sources such as social media and beauticians), often without accompanying evidence. When a patient brings this information to an HCP, and HCPs merely concur on those deemed clinically effective, it can come across as a 'secret' they had been previously withholding. The Advisers felt the profession needs to get ahead of this: to own and communicate the evidence, and to make the case for value as well as cost, particularly for patients self-funding on limited incomes. It was further noted that artificial intelligence tools and search algorithms will surface whatever evidence is publicly available, adding urgency to establishing good evidence and consensus guidance.

A note of caution was raised on formulary economics: defaulting to the cheapest product is a false economy if the result is non-adherence and repeat consultations, which cost the NHS far more than the price difference between emollients.

## WHERE THE PATHWAY BREAKS – AND WHY PHARMACY IS THE PLACE TO START

Three recurring failure points were identified as patients move between dermatology, general practice and pharmacy.

**Rigid formularies with poor signposting.** Where a product is not prescribable, it was stressed that signposting should be emphasised. HCPs have a responsibility to direct patients to good-quality information about ingredients, so that advice



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remains consistent whether a product is prescribed or purchased. The developing national formulary for England was seen as a significant opportunity for dermatology and pharmacy organisations to embed agreed emollient guidance and signposting at scale.

**Absent communication in both directions.** By the time patients reach secondary care they have typically tried five, six or more emollients, and can rarely recall which. With no shared record, clinicians fine-tune regimens blind. Importantly, it was argued that alignment does not require every setting to give identical care – it requires each setting to know what the others have done.

> If we really want to improve the ways in which we communicate with each other... we just need to know what has already been tried, what patients have been told, and then we can adjust as necessary.
>
> Suggested pathway communication improvements

**Knowledge and confidence gaps at the front door.** Dermatology occupies a small place in both medical and pharmacy training, despite skin problems being the most common presentation among new general practice consultations, and one in five children having eczema.[1,2] In community pharmacy, the gap was framed as one of pathway awareness rather than clinical skill: without insight into the wider care pathway, opportunities for early intervention are missed and patients absorb the assumption that nothing useful is available at the pharmacy counter. It was estimated that the majority of paediatric dermatology referrals could be managed in primary care if the knowledge and confidence existed there.

On substitution, the Advisers were unambiguous: swapping a working emollient for a cheaper equivalent is not acceptable practice, and for severe disease some centres now issue an "emollient letter" specifying the product, the clinical rationale and the quantities required. It was also observed that the greater risk at the front of the pathway may be diagnostic rather than product-related. Conditions such as impetigo are frequently mislabelled or overlie an untreated background condition, making a clear safety net and escalation route essential.

Pharmacy First was nonetheless seen as an open door. With three of its seven gateway conditions already dermatological, and every newly registered pharmacist now a prescriber, embedding structured emollient care within the service was considered both natural and timely.

## PATHWAYS TO PROGRESS, BY SPECIALISATION

### What community pharmacy can do now

Standardise emollient counselling: every patient handed an emollient should be shown how to apply it, how much to use and how often — mirroring the transformation achieved in respiratory care through routine inhaler

technique checks. Embed emollient reviews and optimisation into Pharmacy First contacts, treating every dermatological presentation as an opportunity to check quantities, technique and suitability. Record the products patients have tried through a patient-held "emollient passport" distinguishing genuine treatment failure from poor tolerability, patient preferences or incorrect use, and encouraging patients to photograph products that work and feed this back to prescribers. Use existing channels, such as prescription-ready text alerts, to offer emollient reviews or application guidance.



> Why shouldn't every community pharmacist be able to say, ' This is what we provide as routine care for everybody needing an emollient,'... and then make sure patients know how to use it properly?
>
> An Adviser on the pathway to emollient provision

### What general practice can do now

Prescribe clinically appropriate quantities, on repeat, so patients are not left chasing scripts, and check at review that supply matches use. Reinforce consistent messaging: emollients framed as the preventer and topical steroids as the reliever, an analogy patients with asthma grasp immediately. Document successful products in the record and protect them from substitution. Use waiting-room information screens and QR-code links to approved application videos from bodies such as the BAD and PCDS.

### What dermatology services can do now

Support education across primary care, through bridging teaching sessions from tertiary centres and the development and competency framework for pharmacists being built with the Royal College of Pharmacy and the BAD. Develop practical prescribing guidance, including "emollient letters" that specify product, rationale and quantities for severe disease, and ingredient-level information that helps prescribers select by property rather than trial and error. Improve communication back into community settings, so that pharmacy and general practice know what has been recommended and why.

### System-level change

Use the developing national formulary for England to align emollient pathways and embed agreed signposting at scale. Redesign formulary presentation around ingredients and their properties – barrier support, humectancy, anti-itch – rather than product categories alone. Build shared educational resources and national signposting standards so patients receive the same advice at every point of contact. And put pharmacists, GPs and commissioners around the same local table: the best outcomes described by the Advisers came from formularies and pathways built together.



> This is an area where we can really expect people to appreciate being educated and empowered.
>
> An Adviser on likely perspectives from patients

## SUMMARY

The round table offered a thorough examination of why a therapy as fundamental as emollients remains inconsistently delivered across NHS pathways. The barriers identified were not scientific but structural and cultural: emollients miscast as optional extras, under-prescribing, under-taught technique, rigid cost-driven formularies, fragmented communication, and advice that changes at every step of the journey.

The answer, the Advisers concluded, is hiding in plain sight. Community pharmacy –accessible, trusted, seeing patients more often than any other part of the system, and newly equipped with prescribing capability – is uniquely positioned to coordinate prevention-focused emollient care, with general practice, dermatology and national policy aligned behind it. The ingredient-level evidence, including for colloidal oatmeal, must be owned and communicated by HCPs rather than left to patients to discover.

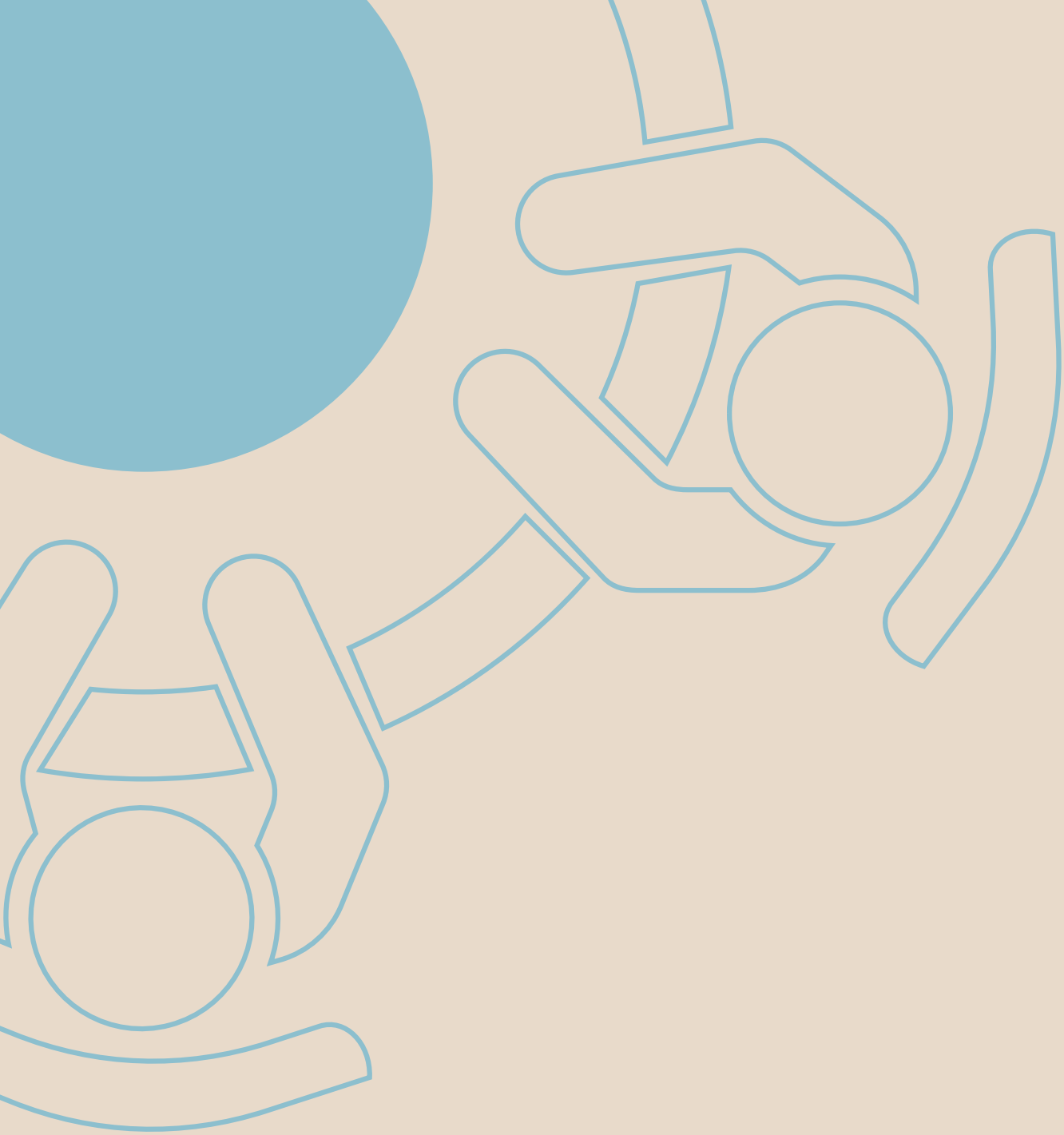
Ultimately, the Advisers converged on a core message: get the basics right. This includes the right emollient, in the right quantity, applied correctly and consistently, with the same advice at every point of contact. In turn, improved outcomes, better adherence and reduced clinical burden are expected to follow.



> We're not talking about high-flying science or weird and wonderful evolving medications. We're talking about getting the basics right.
>
> Round table perspective on the ultimate goal ahead

## Consensus recommendations

- **Recognise emollients as core preventative therapy — not an optional extra**
- **Standardise education on emollient application technique, for HCPs and patients**
- **Improve visibility of the products each patient has already tried**
- **Incorporate ingredient-based decision-making into formularies**
- **Embed structured emollient support within Pharmacy First**



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