National Institute for Health and Clinical Excellence

NICE Quality Standards Consultation – Atopic eczema in children

Closing date: 5pm – Tuesday 16th April 2013

Organisation	**British Association of Dermatologists (BAD)**
Title (e.g. Dr, Mr, Ms, Prof)	See below
Name	**Dr Jenny Hughes, Chair of the Therapy & Guidelines Sub-committee, BAD representing the organisation with individual comments from Dr Julia Schofield, Dr Nick Levell, Dr Mary Glover, Dr Pamela McHenry, Dr Emilia Duarte Williamson and Dr Jenny Hughes**
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Please note: comments submitted on the draft quality standard are published on the NICE website.	
Would your organisation like to express an interest in endorsing this quality standard? ☒ Yes ☐ No For information about endorsing quality standards please visit http://www.nice.org.uk/guidance/qualitystandards/indevelopment	

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Please provide comments on the draft quality standard on the form below, putting each new comment in a new row. When feeding back, please note the section you are commenting on (for example, section 1 Introduction). If commenting on a specific quality statement, please indicate the particular sub-section (for example, statement, measure or audience descriptor). If your comment relates to the standard as a whole then please put ógeneralô

In order to guide your comments, please refer to the general points for consideration on the NICE website as well as the specific questions detailed within the quality standard.

Please add rows as necessary.

Section	Comments
e.g. Section 1 Introduction or quality statement 1 (measure)	e.g. Comment about quality statement 1.
1. Holistic assessment	History taking should include details of sleep disturbance for both child and the parents, impact on the family and any gastrointestinal symptoms. Service providers need to ensure that systems are in place to offer the assessments stated and that this is consistent in all areas to allow equity of access to services. This standard is welcome and the emphasis on assessment is important. However, this could be improved by specifying that the assessor is competent to diagnose eczema and is suitably trained in the assessment of eczema severity.
2. Recording of physical severity	Comments were made that using a definition of atopic eczema as ñmildò, ñmoderateòor ñsevereòdoes not allow for consideration for the site affected if solely based on body surface area involvement; for example, some children may have very severe eczema localised to the face or hands, which has a huge impact on quality of life. This quality statement needs expansion to include recording of sites of involvement and severity at high-impact body sites.

Section	Comments
3. Recording of psychological well being and quality of life	This is an integral part of the holistic assessment and doesn't need to be a separate quality statement. The emphasis on measuring impact on quality of life is welcome. There are excellent, easy to use, readily available validated tools available (Child and Family Dermatology Life Quality tools). These are widely used in clinical practice at initial assessment and to measure response to treatment (clinical outcome). This standard would benefit from making clear that the use of these tools is considered essential to assess impact on quality of life of the child, family and carers (quality of life impact does not always map to clinical severity) at time of initial assessment and also as a robust measure of response to interventions.
4. Stepped approach to management of eczema	In addition to the advice on how to treat the skin, mentioning steroids as the accepted and safe treatment of choice to allay fears about their use, education should also address the avoidance of irritants, details of sun protection and avoidance of contact of individuals with cold sores. A comment was made about the need to indicate age restrictions for calcineurin inhibitors and phototherapy. The standard describes the need for a stepped approach to treatment to be available. It does not make clear that commissioners should demonstrate that they are commissioning the treatments (such as phototherapy, bandaging) that are listed. This could be tightened.
5. Emollient prescribing standard	No further comments ï we agree with the quality standard with regard to emollients.
6. Review of medications	No further comments ï we agree with this quality standard.
7. Treatment of infections	General practitioners should be able to treat these patients as it is a common problem and reviewers agreed with the timeframe for urgent referrals of 2 weeks or less.
8. Treatment of	With regard to the recommendation for the general practitioner to give immediate treatment with systemic aciclovir

Section	Comments
eczema herpeticum	we felt that this needed clarification and specification of oral treatment, and may not always be practical if they are attending for same-day specialist advice. Also, if the child is systemically unwell or has eye involvement they will need intravenous aciclovir
9. Referral to specialists	We agree with this quality standard and in response to question 5 we think that stating an ideal timeframe for children with severe eczema to be seen by a designated specialist is a useful standard, ideally within 6 weeks. Reference to specialist services when psychological problems are present is welcome. However, this needs to be supported by a statement about psychological services being available within the specialist service. Psychological services in specialist dermatology services are extremely limited and patient care would improve if commissioners required such services to be available. This standard might also benefit from including the need to refer to specialist services in the context of safeguarding anxieties, where there is concern that parents are resisting the use of conventional treatments to the detriment of a childôs wellbeing (e.g. steroid phobia).
10. Suspected food allergy	We felt that this was the most controversial quality standard and needed modification. Firstly, moderate or severe atopic eczema would not respond to emollients and mild topical steroids, so this erroneously implies that all children in this category need dietary intervention whereas more potent topical steroids and other standard treatments should be tried first. The phrase ñrare allergy casesòwas not clear and needs explanation. With regard to the advice that a 6-8 week trial of extensively hydrolysed hypoallergenic formula or amino acid formula ï could evidence be provided about this potentially hugely expensive intervention in children without a history suggestive of gut dysmotility or faltering growth? The type of ñspecialist adviceòis also not elaborated upon.

Section	Comments
	Although dietary treatment has an important role in a small percentage of children with eczema, there is limited evidence to support expensive dietary intervention in all cases of moderate or severe eczema. Exclusion diets based on hospital allergy testing can be considered for children in whom there is a history or clinical signs suggestive of food allergy or in children failing to respond to adequate topical treatment. Children require a balanced diet so any changes should be closely supervised by a doctor or dietician.
General	We also think a separate quality standard for systemic treatments in secondary care is important.
General: Domains and NHS Outcomes Framework	The overarching indicator and improvement areas for childhood eczema do not sit with Domain 1, i.e. prevention of premature death. Childhood eczema is rarely, if ever, life threatening. In contrast, it is often a long-term condition impacting on quality of life of child, family and carers. The Domain that this standard sits with, in terms of the NHS Outcomes Frameworks, is Domain 2. The management of childhood eczema should be mostly community-based and the NICE guidance and Quality Standards should seek to enhance the quality of care for children and their families. Outcome measures that use mortality and Potential Years of Life Lost (PYLL) are inappropriate and are unlikely to demonstrate any change. It is appropriate to include reference to Domain 4, as enhancing patient experience is important for this group. The relevant NICE guidance seeks to encourage an increase in the knowledge of the condition in order to optimise self-management, and this too sits within Domain 2.
General: safeguarding the well-being of children	No mention is made of safeguarding the interests of the child with eczema where parents use alternative therapies and withhold conventional treatments, leading to uncontrolled eczema. This is an important area. It could perhaps be included in Standard 9.
General	We would like to highlight the Working Party Report on Minimum Standards for Paediatric Services 2012 by the British Association of Dermatologists and British Society for Paediatric Dermatology.

Closing date: Please forward this electronically by 5pm on **Tuesday 16th April 2013** at the very latest to QSconsultations@nice.org.uk

PLEASE NOTE: The Institute reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion of the Institute, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.