Draft pro-forma for consultation on public health quality standards library

Overview

NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. They are developed from existing guidelines developed or accredited by NICE. Quality standards consider the complete care pathway, from public health to health and social care. Although some standards will be area specific, there will often be significant overlap across areas and these are considered during development of the standard.

Following the new public health responsibilities for local authorities, which came into effect in April 2013, NICE was referred an initial programme of quality standards for public health, which covered alcohol, obesity and smoking. These were in addition to referrals NICE had previously received for quality standard development which addressed areas of public health concern, such as drug use disorders. We have included the currently referred and published public health related quality standards for information.

This consultation aims to seek views on potential further topics for quality standard development to help improve the quality of public health. Where there are no existing relevant guidelines, this topic list will inform the development of future guidelines. As a result, the scheduling and publication dates of the quality standards will be affected by the availability of appropriate guidance. We are hoping to collect your views on an initial proposed list and any other areas you feel need to be included. The consultation will be open from **the 27th September until the 20th of December**.

Each proposed topic will be considered, but it is not possible to guarantee that all of these topics will be taken forward for development as this is dependent on a number of elements such as the crossover and interface with other quality standards topics scheduled for production, existing evidence based guidance and sector/Government priorities.

Organisation	**British Association of Dermatologists**
Title (e.g. Dr, Mr, Ms, Prof)	**(see below)**
Name	Prof Christopher Bunker; Dr Jenny Hughes (Consultant Dermatologists)
Job title or role	President, British Association of Dermatologists; Chair, Therapy & Guidelines sub-committee
Address and post code	Willan House, 4 Fitzroy Square, London W1T 5HQ
Telephone number	0207 383 0266
Email address	clinicalstandards@bad.org.uk
Please note: comments submitted may be published on the NICE website.	

The personal data submitted on this form will be used by the National Institute for Health and Care Excellence (NICE) for the purpose specified. The information will not be passed to any other third party and will be held in accordance with the Data Protection Act 1998.

Currently referred/published public health quality standards

The National Institute for Health and Care Excellence has already received referrals for quality standard development that address public health areas. As a result these do not form part of the consultation. However, these are presented below for information so that stakeholders are able to appropriately comment on the proposed library.

Previously referred topics	Quality standard status	Areas covered
Alcohol dependence and harmful alcohol use	Published (QS 11)	Screening and brief interventions, physical complications and alcohol dependence.
Alcohol: preventing harmful alcohol use in the community	To be developed	To be determined.
Smoking cessation: supporting people to stop smoking	Published (QS 43)	Identification, referral, pharmacotherapy and outcome measurement
Smoking: reducing tobacco use in the community	To be developed	To be determined.
Obesity: prevention and management in adults	To be developed	To be determined.
Obesity: prevention and management in children	To be developed	To be determined.
Physical activity: encouraging activity in all people in contact with the NHS	To be developed	To be determined.
Drug use disorders	Published (QS 23)	Needle and syringe programmes, assessment, psychosocial interventions and rehabilitation.
Contraceptive services (including emergency contraception)	To be developed	To be determined.
Provision of termination of pregnancy services	To be developed	To be determined.
Mental well-being: older people in care homes	To be developed	To be determined.
Dementia	Published (QS 1 and QS 30)	Assessment and personalised care planning, liaison services, respite services, choice and control in decisions, relationships and needs and preferences
Health and well-being of looked after children and young people	Published (QS 31)	Collaborative working between services, stability and quality of placements, support from specialist services and continuity of

Previously referred topics	Quality standard status	Areas covered
		services.
Hepatitis B	To be developed	To be determined.
Infection control	To be developed	To be determined.
Sepsis	To be developed	To be determined.
Tuberculosis	To be developed	To be determined.
Bacterial meningitis and meningococcal septicaemia in children and young people	Published (QS 19)	Monitoring, initiation of antibiotics, lumbar puncture, access to specialists, transfers and follow up.

Proposed topics for the public health quality standards library

The table below lists the proposed topics for the public health quality standards library. It should be noted that the proposed list does contain topic areas which have previously been referred to NICE or that have been consulted upon as part of the potential Social Care library. In these instances the proposed coverage of the topic and the interfaces with health and social care will be taken into account when considering stakeholder feedback. Stakeholders are asked to consider the list below and provide the following feedback:

- Should the topic be included (Yes/No)?
- Why should the topic be included/excluded?
- If it is to be included what key areas should be covered?

In order to analyse the responses we would appreciate it if stakeholders could answer either yes or no to the first question and provide a more detailed rationale in the subsequent columns.

Proposed Topic	Should this be included within the quality standards library? (Yes/No)	Why should this be included/excluded?	If included what are the key areas to cover?
Tobacco			
Smoking: harm reduction			
Accident and injury prevention			
Falls: prevention			
Preventing unintentional injury			
Road safety			
Homes: preventing accidents and injury			
Violence			
Domestic violence			

Proposed Topic	Should this be included within the quality standards library? (Yes/No)	Why should this be included/excluded?	If included what are the key areas to cover?
Physical environment			
Spatial planning			
Housing: planning to improve health and well-being			
Transport and Health			
Oral Health			
Oral health promotion in the community			
Oral health promotion in care homes and hospitals			
Drugs			
Drug use prevention			
Sexual health			
Sexual health across the life course			
Mental health and well-being			
Mental well-being: life course, settings and subgroups			
Suicide prevention			
Cross cutting interventions			
Primary prevention: population and community based primary prevention strategies, including the role of A&E, at different stages of the life course.			
Secondary prevention: population and community based secondary prevention strategies at different stages of the life course			

Proposed Topic	Should this be included within the quality standards library? (Yes/No)	Why should this be included/excluded?	If included what are the key areas to cover?
Community engagement: effective strategies for behaviour change			
Programme management: effective ways to run public health programmes to generate a change in behaviour			
Setting based approaches			
Workplace: long-term sickness absence management			
Workplace: health promotion and mental well-being			
School-based interventions: health promotion and mental well-being			
Community pharmacy: promoting health and well-being			
Specific population groups			
Maternal health: promoting maternal health through community based strategies			
Older people: promoting mental wellbeing and independence through primary, secondary and tertiary prevention.			
Maternal and child nutrition: improving nutritional status			
Black and minority ethnic groups: strategies for promoting health and preventing premature mortality			

Proposed Topic	Should this be included within the quality standards library? (Yes/No)	Why should this be included/excluded?	If included what are the key areas to cover?
Vulnerable populations: strategies for tackling inequalities, including people with severe mental ill-health, the homeless and learning disabilities			
Prison population and offenders: health promotion and mental well-being.			
Early years: promoting health and well-being in the early years, including those in complex families.			
Topic focussed			
Skin cancer: prevention	Yes	Ultraviolet radiation (UVR) exerts a number of biological effects on the skin, influencing the immune system and vitamin D metabolism as well as causing DNA damage, photoaging, cancer, and pigmentary changes through biologically complex mechanisms. That UVR exposure is directly linked to skin cancer is indisputable, but because of the differences in relationships of the differing tumours, as well as the complexity of the messages relating to sun exposure, it has been difficult to provide a simple, coherent and safe message that influences public opinion effectively. For this reason a Quality Standard in this area would be hugely beneficial to the public and healthcare professionals alike.	There are several factors that influence recommendations: CAUSES: There is more than one type of skin cancer, and UVR plays a different role in each. VARIABLES: Risk factors vary according to skin type, location, environment, etc. VITAMIN D: UVR carries health benefits as well as health risks, so public messaging must balance these conflicting risks and benefits.
Preventing sight loss			
Sexually transmitted infections			

Proposed Topic	Should this be included within the quality standards library? (Yes/No)	Why should this be included/excluded?	If included what are the key areas to cover?
Reducing sexually transmitted infections			
HIV testing: encouraging uptake			
Immunisation			
Immunisation: promoting uptake in children and vulnerable groups			
Infectious diseases			
Hepatitis C			
Meningitis in adults			
Healthcare associated infections: prevention and management			
Water borne infections			
Influenza			
Legionella			
Norovirus			
Disease control programmes: approaches to effective management			
Lyme disease	Yes		
Antibiotic management			
Effective antimicrobial stewardship			
Non-antibiotic clinical management of infectious diseases			
Emergency planning and resilience			
Winter deaths: preventing excess winter deaths			
Outbreak planning and control			

Proposed Topic	Should this be included within the quality standards library? (Yes/No)	Why should this be included/excluded?	If included what are the key areas to cover?
Emergency planning and disaster response			
Heatwave planning			
Environmental health			
Healthy commercial premises: improving catering provision and implementing effective smoking and alcohol policies			
Radon exposure: protection from radon exposure			
Outdoor air: maintaining good quality air			
Internal air: maintaining good quality air in different setting			
Natural environments			
Environmental noise			

Topics not currently referred to NICE and not within the proposed library

This table is provided for stakeholders to suggest additional topics that are not contained elsewhere within the document. In order for the topics to be considered we would appreciate if stakeholders could provide a rationale and proposed remit for any additional topics.

Are there any other topics that should be included?	Why should this be included?	If included what are the key areas to cover?
Cellulitis	Lower Limb Cellulitis is an infection of the lower leg. Cellulitis is responsible for over 400 000 bed days in the NHS in 2009/10 costing approximately £96 million. It is a recurring problem in many people. This recurrence damages the leg, causing swelling (oedema) that can lead to leg ulceration. There are simple measures that can be taken to reduce the risk of recurrent infection, such as treatment of underlying skin disease present in 25% of cases[1] and taking prophylactic antibiotics.[2] Approximately 33% of cases of cellulitis diagnosed by GPs or hospital doctors referred to a dermatology cellulitis clinic were found to have diagnoses other than cellulitis.[1] People with leg eczema are commonly misdiagnosed with cellulitis, admitted to a hospital bed and treated with expensive, inappropriate intravenous antibiotics for several days until the failure to improve is noted: this triggers a dermatology referral, prescription of cream and discharge. This model of care is inefficient and bad for patients. New models of care involve early dermatology intervention for (1) accurate diagnosis (2) early management of underlying skin disease to reduce recurrence. Community antibiotics given once daily have been shown to be an effective method of treatment for most people with lower limb cellulits.[1] This enables people with lower limb cellulitis to be managed mainly in the community after accurate, early hospital dermatology based diagnosis; this reduces hospital admissions and enables effective shared care. 1. Br J Dermatol 2011, **164:** 1326-8 2. N Engl J Med 2013 May, **368:** 1695-703	Compliance against published standards of care in both community and secondary care settings.

Genital dermatoses	Lichen sclerosus is relatively common, with data suggesting that between 1 in 300 and 1 in 1000 of female patients attending dermatology clinics are affected. There are approximately 1200 cases of vulval intraepithelial neoplasia (VIN) and 500 cases of penile intraepithelial neoplasia (PIN) in the UK every year. Male genital dermatology is poorly managed in the UK; this situation has arisen because multiple inappropriately trained specialties have been involved in managing patients with genital dermatological conditions. Appropriately trained dermatologists, supervising, mentoring or training colleagues from associated specialties (GUM and urology), should be the key workers. Dermatological conditions of the male genitalia have an important and significant impact on the psychosocial, socioeconomic and psychosexual behaviour of affected individuals. Failure to recognise and treat a number of these conditions may lead to penile cancer. Patients presenting with vulval symptoms may be referred to several different specialities. They may also self-refer to genito-urinary clinics. A study of referrals to a vulval clinic shows that diagnostic accuracy is often poor[1] and there can be a significant delay before the correct diagnosis and appropriate management starts. Early diagnosis and treatment is especially important in the field of female genital disease as some of the common conditions seen such as lichen sclerosus and lichen planus lead to scarring and also carry a small risk of developing vulval cancer.[2] Erosive lichen planus can affect multiple sites which needs the input of other specialities who are familiar with the condition and its complications.[3] Pre-malignant diseases, e.g. VIN and extra-mammary Paget's disease can mimic benign dermatoses and need specialist expertise in investigation and management. Lastly, vulval dermatoses and especially vulval pain syndromes lead to significant psycho-sexual morbidity. Standards of care for women with vulval conditions have been published.[4] Specialist vulval clinics can provide a multi-disciplinary service with links to relevant specialties for patients with complex disease. Referral to this type of clinic can avoid unnecessary investigations and treatments. 1. J Obstet Gynecol 2006, **26:** 435-7 2. Br J Dermatol 2010, 163: 672-82 3. Eur J Obstet Gynaecol Reprod Med 2013, **171:** 214-9	Compliance against published standards of care in both community and secondary care settings.

	4. http://www.bssvd.org/images/stories/documents/Standards%20of%20care%20for%20women%20with%20vulval%20conditions_01_.pdf	
Infections and infestations of the scalp in children	Scalp infections in children really refer to tinea capitis infection. There has been a 40-fold increase in incidence in this country in past 2 decades,[1] and the condition has reached epidemic proportions in urban areas. The primary pathogen responsible is trichopyton tonsurans, and the condition has become more widespread through immigration.[2] The disease may manifest in a variety of ways, and children may only have very subtle signs, yet remain highly infectious. As such expertise is required in making the correct diagnosis and instituting treatment. Obtaining formal mycology confirmation is advised, as currently most treatment regimens are unlicensed in the UK. As such, this is best undertaken by experienced dermatologists familiar with the drug regimens. Additionally, 50% of family contacts will be asymptomatic carriers or have occult infection,[3] and need to be screened and treated accordingly, to achieve effective clearance and reduce further spread. Scalp infestations (pediculosis capitis) are common, especially in primary school age children, and eradication/treatment measures are managed in a community setting, ideally with the involvement of school nurses.[4] 1. Tinea capitis in the UK: Health protection agency 2. Scott Med J 2009, **54:** 13-6 3. J Eur Acad Dermatol Venereol 2007, **21:** 1061-1064 4. The Prevention, Identification and Management of Head Lice Infection in the Community : HPA (NW)	Compliance against published standards of care in both community and secondary care settings.
Contact dermatitis (including occupational contact	By adolescence 15% of children have become sensitised to a contact allergen and 7% give a history of reacting following exposure This allergy usually lasts for life. Between 1-3% of adults are sensitised to ingredients of personal care products[1] including fragrance. Skin disease is the second commonest occupational disease in the European Union after	Compliance against published standards of care in both community and secondary care settings.

dermatitis)	musculoskeletal disorders. Contact dermatitis accounts for 70-90% of all occupational skin disease, while contact urticaria accounts for less than 10%. Up to half of workers with occupational contact dermatitis (eczema) experience adverse effects on quality of life, daily function and relationships at home.[2] Standards of Care for management of occupational disease have been published.[3] Specialist dermatology centres provide diagnostic services for complex cases e.g. those involving outbreaks of allergic dermatitis in the workplace or wider community, multiple allergens and photo-allergy. It may involve factory or work place visits as well as specialist patch and photo testing and specialist pharmacy services. Investigation is time intensive requiring a minimum of 3 visits over 5 days and for effective use of resource it is important that the patient is seen at an appropriate centre from the outset. A recent regional audit in Yorkshire identified that there was poor compliance with the minimum standards for provision[4] of such a service. Including cutaneous allergy services would help to drive up standards and by ensuring accurate diagnosis minimise ongoing morbidity and improve the health of the workforce. 1. Br J Dermatol 2001; **144:** 523-32 2. http://www.bohrf.org.uk/projects/dermatitis.html 3. Br J Dermatol 2013; **168:** 1167-75 4.http://www.bad.org.uk/Portals/_Bad/Clinical%20Services/BAD%20%20BSCA%20Working%20Party%20Report%20on%20Cutaneous%20Allergy%20Services%202012.pdf	

Closing date: Please forward this electronically by **5pm on the 20th December 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.