**National Institute for Health and Care Excellence**

**Atopic Eczema in Children**

**Quality Standard Consultation Comments Table**

| No. | ID | Stakeholder | Statement No | Comments | Response |
|---|---|---|---|---|---|
| 1 | 1 | TIPS Ltd | Introduction | My suggestions for additions are in red text.<br>Atopic eczema often has a genetic component that leads to the breakdown of the skin barrier although a common cause is early over exposure of baby skincare products during the neonatal period (Trotter 2010). Avoiding baby skincare products in the neonatal period reduces the risk of babies developing atopic eczema and is recommended in the Postnatal guidelines (NICE 2006). The potential for harm caused by baby products needs to be mentioned in the introduction of this Standard as it is pivotal to the diagnosis and eventual treatment plan. A parent may only need to avoid using products on their baby to affect a complete cure without the need for a diagnosis of atopic eczema or any need for the prescription of emollients. Trotter S (2010). Neonatal skincare. In: Care of the Newborn by Ten Teachers. Hodder Education, Health Sciences, Chapter 7. | Thank you for your comment. The introduction provides an overview but cannot include recommendations. |
| 2 | 2 | Nottingham support group for parents of children with eczema | General | We welcome the development of the quality standards for childhood eczema. With so many children experiencing eczema (20%), it should help children with eczema and their carers know what the minimum level care of care they can expect regardless of where they live or other equality considerations. | Thank you for your comment. |
| 3 | 3 | British Medical Association | General | We would suggest that the scope of the quality standards are extended as atopic eczema continues to affect young people after the age of twelve. Indeed, this is recognised in the introduction to the statement. | Thank you for your comment. The scope of this Quality Standard is based on age up to 12 years as outlined in the Clinical Guideline 57 'Atopic eczema in infants, children and young people'. |

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| 4 | 3 | British Medical Association | General | As general practice generally deals well with eczema, these quality statements are only appropriate for the more severe end of the spectrum or for more moderate cases which have deteriorated. Mild flexural eczema does not need this sort of approach, as should be made clear in the quality statement. It would also be beneficial if the quality standard specified how long GPs should continue to monitor moderate cases of eczema which have improved to become mild cases. | The Topic Expert Group (TEG) prioritised the areas of care they felt were most important for patients, based on the development sources listed. |
| 5 | 12 | Primary care dermatology Society | General | We feel that Dermatology does not sit exclusively within Domains 1 and 4.but should also fit within domain 2 "Enhancing quality of life for people with long-term conditions", in addition to Domains 1 and 4. Eczema is a chronic, relapsing condition. Notwithstanding the comments below we support the general principle and content of this Quality standard. | Thank you for your comment.<br>The technical specification for Domain 2 of the NHS Outcomes Framework does not include atopic eczema for children among its long-term conditions. |
| 6 | 13 | British Association of Dermatologists (BAD) | General | We also think a separate quality standard for systemic treatments in secondary care is important. | Thank you for your comment. The Topic Expert Group (TEG) prioritised the areas of care they felt were most important for patients, based on the development sources listed. |
| 7 | 13 | British Association of Dermatologists (BAD) | General | 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 | Thank you for your comment.<br>The technical specification for Domain 2 of the NHS Outcomes Framework does not include atopic eczema for children among its long-term conditions. |

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| | | | | 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. | |
| 8 | 13 | British Association of Dermatologists (BAD) | General | 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. | Thank you for your comment. The Topic Expert Group (TEG) prioritised the areas of care they felt were most important for patients, based on the development sources listed. |
| 9 | 13 | British Association of Dermatologists (BAD) | General | We would like to highlight Working Party Report on Minimum Standards for Paediatric Services 2012 by the British Association of Dermatologists and British Society for Paediatric Dermatology. | Thank you for comment. The quality standards are based on evidence-based recommendations from national accredited guidance. |
| 10 | 14 | National Commissioning Board (NHS England) | General | The overarching indicator and improvement areas for childhood eczema do not sit with Domain 1, 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 Quality Outcomes Frameworks, is Domain 2. The management of childhood eczema should be mostly community based and the NICE guidance and Quality Standard should seek to enhance the quality of 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, this too sits within Domain 2. | Thank you for your comment.<br>The technical specification for Domain 2 of the NHS Outcomes Framework does not include atopic eczema for children among its long-term conditions. |
| 11 | 14 | National Commissioning Board (NHS | General | No mention is made of safe-guarding the interests of the child with eczema where parents use alternative therapies and withhold conventional treatments, leading to uncontrolled | Thank you for your comment. The Topic Expert Group (TEG) prioritised the areas of care they felt were most important for |

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| | | England) | | eczema. This is an important area. It could perhaps be included in Standard 9. | patients, based on the development sources listed. |
| 12 | 7 | Dermal Laboratories | Introduction | The quality standard on atopic eczema in children could contribute to Domain 2 of the NHS Outcomes Framework – Enhancing quality of life for people with long-term conditions, in addition to Domains 1 and 4.<br><br>As defined in the Department of Health Policy Statement - Improving quality of life for people with long term conditions, a long term condition is a health problem that can't be cured but can be controlled by medication or other therapies.<br><br>As stated in the NICE Clinical Guideline "atopic eczema is a chronic inflammatory itchy skin condition that develops in early childhood in the majority of cases. It is typically an episodic disease of exacerbation (flares, which may occur as frequently as two to three per month) and remissions. In some cases it may be continuous."<br>"Many cases of atopic eczema clear or improve during childhood, whereas others persist into adulthood."<br>Taking these definitions into account atopic eczema should be classified as a long-term condition with the quality standard contributing to Domain 2 of the NHS Outcomes Framework. | Thank you for your comment.<br>The technical specification for Domain 2 of the NHS Outcomes Framework does not include atopic eczema for children among its long-term conditions. |
| 13 | 5 | Royal College of Paediatrics and Child Health | Consultation Question 2 | The absence of any suggestion to conduct an allergy assessment is unacceptable. The term "atopy" denotes an inherited tendency to develop allergies and yet the standards make scant reference to this component. An allergy assessment is essential for all eczema sufferers in order to accurately identify triggers which could be avoided. Furthermore as eczema is commonly the first step in the atopic march the finding of inhalant allergies predicts a high risk of subsequent asthma and/or rhinitis. This will aid prognosis and guide future | Thank you for your comment. Quality Statement 7 covers investigation for food and other allergies. Quality Statement 1 refers to potential trigger factors (that include allergies). |

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| | | | | therapy. | |
| 14 | 12 | Primary care dermatology Society | Consultation Question 2 | We are disappointed to see no mention of the vital role of Nurses in primary care apart from the specialist nurses working under secondary care umbrella. Indeed since most of eczema care is a primary care function more emphasis should be placed on the primary care setting. | Thank you for your comment. The statements are patient-centred, describing the care that children with eczema should receive. Healthcare practitioners in primary care will include nurses. |
| 15 | 5 | Royal College of Paediatrics and Child Health | Consultation Question 5 | There should be a time frame for referral to a paediatric allergist. As this is about children, a generic dermatologist is unacceptable. The referral must be to a paediatric dermatologist. | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |
| 16 | 12 | Primary care dermatology Society | Consultation Question 5 | A time scale is impossible where dermatologist support is patchy or absent or not specialised enough for example where a paediatric trained and qualified dermatologist is required may cause significant problems for patient travelling long distances to access such services. (statement 9)<br>Nevertheless we support a general expectation of local services as a contracting requirement for AQP choices. | Thank you for your comment. This suggestion is now reflected within our Equality Impact and Assessment form which will publish alongside this Quality Standard report which states transport access – 'Significant patient travel problems may arise when accessing a specialist paediatric trained and qualified dermatologist, on referral. The quality standard will specify person-centred care requirements based on need'. |
| 17 | 14 | National Commissioning Board (NHS England) | Consultation Question 5 | This question relates to specifying a time frame for referral to specialist services. The key is that any referral is timely dependent on the severity of the eczema. Specialist dermatology services should be commissioned so that urgent access is available for children with acute severe flares and infections, such as eczema herpeticum, failure to respond to | Thank you for your comment. Timeframes were reviewed for this statement by the TEG but as there was no overall consensus, a timeframe was omitted from the final statement. |

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| | | | | conventional therapy and severe impact on family life. | |
| 18 | | TIPS Ltd | QS1 | Children with atopic eczema are offered an assessment that includes recording of their detailed clinical and treatment histories and identifying potential trigger factors, including feeding method (breast or formula), early use of baby skincare products, irritants, allergens and psychological factors. This needs to be updated in all sections where this is repeated | Thank you for your comment. The Topic Expert Group (TEG) agreed the more concise wording of Quality Statement 1, supported by definitions. |
| 19 | 3 | British Medical Association | QS1 | It would be useful if this statement mentioned the role of health visitors in recognising eczema and in providing support and advice to parents of children under 5. This would also have the benefit of encouraging commissioners to ensure that health visitors are trained in this work. | Thank you for your comment. This is reflected in the Introduction section of the Quality Standard which states that 'all healthcare professionals involved in diagnosing and managing atopic eczema in children should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard' |
| 20 | 6 | Johnson & Johnson Ltd | QS1 | We believe that patient choice of emollient is essential in ensuring compliance in a well managed emollient programme.<br><br>The NICE Clinical Guideline CG57 clearly indicates the element of patient choice and preference, and this is similarly utilised in the NHS Clinical Knowledge Summaries on Prescribing Information for Atopic Eczema as detailed below.<br><br>Therefore it is suggested that an assessment that includes recording of their clinical and treatment histories, exploring factors influencing their adherence to them and identifying factors affecting compliance with treatments should be specified and documented as a part of their treatment history.<br><br>Currently: “Evidence of local arrangements to ensure that children with atopic eczema are offered an assessment that | Thank you for your comment. Patient choice and preference is now reflected in the rationale section of Quality Statement 4 when we state that patient choice of emollient should be 'suited to their needs and preferences.' |

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| | | | | includes recording of their detailed clinical and treatment histories, identifying potential trigger factors, including irritants, allergens and psychological factors."<br><br>Suggested: "Evidence of local arrangements to ensure that children with atopic eczema are offered an assessment that includes recording of their detailed clinical and treatment histories, identifying potential trigger factors, including irritants, allergens and psychological factors, as well as responses to previous and current treatments, documenting patient compliance with them and factors affecting this."<br><br>Support<br><br>NICE Clinical Guideline Atopic Eczema in Children CG57<br>"the correct emollient is the one that the child will use" and<br>"adherence to emollient treatment is the key to successful therapy for atopic eczema"<br><br>NHS Clinical Knowledge Summaries Atopic Eczema Prescribing Information<br>"Patient preference is essential when selecting an emollient" | |
| 21 | 7 | Dermal Laboratories | QS1 | While assessment of children with atopic eczema is clearly detailed in Draft Quality Statement 1 there is no mention that diagnosis should be made by a healthcare professional as per criteria listed in Section 1.1.1.2 of the NICE Clinical Guideline on atopic eczema in children.<br><br>Typo in Service Provider paragraph – delete 'are offered' | Thank you for your comment. In the audience descriptors under Quality Statement 1 we mention healthcare practitioners ensure that they offer children with atopic eczema an assessment at diagnosis that includes recording of their detailed clinical and treatment histories and identification of potential trigger factors. We have also corrected the typographical error under service provider. |

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| 22 | 13 | British Association of Dermatologists (BAD) | QS1 | 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.<br><br>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. | Thank you for your comment. The Topic Expert Group (TEG) agreed the more concise wording of Quality Statement 1, supported by definitions. |
| 23 | 2 | Nottingham support group for parents of children with eczema | QS1 | Identification of potential triggers is not something which happens much in primary practice at the moment. It will hopefully be specific to that child with eczema. Each eczema responds to different triggers and for this to be meaningful, the specific triggers should be identified from the long list of potential triggers. This may require not only an allergy orientated history being taken – but where there is doubt, patch testing to be available. | Thank you for your comment. |
| 24 | 14 | National Commissioning Board (NHS England) | QS1 | 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. | Thank you for your comment. This is reflected in the Introduction section of the Quality Standard which states that 'all healthcare professionals involved in diagnosing and managing atopic eczema in children should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.' |
| 25 | 12 | Primary care dermatology Society | QS2 | The ability to easily record the suggested information at every relevant consultation is a major task which, unless there are simple tick-box standardised computer algorithms and searchable codes is unworkable in primary care. Indeed as the | Thank you for your comment. Draft Quality Statement 2 has now been merged with Draft Quality Statement 4. The TEG considered the recording of eczema |

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| | | | | document comments under 4 “Using the quality standard” “desired levels of achievement should be defined locally” thus suggesting a huge document to say that a CCG could argue lack of funds/personnel or interest in dermatology would allow the “bar “ to be set very low and just regard the quality as an aspiration. | severity as part of the stepped care plan to be a key area for quality improvement. |
| 26 | 3 | British Medical Association | QS2 | The statement should make clear that the assessment should only be made at each consultation about the child’s eczema, rather than at each consultation with the child. | Thank you for your comment. The TEG reviewed your suggestion and 'at each consultation' is now stated in Quality Statement 3 |
| 27 | 4 | British Society for Paediatric Dermatology | QS2 | Growth measurements are very important in the management of these children. We would recommend specifying that accurate height and weight measurements must be taken at each attendance. | Thank you for your comment however the Topic Expert Group (TEG) agreed to focus Quality Statement 2 on the stepped care plan. |
| 28 | 13 | British Association of Dermatologists (BAD) | QS2 | Comments were made that using a definition of atopic eczema as “mild”, “moderate” or “severe” does 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. | Thank you for your comment. The following is now stated within the rationale section of Quality Statement 2- 'Areas of atopic eczema of differing severity can coexist in the same child and each area of the body should be treated independently'. |
| 29 | 2 | Nottingham support group for parents of children with eczema | QS2 | The recording of the skin condition at every consultation is the first step on the way to reliable monitoring of the skin condition. It behoves on the HCP that they do something with the recording – proactively considering the picture of the eczema which will build up over time. | Thank you for your comment. |

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| 30 | 14 | National Commissioning Board (NHS England) | QS2 | This standard is welcome and the emphasis on assessment is important. However this could be improved by specifiying that the assessor is competent to diagnose eczema and is suitably trained in the assessment of eczema severity. | Thank you for your comment. This is reflected in the Introduction section of the Quality Standard which states that 'all healthcare professionals involved in diagnosing and managing atopic eczema in children should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard' |
| 31 | 12 | Primary care dermatology Society | QS3 | The ability to easily record the suggested information at every relevant consultation is a major task which, unless there are simple tick-box standardised computer algorithms and searchable codes is unworkable in primary care. Indeed as the document comments under 4 “Using the quality standard” “desired levels of achievement should be defined locally” thus suggesting a huge document to say that a CCG could argue lack of funds/personnel or interest in dermatology would allow the “bar “ to be set very low and just regard the quality as an aspiration. | Thank you for your comment. The TEG considered the recording of wellbeing and quality of life to be a key area for quality improvement. |
| 32 | 3 | British Medical Association | QS3 | We feel strongly that the implementation of this quality statement will remove time from the consultation which could be better used for education, without providing any benefits to the child or parents. This is particularly true as the statement requires the assessment to be done at each consultation. | Thank you for your comment. The TEG considered the recording of wellbeing and quality of life to be a key area for quality improvement. |
| 33 | 4 | British Society for Paediatric Dermatology | QS3 | More specific on QoL measurements needed. A general holistic discussion about the effect on the child’s life might be more practical than validated measures such as CDLQI.. etc | Thank you for your comment. This will be included in the NICE support for commissioning for atopic eczema in children report which will be published alongside this Quality Standard. |
| 34 | 13 | British Association | QS3 | This is an integral part of the holistic assessment and doesn’t | Thank you for your comment. The TEG |

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| | | of Dermatologists (BAD) | | need to be a separate quality statement.<br>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. | considered the recording of wellbeing and quality of life to be a key area for quality improvement. Approaches to measuring quality of life will be included in the NICE support for commissioning for atopic eczema in children report which will be published alongside this Quality Standard. |
| 35 | 14 | National Commissioning Board (NHS England) | QS3 | 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. | Thank you for your comment. Approaches to measuring quality of life will be included in the NICE support for commissioning for atopic eczema in children report which will be published alongside this Quality Standard. |
| 36 | 2 | Nottingham support group for parents of children with eczema | QS3 | Again, it is important that the recording of the quality of life and the psychological impact of the eczema is not seen as sufficient action. If there are warning signs, intervention must be available in a timely manner. | Thank you for your comment. The rationale for Quality Statement 3 explains that understanding wellbeing and quality of life is part of a holistic approach, and can inform treatment strategies. |
| 37 | 12 | Primary care dermatology Society | QS4 | The ability to easily record the suggested information at every relevant consultation is a major task which, unless there are simple tick-box standardised computer algorithms and searchable codes is unworkable in primary care. Indeed as the | Thank you for your comment. Draft Quality Statement 4 has now been merged with Draft Quality Statement 2. The TEG considered the recording of eczema |

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| | | | | document comments under 4 “Using the quality standard” “desired levels of achievement should be defined locally” thus suggesting a huge document to say that a CCG could argue lack of funds/personnel or interest in dermatology would allow the “bar “ to be set very low and just regard the quality as an aspiration. | severity as part of the stepped care plan to be a key area for quality improvement. |
| 38 | 3 | British Medical Association | QS4 | We would argue that the plans offered in this quality statement are somewhat poorly defined, particularly as there are few resources available for education of this sort. | Thank you for your comment. Draft Quality Statement 4 has now been merged with Draft Quality Statement 2. The TEG considered the recording of eczema severity as part of the stepped care plan, supported by education to be a key area for quality improvement. |
| 39 | 4 | British Society for Paediatric Dermatology | QS4 | We consider this to be the most important Quality standard. More emphasis and explanation should be given to education as it is such a valuable part of the management ( either written, verbal electronic etc) | Thank you for your comment. Draft Quality Statement 4 has now been merged with Draft Quality Statement 2. The final statement focuses on offering treatment based on recorded eczema severity using the stepped-care plan to include 'supported by education' in the actual statement. |
| 40 | 4 | British Society for Paediatric Dermatology | QS4 | More emphasis and explanation should be given to education as it is such a valuable part of the management ( either written, verbal electronic etc) | Thank you for your comment. Draft Quality Statement 4 has now been merged with Draft Quality Statement 2. The final statement focuses on offering treatment based on recorded eczema severity using the stepped-care plan to include 'supported by education' in the actual statement. |
| 41 | 4 | British Society for Paediatric Dermatology | QS4 | No mention is made about maintenance therapy with topical steroids and calcineurin inhibitors for repeated flares of atopic eczema. | Thank you for your comment. Draft Quality Statement 4 is now been incorporated within Quality Statement 2 which includes |

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| | | | | | the stepped approach to management in the definitions section. Within this section, topical calcinuerin and corticosteroids are included as part of the management approach. |
| 42 | 9 | Astellas Pharma Ltd | QS4 | Astellas propose that recording the frequency of flares, or average duration of flare-free periods as a proxy for the measurement of overall disease control and quality of life would be a valuable addition to the quality standard | Thank you for your comment. Draft Quality Statement 4 is now been incorporated within Quality Statement 2 which includes education on recognition and management of flares within its definitions. The TEG did not identify average duration of flare-free periods as a potential quality measure. |
| 43 | 13 | British Association of Dermatologists (BAD) | QS4 | 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.<br><br>A comment was made about the need to indicate age restrictions for calcineurin inhibitors and phototherapy.<br>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. | Thank you for your comment. Draft Quality Statement 4 has now been merged with Draft Quality Statement 2. The final statement focuses on offering treatment based on recorded eczema severity using the stepped-care plan, supported by education. |
| 44 | 14 | National Commissioning Board (NHS England) | QS4 | 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. | Thank you for your comment. Draft Quality Statement 4 has now been merged with Draft Quality Statement 2. Quality Statement 2 includes the stepped approach to management in the definitions section. Within this section, bandages and phototherapy are included as part of the |

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| | | | | | management approach. |
| 45 | 3 | British Medical Association | QS4 | It is often very difficult to persuade parents to use emollients as they are inconvenient. It would be easier to persuade parents of their benefits, and would improve care for children, if the NHS provided "sample packs" of various emollients available so that parents could try them all and then request a prescription for the one which had been most helpful for their child. | Thank you for your comment. In the final Quality Statement 2, the TEG has emphasised the importance of education as part of the stepped care plan which includes teaching and demonstration on the use of emollients. |
| 46 | 2 | Nottingham support group for parents of children with eczema | QS4 | We are really pleased to see that the wherewithal for management of flares by the child or their carers will be given. It is important that any education takes into account the different way that eczema can appear on different coloured skins. | Thank you for your comment. The issue on eczema on different coloured skins has already been noted by the TEG in our Equality Impact and Assessment form which will publish alongside this Quality Standard |
| 47 | 1 | TIPS Ltd | QS5 | There is no mention of silk clothing or bedding sheets for the treatment of atopic eczema despite the excellent success of this type of product (http://www.dermasilk.co.uk/clinical-trials.htm) which can be used without the need for emollients? What about including advice on avoiding all skincare products, less frequent bathing and natural solutions like porridge oats added to bath water before starting emollient therapy? This may seems obvious but these solutions REALLY work and cost nothing to implement. I have been studying this for 17 years and I know this approach works and could save the NHS millions.<br>There is a distinct lack of information regarding the involvement of health professionals, especially midwives, in the promotion of safe skincare guidelines in the neonatal period. Conversely there is a heavy emphasis on the promotion of pharmaceutical preparations which, in my experience, can exacerbate skin conditions.<br>An important step in the avoidance of atopic eczema is for | Thank for your comment. The TEG prioritised the areas of care they felt were most important for patients, based on the development sources listed.<br>The TEG prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. |

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| | | | | parents to follow simple guidelines from birth which have the ability to greatly reduce the incidence and development of neonatal skin conditions of which atopic eczema is one example. The avoidance of baby skincare products in the neonatal period should be advocated in the Atopic eczema guidelines so as to be consistent with the advice given in the Postnatal Care guidelines (NICE 2006) and online at NHS Choices. Baby skincare products should be mentioned specifically alongside soaps and detergents within 'potential trigger factors'. | |
| 48 | 3 | British Medical Association | QS5 | It is often very difficult to persuade parents to use emollients as they are inconvenient. It would be easier to persuade parents of their benefits, and would improve care for children, if the NHS provided "sample packs" of various emollients available so that parents could try them all and then request a prescription for the one which had been most helpful for their child. | Thank you for your comment. In the final Quality Statement 2, the TEG has emphasised the importance of education as part of the stepped care plan which includes teaching and demonstration on the use of emollients. |
| 49 | 5 | Royal College of Paediatrics and Child Health | QS5 | This standard is very welcome as GPs are very disinclined to prescribe sufficient quantities. | Thank you for your comment. The intent of this is reflected in final Quality Statement 4. |
| 50 | 6 | Johnson & Johnson Ltd | QS5 | We believe that patient choice of emollient is essential in ensuring compliance in a well managed emollient programme.<br><br>The NICE Clinical Guideline CG57 clearly indicates the element of patient choice and preference, and this is similarly utilised in the NHS Clinical Knowledge Summaries on Prescribing Information for Atopic Eczema as detailed below.<br><br>Additionally research undertaken in 2009 by the York Health Economics Consortium and the School of Pharmacy, University of London, indicate that the gross annual cost of NHS primary and community care prescription medicines wastage in England is currently in the order of £300m per year, with £90m of | Thank you for your comment. Patient choice is now reflected in the rationale section of final Quality Statement 4 when we state that patient choice of emollient should be 'suited to their needs and preferences.' |

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| | | | | unused medicines in patient's homes. In order to help reduce wasted emollient prescription and ensure correct management and treatment of the condition, we believe patient choice should be taken into account early in the eczema continuum.<br><br>Therefore it is suggested that "choice" should be moved from "definitions" into the Quality Standard as per the suggested wording below:<br><br>Currently: "Children with atopic eczema are prescribed sufficient quantities (up to 500g weekly) of unperfumed emollients for daily use."<br><br>Suggested: "Children with atopic eczema are prescribed sufficient quantities (up to 500g weekly) of unperfumed emollients suited to their needs and preferences for their daily use"<br><br>Support<br><br>NICE Clinical Guideline Atopic Eczema in Children CG57<br>"the correct emollient is the one that the child will use" and "adherence to emollient treatment is the key to successful therapy for atopic eczema"<br><br>NHS Clinical Knowledge Summaries Atopic Eczema Prescribing Information<br>"Patient preference is essential when selecting an emollient"<br><br>Improving the use of medicines for better outcomes and reduced waste – Action Plan. Chapter 5 details how to engage | |

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| | | | | patients in decisions on medicines "If the NHS is to be successful in reducing waste and improving health outcomes by optimising the use of medicines, patients must be at the centre of the decision making process about their treatment". | |
| 51 | 6 | Johnson & Johnson Ltd | QS5 | The definition section includes a warning that aqueous cream is associated with "stinging" when used as a leave on emollient.<br><br>The MRHA has recently published a Safety Warning and Message on the use of aqueous cream that it "may cause skin irritation, particularly in children with eczema". Safety Warning March 26 2013<br><br>Recent studies have concluded that for many children aqueous cream is an irritant. Additionally Professor Richard Guy from the University of Bath, following his study in 2010, has stated that "Aqueous Cream contains 1% sodium lauryl sulphate (SLS) and this is the ingredient, we believe, that causes damage to the skin barrier". (Interview with the National Eczema Society).<br><br>We therefore suggest that mention is made of sodium lauryl sulphate as a potentially damaging ingredient in skincare preparations, especially for children with eczema.<br><br>Support<br><br>Cork M et al, The Pharmaceutical Journal, 271: 747-748, 2003) Tsang, M. and Guy, R. H., 2010. Effect of Aqueous Cream BP on human stratum corneum in-vivo. British Journal of Dermatology, 163 (5), pp. 954-958. | Thank you for your comment. SLS is now reflected in the definitions section of final Quality Statement 4. |
| 52 | 6 | Johnson & | QS5 | The Quality Statement includes an upper limit of emollient | Thank you for your comment. In the final |

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| | | Johnson Ltd | | prescribing amount for a child “up to 500g weekly”. We suggest that, in order to improve compliance and emphasise the value of emollient usage, a minimum amount is also added to the quality standards.<br><br>Whilst at this time, there does not appear to be a strong science or clinical base for this suggestion, we believe there is merit in acknowledging the importance of emollients for the health professional, the patient and the carer, to ensure emollients are the first line of treatment and management in this condition.<br><br>Support<br><br>The NICE Clinical Guideline Atopic Eczema in Children CG57 states that “children with generalised atopic eczema typically require about 250g per week or more of an emollient”, and “Leave-on emollients should be prescribed in large quantities (250–500g weekly)”. | quality statement 4 we have decided to state a minimum quantity of 250g weekly as per recommendation 1.5.2.1 in CG57 in the definition section.<br><br>The importance of emollients as a first line of treatment is a key area of the stepped care plan of statement 2. |
| 53 | 8 | Royal College of General Practitioners | QS5 | I am surprised by the detail and clarity of these quality standards which on the whole are sound.<br>I forsee difficulties with the fifth standard especially about the prescription of adequate amounts of emollient and expect that GPs will object.<br>Locally our prescribing adviser has told all GPs that bath emollients are of doubtful efficacy for example.<br>Emollients vary a lot in price and effectiveness depending also on how and when they are applied!! Perhaps the QS could be more specific or add a proviso that "when needed" the parents can obtain appropriate emollients. It would be measured then by parental questionnaire (as some of the other measures).<br>I was also surprised to see no mention of anti-histamine medicines to help relieve "itch"!! | Thanks you for your comment. The TEG focused on the prescribing of sufficient quantities of emollients for daily use as a quality improvement area. Patient choice is now reflected in the rationale section of new Quality Statement 4 when we state that patient choice of emollient should be 'suited to their needs and preferences.' |

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| 54 | 13 | British Association of Dermatologists (BAD) | QS5 | No further comments – we agree with the quality standard with regard to emollients. | Thank you for your comment. |
| 55 | 2 | Nottingham support group for parents of children with eczema | QS5 | We are pleased to see that in the supporting text there is mention of the need to have a variety of emollients available to be able to suit the skin and lifestyle of the child or carer. | Thank you for your comment. |
| 56 | 12 | Primary care dermatology Society | QS5 | There is a disappointing inclusion of Aqueous cream as an emollient which most would regard only as a wash product. The very inclusion, albeit cautionary, gives it support to those whose only interest is cost. There have been PCTs who have tried to force its use as the “emollient” to be exclusively used! An audit measure we recommend is the emollient/topical steroid ratio which should be at least 10:1.<br>We strongly support the NICE clinical guideline 57 which recommends a choice of emollients but would add not just offered but “actually prescribed” to counteract the movement towards regarding emollients to be purchased by the sufferer or their parents. | Thank you for your comment. In final Quality Statement 4, emollient prescription and patient choice is now stated. The definitions section within this Quality Statement now includes notes on potential issues associated with aqueous cream. |
| 57 | 1 | TIPS Ltd | QS6 | Children with atopic eczema should have their repeat prescriptions of individual and combinations of products reviewed at least annually (every three to six months). I would not expect a parent to be left with the same treatment regime for their child for as long as a year without review. This needs to be updated in all sections where this is repeated | Thank you for your comment. The Topic Expert Group (TEG) felt that medication review was integral to the stepped care plan, and this is now included in the definitions section of final Quality Statement 2, rather than being a separate quality statement. |
| 58 | 5 | Royal College of Paediatrics and Child Health | QS6 | Annual review should include a re-evaluation of the allergic status | Thank you for your comment. The Topic Expert Group (TEG) felt that medication review was integral to the stepped care plan, and this is now included in the definitions section of final Quality |

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| | | | | | Statement 2, rather than being a separate quality statement. |
| 59 | 13 | British Association of Dermatologists (BAD) | QS6 | No further comments – we agree with this quality standard. | Thank you for your comment. The Topic Expert Group (TEG) felt that medication review was integral to the stepped care plan, and this is now included in the definitions section of final Quality Statement 2, rather than being a separate quality statement. |
| 60 | 2 | Nottingham support group for parents of children with eczema | QS6 | It is important that treatments are reviewed and the patients understanding and use of their medications assessed at that time. It is possible to get confused as to which cream to use, how often and how much. It is equally essential that the review is conducted by someone who understands and can react to the information discovered under the review. The review should be performed with the child or carer as equal partners in the review. | Thank you for your comment. The Topic Expert Group (TEG) felt that medication review was integral to the stepped care plan, and this is now included in the definitions section of final Quality Statement 2, rather than being a separate quality statement.<br>In the Introduction section of the Quality Standard it states that 'all healthcare practitioners involved in diagnosing and managing atopic eczema in children should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.' |
| 61 | 13 | British Association of Dermatologists (BAD) | QS7 | 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. | Thank you for your comment. The Topic Expert Group (TEG) reviewed all comments on Statement 7 and decided to merge the intent of recognising the symptoms and signs of bacterial and viral infection in eczema within final Quality Statement 2 on the stepped approach to management, |

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| | | | | | supported by education. |
| 62 | 2 | Nottingham support group for parents of children with eczema | QS7 | Great idea to help children and their carers recognise the symptoms of infection. It is equally important that they know what to do once they have recognised the symptoms. And it is vital that the onus for recognising infected eczema does not rest solely on the shoulders of the child and carer. | Thank you for your comment. The Topic Expert Group (TEG) reviewed all comments on Statement 7 and decided to merge the intent of recognising the symptoms and signs of bacterial and viral infection in eczema within the final Quality Statement 2 on the stepped approach to management, supported by education. |
| 63 | 12 | Primary care dermatology Society | QS8 | Mention of available ophthalmological opinion and support would be important for peri-ocular eczema herpeticum. | Thank you for your comment. The definitions section of final Quality Statement 7 now states that if eczema herpeticum involves the skin around the eyes, the child should be referred for same-day ophthalmological and dermatological advice. |
| 64 | 13 | British Association of Dermatologists (BAD) | QS8 | With regard to the recommendation for the general practitioner to give immediate treatment with systemic aciclovir 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 | Thank you for your comment. The definitions section of final Quality Statement 7 now states that if eczema herpeticum involves the skin around the eyes, the child should be referred for same-day ophthalmological and dermatological advice. |
| 65 | 3 | British Medical Association | QS9 | We would recommend including a short timeframe for this quality statement, as referral and follow-up generally need to be undertaken quickly. | Thank you for your comment. This Quality Statement is now Statement 5 which reads 'Children with uncontrolled or unresponsive atopic eczema, including recurring infections, or psychosocial problems related to the atopic eczema are referred for specialist dermatological advice'.<br>At consultation, there was no consensus on |

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| | | | | | timeframes regarding referral so the Topic Expert Group (TEG) decided not to include a timeframe. |
| 66 | 4 | British Society for Paediatric Dermatology | QS9 | To include referral to specialists paediatric dermatologist for uncertain diagnosis as well as uncontrollable disease, | Thank you for your comment. This Quality Statement is now final Quality Statement 5 which now reads 'Children with uncontrolled or unresponsive atopic eczema, including recurring infections, or psychosocial problems related to the atopic eczema are referred for specialist dermatological advice'. |
| 67 | 5 | Royal College of Paediatrics and Child Health | QS9 | Difficult eczema also requires an allergy assessment. The more severe the eczema the greater the likelihood of allergy being a significant cause. | Thank you for your comment. Final Quality Statement 6 is specifically on allergies- 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |
| 68 | 13 | British Association of Dermatologists (BAD) | QS9 | 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.<br>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 child's | Thank you for your comment. This Quality Statement is now final Quality Statement 5 which reads 'Children with uncontrolled or unresponsive atopic eczema, including recurring infections, or psychosocial problems related to the atopic eczema are referred for specialist dermatological advice.'<br><br>In regards to psychosocial services in specialist dermatology services, this will be will be included in the NICE support for commissioning for atopic eczema in children report which will publish alongside |

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| | | | | wellbeing (e.g. steroid phobia). | this Quality Standard.<br>At consultation, there was no consensus on timeframes regarding referral so the Topic Expert Group (TEG) decided not to include a timeframe. |
| 69 | 14 | National Commissioning Board (NHS England) | QS9 | 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.<br>This standard might also benefit from including the need to refer to specialist services in the context of safe guarding anxieties where there is concern that parents are resisting the use of conventional of treatments to the detriment of a child's wellbeing (eg steroid phobia). | Thank you for your comment. This Quality Statement is now Statement 5 which reads 'Children with uncontrolled or unresponsive atopic eczema, including recurring infections and psychosocial problems, are referred for specialist dermatological advice.'<br><br>In regards to psychosocial services in specialist dermatology services, this will be will be included in the NICE support for commissioning for atopic eczema in children report which will publish alongside this Quality Standard.<br><br>At consultation, there was no consensus on timeframes regarding referral so the Topic Expert Group (TEG) decided not to include a timeframe.<br><br>In regards to safeguarding, the Topic Expert Group (TEG) prioritised the areas of care they felt were most important for patients, based on the development sources listed. |
| 70 | 2 | Nottingham support group for | QS9 | It is disappointing that this measure does not make it clear in the supporting information that the NICE guidelines make it | Thank you for your comment. The rationale for final Quality Statement 5 now says |

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| | | parents of children with eczema | | clear that referral to a specialist should be possible if the child or carer are dissatisfied with their current treatment. At the moment it can be very hard to get past some GP gatekeepers to secondary help. It is also very important that the child or carer is aware of the type of HCP to whom they are being sent (eg dermatologist on the RCP register, a dermatologist without RCP registration as a specialist or a GPwSI). How do the newly published standards for teledermatology fit into this? | "Parents' or carers' assessments of a child's physical or psychosocial wellbeing should be regarded as important determinants of the need for specialist dermatological advice".<br><br>Also within the definition section of this Statement it includes the need to refer to different sorts of specialist depending on clinical need. |
| 71 | 10 | British Society for Allergy and Clinical Immunology (BSACI) | QS10 | In some cases, for example in rare allergy cases, referral for specialist allergy advice may be appropriate, depending on the availability of paediatric allergy specialists. "<br><br>Given that 30% of children of all ages with moderate to severe eczema having an associated food allergy and at least 50% co-existent asthma or allergic rhinitis the statement that in "rare allergy cases" specialist allergy advice may be appropriate is clearly incorrect and at odds with the food allergy NICE guidance and RCPCH care pathways.<br><br>The statement should read that "all infants 0-2 years with moderate to severe eczema should be referred for specialist allergy advice"<br>Children with moderate to severe persistent eczema should be referred for specialist allergy advice where multiple food allergies are suspected by the patient or carer or where there is a strong clinical suspicion of IgE mediated food allergy.<br><br>The above statements would be more in line with the statements within the NICE food allergy guideline | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |
| 72 | 10 | British Society for | QS10 | "depending on the availability of paediatric allergy specialists. " | Thank you for your comment. The TEG |

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| | | Allergy and Clinical Immunology (BSACI) | | The BSACI has a published website citing the location of up to 30 specialist allergy clinics within the UK. Referral to a regional allergy service should be possible in all cases. | reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |
| 73 | 3 | British Medical Association | QS10 | We are strongly supportive of this recommendation. | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |
| 74 | 4 | British Society for Paediatric Dermatology | QS10 | To consider dietary manipulation (with hydrolysed formula etc) for those under 6 months of age after trial of both mild and moderately potent topical steroid. | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |
| 75 | 5 | Royal College of Paediatrics and Child Health | QS10 | We are amazed that there is a recommendation to change milk formulae in infants without first conducting an assessment to establish that milk allergy is present. The indiscriminate use of special milk formulae has increased NHS costs significantly and should not occur without a diagnosis of milk allergy or intolerance being established. Furthermore, egg allergy is | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been |

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| | | | | actually more common in infants with eczema. Dermatologists in general are poor at interpreting the results of allergy tests. They should have received additional training or refer to an allergy clinic. There is a paper available on-line in Arch Dis. Child (Arch Dis Child doi:10.1136/archdischild-2012-302721) from Israel demonstrating that a misdiagnosis of milk allergy is associated with early onset eczema and thus emphasising the need for a full expert allergy assessment. | controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |
| 76 | 5 | Royal College of Paediatrics and Child Health | QS10 | This standard does not address the problem of eczema in breast fed infants, are more problematic (being exposed to a greater range of allergenic foods via the mothers breast milk), than formula fed babies. It also does not take into account other food allergies (as mentioned, egg is more likely to be associated with eczema than milk allergy). The statement 'Children with moderate or severe atopic eczema should be offered referral for specialist investigation if food allergy is suspected'. This would be more appropriate and would be in line with the NICE Guidelines for the management of food allergy. | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |
| 77 | 10 | British Society for Allergy and Clinical Immunology (BSACI) | QS10 | There are concerns that there is no mention of need to refer for specialist allergy advice or allergy testing. As 30% of children and 30-65% of infants 0-2 years with moderate to severe eczema have a co-existent IgE mediated allergy and others a mixed picture of IgE and non-IgE mediated allergy, this is an omission.<br><br>NICE guideline: pg68 "The prevalence of food allergy in children with atopic eczema in secondary care settings was estimated to be 37-56%<br><br>Hill DJ, S.R., Thorburn J, Hosking CS, The association of atopic dermatitis in infancy with immunoglobulin E food sensitisation. J Paediatr, 2000. 137(4): p. 475-479. | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |

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| | | | | In 60% of children with food allergy more than one food allergen is implicated. (Sampson HA 1983 ;JACI 71;473-80) Whilst a formula change will be helpful in treating those infants with cows milk allergy it does not address the problem of other possible associated food allergens ie egg. In infants with eczema, IgE mediated allergy to egg is more frequent than cows milk allergy. Hill D 2011 JACI ; 127(3):668-76) | |
| 78 | 10 | British Society for Allergy and Clinical Immunology (BSACI) | QS10 | Whilst it is recognised that the advice regarding a hypoallergenic formula is important for infants with moderate to severe eczema this should not be a stand alone statement. The statement needs to be linked to advice regarding referral for specialist allergy advice.<br><br>Thus the statement below<br><br>Infants aged under 6 months who are bottle fed and who have moderate or severe atopic eczema that has not improved after treatment with emollients (moisturisers) or topical corticosteroids (creams or ointments used to reduce inflammation) are offered formula that is free from cow's milk for a trial period of 6 to 8 weeks, and referred to a specialist.<br><br>should be changes to read<br><br>Infants aged under 6 months who are bottle fed and who have moderate or severe atopic eczema that has not improved after treatment with emollients (moisturisers) or topical corticosteroids (creams or ointments used to reduce inflammation) are offered formula that is free from cow's milk for a trial period of 6 to 8 weeks, and referred to an allergy specialist. | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |

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| 79 | 10 | British Society for Allergy and Clinical Immunology (BSACI) | QS10 | It is incorrect to offer advice only to bottle fed infants. Some of the most allergic infants with moderate to severe eczema are exclusively breast fed. Within the original NICE statement it was stated that a trial of an allergen specific exclusion diet should be considered if food allergy is strongly suspected. Thus we would recommend that the above statement regarding bottle fed infants should be followed by: A trial of an allergen specific exclusion diet should be offered to the mothers of breast fed infants with moderate to severe eczema for a 4-6 week trial period whilst awaiting referral for specialist allergy advice. This has to be supported by a qualified dietician. | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |
| 80 | 11 | Royal College of Nursing | QS10 | Referral for specialist advice: It should be made clear in this statement that it is crucial to involve a paediatric dietician to facilitate and monitor the suggested trial of hydrolysed formulas. | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |
| 81 | 12 | Primary care dermatology Society | QS10 | There is no mention of early dietician support | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |
| 82 | 12 | Primary care dermatology Society | QS10 | It is not clear whether the prescribing of a cows milk free diet should be by the GP prior to specialist referral. This would be a suitable place to gainsay the use of Soya milks in this situation | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has |

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| | | | | since it is widely misused. | refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |
| 83 | 13 | British Association of Dermatologists (BAD) | QS10 | We felt that this was the most controversial quality standard and needed modification.<br><br>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 "rare allergy cases" was not clear and needs explanation.<br><br>With regard to the advice that a 6-8 week trial of extensively hydrolysed hypoallergenic formula or amino acid formula – 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 "specialist advice" is also not elaborated upon.<br><br>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. | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |

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| 84 | 14 | National Commissioning Board (NHS England) | QS10 | This standard is a bit confusing. It makes mention of referral to specialists but it is not clear whether this is a dietician or dermatologist. It would be helpful to make this clearer. | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |
| 85 | 3 | British Medical Association | QS10 | We are strongly supportive of this recommendation. | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |
| 86 | 10 | British Society for Allergy and Clinical Immunology (BSACI) | QS10 | The specialist advice sought will vary according to the outcome of the trial with formula. If a child continues to have the cow's milk-free diet for longer than 8 weeks they should be referred for specialist dietary advice because it did not lead to an improvement in the atopic eczema. In some cases, for example in rare allergy cases, referral for specialist allergy advice may be appropriate, depending on the availability of paediatric allergy specialists.<br>If they do not continue with the cow's milk-free diet they will need to be referred for specialist dermatological advice.<br><br>The above statement is clumsy and does not reflect what happens in clinical practice. Both responders and non-responders to a milk free diet may be food allergic. In the non- | Thank you for your comment. The TEG reviewed all consultation comments on draft Quality Statement 10, and has refocused final Quality Statement 6 on 'Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist allergy advice to identify possible food and other allergies'. |

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| | | | | responders the allergen in question may not be milk. In those that are clinically responsive there may still be other allergens not yet identified.<br>Important messages will be lost unless these infants are assessed early and appropriately within a specialist allergy service.<br>It is therefore best to simply state that<br><br>Bottle-fed infants under 6 months with moderate or severe atopic eczema that has not been controlled by optimal treatment with emollients and mild topical corticosteroids should be offered a 6 to 8 week trial of an extensively hydrolysed hypoallergenic formula or amino acid formula and referred for specialist allergy advice. | |