Food allergy and anaphylaxis due to any cause NICE quality standard

Draft for consultation

October 2015

Introduction

This quality standard covers the diagnosis and assessment of food allergy. It also covers anaphylaxis (caused by any stimulus), including what to do after acute treatment, assessment to confirm an anaphylactic episode and referral to a specialist allergy service. For more information see the Food allergy and anaphylaxis topic overview.

NICE quality standards focus on aspects of health and social care that are commissioned locally. Areas of national policy, such as national training standards, are therefore not covered by this quality standard.

Why this quality standard is needed

Food allergy is caused by an immune response to a food. It can be classified into IgE-mediated and non-IgE-mediated reactions (although some responses can involve both types of reaction). IgE-mediated reactions are acute and often have a rapid onset whereas non-IgE-mediated reactions are usually characterised by delayed and non-acute reactions. Food allergy can be difficult to diagnose and is often confused with food intolerance (a non-immune reaction that can be caused by enzyme deficiencies, drugs and naturally occurring substances).

Food allergy is one of the most common types of allergy and is a major health problem in Western countries. This is because of the potential severity of the reactions and a dramatic increase in their prevalence. For example, between March 2013 and February 2014, a 6.4% increase in admissions for food allergy to hospitals in England was reported compared with the previous year (Health and Social Care Information Centre, Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatients and Accident and Emergency Data – April 2013 to

February 2014). The NICE guideline on food allergy in children and young people (CG116) states that the prevalence of food allergy in children under 3 years in Europe and North America ranges from 6% to 8%.

Anaphylaxis is a severe, life-threatening, generalised or systemic hypersensitivity reaction. It is characterised by rapidly developing, life-threatening problems involving the airway (pharyngeal or laryngeal oedema) or breathing (bronchospasm with tachypnoea) or circulation (hypotension or tachycardia). In most cases, there are associated skin and mucosal changes.

The incidence of anaphylaxis in the UK is increasing, with a reported increase in hospital admissions for anaphylaxis from 1.0 to 7.0 cases per 100,000 population per year between 1992 and 2012[1]. There are an estimated 20 deaths from anaphylaxis reported each year in the UK.

The quality standard is expected to contribute to improvements in the following outcomes:

- incidence of further anaphylactic episodes
- admission rate for further anaphylactic episodes
- mortality from further anaphylactic episodes
- health-related quality of life associated with diagnosis or misdiagnosis of food allergy.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

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[1] Turner PJ, Gowland MH, Sharma V et al. (2015) Increase in anaphylaxis-related hospitalizations but no increase in fatalities: an analysis of United Kingdom national anaphylaxis data, 1992-2012. Journal of Allergy and Clinical Immunology. 135: 956-963

- NHS Outcomes Framework 2015–16
- Public Health Outcomes Framework 2013–2016.

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicators*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare ii Children and young people ***Improvement areas*** **Reducing mortality in children** 1.6 i Infant mortality*
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Reducing time spent in hospital by people with long-term conditions** 2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions

4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care i GP services 4b Patient experience of hospital care 4c *Friends and family test* *4d Patient experience characterised as poor or worse* *I Primary care* *ii Hospital care* ***Improvement areas*** **Improving people’s experience of outpatient care** 4.1 Patient experience of outpatient services **Improving people’s experience of accident and emergency services** 4.3 Patient experience of A&E services **Improving children and young people’s experience of healthcare** *4.8 Children and young people’s experience of inpatient services*
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics are in development	

Table 2 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.3 Pupil absence 1.9 Sickness absence rate
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.1 Infant mortality* 4.3 Mortality rate from causes considered preventable** 4.11 Emergency readmissions within 30 days of discharge from hospital*
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary	

Patient experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to food allergy and anaphylaxis.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services and service user experience in adult mental health services (see the NICE pathways on patient experience in adult NHS services and service user experience in adult mental health services), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect patient experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for food allergy and anaphylaxis specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole food allergy and anaphylaxis care pathways. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people with food allergies or anaphylaxis.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality food allergy or anaphylaxis service are listed in Related quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating people with food allergy or anaphylaxis should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source(s) on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting people with food allergy or anaphylaxis. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1. Children and young people with suspected food allergy have an allergy-focused clinical history taken.

Statement 2. Children and young people whose allergy-focused clinical history indicates an IgE-mediated food allergy are offered a skin prick test or blood test for specific IgE antibodies to the suspected foods and likely co-allergens.

Statement 3. Children and young people whose allergy-focused clinical history suggests a non-IgE-mediated food allergy are offered a trial elimination and reintroduction of the suspected allergen.

Statement 4. Children and young people are referred to secondary or specialist allergy care if indicated by their allergy-focused clinical history or subsequent diagnostic testing.

Statement 5. People who have emergency treatment for suspected anaphylaxis due to any cause are referred to a specialist allergy service.

Statement 6. People who are prescribed an adrenaline auto-injector after emergency treatment for suspected anaphylaxis due to any cause are given training in how and when to use it.

Statement 7 (placeholder). Diagnosing food allergy in adults

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Question 3 Do you have an example from practice of implementing the NICE guidelines that underpin this quality standard? If so, please submit your example to the NICE local practice collection here. Examples of using NICE quality standards can also be submitted.

Questions about the individual quality statements

Question 4 For draft placeholder statement 7: Do you know of any evidence-based guidance that could be used to develop this placeholder statement? If so, please provide details. If not, would new evidence-based guidance relating to the diagnosis of food allergy in adults have the potential to improve practice? If so, please provide details.

Quality statement 1: Food allergy – allergy-focused clinical history

Quality statement

Children and young people with suspected food allergy have an allergy-focused clinical history taken.

Rationale

An allergy-focused clinical history is a key first step in the diagnosis of food allergy and can help to distinguish between IgE- and non-IgE-mediated food allergy, and to decide which other tests are needed and how the food allergy should be managed.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that children and young people who present with signs or symptoms of food allergy have an allergy-focused clinical history taken.

Data source: Local data collection.

Process

Proportion of children and young people presenting with suspected food allergy who have an allergy-focused clinical history taken.

Numerator – the number in the denominator who have an allergy-focused clinical history taken.

Denominator – the number of children and young people presenting with suspected food allergy.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (primary care providers) ensure that healthcare professionals can recognise the signs and symptoms of food allergy in children and young people and that healthcare professionals with appropriate expertise are available to take an allergy-focused clinical history.

Healthcare professionals (such as GPs, dietitians, allergy-trained primary care nurses and health visitors) recognise the signs and symptoms of food allergy in children and young people and ensure that an allergy-focused clinical history is taken by a healthcare professional with appropriate competencies.

Commissioners (clinical commissioning groups and NHS England) commission services that recognise the signs and symptoms of food allergy in children and young people and that have healthcare professionals with appropriate expertise available to take an allergy-focused clinical history.

What the quality statement means for patients, service users and carers

Children and young people with signs and symptoms of food allergy (and their parents or carer if appropriate) are asked about their symptoms and lifestyle to try to find out if they have a food allergy and what should happen next.

Source guidance

- Food allergy in children and young people (2011) NICE guideline CG116, recommendation 1.1.3

Definitions of terms used in this quality statement

Allergy-focused clinical history

An allergy-focused clinical history should be taken by a healthcare professional with the appropriate competencies (either a GP or other healthcare professional such as a dietitian, primary care nurse or health visitor) and should be tailored to the presenting symptoms and age of the child or young person. It should include:

- what the suspected allergen is
- details of any foods that are avoided and the reasons why
- who has raised the concern and suspects a food allergy
- an assessment of presenting symptoms and other symptoms that may be associated with food allergy [see recommendation 1.1.1 in the NICE guideline on food allergy in children and young people (CG116), including questions about:
  - age when symptoms first started
  - speed of onset of symptoms after contact with the food
  - duration of symptoms
  - severity of reaction
  - frequency of occurrence
  - setting of reaction (for example, at school or home)
  - reproducibility of symptoms on repeated exposure, including:
    - ◊ whether common allergenic foods such as milk, eggs, peanuts, tree nuts, soy, wheat and seafood are usually eaten without symptoms happening
  - what food and how much exposure to it causes a reaction
- details of any previous treatment, including medication, for the presenting symptoms and the response to this
- any response to eliminating and reintroducing foods.
- the child or young person's feeding history, including the age at which they were weaned and whether they were breastfed or formula-fed – if the child is currently being breastfed, consider the mother's diet
- any personal history of atopic disease (asthma, eczema or allergic rhinitis)
- any individual and family history of atopic disease (such as asthma, eczema or allergic rhinitis) or food allergy in parents or siblings
- cultural and religious factors that affect the foods they eat

[Adapted from Food allergy in children and young people (NICE guideline CG116), recommendation 1.1.3]

Guidance on taking clinical histories to detect food allergy can be found in the European Academy of Allergy and Clinical Immunology’s Food allergy and anaphylaxis guidelines. [Expert opinion]

Children and young people with suspected food allergy

Children and young people includes those aged 18 and under.

Food allergy can be suspected by a healthcare professional or by a parent, carer, or by the child or young person themselves [Food allergy in children and young people (NICE guideline CG116), recommendation 1.1.3]

Recommendations 1.1.1 and 1.1.2 in the NICE guideline on food allergy in children and young people (CG116) also give details on the signs and symptoms that should lead healthcare professionals to suspect food allergy in a child or young person.

NICE clinical knowledge summaries Cows' milk protein allergy in children, the MAP Guideline and the BSACI guideline for the diagnosis and management of cow's milk allergy give further guidance on recognising when to suspect cows' milk allergy. [Expert opinion]

Quality statement 2: Food allergy – diagnosis of IgE-mediated food allergy

Quality statement

Children and young people whose allergy-focused clinical history indicates an IgE-mediated food allergy are offered a skin prick test or blood test for specific IgE antibodies to the suspected foods and likely co-allergens.

Rationale

Skin prick tests and blood tests for specific IgE antibodies can confirm allergy status in a child or young person with suspected IgE-mediated food allergy. It is important that the tests are not performed before an allergy-focused clinical history is taken because sensitisation to an allergen (as shown by a positive test result) does not necessarily mean that it will cause an allergic reaction or symptoms of allergy. All test results should be interpreted in the light of an allergy-focused clinical history.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that children and young people whose allergy-focused clinical history indicates an IgE-mediated food allergy are offered a skin prick test or blood test for specific IgE antibodies to the suspected foods and likely co-allergens.

Data source: Local data collection.

Process

a) Proportion of children and young people whose allergy-focused clinical history indicates an IgE-mediated food allergy who are offered a skin prick test or blood test for specific IgE antibodies to the suspected foods and likely co-allergens.

Numerator – the number in the denominator who receive a skin prick test or blood test for specific IgE antibodies to the suspected foods and likely co-allergens.

Denominator – the number of children and young people whose allergy-focused clinical history indicates an IgE-mediated food allergy.

Data source: Local data collection.

b) Proportion of children and young people who have a skin prick test or blood tests for specific IgE antibodies to suspected foods and likely co-allergens who did not have an allergy-focused clinical history taken before the tests.

Numerator – the number in the denominator who did not have an allergy-focused clinical history taken before the tests.

Denominator – the number of children and young people who have a skin prick test or blood tests for specific IgE antibodies to suspected foods and likely co-allergens.

Data source: Local data collection.

Outcome

a) False-positive diagnosis of IgE-mediated food allergy in children and young people.

Data source: Local data collection.

b) Incidence of recorded IgE-mediated food allergy.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (such as primary and secondary care providers) ensure that services can direct, perform and interpret skin prick tests and blood tests for specific IgE antibodies in children and young people with suspected IgE-mediated food allergy. These tests may be done in primary care if the expertise to conduct and interpret the tests is available; otherwise there should be agreed local pathways for referral to secondary care. At locations where skin prick tests are undertaken, service providers should also ensure that there are facilities available to deal with an anaphylactic reaction.

Healthcare professionals (such as GPs, nurses or dietitians with appropriate allergy competencies) offer children and young people a skin prick test or blood tests for specific IgE antibodies if an allergy-focused clinical history has suggested an IgE-mediated food allergy. Healthcare professionals should interpret the results of the tests in the light of the allergy-focused clinical history. If the expertise to direct, perform and interpret these tests is not available in local primary care, healthcare professionals should refer children and young people to local secondary care services.

Commissioners (clinical commissioning groups and NHS England) commission services that offer skin prick tests or blood tests for specific IgE antibodies to children and young people whose clinical history suggests an IgE-mediated food allergy.

What the quality statement means for patients, service users and carers

Children and young people who are thought to have a food allergy caused by IgE antibodies are offered either skin prick tests or blood tests to confirm the diagnosis.

Source guidance

- Food allergy in children and young people (2011) NICE guideline CG116, recommendations 1.1.5 and 1.1.9.

Definitions of terms used in this quality statement

IgE-mediated food allergy

An allergic reaction caused by IgE antibodies which is acute and frequently has rapid onset. Signs and symptoms of IgE-mediated food allergy are given in Food allergy in children and young people (NICE guideline CG116), recommendation 1.1.1.

Skin prick test and blood tests for specific IgE antibodies

These tests should only be done by healthcare professionals with the appropriate competencies to select, perform and interpret them. Skin prick tests should only be done where there are facilities to deal with an anaphylactic reaction. [Food allergy in children and young people (NICE guideline CG116), recommendations 1.1.6 and 1.1.7]

Guidance on performing and interpreting tests can be found in the British Society of Allergy and Clinical Immunology's Cow's milk allergy guideline and Egg allergy guideline, and the NICE clinical knowledge summary Cows' milk protein allergy in children. [Expert opinion]

Quality statement 3: Food allergy – diagnosis of non-IgE-mediated food allergy

Quality statement

Children and young people whose allergy-focused clinical history suggests a non-IgE-mediated food allergy are offered a trial elimination and reintroduction of the suspected allergen.

Rationale

A trial elimination of a suspected allergen (followed by reintroduction) is important to confirm a diagnosis of non-IgE-mediated food allergy if this is suspected after an allergy-focused clinical history. This process will identify any foods that cause an allergic reaction if elimination resolves symptoms and reintroduction causes a recurrence of symptoms.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that children and young people whose allergy-focused clinical history suggests a non-IgE-mediated food allergy are offered a trial elimination and reintroduction of the suspected allergen.

Data source: Local data collection.

Process

Proportion of children and young people whose allergy-focused clinical history suggests a non-IgE-mediated food allergy who are offered a trial elimination and reintroduction of the suspected allergen.

Numerator – the number in the denominator who have a trial elimination and reintroduction of the suspected allergen.

Denominator – the number of children and young people whose allergy-focused clinical history suggests a non-IgE-mediated food allergy.

Data source: Local data collection.

Outcome

Incidence of recorded non-IgE-mediated food allergy.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (primary care providers) ensure that healthcare professionals offer a trial elimination of a suspected allergen, with reintroduction into the diet after the trial, to children and young people whose clinical history suggests a non-IgE-mediated food allergy. Service providers should also ensure that dietitians with appropriate competencies are available to give advice to health care practitioners about adequate nutritional intake, timings of elimination and reintroduction, and follow-up.

Healthcare professionals (such as GPs, primary care nurses, health visitors, paediatricians) offer a trial elimination of a suspected allergen, with reintroduction after the trial, to children and young people whose clinical history suggests a non-IgE-mediated food allergy. Healthcare professionals should also seek advice from dietitians with appropriate competencies about adequate nutritional intake, timings of elimination and reintroduction, and follow-up. Healthcare professionals also offer children and young people (and their parent or carer if appropriate) information on what foods and drinks to avoid, how to interpret food labels, alternative sources of nutrition to ensure adequate nutritional intake, the safety and limitations of an elimination diet, the proposed duration of the elimination diet, when/where and how an oral food challenge or food reintroduction may be undertaken and the safety and limitations of the oral food challenge or food reintroduction procedure.

Commissioners (clinical commissioning groups and NHS England) commission services that offer trial elimination and reintroduction of allergens to children and young people whose clinical history suggests non-IgE-mediated food allergy and have dietitians to provide advice to health care practitioners about adequate nutritional intake, timings of elimination and reintroduction, and follow-up.

What the quality statement means for patients, service users and carers

Children and young people who are thought to have a food allergy that is not caused by IgE antibodies are offered a trial of cutting out the food thought to cause the allergy (known as elimination) with introduction of the food again at a later date. This is to confirm the diagnosis.

Source guidance

- Food allergy in children and young people (2011) NICE guideline CG116, recommendation 1.1.11

Definitions of terms used in this quality statement

Non-IgE mediated food allergy

These reactions are generally characterised by delayed and non-acute reactions. Non-IgE reactions are poorly defined both clinically and scientifically, however many are believed to be T-cell-mediated. Signs and symptoms of non-IgE-mediated food allergy are given in Food allergy in children and young people (NICE guideline CG116), recommendation 1.1.1.

Trial elimination of the suspected allergen

Trial elimination of the suspected allergen would normally be for 2–6 weeks, followed by reintroducing the allergen. Advice should be sought from a dietitian with appropriate competencies, about adequate nutritional intake, timings of elimination and reintroduction, and follow-up. [Adapted from Food allergy in children and young people (NICE guideline CG116), recommendation 1.1.11]

Advice on diagnosing non-IgE-mediated cows' milk allergy can be found in NICE's clinical knowledge summary on Cows' milk protein allergy in children and also the British Society for Allergy and Clinical Immunology's guidance on Cow's milk allergy. [Expert opinion]

Quality statement 4: Food allergy – referral to secondary or specialist care

Quality statement

Children and young people are referred to secondary or specialist allergy care if indicated by their allergy-focused clinical history or subsequent diagnostic testing.

Rationale

Referral to secondary or specialist allergy care when indicated will help to avoid prolonged anxiety about which foods are safe, will reduce the risk of further allergic reactions and the risk of nutritional problems because of inappropriate care.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that children and young people are referred to secondary or specialist allergy care if indicated by their allergy-focused clinical history or subsequent diagnostic testing.

Data source: Local data collection.

Process

Proportion of children and young people who have an allergy-focused clinical history or subsequent diagnostic testing that indicates a need for a referral to secondary or specialist allergy care who are offered a referral to secondary or specialist allergy care.

Numerator – the number in the denominator who are referred to secondary or specialist allergy care.

Denominator – the number of children and young people who have an allergy-focused clinical history or subsequent diagnostic testing that indicates a need for a referral to secondary or specialist care.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (primary and secondary care providers) ensure that there are local arrangements for children and young people to be referred to secondary or specialist allergy care if this is indicated by their allergy-focused clinical history or subsequent diagnostic testing. Liaison between primary care and local allergy services may be needed to establish agreed local pathways of care.

Healthcare professionals (GPs) refer children and young people to local secondary or specialist allergy care if this is indicated by their allergy-focused clinical history or subsequent diagnostic testing.

Commissioners (clinical commissioning groups and NHS England) commission services with agreed local pathways to refer children and young people to secondary or specialist allergy care if this is indicated by their allergy-focused clinical history or subsequent diagnostic testing.

What the quality statement means for patients, service users and carers

Children and young people are offered a referral to secondary or specialist allergy care if their symptoms or results of tests suggest that specialist opinion is needed to find out the best treatment for them.

Source guidance

- Food allergy in children and young people (2011) NICE guideline CG116, recommendation 1.1.17

Definitions of terms used in this quality statement

Indications that a referral to secondary or specialist care is needed

Based on the allergy-focused clinical history, referral to secondary or specialist care should be considered in any of the following circumstances:

- The child or young person has:

  - faltering growth in combination with one or more of the gastrointestinal symptoms described in recommendation 1.1.1 [Food allergy in children and young people (NICE guideline CG116)]
  - not responded to a single-allergen elimination diet
  - had one or more acute systemic reactions
  - had one or more severe delayed reactions
  - confirmed IgE-mediated food allergy and concurrent asthma
  - significant atopic eczema where multiple or cross-reactive food allergies are suspected by the parent or carer.
- There is:
  - persisting parental suspicion of food allergy (especially in children or young people with difficult or perplexing symptoms) despite a lack of supporting history
  - strong clinical suspicion of IgE-mediated food allergy but allergy test results are negative
  - clinical suspicion of multiple food allergies.

[Food allergy in children and young people (NICE guideline CG116), recommendation 1.1.17]

Secondary or specialist allergy care

Details of local allergy services can be found on the website of the British Society for Allergy and Clinical Immunology or from NHS Choices. Selecting the right allergy clinic is important because not all allergy clinics offer comprehensive food allergy-related services and some see adults or children only.

Equality and diversity considerations

When referring people to a specialist allergy clinic, any potential difficulties in access such as age, travelling distance, disability or financial barriers should be taken into account. For example, by considering the provision of transport to clinics or the potential to provide off-site or mobile clinics.

Quality statement 5: Anaphylaxis – Referral to specialist allergy services after acute treatment for anaphylaxis

Quality statement

People who have emergency treatment for suspected anaphylaxis due to any cause are referred to a specialist allergy service.

Rationale

Specialist allergy services can identify the cause of an anaphylactic reaction and ensure that a person receives correct advice and treatment. If people are not referred to a specialist allergy service after emergency treatment for suspected anaphylaxis the likelihood of receiving a definitive diagnosis is reduced and patient safety is compromised. This can lead to anxiety, inappropriate management and recurrent anaphylactic reactions. It may also increase the need for avoidable acute care.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that people who have had emergency treatment for suspected anaphylaxis are referred to a specialist allergy service.

Data source: Local data collection.

Process

Proportion of people who receive emergency treatment for suspected anaphylaxis who are referred to a specialist allergy service.

Numerator – the number in the denominator who are referred to a specialist allergy service.

Denominator – the number of people who receive emergency treatment for suspected anaphylaxis.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (primary care providers, emergency departments, paediatric services) ensure that people who have had emergency treatment for suspected anaphylaxis are offered a referral to a specialist allergy service.

Healthcare professionals (such as GPs, emergency department staff, members of paediatric and adult medical teams) refer people who have had emergency treatment for suspected anaphylaxis to a specialist allergy service.

Commissioners (clinical commissioning groups) commission local specialist allergy services or agree pathways for referral to these services for people who have had emergency treatment for suspected anaphylaxis.

What the quality statement means for patients, service users and carers

People who have had emergency treatment for suspected anaphylaxis are offered a referral to a specialist allergy service. This is to find out the cause of the reaction and to get advice on what to do in the future.

Source guidance

- Anaphylaxis (2011) NICE guideline CG134, recommendation 1.1.9

Definitions of terms used in this quality statement

Suspected anaphylaxis

The diagnosis for people who present with symptoms of anaphylaxis, before they are assessed by an allergy specialist.

In emergency departments a person who presents with the signs and symptoms of anaphylaxis may be classified as having a 'severe allergic' reaction rather than an 'anaphylactic' reaction (the NICE guideline on anaphylaxis and the Royal College of Physicians’ concise guideline on emergency treatment of anaphylaxis in adults give details on clinical features that suggest that an anaphylactic reaction has occurred). Anyone who presents with such signs and symptoms should be classed as experiencing a 'suspected anaphylactic reaction', and should be diagnosed as having 'suspected anaphylaxis'. [Adapted from Anaphylaxis (NICE guideline CG134)]

Specialist allergy service

A service consisting of healthcare professionals with the skills and competencies needed to accurately investigate, diagnose, monitor and provide ongoing management of, and patient education about, suspected anaphylaxis. The service should be age-appropriate if possible. [Anaphylaxis (NICE guideline CG134) recommendation 1.1.9]

It is important that people are referred to specialist allergy services with expertise in dealing with the trigger of their anaphylaxis. For example, people with venom-induced anaphylaxis should be referred to a service with experience in venom allergy that can offer venom immunotherapy as a treatment option. [Expert opinion]

Details of local allergy services can be found on the website of the British Society for Allergy and Clinical Immunology (BSACI) or from NHS Choices. The BSACI website can also be used to find allergy services with appropriate expertise to deal with a particular allergy (for example food, drug, venom allergy). [Expert opinion]

Equality and diversity considerations

When referring people to a specialist allergy clinic, any potential difficulties in access such as age, travelling distance, disability or financial barriers should be taken into account. For example, by considering the provision of transport to clinics or the potential to provide off-site or mobile clinics.

Quality statement 6: Anaphylaxis – Education in adrenaline auto-injector use

Quality statement

People who are prescribed an adrenaline auto-injector after emergency treatment for suspected anaphylaxis due to any cause are given training in how and when to use it.

Rationale

Adrenaline auto-injectors should be given to people after emergency treatment for anaphylaxis as an interim measure before they have a specialist allergy service appointment. It is important to use an adrenaline auto-injector as soon as possible if an anaphylactic reaction is suspected. Ensuring that people know when and how an adrenaline auto-injector should be used will ensure timely and correct use in the event of a further anaphylactic reaction.

Quality measures

Structure

Evidence of local arrangements and written protocols to ensure that people who are prescribed an adrenaline auto-injector after emergency treatment for suspected anaphylaxis (and their families or carers, as appropriate) are given training in how and when to use it.

Data source: Local data collection.

Process

Proportion of people who are prescribed an adrenaline auto-injector after emergency treatment for suspected anaphylaxis (and their families or carers, as appropriate) who are given training in how and when to use it.

Numerator – the number in the denominator (and their families or carers, as appropriate) who are given training in how and when to use it.

Denominator – the number of people who are prescribed an adrenaline auto-injector after emergency treatment for suspected anaphylaxis.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (primary care providers, emergency departments, paediatric services) ensure that healthcare professionals can demonstrate the correct use of adrenaline auto-injectors and provide training in how and when to use them for people who have had emergency treatment for anaphylaxis. Service providers should also ensure that patient information is available on how and when to use the auto-injectors, and that healthcare professionals understand and can explain the information, and give it to people who are prescribed adrenaline auto-injectors (and their families or carers, as appropriate). Trainer pens should be available for practice.

Healthcare professionals who prescribe adrenaline auto-injectors after emergency treatment for suspected anaphylaxis ensure that its correct use is demonstrated, that there is an opportunity to practice using a trainer pen and also that patient information about how and when to use it is provided. The demonstration and information can be given by the prescriber or a professional with training and skills in this area (such as health visitors, dietitians, practice nurses or pharmacists).

Commissioners (clinical commissioning groups) commission services that provide training in how to use adrenaline auto-injectors, and patient information about how and when to use them, for people who have been prescribed an adrenaline auto-injector after emergency treatment for anaphylaxis (and their families or carers, as appropriate).

What the quality statement means for patients, service users and carers

People who are prescribed an adrenaline auto-injector because they have had emergency treatment for a suspected anaphylaxis are shown how to use it, can practise using a ‘trainer pen’, and are given information that explains how and when they should use it.

Source guidance

- Anaphylaxis (2011) NICE guideline CG134, recommendation 1.1.11

Definitions of terms used in this quality statement

Training in how and when to use an adrenaline auto-injector

This includes a demonstration of using an adrenaline auto-injector and practice using a trainer pen. Information should also be given about anaphylaxis, including the signs and symptoms of an anaphylactic reaction and what to do if an anaphylactic reaction happens (use the adrenaline auto-injector and call emergency services) [Adapted from Anaphylaxis (NICE guideline CG134), recommendation 1.1.11 and expert opinion]

Equality and diversity considerations

Any information provided about using adrenaline auto-injectors should be accessible to people with additional needs, such as physical, sensory or learning disabilities.

Quality statement 7 (placeholder): Diagnosing food allergy in adults

What is a placeholder statement?

A placeholder statement is an area of care that has been prioritised by the Quality Standards Advisory Committee but for which no source guidance is currently available. A placeholder statement indicates the need for evidence-based guidance to be developed in this area.

Rationale

Improvements in recognising symptoms of food allergy in adults will help to determine which diagnostic tests should be used and how the condition should be managed. Food allergy can be more complex in adults than in children and young people, and often involves multiple foods, allergic co-morbidities and also reactions to food that happen only in the presence of a co-factor (for example, with alcohol). Distinguishing food allergy from food intolerance and conditions such as irritable bowel syndrome in adults can be difficult; misdiagnosis results in inappropriate referrals to secondary care. Improved diagnosis of food allergy (both IgE- and non-IgE-mediated) in adults can greatly reduce healthcare burden, save NHS resources and improve quality of life.

Question for consultation

Do you know of any relevant evidence-based guidance that could be used to develop this placeholder statement? If so, please provide details. If not, would new evidence-based guidance relating to the diagnosis of food allergy in adults have the potential to improve practice? If so, please provide details.

Status of this quality standard

This is the draft quality standard released for consultation from 5 October to 2 November 2015. It is not NICE's final quality standard on food allergy and anaphylaxis. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 2 November 2015. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from March 2016.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of

100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in Development sources.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

Good communication between healthcare professionals and people with food allergies or anaphylaxis, and their families or carers (if appropriate), is essential. Treatment, care and support, and the information given about it, should be both age-appropriate and culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with food allergies or anaphylaxis and their families or carers (if appropriate) should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards Process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Royal College of Physicians (2013) Emergency treatment of anaphylaxis in adults: concise guideline
- Anaphylaxis (2011) NICE guideline CG134
- Food allergy in children and young people (2011) NICE guideline CG116

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- NHS England (2013) Specialised Immunology and Allergy Services Clinical Reference Group service specification. Specialised allergy services (all ages)
- NHS England (2013) Specialised Paediatric Services Clinical Reference Group service specification. Paediatric medicine: specialised allergy services
- World Allergy Organization (2013) WAO white book on allergy: update 2013
- Royal College of Paediatrics and Child Health (2011) Allergy care pathways for children: anaphylaxis
- Royal College of Paediatrics and Child Health (2011) Allergy care pathways for children: food allergy
- Scottish Medical and Scientific Advisory Committee (2009) Review of allergy services in Scotland
- Department of Health (2007) Government response to the science and technology committee report on allergy

Definitions and data sources for the quality measures

- Anaphylaxis (2011) NICE guideline CG134
- Food allergy in children and young people (2011) NICE guideline CG116
- Royal College of Physicians (2009) Emergency treatment of anaphylaxis in adults: Concise guideline

Related NICE quality standards

Published

- Drug allergy: diagnosis and management (2015) NICE quality standard 97
- Atopic eczema in children (2013) NICE quality standard 44
- Asthma (2013) NICE quality standard 25

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Acute medical admissions in the first 48 hours
- Readmission to ICU within 48 hours

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 4. Membership of this committee is as follows:

Miss Alison Allam
Lay member

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Head of Quality and Safety, North Kent Clinical Commissioning Group

The following specialist members joined the committee to develop this quality standard:

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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