

Allergy: the unmet need

A blueprint for better patient care

A report of the Royal College of Physicians Working Party
on the provision of allergy services in the UK



Royal College of Physicians

June 2003

Royal College of Physicians of London
11 St Andrews Place, London NW1 4LE

Registered charity No. 210508

Copyright © 2003 Royal College of Physicians of London

ISBN 1 86016 183 9

Cover design: Merriton Sharp

Typeset by Dan-Set Graphics, Telford, Shropshire

Printed in Great Britain by The Lavenham Press Ltd, Sudbury, Suffolk

Contents

Members of the Working Party	vii
Foreword	ix
Preface	xi
Executive summary and recommendations	xiii

PART ONE

Allergy services: current deficits and recommendations for improvement

1. What is allergy?	3
2. The burden of allergic disease in the UK	7
A study on prevalence, healthcare utilisation and trends	7
3. Allergy in children: special issues	9
Prevalence of paediatric allergic diseases in the UK	9
Special requirements of children with allergy	9
Delivery of care	9
Nutrition, growth and development	10
Psychological, social and educational issues	10
Patient education	10
Deficits in current paediatric care	11
Primary care	11
Lack of trained paediatric allergists	11
Fragmented specialty care	11
Medication and side effects	11
Research and preventive measures: the importance of early life events	12
4. Allergy in primary care	13
A UK survey of allergy care in general practice	13
Methods	13
Results	13
Discussion	14
Further research on primary care	15
Management of allergy in primary care	15
The need for more training	16
GP with a special interest (GPSI) in allergy: a new concept	16
Recommendations	17

5. The role of allergy charities	19
Evidence of need	19
The demand for information	19
Meeting demand	19
6. Proposals to improve NHS allergy services	21
Disorders managed by an allergist	21
Lack of expertise and lack of training in allergy	21
Hospital care: mostly provided by non-allergists	21
Multi-system allergy	23
Paediatric allergy	23
Primary care	23
Helplines	23
Benefits of a specialist allergy service	23
The costs of mismanagement	24
Current NHS allergy clinics	24
Demand for services	26
Regional commissioning for allergy	26
Recommendations	28
General recommendations for an improved allergy service	28
Specific recommendations	28
Regional allergy centres	28
Trainees in allergy	30
Other consultant posts in allergy	30
Training in allergy for primary care	30
Organ-based specialists with an interest in allergy	31
Mechanisms for expansion	31

PART TWO

Allergy: a brief guide to causes, diagnosis and management

7. Environmental exposure to airborne allergens	35
Sources of outdoor inhaled allergens	35
Allergenic pollen and spores in the UK and seasonal variation	35
Sources of indoor inhaled allergens	37
House dust mites	37
Domestic pets	39
Indoor fungi	39

8. Common diseases associated with allergy	41
Asthma	41
Allergic rhinitis	44
Drug allergy	47
Food allergy and intolerance	52
Allergy and the skin	59
Venom allergy (allergy to stings)	62
Anaphylaxis	65
Occupational allergy	69
9. Diagnostic tests	73
10. Specialist services: treatment and challenge tests	79
Anaphylaxis	79
Glottal oedema	79
Immunotherapy (desensitisation)	80
Efficacy	80
Indications	80
Practical aspects	80
Mechanism	80
Other vaccines	81
Future therapies	81
Challenge tests	81
11. Prevention	83
Genetic factors	83
Environmental factors	84
Immunotherapy	85
Appendix 1. The burden of allergic disease in the UK	87
Introduction	87
Aims and objectives	87
Methods	87
Main findings	88
Epidemiology	88
Costs to the NHS	89
Trends in disease frequency	90
Appendix 2. Useful addresses	93

Members of the Working Party

Stephen T Holgate MD DSc FRCP FRCPE FIBiol FRCPATH FMedSci (*Chair*), MRC Clinical Professor of Immunopharmacology, School of Medicine, University of Southampton

Pamela W Ewan MA MB FRCP FRCPATH (*Deputy Chair*), Consultant in Allergy and Honorary Lecturer, Addenbrooke's Hospital, University of Cambridge Clinical School

Anthony P Bewley MB ChB FRCP, Consultant in Dermatology, Whipps Cross Hospital, London

Carol M Black CBE ND PRCP, President, Royal College of Physicians

Jonathan Brostoff DM DSc(Med) FRCP FRCPATH FIBiol, Senior Research Fellow, Professor Emeritus of Allergy and Environmental Health, King's College London

Christine Carter BSc SRD, Specialist Paediatric Dietitian, Great Ormond Street Hospital for Children, London

John W Coleman BSc PhD, Reader, Department of Pharmacology and Therapeutics, University of Liverpool

Paul Cullinan MB FRCP, Senior Lecturer, Department of Occupational and Environmental Medicine, Imperial College National Heart and Lung Institute, London

Adnan Custovic PhD DM MD, Professorial Clinical Research Fellow, North West Lung Centre, Wythenshawe Hospital, Manchester

Stephen R Durham MA MD FRCP, Professor of Allergy and Respiratory Medicine, Faculty of Medicine, Imperial College National Heart and Lung Institute, London

Jean Emberlin PhD, Director, National Pollen Research Unit, University College Worcester

Anthony J Frew MD FRCP, Professor of Allergy and Respiratory Medicine, School of Medicine, University of Southampton

G John Gibson MD FRCP FRCPE, Professor of Respiratory Medicine, University of Newcastle upon Tyne

Ian T Gilmore MB FRCP, Registrar, Royal College of Physicians

Julian M Hopkin MD MSc FRCP FRCPE, Professor of Medicine and Director of the Clinical School, University of Wales Swansea

Peter H Howarth DM FRCP, Consultant Allergist, Southampton General Hospital

A Barry Kay PhD DSc FRCP FRCPE FRCPATH FRSE FMedSci, Professor of Allergy and Clinical Immunology, Imperial College National Heart and Lung Institute, London

M Thirumula Krishna MB PhD MRCP MRCPATH, Specialist Registrar in Allergy, Southampton General Hospital

Gideon Lack BM BCH FRCPCH, Consultant in Paediatric Allergy and Immunology, St Mary's Hospital, London

Tak H Lee MA MD ScD FRCP FRCPATH FMedSci, Head of Division, Department of Asthma, Allergy and Respiratory Science, Guy's, King's and St Thomas' School of Medicine, London

Roy E Pounder MD DSc(Med) FCRP, Clinical Vice President, Royal College of Physicians

Richard J Powell DM FRCP FRCPath, Reader and Consultant Physician in Allergy and Clinical Immunology, University Hospital, Queen's Medical Centre, Nottingham

David Reading Director, Anaphylaxis Campaign, Farnborough, Hants

Dermot Ryan MB MRCGP RCPI DCH, General Practitioner, Woodbrook Medical Centre, Loughborough; Clinical Research Fellow, University of Aberdeen

Samantha Walker RGN PhD, Director of Research, National Respiratory Training Centre, Warwick

John O Warner MD FRCP FRCPCH, Professor of Child Health, Southampton General Hospital

Those who were consulted

H Ross Anderson MD FRCP, Professor of Public Health Medicine, St George's Hospital Medical School, London

Peter S Friedman MD FRCP FMedSci, Professor of Dermatology, School of Medicine, University of Southampton

Jeffrey M Graham MA PhD FFPHM, Department of Health

Ramyani Gupta MSc, Epidemiologist, Lung and Asthma Information Agency, St George's Hospital Medical School, London

Phil Hannaford MD FRCGP MFFP MFPHM DRCOG DCH, Grampian Health Board Chair of Primary Care; Director of Institute of Applied Health Sciences, University of Aberdeen; Department of General Practice and Primary Care, University of Aberdeen

Mark L Levy MBChB FRCGP, General Practitioner, Harrow; Senior Lecturer, Department of Primary Care and General Practice, Aberdeen University

MS Shuaib Nasser MD MCRP, Consultant in Allergy and Asthma, Addenbrooke's Hospital, Cambridge

David Price MA MB DRCOG MRCGP, General Practice Airways Group Professor of Primary Care Respiratory Medicine, Department of General Practice and Primary Care, University of Aberdeen

Aziz Sheikh MD MSc MRCP MRCGP, NHS R&D National Primary Care Post Doctoral Fellow, St George's Hospital Medical School, London

Colin Simpson MSc PhD, Research Fellow, Department of General Practice and Primary Care, University of Aberdeen

David Strachan MD FRCP FFPHM MRCGP, Professor of Epidemiology, St George's Hospital Medical School, London

Stephen Wasserman MD, Professor of Medicine, University of San Diego, California

Xiaohong Zheng MSc PhD, Research Assistant, Department of General Practice and Primary Care, University of Aberdeen

Foreword

Allergy is a major public health problem in developed countries. In the UK over the last twenty years, the incidence of common allergic diseases has trebled, giving this country one of the highest rates of allergy in the world. In any one year, 12 million people in the UK (one-fifth of the population) are now likely to be seeking treatment for allergy. Potentially life-threatening but previously rare allergies, such as peanut allergy which now affects one in 70 children, are increasing. But despite the epidemic proportions of the disease, the health service is failing to meet the most minimal standards of care – far less clinical governance.

This report shows clearly that there are far too few specialist allergists to meet the needs of the population, either in terms of delivering direct care in dedicated allergy centres, or in providing training for other specialists, general practitioners and practice nurses. It should be possible for milder cases of allergy to be recognised and treated in primary care so that only the more severe and complex cases need referral to a consultant. However, without the appropriate infrastructure and training this is not possible – and the health service will continue to fail to keep pace with the needs of allergy patients.

In publishing this report, the Royal College of Physicians aims to put allergy higher on the healthcare agendas of the Department of Health and planners and managers. We have made proposals for a much improved allergy service which, given the will to change and understanding of the problems faced by allergy patients, will result in more consultants, a network of accessible centres around the country, and much improved and wider training of those who care for patients. These proposals require urgent action.

June 2003

Professor Carol Black
President,
Royal College of Physicians

Preface

Allergic disease is one of the major causes of illness in developed countries and its prevalence is increasing steadily. In the UK, allergic disease affects about one in three of the population. In 13- to 14-year-old children, 32% report symptoms of asthma, 9% have eczema, and 40% have allergic rhinitis.¹ The UK ranks highest in the world for asthma symptoms, with a prevalence 20-fold higher than that of Indonesia, and is also near the top of the world ranking for allergic rhinitis and eczema.^{1,2} High and increasing trends are also apparent in nut allergy,^{3,4} anaphylaxis,^{5,6} occupational allergy (eg latex),⁷ and allergic reactions to drugs.⁸

Although genetic susceptibility is an important risk factor for allergic sensitisation and its expression as disease in different organs, the current allergy 'epidemic' is a consequence of our changing environment. Increased exposure to allergens and air pollutants, over-use of antibiotics and other drugs, reduced fruit and vegetable intake, reduced early life exposure to bacterial products, and an alteration in bacterial colonisation of the gut have all been blamed.

Allergy is an important branch of medicine and specialisation is required to provide a high-quality service for the diagnosis and treatment of allergic disease.⁹ Unfortunately, in the UK such a service has not developed. Allergic disease now causes problems of increased complexity and commonly involves several organ systems,¹⁰ so patients are often referred to a succession of different specialists, resulting only in confusion. Instead, a single referral to an allergy specialist would be both effective and cost saving. General practices and hospitals usually have little, if any, resources for establishing the presence (or absence) of sensitisation to specific allergens. In consequence, most allergic disease is treated with drugs, with little attention being paid to establishing causative agents and allergen avoidance strategies.

There is a major shortage of allergy specialists, with only six fully staffed allergy clinics in the UK, that have developed mainly around research interests. Allergy barely features in the undergraduate medical curriculum, and the lack of specialists means virtually no clinical training is available. Opportunities for postgraduate clinical training are limited. Knowledge of good allergy management in practice is therefore minimal or non-existent.

The allergy charities, along with NHS Direct, are inundated with telephone enquiries from a public desperate for help with their allergy problems. The severity of their symptoms, with attendant high morbidity, has forced the public to look outside the NHS. This has led to the proliferation of dubious allergy practice in the field of complementary and alternative medicine, where unproven techniques for diagnosis and treatment are used.^{11,12} In 1992, the Royal College of Physicians (RCP) produced a report, *Allergy: conventional and alternative concepts*,¹³ which drew attention to the importance of good clinical practice in allergy and the dangers of relying on practitioners of complementary and alternative medicine to deliver a competent allergy service to the public. In 1994, this was reinforced by a second report, *Good allergy practice: standards of care for providers and purchasers of allergy services within the NHS*.¹⁴ Although both reports were well received, their impact on improving the provision of allergy services in the NHS has been limited.

The impact of allergic disease, the dearth of NHS services, and wide differences in disease management across the UK created the impetus for this third RCP report. In drawing attention to the high and ever-increasing prevalence and complexity of allergy, the disease burden this creates, and the lack of any cohesive approach to delivering an adequate clinical service within the NHS, this report highlights the unmet needs of the many patients who suffer from allergy, and the impaired quality of life that they endure.^{4,15} With the influence that the public now exerts over their healthcare, the increase in multi-professional working, and the political will to provide further resources for the NHS, the time has come to make a determined effort to improve clinical services for patients with allergic disease in the UK.

June 2003

Stephen T Holgate
Pamela W Ewan

References

- 1 The International Study of Asthma and Allergies in Childhood (ISAAC) Steering Committee. Worldwide variation in prevalence of symptoms of asthma, allergic rhinoconjunctivitis, and atopic eczema: ISAAC. *Lancet* 1998;351:1225–32.
- 2 European Community Respiratory Health Survey. Variations in the prevalence of respiratory symptoms, self-reported asthma attacks, and use of asthma medication in the European Community Respiratory Health Survey (ECRHS). *Eur Respir J* 1996;9:687–95.
- 3 Tariq SM, Stevens M, Matthews S, Ridout S *et al*. Cohort study of peanut and tree nut sensitisation by age of 4 years. *BMJ* 1996;313:514–17.
- 4 Grundy J, Matthews S, Bateman B, Dean T, Arshad SH. Rising prevalence of allergy to peanut in children: data from 2 sequential cohorts. *J Allergy Clin Immunol* 2002;110:784–9.
- 5 Ewan PW. Anaphylaxis. *BMJ* 1998;316:1442–5.
- 6 Sheikh A, Alves B. Hospital admissions for anaphylaxis: time trend study. *BMJ* 2000;320:1441.
- 7 Garabrant DH, Schweitzer S. Epidemiology of latex sensitization and allergies in health care workers. *J Allergy Clin Immunol* 2002;110:582–95 (Review).
- 8 Demoly P, Bousquet J. Epidemiology of drug allergy. *Curr Opin Allergy Clin Immunol* 2001;1:305–10.
- 9 Pepys J. ‘Clinical immunology’ and the ‘practise of allergy’. *Clin Allergy* 1971;1:1–7.
- 10 Bousquet J. Allergy as a global problem: ‘Think globally, act globally’. *Allergy* 2000;57:661–2.
- 11 Bielory L. ‘Complementary and alternative medicine’ population based studies: a growing focus on allergy and asthma. *Allergy* 2002;57:6455–8.
- 12 Schäfer T, Riehle A, Wichmann H-E, Ring J. Alternative medicine in allergies: prevalence, patterns of use and costs. *Allergy* 2002;57:694–700.
- 13 Royal College of Physicians. *Allergy: conventional and alternative concepts*. Report of the Royal College of Physicians Committee on Clinical Immunology and Allergy. London: RCP, 1992.
- 14 Royal College of Physicians and Royal College of Pathologists. *Good allergy practice: standards of care for providers and purchasers of allergy services within the NHS*. London: RCP, 1994.
- 15 Van Vijk RG. Allergy: a global problem. Quality of life. *Allergy* 2002;47:1097–110.

Executive summary and recommendations

Background

This report discusses the implications for the NHS of the dramatic increase in allergy in recent years, including severe life-threatening and multi-system allergies. Drawing on recent research on the prevalence of allergic disease in the UK, it reveals the gulf between the need for effective advice and treatment and the lack of appropriate professional services, and proposes a strategy to address this. There is an urgent need for these proposals to be implemented, given that the incidence of allergy and related diseases is almost certain to continue to rise. The report is therefore addressed to the Department of Health, primary care trusts, hospital trusts, as well as all healthcare professionals involved in allergy care, including those in primary care.

Allergy and allergy specialists

Allergy specialists deal with a wide range of disorders, such as rhinitis, asthma, urticaria, angioedema (including hereditary angioedema), eczema, anaphylaxis, and allergy to food, drugs, latex rubber and venom. They also have the expertise to exclude allergy as a diagnosis, allowing the patient to proceed with other appropriate investigations.

The above disorders may result from generation of IgE antibody (allergic antibody), but the same disorders and symptoms, eg anaphylaxis, drug or food allergy, can occur through mechanisms that are independent of IgE. Whilst symptoms may be restricted to one organ – for example the nose in hay fever – in many allergic disorders there are systemic effects that involve several different sites in the body.

Allergy specialists undergo a long period of training to acquire the knowledge and experience needed to correctly diagnose and treat both IgE- and non-IgE-mediated allergies.

An increasing problem

Allergy is an increasing problem in the UK for three main reasons:

Increased incidence The incidence of allergy has increased dramatically in the UK in recent years and is still rising. Recent studies put the rise as approximately three-fold in the last 20 years, giving the UK one of the highest rates of allergic disease in the world. The latest estimates suggest that one-third of the total UK population – approximately 18 million people – will develop allergy at some time in their lives.

Increased severity The nature of allergic disease has also changed, so a number of severe and potentially life-threatening disorders, which were previously rare, are now common. As part of the increase in incidence, more children are now affected, particularly by previously little-known food allergies, such as peanut allergy. These are also among the most serious allergies, and accurate diagnosis, advice and treatment are vital.

Increased complexity Another development is that patients now usually have disorders affecting several systems. For example, a child with peanut allergy often also has eczema,

rhinitis and asthma – so-called ‘multi-system allergic disease’. Poorly controlled asthma in a patient with nut allergy is a risk factor for life-threatening or fatal reactions.

The following statistics, taken from the body of the report, illustrate these changes (some of these statistics are underestimates, since allergy can remain undiagnosed):

- ▶ Asthma, rhinitis and eczema have increased in incidence two- to three-fold in the last 20 years.
- ▶ Anaphylaxis, a severe and potentially life-threatening reaction, occurs in over one in 3,500 of the population each year as a result of exposure to substances to which the sufferer is allergic. Hospital admissions because of anaphylaxis have increased seven-fold over the last decade and doubled over four years.
- ▶ Food allergy is increasingly common and is the most common cause of anaphylaxis in children. Peanut allergy, the most common food allergy to cause fatal or near-fatal reactions, has trebled in incidence over four years and now affects one in 70 children in the UK. Yet only 10 years ago this was a rare disorder.
- ▶ Drug allergy is also increasingly common. Adverse drug reactions account for 5% of all hospital admissions in the UK. Up to 15% of inpatients have a hospital stay prolonged as a result of drug allergy. These figures do not include the majority of drug allergies, which occur in primary care and remain undiagnosed and unrecorded.
- ▶ Some 8% of healthcare workers now have an allergy to latex rubber, which in some cases can lead to anaphylaxis. Yet until 1979 only two cases of latex allergy had been reported.
- ▶ Allergic disease currently accounts for 6% of general practice consultations, 0.6% of hospital admissions, and 10% of the GP prescribing budget. The cost (in primary care, excluding hospital services) to the NHS is £900 million per annum.

Current deficits in NHS allergy services

Responsibility for the treatment of allergic disease in the NHS is shared between GPs and hospital services. However, there are three major problems:

1 Even before the recent increases in the incidence of allergic disease, there was a shortage of specialists with the expertise required to give the necessary advice and treatment, and to lead the search for ways to contain the ‘epidemic’:

- ▶ **Across the whole country, only six major centres staffed by consultant allergists offer a full-time service with expertise in all types of allergic problems. A further nine centres staffed by allergists offer a part-time service.**
- ▶ The remaining allergy clinics in the UK – the majority – are run part-time by consultants in other disciplines. However, they do not have the facilities to cope with the rising tide of allergies or with the problems posed by severe or multi-system allergic disorders.
- ▶ **There is a marked geographical inequality in service provision**, as most allergy specialists are based in London and the south-east. Services are extremely poor in the rest of the country.
- ▶ Overall, the provision of consultant allergists is approximately one per 2 million of the UK population, compared with rates of around one per 100,000 for mainstream specialties such as gastroenterology, cardiology, etc.

2 Allergy services in hospitals have traditionally been provided by different specialists according to the organ system affected; for example, allergic asthma is often managed by chest physicians, allergic skin disorders by dermatologists, and allergic rhinitis by ENT specialists. However, **most organ-based specialists have no training in allergy**. In addition, the development of severe, multi-system and non-organ-based disorders means that allergy now has to be considered as a health issue in its own right.

3 Currently, many allergy cases are dealt with by GPs, but because allergy has only recently become such a major problem, **the majority of GPs have no clinical training in allergy**. Furthermore, the shortage of specialists means that GPs often have no ready source of expert advice. The skill base needed to develop allergy services which are led directly from primary care is currently absent.

As a result of the problems outlined above, patients generally find great difficulty in obtaining good advice on allergy. The health service lacks the infrastructure to close the gap between needs and services. Thus, the most common reasons for calls to helplines run by allergy charities, eg the Anaphylaxis Campaign or Allergy UK, are:

- ▶ ‘My GP does not know about allergy.’
- ▶ ‘There is no allergy service near me.’
- ▶ ‘The “allergy clinic” I was referred to did not know how to help me.’

A strategy for addressing the problems

1 Allergy needs a ‘whole system’ approach in which allergy is treated as a condition in its own right, and not as a series of diseases depending on the organ system involved.

2 The number of allergy specialists is totally insufficient to meet the need. Proper provision of allergy specialists would mean better access, diagnosis and advice for patients, and would provide a knowledge base from which primary carers could develop their services.

3 A more effective partnership is required between allergy specialists and the primary carers, who will need to provide the bulk of the day-to-day support for people with allergy. A hub-spoke network with allergists supporting GPs and organ-based and other specialists in local hospitals should be developed.

Recommendations

The recommendations set out in this report are intended to form the basis for the development of a coordinated service over the coming decade. It is envisaged that such a service will progressively become primary care led, with expertise available from the hospital setting for more severe and complex problems. However, given the current lack of training and knowledge in primary care, initially an allergy service would need to be led by allergy specialists. It follows that there must first be an increase in numbers of allergy consultants, as detailed below. Within the hospital sector, the increase in multi-system and severe allergic disease indicates the need for consultant allergists who can provide a ‘one-stop-shop’ approach for patients.

General recommendations for an improved allergy service

- 1 The provision of allergy care in the NHS must be led by specialists trained in allergy so that appropriate standards of care can be achieved and maintained. Given the scale of what amounts to a national epidemic, the front line for allergy management must be within primary care. However, with virtually no primary care skill base to work from, clinical leadership must come initially from specialist centres. They will need to take on the dual role of diagnosis and management of the most complex cases, and of supporting the development of capacity within primary care.
- 2 The NHS therefore needs to move forward on two fronts. As an essential first step, more consultant posts and funded training posts in allergy are required. Specialist allergists must become the core leadership for a national training and clinical development initiative for the whole service. They must also provide the essence of a genuinely national allergy service for the NHS. The creation of these posts, and their appropriate service development context, requires a recognition of need by the Department of Health, the Workforce Numbers Advisory Board, primary care trusts, regional commissioners and trust managers.
- 3 The report proposes the setting up of appropriately staffed regional allergy centres evenly distributed across the whole country. Based on the service models which exist in those parts of the UK fortunate enough to have established specialist centres, they will give equality of access to appropriate allergy services for adults and children in all parts of the country. They will also provide expertise and lead the development of other local services, networking with organ-based specialists and GPs.
- 4 Regional commissioning for specialist allergy must also be implemented. This will require central direction.

The specific recommendations of the report are grouped below under five headings.

Specific recommendations

Regional allergy centres

- 5 The working party endorses the recommendations of the British Society for Allergy and Clinical Immunology (BSACI) that **each of the eight NHS Regions in England (as configured in 2001, each with a population of approximately 5–7 million), as well as Scotland, Wales and Northern Ireland, should have an absolute minimum of one regional specialist allergy centre.**
- 6 Staffing levels required to set up a new regional centre or develop an existing one are as follows:
 - ▶ a minimum of two new/additional (whole time equivalent) consultant allergists (for adult services) offering a multidisciplinary approach. This is the minimum requirement to provide necessary cover for diagnostic procedures and specialist treatment.
 - ▶ a minimum of two full-time allergy nurse specialists
 - ▶ one half-time adult dietitian and one half-time paediatric dietitian with specialist training in food allergy
 - ▶ two consultants in paediatric allergy, supported by paediatric nurse specialists and dietitians with expertise in paediatric allergy
 - ▶ facilities for training for two specialist registrars in allergy (in some centres).

- 7 The regional centres should:
- ▶ provide specialist expertise for adult and paediatric allergic disease throughout their Region (tertiary care), including allergic disorders recognised for regional commissioning
 - ▶ manage allergic disease in the local population which cannot be dealt with in general practice (secondary care)
 - ▶ act as an educational resource for the Region
 - ▶ network with and facilitate local training in allergy for organ-based specialists and paediatricians
 - ▶ support training at local level for GPs and nurses in the management of common allergies in primary care.

Trainees in allergy

- 8 **In order to create new consultant posts, it is essential to increase the number of trainees in the speciality.** There are now only five trainees nationally.
- 9 The lack of trainees is creating a planning blight, because NHS trusts wishing to create new consultant posts cannot readily find suitable applicants. The Department of Health and the Workforce Numbers Advisory Board must recognise the need and provide for more funded training posts in allergy. Despite the pressing case for an increase in specialist registrar numbers, and a provisional agreement for seven additional funded posts, allergy has been allocated no new funded posts for 2003–5.

Other consultant posts in allergy

- 10 **In addition to regional allergy centres, further consultant allergist posts need to be created in other teaching hospitals and district general hospitals in each Region to deal with local needs.** All teaching hospitals should have an allergy service provided by a consultant allergist. One model might be for a shared appointment between trusts. This should follow the establishment of regional centres.

Training in allergy for primary care

- 11 Primary care must ultimately provide the front line care for allergy but considerable development is needed.
- 12 **The training of GPs and practice nurses in allergy needs to be improved.** A key part of this will follow from interaction with consultant allergists, and the inclusion of clinical allergy training in the undergraduate medical curriculum. There are currently a number of allergy courses for GPs and practice nurses, eg through the National Respiratory Training Centre, Southampton University, or one-day training courses run by the BSACI. However, a much more comprehensive nationwide approach is needed, covering primary care training across the NHS. The development of general practitioners with a special interest (GPSIs) in allergy, trained in and linked to regional centres, should support this.

Organ-based specialists with an interest in allergy

- 13 Organ-based specialists will continue to contribute to allergy care and have primary responsibility for patients with asthma and eczema, in patients with single-organ involvement. They should network with the specialist allergist who can act as a resource in identifying/managing allergy. The increase in allergy means that greater awareness of the contribution of allergy in these organ-based specialties is important.

Summary

The NHS is currently not coping with the size and nature of the problems presented by allergy and related conditions. In order to develop a coherent model of service delivery, which would eventually be primary care based but networked to specialist allergists, major allergy centres must first be developed in all parts of the country. This requires the urgent creation of more consultant posts and training posts in allergy. These are key to:

- ▶ the improvement of patient care
- ▶ the prevention of severe and fatal allergic reactions
- ▶ the development of a coordinated allergy service
- ▶ understanding and containing the allergy 'epidemic'.