Allergy: the unmet need

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The Royal College of Physicians Working Party report on the provision of allergy services in the UK, *Allergy – the unmet need: a blueprint for better patient care*,[1] was launched on 25 June. This excellent report was the result of detailed discussion and consultation between a multidisciplinary group of healthcare professionals, which included allergists, clinical immunologists, dermatologists, chest physicians, general practitioners, specialist nurses, dietitians, epidemiologists and pharmacologists. The Working Party also included representatives from patient organisations, the Department of Health and the Royal College of Physicians. To inform the Working Party, the British Society for Allergy and Clinical Immunology (BSACI) commissioned two pieces of research, on the prevalence of allergic disease and on GPs' attitudes to and knowledge of allergy, the findings of which were included in the report.

The report highlights the implications for the NHS of the trebling of the prevalence of common allergic disease in the last twenty years in the UK, resulting in approximately one-fifth of the UK population likely to be seeking treatment for allergy. Potentially life-threatening but previously rare allergies, such as peanut allergy, now affect approximately one in 70 children and are still increasing. Asthma, rhinitis and eczema have increased two- to three-fold in the last twenty years. Hospital admissions for anaphylaxis have increased seven-fold in the last decade and doubled in the last four years. Despite the rise in allergic diseases in epidemic proportions, there is no cohesive approach to delivering an adequate allergy clinical service within the NHS and this has to be remedied with the greatest urgency.

At present, there is approximately one consultant allergist per two million of the UK population, which is substantially less than the rates of around one per 100,000 for other major specialties. Across the whole country only six major centres, based in London (Guy's Hospital, Royal Brompton Hospital and St Mary's Hospital), Cambridge, Southampton and Leicester, are staffed by consultant allergists who 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. There is a striking geographical inequality in service provision, so that patients with severe allergies living in the north-west and south-west of England, Wales, Scotland and Northern Ireland may find it impossible to obtain expert help locally. This example of 'postal code medicine' is close to scandalous in a country that prides itself on providing equal opportunities for access to medical services within the National Health Service framework. This problem has been recognised by the Scottish Executive, which recently emphasised the urgent need for consultant allergists in Scotland, where at present there are none.

The report makes several timely and important recommendations on healthcare delivery as well as on education and training in allergy. It envisages that a coordinated allergy service will progressively become based in primary care, with expertise available from the hospital-based allergy centre for more severe and complex problems. However, given the current lack of training and knowledge in primary care, an allergy service will need to be led initially by allergy specialists. The logic is compelling that there must first be an increase in the number of allergy consultants in hospitals.

It is impossible to dissociate the creation of more consultant posts from the funding of more training posts in allergy, as appointment to these senior posts requires availability of suitably trained clinicians. Presently, however, all trainees who are suitably qualified have already been appointed to consultant posts and the lack of the next cohort of trainees is creating a planning blight. It was therefore with dismay that the Joint Committee on Immunology and Allergy for the Royal College of Physicians and Royal College of Pathologists learnt that, despite acceptance of the pressing case for an increase in the numbers of specialist registrars (SpRs) by the Department of Health, allergy was still not allocated any additional funded SpR posts for 2003 to 2005. The reason is unclear and the lack of transparency is unsatisfactory. Even if it was agreed to establish more SpR posts immediately, it would still take several years for such trainees to work their way through the curriculum, and the ability to recruit from abroad may be limited. It is important that the Government, Department of Health, Workforce Numbers Advisory Board, primary care trusts (PCTs), regional health commissioners and trust managers recognise the crisis so that there is no further delay in providing more training posts in the specialty. As primary care must ultimately provide the front-line care for allergy, the Working Party advised that training of GPs and practice nurses in allergy must

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also be improved.

The Working Party endorsed the recommendations of the BSACI that each of 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 which is appropriately staffed. This should include: a minimum of two new/additional (whole time equivalent) consultant allergists (for adult services), offering a multidisciplinary approach; a minimum of two full-time allergy nurse specialists; one half-time adult dietician and one half-time paediatric dietician with specialist training in food allergy; two consultants in paediatric allergy, supported by paediatric nurse specialists; and facilities for training two specialist registrars in allergy in selected centres.

Based on service models which already exist in those parts of the country that have specialist centres, the new regional allergy centres would give access to appropriate allergy services for adults and children in all parts of the country, which is currently not the case. They would also provide expertise and lead the development of other local services, by networking with organ-based specialists and GPs.

Allergy is on the Department of Health's list for specialist commissioning, and it would be a significant step forward if regional commissioning for specialist allergy is implemented expeditiously. This will be challenging; for example, there is concern about whether current arrangements are sufficiently robust to cope with the financial pressures and service aspirations of specialist regional centres. Already one can sense the inevitable debate on the funding of specialist services versus funding of local initiatives. A recent advisory report from the Academy of Medical Royal Colleges on specialist services (2002) emphasised that it is essential for the commissioning process to understand the need to provide care for larger populations by specialist teams, and it will be essential to guarantee quality of patient care while simultaneously allowing time and space for the training of specialists and for promoting innovation and research. This will require vision and firm direction from the Department of Health as well as cooperation from PCTs. The experience of a clinical immunology network for managing primary immunodeficiencies that is currently being piloted in London will be exceptionally informative when discussions start on the possible creation of regional allergy centres.

Regional allergy centres would provide:

- expertise for adult and paediatric allergic disease throughout their Region, including allergic disorders recognised for regional commissioning
- infrastructure for management of allergic disease in the local population which cannot be dealt with in general practice
- an educational resource for the Region
- an opportunity to network with and facilitate local training in allergy for organ-based specialists and paediatricians
- support for training at local level for GPs and nurses in the management of common allergic problems in primary care.

In addition to regional allergy centres, further consultant allergist posts should be created in other teaching hospitals and district general hospitals in each Region to deal with local needs. It is proposed that all teaching hospitals would have an allergy service led by a consultant allergist, and one model might be for a shared appointment between trusts. Organ-based specialists will continue to contribute to allergy care and have primary responsibility for patients with specific diseases with single-organ involvement, eg asthma, but it is suggested that they consider networking with a specialist allergist who can act as a resource in identifying or managing allergic causes of multi-organ disease.

The Government has pledged ambitiously to have 1,000 GPs with a special interest (GPSIs) in post by 2004. This novel tier of healthcare delivery could be integrated into the overall strategy on allergy, and would play an important role in providing readily accessible expert advice and assessment. GPSIs in allergy and allergy nurse consultants could provide strategic advice to primary care organisations and other public bodies on issues concerning the management of children and adults with allergic disorders. Other nurses with specialist allergy training, who could be involved in educating and managing patients, could also provide invaluable support. GPSIs in allergy should be able to identify much of what is not allergy, referring such cases back to the primary care team for ongoing management. For more severe disease, GPSIs should have well-developed pathways of communication with regional consultant allergists and organ-based specialists with an interest in allergy, to facilitate referral to more specialist care. Allergy is not on the Department of Health's list for GPSIs at present and a persuasive case must be made to ensure that it is included in the future. Continuing discussion is also needed with the Department of Health about clinical governance, so that a uniform system is established to ensure quality and monitor core clinical competencies in which both patients and the profession can have confidence.

The unmet need for a national clinical service to care for patients with allergic diseases has resulted in allergy charities, along with NHS Direct, being inundated with telephone enquiries from a public desperate for help with their allergy problems. It has inadvertently encouraged the proliferation of allergy practice where unproven techniques for diagnosis and treatment are used. This problem had already been highlighted in previous reports from the Royal College of Physicians: in 1992 *Allergy: conventional and alternative concepts*[3] and in 1994 *Good*

allergy practice: standards of care for providers and purchasers of allergy services within the NHS.[4] It is emphasised again in the current report, which describes clearly the tests used in allergy diagnosis, and lists 'alternative' tests, which are of no proven value in allergy diagnosis. This should provide useful guidance for clinicians so that patients are prevented from being started on management plans, such as unwarranted elimination diets, based on unvalidated procedures.

A compelling case has been presented for allergy to be placed higher on the national healthcare agenda and proposals have been made to provide a coherent way forward. It is now the turn of Government to respond, and if it decides not to act then it has a duty to explain to our patients why not.

References:

1 Royal College of Physicians. *Allergy: the unmet need: a blueprint for better patient care*. Report of a working party. London: RCP, 2003.

2 Academy of Medical Royal Colleges. *Specialist services: is their future secure?* Advisory report. London: Academy of Medical Royal Colleges, 2002.

3 Royal College of Physicians. *Allergy: conventional and alternative concepts*. Report of a working party. London: RCP, 1992.

4 Royal College of Physicians. *Good allergy practice: standards of care for providers and purchasers of allergy services within the NHS*. Report of a working party. London: RCP, 1994.