Royal College of Physicians

A meeting to discuss the formation of the
Working Party (WP) on Implementation of the HoL Allergy Report
was held at the **HoL** on **Friday 27 February 2009, 11.00hrs**

Present:

Dr Bill Egner	Working Party Secretary
Baroness Ilora Finlay	Working Party Chair
Professor Barry Kay	Working Party Vice-Chair
Simon Land	Consultations & Committee Services Manager, RCP

1. What has to be achieved

Purpose/Objective/Scope
DH, HoL and College reports all highlight large gaps in service provision for allergy and many quality issues around service provision. There is an opportunity to:

- provide direct professional input and guidance into the process
- develop a working model of multi-disciplinary allergy practice
- ensure that on-going deficiencies in resourcing, standardisation and accreditation are highlighted.

It was hoped that the final report will:

- provide an agreed multidisciplinary professional steer in the implementation of the HoL Allergy report
- engage with parliament in the implementation process
- provide College oversight and input into the implementation process and evaluation of outcomes against agreed criteria

It was noted that a variety of solutions would be needed to improve allergy provision across the UK. This might range from cluster arrangements in some areas to increasing the mono-specialist workforce in others. The recommendations of the report would make it clear that there was not 'a one size fits all' solution.

Target audience

- Patients
- Government
- Commissioners
- Multiple medical disciplines involved in allergy service provision

Terms of Reference

- To evaluate the implementation of the recommendations of the House of Lords Allergy Report 2007.

2. Who will take part?

Membership

Chair - Baroness Finlay
Vice-Chair – Professor Kay
Secretary – Dr Egner
National Allergy Strategy Group – Baroness Finlay to discuss the background and aims of the work with Dr Pam Ewan and invite her to join the membership as Chair of NASG.
BSACI – Invite a nomination suggesting Dr Glenis Scadding (should also cover ENT).
BTS – Invite a nomination suggesting Professor Stephen Holgate
BAD – Invite a nomination. Baroness Finlay to supply details of suggested rep.
British Paediatric Allergy, Immunology & Infection Group (BPAIGG) – Invite a nomination
RCGP – Invite a nomination
RCP Patient & Carer Network member – Seek an appropriate member to Chair, coordinate and collate the views of patient groups.
RCN – Invite nomination from special interest group
JCIA/RCPath – Invite a joint nomination
DH observer – Invite Clare Mills – Civil Servant
Faculty of Occupational Medicine - Invite a nomination suggesting Raymond Agius (Newcastle)
BSI – Invite a nomination suggesting Dr Egner

Expert witnesses

Simon Banks – NW Allergy Centre
FSA
Members to make further suggestions

3. How it will be achieved

Chairs and authors

- Chapters/sections to be drafted by appropriate Working Party Members.
- Dr Egner to synthesize the work and to liaise with the RCP Publications Department where appropriate.

Funding arrangements

- Jointly funded between the BSACI and RCP.

Evidence gathering

- Evidence would initially be collected via targeted letter and e-mail, seeking progress reports. A questionnaire based on the chapters of the HoL report would be formulated. Answers would be based on simple numbers to aid comparison.
  Potential questions

  Are you providing evidence based service or cluster?
  Please list all consultants involved.
  How many parallel clinics are run?

- The contact list of the HoL Report could be used to take this forward and Sarah Jones, Committee Clerk could supply this. The following would also be surveyed:
  SHAs. How have they responded to the recommendations?
  Foundation Trusts (via MONITOR).
  NW pilot via Simon Banks

- It was hoped that the RCP Patient and Carer Network (PCN) member of the working party would chair a meeting/s of the relevant patient groups – to run in parallel with the working party. Written and verbal evidence would be sought on the issues. Also an evaluation of the findings of the HoL report from the patient perspective. This work would then be fed into the working party via the PCN representative and contribute towards a patient appendix. It was felt that a patient engagement questionnaire would be required and it was suggested that Dr Neil Bacon (external contractor and founder of www.iWantGreatCare.org) had the relevant skills to provide steer on question setting and evaluation.

4. Support from College Departments

- Support available from the following College Departments was briefly outlined. It was noted that a representative from each would attend meetings (as required).
  Committee Services
  Evidenced based medicine approaches (Clinical Standards)
  Information Centre
  Press & PR
  Publishing
- The following points were noted with regard to the publication:
  Output (format)/Timeframes?
  Short length report – punchy Executive Summary followed by Key Points and Recommendations on 'where next'. Appendices (including Patient Group Appendix)
  Format PDF – illustrations and diagrams. Short run of hard copies for distribution to coincide with launch may be required.
  Publications required 12 weeks to produce a report following final sign-off by RCP Council. The ideal was to co-badge the report from the RCP and the RCPath for maximum effect. It was noted that in the RCP's experience reports could take significantly longer to produce when co-badged. This was therefore referred back to RCP Senior Officers for decision.

  RCP would retain copyright and further discussion would be required on dissemination and costs as the work progressed (especially if joint badged).

5. When it will be achieved?

Timeline

- Aim to publish late Summer/early Autumn 2010.

Number of meetings

- Between 4 and 6 WP meetings (some possibly by teleconference). Separate meeting/s to ascertain patient perspective to run in parallel (possibly chaired by RCP Patient and Carer Network member).

Governance arrangements – monitoring and signing off

- An RCP Councillor would be assigned to oversee the progress of the working party. They will be a non-attending observer.
- Sign off would be by RCP Council and an appropriate RCPath mechanism (PRCPath?) if jointly badged.

6. Any other business

Meeting dates

- Look to schedule first meeting in May 2009. Preference for Wednesday mornings (10.30am start)

Royal College of Physicians

A meeting to discuss the formation of the
Working Party (WP) on Implementation of the HoL Allergy Report
was held at the **Royal College of Physicians** on **Tuesday 13 May 2009** at 10.30am

Present:

Dr Paul Cullinan	Faculty of Occupational Medicine
Dr Bill Egner	Secretary & BSI representative
Dr Pam Ewan	NASG
Dr Adam Fox	BPAIIG (by teleconference)
Professor David Gawkrodger	BAD
Dr Richard Herriot	JCIA/RCPath
Professor Stephen Holgate	
Professor Barry Kay	Vice-Chairman (in the Chair)
Simon Land	RCP, Committee Services Manager
Dr Glenis Scadding	BSACI
Professor Aziz Sheikh	RCGP
Anne-Cecile Ville	Working Party Administrator
Professor John Warner	

1. Welcome, apologies and introduction

Apologies were received from Mr Pat Conneely, Baroness Ilora Finlay, Dr Rodney Burnham, Professor Andrew Wardlaw and Mrs Mary Brydon.

In the absence of Baroness Finlay, Professor Kay took over as Chair for the meeting.

Professor Ian Gilmore, President of the RCP joined the meeting to offer the support of the College to the work. He apologised that he was unable to attend the meeting in its entirety due to RCP Council meeting at the same time.

Members agreed to invite the following to join the committee:

- Dr Nigel Harper as representative for the College of Anaesthetists
- Dr Joas Soar as a representative for Emergency Medicine
- It was also agreed that Professor John Warner would become a member of the committee.

Action: Anne-Cecile Ville

2. Aims and Objectives

(a) Ascertain what progress - if any - has been made towards addressing the key recommendations of HOLS&TSC 6th Report 2006-2007 on Allergy against each of the sections (see appendix A)

It was agreed that Dr Bill Egner would contact the North West Specialised Commissioning Team in order to obtain documents on their structure and progress so far.

Action: Dr Egner

Members agreed to take on the task of finding out centres or/and individuals with specialist interest through the country (England and Wales) and produce a Powerpoint presentation of the findings for the next meeting:

- Dr Paul Cullinan agreed to survey Occupational Health Medicine.
- Dr Adam Fox agreed to survey the Paediatrics side
- Professor David Gawkrodger agreed to survey the Dermatology side
- Dr Glenis Scadding agreed to survey ENT (The British Association of Otorhinolaryngologists)

- Dr Richard Herriot agreed to survey Immunology

The Powerpoint presentation should be returned to Anne-Cecile Ville by July 8th.

Action: Dr Cullinan, Dr Fox, Professor Gawkrodger, Dr Scadding and Dr Herriot

Dr Bill Egner agreed to draft a standardised template questionnaire for the above task.

Action: Dr Egner

3. Identify means for collecting evidence and specific questions to be asked

(a) Patient focus groups –

It was proposed and agreed that the Patient Panel (Chaired by the RCP Patient & Carer representative) would meet on 19th June and members agreed to e-mail Anne-Cecile a.s.a.p. with names and contact details of organisations that should be invited to attend.

Action: all

(b) Progress report surveys of SHAs and Foundation Trusts (via MONITOR) asking them to identify progress toward establishing clusters/implementing recommendations –

Members suggested to discuss SHA commissioning and Dr Bill Egner agreed to write to the relevant parties to find out whether they planned to hold a meeting with commissioners.

Action : Dr Egner

4. Agree format, production and publication strategy for report

It was agreed that the report would be short in length and aim for publication in September 2010. It was noted that the RCP Publications Department required 12 weeks notice to prepare for publishing and that approval by Council would be required.

It was agreed that a literature search by the RCP Information Centre would likely not be required as the Working Party was conducting its own research.

5. Any other business

There was none.

6. Date of next meeting:

Wednesday 15 July 2009 at 10.30am

Royal College of Physicians

A meeting to discuss the formation of the
Working Party (WP) on Implementation of the HoL Allergy Report PCN Day
was held at the **Royal College of Physicians** on **Friday 19 June 2009** at 2.00pm

Present:

Mrs Suzie Hughes	Chair and RCP PCN representative
Baroness Ilora Finlay	Chair of the Working Party
Margaret Cox	Chief Executive of the National Eczema Society
Mandy East	
Lesley Fudge	Vice-Chair of the LASG
Hazel Gowland	Allergy Action
Professor Barry Kay	Vice Chair of the Working Party
Andrew Langford	Chief Executive of the Skin Care Campaign
Jules Payne	Allergy UK
David Reading	Representing the Anaphylaxis Campaign on behalf of Lynne Regent
Anne-Cecile Ville	Working Party Administrator

1. Welcome, apologies and introduction

Mrs Suzie Hughes welcomed all to the meeting.

2. Summary of the Working Party first meeting on Wednesday 13 May 09

(a) Professor Barry Kay reported that the initial meeting for the Working Party was held on 12 May 2005 and that members had agreed to take on the task of finding out centres or/and individuals with specialist interest through the country (England and Wales) and produce a Powerpoint presentation of the findings for the next meeting. Baroness Finlay agreed to have the minutes of that meeting circulated to PCN members.

Action: Anne-Cecile Ville

(b) Professor Kay also reported that although the College has a format for working parties comprising of one PCN (Patient and Carer Network) representative per working party, Baroness Finlay had felt it beneficial to hold a separate Patient voiced group for England and Wales.

(a) Ascertain what progress - if any - has been made towards addressing the key recommendations of HOLS&TSC 6th Report 2006-2007 on Allergy against each of the sections (see appendix A)

Members of the PCN group agreed to survey their own areas and members. The questions asked would be:

1) What is happening to advance these recommendations?
2) What works well (examples of good practice)
3) What can you, as a patient representative can do to work towards implementing these recommendations in your particular area?

Action: members

3. Identify means for collecting evidence and specific questions to be asked

(a) Patient focus groups –

It was agreed that further dates would be agreed at a later date depending on the working party requirements.

Members agreed to try and find a representative for each of the regions in order to contribute towards implementing the report.

Action: members

(b) Progress report surveys of SHAs and Foundation Trusts (via MONITOR) asking them to identify progress toward establishing clusters/implementing recommendations –

The Chair suggested that PCN members should be invited to the next working party meeting on 15 July 2009 to attend a presentation on the above survey reports.

Action: All

4. Agree format, production and publication strategy for report

This was not discussed at the meeting.

5. Any other business

There was none.

6. Date of next meeting:

Wednesday 15 July 2009 at 10.30am

Royal College of Physicians

A meeting to discuss the formation of the
Working Party (WP) on Implementation of the HoL Allergy Report
was held at the **Royal College of Physicians** on **Wednesday 15 July 2009** at 10.30am

Present:

Baroness Ilora Finlay	Chair
Dr Paul Cullinan	Faculty of Occupational Medicine
Mandy East	
Dr Bill Egner	Secretary & BSI representative
Dr Pam Ewan	NASG
Dr Adam Fox	BPAIIG (by teleconference)
Professor David Gawkrodger	BAD
Hazel Gowland	Allergy Action
Dr Nigel Harper	Royal College of Anaesthetics
Mrs Suzie Hughes	RCP Patient & Carer Network member (Chair of the Lay Group)
Professor Barry Kay	Vice-Chairman (in the Chair)
Aleks Kinay	LASG
Dr Susan Leech	RCPCH
Ms Jules Payne	Allergy UK
Lynne Regent	The Anaphylaxis Campaign
Dr Glenis Scadding	BSACI
Professor Aziz Sheikh	RCGP
Professor Andrew Wardlaw	BTS
Anne-Cecile Ville	Working Party Administrator
Professor John Warner	

In attendance:
Mr Dudley-Southern - Associate Director (strategy) North West Allergy Centre
Dr Adnan Custovic - Professor of Allergy and a Head of Respiratory Research Group at the School of Translational Medicine

1. Welcome, apologies and introduction

Apologies were received from Ms Claire Mills and Mrs Mary J Brydon.

- Membership: The Registrar agreed to send a letter to the Royal College of Emergency Medicine to inquire whether Dr Soar would be suitable to represent them on the working party

Action: Registrar

2. Minutes of the meeting held on 13 May 09

The minutes of the meeting held on 13 May 09 were confirmed as accurate.

(a) Ascertain what progress - if any - has been made towards addressing the key recommendations of HOLS&TSC 6th Report 2006-2007 on Allergy against each of the sections (see appendix A)

- Members agreed to put a commentary against the summary in the agenda to see whether there has been any progression made on the recommendations within 3 weeks.

Action: all

3. Reports from the questionnaire

(a) Patient focus groups – Ms Suzie Hughes

- Ms Jules Payne agreed to survey pharmacists on the services they provided

Action: Ms Payne

- PCN members agreed to email responses from questionnaire to Anne-Cecile Ville to be submitted at the next PCN meeting on 1 October 2009.

Action: PCN members

4. Report from the Patient Group meeting held on 19 June 09

Ms Suzie Hughes reported that the following key themes were agreed:

- It was agreed that there is a need for patient and carer organisations to work in collaboration in order to enable smooth implementation and ease capacity issues.

- The group agreed that a hub and spoke approach at Strategic Health Authority level is needed to ensure involvement and implementation is achieved at a local level for patients and carers.

- In order to achieve the above the organisations around the table agreed to audit how many representatives they have in order to develop a hub and spoke approach.

5. Presentation on the North West development

[Tabled paper: North West Allergy Centre progress report]
Mr Roy Dudley-Southern produced a presentation on the progress made so far at the North West Allergy Centre. The Following action points resulted from this presentation:

- Ms Jules Payne agreed to provide a questionnaire on coding to Mr Roy Dudley-Southern

Action: Ms Jules Payne

- Members agreed to send suggestions on how to improve service to Mr Roy Dudley-Southern

Action: all

- Members agreed to look into possible outcome measures for Allergy, filter them and list them in order of importance

Action: all

6. Aims and Objectives: as previously stated

7. Review of progress against the work streams

- Dr Bill Egner agreed to collect all the data received from members and devise an "Allergy Services" map of the UK.

Action: Dr Bill Egner

- Dr Bill Egner agreed to collect all responses from SHAs and write/send a letter to Foundation Trusts, PCTs and NHS Trusts and their equivalents in Wales.

Action: Dr Bill Egner

- Dr Paw Ewan agreed to provide information on what service GPs provided and the reponses form commissioners and Trusts to previous NASG surveys on Allergy service provision

Action: Dr Pam Ewan

- Professor John Warner agreed to liaise with Bill Egner with regards to the questionnaire submitted to PCTs.

Action: Professor Warner and Dr Egner

- Dr Glenis Scadding agreed to look into EQ5D scoring in Dermatology to see if this might be suitable for adoption for allergy service outcome measurement

Action: Dr Glenis Scadding

- Dr Andrew Wardlaw agreed to survey Chest Medicine and Dr Nigel Harper agreed to survey Anaesthetics service provision

Action: Dr Andrew Wardlaw

8. Agree format, production and publication strategy for report

- Members felt that the working party should work towards producing a report by February 2010.
- Funding was discussed. Dr Egner and Dr Herriot would approach the RCPath for a financial contribution to the publication costs of a joint report Action Bill Egner/Richard Herriot
- We elected to primarily produce an electronic PDF and limited hard copy

9. Date of next meeting:

Tuesday 24 November 2009 at 10.30am

For information:
Friday 1 October 2009 at 10.30am (PCN members only)

Royal College of Physicians

A meeting to discuss the formation of the
Working Party (WP) on Implementation of the HoL Allergy Report PCN Day
was held at the **Royal College of Physicians** on **Thursday 1 October 2009** at 10.30am

Present:

Mrs Suzie Hughes	Chair and RCP PCN representative
Baroness Ilora Finlay	Chair of the Working Party (by phone)
Claire O'Beirne	Asthma UK
Lesley Fudge	Vice-Chair of the LASG
Hazel Gowland	Allergy Action
Professor Barry Kay	Vice Chair of the Working Party
Aleks Kinay	Chair LASG
Lynne Regent	The Anaphylaxis Society

1. Welcome, apologies and introduction

Mrs Suzie Hughes welcomed all to the meeting. All parties expressed disappointment with apparent lack of progress in NW project. Thoughts on catalysing progress were sought by the chair.

(a) Need a Realistic assessment of progress and possibilities in NW taking account of:

i. In current financial context
ii. With appropriate leadership able to carry forward service re-configuration and - ideally someone an Allergist or someone who sends all their time on allergy service provision and with relevant expertise but leadership qualities essential and flexibility may be required - person must have confidence of the members of the network, work for the interests of patients and all the participant services
iii. PCN wished to explore how they might support progress in delivering this specialist service
iv. NW process important example but not only possible model, however it would look awful if the only funded service (albeit to the tiny amount of £60K non-recurrently) did not produce benefits for patients
v. Maintenance and delivery of Specialist services like allergy was a huge challenge in current financial and managerial climate.
vi. The allergy WP should attempt to engage with NW process to offer assistance and gain further understanding of the barriers/challenges by holding next meeting in Manchester. Nov 24 2009.

Action: Anne-Cecile Ville

(b) Specific questions to address include:
i. What was impact of evaluation money

ii. Patient outcome evaluations
iii. Propose that the NW involve the organisation I want better/great care (via Neil Bacon) to co-ordinate patient outcomes evaluation
iv. Propose evaluation is compared to that of an established recognised service of excellence to benchmark
v. Quality agenda should not be forgotten despite financial difficulties. World class commissioning - make sure outcomes meet those criteria set down for PCTs by DoH.

Specific list of questions to be produced by WE based on HOL report recommendations and additions/amendments by PCN group before submission to NW

Action: PCN members

Anne-Cecile to invite DOH representative to next MCR meeting (was to be invited to London meeting in any case)

Action: Anne-Cecile Ville

Mandy East to provide a list of Parliamentary questions to go out with meeting agenda to inform NW process of likely requests for information.

Action: Mandy East

2. Minutes of the joint meeting held on 15 July 2009 (enclosed)

Minutes last meeting approved with following amendments

Correction it was 2 PCN meeting not 3rd lay meeting
Remove "UK" form Allergy Action name

3. Matters arising

(a) 57 replies from August letter to PCTS/Trusts so far - only 24 contained details of allergy services

It was agreed that the results were disappointing but not surprising

(b) Results of GP survey conducted by NASG discussed

Despite enrichment for GPs with recent experience and training of allergy (200/700 had training) the majority didn't feel they had access to specialist care nor sufficient expertise for complex cases - it was suggested that it may be helpful if Allergy incorporated into GP re-validation requirements.

Agreed: GP training and educational support will not be enough in itself. Its difficult to know what you don't know. QOF needed but no signs of progress or prioritisation and (DES for dermatology not the answer. Further thoughts on how to incentivise GPs to deliver better allergy care was required

(c) There will be a forthcoming publication on allergy General practice in Aberdeen from Aziz Sheik in RSM Journal- we will need to be alert to it and its messages.Mandy to check if we would be allowed advance copy under embargo.

Action: Mandy East

(d) Concern was expressed that the map of medicine may not yet be of sufficient quality to be of use as a surrogate patient pathway for GP guidance. To consider inviting Dr Liz Angier invite to talk about sources of allergy information for GPs.

Action: Dr Bill Egner and Anne-Cecile Ville

(e) It was proposed that a single consortium of patient groups with a co-ordinated spokesperson might be able to speak with a stronger voice - Baroness Finlay suggested that they may wish to consider a federated arrangement. Patient organisations agreed to consider the suggestion and that some moves in that direction had already been explored.

Action: PCN members

(d) Noted: Suggestion of potential cost-saving analysis on waste of unused medication as a result of failure to access specialist care - cost saving - patient review group in PC. Action: NASG were producing a document of what patients want which could be of use at the MCR meeting. Bill Egner agreed to E mail Mr Roy Dudley-Southern to organise a Venue in MCR for afternoon meeting.

Action: Dr Bill Egner

Mandy East agreed to summarise a briefing paper of all patient organisational feedback to WP request for information.

Action: Mandy East

(g) Noted: Lynne Regent reported that a process was underway to identify/appoint a Patient rep for each SHA by Anaphylaxis campaign and additional reps may be appointed from each patient organisation.

(h) Noted that the RCPath had provided £1600.00 to enable publication of the report.

Royal College of Physicians

A meeting of the
Working Party (WP) on Implementation of the HoL Allergy Report
was held at the **Royal Infirmary Manchester** on **Tuesday 24 November 2009** at 1.00 pm
Central Manchester University Hospitals NHS Foundation Trust
Royal Liverpool and Broadgreen University Hospitals NHS Trust
Lancashire Teaching Hospitals NH Foundation Trust
Salford Royal Hospital NHS Foundation Trust
University Hospital of South Manchester NHS Foundation Trust
Alder Hey Children's Hospital NHS Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust

Present:

Baroness Finlay	Chair of the WP
Dr Bill Egner	Secretary of the committee
Dr Barry Kay	Vice Chair of the Working Party
Anna Addison	Associate Director Services Improvement, Central Manchester University Hospitals NHS Foundation Trust
Dr Hana Alachkar	Consultant Immunologist, Salford Royal Hospital NHS Foundation Trust
Dr Peter Arkwright	Consultant Paediatric Immunologist, Central Manchester University Hospitals NHS Foundation Trust
Fiona Chew	Allergy Nurse Specialist, Royal Liverpool and Broadgreen University Hospitals NHS Trust
Sandra Coleman	Staff Nurse, Lancashire Teaching Hospitals NH Foundation Trust
Prof Adnan Custovic	Professor of Allergy, University Hospital of South Manchester NHS Foundation Trust
Dr CJ Darroch	Clinical Director (Immunology) , Royal Liverpool and Broadgreen University Hospitals NHS Trust
Dr Tina Dixon	Consultant Allergist, Royal Liverpool and Broadgreen University Hospitals NHS Trust
Alex Farragher	Nurse Specialist, Central Manchester University Hospitals NHS Foundation Trust
Julia Hamer	Directorate Manager - Respiratory Medicine and Vascular Surgery, University Hospital of South Manchester NHS Foundation Trust
Sheena Hopkins	Allergy Nurse Specialist, Royal Liverpool and Broadgreen University Hospitals NHS Trust
Colin Lumsden	General Paediatrician, Lancashire Teaching Hospitals NH Foundation Trust
Dr Susana Marinho	Consultant Allergist, University Hospital of South Manchester NHS Foundation Trust

Dr Gail Marshall	ADM, Specialist Medicine, Central Manchester University Hospitals NHS Foundation Trust
Dr Sacha Marsland	Consultant Dermatologist, Salford Royal Hospital NHS Foundation Trust
Prof. Michael Pearson	Professor of Clinical Evaluation, University of Liverpool
Dr Stephen Hughes	Paediatric Immunologist, Central Manchester University Hospitals NHS Foundation Trust
Kirsten Major	Director of Finance, Director of Health System Development, NHS North West
Dr Naveen Rao	Consultant Paediatrician, University Hospital of South Manchester NHS Foundation Trust
Dr Anthony Rowbottom	Consultant Clinical Scientist in Immunology, Lancashire Teaching Hospitals NH Foundation Trust
Jenny Scott	Director of Commissioning, North West Specialised Commissioning Group
Louise Sinnott	Allergy Project Manager, North West Specialised Commissioning Group
Jo Stringer	Communications Manager, , North West Specialised Commissioning Group
Dr P Vijayadurai	Consultant Immunologist, Lancashire Teaching Hospitals NH Foundation Trust
Dr Jason Williams	Consultant Dermatologist, Salford Royal Hospital NHS Foundation Trust
Prof. Andrew Wardlaw	BTS
Dr Glenis Scadding	BSACI
Dr Adam Fox	BPAIIG
Claire O'Beirne	Asthma UK
Aleks Kinnay	Allergy UK and Allergy Alliance, LASG
Mandy East	
Suzie Hughes	Chair of the Patient & carer Network committee
Prof David Gawkrodger	BAD
Dr Nigel Harper	Royal College of Anaesthetics
Dr Richard Herriot	JCIA/ RCPath
Ms Sian Gordon-Brown	DH
Ms Lynne Regent	The Anaphylaxis Society
Ms Lesley Fudge	Latex Allergy Support Group

Dr Martin Myers	Clinical Director for the Allergy Services , , Lancashire Teaching Hospitals NH Foundation Trust
Dr Sibghat Ullah	Senior Contracts & Commissioning Manager NHS Manchester
Anne-Cecile Ville	RCP working party administrator

1. Welcome, apologies and introductions

Apologies were received from Professor Aziz Sheikh, Professor John Warner, Dr Jasmeet Soar, Dr Pamela Ewan, Ms Muriel Simmons, Dr Adam Fox, Dr Mathew Helbert, Dr Susan Leech, Dr Paul Cullinan, Mr Roy Dudley-Southern, Professor Stephen Holgate and Dr Andrew Bentley.

2. Minutes of the minutes held on 15 July 09 and 1 October 09 (enclosed)

The minutes of the meeting in July and October were approved. It was noted that Mandy East was present at both meetings and had been inadvertently omitted.

3. Introduction: Baroness Finlay

The Chair, Baroness Finlay welcomed and thanked all for attending this meeting. The Chair reported that the Implementation of the House of Lords Allergy Report Working Party was created in the follow up of the House of Lords Science and Technology report on Allergy and that it was a joint venture between the Royal College of Physicians and the Royal College of Pathologists.

The Chair and members had felt that it was important to hold a meeting in Manchester where the pilot project was being trialled. The original inquiry had looked into the science behind the explosion in allergy related diseases and as the inquiry progressed it had become evident that it was almost impossible to look at the science because of its lack of translation into clinical practice.

The working party had tried to prioritise the recommendations to an extent but as the working party progressed, members acknowledged that funding would decrease as the recession hit the economy and that this lack of funding would therefore impact on the implementation of those recommendations. More for Less and smarter working was required for existing services.

The model that the report had originally put together was a “cluster” but the term was abandoned. In hindsight the Chair felt that the term “cluster” seemed to be more relevant to the current situation as bringing together people with an interest in allergy should benefit the provision of services. The latest report from the Department of Health supports that approach. The Chair also commented that once the results of the Northwest pilot were evaluated they would hopefully be rolled out to all the Strategic Health Authorities as a potential model so there was a tremendous responsibility and hope for this pilot.

4. NW Allergy Project Overview Presentations (10 min each)

a) 'Commissioning Specialised Allergy and Clinical Immunology Services in the North West - Jenny Scott, Director of Commissioning and Louise Sinnott, NW Allergy Project Manager, North West Specialised Commissioning Group

The NW Allergy project was one of the top nine works programmed priorities for the NWSCG. A whole pathway approach was being taken to ensure effective use of over £1,000,000 investment over 2 years.
Mrs Jenny Scott and Mrs Louise Sinnott reported that the North West Specialised Commissioning Team had been working towards ensuring that the right patient got the right treatment delivered by the right clinical team at the right place and at the right cost with patient involvement. A recent public engagement initiative had demonstrated that 72% of patients want to be seen by a specialist, but >50% want that service to be local. This had been a difficult task as the demand (not need) has almost doubled since 2005 to > 6,000 referrals hence the increasing emphasis towards providing the right treatment for the right patient to ensure appropriate use of limited resources . The aim was to provide integrated, equitable, high quality, clinically effective allergy and clinical immunology services for children and adults across the NW.

The vision for the Region:

- To create **specialist-led centres** acting as 'hubs', leading the managed clinical network.
- Allergy centres across the region will be linked to form a **'Virtual Allergy Centre'.**
- The development of an integrated, co-ordinated, regional clinical allergy service bringing together a group of health professionals and organisations from **primary, secondary and tertiary care**.

The Progress made so far:

- Over **£1 million** additional 'pump priming' investment from NW PCTs in 2 years to support service improvement.
- High Priority' in NWSCG work plan
- Clinical Evaluation Study Commenced (DH funded £80k)
- Designation of Tier 2b Paediatric Allergy Centres (early 2010)
- Dedicated Project Support(DH funded £120k over 2 years)
- PCT Chief Executive Lead engaged

The Future:

- Manage service provision between the different centres - (2009/10 and 2010/11)
- Educate physicians, nurses and general practitioners - (2010)
- Improve links with local PCTs and local hospitals - (2010)
- Work with different disciplines and professions - (2010)

- Develop and reinforce regional patient pathways - (2010)
- Develop and test locally agreed tariff for implementation and evaluation regionally (2010/11)
- Develop Standard Operating Procedures and protocols - (2010/11)
- Make the best use of skills, money, equipment and accommodation

Obstacles:

- Competing with other PCT 'must-dos'
- Absence of Allergy in QOF and primary care regulation i.e. *Care Quality Commission*
- Lack of available workforce
- No benchmark (poor quality data)
- Limited or no additional funding from 2010/11

b) 'Proposals for the future development of Adult Allergy Services in the North West of England' Dr Tina Dixon, Consultant Allergist and NW Project Chair

The project builds on a 2003 framework which suggested 3 centres but was unfunded.
Key objectives include:

- Community pharmacist protocols
- Referral protocols
- Training for primary care
- Secondary/tertiary interface services
- Reinforce existing services
- Enhance durability/continuity
- Consensus quality standards
- Enhanced VERY specialized services for region
- Enhanced dietetic services
- Enhanced contact dermatitis, refractory urticaria, anaesthetic allergy services etc
- Quality Assurance of Allergy Testing – especially with near patient testing – possible outreach role for nurse specialists
- Enhanced use of GPswSI

The project had developed a shared vision and a commitment to cooperation and had shown good working relations between managers and clinicians, Trusts and PCTS was essential.

Challenges remaining included development of referral screening and management plans guidance for primary care, cross boundary referral mechanisms, more efficient ways of working (e.g. challenge Fridays to enhance though-put).

Challenges also include:

- Building up hubs and developing virtual allergy concept – efficiency problems with creating service where all services physically coalesce at same time & conflict with equity of access etc.
- Challenge to increase education for supporting primary care acknowledged
- New paediatric allergist appointed for Liverpool New adult allergist for South Manchester
- Need to improve benchmarking data
- Need to complete "must dos" first
- Need to make best use of existing skills/accommodation/facilities/equipment
- Move to managed service provision in 3 hubs over next 18 months and then cascade train spokes and outreach services
- Focus on education of nurses and GPS next year.
- Improve links with PCTS with community outreach and nurse-led services
- Work with different disciplines and professions
- Develop regional patient pathways
- Locally agreed tariff tbd

c) 'Proposals for the future development of Specialist Paediatric Allergy Services in the North West of England'
Dr Peter Arkwright, Paediatric Immunologist, Manchester Royal Children's Hospital'

Dr Peter Arkwright reported that the North West vision of paediatric allergy was not specialist-centered but rather "specialist-directed" networking and training of primary, secondary and tertiary healthcare workers to provide efficient and effective service for patients close to home. Dr Arkwright stressed the issue that children are different from adults and that they therefore need their own model of care.

The vision and future for paediatric services in the North West region is to consolidate specialist paediatric allergy service within current tertiary Paediatric Centres (Alder-Hey and Central Manchester) to train, educate and empower the network to deliver services close to patients' homes, manage severe, complex allergy in association with subspecialty colleagues, engage in state-of-the-art research in conjunction with academics.
£410K of enhanced service had been identified with 1 extra specialist allergist for each centre, 2 extra nurses, 2-4 paediatricians with an interest, part-time dietician and admin support.

Dr Arkwright welcomed members' input and support on:

- Funding Gap: funding for 2 specialist nurses and admin staff (2010-11) has not yet been secured.
- Allergy interest groups: development of consensus information & guidelines agreed by all Tiers of the network and based on the latest evidence.

d) Discussion: Baroness Finlay (Chair)

Questions have been summarised under item 8

5. The Patient View, Mandy East, National Allergy Strategy Group (NASG)

Ms Mandy East reported that NASG had been devised as a coalition between the British Society of Allergy and Clinical Immunology, Allergy UK, The Allergy Alliance, the Anaphylaxis Campaign and Industry partners. Ms East remarked that patients had reported complaints from lack of knowledge to a lack of all round care and/or management. To remedy this, patients would like to have access to a Specialist led Centre, correct and accurate diagnosis, the provision of ongoing management of conditions and training for physicians.

Finally patients felt that having a Specialist Centre would ultimately improve patients' lives and save the NHS money.

6. NW Allergy Specialists (5 min presentation on each speciality)

a) Anaesthetic Allergy: Dr Nigel Harper, Anaesthetist, Manchester Royal Infirmary

Dr Nigel Harper remarked that aside from obvious benefits such as correct diagnosis of anaesthetic reaction preventing death or persistent health problems, a cooperation between anaesthetists and immunologists/allergists was beneficial as patients who have experienced anaesthetic reactions felt more safe having further anaesthetics knowing that the diagnosis was accurate. There were 500-1000 very severe reactions per annum but only a few UK specialist collaborative clinics with immunologists/allergist.
Approximately 32% of his neuromuscular blocking agent allergies had potential cross reactivity with other similar drugs requiring specialist advice.
The AAGBI protocol was developed with input from Manchester experts and was now available in every anaesthetic room in the country in laminated form.
The incorporation of joint anaesthetic clinic activity in the NW project

<u>Objectives for Anaesthetic Allergy</u>:

- Hub and spoke
- Reduce waiting times
- Increase in funded sessions
- Expansion of challenge testing
- Expansion of joint paediatric clinic

b) Urticaria : Dr Sacha Marsland, Dermatologist, Salford Royal Hospital

A very important disorder, often underestimated with impact on QOL comparable to coronary vascular disease and a prevalence of 0.6% for chronic urticaria generally and 4% in Dermatology clinics - Referral and gating protocols were being developed with triaging on a basis of GP referral letter information.

c) Contact Dermatitis: Dr Jason Williams, Dermatologist, Salford Royal Hospital

Dr Jason Williams commented that the Contact Dermatitis Investigation Unit was the largest in Europe and that it had excellent links with University, occupational physicians and industry. The unit aimed to provide assessment, accurate diagnosis and advice in a tertiary referral centre and ongoing management by a GP/specialist. Dr Williams felt that lack of appropriate tariff was a barrier to progress in that area.

d) Respiratory: Prof Mike Pearson, Aintree University Hospital

Professor Mike Pearson reported that although the management of Asthma related conditions had improved over the past 20 years, Asthma related conditions were still a challenge and common (5% in adults and 10% in children). On the other hand the problems of "difficult asthma" are most often non-allergic in nature so the question remained whether there was a need for a tertiary allergy service for asthma. Professor Pearson commented that to answer that question, it would be useful to follow these lines of inquiry:

Survey Information:

- Establish what is happening in Speciality-based Allergy Services (respiratory/dermatology/ENT) outside the NW Tertiary Centres
- Establish what primary care think they are delivering and what they perceive to be the needs – and from that to be able to discuss what can and cannot be delivered in primary care.

Examine existing data:

- Establish what the current Tertiary services for allergy are delivering: where are referrals coming from? For what reasons? From which PCTs?.
- Work with the tertiary units to agree the data collection of a minimum data set on ALL patients attending tertiary allergy clinics across the NW SHA.
- Emergency services for anaphylaxis: examine A&E data for acute allergy diagnoses and where they have come from. Set up limited data extraction project to gather data from (i) ambulance services and (ii) emergency depts on anaphylaxis/angioedema aimed at recording the extent of the workload and outcome

NOTE: Most allergy work is outpatient based so there is limited data available.

Develop new data systems for:

- Better recording of the outcomes of allergy patients across the central units and perhaps some key secondary units
- Patient recorded outcome measures for allergy: To establish a routine e-mail follow up at 3 months of those attending the tertiary clinics and from it develop a PROM (patient recorded outcome measure) index of success.

e) Discussion: Baroness Finlay (Chair)

Questions have been summarised under item 8

7. Outcome Measures (format TBC working with patient groups)

a) 'Analysis of North West Allergy Services' - Prof Mike Pearson, Professor of Clinical Evaluation, University of Liverpool
This item has been discussed under item 4 a) and b)

b) 'Quality of life measures: What's important to patients?'- Mandy East, National Allergy Strategy Group
This item was discussed under item 5

c) Discussion: Baroness Finlay (Chair)
Questions have been summarised under item 8

8. Q&A: Baroness Finlay Chair

Expert Panel:
Dr Tina Dixon, Allergist
Prof Adnan Custovic, Professor of Allergy
Dr Peter Arkwright, Paediatric Immunologist,
Dr Hana Alachkar, Immunologist, Salford Royal Hospital
Jenny Scott, Director of Commissioning
Louise Sinnott, NW Allergy Project Manager
Patient Reps (TBC)
Working Group Representatives (TBC)

1	**What are the timeframes for the role out of the pilot and its evaluation? 2-year pilot**

The NW Project is currently working to the following timescales:

- Manage **service provision** between the different specialist centres
  (2009/10 and ongoing)
- **Educate** physicians, nurses and general practitioners
  (from 2010)
- **Improve links** with local PCTs and local hospitals
  (from 2010)
- Work with different **disciplines** and **professions**
  (from 2010)
- Develop and reinforce regional **patient pathways and engage the public in their development**
  (from2010)
- Develop, test and implement agreed regional tariff
  (2010/11 and 2011/12)

- Develop **Standard Operating Procedures** and protocols (from 2010/11)
- Develop quality assurance processes (from 2010)

Impact will need to be assessed over a number of years. Earliest impact could be assessed in 2011 when we will be in a position to compare data collected with the established baseline activity in 2010 appropriate baseline.)

2	**What is the assessed impact of the current financial context for PCTs likely to be on the delivery of the NW Pilot?**

'Allergy' is one of the 9 high priorities identified by PCTs as being in their North West Specialised Commissioning Group (NWSCG) work plan. The work focuses on the entire patient pathway and the improved diagnosis and management of patients in primary and secondary care (where the majority of patient will be seen). In essence the right patients will be seen by the right people in the right place

It is unlikely that, should any additional funding become available for specialised services, that it will be spent in allergy services. North West proposals attempt to make the best use of existing resources. The development and introduction of a locally-agreed tariff would ensure that additional activity (increased patient numbers) would be charged at an appropriate level to ensure future sustainability.

3	**Will alternative models also be evaluated i.e. that of an established recognised service?**

The North West is working with the DH to identify a suitable comparator, though this will be challenging given the geographical and wide-ranging population differences between the NW and other areas such as Cambridgeshire, Southampton, London.

4	**DoH report: I would also be interested to know whether an audit on the training in schools for staff within schools and early years settings has taken place.(Recommendation 10.35)**

DH to respond

5	**When is DH going to put some serious money into supporting specialist centres – the amount of money for Manchester was negligible!**

DoH monies were invested to support the pilot (Project Management and Metrics – NOT SERVICES) on a non-recurrent basis. Over £1m additional support for service improvements in NW allergy services have been funded from existing PCT budgets over the past two years.

6	**Why is it that regional centres that have got their act together are not receiving support? More value for money would come from developing models that work rather than struggling with defective models**

[DoH to respond with their rationale for choosing the NW to be the allergy pilot.]
Consider:

- *The NW presented itself as an area where specialists from a variety of disciplines, and with an avowed interest in allergy, were willing to work collaboratively to provide a 'joined up' service.*
- *Significant work had been undertaken (2003) to review NW allergy services and propose a model for service improvements, which although was commended by NW PCTs, was not approved/given investment – NW was in a good place to hit the ground running.*
- *Attention and funding should be directed in parts of the country where services are less than adequate. Existing large tertiary centres on a single site may not be the best way forward or most cost effective model for many parts of the country.*

7	**Why are models of good practice not being used as templates elsewhere.**

What constitutes a 'model of good practice' for one region, may not meet the needs of other regions or build on existing expertise. There is a need for clearly defined models of 'good practice'.

8	**Foundation Trust status means that Hospitals have no incentive to hand work over to Regional Centres, as their goals is to maximise their income. This affects both the clinical services but also supporting laboratory services, which need to be supported by specialists.**

NW is working on the establishment of a virtual network, based on the needs of geographical challenges and areas of expertise within the region. Commissioners will determine services based on the needs of the population and payment will reflect this.

A local tariff has yet to be established to ensure that specialists see clinically appropriate patients with clear referral criteria.

9	**There is a view that blood tests can be done by any old lab, including private labs, pharmacies etc, and provided on a numbers only service: this will lead to serious misdiagnosis. Laboratories providing allergy diagnostic services need to be run by specialists skilled in the interpretation and management of allergic disease (Immunologists). DH needs to commission evaluations of allergy tests offered through shops, pharmacies and the post and internet and ensure that:**
a)	**only tests that meet the proper standards for specificity and sensitivity are licensed for sale to the general public;**
b)	**Such testing is covered by the requirement to register for the laboratory accreditation scheme run by CPA on behalf of UKAS and participate in International quality assurance schemes;**
c)	**tests are only offered as part of a package that includes a proper diagnostic consultation with skilled practitioners who have received proper training in allergy. At the present anyone can offer allergy tests to the public with any old test of dubious or no value! This approach has safeguarding implications for children**

The North West agrees. Laboratories need to be closely linked to clinical services and taken into account by commissioners when developing services.

10	**Why does the NHS not learn from its own experts?**

NW proposals are centered on using our own, existing specialist knowledge within the region. The principle is the foundation for regional service improvements – sharing skills, knowledge and expertise to better meet the needs of local people.

11	**Further on from diagnosis, there is absolutely no support for patients whose severe allergies are under control and who seek treatment for unrelated problems.**

As patient choice develops, patients will have the opportunity to choose the provider of service for their unrelated problem. They may choose to go to the hospital from which their severe allergy is being managed. Our aim is to provide the type and quality of service that patients want.

12a	**Regardless of how good the centre of excellence or the 'hub and spoke' are, the patient's experience is dependent on access to the services of either. That access is only achieved via the general practitioner referring the patient to the service or to other secondary care. Therefore, how has the NW project ensured that all patients have equitable access, bearing in mind the variations in GPs' knowledge and interest, and also PCTs' ability? (GPs vary from GPs with special interest; to those with some knowledge of allergy and allergy services; and then to those who 'don't know what they don't know'. PCTs can range from innovative; to ineffective; to inept; and sometimes can be all three at once.)**
b	**What have they done to ensure knowledge of the service is out there?**
c	**What have they done to increase GPs' knowledge of allergy (diagnosis and management)?**
d	**How has it been monitored?**
e	**Any input from the Deanery / medical schools?**
f	**Any guidelines, care pathways, protocols etc that can be shared with other regions / SHAs?**
g	**Recent HES data analysed by Asthma UK http://www.asthma.org.uk/news_media/news/new_data_reveals_hig.html - suggests asthma outcomes in the NW are worse than other areas in terms of avoidable, unplanned (and very expensive) hospital admissions. Does the NW allergy centre have plans/strategies in place for improved outcomes in allergic asthma?**

We are seeking to improve the education and training of GPs and secondary care clinicians, the issue of variable knowledge and interest applies across the whole field of medicine and is not unique to allergy. But this is a huge and challenging series of issues and will not be solved quickly. Sharing of expertise between hub and spokes is a recognised issue for many specialist services despite having been established for many years.

We are exploring the role of Deaneries and Medical Schools and working with the SHA on how to best share guidelines and learning experiences with national stakeholders.

13 A personal gripe: as with its predecessor, NHS Evidence has no specialist collection for Allergy. Allergy related items are scattered among the various organ specialisms - respiratory, skin, ENT, GI - mirroring the fragmentation of services in the NHS! This reinforces the impression that Allergy is a low priority in the NHS. I did contact Sir Muir Gray's office a couple of years ago about this but was basically fobbed off.

Out of Project scope, but this issue is presenting a significant problem for the NW (understanding allergy activity in specialties outside the 'clinical allergy' specialty.

14 Have you got somebody as a designated lead to drive this forward? Have you got one clinician for adults, and one for paediatrics?

Dr Peter Arkwright, Consultant Paediatric Immunologist at Manchester Royal Children's Hospital chairs the 'Working Group' and has led the development of proposals for paediatric allergy and clinical immunology services.

Dr Tina Dixon, Adult Allergist at Liverpool's Broadgreen Hospital recently became the third elected Chair of the adult 'Working Group' and is the overall lead for taking this work forward.

15 How does it benefit patients to have a 'virtual' allergy centre?

In line with NHS policy, proposals for service improvement attempt to improve equity and access to services closer to home. The proposals also build-on sustaining clinical allergy in existing centres and related expertise i.e.:

- South Manchester – Respiratory
- Liverpool – Immunotherapy
- Preston – ENT
- Central Manchester – Anesthetic Allergy
- Salford – Dermatology

Rather than dilute those specialties, the focus is on consultants working within a virtual network referring patients to colleagues with expertise in relevant areas. Specialist Services are provided in catchment areas of at least 1m people, this means that patients with complex needs may need to travel to get the most appropriate care. We will be looking at developing common audit and standard operating procedures in these areas, to link services together in an overall sense.

To date, efforts have concentrated on the stabilisation of specialist allergy services that deal with more complex patients. When appointments have been made to key posts, and the skill base is in place within specialist centres, plans exist to increase capability and capacity in Primary and Secondary Care.

Physically bringing together existing services would not be in the interests of the population in terms of the training of non-allergy specialists looking after allergy patients, as this would mean breaking links with the main specialty of clinical allergy.

With very limited resources, we we hope to proved a framework for the continued development of an allergy service that is available to all wherever they live in the SHA and has real expertise to deliver quality.

16 You are relying heavily on general paediatricians with an interest in allergy and there is a huge surge in demand. My main concern is training because with some of them, their 'interest' will be minimal…

We have done this kind of networking before and it has worked. Dr Richard Pumphrey used to visit 6 DGHs, running regular clinics with general paediatricians, and he was able to maintain and develop a degree of expertise to be able to deliver outreach/satellite clinics. As a first phase, we plan to develop 'Tier 2b Paediatric Allergy Centres'. These Centres will run regular joint paediatric allergy clinics with a general paediatrician with an interest in allergy and a visiting paediatric allergy specialist on a monthly basis. It is also envisaged that general paediatricians with an interest will visit the tertiary centre at regular intervals to develop and maintain their knowledge and skills in the management of more complex allergy, working to agreed North West Protocols/Standard Operating Procedures.

Consideration of the appropriate relationship between Paediatricians with a stated interest in allergy at other hospitals and their Tier 2b Centre will be explored as part of phase 2.

17 Do you have sufficient 'buy in' from PCTs to make sure the approach to the pathways works?

'Allergy' is one of the 9 high priorities identified by PCTs as being in their North West Specialised Commissioning Group (NWSCG) work plan. The work focuses on the entire patient pathway and the improved diagnosis and management of patients in primary and secondary care (where the majority of patients will be seen). Any associated increase in tertiary referrals could require additional resources at that level (currently not committed and would be for PCTs to fund).

18 The number of [paediatric] referrals seems awfully low. It would appear that some hidden allergies are being missed. How are you going to pick up those children?

The number of patients coming to dedicated clinics is extremely small but increased data will be facilitated through the establishment of tier 2b clinics. The University of Liverpool has also started a study to identify patients being treated for allergy by other specialties (not coded as 'allergy' but seen in respiratory, ENT or in a general paediatric clinics).

We envisage that the GP education programme will help to identify 'hidden' allergic children – previously unknown/undiagnosed.

19 Have you got links with A&E?

One of the key priorities of the service will be to liaise with A&E to ensure patients presenting to emergency departments are appropriately referred to specialist centres within the region and to build-on examples of good practice such as the 'Rapid Access Asthma & Allergy Clinics' that have been running successfully for over 4 years led by the Advanced Nurse Practitioner at Alder Hey Children's Hospital (twice weekly clinics from the A&E department).

Children can be referred to this clinic after they have presented to A&E with either an acute exacerbation of asthma or after an acute allergic reaction, they are then offered a follow-up appointment whining the 10 days.

20 GPs need to know when to refer patients – would revalidation provide an opportunity to monitor GP knowledge?

NW acknowledges that getting knowledge out to primary care is a huge challenge. Revalidation attempts to ensure that doctors are fit to see patients. The NW is working towards the establishment of an education programme that will attract CPD points and therefore incentivise GP participation.

21a Allergy plays a bigger part in asthma than recognised. Is there a role for an allergist in the treatment of asthma?

b What are you doing for adults with severe atopic eczema and food or respiratory allergies?

c Patients with latex asthma – would they be referred to an allergist?

d By bringing together dermatologists, respiratory physicians, anaesthetists etc – could they not work together rather than have to employ a full time allergist?

[In response to all of the above]

The idea of a virtual network is about looking to develop the expertise within the hubs, encouraging liaison between those hubs and who to go to for help.

Patients do not mind travelling long distances to specialists, but we are working towards more joined up, locally-accessible services across the region, sharing expertise, working more closely together to standard operating procedures and developing agreed referral criteria between primary, secondary and tertiary centres.

Joint clinics may not be the best approach for this specialist service i.e. patient may need an allergist now, and a dermatologist later or vice versa. The two specialties are not always in synch in terms of the development and treatment of a patient's condition and inefficient use of scarce

resources. The development of referral criteria should ensure that patients are sent to the appropriate service.

22 Are commissioners developing services within primary care to make sure that GPs have the information they need to make referrals?

Education, training and promotion of referral pathways via 'Map of Medicine' is a network priority for 2010.

23 How far are PCTs actually engaged with the development of the pilot?

PCTs need an evidence base for service redesign and it is very difficult to collect data relating to allergy. We need to show PCTs how much they are spending on allergy to prove the case for change. How do GPs and secondary care services code allergy? The pathways need to be explored.

24 How should we measure success in an allergy network or service?

There are a number of projects around the country focusing on collecting patient experiences. This has to be done electronically.

How do we get the right questions in there? Incorporating the goals of the physician, provider and patient is really complicated.

There should be follow-up within the first 6 months but long-term follow up is also needed.

Need to present the patient perspective to PCTs. Primary care refers patients on to secondary care, and secondary care diagnose, treat and discharge or refer on to tertiary care where they feel appropriate. Who should be responsible for ongoing care and management?

26 Is the Dept of Health looking for anything in particular?

The DH entered into a general Service Level Agreement with NHS North West to allow the project maximum flexibility in the development of services/outcomes/metrics, given that there is very limited baseline information for comparison.

27 How are meetings of disparate groups brought together?

There are different ways of doing things in various parts of the North West. These will be coordinated through the establishment of a Virtual Centre. The vision is that we will have consultant allergist-led foci – at least three within the region.

Sustainability of the Network will be achieved through the establishment of a Strategy Board, developing pathways etc. The board will be chaired by a PCT CEO. It will meet from Jan/Feb 2010 on a bi-monthly basis with current 'Working Groups' evolving into 'Implementation Groups'.

24. We hope the NW model will be a success and will be rolled out to the rest of the country. What will be the teaching of the NW to the rest of the country?

We hope we will be able to share lessons learned from the NW approach. Early learning has demonstrated challenges to breaking down barriers to capitalise on existing expertise in services and that there are two issues – how to develop the services in the future, and how to improve on what is already there.

25. What is the single, understandable, message to GPs?

We are working with GP colleagues on an effective and appropriate approach to reach our target audience. Dr Tim Frank, is a representative from the NW Deanery and a local GP and joins NW Network Meetings,

We also work closely with a local GP who is in training to become the NW's first GP with a Special Interest (GPwSI) in Allergy. He has developed an approach to evaluating training with NW GP colleagues.

26. GPs and primary care are important stakeholders. How do you communicate with them?

PCT Practice Based Commissioning (PBC) Consortia/Boards are a good forum for interaction with GPs, bringing GPs and out of hours staff together in clusters throughout the region.

There is no clear answer to the question of how to best communicate with primary care colleagues, but we hope to improve awareness through establishing training programmes and exploring channels of communication.

27 Why does the NHS not learn from its own experts?

NW proposals are centered on using our own, existing specialist knowledge within the region. The principle is the foundation for regional service improvements – sharing skills, knowledge and expertise to better meet the needs of local people.

28 Further on from diagnosis, there is absolutely no support for patients whose severe allergies are under control and who seek treatment for unrelated problems.

As patient choice develops, patients will have the opportunity to choose the provider of service for their unrelated problem. They may choose to go to the hospital from which their severe allergy is being managed.

9. Date of next meeting:

Thursday 28 January at 10.00am

Royal College of Physicians

A meeting to discuss the formation of the
Working Party (WP) on Implementation of the HoL Allergy Report
was held at the **Royal College of Physicians** on **Thursday 28 January 2010** at 10.30am

Present:

Baroness Ilora Finlay	Chair
Dr Paul Cullinan	Faculty of Occupational Medicine
Dr Bill Egner	Secretary & BSI representative
Dr Pam Ewan	NASG
Dr Adam Fox	BPAIIG
Professor David Gawkrodger	BAD
Dr Nigel Harper	Royal College of Anaesthetics
Dr Richard Herriot	RCPath
Mrs Suzie Hughes	RCP Patient & Carer Network member
Professor Barry Kay	Vice-Chairman (in the Chair)
Joanna Reid	Managing Editor
Dr Jasmeet Soar	Emergency Medicine
Professor Aziz Sheikh	RCGP
Anne-Cecile Ville	Working Party Administrator

1. Apologies

Apologies were received from Professor John Warner, Dr Glenis Scadding, Dr Andrew Wardlaw, Dr Susan Leech, Dr Gavin Spickett and Professor Stephen Holgate

2. Minutes of the minutes held on 24 November 2009

The minutes were approved. Mrs Suzie Hughes suggested naming the various organisations, who contributed to the patient's questions.

3. Feedback from the November meeting at the North West Centre

3.1. Feedback from the NW Allergy and Clinical Immunology Network (Bill Egner)
Members felt that the meeting had been very informative. The North West Centre seemed well aware of funding restrictions and had concentrated on building on existing knowledge and experience and they have also tried to identify gaps in the system. It was unclear how they would manage a "virtual allergy centre" or allergist led service and who/how they would measure it. Dr Bill Egner agreed to draft a letter in response to the Presentation in Manchester on behalf of the committee

Action: Dr Bill Egner

3.2. Discussion and review of presentations (All)
Comments are summarised under 4 and 5.

4. Review of progress against the work streams: (Bill Egner)

4.1. Summary of responses from SHA/PCTs (BE)

- Dr Bill Egner agreed to contact the Directors of Commissioning who have not responded to the original request and give a week final deadline for comments.

Action: Dr Bill Egner

- Dr Bill Egner agreed to compare the data collected and cross reference it with BSACI.

Action: Dr Bill Egner

- Dr Bill Egner agreed to circulate the cross referenced document to members and members agreed to comment/feedback using their own data

Action: members

4.2. Evidence from Patient Societies (BE)
Mrs. Suzie Hughes agreed to contact Allergy UK and the Anaphylaxis Campaign for more clarification on the documents they submitted. Mrs. Suzie Hughes also agreed to pull more information from other patient representatives.

Action: Mrs Suzie Hughes

4.3. Evidence from Specialist and Professional Societies (BE)
Respiratory Medicine: allergists could have a role in asthma but it would need to be clearly assigned.

4.4. Evidence from the DOH (BE)
No comments were raised.

4.5. Evidence from the NW Project (BE)
Anne-Cecile Ville agreed to contact Louise Sinnott to inquire how many (if any) paediatrician allergists worked in the North West.

Action: Anne-Cecile Ville

<u>Paediatrician allergists</u>: Anne-Cecile Ville agreed to contact Louise Sinnott to inquire how many (if any) paediatrician allergists worked in the North West .

Action: Anne-Cecile Ville

4.6. NICE guidance on Paediatric Food Allergy (BE)

NICE are developing a short clinical guideline on Food Allergy in children. Dr Adam Fox is involved in that process.

4.7. Discussion (All)

Dr Pam Ewan reported that BSACI was involved in writing a small paper on health and economics in allergy. The Chair felt that this topic should be included as a chapter in the final report. Dr Pam Ewan agreed to write a summary for the report.

Action: Dr Pam Ewan

4.8. Next steps

- QOF: Professor Aziz Sheikh agreed to discuss at the next QOF meeting on behalf of the working party whether QOF targets for Allergy could be raised.

Action: Professor Aziz Sheikh

- Drug manufacturers: Dr Bill Egner agreed to write to drugs manufacturers with regards to drugs licensing.

Action: Dr Bill Egner

- The British Pharmaceutical Society: Dr Bill Egner agreed to write to the British Pharmaceutical Society. Professor Barry Kay commented that pharmacists were increasingly involved in the treatment of allergy related conditions.

Action: Dr Bill Egner

- Cooperation with RCGP: Professor Sheikh agreed to inquire with the RCGP whether they would endorse the report.

Action: Professor Sheikh

5. Agree format, production and publication strategy for report

5.1. Agree key messages for the report (All)

The Chair commented that the report should reflect the amount of time and work involved by the relevant parties and accredited in that order.

- "Open access": Members agreed that the final report should be in the form of a 48 page Pdf file. The Chair agreed to draft a letter to the Registrar to inquire whether the final report could be made public. It was noted that RCPath were planning to do this and Ms Hughes commented that Patient Representatives who contributed to the report would also want to have access.

Action: the Chair and the Registrar

- "Time line to Publication": It was agreed that the report would be submitted to the 17 March Council meeting with a view to have it signed off by 1 March. Dr Bill Egner agreed to produce the first draft by 14 February.

Action: Dr Bill Egner

- "Draft version of the report": Dr Bill Egner tabled a draft version at the meeting. Dr Bill Egner agreed to redraft it and circulate a new version to members including feedback/comments from the meeting within 2 weeks (see time line to Publication).

Action: Dr Bill Egner

6. Any other business

None were raised.

7. Date of next meeting:

It was agreed that there would not be any further formal meetings and that all action points would be dealt with electronically.

The meeting closed at 1 pm.

NASG GP survey
Dr Pam Ewan

GP Survey on Allergy

Executive Summary

A survey was carried out of GPs views on allergy by the NASG in conjunction with Allergy UK during the autumn of 2008. The survey produced the following key points:

- A total of 750 surveys were sent with 74 completed, making a 10% response rate
- Of those completed, 74% of GPs felt that milder allergy should be treated in primary care
- 74% felt they did not have the necessary skills and knowledge to treat allergy
- 62% need help with allergy education; 33% need more time and 17% needed practical help such as more staffing
- When asked if they had attended any courses in allergy, 59% said no and 39% said yes
- Of those who had attended courses, 56% had not done so in the last year, but only 14% of respondents overall had received any allergy education in the last year
- Of those who had had training, 81% have applied their learning to their GP practise
- 89% of those surveyed had referred patients to a secondary care specialist
- Of those who hadn't, a third said this was due to there being no allergy specialist to refer to and a further third said the specialist was too far away

Quotes from free text section of the survey:

- GPs know there is a huge unmet need. We often avoid looking for it as we do not have the time/other clinical priorities/lack of access to testing (skin prick testing particularly) in primary care/do not want to overload secondary care with mild-moderate cases. I also think a lot of GPs question the value of seeking allergy in atopic patients and generally are not aware of available medications/interventions
- I would like to have more update meetings involving allergy specialist within our area
- Need allergy clinics on the NHS to identify cause of allergy. In the few available – they have long waiting lists

Survey Group

750 GPs were surveyed.

Allergy UK (AUK) managed the survey using their database of GPs. The survey was sent to 200 GPs who had attended an AUK allergy masterclass (a primary care educational day) or an AUK diploma course; and a further 550 who were randomly selected from English GPs on their database. Thus 36% of the survey group were known to have attended an allergy course, so this was not an unselected group of GPs but was biased towards those with an interest in obtaining some allergy education.

Surveys were sent to the named GP on the database, usually the principal partner or in the case of masterclass/diploma course attendees, the named delegate from the day.

38 PCTs were confirmed on the returned survey, 28 did not state which PCT they came from.

46 GPs (62%) noted that they were from England, 28 did not comment on where they were based.

Responders

74 of 750 responded (10%); 66 were identified, 8 were not.

These GPs were from 38 PCTs.

Questions
These related to attitudes and knowledge of allergy, education in allergy, as well as access to services for allergy referral, and support from allergy specialists locally.

Findings

Skills and knowledge of allergy
The majority (74%) felt they did not have the necessary skills and knowledge to treat allergy in primary care.
However a similar number (74%) felt it appropriate that milder allergy should be treated in primary care.

Areas GPs found most difficult were:
Allergy diagnosis
Food allergy
Multi-system allergic disease
Children
Difficult to control urticaria
Interpretation of blood tests for allergy

Education in allergy

- 62% felt they required help with allergy education
- 59% had not attended any courses in allergy
- Of those who had attended courses, 60% had not done so in the last year
- Of those who had attended courses, in 80% this was a study day.
- Most had had only one day of education, and in the majority this was not in the last 3years.
- Of those who had had training, only 16% have applied their learning to their GP practise

Effect of education

- More patients were being treated in primary care
- More blood testing for allergy (Specific IgE) was being performed to support allergy diagnosis

Ability to refer to secondary care

Only 50% were easily able to refer to secondary care for an allergy opinion.

What help GPs felt they needed

- In order to deal with patients with allergy, 33% of GPs felt they needed more time, and 17% required practical help such as more staffing
- A need for close working with an allergy specialist in the area was identified. For example this lack was reported for an area in the Home Counties (Reading) serving a very large population. (A single handed consultant allergist retired and the funding which had been put together from various sources was clawed back to individual departments (ENT, dermatology etc) and there is now no allergy service. The nearest are Southampton and London.

Summary

This survey identifies the lack of knowledge in primary care, the lack of education (particularly important in that the vast majority of GPs receive no training in clinical allergy as medical students) and the lack of support GPs have in access to local specialists in allergy for advice and support.

Anaphylaxis Campaign – Ms Claire O'Beirne

Firstly, regarding the respiratory specialist view questioning the relevance of specialist allergy services to asthma (p.18 draft): the lack of awareness, good information and access to reliable allergy diagnosis emerged as a major theme in the consultations on the DH draft copd/asthma strategy held in late 2009 and attended by just over 100 delegates from Asthma UK (forwarded on 12 Feb). Many of those who attended suffer from atopic co-morbidities such as eczema and allergic rhinitis and quite a few also from food allergies: their common complaint is that the care they receive is fragmented. One participant mentioned having to present separately in primary care for asthma, eczema, hayfever. An extreme and tragic example of the lack of joined-up care in asthma and allergy is given in the recent reports of the inquest into the anaphylaxis death of a teenager in Altrincham last August, an asthmatic boy with diagnosed peanut allergy who had not been prescribed an epipen and where there may not have been sufficient awareness of the implications of food allergy alongside asthma (press report attached)

I am aware of the unfavourable economic climate and the need to maximise present available resources but, according to Asthma UK data on asthma hospitalisations (rather expensive events), our current management of asthma is not particularly cost effective given that many are these are avoidable with better management. It is interesting to note that, according to recent OECD data, the UK is considerably above the OECD average for unscheduled asthma hospitalisations (51 per 100,000 cases) as it hospitalises 75/100,000 cases. Other EU countries perform better, according to the data, particularly Germany, well below the OECD average with 21/100,000 cases. It would be interesting to research the reasons for the differences in these unscheduled hospitalisation rates to find out if the more widespread access to specialist allergy care (e.g. immunotherapy for allergic rhinitis) in other EU countries is having a beneficial influence on asthma hospitalisation rates.

Finally, I have seen that the ACAAI (American College of Allergy, Asthma and Immunology) has updated its 'Blue Book' - "Asthma management and the allergist - better outcomes at lower cost", available here - http://www.acaai.org/Member/Practice_Resources/asthma_outcomes.htm . Obviously this is written in the context of the US healthcare system which has a different professional and financial structure but I thought I would pass on the link for interest.

BSACI – Dr Glenis Scadding

bsaci
improving allergy care

Response to the House of Lords recommendations from the British Society for Allergy & Clinical Immunology

ALLERGY CENTRES

10.1. Creation of new centres/New clusters of expertise

The BSACI supports the implementation of this recommendation. There should be at least one allergist-led allergy centre staffed by consultants in adult and paediatric allergy in every region. Existing allergy centres, which often have inadequate NHS resource to deal with work load, also need to be strengthened. In particular the NHS should provide funding where existing staff are being maintained on academic or "soft" funding but are providing an NHS service.

There have been a few initiatives in existing centres(vide infra), suggesting that once a centre is established the benefit of allergy services is recognized.

The Allergy department of the Royal National Throat, Nose and Ear Hospital has been augmented by the addition of two new part time Consultant Allergists, whilst for the time being retaining the services of its recently retired Consultant on a part time basis. This increases the sessions from 10 to 14.The paediatric clinic has been augmented by the addition of rotating paediatric consultants who are undertaking allergy training and a paediatric allergy nurse specialist. This will enable further services such as injection immunotherapy and food and drug challenges to be made available with the co-operation of the Royal Free Hospital Immunology department. The Centre will then be able to provide a complete allergy service, increasing the number of such clinics to 7.

Imperial College London Healthcare NHS trust has large adult and paediatric allergy services and has recently appointed a new Clinical Senior Lecturer for paediatrics and will shortly appoint a new consultant in the adult service. However, despite a large staff complement by comparison with most specialist units and daily clinics in both services, the patient load exceeds capacity.

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The four PCTs in Devon & Cornwall have agreed to expand allergy services. A third Consultant Immunologist post has been advertised. There are deficiencies in the provision of Paediatric Allergy services and this area needs addressing.

There has been considerable expansion at Guy's and St Thomas' Hospital Allergy Services. This has been a joint Trust and Academic initiative. An Adult Allergy consultant post has been created with 5 academic sessions (supported by the Biomedical Research Centre) and 5 NHS sessions adding to the current complement of 3 consultants. The Adult Services have also benefitted from the appointment of an Adult Allergy Nurse Specialist. There has been considerable growth in Paediatric Allergy, now running 17 clinics per week, with the appointment of a fourth

Paediatric Allergy Consultant. New joint specialist clinics have been created with Allergy / Gastroenterology, Allergy/ENT and Allergy/Dermatology as well as a transitional adolescent allergy clinic. Specialist paediatric clinics are also run for Immunotherapy, Drug Allergy as well as a high risk vaccination service

10.2. Improved diagnostic facilities necessary to investigate complex allergy, accredited allergy training.

- Regular multi-disciplinary team meetings
- Service places needs of the patient first
- Involvement of paediatric allergists
- Improved transition from paediatric to adult allergy care

This recommendation is supported by the BSACI.

St. Mary's Hospital as part of the Imperial College Healthcare NHS Trust has a monthly transition clinic for young people with allergy and is about to appoint another consultant to specifically lead this component of the service.

Imperial College has an Allergy MSc which commenced in 2008/9. It already has more applicants for the next year than can be accommodated. There is also an Allergy MSc in Southampton. BSACI support improved services for complex allergy. Diagnostic facilities for complex allergic problems, eg drug allergy, have not improved.

10.3. Improved patient pathways to support primary or general secondary care or patient self-management

- Appropriate provision of Allergen immunotherapy

The BSACI supports the appropriate provision of allergen immunotherapy but recognises that, in order for such a service to grow and develop, there must be a marked increase in the number of allergy trainees and centres able to administer such treatment. As well as new allergy centres, there must be increased resource to those existing centres to ensure their long term survival. In addition, for patients to access immunotherapy, they must have been properly diagnosed in the first place to be sure the immunotherapy will be effective.

The provision of sublingual immunotherapy for severe uncontrolled hay fever is constrained by the unwillingness of many PCTs to provide funding.

The RCPCH has a working group now developing proposals for care pathways for children with anaphylaxis, asthma/rhinitis and food allergy. However, there is currently insufficient funding for this to be extended to other very important allergic conditions.

10.4. New centres should enhance and build, develop and expand upon the services already offered.

Despite the recommendations from both the RCP report in 2003 and the Commons Select Committee for Health inquiry into allergy in 2004, which recommended the creation of 20 new paediatric and 20 new adult allergist training posts, there are only 12 allergy trainee posts

(adult) in England ie about new 2 trained allergists are produced each year. This is grossly inadequate. The only completely new posts established last year:

- 1 consultant allergist at Nottingham
- 1 paediatric allergist at Guy's Hospital

10.5. Equitable geographical distribution/access to services

- National reference centres and supporting referral pathways for super-specialist allergy

Access to services is a key issue. We support this recommendation and recognise that super-specialist allergy services will need to be concentrated in specialist centres; however the care pathways for these services will need to be clearly defined so that these services are accessible to all patients who need them.

10.6. Improved educational activities for local GPs and other healthcare workers in allergy.

- Development of GPwSI in allergy

The BSACI supports this recommendation but is not in agreement with the proposed provision of pharmacists with Special Interest in Allergy acting as clinicians since they have not received the relevant basic clinical training.

The BSACI has set up a Primary Care Group whose remit is to improve allergy care at this level. A first step is the translation of BSACI guidelines into a format which is easy for primary care staff to access and use. Two of these (urticaria and rhinitis) are available through e-guidelines. The full versions can be accessed via the BSACI website: www.bsaci.org

The Primary Care Group is also developing competencies to support the development of the PwSI in allergy role. This work is nearing completion and will be submitted to the RCGP for consideration and eventual implementation. The cost of this process is estimated at £10k. This process will involve consultation with, and a meeting of all the relevant stakeholders.
BSACI is combining with the Kings College London Allergy Academy to provide educational meetings for primary care throughout the UK.

We would strongly support the inclusion of allergy indicators in the Quality & Outcomes Framework which would incentivise the primary care team to focus on allergy. It would also encourage PCTs as the commissioners of clinical allergy services to prioritise them in relation to local need.

A survey carried out by Allergy UK on behalf of the National Allergy Strategy Group showed that 74% of those surveyed felt they did not have the necessary skills and knowledge to treat allergy, with 62% needing help with allergy education; 33% needing more time and 17% needing practical help such as more staffing.

The number of largely generalist paediatricians becoming BSACI members has increased significantly over the past year. An e-mail based Paediatric Allergy Group set up in 2008 by Dr George du Toit, Professor John Warner and Dr Glenis Scadding now has some 800 members.

This demonstrates the awareness of allergy among general paediatricians as an important factor in much paediatric illness.

Fully trained paediatric allergists are still needed for complex patients.

10.7. Public information and advice

- Centres should provide education and training courses for allergy patients, their families, school staff and employers, in how to prevent and treat allergic conditions
- work in collaboration with
    - allergy charities
    - schools
    - local businesses.
- Patient engagement: Better feedback between patient groups and allergy centres

The BSACI supports this recommendation and is encouraging collaboration between Allergy Centres and patient groups.

10.8 Establishment of lead Strategic Health Authority to work with its Primary Care Trusts to develop the first allergy centre

- A full cost analysis
- Assess the efficacy of diagnosing and managing allergy using the "hub and spokes" model.
- Improved education of clinicians in allergy, with an accurate diagnosis recorded on the Systemised Nomenclature of Medicine (SNOMED) system
- The lessons learnt from the pilot allergy centre used to inform the development of further allergy centres in other regions.

The BSACI welcomes the recommendation to pilot a regional allergy centre in the NW and would welcome involvement in the development of the model. There remain concerns around its development and the sustainability of the pilot:

- In order for the centre to be effective, it needs to be set up and led by a consultant allergist, as recommended by the HoL enquiry. This specialist must be there from inception in order to lead and grow the service. Establishing a regional centre for allergy is an enormous task and will take a considerable amount of time to develop. As well as treating patients, the service must act as an information centre for the surrounding health care professionals and local community.
- Funding is inadequate. Apart from the initial £60k, all the funding has so far been allocated locally from existing budgets. Only one consultant post has been created and whilst we understand funding is available for two further paediatric posts, many more are needed which indicates the growth of the service in the NW will be slow.
- The total number of consultant allergist posts required in the NW is 12. This is necessary to deliver services across such a wide population base.
- The lack of funding means that the process of development of the centre will be slow and as a result any evaluation cannot be effective until the service is established. There is no service to evaluate currently; if the DoH wishes to evaluate the effectiveness of an

- The centre in the NW will appropriately be created to serve the local population. It is essential to note that this model will not necessarily work elsewhere in the country.
- It is important that the expectations for this project are clear to all parties.

10.9. Sharing of resources – such as standard operating procedures, clinical guidelines and patient information.

- The lead Strategic Health Authority should ensure that there are national reference centres for rarer allergic conditions such as some occupational disorders or adverse drug reactions.

The BSACI supports this recommendation. To date there is no evidence that this has been taken forward. The DoH role has yet to be clarified with regard to this proposed centralisation.

Occupational allergy remains an issue. For example when the upper respiratory tract is affected occupationally the patient is often seen by an ENT surgeon with little allergy or respiratory expertise. The diagnosis may be overlooked which is a missed opportunity to reduce allergy problems since rhinitis almost always precedes asthma and carries a high risk for its development. Early diagnosis and appropriate management could reduce the onset of more significant problems which may render the patient unable to work and in need of long term NHS care.

In that the NW SHA has a major task in developing a new allergy service and consultant allergists need to be appointed to develop local expertise, it is suggested that this role would more appropriately be dealt with elsewhere within DoH eg by NSCAG.

10.10. A patient database to support clinical research within each region.

- The Office for Strategic Coordination of Health Research and the Translational Medicine Funding Board should work with the lead Strategic Health Authority to support clinical research in the allergy centres and co-ordinate national research projects.

The BSACI supports this recommendation, suggests this requires the involvement of SHAs where there are established allergy centres, and looks forward to its implementation.
With respect to long term cohort studies and interventional studies, there is a window of opportunity to intervene and prevent allergic disease and the ability to define a high risk group of children who will develop allergic disease. Long term cohort and interventional studies require trained staff, clinical trial facilities, and the resources to conduct studies over 5-8 years. While the cost of these studies is considerable, the potential benefit is greater.

PROFESSIONAL EDUCATION

10.11. Health and Safety Executive & Department of Health to improve education in the diagnosis and treatment of occupational allergic disorders.

- Health and Safety Executive should work with stakeholders to produce a standard of care document for occupational allergic skin disease similar to that for diagnosis of occupational asthma by the HSE Group of Occupational Respiratory Disease Specialists.

The BSACI supports implementation of this recommendation. The work of the Latex Allergy Support Group is key in this area and the Standards of Care Committee of BSACI is in the process of developing a guideline on latex allergy with the LASG and BAD .

10.12. Improving the training of those in primary care.

- Royal Colleges should work together to ensure that the training undergraduate medical students receive enables them to recognise the role of allergy in disease processes and to refer patients appropriately.
- General practitioners to develop their allergy knowledge through continuing professional development and as part of their membership of the Royal College of General Practitioners.

The BSACI supports this recommendation.

The training in Allergy received by medical students is extremely limited when compared to the burden of allergic disease in the population for which they will have to care. It is essential that medical students (the GPs of the future) are taught some allergy. However until there are consultant allergists in teaching hospitals this will not occur.

A pilot study of GP / Allergy clinic interaction is in progress in North London.

The BSACI Primary Care Group recently led a successful application to establish allergy as a clinical priority by the RCGP in 2010-2012. The Group will continue to work closely with the RCGP's 'Clinical Allergy Champions' to push for improvements in allergy services following confirmation of the appointment of the Champion/s in autumn 2009.

10.13 New quality-assured education opportunities:

- The Royal Colleges, the postgraduate Deans, the Postgraduate Medical Education and Training Board and the British Society for Allergy and Clinical Immunology, should work together to develop generic quality-assured clinical postgraduate courses in allergy, for doctors in both primary and secondary care and for nurses and others, particularly those wishing to become an accredited specialist in allergy.

The BSACI supports this recommendation. A second MSc Allergy course is now running at Imperial College to complement the one at Southampton University which has been revised.

These two post-graduate courses themselves complement the accredited Dip HE/BSc level allergy modules available via Education for Health and others.

RESEARCH AND PRODUCT DEVELOPMENT

10.14 Office for Strategic Coordination of Health Research to improve the co-ordination and funding for further research on the environmental factors contributing to allergy development and the "allergy epidemic".

- Long-term cohort studies
- Interventional studies

The BSACI supports this recommendation and looks forward to its implementation.

10.15 Improved Translation bench to bedside

- The Translational Medicine Funding Board must ensure that allergy research is applied to develop novel individualised treatments and allergy research directly related to health care.
- Establishing a comprehensive patient database within each allergy centre - maintained by ownership at a local level

The BSACI supports this recommendation and looks forward to its implementation.

10.16 We recommend that NICE should conduct a full cost-benefit analysis of the potential health, social and economic value of immunotherapy treatment.

The BSACI supports this recommendation and looks forward to its implementation.

FOOD

10.17. FSA should work with other training providers to produce consistent practical training courses of a high standard.

- Adequately and comprehensive training in practical allergen management for environmental health officers, trading standards officers and catering workers.

The BSACI supports this recommendation. There has already been considerable progress in this area prior to publication of the House of Lords report largely by co-operation between the FSA and the Anaphylaxis Campaign.

However two recent posters at the BSACI Annual meeting in July 2009 demonstrate a dangerous lack of knowledge on the part of workers in restaurants, many of whom are temporary employees.

10.18 Learning Early About Peanut allergy (LEAP) study

- Withdraw Department of Health dietary advice regarding peanut consumption for pregnant women and infants plus a comprehensive review by the Food Standards Agency and the Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment.

This advice has now been withdrawn (August 2009)

The BSACI believes further research is required so that there is evidence on which to base advice. There are studies in progress which should provide the evidence base on which to give advice, and results should be available in 4 years. The LEAP Study will examine the role of early consumption versus avoidance of peanuts in young atopic infants.

SCHOOLCHILDREN

10.19. Department for Children, Schools and Families should review the clinical care that hayfever sufferers receive at school, and should reassess the way in which they are supported throughout the examination season.

- The Department for Children, Schools and Families should also ensure that the provisions made by different schools are fair and consistent.

Children with hay fever may suffer significant cognitive impairment, their quality of sleep is impaired, they complain of being tired and unable to concentrate at school, and this has been shown to decrease their ability to learn and is also reflected in a deterioration in examination results compared to normal children. There is an opportunity to intervene very early and to treat hay fever, thereby improving educational performance, and the children's future life prospects. Thus there are strong clinical, social and economic reasons to intervene early in the treatment of hay fever. "

The BSACI suggests that services for hay fever should be improved and that this requires more specialist allergy centres and more facilities and funding for pollen immunotherapy in children. Improving the control of hay fever is vital to ensure children can perform at their full potential.

FURTHER RECOMMENDATIONS

MONITORING ALLERGY

10.20. Department of Health should ensure the Systemized Nomenclature of Medicine (SNOMED) system is supported by appropriate training, to ensure its efficacy as a simple consistent classification system to record allergic disease, monitor its prevalence and inform the commissioning of allergy services.

- Progress with standardising the collection of data on occupational illness via the Health and Safety Executive in EU working groups.
- Health and Safety Executive should fund the Health and Occupation Reporting Network with the full economic cost of its surveillance programmes
- Government to ensure support for this work in the future.

The BSACI supports this recommendation and looks forward to its implementation.

10.22. Future epidemiological studies to record the prevalence of confirmed allergic sensitisation.

The BSACI supports this recommendation.

THE AIR WE BREATHE

10.23. Department of Health should work with the Department for Communities and Local Government to support and encourage controlled trials involving multiple interventions, to examine the effect of ventilation, humidity and mite-reduction strategies on allergy development and control.

- Further evaluation chemicals used in the construction industry in triggering symptoms in some allergic patients in order to inform procurement policies.

The BSACI supports this recommendation and notes that measures to reduce the need for heating homes by increasing insulation may decrease ventilation and increase mould and house dust mite populations.

10.24. Implementation of recommendations in the report, *Air Quality and Climate Change: A UK perspective*.

- Government should take account of the interlinkages between air quality, climate change and human health when developing policies for industry, transport or housing.

The BSACI recommends greater co-operation between Met. Office and pollen counting centres to provide timely advice regarding fungal spore levels which have been associated with near-fatal and fatal asthma in July and August with prevalence rates expected to increase due to climate change.

SCHOOLCHILDREN

10.25. Improved management of allergic emergencies in schools

- The use of individual care plans for children with medical needs
- Department for Children, Schools and Families should audit the level of allergy training teachers and support staff within schools receive, and should take urgent remedial action to improve this training where required.

The BSACI supports this recommendation.

Expert assessment and a management plan reduce further reactions. (Ewan P.W., Clark A.T. Long-term prospective observational study of patients with peanut and nut allergy after participation in a management plan. Lancet 2001; 357: 111-15).

All seriously allergic school children should have a comprehensive management plan which has been produced by an allergy specialist with the parents and communicated to the school involved in the child's care. Links should be established between the allergy team and the community paediatric team to ensure training of school staff. We would like to see guidance from the Government to ensure that this occurs in all schools.

There are some local initiatives which have been highly successful and adopted by Anaphylaxis Campaign and Asthma UK. Sharing of good practice will be important.

10.26. Lack of clear guidance regarding the administration of autoinjectors to children with anaphylactic shock in the school environment.

- Government should review the case for schools holding one or two generic autoinjectors.

The BSACI supports this recommendation and agrees with the approach of the Australian Society for Clinical Immunology and Allergy (ASCIA), which suggests an adrenaline autoinjector for general use to be contained in first aid kits in high risk areas. This autoinjector can then be used for individuals not previously diagnosed, as back up if the first injector misfires or when a second dose of adrenaline is required but only one device has been provided.

However this cannot substitute for accurate allergy diagnosis and an individualised allergy management plan.

WORKFORCE

10.27. Development of Education work with the Health and Safety Executive to raise awareness and decrease the risk of occupational allergic disorders amongst employers and staff.

- Once allergy centres have been developed we recommend that the HSE should liaise with the occupational allergy specialist in each centre to inform its policies and develop strategies to prevent occupational allergic disorders.

The BSACI supports this recommendation and looks forward to its implementation.
Please see earlier comments on occupational allergy.

10.28. Job centres should review the way they work with employers, to improve the way in which they can assist employees who are forced to leave work due to an occupational allergic disease to enter retraining schemes and find alternative employment.

The BSACI supports this recommendation and looks forward to its implementation.

INFORMATION FOR CONSUMERS

10.29. Avoidance of vague defensive warnings on labels. Food Standards Agency should ensure the needs of food allergic consumers are clearly recognised during the review of food labelling legislation being undertaken by the European Union.

The BSACI supports this recommendation.

Defensive warnings on food labels are likely to lead to risk taking behaviour, particularly among teenagers with anaphylactic potential.
Warnings must be accurate.

10.30. Food labels should clearly specify the amount of each allergen listed within the European Union directive, if it is contained within the products.

BSACI thinks that this is neither necessary nor sensible since the amount of allergen needed to produce anaphylaxis varies with individual and with circumstances. The presence of any allergen should be noted, the amount is irrelevant.

10.31. “Hypoallergenic" and "dermatologically tested" products should warn those with a tendency to allergy that they may still get a marked reaction to such products.

The BSACI suggests that “hypoallergenic” and “dermatologically tested” terminology should be disallowed.

ADVICE FOR ALLERGY SUFFERERS

10.32. Improved education of high risk groups. Department of Health, working with the Food Standards Agency, charities and others, should explore novel ways to educate teenagers and young adults about allergy and the prevention of anaphylaxis.

The BSACI agrees that this is crucial.

10.33. The Interdepartmental Steering Group producing the "Children's Environment and Health Strategy” should improve education of children about indoor air quality and its role in allergy development.

The BSACI supports this recommendation.

10.34. Consistent, evidence-based policies and public advice are provided with close collaborative working with Allergy Charities/Patient Support Groups and allergy services

The BSACI supports this recommendation and suggests that all patient charities should have well qualified clinical allergy advisors.

10.35 Allergy advice offered by pharmacists is accurate, given by trained pharmacists rather than unqualified assistants.

- Pharmacists and Pharmacy Technicians Order 2007 should mandate adequate allergy education for all pharmacists, to ensure that they provide high quality advice to allergy sufferers.

The BSACI view is that all allergy testing should be undertaken in a clinical setting and overseen by a member of the medical profession.

Inappropriate exclusion diets can lead to serious nutritional deficiencies, especially in children. Negative specific IgE test results do not always rule out allergies. Thus, inappropriate interpretations of negative and positive specific IgE results performed in the pharmacy could lead to anaphylaxis as well as nutritional deficiencies in patients.

Pharmacists are well qualified to help allergy patients with advice about medications but are poorly qualified to make diagnoses since they lack basic clinical training.

EVALUATION OF COMPLEMENTARY TECHNIQUES

10.36 Robust research into the use of complementary diagnostic tests and treatments for allergy should examine the holistic needs of the patient, clinical improvement of allergy symptoms, and the impact upon patient wellbeing. Such trials should have clear hypotheses, validated outcome measures, risk-benefit and cost-effectiveness comparisons made with conventional treatments.

- Information about any indirect consequences of misdiagnoses or delayed treatment.

The BSACI supports this recommendation and looks forward to its implementation. Some well conducted studies have been published and show that some complementary diagnostic techniques such as kinesiology and vega testing give totally fallacious information yet many patients remain unaware of this and waste their money on such tests and on resulting unnecessary and possibly harmful diets.

10.37 Near patient testing.

- Improved interpretive support for self testing kits available to the public are by appropriately trained healthcare personnel- Evidence of good and bad practice
- Pharmacy IgE tests are being used to support unnecessary diets such as wheat exclusion in patients with no relevant symptoms. Many patients with hay fever will have positive IgE to wheat which is a grass but are able to eat wheat without problems.
- Avoidance of IgG food antibody test is being used to diagnose food intolerance in the absence of stringent scientific evidence.

- Further research into the relevance of IgG antibodies in food intolerance by controlled clinical trials

- General practitioners, pharmacists and charities not to endorse the use of these products until conclusive proof of their efficacy has been established.

The BSACI believes that there should be sufficient access to an appropriate level of allergy services provided by the NHS to ensure that these tests, which do not command the support of the medical profession, are not used as a default service by the general public.

Department of Health:
Progress following the House of Lords Science and Technology Committee report on Allergy – Ms Sian Gordon-Brown

November 2009 Update

This report gives an update on the progress of the Government's response to the 2007 report of the House of Lords Science and Technology Committee into Allergy.

The recommendations of the report are given in **bold** text, followed by the progress update relating to the recommendations in plain text below. This information is intended as an update to, and should be read alongside the Government Response to the House of Lords Science and Technology Committee Report on Allergy – 6 Report of Session 2006-07 (Cm 7255) and the 'Progress following the House of Lords Science and Technology Committee report on Allergy – April 2009 Update'.

In August 2008, the Department of Health appointed the North West Strategic Health Authority (NWSHA) to pilot improvements in allergy services. Many of the initiatives included in this update are currently being piloted by NWSHA with a view to rolling them out nationally, if successful.

CONTENTS

KEY RECOMMENDATIONS

ALLERGY CENTRES

RECOMMENDATION 10.1

We recommend that at least one allergy centre, led by a full time allergy specialist, should be established in each Strategic Health Authority. These centres would act as clusters of expertise of those with an interest in allergy, and should each contain a chest physician, dermatologist, ENT specialist, clinical immunologist, gastroenterologist, occupational health practitioner and paediatrician. Specialist nurses and dieticians trained in allergy would also be core team members.

The Department of Health has appointed the North West Strategic Health Authority as the lead strategic health authority for allergy and they are piloting an approach which, once evaluated, can be rolled out to each Strategic Health Authority.

RECOMMENDATION 10.2

Each allergy centre should provide the diagnostic facilities necessary to investigate complex allergies, and should ensure that those who perform these tests have received accredited allergy training. Parallel clinics could avoid the need for multiple referrals and separate visits to hospital for those with multi-system allergic disease. Regular multi-disciplinary team meetings will ensure knowledge is shared and complex cases are discussed. This places the needs of the patient first, allowing rapid accurate diagnosis that informs comprehensive patient management plans. The inclusion of paediatric allergists within allergy centres will ensure that children with allergic conditions are treated appropriately and will enable a smooth transition from paediatric to adult allergy care.

In the North West Strategic Health Authority pilot there will be multi-disciplinary services to investigate and meet the needs for managing very specialised/complex allergy problems, and these will be provided by a restricted number of specified Trusts in the North West building on existing specialist expertise (see response to 10.3 below). Examples include Contact Dermatitis, Refractory Chronic Idiopathic Urticaria, Injection Immunotherapy for multiple allergens, anaesthetic reactions and vaccine reactions. Consideration will also be given to the best care of patients with multi-system allergic disease, including whether parallel diagnostic clinics could be trialled.

RECOMMENDATION 10.3

Once a diagnosis is obtained and a treatment plan developed at the allergy centre, the patient's disease can often be managed back in primary or general secondary care. However, patients with severe or complex allergic conditions may need long-term follow-up from specialists in the allergy centre. Allergen immunotherapy by injection should always be carried out by specialists within the allergy centre because of the risk of anaphylaxis.

RECOMMENDATION 10.4

New allergy centres should enhance and build on existing pockets of excellence to bring together existing clinics and specialists, and to develop and expand upon the services already offered. Where specialist allergist posts already exist, these allergists will be key to the new

allergy centres and should take the administrative lead with the appropriate time commitment. In other areas, new allergist posts should be established.

Adult Allergy Services in the NWSHA pilot

North West proposals for Adult Allergy Services are:

- Training and support for GPs who will continue to diagnose and treat the bulk of allergy using agreed Map of Medicine pathways that will detail when to refer on.
- Recommending training for community pharmacists in symptomatic treatment for conditions such as hay fever and the encouragement of appropriate Quality Assurance measures for pharmacists undertaking point-of-care allergy testing.
- More relatively complex cases will be seen closer to home by Specialist Nurses and GPs with Special Interests (GPwSIs).
- The Trusts providing GP access referrals which will continue to see moderately complex cases which cannot be managed in primary care will be University of South Manchester Foundation Trust (UHSM), Salford Royal Hospital Foundation Trust (SRFT), Central Manchester University Hospitals Foundation Trust (CMFT), Lancashire Teaching Hospitals Foundation Trust (LTHT) and Royal Liverpool and Broadgreen University Hospitals Trust (RLBUHT).
- Several Trusts will continue to provide moderately specialised services such as drug challenges and injection immunotherapy for single allergens (typically grass pollen or insect venom). This will require referral from one allergist to another, within the North West Allergy Service.
- A few Trusts will continue to provide very specialised allergy services within the North West Allergy Service to build a cadre of practitioners with experience. Examples include Contact Dermatitis, Refractory Chronic Idiopathic Urticaria, Injection Immunotherapy for multiple allergens, anaesthetic reactions, Vaccine reactions and so on.

A full time (adult) Consultant Allergist has been appointed at the University Hospital of South Manchester NHS Foundation Trust (UHSM).

Immunotherapy services have been identified to be patchy in the North West. The pilot is considering service developments to increase the number of patients being treated for venom, pollen, drug desensitisation using standard approaches.

Paediatric Allergy Services in the NWSHA pilot

In the North West Strategic Health Authority pilot funding for two new Paediatric Allergists has been agreed and recruitment begun. North West proposals are for tertiary paediatric services in Liverpool and Manchester with a remit to:

- Educate and train primary and secondary care clinicians in the diagnosis and treatment of patients with allergies,
- Work with the media and voluntary organisations to ensure the public and patients are informed with evidence-based information,
- Clinical management of complex cases and,
- Database and Audit and Research.

The two paediatric allergy services will be based with the two tertiary children's services in the North West at Alder Hey Hospital and the new Royal Manchester Children's Hospital, to take advantage of the current allergy services infrastructure and workload and facilitate close liaison with other tertiary paediatric services such as dermatology, ENT, respiratory, gastroenterology, immunology and infectious diseases.

RECOMMENDATION 10.5

Allergy centres should be distributed nationwide, but it is not necessary for every allergy centre to provide every service; some should become national reference centres for less common allergies, such as anaesthetic allergy. Therefore patients may need to travel a relatively long distance to a national reference centre for their condition, for accurate diagnosis and management planning. The patient should then be referred back to their local service and primary care practitioners for ongoing management.

To take this forward clarity would be needed nationally as to what needs to be done on a supra-regional level and who decides which centre would lead on each specialist service. This will be informed by the pilot in the North West.

The development of protocols and quality standards across the North West is in the early stages. They are working on increasing capacity and capability in Primary Care.

Paediatric services have larger referral populations. Paediatric Allergy Specialists in the North West Network will run joint paediatric allergy clinics with general paediatricians with an interest in allergy at a number of locations across the area to bring specialist care closer to home.

RECOMMENDATION 10.6

Collaboration between clinicians in primary, secondary and tertiary care is key to improving the diagnosis and management of people with allergic conditions. Once established, the allergy centre in each region should encourage and co-ordinate the training of local GPs and other healthcare workers in allergy. In a "hub and spokes" model, the allergy centre, or "hub," would act as a central point of expertise with outreach clinical services, education and training provided to doctors and nurses in primary and secondary care, the "spokes." In this way, knowledge regarding the diagnosis and management of allergic conditions would be disseminated throughout the region. In regions where there are GPwSI in allergy, they should also play a role in the "hub" of the allergy centre.

The key features of the North West Strategic Health Authority plans for implementation will encompass a network-based approach to allergy care in the North West. The network approach will also be developed to clinical governance including audit. Paediatric services will be linked to adult services and delivered from a number of locations across the region. There will be re-enforcement of existing specialist services to meet all service standards and build sustainability.

Training initiatives will develop diagnostic and treatment skills in primary and secondary care. There will also be agreed regional protocols for referral, management and Standard Operating Procedures.

The North West is exploring the development/improvement of allergy Continuing Professional Development (CPD) for GPs and a General Practitioner with Specialist Interest (GPwSI) is currently training in Manchester.

Plans exist to develop primary/secondary care interface posts in PCTs. These services may focus on areas of high prevalence of allergic disease if these can be identified. The Network plans to develop agreed policies across provider Trusts regarding access to clinics and use of Choose and Book.

Assess the efficacy of diagnosing and managing allergy using the "hub and spokes" model

The North West vision is to create Consultant Allergist-led foci acting as 'hubs', leading the managed clinical network, recognising the significant contribution to this work of organ-based specialists and immunologists. These allergy foci across the region will be linked to form a 'Virtual Allergy Centre'. This plan envisages the development of an integrated regional clinical allergy service bringing together a group of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner to ensure the equitable provision of high-quality, clinically effective services in allergy across the North West. The 'spokes' might be organ-based specialists with an interest in allergy and/or the relatively few locations at which the allergy specialists advise and assist secondary care colleagues in more general, joint clinics. The NW currently employees one recently appointed full time allergist. Patients are seen by a number of other specialists, so fully realising the vision is expected to take a considerable amount of time.

RECOMMENDATION 10.7

The allergy centre should act as a lead in providing public information and advice. Specialists at the centre should work in collaboration with allergy charities, schools and local businesses to provide education and training courses for allergy patients, their families, school staff and employers, in how to prevent and treat allergic conditions. Feedback between patient groups and allergy centres would enable the allergy centres to assess whether they were providing the necessary services, and would ensure that the advice offered by patient groups was accurate and updated in the light of rapidly changing scientific evidence.

In the North West Strategic Health Authority pilot, the network has started an early exploration into the possible development of a lead consultant with a responsibility for 'Involvement' who could be the 'voice of the network' and have a significant role in the provision of information to the public.

Work has started to develop Patient Recorded Outcome Measures (PROMs). Members of the Royal College of Physicians House of Lords Allergy Report Implementation Working Group have agreed to share existing metrics/patient questionnaires on Quality of Life to support the North West work in this area.

RECOMMENDATION 10.8

We recommend that the Department of Health should establish a lead Strategic Health Authority, preferably not in the South of England, which would work with its Primary Care Trusts to develop the first allergy centre. A full cost analysis should be integral to this to assess

the efficacy of diagnosing and managing allergy using the "hub and spokes" model. Improved education of clinicians in allergy, with an accurate diagnosis recorded on the Systemised Nomenclature of Medicine (SNOMED) system, should assist a thorough cost analysis to be carried out. The lessons learnt from the pilot allergy centre should then be used to inform the development of further allergy centres in other regions.

The Department of Health has appointed the North West Strategic Health Authority as the lead strategic health authority.

A full cost analysis

- Implementation of the proposals is dependent upon North West PCTs' resources being allocated to support this work. This is being actively pursued, but is challenging in the current financial climate.
- Development of allergy services is in competition with other priority areas in a context of increasing fiscal restraint to reduce public expenditure and the still emerging impact of the introduction of Health Resource Group (HRG)4 as a basis for assessing financial contributions under Payment by Results (PbR).
- The pilot is exploring opportunities for tariff-based funding of the services delivered by the networks (self-financing), requiring the development of tariff bands for the different activities that take place, particularly in out-patient settings. It is also exploring the means for funding outreach training by specialists who would otherwise be generating income by treating patients.
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Initially, the Network plans to engage in audit and patient-recorded outcome assessment to determine the effectiveness of the model of care for patients with acute allergy in secondary and tertiary services and to provide a North West view of trends in referral patterns (numbers and types of conditions treated).

RECOMMENDATION 10.9

Once established, allergy centres in different regions should have a contractual obligation to share the resources they develop, such as standard operating procedures, clinical guidelines and patient information. The lead Strategic Health Authority should ensure that there are national reference centres for rarer allergic conditions such as some occupational disorders or adverse drug reactions.

Each Trust providing specialist Allergy Services in the North West pilot has agreed to develop standard operating procedures and clinical guidelines across the North West. 'Skin Prick Testing' is the first protocol to be addressed. These will be shared once they have been developed and tested.

RECOMMENDATION 10.10

The lead allergist in each allergy centre should be responsible for maintaining a patient database to support clinical research within their region. The Office for Strategic Coordination of Health Research and the Translational Medicine Funding Board should work with the lead Strategic Health Authority to support clinical research in the allergy centres and coordinate national research projects. The establishment of allergy centres would provide the clinical environment to undertake future clinical evaluations of immunotherapy and complementary therapies.

The North West SHA pilot has not as yet undertaken any research projects but this will be taken forward in the future by the North West Specialised Commissioning Team.

PROFESSIONAL EDUCATION

RECOMMENDATION 10.11

It is vital that the Health and Safety Executive works with the Department of Health to ensure that medical practitioners are adequately educated in the diagnosis and treatment of occupational allergic disorders. We support the work of the Group of Occupational Respiratory Disease Specialists convened by the HSE, which has developed a standard of care document for the diagnosis of occupational asthma, and recommend that the Health and Safety Executive should work with stakeholders to produce a similar document for occupational allergic skin disease.

The Health and Safety Executive (HSE) has supported (and part funded) the work of the Health and Safety Laboratory (HSL) on the development of a GP e-training programme for occupational asthma. Key messages for this tool were taken from British Occupational Health Research Foundation (BOHRF) guidelines and the Standard of Care Document.

The first step in developing a Standard of Care Document for occupational allergic skin disease - the development of a robust evidence-base - is underway. BOHRF is currently developing evidence-based guidelines for the identification, prevention and management of occupational dermatitis and urticaria (http://www.bohrf.org.uk/content/cur_proj.html#cod). A multi-disciplinary Working Group has been set up to develop the guidelines, which are scheduled to be published in March 2010. HSE is providing funding in kind, by providing the scientific secretarial role.

RECOMMENDATION 10.12

The development of NICE clinical guidelines for the diagnosis and management of allergic conditions is no substitute for improving the training of those in primary care. We recommend that the Royal Colleges should work together to ensure that the training undergraduate medical students receive enables them to recognise the role of allergy in disease processes and to refer patients appropriately. It is imperative that general practitioners develop their allergy knowledge through continuing professional development and as part of their membership of the Royal College of General Practitioners.

The Department of Health agrees the importance of such training. However:

Undergraduate training

The General Medical Council (GMC) has the statutory responsibility to determine the extent and knowledge and skill required for the granting of primary medical qualifications in the UK. Their recommendations on undergraduate medical education are contained in *Tomorrow's Doctors* (updated version published, September 2009), which:

- provides the framework that UK medical schools use to design detailed curricula and schemes of assessment

- sets out the standards that the GMC use to judge the quality of undergraduate teaching and assessments at individual medical schools.

It is the responsibility of the medical schools to ensure that specialist teaching meets the standards set out in *Tomorrow's Doctors* in order to retain GMC recognition of their course.

CPD for GPs

Post-registration training needs of GPs are determined by regulatory requirements and local NHS priorities, through appraisal processes and training needs analyses informed by Local Delivery Plans and the needs of the service. It is not possible for the centre to be prescriptive about GPs' specific training and development needs.

RECOMMENDATION 10.13

The Royal Colleges, the postgraduate Deans, the Postgraduate Medical Education and Training Board and the British Society for Allergy and Clinical Immunology, should also work together to develop generic quality assured clinical postgraduate courses in allergy, for doctors in both primary and secondary care and for nurses and others, particularly those wishing to become an accredited specialist in allergy.

The content and standard of postgraduate medical training is the responsibility of the Postgraduate Medical Education and Training Board (PMETB), which is the competent authority for postgraduate medical training in the UK. Its role is that of custodian of quality standards in postgraduate medical education and practice. PMETB is an independent professional body. In addition, the General Medical Council's Undergraduate, Postgraduate and Continued Practice Boards have the general function of promoting high standards of medical education and co-ordinating all stages of medical education to ensure that students and newly qualified doctors are equipped with the knowledge, skills and attitudes essential for professional practice.

These bodies have a vested interest in ensuring that doctors are equipped to deal with the problems they will encounter in practice. It is not however practicable or desirable for the Government to prescribe the exact training that any individual doctor will receive.

As all Colleges' curricula are up for review by PMETB at the end of 2009 and the beginning of 2010, it is a good time for those who wish to add to those curricula to approach the training leads of the relevant College. For generic issues, where it is considered that all curricula should contain the relevant competences, the Academy of Medical Royal Colleges should be approached as they are currently compiling this generic curriculum. A meeting is being scheduled in December 2009 with the department of Health and the National Allergy Strategy Group to discuss allergy training and manpower issues further.

In terms of nurses and others, the responsibility for setting the allergy standards required for professional registration for both pre and post registration sit with their professional regulators. The training curricula are designed to meet these standards by the higher education institutes working in partnership with NHS service providers and the regulators. The Department of Health, along with local NHS bodies that commission professional training, continue to work with the regulators and higher education institutes (HEIs) to ensure that their standards and curricula reflect the changing needs of patients and service delivery. In this case, we welcome

appropriate training for those wishing to become an accredited specialist in allergy based on the Royal Colleges, the postgraduate Deans, the Postgraduate Medical Education and Training Board and the British Society for Allergy and Clinical Immunology working together and also linking constructively with HEIs and NHS Service providers.

RESEARCH AND PRODUCT DEVELOPMENT

RECOMMENDATION 10.14

Although high quality research into cellular and molecular mechanisms of allergy is advancing, the factors contributing to allergy development and the "allergy epidemic," are poorly understood. It is imperative that further research should focus on the environmental factors, such as early allergen exposure, which may contribute to the inception, prevention or exacerbation, of allergic disorders. Long-term cohort studies are a vital part of this research, and interventional studies are key to verifying the role which these factors may play. We look to the development of the Office for Strategic Coordination of Health Research to improve the co-ordination and funding for these types of projects.

The Office for Strategic Coordination of Health Research (OSCHR) facilitates more efficient translation of health research into health and economic benefits in the UK through better coordination of health research and more coherent funding arrangements to support translation. In doing so, OSCHR supports NIHR, MRC and the other OSCHR Partners.
The Medical Research Council (MRC), the Department of Health through the National Institute for Health Research, (NIHR), and the Food Standards Agency (FSA) are actively supporting research in these areas, and the level of that investment is increasing.

The MRC, with Asthma UK, continues to support the Asthma UK Centre in Allergic Mechanisms of Asthma (Kings College London School of Medicine and Imperial College London). The Centre is carrying out research to advance understanding of allergic mechanisms at system, cellular and molecular levels, and to inform the development of new, effective and targeted treatments. It provides a high quality integrated environment for basic and clinical research training in allergy and asthma, and authoritative public information on asthma and allergy in conjunction with stakeholders and partners.

The MRC is also working with the Health Protection Agency (HPA) to support the MRC-HPA Centre for Environment and Health (Imperial College and King's College London) researching the effects of air pollution and health, particularly the impact of airborne allergens on asthma and other respiratory diseases. The main conceptual thrust for the Centre is to integrate individual-level and small-area analyses of environmental exposures and health - using advanced geographical information systems (GIS) and statistical modelling techniques, combined with experimental data, biomarker and mechanistic studies, and analyses of large population cohorts to tackle environmental health problems of public health and scientific importance. This involves further development of the national databases at Imperial College London which include health data, data on populations, environmental exposures and sources of environmental pollution. Advantage will also be taken of the air quality databases held at King's College London and their modelling capacity.

In addition to previously identified cohorts supported by MRC, more than £7 million has been awarded to researchers in an initiative to create small, extensively defined groups of patients to help detect, treat or prevent disease in 2008. The cohorts in this pilot study are in areas of high unmet need or where there are bottle-necks in turning research into therapies. Funding for the pilot has come from the MRC and the NIHR in England and the health research departments in Scotland and Wales. The Wessex severe asthma cohort hosted by University of Southampton was funded under this initiative (£680k).

The NIHR Biomedical Research Centre at the Guy's and St Thomas' NHS Trust/ University College London, is undertaking research on asthma and allergy, including studies on immunotherapy, new therapeutic strategies, and the early origins of disease. The NIHR has allocated £4.7 million over 5 years to the Centre for this purpose. In addition, the Imperial College Healthcare NHS Trust/ Imperial College Biomedical Research Centre is being funded to undertake research to identify novel targets for the prevention and treatment of childhood allergy and asthma.

RECOMMENDATION 10.15

We are concerned that the knowledge gained from cellular and molecular research is not being translated into clinical practice. We therefore regard allergy research directly related to health care to be an area of unmet need that requires greater priority. The Translational Medicine Funding Board must ensure that allergy research is applied to develop novel individualised treatments. The cost of a central disease registry may be too high to warrant investment. Therefore, a comprehensive patient database within each allergy centre will be key to epidemiological and other studies, and is best maintained by ownership at a local level.

The Translational Medicine Board was established by OSCHR in July 2007. Within its evolving role, it originally worked with MRC and NIHR to develop a fully aligned approach in translational research. Its emphasis is now increasingly on monitoring the coordination and implementation of the OSCHR Partners' coordinated approach to translational research on behalf of OSCHR.

The MRC continues to support high quality research into the underlying causes of allergic responses and underpinning research into the development of novel approaches to combating these conditions, spending £5.9 million in 2007-08.

Under the Experimental Medicine initiative, funds were committed to furthering our understanding of immunotherapy in allergic dermatitis and therapies for asthma totalling £735, 000. In addition, work within the MRC Centres previously mentioned is targeted towards translation of findings into patient benefit, including asthma and food allergy.

MRC is also working with the Food Standards Agency to explore opportunities for synergy between basic immunology and food allergy research to explore potential mutual benefit in drawing together researchers and clinicians working in the food allergy arena with basic immunologists working on other aspects of immunological disease. This would allow identification of potential opportunities for synergy in future research on the immunology of food allergy, and to promote greater engagement between these two fields of research.

The NIHR Health Technology Assessment programme has commissioned two studies with a combined value of £2 million on asthma treatments:

- a randomised controlled trial of intravenous or nebulised magnesium sulphate or standard therapy for acute severe asthma;

- an assessment of alternative approaches to the management of asthma in school aged children on therapy.

Other NIHR funding streams remain open to allergy researchers able to make proposals for applied research that meet the standard required for success in competition with others.

RECOMMENDATION 10.16

Immunotherapy is a valuable resource in the prophylactic treatment of patients with life-threatening allergies, or whose allergic disease does not respond to other medication. Although initially expensive, immunotherapy can prevent a symptomatic allergic response for many years, and may prevent the development of additional allergic conditions, so its wider use could potentially result in significant long-term savings for the NHS. We recommend that NICE should conduct a full cost-benefit analysis of the potential health, social and economic value of immunotherapy treatment.

There has been a considerable amount of activity to determine how best NICE could add value in the area of allergy, and specifically immunotherapy. Following the House of Lords recommendation, NICE considered whether it would be possible to develop guidance on the use of immunotherapy generally. NICE concluded that the suggested topic was too broad and asked for more focused topics to be developed.

Following consideration of a number of proposed allergy topics by NICE's topic selection panel, NICE held a workshop with allergy specialists in February 2009 to generate possible topics for discussion by the consideration panels and subsequent referral to NICE's work programme. The workshop generated several topics and, following prioritisation by the consideration panels, Ministers have now referred two allergy-related short clinical guidelines to NICE's work programme. The two short clinical guidelines relate to "the diagnosis and assessment of food allergy in children" and "the initial assessment and decision to refer following emergency treatment for an anaphylactic episode".

A number of other allergy-related topics relating to areas such as allergic rhinitis, drug allergy and wasp/bee immunotherapy are in NICE's topic selection process.

FOOD

RECOMMENDATION 10.17

It is imperative that environmental health officers, trading standards officers and catering workers are adequately and comprehensively trained in practical allergen management. We welcome the development of a training programme by the Food Standards Agency and recommend that the FSA should work with other training providers to produce consistent practical training courses of a high standard.

In 2005 the Agency worked with the National Occupational Standards bodies to introduce food allergy into food safety training for the hospitality sector.

In January 2006 the Agency introduced 'Safer Food Better Business', a food safety management pack that was developed to help small catering businesses such as restaurants, cafes and takeaways comply with new hygiene regulations. Within the pack there is a dedicated section dealing with allergens. In September 2009, the Agency published 'Safer Food Better Business' teaching resources for use in catering colleges.

In 2007 the Food Standards Agency launched a series of training workshops to help raise awareness of food allergy issues among local authority enforcement officers. The aim was to help enforcement officers to provide appropriate advice for food businesses on allergen management. The training was rolled out across the UK and the courses were very well received by enforcement officers. In 2008 the Agency extended the training it was providing on allergen management for enforcement officers to include an e-learning module, which is freely available from the Agency's website to anyone that needs advice about managing food allergens. E-learning is particularly helpful for small catering businesses as they find it particularly difficult to find the time and money for staff to attend training courses.

In addition, the Agency has run a series of incident prevention workshops and allergen training workshops across England to raise allergy awareness with local businesses and local authority enforcement officers respectively.

In addition, the Agency has published two best practice guides on food allergen management. The first, published in 2006, on allergen management and consumer information is aimed at manufacturers, retailers and enforcement officers and discusses controlling food allergens in a factory situation with the ultimate aim of reducing the number of 'May Contain' type warnings. The other guide, published in 2008, covers the provision of allergen information for foods that are not pre-packed, which includes foods sold in catering. This guidance is aimed at businesses which provide such food, helping them to provide accurate information about food allergens in their products. Both of these guides are helpful for enforcement officers who advise such businesses and are often standard material for course work.

RECOMMENDATION 10.18

It is imperative that work is carried out to investigate whether peanut consumption or avoidance in early life significantly affects a child's risk of developing peanut allergy. We therefore support the work of the Learning Early About Peanut allergy (LEAP) study. We are very concerned that Department of Health dietary advice regarding peanut consumption for pregnant women and infants is based upon evidence that was reported nine years ago. Recent evidence suggests that this advice has not succeeded in reducing the prevalence of peanut allergy and may indeed be counterproductive. We recommend that this advice should be withdrawn immediately, pending a comprehensive review by the Food Standards Agency and the Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment.

The Committee on Toxicity considered the review of the relevant evidence published since the previous Government advice was issued in 1998 and issued its statement in December 2008. This Statement is available from the COT's website at:
http://cot.food.gov.uk/cotstatements/cotstatementsyrs/cotstatements2008/cot200807peanut

The Food Standards Agency and the Department of Health have revised the advice to take account of the new COT conclusions and this advice was trialled with consumers and health professionals to ensure that it was easy to understand and use. The final revised advice was issued in August 2009 and is available from the Agency and DH websites at the following web addresses: http://www.food.gov.uk/safereating/allergyintol/peanutspregnancy
http://www.dh.gov.uk/en/Healthcare/Children/Maternity/Maternalandinfantnutrition/DH_104490.

It is also being incorporated into advice given to mothers about pregnancy and development of their baby, such as the Pregnancy and Birth to Five books in England that were re-launched in August 2009:

"In summary, if you would like to eat peanuts or foods containing peanuts (such as peanut butter) during pregnancy or whilst breastfeeding, you can choose to do so as part of a healthy balanced diet, unless you yourself are allergic to them or unless your health professional advises you not to.

You should try to exclusively breast feed your baby until about six months of age. If you choose to start giving your baby solid foods before 6 months of age, after talking to your GP or Health Visitor, do not give peanuts or peanut products until after six months of age.

If your child already has a known allergy, such as a diagnosed food allergy or diagnosed eczema, or if there is a history of allergy in your child's immediate family (if the child's parents, brothers or sisters have an allergy such as asthma, eczema, hayfever, or other types of allergy), then your child has a higher risk of developing peanut allergy. In these cases you should talk to your GP, health visitor or medical allergy specialist before you give peanuts or foods containing peanuts to your child for the first time.

Whole peanuts or whole nuts should never be given to children under five because of the risk of choking. **"**

SCHOOLCHILDREN

RECOMMENDATION 10.19

We recommend that the Department for Children, Schools and Families should review the clinical care that hayfever sufferers receive at school, and should reassess the way in which they are supported throughout the examination season. The Department for Children, Schools and Families should also ensure that the provisions made by different schools are fair and consistent.

The Joint Council for Qualifications already advises exam boards that pupils who suffer from hayfever can be considered for special consideration when taking exams. Applications for special consideration are considered on a case by case basis with appropriate supporting evidence.

FURTHER RECOMMENDATIONS

MONITORING ALLERGY

RECOMMENDATION 10.20

We recommend that the Department of Health should ensure the Systemized Nomenclature of Medicine (SNOMED) system is supported by appropriate training, to ensure its efficacy as a simple consistent classification system to record allergic disease, monitor its prevalence and inform the commissioning of allergy services.

The move to incorporate SNOMED CT into care records as part of the National Programme for IT was described in the Government's response of November 2007.
The training requirement to ensure the proper use of SNOMED CT is related to the deployment of detailed care record systems by local service providers as part of the National Programme for IT. SNOMED CT is being built into these systems and training will be a local responsibility associated with their deployment. The National Programme for IT recognises the importance of training and has agreements with local service providers to ensure that appropriate training of trainers is undertaken.

RECOMMENDATION 10.21
We welcome the involvement of the Health and Safety Executive in EU working groups to standardise the collection of data on occupational illness. The use of common standards in the diagnosis of occupational allergic conditions would allow international comparisons of disease incidence, and enable the evaluation of disease reduction strategies. We recommend that the Health and Safety Executive should fund The Health and Occupation Reporting network with the full economic cost of its surveillance programmes, and we urge the Government to ensure support for this work in the future.

The Government response of November 2007 continues to reflect the present situation. The Health and Safety Executive is currently considering the future of all the extant schemes and the need to continue funding them beyond the current contracts.

RECOMMENDATION 10.22
Information from children on sensitisation and symptoms is especially important and must be followed up to assess the progression of allergic diseases in order to predict workload. We recommend that future epidemiological studies measure not only the incidence of allergic symptoms, but also record the prevalence of confirmed allergic sensitisation.

The Government noted the Committee's recommendation. The Director General of Research and Development at the Department of Health has written to research funders to draw their attention to it.

THE AIR WE BREATHE

RECOMMENDATION 10.23

We recommend that the Department of Health should work with the Department for Communities and Local Government to support and encourage controlled trials involving multiple interventions, to examine the effect of ventilation, humidity and mite-reduction strategies on allergy development and control. As chemicals used in the construction industry may play a role in triggering symptoms in some allergic patients, further evaluation of their role is also required in order to inform procurement policies.

As a member of the Inter Departmental Group on air pollution, led by the Department for Environment Food and Rural Affairs (Defra), the Department of Health seeks to promote public health policy in this area. The Department has been working with the Department for Communities and Local Government on the proposed Building Regulations, which cover ventilation (part F). Proposals for amending the regulations are currently the subject of public consultation and highlight concerns that health standards are not undermined by proposed changes in energy efficiency requirements, which are likely to encourage more air tight buildings. Changes are proposed to help ensure that adequate purpose provided ventilation and air quality are maintained to guard against mould growth. The Committee on the Medical Effects of Air Pollutants (Chair: Prof Jon Ayres) has begun work on a report on the possible role of air pollutants as a cause of asthma – in addition to being, as is recognised, a risk factor for triggering asthma attacks.

The MRC is also working with the Health Protection Agency (HPA) to support the MRC-HPA Centre for Environment and Health (Imperial College and King's College London) researching the effects of air pollution and health, particularly the impact of airborne allergens on asthma and other respiratory diseases. The main conceptual thrust for the Centre is to integrate individual-level and small-area analyses of environmental exposures and health - using advanced geographical information systems (GIS) and statistical modelling techniques, combined with experimental data, biomarker and mechanistic studies, and analyses of large population cohorts to tackle environmental health problems of public health and scientific importance. This involves further development of the national databases at Imperial College London which include health data, data on populations, environmental exposures and sources of environmental pollution. Advantage will also be taken of the air quality databases held at King's College London and their modelling capacity.

The NIHR Biomedical Research Centre at the Guy's and St Thomas' NHS Trust/ University College London, is undertaking research on asthma and allergy, including studies on immunotherapy, new therapeutic strategies, and the early origins of disease. The NIHR has allocated £4.7 million over 5 years to the Centre for this purpose. In addition, the Imperial College Healthcare NHS Trust/ Imperial College Biomedical Research Centre is being funded to undertake research to identify novel targets for the prevention and treatment of childhood allergy and asthma.

RECOMMENDATION 10.24

As climate change and air pollution may significantly impact upon the development of allergic disease, we support the thrust of the recommendations in the report, Air Quality and Climate Change: A UK perspective. We recommend that when developing policies for industry,

transport or housing, the Government should take account of the interlinkages between air quality, climate change and human health.

The Department of Health is working closely with both the Department for Environment Food and Rural Affairs (Defra) and Department of Energy and Climate Change (DECC) on air quality and climate change issues. Defra and DECC lead on the implementation of recommendations in the report, *Air Quality and Climate Change: A UK perspective*. The Health Protection Agency (HPA) has established a small group of experts to work on the effects of ozone and heat waves on health. The medical consequences of flooding has also been recognised by the HPA as a priority area. Work on the post-flooding indoor environment has begun. This is, in part, focused on mould growth in damp conditions. The Department has also part funded the publication of the World Health Organisation (WHO) guidelines for indoor air quality: dampness and mould, which have recently been published.

SCHOOLCHILDREN

RECOMMENDATION 10.25

We support the use of individual care plans for children with medical needs, as described in the Government guidance *Managing Medicines in Schools and Early Years Settings*. However, we are concerned that many teachers and support staff within schools are not appropriately educated in how to deal with allergic emergencies. We recommend that the Department for Children, Schools and Families should audit the level of allergy training these staff receive, and should take urgent remedial action to improve this training where required.

As announced in the Child Health Strategy, all children with long term medical conditions and/or significant disabilities should have an individual care plan by 2010. Guided by this plan, health professionals and teaching staff will anticipate, avoid, and respond appropriately to events such as anaphylactic shocks - contributing to a reduction in the number of emergency admissions to hospital. Key workers of those with an individual care plan should liaise with the Healthy Child Programme team to ensure that their care is coordinated where possible with universal services.

Staff managing the administration of medicines and those who administer medicines should receive appropriate training and support from health professionals. Health and Safety legislation places duties on employers for the health and safety of their employees and anyone on the premises. In schools this includes responsibility for pupils. Advice produced by the Department, “Guidance on First Aid for Schools” gives an indication of the levels and type of first aid that are most likely to be needed in a school, which would include appropriate action for allergic reactions. Schools must, on their employer's behalf, take reasonably practicable steps to ensure their pupils' health and safety.

RECOMMENDATION 10.26

We are concerned about the lack of clear guidance regarding the administration of autoinjectors to children with anaphylactic shock in the school environment, and recommend that the Government should review the case for schools holding one or two generic autoinjectors.

Adrenaline auto-injectors are a prescription item. The Resuscitation Council (UK) advise that these devices should be prescribed on an individual basis by a specialist in allergy and that a

second device should be prescribed for school children if one is to be kept at school, or if there is history of requiring multiple doses.

Department for Children, Schools and Families (DCSF) guidance advises that schools and settings should only accept prescription medicines that have been prescribed specifically for a named child. Spare devices, held by the school to use in the event of emergency, should be clearly labelled for that child. This ensures that the correct response is made - and eliminates errors which may otherwise occur in the event that generic devices were made available.

WORKFORCE

RECOMMENDATION 10.27

We welcome the educational work of the Health and Safety Executive to raise awareness and decrease the risk of occupational allergic disorders amongst employers and staff, and would like to see this work developed. Once allergy centres have been developed we recommend that the HSE should liaise with the occupational allergy specialist in each centre to inform its policies and develop strategies to prevent occupational allergic disorders.

Although allergy centres as envisaged in the Committee's report are not yet established, the Health and Safety Executive continues to engage (through groups such as the Group of Respiratory Disease Specialists (GORDS) and also less formally) with clinicians expert in the field of allergic occupational lung disease.

RECOMMENDATION 10.28

We are concerned that employees who are forced to leave work due to an occupational allergic disease can remain unemployed for long periods of time. We recommend that job centres should review the way they work with employers, to improve the way in which they can assist these workers to enter retraining schemes and find alternative employment.

The original response to the report recommendation outlined the way in which Jobcentre Plus works with employers not only in terms of helping to meet their recruitment needs, but also in providing information, advice and guidance on employment and retention of people with a health problem or disability.

It also outlined the programmes available to help people with a health problem remain in employment or move into alternative employment, which includes Access to Work, WORKSTEP, Work Preparation, New Deal for Disabled People, Pathways to Work and specialist help from a Disability Employment Adviser.

Since then, Jobcentre Plus have been developing and improving the services that Jobcentre Plus provide to people with a health problem or disability, including those forced to leave employment due to an occupational allergic disease.

Most notably, a consultation exercise has been undertaken and from Autumn 2010, a new specialist disability programme will replace the existing WORKSTEP, Work Preparation and Job Introduction Scheme with a single streamlined and flexible package of support tailored to individual needs. The new programme will be available for those disabled customers with the most significant barriers to work and the Disability Employment Adviser (DEA) will play a crucial role as gatekeeper to the programme. Closer links with Access to Work and the programme will also be developed.

Following concerns raised recently by the Sheffield Occupational Health Association Jobcentre Plus will be considering if there are any practical steps Jobcentre Plus could take to raise awareness of Access to Work amongst people claiming Industrial Injury Disablement Benefit (IIDB) to support them in returning to work. IIDB may be available to some people with more severe allergic reactions, such as dermatitis caused by certain substances.

INFORMATION FOR CONSUMERS

RECOMMENDATION 10.29

Vague defensive warnings on labels for consumers with food allergy can lead to dangerous confusion and an unnecessary restriction of choice. We recommend that the Food Standards Agency should ensure the needs of food allergic consumers are clearly recognised during the review of food labelling legislation being undertaken by the European Union.

A proposal for an EU Regulation on Food Information was published in January 2008. The Food Standards Agency leads for the UK on negotiations on this proposal and is active in ensuring that the needs of the allergic consumer are protected. The proposal includes a new requirement for the provision of allergy information on foods sold unpackaged, including catering establishments.

The Agency has already produced best practice guidance (published in July 2006) to help businesses improve their allergen management and decision-making on the need for advisory ('May Contain') labelling. Evaluation of the effectiveness and impact of this guidance was conducted at the end of 2008 and the evaluation report published in April 2009 (www.food.gov.uk/multimedia/pdfs/publication/allergenmanage0409.pdf). The guidance was highly rated by both food businesses and enforcement officers and was used by almost all enforcement officers to inform their own approach and as a tool in their communications with food businesses.

The clinical sensitivity of individual allergic consumers is generally not determined and can vary over time. Therefore specifying the level of an allergenic ingredient in a food is unlikely to be of benefit to individual consumers in making food choices. However the Agency is actively involved in driving forward international discussions on approaches that can be used to set allergen management thresholds for use by the food industry in more properly labelling possible cross-contamination. This has included joint-funding two international multi-stakeholder workshops, the first discussing approaches to allergen risk assessment and the second tolerable levels of risk. The outputs from these workshops will be taken forward in international initiatives to develop agreed allergen management thresholds, but this is expected to be a long-term objective.

RECOMMENDATION 10.30

As sensitivities to various allergens vary widely, we believe that setting standardised threshold levels for package labelling is potentially dangerous for consumers with allergies. Instead, we recommend that food labels should clearly specify the amount of each allergen listed within the European Union directive, if it is contained within the products, and we endorse the Food Standards Agency's initiative to discourage vague defensive warnings.

See response to 10.29 above.

RECOMMENDATION 10.31

The phrases "hypoallergenic" and "dermatologically tested" are almost meaningless, as they only demonstrate a low potential for the products to be a topical irritant. We recommend that such products should warn those with a tendency to allergy that they may still get a marked reaction to such products.

The General Product Safety Regulations apply. This places a general duty on all suppliers/producers of consumer goods to supply products that are safe in normal or reasonably foreseeable use, which includes providing consumers with appropriate warnings and instructions for use (list ingredients, compounds, sell by dates, child warnings, instructions etc. and in the language of the market). Guidance on the regulations can be found at this BIS website link - http://www.berr.gov.uk/consumers/Safety/products/general-regulations/index.html. Trading standards enforce the GPS regulations and will be able to take action when they feel an absence of appropriate labelling/warnings renders a product unsafe.

ADVICE FOR ALLERGY SUFFERERS

RECOMMENDATION 10.32

Many teenagers and young adults with food allergies sometimes take dangerously high risks when buying food. We therefore recommend that the Department of Health, working with the Food Standards Agency, charities and others, should explore novel ways to educate young people about allergy and the prevention of anaphylaxis.

The Food Standards Agency is working with the Department of Health to promote its resources for food allergic consumers to help them make safe and informed food choices when shopping and eating out. In 2007 the Agency collaborated on the production of two short films for the Life Channel for use in GP surgeries, on food allergy and food intolerance.

The Agency also worked to include food allergy within the National Curricula for schools across the UK, including resources for use by teachers, and with the National Governors Association in the production of the second edition of its 'Food Policy in Schools – a Strategic Policy Framework for Governing Bodies', that was published in May 2007.

In 2008, the Agency produced chef cards which are an online resource that can be filled in and printed by allergic consumers, to use when discussing their food allergy with caterers.

The Agency has also published articles, in 2008, in the print media aimed at teenagers to highlight the issue of food allergy and the information that is available from the Agency to help food allergic people manage their food choices.

RECOMMENDATION 10.33

We recommend that the education of children about indoor air quality and its role in allergy development, should be a priority for the Interdepartmental Steering Group producing the "Children's Environment and Health Strategy."

The Children's Environment and Health Action Plan for Europe (CEHAPE) is an initiative led by the World Health Organization Regional Office (WHO) for Europe.. The Health Protection Agency was commissioned by the Department of Health, on behalf of the Interdepartmental Steering Group on Environment and Health, to evaluate children's environmental health in the United Kingdom (UK) and develop recommendations as to how the UK can best meet its commitments under CEHAPE and further protect children's health. A Children's Environment and Health Strategy for the UK was published on 24 March 2009. The Strategy provides a brief overview of children's health in relation to their environment in the UK and recommends areas that should be taken forward in order to protect and promote children's health and to meet the UK's commitment to CEHAPE. The Strategy included a chapter on respiratory health, indoor and outdoor air pollution. See also the response to recommendation 10.23, on further action by the HPA and Government Departments in this context.

RECOMMENDATION 10.34

Allergy charities play an important role in providing public advice, but must continue to work together and with clinical services to avoid duplication of work, and ensure that consistent, evidence-based policies and public advice are provided.

The Government recognises the important contribution of allergy charities. It supports the recommendation that they should continue to work together and with clinical services, in order to maximise their impact and ensure consistency. The Department of Health has provided support through the Third Sector Investment Programme by awarding £51,000 to Allergy UK for their project Alliance for Health in 2009-10.

RECOMMENDATION 10.35

Pharmacists are often consulted by the general public about allergic conditions, and thus lift a significant burden from general practitioners. It is therefore essential that the advice offered regarding allergy is accurate, and should be given by trained pharmacists rather than unqualified assistants. We recommend that as part of the implementation of the Pharmacists and Pharmacy Technicians Order 2007, adequate allergy education should be provided for all pharmacists, to ensure that they provide high quality advice to allergy sufferers.

The Department is currently drafting the Pharmacy Order 2009 which will replace the Pharmacy and Pharmacy Technician's Order 2007 next year. The new Order takes a different approach and give the new General Pharmaceutical Council the power to set standards in education and training. The standards will be the subject of consultation this Autumn.

EVALUATION OF COMPLEMENTARY TECHNIQUES

RECOMMENDATION 10.36

We recommend that robust research into the use of complementary diagnostic tests and treatments for allergy should examine the holistic needs of the patient, assessing not only the clinical improvement of allergy symptoms, but also analysing the impact of these methods upon patient wellbeing. Such trials should have clear hypotheses, validated outcome measures, risk-benefit and cost-effectiveness comparisons made with conventional treatments. Allergy centres will allow the collection of information about any indirect consequences of misdiagnoses or delayed treatment.

The Government accepts that research into the effectiveness of complementary treatment should address the outcomes the Committee identifies. The Director General of Research and Development at the Department of Health has written to research funders to draw their attention to the Committee's recommendation.

The Medical Research Council would welcome applications from this area of research and would consider these for response mode funding should applications meet the required standards for competitiveness.

RECOMMENDATION 10.37

We are concerned both that the results of allergy self testing kits available to the public are being interpreted without the advice of appropriately trained healthcare personnel, and that the IgG food antibody test is being used to diagnose food intolerance in the absence of stringent scientific evidence. We recommend further research into the relevance of IgG antibodies in food intolerance, and with the establishment of more allergy centres, the necessary controlled clinical trials should be conducted. We urge general practitioners, pharmacists and charities not to endorse the use of these products until conclusive proof of their efficacy has been established.

<u>Improved interpretive support for self testing kits available to the public are by appropriately trained healthcare personnel - Evidence of good and bad practice:</u>

Self diagnostic test kits for allergy to food placed on the market for use by a lay person must meet the safety quality and performance requirements of the Medical Devices Regulations. Instructions for use for such kits should warn users of possible false results, provide guidance on the interpretation of the results and the need for medical advice and the results of the tests must be expressed and presented in a way that is readily understood by a lay person. MHRA is aware of only one allergy test kit available over the counter to the public. It has not received any adverse incidents with regard to problems in interpreting the results.

The Medical Devices Regulations transpose the EC In Vitro Diagnostic Device Directive into UK law. The Directive relates to the test or reagent placed on the market by the manufacturer and aims to harmonise standards across Europe to create a single market. They do not regulate the service provider or advice to patients as to the clinical regime to be followed as a result of test results obtained. Limiting the use of such kits to health care professionals would therefore require separate national service legislation.

Avoidance of IgG food antibody test is being used to diagnose food intolerance in the absence of stringent scientific evidence:

IgG food antibody tests would only be regulated as medical devices if they claim to diagnose a medical condition. If they were presented to the market with such claims the manufacturer would be expected to provide supportive data and evidence to demonstrate a lack of harm, for instance from the cutting out of food groups from a patients diet without proper support from a dietician. MHRA is not aware of any scientific evidence that IgG antibodies are linked to food intolerance. If such tests are on the market making claims to diagnose specific medical conditions, MHRA would be interested to discover the details of these products, in order that investigation might be conducted, under their enforcement role as the regulatory authority for medical devices in the UK.

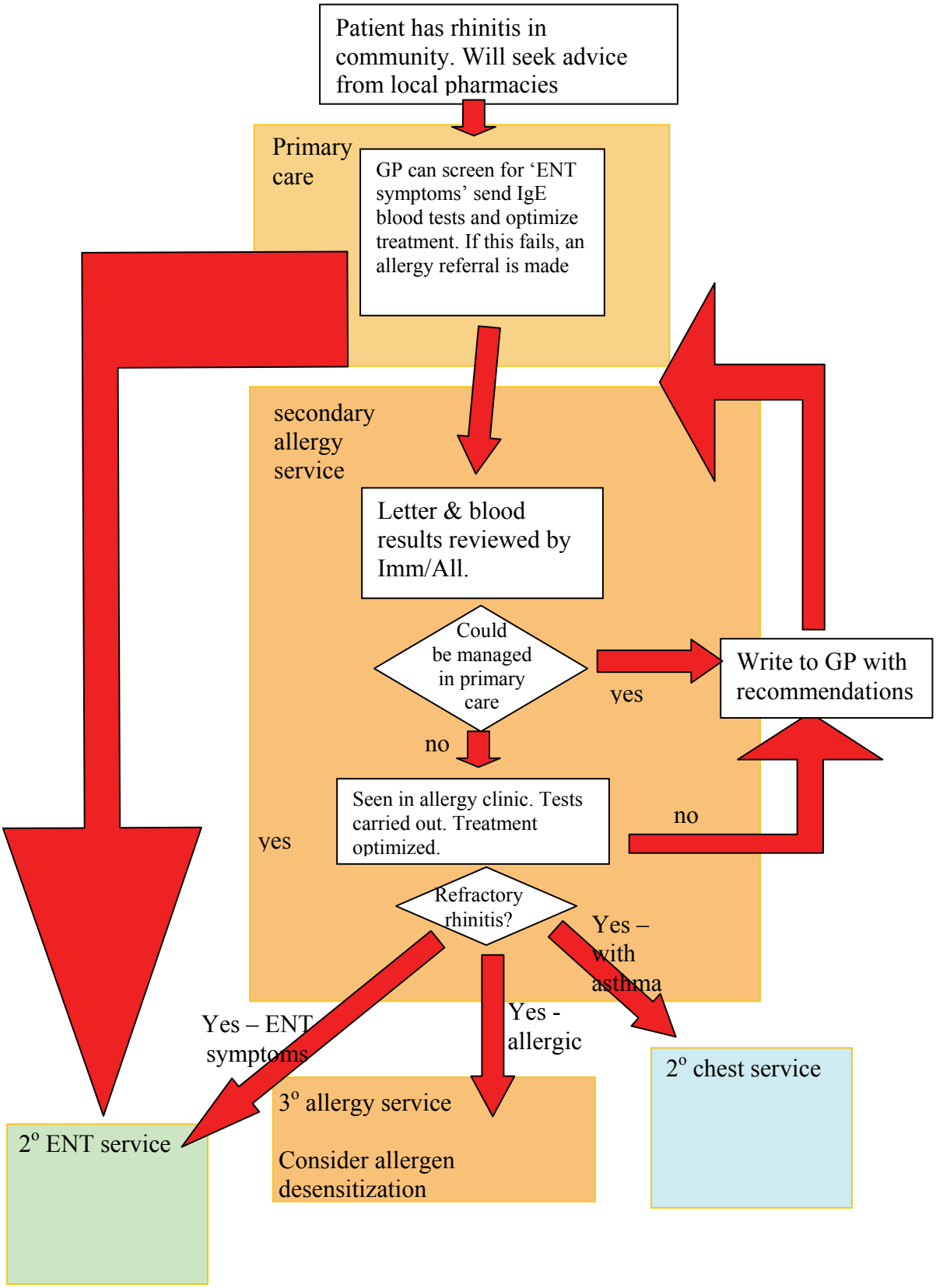
Further research into the relevance of IgG antibodies in food intolerance by controlled clinical trials:

The need to encourage or fund general scientific research into the relevance of IgG antibodies would require consideration by the Department of Health and research funders (see above). However, if a clinical trial is to be conducted in the UK into an IVD test kit using IgG antibodies to provide evidence for the manufacturers claims and eventual CE marking of the product under the Medical Devices Regulations prior to placing on the market, the manufacturer is required to notify MHRA 60 days in advance of commencement so that any objections to the methodology can be raised if necessary.

General practitioners, pharmacists and charities not to endorse the use of these products until conclusive proof of their efficacy is established:

As previously explained the Medical Devices Regulations do not regulate the use the device is put to or its efficacy. This is left to the individual clinician or service authorities to determine on the basis of the manufacturer's claims.

Ideal Rhinitis Adult Patient Pathway - Dr Tina Dixon



Faculty of Occupational Medicine – Dr Paul Cullinan

House of Lords Implementation Committee: Allergy Report

Allergy in the workplace; *draft*

A. General preamble

Occupational issues are focal in allergy. An important proportion of allergic respiratory and skin diseases are directly attributable to exposures encountered at work; and, conversely, allergies of any type may make it difficult for patients to function properly at work. Understanding and managing these issues requires a set of skills that are complementary to those used in 'normal' clinical practice.

In relation to service provision, two matters are particularly important:

- **Access to appropriate services**. Most occupational health practitioners, physicians and nurse 'advisors', have the necessary skills to recognise (and manage) employees with possible (or confirmed) work-related respiratory and skin diseases but very few have, to hand, the necessary diagnostic tools. Thus specialist referral is generally necessary. Since almost all occupational health provision is outside the NHS, appropriate referral can be very difficult and most is initiated through the employee's general practitioner. This approach has been shown not to work well; a system of direct specialist access would be far more efficient but is currently impossible or difficult. This issue is not discussed in the HoL report.
- In any case, fewer than 20% of working adults have access to occupational health provision; and those that do are often those at relatively low risk of occupational allergic disease.
- **Provision of specialist services.** Currently, specialist services for occupational respiratory and skin diseases are provided by a small number of chest and dermatology physicians respectively. The distribution and funding of these services is haphazard and in some cases fragile.
- Recent British Thoracic Society standards of care suggest that patients with possible occupational asthma are cared for by those with a particular interest and expertise. There are six such specialist centres in England[1], but none in Wales. For dermatology, there is no longer any hospital which offers a specific occupational service; 18 dermatologists in England and Wales report that they see patients with work-related skin diseases in their contact dermatitis clinics.
- Few hospital-based allergy services have extensive experience of workplace-related conditions and fewer still have ready access to the full range of diagnostic methods.

B. Specific Recommendations

[1] Group of Occupational Respiratory Disease Specialists (GORDS)

The Report contains four key (and one further) recommendations that are specific to occupational allergies. These, the government's responses to them in November 2007, and the information on their subsequent implementation that I have managed to garner, are listed below:

"3.16. We welcome the involvement of the Health and Safety Executive in EU working groups to standardise the collection of data on occupational illness. The use of common standards in the diagnosis of occupational allergic conditions would allow international comparisons of disease incidence, and enable the evaluation of disease reduction strategies. We recommend that the Health and Safety Executive should fund The Health and Occupation Reporting network with the full economic cost of its surveillance programmes, and we urge the Government to ensure support for this work in the future."

- *Response from government (November 2007):*
  The Health and Safety Executive (HSE) is keen to secure the future of The Health and Occupation Reporting (THOR) network. Agreement has been reached with Manchester University on the scope and cost of the work that it will deliver on HSE's behalf. The agreement guarantees funding of the two surveillance schemes that are most directly involved in the monitoring of allergic disease – SWORD (Surveillance of Work- Related and Occupational Respiratory Disease) and EPI-DERM (surveillance scheme for occupational skin disease). Both these schemes will be funded until 31 December 2011.

  In addition, the agreement provides funding for the THOR GP scheme and OPRA (Occupational Physicians Reporting Activity) until 31 December 2010, and SOSMI (Surveillance of Occupational Stress and Mental Ill Health) and MOSS (Musculoskeletal Occupational Surveillance Scheme) until 31 December 2008. Subject to satisfactory resolution of an intellectual property issue raised by the University, both parties will sign a contract in the near future.

  Various important issues in the field of occupational health are being investigated as part of HSE's Science and Innovation programme. Funding of THOR beyond the planned contractual arrangements will be considered in the light of the specific nature of the proposed work and the relative merits of other competing areas of research. It is, however, extremely unlikely that HSE will be in a position to fund the THOR network at the level of full economic costs that have been quoted by Manchester University, which are more than twice the level of the costs already agreed

- *Response from Professor Raymond Agius, Director of THOR (June 2009):*
  The HSE has provided welcome but limited funding for the continuation of data collection by The Health and Occupation Reporting network (THOR). (HSE funding of data collection regarding infectious disease has ceased while some other data collection is being supported only until the end of 2009.) Specifically as regards occupational allergy, data collection from occupational physicians and from general practitioners is only being supported by HSE until the end of 2010, while data collection from respiratory physicians and from dermatologists

is being supported until the end of 2011. HSE funding supports contract staff and direct non-staff costs but is not yet based on full economic costing (notably it does not contribute to the HEFCE funded senior staff). The ongoing work is permitting continuation of valuable data collection and analysis of trends in the incidence of occupational allergy, and these data continue to feature on a year by year basis on the HSE website, as well as in peer reviewed publications. The University of Manchester has been seeking further funding from other sources to achieve and maintain the full economic funding of the breadth of THOR activity for the foreseeable future. The University team managing THOR has formed a network along with counterparts in the EU so as to develop a pan European approach to monitor trends in occupational allergy and other ill health, as well as to continue to identify new allergy hazards. This network is seeking EU funding.

"10.1 We recommend that at least one allergy centre, led by a full time allergy specialist, should be established in each Strategic Health Authority. These centres would act as clusters of expertise of those with an interest in allergy, and should each contain a chest physician, dermatologist, ENT specialist, clinical immunologist, gastroenterologist, occupational health practitioner and paediatrician."

- *Response from government (November 2007):*
  None specific to 'occupational health practitioner'

- *Response (July 2009):*
  The first Allergy Centre is being developed in Manchester. At this stage no formal occupational health practitioner input has been organised.

"10.11 It is vital that the Health and Safety Executive works with the Department of Health to ensure that medical practitioners are adequately educated in the diagnosis and treatment of occupational allergic disorders. We support the work of the Group of Occupational Respiratory Disease Specialists convened by the HSE, which has developed a standard of care document for the diagnosis of occupational asthma, and recommend that the Health and Safety Executive should work with stakeholders to produce a similar document for occupational allergic skin disease."

- *Response from government (November 2007):*
  The Health and Safety Executive (HSE) recognises the importance of working with medical practitioners and other interested parties, to help improve early recognition and effective preventative action for occupational allergic disorders. HSE is committed to working with stakeholders to achieve improvements in occupational health and will do so to encourage the development of a standard of care document for occupational dermatitis.

- *Response from Paul Nicholson (July 2009):*
  In 2008, the British Occupational Health research Foundation (BOHRF) granted funding for the development of an evidence-based guideline on occupational

skin diseases, under the chairmanship of Paul Nicholson. The guideline is expected to be delivered in March 2010.

Note : PC underlines

"10.27. We welcome the educational work of the Health and Safety Executive to raise awareness and decrease the risk of occupational allergic disorders amongst employers and staff, and would like to see this work developed. Once allergy centres have been developed we recommend that the HSE should liaise with the occupational allergy specialist in each centre to inform its policies and develop strategies to prevent occupational allergic disorders".

- *Response from government (November 2007):*
  The Health and Safety Executive (HSE) welcomes the opportunity to liaise with occupational allergy specialists, wherever they are based. This ensures that HSE continues to have the best evidence on which to base new policies and strategies for the prevention of occupational allergic disorders, and that occupational allergy specialists have HSE's support in improving diagnosis and management more widely in the medical community.

- *Further response from HSE (July 2009):*
  None yet

"10.28. We are concerned that employees who are forced to leave work due to an occupational allergic disease can remain unemployed for long periods of time. We recommend that job centres should review the way they work with employers, to improve the way in which they can assist these workers to enter retraining schemes and find alternative employment."

- *Response from government (November 2007):*
  Jobcentre Plus is a Government agency supporting people of working age from welfare into work. Jobcentre Plus works closely with employers offering a range of services, including advice on equality issues relating to recruitment and selection, guidance on employing people with health problems or disabilities, and developing recruitment solutions. Jobcentre Plus also delivers a number of programmes to help people with disabilities and health conditions remain in or move into employment, including those with occupational allergies. These programmes include Access to Work, WORKSTEP, Work Preparation, the New Deal for Disabled People and Pathways to Work. If customers require additional employment support or are concerned about losing their job because of an allergy, they can be referred to a Disability Employment Adviser (DEA). DEAs can also liaise with employers on behalf of their customers, including exploring practical ways to help them keep individuals in their jobs such as offering employees alternative roles, should they exhibit allergic symptoms due to their specific workplace environment.

The Department for Work and Pensions is planning to undertake a public consultation, later this year, about its range of specialist services that help disabled people with complex issues to find, gain or retain paid employment. The consultation proposes reforms to the Job Introduction Scheme, Work Preparation, WORKSTEP and Access to Work programmes and the roles of DEAs in Jobcentre Plus. The proposed reforms will establish a more coherent range of specialist services that can respond more flexibly to the needs of individual disabled people and their employer.

- *Response from Joanna Bramhall, on behalf of Clive Churm, Job Centres Plus (June 2009):*
  The original response to the report recommendation outlined the way in which Jobcentre Plus works with employers not only in terms of helping to meet their recruitment needs, but also in providing information, advice and guidance on employment and retention of people with a health problem or disability. It also outlined the programmes available to help people with a health problem remain in employment or move into alternative employment, which includes Access to Work, WORKSTEP, Work Preparation, New Deal for Disabled People, Pathways to Work and specialist help from a Disability Employment Adviser.

  Since then, we have been developing and improving the services we provide to people with a health problem or disability, including those forced to leave employment due to an occupational allergic disease. Most notably, the department has (as promised) undertaken a consultation exercise and from Autumn 2010, a new specialist disability programme will replace the existing WORKSTEP, Work Preparation and Job Introduction Scheme with a single streamlined and flexible package of support tailored to individual needs. The new programme will be available for those disabled customers with the most significant barriers to work and the DEA will play a crucial role as gatekeeper to the programme. Closer links with Access to Work and the programme will also be developed.

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Paul Cullinan
August 4 2009

NASG – Dr Pam Ewan
The National Allergy Strategy Group
Elliot House, 10-12 Allington Street
London SW1E 5EH

Cost effectiveness of specialist allergy services
(extracted from NASG paper, unpublished)

- Allergic disease accounts for a high cost to the NHS.
- Costs are rising as the more serious systemic disorders are rapidly increasing.
- A significant proportion of this could be avoided with accurate allergy diagnosis and management. This reduces or controls further disease.
- For example, identification of a food or a drug allergy causing disease allows avoidance of the allergic trigger and amelioration or complete resolution of disease. This principle applies to acute allergic reactions including anaphylaxis as well as to chronic disease including asthma and eczema.
- Exclusion of a suspected drug allergy may save subsequent cost (examples below)
- Published data shows that management of nut allergy by a specialist allergy service, reduced subsequent reactions with
  - Low rate of further reactions 3% annual incidence, with reduced hospital or GP attendance.
  - Further reactions were mild, almost all requiring little or no self-treatment
  - 60-fold reduction in severe reactions
  - Need for administration of adrenaline was rare.

  and improved the level of knowledge by carers
- ENT surgery can be avoided by diagnosis and medical management of rhinitis by an allergist.
- Identification of allergic triggers for asthma can prevent acute severe attacks, and reduce A&E attendance and hospital admissions
- Immunotherapy in severe pollen allergy can be cost effective.
- In addition, there are socio-economic costs with loss of time from work or school, poor concentration; and effects on quality of life.

Illustrative cases

A 38 year old man with severe hay fever and pollen asthma such that he could not work (profuse nasal discharge, uncontrollable sneezing plus intensely itchy eyes). Repeated treatment with depot steroids by his GP led to bilateral necrosis of the hip. He will require repeated hip replacement over his life time. Referral to an allergist was followed by pollen immunotherapy, which required specialist care (the severity of his allergy meant high risk of anaphylaxis to the treatment). His hay fever was transformed and he was able to lead a normal life and work effectively.

An incorrect diagnosis of allergy to local anaesthetic led to a lady being admitted for general anaesthetic for a minor procedure which could have been done under local anaesthetic.

Antibiotics costing thousands of pounds were given by nebuliser to a sick patient, when a cheaper antibiotic would have been effective, because of an incorrect diagnosis of drug allergy.
Pamela Ewan 14 February 2010

NASG response – Dr Pam Ewan and Ms Mandy East

The National Allergy Strategy Group, Elliot House, 10 – 12 Allington Street,
London, SW1E 5EH

Implementation of the House of Lords Allergy Report Working Party

Response from the National Allergy Strategy Group to the recommendations in the House of Lords report

Key recommendation

Introduction

1. The National Allergy Strategy Group (NASG) welcomed the House of Lords report and the key recommendation that at least one allergy centre should be established in each SHA region. The Department of Health subsequently agreed to create one 'pilot' centre. The Royal College of Physicians report on allergy had recommended, in 2003, the creation of a new allergy centre in every region where one did not exist and to expand, consolidate and secure the future of existing centres (often reliant on academic funding and leadership). Six years later there is no new centre but the first is to be developed in the North West. It should be noted this is a very small national response in view of the very large number of patients with allergy (20 million of whom about 7 million are estimated to need allergy referral, assuming the conditions were created to allow primary care to do more for allergy), the patient burden and need.

The Model

2. It is important that the right model is set up. As recommended in the House of Lords Report (and the Royal College of Physicians Report) this needs to be headed up by consultant allergists. Leadership with experience and expertise is essential as the task is huge. This involves developing services, providing comprehensive allergy care including the most complex, supporting other doctors providing allergy services in secondary care, supporting and educating GPs in the region and conducting research. It is a major task even to develop a specialist service. For services to be efficient and provide quality of care requires doctors not just to be good but to have experience of large numbers of the same type of case. Allergy is very broad involving a number of diseases each requiring depth of knowledge. An adequate number of adult and paediatric allergists needs to be built up to develop a centre. Staff and services need time to develop. Another task is to engage with primary care – to build primary care capacity to deal with allergy through service networks centred on regional specialist allergy centres.

Funding

3. There is a serious lack of funding. No central funding for the clinical services has been provided and developments rely on local funding. So far one consultant allergist post has been created – and this with money agreed prior to the North West development. We understand that funding for two paediatric allergist posts has been identified subsequently. The lack of 'upfront' funding, combined with times of financial restraint, means that development will inevitably be difficult and slow.

4. No one has considered the requirements to deliver an initial service. For the population base (and considering the geography with two large conurbations in Manchester and Liverpool, and further major population bases) it would be realistic to request twelve consultants (six adult and six paediatric allergists) as a minimum if expertise has to be developed in 2 – 3 sites. For efficiency, adult and paediatric allergy should be developed together.

Evaluation

5. The Department of Health has stated they wish to evaluate the centre for effectiveness to see whether it can 'be rolled out' in other regions. It is not appropriate to evaluate at this stage (the service has barely started, there is no centre, either real or virtual, and it will take years to develop). Evaluating a vestigial service will not give meaningful information.

6. Evaluation that would be meaningful requires a research project and commensurate funding. It would be a poor use of resource to use the very limited funding available for evaluation. Under the circumstances, any funding that comes available should be spent on clinical services. It is suggested that the best that could be done at this early stage would be to monitor i. the number of consultant allergists in the system (and their whole time equivalents) ii. the number of patients being seen and iii. demand (referrals) iv. coding the work as allergy. These would be simple measures of some sort of service development. In order to evaluate complexity, case mix, specialist diagnostic procedures/therapies and clinically meaningful outcomes e.g. reduction of further anaphylaxis and the accurate identification of drug or food allergies where the allergen can be avoided preventing further reactions there is a requirement for time, funding and a mature service.

7. If the Department of Health wished to evaluate effectiveness of allergy centres there are a number of established centres and it might be more feasible to evaluate these. They cover both urban (London) and more rural areas.

Generaliseability

8. The North West has a large population (approximately 7 million) centred mainly on Manchester and Liverpool but with further focus in Preston and northwards. The model for service delivery has to be tailored to the population and the geography so that a model appropriate for the North West will not necessarily be applicable to other regions in the country. This should be recognised.

Conclusion

9. NASG strongly supports the key recommendation in the Lords report that at least one allergy centre should be established in each SHA region. However, the DH response to develop only one new centre in England is an inadequate response for the patient need nationally. A great deal hangs on this centre which is being held up as a model. But it is not being given the means to develop. To deliver its roles, the new centre needs funding and adequate staffing with appropriate expertise. It then needs time to develop before any realistic evaluation could be undertaken.

10. We suggest the committee press for fuller implementation of the key recommendation. One need to support delivery of this is growth in allergy manpower (consultant allergists and allergy SpRs). If only one new centre goes ahead, a more realistic approach is needed by DH. The centre requires the resources to develop a regional specialist allergy service.

NASG response (Patient's view)
Ms Mandy East

National Allergy Strategy Group response to the RCP House of Lords repor
committee working group with emphasis on the patients' v

Comment on the recommendation to develop regional allergy centres or clusters with specific emphasis on the appointment of the NW SHA as the lead for this pilot project.

Introduction

The National Allergy Strategy Group (NASG) welcomed the House of Lords recommendation to establish one regional allergy centre in each SHA area and to begin with a pilot in the NW in order to develop and sustain a service which can serve the local community.
We are, however, concerned that the right model is developed in the NW and that it is carefully planned to ensure those living with allergy locally end up with a robust regional allergy centre. Many allergy patients are currently receiving poor or non-existent care from the NHS with the vast majority not been seen by an allergy specialist due to the lack of local services. Allergy is a complex condition and patients need a specialist who can diagnose and treat the whole person not just the individual symptoms. What the NW centre needs to provide for those with allergy living locally is a service which can offer an holistic approach to the patient as well as an integrated network to ensure they can continue to receive high level care in their local community.

The NW Centre

From the patients' point of view, it is important that the NW centre is set up correctly from the start. In order for it to grow and be sustainable, it must be run by allergy specialists as recommended in the House of Lords report and the previous RCP report. These specialists need to have the expertise and experience to not just treat patients but to create a centre which can act as a hub for the local community. Setting up a centre such as this is an enormous task and will involve the development of all allergy care, including the most complex, supporting other medical professionals providing allergy services in secondary care and educating GPs, healthcare professionals and the local community in the region.
Allergy as a disease is often complex and involves a wide range of symptoms. It is therefore important that there are sufficient adult and paediatric specialists to develop the centre. It is important for patients that there is a clear pathway for young people to follow as they transfer from paediatric to adult services to ensure they do not slip through the net and fail to receive necessary ongoing care.
In is recognised that allergy is not as well served as it might be in primary care but with a well led regional centre, GPs and other health care professionals can access information and support from the lead consultant and their team.

Funding

This project has a lack of central funding from the start. The additional funding has been allocated from other parts of the local budget. This cannot be sustained to give the level of development required by the NW centre. The lack of central funding will mean the centre will not grow and not achieve the levels of staffing required to operate a successful service.
The area the network is intended to cover is huge and has a high population of approx 8 million people. Realistically it will need 6 adult and 6 paediatric consultants to operate efficiently. So far only one adult consultant post has been created meaning that person will have an enormous workload from the start as they will need to not only treat patients but work to develop the service.

Evaluation

At present, there seems to be very little that can be done to evaluate this service as the service is not yet set up. The NASG agrees that evaluation and monitoring is crucial to the development of similar networks across the country and recognises that for patients we must ensure we learn as we go along but this will take time. Realistically it will be a number of years before the resources and staffing levels are such that the centre can be properly evaluated. Evaluating a service that is only just beginning in meaningless and not a good use of available funds.

What patients want from an NHS allergy service

Working with the leading patient groups the NASG has identified the following as the key points:

- When presenting to the local surgery, with symptoms for the first time, the allergy patient should expect to see a doctor or nurse trained in the diagnosis and management of allergy
- The allergy patient should expect their doctor to be well versed on the practicalities of making a referral and the capacity, skills and treatment available at the next level
- A quick referral is required by those patients whose allergies are complex, severe and potentially life threatening
- The GP should be trained well enough to make this decision
- Each child should be referred to a consultant paediatric allergist so that all issues relating to their health can be considered
- All patients should have access to a full allergy service and dedicated allergy teams
- All allergy patients need allergy care based on a personalised allergy plan which supports the day-to-day control and management of their condition
- In order to have an individual management plan, the health service needs to ensure adequate time is set aside for full discussion of symptoms, treatment, appropriate medication and trigger avoidance
- To avoid an overload of information on diagnosis, a series of appointments is appropriate although in some cases a “one stop shop” may be preferred. Either way it is important that the patient has access to follow up information and advice via both the specialist service and relevant patient groups
- All patients at risk of life-threatening allergies need to know that during any emergency, those responsible for their care are following locally agreed, standard emergency management protocols

- After any severe reaction every patient needs to be referred to a specialist in allergy irrespective of whether they have seen a consultant in the past
- Every patient suspected to be at risk of severe allergy should have at least one visit to a local, consultant allergist who provides a dedicated allergy service

Conclusion

In the NW allergy network, we have an excellent opportunity to give local people a centre of excellence and to create a model which works and can be adapted for other parts of the currently. What works in the NW will not be right for other regions but we will have a better understanding of the fundamentals of a successful allergy service. The NW is a huge area and covers a wide geographical spread so comes with its own challenges. The NASG will continue to work with the NW SHA via the NWSCT to help develop a service which can best serve patients locally and, eventually, be evaluated effectively. The NASG believe there needs to be a long term approach to the development of a centre that can grow and be sustained for the future.

RCPCH response – Dr Adam Fox
Comments from **Royal College of Paediatrics and Child Health (RCPCH)**
And **British Paediatric Allergy, Immunology and Infectious Diseases group (BPAIIG)**
Dr Susan Leech, Consultant in Paediatric allergy, Kings College Hospital, Denmark Hill, London SE5 9RS
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Appendix A: **KEY RECOMMENDATIONS FOR EVALUATION**

ALLERGY CENTRES

10.1. Creation of new centres/New clusters of expertise

In September 2007 there were 9 paediatric allergists in the UK in 6 centres – 3 centres in London (St Mary's, GSTT and Kings College Hospital) and 3 elsewhere (Cambridge, Southampton and Newcastle).

In June 2009 there are now 16 paediatric allergy specialists in 9 centres – 3 centres in London and 6 elsewhere.

2 additional paediatric allergy consultant posts are being developed in the North West.
The degree and pattern of networking around the centres is variable. Thus some have regular meetings, others have developed agreed management protocols, and at least one has developed combined appointments to facilitate DGH consultant involvement with the tertiary centre. Care pathways are not clearly defined but are being developed by an RCPCH working group and in the NW region.

10.2. Improved diagnostic facilities necessary to investigate complex accredited allergy training.

- Regular multi-disciplinary team meetings
- Service places needs of the patient first
- Involvement of paediatric allergists
- Improved transition from paediatric to adult allergy care

All of these initiatives are considered good practice and are being implemented at local level.
The development of services for young people which extends way beyond just transition clinics is in its infancy in all disciplines in the UK. There are a few transition clinics but these do not meet the expectations of young people or address the requirements of the NSF for children, young people and maternity services.

10.3. Improved patient pathways to support primary or general secondary care or patient self-management

a) The Department of Health has commissioned the Royal College of Paediatrics and Child Health to develop a national Care Pathway for the diagnosis and treatment of Children with

Allergy. Working groups have been established to look at Anaphylaxis, Food allergy and gastrointestinal disease and Asthma and rhinitis. A project co-ordinator has been appointed by the RCPCH. Work has been started on the anaphylaxis pathway. However, the funding from the DoH is not sufficient to allow the group to cover all the topics originally proposed. Thus eczema, special allergies (drugs, venom, latex), urticaria/angio-oedema, multiple non-specific symptoms, and multi-system allergic disease are not currently included

b) Establishment of competencies. Competencies for paediatric allergy subspecialty training have been established by the RCPCH (July 2006). The RCPCH / BPAIIG is in the process of defining a syllabus and competencies for training General paediatricians with an interest in allergy. The competency levels will also be used to inform the Care Pathway project

- Appropriate provision of Allergen immunotherapy

Allergen immunotherapy is offered in all 6 specialist paediatric centres. A sublingual immunotherapy product (Grazax) now has a paediatric licence, which will enhance the availability of immunotherapy to children. However, funding this treatment will only be consistently available when NICE have published a health technology assessment. This is currently being considered as a topic, though it is by no means certain whether it will be accepted. There are various initiatives to support additional centres offering immunotherapy to children such as practical postgraduate study days. For children, the recent survey revealed only 6 centres beyond the 6 major tertiary services (and in some this was limited to only sublingual).

10.4. New centres should enhance and build, develop and expand upon the services already offered.

- New posts established?

As has been made clear from the NW region initiative this is only likely to be effectively delivered if increased funding is identified and in the current environment this is highly improbable.

10.5. Equitable geographical distribution/access to services

Currently this is clearly not the case. In regions with no local allergy champion it is unlikely in the current climate to ever be addressed.

- National reference centres and supporting referral pathways for super-specialist allergy

See 10.3

10.6. Improved educational activities for local GPs and other healthcare workers in allergy.

- Development of GPwSI in allergy

Initiatives such as the allergy MScs at Imperial College (established 2008) and University of Southampton (established 2004) and Kings College Allergy Academy (established 2007) will enhance teaching and training at tertiary, secondary and primary care level. The BSACI also has a developing initiative to support the provision of primary care educational events nationally.

10.8. Public information and advice

- Centres should to provide education and training courses for allergy patients, their families, school staff and employers, in how to prevent and treat allergic conditions
- work in collaboration with
    - allergy charities
    - schools
    - local businesses.
- Patient engagement: Better feedback between patient groups and allergy centres

As far as we are aware the only centre that has achieved this objective is Southampton which has had a programme of education of school nurses to cascade information and support into schools and early years settings for the last 12 years. A recent initiative at King's College London has seen regular events led by specialist nurses provided for school nurses.

10.8 Establishment of lead Strategic Health Authority to work with its Primary Care Trusts to develop the first allergy centre

- A full cost analysis
- Assess the efficacy of diagnosing and managing allergy using the "hub and spokes" model.
- Improved education of clinicians in allergy, with an accurate diagnosis recorded on the Systemised Nomenclature of Medicine (SNOMED) system
- The lessons learnt from the pilot allergy centre used to inform the development of further allergy centres in other regions.

10.9. Sharing of resources - such as standard operating procedures, clinical guidelines and patient information.

The BSACI is slowly working on this.

- The lead Strategic Health Authority should ensure that there are national reference centres for rarer allergic conditions such as some occupational disorders or adverse drug reactions.

10.10. A patient database to support clinical research within each region.

- The Office for Strategic Coordination of Health Research and the Translational Medicine Funding Board should work with the lead Strategic Health Authority to support clinical research in the allergy centres and co-ordinate national research projects.

The main problem is that the current electronic clinical record systems are not suitable for identifying patients for research studies.

PROFESSIONAL EDUCATION

10.11. Health and Safety Executive & Department of Health to improve education in the diagnosis and treatment of occupational allergic disorders.

- Health and Safety Executive should work with stakeholders to produce a standard of care document for occupational allergic skin disease similar to that for diagnosis of occupational asthma by the HSE Group of Occupational Respiratory Disease Specialists.

10.12. Improving the training of those in primary care.

- Royal Colleges should work together to ensure that the training undergraduate medical students receive enables them to recognise the role of allergy in disease processes and to refer patients appropriately.
- General practitioners to develop their allergy knowledge through continuing professional development and as part of their membership of the Royal College of General Practitioners.

The World Allergy Organisation is producing a recommended syllabus on under-graduate allergy training. At present the responsibility for U/G education rests with the individual universities together with an over-sight from the GMC. Improving knowledge in primary care will only occur if there is a consistent input to U/G teaching. At present this is very variable with no co-ordination of allergy teaching in any medical school in the country.

10.13 New quality assured education opportunities:

- The Royal Colleges, the postgraduate Deans, the Postgraduate Medical Education and Training Board and the British Society for Allergy and Clinical Immunology, should work together to develop generic quality-assured clinical postgraduate courses in allergy, for doctors in both primary and secondary
-

care and for nurses and others, particularly those wishing to become an accredited specialist in allergy.

The allergy MScs identified above are validated through the university education structures.

3 centres have now been approved for subspecialty training in paediatric allergy by the RCPCH. Training numbers for paediatrics are restricted, making expansion of training places and numbers of trainees difficult. Training numbers have to be transferred from other specialties.

The BSACI have expanded the paediatric allergy component of their annual meeting. In 2010 the BSACI will be holding a meeting in conjunction with the BPAIIG at the annual EAACI meeting in London.

RESEARCH AND PRODUCT DEVELOPMENT

10.14 Office for Strategic Coordination of Health Research to improve the co-ordination and funding for further research on the environmental factors contributing to allergy development and the "allergy epidemic".

- Long-term cohort studies
- Interventional studies

There are a number of cohort studies which are addressing the early life origins of allergic disease, but funding often is restricted to a limited follow-up period with progressively greater difficulty over time in maintaining cohorts. The Manchester study is a fine example.

10.15 Improved Translation bench to bedside

- The Translational Medicine Funding Board must ensure that allergy research is applied to develop novel individualised treatments and allergy research directly related to health care.

There are many examples of good translational research in paediatric allergic disease. However, the main problem is limited funding and a long delay before new insights gained from research are applied in practice.

- Establishing a comprehensive patient database within each allergy centre - maintained by ownership at a local level
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This is considered good practice for all paediatric allergy centres, however the current clinical record systems are not fit for purpose.

10.16 We recommend that NICE should conduct a full cost-benefit analysis of the potential health, social and economic value of immunotherapy treatment.

The topic selection group met on 17 July to discuss allergy. It is not certain that any of the recommendations will be accepted. The most likely are food allergy in children, venom immunotherapy as an HTA, and a guideline on the management of seasonal rhino-conjunctivitis.

10.17. FSA should work with other training providers to produce consistent practical training courses of a high standard.

- Adequately and comprehensive training in practical allergen management for environmental health officers, trading standards officers and catering workers.

10.18 Learning Early About Peanut allergy (LEAP) study

- Withdraw Department of Health dietary advice regarding peanut consumption for pregnant women and infants plus a comprehensive review by the Food Standards Agency and the Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment.

The CoT review has taken place and drew the same conclusions as the HoL committee regarding withdrawal of the advice. According to the FSA website, the findings from the CoT report were passed to the DoH in December 2008. However, advice about avoiding peanuts is still included in the section on 'Maternal nutrition' (dated 14 May 2009) during pregnancy, breastfeeding and until the child is 3 years old. (DOH website accessed 20/7/09).

SCHOOLCHILDREN

10.19 Department for Children, Schools and Families should review the clinical care that hayfever sufferers receive at school, and should reassess the way in which they are supported throughout the examination season.

This has not been done.

Guidance on the administration of medication in schools was published by the DoH and DfES in March 2005 (Managing Medicines in Schools and early years Settings). It includes sections on asthma and anaphylaxis and guidance on administration of prescribed medication. It sets out a clear framework ensuring that children requiring medicines receive the support they need. Implementation of the recommendations is decided on an individual basis between the head teacher, the child's parent / carer and medical staff. Administration of medication to a child by a teacher is a voluntary role as recognised by the DfCSF. The National Union of Teachers advises it's members that they should be wary of administering medications or supervising a child taking a medication.

There is considerable variability in the way these recommendations are interpreted by schools and much depends on the head teacher.

- The Department for Children, Schools and Families should also ensure that the provisions made by different schools are fair and consistent.

Support for children at risk of anaphylaxis in schools continues to be patchy. Support provided depends on the co-operation of the Head and the Board of Governors and is inconsistent. Problems arise where head teachers are not engaged.

FURTHER RECOMMENDATIONS

MONITORING ALLERGY

10.20. Department of Health should ensure the Systemized Nomenclature of Medicine (SNOMED) system is supported by appropriate training, to ensure its efficacy as a simple consistent classification system to record allergic disease, monitor its prevalence and inform the commissioning of allergy services.

- Progress with standardising the collection of data on occupational illness via the Health and Safety Executive in EU working groups.
- Health and Safety Executive should fund the Health and Occupation Reporting Network with the full economic cost of its surveillance programmes
- Government to ensure support for this work in the future.

10.22. Future epidemiological studies to record the prevalence of confirmed allergic sensitisation.

THE AIR WE BREATHE

10.23. Department of Health should work with the Department for Communities and Local Government to support and encourage controlled trials involving multiple interventions, to examine the effect of ventilation, humidity and mite-reduction strategies on allergy development and control.

- Further evaluation chemicals used in the construction industry in triggering symptoms in some allergic patients in order to inform procurement policies.

10.24. Implementation of recommendations in the report, *Air Quality and Climate Change: A UK perspective*.

- Government should take account of the interlinkages between air quality, climate change and human health when developing policies for industry, transport or housing.

SCHOOLCHILDREN

10.25. Improved management of allergic emergencies in schools

- The use of individual care plans for children with medical needs
- Department for Children, Schools and Families should audit the level of allergy training teachers and support staff within schools receive, and should take urgent remedial action to improve this training where required.

The Anaphylaxis Campaign has a training programme for school nurses across the country. This is freely available on its web-site. The average state school nurse has to look after more than 2,500 school children and is taking on an increasing number of responsibilities.
The DfCSF has not audited the level of allergy training teachers and support staff need.

10.26. Lack of clear guidance regarding the administration of autoinjectors to children with anaphylactic shock in the school environment.

There is general consensus regarding the indications for provision and administration of adrenaline autoinjectors. The EAACI anaphylaxis position paper (2007) recommends absolute and relative indications for prescribing adrenaline autoinjectors and providing individualised management plans.

- Government should review the case for schools holding one or two generic autoinjectors.

There are clear guidelines for the administration of prescribed medication in schools (Managing Medicines in Schools and early years Settings; DOH, DfES March 2005). Medication must be prescribed for each child individually. However, one or two disticts have developed local strategies with generic prescribing of auto-injectors, most notably in Basingstoke. This has the potential to save the health service considerable sums.

WORKFORCE

10.27. Development of Education work with the Health and Safety Executive to raise awareness and decrease the risk of occupational allergic disorders amongst employers and staff.

- Once allergy centres have been developed we recommend that the HSE should liaise with the occupational allergy specialist in each centre to inform its policies and develop strategies to prevent occupational allergic disorders.

10.28. Job centres should review the way they work with employers, to improve the way in which they can assist employees who are forced to leave work due to an occupational allergic disease to enter retraining schemes and find alternative employment.

INFORMATION FOR CONSUMERS

10.29. Avoidance of Vague defensive warnings on labels. Food Standards Agency should ensure the needs of food allergic consumers are clearly recognised during the review of food labelling legislation being undertaken by the European Union.

10.30. Food labels should clearly specify the amount of each allergen listed within the European Union directive, if it is contained within the products,

10.31. “Hypoallergenic" and "dermatologically tested" products should warn those with a tendency to allergy that they may still get a marked reaction to such products.

Recent research suggests that food allergy sufferers are variable in their interpretation of the wording of precautionary labels.

ADVICE FOR ALLERGY SUFFERERS

10.32. Improved education of high risk groups. Department of Health, working with the Food Standards Agency, charities and others, should explore novel ways to educate teenagers and young adults about allergy and the prevention of anaphylaxis.

Various initiatives are being implemented at local level and championed by allergy centres. However, this is not uniformly delivered across the country.

10.33. The Interdepartmental Steering Group producing the "Children's Environment and Health Strategy should improve education of children about indoor air quality and its role in allergy development."

10.34. Consistent, evidence-based policies and public advice are provided with close collaborative working with Allergy Charities/Patient Support Groups and allergy services

10.35 Allergy advice offered by pharmacists is accurate, given by trained pharmacists rather than unqualified assistants.

- Pharmacists and Pharmacy Technicians Order 2007 should mandate adequate allergy education for all pharmacists, to ensure that they provide high quality advice to allergy sufferers.

There is considerable concern about the initiative of Allergy UK in delivering allergy diagnostics via pharmacists who are clearly not adequately trained to interpret results.

EVALUATION OF COMPLEMENTARY TECHNIQUES

10.36 Robust research into the use of complementary diagnostic tests and treatments for allergy should examine the holistic needs of the patient, clinical improvement of allergy symptoms, and the impact upon patient wellbeing. Such trials should have clear hypotheses, validated outcome measures, risk-benefit and cost-effectiveness comparisons made with conventional treatments.

- Information about any indirect consequences of misdiagnoses or delayed treatment.

10.37 Near patient testing.

- Improved interpretive support for self testing kits available to the public are by appropriately trained healthcare personnel- Evidence of good and bad practice
- Avoidance of IgG food antibody test is being used to diagnose food intolerance in the absence of stringent scientific evidence.

- Further research into the relevance of IgG antibodies in food intolerance by controlled clinical trials
- General practitioners, pharmacists and charities not to endorse the use of these products until conclusive proof of their efficacy has been established.