



Issue 7
Spring 2006

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www.bsaci.org

Allergy Update

The Newsletter of the British Society for Allergy & Clinical Immunology

Government Review of Allergy Services

Report expected this summer; BSACI consolidates its advice; need for DH to improve allergy services will test Government Health Service rhetoric

As we go to press the Health Department officials responsible for the allergy review are writing their report. The Chief Medical Officer, Liam Donaldson, will present the findings and recommendations to Health Ministers who, we understand, hope to report to the Commons Health Committee before the summer recess. All this means, is that we can expect to know what the Department of Health is going to do about allergy services by late July.

The evidence

We understand that two commissioned reviews will, unfortunately, not be published by the Health Department, at least until after its Report becomes available. It is unfortunate that the Department has not been able to allow access to all the evidence it is assessing, opening all aspects of the review to public scrutiny. However, all discussion in NAAG, all patient organisation advice to the review, three keynote BSACI papers, and consensus meetings convened by the Royal College of Physicians and the Royal College of General Practice have been consistent in what they have to say.

There is unmet allergy need and a service gap. The Health Department must find ways to improve allergy services. The best way forward was set out in the Royal College of Physicians report, "Allergy: the Unmet Need", in June 2003.

The information and advice sent to the review has consolidated and extended earlier evidence and advice. There is now no "wobble room" left on the existence of an allergy epidemic; and NHS allergy services are at best highly fragmented, and many would say virtually non-existent.

The patient organisations have continued to supply evidence of blocked access to allergy services and patient and parent distress.

The BSACI has sent three keynote papers to the review team, all of which will be placed on the Society website later in the year. These submissions show the following:-

On the extent of allergy,

- Poor recording and data capture makes some areas of allergy – like drug allergy, food allergy, angioedema and the vast

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BSACI 2006
Annual Meeting

Leading Edge Science and
Best Clinical Practice in Allergy
10 – 12th July
Loughborough University, UK

BSACI will also be hosting a primary care day on Wednesday in partnership with Education for Health. Further details can be obtained by visiting www.bsaci.org or by emailing info@bsaci.org

Important news and up-to-date reviews

Dr Nasreen Khan

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Greetings to members from the staff at Allergy Update.

This spring edition is packed with a super selection of articles many of which deal with deeply serious issues. The first being a summary of all the hard work leading up to the current critical point in the Government Review of allergy services. Such dedicated and honest campaigning must surely be recognised and acted on and we await the report with baited breath.

In a similar vein our outgoing president looks back over an extremely productive and action packed three years of service for the society. During this time his enthusiasm has been endless, and as a result brought out the best in his colleagues. Consequently the society continues to go from strength to strength. We wish him all the best and look forward to welcoming Stephen Durham in his stead. Stephen I am sure will take the presidential reins with his usual flourish.

And what better occasion to mark this transition than our annual meeting in Loughborough which promises once more to combine the very best in educational opportunities with those of a more sociable nature. Chris Brightling, in his first year as meetings secretary, gives us a soupcon of what treats are in store. I am sure you will all agree that the programme looks excellent and do hope that Chris's hard work will be rewarded by yet another rise in attendance. It is always a pleasure for me to meet new colleagues, share ideas and contemplate professional collaboration.

Moving on to bread and butter issues, anaphylaxis has once more achieved prominence following celebrity endorsement of the Anaphylaxis Campaign charity. As the problem continues to grow and gain notoriety we publish a pragmatic guide to managing cases in primary care. Samantha Walker and Aziz Sheikh, both veterans in the field of allergy, demonstrate their ample qualifications in a thoroughly researched and readable paper.

Runa Ali, whom we congratulate on her appointment at Barts and the London, updates us on the current position of allergy with regard to 'payment by results'. It seems imperative that we understand and work with this system as soon as possible in order to meet the 2009 deadline. In these financially uncertain times we must all face up to the importance of departmental income. Welcome to Runa, and I look forward to the next instalment.

The field of aerobiology is a recent fascination for me, perhaps because I am fortunate enough to work close to a newly relocated and restructured department. With this in mind, Abbie Fairs writes about training and her future plans for a career in aerobiology. Abbie's enthusiasm is contagious and her knowledge of the subject already considerable. Once more, we hope that Abbie will become a regular contributor to AU.

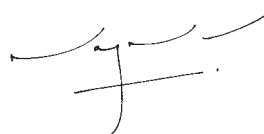
Tony Frew brings us news from the continent in his new guise as EAACI president in waiting. How exciting that we can look forward to a joint congress in London in 2010. Events such as this can only help to raise to profile of the BSACI, not to mention giving us a chance to mingle with our European counterparts and leaders in their field.

On a lighter and more local note I was delighted to read Andrew Williams' account of the workings of the Allergy Department based at Homerton Hospital in East London. Andrew is clearly amply qualified and full of energy for his subject. The department prides itself on providing a comprehensive and high quality service to the local community. How wonderful for the BSACI to

have such hard working and happy members!

Last but not least, as I sign off I would like to thank Fiona Rayner yet again for continuing to play an indispensable role in the production of AU. I wish Fiona all the best for her impending maternity leave and only hope that AU will survive intact until she returns in 2007!

Happy reading, see you in Loughborough.



It's goodbye from me...

Professor Andrew Wardlaw

President of BSACI

This is my swansong as president of the BSACI. Stephen Durham takes over at the annual meeting in July and I retire to the backwaters of Leicestershire. It is time then to look at what has been achieved over the last three years and what remains to be done. The BSACI is now on a firm administrative footing. For the first time we have a full time professional secretariat outstandingly led by Fiona Rayner whose loyalty and commitment has made her a major asset for the BSACI. She is ably supported by Cate Barrington-Ward and our newest recruit Pia Huber who is helping move the guideline process forward. As well as Fiona and the team considerable thanks must go to Jack Barnes who set the whole thing up and saw it through to firm foundations. Our administration is therefore in good shape with secure finances, strong budgetary control, well suited accommodation with the British Thoracic Society, improved information and communication networks including a greatly improved website and the excellent Allergy Update which I am very grateful to initially Glenis Scadding and then Nasreen Khan for editing. In a relatively short time since the retirement of Sue Duff we have therefore become an effective and disciplined outfit.



This is reflected in the transformation of the annual meeting which as a result of improved sponsorship has become financially sound as well as continuing its vital role as a flagship activity for the society and a showcase for cutting edge research and clinical developments in allergy. All thanks again to Fiona as well as the hard work and commitment of Andrew Bentley and now Chris Brightling as chairs of the meetings committee to make this happen.

A slightly dull but necessary achievement has been the restructuring of the society and updating of its rules to make us a more effective organisation. In particular the creation of a number of sub-committees of council have helped us to focus our efforts. One benefit of this is to create a broader base of support for the BSACI to more accurately reflect the membership. This has included greater input from the paediatricians which are successfully expanding their allergy base and I am grateful to Jonathan Hourihane and now John Warner for making the paediatric sub-committee such as success.

More high profile has been the long term lobbying campaign by the BSACI in partnership with its colleagues in Allergy UK and Anaphylaxis Campaign to improve allergy services. This has culminated in the Department of Health Review. Whatever the outcome of the review the BSACI, mainly through the efforts of Pam Ewan with great support from Stephen Holgate and Jack Barnes, have put allergy care firmly on the map. We couldn't have done more to promote a long overdue improvement in allergy services.

A running sore for the BSACI is the rift between the allergy and clinical immunology communities. I regret that in our enthusiasm to put the allergy case to the Health Select Committee review as forcefully as possible we unwittingly exacerbated this tension by not being sufficiently sensitive to how our evidence would sound to our clinical immunology colleagues. However I am delighted that the working party I set up to consider the issue of relations between the two communities has come up with a consensus report which I think points the way forward for an improvement in relations. It is essential that at the very least the two disciplines communicate effectively. With this in mind an important recommendation of the group which I hope will be accepted by council, is to create a clinical immunology sub-committee the chair of which will be a member of the executive. This will guarantee that the clinical immunology view is consistently heard in the day to day running of the society. It is important that the clinical immunology members

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BSACI Travel Fellowships

Each year the Society makes available up to nine awards of £500 for each BSACI member to attend scientific meetings. Further details can be found on www.bsaci.org or by emailing info@bsaci.org

Membership

To enjoy all the benefits of being a BSACI member why not apply to join the society today. For an application form please visit www.bsaci.org or email info@bsaci.org

of the society engage positively with this development. I would like to express my considerable thanks to the members of the group who worked hard to create this consensus.

There have been other achievements; thanks to Shuaib Nasser and his committee the guideline process is bearing fruit, Tina Dixon is developing a stable of information leaflets which will start to appear shortly and in an initiative headed by Stephen Durham in partnership with Sam Walker and Education for Health we are piloting a series of regional educational workshops targeted at primary care as well as our first primary care day at the annual meeting. Amena Warner is leading an initiative on nurse led services, the clinic list is being updated and we have revamped our membership processes.

Although much has been done there are many challenges ahead. The costs of running the society have increased considerably and we are dependent on the income from the journal for our viability. The journal is therefore crucial to our continued success and it is important that there is smooth transition of editor(s) with the retirement of Barry Kay and Stephen Holgate in 2007/8. Many more guidelines and patient information leaflets are required. We have to plan under Tony Frew's direction for the EAACI meeting in 2010. Whatever the outcome of the Department of Health Review there will be a continuing need to encourage the development of high quality NHS allergy services in partnership both with the patient groups and our professional colleagues in the organ based specialities. There is increasing emphasis on the importance of primary care in delivering allergy services and we need to play our full part in making sure that developments in this area proceed smoothly and effectively. We will continue to need to work hard to maintain good relations between 'allergists' and clinical immunologists. One aspect of this relationship I think should be seriously looked at is the value of bringing both training programmes under the same umbrella. In the long term I believe this would solve a lot of problems. Although this is not strictly within the BSACI's remit if we come to the conclusion that it is the right way forward we can have major influence on making it happen. The BSACI has with some justice, been accused of being the preserve of a small clique (three of the last four presidents will have been trained by Barry Kay) and we must encourage a new cadre of young people interested in allergy and clinical immunology from a wider background to be involved in running the society.

Happily these challenges are for Stephen Durham and his team to address while I move off into the sunny uplands. I have greatly enjoyed working with the many colleagues and friends whose hard work over the last three years has helped to make the BSACI a successful organisation. It has been very much a team effort and to finish I would like to express special thanks to my fellow officers Chris Corrigan and Tony Frew, who have worked tirelessly for the society over the last three years and without whose stalwart support little would have been achieved.

...and it's goodbye from him

Some memorable moments of the BSACI President's team during the five-a-side football competition at 2005 Annual Meeting



Here the action man president takes an amazing dive for his team mates.

Even coming in last place couldn't affect the confidence of our sporty president. Check out those knees!



A president who it is said 'never takes his eye off the ball' decides to change tactics.

Government Review of Allergy Services

continued...

Continued from page 1

volume of co morbidity in allergy- virtually invisible to the NHS outside the immediate clinical setting. Nevertheless, enough can be said from the evidence that is available to expose the seriousness of the situation.

- Building on earlier work, the Society's review documents extensively the serious problem of multiple allergy / co morbidity in allergy. Outside the allergy centres, the NHS tends to respond to and treat separate allergy symptoms rather than addressing underlying causes. In consequence the service is treating perhaps twice as much allergic disease incidence as it is people with allergy – surely scope for efficiency improvement, to say nothing of providing better patient care.
- Over 20 million people in Britain have allergy related disorders; perhaps up to half of these can safely self manage their allergy, or have their symptoms reduced with help from primary care, without an extensive allergy diagnosis.
- But we estimate that 10 million people need an allergy diagnosis for effective care to be provided. These people will have more serious allergies, often with multiple symptoms. And a minimum of 3.5 million of them – and possibly as many as 7 million – need specialist help of the kind it would not be appropriate to provide through primary care. Nor would it be cost effective to try to make the primary care services fit for the task. Care in a specialist setting is required for this currently dispossessed group of patients.
- At the same time, very large numbers of people, and their doctors in some cases, are acting in the unfounded belief they have allergy – and are unnecessarily restricting their diet, choice of drugs or other aspects of their lifestyle.

On the effectiveness of allergy clinical interventions we have advised that:

- An allergy intervention based on accurate diagnosis and total avoidance of the provocative trigger can be totally effective – as in the case of drug allergy, food allergy, latex allergy.
- Immunotherapy is safe and very effective when appropriately administered for rhinitis and venom allergy.
- Avoidance strategies where the provocative agent is pervasive or hidden are also effective; but – as we know – these require great vigilance by the patient and expert advice and support from a clinician. Multiple reactions compound this problem.
- Poor clinical practice – stepping up or protracted symptomatic treatments without first considering the identification and avoidance of allergy triggers; or poorly targeted allergen avoidance, or patient selection – reflects on poor practice, not on the effectiveness of the allergy intervention per se.
- Specialist clinical services carry more expertise and have more authority with patients than generalist ones; and specialist clinics are needed for the diagnosis and management of serious illness.

Patient pathways for well managed care have been identified and used to strengthen and to extend the earlier advice by the Royal College of Physicians on the need to consolidate and extend across the country the coverage of specialist allergy centres. Given the widespread co morbidity in allergy, and the need for local clinical leadership to coordinate and enhance service potential, investment in an infrastructure of multipurpose centres able to see and treat the widest range of allergy is proposed (once again) as the most cost effective way forward.

In addition, with the involvement, among others, of the Royal College of General Practice, Royal College of Nursing and the NHS Alliance advice has been given to the DH

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“The Review findings and the action decided must be credible with audiences both within and outside the Department of Health.”

review team on how to help primary care to respond to the allergy epidemic. The introduction of allergy measures to the Quality and Outcomes Framework for GPs, an investment in practitioners with special interests in allergy, and the systematic introduction of more allergy training at both undergraduate and post qualifying levels were all outlined as potential ways forward. Both the introduction of more generic allergy awareness across the whole service and the development of strategic allergy expertise within primary care were seen to be required. Allergic illness underlies the symptoms of so much of the morbidity seen in primary care. By managing some of its current case load better, primary care can do more to help its patients with their allergy.

Options for the Department of Health

The Review officials have emphasised that, to be credible, any recommendations they might make must ‘work with the grain’ of how the NHS is being managed and developed.

At the time of writing it is evident to the *Allergy Update* editorial team that the Review will test the Department’s purpose in at least two respects. How serious is the current funding problem in the health service? Is it an

inexplicable, long-term problem requiring fundamental reassessments of health priorities? Or is it a marginal and transitory adjustment to a new and more transparent funding regime – as Ministers have repeatedly said?

In the former case, we should expect management of a cause of illness driving the presented symptoms of as many as one third of the population to figure more prominently in any newly founded health service for Britain. In this latter case, lack of funds now and for the immediate future cannot be allowed to become an excuse for inaction on allergy.

How, given the reliance to be placed on local health authorities and trusts developing “close to patient/close to local population” priorities and programmes, is funding headroom and service planning intelligence to be imparted to those local agents, given their current virtually inert state as far as allergy is concerned?

The Review findings and the action decided must be credible with audiences both within and outside the Department of Health. The BSACI and those who share our concerns as clinicians, no doubt the Parliamentary Health Committee, and absolutely without doubt people with allergy and their parents and families look forward to seeing how the circle is squared.

BSACI Standards of Care Committee

We had a terrific response to the draft urticaria guidelines posted on the members’ only pages of the BSACI Website and the Standards of Care Committee (SOCC) would like to thank all those who responded and gave their invaluable suggestions. All responses were carefully considered by the SOCC in early February with many of the suggestions incorporated into the latest version of the Urticaria Guidelines. This has now progressed to a near final document and we hope to submit for publication to a specialist journal in the next few months.

The updated rhinitis guidelines are now in an advanced stage of development and again a draft rhinitis document will be placed on the BSACI members-only webpages in order to

give members an opportunity to comment and offer suggestions. Members of the SOCC have worked very hard to develop these guidelines and greatly value your input. The guidelines are there to help with the practice of allergy and it would be helpful to have as much feedback as possible while they are on the website. Work has already begun for vaccine, beta lactam and egg allergy guidelines.

The guideline development process is intended to serve the allergy specialist community but briefer versions will also be published for General Practitioners, which, it is hoped, will be included in the future.

Shuaib Nasser (SOCC Chair) and Pia Huber (BSACI Research Officer)

BSACI Annual Scientific Meeting 2006

Chris Brightling

BSACI Meeting Secretary

With the onset of spring and the promise of a glorious summer it is now time again for us to book our places for the annual BSACI Scientific meeting.

This year's annual meeting will be held again at Burleigh Court, Loughborough.

Burleigh Court has undergone a substantial extension with more meeting rooms, further hotel facilities, an extended gym and larger pool for the

health conscious and a bigger bar for those who like to be less conscious. Most delegates can now be housed on site but to avoid disappointment it is essential to book early.

The programme reflects the ambitions of our expanding society. In keeping with the structure of previous meetings we have two and a half days for the main scientific meeting from Monday to the Wednesday 10th-12th July, but as a new feature for this year we also have an additional Primary Care Day on the Wednesday that will dove-tail with the main meeting. The scientific programme includes sessions on cutting edge science such as our current understanding of antigen presentation and immune regulation and the role of structural cells in asthma balanced with sessions on best clinical practice in allergy such as the role of anti-IgE and a clinical grand round. The primary care day includes key plenary sessions as well as workshops. These examples are by no means exhaustive and a full programme is available on the website www.bsaci.org

Following on from the success of the AB Kay award for best abstract last year we have

expanded the sessions for poster presentation of original research. There will be the opportunity to display the posters throughout the meeting and specific sessions are arranged for both clinical and scientific posters. The annual meeting is extremely well attended by senior

members of the society so it is a fantastic opportunity for budding allergists to mingle with leaders in allergy in an informal setting.

The financial health of the meeting is dependent upon the tremendous support we have from industry. Following on from the success last year of the satellite symposia this will again be a feature of the meeting and sponsors will be available to chat to throughout the meeting in the exhibitors area. I encourage you to take time to meet our sponsors and to learn about the advances in industry and perhaps purchase a new book.

The meeting is never exclusively about education and scientific breakthroughs, but is also about meeting new and old friends. After much deliberation the meetings committee opted for a buffet and quiz night in the bar on the Monday rather than organising a sporting event. We feel this aptly reflects the sporting prowess of the committee. The Tuesday evening is an opportunity for members to show off their favourite summer evening wear at the President's dinner to be held at the splendid Prestwold Hall.

The annual meeting 2006 promises to be an excellent meeting so make sure you book your place now.



“The programme reflects the ambition of our expanding Society.”

Diary dates

■ **10th – 14th June 2006**

EACCI 2006 Congress, Vienna, Austria

■ **14th – 16th June 2006**

BTS Summer Meeting, Aberdeen

■ **10th – 12th July 2006**

BSACI 2006 Annual Meeting

Loughborough, Leicestershire, UK

■ **6th – 9th September 2006**

BSI – Joint Meeting of European National Societies of Immunology
Paris, France

■ **10th – 15th November, 2006**

American College of Allergy, Asthma and Immunology (ACAAI)
Annual Congress, Philadelphia, USA

Managing anaphylaxis in primary care

Samantha Walker, RGN PhD

Director of Research, Education for Health

Aziz Sheikh, MRCGP MD

Professor of Primary Care Research and Development, University of Edinburgh

A guide for those who might encounter this most severe of allergic reactions outside of the hospital environment. Easy to follow advice to enable primary care physicians to deal with both patients and relatives.

Anaphylaxis is an acute potentially life-threatening medical condition that is usually due to a systemic allergic reaction to an allergen, e.g. a food, drug or insect sting. Its onset is immediate and rapid. In patients who have experienced an episode of anaphylaxis there is an appreciable risk of recurrence, but in far too many of these episodes, patients fail to receive potentially life saving treatment with adrenaline.¹

Recent estimates suggest that anaphylaxis is responsible for between 20-30 deaths each year in the UK.² Although patients with acute symptoms rarely present in primary care, it is still essential that community-based medical and nursing staff are familiar with managing acute symptoms. Equally important, and perhaps more relevant in primary care, is the need to consider anaphylaxis not only as an acute episode, but as a chronic condition

requiring long term follow up and detailed health education.

Definition and clinical features

A precise definition of anaphylaxis is disputed because of disagreement about which of the many symptoms involved constitute its essential features.³ Traditionally the term anaphylaxis indicates the presence of severe systemic features including hypotension and respiratory distress, although early signs (which are often ignored or misinterpreted) include flushing and systemic urticaria. Treatment may be delayed due to non-recognition of early signs and delayed administration of adrenaline is associated with increased mortality.

The main clinical features that characterise anaphylaxis are summarised in Table 1; differential diagnoses are shown in Table 2.

Acute and longer-term care

Treatment of anaphylaxis can be considered as a two-stage process: immediate treatment and longer-term care.

In primary care, immediate treatment consists of:

- Basic and advanced life support (if required)
- Restoring blood pressure (by lying the patient flat, and raising the feet)
- Adrenaline given by intramuscular injection: the dose of adrenaline that should be given varies with age⁴
- Administering high-flow oxygen (if available)
- Arranging emergency admission to hospital

A protocol can help primary care professionals respond quickly and efficiently to anaphylaxis in a crisis situation. An algorithm based on the Resuscitation Guidelines^{4,5} is useful. The protocol should be explicit, explaining how to recognise symptoms, advising precisely when to administer epinephrine in response to which symptoms, and state what dose of epinephrine to give. It should also include a reminder to

Table 1: Clinical features of anaphylaxis

Organ	Symptoms and signs
Skin	● Pruritis, flushing, urticaria, and angioedema
Respiratory system	● Rhinitis, sneezing, stridor and hoarseness as features of upper airways inflammation and oedema ● Cough, wheezing, and dyspnoea due to lower airway obstruction. If untreated cyanosis and asphyxia may develop
Cardiovascular system	● Vasodilatation, tachycardia, hypotension, circulatory collapse, leading to shock and infarction of tissues
Gastrointestinal	● Tingling and swelling of the lips and tongue, palatal itch, nausea, vomiting, abdominal cramps and diarrhoea
Neurological	● Anxiety, headache, convulsions and loss of consciousness

Table 2: Differential diagnosis of anaphylaxis

Condition	Comment
Vasovagal attack	<ul style="list-style-type: none"> • Bradycardia not tachycardia • No urticaria, pruritis, angioedema, upper respiratory obstruction. • Pallor instead of flushing • Nausea without abdominal pain
Serum sickness	<ul style="list-style-type: none"> • Slower onset (over days instead of minutes) • No upper respiratory obstruction, bronchospasm or hypotension
Mastocytosis	<ul style="list-style-type: none"> • No upper respiratory obstruction • Slower onset • Chronic low level symptoms between attacks
Angioedema and C1-esterase inhibitor deficiency	<ul style="list-style-type: none"> • No flushing, pruritis, urticaria, bronchospasm or hypotension • History of C1-esterase inhibitor deficiency
Globus hystericus	<ul style="list-style-type: none"> • No clinical evidence of upper respiratory obstruction • No flushing, pruritis, urticaria, angioedema, bronchospasm, hypotension
Acute or chronic hypotension	<ul style="list-style-type: none"> • Generalised rash without respiratory symptoms or urticaria

dial 999 and to transfer the patient to hospital.

Longer term care should involve identification of the trigger, advice on avoidance and instructions on the immediate management of further episodes. Identification of the triggers most likely to be responsible for provoking anaphylaxis in different age groups may prevent future reactions by making allergen avoidance possible. An anaphylaxis management plan has been shown to improve reduce the number and severity of reactions in children with peanut or nut allergy⁶ and such plans should be developed and tailored to individual patient use.

Other considerations

Many health professionals prescribe self-administered adrenaline (Epi-pens) while the patient waits for an appointment with an allergist. This may be unnecessary⁷ as it may be later discovered that the patient did not have anaphylaxis or that they had a reaction for which epinephrine is no protection. Patients in whom an allergic trigger has been identified may benefit from a Medic-Alert bracelet which gives details of their allergy to others in an emergency.

Conclusions

Many of the deaths from anaphylaxis are

considered preventable. Patients treated in casualty departments often receive no follow up or advice on management of future reactions. It is vital, therefore, that primary care staff are equipped to provide long term management strategies for patients who have experienced anaphylaxis.

Living with anaphylaxis is for many people an extremely stressful experience. A detailed management plan, developed in collaboration with the patient, provides practical, structured advice about symptom management and may reassure the patient of their ability to manage reactions competently. Anxieties and concerns, especially in the case of children, are likely to be high and one of the key roles of the primary care practitioner is to explore and tackle such issues, thereby helping those prone to anaphylaxis to live with their condition with confidence and a sense of self-control.

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“Recent estimates suggest that anaphylaxis is responsible for between 20–30 deaths each year in the UK.”

Payment by Results

- A Rough Guide and Potential Pitfalls

Runa Ali

Consultant Physician, Allergy Clinic, Barts and the London NHS Trust

Runa Ali, our self styled financial advisor guides us through yet another new government initiative. Do read on, what follows is important information!

“There is concern about how Payment by Results will cope with intermittent and unpredictable activity.”

Last October, I attended a Payment by Results (PbR) workshop at the Royal College of Physicians, as BSACI representative. This was a forum in which all the medical specialties could engage with representatives from the Department of Health and the Prime Minister's Delivery Unit. A further meeting followed this in March. Before my report, here's a short guide for the uninitiated.

What PbR means

PbR began introduction in April 2004, starting in Foundation Hospitals, with the aim for everyone to be working under the new system by 2008/9. Under the old system, providers have traditionally been paid to deliver care by block contracts from the PCT. In line with the concept of patient choice and “Choose and Book”, funding will now strictly follow the patient, wherever they choose to go, earning money for the selected hospital and encouraging competition. Therefore, PCT's will now commission:

- the volume of activity required to deliver service priorities
- from a plurality of providers
- on the basis of a standard national tariff for each type of case, adjusted for regional variation in wages and other costs of service delivery.

Tariffs are derived from Healthcare Resource Groups (HRGs)

HRGs were originally developed to try and group together either Procedures (OPCS4 codes) or Diagnoses (ICD10 codes) that were similar, both from a clinical and a resource-consuming aspect. HRGs are now used as a commissioning currency/activity measure to derive the national tariffs. Under the old system, tariffs were based on the average historical cost of the local service, collected via reference costs (2 years behind) and uplifted for inflation.

Packages of care

Commissioners (e.g. PCT) may also commission a package of care under PbR including e.g. not only an acute inpatient stay or

daycase procedure defined in a HRG but also other elements e.g. follow-up outpatient visits, transport costs for patients.

Service Level Agreements (SLAs)

These exist between Commissioning PCTs and providers in order to:

- Make clear how funding will be charged where the activity is actually delivered, and adjusted for casemix.
- Manage and share volume risk so as to encourage volume growth only where it is desirable for clinical and access reasons.

Sounds good. What's the problem?

Well, all the medical specialties without exception raised significant concerns about the scheme at the initial meeting:

HRG codes just don't exist for everything and the currently existing ones are too inadequate and out-of-date to cover the complexity of modern cases. The only adjustment proposed by the DoH was based around average length of stay. This “one size fits all” model would particularly punish tertiary centres that accepted complex cases, needing extensive in-patient investigations or less commonly performed procedures. They would then earn the same as patients with less complex cases with a similar umbrella diagnosis. Strong arguments were made for the scheme to be postponed until newer, more appropriate HRGs were available.

Coding was felt to be inadequate: coding is done by clerks based on discharge information produced by junior doctors. If information is inaccurate at any stage of this pathway, particularly if every single intervention is not listed, incorrect payment could result. Coding will be examined by the RCP eg: education for juniors through workplace based assessment on coding and discharge summaries, use of increased electronic near patient coding, etc.

There was concern about how PbR will cope with intermittent and unpredictable activity. The DoH plan is that Providers who underperform will have funding reduced in-year, on a quarterly basis, so that patients can be treated elsewhere. With unforeseen increased

demand in-year, Providers and Commissioners will need to agree in their SLA's on how to respond. This may or may not involve funding to cover extra activity. There will continue to be caps on the level of activity PCTs commission. i.e. overactivity may not necessarily be rewarded.

Some NHS Trusts have costs per HRG significantly higher or significantly lower than average. The intention is to enable Trusts to retain surpluses they earn if they are able to provide services at lower costs than the tariff rate. However, many Trusts are going to experience a net deficit with the switch.

Implementation is happening at a difficult time when providers are in debt and the drive is to push routine cases to independent/private sector providers. Trusts need to be in non-deficit position to be considered for Foundation Trust status and may be unwilling to take financial risks with services that they felt would be costly to run and low-income generators.



The March 2006 Meeting Update

The DoH announced that three bands of complexity are to be built into the HRGs. Also, tariffs will be available for Elective, Non-Elective, A&E and Out-Patient cases. Nurse-Led Clinics are now to be included, but Allied Health Professional (AHP) clinics, such as Dietician-led, will be excluded. Anything outside the tariff will be subject to local negotiation if that service is to continue – although this is the opposite of what PbR is trying to achieve ! The rationale is that the PCT may wish to provide equivalent community-based AHP clinics more cheaply, although this will again affect patients with complex cases, who need to see specialist AHP's in a multi-disciplinary hospital setting. Nine out-patient procedural tariffs are to be brought in e.g. subcutaneous injection.

The meeting is to establish itself as a Standing Group and will reconvene in June to discuss progress. There is a strong feeling that dialogue should occur outside of this group and directly between the individual specialties and the DoH, in order to assist in HRG/Tariff development.

Allergy Services: Implications

The six specialist centres seeing large numbers of allergy patients have their work coded as Allergy; however the majority of Allergy clinics have their OP work coded under the consultant's main specialty and it may be difficult to assess how much income Allergy cases are generating, unless they are separated.

Codes for Allergy services, including day case procedures, were listed in the DoH Allergy specialist services definition, developed in 2002, by a national working party. <http://www.dh.gov.uk/assetRoot/04/01/96/05/04019605.pdf>

The urgent problem now is to engage with the DoH directly to establish agreed national tariffs for allergy services, in particular for immunotherapy, food and drug challenges. Local negotiation will lead to wide variation with, for example: immunotherapy being classed as a day-case, out-patient follow-up visit, subcutaneous injection or 3-year package of care, depending on the centre, thereby creating substantially differing incomes. Food and drug challenges should be considered for national day-case tariffs. Finally, a concerted effort is required by the combined specialties to include AHP's in PbR, so that Allergy Dietician clinics are not under threat. I am sure many of you have other points and suggestions, which the BSACI look forward to receiving.

“The urgent problem now is to engage with the DoH directly to establish agreed national tariffs for allergy services, in particular for immunotherapy, food and drug challenges.”

Fascinating facts about sampling the environment

Abbie Fairs

Research Assistant in Aerobiology, University Hospitals Leicester, kindly sponsored by MAARA

How the study of aerobiology provides vital information for allergy sufferers

“The importance of the service was highlighted in 2005 when the highest grass pollen count recorded in MAARA’s 30 year history sparked a frenzy of media interest.”

After a year of research at the Institute for Lung Health in Leicester and extensive aerobiology training, I am now continuing and developing the service provided by the Midlands Asthma and Allergy Association (MAARA), following the retirement of the principal aerobiologist in Derby.

In the last year, I have been privileged to work alongside inspiring professionals in a friendly and supportive clinically driven department at the frontline of allergy research. Having been faced with the indecision facing many graduates on completion of their degrees, I am grateful for the path I have, in many respects, fallen into. With a background in Physiology and Pharmacology, I had never considered aerobiology as a research career path. However, this is the position I find myself very much enjoying and am relishing the opportunity of pioneering research in what is an under-researched area of asthma and allergy.

The importance of the aerobiology service provided by MAARA was highlighted in the 2005 pollen season, where the highest grass pollen count ever recorded in MAARA's 30 year history sparked a frenzy of media interest and enquiries from symptomatic hay fever sufferers. Having been lucky enough not to

experience hay fever myself, the experience of the 2005 pollen season was a real eye-opener for me with regard to the scale of people affected, the severity of symptoms endured by sufferers, particularly during the summer months, and thus the importance of the service that MAARA provides.

Having only limited knowledge regarding aeroallergens prior to my training, learning about aerobiology to a degree of understanding that would enable the smooth transition of the take-over period of MAARA from Derby to Leicester has been demanding, but successful, which is very much a testament to the long-standing members of MAARA, whose support, experience and expertise have made this possible. I have learned the methods involved for preparation of materials for capture and analysis of aeroallergens and learned to differentiate between the numerous types of pollen and fungal spores, of which many are long-established aeroallergens and which I can now identify to genus level.

Commencing 1st January 2006, the responsibility of collecting aerobiological data and making summaries of the data readily available to the general public was undertaken by the Institute for Lung Health in Leicester. We now look to promote the service and drive forward research into aeroallergens and allergy.

Through impending research collaborations, we have the exciting opportunity of revolutionising the service towards the development of clinically oriented research projects, in addition to maintaining the high level of service expected of the charity. We will shortly also be commencing collection of aeroallergen data in Leicester, which will allow comparative analysis with Derby and patient aeroallergen exposure data.

At this key time in the development of aerobiology research, I am very grateful for the opportunities that I have been given and look forward to the development of aerobiology through pioneering research directed toward increasing understanding of the role of aeroallergens and reducing symptoms of asthma and allergy.



News from Europe

Anthony J Frew

BSACI Treasurer

Our Treasurer explains the roles and benefits of the British and European allergy societies

The EAACI meeting is being held in Vienna this year from 10-14 June, and I hope that many BSACI members will be able to attend. Over 1600 abstracts were submitted, which is a record for an EAACI congress, and about 25% more than at the recent AAAAI meeting. We expect attendance at the meeting to be close to the level of the World Congress held last year in Munich. This bodes well for BSACI's plans to host the 2010 congress in London, although we have to be aware that the regulatory climate is constantly changing and we will need to adapt our plans as and when changes occur.

EAACI continues with its programme of winter and summer schools: a very successful winter school was held in Grainau, near Garmisch-Partenkirchen, Germany in February, and a meeting on mouse models of asthma was held in Antalya, Turkey in March. The next summer school is in Chalkidiki, Greece, in late June, with a special focus on asthma. A further winter school will be held in Davos in January 2007 on the interface between immunology and asthma, and I would strongly encourage young researchers to think about attending. The meeting is really high quality, with keynote lectures from outstanding scientists, the chance to present your work in a convivial and friendly setting, and to get lots of feedback from the faculty. Our analysis indicates that people get about 5 times more feedback on their work at a winter school, than they do from a comparable presentation at a large congress. Applications are on a competitive basis, and are circulated to all EAACI junior members. Junior membership is completely free to under-35s so if you meet the criteria and you haven't yet joined please do so!

On the political front, EAACI has been campaigning for the highest possible profile to be given for allergy research within the new EU funding scheme (Framework Programme 7). To that end I recently met MEPs from the relevant committee to emphasise the importance of allergic conditions, and the need for further research to understand their causes and develop preventive and therapeutic strategies. One of the key arguments for further EU investment is the

variation that currently exists across Europe – this suggests that as European states become more prosperous they can expect further increases in the prevalence of allergic conditions, but at the same time we should be able to take advantage of this variation to study allergy and perform translational research.

Some reorganisation of EAACI is also taking place – the executive committee is being restructured to give each of the committee members a clearer remit and hopefully to make more effective use of the time that they volunteer for EAACI. We are also trying to achieve a greater focus on communication and membership issues, including postgraduate education and the possible development of a pan-european exam in allergy.

We have reached agreement on a formula for lower membership fees for members from less advantaged parts of Europe, without asking the more prosperous areas to pay more. Our hope is this will encourage our many junior members from Eastern Europe to become full members. Further work over the next year will involve looking at the financial structures of our congresses to see whether we can restructure the benefits offered to speakers and invited guests, with the aim of reducing the registration costs. BSACI will be keeping a close eye on this as we plan our London congress for 2010.

“We expect attendance at the meeting to be close to the level of the World Congress held last year in Munich. This bodes well for BSACI's plans to host the 2010 Congress in London.”

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Provision of allergy services to the community in Hackney, East London

Andrew Williams

Clinical Nurse Specialist – Allergy, Homerton University Hospital NHS Foundation Trust

An enthusiastic account of a busy hospital-based allergy service in east London



“I thoroughly recommend that anyone involved in mainstream allergy seeks membership of the BSACI.”

Despite current uncertainties in the NHS, allergy is still a very exciting place to be. Public and professional pressure for better services that serve patients as we would like our own families to be served continues to rise – and in a ‘public-led’ NHS we will, in time, reap the harvest of all the hard graft and lobbying that is being put in by the likes of BSACI members.

It has always been a great encouragement to us at Homerton that the British, and indeed European, ‘allergy community’ is so supportive of local clinics and research. I thoroughly recommend that anyone involved in mainstream allergy seeks membership of the BSACI and attends its annual conference where one can make contact with like minded teams and individuals. Working in allergy in many parts of the UK can be pretty isolated without such links or the occasional friendly email.

If we look at the statistics below, which you may well be familiar with, it is easy to understand why it is critical that our local services, both primary and secondary have to have a clear vision of what service provision should be as opposed to what is available now.

- Allergic conditions have increased four-fold over the last 20 years

- One in three adults will develop an allergy at some time
- Four out of ten school children have at least one allergy
- One in five children has asthma
- An estimated 6 million people have eczema
- Over 9 million people have hayfever
- Over 1 million people have a food allergy

While we wait for developments from the National Allergy Advisory Group/DoH we should continue to be optimistic about the future of allergy services and to plan for growth and expansion in our department.

Our clinics at Homerton University Hospital NHS Foundation Trust

Homerton is an innovative and friendly hospital based in the Borough of Hackney, east London. We provide a pretty comprehensive and continually developing allergy service across east London and beyond. It was only ten years ago that Dr Raja Rajakulasingam inceptioned the beginnings of the allergy service with a once weekly session. This has grown over the years to the services listed below:

- Adult and paediatric allergy clinics
- Skin prick testing, prick – prick testing, IgE tests
- Dietetic advice & oral food challenges
- Immunotherapy (grass, tree, HDM, venom)
- Paediatric & Adult Dermatology Nurse Specialists
- Adrenaline pen/basic life support training for families
- Anaphylaxis outreach to A&E and ICU
- Asthma Nurse Specialist
- Allergy Nurse Specialist (adult and paediatric)
- Asthma clinic
- Lung function assessment
- Research & Education

One of our main strengths is immunotherapy. There has been much more interest in this from health professionals in recent years wanting to augment their allergy services, and interest from the public has always been strong since we commenced these treatments at Homerton as part of clinical trials back in 1998. Indeed, support from industry must be gratefully acknowledged, since this is the means by which many immunotherapy clinics in the UK have been able to start up, initially as part of clinical trials before gaining funding from other sources. We also are very fortunate to have had the support of the Chief Executive, who ensured that the service has adequate funding to pay for the continued services of the Nurse Specialist.

It continues to be a pleasure to be part of national and international trials of new medications such as tablet immunotherapy and we are proud to be associated with many other groups in Europe engaged in such research. We are able to offer immunotherapy on an NHS clinical need basis too, with growing support and referrals from local GPs. A limited service for older children is to start soon. This is a specialist area where safety is the priority. Rigorous attention to patient suitability for the treatment can only be gained with a full history and conclusive skin prick tests. The guidelines of the committee on the safety of medicines

must be followed and it is sensible to adopt a protocol so that there can be no confusion as to the treatment; an excellent guide by Professor Stephen Durham & Dr Samantha Walker is available on the BSACI website members section. ‘Hands on’ experience is a must, and personally I would recommend between three and six months attendance, for a novice, at an established immunotherapy clinic depending on the regularity of sessions. It really is a treatment that one requires a ‘feel’ for as well as knowledge.

We find that most patients are so desperate for relief from their debilitating symptoms that the intense ‘up dosing’ phase of the treatment doesn’t present the DNA (Did Not Attend) issues one might expect and they become very loyal, particularly after the first pollen season following their treatment.

We continue to push forward for the provision of allergy services both locally and nationally and look forward to our continued collaboration with many of you reading this in the coming years.

“We continue to push forward for the provision of allergy services both locally and nationally and look forward to our continued collaboration with many of you reading this in the coming years.”

Some of the Homerton allergy team in the paediatric “Starlight” outpatients department. Left to right: Dr Raj K Rajakulasingam Consultant Physician Respiratory Medicine, Hester Blair Paediatric Dietician, Andrew Williams Clinical Nurse Specialist (Adult & Paediatric), Dr Rajiv Sood Consultant Paediatrician & Allergist, Raphaela Derrick Paediatric Nurse Practitioner and Yvonne Polydorou Paediatric Dietician

