

NSSDS 17 Specialised allergy services (all ages)

1. Recommendation of what the NHS Commissioning Board will commission

The NHS Commissioning Board will commission specialised services for patients with severe allergic conditions and for patients with more common allergic conditions for whom conventional guidelines have failed and for whom specialist treatments are required. Services will be commissioned from specialist allergy centres and from outreach services run by specialist teams at more local hospitals through networking arrangements.

2. Four TOG questions

TOG question	Response
Which elements of the service will be commissioned by the NHS Commissioning Board?	<p>The NHS Commissioning Board will commission services (including procedures and treatments) for patients with:</p> <ul style="list-style-type: none"> • Complex drug allergy requiring specialist investigation and/or drug challenge • Rare conditions such as eosinophilic disease, mast cell disorders and hereditary angioedema • Complex eczema and asthma when referred from another specialist and requiring dietary manipulation or biologic therapy • Complex rhinitis/sinusitis, or refractory anaphylaxis where conventional guidelines fail and specialist treatments such as desensitisation immunotherapy or allergen challenge are required <p>See scope for complete list</p>
Which elements of the service will be commissioned by CCGs?	<p>CCGs will commission:</p> <ul style="list-style-type: none"> • Services for the conditions listed in the document if the patient requires specialist allergy intervention
How will activity be separately identified?	<ul style="list-style-type: none"> • Most activity takes place in a day case or outpatient setting and is captured using HRG/OPCS codes and will need to be identified by triangulation with ICD10 codes and

	<p>local patient databases. Although ICD 10 codes are not currently collected against OP activity, it is possible to do so using existing mechanisms and this would be part of the contract.</p> <p>The Allergy treatment function code 317 should be used to differentiate this activity in all specialist centres.</p> <p>C1 inhibitor replacement for HAE is part of NSSDS 16 Immunology and therefore allergy centres may also be providing services under the Immunology NSSDS.</p>
How many provider contracts will there be?	There are 9 full-time Allergy centres exclusively delivering allergy services, 9 paediatric allergy centres and approximately 16 adult Immunology centres in England providing a mix of immunology and allergy services in England delivering some or all of the NSSDS specialist service scope (this will vary with the centre).
Running costs associated with commissioning the service	Costs would likely be reduced if the service was commissioned in totality by the NHS Commissioning Board rather than by diverse and non-standardised commissioning arrangements and policies.

3. Four factors on the bill

Factor	Still met?
The number of individuals requiring the service	Our best estimate is that about 8,000 people require referral to a specialist centre in each year for specialist assessment.
The cost of delivering the service	The infrastructure is already in place in the current specialist centres, although it is acknowledged that there are areas of the country not well served by specialist services at present. However a national commissioning arrangement and commissioning policies could address this and provide the potential for improved cost-efficacy in commissioning.

The expertise required to deliver the services	Extensive Allergy expertise is required and few people have the necessary experience, training and qualifications to deliver services of this level. There are only nine providers of specialised paediatric allergy services and 9 centres staffed by full-time Consultant Allergists.
The financial risk to CCGs	National commissioning will avert the risk of unpredictable fluctuations of cost due to expensive therapies such as C1inh replacement, biological agents, immunotherapy and drug challenge procedures. National commissioning policies may reduce cost by eliminating IFR requests. National planning will ensure the most cost-effective access to care.

4. Assurance processes

Assurance Group	Comments
Clinical Assurance Group	<ul style="list-style-type: none"> • How will activity be identified – if it is through a treatment function code for Allergy 317, some activity (and associated specialist centres) will be excluded. [See response from SCG Finance Network]. However correct coding of the activity as Allergy should easily address this problem • We are confident that triangulation of local databases with application of ICD 10 codes and locally recorded activity to existing captured TRF data will be sufficient to capture the specialist activity and differentiate it from any non-specialist activity in the same centre (where that exists). • Population of a web-based national database is another potential way of improving data capture on specialist activity and could be made compulsory for specialist centres.
Patient and Public Engagement Group	<ul style="list-style-type: none"> • Content to provide assurance
SCG Finance Network	For both ADULT and PAEDIATRIC patients, ICD10 codes are available for most OP activity and although not currently used in this setting there is a field on the patient administration system

	<p>to record this data. Specialist allergy procedures including drug investigation, immunotherapy, anti-IgE treatment and food challenge activity is already captured using OPCS procedure and HRG coding. Patients with mast cell disorders, hereditary angioedema, refractory anaphylaxis and hypereosinophilic disorders will be identified by ICD10 and differentiated on a named-patient basis using databases held by specialist centres.</p>
Finance Assurance Group	<ul style="list-style-type: none"> • Need to confirm that adult activity can be identified on a named patient basis before assurance can be given – see response above and in the Allergy document • See mechanism proposed above.

5. Other key issues that the CAG needs to note:

- Some allergy centres might not meet the definition of a specialist service delivering complex allergy but could be encouraged to improve according to IQAS (Improving Quality in Allergy Services) criteria
- The current geographical distribution does not facilitate equity of access to services for all and some patients are required to travel long distances for treatment – national networking and outreach could be developed as part of the contract to attempt to address this within current resources.

SSDS 17 Allergy

Interim Scoping Document v3.4 25th April 2012

1.1 Introduction

Allergic disease is defined as an immune-mediated adverse event resulting from an externally-delivered agent. Allergy specialists deal with allergic reactions, particularly anaphylactic reactions to drugs, venoms and foods, as well as angioedema, hypereosinophilic disorders, and urticaria. Allergy specialists also play an important role in excluding allergy as a diagnosis to avoid inappropriate use of NHS resources. It follows that a specialist in allergic disease needs a wide range of clinical skills as well as a detailed understanding of allergic disease.

Allergic disease is very common affecting up to 30% of adults and 40% of children at some point in their lives. Allergic disease has increased in prevalence, complexity and severity over the past two decades. The vast majority should be managed in primary and secondary care and specialist centres have a role in supporting this activity with education, patient pathways and advice.

Individuals requiring access to very specialist services as defined below represent a small subset of the most severe and complex patients Allergy the Unmet Need 2003 from the Royal College of Physicians (RCP) (4), House of Commons Health Committee Report on Allergy Services 2004 (5), Department of Health Review of Services for Allergy 2006 (12), House of Lords Science and Technology Select Committee report on Allergy 2007 11 and RCP 2010 (8).

Specialist allergy centres have expertise not available in other settings. There is likewise a need for childhood allergy to have specialist services that take into account the special requirements of paediatric service provision (RCPCH Allergy care pathways <http://www.rcpch.ac.uk/allergy> , NSF for children http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089100 , NICE food allergy for children <http://guidance.nice.org.uk/CG116> , DRACMA WAO milk allergy guideline www.worldallergy.org/publications/WAO_DRACMA_guidelines.pdf).

1.2 Allergy Definition set

*Workload estimated from actual audit data from a large adult and a large paediatric specialist centre

Specialised Allergic Conditions	Workload* (all centres combined)
Most specialist services will provide:	
Complex Drug allergy: Investigation including drug challenges, and desensitization (antibiotics, analgesic - NSAID/Aspirin/Opiates, anaesthetic, contrast media, biologics)	3,000 adults /yr 120 children/yr
Bee and Wasp venom allergy requiring specific immunotherapy (as recommended by NICE).	400 adults/yr 80 children/yr
Vaccine Allergy	150 adults 48 children /yr
Anaphylaxis which is recurrent, idiopathic or if there are multiple triggers (as recommended by NICE)	Approximately 200 per centre per year.
Systemic Mast cell disorders (predominantly adults) Rare and complex disease in adults presenting with allergic symptoms and anaphylaxis. No other specialist service deals with these patients routinely. Children often present with a benign self-limiting form called urticaria pigmentosa which disappears in adulthood which is not included here.	240/yr
Severe rhinitis/sinusitis When referred from another specialist because of inability to control the disease or requirement for specific immunotherapy (subcutaneous or sublingual)	1,500/yr
Hereditary Angioedema (Some specialist allergy services also manage hereditary angioedema under NSSDS number 16, Immunology).	Approximately 30-50 per centre on average (usually require long-term follow-up – see NSSDS Immunology, 600-900 patient sin England)
Severe atopic dermatitis (when referred from another specialist because of inability to control the disease or requirement for complex dietary manipulation, predominantly paediatric centres)	680 children/yr
Severe allergic asthma (when referred from another specialist because of inability to control the disease or requirement for complex allergy tests or biologic therapy (NICE TAG133) and in some cases in conjunction with specialised respiratory services.	150/yr (usually require long-term follow-up)
Hypereosinophilic disorders These are managed predominantly in a subset of the specialised centres	1000 patients (usually require long-term follow-up)

1.3. Specialist procedures undertaken by Allergists

Specialist allergy testing techniques

Using drugs, foods or venom (skin prick / intradermal not available elsewhere)

High Risk allergen challenge/provocation testing

Both high risk individuals and provocation to rare allergens when other procedures have failed to diagnose allergy using foods/venom/latex/aeroallergens and drug challenges including aspirin, NSAIDs, penicillins and other antibiotics(oral, injected, subcutaneous, inhaled, nasal)

Immunotherapy

Allergy centres have a gateway function for selection of the most severe patients for hospital-based injected allergen and home-based treatment via oral immunotherapy according to criteria laid out in National BSACI guidelines.

Multidisciplinary Team Management of the complex patient;

Including ENT, respiratory medicine, immunology and dermatology with specialist allergy nurses, allergy dietician, social care and laboratory diagnostic support providing comprehensive management.

Drug allergy investigation and desensitization (oral or injected)

Centres manage high risk desensitization procedures for antibiotics and biologics when alternatives are not available. Experience and specialist expertise is only available in centres with a high volume and broad-ranging drug allergy practice which is required to provide support, advice and risk assessment for drug and anaesthetic allergy to other hospital specialties.

Monoclonal anti-IgE biological therapy for severe allergic asthma

In patients with multiple hospital admissions managed either in by Allergy or Respiratory Medicine but always in collaboration between allergists and respiratory physician as per NICE guidance TAG133)

1.4 Allergy Models

Delayed diagnosis, lack of equitable service provision across the UK and inappropriate management continues to be a major issue of concern for physicians and patients (National Allergy Strategy Group (NASG) and Anaphylaxis Campaign, RCP, DH Review). Of the 20 million people with allergies in the UK, the majority could be managed in primary care, once education is improved (BSACI NASG Nature and Extent of Allergy in the UK 2006, BSACI Regional training days).

However this scope focuses on the provision of the top tier of specialist service provision and does not provide a solution for the whole of allergy service provision.

A model proposed by RCP 2003 envisaged hubs of specialist allergy centres based in teaching hospitals linking with organ-based specialists and immunology laboratories and

integrating with primary care. Centres would be established according to agreed criteria based on quality standards and led by trained allergists (RCP Consultant Physicians working with patients, allergy 4th ed 2008). They would offer services for patients where the condition is complex and unusual where only allergy specialists will have the necessary expertise to diagnose and manage effectively (House of Lords STSC Allergy Report 2007 (11), RCP 2010 (8)).

Specialist paediatric allergy centres fulfilling the same criteria but led by accredited Paediatric allergists fulfill a similar role (Children's National Service Framework http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Healthcare/Children/DH_4089111 , House of Commons Select Committee 2004 (5); Children and Young Peoples health – where next? The NHS Co-federation, 2011 <http://www.nhsconfed.org/Publications/reports/Pages/Children-young-people-health.aspx>).

1.5 Nature of the Existing Specialised Services

Most allergy hospital activity takes place in an outpatient or day-case setting. Specialist services are currently delivered exclusively by adult or paediatric physicians trained in Allergy or Immunology or who have had long experience in the practice of allergy.

In England there are 9 full-time Allergy centres exclusively delivering specialist allergy services, 9 paediatric allergy centres and 16 adult Immunology centres providing some of the current specialised allergy scope. Some centres are already providing all or most of the specialist activity listed above, others will provide allergy activity in only some of the domains listed. Some are involved in regional networks.

The current geographical distribution of allergy centres has led to unequal access to services and there are some regions where patients are obliged to travel long distances for expert allergy care.

There are similarities between adult and paediatric care pathways but separately accredited training programs for adult and paediatric allergists. The services are mostly separate although some work collaboratively.

Specialist allergy centres have an active role in audit and research into allergic diseases. Continual CPD in allergy and networking to keep abreast of new developments in diagnostics and therapy is required.

Specialist guidelines have been developed Royal Colleges, reinforced by the BSACI (http://www.bsaci.org/index.php?option=com_content&task=view&id=117&Itemid=1). Some multicentre groups share protocols and guidelines production of a TRIAC Compendium of allergy in progress) to harmonise care.

Specialist allergy services work in multi-disciplinary teams with specialist allergy nurses and access to an allergy specialist dietician, and are actively involved in education and training within the hospital, within their catchment area and supporting primary care.

1.6 Workload

The definition set detailed above allows for accurate collection of data and monitoring of the work load.

1.7 Coding of Allergy Services

ICD10 codes are available for most OP activity and although not currently used in this setting there is a field on the patient administration systems to record this data. Specialist allergy procedures including drug investigation, immunotherapy, anti-IgE treatment and food challenge activity is captured using OPCS procedure and HRG coding. Patients with mast cell disorders, hereditary angioedema, refractory anaphylaxis and hypereosinophilic disorders will be identified by ICD10 and differentiated using local databases held by specialist centres. There is obviously scope for a national database and a web-based facility to record activity provided by professional organisations such as IQAS or by the Transition Team.

There is considerable need for improvement of the granularity of OPCS codes in the longer term but this is not a barrier to capturing activity at present as proposed above. Best practice tariffs have been developed and submitted for allergy activity but not accepted because of insufficient coding and activity data. Improved coding structures and mechanisms to differentiate nationally commissioned specialist work from other activity have been proposed and can be supplied.

Increasingly, patient self-administration of immunotherapy at home through hospital-managed home therapy programs is delivered through allergy centres. This activity data can be captured with existing methodologies, but requires consistent use of coding (8).

1.7.1 Adult Services

There is no current mandatory national tariff for allergy. Accurate recording of activity depends on adequacy of current coding and whether the allergy TFC (317) is used or activity is coded to another discipline e.g. respiratory or immunology. Where immunology and allergy services are delivered as part of the same service, the allergy and immunology activity should be differentiated by use of the appropriate immunology (single code to replace 313 and 316) or allergy (Treatment Function codes 317) and this can form part of the contract.

Procedure and HRG codes are currently insufficient to describe the standard procedures that may take place in an allergy clinic or day case episode but this is not a barrier to capturing activity at present as proposed above. A suggestion for future coding, submitted to CfH via PbR is appended (Appendix A). A nationally agreed non mandatory tariff for Allergy 317 is currently under review.

1.7.2 Paediatric

Specialist paediatric allergy should be coded under paediatric clinical immunology and allergy (255). A nationally agreed non mandatory tariff for Paediatric Allergy 255 is currently under review. Desensitization therapy together with food and drug challenges and management of severe eczema/asthma/enteropathy are conducted in day-care facilities. Day case OPCS and HRG coding are insufficient to accurately record this activity.

1.8 Entry and Exit Criteria

1.8.1 Entry Criterion

Patients enter the specialist service through referrals from hospital specialists and general practitioners against set criteria. Source of referral in paediatrics is a useful surrogate for part of the specialist activity. These criteria could be standardised as part of national commissioning. Most centres will triage referrals to ensure that cases are of the appropriate complexity. National care pathways with common referral thresholds will assist in this regard.

Most allergy centres receive referrals from other secondary care physicians, anaesthetists and surgeons (same or different trust), occupational health or direct from primary care, local or regional or further afield depending on geographical location and special expertise).

1.7.2 Exit Criterion

Some patients leave the specialist service once a diagnosis and management plan has been established but others, including some groups of children and adults with specific disorders, require long term care.

Patients then self-manage at home with the assistance of their general practitioner. Patients who complete time-limited immunotherapy are discharged back to the community.

1.8 Funding/Commissioning

National commissioning for highly specialist allergy services would ensure equity of access and continuity of provision and be consistent with national consultations on rare diseases, paediatric policies and papers (NICE guidance, national care pathways, NSF, BSACI guidelines).

In the absence of national commissioning, it would prove both difficult and expensive for CCGs to obtain expert advice in complicated and difficult allergy.

Many of the procedures carried out by Allergy Specialists are high risk, requiring expertise and experience but saving NHS resources by allowing the use of less expensive drugs, reducing the need for repeated hospital admissions in asthmatics and patients with anaphylaxis, allowing the appropriate re-introduction of foods and avoidance of the medicolegal costs and potential fatalities of avoidable allergic drug reactions.

There is also a risk that patients might be referred to inadequately trained practitioners or the patients themselves may, out of desperation, seek alternative unvalidated diagnostics and treatment, with adverse consequences, as has been seen in the past (11).

1.9 Conclusion

In terms of the four factors set out by the Secretary of State:

- a) The number of individuals who require the provision of the service or facility
 - This meets the criteria – estimated numbers have been provided.
- b) The cost of providing the service or facility
 - This is unlikely to be higher than at present.
 - There appear to be no major requirements for equipment and facilities which do not already exist unless geographic inequality is to be addressed.
 - Improved allergy care is cost-effective, preventing disease, requirement for surgery and reducing hospital admissions, ED attendances, GP consultations

and costs associated with drug allergy. Thus net cost to the NHS may decrease

- Improved cost efficiency as patients with complex multi-organ disease can consult a single specialist rather than several separate organ-based specialists (e.g. ENT, respiratory, dermatology and gastroenterology).
- There is a clear rationale for maintaining and expanding the existing network functions to harmonise provision and improve cost-effectiveness.

c) The number of persons able to provide the service or facility

The number of allergy trainees is currently small, insufficient for current overall need, and with insufficient trainee numbers. However there are sufficient exiting practitioners and centres to allow existing nationally commissioned centres to deliver what is required of them.

d) The financial implications for CCGs if they were required to arrange for the provision of the service or facility.

- The costs are already borne locally and therefore the main challenge is to identify current specialist activity by providing new codes and using clearly defined TFCs. The use of the allergy code (317) for all allergy specialist activity will enable better data collection.
- There should therefore be no major financial risk to commissioners overall.
- National commissioning would remove the financial risk to local commissioners due to the unpredictability of the number of rare and specialist allergic activity within each local CCG.
- A formalized national network of specialist allergy services would ensure access to specialised investigation and management of drug allergy which is a major risk to patients and cost-effective health care provision.

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APPENDIX A

Allergy coding for more complex procedures

Requests for new allergy codes – submitted by IC to Connecting for Health

The requests submitted were:

- Skin prick tests
- Prick prick tests
- Allergen immunotherapy subcutaneous
- Allergen immunotherapy sublingual
- Complex challenge test by injection
- Complex challenge other specified
- Complex challenge other NEC
- Complex challenge unspecified
- Complex drug allergy tests without challenge
- Complex oral challenge test
- Complex physical challenge test
- Complex topical challenge test
- Intermediate allergy tests without challenge

Version 1.3

<p>U38 Diagnostic Allergy Tests Note: Principal category, extended at U39 <i>Diagnostic allergy tests demonstrate the presence of allergic antibodies.</i></p> <p>Complex <i>intradermal tests are used for restricted substances mainly drugs (U38.1 and 38.2).</i> <i>Challenge tests involve administering a food or drug by the route as for therapeutic use.</i> <i>Simple tests are skin prick test (U39.1).</i></p>
<p>U38.1 Complex allergy tests with subcutaneous, intramuscular or intravenous injection challenge <i>Includes: Skin Prick and/or Intradermal tests with subcutaneous, intramuscular, or intravenous injection challenge</i></p> <p>Day case procedure. This applies mainly to diagnosis or exclusion of allergy to certain drugs; and sometimes to venom. The drugs are those which cannot be administered in an oral form. Tests involve a series of steps with skin prick test, then intradermal test, then injection challenge. Progression to the next level of testing depends on various factors including the result of the previous tests, and the known diagnostic limitations of tests for particular drugs. Not all need be required. There is risk of anaphylaxis from intradermal tests and a higher risk with challenge. The challenge component therefore requires incremental doses at set time levels and therefore is a time consuming procedure, taking several (often 4 hours). A 2 hour observation is required after the last dose. Patients must be monitored throughout for development of allergic reaction, and a team able to treat such reactions including anaphylaxis and acute asthma must conduct the tests in an appropriate facility. Skills/components: specialist allergy expertise; allergy team, day case facilities, time consuming, high risk; drug costs – many drugs may be required for skin tests simultaneously.</p>
<p>U38.2 Complex allergy tests with oral challenge <i>Includes; Skin Prick and/ or intradermal tests with oral drug or food challenge</i></p> <p>Day case procedure. As U38.1 but for drug/food where the challenge can be conducted orally. Note: Intervals between doses for oral drugs are usually longer i.e. procedure time longer. Skills/components: specialist allergy expertise; allergy team, day case facilities, time consuming, high risk; drug costs – many drugs may be required for skin tests simultaneously</p>
<p>U38.3 Complex allergy tests with topical, inhalational, nasal, conjunctival or mucosal challenge <i>Includes; Skin Prick and/ or intradermal tests with topical or inhalation challenge</i></p>

Day case procedure. As U38.1 but for substances such as chlorhexidine, latex, inhaled drugs, occupational and other allergens etc. which require topical, inhalational, nasal or mucosal challenge. Skills/components: specialist allergy expertise; allergy team, day case facilities, time consuming, high risk; drug costs
U38.4 Complex challenge by subcutaneous, intramuscular or intravenous injection <i>Excludes: Without skin prick tests</i>
Day case procedure. This involves the challenge component of U38.1. Required i) For drugs where skin tests are not appropriate; or ii) the challenge has to be done on a separate occasion from skin tests because of time constraints or iii) because a second drug challenge is required. Skills/components: specialist allergy expertise; allergy team, day case facilities, time consuming, high risk; drug cost
U38.5 Complex challenge by oral drugs <i>Excludes: Without skin prick/intradermal tests</i>
Day case procedure. This involves the challenge component of U38.2. Required i) For food/drugs (e.g. cox 2 NSAIDs or aspirin) where skin tests are not appropriate; or ii) challenge has to be done on a separate occasion from skin test because of time constraints or because a second food/drug challenge is required Skills/components: specialist allergy expertise; allergy team, day case facilities, time consuming, high risk; drug cost
U38.6 Complex challenge by topical, inhalational, nasal, conjunctival or mucosal administration <i>Excludes: Without skin prick/intradermal tests</i>
Day case procedure. This involves the challenge component of U38.3. Required substances such as chlorhexidine, latex, inhaled drugs, occupational and other allergens etc. i) when skin tests are not appropriate; or ii) challenge has to be done on a separate occasion from skin test because of time constraints or because a second challenge is required Skills/components: specialist allergy expertise; allergy team, day case facilities, time consuming, high risk; drug cost
U38.7 Complex Challenge other NEC
Day case procedure. This involves challenges not covered in U38.4, 38.5 or 38.6. Required where other tests are not appropriate or sufficient e.g. exercise, cold; or ii) challenge has to be done on a separate occasion from skin test
U38.8 Other Specified
U38.9 Unspecified
U39 Diagnostic allergy Tests Note: Extended category, principal at U38
U39.1 Complex allergy tests without challenge <i>Includes: skin prick/intradermal test to two or more classes of drug</i>
Day case procedure. This involves the skin prick and/or intradermal test components, of U38.1. Two or more classes of drugs (and multiple drugs within each class) are implicated in the reaction under investigation so all of these need to be tested. Multiple drug solutions are required with cost and time as well as risk. Shorter procedure than 38.1 and 38.2 but because multiple drugs have to be tested considerable time preparing different test concentrations for each and conducting tests plus clinical complexity. Skills/components: specialist allergy expertise; allergy team, day case facilities, time consuming, risk; high drug cost
U39.2 Intermediate allergy tests without challenge <i>Includes: skin prick+/- intradermal test to one drug or intradermal tests to venom</i>
Day case procedure. As 38.6 but fewer tests. Used for testing single drugs or venom
U39.3 Skin Prick tests <i>Includes: Conducting skin prick (or prick-prick) tests for allergy diagnosis</i>
Skills/components; allergy knowledge, taking a brief allergy history to determine problem and select appropriate allergens to be tested; knowledge of skin testing procedure, allergen extracts, limitations of tests, safety, risks, ability to detect and manage allergic reactions.
U39.8 Other Specified

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APPENDIX B GROUP 3 SERVICES – TEMPLATE FOR SERVICE SCOPE DEVELOPMENT

This template is intended to provide a checklist to aid the development of service scopes and also to provide an audit trail to demonstrate that all the principles for service scope development have been factored into the discussions.

Name of service:
Allergy
1. Does the scope reflect version 3 of the Specialised Services National Definitions set? Yes.
2. Does the scope reflect existing service specifications and policies, where they exist? Please list any considered. Yes <ol style="list-style-type: none"> 1. RCPCH care pathways 2. NICE guidance – anaphylaxis, venom IT, food allergy in children 3. BSACI guidelines – venom IT, IT for allergic rhinitis, rhinitis, rhinosinusitis and drug allergies http://www.bsaci.org/index.php?option=com_content&task=view&id=117&Itemid=1 4. EAACI guidelines – Declaration on immunotherapy

3. Does the scope reflect any agreed professional standards, both those listed in the SSNDS and those developed since their publication? If the service is a paediatric service, does it reflect the clinical relationships set out in *Commissioning safe and sustainable specialised paediatric services: a framework of critical inter-dependencies*? Please list those developed since publication.

Yes

1. Developing IQAS accreditation/registration standards
<http://www.rcplondon.ac.uk/resources/improving-quality-allergy-services-iqas-registration-scheme>
2. RCPCH care pathways <http://www.rcpch.ac.uk/allergy>
3. BSACI Guidelines
http://www.bsaci.org/index.php?option=com_content&task=view&id=117&Itemid=1
4. Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommendations on Suspected Anaphylactic Reactions Associated with Anaesthesia <http://www.aagbi.org/publications/publications-guidelines/S/Z>

4. Does the scope reflect national policy direction, where this exists? Please list the names of policy/ies reflected.

Self care of patients with long term conditions
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063157

5. Does the scope result in fewer than 50 providers (if the service is for all ages) and fewer than 20 providers for children's services? If not, explain the reason for this. Please append a list of the providers that would deliver the service?

Yes – see BSACI/IQAS registered centres list/procedures (currently in preparation).
http://www.bsaci.org/index.php?option=com_clinics&Itemid=26

6. Is the scope based on factors that can be objectively measured? What are the objective measures?

Yes – workload measurement processed can be developed as proposed

IQAS standard compliance can be monitored

Outcomes can be monitored by patient related outcomes measures (PREMS) and Quality of life tools HRQOL e.g. Itchy, sneezy, wheezy website – audit tool (paediatric)

Health related quality of life – EQ5D (adult)

Referrals pathways and adherence to guidance can be monitored.

A quality dashboard can be constructed.

7. What are the consequences of introducing the scope? For example: including activity that is not specialised, excluding specialised activity that takes place outside of specialised centres, excluding activity that takes place in outreach clinics.

1. Reduced variation in cost and quality of care
2. Continued inequality of access to specialist care
3. Worsened health outcomes for allergy sufferers with complex conditions
4. Avoidance of inappropriate use of non-conventional or ineffective therapies.
5. Potential that limited national commissioning of the specialist element of care will adversely impact on commissioning of local non-specialised allergy care

National commissioning should result in a more equitable distribution of highly specialised allergy services which are potentially at risk in the move to local commissioning.

It offers the possibility of improved governance, standardization, patient experience and quality as well as possible cost-efficacy improvements. It cannot address the unmet need for allergy services as a whole but can provide a nationally-commissioned framework of expert centres for rare and complex conditions and differentiate this activity from the bulk of locally commissioned allergy workload.

It should prevent patients from being treated inappropriately with potential dangerous therapies by inadequately trained personnel. Patients would not be driven in desperation to seek care from alternative practitioners.

8. Are there any financial consequences of introducing the scope? For example, loss of income for providers that would no longer be considered to be specialised.

Provided that local, less specialised services are commissioned by CCGs there should be no adverse effect on other providers.

The provision of a network of nationally commissioned specialised services and commissioning policies would reduce variation in cost and care.

This would simply be a national commissioning strategy for specialised allergy to reduce variation and cost and improve quality.

9. Please describe any political consequences of introducing the scope? For example, exclusion of providers who deliver a specialised service within an otherwise non-specialised setting or unhappiness amongst patient groups.

There may be some allergy centres who will not meet the definition of a specialist service delivering complex allergy at present, but they will be encouraged to improve according to IQAS criteria and network to ensure.

The anaphylaxis campaign fully supports national commissioning for the benefit of patients.

10. Would the scope benefit or disbenefit particular CCGs? For example, if non-specialised activity was included because it takes place within a tertiary centre, would the CCGs that refer to that centre benefit. What would be the impact of the scope on technologies/drugs that are currently often commissioned through individual funding requests?

Provided we differentiate clearly specialist from non-specialist care there should be no cross-subsidy.

Variation in access to IFR drugs/desensitisation would be reduced by common policies.

The benefit would be improved targeting of suitable subjects for anti-IgE and immunotherapy and also appropriate allocation and guidance.

11. Please describe any complexities in introducing the scope. For example, if the service is not currently commissioned by SCGs, will it be very difficult to assess the current level of spend on the service?

There are existing problems with coding which can be solved and a longer term solution can be evolved. There is a need to separate allergy and Immunology coding, both in adults and children. We are confident that accurate costing can be delivered using the tools available to us at present.

12. Is this an 'interim' scope? What could practically be done to refine the scope so that it better differentiated between directly commissioned services and those commissioned by CCGs?

This is the final scope.

13. Is there anything else that you think the Clinical Advisory Group should know about the scope?

National commissioning would ensure that the more severely effected patients are seen by a skilled and appropriate service. This would result in improved patient care, including better school/work attendance and performance, decreased morbidity and mortality and reduction of consequent health service costs of poor access to specialised care.

FEEDBACK

This process will need to be used to develop service scopes for all other specialised services. Please use this space to provide feedback on any ways in which the process could be improved.

Clearly the process is far too compressed in this instance. Insufficient time has been given to produce scopes and the support resource is inadequate for the huge task in hand.

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