



The Relationship Between Allergy and Clinical Immunology

**Report of a Working Group
Convened by the BSACI**

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Abbreviations

BPAIIG:	British Paediatric Allergy Immunity and Infection Group
BSACI:	British Society for Allergy and Clinical Immunology
BSI:	British Society for Immunology
CST:	Certificate of Specialist Training
CPD:	Continuing Professional Development
CSAC:	College Specialist Advisory Committee
EAACI:	European Academy of Allergy and Clinical Immunology
HST:	Higher Specialist Training
JCIA:	Joint Committee on Immunology and Allergy
JCHMT:	Joint Committee on Higher Medical Training
MRCP:	Membership of the Royal College of Physicians
NASG:	National Allergy Strategy Group
NTN:	National Training Number
PID:	Primary Immunodeficiency
PIN:	Primary Immunodeficiency Network
RCP:	Royal College of Physicians
RCPATH:	Royal College of Pathologists
RCPCH:	Royal College of Paediatrics and Child Health
SpR:	Specialist Registrar (with an NTN)

Recommendations

The BSACI and Clinical Immunology

Representation of clinical immunologists within the BSACI needs to be improved. While there are clinical immunologists on BSACI council there are no clinical immunologists on the executive or within some of the council sub-committees. We recommend that clinical immunologists are represented on each of the sub-committees of council and that a clinical immunologist is a member of the executive as chair of a clinical immunology sub-committee. It should be emphasised that the intention of establishing a clinical immunology sub-committee is to improve communication within the society and not to represent clinical immunology in any general sense. The BSACI should aim to improve communication with the wider clinical immunology community through links with their various representative bodies.

Allergy Services

The allergy community recognises the important role played by clinical immunologists in the delivery of allergy services in the UK.

The allergy and clinical immunology communities agree to endorse the principles described in the enclosed paper on allergy services.

The two communities will work closely together to improve NHS services for patients suffering from allergic and other immunology-mediated diseases.

Paediatric Allergy and Immunology

The BSACI continues to support the paediatric allergy and clinical immunology communities in their efforts to expand both sub-specialties.

Training

The BSACI should continue to focus on improving its educational and training programmes in allergic disease. The main vehicle for this will be the annual scientific meeting which should maintain its current format including a strong clinical immunology strand. As the number of allergy trainees increase consideration should be given to creating a programme of training days open to both allergy and clinical immunology trainees. The BSACI should make a priority the expansion of its educational activities by supporting directly and indirectly opportunities for CPD type activities in allergy, accessible to both Clinical Immunology and Allergy trainees and consultants. Efforts should be made to improve links between these two sets of trainees

Introduction

This working group was convened by the President of the BSACI (Andy Wardlaw) in response to a discussion about the relationship between allergy and clinical immunology at a BSACI 'think tank' meeting in October 2003 when it was felt that there was a degree of disharmony which was potentially damaging to both disciplines. The aim of the working group was to determine what could be done by the BSACI to improve relations between the two communities. The President is grateful to the members of the group for all their hard work and constructive comments during the production of this paper. It should be emphasised that the members of the group were acting as individuals and not representing any particular group within or outside the BSACI. This discussion paper is intended to stimulate debate and will be amended according to the comments received. When this debate is completed it is hoped that a final version will be adopted as a position paper by the BSACI.

The BSACI and Clinical Immunology

From the recent membership survey the current membership of the BSACI consists of 28% who describe themselves as allergists, 20% respiratory physicians, 20% Paediatricians and 16% clinical immunologists. We have 35 nurse members and 25% of the membership describe themselves as scientific. 3% were ENT surgeons, dermatologists, or gastroenterologists. Most but not all clinical immunology consultants and trainees are members of the society. Despite its name the BSACI is perceived, with justice, as being an allergy society. Its roots were in allergy and its main thrust has always been to take responsibility for allergy rather than clinical immunology (laboratory immunology, immunodeficiency, connective tissue disease, cancer immunology) services. It has tried to reach out to the immunology community firstly by holding joint meetings with the BSI and more recently by ensuring a strong clinical immunology strand at the BSACI annual meeting. These have however been relatively limited initiatives. One question that arises when considering the relationship between the allergy and clinical immunology communities is the extent to which the BSACI should do more to represent the interests of clinical immunologists.

Currently, clinical immunologists have a distinct identity but do not have a single professional society as their home. They associate with the BSI, BSACI, Royal College of Pathologists and UKPIN. At a representative level, they are represented at both the College of Pathologists and the College of Physicians and their interests in these colleges are represented by the Joint Committee on Immunology and Allergy (JCIA). Clinical immunologists generally take the MRCP and MRCPATH exams with CPD activities taken from both Colleges (but administered by the RCPATH). Oversight of the training programmes is held by the SAC in Immunology and Allergy which is a composite body based in the College of Physicians with representation from RCPATH, RCP, BSACI, BSI etc.

UK-based postgraduate activity for clinical immunologists is organised around both Royal Colleges, UKPIN, BSI, Travellers Club and its associated Junior Branch, (Hitchhikers) and the UK Supraregional Immunology Audit Groups.

From our initial enquiries, there is strong support for the idea that immunologists and allergists should work more closely together but mixed views about whether the BSACI should be the main professional body for immunologists. As a society the BSACI may have not clarified adequately our role for the immunologist in terms of their routine work practice and educational needs. The two communities have complementary strengths and allergists, through the BSACI wish to establish strong ongoing links for the benefit of allergy sufferers and to improve education, training and research links that satisfy both communities.

Educational needs and research activity overlap between the two groups and it would seem perfectly appropriate to create a common forum within BSACI where clinical allergists and clinical immunologists could meet and discuss matters of common interest. The concept of joint meetings between the BSACI and appropriate clinical immunology groupings should be explored as the need arises.

The clinical immunology community is well represented within the BSACI membership but representation of clinical immunologists within the deliberative bodies of the BSACI needs to be improved. While there are clinical immunologists on BSACI council there are no clinical immunologists on the executive or within some of the council sub-committees. We recommend that clinical immunologists are represented on each of the sub-committees of council and that a clinical immunologist is a member of the executive as chair of a clinical immunology sub-committee. It should

be emphasised that the intention of establishing a clinical immunology sub-committee is to improve communication within the society and not to represent clinical immunology in any general sense. The BSACI should aim to improve communication with the wider clinical immunology community through links with their various representative bodies.

Allergy and Clinical Immunology Services

Introduction

Allergic disease is very common and there are large numbers of patients who need help at different levels of involvement. A variety of existing service models have evolved in response to local needs and individual interests. In secondary care many, if not most, clinical immunologists provide specialised services in clinical allergy (according to the DH definition set no 17). Organ-based clinicians (chest specialists, dermatologists, ENT surgeons etc) and paediatricians also see patients with allergic disease.

In the UK there are insufficient specialised allergy services to meet the growing demand. Where both allergy and clinical immunology are undermanned disciplines, patients with allergic disease have traditionally either not been seen (the great majority) or seen by organ-based specialists. More recently with the expansion in the number of consultant clinical immunologists in the UK, approximately as many patients with allergic disease have been seen by this speciality as by allergists. The BSACI has estimated from its database of clinics and knowledge of members specialities that approximately 40% of allergy referrals to secondary care are seen by consultants who would regard themselves as allergists, 40% by clinical immunologists and a 20% by organ-based specialists with an interest in allergy. There is considerable geographic variability with almost all the allergists being concentrated in the south east of England. Thus allergy services for at least 21.75 million UK citizens are provided largely by clinical immunologists. In paediatrics there are fewer allergists or clinical immunologists and many patients are seen by general paediatricians with an interest. It was estimated in the RCP report 'Allergy the Unmet Need' that only about 10% of the patients who should be seen in secondary care are currently being referred by GPs for a specialist opinion. Several organ-based specialities in the UK are involved in providing adult allergy services including respiratory physicians, dermatologists, gastroenterologists and ENT surgeons. Organ based specialists often offer a limited service focused on the diseases relevant to their speciality. Both allergists and clinical immunologists vary in the allergy service they offer ranging from a comprehensive service to a limited one depending on local needs and resources. Few clinics have the resources and infrastructure support recommended by the Royal College of Physicians for an optimal allergy service (Allergy: Working for Patients)

Medical practitioners whether they come from a background of allergy, clinical immunology or an organ based speciality share a common objective in providing the highest standards of care for patients with allergic disease. We all strive to provide the best service and it is important that we respect and support the efforts of colleagues whatever discipline they are associated with in their efforts to provide allergy services often under sub-optimal circumstances. However all allergy providers recognise that the current situation is not ideal particularly in terms of lack of capacity for seeing patients.

We all share the aim of improving the level of care by increasing capacity, optimising patient care pathways and devising a model of care that best caters for their needs. Over the last three decades the nature of medicine, the resources devoted to it and the expectations of the patient have changed dramatically and will continue to do so. In particular there has been a trend for ever increasing specialisation. Both allergists and clinical immunologists recognise that the training they received and the environment in which their career paths and job plans matured may be substantially different to current and future trainees. With the recognition of allergy as a distinct specialty, it is timely to look at where we would like to be in ten years' time in terms of the provision of a more optimal service. The new model needs to take account of the capabilities of the existing and future trainees, the training curricula and training resources available while at the same time taking advantage of existing expertise.

The principal factor influencing the relationship between allergy and clinical immunology is the question of who delivers NHS based allergy services and how those services are structured. This

question has come into sharp focus with the formal establishment of Allergy as a speciality distinct from Clinical Immunology with a separate NHS code, training programme and CST and with the efforts of the allergists to campaign for better allergy services. The two communities to an extent have a different view of their role in delivering allergy services. The polarised and largely unrepresentative views are that on the one hand allergy services should only be led by consultants who see themselves as full time allergists (and who in future will have a CST in allergy). The alternative view is that clinical immunologists, who currently manage a very substantial number of allergy patients and deliver a high quality allergy service are both necessary and sufficient to lead NHS Allergy services in the future. A logical solution is that both models could be expanded to operate side by side, with mutual support from both the allergy and clinical immunology communities. Understandably, Clinical Immunologists may feel aggrieved that their very significant contribution to the delivery of allergy services has not always been properly recognised by allergists. This has been due in large part to a failure of communication between the two groups and highlights the need for a joint forum and a more full involvement of clinical immunologists in the development of allergy services, not least in now providing a unified response to government in their current review of allergy services. Allergy and clinical immunology are both small disciplines with overlapping interests. It is important that the two communities support each other and work in tandem to develop allergy services at national, regional and local levels.

The relationship between paediatric allergists and immunologists is harmonious and the principal issue (which is generic to all paediatric specialties), is the relationship between general paediatricians and paediatric allergists and immunologists.

Allergic (and allergy related) diseases

Central to the question of how allergy services should be delivered is the question which (if any) patients with allergy and immunology related conditions would be optimally managed by the specialist allergist rather than the Clinical Immunologist or an organ based specialist, which conditions overlap to a large degree and which patients are best managed by the Clinical Immunologist or organ based specialists.

In countries with well-developed allergy and clinical immunology services (USA and continental Europe) there is no distinction between allergy and clinical immunology in terms of competence or remit in allergic diseases. In many of these countries including the USA immunology laboratories are not run by Clinical Immunologists and allergy and clinical immunology services are provided solely by physicians which makes any comparison with the UK unhelpful.

The Royal College of Physicians and the Royal College of Pathologists manpower committees from the approximate incidences of allergic and immunological disease and the rates of referral suggest that both specialities require a considerable expansion in numbers of consultants (RCPATH manpower committee estimates a doubling of consultant immunologists to about 100 is required). The allergy community have promoted the idea of a network of specialised centres as described in 'Allergy the Unmet Need'. This envisages 2WTE adult and 2WTE paediatric allergy consultants serving a population of about 5 million with a total of about 12 regional Allergy centres in the first instance. If there is no central initiative it is even more important that allergy and clinical immunology work together on a local basis, with the type of consultant appointed (allergist and/or immunologist) being driven by local patient needs and the effective lobbying of both specialties in agreement rather than in competition.

Future Model of Allergy and Clinical Immunology Services

In the short to medium term specialised allergy services will continue to be delivered by a mix of clinical immunologists, allergists, and organ-based specialists with an interest in allergy. However it is widely recognised that the current position with regard allergy services in the UK is unsatisfactory and the central issue is how we can realistically work towards a high quality service in the next ten years and what this service would look like. There needs to be an ongoing debate between allergists and clinical immunologists on how best to develop allergy services in the future to better cater for the needs of patients with allergic disease. Solutions may vary geographically according to local circumstances.

The way forward

To form a basis for agreement we suggest that both disciplines sign up to the following principles:

- Allergic diseases are common and cause considerable avoidable morbidity and significant mortality in children and adults. Current capacity within the NHS is woefully insufficient at both a primary and secondary care level to adequately meet patient needs.
- Allergy and clinical immunology are overlapping disciplines with a shared underlying scientific basis.
- Both communities fully support the development of better allergy services and will work together to develop appropriate models of care which may include a network of well-resourced centres providing allergy services.
- The allergy community fully recognises the vital role made by clinical immunologists in the delivery of NHS secondary and tertiary level allergy services.
- The allergy community recognises that the current training of clinical immunologists is sufficient to enable them to provide a secondary and tertiary level allergy service in adults. They are committed to providing further support for training of clinical immunologists in allergy.
- The clinical immunology and allergy communities agree to fully support the development plans of each speciality including the creation of new SpR and consultant posts both at a local and national level.

Training and Education

Background

Training for immunologists has for some time been overseen by both the Royal College of Physicians and Royal College of Pathologists reflecting the fact that immunological disorders or deficiencies play an important role in many chronic diseases. Immunologists are typically responsible for the management of immunology laboratories and patients with immunodeficiency (especially primary immunodeficiencies) and other immunologically mediated disorders such as allergy, vasculitis and many others. Over the last 10-20 years direct clinical care activities have increased significantly. Training has evolved over the years to encompass these needs. In recognition of the increasing need for Immunologists to manage patients with complex medical problems, successful completion general professional training and MRCP (or equivalent) became mandatory requirements for entry to higher specialist training in Immunology over 10 years ago. Competence is tested through compliance with the JCHMT Training Curriculum, completion of laboratory training records and by the obtaining of the MRCPPath examination in immunology, which is still mandatory before trainees can be appointed to a consultant immunology post. The training curriculum for immunologists has been very well defined for some time.

Clinical scientist training programmes in immunology have also been developed. Clinical scientists who have undertaken such programmes and successfully completed MRCPPath then may then go on to manage hospital diagnostic immunology services. Although currently few in number continued expansion of the Clinical Scientist grade may provide the clinical immunologists with increased time for direct patient care in the future.

Allergic disease is largely managed by a combination of GP's, allergists, immunologists and organbased

(skin, nose, lung, gut) specialists. This workforce has been enhanced by academics studying allergy and allergic diseases such as asthma. The provision from this source has been centred round several academic centres. In the absence of a formal training curriculum, certification of training in allergy has until recently been awarded largely on an *ad personam* basis. Since 2001 allergy has been a separate speciality as defined by the Royal College of Physicians. The training curriculum is firmly established and approved such that informal accreditation in allergy, as with any other medical speciality, is no longer possible.

Training posts in both immunology and allergy are limited and have traditionally been afforded a low priority by the Workforce Committee of the present government. At the time of writing there were 33 SpR trainees in clinical immunology and 8 allergy SpR posts established in England and Wales. The paucity of training posts in allergy and immunology creates a lack of knowledge of the specialties and a reluctance for trainees to apply. The BSACI working with other professional groups should play a more major role in the breaking of this "vicious circle" by helping to advertise and popularize both specialties.

The Structure of Immunology and Allergy Training

In the UK at present, recruits to immunology and allergy SpR posts are expected to have spent a sufficient period of time exposed to acute general medicine, usually in a series of SHO posts, to be

able to effectively manage general medical problems and emergencies. Ratification of this training culminates in passing the MRCP examination. Possession of MRCP (or an equivalent qualification from abroad, ratified by the JCHMT of the RCP) is a mandatory requirement for obtaining an SpR post in immunology or allergy. Structured training is for 5 years and covers the entire curriculum in immunology or in allergy. Research is not an integral part of training curricula in immunology, allergy (or any other medical speciality). If undertaken substantively it is performed while “on leave” from the training programme, which is resumed when the research is completed. Up to one year of full time research can be counted towards the trainee’s 5 year training period.

An important role for the BSACI must be the encouragement of young doctors into both allergy and clinical immunology by increasing the exposure for undergraduates and newly qualified doctors to the area. At present, SHO posts are acquired more or less on a random basis. This is set to change with the government’s “Managing Medical Careers” curriculum, when specialist knowledge can be acquired as early as the second foundation year of training. This provides an opportunity to “capture” potential recruits at an earlier stage in their careers, though this carries an inherent requirement that Immunology and Allergy are involved at the Foundation level of training. In this regard the advent of ring fenced funding for small and shortage specialities might be helpful.

In Europe and North America, allergy training evolves out of increasingly specialised practice in medicine as the trainee gains experience. Allergy and Immunology trainees aim for “Board Certification” in their speciality, a process similar to undertaking SpR training within the UK. This is considerably more flexible in terms of timing and the undertaking of research. In the USA, the curriculum is well circumscribed. In Europe, attempts are being made by the EAACI to standardize the training curriculum across EU member countries, with the aim of producing “EU certified” trainees qualified to practice in any EU country. In Australia and New Zealand training of immunology and allergy is through a 4 year joint training programme covering all aspects of laboratory and clinical immunology and allergy.

Training Curricula

The training curricula for allergy and immunology are unique and largely independent at present. The corollary is that each speciality requires unique and distinct sets of trainers. In the allergy training curriculum, the only specified training in immunology is a period of laboratory training in the principles of laboratory tests relevant to allergy, and a “working knowledge” of the principles of diagnosis of the common immunodeficiency syndromes as well as principles of intravenous immunoglobulin therapy. These subjects are limited to a “working knowledge”, and unlike an immunology trainee the allergy trainee is not expected to know in detail how to independently perform laboratory tests or become involved in quality control and audit. Conversely for the trainee in clinical immunology, allergy training would normally be a minimum of six months spent in a general allergy and immunotherapy clinic. During this period the trainee would be expected to have extensive knowledge and experience in the diagnosis and management of general allergy problems.

In view of this, if the Society is to contribute to the training and education of immunologists as well as allergists, this would be very much a dual task and would require the expertise of clinical immunologists as well as allergists. In addition, although some training requirements would overlap, many would be unique either to allergy or to immunology. The Society would be required to extend the breadth of its remit and would need resources and increased breadth of membership to support this. The Society has a long way to go in terms of supporting training and research for allergists, let alone immunologists.

Current educational activities available to allergists and clinical immunologists include:

- The Society's annual meeting, which addresses topics of interest, both basic and clinical, presented by national and international experts and is a forum for the presentation of research in the form of submitted abstracts. There is some time and space devoted to clinical immunology, but this is limited.
- Clinical and Experimental Allergy, which is the second ranking allergy journal in the world. This contains regular reviews and editorials, although there is a relative paucity of practical guidelines and clinical case discussions which would be of more use to clinical trainees.
- The BSI annual meeting which is cheap to attend for all comers and especially juniors and trainees, and offers "state of the art" talks by international experts in the various fields of immunological research. The BSI also provides funding for local meetings, some of which may be clinically orientated. Overall, however, as with the BSACI meeting, there is relatively little emphasis on clinical immunology.
- Supraregional Immunology training is organised via the Association of Clinical Pathologists who arrange a programme of training days at the immunology centres throughout the country. These are held for 1-2 days approximately bimonthly and cover topics directly relevant to MRCPATH and clinical training. Sessions are open to both allergy and immunology trainees.
- UKPIN has a biannual meeting for 2 days which goes further to specifically address issues directly relating to primary immunodeficiency. UKPIN is also in the process of writing guidelines for the diagnosis and treatment of primary immunodeficiency disorders, some of which are available via their website which is easily accessible.

Both the BSACI and BSI suffer from lack of ongoing, day to day support for their clinical members, and especially trainees. This could be improved by the production of relevant literature and the organisation of meetings, and other teaching and CPD material, either published or on the internet. Again, although some of this material would be of common interest and relevance to both allergy and immunology trainees, much of it would be unique to each speciality and would be required to be produced by different sets of specialists.

An underlying problem is manpower. Both allergy and immunology are relatively small specialities, and organisation within both the BSACI and the BSI tends to be undertaken by a small group of dedicated individuals. The question arises whether the BSACI can undertake the production of training resources for allergists and clinical immunologists within its own membership, or whether the production of these resources would have to be contracted out, and if so how the costs of such a procedure could be borne.

Training Posts

Training posts in both allergy and immunology, as well as the trainers necessary to run them, are in short supply in both specialities. In the case of allergy, the government has consistently refused to acknowledge the obvious need for increased allergy services. This can be changed only by political pressure and enlightenment of politicians, commissioners and health care providers. The BSACI has made efforts to address this problem on a national front through the National Allergy Strategy Group, and also by other mechanisms. The development of immunology posts has been driven partly through local initiative partly through the need to have reliable immunology diagnostic facilities in place, at least on a regional basis and through a need to provide clinical allergy as well as PID services by appropriately trained and experienced staff.

Continuing Professional Development

In many countries, professional societies play a major role in the CPD of both trainees and established specialists. In the USA, most if not all allergists expect to attend the annual Academy meeting and derive many, if not all of the CPD points they require to continue to practice at this meeting. The Society might aspire to increasing attendance at its annual meeting by further addressing CPD needs in clinical allergy aimed at both clinical immunologists and allergists, as well as other professional stakeholders. This could be through meetings, articles, book or web based learning and an organised assessment system.

Implications for the Society

Fully embracing all aspects of training and continuing education of clinical immunologists would require considerable changes to the structure of the Society and additional expenditure.. This would be a major undertaking for the BSACI. and perhaps unnecessary since there are many other well established sources of training and CPD for immunologists. Therefore an alternative would be for the society to be the natural home and provider for CPD in allergy for both sets of physicians.

In summary it was felt by the group that the allergy and clinical immunology curricula were mature and the training programmes well defined, distinct but overlapping. With limited resources the BSACI should focus on improving its educational and training programmes in allergic disease which would be of benefit to both allergy and clinical immunology SpR's, consultants and other health professionals. The main vehicle for this would continue to be the annual scientific meeting which should maintain its current format including a strong clinical immunology strand. Other initiatives such as guidelines were also considered very important in this regard. As the number of allergy trainees increases, consideration should be given to creating a programme of allergy training days which would also be of benefit to clinical immunology trainees. The BSACI should prioritise the expansion of its educational role by directly and indirectly supporting opportunities for CPD type activities in allergy. These might include regional meetings in allergy, co-badged sessions on allergy within medical specialty national meetings (in respiratory medicine, dermatology, ENT, immunology and paediatrics) as well as educational initiatives in primary care, many of which are 'up and running'. Web-based activities include publication of position papers, guidelines, slides from sessions at the BSACI annual meeting and an on-line 'chat room' for members to post and discuss complex cases. More emphasis will be placed on involvement of trainees and other junior members of the society in our annual meeting, with discussed poster sessions and annual prizes for the best submitted clinical and scientific abstracts.

Joint Training Programmes

The idea of looking again at whether a joint training programme for allergy and clinical immunology was feasible and desirable was discussed. While there was some support for the idea both within the working group and during informal consultations at the JCIA and BSACI annual meeting there was no consensus for such a recommendation. It may be appropriate to revisit this issue in the near future, prior to any expansion within trainee numbers in both specialties.

Paediatric Immunology and Allergy

Background

The membership of the Royal College of Paediatrics and Child Health (RCPCH) includes physicians trained in all aspects of paediatrics and the College seeks to improve the health of all children in the UK. The Paediatric Immunology/Infectious Diseases/Allergy community in the UK is small, and is represented by a common special interest group within the RCPCH, the British Paediatric Allergy Immunity and Infection Group (BPAIIG). Higher specialist training within paediatrics falls under the remit of college specialty advisory committees (CSACs). A single CSAC oversees training programmes in paediatric allergy, immunology and infectious diseases.

Current Training Programmes

The National Service Framework for children set many standards for the care of children both within community and hospital environments. In particular it emphasised that all staff caring for children should have appropriate, child focussed training. This is recognised in Paediatric Specialist Registrar training programmes which are split into two years of general “core” training (general paediatrics, neonatology and community paediatrics) followed by three years of higher specialist training. One year of higher specialist training may be used for “out of programme” experience, such as research or experience abroad. The majority of Paediatric Immunology/Infectious Diseases/Allergy trainees use year 3 for out of programme experience, leaving 2 years for specific specialty training. Successful completion of this training programme results in a CCST in Paediatrics, with a special interest in paediatric Immunology Infectious diseases and Allergy.

Although there are some common elements of training, trainees in Paediatric Immunology, Allergy and infectious diseases follow a higher specialist training programme with an emphasis on only one of these areas. At the current time HST training posts are offered through the “National Grid” or through a variety of year 3, 4 and 5 year posts based in centres approved by the CSAC for training.

Most trainees in Paediatric Immunology/Infectious diseases/Allergy are seeking a career in infectious diseases, with numbers of immunology trainees remaining limited due to the current constraints on consultant post availability. A number of SpR posts in Paediatric Immunology/Infectious Diseases/Allergy are year 3 posts for trainees wishing to be general paediatricians. This system provides paediatricians with training to undertake elements of these specialities at secondary level, with support available from their monospeciality colleagues.

Paediatric Immunology

The RCPCH, via the BPAIIG, recommends that each region should have a tertiary service in Paediatric Immunology and Infectious diseases with at least 2 consultants. This is far from being achieved. At present, there are 6 NHS immunologists, a similar number of academic colleagues performing substantial amounts of clinical work and a small number of Paediatric infectious diseases consultants who also manage immunodeficiency patients. Most of these Consultants are based in two tertiary centres (Great Ormond Street, London and Newcastle). The training and job plans of paediatric Immunologists are substantially different to adult immunologists. With a single exception, they are solely clinicians and do not lead immunology laboratory services. Their clinical caseload varies between centres, but primary immune deficiency is the predominant component, with variable input to allergy, autoimmunity, rheumatology, bone marrow transplantation and infectious diseases. Much paediatric Immunology is still undertaken by adult immunologists supported by their general paediatric colleagues.

Paediatric Allergy

Allergic disease is the commonest cause of chronic disease in childhood and 48% of British children have atopic symptoms. Although a significant amount of paediatric allergy work is undertaken in the UK, provision varies geographically with only 6 Consultant Paediatric Allergists based in 4 tertiary centres (predominantly in the South). Care outside these centres is provided by many other professionals including general paediatricians with a special interest, specialist paediatricians (dermatology, respiratory), some paediatric Immunologists or general paediatricians supported by adult immunologists/allergists.

Future expansion of training opportunities and Consultant posts

In recent years there has been some expansion in Consultant posts in Paediatric Immunology, and although coverage remains poor in many geographical areas this is slowly improving. The CSAC and the Paediatric Immunology/Infectious Diseases/Allergy community recognises the need for increased numbers of paediatric allergists in the UK, both to treat complex allergy and to support the excellent work being undertaken in food and other allergies by general and other specialist paediatricians. There needs to be both an expansion of training opportunities, and ultimately an increase in the number of centres offering specialist allergy services, with an even spread across the UK. The intention of the CSAC is to increase national Immunology/Infectious Diseases/Allergy NTN's to 6. Given the current constraints on NTN's, and the national need for more general and community paediatricians, the CSAC has recognised that expansion of training opportunities in paediatric allergy cannot be achieved by central allocation of new NTN's. Instead, centres wishing to be training centres are encouraged to convert existing year 4/5 NTN's to dedicated allergy national grid numbers. This is already underway, with the first national allergy trainee post being made available in 2004.

Consultants in Paediatric Immunology, Allergy and Infectious Diseases recognise the need for all consultants treating children to have a broad training in general paediatrics at middle grade level, and for higher specialist training in all of the subspecialties to include experience of elements of the other two specialties. In paediatrics, there are inadequate numbers of consultant posts in both Immunology and allergy, and the community is moving together to rectify these issues. At the present time there are moves afoot to create a specialist-training pathway in paediatric allergy with the recent creation of two national training posts. The future will hopefully see the expansion of such training posts to meet the growing demands for paediatric allergy services.

In summary the relationship between paediatric immunology and allergy is good. The main issue is the establishment of more specialist posts in each discipline in competition for sub-specialist posts in other paediatric disciplines. The main recommendation is for the BSACI to support the paediatric community in their efforts to secure training posts and consultant positions for both allergy and immunology.