Key Constraints for ALLERGY Service Provision

Note much of allergy is specialist commissioned

- Staffing – medical, nursing, allied health, administrative
- Outpatient facilities with sufficient social distancing – requirement for some face-to-face visits; need for *in vivo* testing (eg skin prick and intradermal testing)
- Day-case facilities with sufficient social distancing – requirement for day-case procedures (eg food/drug challenges, drug desensitisation, venom/aeroallergen immunotherapy, home-therapy training)

Priorities

At 25% staffing/facilities capacity the following activity would be prioritised.

This assumes that patients will be reviewed by telephone clinics only, with subsequent face-to-face visit for testing where needed. Assumes very limited if any day-case facility availability.

Outpatient assessment:	Procedures:
- Drug allergy when urgently required and alternatives unacceptable* Including general/local anaesthetic allergy and chemotherapy/biologics* - Food allergy assessment where there is nutritional concern* - Angioedema with low complement C4 - Likely systemic mastocytosis with B or C findings - Severe anaphylaxis	- Facilitation of rapid drug desensitisation if possible when required - Food and drug challenges only in exceptional circumstances - Stop all immunotherapy (IT) up-dosing and restart when capacity resumes - Maintenance venom IT only if high benefit and low vulnerability

At 50% staffing/facilities capacity, in addition to the activities above the following activity would be prioritised.

This assumes that patients will be reviewed face-to-face if testing is required, with the majority being telephone clinics. Assumes some day-case facility availability.

Outpatient assessment:	Procedures:
- Drug allergy if alternatives available but therapeutically inferior* - Food allergy where there is limited diet* - Idiopathic anaphylaxis - Severe spontaneous urticaria and angioedema (for biologic therapy) - NSAID-exacerbated respiratory disease - Occupational allergy* - Venom allergy* - Severe asthma/eczema*	- Food and drug challenges if essential - Omalizumab home therapy training - Initiation of venom IT - Maintenance venom immunotherapy (IT) - Initiation of sublingual immunotherapy (SLIT)

At 75% staffing/facilities capacity, in addition to the activities above the following activity would be prioritised

This assumes that patients will be reviewed face-to-face if testing is required, with the majority being telephone clinics. Assumes regular day-case facility availability.

Outpatient assessment:	Procedures:
- Anaphylaxis with simple trigger and cofactors (eg asthma)* - Drug allergy with likely future need* - Non-immediate GI food allergy (eg eosinophilic oesophagitis) - Moderately controlled spontaneous urticaria and angioedema - Chronic rhinosinusitis with asthma*	- Food and drug challenges - Maintenance aeroallergen subcutaneous IT - In-hospital omalizumab dosing

At 90% staffing/facilities capacity, in addition to the activities above the following activity would be prioritised

This assumes that patients will be reviewed face-to-face if needed, with the remainder being telephone clinics. Assumes dedicated day-case facility availability.

Outpatient assessment:	Procedures:
- First presentation anaphylaxis* - Spontaneous urticaria and angioedema - General food allergy* - General drug allergy* - Chronic rhinosinusitis*	- Initiation of aeroallergen subcutaneous IT

*probably requires at least one face-to-face visit for skin testing or other investigation