



National Allergy Strategy Group (NASG) response to NHS 10-year plan FINAL

Q1. What does your organisation want to see included in the 10-Year Health Plan and Why?

Why change is needed? Introduction

Allergy is common affecting more than 1/3rd of adults and 40% of children- more than 20 million people. It causes a wide range of diseases, from mild to severe or life-threatening, and often one patient has multiple disorders and multiple allergies. These include food allergy, drug allergy and anaphylaxis, as well as rhinitis, asthma and eczema, urticaria and angioedema. NHS digital data shows a persistent rise in admissions for anaphylaxis and other allergies ¹. Acute reactions result in increasing numbers of ED attendance and allergic disease creates a huge burden of disease.

The NHS is ill-equipped to deal with this because Allergy is a Cinderella speciality. Growth has been patchy and driven by individuals locally. It is very difficult to start a new allergy service; with very little organisational will, made worse by lack of trainees to take up new consultant posts. There are too few specialist allergy services in hospitals; marked geographical inequality; and primary care has little knowledge of allergy. Patients are not diagnosed and managed properly, resulting in ongoing illness and cost, which should be preventable. This leads to more GP consultations, ED visits and admissions. Better quality allergy care means that disease is better controlled, better patient outcomes and reduced burden on the NHS.

There have been a series of national Reports from Royal Colleges and parliamentary bodies over the last 20 years, setting out this problem with evidence, most recently from the All-Party Parliamentary Group for Allergy and NASG, 2021 ². A detailed report by the British Society for Allergy & Clinical Immunology (BSACI) provided a count of disease episodes; and where in the NHS these could be managed: the numbers who could be managed in primary care if it was skilled up in allergy; and the numbers in specialist care. Numbers of patients with allergy and the complexity of the disease have increased since then. An Expert Advisory Group on Allergy (EAGA) has recently been created, jointly chaired by DHSC and NASG to support the development of a National Allergy Strategy although this strategy is currently not formally endorsed either by DHSC or NHSE.

The cause of the rise in allergy prevalence over recent decades remains unclear but based on current disease trends, the health burden imposed by allergy is likely to increase further.

What NASG wants to see (in brackets, in italics, examples of why this is needed)

1. Recognition of the need for improved allergy care for patients across the NHS and addressing the need for change.
(set out in Introduction)
2. This requires more specialist adult and paediatric allergy services in hospitals.
(inadequate specialist allergy services for population need; some areas have no service; some part-time services have closed, adding to the pressure on major centres; patients have to travel long distances; undiagnosed and untreated disease leads to increased workload and cost for the NHS)
3. This in turn requires increasing the number of trainee posts in Allergy & Clinical Immunology. Workforce planning should recognise the need to improve and extend adult and paediatric allergy hospital services.
(allergy and clinical immunology has the smallest number of trainees of any speciality; despite the huge burden placed on the NHS by allergic disease)
4. Improved education in allergy for GPs to enable more allergy care to be delivered in the community. Some training in a limited number of areas of allergy is needed for all GPs. Work between the Royal College of General Practitioners and NASG resulted in an 'Action plan for better allergy management in primary care'. After subsequent work, Allergy was added to the GP curriculum in 2019 but is not a requirement, and this is only relevant to GP trainees (not the established GPs).
(Allergy training and education is inadequate and most GPs do not access it; most medical students and GP trainees receive no clinical training in allergy. It is possible to become a GP with minimal or no knowledge of allergy. Short training opportunities are offered by BSACI).
5. Education in allergy for allied health professionals in the community, including nurses, dieticians and pharmacists. Extending the role of the asthma nurse to cover allergy would support long-term management in the community
(to improve allergy care in the community and increase the amount done in the community)
6. Inclusion of GPs with an extended role (GPwER) in allergy in the overall plan for allergy care. This is a new scheme. These GPs with more knowledge and more time than in a routine GP consultation could do more for allergy care.
7. Synchronised service development is needed if balanced progress is to be made. Widespread recognition of allergy within primary care, without service guidance on its management and without the creation of effective referral options for complex cases, would not be in patients' best interests. Primary care and specialist services need to be developed together.
8. Commissioning for allergy. A national and local commissioning plan is required. Some specialist services, e.g., for investigating anaphylaxis during anaesthesia, should be commissioned nationally. Some ICBs are not aware of the allergy needs of their population, and some do not commission allergy services. There should be clear referral pathways for adult and paediatric allergy in every region.

(some ICBs commission a form of immunotherapy that requires multiple hospital visits, but refuse to commission another form that requires one treatment visit)

9. Increase the provision of and access to immunotherapy treatments. The combination of lack of commissioning and lack of NHS specialised services means that patients are denied this disease-modifying treatment, even where NICE approved e.g. Palforzia for peanut allergy. Many fewer UK patients receive immunotherapy than in Europe and the US, e.g. only 7 in 100 eligible patients receive NICE-approved immunotherapy for venom anaphylaxis.

(patients are denied immunotherapy, the only disease-modifying treatment for allergy)

10. National leadership and oversight for this complex process for example through the creation of the post of an Allergy Tsar, to enable and oversee these developments.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

The large burden of allergic disease (described in Q1 above) is poorly managed because of a lack of knowledge of allergy at all levels in the NHS.

Challenges

- 2.1 Improved allergy knowledge for the whole healthcare community including GPs, nurses, pharmacists, dieticians, health visitors and midwives, is required to move care into the community.

- 2.2 Learning how to take an allergy history is key to making an accurate diagnosis but this is rarely taught and poorly understood and is the first barrier to competent management.

- 2.3 Education on ordering and interpreting specific IgE (allergic antibody) blood tests. Because of a lack of allergy knowledge, GPs often order random allergy screens, but the results can only be interpreted with an allergy history. A positive test is assumed to mean allergy which is often not the case. The wrong diagnosis is made.

(A short webinar providing targeted education could deal with this but must reach a very large number of doctors and AHPs.)

- 2.4 In large parts of the country there are no allergy specialists. Without this, support and training for doctors delivering allergy services in the community will not occur.

- 2.5 Adrenaline auto-injectors (AAIs), a treatment patients can self-administer for severe or life-threatening allergic reactions are prescribed by GPs. However, training on how to administer the AAI is often not given and the patients are unable to use the device³. This could be a role for the allergy nurse or the pharmacist.

- 2.6 Asthma (with ~65,000 admissions per year) is often driven by allergy, especially in children and younger adults but this is often not recognised. Failure to identify allergic triggers for asthma, e.g. pollens and fungal spores, was a contributory factor in the National Review of

Asthma Deaths (NRAD) ⁴. Identifying the asthma trigger and avoiding or managing this, reduces acute severe attacks. Separately poorly controlled asthma is a risk factor for severe and fatal food-induced anaphylaxis.

Enablers

- 2.7 Education of the many health professional groups is required. British Society for Allergy & Clinical Immunology (BSACI) and others provide education in various forms including primary care training days. Training via short modules or webinars would reach more staff. This could cover the simple allergic disorders, how to take an allergy history, how to select appropriate blood tests, and management. More patients could then be managed in primary care. Such education needs to be on the curricula of medical schools.
- 2.8 GPs with an extended role (GPwER) can now train in allergy. This is a new development. This role should be encouraged, perhaps through local commissioning. A trained GP, supported by allergy trained nurse, could be responsible for the allergy needs of a group of practices. They would have the expertise to deliver more specialist care than the general practitioner who has more limited time and knowledge. There is good evidence that this model can work well, reducing specialist referrals and saving money.
- 2.9 Developing primary care allergy services must be accompanied by a parallel increase in specialist allergy hospital-based services.
- 2.10 Primary care asthma nurses should understand the importance of identifying asthma triggers. And be able to give advice on avoiding or controlling triggers. Asthma nurses to be trained in basic allergy, and a new combined role of asthma-allergy nurse to be created.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in healthcare?

Challenges

- 3.1 Data sharing. Lack of shared access to medical records, across boundaries, particularly between hospital trust and primary care. Hospitals can access some GP records via GP Connect, but other practices are not connected (even when they regularly refer to their local hospital). The specialist is denied access to prescription records, blood test results and clinical information e.g. the drug(s) taken in the case of suspected drug allergy.
- 3.2 Various electronic records are in use across the NHS, EPIC being commonly used. Systems should be standardised to reduce electronic barriers between different Trusts or with primary care.

- 3.3 Data is needed to inform digital health in a modern NHS. There is a lack of allergy-specific data and data tracking across the NHS. Allergy coding is incomplete.
- 3.4 Integrated Care Boards (ICB) are responsible for commissioning allergy services to support their population's health needs; however, many do not hold data on the allergy needs of their community.
- 3.5 Access to near-to-patient diagnostics, such as remote spirometry or exhaled nitric oxide are not available for patients with asthma. This could support virtual consultations.

Enablers

- 3.5 An integrated digital system would facilitate medical record access across systems linking primary care to hospital systems and crossing ICS boundaries, speed up clinical assessments, and allow better coordination of allergy care by different HCPs treating the same patient.
- 3.6 Use of a standardised electronic system across the NHS
- 3.6 The NHS should facilitate the provision of national data on all allergic conditions to support service delivery, and workforce planning, that requires ICB reporting. Allergy UK propose a National Allergy Register to provide digital data to improve patient pathways and enable more proactive care planning, workforce planning, and improve patient care
- 3.7 The World Allergy Organisation's Upper Airway Diseases Committee has defined and proposed 16 Quality Assurance Criteria for E-Health in Allergy and Respiratory Care. These include patient education on the disease, co-morbidities, correct use of medication, information for HCPs on disease management, treatment, and research options, legal protection of the patient's data, accessibility of use, and integration of data into the patient's electronic records. These criteria for e-health tools aim to improve use by HCPs and patients, to ultimately improve patient health and outcomes of care. ⁵

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Challenges:

- 4.1 Incorrect drug allergy labels are common. About half a million people admitted to NHS hospitals each year have a diagnostic 'label' of drug allergy, with the most common being penicillin allergy. But 9 in 10 people with a diagnosis of penicillin allergy are not allergic. This has consequences – they are given alternative antibiotics which are costly and have more side-effects, resulting in prolonged hospital stays. This also carries the risk of increasing antibiotic resistance. Increasing GP's knowledge of the features of penicillin and other drug allergies would lead to fewer inaccurate drug allergy labels. NICE guidance is documentation, i.e. in suspected drug allergy to record the features at the time (this is usually in primary care) ⁶. Currently, when patients are investigated decades later, this information is not known. There is a BSACI guideline on penicillin allergy de-labelling, which can be provided by non-allergists, as yet slow to take off.

- 4.2 Failure to induce resolution of food allergy. Egg and milk allergy are common in infants and young children. Avoidance is the initial management. However early and gradual reintroduction starting with baked egg or milk products and slowly increasing (using the ‘egg or milk ladder’) leads to resolution in the majority. Often controlled reintroduction does not happen because of lack of access to paediatric allergists or allergy advice and the disease persists and becomes more severe.
- 4.3 Early introduction of potentially allergenic foods such as peanut, into the infant weaning diet, can reduce the risk of potentially lifelong allergy developing (the LEAP and EAT studies ⁷). This research impacted on international public health guidelines. These findings need to be implemented in the UK. Increased allergy knowledge and training among healthcare providers, including dieticians and health visitors, can help prevent those who are at risk by managing diets effectively in the community to reduce the prevalence of future allergy without hospital visits.
- 4.5 Identifying and managing allergy leads to control of the disease e.g. in food and drug allergy- symptoms can be stopped; in severe hay fever, asthma and eczema, disease control is better; with venom immunotherapy life-threatening anaphylaxis is prevented; with pollen immunotherapy for severe hay fever, patients can function and go to work. In many ways an allergy service reduces illness. However these benefits are available in a patchy way across the country, and many patients are denied access.

Enablers

- 4.6 Improving the allergy education of GPs and AHPs in the community
- 4.7 Creating GPs with a special interest in allergy (GPwER)
- 4.8 In parallel, increase the workforce in specialist allergy services in hospitals (both adult and paediatric)
- 4.9 Enable improved provision of allergen immunotherapy from the extremely low level, by increasing specialist service availability and improving commissioning.
- 4.10 The recommendations above (4.6 - 4.9) - will allow the identification and management allergy and control of the disease

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in. In order of descending priority

- 5.1 Establish an Allergy Tsar role, similar to a National Clinical Lead, but with the remit to progress the development and implementation of a National Allergy Strategy, in partnership with the National Allergy Strategy Group. The Tsar would be afforded cross-government cooperation and report to the Secretary of State for Health. They would engage with departmental policy leads, clinicians, and professional stakeholders

through the recently established Expert Advisory Group on Allergy and with the public through relevant patient groups. [Time frame 1 year]

- 5.2 Workforce planning to address the need for more specialist allergy services and increase the number of trainee posts in Allergy & Clinical Immunology: to allow the creation of new specialist services and expansion of existing allergy centres to meet patient needs. [Time frame 1 year]
- 5.3 Change to structure of ICBs such that each ICB has a designated lead for allergy services with the responsibility to collect and report on metrics related specifically to allergy, and allergy therapies delivered (treatments to include immunotherapy, adrenaline autoinjector uptake). A national register can then be compiled from the accumulated data from different ICBs thus allowing for evidence-based resource planning. Each ICB to have an officer responsible for commissioning local allergy pathways (or delegated responsibility) and to ensure patients have clear pathways to local allergy care (e.g. GPwER) and specialist services within reasonable geographical distance. This would include initiatives to integrate allergy-trained nurses and dietitians within primary care to address immediate service gaps. [Timeframe 1- 2 years]
- 5.4 Increase GP education in allergy, because 1 in 3 patients have allergy. Allergy to be included in the MRCGP examination (exit exam for newly qualifying GPs). Short allergy modules recommended for all established GPs [Time frame 2 years]
- 5.5 Allergy modules in nursing education and dietetic training alongside other relevant allied healthcare professions such as physician associates and pharmacists to be developed and mandated. [Time frame 2 years]
- 5.6 Specialist allergy centre service specification to include a requirement to support GPwER through the latter part of allergy training as well as networking to strengthen community health centres by incorporating allergy-focused services and expanding training, ensuring accessible and consistent allergy care across the country. [Time frame 2 years]
- 5.7 Break down barriers in access to specific IgE testing. For example, many specialists can offer excellent advice and guidance to GPs if they have the results of specific IgE blood tests. However, many GPs are barred from accessing these tests due to cost rules, preventing timely A&G. This requires a parallel increase in allergy education for GPs, on selection and interpretation of these tests. [Time frame 2 years]

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