BSACI
Improving Allergy Care
through education, training and research

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NHS 10-year survey (Coordinating a response with NASG)

NB: Asks for case studies, how you would prioritise these and at what level would you recommend addressing these centrally or locally?

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

1. Development of well-supported community healthcare workforce (GPs, practice nurses, pharmacists, health visitors) with accredited expertise in management of common allergic diseases.
   Training and education in allergy for GPs, Allied Healthcare Professionals and in the medical schools at present is wholly inadequate. Improved knowledge of allergy would mean more patients will have their allergy recognised and treated and the burden of disease reduced.[1]
2. Clear national commissioning plan with regional commissioning for allergy, reaching all regions of the United Kingdom. Creation of the post of a National Clinical Director for Allergy.
   Integration and moving into the community has failed in areas because allergy services have not been commissioned in a sustainable fashion or funded. ICBs are not aware of the allergy needs of the community and that allergy & immunology is a separate specialty. Some large parts of the country have no specialist allergy service at all. Ensuring clear referrals pathways to both adult and paediatric allergy care to be delivered in the community in essential. [2]
3. Increase in provision of and clear pathways for access to allergen immunotherapy in region of the UK.
   The provision of immunotherapy in the UK, is the only disease modifying treatment in allergy, yet many patients are unable to access treatment. Despite being a highly efficacious treatment, it is underused. Funding and access to NICE approved immunotherapy can significantly reduce the long-term burden of allergic disease and reduce health inequalities.
4. Development of integrated digital systems to facilitate medical record access across systems boundaries to speed up clinical assessments and allow better co-ordination of allergy care by different HCPs treating the same patient.

Development of digital systems to provide evidence base for workforce planning and service delivery. National agreements on data consent process for information sharing. Resources and support for implementation of patient-portals across integrated systems, including children and young people. Empowers patients, reduces health inequality.
Some areas are well served electronically yet not joined up. Links to primary care are very poor. Data consent policy is inconsistently applied.

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

Approximately 1 in 3 people have some form of allergy: a significant proportion of these are severe or complex where patients have multiple disorders with each one being triggered by different allergies. Fatal reactions occur, due to food, drugs and insects. Allergies can be complex but are poorly managed in the NHS due to lack of training and education. The British Society for Allergy & Clinical Immunology (BSACI) believe the 10 Year Plan should include:

- Improved allergy knowledge for the whole healthcare community who can offer seamless management across the whole healthcare community spectrum from GPs, Pharmacists (often first healthcare professional consulted for advice) nurses, dieticians, health visitors and midwives.

- Allergy was added to the 2019 revision of the GP training curriculum but to ensure allergy learning is undertaken it needs to be further embedded in the MRCGP examination. This means that GPs in future will have improved knowledge of allergy and be able to manage patients in the community and only refer the most complex cases to specialist allergy services.

- GPs with an extended role (GPwER) can train in allergy. This new scheme needs extra capacity for support from specialist centres to ensure that GPwER can complete their training.

- In large areas of the country, there are no allergy specialists. Without this, training and support for doctors working in allergy in the community will not occur and the move from hospital to community will not occur. Access to specialist care for the most severe patients will remain very poor.

- Foundation doctors (Years 1-2 of post-graduate vocational medical training) have no formal allergy training stipulated in the curriculum.[3,4] Changing this will

increase the profile of allergy and help increase the allergy knowledge of the whole medical workforce.[5]

- Pharmacists play an important role in advising appropriately on the self-management of allergic conditions such hay-fever and also in guiding those who may have a diagnosis but would benefit from more help and advice. Pharmacists could also support advice / training on how to administer an adrenaline auto injector and sign-post patients to other sources of support such as patient organisations who support those living with allergic diseases. Studies have shown that only one-third to one half of patients are able to demonstrate correct technique of use: this is a major problem.[6] Pharmacists are essential for advice on self-management and should play a role in adrenaline auto-injector training.

- Poorly controlled asthma is a risk factor for fatal food induced anaphylaxis. Asthma nurses should know how to take a focussed asthma and allergy history so that allergic triggers can be identified. They should be able to advise allergic trigger exposure control and be knowledgeable of the associated multi-system features of allergic disease such as eczema and rhinitis which commonly go unrecognised. Nurses also need to provide patients with practical training on how to use their devices and medications, especially adrenaline auto injectors. Extending the role of the asthma nurse to cover allergy would help with long-term management and could lessen the risk of severe reactions.

- Dieticians have no formal training in allergy, however they play an important role in managing both children and adults with food allergy. Ensuring dieticians in the community are adequately trained to manage food allergy patients is paramount.[7] The BSACI work closely with the Food Allergy Specialist Group (FASG) to increase allergy knowledge, however food allergy training should be made mandatory.

- Health visitors and midwives should be aware of and be able to recognise and advise on presenting symptoms of food allergy in infants. Current data on the failure to recognise this results in unacceptably long delays to diagnosis. This however can change by ensuring midwives receive appropriate allergy training linked to competencies. BSACI are developing an education platform which will deliver education for the healthcare community; however, education again will need to be mandated.

- ICBs not aware of the allergy needs of the community and that allergy & immunology is a separate specialty. Ensuring clear referrals pathways to both adult and paediatric allergy care to be delivered in the community is essential.

The NHS should facilitate the provision of evidence-based data on allergic conditions to enable workforce planning and service delivery. At present, routinely available data such as hospital episode statistics are insufficient for this purpose.

- Electronic patient records have variable and inconsistent allergy alert flag mechanisms and available codes are insufficient. This is a risk to patients. National recommendations, informed by allergy experts, for best practice in recording, coding and flagging allergies to food and non-drugs in addition to existing drug-allergy recording are required.

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

Challenges:

- Lack of shared ('across boundary') access to medical records. For example, if a medical team is asked to investigate a case of possible anaphylaxis, or of drug allergy, having ready access to the notes from the time of admission with anaphylaxis, or in the case of drug allergy, access to the past medication used, would really speed up and enhance the quality of that assessment.
- Data sharing agreements within the NHS vary inconsistently, frustrating the efforts of teams even in neighbouring systems to access essential patient data. This is a significant issue not only between referrer and e.g. hospital specialist, but also at regional level when teams come together to work on quality improvement projects, in particular those relating to patient safety.
- The NHS has not been able to access near to patient diagnostics, such as remote spirometry or exhaled nitric oxide for patients with asthma.
- Inconsistent and patchy implementation of patient access to their electronic health-records beyond the NHS App. Minimal consideration of children and young people for this. This misses an opportunity to empower patients and improve equity of access.
- Poorly designed workflows and electronic patient record systems lead to an increase in administrative work for clinical teams and contribute to burn-out across the workforce therefore reducing the availability for appointments.[8]

Enablers:

- Development of an integrated digital system to enable HCPs to access each other's medical records, linking primary care to hospital systems and crossing ICS boundaries.

- Development of an evidence-based data stream focussed on allergy health care to support workforce planning and service delivery with ICB reporting.
- By collecting and analysing data from patients, healthcare providers can gain valuable insights into the effectiveness of treatments such as immunotherapy. Investment in registries such as the BRIT Registry for Immunotherapy offer the prospect of learning about geographical inequalities in treatment provision, in the quality of treatments offered, and also on changes in population health (secondary prevention) that may occur in areas where provision is better.
- Offer patients remote spirometry (e.g. send device to patient and have remote coaching) to enable effective virtual clinics.
- Support rapid implementation of other high quality remote monitoring systems in the future.
- Support healthcare providers with the implementation/roll-out of electronic patient portals for all systems and support patients and/or their proxies to sign up and use the portals to ensure equity of access to their information and empower self-management and patient activation.
- Ensuring that clinician interaction with electronic health records is kept to a minimum, supporting data entry by other staff and rapid commissioning of secure other solutions such as e.g. AI note-takers where appropriate will free up clinical staff to deliver more patient care.

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

Challenges:

If an allergy to a food or drug is identified, avoidance can prevent further acute episodes:

1. Most patients with food allergy are managed outside of specialist care and there are low rates of adrenaline autoinjector prescription for those who have previously had anaphylaxis, putting patients at risk of potentially fatal consequences, or, where a food allergy label is incorrectly applied, resulting in unnecessary food restrictions and lower quality of life.[9]
2. Local anaesthetic allergy is often suspected but is only rarely present. Confirming this and removing the 'allergy' label means that these patients no longer need a general anaesthetic for minor surgery or dental extraction, reducing resources to the NHS and hugely benefits the patient.
3. The 'EAT' study (Early introduction of allergenic foods to induce tolerance) demonstrated that early introduction of potentially allergenic foods such as peanut, into the infant weaning diet, can reduce the risk of potentially lifelong

allergy developing. This research impacted on international public health guidelines. These findings need to be implemented on a national scale. More knowledge and training amongst healthcare providers 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. Access to, and knowledge among HCPs about aeroallergen immunotherapy is poor. This results in avoidable suffering from severe seasonal allergic rhinitis or risk of severe reactions due to venom allergy.
5. Gaps in allergy awareness and knowledge delay access to care for conditions, such as e.g. infant eczema, where early diagnosis and treatment will support secondary prevention of associated conditions.

Enablers:

1. Improving education of general practice workforce and expansion of GPwER network.
2. Improving provision of allergen immunotherapy so allergic disease secondary prevention reaches the population it should.
3. Improving the education of primary care nurses (asthma nurses can learn to deliver allergy care to meet the needs to their asthmatic patients), health visitors and pharmacists.

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 (all are about the same priority)

1. Change to structure of ICBs such that each ICB has responsibility to collect and report on metrics related specifically to allergy, and allergy therapies delivered (treatments to include immunotherapy, adrenaline autoinjector uptake). Each ICB to have 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 opinion within reasonable geographical distance.
   [Timeframe – inside 2 years]
2. Specialist allergy centre service specification to include requirement to support GPwER through latter part of allergy training.
   [Timeframe – inside 1 year]

3. 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.
   [1 year]
4. Allergy modules in medical schools and in foundation training to be developed and mandated, with inclusion of allergy in the MLA (medical licensing exam)
   [Time frame 2 years][10]
5. Allergy modules in nursing education and dietetic training to be developed and mandated.
   [Time frame 2 years]

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