AN NHS PLAN FOR ALLERGY - MAKING A START

1. This paper sets out the options available to the Department of Health on how to modernise NHS allergy services. A summary is given in paragraphs 2 to 5 below.

2. Central Government initiatives are required to give an effective start to the improvement in NHS allergy care. The initiatives need only be small scale. They would be the precursor, not an alternative, to close to patient developments which can be the main driver for change once allergy services have become part of the NHS mainstream. Central intervention to begin change will give direction and leadership, will make it possible to address the most serious gaps in service first, and will help to make the overall process more effective and more efficient.

3. Mixing (supportive) central initiatives with (mainstream) local developments would be the right way to develop services for allergy. It need not create difficult policy precedents for the Government, given its desire to make service development a local health authority responsibility.

4. The initiatives which are needed would help to create a core NHS allergy service where currently none exists. This would eventually cost an additional £5.6 million pa for the English NHS, building up over a number of years. Some of the costs will be offset by necessary interventions to prevent an imminent deterioration in allergy care. And – although this cannot be quantified, given the information which is currently available on the NHS – reduced calls on other parts of the NHS would also result as provision for allergy becomes consolidated around the new core.

<u>The Analysis – Four Parts</u>

5. Four aspects to the analysis are presented, as follows

A : Growing need and inadequate services : There is a current epidemic of allergy in Britain. An estimated thirty percent of the population now have allergic disease; the proportions for children are ten percentage points higher still; the numbers with complex, severe or life threatening illness are growing disproportionately. Faced with the unprecedented levels of need which result, but with no effective service base from which to grow, the allergy service of the NHS needs to be transformed if it is to provide 21st century care. A start must be made on doing this.

B: *Achieving Change - the right response* : The core issue is how to create a health service capable of meeting the needs of the 1/3 of the population who have allergy - given the current, effective absence of any national, clinical or commissioning infrastructure for such a service within the NHS.

- While recognising there is a problem, the Department of Health has said that it does not see any need for central intervention. Additional general flows of funds into the health service, combined with close to patient decision taking within a devolved NHS, will – Ministers have said - be sufficient to address any significant problems the service may face from the epidemic.
- A consensus of clinical and patient opinion, however – including the Department's own expert advisers on the management of the NHS medical workforce – have concluded that some central action will be required to respond to the situation which is developing. Well managed, what has become necessary could be the start of an effective change process resulting in the creation of new services for people with allergy within the NHS.
- That said, the choices facing the Health Department are not – as they have been presented - between centralised or devolved decision taking. The advice being offered to the Department – principally by the Royal College of Physicians - is that strategic central investment in medical manpower will support and complement, not cut across, locally driven change.

C: *The NHS allergy workforce* : The NHS currently offers a vestigial allergy service across all sectors of care.

- The small group of specialist, consultant allergists is forecast to become even smaller in the coming decade because not enough doctors are being trained to replace those who will retire. This is an exceptional situation across virtually all medical disciplines in the NHS.
- In consequence the Department's expert advisers on the medical workforce are proposing that the balance should be redressed. If their advice is accepted, the resulting increase in centrally funded, specialist training would begin a process of improvement in the way recommended by the Royal College.
- For paediatric allergy, where successive birth cohorts of children are driving the epidemic, allergy doctors face a very serious and growing imbalance.
- Ensuring the medical workforce is appropriately trained - given the national information requirements for planning, the very high premium on getting workforce numbers right and the timescales and costs of delivery – is anyway a responsibility of central government.
- Using a workforce intervention to initiate change need not, therefore, be seen as cutting across the preference for allowing local health decision taking to drive change wherever possible.

D: *Ends and Means* : Government's plans for the NHS promise a service which is there when its patients need it, access which is timely and convenient to arrange and which offers the best in modern medicine. Wide ranging change will be needed if an NHS allergy service is to become part of the mainstream NHS, delivering on this promise. With commitment and imagination most of what is required can be developed within a devolved service; but creation of the initial core group of allergy doctors cannot. For this group to be recruited, trained and located, Government must act using resources it controls centrally. Doing this opens the way for other changes which can be driven locally and within the medical profession.

A BREAKDOWN OF THE PROBLEM AND A WAY FORWARD

The allergy epidemic and current services

6. In June 2003 a Royal College of Physicians' expert committee (1) reported, having studied the emerging allergy epidemic in Britain. The report contained new clinical and epidemiological estimates of allergy prevalence - the latter based on official data - an appraisal of the current state of allergy services in the NHS and recommendations for improvement.

7. On allergy prevalence, the Royal College found reliable evidence of an allergy epidemic in the UK.
a) an estimated 30% of the population have an allergic disease (15 million people in England); 10 million people have active allergic symptoms in any year;
b) at least 2.5 million people (1 in 6 of those with allergy) have sufficiently severe symptoms to require tertiary level clinical help. A further group of people need more specialist help than can be provided in primary care; it is difficult to estimate the size of this group;
c) these prevalence rates are among the highest in the world;
d) 40% of children have allergy – each birth cohort increases the numbers of people needing help; the epidemic continues to grow, making allergy a particular problem for today's children, and their families, and for tomorrow's young adults;
e) there are no socio economic class, ethnic origin or geographic variations in the disease.

8. On NHS allergy service provision, the College found widespread poor standards. There is insufficient understanding, training and adherence to good clinical practice within primary care, where major parts of a disease with such widespread prevalence must ultimately be managed. NHS Commissioners have inadequate information about allergy; and few of them seem to have thought about the illness or the requirements for an allergy service. In the hospital sector, the College found clinics providing services for allergy patients mixed in with the management of other conditions. And, in the absence of specialised alternatives, doctors who are not allergists, some of whom have had little or no training in allergy, are working to help to manage the epidemic, as an add-on to their main role. It follows that patients are not receiving adequate standards of care; children may be particularly badly served.

9. As far as the specialised allergy services are concerned, the College found gross under resourcing and an inequitable geographic distribution. However, in 6 locations across the country (3 of these in London, with others in Southampton, Cambridge and Leicester) the College found a significant concentration of allergy expertise, and service and training capacity. For the most part – although not exclusively - this national expertise on allergy had been developed by doctors funded primarily in their capacity as clinical academics and researchers.

10. Therefore, major improvements in the hospital based services, combined with a significant "reskilling" programme in primary care, are required to enable the NHS clinical workforce to meet the challenges of the allergy epidemic.

11. An independent assessment of one aspect of what will eventually be needed is available from the Royal College of Physicians' report on NHS specialist workforce requirements across all medical disciplines (2). Using a methodology common to all specialities to take account of emerging need, the latest Royal College assessment is that 520 additional consultant allergist posts in England and Wales are needed in order to provide a competent, reputable and fully fledged specialist allergy service within the NHS. This is just one measure of how far commissioning will need to drive the service once its basic infrastructure is in place.

12. The patient's organisations, quite reasonably, are asking for

- Convenient and timely access to the health service; and appropriate and accurate diagnosis of allergy;
- Treatment or referral; convenient and timely access to a clinic in the case of referral;
- For evidence based information to be provided to individual patients on how to manage their allergy;
- Continuity of care to be available; and
- For emergencies both to be well managed by clinical staff who know about allergy and for the emergency to be used as an event triggering an appropriate medical review.

13. Meeting these aspirations for allergy patients from today's virtual standing start will require

- The introduction into primary care, more or less de novo, of competence to diagnose and manage allergy (as opposed to the drug treatment of specific allergy driven diseases, such as asthma);
- The parallel introduction into most teaching hospitals of an allergy service, providing convenient local access for people with more complex allergy;
- And the development of a regional or tertiary level service which can manage the most complex cases and provide overall leadership during a time when, however fast the service grows, a serious imbalance between needs and capacity will exist.

14. We have estimated the service gap which exists. Estimation is inevitably imprecise because the NHS has virtually no clinical information available on allergy. The most complex cases will be appearing throughout the service classified and managed as other, specific illness. We can make no estimate of the gap in the case of primary care. But we have concluded as follows for specialist services, for the UK as a whole

> "The numbers of children with allergy in need of specialist help are estimated to be increasing by over 40,000 each year across the UK. An estimated minimum of 2.7 million people currently need specialist diagnosis and treatment for their allergy. NHS allergy clinics are able to cope with a maximum of 50,000 new cases a year – less than 2% of estimated unmet need assuming no annual increase in need. All current clinics, working as they are, would take 50 years to clear the backlog, if there were to be no new cases of severe or complex allergy". See the annex to this paper for more detail.

Achieving Change

15. Department of Health Ministers have agreed - in debates in the House, in answer to Parliamentary Questions and in correspondence - that there is a need for improvement. But they have also said that decisions on how great a need, and on what priority should be given to this in relation to other areas of need for service, are the responsibility of local health authorities and trusts in partnership with other local stakeholders – not of central government.

16. For allergy, this approach is bound to result in inaction. The reasons for this are common to all clinical areas not currently identified as a centrally determined, **national priority** – even with the increases in health finance currently in evidence, local priorities are being squeezed out by the pressing urgency to deliver results on centrally driven targets.

17. And in the case of allergy there are additional considerations, namely

a) *clinical knowledge of allergy is poor* across all sectors. A primary care led approach, for instance, would not be appropriate at this point for this reason (1,3). This does not rule out investment in a better prepared primary care workforce – indeed the reverse – but expectations of what can be achieved through such an investment must be constrained until there is an infrastructure of clinical expertise within which it could be fully utilised. And local clinical leadership is precisely what is lacking.

b) *the NHS does not know, in any regular and reliable way, where its allergy cases are, how many there are and who is managing them.* It needs to rely on estimates of the kind provided through the Royal College, and in the annex to this statement, in the absence (until recently (4)) of a recognised way of coding allergy work within the NHS. Even then, because allergy care is suffused across a wide range of NHS and private health care, it will remain difficult to build a true picture of the clinical workload for the foreseeable future. In this situation local commissioners have, and will have, effectively no robust, local clinical information base to work from.

c) the seriousness of the developing *workforce situation* explained in paragraphs 24 – 30 below, and local awareness of the national picture, is a case in point. We are aware of no Department of Health instructions, advice or information which has been given to local service commissioners on how to decide or predict local specialist workforce capacity or requirements**.** And local commissioners seem unaware or at best unclear about the appropriate investment levels for the future clinical workforce. And in the circumstances, when juggling to meet cost pressures from existing services, they can hardly be expected to take a new situation seriously, and develop new services, unless told to do so or unless local pressures build up in an unavoidable way. It is then, of course, too late for long term investment into having the right workforce in place to manage the new situation.

d) not surprisingly, *local commissioners are paying little or no attention to the population's allergy need*. To give one example: in January 2004 Department of Health Ministers and officials provided the names and contact details of NHS officials in lead PCTs in England responsible for commissioning allergy services. Thirty contact names and addresses were provided. All were immediately contacted to ask what they had done with respect to allergy services and what priority they attached to the area. 5 months later 7 have replied. One has said they attach importance to allergy. One has refused to answer the questions. The others do not commission allergy services, so do not appear to think allergy is important. The response from the authority saying allergy is important in their area is difficult to interpret as it is in a part of the country which relies on "block contracting". Under this arrangement those who provide a range of services receive a general guarantee and are trusted to determine the mix they provide across clinical services. It is difficult to see any scope for commissioner driven change in this situation. And elsewhere commissioners clearly have other things on their minds.

18. How, then, to start the changes required beginning from this situation? It has been said that if allergy patients were to become more vocal, and to make their voices heard by local health authorities, then the prospects for change would improve. Certainly patient's organisations in allergy are contacted by very large numbers of people seeking help; the Royal College Report documents the contact levels. But it would be perverse if the only way to achieve change in a health service professing to be sensitive to patient need was by turning patient's requests for help into campaigns for service improvement.

19. There must be a better way. The Royal College of Physicians have proposed a way. Other growth strategies, it was thought, would demand substantially larger investment to get them off the ground and, without clinical leadership, the results across the country would be at best uncertain.

20. The College has, therefore, proposed an initial concentration on tertiary allergy care for those in the most need to give the earliest and most direct possible impact on the provision of high quality allergy services across the NHS. It has proposed that

a) a core initial infrastructure of regional allergy centres could be created, a minimum of 1 for each population of 5 – 7 million people and providing for both adult and paediatric allergy;

b) the centres might be centrally sited within their local populations, or dispersed across the region – depending on local service configuration;

c) they would deal directly with the most complex clinical cases; in doing so they would be addressing the most serious need and would help to reduce service pressures, making more effective the clinical management of the most complex cases;

d) they would also be an educational and information resource for their areas – providing training and clinical assistant opportunities, and path finding the clinical management of emerging, complex allergy; and they would network with others contributing to allergy care;

e) in these wider roles they would support the development of regional and local expertise among both service commissioners and other providing units;

f) and they would become the allergy champions making locally driven service development a reality. The wider roles would therefore be at least as important as that of direct service provision.

21. The College judgement is that, with this core in place, the essential initial impetus would exist for more local developments to drive change. Implementation of such a way forward requires training to be provided for an additional 32 specialist allergy consultant posts, covering adult and paediatric allergy – 4 posts, 2 for adult allergy consultants and 2 for paediatric allergists in each regional centre (numbers of posts are calculated as whole time equivalents for clinical care). The consultant posts themselves would not need to be resourced until consultant training for them had been completed. But prior commitment to create these would be needed to attract good young doctors into the new core service structure for allergy. The costs would build up to an additional £5.6 million pa when all the trained consultants were in post.

22. Capacity exists to provide this amount of additional training for specialist allergy. But new ways of networking will need to be developed so that the new allergy doctors have access to both specialised supervision and to patients in parts of the country where new specialist services must be located. While other parts of the country have allergy services run by doctors from other specialities, and it is important that these are recognised, there are currently no specialist allergy services in England west of Bournemouth and north of Manchester. The current specialist allergy centres will, therefore, need to find ways of networking with clinics located in the north, west midlands and west of the country.

23. It is perhaps relevant to set the additional costs in context. Academics from three British universities have very recently published estimates of the current cost of allergy to the NHS (5). They have estimated £1 billion across the UK; and they have concluded that "the more serious systemic disorders…. are rapidly increasing". This will prove to be an underestimate. It is based on historic NHS data; and, as the authors say, the epidemic is escalating and the rates of serious and complex allergy are growing disproportionately. Reality may well now have outstripped this assessment. It is also relevant that

a) expensive medical emergencies for allergy are increasing. There was an eight fold increase in community prescriptions for allergic emergencies in the decade to 2001 (6). Since the 1990s, hospital admissions for anaphylaxis increased seven fold and more than doubled for other systemic allergic conditions (6).

b) adverse drug reactions account of 5 percent of all hospital admissions and 15 percent of inpatients have a hospital stay prolonged as a result of drug allergy (7).

c) Service pressures resulting from the allergy epidemic which are currently experienced across the NHS would be relieved if a dedicated allergy service were to be developed. See annex - we have assumed a ten year period to clear the current care backlog. In that scenario, and not taking account of new cases, between 10 and 12 percent of clinic care provided for allergy patients could be delivered by doctors with other specialities providing allergy cover. These valuable services would need to remain in place, working as they are. But pressures on them would be correspondingly less.

Workforce Issues

24. There are currently only 26.5 whole time equivalent specialist allergy consultant posts in the English NHS, with a higher proportion than in other specialities being filled by individuals supported by academic funding (42%) and / or working part time for the NHS.

25. Tertiary services, once established, will be required to provide training and education to undergraduates; primary and secondary care education and support in establishing allergy clinics; and very importantly research and development to inform clinical practice . Consultants in these centres will have to deliver a mix of academic and service provision. The number of consultants proposed (see 21.) is calculated on the basis of whole time equivalent NHS funded service posts.

26. In total 5 NHS funded training posts currently exist in allergy. Recently an additional training post became available for 2004, in future making a total of 6 (5 of which are centrally funded) training posts.

27. With the extra post included, the most recent forecast of the expert group set up by the Department to advise on medical workforce planning (the Workforce Review Team (9)) is that by 2012 the NHS specialist allergy consultant workforce will have declined by 3 per cent, taking into account predicted retirements, the academic and service mix of the discipline and all current and planned training. The advice, therefore, is that allergy will soon fail to maintain even its current specialist service contribution to the NHS. It will be one of only two medical disciplines which will decline in size across the medical workforce planning horizon. The allergy services available to patients will deteriorate in consequence, from a mixture of increased need and reduction in the size of the workforce.

28. The situation is considerably more serious in respect of paediatric allergy. There are only 6 consultants in paediatric allergy, 4 of whom receive academic funding. Four of the 6 have been appointed in the last 3 years; so, the paediatric allergy workforce is likely to decline slightly in size in the next decade; but it is of course totally, inadequately small. None of the 6, because they have academic responsibilities or are part-time, spend time equivalent to a full-time NHS consultant on clinical care for children with allergy.

29. The Department's medical workforce advisers are therefore saying that centrally supported training provision in adult allergy should be increased by an additional 10 posts for 2005 – 06, with a further 10 for 2006 – 07 (10) . If implemented as part of a national plan for allergy, this would both make up the impending shortfall due to retirements and fully implement the proposals of the Royal College as far as services for adults with allergy are concerned. Initial training costs would be met from the medical manpower training programme; and they would be contained overall within the total cost estimates provided in the Royal College Report. A Government decision is awaited on this latest advice.

30. A way forward for paediatrics is different because the training arrangements for doctors who work with children are specific to that discipline. Regional Committees work with training quotas for paediatricians from all the disciplines within their region and may assign training numbers for sub specialities. It is possible therefore to assign to paediatric allergy some proportion of each region's general paediatric training quota. A training programme for paediatric allergy but combined with 2 other specialisms has just been developed, and one national grid post created. However, a separate sub-speciality training programme for paediatric allergy is needed; and the whole arrangement is exposed to the catch 22 discussed in this paper. Without experts and advocates for allergy within the planning and allocation arrangements, the need for change cannot be registered effectively. As elsewhere, the approach of the Regional Committees would change if the Department of Health were to say that it is important to develop the service.

Ends and Means

31. Allergy commonly affects many organ systems and it is common practice in the UK for such patients to end up attending separate clinics for different problems, which are often not recognised as allergic in origin. The burden of disease in allergy patients is therefore unrecognised as well as unmet, and current management is wasteful of NHS resources. A comprehensive allergy service will not only improve the holistic care of patients and remove this enormous burden on their quality of life, but also has the potential to reduce costs and relieve the load on other disciplines currently picking up these patients. An improved allergy service would thus be cost efficient.

32. This paper has discussed the rationale, context and options for making a start on the improvement of allergy services in the NHS. It key recommendation is straight forward and is in line with the recommendations of the Royal College of Physicians. There needs to be an initial, central investment to create a core workforce of allergy specialists. The investment would be through the medical training programme in the first instance. As such, it would not be in open conflict with a general desire to devolve decisions into the NHS wherever possible. It would need to be a followed up by commitments to finance subsequent new consultant posts in allergy.

33. By taking this step, and by saying it is important to do so, and why, a way would become open to move forward discussion on other issues – like the training of primary care doctors in allergy, within the structures being created; and like improving the paediatric allergy training curriculum. While these are not direct Government responsibilities, acting on those issues which are its responsibility would help to create an environment where other work can be orchestrated and progressed. Subsequent developments, having created the new core for an allergy service, could be locally and professionally driven.

34. The Department is being asked to bring allergy care into the mainstream of the NHS and to let it be known that this is the intention. To achieve this end a national plan for allergy will ideally be needed, with both central and local aspects.

At the start, a core specialist service is required. For this, commitment by the Department to the following essentials is needed.

- Intervention to provide for 20 additional specialist training posts in adult allergy (CCST Allergy) by 2007; and 18 additional adult and 18 additional paediatric allergy consultant posts for trainees to move into;
- Support for the creation of a separate paediatric allergy sub speciality and allocation of training posts in this by 2007;
- Support for discussion with RCGP on making allergy a more central part of training of tomorrow's GPs;
- Development and distribution of an action plan which would make clear who, within the devolved NHS, is accountable for the allergy service locally and which would provide the information and other means for the accountability to be discharged.

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Annex :

Estimates of specialist allergy clinic capacity and population need

Summary

1. The numbers of children with allergy in need of specialist help are estimated to be increasing by over 40,000 each year across the UK. An estimated minimum of 2.7 million people currently need specialist diagnosis and treatment for their allergy. NHS allergy clinics are able to cope with a maximum of 50,000 new cases a year – less than 2% of estimated unmet need, assuming no annual increase in need. All current clinics, working as they are, would take over 50 years to clear the backlog, if there were to be no new cases of severe or complex allergy.

Approach

2. We thought it useful to form estimates of allergy clinic capacity in relation to estimated population need.

3. In the time and with the data available the estimating process is inevitably imprecise. Estimates are provided for the UK taken as whole.

4. In the calculations below an indication is given, at each step, as to whether an aggregate under or over estimate is likely to result.

Clinic capacity

5. *Clinics.*

The BSACI data base of NHS allergy clinics, published on the BSACI website (bsaci.org) was used for the estimate. Other clinics in the country may offer an allergy service. True capacity may therefore be somewhat higher than these estimates. But we have no reliable data on the additional services on offer. And it was judged that the BSACI members' clinics comprise the core of the current national, evidence based allergy service.

6. *Doctor Sessions.*

The numbers of self defined, half day doctor sessions available for each clinic in the data base were used as the measure of clinical capacity. These show

   a. Dedicated clinics led by an allergy specialist have 123.5 half day sessions available per week.
   b. Other clinics offer 184.5 half day allergy sessions (since patients with other illnesses may also be treated in these clinic, this may be an over estimate of true capacity). Most do not offer a comprehensive service. These clinics are run by consultants in other specialties.
   c. Total tertiary and secondary care for allergy is therefore estimated at 308 half day doctor sessions a week.

7. *New Patients per session.*

It was assumed that a doctor might diagnose and treat 4 new and 4 repeat cases at each clinic session. This is a broad approximation; the true figure will vary with the case mix being managed in the clinic. Many clinics are trying to see patients only once (increasing throughput); this means that they see patients only once, but for longer.

8. *The working year*

The Royal College of Physicians working year protocol for manpower forecasting was used - a 42 week clinic year. On this basis the existing clinics can diagnose and treat new cases as follows

a. Specialist clinics (123.5 x 4 x 42) = c 20,748 patients a year
b. Other clinics (184.5 x 4 x 42) = c 30,996 patients a year
c. Total capacity (308 x 4 x 42) = c 51,744 new cases a year.

9. *Numbers already treated*.

In order to form an estimate how many people who require specialist help may already have received it, we assumed that all current clinics offering an allergy service have operated for the last 5 years and have discounted from the equation the number of new cases they might be assumed to have treated. (This is could result in either under or over estimates. Clinics have closed over the period; and the number of doctors working in the existing clinics have increased. On balance, given the need to decide a broad estimate based on the most robust available data, we have assumed equivalent capacity exists over the five year period).

10. The results indicate that, of the need estimate – see paragraphs 11 to 15 below – (51,744 x 5) = 260,000 of the people needing specialist help may already have received it.

Population need

11. The allergy population estimates published in *Allergy : the Unmet Need* were principally used for this.

12. *Aggregate need*

30% of the total population (18 million UK; and 15 million in England) have allergy. 40% of children in allergy

Specialist care for adults

1 in 6 people of those who have allergy are estimated to have sufficiently severe symptoms to require tertiary level, specialist help – 3 million people. It was recognised by the Royal College that a further group of patients required more specialist care than could be provided in primary care; but no estimates could be made of the size of this additional population.

14. *Outstanding potential case load.*

The total of outstanding allergy cases in need of specialist help is in consequence estimated at a minimum of (3,000,000 – 260,000) = **a minimum of 2,740,000 across the UK**.

15. *Specialist care for children - new cases each year*

With a UK current birth cohort of 650,000 and using the same assumption as in the paragraphs above for children, an estimated **minimum of 43,000** new cases of paediatric allergy requiring specialist advice can be expected to present each year. This discounts all new cases of adult onset allergy.

Needs and current capacity

16. *Conclusion*

Estimation with the information available can give at best order of magnitude results. As services develop, more robust data must be created to support service planning. Taken as a whole the results show

a. *Current Need*
   - An estimated minimum of 2,740,000 people need specialist help with their allergy. They have not received it.
   - The available specialist allergy clinics are able to diagnose and treat 20,748 patients a year – around 0.8% of estimated current need.
   - All clinics offering some type of allergy service, with any capacity to diagnose and treat allergy above primary care level, are able to manage 51,744 patients a year – less than 2.0% of estimated current need.
   - To put this another way. All current clinics, working as they are, would take more than 50 years to clear the allergy backlog, if nothing changed.
   - To put this another way again. Concentrating growth in service capacity into the development of a specialist allergy service within the NHS (as recommended by the Royal College) would still need to be supported by other clinical services. But pressure on these services would be relieved. Assuming a ten year clear up rate for the estimated needs backlog, and also assuming no new need emerging, the other clinics would be able to contribute 10 – 12 % of clinic care over the period, working as they are.

b. *Developing need*
   - An estimated minimum of 43,000 new cases of paediatric allergy in need of specialist help are occurring year on year.
   - Therefore, new severe, paediatric allergy need requiring specialist advice, year on year, is estimated to be more than twice the size of the capacity of current specialist allergy clinics (adult and paediatric taken together); and eighty percent of total clinic capacity.

c. *The total picture*

   These estimates take no account of imbalances which exist in primary care. Insufficient data exists to make any such estimates.