How can nurses contribute to providing better allergy services and care for patients?

Even though allergy affects one third of the UK population, NHS allergy care is suboptimal. Treatment guidelines can help staff to make changes to their practice.

INTRODUCTION

There is now good evidence to show that around one third of the UK population will develop allergic symptoms at some point in their lives, accounting for approximately 6% of GP consultations (Gupta et al, 2007).

The most common problems are allergic rhinitis, asthma and atopic eczema (Fig 1), all of which have increased significantly in prevalence over the last 3-4 decades but now appear to be levelling off. In contrast, small but increasing numbers of patients experience the more acute systemic allergic disorders, namely food allergy, urticaria (Fig 2), angioedema (Fig 3) and anaphylaxis.

Hospital admissions for severe allergic problems, such as hay fever, symptoms can be irritating, disruptive and sometimes disabling and have been shown to impair exam performance in schoolchildren (Walker et al, 2007). They also constitute a significant healthcare cost; a recent report (Walker et al, 2007) estimated the cost of allergic rhinitis in the US at over $11bn (The Lancet, 2008).

Comorbidity is common and it is this that is particularly problematic to manage for both patients and healthcare providers.

Several respected organisations have clearly stated that allergy services need to be improved (House of Lords Science and Technology Committee, 2007; House of Commons Health Committee, 2004; Royal College of Physicians, 2003), and it is almost unprecedented that such consistent statements indicating a need for improvement have resulted in so little action in the NHS itself.

MODEL OF CARE

The majority of people with allergic problems in the UK are managed in primary care by healthcare professionals. GPs continue to express grave concern about access to allergists and NHS allergy care overall (Hazeldine et al, 2010). GPs may receive specialist medical support in this role primarily from general paediatricians and organ based hospital specialists (for example, an ENT specialist for allergic rhinitis, a gastroenterologist for food allergy and a respiratory specialist for asthma), with additional support, in some regions, from clinical immunologists and allergists.

While this model could be satisfactory for the majority of people with relatively mild single organ disease, it has several significant shortcomings which mean that allergy is not managed optimally in the UK.

Most healthcare professionals have received little training in diagnosing, assessing and managing people with allergic problems that may occur in multiple organ systems. However, most mild or moderate allergy symptoms (such as hay fever, allergic asthma, urticaria and some food allergy problems) can be managed successfully in primary care by healthcare professionals with appropriate interest and training. Nurses with an interest and training in allergy have an important role in managing people with allergic comorbidities.

Allergy training must enable practitioners to take a holistic approach to diagnosing and managing allergic conditions so that mild or moderate symptoms can be managed effectively and life threatening ones identified and referred to specialist allergy services where necessary.

The House of Lords Science and Technology Committee (2007), House of Commons Health Committee (2004) and RCP (2003) all highlighted the lack of postgraduate training in allergy, and the RCP recommended improved access to postgraduate training as an essential prerequisite to improving allergy practice in primary care. There is good evidence to show that structured allergy training for primary healthcare professionals improves patients’ quality of life (Sheikh et al, 2007).

The second shortcoming is that GPs and practice nurses who want to identify an allergic trigger are hampered by difficulty in obtaining finance for diagnostic tests. Skin prick testing requires training, involves a cost, is time consuming and is not reimbursed by the NHS; specific IgE testing is difficult if not impossible to obtain in

PRACTICE POINTS

- People with allergy problems in the UK do not receive optimal care, despite the fact that several organisations have highlighted shortcomings.
- While more specialist allergy centres have been recommended, primary care must remain at the forefront of allergy care.
- Nurses in primary care can contribute to improving services by setting up clinics, and in acute care, specialist nurses can arrange training in allergy management.
- All nurses should be familiar with clinical guidance on common allergic conditions.
many regions. Both tests require specialist interpretative skills, which the majority of primary care teams do not have, while other diagnostic tests, such as patch testing or double blind placebo controlled food challenges, are generally not available and should in any case be undertaken in a specialist setting.

Third, in more complex cases where specialist advice is needed, most GPs have little choice but to refer to local organ based specialists, which is often problematic as they themselves may have little allergy expertise. This means patients often see more than one organ based specialist if their allergies affect multiple systems.

Finally, while it would certainly be preferable for a fully trained allergist to assess and manage such people, this is often impossible as very few UK specialist allergy centres provide a comprehensive package of care (see www.bsaci.org for details of NHS allergy clinics).

In response to the House of Commons Health Committee’s (2004) damning report on allergy services, the Department of Health (2006) reviewed all aspects of allergy care provision and identified three areas in which initial action was of vital importance:

- Establishing levels of need for allergy services;
- Exploring the scope for creating extra training places for allergists;
- Considering the options for NICE guidelines on allergy, and work with the Royal Colleges on other guidance.

This was closely followed by the House of Lords Science and Technology Committee (2007) report, which recommended that more allergy centres should be established. However, it is clear that for careful monitoring and evaluation will mean it may be several years before people with allergy problems can look forward to being able to easily obtain a referral to a local specialist.

THE CAMPAIGN TO IMPROVE CARE FOR PEOPLE WITH ALLERGIES

Specialist led initiatives to increase the number of hospital training posts in allergy have so far failed to generate further training places for allergy as a single specialty. Although the campaign to improve access to tertiary allergy services continues, this model is unlikely to meet the needs of the large numbers of patients involved (5-10% of the population), the majority of whom have mild or moderate allergy symptoms.

Moreover, in view of the failure of allergen avoidance measures to improve clinical outcomes for people with eczema, rhinitis and asthma, and the costs of establishing consultant-led specialist centres, an amoral pragmatic and cost-effective approach would arguably be for greater investment in improving service provision in primary care. Healthcare professionals interested in allergy in primary care are focusing on policy change at primary care trust and strategic health authority level, trying to engage commissioners with recognising the importance of providing high quality allergy services.

The British Society for Allergy and Clinical Immunology’s primary care group (see www.bsaci.org) recently successfully established allergy as one of the Royal Colleges of General Practitioners’ clinical priorities during 2010-12 (tinyurl.com/rcgp-priority). The RCGP is in the process of developing competencies to underpin the development of community based allergy services. While all these initiatives are important to establish a service framework, much can be achieved by individuals working within their practice/primary care trust to identify their own level of interest and knowledge and set up services accordingly.

To help healthcare professionals identify what level of services they might consider setting up, different levels of training in allergy management have been developed based on the different needs of primary care professionals (Ryan et al, 2005). DEVELOPING LOCAL ALLERGY SERVICES

Primary care must remain the frontline provider of allergy care. Standards of care, however, do need to improve and to achieve this, a multifaceted approach is needed including:

- Improving access to accredited postgraduate training courses;
- Improved access to diagnostic testing;
- Identifying quality outcome parameters which may be incorporated into future versions of the General Medical Services contract;
- Introducing practitioners with specialist interests in allergy to oversee and facilitate implementation of such an approach.

Roles for community nurses in allergy management can be embedded within existing services by ensuring that allergic triggers are considered when seeing patients with asthma, rhinitis, conjunctivitis, urticaria/angioedema and eczema. Sensitivity to suspected allergens can be confirmed by measuring specific IgE (not total IgE, which is not diagnostic) in the blood, although such tests are unreliable if interpreted without linking them to a good allergy history (Levy et al, 2006; Ryan et al, 2005).

Primary care allergy services may take many different forms, depending on local skills, interest and funding available (Levy et al, 2009). One route is to set up a specific allergy clinic within a practice or PCT that acts as a local referral centre for people with allergy, with the aims of:

- Improving the care of people with allergy and their symptoms and quality of life;
- Reducing inappropriate referrals to acute or tertiary care;
- Ensuring appropriate pharmacological and non-pharmacological management;
- Providing education and advice to help patients to manage symptoms.

Specific objectives might include:

- Confirming or refuting a diagnosis of allergy previously suspected by the GP or the patient;
practice review

BOX 1. OTHER RESOURCES

- Allergy training at diploma and degree level is available from Education for Health; please contact Laura Edwards, allergy education coordinator, on 01926 838 969.
- The British Society for Allergy & Clinical Immunology, a healthcare professional organisation, aims to improve the management of allergic diseases in the UK. It has recently established a primary care group that represents the interests of GPs and community based nurses, and has an online discussion forum which can be accessed by non BSACI members by contacting Gail Ryan at primarycare@bsaci.org or 0121 351 4455.
- A joint conference – The Essential Primary Care Allergy Update – organised by the PCRS-UK, BSACI, RCGP and Education for Health is taking place on 9 September 2010. For more information see www.redhotions.com/allergyday or www.pcrs-uk.org

- Further developing and implementing a care pathway for people with allergy;
- Maximising quality of life by eradicating symptoms through minimum treatment and advising GPs on prescribing;
- Facilitating patient self management via patienteducation, allergen avoidance advice and correct use of medication;
- Ensuring appropriate follow-up;
- Reducing inappropriate referrals to allergists/immunologists/ENT specialists, thereby reducing waiting times.

It is important to provide guidance on which patients should be referred to and to standardise the patient pathway within each PCT.

DEVELOPING SPECIALIST NURSES WITH AN INTEREST IN ALLERGY

Although specialist allergy clinics are few and far between, much can be achieved by nurses working in existing nurse specialist roles in acute care respiratory, dermatology, immunology, paediatric and ENT units.

Again, training in allergy management is required to develop the skills associated with complex allergy diagnosis. Allergy specialist nurses do exist (see www.bsaci.org for NHS allergy units) from whom others can learn. Such roles include responsibility for performing diagnostic skin prick testing, patch testing (to investigate contact dermatitis), conducting food and drug challenges (diagnostic investigation of food or drug allergy by administering test doses of the suspected trigger and monitoring the response) and administration of allergen immunotherapy.

PLANNING FOR THE FUTURE

Although allergy continues to be poorly managed in the NHS, there are significant and varied opportunities for nurses in primary, acute and tertiary care to improve services for people with allergic disorders.

Support from professional societies such as the BSACI (which has primary care, nursing and paediatric subgroups) and the Primary Care Respiratory Society UK is available. Free resources such as the toolkit entitled How To Make Your Case For Education and Training are available from the charity Education for Health (www.educationforhealth.org). This contains evidence based, disease specific business proposals for nurses to use to establish their levels of knowledge, understanding and experience. They can use it to plan development of their competencies to meet the health needs of their practice population in a way that is meaningful to the Quality and Outcomes Framework, the Knowledge and Skills Framework and national workforce competencies.

Box 1 provides further details on resources available.

CONCLUSION

With no extra money coming through centrally forestablishing new allergyspecialist services, we need to do what we can within existing services to ensure people with allergic problems receive the best possible care.

Given that allergy affects approximately one third of the UK population in one form or another, it is something that most nurses are likely to encounter regularly.

Familiarising yourself with treatment guidelines for common conditions (for example rhinitis, asthma or eczema) could help make small changes to individuals’ everyday practice and would be collectively and cumulatively effective over time.

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