British Society for Immunology

CIPN

Clinical Immunology Professional Network

BSI-CIPN WORKFORCE REPORT:

Moving towards a workforce equipped for the future

December 2025

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This report was funded through the provision of educational grants from BioCryst, CSL Behring, Grifols and Octapharma. These organisations have neither influenced nor contributed to the content of the report or any of its associated activities.

Who we are

The British Society for Immunology Clinical Immunology Professional Network (BSI-CIPN) is an integrated and impactful professional network for individuals working within clinical immunology. Our mission is to lead the delivery of excellence in patient care in clinical immunology through education and training, advocacy and engagement, and research. We provide a strong voice for clinical immunology in policy and public affairs and support the immunology community to network and engage with each other across many disciplines.

The BSI-CIPN's membership includes over 220 professionals in the clinical immunology space including doctors, healthcare scientists, pharmacists and specialist nurses. The Network is used to share best practice and guidelines and to foster collaboration, ultimately improving care for patients.

This report has been endorsed by the following organisations:

The Association of Clinical Pathologists

BSACI Improving Allergy Care through education, training and research

Immunology & Allergy Nurse Group

IBMS Institute of Biomedical Science

Association for Laboratory Medicine

British Society for Immunology CIPN Clinical Immunology Professional Network

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Foreword

It is a critically important time for clinical immunology. As we come to understand more about the immunological mechanisms behind a growing number of conditions, we are not only learning more about how the immune system works but also discovering and applying new ways to treat immune-related conditions to help improve our patients' quality of life.

Recent research has demonstrated that there is a rising demand for our services, with the latest data highlighting increases of 11% each year,[1] alongside minimal, if any, increases in staffing. In particular, demand is rising in allergic disease, for which clinical immunology teams also provide care. Team members across our services and from different professional groups are feeling this strain. We want to give the best care that we can provide, but in the current climate it is becoming increasingly difficult to meet the pace of need with the workforce that we have.

As the BSI-CIPN, we want to make the status of our workforce clear to government, regulatory and commissioning organisations, NHS workforce planners, and within our own localities. There is much more that could be done to support and welcome a flow of new talent into our community, to prevent valued staff leaving the profession, and to ensure there is stronger national oversight and understanding of the specialty so our patients can access the services they need.

But first, we need to shine a light on the current staffing levels within our services across different professional groups, and demonstrate how this corresponds to population size and need. As such a small specialty, we are especially vulnerable to service collapse, and this new analysis shows the extent to which some services are running on what can only be described as skeleton staffing for large swathes of the population. This is not good enough, for our patients or for our dedicated and passionate teams.

There needs to be urgent recognition of the value of clinical immunology and allergy, as well as commitment from national decision-makers to address workforce challenges before these issues become unmanageable. As professionals working within clinical immunology and allergy, we know that demand for our services is only going to increase exponentially given the surge in the development of new immune therapies, demographic changes, and increasing prevalence of many conditions we see in our practice.[2,3]

We urge decision-makers at the national and local levels to read our report and action the recommendations. We're grateful to everyone who considers this piece of work, and look forward to working with you to make meaningful change, for the benefit of the patients we serve.

Professor Siniša Savić,
BSI-CIPN Chair

Dr Patrick Yong,
BSI-CIPN
Workforce Lead

Executive summary

The NHS workforce is the engine that keeps our healthcare system running. It needs support, investment, and growth in line with clinical innovation and patient need.

The clinical immunology and allergy workforce is currently under severe strain, and some services are extremely vulnerable. Patient demand is growing across all areas of clinical immunology and allergy practice, and it is highly likely these trends will continue in the coming years.[1]

In this report, we highlight the current state of the specialist clinical immunology workforce in the UK, with a new analysis cross-referencing staffing with population numbers at a national level, and at a regional level in England.

Findings

Our findings demonstrate the high variability in staffing of clinical immunology and allergy services in parts of the UK when weighted to population numbers across professional groups. The situation is particularly critical in Scotland, with Wales also in a challenging position.

Fifteen services across the UK are covering huge population footprints with only one or two consultant immunologists, leaving these services extremely vulnerable to collapse. Staffing across other professional groups, in particular nursing, healthcare science, and support staffing, also presents a varied picture, highlighting the need for a comprehensive assessment of the clinical immunology and allergy workforce that is needed to meet current and future patient demand.

We urge national decision-makers to take urgent action to prevent the situation from continuing to deteriorate so that patients across the UK can access timely, local care.

Recommendations

1. There should be an urgent, nationally driven, full-service review for clinical immunology and allergy within each of the four UK nations to establish the workforce that is needed.

2. We support the Royal College of Pathologists recommendation to establish 17 additional immunology training posts by 2027 to cover current vacancies and a further 35 by 2030 combined with a commensurate increase in consultant posts.[1]

3. Longer term, comprehensive workforce planning for clinical immunology and allergy should be routinely carried out at a national level in each of the four UK nations. Training pathways should form a core part of this work for all professional groups.

4. Alongside national action to improve training pathways, employers should proactively support the next generation of clinical immunology and allergy staff and help future-proof services by taking steps to ensure ringfenced training, education, and supervisory time within senior clinical, nursing, and scientific job plans is genuinely implemented.

5. Data on service activity, workload, and outcomes should be collected locally and published nationally. Efforts to improve coding within published workforce data should also be initiated to give a more accurate picture of the immunology and allergy workforce.

6. There should be strengthened efforts to ensure regional and local commissioning organisations understand the value of clinical immunology and allergy services, and future service need, to optimise outcomes for patients.

"Healthcare scientists are a crucial part of the clinical immunology workforce. We must better support our valued staff currently working within clinical immunology and allergy to ensure that a career in the sector is both rewarding and attractive, and promotes ongoing professional development.

This report demonstrates that additional resource is needed to be able to nurture and retain new talent coming into the specialty across professional groups. Longer term, comprehensive, workforce planning is needed, with training pathways at the core of this. It's time for policymakers to commit to bolstering the immunology and allergy workforce for the future."

Rachel Dale, Healthcare Scientist Representative for the BSI-CIPN and Clinical Scientist, University Hospitals of Derby and Burton NHS Foundation Trust

"The clinical immunology and allergy field is facing unprecedented demand. This new report showcases just how fragile the workforce has become due to a lack of workforce planning. My nursing colleagues work hard to deliver quality care to our clinical immunology and allergy patients as part of a multi-disciplinary team, and as workload increases, support for the workforce must keep pace.

Support for our patients is at the heart of what we do, and our patients deserve to be confident in accessing services no matter where they are in the country. It's clear that now is the time for a national workforce review and for policymakers to establish a long-term plan to stabilise and grow clinical immunology and allergy services."

Jill Edmonds, Nursing Representative for the BSI-CIPN and Consultant Nurse, Liverpool University Hospitals NHS Foundation Trust

"Clinical immunology and allergy is a small but critical NHS specialty, yet years of inadequate workforce planning have left services under-resourced and, in some areas, close to collapse. Despite the dedication of our clinical teams, current staffing levels cannot keep pace with patient demand. This report sets out clear evidence of a service at breaking point, with staff stretched to look after huge populations. Too many patients are facing a postcode lottery when it comes to access to services, with the situation in Scotland and Wales particularly critical.

With this report, we are calling for an urgent, nationally led workforce review with sustainable, long-term planning at its centre. To inform this, we need better data on workforce activity, capacity and demand.

Policymakers must act now to reduce pressure on services and ensure specialist clinical immunology and allergy services can be accessed by everyone who needs them – no matter where they live. The BSI-CIPN stands ready to work with the wider sector to implement the report's recommendations and build vital capacity within the specialty."

Professor Sinisa Savic, Chair of the British Society for Immunology Clinical Immunology Professional Network (BSI-CIPN) and Consultant in Clinical Immunology and Allergy, Leeds Teaching Hospitals NHS Trust

Introduction

Clinical immunology and allergy in the UK

The focus of clinical immunology and allergy specialist care in the UK is on understanding, diagnosing, and treating immunodeficiencies, complex allergies, and autoimmune and autoinflammatory disorders, as well as providing diagnostic laboratory services for immunological testing. The scope of practice and research continues to evolve, driven by expanding use of immune-based therapies in conditions such as allergies, cancer, and autoimmune conditions.

Specialist teams are led by one or more consultant clinical immunologists and/or consultant clinical scientists. The team includes clinicians specialising in immunology and/or allergy, healthcare scientists, nurses, and pharmacists. The specialist services may take input from other members of the multidisciplinary team, including psychologists or genetic counsellors, and allied healthcare professionals, such as dieticians and respiratory physiotherapists.

Why did we write this report?

It is an important time for the NHS in the UK. All four UK nations are still feeling the strain from the pandemic and many providers are still struggling with the backlog alongside growing patient demand and increasing complexity.[4] The NHS workforce is the engine that keeps the healthcare system running. It needs support, investment, and growth in line with clinical developments and patient need.

Our clinical immunology community has identified the workforce as a key priority for the specialty, as many are understandably concerned that this support and investment is not currently in place. For a small and vulnerable speciality such as clinical immunology, the challenges with workforce are multifaceted. These include current staff numbers being too low to fully meet demand, routes into and out of the workforce (with significant numbers of consultants due to retire), and a fragile pipeline of new trainees and staff coming into the specialty across professional groups.[1]

Demand from within the core patient cohorts seen within the speciality – immunodeficiency and allergy – is also rising, along with the complexity and volume of diagnostic laboratory testing. Recent insight from the Royal College of Pathologists[1] shows that 76% of services reported that they do not have enough consultants to meet clinical demand, with a majority relying on unpaid overtime. The College also obtained insight from a Freedom of Information request that demonstrated that immunology and allergy referrals are rising, on average, by 11% year-on-year, with the number of tests requested also rising at 11%, reflecting the increasing complexity of pathology testing per individual case. When compared with current workforce increases of between 0% and 2% each year, the problem is evident.[1] Furthermore, the number of patients with secondary immunodeficiencies due to the use of new immune therapies is growing.[5] Clinical immunology services are feeling the strain from needing to be involved in an increasing number of these cases which they are not fully resourced or staffed for.

In this report, we aim to highlight the current state of the specialist clinical immunology workforce in the UK with a new analysis cross-referencing clinical immunology staffing with population numbers at a national level across England, Northern Ireland, Scotland and Wales, and at a regional level in England. From this analysis, we make robust recommendations to support and grow the workforce across clinical immunology and allergy professional groups to meet the needs of the population.

Who is this report for?

With the current critical workforce shortages, we would like the analysis and recommendations within this report to be seen and acted upon by national, regional and local decision-makers. National healthcare workforce planning departments across the four UK nations may find the insight within this report helpful, particularly as immunology and allergy is a small specialty, and therefore may currently gain less focus at a national level than larger specialties.

Given trends in both increasing patient need across immunology and allergy, and the growing pipeline of immune-based treatments for a range of conditions, it is critical that national workforce planning teams act now to look closely at how they are resourcing this specialty to meet future demand. While professionals from different specialties are continually gaining expertise in managing patients on immune-based medications, there will be an increasing number of those complex cases in which specialist immunology input is vital to ensure good patient outcomes.

Locally, we hope that regional workforce planning teams will consider this analysis when undertaking planning exercises on small and specialist services and can refer to it to gain an in-depth understanding of workforce needs across different professional groups within immunology and allergy.

Although the onus to undertake proper workforce planning shouldn't be with services themselves, we also hope that clinical immunology and allergy teams can use this analysis to make the case for continued or increased support for their services at provider and commissioning level. Too many services are struggling to successfully advocate for new posts, even if the need is very clear.

Workforce planning in the NHS

Workforce planning in the NHS happens at many different levels, and involves a large number of organisations. Although responsibility for comprehensive planning sits at a national level, the small but vital specialty of immunology and allergy continues to be overlooked and under-resourced. Across the NHS, workforce is a key factor that holds services back from meeting demand, and organisations representing healthcare professionals have strongly advocated for better workforce planning, resulting in England in the publication of the first ever NHS Long Term Workforce Plan in 2023.[6] At the time of writing, this workforce plan is due to be revised and re-launched, aligned to the three themes of the *'10 Year Health Plan for England'* – sickness to prevention, hospital to community, and analogue to digital.[7]

In October 2025, Scotland consulted on its medical workforce, as part of commitments outlined in the *'National Workforce Strategy for Health and Social Care in Scotland'* published in 2022.[8] Northern Ireland is nearing the end of the implementation period of its healthcare workforce strategy *'Health and Social Care Workforce Strategy 2026: Delivering for Our People'*,[9] which was launched in 2018. Wales is mid-way through implementing its healthcare workforce strategy launched in 2020 *'A Healthier Wales: A Workforce Strategy for Health and Social Care'*.[10]

Across the four UK nations, medical specialty training places can be funded at the national, regional, and provider levels – or through a combination. Healthcare scientist training posts can also be funded nationally or locally, depending on the pathway, whereas for nurses, pharmacists, and other roles such as support staff, training is usually 'on the job' and funded locally.

At a local level, provider organisations, within which clinical immunology and allergy services sit, also plan and resource their own workforce according to local population need. Although not responsible for ensuring a pipeline of trainees to come into their services, they are responsible for staffing the services for which they've been commissioned to provide.

Scope, methodology and data limitations

In this report, we will study data on medical, nursing, scientific, and support staff working within clinical immunology across the UK. We have used published data from NHS England for analysis of the workforce within England,[11] and have manually collected comparable data from the devolved nations with the same criteria and timepoints.

We have used workforce data from mid-point 2024/2025 (September 2024), as this enabled us to cross-reference staffing numbers with the closest population size estimates we could obtain.

We have used population data estimates from NHS England and from the national census providers in the devolved nations (see box), to cross-reference clinical immunology staffing with population numbers to better understand variance in coverage. We have used regional population numbers within England, but have used national population numbers from the devolved nations as they are comparable with regional population sizes in England.

NHS England workforce statistics code staff to either immunology or allergy as a 'secondary area of work'. Although the coding is binary, for the majority of services, in reality these staff will be providing services for immunodeficiency, allergy and diagnostic laboratory work. Staff numbers coded to immunology were used for this analysis. Staff numbers coded to allergy are not included in the main analysis as, on detailed inspection of the data, unfortunately the numbers were small and included staff working within paediatrics, respiratory, emergency medicine and other care areas, making accurate analysis unreliable. This data is provided within Appendix A for information, and to highlight the need to improve workforce coding and data.

We also removed paediatric trusts from our analysis at this point because it was not possible to separate out paediatric immunology from general paediatrics in the data, so this will need a bespoke approach. We plan to carry out a piece of work on the paediatric immunology workforce in the future.

The professional groups covered within the data include doctors, healthcare scientists and technical staff, nurses, and support staff. We were not able to analyse the data on roles such as specialist pharmacists and psychological practitioners at this time but again, we hope to gain more insight on these professional groups in future work.

We view this report as a starting point, building on the valuable insight that censuses such as the Royal College of Pathologists annual workforce census and the Royal College of Physicians Quality in Primary Immunodeficiency Services census have provided us with so far.

The 2024 population data used in this report is drawn from:

- England only: NHS England Allocations, Allocation of resources 2023/2024, A (includes modelling on regional 2024/25 population numbers, which we have used for this report)[12]
- Wales: The Office for National Statistics (2024 population estimate)[13]
- National Records of Scotland (2024 population estimate)[14]
- Northern Ireland Statistics and Research Agency (2024 population estimate)[15]

Medical consultants

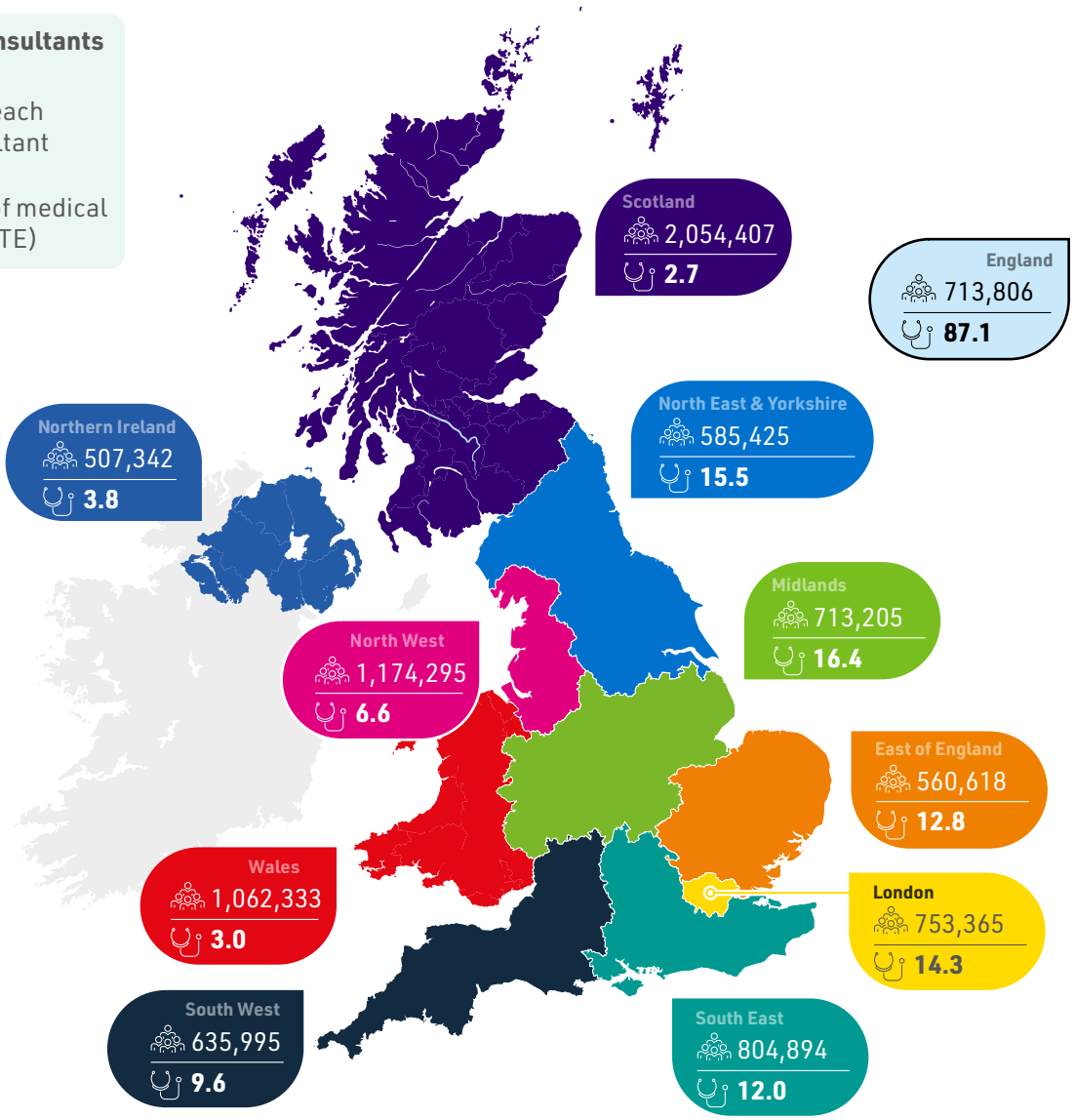
Figure A – Medical consultants shows the Full-Time Equivalent (FTE) numbers for medical consultants coded to immunology for England and reported as working in immunology from the devolved nations. The vast majority of these consultants will be delivering services in allergy, immune deficiency and diagnostic laboratory work. We have cross-referenced these numbers with population data to show the average population size that consultants in each region cover.

There is additional context that is important to consider when reviewing the data. For example, differences in physical geography and population demographics can mean that health inequalities are exacerbated in some areas, even if the area has a higher number of consultants than other localities. Additionally, patients are not restricted to being seen in the region that they live in and may cross regional boundaries for care.

Figure A - Medical consultants
Key:

Population to each medical consultant

Total number of medical consultants (FTE)



Recent analysis on the clinical immunology workforce from the Royal College of Pathologists estimated the UK needs 30% more medical consultant immunologists to meet current clinical demand. Based on data from their survey of immunology centres, they estimated that at least one medically trained consultant immunologist is needed per 451,000 population*. Although this is an estimation, rather than a calculation, it does give an indication of need from the perspective of the clinicians leading these services. Due to a lack of national workforce planning, it is difficult to calculate staffing numbers needed at a high level. More thorough planning based on improved data would help establish stronger markers to determine the adequacy of staffing levels.

We can therefore view the average population size that each medical consultant is covering in Figure A – Medical consultants. This shows that none of the England regions and devolved nations meet this population size recommendation of 451,000 population per consultant, with significant variation between the regions. Scotland's data is extremely stark, with 2,054,407 population per consultant. This means Scotland's consultants are supporting a population which is approaching five times the size that is recommended to meet clinical need. Wales is also in a concerning position, with 1,062,333 population per consultant.

Given current vacancy rates (39% of services with one or more consultant vacancies) and predicted retirement rates (21% of the consultant workforce are due to retire in the next 5 years), it is extremely concerning that this picture is likely to worsen in coming years if urgent action is not taken, particularly for the areas with very low numbers of consultants to population footprint. The College also heard through their survey that 71% of services reported that they rely on the goodwill (unpaid overtime) of staff to meet excess clinical demand. Even for the regions that appear to be better staffed, they often take referrals out of area to try and support patient access for areas where there is not enough cover. For example, Newcastle takes referrals from Scotland, Manchester takes referrals from North Wales, and London takes referrals from the South East.

Given the variance in staffing levels across different localities and professional groups demonstrated within this analysis, more data is needed on workload, service activity, and patient outcomes, to understand how much demand is exceeding capacity. As care for patients with immunodeficiency and complex allergy is often long term, standard measures of service activity such as Referral to Treatment performance and waiting list size do not accurately capture workload.

Furthermore, a significant amount of the care for these long-term patients often happens outside of a formal outpatient clinic through phone calls, advice, and email, and so requires more clinical time. Provision of clinical liaison and laboratory diagnostic advice is also often invisible and not accurately captured in job plans. With these factors in mind, we recommend that any metrics implemented must be designed to accurately capture the significant amount of hidden clinical activity undertaken.

*Although the data used by the Royal College of Pathologists in their report (2025) is slightly newer than the data we have analysed (2024), we are confident that there have not been significant enough changes in the staffing of services over the last year for their calculations to not be applicable to our analysis.

Extremely fragile services

Table A – Extremely fragile services shows services that are running with only one or two medical consultants coded to immunology for England and reported as working in immunology from the devolved nations.

Table A – Extremely fragile services	
Region service is based	**Medical consultants (FTE)**
South East	0.2
Scotland	0.7
East of England	1.0
London	1.0
North West	1.0
North West	1.0
Scotland	1.0
Scotland	1.0
South East	1.0
North West	1.6
Midlands	1.9
Midlands	2.0
Midlands	2.0
North East and Yorkshire	2.0
South East	2.0

Our findings show that 15 services across the UK are running with only one or two medical consultants. This is a cause for concern. These services are extremely vulnerable, as if one consultant were to leave, this would leave some of these services with no medical lead, and others with only one medical lead.

We are aware that some areas staffed by a single consultant may have support from services in neighbouring localities; however, every region still should be adequately staffed in its own right in the interests of reducing health inequalities, increasing patient access, and workforce wellbeing.

Any consultant having to operate alone will understandably be under a huge amount of pressure, and the service would essentially collapse if they were to leave, putting neighbouring services under increased pressure as well. Even if a service is running with two or three consultants, access to care would suffer if one consultant were to leave. It would also be difficult for services with such low staffing numbers to prioritise their own or other staff members' professional development. This situation should be treated like the significant and urgent risk it clearly constitutes by both local and national decision-makers, with appropriate action taken at different levels.

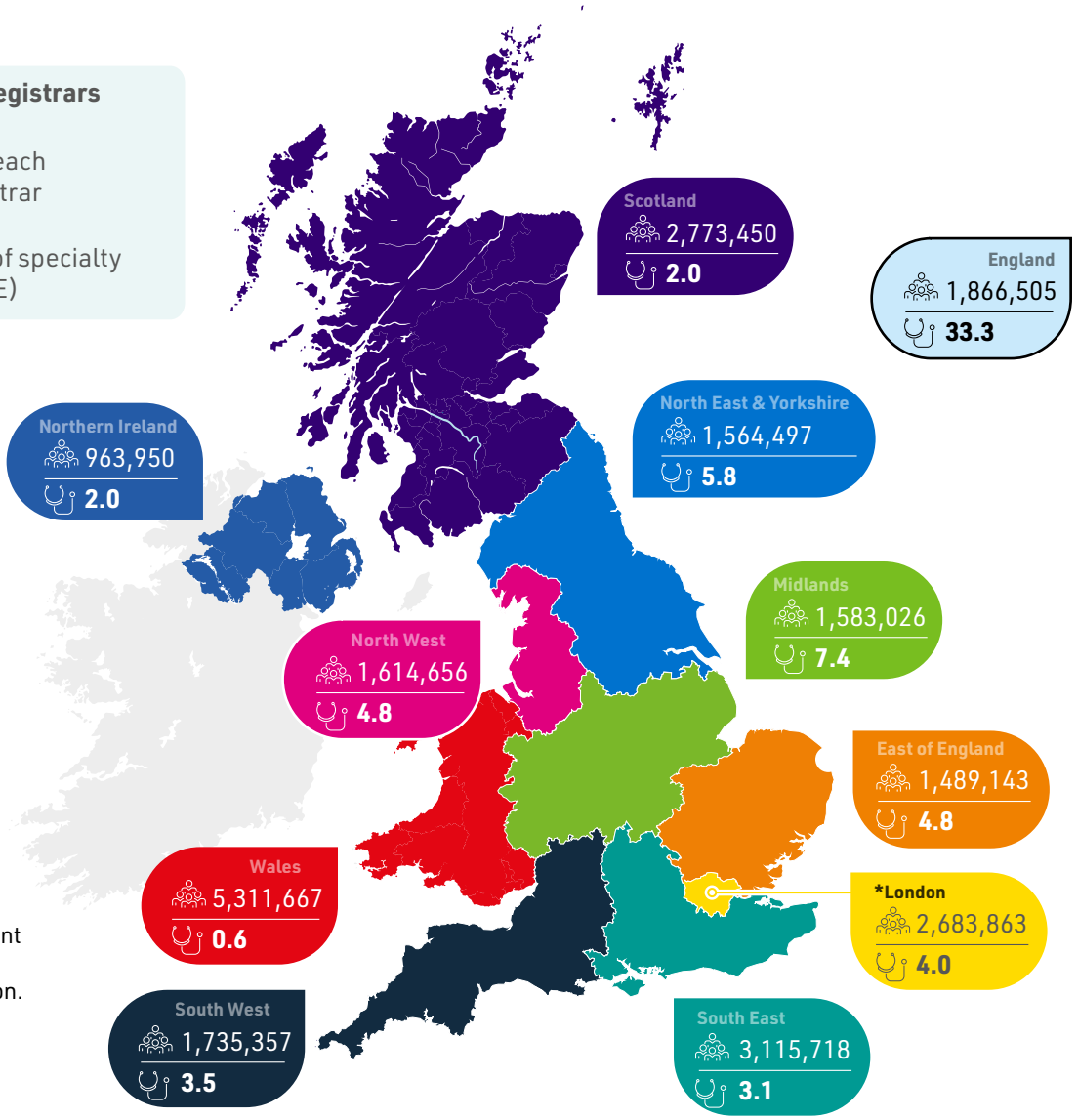
Specialty registrars

Figure B – Specialty registrars (SpRs) outlines the FTE numbers for specialty registrars coded to immunology for England and reported as working in immunology from the devolved nations, cross-referenced with population data.

Figure B - Specialty registrars
Key:

Population to each specialty registrar

Total number of specialty registrars (FTE)



*See Appendix A – Allergy Data – there are a significant number of SpRs coded to allergy in the London region.

Specialty registrars are of particular interest, because they are on the path to becoming consultants, and can help us understand how the medical staffing of future immunology and allergy services may look.

There are currently higher numbers of applicants for specialty training posts than there are posts available, despite immunology services being acknowledged as being medically understaffed.[16] This again demonstrates ineffective national workforce planning, and should be of concern to national workforce planning teams. Increasing training posts is the only sustainable way to increase the low numbers of consultants in services across the UK.

A recent survey by the Royal College of Physicians found that 75% of trainees moving into consultant roles took up a post in the same region where they trained.[17] This indicates that for the areas with small numbers of SpRs, such as Wales and Scotland, it could be challenging to recruit an adequate number of consultants in the future without further support for training posts being put in place urgently. As Figure A demonstrates, these are also currently the regions with the lowest numbers of consultants to population footprint. If action is not taken this inequitable situation will continue to persist, ultimately impacting patient care.

Nurses

Table B and Figure C - Nurses outline the FTE numbers and distribution of nurses coded to immunology for England and reported as working in immunology from the devolved nations. It should be noted that, unfortunately, although there are a number of nurses coded to allergy in post throughout England (see Appendix A), we weren't able to confidently include this data (as is the case throughout this report) and so the below data focuses on nursing staff who are coded to immunology. It is likely that most of the nurses coded to either immunology or allergy are providing both allergy and immunodeficiency services. This highlights the need for better data on which elements of the service are being provided by which staff.

Table B – Nurses

Region	Nurses by band (FTE)				Combined total
	Band 5	Band 6	Band 7	Band 8a+	
England	**85.7**	**84.5**	**55.5**	**11.3**	**237**
East of England	20.9	7.0	2.7	2.0	32.6
London	6.7	10.7	13.5	3.0	34.0
Midlands	4.3	11.4	8.7	1.9	26.2
North East and Yorkshire	11.7	14.5	8.5	1.0	35.7
North West	2.0	12.3	5.9	0	20.2
South East	22.8	11.2	4.8	0	38.8
South West	17.3	17.5	11.4	3.4	49.5
Wales	**6.0**		**1.0**	**1.0**	**8.0**
Scotland	**1.9**		**1.8**	**1.0**	**2.3**
Northern Ireland	**1.0**	**3.0**	**2.0**	**0**	**6.0**

Nursing teams are critical for patient care, and are increasingly working with more autonomy. Nurses in immunology and allergy should work to the top of their license, and should be adequately supported to do so.

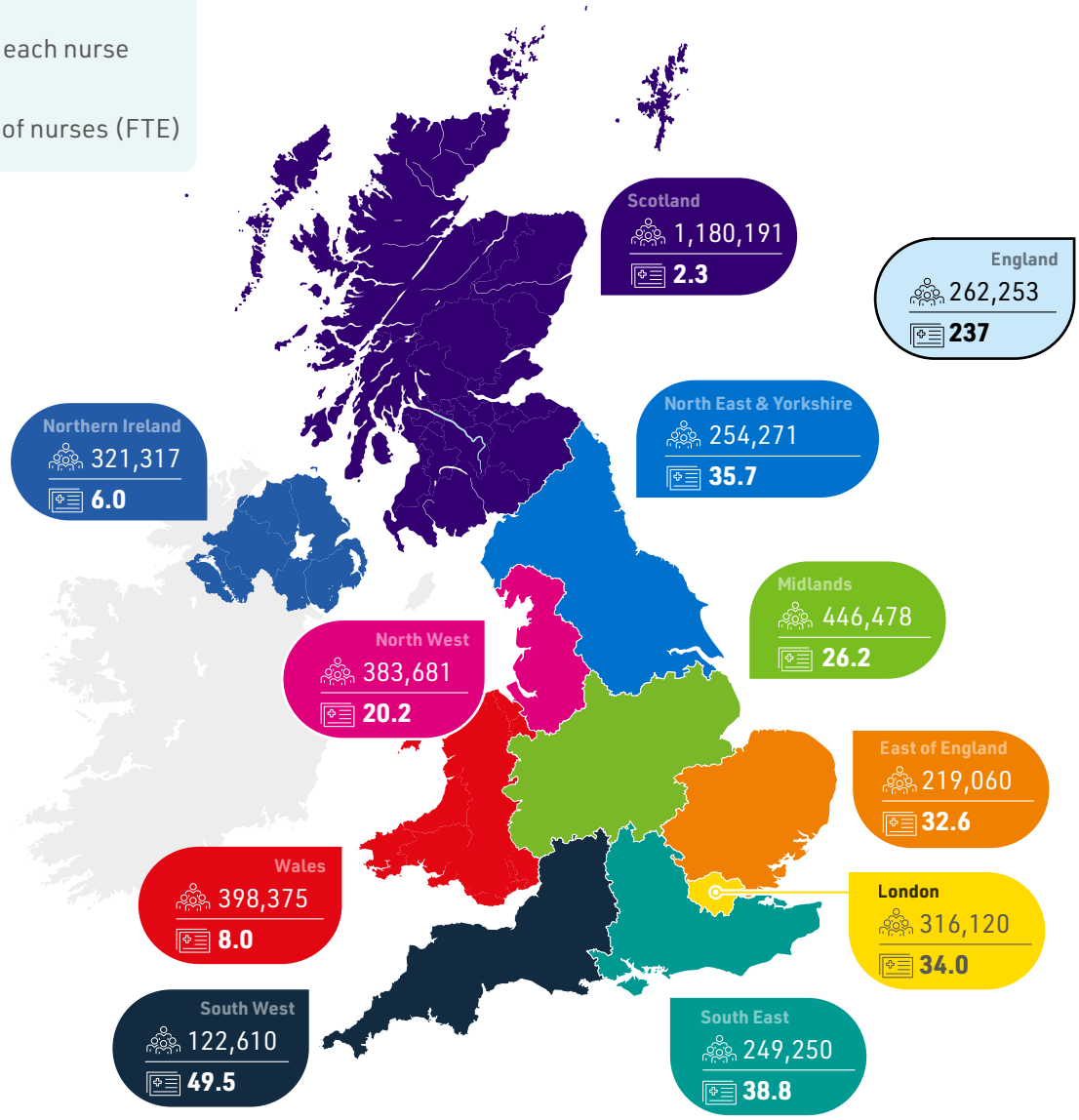
Although there aren't currently recommendations on the appropriate size and composition of a nursing team for a set population, we have still weighted numbers of nurses to population footprints to demonstrate the amount of variability in clinical immunology nursing provision across the UK. Again, in Scotland, the numbers are incredibly stark and are clearly an outlier, with over 1 million population per nurse. There is also some variability among the England regions, which should be further explored.

Nurses working at Band 5 are unlikely to be clinical nurse specialists; for example, they could be working as infusion nurses and serving more than one specialty. This means that the data included potentially overestimates the nurses specialising in clinical immunology, and also therefore the potential future nursing workforce as well. Conversely, it could be the case that infusion nurses are supporting immunology and allergy work, but being coded elsewhere, which underlines the need for more accurate data.

Figure C - Nurses
Key:

Population to each nurse

Total number of nurses (FTE)



More could be done to support and train nurses coming into immunology and allergy services to help them gain confidence and encourage them to specialise and stay within the specialty. Currently much of the training for nurses is informal and will depend on the capacity and staffing structure of the service they work in. Due to this lack of centralised training, the independent sector has stepped in and the British Society for Immunology now provides an Immunology Nurses Training Programme,[18] with the British Society for Allergy and Immunology providing a training programme for allergy nurses.[19]

The leadership and support nurses can offer services underlines the importance of employers supporting their professional development and ensuring nurses are aware of the opportunities they are entitled to, and have equitable access to development and training opportunities wherever possible.

Healthcare science staff

Within the NHS England workforce statistics, the category that covers healthcare science staff is 'Scientific, technical and therapeutic staff'. We have assumed that the majority of staff within this group in immunology will be healthcare scientists (clinical and biomedical scientists). For data on the devolved nations, we have indicated we are referring to laboratory staff. Due to the assumption relating to the NHS England data, the numbers may not be as accurate as for other roles. However, we still expect them to be broadly indicative, and so will refer to healthcare science staff from herein.

It should also be noted that the likelihood of healthcare scientists working in immunology being coded to another scientific discipline is quite high. For example, we are aware that some immunological tests are carried out in biochemistry or blood sciences laboratories, and in these cases coding could be improved to help accurately interpret data.

Table C – Healthcare science staff highlights the coverage of FTE healthcare science staffing coded to immunology for England and reported as working in immunology from the devolved nations.

Trainee and qualified healthcare scientists will work at Band 5 and above, with support staff at Band 3 and 4. Qualified clinical scientists will work at Band 7 and above. Biomedical scientists who have completed their specialist portfolio working at Band 6 are also considered specialised.

We have disaggregated data on Band 8a and above into two categories to gain an indication of how many consultant, or very senior, healthcare scientists are in post and therefore leading laboratory services. We would expect that any healthcare scientist working at Band 8c or above will be operating in a very senior – likely consultant level – position.

Table C – Healthcare science staff

Region	Healthcare science staff by band (FTE)				Combined total
	Up to Band 6	Band 7	Band 8a and 8b	Band 8c,8d and 9	
England	**207.6**	**102.0**	**55.4**	**23.1**	**388.1**
East of England	19.1	6.4	0.8	0	26.2
London	27.0	12.0	9.4	6.3	54.7
Midlands	38.2	15.2	9.2	1.0	63.6
North East and Yorkshire	48.6	27.6	16.5	7.0	99.6
North West	29.3	14.1	6.9	3.0	53.3
South East	25.6	12.9	7.6	3.8	49.9
South West	19.8	13.9	5.0	2.0	40.7
Scotland	**16.5**	**10.0**	**5.7**		**32.1**
Wales	**16.9**	**7.9**	**2.0**		**26.8**
Northern Ireland	**5.0**	**5.8**	**1.0**	**0**	**11.8**

Table D and Figure D – Senior healthcare science staff highlight the FTE numbers of senior and very senior healthcare scientists in post weighted to population numbers. We have included Band 7 and above as these individuals will be senior professionals who will be specialised in clinical immunology and often in leadership roles.

We recognise that a population weighting for healthcare science staff is possibly not as useful in analysing the capacity of laboratory services than for nursing and medical care due to the likelihood of variation in coding distorting the results; however, we have included it to provide an overview of the spread of specialist scientific staff coded to immunology across the UK.

While different services may have different staffing needs for a variety of reasons, we can see from Tables C and D some regions have significantly fewer healthcare scientists than others, which may not always correspond to population footprint size. The reasons for this variability should be explored (if not related solely to coding issues) to understand which staffing models are most effective, and how they are best structured to help meet service demand. If it is discovered that low numbers of scientific staff does constitute understaffing, then action should be taken to help bolster scientific teams where needed.

Table D – Senior healthcare science staff

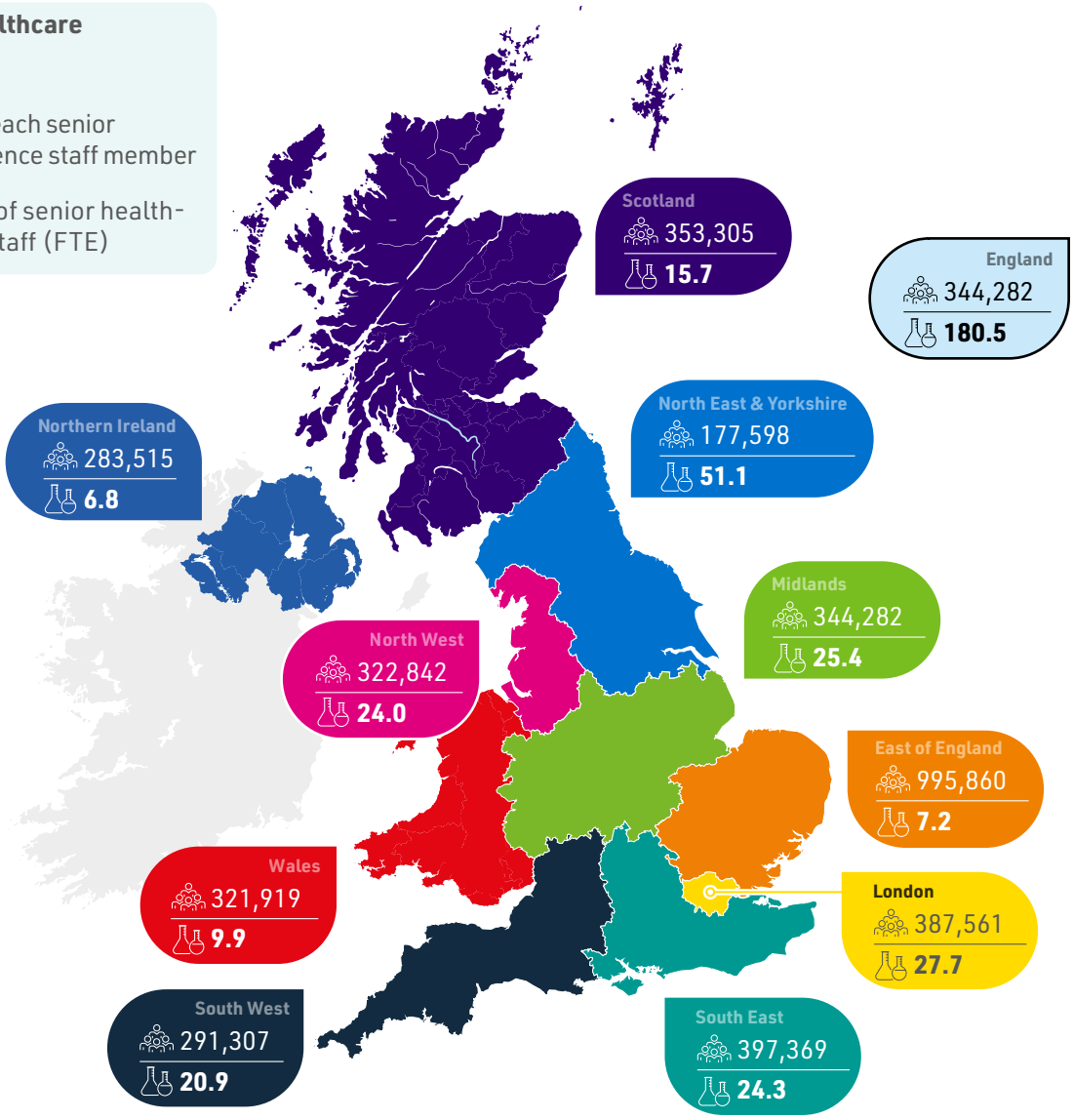
Region	Senior healthcare science staff by band (FTE)			Combined total
	Band 7	Band 8a and 8b	Band 8c, 8d, and 9	
England	**102.0**	**55.4**	**23.1**	**180.5**
East of England	6.4	0.8	0	7.2
London	12.0	9.4	6.3	27.7
Midlands	15.2	9.2	1.0	25.4
North East and Yorkshire	27.2	16.2	7.0	51.1
North West	14.1	6.5	3.0	24.0
South East	12.9	7.6	3.8	24.3
South West	13.9	5.0	2.0	20.9
Scotland	**10.0**	**5.7**		**15.7**
Wales	**7.9**	**2.0**		**9.9**
Northern Ireland	**5.8**	**1.0**	**6.8**	**6.8**

Figure D - Senior healthcare science staff

Key:

Population to each senior healthcare science staff member

Total number of senior healthcare science staff (FTE)



We can also see from the data in Figure D that the number of senior healthcare scientists is variable across the country weighted to population. As with other professional roles, senior healthcare scientists can interpret test results, make high-level decisions and lead elements of the laboratory service, or the whole laboratory service in the case of consultant clinical scientists. Further work should be undertaken nationally to understand where more senior roles are needed, and where higher numbers of junior and mid-healthcare science roles are also required to ensure an effective service. Healthcare scientists, as with other professions, should work to the top of their license to most effectively support the service.

In England, there is also a challenge within the clinical science training pathway regarding training and role progression. In recent years, there have not been enough funded posts within trusts across the country to allow all National School for Healthcare Science qualifying clinical scientists to progress into senior positions. This is unfortunate as it means the NHS is losing talented candidates that it has paid to train to other sectors. The lack of senior posts available reflects the lack of workforce planning at a national level, particularly for immunology and other smaller pathology sub-specialties. Biomedical scientists do not have a nationally planned training pathway in immunology, and are largely supported in progression by the Institute of Biomedical Science, which sets central standards.

Support staff

Table E – Support staff outlines the FTE numbers of support staff coded to immunology for England and reported as working in immunology from the devolved nations.

Support staff are critical in ensuring effective service provision, from laboratory support functions, to supporting direct patient care. Support staff can be working within the laboratory in roles including technicians and assistants, and as support to medical and nursing staff in roles including healthcare assistants and secretaries.

Although we haven't been able to identify individual roles, we still have insight from the data we have collated which brings together the FTE numbers of support staff across the UK.

These staff help keep services operating effectively and are a crucial part of the workforce. Their support should enable more senior clinical and scientific staff to work to the top of their license and provide general support. Once again, we can see that the numbers of support staff vary across the country, although there does not appear to be any very significant outliers, as for other professional groups and localities.

Table E – Support staff

Region	Number of support staff for doctors and nurses (FTE)	Number of doctors and nurses (FTE)	Number of support staff to each doctor or nurse	Number of support staff for healthcare science staff	Number of healthcare science staff (FTE)	Number of support staff to each healthcare science staff member
England	**135.0**	**367.1**	**0.4**	**185.6**	**388.1**	**0.5**
East of England	28.2	50.2	0.6	4.2	26.2	0.2
London	12.4	53.2	0.2	36.0	54.7	0.7
Midlands	16.3	51.2	0.3	23.1	63.6	0.4
North East and Yorkshire	20.9	60.8	0.3	59.7	99.6	0.6
North West	15.7	32.6	0.5	18.2	53.3	0.3
South East	14.1	53.8	0.3	28.9	49.9	0.6
South West	27.4	65.2	0.4	15.5	40.7	0.4
Scotland	**3.4**	**9.9**	**0.3**	**13.4**	**32.1**	**0.4**
Wales	**3.0**	**13.0**	**0.2**	**5.9**	**26.8**	**0.2**
Northern Ireland	**1.0**	**12.8**	**0.1**	**2.0**	**11.8**	**0.2**

Conclusions

This data shows that there is a lot of variance in immunology staffing across some parts of the UK when weighted to population numbers across professional groups, which warrants urgent attention – most critically in Scotland and Wales. All clinical immunology services in the UK would be considered short staffed in light of recent Royal College of Pathologists recommendations on medical consultant coverage, and some services are seriously under-resourced – covering huge population footprints with only one or two consultants, which leaves them at risk of collapse.

This does not only raise serious questions about equity of access to care, but also places these teams under intense pressure, resulting in a situation that is unsustainable for both the workforce and the patients they care for.

To obtain a more accurate picture of demand and capacity, capturing activity, workload, and outcomes data should be prioritised both locally and nationally, as well as improving data on how much allergy, immunodeficiency and diagnostic laboratory immunology is being provided by professionals coded to either immunology or allergy. This data should take into account the model of care needed for supporting long-term patients with complex conditions as well as service structure. It should not rely solely on metrics that do not accurately capture the time needed to provide adequate care in this context.

If there were validated data available for both workforce and activity across the specialty, it would help immensely in both demonstrating the need for these vital services, and highlighting where there are capacity challenges that are affecting patient access. This would also be helpful in determining key questions such as the proportion of staff time spent between allergy, clinical immunology and laboratory immunology, and may also give an indication of rising demand from patients with secondary immunodeficiencies. Furthermore, it would also help inform local commissioners' understanding of the value that these specialist services bring to patients, how they are structured, and the nuance needed to accurately understand demand, workload, and productivity.

As a starting point to remedy the more urgent staffing challenges, there should be a nationally driven full-service review for clinical immunology and allergy within each of the four UK nations. When completed, the reviews should be published to ensure transparency and should include full implementation plans with detail of investment and infrastructure needed to reach defined targets and goals, as well as central commitment to securing that investment.

We also support the call from the Royal College of Pathologists to urgently increase the immunology medical workforce in a phased approach over the next five years. This would give additional opportunities for much-needed trainees to specialise in immunology and allergy. It could also help form the basis of calculations on by how much the corresponding workforce in other professional groups should also increase (as to provide an effective service, consultants need healthcare scientists, nurses, support staff, and ideally pharmacists and psychological practitioners within their teams).

Clinical immunology and allergy services provide vital care for their patients. Ultimately, when these services are understaffed, it is not only a challenging and unsustainable situation for the dedicated teams trying to keep their services afloat, but patients also lose out. This is not acceptable, and we urge national decision-makers to take up the recommendations within this report to prevent the situation from continuing to deteriorate and to ensure that patients across the country can access timely, local care from specialist clinical immunology and allergy teams.

Recommendations

1. **There should be an urgent nationally driven full-service review for clinical immunology and allergy within each of the four UK nations to establish the workforce that is needed.**

   When completed, the reviews should be published to ensure transparency and should include full implementation plans with detail of investment and infrastructure needed to reach defined targets and goals, as well as central commitments to securing investment and ensuring implementation. Commitment to undertake these reviews should be made at a governmental level, with responsibility delegated, if needed, to the appropriate national body or organisation. The reviews should consider areas that are severely understaffed and explore options to support urgent workforce growth in these regions.

2. **We support the Royal College of Pathologists recommendation to establish 17 additional immunology training posts by 2027 to cover current vacancies and a further 35 by 2030 to meet the workforce demand, combined with a commensurate increase in consultant posts.**[1]

   Nationally driven service reviews in each of the four UK nations should implement this recommendation, including how to resource appropriate staffing across different professional groups to work alongside the new trainees and consultants.

3. **Longer term, comprehensive workforce planning for clinical immunology and allergy should be routinely carried out at a national level in each of the four UK nations. Training pathways should form a core part of this work for all professional groups.**

   Regular planning should ensure there is clear understanding of the workforce needs and training pathways, across all professional groups working within the specialty, corresponding to patient demand. This is particularly important in the context of extremely fragile services, as national and local organisations should be aware of the patient groups who could lose access to appropriate care should these services cease to function.

4. **Alongside national action to improve training pathways, employers should proactively support the next generation of clinical immunology and allergy staff and help future-proof services by taking steps to ensure ringfenced training, education, and supervisory time within senior clinical, nursing, and scientific job plans is genuinely implemented.**

   Employers should also ensure that all staff across professional groups are able to access professional development opportunities.

5. **Data on service activity, workload, and outcomes should be collected locally and published nationally. Efforts to improve coding within published workforce data should also be initiated to give a more accurate picture of the immunology and allergy workforce.**

   Collecting service activity and workload data and making it public would ensure there is shared understanding of referral rates, waiting lists, service activity, workload, service structure, and patient outcomes within immunology and allergy. It would also bring immunology and allergy in line with other specialties and help inform a more comprehensive understanding of patient need.

6. **There should be strengthened efforts to ensure regional and local commissioning organisations understand the value of clinical immunology and allergy services and future service need, to optimise outcomes for patients.**

   This is particularly important in the context of growing demand in secondary immunodeficiency and allergy, and current geographical inequalities in access to care.

Appendix A: Workforce data coded to allergy

The data on staff coded to allergy within the NHS England Workforce Statistics dataset we analysed from September 2024 can be found below.[11] We do not have the full breakdowns of allergy staffing within the devolved nations.

As previously noted, we have not included this in the main data tables in this report due to small numbers and data quality issues, such as those coded to allergy working within other care areas. On a detailed inspection of the data, we found that consultant medical staffing coded to allergy was very variable, and large numbers were working in other settings, for example paediatrics, respiratory medicine, infectious diseases, and emergency medicine.

There were 164.1 FTE staff coded to allergy in England in September 2024 (including those who were working in the other settings mentioned above). To share context on proportions, there were 1,109.7 FTE staff coded to immunology. The data on staff coded to allergy included:

- 29.2 FTE consultants
- 14.2 FTE specialty registrars
- 2.8 FTE scientific, therapeutic and technical staff working at Band 7
- 1.4 FTE scientific, therapeutic and technical staff working at Band 8a and above
- 36.9 FTE nurses working at Band 6 and below
- 18.5 FTE nurses working at Band 7
- 8.6 FTE nurses working at Band 8a and above
- 38.6 FTE support staff for doctors, nurses and midwives
- 1.0 FTE support staff for scientific, therapeutic and technical staff
- 12.9 other staff including a small number of non-consultant medics

The spread of the allergy data across different regions was also very variable, potentially pointing to coding inconsistencies across the country. For example, London had the vast majority of allergy coded consultants and specialty registrars, respectively 22.1 out of 29.2 consultants, and 11.0 out of 14.2 specialty registrars. London also had high numbers of nurses and nursing and medical support staff coded to allergy compared with other regions. Conversely, the South West had no staff coded to allergy with the exception of one Band 6 nurse. This was also the case for the North East and Yorkshire, with the exception of 1.9 Band 7 nurses.

Appendix B: References

1. The Royal College of Pathologists. 2025. Clinical immunology workforce report. https://bit.ly/47D3aBH

2. Allergy UK. 2024. Allergy Rise – The Statistics. https://bit.ly/4oRiiSL.

3. Pourshahnazari *et al*. 2024. Secondary immunodeficiency. *Allergy Asthma Clin Immunol* **20** (Suppl 3), 80. https://doi.org/10.1186/s13223-024-00925-4

4. The Health Foundation. 2023. Nine major challenges facing health and care in England. https://bit.ly/3LodxSj

5. Tuano *et al*. 2021. Secondary immunodeficiencies: an overview. *Ann Allergy Asthma Immunol*, **127**, 617–626. https://bit.ly/43Rvyig

6. NHS England. 2023 (updated 2024). NHS Long term workforce plan. https://bit.ly/43yGrpl

7. Department for Health and Social Care. 2025. 10 Year Health Plan for England: fit for the future. https://bit.ly/49JTrMt

8. Scottish Government. 2022. Health and social care: national workforce strategy. https://shorturl.at/FJGzS

9. Department of Health Northern Ireland. 2016. Health and Social Care Workforce strategy, 2026. https://shorturl.at/rrxXX

10. NHS Wales. 2020. A healthier Wales: our workforce strategy for health and social care. https://shorturl.at/F2jVb

11. NHS England. 2025. NHS Workforce statistics – September 2024. https://shorturl.at/0toV5

12. NHS England. Allocation of resources 2023/24 to 2024/25. https://shorturl.at/UB6im. Accessed October 2025.

13. Welsh Government. 2025. Mid year estimates of the population: 2024. https://shorturl.at/sCoMH

14. National Records of Scotland. 2025. Mid-2024 population estimates. https://rebrand.ly/pfwbkft

15. Northern Ireland Statistics and Research Agency. 2025. 2024 Mid-year Population Estimates for Northern Ireland. https://rebrand.ly/qmrvh47

16. NHS England. 2024. Competition ratios for 2024. https://bit.ly/4qOmBjx. Accessed October 2025.

17. Royal College of Physicians. 2025. Majority of new consultants take up posts where they trained: new RCP survey findings show that NHS should improve training experience to recruit and retain senior doctors. https://bit.ly/3JSJxO3

18. British Society for Immunology. 2025. BSI Immunology Nursing Excellence Programme. https://bit.ly/43kg7yY. Accessed October 2025.

19. British Society for Allergy & Clinical Immunology. 2025. Nurses and Allied Health Education. https://bit.ly/486fTOE. Accessed October 2025.

Acknowledgements

We would like to thank the British Society for Immunology Clinical Immunology Professional Network Steering Group, who have helped guide this report, and provided critical insight to help inform it.

In particular, thanks go to Dr Patrick Yong in his role as the clinical lead on this report, as well as Professor Siniša Savić, Dr Suzy Elcombe, Jill Edmonds, and Rachel Dale for providing oversight and perspectives across professional groups. We are also grateful to our colleagues in the devolved nations who have collected specific and historical workforce data, and supported work on local recommendations.

We would like to thank the organisations that represent different professional groups working within clinical immunology and allergy in helping to inform this report and providing valuable insight into specific challenges their own areas, as well as recommendations to help support and grow the immunology and allergy workforce. These organisations are:

- Association of Clinical Pathologists
- British Society for Allergy and Clinical Immunology
- Immunology and Allergy Nurses Group
- Institute of Biomedical Science
- LabMed Immunology Professional Committee
- Royal College of Pathologists

We would also like to thank the Royal College of Pathologists workforce team for valuable insight during the past year as they carried out their most recent clinical immunology census, as well as the Royal College of Physicians Quality in Primary Immunodeficiency Services team who have also collected data for their census on UK primary immunodeficiency services.

Finally, we would like to thank the BSI staff team for their support in bringing the report together, to Rosanna Flury for researching and writing the report, Wai Yan Cheng for her role in developing the analysis, Laura Cox and Madeline Crouch for leading on communications, and Jennie Evans for oversight and providing valued support.

More information on this report and an online version can be found on the British Society for Immunology website. Visit www.immunology.org/cipn. If you have any queries on this report, please email the BSI-CIPN team at cipn@immunology.org.

The British Society for Immunology Clinical Immunology Professional Network's (BSI-CIPN) mission is to lead the delivery of excellence in patient care in clinical immunology through education and training, advocacy and engagement, and research.

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