Global Policy Network

Allergy Series 2026

Closing the Gaps in CMPA- Prevention, Timely Diagnosis and Equitable Access to Care: A Policy Report

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Abbreviations

BFI – Baby Friendly Initiative

BSACI – British Society for Allergy & Clinical Immunology

CMPA – Cow's Milk Protein Allergy

DHSC – Department of Health and Social Care

GP – General Practitioner

GPN – Global Policy Network

ICB – Integrated Care Board

IgE Allergy – IgE-mediated allergy involves immediate, antibody-driven reactions to allergens (Allergy UK, n.d.).

Non-IgE Allergy - non-IgE-mediated allergies "involve different components of the immune system and have a delayed onset" (Allergy UK, n.d.).

MAP – Milk Allergy in Primary Care

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NHS – National Health Service

Non-IgE Allergy - non-IgE-mediated allergies "involve different components of the immune system and have a delayed onset" (Allergy UK, n.d.).

UK – United Kingdom

About Global Policy Network

Global Policy Network (GPN) is an independent, noy-for-profit global policy institute committed to advancing evidence-informed dialogue in global health, education, and sustainability. GPN combines research, stakeholder insight, and practical policy analysis to shape thoughtful, actionable conversations around some of today's most complex public policy challenges.

Through policy reports, forums, and collaborative programmes, GPN brings together voices from government, civil society, academia, and the private sector to identify solutions grounded in real-world experience. With a growing network of international practitioners and policymakers, the organisation works to bridge the gap between policy ideas and implementation, ensuring relevance, equity, and sustainability remain at the heart of systems change.

About the Allergy Policy Series

The Allergy Policy Series explores how to respond to the rising burden of allergic disease through system-wide action across childhood and primary care. Through focused roundtables that bring together clinicians, commissioners, policymakers, and community leaders, the series examines how medicine, lived experiences, and policy ambitions can be translated into practical pathways that work for families and health services. Each roundtable generates an independent policy report that combines stakeholder insight with emerging evidence to identify realistic reforms for allergy governance, workforce, data, and equitable access to care.

Roundtable One: Closing the Gaps in CMPA: Prevention, Timely Diagnosis and Equitable Access to Care

Roundtable One in the Allergy Policy Series, "Closing the Gaps in CMPA: Prevention, Timely Diagnosis and Equitable Access to Care", focused on how the United Kingdom (UK) system recognises and manages cow's milk protein allergy (CMPA) in infancy and early childhood. Participants from paediatric allergy, dietetics, health visiting, community pharmacy, primary care, and commissioning examined why diagnostic journeys remain long, pathways fragmented and outcomes unequal despite growing clinical guidance and awareness.

The discussion centred on the role of CMPA as an early-life entry point for prevention, exploring how earlier recognition, clearer system ownership and culturally appropriate dietary support could reduce avoidable harm while narrowing inequalities and relieving pressure on allergy services. Insights from the roundtable underpin this policy report's recommendations for Department of Health and Social Care (DHSC), National Health Services (NHS), Integrated Care Boards (ICBs) and local teams on strengthening CMPA pathways as part of the UK's wider prevention and health equity agenda.

Acknowledgements

We extend our sincere thanks to everyone who contributed their expertise to this roundtable. Chaired by Prof. Nick Makwana, Consultant Paediatrician at Sandwell and West Birmingham Hospitals, the session benefited from his leadership and clarity of purpose.

We are especially grateful to our speakers: Natalie Yerlett (Lead Dietitian at Great Ormond Street Hospital), Prof. Carina Venter (Professor of Paediatrics at Children's Hospital Colorado) and Nirusha Govender (Associate Director for Pharmacy Workforce, Medicines Quality & Safety at NHS Kent and Medway) for their thoughtful insights and commitment to advancing the future of cow's milk protein allergy care.

We also thank the 11 delegates whose perspectives, shared under the Chatham House Rule, provided the lived experience that anchors this report. This document reflects the collaborative effort of all involved.

We are also grateful to our GPN Fellows who supported this policy roundtable and report; they include Clemence, Greg, Iqmat, Jeanne and Magdelena.

Foreword by Prof. Nick Makwana, Consultant Paediatrician, Sandwell and West Birmingham Hospitals

It was a privilege to serve as Chair for the first roundtable in Global Policy Network's Paediatric Allergy Policy Series. This roundtable, focused on CMPA, brought together a wide range of experts to reflect on how care for CMPA-affected infants and their families can be improved. The discussion created an important space for clinicians, dietitians, pharmacists, researchers, and system leaders to share their experiences and perspectives on a condition that is both common and challenging to manage. As a Consultant Paediatrician specialising in allergy, I have seen the impact that delayed recognition and inconsistent pathways can have on children and their families.

While our understanding of CMPA has developed significantly, this has not always translated into consistent practice across the healthcare system. Many families continue to face uncertainty, repeated consultations, and delays in receiving appropriate support. These challenges are not confined to one part of the system but are evident across the entire pathway from health visitors to specialist care.

The roundtable discussion made it clear that the current pathway of care for CMPA-affected children is characterised by delays, inequalities, and hazards to children's safety and development. Participants spoke openly about the barriers that remain, but also highlighted examples of paths forward to strengthen and standardise care. There was universal agreement among the panel that greater coordination between services, alongside earlier and more reliable diagnosis, could make a meaningful difference to outcomes for children and families.

This report brings together those insights with a significant body of evidentiary literature, offering practical and actionable ways to improve care going forward. The task ahead is to ensure that this knowledge is applied consistently so that all children receive timely and appropriate support, regardless of when and where they enter the system.

Foreword by Ameneh Ghazal Saatchi, Founder and CEO, Global Policy Network

At GPN, we believe that effective policy guided by evidence, diverse voices, and lived experience can create meaningful improvements in people's lives. Clinical care in early childhood is an important point for such interventions, as these years can shape a child's health and development for life. However, oftentimes knowledge and solutions face barriers to becoming practical guidance in children's care.
CMPA affects countless children in the UK and provides a standout example of this issue. Despite being one of the most common allergies affecting UK children, it can be overlooked due to its complex symptoms and onset. Missing or delaying a CMPA diagnosis can have significant negative effects, such as prolonged pain and symptoms for infants, stress and anxiety for parents and families, and further burdens on health services.

With these risks in mind, we organized this roundtable of clinicians, dietitians, researchers, and other experts as a space to share experiences of CMPA within their own systems. Together we built not only a shared understanding of the challenges presented by current pathways to care but also defined clear actions to begin addressing these challenges. These strategies involve all levels of the UK healthcare system, from health visitors, primary care offices, and pharmacists to Integrated Care Boards and the NHS itself. Challenges in CMPA care span the full continuum of care, and no single care setting can solve these problems alone. To the contrary, a unified, system-wide approach is needed to ensure consistency and equity for CMPA-affected children and their families. GPN will continue committing its efforts to supporting professionals across the UK healthcare system as they use these recommendations to improve children's health and safety.

Executive Summary

The policy report summarises insights and recommendations from Global Policy Network's United Kingdom (UK) Allergy Policy Series Roundtable One, held on the 13th of March 2026. The session, titled "Closing the Gaps in CMPA: Prevention, Timely Diagnosis and Equitable Access to Care", brought together paediatric allergy specialists, dietitians, health visitors, pharmacists, commissioners and patient advocates to examine how CMPA is currently recognised and managed across the system, and how these pathways shape long-term allergic risk and inequality of access to care.

The roundtable highlighted that CMPA must move from being treated as an individual clinician problem to being addressed as a complex system-wide condition embedded within early-years, primary-care and allergy pathways, directly reinforcing the NHS Long Term Plan's emphasis on prevention, early intervention and reducing the burden of long-term conditions. In that way, CMPA was framed as an early-life condition where timely recognition and management can prevent avoidable harm, reduce progression along the atopic march and avoid high-cost care throughout life. Operational, workforce and governance constraints currently hinder this shift. Indeed, delayed and uneven diagnosis, fragmented ownership between services, and weak data on allergy activity generate avoidable harm for children and families and amplify existing inequalities in access to care. At the same time, front-line professionals who are pivotal to CMPA care often lack the time and training needed to deliver consistent, culturally appropriate advice.

Against this backdrop, CMPA offers a concrete opportunity for the DHSC, ICBs and local authorities to operationalise national prevention ambitions by acting earlier in infancy to alter long-term allergic trajectories, reduce avoidable healthcare use and narrow inequalities. CMPA, therefore becomes a concrete test of how far national ambitions on prevention and tackling inequality in key documents such as the NHS Long Term Plan are being translated into everyday practice for infants and young children. This report identifies insights and recommendations on CMPA diagnosis, inequality and pathway design and sets out actionable recommendations for the DHSC, ICBs, local authorities, professional bodies, and education partners.

Key Insights

1. **CMPA needs to be recognised as a prevalent condition**

CMPA is one of the most frequent early-life food allergies, yet non-IgE presentations remain difficult to recognise and are often diagnosed late. Indeed, UK cohort data show a median delay of around 56 days between first documented symptoms and confirmed CMPA diagnosis, with families repeatedly cycling through primary care and emergency services before receiving appropriate management (Allen et al., 2024). These delays contribute to substantially increased healthcare use and cost, with a study reporting that children with CMPA have *"50% more GP contacts, 167% more specialist referrals and 52% more hospital admissions than those without"*, alongside annual healthcare costs more than eight times higher, largely driven by unresolved symptoms and associated comorbidities (Cawood et al., 2022). Reframing CMPA as a system-level condition, rather than a series of individual clinical encounters, is therefore essential to reduce avoidable demand, prevent growth faltering and protect long-term health as children move along the atopic march.

2. **CMPA pathways currently reproduce and amplify existing health inequalities**

Across the discussion, participants repeatedly reported that delays in diagnosis and access to specialist input track deprivation, with children in more disadvantaged families waiting the longest and having the least capacity to absorb harm. Ethnic minority and migrant families, who now account for a large share of births in England and Wales, face additional barriers linked to poorer baseline outcomes, under-representation in research, food insecurity and travel costs (Osborne et al., 2025; Jones et al., 2022; Office for National Statistics, 2023). In this context, CMPA care becomes a postcode lottery: whether a child receives timely, high-quality support depends heavily on where they live, which professionals they see and how able their family is to navigate the system.

3. **Communication, culture and digital access are core safety issues**

Language barriers, culturally misaligned resources and digital poverty were highlighted as major drivers of inequitable CMPA care. Parents who do not speak English as a first language, or who receive milk ladders featuring unfamiliar foods, struggle to understand and implement advice safely, even when they have contact with services. As records, letters and appointments move online, several contributors, particularly tertiary-care dietitians, warned that families without reliable devices or connectivity are left behind, reinforcing digital poverty and lengthening the time it takes to receive the right diagnosis and follow-up. Thus, treating communication, cultural fit and digital access as integral to pathway design is critical for both safety and equity.

4. **Front-line professionals are pivotal but not consistently enabled to act**

Health visitors, dietitians, pharmacists and community teams occupy key touchpoints in the CMPA journey, yet their roles are constrained by variable training and local interpretations of policy. Health visitors see families early and often, but confident discussion of prescribable specialised hypoallergenic formula in mothers who are unable to, or choose not to breast feed,

can be shaped by local interpretations of the UNICEF UK Baby Friendly Initiative (BFI). BFI rightly prioritises breastfeeding and protection from inappropriate formula marketing, but may not always be accompanied by sufficiently clear, practical guidance on how to provide balanced, non-promotional information about specialist formula when clinically indicated. While formula education is formally included within Baby Friendly standards, qualitative evidence shows that some midwives and health visitors feel they are not permitted to raise formula as an option in non-breastfeeding mothers, suggesting a gap between the intent of the standards and their implementation in practice (Lagan et al., 2014). Additionally, women report feeling pressured to breastfeed without receiving balanced information about alternatives, suggesting that current local interpretations of the guidance may be inadvertently restricting important antenatal and postnatal conversations about infant feeding (Lagan et al., 2014). This matters acutely in CMPA, where mothers who cannot, or choose not to breastfeed need timely, accurate guidance on appropriate formula choice rather than encountering a professional reluctance to engage with the topic at all. Addressing this gap offers an opportunity for UNICEF UK BFI, DHSC and ICBs to clarify expectations and strengthen supportive, prevention-focused infant feeding practice in CMPA pathways. Lastly, dietitians were described as central to safe diagnosis, overall management, growth monitoring and ladder support, but dietetic capacity is severely stretched, with some services unable to meet demand. Pharmacists are frequently the first contact for families with concerns about reflux, rashes or formula changes, yet they often lack structured allergy training and clear escalation pathways. Harnessing these professions effectively requires aligning the workforce and training with CMPA pathway goals.

5. Fragmented ownership impedes coordinated improvement

Multiple participants, including clinicians and a policy officer, emphasised that responsibility for CMPA, and allergy more broadly, is currently diffuse with no single body clearly accountable for understanding how many patients are in the system, where they sit along the pathway, or how well that pathway is performing. Recent data show that only a minority of ICBs could report even basic allergy activity, and that many ICBs viewed allergy data as the responsibility of GP practices or hospital trusts rather than of the ICB itself (Allergy UK, 2025). Without this baseline visibility, it is extremely difficult to define pathway performance, to standardise practice, or to target additional support to areas of greatest need. Establishing clear ownership for allergy, alongside routine data collection on CMPA volumes, pathway stages and outcomes across ICBs, is therefore a prerequisite for any sustained improvement effort.

6. Inconsistent advice on milk ladders and early introduction undermines outcome

Advice on when and how to reintroduce cow's milk varies markedly between clinicians and services, despite growing evidence in favour of structured, standardized and supervised ladders. Some families are advised to delay milk introduction for years, while others start ladders in late infancy and report fewer children with persistent CMPA into later childhood. Experts stressed that over- and under-diagnosis both carry risks, but that under-diagnosis uniquely exposes children to life-threatening reactions and significant malnutrition. Standardising ladder and early-introduction practice within national guidance, and ensuring

families have responsive support, is therefore central to improving both safety and equity in CMPA care.

Introduction

Allergic disease in childhood is a growing concern for health systems, families and policymakers, with early-life food allergy emerging as a critical entry point for prevention efforts. In this context, CMPA is one of the most common food allergies in infancy, affecting 2 to 3% of children in the UK (Anaphylaxis UK, 2002), and is often the first clinical expression of atopy. For many children, CMPA does not occur in isolation but can mark the beginning of an "atopic march", with increased risk of later eczema, asthma and rhinoconjunctivitis amongst other conditions (Nocerino et al., 2021). Framing CMPA as an early actionable step in this trajectory shifts it from a narrow paediatric nutrition issue to a strategic lever for reducing the long-term burden of allergic disease in the UK.

The international evidence for CMPA management is evolving in ways that have significant implications for UK practice. Updated World Allergy Organisation Diagnosis and Rationale for Action against Cow's Milk Allergy recommendations now emphasise that nutritional strategies and formula choice can influence not only symptom control but also tolerance development and subsequent allergic outcomes (Venter et al., 2024). Data, including from the Atopic March Cohort Study, suggests that early management decisions in CMPA could shape the pattern and severity of future allergic manifestations (Nocerino et al., 2021). Taken together, these developments point towards a more prevention-oriented model of CMPA care, in which what clinicians do in the first months and years of life can alter children's long-term allergy trajectories. However, translating this evolving international evidence into everyday practice remains a major challenge in the UK, even when the stakes are high; beyond acute symptoms, CMPA disrupts family life and is associated with greater use of primary care and prescription treatments than in non-allergic peers (Cawood et al., 2022). A UK study examining the perspectives of parents and healthcare professionals found that families often experience prolonged diagnostic journeys and uncertainty, and general practitioners (GPs) work with inconsistent access to allergy expertise. This highlights the gap between clinical knowledge and frontline delivery (Lozinsky et al., 2015). These individual experiences are embedded in a wider growing "national allergy crisis", an issue consistently monitored by the UK government since 2003 (All Party Parliamentary Group for Allergy and National Allergy Strategy Group, 2021).

Against this backdrop, there is a critical window of opportunity for the UK health system: action taken today in the recognition and management of CMPA could alter children's long-term allergic trajectories and relieve pressure on an already stretched NHS allergy system. This approach directly aligns with the prevention agenda set out in the NHS 10-Year Plan (DHSC, 2025), which calls for a fundamental shift from treatment to prevention and from acute, hospital-based care to community-focused support. It is in this context that, on the 13th of March 2026, the GPN gathered UK paediatric allergy clinicians, dietetic leaders, primary and community care professionals for a discussion around a central topic: Closing the Gaps in

CMPA: Prevention, Timely Diagnosis and Equitable Access to Care. This report sets out to examine the current challenges and emerging opportunities in CMPA and future allergy risk.

Policy Landscape

Over the last two decades, UK allergy services have often been described as fragmented, under-resourced and lacking an overarching national strategy, despite rising prevalence and complexity of paediatric allergic disease (All Party Parliamentary Group for Allergy and the National Allergy Strategy Group, 2021; British Society for Immunology, 2026). While the prevalence of CMPA in Europe is estimated at around 1.2–1.9% and in the United States at approximately 1.9%, UK data suggest rates closer to 2–3% of children, representing a substantially higher proportion of the population and a significant financial burden (Madrazo et al., 2022; van Tulleken, 2018).

A 2021 British Medical Journal editorial, drawing on the All-Party Parliamentary Group for Allergy and National Allergy Strategy Group report, argues that allergy has been neglected as a public health priority and calls for a national allergy strategy, a national clinical director for allergy, and improved allergy training for doctors (O'Dowd, 2021). The same article highlights that allergy accounts for a substantial share of GPs workload, yet has historically occupied limited space in medical curricula, contributing to gaps in competencies, inconsistent use of diagnostic tools and wide variation in referral patterns. These wider system weaknesses form the backdrop against which early-life food allergies, including CMPA, must be identified and managed in everyday NHS practice. Overall, the increases in healthcare usage observed among infants with CMPA were associated with an annual healthcare cost more than eight times greater than that of an infant without CMPA, which exceeded £25.7 million per year across the UK (Cawood et al., 2022).

Within this broader allergy landscape, CMPA is shaped by clinical guidelines, professional consensus documents and locally commissioned pathways that translate national principles into frontline practice. The National Institute for Health and Care Excellence (2011) guideline on food allergy in under-19s positions primary-care and community-based professionals as central to recognising both IgE- and non-IgE-mediated food allergy. They recommend referral to specialist services for suspected IgE-mediated and more severe non-IgE-mediated presentations. National Institute of Health and Care Excellence however focuses mainly on assessment and diagnosis and offers limited operational detail on day-to-day management of mild-to-moderate non-IgE-mediated CMPA in primary care. In parallel, the British Society for Allergy & Clinical Immunology (BSACI) CMPA guideline provides a specialist perspective, covering epidemiology, diagnosis, treatment and graded reintroduction, but is primarily aimed at secondary and tertiary care rather than general practice (Luyt et al., 2014). To bridge this gap, the Milk Allergy in Primary Care (MAP) guideline and its international 2019 update, iMAP, were developed specifically to support GPs, health visitors and community teams in recognising and managing CMPA in primary-care settings, providing structured algorithms for both IgE- and non-IgE-mediated presentations (Fox et al., 2019). Despite being designed

precisely for this purpose, iMAP remains underused in frontline practice, with considerable variation in whether and how its recommendations are applied locally, meaning the population it was developed to serve does not consistently benefit from its guidance. Together, these documents create the framework within which more pragmatic, primary-care-focused CMPA algorithms have been developed and implemented in the UK.

Empirical work using UK primary-care databases helps explain why structured CMPA pathways have been seen as a policy imperative. Retrospective cohort studies show that children with CMPA have more gastrointestinal, skin and respiratory symptoms, and more infections, than children without CMPA, with clear implications for consultation rates and prescribing in primary care (Sorensen et al., 2021). Health-economic analyses demonstrate that CMPA is associated with higher healthcare utilisation and costs for the NHS, including increased primary-care visits linked to prescriptions and referrals (Cawood et al., 2022). Earlier modelling of resource implications and budget impact also suggested that diagnostic strategies and formula choices could significantly affect costs and service demand (Sladkevicius et al., 2010). Taken together, these studies indicate that, before widespread use of structured algorithms, CMPA management in UK primary care was variable and resource-intensive, reinforcing the case for clearer pathways to support more consistent diagnosis, prescribing and review.

Broader epidemiological and burden-of-illness research on CMPA further defines the scale and nature of the challenge for health systems such as the NHS. A comprehensive review of CMPA epidemiology reports challenge-confirmed prevalence in European infancy cohorts of up to around 3%, with higher estimates when based on self-report or unconfirmed diagnosis, illustrating both the frequency of the condition and the risk of misclassification in routine care (Flom and Sicherer, 2019). Longitudinal data summarised in this review show that many children develop tolerance to cow's milk in early childhood, but a substantial minority experience persistent disease, and that CMPA, particularly when IgE-mediated, can affect growth, nutritional status and quality of life. A recent review of the burden of CMPA in paediatrics describes it as a frequent food allergy affecting a significant proportion of infants worldwide and details its clinical, economic and psychosocial impact on families and health systems (Nocerino et al., 2025). These findings reinforce the case for early, structured and equitable CMPA management as part of health-system planning rather than only a matter of individual clinical practice.

More recent narrative and systematic reviews link these system considerations to evolving ideas about prevention and long-term outcomes. A 2024 review of CMPA in infants and children stresses that it is one of the most frequent paediatric food allergies and discusses how distinct immunological phenotypes, feeding patterns and nutritional strategies can influence the timing and likelihood of tolerance acquisition (Pushpa Sathya and Fenton, 2024). The authors emphasise that management decisions such as duration of elimination, type of hypoallergenic formula and design of reintroduction protocols are increasingly studied for their potential to modify future allergic disease, embedding CMPA care within a more prevention-oriented paradigm. Complementary burden-of-disease reviews argue for integrated

strategies that combine clinical, economic and organisational perspectives to optimise CMPA pathways and reduce downstream pressure on allergy services (Nocerino et al., 2025).

Lastly, evidence directly correlating CMPA with ethnicity in the UK remains scarce, but work on food allergy more broadly has begun to map sociodemographic inequities, including higher burdens of eczema and asthma among minority ethnic groups and differential access to specialist care, both of which are closely linked to CMPA (Osborne et al., 2025). This suggests that examining CMPA alongside its common comorbidities, rather than in isolation, may be a productive way to understand and address ethnicity-related disparities in early-life allergy risk.

Taken together, these diverse academic contributions position CMPA as a strategically important focal point within the UK's evolving allergy policy landscape. On one hand, CMPA exemplifies the broader structural issues identified by parliamentary and professional commentators: a high-volume, high-impact condition largely managed in primary care, in a system where allergy training, specialist capacity and national coordination remain limited. On the other hand, UK-specific guidelines, BSACI recommendations, burden and economic studies, and emerging reviews on tolerance trajectories collectively illustrate how targeted policy instruments can begin to shift CMPA care from ad hoc symptom management towards more standardised, prevention-aware pathways. In this sense, CMPA operates as a practical test case for whether the UK can translate international allergy science and domestic concern about a "national allergy crisis" into coherent, system-level change in the early-life allergy space.

Discussion: Key themes from the roundtable

This discussion section moves beyond describing what was said in the room to distilling what it means for CMPA policy and practice. Drawing on the roundtable, it highlights areas of clear consensus. For example, that CMPA is both common and complex, that delayed diagnosis amplifies harm, and that dietetic capacity and coordinated pathways are indispensable, alongside points where experiences and views diverged, such as the consistency of advice on milk ladders, local interpretations of Baby Friendly guidance, and how far current ICB arrangements are delivering equitable care. Together, these perspectives are used to identify the most actionable priorities for DHSC, NHS England, ICBs and local systems.

Delayed Diagnosis of CMPA

Participants described CMPA as a common but clinically complex condition, particularly in its non-IgE-mediated form. Unlike IgE-mediated allergy, which presents with a clear and rapid onset, non-IgE CMPA is characterised by vague, overlapping symptoms, including reflux, colic, eczema, and loose stools, mirroring both normal infant behaviour as well as common conditions of infancy. It is this inherent ambiguity that makes early recognition difficult and places significant weight on clinical judgement in primary care, setting the conditions for both diagnostic delay and avoidable demand across services.

1. Diagnosis Uncertainty and Avoidable Demand in CMPA pathways

Participants also stressed that these delays caused significant harm for children and their families. In this context, diagnostic uncertainty will "*amplify harm across every dimension of the patient and the system*" (Consultant Paediatrician). Structural gaps in primary care capability drive predictable and avoidable demand.

The group anchored their discussion in specific data on diagnostic journeys. It was highlighted that "*it takes an average of five visits to the GP before a diagnosis is made and in 15% of families it takes 10 visits to the GP and almost 50% wait three months for a diagnosis - that's a long time."* (Consultant Paediatrician). These repeated contacts are not a reflection of the complexity of cases found in the management of CMPA, but of the difficulty accessing timely, confident review in primary care.

Participants linked these delays directly to gaps in primary care confidence and capacity. Although guidance exists, a GP in attendance claimed, *"it's not necessarily implemented or understood,"* and short appointment times limit the ability to explore feeding history, symptom clustering, exclusion diets and formula choices. They further emphasised that symptoms are often viewed *"separately rather than as a pattern,"* and that the absence of decision-support tools means clinicians hesitate to commit to a diagnosis. Practitioners do not currently have the time, tools or confidence required to reliably recognise non-IgE CMPA. This creates a structural barrier to early diagnosis, making repeated contacts and onward referrals predictable rather than exceptional. Without strengthening primary care capability, the system cannot reduce avoidable demand or ensure children receive timely, accurate assessment.

Families sense this uncertainty and *"go and seek further reassurance from elsewhere,"*(Consultant Paediatrician), leading them to cycle through GPs, health visitors and emergency departments, often with multiple formula changes before CMPA is recognised and managed. As summarised by that same paediatrician, *"that's why cases land up in secondary care, not necessarily because they're complex but because of that difficulty accessing appropriate and timely review and diagnosis."*

2. Post-Diagnosis Variation and the Risks of Limited Follow-Up

Crucially, these capability gaps do not end at the point of diagnosis. Participants described how the same structural pressures shape post-diagnostic care, where limited follow-up compounds the variation already introduced earlier in the pathway. Families may be reviewed once and told *"maybe I'll see you in six months' time,"* leaving parents unsure, *"where did this fall on the milk ladder? I had a reaction. Should I stop?"*. With long gaps before the next appointment and no confident primary care touchpoint to bridge them, parents are forced to make decisions alone: *"people go to what they think is safe, and they just stop," even though "that's the least safe thing to do"* (GP). The consequence is a persistent and severe milk allergy that becomes harder to treat, alongside avoidable nutritional risk in cases where milk could have been safely reintroduced. Shorter waits, better access to specialists, and informed primary care support are therefore not separate asks but components of the same underlying need: a workforce equipped to provide timely clinical guidance across the whole pathway, not only at diagnosis.

Taken together, large volumes of clinical time are absorbed by repeated contacts, both before diagnosis and in its aftermath, for a condition that could be recognised and managed earlier. This reduces the capacity of the system to respond to genuinely complex healthcare challenges. In other words, we are spending scarce clinical time on avoidable activity, and the children who most need specialist attention risk longer waiting periods or being overlooked. This is not simply inefficient; it is a structural risk to equity and safety.

3. Delayed Diagnosis Creates Preventable Harm for Children

Delays in diagnosis of CMPA amplify harm for patient and their families. For children, this means *"prolonged symptoms, feeding difficulties, disrupted sleep and potentially growth faltering that could have been avoided"* (Consultant Paediatrician). Participants stressed that these are not inherent features of CMPA, but the direct consequences of delayed or inconsistent diagnosis. Given that CMPA is a recognised marker of future atopic risk, delays in diagnosis may also contribute to the progression of allergy, increasing the likelihood of more complex presentations later in childhood. Therefore, beyond these immediate effects, delayed diagnosis can also mean missed opportunities for early intervention that may alter the course of a child's allergic disease trajectory.

For families, delays resulted in *"distress, lack of sleep, exhaustion, [and] erosion of parental confidence in healthcare services"* (Consultant Paediatrician). These pressures affect daily functioning, feeding relationships and parents' ability to manage symptoms effectively. When families repeatedly seek help without receiving clarity, trust in the system deteriorates, making future engagement more difficult. In that vacuum, parents may feel compelled to take matters into their own hands: prematurely removing milk from the diet, restricting foods unnecessarily or making repeated formula changes. These actions, taken in the absence of clinical guidance, can unintentionally worsen the child's condition by compromising nutritional intake, impeding growth and prolonging symptoms, while at the same time intensifying the burden on families who must care for an even sicker child with still limited professional support. Parents not only carry the weight of seeing their child deteriorate despite their perceived efforts, but also face escalating practical strain, from more appointments to chase to more anxiety about every feed, thus reinforcing a vicious cycle in which the lack of timely, trusted care harms both children and those looking after them.

Timely and accurate diagnosis is therefore essential not only to prevent avoidable suffering but to support healthy development, maintain nutritional safety and protect family wellbeing. Without consistent early recognition, children endure avoidable harm for longer than necessary.

Inequalities in Access: Deprivation, Ethnicity, Service Configuration

Moreover, a running theme throughout this discussion was the recognition that delayed diagnosis and pathway failures do not affect all families equally. Instead, inequalities were seen to map onto deprivation, ethnicity, migration status, and local service configuration, creating what several contributors described as a "postcode lottery" in access to timely diagnosis, dietetic input and specialist care.

1. Socioeconomic Deprivation and Differential Capacity to Absorb Harm

A consultant paediatrician explicitly stated that diagnostic delays *"are not randomly distributed."* Drawing on wider evidence, they stated that *"the children who wait the longest are often those with the fewest resources to absorb that harm."* This claim was connected to broader allergy inequalities, and related to data from the BSACI Registry for Immunotherapy Registry revealing a stark access gap: patients from the most affluent groups were approximately three times more likely to receive NHS allergen immunotherapy compared to those from the most deprived communities, underscoring systemic barriers beyond clinical need (Erlewyn-Lajeunesse et al., 2025).

Although this example is related to immunotherapy, participants suggested that CMPA pathways show similar gradients: families in more deprived areas face greater practical and financial barriers, including travel, time off work, and the financial demands of specialist diets and special milks. These pressures make it harder to seek timely review, sustain recommended management, and buffer the consequences of delayed diagnosis. Children in deprived families experience longer delays, more severe consequences, and fewer opportunities for early intervention. Socioeconomic deprivation does not just increase exposure to delay; it increases exposure to harm. Families with fewer financial and practical resources face greater disruption to daily life. This reveals a structural inequity: children from affluent families receive faster, more direct access to care, while those in deprived circumstances must navigate longer, more complex pathways that amplify harm. Unless CMPA pathways explicitly address deprivation, the system will continue to reproduce and deepen existing inequalities, with children already at a disadvantage experiencing even greater avoidable harm simply because of their socioeconomic position.

Beyond these structural patterns, participants described how day-to-day realities of food insecurity reinforce inequity. Indeed, a dietitian observed that this affects those *"on a special diet, [...] having to purchase specialist milks [that are more expensive] to substitute cow's milk."* Many families *"can't afford to do that,"* with the result that *"it becomes not only a food insecurity issue, but also a postcode lottery"*. A pharmacy lead linked this directly to prescribing practice, explaining that specialist formulas are expensive and *"there is often concern about prescribing costs. But the reality is that delayed diagnosis and inappropriate prescribing can be even more costly,"* with families *"cycling through multiple formulas before reaching the appropriate one*". In deprived areas, concerns about immediate cost can therefore paradoxically increase long-term expense and harm, as families struggle to afford repeated changes while still waiting for the correct diagnosis and management plan.

Inequalities do not end once a diagnosis is made, they persist in the day-to-day management of CMPA. Children already disproportionately affected by delayed diagnosis are then disproportionately affected by the cost of treatment, turning socioeconomic disadvantage into nutritional and health disadvantage. In effect, deprivation is converted directly into health risk. Without targeted support, the system asks the most of those who have the least, deepening rather than mitigating existing inequalities.

2. Ethnicity, Migrant Families and Under-Representation

In parallel, a participant highlighted stark demographic and outcome patterns, noting that *"About 40% of the 600,000 babies born in 2023 in England and Wales were from an ethnic minority group. And about a third of births in that year were to non-UK born mothers."* (Specialist Dietitian) They emphasised that this represents a high proportion of the population, yet national data consistently show that children born to mothers from ethnic minority backgrounds have poorer access and poorer outcomes in both maternal and neonatal health (Raleigh, 2025). When nearly half of all babies are born into groups that already experience poorer access and outcomes, inequity in CMPA pathways becomes a population-level issue, not a marginal one. This preventable harm is not evenly distributed; it is patterned along lines of ethnicity and migration status.

Participants further emphasised that these groups are *"also underrepresented in research,"* which risks embedding their disadvantage into the evidence base that informs guidelines and pathway design (Head Dietitian). Without deliberate inclusion, the system cannot reliably identify or address their needs. That same dietitian argued, ethnic minority groups must be *"included in that data, included in that monitoring,"* and this must be done *"in a way that makes them feel heard or represented and in a way that they can access easily."* This aligns with literature documenting ethnic-related disparities in allergy service access and outcomes (Erlewyn-Lajeunesse et al., 2025). Under-representation in data and research leads directly to under-representation in service design, which in turn leads to poorer access and poorer outcomes. Unless CMPA pathways intentionally include ethnic minority and migrant families in evidence generation, monitoring and service development, existing disparities will not only persist but become structurally embedded.

3. Service Configuration, Geography and the Postcode Lottery

Participants also highlighted how the configuration and distribution of services create a postcode lottery in CMPA care. A head dietitian working in a tertiary centre in London explained that *"people have to travel far, far and wide to get to us, and it sometimes is just not possible"*. For many families, the cost, time and logistics of travelling to specialist services are shaped by the ability to absorb these practical burdens, rather than clinical needs.

Access to dietitians and allergists *"really depends on where they are,"* with waiting lists *"being really impacted"* so that patients *"are waiting a long time to get the information that they need"*, a head dietitian noted. When access to dietitians, allergists and specialist advice depends on geography, families who live outside well-resourced areas face longer waits, fewer options and greater difficulty reaching the right expertise. Those who cannot repeatedly advocate for themselves, travel long distances or absorb the associated financial and practical burdens are placed at a clear disadvantage. In practice, the level, timeliness and quality of care a child receives is shaped as much by where they live as by their clinical needs. This means that identical symptoms can lead to very different pathways and outcomes, entrenching inequity within the system rather than mitigating it.

In some areas, *"you can only see a dietitian, and you can't see an allergist, or you can't see a dietitian because our health visitors are meant to be able to support you"* (GP), while in others, tertiary services are available. This reflects the broader lack of consistency in care pathways, where the level of care received depends almost entirely on where a family lives and which professionals they happen to encounter, rather than on the clinical needs of the child.

Without reform to service configuration and a more equitable geographic distribution of specialist provision, the postcode lottery in CMPA care will persist, contrary to the express commitments of the NHS 10 Year Health Plan, which identifies geographic inequity in access as a central challenge requiring structural redress (NHS England, 2025a).

4. Professional Variation and Reliance on "Allergy-Curious" Clinicians

The interplay between structural factors and individual professional practice was also highlighted. A GP working predominantly in private allergy care reflected candidly on their own position: "*I would be honest and say that nearly all my work is private allergy these days. So, do I offer an equitable care? Well, no, because I primarily look after a private base."*

For them, this mixture of postcode lottery and professional variation means that *"if you have a GP like me who has a personal interest in allergy, then the level of care you're going to get is quite different because they understand the challenges and would be quite a supportive person of you"* (GP), underlining how individual interest and training can mitigate or exacerbate structural inequities. Rather than a simple issue of service availability, CMPA thus becomes a test of how far paediatric care still relies on allergy-curious practitioners to plug systemic gaps, raising concerns about what happens to children whose journeys unfold entirely within standard services where such specialised interest is absent.

This reliance is not a sustainable model. When equitable care depends on the personal interest of individual clinicians rather than on standardised training and clear referral protocols, outcomes become arbitrary, determined by professional lottery as much as postcode lottery. The implication for policy is clear: embedding allergy competency into core primary care training and establishing minimum standards for CMPA identification and referral is a prerequisite for ensuring that every child receives consistent, timely care regardless of which clinician they first encounter.

Language, Culture, Digital Poverty and Mental Health

Alongside socioeconomic and ethnic inequalities, participants identified a cluster of "hidden" determinants that significantly shape families' experiences of CMPA: language barriers, cultural fit of resources, digital exclusion and psychological burden. These were not viewed as peripheral issues but as central to understanding why apparently similar pathways can have very different impacts on different families.

1. Language Barrier in Accessing Provided Tools

Language emerged as a major compounding factor. A participant emphasised that:

"We have to acknowledge that a large proportion of our population doesn't speak English as their first language, and in healthcare communication, if languages are not translatable and we don't use interpreters effectively, even just the understanding of a diagnosis, the understanding of who to ask and how to get help is greatly impacted." (Specialist Dietitian)

This is consistent with the NHS's own evidence base: an estimated one million people in the UK speak little to no English, and people with limited English proficiency are more likely to experience adverse events, have a greater likelihood of developing life-threatening conditions, and face poorer access to, and experiences of, healthcare at every stage of their journey (NHS England, 2025b). In the context of CMPA, this means that a substantial share of infants at risk are growing up in families who are less likely to reach timely diagnosis, less able to absorb complex dietary advice or milk ladder instructions, and more vulnerable to unsafe or incomplete implementation of care, directly reinforcing the inequities described earlier in this report.

2. Cultural Relevance of Dietary Resources

Dietary resources were a particular focus. It was additionally observed that *"We love a good leaflet, we love a good picture diagram giving people milk ladders that they can follow,"* but *"if that's not in their language, if those foods on that milk ladder are not foods that they eat in their household, the recipes are not from foods that they would eat, we're already making them at a disadvantage."* (Specialist Dietitian)

In response to this, a participant added that developing culturally adapted ladders is technically demanding and not necessarily the most effective: the Indian milk ladder *"took us about three years to write because I had to adapt the recipe so much to get the fat and sugar content to something remotely close to the World Health Organization guidance"* (Professor of Paediatrics).

This timeline reflects a systemic inefficiency, where the costs, based on specialist time and on the period during which diverse families are left without usable guidance, are substantial. It should serve as evidence that no individual service should be expected to undertake this work alone. Culture and language are explicit barriers to both accessing and navigating CMPA care and management. Being diagnosed is only the first hurdle. Once families receive a diagnosis, they are frequently given tools and guidance that fail to reflect their cultural context, dietary practices, or linguistic needs. Effectively requiring them to reorganise their entire way of life around a condition that, in many cases, resolves within the first few years of life. This is neither equitable nor sustainable. Milk ladders and reintroduction protocols, in particular, must be not only translated but genuinely culturally adapted. This process should ideally be co-developed with experts from the communities they are intended to serve. Internationally developed tools and cross-cultural adaptation frameworks offer a foundation that a nationally coordinated approach could build on, but only if cultural appropriateness is treated as a design requirement.

3. Digital Poverty and Exclusion from "Modern" Care

At the same time, the shift towards digital healthcare, from appointments, to letters, results and messaging, was seen as a double-edged sword. Indeed, participants highlight that *"if you don't*

have a mobile phone or a tablet to access any of those, you're at an instant disadvantage. And more so again, if all that digital information is not in the language that you speak or understand." (Specialist Dietitian)

This combination was labelled "digital poverty," with participants warning that as healthcare *"is becoming more digitised, data is digitised, research is digitised,"* the very families at greatest risk of delay may find it *"just a much longer time (...) to get the right information, the right diagnosis, and therefore equitable cow's milk protein allergy management."* This is particularly significant in the context of CMPA, where timely diagnosis and dietary intervention in infancy carry long-term nutritional consequences. A care model that assumes digital access does not merely inconvenience excluded families. It actively compounds existing inequalities by creating a two-tier system in which the most vulnerable are the least able to navigate it.

Lastly, another contributor raised the issue of mandated *"digital adjustment flags"* within electronic records, noting that allergy did not appear to be included and questioning whether this represented a missed opportunity to systematically identify and support patients with CMPA. The absence of allergy from these flags is not a technical oversight but a policy gap: without structured prompts within electronic records, clinicians have no systematic mechanism to identify patients who may need non-digital alternatives, interpreter support, or culturally adapted materials. The NHS 10 Year Health Plan sets an explicit ambition to shift care "from analogue to digital," with the NHS App positioned as the primary route through which patients will access services and manage their care (NHS England, 2025a). That ambition is welcome but carries a real risk for the families described throughout this report. Those already navigating language barriers, limited connectivity, or low digital confidence are unlikely to benefit equally from a system redesigned around digital access, and may in practice find themselves further from care, not closer to it. Incorporating allergies into digital adjustment flagging, the mechanism by which electronic records alert clinicians to patients who may need non-digital routes to access their care, would be a modest and practical step toward ensuring that the drive for digital transformation does not widen the very gaps it elsewhere promises to close.

4. Parental Mental Health, Feeding Anxiety and Long-Term Impact

Speakers emphasised the psychological burden of CMPA on parents and children, arguing that it remains under-recognised in both clinical practice and service design. Drawing on professional and personal experience, a dietitian commented that *"restricted diets are very underplayed when it comes to the impact of mental health and quality of life."* Indeed, families *"have to check labels constantly, and we're asking families to be vigilant all the time, and this hypervigilance really creates a chronic stress, and I can't stress that enough. It impacts every day. It impacts social behaviours, eating, you know, school activities that involve cooking and recipe making."*. This reflects a pattern well recognised in UK clinical practice: CMPA can significantly impact a parent's quality of life, leading to feelings of frustration, anxiety and isolation, with the restrictions imposed by dairy avoidance interfering with daily activities, social interactions and dietary choices across the whole family (Roberts, n.d.).

The participants also noted that *"when you talk to children who are going through this who are old enough to speak to you, it does impact their quality of life and their future potential for sure"* (Head Dietitian).

Parental feeding anxiety was described as a key mechanism: being *"anxious around mealtimes, being anxious around eating out, it all impacts the children and their enjoyment of eating, and then they often display restricted eating behaviours"* (Head Dietitian). Importantly, *"often you see that persist way beyond actually when the allergy may be treated and resolved, especially in non-IgE mediated cow's milk protein allergy"* (Head Dietitian), with ongoing implications for nutritional status as children grow older. NHS clinical guidance already acknowledges that elimination diets carry a negative psychological effect and can adversely impact quality of life. Yet this recognition has not translated into routine psychosocial support being built into CMPA pathways (Raptis, Maclean and Inglis, 2021). The gap between clinical acknowledgement and service provision is itself a finding: the psychological burden of CMPA is not an unrecognised problem, but one that receives far too little practical action.

This points to a clear priority for pathway redesign: psychosocial screening and support should be considered a clinical component of CMPA management, not an optional referral made only when families themselves raise concerns

Roles, Responsibilities and Professional Variation

Finally, the conversation dived into the cross-cutting nature of CMPA across multiple parts of the system, and the consequences of unclear ownership, diffuse responsibility and variable professional preparation. CMPA was characterised as a condition that "touches" primary care, health visiting, community pharmacy, dietetics and specialist paediatrics. Yet without a single point of accountability, responsibility for timely diagnosis and management risks falling between services rather than being held by any one of them.

1. Fragmented Ownership and Weak Accountability

The structural problem of CMPA diagnosis was summarised succinctly:

"At the moment, no single clinical setting owns the CMPA pathway. What that fragmentation means is unwarranted variation in outcomes, unnecessary cost and therefore systemic inequity. CMPA is a system problem, not an individual clinician problem." (Consultant Paediatrician)

Indeed, following a written parliamentary question, Baroness Merron – the Parliamentary Under-Secretary of State for Women's Health and Mental Health – had indicated that responsibility lay with ICBs. Yet, when Allergy UK (2025) submitted Freedom of Information requests to all 42 ICBs, *"only nine of them could give us data on how many patients they have with allergies"* while several others either supplied incomplete figures or stated they held no such data at all. This aligns with our participant's account that, in at least one case, *"two different departments tried to say the other one was responsible for allergy and we should go to them"* leading them to conclude that *"It's a mess. There is no real centralised data"* and that *"there is a real misunderstanding over who should be responsible"*, a governance gap which should be tackled before even considering treatment solutions (Policy Officer). This lack of

foundational agreement about who holds responsibility and where allergy sits within local structures shows that there are no clear pathways or lines of ownership. When even departments and professionals are unsure who is in charge, care on the ground becomes fragmented and inconsistent, and families navigating CMPA experience poor and confusing support rather than a coherent pathway.

Furthermore, without reliable data at the ICB level, it is impossible to organise the workforce, allocate dietetic capacity, commission appropriate services, or monitor whether care is equitable across populations. It is in this context of unclear governance that the clinical burden of food allergies in the UK is growing. Indeed, hospital admissions for food-induced anaphylaxis have more than tripled over the past two decades, with annual increases of over 5% and the steepest rise seen in children (Baseggio Conrado et al., 2021). Within this broader trend, cow's milk has become a particular concern: despite overall case fatality rates falling over the same period, deaths attributable to cow's milk exposure have increased, and cow's milk is now the most common cause of fatal food anaphylaxis in school-aged children in the UK, responsible for 26% of food anaphylaxis deaths in that age group (Baseggio Conrado et al., 2021). This thus implies that allergies, and particularly CMPA, are an escalating health issue in a system which still lacks clear pathways and understanding of the patient journey, and whether they are receiving appropriate care. When no one feels accountable for CMPA, families are repeatedly being redirected between primary care, dietetics and hospital services without anyone taking ownership of their journey. Consequently, children do not receive the right care at the right time, preventable harm accumulates, and anxiety for parents intensifies. Clarifying accountability at both national and ICB levels is therefore a core patient-safety requirement.

2. Lack of designated professional training for healthcare workers

Firstly, health visitors were highlighted as a crucial first point of contact: *"health visitors see families very frequently in the first year of life, and we often hear about feeding concerns very early on, but one of the challenges is that symptoms of cow's milk allergy overlap with very common infant behaviours, such as babies being unsettled, crying, bringing up milk. Distinguishing between normal infant behaviour and potential allergy can be difficult. That's why training and collaboration with other professionals is really important, alongside clear pathways to refer or escalate concerns."* (Health Visitor). In other words, without consistent allergy training and clear CMPA pathways, they are left relying on judgment alone to distinguish normal variation from possible allergy and to know when and how to escalate, a process which in turn lengthens the diagnostic journey.

Dietetic capacity more broadly was viewed as a critical component for safe and equitable care. A consultant paediatrician stated that "*the most important person in my clinic is the dietitian, not me,"* but that *"dietetic support is very severely lacking in all our services, including allergy and the NHS as a whole"*. Without enough dietitians with paediatric allergy expertise, children with suspected CMPA may not receive timely nutritional assessment, growth monitoring or structured support with elimination and ladders, even once they reach specialist services.

GP training emerged as a particular gap. Echoing the case described above, the GP whose personal experience with CMPA prompted them to seek out additional allergy training and develop a strong CMPA interest acknowledged that most GPs would not have the time, mandate or personal motivation to pursue equivalent training. This underlines how fragile it is to rely on individual "allergy curious" clinicians rather than system-wide allergy education and minimum standards for CMPA recognition and referral.

Additionally, pharmacists and community teams were identified as under-recognised support in CMPA pathways. A pharmacy lead highlighted that "*pharmacists are often the first healthcare professional that parents speak to,"* presenting *"a real opportunity to recognise when symptoms might suggest cow's milk allergy and to advise families to seek medical assessment" (Pharmacy Lead)*. Because community pharmacists are highly accessible and see many families, targeted CMPA training and clear referral routes would allow them to assess and potentially redirect children who do not have CMPA, eliminating unnecessary GP and emergency appointments, while guiding those with concerning symptoms to appropriate assessment. Clear pathways could also help pharmacists advise on first-line steps, such as when to consider cow's milk exclusion and thus reducing the risk of families either stopping milk unnecessarily, or continuing milk when significant symptoms are present.

These concerns are not isolated to CMPA. The UK's first National Allergy Strategy (National Allergy Strategy Group, 2026), the British Dietetic Association (BDA) (2023) and the All-Party Parliamentary Group for Allergy (APPG) (Anaphylaxis UK, 2021) all come to the same conclusion: allergy training is insufficient across the professionals who see patients first. The National Allergy Strategy highlights that most GPs start work with no formal allergy training, despite allergy accounting for a large share of their consultations, while the BDA warns that dietetics is largely absent from the NHS Long Term Workforce Plan, even though prevention is a stated priority, and the APPG urges every primary-care practice to designate a health visitor and/or practice nurse with specific responsibility for allergy. Our roundtable reached the same conclusions for CMPA: the professionals most likely to encounter CMPA in its earliest stages are routinely under-trained, under-resourced, and poorly connected to one another. Until allergy, and infant allergy specifically, is embedded meaningfully into professional education, community workforce planning, and NHS commissioning frameworks, improvements in clinical guidelines alone will have limited reach.

3. Baby Friendly Initiative

This linked directly to concerns about how the UNICEF UK BFI is implemented locally. The initiative, while valuable in promoting breastfeeding as the optimal source of infant nutrition, creates a tension at the clinical frontline: in prioritising breastfeeding, it can inadvertently sideline the training and confidence needed to support families for whom breastfeeding is not possible or not chosen. A health visitor noted that many early years services *"are being pushed to achieve baby friendly initiative status, so a lot of individuals actually won't get any training or guidance on formula milk,"* questioning how teams can be *"well equipped"* in CMPA when policy appears to restrict formula-related education. This matters because a clinician who lacks training in specialist formulas, or who feels that recommending formula conflicts with their

institutional mandate, may delay or avoid giving guidance at exactly the moment a family needs it most. At the same time, another participant reiterated that *"we always say breastfeeding is the best way to provide nutrition to any baby with CMPA,"* while acknowledging that some mothers *"can't breastfeed or choose not to,"* so practical support on specialist formulas remains essential (Consultant paediatrician). Yet this acknowledgement itself reveals the divide: breastfeeding is positioned as the default, and departing from it, even when clinically warranted, requires a justification that not all practitioners feel equipped or permitted to make. The result is a gap between what policy promotes and what families need, one that falls disproportionately on those whose particular health circumstances or choices do not fit the assumed norm. What is needed is not a weakening of breastfeeding promotion, but an explicit recognition within BFI implementation guidance that supporting infant feeding in CMPA requires a distinct, parallel competency, and that withholding formula education in the name of breastfeeding advocacy is itself a clinical risk.

However, a community-level example showed that these goals can be reconciled. In Derbyshire, *"they have baby-friendly status, and they have two infant feeding specialist leads that are responsible for all the training of all the health visitors (...) Of which I've trained them all on cow's milk protein allergy"* (Community dietitian). Health visitors there are now *"as part of Baby Friendly allowed to talk about specialist formula, and have embraced this absolutely brilliantly,"* demonstrating that Baby Friendly "*isn't against it*" when locally interpreted to include allergy support (Community dietitian). This indicates that the problem is not the initiative, but rather the absence of allergy-aware implementation and training. Given these outcomes, the BFI represents a promising approach that provides a practical model that other UK regions and services can adopt.

4. Variation in Advice and Evolving Evidence on Ladders and Early Introduction

Lastly, participants highlighted variation in advice on allergen introduction and milk ladders across the UK, despite converging evidence on the benefits of timely, structured reintroduction. One speaker described *"such a difference in information about milk ladders (...) around the 'don't start until you're this age if it's IgE-mediated allergy',"* arguing that waiting fora "*magic skin prick number"* ignores *"increasing evidence that early consumption might help reduce the ongoing allergy rather than just avoid and wait.* (GP).

By contrast, other services routinely introduce baked milk earlier; one contributor noted that *"we start all our milk allergy kids at 10 months old so we've got very few now who actually go into* late *childhood with ongoing milk allergy"* but we still receive referrals from areas where parents are told *"you must not introduce any baked milk until 18 month or two years old."* (Consultant paediatrician). Another speaker reported that an international position statement is being developed to standardise ladder use, noting that *"four times more children react when they avoid milk than children following ladders"* (Academic dietitian). This variation in practice, despite growing evidence and emerging international positions, suggests an urgent

need for consolidated national recommendations on milk ladder use across UK paediatric and dietetic services.

These findings expose a gap between accumulating evidence and frontline practice that carries direct clinical consequences. When there is significant variance in guidance, avoidance becomes the default, not because it is safer but because it feels safer, and families are rarely equipped to challenge that assumption. The data cited above suggest this risk calculus is inverted: structured early introduction, even in IgE-mediated cases, appears to reduce rather than increase long-term reactivity. The development of an international position statement on milk ladder standardisation therefore arrives at the right moment. For it to translate into consistent practice in the UK however, it will need to be accompanied by clear communication to primary care about revised timing thresholds, and by follow-up protocols that support families through reactions mid-ladder rather than leaving avoidance as the path of least resistance.

Recommendations

Establishing System Ownership and Accountability for CMPA

UK policymakers should explicitly recognise CMPA and paediatric food allergy as priority conditions within national child-health and health-inequalities strategies, embedding them in the wider prevention agenda and aligning them with the NHS Long Term Plan's goals on early intervention and reducing the burden of long-term conditions. Finland developed a ten-year national allergy programme from 2008 to 2018, which systematically reduced the prevalence of food allergy diets in children by up to 80% through coordinated public-health and clinical action (Haahtela et al., 2021). A comparable approach to CMPA management in the UK could similarly improve population outcomes, avoid costly late presentations and help prevent progression along the atopic march, thereby saving substantial NHS resources over the life course.

NHS England should designate CMPA as a priority pathway within national allergy policy and early-years programmes. This should set clear expectations that all ICBs should develop and monitor local pathways rather than leaving provision to individual clinical interest. This work should be grounded in existing tools such as MAP guidelines, which already detail structured approaches to recognition and elimination for non-IgE CMPA. Where these tools are not consistently embedded in daily practice, NHS England should create the infrastructure and incentives needed to bridge the gap between guidance and delivery, as the roundtable discussion made clear that awareness of guidelines does not automatically translate into their use.

ICBs should establish CMPA pathway groups bringing together paediatricians, primary-care leads, dietitians, pharmacists, health visitors and public-health representatives so that responsibility is distributed across the system rather than residing in a single profession. These groups should pay particular attention to variation between deprived and more affluent areas,

as the roundtable highlighted that diagnostic delays in CMPA track socioeconomic deprivation closely.

Royal colleges and specialist societies, including BSACI, Royal College of Paediatrics and Child Health, Royal College of Nursing and the BDA, should explicitly reference CMPA in their position statements on paediatric allergy, signalling that this is a core component of routine child health rather than a fringe subspecialty.

Strengthening Early Recognition, Primary-Care Management and Front-Line Roles

NHS England should issue concise practical guidance for primary care and health visiting on recognising and managing CMPA, with emphasis on non-IgE presentations that overlap with common infant conditions. This guidance should align with MAP guidelines for primary-care assessment and incorporate National,European and Global paediatric allergy and gastroenterology recommendations on diagnostic elimination and challenge. It should also explain how CMPA assessment can be embedded within health-visiting schedules and early-years services, while remaining consistent with BFI standards. This initiative could draw inspiration from Finland's national allergy programme, which demonstrated that re-educating health professionals on food allergy can successfully reduce unnecessary dietary restrictions without undermining breastfeeding promotion (Haahtela et al., 2012).

ICBs should ensure that CMPA recognition algorithms are integrated into GP and health-visitor electronic systems as decision-support prompts, so that when relevant symptom combinations are recorded, the system links clinicians to the local pathway. For instance, in the United States, use of electronic health record tools to document food allergy and connect patients to appropriate resources has been identified as a key strategy for reducing inequities in access to care, particularly for families from lower-income backgrounds (Dehborzogi et al., 2024). ICBs should also fund dedicated CMPA training for health visitors and early-years practitioners that goes beyond generic infant-feeding messages and provides practical tools for recognising symptom patterns, supporting families with formula feeding if required and knowing when to refer.

Professional bodies and universities should embed CMPA into undergraduate and postgraduate curricula across paediatrics, general practice, nursing, dietetics and pharmacy, using realistic case scenarios that reflect symptom overlap and equity dimensions. US literature on health equity in food allergy highlights that culturally sensitive education for both caregivers and primary-care clinicians is one of the most effective yet underexplored strategies for reducing disparities in early recognition and management (Dehborzogi et al., 2024).

Expanding Dietetic Capacity, Reducing Inequalities and Addressing Language, Culture and Digital Poverty

NHS England should coordinate a national programme to develop and disseminate CMPA educational materials translated into major community languages and featuring foods, recipes and images that reflect the cultural practices of diverse families. The Indian milk ladder, developed by adapting recipes to meet World Health Organisation nutritional standards, illustrates both the feasibility and the effort required to produce culturally appropriate tools, making a centrally coordinated programme more efficient than expecting individual services to undertake this work alone (Ramakrishna et al., 2023).

ICBs should commission dietetic sessions directly linked to primary-care and community paediatric CMPA pathways so that non-IgE cases can be managed closer to home with specialist oversight, without requiring families to access tertiary centres. French national dietetic recommendations for CMPA in infants emphasise early nutritional assessment, appropriate formula substitution and regular growth and micronutrient monitoring as the foundation of safe community-based management, providing a model that UK ICBs could adapt. ICBs and local authorities should also assess digital access within their populations and ensure that CMPA care does not rely exclusively on apps or online portals, so that families who are not digitally connected receive information and follow-up through letters, telephone calls or in-person appointments at key stages, such as diagnosis and ladder initiation. Interpreter services should be offered proactively for families whose first language is not English, given that the roundtable identified language as a significant barrier to understanding diagnosis and implementing dietary changes.

Community providers should consider integrating psychosocial screening and support into CMPA pathways, recognising the parental anxiety and restricted eating behaviours that roundtable participants described as significantly under-addressed. In Ireland, incorporating psychology and family support has demonstrated improved coping and quality of life for individuals managing food allergy (Antolín-Amérigo et al., 2016).

Next Steps

To support implementation, the table below summarises priority actions, proposed owners and indicative timing, translating the roundtable insights into a clear workplan.

Action	Owner(s)	Timing
Explicitly recognise CMPA and paediatric food allergy as priority conditions within national child-health, prevention and health-inequalities strategies, signalling their importance in delivering the NHS Long Term Plan.	DHSC, NHS	Short term (within 12–18 months)
Require ICB to map and monitor a local CMPA pathway, with routine reporting on diagnostic timeliness, escalation, and equity (by deprivation and ethnicity).	NHS, ICBs	Short to medium term (1–3 years)

Embed standardised CMPA recognition and management algorithms (e.g. iMAP) in primary-care IT systems and local guidance, alongside targeted training for GPs, health visitors, community pharmacists and early-years teams.	ICBs, Primary-care networks, Professional bodies (RCPCH, RCGP, RCN, RPS)	Medium term (2–4 years)
Use emerging Integrated Neighbourhood Teams to convene local CMPA huddles, bringing together GPs, health visitors, pharmacists, dietitians and early-years leads to review local pathways, agree roles and start improvement cycles.	Integrated Neighbourhood Teams, Place-based partnerships, Clinical leads	Short term (start within 12 months) and ongoing
Increase community and secondary-care dietetic capacity in areas with the greatest deprivation-linked delays, recognising dietitians as the cornerstone for safe diagnosis, growth monitoring and ladder support.	ICBs, Provider trusts, Workforce planners	Long term (2–5 years)
Commission or adapt culturally relevant, language-appropriate CMPA resources (including milk ladders) and ensure non-digital routes to information are available alongside digital tools.	ICBs, Community providers, Local authorities	Medium term (2–4 years)
Support development and rapid adoption of national guidance on milk ladders and early introduction (including for IgE-mediated CMPA) to reduce unwarranted variation and share risk across the system.	BSACI, WAO/EAACI working groups, NHS	Short to medium term (work underway - adoption within 2–3 years)

Closing Discussion

Taken together, the roundtable discussions underscore that CMPA is not a niche paediatric nutrition issue but a revealing test case for how the UK health system recognises, manages and distributes risk in early-life allergy. CMPA exposes the consequences of delayed recognition, fragmented ownership and uneven access to dietetic and specialist input, but it also highlights the potential of coordinated pathways, culturally competent communication and empowered front-line professionals to change trajectories for children and families.

Participants stressed that many of the tools needed to improve CMPA care already exist but are not yet consistently deployed or aligned with equity goals. The challenge now is more about embedding what is known into everyday practice, clarifying responsibility across ICBs, and measuring progress on timeliness and fairness of access.

Overall, CMPA offers a practical starting point for a broader allergy strategy: by acting early, supporting families where they live, and designing pathways that work for those at greatest risk, the NHS can reduce avoidable harm today while building a more resilient, equitable allergy system for the future.

Lastly, looking ahead at the next steps in GPN's work towards understanding pathways for sustainable and equitable CMPA treatment beyond the UK, a global symposium gathering international experts will delve further into questions initially explored in this report. Amongst the expected topics are questions around the universality of milk ladders, gut microbiome, or

the overlap of malnutrition with CMPA, all discussed through insights from practitioners from all around the world.

Attendees of Roundtable One

The insights and recommendations of this report have been informed by a roundtable event which took place on the 13th of March 2026, under Chatham House Rule. A diverse group of 16 delegates from across different sectors shared their expertise and insights to inform this policy report.

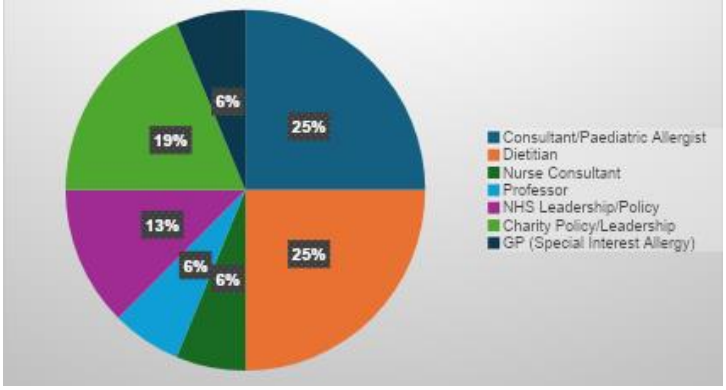

Figure 1: Roundtable One Delegates: Organisational Background.

Participants List

1. **Nick Makwana -** Consultant Paediatrician, Sandwell and West Birmingham Hospitals
2. **Natalie Yerlett -** Head of Dietetics, Great Ormand Street
3. **Carina Venter -** Professor of Paediatrics, Children's Hospital Colorado
4. **Nirusha Govender** - Pharmacy Health Systems Leader, NHS and GPN associate
5. **Mallika Datar -** Information Officer, Anaphylaxis UK
6. **Misbah Primett -** Paediatric Allergy Dietitian, Little People Dietitian & St George University Hospitals NHS Foundation Trust
7. **Lisa Waddell -** Community Paediatric Allergy Dietitian, Food Allergy Nottingham Service Ltd
8. **Aneta Ivanova** – Nurse Consultant/Paediatric Allergy, Sandwell and West Birmingham Hospitals NHS Trust
9. **Kumar Somasundaram -** Paediatric Allergist, Maidstone and Tunbridge Wells NHS Trust
10. **Lucy Upton -** Paediatric Dietitian, The Children's Dietitian Ltd
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