Royal College of Physicians

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Improving Quality in Allergy Services (IQAS)

Accreditation standards and evidence requirements

Royal College of Physicians and Royal College of Pathologists
Joint Committee on Immunology and Allergy

February 2016

The Royal College of Physicians

The Royal College of Physicians is a registered charity that aims to ensure high quality care for patients by promoting the highest standards of medical practice. It provides and sets standards in clinical practice and education and training, conducts assessments and examinations, quality assures external audit programmes, supports doctors in their practice of medicine, and advises the government, public and the profession on healthcare issues.

Joint Committee on Immunology and Allergy

The medical royal colleges' Joint Committee on Immunology and Allergy (JCIA) established a working group (a subgroup of the JCIA) which, along with expert guidance from the RCP's accreditation unit, developed the IQAS accreditation standards.

Key stakeholders

This work has been possible because of the financial support of the RCP, the British Society for Allergy and Clinical Immunology, the British Society for Immunology and the Royal College of Pathologists.

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Background

Allergy accreditation

There has been discussion in the allergy community for a number of years about the need to develop a process by which the quality of allergy services can be assured. The importance of this was highlighted in the RCP working party report *Allergy services: still not meeting the unmet need* (RCP, 2010). Responding to this need, Improving Quality in Allergy Services (IQAS) was launched in October 2011, initially as a registration scheme, but with plans to develop standards for a robust accreditation scheme. The aims of the IQAS registration scheme were to prepare the allergy community for the challenging and rigorous process of meeting high quality accreditation standards, and to begin a programme of quality improvement so services would be ready to meet such standards.

The medical royal colleges' Joint Committee on Immunology and Allergy (JCIA) – with expert guidance from the RCP's accreditation unit – has developed these standards to underpin a robust, yet supportive adult allergy accreditation scheme. This work has been possible because of the financial support of the RCP, the British Society for Allergy and Clinical Immunology, the British Society for Immunology and the Royal College of Pathologists.

The RCP accreditation unit

The RCP accreditation unit was established to improve the quality, safety and outcomes of healthcare through accreditation assessment against agreed standards. Accreditation is a supportive process involving self-assessment, training, consultancy, support, recommendations, and the sharing of best practice by teams. The RCP hosts several accreditation schemes, including the Joint Advisory Group (JAG) on gastrointestinal endoscopy (established in 1994), Safe Effective Quality Occupational Health Service (SEQOHS), Improving Quality in Physiological Diagnostic Services (IQIPS) and Quality in Primary Immunodeficiency Services (QPIDS).

The accreditation unit has clinical and technical expertise in accreditation, a well-established accreditation methodology and tried and tested supporting policies and procedures. It has a large administrative capacity and experience of developing and running the web-based accreditation tools that support the accreditation pathway. It also has an understanding of operating a sustainable business model, which balances value for money with a high quality scheme.

About this document

This document has been designed to assist UK adult allergy services to prepare for Improving Quality in Allergy Services (IQAS) accreditation. It defines the evidence requirements to meet the standards for IQAS accreditation.

Aim

The aim of the standards and supporting evidence is to support the achievement of safe, appropriate and effective quality allergy services in the United Kingdom.

Purpose

The purpose of this document is to define the evidence requirements that apply to allergy services that participate in the IQAS accreditation scheme.

Scope

The standards and evidence requirements apply to comprehensive adult allergy services based in the UK. Paediatric allergy services are out of scope. The standards are not aimed at allergic contact dermatitis services.

General allergy, allergen-specific immunotherapy and challenges (food and drug) are core to a 'comprehensive allergy service'. Services are eligible for accreditation only if they offer these 'core services'. Centres where a certain aspect of the 'core service' is provided by another department within the same NHS Trust (eg allergen-immunotherapy is provided by Respiratory Physicians, or drug challenges are provided by Clinical Pharmacologists or Anaesthetists), can also be accredited subject to demonstration of clear referral pathways, governance structure and adherence to the standards. Services with a single consultant (or limited capacity) or offering a limited range of the 'core services' within their trust cannot be accredited as a 'comprehensive allergy service' but can apply as a 'spoke' to a 'hub' in a joint application process.

Principles

The standards and evidence requirements were developed with the following principles in mind:

- **Openness:** the content of the standards will be in the public domain to ensure that providers and purchasers understand the standards expected of allergy services.
- **Accessibility:** allergy services in both the public and independent sector will be able to apply for accreditation, but all allergy services must meet the same high standard of quality to achieve accreditation. The fees charged for assessment for accreditation shall be affordable and realistic.
- **Significance:** standards and the evidence requirements will reflect existing national policy, guidelines and professional guidance.
- **Objectivity:** eligibility for the award of accreditation shall be assessed on the basis of the collection and presentation of suitable documentary evidence and observation.
- **Prudence:** ideally evidence should be produced as a by-product of another routine activity to avoid causing excessive administrative burden. Applicants should not have to change their own information gathering or reporting cycles to fit the accreditation review unless it makes sense to do so. Evidence should be recent information, gathered within the last 12 months.

Introduction

The following standards and evidence requirements are designed to be applied within a UK clinical accreditation scheme. These are professional standards for allergy services. In addition to maintaining high standards of service delivery, providers of allergy services must also be committed to upholding and promoting standards of best practice in accordance with standards set by the relevant professional bodies. Consequently, the standards for IQAS take into consideration and complement the standards set by these professional bodies.

Definitions

A **standard** is something considered by an authority or by general consensus as a basis of comparison in measuring or judging adequacy or quality. These standards have been developed by a subgroup of the Royal College of Physicians and Royal College of Pathologists Joint Committee on Immunology and Allergy (JCIA). In this document standards are expressed as something which allergy services must do as an overriding duty of principle in order to meet the requirements for accreditation. They provide the basis for evaluating quality of service and will evolve over time.

For each standard, the **evidence criteria** are defined as:

Level B - good; the minimum requirement for accreditation.
Level A - excellent, aspirational; demonstration of excellence above the minimum requirements of an accredited service.

The IQAS **evidence criteria** are intended to be well-defined and easy to understand. The level B criteria must be met to demonstrate adherence to the standards, while the level A evidence criteria are additional criteria to show exceptional performance by a service.

The **examples of suitable evidence** illustrate the types of information that can be used to demonstrate compliance with a standard. This is not intended to be either prescriptive or exhaustive. Services may provide what they consider the most convincing evidence available for their achievement of each standard, whether or not it appears among the examples. However, where services provide evidence to demonstrate adherence to the level A evidence criteria, they must also provide evidence to show adherence to level B. Services should also consult the IQAS Knowledge Management System (KMS) for further guidance on each standard.

Services must ensure that all evidence submitted for assessment has been anonymised, and contains no patient identifiable information. In addition, it is expected that all evidence is up to date, with clear document control measures including version numbers and dates of review.

Accreditation is a voluntary and cyclical process. Accreditation provides independent validation that an allergy service has demonstrated competence measured against the standards and is considered to be fit for purpose. Accreditation is not an end point. It drives continuous improvement, allowing allergy services to self-assess their services and performance against standards, identify areas for improvement and take appropriate actions.

Standards

The IQAS standards are split across six domains, covering all aspects of an allergy service. The domains are listed below.

Domain 1: Patient experience

Domain 2: Service structure

Domain 3: Facilities

Domain 4: Quality and safety

Domain 5: Audit and research

Domain 6: Training and development

Domain 1: Patient experience

The purpose of the **patient experience domain** is to ensure that service delivery is patient-focused and respectful of the individual patient and their specific requirements. This is achieved through provision of appropriate information and support for patients and carers with due regard to differences in culture, religion, age and other factors. Effective feedback systems for patients and carers are necessary.

No	Standard	Level	Evidence criteria	Examples of suitable evidence
1.1	**Patient involvement in the service:** There are defined systems in place to involve patients in the development and management of the service.	**A**	*No level A.*	
		B	There is current evidence that patients have been consulted over key aspects of the service.	A document from the service lead describing how patients are involved in the running of the service with written evidence of examples of patient involvement. This might include minutes from the previous 12 months of meetings with the patient representative(s).
1.2	**Biennial assessment of patient satisfaction with the service:** There are defined systems in place to obtain and manage feedback from patients.	**A**	There is a formal audit (ie registered with the clinical governance unit) of patient satisfaction of some part of the service with greater than 85% satisfaction achieved and evidence by re-audit that any weaknesses have been addressed.	The 'in year' audit with supporting re-audit.
		B	There is formal audit (ie registered with the clinical governance unit) of patient satisfaction of some part of the service with greater than 65% satisfaction with a plan to address any weaknesses identified.	The 'in year' audit with supporting action plan.
1.3	**Policy for dealing with management of referrals:** There are agreements with commissioners what services are available to which group of patients. This includes the nature of the service and the way it is delivered.	**A**	The referral or access policy has been drawn up in consultation with patients, GPs commissioners and colleagues from other specialties.	A copy of the current agreed access policy with a summary of how it has been developed and who was involved.
		B	The referral or access policy clearly sets out how patients are directed to different parts of the service or linked providers	A copy of the current agreed access policy.
1.4	**Timeliness of referrals:** There is agreement with commissioners in what timeframes services are delivered.	**A**	There are systems in place to ensure that all national targets for patient waiting times are met for >95% of patients.	Document summarising the most recent monthly waiting list report/data (new patients) and breaches.
		B	There are systems in place to ensure that >80% of patients are seen within agreed national targets.	Signed declaration or report from the service manager stating that current national standards for waiting times are met.

1.5	**Timeliness of letters:** There are systems in place to ensure effective communication with patients and referrers.	**A**	>90% of letters are sent to the GP (referrer) and patient within seven working days of the patient being seen.	Report from a randomly selected month of the current year. Turnaround time relates to time from clinic review to letter being authorised and forwarded to the referring clinician.
		B	>75% of letters are sent to the GP (referrer) and patient within 14 working days of the patient being seen.	
1.6	**Patient information:** There are systems in place to ensure effective communication with patients and carers about health conditions.	**A**	Written information is available on >90% of topics listed by IQAS relevant to the conditions seen by the service.	Summary spreadsheet listing currently used patient information sheets and their source.
		B	Written information is available on >70% of topics listed by IQAS relevant to the conditions seen by the service.	
1.7	**Patient input into patient information:** There are systems in place to ensure patients feedback and frequently asked questions are built into all patient information.	**A**	All patient information leaflets are developed with patient input.	Letter from head of service summarising the method of patient (or patient organisation/s) involvement in the development and/or review/feedback regarding patient information sheets.
		B	There are explicit plans for new patient information leaflets to be developed with patient input.	Details of the plan including timelines for development.
1.8	**Patient education:** There are trained professionals and systems in place, supported by educational materials, which make the options for care and treatment explicit to patients and their carers.	**A**	There is a specialist allergy nurse available in every clinic for allergy education.	Written confirmation by the specialist allergy nurse of his/her participation in the service including qualifications and experience.
		B	There is a non-specialist clinic nurse available in the clinic competent to deliver allergy education.	Written confirmation by the head of service that the clinic is supported by a registered nurse with experience in allergy. This should include references to competencies used.

Domain 2: Service structure

The purpose of the **service structure domain** is to ensure that adequate resources are provided and used effectively to provide a safe, efficient, and accessible service. This is achieved through appropriate, competent staffing aligned with effective communication. This is underpinned by the application of appropriate patient codes.

No	Standard	Level	Evidence criteria	Examples of suitable evidence
2.1	**Structure of the service:** There is a description of the service for referrers, patients and their carers.	**A**	There is a brochure or website produced to a high standard with documents available to patients describing in detail the structure of the service and what it offers patients with allergic disease.	A copy of the brochure or the URL of the website describing the service.
		B	There is an up-to-date detailed description of the service including the services offered.	An up-to-date (in year) copy of the service description either as an approved operational policy or other documented approved service document.
2.2	**Consultants delivering the service:** There are sufficient consultant staff within the service to enable safe and effective delivery of the service.	**A**	There are two or more than two consultants* (≥ 1.0 WTE) in good standing with the hospital (ie have up-to-date appraisals and revalidation) with expertise in allergic disease delivering the service. *CCT in allergy or immunology or a minimum of 2 years' experience in running an allergy service at consultant level.	The service description presented in standard 2.1, or an operational policy with a confirmation by the organisation. If the service operates as a network model, include a description of this and how consultants operate within it.
		B	There are minimum of two consultants* (equivalent to 1.0 WTE) in good standing with the hospital (ie have up-to-date appraisals and revalidation) with expertise in allergy delivering the service. *CCT in allergy or immunology or minimum of 2 years' experience in running an allergy service at consultant level.	
2.3	**Specialist nurse support:** There are sufficient specialist staff within the service with an appropriate mix of skills to enable safe and effective delivery of the service.	**A**	There is a minimum of two specialist nurses equivalent to at least 1.0 WTE.	Documented job plans for specialist nurses; this may be included in the service description or operational policy. If nurses are supporting a network model, then include a summary description of this and how they operate within it. Evidence of appraisal and professional development.
		B	There is between 0.2 and 1.0 WTE specialist allergy nurse input into the service.	
2.4	**Dietician support (for services seeing patients with food allergy):** There are sufficient specialist staff within the service with an appropriate mix of skills to	**A**	There is at least 0.2 WTE specialist allergy dietician time available to the service.	Documented in service description or operational policy. Written confirmation of their role and job plan from the dietetic service or the lead for the allergy service.
		B	There is specialist allergy dietetic advice available when required.	

	enable safe and effective delivery of the service.			
2.5	**Physiotherapy (in services which manage asthma):** There is agreed access to technical specialist services to support appropriate patient care.	**A**	There is a defined pathway for access to a specialist respiratory physiotherapist trained in the management of hyperventilation and pulmonary rehabilitation.	A document from the head of physiotherapy summarising the pathway and service provided.
		B	There is a defined pathway for access to a respiratory physiotherapy service available for support of the breathless patient.	
2.6	**Referral to companion specialties:** There is agreed access to specialist clinical services to enable timely interventions and safe and effective delivery of patient care.	**A**	The service has a written pathway for referral to other specialties involved in allergy care (eg gastroenterology, dermatology, ENT, respiratory medicine, haematology), with evidence of engagement of other specialties in an allergy network and agreement from the commissioners that inter-consultant referrals will be permitted. This should also include a system for referral of patients seen in A&E directly into an allergy clinic.	Service description document which has details of referral pathways to allied specialties, approved by the head of department or Clinical Director H.O.D or CD Letter of confirmation regarding the interdisciplinary referral pathways from commissioner.
		B	The service has a clear pathway for referral to companion specialties and from A&E.	Service description document which has details of referral pathways to allied specialties, approved by the head of department or Clinical Director H.O.D or CD
2.7	**Treatment codes:** There are systems in place to ensure that allergy-related treatment codes are used.	**A**	There are appropriate allergy-related treatment codes used for all patients with the ability to distinguish between local and nationally commissioned services.	Documented in the service description or operational policy, or a standalone document
		B	Treatment codes used in seeing patients are clearly documented.	
2.8	**New patient numbers:** There are systems in place to ensure that the service sees appropriate number of patients for an allergy service.	**A**	*No level A.*	
		B	Each consultant should see at least 160 new patients per year or >320 new patients a year for the service as a whole.	Approved data report for the service provided by the organisation.
2.9	**Meetings structured to discuss management issues:** There are systems in place to ensure effective service delivery including communications in the allergy team.	**A**	There are formal minuted monthly meetings to discuss service management issues.	Example of a set of minutes (redacted where appropriate) together with confirmation of the formal nature of the meetings by the service manager.
		B	There are regular (at least once every two months) informal meetings to discuss service management issues.	Written evidence that these meetings take place.

Domain 3: Facilities

The purpose of the **facilities domain** is to ensure that adequate resources are provided and used effectively to provide a safe, efficient, comfortable and accessible service. This is achieved through appropriate, specialist and adequate facilities (rooms and equipment).

No	Standard	Level	Evidence criteria	Examples of suitable evidence
3.1	**Outpatient facilities (all):** There is a description of the services provided and the physical resources required to deliver the service. *(note: should include facilities, specific equipment and IT)*	**A**	The outpatient facility where the service practices has passed a patient-led assessment of care environment (PLACE).	A description of the facilities available.
		B	The outpatient facility where the service practices is in reasonable compliance with the standards recommended by NHS England for outpatient facilities (see supporting documents).	
3.2	**Lung function (in services which manage asthma):** There is a comprehensive description of the physical and technical services accessible to the allergy service and the physical resources required to deliver the service. *(note: should include facilities, specific equipment and IT)*	**A**	There are facilities easily accessible by the service for comprehensive lung function measurement.	Facilities available documented in writing by the head of the respiratory physiology service. Service definition and facilities description document.
		B	There are facilities easily accessible by the service for measurement of spirometry, reversibility and airway hyperresponsiveness.	Facilities available documented in writing by the head of the respiratory physiology service. Service definition and facilities description document.
3.3	**Rhinitis (in services which manage rhinitis):** There are specialist physical resources required to deliver the service. *(note: should include facilities, specific equipment and IT)*	**A**	There are facilities within the service (including networked with an ENT surgeon with a specialist interest) for a comprehensive assessment of the upper airway	A description of the facilities available. A letter from the clinical lead or service manager of the ENT service describing the support offered to the allergy service.
		B	There is a readily accessible, clearly defined pathway for referral to an ENT service to examine the upper airway.	
3.4	**Facilities for immunotherapy (in services which manage allergic rhinitis and venom anaphylaxis):** There are appropriate facilities and physical resources required to deliver the service.	**A**	*No level A.*	
		B	Dedicated space with sufficient room for individual patient comfort, safety and confidentiality, a telephone and a computer. Availability of a couch in the event of a patient becoming unwell. A lockable and temperature controlled refrigerator. A cardio-resuscitation trolley within immediate reach. Immediate access to medications that may be required for any allergic emergency.	A detailed description of facilities.

3.5	**Facilities for drug allergy (in services which manage drug allergy)** There are appropriate facilities and physical resources required to deliver the service.	**A**	The service is supported with day case facilities compliant with national standards for day case surgery.	A document with a clear description of the facilities for the delivery of this service. Standard operating protocols for the procedures offered in the centre. Letter from senior pharmacist covering the service confirming that staff involved are following acceptable safety standards for administration of drugs and preparation of dilutions involved in challenges.
		B	Dedicated space with sufficient room for individual patient comfort, safety and confidentiality, a telephone and a computer. Availability of a couch in the event of a patient becoming unwell. A lockable and temperature controlled refrigerator. A cardio-resuscitation trolley within immediate reach. Immediate access to medications that may be required for any allergic emergency.	
3.6	**Facilities for food challenge (in services which manage food allergy):** There are appropriate facilities and physical resources required to deliver the service.	**A**	The service is supported with day case facilities compliant with national standards for day case surgery. Availability of suitable facilities and resources for preparing food for allergen challenge.	A document with a clear description of the facilities for delivery of this service. Letter of confirmation from the organisations health and safety officer that the facilities for preparing food for challenges meets current standards. Standard operating protocol approved by head of service.
		B	Dedicated space with sufficient room for individual patient comfort, safety and confidentiality, a telephone and a computer. Availability of a couch in the event of a patient becoming unwell. A lockable and temperature controlled refrigerator. A cardio-resuscitation trolley within immediate reach. Availability of suitable facilities and resources for preparing food for allergen challenge.	
3.7	**Immunology laboratory (all services):** There are accredited specialist pathology services to support the service fully.	**A**	The service has access within the NHS hospital to a fully equipped and CPA accredited immunology laboratory providing a comprehensive range of immunological investigations.	Confirmation of CPA status and a service description.
		B	The service has access to a CPA accredited laboratory for immunological investigations such as measurement of total and specific IgE (full panel), serum tryptase and investigations relevant to the management of urticaria and angioedema.	
3.8	**Intensive Care (all challenge procedures and immunotherapy):** There is a description of the services provided and the physical resources required to deliver the service. *(note: should include facilities, specific equipment and IT)*	**A**	*No level A.*	
		B	There is access to an on-site general intensive care unit.	A description of the service is available. This may be included in the service operational policy or an equivalent document

Domain 4: Quality and safety

The purpose of the **quality and safety domain** is to ensure that services provide the highest level of safety for patients, staff and others who come into contact with the service. This is achieved through assessment and management of the risks associated with delivery of the service.

No	Standard	Level	Evidence criteria	Examples of suitable evidence
4.1	**Reviewing adverse events:** The service has a system for capturing, recording and reviewing adverse events.	**A**	All serious adverse events related to allergic disease in the hospital are reviewed within a reasonable time frame of occurrence and formally discussed at least quarterly at a morbidity and mortality meeting. A written response to adverse events including a plan for reducing future risk is prepared and acted upon.	A copy of meeting structure and frequency. A copy of the minutes of one of the meetings. A description of any adverse event and the risk reduction strategy.
		B	Adverse events within the service are formally reviewed as a standing item at a formal regular (minimum of quarterly) service meeting with analysis of the cause of the adverse event and a plan for risk reduction.	A copy of meeting structure and frequency. Copy of signed sample minutes from one of the meetings. A description of any adverse event and the risk reduction strategy.
4.2	**Standard operating procedures (degree of overlap with drug, food IT):** There are written standard operating procedures/protocols for the allergy service.	**A**	There are SOPs for the breadth of procedures which the service manages and these are readily available to all members of the service.	Spreadsheet with a list of SOPs currently available and implemented in the service Evidence of an audit to confirm adherence to departmental SOP.
		B	There are SOPs available for all the major procedures with a plan in place to develop a full suite of SOPs.	
4.3	**Guidelines:** The service has written clinical guidelines with auditable outcomes for the allergy service.	**A**	Peer reviewed guidelines (where available) recommended by IQAS for all the conditions managed by the service are readily accessible to all members of the service.	Spreadsheet listing the guidelines accessible to all members of the service.
		B	Peer reviewed guidelines (where available) recommended by IQAS for >80% of the conditions managed by the service are readily accessible to all members of the service.	
4.4	**Clinical meetings:** The service has meeting systems in place for effective management of patients.	**A**	There is a minuted MDT held at least alternate weeks to discuss difficult clinical cases.	Description of the structure and management of the MDT.
		B	Consultants in the service meet on a semi-formal basis at least once a month to discuss cases.	Description of how the meetings are organised.
4.5	**Complaints:** The service implements and monitors systems to manage complaints.	**A**	*No level A.*	
		B	There are regular service meetings to review and act on service complaints. These are satisfactorily addressed according to hospital policy.	Description of the number of complaints and how they were addressed.

4.6	**Immunotherapy (patient numbers):** There are systems in place to ensure that the service sees appropriate number of patients for an allergy service.	**A**	*No level A.*	
		B	The number of patients treated is greater than the minimum standard defined by IQAS. (At least 10 patients currently undergoing SCIT for either venom or aeroallergen immunotherapy).	Written information regarding the number of patients treated.
4.7	**Immunotherapy (database):** There is a patient register in place that is able to capture KPIs and auditable outcomes on a continuous basis.	**A**	There is a comprehensive electronic database of patients, past and present, treated with immunotherapy. The database should be compliant with local information governance and data protection policies.	An electronic or paper copy of database is made available during the site assessment in an anonymised format (no patient identifiable data). Details of the minimum fields that the database should contain are patient demographics, allergen, start date and completion date.
		B	There are written records which document the information required by IQAS.	Submission of an example of the written record.
4.8	**Immunotherapy (SOPs):** There are written standard operating procedures/protocols for clinical conditions.	**A**	*No level A.*	
		B	A detailed SOP based on published guidelines for each type of immunotherapy is available providing information on the criteria for patient selection, the details of how immunotherapy is given including how effectiveness is audited and how adverse events are dealt with.	A copy of the SOP and evidence of staff understanding at site visit.
4.9	**Patient numbers for diagnosis and management of drug and food allergy:** There are systems in place to ensure that the service sees appropriate number of patients for an allergy service.	**A**	The number of patients treated is double the minimum standard defined by IQAS. (At least 200 patients should be seen for investigation of drug allergy with at least 60 patients undergoing a challenge procedure. At least 20 patients a year should be undergoing food challenge). Investigation of general anaesthetic allergy should be undertaken in the context of a general drug allergy service.	An anonymised database, as per standard 4.10. A projection of total number of patients assessed with (or for suspected) food or/and drug allergy could be provided by an audit of new patients referrals evaluated by the service
		B	The number of patients treated is greater than the minimum standard defined by IQAS. (At least 100 patients should be seen for investigation of drug allergy with at least 30 patients undergoing a challenge procedure. At least 10 patients a year should be undergoing food challenge). Investigation of general anaesthetic allergy should be undertaken in the context of a general drug allergy service.	

4.10	**Drug allergy database:** There is a patient register in place that is able to capture KPIs and auditable outcomes on a continuous basis.	**A**	There is a comprehensive electronic database of patients past and present managed for drug allergy. The database should be compliant with local information governance and data protection policies.	An electronic or paper version of the database (which is anonymised) to be made available for review during the site assessment. The database should contain the following information: 1. Demographics 2. Name and/or class of drug/s (or food allergen in food challenge database) 3. Date of the procedure 4. Outcome
		B	There are written records which document the information required by IQAS.	Submission of an example of the written record.
4.11	**Drug and food allergy SOPs:** There are written standard operating procedures/protocols for clinical conditions.	**A**	*No level A.*	
		B	There is a detailed SOP for each type of drug and food allergy investigation based on current guidelines, including how adverse events are dealt with.	A copy of the SOP and evidence of staff understanding at site visit.
4.12	**Latex allergy:** There are written standard operating procedures/protocols for the allergy service.	**A**	There are written and agreed hospital policy for management of latex allergy including SOPs for latex challenge and access to patch testing.	A copy of the policy and SOPs and evidence of staff training and understanding at site visit.
		B	There are SOPs available for the management of latex allergy.	

Domain 5: Audit and research

The purpose of the **audit and research domain** is to ensure that the service is monitoring its quality and seeking to maintain and develop the effectiveness of the service.

No	Standard	Level	Evidence criteria	Examples of suitable evidence
5.1	**Local audit activity:** The service has systems in place to ensure regular audit of current clinical practice, review and dissemination of findings and appropriate action in particular focussing on adherence to guidelines.	**A**	More than one formal audit has been undertaken in the last 12 months under the auspices of the hospital audit protocol with evidence that lessons learned have been used to improve the service. The service has a structured approach to audit with a defined programme and review supported by the hospital.	A description of the audit(s) signed off by the organisation's clinical governance department. The audit(s) and results should be provided.
		B	One formal audit (in addition to patient satisfaction) has been undertaken in the last 12 months under the auspices of the hospital audit procedures with evidence of lessons learned being used to improve the service.	
5.2	**National or regional audit activity:** The service participates in regional and national audits of current clinical practice.	**A**	The service has led a national or regional audit in the last two years.	A description of the audit. Letter confirming participation from the relevant organisation or responsible personnel.
		B	The service has participated in a national or regional audit in the last five years.	
5.3	**Research activity** (not necessary for accreditation).	**A**	There is an active research programme into allergic disease.	List of research projects, papers published and external grant funding.
		B	*No level B.*	

Domain 6: Training and development

The purpose of the **training and development domain** is to ensure that members of staff maintain their competence and influence other healthcare providers in optimal care of patients with allergic diseases.

No	Standard	Level	Evidence criteria	Examples of suitable evidence
6.1	**Allergy educational activity for colleagues:** There are systems in place to ensure effective education and shared learning.	**A**	There is more than one formal education event arranged for colleagues in primary and/or secondary care in the last twelve months, not including anaphylaxis training.	Programme of the events.
		B	There is one formal education event organised for colleagues in the last 12 months, not including anaphylaxis training.	Programme of the event.
6.2	**Staff competence:** The service implements and monitors systems to ensure staff are fully trained and competent to deliver the service.	**A**	There is evidence of attendance at a major allergy meeting in the previous 12 months by all consultants involved in delivering the service.	Documentary evidence of attendance.
		B	There is evidence of attendance at a major allergy meeting in the previous three years by all consultants involved in delivering the service.	
6.3	**Education and training for members of the service:** There are systems in place to ensure staff are competent to undertake the role to which they have been appointed, including a process for remedial action if concerns around staff competency are raised.	**A**	The specialty nurses and dieticians have a higher qualification in allergic disease (eg MSc, diploma or PG certificate in allergy).	Evidence of post-graduate qualification.
		B	Specialty-specific training for nurses and dieticians in the diagnosis and management of allergic disease.	Description of training from lead consultant or head of service.
6.4	**Anaphylaxis training:** There are systems in place to ensure staff have access to mandatory and specialist technical training to support safe delivery of the service.	**A**	There is a formal programme led by the allergy service to train members of the service and the general hospital staff in the management of anaphylaxis. There is a mock drill once a year in the management of anaphylaxis for members of the allergy service.	A description of the training provided together with a copy of a signed log of attendance.
		B	There is formal training once a year of the allergy service involving a mock drill.	
6.5	**Resuscitation training:** There are systems in place to ensure staff have access to mandatory and specialist technical training to support safe delivery of the service.	**A**	*No level A.*	
		B	All members of staff involved in the service should have up-to-date training in resuscitation techniques.	Evidence of course attendance for each relevant member of staff. A document from the head of service confirming the staff have undergone annual BLS training.