Improving Quality
in Allergy Services

Improving Quality in Allergy Services: Standards 2019

Background

The Improving Quality in Allergy Services (IQAS) accreditation programme has been in place since 2015. During 2018, the programme has carried out a review and consultation of the standards, gathering feedback from a wide range of stakeholders in the allergy community including patient groups. In April 2019, the new IQAS standards were formally launched and all allergy services are invited to participate. There may be specific areas which are not applicable to 'general allergy services' and this will be made clear during navigation of the IQAS webtool.

Definitions

Comprehensive allergy services (for adult patients only): A comprehensive allergy service is defined as one which provides **all** four 'core' services:

- General allergy services (accept referrals relating to all allergic conditions/allergies and suspected allergic conditions/allergies and perform an initial clinical assessment and allergy workup)
- Food challenge tests
- Drug challenge tests
- Allergen-specific immunotherapy

General allergy services (for adult patients only): General allergy services must provide the core 'general allergy service' and may also provide one or two of the following core services:

- Food challenge tests
- Drug challenge tests
- Allergen-specific immunotherapy

Table 1: Summary of services applicable to each allergy service type.

	General allergy services	Food challenge tests	Drug challenge tests	Allergen-specific immunotherapy
Comprehensive allergy services	✓	✓	✓	✓
General allergy services	✓	Optional	Optional	Optional

IQAS Standards 2019

1. Leadership domain		
Requirement	**Guidance**	**Evidence**
1.1 The clinical service has a service description.	• The service description must describe: ○ Overall scope of the service provided (including who the service aims to provide treatment/care for and whether research or training is undertaken) ○ Information about service delivery, such as opening hours and clinic times ○ The range of services offered ○ Facilities available, including access for service users with special needs ○ Any links with other clinical services and/or stakeholders, including: ▪ relationships with other organisations where referrals are sent/received ▪ how the referral pathways are managed ○ Team composition, including number of sessions in job plan dedicated specifically to the allergy service ○ How patients are involved in the running of the service, with examples of patient involvement ○ How to contact the service for help and advice, including 'out of hours' information • The external-facing information must be agreed in advance with patients/carers and made available to stakeholders, including patients and their families/carers, staff, referrers and commissioners.	• A document outlining the key service details (for example, an operational policy). • Evidence of patient involvement in the service (for example, minutes of focus groups or meetings). • Link to website page or other electronic document that provides information for patients/service users/referrers.
1.2 The clinical service leadership team is visible and responsive to service needs and uses a variety of methods to communicate regularly with staff.	• The roles and responsibilities of individuals in the leadership team should be clearly defined (for example, within an operational policy). • The leadership team holds regular (at least quarterly) meetings to discuss service management issues. • Communication should include face-to-face methods (for example, huddles/debriefs). • Communication to staff and relevant stakeholders should include: ○ important changes to the delivery of the service ○ new statutory information impacting the service ○ updates on quality, safety and clinical governance	• A document outlining the names and key roles and responsibilities of each member of the leadership team. • Minutes of regular service meetings. • Examples of notices, bulletins or other communications to staff. • Examples of communication to stakeholders outside of the clinical service, where there have been changes to service delivery.

1.3 The service develops and implements an annual plan.	• This document should include:
	  ○ Measurable objectives and KPIs for the service for that year
	  ○ Plans for service development, depending on local need
	  ○ Plans for service improvement and innovation
	  ○ A training and workforce development plan
	• The plan should be developed with multidisciplinary input (for example, the use of an 'away day' may be helpful). The allergy annual plan may be part of a wider directorate strategy, as long as the allergy-specific needs are considered.
		• A document outlining the annual plan.
		• Minutes of service management/clinical governance meetings where the annual plan is discussed.
		• Evidence of implementation of the plan.
		• Evidence of how key measures are shared with the wider team.

2. Service user experience		
2.1 The service provides users with information about their rights and what they can expect from the service.	• The service description should include the choices that are available within the service. • Information about service user rights, including shared decision making, should be readily available and communicated to those attending the allergy service (for example, through appointment letters). • Staff have a responsibility to involve service users (and carers/family as appropriate) in making decisions about their care.	• A document, example letters to service users/carers and a link to a website page outlining what users can expect from the service. • A patient satisfaction survey that explicitly asks how the service communicated information and shared decision-making principles. • At least 20 randomly selected clinic letters, demonstrating service user involvement in treatment plan (selection process to be determined and documented by service). Note: Assessors will explore this with staff and patients on the day of the site assessment.
2.2 The clinical service has a public-facing document explaining how service users can navigate the clinical pathways.	• The document must be provided to referrers, service users and other companion specialties that might be involved in the allergy service pathway. • The document must outline a named person or point of contact to answer questions and help navigate the service.	• A document or link to a website page. • Evidence of this being made available to service users, referrers and companion specialties.
2.3 The service documents person-centred treatment/ care plans, based on the needs of the individual service user.	• There should be documentation for service users to prepare them for planned treatment/ care, prescribed therapy, clinical procedures and post-clinical procedure care. • Support should be offered to carers and representatives where relevant. • Written information on common allergy conditions is provided to service users, where applicable. • Patient education should be provided, where relevant, to cover self-management of allergic reactions and allergen avoidance measures. • Staff make service users aware of, and encourage access to, local/ national service user support groups. Service has an agreed process for ensuring that patient information and signposting is consistently happening across the department and all staff are aware of their responsibilities to do so (including temporary/locum staff).	• Patient/carer surveys specifically asking about support provided, information given and patient education provided and any actions taken as a result of feedback. • Evidence of comprehensive written/online material available to support patient learning e.g: relevant patient information sheets, preferably those developed by patient organisations and/or the British Society for Allergy and Clinical Immunology (BSACI). • Evidence of providing this information to patients/carers and signposting to

		local/national support groups (for example, posters in clinical area or anonymised patient letters). • Process document or communication to staff about their responsibilities for signposting/providing patient information.

2.4 The service enables users to provide feedback on their experience of the service confidentially.	• Service users should be encouraged to make comments on improvements to the service in ways that are readily available and accessible (for example, posters in clinic with clear signage or leaflets readily accessible to patients).
	• Staff members should be notified of all feedback from service users, carers or representatives.
	• A formal survey should include, as a minimum:
	    ○ Quality and safety of treatment and/or care provided
	    ○ Involvement of the clinical service user in their treatment and/or care
	    ○ Quality and clarity of information provided
	    ○ Dignity, respect and compassion
	• Any action taken or improvements made in response to service users' views should be shared with users who provided feedback or raised concerns. They should also be reported in summary form annually.
		• PALS report for the last year and how the service responded to these.
		• Patient/carer survey responses and other feedback (Friend and Family Test or comments box), and actions taken.
		• Examples of how issues arising from feedback have been addressed and shared with patients (for example, 'you said/we did' poster).
		• Evidence of communication to staff sharing feedback from service users.

3. Clinical care and performance		

3.1 The service sets, monitors, and reports on metrics, and has an improvement plan	• This must be for:
	    ○ Waiting times for new outpatient appointment (routine and urgent)
	    ○ New to follow-up ratios at consultant level
	    ○ Waiting time for challenge tests for food and drug allergy investigations
	    ○ DNAs (failure to attend) (including strategies for reducing rates)
	• An improvement plan should highlight strategies for continuing to improve against the metrics.
	• The service offers 'advice and guidance' for allergy referrals as agreed with local commissioners.
	• Where relevant/applicable, the service and senior management have strategies in place to address waiting lists (eg: triage, telephone consultation, etc).
	• Organisation is meeting agreed local targets for turnaround time for letters following clinic review sent to the referrer (GP or secondary care) and patient.
		• Improvement plan.
		• Report documenting the metrics and evidence that national waiting times (for new outpatient appointments) and RTT are being met consistently in the previous 12 months.
		• Evidence of discussion with CCGs where waiting times are consistently not being met.
		• Minutes of service management meetings where this is discussed.

3.2 The service monitors journey times across clinical pathways.	• This must include referrals to different specialist teams both within the Trust (for example, patch tests *via* Dermatology for contact dermatitis, nasendoscopy for suspected nasal polyps *via* ENT etc) and outside the Trust (particularly for general allergy services – should demonstrate an established pathway to a larger service for specialist treatment[s]/procedure[s] that is [are] not available in their centre) as per nationally defined pathways for accessing specialist investigations.	• A copy of the current Trust-wide access policy. • The referral management process specifically for allergy-related conditions. • Evidence of documenting and reviewing journey times for patients across different clinical pathways in allergy. • A patient feedback report, specifically in

	• Note: This standard relates to reviewing journey times for the condition that the patient was initially referred.	relation to journey times across specialist teams.
3.3 The service identifies and participates in local audit/assessment programmes and national audit programmes, where relevant.	• The service must be committed to national audits (for example, those carried out by BSACI). • The service must develop an annual rolling audit programme and maintain a database that aligns with the IQAS quality and workforce metrics. • Participation in other local audits as deemed necessary. • Audits should include compliance with various guidelines. • Audit of patient selection for immunotherapy. • Quality improvement plan that aligns with the IQAS annual quality metrics output and data generated from local audits.	• Evidence of participation in national audits, including BRIT audit (or a plan in place to participate). • An audit report of 20 sets of consecutive notes for allergen-specific immunotherapy, including sampling methodology. An improvement plan is required if the audit revealed deficiencies. • The service's documented annual audit plan, including clear timescales for audit completion (note: should include quality and other audits). • Evidence of how audit results have shaped changes in service. • Evidence of service implementing audit results into plan-do-study-act (PDSA) cycles or equivalent to continue to improve. • Description of quality improvement plans and lessons learnt from audit/s including dissemination to the team.
3.4 The clinical service has a risk management policy, which includes a process for carrying out risk assessments.	• There is a dedicated named individual who is responsible for risk management in the service and whose role has been communicated to the team. • There are risk assessments carried out in clinical and non-clinical areas that could affect the service provided (for example, risks with specific clinical procedures, GP letters backlog, or facilities issues). • There are standard operating protocols (SOPs) covering common procedures (for example, skin tests) and specialist procedures (for example, allergen-specific immunotherapy, drug allergy tests, or food challenges) undertaken by the service. The latest version of the SOP should be made accessible to all relevant members of staff in all relevant clinical areas where the treatment/procedure is delivered. There should be procedures in place to make the team aware of any changes to the SOP, with evidence of an audit trail. The SOPs should be aligned with BSACI guidelines, and where these are not available to other international guidelines or consensus documents. • A risk assessment should be carried out for all procedures involving potential risk of provoking anaphylaxis. This should be evident in the SOPs.	• A copy of the risk management policy (could be Trust-wide). • Evidence of risk assessment and mitigation measures. • SOPs covering relevant common and specialist procedures and evidence of dissemination.
3.5 The clinical service has a procedure outlining how incidents, adverse events and 'near-misses' are reported and investigated.	• The procedure should include: o How to notify staff and/or service users affected by incidents. o Escalation process where the timescales for closing the incident cannot be achieved.	• Evidence of review of incidents, adverse events and 'near-misses' across the team. • Copies of meeting minutes where governance issues are discussed with a multidisciplinary group involved in the allergy service (medical, nursing and administration as a minimum).

		• Anonymised copies of incident reports for one month. • Anonymised copies of investigations.
3.6 The clinical service communicates lessons learnt from incidents, adverse events and 'near-misses' to the wider team and uses this information to improve the service.	• The service should promote an ethos of openness, 'no blame culture' and transparency to reporting adverse events and 'near misses' to their team and management (and wider in their organisation where relevant). • The service should perform a root cause analysis for adverse events and 'near misses' with an aim to improve systems and keep their patients and staff safe.	• Evidence of sharing lessons learnt with staff. • Evidence of making service improvements as a result of feedback from incidents.
4. Workforce		
4.1 The clinical service carries out a skill mix review of the workforce at least once a year, or whenever there is a significant change in the clinical service.	• The service must demonstrate a multidisciplinary team approach to service delivery. The composition of the team should take the local population's needs and circumstances into consideration. The service may include dieticians, physiotherapists, pharmacists and other healthcare professionals. • The skill mix review should also consider administrative support for the service. • The review should outline any planned appointments to support new or existing work. • The service considers contingency and succession planning to mitigate disruption to services.	• A document showing skill mix review. • Meeting minutes or action plans that show how deficits in workforce will be addressed.
4.2 The clinical service implements a service-specific orientation and induction programme that new staff members must complete and document.	• The induction should highlight who the leadership team is and key details of how the service is run. • A clear strategy should be in place for clinical supervision of specialist trainees.	• Documentation of induction and orientation for allergy service. **Note:** Assessors will also ask staff (and trainees, where applicable) about their orientation during the site assessment.
4.3 The clinical service implements an appraisal process for staff members.	• Appraisals should be conducted annually and all staff contributing to the service (including GPs and AHPs who are part of the service) should show evidence of commitment to CPD in allergy. For some staff members, contribution to regional and national networks may also be important.	• CPD certificates, specifically in relation to allergy. • Evidence of attending post-graduate training programmes, conferences or courses relevant to allergy in the last 12 months. • For nursing staff, portfolios and use of BSACI nurses competency and education strategy. • Appraisal record, including names of staff and date of meeting).
4.4 The clinical service has training plans in place for staff members.	• The service should carry out a risk assessment for all new staff members and junior trainees, as per SOPs for specialist procedures that carry a potential risk of provoking anaphylaxis. • The service should maintain training records of all induction, educational and professional development activities for staff members. • The training plan should have protected time for those responsible for training and mentoring and those responsible for supervising students, trainees, observers,	• Training plans for staff. • Examples of training records for staff. • Evidence of protected time for those with training/mentoring responsibilities. • Induction logs (for example, for specialist procedures for junior trainees, new member of staff).

	locums/agency staff and unqualified staff. • The service should demonstrate a commitment towards teaching in allergy; this may be within and/or outside the service (for example, teaching to other disciplines in secondary/tertiary care, primary care and undergraduate medical and nursing staff).	• Evidence of involvement in service-specific teaching within/outside the service, with feedback (where available).
4.5 Team members are supported in providing feedback on how the service is performing and implementing ideas for improvement to the service, team, and environment.	• There are methods for staff to provide confidential feedback on the service. **Note:** where the service is very small, confidentiality may be harder to maintain. In this case, there should be a process for sharing feedback with the wider directorate team, if needed. • There should be an open culture where team members can suggest strategies for service improvement and have support to implement these ideas (for example, time, resource, and/or space).	• Examples of staff being involved in quality improvement initiatives. • Examples of communications to staff to engage in improvement. • An action plan in response to staff feedback. **Note:** Assessors will also speak to staff about their opportunities to contribute to improving the service during the assessment.
5. Facilities and equipment		
5.1 The clinical service regularly conducts an assessment of the facilities and equipment required to deliver the service.	• The assessment must include: ○ Shortfalls of existing facilities and equipment ○ Planned replacement of existing facilities and equipment ○ Planned purchase of facilities and equipment ○ Meeting accessibility requirements ○ Maintenance plan of all areas used by the service ○ Review of the facilities where patients are seen and treated, ensuring that the facilities meet the needs of the clinical team and patients ○ Review of the facilities to ensure privacy, dignity and confidentiality of patients is maintained, including restricted areas. • Regular environmental checklist and Patient Led Assessments of the Care Environment (PLACE) or equivalent. • The service must have access to immediate management of anaphylaxis and cardio-respiratory resuscitation equipment/team. Immediate access to acute medical care/intensive care unit must also be available to those offering specialist treatments, including allergen-specific immunotherapy, omalizumab for chronic spontaneous urticaria and drug/food challenge tests. • Services managing food challenges must have weighing scales and a dedicated fridge, where patients are bringing in their own food. Appropriate dietetic and pharmacy input are required.	• Documentation of the assessment of facilities and equipment. • Patient satisfaction survey that explicitly asks about facilities. • Completed environment checklist developed by IQAS. • Evidence of regular completed PLACE checklists (or equivalent). • Patient risk assessments • SOPs relating to food and drug challenges. **Note:** On the day of the assessment, the assessors will also review the clinical environment and talk to staff (including pharmacists and dieticians) and patients about the facilities.
5.2 The service has a process for document control	• The process should include SOPs, clinical guidelines, patient leaflets and policies.	• Evidence of reviewing documents and archiving/removing historic versions so that only the current version is available to staff/patients