



Royal College
of Physicians

IQAS

Improving Quality in Allergy Services

Standards published April 2019



Contents

Getting started checklist	1
Eligibility criteria for assessment	2
Improving Quality in Allergy Services: standards 2019	3
IQAS standards 2019	5
1. Leadership domain	5
2. Service user experience	6
3. Clinical care and performance	8
4. Workforce	11
5. Facilities and equipment	14
Clinical quality and workforce metrics	15

Introduction

This document has been designed to assist allergy services across both specialist and general services to prepare for their Improving Quality in Allergy Services (IQAS) accreditation assessment.

It defines the standards and evidence required to achieve IQAS accreditation. The standards have been established with the allergy community and patient and service representatives. They are based on the **British Standard Institution's (BSI's)** specification for accreditation of clinical services.

You can find a number of helpful templates and guidance documents in the resources library on the accreditation website found at www.iqas.org.uk

Getting started checklist

- 1** Log into the website and set up logins for all relevant staff (max 10 people)
- 2** Locate the resource library on the website and review useful documents
- 3** Book onto 'how to prepare for accreditation' training
- 4** Set up an accreditation programme working group or add as agenda item on team meeting
- 5** Share out tasks with the team
- 6** Involve patients in your accreditation journey
- 7** Ensure documents are all < 12 months old where necessary
- 8** Start uploading evidence onto the website
- 9** Review and meet eligibility criteria for an assessment request

Eligibility criteria for assessment

Assessment eligibility

All registration details are correct and up to date, including managing trust/organisation and CEO/MD details

The service has paid all invoices for IQAS including the annual subscription

A representative of the service has attended the IQAS accreditation training day

Service/profile composition

All evidence uploaded against the accreditation standards is correct, up to date and relevant

All contact details for staff at the service have been verified as correct

All of the sites delivering the service to undergo assessment are named in your self assessment and the address details on the website and are verified as correct

Assessment requirements

The service will have a clinic running on the day of the site assessment

The service leads, a clinical director or equivalent and a patient will be available and present on the day of the assessment to talk to the assessment team

Multi-site assessments

All policies are shared across all sites within the service

All audits are conducted and presented as a service

Privacy and dignity standards are met equally across all sites within the service

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 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 join the programme. There may be specific areas which are not applicable to 'general allergy services' and this will be made clear during navigation of the IQAS website.

What are the key differences between the new standards and previous version of 2016?

The majority of the standards remain the same and some areas of evidence have been strengthened. There is more emphasis on supporting and developing the workforce, patient involvement and the overall governance and leadership of the service, which we know are important aspects of a high-quality service.

When will the standards be re-reviewed?

Our standards are reviewed at least once every 5 years and so we expect the next iteration of the IQAS standards to be in 2024. If you have any feedback for changes for the next version, please log them with the IQAS office team by emailing askiqas@rcplondon.ac.uk.

We recognise that guidelines and research may come out between now and then, which could impact the standards and so we may make some changes to reflect new practice. You will be notified by the IQAS office team when this happens.

Definitions

Specialist allergy services (for adult patients only): A specialist 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 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
Specialist allergy services	✓	✓	✓	✓
General allergy services	✓	Optional	Optional	Optional

Document version history

April 2019	Finalised standards
November 2019	Branding changes, no change to content of standards. Addition of page 2 to outline some background information
October 2020	Final version with branding changes

IQAS standards 2019

1. Leadership domain

▶ **Standard 1.1** The clinical service has a service description.

Evidence requirements

- ▶ 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.

Guidance

- ▶ 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.

▶ **Standard 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.

Evidence requirements

- ▶ 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.

Guidance

- ▶ 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.

▶ **Standard 1.3** The service develops and implements an annual plan.

Evidence requirements

- ▶ 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.

Guidance

- ▶ This document should include:
 - measurable objectives and key performance indicators (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.

2. Service user experience

- ▶ **Standard 2.1** The service provides users with information about their rights and what they can expect from the service.

Evidence requirements

- ▶ 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.

Guidance

- ▶ 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.

- ▶ **Standard 2.2** The clinical service has a public-facing document explaining how service users can navigate the clinical pathways.

Evidence requirements

- ▶ A document or link to a website page.
- ▶ Evidence of this being made available to service users, referrers and companion specialties.

Guidance

- ▶ The document must be provided to referrers, service users and other companion specialties that might be involved in the allergy service pathway.

- ▶ **Standard 2.3** The service documents person-centred treatment/care plans, based on the needs of the individual service user.

Evidence requirements

- ▶ 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, eg 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.

Guidance

- ▶ 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).

- ▶ **Standard 2.4** The service enables users to provide feedback on their experience of the service confidentially.

Evidence requirements

- ▶ Patient Advice and Liaison Service (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.

Guidance

- ▶ 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.

3. Clinical care and performance

- ▶ **Standard 3.1** The service sets, monitors, and reports on metrics, and has an improvement plan.

Evidence requirements

- ▶ Improvement plan.
- ▶ Report documenting the metrics and evidence that national waiting times (for new outpatient appointments) and referral to treatment (RTT) are being met consistently in the previous 12 months.
- ▶ Evidence of discussion with clinical commissioning groups (CCGs) where waiting times are consistently not being met.
- ▶ Minutes of service management meetings where this is discussed.

Guidance

- ▶ This must be for:
 - waiting times for new outpatient appointments (routine and urgent)

- new to follow-up ratios at consultant level
- waiting time for challenge tests for food and drug allergy investigations
- DNAs (did not 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.

- ▶ **Standard 3.2** The service monitors journey times across clinical pathways.

Evidence requirements

- ▶ A copy of the current organisation-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 relation to journey times across specialist teams.

Guidance

- ▶ This must include referrals to different specialist teams both within the organisation (for example, patch tests via dermatology for contact dermatitis, nasendoscopy for suspected nasal polyps via ear, nose and throat (ENT) etc) and outside the organisation (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.
- ▶ Note: this standard relates to reviewing journey times for the condition that the patient was initially referred.

- ▶ **Standard 3.3** The service identifies and participates in local audit/assessment programmes and national audit programmes, where relevant.

Evidence requirements

- ▶ Evidence of participation in national audits, including the BSACI Registry for Immunotherapy (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.

Guidance

- ▶ 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.

- ▶ **Standard 3.4** The clinical service has a risk management policy, which includes a process for carrying out risk assessments.

Evidence requirements

- ▶ A copy of the risk management policy (could be organisation-wide).
- ▶ Evidence of risk assessment and mitigation measures.
- ▶ SOPs covering relevant common and specialist procedures and evidence of dissemination.

Guidance

- ▶ 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.

- ▶ **Standard 3.5** The clinical service has a procedure outlining how incidents, adverse events and ‘near-misses’ are reported and investigated.

Evidence requirements

- ▶ 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.

Guidance

- ▶ The procedure should include:
 - how to notify staff and/or service users affected by incidents
 - escalation process where the timescales for closing the incident cannot be achieved.

-
- ▶ **Standard 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.

Evidence requirements

- ▶ Evidence of sharing lessons learnt with staff.
- ▶ Evidence of making service improvements as a result of feedback from incidents.

- ▶ 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.

Guidance

- ▶ 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).

4. Workforce

- ▶ **Standard 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.

Evidence requirements

- ▶ A document showing skill mix review.
- ▶ Meeting minutes or action plans that show how deficits in workforce will be addressed.

Guidance

- ▶ 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.

- ▶ **Standard 4.2** The clinical service implements a service-specific orientation and induction programme that new staff members must complete and document.

Evidence requirements

- ▶ 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.

Guidance

- ▶ 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.

- ▶ **Standard 4.3** The clinical service implements an appraisal process for staff members.

Evidence requirements

- ▶ CPD certificates, specifically in relation to allergy.
- ▶ Evidence of attending postgraduate training programmes, conferences or courses relevant to allergy in the last 12 months.
- ▶ For nursing staff, portfolios and use of BSACI nurse's competency and education strategy.
- ▶ Appraisal record, including names of staff and date of meeting.

Guidance

- ▶ Appraisals should be conducted annually and all staff contributing to the service (including GPs and allied healthcare professionals (AHPs) who are part of the service) should show evidence of commitment to continuing professional development (CPD) in allergy. For some staff members, contribution to regional and national networks may also be important.

▶ **Standard 4.4** The clinical service has training plans in place for staff members.

Evidence requirements

- ▶ 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).
- ▶ Evidence of involvement in service-specific teaching within/outside the service, with feedback (where available).

Guidance

- ▶ 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, 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).

▶ **Standard 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.

Evidence requirements

- ▶ 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.

Guidance

- ▶ 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).

5. Facilities and equipment

- ▶ **Standard 5.1** The clinical service regularly conducts an assessment of the facilities and equipment required to deliver the service.

Evidence requirements

- ▶ 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.

Guidance

- ▶ 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.

-
- ▶ **Standard 5.2** The service has a process for document control.

Evidence requirements

- ▶ Evidence of reviewing documents and archiving/removing historic versions so that only the current version is available to staff/patients.

Guidance

- ▶ The process should include SOPs, clinical guidelines, patient leaflets and policies.

Clinical quality and workforce metrics

Summary

The clinical quality and workforce metrics data is a new initiative by IQAS, which is aimed at helping shape future standards in allergy service provision nationally.

The data will be collected by registered IQAS services and uploaded onto the website annually. The data will then be analysed and a summary shared to help understand the status against these key metrics in allergy across the UK and Ireland.

Based on the standardised data received over the forthcoming years, the IQAS steering group will shape future standards. We hope that these will be relatively straightforward and useful metrics to collect, and add great value at a national level. In other words, the metrics will not be directly linked to accreditation assessments, but will help shape future standards for accreditation.

Registered services will be expected to collect data from 1 April 2019, with the first upload due in March 2020. The IQAS office team will be in contact with registered services to provide further details.

Drug allergy

Quality measure 1: percentage of referred patients in whom a pre-existing drug allergy label has been removed

Information needed

- > Total number of patients in these categories who have been seen:
- > Total number of patients who have tested negative:

Quality measure 2: rate and severity of adverse reactions during challenge testing

Information needed

- > Number of patients undergoing drug challenges:
- > Number of patients with positive challenges:
- > Severity of reactions (please provide data either as free text or in a table, as per scoring system):

Quality measure 3: percentage of patients referred for general anaesthetic (GA) allergy testing in whom the identity of the culprit drug is confirmed

Information needed

- > Total number of patients seen for GA allergy testing:
- > Number of patients in whom a culprit drug is identified:
- > Number of patients in whom an allergic cause cannot be confirmed:

Quality measure 4: percentage of patients in whom the appropriate level of information is obtained prior to testing:

Information needed

- > Total number of patients seen for GA allergy testing:
- > Number of patients for whom a completed AAGBI referral form and/or copy of anaesthetic chart and tryptase results (if performed) were available:

Food allergy

Quality measure 5: percentage of patients in whom food allergy label was removed post-challenge:

Information needed

- > Total number of patients challenged to foods:
- > Total number of food challenges undertaken:

% of patients challenged in whom a food allergy has been excluded

- > Number of double-blind, placebo-controlled food challenges (DBPCFCs):
- > Number of open food challenges:
- > Number of single-blind, placebo-controlled food challenges (SBPCFCs):
- > Number of patients with a positive skin test \pm sSIgE to the relevant food allergen:
- > Total number of patients with a positive challenge:
- > % of challenge-induced anaphylaxis (defined as per World Allergy Organization criteria for anaphylaxis):

Omalizumab for chronic spontaneous urticaria

Quality measure 6: mean improvement in UAS7 symptom scores following treatment with omalizumab:

Information needed

- > Total number of patients commenced on omalizumab:
- > Total number of patients meeting National Institute for Health and Care Excellence (NICE) guidelines for therapy:
- > % of patients meeting NICE guidelines for treatment:
- > Mean UAS7 symptom scores before treatment:
- > Mean UAS7 symptom scores post treatment: % of patients in whom omalizumab had to be recommenced due to recurrence:

How many new allergy outpatients do you see in your service annually?	
How many follow-up allergy outpatients do you see in your service annually?	

Please provide details of the budgeted workforce (ie exclude vacancies) who provide allergy care

Grade	Total number	Time dedicated to allergy service
Consultants in allergy/immunology		Drop down box in PAs
Consultant/s in respiratory medicine / dermatology or other specialty contributing to allergy service		Drop down box in PAs
Specialty trainees / junior doctors		Drop down box in PAs
GPs		Drop down box in PAs
Specialist allergy nurse/s		Drop down box in hours
Dieticians		Drop down box in hours
Pharmacists		Drop down box in hours
Psychologists		Drop down box in hours
Other (specify)		Drop down box in hours

Further information

For further information on IQAS
visit www.iqas.org

If you have any queries about the
work of the IQAS, please email
us at askiqas@rcplondon.ac.uk

IQAS Office

Accreditation Unit
Royal College of Physicians
11 St Andrews Place
Regent's Park
London NW1 4LE



**Royal College
of Physicians**

IQAS