Royal College of Physicians

Quality in Primary and Secondary Immunodeficiency Services

QPIDS accreditation standards

2024 standards review

Revised standards
Public consultation June 2025

About

This document contains the proposed new QPIDS accreditation standards. All accreditation programmes within the Royal College of Physicians are required to review their accreditation standards every 5 years to ensure they remain relevant, up-to-date, and ensure the highest standards in quality and care.

In 2024, QPIDS invited feedback on the current 2019 accreditation standards. Feedback was received from clinical immunology services, assessors and key stakeholders. With the introduction of the Allergy, Clinical and Laboratory Immunology (ACLI) training pathway in 2021, it was recognised that there was an opportunity to align the QPIDS and the Improving Quality in Allergy Services (IQAS) accreditation standards. This alignment aimed to streamline the process and reduce the burden on services delivering both allergy and clinical immunology care.

Based on feedback received, it was decided that the QPIDS and IQAS accreditation programmes would review their accreditation standards simultaneously. A working group was formed, comprising members of the allergy and clinical immunology community, including key stakeholders such as the British Society for Immunology (BSI), British Society for Allergy & Clinical Immunology (BSACI), Immunodeficiency UK, Allergy UK, Anaphylaxis UK, and NHS England Clinical Reference Group (NHSE CRG). The working group reviewed the 2019 standards and provided further feedback to help form this update. We now invite feedback on the proposed new QPIDS accreditation standards.

QPIDS proposes the new structure as follows, containing six domains and 33 standards:

1. Leadership, strategy and management
2. Systems to support service delivery
3. Person-centred treatment and/or care
4. Risk and patient safety
5. Clinical effectiveness
6. Workforce

The consultation will remain open until Monday 23 June. Please use this online form to provide feedback on the standards.

Based on feedback, further changes will be implemented, with the final standards being made publicly available in Summer 2025. All registered services will receive communication regarding the implementation of the standards, outlining how this applies to those working towards achieving accreditation, or working towards an annual review or reaccreditation assessment.

If you have any questions regarding the new standards, or want to provide feedback about the process, please contact askQPIDS@rcp.ac.uk.

QPIDS accreditation standards

Domain	Standard	Guidance	Evidence requirements
1. Leadership, strategy and management	**1.1** The clinical service has a service description.	The document should include as a minimum: • vision for the service • organisational chart for the service • the names and key roles and responsibilities of each member of the leadership team (medical and nursing) • team composition, including number of sessions in job plan dedicated specifically to the immunology service • 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 locations, opening hours and clinic times, and modes of delivery (face-to-face or virtual) • the range of services offered • facilities available, including access for patients with special needs • how to contact the service for help and advice, including out of hours information • description of joint clinics and referral pathways to other clinical specialities, including key contacts for each companion speciality (eg ear, nose and throat (ENT), respiratory medicine, gastroenterology, infectious diseases, haematology/oncology, paediatrics, clinical genetics, rheumatology, dermatology, psychology) • detailed pathways outlining how referrals are managed across different specialities and across other immunology centres (both to and from), and referral criteria	A document outlining the key service details.

		• how the immunology service works with NHS (England, Northern Ireland, Scotland, and Wales), HSE (Republic of Ireland (ROI)) or other specialist commissioning teams and regional Immunoglobulin Advisory Panels (IAP) (where these are established) or equivalent • description of management of complaints • description of risk management • description of how patients are involved in the service • an appendix to all Standard Operating Procedures (SOPs) that are in current use (eg SOP for specialist procedures, infusions and home therapy).	
	1.2 The service has a leadership team that is visible and responsive to service needs, are approachable and uses a variety of methods to communicate regularly with staff.	The leadership team holds regular (at least quarterly) meetings to discuss service management issues. Communication should include face-to-face methods (eg huddles/debriefs). Communication to staff and relevant stakeholders (eg diagnostics, companion specialities, referrers, general practitioner (GPs) etc.) should include: • important changes to the delivery of the service • new statutory information impacting the service • updates on quality, safety and clinical governance.	A minimum of four sets of minutes of regular management meetings from the past 12 months. Examples of communications to staff (eg notices/bulletins etc). Evidence of dissemination of new statutory information (notice board/staff folders/minutes of meetings). 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 operational plan.	This document should include as a minimum: • measurable objectives, key performance indicators (KPIs), service evaluation and metrics for the service for that year • plans for service development, depending on local need • plans for service improvement and innovation	Operational plan document, that references a 5-year strategy. Minutes of service management/clinical governance meetings where the operational plan is discussed.

		• assessment of facilities and equipment and replacement schedule (eg business cases) • a training and workforce development plan, a skillmix review including administrative support, appointments to support new or existing work, retirement planning and staff retention. The operational plan should be developed with multidisciplinary input (eg the use of an away day may be helpful) and include reference to how patient's views have been considered in service planning. The operational plan may be part of a wider directorate strategy, if the clinical immunology specific needs are considered.	Evidence of implementation of the plan. Evidence of how key measures are shared with the wider team. Annual review of the operational plan.
	1.4 The service leadership team carry out a staff survey and provide opportunities for informal feedback.	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 (eg time, resource, and/or space). Regular feedback is required, in addition to an immunology-specific annual survey which should include feedback on: • leadership • communication and support • opportunities for training, development and making improvements • how staff are recognised and rewarded • the ability and process to raise concerns • support during incidents and near misses.	Staff survey specific to immunology in the last 12 months, including survey template, data and action plan outlining areas to improve and ways to continue to do well (where feedback is positive), including timescales and named leads. Examples of how staff are encouraged to provide informal ad hoc feedback, where appropriate. Examples of staff being involved in quality improvement initiatives. *Note: assessors will speak to staff about their opportunities to contribute to improving the service during the site assessment.*

	1.5 The service promotes the health and wellbeing of staff members.	The service should provide a supportive environment for staff. This may include organisation level schemes.	Examples of how wellbeing is promoted. Process in place for debriefing after a critical incident/event, within the service.
	1.6 There are escalation procedures for staff members.	This must include: • the sharing of information and raising general concerns • challenging questionable and/or poor clinical practice • breaches of code of conduct and accountability; raising concerns of an ethical nature • disrespectful, discriminatory, abusive behaviour or harassment • provision of information and support for staff members raising concerns to clarify that there is no blame for adverse consequences.	Raising concerns, whistleblowing and/or harassment and bullying policy (can be organisation's policy). Evidence of disseminating policies and principles of escalation to staff.
2. Systems to support service delivery	2.1 The service regularly assesses the facilities and equipment required to deliver the service.	The assessment must include: • shortfalls of existing 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. This must include emergency equipment, including resuscitation trolleys. Regular outpatient clinics for assessment and follow-up should be held separately for adults and for children.	Completed environment checklist developed by QPIDS. Evidence of regular completed Patient-Led Assessments of the Care Environment (PLACE) checklists (or equivalent). Robust systems for dispensing and storage of immunoglobulin products. Nursing and medical staff having access to adequate office space (including access to necessary hospital systems, telephones, computers, email and internet). Adequate clinic space for regular face-to-face and remote outpatient clinics for assessment and follow-up. The service must have the capacity to review all

			patients in clinic face-to-face when clinically indicated. Evidence that paediatric patients are seen in a separate area or time to adults being seen. Evidence of shared care agreements with other infusion sites (ie other organisations). *Note: assessors will review the clinical environment and explore this with staff (including pharmacists and dieticians) and patients about the facilities on the day of the site assessment. If assessors are not able to visit all sites that are used by the service due to distance and numbers, evidence of their suitability must be provided. This may include floor plans, photos and descriptions, and patient feedback.*
	2.2 The service has a process for document review and control.	A system of document control management, to include: • dates and formats of protocols • version numbers • planned review dates • author and authorising individual • who the distribution list is and that a reminder that photocopying is not permitted.	Evidence of protocols and local patient information meeting this standard.

		This process should apply to SOPs, clinical guidelines, patient leaflets and policies, and there should be procedures in place to make the team aware of any changes, with evidence of an audit trail.	
	2.3 The service has a patient database that is kept up to date.	The service should hold up-to-date data about patients under long-term follow up for information sharing and quality improvement, such as dissemination of information and/or local and national audit purposes. The data should be held in line with local governance.	A patient database covering long-term follow-up, Immunoglobulin Replacement Therapy (IgRT), Hereditary Angioedema (HAE), standalone or integrated register of home therapy patients, which is maintained up to date and in line with local governance.
	2.4 There is appropriate support from laboratory and radiology services.	The service should have access to high quality timely support services.	Evidence of laboratory services, United Kingdom Accreditation Services (UKAS) accreditation, or equivalent (Irish National Accreditation Board (INAB) accreditation for services in the ROI). If not accredited, there must be a mitigation and improvement plan in place. Evidence of timely access to radiology.
3. Person-centred treatment and/or care	**3.1** The service has an up-to-date website and/or public facing document, which provides key information to services users.	The document and/or website must include the following as a minimum: • the scope of the service provided (including whether research or training is undertaken) • the range of services offered, frequency, their location(s), any infusion sites, clinic times and how to contact services (email and phone numbers), including any out-of-hours provision • clinical staff members involved in delivering the service • facilities available, including access for users with specific needs • expected timescales for the patient pathway, including initial assessment and the process for urgent reviews	A public facing document and/or link to public facing website updated in the last 2 years. Evidence that service users are aware of the above, • evidence of this being provided in other accessible formats, where required.

		• any links with other clinical services/ stakeholders, including relationships with other organisations where referrals are managed • how patient involvement is incorporated into the running of the service • information on how to raise a complaint, including a link to Patient Advice and Liaison Service (PALS) • links to national patient representative groups • links to self-referral to local psychology services, where available. 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.	
	3.2 Patients and carers are involved in the development of the service	The service should utilise external resources such as patient support groups. The service should consider including information about patient involvement in the design and delivery of the service as part of standard 3.1 and implement strategies to facilitate input from a range of service users which considers equality, diversity, and inclusion (EDI) issues.	Evidence of ongoing patient/carer involvement in the design and delivery of the service (eg minutes of focus groups or meetings, patient days, or co-production).
	3.3 The service communicates to service users their rights and responsibilities.	Information about service user rights, including shared decision-making, should be readily available and communicated to those attending the service (eg through consent, and/or appointment letters), • staff have a responsibility to involve service users (and carers/family as appropriate) in making decisions about their care.	A section on the website and/or public facing document that describes patient responsibilities. Anonymised patient letter examples. Home therapy agreement, where applicable.

		Information about service user responsibilities should be readily available and communicated to those attending the service (eg through appointment letters) including: • notifying the service of appointment changes or cancellations • discussing with the clinical team any desired changes to treatment/care • visiting GP or other out of hour's service as appropriate if unwell between appointments • discussing with the service where expectation of treatment/care are not being met • abiding by any codes of conduct (eg zero tolerance for aggressive behaviour) or patient/carer charters. The patient carer should be encouraged to contact their immunology service if they are admitted to another hospital, to ensure specialist input is provided into their care.	*Note: assessors will explore this with staff and patients on the day of the site assessment.*
	3.4 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, home therapy, clinical procedures and post-clinical procedure care. Support should be offered to carers and representatives where relevant. Staff should make service users aware of, and encourage access to, local/national service user support groups, • the service should have an agreed process for ensuring 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).	Evidence of comprehensive written/online material available to support patient learning, either local or by signposting to national resources (eg patient support groups) and evidence of providing this information to patients/carers (eg posters in clinical area or anonymised patient letters). Evidence of patient education to cover self-management. Where applicable, evidence that the need for competency assessments is discussed with all home therapy patients.

			Where applicable, evidence that home therapy technique is maintained through practical reassessments of patient/carer competencies. Where applicable, regular submission of logs (and diaries if used) for home therapy patients.
	3.5 The service enables patients and carers to feedback on their experience of the service confidentially.	There should be opportunities for patients/carers to provide regular feedback. Service specific patient/carer survey should include, as a minimum: • facilities and equipment provided • quality and safety of treatment and/or care provided • shared decision-making and involvement of the service user in their treatment and/or care • quality and clarity of information provided • dignity, respect and compassion • availability of patient information, support and education, and signposting to local/national support groups, particularly for paediatric-adult transition • access to psychological support • ease of getting in touch with the service and a response within 2 working days for non-urgent queries. Actions taken and improvements made by the service in response to patient/carer views should be offered to patients/carers who have provided feedback. They should also be reported in summary form annually.	A service specific patient/carer survey conducted in the last 12 months, including survey template, anonymised responses and/or survey data. Evidence of how patients/carers are continually encouraged to provide unsolicited feedback outside of a formal patient survey (eg posters in clinic, comment box etc). Evidence of how patient/carer feedback has been considered within the service, and reasons for any change implemented or not implemented (eg meeting minutes showing evidence of patient/carer feedback discussions with staff, with agreed actions taken). Examples of how issues arising from feedback have been addressed and shared back with patients (eg you said, we did). Evidence must include patients from all pathways, including day case, outpatients and home therapy.

	3.6 The service supports patients transitioning from paediatric to adult care, and patients being transferred in/out from other regions.	The service should have a clear policy to ensure that patient care is seamless and there is overlap in provision. For handover from paediatric to adult services, a virtual or in person joint clinic is recommended for patients on long-term therapies.	Document highlighting the process for transition from paediatric to adult, including a named lead within the adult service and clear pathway (this could be within the service description). Document explaining how transfers to/from other regions are managed. Evidence of gathering feedback on the effectiveness of transition from different services and paediatric-adult transition.
	3.7 The service records, investigates and learns from concerns and complaints.	The service should have a culture of positively seeking out complaints and regularly incorporating them into meetings where quality improvement and service development is discussed.	A section in the service description describing how complaints are managed. Review of complaints and actions in service meetings, disseminating themes, actions and learnings to all staff in service. Log of all complaints (formal and informal, including PALS report), over the last 12 months, including response times.
	3.8 The service has procedures for patient admissions.	The service has a plan in place for admitting patients from their care when necessary. There must be a policy for liaising with day case teams to provide specialist immunology clinical and nursing support. This should include alerting patients to the need to contact the team if they are admitted.	A SOP describing procedure for patient admissions to include agreed pathway for: • admission from home • outpatients • day case. Evidence that the service ensures day case support/advice is provided to teams managing immunology patients in hospitals remote to the main immunology centre.

	3.9 The service provides clinical advice to primary care.	Services should develop local solutions to ensure the provision of timely clinical advice to primary care within 7–10 working days. The service should use local hospital/NHS systems to evaluate patterns of referral and consider impact of socioeconomic on access to specialist advice. This can also support transfer of care from hospital to primary care.	Evidence of how the service provides clinical advice to primary care within a clinically appropriate timeframe.
4. Risk and patient safety	**4.1** The service has risk management procedures.	The service carries out risk assessments in clinical and non-clinical areas that could affect the service provided (eg risks with specific clinical procedures, GP letters backlog or facilities issues such as shortage of products for treatment, eg immunoglobulin).	Risk management policy (could be organisation policy). Named individuals responsible for risk management in the service (could be included in the service description) and evidence of communicating their role to the team. Evidence of risk assessment and mitigation measures. A risk register and evidence of discussion at management/clinical governance meetings, timescales for implementing changes and evidence of escalation, where appropriate. Evidence of cascading information about risks to all team members.
	4.2 The service has a procedure for how incidents, adverse events and near misses are reported, investigated and	The procedure must include: • a statement encouraging staff members to report incidents, adverse events and near misses • a process for notifying staff and/or service users affected by incidents and documenting in their records • a process for mitigating risk incident(s) happening again	A section within the service description, or reference to an SOP that summarises safety/adverse event monitoring and reporting in the service.

	used to inform changes to service delivery.	• escalation process where the timescales for closing the incident cannot be achieved. 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.	Anonymised summary of incident reports (eg adverse events and near misses) over the last 12 months, • this should include the number of events, and a brief description of the nature of these. These can be clustered into incident themes (eg incorrect filling, medication errors, safety issue within a building). Evidence of discussion with a multidisciplinary team (MDT) involved in the service (medical, nursing and administration as a minimum, and include other networked departments where applicable). Evidence of where learning/service improvement has occurred. A summary of the investigation cycle relating to at least two individual incidents should be provided.
	4.3 The service undertakes and records a clinical risk assessment of individual patients, where required.	The service should have procedures in place to safeguard patients and the health and safety of staff members. A risk assessment will be necessary when there is a risk of harm to the patient and/or others or challenging behaviour. A clinical risk assessment must include: • the risk of harm to the patient and others • the patient's changing risks • deteriorating health and wellbeing	An SOP for identification of risks and mitigations, eg home therapy documentation. Evidence of an MDT approach to identify and discuss mitigation of any individual patient clinical risk. Evidence of a consent process for any high-risk treatments.

		• challenging behaviour • medical emergencies • medication management. A risk assessment should be carried out for all procedures involving potential risk of provoking anaphylaxis. The results of the risk assessment must be recorded in the patient record.	Risk assessment template (could be organisation wide). Evidence of staff training/competence in clinical risk assessment. Restraint and mental capacity procedure (or equivalent). A safeguarding policy and evidence of its implementation. Where applicable, evidence of team discussion of patients who pose a risk and management plan (eg during handover, MDTs, LeDeR reviews and/or equivalent). Where applicable, evidence of liaison with safeguarding team for vulnerable adults/ children. If home visits are undertaken, lone worker policy to ensure safety of staff going on visits.
5. Clinical effectiveness	**5.1** The service sets, monitors, and reports on metrics, and has an improvement plan supported by the management team.	The metrics to monitor and meet fully are: • waiting times for new outpatient appointments within 18-week national targets and capacity to see new urgent referrals within 2 weeks • waiting times for follow-up appointments should not exceed 2 months after the clinically agreed review date • waiting times for undertaking home therapy training • maximum waiting time to start IgRT	Report documenting each of the metrics below and evidence of monitoring and benchmarking against national targets (waiting times for new and follow-up appointments). Improvement plans required if not meeting national targets. Minutes of service management meetings to show regular monitoring of metrics and where this is discussed, and escalation

		• 75% of clinic letters being sent to GPs and patients within 2 weeks of the appointment, including a facility for urgent letters to be sent within 2 days • Did not attends (DNAs) including strategies for reducing rates. The service must have a mechanism for recording delays in starting treatment for immunoglobulin and home therapy beyond the clinically agreed start date. The improvement plan should: • highlight strategies for continuing to improve against the metrics • include meaningful involvement of staff in development of the plan • include patient/carer involvement, where applicable, to help support change and improvement. The service should separate clinical immunology clinics and allergy clinics.	through senior management where additional support is required. Evidence of discussion with organisation senior management team/commissioners where waiting times are consistently not being met.
	5.2 The service participates in local and regional audit/assessment programmes.	Audits should be a meaningful part of service improvement and development; for targeted local audits, there should be a narrative to show how the audit/quality improvement project was chosen. Audits should cover patients in all geographic and clinical areas of the service, eg including home therapy, local day case infusions and infusions in centres at other hospitals, HAE, and other patients under the care of the service. For adult services: • an audit should include at least 30 patients, unless exceptionally the audit question only applies to a smaller number of patients.	A documented annual audit plan, including clear timescales for audit completion. Evidence of involvement in regional/network audit, where available. Targeted quality improvement projects generated from local discussion of perceived areas for improvement in the service. Evidence that changes made following audits have led to improvement, including

		For paediatric services: • Ann audit should include a minimum of 50% of the relevant patient cohort.	dissemination of lessons learnt to the team. For adult services: Rolling annual audits for Common Variable Immunodeficiency (CVID), HAE, immunoglobulin administration, and consent process for all patients receiving blood products in the service. For paediatric services: Rolling annual audits for immunoglobulin administration and consent process for all patients receiving blood products in the services. And a minimum of one other audit as part of a rolling annual audit programme. This would cover the majority of patient cohort over a 5-year audit cycle. All audits must include: • method of selection of patients for inclusion in the audit • quality improvement plan, eg plan, do, study, act (PDSA) cycle or equivalent, developed as a result of the data generated from audit outcomes.
	5.3 The service participates in national	The service must be committed to national audits, and these will be linked to commissioning of services.	Evidence of participation in QPIDS census. Evidence of involvement in the UK Primary Immunodeficiency (UKPID) registry,

	audit/assessment programmes.		European Society for Immunodeficiencies (ESID) registry, the Intravenous Immunoglobulin (IVIg) and Subcutaneous Immunoglobulin (SCIg) database, and NHSE Specialised Services Quality Dashboards (SSQD) where available.
	5.4 The service reviews and updates all relevant guidelines and clinical pathways.	There should be SOPs covering common procedures (eg home therapy) and specialist procedures undertaken by the service. Latest versions of SOPs should be made accessible to all relevant members of staff in all relevant clinical areas where the treatment/procedure is delivered. SOPs should be aligned with national guidelines, and where these are not available, to other international guidelines or consensus documents.	The service description must link to all current SOPs. Evidence of reviewing local or regional protocols for CVID, HAE, immunoglobulin use, and all other conditions managed by the service. Evidence of reviewing guidelines and staff aware of how to access.
	5.5 The service keeps a register of all research undertaken, where relevant.	Register should as a minimum record the lead investigator from the centre and number of patients recruited.	Register of research undertaken. Evidence of communicating to the team which research projects are ongoing.
6. Workforce	**6.1** The service undertakes a review of the workforce.	The workforce review must include: • skillmix needs for the service • any planned appointments to support new and/or existing work • mitigation action for any workforce deficits • retirement planning • staff retention.	Evidence in operational plan of annual administrative and clinical workforce review, or earlier if there is a significant change in the service. Meeting minutes or action plans that show how deficits in workforce will be addressed. Evidence of an appropriately trained consultant clinical immunologist in charge of the service.

		The service must demonstrate an MDT approach to service delivery. The composition of the team should take the local population's needs and circumstances into consideration. The service must include contingency and succession planning to mitigate disruption to service. Consultant clinical immunologist in charge: • Adult services in the UK: a CCT (or equivalent) in immunology • Adult services in the ROI: evidence of inclusion on the specialist division on the Irish medical register • Paediatric services in the UK and ROI: a CCT (or equivalent) in paediatric immunology and infectious diseases, or 5 years of post CCT evidence of substantial continuing paediatric immunology patient management • For adult trained immunologists managing paediatric primary immunodeficiency: evidence of joint clinics with paediatric immunologist or MDT where specifics of paediatric patient management are discussed. Consultants seeing clinical immunology patients should manage a sufficient number of patients with immunodeficiency to maintain competence. Note: single-handed practice is not recommended. If single-handed practice is unavoidable, evidence of working with other services to review cases, including attendance at immunodeficiency network meetings. Senior nurse: • For all services: a band 7, or above, lead nurse (or equivalent) with at least 1 years' experience of working in primary immunodeficiency and evidence of appropriate training,	Evidence of an appropriately trained senior nurse to provide nursing care and run the home treatment programmes. Evidence of deputising arrangements, including holiday cover. Adequate staffing for regular face-to-face and remote outpatient clinics for assessment and follow-up. The service must have the capacity to review all patients in clinic face-to-face when clinically indicated. Evidence of job descriptions identifying scope of role. Where applicable, evidence of trainees being adequately supported to fulfil their clinical duties. Where applicable, evidence that infusion sites are supported by appropriately trained nurses.

		competencies, continuing professional development (CPD) and job plan • **For services with a band 6, or above, deputy lead nurse (or equivalent) from another specialty:** evidence of appropriate training, competencies and job plan • **For services seeing paediatric primary immunodeficiency patients:** evidence of appropriate training, competencies, CPD and job plan for a paediatric trained nurse in the service.	
	6.2 There is a service-specific orientation and induction programme, which new staff members and those with a change in role are required to complete.	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.	Induction pack(s) for staff including medical, nursing and administrative team members. Evidence of gathering feedback from staff about the induction process and what, if any, improvements were made. *Note: assessors will ask staff (and trainees, where applicable) about their orientation during the site assessment.*
	6.3 The service has a process to assess staff members as competent in specialist techniques every 2 years and for new starters.	Staff members should have a clear framework for evidencing competency and scope of practice. There should be clear roles of responsibility and supervision. For example, new roles such as physician associates should align with RCP guidance. Staff should maintain competency through regular CPD and work within their scope of practice.	This applies to staff new to the department, and all staff once every 5 years. Anonymised completed examples of competency framework for different staff groups, undertaking: • cannulation • venepuncture • administering infusions.

			Staff member competency logs, • for nursing staff, portfolios and use of BSI-CIPN immunology nursing competency framework. Note: this can be peer-assessed.
	6.4 The service has training plans in place for staff members.	The service should demonstrate a commitment towards teaching; this may be within and/or outside the service (eg teaching to other disciplines in secondary/tertiary care, primary care and undergraduate medical and nursing staff).	Training needs analysis, including how training will be resourced. Log of training records, including all induction, educational and professional development activities. Mandatory training schedule and compliance (100% compliance, with explanation of any non-compliance). Evidence of support for staff to undertake CPD, quality improvement and other development opportunities for learning. Evidence of support for staff to attend national educational opportunities. Evidence of protected time within job plan(s) for those with training and mentoring responsibilities, including supervision and support of students, trainees, observers, locum/agency staff and unqualified staff. Evidence of involvement in service-specific teaching within or outside the service, with feedback (where available).

			A health and safety policy and evidence of its implementation.
	6.5 The service has an appraisal process for staff members.	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 CPD in clinical immunology.	A policy that describes appraisals and staff development processes and managing and supporting performance. Log of appraisal dates, including names of staff. Evidence of CPD, specifically in relation to clinical immunology.
	6.6 The service encourages networking with other clinical services.	Clinical immunology networks should be used to share learning and disseminate good practice. In additional, members from a regional network can feedback information from other groups, eg the clinical reference group, or specialist interest groups. They are a point of contact with regional commissioning.	Evidence of at least one department representative attending national and network meetings (at least 3 out of 4 meetings per year) and evidence of sharing learning back with the team. **For UK services:** as a minimum, lead nurse should be a member of Immunology and Allergy Nurses Group UK (IANG). **For ROI services:** evidence of attending national network meetings such as Irish Association for Allergy and Immunology (IAAI).