



Royal College
of Physicians

Quality in Primary
Immunodeficiency Services

Accreditation standards review

Project overview and report
September 2025

Overview

As part of the Royal College of Physicians' commitment to maintaining excellence in healthcare, all accreditation programmes are required to review their standards every 5 years. This ensures that they remain current, relevant, and continue to uphold the highest levels of quality and care.

In 2024, the Quality in Primary Immunodeficiency Services (QPIDS) programme initiated a review of the 2019 accreditation standards. Feedback was actively sought from immunology services, QPIDS assessors, and key stakeholders across the sector.

The introduction of the Allergy, Clinical and Laboratory Immunology (ACLI) training pathway in 2021 presented an opportunity to align the QPIDS standards with those of the Improving Quality in Allergy Services (IQAS) programme. This alignment aims to streamline accreditation processes and reduce the administrative burden on services delivering both allergy and clinical immunology care.

To guide this process, a standards review working group was established. The group comprised representatives from the allergy and immunology communities, alongside stakeholders with relevant knowledge, experience and expertise. Through a series of focus group discussions, the group reviewed proposed changes to the 2019 standards, offered further input, and reached consensus on a revised set of accreditation standards.

A public consultation on the proposed revisions was held in June 2025. Additional feedback was received from services, assessors and patient organisations, further shaping the final version.

The 2025 QPIDS accreditation standards are scheduled for official launch on 1 October 2025. A transition period will take place between the 2019 and 2025 standards.

Further details, including training opportunities for services and assessors will be made available at www.qpids.org.uk.

Working group

The QPIDS and IQAS programmes convened a standards review working group in November 2024, with the following membership:

- > Dr Ariharan Anantharachagan, IQAS service representative
- > Dr Claire Bethune, chair of NHSE clinical reference group
- > Dr Lisa Devlin, IQAS and QPIDS Northern Ireland representative on steering group
- > Dr Matt Doyle, BSACI primary care representative
- > Dr Sarah Goddard, QPIDS clinical lead and BSI-CIPN representative
- > Ms Kate Gray, accreditation unit lay assessor
- > Dr Scott Hackett, QPIDS paediatric representative on steering group
- > Dr Sophie Hambleton, QPIDS paediatric medical assessor
- > Dr Archana Herwadkar, QPIDS service representative
- > Dr Aarn Huissoon, IQAS and QPIDS medical assessor
- > Dr Steve Jenkins, BSACI adult allergy special interest group representative

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- > Ms Mary Kelly, Anaphylaxis UK representative
- > Dr Peter Kewin, IQAS Scotland representative on steering group
- > Dr Nasreen Khan, IQAS clinical lead
- > Dr Sara Lear, QPIDS service representative
- > Ms Kathryn Powrie, IQAS nurse assessor
- > Dr Guy Scadding, BSACI representative
- > Dr Nafsika Sismanoglou, QPIDS resident doctor representative on steering group
- > Dr Kosta Stoenchev, IQAS resident doctor representative on steering group
- > Ms Christine Symons, QPIDS nurse advisor and assessor
- > Dr Paul Turner, BSACI paediatric allergy special interest group representative
- > Ms Susan Walsh, Immunodeficiency UK representative
- > Ms Amena Warner, Allergy UK representative.

Public consultation feedback

Feedback was received from adult and paediatric immunology service leads, QPIDS assessors and patient organisations. The following key themes emerged from the consultation:

Key themes

- > The alignment between QPIDS and IQAS standards was widely welcomed and seen as beneficial for services operating across both programmes. Respondents noted that this supports the development of integrated quality management systems. Several contributors described the revised standards as 'well thought out'
- > There was a recommendation to further streamline and consolidate the standards to reduce duplication and minimise the volume of evidence required
- > The inclusion of a requirement for adequate clinic space for both face-to-face and remote consultations was praised. Respondents highlighted its value in supporting services operating in constrained environments and in providing leverage when negotiating with host organisations
- > Respondents highlighted the need for clear transition pathways and accessible patient-facing documentation. They recommended publishing formal protocols, providing patients with copies of signed documents, and clearly outlining their responsibilities and expectations
- > Concerns were raised about local hospital admissions where specialist teams were not contacted, posing a risk to continuity of care. Respondents stressed that systems should not rely solely on patients to advocate for themselves during acute episodes
- > The less prescriptive approach to audits was positively received. Respondents appreciated the flexibility it offers, particularly for services with smaller patient populations or those adopting continuous improvement models
- > The clarification regarding paediatric services within the workforce standards was well received. The standards were described as robust, with no concerns raised by respondents.

Accreditation standards 2025

Domain	Standard
1. Leadership, strategy, and management.	1.1 The clinical service has a service description.
	1.2 The service has a leadership team that is visible and responsive to service needs, is approachable and uses a variety of methods to communicate regularly with staff.
	1.3 The service develops and implements an annual operational plan.
	1.4 The service leadership team carries out a service-specific staff survey and provides opportunities for informal feedback.
	1.5 The service promotes the health and wellbeing of staff.
	1.6 There are escalation procedures for staff.
2. Systems to support service delivery.	2.1 The service regularly assesses the facilities and equipment required to deliver the service.
	2.2 The service has a process for document review and control.
	2.3 The service has a patient database that is kept up to date.
	2.4 There is appropriate support from laboratory and radiology services.
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.
	3.2 Patients and carers are involved in the development of the service.
	3.3 The service communicates to service users their rights and responsibilities.
	3.4 The service documents person-centred treatment/care plans, based on the needs of the individual service user.
	3.5 The service enables patients and carers to feedback on their experience of the service confidentially.
	3.6 The service supports patients transitioning from paediatric to adult care, and patients being transferred in/out from other regions.
	3.7 The service records, investigates and learns from concerns and complaints.
	3.8 The service has procedures for patient admissions.
	3.9 The service provides clinical advice to primary care.
4. Risk and patient safety.	4.1 The service has risk management procedures.
	4.2 The service has a procedure for how incidents, adverse events and near misses are reported, investigated and used to inform changes to service delivery.
	4.3 The service undertakes and records a clinical risk assessment of individual patients, where required.
5. Clinical effectiveness.	5.1 The service sets, monitors, and reports on metrics, and has an improvement plan supported by the management team.
	5.2 The service participates in local and regional audit/assessment programmes.
	5.3 The service participates in national audit/assessment programmes.
	5.4 The service reviews and updates all relevant guidelines and clinical pathways.
	5.5 The service keeps a register of all research undertaken, where relevant.
6. Workforce.	6.1 The service undertakes a review of the workforce.
	6.2 There is a service-specific orientation and induction programme, which new staff and those with a change in role are required to complete.
	6.3 The service has a process to assess staff as competent in specialist techniques.
	6.4 The service has training plans in place for staff.
	6.5 The service has an appraisal process for staff.
	6.6 The service encourages networking with other clinical services.

Annual review assessment criteria 2025

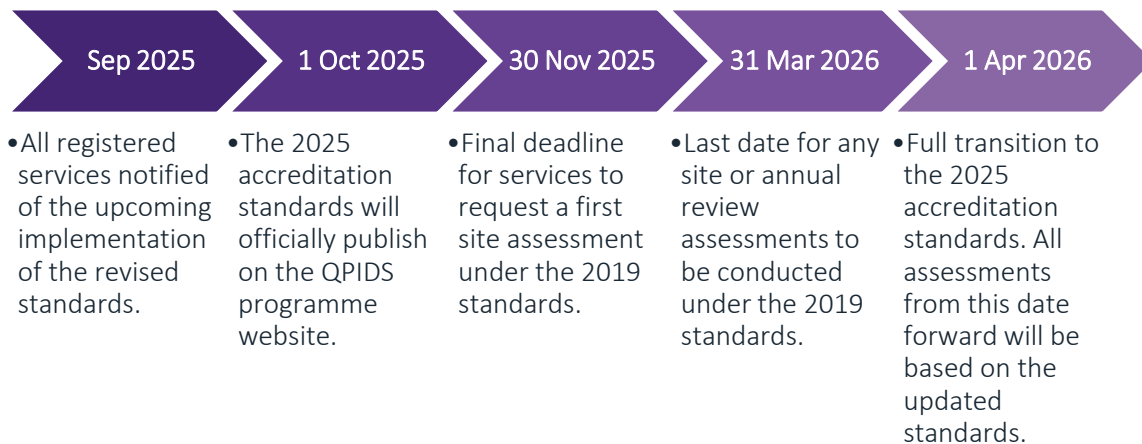
Services awarded QPIDS accreditation are required to submit annual evidence demonstrating continued compliance with the accreditation standards. This ensures that high standards of quality and care are maintained throughout the accreditation cycle.

In addition, services undergo a full site reaccreditation assessment every 5 years.

To support this process, the QPIDS annual review assessment criteria have been reviewed and updated to reflect the revised 2025 accreditation standards, ensuring alignment and consistency across all evaluation points.

Criteria	Guidance
1. Continuous improvement.	Please provide documentation of your service's metrics for the previous 12 months, and any improvement plans implemented.
2. Continuous development.	Please provide details of your service development priorities in the previous 12 months, including how these were identified and how you implemented them.
3. Workforce – staffing changes.	Please provide details of any staffing changes to the administrative or clinical workforce in the previous 12 months.
4. Staff feedback.	Please provide details on service-specific staff survey conducted in the previous 12 months.
5. Patient feedback.	Please provide details on service-specific patient/carers survey conducted in the previous 12 months. If your service has had any complaints, please provide details for these.
6. Audits.	Please provide details of your audit programme for the previous 12 months. Across a 5-year cycle, 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.
7. Learning from incidents and near misses.	Please provide details of any clinical incidents, adverse events or near misses in the previous 12 months.

Implementation



Further details on transition to the 2025 QPIDS accreditation standards

First site assessments

- > Services with an open self-assessment on the 2019 standards who wish to be assessed on this version, must submit their self-assessment and request a first site assessment by 30 November 2025. The requested site assessment must take place on or before 31 March 2026.
 - All remaining self-assessments on the 2019 standards will be cancelled as of 1 December 2025.
- > Services without an open self-assessment may begin a new self-assessment on the 2025 standards starting 1 October 2025.

Annual review assessments

- > Services that are accredited will follow this transition:
 - if the annual review is due before 1 April 2026, it will be assessed against the existing 2019 criteria
 - if the annual review is due on or after 1 April 2026, it will be assessed against the updated 2025 criteria.

Reaccreditation site assessments

- > Services due for reaccreditation before 1 April 2026 will continue to be assessed against the 2019 standards.
- > Services due for reaccreditation on or after 1 April 2026 will be required to meet the 2025 standards.

Further information

For further information please contact the QPIDS office at askQPIDS@rcp.ac.uk.