BOC Limited

# BOC Healthcare Headquarters

**Inspection report**

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

| | |
|---|---|
| Overall rating for this location | Outstanding ☆ |
| Are services safe? | Good ● |
| Are services effective? | Outstanding ☆ |
| Are services caring? | Outstanding ☆ |
| Are services responsive to people's needs? | Outstanding ☆ |
| Are services well-led? | Outstanding ☆ |

# Summary of findings

## Overall summary

Our rating of this location improved. We rated it as outstanding because:

- The service had enough staff to care for patients and keep them safe. Staff had training in advanced specialist skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records underpinned with extensive auditing. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Managers monitored the effectiveness of the service through a programme of continual, ambitious auditing and benchmarking. They made sure staff were competent by providing an extensive programme of continual professional development focused on developing innovative care.
- Staff worked well together for the benefit of patients and used a wide range of multidisciplinary opportunities to explore opportunities for improved care. Staff advised patients on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Staff sought an expansion of health promotion services where this would improve patient outcomes.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers and adapted care delivery based on individual needs.
- The service planned care to meet the needs of people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills through a programme of engagement. Staff understood the service's vision and values, applied them in their work, and used provider standards to challenge the status quo. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care and creating a working environment that promoted innovation and development. Staff were clear about their roles and accountabilities. The service engaged meaningfully with patients and the community to plan and manage services and all staff were committed to improving services through research and exploration of new evidence-based practice.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Community health services for adults** | Outstanding ☆ | Our rating of this service improved. We rated it as outstanding<br>Please see the main summary. |

# Summary of findings

## Contents

# Summary of this inspection

## Background to BOC Healthcare Headquarters

BOC Healthcare Headquarters is operated by BOC Limited. The organisation started providing healthcare services in 2011. It is based in Guildford, Surrey and delivers community care through 9 commissioned health contracts for NHS patients throughout England and Northern Ireland. The service directly employs a wide range of health professionals including registered nurses, healthcare assistants, physiotherapists, exercise physiologists, and exercise technicians. Sessions are delivered in Wigan, Rochdale, Hounslow, Somerset, Bradford, North Lincolnshire, Norfolk, Newcastle upon Tyne, and Great Yarmouth.

The clinical services department is responsible for delivering care that falls within the remit of the regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

Regulated care includes cardiac rehabilitation, pulmonary rehabilitation, respiratory disease management, and respiratory diagnostics. The service also delivers home oxygen therapy services.

We last inspected the service in April 2019 and rated it good overall.

## How we carried out this inspection

The provider delivers regulated activities from multiple community sites across England. We planned inspections to include the greatest range of care possible in addition to meeting key staff. We met with the provider's senior leadership team at their head office on 27 September 2022 and carried out announced inspections in Middleton, Manchester on 2 November 2022 and Wigan, Greater Manchester, on 9 December 2022 and carried out remote interviews on 21 December 2022.

We announced inspections because we needed to make sure the service would be operating at the time of our visit.

After our inspection the provider supplied us with a range of evidence, which forms part of our judgement and report.

The inspection was carried out by a lead inspector, with a specialist advisor during site inspections, and off-site support from an inspection manager.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

## Outstanding practice

We found the following outstanding practice:

- Staff across clinical specialties had carried out research and community engagement work to better understand the needs of the most vulnerable patients, including those at risk of social isolation. This led to the establishment of befriending services and new care networks to improve outcomes from rehabilitation services.

# Summary of this inspection

- Staff were proactive in exploring new evidence to support and develop care standards that exceeded accepted clinical standards. This included adapting emerging international research to UK needs.
- The service encouraged research amongst clinical teams to extend the value of audits and benchmarks by establishing new standards of practice that reflected international evidence and developments. Staff were proactive in lobbying integrated care boards and other budget-holders with commissioning responsibility to support the implementation of programmes that would drive care beyond the accepted norm.
- Staff developed care standards in the wider clinical field beyond their immediate remit to ensure patients benefited from holistic, multidisciplinary care that promoted positive outcomes for those living with complex comorbidities.
- The service partnered with specialist multidisciplinary colleagues to establish care practices that addressed those affected by health inequalities, including IT illiteracy.
- Staff went to great lengths to work with other professionals involved with patients to help coordinate care and recovery, such as by coordinating care approaches with college staff and prison officers.
- Staff delivered an extensive education package to colleagues in other services, including community matrons, district nurses, and GPs, and worked with NHS consultants to build knowledge and capacity across the health landscape.
- Health promotion was a significant element of care pathways and deeply embedded across care services, including for mental health. Staff consistently exceeded targets for the implementation of health promotion work.
- Staff carried out extensive work with carers to establish support processes that included an accredited training programme and options for support and advice.
- The service developed waiting well pathways for patients referred to services who were delayed by COVID-19 service closures. This prevented a further deterioration of health by providing remote support and targeted exercise programmes.
- Staff worked extensively to understand individual needs and reduce health inequalities that affected access to services across the communities in which they worked. Clinical specialist respiratory physiotherapists evaluated patient characteristics of those who took part in remote pulmonary rehabilitation sessions and found differences in patient outcomes based on internet literacy, level of social support, and their hearing and vision status. Staff used the findings to implement learning and programme changes for future work to promote equitable access to care.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Community health services for adults | Good | ☆ Outstanding | ☆ Outstanding | ☆ Outstanding | ☆ Outstanding | ☆ Outstanding |
| Overall | Good | ☆ Outstanding | ☆ Outstanding | ☆ Outstanding | ☆ Outstanding | ☆ Outstanding |

Outstanding

# Community health services for adults

| | |
|---|---|
| Safe | Good |
| Effective | Outstanding |
| Caring | Outstanding |
| Responsive | Outstanding |
| Well-led | Outstanding |

## Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

**Mandatory Training**

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

Staff received and kept up to date with their mandatory training, which was comprehensive and met the needs of patients and staff. Mandatory training included 20 modules such as moving and handling, infection control, safeguarding, and fire safety. The provider had a completion target of 90% for training updates. At the time of our inspection overall compliance was 85% although this reflected a range of completion rates, including 47% of staff who met or exceeded the 90% target.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. This was tailored to demand in specific regions and clinical services and reflected a growing need for more holistic care.

Managers monitored mandatory training and alerted staff when they needed to update their training. They arranged practical training with whole teams and staff accessed e-learning using protected time.

In addition to the standardised mandatory programme, staff undertook specialist training based on their individual role, such as pulmonary rehabilitation training, breathlessness and differential diagnosis, clinical assessment and management of chronic obstructive pulmonary disease (COPD), interpreting and performing spirometry and the management of inhaler devices and techniques.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Staff received training specific for their role on how to recognise and report abuse. All staff had level 1 adults and children training and patient-facing staff completed training to at least level 2. The service did not provide care for children and staff maintained training as good practice in recognition that children might be present in areas in which care was delivered. Staff completed national preventing radicalisation training to level 3 and demonstrated in-depth knowledge of the specific community risks in their region of work. The clinical lead held advanced level 5 training and was the national point of contact and escalation for all sites.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act (2010).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. For example, they took rapid, proactive action to protect a patient from harm following an allegation of neglect during a clinical session. Staff coordinated a response with the local crisis team and followed the case to resolution through the governance system. The senior team worked with staff nationally to review the incident, identify good practice, and consider opportunities for learning. Staff reported 4 such incidents in 2022 and documented discussions, handovers with other professionals, and outcomes in each instance. Evidence demonstrated a deep knowledge of good standards of safeguarding across the team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service operated a dual reporting system in each region. This meant staff reported safeguarding concerns or referrals using the provider's systems and to the local authority team.

Staff provided a range of examples of how they protected people through good use of safeguarding processes and policies. For example, the respiratory team acted to ensure a patient received the most appropriate care when they found a relative was speaking on their behalf. They identified a capacity and communication need and worked with the multidisciplinary team to ensure the patient was safe and supported.

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.**

Rehabilitation services were based out of a range of premises, including community centres. They were not clinical environments and did not need to comply with national requirements from the Department of Health and Social Care (DHSC). Staff made sure spaces used by patients were fit for purpose, clean and hygienic, and in a good state of repair. They carried cleaning products, such as antibacterial gel and wipes, with them and checked local cleaning standards by the building operator.

The spirometry service operated from a shared primary care centre and staff worked to national infection prevention and control standards. There were clear lines of responsibility for cleaning between this service's staff and the housekeeping team attached to the centre operator. This meant patients were always seen in clean and safe areas.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff audited hand hygiene and infection prevention and control practice bi-annually. In the previous 12 months audits found full compliance with expected standards.

Staff cleaned and decontaminated equipment after patient contact and maintained cleaning records.

Staff in the respiratory and spirometry services followed enhanced PPE processes to reduce the risk of infection to those at risk from COVID-19. This included the use of FFP3 surgical masks and controlled ventilation. Staff involved with aerosol-generating procedures underwent fit testing of masks in line with national standards.

**Environment and equipment**

**The design, maintenance and use of facilities, premises and equipment kept people safe. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.**

Services operated from a variety of locations including rented space in primary care centres, GP practices, and community hubs. The service pre-assessed each space to ensure it was suitable for the care being delivered and worked with local facilities managers to ensure they remained in good condition and well maintained.

The spirometry service operated from a primary care centre from clinical rooms adapted to ensure ventilation with 13 air changes per hour, which met national standards. This environment was fully compliant with national Department of Health and Social Care requirements in relation to flooring and infection control in the clinical environment.

Our inspection included cardiac rehabilitation that took place in a community hub in a shopping centre, and respiratory care that took place in a primary care centre. In both cases staff adapted well to their environment and ensured it was safe for patients. For example, the community hub was not a clinical space. Staff carried portable emergency equipment with them including therapeutic oxygen, masks for cardiopulmonary rehabilitation (CPR), and an automatic external defibrillator (AED) to ensure they were prepared for unexpected patient deterioration. The primary care centre was equipped with emergency medical equipment that reflected the nature of the service.

Staff in the respiratory service implemented a range of precautions to ensure patient safety. This included mandatory pre-clinic COVID-19 tests for patients and reflected the high levels of risk to respiratory patients if they were exposed to airborne viruses.

Staff carried out daily safety checks of specialist equipment. Where they provided care from rented premises, they completed a pre-service checklist to ensure expected equipment, such as emergency oxygen and clinical disposables. Staff had a single point of contact with the site manager to ensure any missing equipment or supplies were replaced.

The service had enough suitable equipment to help them to safely care for patients. Staff carried key equipment with them to some sessions and other locations had secure storage available. They adhered to a programme of planned and preventative maintenance and the service maintained up to date records of equipment calibration and certification.

Staff used an equipment maintenance and escalation process to obtain support from manufacturer technicians. The service had back-up systems and plans to mitigate the impact of equipment failures in clinics and staff were trained to carry out alternative assessments and monitoring to reduce the risk of a delay in care. The team shared local learning and advice from such instances in best practice teams with national colleagues, which helped staff to learn from each other and prepare for similar issues locally.

All staff completed fire safety training that included the principles of risk management followed by practical in-person training for local arrangements in their areas of work. This reflected good practice as staff provided care in a range of different settings that were usually shared with other services.

**Assessing and responding to patient risk**

Outstanding ☆

# Community health services for adults

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

Staff monitored patients for changes in their condition or unexpected symptoms during rehabilitation. For example, if patients complained of chest pain, staff documented observations, used a glyceryl trinitrate (GTN) spray (used for complications relating to angina), and monitored blood pressure. They used an escalation protocol to trigger an urgent referral or call to 999.

Staff completed risk assessments for each patient on initial assessment, using a recognised tool, and reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues. Cardiac rehabilitation took place a minimum of 8 weeks after surgery and staff undertook a range of risk assessments before sessions started depending on individual needs. For example, nurses checked patient's surgery wounds and asked about any unusual or unexpected symptoms. If a wound was not in the expected state, the nurse referred the patient back to their GP or consultant for care before continuing their programme.

The service recognised increasing needs presented by patients relating to mental health. Local teams worked with commissioners and the wider healthcare network to identify services to which they could refer or signpost patients.

Staff shared key information to keep patients safe when handing over their care to others. For example, they gained consent to share clinical outcomes and assessments with referring professionals, such as GPs, and when working with consultants based in in NHS hospitals as part of continuing care.

Staff carried out an individual risk assessment for each patient who received home oxygen therapy using a risk scale that enabled the service to coordinate level and intensity of care.

Staff monitored each patient's blood oxygen level and pulse halfway through cardiac rehabilitation sessions to achieve the best pace for each patient. For example, they ensured patients with readings outside of the expected level rested before continuing.

Staff completed resuscitation training to level 2 for adults and children and cardiac nurses completed advanced life support (ALS) training.

Staff used extensive referral acceptance criteria that included considerable pre-assessment for patient risk. For example, they required the most recent echocardiogram (ECHO) results for patients who had experienced heart failure and the most recent electrocardiogram (ECG) data for arrythmia patients. This varied based on the patient's history as staff needed to adapt rehabilitation exercise to ensure it was safe based on each patient's specific needs. Staff used exclusion criteria where rehabilitation presented excessive risk, such as those with unstable cardiac disease or uncontrolled hypertension.

Staff completed falls risk assessments for all patients at the initial assessment before rehabilitation sessions. Staff in the home oxygen service used a trigger system to identify elevated risks for patients such as their home condition or smoker status. The system meant staff planned for home visit safety, such as by implementing a 2-staff visit rule or liaising with the patient's other health providers to coordinate care planning.

### Staffing

Outstanding ☆

# Community health services for adults

**The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave staff a full induction.**

The service had enough nursing and support staff to keep patients safe. The clinical services team included 52 individuals structured in regional teams to meet demand and commissioning arrangements. A specialist nurse led each clinical specialty and a senior team lead was responsible for each region.

The team was multidisciplinary and included respiratory nurses, cardiac nurses, technical instructors, exercise physiologists, oxygen practitioners, a care coordinator, and physiotherapists.

Staffing levels were determined by commissioning arrangements and senior team leaders planned the skill mix in advance.

The service had variable vacancy rates and reported a 15% turnover rate in 2022, which reflected significant changes in the work environment due to the pandemic. The senior team were working with commissioners to recruit staff to a new service in Hounslow. The local NHS trust had reported the area as experiencing significant staffing concerns and the service had been unable to recruit. To ensure the service continued safely and uninterrupted, the senior team coordinated temporary cover from staff in other areas and were working with commissioners to join locality discussions about system-wide staffing pressures. Except for the Hounslow site, the service had successfully recruited to all open posts, including those created by turnover.

The service had stable sickness rates and team leaders monitored rates of sickness to plan the service and arrange support for staff.

All staff undertook an induction and mentoring period before they could work alone. All staff worked directly for the provider and the service did not use agency staff.

**Records**

**Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.**

Patient notes were comprehensive, and all staff could access them easily. The service used an electronic patient records system in use nationally with other healthcare services, including GPs. Staff could access the system remotely and the senior team used this function to audit standards of practice.

When patients transferred to a new team, there were no delays in staff accessing their records. Any healthcare professional involved in the patient's care and with access to the electronic system could access their records with patient consent.

The service audited staff quarterly on their use of the electronic records system. In the previous 12 months the audit showed overall compliance of over 99%, with 7 months of 100% compliance.

Spirometry nurses prepared lung assessment reports for the patient and their referrer within 1 week of initial assessment. They documented recommendations for care, such as a change in inhaler or changes in lifestyle.

Senior team leaders carried out periodic patient record audits to assess the consistency of standards. Recent audits showed 99% compliance with provider standards, including the accuracy of content and adherence to guidance on timeframes of completion.

The electronic system ensured records were stored securely with encrypted, controlled access. Staff used identification cards to access records, which provided a security trace for each entry.

**Medicines**

**The service did not prescribe or manage medicines. Trained non-medical prescribers managed oxygen prescription.**

Cardiac rehabilitation nurses checked each patient's prescribed medicines at the beginning of sessions to ensure they were safe and appropriate for their needs. For example, patients were often long-term users of angina sprays and inhalers and the cardiac team needed to ensure exercise sessions were safe.

Clinical staff undertook training and competency assessments in obtaining medication histories from patients that included adherence and inhaler techniques. This was an integrated process with the local clinical network and staff documented their findings on the electronic patient records system.

Staff worked continuously with patients who used inhalers to address widespread incorrect use that reduced efficacy. This was part of the service's core education delivery and staff worked to support patients by planning structured coaching and liaising with primary care services to supply inhaler aids such as spacer devices.

Non-medical prescribers were trained in national guidance and British National Formulary standards in oxygen prescribing decision making. They included British Thoracic Society oxygen guidance to ensure standards were benchmarked. Senior staff audited standards of practice for managing patient use of inhaled medicines and against National Institute for Health and Care Excellence (NICE) COPD severity and quality guidance.

Clinical staff completed Medicines and Healthcare products Regulatory Agency (MHRA) training in use of the yellow card system and pharmacovigilance. Both areas are designed to identify unaddressed risks in certain medicines. Each non-medical prescriber received individual MHRA updates on safety alerts and new recalls or information on medicines and medical devices. This represented a high standard of practice as it meant staff maintained up to date knowledge of changes in the wider clinical field beyond their immediate remit. Most patients who received care had multiple comorbidities and this practice helped maintain their safety.

Oxygen prescribing processes met national standards for the use of prescription pads and professional registration in line with the NHS Business Services Authority.

Each non-medical prescriber had direct support from a prescribing consultant who worked within the Royal Pharmaceutical Society Competency Framework for Prescribers, which benchmarked the service against national standards.

**Incidents**

Outstanding ☆

# Community health services for adults

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

All staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with provider policy. In 2022 staff reported 47 incidents. Regional team leaders investigated and categorised each incident to identify trends and themes and the senior team monitored incidents by region and clinical specialty. The most common types of incident were equipment problems or patient safety incidents, each of which represented 25% of the total.

The service had a standardised incident reporting system across all services nationally, which staff accessed remotely. Team leaders and the clinical lead shared learning from incidents in other sites as a standing agenda item in team meetings. This reflected good practice and meant staff had the opportunity to learn from the work of colleagues in other areas.

Managers had agreements with NHS services to share learning from serious incidents and never events that happened elsewhere. The service arranged this locally with individual NHS trusts and it meant staff were aware of changes in practice or standards relevant to the care they provided in the region.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Senior team leaders were responsible for the implementation of the duty of candour in their region with support from the clinical lead.

Staff had an in-depth understanding of patient safety risk in their region and were proactive in adapting systems and processes to protect people from avoidable harm. For example, a team noticed an increase in patients arriving for their first assessment with pressure areas. They reviewed each patient and identified trends between geographic areas and referrers. In response they reviewed discharge bundles from local hospitals and found a need for improved assessments and reporting. The team implemented a new requirement in the referring system for evidence of a skin integrity check for each patient.

## Is the service effective?

Outstanding ☆

Our rating of effective improved. We rated it as outstanding.

**Evidence-based care and treatment**

**The service provided truly holistic care and treatment based on national guidance, evidence-based practice, and research. Managers checked to make sure staff followed guidance.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. They mapped national best practice to individual patient records as part of an audit process to ensure care was evidence-based.

Outstanding ☆

# Community health services for adults

Staff held national best practice meetings for each clinical area of the service. Local teams presented complex or unusual care case studies as well as national work to identify gaps in practice and benchmarked standards against those of relevant organisations such as the British Thoracic Society (BTS), the Primary Care Respiratory Society, and the National Institute for Health and Care Excellence (NICE).

Care was pathway based and designed to meet NHS requirements and national best practice in each clinical specialty. For example, the service adhered to BTS requirements in the use of standard operating procedures such as supporting patients through individually structured written plans.

Staff were proactive in exploring new evidence to support and develop care standards. For example, the home oxygen team sourced emerging international research for non-invasive monitoring when they found differences in standards of providers across a region. The senior team supported this process and ensured the evidence complied with the requirements of UK standards and was appropriate to patient care. They shared such work nationally through a highly effective best practice meeting process, which included all staff across clinical specialties.

Staff worked continuously to identify opportunities for better use of care tools and accepted measures. For example, pulmonary rehabilitation staff used international walk tests to support patients living with breathlessness. A member of the team carried out a research programme to identify the best evidence-based tool to use with patients in their region. The programme compared the best walk tests to use based on patient needs and the best evidence of improved outcomes for each individual. They shared findings with colleagues nationally as best practice to help each regional team establish the best approach for their patients.

Staff completed an equality impact and risk assessment for each policy or standard operating procedure update and newly introduced. This ensured each was compliant with the Equality Act and supported equitable access to care.

**Nutrition and hydration**

**Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery.**

The scope of the service did not include nutritional monitoring or responsibility. However, staff worked within a comprehensive health promotion and health monitoring programme that included nutrition and hydration as part of a holistic approach to care. Staff had developed deep connections within regional health economies and provided signposting and referrals to dieticians and nutritionists where patients needed support.

Patients had access to drinks and snacks in rehabilitation services in line with the facilities of each site.

**Pain relief**

The scope of the service did not include pain management. However, staff carried out comprehensive health assessments and monitoring with patients and liaised with primary and secondary care specialities to secure pain assessments.

**Patient outcomes**

Outstanding ☆

# Community health services for adults

**All staff actively monitored the effectiveness of care and treatment through continual, extensive assessment processes. They used the findings to make improvements and achieved good outcomes for patients that consistently exceeded expectations.**

The service participated in relevant national clinical audits. The service participated in the National Asthma and COPD (chronic obstructive pulmonary disease) Audit Programme (NACAP) and the Pulmonary Rehabilitation Organisation audit, which benchmarked key indicators against similar services nationally. Results for the most recent data from 2021 indicated the service performed in line with national benchmarks, including consistent completion of initial assessments and designated sessional time for clinical leads to manage and develop the service. The audit found the service met Medical Research Council guidance in relation to providing rehabilitation classes to patients with self-reported exercise limitations.

Outcomes for patients were positive, consistent and met expectations, such as national standards. There was a persistent focus on improving patient outcomes through pilot programmes and research. Staff were proactive in lobbying integrated care boards and other budget-holders with commissioning responsibility to support the implementation of programmes that would drive care beyond the accepted norm. For example, in 2021 staff successfully secured commissioner support for a one-year pilot to provide breathlessness rehabilitation for heart failure patients, who regional teams found were rarely referred for such care. The team established there were no national quality targets for such rehabilitation and adapted the 70% completion rate target for pulmonary rehabilitation, which was comparable in scope. Of patients who completed the programme, 64% saw a measurable improvement in their breathlessness using accepted best-practice scales such as the Minnesota living with heart failure questionnaire and tools to measure mental health and anxiety levels. The programme leads received positive feedback from patients and other healthcare colleagues and planned to identify opportunities to implement learning nationally.

Staff in the Newcastle rehabilitation service carried out an internal audit to compare patient outcomes from the 6-minute walk test (6MWT) before COVID-19 in 2019 and after restrictions eased in 2022. The audit found differences in 6MWT prescribing that improved patient outcomes through greater accuracy and attention to detail.

Staff measured outcomes in a range of holistic measures, such as improvements in self-reported anxiety, depression, quality of life, and ability to complete the 6MWT. This was supplemental to prescribed rehabilitation and helped to establish long-term health and wellbeing improvements for patients. In the previous 12 months, audits found an average 88% improvement rate across the 4 measures.

Staff carried out an audit of patients who had been referred to the respiratory service inappropriately due to clinical exclusion criteria, which represented 20% of all referrals in 1 region. The local team identified similarities between each referral and worked with referring professionals to improve knowledge and understanding of the clinical inclusion criteria.

Staff worked during the pandemic to develop, test, and implement new care pathways to support patients after they were discharged from hospital.

Staff followed best practice in their respective clinical specialty. Spirometry nurses obtained a complete respiratory history from each patient at the lung capacity test and pre-treatment assessment stage. The cardiac rehabilitation team followed a 6-week, 10-topic care pathway with twice-weekly facilitated sessions. This was a staged approach to care and allowed patients to progress through different exercise topics during their programme

# Community health services for adults

Staff delivered cardiac services within a phased rehabilitation programme that included other organisations. After patients completed their programme with BOC, they had the option of progressing to the care of another organisation that provided supervised gym and pool exercise classes as well as social support programmes.

The east coast team had completed a comprehensive quality improvement project aimed at improving patient outcomes by addressing high levels of 'did not attend' (DNA) instances at pulmonary rehabilitation sessions. The team reviewed each DNA and identified opportunities for improvements in the booking and confirmation process. They piloted and implemented a range of changes, resulting in a reduction in DNAs from 28% to 15%. The team planned the audit to focus on specific patient trends, such as a high DNA rate amongst patients treated for cluster headaches. Staff recognised patients with this condition often lived with high levels of anxiety and mental health comorbidities and worked with them to identify strategies to improve completion of prescribed care.

The North Lincolnshire pulmonary rehabilitation team audited patient outcomes to address a high number of patients referred to the service who were unsuitable for care. This approach was in line with the Pulmonary Rehabilitation Services Accreditation Scheme requirements regarding outcome sessions, which were used to identify patients unsuitable for rehabilitation during initial assessments. The audit found 20% of patients referred were unsuitable, most due to uncontrolled hypertension. As a result, staff arranged to present at primary care network team meetings, which involved GPs, practice managers, and community respiratory leads, to improve understanding of the service. The team also met with care navigators, a new role in the community, to help integrate the service more appropriately into the local care system.

The service participated in the national Royal College of Physicians NACAP waiting times audit. The audit benchmarked pulmonary rehabilitation services for the time from referral to assessment and treatment as a key marker of good outcomes. In the previous 2 years the service performed in line with, or better than, the national average in all but 5 months when the service experienced delays due to COVID-19 restrictions on providing pulmonary care.

The service involved patients in the management of their own outcomes as part of a best practice approach to understanding how each patient measured success. For example, the home oxygen team worked with patients who received oxygen therapy to manage cluster headaches. Staff coordinated a new review process after finding a patient prescribed home oxygen through primary care for the past 30 years instead had undiagnosed asthma. This was a significant finding that materially improved patients' wellbeing.

**Competent staff**

**The service made sure staff were competent for their roles through the continuous development of skills and knowledge. Education was a substantive part of the service. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

The senior team demonstrably promoted a culture of continuous professional development that included coaching, support to attend conferences, and gold standard critically reflective practice.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service used an extensive 38-part competency framework to support and develop staff based on their specialty.

# Community health services for adults

Managers gave all new staff a full induction tailored to their role before they started work. Experienced staff provided a buddy system to support new colleagues for their first 3 months in post. The induction was structured to the needs of patients and the nature of the service and staff progressed at a pace appropriate to them, with additional time and training if needed.

Managers supported staff to develop through yearly, constructive appraisals of their work. They supplemented the formal process with regular touchpoints on request from staff or following a change in need.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Each member of staff had a senior team leader who met with them weekly during their probation to support the completion of competencies. The senior team tailored this process to the individual's level of experience and previous training.

The senior team coordinated clinical forums that supported the learning and development needs of staff. Staff took part in regular cross-specialty best practice meetings. This enabled them to share learning from training and conferences with each other and contributed to multidisciplinary competence.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. They identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, the cardiac nurse was undertaking a training qualification that would see them become the provider's national trainer for life support. This represented an ambitious, forward-thinking culture of professional development.

The senior team supported and encouraged academic development for all staff. For example, clinical staff could undertake a master's qualification and exercise instructors could enrol on a Diploma in exercise and sports coaching with a cardiac rehabilitation specialty. Technical instructors held level 4 qualifications in COPD management or exercise delivery and had access to a master's in exercise physiology. Physiotherapists were members of the Chartered Society of Physiotherapy and accessed training updates as they were released.

Senior team leaders carried out 1-to-1 supervisions with each member of the regional team. Staff completed an annual appraisal as part of a formal process and 100% of the team were up to date at the time of our inspection.

Staff used best practice and clinical supervision meetings to discuss challenges and suggestions for improvements, such as introducing clinical case studies to meetings to help share experiences and learning with staff across different regions.

Staff participated in an annual clinical forum facilitated by the provider in partnership with a range of specialists in their field. For example, the most recent forum included upskilling in thoracic surgery implications for rehabilitation, updates to inhaler techniques, and new clinical guidance on chest auscultation (a measure of breath intensity).

A best practice group for each clinical specialty worked nationally to standardise care across regions and build a national team communication, support, and competency standard. The groups met quarterly and staff from each specialty attended to benefit from multidisciplinary learning and collaboration.

# Community health services for adults

The service partnered with a specialist university health research team to assess how patients engaged with remote rehabilitation sessions during pandemic restrictions. They found differences in outcomes based on information technology (IT) literacy and health inequalities. The team used this information to work with patients closely to understand their needs and how to adapt remote work to their individual circumstances.

Staff development reflected the multidisciplinary nature of the service. For example, a nurse was undertaking an exercise qualification in reflection of the physiotherapy-oriented discipline of cardiac rehabilitation.

**Multidisciplinary working**

**Multidisciplinary healthcare professionals were dedicated to collaborative working to benefit patients. They supported each other to provide consistent, joined-up care across health economies and to establish new care pathways in underserved specialties.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Each regional team joined multidisciplinary groups appropriate to the local scope of care and community service structure. For example, the Somerset team joined meetings with social workers, respiratory advisors, and primary care network staff to coordinate care for vulnerable patients who received home oxygen therapy. The team used this approach to improve care for a patient living in risky circumstances and ensured other members of the multidisciplinary care system worked together to support them.

Staff arranged multidisciplinary case review meetings to coordinate care services for patients with complex needs. For example, the Hounslow team worked with GPs, fire services, and an inpatient respiratory team to coordinate support for a home oxygen therapy patient whose needs reflected a significant level of risk. The team navigated securing support from sleep services during a period of transition of provider and secured support from a breathing specialist physiotherapist.

The service adapted multidisciplinary working to match local commissioning requirements and the needs of patients in each area. For example, in Hounslow staff arranged multidisciplinary meetings for complex cases with a consultant from the local NHS trust. In North Lincolnshire, the team used this process to manage the increasing complexity of referrals to the service.

Staff referred cardiac rehabilitation patients to their GP when they felt their post-surgical recovery was not progressing as expected.

Staff in each region worked with multidisciplinary post-COVID recovery teams to ensure planned care was integrated with wider community services. This was particularly useful for patients who had recently been discharged from critical care and meant rehabilitation took place alongside physiotherapy and occupational therapy provided by other organisations.

Staff went to great lengths to work with other professionals involved with patients to help coordinate care and recovery. For example, a nurse attended a team meeting at a college where a patient studied to identify ways to better support their oxygen therapy support needs during attendance. This was a substantive approach to improving the patient's outcomes and quality of life and included consideration of their social needs, such as being able to join their friends during breaks between classes.

Staff delivered an education package to colleagues in other services, including community matrons, district nurses, and GPs. Similarly, staff had opportunities to shadow consultants in local NHS hospitals to build their skills in areas such as ear, nose, and throat (ENT) medicine. This was part of an ethos to build knowledge and capacity across the health landscape.

The spirometry team worked with the community respiratory team and a consultant to coordinate care for patients with complex needs.

**Health promotion**

**Staff gave patients targeted, practical, highly effective support and advice to lead healthier lives.**

Health promotion was a significant element of care pathways and deeply embedded across care services. The service included 11 health promotion key performance indicators (KPIs) in the quality framework to ensure each patient received holistic care beyond their immediate clinical referral. For example, staff used the hospital anxiety and depression score to measure mental wellbeing and a national quality of life tool to establish additional wellbeing needs. Staff offered individual exercise programmes and support to create a self-management plan with each patient. KPIs included a target that staff refer 90% of smokers who wished to cut down or stop to cessation services and 90% of patients with a body mass index (BMI) over 45 to a weight management service. Staff achieved KPIs consistently and in the previous 12 months, 100% of targets were met or exceeded. Smoking and weight management targets were exceeded substantially, with a consistent 100% referral rate in both.

Staff incorporated health promotion into rehabilitation sessions. Each cardiac session included 10 minutes of health promotion activity based on a 10-topic plan and staff delivered this interactively, basing information and guidance on individual needs. They included information such as diet management for those living with diabetes, smoking cessation, and alcohol management. The team included mental wellbeing in the sessions and discussed with patients how to manage the wider impact of their treatment needs.

Spirometry nurses worked closely with respiratory patients to understand lifestyle factors that might influence their symptoms and needs. They provided health promotion advice and guidance to help reduce symptoms, such as exercise or smoking cessation.

Staff proactively monitored changes to national guidance and health promotion information to support patients to manage their care. For example, guidance on the use of inhalers for patients living with some respiratory conditions changed in 2020 but this was not communicated nationally through primary care. Staff worked with patients who joined the service to ensure they understood the safest and most effective way to use their inhaler.

The service provided a 6-week exercise rehabilitation programme that included twice-weekly sessions. This included practical discussions on managing mental wellbeing as part of holistic care that aimed to promote long-term improvements in health and standard of living.

The service had designed, tested, and implemented an online training programme for carers of patients who received home oxygen therapy. A specialist third party organisation had accredited the training as meeting people's needs and staff supported all carers to access this.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Outstanding ☆

# Community health services for adults

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

GPs and other health professionals referred patients to the service with their consent. Patients attended the service for an assessment prior to the delivery of any care or treatment and consented to the process again. Staff asked for consent before undertaking and processes such as wound inspection or spirometry.

Referring health professionals made decisions about mental capacity at the point of referral and patients needed to able to understand their care at that stage. If staff felt a patient could not understand their care or its goals, they stopped the process and liaised with the individual's GP for advice.

The service maintained up to date links on national guidance and best practice in relation to the Mental Capacity Act 2008 (MCA) and the Deprivation of Liberty Safeguards on the staff intranet. This included local referral and escalation processes and contact details of specialist services.

Staff documented mental capacity information from referrals and initial assessments in patient records. They adapted such assessments to the type of care patients received. For example, patients in the respiratory service sometimes presented with hypoxia, which affected their speech and thought processes but was not an indication of a mental health need. Staff worked with colleagues across the health and social care sector to support care. For example, they found a resident in a care home had been misdiagnosed with dementia due to a lack of local expertise on hypoxia. Their intervention meant the individual received the right care.

None of the contracts within which staff offered care required the service to audit compliance with the MCA. However, the health analyst carried out checks of this independently to ensure consistent practice. In the previous six months the audit included 761 patients and found 100% compliance with mental capacity checks and documentation.

Staff discussed information management with patients during their first assessment and obtained consent to share clinical information with other services in line with care needs and the patient's wishes.

## Is the service caring?

Outstanding ☆

Our rating of caring stayed the same. We rated it as outstanding.

**Compassionate care**

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and went above and beyond expected care to take account of individual needs**

Staff were discreet and responsive when caring for patients. They took time to interact with patients and those close to them in a respectful and considerate way and tailored interactions to each individual. In rehabilitation services, staff built a rapport with patients over several weeks and used this to make sure they were happy with progress.

Staff took the time to get to know patients during their care programme. For example, we saw staff remembered a patient had recently returned from holiday and asked if they had enjoyed it. The patient was delighted, and this reflected the familiar, friendly facilitation of the service.

Patients said staff treated them well and with kindness. The service encouraged feedback using a variety of methods, including directly to staff during sessions and by using a questionnaire. Recent feedback included, “Staff were very friendly and kind towards me. They were easy to talk to.” Another patient noted, “I only have compliments for the way the service operates, what a great team.”

Staff followed policy to keep patient care and treatment confidential. While they were friendly and open with patients, they respected each individual’s privacy and used private space for sensitive discussions.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff implemented 1-to-1 working practices to support people who needed additional support. There was a growing area of understanding within the service of the impact of health inequalities and social vulnerabilities amongst patients. Staff demonstrated a clear understanding of the implications of such challenges and provided care and support that was compassionate and kind.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, staff asked patients at the rehabilitation pre-assessment stage how they could adapt care to meet such needs. Staff noted information regarding social and other circumstances in records to ensure care was individualised, such as where an individual’s home situation meant recovery exercises would be challenging. Patients told us they felt staff delivered personalised care. They said, “This is such a brilliant service, it solved a lot of problems for me,” and, “What else could I ask for? [Staff] treat me like family, they’ve been incredible.”

Staff developed extensive support systems for carers and the loved ones of patients based on the shared experience of different teams. For example, staff noted carers or relatives of patients with cardiac needs often demonstrated a need for support in coping but did not discuss this openly. In response staff developed a targeted conversation framework and new assessment in the electronic patient records system to enable teams to identify people in need of extra help.

Staff often arranged extra rehabilitation sessions, such as exercise groups, because patients enjoyed the sessions so much. This was apparent during our inspection where we found staff facilitated sessions as a community with a deep understanding of each individual and a demonstrably compassionate approach to promoting their health and wellbeing.

Staff sought opportunities to review and improve patient care in all aspects of the service. The quality assurance and governance systems were based on patient experience and outcomes and the extensive multidisciplinary research staff undertook across the service reflected their compassion for patients living with vulnerabilities and unmet needs.

Staff exceeded standard care processes to make sure patients were comfortable and well cared for throughout their pathway. They proactively sought opportunities to improve the experience and engagement and the senior leadership team ensured they had the tools, resources, and support to do so. For example, staff worked across different sectors to ensure patients could maximise their rehabilitation potential, such as in a further education environment in which clinical conditions presented barriers to making friends.

**Emotional support**

Outstanding ☆

# Community health services for adults

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal needs and provided individualised care that reduced worry and anxiety.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. They recognised many patients were living with vulnerabilities, including social isolation. During the pandemic staff developed befriending relationships with patients most at risk and kept in touch with them, offering emotional support and service signposting. They maintained this after lockdowns ended and adapted the approach into a vulnerable patient network.

Staff understood the emotional and social impact that a person's care and condition had on their wellbeing and on those close to them. They recognised the significant pressure carers often worked under and provided time to talk as part of a wider support process.

Feedback from patients and their carers was consistently positive. In recent feedback 1 patient noted, "[Staff member] has been friendly and helpful from day 1 and always has time for me and doesn't mind if I contact [them] if I'm worried about anything." Another patient said, "I cannot tell you in words, but it was lovely to see someone who honestly knows what I am going through and makes me feel better within myself, thank you."

Staff undertook training to provide emotional support to patients through positive communication and empathetic listening. We saw this worked well in practice and staff adapted their tone and language to meet each individual's needs.

During COVID-19 service closures, staff developed care plans for patients waiting to be seen. They worked with social care providers, volunteers, and other organisations to provide guidance on activities to keep people well and physically and mentally active.

**Understanding and involvement of patients and those close to them**

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. The service sought to maintain a continual understanding of patient need, expectations, and understanding.**

Staff made sure patients and those close to them understood their care and treatment. During all our observations of care staff explained the plan to patients and gave them the opportunity to ask questions. Staff discussed comprehensive personal and medical histories during initial assessments for areas that could impact care plans, such as smoking and recreational drug use. They did so without judgement and made sure patients understood the importance of such information.

Staff provided patients with information on their planned care at the assessment phase and throughout their programme. During our inspection of the respiratory service, nurses used very high standards of communication to explain the procedure to patients, including the purpose of each step and what would happen next. Staff worked with patients to understand contributing factors to their symptoms and used sensitivity when asking about personal factors such as smoking or recreational drug use.

It was common practice for patients to attend the cardiac rehabilitation service with a relative or friend. The community hub, which hosted the service and was a separate organisation, provided space for those accompanying patients to wait. This included comfortable seating and refreshments and a range of volunteers and staff to provide signposting and companionship with considerable efforts to reduce social isolation.

Outstanding ☆

# Community health services for adults

Staff encouraged carers or a family member to join sessions, with consent from patients, to help them learn how to progress rehabilitation exercises at home.

Patients noted in feedback that staff worked with them to make sure they understood their care. A patient with a hearing impairment said they appreciated the efforts of staff to adapt their communication when explaining their care plan.

Staff had designed and implemented a questionnaire specifically for carers to better understand their anxieties and experiences. The service held patients' involvement in their care as a core value and included this measure in measuring service quality and performance. In the previous 12 months audits found staff had involved patients and, where appropriate, their carers, in 100% of cases including the preparation of care plans and long-term condition management.

Staff worked closely with carers as part of care planning to ensure patients received the right kind of care. For example, staff noted carers or loved ones often took over many tasks of daily living for patients after a heart attack, which compromised recovery and put relationships under pressure. To address this, staff introduced consistent discussions with carers about their insights into the condition or illness. They spoke with patients about the level of involvement they wanted their carer to have and reflected this in notes and care plans to ensure consistency across services.

Staff involved patients and carers in care practices throughout the rehabilitation process. During a cardiac rehabilitation session, the technician spent time with patients demonstrating the function of the heart. They adapted communication so that everyone understood the discussion and ensured it was interactive throughout.

Assessments and rehabilitation sessions took place as a component part of wider care plans that involved other services and specialties. Staff ensured patients understood which organisation was providing their care and how this interlinked with other services. They also made sure patients understood who received information about their health outcomes and onward care recommendations. This was part of a wider culture of transparency to help deliver an inclusive service.

During spirometry assessments staff showed patients each piece of equipment and explained what it did. This worked well to reduce their worry and include them in the clinical process. Staff told us shared decision making was a norm for the service and they did not make decisions about care without first obtaining input from patients.

## Is the service responsive?

Outstanding ☆

Our rating of responsive improved. We rated it as outstanding.

**Service planning and delivery to meet the needs of people**

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

Outstanding ☆

# Community health services for adults

Managers planned and organised services to meet the changing needs of patients in each region. They planned rehabilitation care to meet the standards of referring NHS services. For example, the cardiac rehabilitation pathway for patients who had undergone heart surgery, was pre-set at 8 weeks.

Staff planned care holistically and ensured they considered each patient's whole range of needs and challenges beyond their medical presentation.

Facilities and premises were appropriate for the services being delivered. The provider scoped potential sites for care delivery during commissioning periods to ensure they were suitable. Staff ensured patients understood who was delivering their care and the difference between BOC Limited and the referring NHS provider. For example, signage in both sites we inspected were co-branded with BOC and NHS information. Patients noted this in their feedback to us and said they appreciated the transparency.

The service had systems to help care for patients in need of additional support or specialist intervention. While care programmes were delivered to a prescribed schedule for a predetermined number of weeks based on national NHS standards, staff liaised with colleagues across the health economy to coordinate extended care based on individual need.

Patients in the cardiac rehabilitation service presented with a variety of post-surgical needs including after coronary artery bypass graft (CABG), heart transplants, and heart attack episodes. The team had sound knowledge of the clinical implications of such conditions and treatment and planned care to be responsive to individual needs.

Regional teams implemented winter management plans to support patients with the greatest need during periods of exceptional pressure on NHS services. This aimed to identify patients who were likely to need higher levels of health intervention and implement a structured approach to support their wellbeing during periods of increased levels of flu and norovirus. The team liaised with multidisciplinary colleagues to understand specific capacity pressures in the region and worked with commissioners to ensure the prioritisation of high-risk patients was considered system wide.

Nurses in the spirometry service worked with referring GPs to tailor the service to each patient. For example, some GPs requested only a spirometry report and preferred to make their own clinical decisions. Others asked nurses to provide a recommendation for care with their report, which was part of the service structure.

An NHS consultant worked with the spirometry service in 2 clinics per month. They worked with the team to investigate cases where patients' symptoms did not match their spirometry results. Staff in this clinic saw patients on a 2-week wait pathway for cancer investigations and the consultant coordinated with the trust's diagnostic imaging department to arrange computed tomography (CT) to supplement lung function tests.

**Meeting people's individual needs**

**The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Staff made sure patients living with mental health problems, learning disabilities, and dementia, received the necessary care to meet all their needs. For example, the home oxygen therapy team provided care to patients living in adult social care settings and worked with community nurses to coordinate care for patients who could not retain information or

fully understand their treatment. Where patients had been referred for treatment with undiagnosed dementia or Alzheimer's disease, staff worked beyond the scope of the service to ensure they received the most appropriate level of care possible, such as a multidisciplinary approach to improving physical activity for a patient living with multiple comorbidities.

The provider planned services to be delivered from convenient sites for patients to access. For example, they required all sites to have step-free access to all areas as well as car parking and a local public transport system. For example, staff we spoke with in 1 area had developed an understanding of the local bus network and helped arranged rehabilitation sessions around patients' access to specific schedules. Patients told us this considerably lowered their anxiety and worry.

Staff planned and delivered sessions to meet individual needs. For example, staff in the cardiac rehabilitation programme ensured patients had time for health education and assessments in addition to 40 minutes of directed group exercise.

Staff supported patients living with dementia and learning disabilities by using communication tools and the disability distress assessment (DisDAT) tool. They adapted access to care by prioritising quieter times of the day for people living with autism and worked with patient's wider healthcare teams to reduce health inequalities by providing staff with training on delivering individualised care.

Staff recognised the needs of patients and carers who lived in vulnerable communities and reflected this in summary care records as part of contingency planning to help the wider healthcare team respond to change in need or circumstances.

Staff planned language support in advance for the whole period of a patient's rehabilitation and for individual appointments in the respiratory service. The service worked with local healthcare providers to ensure interpretation met the patient's needs. Where the service received consistent demand for a particular language, the senior team engaged long-term support from a native speaker who joined the team.

Staff delivered a service that was flexible to individual needs and worked with other organisations to adapt to specific challenges. For example, the service received a referral for a patient incarcerated in prison. The team worked with the prison's gym team and trained their personal trainers to deliver therapy safely and in line with the resources and constraints in the environment.

Staff delivered cardiac rehabilitation sessions to include a review of each patient's holistic needs. For example, staff used the first 30 minutes of each session to check patient's surgical wounds, check their vital signs, and review factors such as angina inhalers. This meant staff had assurance patients were safe to take part in the session and enabled them to monitor post-surgical recovery over the course of the programme.

Staff provided refreshments for patients attending rehabilitation sessions.

Waiting times for pulmonary rehabilitation increased during COVID-19 due to the suspension of in-person services. To ensure patients maintained a baseline level of health and fitness while they waited for services to reopen, staff worked with community partners to implement a waiting well pathway. This provided guidance to patients on maintaining fitness levels through remote advice and guidance until they could join rehabilitation sessions and included weekly check-ins with the specialist team.

Outstanding ☆

# Community health services for adults

Care was pathway based and staff adapted these individually to ensure each patient had the best chance of improved health. For example, staff had redesigned the oxygen pathway for patients who experienced cluster headaches to better meet the frequency of their main symptoms. This reduced unnecessary appointments and meant care was planned individually.

**Access and flow**

**People could access the service when they needed it and received the right care in a timely way.**

The provider delivered care to NHS patients who accessed the service through referrals from professionals such as GPs, community physiotherapists, and consultants involved in hospital discharge.

When patients had their session cancelled at the last minute, staff made sure they were rearranged as soon as possible. Service cancellations were rare and had happened due to COVID-19 sickness. In such instances staff phoned each patient and instructed them in therapy exercises they could carry out themselves at home to ensure they maintained their programme. The provider extended the programme duration to ensure each patient received the intended number of in-person sessions.

Staff worked extensively to understand individual needs and reduce health inequalities that affected access to services the communities in which they worked. For example, during COVID-19 lockdowns, the service implemented remote pulmonary rehabilitation support by telephone to ensure patients were not excluded based on access to technology such as computers or smartphones. Clinical specialist respiratory physiotherapists evaluated patient characteristics of those who took part in remote pulmonary rehabilitation sessions and found differences in patient outcomes based on internet literacy, level of social support, and their hearing and vision status. Staff used the findings to implement learning and programme changes for future work to promote equitable access to care.

Staff adapted the initial assessment process regionally based on local referral processes. For example, the cardiac rehabilitation service in Rochdale received referrals for patients before they underwent cardiac surgery, during post-operative recovery, and following emergency procedures. This range meant demand on the service was unpredictable and staff held regular workload reviews as part of team meetings to manage capacity.

Each specialty had a protocol to support patients who did not attend (DNA) a planned appointment. This differed between the type of appointment missed and always included an attempt to contact the patient by phone and communication with the referring professional. The service tracked DNA rates, which varied broadly from less than 1% to 15% depending on the region and type of appointment. Staff worked to reduced DNAs by making phone contact with patients in advance of an initial assessment, improving the information given to referrers about the service to make the process clearer, and working with patients to offer flexibility.

The service had carried out significant liaison work with referring organisations to reduce the number of inappropriate or declined referrals. This included distribution of detailed referral pathway criteria and clinical thresholds for increased or unacceptable risk.

The centralised referrals team was available from 8.30am to 6pm Monday to Friday and staff were trained to identify issues that needed immediate escalation to the clinical team.

**Learning from complaints and concerns**

Outstanding ☆

# Community health services for adults

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Patients, relatives, and carers knew how to complain or raise concerns. Staff carried posters and printed information about the provider's complaint policy with them to each site and displayed these during sessions. The information was written in an easy-read format and provided guidance on response times as well as signposting to the Parliamentary and Health Service Ombudsman (PHSO) in the event a complaint could not be resolved.

Formal complaints were rare. In 2022, the service received 2 formal complaints across all specialties, which amounted to less than 0.1% of patients seen. In both cases the service investigated the complaint within the policy standard of 20 days and provided a full explanation. The senior team leader prepared detailed, compassionate responses and ensured they answered each of the complainant's concerns.

## Is the service well-led?

Outstanding ☆

Our rating of well-led improved. We rated it as outstanding.

**Leadership**

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced and worked tirelessly to address them. They were visible and approachable in the service for patients and staff and had a clear track record of effective, evidence-based leadership strategy. They supported staff to develop their skills and take on more senior roles through 'stretch' goals.**

The provider's clinical lead was the registered manager. They provided leadership and support to regional teams and nominated a named deputy in the event they were away from work. A team of 3 regional senior team leads comprised of 2 specialist registered nurses and 1 specialist respiratory physiotherapist led local teams and provided day-to-day operational support. A clinical services manager and business director had overall leadership responsibility. Staff spoke positively about all aspects of the leadership structure and the provider's senior leadership team.

Senior team leaders joined clinical governance meetings on a rotational basis as part of a plan to develop and upskill into future members of the senior leadership team. The senior team used a wider development strategy that enabled each member of staff to identify their future goals and wishes, including respecting those who did not wish to progress to a leadership post.

Senior leadership staff and team leaders worked together to cover absence, which meant there was never any gaps when the service was in session. Each shift had a designated on-call manager for the region, who was available by phone or online chat. Staff said they felt the hierarchy was "flat" and they were trusted and empowered to make decisions, with support when needed.

Staff had access to an emerging leadership programme that provided structured training and supervision to progress to team leader level and beyond. The service was operated by an international, multi-sector provider and staff had access to a wide range of development opportunities.

Outstanding ☆

# Community health services for adults

**Vision and Strategy**

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The provider had a philosophy based on the provision of high quality, safe, and compassionate care. This was underpinned by shared values and a strategy that combined staff empowerment, community engagement, and people development to drive innovation in community health services grouped into four key principles. The senior leadership team led the clinical performance elements of the vision and strategy and focused on service sustainability alongside meeting the multidisciplinary needs of patients across the different regions in which they provided care.

A significant element of the service's strategy was focused on responding to trends in different health economies. The senior team recognised closures during the pandemic had led to extensive waiting lists and patients were presenting with significantly increasing complex needs. They worked with NHS colleagues and commissioners to reduce waiting times for patients across clinical specialties.

All staff we spoke with understood the provider's vision, purpose, and ethos, and were enthusiastic about the care they were empowered to provide.

**Culture**

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care and proactively sought opportunities for joint working and continuous improvement. The service promoted equality and diversity in daily work and provided personalised opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear and in which senior staff genuinely wanted to understand challenges.**

All staff we spoke with were unreservedly positive about the provider, their role, and the working environment. They said working patterns and arrangements were flexible around other obligations, which helped them commit to the service and achieve a good life balance. Senior staff said this contributed to consistently good retention. They carried out exit interviews with each person who left and used this to identify opportunities for working practices.

The provider maintained an up to date equality, diversity, and inclusion policy and staff undertook training as part of the mandatory programme. The policy identified legislation and guidance relevant to the scope of the service and the human resources team updated this as national requirements changed.

The service carried out a staff survey in 2022 to assess staff wellbeing following a challenging period. The results found most staff felt supported and appreciated a range of benefits of working for the provider, including the culture. However, a minority of staff reported a lack of resilience in staffing structures due to widespread absence as a persistent challenge. The senior team had a clear focus on mental health support, including the provision of mental health first aiders, to supplement recruitment drives to improve staffing. The provider supported leaders by providing specialist mental health training and facilitating a 'culture of care' across teams. This approach included a measure of stress and resilience amongst staff, which was a quantitative tool to identify the areas senior leaders needed to address most urgently, such as demands on staff in the workplace.

Inclusion was a core value of the organisation and a team of diversity and inclusion champions helped to develop strategies and resources to promote best practice and reduce unconscious bias in the workplace. The champions completed a range of specialist training, including on disability in the workplace and menopause in the workplace.

There was a well-established culture of mutual learning, collaboration, and peer review, which staff used to proactively support their development and progression. The work culture meant staff were trained and empowered to solve problems themselves and they always knew who to contact for support or escalation.

**Governance**

**Leaders operated highly effective governance processes, throughout the service and with partner organisations. Governance was measured quantitatively and qualitatively, and the service had substantial evidence of improvement and assurance as a result. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**.

Senior staff shared clinical governance updates as a standing agenda item in team meetings. This included a discussion of the background to decisions and changes, such as policy updates. This was part of a communication strategy designed to ensure staff were involved in governance systems.

Staff maintained good standards of governance documentation to track developments in patient care, including when working with other teams and organisations. For example, they maintained detailed minutes of multidisciplinary meetings including the specific input of different professionals involved in assessing individual needs. This meant the governance framework established a truly multidisciplinary ethos supported by

The clinical governance committee met monthly and reported to the provider's senior management team. The committee had a longstanding substantive membership, including senior team leaders, and the clinical lead was the chair. The clinical governance framework was fit for purpose and provided consistent oversight of safeguarding, incidents, audits, national safety alerts, staff training, and relationships across the healthcare landscape.

Meeting minutes demonstrated a consistent approach to reviewing internal performance and a keen focus on learning from other services, including international agencies, as a part of a governance culture of continuous review and improvement. The committee monitored work by agencies such as the European Respiratory Society and the British Thoracic Society to ensure they remained up to date with leading edge guidance and research.

Regional teams worked closely with other organisations alongside integrated care boards (ICBs) in working groups to establish good governance within allocated budgets and areas of accountability. They joined meetings to review key performance indicators across their region and work together with other services to make sure patients received coordinated care underpinned by appropriate data.

A steering group committee was responsible for ratifying policies and management of the overall governance information system, including the access control policy.

**Management of risk, issues and performance**

Outstanding ☆

# Community health services for adults

**Leaders and teams used systems to manage, assess, and improve performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Risk management was holistic and extensive and included tested plans to cope with unexpected events.**

The provider had a visible safety-conscious culture and included risk management during onboarding and induction processes for new staff.

The service managed risk on a continuous basis and in responsive to local circumstances. For example, the senior team worked with local staff to manage to manage risk during severe weather or disruptive events in their locale. Local staff carried out risk assessments for patients accessing sites to ensure they could do so safely. For example, the Somerset team carried out risk assessments in advance to help them reach patients despite poor road infrastructure during the Glastonbury music festival. Staff prioritised the most at-risk patients during such times and liaised with emergency services to ensure planning was fit for purpose.

Staff in the respiratory service worked with equipment manufacturers and health authorities to adapt premises during COVID-19 restrictions when risk assessments found air circulation processes needed improvement. The service adapted to continue to provide care safely, such as by installing new carbon monoxide monitoring equipment.

Risk management processes reflected the nature of rented care spaces. For example, the local team worked with the management team of a premises in which standards of cleanliness had deteriorated. The senior team moved the service nearby when the building operator did not improve standards.

Staff who delivered the home oxygen service carried portable oxygen cylinders with them to patient's homes. They followed risk assessments for this, including documentation for emergency services in the event of a collision. Oxygen risk policies meant staff did not carry equipment on public transport and provided the service only if they were a licensed driver.

Staff worked with home care patients to help them understand the need for good fire safety management in relation to their oxygen cylinders. Where staff found patients had risks outside of their expertise or influence, they arranged for the local fire service to visit the patient and carry out an individualised risk assessment.

The service used a service quality performance system to measure standards of care across all services. This included a series of key performance indicators (KPIs) focused on health and wellbeing outcomes as a measure of quality. For example, one KPI required staff to triage 100% of referrals within 2 operational days. Another targeted 100% of all discharge letters to be sent to the patient's GP within 5 days. In the previous 12 months, the service achieved 100% compliance for both measures as well as the targets for the other 12 KPIs.

The senior team used a risk register to monitor and track risks across the service. There were 6 active corporate risks at the time of our inspection, each with a named accountable member of the senior team and evidence of progress and risk mitigation. Senior team leaders managed risks in their regions and worked with staff to mitigate these at a local level using risk assessments and standard operating procedures. We saw this system worked well in practice and meant staff could tailor risk management systems to their specific site of work.

**Information Management**

Outstanding ☆

# Community health services for adults

**The service invested in innovative and best practice information systems and processes. The information used in reporting, performance management and delivering quality care was consistently accurate, valid, reliable, timely and relevant. There was a demonstrable commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement.**

The service maintained a high standard of information governance that involved staff across the service. Staff followed the provider's data protection and security policy and the senior team shared details of alerts and breaches, including from local NHS services, with each team. This reflected good practice and meant staff learned from the experiences of other services.

The information governance lead was responsible for internal processes as part of the governance and training frameworks. The organisation maintained accreditation to the international ISO 27001 standard for security management systems. A Caldicott Guardian was in post and staff knew how to contact them for support or advice.

The provider had information governance policies and processes for the safe use of the electronic patient records system. The system was shared with other healthcare providers based on local NHS agreements at each site. Information governance standards protected patient confidentiality and meant information was retained and stored in line with contractual obligations. For example, referring consultants accessed the system to monitor patient progress during treatment programmes.

Compliance with information governance standards was included in patient records audits. Recent audits found 100% compliance with expected standards of data management and confidentiality.

The service worked with other providers to establish information sharing policies when care was delivered as part of region-wide pathways. For example, staff delivered care as part of long-Covid pathways with 18 other organisations in the region. Each contributed to the information sharing agreement

The provider delivered services based on local contracts with ICBs and NHS trusts. Where contracts moved to another provider, the senior team completed data protection and information management handovers to ensure patients' details were managed safely and appropriately.

Information governance was embedded across the service and reflected a deep level of risk management focus. When staff carried out premises risk assessments to establish if a facility was suitable for the service, such as a primary care centre, they incorporated information governance measures. For example, staff checked if private rooms were soundproofed to protect sensitive conversations, reviewed the use of CCTV, and checked the security level offered by the centres' Wi-Fi service to identify if it was secure enough for clinical use.

Staff acted quickly when they found concerns or issues. For example, at 1 site staff found the building owner had changed their CCTV system and it now included their clinical area. As this was not advertised and patients had not consented, local staff worked to update the standard operating procedure.

During COVID-19 service restrictions, staff explored the implementation of remote consultation and rehabilitation services. They found some digital video chat platforms did not comply with national data protection requirements, such as the need for encrypted transmission if videos passed through the systems of other countries. To avoid this risk staff arranged alternation communication to protect data and personal information.

The provider was certified in information governance standards by an external specialist organisation, which enabled it to perform at a more advanced level than usually expected in the community care setting. A 5-year re-certification took place in late 2022.

The senior team monitored news from the Information Commissioner's Office about incidents involving other public services and used the outcomes to learn from the experiences of others. This reflected a high standard of practice because staff often worked independently and remotely and were required to maintain accountability for data protection.

The service had a substantial system for data protection designed to protect personal information. For example, each member of staff had a laptop built for their specific role with a no-sharing policy that could be accessed only through use of the NHS security system. Staff used the NHS e-mail platform, which enabled safe communications across health providers,

**Engagement**

**Leaders and staff actively and extensively engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. This approach demonstrably led to high quality care and staff empowerment.**

The senior leadership team worked with colleagues during pandemic challenges to provide an extensive range of care and support. For example, they provided direct support for the family of a member of staff who was severely unwell by helping them navigate the health service and planning for long-term recovery.

All staff we spoke with said they felt engaged and involved in the running of the service. They were empowered to bring suggestions to team meetings and governance meetings and said senior colleagues always listened. Senior staff we spoke with said this was an active part of the engagement and working culture and they encouraged anyone to contact them with ideas.

The service encouraged feedback from patients in any way they felt was convenient. Staff maintained a monthly record of qualitative feedback from patients, such as from e-mails, letters, and conversations after sessions. Feedback was consistently positive, and patients noted the kindness of staff, support to manage their condition, and standards of care as key aspects of the service.

We saw staff proactively engaged patients during rehabilitation sessions and group exercise. They adapted communication and level of encouragement to each individual, demonstrated an understanding of each person's needs and confidence, and established a highly tailored approach ensuring each person got the most out of their session. Staff were enthusiastic and reassuring and we saw patients responded positively to this.

Staff recognised the importance of carers in supporting patient care and engaged with them at a level appropriate to each patient's needs. The team produced printed information specifically for carers on managing home oxygen equipment, which included photographic guides to problem solving and contact details in the event of a problem. The service produced a national carer support guide that included contact details for NHS and local authority services in each commissioned area as well as signposting to get help for specific problems or worries, such as mental health needs.

# Community health services for adults

Regional teams maintained an extensive up to date directory of community support groups and specialist organisations that provided services to patients and their loved ones. This included activities and events by organisations such as Asthma and Lung UK and groups commissioned by NHS trusts. Staff regularly joined social and support groups to provide clinical input into rehabilitation and provide care guidance. Teams produced comprehensive quarterly newsletters that included contact details of each group, schedules of meetings, and success stories of patients who had achieved their goals.

An exercise physiologist carried out an internal audit of the referrals to the pulmonary rehabilitation service designed to address poor quality documentation that did not include medical history or include the patient in the decision to refer to BOC. The audit found 28% of referrals did not include a GP summary and that 8% of referrals included exclusion criteria. As a result of the audit, the team implemented a programme of clinical engagement with referring organisations to improve standards of documentation.

The audit found 25% of patients did not know they had been referred to another organisation and did not understand the potential benefits of pulmonary rehabilitation. The team worked with referring organisations to ensure they provided patients with information on the service and the types of care offered.

Staff were opportunistic in seeking feedback from patients from non-routine care, such as pilot programmes or outreach work. Patient feedback was consistently positive and reflected the caring nature of staff and their work to improve health and wellbeing. For example, a patient who participated in a heart failure breathlessness rehabilitation programme said, “The team are angels, [I] don’t know what I would have done without them I am now able to sleep alone if needed as I have the strength to get myself out of bed which I did not have before.” Another patient noted, “…I have noticed a remarkable difference… it has made me feel more confident [and] I feel I have made massive progress.”

During COVID-19 service restrictions the team implemented weekly question and answer sessions for patients to help them maintain good standards of health. This proved popular and staff adapted the service to continue to provide this for some patients in more vulnerable circumstances.

Engagement with patients was closely connected to improving services and achieving the best patient outcomes. Staff developed a questionnaire for use with patients who dropped out of rehabilitation without completing the programme. Teams used the feedback to identify potential improvements to the programme.

Staff facilitated patient focus groups for each clinical specialty and an expert user joined each meeting. The groups helped patients discuss worries, concerns, and experiences with each other as a peer support process and meant staff gathered feedback in real time. During the pandemic the service moved focus groups online and had recently reinstated these in person, with the option to join remotely for patients who wished.

**Learning, continuous improvement and innovation**

**All staff were demonstrably committed to continually learning and improving services through inquisitive working, professional development, and research. They had an advanced understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

The senior team prioritised social enterprise centres as sites for rehabilitation programmes, which reflected the needs of vulnerable patients. One of the centres we visited included a library service, coffee social mornings, activity groups, a community credit union, an internet café, and a food bank, with a substantial programme of community support.

Outstanding ☆

# Community health services for adults

The senior team facilitated an explorational, research-positive environment and the provider gave all staff access to an international research and literature database.

The service had a significant track record of working with staff to establish improved support and flexibility. For example, the organisation supported the creation of a new employee resource group for those living with neurodiversity, which includes cognitive challenges such as Tourette's syndrome, dyslexia, and acquired brain injury. The new group aimed to create a 'neuro-minority friendly environment' that was inclusive and provided a safe space for staff to disclose their needs. The service extended this to staff who had neurodiverse relatives.

The service was agile, and staff worked flexibly and proactively to coordinate new initiatives to maintain care during periods of extreme pressure. For example, demand on the spirometry service increased significantly during the pandemic with extended waiting lists caused by facilities unsuitable for respiratory care due to new national guidance. The spirometry team worked with regional partners and commissioners to create diagnostic hubs. In line with Association of Respiratory Technology & Physiology (ARTP) guidance, the hubs repurposed community sites to provide extra capacity within new infection control guidance.

Staff were recognised at an international conference for their work to adapt care based on patient health literacy. This included using new tools to gain a better understanding of each individual's IT access and literacy as well as working with other healthcare organisations to reduce barriers to remote care caused by differences in socioeconomic status.

A senior team leader represented the service on a specialist Association of Chartered Physiotherapists panel to contribute to national work underway to assess the potential for virtual rehabilitation.

The service monitored national data to establish the areas most in need of focus for innovation and care development. For example, the senior team used NHS England data on the causes on unplanned, avoidable hospital admissions to expand the training and competencies of nurses to review medical and medicine prescribing histories of patients. They established an extensive package of material, available through discussion with staff as well as ain printed, Braille, and translated format, to improve knowledge and education.