BOC Healthcare Headquarters

Quality Report

BOC Healthcare Limited
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

BOC Healthcare Headquarters is part of the British Oxygen Company (BOC). BOC has diversified from manufacturing hospital and industrial gases to include a range of engineering and healthcare services.

Within BOC Healthcare Headquarters, the service we inspected is operated by the Clinical Services department of the homecare division.

NHS commissioners in England have purchased a variety of community service contracts from BOC such as assessments for home oxygen therapy and rehabilitation classes for people with lung or heart disease.

Services are delivered through home visits and clinics based at community medical centres or classes in gymnasiums and leisure centres. The service is controlled from the corporate headquarters in Guildford and overseen by a nominated individual and three registered managers. All documentation is held electronically through a centrally-hosted clinical computer system.

We inspected this service using our comprehensive inspection methodology. We carried out unannounced visits to assessment clinics and rehabilitation classes in London, Surrey, Hampshire and Nottinghamshire on 29 and 30 April 2019, along with a further inspection visit to the headquarters location, in Guildford, on 2 May 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

This community health service is not provided to children or young people under the age of 18.

Services we rate

This is our first rating of this service. We rated it as **Good** overall.

- This was an ambitious service that sought to benefit from technology and fully utilise the support provided by its parent corporation. Given the variety of dispersed contracts undertaken throughout England, we found a relatively small number of specialist staff providing a service that was safe and effective; caring, well organised and well managed by highly-committed and charismatic leaders.
- We judged the way the service involved and treated people with compassion, kindness, dignity and respect as outstanding, with all other aspects as good.

However,

- The service did not keep staff records containing a full work history, reasons for leaving previous employment in a regulated service or explanation of employment gaps in staff files as required by legislation. We acknowledge that managers retained curricula vitae for new starters, but this did not necessarily contain all the information needed.
- We saw some instances where infection control guidance was not being followed. At one site we saw one staff member not cleaning their hands, or blood pressure cuffs after carrying out patient observations. This did not comply with best practice where hands and equipment should be cleaned after each patient contact.

Following this inspection, we told the provider that it should make two changes, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Summary of findings

Dr Nigel Acheson
Deputy Chief Inspector of Hospitals (South East), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Good 	Within BOC Healthcare Headquarters, the registered service is operated by the Clinical Services department of BOC Homecare. The corporation has diversified from the production of medical and industrial gasses and has successfully tendered for a variety of community health services purchased by NHS commissioners. These include home oxygen therapy, support for people suffering from respiratory illnesses and educational programmes and rehabilitation classes for people with respiratory or cardiovascular disease. BOC Clinical Services are responsible for home oxygen assessments and reviews as well as lung and heart failure rehabilitation classes. This was an ambitious service that sought to benefit from technology and fully utilise the support provided by its parent corporation. Given the variety of dispersed contracts undertaken throughout England, we found a relatively small number of specialist staff providing a service that was safe and effective, well organised and well managed by highly-committed and charismatic leaders. We judged the way the service involved and treated people with compassion, kindness, dignity and respect as outstanding, with all other aspects as good.

Summary of findings

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Community health services for adults.

Summary of this inspection

Background to BOC Healthcare Headquarters

BOC Healthcare Headquarters is the registered location for BOC Limited. BOC started providing healthcare services in 2011. It is based in Guildford, Surrey but holds NHS contracts throughout England and Northern Ireland.

Within BOC Healthcare Headquarters, the service we inspected is operated by the Clinical Services department of the homecare division.

The Homecare division employs about 160 staff and is divided into three areas of business. Clinical services employ around 52 healthcare professionals who are responsible for home oxygen assessments and reviews as well as cardiac (heart) rehabilitation classes, chronic breathing (respiratory) disease management clinics and respiratory diagnostic clinics.

About 45 logistic and technical staff operate the BOC home oxygen service which supplies portable oxygen cylinders and breathing equipment to patients who need respiratory support at home. Patients and staff from both businesses are supported by a team of patient advisors who are based in a telephone contact centre in Manchester.

As BOC Clinical Services is responsible for the activities registered with the CQC, we do not report on the home oxygen service or customer service centre.

The service has one CQC 'nominated individual', who is the BOC Homecare business manager and three CQC registered managers, who are the regional clinical managers.

We have not inspected this service before.

Our inspection team

Four separate teams, drawn from different CQC regions, inspected the service. The overall inspection group comprised a CQC lead inspector; five inspectors and three specialist advisors with experience in community respiratory and rehabilitation services.

The inspection as supervised and assisted by an inspection manager and overseen by Catherine Campbell, Head of Hospital Inspection (South East Region).

Information about BOC Healthcare Headquarters

BOC Homecare (BOC Limited) is an independent community health service for adults and is registered to provide the following regulated activities:

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

During the inspection, we visited five sites offering home oxygen assessments or rehabilitation classes. All sessions were held in premises rented by BOC and were chosen at random by CQC teams operating across greater London and three separate counties.

We also visited the registered location, which is the BOC national headquarters in Surrey. The service is managed from this centre and all documentation and records are held electronically. Staff and managers, working remotely from the location, used portable computers linked to mobile data connections to access the information and records they required.

We spoke with 14 employees including registered nurse specialists, physiotherapy specialists, exercise physiologists as well as technical instructors, managers and administrative staff. We spoke with four patients and two relatives in clinics as well as several patients and their carers attending rehabilitation classes.

Summary of this inspection

We looked at patient notes, policies and procedures, staff training and appraisal records along with meeting notes, audit reports, the environment and equipment used. We also received written feedback from five NHS commissioning groups.

There were no special reviews or investigations of the service by the CQC during the 12 months before this inspection.

Activity

In the reporting period January 2018 - December 2018, BOC Clinical Services operated 14 community health contracts commissioned and funded by the NHS.

The service treated 3,500 patients in the reporting period.

The service employed 41.9 FTE staff, made up of a mixture of registered nurses and physiotherapists supported by technical instructors and business managers. The nurses and physiotherapists specialised in pulmonary rehabilitation and ranged from nursing practitioners to specialist nurses or physiotherapists who were also independent prescribers.

There was no provision for bank or agency staff. The service covered planned absences using team colleagues. Unplanned absences were covered by suitably qualified managers or by cancelling and then re-booking sessions.

The service did not hold any medication. Some clinical staff carried portable cylinders of oxygen in their cars in case a patient attending a clinic or rehabilitation class needed a replacement cylinder. Carriage of oxygen complied with company policy.

Track record on safety

- One serious incident reported in the past year, relating to the loss of a computer service.
- One formal complaint which was not upheld after investigation.

Services accredited by a national body:

- Lloyd's Register Quality Assurance/United Kingdom Accreditation Service for ISO/IEC 27001:2013 - Management of information security.

Services provided under service level agreement:

- Clinic rooms and exercise spaces including all facilities such as reception arrangements, fixtures and fittings, furniture, cleaning and waste removal.
- Supply of home oxygen equipment. Patients obtained home oxygen equipment from providers under contract with the NHS. This could be BOC Homecare or another company.
- Appointment and advice contact centre (BOC Homecare).
- Telephone interpreting services.
- Maintenance of medical testing and exercise equipment.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated it as Good because:

- We found clearly defined and embedded systems, reliable processes and procedures to keep people safe and safeguarded from abuse. These were reviewed regularly, and safeguarding was well understood by all staff.
- Staff received effective training in safety systems, processes and practices and we saw records confirming that all employees had completed this training.
- Safety information was displayed at sessions and contained in patient folders. These included contact telephone numbers for use in the event of equipment failure. Staff completed and updated risk assessments for each patient at every clinic appointment and at set stages during rehabilitation classes.
- The service kept clear electronic records using digital systems that were identical to those used by NHS medical and nursing colleagues. The service had achieved ISO accreditation (27001) for management of information security.
- There were enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. BOC Clinical Services employed staff who were nurses and physiotherapists with additional qualifications or experience in respiratory care and rehabilitation.
- We found an open culture where safety concerns raised by staff and people who used the service were highly valued as opportunities for learning and improvement. Staff and managers alike were open and transparent, and fully committed to reporting incidents and near misses.
- Infection risks were controlled, and the service worked hard to ensure the premises they used were suitable and supported the safe delivery of care. We saw that clinic rooms were well-equipped, air-conditioned when appropriate and had enough furnishings for their intended purpose.
- However, we saw some instances where infection control guidance was not being followed. At one site we saw one staff member not cleaning their hands, or blood pressure cuffs after carrying out patient observations.

Are services effective?

Good

We rated it as **Good** because:

Summary of this inspection

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- British Thoracic Society (BTS) and National Institute for Health and Care Excellence (NICE) guidelines were used to support the care and treatment delivered. Rehabilitation courses had been registered for the pulmonary rehabilitation services accreditation scheme (PRSAS).
- We found a clear approach to monitoring, auditing and benchmarking the quality of services and outcomes. The service routinely monitored the effectiveness of rehabilitation sessions and used the findings to improve them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service
- We saw good examples of coordinated care with clear and accurate information exchange between relevant health care professionals. The service had established strong links with NHS community medical services including GPs, occupational physiotherapists and social workers.
- The service worked hard to involve patients in regularly monitoring their own health; empowering them to manage their condition, care and wellbeing and to maximise their independence.

Are services caring?

Outstanding ☆

We rated it as **Outstanding** because:

- We saw staff taking the time to interact with patients and their relatives or carers in a respectful and considerate way.
- Pulmonary rehabilitation staff showed an encouraging, sensitive and supportive attitude to people in their exercise sessions. Home oxygen assessment appointments were conducted in clinic rooms that ensured privacy and dignity.
- All the patients we interviewed told us that they were given excellent care, and that all staff were always kind and compassionate. At sessions we observed, staff introduced themselves, the visiting manager and the inspection team to the group.
- Patients told us they were actively involved in all decisions made regarding their care. We heard how their referrals had been acted upon very quickly and they felt listened to and valued.
- Staff demonstrated compassion and insight into how patient conditions may negatively affect their quality of life and made appropriate adjustments wherever possible.

Summary of this inspection

- Staff said patients who were not keen on joining a group session were supported at home Staff were mindful of patients with special needs and gave examples such as positioning a patient nearer to the nurse if they had difficulties hearing.

Are services responsive?

Good

We rated it as **Good** because:

- This was an ambitious service that constantly looked for opportunities to work with the commissioners and other health and social care providers to meet the needs of people with long-term heart and lung conditions.
- It was actively implementing technology to help improve the way services were delivered. Rehabilitation services and supporting materials had been reconfigured to achieve national accreditation.
- Rehabilitation courses were operated continuously in a 'cycle' and sessions repeated twice a week. This meant patients could join a class soon after referral or re-join the programme after any absence. Patients could also choose a time and venue to suit their circumstances.
- Feedback from commissioners showed the service met performance targets relating to referral times and responded proactively to patient needs and any changes required.
- The service actively worked to promote inclusivity and we saw and heard about examples where friends, relatives and carers were encouraged to attend and contribute fully to sessions. We also saw examples of where the service made changes to help accommodate patients from distinct cultural groups and with differing language needs and literacy levels.
- Feedback from patients and staff was always sought and acted on.

Are services well-led?

Good

We rated it as **Good** because:

- We found a service that had compassionate, inclusive, and effective leadership at all levels. The management team showed high levels of experience, ability and capability needed to deliver excellent and sustainable care. There was a firmly embedded system of leadership development and mentorship.
- As a smaller service, it clearly benefitted from extensive support provided by the parent corporation. The service was safe and effective, ambitious, well organised and managed by highly-committed and charismatic leaders.

Summary of this inspection

- Staff told us they felt well supported, valued and that that their opinions counted. Regional leaders knew what their teams were doing well and could name the challenges and risks their teams faced.
- We found a systematic and integrated approach to monitoring, reviewing, and giving evidence of progress against the strategy and plans. Plans were consistently and thoughtfully implemented and had a positive impact on quality and sustainability of services.
- The service published information about its mission, values, and vision on corporate and public websites.
- Frequent governance meetings occurred at senior level and staff reported that monthly team meetings also included governance agenda items.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Community health services for adults

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

Are community health services for adults safe?

Good

Our rating for safe was **good**.

Mandatory training

- Staff received effective training in safety systems, processes and practices and we saw records confirming that all employees (100%) had achieved training compliance. The service determined statutory and mandatory training topics based on desired staff competencies as well as skills requirements set by the NHS commissioners.
- Some of the statutory and mandatory training was delivered 'face to face' at an annual clinical forum. This event was held over two days and attendees included colleagues from similar BOC respiratory services based in Ireland. In addition to continuous professional development sessions with guest lecturers, training included manual handling and basic life support classes with the use of automatic external defibrillators (devices used to help treat people suffering from heart attacks).
- The rest of the mandatory training programme was delivered using an electronic system purchased from the NHS called 'E-Learning for Health'. This meant staff received the same type of mandatory training as NHS colleagues doing similar work. The e-learning modules taken included infection prevention and control, consent, safeguarding (including arrangements to safeguard young people at risk of radicalisation), information governance and data protection as well as equality and diversity awareness.
- Staff told us that the mandatory training was effective and helped to support them deliver safe care. Staff confirmed they had 'protected time' to help complete the e-learning. The internet-based system also gave staff the flexibility to complete training after work at home if they preferred.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. All staff present during our inspection confirmed they undertook annual safeguarding training, could identify the BOC safeguarding lead and understood how to report a suspected safeguarding concern.
- Both adult and child safeguarding training was provided because staff attended family homes where children and young people could reside. We saw that managers and senior clinical staff were trained to level three and those who worked within GP practices and other public venues were trained to level two. The safeguarding lead was trained to level four. Safeguarding roles and training were aligned with national guidance contained in the 'Safeguarding Children and young people: roles and competencies for healthcare staff, published by the Royal College of Paediatrics and Child Health in 2014.
- None of the staff we spoke with could recall the need to raise a safeguarding concern in the last year,

although a manager was able to give a good example from the past involving a child seen during a home visit and how the concern was handled in cooperation with external agencies.

- Female genital mutilation and child sexual exploitation awareness was incorporated into safeguarding training which was delivered as part of the statutory and mandatory training programme as well as in induction courses for new staff.
- We saw meeting agendas that showed safeguarding was a standing item at clinical governance meetings, and concerns were escalated to executive and board level if needed. These meetings were also minuted and circulated to all staff by email. Key learning points were included in the quarterly staff newsletter and monthly team meetings.
- The service had a well-defined recruitment pathway and procedures to help ensure that the relevant recruitment checks had been completed for all staff. This included a disclosure and barring service (DBS) check every two years, photo-ID, occupational health clearance, references and qualification and professional registration check.
- However, the service did not keep staff records containing a full work history, reasons for leaving previous employment in a regulated activity or explanation of employment gaps as in staff files as required by legislation. We saw that managers retained a curriculum vitae but this did not necessarily contain all the information needed.

Cleanliness, infection control and hygiene

- Infection risks were contained. Staff kept themselves and the equipment being used clean and employed control measures to help prevent the spread of infection.
- We observed a variety of premises in use, ranging from consultation rooms in medical centres to exercise spaces in gymnasiums. The service leased premises from NHS or private organisations. We did not inspect the buildings in detail as they were rented, but the rooms used by BOC were visibly clean, tidy and free from clutter.
- Overall, staff adhered to good infection control practice, such as those published in the National Institute for Health and Care Excellence (NICE) Clinical guideline (CG139) 'Healthcare-associated infections: prevention and control in primary and community care'. Liquid soap and hand gel were available in all the places we visited, and we saw staff using these products. We also saw staff and patients using hand gel and wipes during rehabilitation classes and we saw staff cleaning exercise equipment before and after use. This included items like exercise bikes.
- The service undertook quality control audits which showed good compliance with the service's infection control policy, which was 'in date'.
- In addition, we noted that staff were dressed in short-sleeved uniforms, which meant that staff were 'bare below the elbows' in accordance with NICE CG139. Some of the premises we visited had hand hygiene posters on display, but this varied depending on the property owner.
- However, we saw some instances where infection control guidance was not being followed. At one site we saw one staff member not cleaning their hands, or blood pressure cuffs after carrying out patient observations. This did not comply with best practice where hands and equipment should be cleaned after each patient contact. Local managers told us cuffs were disposed of if seen to be visibly dirty.

Environment and equipment

- We did not inspect venues in detail as these were rented, on a sessional basis, from other organisations. However, we saw modern premises that supported the safe delivery of care. We saw that clinic rooms were well-equipped, air conditioned when appropriate and had enough furnishings for their intended purpose
- Storage areas we checked appeared visibly clean and well-organised. We saw examples of non-public areas (such as cleaners' cupboards and storerooms) secured by keypad locks to control access.
- Fire safety equipment and safety evacuation signs were present throughout and we saw that external contractors had completed fire equipment safety checks.

- Nearly all the venues we visited had a shared reception desk. Our teams saw patients being signed in and out at reception.
- At one practice we could not find a Health & Safety Executive (HSE) approved law poster on display, which is a legal requirement. At the same venue, we noted the clinic was on the first floor and we could not see any fire evacuation aids provided. These aids are designed to assist staff help those with limited mobility descend the stairs in an emergency. BOC staff told us these issues had been reported to the property owner. We mentioned our observations to a venue manager.
- Staff confirmed that venue assessments were undertaken monthly or whenever a change in the accommodation was seen, such as renovations or repairs. Any concerns raised were recorded and either addressed locally or escalated to regional leads for further action. Staff were then updated on progress at the monthly team meeting or by email. Managers emphasised that if their intervention did not solve the issue or concern they were authorised and encouraged to source any suitable alternative within budget.
- We saw examples of 'planned workplace inspection' forms that had been completed by staff on sessions or in clinics. Managers stated that these venue assessments were part of a corporate-wide programme operated by BOC called 'safety, health, environment and quality (SHEQ). This programme was based on principles applied to industrial safety and good manufacturing practice and meant that local processes were linked to a fully supported and integrated safety management system.
- Rehabilitation classes were undertaken in air-conditioned fitness studios. Managers explained that the British Thoracic Society guidelines recommended room temperatures should be between 18o – 22o degrees Celsius. When we checked air-conditioning controls, we saw they were set to within these readings.
- We saw BOC-owned electrical devices labelled with the dates of the most recent service or test, which provided a visual check that they had been examined to ensure they were safe to use. We were also shown records that provided evidence of recent maintenance inspections. This indicated that BOC complied with guidelines contained in the HSE 'maintaining portable electrical equipment HSG107' (2013) and Medicines and Healthcare Products Regulatory Agency's 'Managing Medical Devices' (April 2015).
- At one clinic we noted the temperature log was missing from the medication refrigerator. This refrigerator contained blood gas test reagents, and the lack of a record meant it was not possible to show that the test chemicals had been stored within the manufacturer's specification. The clinic nurse explained this had been reported and we saw a new log was provided by a manager before we left the building.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient at every clinic appointment and at set stages during rehabilitation classes. Assessment records were kept on digital systems that were similar to those used by NHS medical and nursing colleagues. This made it easier for general practitioners (GPs) and practice nurses to check the assessment status and progress of patients who had consented to information sharing.
- The service only accepted adult patients referred from their GP or other agreed source. Referrals were completed on the shared digital system and this included information about patient risks.
- The referral form also detailed environmental or more general risks, such as pets in the home. We were told that in some cases, assessment or review visits were made to the patient's own home. In these instances, two staff would attend the initial visit as well as subsequent appointments if necessary.
- Digital referrals for pulmonary rehabilitation courses included prompts to identify medical conditions that made the patient unsuitable for certain types of exercise.
- Pulmonary rehabilitation classes were operated by a minimum of two staff in case any patients felt unwell. Relatives and carers were encouraged to attend home oxygen assessments to participate in risk assessment discussions and patient education.

- BOC Clinical Services conducted oxygen risk assessments for all patients in the home oxygen assessment and review services that they provide. The initial assessment appointment lasted for one and a half hours and included aspects such as falls, manual handling and other risks unique to oxygen therapy. We saw topics covered such as how to correctly use the oxygen, safe cylinder storage and avoiding hazards such as heat and light sources, electrical equipment, smoking and the safe use of flammable liquids and petroleum products (hairspray and petroleum jelly).
- This information was augmented by a comprehensive series of leaflets, which were distributed to patients in specially provided folders. These contained clearly written advice on oxygen safety and a variety of subjects including using oxygen on holiday.
- Patient risk was assessed using an oximeter (a small device clipped to an ear lobe that measures how much oxygen is carried in the blood) and blood gas analysis (a small sample of blood is taken to measure levels of oxygen and carbon dioxide in the blood). The service provided blood gas testing machines to clinics and oximeters for clinics and rehabilitation classes.
- We saw staff performing these tests and we also saw staff using blood pressure measurements to help assess patients during rehabilitation classes. These results were recorded on the digital patients notes and were used along with baseline health measurements as part of assessments made to show the improvement made after completion of the programme.
- Staff said they had been trained in the use of the blood gas analysis and oximetry devices and felt confident that they could interpret the results correctly. Staff we spoke with understood when and how to re-refer a patient to their GP if the had any test results or other concerns.
- We saw that leisure centre facilities used by the service included the provision of automated external defibrillators which staff stated were checked daily or, in one case, weekly. We did not have access to records to confirm this. One inspection team were shown a defibrillator purchased by BOC following risk assessment of nearby facilities. This indicated that the service actively implemented control measures to help mitigate identified risks.
- Each rehabilitation class had a basic life support kit provided for emergency use. This was checked before each session and we saw records confirming this. We also noted first aid kits on site and these were in date.
- At the start of the session, staff checked everyone had signed in. Staff then reminded everyone were the fire exits and toilets were and that if they went out, they needed to let a BOC staff member know where they were.
- We also saw patients being asked if they had their inhaler or spray (for angina) and if they have made any lifestyle changes. This was recorded in the session register.
- If a patient felt unwell or their condition deteriorated during an exercise session, an acute clinical assessment was undertaken, and the person referred to other services as needed, such as their GP, local hospital or an ambulance was called. All staff carried mobile phones and were trained in basic life support, which was updated annually.
- Should a clinic or rehabilitation session be cancelled for an unplanned absence, one of the regional clinical managers checked the appointment list against the digital patient record for each patient. They then added instructions to the digital record which meant patients were prioritised for alternate appointments based on their clinical risk. Once this was done, patient advisors from BOC homecare call centre contacted patients to re-book their appointments.

Staffing

- Overall, we found the service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- BOC Clinical Services employed staff who were nurses and physiotherapists with additional qualifications or experience in respiratory care and rehabilitation. Staff with exercise or sports physiology qualifications were used as technical instructors for the rehabilitation classes.

Good

Community health services for adults

- Senior managers said the skill mix used to deliver care was determined by the NHS commissioners as part of the contract.
- Home oxygen assessment clinics were operated by one or two registered nurses or physiotherapists and we learned that initial home visits were undertaken in pairs.
- Rehabilitation classes were also operated by a minimum of two staff, one of whom was a registered nurse or physiotherapist. If one member of staff was absent from a rehabilitation session, the exercise class was cancelled to ensure safety. The education session and parts of the assessment could continue.
- The service did not use any bank or agency staff. If a staff member was not available each region had contingency arrangements to move colleagues from other sites or, if necessary a regional manager with clinical skills covered the session. We were also given examples of when more permanent arrangements were put on place to cover extended absences such as through long term illness or parental leave.

Quality of records

- Staff kept detailed records of patients' care and treatment, which were regularly audited by the service to help ensure they were complete and correct. Records were clear, up-to-date and easily available to all staff providing care.
- The service was managed from a single headquarters location and all documentation and records were held electronically. Regionally-based staff and managers used portable computers linked to mobile data connections to access the information and records they required. Patient and service records, policies and procedures are accessed by staff using a combination of commercially available and bespoke computer software.
- Each member of staff had their own smartphone and laptop which allowed secure access to the data systems. Staff demonstrated the ease with which the systems worked and confirmed they could rapidly obtain the information and guidance they needed. We saw that clinical and organisational policies were accessible via the intranet.
- Managers stated they were not able to access NHS hospital records but relied on GP letters and referral summaries. The service used the same electronic system as many GPs, which meant that information could be shared with the consent of the patient. Likewise, the patient's GP or practice nurse could access the BOC notes and review outcomes of the programmes
- We saw venue folders that staff said had been recently introduced. Each one contained venue assessment and equipment check forms as well as copies of basic life support and anaphylaxis guidelines. Managers explained that this information was also available on staff laptop computers, but the folders had been adopted to make access easier.

Medicines

- The service did not provide any medicines other than oxygen, which was used as part of the clinical assessment and also kept ready for any emergency situation. The home supply of oxygen varied depending on local NHS contract. At one clinic, for example, we saw patients attending assessment appointments but using portable oxygen equipment provided by another organisation.
- Prescriptions are not required for the supply of oxygen in the community. Since 2006, the Department of Health has permitted the use of a 'home oxygen order form' (HOOF). This must be used in conjunction with a 'home oxygen consent form' (HOCF) along with evidence of a competed safety assessment called an 'initial home oxygen risk mitigation form' (IHORM).
- We saw correctly completed examples of these forms in the digital patient notes and these were routinely audited by regional managers and the results reported to the clinical governance forum.
- All clinical staff were competency assessed on the use of these systems during their induction period.
- Staff explained they carried one or two spare oxygen cylinders in their cars as a reserve. We saw the BOC policy concerning safe storage and transport of oxygen and staff demonstrated a clear understanding of the driver responsibilities. We viewed staff competency

logs that specifically included a section about the safe transport of cylinders in cars. These logs were completed for each employee during induction and 'signed off' by the regional manager.

- We saw staff checking that patients had brought their own medication with them ready for their pulmonary rehabilitation classes. These were sprays and inhalers designed to help ease angina and breathing difficulties and had been prescribed by their GPs for self-administration.

Incident reporting, learning and improvement

- We found an open culture where safety concerns raised by staff and people who used the service were highly valued as opportunities for learning and improvement. Staff and managers alike were open and transparent, and fully committed to reporting incidents and near misses.
- We saw evidence of a good culture of reporting. Staff used an online system to report incidents. All staff we spoke with understood the requirement to report a near miss and could explain how to report an incident using the services systems and processes.
- As part of their CQC registration, healthcare providers must report, investigate and respond to serious incidents. Examples of serious incidents include unexpected or avoidable death, injury resulting in serious harm and incidents that threaten an organisation's ability to continue to deliver an acceptable quality of healthcare services.
- BOC reported one serious incident in the last year. This came under the category of a business continuity event and related to the failure of the 'virtual desktop' in October 2018. This prevented mobile staff having access to real-time or live information on their laptop computers. Administrative staff could still access the software, so to mitigate the problem, mobile clinical staff used paper notes which were locked away and then sent to the call centre to be scanned into the system. Managers told us that the incident helped show that their business contingency plans were effective.
- There were two incidents reported, both classified with a lower grading. One was from a clinic venue where the walking distance from the waiting area to the assessment room was unsuitable and the other related to a nurse making a home visit to find neighbours had called the ambulance to attend the patient's husband. Comments entered on the log demonstrated that staff had taken appropriate immediate action; the service had analysed the incident to draw out lessons and any changes required to mitigate further risk. Although the number reported was minimal, staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- We saw that managers applied duty of candour as part of their investigations in line with their policy. The policy was up to date and the service provided e-learning for all staff on duty of candour as part of their annual mandatory training. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff we spoke to were aware of the obligation.
- Any incidents or complaints that triggered duty of candour were also reported monthly to NHS commissioners as a condition of the contract. We saw examples of quality reports confirming this a 'national quality requirement'. The data showed no reports in the last year.
- Key staff were informed of incidents in real time. The reporting system automatically emailed reports to the NHS commissioner as well as BOC managers and the clinical governance lead, who watched for trends or patterns and reported summaries monthly as part of governance meetings.
- All staff confirmed that incidents from all regions were discussed at the team meetings and are part of the standard agenda. We saw meeting papers that supported this. Staff also received individual feedback if needed.
- The service learnt from incidents. For example, a manager told us about an incident of a patient who fainted because they had not told rehabilitation staff that they had started a ketosis diet. Learning from this incident resulted in the lifestyle checks now

undertaken at the start of each session. Staff also spoke about ambient temperatures issues from last summer when some patients could not exercise due to excessive heat. Learning from this, the service began temperature logs which were reviewed and used to predict when mitigation was needed. In some cases, during the heatwave sessions were adjusted according to individual patient health and on occasion only teaching sessions to prevent risk to patients from heat exhaustion.

Are community health services for adults effective?

(for example, treatment is effective)

Good

Our rating for effective was **good.**

Evidence based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- We saw that British Thoracic Society (BTS) guidelines were used to support the care and treatment delivered. The guidelines produced by the BTS are accredited by the National Institute for Health and Care Excellence (NICE). Care for those with chronic lung disease complied with NICE Quality Standard 10 (Chronic obstructive pulmonary disease in adults).
- Managers said that rehabilitation courses had been registered for the pulmonary rehabilitation services accreditation scheme (PRSAS), which was launched last year by the Royal College of Physicians in collaboration with the National Asthma and COPD Audit Programme (NACAP). This scheme was aimed at improving the quality of pulmonary rehabilitation services throughout the UK and accreditation will provide BOC with an extra level of assurance.
- We saw examples of new patient information documents prepared to meet the requirements of the scheme and we were told it had already begun in a team we did not inspect.
- BOC homecare had also taken part in the last National Asthma and COPD Audit Programme (NACAP), which is undertaken every 18 months and we saw examples of the leaflets and consent forms distributed to patients. The results of this audit were not yet published.
- We saw the service conducted regular audits on topics such as hand hygiene, patient documentation, home oxygen usage and patient self-administered medication. Managers stated that some audits were conducted for local risk assurance and some were required by NHS commissioners as part of existing contracts.
- Our inspectors saw a good example of an audit undertaken by BOC Clinical Services in one region. This was about the management of home ventilation, which revealed a gap in the local service economy and resulted in BOC working with the local CCG and NHS trust to support patients better. This indicated that BOC actively sought ways to help achieve good outcomes for patients in the communities they served.
- All policies and procedures were available to staff in electronic form. We viewed a selection of policy documents with staff and clinical managers and spoke with the manager responsible for editing and review as well as the divisional lead for governance. All documents were 'in date', had been produced in accordance with BOC corporate guidelines and coded to assist with version control and distribution.
- The service benefitted from 'on demand' graphic design and printing facilities located at the corporate headquarters. Editorial reviews were part of the printing sign-off process, which helped to ensure information was always current. In addition, as the documents were printed on demand, there was less chance of outdated stock being held in store.
- The service used standardised measurements such as a breathlessness scale for home oxygen patients (called the Borg scale) and rate of perceived exertion (RPE) for rehabilitation patients. Other standard tests employed included a 6-Minute walk tests, COPD assessment test (CAT) as well as GAD7 and PHQ9 anxiety and depression questionnaires.

- At the rehabilitation classes, we saw wall charts showing Borg scales and posters explaining each exercise. These were displayed on the wall next to each exercise 'station' and we saw patients referring to them.

Nutrition and hydration

- The service did not provide care or meals in peoples' homes. Drinking water was freely available to all patients at the venues we visited, and we saw staff offering tea or coffee to patients and their relatives during assessment appointments, which lasted for extended periods of time.
- We also observed water being offered to patients during the pulmonary rehabilitation and education sessions.
- Some of the exercise venues at larger leisure centres had water fountains in the exercise areas as well as café facilities, and we saw patients using these after classes.
- The service provided advice on nutrition and we saw examples of BOC and British Lung Foundation leaflets on sessions. These were also given to patients at assessment clinics and staff told us that patients were referred to their GPs for further advice and support if there were concerns about weight management or other aspects of nutrition.

Pain relief

- Staff assessed and monitored patients during exercise sessions to see if they were in pain. We saw the use of standardised pain scales such as numeric ratings and staff said they had also used pictogram assessment scales and British sign language in the past.
- We were told that musculoskeletal pain was common during the exercise sessions and senior physiotherapists were authorised to adapt exercises for patients with higher than desired levels of pain or breathlessness.
- Patients with spinal injury issues or pre-existing high blood pressure had different exercise plans, which were set during the initial assessment with a senior physiotherapist.
- Education sessions included advice to help patients recognise muscle soreness and exclude symptoms representing causes of concern.

Patient outcomes

- We found a clear approach to monitoring, auditing and benchmarking the quality of services and outcomes. The service routinely monitored the effectiveness of rehabilitation sessions through patient surveys and commissioner feedback and used the findings to improve them.
- Initial assessment data was collected at the point of acceptance onto the rehabilitation programme was then reviewed with the results of repeated tests at the end of the programme to help determine progress. This information was shared with the referring GPs using the digital records system. We saw key performance reports which were measured monthly and showed that 100% of patients had been assessed. This met the target required by NHS commissioners.
- During the inspection, patients and relatives commented favourably to us about the rehabilitation classes. This feedback was similar to satisfaction survey results we saw from other areas of the country: "I achieved my goals and really enjoyed the program", "I feel better in myself and now do a lot of the exercises at home" and "Since I started the course I've used my inhaler nowhere near as much".
- We saw that local results were compared with those of similar regional services and national data. This was done either through reporting to commissioners or by participation in the national clinical national audits.
- The service was also actively involved in quality improvement initiatives, such as national clinical audits and an accreditation scheme. We saw that managers at all levels of the service were involved in monitoring and benchmarking, and we saw examples where this information was used to improve outcomes and services. Outcomes were also routinely reported to NHS commissioners. We saw key performance data reports showing that the service met a target of a minimum 5% of active cases undergoing clinical audit. Results were reported to commissioners annually.

Competent staff

Good

Community health services for adults

- The service made sure staff were competent for their roles. Managers appraised staff's work performance in line with company policy and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff had their learning needs identified based on a behavioural competency framework. The competency module was a combination of business competencies with specific healthcare competencies that mirrored behavioural competencies used in the NHS.
- Managers stated that the model was a developmental tool for staff at all levels and offered a guide to best practice in terms of how staff should do their jobs. There were 17 competencies grouped into five categories. Each role typically had between 5 to 8 competencies and each one had a title, definition and four levels of proficiency.
- We saw a new staff member undergoing induction and saw that their training notes were based on the competency framework. The person said they felt well-supported, the training met their needs and they had enough protected time to complete their learning objectives.
- Managers stated the staff were not permitted to perform any task until their competency in that skill or knowledge was assessed by a senior clinical manager and 'signed off'.
- Staff at all levels were encouraged and given opportunities to develop. In addition to external courses, staff and managers could access a variety of BOC corporate training programmes in leadership development, project management, product management and quality assurance.
- Managers in the service benefitted from a mentorship scheme that was an integral part of BOC corporate policy. Managers were mentored by senior colleagues (two levels above) for a period of 18 months and from a different area of the business. Managers on the mentorship programme spoke about the value of working with a leader from other disciplines such as engineering, pharmaceuticals or marketing.
- BOC Clinical Services had good arrangements for supporting and managing staff to help them deliver effective care and treatment. We saw staff had one-to-one meetings, mid-year reviews and annual appraisals, clinical supervision and revalidation support for registered practitioners. Every member of staff we asked had an appraisal in the last year and reported regular meetings with their line manager. Appraisal rates were monitored and reported at governance meetings. We saw meeting minutes confirming this.
- Opportunities for continuous professional development were encouraged through sponsored participation in clinical events and conferences as well as regular interactions with fellow healthcare professionals working for BOC in Ireland and acute respiratory services associated with the BOC in the UK.
- Staff gave us other examples of work-based learning and development such as observing lung reduction surgery and supported attendance at a tracheostomy course.

Multidisciplinary working and coordinated care pathways

- We saw good examples of coordinated care with clear and accurate information exchange between relevant health care professionals. The service had established strong links with NHS community medical services including GPs, occupational therapists and social workers.
- Staff gave examples of the links they had with other healthcare workers. For instance, an assessment nurse told us about regular clinical supervision sessions she had with a consultant where they could discuss complex cases.
- Within the service, we saw close working relationships between physiotherapists, nurses and technical instructors as well as representatives from the home oxygen delivery service and wider corporate services such as finance, marketing and human resources (HR) departments
- Managers explained that regions encouraged and accepted placements from student physiotherapists, student nurses and GPs. We were also shown a recent example of the service working with a local public health expert. In this case, a 6-month joint audit of a rehabilitation programme was undertaken that resulted in a medical society award.

- At one clinic, we observed a patient who had been provided with their own oxygen equipment by another company. While they said they were given clear instructions on how to use the equipment, they were still unsure about when they should change the oxygen tubing. The clinical lead was able to advise them on recommended courses of action and also explained how she would send this feedback to the other provider. This was a simple but effective illustration of positive interagency working to provide coordinated care to the patient.
- Our observations were supported by feedback from commissioning groups, who cited positive examples such as "they have worked positively and constructively with the CCG and supported two in-depth quality reviews and are currently they are working with us on a public health equity audit to ensure that the service they offer is equitable" and "we are very satisfied with the professional way the team conduct themselves and the outcomes achieved from the services".

Health promotion

- The service worked hard to involve patients in regularly monitoring their own health; empowering them to manage their condition, care and wellbeing and to maximise their independence.
- In addition to advice leaflets on display at clinics and rehabilitation sessions, we saw education sessions being conducted, usually for groups of ten patients at a time and led by a specialist nurse. The sessions included discussion about symptom management, exercise and diet. The education sessions given to patients were personalised. For example, smoking cessation was only discussed with patients who smoked rather than all groups.
- These sessions were delivered effectively and tactfully. We saw training aids such as marker boards and flipcharts used to draw diagrams and explain key points. We saw that staff checked people could hear and see what was being written. There were specific documents and leaflets available for all patients according to their disease.
- These included how to manage deterioration in their condition and where to obtain assistance in the most appropriate way. For instance, in one service our inspectors saw that local agreements with NHS hospital trusts included a 'pink card' rapid admission processes for patients with lung disorders.
- All patients had a tailored self-management plan for completion to better understand their symptoms and recognise deterioration. This included a traffic light system and action points. Patients we spoke with found this especially useful as it gave them more control in managing their condition.
- Staff showed us a standardised questionnaire used before and after the course to help assess patient progress. They explained this was a useful way of identifying patients susceptible to anxiety and depression related to their chronic lung disease. There were agreements with the NHS Improving Access to Psychological Therapies (IAPT) who did specific anxiety and depression talks and according to staff "had been really successful".
- NHS commissioners had included referrals to health promotion for identified patients as part of the rehabilitation contracts. The service reported these key performance indicators monthly to commissioners and we saw data that showed 100% of concerned smokers had been referred to smoking cessation classes and 100% of patients with a body mass index (BMI) of 45 or over had been referred to weight management services.
- The teams made patients aware of what support groups were available locally, such as 'Breathe Easy' groups, which were an initiative of the British Lung Foundation (BLF). Foundation resources included help about finances, how to get help if they have a 'cold house' and referring on to local authorities or other agencies such as Age UK.
- Some staff said they attended local breathe easy groups and one nurse had asked to learn 'tai chi', so they could teach it to the patient group. Another initiative was called 'singing for breathing' and had been recently started and was regarded as successful. These health promotion initiatives indicated that staff were positively involved in the ongoing development and improvement of the service.
- The service offered technology options such as a specialised smartphone application designed to help

educate and empower patients suffering at home with chronic lung disease. The software, once installed onto a smartphone, helped patients learn how to take their inhalers correctly, provided a prescription assessment function and a self-management plan that was customised to the individual patient by the clinical team. The application also contained video material and advice that supported the 6-week rehabilitation programme operated by BOC.

- BOC staff had identified that a proportion of patients required help completing written paperwork during the pulmonary rehabilitation courses. This raised concerns about "health literacy" levels more generally. On researching the topic, managers noted that low health literacy had been linked to poor clinical outcomes. On this basis, an audit was conducted in 2018, across all regional teams, to discover the extent of the problem. The audit indicated that several patients may not be able to effectively self-manage due to health illiteracy, memory, cognition, eyesight, hearing and language barriers. As a result of this audit, the service had started improving and simplifying all its written materials supporting health promotion. This included clarity of layout and the use of photographs and diagrams.
- The research undertaken has been published outside the service and has helped to show that further work is needed to be done regarding patient education across all health services. This is a good example of how the service has contributed to improving the population's health.

Consent, mental capacity act and deprivation of liberty safeguards

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service's policy when a patient could not give consent. Staff could describe their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- We reviewed a sample of patients guides and advice leaflets from sessions we observed as well as examples from other regions supplied to us by managers. We found these contained clear explanations about the services offered, what to expect, records and data protection along with consent. These details helped patients to make informed decisions about their treatment.
- We saw that verbal consent was sought from patients prior to carrying out the physical assessment of blood pressure, pulse and oxygen levels by staff.
- Written patient consent was sought to allow their data to be used for audit purposes.
- During our inspection we saw that verbal consent from patients was also obtained before the inspection team started clinic or rehabilitation session observations.

Are community health services for adults caring?

Outstanding ☆

Our rating of caring was **outstanding.**

Compassionate care

- Without exception, we saw staff taking the time to interact with patients and their relatives or carers in a respectful and considerate way. During the pulmonary rehabilitation classes, we saw that staff showed an encouraging, sensitive and supportive attitude to people in their exercise sessions. Home oxygen assessment appointments were conducted in clinic environments that ensured privacy and dignity.
- Patients we interviewed told us that they were given excellent care, and that all staff were always kind and compassionate. At sessions we observed, staff introduced themselves, the visiting manager and the inspection team to the group.
- Depending on the contract requirement, patient satisfaction surveys were conducted and reported monthly to the commissioning body. The service was required to poll 95% of patients and of these, the target was 85% of patients rating the overall service as good or excellent. This was reported monthly and according to data we saw, this was consistently achieved with scores ranging from 98% to 100%.

- During our inspection, the rehabilitation groups we observed were mixed gender. However, managers said that single sex groups had been arranged on request. The service had an in-date chaperone policy which was understood by staff.
- Managers explained that the digital referral form included a prompt to remind GPs or other referrers of the need for a chaperone. It was recognised that intimate examinations or comprehensive physical assessments were not part of the treatment pathway for this service. We saw that during assessment appointments, tests were only conducted using ear probe oximeters or blood samples for blood gas analysis.
- At the time of our visits, all attending assessment appointments were accompanied by a spouse or relative. Staff said this was encouraged by the service, although they would also ask patients during the start of the consultation whether they required a chaperone. This was specially the case is the patient had been identified during the referral process as having hearing, visual or speech difficulties; was considered a vulnerable adult such as with a learning disability or cognitive impairment or does not use English as their first language.
- Where the need for a chaperone was identified in advance, staff explained that another health care professional would attend. For late notice requests staff would ask a member of the GP practice to assist.
- We noted patients were called by their first name. We were told permission was sought at the start of the course and patients confirmed they were happy with this.

Emotional support

- Staff recognised and supported the broader emotional wellbeing of people with long term pulmonary conditions.
- Staff gave us examples of the service making changes to meet cultural and religious needs of specific groups.
- All patients were assessed for anxiety and depression, as one of the key requirements of the NHS contracts. Compliance was reported to commissioners monthly. We observed staff working with patients to complete the chronic obstructive airway disease assessment tool (CAT), general anxiety assessment tool (GAD7) and patient health questionnaire No. 9 depression assessment (PHD9).

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment. Staff communicated clearly with patients, relatives and carers to ensure they understood the care they would receive. This was supported by a comprehensive range of advice leaflets and literature about treatment pathways.
- Patients attending pulmonary rehabilitation session had a folder given to them at the start of the course. Each folder contained colour-printed booklets showing class and home exercises (with space for progress notes), as well as advice leaflets on the service, equipment use and safety, key contact details, confidentiality and how to raise any concerns.
- Patients were asked to bring the folder to each session where the exercise sheets were also reviewed and updated. The folders had space for additional papers distributed during the patient education presentation that was conducted as part of the rehabilitation session.
- Patients told us they were actively involved in all decisions made regarding their care and we saw examples of service status reports where this aspect was monitored by the NHS commissioner as a key performance. We heard how they felt listened to and valued.
- Rehabilitation class patients were encouraged to ‘bring a buddy’ to help provide support and encouragement. Staff demonstrated compassion and insight into how patient conditions may negatively impact on their quality of life and made the appropriate adjustments wherever possible.
- The service encouraged relatives and carers to attend clinics and classes and, we saw arrangements to refer people for carer’s assessments or to further information (such as the lung foundation) and support groups such as ‘Breathe easy’.

Good

Community health services for adults

- The reasons for any tests carried out were explained to each patient and results given immediately.
- We observed interactions such as a nurse spending time explaining to a patient about recognising when to call 999, or 111 or make a GP appointment, positive rapport with a patient during 1:1 weight exercise and advising another about the management of swollen ankles using calf pumps and elevation.
- During group sessions we saw patients asking questions and supporting each other with advice and tips.

Are community health services for adults responsive to people's needs?

(for example, to feedback?)

Good

Our rating of responsive was good.

Planning and delivering services which meet people's needs

- We found an ambitious service that constantly looked for opportunities to work with the commissioners and other health and social care providers to meet the needs of people with long-term heart and lung conditions. It was actively implementing technology to help improve the way services were delivered and we saw that rehabilitation classes and supporting educational materials had been reconfigured in preparation for accreditation by a national body.
- Rehabilitation courses were operated continuously and repeated during the week. Patients could choose between time and venue to suit their other commitments and the service offered an '0800' call-centre number that operated for extended hours, which meant patients could obtain advice and information conveniently and quickly.
- Staff allowed flexibility when booking future appointments and gave us examples of patients being visited at home instead of attending rehabilitation classes in certain circumstances.
- Sessions were planned when accessible. Staff told us about one community location where rehabilitation classes were scheduled to avoid a conflict for patients between attending the session or afternoon prayers at the local mosque.
- In one region, we learned about 'discovery interviews' the service was undertaking with cardiac rehabilitation patients focusing on their relationships with their partners following cardiac events. Aspects identified during this process included anxieties around sexual intimacy and financial concerns. As a result, the education programme had now been adapted to include sessions on these topics and provision of more literature about local services and benefits advice. The format was also changed to incorporate patient, relative and carer led question and answer session.
- Feedback from patients and staff was sought and acted upon. The service monitored the suitability of the venues it used and improved the service where it could. For example, one program we visited was changed form a church hall from a sports centre as it was more accessible for patients and had better parking facilities. Patients told us they much preferred this venue.
- Digital records helped staff to monitor completion and non-attendance. If a patient was off for any reason, they could re-join the next cycle of the course. While a 'rolling programme' was more challenging for the staff, this meant that patients could access the programme much sooner after referral or a break.
- Feedback from commissioners showed the service met key performance indicators such as referral to treatment times. According to data shown to us, all referrals (100%) made during the reporting period had been triaged within the target of two working days.
- The service had a key performance target of sending discharge letters to GPs within 5 working days of the date of discharge. The discharge letter included an individualised care plan for the patient including diagnosis; tests and procedures carried out, action plan and expected outcomes. Performance was monitored monthly and we saw figures showing 100% compliance.

Good

Community health services for adults

Meeting the needs of people in vulnerable circumstances

- Our teams observed several examples of the way the service worked to identify and meet the information and communication needs of people in vulnerable circumstances such as those with a sensory loss, as well as meeting the diverse needs of local people.
- Carers and relatives were welcomed to rehabilitation sessions, which meant that patients who were assessed as suitable but had learning needs had the support they needed to help them participate in the sessions.
- At one session we saw staff working with military families originating from Nepal and people with hearing difficulties. Staff confirmed that interpreters had been provided when required and gave us a recent example of the use of a sign language interpreter during a rehabilitation course.
- The digital records and printed material we saw complied with the NHS assessible information standard. The standard is a requirement of all organisations providing publicly-funded care, and aims to ensure a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients with a disability, impairment or sensory loss.
- BOC Clinical Services had access to an 'in house' printing design and production unit based at the headquarters in Guildford. This meant information could be printed 'on demand' in small quantities using special fonts, colours and languages to suit the individual needs of the people in vulnerable circumstances. This included the production of literature in Braille, which is a system of touch reading and writing using raised dots to represent the letters of the alphabet and numbers, as well as music notes and symbols.
- The clinics and exercise classes we visited were in buildings that were wheelchair accessible and suitable for use by people with limited mobility. We saw priority car parking spaces available for use and the venues had dropped curbs at entrances and automatic doors to help make entering the building easier. Corridors, lifts, clinic rooms and toilets were spacious with doors wide enough to fit wheelchairs.
- Reception areas had hearing loops installed to help improve the way hearing aids worked for people who used them.

Access to the right care at the right time

- Depending on the agreement with the NHS commissioners, patients could be referred into the service from multiple sources. Staff explained that the primary source was the patient's own GP, but referrals also came from GP practice nurses, the district nursing services or community care hospitals. In some areas, patients long standing lung conditions could self-refer.
- Managers explained that no matter the source of the referral, these were received and collated by a central administration team. Once the referral had been added to the digital records system, clinical managers then sorted the referrals into clinical priority before the administration team contacted the patient to offer an appointment.
- If, during the initial assessment the patient was deemed unsuitable, the referral went back to the originator explaining the concerns so that these could be addressed prior to re-referral and acceptance. This information was all held on the same type of system that GPs and other primary care providers used, which facilitated communications and helped ensure a timely process for the patient.
- We saw that people could access the service when they needed it. For example, rehabilitation classes ran twice a week in all locations and patients could choose which venues they wanted to attend. We saw an instance when a patient could only come to one session a week due to childcare commitments and staff modified her attendance arrangements to suit.
- There was no waiting list for this service. The rehabilitation course was a rolling programme that meant new patients could join the class sessions at any point.
- All patients were given a direct contact number to speak directly to the session team.
- Managers stated that, should a clinic or rehabilitation session be cancelled for any reason, patient advisors

from the BOC homecare call centre contacted patients to re-book their appointments. Staff told us there were "no problems" with fitting patients into alternate sessions.

- Sessions were operated in a way to help ensure the set topics and activities were covered efficiently. For example, we saw laminated checklists used by the technical trainers during rehabilitation classes.
- Breathlessness management techniques were integrated into the exercise regime. We saw individuals getting one to one advice about how to modify the exercises and breathing techniques if they were struggling.
- There was a main contact centre for patients to ring to changing appointment times. There was a free call number which was from 8 am to 5 pm Monday to Friday with an answerphone to record any out-of-hours messages. Contact centre staff also called the patient the day before an appointment to remind them.
- Non-attendance (DNA) rates varied. We were shown monthly performance reports which were required by the commissioning bodies. DNA rates were monitored and compared to the target of less than 10%. The results varied from service to service and from month to month.
- While assessment appointment rates were within target, we saw 'all appointment' figures ranging from 9 – 17%. Managers monitored these figures weekly and stated the variations were often caused by seasonal issues and illness. The service was using strategies such as text messaging and pre-appointment courtesy calls to help reduce DNA rates and managers stated that the rolling programme of classes and alternate sessions offered meant that patients could quickly resume rehabilitation.
- In all but one rehabilitation venue we visited, patients unable to attend a session for any reason were offered an extra date so that they were able to complete the course. The remaining venue was less flexible due to demand on places, but staff and patients confirmed that getting alternate dates "had never been a problem".
- Patients could be referred into the pulmonary rehabilitation service every year if clinically indicated. Managers explained that the effects of the programme were known to last a year if the patient continued to use the methods taught. We saw example of patients returning for a second or subsequent programme.
- Rehabilitation sessions could accommodate up to 16 patients depending on patient requirements. When sessions were booked staff checked how many oxygen users were on each course to reduce numbers attending the group as two or three oxygen users may need more nursing intervention.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- How well do people who use the service know how to make a complaint or raise concerns and how comfortable do they feel doing so in their own way? How are people encouraged to make a complaint, and how confident are they to speak up?
- Staff explained that any complaints received were dealt with informally 'on the spot' before going down the formal route. Patients were given leaflets on how to complain and there was also a feedback form they could fill in.
- We saw that compliments and complaints were part of the standing agenda in clinical governance meetings and the service had a 'dashboard' to show where they could implement changes because of complaints or compliments.
- The service had received one formal complaint in the last year which, after investigation was not upheld. We looked at the details of a complaint being processed, which demonstrated that managers had patient-centred focus. We saw good record keeping practice and prompt progression. Learning points had been identified and action points had already been formulated with options for resolution prepared, with the intention to check findings with the commissioner before response to the individual concerned.
- The complaints policy was comprehensive and current.

Good

Community health services for adults

Are community health services for adults well-led?

Good

Our rating of well-led was good.

Leadership

- We found a service that had compassionate, inclusive, and effective leadership at all levels. The management team showed high levels of experience, ability and capability needed to deliver excellent and sustainable care.
- This was an ambitious service that sought to benefit from technology and fully utilise the support provided by its parent corporation, which included human resource management, finance and accounting, pensions & payroll and an IT service desk.
- Given the dispersed variety of contracts won throughout England, we found a relatively small number of specialist staff providing a service that was safe and effective, well organised and well managed by highly-committed and charismatic leaders.
- There was a firmly embedded system of leadership development and mentorship that drew on senior lenders from workstreams outside healthcare, offering a broad level of support for aspiring clinical managers.
- Development opportunities for leaders included 'in house' access to certificated courses teaching project management methodologies designed to eliminate process defects and improve the quality of products or services. Students could progress through the various levels of training (assigned as colours) to achieve internationally-recognised qualification.
- According to key performance data; feedback from patients and the feedback from NHS commissioners, it was clear that this organisation offered users a quality service that met or exceeded the standards required. The service had successfully and consistently achieved this for a range of NHS commissioners spread across a widely dispersed geographical area.
- Staff told us they felt well-supported, valued and that that their opinions counted. Regional leaders knew what their teams were doing well and could name the challenges and risks their teams faced.
- Staff spoke in positive terms about the visibility of the senior management team. Staff gave examples of training, conference and team-building events that demonstrated the friendly and positive work culture that had been created and fostered by the leadership.
- This feedback was supported by the results of the annual confidential staff survey, which included questions designed to assess leadership, communications and overall job satisfaction. Response rates were higher than similar services in the NHS and of the 32 questions asked, all but two showed results better than the NHS with the two remaining questions equal to the NHS result.

Vision and strategy

- We found a systematic and integrated approach to monitoring, reviewing, and giving evidence of progress against the strategy and plans. Plans were consistently implemented and had a positive impact on the quality and sustainability of services.
- As part of a five-year corporate business plan, the service's strategy was to "put the patient at the heart of everything we do whilst working efficiently" and the vision was to "be recognised by the NHS as the safest, most reliable provider of home oxygen therapy whilst offering outstanding value for money. In our chosen clinical fields, we deliver outstanding patient care in the community to manage chronic diseases and avoid hospital admissions."
- These vision and strategy statements were readily available in published booklets for staff and incorporated into patient leaflets. We also saw examples displayed on the staff intranet as well as a corporate website designed for the public to view.
- We saw meeting papers and agendas that showed the strategy linked to performance indicators and managers explained these were reviewed during the homecare governance meetings and progress shared in the staff newsletter.
- Leaders worked hard to emphasise that safety and a positive patient experience was considered as

important as the business objective. For example, patient satisfaction was measured and used as one of the indicators for awarding individual performance bonuses.

- Staff at all levels spoke positively and passionately about the organisation. People we spoke with clearly understood what the vision, values and strategy for the division was and how their own work contributed to achieving this.
- The service also conducted an annual confidential staff satisfaction survey which included questions designed assess how well the corporate vision and strategy was communicated to employees. Senior managers benchmarked response rates and compared results with similar services in the NHS. In the last survey (2018), 69% of BOC Clinical Services staff responded, compared to 46% for the NHS. Of those responding, 75% said they understood the strategic goals of broader organisation and 83% knew their role in helping the company meet its goals and objectives.
- The results of the survey were cascaded to all staff and changes and improvements discussed at the annual clinical forum and monthly team meetings.
- BOC Homecare had launched several initiatives as part of a 'digital agenda' strand of the strategy. In Clinical Services, these included the use of digital systems to improve the accuracy of the home oxygen order forms; a "LiveChat" service designed to enhance patient communication and an application for smartphones designed to help patients to learn about their oxygen therapy.

Culture

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. In the last staff survey 91% of respondents agreed that they worked in teams with shared objectives, which compared significantly better than the NHS result of 73%.
- 94% of staff agreed that the organisation took positive action on staff health and wellbeing. We saw that an occupational health helpline was available 24 hours a day and Clinical Services staff were also represented at a corporate-wide employee consultative forum.
- As a specialist group working in a larger corporation, staff confirmed they felt supported and valued by clinical managers and business leads; confirming that training opportunities and conference attendance were supported along with the opportunity to shadow staff or be mentored if development needs were identified. In the last staff survey 88% of respondents said that had training in the last year (in addition to mandatory training) compared to 71% in the NHS.
- Staff gave us personal examples of how the service had helped them to develop, gain promotion and further qualifications. One person we spoke to, with five years' experience in the company, characterised the support and development they had received "amazing".
- Staff confirmed that they felt listened to by the organisation and received annual appraisal with mutually agreed objectives.
- Staff confirmed they attended a twice-yearly two-day BOC national meeting which allowed all teams to meet up be involved in group learning and team building.
- In addition, some staff volunteered examples of returning to work after illness and used these examples to emphasise how well managers and colleagues had supported them.
- The service actively promoted patient satisfaction through the annual staff bonus scheme. Senior managers explained that while they had performance objectives relating to the business, a deliberate decision had been made to focus on patient satisfaction as a performance objective for clinical staff.
- The organisation celebrated positive feedback we saw examples of patient comments in the monthly newsletter.
- The workforce race equality standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent

organisations to submit data to NHS England on an annual basis. We saw evidence that BOC Clinical Services complied fully with this requirement. During the inspection, we found that staff were aware of the standard and managers could identify ways in which the organisation monitored and improved equality for staff. Managers had also received training in recruitment processes and interviewing and equality and diversity was part of annual mandatory training and all staff we spoke with were positive about the way the company provided access to opportunities for development and education. The organisation also measured this in its confidential staff survey, when 94% of respondents agreed that the organisation acted fairly with regard to career progression/ promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age. This compared favourably to the NHS result of 83%.

Governance

- The service systematically improved quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish. We saw that frequent governance meetings occurred at senior level and staff reported that monthly team meetings also included governance agenda items. We saw meeting notes that confirmed this.
- We saw in-date documents that supported the board assurance framework, governance, corporate risk and requirements for fit and proper persons at senior executive level.
- Contract managers and regional clinical leaders reported to the Head of Homecare (BOC Clinical Services), who reported to the Head of Healthcare. The senior management team also included a Finance Controller, Head of Patient Service Centre and a Clinical Affairs Manager who was also the senior clinician and acted as the chair of the Clinical Governance Committee, Safeguarding Lead and Caldicott Guardian
- The senior management team had overall responsibility for ensuring the standard of the service, reviewed the minutes of the clinical governance committee and actions where required.
- The governance committee, called the 'Clinical Services – Clinical Governance Committee' met each month. This committee's purpose was to support continuous improvement of Clinical Services by creating and promoting a 'no blame' culture in which "excellence will flourish".
- We saw standard agenda items for this meeting: Quality, Safety, Safeguarding, Mental Capacity, Regulatory Activities, Audits, Alerts, Risk Assessments, Policy Updates, Reviews, Guidelines, Workforce, Training and Patient Experience.
- A clinical leadership committee met weekly to also support continuous improvement and deal with day to day matters. Standard agendas for this forum included the same items as the governance committee (which the chair reported to) plus individual service reviews, workforce review, appraisal and revalidation updates as well as study or training requests.
- The BOC Homecare 'Cluster Governance Committee' met on alternate months to review and discuss business performance indicators, financial budgets, contracting specifics, safety, serious incidents, review of risk register and workforce matters.
- Within each region, clinical service team meetings were held monthly to discuss and communicate clinical and business aspects from the above meetings at an individual service level.

Management of risk, issues and performance

- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected. There was a clear commitment to best practice performance and risk management systems and processes.
- The organisation reviewed how they function and ensured that staff had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.
- We saw a high-level risk register for the service which had been recently reviewed and showed actions completed. This indicated the service actively identified risks, reviewed them, and implemented control assurance and mitigation measures.

- The document contained a detailed description. Business and clinical risks were included and each clinical risk included a reference to the national guidance and standards to ensure compliance.
- Risks were rated using a matrix and risk order of the medications were adopted. We saw corporate guidance on how to rate and charge risks.
- In the last staff survey, 97% of respondents agreed that the service encouraged staff to report errors, near misses or incidents and when these were reported, 89% agreed that the organisation acted to ensure that they did not happen again. These figures were significantly higher than the NHS results (88% and 70%).
- The service took the safety of its employees seriously and had arrangement to minimise risks of working in a community setting. We saw a lone worker policy, which was current. When staff finished their shift, they would phone or text their manager to let them know. Rotas are accessible by the managers and there are two managers present all the time.
- All staff were issued with smart phones that also enabled internet access. If there was a problem or if staff felt unsafe there was an emergency button on the laptop. There was also agreed phrases to be used with telephone service centre colleagues who had location and contact details for all sessions and clinics. Managers explained this had been tested and worked well.
- Performance management was well embedded into the service and linked to both business and clinical objectives.

Information management

- The service collected, analysed, managed and used information well to support all its activities, using standardised and secure electronic systems with security safeguards.
- We saw certificates confirming that the service had achieved ISO accreditation (27001) for management of information security.
- At each of the venues we visited, we saw that all staff and managers had been issued with portable computers linked to mobile data connections. This meant they all had access to the software programs and information they required.
- All patient records were electronic, and we saw good governance with staff locking computers when leaving the desk. We saw multiple 'sign-in's being performed on portable computers and the use of secure NHS email addresses for any information which included patient details. In addition, the digital patient records were password protected.
- The safeguarding lead was also the nominated Caldicott guardian for BOC. A Caldicott guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

Public engagement

- The service engaged well with patients, staff, the public and commissioners to plan and manage appropriate services and collaborated with partner organisations effectively.
- Patients told us they were aware of the service because of information they had seen at their GP's or that they were attending as a returning patient.
- Managers gave us examples of how the service sought to involve patients, carers, friends and family in service development and quality improvement. This was done through continuous feedback and targeted projects. We saw results of patient satisfactionsurveys and 'friends & family' questionnaires which generated suggestions for improvement, which were discussed and monthly meetings. We were told about recent feedback from a location where patients are struggling to travel to the venue and would prefer one closer to home. As a result, the service reviewed staff rosters an is introducing a third venue option.
- Managers explained that it proved difficult to obtain feedback from patients who drop off programmes or decline to opt-in. As a result, the service employed a 'Clinical Engagement Co-Ordinator' specifically to contact patients to seek their feedback and try and

remove any anxieties or barriers preventing them from participating. This had helped to improve 'do not attend' figures which were measured and reported to commissioners monthly.

- We saw the results of a survey conducted by BOC (April 2019) where 22 commissioning bodies were sampled. All respondents (100%) said they found it easy to contact a member of the BOC team and all respondents agreed that BOC was responsive to their and their patients'. Comments included: "I have always said that I wish my other providers were as helpful cooperative and willing as the BOC team" and "The staff are professional and knowledgeable about the service".
- These comments were similar to feedback we had obtained prior to our inspection.
- We saw a report in the April 2019 homecare newsletter about the successful appointment of two senior clinicians joining the national committee of the primary care respiratory society (PCRS). The PCRS is a UK wide professional society and charity which supports Healthcare professionals of all disciplines to deliver high-value patient-centred respiratory care.
- Staff described how the service had held community events during that last 12 months and we saw examples of posters and fliers advertising 'come for a chat' and 'healthy heart' community events, which were drop-in sessions aimed at raising public awareness of heart disease in the local community, educating and empowered people to make a positive choices and to take responsibility for their own health and wellbeing.These events were interactive workshops, competitions and healthy cooking demonstrations as well as basic life support instruction. We also saw leaflets advertising community events aimed at helping people to stop smoking.
- Managers described how the service encouraged work experience and clinical placements for student nurses and physiotherapists.

Staff engagement

- The management team told us that any innovative ideas put forward by staff were discussed at monthly team meetings. All the staff we spoke with felt informed and involved with the day-to-day running of the service and its strategic direction.
- The service also measured staff satisfaction with manager feedback. On the last survey, 80% agreed that their manager gave them clear feedback on their work. This was significantly better than benchmarked NHS results (61%).
- We saw examples of the homecare newsletter which included updates on strategy, industry news items, patient feedback, news from the other parts the business and information governance news. There was a section called 'clinicians' corner' which advertised items of interest such as respiratory academy courses that staff were encouraged to take.
- The service had access to corporate staff recognition and incentive schemes, and we saw articles in the newsletter congratulating and recognising high performing staff.
- Managers gave us examples of team building activities and learning events. We saw items in the staff magazine reporting visits to other parts of the organisation to learn about pharmaceutical production.
- BOC operated a 'matched giving' charity sponsorship scheme. Staff were encouraged to apply if they were fundraising for charitable causes away from work. We heard from staff who had received donations from BOC and how appreciative they were for this kind of support.
- Managers told us that the service recruited experienced staff and consequently a high percentage of staff had extensive NHS experience in respiratory care. Around 25% were from intensive care backgrounds.

Innovation, improvement and sustainability

- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

Good

Community health services for adults

- We found a 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 way the provider supported and encouraged innovation was a strength. We saw good examples across the regions and our observations were consistent with positive feedback we received from commissioners and staff alike.
- For example, we noted an item in the quarterly staff newsletter reporting activities of BOC homecare colleagues in Northern Ireland. The Irish Service had expanded into sleep apnoea and ventilation, which was new to the English Service. This indicated the service was actively encouraging multidisciplinary communication and exchange of ideas to help improve services.
- The service was actively investigating and adopting technology solutions to improve care, such as a smartphone application designed to help educate and empower patients suffering at home with chronic pulmonary disease.

Outstanding practice and areas for improvement

Outstanding practice

- Staff at all levels of the service had excellent opportunities for education and career development, which were provided either 'in house' or externally. Staff and managers alike gave us examples of achieving promotion and being well supported throughout by mentoring, development and appraisals.
- The service engaged with others to improve the body of healthcare knowledge. We saw examples where the service had contributed to academic studies, such as working to identify and respond to low health literacy levels amongst its patient population.
- BOCs was actively investigating and adopting technological solutions to improve care, such as a smartphone application designed to help educate and empower patients suffering at home with chronic pulmonary disease.

Areas for improvement

Action the provider SHOULD take to improve

- The service should modify procedures to ensure staff records, on appointment, contain a full work history, reasons for leaving previous regulated activity or explanation of employment gaps as required by legislation.
- The service should review procedures to provide assurance that hand cleaning and testing equipment is cleaned after each patient contact.