Royal College of Physicians | PRSAS

PRSAS accreditation standards

2025 standards review

Revised standards
Public consultation September 2025

Pulmonary Rehabilitation Services Accreditation Scheme

About

This document contains the proposed new Pulmonary Rehabilitation Services Accreditation Scheme (PRSAS) accreditation standards. All accreditation programmes within the Royal College of Physicians are required to review their accreditation standards every 5 years to ensure that they remain relevant, up to date and ensure the highest standards in quality and care.

In 2024, PRSAS invited feedback on the current 2020 accreditation standards. Feedback was received from pulmonary rehabilitation (PR) services, assessors and key stakeholders. This was the first full review of the PRSAS accreditation standards since the launch of the programme in 2018, an opportunity to reflect and learn from accreditation assessments that have taken place in the past few years, and to consider the latest current knowledge and best practice for PR published in September 2023 within the British Thoracic Society (BTS) Clinical Statement on PR.

A working group was formed, comprising members of the PR community, including key stakeholders such as the BTS, Asthma + Lung UK, National Respiratory Audit Programme (NRAP), NHS England Respiratory Programme, Association of Respiratory Nurses (ARNS), Scottish Pulmonary Rehabilitation Action Group (SPRAG), and Health Service Executive Ireland. As well as representatives from assessors, services, and patients. The working group reviewed the 2020 standards and provided further feedback to help form this update. We now invite feedback on the proposed new PRSAS accreditation standards.

PRSAS proposes to retain the current structure, comprising seven domains and 37 standards:

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

The consultation will remain open until 9am on Monday 22 September. Please use this online form to provide feedback on the standards.

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

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

PRSAS accreditation standards

Domain	Standard	Guidance	Evidence requirements
1. Leadership, strategy and management	Standard 1.1: The clinical service has a service description.	This should be a comprehensive document, where the Pulmonary Rehabilitation (PR) service is described in detail. It should be a valuable tool that will enable complete understanding of how the entire PR service runs on a day-to-day basis within the location which it serves – including referral management, clinical care, the workforce, staff management, communication, reporting and performance. The document should include as a minimum: • vision for the service • ethos, values and objectives for the organisation • organisational chart for the service, with names and whole-time equivalents (WTEs) • the names and key roles and responsibilities of each member of the leadership team, both clinical and managerial • overall scope of the service provided (including who the service aims to provide treatment/care to and whether research or training is undertaken) • information about service delivery, such as frequency of assessment clinics, PR classes and times, their location(s), evidence-based models of delivery (eg centre based twice weekly directly supervised, digital), how to contact the service for help and advice, including out of hours • facilities available, including access for users with specific needs • description of process for equipment maintenance and replacement, including reporting procedure for damaged equipment • detailed patient pathways (including expected timescale), including initial assessment, start of PR, length of programme and discharge assessment, and how these are communicated to patients	A service description outlining the key service details.

		• information about relevant stakeholders and relationships to community-based opportunities after PR completion • information about patients' rights and responsibilities • description of the clinical care delivered and the rationale behind the chosen approach • description of procedures for DNA and inappropriate referrals • description of governance processes that the service adheres to, outlining the communication between the service, the organisation and commissioners • description of escalation procedures for the service • description of document management control and information governance, including the transportation of data off site • description of data collection and storage, including reporting against performance, both internally and externally for benchmarking • description of managerial and administrative support for the service • description of IT and audit support for the service • link(s) to the service webpage(s) • an appendix to all Standard Operating Procedures (SOPs) and organisation policies that are in current use. The primary offer of PR should be centre based, twice weekly directly supervised for a minimum of 6 weeks duration. Alternative evidence-based models of delivery should be offered to service users who decline or are unable to undergo supervised centre-based PR. Please note, only certain elements of alternative models of PR will be assessed by PRSAS, such as initial assessment and discharge assessment.	
	Standard 1.2 The service has a leadership and management team that is visible and	The roles and responsibilities of individual(s) in the leadership team should be clearly defined. The service should be delivered by experienced and specialist healthcare professionals – it is expected that the service will have physiotherapist	A section within the service description that outlines the names and key roles and responsibilities of each member

	responsive to service needs and communicates regularly with staff within the service and wider organisation/stakeholders	and/or nursing input in collaboration with a broader multidisciplinary team. The leadership team holds regular (at least quarterly) PR team meetings to discuss service management issues and sharing of information. The named PR lead(s) should: • be a registered healthcare professional with appropriate specialist competencies in this role and should oversee regular clinical work within the service • have overall responsibility and accountability for the service • have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services • attend any relevant meetings representing PR internally within the organisation, and regional network meetings, where applicable • have opportunities to engage in leadership training and/or support/ mentorship. Communication to staff and relevant stakeholders should include: • important changes to the delivery of the service • new statutory information impacting the service • updates on quality, safety and clinical governance • feedback mechanism for referrers, stakeholders and service users to assist in service development.	of the leadership team, both clinical and managerial. A minimum of two sets of minutes of regular PR team meetings from the last 12 months. Evidence of relevant qualifications/training certificates of the leadership team, or evidence of equivalent experience working in PR (eg curriculum vitae). Examples of communication to staff (eg notices/bulletins etc). Examples of communication to stakeholders outside of the service, where there have been changes to service delivery.
	Standard 1.3: The service develops and implements an annual operational plan.	Each year the service should complete an internal service evaluation of performance. The leadership team should ensure the internal service evaluation is wide reaching, holistic, and covers all aspects of service delivery.	Annual internal service evaluation document. Annual operational plan document.

		It should include as a minimum: • patient flow, performance and clinical data • measurable objectives, key performance indicators (KPIs) and metrics for the service • a training and workforce development plan • review of staff and service user survey results • assessment of venues, facilities and equipment • assessment of risks • safety/adverse events • quality improvement (QI) • organisational and/or national strategic priorities, including emerging evidence base. • relevant dialogue with commissioners. The service should develop and implement an annual operational plan that reflects the key themes and actions from the internal service evaluation. The named service lead(s) should be responsible for delivering improvement related to agreed actions. Both the internal service evaluation and annual operational plan should be developed with multidisciplinary input (eg the use of an away day may be helpful) and include: • reference to how service user's views have been considered in service planning • an understanding of the needs of the local population, including geographical and clinical profiling, disease burden, and local and national requirements • named leads with timeframes for agreed actions.	Minutes of service management/PR team meetings where the operational plan is discussed.

		The annual PR internal service evaluation and the subsequent operational plan should be disseminated and discussed within the PR team and within the organisation via relevant communications	
	Standard 1.4: The service leadership team carry out a PR staff survey and provide opportunities for informal feedback.	There are systems in place to ensure that staff can provide confidential feedback on the service. There should be an open culture where team members can suggest strategies for service improvement and have support to implement these ideas (eg time, resource, and/or space). Regular feedback is required, in addition to an annual PR specific staff survey which should include feedback on: • leadership • communication and support • opportunities for training, development and making improvements • working environment and safety • service delivery and staffing levels • how staff are recognised and rewarded • the ability and process to raise concerns • experience of IT systems to support clinical work • support during incidents and near misses. There should be analysis of the PR specific staff survey results, highlighting of key themes and agreed actions.	PR specific staff survey from the last 12 months, including survey template, data, and action plan outlining areas to improve and ways to continue to do well (where feedback is positive), including timescales and named leads. Examples of how staff are encouraged to provide informal ad hoc feedback, where appropriate. Minutes from PR team meeting(s) from the last 12 months that demonstrate clear staff involvement in the service.
	Standard 1.5: The service promotes the health and wellbeing of staff members.	The service should provide a supportive environment for staff. There should be a culture of promotion of staff wellbeing, and opportunities for staff to discuss and attend wellbeing related activity, either personally or as part of organisation level schemes.	Examples of how wellbeing is promoted. Meeting minutes of communicating wellbeing

		There should be a process in place for debriefing after a critical incident/event within the service.	initiatives to staff (or alternatives, eg newsletters). Evidence of shared learning after a critical incident/event within the service, where applicable.
	Standard 1.6 There are escalation procedures for staff members.	There should be an open culture where team members can discuss and feedback on incidents, complaints and behaviour. This must include: • the sharing of information and raising general concerns • challenging questionable and/or poor clinical practice • breaches of code of conduct and accountability; raising concerns of an ethical nature • disrespectful, discriminatory, abusive behaviour or harassment • provision of information and support for staff members raising concerns to clarify that there is no blame for adverse consequences • staff awareness of organisational policy on bullying and harassment.	A section within the service description that outlines incident reporting and escalation procedures. Raising concerns, whistleblowing, and harassment and bullying policy. Can be organisation policy(s). Organisation policy for incident reporting. Evidence of disseminating policies, policy updates and principles of escalation to staff. Anonymised incident report examples, where applicable. Evidence of shared learning after an incident within the service, where applicable.

	Standard 1.7: There is promotion of the service to referrers and referrer feedback is reviewed.	The service promotion to referrers must include: • the scope of the service provided (including inclusion and exclusion criteria, and who the service aims to provide treatment/care to) • the range of services offered and expected clinical outcomes • service organisation including frequency of classes, dates and times, and their location(s) • expected timescales for the patient pathway, including initial assessment, start of PR, length of programme and discharge assessment • barriers to attendance and alternative evidence-based models offered. There should be clear referral pathways, for both post exacerbation PR (PEPR) and elective PR. The service should be working with referrers to ensure patients are engaged with the referral process. Referrers should be made aware the primary offer of PR should be centre based, twice weekly directly supervised for a minimum of 6 weeks duration. Alternative evidence-based models of delivery should be offered to service users who decline or are unable to undergo supervised centre-based PR. Please note, only certain elements of alternative models of PR will be assessed by PRSAS, such as initial assessment and discharge assessment.	A section within the service description that outlines the promotion of the service. Examples of relevant material (eg leaflets, posters, websites, videos etc) promoting PR. Anonymised examples of referral forms. Examples of review of referral forms with relevant stakeholders (at relevant intervals, as determined by service need). Evidence that PR is available for people with a Medical Research Council (MRC) Dyspnoea scale of 2 to 5, as defined by the British Thoracic Society (BTS) quality standards for PR. Evidence of communication to referrers. Annual referrer feedback form in various forms with accompanying evidence of discussion of feedback and planned actions for continual improvement.

2. Systems to support service delivery	Standard 2.1: The service regularly assesses the equipment required to deliver the service.	As a minimum, the equipment available onsite must include: • aerobic equipment • suitable and appropriate range of weights and resistance equipment • oximeters, BP monitor • stopwatches • two bright cones, tape measure (10 metre for incremental shuttle walk test (ISWT) or 30 metre for 6-minute walking test (6MWT)) • chairs • telephone access • emergency equipment (instructions for use should follow organisation policy on resuscitation) • laptop/projector/flipcharts/white boards and supplementary written material for educational sessions. All clinical equipment should be: • assessed and replaced/maintained according to organisation policy • cleaned according to organisation's infection prevention and control (IPC) guidelines • recorded, and records kept up to date to show compliance.	A section within the service description outlining processes for safety checks, infection prevention and control (IPC), maintenance and replacement plan of equipment, and reporting procedures for damaged equipment. Completed equipment checklist, for each site. These should be completed prior to the commencement of PR classes. IPC policy. Can be organisation's policy.
	Standard 2.2: The service has a process for document management, review and control.	The process for the control of documents requires that: documents are kept up to date, secure and where necessary, confidential information that is obsolete is removed from use and archived. A system of document control management, to include: • dates and formats of protocols • version numbers • planned review dates and authorising individual(s) • who the distribution list is.	A section within the service description outlining the process for document management and control. Evidence that documents, including the service description, and service user information, follow document control process and are meeting this standard.

	Standard 2.3: The service uses IT systems which are designed to facilitate the collection, management, and monitoring of data to support service delivery.	The service should: • work with the organisation to identify IT systems that facilitate ease and accuracy of data collection, extraction, and monitoring relevant to PR • have access to relevant data to assist with evaluation of service performance. If purchasing or implementing new IT systems; the service must assess how they relate, communicate and interact with other IT systems within the service. The service must adhere to organisation information governance policy.	A section within the service description outlining the process for data collection, management and monitoring. Information governance policy (can be organisation policy). Evidence of review of IT system needs (eg in minutes of PR team meeting, or internal service evaluation document). Anonymised examples of IT system used.
3. Patient-centred treatment and/or care	**Standard 3.1: The service has an up-to-date website and/or public-facing document which provides key information to service users.**	The website and/or document must include the following as a minimum: • overall scope of the service provided (including who the service aims to provide treatment/care to and whether research or training is undertaken) • how to contact the service for help and advice, including out of hours • information about service delivery, such as frequency of classes and times, their location(s) and details, models of delivery (eg centre based twice weekly directly supervised, digital) and equipment used • clinical staff members involved in delivering the service • facilities available, including access for users with specific needs • expected timescales for the patient pathway, including initial assessment, start of PR, length of programme and discharge assessment • any links with other clinical services/stakeholders, including relationships with other organisations where referrals are managed • how patient involvement is incorporated into the running of the service	A link to an accessible public facing website and/or document, updated in the last 2 years. Evidence that service users are aware of the above, • evidence of this being provided in other accessible formats, where required.

		• information on how to raise a complaint, including a link to Patient Advice and Liaison Service (PALS) • links to resources and national patient representative groups (eg ALUK, Breathe Easy groups). The service should consider patient involvement in the design and delivery of the service. The external facing information must be agreed in advance with patients/carers and made available to stakeholders, including patients and their families/carers, staff, referrers and commissioners.	
	Standard 3.2: Patients and carers are involved in the development of the service.	The service should engage with eligible patients and carers to support the service development, including those who decline or are unable to undergo PR. The service should utilise external resources such as patient support groups, where available. The service should consider input from a range of service users which considers equality, diversity, and inclusion (EDI) issues that reflect the needs of the local population.	Evidence of ongoing patient/carer involvement in the design and delivery of the service (eg patient focus groups or meetings, patient days, or co-production). Evidence of changes in the service because of patient/carer involvement (eg you said, we did) Evidence of support from organisation patient engagement team, if applicable.
	Standard 3.3: The service communicates to service users their rights and responsibilities.	Fundamental aspects of care for any patient should include, building relationships with key staff, effective communication, ensuring comfort and alleviating pain, and promoting independence. Information about service user rights and expectations, should be readily available and communicated to those attending the service.	A section within the service description outlining patient's rights and responsibilities. Evidence of comprehensive written/online material available to support patient learning, either

		Staff have a responsibility to involve service users (and carers/family as appropriate) in making decisions about their individualised care. Support to make decisions about their care should be offered to carers and representatives where relevant (eg class options, accessibility requirements, interpreters, alternative evidence-based models of delivery etc.). Information about service user responsibilities should be readily available and communicated to those attending the service, including: • keeping appointments • notifying the service of appointment changes or cancellations • discussing with the service desired changes or decisions to terminate treatment and/or care • discussing with the service where expectations of treatment and/or care are not being met • abiding by any codes of conduct (eg zero tolerance for aggressive behaviour) or patient charters. The service should provide information to patients on what to wear and what to bring to PR assessment and PR classes. The service should have a process in place to protect patient's belongings at PR classes.	local or by signposting to national resources (eg patient support groups) and evidence of providing this information to patients/carers. Examples of anonymised patient letters. Evidence that the service supports families and carers when they are involved in patient care. Evidence of anonymised care/treatment plans that are agreed with patients/carers.
	Standard 3.4: The service respects and protects patients and carers.	There should be procedures in place to safeguard the rights, privacy, dignity, confidentiality and security of patients/carers at all times, especially during subjective parts of initial and discharge assessments.	Privacy, dignity and respect policy (can be organisation policy). Evidence of staff attending mandatory training related to privacy, dignity and respect.

	Standard 3.5: The service keeps service users informed of the clinical pathway.	The service should review waiting times and inform service users on expected waiting times for assessments and commencement of PR class. Communication to service users about wait times could include signposting to other relevant resources and contact if anything changes with their condition.	A section within the service description outlining how the service communicates with service users. Anonymised patient invitation letters describing waiting times for relevant appointments.
	Standard 3.6: The service provides an evidence-based programme of exercise, which is assessed, prescribed and progressed.	Each patient should receive an individualised exercise programme, considerate to their goals, while suitable for a group setting and available equipment. A PR programme should: • utilise best current evidence in the PR population and refer to national guidelines (eg BTS guideline on pulmonary rehabilitation in adults) • include a minimum of 20 minutes of aerobic exercise • include two to four sets of upper and lower limb strength exercises, with each set comprising 10–15 repetitions • include patient's goals. Exercise prescription and progression should be led by the healthcare professional experienced in prescribing exercise in PR.	A section within the service description outlining class structure and exercise approach, including chosen aerobic and strength assessment and exercise methods. An SOP for conducting walking test(s) to national and international technical standards. An SOP for aerobic exercise prescription and progression. An SOP for lower limb strength assessment. An SOP for strength exercise prescription and progression. Anonymised examples of completed home exercise plans.

			Anonymised examples of completed exercise sheets, that includes evidence of, • aerobic and strength prescription • progression of exercise following the FITT principles.
	Standard 3.7: The service provides a comprehensive programme of education	Each patient should receive a comprehensive package of education material to facilitate self-management. A PR education programme should include as minimum, • anatomy, physiology, pathology – in health and in chronic respiratory disease • medication (including oxygen therapy) • dyspnoea/symptom management • chest clearance techniques • nutritional advice • exacerbation management (including coping with setbacks and relapses). • the benefits of physical exercise • self-management plans. Service should refer to content set out in the BTS guideline on pulmonary rehabilitation in adults, appendix H: suggested education talks to encompass in the pulmonary rehabilitation programme.	Evidence of a comprehensive programme of education and learning. The learning material offered equates to at least 6 hours of learning. Evidence that the learning/education programme is accessible for all and has been adapted into different formats for those with specific needs. Evidence that the learning material is available for participants to learn independently (written information/videos/website). Evidence of knowledge/learning needs assessment has been undertaken.

		The service should involve multidisciplinary input and consider equality, diversity, and inclusion (EDI) when planning and implementing their education programme.	
	Standard 3.8: The service has a procedure for managing patient transitions out of the service, to self-management, or to other services.	The service should: • identify and make service users aware of and encourage access to local and national patient support groups • provide access to information to support patients in managing their condition • have links and referral pathways to community-based opportunities after PR completion.	A section within the service description outlining the process of transition of care. Evidence that all service users completing PR are provided with an individualised discharge exercise plan for ongoing exercise after PR completion. Evidence of discharge exercise plans being co-produced with patients/carers. Evidence of promotion of evidence-based self-management. Anonymised record of patients who have declined centre based twice weekly directly supervised PR and what alternative model(s) have been offered.
	Standard 3.9: The service enables patients and carers to feedback on their	There should be opportunities for patients/carers to provide regular feedback.	A PR service specific patient/carer survey conducted in the last 12 months, including survey template, survey data and

	experience of the service confidentially.	PR service specific patient/carer survey should include, as a minimum: • quality and safety of treatment and/or care provided • decision-making and involvement of the service user in their treatment/care • quality and clarity of information provided • privacy, dignity, respect and compassion • all aspects of the patient pathway including referral and assessment • signposting to local/national support groups • space/facilities/equipment/access during both assessments and PR classes • ease of getting in touch with the service and receiving a response. • patient information provided (service website and/or public-facing document, and relevant patient leaflets). Feedback must include patients from all PR sites and models of delivery. Staff should be notified of all feedback from patients/carers. Actions taken and improvements made by the service in response to patient/carer views should be offered to patients/carers who have provided feedback, where possible. They should also be reported in summary form annually.	analysis, and relevant action plans. Evidence of how patients/carers are continually encouraged to provide unsolicited feedback outside of a formal patient survey (eg posters in clinic, comment box etc). Minutes of meetings showing evidence of patient/carer feedback discussions with agreed actions, named leads, and timelines. Examples of changes made in response to patient/carer feedback (eg you said, we did).
	Standard 3.10: The service records, investigates, and learns from concerns and complaints.	The service has processes in place to ensure complaints are reported, investigated, recorded and analysed with findings disseminated to relevant parties and acted upon. The service should have a culture of positively seeking out complaints and regularly incorporating them into meetings where quality improvement and service development are discussed.	An SOP and policy on managing complaints (can be organisation policy). Anonymised examples of concerns/complaints from the last 12 months (can be formal and informal, including patient

			advice and liaison service (PALS) report), where applicable. Review of complaints and actions in PR service team meetings, disseminating themes, actions and learnings to all staff in service, where applicable.
4. Risk and patient safety	Standard 4.1: The service has risk management procedures.	The service can demonstrate risk is identified and managed within the service and escalated within the organisation as required. A service level risk log should include description, risk scoring, named risk owners, risk mitigation, timescales for implementing changes and evidence of escalation, where appropriate. Service level risk log should include as a minimum: • slips, trips and falls • infection control • medicine management • oxygen management • workforce planning.	A section within the service description that outlines the risk management approach with respect to individual patients, PR sites, the PR service, and wider organisation. Risk management policy (can be organisation policy). Evidence of local monitoring of risk, eg service level risk log. A departmental/divisional/organisation level risk register, where a risk has been escalated. Evidence of communication to staff about risk management and mitigation plans, risk reduction activities and the results of risk assessments and associated metrics.

			Evidence of risk training for staff.
	Standard 4.2: The service has a procedure for how incidents, adverse events and near misses are reported, investigated and used to inform changes to service delivery.	The procedure must include: • a statement encouraging staff members to report incidents, adverse events and near misses • a process for notifying staff and/or service users affected by incidents and documenting in their records • a process for mitigating risk incident(s) happening again • escalation process where the timescales for closing the incident cannot be achieved. The service should promote an ethos of openness, no blame culture, and transparency to reporting adverse events and near misses to their team and management (and wider organisation where relevant). The service should perform a root cause analysis for adverse events and near misses with an aim to improve systems and keep their patients and staff safe.	A section within the service description outlining how incidents, adverse events and near misses are managed. Examples of communication to staff to encourage reporting. Anonymised summary of incident reports (eg adverse events and near misses) over the last 12 months, this should include the number of events, and a brief description of the nature of these. Evidence of discussion within a PR team meeting. Evidence of where learning/service improvement has occurred.
	Standard 4.3: The service undertakes and records a clinical risk assessment of individual patients.	The service should have procedures in place to safeguard patients and the health and safety of staff members. A patient risk assessment is part of your clinical assessment which can help identify if there is a risk of harm to the patient and/or others or highlight the dependency of the patient which may influence class composition and/or staffing.	An SOP for completing patient risk assessments, with evidence of risk stratification included. Example of an anonymised completed patient assessment

		The result of the risk assessment may influence what PR programme is offered to the patient to ensure safety. Staff should have training in how to complete a patient risk assessment. The patient risk assessment must include: • the patient's changing risks • medical co-morbidities that may influence or deteriorate health and wellbeing • challenging behaviour • medical emergencies • dependency/mobility • medication and/or oxygen management. The results of the risk assessment must be recorded in the patient record.	with consideration of individual risk. Evidence of staff training/competence in clinical risk assessment.
	Standard 4.4: The service carries out risk assessment of clinical space.	The clinical space for PR assessment and delivery of PR classes can be different. All clinical space must meet clinical standard required to deliver healthcare (eg direct patient care spaces, staff space, and equipment space). The service must complete risk assessments for all clinical spaces, including external sites. Some external sites may have their own risk assessment procedures. The following should be considered: • size, location and times available • storage facilities for equipment • accessibility • parking facilities/local transportation • IPC processes	Completed risk assessment for each PR site. Photographic evidence of all clinical areas within the service (photographs of all sites, covering all areas used by staff and patients). If patients are in the photos, please ensure consent is gained. Examples of completed environment checklist, for each site.

		• space for private conversations • weather contingency plans • resuscitation equipment (eg defibrillator) in public space. The service should complete an environment checklist prior to the commencement of each PR class (eg temperature, extreme weather conditions).	
5. Clinical effectiveness	Standard 5.1: The service sets, monitors and reports on clinical outcomes.	The clinical outcomes that must be monitored and reported on at the start and end of a PR programme are: • validated measurements of exercise capacity, breathlessness and health status • validated walking test (eg 6-minute walking test (6MWT), incremental shuttle walking test (ISWT), or endurance shuttle walking test (ESWT)) • validated measurement of lower limb strength • performance against accepted minimal clinically important differences (MCID), where applicable. The service must also use disease specific quality of life questionnaires. Data and performance should be discussed at annual service audit, with action plans influencing the annual operational plan and/or QI projects.	For all PR services: • Documentation outlining the clinical outcome performance for all eligible patients referred, with effective action plans identified to improve against local and national targets, where applicable • Evidence that clinical outcome data are regularly collected and discussed with staff. For PR services in England and Wales: • National Respiratory Audit Programme (NRAP) run chart(s) from the last 12 months • Evidence of meeting national median for:

			○ % of patients achieving satisfactory outcomes for exercise performance ○ % of patients achieving satisfactory clinical outcomes for health status. • Data should be measured against accepted minimal clinically important differences (MCID) and/or national audit figures.
	Standard 5.2: The service sets, monitors and reports on clinical pathway metrics, and has an improvement plan supported by the management team.	The clinical pathway metrics that must be monitored and reported on are: • did not attend (DNAs) rates • inappropriate referrals • waiting times and completion data for all patients (services to define how they determine patient completion), across all pathways. Improvement plans should: • highlight strategies for continuing to improve against the metrics • include meaningful involvement of staff in development of the plan • include patient/carer involvement, where applicable, to help support change and improvement. Data and performance should be discussed at annual service audit, with action plans influencing the annual operational plan and/or QI projects.	For all PR services: Documentation outlining the clinical pathway metrics performance for all eligible patients, with effective action plans identified to improve against local and national targets, where applicable. Sections within the service description to outline: • DNA management procedure for the service • Procedure to review and communicate inappropriate referrals to the referrer

			Evidence that each metric is regularly collected and discussed with staff. Evidence of communication and feedback to referrers. **For PR services in England and Wales:** NRAP run chart(s) from the last 12 months. Evidence of meeting national median for: • % of patients with stable COPD enrolled within 90 days of referral • % of patients referred following hospitalisation for acute exacerbation of COPD (AECOPD) enrolled within 30 days of referral • % of COPD patient completion rates as evidenced by patients attending a discharge assessment and receiving a written discharge exercise plan.

	Standard 5.3: The service participates in local and national audit/assessment programmes.	Audits should be a meaningful part of service improvement and development. Audits should cover patients in all geographical and clinical areas of the service. For PR targeted local audits, there should be a narrative to show how the audit/QI project was chosen. Benchmarking between PR services in the region can be useful to create action plans and local targets. Service audit plan can also include organisation set audits, eg IPC. The service should audit data validation to ensure accurate data entry.	**For all PR services:** • A documented annual audit plan, including named leads and clear timescales for audit completion • Evidence of data validation. **For PR services in England and Wales:** • Evidence of participation to the NRAP PR audit, which is representative of the services eligible PR patients • Evidence of compliance of NDOO process.
	Standard 5.4: The service reviews and updates on all relevant guidelines, quality standards and benchmarking data.	It is important for the leadership team to be up to date with latest publications relating to PR and service delivery. The service lead(s) must: • have a continuous training/educational programme for staff on relevant guidelines • disseminate guidance and facilitate discussion with staff to create learning opportunities and improvement.	Evidence of annual review of national guidance and discussion with and/or dissemination of information to staff (can be minutes from PR team meetings). Benchmarking of audit data: • **For PR services in England and Wales:** to NRAP national reports • **For all other PR services:** to local or regional level, where available.

6. Workforce	Standard 6.1: The service undertakes an annual review of the workforce.	The workforce review must include: • strengths, weaknesses, and training needs for the service • demand and capacity exercises to demonstrate understanding of current and future workforce needs, including skillmix and whole-time equivalents (WTE) of clinical, management and administrative staff • planned future workforce to support new and/or existing work, such as reduction and/or maintenance of waiting times. For PR services part of wider/integrated respiratory service: • staffing needs to be identified specific to PR requirements, demonstrating profession, banding and WTEs. For all PR services: The minimum staffing levels should include: • a ratio of 1:8 for exercise sessions • a ratio of 1:16 for education sessions • a minimum of two staff members in attendance; one of whom should be a qualified registered healthcare professional with cardio-respiratory experience, competent to deal with the deteriorating respiratory patient and able to supervise the exercise component • a greater staff:patient ratio is required if oxygen users/complex patients are in attendance.	A section within the service description outlining how workforce reviews are managed, safe staffing levels, and a summary of current PR workforce. Evidence of an annual administrative and clinical PR workforce review, or earlier if there is a significant change in the service. Meeting minutes, action plans, and business cases, where relevant, that show workforce issues and reviews have been discussed within the service, stakeholders and wider leadership team within the organisation.
	Standard 6.2: There is a service-specific orientation and induction programme, which new staff members and those with a change in role	The induction should highlight all members of the leadership team, key details of how the service is run, and all aspects of PR relevant to the responsibilities of the individual staff member. Training on approved national courses related to PR is key to standardise care and knowledge, all clinical staff working PR should have access to the BTS fundamentals in PR and advanced practice in PR courses.	Completed local Induction checklist for all staff grades and roles. Evidence of clinical staff attending BTS fundamentals in PR, advanced practice in PR, and

	are required to complete.		other postgraduate training programmes relevant to PR. Evidence of gathering feedback from staff about the induction process and what, if any, improvements were made.
	Standard 6.3: The service has a process to regularly assess and review staff members as competent in specialist techniques.	Staff members should have a clear framework for evidencing competency and scope of practice. There should be clear roles of responsibility and should align with BTS professional development framework for PR. All clinical staff must be able to demonstrate competency in: • exercise and strength testing • individualising prescription and progression, with respect to goal setting • education delivery. This applies to all staff, including rotational, short term, and temporary staff.	This applies to staff new to the team, and all staff at least every 2 years. A section within the service description outlining the process of staff competency assessment. Anonymised completed examples of competency framework for different staff groups.
	Standard 6.4: The service has training plans in place for staff members.	The service should: • demonstrate a commitment towards training; this may be within and/or outside the service • provide staff members with the support and protected time to undertake QI training. Training needs should be identified at 1:1, feedback and/or appraisal sessions.	Training needs analysis for the service, including how training will be resourced. Anonymised examples of training discussion in appraisal documents.

		All staff should receive mandatory training, appropriate to their clinical role, on procedures to safeguard patients and to protect the health and safety of patients and colleagues.	Training log recording all educational and professional development activities, including training in aerobic and strength assessment, exercise prescription, progression and QI. Evidence of mandatory training compliance for PR team as appropriate to clinical roles. Evidence of dedicated time allocated to staff for appropriate QI training. Study leave, clinical supervision, safeguarding, and health and safety policy (can be organisation policy).
	Standard 6.5: The service has an appraisal process for staff members.	Appraisals should be conducted annually and all staff contributing to the service should show evidence of commitment to continuing professional development (CPD). Developing staff is essential in developing a good resilient workforce which is knowledgeable and competent. The service should encourage networking with other clinical services and provide adequate protected time for completion of objectives.	Staff appraisal, development, and performance management policy (can be organisation policy, or a section within the service description). Log of appraisal dates, including names of staff. Anonymised completed example of staff appraisal.

	Standard 6.6 The service has documented procedures in place for staff members who have responsibility for students, trainees and observers	Students, observers and trainees are important for PR, in respect to increasing exposure to PR for the future workforce and patient referrals. The service should have a process in place to appropriately manage students, including linking in with universities and having clear pulmonary rehabilitation learning objectives. Staff supervising students should receive training and support from universities in understanding the curriculum, learning objectives for placements, and teaching approaches. *Note*: for services who do not take students, trainees or observers, please indicate to assessors using the comments' function.	A section within the service description outlining the process for managing student, observer and trainee placements, where applicable. Documented training of key staff for student/trainee placements, where applicable. Documentation from the end of the student/trainee placement interview, where applicable. Evidence of student/observer/trainee feedback data, and evidence of review of data and actions to continually improve, where applicable. Documentation of barriers to offering student/trainee placements, where applicable.
7. Improvement and innovation	Standard 7.1: The service develops a quality improvement (QI) plan based on clinical outcomes, clinical pathway	The QI plan must be reviewed annually and should include: • all priority areas for improvement based on NRAP or other benchmarking data performances, staff feedback, patient/carer feedback, stakeholder feedback and organisational needs • measurable objectives and timescales for improvement initiatives • metrics for clinical effectiveness	An annual service QI plan. Example of a completed PR specific QI project dated within the last 12 months, from identification of change to implementation, and re-evaluation.

	metrics, and patient/ carer feedback.	• information on how the QI plan is reviewed, monitored, reported and evaluated • outline of QI projects including how it was identified, named leads and timelines • allocation of time, resources and staff members to achieve the above. Where clinical metrics and/or patient/carer data demonstrates positive results, the QI plan could focus on ways to embed and disseminate best practice and continue to improve. There should be clear linkage between the service's annual review, annual operational plan and QI plan. There should be named lead(s) for QI within the service. Poster presentations, written submissions, and articles can highlight emerging ideas that may inform future research or contribute to the review of existing studies. They offer a valuable opportunity to showcase the service and its innovations. Consider sharing learning from QI projects within local and national networks.	Examples of evidence-based QI methodology being used. Evidence of engaging staff and patients/carers in developing QI projects. Evidence of dissemination of key areas of the QI projects to staff members, patients/carers, and stakeholders as appropriate. Evidence of dedicated time allocated to staff to conduct appropriate QI work.
	Standard 7.2: The service develops an innovation programme.	Innovation can include: • research to develop new ways of working • applying recommendations by regional or national bodies • the adoption of technology, facilities and equipment to improve quality and/or value • implementing new evidence-based PR models of delivery. The following are examples that would not be considered forms of innovation: • update to service documentation	Evidence of adoption of innovation (service innovations or ways of working) to improve the service.

		• update to patient information • new PR sites or estates.	
	Standard 7.3: The service keeps a register of all research undertaken, where relevant.	The service should provide information on how they participate in research projects and the processes involved, where relevant. *Note*: if no research is undertaken in the service, please indicate to assessors using the comments' function.	Abstracts, audits, and developments can be evidenced if not active in research. Examples of ethics approval, if applicable.