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The Community Services benchmarking project
Section 1: Introduction

Content of this report

When reviewing this document, please note:

- the 2019 Community Services project collected and analysed data for the NHS financial year 2018/19. The “2018 project” refers to 2017/18 data.
- any reference to the “national average” within this document refers to the mean average of 2019 project participants.
- all charts and data in this report refer to the overall UK position. Peer group profiling is available in the online toolkit.
- on bar charts, each blue bar represents an individual service. The orange horizontal line represents the mean average value of all services.
- this report is an overview national report and therefore the charts in this report do not show the position of any one organisation in particular. Member organisations who participated in the Community Services project can check their individual positions in the online toolkit, which is issued to members once the dataset has been finalised. This allows individual comparison of every metric collected against the sample position.

<table>
<thead>
<tr>
<th>NHSBN Community Services 2019 - Community End of Life Teams</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1,687</strong></td>
</tr>
<tr>
<td>Face to face contacts per 100,000 population</td>
</tr>
<tr>
<td><strong>104</strong></td>
</tr>
<tr>
<td>Unique service users per clinical WTE in post</td>
</tr>
<tr>
<td><strong>6</strong></td>
</tr>
<tr>
<td>Face to face contacts per service user</td>
</tr>
</tbody>
</table>
Executive summary Community End of Life Teams

Community End of Life Teams provide specialist support to patients with advanced, progressive, or incurable illness to live as well as possible until they die, providing both supportive and palliative care needs for patients and their families. The main services delivered include; pain and symptom control, emotional/psychological support and nursing care.

Many community and acute services are starting to become increasingly integrated, and be provided by one organisation, in order to provide seamless care which wraps around patients and their carers. In 2019, 54% of Community End of Life Teams reported to have links with acute services; an increase of 36% from 2017, highlighting that Community End of Life Care Teams are increasingly becoming an integrated service.

Do your Community End of Life Teams have links with acute services?

<table>
<thead>
<tr>
<th>Year</th>
<th>Service managerially and functionally integrated with acute services</th>
<th>Service providing in-reach into the acute services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>33%</td>
<td>54%</td>
</tr>
<tr>
<td>2018</td>
<td>19%</td>
<td>33%</td>
</tr>
<tr>
<td>2017</td>
<td>19%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Additional work could be done to increase the availability of Community End of Life Teams. The 2019 results show that several Community End of Life Teams do not operate at the weekend. The headcount of staff further drops at the weekend, where the weekend staffing levels are 17% of weekday staffing.
An increase in the demand for Community End of Life Teams is reflected in the 2019 figure for the number of referrals received per 100,000 registered population. In 2019, on average 408 referrals were received per 100,000 registered population, ranging from 72 to 1,220.

Service users received 6 face to face contacts, at an average length of 60 minutes in 2019. The Community Services benchmarking project collects the average length of a face to face contact across all community services. For Community End of Life Teams, the average length of a contact reported in 2019 was 60 minutes, representing the intensity of provision required for people approaching the end of their life.

Nursing staff continue to make up the majority of the Community End of Life workforce, reported at 77% in 2019. Of nursing staff, Band 6 & Band 7 account for over a half of the skill mix, at 54%.

Preferred place of care, as referenced in the NHS Long Term Plan, 2019 is an indication of the individualised care received by the dying patient and reflects the wishes of the person to die in their place of choice wherever possible. The percentage of people under the care of community end of life services dying in their preferred place of care, was reported at 79% in 2019, which is consistent with the 2018 reporting.
National policy context

Community Services

England

The NHS Long Term Plan, published in January 2019, highlights the importance of community services in supporting service users in the community and reducing unnecessary hospital admissions. The Long Term Plan sets out to:

- boost ‘out-of-hospital’ care, and dissolve the historic divide between primary and community health services
- increase investment in primary medical and community health services, which will equate to an extra £4.5 billion a year by 2023/24. Extra money will start to flow to community via Sustainability and Transformation Partnership (STP)/ Integrated Care Systems (ICS) and Primary Care Networks (PCN) via Directed Enhanced Service (DES) contracts in 2020/21. The Long Term Plan Implementation Framework outlines funding allocations, with funding for Primary Care flowing more quickly than funding for Community Services
- increase the capacity and responsiveness of community and intermediate care services via a new offer of urgent community response and recovery support. These services will aim to prevent unnecessary admissions to hospitals and residential care, as well as ensure a timely transfer from hospital to community
- expand community multidisciplinary teams aligned with new Primary Care Networks based on neighbouring GP practices. Expanded neighbourhood teams will comprise a range of staff such as GPs, Pharmacists, District Nurses, Community Geriatricians, Dementia workers and AHPs.

Does your organisation operate with any Primary Care Networks (PCNs)?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20%</td>
<td></td>
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</tr>
<tr>
<td>40%</td>
<td></td>
<td></td>
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<tr>
<td>60%</td>
<td>69%</td>
<td>31%</td>
</tr>
<tr>
<td>80%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section 2: National Policy Context
Although the focus of community services within the NHS Long Term Plan is on adult services, wider children’s services and providing a strong start in life for children and young people is also highlighted in the plan. The Long Term Plan sets out to:

- bring together the NHS, Local Authorities and other local partners through local maternity systems, with the aim of ensuring women and their families receive seamless care, including when moving between maternity or neonatal services or to other services such as primary care or health visiting
- expand and invest in mental health services for children and young people
- design and implement models of care that are age appropriate, closer to home and bring together physical and mental health services. These models will support health development by providing holistic care across Local Authority and NHS services, including primary care, community services, speech and language therapy, school nursing, oral health, acute and specialised services
- roll out clinical networks to ensure improvement in the quality of care for children with long-term conditions such as asthma, epilepsy and diabetes.

### Wales

Community services strategy in Wales is contained within the document [A Healthier Wales: Our Plan for Health and Social Care](#) and sets a clear ambition to bring health and social care services together for the benefit of service users. This is not a new vision, but is supported by clear expectations, milestones and design principles to establish new models of care in every part of Wales.

The overall aim is to provide services that are designed and delivered around the needs and preferences of individuals, with greater emphasis on sustaining a healthy population and preventing ill health. To achieve this ambition, Wales must continue to break down the barriers that prevent health and social care services and their wider partners from operating across the whole system, delivering seamless care to the people of Wales.

Good planning arrangements are critical to bring together multiple providers and allow the system to be pre-emptive and anticipatory, ensuring that the right level of care is provided at the right time, from the right source and in the right setting.
A Healthier Wales outlines the following strategies, all of which relate to the provision of community services:

- services which support people to stay well, not just treat them when they become ill
- when people need help, health and social care services will work with them and their loved ones to find out what is best for them and agree how to make those things happen. This is the basis of the ‘person-centred approach’
- more services will be provided outside of hospitals, closer to home, or at home, and people will only go into hospital for treatment that cannot be provided safely anywhere else. This ‘community-based approach’ will help take pressure off the Welsh hospitals, reduce the time people have to wait to be treated, and the time they spend in hospital when they have to go there
- health and social care services will use the latest technology and medicines to help people get better, or to live the best life possible if they aren’t able to get better.

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**Northern Ireland**

Northern Ireland have a strategy which, in tandem with the modernisation of acute hospitals, seeks to expand the range of services that can be delivered in the community and is described in *A Healthier Future*. This encompasses the following:

- the key aim is to support an increasing number of people to live independent lives, preferably in their own homes
- to do this, the Health and Social Care Board and the Public Health Agency in Northern Ireland need to develop effective alternatives to hospital care, which are designed to reduce inappropriate admissions and unnecessary lengths of stay
- there also needs to be a strong focus on rehabilitation in tandem with assessment of long term care needs to avoid unnecessary reliance on residential and nursing home care.

To deliver on this vision, the following strategies are being pursued in relation to community services provision in Northern Ireland:

- secure an appropriate balance between hospital and community based services within local health economies
- continue the expansion and evaluation of intermediate care as a way of working that is designed to prevent unnecessary hospital admission, promote faster recovery from illness, support timely discharge, maximise independent living and improve the quality of assessment of long-term health and social care needs
in co-operation with the independent sector, expand the use of supported living, domiciliary care, day care and assistive technologies as alternatives to residential accommodation, focusing on rehabilitation and independent living

- develop a range of housing and care options for different levels of support, offering a continuum of care as people’s needs change

- contribute to the development of a region-wide single assessment process, focused upon the person and designed to streamline and improve decision making about long-term health and social care needs and simplify access to services

- expand the range of flexible and responsive respite and support services for carers

- increase the take up of Direct Payments

- engage actively with users and the voluntary and community sector in the design and delivery of services.

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### Scotland

The newly created Public Health Scotland’s strategy around community services is embodied in [A Fairer Healthier Scotland 2017-22](#). There are five strategic priorities that have been developed in partnership with stakeholders, including providers of community services. These are as follows:

**Fairer and healthier policy** - ensure that knowledge and evidence is used by policy and decision makers. This is so that strategies focus on fairness and influence the social determinants of health and wellbeing.

**Children, young people and families** - ensure the knowledge and evidence provided is used to implement strategies focused on improving the health and wellbeing of children, young people and families.

**A fair and inclusive economy** - providing knowledge and evidence on socio-economic factors and their impact on health inequalities. This is to contribute to more informed and evidence-based social and economic policy reform.

**Healthy and sustainable places** - ensure the knowledge and evidence provided is used to improve the quality and sustainability of places. This will increase their positive effect on health and wellbeing.

**Transforming public services** - working in partnership with and support public sector organisations to design and deliver services that have fairer health improvement and the protection of human rights at their core.
Community End of Life Teams

Every year, over half a million people die in the UK. Just under half of these deaths occur in hospital, whilst the remainder occur within a community setting.

The Office for National Statistics (ONS) collects data on deaths registered in England and Wales. In 2018, the ONS reported that 24% of people died at home, 22% died in care homes, 6% in hospices and 2% elsewhere. The 2018 figures are shown in the pie chart to the right.

The one certainty in life is that death will affect us all during our lifetime. As outlined in One Chance to Get It Right the Five priorities for care reinforce that the focus for care in the last few days and hours of life must be the person who is dying. The Five priorities of care are as follows:

1. the possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person’s needs and wishes, and these are regularly reviewed and decisions revised accordingly
2. sensitive communication takes place between staff and the dying person, and those identified as important to them
3. the dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants
4. the needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible
5. an individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

The Five priorities for care are applicable across all care settings and are all equally important to achieving good care in the last days and hours of life. Each priority supports the primary principle that individual care must be provided according to the needs and wishes of the dying person.
There are multiple services to support patients known to be at the end of their life, including GPs, Community/District Nursing services, Specialist Nursing teams within the community and Community End of Life Teams/Specialist Palliative Care Teams. The service model delivery will vary depending on the geographical area and local Clinical Commissioning Group (CCG) in which the person resides.

Community End of Life Teams support patients with advanced progressive illnesses, life limiting conditions, frailty and patients who are in the last months or years of their life, within a community setting. Pain and symptom management and the provision of psychological, emotional, social and spiritual support are areas offered by Community End of Life Teams. They play a crucial role in ensuring the patient is comfortable during their final stage of life and that the patients’ wishes and preferences are taken into account when planning their care. Good end of life care is tailored to the individual’s needs.

In 2014, the UK changed its approach towards end of life care, due to concerns expressed with the continued use of the Liverpool Care Pathway by healthcare providers, to a more holistic and personalised approach as covered by the Five priorities for care in One Chance to Get It Right, 2014. The Leadership Alliance for the Care of Dying People (LACDP) published the document, One Chance to Get It Right, to set a principle for improving the care of people who are dying and their families, in the last few days and hours of life, across all care settings. The guidance puts the needs and wishes of the patient, and those important to them, at the centre of care.

Additional initiatives to support the delivery of good end of life care include the Ambitions Framework, 2015. This is a national framework of partnership across statutory and voluntary sectors, which incorporates NHS England’s aims and objectives for end of life care.

NICE Guideline NG31 and NICE Quality Standard 144 further identify communication, involvement in decision making and symptoms management as priority areas for caring for dying adults in the last days of life.

The focus on individual preference and supporting patients to make their own end of life care choices including type and location of care is highlighted in the NHS

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### Extract from National Audit of Care at the End of Life (NACEL), 2019

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with dying person (CNR)</td>
<td>89%</td>
<td>7.8</td>
</tr>
<tr>
<td>Individual plan of care (CNR)</td>
<td>71%</td>
<td>7.2</td>
</tr>
<tr>
<td>Families’ and others’ experience of care (QS)</td>
<td>80%</td>
<td>7.0</td>
</tr>
</tbody>
</table>

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Long Term Plan, 2019. The Long Term Plan sets out that further training will be rolled out to staff, to help improve personalised care planning and identifying those at the end of life.

It may be expected that an increased focus on personalised care may result in a higher proportion of patients dying in their preferred place of care. Early planning and documentation of the patient's preferred place of death within their care plan, will allow for systems to be put in place to help achieve this. The percentage of patients, cared for by Community End of Life Teams, who died within their preferred place of death was documented as 79% in the 2019 project, consistent with 2018. The NHS Benchmarking Network shall continue to monitor the quality and outcome findings from the community services project to assess progress against LTP priorities.

In order to provide personalised care to patients with complex needs within the community, a more multidisciplinary (MDT) approach within the Community End of Life Teams may become evident. The NHS Benchmarking Network will continue to capture data on the workforce and discipline mix of Community End of Life Teams to capture such a variation.

The importance of prompt referral to, and input from, specialist palliative care for those that require it, is outlined as a priority in One Chance to Get it Right. As such, commissioners and providers are advised to implement ‘adequate’ access to the specialist palliative care service; 9am–5pm seven days a week face to face, and have a 24-hour telephone advice service. This recommendation is re-emphasised, with a focus on adult inpatient care, in the National Audit of Care at the End of Life (NACEL) Summary Report for England and Wales (2018 & 2019).

The NHS Long Term Plan addresses children’s palliative and end of life care as a priority for the NHS. In the document, a commitment was made to increase the funding in these services over the next five years, by match funding any investment by Clinical Commissioning Groups. A change in investment from £11 million up to a combined total of £25 million a year by 2023/24 is estimated. An increase in investment into children’s end of life care, is likely to result in more services covering children’s care. Currently, the Community End of Life Teams which participate in the Community Services benchmarking project, report that they mainly offer care to adults (96% in 2019).
Community Services benchmarking - Deep dive report for Community End of Life Teams

Section 3: Key Findings - Community End of Life Teams

Key findings

Community End of Life Teams - service model

- Community End of Life Teams care for patients during the last stage of their life (patients in a progressive state of decline), which includes Palliative Care and Terminal Care.
- The primary service provided by Community End of Life Teams includes pain and symptom control, emotional/psychological support and nursing care. Additional services offered by these teams includes personal care (65%), therapy care (48%), and night sitting services (39%).
- Community End of Life Teams predominantly care for patients in their own homes, residential and nursing homes. More than half of services operate within hospices and community hospitals, whilst fewer numbers of teams care for service users in clinics and health centres (13%).
- 54% of services provide an in-reach service into acute hospitals, whilst 33% of Community End of Life Teams are managerially and functionally integrated with acute services. Community End of Life links with acute services have increased over the past three years.
- Community End of Life Teams are shown to mostly care for adults (18+), where 96% of participants answered that this was their service demographic.
- It is also worth noting that District Nursing services will often provide considerable input/completely manage (in the absence of specialist End of Life Care teams locally) the end of life care needs of patients on their caseload. This should be taken into account when considering the variation noted across the benchmarking examples presented in this report, and noted that the variation may well be due to differences in service models in terms of the split between generic and specialist services.

Services provided

<table>
<thead>
<tr>
<th>Services Provided</th>
<th>Yes %</th>
<th>No %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional / psychological support</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Pain and symptom control</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Nursing care</td>
<td>87%</td>
<td>13%</td>
</tr>
<tr>
<td>Personal care</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td>Therapy care</td>
<td>48%</td>
<td>52%</td>
</tr>
<tr>
<td>Other</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>Pharmacy support</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>Night sitting services</td>
<td>39%</td>
<td>61%</td>
</tr>
<tr>
<td>Chaplain services</td>
<td>13%</td>
<td>87%</td>
</tr>
</tbody>
</table>
Community End of Life Teams - Access

Average waiting time (days)

The orange line on this chart and all subsequent charts represents the mean average value for the metric.

The following chart reflects the mean average waiting time for Community End of Life Teams as 4.2 days. A result consistent with that of the 2018 project at 4.2 days.

Weekend hours as a percentage of weekday availability

Whilst a number of services in the 2019 project report the same hours of availability during the week as at the weekend, 4 services report having no weekend provision at all. The mean average weekend hours as a percentage of weekday availability is reported as 70%, as shown in the chart, whilst the median is reported as 100%.

Results from the 2019 project further show a reduction in the number of staff available at the weekend in comparison to a weekday. The mean staff headcount on a weekday was reported at 11, whilst the average headcount of staff during the weekend was 2.
Community End of Life Teams - Activity

The mean average number of referrals received by Community End of Life Teams during 2018/19, was reported at 408 per 100,000 registered population.

Demand levels are shown to vary across Community End of Life Teams, where referrals range from 72 - 1,220 per 100,000 registered population. The median is 383 referrals per 100,000 registered population.

The 2019 results reflect an increase in the demand for Community End of Life Teams. In 2018, a mean average of 294 referrals per 100,000 registered population was reported.

In 2019, 90% of the referrals accepted by Community End of Life Teams were assessed and seen within 28 days. The mean average is consistent with the activity recorded during 2018, at 90%.
Community End of Life Teams - Activity

On average 1,687 face to face contacts were delivered per 100,000 registered population by Community End of Life Teams.

The results from the 2019 project can further be split to show that 423 face to face contacts were delivered per clinical WTE in establishment and 6 per service user.

The average length of a face to face contact, delivered by Community End of Life Teams, was 60 minutes.

Analysis of patient facing clinical time

Community End of Life Teams spend a higher proportion of their time in the delivery of patient facing activity than many other community services. On average 55% of staff clinical time is spent patient facing.

Travel time is also high for this service at 10%. Community End of Life Teams are required to be mobile and travel between locations, given that 100% of services deliver care in service users own homes and residential homes.
Community Services benchmarking - Deep dive report for Community End of Life Teams

Section 3: Key Findings - Community End of Life Teams

Community End of Life Teams - Activity

Unique service users per 100,000 registered population

The chart to the left shows the mean average number of unique service users per 100,000 population as 263.

There was a large amount of variation reported in the number of patients seen per service, ranging from 38 to 578.

A contributing factor impacting the number of service users is the area type within which the service is delivered. Urban areas tend to have a higher volume of service users than in mixed areas (rural and urban). This area breakdown is available via the online toolkit and reflects the Office of National Statistics (ONS) classifications.

Unique service users per clinical WTE in establishment

The mean average number of unique service users per clinical WTE in establishment was reported as 77 for Community End of Life Teams, reflecting the caseload of patients seen by a clinician during 2018/19.

The project also takes into account the clinical staff vacancy rate, with an average of 104 unique service users are seen per clinical WTE in post.
Community End of Life Teams - Workforce

Clinical staff WTE per 100,000 registered population

The sample mean for the number of clinical staff WTE (in establishment) per 100,000 registered population was 4.6, with a range from 0.7 to 13.

Nursing staff were the largest staff group within the clinical workforce, with band 7 being the most common, making up 32% of the nursing workforce. 21% are band 6 and 19% band 3.

The average non clinical staff WTE (in establishment) per 100,000 registered population was 0.8.

Discipline mix

The discipline mix shows the proportion of staff disciplines delivering the service. The above findings are consistent to previous years, with little change in the composition of the Community End of Life Team workforce.

Community End of Life Teams are predominantly comprised of Nursing staff, representing 77% of the workforce.

Allied Health Professionals (AHPs) and Medical staff further play a part in the delivery of this service, summing to 11%, whilst the remainder 12% of staff are non-clinical. Non-clinical staff within Community End of Life Teams often include chaplains and counsellors.
Community End of Life Teams - Workforce

The chart above shows a range of HR KPIs for Community End of Life Teams during 2018/19. The average clinical staff vacancy rate was reported at 18.3%, emphasising the struggle to retain and recruit staff within Community End of Life Teams. Vacancy rates for non-clinical staff was reported at a lower rate of 9.2%. Sickness rates and staff turnover rates were reported at an average of 5.0% and 11.3% respectively.
Community End of Life Teams - Finance

The bar chart to the left compares the budget for Community End of Life Teams in 2018/19 and the planned budget for 2019/20, per 100,000 registered population.

Community End of Life Teams, on average, budgeted £225,491 for the payment of clinical staff per 100,000 registered population in 2018/19.

The results show a decrease in the budget from 2018/19 to 2019/20. The largest difference being a 19% decrease in non-pay costs, followed by a 18% decrease in the clinical staff pay cost per 100,000 registered population. It is possible that the aim of reducing costs has resulted in alterations to the skill mix.

In 2019, 67% of participants accounted a skill mix review as a contributor to achievement of CIP/CRES targets.

<table>
<thead>
<tr>
<th>Year/Cost</th>
<th>Clinical staff pay cost (£)</th>
<th>Non-clinical staff pay cost (£)</th>
<th>Non-pay cost (£)</th>
<th>Indirect costs and overheads (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget 2018/19</td>
<td>225,491</td>
<td>22,164</td>
<td>14,943</td>
<td>49,661</td>
</tr>
<tr>
<td>Budget 2019/20</td>
<td>184,018</td>
<td>19,540</td>
<td>12,063</td>
<td>42,503</td>
</tr>
</tbody>
</table>
**Community End of Life Teams - Finance**

The bar chart to the left reflects the budget in comparison to the actual spend of Community End of Life Teams in 2018/19, per 100,000 registered population.

The results highlight that on average Community End of Life Teams underspent during the year for all four costs shown on the chart.

To further support the cost improvement results, in 2019, 70% of participants stated that they had achieved their CIP/CRES target.

<table>
<thead>
<tr>
<th>Year/Cost</th>
<th>Clinical staff pay cost (£)</th>
<th>Non-clinical staff pay cost (£)</th>
<th>Non-pay cost (£)</th>
<th>Indirect costs and overheads (£)</th>
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<tr>
<td>Budget 2018/19</td>
<td>225,491</td>
<td>22,164</td>
<td>14,943</td>
<td>49,661</td>
</tr>
<tr>
<td>Spend 2018/19</td>
<td>205,696</td>
<td>18,590</td>
<td>13,417</td>
<td>47,359</td>
</tr>
</tbody>
</table>
Bank and agency spend can account for a large amount of the Community Services budget where vacancy rates are high. On average, Community End of Life Teams report bank spend as 2.4% of the total pay budget, where spend on agency staff is lower at 1.1% of pay budget.
Community End of Life Teams - Quality and outcomes

99.6% of patients had a care plan documented and agreed with the service user.
National guidance emphasises the importance of an individualised care plan for patients at the end of life that includes the documentation of food, drink, symptom control, psychological, social and spiritual support. Almost all patients accessing Community End of Life services in 2019 had care plan documented.

The average friends and family test (FFT) result was 98.1%.
As outlined in One Chance to Get It Right, good end of life care covers not only the patient, but those important to them, to support their needs as far as possible. One way of measuring the experience of care provided to the patient and those important to them is by the FFT. Overall, Community End of Life Care Teams participating in the 2019 project received positive feedback from friends and family, emphasising that patients were happy with the service provided, with little improvement needed. This result is only slightly lower to the 2018 figure reported of 99.1%.

79% of people in community end of life services were reported as dying in their preferred place of care. Benchmarking data outlines an increase of 1% since 2015, where 78% of service users died in their preferred place of care.

Whilst there is no set standard for the percentage of patients who should die in their preferred location, the importance of this topic is covered by Priority 5 within One Chance to Get It Right; which focuses on the importance of an individualised plan of care.

In summary, Priority 5 states that patients needs and wishes, should be discussed, co-ordinated and delivered where possible, to maximise the patients last stage of life.
References


Leadership Alliance for the Care of Dying People. *One Chance to Get It Right. Improving people’s experience of care in the last few days and hours of life.* 2014


NICE. *Quality Standard QS144 Care of dying adults in the last days of life.* 2017

NICE. *Guideline NG31 Care of dying adults in the last days of life.* 2015


The Health Foundation/Nuffield Trust. *Community Services. What do we know about quality? November 2017*

Welsh Government. *A Healthier Wales: Our Plan for Health and Social Care.* June 2018
The Community Services project is one of the NHS Benchmarking Network’s longest standing projects, being a key area for members to want to benchmark, given the lack of national data available in this area. Community services represent over £10 billion of NHS expenditure and they play a key role in supporting service users at home and reducing unnecessary hospital admissions. The Next Steps on the NHS Five Year Forward View highlights the importance of close working with community services, with an aim to free up capacity in 2,000-3,000 hospital beds over the next two years. Despite this policy intention, The Nuffield Trust reports that funding given to NHS Trusts for community services fell by 4% last year. An NHS priority over the next 10 years is to help older people stay healthy and live independently in their communities, with a move towards more integrated care for this cohort. Community services provision is expected to play an important part in the NHS Long Term Plan.

National data on community services is currently limited and the Network’s Community Services project aims to fill this information gap, taking a view across all aspects of service provision including access, activity, workforce, finance and quality metrics. The project provides a detailed view of 25 different community services, and there is a series of case study reports for every single service benchmarked.
The Community Services benchmarking project runs on an annual cycle; project scoping taking place with the Community Reference Group from January through to April; data collection from May through to June; data analysis and validation in September and October, with the national event and other outputs being made available in November and December. There may be some changes to the community services where data is collected between the years the project has been operating.

The Community Services benchmarking project collects provider level data on access, activity, workforce, finance and quality and outcomes at aggregated organisational level for the whole year. Some organisations may choose to make multiple submissions, often where service models differ between different geographic areas or their service covers multiple CCG areas. The metrics are agreed with the Network’s Community Reference Group and definitions are provided for every metric to ensure consistency of interpretation of metrics. The Network provides a Helpline to help with interpretation and give advice on data collection. Metrics are reviewed at the end of each cycle, with a view to refining data collection, and ensure that metrics and definitions utilised are relevant and up-to-date. Metrics with a poor response rate tend to be discarded for the next year’s benchmarking. Within the membership, participants take part in the Community Services benchmarking project from all four UK countries. The project provides the most comprehensive dataset available in the NHS on Community Services.

Data is collected via an online data collection tool, input via the online data collection pages in the Network website members’ area. The project collects data for subsequent NHS financial years, running from 1st April to 31st March, so the 2019 iteration of the Community Services project collected data from 1st April 2018 to 31st March 2019. As the project has run for many iterations, time series analysis is available, through toggling between the years on the online toolkit.

During the data validation phase, all submissions are reviewed and participants are given the opportunity to amend or update their data where any outlier positions are identified. These are checked following the production of a draft online benchmarking toolkit, which shows the draft benchmarked findings for the whole sample against every metric collected. All outputs are anonymised, and provider organisations can see their own position(s) only.
Next cycle

The Community Services project will feature in the Network’s 2020/21 work programme, collecting 2019/20 outturn data. In response to member requests, the data specifications have been cut down and the number of community services being benchmarked in this year’s cycle has been reduced, to enable members to have the capacity to complete the benchmarking, following the coronavirus pandemic.

NEW Community Services Covid-19 tracker

The Network is also offering a [NEW Community Services Covid-19 tracker dashboard project](#) which reports on a monthly basis on a limited set of metrics to track the impact of the pandemic upon community services provision.

Project outputs

Every participant in the Community Services benchmarking project receives a suite of outputs. All of the outputs from the Community Services project are available via the members’ area of the NHS Benchmarking Network’s website. Log-in details are required to access the member’s area. To request new, or to be sent a reminder of existing log-in details, please email [enquiries@nhsbenchmarking.nhs.uk](mailto:enquiries@nhsbenchmarking.nhs.uk).

Once logged-in to the members’ area, each of the Network’s projects is listed on the home page. The following outputs can be accessed:

- Online toolkit
- Project reports
- Good Practice Compendium
- Presentations from the Network’s 2019 Community Services national conference

In addition to the project outputs, organisations who participated in the project are still able to view their data submission via the online data collection pages in a read-only format. Please contact [Lucy Atherton](mailto:LucyAtherton) if you need any assistance accessing the project outputs.

Networking and sharing good practice

The Network is keen to facilitate networking and sharing good practice examples between project participants. If your organisation is interested in contacting other project participations, please email [Lucy Atherton](mailto:LucyAtherton) and, providing consent is granted, the relevant project lead contact details can be passed on. Please note, although some organisations choose to share their organisation’s identifier codes between each other, the Network keeps all data supplied to the benchmarking projects anonymous. The Network will never pass on identifier codes to colleagues outside your organisation.