

NHS Benchmarking Network

Generic Community Services Report 2020/2021



Bespoke reports have been provided directly to participating members. This version of the report does not highlight a specific organisation's data, but shows the national findings from the 2021 Community Service Benchmarking Project.





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Section 1: Introduction

1.1 Content of this report

Welcome to the generic report for the NHS Benchmarking Network (NHSBN) 2021 Community Services Project. Data covers the 2020/21 period from April 2020 to March 2021 and therefore provides the first significant assessment of the impact of the Covid-19 pandemic on community services.

Once again, the Community Services Project provides the most comprehensive dataset available in the NHS on community services. This report is designed to supplement the online community services benchmarking [toolkit](#).

Prior to the 2019/20 project, benchmarking of 25 community services took place annually. Due to the pandemic, it was agreed that the project would focus on 9 community services in 2019/20 with the addition of community respiratory teams for the 2020/21 year which therefore covers 10 services.

This report provides a deeper dive into the 6 community services which are considered the most important in terms of delivery of the devolved Governments' strategies on out of hospital care. The other 4 community services which were benchmarked this year have service dashboards included within this report, to ensure that every member receives feedback on their benchmarked positions.

The table below outlines the community services that were benchmarked as part of the 2021 cycle.

Services included in the 2021 project
Cardiac Community Teams
Children's Community Nursing Teams
Community/District Nursing Service
Community Integrated Care Teams
End of Life Community Teams
Health Visiting Service
Physiotherapy Service – Adult
Podiatry Service
Respiratory Teams
Speech and Language Therapy Service - Adult

The 2021 project had participation from members across England, Wales and Northern Ireland. 91 submissions were received from 61 community service providers, providing data for 418 community services.

Within the 2021 project, information was gathered for the first time in relation to the management of people living with frailty. These findings will be summarised separately in conjunction with data gathered from the 2021 Intermediate Care Project, in a short report, "**Management of people living with Frailty**" (available on the [members' area](#) in early 2022).

In addition to this project, there is the opportunity for members to be involved in the monthly Community Indicators Project, where a smaller selection of indicators are reported on a monthly basis. For more information please contact nhsbn.cst@nhs.net

Section 1: Introduction

1.1 Content of this report

How our members use their benchmarking data to support service improvement

As national data on community services is currently limited, the NHSBN Community Services Project aims to fill the information gap, taking a view across all aspects of service provision. Metrics are agreed in collaboration with the Community Services Reference Group to ensure that the project remains relevant and useful to our members.

Some examples of how our members have used their benchmarking data to support service improvement are:

- The development of a 2-hour rapid response service, using benchmarking data to design the service and demonstrate the need for investment.
- Benchmarking data identified a high DNA rate within the podiatry service, which was addressed through a review of the appointment letter and the introduction of a process to contact patients the day before their appointment to confirm attendance.
- District nursing teams have used benchmarking data to develop an action plan on areas that they identified as an outlier. In addition the data has been used to improve record keeping and provided the ability to undertake demand and capacity planning.
- Within the podiatry service, benchmarking data identified a low level of funding for the population size. This evidence enabled the service to secure temporary funding from NHS England, which enabled them to meet the NICE guidance for diabetic foot care.

A number of guides outlining how members have used benchmarking for service improvement can also be found on the [Network website](#).

Section 1: Introduction

1.2 National policy context

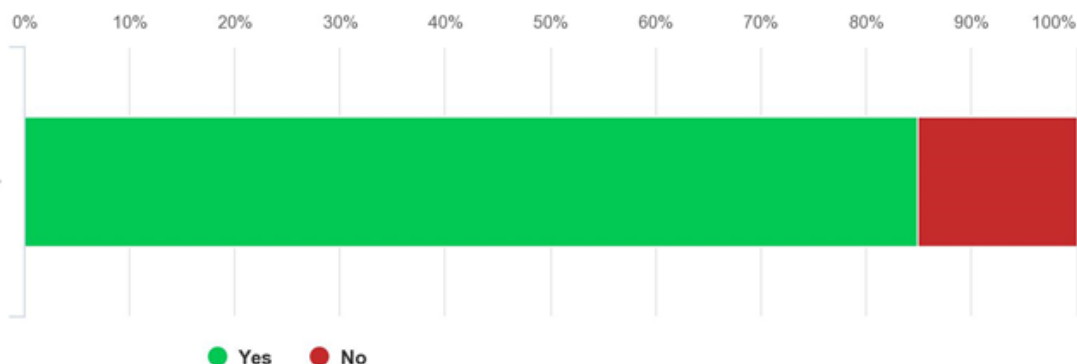
The 2021 Community Services Project provides data covering the COVID-19 pandemic year 2020/21.

Despite the challenges of COVID-19, the future of community health services as laid out within the [NHS Long Term Plan](#) (LTP) has remained the focus, with some areas of change being expedited by the pandemic.

The Long Term Plan set out a clear direction for community health services, to support service users in the community and reduce unnecessary hospital admission, with some key commitments:

- **Boost 'out-of-hospital' care** - dissolving the historic divide between primary and community health services. An example of this is the introduction of the framework for [Enhanced Health in Care Homes](#) (EHCH) in March 2020, requiring primary care and community services to work collaboratively to deliver proactive care.
- **Increased investment** – for primary medical and community health services, equating to an extra £4.5 billion a year by 2023/24. System Development Funding (SDF) has been made available to support priority areas such as the Ageing Well Programme. During the pandemic, non-recurrent funding has also been made available for areas such as the implementation of hospital discharge services.
- **Urgent community response and recovery support** - increase the capacity and responsiveness of community and intermediate care services. Two new targets have been introduced; a 2 hour wait for crisis response services and a two day wait for other urgent community response services. Data from the [NHSBN Intermediate Care Project](#) outlines the progress on this during 2020/21.
- **Expanded community multi-disciplinary teams aligned with new primary care networks (PCNs)** - these teams will comprise a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and allied health professionals (AHPs). From the NHSBN Community Services Project in 2021 we can see that 85% of organisations report operating with PCNs, which is an increase from 69% in 2019.

Does your organisation operate with any primary care networks?



Section 1: Introduction

1.2 National policy context

To support community services, during 2021, several work programmes from within NHS England and NHS Improvement were brought together to form one national team to be known as 'Discharge and Community Services'. This team has three core workstreams:

1. **Community care** – focused on the Long Term Plan commitments of 2-hour crisis response, anticipatory care and enhanced health in care homes. Also covering NHS support to the care sector and community children's services.
2. **Hospital discharge and rehabilitation** – focused on implementation of the discharge to assess policy, modernising both NHS continuing healthcare and the Better Care Fund, as well as community rehabilitation services.
3. **Transforming community services** – focused on improvement of the digital and data infrastructure and transforming the community health workforce.

These workstreams aim to reflect the long term plan commitments, build on the work resulting from the pandemic including the restoration of services, tackling health inequalities and embedding innovation.

Alongside this, a major national change in the organisation of health and care services is underway. In February 2021 the UK Government published the white paper, [Integration and Innovation: working together to improve health and social care for all](#) which set out legislative proposals for a health and care bill aiming to build on the pace and scale of collaboration across health and social care seen during the coronavirus pandemic.

In July 2021, the draft [Health and Care Bill](#) was published which, as this report is being written is being debated in parliament, with the expectation that it will be passed in time for the changes to come into effect in April 2022.

The Bill builds on existing work to integrate health and care, formalising the development of integrated care systems (ICSs) across England in line with the NHS Long Term Plan (LTP), putting ICS' on a statutory footing alongside the abolition of clinical commissioning groups (CCGs).

Integrated care systems will bring together health and care organisations to plan and deliver joined up services, with the triple aim of, better health for everyone, better care for all and efficient use of NHS resources.

During 2021 preparatory work has been ongoing, and as such all parts of England are now covered by one of 42 ICSs.

A similar approach is being taken in Wales, as outlined in the publication '[A Healthier Wales: our Plan for Health and Social Care](#)'. The plan describes the vision of, '*a whole system approach to health and social care, which is focussed on health and wellbeing, and on preventing illness.*'

Similar to England, this approach includes a focus on community-based models of health and social care, integrating services at a local and regional level. The offer within primary and community care will be widened with clusters of health and care professionals working closely, focussing on prevention and early intervention.

The model of shifting resources from hospital-based care aims to deliver care as close to home as possible, speed up recovery and improve access to hospital care when it is needed.

Section 1: Introduction

1.3 The impact of COVID-19 on community health services

Community health services have been vital in ensuring continued care to their respective communities from the outset of the pandemic.

National modelling suggested that, by April 2020, the NHS was at risk of being overwhelmed by an initial peak of COVID-19 patients requiring hospitalisation. NHS England instructed trusts, many of whom were operating at over 90% capacity, to discharge all medically fit patients out of acute and community hospital beds. To support this, community providers rapidly designed and implemented discharge to assess services and pathways and subsequently managed bed capacity down to 50% – 60%.

Community services reprioritised and redeployed staff to continue to support discharge to assess pathways and to maintain non COVID-19 essential services.

Timeline of NHS response to COVID-19

Date	Phase
29 Jan 20	First confirmed case of COVID-19 in the UK
17 Mar 20	Phase 1 of NHS response: <ul style="list-style-type: none"> • Free up inpatient and critical care capacity • Prepare for incoming COVID-19 cases • Reduce/cease non-urgent elective care • Put process in place to support NHS staff
19 Mar 20	<ul style="list-style-type: none"> • Guidance published on prioritisation of community health services, outlining which services should be stopped, partially stopped or continued • Community services staff redeployed to support essential services • COVID-19 Hospital Discharge Service requirements published
26 Mar 20	Start of 1st national lockdown
15 Apr 20	Novel coronavirus (COVID-19) Standard Operating Procedure for community health services published.
29 Apr 20	Phase 2 of NHS response: <ul style="list-style-type: none"> • Sustain the hospital discharge service • Prepare to support an increase in patients recovering from COVID-19 and needing ongoing community health support • Continue to provide essential community health services • Scale up the use of technology-enabled care
3 Jun 20	Updated guidance on restoration of services for children and young people.
30 Jul 20	We are the NHS – People Plan 2020/21 published.
31 Jul 20	Phase 3 of NHS response: <ul style="list-style-type: none"> • Aim to return to near-normal levels of non-COVID-19 activity, including restoration of all adult and older people’s community health services • Prepare for winter/second wave • Implement learning
5 Nov 20	Start of 2 nd national lockdown (England)
23 Dec 21	Operational plans for winter 2020 <ul style="list-style-type: none"> • Responding to COVID-19 demand • Pulling out all the stops to implement the COVID-19 vaccination programme • Maximising capacity in all settings to treat non-COVID-19 patients • Responding to other emergency demand and managing winter pressures • Supporting the health and wellbeing of our workforce
6 Jan 21	Start of 3 rd national lockdown



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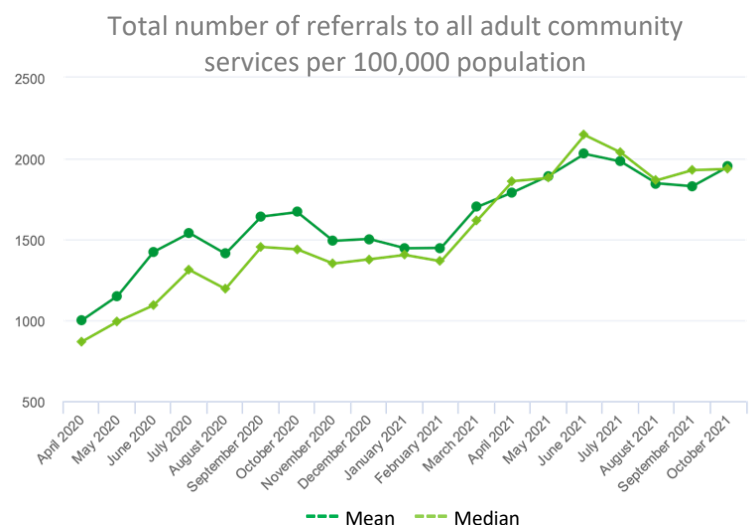
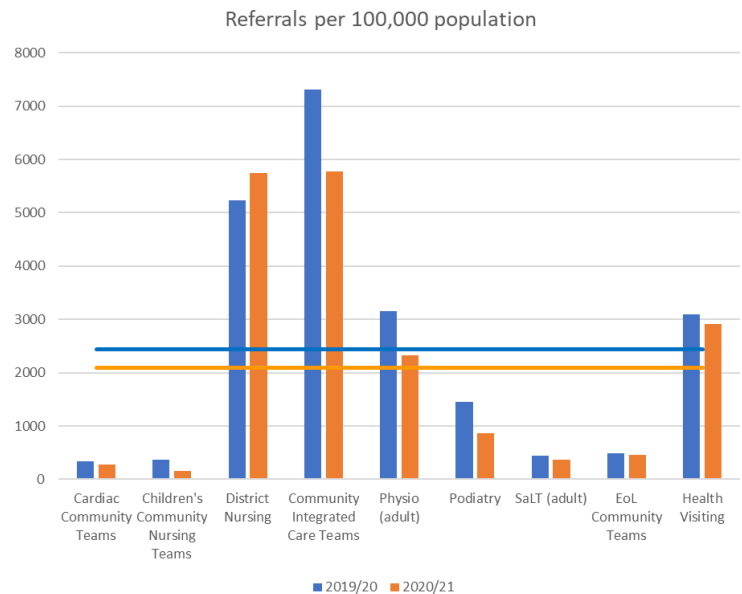
1.3 The impact of COVID-19 on community health services

Information collected through the Network’s community sector projects outlines the many impacts on community services during 2020/21.

- **Referrals:** As can be seen from the chart on the right, with the exception of district nursing, total referrals per 100,000 population were lower across all services benchmarked for 2020/21 compared to 2019/20, equating to an overall average reduction of 16%.

Data gathered from the Community Indicators Project also shows the monthly trend around referrals.

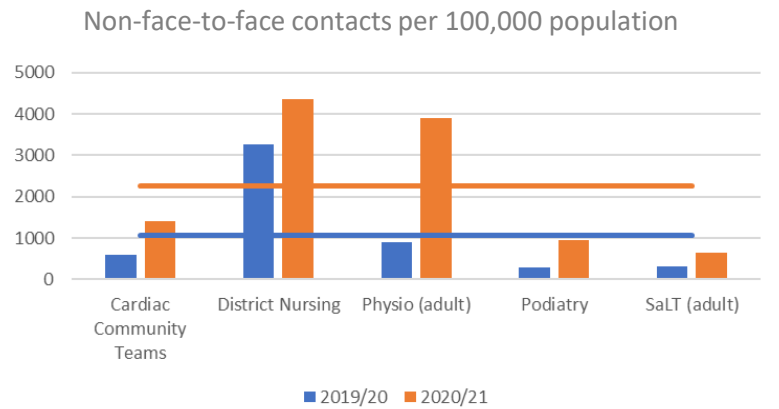
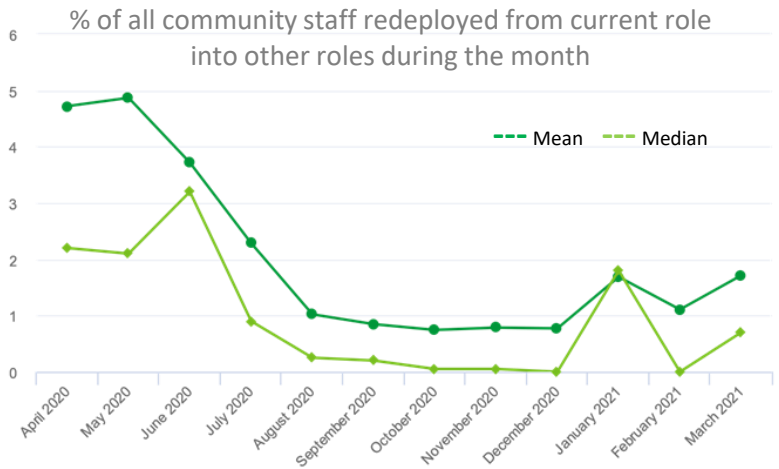
The bottom chart on the right shows the total number of referrals to all adult community services per 100,000 population, where low points are seen in April 2020, November 2020 and January 2021 in line with the three national lockdowns. Referrals have steadily increased since March 2021.



Section 1: Introduction

1.3 The impact of COVID-19 on community health services

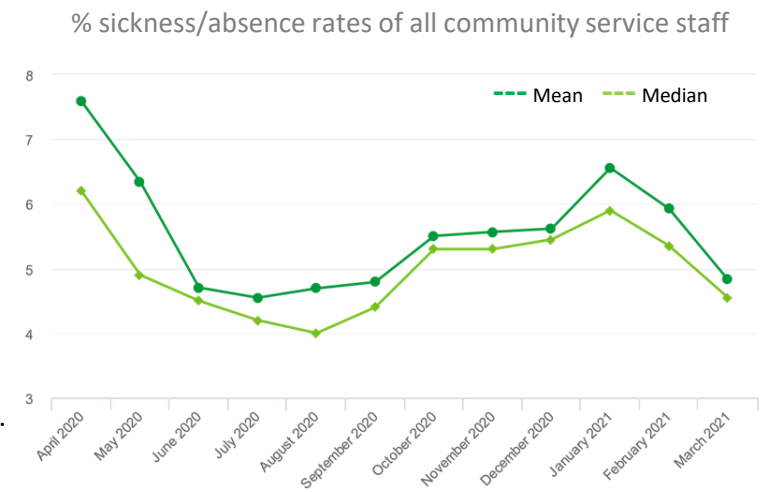
- Redeployment:** At the start of the pandemic, members reported via our monthly [COVID-19 dashboard](#), an average of 5% of staff having been redeployed, with one service reporting 21% in May 2020. Since August 2020, the mean average redeployment rate (dark green line) has remained between 0.7% - 1.7%.
- Remote delivery:** Adult and children’s community services have had to adapt how they deliver services, with many increasing their non-face-to-face provision. From a sample of adult services (cardiac teams, district nursing, physiotherapy, podiatry and SaLT) the average number of non-face-to-face contacts per 100,000 population in 2019/20 was 1,069 compared with 2,248 per 100,000 population in 2020/21, an increase of 110%.



- Face-to-face delivery:** On average, between April 2021 and September 2021, members, via the monthly Community Indicators Project, report 0.35% of service users on their caseloads having acute COVID-19, with a variation of 0% - 2.5% between services. During the same time period, total contacts with service users with acute COVID-19 reported by members is approximately 50 per 100,000, with variation between services ranging from 0 through to as high as 404 per 100,000. District nursing services report that 87% of contacts are seen face-to-face.

- Outbreaks:** Self-isolation is required if staff tested positive for COVID-19 and during 2020/21 if staff have been in contact with someone with COVID-19. Members reported sporadic incidents as well as outbreaks occurring, which made it a challenge to ensure services were adequately staffed.

The chart below shows the percentage sickness/absence rates of all community staff between April 2020 and March 2021. The high points in April, November and January correspond with the peaks in COVID-19 cases throughout the year.



Section 1: Introduction

1.3 The impact of COVID-19 on community health services

- **Using personal protective equipment (PPE):** Although PPE is essential to supporting staff safety, this didn't come without its challenges. Members reported issues around discomfort of equipment and time consumed donning equipment and subsequently disposing and cleaning of equipment.
- **Patient perceptions:** Some members reported reduced engagement from patients, including declining access to services. Reasons included anxiety due to levels of risk through to not wanting to complete isolation periods prior to appointments.
- **Wellbeing:** A number of members reported that challenges were experienced in keeping staff members calm, particularly if working in a high-risk environment. It is also reported that the pandemic has been challenging both physically and mentally and tested staff resilience.

Good practice

A range of good practice evolved in response to the pandemic, such as:

- **Integrated working:** Some members reported new opportunities to work in different ways, which resulted in establishing more holistic and streamlined services. Improvements included, increased access to IT hardware which meant that multiple agencies could work in a more agile way, increasing visibility which in turn improved working relationships. Some providers also reported improved relationships with third sector organisations.
- **Remote meetings/consultations:** With national lockdowns in place digital technology was adopted to interact with patient family members and other stakeholders. This agile approach helped with productivity/efficiency, allowed increased time to focus on care and saved travel time. Other benefits reported as a result of this includes senior management and clinicians spending less time in meetings and more time actively engaged in operational issues, particularly during times of increased pressure. Introduction of technology also enabled services to deliver self-help videos and to assess and triage patients via live video sessions or via photographs.
- **Service improvements/changes:** Members reported that the pandemic provided an opportunity to review how services were delivered and to make changes that have resulted in extended hours, increased capacity, less duplication and adoption of single points of access.
- **Infection prevention control (IPC) practice improvements:** IPC improvements have also been observed, both amongst staff and patients, making for a higher state of hygiene and cleanliness across sites.
- **Wellbeing:** Many members reported an increased focus on staff wellbeing during the pandemic including increased openness amongst staff at all levels.

Full details of good practice reported by members can be found in the good practice compendium within the summary findings on the [community services dashboard](#).

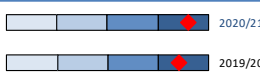
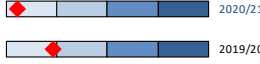
Section 1: Introduction

1.4 How to read this report

Key findings

The key findings table shows the 2020/21 value calculated for the highlighted submission against the sample mean position submitted for 2020/21 by participants in the 2021 cycle of the Community Services Project. Next to this are the values submitted for the previous iteration of the project.

The relative comparison shows where the highlighted submission lies within a range of values submitted by participants for 2020/21 and 2019/20. For each metric, two graduated blue bars are shown; the top bar represents the 2020/21 values and the bottom bar the 2019/20 values. The different blue graduation represents the four quartile ranges within the data responses. If a service provided data for this metric, this will be represented by a red marker. The median value is also shown.

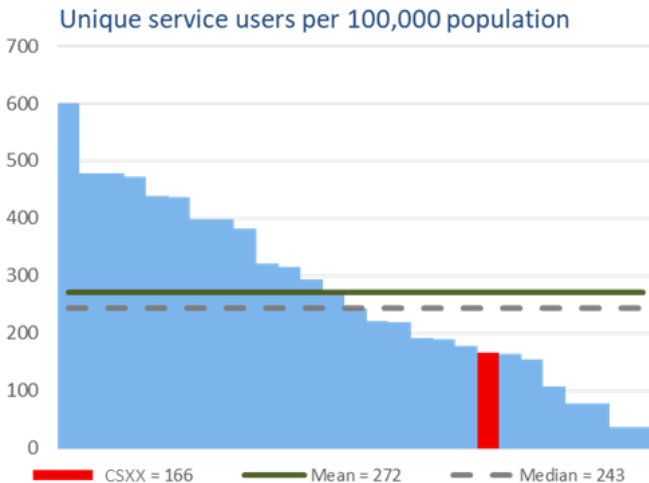
Summary metrics	2020/21		2019/20		Relative comparison Lowest Median Highest
	CSXX	Mean	CSXX	Mean	
Referrals per 100,000 population	454	275	527	152	
Referrals via e-triage	52%	84%	4%	5%	

Values to the right represent a higher value and to the left, a lower value. Values at either end of the blue bar represent the highest (right) or lowest (left) values in the group.

For example, the table above shows that the service submission CSXX received 454 referrals per 100,000 population in 2020/21, in comparison to the sample mean average of 275 per 100,000 population. The relative comparison chart shows that in both 2020/21 and 2019/20, CSXX sat in the fourth quartile.

Bar charts

Bar charts are a common way to display information. The 2020/21 data is sorted from highest on the left to lowest on the right. The highlighted organisation/submission's value will be highlighted with a red bar. The mean values for all submissions, and the median position, are shown as horizontal bars. The solid line indicates the mean value, and the dashed line indicates the median value. The blue graduated bars represent the service submissions respondents.

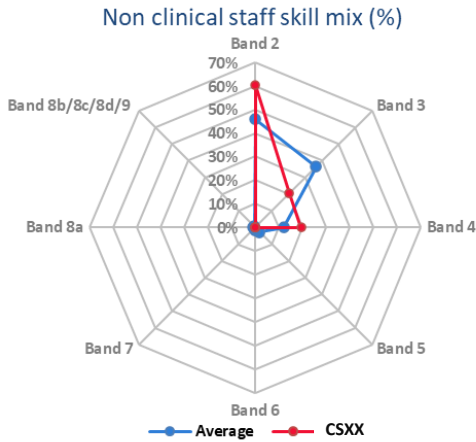


For example, the chart to the left shows the number of unique service users per 100,000 population within 2020/21. The sample average is 272 unique service users per 100,000 population. Submission CSXX sits below the sample mean average at 166. The chart shows a large degree of variation amongst services from 30 to 600 unique service users per 100,000 population.

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1.4 How to read this report

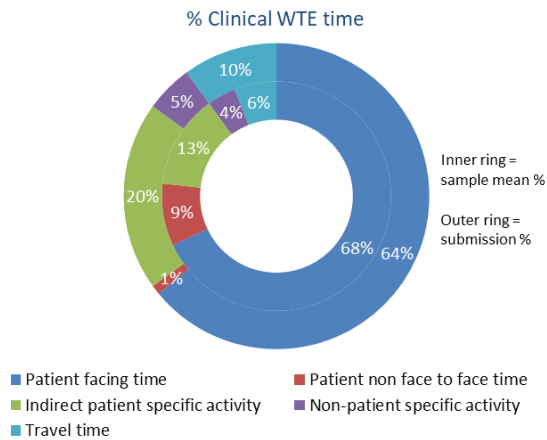
Radar charts



Radar charts are used to display the skill mix and discipline mix for each service. The red line shows the submission’s profile, and the blue line is the average from the group.

For example, the radar chart to the left shows that the sample mean average for non clinical staff skill mix is made up of mainly band 2 and 4 staff. Whilst 62% of the non clinical staff workforce are reported as band 2 staff and 20% band 4 staff by CSXX.

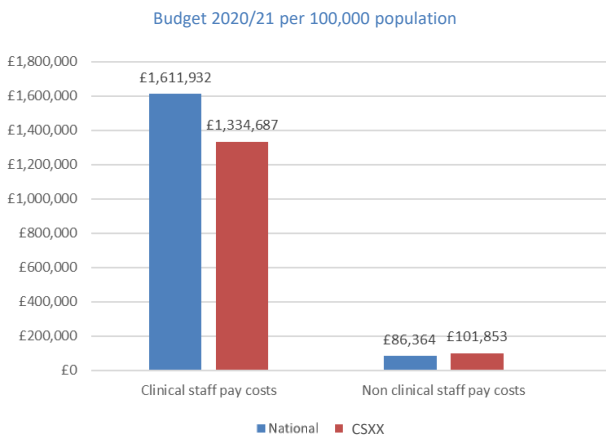
Donut charts



Donut charts are used to display the split of clinical time for each service. The donut chart shows the relative proportion of clinical time allocated to each area. The outer ring shows the submission’s profile, and the inner ring shows the sample mean position.

For example, the donut chart to the left shows that less clinical WTE time is spent patient facing (64%) by the service submission CSXX when compared to the sample average of 68%.

Column charts



Column charts are used to display the split of costs for each service. Blue bars reflect the sample average spent per 100,000 population. The red bars show the service position

For example, CSXX appears to spend less on clinical staff pay costs per 100,000 population in comparison to the sample average, whilst spending more on non clinical staff pay costs.

Section 2. Service findings

2.1 Cardiac community teams

National context

Cardiac community teams provide specialist services to those affected by heart and circulatory diseases, such as heart failure and post-myocardial infarction. They deliver nursing care, symptom management, cardiac rehabilitation, medication review and lifestyle advice. These teams are often multi-disciplinary teams, including specialist heart failure nurses, who mostly work within a patient's own home and in community clinics.

The aim of these community teams is to:

- Reduce hospital admissions and associated costs,
- Improve the quality of care, quality of life and patient experience and
- Support people to self-manage their condition.

Cardiovascular disease (CVD) is a priority area within the [NHS Long Term Plan \(LTP\)](#), which states *"...cardiovascular disease, causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. This is the single biggest area where the NHS can save lives over the next 10 years..."*. It details how *"Cardiac Rehabilitation is an intervention recommended by NICE which can save lives, improve quality of life and reduce hospital readmissions"*. The plan sets out a number of key actions around cardiovascular disease to support the aim of preventing up to 150,000 heart attacks, strokes, and dementia cases in England over the next 10 years, for cardiac rehabilitation these are to:

- Increase access and uptake of cardiac rehabilitation services from the reported rate of 52% to 85% by 2028
- Scale up and improve marketing of cardiac rehabilitation

In last year's report, we highlighted that, like other community services, COVID-19 had a large impact on cardiac teams with many nursing staff being redeployed; with the network's COVID-19 dashboard showing that 5% of community staff were redeployed from their current role to other roles in April 2020. As of March 2021 this rate had reduced to 2%.

The [British Heart Foundation National Audit of Cardiac Rehabilitation Quality and Outcomes Report 2020](#) highlights the wider impact of COVID-19, such as a significant drop in group-based exercise (-36%) and group-based education (-29%) with an increase (+16%) in Cardiac Rehabilitation staff supporting self-managed options. Additionally, there was a 40% reduction in hospital admissions for acute coronary syndrome, a 4% reduction in the number of people treated with surgery and a 1.4% drop in people with heart failure identified by cardiac rehabilitation teams in the first six months of the COVID-19 period.

Cardiac community teams will now face various challenges, including delivering services safely and encouraging continued uptake in an increased risk cohort who may express heightened levels of anxiety due to the ongoing pandemic. Our key findings for 2020/21 overleaf show that demand, caseload, length of contact and percentage of patient facing time have all reduced since 2019/20. However, the pandemic has also shown the feasibility of remote delivery and the potential for cardiac telerehabilitation. These new opportunities may be a key enabler for cardiac rehabilitation services to achieve and sustain the access and uptake rate of 85% of those eligible by 2028.

Section 2. Service findings

2.1 Cardiac community teams

Key findings

In the 2021 benchmarking cycle, 40 services supplied data for their cardiac community teams.



Access

Cardiac community teams deliver a range of services such as medication reviews (91%), education programmes (82%) and programmes of exercise (69%). Consistent with previous cycles of the benchmarking, cardiac community teams largely deliver services during the week only, with no services in 2020/21 reporting any weekend cover. These services are predominantly delivered in the service users own home or in clinics and health centres (reported by 97% of providers) with services also delivered within nursing and residential homes (83% and 86% of providers reported, respectively) amongst other locations.

Average waiting times into cardiac community teams were reported as 14 days in 2020/21, a reduction of 5 days from the 19 days reported in the 2019/20 data. Average DNA rates have reduced from 5% in 2019/20 to 3% in 2020/21.



Activity

In terms of demand placed upon the services, a 20% reduction has been observed from the 2019/20 total (343 per 100,000 population), with 275 referrals per 100,000 population reported in 2020/21. Services reported that on average, 82% of these referrals were accepted, assessed and seen by the service within 28 days, a 13% increase on 2019/20.

The 2021 cycle of benchmarking is the second year of reporting on referrals triaged via e-triage/virtually. In 2019/20, an average of 39% of referrals were e-triaged, however in 2021 this has risen to 84% of referrals being e-triaged. This is in line with the [guidance](#) issued in April 2020 which stated that, *“to minimise risk of [COVID-19] transmission, services should adopt virtual triage as default ...”*

Average caseload per clinical WTE in post was 60 in 2020/21, a reduction of 20 from the reported findings of the 2019/20 benchmarking (80). The average time on the caseload has also decreased from the 194 days in 2019/20 to 186 days in 2020/21; this is still higher than the 161 days reported in the 2018/19 findings.

The average length of a contact was 43 minutes in 2020/21, which is a decrease from the 55 minutes reported from the 2018/19 findings and 50 minutes observed in 2019/20.

On average, 39% of clinical time was reported as patient facing in 2020/21; this continues the decreasing trend observed in 2018/19 (57%) and 2019/20 (51%).

On average, service users have had 8 contacts for each episode of care in 2020/21. This is an increase of 2 contacts since last year’s reporting.

Section 2. Service findings

2.1 Cardiac community teams

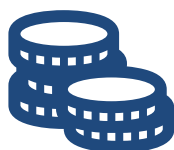
Key findings



Workforce

Discipline mix within cardiac community teams is reported to be 77% Nursing staff, with AHP (12%), non-clinical staff (10%) and medical staff (1%) accounting for the remaining 23%. This year's data shows changes in non-clinical staff, down from 14%, compared to the 2019/20 findings.

In terms of vacancy and sickness/absence rates, there have been some changes observed in 2020/21 compared with 2019/20 reporting. Clinical staff vacancies have halved from 8% in 2019/20 to 4% in 2020/21, and in non-clinical staff vacancies have increased from 3% in 2019/20 to 7% in 2020/21. Sickness absence was reported as 4% in 2020/21, which is 1% higher than what was observed in both 2019/20 and 2018/19.



Finance

Total pay cost in 2020/21 was £137k per 100,000 population (budget) against an actual spend of £130k per 100,000 population (spend). The use of bank and agency staff by cardiac community teams is relatively low compared to other community services. For 2020/21 agency and bank spend as a percentage of total pay budget was reported as 2%.



Quality and outcomes

Cardiac community teams report having a 96% average score for the Friends and Family Test in 2020/21 (99% in 2019/20).



Management of people living with frailty

Frailty metrics were introduced for the first time in 2020/21, with only 25% of cardiac community teams reporting that they routinely identify frailty using the Clinical Frailty Scale undertaken on admission to the service.



Learning disabilities

In 2019/20 cardiac community teams reported that 59% of services had a training/awareness programme for staff delivering care to patients with learning disabilities. In 2020/21, the average has increased and 75% of services now report having a training/awareness programme for staff delivering care to patients with learning disabilities.

Section 2. Service findings

2.1 Cardiac community teams

Key findings

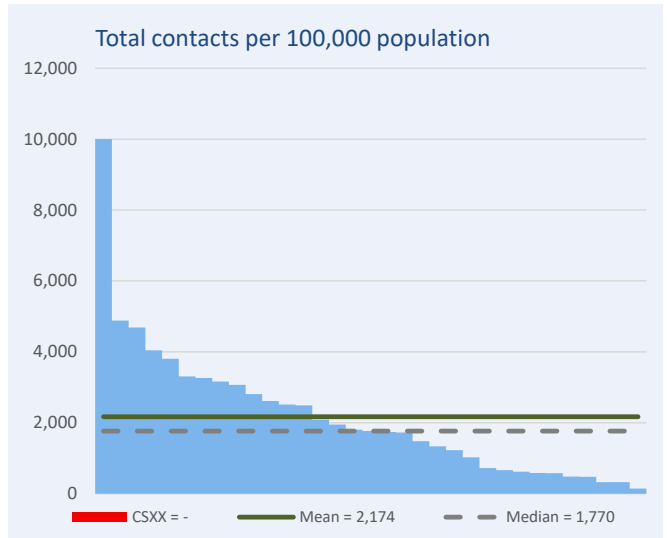
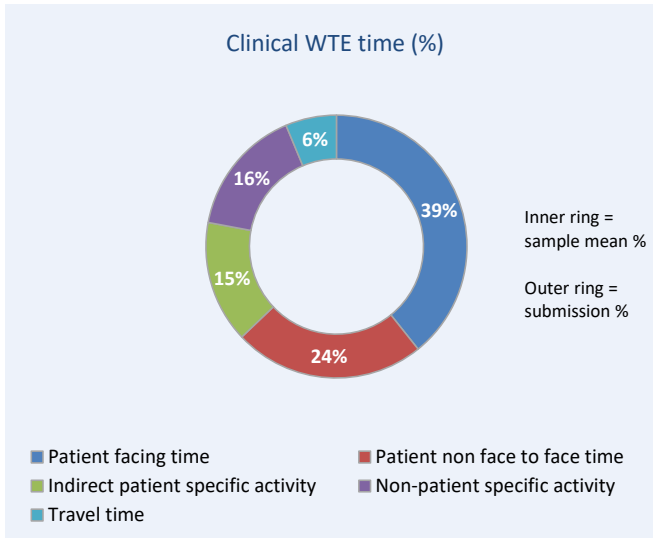
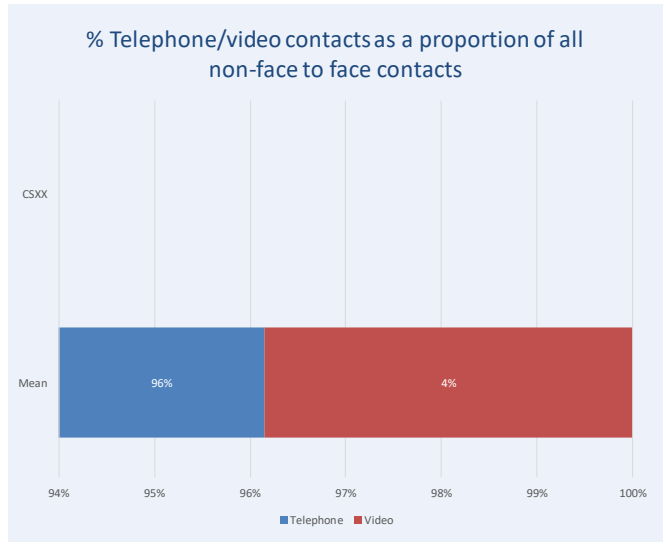
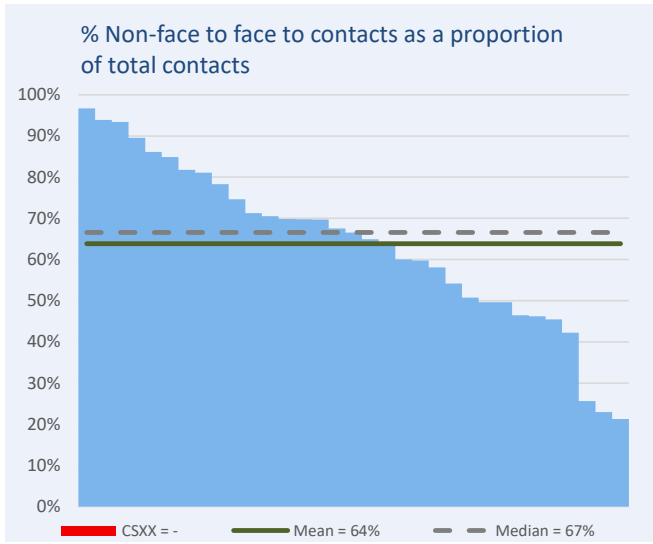
Summary metrics	2020/21		2019/20		Relative comparison		
	CSXX	Mean	CSXX	Mean	Lowest	Median	Highest
Referrals per 100,000 population	...	275	...	343			
Referrals via e-triage	...	84%	...	39%			
Average waiting time (days)	...	14	...	19			
F2F contacts per clinical WTE in establishment	...	380	...	736			
F2F contacts per service user	...	3	...	4			
Non F2F contacts per clinical WTE in establishment	...	631	...	348			
Non F2F contacts per service user	...	5	...	2			
Clinical WTE per 100,000 population	...	2	...	2			
Clinical staff vacancy rate	...	4%	...	8%			
Clinical staff pay budget per 100,000 population	...	£118,828	...	£99,430			
Total budget per 100,000 population	...	£186,763	...	£177,319			
Agency and bank spend as a % of total pay budget	...	2%	...	1%			
Friends and Family Test average score	...	96%	...	99%			



Section 2. Service findings

2.1 Cardiac community teams

Activity



Activity metrics	CSXX	Mean	Median
Average waiting time (days)	...	14	11
DNA rate	...	3%	2%
Referrals per 100,000 population	...	275	194
Referral acceptance rate	...	90%	94%
Referrals accepted, assessed & seen within 28 days of receipt	...	82%	89%
Referrals via e-triage	...	84%	98%
F2F contacts per 100,000 population	...	778	439
F2F contacts per clinical WTE in establishment	...	380	305

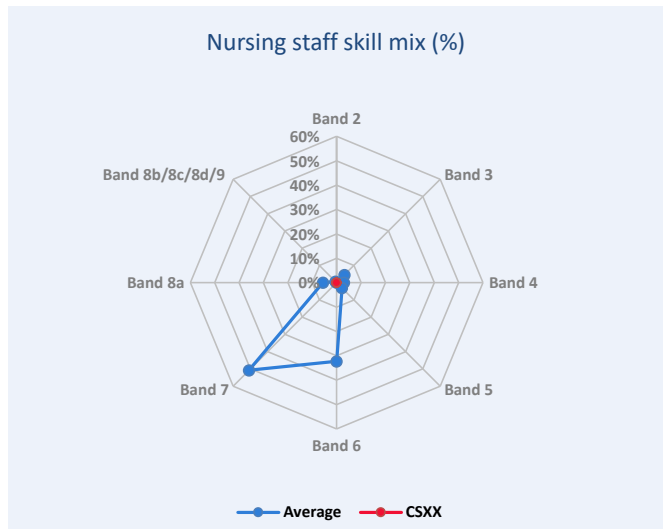
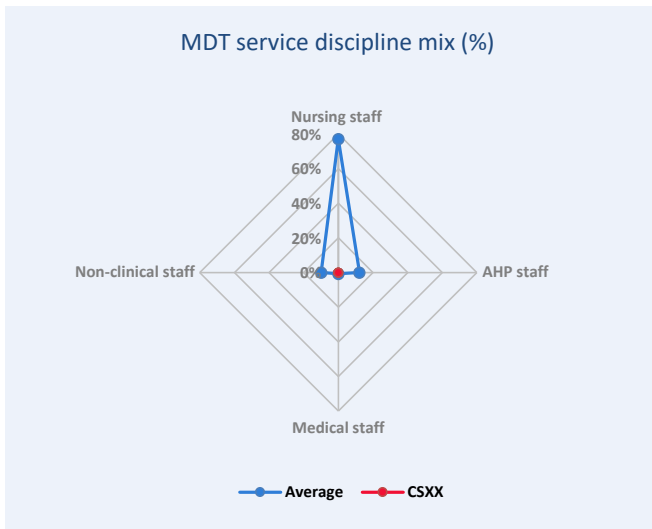
Activity metrics	CSXX	Mean	Median
F2F contacts per service user	...	3	2
Non F2F contacts per 100,000 population	...	1,407	1,082
Non F2F contacts per clinical WTE in establishment	...	631	592
Non F2F contacts per service user	...	5	5
Caseload per clinical WTE in establishment	...	60	56
Unique service users per clinical WTE in establishment	...	132	123
Unique service users per 100,000 population	...	275	233
Average length of a contact (minutes)	...	43	38



Section 2. Service findings

2.1 Cardiac community teams

Workforce



MDT service discipline mix	CSXX	Mean
Nursing staff	...	77%
AHP staff	...	12%
Medical staff	...	1%
Non-clinical staff	...	10%

Nursing staff skill mix	CSXX	Mean
Band 2	...	0%
Band 3	...	5%
Band 4	...	3%
Band 5	...	3%
Band 6	...	32%
Band 7	...	51%
Band 8a	...	6%
Band 8b/8c/8d/9	...	1%

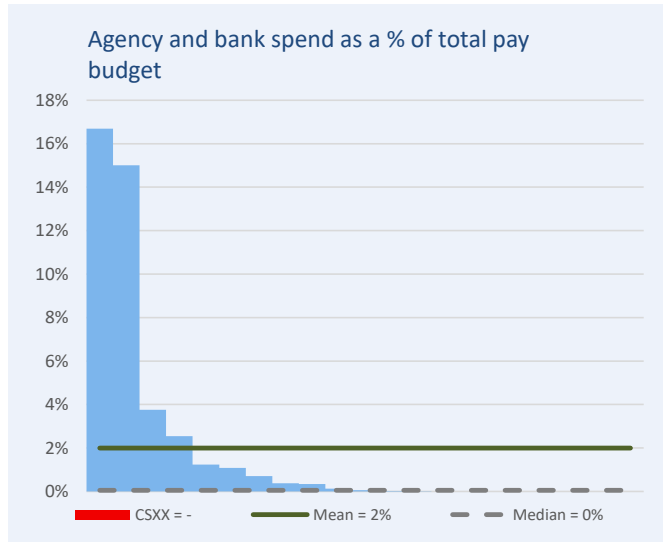
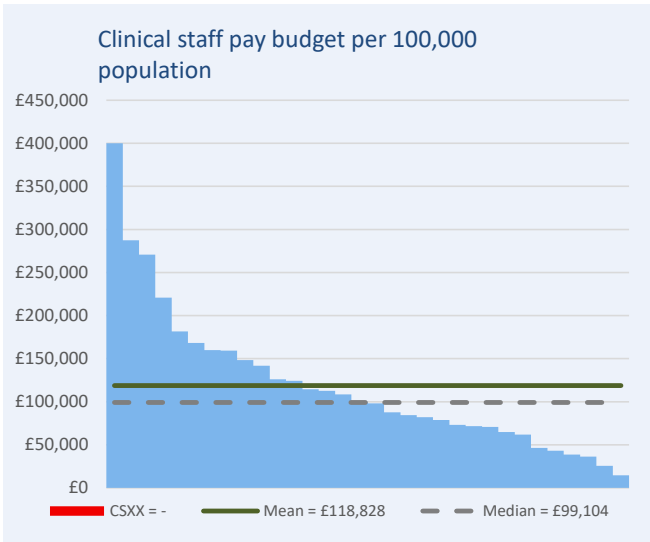
Workforce metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Clinical WTE per 100,000 population	...	2.4	2.0	1.2	3.4
Non clinical WTE per 100,000 population	...	0.4	0.2	0.1	0.3
Pay budget per clinical WTE	...	£52,836	£49,366	£45,918	£54,338
Pay budget per non clinical WTE	...	£35,265	£31,186	£24,866	£44,395
Clinical staff vacancy rate	...	4%	1%	0%	9%
Non clinical staff vacancy rate	...	7%	0%	0%	1%
Staff sickness	...	4%	3%	2%	6%
Staff turnover	...	10%	6%	0%	14%

Weekend staffing	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Staffing levels (WTE) as a % of weekday staffing	...	0.0%	0.0%	0.0%	0.0%
Hours of availability as a % of weekday availability	...	0.0%	0.0%	0.0%	0.0%

Section 2. Service findings

2.1 Cardiac community teams

Finance



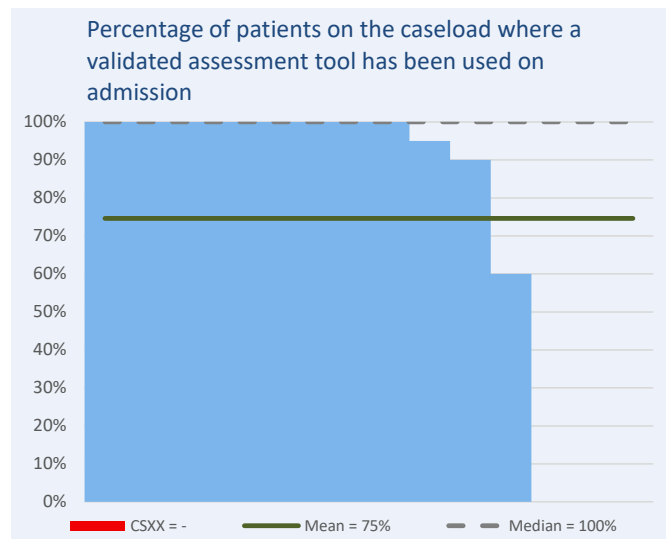
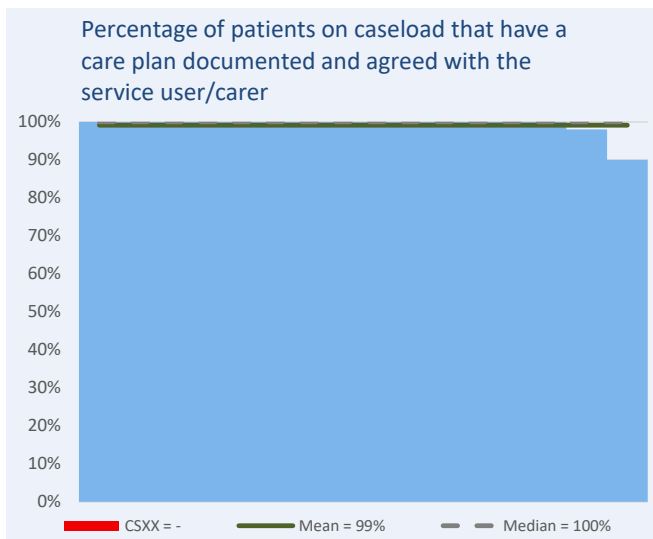
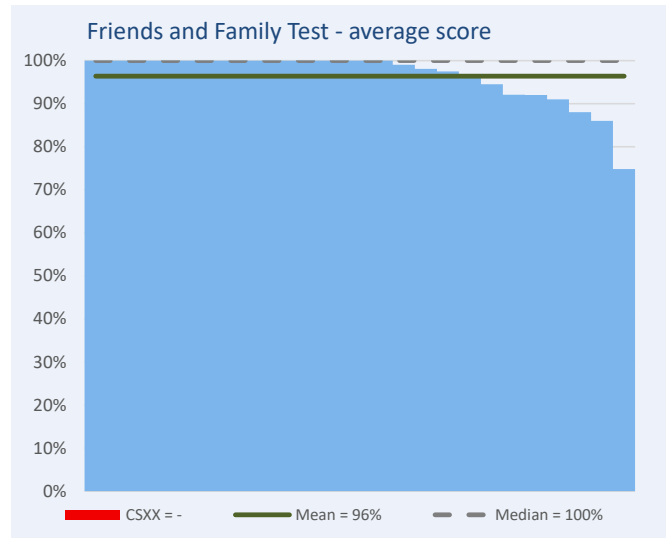
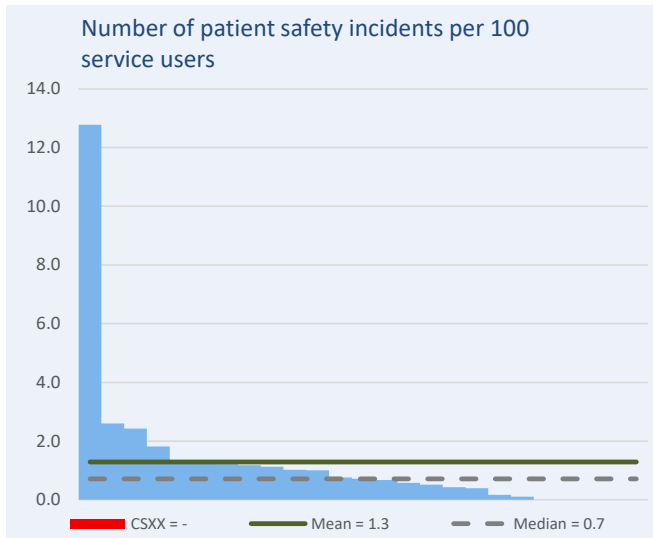
Finance metrics	CSXX			Mean		
	Budget 2020/21	Spend 2020/21	Budget 2021/22	Budget 2020/21	Spend 2020/21	Budget 2021/22
Clinical staff pay cost per 100,000 population	£118,828	£112,931	£119,680
Non clinical staff pay cost per 100,000 population	£13,571	£11,701	£14,151
Non pay cost per 100,000 population	£12,048	£11,356	£10,042
Indirect costs and overheads per 100,000 population	£51,602	£59,250	£51,446
Total cost per 100,000 population	£186,763	£202,059	£191,482
Total cost per service user	£720	£870	...
Agency cost as % of total pay costs	0.5%	0.4%	...
Bank cost as % of total pay costs	1.4%	1.6%	...



Section 2. Service findings

2.1 Cardiac community teams

Quality



Quality metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Number of patient safety incidents per 100 service users	...	1.3	0.7	0.2	1.2
Friends and Family Test results – average score	...	96%	100%	95%	100%
Percentage of patients on caseload that have a care plan documented and agreed with the service user/carer	...	99%	100%	100%	100%
Percentage of patients on the caseload where a validated assessment tool has been used on admission	...	75%	100%	68%	100%

Section 2. Service findings

2.2 Community/district nursing teams

National context

Community/district nurses continue to play a vital role in managing and leading care within the community by providing support to patients within or close to their homes. Every year, millions of people of all ages need professional nursing care. People today live longer, often with complicated health conditions. Community/district nursing teams play a key role in preventing hospital admissions, supporting the transfer of care out of acute hospitals, enabling quicker discharges. As well as providing care, their combination of expert leadership, fine-tuned clinical skills and in-depth knowledge enables them to support and educate patients on how to manage their long-term health conditions and maximise their independence.

[NICE guidelines](#) recommend that nurse-led support is provided in the community for people at increased risk of hospital admission or readmission. Condition-specific clinical knowledge, as well as knowledge of the individual patient, enables teams to provide personalised and effective care. It is also noted that community nurse-led care is cost effective compared to acute admission.

[The NHS Long Term Plan](#) outlines an ambition to increase the numbers of patients receiving community care, outside of an acute setting, to free-up acute bed capacity and reduce pressure on acute services. Additional investment for primary care and community services should contribute to the expansion of community multi-disciplinary teams aligned with primary care networks. Community/district nursing services will play a key role in delivering integrated community-based care.

Increasing pressures on the NHS workforce have resulted in increased vacancy rates across many services. The [Interim NHS People Plan](#) published in 2019 highlighted nursing as an area of concern with community nursing outlined as one area with significant shortages. This is backed up by [evidence](#) from The Queen's Nursing Institute (QNI) and the Royal College of Nursing (RCN) who estimate the number of district nurses has decreased by almost 43% in England in the last ten years.

Plans to tackle the nurse shortage are set out in the [People Plan 2020/21](#), which outlines how the pandemic has initiated an unprecedented interest in NHS careers, with a 138% increase in visitors looking for information on training to be a nurse between March and June 2020 on the Health Careers website. Nursing-related courses have also seen a 17% rise in applications. The People Plan 2020/21 also highlights the approach to encouraging former staff to return to the NHS, in addition to the introduction of a new health and care visa to encourage applications from overseas healthcare staff.

The Royal College of Nursing (RCN) finds that community nurses have a higher age profile than the nursing workforce in general, with 38% of nurses in the community being over 50, compared to 24% of the general nursing workforce, causing further strain on services as and when community nurses retire. The People Plan 2020/21 also aims to address this, with employers encouraged to do more to retain staff approaching retirement including conversations to discuss any adjustments that may be need to their role.

Community/district nursing teams have continued to deliver complex care within patients' homes throughout the pandemic, with many [reporting](#) that the demand for care has increased. Visits have now been extended to ensure enough time to provide enough psychological support to manage the impact of lockdown and resulting loneliness that patients have been feeling. Many patients have also been refusing admission because of concerns surrounding COVID-19 and are therefore choosing to be cared for at home, including those with acute and long-term conditions. This has resulted in an increase in workload for many community/district nurses.

Section 2. Service findings

2.2 Community/district nursing teams

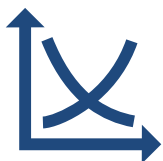
Key findings

In the 2021 benchmarking cycle, 66 services supplied data for their community/district nursing service.



Access

All community/district nursing service reported that they deliver care in a service user's own home. Most services (95%) also provide care in residential homes. 57% of services provide care in clinics and health centres and 55% in nursing homes.



Activity

The mean total number of referrals per 100,000 population has increased from 5,237 to 5,745 in 2020/21, suggesting that in line with the NHS Long Term Plan, more patients are being referred to community/district nursing services. The number of referrals accepted has also increased from 4,938 in 2019/20 to 5,352 in 2020/21. Of the services benchmarked in 2020/21, community/district nursing is the only service to report an average increase in referrals with all others reporting an average decrease.

This change is not seen on the caseload. The average number of users on the caseload has decreased from 32 per WTE to 29 per WTE. The caseload turnover has increased from 4.3 up to 5.4, suggesting that the decreased number of cases on the caseload could instead be due to individuals spending less time on the caseload. This is consistent with our average time on the caseload data which shows a decrease from 113 days in 2019/20 to 101 days in 2020/21.

The mean number of unique service users per 100,000 population has decreased slightly from 2,742 to 2,597, however the median has increased from 2,312 to 2,409. This suggests there has been an increase in caseload from services that have previously reported smaller caseloads.

The average length of a contact has increased from 26 minutes in 2019/20 to 28 minutes in 2020/21, and the average number of contacts per service user per year has increased from 22 to 25. Along with providing care for physical conditions, this allows more time to provide psychological support to manage the impact of lockdown and resulting loneliness that patients have been feeling, as outlined in a [report](#) on the impact of COVID-19 on community health services.



Workforce

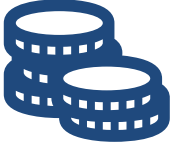
Staffing levels have remained close to constant at a position of 43 clinical WTE per 100,000 population for 2020/21. The clinical staff vacancy rate has remained constant at 10%. However the median clinical staff vacancy rate has increased by 1%, from 10% in 2019/20 to 11% in 2020/21. This suggests that as seen in the data, there are a greater number of services with a high staff vacancy rate that are experiencing increasing high level of pressure on community/district nursing teams. Spend on bank and agency staff, used to fill workforce vacancies, represent 6.3% and 4.3% of the pay budget respectively. This has decreased from the previous year.

Section 2. Service findings

2.2 Community/district nursing teams

Key findings

Finance



In line with the additional investment for community services outlined in the NHS Long Term Plan, community/district nursing services have seen a 6% increase in the mean total staff pay budget for 2020/21, which has increased from £1.7 million per 100,000 registered population in 2019/20, to £1.9 million. Interestingly, in this time the median total staff pay budget has also increased from £1.5 million per 100,000 population to £1.8 million. As the median is now the similar to the mean, it can be interpreted that the mean value is no longer pulled higher by a small number of services reporting very high budgets.

Quality and outcomes



Data on pressure ulcers are collected for community/district nursing services with reports for 2020/21 outlining a significant increase in both prevalence and incidence. Pressure ulcer prevalence refers to the proportion of patients with a pressure ulcer (of any origin, category 2-4) documented following skin inspection, which has risen from 5% in 2019/20 to 18% in 2020/21.

Pressure ulcer incidence refers to the proportion of patients with a new pressure ulcer (category 2-4) documented following skin inspection, developed post 72 hours of admission into the service. In 2020/21 incidence has risen to 24% from 3% in 2019/20.

The 2021 project included some additional measures around quality and outcomes. For 2020/21 community/district nursing teams reported that an average of 91% of patients on the caseload had a care plan documented and agreed. It was also reported that 99% of patients on the caseload had patient goals set, with 81% of those goals being fully met.

Management of people living with frailty



Frailty metrics were introduced for the first time in 2020/21, with only 29% of community/district nursing teams reporting that they routinely identify frailty using the Clinical Frailty Scale undertaken on admission to the service.

Learning disabilities


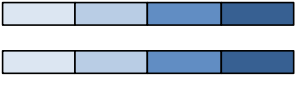

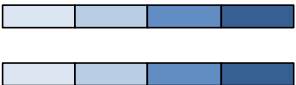
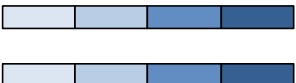
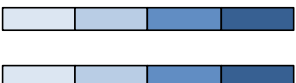
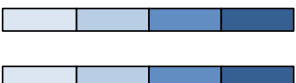
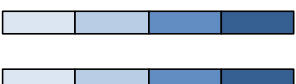
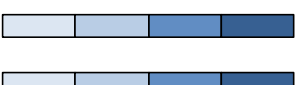
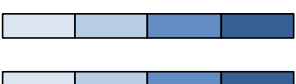
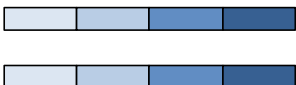
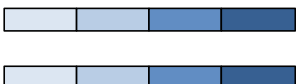
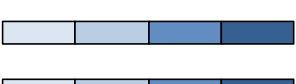


In 2019/20 community/district nursing teams reported that 62% of services had a training/awareness programme for staff delivering care to patients with learning disabilities. In 2020/21, the average is similar at 61% of staff.

Section 2. Service findings

2.2 Community/district nursing teams

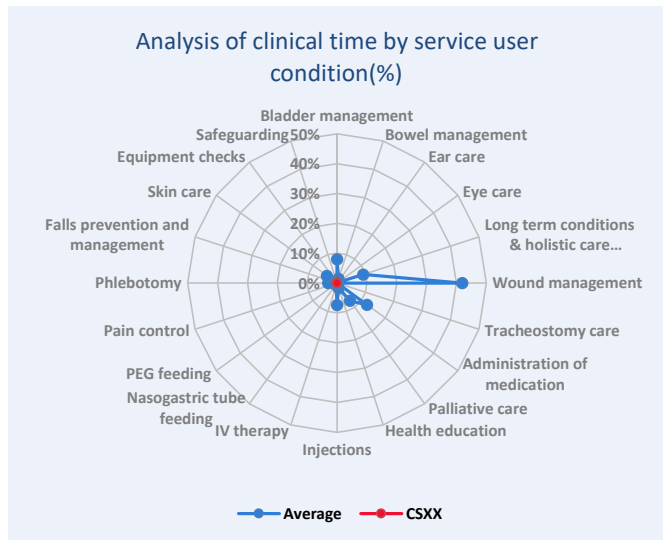
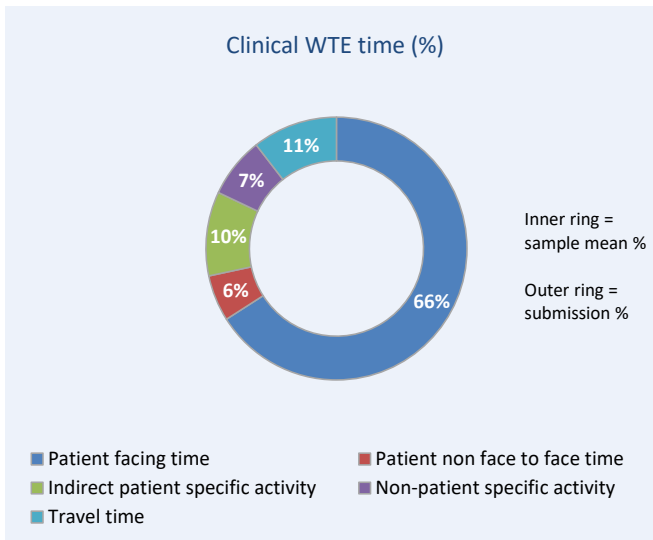
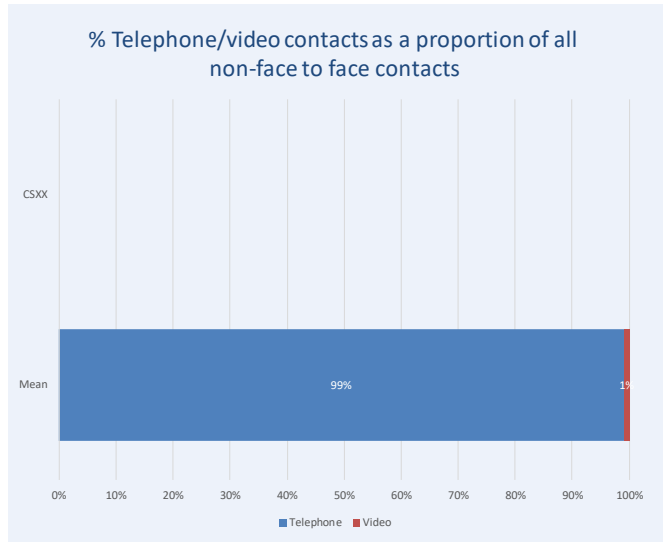
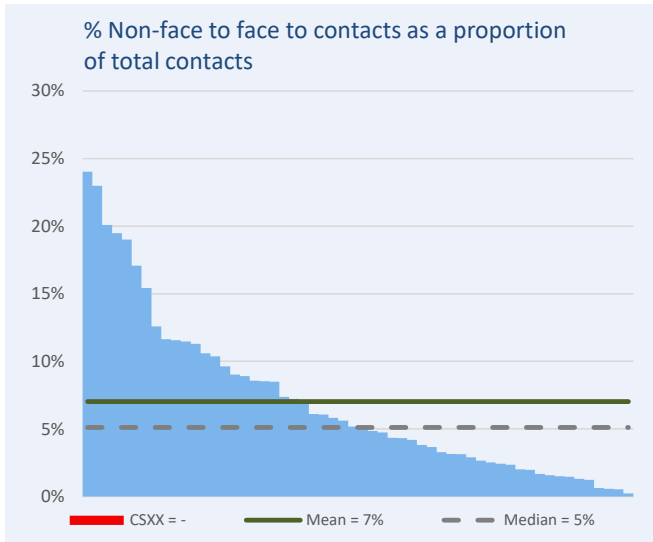
Key findings

Summary metrics	2020/21		2019/20		Relative comparison		
	CSXX	Mean	CSXX	Mean	Lowest	Median	Highest
Referrals per 100,000 population	...	5,745	...	5,237		2020/21	2019/20
Referrals via e-triage	...	34%	...	25%		2020/21	2019/20
Average waiting time (days)	...	6	...	6		2020/21	2019/20
F2F contacts per clinical WTE in establishment	...	1,369	...	1,410		2020/21	2019/20
F2F contacts per service user	...	23	...	22		2020/21	2019/20
Non F2F contacts per clinical WTE in establishment	...	93	...	80		2020/21	2019/20
Non F2F contacts per service user	...	2	...	1		2020/21	2019/20
Clinical WTE per 100,000 population	...	43	...	42		2020/21	2019/20
Clinical staff vacancy rate	...	10%	...	10%		2020/21	2019/20
Clinical staff pay budget per 100,000 population	...	£1,723,261	...	£1,611,932		2020/21	2019/20
Total budget per 100,000 population	...	£2,707,171	...	£2,561,729		2020/21	2019/20
Agency and bank spend as a % of total pay budget	...	11%	...	12%		2020/21	2019/20
Friends and Family Test average score	...	96%	...	96%		2020/21	2019/20

Section 2. Service findings

2.2 Community/district nursing teams

Activity



Activity metrics	CSXX	Mean	Median
Average waiting time (days)	...	6	4
DNA rate	...	1%	1%
Referrals per 100,000 population	...	5,745	4,942
Referral acceptance rate	...	92%	96%
Referrals accepted, assessed & seen within 28 days of receipt	...	88%	94%
Referrals via e-triage	...	34%	10%
F2F contacts per 100,000 population	...	56,140	54,723
F2F contacts per clinical WTE in establishment	...	1,369	1,345

Activity metrics	CSXX	Mean	Median
F2F contacts per service user	...	23	21
Non F2F contacts per 100,000 population	...	4,349	2,933
Non F2F contacts per clinical WTE in establishment	...	93	73
Non F2F contacts per service user	...	2	1
Caseload per clinical WTE in establishment	...	29	21
Unique service users per clinical WTE in establishment	...	65	64
Unique service users per 100,000 population	...	2,597	2,409
Average length of a contact (minutes)	...	28	28

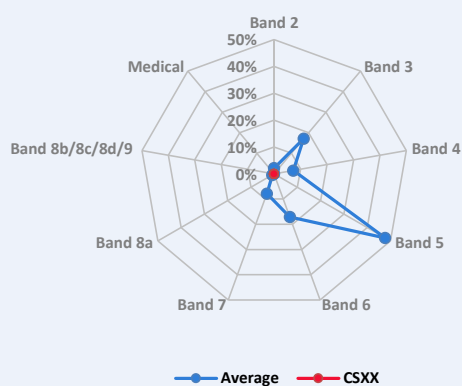


Section 2. Service findings

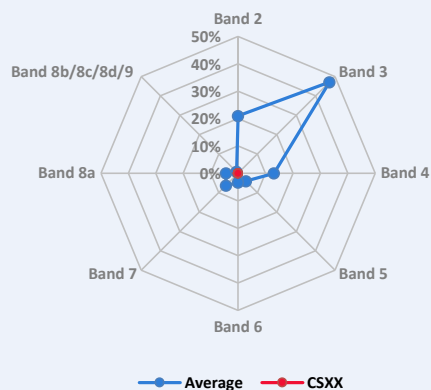
2.2 Community/district nursing teams

Workforce

Clinical staff skill mix (%)



Non clinical staff skill mix (%)



Clinical staff skill mix	CSXX	Mean
Band 2	...	2%
Band 3	...	17%
Band 4	...	7%
Band 5	...	48%
Band 6	...	17%
Band 7	...	8%
Band 8a	...	1%
Band 8b/8c/8d/9	...	0%
Medical	...	0%

Non clinical staff skill mix	CSXX	Mean
Band 2	...	21%
Band 3	...	47%
Band 4	...	13%
Band 5	...	4%
Band 6	...	3%
Band 7	...	6%
Band 8a	...	4%
Band 8b/8c/8d/9	...	1%

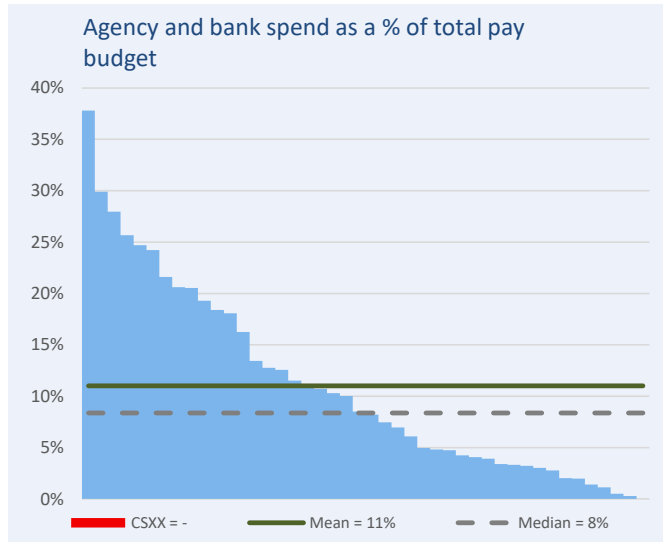
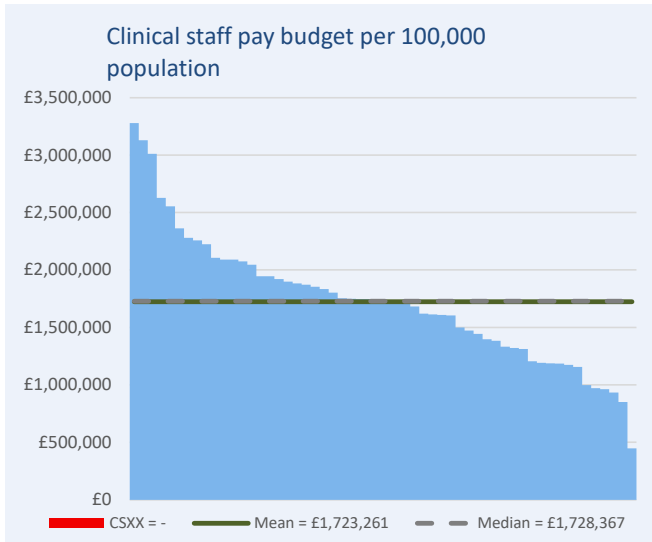
Workforce metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Clinical WTE per 100,000 population	...	42.5	41.8	35.3	51.3
Non clinical WTE per 100,000 population	...	3.7	3.0	2.3	4.4
Pay budget per clinical WTE	...	£41,754	£40,168	£37,702	£44,982
Pay budget per non clinical WTE	...	£30,266	£29,635	£25,480	£34,422
Clinical staff vacancy rate	...	10%	11%	3%	15%
Non clinical staff vacancy rate	...	10%	4%	0%	16%
Staff sickness	...	6%	6%	4%	8%
Staff turnover	...	12%	11%	8%	14%

Weekend staffing	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Weekend day staffing levels (WTE) as % of weekday WTE	...	45%	40%	33%	50%
Weekend evening staffing levels (WTE) as % of weekday WTE	...	93%	100%	100%	100%
Weekend night staffing levels (WTE) as % of weekday WTE	...	100%	100%	100%	100%

Section 2. Service findings

2.2 Community/district nursing teams

Finance



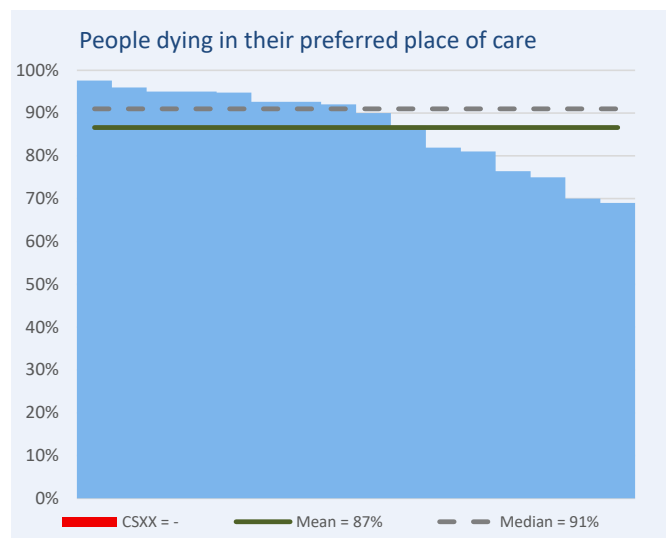
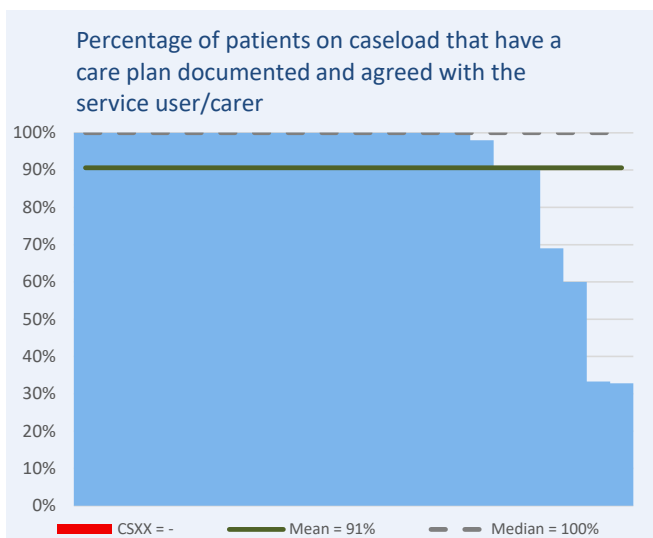
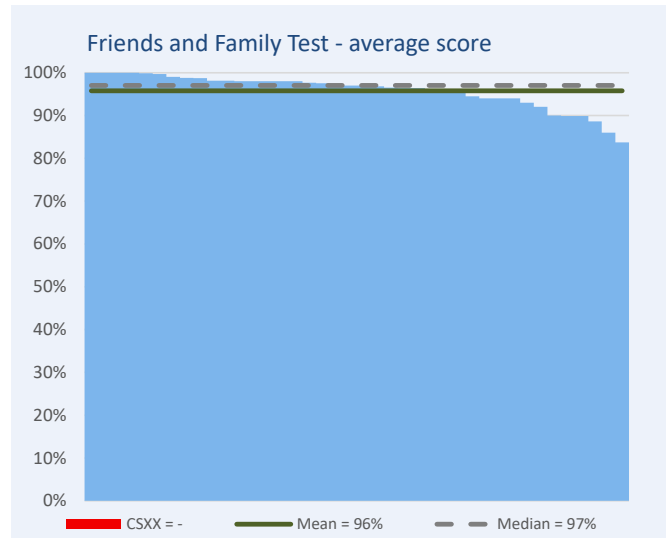
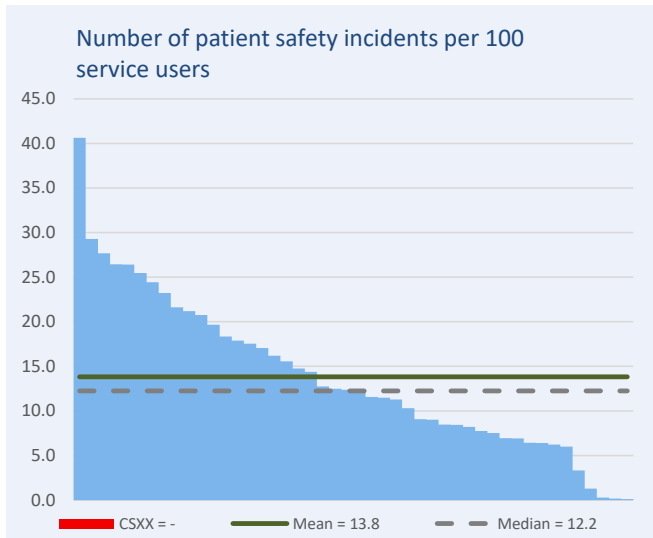
Finance metrics	CSXX			Mean		
	Budget 2020/21	Spend 2020/21	Budget 2021/22	Budget 2020/21	Spend 2020/21	Budget 2021/22
Clinical staff pay cost per 100,000 population	£1,723,261	£1,713,070	£1,768,477
Non clinical staff pay cost per 100,000 population	£107,276	£105,393	£115,285
Non pay cost per 100,000 population	£188,093	£177,392	£181,240
Indirect costs and overheads per 100,000 population	£638,810	£683,684	£642,854
Total cost per 100,000 population	£2,707,171	£2,685,274	£2,730,530
Total cost per service user	£1,208	£1,174	...
Agency cost as % of total pay costs	4%	4%	...
Bank cost as % of total pay costs	6%	6%	...



Section 2. Service findings

2.2 Community/district nursing teams

Quality



Quality metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Number of patient safety incidents per 100 service users	...	13.8	12.2	7.6	19.3
Friends and Family Test results – average score	...	96%	97%	94%	98%
Percentage of patients on caseload that have a care plan documented and agreed with the service user/carer	...	91%	100%	96%	100%
Percentage of patients on the caseload where a validated assessment tool has been used on admission	...	91%	100%	96%	100%
People dying in their preferred place of care	...	87%	91%	80%	95%
Number of SUIs per annum per 100 WTE staff	...	8.3	0.8	0.0	3.1
Number of pressure ulcers (grade 2,3 & 4) per 100 service users	...	3.9	3.2	2.1	5.0
Number of complaints per 100 WTE staff	...	6.5	4.0	2.2	8.7

Section 2. Service findings

2.3 Health visiting

National context

Health visiting services provide advice, support and interventions to facilitate families with children to lead healthy lifestyles to prevent illness. Health visitors are registered nurses/midwives who have additional training in community public health nursing. They help to guide families to make decisions that affect their health and wellbeing to give pre-school-age children the best possible start in life, working mainly with children and their families for the first five years of life. They also work with at-risk or deprived groups such as the homeless, addicts or travellers.

The [Health Visiting and School Nursing Programme](#) sets out the recommended pathway to improve outcomes for children and families, based around four areas of provision:

- **Your community** - a range of health services, including some children’s centres and the service families and communities provide for themselves. Health visiting services work to develop these and make sure families know about them.
- **Universal services** – provision of the Healthy Child Programme, including the five mandated visits (28 weeks pregnant, 14 days after birth, 8 weeks after birth, 12 months, and 2.5 years) to examine development and needs in young children.
- **Universal plus** - delivers a rapid response from the health visiting team when specific expert help is needed, e.g. with parental mental health, attachment, toilet training, behaviour management, domestic violence.
- **Universal partnership plus** - ongoing support from the health visiting team, bringing together a range of local services, to help families who have complex additional needs.

[The NHS Long Term Plan](#) for England offers a commitment to redesign services for children and young people, through the creation of a Children and Young People’s Transformation Programme. This focuses on delivering improvements in key health outcomes, including infant mortality, breastfeeding, obesity, and uptake of childhood immunisations. The funding of these services is also outlined in the Long Term Plan, where local authorities have become responsible for commissioning and funding preventative health services, including health visiting services.

Health visitors lead the delivery of the [Healthy Child Programme](#), a universal prevention, health promotion and early intervention programme available to all families. In March 2021 Public Health England published new guidance, [Best Start in Life and Beyond: Improving public health outcomes for children, young people and families](#). The guidance was published to aid local authorities in the commissioning of both health visiting and school nursing services to support the delivery of services for children aged 0 to 19. Ensuring every child has the best start in life is one of Public Health England’s key priorities and ‘Best Start in Life’ has been identified as a priority within Public Health England’s 5-year strategy, which runs from 2020 to 2025. Some of the main updates in the guidance were the inclusion of two new additional universal contacts (one at 3-4 months and one at 6 months), changes to the language of the “4,5,6 model”, an increased emphasis on personalised care and increased scope for emotional health and wellbeing assessments (including mothers, fathers and babies).

Section 2. Service findings

2.3 Health visiting

Key findings

In the 2021 benchmarking cycle, 44 services supplied data for their health visiting service.



Access

In 2020/21 all services were delivered in the service user's own home (community domiciliary) with 98% and 95% of services reporting that their services were also located in clinics & health centres and in children's centres, respectively. 100% of services reported that in addition to universal provision they also provide universal plus provision, 98% reported providing the universal partnership plus provision and 49% reported that they provide other services (not specified).

It has been reported that health visitors are mainly available during the week, averaging 8 hours availability on weekdays, with only 4 services offering some availability on weekends. This is highly consistent with previous project cycles.

Average DNA rates for health visiting were reported as 8% which is a slight decrease from those reported in 2019/20 (9%) but still higher than the 2018/19 cycle (7%).



Activity

Demand for health visiting services can be measured by the number of referrals received. In 2019/20 there was an average of 3,099 referrals per 100,000 population, in 2020/21 the average sat slightly lower, at 2,910 referrals per 100,00 population. On average, health visiting services received 2,735 universal provision referrals per 100,000 population and 474 other provision referrals in 2020/21. Of the total referrals received, 72% were accepted, assessed, and seen within 28 days of receipt of the referral.

The average caseload per clinical WTE in establishment decreased again this year from 408 in 2019/20 to 392 (2020/21), the 4% decrease here mirrors the 4% decrease in live births between 2019 and 2020. There was a large decrease reported in the average time on the caseload, with an average of 879 days in 2020/21 compared to 1,135 days in 2019/20. The average length of contact reported in 2020/21 was 45 minutes, slightly higher than the 38 minutes reported in 2019/20. On average, service users can expect 3 contacts each year which is inline with the mandated visits required.

Health visiting services reported that 74% of first mandated visits were carried out in the designated time period, an increase from the 67% that was reported in 2019/20. Out of these first visits, 97% were carried out by a registered health visitor. 89% of second mandated visits were carried out in the designated time period, with 94% of these visits being carried out by a registered health visitor.

Services reported that 70% of fifth mandated visits were carried out within 2.5 years, a decrease from the 81% reported in 2019/20. 55% of these visits were carried out by a registered health visitor, a slight decrease from the 59% reported in the previous year (2019/20).

Section 2. Service findings

2.3 Health visiting

Key findings

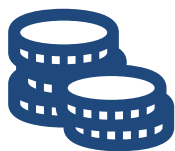


Workforce

In 2020/21 members reported a reduction in the average clinical WTE in establishment per 100,000 population, which has fallen to 22 from 24 in 2019/20.

Clinical staff mix is amongst several workforce metrics the project collects. This year it was reported on average that 21% of the clinical workforce were band 4 and 55% were band 6. This has shifted slightly from 2019/20, where 19% of the clinical workforce were reported as band 4 and 57% band 6.

Both clinical and non-clinical vacancy rates are collected for each participating service. In 2020/21 12% was the average rate reported for clinical staff vacancies, which is an increase from 8% in 2019/20. The non-clinical staff vacancy rate was reported as 18% (12% in 2019/20). Non-clinical staff vacancy rates are often higher than clinical staff rates due to the teams generally being smaller in size. The average sickness rate for Health Visiting Services was reported as 4% in 2020/21, a slight decrease from the year prior (5%).



Finance

Total pay cost budget in 2020/21 remained the same as the previous year at £1.1 million per 100,000 population, this is against an actual spend of £1 million per 100,000 population (a decrease from £1.1 million per 100,000 population in 2019/20). The average spend for agency and bank staff was 4% of the total pay budget in 2020/21, the same as 2019/20.



Quality and outcomes

Health visiting services reported a 94% average score for the Friend and Family Test in 2020/21 a slight decrease when compared to the 96% reported in 2019/20.

The average reported breast feeding rate at 6-8 weeks post birth has increased from 51% in 2019/20 to 58% in 2020/21.

The percentage of children achieving a good level of development at 2 to 2½ years and the percentage of children who received a 2 to 2½ year review in the period for whom the ASQ-3 (Ages and Stages questionnaire) is completed as part of their review, are a selection of some of the new quality metrics introduced to the project this year. It was reported that on average 81% of children achieved a good level of development at 2 to 2½ years and 87% received a 2 to 2½ year review in the period for whom the ASQ-3 is completed.



Learning disabilities

64% of services reported that they have a training/awareness programme for staff on delivering care to patients with learning disabilities, this is a decrease from the 71% reported in the 2019/20 project cycle.

Section 2. Service findings

2.3 Health visiting

Key findings

Summary metrics	2020/21		2019/20		Relative comparison		
	CSXX	Mean	CSXX	Mean	Lowest	Median	Highest
Referrals per 100,000 population	...	2,910	...	3,099			
Referrals via e-triage	...	33%	...	10%			
Referral acceptance rate %	...	96%	...	96%			
F2F contacts per clinical WTE in establishment	...	316	...	642			
F2F contacts per service user	...	2	...	2			
Non F2F contacts per clinical WTE in establishment	...	544	...	113			
Non F2F contacts per service user	...	1.7	...	0.4			
Clinical WTE per 100,000 population	...	22	...	24			
Clinical staff vacancy rate	...	12%	...	8%			
Clinical staff pay budget per 100,000 population	...	£984,655	...	£1,024,479			
Total budget per 100,000 population	...	£1,585,377	...	£1,575,433			
Agency and bank spend as a % of total pay budget	...	4%	...	4%			
Friends and Family Test average score	...	94%	...	96%			

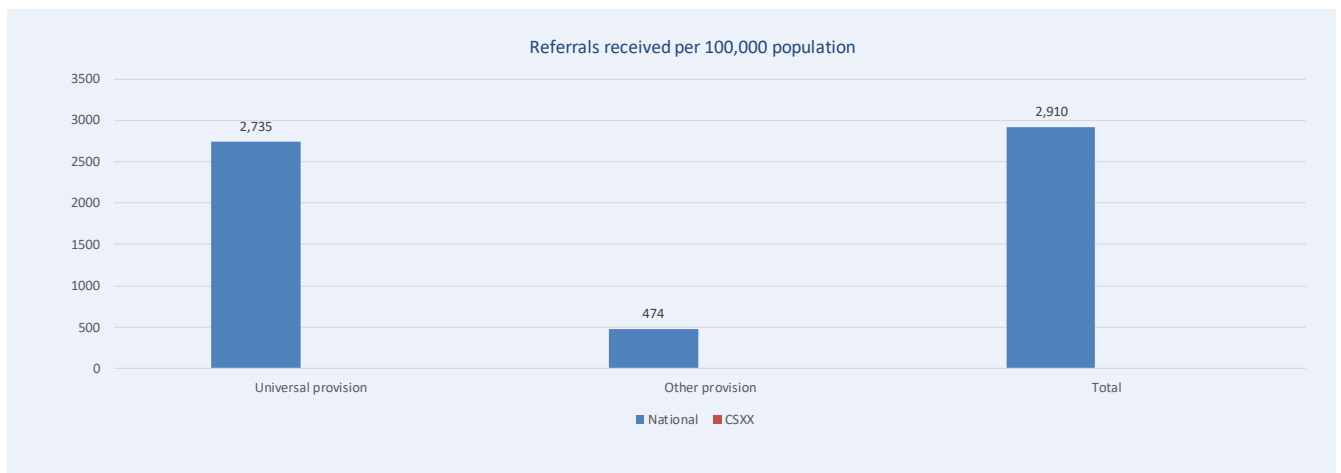


Section 2. Service findings

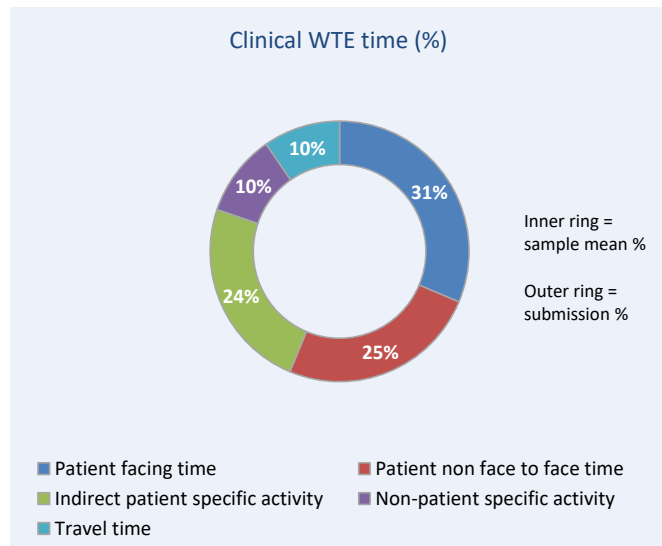
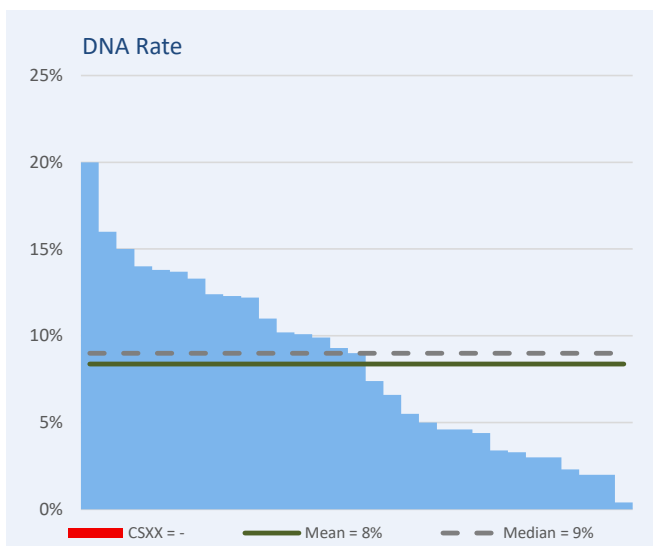
2.3 Health visiting

Activity

Referrals	Universal provision		Other provision		Total	
	CSXX	Mean	CSXX	Mean	CSXX	Mean
Referral acceptance rate	...	95%	...	94%	...	96%
Referrals accepted, assessed & seen within 28 days of receipt	...	68%	...	63%	...	72%
Referrals via e-triage	...	39%	...	43%	...	33%



Caseload	Universal provision		Other provision		Total	
	CSXX	Mean	CSXX	Mean	CSXX	Mean
Caseload per clinical WTE in establishment	...	362	...	46	...	392
Unique service users per clinical WTE in establishment	...	228	...	34	...	249
Unique service users per 100,000 population	...	5,250	...	728	...	5,641

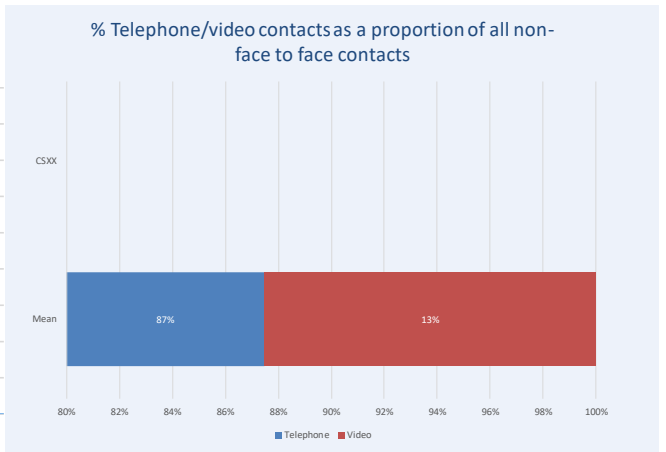
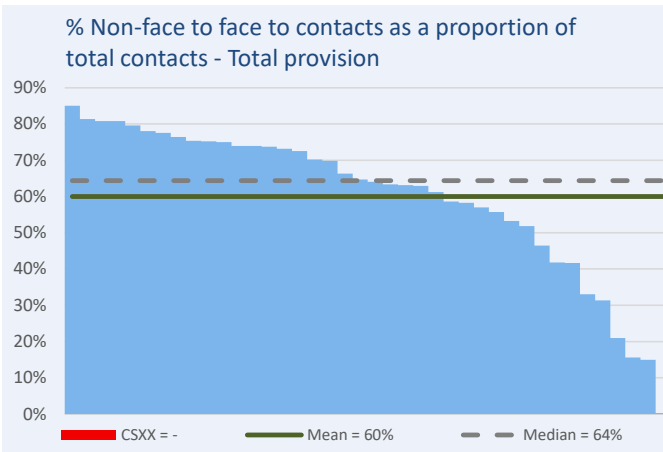


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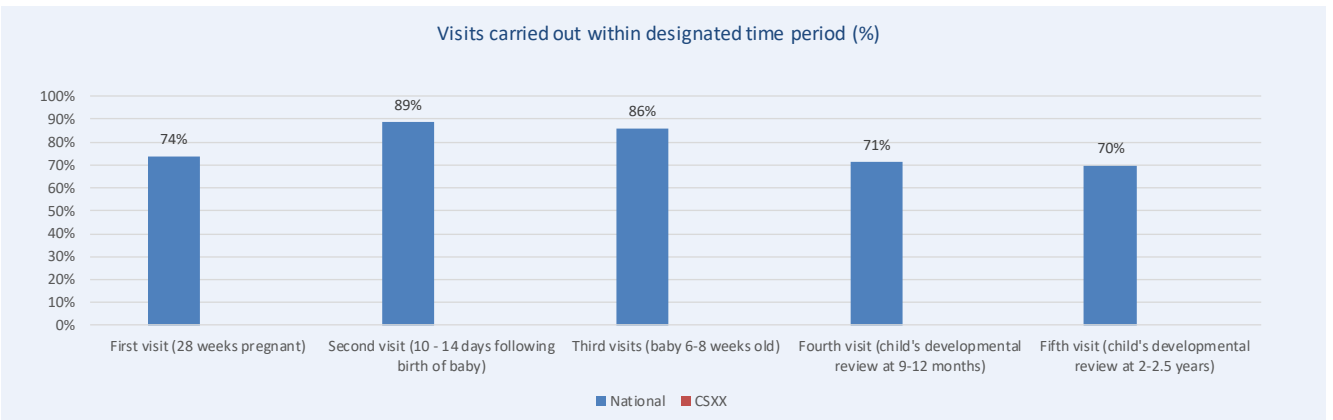
2.3 Health visiting

Activity

Contacts	Universal provision		Other provision		Total	
	CSXX	Mean	CSXX	Mean	CSXX	Mean
F2F contacts per 100,000 population	...	7,125	...	1,562	...	6,904
F2F contacts per clinical WTE in establishment	...	297	...	65	...	316
Average length of a contact (minutes)	...	46	...	49	...	45
Non F2F contacts per 100,000 population	...	7,845	...	2,419	...	10,243
Non F2F contacts per clinical WTE in establishment	...	335	...	98	...	544



Visits	Face to face contacts per 100k population			Non face to face contacts per 100k population		
	CSXX	Mean	Median	CSXX	Mean	Median
First visit (28 weeks pregnant)	...	202	93	...	241	168
Second visit (10 - 14 days following birth of baby)	...	757	613	...	530	455
Third visit (baby 6 - 8 weeks old)	...	616	408	...	605	644
Fourth visit (child's developmental review at 9 - 12 months)	...	491	306	...	614	617
Fifth visit (child's developmental review at 2 - 2.5 years)	...	540	311	...	585	527

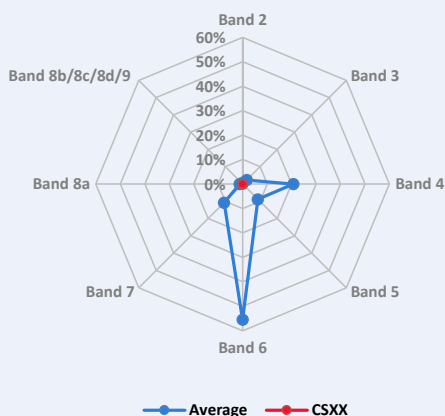


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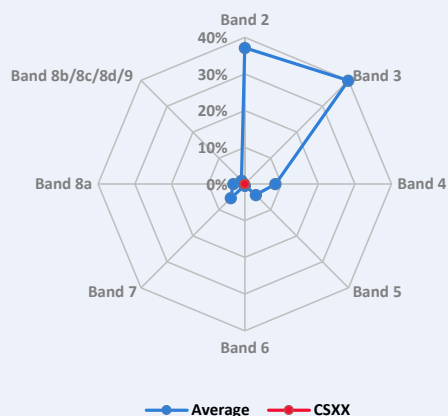
2.3 Health visiting

Workforce

Clinical staff skill mix (%)



Non clinical staff skill mix (%)



Clinical staff skill mix	CSXX	Mean	Non clinical staff skill mix	CSXX	Mean
Band 2	...	1%	Band 2	...	37%
Band 3	...	2%	Band 3	...	40%
Band 4	...	21%	Band 4	...	8%
Band 5	...	9%	Band 5	...	4%
Band 6	...	55%	Band 6	...	0%
Band 7	...	11%	Band 7	...	5%
Band 8a	...	1%	Band 8a	...	3%
Band 8b/8c/8d/9	...	0%	Band 8b/8c/8d/9	...	1%

Workforce metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Clinical WTE per 100,000 population	...	22.2	20.9	18.1	25.4
Non clinical WTE per 100,000 population	...	3.4	3.2	2.2	4.0
Pay budget per clinical WTE	...	£46,778	£44,402	£41,319	£51,325
Pay budget per non clinical WTE	...	£35,875	£26,314	£22,555	£37,234
Clinical staff vacancy rate	...	12%	9%	5%	14%
Non clinical staff vacancy rate	...	18%	8%	0%	26%
Staff sickness	...	4%	4%	3%	5%
Staff turnover	...	11%	11%	8%	13%

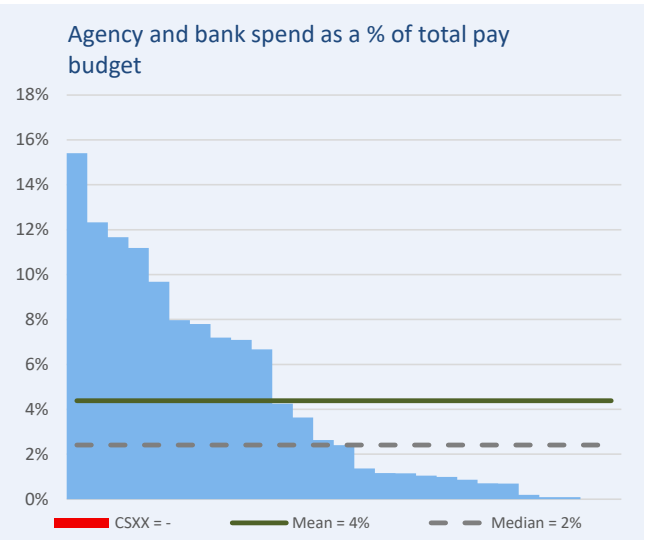
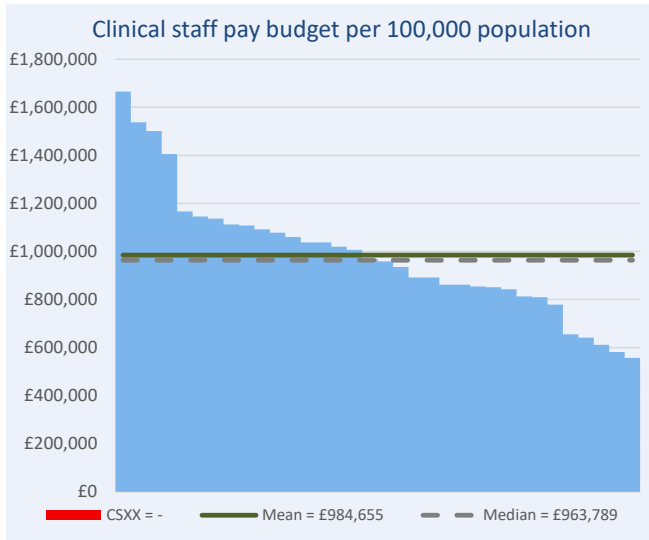
Weekend staffing	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Staffing levels (WTE) as a % of weekday staffing	...	0.1%	0.0%	0.0%	0.0%
Hours of availability as a % of weekday availability	...	9.7%	0.0%	0.0%	0.0%



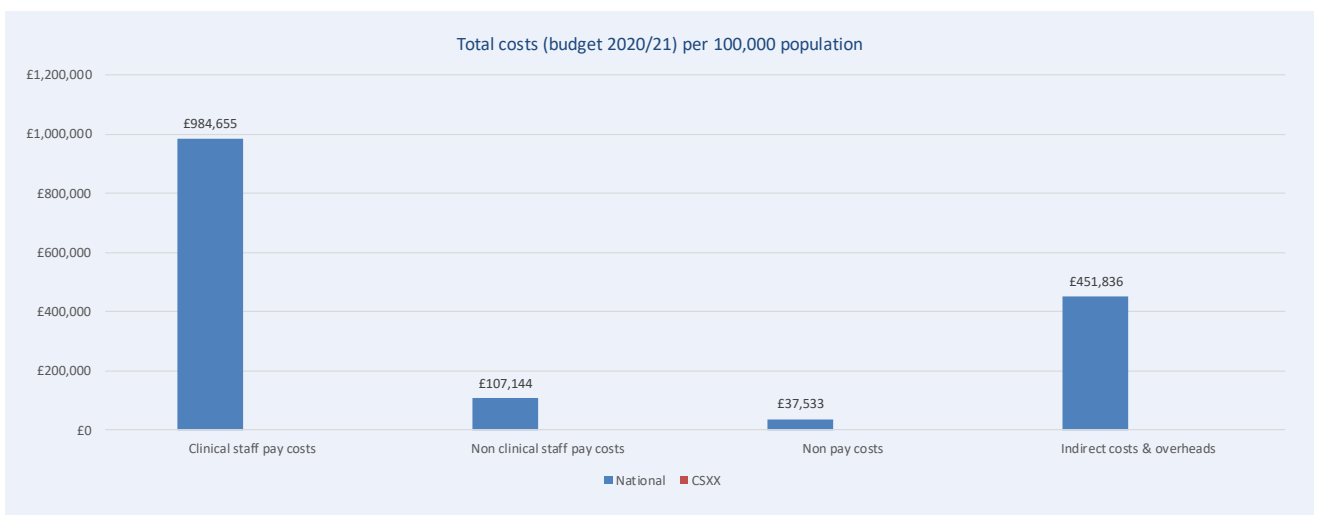
Section 2. Service findings

2.3 Health visiting

Finance



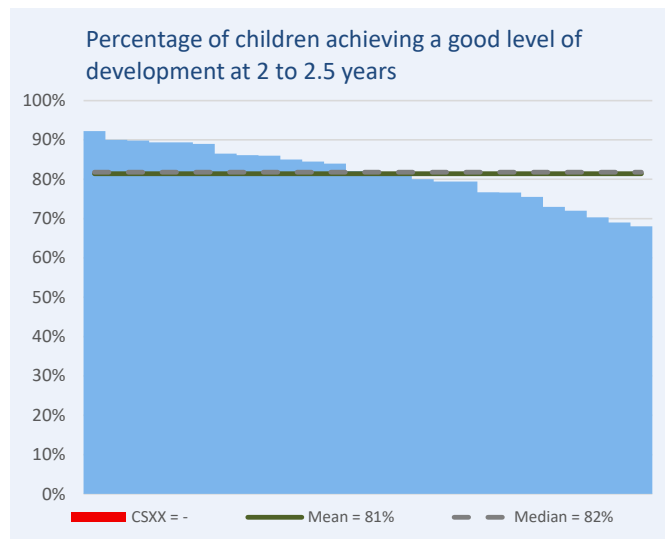
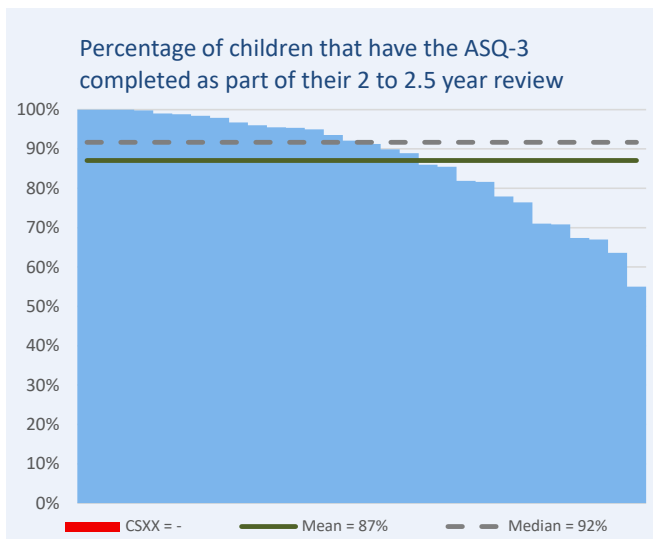
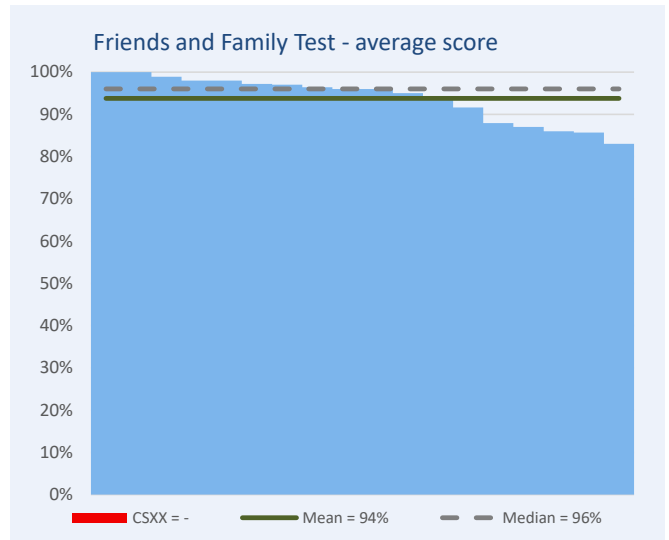
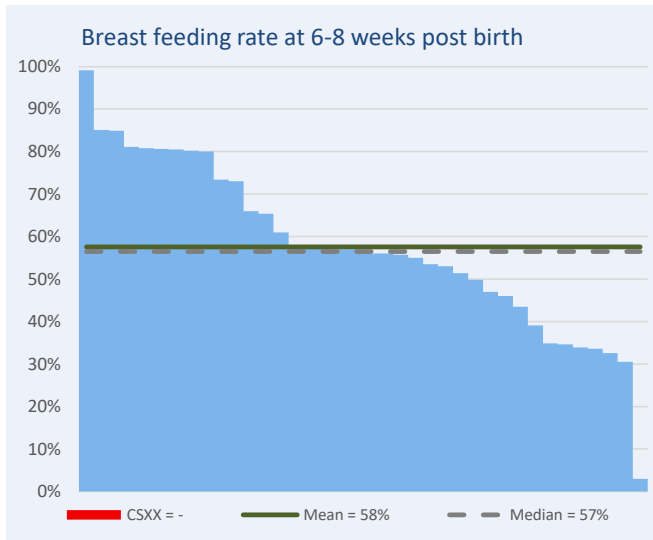
Finance metrics	CSXX			Mean		
	Budget 2020/21	Spend 2020/21	Budget 2021/22	Budget 2020/21	Spend 2020/21	Budget 2021/22
Clinical staff pay cost per 100,000 population	£984,655	£912,937	£970,795
Non clinical staff pay cost per 100,000 population	£107,144	£95,016	£102,988
Non pay cost per 100,000 population	£37,533	£34,027	£36,757
Indirect costs and overheads per 100,000 population	£451,836	£463,319	£416,188
Total cost per 100,000 population	£1,585,377	£1,488,542	£1,507,439
Total cost per service user	£277	£281	...
Agency cost as % of total pay costs	2.0%	2.4%	...
Bank cost as % of total pay costs	2.2%	2.4%	...



Section 2. Service findings

2.3 Health visiting

Quality



Quality metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Breast feeding rate at 6-8 weeks post birth	...	58%	57%	46%	73%
Friends and Family Test results – average score	...	94%	96%	89%	98%
Percentage of children that have the ASQ-3 completed as part of their 2 to 2.5 year review	...	87%	92%	79%	98%
Percentage of children achieving a good level of development at 2 to 2.5 years	...	81%	82%	77%	86%

Section 2. Service findings

2.4 Physiotherapy - adult

National context

Physiotherapy services aim to restore movement, function and improve wellbeing for service users affected by injury, illness or disability. Another key focus of these services is giving service users the knowledge and tools to prevent future injury or illness. Services are provided by physiotherapists who have a wide ranging skill set, enabling them to treat many different health conditions, including problems affecting the musculoskeletal (MSK), nervous, cardiovascular and respiratory systems.

Physiotherapy provided in the community is a key part of improving care and rehabilitation for people living with long term health conditions, and for residents in care homes. Physiotherapy can be provided to people of all ages, however only adult physiotherapy service data was collected in the 2021 cycle of the Community Services Project.

[The NHS Long Term Plan](#) (LTP), published in January 2019, committed to “*increase investment in primary medical and community health services*” between 2019/20 and 2023/24, with spending projected to be at least £4.5 billion higher. [The Chartered Society of Physiotherapy \(CSP\)](#) described this as a major breakthrough for physiotherapy in England.

On average in the UK, 30% of GP appointments are considered to be for MSK problems. Amongst many things, the LTP committed to the roll out of [first contact physiotherapists](#) - a model which aims to reduce the MSK burden on general practice. The model aims to place physiotherapists in GP practices to enable patients with MSK problems to connect directly to their local physiotherapist without the need for a GP or hospital referral, thereby reducing the demand for GP appointments. NHS England aim to have this in place by 2024 with all adults being able to see a MSK first contact physiotherapist at their local GP practice.

The [Interim NHS People Plan](#) highlighted the need for an additional 5,000 physiotherapists working within Primary Care Networks by 2023. In 2018, the CSP reported a 17% increase in the number of places on physiotherapy courses in 2017. Since the publication of the LTP the CSP has been lobbying for physiotherapy staffing targets to be increased to make use of the increasing numbers of physiotherapy graduates. Health Education England (HEE) have released new strategic workforce plans which outline the commitment to meet Allied Health Professional (AHP) return to practice targets, which could help to tackle the physiotherapy workforce problem.

Section 2. Service findings

2.4 Physiotherapy - adult

Key findings

In the 2021 benchmarking cycle, 39 services provided data for their adult physiotherapy teams.



Access

All services reported providing therapeutic exercise, rehabilitation, support to restore, maintain and improve movement and activity and the provision of specialist equipment, mobility aids, splints and supports in 2020/21. This is consistent with the findings from 2018/19 when this metric was last reported.

A decrease in the average waiting time for adult physiotherapy services from 34 days in 2019/20 to 29 days in 2020/21 was seen, a contrast to the general rise in waiting times since benchmarking commenced for this service in 2013.

In 2020/21 the average DNA rate for adult physiotherapy services was reported as 5%, a slight decrease from the 6% reported in the year previous.

Most adult physiotherapy services operate during the weekdays, averaging 9 hours of availability. Only 6 services reported availability at the weekend with reduced hours of availability (2 hours). This is consistent with previous project cycles.

Activity



A 27% decrease in the number of referrals received for physiotherapy per 100,000 population from 3,158 in 2019/20 to 2,320 in 2020/21 has been reported. The 2020/21 figure is now in line with 2018/19 reporting where the average number of referrals received per 100,000 population was reported as 2,534. The referral acceptance rate slightly increased from 94% in 2019/20 to 96% in 2020/21.

On average, 54% of referrals received were reported as being virtually triaged (e.g. via telephone or video link consultation) in 2020/21. This is an increase on the 19% reported in 2019/20 suggesting the wider uptake of e-triage methods in response to the COVID-19 pandemic. The percentage of referrals which were accepted, assessed and seen within 28 days of receipt of the referral has risen from 50% in 2019/20 to 62% in 2020/21.

Following the decrease in referrals received, the average caseload per clinical WTE in establishment decreased from 153 reported in 2019/20 to 119 reported in 2020/21. The average number of face to face contacts per 100,000 population also decreased dramatically from 6,850 in 2019/20 to 2368 in 2020/21. The average length of a contact increased from 43 minutes in 2019/20 to 46 minutes in 2020/21.

Section 2. Service findings

2.4 Physiotherapy - adult

Key findings

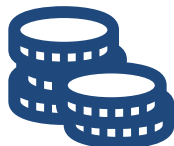


Workforce

WTE clinical staffing levels have seen a slight increase on the previous cycle, in 2020/21 on average there were 8 clinical WTE per 100,000 population in comparison to the 7 reported in 2019/20.

Skill mix is varied amongst clinical physiotherapy teams. On average adult physiotherapy services were made up of 40% band 6 staff (2019/20: 42%), 19% band 7 staff (2019/20: 17%) and 16% band 5 staff (2019/20: 14%).

Both clinical and non-clinical vacancy rates are collected for physiotherapy services. The 2020/21 average clinical staff vacancy rate was reported as 7% with a non-clinical staff vacancy rate of 13%. The figures reported in 2019/20 were 12% and 6%, respectively, showing a change during 2020/21.



Finance

The 2020/21 average total pay cost budget per 100,000 population was reported as £390,380, against an actual spend of £361,025 per 100,000 population. This is an increase on the 2019/20 figures where it was reported that the average total pay cost budget per 100,000 population was £329,731, against an actual spend of £323,024.

In 2020/21, 5% of the total pay budget was spent on agency and bank staff, which is the same as the 2019/20 position.

Quality and outcomes



Consistent with the previous cycle, the 2020/21 project reported positive feedback from service users, with an average Friends and Family Test score of 97%.

52% of adult physiotherapy services reported that they use a patient reported experience measure (PREM) and 57% reported using a patient centred outcome measure (PCOM) to gain insights into the patient experience of the service.



Management of people living with frailty

Frailty metrics were introduced for the first time in 2020/21, with only 23% of adult physiotherapy services reporting that they routinely identify frailty using the Clinical Frailty Scale undertaken on admission to the service.



Learning disabilities

In 2020/21 91% of services reported that they had access to liaison with a specialist learning disabilities team, this was an increase in the 89% reported the year prior. 97% of services agreed that their staff were trained to identify those at risk of abuse and to help them understand and make sense of the safeguarding processes and procedures, a decrease from the 100% reported in 2019/20.

Section 2. Service findings

2.4 Physiotherapy - adult

Key findings

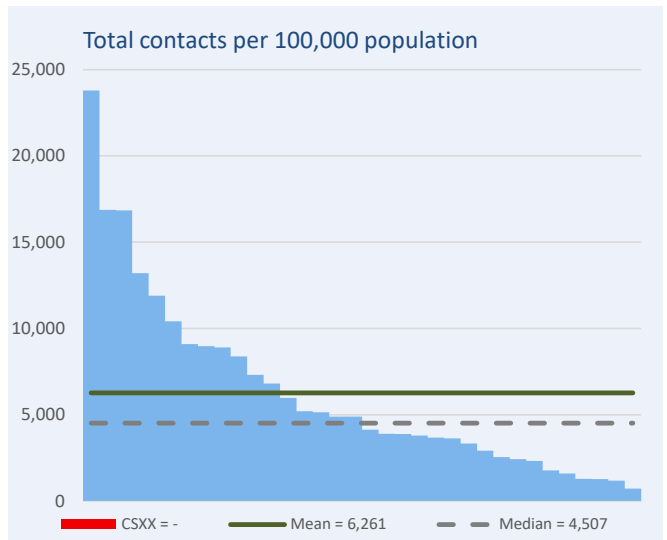
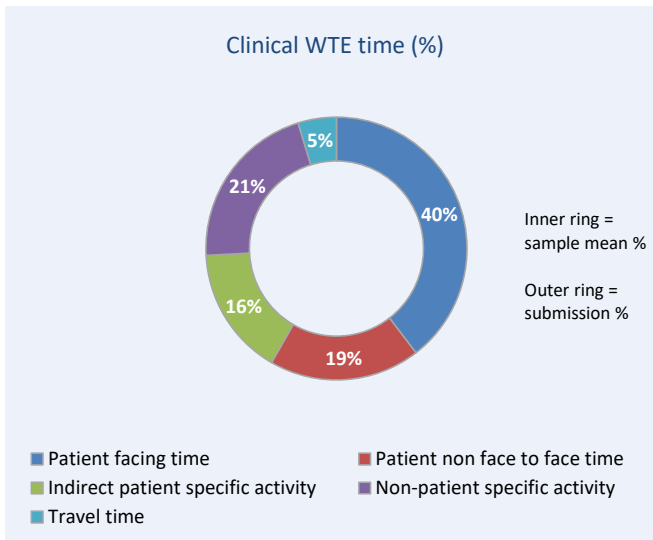
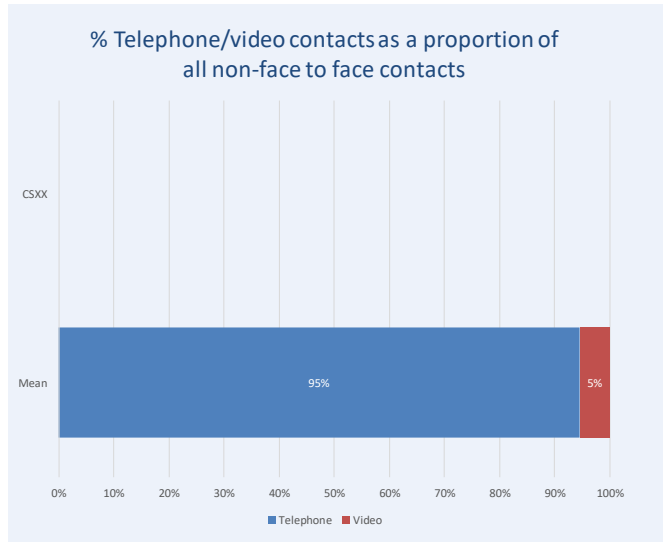
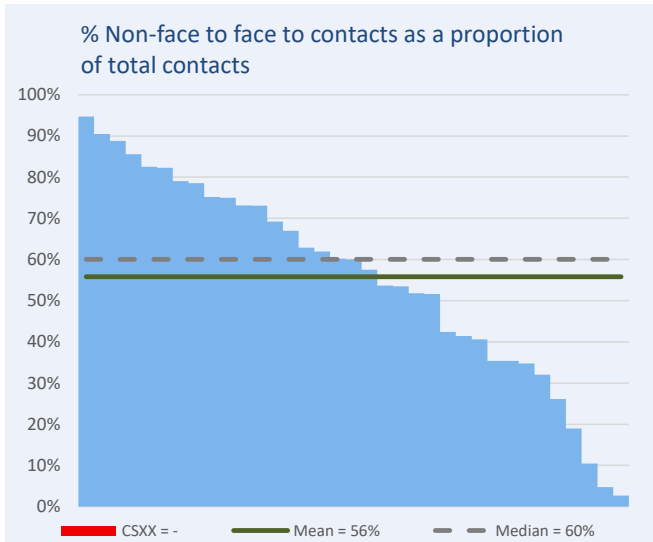
Summary metrics	2020/21		2019/20		Relative comparison		
	CSXX	Mean	CSXX	Mean	Lowest	Median	Highest
Referrals per 100,000 population	...	2,320	...	3,158			
Referrals via e-triage	...	54%	...	19%			
Average waiting time (days)	...	29	...	33			
F2F contacts per clinical WTE in establishment	...	340	...	914			
F2F contacts per service user	...	2	...	3			
Non F2F contacts per clinical WTE in establishment	...	546	...	164			
Non F2F contacts per service user	...	3	...	1			
Clinical WTE per 100,000 population	...	8	...	7			
Clinical staff vacancy rate	...	7%	...	12%			
Clinical staff pay budget per 100,000 population	...	£330,635	...	£283,106			
Total budget per 100,000 population	...	£536,417	...	£483,873			
Agency and bank spend as a % of total pay budget	...	5%	...	5%			
Friends and Family Test average score	...	97%	...	97%			



Section 2. Service findings

2.4 Physiotherapy - adult

Activity



Activity metrics	CSXX	Mean	Median
Average waiting time (days)	...	29	24
DNA rate	...	5%	5%
Referrals per 100,000 population	...	2,320	1,566
Referral acceptance rate	...	95%	97%
Referrals accepted, assessed & seen within 28 days of receipt	...	62%	66%
Referrals via e-triage	...	54%	54%
F2F contacts per 100,000 population	...	2,368	1,989
F2F contacts per clinical WTE in establishment	...	340	285

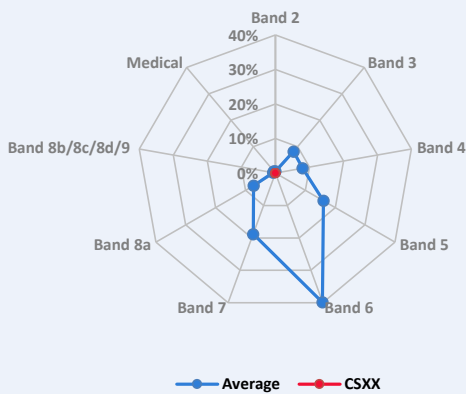
Activity metrics	CSXX	Mean	Median
F2F contacts per service user	...	2	2
Non F2F contacts per 100,000 population	...	3,893	2,598
Non F2F contacts per clinical WTE in establishment	...	546	441
Non F2F contacts per service user	...	3	2
Caseload per clinical WTE in establishment	...	119	97
Unique service users per clinical WTE in establishment	...	241	229
Unique service users per 100,000 population	...	1,841	1,225
Average length of a contact (minutes)	...	46	44

Section 2. Service findings

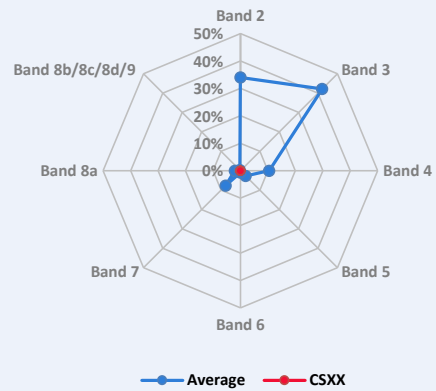
2.4 Physiotherapy - adult

Workforce

Clinical staff skill mix (%)



Non clinical staff skill mix (%)



Clinical staff skill mix	CSXX	Mean
Band 2	...	1%
Band 3	...	8%
Band 4	...	8%
Band 5	...	16%
Band 6	...	40%
Band 7	...	19%
Band 8a	...	7%
Band 8b/8c/8d/9	...	1%
Medical	...	1%

Non clinical staff skill mix	CSXX	Mean
Band 2	...	34%
Band 3	...	42%
Band 4	...	10%
Band 5	...	3%
Band 6	...	1%
Band 7	...	8%
Band 8a	...	2%
Band 8b/8c/8d/9	...	0%

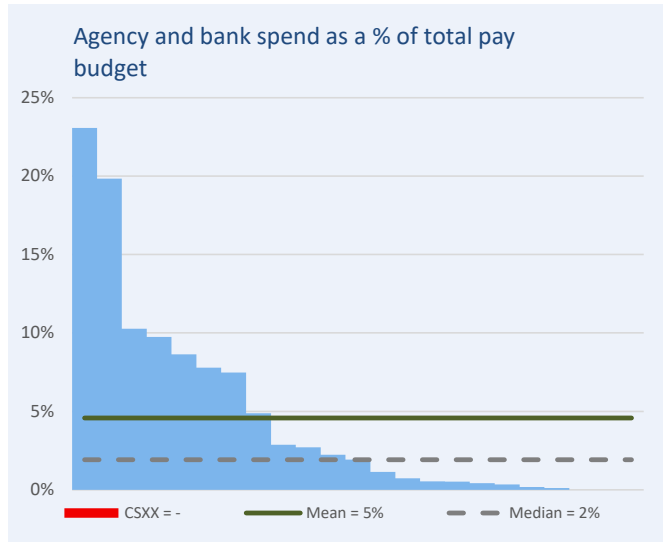
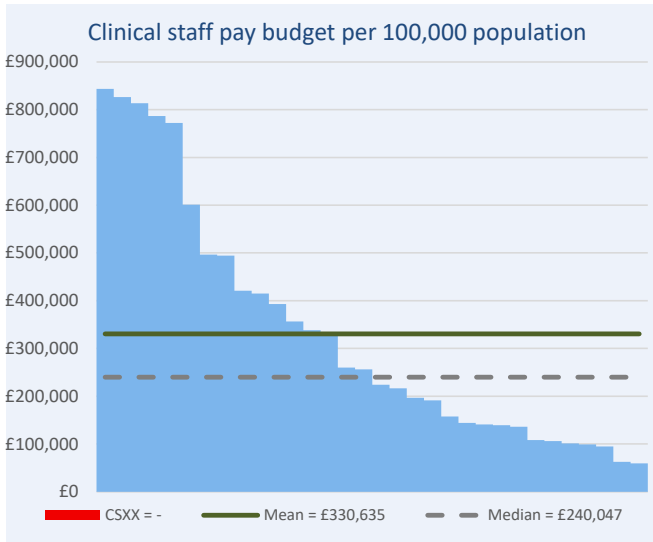
Workforce metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Clinical WTE per 100,000 population	...	7.7	5.4	3.0	11.0
Non clinical WTE per 100,000 population	...	2.0	1.1	0.4	2.0
Pay budget per clinical WTE	...	£47,934	£40,921	£39,022	£47,776
Pay budget per non clinical WTE	...	£38,066	£27,381	£24,128	£37,234
Clinical staff vacancy rate	...	7%	2%	0%	12%
Non clinical staff vacancy rate	...	13%	6%	0%	23%
Staff sickness	...	4%	3%	2%	5%
Staff turnover	...	10%	10%	7%	14%

Weekend staffing	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Staffing levels (WTE) as a % of weekday staffing	...	4.0%	0.0%	0.0%	0.0%
Hours of availability as a % of weekday availability	...	17.8%	0.0%	0.0%	0.0%

Section 2. Service findings

2.4 Physiotherapy - adult

Finance



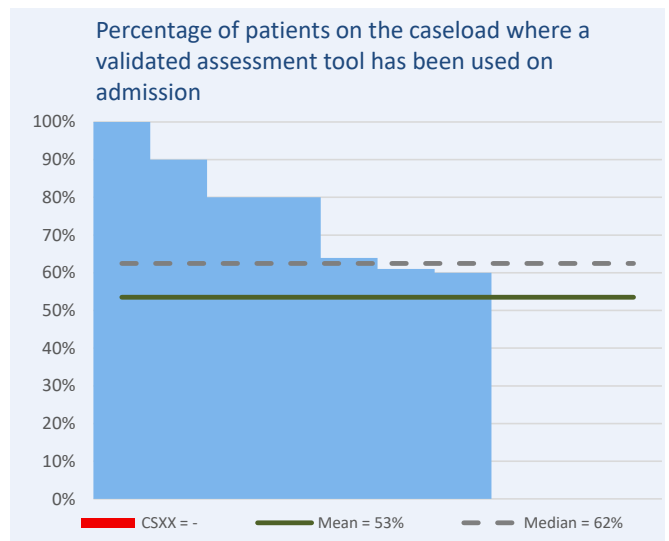
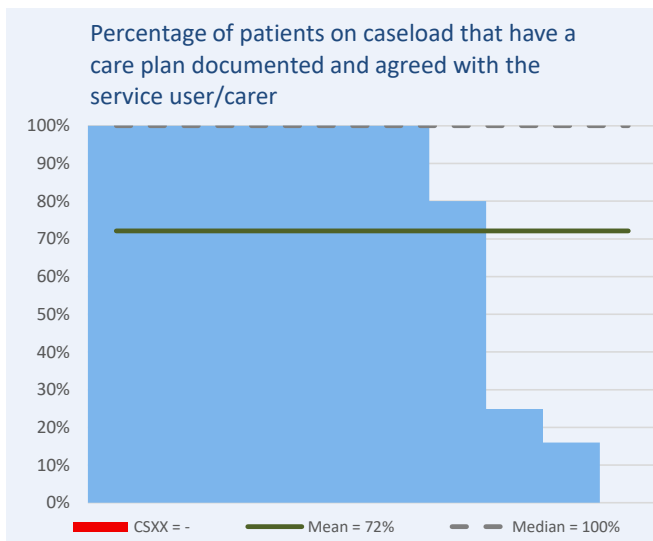
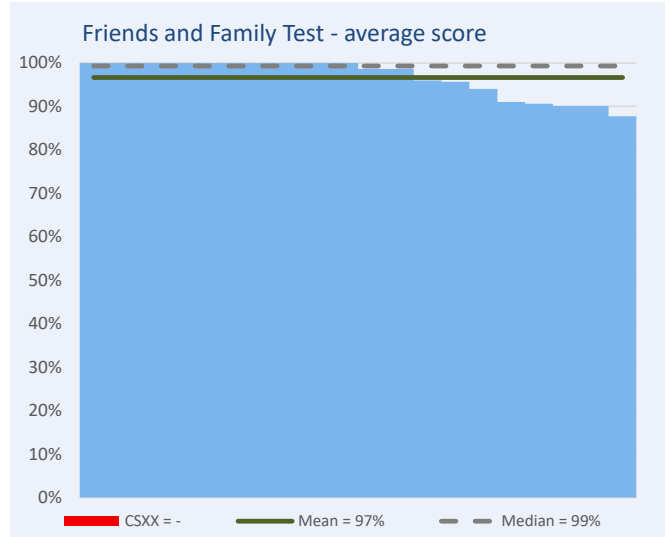
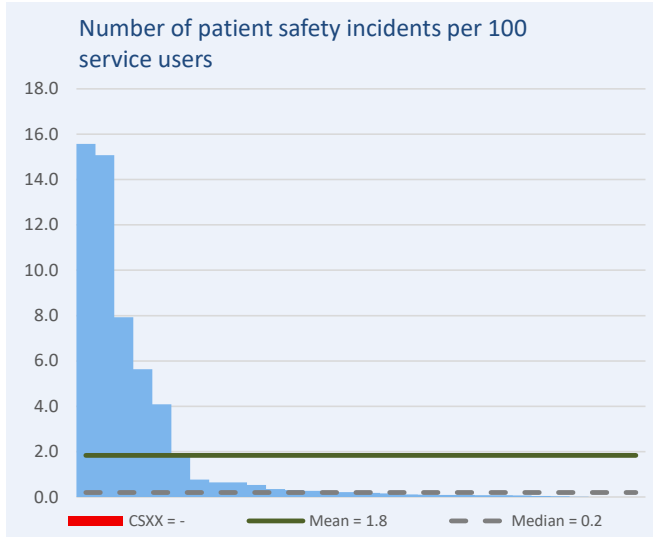
Finance metrics	CSXX			Mean		
	Budget 2020/21	Spend 2020/21	Budget 2021/22	Budget 2020/21	Spend 2020/21	Budget 2021/22
Clinical staff pay cost per 100,000 population	£330,635	£309,131	£367,023
Non clinical staff pay cost per 100,000 population	£57,288	£49,285	£54,817
Non pay cost per 100,000 population	£22,289	£21,710	£25,728
Indirect costs and overheads per 100,000 population	£148,774	£155,698	£123,312
Total cost per 100,000 population	£536,417	£537,642	£521,213
Total cost per service user	£491	£477	...
Agency cost as % of total pay costs	2.8%	2.3%	...
Bank cost as % of total pay costs	1.7%	1.6%	...



Section 2. Service findings

2.4 Physiotherapy - adult

Quality



Quality metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Number of patient safety incidents per 100 service users	...	1.8	0.2	0.1	0.7
Friends and Family Test results – average score	...	97%	99%	93%	100%
Percentage of patients on caseload that have a care plan documented and agreed with the service user/carer	...	72%	100%	39%	100%
Percentage of patients on the caseload where a validated assessment tool has been used on admission	...	53%	62%	15%	80%

Section 2. Service findings

2.5 Podiatry

National context

The main focus of podiatrists, also known as chiropodists, is to improve the independence, mobility and overall quality of a patient's life, by treating and helping them care for their feet and lower limbs. Podiatrists assess, diagnose and treat conditions relating to the foot and the lower limb, as well as offering advice on preventing foot problems. Podiatry services treat both children and adults, with a variety of conditions both long term and acute. Podiatrists care for patients at high risk of amputation, such as those suffering from arthritis or diabetes, as well as sports related injuries and day to day foot problems. The workforce comprises trained healthcare professionals, who often have additional skills in biomechanics, orthoses, and wound care.

National guidance is concentrated on diabetes foot care, e.g. NICE Guideline [NG19](#), on diabetic foot problems, prevention and management, and [The National Diabetes Foot Care Audit \(NDFCA\)](#). Both publications highlight podiatrists as playing a key role in the provision of multi-disciplinary foot care service, where NG19 advises that podiatrists should lead such services for best quality and outcomes. Foot complications are especially common with diabetes, where patients can develop foot ulcers, sometimes leading to amputation and mortality.

The [NHS Long Term Plan](#) (LTP) incorporates podiatrists within the expanded neighbourhood teams to be rolled out across primary care networks (PCNs). Since April 2020, PCNs have been able to claim reimbursement for podiatrists under the [Network Contract Directed Enhanced Service \(DES\) Additional Roles Reimbursement Scheme](#). In addition to commitments to expanding multi-disciplinary teams within the community, the LTP further commits to expanding the number of allied health professionals (AHPs) across the NHS to support the demand.

Health Education England (HEE) further [predicts a shortfall of podiatrists](#) to cover patient need by 2025, with an ageing profile of professionals, a higher percentage of staff leaving the service as well as a reduced number of students applying to study podiatry. In response, HEE have come together with partner organisations to set national standards for foot health practitioners, in addition to solutions such as apprenticeships, return to practice and international recruitment to support the podiatry workforce. The Network holds unique intelligence on the podiatry workforce and will continue to monitor any change to the service.

COVID-19 hugely impacted the provision of podiatry services in 2020/21. As part of the initial strategy to release capacity to support the COVID-19 preparedness and response, podiatry and podiatric surgery were partially stopped within clinics, inpatient wards and homes. Services continued for high risk vascular/diabetic service users and non-diabetic corrective procedures. The podiatry profession proved its flexibility and adaptability during the pandemic, to adjust rapidly to ensure that patients were able to access treatment to reduce risk of infection, ulceration and amputation.

The closure of podiatry services has resulted in a backlog of patients to be seen since re-opening, adding further strain on staff at a difficult time, where sickness/absence rates are also high. Further impacts of COVID-19 on podiatry teams include the redeployment of staff to provide wound care, notably to community nursing teams, as well as using their transferable skills to support ICUs and frontline NHS staff. The 2021 Community Services Project captured examples of learning and good practice resulting from the pandemic, such as improved integrated working with MSK and district nursing teams to identify patients needing referral to podiatry teams, the use of photographs to triage patients for wounds and the use of digital consultation via telephone and video. This shows podiatrists have embraced remote technology to ensure that patients are correctly and safely triaged, signposted to services and given appropriate self-care advice.

Section 2. Service findings

2.5 Podiatry

Key findings

In the 2021 benchmarking cycle, 57 services supplied data for their podiatry teams.



Access

Average waiting times from referral to first appointment for podiatry teams were the highest across all services collected in the 2020/21 project. This was reported at 46 days, an increase from 45 days since 2019/20. DNA rates are down from 8% in 2019/20 to 5% in 2020/21.

Also noted in this benchmarking project is the absence of seven-day working by podiatry teams, where no services reported weekend availability. The average availability of the service is 8 hours per day, weekdays only, which is the same as the position for 2019/20



Activity

The average number of referrals per 100,000 population fell from 1450 in 2019/20 to 869 in 2020/21. This follows the trend we have seen within other community services during 2020/21. The percentage of referrals accepted, assessed, and seen within 28 days of receipt of the referral was 58% in 2020/21, up 18% percent since 2019/20. This could be due to the lower number of referrals received, however the referral acceptance rate has fallen from 94% in 2019/20 to 91% in 2020/21 which may have also had an impact.

A high volume of unique service users is seen by podiatry teams reported at 1,484 per 100,000 population, however this is down from 2,344 in 2019/20 reflecting the reduction in referrals.

On average, service users can expect to receive 3 face to face contacts each, being 35 minutes in length. Virtual contacts by podiatrists are not as widely used in comparison to other AHP services, with an average of 18% of contacts taking place non face to face, however as expected due to the pandemic, an increase is reported since the previous year's project. In 2020/21, 939 non face to face contacts were delivered per 100,000 population, with variation from 0 to 3,455, increasing from 297 per 100,000 population in 2019/20.



Workforce

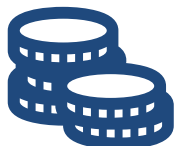
Of a podiatrist's clinical WTE time, on average 68% is being spent patient facing, 9% patient non-facing, 11% indirect patient specific activity, 8% non-patient specific activity and 4% on travel time.

The podiatry workforce is averaged to have 5 clinical WTE in establishment per 100,000 population in 2020/21, mainly consisting of band 5 (13%), band 6 (45%) and band 7 staff (23%). The make-up of the podiatry workforce remains in line with last year's reporting. Other workforce key performance indicators collected in the project include clinical staff vacancy rate, reported at 10% in 2020/21, up 2% points since 2019/20. Staff sickness absence rate were reported at 5% in 2020/21, and staff turnover reported at 10%, down from 12% in 2019/20.

Section 2. Service findings

2.5 Podiatry

Key findings



Finance

The budget for total pay costs were reported at £287k per 100,000 population in 2020/21, this being the budgeted figures for clinical and non-clinical staff combined. This is a slight increase on the pay budget for 2019/20, which was £278k.

In comparison to the actual spend on total pay costs, services show they underspent in 2020/21, with an average of £271k of actual spend per 100, 000 population. Agency and bank spend as a percentage of total pay budget were reported at 5% in 2020/21.



Quality and outcomes

In 2020/21 podiatry reported an average Friends and Family Test result of 91%, down from 96% in 2019/20.

49% of services also reported that they are using a patient reported experience measure (PREM), with 35% using a patient centred outcome measure (PCOM).



Management of people living with frailty

Frailty metrics were introduced for the first time in 2020/21, with only 2% of podiatry teams reporting that they routinely identify frailty using the Clinical Frailty Scale undertaken on admission to the service.



Learning disabilities

In 2019/20 podiatry teams reported that 62% of services had a training/awareness programme for staff delivering care to patients with learning disabilities. In 2020/21, the average has increased and 72% of services now report having a training/awareness programme for staff delivering care to patient with learning disabilities.

Section 2. Service findings

2.5 Podiatry

Key findings

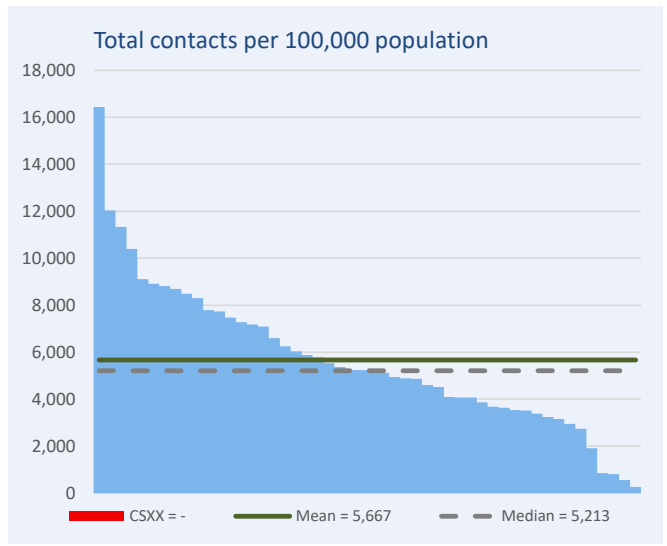
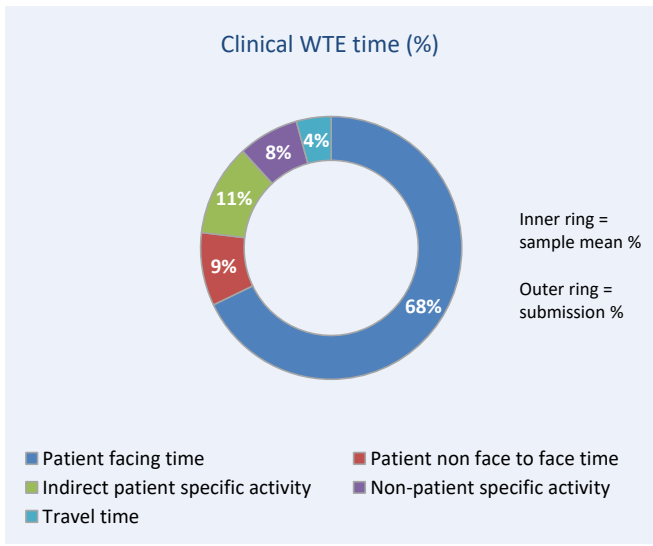
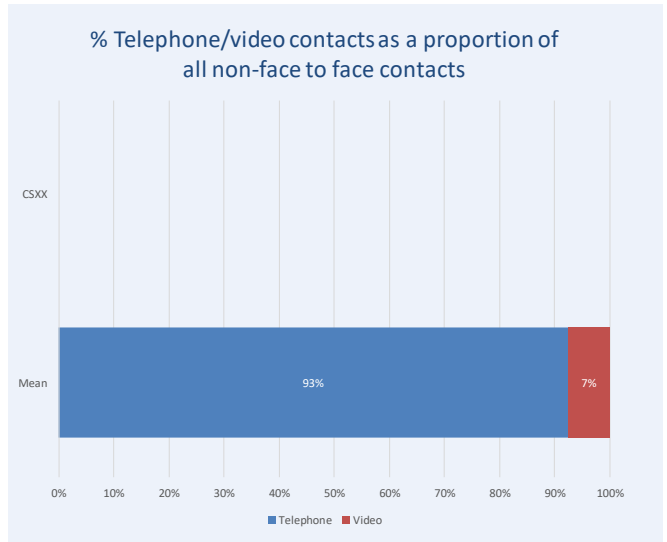
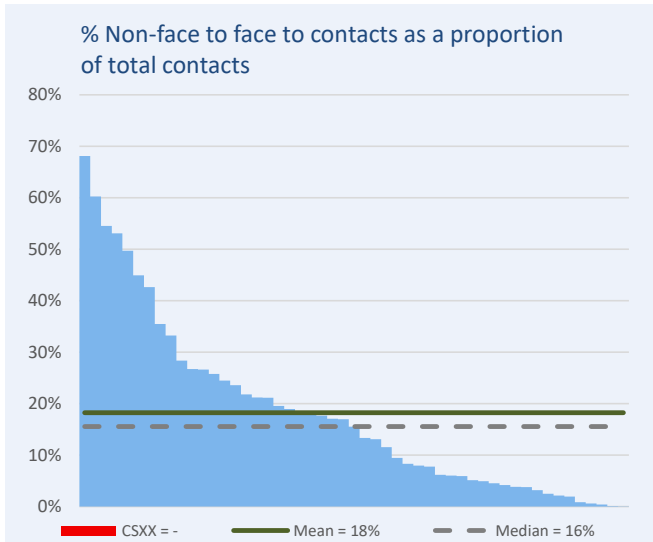
Summary metrics	2020/21		2019/20		Relative comparison		
	CSXX	Mean	CSXX	Mean	Lowest	Median	Highest
Referrals per 100,000 population	...	869	...	1,450			
Referrals via e-triage	...	33%	...	2%			
Average waiting time (days)	...	46	...	45			
F2F contacts per clinical WTE in establishment	...	844	...	1,420			
F2F contacts per service user	...	3	...	4			
Non F2F contacts per clinical WTE in establishment	...	173	...	52			
Non F2F contacts per service user	...	0.7	...	0.2			
Clinical WTE per 100,000 population	...	5	...	6			
Clinical staff vacancy rate	...	10%	...	8%			
Clinical staff pay budget per 100,000 population	...	£245,741	...	£237,424			
Total budget per 100,000 population	...	£452,742	...	£446,116			
Agency and bank spend as a % of total pay budget	...	5%	...	5%			
Friends and Family Test average score	...	91%	...	96%			



Section 2. Service findings

2.5 Podiatry

Activity



Activity metrics	CSXX	Mean	Median
Average waiting time (days)	...	46	47
DNA rate	...	5%	5%
Referrals per 100,000 population	...	869	847
Referral acceptance rate	...	91%	95%
Referrals accepted, assessed & seen within 28 days of receipt	...	58%	56%
Referrals via e-triage	...	33%	25%
F2F contacts per 100,000 population	...	4,674	4,140
F2F contacts per clinical WTE in establishment	...	844	872

Activity metrics	CSXX	Mean	Median
F2F contacts per service user	...	3	3
Non F2F contacts per 100,000 population	...	939	522
Non F2F contacts per clinical WTE in establishment	...	173	132
Non F2F contacts per service user	...	1	0
Caseload per clinical WTE in establishment	...	354	315
Unique service users per clinical WTE in establishment	...	286	268
Unique service users per 100,000 population	...	1,484	1,374
Average length of a contact (minutes)	...	35	35

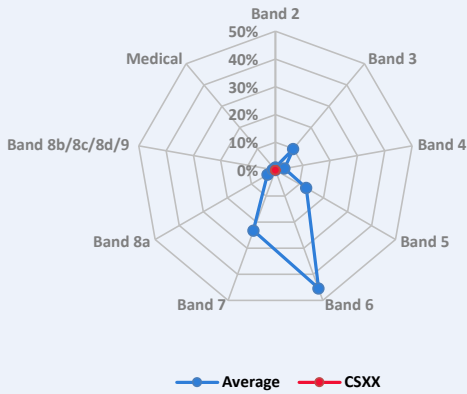


Section 2. Service findings

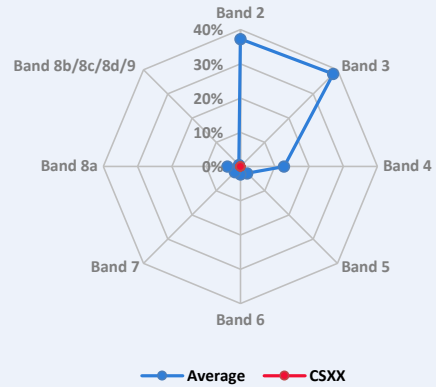
2.5 Podiatry

Workforce

Clinical staff skill mix (%)



Non clinical staff skill mix (%)



Clinical staff skill mix	CSXX	Mean
Band 2	...	1%
Band 3	...	10%
Band 4	...	3%
Band 5	...	13%
Band 6	...	45%
Band 7	...	23%
Band 8a	...	3%
Band 8b/8c/8d/9	...	1%
Medical	...	0%

Non clinical staff skill mix	CSXX	Mean
Band 2	...	37%
Band 3	...	38%
Band 4	...	13%
Band 5	...	3%
Band 6	...	2%
Band 7	...	2%
Band 8a	...	4%
Band 8b/8c/8d/9	...	1%

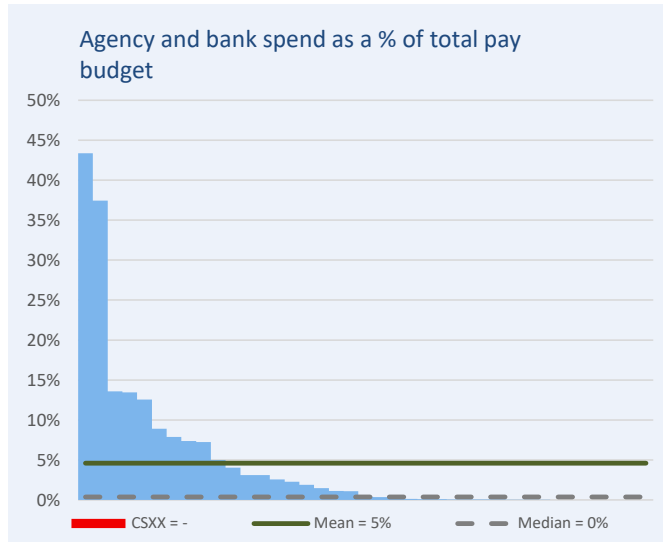
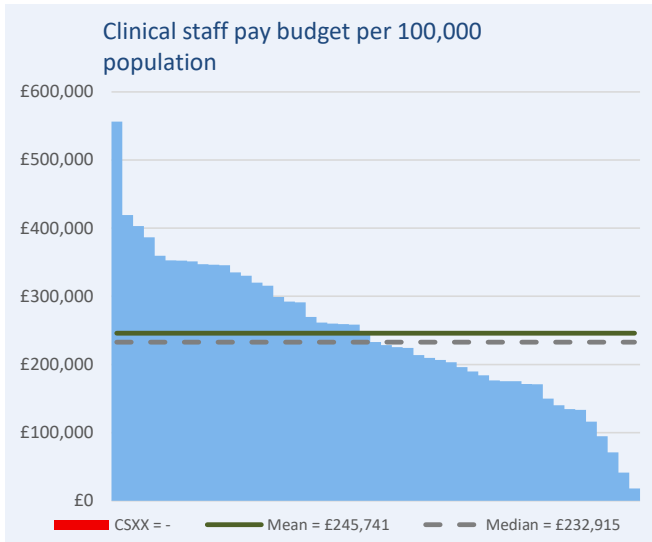
Workforce metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Clinical WTE per 100,000 population	...	5.4	5.2	3.6	7.0
Non clinical WTE per 100,000 population	...	1.1	0.9	0.2	1.4
Pay budget per clinical WTE	...	£48,222	£47,235	£43,727	£51,597
Pay budget per non clinical WTE	...	£30,793	£26,618	£23,590	£33,060
Clinical staff vacancy rate	...	10%	6%	2%	13%
Non clinical staff vacancy rate	...	8%	0%	0%	10%
Staff sickness	...	5%	4%	3%	6%
Staff turnover	...	10%	9%	5%	13%

Weekend staffing	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Staffing levels (WTE) as a % of weekday staffing	...	0.0%	0.0%	0.0%	0.0%
Hours of availability as a % of weekday availability	...	0.0%	0.0%	0.0%	0.0%

Section 2. Service findings

2.5 Podiatry

Finance



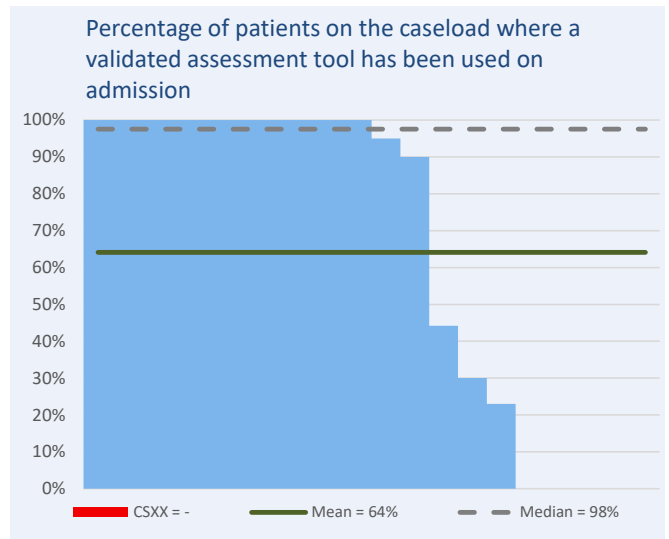
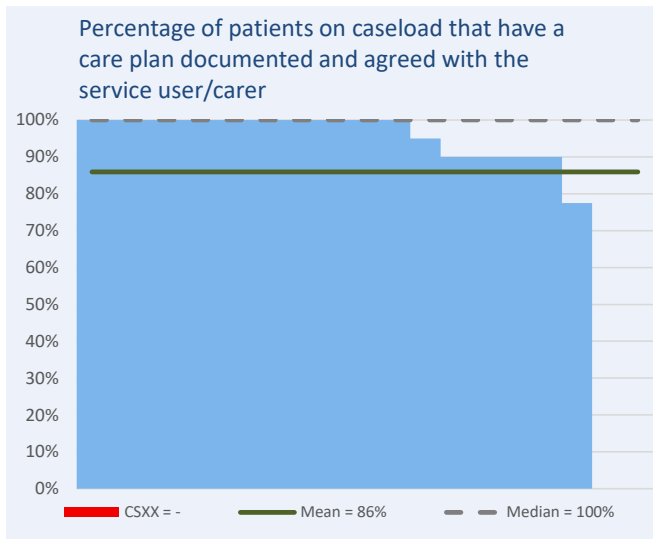
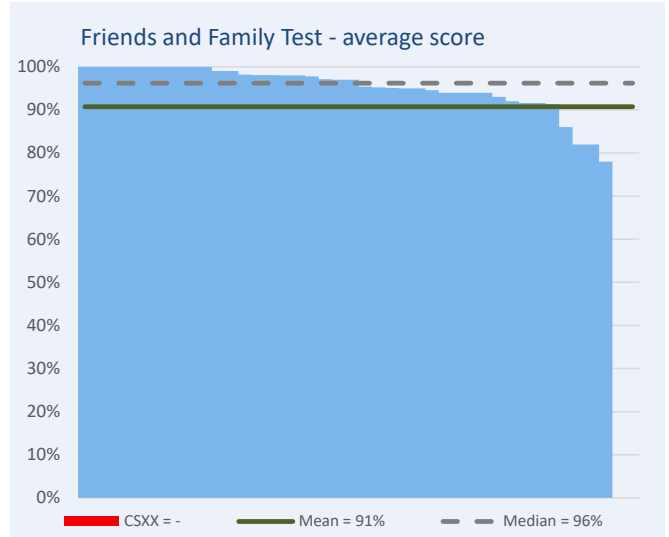
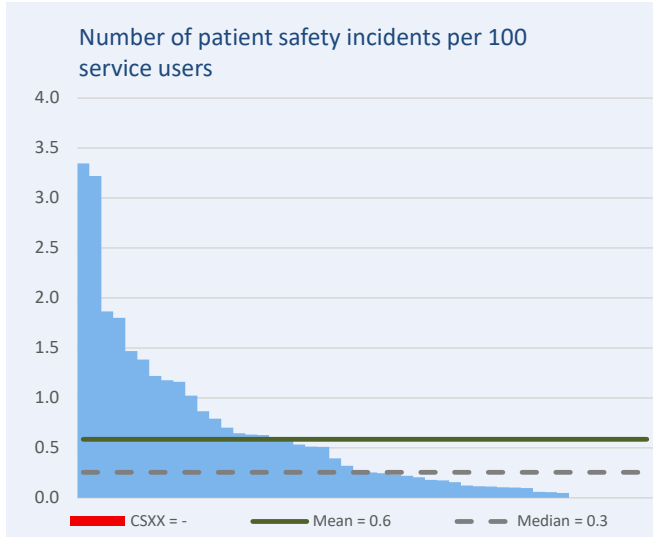
Finance metrics	CSXX			Mean		
	Budget 2020/21	Spend 2020/21	Budget 2021/22	Budget 2020/21	Spend 2020/21	Budget 2021/22
Clinical staff pay cost per 100,000 population	£245,741	£234,638	£249,484
Non clinical staff pay cost per 100,000 population	£37,409	£31,479	£41,356
Non pay cost per 100,000 population	£42,485	£33,339	£41,695
Indirect costs and overheads per 100,000 population	£123,465	£127,600	£120,407
Total cost per 100,000 population	£452,742	£425,011	£442,518
Total cost per service user	£338	£319	...
Agency cost as % of total pay costs	1.8%	1.9%	...
Bank cost as % of total pay costs	2.6%	2.4%	...



Section 2. Service findings

2.5 Podiatry

Quality



Quality metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Number of patient safety incidents per 100 service users	...	0.6	0.3	0.1	0.7
Friends and Family Test results – average score	...	91%	96%	93%	99%
Percentage of patients on caseload that have a care plan documented and agreed with the service user/carer	...	86%	100%	90%	100%
Percentage of patients on the caseload where a validated assessment tool has been used on admission	...	64%	98%	17%	100%

Section 2. Service findings

2.6 Speech and language therapy - adult

National context

Adult speech and language therapy (SaLT) services provide treatment, support and care for adults (18+), mostly within the community, who have difficulties communicating, eating, drinking and swallowing. These services are mostly provided by speech and language therapists (SLTs), who are usually part of a multi-disciplinary team, working closely with doctors, nurses, psychologists, occupational therapists, and other health professionals. [The Royal College of Speech and Language Therapists](#) (RCSLT) estimate there are around 17,000 practicing SLTs in the UK working in a variety of settings.

Alongside adult SaLT, children's SaLT is also provided throughout the community to help children with speech and communication problems, including children with autism and learning difficulties. Data for children's speech and language therapy services wasn't collected as part of the 2021 cycle due to the impact of the pandemic on members, but these services may be included in the 2022 cycle.

In January 2019 the [NHS Long Term Plan](#) was published, which outlined the NHS ambitions to support prevention, early intervention and tackle health inequality. The ambitions within the plan have potential to improve the care provided for people with communication and swallowing needs, suggesting SLTs will play a significant role. The [plan acknowledges that SLTs are a workforce group which is in short supply](#), as well as outlining a new model of care for children and young people.

Like many services within the community, COVID-19 has had a big impact on how speech and language therapy services are delivered. In March 2020, NHS England issued [guidance](#) outlining how community services could release capacity to support the pandemic response. It stated that all adult rehabilitation and therapy interventions should be partially stopped, enabling staff (including SLTs) to be redeployed into services where more staffing support was needed. Care was continued for patients with urgent care needs e.g. patients at a high risk of aspiration pneumonia due to difficulties with swallowing.

In October 2020, the RCSLT [released a response](#) to the redeployment of staff. The statement showed support for the redeployment of SLTs to the wider health and social care system in a national effort to reduce the impact of COVID-19 on heavily burdened services. However, the statement also highlighted the need to balance the redeployment of staff with the mounting pressures that were already on the speech and language therapy services to reduce waiting lists and meet targets. Encouraging retired staff to return to the workforce, volunteers and students were solutions suggested to help to alleviate some of the pressures faced. Concern was also shown regarding the suitability of redeployed staff for roles that may not be utilising the staff skill set in the most effective way.

The effects of long COVID-19 are now being seen within community services. [A survey carried out by the RCSLT](#) between February and March 2021 reported that all respondents received referrals of people who had long COVID-19 with ongoing speech and language therapy needs. The survey was targeted to RCSLT members to gain an insight into the experiences of staff working with long COVID-19 patients. It was reported that in some services, SLTs are recognised as a core part of the multi-disciplinary team for assessment of Long COVID-19. A significant variation in the number of people referred for therapy after having COVID-19 was also noted as a concern, as this could show a lack of awareness of SaLT needs after COVID-19. This could manifest as missed opportunities and unmet need. The RCSLT made 11 recommendations in response to the survey findings with aims to ensure that any person, including those with long COVID-19, with difficulties communicating or swallowing has access to high quality SaLT when and where needed.

Section 2. Service findings

2.6 Speech and language therapy - adult

Key findings

In the 2021 cycle, 45 services supplied data for their adult speech and language therapy services.

Access



For 2020/21, 98% of speech and language therapy services reported that they delivered their services in the service user's own home (community domiciliary), in nursing homes and in residential homes. These values were slightly higher than the values last reported in 2018/19 where 96% of services were located in the service user's own homes, 98% in nursing homes and 93% in residential homes.

100% of services reported providing care for degenerative condition management, 98% provided treatment, support and care for adults who have difficulties with communications or with eating, drinking and swallowing. Only 46% of services reported that they provided transgender services.

Speech and language therapy teams, work mostly in the week with only one service reporting having availability on the weekend. The average waiting time into the service, was 31 days which remains consistent with the 31 days reported in 2019/20 and the 32 days reported in 2018/19.

This year the DNA rate for speech and language therapy decreased from the 5% reported in 2019/20 back to the 3% that was reported in 2018/19.

Activity



Demand for speech and language therapy services can be assessed by the number of referrals received into the service. In 2020/21 on average 370 referrals were received per 100,000 population, this is a decrease from the 436 referrals received the year prior. Of the referrals received, on average 65% were accepted, assessed and seen within 28 days of receipt of the referral, an increase from the 52% average reported in 2019/20. 60% of the referrals received were triaged via e-triage/virtually which was an increase from the 13% reported in 2019/20, reflecting the move to more virtual consultations due to the COVID-19 pandemic.

The average caseload per clinical WTE in establishment increased from 66 in 2019/20 to 72 in 2020/21. An increase was also reported in the average time spent on the caseload from 94 days (2019/20) to 101 days (2020/21).

The average length of a contact remained similar to the previous two years, reported as 48 minutes in 2020/21. However, the number of contacts has increased from an average of 3 per service user in 2019/20 to 5 in 2020/21. Of these contacts, there has been an increase in non-face-to-face from 1 per service user in 2019/20 to 3 in 2020/21.

Section 2. Service findings

2.6 Speech and language therapy - adult

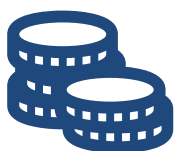
Key findings



Workforce

Speech and language therapy teams on average have 2 clinical WTE in establishment per 100,00 population, this has remained consistent with the previous year's figure. On average, the teams are mostly made up of band 6 (37%), band 7 (27%) and band 5 (18%) staff, these figures are very consistent with 2019/20.

In 2020/21 the average clinical staff vacancy rate was 8% whereas the non-clinical staff was 3%. In 2019/20 the clinical staff vacancy rate was reported as 10% with non-clinical staff at 2%.



Finance

In 2020/21 the average total pay cost budget was reported as £90,394 per 100,000 population (compared to £90,519 in 2019/20), this is against an actual spend of £86,718 per 100,000 (compared to £79,336 in 2019/20). The total cost per unique service user (spend) was £537 for 2020/21 which is an increase on the £381 reported 2019/20. Bank and agency spend made up 5% of the total pay budget for 2020/21, which has remained constant since 2019/20.



Management of people living with frailty

Frailty metrics were introduced for the first time in 2020/21, with only 14% of speech and language therapy teams reporting that they routinely identify frailty using the Clinical Frailty Scale undertaken on admission to the service.



Quality and outcomes

Speech and language therapy teams report an average Friends and Family Test score of 89% in 2020/21 compared to 96% in 2019/20.

In the 2021 project some additional quality measures were introduced, with services reporting that an average of 92% of the caseload had a care plan documented and agreed with the service user. In addition, an average of 67% of patients on the caseload had patient centred goals set, with 71% reporting that those goals were fully met.



Learning disabilities

73% of services reported that they have a training/ awareness programme for staff on delivering care to patients with learning disabilities, this is an increase from the 56% reported in the 2019/20 project cycle.

Section 2. Service findings

2.6 Speech and language therapy - adult

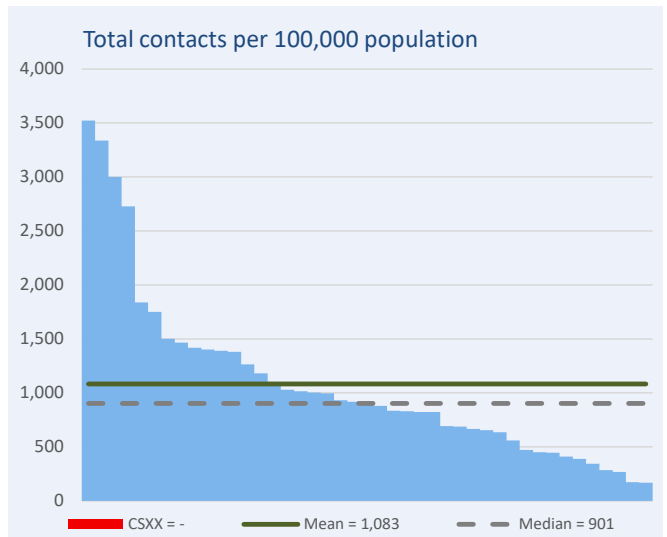
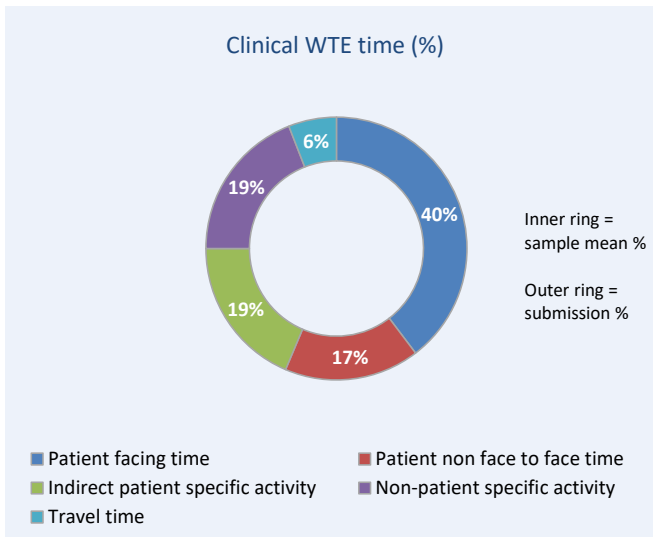
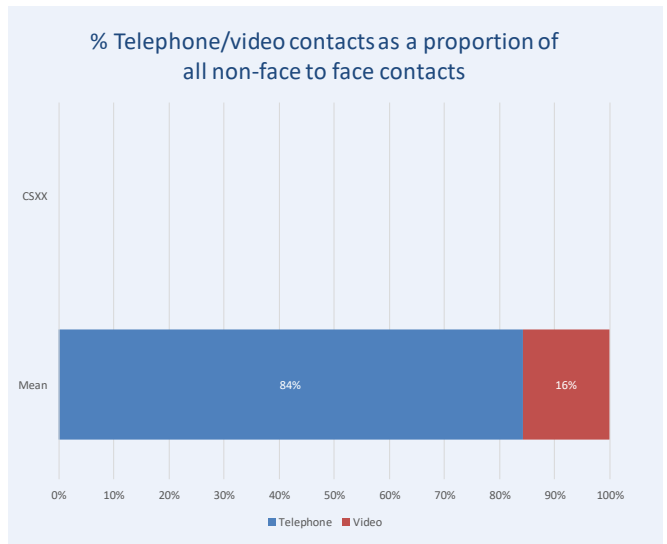
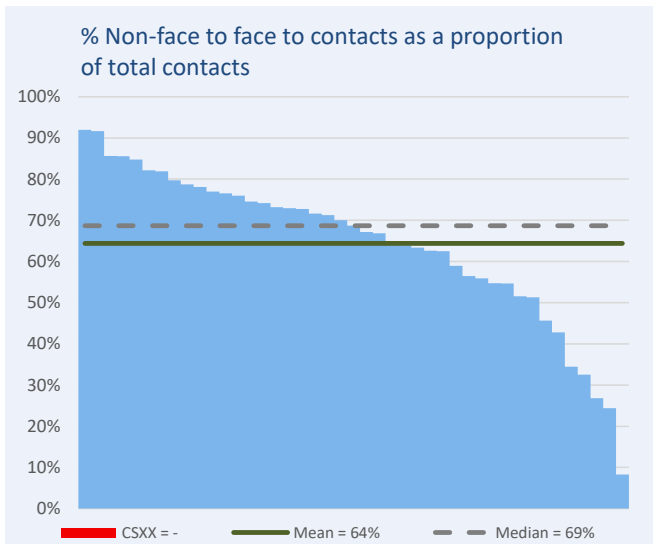
Key findings

Summary metrics	2020/21		2019/20		Relative comparison		
	CSXX	Mean	CSXX	Mean	Lowest	Median	Highest
Referrals per 100,000 population	...	370	...	436			
Referrals via e-triage	...	60%	...	13%			
Average waiting time (days)	...	31	...	31			
F2F contacts per clinical WTE in establishment	...	257	...	463			
F2F contacts per service user	...	2	...	2			
Non F2F contacts per clinical WTE in establishment	...	508	...	221			
Non F2F contacts per service user	...	3	...	1			
Clinical WTE per 100,000 population	...	2	...	2			
Clinical staff vacancy rate	...	8%	...	10%			
Clinical staff pay budget per 100,000 population	...	£81,950	...	£82,543			
Total budget per 100,000 population	...	£123,683	...	£119,586			
Agency and bank spend as a % of total pay budget	...	5%	...	5%			
Friends and Family Test average score	...	89%	...	96%			

Section 2. Service findings

2.6 Speech and language therapy - adult

Activity



Activity metrics	CSXX	Mean	Median
Average waiting time (days)	...	31	23
DNA rate	...	3%	2%
Referrals per 100,000 population	...	370	309
Referral acceptance rate	...	93%	94%
Referrals accepted, assessed & seen within 28 days of receipt	...	65%	70%
Referrals via e-triage	...	60%	56%
F2F contacts per 100,000 population	...	437	237
F2F contacts per clinical WTE in establishment	...	257	182

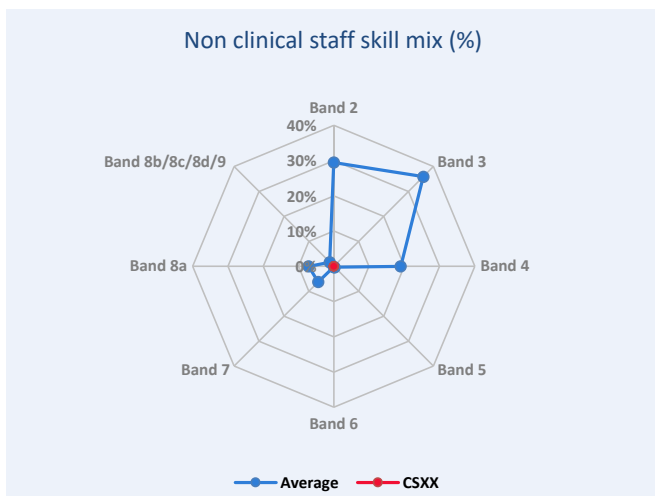
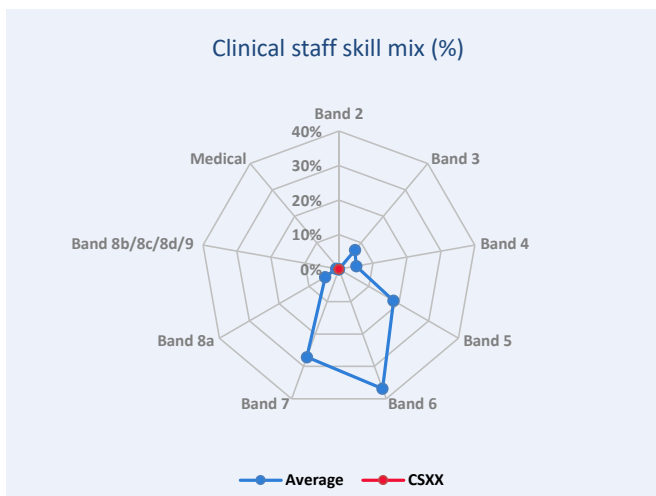
Activity metrics	CSXX	Mean	Median
F2F contacts per service user	...	2	1
Non F2F contacts per 100,000 population	...	645	531
Non F2F contacts per clinical WTE in establishment	...	508	421
Non F2F contacts per service user	...	3	3
Caseload per clinical WTE in establishment	...	72	59
Unique service users per clinical WTE in establishment	...	233	154
Unique service users per 100,000 population	...	271	259
Average length of a contact (minutes)	...	48	46



Section 2. Service findings

2.6 Speech and language therapy - adult

Workforce



Clinical staff skill mix	CSXX	Mean
Band 2	...	0%
Band 3	...	7%
Band 4	...	5%
Band 5	...	18%
Band 6	...	37%
Band 7	...	27%
Band 8a	...	5%
Band 8b/8c/8d/9	...	1%
Medical	...	0%

Non clinical staff skill mix	CSXX	Mean
Band 2	...	29%
Band 3	...	36%
Band 4	...	19%
Band 5	...	0%
Band 6	...	0%
Band 7	...	6%
Band 8a	...	7%
Band 8b/8c/8d/9	...	2%

Workforce metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Clinical WTE per 100,000 population	...	1.8	1.7	1.0	2.2
Non clinical WTE per 100,000 population	...	0.3	0.2	0.1	0.3
Pay budget per clinical WTE	...	£46,717	£44,514	£42,202	£49,174
Pay budget per non clinical WTE	...	£30,634	£28,865	£20,858	£33,874
Clinical staff vacancy rate	...	8%	3%	0%	13%
Non clinical staff vacancy rate	...	3%	0%	0%	0%
Staff sickness	...	3%	2%	1%	4%
Staff turnover	...	13%	10%	2%	18%

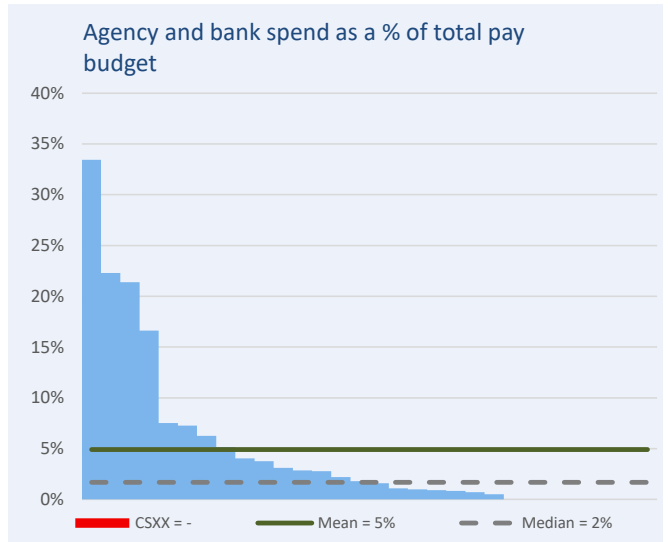
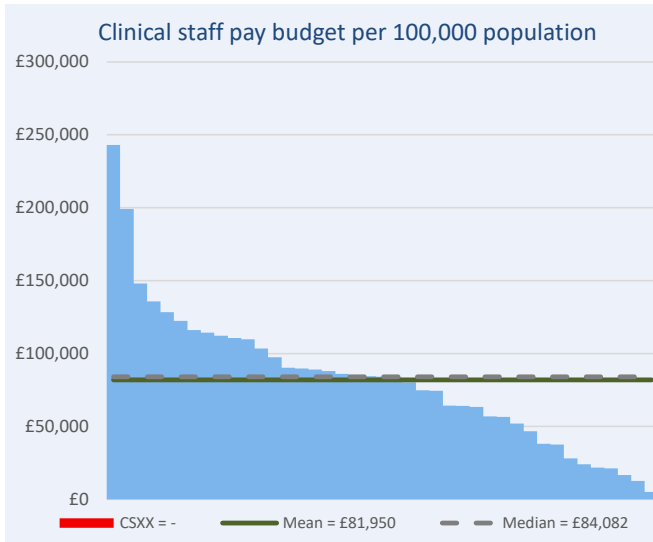
Weekend staffing	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Staffing levels (WTE) as a % of weekday staffing	...	0.4%	0.0%	0.0%	0.0%
Hours of availability as a % of weekday availability	...	2.8%	0.0%	0.0%	0.0%



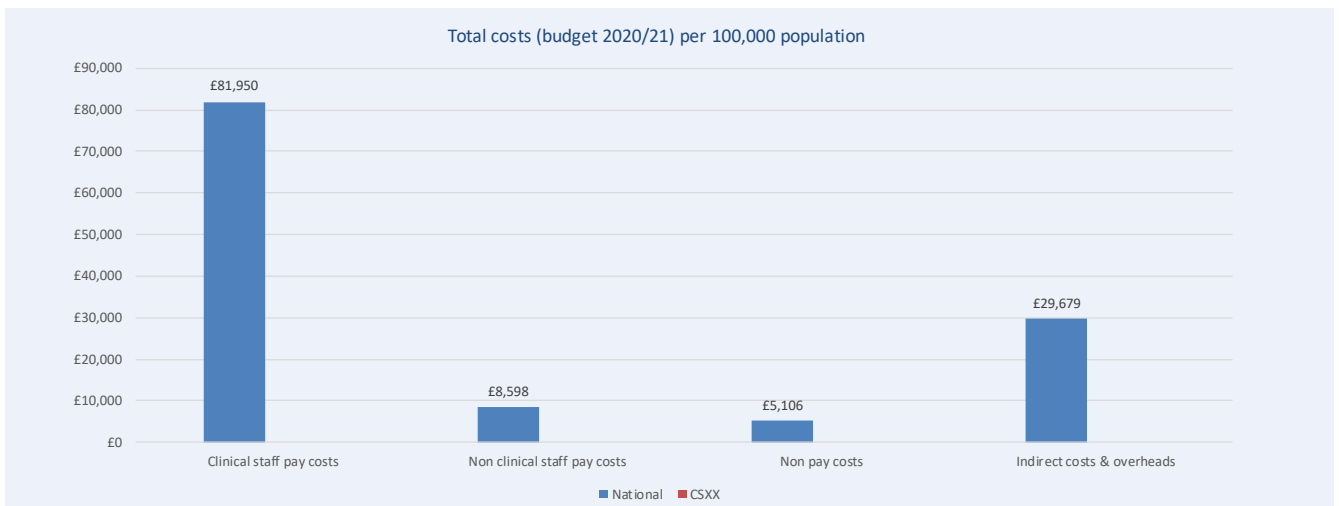
Section 2. Service findings

2.6 Speech and language therapy - adult

Finance



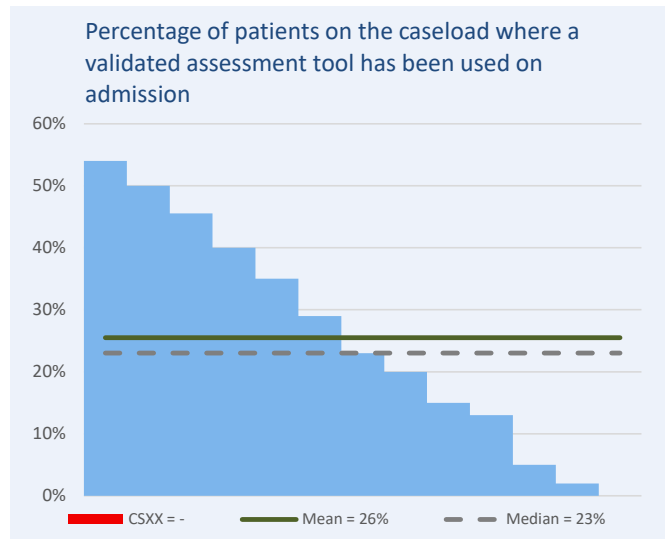
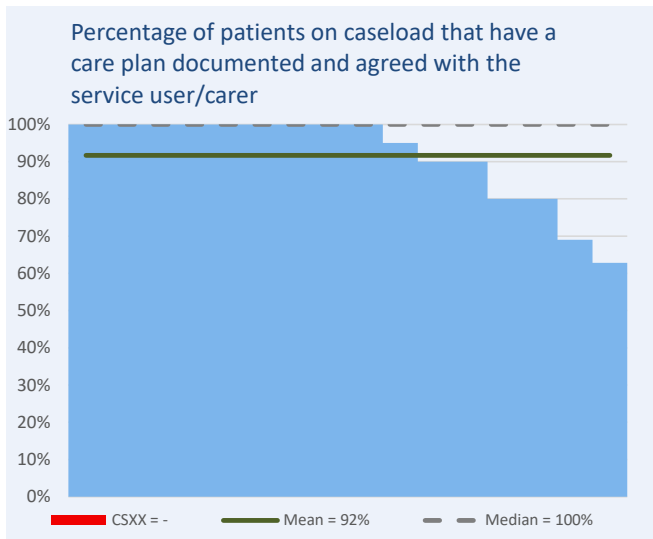
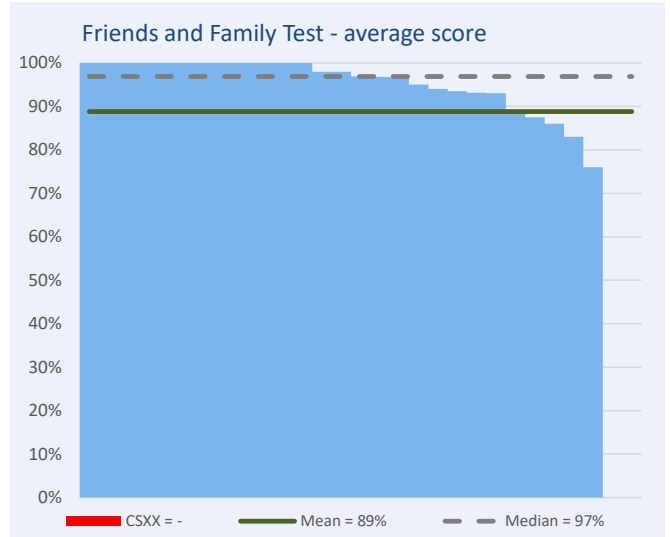
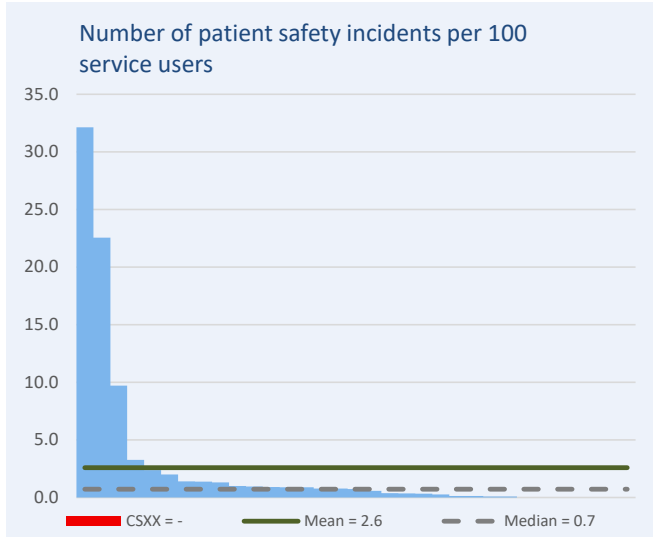
Finance metrics	CSXX			Mean		
	Budget 2020/21	Spend 2020/21	Budget 2021/22	Budget 2020/21	Spend 2020/21	Budget 2021/22
Clinical staff pay cost per 100,000 population	£81,950	£78,091	£88,770
Non clinical staff pay cost per 100,000 population	£8,598	£8,028	£9,568
Non pay cost per 100,000 population	£5,106	£3,950	£5,281
Indirect costs and overheads per 100,000 population	£29,679	£30,492	£29,172
Total cost per 100,000 population	£123,683	£119,430	£130,985
Total cost per service user	£548	£537	...
Agency cost as % of total pay costs	3.7%	3.5%	...
Bank cost as % of total pay costs	1.9%	2.0%	...



Section 2. Service findings

2.6 Speech and language therapy - adult

Quality



Quality metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Number of patient safety incidents per 100 service users	...	2.6	0.7	0.1	1.3
Friends and Family Test results – average score	...	89%	97%	93%	100%
Percentage of patients on caseload that have a care plan documented and agreed with the service user/carer	...	92%	100%	88%	100%
Percentage of patients on the caseload where a validated assessment tool has been used on admission	...	26%	23%	13%	40%

Section 3. Service dashboard

3.1 Children's community nursing teams

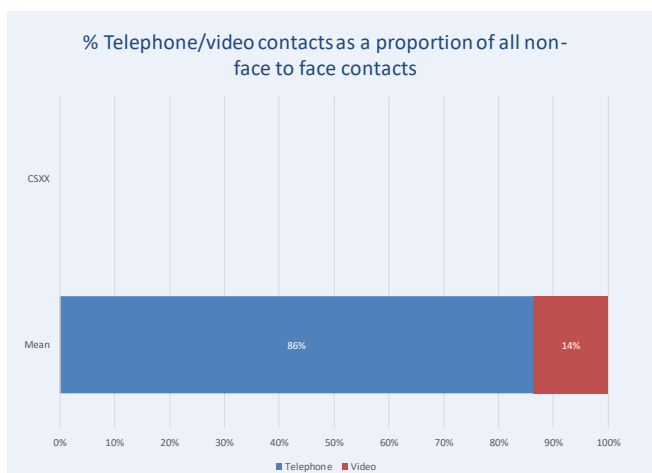
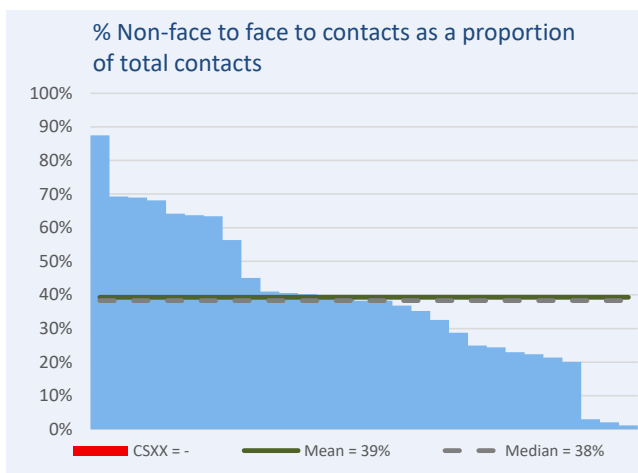
Overview

Children's community nurses work together to provide care for ill and disabled children, and the people close to them, usually within their own homes. The nurses support children with complex long-term conditions as well as children who require short-term care. The average total referrals per 100,000 population decreased from 371 in 2019/20 to 155 in 2020/21. Despite this, average waiting times are reported as 23 days, longer in 2020/21 than the 19 days reported in 2019/20. Referral acceptance rate is still high in 2020/21 at 93% and DNA rates remain low at below 2%. In addition 46% of clinical time spent is patient facing, with each contact lasting on average 43 minutes.

Key findings

Summary metrics	2020/21		2019/20		Relative comparison		
	CSXX	Mean	CSXX	Mean	Lowest	Median	Highest
Referrals per 100,000 population	...	155	...	371			
F2F contacts per clinical WTE in establishment	...	305	...	448			
F2F contacts per service user	...	10	...	10			
Clinical WTE per 100,000 population	...	6	...	4			
Total budget per 100,000 population	...	£426,324	...	£272,277			
Friends and Family Test average score	...	96%	...	97%			

Activity metrics	CSXX	Mean	Median
Average waiting time (days)	...	23	15
DNA rate	...	2%	0%
Referrals per 100,000 population	...	155	72
Referral acceptance rate	...	93%	98%
Referrals accepted, assessed & seen within 28 days of receipt	...	76%	82%
Referrals via e-triage	...	39%	20%
F2F contacts per 100,000 population	...	1,440	1,043

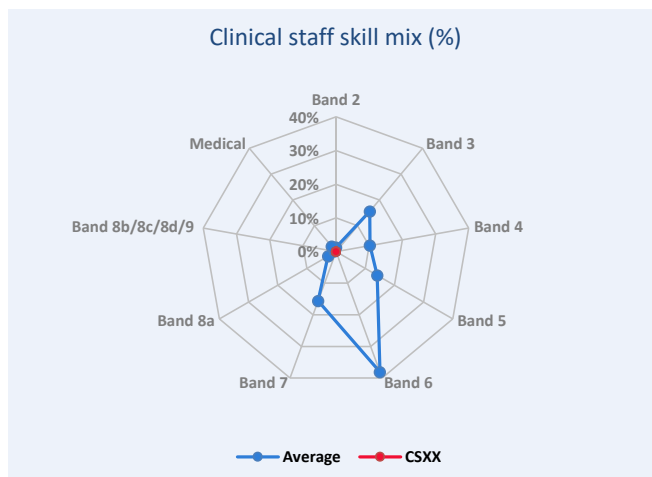


Section 3. Service dashboard

3.1 Children's community nursing teams

Activity metrics	CSXX	Mean	Median
F2F contacts per clinical WTE in establishment	...	305	256
F2F contacts per service user	...	10	7
Non F2F contacts per 100,000 population	...	1,501	660
Unique service users per clinical WTE in establishment	...	50	41
Unique service users per 100,000 population	...	212	150
Average length of a contact (minutes)	...	43	35

Workforce metrics	CSXX	Mean	Median
Clinical WTE per 100,000 population	...	5.9	4.6
Non clinical WTE per 100,000 population	...	0.6	0.4
Pay budget per clinical WTE	...	£45,352	£45,172
Pay budget per non clinical WTE	...	£37,064	£28,891
Clinical staff vacancy rate	...	7%	5%
Non clinical staff vacancy rate	...	7%	0%
Staff sickness	...	5%	4%
Staff turnover	...	11%	12%



Weekend staffing	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Staffing levels (WTE) as a % of weekday staffing	...	15.6%	13.3%	2.2%	24.5%
Hours of availability as a % of weekday availability	...	65.6%	100.0%	12.5%	100.0%

Finance metrics	CSXX			Mean		
	Budget 2020/21	Spend 2020/21	Budget 2021/22	Budget 2020/21	Spend 2020/21	Budget 2021/22
Clinical staff pay cost per 100,000 population	£248,019	£227,007	£248,885
Non clinical staff pay cost per 100,000 population	£21,361	£21,599	£22,066
Non pay cost per 100,000 population	£40,528	£46,194	£36,814
Indirect costs and overheads per 100,000 population	£88,264	£81,294	£89,703
Total cost per 100,000 population	£426,324	£397,334	£428,682
Total cost per service user	£2,957	£3,594	...
Agency cost as % of total pay costs	0.5%	0.7%	...
Bank cost as % of total pay costs	2.0%	1.8%	...

Quality metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Number of patient safety incidents per 100 service users	...	6.5	1.8	0.7	7.1
Friends and Family Test results – average score	...	96%	99%	93%	100%





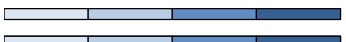


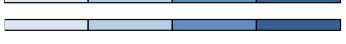
Section 3. Service dashboard

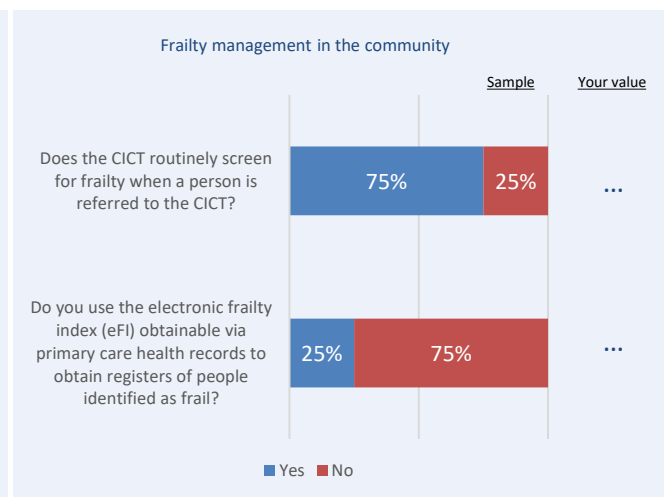
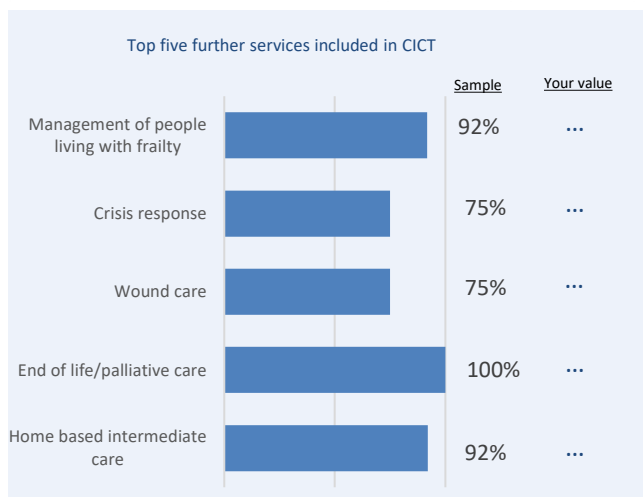
3.2 Community integrated care teams

Overview

Community integrated care teams are defined as services that operate across different professional disciplines and different agencies to provide complex care to service users in their own homes (including residential care homes). Core services delivered by the teams include long-term condition management, support for self-management and keeping people as independent as possible. All of the community integrated care teams reported that they had a single point of access for referral into the team during 2020/21. 92% of services reported that they support people living with frailty in 2020/21, and 75% of services routinely screen for frailty. On average in 2020/21, service users waited 14 days before receiving their first appointment, with 2,468 unique service users on the caseload a year per 100,000 population.

Key findings

Summary metrics	2020/21		2019/20		Relative comparison Lowest Median Highest
	CSXX	Mean	CSXX	Mean	
Referrals per 100,000 population	...	5,778	...	7,305	
F2F contacts per clinical WTE in establishment	...	751	...	802	
F2F contacts per service user	...	10	...	15	
Clinical WTE per 100,000 population	...	40	...	43	
Total budget per 100,000 population	...	£3,179,888	...	£2,484,048	
Friends and Family Test average score	...	95%	...	96%	



Activity metrics	CSXX	Mean	Median
Average waiting time (days)	...	14	18
DNA rate	...	3%	2%
Referrals per 100,000 population	...	5,778	4,099
Referral acceptance rate	...	92%	96%
Referrals accepted, assessed & seen within 28 days of receipt	...	82%	79%
F2F contacts per 100,000 population	...	38,312	55,461

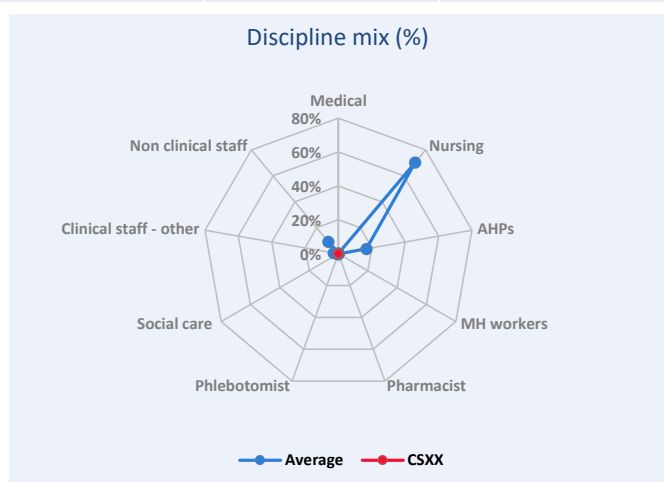


Section 3. Service dashboard

3.2 Community integrated care teams

Activity metrics	CSXX	Mean	Median
F2F contacts per clinical WTE in establishment	...	751	795
F2F contacts per service user	...	10	9
Non F2F contacts per 100,000 population	...	5,478	4,693
Unique service users per clinical WTE in establishment	...	82	82
Unique service users per 100,000 population	...	2,468	2,423
Average length of a contact (minutes)	...	41	37

Workforce metrics	CSXX	Mean	Median
Clinical WTE per 100,000 population	...	40.4	35.1
Non clinical WTE per 100,000 population	...	4.5	4.2
Pay budget per clinical WTE	...	£45,874	£41,155
Pay budget per non clinical WTE	...	£58,444	£27,004
Clinical staff vacancy rate	...	11%	10%
Non clinical staff vacancy rate	...	3%	2%
Staff sickness	...	5%	5%
Staff turnover	...	11%	11%



Staffing levels	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Hours of availability on weekdays (max 24)	...	14.3	13.0	9.75	17.25
Hours of availability on weekdays (max 24)	...	11.8	12.0	8	14.75

Finance metrics	CSXX			Mean		
	Budget 2020/21	Spend 2020/21	Budget 2021/22	Budget 2020/21	Spend 2020/21	Budget 2021/22
Clinical staff pay cost per 100,000 population	£1,608,359	£1,569,208	£1,606,091
Non clinical staff pay cost per 100,000 population	£139,183	£138,550	£149,164
Non pay cost per 100,000 population	£190,818	£196,458	£194,459
Indirect costs and overheads per 100,000 population	£596,210	£550,728	£592,289
Total cost per 100,000 population	£3,179,888	£2,975,896	£3,199,932
Total cost per service user	£879	£836	...
Agency cost as % of total pay costs	4.9%	4.8%	...
Bank cost as % of total pay costs	2.9%	2.9%	...

Quality metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Number of patient safety incidents per 100 service users	...	9.90	3.26	1.11	19.77
Friends and Family Test results – average score	...	95%	95%	93%	99%



Section 3. Service dashboard

3.3 End of life community teams

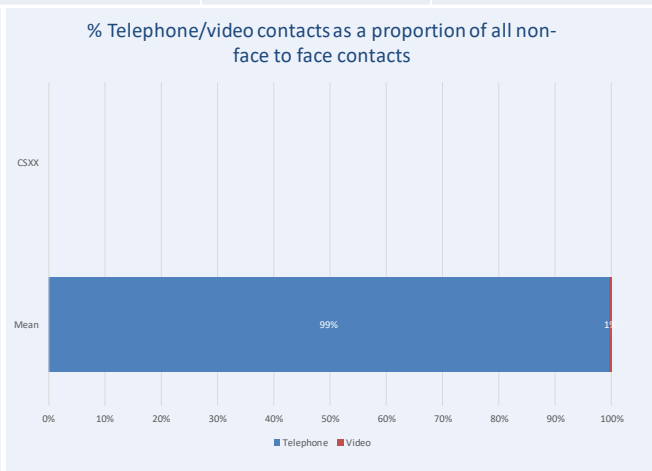
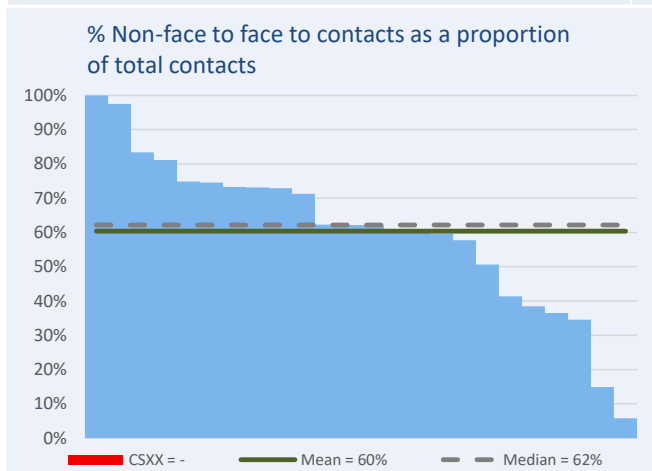
Overview

End of life community teams provide specialist support to patients in their last month(s) or year(s) of life. They help patients with advanced, progressive or incurable illness to live as well as possible until they die, providing support and palliative care for both patients and their families. In 2020/21 all teams reported providing services in the service user's own homes, 96% reported providing services in nursing and residential homes, 63% in community hospitals, 58% in mental health inpatient facilities and 54% of teams reported providing services in hospices. Teams typically provided pain and symptom control (100%), emotional and psychological support (96%) and nursing care (96%), but only 58% of teams provided therapy support and only 52% provided pharmacy support. Only 20% of services offered night sitting provision. The average waiting time for the service was reported as 6 days and the average length of a contact was 56 minutes.

Key findings

Summary metrics	2020/21		2019/20		Relative comparison		
	CSXX	Mean	CSXX	Mean	Lowest	Median	Highest
Referrals per 100,000 population	...	458	...	493			
F2F contacts per clinical WTE in establishment	...	317	...	355			
F2F contacts per service user	...	4	...	4			
Clinical WTE per 100,000 population	...	4	...	5			
Total budget per 100,000 population	...	£332,792	...	£360,516			
Friends and Family Test average score	...	95%	...	97%			

Activity metrics	CSXX	Mean	Median
Average waiting time (days)	...	6	6
DNA rate	...	0%	0%
Referrals per 100,000 population	...	458	385
Referral acceptance rate	...	93%	97%
Referrals accepted, assessed & seen within 28 days of receipt	...	90%	96%
Referrals via e-triage	...	59%	54%
F2F contacts per 100,000 population	...	1,399	1,164

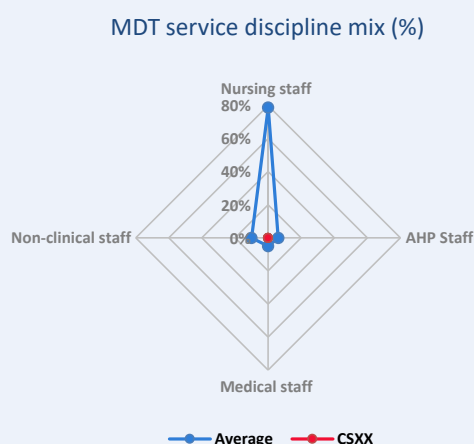


Section 3. Service dashboard

3.3 End of life community teams

Activity metrics	CSXX	Mean	Median
F2F contacts per clinical WTE in establishment	...	317	264
F2F contacts per service user	...	4	3
Non F2F contacts per 100,000 population	...	1,981	1,812
Unique service users per clinical WTE in establishment	...	88	71
Unique service users per 100,000 population	...	363	294
Average length of a contact (minutes)	...	56	53

Workforce metrics	CSXX	Mean	Median
Clinical WTE per 100,000 population	...	4.3	3.7
Non clinical WTE per 100,000 population	...	0.6	0.5
Pay budget per clinical WTE	...	£56,509	£52,585
Pay budget per non clinical WTE	...	£43,390	£27,863
Clinical staff vacancy rate	...	6%	5%
Non clinical staff vacancy rate	...	2%	0%
Staff sickness	...	5%	4%
Staff turnover	...	7%	4%



Weekend staffing	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Staffing levels (WTE) as a % of weekday staffing	...	17%	15%	11%	21%
Hours of availability as a % of weekday availability	...	106%	100%	100%	100%

Finance metrics	CSXX			Mean		
	Budget 2020/21	Spend 2020/21	Budget 2021/22	Budget 2020/21	Spend 2020/21	Budget 2021/22
Clinical staff pay cost per 100,000 population	£253,913	£230,815	£255,895
Non clinical staff pay cost per 100,000 population	£20,716	£17,576	£20,314
Non pay cost per 100,000 population	£11,088	£9,583	£10,716
Indirect costs and overheads per 100,000 population	£75,317	£90,246	£69,572
Total cost per 100,000 population	£332,792	£358,303	£300,056
Total cost per service user	£1,074	£1,134	...
Agency cost as % of total pay costs	1.1%	0.9%	...
Bank cost as % of total pay costs	2.1%	3.0%	...

Quality metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Number of patient safety incidents per 100 service users	...	2.9	1.4	0.7	3.4
Friends and Family Test results – average score	...	95%	100%	92%	100%
People dying in their preferred place of care	...	82%	86%	77%	90%



Section 3. Service dashboard

3.4 Respiratory teams

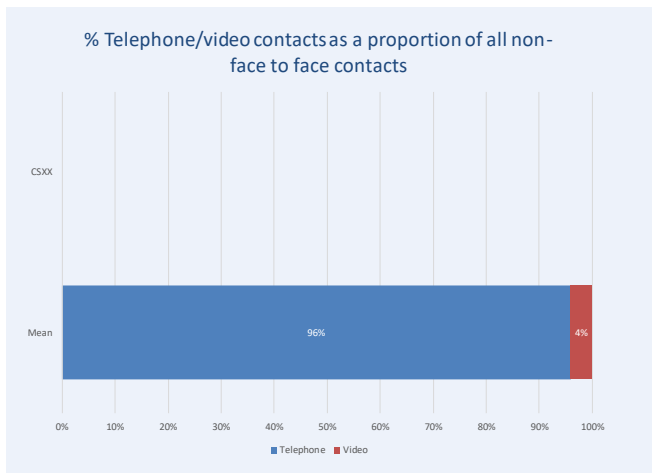
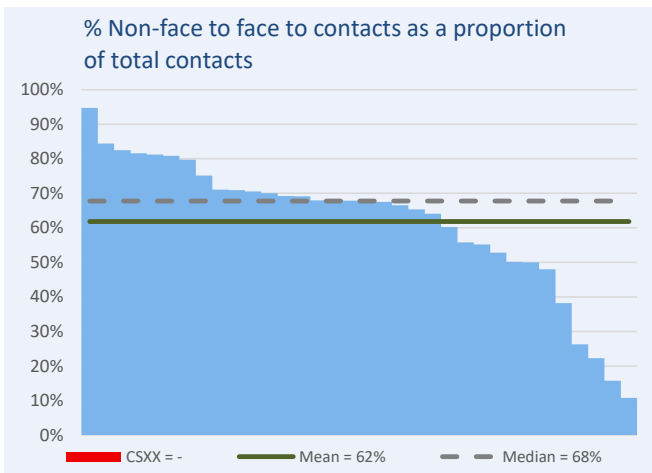
Overview

Community respiratory teams provide specialist services focussing on the management of chronic obstructive pulmonary disease (COPD) and other respiratory conditions. In 2020/21, on average, 376 referrals were received per 100,000 population in comparison to the 407 referrals received per 100,000 population in 2018/19*. The majority of referrals into respiratory services were deemed appropriate, with 90% of referrals accepted. Of the referrals received, 66% were accepted, assessed and seen within 28 days of receipt of referral, consistent with the figures from the 2018/19* project cycle. Service users accepted onto the caseload received, on average in 2020/21, 3 face to face contacts (compared to 5 in 2018/19).
 *the last year data was collected for this service.

Key findings

Summary metrics	2020/21		Relative comparison		
	CSXX	Mean	Lowest	Median	Highest
Referrals per 100,000 population	...	376			
F2F contacts per clinical WTE in establishment	...	241			
F2F contacts per service user	...	3			
Clinical WTE per 100,000 population	...	3			
Total budget per 100,000 population	...	£208,519			
Friends and Family Test average score	...	95%			

Activity metrics	CSXX	Mean	Median
Average waiting time (days)	...	34	28
DNA rate	...	4%	3%
Referrals per 100,000 population	...	376	238
Referral acceptance rate	...	90%	92%
Referrals accepted, assessed & seen within 28 days of receipt	...	66%	69%
Referrals via e-triage	...	74%	80%
F2F contacts per 100,000 population	...	652	472

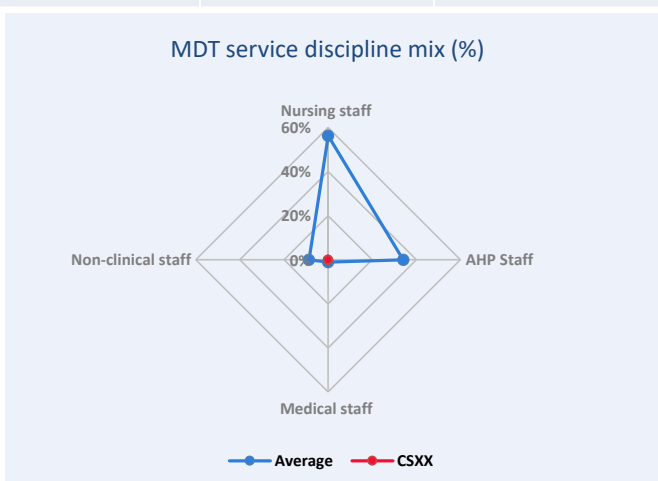


Section 3. Service dashboard

3.4 Respiratory teams

Activity metrics	CSXX	Mean	Median
F2F contacts per clinical WTE in establishment	...	241	196
F2F contacts per service user	...	3	2
Non F2F contacts per 100,000 population	...	1,186	1,043
Unique service users per clinical WTE in establishment	...	104	106
Unique service users per 100,000 population	...	266	245
Average length of a contact (minutes)	...	50	51

Workforce metrics	CSXX	Mean	Median
Clinical WTE per 100,000 population	...	2.9	2.6
Non clinical WTE per 100,000 population	...	0.4	0.3
Pay budget per clinical WTE	...	£44,411	£46,608
Pay budget per non clinical WTE	...	£37,717	£25,963
Clinical staff vacancy rate	...	5%	3%
Non clinical staff vacancy rate	...	9%	0%
Staff sickness	...	3%	3%
Staff turnover	...	10%	8%



Weekend staffing	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Staffing levels (WTE) as a % of weekday staffing	...	5%	0%	0%	0%
Hours of availability as a % of weekday availability	...	25%	0%	0%	39%

Finance metrics	CSXX			Mean		
	Budget 2020/21	Spend 2020/21	Budget 2021/22	Budget 2020/21	Spend 2020/21	Budget 2021/22
Clinical staff pay cost per 100,000 population	£128,947	£124,480	£144,723
Non clinical staff pay cost per 100,000 population	£11,642	£10,511	£11,858
Non pay cost per 100,000 population	£16,104	£13,555	£16,709
Indirect costs and overheads per 100,000 population	£55,467	£56,285	£53,029
Total cost per 100,000 population	£208,519	£206,584	£220,551
Total cost per service user	£784	£784	...
Agency cost as % of total pay costs	0.6%	0.6%	...
Bank cost as % of total pay costs	1.9%	2.0%	...

Quality metrics	CSXX	Mean	Median	Lower Quartile	Upper Quartile
Number of patient safety incidents per 100 service users	...	0.5	0.4	0.1	0.6
Friends and Family Test results – average score	...	95%	97%	94%	100%



Section 4. Next steps

2022 work programme

The Community Services Project will be included in the 2022 work programme.

Services to be included in the 2022 Community Services Project and the data specification will both be reviewed and agreed by the Community Reference Group in early 2022. The data specification will be finalised by the end of April 2022.

If you have any comments on the data specification, either on the existing content or definitions please email nhsbn.cst@nhs.net

Data collection will open during summer 2022. The project will be collecting 2021/22 data.

The Network also runs the Community Indicators Project, which collects monthly data on a smaller range of metrics. This project reports to Trusts/Health Boards throughout the year, tracking changes in patient safety and quality, access, productivity, workforce, finance and COVID-19. Members are able to participate in this project at any point during the year. For further information, please contact nhsbn.cst@nhs.net

Appendix 1. Participants

Organisation	Submission
Aneurin Bevan University Health Board	ABUHB - Cardiac
	ABUHB - District Nursing - Blaenau Gwent
	ABUHB - District Nursing - Caerphilly
	ABUHB - District Nursing - Monmouthshire
	ABUHB - District Nursing - Newport
	ABUHB - District Nursing - Torfaen
Barnet, Enfield and Haringey Mental Health NHS Trust	Barnet, Enfield and Haringey Mental Health NHS Trust
Belfast Health and Social Care Trust	Belfast Health and Social Care Trust
Berkshire Healthcare NHS Foundation Trust	Berkshire Healthcare NHS Foundation Trust
Birmingham Community Healthcare NHS Foundation Trust	Birmingham Community Healthcare NHS Foundation Trust
Black Country Healthcare NHS Foundation Trust	Black Country Healthcare NHS Foundation Trust
Bolton NHS Foundation Trust	Bolton NHS Foundation Trust
Bromley Healthcare CIC Ltd	Bromley Healthcare CIC Ltd
Buckinghamshire Healthcare NHS Trust	Buckinghamshire Healthcare NHS Trust
Cambridgeshire Community Services NHS Trust	Cambridgeshire Community Services NHS Trust
Central and North West London NHS Foundation Trust	Central and North West London NHS Foundation Trust – Camden
	Central and North West London NHS Foundation Trust – Harrow
	Central and North West London NHS Foundation Trust – Hillingdon
	Central and North West London NHS Foundation Trust – Islington
	Central and North West London NHS Foundation Trust – Milton Keynes
Central London Community Healthcare NHS Trust	Central London Community Healthcare NHS Trust- Barnet
	Central London Community Healthcare NHS Trust- Brent
	Central London Community Healthcare NHS Trust- Ealing
	Central London Community Healthcare NHS Trust- Hammersmith and Fulham

Appendix 1. Participants

Organisation	Submission
Central London Community Healthcare NHS Trust	Central London Community Healthcare NHS Trust- Harrow
	Central London Community Healthcare NHS Trust- Hertfordshire
	Central London Community Healthcare NHS Trust- Merton
	Central London Community Healthcare NHS Trust- Richmond
	Central London Community Healthcare NHS Trust- Tri- borough
	Central London Community Healthcare NHS Trust- Wandsworth
	Central London Community Healthcare NHS Trust- Westminster
	Central London Community Healthcare NHS Trust- West London
Central Surrey Healthcare Ltd	Central Surrey Healthcare Ltd
Cornwall Partnership NHS Foundation Trust	Cornwall Partnership NHS Foundation Trust
Coventry and Warwickshire Partnership NHS Trust	Coventry and Warwickshire Partnership NHS Trust
Derbyshire Healthcare NHS Foundation Trust	Derbyshire Healthcare NHS Foundation Trust
Dorset HealthCare University NHS Foundation Trust	Dorset HealthCare University NHS Foundation Trust
East Suffolk and North Essex NHS Foundation Trust	East Suffolk and North Essex NHS Foundation Trust
East Sussex Healthcare NHS Trust	East Sussex Healthcare NHS Trust
First Community Health and Care	First Community Health and Care
Frimley Health NHS Foundation Trust	Frimley Health NHS Foundation Trust
Gloucestershire Health and Care NHS Foundation Trust	Gloucestershire Health and Care NHS Foundation Trust
Hertfordshire Community NHS Trust	Hertfordshire Community NHS Trust
Hounslow and Richmond Community Healthcare NHS Trust	Hounslow Submission
	Richmond Submission
Humber Teaching NHS Foundation Trust	Humber Teaching NHS Foundation Trust
Kent Community Health NHS Foundation Trust	Kent Community Health NHS Foundation Trust

Appendix 1. Participants

Organisation	Submission
Lancashire & South Cumbria NHS Foundation Trust	Lancashire & South Cumbria NHS Foundation Trust - Blackburn
	Lancashire & South Cumbria NHS Foundation Trust - Central
Leicestershire Partnership NHS Trust	Leicestershire Partnership NHS Trust
Lincolnshire Community Health Services NHS Trust	Lincolnshire Community Health Services NHS Trust
Livewell Southwest	Livewell Southwest
Mid Cheshire Hospitals NHS Foundation Trust	Mid Cheshire Hospitals NHS Foundation Trust
Midlands Partnership NHS Foundation Trust	MPFT - Children & Families
	MPFT - Haywood MIS
	MPFT - North and South Staffordshire
	MPFT - North Staffordshire
	MPFT - South Staffordshire
North Tees and Hartlepool NHS Foundation Trust	North Tees and Hartlepool NHS Foundation Trust
North West Boroughs Healthcare NHS Foundation Trust	North West Boroughs Healthcare NHS Foundation Trust
Northamptonshire Healthcare NHS Foundation Trust	Northamptonshire Healthcare NHS Foundation Trust
Northern Lincolnshire and Goole NHS Foundation Trust	Northern Lincolnshire and Goole NHS Foundation Trust
Nottinghamshire Healthcare NHS Foundation Trust	Nottinghamshire Healthcare NHS Foundation Trust
Oxford Health NHS Foundation Trust	Oxford Health NHS Foundation Trust
Rotherham Doncaster and South Humber NHS Foundation Trust	Rotherham Doncaster and South Humber NHS Foundation Trust - Doncaster
	Rotherham Doncaster and South Humber NHS Foundation Trust – North Lincs
Royal Surrey NHS Foundation Trust	Royal Surrey NHS Foundation Trust
Salford Royal NHS Foundation Trust	Salford Royal NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust	Sheffield Teaching Hospitals NHS Foundation Trust
Sirona Care & Health CIC	Sirona Care & Health CIC

Appendix 1. Participants

Organisation	Submission
Solent NHS Trust	Solent NHS Trust – East
	Solent NHS Trust - West
Somerset NHS Foundation Trust	Somerset NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust	South West Yorkshire Partnership NHS Foundation Trust
Southern Health NHS Foundation Trust	Southern Health NHS Foundation Trust
St Helens and Knowsley Teaching Hospitals NHS Trust	St Helens and Knowsley Teaching Hospitals NHS Trust
Stockport NHS Foundation Trust	Stockport NHS Foundation Trust
Tameside and Glossop Integrated Care NHS Foundation Trust	Tameside and Glossop Integrated Care NHS Foundation Trust
The Dudley Group NHS Foundation Trust	The Dudley Group NHS Foundation Trust
The Newcastle upon Tyne Hospitals NHS Foundation Trust	The Newcastle upon Tyne Hospitals NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust	University Hospitals Birmingham NHS Foundation Trust
University Hospitals Dorset NHS Foundation Trust	University Hospitals Dorset NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Foundation Trust	University Hospitals of Morecambe Bay NHS Foundation Trust – North Lancashire
	University Hospitals of Morecambe Bay NHS Foundation Trust – South Cumbria
Walsall Healthcare NHS Trust	Walsall Healthcare NHS Trust
West London NHS Trust	West London NHS Trust
West Suffolk NHS Foundation Trust	West Suffolk NHS Foundation Trust
Whittington Health NHS Trust	Whittington Health NHS Trust - Haringey
	Whittington Health NHS Trust – Haringey and Islington
	Whittington Health NHS Trust - Islington
Wiltshire Health and Care	Wiltshire Health and Care
Wirral Community Health and Care NHS Foundation Trust	Wirral Community Health and Care - East Cheshire
	Wirral Community Health and Care NHS Foundation Trust - Wirral

Appendix 2. Metrics

Chart title	Data needed	Calculation
Summary Metrics		
Referrals per 100,000 population	<ul style="list-style-type: none"> Number of referrals received ONS resident population 	$(\text{Number of referral received} / \text{ONS resident population}) * 100,000$
Referrals via e-triage	<ul style="list-style-type: none"> % of referrals received which were triage via e-triage/virtually 	Raw data
Average waiting time	<ul style="list-style-type: none"> Average waiting time 	Raw data
Referral acceptance rate	<ul style="list-style-type: none"> Number of referrals received Number of referrals accepted 	$(\text{Number of referrals accepted} / \text{Number of referrals received}) * 100$
F2F contacts per clinical WTE in establishment	<ul style="list-style-type: none"> Face to face contacts Total WTE clinical staff combining nursing/AHP/medical or clinical/medical or as appropriate. 	$\text{Face to face contacts} / (\text{total WTE clinical staff})$
F2F contacts per service user	<ul style="list-style-type: none"> Face to face contacts Number of unique service users seen in the year 	$\text{Face to face contacts} / \text{number of unique service users seen in the year}$
Clinical WTE per 100,000 population	<ul style="list-style-type: none"> Total WTE clinical staff combining nursing/AHP/medical or clinical/medical or as appropriate. ONS resident population 	$(\text{Total WTE clinical staff} / \text{ONS resident population}) * 100,000$
Clinical staff vacancy rate	<ul style="list-style-type: none"> Clinical staff vacancy rate 	Raw data
Pay budget per clinical WTE	<ul style="list-style-type: none"> Pay costs: clinical staff (budget 2020/21) Total WTE clinical staff combining nursing/AHP/medical or clinical/medical or as appropriate 	$\text{Pay costs: clinical staff (budget 19/20)} / \text{Total WTE clinical staff}$
Total costs per 100,000 population	<ul style="list-style-type: none"> Pay costs: clinical staff (spend 2019/20) Pay costs: non-clinical staff (spend 2019/20) Non pay costs (spend 2019/20) Indirect costs and overheads (spend 2019/20) ONS resident population 	$((\text{Pay costs: clinical staff} + \text{pay costs: non-clinical staff} + \text{non pay costs} + \text{Indirect costs and overheads}) / \text{ONS resident population}) * 100,000$
Agency and bank spend as a % of total pay costs	<ul style="list-style-type: none"> Agency spend Bank spend Pay costs: clinical staff (spend 2019/20) Pay costs: non-clinical staff (spend 2020/21) 	$((\text{Agency spend} + \text{bank spend}) / (\text{Pay costs: clinical staff} + \text{pay costs: non-clinical staff})) * 100$
Friends and Family Test results - average score (%)	<ul style="list-style-type: none"> Friends and Family Test results - average score (%) 	Raw data

Appendix 2. Metrics

Chart title	Data needed	Calculation
Activity		
%Non-face to face to contacts as a proportion of total contacts	<ul style="list-style-type: none"> Non face to face contacts Face to face contacts 	$(\text{Non-face to face contacts}) / (\text{face to face contacts} + \text{non-face to face contacts}) * 100$
% Telephone/video contacts as a proportion of all non-face to face contacts	<ul style="list-style-type: none"> Non face to face contacts – Telephone Non face to face contacts – Video Non face to face contacts - Total 	$(\text{Non face to face contacts – Telephone}) / (\text{Non face to face contacts – Total}) * 100$
% Clinical WTE time	<ul style="list-style-type: none"> Patient facing time Patient non face to face time Indirect patient specific activity Non-patient specific activity Travel time 	Raw data
Total contacts per 100,000 population	<ul style="list-style-type: none"> Face to face contacts Non-face to face contacts ONS resident population 	$((\text{Face to face contacts} + \text{non-face to face contacts}) / \text{ONS resident population}) * 100,000$
Average waiting time	<ul style="list-style-type: none"> Average waiting time 	Raw data
DNA Rate (%)	<ul style="list-style-type: none"> DNA Rate (%) 	Raw data
Referrals per 100,000 population	<ul style="list-style-type: none"> Number of referrals received. ONS resident population 	$(\text{Number of referral received} / \text{ONS resident population}) * 100,000$
Referral acceptance rate (%)	<ul style="list-style-type: none"> Number of referrals received. Number of referrals accepted 	$(\text{Number of referrals accepted} / \text{Number of referrals received}) * 100$
Referrals accepted, assessed & seen within 28 days of receipt (%)	<ul style="list-style-type: none"> Referrals accepted, assessed & seen within 28 days of receipt (%) 	Raw data
% of referrals via e-triage	<ul style="list-style-type: none"> % of referrals received which were triage via e-triage/virtually 	Raw data
F2F contacts per 100,000 population	<ul style="list-style-type: none"> Face to face contacts ONS resident population 	$(\text{Face to face contacts} / \text{ONS resident population}) * 100,000$
F2F contacts per clinical wte in establishment	<ul style="list-style-type: none"> Face to face contacts Total WTE clinical staff combining nursing/AHP/medical or clinical/medical or as appropriate 	$\text{Face to face contacts} / (\text{total WTE clinical staff})$
F2F contacts per service user	<ul style="list-style-type: none"> Face to face contacts Number of unique service users seen in the year 	$\text{Face to face contacts} / \text{number of unique service users seen in the year}$
Non F2F contacts per 100,000 population	<ul style="list-style-type: none"> Non face to face contacts ONS resident population 	$(\text{Non-face to face contacts} / \text{ONS resident population}) * 100,000$

Appendix 2. Metrics

Chart title	Data needed	Calculation
Non-F2F contacts per clinical wte in establishment	<ul style="list-style-type: none"> Non-face to face contacts Total WTE clinical staff combining nursing/AHP/medical or clinical/medical or as appropriate. 	Non-face to face contacts/ (total WTE clinical staff)
Non-F2F contacts per service user	<ul style="list-style-type: none"> Non-face to face contacts Number of unique service users seen in the year 	Non-face to face contacts/number of unique service users seen in the year
Caseload per clinical wte in establishment	<ul style="list-style-type: none"> Total number of service users on caseload at beginning of the year Total number of service users on caseload at the end of the year Total WTE clinical staff combining nursing/AHP/medical or clinical/medical or as appropriate. 	((Total number of service users of caseload at beginning of the year + total number of service users on caseload at end of the year)/2) / (total WTE clinical staff)
Unique service users per clinical WTE in establishment	<ul style="list-style-type: none"> Number of unique service users seen in the year Total WTE clinical staff combining nursing/AHP/medical or clinical/medical or as appropriate. 	(Number of unique service users seen in the year/ total WTE clinical staff)
Unique service user per 100,000 population	<ul style="list-style-type: none"> Number of unique service users seen in the year ONS resident population 	(Number of unique service users seen in the year/ OMS resident population) * 100,000
Average length of contact	<ul style="list-style-type: none"> Average length of contact 	Raw data
Workforce		
Clinical staff skill mix (%)	<ul style="list-style-type: none"> Clinical staff (Establishment) (Band 2-9) 	Clinical staff (Establishment) (Band N)/Clinical staff (Establishment) (Total)
Non clinical staff skill mix (%)	<ul style="list-style-type: none"> Non clinical staff (Establishment) (Band 2-9) 	Non clinical staff (Establishment) (Band N)/Non clinical staff (Establishment) (Total)
Clinical wte per 100,000 population	<ul style="list-style-type: none"> Total WTE clinical staff combining nursing/AHP/medical or clinical/medical or as appropriate. ONS resident population 	(Total WTE clinical staff/ONS resident population) *100,000
Non-clinical wte per 100,000 population	<ul style="list-style-type: none"> Total WTE non-clinical staff ONS resident population 	(Total WTE non-clinical staff/ONS resident population) *100,000
Pay budget per clinical WTE	<ul style="list-style-type: none"> Pay costs: clinical staff (budget 2020/21) Total WTE clinical staff combining nursing/AHP/medical or clinical/medical or as appropriate. 	Pay costs: clinical staff (budget 20/21) / Total WTE clinical staff

Appendix 2. Metrics

Chart title	Data needed	Calculation
Pay budget per non-clinical WTE	<ul style="list-style-type: none"> Pay costs: non-clinical staff (budget 2020/21) Total WTE non-clinical staff 	Pay costs: non-clinical staff (budget 20/21) / Total WTE non-clinical staff
Clinical staff vacancy rate	<ul style="list-style-type: none"> Clinical staff vacancy rate 	Raw data
Non-clinical staff vacancy rate	<ul style="list-style-type: none"> Non-clinical staff vacancy rate 	Raw data
Staff sickness	<ul style="list-style-type: none"> Staff sickness 	Raw data
Staff turnover	<ul style="list-style-type: none"> Staff turnover 	Raw data
Staffing levels as % of weekday staffing	<ul style="list-style-type: none"> Staff available weekdays Staff available weekends 	(Staff available weekends/ staff available weekdays) *100
Hours of availability as a % of weekday availability	<ul style="list-style-type: none"> Hours available weekdays Hours available weekends 	(Hours available weekends/ staff available weekdays) *100
Finance		
Clinical staff pay spend per 100,000 population	<ul style="list-style-type: none"> Pay costs: clinical staff (spend 2020/21) ONS resident population 	(Pay costs: clinical staff (spend 2020/21)/ ONS resident population) *100,000
Agency and bank spend as a % of total pay costs	<ul style="list-style-type: none"> Agency spend Bank spend Pay costs: clinical staff (spend 2020/21) Pay costs: non-clinical staff (spend 2020/21) 	((Agency spend + bank spend)/ (Pay costs: clinical staff + pay costs: non-clinical staff)) *100
Total costs per 100,000 population	<ul style="list-style-type: none"> Pay costs: clinical staff (spend 2020/21) Pay costs: non-clinical staff (spend 2020/21) Non pay costs (spend 2020/21) Indirect costs and overheads (spend 2020/21) ONS resident population 	((Pay costs: clinical staff + pay costs: non-clinical staff + non pay costs + Indirect costs and overheads)/ ONS resident population) *100,000
Non-clinical staff pay spend per 100,000 population	<ul style="list-style-type: none"> Pay costs: non-clinical staff (spend 2020/21) ONS resident population 	(Pay costs: non-clinical staff (spend 2020/21)/ ONS resident population) *100,000
Non-pay spend per 100,000 population	<ul style="list-style-type: none"> Non pay costs (spend 2020/21) ONS resident population 	(non-pay costs (spend 2020/21)/ ONS resident population) *100,000
Indirect costs and overheads per 100,000 population	<ul style="list-style-type: none"> Indirect costs and overheads (spend 2020/21) ONS resident population 	(Indirect costs and overheads (spend 2020/21)/ ONS resident population) *100,000

Appendix 2. Metrics

Chart title	Data needed	Calculation
Cost per service user	<ul style="list-style-type: none"> Pay costs: clinical staff (spend 2020/21) Pay costs: non-clinical staff (spend 2020/21) Non pay costs (spend 2020/21) Indirect costs and overheads (spend 2020/21) Number of unique service users seen in the year 	$\frac{\text{Pay costs: clinical staff} + \text{pay costs: non-clinical staff} + \text{non pay costs} + \text{Indirect costs and overheads}}{\text{Number of unique service users seen in the year}}$
Agency spend as a % of total pay costs	<ul style="list-style-type: none"> Agency spend Pay costs: clinical staff (spend 2019/20) Pay costs: non-clinical staff (spend 2019/20) 	$\frac{\text{Agency spend}}{\text{Pay costs: clinical staff} + \text{pay costs: non-clinical staff}} * 100$
Bank spend as a % of total pay costs	<ul style="list-style-type: none"> Bank spend Pay costs: clinical staff (spend 2019/20) Pay costs: non-clinical staff (spend 2019/20) 	$\frac{\text{Bank spend}}{\text{Pay costs: clinical staff} + \text{pay costs: non-clinical staff}} * 100$
Quality and Outcomes		
Number of patient safety incidents per 100 service users	<ul style="list-style-type: none"> Number of patient safety incidents reported by the service during the year. Number of unique service users seen in the year 	$\frac{\text{Number of patient safety incidents reported by the service during the year.}}{\text{Number of unique service users seen in the year}} * 100$
Friends and Family Test results - average score (%)	<ul style="list-style-type: none"> Friends and Family Test results - average score (%) 	Raw data
Percentage of patients on caseload that have a care plan documented and agreed with the service user/carer	<ul style="list-style-type: none"> What % of patients on the caseload have a care plan documented and agreed with the service user/carer? 	Raw data
Weekend day staffing levels (WTE) as a % of weekday WTE	<ul style="list-style-type: none"> Number of staff on shift weekdays – day staff on shift Number of staff on shift weekends – day staff on shift 	$\frac{\text{Number of staff on shift weekdays – day staff on shift}}{\text{Number of staff on shift weekends – day staff on shift}} * 100$
Weekend evening staffing levels (WTE) as a % of weekday WTE	<ul style="list-style-type: none"> Number of staff on shift weekdays – evening staff on shift Number of staff on shift weekends – evening staff on shift 	$\frac{\text{Number of staff on shift weekdays – evening staff on shift}}{\text{Number of staff on shift weekends – evening staff on shift}} * 100$
Weekend night staffing levels (WTE) as a % of weekday WTE	<ul style="list-style-type: none"> Number of staff on shift weekdays – night staff on shift Number of staff on shift weekends – night staff on shift 	$\frac{\text{Number of staff on shift weekdays – night staff on shift}}{\text{Number of staff on shift weekends – night staff on shift}} * 100$

Appendix 2. Metrics

Chart title	Data needed	Calculation
People dying in their preferred place of care	<ul style="list-style-type: none"> Percentage of people dying in their preferred place of care (%) 	Raw data
Number of SUIs per annum per 100 WTE staff	<ul style="list-style-type: none"> Number of SUIs per annum Total number of staff (Clinical, Medical and Non clinical) 	(Number of SUIs per annum/ Total number of staff)*100
Number of pressure ulcers (grade 2,3 & 4) per 100 service users	<ul style="list-style-type: none"> Number of pressure ulcers (grade 2, 3 & 4) acquired whilst under the care of the service Number of unique service users seen in the year 	(Number of pressure ulcers (grade 2, 3 & 4) acquired whilst under the care of the service / Number of unique service users seen in the year)*100
Number of complaints per 100 WTE staff	<ul style="list-style-type: none"> Number of complaints per annum Total number of staff (Clinical, Medical and Non clinical) 	(Number of complaints per annum/ Total number of staff)*100
Health Visiting		
DNA Rate (%)	<ul style="list-style-type: none"> DNA Rate (%) 	Raw data
% of first/ second/ third/ fourth/ fifth visits carried out within designated time period	<ul style="list-style-type: none"> % of first/ second/ third/ fourth/ fifth visits carried out within designated time period 	Raw data
First/ second/ third/ fourth/ fifth face to face contacts per 100,000 population	<ul style="list-style-type: none"> First/ second/ third/ fourth/ fifth face to face contacts ONS resident population 	((First/ second/ third/ fourth/ fifth face to face contacts) / ONS resident population) * 100,000
Breast feeding rate at 6-8 weeks post birth (%)	<ul style="list-style-type: none"> Breast feeding rate at 6-8 weeks post birth (%) 	Raw data
Percentage of children that have the ASQ-3 completed as part of their 2 to 2.5 year review	<ul style="list-style-type: none"> Percentage of children that have the ASQ-3 completed as part of their 2 to 2.5 year review 	Raw data
Percentage of children achieving a good level of development at 2 to 2.5 years	<ul style="list-style-type: none"> Percentage of children achieving a good level of development at 2 to 2.5 years 	Raw data
Cardiac		
MDT service discipline mix (%)	<ul style="list-style-type: none"> Nursing staff (WTE) AHP staff (WTE) Medical staff (WTE) Non clinical staff (WTE) 	Nursing staff/AHP staff/Medical staff/Non clinical staff) as a percentage of total workforce (sum of all)
Nursing staff skill mix (%)	<ul style="list-style-type: none"> Nursing staff (WTE) Band 2 – Band 9 	Nursing staff band 2-9 WTE as a percentage of total nursing workforce (sum of all bands)

Appendix 2. Metrics

Chart title	Data needed	Calculation
Community integrated care teams		
Top five further services included in CICT	<ul style="list-style-type: none"> Functions provided by CICTs: Management of people living with frailty, Crisis response, Wound care, End of life/palliative care & Home based intermediate care 	Raw data / Yes/No %
Frailty management in the community	<ul style="list-style-type: none"> Does the CICT routinely screen for frailty when a person is referred to the CICT? Do you use the electronic frailty index (eFI) obtainable via primary care health records to obtain registers of people identified as frail? 	Raw data / Yes/No %
Hours of availability on weekdays (max 24)	<ul style="list-style-type: none"> Hours of availability on weekdays (max 24) 	Raw data
Hours of availability on weekdays (max 24)	<ul style="list-style-type: none"> Hours of availability on weekdays (max 24) 	Raw data

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