



# The value of community services: comparison with acute settings



## Summary

The *NHS long term plan*<sup>1</sup> has reversed an established trend of overlooking the importance of community health services in the delivery of care. The need to expand community health services was emphasised in the *Five year forward view*<sup>2</sup> to support the development of a population health approach and this has been developed in the recent plan. However, while it is recognised that caring for people in their own homes or communities is beneficial to health and wellbeing, understanding where it can have the most impact continues to be a challenge.

This briefing is the first of a series looking at how services delivered in the community add value to both the patient and the wider health and care economy. This report focuses on the value of delivering services in the community that were traditionally provided in an acute hospital setting. Future briefings will consider how community services support prevention and improve patient activation plus look at the sector's role as a system integrator.

## Introduction

Moving care into the community has been a long-held ambition of the NHS with *The hospital plan for England and Wales*<sup>3</sup> in 1962 emphasising the need to expand community services in order to keep hospital use and costs under control. The perception continues that taking care out of expensive acute trusts will enable the system to make financial savings through the use of lower cost community services, although the *NHS long term plan* does not assume that increased community investment will reduce hospital bed capacity. Many studies have shown that community care is not a

<sup>1</sup> NHS England, *NHS long term plan*, Jan 2019

<sup>2</sup> NHS England, *Five year forward view*, Oct 2014

<sup>3</sup> UK Parliament, *The hospital plan for England and Wales*, 1962

cheaper option when considering all the costs involved in the provision on a like for like basis with acute care. However, the picture changes when considering the value of community care.

Value based healthcare focuses on maximising the outcomes that matter to people at the lowest possible cost. Better outcomes mean that resources are used to best effect, providing improved value for money for the health and care system. Better outcomes for patients may manifest through improved resilience and self-care, fewer admissions and reduced use of urgent and emergency care. Therefore, when considering the value of community care, a holistic and long-term approach has to be taken in order to understand the impact across the whole health and care system both now and in the future, through improved prevention and reduced exacerbation of condition.

This first briefing seeks to understand the value added for patients and the health economy through providing services in the community, or in the home, that would traditionally have required a visit to an acute hospital.

## Scope and methodology

People are supported to stay well in the community by a wide variety of services, across health, social care and the third sector. This briefing has been prepared with the HFMA's Healthcare in the Community Special Interest Group; it therefore focuses on those services provided by NHS organisations, such as NHS trusts or community interest companies delivering NHS services.

The briefing draws on case studies from across the United Kingdom to illustrate the benefits of delivering services in the community that were traditionally delivered in acute hospitals. Case studies have been submitted by HFMA members with further detail added through telephone interviews with service leads. These are therefore a self-selected sample. These examples have been supplemented with information from presentations at HFMA events and case studies in the public domain from other bodies.

The briefing looks at the delivery of care in a number of alternative settings – community hospitals; community clinics; primary care; other community spaces; and the patient's home to show the breadth of settings in use and the possibilities that exist. It sets out the reasons why the service has moved and the benefit that it provides in doing so, with supporting data where available.

## Determinants of value

Value based healthcare focuses on achieving better outcomes for people within the resources available. The creation of these better outcomes can be achieved in several different ways. The Nuffield Trust suggests that value may be increased through addressing unmet need or by meeting need in different ways<sup>4</sup>, however that need has to be identified in the first instance through understanding the population so that resources are directed to the correct services. Value can also be created by developing, and retaining, a more engaged workforce who, in turn, deliver better care for the population that they serve.

Value can be considered from several perspectives. Technical value considers the optimal way to use resources to achieve the best outcomes for a patient within a given process. Population value, or allocative value, considers the value offered to the whole population by allocating resources effectively across the health and care system.

The optimisation of a particular treatment or process is only part of the patient's pathway and using resources differently to support people in the community may lead to better outcomes, reduce unnecessary service usage and prevent acute admissions. A more effective allocation of resources can release both funding and effort to focus on improving patient care.

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<sup>4</sup> Nuffield Trust, *Shifting the balance of care*, 2017

For the patient, personal value can be something much less tangible; a less stressful experience, being able to have the support of family and friends or just having the confidence and assistance to stay in their own home.

Value based healthcare seeks to improve patient defined outcomes, which encompass both patient reported outcome measures (PROMS) linked to the success of their treatment and patient reported experience measures (PREMS) which focus on their experience of care. The case studies in this briefing consider both aspects in their analyses of impact.

The measurement of value and assessment of impact is a widely recognised challenge across the community health services sector. This briefing seeks to share good practice and support the development of community services as set out in the *NHS long term plan*.

## The use of alternative settings

### Community hospitals

A recent report by the University of Birmingham<sup>5</sup> sought to define what a community hospital is and offers the following description:

- a hospital with fewer than 100 beds serving a local population of up to 100,000, providing direct access to GPs and local community staff
- typically GP-led or nurse-led with medical support from local GPs
- services provided are likely to include inpatient care for older people, rehabilitation and maternity services, outpatient clinics and day care as well as minor injury and illness units, diagnostics and day surgery. The hospital may also be a base for the provision of outreach services by multidisciplinary teams (MDT)
- will not have a 24-hour accident and emergency (A&E) department nor provide complex surgery
- in addition, a specialist hospital (for example, a children's hospital, a hospice or a specialist mental health or learning disability hospital) would not be classified as a community hospital.

The report also noted that the level of patient acuity being seen in the setting, is increasing.

While step down from acute beds accounts for the majority of community inpatient admissions, most acute services delivered at the hospitals are in the form of outreach clinics from acute trusts. These may cover simple surgical procedures such as endoscopy and cataracts; ambulatory care such as chemotherapy and stoma services; or diagnostic tests such as x-ray, ultrasound or phlebotomy. Routine outpatient appointments can also be held at community hospitals rather than at the acute trust. The *NHS long term plan* sets out the intention to modernise outpatient provision with the increasing use of digital technology which should significantly reduce the number of face to face appointments required. However, where appointments are needed, there continues to be a drive to offer these closer to home.

In Greater Manchester<sup>6</sup>, staff from the acute trust deliver a cardiac pacing diagnostic service from community hospitals to enable services to be delivered closer to the patients' homes, therefore reducing the need to travel for routine pacemaker checks. The service was designed to mirror the diagnostic environment of the acute trust to assuage staff and commissioner concerns about maintaining the quality of provision. The outcome of the service is not only an improved patient experience, but also increased confidence for staff in their own abilities to carry out this work autonomously. The staff work on a rotational basis between the acute trust and community hospital.

Improving diagnostics at a community hospital in Bradford<sup>6</sup> meant that a podiatric surgery service could be established. This again meant that patient travel could be reduced by providing care closer to home, while freeing up theatre capacity at the acute trust. By co-ordinating community theatre

<sup>5</sup> National Institute for Health Research, *Analysis of the profile, characteristics, patient experience and community value of community hospitals: a multimethod study*, Jan 2019

<sup>6</sup> National Healthcare Science Quality Improvement Champions Group, *Case studies*, 2016

sessions with community clinic times, resources can be used more efficiently therefore reducing waiting times.

## Community clinics

For the purposes of this briefing, community clinics offer acute type services in a medical setting, outside of a hospital environment. Clinics may take place in primary care premises or dedicated community services facilities.

Community clinics support the aim of delivering services closer to home, enabling specialist clinics to be run in the areas where need is located. The most common examples of this approach are the mobile clinics run by acute trusts to deliver clinics in community spaces, such as breast screening in supermarket car parks. For preventative acute services such as this, delivering services near to where people live and work means that uptake is improved as it is convenient to attend. This approach is also used in some areas to deliver routine acute eyecare to prevent the need for patients to travel to the acute trust site.

## Primary care

The *NHS long term plan* recognises the importance of primary care in improving population health due to the sector's knowledge of the community that they serve and the links that they have with it. Delivering acute interventions and treatment within a primary care setting, be that by GPs or other healthcare professionals, can support the aim of delivering care closer to home and can also improve acute referrals through adding to local knowledge about when a referral is necessary.

Many recent studies of community services highlight that the impetus to move services closer to home has come at a time when the community workforce is decreasing, both within the services themselves and within primary care, who are often called upon to support new service developments outside of hospital. However, commentators differ on the impact on primary care, with the Nuffield Trust's view<sup>4</sup> being that much of the success of community services relies on GPs doing more whereas NHS Providers<sup>7</sup> believe that the development of a better community offer is more likely to reduce pressure on primary, rather than acute, care. As the *NHS long term plan* encourages the spread of primary care networks to develop fully integrated community-based care, the role of primary care will become even more important.

Primary care does not only cover GP services, the sector also includes dentists and optometrists. Aneurin Bevan University Local Health Board (ABUHB) has developed a service to utilise the expertise of optometrists working in the community to deliver assessment, diagnosis and treatment for glaucoma and wet age-related macular degeneration conditions (Case study 1).

### Case study 1: Aneurin Bevan University Local Health Board Ophthalmic Diagnostic and Treatment Centres

Aneurin Bevan University Local Health Board (ABUHB) covers the five Gwent local authority areas in the south east of Wales, serving a population of 600,000 people.

The overall aim of the Ophthalmic Diagnostic and Treatment Centre (ODTC) service is to provide assessment, diagnosis and treatment for glaucoma and wet age-related macular degeneration (AMD) conditions in a community setting. This has improved access to ophthalmology services and reduced the risk of harm as a result of reducing waiting times for patients currently on acute waiting lists.

The service aimed to address key concerns around the ophthalmology provision by achieving the following:

- reducing delayed follow ups

<sup>7</sup> NHS Providers, *NHS community services: taking centre stage*, May 2018

- reducing hospital based follow up outpatient appointment demand
- reducing waiting times for new outpatient appointment and treatment
- developing sustainable ophthalmology services allowing specialists to focus on more complex work
- reducing clinical risk of patients coming to harm by reducing waiting times
- meeting the 14-day NICE target for the treatment of wet AMD
- developing an integrated model for delivering ophthalmology services to the population.

Six primary care ODTIC providers have been commissioned in ABUHB to deliver services for patients with suspected and confirmed glaucoma and wet AMD.

Over a two-year implementation programme, the scheme has offered:

- glaucoma new and follow up assessments
- monitoring of low risk/stable glaucoma patients
- suspected wet AMD assessments
- intravitreal treatment for wet AMD
- treatment of diabetic macular oedema and retinal vein occlusion.

The services are provided by a team including optometrists, nurse practitioners and visiting consultants.

This service improves access to ophthalmology services, provides a platform for the sustainability of ophthalmology services and transfers care previously provided in hospitals to primary care.

The key benefits for service users are:

- improved access to ophthalmology services with reduced delays
- reduced risk of coming to harm while waiting on new or delayed follow up waiting lists
- care closer to home.

The ODTIC service has been a success in terms of the planned objectives, it has supported ABUHB in providing sustainable services, locally, to patients. While there is not a significant cost saving, there is a significant value gain for ABUHB and patients in terms of service model and sustainability, given the limiting factors on the acute sector.

## Other community spaces

For some people, a visit to the local acute trust, or even another medical facility, is something to be avoided. For others in very rural locations, distance and travel difficulties can make attendance impossible. It is in these cases that the delivery of care in non-medical community spaces can add value to people who would otherwise not receive care until they were admitted as an emergency. In Lincolnshire, the community tuberculosis service is reaching people who would otherwise not access services (Case study 2).

### Case study 2: Lincolnshire countywide tuberculosis service

The Lincolnshire countywide community tuberculosis (TB) service was set up to meet the objectives in the Collaborative TB strategy developed by Public Health England and NHS England. The onset of TB can be difficult to detect and there are significant diagnostic delays in England, but the incidence of the disease is higher than in most Western European countries. Late diagnoses are associated with worse outcomes for the individual; the diagnosis of latent TB in somebody who is within an 'at risk' group can prevent the disease from being activated.

The TB service undertakes active case finding in targeted groups where the disease is more likely to occur. These groups are often under-served populations such as homeless people who can be



difficult to access. One of the nurses within the Lincolnshire service attends a local voluntary centre several times each week to treat patients and build relationships, which has helped to spread the word through networks of contacts and, as a result, has identified more cases than may otherwise have gone undetected until a crisis was reached.

The detection of unmet TB need in these under-served groups can also result in other health issues being addressed, such as alcohol consumption, smoking and a need to access other services such as physiotherapy. The service has also supported health improvements for people through regularly monitoring weight, bloods and providing access to a food bank.

Active case finding has enabled the service to not only improve the detection, diagnosis and treatment of TB but has also contributed to the improvement of people's general wellbeing thus reducing the likelihood of reliance on urgent care and other services in the future. The improvement in outcomes directly demonstrates the value of this community-based service, rather than an acute centred TB provision.

## Care homes

Patients resident in intermediate care homes are often elderly, frail and confused. It is known that admitting elderly people to hospital can have an adverse impact on their physical ability<sup>8</sup>. Therefore, avoiding unnecessary admissions not only reduces cost to the system but also improves the person's outcome. However, even an outpatient visit to a busy acute setting can cause distress.

In Manchester<sup>6</sup>, work has been undertaken to reduce the number of hospital visits by care home residents through enabling point of care testing to monitor INR<sup>9</sup> for those patients on Warfarin. The acute care team have trained intermediate care staff to use the testing device and the results are entered directly onto the anticoagulant patient record system. Developing the technology links between the two settings was a challenge, but it enables the acute specialist to review the test results remotely and suggest any medication changes without the patient having to make an unnecessary, and potentially distressing, ambulance journey to the acute trust.

The development of INR testing in the intermediate care environment has had a direct impact on the patient experience. Not only has it reduced patient anxiety around the test itself, but it also means that meals and routine medication are not missed through being away from their care setting, ensuring outcomes are not compromised. Staff in the community have increased their skills; staff at the acute trust are not dealing with unnecessarily distressed patients and ambulance journeys have been reduced.

## Patients' homes

Delivering care in people's own homes supports recovery through delivering services in a familiar environment. Healthcare professionals can ensure that the treatment being administered is appropriate for the patient's situation and have a greater knowledge of the person's support needs. Often, treatment at home enables family or carers to be involved, therefore supporting an informal continuity of care. Consequently, the patient's support network can develop greater understanding of the person's care needs and develop the appropriate skills to assist them with day to day life.

The Sussex hospital at home service (Case study 3) illustrates that the value in delivering acute care in the home extends beyond the value to the patient and the NHS. By enabling people to continue with their lives where possible, the impact on the patient's family is reduced and the wider economy retains effective employees.

<sup>8</sup> University of Oxford, *Hospital or hospital-at-home - what's best for older people?*, 2018

<sup>9</sup> A regular blood test called the international normalised ratio (INR) that measures how long it takes blood to clot

### **Case study 3: Sussex hospital at home**

The hospital at home service in Sussex looks after 'sub-acute' patients; patients who would normally remain in a hospital bed but can be supported in their own homes.

The service is commissioned from Sussex Community NHS Foundation Trust by the acute provider, Brighton and Sussex University Hospitals NHS Trust. Patients remain under the care of an acute consultant while being cared for in their own homes, but the service is delivered by community nursing staff.

Currently the service covers:

- anti-microbial therapy pathway
- bronchiectasis admission avoidance pathway
- negative pressure wound therapy for vascular patients.

Other pathways are in development as the service expands.

For the patients, this service allows them to get on with life, some still work or continue their own caring responsibilities while having treatment. Staff have noticed that patients tend to recover quicker in their own home, both physically and emotionally, and the readmission rate is very low.

The service receives positive feedback from the patients and an example is shared below.

'The outstanding service allowed me to avoid hospital admission and receive treatment at home. I have two young children (3 years and 18 months) and was able to continue being their main carer. The team came to my home three times per day to administer intravenous antibiotics and were always flexible to fit around any family commitments. They were utterly brilliant with my children and helped to keep them entertained while I was immobile.'

Financial analysis has shown a saving of 27% when compared with the same treatment at the acute trust. The service has released bed capacity and has helped to better manage demand.

Delivering acute inpatient services in the home is not only beneficial for the patient but also provides a fulfilling role for the staff involved. The team in Sussex come from a variety of acute backgrounds and are able to retain their skills through their caseload. This means that turnover in the service is very low and recruitment to vacancies is straightforward; staff seek them out rather than the other way around. The value of an engaged workforce is evident through the feedback received for the service.

This phenomenon is not unique to Sussex. Similar services in other parts of the country have also noticed the positive impact that it has on staff and the consequential effect on staff, and patient, wellbeing. The West Norfolk intermediate care service and virtual ward has been in operation since 2014 (Case study 4).

### **Case study 4: West Norfolk intermediate care service and virtual ward**

The virtual ward concept was developed in 2006 and has been part of the community services offer in West Norfolk since 2014.

The overall aim of the service is to provide short term care and support to patients who are medically stable and would require admission to hospital without additional support. The service also provides support for patients at home so that they can be discharged earlier, hence reducing acute bed days. The virtual ward forms part of the intermediate care service which includes community intravenous (IV) services and in-reach to local care home beds.

The service model currently has a high proportion of unregistered staff but with increasing patient complexity this is being revised to increase numbers of qualified staff. Staff are attracted to the unusual nature of the service and most of the registered nurses have moved from more traditional community roles. The IV service is particularly attractive as it works closely with the acute trust and enables nurses to develop or utilise skills that can usually only be applied in an acute setting.

The commissioning CCG receives daily reports from the service which details caseload, new admissions and discharges. This includes information about the conditions of those being supported, demonstrating the wide range of competencies within the team. The report also includes the available capacity, enabling the CCG to utilise the service to meet other issues in the system, be that pressure at the acute trust or the need for additional social care services in order to allow a patient to be discharged. The intermediate care team includes social care staff as part of the multi-disciplinary approach.

Similar services operate in other parts of the United Kingdom. The enhanced care at home service run by South Eastern Health and Social Care Trust in Northern Ireland, aims to help people over the age of 65 experience physical and psychological wellbeing and live well until the end of life. The service supports patients through brief periods of illness or debility in their own homes avoiding the need for emergency attendance or hospital admission. The service saved 1,749 bed days in a three month period between August and October 2018, with over 80% of patients remaining in their own home upon discharge from the service.

Services delivered at home can also focus on specific interventions. In Bolton<sup>8</sup>, a specialist community IV therapy service operates seven days per week in patients' homes which helps to avoid admissions and offers a better experience for the patient. Some of these patients have a compromised immune system so care at home avoids the risk of hospital acquired infections.

Lincolnshire has developed a hospital at home model that focuses on chronic obstructive pulmonary disease (Case study 5).

#### **Case study 5: Lincolnshire acute respiratory assessment service<sup>10</sup>**

The community respiratory team within Lincolnshire Community Health Services NHS Trust are commissioned to provide a hospital-at-home/ admission avoidance service for patients with chronic obstructive pulmonary disease (COPD). This service is called the acute respiratory assessment service (ARAS).

The service is designed to prevent admission and facilitate earlier discharge for those who present at the acute trust as an emergency. It is staffed by respiratory nurse specialists who are able to carry out and interpret capillary blood gas assessments. Referrals are made from primary and secondary care, plus those who are already known to the service are able to self-refer.

In the 12 month period from 1 April 2014 to 31 March 2015 128 patients were referred to the service. Some 21 patients would have met the criteria for acute admission for respiratory conditions but only two were actually admitted.

It is likely that if the 21 patients had been seen by generalist practitioners in A&E they would have been admitted and the cost would have been £76,386. The ARAS specialist nurse visiting patients in their own homes reduced that cost to £28,972 – a cost saving of £47,414. This calculation assumes that none of the remaining 107 patients would have been admitted, although it is probable that a proportion may have been.

<sup>10</sup> [British Journal of Nursing, Avoiding hospital admission in COPD: impact of a specialist nursing team, 2017](#)



A retrospective study of case notes has been published in the British Journal of Nursing<sup>11</sup>. Further work is underway to use patient level data to assess whether the service has reduced related hospital admissions for the patients referred. Currently it is known that COPD admissions have reduced but these cannot be linked to the individuals seen by ARAS.

‘Specialist nurses have a key role to play when supporting admission avoidance and have the ability to care for patients safely and effectively and prescribe treatment that would otherwise necessitate hospital admission if managed by generalists. This therefore emphasises the importance of continued education and training to develop and maintain specialist roles.’<sup>11</sup>

## Enabling the delivery of care in community settings

The report by the University of Birmingham<sup>5</sup> into community hospitals noted that the acuity of patients being seen in the setting was increasing. This is true of care delivered in each of the alternative settings discussed in this briefing. The case studies highlight two key enablers to this transfer of care; the use of technology and workforce development.

The ability to deliver care in community settings that was traditionally only available at an acute hospital has been greatly enhanced by the development of equipment that is portable and can be safely used in a patient’s home as well as in more clinical settings. The ability to transmit data to other clinical staff or facilities means that services delivered in the community have access to specialist knowledge and support, if it is required. This improves confidence in the service for staff, commissioners and the patient as safety is not compromised.

However, not all services are dependent upon technology in order to deliver them. Even those that are, require staff that are competent in its use and confident in the service that they are delivering. The community workforce is dealing with ever more complex patients and this is supported by ongoing staff development. Increasing system integration means that the opportunities for staff to work in different areas, and develop additional skills, are increasing. In addition, acute hospitals recognise the benefits that delivering services in the community can bring and closer working between trusts allows information and knowledge to be shared. Having the back up of access to specialist knowledge, increases staff confidence to carry out care, as demonstrated in the cardiac pacing diagnostic service in Greater Manchester discussed earlier. Finally, and increasingly, community services are becoming more attractive for acute trained staff to work in as they can utilise their clinical skills and share that knowledge with others.

## The value of delivering acute type services in alternative settings

### Value for patients

Improving the patient experience is fundamental to all of the case studies included in this briefing, even where the initial imperative for change may have been a lack of capacity in the acute sector.

The report by the University of Birmingham<sup>5</sup> into the community value of community hospitals highlighted the ‘homeliness’ of them and how the experience of attending a service there felt less intimidating and friendlier than a larger hospital. Community services offer a much more personalised approach to care, allowing relationships to form which engender confidence in patients to manage their condition and undertake the treatment offered, even when that is for a more acute issue. For the frail elderly, attending a community service to receive acute care, or receiving it in their own home, can reduce confusion and distress as well as mitigating the risk of hospital acquired infections.

Value-based healthcare focuses on the achievement of improved patient outcomes. However, the formal measurement of patient outcomes is often ignored in favour of the numerical measures demanded by commissioners and the wider system. Evidence of improved outcomes is often anecdotal or limited to the results of the service’s friends and family test. This lack of consistent information can cause difficulties when asked to demonstrate value and proxy measures must be used such as hospital admissions and length of stay, rather than the results that the service creates.

However, the value for the patients is not just about the care received. Value is attributed to the reduced travel time, the maintenance of social networks and the ability to minimise disruption to everyday life.

### **Value for staff**

The experiences of staff delivering the services have been evident throughout the case studies. For staff employed by the acute trusts, but delivering care in the community, value is given through the increased autonomy of the service and the ability to meet patients in a less formal environment. For community service staff, the ability to deliver acute style services means that skills are gained or maintained, leading to a greater variety of work within their caseload. In both cases, staff are reported to be more engaged which, in turn, leads to better care for the patients.

### **Value for wider health and care system**

The difficulty of assessing the impact of community services is well documented. The lack of good quality data in the sector means that their contribution often remains anecdotal rather than being supported by the evidence demanded by commissioners and others.

However, the services discussed in this briefing are acute services being delivered in alternative settings. Data recording for these services is often more straightforward as the systems are in place in the acute trust to ensure payment is made for the activity carried out. Some of the case studies included have been able to demonstrate the financial impact of changing the place of provision through a direct comparison with equivalent costs in an acute setting.

The value for the wider health and care system is much greater than direct cost savings in a few places, as valuable as those are for a financially stretched system. For many services, offering a community-based provision has enabled capacity to be freed up in the acute trust to deal with the more complex cases that may otherwise have been delayed, or have delayed the routine condition maintenance being carried out elsewhere.

By increasing capacity, and reducing waiting list delays, the community-based services ensure that people are seen when they need to be therefore preventing unnecessary exacerbation of their condition which may result in an emergency attendance.

Services delivered in the home also make a valuable contribution to the wider health and care economy. Anecdotal evidence suggests faster, and more sustainable, recovery and family members become more familiar with condition management and are able to support people at home in an informal capacity.

The HFMA is carrying out research to understand how population value can be measured and the data required to assess the impact of resource allocation decisions across the health and care system.

### **Value for society**

Many of the case studies in this briefing focused on the importance of bringing care closer to home, reducing patient travel time and unnecessary journeys. The *NHS long term plan* makes a commitment to support wider action on air pollution by reducing road travel for patients and staff. Services delivered in the community contribute to this aspiration and this impact will grow as more areas are able to deliver increasingly acute services in alternative settings.

Delivering services in the home is not only beneficial for the person and the NHS. By spending less time in hospital, the impact on day to day life is dramatically reduced. This has a consequential impact on the patient's ability to undertake and remain in employment; it can support children and families to access education more consistently and the person maintains their community links which may support others. Stable employment is a major factor in maintaining good mental health and the *NHS long term plan* identifies this as one of several wider social goals that it seeks to support. The social value of enabling somebody to remain at home and active in their life is something that community services deliver through all the settings that they work in.

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