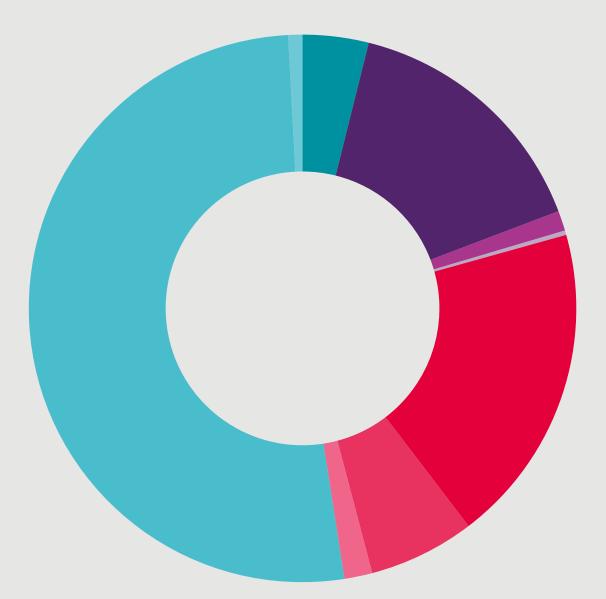QualityWatch

Community services

What do we know about quality?

Briefing

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November 2017

The Health Foundation

nuffieldtrust

About QualityWatch

QualityWatch is a major research programme providing independent scrutiny into how the quality of health and social care is changing. Developed in partnership by the Nuffield Trust and The Health Foundation, the programme provides in-depth analysis of key topics and tracks an extensive range of quality indicators. It aims to provide an independent picture of the quality of care, and is designed to help those working in health and social care to identify priority areas for improvement. The programme is primarily focused on the NHS and social care in England, but also draws on evidence from other UK and international health systems.

The QualityWatch website **www.qualitywatch.org.uk** presents key indicators by area of quality and sector of care, together with analysis of the data. This free online resource also provides research reports, interactive charts and expert commentary.

About this report

QualityWatch briefings use publicly available data to provide a snapshot view of quality in specific areas of health and social care. This briefing looks at trends in national measures in English community trusts to try to gain a view of quality in community services more generally. However, the difficulties experienced in gathering useful information on community services indicate that the national lack of community data needs to be resolved before questions of quality can be meaningfully answered.

Acknowledgements

Key points

- Community services aim to improve local health and wellbeing, bring care closer to home, and allow people to live independently. They encompass a broad range of specialties, domains and health professionals, and are delivered in a multitude of settings, from people's own homes, to schools and hospitals.

- Policymakers see community-based care as a crucial part of tackling some of the pressures on the NHS, particularly on accident and emergency (A&E) departments. As community care features in key documents such as the Five Year Forward View, we ask what the quality of community services is like at a national level.

- This analysis looks at trends in routinely collected national quality measures in 18 community trusts in England, which account for a quarter of all community health services delivered in the NHS.

- Some of the key findings were:

  - Care in community trusts was predominantly delivered by professionally qualified clinical staff such as community health nurses, allied health professionals and community health visitors. Staff numbers in the 18 trusts stayed roughly stable between late 2013 and 2016, although demand has almost certainly increased.

  - These staff were roughly as satisfied with their jobs as staff in all NHS trusts, although they were less likely to recommend their trust as a place to work.

  - The median waiting time for an outpatient appointment was three days longer in the community than across all trusts in England.

  - Patients using services offered by community trusts would generally recommend them to a friend and were less likely to experience harm compared to those using services provided by non-community trusts.

- These quality measures gave us a much more limited picture of the quality of care in community services than anticipated. This is particularly concerning when policy continues to encourage the shift of more care into the community while far more remains to be understood. Ultimately, providers can only effectively manage what they can measure, so if moves to improve national quality measures in community services fall short, we will continue to 'fly blind' on the care received by millions of patients every year

What is the policy landscape?

In recent years, many local and national policy initiatives have attempted to find ways to reduce pressure on acute hospitals and A&E units. National policymakers see community-based care as a crucial part of meeting these challenges. The Five Year Forward View sets out a vision for shifting services closer to people's homes and delivering more integrated care locally to help relieve some of these pressures (NHS England, 2014). There are high hopes that the new models of care within the 44 Sustainability and Transformation Partnerships will find innovative and sustainable ways of moving care from hospitals into the community. So what do we know about quality in community services? This briefing tries to answer this question.

First, we explain what community services are and how they are organised in England. We then focus in on only those community services that are delivered by community trusts. For these 18 community trusts, we pull together publicly available data on quality and try to describe trends over time – but with limited success.

Box 1: A brief history of community services reorganisation

Community-based health services have existed for a long time, dating back to the beginning of organised district nursing in 1859 (The Queen's Nursing Institute, 2012). Since the 1950s, there has been an emphasis, particularly in the case of mental health care, on shifting care from institutional settings to the community. This was partly due to the belief that community services could provide better quality care and were cheaper to deliver, at a time when demand and costs were growing (Thane, 2009).

Over the decades, there have been many changes to who is responsible for the sector: community nursing and child health fell under the remit of local authorities from 1948, but returned to the NHS in 1974. There was an NHS purchaser–provider split in 1991, when community services increasingly established themselves as standalone trusts; but commissioners ultimately became providers of community care once again with the formation of primary care trusts (PCTs) from 2001 (Foot, 2014).

The biggest recent change to the provision of community services came in 2009, when 'Transforming Community Services' was launched (Department of Health, 2009). All community providers were required to undergo at least some degree of organisational change to separate PCT commissioning and service provision (Addicott and others, 2015), thereby introducing competition into the market (Gershlick and Firth, 2017).

What are community services?

The term 'community services' refers to a broad set of services 'ranging from universal public health functions such as health visiting and school nursing to targeted specialist interventions in musculo-skeletal services, chronic disease management and intensive rehabilitation' (Edwards, 2014; see Table 1 for more information on the different types of community services). As a result, community services are provided by a broad range of health professionals such as nurses, physiotherapists and dentists, in people's own homes, and at schools and in hospitals. Broadly, community service providers aim to improve local health and wellbeing, bring care closer to home, and allow people to live independently.
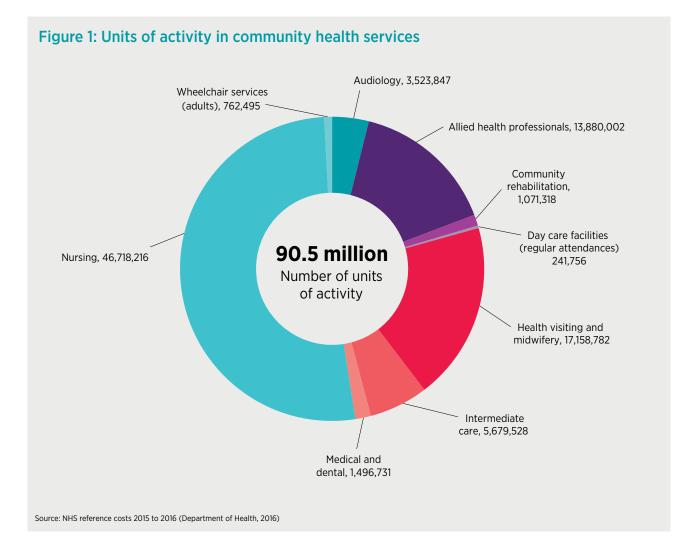
Table 1: Examples of common services provided by community trusts in England

Area	Services
Adult services	• Dentistry • Allied health professionals (e.g. podiatry, physiotherapy) • District nursing • Community nursing • Falls prevention • Adult mental health care • Clinics for those with certain long-term conditions
Children, young people and families	• Paediatric dentistry/orthodontics • Health visiting • Infant feeding • Newborn screening • School nursing
Specialist services	• Sexual health • Women's health • Prison health • Minor injuries unit • Alcohol and drugs

Source: compiled from websites and board papers of various community trusts

Using NHS reference costs data we estimate that 90.5 million units of activity (such as a single appointment, service or course of treatment) were delivered by NHS community services in 2015–16 (Department of Health, 2016).

Figure 1 shows the breakdown of these units of activity, by service type. Nursing accounted for just over half (51.6%) of all activity.

Figure 1: Units of activity in community health services

Source: NHS reference costs 2015 to 2016 (Department of Health, 2016)

The provision of community care is much more diverse than the provision of acute care, which comes mostly from NHS-owned providers. A 2016 study of 161 clinical commissioning groups (CCGs) showed that 39% of community service contracts were with private companies (e.g. opticians, pharmacies, home care); 21% with NHS providers (mostly NHS trusts); and around 12% each for general practitioners, third sector (e.g. palliative and cancer care charities) and 'other' providers (e.g. community interest companies and local authorities). However, when considering the annual spend on these providers, it is clear that the NHS and 'other' providers deliver the lion's share of community care (53% and 36% of total annual contract values, respectively) (Gershlick and Firth, 2017).

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Why is it important to measure quality?

As seen in the previous section, we know that many people depend on care from a community service. In 2015, around £10 billion was spent by the NHS on these services (Monitor, 2015), which is roughly 8% of the entire NHS budget. As there are plans to increase the amount of care delivered in the community, it is essential to understand more about the quality of care that people are receiving.

However, measuring quality of any healthcare service is difficult: quality is complex, multifaceted and difficult to define; rigorous and consistent measurement and assessment is challenging; and there are significant limitations to the data available (Nuffield Trust and The Health Foundation, 2015). Anecdotally, this challenge is even greater for community services, where there is wide variation in how services are organised and defined, and where they are delivered (Foot, 2014).

What are the key data sources for indicators of quality?

In this analysis, we sought to identify sources of national, routinely available data that could describe an aspect of quality in community services, as detailed in Table 2. These cover the key quality domains of access, capacity, effectiveness, equity, person-centred care and safety (Leatherman and Sutherland, 2008).

Table 2: Community service data sources selected for inclusion

NHS England	NHS Digital
• Data on written complaints	• Workforce statistics and sickness
• Patient Friends and Family Test	• NHS Safety Thermometer
• Staff Friends and Family Test	• Outpatient Hospital Episode Statistics
• NHS Staff Survey	

Standalone community trusts

The majority of NHS trusts provide some community services. However, it is difficult to disentangle the community services from other trust activity. For the purposes of this analysis, we focus on 18 standalone community trusts, rather than all trusts that provide community care alongside other types of services (see appendix). Based on national reference cost data, these 18 community trusts account for only a quarter of all NHS community service activity (26.7%) and cost (27.2%). However, all of the care delivered in these trusts is attributable to community care.

Taking a snapshot of the 18 community trusts in March 2017, we see that non-clinical staff accounted for 45% of all staff (20,831 full-time equivalent (FTE)) and the other 55% was made up of professionally qualified clinical (PQC) staff (25,241 FTE). Of these, 96% of FTE PQC staff were non-medical professionals, compared

to 81% across all trusts. This proportion varied by community trust, but was consistently high, ranging from 92% to 99%.

'Non-medical PQC staff' include a diverse range of professions. As shown in Table 3, in March 2017, community health nurses accounted for 44% of all non-medical PQC staff working in community trusts (10,571 FTE), while allied health professionals (AHPs) accounted for 25% (6,111 FTE), and community health visitors for 12% (2,854 FTE). AHP is an umbrella term for a range of health professionals such as physiotherapists (37% of all AHPs; 2,241 FTE), occupational therapists (26%; 1,573 FTE), and speech and language therapists (20%; 1,242 FTE).

Table 3: Non-medical professionally qualified clinical FTEs by staff group, in community trusts, March 2017

Staff group	FTE	Proportion
Community health nurses	10,571	44%
Allied health professionals	6,111	25%
Community health visitors	2,854	12%
Adult nurses	1,801	7%
Other scientific, therapeutic and technical staff	1,575	6%
Mental health nurses	444	2%
Children's nurses	430	2%
Learning disabilities nurses	289	1%
Healthcare scientists	100	0%
Ambulance staff	38	0%
Midwives	32	0%
Other training nurses	26	0%
Total	24,271	

The remaining 4% of PQC staff (970 FTE) in community hospitals in March 2017 were medical staff, 38% (369 FTE) of whom were specialists in public health medicine and community health services.

Staffing data were readily available from September 2013 to February 2016. Over that period, the number of staff working in the 18 community trusts has remained mostly stable, while demand is likely to have increased.

What can we say about quality in community trusts?

High-quality care should be safe, effective, person-centred and timely, and be provided in an appropriate and well-resourced setting (Nuffield Trust and The Health Foundation, 2013). In this analysis, we try to map trends over time in these quality indicators, across the 18 community trusts.

Staff satisfaction

Levels of staff satisfaction were similar across community and all trusts, but community staff were less likely to recommend their trust as a place to work

Staff wellbeing is important for enabling staff to deliver care with compassion and empathy. According to the NHS Staff Survey, staff working in community trusts had relatively similar levels of job satisfaction and overall engagement (both scored 3.8 out of 5) as staff in all NHS trusts in England in 2015 and 2016. On the same five-point scale, staff in community trusts (3.8) were similarly as satisfied with the quality of their work as staff in all trusts (3.9), and with resourcing and support (3.3 for both). Community staff were slightly more likely (38.7%) to have felt unwell due to work-related stress in the last 12 months than staff in all trusts (37.1%).

Community staff were less likely to have reported that they experienced violence from patients (8.1% compared with 15.1% at all trusts), and were more likely to report harassment, bullying or abuse they witnessed (52.9% compared with 48.9% in all trusts) in 2016.

In addition to the NHS Staff Survey, the NHS puts the Friends and Family Test to its staff across all trusts, asking whether they would recommend their organisation to friends and family: first as a place to receive care if needed, and second as a place to work. In 2016/17, 81.0% of those surveyed in community trusts said they would recommend their organisation as a place to receive care if they needed it, compared with 79.3% of all trusts in England. However, only 57.5% of staff in community trusts would recommend their organisation as a place to work, which is considerably less than staff in all trusts (63.7%; Figure 2).
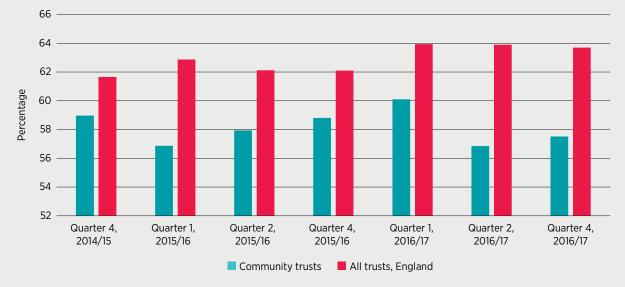
Figure 2: Staff who recommend their trust as a place to work, in community trusts compared to all trusts

Source: NHS Friends and Family Test (NHS England 2017)

Accessing community services

It takes longer to access a community outpatient appointment

In 2015/16, the median waiting time for any first outpatient appointment for those referred from general medical and dental practitioners in England was 29 days. In standalone community trusts this was higher, at 32 days.

Of all the community trust outpatient appointments (1,357,195 in 2015/16), around a quarter (26.1%) were first attendances rather than follow-up appointments. Over half (51.8%) of outpatient appointments in community trusts were a result of referrals from a general medical practitioner. Community trusts had a slightly higher rate of patients not attending appointments than was the case across all trusts in 2015/16 (8.2% compared with 6.6%).

Person-centred community care

Users of community services were likely to recommend them to a friend or family member

Since the Friends and Family Test was introduced in community services in January 2015, around 95% of respondents said that they were 'likely or extremely likely' to recommend the service to their friends and family if they needed similar care or treatment. In March 2017, 96.1% of respondents in the 18 community trusts said they would recommend the service to friends and family. This was similar to the proportion of patients who would recommend inpatient (96.0%) and outpatient services (94.0%), and higher than mental health (89.0%) or A&E (87.1%) services. The response rates and levels of satisfaction haven't changed significantly since the test was introduced.

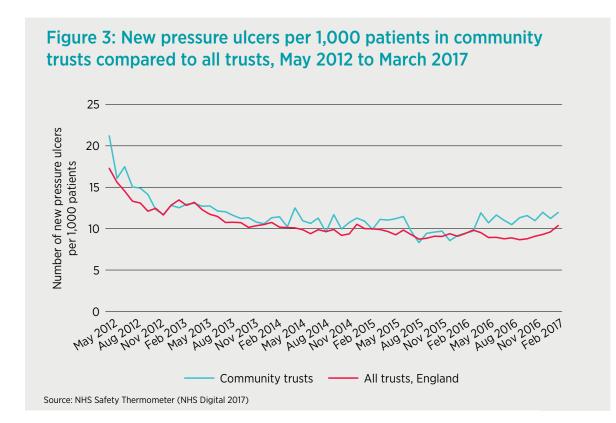**Fewer complaints are upheld in community trusts**

The NHS complaints procedure is the statutory mechanism for dealing with complaints about NHS care and treatment. The 18 community trusts received 2,896 new complaints in 2015/16 and 2,774 in 2016/17. Reported complaints are not necessarily a bad thing if the trust welcomes them as an opportunity to learn and improve services. Where enough evidence is found to support the complaint, the complaint is upheld. This is an indication that the quality of care was below the expected standard. In 2015/16, 56.5% of complaints received by community trusts were at least partially upheld, compared with 64.9% across all NHS trusts. In 2016/17, this rose to 60.9% of complaints received by community trusts being at least partially upheld, compared with 64.7% in all trusts. Unfortunately, these complaints data are not broken down by the level of seriousness of the complaints.

Safety of community services

The incidence of urinary tract infection and venous thromboembolism is lower in community trusts

The NHS Safety Thermometer monitors local improvement in harm-free care over time. Measures of harm include new pressure ulcers, new venous thromboembolism (VTE), falls that resulted in harm while in hospital, and catheters with a new urinary tract infection (UTI). Since March 2017, these measures are no longer classed as official statistics, due to the lack of agreed

standards and the voluntary nature of data collection. So they should be interpreted with caution, but may still be useful as a local improvement tool (NHS Digital, 2017b). Comparing events that resulted in harm between the 18 community trusts and all trusts in March 2017, we see that community trusts had fewer falls (1.5 vs 1.9 per 1,000 patients), UTIs (2.6 vs 3.8 per 1,000 patients) and VTEs (2.6 vs 4.7 per 1,000 patients) than all trusts. New pressure ulcers were more prevalent in community trusts (11.5 per 1,000 patients) than all trusts (10.4 per 1,000 patients). Figure 3 shows the overall decline and then levelling off in the number of new pressure ulcer events per 1,000 patients.

Figure 3: New pressure ulcers per 1,000 patients in community trusts compared to all trusts, May 2012 to March 2017

Source: NHS Safety Thermometer (NHS Digital 2017)

Limitations of the data

Changes in organisational structures, definitions and data collection have made it difficult to analyse differences in the data over time. For example, only 11 of the 18 community trusts submitted outpatient data to the Hospital Episode Statistics dataset between 2012/13 and 2015/16. The data that were submitted had varying degrees of completeness, with the volume of outpatient appointments varying drastically each year in some instances. This was often due to differences in reporting by some trusts in some years, but this is not consistently reported in the data quality notes provided by NHS Digital.

All of the publicly available data used in this analysis were largely reflective of acute inpatient measures of quality. Community care is often more about enhancing quality of life than directly saving a life. A patient's reported experience of a service, and their own verdict of their outcome, which is missing from the routine data sources across community services, may be far more important.

For example, community care is often more focused on patient goals and rehabilitation. This is described by one community trust in their annual report as a key quality priority: 'we want to help our patients achieve the goals that they have agreed, with the nurse or therapist looking after them, to improve their health and wellbeing'. Measures such as patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs) could be particularly useful for understanding quality in community services, but they are not routinely collected.

What does the future hold for quality measurement in community services?

In the absence of a comprehensive national dataset on community services, a number of organisations have either created common quality indicator lists or are actively collecting data from community service providers, although these data are not typically publicly available. The sources of data that we analysed for this briefing were those that had national, routinely available data and were almost all included in the benchmarking lists of the stakeholders we spoke to. Some of these data sources are detailed below:

• NHS Benchmarking Network publishes a report to members annually, collating data received from around 40 NHS and independent community organisations, on a broad range of metrics around service models, capacity, access, HR, activity, finance, clinical governance and outcomes (NHS Benchmarking Network, 2017).

• The Community First NHS Network is a network of leaders of community NHS trusts in England. The network has drawn together indicators on quality, productivity, workforce, data quality and finance (Community First, 2015).

• NHS Improvement developed a community services scorecard on whether NHS trusts were responsive, effective, safe, caring and well-led. The monthly scorecard is publicly available and was first published in May 2017 (NHS Improvement, 2017a).

• The Care Quality Commission carries out inspections of community health services and regularly publishes ratings on their website (Care Quality Commission, 2017).

• In Autumn 2017, NHS Improvement was due to publish findings on work done with 23 community and mental health combined trusts on how these trusts operate and what could help improve productivity and efficiency (NHS Improvement, 2017b).

• After several years of delay, on 1 October 2017 all health and care providers were due to begin submitting data to a national Community Services Dataset, which aims to provide information on a number of aspects of community care for children and adults (NHS Digital, 2017a). This patient-level dataset intends to cover information on service user demographics; social and personal circumstances; breastfeeding and nutrition; care events and screening activity; diagnoses, including long-term conditions; and disabilities and scored assessments.

Providers that are expected to submit data include acute, mental health and community trusts, alongside care trusts, social enterprises, integrated care organisations, independent sector providers (including third sector) and local authorities.

This dataset offers a glimmer of hope to those measuring quality in community services, but it will take time to build up good data. It is important that these data are suitable for developing quality metrics appropriate to and for community services.

Conclusion

A large amount of care is already delivered in the community and this is only likely to increase: the Five Year Forward View made it clear that community care is very much the direction of travel for the NHS. Yet, while measures of care in acute care are prolific, the quality of community services receives little attention – as this briefing has highlighted. Community services are a disparate group with considerable local variation in organisational structures, so in order to have a relatively comparable set of providers, this analysis focused on the quarter of activity that is delivered by 18 standalone community trusts. We collated routine data that are available at a national level to look at trends over time. However, there were substantial challenges in doing this.

Where we were able to analyse data, we found a mixed picture in quality over time, with positives seen in patient experience, staff satisfaction and safety, but room for improvement in waiting times. Based on the routinely collected data, this is all that can be said about the quality of community services. In a sector that patients come into contact with 90 million times per year and which accounts for roughly 8% of the NHS budget, this is poor. If the policy direction continues with moving services into the community, far more needs to be understood about the quality of these services. There is a glimmer of hope offered by the plans to publish a new person-level community services dataset, but given numerous delays in the past, it remains to be seen whether this will fill the void in information around quality in community services.

Ultimately, providers can only effectively manage what they can measure, so if moves to improve national quality measures in community services fall short, we will continue to 'fly blind' on care being received by millions of patients every year.

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Appendix

In order to reduce the impact on the data of variation in how services are organised, the focus of this analysis was primarily on the 18 standalone community trusts. In order to define these standalone NHS community trusts, we looked at how trusts were classified in the NHS Staff Survey and NHS Improvement safety data. We cross-referenced this with those trusts that are members of the Community First Network, a self-selecting group of NHS community trusts. Every trust that appeared in at least two of these three sources was included in analysis. The 18 trusts eligible for inclusion are listed below.

Table A1: Community trusts included in this report

Trust name	Code
Birmingham Community Healthcare NHS Foundation Trust	RYW
Bridgewater Community Healthcare NHS Foundation Trust	RY2
Cambridgeshire Community Services NHS Trust	RYV
Central London Community Healthcare NHS Trust	RYX
Derbyshire Community Health Services NHS Foundation Trust	RY8
Gloucestershire Care Services NHS Trust	R1J
Hertfordshire Community NHS Trust	RY4
Hounslow And Richmond Community Healthcare NHS Trust	RY9
Kent Community Health NHS Foundation Trust	RYY
Leeds Community Healthcare NHS Trust	RY6
Lincolnshire Community Health Services NHS Trust	RY5
Liverpool Community Health NHS Trust*	RY1
Norfolk Community Health And Care NHS Trust	RY3
Shropshire Community Health NHS Trust	R1D
Staffordshire And Stoke On Trent Partnership NHS Trust	R1E
Sussex Community NHS Foundation Trust	RDR
Wirral Community NHS Foundation Trust	RY7
Worcestershire Health and Care NHS Trust**	R1A

* RY1 is not a member of the Community First Network

** R1A was classified as a combined mental health/learning disability and community trust

About the authors

Nora Cooke O'Dowd started with the Nuffield Trust as a research analyst on Quality Watch in March 2016 and was appointed Nuffield Trust Research Analyst in July 2016. Prior to joining the Nuffield Trust, she worked as an epidemiologist and statistician with the Public Health Intelligence team of the London Borough of Richmond-upon-Thames. There she provided an analytical resource to the Public Health Department of the local authority and to the clinical commissioning group to inform operational processes on topics such as urgent care and strategic needs assessment on child sexual exploitation. In 2015, she completed a double Master's degree in European Public Health at the School of Health and Related Research (ScHARR) at the University of Sheffield and the EHESP French School of Public Health, where she specialised in Epidemiology and Biostatistics. She wrote her Master's thesis, A Quantitative Comparison of Social Protection for Long-term Care for the Elderly in England, France & the Netherlands, at the OECD in Paris. Nora holds an undergraduate degree in Economics and German, from Trinity College Dublin. She worked with the Irish economic development agency in Germany before undertaking her Master's degree.

Holly Dorning joined the Trust as research analyst in May 2013 and became a Senior Research Analyst in May 2016. Her research projects included: understanding how people with mental ill health get support for their physical health conditions in a hospital setting; gathering a consensus from patients and carers, health and social care professionals, and policy makers on what the most important aspects of quality are to measure; and evaluating the implementation of Stroke Association Voluntary Groups and their impact on beneficiaries. Holly started her career in medical research charities and before joining the trust worked at the Multiple Sclerosis (MS) Society. While there she worked on a number of research projects and initiatives. Primarily she led the analysis of the My MS, My Needs project which is the largest survey of people with MS in the UK and explored if people with MS were getting what they needed from health and social care services. The results of this project were used to develop 'A lottery of treatment and care – MS services across the UK'. Prior to this, Holly worked in the research team at Prostate Cancer UK and has a degree in Physics from the University of Warwick, where she had a particular interest in medical physics.

QualityWatch

QualityWatch, a Nuffield Trust and Health Foundation research programme, is providing independent scrutiny into how the quality of health and social care is changing over time.

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