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# Analysis of the profile, characteristics, patient experience and community value of community hospitals: a multimethod study

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## Scientific summary

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# Background

**The evolution of community hospitals in England over the last 150 years has led to significant variation in their form and function and a lack of clarity over their definition.**

There is uncertainty about the precise number of community hospitals, what services they provide and how they are experienced by patients or valued by communities. Pre-existing research suggests that patient satisfaction and outcomes of care in community hospitals compare favourably to other models of care, but little systematic research has been undertaken on

patient (or carer) experience. Although community hospitals are often seen as having a distinctive relationship with their local populations, the extent and nature of community involvement and the value communities derive from them remain under-researched. At a time when the NHS in England is in a state of significant change, it is imperative that community hospitals, and their contribution to patients and communities, are fully understood.

# Research questions

**The aim of this study was to provide a comprehensive analysis of the profile, characteristics, patient experience and community value of community hospitals. The study research questions were as follows:**

*What is a community hospital?*

*What are patients' and carers' experiences of community hospitals?*

*What does the community do for its community hospital and what does the community hospital do for its community?*



# Methods

The study adopted a multimethod (qualitative and quantitative) approach, with the research conducted in three phases.

## Phase 1

Guided by a working definition of community hospitals developed from a review of the literature, phase 1 involved national mapping through the integration, reconciliation, verification and subsequent analysis of data captured in various national data sets (eg, Patient-Led Assessments of the Care Environment, Estates, NHS Digital, Community Hospital Association directory).

## Phase 2

Phase 2 involved the selection of nine diverse case study community hospitals. Each case study involved seven elements: (1) *scoping* (stakeholder conversations and key document review); (2) *local reference groups (LRGs)* (bringing key staff and community members together to inform the study and reflect on emerging findings); (3) *semi-structured interviews with staff* (across the nine cases, 89 staff were interviewed), *volunteers* (35 interviewed) and *community stakeholders* (20 interviewed); (4) *discovery interviews with patients* (60 interviewed); (5) *semi-structured interviews with carers* (28 interviews); (6) *focus groups with multidisciplinary teams (MDTs)* (eight focus groups across the nine sites, involving 43 respondents), *volunteers* (six groups, 33 respondents) and *community stakeholders* (eight groups, 54 respondents), and (7) *telephone interviews with provider managers and commissioners* (n = 9). Interviews and focus groups were recorded and transcribed before being imported into NVivo11 software and analysed thematically.

## Phase 3

Phase 3 involved quantitative analysis of Charity Commission data on the finances (income and expenditure) and volunteering rates of League of Friends (and other allied charities) associated with community hospitals in England. The sample was formed of 245 such charities for which financial information was available for at least one year between 1995 and 2014.

The approach to analysis allowed findings from the three phases to be integrated at different stages of the research process.

# Findings

## What is a community hospital?


National mapping identified 296 community hospitals (with beds) in England in 2015, although detailed data were available for only 267 of them. Analysis of the 267 sites showed that community hospitals with beds typically:

- Were **small** – 70% of community hospitals had ≤ 30 beds
- Were **rural** – 78% were based in rural or significantly rural areas
- Were **led by general practitioners (GPs), in-house doctors and nurses** – historically GPs have been an integral part of community hospital provision and their involvement remains significant, but it has reduced, whereas the in-house employment of doctors has grown; in practice, most community hospitals are nurse-led
- Were **without 24/7 medical cover** – community hospitals do not have 24/7 on-site medical cover and are reliant on nursing staff and out-of-hours doctors outside core hours
- Provided **step-down and step-up care** for frail, older inpatients
- Had **an average length of stay of < 30 days** (median 24 days; mean 27 days)
- Had **a range of additional local, intermediate and generalist care services** on a spectrum from primary to acute care orientations



The case studies identified other common characteristics and highlighted the dynamic reality of community hospitals at a local level. Community hospitals were also typically:

- **Historically embedded** within and valued by their local communities.
  - Operating with **complex models** of ownership and provision.
  - Providing a **valued, relational** model of care.
  - Based on **integrated, multidisciplinary** working.
  - Constantly **evolving** in response to external demands.
- Significant recent developments include a reduction in inpatient beds, withdrawal of GPs, a shift towards step-down provision and a growing acuity of patients.

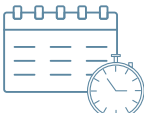
70% of community hospitals had  **≤ 30** beds

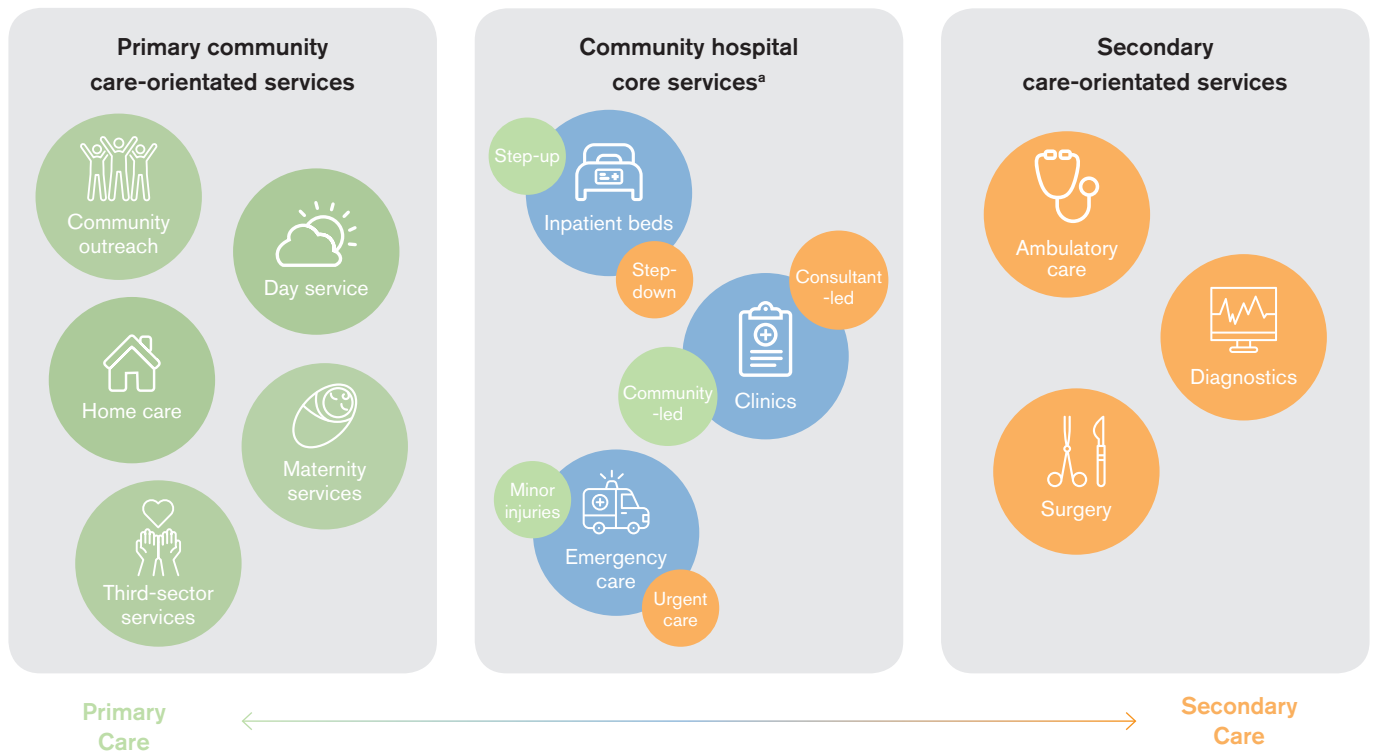
providing  **step-down** and **step-up** care for frail, older inpatients

 led by **GPs** in-house doctors and **nurses**

78% were based in significantly  **rural areas**

community hospitals **do not** have **24/7**  on-site medical cover

an **average length of stay** of **< 30**  days



Beyond defining community hospitals and identifying common characteristics, the study led to the development of a typology that recognised community hospitals as operating on a spectrum of intermediate care provision:

- **Core community hospital services:** includes inpatient beds, outpatient clinics and minor injury/urgent care units (found in half of all community hospitals). Services may vary in extent and orientation, with some being more community orientated (step-up beds, community led clinics and a minor injuries and ailments service) or acute orientated (step-down beds, consultant-led clinics and an urgent care unit).
- **Primary/community care-orientated services:** are likely to be extensions of a GP practice, sited within a community base with services such as day care and community teams.

- **Primary/community care oriented services:** are likely to be those that might otherwise have been provided in an acute hospital such as surgery and diagnostics, but have been moved out into the community. Typically, these services are provided as an outreach function to general hospitals and are supported by specialist practitioners.

This typology enables community hospitals to locate themselves within a frame of reference that stakeholders have found to be realistic and have intuitive appeal; i.e. alongside core services, some community hospitals are more orientated towards primary care provision, whereas others are more orientated towards acute provision.

## What are patients' and carers' experiences of community hospitals?

Patients and family carers were overwhelmingly positive in their descriptions of their experiences of using community hospital services. Three sets of factors were highlighted as being key to patient and carer experiences:

1. **Closeness to home** – patients experienced the hospitals' locations as convenient and accessible; their environment and atmosphere as more familiar, homely, relaxed, less stressful and more reassuring than those of acute hospitals; and the relationships they fostered with staff and others as key.
2. **Holistic and personalised** – facilitated through a 'closeness to home' combined with the range of co-located, integrated, intermediate care services; the fostering of multi-disciplinary working, and a work ethic that encouraged staff to look beyond traditional professional boundaries.
3. **Supporting difficult psychological transitions** – admission to a community hospital often triggered a major life event, with associated psychological and social implications. Community hospitals responded in different ways to support patients and family carers through these difficult transitions.

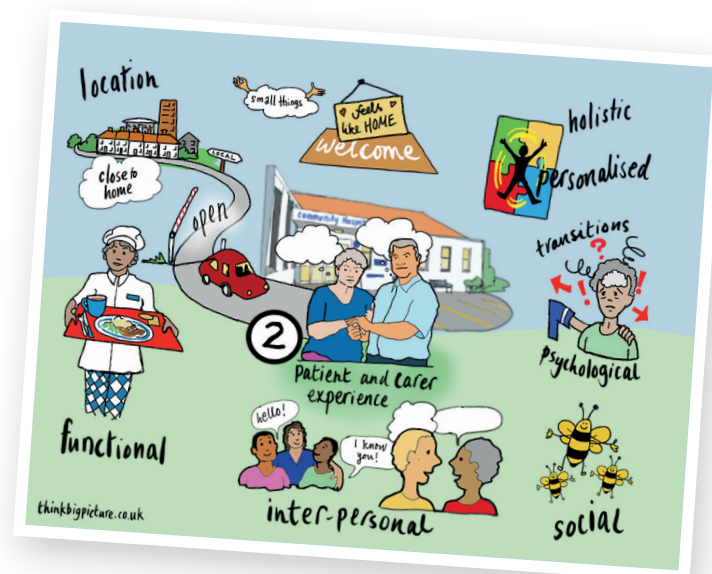
Cutting across these different accounts of patient and carer experience were four dimensions:

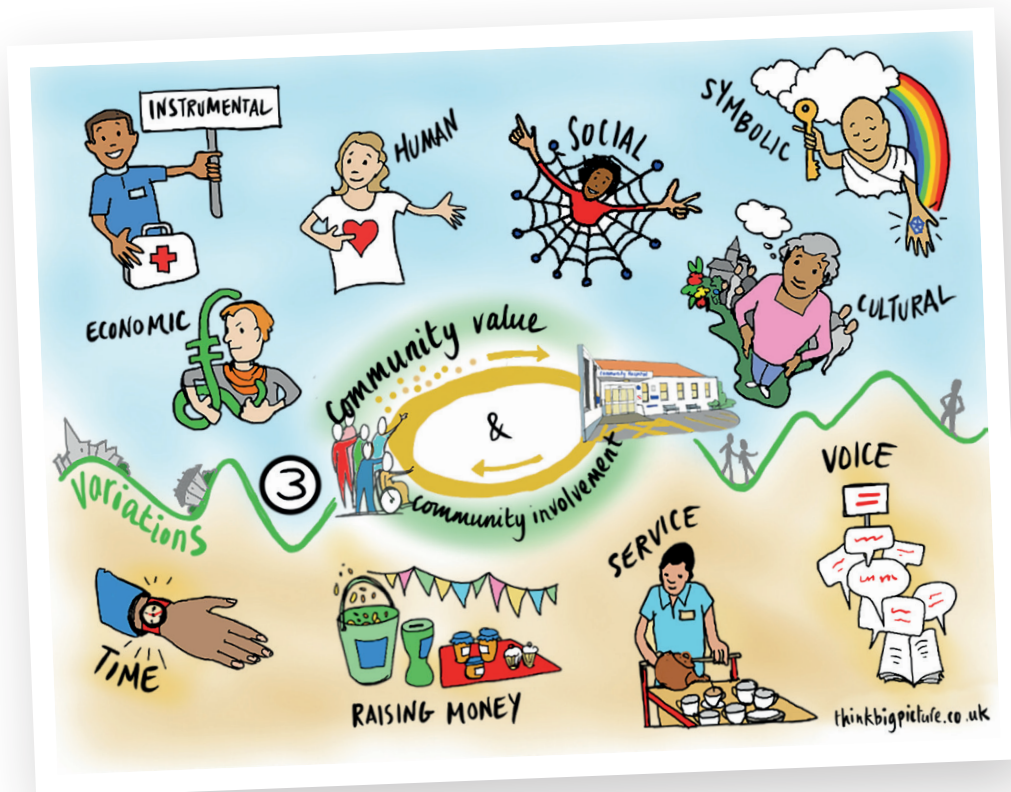
1. **Functional**, particularly **environmental**, features of community hospitals were fundamental to patient and family carer experiences. These included their locations, accessibility, surroundings, interiors, food and atmosphere.
2. **Interpersonal** aspects of care, such as relationships between staff, patients and family carers, were central to experiences of using community hospitals. Patients cited the warm and welcoming staff, being looked after personally with sensitivity and respect, staff (and volunteers) spending time with them, being listened to, keeping their spirits up and time taken to care for the whole person.
3. **Social** aspects of patient experience included the importance of having family and friends close by so that they could be visited often and the importance of the hospital being community based, thereby increasing the chance of meeting familiar faces and being known, and of maintaining (a social) life rather than pausing it.
4. **Psychological** aspects of patient experience included feeling less anonymous and frightened, feeling more confident and hopeful, while also coming to terms with loss and change. Although community hospitals were generally seen to build patients' confidence and physical health, a greater focus on psychological, emotional and mental health was needed.

Patients and family carers were overwhelmingly positive in their descriptions of their experiences of using community hospital services.

When considered together, these largely positive experiences point to community hospitals providing a relational (rather than transactional) model of care: relationships between patients, their families, staff and community members and relationships between all these people and their environments were an intrinsic factor in people's rehabilitation and recovery.

These elements were all subject to context and were in flux; for example, functional aspects of patient experience were changing as patients were drawn from an increasingly wide geographical area, whereas, in other cases, the interpersonal aspects were challenged by pressures on staff, recruitment challenges and growing pressures on beds.





## What does the community do for its community hospital?

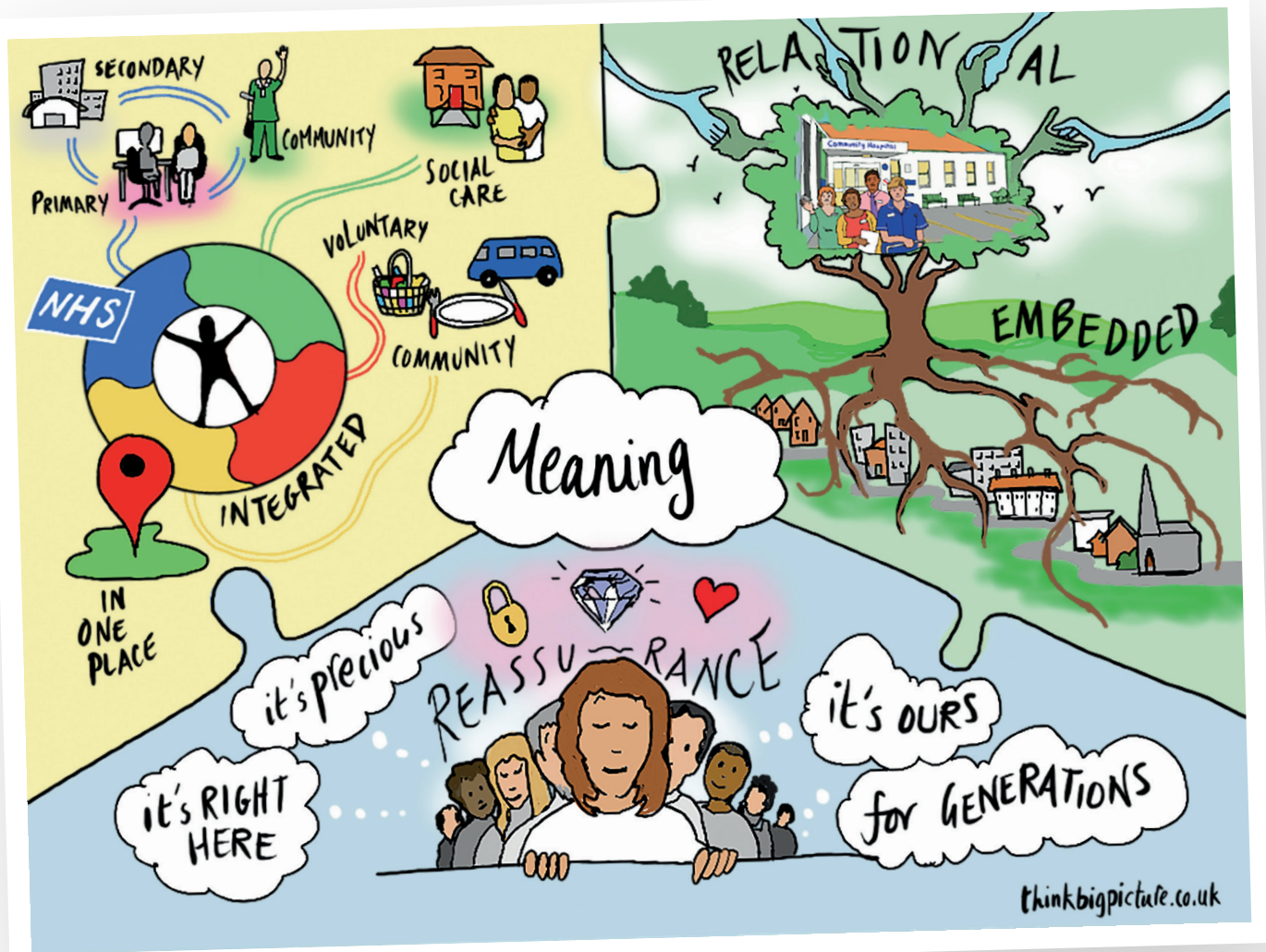
Communities support their local hospitals in four key ways:

1. **Giving time** – community hospitals, identified as having a League of Friends (or equivalent) registered with the Charity Commission, involve 24 volunteers on average, suggesting the involvement of 5,880 volunteers across the 245\* community hospitals. This is estimated to equate to between 1.4 and 2.5 full-time equivalent personnel per hospital, at a national value of between £3.8 million and £6.9 million. Volunteers were drawn predominantly from older age groups, raising concerns about future sustainability. Limits to the involvement of volunteers included a perceived lack of investment in their recruitment, co-ordination and support beyond that provided by the League of Friends or individual hospital staff.
2. **Raising money** – in 2014, community hospital Leagues of Friends generated an average income of £45,387 (median £15,632). Two-fifths of all income to Leagues of Friends came from legacies. There was considerable variation in levels of income across community hospitals that could not be explained solely by levels of deprivation but instead appear to be influenced by a range of community- and hospital-level factors. Average levels of income also vary over time: since 1995, the charitable income of Leagues of Friends has declined by an average of £901 a year.
3. **Providing services** – beyond the service delivery roles of individual volunteers and Leagues of Friends, various voluntary and community groups also contribute to community hospitals through the provision of a wide range of services and activities both within and outside the hospitals.
4. **Giving voice** – despite a long history of community involvement in strategic decisions about community hospitals, the mechanisms and depth to which this happens vary considerably. There was considerable frustration expressed about the ability of communities and individuals to influence decisions, both within specific consultation exercises and on a more sustained, continuous basis.

Variations exist in the level of support that communities provide to community hospitals in the following ways:

- **Between communities** – this could not be explained by levels of prosperity/deprivation alone but was influenced by the history of the hospital, the local geography and the service and provider mix
- **Within communities** – there was a particular dominance of older people among those who were most active in their support
- **Over time** – quantitative evidence showed the dominant trend was one of decline, particularly in terms of income, although this was not raised as a particular concern among the case studies

\* Only 245 community hospitals were registered with the Charity Commission



## What does the community hospital do for its community?

Community hospitals fulfil a number of important functions within the communities in which they are based and provide significant value. They represent a significant community asset, with a strong sense of community ownership. Their provision of local, accessible health and social care services has an important practical and symbolic significance, particularly in more isolated rural communities. Evidence was found that community hospitals can contribute to six areas of 'community value':

1. **Instrumental** – primarily through the provision of local, accessible and integrated intermediate health and social care services.
2. **Economic** – through the provision of local employment and the reduction of travel costs associated with accessing more distant healthcare services.
3. **Human** – through the development of skills and confidence among not just staff (and patients), but also volunteers.
4. **Social** – through the development of networks of interaction, trust and reciprocity, built directly through the services provided by the community hospital and indirectly through community engagement activities.
5. **Cultural** – through a sense of identity, belonging and civic pride for individual staff and volunteers, and across the community through a collective sense of place.
6. **Symbolic** – as a symbol of vitality and viability of the community, community hospitals contribute to perceptions of resilience and autonomy and as a source of security and reassurance.



# Conclusions and research recommendations

**The study sought to provide a comprehensive profile and analysis of the characteristics, patient experience and community value of community hospitals that, to date, had been lacking. In addressing the study questions, new understandings have been provided of these different aspects of a community hospital. Taken together, these findings take us beyond responses to the individual questions of what a community hospital is and how it is experienced, supported and valued (as outlined previously), to new understandings of what community hospitals mean.**

Community hospitals mean more to communities (inclusive of patients, carers, staff, volunteers and other local residents) than simply a place to receive health care. The study highlighted three particular inter-related meanings:

1. Local, integrated intermediate and generalist care that brings together primary, community and secondary health care, and health and social care, statutory, voluntary and community provision in one accessible location.
2. An embedded, relational model of care that stems from the embeddedness of community hospitals, not only to their local healthcare systems, but more fundamentally to the histories, geographies and social relations of the communities in which they are based.
3. A deep sense of reassurance (akin to the concept of 'ontological security') that comes from the physical proximity and presence of the hospital, but also from the different forms of interaction with it and the sense of ownership that this inspires.

These meanings, however, vary between and within communities and can change over time. This research has highlighted the dynamic nature of community hospitals and their susceptibility to change because of both internal and external developments, which has contributed to their current diversity and, arguably, to their agility and resilience. The current demographic, economic and policy contexts are putting them under pressure and pulling them in different directions. The withdrawal of GPs, the shift towards step-down care, the delivery of services to a wider geographical area and associated increased acuity of inpatients and questions over the future of inpatient beds are particular demonstrations of those pressures. They have the potential to shift not just the characteristics, functions and patient experience of community hospitals but also their value and meaning.

Study limitations include limits to the secondary data available for mapping the community hospital sector in the face of rapid change, the spending of charitable funds, patient ratings through the Friends and Family Tests and the concentration of respondents with some connection to the community hospital.

Future research priorities include comparative studies of patient experience in different settings, longitudinal studies of community support and value, studies into the implications of changes in community hospital function, GP involvement, provider-mix and ownership, and international comparative studies.

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# Patient and public involvement

**Our commitment to patient and public involvement ensured that key stakeholders were involved in the design and delivery of this study, including through a national steering group and through Local Reference Groups within each of the case study areas.**

Our commitment to patient and public involvement (PPI) ensured that patients, carers and the public were involved in this study before and during its conduct. PPI involvement in the study design was facilitated by one of the researchers, who first consulted with 10 PPI members of the Swanage Health Forum, representing the League of Friends; a GP practice Patient Participation Group; Swanage Carers; Partnership for Older People's Programme; Wayfinders; the Senior Forum; the Health and Wellbeing Board; Cancare; a public Governor for Dorset Healthcare NHS Trust; and a retired GP. This group provided an endorsement of the study's proposed focus and methodology.

At the national level, 13 board members of CHA (four GPs, six nurses, two managers and one League of Friends member) co-produced the initial research proposal. Two members then became part of the study steering group, which met regularly throughout the study, supported the development of research materials and supporting documentation, helped facilitate access to potential case studies, contributed to the local and national reports and reviewed several drafts.

We also engaged with approximately 100 delegates at three CHA annual conferences (presentations and workshops focused on working with findings) that included not only practitioners but members of community hospital Leagues of Friends.

In addition, a cross-study steering group, chaired by Professor Sir Lewis Ritchie, University of Aberdeen, provided guidance across all three Health Services and Delivery Research community hospital studies, with representation from the CHA, Attend (National League of Friends) and the Patients Association, alongside the three study teams. The steering group met seven times over the period of this study, offering opportunities to share findings and explore experiences between the studies.

At the local level we established Local Reference Groups (LRGs) within each of our case study sites to bring local people together (hospital staff, volunteers and community members, a number of whom were patients and/or carers) to steer, support and inform the case study research.

To facilitate cross-case learning, we brought together representatives from each of the LRGs three times to share experiences, identify best practice and network. Annual Learning Event themes reflected each of the three research questions, and the days offered time for case study representatives to work together, share across sites, hear from national experts, contribute to the ongoing development of the study and reflect on emerging findings and their implications.

# Health Services and Delivery Research

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## Health Services and Delivery Research (HS&DR) programme

The HS&DR programme, part of the National Institute for Health Research (NIHR), was established to fund a broad range of research. It combines the strengths and contributions of two previous NIHR research programmes: the Health Services Research (HSR) programme and the Service Delivery and Organisation (SDO) programme, which were merged in January 2012.

The HS&DR programme aims to produce rigorous and relevant evidence on the quality, access and organisation of health services including costs and outcomes, as well as research on implementation. The programme will enhance the strategic focus on research that matters to the NHS and is keen to support ambitious evaluative research to improve health services.

For more information about the HS&DR programme, please visit the website: [www.nets.nihr.ac.uk/programmes/hsdr](http://www.nets.nihr.ac.uk/programmes/hsdr)

## This report

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