



A comprehensive profile and comparative analysis
of the characteristics, patient experience and
community value of the classic community
hospital

STUDY PROTOCOL

Chief Investigator:

Jon Glasby, Health Services Management Centre, University of Birmingham

Co-Investigators:

Iestyn Williams, Health Services Management Centre, University of Birmingham

Deborah Davidson, Health Services Management Centre, University of Birmingham

John Mohan, Third Sector Research Centre, University of Birmingham

Helen Tucker, Helen Tucker Associates Ltd

Tessa Crilly, Crystal Blue Consulting Ltd

John Crilly, Crystal Blue Consulting Ltd

Dr. David Seamark, GP

Researchers:

Angela Ellis Paine, Third Sector Research Centre, University of Birmingham

Daiga Kamerade, Third Sector Research Centre, University of Birmingham

1 Context

In 2006 in England, the government heralded a new direction for community services¹, focusing on care closer to home with a call for commissioners to shift resources from secondary care to the community, wherever it was cost effective and beneficial to local people. The fundamental driver for this care closer to home policy was the need to stem the flow of unnecessary hospital admissions into acute care.² The potential for outpatient tests, clinics and treatments taking place in community settings and replacement of acute bed days through better use of community hospital (CH) services and intermediate care facilitating early discharge or admission prevention, were key themes in this shift of services and resources. A financial commitment was made available to develop CHs as a key element of a strategy to create capacity for integrated health and social care services. However, by 2010, the Audit Commission³ suggested little progress had been made in England with unplanned emergency admissions growing at 3% per annum.

There are a number of interdependent issues insufficiently addressed to date that need to be understood about the role and value of CHs and their place within the health care system. Our focus will be to map, explore and understand three specific issues: definitions and function; patient experience; and community value.

Our study is one of three currently funded by NIHR which, **between them**, explore the definitions, patient experience, community value, service provision models, performance and effectiveness. The RAND and Bournemouth University study, led by Ellen Nolte at the LSHTM, comprises a scoping review of the literature and four international case studies, to explore definitions, service provision models, and evidence of effectiveness and efficiency. The Leeds University and NHS Benchmarking study, led by John Young, consists of a national survey, benchmarking exercise and qualitative study of 3 case study sites, focusing on issues of performance. A National Steering Group has been established to bring the three studies together, with members nominated by each team (see section 5.1 on page 21 for further details; see also appendix 1). The studies are complementary and findings from each will be used to inform the others, and mechanisms will be put in place to ensure that potential for duplication is minimised, research instruments are aligned, findings are shared at an early stage, and reporting is coordinated.

1.1 Community hospital definitions and functions

There is significant variation in what we understand to be a CH,⁴ and a lack of robust research means little is known of the numbers, distribution and facilities offered by such hospitals.⁵ Weaknesses have centred around CH definitions. While this has been addressed to some extent in previous work,⁶ the increased emphasis on a primary care-led NHS, together with different national

approaches, means the contrasting characteristics and differences in client groups, range of services, organisations involved and ownership makes classification complex. Further changes have also taken place in England in recent years with the current health reforms and the merger of a number of provider services following the Transforming Community Services agenda. Heaney et al⁷ also suggest that there is little robust evidence of the role and function of CHs, in part due to their ad hoc evolution and a lack of strategic vision for their future. Ritchie and Robinson⁸ point to numerous descriptive studies indicating a distinct and important role within health care delivery, but state that definitive evidence is lacking. Seamark et al⁹ state that characteristics such as links with local communities, GP involvement, multidisciplinary rehabilitation services and diagnostic facilities suggest CHs should have a significant role in the evolution of intermediate care, as well as rehabilitation, palliative care and a wide range of diagnostic and therapeutic services. *Our Health, Our Care, Our Say*¹⁰ stresses that CHs provide care to the whole community, including care for people with long-term conditions, palliative care, rehabilitation and emergency care. This variation in definition and function makes it difficult to define CHs and to assess their role and strategic value to the NHS and local communities.

1.2 Patient experience

NHS services, particularly hospitals, are consistently rated highly¹¹ with patients rating doctors the most trusted and respected professionals.¹² However, as a result of a series of major healthcare scandals in the last 20 years, community campaigning groups, the media and politicians have all made the quality of NHS care a matter of public concern. National campaigns to address this have emerged, focusing on areas such as respect, dignity¹³ and patient safety,¹⁴ and improving patient experience is a key priority.¹⁵ More recently, the scandal into patient deaths at Mid-Staffordshire NHS Foundation Trust¹⁶ highlighted the poor quality of care and re-emphasised the need for compassion. The trend towards ‘bigger is better’ arguments in favour of larger healthcare institutions, along with increased use of technology as a cost saving mechanism, are depersonalising patients’ experiences and their need for a “connected and reciprocal relationship with staff.”¹⁷ Against this background, some studies appear to suggest that patient satisfaction and outcomes of care in CHs compare favourably with other models of care,¹⁸ with patients saying that they are treated as an individual.¹⁹

However, little systematic research has been undertaken on patient experiences in CHs, and the evidence base for such claims remains under-developed. On the one hand, anecdotal evidence provided to the Community Hospitals Association by local CHs and patient groups suggests that some people value the continuity of care delivered in CHs and appreciate the fact that many staff

are local people, living near the CH where they work and coming from the same local community as patients. Equally, an alternative hypothesis is that some patients might experience worse care in the absence of onsite 24 hour medical cover and in settings that may sometimes be perceived as remote, isolated and closed environments. Exploring patient experience within CHs is therefore important.

1.3 Community value

Local CHs are known and valued by their communities,²⁰ and play an important part in responding to the health and social care needs of local populations. They help to take pressure off acute hospitals by treating people locally so they do not have to go into a big general hospital or as a step down from a big general hospital as part of rehabilitation.²¹ Support for, and satisfaction with, CHs by the public, patients and staff remains steadfast,²² as does professional support from GPs.²³ Heaney et al (op cit) found that patients appeared generally satisfied with ease of access, continuity of care and knowledge of staff. They were, however, surprised at the lack of research into the wider role that CHs may play in the communities in which they are located.

Histories of CHs and studies of small hospitals²⁴ emphasise the importance of voluntarism, but there is no existing evidence which provides an overview of such activity. Hospital Leagues of Friends (LoFs) are a primary focus of voluntary support for hospitals, but the only British study of LoFs in an academic journal²⁵ is over 50 years old. Survey evidence does not allow the identification of health-related voluntary activity in anything but the most general terms.²⁶ Nevertheless, statistical analyses report a consistent picture of strong social and geographical gradients in voluntary activity,²⁷ and point to a “civic core,” delivering the bulk of voluntary effort,²⁸ dominated by prosperous, well-educated, middle-aged groups of the population. Because such groups are not evenly distributed geographically, variation would be expected in voluntary effort between communities and, therefore, between CHs. Furthermore, the mobilisation of voluntary effort requires a degree of organisation and formality.²⁹ We are unaware of literature on the management of voluntary effort in CHs, although there is some relevant work on hospices.³⁰

There are no systematic studies of fundraising or charitable support for CHs. Studies of charitable support for the NHS or specific subsectors of health care³¹ focus on relatively large institutions and organisations. Older studies used data for District Health Authorities; support for individual institutions could not be identified.³² There is consequently no clear picture of financial support from communities for CHs. Historical evidence on the pre-NHS period hospitals suggests that we should expect considerable variations.³³

Overall, the relationship between CHs and their local communities often seems very strong (as witnessed by local protest movements of local commissioning suggesting closing or downsizing a local CH). However, very little is known in formal terms about how CHs relate to their local community (and vice versa). Against this background, it is important to investigate the interdependence of the relationship between CHs and their communities, including what the community does for its CH, and what the CH does for the community. There is a need to explore the variations in community engagement, and consequently the scope of and limitations of policies predicated on community support. In particular, it is important to establish the extent to which community engagement can be encouraged, nurtured and developed; to investigate how the infrastructure for recruiting, engaging and managing volunteers is resourced, how organisations go about recruiting and managing volunteers, and with what degree of success.

There is a literature on the role played in local communities by large institutions (e.g. universities),³⁴ but no comparable work on CHs. The role of institutions in this regard is an important emerging theme of North American research on communities.³⁵ We will focus on qualitative dimensions such as the contribution that CHs make to the functioning of other local organisations (e.g. providing in-kind support which facilitates collaboration), or the ways in which CHs enable the community to come together for the common good. We will also explore the role of the CH in community life as long-standing community landmarks, their contribution to the wider health economy, to employment and volunteering opportunities, and their importance as a social focus (e.g. fundraising events) and a source of social networks and support.

2 Study objectives

Against this background, and supported by the Nolte research team's scoping review and Young research team's national benchmarking exercise, the primary aim of this study is to provide a comprehensive profile and comparative analysis of the characteristics, patient experience and community value of the classic community hospital in contrasting local contexts and in relationship with local communities. In summary, this study seeks to:

- 1) Construct a national database and develop a typology of community hospitals (*what is a community hospital?* workpackage 1)
- 2) Explore and understand the nature and extent of patients' experiences of community hospital care and services (*What are patients' experiences of CHs?* workpackage 2)
- 3) Investigate the value of the interdependent relationship between community hospitals and their communities (*What does the community do for its community hospital, and what does the community hospital do for its community?* workpackage 3)

These objectives will be met through addressing a series of research questions, and realised through three interdependent work packages, each with a number of research elements. The research questions and approaches associated with each of the work packages are summarised in the table below, and discussed in greater detail in section 3.

Objective	Research question	Sub-questions	Study element/method
1. Construct a national database and develop a typology of CHs through national community hospital mapping and surveying	What is a Community Hospital?	How are CH defined?	Scoping National mapping – data set reconciliation <i>*Nolte – literature review</i>
		How many CH are there?	National mapping – data set reconciliation
		Where are CHs located?	National mapping – data set reconciliation
2. Explore and understand the nature and extent of patients' experiences of community hospital care and services through in-depth case studies of patient experience (qualitative)	What are patients' experiences of CHs?	How do patients rate their experience of CH care, support and treatment?	Case Studies (CS) - Secondary analysis of PREMS
		Would patients recommend the CH to friends and family?	CS - Secondary analysis of Friends and Family test
		How do patients and carers describe their experience of CH care, support and treatment?	CS – Patient discovery interviews CS – carer interviews
		What factors influence those experiences (e.g. organisational, human, relational, contextual)?	CS – Patient discovery interviews CS – carer interviews CS – MDT focus group CS – stakeholder interviews
3. Investigate the value of the interdependent relationship between CHs and their communities through in-depth case studies of community value (qualitative study) and analysis of charity commission data (quantitative study)	<i>What does the community do for its community hospital, and what does the community hospital do for its community?</i>	What is the value of voluntary financial income raised for CHs (primarily by LoF, inc legacies)? -	Charity commission dataset analysis CS –scoping/ documentary analysis
		What is the level of volunteering within CHs? (LoF, direct, others vol orgs, governance)	Charity commission dataset analysis CS –scoping/ documentary analysis CS- stakeholder and community interviews
		How do CHs promote, organise and manage voluntary efforts (LoF, direct, governance)?	CS- stakeholder and community interviews CS - volunteer focus groups CS – community focus groups
		How do patients, staff and residents perceive the social value of Community Hospitals?	CS- stakeholder and community interviews CS - volunteer focus groups CS – community focus groups

3 Study approach

In this section we outline the way that we are approaching the study of CH definitions, patient experience and community value and the different methods we will use to explore the study questions. Our approach has four main elements: scoping; mapping and surveying; charity commission data analysis; case studies. Each of these is expanded upon below.

3.1 Scoping

As suggested in section 1.1 above, there is significant variation in what we understand to be a CH. As part of the first work package, and to contribute to the development of a widely accepted definition of community hospitals, our scoping study will draw on the review of the literature on Community Hospitals from 2005 being conducted as part of the Nolte study. The literature review will be supplemented with conversations between ourselves and key stakeholders, including the Community Hospitals Association and a small number of individual Community Hospital staff.

Our proposed definition of CHs, to be tested against the data and in conversation with stakeholders, is as follows:

- A hospital with less than 100 beds serving a local population of up to 100,000 providing direct access to GPs and local community staff.
- Community hospitals are typically GP-led, or nurse-led with medical support from local GPs.
- The 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.
- A CH will not have a 24 hour A&E nor provide complex surgery. In addition a specialist hospital (e.g. children's hospital), a hospice or a specialist mental health or learning disability hospital would not be classified as a CH.

3.2 UK wide mapping and surveying of community hospitals

As we know little about the overall numbers, distribution, facilities and services offered by CHs, the next element of this study will be to conduct a national mapping exercise. The data from both these exercises will enable us to then construct a national database and directory, and work with the CHA to build on their existing database, to provide this as an open resource on their website. The mapping and surveying work will have five key phases:

- reconciling and consolidating existing national data sets of CHs
- constructing a national database of CHs
- working with the Young et al study team to contribute to a national survey of CHs
- developing a directory of CHs and accessible web-based resource at the CHA
- developing a typology of CHs

i. Reconciling and consolidating existing datasets

Using the **working definition above** (and guided by insights from the Nolte and Young studies), we will produce a definitive list of CHs across the UK by collecting, reconciling and consolidating data from the following (non-exhaustive list of) potential sources:

- Community Hospitals Association (CHA) database of community hospitals
- NHS National Benchmarking data
- NHS databases: Estates, ERIC, Patient Environment Action Team (PEAT)
- NHS Property Company database
- Information Centre Address Finder
- Health and Social Care Information Centre
- ONS (population density and deprivation indices)

The initial approach for identifying and mapping CHs will be through use of national coding of hospitals. Early analysis of datasets has highlighted coding problems and a number of inconsistencies, suggesting differences in definitions. The total number of CHs in England is 395 (233 common to CHA & NHS Estates, 99 NHS Estates only, 63 CHA only; PEAT is a subset of the combined data). We therefore estimate the number of potential sites across England to be around 400 (although this may well prove an over-estimate due to potential double counting and variations in definition which will be reconciled through cross-referencing databases).

Country	Number of Potential Sites
England (assumes several new sites)	400
Scotland (from NHS Scotland)	96
Wales	60
N. Ireland (web search)	5
Total	561

ii. Constructing a national database of CHs

Detailed work will then be undertaken to:

- Compile a list of CHs based on reconciliation above
- Define CCG populations and land area
- Map CHs to CCGs
- Map other facilities/organisations to CCGs (e.g. all Hospital Trusts, care homes)
- Map activity levels to organisations within CCGs (e.g. hospital episodes, admissions, bed days, outpatient attendances, births)

It should be noted that this database is a resource that forms the foundation of the rest of the data collection, and will be shared with all projects in this NIHR-funded CH research programme.

iii. Collaborating with Young et al study to conduct a national survey of CHs

We will collaborate with the Young et al team who are leading on a national survey of Community Hospitals. The survey design and implementation will be led by Young et al, but with input from us in terms of question design and survey follow-up to boost response rates. Members of our team - Crystal Blue Consulting - have considerable previous experience in doing this workⁱ and will take on this role for the joint survey. This collaboration generates four considerable benefits:

- CHs benefit from only receiving one survey
- The survey distribution has been extended considerably to include around 70% of CHs not previously included in the Young et al study
- There will be a comprehensive national data set with several new fields of data collected not previously held by NHS Benchmarking
- There will be individualised follow-up with each CHs to assist them in completing the survey ensuring a high response rate as well as comprehensive completion and high integrity of the data provided

Data will then be made accessible to our study team and analysed for the purposes of the directory, and typology. Work will also be undertaken at this stage to compare specific site level measures relating to community engagement to support workpackage 3.

ⁱ We previously conducted this individualised exercise with police forces and CCGs for the DH in relation to sexual offences services and achieved a 79% response rate with a high level of completion of data required (85%) of participating police forces and CCGs and reasonable integrity of the data as audit trails were used.

iv. Development of a directory of CHs and accessible web-based resource for the CHA

Once all the mapping and survey data is analysed, we will work with the CHA to create an open access resource on their website, to enable service users, carers, commissioners and community hospital teams to search for community hospitals in relation to: number, origin (ownership & age); geographical location; size of institution and community characteristics. Identifying which of the available data is needed will be agreed with CHA members on the team and in liaison with those at the CHA involved in building the specific web pages.

v. Development of a typology

A preliminary typology of community hospitals will be jointly developed with the Nolte et al team, informed by their scoping review, our mapping of community hospitals and the working definition of CHs agreed. This will aid sampling when recruiting case studies for workpackages 2 and 3.

Drawing on the categories from our agreed definition of CHs, we will jointly seek to refine this categorisation by identifying a set of characteristics to allow for clustering of types of CH based on a range of features (see below for a worked example). Categories likely to be included are: community characteristics, since these will influence healthcare needs, and also the availability of community support; ownership, since while the majority of CHs are in NHS control, a small number are registered charities and social enterprises; age, to reflect the fact that while the majority of CHs were in existence prior to hospital nationalisation in 1948, a small number of purpose-built CHs have been developed subsequently; size, to distinguish between many of the one ward units and those that are larger as well as documenting the range of services offered; and location, to distinguish rurality and location in country.

Categories	Detail
Location I	North; South; East; West
Location II	Rural; Urban; Coastal
Ownership	NHS; Non-NHS
Age	Pre-1948; Post-1948 (pre-1970; post-1970; post-2006)
Size	Number of beds (≤ 30 and ≥ 30), range of activity
Community characteristics	Deprivation index (local authority boundaries) ⁱⁱ

This will be expanded to include the additional Nolte et al study categories: the nature and scope of services provided, activity and role in the local health economy, linkage and interaction with other

ⁱⁱ This category is important for the community value element, but may not be as clear for each case study site. If this is the case, then we will apply it at sampling stage

providers and multi-agency working, and others. The emergent CH 'types' will inform our subsequent case study sampling strategy.

3.3 Charity Commission data analysis

The third study element, associated with work packages one and three, is to collate and analyse data on the voluntary financial and non-financial (e.g. volunteer) input to CHs through analysis of Charity Commission returns from League of Friends groups. This will be supplemented and added to through capturing and classifying more detailed information from organisations' annual reports and accounts data.

Through analysing the Charity Commission (CC) data, we will investigate:

- (i) variations in the likelihood that hospitals receive support through a formal organisational structure such as a League of Friends (LoF) and
- (ii) (ii) if so, variations in its scale (in financial terms) between communities.
- (iii) uses of the funds raised (e.g. capital development, equipment, patient amenities).

We will use: (a) records of institutions (NHS Trust annual reports/financial statements; for non-NHS controlled institutions, we will seek annual reports/accounts from hospitals themselves), or from the CC website in the case of registered charities; and (b) records of fundraising organisations (e.g. League of Friends, or independently-registered charitable appeals) via the CC. Several hundred LoFs which are registered charities have been identified through TSRC's CC databases covering 160,000 charities in England and Wales (1995-). At least 500 of these report financial figures for several financial years. Several CHs are charities in their own right. We will cross-reference CC records with listings of CHs; we believe that practically all CHs have a LoFs or similar organisation. In England and Wales, annual reports of charities with incomes greater than £25,000 are publicly available through the CC website.

We will approach organisations below that threshold directly for copies of their annual reports, and we will capture data from those sources. The CHA database, and links with the national networks of League of Friends, will facilitate this work. In a previous project [36] we have set up data entry systems to capture financial information for charities which can be modified to suit the purposes of this project. Where possible, sources of income will be separately identified. In the case of League of Friends, this will principally be income from trading activities (e.g. running catering services), with some donations and other fundraising activities. For CHs which are registered charities in their own right, other sources of income will be evident, such as contracts with the NHS/social care and subcontracts from other providers.

We will analyse the extent of and variations in financial contributions from the local community to hospitals – standardised appropriately (e.g. relative to hospital budgets). We will relate these variations to other characteristics of CHs such as location and local socio-economic conditions (e.g. are there variations by region or as between urban areas?), legal form and age (we have foundation dates for former voluntary hospitals in the UK gathered in previous work by Mohan under his Portsmouth voluntary hospitals project - see <http://www.hospitalsdatabase.lshtm.ac.uk/>; the CHA has dates for almost all other CHs).

While many CHs have LoFs or similar organisations which are registered charities and which are likely to account for a majority of the volunteering taking place, not all are currently required by the Charity Commission (CC) to report on volunteer numbers, so data from the CC returns is incomplete. We will seek information on numbers of volunteers from annual reports and accounts, and failing that from interviews. We will construct estimates of the input of unpaid labour (converted to notional cash value using established methodologies for assessing the value of volunteering). From 2013 it has been mandatory for charities in England and Wales to record numbers of volunteers in their Annual Return, if their annual income exceeds £10,000. Such data are routinely gathered by the University of Birmingham's Third Sector Research Centre (TSRC). This will enable investigation of variations in relation to known characteristics of the institution such as size (budget) and location (socio-economic status). While data on the social characteristics of volunteers would be valuable, extensive experience, even from work on large national voluntary organisations, suggests that few organisations gather or retain data on the demographics of their volunteers in a consistent way.

3.4 Qualitative case studies

The fourth element of the study involves undertaking nine in-depth, qualitative case studies, each with eight elements, in order to address the questions of patient experience (work package 2) and community value (work package 3).

Given the gaps in the literature highlighted in section 1 above, a case study approach is a helpful way to uncover different aspects of the contribution made by CHs, helping us to identify key themes within and between cases.³⁷ This section of the proposal therefore summarises our approach to case study selection and set up (section 3.4.1) before moving on to discuss the individual research elements to be used in each case study (section 3.4.2).

3.4.1 Case study selection

In selecting our case study sites, we will take a realist approach to sampling³⁸ because we recognise that case study research moves back and forward between 'ideas' and 'evidence' and therefore needs to be tested out and refined as we encounter the data. While we seek to design a sampling strategy ahead of the research, this may be redesigned as the research progresses and data emerges on information rich cases.³⁹ We anticipate that case studies will be selected in order to reflect the diversity of community hospitals according to the following dimensions:

1. Location (N/S/E/W; urban/rural/coastal)
2. Community characteristics (level of deprivation)
3. Ownership (current and historic)
4. Age (of institution, of current building)
5. Size (beds, staff)
6. Range of services provided and on-site providers involved
7. Levels of community/voluntary financial support

We have tested these initial categories to identify the minimum number of case studies required to reflect the diversity of CH types. This has shown that nine is the minimum number of case study sites needed to enable us to capture diversity in CH provision.

This study depends upon the research team working alongside engaged case study sites, and the current team is experienced in developing positive relationships between research and practice at local level. Our research team deliberately includes members with expertise around organisational development and implementation and significant senior management and practice experience, alongside strong qualitative research skills. Our approach here will include:

- **Initial set up of case study sites:** Significant time has been allocated for a range of tasks required in the satisfactory set up of local case study sites, for example: preparation, design and timetabling of data collection instruments, questionnaires and site visits. Once the sample has been identified, contact with proposed case study sites will commence to seek agreement for participation. In addition, local ethics and governance requirements will be undertaken. Identification and contact details of key CH personnel, local stakeholders and organisations will also take place.
- **Local Reference Groups:** We see Local Reference Groups (LRG) as a pivotal part of our research, bringing people together to steer and support the research at a local level, so we

intend to establish one LRG per case study site. These will comprise representatives of for example, CH volunteers, League of Friends, the third sector, councillors, community groups, service users and carers as well as CH staff and managers. Their role will be to contribute to defining the outcomes and indicators of success for the project locally; helping to develop and build a picture of the local context to assist in making sense of the findings; publicising the project to build support and involvement across the local community; planning the dissemination and implementation of the research findings; and participating and contributing to Annual Learning Events where experiences and best practice is shared (see below). There will be at two LRG consultations during the local fieldwork stage.

- **Annual Learning Events:** We will bring around 60 people from across all case study sites together on an annual basis to share experiences, identify best practice and network. There will be three Annual Learning Events during the fieldwork and reporting stages. Our final report will incorporate the outputs and learning derived from these events, and continued shared learning will be disseminated on an ongoing basis via our website.

3.4.2 Research elements

Each case study will involve eight key research elements, as summarized in the following diagram. We propose to conduct all of these aspects over 4 visits to each case study community hospital: the diagram below indicates at which visit each of the aspects (including local reference group meetings) will be undertaken.



3.4.2.1 Secondary analysis of key hospital data and documents

Key documents and data relating to each of the case study CHs will be collected, collated and analysed. Where available, this will include:

- Friends and Family Test data
- PREMS data
- Histories
- Annual reports for the CH/Trust
- Annual reports for LoF
- Media coverage

These key documents will be collected during a scoping visit to each of the case studies.

3.4.2.2 Semi-structured interviews with key stakeholders

Semi-structured interviews will be conducted with key staff and stakeholders associated with each of the case study CHs, including for example: lead staff (clinical, managerial); volunteer coordinators; chair of the League of Friends; Trust Board members; key community organisations/representatives. Respondents will be selected through purposive sampling, following scoping reviews and conversations, advice of led clinicians, our Local Reference Groups, and snowballing. We will contact potential respondents directly, and will not inform others who has accepted or declined. The interviews will either be conducted face-to-face or via the telephone, depending on availability of respondents, at a time and place of the respondents' choice. Participation will be voluntary and confidential, and invitations to take part will be made by the research team.

The questions to be asked in interview will be open-ended. Depending on the stakeholder in question, topics to be explored in the interview include:

- Background to organisation(s) (history, services, staff, volunteers, funding, challenges and opportunities)
- Background to the local community context
- Role in/ relationship with the community hospital
- Mapping 'typical' patient pathways
- Mapping of connections with local community
- Scale of support provided to/through the community hospital
- Perceptions of the value of the community hospital to the local community
- Perceptions of the value of the community's involvement to the community hospital
- Perceptions of the link between community engagement and patient experience

Each interview will last on average 60 minutes and will be digitally recorded for transcription and analysis (see below).

3.4.2.3 Discovery interviews with patients

To gain greater insight into patient experience, we will seek to understand the contribution of CHs in terms of the lived experience of patients themselves. The organisational, cultural and practical barriers that obstruct the use of standardised patient experience data in healthcare quality improvement are well known,⁴⁰ so we will privilege an experience-centred approach⁴¹ over a functionalist one focused on services and service mechanisms. Our methodology will draw on the principles of two qualitative data collection methods: narrative approaches⁴² and discovery

interviewing.⁴³ Narrative approaches invite participants to tell their stories rather than respond to pre-determined questions, giving control to the 'storyteller.' This approach can elicit richer and more complete accounts than other methods,⁴⁴ because reflection enables participants to contextualise and connect different aspects of their experiences. Discovery interviewing is an approach designed to capture patients' experiences of healthcare and is often used for quality improvement purposes.⁴⁵ The interview is structured by a 'spine' that guides the participant through a pathway of care. The purpose of the spine is to trigger significant memories and thoughts, rather than to set out an agenda for the participant to follow. While an experience-centred approach may limit the kind of instrumentality that many NHS and policy oriented studies prefer, lessons from previous studies⁴⁶ show that gathering experiences in the form of stories enhances their power and richness.

Six discovery interviews⁴⁷ will be conducted with patients (inpatients and outpatients) exploring experiences of, and satisfaction with, CH services and planned and emergent encounters with services. This will also provide a narrated and depicted user-centred map of all stages of the patient pathway and will be triangulated with data collected in MDT focus groups. If possible, we will also examine the ways in which patient experience and quality is understood and represented in the interactions between staff and patients/carers to evaluate the level of connected and reciprocal relationships between patients and staff.⁴⁸

We recognise the challenge when seeking to explore complex lived experiences through narrative accounts, and therefore will draw upon the 2011 NHS National Quality Board's (NQB) working definition of patient experience⁴⁹ to guide the measurement of patient experience at two levels. This framework is based on the well-used Institute of Medicine's⁵⁰ definition of patient-centred care (which outlines those elements which are critical to the patients' experience of NHS services), and a modified version of the Picker Institute Principles of Patient-Centred Care, an evidence-based definition of a good patient experience. Although the NQB framework has been superseded by the 2012 NICE quality standard for patient experience in adult NHS services,⁵¹ the IoM and Picker frameworks upon which the NQB framework was based have been more widely applied and offer us greater opportunities for comparison with other studies. We will take a systemic⁵² approach to data analysis using Leatherman and Sutherland⁵³ models of health systemsⁱⁱⁱ because patients' experience in hospital is shaped, directly and indirectly, by organisational and human factors interacting in dynamic and complex ways at all four levels.⁵⁴ We will also focus on factors shaping patients' experience in hospitals as indicated by Bridges⁵⁵ (individual interaction between patient and staff

ⁱⁱⁱ patient and family; individual staff member; team, unit, department; [community] hospital; and wider healthcare system

members) and explore the possibility of using Wasson et al's⁵⁶ ideas about analysis at the level of the clinical micro-system, which may be a department, a ward or a clinical pathway.

The processes of identifying our patient sample and recruiting respondents depends upon the support of clinical collaborators and associated staff. In each case study, half of the sample (3 patients) will be drawn from inpatients with a length of stay in the range of 10-35 days: all inpatients falling within this range over a six week period prior to interview will be eligible to take part. In addition, in order to ensure we sample across a range of different patient experiences, the other half of the sample (3 per case) will be drawn from patients on a particular pathways (e.g. renal, maternity) identified according to the services provided within that hospital. All out-patients who have their second, or subsequent, outpatient appointment within a six week period prior to interview will be eligible to take part. A designated administrator within each case study hospital will write to all potential participants requesting their participation, and enclosing an information sheet, consent to participate form, and SAE. If the person lacks the capacity to consent, but is known to have a person who is able to act on their behalf as a consultee, the consultee will be contacted with the request to participate. In addition, participants also will be invited to have a friend or family member present during the interview, for support. Where necessary, the paperwork will be made available in alternative language / formats. Recruitment will continue for a six week period until 6 patients, with a mix of demographic characteristics, in each case study have agreed to participate.

The discovery interviews will be conducted on a one-to-one basis, at a time and place of the patient's choice. Each interview will last on average 90 minutes and will be digitally recorded for transcription and analysis (see below). We do not expect to follow up participants.

3.4.2.4 Semi-structured interviews with carers

Semi-structured interviews will be conducted with a small sample (2) of carers from each of the hospitals.

Respondents purposively sampled will be related to patients selected for interview, except where they have already been nominated as a consultee. We will contact potential respondents directly. The interviews will either be conducted face-to-face or via the telephone, depending on availability of respondents, at a time and place of the respondents' choice. Participation will be voluntary and confidential, and invitations to take part will be made by the research team.

The interviews will be used to explore:

- Carers journey/pathway
- 'Service' encounters
- Carer experience
- Perceived value of community involvement in CH
- Perceived value of CH in community

The processes of identifying our carer sample and recruiting respondents depends upon the support of clinical collaborators and associated staff. A designated administrator within each case study hospital will write to all potential participants requesting their participation, and enclosing an information sheet, consent to participate form, and SAE. Where necessary, the paperwork will be made available in alternative language / formats. Recruitment will continue for a six week period until 2 carers in each case study have agreed to participate.

The interviews will be conducted on a one-to-one basis, at a time and place of the carer's choice. Each interview will last on average 60 minutes and will be digitally recorded for transcription and analysis (see below). We do not expect to follow up participants.

3.4.2.5 Multidisciplinary focus group

We will then conduct a focus group with members of the CH multi-disciplinary team (MDT). We will use an analytical framework⁵⁷ to map patient experiences, conditions, pathways and services used. We will also seek to identify CHs' links with other services. Topics to be explored through the MDT focus groups include:

- Patient journeys
- 'Service' encounters
- Perceptions of patient experience
- Community engagement
- Perceived value of community involvement in CH
- Perceived value of CH in community

MDT focus group participants will be identified through working collaboratively with clinical and other staff within the hospital. We will contact potential respondents directly, and will not inform

others who has accepted or declined. Participation will be voluntary and confidential, and invitations to take part will be made by the research team.

Each focus group will last on average 90 minutes and will be digitally recorded before being transcribed for analysis.

3.4.2.6 Volunteer focus groups

A focus group will be conducted of volunteers within each of the case study hospitals (in addition to individual volunteers being interviewed through the stakeholder interviews). The focus groups will bring together a range of different volunteers (approx. 10) involved in different aspects of the hospital; while most may be involved through the League of Friends (in a variety of roles), others may be recruited directly by the hospital or through other charities working within/through the hospital. The focus groups will explore:

- Motivations and route in
- Role
- Support and management
- Outcomes

Volunteer focus group participants will be identified through working collaboratively with League of Friends and other voluntary organisations working through the hospital. We will contact potential respondents directly, and will not inform others who has accepted or declined. Participation will be voluntary and confidential, and invitations to take part will be made by the research team.

Each focus group will last on average 90 minutes and will be digitally recorded before being transcribed for analysis.

3.4.2.7 Focus groups with community representatives

A focus group will be conducted with community representatives, each with a 'stake' in the community hospital and/or its local community. The sample will be identified through scoping work, guidance from our Local Reference Group and snowballing. Possible candidates might include Local Authority Officers, Councillors, Council for Voluntary Service leads, local voluntary organisations, social enterprises and business community representatives. We will contact potential respondents directly, and will not inform others who has accepted or declined. Participation will be voluntary and confidential, and invitations to take part will be made by the research team.

The focus groups will explore:

- Mapping connections between the community and the community hospital
- Individual experiences of engaging with the hospital – in different ways (e.g. as patient, carer, volunteer, partner)
- Perceptions of the value of the community hospital to the local community
- Perceptions of the value of the community's involvement to the community hospital
- Perceptions of the link between community engagement and patient experience

Each focus group will last on average 90 minutes and will be digitally recorded before being transcribed for analysis.

3.4.3 Case study data analysis

As noted above, interviews and focus groups will be digitally recorded and transcribed, verbatim, for analysis. Field notes will be written up immediately after each case study visit. Unique identifiers will be used for all transcripts for the purposes of confidentiality and anonymity. QSR's Nvivo 10 will be used for data management, exploration and analysis, with all transcripts, fieldnotes, policy documents, and other relevant case study documentation imported.

We will use a mixed deductive and inductive approach to analysing the qualitative case study data. Following an initial review of all the transcripts, a coding frame will be developed based on broad categories and themes. The transcripts will then be coded to those themes, with subsequent analysis leading to the creation of more finely grained sub-codes. The process will be iterative, with the analysis framework and coding frame being modified and developed throughout the data collection and analysis process.

Where appropriate, the qualitative case study findings will be triangulated with those from both the Mapping and Surveying and the Charity Commission data base analysis, to refine and verify our analysis of the definitions, categorisation, patient experience and community value of Community Hospitals.

4 Ethical review

Ethics approval will be secured for the project, as it involves focus groups with staff and in-depth interviews with staff, service users, carers and community representatives. There are three layers of ethics required:

- Work package 1: UoB ethical review and sponsorship;
- Work package 2 & 3: NRES ethical review and approval. An application will be made in the autumn of 2014, for a June 2015 start of these work packages; and
- Work package 2 & 3: Local R&D /Caldicott approvals

4.1 UoB ethical review and sponsorship

Work package 1 (mapping and survey) will require University of Birmingham ethical review and sponsorship to be obtained during month 1.

The University of Birmingham requires that all Chief Investigators should, in the first instance, complete a Self-Assessment Form (SAF) before beginning any new research project. This is required for all work classified as research by the University, including projects deemed to be service evaluation by the NHS. This form acts as both the first stage of the University's ethics review process, and as a request for sponsorship in line with the Department of Health's Research Governance Framework. Where this review indicates an Application for Ethical Review is required this then needs to be completed and submitted for further review. This must take place before the start of any substantive research (including pilot studies, but excluding literature review and use of secondary data where no identifiable patient data is involved). A SAF has been completed for work package 1 of this study.

4.2 NRES ethical review and approval

Work packages 2 and 3 (case studies) will require ethical approval through NRES to be obtained during Months 5-9, as work package 2 involves interviews with patients and carers and focus groups with staff, and work package 3 involves interviews and focus groups with a range of volunteers and community stakeholders.

Consent to participate in the study will be sought from all potential respondents – staff, patients, carers, volunteers and community representatives (see above). All respondents will be informed, at each stage, of their right to withdraw or to withdraw their data at any time, without consequence. The consent process for patients will comprise a number of elements:

- Discussions will take place with CH staff about the most appropriate way to alert and inform patients of the study and seek participation, including the process and methods for

communication, to ensure that they do not feel under pressure from known clinicians, to participate.

- In line with the Mental Capacity Act 2005 Code of Practice, we will make provision for the appointment of **consultees** in situations where potential participants lack the capacity to consent to participation in the project. Participants also will be invited to have a friend or family member present during the consent process and/or interview, for support. In addition, the study will use a model of ‘ongoing consent;’ offering information on a regular and repeated basis as well as opportunities to withdraw, and researcher discussion and reflection on the research process;
- Plain language and large print information and consent sheets will be designed that minimises the volume of text while ensuring all salient information is provided. Where required, paperwork will be translated into different languages and/or formats.
- Patients who are willing to take part will be asked to give their consent to be included in the study through completing and returning a reply slip direct to the study team.

Similarly, discussions will take place with CH management about the best way to alert and inform staff of the study and seek participation, including process for communication to ensure that they do not feel pressurized from CH management to participate.

All potential respondents will be sent an **information sheet** about the study, prior to their involvement. This will include information on:

- An explanation of the study focus and use of data;
- What participation entails including information on the time it will take and data collection method used ;
- That the interview/ focus group will be recorded and discussions transcribed;
- That information provided will be anonymised, and stored securely in encrypted files, in keeping with the UK Data Protection Act 1998, to protect identity and ensure confidentiality.
- That participation is entirely voluntary and they may withdraw at any time
- The contact details of the researcher and CI should they have any questions or concerns
- Details of how to make a complaint if necessary.

All potential respondents who consent to participate will then be provided with a **consent form** to complete at point of interview, confirming they have read and understood the letter of information, been given the chance to ask questions, understand that their participation is voluntary and free to

withdraw at any time, agreeing for the interview/focus group to be recorded, and signing that they agree to take part in the study.

All members of the research team who are responsible for conducting the case study fieldwork are experienced qualitative researchers.

4.3 Local R&D /Caldicott approvals

If/where necessary, local R&D / Caldicott approvals will be sought.

5 Research governance and management

5.1 Governance

Several elements have been built into this study to ensure appropriate levels of governance and management. These include:

- Participation in a **National Steering Group (NSG)** which brings together this study along with those being led by Nolte and Young (see above), with members nominated by each team. The NSG will meet four times over a period of 36 months, with provision made for conference calls in between. Sir Lewis Ritchie has kindly accepted the invitation to be Chair. Four PPI representatives on the National Steering Group have been identified across the studies including: Heather Eardley, Director of National Projects, the Patients Association (Young et al Study), a representative from INsPIRE, a PPI panel from Cambridgeshire and Bedfordshire (Nolte et al study), a representative of Attend (originally the National Association of Leagues of Hospital Friends and of which many CH LoFs are members) and Jan Marriot, Vice Chair of the Community Hospitals Association (Glasby et al study). Each study team will nominate a further two members. Outside of the national steering group, more informal **cross-study team meetings** will take place to ensure that interdependent study elements and findings are aligned and a **joint electronic repository** (e.g. HS&DR Google Apps) will be set up for the sharing of draft instruments, information, findings and reports.
- **Patient and Public Involvement (PPI):** PPI is something that the team take very seriously and has been a hallmark of our values and practice in previous research activities (for example, our research into older people's transitions demonstrated the positive impact of patients and the public participating in all stages of the study). From our experience, PPI has greatest meaning and impact at a local level, because it provides more than representation; it provides for active involvement and participation. For this reason, we have concentrated

significant PPI at a local level and across case study sites for peer learning and knowledge exchange. However, we recognise that there needs to be PPI demonstrated at a strategic level, as local experiences need to be translated at a national level into policy. On that basis we see patient and public involvement as important in all elements of the project. For this study it involves:

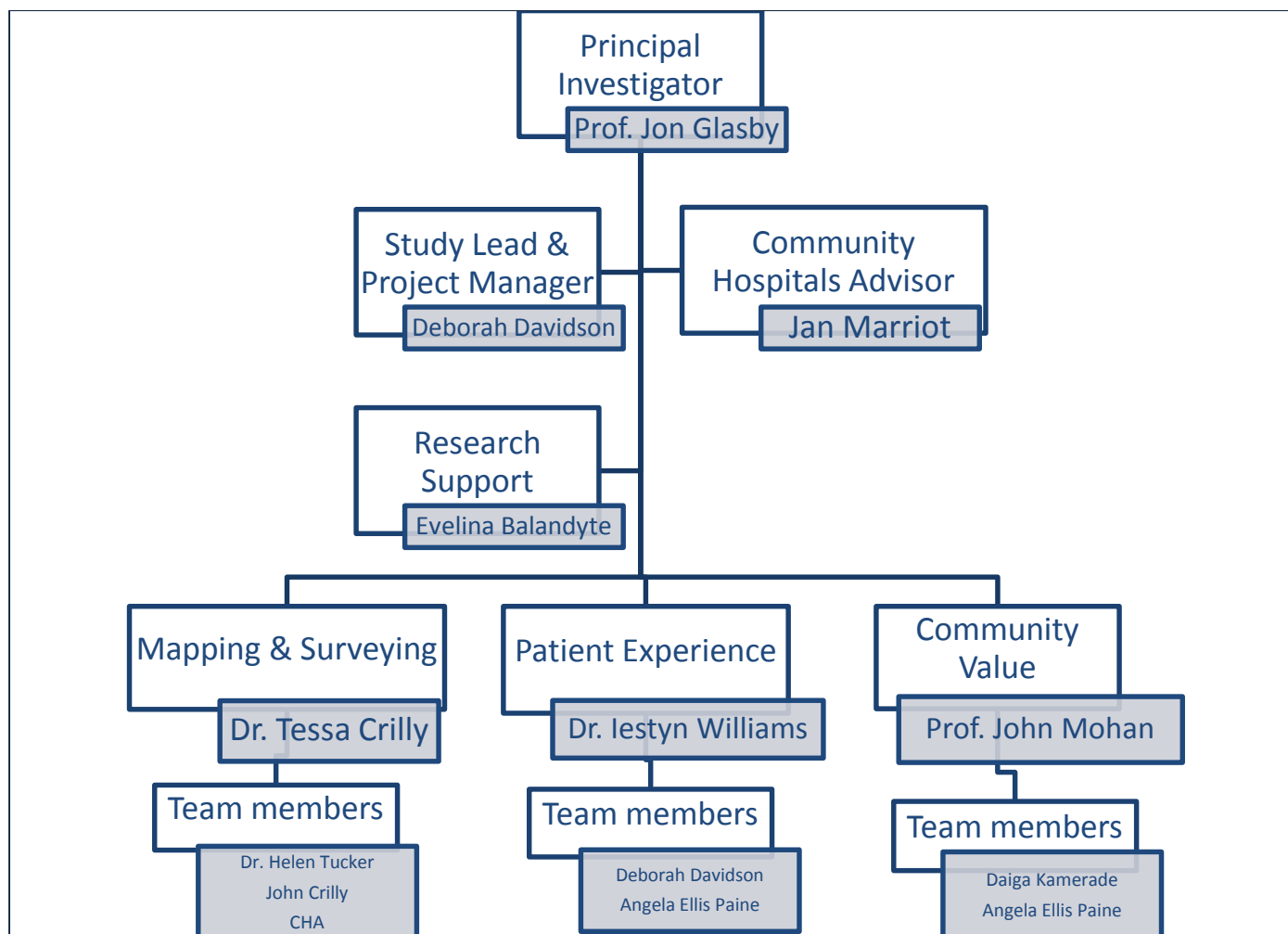
- Involvement and consultation of CH staff and members in putting together the study
- Designing in the establishment of Local Reference Groups (see above) and cross-site Annual Learning Events, bringing together local players who have a key stake in their local CH
- Including interviews with service users and carers in the case study design
- Including focus groups with local community members as part of the community engagement design
- Identifying and agreeing four specific representatives on the National Steering Group with the Nolte et al and Young et al teams (see below)

5.2 The team

The team composition deliberately spans the research and practice divide: senior qualitative research expertise is provided by Professor Jon Glasby and Professor John Mohan at the University of Birmingham. This is combined with crucial policy and practice networks, local contacts and content expertise provided by Helen Tucker and the Community Hospitals Association. Since several members of the research team have less experience of formal HS&DR research and of producing high quality peer review outputs, we have identified Professor Russell Mannion, Professor of Health Systems at the University of Birmingham, to provide active mentoring for other, less experienced team members and to take a particular role in supporting the production of high quality academic outputs (with a mix of commenting on drafts, support in framing and with broader literature/theory and co-authoring). We feel that such capacity building is crucial for such large-scale national studies, helping to develop future researchers above and beyond the current senior team.

5.3 Team structure and leadership

The structure and leadership of the study as well as the different work packages is shown below. Workpackage leads and team members have a track record of working with each other in large research studies, and team membership overlaps across different elements of the study to provide an additional element of continuity and coherence between workpackages.



5.3.1 Programme oversight, management and reporting

- Jon Glasby: responsible for overall programme management and delivery, including the National Steering Group, team meetings, overall study design and coordination, case study sampling, research synthesis and reporting and dissemination.
- Deborah Davidson: responsible for project management, including oversight of national and local ethical review and practice requirements, day-to-day programme management and coordination, work stream coordination, budget management, case study sampling and typology, Annual Learning Events and Local Reference Groups.

5.3.2 Community hospitals advisor

- Jan Marriot : Overview, advice and support regarding Community Hospitals history, knowledge, national and local liaison and access.

5.3.3 Workpackage 1 (mapping and surveying)

Will be led by Tessa Crilly (who will be responsible for survey design and implementation, analysis and interpretation of results, case study sampling and typology). Additional team members include:

- Helen Tucker: working on survey design/surveying, liaison with CHA and community hospitals, case study sampling and typology
- John Crilly: working on survey design/surveying, reconciling national data sets, generating a directory, generating and analysing large data sets
- Jan Marriot (CHA): working on data extraction from existing database, liaison with CHs in relation to information, update of server/preparation of new server capacity, design and inputting of web information^{iv}, targeted dissemination of database information to commissioners and providers

5.3.4 **Workpackage 2 (patient experience)**

Will be led by Iestyn Williams (who will be responsible for overall design, local reference groups, site visits, focus groups/interviews, analysis and reporting). Additional members include:

- Deborah Davidson: leading case study set up and local reference groups, and working on data collection and analysis
- Angela Ellis Paine working on case study set up and local reference groups data collection and analysis
- Another part time qualitative researcher will be recruited to work on case study set up and local reference groups data collection and analysis

5.3.5 **Workpackage 3 (community value)**

Will be led by John Mohan, who will have overall responsibility for set up, design, workpackage coordination and supervision, overseeing data collection, analysis, synthesis and reporting.

Additional team members include:

- Daiga Kamerade: working on the interrogation, linking and analysis of TSRC and Charity Commission data sets, mapping of CHs to charities, interrogation of annual reports and accounts, transfer of data and liaison with Centre for Data Digitalisation and Analysis (CDDA), Queens University Belfast, synthesis and reporting

^{iv} Deborah Davidson will support the CHA web design, implementation, dissemination and impact of new directory

- Angela Ellis Paine: working on site visits, local reference groups, focus groups, interviews, follow-up and phone calls, analysis and reporting
- Helen Tucker: working on design, site-visits, local reference groups and focus groups

5.3.6 Additional clinical expertise

Will be contributed by Dr David Seamark, who will be responsible for contributing to research design at case study level, interpretation of data and the implications of findings, and providing a clinical perspective on the study as a whole. Dr Seamark has been actively involved in CHs, both as a practising GP and as an academic. Dr Seamark was the lead research GP for his practice in Devon, and encouraged research and training links with his local CH. He is a Clinical Research Champion in a Primary Care Research Network, and is an honorary clinical senior lecturer for the Peninsula Medical School. He was an active committee member for the Community Hospitals Association for many years, and has researched topics such as CHs and end of life care.

6 Outputs, reporting, dissemination and impact

HSMC has a stated commitment to 'rigour and relevance' in health and social care. We therefore carry out high quality, innovative research – but seek to do so in a way which has as a maximum impact on real-life policy and practice issues. In this study, HSMC's longstanding track record in influencing policy and supporting changes in front-line services is supplemented by the involvement of the Community Hospitals Association so that findings from the study can benefit from CHA's expertise but also directly support the work of the Association going forward. Our Local Reference Groups and Annual Learning Events are also key to disseminating emerging findings and ensuring local ownership of the research. We will also actively collaborate with other studies within the HS&DR programme so that knowledge is shared and study outcomes, integrated.

6.1 Outputs and contribution

We are very conscious that this is a large and detailed study, and that a range of key 'products' will be needed in return for the investment sought (with some early outputs as well as final products at the end of the study). With this in mind, key outputs will include:

6.1.1 *Work package 1*

A database of community hospitals on the CHA web site. This will be a freely available online resource for policy makers, commissioners and providers (available: September 2015)

6.1.2 *Workpackage 2*

Systematic evidence of patient experience with services, as well encounters with services across different patient pathways and at the interface with other local community resources.

6.1.3 *Workpackage 3*

A robust and systematic study of financial support for CHs through the vehicle of League of Friends and other fundraising mechanisms; of what that support is used for and how it varies between communities and between types of institution; of volunteer support for CHs and engagement in governance; of how community engagement is managed; and of how CHs support the broader community.

6.2 Final project stages

The last seven months of the project will comprise a final report for HS&DR, suitable for peer review and forming a basis for broader academic publications (see attached CVs for evidence of our track record in this area). We will also produce a plain language executive summary for community stakeholders involved in the study, as well as a short document for each case study site, detailing key findings on performance, satisfaction, the role of the CH in the local health and social care context and community, and implications for commissioning.

In addition, we will make presentations to key stakeholder audiences and NHS/academic conferences (for example, the annual CHA and NHS Confederation conferences). As a topic with international resonance, the European Health Management Association (which will be hosted by Birmingham in 2014) and the Organisational Behaviour in Health Care Annual Conference (previously hosted by Birmingham) will be potential vehicles to share the work internationally.

6.3 Wider dissemination

A range of additional activities will also be undertaken. These ideas below are for illustrative purposes and would need further scoping. Such activities could also be conducted in a phased manner so that dissemination takes place throughout the life of the study.

- Dedicated webpages provided by the CHA to publicise our research findings as well disseminating through usual newsletters and networks
- As partners in the research, the CHA, Attend and other national collaborators on the National Steering Group will work to disseminate the results to health and social care commissioners and providers throughout the UK
- The involvement in our National Steering Group of Sir Lewis Ritchie as a key academic working in this area testifies to the academic interest and relevance of this research and will support dissemination
- Our international research links in Canada, New Zealand and Australia will facilitate cross-national comparison and dissemination as well as providing opportunities for future collaborative research
- We would be keen to boost dissemination and to explore additional forms of dissemination and impact with HS&DR, with a greater focus and emphasis on influencing policy nationally and locally. For example, this might include:
- A special edition of the Journal of Integrated Care (a very policy- and practice-focused journal, of which Professor Jon Glasby is Editor-in-Chief). With the permission of the editorial Board, we would aim to publish a themed edition of the Journal on the role of CHs in the whole system, disseminating our findings and also showcasing good practice collected during the study.
- We will aim to run a national policy event on the future of CH services part-way through and at the end of the project, seeking to engage a national policy audience with the issues emerging from our research and exploring the implications of our findings for national and local funding strategies.
- We will approach the Social Care Institute for Excellence to explore scope for them to make a 'Social Care TV' video clip as part of their work on health and social care integration. We are already working with SCIE on a Research for Patient Benefit-funded study on older people's experiences of emergency admissions, and we will explore scope to engage them in this research.
- In previous research into older people's experiences of moving across service boundaries, we were also able to offer case study sites some funded support from our organisational

development specialists to help implement findings/work on emerging themes. If HS&DR felt it appropriate we could explore a similar approach in this study.

- Enhancing dissemination further through social media (for example: via outlets such as The Conversation UK (<http://theconversation.com/uk>), Guardian opinion pieces, The Birmingham Brief (www.birmingham.ac.uk/news/thebirminghambrief/index.aspx) and Birmingham Perspectives (www.birmingham.ac.uk/research/impact/perspective/legal-aid-andrew-sanders.aspx).
- Building on strong links with the NHS Alliance to disseminate to their members via their website, direct mailing and/or at conferences and events.
- Creating a regular project-specific blog – no further costs would need to be sought for this as we could look to sites such as Wordpress which allow us to create these free of charge whilst still allowing a great deal of ‘customisability.’
- Podcasts and Vidcasts which we can disseminate in whichever way is most suitable (e.g. via a project-blog; targeted emails etc).
- Making use of the annual ESRC Festival of Social Science, which offers a good avenue for dissemination/impact generation to non-academic audiences and applications for funded events (up to £2000) can be submitted (we have had success here for previous SDO funded research).

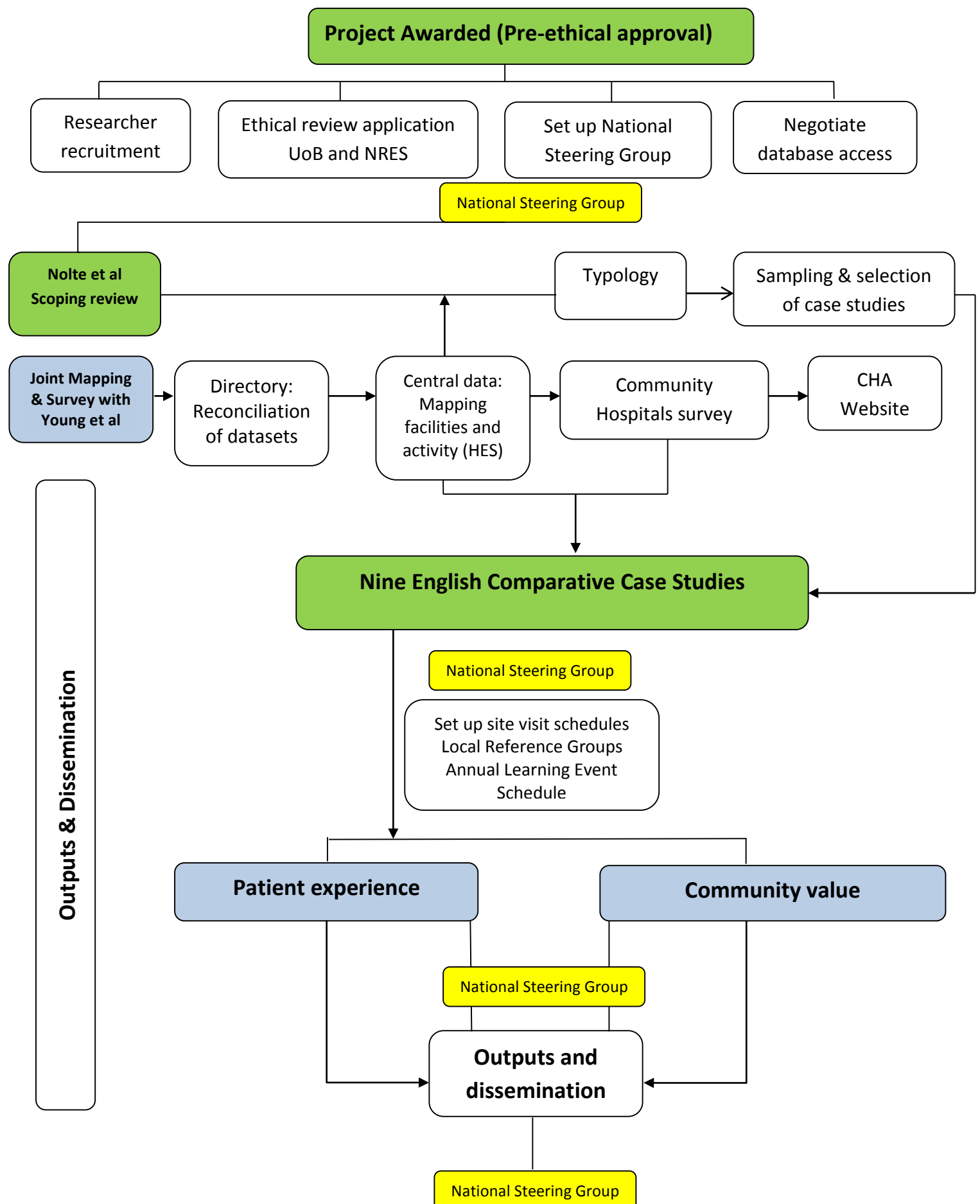
In addition to those dissemination ideas, we can confirm we will:

- Invite those we are engaging with (communities, patients, staff) to suggest appropriate ways of dissemination. There will be some methods that will be very specific to localities, and we will use local methods that are successful. For instance in Swanage the Purbeck Gazette is considered to be an effective communication tool. There is also a Facebook page for the LoF for the hospital.
- In respect of national dissemination, we will be listening to staff and patients and seeing where they would typically source information and co-design dissemination with them.
- We will seek to develop a national good practice guide, badged by the Community Hospitals Association, but also seeking support from organisations such as the NHS Confederation, the Association of Directors of Adult Social Services and Age UK. This would aim to disseminate learning from the study and showcase good practice examples. We have support from these organisations for a study around older people’s experiences of emergency hospital admission, and would aim to engage these partners in the current project as well.

In particular, we will make significant use of the Community Hospitals Association's networks and influence:

- The CHA will continue its work to support members (which include CH staff, provider organisations, commissioners, academics and Leagues of Friends) and will share issues/trends with the research team as a collaborator on the project. This will give a wider perspective to the study, and is in keeping with the ongoing role of the CHA.
- The CHA has meetings with politicians and policy makers to share information and present briefing papers which have been used to inform parliamentary debates and reports to the Health Select Committee. The CHA/research team can continue to do this. For instance, Dr Sarah Wollaston (an MP/GP who sits on the Health Select Committee) has spoken to the last 2 CHA conferences and is in regular contact with CHA. The CHA has also been involved with Norman Lamb and Dan Poulter through their local CH as well as on national issues. This activity could be increased as there is more information to share.
- The database developed in workpackage 1 will enable those CHs wanting to compare their hospital with hospitals in similar situations or with similar profiles. After initial development, the CHA will take on a maintaining and updating the database as this is a fundamental resource for members.

Appendix 1: Project design structure



-
- ¹ Department of Health (2006) "Our Health, Our Care, Our Say: A new direction for community services." London: Department of Health
- ² NHS Benchmarking Community Hospitals – Report (124 CH)
www.nhsbenchmarking.nhs.uk/Projects/current.aspx
- ³ Audit Commission (2010) "More for Less: Are productivity and efficiency improving in the NHS?" London: Audit Commission
- ⁴ Heaney, D., Black, C., O'Donnell, C. A., Stark, C., van Teijlingen, E., Bird, S. Bain, L. McIntyre., Thomas, S. (2004) "Research Literature Review on Community Hospitals." Centre for Rural Health, University of Aberdeen
- ⁵ Seamark, D., Moore, B., Tucker, H., Church, J. and Seamark, C. (2001) "Community hospitals for the new millennium." *British Journal of General Practitioners*, 51(463):125-127
- ⁶ Tucker, H. (1987a). "The Role and Function of Community Hospitals – King's Fund Project Paper Number 70." London: Kings Edward's Hospital Fund for London; Tucker, H., Moore, B., Jones, S. and Marriott, J. (2008) "Profiling Community Hospitals in England 1998- 2008." Community Hospitals Association: Department of Health and Community Health Partnership.
- ⁷ Heaney, D., Black, C., O'Donnell, C. A., Stark, C. and van Teijlingen, E. (2006) "Community hospitals- the place of local service provision in a modernising NHS: an integrative thematic literature review." *BMC Public Health*, 6: 309
- ⁸ Ritchie L.D. and Robinson, K. (1998) "Community hospitals: new wine in old bottles." *British Journal of General Practice*, 1039-1040
- ⁹ Seamark, D., Moore, B., Tucker, H., Church, J. and Seamark, C. (2001) "Community hospitals for the new millennium." *British Journal of General Practitioners* 51(463): 125-127
- ¹⁰ Department of Health *Our Health, Our Care, Our Say* (2006) op cit
- ¹¹ Coulter, A. (2005) "Trends in Patients' Experience of the NHS." Oxford: Picker Institute; Healthcare Commission (2007) "Survey of Adult Inpatients in the NHS 2007." London: Healthcare Commission
- ¹² Ipsos Mori (2008) "Trust in Professions 2007: Public awareness of physicians and trust in professionals - research study conducted for the Royal College of Physicians." London: Royal College of Physicians
- ¹³ Royal College of Nursing (2008) "Defending Dignity – Challenges and opportunities for nursing." London: RCN; Levenson, R. (2007) "The Challenge of Dignity in Care – upholding the rights of the individual." London: Help the Aged; Department of Health (2006) "Dignity in Care." London: Department of Health
- ¹⁴ Department of Health (2006) "Safety First: A report for patients, clinicians and healthcare." London: Department of Health
- ¹⁵ Department of Health (2008) "High Quality Care for All – NHS Next Stage Review final report." London: Department of Health
- ¹⁶ Francis, R. (2010) "Independent Inquiry into Care Provided by Mid-Staffordshire NHS Foundation Trust January 2005 – March 2009 - Volume I; and January 2005 – March 2009 - Volume II." London: The Stationery Office
- ¹⁷ Bridges J., Flatley, M., Meyer, J. (2010) "Older people's and relatives' experiences in acute care settings: Systematic review and synthesis of qualitative studies." *International Journal of Nursing Studies*, 47: 89–107
- ¹⁸ Green, J., Young, J., Forster, A., Mallinder, K., Bogle, S., Lowson, K. and Small, N. (2005) "Effects of locality based community hospital care on independence in older people needing rehabilitation:

- randomised controlled trial." *British Medical Journal*, 331(7512): 317-322; Small, N., Green, J., Spink, J., Forster, A., Lowson, K. and Young, J. (2007) "The patient experience of community hospital - the process of care as a determinant of satisfaction." *Journal of Evaluation in Clinical Practice*, 95-101
- ¹⁹ Wilce, G. (1988) "A Place Like Home: A radical experiment in health care." London: Bedford Square Press
- ²⁰ Tucker, H. (2001) "Turning community hospitals into assets," Meads G. and Meads, T. "Trust in Experience." Abdingdon: Radcliffe Medical Press, pp103-120
- ²¹ Green, J. et al (2005) op cit
- ²² Hine, C., Wood, V.A., Taylor, S. and Charny, M. (1996) "Do community hospitals reduce the use of district hospital inpatient beds?" *Journal of Royal Society of Medicine*, 89(12): 681-687; Heaney et al (2006) op cit
- ²³ RCGP (1983) "General Practitioner Hospitals: Report of a Working Party appointed by the Council of the Royal College of General Practitioners - Occasional Paper 23." London: Royal College of General Practitioners; RCGP (1990) "Community Hospitals: Preparing for the future - Occasional Paper 43." London: Royal College of General Practitioners and Association of GP Community Hospitals
- ²⁴ Emrys-Roberts, M. (1991) "Cottage Hospitals 1859-1990: Arrival, Survival and Revival." Dorset: Tern Publications; Higgins, J. (1993) "The Future of Small Hospitals in Britain." Institute for Health Policy Studies, University of Southampton
- ²⁵ Cooney, E. (1960) "The Leagues of Hospital Friends." *Public Administration*, 38: 263-272
- ²⁶ Naylor, C. et al (2013) "Volunteering in Health and Care: Securing a sustainable future." London: King's Fund
- ²⁷ Rochester, C. et al (2009) "Volunteering and Society in the 21st Century." London: Palgrave Macmillan; Staetsky, L. (2011) *Individual Voluntary Participation in the UK*, TSRC WP-6, available from www.tsrc.ac.uk.
- ²⁸ Mohan, J. and Bulloch, C. (2012) "Is there a British 'Civic Core'? Evidence from the Citizenship Survey," TSRC WP-73, available at www.tsrc.ac.uk
- ²⁹ Rochester, C. et al (2009) op cit; Machin, J. and Ellis Paine, A. (2008) "Management Matters: A national survey of volunteer management capacity." London: IVR
- ³⁰ Addington-Hall, J. and Karlsen, S. (2005) "A national survey of health professionals and volunteers working in voluntary hospices in the UK: (II) staff and volunteers' experiences of working in hospices." *Palliative Medicine*, 19: 49-57
- ³¹ Mocroft, I and Pharoah, C. (2001) "Coming Full Circle: Charitable funds in London's health. London: King's Fund; Pharoah, C. and Harrow, J. (2011) "A legacy for the nation's health: the challenges faced by UK health charities in legacy funding." *Journal of Communication in Healthcare*, 41: 13-26; Linck, P., Tunnage, B., Hughes, D.A. and Edwards, R.T. (2008) "Charitable contributions to funding cancer services for children and young people in England and Wales." *Journal of Child Health Care*, 12(2): 156-168
- ³² Lattimer, M. and Holly, K. (1992) "Charity and NHS Reform." London: Directory of Social Change; Lattimer, M. (1996) "The Gift of Health." London: Directory of Social Change
- ³³ Mohan, J. (2003) "Voluntarism, municipalism and welfare: the geography of hospital utilization in England in the 1930s." *Transactions, Institute of British Geographers*, 28(1): 55-74; Mohan, J. (2006) "The 'caprice of charity': regional variations in the finances of voluntary hospitals in Britain before the NHS," in Gorsky, M. and Sheard, S. (eds) "Financing British Medicine." London: Routledge, pp. 77-92
- ³⁴ Goddard, J. and Vallance, P. (2013) "The University and the City." London: Routledge
- ³⁵ Sampson, R., MacIndoe, H., McAdam, D. et al (2005) "Civil society reconsidered: the durable nature and community structure of collective civic action." *American Journal of Sociology*, 111: 673 – 714

-
- ³⁶ Lindsey, R. (2013) "Exploring local hotspots and deserts: investigating the local distribution of charitable resources." *Voluntary Sector Review*, 4(1); Lindsey, R. and Mohan, J. (2013) "Local charitable ecologies? Tracking flows of charitable resources into contrasting communities in South East England", submitted to *Policy and Politics* (forthcoming)
- ³⁷ Eisenhardt, K. (1989) "Building theories from case-study research." *Academy of Management Review*, 14: 532-550; Lincoln, Y.S. and Guba E.G. (1985) "Naturalistic Inquiry." Beverly: Sage; Ovretveit, J. (1998) "Comparative and Cross-cultural Health Research: A practical guide." Abingdon: Radcliffe Medical Press; Thomas, G. (2011) "How to do your Case Study. London: Sage
- Yin R. (1984) Case-study research design and methods, Beverly Hills: Sage
- Yin R. (1999) Enhancing the quality of case-studies in health services research. *Health Services Research* 34: 1209-1224.
- ³⁸ Emmel, N. (2013) "Sampling and Choosing Cases in Qualitative Research: A realist approach." London: Sage
- ³⁹ Patton, M.Q. (2002) "Qualitative Research and Evaluation Methods" (3rd ed.). London: Sage
- ⁴⁰ Davies, E. and Cleary, P.D. (2005) "Hearing the patient's voice? Factors affecting the use of patient survey data in quality improvement." *Quality and Safety in Health Care*, 14(6): 428-32
- ⁴¹ Patterson, W. (2002) "Strategic Narrative: New perspectives on the power of stories." Oxford: Lexington
- ⁴² Andrews, M., Squire, C. and Tamboukou, M. (2008) "Doing Narrative Research." London: Sage
- ⁴³ Bridges, J., Gray, W., Box, G., Machin, S. (2008) "Discovery interviews: a mechanism for user involvement." *International Journal of Older People Nursing*, 3(3): 206-10
- ⁴⁴ Riessman, C. and Quinney, L. (2010) "Narrative in social work: a critical review." *Qualitative Social Work*, 4(4): 391-412.; Elliott, J. (2011) "Listening to people's stories: the use of narrative in qualitative interviews" in Elliott, J. (ed.) *Using Narrative in Social Research: Qualitative and quantitative approaches*. Thousand Oaks, CA: Sage
- ⁴⁵ CHD Collaborative (2004) "Learning from Patient and Carer Experience: A guide to using discovery interviews to improve care." Leicester: NHS Modernisation Agency
- ⁴⁶ Ellins, J., Glasby, J., Tanner, D., McIver, S., Davidson, D., Littlechild, R., Snelling, I., Miller, R., Hall, K., Spence, K. and the Care Transitions Project co-researchers (2012) "Understanding and Improving Transitions of Older People: A user and carer centred approach." NIHR Service Delivery and Organisation programme; 2012
- ⁴⁷ Bridges, J., Gray, W., Box, G. and Machin, S. (2008) op cit
- ⁴⁸ Bridges J., Flatley, M. and Meyer, J. (2010) op cit
- ⁴⁹ <https://www.gov.uk/government/publications/nhs-patient-experience-framework> op cit
- ⁵⁰ Institute of Medicine (2001) op cit
- ⁵¹ National Institute for Health and Clinical Excellence (2012) "NICE Quality Standard for Patient Experience in Adult NHS Services." Manchester: NICE
- ⁵² Fruggeri, L. (1991) "New Systemic Ideas from the Italian Mental Health Movement." London: Karnac
- ⁵³ Leatherman, S. and Sutherland, K. (2008) "The Quest for Quality: Refining the NHS reforms – a policy analysis and chartbook." London: The Nuffield Trust.; Leatherman, S. and Sutherland, K. (2003) "The Quest for Quality in the NHS: A mid-term evaluation of the ten-year quality agenda." London: Nuffield Trust
- ⁵⁴ Goodrich, J. and Cornwell, J. (2008) op cit
- ⁵⁵ Bridges et al (2010) (op cit)
- ⁵⁶ Wasson, J.H., Anders, S.G., Moore, L.G., Ho, L., Nelson, E.C., Godfrey, M.M. and Batalden, P.B. (2008) "Clinical microsystems: part 2 - learning from micro practices about providing patients the care they want and need." *Joint Commission Journal on Quality and Patient Safety*, 34(8): 445–52
- ⁵⁷ <https://www.gov.uk/government/publications/nhs-patient-experience-framework> (Accessed 3 April, 2013)

