HS&DR Project 12/177/14 Advancing community hospitals and services in the NHS: learning from international experiences

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Contracting Organisation: RAND Europe
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Protocol

Aims and objectives

The proposed research seeks to answer five principal research questions:

1. What is the nature and scope of service provision models that can be considered under the umbrella term 'community hospital' in the UK and other high income countries?
2. What is the evidence of effectiveness and efficiency of community hospitals and comparable service models in the UK and other high income countries, including of patient outcomes?
3. What is the wider role and impact of community engagement in community hospital service development and provision?
4. How do models that are comparable to community hospitals in England operate and what is their role within the wider system of service provision in other countries?
5. What is the potential for models that are comparable to community hospitals in England to perform an integrative role on the delivery of health and social care in other countries?

To address these questions we will first undertake a comprehensive evidence synthesis of current provision of community hospital services in the UK and other high income countries by means of a scoping review of the academic and grey literature. Second, we will carry out an international comparative study that seeks to explore experiences in other countries by means of (i) a review of the nature, scope and distribution of service delivery models that can be considered as community hospitals in five high-income countries through the development of country reports based on a structured assessment of the features of the system context within which healthcare is governed, financed, organised and delivered and (ii) four in-depth case studies of the specific financial, organisational and governance features of community hospital models in selected countries.

Throughout the work we will collaborate closely with those conducting the two complementary studies of community hospitals submitted under this call, in order to compare and contrast our findings and inform future strategic planning of health and social care services in England.

Research Plan / Methods

The proposed work comprises two principal research work streams: (I) Evidence synthesis of community hospitals; and (II) Learning from international experience.

At the outset it is important to note that the work described below was developed with two complementary studies considered by the NIHR HS&DR Programme under this call for proposals in mind. The three projects were asked to work together and ensure that their projects enhance each other. Therefore, in the following we seek to ensure that the proposed work builds on and feeds into the complementary studies where appropriate and relevant.

I. Evidence synthesis of community hospitals in the UK and other high income countries

We will undertake a scoping review to understand how community hospitals have been conceptualised and defined in the United Kingdom and other high income countries. We will seek to identify the range of organisational models of service delivery that can be broadly subsumed under the heading of a community hospital and what is already known about service provision and their role in the local and wider healthcare economy. Specifically, we seek to explore how community hospitals have been conceptualised; the range of services provided and their activity; their evolution and their role within the wider system of service provision in relation to other providers. We further aim to assess the evidence of effectiveness and efficiency of community hospitals, including measures of patient outcomes such as patient experience, and what is known about their wider role and impact in terms of community engagement. We will build our review on the 2006 review of community hospitals by Heaney and colleagues [1].

We use the definition of a scoping review as one which 'aims to map rapidly the key concepts underpinning a research area and the main sources and types of evidence available' [2]. The basic approach follows that of a systematic review: defining the research question, identifying relevant references, and screening references for eligibility for inclusion [3]. However, our scoping review approach differs from that of a systematic review in three main ways. First, the criteria for exclusion and inclusion will not be based on the quality of the studies or on particular study designs (e.g. randomised controlled trials), but rather on the relevance of the topic. We know from the review by Heaney et al. (2006) that few studies will include (quasi-)experimental design and thus restricting the review by study design would provide limited learning to address our overall aims and objectives of this research [1]. Although the quality of studies will not form an exclusion criterion as such, quality assessment forms a core component of the review and will be undertaken at the stages of data extraction, analysis and reporting. We anticipate that the scoping review will result in a large volume of potentially eligible grey and academic literature. Second, the search strategy is iterative, so whereas a systematic review defines its boundaries precisely at the start of the review, the need for a scoping review to identify all relevant literature means that the approach to searching and analysing literature may have to be adapted during the course of the study. Third, although we will chart data in a similar way to a systematic review, the emphasis on analysis will be on narrative description of major themes and analytical reinterpretation of identified literature rather than quantitative synthesis of the data (e.g. meta-analysis) [4].

In defining the search strategy and review process (see also below), we will be collaborating closely with the project teams of the two complementary studies (led by Professor Jon Glasby and Professor John Young, respectively) in developing and agreeing on the review protocol, in particular defining the search terms, in- and exclusion criteria, and approach to analysis and synthesis. This is to ensure that the scoping review meets the evidence needs to inform the Glasby and Young projects while minimising the risk of duplication. For example, we will seek to take account of the findings of an ongoing systematic review of randomised controlled trials of intermediate care led by Professor Young (see also [5]). We will ensure collaboration through regular face-to-face or telephone meetings and email exchange to update teams on progress and share documents including Endnote files as well as documents and reports identified by other teams that might feed into the review (please see also Section 'Project management').

(i) Search strategy

The scoping review will build on Heaney et al.'s 2006 review of community hospitals [1]. One of the co-applicants, Professor Edwin van Teijlingen, was part of that review and he will thus bring vital experience to informing the scoping review proposed here. At the outset we envisage including Medline, Embase, CINAHL, British Nursing Index, Scopus, HMIC, and the King's Fund Library Database. Again initial search terms will be based on those used by Heaney et al. (2006) (e.g. 'community hospital', 'cottage hospital', 'general practitioner* hospital') but further developed within the context of our scoping review and adapted for the specific databases used. We know from Heaney et al (2006) that these search terms may not necessarily be sufficient to identify service models similar to community hospitals in other countries and will work, with support from an information scientist from RAND Knowledge Services, to identify search terms that will identify relevant literature from other high income countries. From our experience in similar fields of work we expect a sizeable part of the relevant literature to be located outside academic, peer-reviewed journals. We will therefore pay particular attention to the grey literature and we will be seeking to access the King's Fund's library services to assist further in sourcing the relevant literature. As indicated above, our collaboration with the two complementary projects considered under this call for proposals will seek to ensure that any additional literature identified in the course of their work that might inform the scoping review will be shared in a timely manner.
The review by Heaney et al. (2006) considered the academic and grey literature published from 1984 to February 2005. We anticipate focusing our review on the period 2000 onwards, following political devolution in 1999 to the Scottish Parliament and Assemblies in Wales and Northern Ireland and resulting in the creation of four different National Health Services (NHSs) in the four countries of the UK. Opting for a period of overlap between the two reviews will ensure continuity of work reviewed while also bringing in a range of potentially eligible studies published in languages other than English, which were excluded by Heaney et al. (2006) [1]. Arguably, the process of political devolution in the UK is of little relevance to the configuration of service delivery models that are comparable to

community hospitals in other countries. At the same time, countries that may be considered to provide relevant examples have undergone considerable change during the past decade or so, with moves towards more integrated care of key importance to several of the countries we propose for further investigation (and those mentioned in the commissioning brief) (see for example [6, 7]). We therefore believe focusing on the more recent literature will be of most relevance to inform service development in England. We have set budget aside to allow for translation of full papers where abstracts indicate eligibility of studies and where the language in question cannot be covered from within the multilingual research team.

(ii) Study selection, data charting and analysis

The steps of charting the data, collating and summarising and consultation will follow recommendations for good practice in scoping studies [4]. Inclusion and exclusion criteria will be based upon the research questions and our knowledge of the subject area, and, informed by the two complementary projects described above, piloting the use of new search terms. Two members of the research team will independently review titles and abstracts initially, meeting to discuss areas of uncertainty and refine inclusion criteria if required. Following this, two reviewers will then independently review the full articles for inclusion. Areas of disagreement between the reviewers will be discussed and resolved within the research team, and, where appropriate, in consultation with the two complementary projects.

A data charting form will be developed, to meet data needs for each of the review questions, and further refined as required. This will include extraction of specific information about the type and focus of study as well as important results, informed by our research aims. Two members of the research team will independently extract data for the first 5-10 papers to ensure consistency in understanding. Reviewers will extract data for all the remaining papers separately, with consultation about any queries arising; as above, this may include discussion across the three project teams.

Analysis of the extracted data will be based on thematic analysis, where the researchers will refine recurring themes and draw out information in relation to these. In addition we will develop a summary table to present areas of strength and gaps in the evidence in order to highlight where further research is needed. Consultation has been suggested as an optional stage in scoping reviews as an opportunity for stakeholder involvement, to identify any missed literature and to gain insights beyond the literature. We have scheduled the timing of this phase to coincide with the first National Steering Group (NSG) meeting (see Annex), to gauge feedback from stakeholders, including patient representatives, and the complementary projects. We will use this group as a form of validation for our analysis and interpretation and also to consider the implications of the review.

II. Learning from international experience

Work stream II comprises two tasks: (i) reviews of five countries, and (ii) case studies of models of community hospitals in selected countries.

(i) International experiences: an overview of five countries

Informed by the scoping review, we will develop a working definition of ‘community hospital’ which will guide the selection of five countries for a more detailed exploration of the nature, scope and distribution of service delivery models that can be considered comparable to community hospitals in England. This component draws on our expertise built within an ongoing project that provides comparative information and intelligence on healthcare policies in a range of European and other high income countries for the Department of Health in England. Specifically, we will develop country reviews using two principal instruments for data collection: (i) a structured data collection template, reviewed and validated by an expert in each country as identified from our established International Healthcare Comparisons network (http://www.international-comparisons.org.uk), and (ii) key informant interviews. The structured data collection template will provisionally seek to systematically compile information on the basic features of the system context within which healthcare is governed, financed, organised and delivered more broadly, and the types of models of community hospital in particular. It will also seek to set out the specific situational, structural, environmental and cultural factors that are thought to influence healthcare decision making in the countries under review so as to enable

assessment of the potential transferability of identified models to the English context.

The initial data will principally be collected by means of a review of the published and grey literature, complemented by interviews with key informants. Interviews will be particularly important for describing issues that are poorly documented or require a level of expertise and insight that is not easily accessible through information extracted from the published or grey literature. They help advancing our understanding of the more salient issues pertaining to the health policy process and identifying and categorising the often 'messy' elements of policy development. Expert judgement assessed through key informant interviews can be used to delineate the 'knowns' and 'unknowns' about the future of policy on a particular key health issue, and can help examine those issues and factors that may be difficult to measure or quantify.

For the present study, we propose eight key informant interviews per country under review, representing the different stakeholders at the system level involved in the governance and funding of healthcare services, with particular focus in service delivery models that are comparable to community hospitals in England. At the outset we propose considering representatives from provider and professional associations, regulators, funders and patient associations, although the final selection will be determined by the specific system context. We have previously used this approach to for example assess approaches to healthcare planning in different countries [8], to understand the role of ministries of health in decision making on healthcare coverage in four European countries [9] or to examine facilitators and barriers to the evaluation of chronic care approaches in six EU Member States [10]. Based on our previous work in a related area [11], a preliminary review of the published evidence, and our detailed understanding of health systems in high income countries more broadly, we propose sampling from a wider range of countries including Finland, Italy, Norway, Scotland, and, potentially, Australia, Canada or Germany. We propose these countries because of their diversity in healthcare organisation and financing, with the majority using tax-based funding mechanisms (Finland, Italy, Norway, Scotland, Australia and Canada) while drawing on different combinations of local and national taxes and, more importantly, diversity in the governance of health and social care at local and national levels. The Nordic countries may be of particular interest to England with regard to the multilevel public governance of the health and social care systems, with recent reform efforts seeking to better link the purchasing function for health and social care in an attempt to enhance service coordination [6]. Germany, while based on a different financing model with the majority of healthcare funded through statutory health insurance, has begun experimenting with new models of care that seek to move services into the community while enhancing integration of care overall, with potentially important lessons for models elsewhere [12]. However, we propose the countries listed here as potential options only; the final selection of countries to be included in the country review will be determined by the scoping review described in task (i) above, and in consultation with our National Steering Group.

(ii) Case studies of models of community hospitals in selected countries

We will undertake detailed case studies of community hospital models in a small subset of the countries under review to provide a more in-depth perspective of the specific financial, organisational and governance features of a given model, the specific service delivery model, its origins and likely future development; staffing and staff roles; the role of the community hospital in the local system of service delivery economy and the nature of the relationships with other providers and the community more widely; the vision on the future role of the community hospital in service delivery; and alongside the challenges to and likely changes of provision of services in the light of socio-demographic and economic pressures. We will aim to select examples that appear innovative, and we will draw on the findings of detailed country reviews and the National Steering Group to the three complementary projects to advise on the selection. While we do not wish to pre-empt the findings of the country reviews, at the outset, we propose including Scotland as one of the countries and propose undertaking two in-depth case studies here. This is in reflection of the established and rich tradition of community hospitals in Scotland, and the 2012 'Community hospitals strategy refresh' [18]. This strategy envisages community hospitals to have a key role in the delivery of more integrated health and social care in Scotland, which is core to the Scottish Government's vision for the future provision of health services in Scotland [13].

We also consider undertaking one case study in Italy. This is in recognition of recent (2012) reforms

which involve a reorganisation of hospital care and envisage community hospitals to play an important role in the delivery of more integrated services as the local level [14]. The fourth case study is likely to be set in Norway or Finland, drawing on the available published evidence (e.g.[15,16]) although we would seek to draw on the country reviews under (i) to inform the final selection.

Case studies will follow a structured approach, involving the following steps [17]: (a) a local stakeholder mapping to understand the role and activity of the community hospital in the local system of service delivery; (b) a review of available documents and online resources describing organisation, mission, status, activities, and degree of multi-agency working (for example annual reports, strategic documents); (c) profiling the population served using available local data to develop a detailed assessment of the population served and to understand the community hospital in relation to other health and social care services; (d) interviews with a range 8 to 10 stakeholders per case study; and (e) non-participant observation of the community hospital setting.

We will consult with the research team lead by Professor Jon Glasby during the development of the case study to ensure learning across projects and to maximise the potential for cross-country lesson drawing, for example, if common elements can be used in the case studies in both projects. The interviews will seek to understand how stakeholders view the contribution of the community hospital, presently and in the future, to local service delivery; gain an understanding of different models of working, including interagency working; and identify perceived barriers and facilitators to the community hospital in delivering the model of care to understand long-term sustainability. Interviewees will be drawn from the stakeholder mapping and will differ accordingly in each case study but we anticipate that these will include representatives of community hospitals (senior management and front-line staff), funders, other local providers, and patient group representatives.. From our experience, non-participant observation can be a powerful means to gain an understanding of organisational functioning in healthcare settings [18]. We will not carry out observations of direct patient care; rather we will spend time in the selected community hospital settings to understand aspects of interest such as multi-agency working, community engagement and the role of the hospital in the local health economy.

We have budgeted to complete two case studies in Scotland where the core research team will undertake all of the research. For case studies in the countries other than Scotland, we will work with research teams in the country under consideration to undertake the fieldwork. We have considerable experience of working with collaborators in different countries to a common research protocol [19] and will visit case study sites at the beginning of data collection.

Synthesis

We will synthesise the findings from the two strands of work, (I) Scoping review and (II) Learning from international experience. This will include cross case analysis of the in-depth case studies to identify regularities, while acknowledging the diversity of cases. Overall, the synthesis stage seeks to:

a. Comment on the role and contribution of community hospitals in different health system contexts in the UK and internationally
b. Discuss the diversity of the community hospital model in the light of contextual and system factors both internally (governance models, service provision) and externally (populations served, local health economy, wider cultural factors) and identify lessons learned for the further advancement of different models to inform commissioning in the English NHS
c. Identify the needs for future research in this area
d. Summarise the findings in a way that will be readily accessible to policy-makers and managers.

The commissioning brief acknowledges that much of the current evidence on community hospitals is largely descriptive and dated. One of the aims of the synthesis will be to identify specific needs for research in the area as well as to draw cross country learning on models of community hospitals that may be best served to meet the health and social care needs of the populations which they serve.

Dissemination and projected outputs

The proposed research aims to lead to a better understanding of the contribution of community

hospitals to the health system in England. The work will provide a comprehensive review of the existing evidence base on community hospitals and equivalent service delivery models nationally and internationally, examining a range of organisational characteristics, evidence of effectiveness and efficiency and an understanding of the wider role and impact of community engagement in community hospital service provision and development. It will also provide evidence from comparable models in other high income countries to understand the potential for community hospitals to perform integrative roles in the delivery of health and social care. This research will thus provide important new information for national and local policy makers and commissioners, setting out the current and future options for community care provision. Contextual information will allow local commissioners to assess which models of provision might be applicable to their own context. More effective provision of community care will benefit patients, allowing a more streamlined service, and care more suited to their needs.

The proposed research aims to produce change and improve the quality of healthcare services provided by the NHS. It will include passive dissemination of research findings through publication in peer-reviewed journals as well as active dissemination, or policy engagement, to ensure that the project's outputs reach its intended stakeholders, namely all those who have an interest in and a likelihood of taking forward findings that emerge from this project. These include policy makers at local and national level, local service managers, NHS providers, researchers, and patient groups and other stakeholder groups who are seen to influence health services research and decision-making in England.

Written outputs will include articles in peer reviewed journals, together with a final report as specified by the Health Services and Delivery Research (HS&DR) Programme. In addition, we anticipate producing a summary of the main findings and recommendations in the form of short research briefs, which will be targeted at busy policy-makers, healthcare commissioners and providers at a local level. The PPI members (see below) will inform the dissemination strategy and research outputs. We anticipate that they will help to identify the findings that are most relevant for the public, identify dissemination routes that the research team may not have considered and also contribute to the published outputs from the research. The contribution of PPI members will be fully and appropriately acknowledged in all our publications.

Active dissemination will also include presentation of the findings of the research at national and international conferences and workshops in which members of the research team routinely participate, including the annual symposium of the UK Health Services Research Network. We would seek to present the findings at the Community Hospitals Association Annual Conference, and are planning, in collaboration with the two complementary projects under this call, to hold a national conference following the completion of the work led by Professor John Glasby (conference provisionally scheduled for April 2017).

Approval by ethics committees

Below we assess the requirements for ethical approval for each component of the study:

(i) Comprehensive scoping review. Based on published literature, does not require review by an ethics committee.

(ii) International experiences: an overview of five countries. This component is based on country review which does not include patients or patient level data or healthcare providers. It will include interviews with key informants at national level. We will seek to secure ethics review for these interviews from the relevant national bodies in each country considered for review.

iii) Case studies of models of community hospitals in selected countries. Case studies will include interviews with stakeholders, primarily healthcare providers and representatives of local funding agencies. We will also interview representatives of patient groups, to assess indirectly the views of patients and undertake non-participant observation, but not direct patient care. We consider that the case studies will require review and approval from an ethics committee and we will seek this from relevant review committees in each country setting. We will also undertake to receive R&D approval or equivalent as required. In our project planning we have set time aside to develop the ethics

application while the scoping review is being undertaken. We will seek ethical approval as appropriate and required for each of the countries considered for in-depth review.
We will conduct all of our research in line with good ethical practice whether or not ethical approval is required. We will use the Social Research Association ethical guidelines to guide the research and will follow institutional policies on protection of researchers during the case studies. RAND Europe has an institutional research ethics panel which will act in an advisory capacity to the project and beyond formal approval requirements.

Participation in the study will be voluntary. Consent (verbal/written) will be sought before interviews. Consent may not be gained from each individual observed during the non-participant observation but staff at the community hospital will be well informed about the study and information will also be publicly displayed. The observations will be focused on the general activities and organisational features of the community hospitals rather than particular people or interactions between people. All data will be kept securely in password protected files and confidentiality maintained. Any reporting will be anonymous. RAND Europe complies with the Data Protection Act (1998), which is the main piece of legislation covering the management of personal and sensitive personal data in England and Wales. All employees are asked to sign that they have read and understood these policies when commencing employment. The Act lays out 8 principles of good data protection related to personal and sensitive data, which RAND Europe abides.

Patient and Public Involvement

Patients and members of the public will not be involved as participants in this research other than in the capacity of patient representatives in the case studies. However, the role and scope of community hospitals is highly relevant for patients and members of the public in the areas that they serve. Our aim of PPI involvement is to ensure the relevance of the research throughout, improve interpretation of results and develop and appropriate and effective dissemination stratey. In preparation for this proposal, we shared our research plan with a PPI panel, INsPIRE. Panel members were asked to comment on:

- Is the lay/plain English summary understandable (if no, please could you offer suggestions
- from a lay perspective)?
- Is the extent and quality of service user and carer involvement in the research satisfactory
- and could people be involved in any other way?
- Are the proposed research questions important and relevant to service users?
- Is the proposed research is likely to be beneficial to service users?
- Do you have any other comments on the research plan, research questions or methods
- suggested?
- Is our plan for PPI involvement throughout the study appropriate?

PPI respondents commented that the proposed research is of value and made suggestions for improvement. The word ‘taxonomy’ was thought to be overly technical and we have removed it from the lay summary. PPI members also suggested that it may be useful to present the models of community hospital we identify in diagrammatic or schematic form and include the perspective of a patient’s journey. We will seek to use schematic representation as appropriate and with further PPI consultation.

We will recruit two members through INsPIRE, the Cambridge and Bedfordshire PPI panel. We anticipate that the PPI members will contribute throughout the project, specifically in relation to: (1) the relevance of the research to the public and services users at all stages; (2) the design of research and communication materials; (3) interpretation of results at key points; (4)the validity of conclusions from a public perspective; (4) the project dissemination strategy. PPI members will also be invited to join the National Steering Group (NSG). In addition to their role as members of the NSG, we have planned for regular review and consultation with PPI members throughout the duration of the project at four points: the scoping review, case studies, synthesis and dissemination. We have budgeted for 3 days in total for both members on this project and a further 3 days to enable preparation and attendance NSG meetings. We believe that our planned model of involvement will mean that PPI members are able to support each other, both on this project and across projects. PPI members from INsPIRE are experienced in their involvement in research and we do not anticipate providing training beyond introduction to our specific study. However, if training is required, RAND Europe provides an extensive professional development programme that the PPI member can access.

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