Community Hospitals Association

REPORT

Community Hospitals: Embedding COVID-19 positive impact changes through shared learning

September 2022

Q is led by the Health Foundation and supported by partners across the UK and Ireland

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FOREWORD

by Heather Penwarden, Chair of the Advisory Group

In 1986 as a young staff nurse I first stepped into Honiton Community Hospital. To be honest I could not believe the luck of landing pretty much my first position post-qualifying, right there in the community to which I belonged. Even back then there was something in me that recognised the importance of good quality, person-centred, safe, appropriate and truly integrated care been available so close to where people live, and I was incredibly proud to become a part of it all.

This hospital, like so many others around the UK is not just a building that sits in the heart of our community: it is so much more than that, a hospital without walls if you like. Yes, a place where people come for their various health and care needs and in Honiton also a base for the community teams, GP practice, mental health team and GP out of hours' service. I see it also as a space where individual members of my community can bump into and connect with each other – so very important in helping us to feel that we belong somewhere and have a place in the whole scheme of life around us, especially when we may be feeling vulnerable and not totally on top of our game with our physical or emotional wellbeing.

Whilst I have said that this site has a physical presence in the centre of the community, it also holds a very special place right in the hearts of the people it serves and you would be pushed to find anyone in our rural population of around 12,000 who does not know where it is, has used it themselves or know someone that has. Anyone who has had a connection with a Community Hospital will know exactly what I mean.

Often people living in the reaches of a Community Hospital will very much see it as "their hospital". Hospital Leagues of Friends provide the charitable support and in some cases generations of people volunteering their time to run fundraising events, carry out vital volunteer roles within the hospital and the grounds, and generally be fabulous ambassadors for all the staff and services that make up their particular Community Hospital.

When thrown into a pandemic it was amazing to see how all the various volunteer and community groups in the town came together along with our Hospital and team managers, our Social Care teams and GP Practice to form the Honiton Community Coronavirus Support Network.

From my connections with the Community Hospitals Association I am aware how all Community Hospitals across the UK are equally precious to those who work in them and are served by them. Each has its own unique footprint of care offered and many hold an innate capacity to respond swiftly to changing circumstances, to work across disciplines and often as equal stakeholders with the communities they sit in.

The Community Hospitals Association has a long-standing record of not only supporting staff and advocating nationally for the excellence of care provided from these hospitals but also in supporting quality research that has begun to build up a credible and respected body of evidence to support what many of us already know from lived experience: that our Community Hospitals and all they represent are some of the most incredible assets we have in our NHS and Social Care portfolio.

I was delighted when I heard the CHA had set up a small Project Team to lead a study aiming to capture the experiences of staff working in UK Community Hospitals during the pandemic with a focus on embedding COVID-19 positive impact changes through shared learning. Who would have doubted that this

Incredibly dedicated group of people would not let such an opportunity pass to produce the study detailed in this report? It will blow you away I promise. The number of interviews carried out, the extraordinary amount of quality data collated, the calibre of highly experienced and national experts in their field who have contributed and of course the candour and innovation demonstrated by all the staff interviewed and featuring in the case studies.

It was with great humility and a healthy dose of trepidation that I accepted the invitation to chair an Advisory Group made up of national academic and community experts with the aim of providing a higher level of guidance to this study. A group of strangers initially and from such a wide spectrum of experiences, it was heartening to see how we all came together generously sharing skills, experience, wisdom and time, to play our small part in this seminal piece of work. Many of the group [names will appear later] have so very kindly offered to stay on as expert professional advisors to be called upon by CHA as and when needed.

Just to give a flavour of this group I have included a couple of quotes from members;

> ***It has been a great privilege to support the Advisory Group for this project. A huge thanks to the CHA for sharing so many inspiring examples of the dedication and innovation of staff during the pandemic. The case studies tell a wonderful story of how Community Hospitals improve lives for people and community.***
>
> PROFESSOR ANNE HENDRY SENIOR ASSOCIATE, INTERNATIONAL FOUNDATION FOR INTEGRATED CARE (IFIC); DIRECTOR, IFIC SCOTLAND; HONORARY SECRETARY, BRITISH GERIATRICS SOCIETY

> ***All over the United Kingdom, the Covid-19 pandemic tested the flexibility of community hospitals and they responded admirably. Many community hospitals took on additional or new roles at very short notice. Operating models were transformed with a focus on delivering superior patient care and securing staff and patient wellbeing. The examples explored in this study, and the benefits that they delivered, are all sustainable in the post Covid-19 pandemic world.***
>
> TOM BROOKS, CHA COMMITTEE AND LEAD FOR WALES

All the staff who contributed to this study did so with great courage, often in hugely challenging working conditions, they are an absolute credit to the professions and roles they represent. I also sense a great pride in what they have managed to achieve and with this a generous desire to share through their case studies some of the incredible and unique experiences to have come out of and indeed are still coming from our Community Hospitals as a result of this Covid-19 pandemic.

Whoever you are and whatever your connection if any to Community Hospitals, read this study, along with the excellent "Diary of a Project" by Evelyn Prodger the Project Lead, with an open and curious mind: I think you will, like me, then come to appreciate all that is good and strong about our local hospitals, the incredible resilience of the human beings that work within them and what wonderfulness can be achieved by individuals and communities in times of great adversity.

HEATHER PENWARDEN BEM, RMN, Dip CBT [retired]

- Community Hospitals Association Q Study Advisory Group – Chair
- Honiton Hospital & Community League of Friends – Chair 2012 to 2022
- Dementia Friendly Honiton QAVS – Chair
- Public Governor – Royal Devon University Healthcare NHS Foundation Trust

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EXECUTIVE SUMMARY

Overview

This project captures the experiences of staff working in UK community hospitals during the COVID-19 pandemic, with a focus on positive impact changes.

Through this project, staff working in UK Community hospitals have shared with us, through online interviews, many inspirational examples of how they provided vital, flexible, responsive and resilient services during the pandemic. They describe a strengthening of relationships within and across organisations in the health and care system, and have described examples of more integrated care. Staff themselves saw many benefits including having the freedom to be creative in their responses, being able to make decisions locally, and patients benefiting from compassionate care.

The CHA has used examples of quality improvements drawn from the project in order to develop case studies to share widely across the UK community hospital and beyond.

Introduction

Community hospitals are an important part of local health and care systems, yet there has been very little shared on their role and contribution during the pandemic. This project seeks to redress this, and highlight the role of these local hospitals.

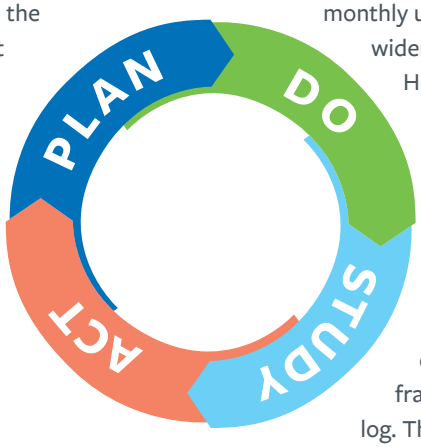
The Community Hospitals Association (CHA) is a membership organisation for staff, patients and community groups concerned with community hospitals across the UK. We were prompted to carry out this project when members from our network made contact during the first year of the pandemic. Staff wanted to share their experiences with us and also seek advice and support.

We designed a two-year project to enable staff to reflect on their experiences and innovations in their community hospitals during the pandemic in a systematic way that facilitated wider sharing and learning. We shared this as an idea on the Health Foundation Q Exchange website. Following many comments, suggestions and support from Q members, we developed it further. Following a competitive process, the CHA was successful in being awarded funding from Q Exchange.

Project Design

We established a Project Team of five committee members all of whom have experience of community hospitals. The team reported monthly to the CHA committee who became the Project Board. We approached national experts in the field who were widely published and had considerable experience, and asked them to form an Advisory Group. The Advisory Group was chaired by a Community Leader who helped give a voice to communities and patients. The CHA nominated the then Chair of the CHA, Chris Humphris, to be the Project Sponsor, who was succeeded in May 2022 by Dr Kirsty Protherough, a Director of the CHA.

The Project Team was supported by staff in a social consultancy who assisted with interviews and data capture.



The Project team reported regularly to the funder, the Health Foundation Q Exchange and shared monthly updates and regular reports with the wider Q community on the Community Hospitals Special Interest Group website page. The project governance combined project management with the Institute for Healthcare Improvement (IHI) quality improvement model. This included developing a Project Initiation Document, Gantt Chart, a theory of change to develop an evaluation framework, and a risk log and learning log. This helped us to review, adapt, modify and learn in line with the PDSA (Plan, Do, Study, Act) cycle. We designed a template for project reporting so that progress against milestones was readily identifiable and consistent.

Method

In order to focus on positive examples of improvement and recognise good practice, we carried out the interviews using an Appreciative Inquiry (AI) approach, which is a strengths-based approach to interviewing which is designed to help focus on positive impacts, innovations and improvements. We selected the sample based on our knowledge and stratified the sample using a number of characteristics such as size and location. We approached 44 organisations, and 20 agreed to participate. These 20 organisations manage 168 (33%) of the 500 community hospitals in all 4 nations of the UK. 85 staff from a range of disciplines volunteered to take part in interviews. Over 30 interviews were held, either individual or in small groups. The project team agreed 3 themes based on our knowledge, communication with members, and an early pilot of the interview process. We used these to frame the semi-structured interviews with staff. The themes were: Practice, People and Planning. The online interviews were recorded, and our field notes from the interviews were shared with staff for validating. The project team agreed quality improvements and initiatives that could be developed as case studies with staff. Staff provided additional information and also photos and diagrams where appropriate.

Findings

The project team and staff developed 31 case studies. 11 case studies are written in detail. 20 case studies are presented in a one-page summary. All case studies illustrate a wide range of quality improvements and provide an accessible way of sharing good practice.

Of the 11 full case studies, examples include quality improvements such as providing enhanced care, designing new models of care, and developing new clinical arrangements. Staff describe communication initiatives in many of the case studies. One of the case studies described how the service extended to be a 7-day service, showing how health care could be transformed for the benefit of patients and staff. We heard about the concerns for staff health and wellbeing during this traumatic time. A staff survey, called Corona Voice, was launched by a Trust and achieved an impressive level of engagement, with active listening and rapid and appropriate responses. We were moved by the way that staff offered compassionate visiting showing the efforts made to create safe spaces for visiting patients at the end of life when COVID-19 restrictions suspended visiting. We were impressed by the many examples of local decision-making, with one case study showing how staff made early interventions to keep a community safe.

The 20 short case studies are one-page summaries and provide small but significant quality improvements to the experiences of patients and staff. We have chosen case studies that include different ways that the community provided support, initiatives to care for isolating patients, and thoughtful measures to help staff during the emotional challenges of the pandemic.

Feedback on the case studies to the project team from a member of staff summed it up:

> ***The case studies are such a celebration of the work of the teams and as a whole they are a wonderful reminder of the importance of community hospitals and the role they played at this epic moment in time, during the pandemic. The case studies tell a wonderful story of how Community Hospitals improve lives for people and community.***

We also revisited CHA award winners from 2020, and expanded and updated these for 2022 with staff. These award-winning examples provided the driving force for this study.

Key Features

We carried out an analysis of the data, from the recordings, field notes and the developed case studies. Our thematic analysis of cross-cutting themes led us to conclude that there were six features of community hospitals that we wanted to draw attention to. We believe that the data shows us that community hospitals are resilient, flexible, responsive, creative, compassionate and integrated.

- RESILIENT
- FLEXIBLE
- RESPONSIVE
- CREATIVE
- COMPASSIONATE
- INTEGRATED

The resilience and flexibility of community hospitals was shown through their continued operation at such a challenging time. Locally devolved decision-making created the space for responsiveness and creativity. Staff described the compassion and care shown to patients through thoughtful initiatives. Existing relationships were strengthened during this time, leading to more integrated working. We would like community hospitals to be recognised for these positive attributes, and their overall contribution to patients, staff, the community and the whole health and care system during the pandemic.

Learning

The project has shown the variety of roles that community hospitals played during the pandemic, illustrating the speed and flexibility of adapting to rapidly changing needs. Staff reported that the role and contribution of community hospitals is now more fully understood and appreciated within their local health and care system, and that relationships have been strengthened with more open data sharing and intensive collaborative working.

The project itself provided vital learning about the critical importance of robust governance and a clear project management system. We also learnt to recognise when the project needed to change and evolve, within a clear structure. We benefited considerably from the many people involved in managing the project, including Q Exchange, Q Community Hospitals Special Interest Group members, the Project Board and the Project Advisory Group.

The project enabled staff to talk about their innovations, quality improvements and positive changes during COVID-19. There is scope to carry out further research on the specific quality improvements described, to further enhance the learning. There is also scope to involve patients and families in future studies.

Recommendations

We have considered the conditions that helped create the opportunities for staff to make quality improvements during COVID-19. We have talked to staff about innovative practice and the changes they have made to improve the service for all concerned. We have discussed how such improvements may be shared and sustained.

IN ORDER TO HELP STAFF LEARN FROM THESE INITIATIVES WE HAVE IDENTIFIED **4 KEY RECOMMENDATIONS:**

IN ORDER TO MAKE THE MOST OF OUR COMMUNITY HOSPITALS WE NEED TO BE:

1 Making Decisions Locally

- Making decisions locally through local autonomy
- Playing a full part in the local health and care system

2 Benefiting from Excellent Leadership

- Being led by bold and compassionate leaders
- Being truly person-centred in all that we do

3 Recognising Community Hospitals as a Community Asset

- Providing care, treatment and support
- Supporting the wider community as a community asset
- Investing in community hospitals
- Making the most of digital options

4 Looking After Our Staff

- Attending to staff health and wellbeing
- Providing staff with opportunities for development and growth

Conclusion

Those working in community hospitals have shared their stories openly in moving accounts that describe how they delivered care and support to patients and families in the context of the fear and anxiety of the pandemic. Where appropriate these positive changes are being sustained and further developed as the learning has informed on-going quality improvement. We hope that this project illuminates the contribution that community hospitals continue to make to the health and wellbeing of their local communities.

> ***Community hospitals are brimming with expertise often untapped! The pandemic demonstrated the true place for them as a major team player in community care provision. Let's be brave in the development of these wonderful places. Lets get it absolutely right for our communities.***
>
> NURSE CONSULTANT

Acknowledgements

- Thank you to the Health Foundation, Quality Exchange for funding, encouragement and support (Funding No. AIMS ID 2447454)
- Thank you to the staff who gave their time and shared their thoughts.
- Thank you to the organisations that agreed to participate, and support their staff in sharing their experiences with us.
- Thank you to Jennie Prodger for undertaking a literature review
- Thank you to Just Ideas, a social consultancy for their assistance
- Thank you to everyone who volunteered their time from the Community Hospitals committee and network.
- Ethics approval was not required for this project. This requirement was tested using the Health Research Authority (HRA) tool.

1

INTRODUCTION

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INTRODUCTION

This report describes the project undertaken by the Community Hospitals Association (CHA) to capture the role and contribution of community hospitals during COVID-19. The focus of the inquiry has been to identify innovations and quality improvements that were prompted by, or accelerated by, the pandemic. The CHA is a membership association concerned with promoting community hospitals and supporting their staff, patients, communities, volunteers and community groups.

Chapters

The CHA recognised that there was a lack of awareness and understanding of the role that Community Hospitals play in the UK health and care systems, and this included their response to COVID-19. This was illustrated by the lack of media attention on community hospitals, and the lack of reviews and research in this area. This project was the CHA response to address this. Our introduction sets the context for this study. **(Chapter 1: Introduction)**

The team designed the project in a way that would enable staff working in community hospitals to share their experiences and provide an insight into the service they offered during the pandemic. We describe our methodology, and in particular our decision to adopt an Appreciative Inquiry (AI) approach, which enabled us to focus on strengths and good practice. **(Chapter 2: Method)**

We have analysed data from the recorded interviews and field notes grouped in three predetermined themes of Practice, People and Planning. We developed 31 case studies with staff, 11 of which are full case studies and 20 are short case studies. The case studies were created to facilitate learning and sharing. The case studies are grouped in these three themes, and analysed. **(Chapter 3: Practice, People, Planning)**

The experiences of staff highlighted the strengths and key features of community hospitals. The team analysed and interpreted the data, and considered what could be learnt about community hospitals from these staff experiences. The team considered the attributes of community hospitals, and concluded that there were six key features that this project had brought out in the findings. These were that community hospitals were resilient, flexible, responsive, compassionate, creative and integrated. **(Chapter 4: Key Features of Community Hospitals)**

In order to make the most of community hospitals, certain conditions need to be met. We have made some recommendations based on the learning from those working in community hospitals. The case studies led us to the recommendations that in order to make the most of our community hospitals we need to be making decisions locally, benefiting from excellent leadership, recognising community hospitals as a community asset, and looking after our staff. **(Chapter 5: Recommendations)**

We reflect on this ambitious project that involved interviews with 85 people within 20 organisations. We have designed a dissemination programme, so will optimise the impact of this project through sharing outputs on our website and social media, speaking at conferences and publishing papers. We discuss our Special Interest Group discussion forums which give staff a chance to talk about the initiatives featured in this report and consider their wider applicability and impact. **(Chapter 6: Conclusions)**

Appendices

Our project governance structure is described in Appendix A. The project was undertaken by a project team of five CHA committee members, supported by researchers in a social consultancy. The team reported to a Project Board, had a Project Sponsor and were guided by an Advisory Group. **(Appendix A – Project Team, Project Board and Advisory Group)**

We provide names and website addresses of the 20 organisations providing community hospital services in the UK who agreed to take part in the study **(Appendix B – Participating Organisations)**

We have listed the 11 case studies and the 20 short case studies, categorised by theme. These 31 examples of innovations and good practice were designed to facilitate learning and sharing. **(Appendix C – Case Studies)**

We reflect on our approach using Institute of Healthcare Improvement (IHI) quality improvement methodology. With the support of our Q Exchange Connector, we developed a theory of change model, stakeholder mapping, and a detailed evaluation plan with metrics. **(Appendix D – Reflections on our Quality Improvement Approach)**

The project team reflected on the strengths and limitations of the project, and the scope for further research. **(Appendix E – Scope Limitations and Further Research)**

Our Dissemination Plan content is summarised, with our aims and objectives set out. **(Appendix F – Dissemination Plan)**

During the project, the Project Lead wrote a monthly diary, to chart progress, share thoughts and emotions, and reflect on each stage of the project, which was shared in the Q Community Hospitals Project page. This is summarised in this report, and is available in full. This has proved to be an invaluable insight into the way that the project developed, and the learning that was shared between the project team and staff involved. **(Appendix G – Diary of a Project Highlights)**

We have included a summary of the award winners from the CHA Annual Innovations and Best Practice Award for 2020. The awards were concerned with COVID-19, and we have updated these submissions with staff for this report. These award winning quality improvements for 2020 provided the inspiration and driving force for this project. **(Appendix H – CHA COVID-19 Award Winners 2020 Updated for 2022)**

We have created a publications list, which details the outputs from this project so far. The team have written about the project for a variety of audiences as part of the dissemination programme. This has included presentations for international conferences, articles for journals and online workshops. **(Appendix I – Project Publications)**

We have created a list of terms used throughout the report, and provided descriptions and definitions of the terms to aid understanding. **(Appendix J – Glossary of Terms)**

We were guided by the current literature and what was already known about this topic. The team has researched relevant papers and publications and created a reference list to help inform the project. **(Appendix I – References)**

2 METHOD

2

METHOD

Problem description

There are 500 community hospitals across the UK [1]. The problem that the Community Hospital Association (CHA) had identified was that there was a lack of awareness and understanding of the role that Community Hospitals (CHs) play in the UK health and care systems, and in particular in their response to COVID-19. Members had expressed this view to us, and as an organisation we were aware of the lack of a strategy for community hospitals within local health and care systems.

During 2020 the CHA had been approached by members who wanted to draw attention to what was happening in community hospitals during the pandemic. We also received submissions for our Annual CHA Innovations and Best Practice Award in 2020 that demonstrated the role of community hospitals during COVID-19. The CHA wanted to explore this further by talking to more CH staff on a systematic basis, and help identify the many different ways that community hospitals were contributing. The CHA shared the idea for the project on the Q Exchange website, and had 27 comments, suggestions and words of support. This led to our application for project funding from Q Exchange and we were successful in January 2021.

Available knowledge

Community hospitals are a long-established health-care facility in the UK, as well as internationally. They can be defined as small hospitals that provide a wide range of locality-based outpatient and inpatient services such as health promotion, rehabilitation, day hospital and diagnostic services [5]. Specific service configurations differ between community hospitals because of local history, proximity to a larger general acute hospital and perceived need [6].

The CHA has been involved in recent research into the value of CHs [2], the efficiency [3] and international comparisons [4] and these three studies have contributed to the knowledge and evidence base on CHs. However there have not been any studies on CHs and their contribution during COVID-19. We undertook a rapid review of the literature, assessing peer reviewed papers and grey literature and confirmed that there was nothing that was specific to community hospitals and COVID-19.

Our literature review did show that a number of healthcare organisations had published information about the impact and innovation of COVID-19 on service provision and staff. Published examples include a study carried out by NHS Wales [15], as well as those identifying positive changes [12], assessing impact on the nursing workforce [13], and commenting on quality and safety at speed [14]. A study by the Health Foundation was particularly helpful in understanding and sustaining health care shifts during COVID-19 [16]. The CHA was concerned to build on the emerging knowledge and carry out a study that was specific to community hospitals.

The CHA which has been in existence for over 50 years, plays an important role in advocating and championing CHs, providing mechanisms to share best practice through conferences, awards, website and links to other networks such as the Academy of NHS FABstuff and NHS Benchmarking Network. We are committed to sharing good practice across the system and between CHs and for this project specifically in relation to their contribution during the pandemic.

Rationale

At the outset, we were committed to using quality improvement methodology to inform the learning from the project delivery [10]. Some of the project group had previous experience of this methodology, and some also accessed training sessions.

We wanted to follow the principle of co-producing improvement case studies through listening and learning from the staff from the community hospitals about their experiences. This was thought to be essential and was seen as a partnership improvement [18]. We adopted an appreciative inquiry method [8] for conducting interviews in a way that fostered positive relationships and built on the present potential of the staff and their hospital. This method builds on strengths, and encourages the interviewee to focus on achievements and improvements.

Setting up the project

A project group of CHA Committee members were set up at the commencement of the project. We were aware at the outset that this could be a significant piece of work, with the potential for high impact and it would be conducted in the context of the on-going pandemic and therefore connecting with community hospitals would need to be virtual. The Q Exchange Funding enabled us to commission a social consultancy to assist with interviews, field notes and case studies. At the initiation of the project it was clear that applying improvement methodology techniques would be critical to capturing the project learning and understanding how the project may be an emergent rather than a prescriptive process. We applied the Institute of Healthcare Improvement (IHI) model for quality improvement, and were pleased to be supported and advised on this by Q and in particular from our Generation Q Fellow professional advisor. We designed the study stages and report format by applying the SQUIRE Standards for Quality Improvement Reporting Excellence, again supported by Q. (*Appendix D*)

Interventions

The planned interventions were outlined in a Project Initiation Document and a supporting Gantt Chart for 2021/2022. We did not require ethical approval, which was confirmed when we applied the Health Research Authority (HRA) Decision Tool. Papers and reports for the project are on our website.

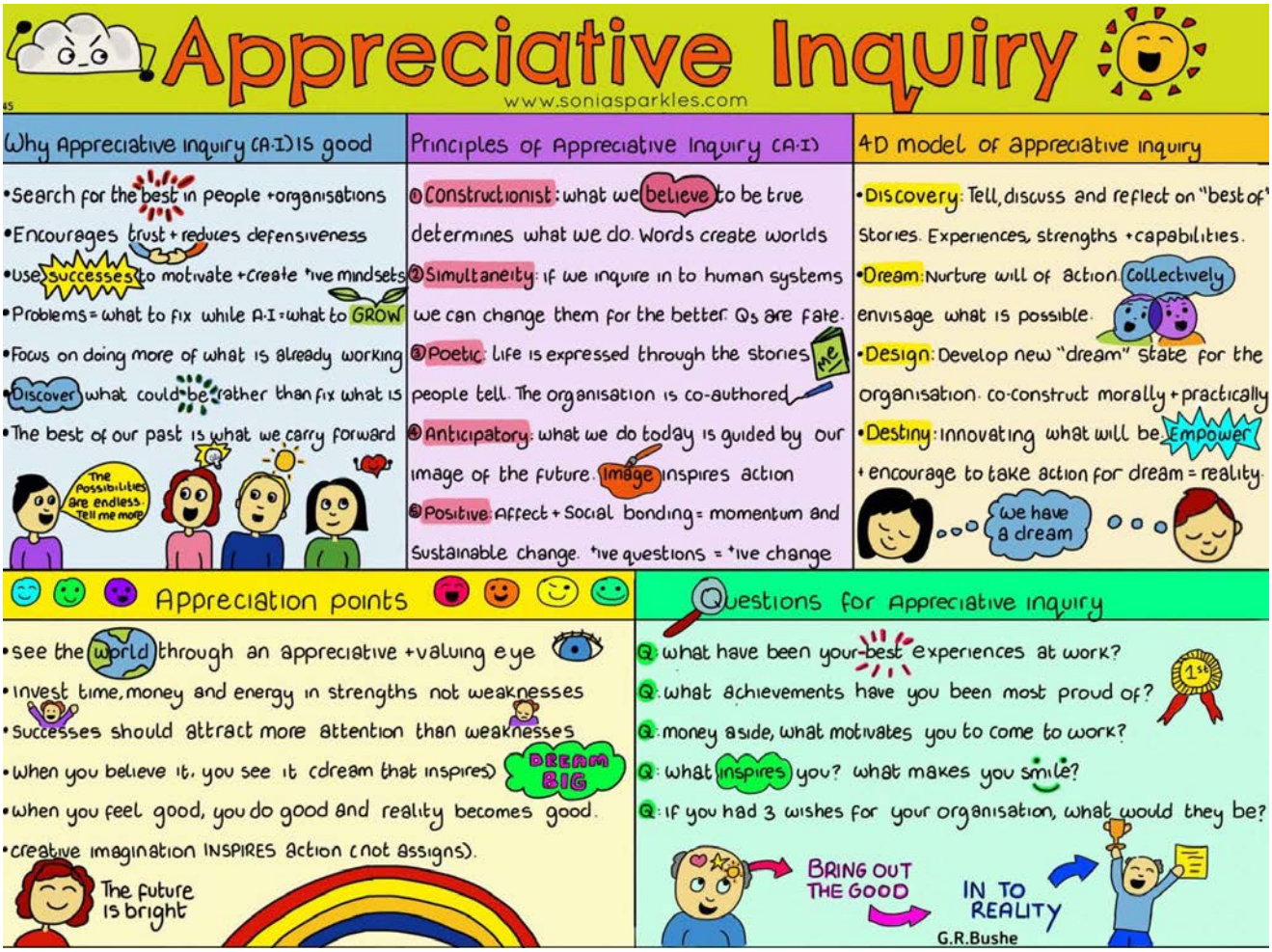
a) We set up a Project structure that had clear governance for the project group to undertake the work with reporting and budgetary expenditure to the CHA Directors and Committee acting as the Q Project Board. We reported to our funders, the Q Exchange who also offered help and support such as Action Learning Sets and training opportunities. We invited a group of national experts to form a Project Advisory Group, which was chaired by a Community Leader. (*Appendix A*)

b) Project design. We designed the project based on interviews with staff so that we would capture experiences and innovations. We piloted our semi-structured questionnaire framed around the 3 themes of practice, people and planning. We used this as a guide with two Trusts. Following feedback, we adjusted the questionnaire and added some free text sections. Organisations agreeing to take part were provided with a Participation Sheet, which clarified roles and responsibilities and issues of data management. Any identifiable data used in the report and case studies has been signed off by the participating organisations. (*Appendix D*)

c) We developed 31 case studies with staff, illustrating quality improvements made during COVID-19 (*Appendix C*)

d) We had several stages of data collection and analysis:

- We carried out in-depth examination of 3 innovations that had attracted a CHA national award for innovation and best practice in 2020 in relation to the pandemic. These examples helped us to develop the interview schedule. (*Appendix H*)
- We made contact with organisations through our CHA network, to recruit organisations to take part in the project. (*Appendix B*)
- We designed an interview template, piloted it, refined it and adopted it.
- We interviewed staff in small groups online using the semi-structured interview template. We captured data in recordings and field notes.
- We carried out an analysis using QI methodology on positive impact changes.
- We developed our methodology and recorded risks and key learning throughout the project
- Where appropriate re-interviewing staff allowed an assessment of the longer-term impact of quality improvements and enabled consideration of sustainability.
- We determined themes which provided an analytical framework.
- With staff we identified initiatives that would be suitable to develop as case studies for wider sharing and learning.
- We analysed the data from case studies and drew from these examples the 6 key features of community hospitals
- We carried out further analysis, and developed 4 recommendations regarding how to make the most of community hospitals.



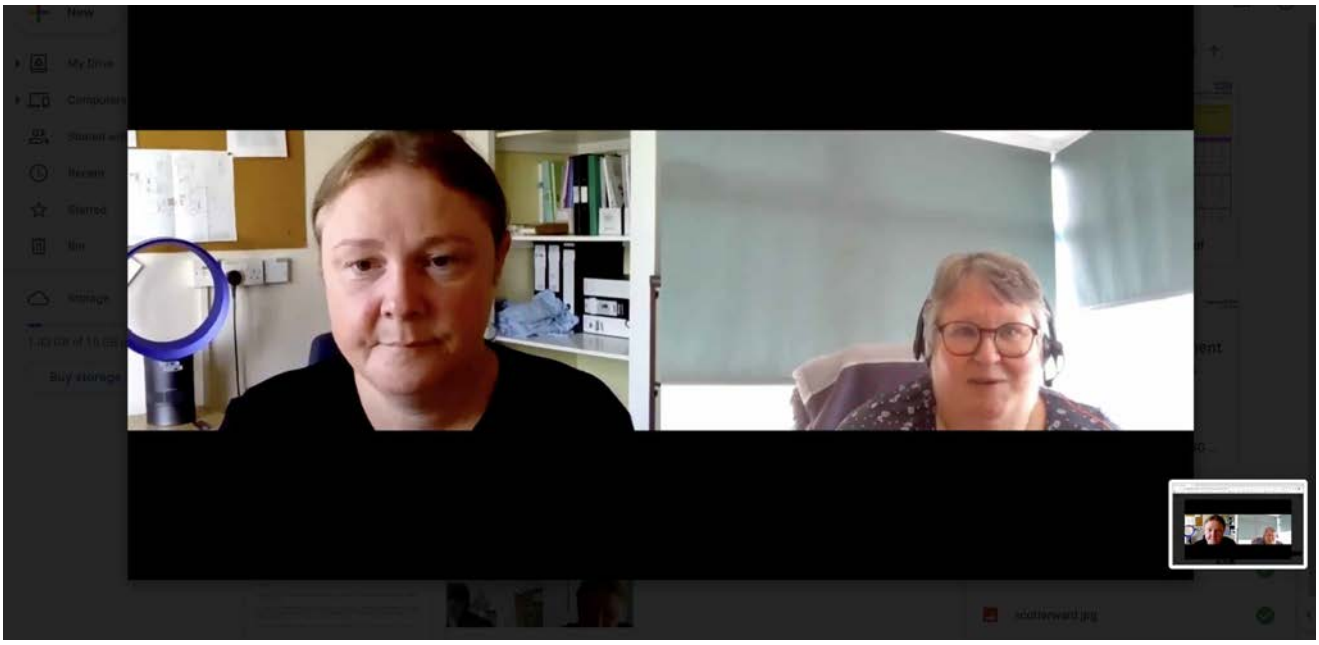
By kind permission of Sonia Sparkles

Staff have been generous with their time and open with their sharing of experiences. This has enabled us to capture many examples of changing practice. The project has exceeded our expectations in terms of the depth and breadth of information gathered.

We have interviewed staff from 20 participating organisations, and between them they manage 168 CHs which is one third of all UK CH. The enthusiasm of community hospital staff and their organisation to participate has been remarkable given the service pressure, and reinforces the initial project suggestion that CHs as typically remote and rural local facilities can be isolated and do not always have the opportunity to share their learning with other community hospitals. With the staff we identified and developed 31 case studies.

ACTIVITY	NO. OF ORGS	COMMUNITY HOSPITALS
30 interviews completed with 85 staff	20	168
Organisations contacted that did not take part	24	–

Table 1: Project Activity



NEARLY 80% OF THOSE INTERVIEWED WERE EITHER NURSES, NURSE MANAGERS OR MANAGERS

NEARLY 20% WERE THERAPISTS, DOCTORS OR SOCIAL WORKERS. THIS REFLECTS THE MULTI-DISCIPLINARY NATURE OF COMMUNITY HOSPITAL STAFFING

JOB TITLE	NO.	%
Nurse / Nurse Manager	52	61%
Therapist	8	9%
Social Worker	1	1%
Health care worker	1	1%
GP	7	8%
Medical Consultant	1	1%
Manager	15	18%
Total	85	100%

Table 2: Job Titles of Staff Interviewed

Dissemination

We are sharing the learning and examples of innovative practice through:

- Setting up of a Q Exchange Special Interest Group for Community Hospitals.
- Applying our dissemination plan to share the learning across the network of Community Hospitals and wider stakeholders (*Appendix F*)
- Developing a glossary of terns, to help make the project accessible (*Appendix J*)
- Publishing papers and presenting at conferences (*Appendix I*)
- Building up our reference list (*Appendix K*)

③ PRACTICE, PEOPLE & PLANNING

3

PRACTICE, PEOPLE & PLANNING

Staff shared openly about the challenges and opportunities during the pandemic. They spoke of the fear and anxiety, and also the resilience of teams. They spoke of how many of the changes had been needed for a while, and that the pandemic had accelerated these improvements. Staff spoke of how existing relationships were strengthened at this time, and how individuals and teams adapted to this crisis situation. Staff confirmed that community hospitals were valued facilities, not only by patients, staff and communities, but now more broadly recognised across the whole health system.

The structure and analysis of the outcomes of the interviews has been grouped into three themes – practice, people and planning. These 3 themes came from our discussions with members and the themes that emerged from the best practice awards particularly in relation to the COVID-19 awards. Case studies have been developed for each of the themes in a format to facilitate sharing and learning.

Themes

PRACTICE

Changing Practice

PEOPLE

Supporting People

PLANNING

Planning & Managing Change

THE 31 CASE STUDIES CAN BE FOUND ON THE **CHA WEBSITE**. EACH CASE STUDY HAS A POWERPOINT SLIDE AND A ONE PAGE SUMMARY

THE 11 DETAILED CASE STUDIES HAVE AN ADDITIONAL MORE DETAILED PAPER

3.1

CHANGING PRACTICE

Services in community hospitals that were open during the pandemic were inpatient beds and urgent care centres/minor injuries units. There were also some clinics that continued to be offered.

In-Patient Care

→ INCREASING CAPACITY

Community hospitals, as small local mainly rural hospitals often have just one or two wards, with bed numbers typically under 30. Staff described the way that their wards were used during COVID-19 in terms of function and capacity, and the speed at which changes were made.

> ***So we have learned that it is possible to create change if we really need to. The key is, we can do this!***
>
> SENIOR MANAGER

Some wards continued to offer their community beds for intermediate care, sub acute care and rehabilitation, so there was no change in function, although many reported more intensive working and a higher turnover of patients.

> ***We were in a wee world of our own. The difference was that you had to be screened but once you were in the ward it was as it was before, apart from masks and visors, just with more adrenaline and fear.***
>
> MATRON

There were many examples of expansions of bed numbers, as extra beds and wards were opened to create capacity for local need.

> ***Our Community Hospital step-down beds became general nursing beds to free up acute beds for Covid patients. Coupled with the community engagement that we are doing, this is making us a stronger player.***
>
> SENIOR MANAGER

In Tewkesbury, Gloucestershire Health and Care NHS Foundation Trust, a ward was rapidly repurposed for end of life care for patients with COVID-19. This initiative illustrated the strength of collaboration across the hospital, and won a CHA Innovations and Best Practice Award in 2020, and has been updated for 2022 (*Appendix H*).

Some wards were re-purposed for specific care such as stroke care and palliative and end of life care. Designation of red (COVID-19) and green (non-COVID-19) wards meant that some community hospitals designated as green could take patients vulnerable and immuno-suppressed patients from acute hospitals. In Torbay, an entire Cancer Care Unit was moved from the acute hospital to Newton Abbott community hospital. Newton Abbott community hospital, which was viewed as a "super green site" became a hub for Non-Surgical Cancer Services (NSCS) as a way of protecting the most vulnerable patients and to ensure the continuation of essential treatments.
(*Torbay and Southern Devon NHS Foundation Trust Case study – Relocating Cancer Care*)

One of the GPs spoke of the challenges of caring for patients with cancer:

> ***"It was an interesting time. It tested our medical knowledge but we looked after those patients in their time of need.*** GP

In Lincolnshire, Skegness community hospital maintained senior nurse staffing for the ward by a creative solution for a remote nurses station. Two Matrons who were required to shield were on rota and supported the ward staff with queries, took part in ward activities, offered advice and attended video meetings. (*Lincolnshire Community Health Services NHS Trust Short Case Study – Virtual Nurses Station*)

The flexibility of the use of the community beds and ways of working with staff was seen to be a positive attribute. All staff spoke of the increasing complexity and acuity of patients during this time.

→ INCREASING CLINICAL CARE

With the rapidly changing use of inpatient facilities came the need for staff training and support for the existing and redeployed staff. Staff spoke of rapid training such as topics such as respiratory disease, Intravenous Therapies (IVs) and caring for patients with naso-gastric tubes (NG tubes). New training videos were filmed at speed and accredited, so that online training could be rapidly available to staff in Trusts including Gloucestershire and Sussex.

Staff in Oxfordshire described how their service became a 7-day a week service, with provision of senior clinical support and management for every day, enabling the community hospitals to play a full part in supporting patient flow and offering bed capacity. The provision of rehabilitation therapies on a 7-day basis provided more intensive rehabilitation leading to swifter patient recovery and shorter lengths of stay. (*Oxford Health NHS Foundation Trust Case Study – Leadership and autonomy enabling a 7-day therapy service*)

> ***“It’s about how we can demonstrate all the good services being delivered and the opportunities to be creative and meet needs. Coming out of the second wave we are more creative. We are taking patients who are sicker/more complex than before – we are giving them the best chance to get home.***
>
> CLINICAL MANAGER

Many staff spoke with pride about the quality of the end of life care that they provided during the pandemic. Staff described what they did in order to provide compassionate care for patients, such as arranging sensitive outside visiting and providing extra therapy to patients.

Staff in Tewkesbury Hospital embarked on a substantial transformation project to create the ward for patients with Covid who were at the end of life. This took place swiftly in one week and required staff to provide a model of care they were unaccustomed to, in an environment most were unfamiliar with, working to processes and procedures that were both untested and under constant review and change. Over time, this change of role was modified to include caring for patients requiring rehabilitation. This initiative won a CHA award for Innovation and Best Practice awarded in 2020, and staff have provided information in order for it to be updated to be included in this study. (*Gloucestershire Health and Care NHS Foundation Trust Case Study – Repurposing a ward*)

→ REHABILITATION SERVICES

Community hospitals are key providers of rehabilitation and intermediate care services. During the pandemic there were changes to the way that rehabilitation was planned and delivered, and in many cases an increase in the frequency of rehabilitation offered. There were also examples of creative ways of supporting patients to improve their independence, given the restrictions of COVID–19 (*Generic Case Study – Rehabilitation*)

→ ENHANCED CLINICAL SUPPORT

> ***Our GPs flexibility and willingness to support us was highly valued. There were already good relationships, but this extended support really shone through, especially with more complex patients and with more (COVID-19-related) deaths.***
>
> MATRON

Staff spoke of the additional support they received from local medical staff. Most staff spoke of increased GP support by increasing their hours to the ward and such as offering telephone support at night. (*Hywel Dda University Health Board Short Case Study – GPs working differently with Community Hospitals*)

Improved access to consultant medical staff was recorded, such as through virtual access, and one staff team spoke of the specific support a consultant provided to transferred COVID-19 patients who required oxygen therapy. (*Cwm Taf University Health Board Short Case Study – Patient Transfers Needing Oxygen*)

The Nurse Consultant for Petersfield Community Hospital, Southern Health was already in the process of redesigning the clinical model for the hospital, by building an Advanced Practice Team. Nurses, therapists and paramedics were offered training and development to become Advanced Practitioners and this will increase the scope of what will be offered in the hospital. This clinical development was accelerated during COVID-19, and was critical when local decisions needed to be made. The Nurse Consultant was described as being responsible for every patient in Petersfield Hospital. The clinical model has enabled the creation of an advanced practice team to work across a developing community Frailty service, community Assessment Unit and community hospital inpatients. (*Southern Health NHS Foundation Trust Case Study – Advanced Practice Team*)

Led by The Health Foundation

Supported by NHS England and Improvement

Short Case Study

Advance Practice Team

The creation of an Advanced Practice Team led by a Nurse Consultant, expanding the clinical services offered to patients with frailty during COVID-19

The pressures on the community hospital services during COVID-19 led to the creation of an Advanced Practice Team. This was led by Jules Kerr, a Nurse Consultant, with the aim of improving the clinical services offered to patients with frailty. The team consists of the Nurse Consultant, Advanced Nurse Practitioners (ANP) and Trainee ANPs. Included in the professions are nurses and paramedics.

The focus on frailty is for all services – bed-based services, the urgent treatment centre and the Rapid Assessment Unit. A simplified pathway has been created so that staff can refer their patients to the services they need.

There is close working across the community hospital and community services to offer continuity of care to patients and families. There is an aim for the community hospital to be a "hospital without walls."

One of the benefits of being able to offer an extended and integrated service is that there has been a reduction in acute admissions.

> **"We wrap the team around patients on admission. There is a much better flow in care.**
>
> JULES KERR

The team have a philosophy of focusing on assets not deficits, and are aiming for the community hospital to be a centre of excellence for frailty.

The community hospital has also gained a reputation in compassionate care for patients at the end of life. The focus on developing outdoor space for patients and staff contributed to wellbeing, and helped everyone in facing the challenges of COVID-19. The community involvement was impressive.

The community hospital has developed a reputation as "the community hospital that says yes," and there is an improving understanding of the role of the community hospital in the local health and care system.

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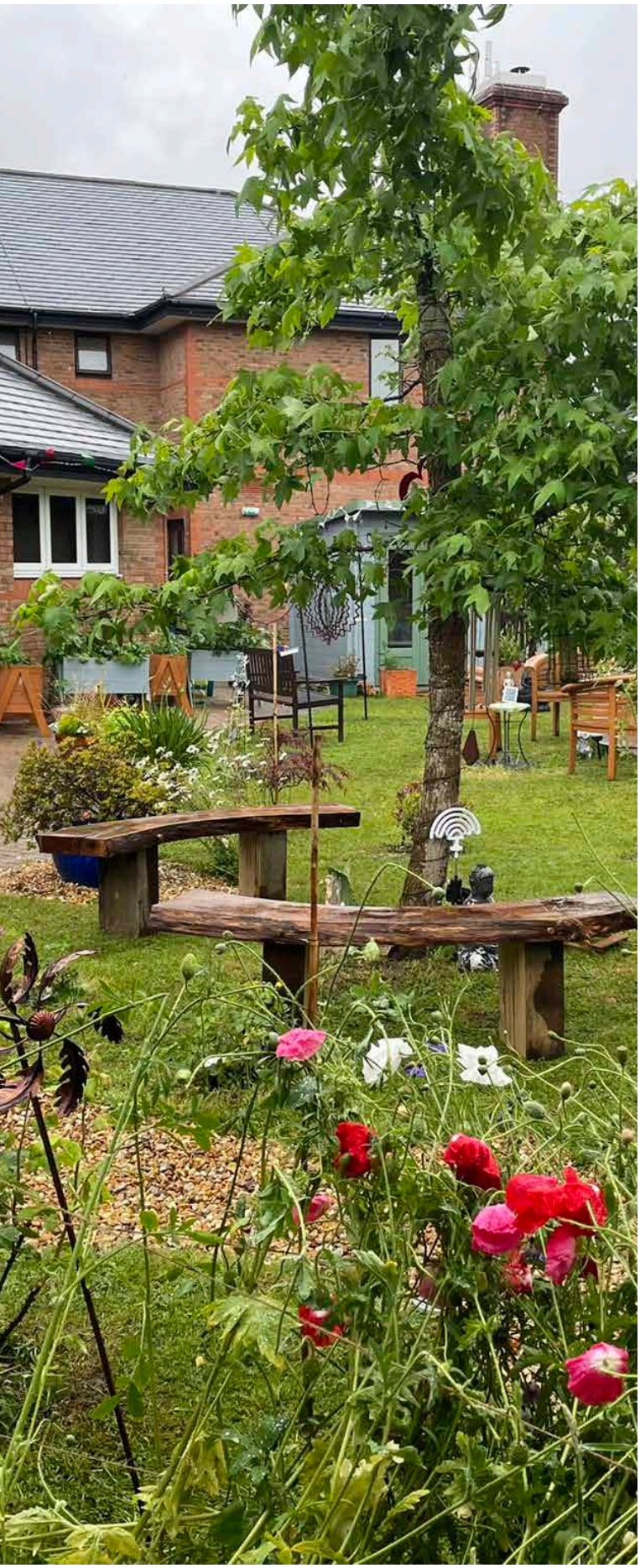
Read more in the full case study >

'The national voice for Community Hospitals'



→ ENHANCED CARE MODEL

Staff in Launceston Community Hospital spoke of the decision to widen the admission criteria to one of their non-Covid wards to include people with multiple conditions including dementia. This enhanced care model required additional staffing, and the hospital trained people from the community who had been furloughed to help with the patients. The service helped with the pressure on care homes as well as the acute hospital, and met a local need. (*Cornwall Partnership NHS Foundation Trust Case Study – Enhanced Care New Model*)

→ IMPROVING ACCESS

> ***The trust developed with the ward teams allowed us to ensure the right patient received the right care at the right time. Working together saved time and resources and resulted in excellent person-centred care.***
>
> CLINICAL LEAD NURSE

Staff talked about how much easier it was now to refer patients and increase patient flow across the system. All staff spoke of the improved systems to manage beds and capacity, with initiatives such as the creation of a Patient Flow Team in Gloucestershire and simplified and standardised referral process in Sussex. In order to facilitate transfers from acute to Teddington community hospital a senior nurse was allocated to in-reach to the acute hospital. The Clinical Lead Nurse went to the acute hospital each day, identified clinically appropriate patients and supported their transfer to Teddington community hospital. The nurse was given access to patient records in the system, which facilitated patient flow and timely transfers. (*Hounslow & Richmond Community Healthcare NHS Trust Short Case Study – Supporting Hospital Discharge During Reset*)

→ COMMUNICATING DIFFERENTLY

> ***Discussions with relatives required different and enhanced skills. There was an additional intensity to the conversations and usual feedback such as non-verbal cues was often absent. Difficult conversations had to happen remotely and often quickly.*** GP

Staff on the wards were caring for patients who were isolating and unable to receive visitors. The staff were often the link between the patient and their family. In the Robinson Hospital and Inver Hospital staff spoke of needing to share sensitive information with relatives through remote systems such as by phone or video call and that this required new skills. The staff said that they were unable to give comfort in the usual way to patients and relatives such as by touch, gesture, a quiet conversation in privacy or even making a cup of tea. (*Northern Health and Social Care Trust Case Study – Creating a Communication Open Door*)

The emotional toll on staff in all community hospitals was considerable, particularly those working on COVID-19 wards and those working on wards with a high level of deaths. The staff were meeting clinical needs of patients as well as their emotional needs.

> ***We have done more good through communication than many other measures. Communication was the thing that we could do, and do well.***
> TEAM MEMBER

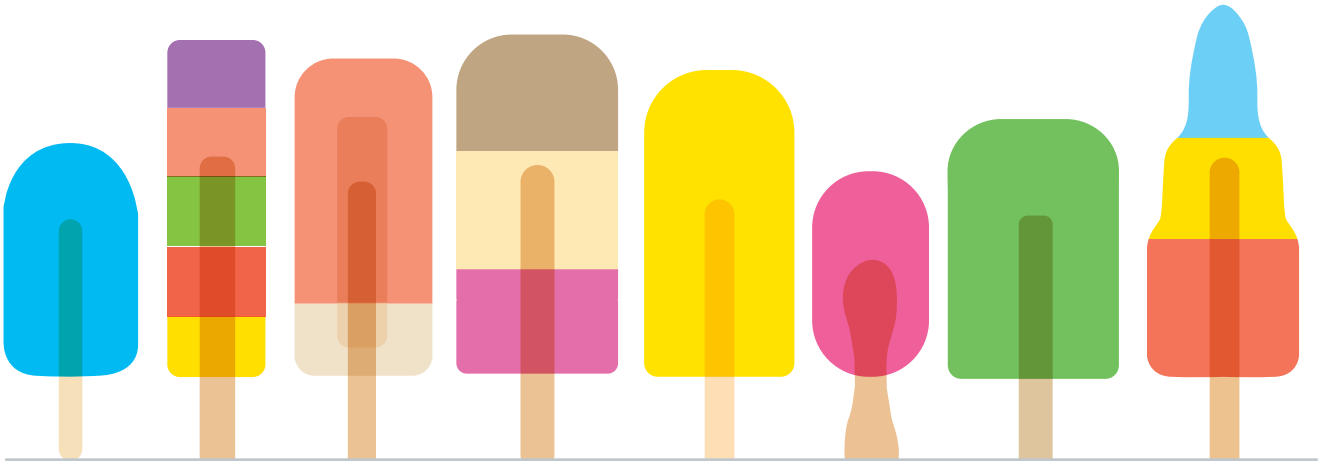
→ HOLISTIC CARE

Staff spoke of some small but significant initiatives that improved the experience of care for their patients. Staff were concerned about the isolation of patients as visiting was suspended. They were also worried about the anxiety of patients, particularly at the start of the pandemic.

A Dementia support worker in one ward created activities for patients and made use of technology through the use of an Alexa kit. This included quizzes and music, and provided stimulation, entertainment and diversion and replaced physical activity as many people recovering from COVID-19 could not leave their beds.
(*Betsi Cadwaladr University Health Board Short Case Study – Using Alexa in Dementia Care*)

In Wallingford community hospital staff created a musical interlude twice a day, linked to a cleaning session that involved everyone including the patients. This was an early initiative designed to lift spirits and also stress the importance of cleanliness. Staff said that there was talk each day about the choice of music, and it became quite a feature of each day. This initiative was a short-term arrangement, but it served a purpose and highlighted an important message about hygiene and infection prevention and control at the start of the pandemic.
(*Oxford Health NHS Foundation Trust Short Case Study – Cleaning to Music*)

In Gloucestershire on wards designated for patients with COVID-19, staff were concerned about maintaining hydration. The staff offered ice lollies, which proved to be very suitable for patients who had lost their sense of taste and needed hydration. Ice lollies also had the added effect of soothing throats and calming coughs. ***"Most importantly, patients very much enjoyed them."*** (*Gloucestershire Health and Care NHS Foundation Trust Short Case Study – Ice Lollies for Patients*)



Unscheduled Urgent Care

Minor injuries units (MIU) and urgent care centres (UCC) in community hospitals offer unscheduled urgent care for minor injuries and in some cases minor ailments.

> ***In rural and semi-rural areas particularly, it is important not to travel to the wrong service. This may present health risks as well as increase travel and time.***
>
> ADVANCED NURSE PRACTITIONER

Many minor injuries units remained open, and in some cases extended their opening times. In the Princess of Wales Hospital and Evesham Community Hospital this was managed through the introduction of a remote triage system managed by Advanced Nurse Practitioners. (*Herefordshire & Worcestershire Health and Care NHS Foundation Trust Short Case Study – Advanced Clinical Practitioners*)

This was developed in conjunction with 111, and enabled patients to be pre-assessed virtually and directed to the appropriate service using local knowledge. Rather than being an open access service as before, patients were given booked appointments which enabled staff to manage patient demand. Staff were able to observe social distancing in the waiting areas by reducing the number of patients at any one time. Some patients were asked to wait in their cars, which was feasible and manageable given the proximity of the car park and the fact that parking was free. Staff reported that patients at the time were struggling to access health services due to COVID-19 so valued the access to the MIU service. A review of patients attending MIUs in Worcestershire showed that 85% of patients having a pre-assessment were seen in the MIU, 10% were treated virtually and 5% were referred on to another provider.

The remote triage system helped to ensure a smoother path to the most appropriate treatment with fewer unnecessary journeys and less exposure to infection. Staff reported that an analysis of activity in Worcestershire had shown when this initiative was introduced in June 2020, 200 calls a month from patients were taken for triage. By September 2021 this had increased to 2000 a month. Staff remarked that the utilisation of MIUs throughout the Trust were now higher than in pre-pandemic times. (*Herefordshire & Worcestershire Health and Care NHS Foundation Trust Short Case Study Pre Assessment for MIU*)

Clinics

Staff told of new clinics and services that were developed during the pandemic such as new heart failure assessment clinic, endoscopy and GP COVID-19 clinics.

A number of clinics were moved out of the acute hospitals to community hospitals.

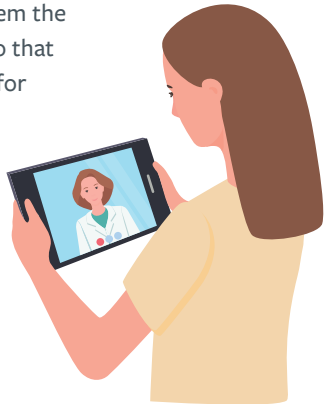
> ***We showed our worth in that time.***
>
> MATRON

The way that clinics were managed changed, and where possible and appropriate staff provided a virtual clinic service through technology such as ***"Attend Anywhere."***

> ***Pre pandemic we had started to use virtual consultations, this then became the norm during the pandemic with patients being able to access consultations at home if necessary.***
>
> MATRON

The Northumbria Trust estimates that there has been an increase in virtual appointments from 7% in 2018/2019 to 45% in 2020/2021. This proved to be successful for a number of specialities. The Trust estimates that this may have saved patients two million miles of travelling between April 2020 and January 2021. (*Northumbria Healthcare NHS Foundation Trust Short Case Study – Virtual Outpatients*)

Therapists also reported their use of technology in order to carry out home assessments remotely as it was not possible for the therapist to visit because of COVID-19 regulations. The Occupational Therapists would ask the relative or friend to show them the patient's home on an iPad, so that they could assess suitability for discharge. The remote assessment proved to be very valuable, and helped prevent delays in patients being discharged. (*Sussex Community NHS Trust Short Case Study – Virtual Home Assessments*)



3.2

SUPPORTING PEOPLE

Staff – working together

> ***Resilience should be the top of the Job Description***
>
> NURSE MANAGER

One of the strongest themes emerging from interviews with staff was teamwork, and the strengthening of relationships and integrated working across disciplines, services and sectors.

> ***We have become a team. That is what COVID-19 has done. It has defined what a team is here***
>
> NURSE CONSULTANT

Staff described a strengthening of existing relationships, and spoke about how important it was that there were already well established working relationships in place.

> ***What is notable is that the team has worked together for a long time – the lowest turnover in Trust, some staff very long standing. This made a difference to how they adapted positively***
>
> CLINICAL SERVICES MANAGER

Staff spoke of the multi disciplinary teams on the wards, and how regular staff meetings referred to as "huddles" included managers and team leaders of all departments of the hospital, not just clinical.

There was closer working across the hospital and community, and sharing of staff. This way of working in which all community and community hospital staff were managed as a local community resource provided flexibility at this time. One member of staff spoke of the openness of the community hospital service, which was more than what happened in the building.

> ***We want to develop as a community hospital without walls***
>
> NURSE CONSULTANT

Support was given by medical staff, with local GPs being part of the local team and Consultants offering on-going support. Many staff spoke of the invaluable extra support offered by GPs at this time. (*Hywel Dda University Health Board Short Case Study – Increased GP support*)

One of the words used frequently was "camaraderie," with staff talking of all being in it together and supporting each other.

> ***I think for me, the blessing of this place is how closely everybody worked together***
>
> SENIOR NURSE

Staff spoke of the closeness of working relationships, and the increased appreciation of everyone's role.

> ***Kindness is being embraced. Whether a Sister, Matron, Leader, Manager, CEO or housekeeping, there is more respect for each other and this flows through to ward staff and their relationships with patients***
>
> NURSE MANAGER

The stability of well-established local teams was seen as a helpful factor in the crisis.

> ***We know each other so well – you know when someone is having a bad time. During that tough time when we could not see our family, we were the family.***
>
> SENIOR NURSE

This message of being like a family to the patient and to each other in the staff team was echoed by many other staff.

Relationships between the acute sector and community services including community hospitals improved with close working and sharing of data. This led to a better understanding of the roles of each of the services and the pressures being experienced.

> ***The acute sector had a deeper appreciation of community hospitals***
>
> SENIOR NURSE.

Several staff teams said that this had helped clarify the contribution of community hospitals, and gave them a clear place in the wider health and social care system.

Staff – Training and Support

Staff welcomed the accelerated training programmes offered including training in basic health care, specific clinical conditions, and topics such as communication skills. In many cases, there was a rapid shift to more online training, with some Trusts making their own training videos on topics such as respiratory conditions and managing breathlessness. The training was aimed at all staff, but there was a particular need to offer rapid accessible training for those staff who were redeployed from other areas. There were situations whereby staff such as health visitors, nursery nurses, theatre staff and clinical staff were redeployed to the wards, and required an urgent refresher. Online videos and interactive training sessions were targeted at urgent training needs.

One of the staff wrote to the Trust, saying:

> ***I just wanted to say thank you for taking the time & effort to put together the YouTube clips, especially the basic care clips. I am a health visitor about to be deployed to the adult rehab unit. I am an adult trained nurse but it's been almost 22 years since I last worked in a ward environment.***
>
> HEALTH VISITOR

New staff roles were created, with staff needing support and training in their new roles. This included the creation of PPE Champions who needed support and training.

In 2020, Sussex Community NHS Trust won an award from the CHA Award for innovation and best practice programme which they titled "Training multi-professional staff at pace during a pandemic" to deliver a competent and confident redeployed workforce for our community hospitals. One of the staff wrote a blog for the CHA website on this, entitled ***"Let's Not Panic About Training In A Pandemic!"*** Information on this successful approach to creating and delivering appropriate and targeted training at speed during the pandemic has been updated for 2022 (Appendix H).

Staff – Health and Wellbeing

Staff health and wellbeing was a major concern.

> ***You have to look after your staff in order for them to look after other people. Never in any other time in my career, 25 years as a charge nurse, did I feel this so strongly***
>
> CHARGE NURSE

Northumbria Healthcare NHS Foundation Trust had put in place a staff survey initiative just before the pandemic, and this proved to be an invaluable resource and support mechanism. The survey was retitled "Corona Voice" and was a weekly survey of staff, inviting them to share their concerns, issues and giving them a chance to reflect. Seven themes emerged from the survey: Listen to me; Care about me; Keep me safe; Keep me connected; Lead me; Keep me going; and Notice me- Honour my work. Staff spoke of the value of the survey and the web-based platform which was a fantastic repository of the on-going reflections of NHS staff during this extraordinary time. (*Northumbria Healthcare NHS Foundation Trust Case Study – Corona Voice supporting staff*)

The Trust listened to staff and responded. A wellbeing website was created with advice, practical information and resources for staff. A team leaders pack was created, to help them support their teams. The survey identified the need to keep connected with staff who were shielding or working from home, so contact by phone and letters was increased. The Corona Voice survey led to practical improvements such as the creation of "chill out" rooms for staff for rest and relaxation.

Led by The Health Foundation

Supported by NHS England and Improvement

Short Case Study

Hearing Staff Voices

Understanding, and meeting, the needs of all staff during the pandemic – 'Corona Voice' Northumbria

As the pandemic started, Northumbria Healthcare NHS Foundation Trust was determined to provide staff with a safe and effective way to raise issues, voice concerns, provide information or just share how they were feeling at the time. They developed a series of very short, COVID-19 specific, staff surveys, to be presented each week to gain a better understanding of staff well-being across the Trust.

'Corona Voice' – a web-based platform was launched on April 6th 2020 as the country went into lock down. In the first three months, it exceeded all expectations, and received 10,400 responses from staff which included their 7 community hospitals/intermediate care units.

Staff motivation was tracked on a weekly basis, with the Trust able to quickly identify which hospital sites or groups needed more support. Staff felt that the survey had given them the opportunity to reflect not only on their own feelings and emotional state over time as the pandemic played out, but also on some of the devastating effects of the virus. Also the Trust was able to respond to the issues that the staff were raising, resulting in focussed actions under the 7 core needs headings that emerged:

1. Listen to me
2. Care about me
3. Keep me safe
4. Keep me connected
5. Lead me
6. Keep me going
7. Notice me – honour my work

> **Everyone had the opportunity to feed into our exec teams. Every matron and team manager had that feedback from their teams.**
>
> ANNALUISA WOOD, MATRON OF ALNWICK AND BERWICK COMMUNITY HOSPITALS

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Read more in the full case study >

'The national voice for Community Hospitals'

One Trust encouraged staff to make use of an Employee Assistance Programme (Vivup) which directed staff to information and resources. Another created a Health and Wellbeing Team (Prevent).

Many staff spoke of the value of having a place where you could take time out away from the pressures of the service. In some cases this was space in the garden, and in others a specific room was allocated, referred to in some hospitals as a "wobble room."

Each Trust and community hospital focused on ways of communicating. Staff described the challenge of communicating with many new and redeployed staff on the ward, so they set up a board for staff to write their questions on. This was referred to as ***"Writing on the Wall"*** and proved to be a simple and effective way of capturing issues for teams on the ward, and answering questions and reviewing practice. (*Birmingham Community Healthcare NHS Trust Short Case Study – Writing on the Wall*)

Staff spoke of the value of a regular ***"West Sussex Chat"*** where staff were encouraged to talk about anything but work. They reported that this helped build strong relationships for the pressured work meetings that they were facing. (*Sussex Community NHS Trust Short Case Study – West Sussex Chat*)

Another way of capturing staff mood was the introduction of the ***"SPEaC Happy App"*** which was visible on the end-of-life care ward and as staff left after a shift, they pressed a button with a face on it, indicating how they were feeling at that moment. This was a quick and easy way of getting a snapshot of the mood of a team. The action of being asked how they were feeling, reflecting on it and communicating it, was found to be beneficial to staff's sense of wellbeing. (*Birmingham Community Healthcare NHS Trust Short Case Study – SPEaC Happy App*)

> ***The feedback that we got from this app is, you can capture the mood of your organisation and people feel better being able to say how they feel.***
>
> SENIOR MANAGER

There was support for staff, but there was a comment that it was less clear or obvious in some cases what support was available for managers. Support at Team Leader level at one hospital was offered through regular meetings with the senior manager, which staff said gave them the fortitude to go onto the ward and be strong for their staff.

"Feeling fabulous for five minutes on a Friday" was an initiative to lift spirits and support staff. This took the form of fun exercises such hula-hooping, relaxation, puzzles etc. The Trust also created a board on the ward called ***"What we are grateful for today,"*** with photos and comments.

"Transformation Thursday" provided an opportunity for staff to reflect on what they had done to make a difference. This is a weekly session where the team can get together, update each other on what they are doing around the patient-centred care, bounce ideas off each other, and share learning. Others from the Trust are invited to drop in and find out what's going on. (*Oxford Health NHS Foundation Trust Short Case study – Transformation Thursday*)

> ***Thinking of it as a QI initiative has been very powerful and energising as a staff, and it's that staff engagement – discussing person centred care at the Transformation Thursdays has been really positive***
>
> SENIOR MANAGER

In one Trust staff were offered an additional annual leave day for wellbeing, and invited to share how they spent their day on a closed Facebook page.

Staff spoke of how much they appreciated what the Trust had done for them.

> ***They gave us a coffee machine… which we are not giving back!***
>
> NURSE

Patients

Staff went to extraordinary lengths to ease the situation of patients and relatives within the restrictions of the pandemic.

There are moving examples of a community showing their support to the hospital staff. One example was a wedding in a community hospital garden. A patient who was receiving end of life care said that he wanted to get married. The Archbishop of Canterbury gave special permission for the wedding. In a moving ceremony the couple were married in the attractive gardens of the community hospital. The staff facilitated this within the rules of COVID-19, and helped make this happen. The patient was a paramedic, known to many staff. His widow now works as a volunteer in the community hospital.

COVID-19 restrictions meant that patients were not able to receive visitors. Communication between patients and families were facilitated through phone calls and video calls, with staff providing support, reassurance and comfort to patients while they were being cared for on the ward. Staff spoke about being there for patients as they drew their last breath, holding their hands. The number of deaths in many of the community hospital wards was much higher than staff were used to, and this was an emotional toll on staff. There were also high levels of anxiety about infection control and risk at the start of the pandemic.

> ***It was a massive emotional journey***
>
> NURSE MANAGER

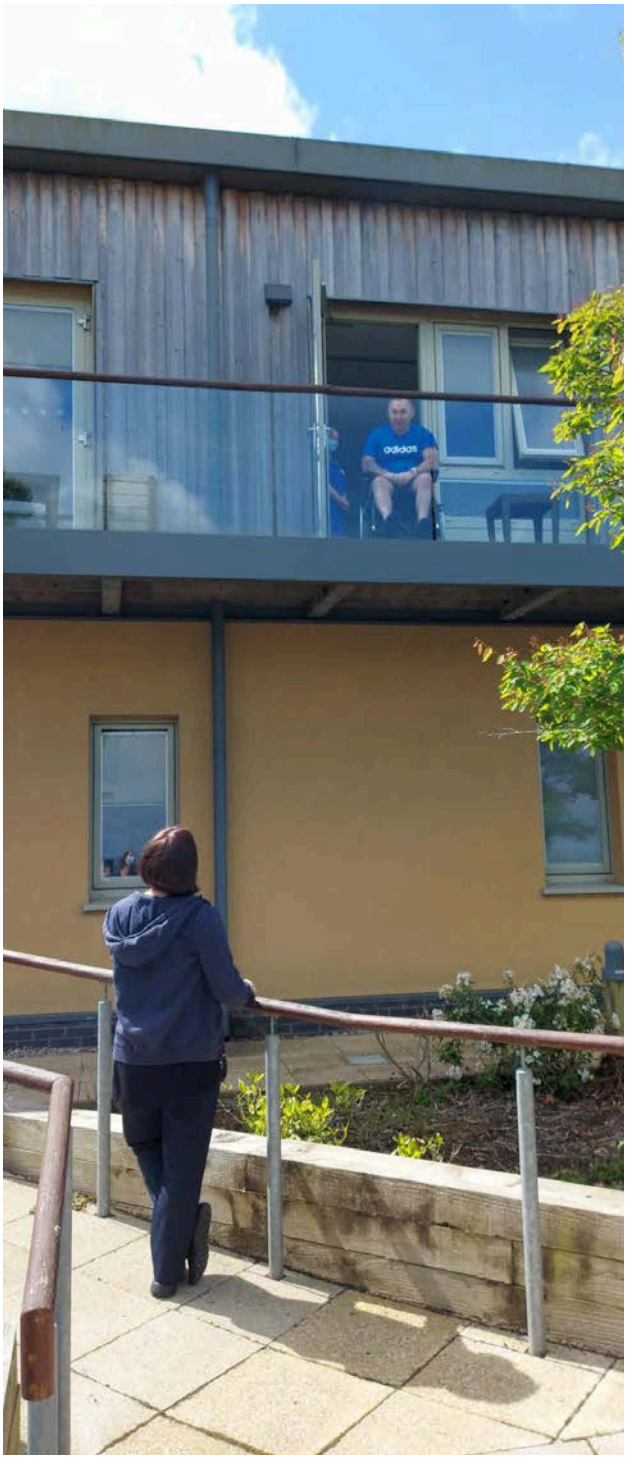
In Somerset NHS Foundation Trust, staff described how they carried out planning and risk assessments to create safe COVID-19-secure spaces for compassionate visiting for patients at the end of life (*Somerset NHS Foundation Trust Case Study – Enabling Compassionate Visiting*)

Staff described the positive feedback from relatives, and how they used external courtyards, gardens and balconies so that patients could have visitors within the COVID-19 restriction.

Staff spoke of the rapid deterioration of some patients with COVID-19, which meant that the management of visits at the end of life had to be timely.

In Northern Ireland, the staff reflected on how they had developed new and enhanced means of communicating with families, staff and professional colleagues to support delivery of person centred care on a COVID-19 unit. New ways of communicating with patients and relatives were developed requiring new skills. (*Northern Health and Social Care Trust – Creating a Communication Open Door*)

> ***We could not change the outcome for patients but the thing we could change was our communication with the families as this was what was going to make the biggest difference to the perception of care***
>
> GP



Community Support

There were many examples of how the local community supported the staff and the hospital. This included donating gifts such as food and toiletries. Local businesses came forward with equipment including PPE. When there were building projects the community response was rapid and supportive. In Nairn community hospital the GPs wanted a room converted in the community hospital to a COVID-19 assessment room, and this was done by local builders who did this within a week, giving it a top priority.

One Trust in Scotland described a range of ways that community hospitals were supported, including a young girl from the village playing the bagpipes for the patients and staff on a weekly basis. In the community there were fundraising events such as a scarecrow competition and a window display event. Donations to the hospital included alcohol gel from a local distillery, meals from restaurants, and visors made by a local business. (*Lanarkshire Health Board Short Case Study – Community Support*)

All of the staff spoke of the variety of ways they were supported by their communities at this time, and appreciated the thoughtful gifts of toiletries, fruit etc.

A knitted hearts project was created by volunteers, as a way of connecting isolating patients and their loved ones. They knitted pairs of hearts, and when a patient was admitted they were given a heart, and their loved one was given the other one in the pair. It was hoped that this would provide some comfort to those who were separated at this difficult time. Providing knitted hearts was just one 'comforting touch' put in place by the Family Communications Teams to ameliorate the distress of families and friends being separated at a time of crisis. (*Gloucestershire Health and Care NHS Foundation Trust Short Case Study – Knitted Hearts*)

In the same way the 'Hearts Project' in Helston community hospital encouraged staff and members of the public to make pairs of matching hearts to connect patient's physically to their relative. A heart would be placed with the patient and a matching heart given or sent to the family to connect them, along with sentiments or bereavement support information. They made them as personal as possible and they became part of everyday connection. (*Cornwall Partnership NHS Foundation Trust Short Case Study – Hearts of Care*)

This support by the community for their local hospital was echoed in all of the interviews.

> ***The community hospital is cherished by its community.***
>
> NURSE

We were impressed with the initiative ***"Creating with Care"***, from Oxford Health NHS Foundation Trust and this won a CHA award in 2020 for innovation and best practice. Staff spoke of the value of encouraging patients in a wide range of activities including dance, painting etc. This impressive innovation has been rolled out across the Trust, with a number of community hospitals having an artist in residence. We spoke to staff and have prepared an update of their award winning innovation for 2022 (Appendix H)

Volunteers

Volunteer support in clinical areas was suspended during COVID-19.

In some cases, the age profile of volunteers meant that they needed to be shielding at home, and therefore could not continue with their volunteering. A CEO of a community hospital spoke of the importance of keeping in touch with all those who were shielding, and keep connected with them so that they were informed and felt valued.

One hospital talked of the role of volunteers in screening people coming into the hospital which was highly valued. Staff reflected on how much they missed the volunteers at this critical time, and staff were considering how best to work with volunteers on their return.

3.3

PLANNING & MANAGING CHANGE

> ***Despite the horrors, we have come a long way. We need to celebrate that***
>
> SENIOR MANAGER

Managers spoke of the learning from the first wave, when senior managers in the Trust had a focus on the national situation and corporate responsibilities, After the first wave, managers turned attention to their local services, and designed management support systems for their community hospitals. In one Trust, the senior management devised a system in which they could offer personal support to each of the hospitals. Senior managers were "buddied" with a specific community hospital, and offered direct access, a presence and increased support. Each individual and site arranged the buddying to suit the context – some spent whole days working at weekends from the site, donning scrubs and getting stuck in on the ward, or doing their 'day job' from that site. Others arranged to pop in at particular touch points. This helped to reassure staff. It also had the advantage of providing managers with a clearer understanding of the pressures on the staff and services. (*Oxford Health NHS Foundation Trust Short Case Study Managers as Buddies*)

> ***It was about staff knowing that we were still available, that we appreciated them. And just trying to help out. But it also enabled us to find out more about what mattered to staff.***
>
> SENIOR MANAGER

A strong theme from the interviews was the increase in local autonomy at this time, and the benefits of being able to make appropriate local decisions. One particularly striking example was a situation when the local GP and clinical staff took early action to make Nairn Town and County hospital, and the community, safe at the very start of the pandemic. It is thought that this community hospital was the first hospital to be locked down, as it predated the national lockdown. The GP posted a public health video on YouTube, giving advice to the community on how to stay safe. This early action was thought to have been very beneficial and gave some protection to staff and patients at the start of the pandemic. (*Highland Health Board Case Study – Keeping our Community Safe*)

Led by The Health Foundation | Supported by NHS England and Improvement

Short Case Study

Keeping our community safe

Keeping our community safe during COVID-19 – making swift local decisions, working more closely together, and making the most of our community hospital and our community.

Early action was taken by Dr Adrian Baker, GP and clinical lead in response to the warnings of the pandemic. As early as 11th March 2020, Dr Baker had taken steps to safeguard the community hospital and GP practice, instigating measures such as limiting and managing access, requiring hand washing and social distancing. It is understood that this is the first hospital and practice to be locked down in the UK.

Dr Baker made a public information video on COVID-19 explaining why changes were being made, and advising on action to protect patients, staff and the community.

There is a history of joint working in Nairn across agencies, and the level of integrated working was strengthened during the pandemic. Frequent team leader meetings involved community ward staff, MIU staff, AHPs, community nurses, social work staff, GPs, hotel services staff and administration. Safe working practices, designed in early March by Dr Baker, were reinforced. Team Leaders supported each other, and staff worked flexibly as needed. There were many examples of community support as well.

This early intervention, supported by strong collaborations across the community, helped to safeguard the community. Staff have advised that none of the inpatients had COVID-19 to date. Only one member of staff had COVID-19 during this time. The system of safe practices meant that compassionate care could be managed, and visits were made possible to patients at the end of their life.

This case study shows the benefit of local decision-making, which in this case was swift and appropriate. This is in keeping with the policy in Scotland of "Place-based" care.

The study shows clinical and managerial leadership, and also the strengthening of collaborative working across the whole community.

Contacts

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NAIRN, SOUTH & MID DIVISION
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Read more in the full case study >

'The national voice for Community Hospitals'

One of the community hospitals in this project is Tetbury Hospital, an independent charitable hospital, with almost all of its operation being funded by the NHS through contracts. The hospital provides elective day surgery and clinics, all of which were suspended during COVID-19. The CEO of the hospital worked with the local NHS to share the equipment and resources, including ventilators and PPE. Staff were also seconded to local Trusts. This level of support was appreciated, and helped to develop relationships across the local health system. With the return of clinics and procedures, the hospital is now busier than ever helping with the waiting list of patients who were not able to be treated during the first wave. The continuation of this valued local hospital was helped by the flexibility shown by commissioners when the hospital had to cease activity because of COVID-19. (*Tetbury Hospital Trust Case Study – Support*)

Many of the staff interviewed spoke of changing management arrangements to cater for the increased needs during the pandemic. Staff in Nairn spoke of the value of Team Leader meetings, which were supported and facilitated by their divisional manager. Team leaders could support each other, and also express their anxieties and concerns within the meeting. This they said gave them the strength to go back to their teams and be positive. (*Highland Health Board Short Case Study Senior Team Huddles*)

One Trust demonstrated considerable system support for the many innovations, and also contributed to COVID-19 research. The combined effect of the innovations, improvements and learning from their involvement in national and local research created the immense change required to respond to the pandemic. (*Birmingham Community Healthcare NHS Trust Case Study – System Impact of Organisation Innovation*)

There were many digital developments that supported the new ways of working for staff. Remote and virtual working required equipment and systems to support this. This included virtual home assessments (Sussex Community Foundation Trust), virtual outpatient clinics (Northumbria Healthcare NHS Foundation Trust) and the virtual nurses station (Lincolnshire Community Health Services NHS Trust). New technology, such as using an Alexa for ward activities was also an initiative demonstrated in a case study. (*Betsi Cadwaladr University Health Board Using Alexa in dementia care*)

④

KEY FEATURES OF COMMUNITY HOSPITALS

4

KEY FEATURES OF COMMUNITY HOSPITALS

The experiences of staff of quality improvements during COVID-19 have been analysed, and the project team has highlighted six features of community hospitals. Staff identified quality improvements that have been created, developed or accelerated during the pandemic.

- → RESILIENT
- → FLEXIBLE
- → RESPONSIVE
- → CREATIVE
- → COMPASSIONATE
- → INTEGRATED

RESILIENT 1

- Continuity of Service
- Bold leadership – clinical and operational
- Staff going above and beyond their role
- Well-established teams
- Maintained staffing with local support
- Support for staff health and wellbeing

FLEXIBLE 2

- Making service changes swiftly
- Changing and adapting the building and facilities
- Redesigning the model of care to meet new needs
- New ways of working
- Adopting technology to support service provision
- Supporting staff redeployed to Community Hospitals through training and buddies
- Increasing staffing capacity to meet rise in demand for care through redeployment, developing new roles using generic workers, moving to 7 day working

RESPONSIVE 3

- Making local decisions for early COVID-19-safety in response to international developments
- Responding to pressures on acute services with services & facilities
- Developing clinical teams to meet increasingly acute and complex patients' needs
- Meeting local needs such as dementia care
- Caring for COVID-19 patients requiring oxygen therapy

COMPASSIONATE 4

- Enabling family visits for patients at the end of life
- Measures to reassure and comfort patients and relatives
- A caring response to patients needs and wishes
- Thoughtful innovations to bridge the lack of visiting
- New ways of communicating virtually with families and external services such as acute Consultants

CREATIVE 5

- Developing ways to stimulate and encourage isolating patients
- Using technology to enhance the patient experience
- Providing emotional support to patients and relatives
- Developing novel approaches to support rehabilitation outside of the physio gym

INTEGRATED 6

- Strengthening team working within the hospital and with community services and partners including in reaching to acute sites
- Improving relationships between acute, mental health, palliative care and Community Hospitals
- Joint working across the whole local health and social care community
- The local community supporting the hospital and its teams

Resilient

- Continuity of Service
- Bold leadership – clinical and operational
- Staff going above and beyond
- Well-established teams
- Maintained staffing with local support
- Support for staff health and wellbeing

Staff have consistently described community hospitals as resilient, and this was clearly demonstrated during the pandemic. Those we spoke to explained how services were maintained and in some cases extended in many community hospitals. For instance bed numbers were increased in some cases, and beds were repurposed. Urgent treatment centres were expanded in terms of opening times and staffing, so patients could avoid going to an acute hospital.

Bold local leadership was a feature. Staff recounted times when managers were present to give the support and leadership needed, and also to make critical local decisions. Many led by example, working alongside staff in patient areas and responding to the pressures on staff.

Matrons in one Trust redesigned the way that they worked, so that there was senior clinical and operational support to staff on wards which increased to a 7-day basis. Internal support from senior managers was provided in one Trust through a "buddy" system, whereby each senior manager was assigned to a community hospital, and had a presence in each.

Staff described many occasions when they slept in at the hospital to make sure that they were able to continue to care for their patients. This ensured staffing levels were maintained through the support and loyalty and dedication of staff. Staff spoke of the long length of service many had given, and that being in a well established team with a low turnover gave some stability in the service.

Skilled and experienced staff who were not able to work in the community hospital as they were shielding were set up to offer a virtual ward service and be available to support the work of the ward. In one community hospital, two matrons who were shielding worked from home by providing administrative support to the ward, contributing by joining ward meetings and hand overs, and providing ongoing advice and support. This was described as a virtual nurses station.

The service was able to be sustained through imaginative ways of retaining and expanding the workforce. Examples included successful international recruitment, redeployment of staff, and the employment of people from the community who were furloughed. Local medical support was extended to the community hospitals, with examples of GPs basing themselves in the community hospital and extending hours. This local support to staff the community hospitals extended what the service could offer, and made sure that the services were sustained.

Support for staff health and wellbeing was provided by organisations, as well as within each of the hospitals. Most hospitals identified a need for staff to take "time out," particularly when working long shifts in PPE, supporting very sick patients, sitting with patients at the end of life, and comforting relatives remotely. Spaces were created, often called "wobble rooms" where staff could take a moment. In some cases, gardens and outdoor spaces were made very attractive so that staff could sit outside for a break. Staff spoke of their appreciation of their Trusts who provided such things as coffee machines and regular baskets of fruit. Leagues of Friends and community groups also provided snacks and toiletries for instance for staff and patients.

A number of Trusts helped maintain the resilience of staff by creating a way of offering staff support from clinical psychologists. Trusts recognised the need for psychological support for their staff working in a crisis situation. In many cases staff were experiencing a higher number of deaths on their wards than was usually the case. Staff were fearful and anxious at the start of the pandemic, concerned not only for their patients and also their own families and friends. The uncertainty, the lack of knowledge of the virus, and the changing guidance was unnerving for staff, and many sought reassurance from managers within their organisation.

Flexible

- Making service changes swiftly
- Changing and adapting the building and facilities
- Redesigning the model of care to meet new needs
- New ways of working
- Adopting technology for remote and virtual services
- Redeployed staff
- Increasing capacity

Small local hospitals have proved to be flexible and adaptable to the changing needs of patients and the service. Physical changes have been reported, such as adapting wards for re-use, redesigning urgent care services to improve safety, creating rooms for COVID-19 assessments, and repurposing closed clinic and day care spaces. Community hospitals have hosted outreach services from acute, such as a Cancer Care Unit. The speed of change, as well as the adaptability of the staff and services, was reported as an achievement.

There are many examples of staff working across roles and departments in order to maintain the service. In these small, local, often remote and rural hospitals, staff teams are typically small and used to working closely together in a flexible way. Staff moved across community, community hospitals and acute hospitals according to need. There were examples of therapists working in housekeeping services in response to urgent need for example. The process of redeploying staff to move across services and teams required rapid support and training, often with a buddying system in place.

Staff have needed to adapt swiftly to new ways of working, and in particular in working with technology for virtual services. This has included virtual home assessments.

Community hospitals reported increased capacity to help with the demands of the pandemic and keep people local.

Responsive

- Local decision for early COVID-19-safety measures
- Responded to pressures on acute services with services & facilities
- Developing clinical teams to meet needs
- Met local needs such as dementia care
- Caring for COVID-19 patients requiring oxygen

Local clinical leads took the initiative and made local decisions in order to keep patients, staff and the community as safe as possible. This included the early implementation of COVID-19 safety measures for the community hospital and the community in response to international developments. Local decision-making also resulted in improved care and support.

Community hospital services have been reported as responsive to the changing needs of patients. In some cases, this meant a change to the clinical offering, such as increasing skills and competencies of staff with regard to clinical procedures such as management of naso-gastric tubes and tracheostomies. In others, admission criteria were widened to include patients with associated cognitive/impairment such as dementia. Staff development was accelerated in some Trusts to offer Advanced Practice Teams and Urgent Care Advanced Clinical Practitioners. Physiotherapists and occupational therapists who were unable to hold clinics were able to offer more therapy time to patients on the wards, and in some cases increasing the service to a 7 day service. This meant that patients had daily rehabilitation and could go home quicker.

For those community hospitals designating wards as COVID-19 wards, there was a challenge with regard to supporting patients requiring oxygen. Some hospitals had piped oxygen in all or part of their ward areas. Others relied on oxygen cylinders and had access to immediate support from acute Consultants on the management of patients.

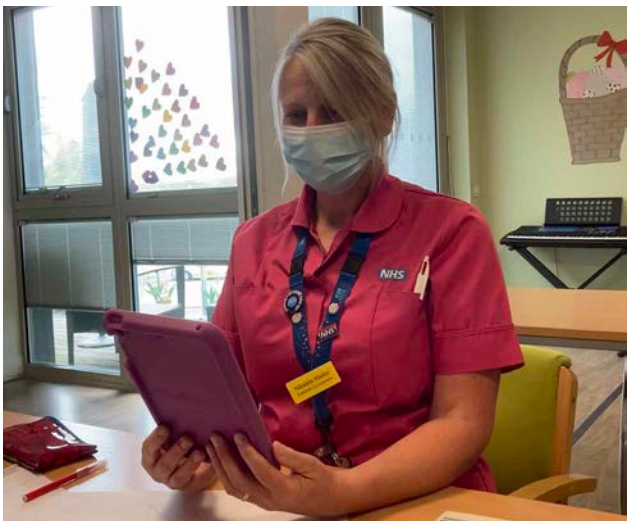
Compassionate

- Safe visiting for patients at the end of their life
- Measures to reassure and comfort patients and relatives
- A caring response to patients needs and wishes
- Thoughtful innovations
- New ways of communicating – virtual and remote

Community hospital staff reported the efforts made to be able to offer compassionate care for all patients and families, and in particular those patients who were at the end of life. At a time when hospital visiting was suspended, staff developed locally sensitive arrangements were made safe visiting for patients at the end of life, for which there was an exception. This included the use of garden areas, the creation of external spaces and the use of open-air balconies. Even visits from pets were arranged. Sensitive and personal arrangements were made to meet the needs of those patients who were dying, in order to try and give them a good death albeit within the restrictions in place.

Staff invented measures to help bring patients and their families together, such as through a knitted heart project. Patients missing their loved ones were offered a pair of knitted hearts, with one of the hearts kept with the patient and the other with the loved one. Staff had to compensate for patients not being able to see their family and friends at a time when the service was exceptionally busy.

Staff supported patients to speak to their families using virtual means. Staff needed to be familiar and skilled in technology such using iPads to support patients communications with family. New and different communication skills needed to be developed by staff, as sensitive sharing news with families was done remotely without the usual comfort and in-person support.



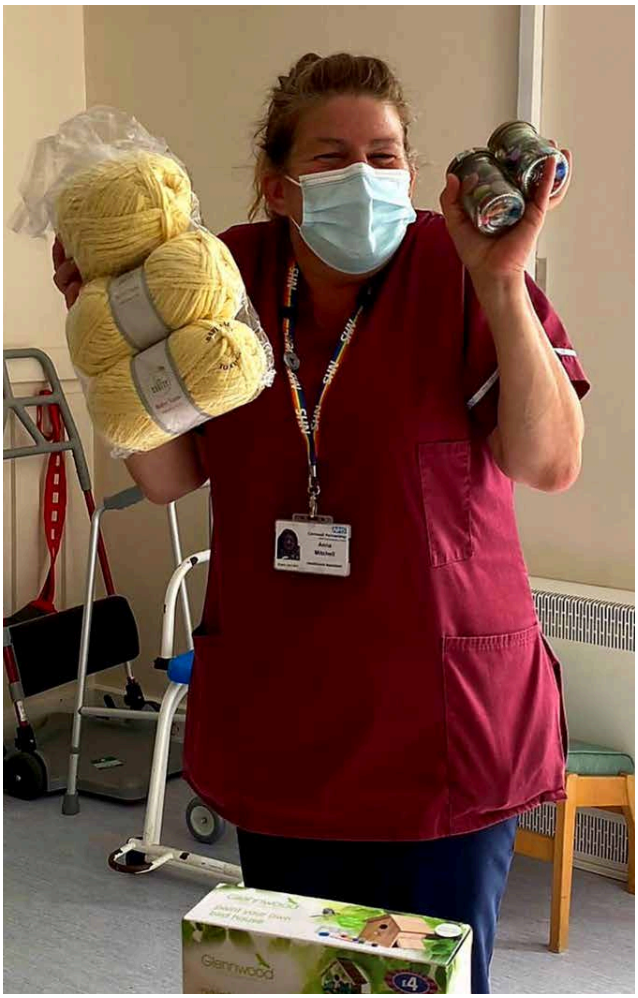
Creative

- Developing ways of stimulating and encouraging isolating patients
- Using technology to enhance the patient experience
- Emotional support to patients and relatives

Staff reported that they were concerned not only about physical needs but also about the welfare and mental health patients, many of whom were elderly, isolated and unable to have visitors.

Staff had initiated a scheme of “creating with care” which sought to stimulate and encourage patients with creative activities. One Trust appointed a “meaningful activities coordinator” to support the wellbeing of patients. One Trust used an Alexa, so that voice prompts could provide music, entertainment and quizzes.

Small but important quality improvements were reported. Patients with COVID-19 who had lost their sense of taste, with sore throats and coughing who were at risk of dehydration were offered ice-lollies which they enjoyed.



Integrated

- **Strengthened team working – hospital and community**
- **Improved relationships between acute and community hospitals**
- **Joint working across the whole local health and social care community**
- **Community support for the hospital**

Staff reported that their relationships across teams, services and agencies were strengthened during COVID-19. Many expressed the view that there was good multi-disciplinary working before COVID-19, but that these were strengthened through the pace of work and the increase in short and targeted staff meetings referred to as "huddles." A sense of pride was reported by many staff in terms of how they worked together as a team and were all in it together.

Multi-agency meetings were held frequently, when total capacity across a whole health and social care system was reviewed and used to optimum effect. This level of sharing data and capacity improved joint working across health, social care and voluntary agencies. Integrated working has been strengthened through the development of systems such as those for patient flow, bed management, and improved data sharing. Improved medical integration was also a feature, with local medical staff (GPs and community consultants) working closely with Consultants and teams in the acute sector.

Community Hospitals have been described as being "embedded" in their communities, with support from the community to the community hospital and the community hospital to the community. Community support was demonstrated throughout all of the community hospitals.

Community Hospitals have been recognised and appreciated for their role in the local health and care economy. Staff reported a higher visibility in the system, and becoming a clearer integral part of the local strategy.

Summary of Key Features

THEREFORE COMMUNITY HOSPITALS HAVE BEEN SHOWN TO BE:

- ✓ **Resilient**
- ✓ **Flexible**
- ✓ **Responsive**
- ✓ **Compassionate**
- ✓ **Creative**
- ✓ **Integrated**

5

RECOMMENDATIONS

5

RECOMMENDATIONS

We have considered the conditions that helped create the opportunities for staff to make quality improvements during COVID-19. We have talked to staff about innovative practice and the changes they have made to improve the service for all concerned. We have discussed how such improvements may be shared more widely and sustained.

In order to help staff learn from these initiatives we have identified

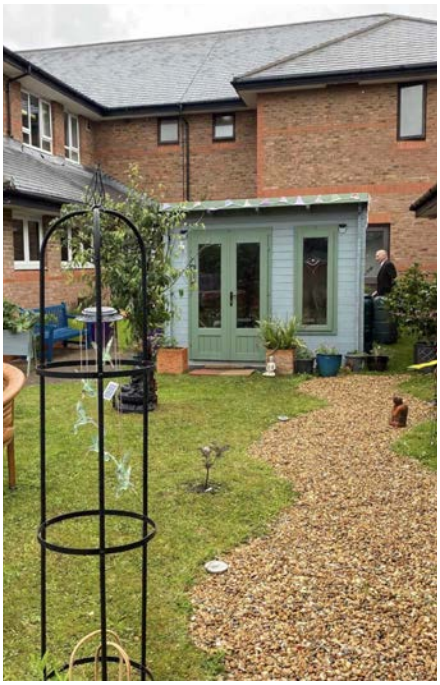
4 RECOMMENDATIONS

We have expanded on these 4 recommendations, drawing on the lessons learnt and experiences of those working in community hospitals.

RECOMMENDATIONS

IN ORDER TO MAKE THE MOST OF OUR COMMUNITY HOSPITALS WE NEED TO BE:

1. Making Decisions Locally
2. Benefiting from Excellent Leadership
3. Recognising Community Hospitals as community assets
4. Looking after our staff



1 Making Decisions Locally

- Making decisions locally through local autonomy
- Playing a full part in the local health and care system

2 Benefiting from Excellent Leadership

- Being led by bold and compassionate leaders
- Being truly person-centred in all that we do

3 Recognising Community Hospitals as a Community Asset

- Providing care, treatment and support
- Supporting the wider community as a community asset
- Investing in community hospitals
- Making the most of digital options

4 Looking After Our Staff

- Attending to staff health and wellbeing
- Providing staff with opportunities for development and growth

Discussion

→ LOCAL AUTONOMY

The case studies showed us how much could be achieved when staff were granted local autonomy and could make decisions appropriate to the local circumstances. In sharing their experiences with us, staff talked about how much they appreciated the trust that was placed in them, and how liberating it was to be able to make locally sensitive decisions. Staff described the removal of some of the "red tape" which created opportunities, particularly when working in partnership with other organisations and needed to share information and work collaboratively. Issues such as financial implications were paused for some of these arrangements. The size and scale of community hospitals, being small facilities often with a wide range of services, meant that changes could be made swiftly across the hospital. Innovative practice could be introduced quickly, given the number of people involved and the size of the facility. One of the strong messages coming from staff was that the role of the community hospital was now being appreciated more than ever. The pandemic led to an increased cooperation across organisations within the NHS, with those with community hospitals having a seat at the table for planning and managing the crisis. The role of the community hospital became clearer in some health economies, and the contribution of small local hospitals being valued. The case studies showed that community hospitals helped with patient flow, end of life care, the relocation of vulnerable patients from acute to community hospitals, and the creation of locally accessible services. We heard from staff that they appreciated the local autonomy, and the support for their quality improvements that were generated "bottom up" rather than "top down."

→ LEADERSHIP

Leadership was also expressed by staff as being a critical factor in being able to provide an appropriate service in the circumstances of the pandemic. Staff spoke of bold and compassionate leadership. Managers spoke of the challenge of having a central and national focus at the start of the pandemic, to the detriment of the local services. This was adjusted as the pandemic progressed, and leaders and managers sought ways to support front line staff. The staff spoke of being person-centred and how this was emphasised during the pandemic when the staff were the main and often the only contact for patients in the hospital. Staff provided care and support for patients who were isolating and unable to see their loved ones, and the ways in which staff went out of their way to reassure and care for patients was inspiring and heart-warming.

→ COMMUNITY HOSPITAL AS COMMUNITY ASSET

Staff wanted to make sure that there was an appreciation that community hospitals were an asset to the community, in its wider sense. In addition to providing high quality care treatment and support to patients whether they be inpatients, visiting clinics or attending urgent care centres, the staff also supported relatives and friends as well as volunteers and the wider community. It is clear that local communities value their local hospitals, and staff spoke of the contributions of food and essential supplies from community groups and businesses. Staff spoke of the need to invest in their community hospitals, and recognised the generosity of Leagues of Hospital Friends and local voluntary groups who support the hospital services. Clearly, the use of digital technology transformed the way that staff worked. Staff made reference to the opening up of systems in which to share clinical information across the local economy for the first time. Many apps were referred to, and the increase in online training and development. Staff spoke mainly of the challenge of keeping patients connected with their families through digital technology. The provision of iPads and tablets (often through the League of Friends) meant that patients could communicate with families remotely. Staff needed to be well versed in the new technologies. Staff gave moving accounts of how this communication may have been the only connections between dying patients and their families, and how much it meant to those involved to be able to hear voices and special music.

→ STAFF HEALTH AND WELLBEING

Staff health and wellbeing became of increasing concern, as staff were working under great pressure, often in full PPE, and working long hours with very sick patients. Staff spoke of the number of deaths witnessed early in the pandemic. They also spoke of their worries for their own families and managing illnesses. Community hospitals created sanctuaries for staff (wobble rooms or garden areas) where they could go to take time out, and this feature was mentioned often by staff as a valuable way of managing the stresses of the situation. Organisations offered psychological help, and there were local initiatives to try and raise spirits. The need to support staff continues. There has been particular attention on training and development, as staff have had to adapt and learn new skills in some circumstances. There is an increase in staff being supported to become Advanced Clinical Practitioners with a recognition of how much can be offered within a community hospital setting.

6 CONCLUSIONS

6

CONCLUSIONS

This has been an ambitious project to capture the experiences of staff working in UK community hospitals during the pandemic with a focus on positive impact changes. It is a project that has involved 85 staff who were interviewed and 35 people who were involved in the management and delivery of the project. This included our project team, committee and advisory group members. So in total 120 people gave their time to this project. This really has been a collective effort.

We had the support of the Q Community and Q Exchange at all times which was invaluable. We also have our Q Community Hospital Special Interest Group with currently 38 members (as of 16th September 2022) and growing.

Those working in community hospitals have shared their stories openly in moving accounts that describe how they delivered care and support to patients and families in the context of the fear and anxiety of the pandemic. Our ongoing discussions with staff as we have developed their case studies with them have shown that many positive changes are being sustained and further developed as the learning has informed on-going quality improvement.

We have tried to capture in this report the achievements of staff, and tried to do justice to the stories that they have told us. Staff shared with us many inspirational examples of how they provided vital, flexible, responsive and resilient services during the pandemic. They describe a strengthening of relationships with organisations in the health and care system and provide examples of more integrated care. Staff themselves saw many benefits including having the freedom to be creative in their responses; and patients benefited from compassionate care. We have used these examples to develop case studies to share with the community.

WHAT WE DID

85	20	31
PRACTITIONERS	ORGANISATIONS	CASE STUDIES
85 staff interviewed using appreciative inquiry	20 organisations took part representing 168 community hospitals	31 case studies selected and developed

Despite the emotional challenges, the uncertainty and the fear staff were still able to see opportunities for innovation and were able to draw on their experience, skills and knowledge to drive change through. This resilience was striking. The interviews themselves creating time and space for staff to reflect and appreciate their contribution to the COVID-19 response and many staff expressed their appreciation for having time to talk about their experiences and their achievements during this exceptionally difficult time in health care.

We have designed a dissemination programme, and aim to optimise the impact of this project through a variety of activities including sharing outputs on our website and social media, speaking at conferences and publishing papers. We plan to continue our Special Interest Group discussion forums, to give staff a chance to talk about the initiatives featured in this report and consider their wider applicability and impact.

We hope that this project illuminates the contribution that community hospitals continue to make to the health and wellbeing of their local communities.

> ***Community hospitals are brimming with expertise often untapped! The pandemic demonstrated the true place for them as a major team player in community care provision. Let's be brave in the development of these wonderful places. Let's get it absolutely right for our communities.***
>
> NURSE CONSULTANT

APPENDICES

APPENDICES

Appendix A

PROJECT TEAM, PROJECT BOARD & ADVISORY GROUP

The Project Team

EVELYN PRODGER

Project Lead
CHA QI Lead
CHA Chair (from May 2022)

TRISH JAY

Project Manager
CHA Committee Member

DR DAVID SEAMARK

CHA Vice President

DR HELEN TUCKER

CHA President

DR EMMA GIBBARD

CHA Associate Member
Q Connector

CHA Q Study Project Board

Chris Humphris	Chair (retired May 2022)
Suzanne Jones	Director (retired July 2021)
Richard Hallett	Director and Treasurer
Tom Brooks	Lead for Wales
Alastair Noble	Lead for Scotland
Shauna Fanin	Lead for Northern Ireland
Katie Scott	Lead from Community
Kirsty Protherough	Director (May 2022 to date)
Roy Sharma	committee
Liz Fenton	committee
Jan Marriott	committee
Helen Rowe	committee
Evelyn Prodger	Chair (May 2022 to date)
Trish Jay	committee
David Seamark	Director
Helen Tucker	President

CHA Advisory Group

→ CORE MEMBERS

Heather Penwarden BEM RMN, Dip CBT [retired]
Chair of the Advisory Group

- Honiton Hospital & Community League of Friends – Chair 2012 to 2022
- Dementia Friendly Honiton QAVS – Chair
- Public Governor – Royal Devon University Healthcare NHS Foundation Trust

Professor Anne Hendry

- Senior Associate, International Foundation for Integrated Care (IFIC);
- Director, IFIC Scotland, Deputy Honorary Secretary, British Geriatrics Society

Professor Catherine Evans

- Professor of Palliative Care and Honorary Nurse Consultant, Sussex Community Foundation Trust and King's College London, Cicely Saunders Institute of Palliative Care, Rehabilitation and Policy

Professor Geoff Meads

- Emeritus Professor of Wellbeing Research at the University of Winchester

Debbie Hibbert

- Associate Director, NHS Benchmarking Network

Matthew Davies

- Programme Manager, NHS Benchmarking Network

→ CHA COMMITTEE

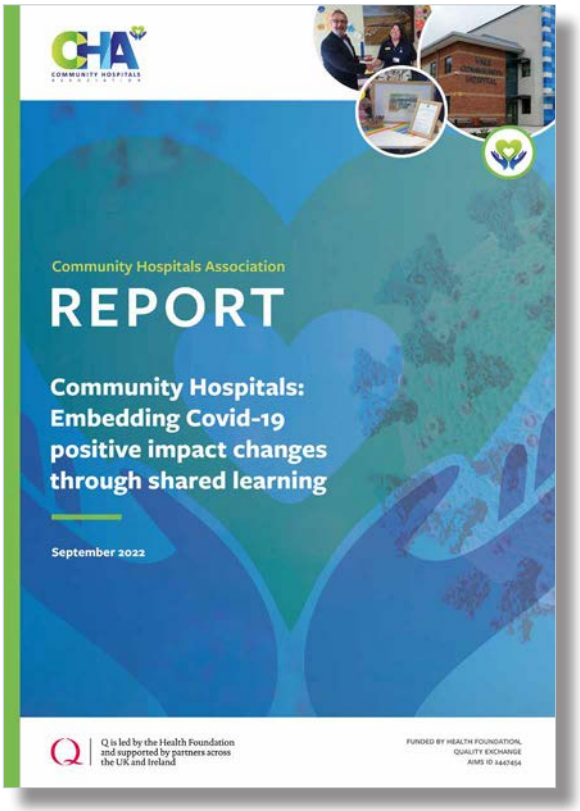
Katie Scott	CHA Lead for Community and Patient Voice
Tom Brooks	CHA Lead for Wales
Alastair Noble	CHA Lead for Scotland
Shauna Fannin	CHA Lead for Northern Ireland

→ PROJECT GROUP MEMBERS

Evelyn Prodger	Project Lead
Trish Jay	Project Manager
Helen Tucker	Project Team member

Professional Advisors

Roy Lilley	Patron CHA
Angela Ellis Pain	Research Fellow University of Birmingham
Emma Adams	Generation Q Fellow and Independent Quality Improvement Consultant
Ann Keen RN NDN FQNI FAAN FRCN	Nursing Advisor Sir Kier Starmer Leader of HM Opposition



Appendix B

PARTICIPATING ORGANISATIONS

20 ORGANISATIONS

PROVIDING COMMUNITY HOSPITAL SERVICES PARTICIPATED IN THE STUDY

BETWEEN THEM THEY MANAGE

168 COMMUNITY HOSPITALS

ACROSS THE UK

NO.	PROVIDER TITLE	PROVIDER LINK
	Northern Ireland	
1	Northern Health and Social Care Trust	www.northerntrust.hscni.net
	England	
2	Birmingham Community Healthcare NHS Trust	www.bhamcommunity.nhs.uk
3	Cornwall Partnership NHS Foundation Trust	www.cornwallft.nhs.uk
4	Derbyshire Community Health Services NHS Foundation Trust	www.dchs.nhs.uk
5	Gloucestershire Health and Care NHS Foundation Trust	www.ghc.nhs.uk
6	Herefordshire & Worcestershire Health and Care NHS Foundation Trust	www.hacw.nhs.uk
7	Hounslow & Richmond Community Healthcare NHS Trust	www.hrch.nhs.uk
8	Lincolnshire Community Health Services NHS Trust	www.lincolnshirecommunityhealth-services.nhs.uk
9	Northumbria Healthcare NHS Foundation Trust	www.northumbria.nhs.uk
10	Oxford Health NHS Foundation Trust	www.oxfordhealth.nhs.uk
11	Somerset NHS Foundation Trust	www.somersetft.nhs.uk
12	Southern Health NHS Foundation Trust	www.southernhealth.nhs.uk
13	Sussex Community NHS Trust	www.sussexcommunity.nhs.uk
14	Tetbury Hospital Trust	www.tetburyhospital.co.uk
15	Torbay and Southern Devon NHS Foundation Trust	www.torbayandsouthdevon.nhs.uk
	Scotland	
16	Highland Health Board	www.nhshighland.scot.nhs.uk
17	Lanarkshire Health Board	www.nhslanarkshire.scot.nhs.uk
	Wales	
18	Betsi Cadwaladr University Health Board	bcuhb.nhs.wales
19	Cwm Taf University Health Board	cwmtafmorgannwg.wales
20	Hywel Dda University Health Board	hduhb.nhs.wales

Table 4: Participating Organisations in the CHA Q Project

OF THE 20 ORGANISATIONS, 13 WERE NHS TRUSTS, 5 WERE HEALTH BOARDS AND 1 WAS AN INTEGRATED HEALTH AND SOCIAL CARE TRUST. IN ADDITION, ONE OF THE ORGANISATIONS IN ENGLAND WAS AN INDEPENDENT CHARITABLE TRUST, ESTABLISHED FOR THE COMMUNITY HOSPITAL

NATION	ORGANISATION	NUMBER
Scotland	Health Board	2
Wales	Health Board	3
Northern Ireland	Health & Social Care Trust	1
England	NHS Trust	13
England	Independent Hospital Trust	1
UK	Total	20

Table 5: Participating Organisations by Country

Appendix C

CASE STUDIES

A summary of the 31 case studies by theme is shown in Table 6 below

TOPIC	CASE STUDIES	SHORT CASE STUDIES	TOTAL
Changing Practice	6	9	15
Supporting People	2	9	11
Planning and Managing Change	3	2	5
Total	11	20	31

Table 6 : Case studies by theme

11 Case Studies

NO.	ORGANISATION	CASE STUDY TOPIC	PEOPLE, PRACTICE, PLANNING
1	Northumbria Healthcare NHS Foundation Trust	Corona Voice supporting staff	People
2	Highland Health Board	Keeping our community safe	Planning
3	Southern Health NHS Foundation Trust	Advanced Practice Team	Practice
4	Northern Health and Social Care Trust	Creating a Communication Open Door	Practice
5	Cornwall Partnership NHS Foundation Trust	Enhanced Care – a new model	Practice
6	Tetbury Hospital Trust	Community Support	Planning
7	Oxford Health NHS Foundation Trust	Leadership and autonomy enabling a 7-day therapy service	Practice
8	Birmingham Community Healthcare NHS Trust	System impact of organisational innovation	Planning
9	Somerset NHS Foundation Trust	Compassionate visiting	People
10	Torbay and Southern Devon NHS Foundation Trust	Relocating Cancer Care	Practice
11	Generic	Rehabilitation services during COVID-19	Practice

Table 7: 11 Full Case Studies

20 Short Case Studies

NO.	ORGANISATION	CASE STUDY TOPIC	PEOPLE, PRACTICE, PLANNING
1	Northumbria Healthcare NHS Foundation Trust	Virtual Outpatients	Practice
2	Hounslow & Richmond Community Healthcare NHS Trust	Supporting Hospital Discharge during Reset	Practice
3	Oxford Health NHS Foundation Trust	Transformation Thursday	People
4	Cornwall Partnership NHS Foundation Trust	Hearts of care	People
5	Sussex Community NHS Trust	Virtual Home assessments	Practice
6	Lanarkshire Health Board	Community support	People
7	Gloucestershire Health and Care NHS Foundation Trust	Ice lollies for patients	Practice
8	Oxford Health NHS Foundation Trust	Cleaning to music	Practice
9	Birmingham Community Healthcare NHS Trust	Speak Happy App	People
10	Birmingham Community Healthcare NHS Trust	Writing on the Wall	People
11	Lincolnshire Community Health Services NHS Trust	Virtual Nurses Station	Practice
12	Betsi Cadwaladr University Health Board	Using Alexa in dementia care	Practice
13	Gloucestershire Health and Care NHS Foundation Trust	Knitted heart	People
14	Herefordshire & Worcestershire Health and Care NHS Foundation Trust	Advanced clinical practitioners	Practice
15	Herefordshire & Worcestershire Health and Care NHS Foundation Trust	Pre Assessment triage for MIU	Practice
16	Cwm Taf University Health Board	Transfers needing oxygen	Practice
17	Hywel Dda University Health Board	Increased GP support	People
18	Highland Health Board	Senior Team Huddles	Planning
19	Oxford Health NHS Foundation Trust	Managers as Buddies	Planning
20	Sussex Community NHS Foundation Trust	West Sussex Chat	People

Table 8: 20 Short Case Studies

Appendix D

REFLECTIONS ON OUR QUALITY IMPROVEMENT APPROACH

We applied quality improvement methodology to our project, which has helped us to reflect and learn.

In this project we have studied quality improvements within community hospitals, but we have not required organisations and staff to demonstrate the adoption of quality improvement methods. A number of Trusts spoke of their QI programmes, and how improvements were being incorporated into their programme for wider adoption. But we recognise that many of the changes were made at speed in the context of a crisis, and we therefore did not require the organisations to supply evaluations or evidence of their changes. This section of the report therefore focuses on QI as it applies to the management of the project.

The project group was committed to using quality improvement methodology as part of this project. With the support of our Q Exchange Connector, we developed a theory of change model, stakeholder mapping, and a detailed evaluation plan with metrics which reflected the project's objectives to:

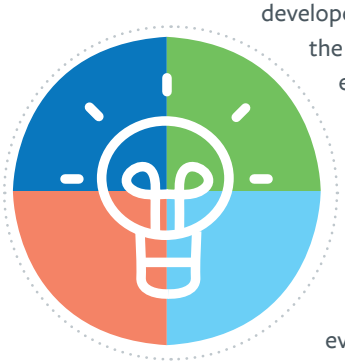
- Identify, capture and share the learning and best practice in response to COVID-19;
- Enhance and develop mechanisms to share good practice across community hospitals;
- Improve awareness and understanding of the role and contribution CH's made in response to COVID-19;
- Grow CHA members, network and reputation (and Q community).

Our evaluation focus helped us to review, adapt, modify and learn. We designed a template for project reporting was developed so that progress against milestones was readily identifiable and consistent, In February 2022, when a formal review of the project was required by the Q Exchange we reviewed the key project interventions and concluded that:

- **PROJECT STRUCTURE:** our governance structure, lessons learnt log and risk register were all helpful, providing a clear governance and learning framework with reporting and budgetary expenditure to the CHA Directors and Committee and the Q Exchange, as well as independent feedback from a project Advisory Group.
- **DATA COLLECTION AND ANALYSIS:** Despite initially acknowledging that a lack of engagement could be a significant risk, the data collection exceeded the project group's expectations in terms of the depth and breadth of information gathered. The enthusiasm of community hospital staff and their organisations to participate has been remarkable given the service pressures, reinforcing the initial suggestion that CHs are often fragmented and do not have the opportunity to share their learning with other community hospitals.

The thematic analysis of all interviews was completed which then led to the selection of 11 full case studies and 20 short case studies which have been agreed with the relevant organisations prior to dissemination which commenced in April 2022.

- **DISSEMINATION:** The project has regularly shared information on social media and at each organisational interview, promoting the sharing of learning across community hospitals and we are delighted in the feedback we are receiving on the case studies shared to date. The project stakeholder mapping was a key exercise which commenced in April 2021 has been built upon over the past 9 months enabling clarity on who to share the learning with and in which format.



Learning

The early evaluation focus in the project enabled clarity on the outcomes, with regular reviews using PDSA cycles on specific interventions. The learning log has over 80 specific lessons learnt which have been themed into:

- **Project planning and processes**
- **Project scope**
- **Project Group**
- **Quality improvement approach**
- **Network and stakeholders**
- **Community Hospital staff engagement**
- **Working with researchers**
- **Q Exchange support**

These demonstrate how the project group have reflected at each project meeting on how things are progressing, what lessons have learnt and what needed to be changed and adapted following the application of PDSA cycles in keeping with the IHI methodology. They are a dynamic reflection of the project.

The project stakeholder mapping was a key exercise which commenced in April 2021 has been built upon over the past 9 months enabling clarity on who to share the learning with and in which format.

Project Evaluation and measures

The Project Group worked with its Q Exchange Connector on a Theory of Change Jam Board, stakeholder mapping and a set of metrics for evaluation of this project. This was developed into a specific Evaluation Framework with the agreed metrics monitored 3 monthly. The evaluation has been formative in nature using a mixed methods approach. The approach utilised existing monitoring data and documentation, building in specific data collection tools such as surveys and interviews to capture the outcomes of this work.

The evaluation has been internal/self-evaluation focusing on the delivery of the project to understand whether the project:

a) progressed as planned, what worked, what lessons were learnt along the way including what needed to be improved or adjusted to achieve our objectives

b) manage to identify and capture the learning and best practice in response to COVID-19

c) enhanced existing mechanisms and develop new mechanisms to share these innovations and good practice across community hospitals

d) improved awareness and understanding of the role and contribution CH's made in response to COVID-19

e) lead to a growth in CHA members, its network and reputation and the Q community

This evaluation enabled us to provide an informed report to Q Exchange demonstrating that the project had achieved its aims, delivered the agreed outputs, and had been managed to time and budget. The report to Q was well received and has been signed off.

The project has shown the variety of roles that community hospitals played during the pandemic, illustrating the speed and flexibility of adapting to rapidly changing needs. Staff reported that the role and contribution of community hospitals is now more fully understood and appreciated within their local health and care system, and that relationships have been strengthened with more open data sharing and intensive collaborative working.

The project itself provided vital learning about the critical importance of robust governance and a clear project management system. We also learnt to recognise when the project needed to change and evolve, within a clear structure. We benefited considerably from the many people involved in managing the project, including Q Exchange, Q CH Special Interest Group members, the Project Board and the Project Advisory Group.

Appendix E

SCOPE, LIMITATIONS AND FURTHER RESEARCH

The experience of COVID-19 for all involved has been harrowing. The global pandemic had immediate and far reaching effects, and continues to do so. When we designed this project, we were working on the assumption that the staff would be able to reflect on their experiences during the pandemic as a past event. The pandemic was formally declared in the early months of 2020 and in spite of a vaccination programme and COVID-19 restrictions, coronavirus is still present. So rather than reflect on a time-limited crisis, staff have been reflecting on their responses and experiences in the first waves of the pandemic, and continue to face challenges for themselves and their services as we continue to talk to them. Our project design and delivery has evolved and adapted accordingly.

We were pleased to have such a high level of engagement from organisations managing community hospitals, and were very pleased that so many staff volunteered to talk to us. We know the pressures on the staff and the service, and that creating time to be involved in interviews is not something to be taken lightly.

The project was designed as a quality improvement project, rather than a formal research study. The project has however been designed to be a robust project, where care has been taken to work methodically and in a way that is auditable. We have had a clear project management system and explicit project governance. The project has not been linked to any academic institution. However, the Advisory Group members include some very reputable and talented academics, who have shared their thoughts and made suggestions to ensure the project optimises its potential.

As a project team we talked to organisations about how best to help staff during this process recognising how emotional it would be, and wanting to ensure that there was support. We had an understanding that those involved could stop engaging at any time. The Advisory Group also offered support to the project team and support staff, recognising that staff would be sharing some of the very dark times they had that may have prompted or led to their changes in practice.

One of the perceived limitations of the study may be that we adopted an Appreciative Inquiry approach, which meant that we encouraged staff to focus on strengths and positives. It may be argued that by only focusing on case studies that demonstrate quality improvements and innova-

tions, we are only sharing part of the picture. We cknowledge that this may be viewed as a limitation, and there may be scope for further research that explores the staff experience in a more rounded way. However, we were explicit about the focus for our project, and believe that the focus on what has been learnt through the pandemic about service improvements has a high value and needs to be shared.

We identified at the start of the project that there was little information or recognition of the contribution of community hospitals during COVID-19. We focused on community hospitals and their staff. We recognise that community hospitals are typically integrated with local services such as GPs and primary care as well as community services and local social care services. A limitation of the study may be that we looked at community hospitals in isolation from other local health and care services, but we hope that we have reflected in the project the many connections that community hospitals have. There is scope for a wider study looking at local health and care systems, and how they worked together during COVID-19.

We chose to speak to staff by way of identifying quality improvements. We acknowledge the major role of volunteers in community hospitals and notes that volunteer roles were suspended in hospitals during the pandemic. We did not approach Leagues of Friends or other local voluntary groups concerned with their community hospitals, but recognise that this could be a rich line of inquiry for further research.

Many of the improvements identified in the case studies describe improvements for patients. We would recommend that a further study be carried out to explore more fully the experience of patients and the impact of these changes in practice. We heard from staff about their perceptions of benefits to patients, which has been very helpful. We would welcome a study that gives patients a voice.

Finally, we acknowledge that the CHA is an association to promote community hospitals, and therefore there may be an issue of bias in this project. We hope that we have given a fair hearing to staff who have spoken to us, listened carefully and recorded, analysed and interpreted the findings in a robust way. We are pleased to have had the opportunity to draw attention to the excellent services offered in community hospitals throughout the UK, and trust that this report will help inform ongoing quality improvements.

Appendix F

DISSEMINATION PLAN

THE CHA PROJECT TEAM HAS DEVELOPED A DISSEMINATION PLAN FOR THE FINDINGS OF THIS STUDY

Aims and Objectives

These are set out below to illustrate the scope and ambition of the plan.

→ AIMS

The overarching aims of the dissemination plan are to:

- Share the learning of community hospitals innovation and practice during COVID-19 across UK community hospitals and other stakeholders
- Promote the value and contribution of community hospitals as part of the health and social care system, and raise their profile
- Share the learning of implementing a quality improvement project with the Q Exchange and Q members

→ OBJECTIVES

Our communication objectives are to:

- Share the detailed Project Report and case studies with identified partners and stakeholders
- Promote the learning (in various formats) over social media
- Promote innovation and excellence through case studies that are awarded CHA Innovations and Best Practice Awards
- Share the Quality Improvement Learning Report with the Q Exchange and the CHA Committee
- Use other communication platforms, presenting at regional, national and international health and social care events
- Promote the Community Hospitals Association and the Health Foundation's Q Exchange

CONTENT OF DISSEMINATION PLAN

- Aims
- Objectives
- Stakeholders identified
- Key Messages
- Dissemination Channels and Methods
- Stakeholder Matrix – targeted dissemination
- Communication Channels
- Timetable
- Ongoing Actions

Appendix G

DIARY OF A PROJECT HIGHLIGHTS

Summary of Project Diary by Evelyn Prodger

ONE YEAR OF THE PROJECT: APRIL 2021 – APRIL 2022

Monthly updates on the project have been shared in full on the Q CHA Special Interest Group for Community Hospitals Website

This is a summary of the project leaders observations and some key milestones reported each month.
A full account is available on the CHA website.

APRIL 2021

Key Milestones:

- Launch meeting with other award winners
- Project governance designed
- Advertised for researchers
- Special Interest Group for Community Hospitals set up

> *QI is such a good approach to sharing, learning and developing and sits neatly alongside the innovation and best practice values of the CHA*

MAY 2021

Key Milestones:

- Approached 10 organisations and all agreed
- Pilot interview and adapted

> *We thought we were excited when we were awarded funding but as the weeks go by and the engagement and enthusiasm of participants and the project group grows we feel so privileged to be able to do this piece of work, ensure Community Hospitals are heard and the work they do valued and shared*

JUNE 2021

Key Milestones:

- Appointed Researchers
- Carried out first interviews
- Identified first potential case study
- Progressing Evaluation and Dissemination Strategies

> *As volunteers within the CHA I think it is fair to say that we had underestimated the amount of work we needed to do but with each step we are gaining new skills and knowledge, learning more about all things QI and forging new relationships while continuing to be inspired by the work done in Community Hospitals*

JULY 2021

Key Milestones:

- Evaluation Workshop – focus on outputs, stakeholders and metrics
- Adding to Learning Log and Risk Log
- Continuing to share the project on Social Media
- Some rescheduling due to COVID-19 and pressures on hospitals

> *As a Project Group we are learning lots about each other and developing new skills and knowledge. We remain as enthusiastic as ever and feel more privileged than ever to be able to take this project forward*

AUG 2021

Key Milestones:

- Heather Penwarden, Community champion, Chairs the Project Advisory Group
- We valued Emma Adams (Generation Q Fellow) contributions to our meeting
- We have learnt more about the IHI Model for Improvement & Appreciative Inquiry

> *The enthusiasm for the project continues – what can we say – Community Hospitals are simply fantastic*

SEPT 2021

Key Milestones:

- Our Q Milestone Report shows good progress against targets (on SIG page)
- Achieved good engagement from organisations and community hospitals

> *As the project has progressed, the Project Team have determined the importance of sharing the learning, as community hospitals have been very enthusiastic to engage and share their experiences and learning*

OCT 2021

Key Milestones:

- Interview schedule being concluded
- Themes being developed
- Appreciate good feedback from Q on our September Milestone Report
- Q Action Learning Set attended by team member
- Learning and Risk Logs continue to be valuable resources

> *Despite the time required we are all so enthusiastic about the work, are coming away with more knowledge and skills than we had when we started and are really excited to be getting to the stage of extracting and sharing the learning. Thanks QExchange for giving us this opportunity*

NOV 2021

Key Milestones:

- Refining List of Case studies and short case studies
- Project governance and quality assurance processes proving to be robust
- Recognise need to rebrand CHA ready for dissemination

> *The work to develop the themes is now well underway and it is humbling to see the breadth and depth of work that Community Hospitals have done and continue to do. Distilling quotes from the interviews has reminded us of the power of storytelling and narrative.*
>
> *We are really impressed with the range of support Q Exchange has provided while allowing us the freedom to develop the project – PDSA cycles in action!*

DEC 2021

Key Milestones:

- Selected final case studies
- Advisory Group proving very valuable – theoretical frameworks etc.
- Refining communication and dissemination strategy

> *Listening back to the interviews and reading the notes I think we all feel in awe of the staff working in Community Hospitals across the United Kingdom for their commitment to patients, their communities and the needs of the wider health and care system*

JAN 2022

Key Milestones:

- Recognition pressures of COVID-19 Omicrom variant on NHS currently
- Reviewed impact of CHA carrying out the study including increased connections
- CHA has new committee members and more followers on social media

> *The innovation, creativity, strength and resilience of Community Hospital Teams deserves to be recognised and appreciated. As a Project Group we remain as busy as ever and just as motivated to ensure that we shine a light on the work that has been and continues to be done in Community Hospitals*

FEB 2022

Key Milestones:

- Report to Q complete showing project delivered using SQUIRE format in 3 pages
- Graphic designer starting on our case study templates
- Ann Keen joined as Professional Advisor
- SIG discussion group held, with presentations of case studies

> *"This month's Project Group meeting felt a little different. The work is moving into a different phase and it is exciting to be starting to share the outputs. Next month we will be discussing an end of project reflection for the Project Group – we think this would be a great way to close the learning loop*

APRIL 2022

Key Milestones:

- Programme of case studies sign off and being shared on CHA website
- Article for submission to BMJ Open Quality
- Poster prepared for ICIC22 in Denmark
- Final Report being written, capturing the learning and sharing

> *"Time to get everything done remains a challenge but seeing the outcomes of the project emerge is bringing excitement, joy, pride and a sense of "we did this!"*

MARCH 2022

Key Milestones:

- Website live – refreshed and updated
- Abstract accepted for Presentation to ICIC22 Conference in Denmark
- Excellent feedback from participants on SIG discussion – "inspirational"

> *"It has been a busy month but the joy in developing and sharing this work continues. Fundamentally, Community Hospitals are fab!*

Final Word to Participating Staff:

> *"The case studies are such a celebration of the work as a whole, they are a wonderful reminder of the importance of community hospitals and the role they played at this epic moment in time*

Appendix H

CHA COVID AWARD WINNERS 2020 – UPDATED FOR 2022

3 CHA INNOVATION AND BEST PRACTICE 2020 AWARD WINNERS – UPDATED 2022

Overview

We invited submissions for the 2020 Innovations and Best Practice Awards, and were pleased to receive a number of impressive submissions, including some examples of how community hospitals had responded during COVID-19. We had already had approaches from members in community hospitals, telling us about their experiences of COVID-19 and asking for information, resources and support from our committee and our network.

It was these three awards in particular that led us to formulate a proposal to submit to Q as an "idea" that others could comment on. The application was for a project that would systematically explore the experience of staff in community hospitals during COVID-19. This idea was posted on the Q Exchange website, and we had 27 comments in response, demonstrating a high level of interest. We were awarded funding for the project in early 2021.

The details of the awards can be viewed on our website. We view these initiatives as the driving force behind our project. They gave us the vision for a comprehensive study, where we could provide community hospital staff across the UK an opportunity to talk about their experiences. We hoped that this would enable us to capture the learning, and lead to a sharing of good practice across community hospitals and beyond.

For this report, we decided to revisit these award-winning services, and update them for this report.

Sandra Speller and her team in Sussex developed a rapid training programme in order to update staff and help support redeployed staff. A series of short videos were created as a pragmatic approach to the urgent need. These proved to be invaluable, as they provided accessible training for all concerned. Sandra wrote a blog for the CHA describing her experience entitled Let's Not Panic About Training In A Pandemic!

Julie Ellery, James Willetts and team won an award for working together effectively to swiftly re-purpose a ward for COVID-19 patients who were on end of life care. There was strong collaboration, and services continued to be adapted for changing needs.

Paula Har and Angela Conlan won an award for their work in Oxfordshire, to bring arts into the community hospitals. The initiative started in Witney Hospital, and has now extended to 6 community hospitals in the Trust.

We would like to thank these teams for their submissions, and congratulate them for their inspirational services. The submissions and the updates for 2022 can be found on our CHA website.

NO.	CHA AWARD 2020 TITLE	ORGANISATION
1	Training Multi-Professional Staff At Pace During A Pandemic	Sussex Community Foundation Trust
2	Staff Support through the Repurposing of Tewkesbury Hospitals' Abbey View Ward	Gloucestershire Health and Care NHS Foundation Trust
3	Creating with Care, an arts-based activities programme	Oxford Health NHS Foundation Trust

Table 9: 3 CHA Innovations and Best Practice Award winners 2020

1 Training Multi-Professional Staff at pace during a Pandemic

This initiative was concerned with training multi-professional staff at pace during a pandemic to deliver a competent and confident redeployed work-force for our community hospitals.

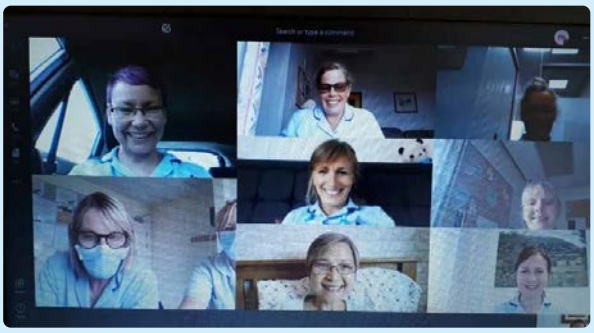
At Sussex Community Foundation Trust (SCFT) we developed a speedy process to enable staff that were being redeployed to support patient care needs and therapy programmes on our community wards to develop their knowledge and essential skills in the key areas required.

The aim was to ensure they could:

- Identify the knowledge and skills they needed to learn or review, by completing a self-assessment tool.
- Watch a range of over 20 "bite-size" videos developed by our therapy clinical skills facilitators which covered the basics of a range of tasks, including washing, dressing, toileting as well as respiratory care, transfers, patient handling using a range of equipment and supporting mobility with or without aids.
- Access 3 weeks of daily virtual sessions so they could ask questions and see further demonstrations on the full range of topics.
- Access further resources and learning, as well as revisit the videos as and when needed by developing a dedicated area on our Trust intranet.

The short training videos were quickly created by local staff, and signed off for content and quality. The process showed that this very practical and pragmatic response to urgent training needs worked well, and made training accessible to all.

This approach received excellent staff engagement and feedback, with 94% of those who responded to the survey sent reporting the training increased their level of knowledge and understanding, and **71% felt more confident in their ability to deliver clinical care** – all before they were asked to start working in a new environment. Obviously, there was further training and support offered once they were redeployed.



The videos made have continued to be used to support staff and the same approach (video and resources for self-learning, followed by virtual Q&A sessions has since be utilized to deliver our band 4 training programme for our community hospital therapy practitioners.

In addition, staff were able to record their learning with our Training team when completed; this will enable the Trust to easily identify staff with the competencies required should we need to redeploy staff again over the winter period.

CONTACT:

Sandra Speller

ASSOCIATE DIRECTOR FOR ALLIED HEALTH PROFESSIONALS

SUSSEX COMMUNITY NHS FOUNDATION TRUST

2 Staff Support through the Repurposing of Tewkesbury Hospitals' Abbey View Ward

In preparation for altering the focus of Tewkesbury Hospitals' Abbeyview ward in to a Covid End of Life care unit staff embarked on a substantial transformation project. This was to take place over the course of one week and would require hospital staff to provide a model of care they were unaccustomed to, in an environment most were unfamiliar with, working to processes and procedures that were both untested and under constant review and change.

This extensive program of change was supported by multidisciplinary staff from all departments within the hospital as well as from colleagues from other community hospitals. The programme was backed by corporate services and senior management, including a herculean effort by the Estates team to ensure we were well prepared for the environmental challenges anticipated.

Initially, the repurposing of the hospital was to provide End of Life Care to patients positive with COVID-19. Over the following weeks this change of role was modified to include caring for patients requiring ehabilitation to meet the needs of the local population and to support our healthcare partners across Gloucestershire.

CONTACT:

Julie Ellery – MATRON
James Willetts – OPERATING THEATRE MANAGER

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

3 Creating with Care, an arts-based activities programme

The Creating with Care programme provides patients with access to arts-based activities in hospital. The arts-based activities have given patients not just meaningful activity but an opportunity to be seen, to be heard and for someone to listen and feel valued.

The programme has included dance, mime, film, music, visual arts, crafts, cabaret, photography, exhibitions, museum and heritage visits. Wellbeing has been enhanced through a programme of activities for staff, patients and their families.

The project demonstrated the important role arts have in healthcare settings in promoting wellbeing for patients, visitors and staff alike while enhancing hospital environments. The expansion to cover six community hospitals in 2019 ensured a greater opportunity for patient and staff engagement in a varied range of activities. The core value of inclusiveness is demonstrated through the engagement and multi generational activities that have been developed. The project has forged stronger community links into the hospital settings, and this is on-going and becoming stronger all the time. The expansion of Creating With Care continues, and has attracted considerable community and business funding, and has been recognised through local, regional and national awards.

CONTACT:

Paula Har & Angela Conlan

OXFORD HEALTH NHS FOUNDATION TRUST

Throughout the pandemic Creating with Care has continued to be innovative in its delivery across Oxfordshire's Community Hospitals.

For example:

- Holding art and poetry workshops, concerts and dance performances for patients and staff in the gardens of our community hospitals.
- Virtual arts sessions with professional artists and musicians for patients.
- Art carts with individual activities for each ward.
- Virtual staff sessions as part of the trusts "Connect and Care for You" programme run by Oxford Health Charity, including dance, origami and pottery.
- A mural at Witney Community Hospital in the staff room co-designed with staff – with the aim of enhancing mood.
- A photobook created with staff on one ward documenting the past 18 months – the highs and lows.
- A mosaic project with staff to commemorate one member of staff who sadly past away during the pandemic from Covid.
- An Artist Residency with 6 Professional Artists now working across our community Hospitals.

Appendix I

PROJECT PUBLICATIONS

Q Exchange Project Idea, Comments and Updates

Q Community Hospital Special Interest Group
Report against milestones September 2021

Q Exchange Report – February 2022
'Community Hospitals: Embedding Covid-19 positive impact changes through shared learning'

ICIC22 Paper for International Foundation of Integrated Care Conference in Denmark
Session 221 May 24th 2022

ICIC22 Poster for International Foundation of Integrated Care Conference in Denmark
Session 221 May 24th 2022

Seamark, D., Prodger, E., Jay, T., Tucker,H. 2022
The response of United Kingdom Community Hospitals to the Covid-19 Pandemic: an Appreciative Inquiry
BMJ Open Quality (*in press*)

Diary of a Project by Evelyn Prodger, Project Lead

Blog on Evaluation by Trish Jay

Q CHA Special Interest Group on Community Hospitals Discussion Group – SIG Discussion Group on Case Studies on 14 July 2022
Discussion and Presentation slides are on the Q website

CHA Strategic Brief – applying the learning from the CHA Q Report on the contribution of community hospitals during COVID-19

Appendix J

GLOSSARY OF TERMS

TERM	ABBREVIATION	DESCRIPTION
Advanced Clinical Practitioners	ACP	Advanced clinical practitioners come from a range of professional backgrounds such as nursing, pharmacy, paramedics and occupational therapy. They are healthcare professionals educated to Master's level and have developed the skills and knowledge to allow them to take on expanded roles and scope of practice caring for patients.
Allied Health Professionals	AHP	There are 14 AHPs includng physiotherapists, occupational therapists and speech & language therapists.
Appreciative Inquiry	AI	AI is about the search for the best in people, their organizations, and the strengths-filled, opportunity-rich world around them.
Case Study		Allows an investigation to retain the holistic and meaningful characteristics of real life events.
Community Hospital	CH	Community Hospitals are small local hospitals that provide a range of services to their local community.
Community Hospital Association	CHA	The national voice for Community Hospitals in the UK. A membership organisation.
Coronavirus disease	COVID-19	Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus.
End of Life Care		End of life care involves treatment, care and support for people who are thought to be in the last year of life.
Health Foundation		An independent charity committed to bringing about better health and health care for people in the UK.
Infection Prevention Control Team	IPCT	A specialist multidisciplinary team providing practical, clinical advice to staff and service users on IPC issues.
Institute of Healthcare Improvement	IHI	Our mission: Improve health and health care worldwide. We use and teach practical quality improvement methods to enable sustainable changes in health and health care.
Intermediate Care		Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital.

TERM	ABBREVIATION	DESCRIPTION
Multidisciplinary Team	MDT	A multidisciplinary team (MDT) is a group of health and care staff who are members of different organisations and professions that work together to make decisions regarding the treatment of individual patients and service users.
NHS Benchmarking Network	NHSBN	The Benchworking network is the inhouse benchmarking service of the NHS.
Palliative Care		Palliative care offers physical, emotional and practical support to people with a terminal illness.
Personal Protective Equipment	PPE	Equipment an individual wears to protect themselves from risks to their health or safety, including exposure to infection agents.
Plan, Do, Study Act	PDSA	The PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).
Purposive Sampling		Purposive sampling is a sampling technique in which researcher relies on his or her own judgment when choosing a sample.
Q Community	Q	A connected community working together to improve health and care quality across the UK and Ireland.
Q Exchange		Funding – Activating ideas together through Q's funding programme.
Quality Improvement	QI	It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement.
Stratified Sampling		Stratified sampling is used to select a sample that is representative of different groups.In a stratified sample, researchers divide a population into homogeneous subpopulations called strata (the plural of stratum) based on specific characteristics.
The Academy of NHS Fabulous stuff	Fabstuff	A social movement for sharing Health & Social Care Ideas, services and solutions that work.

Appendix H

REFERENCES

1. Community Hospitals Association website http://www.communityhospitals.org.uk/what-are-community-hospitals.html#resources personal communication Accessed 23rd March 2022

2. Davidson D, Paine AE, Glasby J, Williams I, Tucker H, Crilly T, et al. Analysis of the profile, characteristics, patient experience and community value of community hospitals: a multimethod study. *Health Serv Deliv Res* 2019;7(1) https://doi.org/10.3310/hsdr07010

3. Young J, Hulme C, Smith A, Buckell J, Godfrey M, Holditch C, et al. Measuring and optimising the efficiency of community hospital inpatient care for older people: the MoCHA mixed-methods study. Health Serv Deliv Res 2020;8(1) https://doi.org/10.3310/hsdr08010

4. Pitchforth E, Nolte E, Corbett J, Miani C, Winpenny E, van Teijlingen E, et al. Community hospitals and their services in the NHS: identifying transferable learning from international developments – scoping review, systematic review, country reports and case studies. Health Serv Deliv Res 2017;5(19) https://doi.org/10.3310/hsdr05190

5. Heaney D, Black C, O'Donnell CA, Stark C, van Teijlingen E. Community hospitals – the place of local service provision in a modernising NHS: an integrative thematic literature review. BMC Public Health. 2006 Dec 21;6:309. doi: 10.1186/1471-2458-6-309.

6. Tucker, H. (2013), "Discovering integrated care in community hospitals", Journal of Integrated Care, Vol. 21 No. 6, pp. 336-346. https://doi.org/10.1108/JICA-10-2013-0038

7. Seamark, D. A., Williams, S., Hall, M., Lawrence, C. J., & Gilbert, J. 1998c, "Palliative terminal cancer care in community hospitals and a hospice: a comparative study", British Journal of General Practice., vol. 48, no. 431, pp. 1312-1316.

8. Trajkovski, S., et al. (2013). "Using appreciative inquiry to transform health care." Contemporary Nurse 45(1): 95-100.

9. T. Plochg, N. S. Klazinga, Community-based integrated care: myth or must?, *International Journal for Quality in Health Care*, Volume 14, Issue 2, April 2002, Pages 91–101, https://doi.org/10.1093/oxfordjournals.intqhc.a002606

10. Health Foundation. *Quality improvement made simple*. 2013. Available from: https://www.health.org.uk/sites/default/files/QualityImprovementMadeSimple.pdf

11. Mateen et al Hospital bed capacity and usage across secondary healthcare providers in England during the first wave of the Covid-19 pandemic: a descriptive analysis. BMJ Open 2021:11(1):e042945

12. Barr-Keenan R, Fay T, Radulovic A and Shetty S. Identifying positive change within the NHS as a result of the COVID-19 pandemic Future Healthc J November 2021 DOI: https://doi.org/10.7861/fhj.2021-0079

13. Couper K, Murrells T, Sanders J et al The impact of COVID-19 on the wellbeing of the UK nursing and midwifery workforce during the first pandemic wave: A longitudinal survey study Int J Nurs Stu 2022;127:104155 https://doi.org/10.1016/j.ijnurstu.2021.104155

14. Fitzsimons J. Quality and safety in the time of Coronavirus: design better, learn faster. *International Journal for Quality in Health Care*; 2020. Available from: https://academic.oup.com/intqhc/advance-article/doi/10.1093/intqhc/mzaa051/5836318

15. NHS-Wales-COVID-19-innovation-transformation-study-report-June.pdf

16. Lewis R, Pereira P, Thorlby R, Warburton W. *Understanding and sustaining the health care service shifts accelerated by COVID-19*. The Health Foundation; 2020. Available from: https://www.health.org.uk/publications/long-reads/understanding-and-sustaining-the-health-care-service-shifts-accelerated-by-COVID-19

17. The Beneficial Changes Network https://www.england.nhs.uk/beneficial-changes-network/ Accessed 23Rd March 2022

18. Coxon, K. (2005) "Common experiences of staff working in integrated health and social care organisations: A European perspective." Journal of Integrated Care 13(2):13-21.

19. Community Hospitals Special Interest Group – Q Community Health Foundation https://q.health.org.uk/community/groups/community-hospitals

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