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Response of UK community hospitals to the COVID-19 pandemic: an appreciative inquiry

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ABSTRACT

Introduction The 500 community hospitals in the UK provide a range of services to their communities. The response of these small, mainly rural, hospitals to the COVID-19 pandemic has not yet been examined and so this study sought to address this gap.

Method Appreciative inquiry was used to understand staff perspectives of how community hospitals responded to the COVID-19 (SARS-CoV-2) pandemic. A total of 20 organisations participated, representing 168 (34%) community hospitals in the UK. Qualitative interviews were conducted, with a total of 85 staff members, using an online video platform. 30 case studies were developed from these interviews.

Results Staff described positive changes that were made in the context of the fear and uncertainty experienced in the pandemic. Quality improvements were reported in a wide range of services and models of care such as the use of the inpatient beds, and the access and management of urgent care services. Rapid changes were made in the way that services were managed, such as communications and leadership. Programmes of accelerated training were offered for existing and redeployed staff. Attention to staff health and well-being was a feature and there were a variety of innovations designed to support patients and their families. The impact of the changes was viewed as strengthening of integrated working between staff and sectors, the ability to rapidly innovate and improve quality, and the scope to use local decision-making to make changes.

Conclusion Staff of community hospitals described innovative and rapid quality improvements in their community hospitals in response to the pandemic. The case studies illustrated the features of community hospitals, showing that they can be resilient, flexible, responsive, creative, compassionate and integrated. The case studies of quality improvements are being used to encourage sharing and learning across community hospitals and beyond.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Community hospitals have been characterised as local community-based services that can be responsive to local need. Research into the effectiveness of community hospitals is limited.

WHAT THIS STUDY ADDS

⇒ The UK community hospitals responded to the COVID-19 pandemic in a rapid and flexible manner with individual innovation, quality improvements and enhanced integrated working. This study has developed 30 case studies of innovations and best practice in response to COVID-19.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ The study has identified a number of best practice and innovations that can be shared across community hospitals to help improve practice and inform decision-making. Case studies alongside the main findings and learning from this study are being disseminated throughout the community hospital sector through individual feedback, Community Hospitals Association presentation of case studies and a Q Community Special Interest Group.

INTRODUCTION

Community hospitals are small local hospitals that are typically rural and provide mainly nurse-led services. There are around 500 such hospitals in the UK,[1] and they have a long tradition of care. Research into community hospitals has been limited but in the past 5 years, three important studies have added to the literature, providing new evidence on value,[2] efficiency[3] and international developments.[4] Community hospitals have previously been characterised as local community-based services that can be flexible to local need, providing a model of care that has been described in terms such as: holistic, person-centred, generalist, intermediate care and integrated care.[5] Rehabilitation and palliative care are key features of the service, although the services have been described as 'cradle to grave' and include many urgent care, ambulatory, diagnostic and treatment services.[6 7] There are around 117 provider organisations that run the UK community hospitals; these include standalone community trusts, acute hospital trusts, social enterprises and charities (Community Hospitals Association (CHA) Database).

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The COVID-19 pandemic created huge turbulence in the National Health Service (NHS) of the UK. The response of community hospitals has not yet been documented in a systematic manner. This study attempts to provide an overview of innovations, quality improvements and best practice in community hospitals in response to the pandemic.

METHOD

The study was designed to capture the experiences and perceptions of staff in community hospitals regarding quality improvements during COVID-19. The method adopted was appreciative inquiry (AI) in order to focus on initiatives and good practice that were adopted during the pandemic. AI was chosen as it makes a conscious choice to study the best of an organisation using a whole system approach, focusing on strengths and fostering a positive dialogue.[8]

The SQUIRE (Standards for Quality Improvement Reporting Excellence) checklist was adopted for the methodology and reporting.[9] The SQUIRE guidelines provide a framework for reporting new knowledge about how to improve healthcare and were deemed appropriate for this project that was focused on improvements on the quality healthcare.

Using a purposive stratified sampling method, organisations with community hospitals were selected based on geography, type of provider organisation, number and location (rural, semirural and urban) of community hospitals. Recruitment to the study was via chief executive officers who were approached asking for their permission for their organisation to participate in the study. The interviews were conducted by the project team online using a video platform (Zoom or Microsoft Teams). Interviews were recorded, and extensive field notes were taken along with verbatim quotes which were subsequently verified from the recordings. Most interviews conducted had more than one participant and they were from a variety of disciplines including nursing, allied health professionals, medicine, social work and management. The semistructured interview schedule was designed by the project team, trialled with community hospital colleagues and modified in light of the findings from the first few interviews. The three themes of the interview were: Practice, People and Planning. Practice changes included changes to services, care delivery and models of care. People was a theme that included staff, volunteers, community groups, patients, carers and families. Planning was a theme that covered planning, management and commissioning.

Data were collected from interviews with 20 organisations (n=20) which was 17% of providers of community hospitals in the UK. The 20 provider organisations manage a total of 168 community hospitals, which is broadly one-third of all community hospitals in the UK. Organisations were coded numerically and according to country: England (E), Scotland (S), Wales (W) and Northern Ireland (NI). In all, 85 community hospital staff members participated in the interviews. Up to three interviews per organisation were conducted to provide more detail and clarification, arranged so that staff could contribute in small groups. All four countries of the UK were represented in the sample and organisations included community trusts, acute trusts, a social enterprise and a charity. Twenty-four organisations (21%) approached did not participate, and those that declined stated that this was primarily for reasons of capacity, time pressure and staff absence.

Of the 85 staff members who took part, 61% of those were nurses. In keeping with the multidisciplinary and multiagency nature of community hospitals, there were therapists, doctors and a social worker in the interviews. The table 1 below shows the designation of staff interviewed as taken from their job titles.

The interviews were analysed by members of the project team using thematic analysis, and the findings presented in a report and highlighted with case studies.

Case studies were identified by the staff themselves as representing a significant improvement. These case studies were then developed by the research team from the interviews and signed off by the interviewees and the provider organisation. Thirty case studies in all were developed. Eleven of the case studies (shown in tables 2–4) were selected as exemplars to illustrate the range of initiatives and were written up in detail. A further 19 short case studies were written in summary to illustrate small but important changes.

Recruitment was ceased when saturation of the data was reached. In practice, this meant repetition of similar examples of best practice and innovation without generation of new examples in the interview. Quality control and verification of the findings was ensured by feeding back a summary of findings to the interview participants and asking for correction and clarification.

The governance arrangements for the study included a project team, project board (CHA committee) and a project advisory group. The advisory group was chaired by a lay person who was a community and patient champion and also chair of a League of Friends for a community hospital.

Table 1 Job titles of staff interviewed

Job title	No	%
Nurse/nurse manager	52	61
Therapist (AHP)	8	9
Social worker	1	1
Healthcare worker	1	1
GP	7	8
Medical consultant	1	1
Manager	15	18
Total	85	100

AHP, allied health professional; GP, general practitioner.

Table 2 Case studies under the theme of 'Practice'

Case study—Practice	Description
Advanced 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.
Creating a communication open door	Developing new and enhanced means of communicating with families, staff and professional colleagues to support delivery of person-centred care on a COVID-19 unit.
Enhanced care—a new model	Redesigning the model of inpatient care and expanding admission criteria to meet the needs of patients requiring enhanced care, and in particular those with associated cognitive impairment/dementia. Offering training to people who had been furloughed in order to help staff the service.
Enhanced leadership to support a move to a 7-day service	A strengthening of leadership at every level enabled a 7-day service to be offered, increasing patients' access to rehabilitation and resulting in reduced lengths of stay.
System impact of organisational innovation	To provide a safe, effective response to the pandemic through innovation and research. The pandemic challenged every member of every team to innovate to support delivery of safe, effective services.
Relocating cancer care	A cancer care unit, including an infusion unit, was relocated successfully from an acute hospital to a community hospital, offering patients who were typically immune-suppressed a local facility, thereby avoiding the secondary care facility.
Offering 7-day rehabilitation	Physiotherapists and occupational therapists were able to offer a 7-day rehabilitation service to inpatients when clinics closed in the pandemic. This impacted on the quality of care to patients and resulted in less time spent in hospital.

The group included academics and community leaders and provided a valuable forum for reflection and guidance.

Patient and public involvement

The design of the study was a focus on staff views and experiences of quality improvements during the pandemic. To ensure that patients and the local community were represented in the study and had a voice, the chair of the advisory committee is a chair of a League of Friends and representative community member. The role of the advisory group to the study proved to be very valuable, and gave another opportunity to be guided by those representing patients and communities.

The CHA committee also acted as the project board. The CHA has a committee of 20 people who act in a voluntary capacity. They include a patient representative, those involved with community groups, members of League of Friends as well as practitioners, managers and researchers.

RESULTS
Responding to the pandemic

The pandemic created huge disruption, fear and uncertainty throughout the NHS and social care, and these emotions were mirrored by community hospital staff.

> It was a massive emotional journey. (E68)

> We were in a wee world of our own. The difference was 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 adrenalin and fear. (S8)

> Nothing in staff training could have prepared them for COVID-19. (NI1)

The staff reflected that they had to respond swiftly, be more agile and take more local decisions than they were used to.

> Redeployed staff, including those who were not nurses, were inducted to the environment, learning

Table 3 Case studies under the theme of 'People'

Case study—People	Description
Corona Voice—supporting staff	In a weekly trust survey, staff were able to safely and effectively raise issues, and share how they were feeling during the pandemic.
Compassionate visiting	Early planning to create safe COVID-19-secure spaces for compassionate visiting for patients at the end of life.

Table 4 Case studies under the theme of 'Planning'

Case study—Planning	Description
Keeping our community safe	Swift local decision-making and early intervention with measures to keep patients, staff and the community safe at the start of the pandemic.
Community support	Support was offered from a hospital that had to cease operations and clinics during COVID-19 but offered staff and equipment across the whole health system including ventilators. There was evidence of strong support structures for staff and volunteers. The collaborations and support across the local healthcare service further improved relationships between organisations.

about COVID-19 to date shared and buddied with a substantive staff member. All came open to helping, open to support and direction and wanting to make a positive difference. The feedback from all of them has been positive. (NI 1)

In this time the hospitals have proved the value of doing things differently and will continue to demonstrate this. (E18)

Our step-down beds have come general nursing beds to free up acute beds for COVID-19 patients. Coupled with the community engagement that we do – we are becoming a stronger player in all that. (E5)

Staff learnt through the experiences of the first wave of the pandemic, and reflected on those new ways of working which were becoming embedded.

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. (E93)

This was a relatively new concept where the whole team gathers round a board in the morning and talks about the day ahead and sharing particular challenges or opportunities or focus. The practice is now embedded and being promoted as a positive innovation. (E5)

There is more autonomy to plan now – and the changes haven't affected the service and red tape has been removed we just get on with it. There is stronger decision-making we look, improve and adapt – it adds to the quality of care. (W3)

In this time the hospitals have proved the value of doing things differently and will continue to demonstrate this. (E18)

Despite the disruption, staff frequently described a strengthening in relationships and integrated working, including multidisciplinary working and integration between the community hospital and the acute sector. There were also examples of multiagency working and joint working with communities. Many of the changes in practice and innovation were common across the sample population, but it was noticeable how many solutions were unique and tailored to the population served and the individual situation.

Practice, People and Planning
Practice
A wide range of practice and service changes were described by staff which reflected the needs of patients and the local health and care system. These included changing the way beds were used and managed, the type of clinical care offered as well as the level of clinical support, and the assessment and triage processes. Table 2 provides seven case studies illustrating changes in practice.

Staff reported changes in ward-based care such as providing flexible use of community beds, increasing bed numbers such as by opening previously closed wards, repurposing beds for patients with COVID-19, and enlarging palliative and enhanced stroke care capacity.

An increase in the clinical care offered was reported. One example was an Enhanced Care Model to extend care to inpatients with multiple conditions including dementia, supported by additional staff including people on furlough. Clinical developments that were described included new intravenous therapy services, providing 7 days a week of rehabilitation and anticoagulation monitoring.

There was also an increase in clinical support for the community hospitals. General practitioners (GPs) in many cases increased their input to the hospital and ward, and consultants gave support particularly for patients with COVID-19. There was significant improvement reported by those community hospitals where they had advanced clinical practitioners. These practitioners had achieved a masters of equivalent qualification, and had increased their skills and knowledge, which meant that they could extend their scope of practice.

Staff reported an improvement in bed management systems, and described initiatives such as the formation of a patient flow team, a standardisation of the referral processes and the allocation of a senior nurse to acute services to facilitate transfers to community hospitals.

There were changes reported for managing access to minor injuries units (MIUs) and urgent care centres (UCCs) through offering remote triage and booked face-to-face appointments, which enabled staff to manage demand. There were examples of staff moving between

MIUs/UCCs and emergency departments, according to need.

An initiative to expand a rapid assessment service with enhanced imaging capacity was considered a positive development. Staff told of new clinics and services that were developed during the pandemic such as new heart failure assessment clinics, new endoscopy and day case surgery lists, and GP clinics to assess potential patients with COVID-19.

People

One of the main themes emerging from the interviews was the staff view on improved working relationships across the local health and care system. Staff described a strengthening of existing relationships, and in particular multidisciplinary working, working arrangements with social services, additional input from social services to the multidisciplinary team (MDT) and extra support from GP and consultant colleagues. Table 3 provides two case studies illustrating changes under the theme of People.

Staff welcomed the accelerated training programmes offered, particularly for redeployed staff. These included training in clinical topics such as respiratory conditions, as well as in communication skills. Initiatives for integrating relocated staff into existing teams were successfully developed. New staff roles were created, such as PPE (personal protective equipment) champions.

Staff health and well-being was a strong theme, and measures were taken to support staff during the many challenges of the pandemic. Initiatives included psychological support and counselling from mental health colleagues, recognition and award schemes, the provision of new safe spaces ('wobble rooms') and improved access to senior staff. There were also steps taken to enable more open communication between staff and managers. The Northumbria Trust had a weekly staff survey called Corona Voice which successfully engaged staff. Examples of how the trust responded to staff feedback included offering a well-being website and staff helpline, offering free milk and free parking, and also installing handwashing facilities at the entrance of the hospitals.

There were many ways of supporting patients and families through this exceptionally difficult time, particularly when visiting was not possible. Ideas such as offering ice-lollies to patients with COVID-19 proved beneficial, particularly for those with little sense of taste and a need to improve hydration. Wards were supplied with iPads in many instances to support communication between patients and families, and others.

Staff were concerned about the isolation and mental health of patients so provided activities. In some wards, a new team was created to assist with the communication between the ward and relatives, such as a new family liaison team.

Volunteer support in clinical areas was suspended during COVID-19, although support was offered in other ways such as through donations of food, drinks, PPE and gifts for staff from local people and the League of Friends.

There are moving examples of how local communities showed their support to the hospital staff.

Planning

Arrangements needed to be put in place swiftly for planning and managing the local health and care service early in the pandemic. There are examples of sharing of resources such as staff and equipment across different organisations across the local health systems. Frequent meetings were held between all organisations concerned, with open sharing of data such as patient need, requirements for beds and equipment, and staffing capacity. This led to a reported strengthening of relationships, particularly between those in acute and community hospitals. With this greater integration came an increased recognition of community hospitals' contribution to the whole health and social care system. A feature of the new way of working was cited as local autonomy, and the ability to make changes and take action at a local level. Table 4 provides two case studies illustrating changes in planning.

Leadership and management support was offered to community hospitals in a variety of ways, with different models and arrangements being tested during the early period of the pandemic. Staff reported a higher presence and more visible support from senior managers, and also reported a greater level of local autonomy.

Staff and managers reported some flexibility in commissioning, such as providing support for services temporarily closed because of COVID-19.

DISCUSSION

The response from community hospital staff to the pandemic illustrated the agility and flexibility afforded by small, typically rural, community-based hospitals. Staff also spoke of being part of their local communities. Evidence emerged for many types and levels of integrated working, in particular the strengthening of relationships between the community hospital and acute hospital (vertical integration) and the expansion of MDT working across health and social care and the voluntary sector (horizontal integration).[10] These findings reflect previous studies that have demonstrated the community integration and flexibility of services offered by community hospitals across a number of countries.[2–4]

Comparison with other literature

Quality assurance has been defined as 'safe, effective and a good experience' for those using the service. It is defined as 'well-led, sustainable and equitable' for those providing the service.[11] The case studies illustrate the quality improvements according to these factors. Attributes of community hospitals emerged from the study, showing them to be flexible and resilient.

Previous studies have demonstrated the community integration and flexibility of services offered by community hospitals across a number of countries.[2–4] No work has yet been published describing the responses to the COVID-19 pandemic from this community-based

population of small hospitals. This study describes flexible responses in the use of community hospital beds and the expansion of bed capacity in some instances and this has been reflected throughout the whole of the NHS in England in a recent study.[12] The effect of pandemic disruption and associated stresses upon NHS staff has been widely reported with some positive outcomes in terms of staff morale and feelings of camaraderie described,[13] which accords with some of the reported outcomes in this study. On the other hand, an increase in probable post-traumatic stress disorder associated with redeployment with inadequate or no training has been observed in a national online survey conducted at three time points,[14] and this would be consistent with some of the feedback received in this study.

The speed of change during this crisis was recognised.[15] According to a study in Wales, the pandemic has provided a broad platform for innovation and transformation, and there has been attention on how to sustain and embed quality improvements achieved during this time.[16] Through case studies, the report identified themes such as improved joint working, accelerated decision-making and attention to staff well-being.

A report on understanding and sustaining healthcare service shifts identified important enablers, and these included local decision-making, and this local autonomy was a strong factor emerging from this study.[17] Examples of quality improvements during COVID-19 are now being shared[18] and it is hoped that this study will add to the body of knowledge.

Strengths and weaknesses

The strengths of this study reside in the extensive networks that exist between the study team, the CHA and the community hospitals of the UK. Applying purposive stratified sampling, the study generated data from 85 staff members in 20 organisations. Multiple viewpoints were obtained by interviewing a variety of staff.

The use of an AI approach could be seen as both a strength and a weakness. The focus on positive changes and quality improvements may not incorporate the many challenging and distressing situations for staff and patients during the pandemic. During the interviews, staff and managers were open and honest about the difficulties, and these were recognised and recorded. Some staff expressed the view that they appreciated a time of reflection with external independent people which the interview offered an opportunity to do, and that there had been little time to do that. The view was expressed that it was helpful to recognise the speed of change and the positive improvements. It was recognised that there was a value in sharing these practices in small hospitals across the UK, and building on the learning from this.

A weakness may be the 'snapshot' approach to an ever-evolving situation. However, this was mitigated to some extent by the repeated interviews required in the documenting of the case studies.

The study relies on community hospital staff views and perceptions only, and this may be viewed as a weakness as it did not bring in the patient and community voice or that of the wider system. However, the value of seeking views of staff working directly in the hospitals was reinforced by an earlier study which was described as 'rooted almost entirely in the world view of the staff respondents', and provided valuable insights.[19] In addition, the design of the study allowed for checks on all data collected and a final validation when each organisation signed off each case study.

The lack of formal evaluation of quality improvements may be viewed as a weakness. Staff were invited to talk about how changes came about during this crisis and what approaches and tools were used. Models of improvement, such as Plan, Do, Study, Act cycles were discussed and in some cases applied, although the speed of change meant that initially these approaches were not always formalised.[11] Staff were asked to share their perceptions and experiences, and were not required to provide evidence, evaluation or outcome measurements, although where this was available this was recorded.

Conclusion

The UK community hospitals responded to the COVID-19 pandemic in a rapid and flexible manner with enhanced integrated working and individual innovation. This study illustrates some of the strengths of smaller, mainly rural, hospitals that are embedded in the community including resilience and creativity. Staff described innovative, flexible and rapid changes in their community hospitals in response to the pandemic. Examples of quality improvements, innovative practice and enhanced integrated working to meet the local needs were evident. Case studies have been developed from the data and are being used to share the learning across community hospitals. Community hospital services were shown to be resilient, flexible, responsive, creative, compassionate and integrated. The case studies of quality improvements are being used to encourage sharing and learning across community hospitals and beyond.

Further research

The main findings and learning from this study are being disseminated throughout the community hospital sector by means of individual feedback, presentations of case studies (in person and virtual) and through a community hospital Special Interest Group of the Q Community.[20]

Contacting the organisations who have taken part in the study after the pandemic has subsided will provide evidence as to whether the quality improvements described have continued and which innovations in practice have become embedded, scaled up and adopted elsewhere in the system. There is scope to further explore the sustainability of quality improvements in community hospitals that were implemented during COVID-19.

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