

“Localism and Intimacy, and... Other Rather Imponderable Reasons of That Sort”: A Qualitative Study of Patient Experience in Community Hospitals in England

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Abstract

Background

The community hospital sector is characterised by high levels of upheaval, variation and dispute. Debates over the value and contribution of community hospitals are hampered by a lack of empirical assessment of the experience of patients using these services. This paper presents findings from a study of patient and family experiences in community hospitals in England.

Methods

We adopted a qualitative design involving nine case study hospitals, selected to represent a range of characteristics. Case study data collected included discovery interviews with patients (n=60) and semi-structured interviews with carers (n=28). We conducted thematic analysis of interview data.

Results

The study confirms some of the distinctive functional and technical aspects of care associated with community hospitals, including: access to services facilities and equipment; the environment and atmosphere; information sharing; continuity, and; the potential for longer lengths of stay. The study also finds high reported levels of personalised care in community hospitals. Our study suggests the importance of additional social and psychological aspects of patient experience. Social aspects included having family and friends close, and the importance of being known and maintaining social connections during periods of hospital treatment. Psychological aspects included feeling less anonymous and frightened than they would in an acute setting, especially when coming to terms with loss and change.

Conclusions

Although the experiences uncovered in this study were not uniformly positive, patients and carers placed a high overall value on the distinctive qualities of the care provided by community hospitals. The study suggests the need to weigh the full range of these dimensions of patient experience – including functional, relational, social and psychological – when assessing the role and contribution of community hospitals.

Introduction

Community hospitals are a longstanding feature of the health and care landscape, both in the UK and internationally, and have remained remarkably durable in the face of multiple system re-organisations [1]. However, this resilience masks some vulnerability. For instance processes of system integration and centralisation, and emphasis on economies of scale through hospital mergers, are frequently accompanied by the proposed closure or downgrading of community hospital services. As Jones and Exworthy [2] argue, the claims made for the efficiency and effectiveness of such changes often rest on inconclusive and partial evidence, which is regularly challenged by those campaigning to retain local

hospital services, particularly in rural areas [3]. These evidence deficits include a lack of empirical assessment of the experience of patients using community hospital services.

Against this background, this paper explores patient and family experiences in community hospitals in England, comparing these in particular to experiences of larger acute hospital services (e.g. [4,5]). The data presented here were collected as part of a study into the profile, characteristics, patient experience and community value of community hospitals in England [6]. In this paper we present findings from in-depth qualitative research with patients and their carers, and propose a new conceptual framework for distinguishing patient and carer experiences of community hospital care; one which differentiates and integrates functional, interpersonal, social and psychological dimensions of care.

Research setting: the community hospital sector in England

In England, community hospitals have been part of the healthcare landscape for more than 160 years. They first emerged in 1859 as small, predominantly rural 'cottage' hospitals. These were typically under the auspices of general practices (GPs) and provided inpatient beds and operating facilities for the sick and injured [7], before evolving to also offer preventative and curative services [8]. Following the establishment of the National Health Service (NHS) in 1948, the government of the day declared its preference for larger hospitals providing higher quality care, as encapsulated in the somewhat disparaging words of Aneurin Bevan, quoted in the title of this paper [9]. Despite this, cottage hospitals remained largely unaffected by government policy, and even the Hospital Plan [10], which proposed the widespread centralization of services, led in practice to few closures. A decade later, national policy set out the need to strengthen the role of the family doctor and community hospital services, with small hospitals now required to provide post-acute care and integrated health provision [11]. This led to: the emergence of the concept of the 'community hospital' [12, 13]; the co-location of GPs and hospital facilities, and; the integration of community and hospital-based medical practitioners [14].

Major subsequent changes to the role of community hospitals were not seen until 1997 when over a period of 11 years they were re-conceptualised as: a 'bridge' between primary and secondary care, providing an alternative setting to the larger district general hospitals for supporting people with 'complex' needs (for example offering local acute diagnostic and treatment services) [15]; a place for providing integrated health and social care [16]; a 'hub' for the provision of community based outpatient clinics and admission prevention [17], and; part of an overall strategy for providing care closer to home [18]. While the services provided by community hospitals varied during this period, core elements included inpatient beds, outpatient clinics and minor injury units, and facilities in which GPs and interdisciplinary teams worked together to support patients and their families, and to rehabilitate patients to return home [19].

Since this time, the place of community hospitals has become more unstable, as a combination of regional reorganisations and workforce shortages have led either to the closure of community hospitals and reduction of inpatient beds, or conversely to investment in new community hospitals and the development of new community hubs [20].

The evidence base

A key reason for such contrasting regional developments is arguably the absence of robust evidence on the role and value of community hospitals. This is compounded by the high levels of heterogeneity among community hospitals; a recent international scoping review found that the sector covers the 'entire spectrum of care provision, from preventative and primary care, through to inpatient and outpatient medical and surgical care' [1, xxii]. Indeed there is no agreed definition of what constitutes a community hospital, especially when considered across international health contexts. Furthermore, and despite claims and counter claims about the role and contribution of community hospitals, there is a notable lack of systematic and in-depth research to inform policy [6]. Whilst a small number of high quality and/or multi-centre studies do exist, these tend to focus on inpatient services and to rely on satisfaction surveys, rather than more in-depth explorations of patient experience.

Despite these limitations, the literature to date suggests the importance of three broad themes when assessing patient experience of community hospitals:

Environment and facilities: many studies of community hospitals identify important *functional* aspects of the care provided, for example: access to services; quality and range of facilities and equipment; environment and atmosphere, and; levels of cleanliness. Typically, such studies find that patients value characteristics such as: close proximity to family and friends; the opportunity to interact with patients from the same geographical location; a homely and friendly atmosphere; an orientation to older people; high levels of cleanliness; availability of single room accommodation, and; the quality, choice and presentation of food [21-27]. By contrast, some patients report that community hospitals can be noisy environments [23, 28], and some inpatients report long periods of boredom [22, 28, 29].

Care delivery: studies also report on the *technical* (e.g. clinical) aspects of community hospital care. For example, inpatients often compare community hospital care favorably to acute care with regards to information sharing, continuity, and the potential for longer lengths of stay [21-23, 26, 28, 30-33]. However, rehabilitation and ongoing needs are reported as not always being met on discharge [29].

Staff: a smaller number of studies focus on the *relational* aspects of care. In these, community hospital staff are often perceived more positively than those at larger hospitals, and associated with more personalized care [21, 22, 26, 28, 30]. However, at times patients report a lack of confidence in the technical skills of some staff and a preference for acute hospitals when requiring more complex medical care [22, 23].

Notwithstanding these studies, the evidence base remains underdeveloped, focusing primarily on the functional and technical aspects of care, and using limited data collection approaches. Bridges et al. [33] argue that patients' and relatives' narratives rarely focus on these aspects of the services they receive, instead foregrounding relational and interpersonal aspects of patient experience. Similarly, previous research into older people's experience of moving across service boundaries found that health and social care services often focused on the physical aspects of transition (for example, relocating from one

setting to another) [4] whereas older people tended to talk about transition in terms of the *psychological* changes in their identity or sense of self, and *social* changes in their relationships with partners, family and friends.

Overall, these limitations in the empirical literature on patient experience of community hospitals are reflected in somewhat reductive models for understanding their role and purpose [34-37]. There is therefore a need to develop empirically-informed theoretical models of the community hospital (albeit recognizing its considerable adaptability and diversity of form) in order to properly assess its role and contribution in a constantly changing health and social care landscape.

Methods

We sought to explore and understand the nature and extent of patient and carer experiences of community hospital care and services, and to identify the factors that influenced those experiences, drawing on notions of the functional, technical and relational, as well as the interpersonal, psychological and social dimensions of care. We adopted a qualitative case study design in order to identify and analyse patterns and variations both within and across cases [38-40]. Nine case study sites were selected from a synthesised data set of 296 community hospitals in England (see [6]), to reflect the diversity of community hospitals in terms of: location across England, number of beds, service provision, models of ownership, levels of voluntary income, and population deprivation.

Patients, carers and the public were involved before and during carrying out of the study. At the national level, 13 board members of the Community Hospitals Association (CHA) co-produced the initial research proposal, with two members continuing on the study steering group. At a local level, reference groups were established to bring local stakeholders together to steer, support and inform the case study research. The study was granted ethical approval by the Wales Research Ethics Committee 6 (reference number: 16/WA/0021).

Case study data collected included discovery interviews (patients) and semi-structured interviews (carers). We initially aimed to triangulate findings with hospital-level data (e.g. patient-reported experience measures and the NHS 'Friends and Family Test'). However, these were not available in a form that could be used in the study, and so were excluded from the analysis. Data collection took place over the period April 2016 - February 2017, once each local reference group was in place. Patients were purposively sampled for a mix of demographics, care pathways and services used: we sought, as far as possible, to select a mix in terms of gender, care pathways (particularly in terms of step up/step down) and services used (inpatient/outpatient). Although many of our respondents were current inpatients, we also interviewed inpatients who had been discharged recently, and long-standing outpatients from a range of clinics.

Potential participants were identified by the hospital matron and/or lead clinician and/or service leads. Each person was written to by the hospital with a request to participate in the study and was sent an information sheet and an opt-in consent form. Patients who were willing to participate sent their replies

directly to the study team and provided informed consent prior to the commencement of the interview. Our final sample across all sites included 60 patients. These interviews lasted between 30 and 90 minutes and were digitally recorded (in all cases except for two because of respondent reference/requirements). To support analysis, at the end of the interviews, we asked respondents to complete a short pro forma to gather basic demographic and service information.

Patient interviews were used to explore the lived experience of being a patient using community hospital services. Lessons from previous studies show that gathering experiences in the form of stories can enhance their depth and richness [4], so an experience-centred interview method was selected that drew on the principles of narrative approaches and, particularly, discovery interviewing [41]. Narrative approaches invite respondents to tell their stories uninterrupted, rather than respond to predetermined questions, giving greater control to the 'storyteller'. This approach can elicit richer and more complete accounts than other methods [42, 43], because reflection enables respondents to contextualise, and connect to, different aspects of their experiences. As such, after a general opening question, our interviews involved an open question inviting respondents to tell their story of being a patient at the community hospital. This question was accompanied by a visual representation of factors found in previous research to have shaped patient experience, to prompt people's thoughts and memories.

The use of discovery interviews enabled us to draw out not only what happened, but also how those experiences made patients and family carers feel about community hospital care [44, 45]. In doing so, the language used (e.g. 'it's home from home', 'they do whatever wants doing') differs from that used in previous research (e.g. 'access to services', 'comprehensive holistic care'), reflecting an experience-centred voice and capturing 'meaning' in the stories told, rather than converting these to pre-established policy or academic terminology (e.g. service 'access', 'integration').

We conducted a further 28 semi-structured interviews with carers in order to explore their distinctive experiences of the community hospital. Carers were either related to, or close friends of, patients at the hospital. In most cases, we interviewed carers of patients who had also been interviewed, but in some cases carers were not directly linked to patients involved in the study (for example, some carers were reflecting on the experience of caring for a patient who had recently died). The main focus of these interviews was on the experience of being a carer of someone at the hospital, with our initial question mirroring the discovery interviews by asking respondents to tell us their story of using the hospital. In addition, as the respondents were typically local residents, we also asked questions about their perceptions of patient experience, and about the wider role of the hospital within the community. A handful of respondents in this group were currently working as members of staff within the hospitals. These were included as they were recently either patients or carers of patients.

Interviews were recorded, transcribed verbatim and anonymised with unique identifiers before being imported into NVivo11 software. We conducted thematic analysis, guided by Clarke et al.'s six step process [46] which involved iterations of reading and coding sub-samples, by three members of the research team to produce a jointly constructed draft coding frame. This was then tested, refined,

reordered and grouped into themes, before the final version was applied across the whole dataset. Processes were put in place to ensure consistency of subsequent coding across the team, including checking each other's coding practices. Themes were further validated during subsequent stages of analysis and reporting, and early findings were discussed with the wider research team and with national and local stakeholders.

The following section describes patients' and carers' experiences of community hospital services, care and treatment, and examines the factors that shaped or influenced those experiences. All sites and individuals are anonymised to ensure participants' confidentiality. Unique identifiers are provided for each respondent quoted, denoting the community hospital (CH 1, 2, 3 etc.) and whether they are patients (P), carers (CA) or staff members (S). The dataset analysed during this study is available from the corresponding author on reasonable request.

Findings

In our study, patients and family carers were overwhelmingly positive when describing and assessing their experiences of community hospital care, support and treatment, echoing findings of earlier studies. Although we did not set out to make direct comparisons, many respondents contrasted their experience of community hospitals with that of acute care. We identified three sets of factors that were highlighted as being key to patient and carer experiences of community hospitals, and which were seen as distinct from other types of hospitals. These are encapsulated in the phrases: 'close to home'; 'personalised and holistic'; and 'supporting difficult transitions'. The experiences reported here relate primarily to inpatient services, with some reflections on outpatient clinics, minor injury units, maternity services and specialist tertiary services.

'It's closer to home'

Many patients and carers talked about community hospitals as not really being '*like a hospital*'. Central to these narratives was a differentiation from acute care. Community hospital's locations were experienced as more convenient, the atmosphere more homely and relaxed, less stressful and more reassuring. Taken together, these different aspects contributed to community hospitals feeling 'closer to home' in ways that went beyond physical proximity or convenience:

'It is unique [...] you go out into the day room and you look across those fields, you know, it's bright and airy and there's no sort of closed corners or anything. It doesn't feel like a hospital does it?' (CH6, S05)

A difference in 'pace' was one aspect of this, with a more relaxed environment, less pressure on staff and a strong sense of feeling less anonymous:

'The whole thing was so much nicer and easier rather than if she'd have gone into the [acute hospital]. She'd have just been one more elderly person in a great big ward.' (CH1, CA06)

Many patients and carers directly used the term 'home' or 'homely' to describe their community hospital. The components of this homeliness included the physical environment of the community hospital which was considered to be less intimidating than larger institutions, and this was felt to be particularly valued by patients who were older, frail and confused, and especially when they were dying.

However, not all patients found all aspects of the environment positive. Issues such as night-time noise from doors or a sluice disturbed some people's sleep. Some also described feeling isolated in single rooms and missing the social interaction of multi-bedded bays. In addition, some younger interviewees in our sample associated community hospitals with an 'old people's home' and felt alienated because of their age.

Beyond the physical environment, being local and accessible (i.e. physically closer to home) was also considered to be important. Patients and carers valued having a local hospital which they felt was more convenient than having to attend the acute hospital, with less distance to travel, ease of parking and less waiting. Convenience was also important for outpatient appointments, particularly for those who had to attend clinics regularly for relatively small procedures, as they enabled people to maintain their independence and self-reliance:

'That was that much more convenient and in fact I can drive myself here ... To do it here makes a big difference in the life of somebody of my age [89 years] and ability to get around and that sort of thing.' (CH1, P01)

Being conveniently located also enabled family members to visit regularly (several times a day for some), which was particularly valued. Weekend services and later opening times for urgent care also provided convenience for the whole family, and a range of local clinics provided easy access. Being able to attend a small, local hospital where they were known also appeared to relieve patient stress: '*you don't get tensed up about coming here.*' Being closer to home, in all the different ways described above therefore helped to ease fears and anxieties, including those of family carers.

'I just knew that he was safe and for me that was huge. I was trying to work, I was trying to sort out what I was going to do with him, I was trying to sort out my father's palliative care ... They just seemed to understand here that that's what we needed.' (CH3, CA01)

However, the location of a community hospital was not convenient for everyone. Some community hospitals were located just outside of a village or town, making them feel somewhat remote and isolated. Moreover, some inpatients who had been referred to a community hospital from outside the local area talked about feeling a long way from home even when care was experienced as good. As an increasing proportion of inpatients within community hospitals are stepped-down from acute services (rather than stepped-up from the primary care) and come from outside of the local, immediate area, this may become an increasing concern for community hospital patients.

Local community engendered a deep sense of ownership and connectedness for some of our interviewees, because they were embedded in community history, civic pride, family values and personal significance. This 'known-ness' was fundamental to many people's experiences of community hospital inpatient care, because it was experienced as less anonymous, more understood, more personalised and connected. Carers, for example, described the immediate and pronounced impact on their family member's mood once they were informed of discharge into the community hospital.

However, whilst for most people being known was a positive factor which they worried would be diluted by the stretching of hospital catchments, for some patients there was concern that '*everyone knows everyone else's business*', and therefore that this could compromise patient confidentiality.

Personalised and holistic

While acute hospitals were seen as treating acute problems, community hospitals were seen as providing more individualized, holistic, rehabilitative care. This was facilitated through a range of co-located services, the fostering of multi-disciplinary team working, and more specifically an ethos which encouraged the time and space to work with people as individuals. This personalised approach extended to domestic and catering staff, and in community hospitals with their own kitchens patients particularly valued the food being cooked on site and personally served to them.

'You never thought that you were taking their time up or getting in their way. Never felt like you were an inconvenience or anything like that.' (CH8, CA01)

'I had the same thing every morning so (laughing) it wasn't as if they needed to ask every morning, now would you like your white toast with no butter and just marmalade? Yes, please. Black tea? Yes, please. And they would remember.' (CH1, P03)

For family carers, the dignity and respect given to their older relatives were important:

'The respect and dignity they gave to my grandma was a huge thing for my mum and my Aunty [...]. I feel the respect that's shown to patients on the ward is – you can't compare it to anywhere.' (CH9, S04)

There were numerous examples cited of staff identifying and addressing issues that had not been picked up during patients' admissions to acute care, and this holistic, 'generalist' approach, was thought to be an important feature of patients' experiences of community hospital. Interviewees reported that staff recognised the importance of involving family members and worked to build a good relationship with them, arranging meetings at the beginning and over the duration of the stay, to inform and involve them in what was likely to happen.

Patients also gave accounts of apparently tailored and personalised approaches to rehabilitation. A woman who spent three weeks in her local community hospital recovering from surgery having badly broken her pelvis, described how staff steadily supported her physical rehabilitation:

'From the moment I got here they made me feel as though they were here to make me better and they were here to help me progress forward; it's not, 'Oh, you're here. You can just sit and do nothing.' 'Oh, you're here; we want you there'. 'You can have that but we want to take your commode away; you're not going to have it there all the time.' 'You will hop down there.' If you're capable you will go and have your own shower and wash your hair and do all those sorts of things. And each day they praise you for achieving something new, I mean stupid little things like I can now stand on one leg and clean my teeth [...] that was another achievement one day. They are looking for you to achieve one little thing maybe not every day but every time you achieve something you get the feeling that they're pleased for you, and I think that's vital and that again is the building of the confidence for people to go home.' (CH7, P05)

However time, and what to do with it, was a significant feature of daily inpatient life, and patients commented on the lack of social stimulation: *[it's] pretty boring laying here all day.* Carers also noticed this, particularly when their relatives were recovering:

'When dad was poorly, when he felt really poorly, it was okay because he was sleeping a lot but as soon as he started to pick up he felt bored... I think once you're getting better there doesn't seem to be very much [...] to keep them stimulated.' (CH9, CA05)

The lack of 'things to do' was observed across a number of case study sites, albeit some good examples of social stimulation were identified, raising a question as to whether more could be done to support social interaction between patients.

Supporting transitions

Given community hospitals' focus on rehabilitation, a significant amount of time and effort was invested in supporting people to return home, following an inpatient stay. Home visits and rehabilitation supported this, and were seen as core to community hospitals' function. One patient talked about her home visit, and how staff assessed, supported and encouraged her, to understand how well she could cope at home:

'Well, the home visit was about three or four days [...] before I was discharged [...] I did walk up the steps... they measured the height of the loo and looked at the shower and the kitchen and had me walking with the Zimmer. So they then had me going round the kitchen, 'furniture walking', they called it. (Laughing) [...] you'd got someone there to see how you coped and offer you advice.' (CH1, P03)

However, discharge could be a source of tension between staff, patients and family carers. Sometimes this was due to patients not wishing to return home because of the impending social isolation, or because discharge had to be delayed due to families needing a break or patients not having sufficient family support. At other times, pressure from acute hospitals to take people who no longer needed acute care (step-down) meant that staff had to juggle priorities and this pressure then could be transferred to family carers who would find themselves responsible for caring for their relatives before they felt able to cope:

'The pressure came because the [acute hospital] was on black so they were under pressure for beds here [...] but I knew that if I didn't stand my ground that we were totally out on a limb. He was in hospital, I knew that he was being cared for, but as soon as I allowed him to be discharged, then I was on my own, so that was really difficult. I sat in meetings with five or six people just saying 'No.' (CH3, CA01)

For many older people, the accident or illness that led to their admission to a community hospital often triggered a major life event, which was emotionally traumatic and a major psychological undertaking, and some had to come to terms with the likelihood that they would not return to their family home. Given the substantial number of people interviewed who were experiencing life transitions and who appeared shaken by those events or who were anxious about an unknown future, there was notably little explicit evidence of mental health needs being integral to inpatient care practice.

While there were many examples of staff supporting patients to build their confidence, and a few examples of staff recognising patients' general anxieties and concerns, we observed little formal assessment of, and work with, anxiety and depression. Although both of these approaches are important strategies in the care and recovery of older people, they appeared to be about distracting people from their general anxieties and concerns, rather than focusing on people's psychological, emotional and mental health, alongside their physical health.

Discussion

Cutting across these different accounts of patient experience are four dimensions that are key to understanding patient and carer experiences: functional, relational, social and psychological. As noted, previous studies have tended to focus on just two dimensions, the functional and relational [47, 48], and their importance is confirmed in our study. For example, functional, particularly environmental, features of community hospitals were fundamental to patient and family carer experiences in our study. However, whilst these features were part of what made community hospitals feel 'closer to home', being closer to home went beyond convenience to represent an environment that was familiar, known, reassuring, and nurturing, particularly for local patients and their families. Interpersonal aspects of care also featured strongly in patients' and carers' narrative accounts: relationships between staff, patients and family carers were central to experiences of using community hospitals, and so too were relationships between patients and the wider community. Patients highlighted warm and welcoming staff, being looked after with sensitivity and respect, staff and volunteers spending time with them, being listened to, keeping their spirits up, and time taken to care for the whole person. This contrasted with a more de-personalising patient experience associated with larger acute hospitals.

Our study also reinforces the primacy of relational dimensions to patient experience of community hospitals, and the need to distinguish this from the *psychological* aspects of care, and the *social* aspects of the patient experience which are largely absent from the current literature. Social aspects of patient experience included having family and friends close and the importance of maintaining social connections during periods of hospital treatment, rather than being distanced and isolated. The

importance of social interactions *between* patients was implicit in the complaints from some that not enough was done to encourage activity and alleviate boredom. Psychological aspects of patient experience were often wrapped up in accounts of feeling less anonymous and frightened within their community hospital than they would in an acute setting, and feeling more confident and hopeful, while also coming to terms with loss and change. Similarly, amongst family carers, the reassurance and reduction of stress associated with patients being cared for, often by people they knew, within a familiar, local community hospital were significant factors. On the other hand, this aspect also captures the shock and enormity of life events and psychological transitions, which frequently coincided with patients' use of community hospitals. While community hospitals were generally seen to build patients' confidence and physical health, a greater focus on psychological, emotional and mental health was needed.

When considered together, these four elements point to community hospitals as providing a primarily embedded and relational, rather than transactional, model of care (see Figure 1).

Personal, reciprocal, relationships between not just staff and patients, but between staff, patients, their families, and the wider community were intrinsic to patients' and carers' experiences. This often contrasted strongly with patient and carer accounts of their experience of acute services. This relational model of care was facilitated through: a closeness to home and community - for patients, their families and staff; the co-location and integration of a range of intermediate, generalist, and personalised services; the small size, familiar and homely environment of community hospitals; and their connection to and integration with the local community.

However, this highly valued, relational model of care cannot be assumed or taken for granted in the current policy context. We became aware that a number of our case study sites were facing challenges as facilities became dated, services were cut back or inpatients were drawn from an increasingly wide geographical area, meaning that community hospitals were no longer always local, convenient or easily accessible to all. The widening of geographical boundaries, and associated shifts towards greater provision of step-down care for increasingly elderly and acute patients, also had implications in some hospitals for the maintenance of the social and interpersonal aspects of care. In others, the interpersonal aspects were challenged by pressures on staff, exacerbated by recruitment challenges, and a withdrawal of GPs from community hospital medical provision.

Limitations And Conclusions

Our proposed, nascent model is intended to provide a basis for future exploration and assessment of the community hospital sector and to encapsulate the range of actual and potential roles it can perform. It implies the need for interpersonal, psychological and social criteria (Bevan's 'imponderables') to be granted greater consideration in future analysis. However, we are aware of some current weaknesses in the model, emanating from limitations to the study underpinning its formulation. First of all, whilst many respondents drew on comparisons with larger hospitals when recounting their experiences, we did not have sufficient resources to incorporate a formal comparison into the study design. Secondly, we were

frustrated in our attempts to incorporate quantitative patient experience data from routine NHS sources. Finally, any assessment of service models and types requires consideration of resources and opportunity cost; whilst these were not formally included in our study, contemporary research has compared community hospital ward efficiency with the NHS acute hospital sector [49]. However, as noted at the outset of this paper, any assessment that we can make is contingent on the ways that community hospitals reflect and interact with ever changing local systems and places, such that they will inevitably remain partial and contested. For example, the patient experiences we present here are not inherent and unchanging properties of the organisations themselves, but rather features of the ways community hospitals interact with local systems and communities, and therefore changes to the latter will in turn affect patient experiences. Despite these challenges, we hope at least to encourage future research to systematically account not just for the areas of care that are common across provider types (and which therefore might be candidates for removal and replacement) but also those that appear unique to, or at least characteristic of, the community hospital sector.

Declarations

Ethics approval and consent to participate

All subjects were 18 years or older. Written informed consent was obtained from all subjects. The study was granted ethical approval by the Wales Research Ethics Committee 6 (reference number: 16/WA/0021). All methods were carried out in accordance with relevant guidelines and regulations.

Consent for publication

All interviewees provided written informed consent for the publication of any associated data.

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available due to their containing information that could compromise the privacy of research participants, but are available from the corresponding author on reasonable request.

Competing interests

The authors have no competing interests as defined by BMC, or other interests that might be perceived to influence the results and/or discussion reported in this paper.

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Authors' contributions

DD led on data collection, analysis and drafting of the manuscript. IW contributed to data analysis and drafting of the manuscript. JG was Principal Investigator and contributed to data analysis and drafting of the manuscript.

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Figures

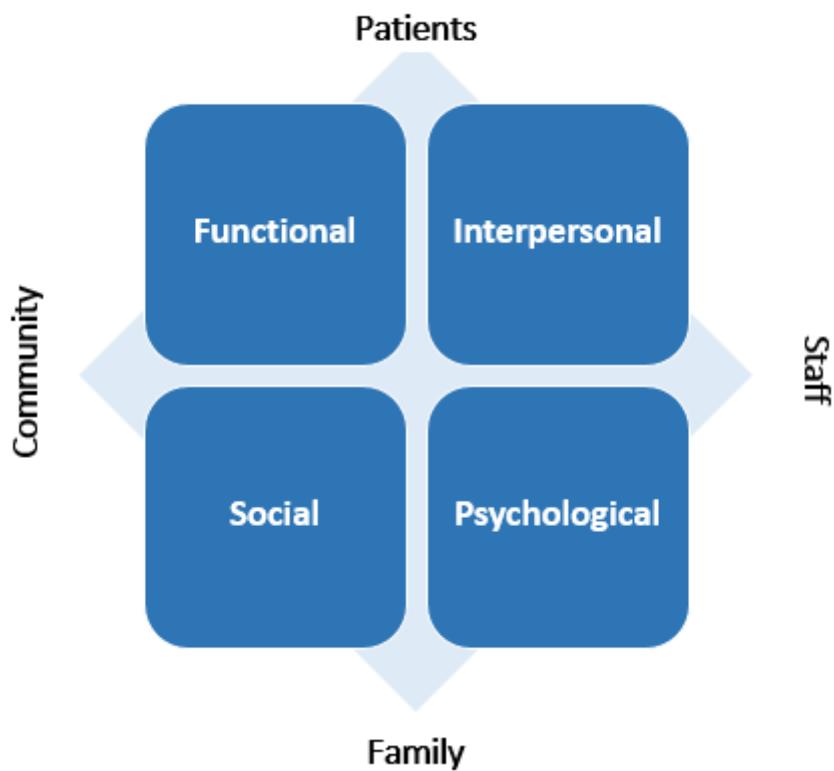


Figure 1

An embedded, relational model of care