UNIVERSITY OF BIRMINGHAM

Rye, Winchelsea and District Memorial Hospital: Profile, Patients, Passion and Pride

A report to the Rye, Winchelsea and District Memorial Hospital Research Case Study Local Reference Group

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1. Proposition: Introducing the research

1.1 Background

In 2006 the government heralded a new direction for community services[i], focusing on care closer to home with a call for commissioners to shift resources from secondary care to the community. The fundamental driver for this was the need to stem the flow of unnecessary hospital admissions into acute care.[ii] The potential for more outpatient tests, clinics and treatments to take place in community settings and for the replacement of acute bed days through better use of community hospital beds were key themes in this shift of services and resources. A financial commitment was made available to develop community hospitals as a key element of the strategy. However, by 2010, the Audit Commission[iii] suggested little progress had been made with unplanned emergency admissions growing at 3% per annum and a continued tendency towards centralisation. This lack of change has raised questions as to what role community hospitals fulfil within the UK's evolving health care system.

Evidence on the role, function and experience of community hospitals is, however, limited. Few studies focus specifically on community hospitals. Indeed, to date there has been no widely accepted definition of what community hospitals are, and data on their number, location, size, scope and resourcing is hard to come by. While a small number of studies have explored certain elements of patient experience of community hospitals, systematic research is rare, and evidence on the experience of carers is even rarer. Further, despite the generally held assumption that community hospitals are deeply embedded within and widely supported by their local communities, there has been limited direct evidence of the relationship between hospitals and their communities or the value that one represents to the other. Overall then, levels of understanding about the role and value of community hospitals and their place within the health care system have to date been relatively poor.

Recognising the weakness of the existing evidence base, the National Institute for Health Research funded three studies exploring: their service model and how this relates to international comparators (RAND International), effectiveness and efficiency (University of Leeds and Bradford Teaching Hospital), and profile, patient experience and community value (University of Birmingham).

1.2 Research questions

The aim of the University of Birmingham's study was to address three key questions:

- Profile: What is a community hospital?
- Patients: What are patients', and carers', experiences of community hospitals?
- Passion and pride: What does the community do for its community hospital and what does the community hospital do for its community?

1.3 Study approach

The research as a whole has involved several different aspects, including a national mapping exercise drawing on hospital estate and service user data, analysis of national charity commission data on levels of voluntary income, and case studies with nine community hospitals which have involved interviews and focus groups with commissioners, staff, patients, carers, volunteers and community members. In total, we have spoken to approximately 370 stakeholders across our nine case study hospitals.

Sites were selected to provide a diversity of community hospitals in terms of geography, size, patient profile, ownership, levels of voluntary income and deprivation. Rye was one of the nine case studies. A Local Reference Group was established for each: at Rye it involved 14 members, who helped to map activities, facilitate access to respondents, and reflect upon early findings. The range and number of respondents involved in the research in Rye are listed in table 1 below. To help ensure confidentiality and anonymity of respondents, unique identifiers are used in our reporting: patients (P), family carers (CA), staff (S), volunteers (V) and community stakeholders (CS), with sequential numbering. We would like to express our gratitude to everyone involved in the research – your cooperation, support and openness was very much appreciated.

Table 1: Rye research respondents

	Interviewees	Focus group participants
Patients (P)	7	
Carers (CA)	3	
Volunteers (V)	8	9
Community Stakeholders (CS)	7	5
Staff (S)	10	7
Commissioners and senior Trust staff (T)	2	
Total	58*	

*There is some double counting here as a small number of participants took part in both an interview and focus group.

1.4 This report

This report provides a summary of the key findings from our research with Rye, Winchelsea and District Memorial Hospital, relating to each of the three central research questions in turn before offering conclusions and reflections. It is focused specifically on findings from Rye, rather than from across the study as a whole. These findings have been integrated with those from other case studies and other research elements into a national report, submitted to the NIHR, and due to published in late 2018. **Please note, the data collection which informs this report took place in Rye during the second half of 2016, at the time when the outpatients department was temporarily closed for refurbishment.**

2. Profile: Describing Rye, Winchelsea and District Memorial Hospital and its local context

2.1 Historic and geographic context

Rye is a small, coastal town in rural East Sussex, with a census ward-level population in 2011 of just over 4,200, although the area and population served by the hospital is much wider. The average (mean) age of Rye's residents is 45.8 years, with the district of Rother within which Rye is situated having an older age profile than the rest of East Sussex. Nearly 98% of Rye's population is white. Compared to the rest of East Sussex, Rye has relatively high levels of deprivation. It was characterised by respondents as containing contrasting pockets of both deprivation and privilege/wealth. We discuss how the local geography has shaped the hospital and its connection to the community below.

Local records suggest that there has been a hospital in the area since the early 12th Century. The current site of Rye, Winchelsea and District Memorial hospital was developed over 100 years ago, following the decision at a public meeting in 1919 to open a hospital as a memorial for those who died in World War I. Built on land donated by a local benefactor and with extensive local fund raising efforts, the memorial hospital was opened in 1921, supported by subscribers and governed by a management committee. In 1948 the hospital became part of the National Health Service. In 1992, however, the NHS took the decision to close the hospital. The local community protested strongly against the closure, and when their campaign to keep it open failed they set to work to establish a community-based charity and to raise millions of pounds to purchase the land and rebuild the hospital. Following a successful campaign, building work was complete in 1995 not just on the 19-bedded hospital but also on 30 extra-care homes. In 2000 a GP surgery was added to the site, and plans are currently underway to develop the site further as a health campus with a range of additional health and social care services (see section 2.2 below). Understanding the history of the hospital is important in understanding its current profile, patient experience and community value, as the rest of this report attests.

The hospital is owned and run by Rye, Winchelsea and District Memorial Hospital Ltd, a charity and company limited by guarantee. After successful negotiations with the NHS, the hospital inpatient services are currently provided by East Sussex Healthcare NHS Trust. Daily medical cover is provided by the local GP practice which is based on the same site as the hospital.

2.2 Providing an evolving range of services

Box 1 details the services that were identified by the Local Reference Group as being available at the Rye, Winchelsea and District Memorial Hospital at the time of research, in mid-2016.

Table 2: Services available at Rye, Winchelsea and District Memorial Hospital

- In-patient, intermediate care beds, for step up and step down rehabilitation, sub-acute and end of life care, including two beds for private patients
- Out-patient clinics, including audiology, chiropody/podiatry, continence, counselling, mental health, diabetes, dietitian, ear nose and throat, orthopaedics, physiotherapy, musculo-skeletal service
- Physiotherapists and occupational therapists
- District and school nurses
- Health visitors
- Adult social care
- Palliative care therapies – provided by the Sara Lee Trust
- Kitchen, providing freshly cooked meals
- Here2Help, a volunteer-run service
- Volunteer-led services, including: library, pat the dog, hair dresser, chaplaincy
- Onsite: Extra-care housing – 30 homes, with 25 new units in development – managed by Sanctuary Housing
- Onsite: Medical centre

The main, in-patient, services and many of the out-patient clinics are provided by the East Sussex NHS Healthcare Trust. Other services are provided by a mix of NHS, private-sector and voluntary sector organisations. Illustrative of the somewhat fluid nature of services within community hospitals, at the time of our research only 15 out of the 19 in-patient beds were open, and the out-patient clinics had been temporarily suspended in order to allow the refurbishment of the rooms/facilities. The complexity of the commissioning environment, and more specifically the commissioning of services to be provided within the hospital (e.g. multiple commissioners with multiple contracts), and the multiple organisations involved in their provision, could at times be challenging.

As we have found in other case studies, some respondents questioned the extent to which the local community, especially people who had recently moved into the area, were aware of the full range of services that were available at the hospital. Respondents identified various misconceptions that they thought existed in the local community about the hospital, that it was, for example, a care home; a private hospital; purely for end of life care; for respite; for minor injuries. It location, 'at the top of the hill', on the outskirts of the town was felt to affect its visibility within the community with knock on effects for levels of awareness, use and engagement.

What was particularly striking about the community hospital at Rye (in comparisons to most of the other case studies) was the desire, ambition and indeed active plan to develop and expand the site and the range of services on offer. Current plans include: the development of a community hub to house a range of local community-based health and social care

groups and organisations and a café; the re-establishment of a full range of outpatient clinics following refurbishment; and the creation of care home beds. While there has been demand expressed from the local community to develop a Minor Inquiry Unit at the hospital this had not to date been possible, due to a range of factors most influentially the predicted footfall which does not currently justify the development of such a service. These ambitious plans reflected a belief that the hospital could be doing more, to provide for the local community's needs and to relieve the pressure on acute services:

> *"And I'm sure there is a lot of stuff that could be delegated down to the community hospital level" CS08, FG*

2.3 Committed teams with strong leadership

A key aspect of the profile of the hospital was ownership, management and staffing structures. Rye is one of only a handful of community hospitals which is owned and managed by a community-based charity. The charity is run by a board of trustees, of all of whom are volunteers, and three staff who are employed to fulfil company secretary, fundraising and property maintenance functions. The strength of leadership within the board was commented upon by several respondents, as was the importance of the strategic connection between the Board and the NHS Trust which provides the in-patient services, which is currently facilitated and enhanced through the Chair's role as a non-executive director within the Trust.

The ward is a nurse-led unit, with medical cover provided by GPs from the adjacent surgery. The strength of the nursing team was commented upon by many respondents, from different perspective – staff, volunteers, patients and community members.

The quality of leadership within the nursing team was highlighted, as was the associated level of autonomy and responsibility devolved across the team (further facilitated by the relatively small size of the nursing team). The stability of the team was also highlighted, along with the apparently low level of vacancies compared to other case study community hospitals involved in the research.

A challenge was, however, identified in terms of the level of medical cover funded. The role of GPs within the hospital was valued by staff and patients alike, but questions were raised as to the visibility of doctors to patients and the challenges which GPs face in providing effective medical cover within the limited time they are allocated/funded.

Overall, the strength of leadership and team working in both the strategic and operations sides of the hospital was highlighted. While most respondents felt that the relationship between the Charity and the staff employed by the Trust was strong, it was apparent that tensions could occasionally arise with a need to maintain clear boundaries over roles and

responsibilities and, most importantly, effective communication channels. As one person said, there was a need for active 'glue' to bring the two teams –the Charity and the Trust (affectionately referred to as 'upstairs and downstairs') - together.

3. Patients: Understanding patient and carer experience

3.1 Patient profile[1]

According to nationally available hospital estates and patient data that was collated as part of our wider research study, in 2012-2013, Rye, Winchelsea and District Memorial Hospital had 13 beds, was responsible for 93 inpatient discharges and 858 out-patient attends. Four-fifth (79%) of its patients were aged 80 years or over, and its average length of stay was 45 days. Evidence collected during our case study fieldwork suggests that there has since been a change in the patient profile, associated with changing admissions criteria which was contributing to a greater number of step-down and fewer step-up patients, and a reduction in the average length of stay.

According to Friends and Family Test results, 98% of patients in 2016-17 would recommend Rye, Winchelsea and District Memorial Hospital. These positive rating were reflected in the qualitative findings that we go on to discuss in this section about patient experience. As one person put it:

> *"I cannot fault it one iota, you know."* P03

3.2 Providing a calm, caring, personal & homely environment

The environment and atmosphere– physical, social and emotional – was widely commented upon as a central aspect of patient experience. The hospital was felt to be a welcoming, calm, peaceful, comfortable and caring place, shaped by both the social and the physical environment. Comments included:

> *"I do think it is a very calm, warm, kind place; it feels very welcoming" CS01*

> *"And I think the whole ambience, the furniture, the building, the grounds it's all in keeping beautifully looked after and makes you feel it's home. You could live here quite happily, are you with me? It's that sort of environment and feeling" P07*

> *"It's very loving, very caring"CS03*

[1] Please note that this data applies to the timescales for national data collection (available for 2012-2013), which differed from local data collection (2016 -2017), and the current profile.

A number of respondents reflected on the 'homeliness' of the hospital, which was influenced by the furniture and decoration (the reception and waiting area was particularly commented upon), the closeness of relationships amongst staff and between patients and staff, and the provision of freshly cooked, *'nourishing',* meals served together in day room (wherever possible) *'as a family*':

> *"it's just a nice family atmosphere" V06*

> *"Over the years you do go to different ones [hospitals] but it is the kindest one I've known but it's like a home, you're walking in, you are welcomed and treated as a member of family rather than just a body." P07*

Reflecting further on the relationship with staff, patients and carers noted the apparent closeness of and stability within the nursing team, and the time that was available/made available for staff to spend with patients, which enabled the development of closer relationships. As one respondent put it: '*nurses get chance to be nurses*'. Patients generally felt as if they were treated with care, dignity and respect, through a personalised approach:

> *"there is a definite air of consideration and respect"CS03*

> *"there were only 21 nurses I think and they all knew you from different shifts and you knew them all. [My husband] and I were definitely a fan of small is beautiful... because it was smaller there was fewer nurses, you certainly formed a relationship with the nurses and even if they were bright and cheerful and burst into your room at 6.00am in the morning saying, "Morning [Jane*]," you know, you got friends with them." P02*

Both patients and carers generally felt that nurses and health care assistances had and took the time to spend with patients, to develop more personal relationships, and this was a key aspect of patient experience. On the occasions when staff were particularly busy – due to absences or 'challenging' patients for example – this was noted and commented upon by patients, but more in contrast to their usual experience rather than as a regular concern. Doctors, however, were less visible, with some patients suggesting that they had expected their GPs to have a greater physical presence than they had so far experienced.

Often reflections of the environment, atmosphere and caring approach within the community hospital were made in comparison and contrast to the experience of being a patient at an acute hospital:

> "*it was an infinitely better experience than the [acute hospital] just because it was smaller and more intimate, you know" P07*

It was suggested that these different aspects of the hospital environment helped make people feel comfortable, less anxious, and to aid recovery and well-being. As one person put it:

> *"…it's a more healing place to be" CS01*

3.3 Within a local and accessible setting

The local and accessible nature of the hospital was another central aspect of both patient and carer experience. Again, this had a number of dimensions to it. The hospital was generally perceived to provide a local service, for local people, with a local staff team, and this was widely valued. It was, however, suggested that changes in the admission criteria and processes, which meant that GPs can no longer directly refer and admit patients, had resulted in patients being drawn in from a much wider geographical area and it becoming increasingly difficult for local people to get a bed. This was a source of some frustration for local residents (which GPs and key nursing staff sometimes bore the brunt of!).

The accessibility of the hospital, due to it being local, with free car park, being served by community transport, and its small size, was important to patients, family carers and friends. This accessibility reduced both the economic and emotional costs to patients and carers. Being able to receive regular visitors was seen as important for patient recovery and general well-being and helped to reduce the carer-burden. Family could pop in and out to visit patients, enabling a continuity of family and work life that would not have been possible if the hospital was further away. It also enabled greater independence for elderly patients who felt able to travel alone to Rye in contrast to a trip to the acute which would depend on a relative or friend being able to take them. Comparisons were often made between the accessibility of Rye, Winchelsea and District Memorial Hospital and of the nearby acute hospital, which was seen as particularly inaccessible due to poor public transport links.

The localness of the hospital meant more, however, than enhanced physical accessibility and the considerable associated benefits of that. It also meant that patients (and carers) were more likely to be familiar with the hospital environment and were in turn more likely to be known by staff (many of whom were local), volunteers and/or other patients within the hospital, both of which were reported as helping to reduce feelings of anxiety induced by attending hospital and to enhance personalisation (see section below):

> *"I think there's a great fear of, you know, going off to the [the acute hospital] and things. There isn't a fear associated with coming into Rye Hospital." S08*

The hospital was, then, *'closer to home'* in more ways than one. The combination of the close proximity of the hospital, along with the chance of knowing the facility and staff who worked there, being accessible to friends and family, combined with a more homely environment (see below) to enhance patient experience:

The sense of being '*closer to home*' or even '*at home'*, however, was felt to have weakened slightly in recent years. Staff in particular reported that with patients increasingly drawn from a wider geographical area, accessibility was being reduced and the chances and benefits of being known were diminishing, with potential implications for continuity of care. Some of the patients and the family carers that we spoke to had to travel considerable distances to come to the hospital and poor public transport was adding to the time and exhaustion involved in such journeys.

3.4 Rehabilitation and transition

The hospital has a clearly defined rehabilitation function, with an emphasis on getting patients ready to return home as soon as possible. A key aspect of this, which was commented upon by a number of the patients we interviewed, was building not just capabilities but also confidence:

> *"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 with the basin which for the first bit, because I couldn't have it hanging there, I couldn't do; that was another achievement one day. And I think it doesn't matter whether it's me or anybody else 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." P05*

While most patients we spoke to shared similar experiences to those reflected in the quote above, it was apparent that some patients had different expectations and/or experienced. Some felt that the therapists did not have as great a presence on the ward as they would have expected or liked. While some patients talked about being encouraged to get up, get moving and join in different activities, others talked about sitting for hours in their chair with their day punctuated only by meal times. One carer reflected:

> *"I think if they are going to be a rehab hospital, they ought to have a little more rehab going on" CA01*

Associated with its rehabilitation function, the role of the hospital in supporting patients (and family carers) in significant service and personal transitions was highlighted. The transition associated with patients moving between acute hospital services and the community hospital was particularly highlighted as challenging for patients, especially when

it happened late at night, was delayed or when there was to-ing and fro-ing between hospitals for tests, specialist appointments or increased acuity etc. While such transitions were not easy for patients, efforts made by staff at Rye to anticipate the needs of patients, to welcome them off the ambulance and quickly settle them in, were appreciated and helped to reduce anxiety. They were helped less, it was suggested, by poor information and occasionally inappropriate referrals being made by the acute.

The transition from Rye hospital to home, was eased by the efforts made by staff to build skills, strength and confidence; but could be hindered by delays in organising care packages which were difficult for patients and family carers to manage.

Beyond supporting patients through challenging service transitions, patients (and family carers) were often experiencing significant life transitions at the time of their stay. These might be associated with a significant loss of independence, with the prospect of death or the loss of a loved one, with considerable psychological implications.

4. Passion and pride: Exploring community engagement and value

The third aspect that the study explored was the relationship between the hospital and its local community – asking what the community did for the hospital as well as what the hospital did for the community (beyond providing healthcare).

4.1 Asset, ownership and identity

The hospital was widely seen as a vital asset for the local community. Typical comments included:

> *"I love our hospital and I'm so grateful for it" CS05*

> *"It really is a fantastic asset" V03*

> *"The hospital, I think, is a very essential part of the community" CS08, FG*

The hospital's history was particularly significant – both its longer term history through its establishment as a WWI memorial, but also its more recent history associated with its closure in the 1990s and the efforts made by the community to raise the funds to rebuild and reopen it. Through such events and efforts, it was seen as being rooted in time. As one respondent said:

> *"I've always felt that it was that history that sort of bedded the new hospital in so strongly" CS02*

The geography of the local area was also seen to be influential in strengthening the significance of the hospital to the community. It was rooted in place, as well as time. The sense of relative isolation, through being 'stretched along the coast', and associated need for self-sufficiency was particularly highlighted. Further, being on the edge of the town, while potentially reducing accessibility, was felt to have significance in terms of acting as a point of connection between the various villages surrounding Rye.

The perception of the hospital as an important asset was underpinned by a strong sense of ownership:

> *"It does feel like **my** community hospital" CS01*

> *"it does feel very much like **our** hospital, yes" V06*

This sense of ownership had its bases in the origins of the hospital, and had transferred across generations. Towards the start of the nineteenth century it had been built, paid for and run by the local community as a WWI memorial, before being incorporated into the NHS, and then towards the end of the century the community had again raised the funds to buy back the land, rebuild and reopen the hospital. While in most of our case studies, the community *felt* that they owned their hospitals, in Rye this really was the case.

Further, amongst the respondents we spoke to, the hospital was generally regarded as one of the key institutions within the local community: an integral part of everyday life and of (individual and collective) identity. It contributed to a sense of belonging within the local community. Comments included:

> *"it is in the psyche that Rye hospital is here" V03*

> *"I think it is one thing that helps to define the community" CS08, FG*

It should be noted, however, that while these feelings of ownership and identity were widespread, they were not felt by all our respondents. Indeed, the relevance of the hospital to different members of the community was questioned by some. As one community stakeholder said *"it doesn't feel like my community hospital".*

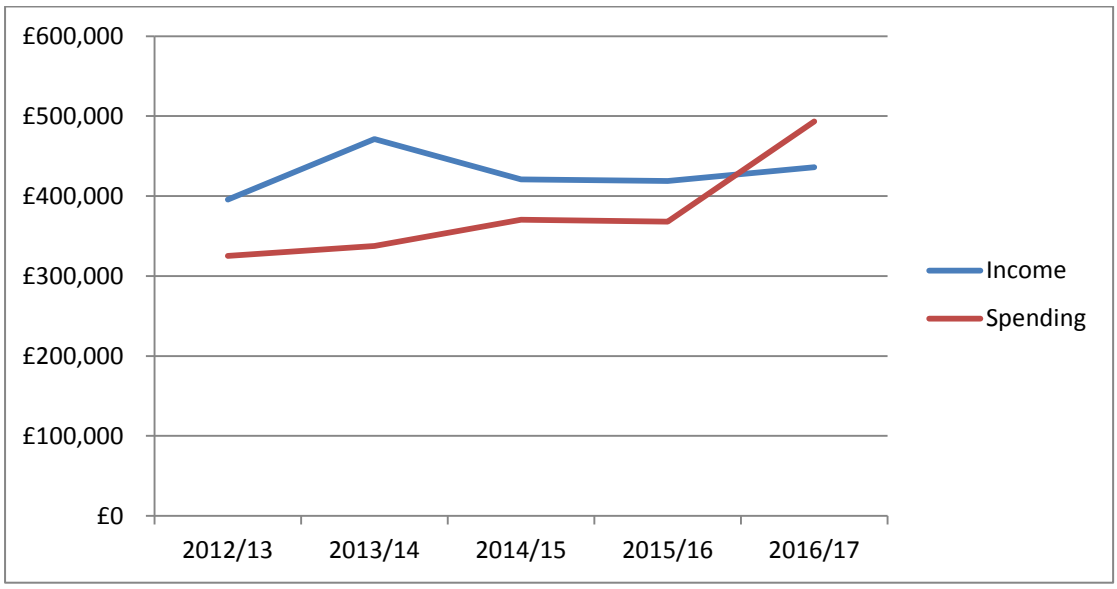
4.2 Strong support

These perceptions of ownership, identity and belonging contributed to strong levels of support for the hospital, albeit for some of a more latent that active basis. Support for the hospital manifested in a number of ways, most notably voluntary income and volunteer time, both of which had until recently been channel through either the Charity or the League of Friends (they merged together a few years ago to enhance transparency and reduce bureaucracy).

Rye, Winchelsea and District Memorial Hospitals received significantly higher levels of voluntary income than the other case studies involved in the study. This was largely

accounted for through the property-related investments made by the Charity, but also due to the significant fundraising efforts made by the League of Friends. The range of fundraising activities undertaken was highlighted, particularly in terms of developing a portfolio of activities in order to engage a diverse range of people across the local community. The following graph, taken from the Charity Commission website, compiled through the annual returns of the Charity, provides an overview of the Charity's finances over a four year period.

Figure 1: Rye, Winchelsea And District Memorial Hospital Limited: Income and expenditure



Date source: Charity Commission website[iv]

The significant levels of voluntary income generated by/for the hospital had implications for other local charities, some of whom felt that it affected their ability to generate funds from the local community. This was recognised by those involved in the hospital:

> *"people would say, you know, you're not giving the other charities a chance to do things because you're too powerful in a way" V06*

In response, the Charity have pulled back on some of their fundraising activities, have handed some over to other charities to run, and have shared resources (money and space) to support a number of related local groups and organisations.

While levels of voluntary income have been consistently high in recent years, membership has been on the decline, from a reported peak of over 15,000 in the 1990s to approximately 400 in 2016. It was suggested that the decline in membership reflected the stage at which the hospital was at – the intensity of efforts needed to rebuild the hospital in the 1990s,

which had led to such high membership levels, were no longer needed and it was a challenge to maintain efforts to generate interest and awareness particularly amongst younger people:

> *"we used to have a lot more when we were raising funds to build the hospital again but they've sort of died off and younger people haven't really joined; they don't know this is a hospital really. Many people in the community don't know; they are learning now that the hospital is here" V02*

Beyond voluntary income and membership, the hospital benefits from a highly committed group of active supporters who volunteer in different ways. There is a relatively small, core group of individuals, many of whom dedicate many hours each week and are involved in multiple roles, sometimes over generations. This core group is supported by a larger group of volunteers who help out on a less regular/intense basis with particular activities or events. The range of roles undertaken by volunteers at Rye was more extensive than in our other case study hospitals, including for example: trustees/ board members, fundraisers, administrators (including covering reception desk duties), befrienders (within the hospital and outside), providing services to patients such as library, refreshments and nails, and providing transport for local residents to attend Rye hospital and/or the acute hospital.

While there was a very active core group of volunteers and a wider network of less intensely involved participants, it was suggested that it generally feels harder to get people actively involved now than it used to. In particular, it was suggested that it was hard to encourage younger people to volunteer at/for the hospital. Despite having actively tried to engage younger people on the board of the Charity, for example, the average age was still – it was reported – over 60. One person said:

> *"but a lot of them are not used to the idea of community involvement" V04*

A further particular challenge had been identified within some of the voluntary roles from rising levels of bureaucracy associated with a shift in who is responsible for coordinating volunteering – away from Rye to wider Trust staff based at the acute hospital (*"I feel it has all been taken out of our hands a little bit"*). Some volunteers, for example, reported having to fill out extensive paper work, needing to travel to the acute hospital for training, and even having to produce urine samples to continue with roles which they had been undertaking for years. This had led some volunteers to question their ongoing involvement.

4.3 Reciprocal care and value

A sense of interdependence and reciprocity of both care and value was expressed between the hospital and the community. As the quote below suggests, there was a sense that the

community hospital depends on the support of the local community to maintain the quality of care it currently provides:

> *"Because a community hospital needs community; if you don't have a community to hand you have nothing. And so when we need support we get it…" V01*

The active engagement of the local community in the hospital helped to enhance patient experience, but at the same time it also strengthened the community, through building social action, resilience, well-being and cohesion:

> *"There's a tremendous range of things that are organised to raise money that in fact are contributing to the social life of the area" CS08, FG*

It was suggested, for example, that the hospital provided a source of unity between different groups within the local area:

> *"Rye is a very divided […] sort of society but the hospital joins us. One of the few things that does" V03*

This sense of reciprocity extended to individual staff within the hospital, many of whom expressed a sense that working at the hospital was 'more than just a job' to them, that it was a source of identity, satisfaction and pride. As one member of staff said:

> *"that is what you get from a community hospital, it is pride in what you provide, because you are walking, you are bumping into people on the street that know that is where you work and you want them to be pleased. It is like with firemen, you are always pleased, whether you see a fire or not you are always, 'Go on,' and the life boats and the air ambulance, it is providing a service for locals that they are proud of and you are proud of." S011*

These feelings were intensified, it was suggested, through the active support of the community- feeling supported and valued by the community, enhanced staff satisfaction and commitment, which in turn enhanced their levels of care, which subsequently impacted upon patient experience.

> *"the staff feel supported and valued by the community, and I think that's quite important for how they feel about their job" CS03*

5. Potential: Conclusions and future considerations

Rye, Winchelsea and District Memorial Hospital was regarded by the respondents we spoke to as an important community asset, providing a high quality, local service, that is valued by patients, carers, staff and community members. Patients particularly value the caring, healing environment and the local and accessible nature of the hospital, which together are seen to enhance patient well-being. Being owned and run by a community-charity distinguishes Rye from (most) other community hospitals, as does its particularly high levels of voluntary income and support. Community support was seen as central to the hospital's facilities and model of care, enhancing staff satisfaction and patient experience. In return, above and beyond the health services it provides, the hospital – and involvement in it – contributes to a sense of identity, unity and resilience within the community. While levels of voluntary income and volunteering are buoyant, membership is however declining and engaging younger people was identified as an ongoing challenge. In addition, while the charity-ownership model was seen to have many benefits, it also had challenges in terms of the need to navigate and work across organisational boundaries – maintaining professional boundaries and ensuring effective communication channels were seen to be key.

The Charity has ambitious plans for the future, striving to maximise the use and relevance of the hospital and associated services for the local community. As one person put it: *"We all want the hospital to be the best".* Current plans for the community hub and care home were part of a longer term vision for the community hospital as health campus, providing day care, extra care, intermediate care, primary care, and residential care – as one person said: *"what a community hospital should do".*

Indeed, it was this ambition, and strategic vision, for the future of the hospital, and the ability/power to put those plans into effect, which distinguished Rye from some of the other case study hospitals. At the same time as working hard to build strategic alliances with relevant healthcare Trusts, local authorities and voluntary organisations, the Charity was also working to maintain and build community support, with a recognition that this cannot be taken for granted. Developing a fundraising strategy that was not all about growth but was also about diversity of income, engagement and profile raising, suggests a recognition of the value of building widespread community involvement and support. Ensuring the hospital remains relevant to all members of the community, however, is likely to remain challenge. Who gets involved and shapes decisions affects services and influences whether other people think it is or is not relevant to them. Actively seeking to broaden the mechanisms for engagement and diversify involvement could help to further secure the future of the hospital and the value that it brings to the community.

6. References

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