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Research Article

Exploring the Support Provided by the Formal and Informal Network Members during "Hospital at Home" Treatment from a Nursing Perspective: An Interview Study

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Pressure on healthcare systems to address growing population needs is forcing services to adapt, which includes supporting acute patients in the community. One emerging service in the United Kingdom that offers this level of treatment is "Hospital at Home" (HaH). Self-management support is an area of particular importance in this context considering that acute treatment is provided in a community setting with limited input and monitoring by healthcare professionals. There is currently limited understanding about the range of formal and informal support and resources needed and accessed by patients in such circumstances, and whether and how HaH professionals engage with the everyday contexts and the network members of patients. Semistructured interviews were conducted with nurses ($n = 9$) from a single Hospital at Home site to further understand their experiences of providing acute treatments in the context of patients' homes; and how self-management and social network support roles are perceived. Thematic analysis was used and four themes were identified: *The value of prioritising illness work at home within a discourse of person-centered care; the work involved in the "naturally" therapeutic environment of the home; partners as key members of the informal care team; limited awareness and engagement with (in)formal networks.* Findings demonstrate tensions between discourses where nurses idealise the value of the home and a holistic service provision, while in practice prioritising illness (over relational, emotional, and practical) work and delivering a service that is routinised, and time- and cost-efficient. Nurses recognise the positive role of network members for illness management in the context of people's everyday life, but awareness and engagement are limited to partners and the formal services that HaH staffs are familiar with. Developing a better understanding of the role of social networks (SNs) in supporting people with acute needs at home can help improve patient experiences and care and HaH services, especially for people who are vulnerable, with complex needs, living alone, and with limited access to resources.

1. Introduction

The trend of aging and increasing populations has meant that maintaining the good health of all people has become increasingly difficult [1]. In the United Kingdom longer life expectancy and a wider availability of treatments have been associated with higher demand for hospital beds and escalating costs of providing care and treatment [2, 3]. One way the National Health Service (NHS) has adapted to this demand has been by establishing out of hospital treatment services for acutely unwell patients. One such service is Hospital at Home (HaH).

1.1. Hospital at Home Services.

The introduction of the NHS "Long Term Plan" in 2019 set out a £4.5bn budget rise for community services, which includes HaH services. There are different HaH models developed internationally. These vary in terms of funding mechanisms, the scope of the service and type of support provided (e.g., including after-hours support, home oxygen, intravenous fluids, education for patients and/or caregivers), the location of the service (e.g., central-hospital based, or more geographically isolated in the community), and the composition of the HaH team (such as nurses, doctors, and allied health professionals) [4]. There is also variation in terms of the types of patients who access the service (e.g., frail patients who have had medication changes, patients with chronic lung conditions who require observation post COVID-19, patients needing intravenous antibiotics or patients with complex surgical wound management needs [5, 6]). In the UK HaH services typically provide short term, hospital level interventions in patients' own homes as a means of avoiding admission or supporting an earlier discharge from hospital [7, 8]. This includes administering treatments such as intravenous (IV) antibiotics and fluids to a patient group that has higher levels of acuity than those using other community based healthcare provisions such as district nursing services [7, 8]. Although there has been some work exploring the workload for healthcare professionals (HCPs) of different patient factors (such as medical condition, age, gender, and rurality), such work has emphasised how the heterogeneity of HaH services nationally makes creating a standardised model of care impractical without further research [4, 5]. Wider research has focussed on measuring and modelling the cost-effectiveness of services [9–11]. There is also evidence that there is no significant increase in morbidity or mortality, a significantly higher level of patient satisfaction compared to inpatient settings [11–14] and a reduction in hospital associated complications such as delirium, cross-infection, and function loss [15].

However, these models of care are healthcare professional and illness focussed and therefore do not sufficiently recognise the full range of informal and formal support, and resources, that are important to patients when care is provided in their homes. Furthermore, there is limited understanding as to what aspects of the service patients value most and why, what is the nature of the work that is required to provide such support, and how is this work distributed between healthcare professionals (HCPs), patients, and other members of their social networks (SNs).

1.2. Person-Centered Perspective on Illness Management. Depending on how HaH models are applied, there are varying levels of acceptance of such service use among patients which may in part be due to, on the one hand, the familiarity of the support provided in "bricks and mortar" care settings [5, 16, 17]; and on the other the unfamiliarity with how to self-manage acute illness at home [15, 18, 19]. Self-management of an illness in the context of everyday life is best understood as a collective (rather than an individual) process that involves wide-ranging support and resources from informal and formal relationships (rather than dyadic relations with key network members such as family or healthcare professionals). Therefore, self-management support involves emotional and practical (not just illness) work, and relational work in accessing support and negotiating tensions. Doing this work requires collective efficacy of networks (not just self-efficacy of individuals), and support that is acceptable (not just available) [20–23]. There is evidence that, for users of HaH services, managing complex illness work can prove challenging considering that it is closely inter-twined with the emotional needs and practical everyday tasks that need to be completed whilst at home [24]. There is recognition of the value of partners and spouses in supporting HaH service users [25–27]; but there is limited understanding of the role of other network members and the process through which they are engaged or not in self-management support [28, 29]. SN members can include a wide-ranging (formal and informal) workforce [23, 30]. There is evidence that people who have access to diverse types of relationships including both "strong," intimate ties (e.g., spouse, partner, and children) and "weak," more distant ties (e.g., acquaintances, HCPs and community group members) report better self-management and quality of support [21, 31, 32]. This is in part due to more adaptive support being provided, reduced risk of burnout, and the scope such networks have to link to other sources of support and information [33, 34]. Although, the value of key network members such as partners and carers is well recognised [25] there is limited understanding of the involvement of people's wider networks, the role they may play in completing different types of work and in helping negotiate the tensions between formal care provision and the needs and preferences of people using HaH services [26]. This raises questions about the potential differences and similarities between mobilising network support in everyday contexts for people living with a chronic illness and the short-term support needed for people using acute services such as HaH.

1.3. Community-Based Support by Healthcare Professionals. One of the potential challenges in providing support for acute illness at home is that HCPs may be under intense pressure when providing illness work during HaH service use, but may also have to do substantial amounts of practical and emotional work to support patients. Previous research has outlined some of the complexities in providing support in community settings where healthcare teams go beyond their professional speciality and attended patient's homes to stoke fires, walk dogs, and spend time discussing personal issues of concern (such as managing patient expectations whilst balancing long travel distances, increased workloads, and the need to practice as generalists) [35, 36]. Furthermore, research into other community services suggests that the amount of nonillness work that individual HCPs do varies, and by doing such work can trigger inconsistent processes that result in negative implications for professionals and service users [37]. For example, where individual HCPs provide wide-ranging emotional, practical, and relational support this raises patient expectation and pressure on other HCPs [35]. Therefore, community-based HCPs might try to link patients to new and reliable sources of emotional and practical support in order to reduce burden on themselves, and continue to support as many patients as possible [23, 38].

Despite an emphasis on acute treatment being delivered outside of inpatient settings, there is currently limited understanding of how the health, emotional and practical needs of patients are met whilst living at home during episodes of short-term, acute illness. The known importance of the process of engaging formal and informal network members to provide support is underexplored within the context of people using HaH services. Developing such understanding can help improve patient experiences and HaH services. This study aimed to offer insights into this gap in knowledge by exploring nurses' perceptions of how patients manage their illness when at home, what is the work involved, and what is the role of HaH professionals, and other SN members (such as friends, family members, and neighbours) in doing this work. This paper explores the experiences of HaH professionals to address the following questions:

1. What is (from the perspective of HaH professionals) the relationship between the illness, practical and emotional work involved in supporting people using HaH services, and how is this work done?
2. Who are the members of the formal and informal workforce that HaH professionals consider relevant for addressing the needs of HaH service users?
3. How do HaH professionals engage formal and informal network members, and what are the tensions and complementarities between different sources of support?

Addressing such questions, can help improve community based services, such as HaH, especially where greater support is needed for more vulnerable people with complex needs and limited access to support [39].

2. Methods

2.1. Design. Qualitative interviews were conducted with HCPs working within a single NHS HaH site in the South-West of England. Patients are referred into the HaH service in order to prevent hospital admission, or facilitate an early discharge. This service has the capacity to accommodate up to 15 patients. The lead author (JG) is employed as the deputy team lead within this service.

2.2. Participants. All registered staff nurses ($n = 4$) and healthcare assistants ($n = 9$) within the HaH service were approached to participate within the study by the lead author (JG). Written informed consent was obtained from all participants.

2.3. Data Collection. All interviews were conducted face-to-face by the lead researcher (JG) in a neutral office within the HaH service. Lead researcher (JG), as a colleague of the participants was aware of the potential factors associated with being an "insider" that could affect the integrity of data collection (such as, pre-existing opinions and biases) [40]. To mitigate this, participants were asked to ignore any pre-existing knowledge that the researcher may have, and an interview schedule was followed to ensure consistency (Appendix A). Insider, peer to peer interviews allowed for open discussion and trusting relationships that enhanced information sharing and comprehension from the researcher [40].

All semistructured interviews were conducted between January 2021 and February 2022. Questions explored the perceptions of HaH professionals of patient experience of living with an acute illness at home, receiving support from the HaH service, the context in providing such support. They were also asked about the involvement of HaH staff with other support services, and the patients' SN members when supporting patients (Appendix A). Demographic (age and gender) data and employment information (job title, length of time working within service) was collected from each participant.

2.4. Data Analysis. Interviews were recorded, anonymised and transcribed verbatim by the lead researcher. A proportion of the transcripts were then reviewed separately by each member of the research team with findings discussed until consensus was reached. The transcripts were analysed using iterative thematic analysis to find recurring trends that could come together into themes and subthemes [41]. Self-transcription, and the manageable size of the data set, resulted in immersion into the data which meant that the researcher was well positioned to undertake thematic analysis manually, without the use of a software program [42]. Focus within the transcripts was applied to the meaningful data relevant to relationships between nurse, patient and the SN of support; the "work" undertaken by the healthcare professional and applied to the context of acute illness at home. At each stage of data coding and analysis, discussions were conducted within the research team to ensure consensus. To demonstrate, an excerpt of the thematic analysis process is shown below (Table 1).

3. Findings

In total, 9 participants were interviewed this included registered staff nurses ($n = 4$) and healthcare assistants ($n = 5$), and male ($n = 2$) and female ($n = 7$) participants. Participants had an age ranging from 32 to 57 (mean age = 46, SD = 8.21) and had worked in the service for a mean of 19 months (range = 4–30 months, mean length in months = 15.2, SD = 8.05). Interviews ranged from 40 to 100 minutes. The findings were summarised in four overarching themes: (1) P*rioritising illness work within a discourse of person-centered care,* (2) *The work involved in the "naturally" therapeutic environment of the home,* (3) *Partners as key members of the care team* and (4) *Limited awareness and engagement with (in)formal networks* (Table 2). Extracts and quotations from the data are used to illustrate each theme, including any differences of perspective and nuances. As such, the extracts are representative of all the data.

Table 1: An excerpt of a larger thematic analysis table demonstrating how data were utilised and organised to form subthemes and themes.

Quotation	Subtheme	Theme
I can't think of one that has come back with any negative feedback. It's always positive. (Participant 7) We, I would say, have most of the things they could need (Participant 3) We're not just task driven (Participant 2) Sad to see us leave [when discharged] because we have a laugh. Especially those who don't have anyone (Participant 1) just. . .umm. . .be just very friendly and open (Participant 7) Chat about sport or family (Participant 2)	Discourse/professional identity/self-perceptions of service Developing an effective nurse-patient relationship and relational work	Relationship with the patient and prioritising health work
At home they're more relaxed. They've got things that they can do, they can get on with things, even if it's just a jigsaw puzzle (Participant 7) Feel more relaxed at home (Participant 2) Some are engaged with their health but some are very passive (Participant 3) we've had people for a day and we've had patients for several months (Participant 7) The younger patient doesn't need a lot. . .you go in, give the antibiotics, have a chat and but there is other patients that probably would want more of your time. (Participant 4)	How being treated at home improves patient experience and nurse-patient dynamics Breadth of patient as a barrier to providing emotional and practical work	SN dynamics in the context of the home

Table 2: Overarching themes with the subthemes.

Theme	Prioritising illness work within a discourse of person-centered care	The work involved in the “naturally” therapeutic environment of the home	Partners as key members of the informal care team	Limited awareness and engagement with (in)formal networks
Sub theme	Sense of developing an effective nurse-patient relationship by going beyond role responsibilities	Environmental factors that improve patient experience	The emotional and practical support from partners	Placing limited value on, and therefore under-exploring the wider network of support
	Logistical barriers to building relationships	The home increases patient autonomy to reduce the additional work of HaH staff	Partner-nurse relationship dynamics	Prioritising formal services over the wider network of friends, family, and acquaintances
	Prioritising illness work	The work involved in adapting the home to support care provision		

3.1. Prioritising Illness Work within a Discourse of Person-Centered Care

3.1.1. Sense of Developing an Effective Nurse-Patient Relationship by Going beyond Role Responsibilities. Respondents had positive perceptions of the service (1–9); with participants claiming that *"I have not had a patient who disliked the service"* (3) and *"we always get good feedback and a good response and they're [the patient] usually very happy to have us"* (6). This gives HaH staff a strong sense of professional identity associated with providing hospital level interventions at home (1, 3–6, 8), making *"people better"* (3) from a health perspective (3, 7, 8) whilst helping to *"save money for the NHS"* (4) by reducing the use of more expensive inpatient "bed-days" (3, 4, 8) and facilitating "*people to be at home and be around loved ones"* (7).

The HaH staff thought that this positive patient-centered perception of the service was in part due to HaH specific factors opposed to being in hospital:

> *"You're coming into their home which is very different than going into their hospital bed-space to deliver care" (6)*

This was because of the longer time HaH staff spend one-to-one with the patients during medical intervention (4–8) which allows nurses the *"time to converse"* (5) and build rapport with patients (1, 2, 3, 5–9). *"Rapport building"* (1) is undertaken in a number of ways by the nurses; but most commonly through informal and unstructured discussions about people's life and concerns unrelated to their health or the specific health interventions and (1–7) and included *"having a good chat about anything really"* (1), *"having a laugh"* (1), talking about sport (2, 3), hobbies (1, 6, 7), jobs (1, 3, 5, 6) and families (3, 6, 8), food (8):

> *"I find it's quite interesting to find out what they did for a living You know to strike up a conversation" (5)*

Participants refer to the time they can designate to one-to-one nurse-patient interactions as an opportunity to build an egalitarian and reciprocal relationship through sharing experiences and personal stories (1, 5–8). This is particularly pertinent in the patients' home where cues such as pictures and artwork can be used as a tool for starting conversations (1, 5). HaH staff *"sit and watch telly with them–like a game show and you do it together"* (1) and share personal information about themselves (1, 5, 7), their pets (1, 7), past employment (6), and are generally *"friendly and open"* (7) to the point where one participant felt they:

> *"get to know them, and they know you. Then you do have that almost "friendship" thing going on" (7)*

Developing relationships with patients is not only seen as an opportunity to provide a degree of emotional support; "*if you can get them laughing then that's really good medicine!"* (7), but also for creating *"a better picture of what this individual is going through"* (5) by asking *"how are you managing?"* (3) in reference to wider practical and emotional support. Patients are considered more likely to disclose information when they have a stronger relationship with the nurse (1, 2, 6, 7). If additional practical work was identified then nurses, particularly healthcare assistants, would likely provide support *"off the hoof"* (1) in the short term (1, 3, 5, 7, 8), with tasks such as making hot drinks (1, 2, 5, 7, 8), *"A simple meal if they needed it. Some toast"* (5), *"feed[ing] the pets"* (7), *"basic shopping"* (5), *"toileting"* (9), or help *"getting into their pyjamas"* (7).

When considering that nurses *"get to know them [the patients] over time"* (1), the acceptability of providing emotional and practical support depends, in part, on the length and intensity of interaction with the service (1, 6, 7). For example, one participant explained that "*It can become much more comfortable [over time]. . .much more jovial"* (6), and that frequent users of the service have stronger relationships than others (3). Furthermore, length of time spent using the service and amount of contact during that time is a determining factor for relationship building (1–9); and considering that a medical diagnosis might necessitate HaH level interventions that range from one day to several months, and once-a-day to three-times-a-day (1–9), those whose medical need requires more interactions from the HaH nursing team are likely to see an increase in relationship strength with the nurse:

> *"if they're being seen three times a day you're going to build up quite a rapport with them" (7).*

3.1.2. Logistical Barriers to Building Relationships. Some of the factors that create challenges for establishing and maintaining relationships with patients are logistical and practical. The most widely cited example of this is the long travel distances to some patients' homes (1–4, 6, 7) which restrict the ability to build a relationship because, for example, it reduces the number if nurse-patient interactions that individual might receive: *"if it's [the patient] far away then it limits the amount of visits a day"* (3) and *"We can go out to 30 miles from [hospital name], but they [the patient] would only get one visit"* (1). This may in turn increase the length of time it takes to build relationships and gather relevant health and social information about the patient (2, 4, 5). When considering that each interaction can take up to an hour (1–4, 6), in addition to long travel distances, this can cause restrictions in the amount of patients that can access the HaH service (1, 3, 5):

> *"the amount of time you're going to spend. . .is going to be excessive and there may be other patients [that need the service]" (5).*

The longer travel distances from main healthcare hubs also limits the access to support available to the patients from other HCPs which means they have to *"trek into appointments"* (1) that replace medical reviews and diagnostic services that would be undertaken routinely whilst admitted to a hospital ward (3, 6, 7, 8).

The nature of the work of HaH staff is very diverse and difficult to standardise, as there are "*patients from the whole spectrum of nursing* [that use HaH services]. *There's surgical patients, there's medical patients; there's young patients from 19. . .right up to your 90s*" (4). This breadth of patient needs and contexts indicates that fitting even only the illness work required into a home context is not automatic. Relationships between nurse and patient are also developed slowly because of staffing limitations (1, 3) and the "*rotate[ing of] the runs*" (1) designed to reduce the burden on staff caused by driving too far in one day (5). One participant felt this causes anxiety among some patients: "*Some get anxious about who is coming in today*" (1). Rotating the attending nurse, designed to reduce the burden of long travel distances on one nurse, may inadvertently result in nurses being increasingly "*isolated and vulnerable*" (3) when facing challenges locating patients which they have never visited before (1, 4, 8) and when they "*don't know where you're going*"*(4),* especially in rural areas (1, 2, 4, 7), "*in the middle of nowhere*" (2), late at night (2, 4) and in bad weather (2, 5) where telephone and GPS signal may be limited (5, 7). Furthermore, some nurses suggested that some factors reduced their willingness to visit certain patients such as dangerous dogs that nurses "*had to make sure was shut out before we got there*" (7), "*police patrolling dangerous neighbourhoods*" (3) and the unclean or unhygienic conditions of some homes (1–3, 5, 7):

> *"Some [homes] are really filthy and you have to wipe your feet on the way out" (7).*

3.1.3. Prioritising Illness Work. The discourse about "natural" and "strong" nurse-patient tie appears to be a limited, infrequent, and unplanned by-product of a health-focussed service suggesting that there is a discrepancy between what HCPs think they can achieve and the reality in practice. For example, despite nurses claiming that best practice is to "*go in and do what you've got to do* [regarding additional practical and emotional work]" (3) and that they're "*not just task driven*" (2), the "*chat*" is superficial and kept within the time permitted for the health intervention (7, 8): "*[have a] Friendly chat until it is time to leave*" (4). From this perspective the relationships are built as a means to "*pass the time, [and] the silence*" (4) during health interventions, rather than as an inherent part of offering a service that is holistic and patient-centered. Therefore, the "*medical conversations take priority*" (3) and although informal discussions may help identify health problems which might otherwise go unrecognised (6) (such as patients "*eating the wrong foods*" (3) and ensuring that patients are "*drinking correctly and that their environment is safe*" (5)), the health focussed approach is used to limit the amount of additional work provided by nurses (4, 6, 7) meaning that "*it's not very often we [HCPs] do anything extra than delivering the antibiotics*" (6). This approach was optimal to some HaH staff because of the time specificity of planned health interventions such as intravenous medication, vital-sign observations and wound dressings (2–4, 6–8). One participant stated it "*is important that the antibiotics are given on time*" (3) whilst another expanded: "*if they're having antibiotics three times a day then they have to have a certain gap between so you have to go at six hours between*" (6). In contrast to the discourse of taking a holistic approach beyond illness work, there was also a perception that undertaking such work would be in tension with the need for clinical reliability within HaH services (3, 4, 5):

> *"I think if we started getting people out of bed and washing and dressing people then we're going to be late for the next visit and then that patient doesn't get their antibiotics" (4).*

Additionally, providing wider ranging support would also restrict the service's ability to assist as many people, with as wide a ranging conditions as possible (4, 5):

> *"we would have to change the whole service and we wouldn't be able to take on as many patients if we were going to provide [personal] care as well" (4).*

The low value and priority of emotional and practical support is also systematically embedded in the service where there is a strong drive towards minimising face-to-face interactions and time spent with patients where possible. Firstly, this is achieved through the use of technology; nurses are able to administer multiple doses of antibiotics across the day despite only visiting the patient once (1, 3, 4, 7, 8). Although some nurses argue that for some patients there is emotional value to this because there is "*less of a burden for them*" (1) if seen only once a day and "*gives them a bit more freedom. . .to enjoy their spare time walking, seeing family*" (1). Others suggested, "*I suppose it does free them up, but really it's for our time management*" (4). Secondly, the reduction in illness work is achieved through medically, illness focussed discharging (5, 7): "*as soon as their infection markers are at a healthy level. . .that's when they go*" (5). This is in spite of nurses acknowledging that patients are often "*sad to see us leave*" (1), particularly those who lack social support (1, 8) or "*don't see a lot of people and get used to you [the nurse] being there every day for their social interaction*" (4).

3.2. The Work Involved in the "Naturally" Therapeutic Environment of the Home

3.2.1. Environmental Factors That Improve Patient Experience. HCPs believe that patients who use HaH services "*feel important*" (7) because they are being treated at home and that they share the nursing values of relieving pressure on NHS provision by "*freeing up a bed for a more acute patient and saving money*" (3). As such, HaH staff anticipate that patients will associate the service (and its employees) with this positive experience (1–4, 8). Experiences are further improved because patients are "*feeling at ease*" (3), are "*more relaxed at home*" (2) and are in their "*safe place*" (1, 5). Home comforts such as a comfortable bed (1, 3, 4) and television (1, 5, 7) are widely cited as important factors to improving the experience of the patient (1–9); less interruption to sleep (3–5, 8) and home cooking (3, 4, 6) adds to patients feeling *"comfortable in their own surroundings rather than being in a busy hospital"* (4).

The nurses feel that these factors contribute to more effective nurse-patient relationships because the patient is more at ease in their own home which, in turn, facilitates a positive service experience. This is substantiated by the increased levels of *"engagement with their health"* (3) and empowerment in their treatment choices (2, 3, 5–8):

> *"It's more personal being in their house. There is, kind of, that working relationship with them [the patients] and [more] talk about their problems and worries" (4)*

3.2.2. The Home Perceived to Increase Patient Autonomy to Reduce the Addition Work of HaH Staff. The main driver for what HaH nurses perceive as benefits of the service for patients appears to have little to do with the holistic work of the nurses and is mainly a by-product of patients being in their own home, which is perceived to be acting as a therapeutic environment. Respondents thought that by being treated at home, patients are able to maintain existing routines and "*just get on with things*" (7) in an environment that is more stable and consistent with their existing norms and values than inpatient settings (2, 5, 8): "*everything is around them that they have lived with all their lives...they have their loved ones with them*" (5). Nurses facilitate the patient's existing routine by providing a treatment service that *"is not regimented"* (5) by the needs of a large hospital (such as limited options and access to food and drink (6, 8)); and disruption when "*sleeping in bays of six*" (4) and by encouraging independent choices such as *"eating and drinking what they [patients] want"* (6) at a time that suits them (4, 6, 8) and *"going to bed when they want to, getting up when you want to"* (5). By doing this, nurses believe that this adaptive dynamic is inherent in the "home environment" and that just being at home allows patients to benefit emotionally (4, 6, 8) but also improves health outcomes because of increased functioning whilst undertaking everyday tasks and the associated *"fitness, strength and stamina"* (4) that will be maintained as a result (4, 6, 7, 8).

3.2.3. The Work Involved in Adapting the Home to Support Care Provision. In contrast to the idealised narrative about comfort and benefits of the home environment, the accounts of the actual work completed indicate that there is need for a substantial amount of additional, work on the part of both patients and HaH staff for the successful integration of care into the existing routines of patients. This additional work is made invisible and normalised as *"one shoe doesn't fit everybody"* (5). For example, HaH staff have to adapt type and quantity of additional work to each individual's attributes such as age (1, 2, 3) and level of illness acuity (3, 4, 7): "*There are a lot more unwell people but there are* [also] *some people who have not felt unwell from the start*" (4). In the extremes, some patients continue to work during HaH admission (1–4) whilst others *"would not be able to stand and cook a meal"* (6). Some patients require formal care (1, 3, 4, 8) because they are "*older and less able and need help with personal needs and around their home*" (1) whilst others are able to undertake home improvement projects (5) and exercise (4).

There were clear counter examples to the discourse about the home as a naturally therapeutic and patient valued environment. Such cases were however narrated as being due to the varying personality traits of individual patients, rather than being an inherent part of the intrusion into people's private space (1, 4, 8). For example, some patients may be *"stoic" and "closed off"* (8) and avoid asking for additional support or simply "*cope better than others on their own, it depends on their personality*" (1) whilst others rely more heavily on the nurses for social support: "*We have a lot of people that don't really want to chat at all. And others that, when you're trying to leave, they're still chatting*" (4). This indicates the high level of relational skills required of the HaH staff who have to practice differently depending on contextual factors, individual needs and preferences, and assumed expectations (1–5, 7, 8):

> *"You wouldn't go into the house of someone who is young and independent and make them a cup of tea; it's not appropriate" (2).*
>
> *"With the younger patient, they don't need...want a lot You go in, give the antibiotics, have a chat and go...but there are other patients that want more of your time" (4).*

While the home setting is narrated as "natural" and easy for patients it was evident that this involved new types of work would have to be done not only by HaH nurses, but also by partners. Partners would spend time to prepare their home for the HaH staff; *"thinking the house needs to be perfect because they [the partner] think that's what we're* [the HaH staff] *looking at, criticising them"* (6) and that there are *"two strangers who you've never met in their home"* (5). HaH staff would aim to develop a collaborative relationship with partners, ensure their wellbeing (1, 2, 5, 7) and, *"check out how they're doing"* (1):

> *"[We need to] check they're okay. Otherwise the whole thing [HaH treatment for the patient] would fall apart" (2).*

3.3. Partners as Key Members of the Informal Care Team

3.3.1. The Emotional and Practical Support from Partners. HaH staff saw partners as playing an important role in supporting patients at home (1–9) and were aware that some partners were registered as long-term carers because of pre-existing health conditions (1, 2, 3, 7). Our respondents thought *"it's easier if they have a husband or wife"* (3) because *"his wife does an awful lot for him"* (6) and that having "*husbands or wives at home help to look after them [the patient]*" (1). There were cases where HaH staff thought that *"without the spouse it's difficult to see [the patient able to be] at home on his own"* (3). Partners undertake wide-ranging work (1–9), which included practical work such as preparing meals (1–7), helping the patient to wash and dress (1, 3, 4), toileting (2, 3, 6), shopping (7) and domestic tasks such as cleaning, and walking and looking after pets (4, 7). HaH staff thought that it was more acceptable for patients that practical everyday work was undertaken by a partner than provided by HCPs (1, 3, 5, 7). This was in part because partners are able to *"maintain a routine that is important for them [the patient]"* due to the one-to-one nature of the relationship (1) and in part because of the concurrent emotional support that partners can provide, such as stimulating conversations (5, 7) and increasing their self-worth (7):

> *"if you feel loved and wanted, you know, you're going to be a lot happier than if you're sat in a room on your own" (7).*

3.3.2. Partner-Nurse Relationship Dynamics. Partners were also involved with substantial amount of illness work such as dispensing medications (1, 3, 7), giving injections (3) and providing transport to medical appointments (4, 5, 8), keeping records of blood pressure and blood test results in order to inform other services (3) and "*she would get stuck in with the [wound] dressings because she had been doing it herself for a long time"* (1). In addition, most partners remain present during HaH staff interactions with patients (1, 3) and use their in-depth knowledge of the patient to take on a care coordinator role within the service (1–4, 9). This is achieved by *"advocating the patient's needs"* (2) to the healthcare professional, writing down and asking questions (1–4), raising concerns that the patient has not (4) and providing contextual detail:

> *"without them [the partner] we would have had much less accurate information" (3).*
>
> *"she [wife] kept a food diary, without her we wouldn't have known [what the patient had eaten and drank between nursing interactions]" (2).*

Furthermore, as with the patients, nurses use informal conversation (4, 5, 7, 8) and *"chat"* (1, 2, 4, 8) to *"converse with them [partners] on a level that is not clinical"* (5). This is firstly done as a means to support the emotional wellbeing of the partner (1, 2, 9) but also to increase trust in the nurse and service (4–8). By doing so the likelihood of accurate information sharing is increased (5, 8):

> *"That bond, that sort of personal way of conversing with someone, is what makes them want to be open with you…they might have something of value they want to share with me" (5).*

Over time, as the levels of familiarity and trust grow, the relational and presentational work that partners and HaH staff do may be reduced also making the overall support more efficient and adapted to partner's needs (3, 4). For example, when there is such trust, partners see nursing visits *"as respite"* (3) or an opportunity for completing practical tasks such as *"go[ing] and do[ing] something in the garden, or go to the shop"* (4) knowing that their respective patient-partner is being treated.

3.4. Limited Awareness and Engagement with Informal Networks

3.4.1. Placing Limited Value on, and Therefore Under-Exploring, the Wider Network of Support. In contrast to discussions about the key role that partners play in supporting patients, respondents had a limited awareness of, and did not appear to place much value on, the support provided by other members of the patient networks. Where there was awareness of the wider network this tended to be from *"pictures of family"* and by *"looking around the home"* (1, 5, 7), and was limited to a generic reference to "family": *"I'd probably say that's about it [for SN members]; normally just family"* (4) or *"They might not have any interaction, they might not have any close friends or relatives"*, and even less so during the Covid-19 pandemic (1, 3, 4, 7). "*Family support"* (2) provided by sons, daughters, grandchildren, parents (2, 3, 6) and other *"loved ones"* (5) was described with limited specificity (1, 2, 5, 6, 8) and was deemed *"helpful but not necessary"* (3).

The value of weaker ties such as neighbours (3, 5, 6, 8), friends (1, 3, 5, 6) and paid services (3) was acknowledged by nurses and was primarily linked to practical support (e.g., cleaning (3) and shopping (3)), while pets were seen as a providers of emotional support and companionship (1, 7). However, support from such ties was poorly understood and considered inferior to support from partners (1, 2, 6, 9), and interpreted primarily in terms of their value for HCPs:

> *"They [weak ties] just don't have the knowledge to support the patient as well [as partners]. They try to help but give less accurate information because they're not [always with the patient]" (2)*

The lack of understanding, awareness and value placed by nurses on the role of weak ties may be, in part, because most wider network members "*tend to stay out of the way [of nurses]"* (1) but also due to the ad-hoc exploration of, and engagement with, other network members. Weak ties are only encountered by chance (1, 3, 6, 8) if *"work colleagues call[ed] whilst we were there"* (3), "*neighbours pop in"* (6) or "*We [nurses] pass them by chance"* (1). Although one participant does explicitly ask patients *"Do you have a relative? Do you have a friend who gets your shopping?"* (5), weak ties are more frequently explored through ad-hoc informal conversations with patients during health focussed interactions, as a way of being friendly and filling time (1, 4, 5, 6):

> *"some of the [antibiotic] drips can take an hour so you've got a long time to go over general chit chat…what they're going to do today…what their children are doing today, what friends they've got" (4).*

3.4.2. Prioritising Formal Services over the Wider Network of Friends, Family, and Acquaintances. When patients do not have a partner, are *"not in a relationship, family [are] very distant and so they're isolated"* (5), nurses tend to focus on helping with access to paid and formal services to fill gaps in support (1–9). For example: *"It's for us [the nurses] to recognise that by talking to them and go "Okay. They would benefit from some outside support"* (5). In such circumstances nurses tend to mobilise formal services on the patients' behalf (1–9): "*You know, get some, get social services support set up"* (5). Such support includes local care agencies that provide help with practical work such as personal hygiene and mobility needs (1–4, 6, 7), to prepare or deliver meals (1–3, 6):

> *"if they weren't able to make a good meal then I'd talk about delivery of meals, of microwave meals. We can offer them a brochure for that" (6).*

Nurses might suggest patients have *"somebody to come in once a week and do the shopping"* (6) and may mobilise this support themselves by "*networking with somebody else, some other service, [such as the] Red Cross service to help with their shopping"* (5). Accessing and relying on formal services may be *"stressful, confusing and busy"* (1) for patients, it is unlikely to fulfil emotional work because *"you can't really ring the carers and say "can you go and sit with them for a chat""* (5), but by mobilising such support HaH staff are able to maintain a focus on the patients" health work (3, 6, 7):

> *"We can do "care" but tend to refer on to others because of the time it takes and the urgency of the antibiotics" (3).*

Linking up with other services was not seen as easy or seamless for professionals either. Unlike engagement with informal support, it was more familiar to HaH staff and was considered an extension to their service. Although accessing some specialist consultant support is known to be difficult among the nursing team (3), such links were made because acting as a patient advocate was seen as part of the nursing role (1, 4, 7). For example, *"If there was another need, we would highlight it to the team leader"* (7) and that *"if I [a nurse] couldn't do it [resolve a health concern], I'll make sure I ask the right person"* (4). In doing so, HaH staff also utilise and build their professional networks (1, 4). This is supported by the service's ability to advocate to other HCPs and specialist services such as dieticians (2, 4), speech and language therapists (2), physiotherapists (1–3), occupational therapists (1, 3, 4) and tissue viability specialist nurses (2, 3). Similarly, patients *"are still under the hospital doctor's care"* (4), the nurses have good links with medical teams (2, 4, 6) and are "*constantly in contact with [doctors], keeping them updated with information"* (6).

4. Discussion and Implications

4.1. Discussion. This study used semistructured interviews to gain insight into HCP perspectives on the types of work they do to support HaH patients, what the involvement of the formal and informal network is, and the mechanisms and tensions which contribute to how this work is done.

Our results demonstrated that the answers to the research questions are intertwined and could not be answered in isolation from each other. In part, this is because the findings demonstrated that the nature of the work required to support patients with acute illness living in community settings is complex and requires deeper understanding of not only aim one; the nature of work that is needed, or two; engagement with personal networks and contextual factors to complete it, but also three; how this can be realistically achieved considering the varying degrees of needs [43] and demographic and environmental factors [17, 44] which effect how this may be achieved.

Firstly, when exploring what work is needed to support HaH service users staff developed discourses of person-centeredness and holistic care as inherent in their ethos and the service they provide. However, the practice of HaH is dominated by a medical model which focussed on managing illness, reducing costs and being time efficient, whilst serving as broad a patient cohort as possible [14, 45]. Such a focus leaves substantial amounts of the emotional, practical, coordination and relational work needed by patients undone, or needing to be done by other SN members [26, 27]. While HaH staff are aware of these gaps in provision the financial and resource priorities within which they work offer limited scope for change in practice–to a patient-centered model which matches HaH staff's self-perception. The arising tensions in patient support are assumed by HaH staff to be self-resolved and framed within a discourse of the "therapeutic environment of the home', which acts as a justification for the limited scope for practice change.

When considering the second research aim, (what members of the formal and informal workforce are involved in the work of patients), HaH staff only had a very limited awareness, interest, and engagement with the network members of service users. Other studies on self-management support have demonstrated the key role of social network members and the value of diverse types of relationships within networks (including strong and weak ties) in addressing the complex needs of people living with an illness in community settings [32, 46–48]. However, our findings indicate that HaH staff understanding of the support networks of their clients is limited to partners and spouses. What is more, the understanding and value of partners' roles is primarily seen through a medical model (i.e., focussed on providing information to improve diagnosis, medication understanding and adherence, interpretation and management of symptoms), where practical, relational, and emotional work is peripheral. The contribution by partners to illness work is highly valued and closely explored by HaH staff because they can act as a substitute when nurses are not present and help with risk management, reducing time and costs, and doing more specialised illness work where there are clients with more complex needs. The reliance of HaH staff on spouses and partners may in part be due to the frequent contact and easy access during visits, proximity to patients, and their perceived reliability, access to resources, and knowledge of patient context and preferences [31, 49, 50].

The dependence on partners and spouses means that HaH staff dedicate little time on exploring the potential role of the patient's wider networks, especially weak ties such as neighbours, friends, colleagues, and community group members. These are only explored through ad-hoc "chat" and as a means of passing time during prolonged health interventions and therefore the work undertaken by these groups is largely unknown. Where nurses do coordinate weak ties this tends to be for clients who live alone (without a partner), who they link to other relevant health and social care services. This is in part due to their awareness of these services and their ability to mobilise support as a part of their professional role. However, previous literature indicates that the assumption that all such work is done by partners for people who did not live alone may be incorrect [21, 23, 31, 32, 47, 51]. This raises questions about if and how is the additional work (practical, relational, emotional, illness) associated with providing support for HAH users done for people who live with a partner as well as those who live alone.

In summary, although HaH service staff may be aware of the important role that members of people's wider networks play in supporting patients, actual engagement with such support tends to be limited to spouses and partners, who are primarily seen as a substitute for HCPs. By engaging with wider network members HaH staff may help reduce burden on strong ties (where these are available) and healthcare professionals. Sequentially, this can improve self-management, broaden patients' sources of knowledge and support, and is likely to be especially important for people who live alone [47, 52].

4.2. Implications. HaH staff needs to improve their awareness and understanding of the work done by patients and members of their wider networks. By changing practice to a way which recognises the contextual value of SN members and the importance of the work they do can lead to improved care and reduced cost for the health service.

Improvement in this area appears potentially challenging in the context of a tension between the need of the HaH service to accommodate a broad patient group whilst providing standardised and reliable illness work and treatment; and one that is restricted by structured intervention timings and limited contact time with patients. However, even given these constraints our findings indicate that there may be underutilised resource within the current service. Specifically, HaH staff experience excess of time (when delivering interventions) which may offer a potential opportunity to reduce tensions between routinizing treatment and serving a broad patient group by embedding an intervention that can improve understanding and engagement with the networks and contextual resources of patients. Some such work is already done by HaH staff but this is only in an ad-hoc manner. For example, from a SN perspective, when assessing what support is available to patients, nurses could engage in a structured and meaningful conversation during excess time that explores the patient's SN and the role each member has within it [46, 48]. Developing such an approach might enhance the service by improving understanding of people's context and availability of acceptable support, and would be in line with how the HaH staff professional role and identity. Further research from patient perspectives is likely to be complimentary to the findings of this study, and contribute to developing a better understand of the full nature of the formal and informal workforce and the work done by HaH patients' network members–knowledge currently limited by the lack of formal exploration by HaH staff.

5. Conclusion

The changing landscape of healthcare services is causing increasingly acute illness to be treated in community settings. As a result, services such as HaH are increasingly common. These services appear to be able to treat wide-ranging conditions for patient living in very diverse circumstances, but this causes the nurses providing treatment a challenge when trying to balance the idealised, patient-centered service their professional identity favours, with the need to routinize service provisions and support as many patients as possible. Developing a better understanding of and engagement with the social network members of HaH patients and the work they do, carries substantial potential in terms of accessing underutilised resources, improving patient support, and making the HaH service more efficient and person-centered.

Appendix

A. Interview Schedule

Staff participant Interview 1 schedule.

Opening (Establish Rapport) (5 mins).

My name is Jack. As a fellow member of staff from the hospital at home service we've probably already met.

We've met today in a different role to get information about your time working for the service. Try to forget that I work for the service and give me your best and most honest (whether that's positive or negative) answers to help improve the service for future users.

You don't have to answer any questions you don't want to. Ask to stop at any time if you wish.

The interview usually takes 30–60 minutes–is this ok? Thank you.

Check understanding, read the PIS and consent form signed. Remind them it is being recorded.

Body of Interview 1. (Roles and responsibilities) (15 mins).

This part of the interview is about you, your role and the service as a whole. Is this ok?

What is your role in the service?

(i) What do you do for the service users?
(ii) Anything else you do for them?. . .consider things beyond the tasks expected of you

What are your thoughts on the service as a whole?

(i) Strengths and weaknesses?

(ii) Do you think there are challenges to treating patients at home compared to hospital? (Time, physical obstacles, rurality, resources etc.)?

What is your understanding on the involvement of the people around the patient during HaH treatment?

(i) What do the people do for the patients? How do you know this?

(ii) What is their involvement with HaH? How do you know this?

(iii) Does the involvement change over time when HaH are involved. . .is it different at the start and end of treatment? What makes you think/know this?

(iv) Is there a difference/affect/relevance depending on who it is? E.g., a neighbour compared to a spouse

[Transition] Great! That's the end of the questions on your role and the role of the service. Is there anything else you would like to add?

Body of interview 2. (Service user experience) (15 mins). [Check happy to continue].

This section is going to ask you about the experiences of the patients.

Generally, how do you think the service is for patients?

(i) Is feedback positive or negative? *[explore pros and cons]*

(ii) Considering the pros and cons discussed, what could be done to improve the service?

What do you know and think about the involvement of the people around the patient's (their social network) during their time with the service?

(i) Do some not have enough support? What happens then? Do staff end up filling gaps in roles that may be filled by friends and family?

(ii) How do patients manage tasks at home?

You said HaH staff help with *[comment from earlier]*. What about when the HaH service ends? Who would help with this then?

(i) What else do you know and think about happens after HaH involvement ends regarding the patient's ability to cope? And with their ongoing health needs?

(ii) How does discharging them make you feel? Positive and negatives?

[Transition] Thank you! That is the end of this section of the interview. Is there anything else you can think of that might be important regarding the time of discharge and afterwards for patients?

Close (5 mins).

We are reaching the end of the interview now. Is there anything else you'd like to add about your role in the HaH service? What could be done to improve it? Or how it affects patients during and after?

Thank-you so much for taking part, as you know I am involved in a PhD research project and the information you have been given will be really helpful in achieving the aims of it.

As you may remember from the PIS there will be another interview in the future to discuss findings from the patient interviews and I look forward to doing that with you then. I will contact you nearer the time.

Data Availability

The data used (transcribed semistructured interviews) in this study are available from the corresponding author on request.

Additional Points

What Is Known about This Topic? (i) New (and under-researched) services such as "HaH" are increasingly required to provide acute illness treatments in the community and reduce the burden on inpatient settings. (ii) A degree of self-management will be required for patients receiving "HaH" treatment but knowledge of chronic illness shows that having support of a diverse SN facilitates this. (iii) Community healthcare professionals often go beyond their professional boundary to provide practical and emotional support. *What This Paper Adds?* (i) Nurses feel they provide patient-centered, individualised care but instead care provision is medicalised, focussed on illness management and routinised. (ii) Nurses are heavily reliant on strong ties (in particular spouses) and formal services, that they are familiar with, to risk-manage and provide illness, emotional, and practical work for patients. (iii) Improved understanding and engagement with members of people's wider network may help HaH staff to offer more appropriate and sustainable support for patients in different circumstances.

Ethical Approval

Following ethical review, this project received a favourable opinion by the Frenchay REC on the 30th of October 2019.

Consent

Written consent was gained by all participants prior to data collection.

Conflicts of Interest

The lead researcher practices clinically as a nurse within the HaH service which was the single site of this project. Maximum efforts were made to remain impartial and the iterative process of reviewing data by the whole research team has been used to reduce this limitation.

Authors' Contributions

Data collection and transcription was undertaken by the lead researcher JG. JG reviewed and analysed all the data and IV and RB reviewed a percentage of the data. JG led the production of the paper and each draft of the paper was reviewed by IV and RB. All authors gave approval of the final draft.

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