Rediscovering community hospitals

THE contribution of community hospitals has been the best kept secret of the contemporary National Health Service (NHS). A cultural anathema during the dark days of the internal market, their size, diversity, and above all their locations, have meant that their collective properties have long gone unrecognised by the large majority of NHS professionals, politicians, and patient representatives. Until the 1997 National Beds Inquiry they scarcely figured in national policy statements and had no designated 'lead' at the Department of Health. The fuzzy popular image has been of a cosy converted country house or whitewashed wartime wards in prefabricated buildings. They belong to a sector seen as steadily diminishing with the movement towards a primary care-led NHS built unequivocally and almost exclusively on the perceived strengths of the individual practice unit. The current demise of NHS Community Health Services Trusts, in this context, could have been expected to signal a further period of decline with community hospitals losing the protection of their natural custodians.

The real picture is actually quite different. As the articles that follow by Seamark *et al*[1] and Donald *et al*[2] indicate the long-term trend is — and more surprisingly has been — for a steady expansion in the number of both community hospital sites and beds across the UK with unprecedented levels of short-term service innovation. Add to these trends the allocation of an extra £900 million to intermediate care in the new NHS Plan,[3] the government's November 2000 Concordat with the private sector, and the advent of both NHS Primary Care Trusts and a new range of integrated health and social care organisations across the country and the prospects for community hospitals are transformed. As a principal source of converting the centrally determined policies of the New NHS into local actions with authentic local engagement and quite possibly with a different 'modernised' generic title, the future for community hospitals has not looked so good since the turn of the century, a hundred years ago.

The transformation has four sources. The revival of interest in community hospitals signals in the first instance a rediscovery of the provider role of primary care, which is closely linked in the second instance to a growing awareness that one of the litmus tests for the New NHS will be how effectively it addresses the needs of minority groups with the special needs of handicap, disability, and disadvantage. The third force shaping strategies for community hospital development is political devolution and, finally, there is the New NHS principle of decentralisation with community hospitals providing the most obvious opportunities in today's health care environment to convert enhanced local engagement into legitimate and socially acceptable systems of co-payment and community ownership.

Over the past decade of tumultuous invention and innovation in primary care the new policy focus has been on primary care as purchaser and primary care for public health. The responsibilities for resource utilisation and population-based preventive and promotional programmes have underpinned the pivotal policy statements of successive governments, embracing both extended models of fundholding and now the alternative models of NHS Primary Care Groups and Trusts. Primary medical care has been neglected at the expense of primary managed care and primary health care, yet the post-1989 period of continuous NHS reform took as it platform the strength of the GP as provider. As we enter a new millennium the cycle is complete with a series of recent studies illustrating the critical contribution expected of community hospital facilities, as policy proposals for extended primary care provision render reliance on the individual practice unit alone increasingly redundant.[4,5]

This broader approach to the provider functions of primary care is of particular significance to what used to be described as the 'priority' service groups of the NHS. For those with degenerative conditions, learning disabilities, mental infirmities, and physical handicaps, social care has already been deregulated. Organisations, such as MIND and MENCAP, now supply what they used to advocate for, or against, in relation to the statutory authorities. The health care needs of these groups could go the same way, especially if they are elderly. As Tucker's research[6] has revealed in particular, however, community hospitals' range of rehabilitative care, respite care, and therapeutic facilities do offer the scope to expand their conventional services for older people to these 'priority' patients and ensure that the NHS continues to be their principal source of health care.

Regional assemblies, unitary authorities, and city mayors must demonstrate that they make a difference. Closer to the action than national government but far enough away to avoid becoming entangled in local politics, this is their moment for showing that health and social services agencies can work together; that localities and professions can pool resources rather than protect income levels and pecking orders, and that participatory democracy can work. Seen from these perspectives of political devolution community hospitals are a godsend. In Scotland, accordingly, where devolution is most pronounced, so too is the National Associations' promotion of community hospitals as 'integrated care' models. This convergence is not just coincidental.

Even in Scotland, with its still powerful public sector ethos, this integration embraces non-NHS resources. Community hospitals do represent the acceptable face of independent (including private) sector services as part of the new mixed economy of today's NHS, especially at its frontline. Covenants, legacies, gift aid charities, sponsorship, corporate donations and loans, lotteries, and commercial or local government grants represent legitimate co-payments under the terms of 'modernisation'. Community hospitals can attract these in abundance. Their diversity means that, according to context, a community hospital can place the NHS in the position of being the proprietor for a range of alternative service providers (e.g. Wimborne) on the one hand, to simply an arm of a service delivery package from privately owned premises (e.g. Rye, Salisbury).[7] Throughout

England, the emerging Primary Care Trusts are finding that their investment potential comes increasingly from their hybrid organisational status and community hospitals fit beautifully into their new frameworks as 'stakeholder' or 'network' organisations.[8]

Having for so long had the label of liability hung around them, community hospitals are now being perceived as potential capital and community assets within the 'whole systems'[9] of service performance that Health Improvement Programmes are designed to create. The four sources for the changing scenario described above amount to exciting times for primary care. General practice now has the chance to take its principles of whole-person centred, locally accessible longitudinal care to another level. In the interests of survival, if nothing else, the community hospital for the new millennium is likely to be the GP's best friend.

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Improving the diagnosis of childhood asthma

DO we diagnose asthma effectively in children? This month, the *BJGP* publishes two studies that indicate that general practitioners are still missing this diagnosis.[1,2] Yet we have known about the problem of childhood asthma for a long time. So why can't we get it right?

Diagnosing asthma

Encouragingly, Frank *et al*[1] found a higher incidence of recognition of asthma in their study than previously reported from general practice. Sixty-five per cent of the milder and 75% of the more severe cases of asthma had a corroborative record in their practice notes that compares well with the 65% recognition of significant childhood asthma reported in the recent ISAAC study.[3] It represents a dramatic improvement on a Tyneside study in 1983 that reported a diagnostic yield of 4% and 33% respectively for all children and for severely affected children with asthma symptoms.[4]

They also found that more severe asthma is more likely to be diagnosed and actively managed in practice than mild or moderate asthma. This finding is unsurprising: the more severe the patient's symptoms the more likely they are to be noticed and diagnosed by the GP. This leaves open the question of the 25% of children with significant asthma symptoms, many of whom had presented repeatedly to their GP and whose asthma remained uncorroborated in their clinical record.

The first problem is that we do not have a clear diagnostic test for asthma.[5] The diagnosis is made largely on clinical grounds. Peak flow variability and airway challenge tests have been proposed as definitive;[6] however, even in combination these tests leave 10% of clinically recognisable asthma unconfirmed. Furthermore, they are cumbersome, error prone, and not always well suited to general practice.[7]

Secondly, diagnosis of asthma may be confounded by the overlapping conditions of episodic virus-related wheeze in early childhood and chronic obstructive pulmonary disease in older adults. This may result in some children and older people being treated inappropriately with long-term inhalers, a question that warrants further review.[8]

Thirdly, diagnosis inside the consultation is not a simple process. It uses partially understood techniques, such as pattern recognition, that are subject to error and bias.[9] In general practice, it takes place within a multi-faceted interaction between doctor and patient in which the biomedical explanation of symptoms forms just one part of a complex agenda, and all within an average of nine minutes.

Finally, diagnosis is the gateway for patients between health and illness. Once this threshold has been crossed there are considerable implications for the patient's anxiety and their self-image.[10] Therefore, to address possible deficiencies in diagnosis important questions need to be answered about determining indeterminate clinical problems — about how and why clinicians arrive at diagnoses, or avoid doing so. Once this has been achieved, the even thornier question remains as to how activity within consulting rooms can be influenced by outside intervention.[11]

Case-finding

What are the benefits of active case-finding in asthma? There can be no doubt that careful planned treatment of asthma following national guidelines favourably influences a range of important outcomes, including work absence, surgery visits, and hospitalisation.[12] But is this equivalent to saying that active case finding will further contribute to these outcomes?

Given that the most severely affected people with asthma have already been diagnosed, active case-finding is likely to identify less severely affected asthmatic patients selectively. Whether long-term benefits will result from such a policy is far from self-evident.[8] Frank *et al*[1] appeal to the theory that fixed airway disease can result from failure to treat asthma airway inflammation. Given the dynamic and heterogeneous nature of asthma and the lack of proof for this hypothesis, this surely represents a call to further research rather than a serious challenge to current clinical practice.

Kable *et* al[2] offer a useful approach that addresses practice at a population level. They suggest that self-administered computerised questionnaires may offer a method of improving asthma recognition. Whether this would be generalisable to, for example, inner-city practices facing problems of language barriers and challenging behaviour is a moot point.

One step beyond this might be a computerised review of practice notes to automatically highlight suspect asthma cases to be followed through opportunistically. Existing computer technology may not be able to accommodate such demands but imminent developments, fuelled by the national information strategy[13] and the demands of new national clinical standards, may offer tools in the UK to enable such an approach.

Accommodating changes in clinical practice

Any change in clinical practice involves a considerable investment in resource from thinly stretched practice teams. Most developmental effort in the UK is currently being expended on the headline requirements of new and demanding clinical care standards, the National Service Frameworks. None of the four frameworks currently published or planned includes consideration of asthma care.

As professionals, we must retain a critical approach towards externally imposed priorities. The *realpolitik* of primary care in the United Kingdom, however, is a service with limited resources entirely paid from the public purse. It is inevitable that resources will be concentrated on well publicised and supported government initiatives. This may be to the detriment of other clinical issues, such as asthma, however significant their associated burden of morbidity and, occasionally, mortality.

Conclusion

The case for due diligence in the diagnosis of asthma is unanswerable. Asthma must be considered as a possible cause of recurrent or chronic respiratory symptoms in childhood, or indeed at any age. Once diagnosed, treatment should be appropriate and regularly reviewed. However, diagnosis is a complex and only partly understood process. Apparent failures in diagnosis need careful evaluation to understand their full context.

The direction of travel in asthma care in the UK is encouraging. Enormous improvements have occurred in recent years both in diagnosis and management in general practice. The papers by Frank[1] and Kable[2] echo the message of ISAAC UK[3] in reminding us that this battle is not yet won.

Interesting questions have also been raised on the rôle of active case-finding in childhood asthma. On the currently available evidence it is difficult to justify the resources that such a change in practice would involve.

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