Charge the community but delay its care

If the delay allows time for thought, good - but it probably won't

Plans that would have enabled vulnerable elderly and disabled people to stay in their own homes were postponed by the government last week (p 142).¹ The poll tax has been a greater burden than expected for local authorities and the public (and a greater vote loser, perhaps). The additional increase needed to pay for community care would be unfair, said Mr Kenneth Clarke, the Secretary of State for Health. Though he blamed local authorities for failing to balance their books, he acknowledged that they would need more time to come to terms with the substantial new responsibility of running community care. This revelation should have been no surprise to the government, given that it is responsible for the administrative hurdles of the poll tax, the new Children Act, and changes to education that face local authorities in the coming year.

The reforms would have redirected social security money to local authorities so that they could assess people's needs for care and appoint case managers to arrange and buy it. For elderly and physically handicapped people this could have meant living at home, with more domiciliary help and more access to day centres. Now they must wait, and so must their families and friends whose unpaid support saves the treasury an estimated £20 billion a year. Money already spent on implementing the reforms by local authorities, voluntary groups, and private firms may have been wasted. Will hospitals be able to reverse plans to close geriatric beds?

For people with psychiatric problems, whose plight has received more attention, there is better news. A specific grant will be paid to local authorities for the social care of severely

mentally ill people. But less than two thirds of the promised £30m will be paid, and local authorities will have to find £9m next year. Although the grant is a step in the right direction (and is probably all that Mr Clarke can get from the Treasury in its fight against inflation), it is not nearly enough. It will spread very thinly among the 550 000 severely mentally ill people who are said to need it, and will pay for the care of only 3000 people with schizophrenia, according to the National Schizophrenia Fellowship.² An additional £2m for those on the streets, recently announced, is another ray of hope but will take up to three years to appear.

The community care proposals were the most welcome part of the government's health reforms. They were by no means perfect: fears were expressed about the hurried time table, the lack of information on existing needs and services, the bureaucratic overload, and, most importantly, the failure to "ring fence" most of the money that local authorities would receive. But coordination of social care was an improvement on the current arrangements. If the next three years are spent constructively, reviewing these deficiencies, then the delay may be a godsend. But if there are other reasons for the delay more pressing priorities might occupy the government's time and the most vulnerable people in our society may suffer.

TRISH GROVES

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1 Warden J. Community care unreformed. *Br Med J* 1990;301:198.

2 Sherman J, Young D. £30m grant for mentally ill is "drop in ocean." *The Times* 1990 July 19:2

Regular Review

Colles' fracture

Failure in management may cause permanent disability

The most common type of wrist fracture was first described by Abraham Colles in 1814; it is at the distal radius and typically the lower radial fragment is dorsally and laterally angulated together with rotational deformity in supination.¹ There is concomitant damage to the inner aspect of the wrist, either stretching or rupture of the ulnar collateral ligament or fracture of the ulnar styloid, this often remaining ununited.

The usual victim is a middle aged or elderly woman who falls on the outstretched palm of her hand, force being translated upwards to the glenohumeral articulation of the shoulder. Classically, there is a "dinner fork" deformity of the wrist with painfully limited movement of the wrist joint and of rotation of the forearm.

Other fractures that occur at the wrist joint are those at the radial styloid, Smith's fracture with the opposite deformity of a Colles' fracture, the unstable marginal fractures of the radius described by Barton, and lunate facet "die punch" injuries from impaction of the lunate into the radius.²⁻⁴ Injuries that need to be considered in the differential diagnosis of Colles' fracture also include isolated damage to the inferior radioulnar joint and fractures of the scaphoid, which are common in young men.

The frequency of Colles' fractures in women increases

sixfold between the ages of 35-39 and 60-64 and then levels off. The incidence is lower in men, with a less dramatic rise in the more elderly.⁵ Epidemics of fractures occur in periods of snow and ice, resulting in considerable demand on accident and emergency departments. Both men and women with osteoporosis tend to have greater deformity after Colles' fractures than do those with normal bone texture, and there seems to be some correlation between deformity and bone quality.⁶

Immediate management

The patient with a Colles' fracture requires radiographs to confirm the diagnosis, and the displaced fracture then requires reduction; this may be performed under general anaesthesia, axillary or interscalene brachial block, intravenous regional anaesthesia (this is not always without risk), or, most conveniently, a haematoma block.⁷⁻¹⁰ The patient is placed supine and, after preparation of the skin, 5 ml of 2% plain lignocaine is injected dorsally into the fresh haematoma; in the patient with acute injury this usually provides perfectly adequate anaesthesia in five minutes (fig 1).

With countertraction on the arm above the elbow, the hand