in the meantime in order to survive financially during the procedure

- Although experience in clinical assistant posts will not be recognised by colleges as accredited training, the duration of any part time senior registrar training need not be strictly prorated and allowance can be made for commitment to the specialty and use of non-sessional time for continued study
- Do not give up. Remember that you have gained a great deal of knowledge and experience in manpower issues and the workings of region: This is excellent first hand management training for your future consultant post.

With ever increasing numbers of women graduating from medical schools, we hope that facilities for part time training will soon be incorporated into all training rotations and that there will be a greater recognition of the validity of part time training and support for the national scheme fostered by the higher training

committees and royal colleges. To quote Virginia Bottomley in her letter to regional chairmen, "Candidates for part time senior registrar training are of high quality. They have well founded individual reasons for wishing to use the part time option in training for consultant posts and are a major resource and asset and a long term investment for the NHS which cannot be wasted."

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Job share a consultant post

Graham Thornicroft, Geraldine Strathdee

Job sharing offers advantages to both employer and employee but it is still uncommon in medicine. Based on the experiences of two psychiatrists sharing a consultant post this article describes some of the problems in obtaining a job share. The most difficult part can be getting an interview, and once a post has been obtained the terms and conditions of service may have to be modified to suit job sharing. Getting on well with your job sharing partner and good communication will not only help overcome the obstacles but ensure that the sharing is successful.

Job sharing in medicine is still a rarity, although the NHS is now beginning to make it easier. We successfully applied together for a single consultant post in community psychiatry and we describe here our experiences of how job sharing a consultant post can be made to work. Our reasons for job sharing were different: one of us has interests in community clinical service development and wanted to retain formal training links with the London School of Economics and the Open University and the other wanted to combine clinical work with research interests in mental health service evaluation and psychiatric epidemiology.

Defining job sharing

Job sharing is an arrangement "whereby two people voluntarily share the responsibility of one full-time position. The salary and benefits are shared between them according to the time they work, and each holds a permanent part-time post."¹ It differs from part time work, which is not shared; joint appointments, in which more than one post is shared; and job splitting, where an existing full time post is split specifically to make work available to more people.

During the past 15 years job sharing arrangements have become much more common. Within the NHS 92 health authorities and boards throughout England, Scotland, and Northern Ireland employ job sharers. Hospital medical posts are shared at every level of seniority, including the consultant grade, in the following specialties: psychiatry, obstetrics and gynaecology, anaesthetics, radiology, and paediatrics. Many general

Advantages of job sharing to employers

- Job sharers' previous work experience is often complementary, and they bring to a single post a wider range of skills and experience than could an individual¹
- Job sharers are able to sustain a higher level of commitment and productivity in the longer term than can one employee, and in some cases staff turnover is reduced¹
- The arrangement increases flexibility: post holders can often cover for each other during leave without having to rely on cover provided by other colleagues, as is usually the case with full time post holders¹
- In practice the job sharers often work far more than their allotted sessions and together contribute considerably more than one person in post²

practitioners job share, and the BMA runs a partnership scheme to match sharers.

Job sharing arrangements are also operating successfully for nurses, occupational therapists, pharmacists, medical social workers, and psychologists in the NHS.² Indeed the post of chief executive of the Lambeth, Southwark, and Lewisham Family Health Services Authority is held on a job sharing basis. Other public services are now well ahead of the NHS: in local government there are over 2000 job sharing employees, and more than a third of local authorities have such arrangements.

Effect on employers

Although employing authorities are often initially cautious, job sharing offers considerable general advantages to them: there is reduced staff turnover and absenteeism, increased staff flexibility, increased productivity, greater continuity, and enhanced availability of skills. Organisations as diverse as the Stock Exchange and the Equal Opportunities Commission have conducted studies of job sharing. Their findings agree (box).

The three main concerns often voiced by employers about job sharing arrangements are poor communication, greater overhead costs, and clinical responsibility.

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Good communication and regular handover sessions are important for successful job sharing

Poor communication—Although in some specialties, such as anaesthetics, sessions may be split with little need for handover, more often good communication and clearly defined responsibilities are vital. But in practice this rarely causes problems. Evaluations of job sharers invariably find that they establish regular handover sessions to ensure continuity in discharging their responsibilities.⁷

Greater overhead costs—There may be small extra costs, especially initially, in the administration of contracts, salaries, and in office space and equipment. Despite this the head of personnel at the Stock Exchange found no significant increase in total costs of employing job sharers. Similarly, national insurance contributions for two job sharers are in almost every case less than for one post holder.⁸

Clinical responsibility—If a single case load is shared or if job sharers each have a case load and cross cover an explicit arrangement is needed concerning exactly which job sharing partner has clinical responsibility for which patients at every time during the week. This arrangement and any changes to it should be communicated to all relevant colleagues. In our case we also made sure that we would be available to colleagues by carrying a radio pager while on duty.

Practical arrangements

Since job sharing is still uncommon for doctors potential job sharers need to be specially careful and thorough when applying for a job. To be shortlisted applicants may need to add their own appendixes to the standard forms setting out what job sharing is, its advantages to employers as well as employees, and expected clinical arrangements—for example, how continuity of care and on call rotas will be organised. We decided that we would need to convince our potential employers that we were each appointable before our joint application would be considered, and so we arranged separate preinterview meetings. We were not told whether we would be interviewed separately or together, and so we prepared for both; the panel in fact did both.

In our clinical work we have each taken clinical responsibility for half the case load of the whole post and we work with separate multidisciplinary teams. We cover for each other for those sessions when the other is not on duty. We negotiated six sessions each on our appointment and the twelfth session is used as a regular planning and handover meeting to discuss clinical, research, teaching, service planning, and administrative issues.

Our usual working arrangement is that all regular clinical activities are carried out by the team's consultant. When one consultant is not on duty the job sharer becomes the responsible medical officer.

During any periods when both job sharers are not available—for example, because of leave or exceptional circumstances—the clinical responsibility is taken by another colleague at the hospital. We normally cover for each other during annual leave, but we made sure in our contract that we were not obliged to cover for each other because we both have children and might need to arrange leave during school holidays.

Terms and conditions of employment

In our hospital there was no precedent for doctors to job share and so we put forward a draft set of contractual terms and conditions as the basis for negotiation with our personnel department. The main issues which we had to clarify were annual leave; allowances for sickness, study, and training leave; and car and pension entitlements. We each received a separate contract with job sharer in the title, which included the following section: "The conditions which apply to full-time employees apply to job sharers jointly (Employment Protection (Consolidation) Act, 1978). Entitlements for which employees qualify by length of service are calculated individually, and where appropriate, on a proportional basis according to the number of hours worked. The concept of proportionality is applied to the conditions of service unless otherwise specified."

We used the principle of proportionality for most of these entitlements—for example, annual leave and pension entitlements were divided pro rata to give us each 6/11 of the full allowance. However, after taking advice we stipulated that sick leave would relate to length of service and that we would be included in the statutory sick pay scheme with seven days per week each as the qualifying days.

We requested and received a full entitlement each for training and study leave and car allowance. We argued that to be effective in our posts we could not accept going on half a training course each and that half a travel allowance was not efficient because our post was to develop community oriented mental health services. The essential user's payment is made on an individual basis to each job sharer, with mileage reimbursement at the same rate as for full time essential users.

The arrangement for our pay was straightforward: we receive the same rates as full time staff and are paid according to the number of hours worked; we are each graded at the appropriate level in the incremental scale (one of us had worked previously as a consultant). We included in the contract that continuous service entitlements would apply for previous periods of service within the NHS and related research organisations. Similarly, pension entitlements were rated according to hours worked on the same basis as full time employees and previous qualifying service was recognised for calculating payments. We were also advised that full merit awards were payable if at least six sessions were worked. In negotiating our contract we were greatly helped by the organisation New Ways to Work, which we strongly recommend to potential job sharers.¹

If one job sharer leaves

The most difficult issue in discussing the terms of the contract was the arrangement in case one of us left the shared post. Our managers needed to ensure that the service would continue fully staffed and that they retained a degree of flexibility in using consultant expertise for the development of the whole service. On our side we needed to maintain job security and to guard against the future possibility of being paired

with an unsuitable partner. People considering sharing a post should give this issue detailed thought and come to a clear written agreement with their employing authority.

In our case we agreed that should one partner leave the employer would first offer that portion of the post to the remaining partner. If this was not accepted the unfilled post would be advertised as a job share vacancy by the health authority and the incumbent would be fully included in the selection procedure. If no suitable candidate was appointed the post would be advertised full time and the remaining post holder would be protected under the terms of the employing authority's redeployment procedure.

One year in post

Our main difficulties came in putting together a strong case when we applied jointly for a single post. Just after our appointment some colleagues expressed confusion and even amusement about what was for them a novel working arrangement: we were asked about our "job splitting" or "work sharing" scheme. Although we have continued to mention that we are each half time, the formal arrangement was soon forgotten and one of the big practical disadvantages of job sharing is the expectation from colleagues that each partner should take on the non-clinical duties of a full time post holder. We have both been invited to participate in increasing numbers of committees, teaching sessions, planning groups, and audit meetings, and stating that we are each half time has sometimes met with short shrift. We started job sharing as friends and this has been an enormous advantage in making the arrangement work well: we

find it hard to imagine sharing a post unless there is at least mutual trust and respect.

Within the remainder of the public sector, in private industry, and more recently in other NHS disciplines, more adaptable working arrangements are now increasingly well established. Medicine is anachronistic in limiting all but full time appointments and in excluding other more imaginative options such as paternity leave, work exchanges, and career breaks.^{9 10} The NHS now needs to combine high standards of treatment and care with working conditions which will give more control, flexibility, and job satisfaction to its staff.

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Countdown to Community Care

Getting ready for change

David Browning

In the past few years community care for elderly and disabled people has been moving steadily up the political agenda. At this year's conference of the Institute of Health Service Management, the secretary of state for health, Virginia Bottomley, announced it to be her top priority. The House of Commons Health Committee has made it one of three subjects for investigation this year (together with dentistry and tobacco advertising). Dubbed the "Cinderella" service for so long, community care may be going to the ball at last. But before it can, those responsible must transform current arrangements into a fully integrated and well coordinated service—making the transformation for Cinders of a few mice, assorted lizards, and the odd pumpkin appear a relatively trivial task.

Community care services provide support for some of the most vulnerable members of society—mainly elderly people, but also people under 65 with physical disabilities, learning disabilities (formerly known as mental handicap), and long term mental illness.

Numbers needing such support are appreciable. In England and Wales by the end of this century there will be a million people aged over 85.¹ There are about half a million people below 65 with a significant physical handicap²; and there are about 125 000 adults with a significant learning disability³ (although the numbers depend on how "significant" is defined). The number of people with long term mental health problems is

notoriously difficult to estimate but is probably in six figures.

Social care is provided by local authorities and health care by community health services. But there is no neat dividing line between social care and health care, and there has been much overlap and some buck passing at the margin. For example, there has been much debate about whether people who need help at home with bathing should receive "health baths" or "social baths." With general practice fund holders set to purchase community health from 1 April 1993, we may yet see the advent of the "practice bath" as a third option.

Community care has developed in a haphazard way with little attention paid to its overall shape and direction. With responsibilities divided between authorities who have different priorities and traditions—and who may not even share the same geographical boundaries—it has been difficult to organise a coherent approach. The result too often has been muddle.⁴

The amount of home care, residential care, or district nursing available has always been as much an accident of history as any reflection of need. Levels of service have been relatively impervious to change because finance has always been provided en bloc from central government with budgets rolled over from year to year with no more than the occasional adjustment up or down at the margin. Potential users of community care have been assessed against set criteria for each

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