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.

We thank New Ways to Work, Sue Osborne, and Sue Williams (job sharing chief executive at Lambeth, Southwark, and Lewisham Family Health Service Authority) for clear and helpful information and our managers, Eric Byers and Jeremy Christie-Brown, for creative support.

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(Accepted 2 November, 1992)

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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BMJ 1992;305:1415-8

Who should run the bath—a health worker or a social worker?

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service, and those trying to meet people's needs have always had to fit them into whatever range of services happened to be available. The overall effect has been to produce a pattern of care which is often disjointed and dominated by the requirements of services rather than by the needs of users.

Pressures on the NHS have been building as the numbers of long stay beds and the lengths of stay of people in acute beds have been reducing, further increasing the numbers requiring community care. The resulting shortfall has been filled by growing numbers of private nursing and residential homes⁵ funded by social security benefits (fig 1)—prompting some to say that a considerable part of the NHS has now been privatised.⁶ The suitability (not to mention the cost) of this form of care, allegedly sometimes provided without the satisfactory consideration of alternatives, has been questioned by many—not least by the Treasury, which has been picking up the bill.

Putting people first

All of this is now set to change. The 1990 NHS and Community Care Act, which comes into force in full on 1 April 1993, introduces a fundamentally different approach. Its main aim for community care is to put the needs of service users and carers first. It gives lead responsibility to local authorities, transferring to them over a period of years much of the finance that is now going in social security payments to users of private homes.⁷

This change in emphasis from services to users and their carers will require many other changes.⁸ Authorities will need to start formulating eligibility criteria to decide who is to receive help and who is not; and they must decide how much help people should receive. This will force them to go back to basics: looking at patterns of need, calculating the resource implications of those needs, and adjusting eligibility criteria so that budgets are not exceeded. These basic rationing decisions will cause great difficulties for many local authorities, requiring some hard decisions on priorities.

Doctors and others within the NHS have a major interest in this process. Community care is inextricably linked with both primary and secondary care. If community care does not operate in consort with both, the NHS could quickly become overloaded with people requiring support but with nowhere to go. At present many hospital beds are occupied by people no longer needing medical care who are simply waiting for suitable arrangements for discharge. General practitioners' surgeries are packed with people whose real needs are for support rather than medical attention.

If local authorities' priorities do not mesh with those

of the NHS, then these sorts of difficulties will grow. It is more important than ever that the NHS and local authorities should sit down and plan together. A drive by a health authority or trust to increase the number of hip replacements, for example, will fail if suitable arrangements for support afterwards are not planned at the same time.

Plans and priorities

All local authorities are required to produce a community care plan setting out their priorities and all must consult with other agencies, including district health authorities and family health services authorities (who should in turn consult with local authorities on their plans). There should, therefore, be a framework in place for authorities to coordinate priorities.

But if this framework is to work a number of long standing problems will need to be addressed. How will local authorities with locally elected members, committees, and committee cycles coordinate their decision making with health authorities that have such new management cultures? What will happen when the priorities of one authority do not match those of another? In particular, what will happen if one authority's priorities require another to spend more money?

Whatever strategic solutions are worked out, clear definitions will be needed setting out which people qualify for help so that general practitioners, other health workers, and social workers all know how to work the new arrangements without wasting each other's time. In particular, assessments by local authority staff will have to be undertaken in conjunction with health staff if they are to provide a balanced picture. Many of the more dependent users of services will require both health and social care, and many tend to approach their general practitioners first when they require either form of care. Last month the department of health circulated guidelines to general practitioners on the subject of assessment for social care.⁹ The success of the community care policy will depend ultimately on practitioners from all authorities making it work at the sharp end.

Care management

To strengthen coordination between practitioners the reforms promote the concept of the "care manager,"

Residential and nursing homes in the independent sector, United Kingdom. From "Laing's Review of Private Health Care 1991/2"

who is to be the social care equivalent of the general practitioner fundholder. Funds are to be devolved to care managers who will coordinate the assessment process, provide advice on possible services, and arrange (and, where appropriate, pay for) services as necessary.

As yet, care management is not widely available and it will probably follow some time after the initial reforms. Many authorities have pilot projects underway, but the usual problems of converting pilot projects to main stream practice apply. Some authorities seem to oppose the concept altogether, while others are trying out different models. In some situations care managers are being based in general practitioners' surgeries, forging closer links with general practitioners and primary health care teams. Perhaps this will bring the concept of the "one stop health care shop" closer to reality. This concept envisages all social and health care coordinated under one roof—with professionals who know each other sorting out the professional boundary disputes together, within the policy framework set by health and local authorities.

Making it work

Just as there will be difficulties coordinating strategic priorities, a number of knotty local problems will need to be unravelled if these arrangements are to work. It is not clear who will coordinate professionals locally or who will deal with disputes. Perhaps community care teams will be loose federations, as many primary health care teams are now. General practitioners may be suitable team leaders but will then have little time for patients. And how will general practitioner fundholders fit in?

The success of care management will depend not only on such local organisational arrangements, but also on the resources available, the quality of people appointed to the job, the support they are given, and the policy framework within which they operate. At first, resources will probably be limited, with most still locked up in existing services. But over time, more money should become available, albeit at different rates in different areas of the country.

The evidence suggests that, where real choice is available, the services selected by care managers are very different from the traditional ones. The Independent Living Fund, set up to plug a loophole in the social security system, provides service users and their carers with cash for care. The resulting patterns of care often involve neighbours and friends paid to come in at odd hours, rather than day centres and residential care (see box).¹⁰ Equally, where care managers have been given real discretion, exciting new initiatives are reported to be emerging. The benefits of the new approach seem real, if difficult to realise.

To give greater choice, care managers should be able to buy services from other agencies, so that local authorities do not continue to provide everything for themselves. Many services in the community are best provided by the community itself rather than by the local council, no matter how well motivated the staff.

Care managers are being recruited from a variety of backgrounds, including teaching and nursing, and not just from social work. The skills required include good organisational abilities, not only the more traditional caring skills. Certainly, care management will have to be supported by suitable financial controls and by information systems which have yet to be developed, and those taking on the job must be trained to use them effectively.

Where hospital doctors fit in

In case hospital doctors are feeling very pleased that they are not involved in all of this, the changes keep the

Case report¹⁰: Mr John H; age 47; multiple sclerosis

Mr H had advanced MS, was confined to bed with a catheter, and could hardly speak. He choked easily and was prone to sudden infections, so his wife felt that whoever was to give her a break by providing care for him must have nursing experience.

For a few months before the ILF award, a care assistant recommended by Crossroads had been employed for three hours a week plus one night to give Mrs H one good night's sleep. The ILF money had enabled her to extend that to seven daytime hours and two nights a week.

"Seven hours to yourself in the week. Seven hours out of 168 gets your head showered"

Mrs H saw the second night as a means of avoiding exhaustion. She had stopped respite care in hospital for her husband because there had been feeding problems and he had developed pressure sores. She was confident that with a bit of help to keep her going, she could provide better care for him at home. Care is "not a big handful if I have help."

Between April and September, social services had also increased the amount of domestic help provided for the H's from five to seven hours, and overall Mrs H felt that care arrangements were working very well for the two of them. Her only regret was that she did not apply to the ILF some time ago when she first heard of it. Getting the award earlier could have prevented a period of extreme exhaustion and distress.

biggest potential sting of all for them. One of the major changes introduced by the 1990 Act is the transfer of funds previously available through the social security system for residential and nursing home places in the private sector to local authorities. Placement of people with limited financial means will henceforth (from 1 April 1993) be at the discretion of social services; and the amount of money available (£399m in 1993-4 in England) will be cash limited.

Surveys suggest that between 250 and 500 people a year are being placed directly into private homes from an average district general hospital. Though this is not a large number, any failure to make suitable arrangements for discharge with local authorities could increase lengths of stay appreciably, with a knock on effect on the availability of beds, the number of patients treated (with financial implications for trusts), and ultimately on waiting lists, which are seen to be a key indicator of performance.

It will therefore be even more essential than before to negotiate appropriate discharge arrangements for patients. This will be a two way process requiring changes in practice in hospitals as well as in social services. In some situations, patients may have been placed in nursing homes as quickly as possible to clear beds without a full assessment of all the options. In future it may be necessary to allow a little more time for proper assessment, with corresponding improvements in the quality of care given. If this creates difficulties because of pressure on beds then interim convalescent arrangements may be necessary while longer term decisions are made. (Hotels are used in the United States, but short term places in nursing homes would serve as well, and possibly better.)

There is much useful guidance on hospital discharge arrangements,¹¹ and it will be important to follow good practice and, if necessary, fund improvements. Any interim arrangements could be funded by both health and social services—concentrating both sets of minds on quick but appropriate solutions. Quite apart from the logistics, the sensitive handling of the difficult transition out of hospital is a crucial part of successful patient care. Certainly, hospital discharge arrange-

ments will provide an early indicator of how well the new community care arrangements are working after 1 April.

Timetable for change

Local authorities are now pressing on with preparations for the changes although, inevitably, there are some who are making more progress than others, prompting the formation of a national "support force" to provide advice and promote good practice.

The implementation of the changes in full at both strategic and operational levels will take many years, and the targets for 1 April 1993 are relatively modest. Health and local authorities must be able to coordinate assessments, especially for discharge from hospital. They must have in place suitable financial arrangements for managing the funds transferred from social security. Finally, they must have negotiated suitable arrangements with private residential and nursing homes, with a requirement to spend at least 85% of the extra money transferred on services not supplied by local authorities. The more profound changes such as care management can be planned at a more leisurely pace.

The theory is now mostly in place with copious guidance from the centre; authorities and practitioners must now make it work. The early signs are that where it works it is worth all the effort, with better patterns of care emerging and a higher quality of life for some of the most disadvantaged members of society. But

community care is not an easy or particularly cheap option.

With increasing emphasis on efficiency and best use of scarce resources, requiring ever shorter lengths of stay and more rationing, the smooth functioning of the rest of the NHS depends increasingly on suitable provision for long term care. Community care is now the main method of providing such care. It is up to everyone to make it work through better assessments, better hospital discharge arrangements, and better cooperation and organisation all round. Failure to do so could mean that the Cinderella services arrive at the ball still in tatters, with profound implications for the NHS and local government alike.

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London after Tomlinson

Community care in London: the prospects

Tessa Jowell

Elderly and disabled people have been led to expect great improvements in the quality of community care after April 1993. The choice to live safely at home is to be offered as an alternative to residential care. The financial and organisational relationships are all intended to support this in practice. The Tomlinson recommendations will create instability for providers, and much new and overdue investment in primary and community services is needed if the community care reforms are to work. There are, however, other obstacles looming which pose an even greater threat to the smooth transition after April 1993. The formula by which government money for implementation will be distributed discriminates against London. The sheer complexity of the organisational transformation has also been underestimated; the machinery of government both locally and centrally is ill equipped to maintain the precedence of the consumer. There are examples of good practice in London boroughs, but the dangers of Londoners ending up with the worst of all worlds are great.

"I know that I'm coping if the windows are clean" said Mrs Blackstock, a woman in her late 70s living alone in a council flat in north London. She was being consulted about the kind of community support she would need if, as her frailty increases, she is to be able to continue to live on her own. She needs other help, too, but the state of her windows is her personal test of her own competence. The outcome of the consultation with Mrs Blackstock and other elderly and disabled people and their carers will provide essential infor-

mation for the London Borough of Islington as it sets about preparing its community care plan.¹

The community care plan is one of the new requirements placed on local authorities by the Department of Health. It is the local authority's statement of intent for the provision of community care: an audit of what is available, what is needed, and how the local authority will bridge the gap. Mrs Blackstock's observation presents an important challenge to the capacity of local authorities to meet the standards of the new legislation.

The community care reforms form part of the National Health Service and Community Care Act. They have been implemented over three years and have seen the introduction of inspection and registration units independent of social services departments, a new complaints procedure, and the production of community care plans. With effect from April 1993 local authorities will assume lead responsibility for assessing the needs of elderly and disabled people and then commissioning "packages of care" within a preagreed budget, which will then be managed by a care manager. The rhetoric of the policy has promoted a misleading degree of cross party consensus. Only now, as the proposals are being implemented in practice and the sheer scale of the task facing local authorities becomes clear, is the consensus beginning to crumble.

Dilemmas for local authorities

Take Mrs Blackstock's apparently simple request, which in no sense represents all her needs. It highlights the dilemma that will face local authorities: a switch away from widespread low cost individual home care to

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BMJ 1992;305:1418-20