competition (as presumably in the case of research council or charitable awards) this is a proper unassailable token of merit. The same cannot be said of the other posts listed in table I, where vigorous protective mechanisms appear to have been at work.

What has happened hitherto is evident from a broader picture—the distribution of all medical staff between London and the regions. Some change in the ratio between London (including undergraduate and postgraduate hospitals) has occurred over the past decade, but this is wholly attributable to a more rapid increase in numbers of medical staff in the provinces: levels increased at both sites. The pattern has not therefore been one of redistribution—merely differential growth (table II).

TABLE II—*Average numbers of hospital medical staff in London and non-London regions per 100 000 population, together with percentage change in absolute numbers of staff between 1977 and 1988*

	1977	1982	1988	% Change
Average Thames region	94	98	101	9
Average non-London region	74	84	91	26
London postgraduate hospitals	—	—	—	14

Data from Office of Health Economics.[5]

High quality clinical service

I do not wish to appear negative. The criteria for a successful setting for postgraduate medical education should be straightforward. The fundamental necessity must remain a high quality clinical service for adequate numbers of patients. This is not, of course, sufficient. There have to be additional staff so that there is time for critical discussion, supervision, and teaching. The environment has to be one in which new developments are being introduced and tested, not as an optional addition to routine service but an accepted part of the culture of the teaching institution. In some cases this may include a broader perspective in such disciplines as epidemiology or biomedical science. My great concern in the Tomlinson recommendations is that he proposes removing the environment crucial to postgraduate teaching even further from its ultimate area of application—patient management. I recognise the logistic argument but regret the inevitable outcome of such a policy both for research and education.

The argument for action on the clinical side is a pressing one. I suspect that the needs of postgraduate education and clinical research will duly be exhibited as arguments for resisting Tomlinson's recommendations. In fact their needs reinforce the argument for change. A historically fixed distribution of resources and people no longer matches the distribution of activity and expertise. The fact that the present situation has developed so far despite so many calls for action is a tribute not only to the high fence which has surrounded the secret garden but also to the protection given to pleasant and quiet groves within that garden.

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Countdown to Community Care

Moving ahead—community care in Gwent

Roger Robinson

This is the third in a series of articles looking at the forthcoming changes to community care

The new rules and recommendations for community care come into force on 1 April. Two previous articles in this series described the reforms which the new law expects[1,2]: the next four will describe how different places in the United Kingdom are preparing for change. The first of these looks at Gwent in Wales.

Gwent is a county of geographical and social variety. It includes Blaenau Gwent in the north, an old mining valley area whose pits had all shut down before the recent wholesale proposals for closure; Newport in the south, with some inner city problems; and Monmouth in the east, a large sparsely populated area of rich farming country.

Gwent has had a head start in preparing for change. In many ways it has been progressive in planning and providing community care. For the past nine years the county has followed the All-Wales Strategy for Mental Handicap (this term is still used instead of learning disability in the title of the scheme),[3] setting up a community based system of care with assessment and planning centred on individual needs. The All-Wales Strategy for Mental Illness has been implemented more recently.[4] Planning is easier than in many counties because the boundaries of local authorities and health authorities coincide. There is a strong and active voluntary sector. Finally, the Welsh Office is responsible for both health and social services.

I spent three days in Gwent talking to some of the people who are planning the new way of community care or who will be affected by it. What follows is a series of impressions which do not necessarily apply throughout the county, or represent generally the attitudes of each interested group, but do indicate what some of those involved in the new plans are thinking and doing.

The planners

SOCIAL SERVICES

"This is the biggest change to have hit social services departments since they started," says Paul Meredith, principal planning officer of Gwent County Council's social service department. He is in no doubt of the scale or importance of the changes in community care, nor of their benefit to the users in the long run. He distinguishes, however, between those statutory changes which must happen by 1 April and those, such as the introduction of care management, which will come in more gradually.

Of the statutory changes, the one causing most general anxiety is the transfer to social services of the social security funds that are now spent on residential and nursing home care. Paul Meredith thinks that this change will force difficult decisions in Gwent, where there has been a huge increase recently in private nursing home placements of elderly people funded by social security. Nearly four fifths of private residential provision in Gwent is in nursing homes, compared

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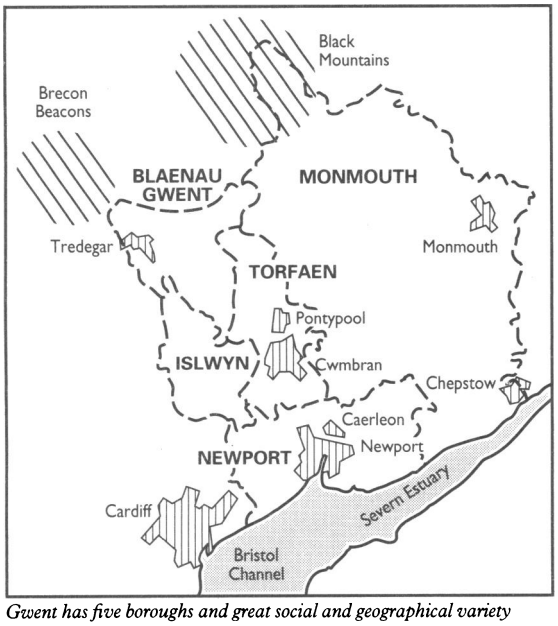

Gwent has five boroughs and great social and geographical variety

with two fifths in the rest of the country. Furthermore, a survey of people in residential care in Gwent showed that those in private nursing homes had very similar levels of dependency to those in local authority (non-nursing) residential homes. Although Mr Meredith is cautious about deriving any conclusions from these statistics, he wonders whether the new assessment and funding procedures may lead to less use of nursing homes in future. He is clear that the transferred funds will not cover the use of private nursing homes if the homes continue to proliferate at the present rate.

Planning for implementing the community care legislation in Wales differs from that in England, in that the user groups targeted do not include those with mental illness or learning disability. Structures of care and some ring fenced funds already exist for them. Chronically and terminally ill people, however, and those who misuse drugs or alcohol, are added to the user groups. Informal carers are not specified as a distinct user group, but their importance is emphasised.

Each of the five boroughs of Gwent has an "area forum" with representatives of health and social services, users, carers, and the voluntary sector. These forums aim to review local community care, advise on developments, and monitor how the service operates. There are also three county based working groups responsible for assessment and care management, training, and accommodation.[5]

The final pattern for the new community care arrangements throughout Gwent will depend partly on the outcome of two pilot projects in assessment and care management. These projects are running in two very different social settings—Tredegar, a former mining community with high levels of unemployment, and Monmouth, a relatively affluent country town.

Mrs Joyce Steven, assistant county treasurer, is chair of the Joint Care Planning Board—the master interagency committee responsible for community care plans. She says that decisions on payments for residential care will be taken initially by planners in County Hall and will be devolved to local teams when there is some experience of how the new system works. The social services department is against making block contracts for care with proprietors of private nursing homes, though that is what the proprietors want. Mrs Steven does not foresee any sudden change in care arrangements on 1 April, and says, "in the initial period, the current pattern will have to be largely preserved."

Mrs Steven thinks that financial flexibility will be very limited at first, although she hopes some money will be freed for new initiatives and developments. Looking further ahead, she wonders if a lot of unmet need will come to light as the new assessment procedures begin to work. From the experience of the strategy for people with learning disabilities, she thinks that the families who will benefit least are those who seem to be coping.

HEALTH SERVICES

A joint directorate and joint planning executive have been formed by Gwent Health Authority and Gwent Family Health Services Authority. Perry Williams, whom I met at headquarters at Pontypool with his assistant Julie Mullins, is the joint planning director. They explained that Wales had a "strategic intent and direction" policy for health, in advance of *The Health of the Nation*,[6] and that Gwent had developed its own health strategy.[7] A shift towards prevention and from secondary to primary care is planned, moving some outpatient and follow up care nearer to the patient's home—for example, to general practice. To support this change, 15% of funds are to move from the hospital service to primary care over three years. These developments have an obvious bearing on community care plans.

Mr Williams and Ms Mullins believe that health screening of people over 75, required by the general practitioner contract, could be a useful part of the new assessment structure and they are prepared to direct money to encourage training for this purpose. They point out that for many clients the general practitioner is, and will remain, the point of entry to whatever new community care arrangements are made. They emphasise that health planners have good relations with those in the local authority, and have no major anxieties about how community care will develop.

Service providers and users

TESTING THE NEW METHODS

The pilot project in Tredegar, mentioned above, has been running for just over a year. Caroline Lewis, the senior social worker organising the project, told me that it has three main aims—to establish an area forum, to set up interagency training of all those who will work the new system, and to develop the new assessment procedures.

One initial problem was finding users and carers to serve on the area forum; Tredegar has many fewer voluntary workers than other parts of Gwent. On assessment Ms Lewis said, "We had to go back a few paces and think out the philosophies first"—in other words, the project team had to think through the idea of needs led assessment rather than begin by choosing particular methods of assessment. Now that the system is up and running the team has started using, and is enthusiastic about, an interactive computer programme TEC-SYS, developed by Bath University to assist assessment and care management. It stores information on clients' changing needs and on available resources and helps to match them.

Ms Lewis has a budget of £20 000 for innovative ways of enabling people to stay in the community rather than go into residential care. Previously it was very unusual for a senior social worker to have a flexible budget of this kind, and she has found it immensely useful for meeting individual needs in individual ways. For example, an elderly woman was on the brink of accepting residential care even though it was not what she really wanted. Providing money for transport for day care twice a week gave her the extra support she needed to remain at home.

Ms Lewis believes that there are substantial unmet needs in the community and thinks that the process of referral—how those in need actually reach the point

of having their needs assessed—should be another important aspect of future plans.

PSYCHIATRY AND PSYCHOGERIATRICS

In southern Gwent a huge shift towards community care for the mentally ill happened long before either the new legislation or the All Wales Strategy for Mental Illness. St Cadoc's at Caerleon is a large mental illness hospital, whose original 700 beds have been reduced over the past 20 years to 68 acute and 10 long stay beds, with further reductions planned.

Dr Stephen Hunter, consultant in psychological medicine, and Dr Nick Warner, psychogeriatrician, give credit for this change mainly to their predecessors. They emphasise the value in community care of community psychiatric nurses and the voluntary sector, such as the local branches of the national association for mental health, MIND. Dr Hunter points out that, in the early years, the money saved by closing beds disappeared into other parts of the hospital service. In the past five years, however, all the savings have gone into community provision—for example, of the vitally important community psychiatric nurses.

Neither consultant expects major difficulties in delivering care under the new system. Dr Hunter has some anxiety that it may be less easy to arrange care for schizophrenic patients leaving acute psychiatric wards. Around one in 20 of these patients will have continuing problems needing community care, and he hopes that a system which has worked well for a long time will not be interfered with. He is worried "on a scale of 3 or 4 out of 10."

Dr Warner is a professed optimist. He does not want assessments done in the psychogeriatric unit to be duplicated in the community, but he has good working relationships with colleagues in social services and says that no one will want to interfere with a system which is working well. "I have never had any problem getting what I want for a patient," he asserts, although both he and Dr Hunter wonder whether the new system will be able to respond to the increasing number of elderly people with dementia and their carers.

Peter Clark is a community psychiatric nurse working in a multidisciplinary team in the Cwmbran area. The proposed changes in April have not yet made any special impact on Mr Clark's work and he expects no great changes in the way his team functions. But he is worried about existing resources and says that young mentally ill people often have needs, such as more help at home or more day care facilities, which the available funds do not meet. As an example of the frustration that the team feels over this, members sometimes spend a weekend cleaning or decorating a patient's flat.

AGE CONCERN GWENT

The voluntary sector is a key player in the plans for community care

GERIATRICS

St Woolos Hospital, near the centre of Newport, is a recently extended former workhouse building with 170 beds for care of elderly people, a day unit, and assessment facilities. I met Dr Ann Freeman, the consultant geriatrician, Professor John Pathy and Dr Jan Beynon, from the associated research unit, and Susan Burnett, the business manager. They all have definite anxieties about the effect of the community care changes, particularly in relation to discharge from hospital.

The new procedures for assessment might increase pressure on hospital beds, causing delays in discharge and leading to increased lengths of stay. The St Woolos team members feel strongly that the detailed assessments which they do should be accepted for this purpose and would also be very happy for the day hospital facilities to be used for assessments from the community. Although local social workers have had good relationships with the team, they often had to repeat the assessments. Professor Pathy believes that there should be central guidance on the nature of the new assessments, pointing out that validated measures and scales are available.

THE VOLUNTARY SECTOR

At Age Concern Gwent in Newport I spoke to Jane Reeks, the organiser. Her office now has a budget of £200 000 per year, some of which comes from the Welsh Office and the health authority and some from social services. Age Concern uses some paid coordinators and support workers, as well as large numbers of volunteers.

Age Concern is running two important schemes in community care in Gwent. One, worked out in cooperation with the geriatric teams, supports patients discharged home from hospital. Paid support workers give intensive help immediately after discharge, then voluntary workers are used, gradually tailing off to prevent the users becoming too dependent. The second scheme is a "home-from-home" service to give relief to carers by offering the elderly person respite care with a host family for a short period. Age Concern hope to be able to arrange 200 placements of this kind each year.

Ms Reeks has some anxieties about the community care changes. The implications of making contracts with care managers to provide help for elderly people have not yet been worked out. She is worried that the funds available to social services departments will not be adequate to meet all needs, that there may be more emphasis on dealing with crises than on prevention, and that the new assessment procedures may introduce rigidity and delay.

GENERAL PRACTICE

The general practitioners I visited feel overwhelmed by the problems of coping with the changes of the past three years—both of the new contract and of becoming fundholders. The community care changes seem to them remote and rather theoretical. Dr Peter Jones and Dr Julian Costello belong to a fundholding practice with six partners, operating from purpose built premises in an underprivileged area of Newport.

Both doctors have had to put enormous effort into reaching targets—for example, for immunisation. They feel no enthusiasm for the screening of their 500 patients over 75, an activity whose value they doubt. They do not feel they have an easy working relationship with social services, who seem available only for crisis intervention. In geriatrics and psychogeriatrics, however, these general practitioners feel that the service provided through the consultants is so

SOUTH WALES ARGUS

Would Mrs May have got more help to look after her mother under the new community care system?

good that contingent social problems will be looked after.

There must be other practices with similar problems and attitudes in Gwent. Dr Freeman, the consultant geriatrician, had a disappointing response when she invited general practitioners to a symposium on screening people over 75. She also confirmed that some, but not all, general practitioners are happy to leave the arrangements for social care of elderly people to the geriatricians.

INFORMAL CARERS

Mrs Ann May cared for her mother with Alzheimer's disease for four years until she died at home 18 months ago. Believing her mother had left her a legacy of knowledge and skill, Mrs May found herself increasingly involved in counselling other carers, providing a telephone support line, and working for several voluntary groups. Recently she has talked at training days for social workers and other professionals and has represented carers on several committees, including the Joint Care Planning Board. She came to these last activities with no previous experience and at first felt lost in the committee jargon and procedures.

Mrs May speaks of the enormous burden and financial cost for carers. "We are disabled ourselves by it," she says. She is hopeful about the new community care plans, but expects no great and immediate changes, which she thinks will take a decade to happen. Mrs May lives with her husband in a small house on the outskirts of Newport and works from a tiny office attached to the house. The office used to be the kennel where she bred Yorkshire terriers until her involvement in caring and carers forced her to give that up. Mrs May has provided her own computer and learned to use it herself, and her work is unpaid except for lecture fees and some travelling expenses.

Common themes

Several of the people I saw expressed concern that there may be a lot of unseen and therefore unmet need for community care, and that if this does get recognised —as it should—by the new procedures the resources will be even more stretched than expected. Two projects, however, argue against a huge pool of unrecognised need.

Dr Warner and his colleagues in psychogeriatrics advertised widely to offer a service to people who had memory problems or knew someone in the family who had them. He had some trepidation about the likely size of the response and the team's ability to cope: in fact the response was very small.

Professor Pathy's team did a pilot project on screening people over 65 for health and other problems.[8] They found about half needing a home visit or some form of referral, but did not uncover a great deal of unmet social need of a kind likely to place a major burden on the community services. On the other hand, the pilot project in Tredegar (which may represent a special social situation) has suggested significant unmet needs.

A central principle of the new style community care is that it should be needs led rather than service led. This principle was strongly held by social service planners and by the Tredegar pilot project, but rarely mentioned by others. There may have been a very good reason for this—most of the people to whom I spoke were so clearly orientated to patients' or clients' needs in their activities and plans that the principle had no novelty.

In one area—the meals-on-wheels service—a move to a needs led service might be expected to help. Mr Clark told me that some of the patients looked after by the community psychiatric team could be helped by this service, but that it is available only to people over 65. Dr Beynon told me that the rules for obtaining the service are so stringent that the team involved in the elderly screening project knew it was often not worth requesting it. This seemed a clear example of a service led activity which should be needs led, but no one seemed to expect that the new structure would solve this problem.

Conclusion

The overall impression in Gwent was of a community advanced in its thinking and practice about community care, with several schemes in operation before the new legislation starts. Nevertheless, the detailed plans for the new structure still need a good deal of filling in.

Most people I met were less bullish than the Audit Commission about the benefits of the new structure for community care and few, except to some extent among the planners, regarded the changes as a revolution or major upheaval. Nearly everyone spoke well of the cooperation between health, social services, and the voluntary sector. There is some anxiety about possible delays in discharge from hospital, particularly for elderly patients, but no real expectation of disaster.

There is, however, an important exception to this rather cautious view of the changes, and an encouraging one for the future. Those I spoke to in social services probably have the clearest understanding of the changes as they are evolving and they were the most enthusiastic. The social worker who has real experience of the new system, and who in a pilot project has the flexibility and funds to operate it, believes that the changes can greatly benefit users and carers.

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