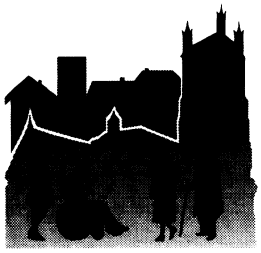
6 Lippman SM, Hong WK. Retinoid chemoprevention of upper aerodigestive tract carcinogenesis. In: DeVita VT Jr, Hellman S, Rosenberg SA, eds. *Important advances in oncology*. Philadelphia: J B Lippincott, 1992:93-107.
7 Department of Veterans Affairs Laryngeal Cancer Study Group. Induction chemotherapy plus radiation compared with surgery plus radiation in patients with advanced laryngeal cancer. *N Engl J Med* 1991;324:1685-90.
8 Brown B, Barnes L, Mazariegos J, Taylor F, Johnson J, Wagner RL. Prognostic factors in mobile tongue and floor of mouth carcinoma. *Cancer* 1989;64:1195-202.
9 Henk M, Langdon JR. *Cancer of the oral cavity*. 2nd ed. London: Edward Arnold, 1993.
10 Gupta NL, Pointon RCS, Wilkinson PM. A randomised clinical trial to contrast radiotherapy with radiotherapy and methotrexate given synchronously in head and neck cancer. *Clin Radiol* 1987;38:575-81.
11 Merlano M, Vitale V, Rosso R, Benasso M, Corvo R, Cavallari M, *et al.* Treatment of advanced squamous cell carcinoma of the head and neck with alternating chemotherapy and radiotherapy. *N Engl J Med* 1992;327:1115-21.
12 Tobias JS. Current role of chemotherapy in head and neck cancer. *Drugs* 1992;43:333-45.
13 Stell PM, Rawson NSB. Adjuvant chemotherapy in head and neck cancer. *Br J Cancer* 1990;61:779-87.
14 Shanta V, Krishnamurthi S. Combined bleomycin and radiotherapy in oral cancer. *Clin Radiol* 1980;31:617-20.
15 South East Cooperative Oncology Group. Randomised trial of combined multidrug chemotherapy and radiotherapy in advanced squamous cell carcinoma of the head and neck: an interim report from SECOG participants. *Eur J Surg Oncol* 1986;12:289-95.
16 Al-Sarraf M. New approaches to the management of head and neck cancer: the role of chemotherapy. *Advances in Oncology* 1990;6:11-4.
17 Tobias JS. Has chemotherapy proved itself in head and neck cancer? *Br J Cancer* 1990;61:649-51.
18 Clavel M, Maged Mansour AR. Head and neck cancer. Prognostic factors for response to chemotherapy. *Eur J Cancer* 1991;27:349-56.
19 Hutchison IL. Improving the poor prognosis of oral squamous cell carcinoma. *BMJ* 1994;308:669-70.
20 Dische S, Saunders MI. The rationale for continuous hyperfractionated accelerated radiotherapy (CHART). *Int J Radiat Oncol Biol Phys* 1990;19:1339-45.
21 Horiot JC, Le Fur R, N'Guyen T, Chenal C, Schraub S, Alfonsi S, *et al.* Hyperfractionated compared with conventional radiotherapy in oropharyngeal carcinoma: an EORTC randomised trial. *Eur J Cancer* 1990;26:779-80.
22 Cancer Research Campaign. Oral and pharyngeal cancer in men and alcohol and tobacco consumption. *Facts on Cancer* 1993;factsheet No 14.
23 Tobias JS, Williams CJ. *Cancer: a colour atlas*. London: Gower Medical, 1991.
24 Cancer Research Campaign. Five year survival rates in advanced head and neck cancer. *Facts on Cancer* 1988;factsheet No 9.

Community Care: The First Year



This is the last of a series of four articles looking at what has happened in community care over the past year

Newcastle: making strides

Sharon Kingman

In the past year those involved in implementing community care in Newcastle have been on a massive learning curve, starting to understand purchasing services, moving towards all kinds of domiciliary services. Provision of services by the independent sector is still developing, leaving the social services department to consolidate its own home care services; voluntary agencies are being contracted to supply others. A new assessment system is evolving. Joint planning is moving forward slowly.

Pinned to the noticeboard in Carolyn Stephenson's office in the social services department at the Civic Centre in Newcastle upon Tyne is a photocopy of a speech made by Dr Brian Mawhinney, minister for health, shortly before the implementation of the NHS and Community Care Act last April. Highlighted in orange are the words: "We must not expect too much too soon. Benefits will flow from these reforms over a decade.... Success will depend not so much on this year's implementation agenda, but more on the continued vision of what can be achieved to allow people to live with independence and dignity."

Carolyn Stephenson, principal assistant (community care), says she used to read this last year when she was under enormous pressure to get the new system up and running in time for 1 April. "It reminded me that what we were really trying to do was to achieve a very fundamental change for people in Newcastle rather than just meet a lot of management deadlines."

The new system changed how local authorities delivered social care for people who needed help because of age, disability, mental illness, or chronic illness. Formerly, for those people deemed eligible by a financial means test, the Department of Health had paid the fees for residential and nursing home care direct to those who provided these services. But from April 1993 the social services departments were to receive this money, to buy both residential care and services to be provided in people's own homes. The government stipulated that 85% of the community care grant had to be spent in the voluntary and private sector.

The aim was to give people the help they needed to stay in their own homes as long as possible, if that was what they wanted. People considering residential and nursing home care, as well as those being discharged from hospital (whether acute or long stay mental hospital) had to be assessed to establish exactly what their needs were. Authorities that failed to get their new systems into place on time would not qualify for the new community care grant.

Meeting the deadline

In September 1992, when Carolyn Stephenson was appointed in Newcastle, just she and a secretary were working full time on the implementation of the community care reforms. She says: "The department realised that if we were to achieve all these targets, we needed to make a major investment in management. We decided to use a project management approach—something that social services had never done before." This involved assigning particular members of staff to carry out certain tasks by specified deadlines.

It worked. Stephenson says: "We met the government's requirements, but only just. We had contracts on residential homes, basic agreements with the health service, and an assessment policy and procedure—but we were only just there."

Across Newcastle, other authorities were holding their breath to see whether social services would make the deadline. Phil Sculthorpe, who early last year held the post of assistant director (community care) at North Tyne Health, an organisation that purchases care on behalf of Newcastle Health Authority, remembers that "in December 1992, we could see that Newcastle was likely to be a named authority that might not get its transitional grant." If social services had failed, the consequences for the NHS could have been very difficult.

"Eighteen months ago," Sculthorpe says, "there were widespread fears that the local authority might fail to deliver on residential care homes. The result would have been beds blocked by people who could not be discharged, difficulty admitting new patients, and people bouncing back in to NHS beds because social care arrangements had failed."

But these worst fears were never realised. "We seem to have achieved basic, safe, and speedy arrangements for discharge which over the past year have improved steadily," Sculthorpe says.

Stephenson agrees that since April 1993 everyone

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NEWCASTLE SOCIAL SERVICES

Demand for home care services has increased

has been on a "massive learning curve." She says: "We have acquired a huge amount of knowledge about how community care works. We have started to understand purchasing services. We have started to move from just residential services towards all kinds of domiciliary services. Our contracts have become more sophisticated and we have gained expertise on writing specifications."

How it was done

So what went right? One important step was devolving budgets to those who carried out most of the assessments for clients entering residential care—the hospital social workers. Graham Armstrong, senior assistant director of the social services department, says the department knew that 70% of the clients it placed into residential or nursing homes were from hospital beds. It was clear that, unless hospital social workers had their own budgets, there would be delays in discharging patients. "So we ploughed money into hospital settings," he says. Out of the £2·2m community care grant, £1m was devolved to hospital social workers.

The requirement that most of the grant had to be spent with the private and voluntary sector presented no culture shock to the hospital social workers. Ray Johnston, senior social worker at the Freeman Hospital, says: "We were already used to working with the private sector—we would always give elderly people as much choice as possible and help them find suitable placements."

Private participation

Even without the community care reforms, Newcastle social workers would have found themselves working more closely with the independent sector. The social services budget for 1994-5 will be £42·6m, £1m less than the previous year. So cuts have been made—including closures of nursing homes run by local authorities. This trend has been continuing for some years: Newcastle used to have about 30 such homes, providing more than 1000 places. Now there are just four specialist homes for elderly mentally ill patients, with about 150 places, and four homes that offer short term respite care and outreach services, also with 150 places in total.

Yet the relationship between the social services department and privately owned residential and nursing homes in Newcastle has been marred during the past year by a dispute about the new contracts drawn up by social services. The Newcastle Care Homes Association sought a judicial review on whether the council was acting beyond its powers by including certain terms in the contracts. But the judgment was in the council's favour: it was concluded that it had not been acting unreasonably.

Jennifer Bernard, director of social services, who took over from Brian Roycroft last autumn, says: "We have now resumed positive relations with the private sector—I would not say there is complete harmony, but we are talking to each other as participants in community care." Simon Beckett, of the association, agrees: "We have had a rational debate since with the council and have both put it behind us."

The owners of private residential and nursing homes in Newcastle might feel reassured by the knowledge that council run homes are closing and that the onus is on the social services department to spend most of its community care grant in the independent sector. But, Graham Armstrong points out, there is an overprovision of residential and nursing homes in the city—and new ones are continuing to open.

No one really knows whether fewer people have been admitted to residential and nursing homes since last April. Firm data are not available. Jennifer Bernard says: "There appears to be a consensus that overall there are fewer people going in, so you could argue that community care is having the desired effect."

Supplying services

The hospital social workers agree that, by buying in domiciliary care, they are avoiding many admissions to nursing homes that formerly would have been inevitable. But they point out that, simultaneously, many severely disabled people who were in NHS continuing care beds are now being assessed by social workers and discharged into nursing homes. This opens the question of who should pay their nursing home fees—the health service or social services?

Moira Woodford, acting principal assistant (health and community) in the social services department, says: "Unfortunately, the funding does not seem to move into the community with them. The only way the health service could continue to pay for their care would be if the beds they moved out of were closed down." Social services ends up picking up the tab. For this reason, the social workers think that there has been no great drop in the numbers of people going into homes—but demand for home care services has undoubtedly gone up. And although the hospital social workers say they have had no difficulty in spending their budget on domiciliary services from the independent sector, everyone agrees that such services are underdeveloped in Newcastle.

Ray Johnston cites respite care, which enables many people to stay out of residential homes, as an example. "We have only ever had limited availability of local authority respite care," he says, "but the private and voluntary sectors are only just beginning to develop respite care." One local organisation has said it is nervous of committing more resources to respite care because the social services department has been unable to guarantee how much it would use such a facility. As Johnston says: "They would prefer us to block-book a bed for respite care—and pay for it to be kept available even when no one is in it."

Jennifer Bernard detects a certain lack of interest by the private sector in providing domiciliary services. Such businesses may require staff to work irregular hours, with peaks in demand in the mornings and evenings—the times when people need help getting up or going to bed. Unlike a service provided in a building, one supplied to many individual homes is going to be much more difficult to supervise and manage.

And there are few controls on who can do such work. No registration or inspection scheme covers companies of this kind. Yet social services need to be sure that the services it buys are both safe and run by suitably qualified staff.

One way of tackling this problem is for the social services department to consolidate its own home care services. Carolyn Stephenson says: "Some councils are drastically reducing their in house services. Newcastle is not going to do that. We want to go on providing strong in house services while purchasing additional specialised services to add on to them." The department, she says, could do a great deal even with the 15% of the grant that it is allowed to spend in this way—and she is well aware that if the government brings in compulsory competitive tendering, these services would have to compete with external tenders.

Newcastle is also contracting with various voluntary agencies to provide services. Age Concern Newcastle, for example, is going to provide domiciliary care overnight and on Saturdays, Sundays, and bank holidays. Sue Pearson, the organisation's director, says the process of negotiating the contract was formal, difficult, and protracted. The council's financial regulations were suited to large companies in the private sector that supplied goods such as school desks, and not to smaller organisations supplying services. Age Concern does not have the resources to allow it to tolerate being paid three months in arrears, for example. But these problems have now been ironed out. The contract will run for two years.

New forms of assessment

Social workers' main fears a year ago were of the hitherto hidden workload that the changes might reveal. Moira Woodford says: "We were concerned about the need to assess everyone going into care—we didn't know how many extra assessments that would mean." But the anticipated dramatic increase has not materialised.

As the months have gone by, the new assessment system has evolved. The forms initially supplied for assessments were untried and untested. The person who was seeking care had to sign his or her name nine times. The form mentioned 141 different types of need. The section that was supposed to be photocopied and sent to the client's general practitioner comprised five pages in the middle of the form—as a result, few copies were ever sent out by hard pressed social work departments.

Carolyn Stephenson says: "The procedures we put in place were too complex for those with low level needs and not rigorous enough for those with greater needs." In addition, although the social services department had said that it would accept assessments from other agencies, such as general practitioners and other members of the primary health care team, it had omitted to tell these people how to present these assessments.

Stephenson has now "totally revamped" the assessment procedure and form; it is now being piloted and going through a consultation period. The new slimmed down version cites just 12 categories of need and is less "structured." Stephenson says: "It now lets people tell us what they want." The same form can be used whether the client's needs are simple or complex. But if the level of care required is high, the form specifies the need for a general practitioner's opinion or specialist medical assessment; for someone with a drug or alcohol problem, additional detailed information is called for.

The hospital social workers, who groaned in unison at the mention of the old assessment forms, are enthusiastic about the new ones. Ray Johnston says: "They have blank pages on them—room for biographical information that will help to put the person in context." Judy Thompson, also a senior social worker at the Freeman, agrees: "It's very important for people going into care for their carers to have some good background—whether they worked down the pits or on the river, for example—and the old forms just didn't allow for that."

The social services department is simultaneously making good its former lack of communication with the primary health care team: among those piloting the new form are district nurses and health visitors. Stephenson says: "If in the course of their work assessing people's health needs, they discover that social needs are not being met, they can send us their assessments and we can provide services on the basis of those assessments."

Feedback to general practitioners should also improve. Just one page in the new form needs to be photocopied and sent to them.

Dr Chris Drinkwater, a general practitioner in Newcastle and a member of the joint health and social services management group, which oversees operational policy on community care, confirms the lukewarm relationship between general practitioners and social services. He thinks that the majority of general practitioners in Newcastle would question whether the new community care arrangements have changed anything. A common complaint, as Carolyn Stephenson anticipates, is that general practitioners rarely get any feedback about the outcome of any referral they make to social services.

Nevertheless, Dr Drinkwater believes that the situation is getting better, with assessments being carried out more quickly than in the past and feedback improving. Named social workers attached to individual general practices would be a step in the right direction, he says. The introduction of the community care act has opened up lines of communication like a dose of salts: "There has been greater dialogue between health and social services and between social workers and primary health care workers in the past two years than in the whole of the previous twenty."

Working together

Joint working between health and social services is crucial to the success of the new community care arrangements. Graham Armstrong says one of the planks on which community care will succeed or fail is whether the two bureaucracies will find it possible to collaborate with each other.

But although Armstrong describes collaboration with the health service to date as "superb," most people agree that joint planning is moving forward only slowly at the moment. A new joint planning system has just been put into place and Ian Kitt, assistant director of North Tyne Health, says: "That is the challenge for the future—can we take joint commissioning forward?"

He would like to see integrated health and social services teams based around general practices. Each team would have a budget that it could use to commission whatever services people needed, rather than some services being seen as a health responsibility and others as a social services responsibility.

Jennifer Bernard also sees joint commissioning as a future priority but points out that everyone has to be clear about who is accountable for spending the money. While the health service can purchase social care, the social services department is not allowed to buy health care. And if the social services department's hold over its budget were weakened, this would have political implications: health authorities are not accountable to the local electorate in the same way that councils are, Bernard points out.

Public perceptions

Ultimately, of course, it's the voters—the users and carers—who matter: what do they think of the changes to date? Christine Lowthian, of Newcastle Alzheimer's Disease Society, says the local authority has tried to look at purchasing care in innovative ways. Some people have begun to receive care that is more closely adapted to their needs: for example, day care that is available at weekends as well as during the week; respite care for a couple of days, rather than a couple of weeks, at a time.

But still bigger changes are needed, she says. For example, many people who have the traditional type of day care might spend two to three hours of the time they are away from home on a bus. Ms Lowthian says suggestions have been put forward to use smaller vehicles or taxis so as to reduce travelling time. "This seems a relatively small alteration to make but it's a big change when you consider that things have always been done that way in the past."

Ms Lowthian says the council also needs to do better on informing the public about the changes. People do not realise that social services can now provide a broad range of help for an elderly relative, rather than just a place in a home. Carolyn Stephenson also quotes examples of types of care that are beginning to break the mould of the old style of provision. The department is negotiating with mental health charities and housing associations, which want to provide "housing with care": homes for people to live in that include domiciliary help and care of a befriending nature. Another scheme involves helping several families each with a member who has a learning disability; the families are planning to set up a company to employ people to provide the care that their relatives need, in a determined effort to keep them out of long stay hospitals.

Many staff do have political reservations about the community care reforms: they believe the new system was introduced in order to cut costs and introduce a "gatekeeping" process for those entering residential care. However, there are also advantages. Carolyn Stephenson says: "In social services there is also a real professional attraction to having some money freed up to provide more choice and flexibility. There's a lot in it for professionals and their clients."

Assessment of training in psychosexual medicine

Nigel Mathers, Morag Bramley, Katherine Draper, Shirley Snead, Alexandra Tobert

The Institute of Psychosexual Medicine offers training in the treatment of psychosexual problems to medically qualified doctors. Training takes place in fortnightly seminars in which trainees present and discuss real cases. Assessment of cases presented at the beginning and end of the six term basic training showed appreciable improvement in doctors' abilities. The proportion of doctors meeting each of the 14 predetermined clinical objectives rose. Factors which affected the amount of improvement were the initial score, the number of cases presented at the seminars, the occupation of the leader, and the duration of training. Accreditation by the Institute of Psychosexual Medicine was shown to be an appropriate outcome measure for the achievement of the required standards for practising psychosexual medicine.

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"We cannot manage to have sex," "why is sex so painful?" "I don't want sex since the baby," or "why can't I get it up, doctor?" are complaints often heard in today's medical practice.[1] Many agencies offer training in the treatment of sexual complaints,[2-5] but in the United Kingdom the Institute of Psychosexual Medicine is the only professional body in this subject which confines its training and accreditation for membership to medically qualified doctors.[6]

In this paper we describe the institute's training process, illustrate changes in the clinical skills of doctors treating psychosexual and related psychosomatic problems and assess these changes quantitatively to determine the relative influence of factors associated with the training.

Origins and setting

The Institute of Psychosexual Medicine evolved from the in service training initiated by the Family Planning Association in 1958 and led by psychoanalyst Michael Balint.[7] The demand for training grew as doctors discovered that patients' sexual problems required skilled help. Tom Main, another psychoanalyst, pioneered a workshop where psychosexually trained doctors could acquire leadership abilities.[8] The accredited leaders then provided psychosexual training throughout Britain. When family planning, but not psychosexual medicine, was assimilated into the NHS in 1974, the Institute of Psychosexual Medicine was formed to promote training and research and to safeguard standards.

Training process

Basic training consists of a six term course of fortnightly seminars over two years. Trainees must be currently treating patients with psychosexual problems in a setting where physical examination is appropriate. Those with special aptitude can do a further six terms of advanced training and present work for accreditation and membership of the institute. In 1993, 182 doctors were training in 20 centres in the United Kingdom.

The training uses problem based methods of learning rather than books and lectures. About eight doctors meet with an accredited leader. The trainees describe encounters with patients, listen to the comments of their peers, and then do the same for the other doctors. Through these processes the doctors learn that active participation of patients is essential to treatment and that only by listening, looking, feeling, and finally thinking about the consultation can the patient's (often unconscious) messages be grasped. The real distress is picked up in the patient's behaviour with the doctor and not by direct questioning.

There is group discussion of difficult problems, in which members focus on the events and feelings in the consultation. Was the patient eliciting sympathy, being polite, portraying himself as a victim? Was the doctor reacting? The relevance of these interactions emerges as discussion focuses on the doctor-patient relationship.

Trainees are given no protocols on procedure. Instead they are taught that each encounter with a patient is unique. Total attention to the patient's words