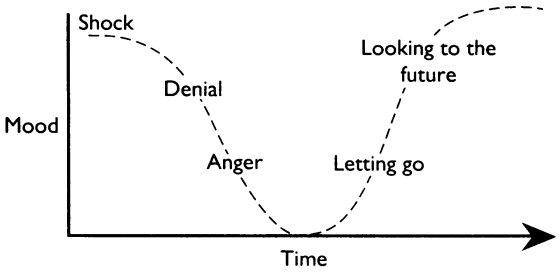
laugh with? If not, how could I begin to build up a support network?

Once the first and crucial step has been taken of recognising that everyone needs help to handle what are very distressing events, the next step is to request and take advantage of all the support available. The stages that people go through during a transition are well charted (see figure). Understanding that the swings of mood are perfectly natural and that time is needed to work through all the stages helps the process. Sensitive counselling at critical periods can help greatly too.

Another key area of preparation is in the creation of "stability zones"—constants in one's life which it is important to maintain. People can handle change more effectively if they keep one thing constant rather than allowing everything to change.[2] Now is the time to identify the constants and protect them. Safeguarding the security blanket can be very important in coping with considerable upheaval.



Stages in transition

An obvious subject for preparation is to remind oneself of one's assets. It is easy to overlook the range of transferable skills and experiences that one has accumulated in the course of a career and will now stand one in good stead. Recognising that security really only comes from within, people need to recognise and appreciate those qualities that will help them to face an uncertain future. In particular, it is worth examining earlier occasions when change was handled effectively and then explore how it was done and what skills and methods were used.

If the policy makers are willing to learn from some of the mistakes made in industry, where hasty changes were made which led to a dramatic brain drain subsequently, the unpalatable adjustments that will need to be made in London should create less harm than will otherwise be the case.

1 Arlie, Russell, Huchchild. *The managed heart.* University of California Press, 1980.
2 Boydell T, Burgoyne J, Pedlar M. *Self development for managers.* London: McGraw Hill (UK) Ltd, 1978.

Countdown to Community Care

Reaching out—community care in Bassetlaw

Trish Groves

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

Bassetlaw is a mainly rural council district in Nottinghamshire, just north of Robin Hood's Sherwood Forest. Its population of 105 000 is concentrated in two market towns, Worksop—known as the gateway to the Dukeries because the wooded hills nearby once belonged to great ducal estates—and Retford, one of the oldest chartered boroughs in the country.

Unemployment among Bassetlaw's men last year was just less than England's overall rate of 9·7%. This could increase, however, if Retford's local coal mine, Bevercotes Colliery, closes. Its almost immediate closure was announced and then retracted last autumn, and its 600 or so employees are now waiting to hear how long the reprieve will last. Manton Colliery, near Worksop, is scheduled to stay open but is no longer recruiting staff to replace those who leave or retire.

In the population census for 1991 nearly one in seven of Bassetlaw's residents said that they had long term illnesses, health problems, or handicaps that limited their daily activities or work. How many of them need but do not receive community care is not known. From April, however, there will be closer cooperation among the various statutory and voluntary services that arrange and provide care and, in the long run, this might lead to more efficient recognition of ill or disabled people who need help with daily life.[1] I visited Bassetlaw last month to see how its community care services work now and how they are set to change.

Making plans for Bassetlaw

JOINT PLANNING

Bassetlaw's community care services will change along with those for the whole of the county of Nottinghamshire. Despite goodwill and a developing sense of partnership among social services, health authorities, the family health services authority (FHSA), and the voluntary sector, the planning process has not been easy. The main reasons are broadly political.

Firstly, the county's health authorities and councils do not share the same boundaries, and those boundaries that do exist are changing. The district health authority of Bassetlaw, for example, merged with that in Central Nottingham last year to form a much larger North Notts district, and this year the nationwide reorganisation of council boundaries will reach Nottinghamshire. Secondly, some people I spoke to thought that local planning had been slowed by uncertainty about last year's general election and the possibility that a Labour government might have diluted or delayed the community care reforms.

Implementing the county's plans will not be easy, either, because of underfunding. The money being transferred from the Department of Social Security to Nottinghamshire for buying residential care will fall short of the amount needed by almost a fifth.

ASSESSMENT AND CARE MANAGEMENT

The government's guidance on assessment and care management is loose enough to allow different interpretations. In Nottinghamshire the social services departments will use teams rather than individual care managers to assess people and arrange packages of care. To test the new procedures, however, county hall decided to spend some of last year's specific grant for mental illness on four new care managers.

In Bassetlaw the care manager for mental health is on maternity leave and the existing social work team is trying out the new procedures. Joy Gibson, senior social worker for mental health, told me that about 50 people with complex needs are being helped in this way. Each gets a written care plan and a named key worker. When the plan is up and running and all

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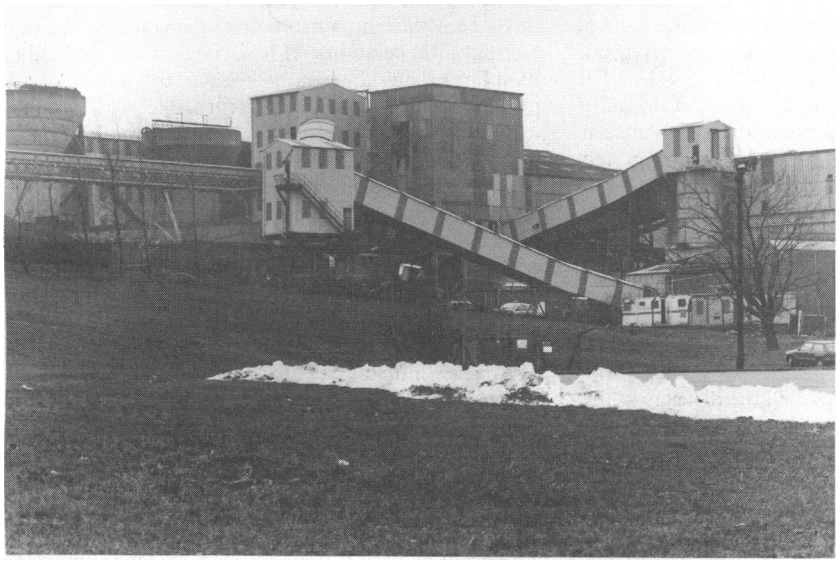


EMPICS

Manton Colliery is no longer recruiting and Bassetlaw's other pit, Bevercotes, is under threat of closure

the identified needs for care are being met, the managing team backs away and performs only intermittent reviews. The system is too new for any conclusions to be drawn yet, but one problem has developed already. The social work and psychiatric teams have different criteria for deciding who needs such intensive community care. The psychiatric team puts the number of local mentally ill people with complex needs at around 150, three times the social work team's estimate. Although this disparity reflects the real world of budget limits, it could scupper the care programmes that the psychiatry department is meant to set up for seriously mentally ill patients and make planning for discharge more difficult.

DISCHARGE FROM HOSPITAL

An all too common kind of crisis for community and primary care teams is that a vulnerable patient is suddenly discharged from hospital on a Friday afternoon without any formal referral or plan for aftercare. To avoid this kind of disaster health authorities in England and Wales will soon have to ensure that proper preparations for community care are made before inpatients who need such care are discharged. The down side, of course, is that hasty discharges often result from shortage of beds and thus the new procedures will probably block beds.

Geriatrics beds are those most likely to be blocked while assessment teams explore alternatives to residential care. At present two thirds of all people admitted to Nottinghamshire's nursing homes go straight from hospital, and most are elderly. In Bassetlaw the liaison sister for elderly people, Frances Fairclough, has been seconded to look generally at community care planning and specifically at discharge procedures.

Over the past year Mrs Fairclough has piloted a scheme with one general practice on discharge planning. All patients from that practice who have been admitted to any department of Bassetlaw Hospital (except the units of psychiatry and paediatrics, which have their own similar systems) have been assessed on admission for their likely needs on discharge. Using a special form, nursing staff have recorded and updated these needs. When a patient in the scheme is discharged a copy of the form, which also has room for the ward doctor's summary and details of any prescription, is faxed to the patient's general practitioner. So far, the scheme is working well. But other aspects of the reforms are still bothering some of Bassetlaw's general practitioners.

THE GP'S ROLE

One general practitioner, who works in a large multipartner practice in Worksop, said that the community care reforms were all a bit of a mystery. Although he knew the basic principles of assessment and care management by social services, he did not know what his own role in the process might be. Feeling overloaded with routine and emergency clinical work (there are no deputising services in Bassetlaw) and with administration, he did not see how he and his colleagues could commit any extra time to assessment.

One of the district's few fundholders was concerned that he had not yet had enough information on how he will be able to buy community health services in April. "No one has told us how this will work," he said. "I presented the district health authority with a list of questions on this three months ago and I've had no reply. For instance, what will happen when we refer patients to the new community mental health team that's being set up? Referrals to community psychiatric nurses are chargeable to the fund but those to social workers are not. This could cause problems with data collection." He was also worried that social workers on the care management team would have the final say on choosing nursing care. If he wanted to refer a patient to a nursing home and the social work team recommended district nursing in the patient's own home, he would not only be overruled but also have to foot the bill for the nurse.

Tony Ruffell, chief executive of Nottinghamshire FHSA, told me that preliminary research in the county suggested that each general practitioner would encounter only a few such difficult decisions a year—perhaps five or six. Regarding the extension of fundholding to community health services such as district nursing and occupational therapy, Mr Ruffell said that fundholders would have to make block contracts in the first year.

Monica Gellatly, community care coordinator for the FHSA, explained why general practitioners were feeling so much in the dark about the changes. "We couldn't start training GPs until we knew what was going to happen locally. Just describing the general principles and answering specific questions with 'we're working on it' wouldn't have been good enough." In January and February the FHSA is putting the record straight by sending all general practitioners in Nottinghamshire an information pack and inviting them to a range of training sessions on community care. These sessions will include four evening "roadshows" of presentations and workshops, illustrated with real examples of how the reforms will be handled locally. Those who attend will be able to claim the postgraduate educational allowance, and the FHSA hopes that the turn out will be good.

Thus, general practitioners in Bassetlaw should soon know what kind of role they will have in assessing people for community care. To facilitate such assessments a joint working party of general practitioners and the FHSA, chaired by Professor Idris Williams from Nottingham University, is producing a standard protocol. The end result of the working party's efforts and a small pilot project in four representative practices should be a single assessment form for doctors to complete. The Department of Health has not decided yet how much general practitioners will be paid for work that exceeds their contractual obligations, such as attending care management meetings and performing certain assessments.

Delivering care

Last year Bassetlaw's district general hospital in Worksop and its related community services became

an NHS trust. According to Dr Peter Pratt, who heads the trust's community health directorate, the unit is particularly well set up to respond to the increasing emphasis on non-hospital care in the NHS. He explained that the district hospital has developed a strong sense of community service, partly because it has always had to find ways of reaching a scattered population. Staff are more willing, perhaps, than those in high profile academic centres to accept the idea that there will be a move away from a hospital based service.

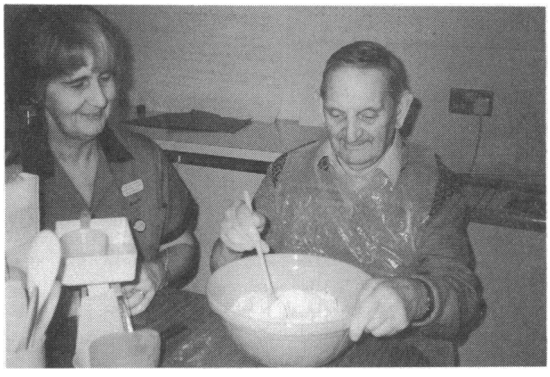
One impending move is the closure of the last remaining ward in Worksop's old Victoria Hospital. It houses long stay elderly patients who will move this year to a new community unit if all goes to plan. Residential care for elderly people is, perhaps, the hottest issue for local planners: of all the districts in the Trent health region, Bassetlaw has the fastest growing population of people over 85. This is mainly because many of the district's relatively cheap large houses have become part III and nursing homes, offering about 300 places in the private sector and around 150 run by social services.

ELDERLY PEOPLE

Of Bassetlaw's 18 000 pensioners, more than 2500 live alone. Fewer than half of the district's households that include a pensioner have a car. It is easy to understand, therefore, that social isolation is a particular problem for local elderly people. Joan Bower of the voluntary organisation Age Concern told me how her local branch takes services to its clients, rather than making them travel. Volunteers run 17 luncheon clubs and three coffee bars around Bassetlaw, many of them in small outlying villages. Last year they served some 19 000 council subsidised meals to elderly people. Both Age Concern and the social services department have set up befriending schemes, sending volunteers or care assistants to spend time with elderly people at home and often giving carers a break.

In addition to practical help, some carers looking after elderly relatives and neighbours may need emotional support. Lynne Moody, nursing sister in Bassetlaw's day hospital for elderly people, runs an informal support group for carers. Because the day unit concentrates on rehabilitation and has a fairly fast turnover none of the eight people who come to talk over tea or coffee has a relative attending the day hospital at the moment. Mrs Moody would like to advertise the group more widely and would be happy to invite former carers whose elderly charges have died or gone into residential homes. She has found that the decision to choose residential care can cause just as much bereavement and guilt as can death.

There is no separate department of geriatric medicine in Bassetlaw. All four physicians admit elderly patients into the district hospital's general medical beds. The medical teams already hold multidisciplinary case conferences to plan continuing care for elderly patients with complex needs. After April they intend to use the standard discharge procedures that have already been piloted with one general practice, as mentioned above. Dr M M Muthiah, consultant physician, told me that existing good relations with social services and other disciplines should ensure a smooth transition to the new style of community care. He was worried, however, that adherence to the new pre-discharge procedures might block acute medical beds unless care management teams were funded adequately and could respond quickly.



BASSETLAW DAY HOSPITAL

Care for elderly people is probably the planner's hottest issue in Bassetlaw

Elderly people with mental illnesses get psychiatric care from the department of psychogeriatrics at Bassetlaw Hospital. Those with dementia may attend the day hospital for the elderly one day a week and may be supported in the community by one of two specialist psychiatric nurses. Penny Peysner, senior social worker at Bassetlaw Hospital, told me that the district had planned to open a special day centre for elderly mentally ill people at a social services residential home, using the mental illness specific grant. That home, however, has just been closed down as part of a refurbishment programme. Mrs Peysner hopes that the money will be used instead to improve day facilities for this group at other homes or to set up a mobile day unit.

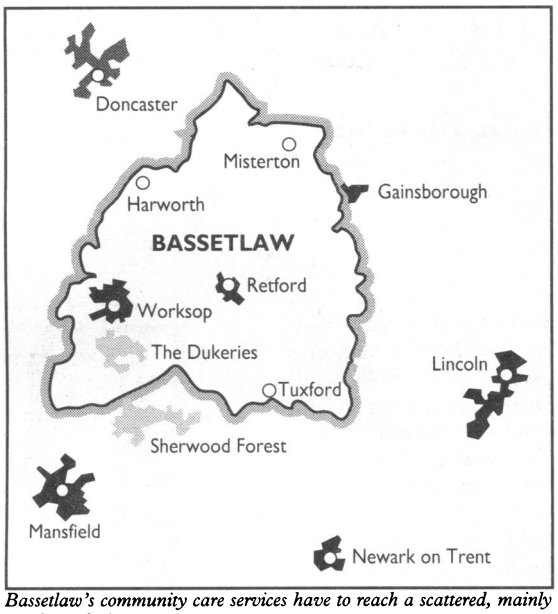
PEOPLE WITH MENTAL DIFFICULTIES

"We have been bashing out plans for care management and for better discharge procedures, and on paper we can offer community care very well," said Jim Walker, acting director of Bassetlaw trust's mental health services. "There will be even better scope for teamwork. I don't think we could ever have made *Caring for People* work when the CPNs were here in the hospital and the social workers were 10 miles away in Retford." From April social workers, the CPNs—community psychiatric nurses—and a psychologist should be working together in a new community mental health resource centre in the middle of Worksop. The centre will be housed in a building previously used for doctors' residences and Joy Gibson, senior social worker for mental health, will head the team.

But Jim Walker told me that, despite these good developments, he was worried that the new system for community care might be underresourced. All the services for mental health seemed to be at full stretch already, he said. The expected shortfall in social services funding for community care had already led to tightening of the criteria that social workers will use to decide who is eligible for care management, and patients with moderate needs for care might lose out altogether. In addition, the hospital's psychiatric unit could not cope with bed blocking: occupancy often reaches 90% in spring and autumn, leaving inadequate space for emergency admissions.

The recommendations of the Reed report, that mentally ill offenders should be cared for by local NHS psychiatric services, could tip the balance even more, said Jim Walker. Ranby prison, midway between Worksop and Retford, would turn to Bassetlaw Hospital for its prisoners' psychiatric care. This could add considerably to the existing demand to rehabilitate patients from Rampton special hospital, which also lies within Bassetlaw.

Patients with severe mental illness who need long term rehabilitation are relatively well served in Bassetlaw. Worksop has two NHS run and fully staffed hostels in the hospital grounds and a 16 bedded hostel run by the charity Turning Point. I visited these facilities two years ago, when the new community care legislation was being set up.[2] Last month Trevor Goodall, team leader of the Turning Point project, told me, "Bits of information on the community care changes are filtering through to us from social services, and we think that we will be involved in the assessment process. Our existing residents will continue to get social security funding for their rent and we assume



Bassetlaw's community care services have to reach a scattered, mainly rural population

that we will still get grants from the health authority and social services for our running costs. We hope the changes won't alter things too much."

Concentrating the resources for community care on people with severe mental illnesses makes sense. Other people with less florid but equally chronic mental health problems, however, could find it much harder in future to get help from the busy statutory services. I spoke to Jean Collis, coordinator of Bassetlaw MIND (the local branch of the national association for mental health), who was worried that people with chronic depression and anxiety would have to rely increasingly on voluntary organisations for help. The local support groups and befriending schemes that MIND was running two years ago[2] are expanding all the time, and a new advocacy service to help people with mental health problems deal with lawyers, the courts, doctors, and other professionals is taking off. But Mrs Collis has found raising funds for these services particularly hard in the past year.

PEOPLE WITH LEARNING DISABILITIES

Schemes for befriending and advocacy are also available for Bassetlaw residents with learning disabilities. These are run by both social services care assistants and volunteers. The community mental handicap team (a title it retains, although its members do not describe their clients as handicapped) has more than 10 years' experience of providing such innovative care to a mainly rural and home based population. A survey in 1989 showed that the team knew of 350 local people with severe learning disabilities, of whom 217 lived with their families and 38 lived with single carers.

Bill Barker, senior social worker, explained that the team had served children as well as adults with learning disabilities until last year. Under the terms of the Children Act, however, responsibility for helping these children now lies with the social services child care team. Although this transfer of responsibility makes sense in many ways, it hampers continuity of care for a group of people with long term needs. Such continuity might also suffer under the new legislation on community care.

"Many families are struggling on, perhaps because they don't want to consider residential care or because the right sort of care isn't available," said Bill Barker. "Helping people with learning disabilities and their families is often a very gradual process. I'm worried that the changes to community care might, paradoxically, spoil this long term relationship. If our priority is to target help at those with most need and to back away when those needs are met, our contacts with families could become simply box-ticking sessions, and it would be harder to get to know them."

People with learning disabilities who need residential care in Bassetlaw can go to one of four staffed homes which were set up partly by the health authority and are run by the Mencap Homes Foundation. From April the rent of new residents will be funded by the council's community care budget. Karen Sands, of the foundation, said that she had no particular worries about the changes in the short term. She wondered, however, whether the philosophy of matching services closely to needs might eventually mean that existing residents who were relatively independent might be thought unsuitable for Mencap's homes. "We tell our residents that we offer homes for life, and we do not expect people to move on," she explained.

Dr C L Narayana, the consultant who covers mental handicap services for the whole North Notts district, works two sessions a week in Bassetlaw. He told me that he too had no particular worries about community care and that the provision of residential care was very good. The only shortfall, he said, was of facilities for patients with very difficult and challenging behaviour. Balderton Hospital in Newark, the old mental handicap hospital for the county, is set to close this year, and Bassetlaw's small inpatient unit cannot provide long term intensive care.

PEOPLE WITH PHYSICAL DISABILITIES

Community social services for people with sensory and physical disabilities are provided from the Eastgate Centre in Worksop. A team of social workers and support staff offers advice and practical help and the day centre provides social contact for about 100 people a day. Molly Allen, the manager of the day centre, explained how the service is moving away from the traditional model of care. The team's philosophy is to encourage disabled people to help themselves and each other, particularly by running parts of the centre themselves. Block funding comes from social services, and Mrs Allen does not foresee any change after April.

Community health services for people with disabilities, such as physiotherapy and occupational therapy, are provided by Bassetlaw trust. Like others I spoke to, Dr Peter Pratt aims to send as many services as possible from his community health services directorate in Retford Hospital to the rural areas of the district. For example, two new mobile units are now taking chiropody and dentistry to the villages. As a member of Nottinghamshire's interagency planning team, Dr Pratt has been involved in setting up community care for the county. He said that he was generally optimistic about the plans and thought that Bassetlaw's combined hospital and community trust was well set up to implement them, not least because the trust has good information systems.

Conclusions

Bassetlaw particularly needs good community care because many of the people who most need help live outside the towns and lack easy access to hospitals and town halls. The district's services seem to reflect this need well already, perhaps because Bassetlaw does not have a teaching hospital to concentrate NHS resources or a city to exhaust social services. Most importantly, the people who will have to implement the community care reforms seem to share the same vision and, despite certain reservations, the same enthusiasm.

1 Secretaries of State for Health, Social Security, Wales, and Scotland. *Caring for people: community care in the next decade and beyond.* London: HMSO, 1989. (Cm 849.)
2 Groves T. After the asylums: the local picture. *BMJ* 1990;300:1128-30.