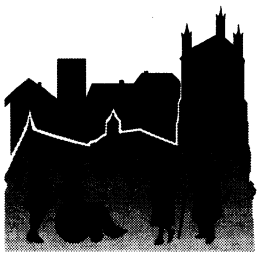
in people who as children were treated with depilatory radiation for ringworm of the scalp,[19 20] but changes in the overall exposure of the general population to ionising radiation are insufficient to have had a major impact on brain cancer incidence. More recently, brain cancer has been linked with exposure to magnetic fields from electrical equipment.[21] However, the evidence for a relation is far from convincing. In particular, it is not clear how magnetic fields would influence the biochemistry of cells in such a way as to initiate or promote cancer formation. As yet, therefore, the trends in brain cancer mortality are not satisfactorily explained.

Conclusions

Analysis of age specific death rates confirms that we are experiencing a true epidemic of cancer but suggests that this is attributable largely to smoking. On the basis of current trends the epidemic can be expected to decline first in men and later in women. There is no evidence that toxic hazards such as pesticides, chemical waste, and other forms of industrial pollution have had a major impact on overall rates of cancer. Some specific cancers do show remarkable changes in incidence and mortality, and it is important to monitor these for the clues they can give us to aetiology and so that the provision of health care can be better planned.

1 Coggon D, Acheson ED. Trends in lung cancer mortality. *Thorax* 1983;38: 721-3.
2 Gillis CR, Hole DJ, Lamont DW, Graham AC, Ramage S. The incidences of lung cancer and breast cancer in women in Glasgow. *BMJ* 1992;302:1331.
3 Osmond C, Gardner MJ, Acheson ED, Adelstein AM. *Trends in cancer mortality 1951-1980: analysis by period of birth and death.* London: HMSO, 1983. (OPCS series DH1, No 11.)
4 Office of Population Censuses and Surveys. *Mortality statistics, cause 1981-1990.* London: HMSO, 1983-1991. (Series DH2, Nos 8-17.)
5 Howson CP, Hiyama T, Wynder EL. The decline in gastric cancer: epidemiology of an unplanned triumph. *Epidemiol Rev* 1986;8:1-27.
6 Coggon D, Barker DJP, Cole RB, Nelson M. Stomach cancer and food storage. *J Natl Cancer Inst* 1989;81:1178-82.
7 Forman D, Newell DG, Fullerton F, Yarnell JWG, Stacey AR, Wald N, *et al.* Association between infection with Helicobacter pylori and risk of gastric cancer: evidence from a prospective investigation. *BMJ* 1991;302:1302-5.
8 Parsonnet J, Friedman GD, Vandersteen DP, Chang Y, Vogelman JH, Orentreich N, *et al.* Helicobacter pylori infection and risk of gastric carcinoma. *N Engl J Med* 1991;325:1127-31.
9 Nomura A, Stemmermann GN, Chyou PH, Kato I, Perez-Perez GI, Blaser MJ. Helicobacter pylori infection and gastric carcinoma among Japanese Americans in Hawaii. *N Engl J Med* 1991;325:1170-1.
10 Mendall MA, Goggin PM, Molineaux N, Levy J, Toosy T, Strachan D, *et al.* Childhood living conditions and Helicobacter pylori seropositivity in adult life. *Lancet* 1992;339:896-7.
11 Barker DJP, Coggon D, Osmond C, Wickham C. Poor housing in childhood and high rates of stomach cancer in England and Wales. *Br J Cancer* 1990;61:575-8.
12 Powell J, McConkey CC. Increasing incidence of adenocarcinoma of the gastric cardia and adjacent sites. *Br J Cancer* 1990;62:440-3.
13 Day NE, Munoz N. Esophagus. In: Schottenfeld D, Fraumeni JF, eds. *Cancer epidemiology and prevention.* Philadelphia: W B Saunders, 1982:596-623.
14 Lee JAH. Melanoma. In: Schottenfeld D, Fraumeni JF, eds. *Cancer epidemiology and prevention.* Philadelphia: W B Saunders, 1982:984-5.
15 Armstrong BK. Epidemiology of malignant melanoma: intermittent or total accumulated exposure to the sun? *J Dermatol Surg Oncol* 1988;14:835-49.
16 Davies JM. Testicular cancer in England and Wales: some epidemiological aspects. *Lancet* 1981;i:928-31.
17 Swerdlow AJ, Huttley SRA, Smith PG. Testicular cancer and antecedent disease. *Br J Cancer* 1987;55:97-103.
18 Davis DL, Hoel D, Fox J, Lopez A. International trends in cancer mortality in France, West Germany, Italy, Japan, England and Wales, and the USA. *Lancet* 1990;336:474-81.
19 Modan B, Baidatz D, Mart H, Steinitz R, Levin SG. Radiation-induced head and neck tumours. *Lancet* 1974;i:277-9.
20 Shore RE, Albert RE, Pasternack BS. Follow-up study of patients treated by X-ray epilation for tinea capitis: resurvey of post-treatment illness and morality experience. *Arch Environ Health* 1976;31:21-8.
21 National Radiological Protection Board. Electromagnetic fields and the risk of cancer. *Documents of the NRPB* 1992;3:1-138.

Community Care: The First Year



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

Community care in Bassetlaw

Trish Groves

Last April the United Kingdom's system for providing community care—practical and social care for ill and disabled people who need help with daily life—was changed in an effort to make it better and more efficient.[1] The *BMJ* ran a series of articles about the changes that included descriptions of community care in four places: Gwent in Wales, Bassetlaw in Nottinghamshire, Northern Ireland, and Newcastle in north east England.[2-5] In this and the next three articles we look at what has happened to community care over the past year in these places.

Most people in Bassetlaw, a council district in North Nottinghamshire, would probably say that local community care services have not changed much over the past year. But some local residents, for instance, those needing extra help at home after leaving hospital, may have noticed that the whole process of getting that help has become easier and, perhaps, quicker than before. The various organisations arranging and providing care have been working hard to communicate and cooperate more effectively and to find the most workable way of giving local people what they need. This planning work behind the scenes should improve services gradually but is already smoothing the potentially problematic processes of referring and assessing people for care.

Making plans for Bassetlaw

"If you'd talked to me a year ago about district planning for community care in Bassetlaw I'd have been tearing my hair out," says David Whitham, chair of the Bassetlaw district joint planning team, which consists of representatives from health and local authorities, the family health services authority, users, carers, and voluntary groups. "But I've been immensely encouraged because the planning team has stuck to its timetable and its members have really concentrated on coming up with a broad response to local people's needs, rather than pushing too hard for the interests of the groups they represent."

Over the past year the team has got to grips with the politics and jargon of planning, recommended how to spend the joint finance budget, and agreed on and sent out for consultation next year's community care plan. The team has got on well partly because its members have worked hard and enthusiastically. It has also benefited from Bassetlaw's long history of successful joint working and serving a mainly rural district scattered around two market towns (see map). There has never been a big and powerful town hall or hospital locally to dominate planning for community care.

Things could get tougher in future, however. "It's still early days," says David Whitham. "The main issue for the team now is to audit existing services and try to match resources to the needs of Bassetlaw's people. We're looking at the local situation by using information like the census, public health data, and needs assessments. We're also recording all unmet needs that arise during individual assessment, but we realise that there may not be enough money to let us fulfil all those unmet needs in the long term. The

British Medical Journal, London WC1H 9JR
Trish Groves, *assistant editor*

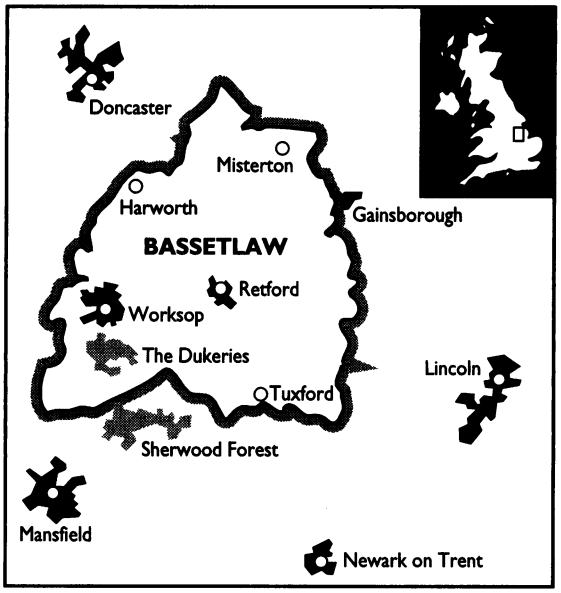
BMJ 1994;308:708-11

information will help us in deciding on priorities as well as reshaping existing services."

David Whitham is worried about one particular aspect of purchasing by the joint team: that it could be complicated by the gradual expansion of general practice fundholding locally. He would like to see a better forum for planning and for working with general practitioners so that any fundamental differences between the team's and fundholders' ideas on purchasing could be resolved.

Another long term concern is that the new funding system for community care might eventually stifle innovation in the voluntary sector. "If you came to us now and said that your scheme wanted money to set up some kind of community care service in Bassetlaw we could give you funding only if you could satisfy us that it was a capital scheme without any revenue consequences. In other words, if you intended to keep the service going for many years beyond the period funded by the original capital, you'd have to be able to show where the money would come from to continue the scheme," David Whitham explains. "That would probably mean you'd have to provide a predictable service that could compete strongly in the market for long term health and social services funding. This could put you and other voluntary organisations off from having new ideas or even from joining in with planning. It may well be hard enough for planners from statutory services to keep up their commitment and enthusiasm; how will those from the voluntary sector cope?"

Barbara Meeke, director of contracting and service evaluation for North Nottinghamshire Health Authority, is also keen to see that the voluntary sector does not get swamped by its new responsibilities. To minimise this risk and strengthen links between the statutory (health and social) services and voluntary organisations the joint team has already employed an officer to liaise with Bassetlaw's council for voluntary services. Barbara Meeke and Philip Marsh, the health authority's joint planning manager, say that the first year has gone well and are particularly pleased that there has been enough money for community care, with the joint budget actually underspent in 1993. They also say that the service has become smoother as Bassetlaw Hospital and Community Services NHS Trust, based in Worksop, has developed better plans for patients discharged from hospital.



Bassetlaw encompasses a scattered, mainly rural population

The story so far: evaluating the changes

At Bassetlaw Hospital since April 1993 a standard format for planning inpatients' discharges has been included in the nursing notes in all wards except in the psychiatry department (where they follow the more specialised care programme approach).[6] The letter sent to a patient's general practitioner on discharge now includes details of any referrals and arrangements for continuing social and practical care, as well as the basic information about diagnosis, clinical management, and treatment that constitutes the traditional discharge letter.

An initial survey of a sample of local general practitioners raised some criticisms, and the discharge letter has been revised to include less incidental or irrelevant information on what happened in hospital and more detail on things like what patients and relatives have been told and what follow up has been arranged. A pilot study during February this year using a further draft of the discharge letter in one gynaecology and one geriatrics ward should hone the letter further.

Frances Fairclough, the community care representative for the trust, has developed the discharge procedures and letters and has trained hospital staff how to use them. Mrs Fairclough also provides immediate back up when problems arise over discharges, visiting wards and helping staff on the spot. Two workshops held last spring also gave selected staff from each of North Nottinghamshire's provider units (in health and social services in both community and hospital settings) more formal training on discharge procedures and the chance to air their concerns about the changes.

More general evaluation of Bassetlaw's community care reforms happened earlier this year in a pilot study of the way health and social services provide complex packages of care. The county council, family health services authority, and purchasers looked jointly to see if the relatively few people with considerable needs for community care were getting the right services. The people studied were very dependent on others through old age, disability, or chronic illness and were receiving at least two visits a day from social services as well as regular community health care. When I spoke to Frances Fairclough the results of the evaluation were not yet available, but she explained that data on any unmet needs should show whether the community care system has sufficient funding, skills, and flexibility to serve the people who need it most.

Providers are also looking at the progress of community care, particularly by using clinical audit. Most say that it is too early to say exactly how the care reforms are affecting patients and other service users, but the doctors, social workers, and other professionals who provide care give anecdotal evidence that things are going smoothly.

General practice

Dr Wafik Moustafa is a single handed, non-fundholding general practitioner in Carlton in Lindrick, a village near Worksop. Dr Moustafa says that communication with Bassetlaw Hospital has definitely improved over the past year—for example, discharge letters are now faxed to him. District and other community nurses say that cooperation and continuity of care is welcomed; they can now visit wards to continue contact with their patients during admissions. Caseloads for district nurses and community psychiatric nurses increased during 1993, yet the average waiting time for new referrals to see a community nurse has fallen from six to eight weeks to three weeks. This is because there are more nurses than previously and because they have been able to provide a personal and regular service to each general practice.

Worksop's town centre

Indeed, the community psychiatric nurse who visits Dr Moustafa's practice has just offered to hold a clinic in the surgery for two new and two follow up patients each week. This should speed up referrals even more and further improve communications with the rest of the primary care team.

"We have had no real problems with community care since April," says Dr Moustafa. "I have not come across any bed blocking in hospital, and referrals to nursing homes seem to be getting easier. The social services home care team seems more accessible and more involved, too."

Monica Gellatly, community care coordinator at Nottinghamshire Family Health Services Authority, agrees that it is too early to say definitely whether the reforms have altered patients' care. But early evaluation of general practitioners' referrals to the social services process suggests that communication problems are resolving, albeit slowly and patchily. From July to September last year the authority surveyed all members of primary care teams making community care referrals to social services in 18 practices across the whole county (half were fundholding). "Each practice responded every month and the response rate of 64% from individual team members was heroic," says Monica Gellatly. The results show that primary care teams are reasonably happy with the administrative process of referral and the paperwork it entails, but they are seeing only slow improvements in the quality of feedback from social services about outcome.

"The community care legislation raised GPs' expectations," adds Monica Gellatly. "So far the changes have simply made the doctors more sensitive to the potential and existing problems of working with social services, like professional differences and slow responses. Overall, our survey showed that, although everything is different now, nothing has changed. Practices which already had good relationships with social workers still communicate well; those with poorer relationships still have problems."

On purchasing Ms Gellatly says, "The community care legislation hasn't yet directly affected purchasing by fundholding GPs, not least because ideas for moving from nursing home and residential home care towards more home based packages of care are still at a preliminary stage. And providers of community care services haven't yet collected the relevant and robust monitoring information that those GPs would need."

Care of elderly people

Dr Mahen Muthiah, consultant physician at Bassetlaw Hospital, confirms that communications with general practitioners and social workers have improved over the past year. But there has been some blocking of acute geriatric beds at the hospital over the winter. This has resulted from unusually high demand for admission from general practitioners, which has seemed, in turn, to reflect increased demand by patients for second opinions.

Dr Muthiah's team is auditing the average length of stay for elderly patients in the hospital and is comparing similar periods in the years before and after the community care reforms began. Initial results suggest that the average length of stay has increased slightly since the reforms. "The new predischarge assessments are much more time consuming, and most of the social workers have become disenchanted by the enormous amount of paperwork that they have to complete. In some instances assessments have been delayed because patients have happened to have social workers working in the community rather than in the hospital, and this has made access and communication less straightforward."

Social services in Bassetlaw have also experienced increased referral rates; but the rise has occured throughout the whole year. Margaret Hunt, service manager for elderly people, explains that private residential care has seen the biggest increase. From April to November 1993 social services assessed more than twice as many people for social care as in the same period the previous year (413 assessments compared with 178), with relatively more going to nursing homes and fewer to residential homes. Social care for elderly people at home has also increased; more than 400 are now getting more than five days' home care a week in a district with a total of around 18 000 pensioners. The district has had to take on extra temporary staff to cope with the increased workload.

Unfortunately, increased demand for residential rather than nursing home care has coincided with a reduction in Bassetlaw's residential home beds. One home run by the local authority was demolished last year because refurbishment proved to be uneconomic and it has not yet been replaced. Another 45 beds will go this spring, because a local authority residential home is being closed for several months' refurbishment. With the help of the district council a sheltered housing scheme is being converted to run as a residential home and this will alleviate the bed shortage a little. But David Whitham (the joint planning team's chair), wearing his other hat as social services district manager, warns that more new referrals will have to be supported in their own homes or go to other parts of Nottinghamshire for care until residential home places are increased locally, and that either option may go against some users' and carers' wishes.

Mental health care

Joy Gibson, senior social worker in mental health, has moved with her team from the social services office in Retford to a new mental health services resource centre in Worksop town centre. The centre combines an existing mental health day centre run by the local authority with a new base for the social workers, the district's community psychiatric nurses, a psychologist, and an occupational therapist. The centre was initially intended to handle referrals as a single joint team. But, as Joy Gibson explains, "The reason that we are unable to handle referrals as a single team is that the hospital is now a trust. GPs are becoming fundholders and, in order to court their business, the trust is offering them access to named community psychiatric nurses, a link that some GPs asked for. As well as coping with these new constraints on the community nurses, my team has to operate within the framework of the community care legislation, giving priority to

people with enduring mental health problems—and rightly so. The upshot is that we carry a mainly long term caseload. Only 10-15% of our work is short term (over 6-12 weeks) and it comes mostly from assessments after deliberate self harm."

"If we had a multidisciplinary allocation meeting, the community nurses would have to respond to GPs' requests as a priority and we would have very little space to pick up new referrals," Joy Gibson continues. "So our development is as a multidisciplinary service as opposed to a multidisciplinary team. I think this will become the reality of the 1990s for mental health services, given the recent legislative and political developments."

The post of mental health care manager in Bassetlaw has remained unfilled over the past year but the social workers continue to share the job as a team, and this seems to suit everyone. Currently the team provides full care management[7] for around 30 people with enduring mental health problems. Last year the psychiatry team considered that the social workers' criteria for those needing care management were too narrow: this year the hospital and the community nurses feel happier about the criteria and say that they are realistic. As before, when clients' identified needs are being met and the situation is stabilised, the care management team enters them into a lower key monitoring system with regular reviews triggered through a computerised database. There is not yet, however, a formal case register for all mentally ill people locally.

Jim Walker, senior clinical nurse in Bassetlaw trust's psychiatry unit, says that the first year of community care went well and the next should be even better. The unit is using the care programme approach fully[6] and is reviewing the way it fulfils its responsibilities under section 117 of the 1983 Mental Health Act (a clause which gives patients discharged from certain treatment orders the legal right to continuing support from psychiatric and social services for as long as is considered necessary).

It has been a good year despite problems with medical staffing which have led to dependence on several locums and very few junior staff. This spring, however, one full time consultant is returning to the unit after two years' secondment to the Department of Health and other new doctors will be appointed to both senior and junior posts. Permanent staffing and imminent alignment with the trust's community health unit to make a joint clinical directorate should make planning and providing an integrated service easier, says Jim Walker.

Some psychiatry services have already become more integrated over the past year. The two hospital hostels (converted doctors' houses on the edge of the hospital site) now offer a more focused rehabilitation service with a greater turnover of patients. Soon they will provide two beds for direct readmission of long term patients from the community. Already, one man with chronic schizophrenia can arrange his own admission (and so can his mother) in times of crisis. In addition, the psychiatric day hospital is offering more sessional care and the psychiatric unit has agreed to cooperate and work together more with the social services day centres in future.

Learning disabilities

In Bassetlaw, as in other parts of Britain, community care for people with learning disabilities was already well established before the reforms. Dr Cheedella Narayana, consultant in learning disabilities at Bassetlaw trust, says that no particular changes have occurred or problems arisen since last April.

A spokesperson for the Mencap Homes Foundation, which runs staffed homes in the county, reports that there have been some complications and confusion over securing rents and personal allowances for its residents since April last year. But this is only to be expected with a new system of funding residential care, says the spokesperson. And there are early signs of some improvements: there seem to have been much closer contact with and more referrals from social workers but, for various reasons, this has not yet led to more residential placements.

The future

Bassetlaw's planners and community care staff are just as enthusiastic now as they were before the reforms came into effect in April 1993. Whether the people who need care, and those people's friends and relatives and general practitioners, will be so enthusiastic remains to be seen.

1 *National Health Service and Community Care Act.* London: HMSO, 1990.
2 Robinson R. Moving ahead—community care in Gwent. *BMJ* 1993;**306**:44-7.
3 Groves T. Reaching out—community care in Bassetlaw. *BMJ* 1993;**306**:132-5.
4 Tonks A. Making progress—community care in Northern Ireland. *BMJ* 1993;**306**:262-5.
5 Smith J. Newcastle : "If it doesn't work here, it can't work anywhere." *BMJ* 1993;**306**:566-9.
6 Department of Health. *The care programme approach for people with a mental illness referred to the specialist psychiatric services.* London: Department of Health, 1990. (HC(90)23/LASSL(90)11.)
7 Thornicroft G, Ward P, James S. Care management and mental health. *BMJ* 1993;**306**:768-71.

ANY QUESTIONS

How soon after being treated for Lyme disease can donors give blood?

Lyme disease is a rare multisystem infection caused by the spirochaete *Borrelia burgdorferi*, which is transmitted through the bite of an infected tick.[1] The infection may be asymptomatic, but skin, nervous system, joint, or other manifestations may occur. No cases of Lyme disease transmitted by blood transfusion have been reported, and no mandatory screening tests or specific exclusions for blood donors are in place.[2]

There is a low prevalence of infection in the general population, as witnessed by the zero seroprevalence in people attending antenatal clinics in a range of cities and towns in Britain. Bacteraemia is likely to be short lived[3] but patients with bacteraemia may well have symptoms which would lead to them not donating blood for a time. If potential donors report infection with *B burgdorferi* it will be safe to allow them to donate after the symptoms that presumably cause them to seek diagnosis have subsided, that is, after they have fully recovered.—S O'CONNELL, *consultant in microbiology and virology, Southampton;* J A J BARBARA, *head of microbiology, North London Blood Transfusion Centre*

1 O'Connell S. Lyme disease: a review. *Commun Dis Rep* 1993;3:111-5.
2 Aoki SK, Holland PV. Lyme disease—another transfusion risk? *Transfusion* 1990;**29**:646-50.
3 Johnson SE, Swaminathan B, Moore P, Broome CV, Pawin H. Borrelia burgdorferi: survival in experimentally infected human blood processed for transfusion. *J Infect Dis* 1990;**162**:557-9.