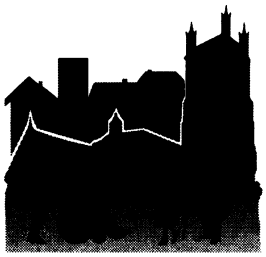

This is the second of four articles looking at the progress of the community care reforms

Gwent: a good start and better prospects

Roger Robinson

Optimism was in better supply than disappointment among the people to whom I spoke about how community care was working in Gwent. I had returned a year after hearing about the plans,[1] and just eight months after the new community care arrangements came into operation on 1 April.[2]

One problem in assessing the effects of the new arrangements in Gwent is that they have not been part of a controlled trial. Too many changes have happened at the same time to draw safe conclusions about the effects of any one of them. For example, on the same day that the community care reforms came into force, the services for mental illness, learning disability, and community health became the responsibility of the new Gwent Community NHS Trust. This change was preceded in 1991 by the establishment of clinical directorates, the move which Dr Stephen Hunter, consultant in mental illness, believes had the most powerful and beneficial effect on the development of this service. All these changes occurred against a background of a long standing and successful local policy of transferring the care of mental illness into the community. Learning disability and mental illness had anyway been given special status by the All Wales strategies.[3,4]

Organisational change has not ended. Proposals currently before parliament would abolish the administrative county of Gwent in 1996 and replace it with new unitary authorities with different boundaries from the present five boroughs (see fig 1). Coterminosity of local authority and health authority boundaries will be lost. General practitioner fundholding, now operating in about a third of practices in Gwent, may have a greater impact next year, when such practices will be able to make their own contracts for some community services including elements of mental health care. Such an avalanche of changes is the despair of anyone trying to identify individual effects, and no paper on clinical treatment with such a messy experimental design would have the remotest chance of appearing in the *BMJ*. But the important question is whether, regardless of the cause, things are better for users of community care services.

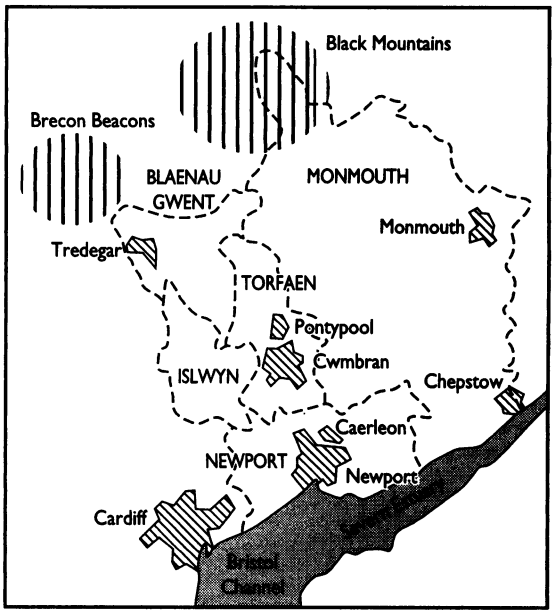

FIG 1—*Gwent may be reorganised in 1996 into smaller counties that will not exactly concur with the existing boroughs shown here*

Mental illness: optimism and enthusiasm

Everyone to whom I spoke about mental health care in Gwent said that users were getting improved services. Stephen Hunter has encountered none of the problems which he feared from the new system—for example, in arranging support for a patient discharged from hospital after an episode of acute mental illness.

Members of the mental health team in Cwmbran confirmed that things are better. Peter Clark is a community psychiatric nurse who last year described a service that was working well, despite the feeling that it was severely underresourced. He is in no doubt that the service improved during 1993. "I am very excited about what can happen; this is just the start," he said. Morale is better, support from social services has improved, new therapeutic groups and day services have opened, accommodation and home care for mentally ill people are more readily available—and it has even been possible to obtain a meals on wheels service for someone under 65.

The previous optimism of Dr Nick Warner, consultant psychogeriatrician, about the effects of the changes has been borne out by the events of the past year. None of the chaos some had predicted has materialised —hospital beds have not been blocked and discharges have not been delayed. Assessments for social care were cumbersome at first but social workers have quickly learnt to use discretion and have been allowed to do so. Fewer patients have gone to nursing homes since April: Dr Warner believes that this is because resources have gone to meet genuine needs, and that the flexibility to do this should increase. Already he is finding it easier to get small items such as smoke alarms which make care at home safer and more practicable.

Care for elderly people: hospital views differ

There was less agreement about the effects of the changes on the care of elderly people with more general health problems: the two hospitals I visited presented different pictures. The clear verdict of those I met at Nevill Hall Hospital, Abergavenny, was that the new community care arrangements are working well, and elderly patients being discharged from hospital are benefiting. Simon Burch, senior social worker, told me that things have worked out at least as well and probably better than he and his colleagues had hoped. He attributes this mainly to good working relations among the different disciplines—the factor which was presented to me last year as the main reason for optimism about the new arrangements.

There has been extra administrative work, particularly in relation to the new assessments and the detailed forms to be completed to make a care plan. Mrs Joyce Rowlands, nurse manager for the elderly, is clear, however, that these requirements have not delayed discharges from hospital. One reason is that the unit has always used weekly multidisciplinary meetings to

British Medical Journal
London WC1H 9JR
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BMJ 1994;308:778-80

discuss patients' needs, so that social workers can consider the views of the other relevant professionals when completing the form and making a care plan. Anne Morgan, head occupational therapist, emphasises that the new arrangements have brought positive benefit to patients—the needs assessments really mean that care after discharge is better tailored to what patients require. She has one small complaint, however: much of what goes into the assessment and care plan comes from the occupational therapists, yet the social worker has final responsibility for both.

Simon Burch agrees that careful needs assessment, rather than financial pressure, has brought about change since April. Fewer patients have been discharged to private nursing homes, and all those who have been discharged to private residential care have benefited from contracts and care plans specifying what is to be provided. Regular case reviews monitor whether satisfactory care is being given. Simon Burch had already found this valuable—for example, in insisting on a degree of privacy for an elderly client that had been stipulated in the contract but was not being provided.

Compared with the experiences of those in Abergavenny, the team at St Woolos Hospital in Newport reports more initial difficulties with the new system. Dr Ann Freeman, consultant geriatrician, says that there was a dramatic fall in nursing home placements last April, and an inability to discharge patients from the hospital's long stay beds. But the team had expected some early problems, and the situation improved later in the year—Susan Burnett, the business manager, points out that the average length of stay at St Woolos has actually fallen by three days since April. Some staff at St Woolos were critical of the format of the assessment process. Professor Pathy still believes that it would have been wise to choose an assessment instrument that had been validated scientifically.[1]

Carers and users: "Where is community care?"

The energetic and perceptive Mrs Ann May has continued to work with users, carers, voluntary organisations, and committees concerned with community care since caring for her own mother with Alzheimer's disease.[1] She also helps to train social workers and supports the families of children with learning disabilities. "Where is community care?" and "community care is not working" are the repeated messages Mrs May has been getting from informal carers in the community over the past year.

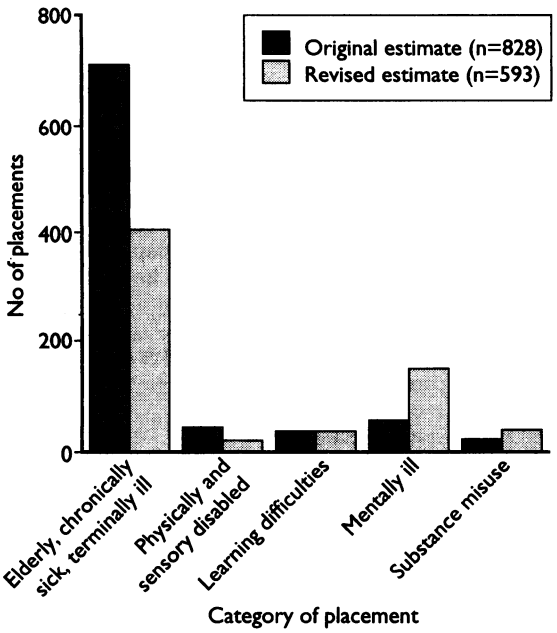

FIG 2—*Estimates of residential and nursing home placements in Gwent 1993-4; revised estimates are based on actual placements April-October. (Most "mentally ill" placements are for elderly people with dementia.) Source: Gwent county council social services planning unit*

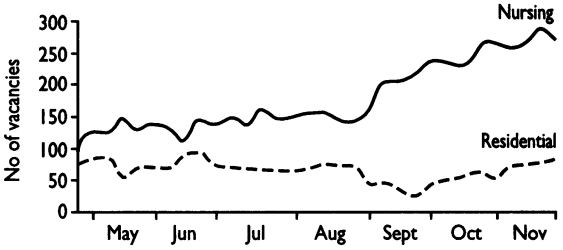

FIG 3—*Numbers of vacancies week by week in residential and nursing homes in Gwent since implementation of community care act. Source: Gwent county council social services contracts unit*

One key principle of the new arrangements is the right of users and carers to choose the care they want. Mrs May describes two cases where this principle has not been respected. Both, surprisingly, concern daughters of women who have had strokes who were pressed to accept nursing home care when they wanted to look after their mothers at home. Clearly there have been some disappointed expectations among carers and users.

Mrs May, however, has always taken a long view of the changes. She believes that because efforts so far have concentrated on the change in the funding structure, and although money is being released because fewer residential placements are being made, resources have not yet become available to help carers in other ways, such as by more respite care. She also points out that the carers who consult her are those for whom the system is not working well, and this may give a biased impression. She believes there have already been some clear benefits from the reforms, such as the funding given by social services to support an ambitious day care unit started by the local Alzheimer's disease association.

Plans and prospects

These different perceptions of how community care is progressing are responses to the earliest stage of a major change in policy. For many years Gwent has had a high rate of use of residential care for elderly people, yet 40% of these residents have been classed as having low dependency.[5] Furthermore, an exceptionally high proportion of private placements have been in nursing homes—79% compared with the national average of 42%. The county council's strategic plan is to reduce residential placements from the present level of about 50 per 1000 elderly population to 28 per 1000, as recommended by the Audit Commission[6] and the Welsh Office, and for 58% of this provision to be within residential homes.

Paul Meredith, principal planning officer of Gwent county council social services, explains that it is not possible to compare directly the rates of residential placement before and after 1 April, because reliable and comprehensive figures were not available before. The statistics since 1 April strongly suggest, however, that there really have been fewer residential placements. Compared with the social services department's estimate of the likely rate of admissions to residential care (which they admit was an overestimate to avoid a crisis at the end of the year), the number of placements is 28% lower than expected (fig 2). Another indicator is that vacancies in nursing homes have risen sharply since April, though vacancies in residential homes have not changed (fig 3). Paul Meredith expects the private sector to respond by seeking dual registration (residential and nursing) for existing nursing homes.

Social services needed to have evidence of this trend away from placement in nursing homes over a reasonable period before reallocating funds. That stage is now approaching, and more money should be available soon for care in the community. Paul Meredith now wants to see the greatest possible flexibility in budgeting thus allowing more innovative approaches, and wants to pass decision making to the lowest operational level as quickly as possible. After all, a person's care plan should depend on their needs as identified by assessment, not on reaching targets for numbers of residential placements. Nevertheless, the Welsh Office's aim to reduce residential care is looking increasingly realistic.

Julie Mullins, associate director for commissioning at Gwent Health (the combined health authority and family health services authority), says that the first stage of the change has gone smoothly and confirms that overall it has not caused any problems of bed blocking.

In the six months from 1 April the average length of stay for elderly people in hospitals throughout the county fell by two days. Long standing good working relationships between hospital staff and social workers have made the transition easier. Julie Mullins recognises that within the broadly encouraging statistics there could be individual cases where there have been delays and difficulties. But she expects an even closer relationship with social services to develop, including the possibility of joint commissioning and contracting. This idea is also welcomed by Paul Meredith and by Mrs Fiona Peel, chairman of the community trust, who feels that there has been a sea change in the attitude to the links between health and social services.

Conclusion

The safe conclusion is that it is too early to assess the impact of the community care reforms in Gwent. Nevertheless, some positive things can be said at this stage. There have been no disasters, despite a change in funding which evoked considerable fears. The general view is that it has been managed commendably smoothly. Most service providers believe that they have been delivering a better service since April that is more suited to the needs of the user. There is much more optimism than pessimism about the longer term consequences, as the shift of funds towards community care packages continues.

The data quoted about residential placements in Gwent suggest that this optimism is well grounded and that the attractive packages of community care intended by the reforms will soon be on offer more widely.

1 Robinson R. Moving ahead—community care in Gwent. *BMJ* 1993;306:44-7.
2 House of Commons. *The National Health Service and community care act.* London: HMSO, 1990.
3 *The all-Wales mental handicap strategy: framework for development from April 1993.* Cardiff: Welsh Office, 1992.
4 *Mental illness services: a strategy for Wales.* Cardiff: Welsh Office, 1989.
5 *Community care in Gwent: Social care plan April 1993-March 1996.* Newport: Gwent county council social services, 1993.
6 Audit Commission. *Managing social services for the elderly more effectively.* London: HMSO, 1985.

Current Issues in Cancer

Cancer of the prostate

D P Dearnaley

This is the second in a series of articles examining developments in cancer and updating what we know about the disease

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BMJ 1994;308:780-4

Prostate cancer presents a growing health problem in Western societies as longevity increases. It is characteristically a disease of elderly men associated with the development of osteoblastic bone metastases and initial hormone responsiveness to androgen deprivation. Previously regarded as a Cinderella of cancers, there is currently more controversy concerning the detection and management of both localised and metastatic disease than for any other common malignancy. A balance needs to be drawn between the potential gains of more aggressive management and the disadvantages in terms of increased treatment side effects and cost, taking into account both the natural course of the disease and the life expectancy of patients.

In England and Wales in 1987 there were 10 837 new cases of prostate cancer. In 1991 prostate cancer ranked second to lung cancer in mortality from malignant disease in men, with 8570 prostate cancer deaths. This pattern of increasing incidence is common to other Western countries. In the United States prostate cancer is now the most frequently diagnosed male malignancy, with 132 000 cases per year[1] and a lifetime risk of 9-11% of developing the disease.[2]

Although prostate cancer predominantly affects the aging male population, it has been calculated that men dying of the disease lose on average nine years of life.[3] In the United Kingdom morbidity and mortality from prostate cancer can be expected to rise as the longevity of the population increases. Currently some 50-60% of men present with metastatic disease,[4] but as prostate awareness and programmes of early detection become more widespread there will be an increasing incidence of patients diagnosed with early disease, as is happening in North America.

Epidemiology and aetiology

Worldwide there seems to be an increase in the incidence of and mortality from prostate cancer (table I). Part of this increase may be due to improved diagnostic accuracy. The wide international variation, however, suggests that environmental factors are implicated in the aetiology and that a Western lifestyle leads to an increased risk. Necropsy studies show foci of microscopic well differentiated prostatic adenocarcinoma in 30-40% of men aged 75 or over.[5] Inter-

TABLE I—*Age standardised prostate cancer mortality and incidence rates per 100 000 men aged 30-74 in various countries in 1985*

Country	Mortality 1985	Recent 5 year trends†	Incidence 1985 (from selected regional cancer registries)	Recent 5 year trends†
United States:				
Black males	17·5	1·5	151·6	(3·1)
White males		—	88·5	12·6
England and Wales	15·2	7·2	32·9	14·1
Japan	3·3	8·4	10·1	30·2

†Recent trends: estimated mean percentage increase per five year period in age specific rates (30-74 years) over 15 years centred on 1980. Parentheses denote recent trends not significant at 5% level. (Adapted from Coleman *et al.*[42])