17.1 years), $P=0.017$) but were not distinguishable by any other variable. Underusers were significantly older than the rest of the study cohort (64.2 years *v* 55.1 years (2.8 to 15.4 years), $P=0.0074$).

Comment

The small number of patients identified in this survey confirms the continued decline in the prescription of benzodiazepines for anxiety.^{3,4} Twenty four patients reported having taken benzodiazepines long term on previous occasions. This should encourage optimism about the prospects of successfully stopping treatment, although it also suggests that patients may start taking benzodiazepines again. It is often forgotten that only a minority of patients taking benzodiazepines long term experience withdrawal symptoms (33% in this study).⁵ A lack of withdrawal symptoms is likely to have enabled patients to stop taking the drugs. Continued benefit and a lack of desire to stop treatment probably both work to ensure continued long term use for many patients.

Only 15 patients (27%) had not come into contact with psychiatric services before. Concern that services could be overwhelmed if all patients taking benzodiazepines long term were referred to psychiatric teams seems to be unfounded.

Our findings fail to confirm popular preconceptions about long term use of benzodiazepines. We found a small number of long term users. Some surprising attitudes were expressed, in particular the desire of

almost half of the group to continue taking their drugs. There were reassuring findings about patterns of use, continued benefit, and frequency of withdrawal symptoms. The association of a desire to stop treatment and experience of withdrawal symptoms with younger age suggests that greater caution should be exercised when considering benzodiazepines for daytime use in younger patients. If community based research is to establish the most appropriate use of benzodiazepines large catchment populations will be needed for sufficient numbers to be identified, particularly for analysis of subgroups.

Our findings do not conform to the benzodiazepine stereotype that is often presented in the media, but they do suggest reasons for the poor response to our withdrawal programme. We suggest that media coverage of this topic should be more restrained.

We thank the general practitioners at the Birchwood Health Centre and Paul Novak.

- 1 Committee on Safety of Medicines. Benzodiazepines, dependence and withdrawal symptoms. *Current Problems* 1988;21:1-2.
- 2 Tyrer P, Murphy S, Riley P. The benzodiazepine withdrawal symptom questionnaire. *J Affective Disord* 1990;19:53-61.
- 3 Ashton H, Golding J. Tranquilisers: prevalence, predictors and possible consequences. Data from a large United Kingdom survey. *Br J Addict* 1989;84:541-6.
- 4 Taylor D. Current usage of benzodiazepines in Britain. In: Freeman H, Rue Y, eds. *The benzodiazepines in current clinical practice*. London: Royal Society of Medicine, 1987:13-8.
- 5 Tyrer PJ. Benzodiazepines on trial. *BMJ* 1984;288:1101-2.

(Accepted 22 February 1994)

NHS and Community Care Act 1990 and discharges from hospital to private residential and nursing homes

Peter A Lewis, Rebecca B Dunn,
Norman J Vetter

University of Wales
College of Medicine,
Cardiff CF4 4XN
Peter A Lewis, senior lecturer
in health informatics
Norman J Vetter, senior
lecturer in epidemiology and
community medicine

St Martin's Hospital, Bath
BA2 5RP
Rebecca B Dunn, consultant
in geriatric medicine

Correspondence to:
Dr Lewis.

BMJ 1994;309:28-9

The NHS and Community Care Act 1990 requires social services departments to assess elderly inpatients who may need help after discharge from hospital and to use a care management process to arrange their care.¹ One of the main aims of the act was to reverse the "perverse incentive" for people to be cared for in private residential and nursing homes. The act tried to achieve this aim by ensuring that money that was originally available through social security to people in private homes who received income support was transferred to social services departments; social services could use the money to maintain people in their own homes.

Concern was expressed that the new assessment and care management might delay patients' discharge from hospital,² and such delays have been reported.³ It was

also thought that a surge in the number of patients discharged to private institutions might occur before the act came into force as consultants tried to avoid becoming entangled in the new administrative procedures.

This study compared the proportions of patients discharged to private residential and nursing homes or elsewhere from a department of geriatric medicine before and after the implementation of the NHS and community care act in April 1993 and the lengths of time patients had spent in hospital before their discharge.

Patients, methods, and results

Data were extracted from the computerised records on discharge for all patients ($n=2234$) discharged from the department of geriatric medicine at St Martin's Hospital, Bath, between 1 April 1992 and 30 September 1993. The average age of the patients (85 years) was similar to that of patients discharged from other departments of geriatric medicine in the Wessex region. We made comparisons between patients discharged between 1 April and 30 September 1993—the first six months after implementation of the act—and the equivalent period in 1992, thus avoiding any systematic bias due to seasonal factors.

The table gives the numbers and percentages of patients discharged to private residential and nursing homes according to the period examined and the corresponding lengths of time spent in hospital before discharge. Between 1 April 1992 and 30 September 1993, 197 (8.8%) of the 2234 of the patients were discharged to a private residential or nursing home; in March 1993, the month before the act came into force, 17 (12.9%) of 132 patients were similarly discharged.

Comment

This is the first study of the effect of the NHS and Community Care Act 1990 on the numbers of elderly

Patients discharged from hospital to private residential or nursing homes and length of stay in hospital before discharge, according to period and year of discharge

	1 April to 30 September 1992	1 April to 30 September 1993	Difference (95% confidence interval)
No (%) of patients discharged from hospital:			
Total	737	738	
To private residential or nursing home	56 (8)	70 (9)	1.2% (3.7% to -2.0%)
Mean length of stay in hospital before discharge (days):			
To private residential or nursing home	55.3	59.8	4.5 days (20.0 days to -11 days)
To other locations	26.6	27.4	0.8 days (4.3 days to -2.7 days)

people being discharged to private residential and nursing homes and on their length of stay in hospital before discharge. The rate of discharge to these homes was not substantially affected by the implementation of the act; this suggests that disabled elderly people are not being given the option of receiving their care at home after their discharge from hospital. The differences in the length of stay in hospital for patients before and after the act came into force were well within the margins of variation expected by chance, with no evidence that discharge was being delayed.

More attempts were made to get patients admitted to private residential and nursing homes in the month before the act came into force than during the period of the study as a whole. The effect on total numbers was

small, but the rise in the number of attempts might account for the shorter lengths of stay in hospital for patients discharged in March 1993. Overall, in its first six months the act seems to have had little impact on the patients in the department that we studied. We do not yet know whether this act, which may bring about innovative methods of home support,⁴ will allow more people than in the past to be managed at home.

1 NHS and Community Care Act 1990. London: HMSO, 1990.

2 Welsh Affairs Committee. *Community care: the elderly*. Fourth report. London: HMSO, 1992.

3 Age Concern. *No time to lose*. London: Age Concern, 1993.

4 Challis D, Darton R, Johnson L, Stone M, Traske K. An evaluation of an alternative to long-stay hospital care for frail elderly patients. 1. The model of care. *Age Ageing* 1991;20:236-44.

(Accepted 3 March 1994)

Outcome of flexible training in East Anglian region

K H Matheson, J S G Biggs

Clinical School,
Addenbrooke's Hospital,
Cambridge CB2 2SP
K H Matheson, acting
associate dean
J S G Biggs, regional
postgraduate dean

Correspondence to:
Dr K H Matheson,
Postgraduate Dean's Office,
University of Cambridge,
Clinical School,
Addenbrooke's Hospital,
Cambridge CB2 2SP.

BMJ 1994;309:29

Part time training for doctors, now known as flexible training, began in the late 1960s. This study aimed to find the outcome for part time trainees who had done all or part of their training in East Anglian Regional Health Authority.

Methods and results

In 1993 a questionnaire, with an explanatory letter, was sent to all doctors who had been part time trainees in two training schemes established by the former Department of Health and Social Security.^{2,3}

The total number of trainees during 1972-93 was 101; only one was a man. In all, 69 replies were received from the 84 traceable trainees (response rate 82%); 63 respondents held hospital posts and six worked in public health medicine or in community paediatrics.

The table compares the grade of posts held at the start of part time training with the grade of the first posts held after training and the grade of current posts held. Fifty five trainees obtained part time training posts within 12 months, of whom 30 did so within six months. After training, forty one respondents continued in part time posts, of whom 11 found difficulty in obtaining their next appointment. Fourteen proceeded to permanent full time posts, although four experienced difficulties. None of the 10 respondents who returned to full time training reported any problems. The remaining four respondents worked as locums, did not work, or did not give sufficient information.

Of the 37 respondents who eventually became

consultants or had jobs of equivalent status, 16 worked full time or the maximum number of hours part time; at the start of their training, four were senior house officers, 11 were registrars, and 22 were senior registrars. Thirty six (73%) of the 27 senior registrars and 22 registrars who entered the training scheme eventually held consultant or academic posts. The three respondents currently working as academics worked either as senior registrars (two) or as a registrar (one) at the start of their training. Fifty one respondents had gained postgraduate qualifications.

The specialties of our respondents were similar to those reported in other studies⁴; the most popular choices were anaesthesia, psychiatry, pathology, general practice, paediatrics, and medical specialties.

Comment

Many criticisms have been levelled at part time training. Our study showed that most trainees had little difficulty in obtaining part time training posts. Some trainees, however, had difficulty in obtaining their next post, after part time training, although those seeking full time posts had fewer problems. The main reasons for the difficulties in finding part time posts were that none was available locally, staff resisted having a permanent part time colleague, and delays occurred in a post being created. The trainees' lack of mobility and the uncertainty of their spouses' next career move imposed difficulties for the respondents, but the trainees were frustrated by the lack of efforts by health authorities to solve the problems of creating posts.

One of the arguments against flexible training is that it is too long and that trainees emerge too old. Most respondents, however, had finished their part time training by the age of 40, which is not appreciably different from the age at which some surgical and medical full time trainees end their training.

Our finding justifies the resources given to flexible training and the continuing efforts of trainers and trainees. The part time training schemes have been successful in the East Anglian region if judged by the high proportion of trainees who obtained training posts within 12 months, gained postgraduate qualifications, and are currently employed. What cannot be quantified is the cost of personal sacrifice and anguish on the part of the trainees and their families.

Posts held by 69 part time trainees in East Anglian region at start of training, after training, and at end of survey. Figures are numbers of trainees

Grade of post	Grade of post		
	At start of training	In first post after training	At end of survey
Consultant or equivalent	0	32	37
General practitioner	0	6	9
Associate specialist or equivalent	0	4	9
Senior registrar	27	2	3
Registrar	22	3	0
Senior house officer	13	5	0
Staff	0	1	0
Academic or researcher	0	3	3
Other	7	13	8

1 NHS Management Executive. Flexible training: report of the joint working party. London: HMSO, 1993. (Dd 8369079 7/93 C60 1679.)

2 Department of Health and Social Security. *Re-employment of women doctors*. London: DHSS, 1969. (NHS HM(69)6.)

3 Department of Health and Social Security. *Opportunities for part-time training in the NHS for doctors and dentists with domestic commitments, disability or ill-health*. London: DHSS, 1979. (PM(79)3.)

4 Jessop EG, O'Brien M, Parkhouse J. Part-time training: experience in the Northern Region. *Public Health* 1984;98:134-8.

(Accepted 16 March 1994)