Improved purchasing skills—The purchasing directorate attracts and employs staff of a higher calibre than we could individually afford to employ as fundholders. In addition, we bring together the skills and breadth of experience of the many general practitioners involved in the purchasing.

Improved planning—The mechanics of the current market risk the export of business from areas where certain specialties have been historically underfunded, threatening an implosion of local provision. A large commissioning group, on the other hand, can plan and improve local provision by resourcing large capital projects. We have already made strides in this direction.

The debate about prescribing costs will decide the future of fundholding. We expect that the NHS Management Executive, rather than introduce drug budgets for non-fundholding general practitioners, will devise a scheme whereby prescribing and purchasing costs are linked at health authority level on a capitation basis. This will be facilitated by the forthcoming merger of district health authorities and family health services authorities and will have a profound effect on prescribing in hospitals and in the community: clinicians will jointly seek to rationalise their drug costs. For example, consultants will be discouraged from prescribing expensive drugs promoted through cut price loss leading contracts with hospital pharmacies.

If the potential advantages of the non-fundholding model are realised the linkage of purchasing and prescribing will jeopardise the fundholding experiment. The purchaser-provider split will remain, but clinicians on both sides will work together more efficiently and their patients will have equal access to scarce NHS resources. We are greatly encouraged that the NHS Management Executive has produced a review of contracting in which the non-fundholding model is recognised.⁵ Non-fundholding is a positive, influential choice.

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Incentives help curb prescribing costs

EDITOR,—Steve Illiffe and James Munro reviewed the use of incentives in general practice.¹ In the same issue Jean Bradlow and Angela Coulter showed that fundholding helped curb prescribing costs.² With the Department of Health's backing, an incentive scheme offering payments of up to £1780 was introduced in Coventry last July. We report the interim results as at 1 November.

The scheme was designed in three parts. Prac-

tices were set a savings target on their indicative prescribing amount, varying from 1% to 5% depending on the size of their budget measured per prescribing unit. This target has to be reached for any payment to be made. In addition, practices were required to increase the proportion of prescriptions for generic drugs. Practices in which prescriptions for generic drugs made up $\geq 42\%$ of all prescriptions were divided into bands and offered additional incentives for increases of 5% to 65%, the incentive rising in value the closer the target of 65% was approached. All practices were also offered a single flat rate payment for an increase in generic prescribing of 5%.

Interim evaluation of the scheme was performed using the projected out-turn figures for October obtained routinely from the Prescription Pricing Authority. These were entered into a database and analysed with the computer package EPINFO 5.1B and analysis of variance. The table shows the results.

The budgets for practices participating and not participating in the incentive scheme were comparable, but those of fundholders were larger. Both fundholders and participants in the scheme had curbed their spending on prescribing significantly more than non-participants. The projected overall costs were lowest for participants in the scheme as the net saving projected for fundholders does not compensate for their higher initial budgets, the projected annual spend being £47.84 per prescribing unit for fundholders and £46.70 for participants in the scheme.

Any payments received by Coventry's general practitioners for their trouble will be spent on improved facilities for their patients. Initial results therefore suggest that prescribing incentive schemes are an effective method of curbing prescribing costs.

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Murder in the NHS

Grantham consultants support scapegoat doctors

EDITOR,—We were encouraged to read W J Appleyard's editorial in support of the paediatricians at Grantham and Kesteven General Hospital who were made redundant in the wake of the murders committed by Beverly Allitt.¹ We wish to reiterate our support for our colleagues, Dr Nelson Porter and Dr Charith Nanayakkara. We have previously conveyed our concern that they were being made scapegoats in letters to the regional medical officer, the district general manager, our member of parliament, and the *Times* (which did not publish our letter). We believe that Drs Porter and

Nanayakkara have suffered a grievous injustice without proper opportunity to defend themselves.

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Audit critical incidents in patients at risk

EDITOR,—W J Appleyard describes the efforts of the consultant paediatricians at Grantham and Kesteven Hospital to uncover the cause of the unusual deaths on their ward.¹ Similar episodes have occurred elsewhere and have proved equally difficult to identify. One series of health care murders continued for 15 months.² In two other cases the available evidence did not secure successful prosecutions, leaving the possibility of repetition.^{3,4}

For any particular patient it may be impossible to identify the unusual nature of the death,² and so patterns of deaths become important. The main difficulties affecting clinicians are the rarity of the event, which results in a low index of suspicion, and the difficulty in identifying a true increase in mortality.³ In deciding whether an increase in unexplained deaths has occurred the possibility of random fluctuation must be considered. There may be no increase in overall hospital mortality during the "epidemic" period even when a health care murderer is subsequently identified. Cause specific death rates may also not show a problem. Random fluctuations can be even more extreme in small units. One possible solution is to look at critical incidents rather than mortality alone²: they may best be monitored with graphic representations of the rates of incidents.³ Even if an unexplained increase is apparent other possibilities, such as errors of medication, must be considered.⁵

Once a problem has been identified epidemiological techniques can further delineate its nature by looking at the time and place of occurrence and association with particular hospital staff. Such investigations can show only association and not a causal relation. Retrospective epidemiological investigations have not always resulted in prosecutions, showing the importance of epidemiologists and clinicians working in tandem, and with police forces when appropriate.⁴

Despite their rarity, health care murders merit attention because of their extraordinary potential for harm. Previous work suggests that elderly and very young patients and those in intensive care units are particularly at risk. Clinicians working in such environments may benefit from remaining alert, as the paediatricians in Grantham did, to the possibility of such events. A system of audit that examines critical incidents and can identify and correct more common problems, as well as criminal actions, should be encouraged.

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Interim results of Coventry Family Health Services Authority's prescribing incentive scheme among practices participating in scheme compared with other practices

Category of practice	No of practices	Mean budget/indicative prescribing amount £/year/prescribing unit	Mean % overspend	No of practices underspending
Fundholders	6	49.16	-2.683	4
Participants	42	45.79	1.979	18
Non-participants	11	45.34	9.109	0
Significance		F=0.601, P=0.5557	F=7.76, P=0.0014	