parties can be met from the same database.[5] Standard microcomputer based systems are being provided for all the surgical specialties to enable surgeons to monitor and audit their inpatient work. In view of the differing case mix among surgeons within the same hospital it has been necessary to establish a mechanism for comparative audit across the region, an activity being facilitated by a regional audit group along similar lines to that in Lothian.[6] Developments in operating theatre systems, which will enable anaesthetic audit to be undertaken, and accident and emergency department systems are extending this strategy into other key areas of the hospital.

Improbable timetable

Despite these developments and those in other parts of the country an immense amount of work remains to be done. The white paper recognises this when it identifies two particular problems: the need for improvements in the coding of medical records and the development of case mix groups. Recognition of the first of these is ironic given the current difficulties and confusion caused by the recent introduction of the new operative procedure codes by the Office of Population Censuses and Surveys.[7-9] Such technical problems can of course be overcome if sufficient resources are applied to seeking solutions. What is less certain is the ability of the NHS to introduce change as rapidly as the government plans. The difficulties encountered over the past few years in the six resource management pilot sites makes it improbable that 20 acute hospital units will be ready by the end of this year, let alone 260 units by March 1992. Not only are such developments likely to cost around £1 billion but they would also require a commitment to training and supporting clinicians and managers throughout the country. These are not arguments against the improvement of information and the introduction of resource management but a plea for a more realistic estimation of the task that lies ahead.

Like many if not all government pronouncements, the NHS white paper is probably as much rhetoric as it is a detailed prescription. If so, and if it leads to major benefits as regards the quality of clinical information it will in that regard at least have made a useful contribution to improving health care in Britain.

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2 Whates PD, Birzgalis AR, Irving M. Accuracy of hospital activity analysis codes. *Br Med J* 1982;**284**:1857-8.
3 Buck N, Devlin HB, Lunn JN. *The report of a confidential enquiry into perioperative deaths*. London: Nuffield Provincial Hospital Trust/The King's Fund, 1987.
4 Skinner PW, Riley D, Thomas EM. Use and abuse of performance indicators. *Br Med J* 1988;**297**:1256-9.
5 Health Services Information Steering Group. *A report on the collection and use of information about clinical activity in the NHS*. London: HMSO, 1982.
6 Gruer R, Gordon DS, Gunn AA, Ruckley CV. Audit of surgical audit. *Lancet* 1986;i:23-6.
7 Office of Population Censuses and Surveys. *Classification of surgical operations and procedures*. 4th revision. London: OPCS, 1987.
8 Earlam R. Körner, nomenclature, and SNOMED. *Br Med J* 1988;**296**:903-5.
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Working papers "to form basis of detailed discussions"

The Secretary of State for Health has now issued the eight working papers on the main proposals in the government's white paper *Working for Patients*. The papers, which form the basis of detailed discussion, cover the following subjects and are summarised below:

(1) Self governing hospitals
(2) Funding and contracts for hospital services
(3) Practice budgets for general medical practitioners
(4) Indicative prescribing budgets for general medical practitioners
(5) Capital charges
(6) Medical audit
(7) NHS consultants: appointments, contracts, and distinction awards
(8) Implications for family practitioner committees.

Copies of the working papers are available from HMSO, £8 for the complete set.

The Secretary of State is sending working papers (2), (3), and (4) to all general practitioners in England and Wales together with a copy of the Department of Health's own report of the year's discussions on *Promoting Better Health* (p 606).

The government intends to complete discussions on any matters which require primary legislation by the end of May.

"Freedom to run their own affairs"

Any hospital can become a self governing NHS hospital trust if it can satisfy the Secretary of State for Health that its management has the necessary skills to run the hospital; that senior professional staff, especially consultants, are committed to management; and that its plans are financially viable. Short stay hospitals with more than 250 beds will be encouraged to seek self governing status from April 1991.

The cardinal principle of the new arrangement is that emergency treatment should be available immediately and without question.

Granted "the greatest possible freedom to run their own affairs" trusts will have their own board of directors headed by a non-executive chairman appointed by the Secretary of State. Executive directors will include the hospital's general manager, a medical director, the senior nurse manager, and the finance manager. They will be numerically balanced by non-executive directors—at least two drawn from the local community and appointed by the regional health authority, the remainder appointed by the Secretary of State after consulting the trust chairman. Members of special interest groups—general practitioners holding practice budgets, employees of health authorities or hospitals, representatives of trade unions with members who work in the NHS, or major hospital contractors or suppliers—will be disqualified from serving on boards.

Trusts will be able to set up the management structures that best suit their particular activities and needs, free of control from district or region. Instructions issued by the NHS Management Executive will not normally apply to them, although they will have to comply with the NHS complaints procedure and arrangements for the control of communicable diseases. They will also be expected to provide limited data about their activities and manpower and institute medical audit. The Secretary of State will retain powers to intervene in the running of trusts in exceptional circumstances.

Self governing hospitals will earn their revenue from the services they perform: most will come from

contracts with health authorities. Other contracts and revenue will come from budget holding general practices, private patients and hospitals, and other self governing hospitals. Services covered by contracts fall into two main categories: "core services," to which patients need guaranteed access, and "other services," for which a greater choice over where a patient may be treated and an element of competition in supply exists.

The new hospital trusts

- Will be given powers to acquire, own, and dispose of assets, ensuring their most effective use
- Will be able to retain operating surpluses and build up reserves
- Will be given an interest bearing debt equal to the value of their initial assets
- Will be able to raise additional finance from the government or commercial sources and from leasing and other financial transactions.

It will be up to the trusts to employ whatever and however many staff they consider necessary, although they will be expected to follow the government's policy of achieving a balance. The government also regards it as particularly important that trusts employ their own consultants. New legislation will empower trusts to set whatever terms and conditions of service they deem fit for doctors, nurses, and others currently covered by national pay review bodies. In the absence of prescriptive legislation trusts will be responsible for their own industrial relations and other personnel matters.

Consultants employed by trusts will still be eligible for distinction awards, with the cost borne by the trust.

Self-governing Hospitals. Working Paper 1.

Paying for hospital services

In future general practitioners and district health authorities will be able to buy health care from hospitals which may be self governing, directly managed, or privately run. The government has emphasised that a cardinal principle of the new arrangements is that "emergency treatment should be available immediately and without question."

From 1990-1 the use of the Resource Allocation Working Party formula will be discontinued and adjustments for cross boundary flow will be replaced by direct payments between regions. By 1992-3 all regions will receive their main allocation on the basis of their population, adjusted for age, morbidity, and the relative costs of providing services. The regions with faster growing populations will be compensated automatically and annually.

Districts will be funded in the same way as regions and the costing exercises will need to be completed no later than the end of 1991 in order to form the basis of the 1992-3 allocations.

The association between district health authorities and general practice budget holders on one hand and hospitals on the other will be based on a contract to provide services. Three types are envisaged:

- Contracts with the private sector may occur either through a district health authority or a general practice contracting with a private hospital or through an employer or insurance company contracting with an NHS hospital
- Management budgets, which will operate between district health authority managed hospitals and their parent authority, will be structured as contracts but will be enforced through the management process
- Contracts within the NHS where there is no direct management relationship will apply to all general practice budget contracts and to contracts between district health authorities and self governing hospitals or hospitals outside the district.

> District health authorities will be responsible for ensuring that a comprehensive range of services is provided and it will be the responsibility of the regional health authority to ensure that hospitals which are not thriving are identified and appropriate steps taken.

By April 1994 at the latest all contracts should be specific to a hospital or a management unit. All contracts will be the subject of agreement between purchaser and provider and will specify the nature and level of service that the provider is expected to give and the basis on which the cost of the services will be reimbursed. It will be for each district to consider what its core services should be.

The government envisages that different forms of contract may be needed in different situations and three broad classes have been identified:

- Under a block contract the general practitioner or district health authority would pay the hospital an annual fee in instalments in return for access to a defined range of services
- Under the cost and volume contracts hospitals would receive a sum in respect of a baseline level of activity, defined in terms of a given number of treatments or cases
- The cost per case contract would be used to fund referrals that did not fall within either of the two previous forms of contract.

Sophisticated costing systems would not be necessary. For block contracts the prices should be based on the known costs of individual hospitals and on comparative national data. Cost and volume and cost per case contracts would require a knowledge of the costs of individual procedures.

A proportion of treatments will be carried out in hospitals with which a district health authority does not have a contract. The lack of a contract should not inhibit the patient from receiving emergency treatment and it is proposed that the cost of treatment in an accident and emergency department should be borne by the hospital itself within the block contract funding but that if emergency admission as an inpatient was required the cost should be met by the district of residence.

The patient's contact with the hospital service will follow a reference by his general practitioner except where emergency treatment is required. It will be the general practitioner's responsibility to ensure that the patient's referral is covered or can be covered by an appropriate contract or non-contractually. General practitioners with their own budgets will have to negotiate and place contracts with those hospitals to which they envisage sending patients. Occasionally general practitioners will wish to refer patients to hospitals with which the district health authority does not have a contract and the district will have to create a contingency reserve to meet the cost of such referrals.

In future the costs of training NHS staff and of the service support of research will be met directly from the region or in the case of the special health authorities by the Department of Health. The government believes that in future ring fencing of an amount related to the continuing costs of medical teaching will be needed.

With more explicit charging for services the working paper suggests that there will be pressure from managers for the informal cost sharing arrangements to be changed. It suggests that hospitals and medical schools might wish to cross charge in respect of clinical

teaching by NHS staff and provision of patient care by clinical academics.

Hospitals must not cut back on postgraduate training in order to achieve immediate cost reductions if the long term effect would be poorer standards of service. It will be the regional health authority's responsibility to ensure that this does not happen and to fund postgraduate training directly where necessary. Future arrangements will need to ensure that hospitals are reimbursed for tuition fees, student maintenance, and any additional costs associated with clinical supervision during placement.

The government will be responding separately to the recommendations in the report of the House of Lords select committee on medical research which is still under consideration. It plans to issue guidance by April 1990 on how the service's need for approved and worthwhile research can best be served.

When it comes to supraregional services the government expects that direct funding from the centre will continue to ensure their viability and to ensure a properly controlled spread of high cost and high technology treatments. Other services that may need to be funded on a separate basis are the blood transfusion and the ambulance services.

Funding and Contracts for Hospital Services. Working Paper 2.

Practice budgets for GPs

Practices may join or leave the practice budget scheme if they wish without financial penalty but there must be no disruption to patient services.

Participating practices

- Will have at least 11 000 registered patients (a figure that may be reduced in the light of experience) and smaller practices will be able to group together
- Must show an ability to manage budgets with adequate administrative support and information technology.

Budgets will meet

- The costs of a defined group of surgical inpatient and day care treatment, with emergency and medical admissions excluded
- Some staff costs
- The costs of drugs prescribed and dispensed.

The budgets will cover the costs of the commoner inpatient or day case procedures for which there is often a choice over time and place of treatment. Once a patient is referred decisions on treatment will be for the hospital consultant but the general practitioner will need to know the consequences for his practice budget of the referral of a patient. The cost will normally be fixed in advance based on the hospital's experience, with the hospital bearing the cost or reaping the benefit if the outcome differs from the estimate. Such treatments will generally be elective and general practitioners will "indicate to the hospital their requirement concerning the timing of treatment."

For outpatient services budgets will cover the costs of diagnosis (including investigations), treatment, continuing outpatient treatment, and outpatient attendances after inpatient and day case surgery.

Referrals for initial diagnostic investigation might be under a contract covering a fixed charge in advance on a cost for each case or a cost for each attendance basis or for a fixed annual fee regardless of the number of referrals.

The costs of treatment in accident and emergency departments will be borne by the hospital and reflected in its contracts with the parent health authority.

Hospital costs for any individual within a year that exceed, say, £5000 will be charged to the patient's district health authority budget and the patient's practice would be responsible for initiating this process.

> The government believes that practice budgets offer general practitioners an opportunity to improve quality and standards of care. Participating practices will not be expected to be selective over who may be registered with them and doctors should have no reason to refuse patients for financial reasons.

General practitioners' directly reimbursable expenses (for staff (70%), cost rents, and improvement grants) will be cash limited from April 1990 and the government is discussing with the profession how to do this. Such expenditure will come within the new practice budgets and doctors in participating practices will continue to receive "a contribution towards staff costs and other expenses indirectly via fees and allowances."

The arrangements for drug budgets are dealt with in working paper 4.

General practices operating budgets will receive them direct from the relevant regional health authority but the reconstituted family practitioner committees will hold the doctors' contracts and monitor their expenditure. The government intends to move towards "a weighted capitation approach" by setting budgets in line with the method proposed for health authorities. For general practice this might initially require more detailed assessments than for health authorities.

The NHS Management Executive is to discuss with the profession the factors, other than the size of list, that need to be taken into account when agreeing the budget component for hospital and community health services.

Within the total budget agreed practices will be free to shift expenditure within the year between individual components—hospital care, staff and premises costs, and drug costs—and according to the department "will be well placed to generate savings" which they can spend on "improving their practices as they judge best."

While practices will be expected to stay within the agreed budget an overspend of up to 5% will be allowed in any one year on the understanding that the extra cost is taken off the next year's budget. Budgets will be reviewed periodically and a practice may ask for a budgetary review if practice circumstances change. Participating practices will be paid a management fee in respect of their budgets. Regions will hold contingency reserves to meet overspending and to cover those costs for individual patients that are above £5000. Arrangements will be made to cover the costs of emergency treatment and temporary residents.

Where general practitioners refer patients for non-NHS treatment no payments will fall on practice budgets. While practice budget holders will be allowed to refer NHS patients to private hospitals for NHS treatment patients wanting NHS treatment will not be allowed to "top up" the practice budget in order to obtain treatment. The full cost of relevant NHS treatments must be met out of the practice budget.

All participating practices will have to operate separate bank accounts for their budgets—practice accounts will be prepared in a prescribed form—and where commercial banks are used the regional health authority will pay monthly in advance. Where extra funds are required the practice will be allowed to draw them from its budget facility, but it will not be allowed to hold "excessive cash balances."

The general practice budget scheme will be subject to statutory audit by the Audit Commission.

Details of the proposed medical audit arrangements for general practice are given in working paper 6.

Hospitals will need to be able to attach costs to individual treatments so as to build up an information base on pricing services. The rapid introduction of microcomputers into general practice is being accompanied by the development of national "core specification of data requirements." Financial systems will be added to enable budget holders to monitor expenditure against budget.

Among factors to be discussed by the NHS Management Executive and "those most closely involved in the implementation of these proposals" will be

- The list of treatments falling within the scope of budgets
- The size of the management fee included within budgets
- The relative weight of factors to be considered in estimating the hospital services component of budgets
- The development of appropriate information systems.

Practice Budgets for General Medical Practitioners. Working Paper 3.

Downward pressure on drugs expenditure

The government wants to place "downward pressure on the expenditure of drugs" to eliminate waste and release resources for other parts of the health service. So in future regional health authorities and family practitioner committees (FPCs) will hold drug budgets and general practices will be given indicative prescribing budgets. The government emphasises that there will be no disincentive to practices to accept patients who need more or expensive drugs or to begin to prescribe expensive medicine to existing patients if there is a clinical need to do so.

The extension of the Prescribing Analyses and Cost scheme (PACT) to six pilot FPCs in 1989-90 will be the basis of the proposals. The FPCs will have access to PACT data on the prescribing patterns of individual doctors and practices; they will discuss prescribing matters with local doctors and begin to monitor individual doctors' prescribing, paying particular attention to those practices whose costs are well in excess of the average. The experience gained will form the basis of guidance to all FPCs, which will all have access to PACT information.

Each year the regional health authority will be allocated a budget to cover expenditure on medicines in the family practitioner services. The allocations will not take account of income from prescription charges, which is not within the control of the FPC or the district health authority. Regions will pass on drug budgets to FPCs, who will be responsible for allocating indicative drug budgets to practices in their areas. The government wants the new arrangements to start in April 1991, allowing time for discussions with interested parties and for legislative changes to be made.

Initially allocations will largely reflect practices' existing spending patterns and the number of their elderly patients, but they will increasingly be based on a weighted capitation formula.

Regional health authorities will be expected to examine the various outpatient prescribing policies in their region, to decide which is outpatient and general practitioner prescribing, and to establish budgets for their districts and FPCs on the basis of the government's policy.

The NHS Management Executive will prepare guidance for FPCs on how to establish a policy for assigning indicative budgets to practices. The committees will be required to discuss the policy with local medical committees and will then assign budgets for the net ingredient cost of prescriptions dispensed to practices. Where current prescribing is the same or less than the average the indicative budget will be set at existing levels. The government expects the scheme to cut prescribing costs in those practices with above average costs and where the differences in prescribing patterns cannot be explained by the composition of their practice list or other accepted factors.

The practice will need an estimated monthly profile of expenditure on drugs and will be expected to devise local policies for effective and economic prescribing within budget.

Where practices diverge from the budget profile initial action will be by peer review or a request to the FPC for help and guidance. PACT will help general practitioners to analyse the reasons for any overspending and to take corrective action as necessary.

The government believes that the ideal way of providing information to practices, FPCs, and regional health authorities on what is prescribed and dispensed would be to develop a more comprehensive PACT system and the NHS Management Executive will discuss with the Prescription Pricing Authority whether this is feasible.

An incentive scheme will be introduced so that an FPC can agree with doctors not in the practice budget scheme an expenditure target that is lower pro rata than the drug budget that the regional health authority had given to the FPC. Where such targets are achieved, half the saving will be retained by the FPC and spent on schemes of improvement in primary health care.

Practices will be expected to keep within their indicative budgets except by agreement with their FPC. Where they fail to do so and where discussion, education, or peer review has had no effect FPCs will be able to take appropriate sanctions, which might eventually mean withholding remuneration from the doctors concerned.

Legislation will be needed to require FPCs and regional health authorities to keep to their drug budgets; to require general practitioners to operate indicative budgets; to provide FPCs with any information they may require in support of the scheme; and to make provision for sanctions.

Indicative Prescribing Budgets for General Medical Practitioners. Working Paper 4.

Registers of assets to be set up

Since 1948 land, buildings, and equipment in the NHS have been treated as free goods. The government now wants to change that and charge for capital so that managers will become more aware of the costs of capital (and so use it better) and to allow proper comparisons of costs with private hospitals (and so increase competition).

The government proposes that the system of capital charges—covering depreciation and interest—will be designed so that there is no net increase in public expenditure on the NHS and also no reduction in funds available for patient care. The details of funding, however, and the transitional arrangements will have to wait for a further working paper in April or May 1989. For now, the government is urging health authorities to make an immediate start on setting up registers of assets so that capital charges can be introduced in April 1991.

A capital asset is defined as a tangible asset capable of being used for more than a year and which costs £1000 or more. Authorities are being asked to draw up asset

registers which identify each asset, describe it, give its location, year of acquisition, and initial and subsequent capital expenditure, and then value it at original or replacement cost. Authorities that have set up pilot registers have, according to the paper, found it quite easy to do so. Land and buildings will also need to be valued at their current value; the government plans to develop a set of standard asset lives for plant and equipment and for calculating depreciation and will lay down a rate of interest to be charged on the value of the assets.

This system will not apply to hospitals that opt to become self governing; they will instead be given an interest bearing debt equal to the value of their initial assets, and interest and depreciation charges will not be levied on capital assets that are given as gifts.

Capital Charges. Working Paper 5.

Improving quality of care

The government wishes to work with the profession to introduce medical audit. So it has recently asked the Standing Medical Advisory Committee to consider and report on how the quality of medical care can best be improved by means of medical audit and on the development of indicators of clinical outcome. A central fund—£250 000 in 1989-90—has been established to support medical audit developments, and ministers have declared their continuing commitment to it.

The government's approach is based on the principle that the quality of medical work can be reviewed only by a doctor's peers. To be fully effective, medical audit requires specialised knowledge of current medical practice together with access to a system of adequate medical records. Professional leadership is therefore essential.

The government recognises that medical audit requires commitment in terms of clinicians' time, the need for good and accessible medical records, adequate information, confidentiality for individual patients, and secretarial staff. It is confident that this investment will prove worth while to both doctors and patients by further improving the quality of service offered. Any costs arising from the development of medical audit will fall to be assessed and considered in future public expenditure surveys.

The government wants to discuss with the profession and with management precisely what practical arrangements should be introduced. Arrangements on the following lines are expected to be in place in each health authority by April 1991.

- A district medical audit advisory committee will be established in each district, chaired by a senior clinician and including representatives of the major medical specialties including general practice, together with doctor(s) representing the district general manager
- The committee's role will be to plan and monitor a comprehensive programme of medical audit; it may involve other disciplines as appropriate; and it will need to ensure that the patient's perspective is incorporated into the programme
- The committee will produce an annual forward programme for medical audit within the district, to be agreed with the district general manager
- The committee will produce an annual report which details the procedures used, services covered, the general results of the audits carried out (with suitable precautions to ensure confidentiality), and where ways of improving the quality or the efficiency of medical care have been identified include any actual or recommended follow up action

> Medical audit can be defined as the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient.

- Relevant parts of both the forward programme and the annual report could be made available to other health authorities considering placing contracts within the district.

The district general manager will be able, in discussing this programme or at other times as appropriate, to ask the committee to initiate an independent review of a particular service. This might be either a peer review carried out by clinicians from outside the district, appointed by the regional audit committee, or a joint professional and managerial assessment of a service where broader issues require examination.

Once satisfactory local arrangements for medical audit are in place, the new job descriptions to be held by all consultants will require revision to reflect the new circumstances.

The government wants a comprehensive system of medical audit covering all general practices in place within three years. It will be based primarily on audit taking place within individual practices. An overview of medical audit on an area wide basis will also be essential because the same difficulties will be faced by many practices. Management will need to know the range of problems and to be assured that appropriate audit systems are in place in all practices.

The government envisages that each family practitioner committee should establish a medical audit advisory group, consisting of doctors (including hospital consultants) and other staff to support and monitor audit procedures in its area. In selecting the professional members of the group, family practitioner committees will need to take account of the views of the local medical committee and consider the inclusion of members of the local faculty of the Royal College of General Practitioners, academic departments of general practice, and other professional members with particular essential skills.

A contractual framework for medical audit in primary care will be essential, and general practitioners' terms of service will be amended after consultation with the profession to include a requirement to participate in medical audit once satisfactory local arrangements are in place.

Medical Audit. Working Paper 6.

Consultants' work in the future

Consultants employed in self governing hospitals will be covered by the proposals in this paper for as long as they retain their existing contracts. The proposed changes to appointment procedures and the distinction award system will also apply to those consultants on contracts whose terms have been determined by an individual self governing hospital.

The government believes that present arrangements for the management of consultants' contracts have "tended to cause confusion about the nature of a consultant's accountability to local management and the DHA" (*Working for Patients* paragraph 5.12). The government does not intend to move contracts to district level as this would cause unnecessary disruption, but it does intend that they should be managed locally. Regional health authorities will, therefore,

appoint district health authorities to act as their managing agents in relation to the arrangement of consultants' duties. This will not require any legislative action and is consistent with the terms of consultants' existing contracts. Regional health authorities are entitled, as employers, to empower the management of the hospital or hospitals in which the consultant is providing his services to act as their agents in working out an acceptable arrangement of his duties.

As part of the same process it is proposed to introduce arrangements which will more clearly define the scope and extent of each consultant's duties. The government intends that district general managers, who will have medical advice available to them, should be responsible for ensuring that a sufficiently detailed job description is agreed with each consultant—that is, both new consultants and those already in post—which will then be reviewable annually. It is intended that by April 1991 all consultants should have job descriptions agreed with local management.

Although the new arrangements will not require formal negotiation, the chief executive of the NHS Management Executive intends to initiate discussions with the profession on a possible model (see box).

At present health authorities appoint consultants in the light of advice from an advisory appointments committee whose membership is predominantly professional. The government will consult representative bodies on proposals to amend the NHS (Appointment of Consultants) Regulations 1982 so as to make the district general manager (or the chief executive in the case of a self governing hospital) or exceptionally a senior member of the management team a full member of the advisory appointments committee.

The government recognises the value of distinction awards in rewarding professional excellence and therefore proposes that all consultants employed by self governing hospitals should be eligible for awards. It sees room for improving the system, in particular to reflect the wider responsibilities of consultants for the effective use of resources and to offer incentives to individuals to maintain and improve their contribution to local services.

The criteria for C awards would be modified so that in future consultants must show not only their clinical skills but also a commitment to the management and development of the service, with a few exceptions to meet the circumstances of consultants, including academics and research workers, whose jobs include only a small NHS management content. The government intends to amend the constitution of the regional committees which make recommendations for C awards so that in future they would be chaired by the regional health authority chairman and include senior managers in addition to the clinical members. Nominations for C awards would be expected to have the support of both the clinicians and the managers. There will be no change in the composition of the regional committees for higher awards, but progression to higher awards will be restricted to those with C awards.

In future awards will be reviewable every five years. Although this will not apply to awards currently held, all new awards of whatever level will be reviewed at five yearly intervals to confirm that the consultant still merits an award.

The government wants the changes introduced with effect from the 1989 awards—that is, those made and notified in early 1990. The changes will also apply to community physicians. Implementation will be discussed with the chairman of the Advisory Committee on Distinction Awards.

The government intends to proceed with negotiation on the basis of the proposals contained in the report of the joint working party, made up of representatives of the health departments, the profession, and the NHS, which examined hospital and community doctors' and dentists' disciplinary procedures.[1]

Proposals have been put separately to the profession for permanent pay arrangements for medical and dental general managers and it is hoped to reach agreement shortly. Consultants are also participating in management other than as general managers—for example, by taking responsibility for specific tasks at unit level or for the implementation of the resource management initiative. The review proposals will help to accelerate this process. The chief executive of the NHS Management Executive will initiate discussions with the profession on how these contributions might be recognised.

Job descriptions are seen as including such elements as the main duties and responsibilities of the post, which would, for example, include details of the clinical, teaching, and administrative elements; a work programme showing for each morning and afternoon the main duties and their location (for example, outpatient clinic at X hospital); participation in medical audit once local arrangements are in place; out of hours responsibilities, including rota commitments; and budgetary and other management responsibilities.

Government's proposed timetable

	1989-90	1990-1	1991-2	1992-3	1993-4	1994-5
(1) Allocations to regions	Already made on RAWP basis	First stage move to weighted capitation	Second stage move to weighted capitation	Fully based on weighted capitation	As before	As before
(2) Interregional cross boundary flow adjustments	Costs agreed between regions	Paid for direct with cash limit adjustments	Cross charged. Replaced by contract funding of self governing hospitals and by general practice budgets	Replaced by district flows or contract funding	Ceased	Ceased
(3) Allocations to districts	To be made on established bases	To be made on established bases, but may be affected by changes at (1) and (2)	Those substantially affected by (5) and (6) switch to funding on basis of existing resident population. Others as before	All funded on resident population. Some move towards weighted capitation	Further movement towards weighted capitation	As before
(4) Interdistrict cross boundary flow adjustments	Reflected in allocations	Reflected in allocations	Removed from some allocations	Removed from all district health authorities allocations	Ceased	Ceased
(5) Self governing hospitals	First wave identified	Shadow funding and operation of first wave	First wave fully operational	More become operational	As before	As before
(6) General practice budgets	First wave identified	Shadow operation and negotiation of contracts	Budget holders	More become budget holders	More become budget holders. Possible relaxation of criteria	As before
(7) Information about patient flows and costs	Costs agreed between regions	Identification of interdistrict costs and flows begins everywhere. Completed for district health authorities affected by (5) and (6) first waves	Identification of costs and flows completed for remaining districts			
(8) Contracts	Models developed	Contracts developed for first self governing hospitals and general practices and used between regions	Mixture of contracts between districts and of self governing hospitals and general practice budgets	Interdistrict contracts phased out where possible. Otherwise as before	Last year for interdistrict contracts	All contracts with hospitals

Discussions on changes described in this paper will also take place in Scotland. These will proceed in parallel with, but separately from, discussions in England and Wales to take account of the different organisational and management arrangements in Scotland.

NHS Consultants: Appointments, Contracts, and Distinction Awards. Working Paper 7.

1 Joint Working Party between Joint Consultants Committee and Department of Health. *Disciplinary procedures for hospital and community doctors and dentists.* London: Department of Health, 1988.

General managers to head FPCs

Family practitioner committee (FPC) administrators will be replaced in open competition by chief executives to be known as general managers. The aim is to have regional managers in post in every committee by the end of 1989 at the latest.

The general managers' tasks will include

- Preparing for the transition to the reconstituted FPC; implementing policies to bring about service development, including the monitoring and review of the family practitioner services
- Controlling and targeting new cash limited budgets for improving general practitioners' premises and for primary care teams
- Instituting, controlling, and monitoring indicative prescribing budgets for general practitioners
- Managing FPC staff—for example, dental practice advisers and independent medical advisers.

Membership of the new committees will be cut to 11 with the chairman being appointed by the Secretary of State and other members appointed by the regional health authority, which will seek nominations from local representative committees and other professional organisations. The legislation will provide for the chairmen and members to be appointed for up to four years.

In future FPCs will have 11 members. The Secretary of State will appoint the chairman and the regional health authority will appoint the other members. In the case of professional members the latter will seek nominations from local professional committees and other professional organisations.

FPCs will become directly accountable to regional health authorities instead of to the Department of Health, and as management of family practitioner services is a new role for authorities one of their members will be an FPC chairman. Regions will be responsible for appointing FPC members; allocating funds to FPCs; monitoring plans coordinated with those of the district health authorities; and reviewing the performance of FPCs.

Each FPC's performance is reviewed each year; the nature of the review is decided by the department and may range from an exchange of correspondence to a formal review either at the FPC offices or at the department. Every FPC has a full scale performance review every four years conducted by a minister or a senior official. Performance reviews are based on a health profile of the population, performance indicators, operational plans, and a report on the achievement of previous objectives.

Regardless of the extent and pace of regional health authority involvement in FPC plans and performance reviews, the government expects regional health authorities to step up their efforts to secure maximum collaboration between district health authorities and FPCs. This, the government believes, will be essential to carry out the present responsibilities and will become even more important as the FPC's role is enhanced with the implementation of the primary care white paper *Promoting Better Health* and the substantial further changes set out in the NHS review white paper *Working for Patients.*

Implications for Family Practitioner Committees. Working Paper 8.

ANY QUESTIONS

At what age should a young woman with a strong family history of breast cancer start routine mammography screening?

When there is evidence of breast cancer in several generations of the family the phenomenon of anticipation has to be considered. If a mother has cancer in middle age it is likely that her daughter will have cancer when she is younger. Indeed, if there is a history of a grandmother with cancer of the breast her granddaughter may have it when she is even younger. It is difficult to put an exact time on when mammography should be done, but it would be advisable for the daughter to be screened first at an age 10 years younger than that at which the cancer occurred in the mother or, if there is a grandmother, at 15 years less than the age of the mother. A baseline film should be taken at the age of 30, then at five yearly intervals until the age of 40, after which she should have it annually. Ultrasonography of the breast should also be considered in the intervening years up to 40 as this would reduce the slight hazard from radiation.—AUDREY TUCKER, *consultant radiologist, London*

If breast feeding mothers pass iron to their babies through their milk do babies whose mothers did not have iron replacement treatment during pregnancy require iron supplements?

Human breast milk has a fairly low iron content of about 0·5 μg/ml. The concentration of iron in milk is probably not influenced by the iron state of the mother and is indeed highly resistant to changes in dietary iron. So there is little evidence that iron deficiency in the mother affects the infant through breast feeding, although we lack information on the effect of severe maternal iron deficiency.

The low iron content of human and indeed cows' milk and the addition of iron to many formula infant feeds have prompted debate on whether and when exclusively breast fed infants require iron supplements. The consensus seems to be that this is not generally required in the case of term babies. Exclusively breast fed infants at 6 months have favourable haemoglobin concentrations and indices of iron stores compared with infants fed on other regimens. This may be because the iron in human breast milk has a high bioavailability. If the baby is preterm, however, or in the unusual circumstance of exclusive breast feeding continuing for more than six months supplements of iron should be given.

Little specific information is available about the effect of breast feeding on the mother's iron stores and haematological variables. Lactation has been estimated to cause iron losses for the mother of 0·3-1·0 mg/day, and the total additional iron requirement for the mother during lactation is 100-180 mg. As this is offset by the suppression of menstruation for the greater part of the usual lactating period it is not thought to represent a considerable iron loss.

In women ending pregnancy with a precarious iron balance who have other risk factors, such as poor diet, lactation may contribute to the development of iron deficiency anaemia in the puerperium or in a subsequent pregnancy if this occurs early.—E H HORN, *lecturer in therapeutics, Nottingham*

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