

## Message from Chief Executive....

The holiday season is fast approaching us again. There is much to look forward to and reflect upon; the pace of change seems to increase as every year passes and this shows no sign of changing.

Within the next twelve months there will be a major reorganisation of PCTs, Strategic Health Authorities and Ambulance Trusts. Added to this the Government is to produce a White Paper on Care Outside Hospital. This follows the supposed consultation with the general public, "Your Health, Your Care, Your Say", about what they want from General Practice.

### Reorganisation

The consultation on the proposed restructuring of PCTs will start towards the end of December and last for three months. Hopefully by the end of March 2006 it will be clear what those structures will be and then they will be in place for October 2006. We sent some information about these proposals to you several weeks ago, so you should all be aware of the implications for your practice and locality.

What does this mean for us? If you read the history of LMCs in the Annual Report, you would realise that LMCs were first formed in 1911 and therefore we are one of the few organisations that have survived constant change and restructuring within the Health Service. Whatever the outcome of the latest reorganisation, I am confident we can adapt and provide even more robust representation than we have done previously.

There are still one or two PCTs who refuse to fully engage with the LMC in Wessex and they tend to be the dysfunctional organisations which have not seen the value of consultation and collaborative working. I am pleased to say that the majority of PCTs and Strategic Health Authorities and now Secondary Care Trusts are looking actively to work with us to achieve what should be common to us all and that is improved patient care.

## Consultation with patients

"Your Health, Your Care, Your Say" was the Government's way of asking patients about Primary Care. Any of you who took the trouble to complete the questionnaire, as I did, would realise that the questions were heavily weighted, probably answers the Government wanted to see. The results of the survey did show patients:

- Liked Primary Care but they wanted more of it
- Valued belonging to a practice
- Feared the loss of seeing a GP they knew and trusted
- Supermarket style provision of healthcare was at the bottom of priorities
- Wanted to be able to change GPs more easily
- Did not want to "shop around" when ill
- Wanted extended opening hours
- Wanted more walk-in centres

So - our patients like what we provide but they want more of it.

These themes are going to be combined with the proposals in the White Paper to shape the developments in General Practice over the next two years.

The new Contract, love it or loathe it, has delivered unprecedented new investment in General Practice. The result of this has produced some interesting reactions from Politicians and Consultants.

Some Consultants have been publicly critical of the fact that now, from NHS earnings, some GPs are paid more than Consultants and that this has been achieved with the added bonus of being able to "opt-out" of on-call work. Some say they believe this has been achieved by the fact that our negotiators were better than theirs; this is certainly true (well done Hamish et al) but why do Consultants think that their jobs are more valuable than ours? As they have become increasingly specialised and focus on smaller and smaller areas of knowledge,

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GPs have expanded their roles and responsibilities and many of us believe that the change in levels of pay is long overdue.

Our Politicians believe that GPs in this country are now the highest paid in Europe and a significant proportion of the increased investment in the NHS has been reflected in pay and not services. Firstly, we should be the highest paid in Europe as we take more responsibility and manage far more patients in General Practice than any other country's GPs. Secondly, increased pay delivered through Agenda for Change or the Consultant Contract has probably changed little, but the significant investment through QOF has clearly demonstrated what can be achieved by the most flexible, innovative and responsive section of the NHS workforce.

### Challenges for the Coming Year

As you will be aware from the Press coverage, the current contract comes to an end in March 2006. Rather than a significant change occurring then, it has been agreed that minor amendments will be made so there is more time to reflect on the successes and difficulties within

the current contract. The 2005/6 version delivered significantly more resources to practices than was promised by the Government. Under the "Red Book" there would have been a "claw back" over the following years. This is not the case in the current contract but what it will mean is that for next year there will not be a rise in either the Global Sums or the value of the QOF; there will also be minor changes in some aspects of the QOF and some Enhanced Services.

The bottom line is the next two years will be financially challenging for practices, so use the increased resources wisely. In addition the Government is going to push to have practices open for longer periods of time to offer a greater spread of appointments and use the private sector threat as a lever to achieve this.

**I would like to take this opportunity to wish you all a Happy Christmas and a prosperous New Year from all of us at the LMC who work tirelessly on your behalf.**

NFW

## Overseas Visitors' Entitlement to NHS Treatment

We still receive a lot of queries about the entitlement of overseas visitors to NHS treatment. We have guidance on our website which was updated in 2004. You can access this at <http://myweb.tiscali.co.uk/lmclive/genguide/ipract/visitpricare/visitpricare.htm>

In an attempt to simplify this topic even more we have now developed further guidance in the form of a power point presentation. This will be added to the previous web site guidance.

The first slide after the title acts as a brief guide and the subsequent slides provide further information and clarification. We have included this first slide with its **Brief Guide to NHS Entitlement** with this Bulletin, but would recommend that you refer to the entire guide on the website for further clarification.

We hope that this will be of use to you and your staff when you need to make a quick decision regarding the NHS entitlement of an overseas visitor.

The new power point guidance also includes advice on the NHS entitlement of pensioners living abroad for part of the year and we would like to draw your attention to the advice on extended prescriptions for these patients.

Pensioners living abroad for part of the year are not automatically entitled to receive NHS scripts to cover all of their medications while living abroad. GPs should not allow themselves to be pressured into prescribing for longer than the normal safe review period. To do so involves a potential health risk for the patient and a medico-legal risk for the GP.

CED

# Brief guide to NHS entitlement

No automatic entitlement – may offer private care	→	•British citizen living outside UK for more than 3/12, except some UK state pensioners*. •Failed asylum seekers
Immediately necessary care Primary & A&E & WIC associated with A&E	→	Any overseas visitor
Immediately necessary care - (as above) + secondary care	→	Any overseas visitor from country with bilateral healthcare agreement
All necessary care	→	Any visitor resident in EEA country or Switzerland
Primary care only - <b>Beware</b>	→	Discretion of GP see further guidance
Primary care + some 2ndary care	→	Patients listed as entitled to some NHS hospital treatment - includes UK state pensioner living >3/12 a year in non-EEA country if lived in UK continuously at least 10 yrs
Primary care + all 2ndary care	→	Ordinarily resident patients + Patients listed as entitled to all NHS hospital treatment – includes UK state pensioner non-resident in EEA less than 6/12 a year - prescription only for safe period unsupervised by prescribing doctor - includes asylum seekers

## Child Protection - Clarification of GP Obligations

**The LMC view is that there is now a clear legal and professional requirement for GPs to engage in and cooperate with local child protection procedures.**

GPs have always had a legal and professional responsibility to take any necessary action to safeguard vulnerable children and to defend any failure to take appropriate action in the event of a child suffering as a result. Since the Laming report it has become quite clear that GPs are expected to work in close collaboration with other professionals involved in child protection.

A recent legal case makes it absolutely clear that, if a GP believes a child to be at risk, the needs of the child are always paramount and override the duty to maintain patient confidentiality.

Interpretation of new legislation is always difficult, but we believe that the new legal requirements now make it essential that GPs work in cooperation with local procedures and can demonstrate to their PCT that they are fulfilling their statutory obligations in this respect.

Section 11 of the **Children Act 2004** sets out quite clearly that PCTs and SHAs must ensure that any services provided by them, or by others on their behalf, are provided with due regard to their new legal obligations. The new duties in relation to child protection extend to all GPs and have been in effect since October 2005. By April 2006 new local safeguarding children boards (LSCBs) must be in place to coordinate and ensure the effectiveness of local work to safeguard and promote the welfare of children. Section 11 sets out that each person or body to whom it applies must have regard to any guidance on the subject provided by the Secretary of State. The staff training and continuing professional development requirements are described in 'Section

11 Statutory Guidance on Making Arrangements to Safeguard and Promote the Welfare of Children', which was published by the government in August 2005. This guidance specifies that staff should understand their role and responsibilities, and those of other professionals and organisations, in order to ensure essential multi and inter-agency collaboration. It also encourages inter-agency as well as single agency training.

Standard 5 of the **National Service Framework for children and young people** relates to Safeguarding and Promoting the Welfare of Children and Young People. It sets out that "all agencies must work to prevent children suffering harm and to promote their welfare, provide them with the services they require to address their identified needs and safeguard children who are being or who are likely to be harmed."

It specifies that PCTs should ensure that their own staff **and those in services contracted by them;**

- are trained and competent to be alert to potential indicators of abuse or neglect in children
- know how to act on their concerns and fulfil their responsibilities in line with the local ACPC (Area Child Protection Committees) or its successor the LSCB (Local Safeguarding Children Boards) procedures
- undertake child protection training, including refreshers to ensure that they are competent and aware of any changes
- are supported by a funded training strategy for child protection.
- have a designated nurse and a designated doctor who have over-arching responsibility across the Primary Care Trust area, **which includes all providers**

**PCTs, with LMC input, are currently trying to make sensible, realistic and safe decisions about child protection training which will fulfil these new legal obligations.**

The Practice Management Organisational Indicators in the GMS contract specify that individual healthcare professionals should have access to information on local procedures relating to Child Protection. A child protection lead in each practice may be a helpful way of ensuring that all statutory and professional standards are met by the practice, although this is not a requirement.

In practical terms the key areas of responsibility for each practice are that all staff;

- are adequately trained
- know the local procedures that are in place
- know how to recognise when a child is at risk
- know who to call for further advice or to notify if a child may be at risk

The LMC will try to provide further updates on child protection as they become available.

Further information may be obtained from;

**Child protection guidance**

<http://myweb.tiscali.co.uk/lmclive/genguide/ichldprt/ichldprt.html>

**Children Act 2004**

<http://www.opsi.gov.uk/acts/acts2004/20040031.htm>

**What to do if you are worried a child is being abused**

[http://www.everychildmatters.gov.uk/\\_files/D9FECC5F6F3BC7B3FBD8950FC949AB09.pdf](http://www.everychildmatters.gov.uk/_files/D9FECC5F6F3BC7B3FBD8950FC949AB09.pdf)

**Section 11 Statutory Guidance on Making Arrangements to Safeguard and Promote the Welfare of Children** [http://www.everychildmatters.gov.uk/\\_files/9204C14C73ACCA279701DDF9731B16F6.pdf](http://www.everychildmatters.gov.uk/_files/9204C14C73ACCA279701DDF9731B16F6.pdf)

**National Service Framework for children**

[http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServiceInformation/ChildrenServicesInformationArticle/fs/en?CONTENT\\_ID=4089111&chk=U8Ecln](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServiceInformation/ChildrenServicesInformationArticle/fs/en?CONTENT_ID=4089111&chk=U8Ecln)

CED

## Professional Recommendation

It is a common occurrence in General Practice for patients to ask the advice of a GP as to which optician, dentist or pharmacist they would recommend.

I would remind you that, under your professional registration, you should not be directional when giving such advice. You are perfectly entitled to suggest a range of options a patient has, but you would be ill advised to make a professional recommendation.

An issue has been brought up with the LMC via the Local Pharmaceutical Committee (LPC) that practices have been recommending patients to use internet pharmacists such as Boots or Pharmacy 2 U. The LMC has resolved these issues on a local basis but

would remind you that if these services are brought to the attention of patients it should be done by way of informing patients of services available, including local pharmacies and not recommending patients use a specific service.

NFW

## Local Pharmaceutical Committees

The Hampshire and Isle of Wight Local Pharmaceutical Committee (LPC) has recently appointed a new Chief Executive, Mr Michael Holden who has met with us on a couple of occasions recently. Both the LMC and LPC are committed to working more closely together and therefore if practices have any issue which they are unable to resolve with pharmacists locally I would be happy for you to contact the office so that we can take this up directly with the LPC.

In addition, Dr Andrew Mostyn had a useful meeting with Mr Chris Dunn (Secretary of the Wiltshire Local Pharmaceutical Committee) when he visited the LMC in August.

NFW

## Performers Lists in UK

Statutory Instrument 2001 No. 3740 set out the legislation for the supplementary lists for the NHS in England. In that legislation the following definitions were provided;

“equivalent body” means a Health Authority in Wales, a Health Board or an NHS trust in Scotland or a Health and Social Services Board in Northern Ireland.

“equivalent lists” means lists kept by an equivalent body. These lists are not regarded as interchangeable

When the supplementary lists were introduced it proved impossible to persuade the Welsh Office to accept that the Welsh and English lists should be interchangeable. As a result the BMA advised GPs wishing to work in England and Wales that they would have to be included in lists in each country.

This interpretation also applied to supplementary lists in Scotland and Ireland.

GPs were allowed to be included on an English supplementary list at the same time.

The National Health Service (Performers Lists) Regulations 2004 for the different countries within the UK have individual variations which have perpetuated this situation. The English, Welsh, Scottish and Irish Performers Lists may not therefore be regarded as interchangeable.

**The simple take home message for all Wessex GPs is that before appointing a partner or a locum it is necessary to ensure that they are on a performer’s list in England.**

CED

Message from Adrian Chamberlain, Head of Contracts, PPSA (Hampshire)

If practices would like a link to their practice website from their respective page on [www.nhs.uk](http://www.nhs.uk), could they please e-mail me permission to do so and include their web address.  
[adrian.chamberlain@hiow-ppsa.nhs.uk](mailto:adrian.chamberlain@hiow-ppsa.nhs.uk)

## Disposal of Sharps and other Clinical Waste

Patients with diabetes should be advised to dispose of their clinical and sharps waste safely using a sharps bin which the GP can prescribe on an FP10. Pharmacists used to collect the filled bins but patients are now being informed that they should be taking the filled sharps bins to their GP practice for disposal instead. We are still getting enquiries from practices about their obligations.

**We can advise that GPs have no obligations in this regard**

In April 2004 the National Diabetes Support Team issued a Fact sheet on **Disposing of Used Syringes and Other Sharp Clinical Waste** ([http://www.cgsupport.nhs.uk/downloads/NDST/Factsheet\\_Sharps\\_Disposal.doc](http://www.cgsupport.nhs.uk/downloads/NDST/Factsheet_Sharps_Disposal.doc))

This includes the following advice:

*“As a general rule waste produced by the householder, including clinical and sharps waste, is the waste of that householder and is therefore collected, on request, by the local authority.”*

It then quotes the Drug Tariff which states that *“Those prescribed the Sharpsbin should be advised that, because of the risk of needle-stick injuries, it should not be disposed of via the normal household refuse collection. Patients should correctly dispose of their Sharpsbin by returning it to their GP for appropriate disposal. Alternatively, local authorities will make separate collections of clinical waste on request and patients should contact their local authority.”*

There is a duty on local authorities, under Section 45(3) of the Environmental Protection Act 1990 and the Controlled Waste Regulations 1992, to collect and dispose of household waste, including clinical/sharps waste from households.

Patients must request this service and ask for their clinical/sharps waste to be collected. Local authorities are entitled to make a reasonable charge, although some provide a free service.

The Department of Health reinforced this guidance in an Information Note in August 2004 on **Diabetic care – Sharps Disposal** [www.dh.gov.uk/assetRoot/04/11/96/59/04119659.pdf](http://www.dh.gov.uk/assetRoot/04/11/96/59/04119659.pdf)

CED

## Medical Records

It has come to the attention of the Joint GP IT Committee (JGPITC) that some practices are sending incomplete medical records on to the next practice when a patient transfers. This usually means that practices don't print and forward letters and other reports that are often scanned and “attached” to the GP electronic patient record (EPR).

Sometimes the incompleteness is highlighted by a note advertising that the records are ‘available on request’, but other times the gaps in the record are only obvious when the records are under review (e.g. for a medical report).

Although the common way to pass information on is by a printed record, some practices are now asking if it is permissible to put the information on a CD-ROM. It is claimed that EMIS, in particular, extract a complete patient record which can be fed directly into the system of the new practice saving a lot of time and any typing errors. Obviously this would work if the new practice used the same system but it is equally obvious that the sending practice has not complied with their PCT agreement where the receiving practice uses a different system. We all expect this to be a temporary problem which will be solved by the introduction of GP2GP transfer of medical records.

**The JGPITC would like to remind practices that they are required to forward the complete medical record when requested to do so by their PCO. However, fully summarised “paper-light” records will generally be sufficient, providing they have been carefully examined to ensure that no important patient details have been omitted. Practices are reminded that it is their duty to ensure that all scanned letters and supporting documentation are explicitly linked in the appropriate place within the patient’s records, to ensure that vital information is transferred safely and efficiently and that context is maintained.**

Obtaining permission to use electronic records would involve practices agreeing to follow the joint GPC RCGP Guidelines and sending all patient records to new practices in a format acceptable to the PCT.

The LMC is investigating the possibility of PCTs accepting a halfway house whereby practices save on a CD-ROM information in a format that all practices can read and use e.g. Word documents, spreadsheets, TIFF etc rather than any proprietary formats.

AD/SDW

## Clinical Repository Project:

### JOINT STATEMENT: LMC/ SHA

There has been some recent email correspondence about the Clinical Repository Project and the access of patients to their records. The SHA and LMC have agreed the following statement.

1. The Hampshire and Isle of Wight Clinical Repository Project is creating an integrated electronic patient record from GP and hospital systems. This is a forerunner of the systems which will be introduced by the National Programme and is providing feedback to national bodies on how to achieve this safely and securely. When the national systems provide similar functionality to the HIOWha Clinical Repository, the project will be closed.
2. Following advice from the GMC, BMA and LMC, records may be merged. To comply with the data protection act, reasonable efforts to advise the public that sensitive information about them is being held in this way have to be made. We have, therefore, made reasonable effort through the distribution of leaflets to households, GP surgeries and other public places. When data is accessed for use in an identifiable form explicit consent from the patient must be sought, informed in a way that they can understand.
3. Patients must be given the opportunity to find out more about this processing and to object to this if they so wish. Patients who have not objected are considered to have given implicit consent.
4. Patients may object to their records being processed in this way and request that they be withheld from the Clinical Repository
5. As for any database, patients may subsequently ask to see any information that is held about them on the CDR. The process laid down by the Department of Health will be followed in this context. This requires:
  - a. Verification of the patient's identity
  - b. Checking that there is no information which is potentially harmful to the patient or identifies a third party in the information to be released. (this excludes health care professionals involved in the patient's care.)
  - c. Explicit consent from the patient to their records being accessed and printed by a medical records officer.
  - d. Printing the records and sending them securely to the patient.
6. All practices receiving patient records for checking, have previously given their consent for their practice data to be extracted into the CDR.
5. Where access to the medical records is requested by a patient, the SHA proposes to pay GPs £10 per record reviewed. If practices are unwilling or unable to undertake this task, the SHA will arrange for an alternative clinician to vet the record.

## Short Term Certificates required by Probation Service

A number of GPs have complained to us that an increasing number of offenders are being sent to them by the Probation Service for short term certificates to justify a failure to report when required.

We contacted the South-East Hampshire and Isle of Wight Probation Service about this problem and they have agreed that Probation Officers in their area will in future have the discretion to accept self certification from offenders on two occasions. If an offender subsequently claims further episodes of short term illness he or she will be permitted to provide alternative medical evidence, such as a copy of a prescription or a medical appointment card.

Obviously a medical certificate may be required if an offender is ill for more than 7 days.

The South-East Hampshire and Isle of Wight Probation Service has advised their staff of this change to their policy and similar provisions should be equally acceptable to other Probation Services in our area.

Please contact us if you continue to experience difficulties.

**CED**

## Patients in Nursing Homes

Patients residing in Nursing Homes carry a significant additional weighting. **Please remember therefore to complete this field when registering such patients on your clinical system** or you will lose the extra funding.

Currently the PPSA can check and amend this information as they are involved in the registration process. However, in the future, when the registration of patients will be undertaken via the national spine, the PPSA will no longer be involved in patient registrations. **It is important therefore, that if you have not been following this practice, start now.**

**SDW**

### Key to Contributors:

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## Pandemic Influenza Planning

As you no doubt have been told frequently, it is expected that pandemic 'flu is a question of 'when' not 'if'. The LMCs have been having meetings on planning for various disaster scenarios with the StHAs and PCTs; we are trying to get some consistency across the patch to ensure that none of these high-level plans assume unrealistic actions for GP practices. When one considers that up to 30% of primary care staff may be ill themselves, it would seem unwise to expect GP practices to absorb a large amount of extra workload effortlessly.

We advise practices to discuss how they would manage their expected increase in work and how they can protect their staff and we will be sending out some checklists to facilitate this. We believe it is much better for practices to make their own plans which will have much more relevance and likely to be effective, compared with each practice getting the same blueprint from above. However, we will keep you informed of the sorts of extra tasks you are likely to face and how to avoid unreasonable ones.

We will keep you posted, this is not likely to go away!

AD

## New Procedure for Handling Concerns about Clinician Performance

Some of you will be aware of the existence of a procedure to be followed when there are questions about the performance of an individual practitioner. Many of you will not have any experience of the procedure as fortunately, most of us will never be involved in its use and it is one of those areas that we are happy to ignore unless we need it.

The original procedure was drawn up in 2001 and shared and agreed with the LMCs and PCTs across Wessex. The procedure is for use when there is the possibility of risk to patients as a result of questions raised about an individual practitioner. It is not for use in cases of partnership dispute, contractual or disciplinary matters, individual patient complaints or suspected criminal activity. These areas are covered either by the contract regulations or by the Medical Performers List regulations.

In working with nineteen PCTs on behalf of the Wessex Local Medical Committees we have seen a steady increase in the number of cases where the procedure is being used. This has meant that at the office we have quickly gained wide experience in this area.

It is apparent that there is some confusion about the process and that the current version of the procedure does not always serve the purpose for which it was initially designed.

We have therefore produced an updated version to provide more clarity and to incorporate some of the thinking at the National Clinical Assessment Authority. This is currently being shared with the PCTs for their input and will then be taken to all of the LMCs and PCTs for their agreement.

**I would emphasise that the procedure exists in order to ensure that questions or doubts about performance are dealt with fairly and proportionately. There is LMC involvement throughout and participation by the individual practitioner is voluntary. If you would like to discuss this further or would like a copy of the updated version when finalised then please contact the office.**

AM

## Practice Based Commissioning

Practice-Based Commissioning is at the core of current NHS modernisation and the recent guidance from the DoH states that all practices will be involved by 2006. Alongside this is the initiative to increase Foundation Trusts (and the extension of Payment by Results), the re-configuration of StHA's and PCTs and the white paper on 'Healthcare outside of Hospitals'.

The belief is that practices working together with PCTs will be able to shift the balance of power from the Acute Trusts to Primary Care and thereby encourage new clinical pathway design that is evidence-based, to improve commissioning and contracting. This can only be achieved by clinicians working together and is a fundamental stage in addressing the mistakes of past commissioning and contracting so that we are able to move forward and provide confidence in the future of General Practice.

General Practice must be alert to the real threat of alternative providers where 'cherry-picking' of primary care services may occur. The Government believes that by offering other providers the opportunity to tender to provide primary care services alongside general practice, (where 'contestability' becomes the norm) improvement in the quality of services to patients will be achieved as well as the weakening of the monopoly of general practice provision. Profit-driven and therefore financially sound organisations will be encouraged and will bid against general practices to 'win' contracts.

Practices need to consider what this will mean for patients and General Practice as a whole i.e. the end of practice-based lists, continuity of care and fragmentation of provision. They need to get together and involve themselves in PBC otherwise could find themselves victims with no influence, no opportunity to expand and no possibility to compete.

Wessex LMCs encourages those practices who haven't yet, to engage with their PCTs in discussions around PBC. We are pleased to say that across Wessex, most have agreed how they will work in cluster groups.

We are the best providers of Primary Care and must thwart or indeed prove to be a credible and strong competitor to any potential 'take-over' of other providers. We have the experience, a proven track-record to date of meeting challenges, know what is best for patients and must involve ourselves in this significant threat to general practice.

The GPC is seeking to secure separate funding for preparatory costs but practices should not wait until a decision is made but become involved in the discussions taking place now. However, those practices who feel they would be disadvantaged by moving forward now should wait for further details due to be made available in January 2006.

The GPC also advises that if practices are currently considering signing PBC agreements with their PCTs, they should add a clause stating that, if later negotiations result in a more favourable rate than the one agreed locally, the local contract should be amended accordingly.

Lockhart's Solicitors have also developed a comprehensive legal agreement at a cost of £2000 +VAT. If you require further details, please contact the office.

**SDW**

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