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**Dr Simon Lockett's Report of the 2007 Annual Conference of LMCs is attached to this flyer**

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I have got to write a couple of items which I am not terribly happy to do. The first because I feel that what has happened is rather against natural justice and the second because I may have been wrong in the advice that I gave and nobody ever likes admitting that! SRL

**Action Plan from Proton Pump Inhibitor Serious Untoward Incident .....** you may be aware that a problem arose earlier this year when the LMC alerted practices immediately it heard of a significant event reported by a practice. Practices had received a pack of information to help prescribe PPIs more cost effectively including sample leaflet(s) for patients. I think the origin of the leaflets was the SHA. A practice sent the leaflets out with an appropriate covering letter; unfortunately a patient ended up reducing and stopping their PPI in line with what they thought the leaflet advised, with very serious consequences.

Norfolk PCT and the SHA had their own internal enquiries, the full findings of which are not public knowledge - I have not seen them. One recommendation is that primary care clinicians should be reminded that it is not acceptable to simply take on trust any document or policy implementation process because it arrives from the PCT or other authoritative source! As I said above, this seems somewhat against natural justice, in that the sort of practice most likely to fall foul of this sort of problem would be one that was attempting to do what the PCT wanted it to do. This does feel like shifting blame rather than supporting practices and is unlikely to improve relationships in the future. Furthermore, if the PCT is going to take this line, it may mean that suggestions from TAG, for example, which ask GPs to behave in a way different from the national guidance are, I would suggest, more likely to fall upon deaf ears if practices realise that they will probably get absolutely no backing from the PCT should a problem occur. An example would be the TAG approved guidance about the ongoing use of anti-dementia medication once patients have been discharged from the mental health trust, with GPs effectively taking on the responsibility for the continued prescriptions. If the PCT is going to appear to be unsupportive of practices it has only itself to blame if there are consequences which it does not like.

On the other hand it is certainly the case that a GP would bear, or at least share, responsibility, for passing, uncensored, to patients, dubious advice, or advice that could be misinterpreted in a way which leads to harms. Hence, I do not feel it is possible to challenge the factual basis of the NPCT statement but, as ever, its communication skills appear to be somewhat lacking.

**Med 5s .....** in my article in the February flyer I called attention to the time wasted by patients having to see the GP so a Med 3 can be issued when they have already seen another clinician, for example, a nurse practitioner or a consultant podiatric surgeon who, not being a doctor, cannot provide a certificate. I suggested it might be reasonable to fill in a Med5, striking out part of it

and making it absolutely clear that the GP was acting upon a report from an appropriately skilled *clinician* who was not a doctor but who had properly assessed the patient and provided a written report. No deceit would be involved as the job title of the individual would be included and it would not be claimed that they were a doctor (nor, indeed, that the GP had seen the patient when they had not - I think a GP elsewhere had been reprimanded for doing this). We consulted our GPC liaison officer who believes that there is a risk in carrying out my advice in that the Med 5 should only be used in specific circumstances, ie when one is using a report from another *doctor*, written within the last four weeks, or who has seen the patient in the last four weeks, and not in the circumstances I suggested.

I must say I may well carry on following my own advice as I think the rules have become outdated and I wouldn't mind too much being a test case but, if anybody else is following the advice as given in the flyer and doesn't fancy being part of such a scenario, the only completely safe way of dealing with the situation is to set eyes on the patient and issue a Med 3. As stated in the previous flyer, we are liaising with the podiatric surgeons in Norwich to see whether there is some way round this for their patients.

Another strategy would be to issue a *private* medical certificate *without charging* - you can clearly choose the wording on that with no risk whatsoever of being guilty of altering a statutory certificate - namely the Med 5. It is irritating that there is currently no other simple and elegant way to proceed but at least this seems a safe way for the GP to save an appointment without there being any risk of being adjudged to have acted improperly.

**KEEPING LOCUMS UPDATED....** A recent enquiry to the office from a locum suggested that the information overload we suffer from in our practices becomes information underload as soon as we retire - certainly if we want to continue to try to keep up-to-date while working as a locum. New protocols and pathways continue to emerge and, even if they are included in a practice's "locum pack", it seems rather unlikely that the locum will have time to read and assimilate them all. Nevertheless please do everything you can to keep your guidance for locums as up-to-date as possible. Also, could any readers involved in producing this sort of guidance please try to make sure that copies are sent to locum doctors. (Note: the LMC office would be happy to advertise their existence via the flyer).

**CERVICAL SCREENING....** The LMC understands that an error in procedure has been identified in this region where a small number of women have been excluded from the cervical screening programme inappropriately. Although this particular process is not part of the standard procedures in any part of Norfolk, the PCT has nevertheless been asked by the East of England Quality Assurance Team to produce and dispatch lists of women who have been ceased from the programme for the reason of 'no cervix' for

surgeries to verify the appropriateness of the cancellation. Quite specifically, the investigation relates to any woman who has had a sub-total hysterectomy and may have been removed from the programme.

Although I am sure that no local practices will have erred the Screening Department at Norfolk PCT (and all other PCTs in the region) would appear to have no alternative but to comply as patients have been put at risk and each is currently producing lists for verification - with the recommendation that surgeries should check the original notification from the hospital to ensure that only women who have had total abdominal hysterectomies including the removal of the cervix should be taken out of the cervical screening programme. I know practices will not be happy about this as they have carried out similar exercises before. If you are confident of your quality control you may only wish to verify those ladies who have joined your list or changed their status since the last time you carried out such an audit. SRL

**GPC GP SURVEY....** From Dr H Meldrum, GPC Chair: "The survey has now been sent to all GPs - I hope you have received your copy and found an opportunity to complete it. There will always be arguments about why some questions were included and not others and it's true that we (GPC) did have some difficult judgements to make. Please complete it before the deadline of 6 July, as it is important that we get a high response rate to ensure meaningful results. The survey can also be completed online at [bma.org.uk/ap.ns/Content/NationalGPSurvey07](http://bma.org.uk/ap.ns/Content/NationalGPSurvey07)

**ADULT ADHD in NORFOLK....** Practices in the south of the LMC's area who receive their Adult Mental Health Services from the Suffolk Mental Health Partnership may be aware that there is a gap in service compared with the rest of Norfolk which relates to the treatment of ADHD patients who are either adult at the time of diagnosis or who become adult. There is also an issue with eating disorder services. It has been agreed that SMHP will provide these services as soon as they are able to set them up but, at the moment, a pathway does not exist for routine referrals into either of these pathways'. In the meantime, could all cases of Adult ADHD that fall into this gap be referred to the Norfolk Exception Treatment Panel to be assessed and for appropriate specialist resources to be identified to support Primary Care.

**MEETING the NORFOLK CORONER....** I recently had a useful meeting with the Greater Norfolk Coroner and one of his Officers. The meeting had not been occasioned by any particular event or incident although the Coroner Services in King's Lynn have been joined with Norfolk. There remain separate coroners for Gt Yarmouth and for Suffolk. As far as I am aware this re-organisation is not causing any particular problems - let me know if that is not the case.

We discussed matters in general. It is clear that

Norfolk doctors who are involved in death certification do their work to a very high standard. One issue, however, that has arisen on several death certificates is giving "mesothelioma" as a cause of death. This disease must always be notified to the Coroner - otherwise the Registrar picks it up at a later stage, usually to the great distress of the family. Apart from this particular issue there is no other problem which is frequent enough to be considered a trend. Mentioned were occasional lapses in the logical sequence in Part 1 of the Certificate and sometimes diseases or incidents that would not have required action by the Coroner if included in the second part of the certificate are included in the first part, necessitating action. An example might be bronchopneumonia due to fractured hip due to fall. If all are included in the first part this is likely to lead to an investigation by the Coroner, whereas bronchopneumonia due to immobility with "contributing factors" being the fractured hip and the fall would not have the same effect on the workload of the Coroner and the histopathologist, as well as the distress of the family.

We discussed the use of "old age" as a cause of death. I wrote a flyer item a while ago saying that this is no longer acceptable - until at least 80. The logic of this is that many people live well beyond 70, so using this as a sole cause of death in the "younger elderly" is clearly problematic. As society continues to age it may well be that this same logic continues to apply to a greater and greater age and that "old age" is never the preferred diagnosis in anyone; unless they are in the Guinness Book of Records there will always be someone around who is older than them and still alive. On the other hand, it is clearly the case that there are many deaths which are not suspicious, whom the GP has seen within the required time and in whom invoking the full force of the Coroner's processes serves no purpose whatsoever. I am certainly guilty of using "old age" as a sole cause in some of my very elderly patients - generally resident in "homes" - who have either no individual pathology which clearly caused their death or else multiple pathology - when it seems inappropriate to select one over the others as the primary cause of death.

I am not sure that we are ever going to get a clear answer on this one; no doubt it is being discussed nationally as well as locally. I am sure that nobody wants to go back to the ubiquitous "bronchopneumonia" just so there is something that looks like a diagnosis - I would much prefer it if it was acceptable to use "old age" as shorthand for "elderly, worn out and no suspicious circumstances". If there is no clear cause of death and no suspicion of foul play and you are minded to use "old age" it would be helpful to discuss that with the Coroner's Officers in advance of the registration of death.

We discussed the general issue of contacting the Norfolk Coroner's Officers; this can sometimes be problematic, for example on a Monday or Friday when, I am sure, they, as we, are most busy. Faxes can be sent and there are ansaphones - so it should always be possible to leave a message that will be acted on as soon as it is possible. A third Coroner's Officer will be taking up post shortly.

Other causes of death that we briefly discussed included MRSA and Clostridium Difficile. It would apparently cause the Coroner's Officers some concern if C Diff was given as the sole cause of death.

A scenario that is not uncommon in partnerships is that the doctor who knows the patient is on

leave when the patient dies. If the usual doctor has made it absolutely clear that s/he would be willing to sign a death certificate then some delay is generally acceptable but the family must be advised that they have a right to involve the Coroner and request a post mortem if having a cause on the certificate is very important to them and they want the process to begin quickly. Death should be notified within five days and, therefore, longer waits, even in an "expected death", are less likely to be appropriate and should be discussed with the Coroner's Officer - even if the delay is acceptable to the family. Again, this is an area on which I would plead guilty having, on occasion, delayed matters for a particular partner to return or perhaps, even worse, bothered them on leave.

The whole area of death certification is complicated with post-Shipman stuff still percolating through the system and with the Coroner's work, the responsibilities of the Registrar and, often, cremation paperwork issues overlapping but with each having slightly different requirements or nuances. I am delighted to say that Mr Armstrong suggested that I accompany him to a meeting with the Registrars in October and the hope is that with all three of us in the room we may be able to identify areas where we can all help each other. So, if you do have any issues about death certification and related issues please get in touch with the LMC office over the summer with details. SRL, June 2007

**Note:** For those who report to HM Coroners for Suffolk and for Great Yarmouth let us know if you have experienced any problems. We have written to Dr Dean and Mr Dowding offering to meet with them if they feel it would be useful.

**Bungay Medical Practice**  
**Maternity Locum Cover Required**

Locum needed due to maternity leave commencing 1<sup>st</sup> October for 6 months for 25 hours per week. For more information please contact Sarah Harris, 01986 892055 or sarah.harris@gp-d83034.nhs.uk

**HPV VACCINE IMPLEMENTATION....**  
The DoH has agreed, in principle, to the introduction of HPV vaccination for girls around 12-13 years. This national immunisation programme could start as early as autumn 2008. At the moment no decision has been made as to what role, if any, general practice will have in the delivery of this vaccine. The GPC has made it clear that if DoH wishes to deliver this through general practice it will be subject to discussion

**UEA Faculty of Health**  
**Postgraduate Taught Programmes in Clinical Education at the UEA, Norwich**

The Postgraduate Taught Programmes in Clinical Education will offer busy health professionals an opportunity to prepare for their role as educators of undergraduate and postgraduate professionals. Routes of study include the Masters/Postgraduate Diploma/Postgraduate Certificate in Clinical Education.

Find out more at our Open Evening on 17 July 2007 6-8pm. For more information please contact Emma Roper in the Faculty of Health Admissions Office, quoting reference LMC on: 01603 593085, foh.pgt@uea.ac.uk or www.ahp.uea.ac.uk

**"NHS CHOICES"....** This NHS website based information service for patients, which contains

information about all NHS services, including general practices, has gone live. It can be accessed through [www.nhs.uk](http://www.nhs.uk). Currently this only contains basic information (eg contact details, opening hours, location etc) but reports are being received of many errors. The advice from Dr Foster, who designed and set up the site for the DoH, is that practices affected should go on the NHS Choices website and log the inaccuracy for the NHS Choices web team to amend. To do this see the link below and follow the instructions after clicking the "website content" button followed by submit: [www.nhs.uk/ContactUs/Pages/contactus.aspx?hlink=website](http://www.nhs.uk/ContactUs/Pages/contactus.aspx?hlink=website)

**MENTAL CAPACITY ACT 2005....** This is already in force if the patient has had an Independent Mental Capacity Advocate (IMCA) appointed. Otherwise the new Lasting Power of Attorney (LPA) rules take effect from 01.10.07. For the latest BMA Guidance for Health Professionals please contact the LMC office or look on the Norfolk LMC website. The GPC is arranging a meeting with the Court of Protection to discuss fees.

**Hoveton & Wroxham Medical Practice**  
**Salaried GP**

We are looking for a salaried GP to work 4 sessions per week from 20.08.07. Ideally this would involve 2 sessions each Monday with 1 session each Tuesday with the remaining session any other day including a second session on Tuesday

- ▶ You would be joining a friendly clinical team of 6 doctors and 4 nurses with a strong administrative backup team achieving high QOF points each year
- ▶ Dispensing practice in modern, purpose-built, premises
- ▶ Already a training practice for Registrars we shall be teaching 4th year medical students in September. It is therefore important to us that the successful applicant is available during term-times
- ▶ Practice list size 8300
- ▶ Fully computersied iSoFT Premiere medical system
- ▶ 6 week holiday pro-rata

*Informal visits or enquiries are most welcome.*  
Applications by CV to Mike Hammond, PM, Stalham Road, Hoveton, NR12 8DU  
or 01603 777907 or [mike.hammond@nhs.net](mailto:mike.hammond@nhs.net)

I am a fully qualified GP looking for a "one session" surgery in the Lowestoft Area. Available Mondays, Tuesday or Friday mornings. Dr Maik Juergens, 01502 519020 or [maike@juergens.fsnet.co.uk](mailto:maike@juergens.fsnet.co.uk)

**Great Yarmouth**  
**Salaried GP - 6 sessions per week**

An opportunity for an enthusiastic GP to join our practice team from the end of July/early August 2007.

- PMS
- 12500+ patients across two sites
- 8 GPs (6.25 wte)
- Full nursing support (3 NPs, 3 PNs, 2 HCAs)
- Full administrative support
- EMIS LV -paperlight
- High QOF points
- No OOH commitment
- Teaching Practice (GPRs & F2s)

Informal visits and enquiries welcome. Please send your CV and references to Gary Smith, PM, Newtown Surgery, 147 Lawn Avenue, Gt Yarmouth, NR30 1QP. Tel: 0844 844 0160, email newtown.surgery@nhs.net and web newtownsurgery.info

## Annual Conference of LMCs 2007 - Report

The Conference got off the ground with the usual well-received and rousing speech by the GPC Chairman, Hamish Meldrum. He spoke about the difficult year since the last conference, the zero percent pay award, the involvement of the DDRB against the wishes of the government and the hope that in future years this will lead to proper consideration of GPs' pay. Also the £11m wasted on the Patient Experience Survey to confirm what everybody knows, that patients have an enormously high opinion of general practice and would like even more contact with us and our staff. The most laugh-out-loud moment of the Chairman's speech was his assessment of the sense of anticlimax we all feel with practice based commissioning, as if one had got tickets for a celebrity party and only Jade Goodey was there. There was a message for the new Prime Minister that it would be in the interests of doctors, patients, the NHS and the government, for him to ensure that proper negotiations restart with GPs.

A theme that emerged strongly in the Chairman's speech, which at first I was a little surprised by, was that GPs should seriously consider going back towards offering more partnerships and less salaried positions. This theme came through from GPs, Registrars and even the first Medical Student to speak at this Conference. The message was that we are leading to a self-fulfilling prophecy by, for whatever reason, offering more and more salaried positions, either because we think this is what doctors coming into general practice want or because there is an idea of concentrating "power" in the hands of those of us fortunate enough to be in partnership at the moment. While it is clearly the case that many doctors wish to spend some time as salaried, apparently the mood has shifted and many more now wish to become partners than formerly. If we want to preserve the independent contractor status and not turn the next generation of GPs into doctors who only feel comfortable getting a salary - and who then might perhaps be more amenable to getting that salary from some large (maybe private) organisation - then we should take action now and get advertising for new partners to fill vacancies.

A big issue on the first day was the failure of the air conditioning system. The hall is subterranean, lacking in natural light and has plenty of hot air from the speakers, so air conditioning is essential. An emergency motion failed to halt the conference because, even though representatives agreed that the climate was not conducive to good health, the only result would have been that important business would not have been transacted. Fortunately, on day two the system started working again. I was slightly disappointed that the teams of "thank-yous" at the end of the conference (to those who had contributed to it) did not include those who had clearly laboured on the system overnight. You never know when the BMA might need a favour from the Air Conditioners & Heat Exchangers Union.

Possibly because of the excessive heat and the resulting torpor in my opinion the first day never really got off the ground as an exciting event. Nevertheless, for the first time in living memory, the motion of "no confidence" in the government's handling of the NHS and in the Secretary of State for Health, was not only debated but also voted on. Normally it is considered too politically risky to pass this motion however much everyone wants to, so there are usually calls for "next business" towards the end of the (usually tendentious and often hilarious) debate. On this occasion I guess it was felt that wholesale changes in the NHS Ministerial Team are inevitable with the new Prime Minister so it would be a relatively risk-free statement of the intensity of GPs' feelings. Time will tell whether it has achieved anything and, if so, whether to good or bad effect.

On the first day most humour was terribly forced, with irrelevant puns that wouldn't be funny anyway and an ongoing, and somewhat unedifying, sequence which seemed to have something to do with the fact that the Chairman of Conference (of the female persuasion) made an early allusion to inspecting the male toilets to check that they were "wholesome".

One of the actual motions that was amusing in itself was the following from Cambridgeshire which deserves to be quoted in full.

*That Conference believes that "Choice" is to the Department of Health what the Loch Ness Monster is to Scotland because:*

- (a) *it is a wonderfully romantic idea and creates the possibility of great publicity*
- (b) *there are opportunities to go and look for it and even some who believe they have experienced it first hand*
- (c) *fundamentally, no one in their right mind believes it exists*

A number of Scottish GPs, mindful of the revenue that the tourist industry provides, opposed the third part.

Over the years, fewer and fewer outlandish, or just downright weird, motions appear. Whilst this has the benefit that all the main issues are, at least, aired and the democratic process is seen to be followed, by and large there is little disagreement as to an audience of GPs the right answer is usually self-evident. Nevertheless people want to speak and Conference saw two newish ploys to improve speakers' prospects. There was a rash of "emergency speaker slips": this is a peculiarly purple card which is waved to attract the Chairman's attention to allow a response to a point made earlier in the same debate on which the (emergency) speaker might have additional information. Some naughty people tried to use these as a way of giving the speech which they had wanted to do anyway; generally when this happened it was far from clear why they had thought Conference might want to hear their contribution. The other method of trying to increase the likelihood of being called was to suggest on the speaker slip that one has specialist knowledge of the matter in question in that particular debate. I remember one of the Scottish GPs tried this with the Loch Ness Monster motion debate though, sadly they themselves had not witnessed Nessie and indeed I cannot actually remember what specialist knowledge they claimed. This must have been one of the times that I was unconscious from the heat.

After lunch on the first day the Norfolk representatives thought it was extremely disappointing that a motion from Cleveland trying to do something about the surprising number of representatives who leave sessions early and return late, such that the Conference is sometimes unable to transact business due to being inquorate, was withdrawn. This is a problem every year and your representatives feel quite strongly that that is not appropriate behaviour. As the motion had been withdrawn we didn't get a chance to be pious this year. We have found out that it was withdrawn on a technical issue - something about using the term "members of conference" when it should have said "representatives of LMCs" - so it should reappear next year - if Cleveland have gone off it then may be it can go from Norfolk.

One of the more disturbing images of conference was in a motion on the zero percent increase in pay and the DDRB. The DDRB has historically been a friend to GP income and may well be again in the future. Members were reminded by one speaker of Michael Parkinson's encounter with Emu when Mr Parkinson made the mistake of attacking Emu rather than the \*\*\*\*\* with his hand up Emu's a\*\*\*\*. Quite what parallel the speaker was trying to draw in the relationship between the DoH and the DDRB I shudder to think, though I am pretty sure that it is not sustainable - the DDRB was certainly not doing what the government would have wanted when it agreed to consider GPs pay.

There are a number of sessions throughout Conference that are not straight business. These are either a blessing if you are interested in the particular issue related to that session or if you are happy to use them as a toilet break or to go and look at the stands, but which may be considered something of an irrelevance for those who believe that better debate on more of the important issues would be good. I do just wonder if there is a better way of organising these slots, which include reports from the individual GPCs of Wales, Scotland and Northern Ireland, reports from Medical Charities, a debate in a rather different format than the usual (this year on the Regulation and Revalidation White Paper - which many thought that was the profession's most important current issue) and a "soapbox" session during which a number of representatives get

stuff of their chests. The best by far was on waste and trying to make the Conference greener and, by inference, General Practice greener.

On the matter of Regulation and Revalidation many concerns were expressed about the potential power that a PCT Medical Director might have and whether they would be able to be “neutral” about colleagues or whether they would inevitably have some preconceived notions about colleagues. In addition it was felt they would find it very difficult for the Medical Director to be “immune from” PCT policy, for example having a different burden of proof for single-handed practitioners if the PCT had a policy of wishing to close down such practices.

There was an interesting debate on the standard of proof required with performance issues with there seeming to be irreconcilable differences between those who believe that a judgement which could deprive a practitioner of his/her professional status and livelihood must be the so-called criminal standard, ie “beyond reasonable doubt”, rather than the so-called civil standard of “by the balance of probability”. You may be surprised that anybody at an LMC Conference would feel that there could be merit in the latter but doctors who work with colleagues who may be performing less well know that it can be the case that an accumulation of evidence suggests risk to patients and a practitioner in difficulty, rather than a single incident which is sufficiently well-evidenced to allow a decision “beyond reasonable doubt”. My understanding is that the GMC believes there would be a sliding scale of judgement so the issue is not entirely black and white.

The second day was a little more lively, possibly due to the mix of debates, possibly due to the air conditioning now working. The first session was questions to the Negotiating Team. There wasn't anything really new there although the regular pensions item was, as ever, my favourite bit of Conference both because Andrew Dearden is one of the best speakers and because it is a subject close to my heart.

I liked the statement in a Practice Based Commissioning debate that most PBC schemes have become “PCT controlled debt management schemes with varying degrees of GP involvement”. Spot on.

A representative managed a genuinely funny speech on prescribing, talking about how they had been advised to change cimetidine to ranitidine to nizatidine to omeprazole to lansoprazole and back to omeprazole and then back to lansoprazole. “No wonder I ended up with an ulcer” was the punch-line. An interesting issue was raised about whether increasing the rate of generics used leads to higher cost branded medication in this country (compared with elsewhere) as drug companies do what they have to maintain their profits and (maybe) maintaining their R&D budgets.

Another point of interest was a Glasgow motion that overseas visitors' eligibility to access to free NHS care should not be determined at the GP Reception Desk.

Norfolk's motion requesting an updating of the rules on certification was bracketed with a Sheffield Motion which was slightly amended by a tortuous process (which would only be of interest to people who really should get a life). This motion was carried, so hopefully there will be some central action on this issue as certification rules are getting somewhat archaic.

There were a number of discussions on “the formula” and the global sum - in effect whether it is ever going to be possible to reconcile practice income and the things that cause practices' work to differ. A speaker divided patients up into five categories, the unworried well, the unworried ill, the worried well, the worried ill, and the dead. Each of these groups causes different types and quantities of work. All practices have differing mixtures of the five groups. Can even the most subtle of formulas cope with this?

Two more laugh out loud moments enlivened the Conference in its last session. A representative who insisted in shouting at and into the microphone at ear splitting intensity, possibly the worse for wear after his lunch or possibly just very sure that he was right, getting the inevitable call from the back of the room to “speak up”; also the speaker who spoke about the way the government is trying to renege on various aspects of the new contract by explaining that he bought a new car at the same time as the new contract came in but the car manufacturers are not now requesting more money or trying to repossess the fog lights. He simply wanted the government to be as open and honest as car salesmen!

Something I wish I had not heard was a statement by Stuart Drage (as chair of the appropriate Committee) commenting on the “referral management” debate that GPs retain responsibility until their patient is

seen by an appropriate clinician - so all the time the patient is being passed around either through referral management centres or failed C&B the GP retains responsibility.

The final point of note was the recognition that the BMA website site is c\*\*p and needs reviewing - which I am sure a lot of you (and your managers) would agree with!

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LMC Secretary

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