ESTRANGED PARENTS

EMPLEYMENT TRIBUNAL

CHANGES TO RCN PRACTICE NURSE INDEMNITY
Welcome to the latest issue of inpractice, the journal for MDU practice manager members.

In October 2011 the Royal College of Nursing (RCN) revealed it was making changes to its indemnity scheme from January 2012 which will affect its members employed in general practice. Following the announcement, the MDU received many calls from concerned GPs, practice managers and practice nurses asking how the change would affect their indemnity. Nick Dungay, MDU director of marketing and sales, explains the implications of the RCN’s move on page 5.

Delays in diagnosis have always been the most common cause of complaint against GPs but an MDU review of general practice complaints shows that they are almost as likely to concern non-clinical matters. Read more in the causes for complaint article on page 7.

Increasingly, practices can find themselves drawn into bitter disputes between separated parents of children. In this issue we look at the medico-legal challenges for the practice, and provide advice on how to deal with a request for information about a child from an estranged parent.

Dealing with a claim against your practice to the Employment Tribunal can be a stressful and costly experience. On page 12 Maria Farnell, case preparation manager, Peninsula Business Services, provides guidance to assist practices who find themselves in this situation.

Also in this issue are articles on the dangers of self-prescribing, the use of email, and advice on how to avoid cases of mistaken identity.

I hope all this makes for an interesting read. Please do not hesitate to contact the MDU advisory helpline if you would like to learn more about any of the issues raised in this edition, or would like to discuss a particular scenario in more detail.

Finally, we welcome your feedback on the new design of the journal. If you have any comments please write to us at the address below, or give us your feedback at the-mdu.com/feedback.

Dr Beverley Ward
Medical editor and MDU medico-legal adviser
GROUPCARE, the MDU group scheme, offers a wealth of benefits for GP practices. GROUPCARE is open to all practices with at least two eligible GPs who are MDU members. And the more MDU GP members you have in the practice, the more benefits you can enjoy.

If you are not already a member, or have a group scheme in place, take a look at how you can multiply your benefits by setting up a GROUPCARE scheme. It is completely free to set up.

For more information about GROUPCARE benefits or how to set up a scheme visit the-mdu.com/groupcare or contact the GROUPCARE team on 0800 012 1318.
What happens when you send an email to someone@gp-a12345.nhs.uk and you should have sent it to someone@gp-a13245.nhs.uk? If the email contains patient information, the result may be a serious breach of confidentiality.

When you are busy, it’s very easy to mistype an email address, or click on the wrong address in your contacts list, especially when people’s addresses are almost identical. The MDU has heard of cases where sensitive patient information has been sent in error to practices at opposite ends of the country.

Particular care should also be taken when forwarding practice emails to personal accounts.

The NHS Connecting for Health stresses that NHSmail is the “only NHS email service secure enough for the transmission of confidential patient information”. More information about NHSmail can be found on the Connecting for Health website.

MDU members are advised to seek specialist IT advice about ensuring the security of email systems. All breaches of patient confidentiality should be reported to your organisation’s data controller.

GPs applying to register with the Care Quality Commission (CQC) will not require a CQC-countersigned enhanced Criminal Records Bureau (CRB) check.

As with GP out-of-hours providers, who must be registered by April 2012, GPs applying to provide or manage primary care services must provide a valid GMC registration number.

These arrangements will apply to primary care services between 2012 and end of March 2013. Further guidance will be published by the CQC shortly.
Changes to RCN practice nurse indemnity

The RCN wrote to its members\(^1\) to say that from 1 January 2012, indemnity cover for work undertaken by a nurse as part of their employment in general practice will be provided by the employer. The costs of any clinical negligence action will fall on the employer and his/her indemnity provider, not on the RCN scheme.

Following the announcement, the MDU received many calls from concerned GPs, practice managers and practice nurses asking how the change would affect their indemnity, and whether they would need to pay more to ensure they are covered.

In making this change, the RCN says that practice nurses’ indemnity cover should always be provided through an employer’s indemnity policy under the principle of ‘vicarious liability’.

This principle is that an employer is liable for the acts and omissions of staff during the course of their employment. In the event of a claim for compensation involving a practice nurse, it is the employer who is exposed to the financial risk – both the legal costs and patient compensation.

Vicarious liability is nothing new and the insurance policy\(^2\) that the MDU provides to its GP members specifically accommodates such claims. An MDU member can already seek assistance if a claim is brought against them as the employer of one of their directly-

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References


* Please note: most NHS GP out-of-hours providers are still required to register by April 2012.

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**GP practices to register for CQC online**

The Care Quality Commission (CQC) recently sent an introduction to the registration process to all primary care providers\(^1\) in which it announced that registration will be online and that GPs will not be required to demonstrate compliance before they can register. The news will no doubt be welcomed by GP practices as the April 2013 deadline for registration approaches\(^*\).

The document confirmed that GPs will not be required to submit evidence to show they comply with CQC standards at the registration stage. In most cases, practices will be allowed to register under transitional arrangements. The CQC states:

“Primary medical services that don’t meet all the standards on 1 April 2013 will still be able to register with us. However, you will need to tell us when you will be compliant and how you are managing any associated risks.

We would only use our power to refuse registration in the most serious of circumstances, and following registration, to close a service down. This would only be in the most extreme cases of risk to patient safety and we would need to take into account the effect on the people who use the services if they were not available.”

The MDU is one of a number of doctors’ organisations advising the CQC in the interests of our members. We will, of course, be producing guidance for MDU members on CQC registration and are always happy to advise members with any specific concerns.

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**In October 2011, the Royal College of Nursing (RCN) revealed it was changing its indemnity scheme from January 2012. The changes will affect RCN members employed in general practice. Here, Nick Dungay, MDU director of marketing and sales, explains the implications of the RCN’s move.**
employed staff, as long as the staff member was acting in the proper course of their employment, and the claim relates to the clinical management of a patient in normal practice/surgery conditions.

**What does the change mean for practice nurses?**

For GPs and nurses who are individual MDU members, nothing has changed following the RCN announcement. However, there may be implications for practice nurses who are currently indemnified by the RCN.

This is because the role of the practice nurse is changing. As nurses and nurse practitioners take on more responsibilities, they become more accountable.

Employed nurses could choose to rely on the indemnity provided under their employers’ vicarious liability in the hope that a claim or complaint is made against the employer. However, many may be concerned that as professionals in their own right a claim or complaint may be brought directly against them in person, and so decide they need to join a medical defence organisation for their own peace of mind. Indeed, the Nursing and Midwifery Council (NMC) recommends that registered nurses have professional indemnity insurance.

For nurses working within GP practices with an MDU GROUPCARE scheme, the cost of their membership may either be free or discounted. For nurse practitioners and nurses in an extended role, the MDU is able to provide personal membership including a professional indemnity insurance policy. Where a GROUPCARE scheme is in place, membership for nurse practitioners and nurses in an extended role is provided at a discounted rate.

**The MDU’s GROUPCARE scheme remains free to all practices with at least two eligible\(^3\) GPs who are current MDU members. Practice managers can find out more on our website, by emailing groupcare@the-mdu.com or by calling 0800 012 1318.

Visit the-mdu.com/groupcare to view the MDU’s RCN and practice nurse indemnity member Q&As.

Members with additional queries are welcome to contact us directly on the freephone membership helpline: 0800 716 376.

**References**

2. Subject to the terms and conditions of the policy underwritten by SCOR UK Company Limited and International Insurance Company of Hannover Limited.
3. Excludes GP locums, GPSTs and trust indemnified GPs.

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**Definition of a Nurse Practitioner**

A nurse practitioner or nurse with an extended role is distinguished from a practice nurse by the MDU if the nurse does one or more of the following tasks without a doctor being present:

- Prescribes from the independent nurse prescribers list
- Assesses and decides on the treatment of patients, other than as part of a chronic disease clinic
- Undertakes surgical or practical procedures not normally undertaken by nurses
- Conducts antenatal or postnatal examinations\(^*\)
- Undertakes any other tasks not normally performed by a practice nurse.

\(^*\)Indemnity for all types of antenatal care will require the specific approval of the MDU and may not always be agreed.
Causes for complaint

Delays in diagnosis have always been the most common cause of complaint against GPs but an MDU review of general practice complaints shows that they are almost as likely to concern non-clinical matters such as practice telephone systems and removal from lists. Fortunately, practice managers are usually able to play a key role in resolving complaints locally and, as we explain here, they are also in a great position to reduce the likelihood of a complaint about a non-clinical matter.

In the context of over 300 million consultations that are estimated to take place each year in England alone, the number of complaints is really very small. Between April 2009 and April 2010, the MDU opened just 2,410 GP practice complaints files, the vast majority of which were resolved locally by the practice.

The files also highlighted several issues of particular interest to practice managers.

More than 382 complaints came from a third party such as a relative, carer or friend, rather than the patient. It is always important to check with the patient that a third party has the necessary authority to lodge a complaint on their behalf. If the patient lacks capacity, the complainant must be able to demonstrate sufficient interest in their welfare and be an appropriate person to act for them. Do check with the MDU if you are unsure.

Practice telephone services prompted 62 complaints, often because patients said the line was constantly engaged, calls were rarely answered, or the caller was put on hold for a long time. Patients also complained about perceived rudeness on the telephone, and there were a handful of complaints about breaches of confidentiality. To help avoid such problems, it is a good idea to consider a practice telephone policy which includes double-checking the identity of callers; dealing with urgent calls; ensuring calls are documented; and the use of nurse triage/telephone surgeries.

Removing patients from the practice list was one of the most common complaints to feature in cases which were referred to the Ombudsman (the second stage of the NHS complaints procedure). While it may seem tempting, when staff feel at the end of their tether with apparently ‘difficult’ patients, removing them from the list raises tensions and often causes more problems than it solves.

Bear in mind too that patients should not be removed from the list simply because they have made a complaint. Removal should only be considered in exceptional circumstances after other options have been explored, including warning the patient about their behaviour. It’s always worth contacting the MDU for individual advice before taking this step.

The good news is that more than 90% of the complaints files opened during this period appear to have been resolved locally, which is a credit to practice managers who often take a lead in managing complaints. Of course, it is never pleasant to discover that a patient is dissatisfied with an aspect of your service but with prompt investigation and a professional response, a complaint does not have to result in ill feeling.

If further help is needed, our practice manager members can find it at the end of the MDU advice line. Members who have a specific query relating to a complaint can contact the 24-hour freephone advisory helpline on 0800 716 646.

References
Before becoming GPLMs with the MDU, Chris worked for our dental division, the DDU, and Vanessa worked for a company selling diagnostic equipment to GP practices and PCTs. Both feel their previous roles have allowed them to hit the ground running quickly.

Vanessa explains: “It means I’m very familiar with the sector and I have plenty of experience in talking to GPs and understanding their concerns.”

Chris, meanwhile, provided support to dental students and recently qualified dentists. He sees the GPLM role as an opportunity to “establish long-term relationships with our GP practice members, including practice managers, and going the extra mile to deliver what they need.”

Both Chris and Vanessa spend much of their time working with practices in the MDU’s GROUPCARE scheme which is free to all practices with at least two eligible GPs who are current MDU members. Three levels of GROUPCARE membership (STANDARD, PLUS and PREMIUM) are available, depending on the size of the practice and number of GPs that belong to the MDU.

Delivering the training seminars is where Chris and Vanessa believe they really make a difference. There are 13 topics in all, covering most of the tricky situations that practice staff and GPs might come across, including handling complaints, breaking bad news and learning from events.

Vanessa describes the impact they can have: “The seminars seem to really unite staff as they give everyone a comfortable forum in which to share their experiences of a particular problem which may usually be difficult to discuss. For example, one of the seminars I deliver is about dealing with difficult patients and this often prompts people to talk about their own experience of a violent incident and benefit from the sympathy, support and advice of their colleagues.”

Delivering practice seminars, carrying out risk assessments to GROUPCARE PREMIUM schemes and helping practices with all their queries about MDU membership means being a GPLM is not for the faint-hearted. As Chris points out: “It requires enthusiasm, energy and expertise in the issues that most concern GP practices.”

1 Excludes GP locums, GPSTs and trust indemnified GPs.
Practice Team category winner, the South Holderness Medical Practice was voted overall winner by readers of GP magazine and received a cheque for £4,000 at the RCGP Annual General Meeting in November 2011.

Dr David Fitzsimons and Dr Robert Blackbourn from the practice in Withernsea, East Yorkshire, were honoured for their one-stop approach to reviewing patients with more than one long-term condition. The approach brings together GPs, nurses, pharmacists and the patients to improve the quality and efficiency of care.

Before a patient’s annual review with the nurse, a GP reviews the current management of the patient’s conditions and the pharmacist checks the record for missing or inappropriate prescribing. The patient also completes a health needs assessment questionnaire.

During a single nurse appointment all the patient’s long-term conditions are reviewed and any suggestions from the GP or pharmacist are discussed. This information is then recorded on the computer system using surgery-designed templates, and an agreed personalised care plan for each condition is printed out for the patient to keep in a special folder with all of their health-related information. Appropriate referrals are also made.

More than 1,000 patients with several long-term conditions have undergone a combined health check in the past year alone.

The local PCT is rolling out aspects of the scheme to other practices. The next step for South Holderness is to expand the concept to patients with single long-term conditions.

Find out how the practice organised the clinic, and read about all the other innovative winners in the GP Enterprise Awards at www.gponline.com/awards

Does your practice have an innovative idea or scheme that deserves wider recognition? If the answer is yes, the GP Enterprise Awards want to hear from you and so does the rest of the profession.

This year’s categories include: Outstanding Practice Team; Innovative Clinical Care, Caring for Vulnerable Groups; Best use of Media and Technology; Improving Quality and Productivity; and the RCGP First 5 Award.

Once again, the readers of GP magazine will also be invited to vote for an overall winner from the successful entrants in the six categories for the MDU Enterprise Award.

What you could win
Each of the category winners will receive £1,000. The overall winner will also be presented with a cheque for £4,000. All winning entrants will be interviewed for publication in GP magazine and appear in GP’s online database of simple guides for improving general practice.

How to enter
For more information on the awards and how to enter go to www.gponline.com/awards or email GPawards@haymarket.com

GP magazine has extended the closing date for submitting entries to 5 March 2012. All entries will be acknowledged by email and winners notified in June 2012.

Full terms and conditions are available at www.gponline.com/awards

The GP Enterprise Awards are presented annually by the RCGP and GP magazine, and proudly sponsored by the MDU. The aim is to celebrate innovation in general practice and promote ideas that can be easily adopted by other practices.
With ever-increasing divorce rates, it’s probably not surprising that one of the common queries the MDU receives from practice managers concerns requests from estranged parents for disclosure of medical records or information regarding a child. This needs to be handled sensitively and correctly in order to avoid a complaint from either the estranged parent (as a result of not disclosing) or the parent who has custody of the child (as a result of disclosing).

When you receive such a request, these are the factors to take into account when deciding how best to respond.

Who has parental responsibility?
The first thing to consider is whether the person requesting the information has parental responsibility. Parental responsibility is defined in the Children Act 1989.

Mothers and married fathers automatically have parental responsibility, unless this has been removed by the court.

Unmarried fathers whose children were born before these dates, or afterwards if they are not named on the child’s birth certificate, do not automatically have parental responsibility. However, they can acquire parental responsibility by obtaining a Parental Responsibility Agreement from the child’s mother or a Parental Responsibility Order from the court. Step-parents and civil partners can also acquire parental responsibility in the same way. Of crucial importance is the fact that parents do not lose parental responsibility if they divorce, although it can be restricted by the court. If a child is adopted, the birth parents will lose parental responsibility for their child. Representatives of the local authority may also be granted parental responsibility if a child is taken into local authority care, and so may a child’s testamentary guardian, special guardian or individual given a residence order.

Does the child have capacity to consent?
Anyone with parental responsibility has a right to seek access to their child’s medical records under the Data Protection Act 1998. However, GMC ethical guidance in this matter also applies. In 0-18 years: guidance for doctors (2007), the GMC explains that doctors should take into account the views of the child if the child has the capacity to be involved in such decisions.

A child or young person who has capacity has the legal right to access their own health records and can allow or prevent others, including their parents, to access their records³. When assessing capacity of a young person, a doctor must ensure that they understand the nature, purpose and possible consequences of what is proposed, as well as the consequences of refusal. In order to have capacity to make a specific decision, they must be able to understand, retain, use and weigh the information they are given, and communicate their decision. This will depend more on the young person’s ability to understand and weigh up options than on age. It should be remembered that at 16 a young person can be presumed to have capacity to consent, and below this age, they may have capacity depending on their maturity.

In Scotland, a child over 12 years old is presumed to have such capacity, although he or she could achieve capacity sooner or later than this.

What are the child’s best interests?
GMC guidance explains that you may allow a person with parental responsibility to access the child’s medical records if the child or young...
person consents, or if he or she lacks capacity and it is in the child's best interests. It states: "If the records contain information given by the child or young person in confidence you should not normally disclose the information without their consent".

The consent of the other parent is not required and there is no obligation to inform the other parent of the request for disclosure. However, it may be wise to ensure that the other parent is aware of the request for information so that you can take into account any objection that they may make, and the reasons for it.

Practice managers often ask whether they need to see proof that the person requesting the information has parental responsibility. If you feel there is any doubt that the individual has parental responsibility, then you can ask to see a copy of the birth and/or marriage certificate, relevant court order or agreement, or a letter from the individual’s solicitor confirming this. However, bear in mind that it is possible that parental responsibility could have been removed after the date of these documents.

Other factors
Other factors to consider are whether there is any third party information within the records. If there is, you will need to obtain consent from the third party to disclose this, unless the relevant information can be anonymised or appropriately redacted. The doctor responsible for the patient should check the records for third party information and remove any information that could pose a significant risk of harm to the child or a third party.

The decision whether to disclose or not is a complex one and it is advisable to involve the patient’s GP so that you can make a full assessment of the situation in line with GMC guidance.

References
2. Ibid. Para 53.
3. Ibid. Para 54.
A member of staff has been dismissed from your practice following a disciplinary hearing. You might have hoped that their departure allows things to get back to normal, but shortly afterwards you receive notification from the Employment Tribunals Service that your former employee has made a claim for unfair dismissal.

It’s a heart-sink moment for many employers and managers, particularly as the person making the claim was once a trusted member of staff, but you are not alone. Between 2008/9 and 2010/11, Employment Tribunals saw a 44% increase in claims. During 2010/11, 122,800 cases were dealt with. This was 33% more than in 2008/9. Among the most common claims were alleged breaches of the Working Time Directive, allegations of unfair dismissal and breach of contract.

Often, the first you will know about a claim is when you receive an ET1 form. It is important not to delay in responding to it. Employers (respondents) have 28 days in which to respond to the claims raised by the claimant, either in writing or online. The response is formally known as an ET3 and you will need to explain, among other things, whether you are resisting the claim and your grounds for doing so, and the procedures followed before the claimant was dismissed.

If you find you are unable to respond in time, it is possible to apply for an extension. However, the application must be presented to the Employment Tribunal Office within the 28-day time-limit, explaining why you cannot comply with the time-limit. It is then up to the Employment Judge to decide whether this explanation is reasonable and whether to grant the extension.

Failure to provide all the requested information within the deadline and on the correct form can have serious repercussions. The Employment Judge may decide to issue a default judgment without you being able to play any part in the proceedings. A default notice may determine liability only or it may also quantify the remedy the claimant is entitled to. An employer’s only option at this point is to apply for a review of the decision. A review hearing may then be heard and if the employer is successful, the matter can then proceed to a full hearing.

If the ET3 form is accepted, the claim then proceeds to the case management stage in which documents are exchanged and the date and length of the full hearing is listed. However, the current practice is to list the case and set out the information required when notifying the employer of a claim, to avoid the need for a case management hearing.

If a case management hearing is held, the claimant and respondent will usually agree when to exchange documents and witness statements. The Tribunal can also order either side to provide further information if necessary. As an employer, failure to comply with such an order can result in the Tribunal awarding costs against you, striking out whole or part of the response and where appropriate debarring you from responding to the claim altogether.

Employment Tribunals also routinely send the employer’s response to the Advisory Conciliation and Arbitration Service (Acas) which means an Acas conciliator may well contact you to see whether the case can be settled without the need for a hearing.
If the case does reach a hearing, this will usually be heard by an Employment Judge sitting alone, although some more complex cases will be heard by a full tribunal. Hearings are usually open to the public and generally last about an hour, during which the claimant, employer and their respective witnesses will give evidence under oath and answer questions, both under cross-examination and from the Employment Judge. At the end, the judgment and the reasons for it will be announced and a copy will be provided to both sides on the day or shortly afterwards.

If the claimant is successful, the Employment Tribunal can order you to pay them compensation. This can be unlimited in certain cases such as successful claims for discrimination but it generally consists of a basic award, based on the claimant’s age, length of service and pay, and compensation including loss of earnings up to a set limit reviewed each year. In addition, if you are ordered to re-employ the claimant and you “fail unreasonably to do so”, a further award can be made against you. In general, both sides pay their own costs but the Tribunal can order one side to pay costs to the other if, for example, one side is thought to have behaved unreasonably.

Both sides can apply for the Tribunal judgment to be reviewed within 14 days of the date on which the judgment was sent. This can be done for specific reasons, such as that new evidence has become available since the hearing which could not reasonably have been known at the time. It is also possible to appeal the judgment of the Tribunal on the grounds that the Tribunal has made an error in applying the law or ‘that the judgment was one which no reasonable tribunal could have reached’. This must be done within 42 days of the date on which the judgment was sent. Further information about reviews and appeals is available from the Tribunals Service at www.justice.gov.uk/guidance/courts-and-tribunals/tribunals/employment/claims/booklets.htm

There are some practical steps that practices can take to help avoid a successful claim by a former employee. These include:

- Check that disciplinary and grievance procedures for practice staff comply with current employment legislation. Acas has produced a code of practice on disciplinary and grievance procedures for practice staff comply with current employment legislation. Acas has produced a code of practice on discipline and grievance procedures and employment tribunals will take this into account when considering cases www.acas.org.uk
- Ensure that staff who deal with employee matters are fully trained in the practice’s disciplinary and grievance procedures. It is also essential that they understand employment law as it applies to the practice.
- Keep a record of emails, letters, minutes of meetings, statements and any other material which may be needed to substantiate the practice’s decisions at a later date.
- Always seek to resolve disciplinary and grievance problems promptly in the workplace or consider using a mediator to help resolve disputes.
- If you receive a claim (ET1 form), seek legal advice straight away. Practice managers, as well as employing GPs and other partners in GROUPCARE practices can call the employment law advice line on 0844 892 2772, quoting your individual MDU membership number, GROUPCARE number and Peninsula authorisation code MDU001.

References

A case of mistaken identity

Mixing up patients with similar names is not unknown in general practice, but the repercussions – for the patient and the practice – can be serious. Here, MDU medico-legal adviser Dr Sally Old explains how to avoid cases of mistaken identity.

Imagine the scene. It is a busy Monday morning at your practice and there is a buzz of activity in the reception area. Your new receptionist is taking incoming phone calls from patients requesting appointments. There are people queuing to speak to her and the waiting room is filling up quickly.

The receptionist takes a call from a patient and looks up his name – James Grey – on the practice computer system. She books him an appointment with one of your GPs later that afternoon to deal with his back pain.

A week later you receive a complaint at the practice. The patient complains that he was prescribed tramadol for his pain when he saw the GP on the Monday and yet this was contraindicated as he was already taking warfarin. The patient’s letter explains that he was admitted to hospital following a bleed and his INR was found to be very high. He wants to know why the GP did not take into account his other medications when prescribing the painkillers.

As you investigate the complaint it becomes clear to you that the patient who has made the complaint is actually called James Bray and he had been mistakenly booked in under the name of James Grey.

This meant that when the doctor saw Mr Bray, he had Mr Grey’s clinical records up on screen. The doctor was not therefore aware of his patient’s past medical history of pulmonary embolism and warfarin therapy, and would not have realised that there was any potential problem for the patient in taking tramadol.

Use identifiers

This is a fictional example, but it is easy to see how two patients with similar sounding names could become mixed up in this way. It is possible to envisage situations where the problem could be even more difficult, for example with father and son having the same name and living at the same address.

Bear in mind that names that sound similar may not look alike when written down and so the potential for mistakes may not be immediately apparent when searching alphabetically through records. The more identifiers you can use, the less likely it is that an error will be made.

It is important that all staff understand the need to ensure that they have identified the patient correctly at every significant step in their interactions with the surgery. The NHS number serves as a unique identifier in the NHS but not many patients will know it or have it to hand.

An alternative might be to ask patients to give you their date of birth and the first line of their address as well as their full name. By asking the patient to give these details to you, rather than simply asking the patient to confirm information you tell them, you can reduce the risk that a patient might mistakenly agree with the incorrect details, for example because they are distracted by a small child wanting attention or because they are hard of hearing.
Supporting your business

We tailor our corporate solution to fit your business rather than the other way around. Understanding your needs and those of your organisation is at the heart of the way we work. Our solutions continually evolve to meet the ever changing needs of your business and the healthcare market.

For more information visit the-mdu.com/corporate or call the freephone membership helpline on 0800 716 376.

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Your feedback
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the-mdu.com/feedback

GP liaison managers
Paul Archer - team manager
archerp@the-mdu.com
Carolyn Barrett - North Thames
barrett@the-mdu.com
Vanessa Jack - South Thames
jackv@the-mdu.com
Mel Davies - South Wales
daviesm@the-mdu.com
David Ireland - South West
ireland@the-mdu.com
Samantha O'Gram - North East
ograms@the-mdu.com
Chris Hall - North West
hallc@the-mdu.com
Gina Wade - Anglia & Oxford
wadeg@the-mdu.com
Donald Worthy - West Midlands
worthyd@the-mdu.com
Nasir Ahmed - East Midlands
ahmedn@the-mdu.com

UK
24-hour freephone advisory helpline
0800 716 646

freephone membership helpline
0800 716 376
calling from mobile or overseas
+44 (0)20 7022 2210

freephone GROUPCARE helpline
0800 012 1318
calling from mobile or overseas
+44 (0)20 7022 2211

advisory email
advisory@the-mdu.com

membership email
membership@the-mdu.com

GROUPCARE email
groupcare@the-mdu.com

website
the-mdu.com