
Healthcare Improvement Scotland
DCRS
Death Certification Review Service
Discussing Complaints in Medical Appraisal
Wednesday 02 September 2026
Dr C George M Fernie
Senior Medical Reviewer and Caldicott Guardian, Healthcare Improvement Scotland
Appraisal Lead Public Services Delivery Scotland and Partner Organisations
Chair UK Caldicott Guardian Council
Chair NHS Scotland Public Benefit and Privacy Panel for Health and Social Care
Visiting Professor Centre for Contemporary Coronial Law, The University of Greater Manchester
george.fernie2@nhs.scot
NHS SCOTLAND

1


Healthcare Improvement Scotland
DCRS
Death Certification Review Service
Discussing Complaints in Medical Appraisal
Wednesday 02 September 2026
Dr C George M Fernie
Senior Medical Reviewer and Caldicott Guardian, Healthcare Improvement Scotland
Appraisal Lead Public Services Delivery Scotland and Partner Organisations
Chair UK Caldicott Guardian Council
Chair NHS Scotland Public Benefit and Privacy Panel for Health and Social Care
Visiting Professor Centre for Contemporary Coronial Law, The University of Greater Manchester
george.fernie2@nhs.scot
NHS SCOTLAND

2

Introduction

Arrangements for death certification and registration in Scotland changed in 2015

One of the main changes was the establishment of the Death Certification Review Service which is part of Healthcare Improvement Scotland. The review service checks on the accuracy of a sample of Medical Certificates of Cause of Death (MCCDs). An MCCD is the form a doctor completes when someone has died.

The aims of the Death Certification Review Service are to improve:

- the quality and accuracy of MCCDs
- public health information about causes of death in Scotland, and
- clinical governance in relation to death certification.

3

Healthcare Improvement Scotland | DCRS Death Certification Review Service | The Scottish Government

BMA | NHS Scotland | MDDUS | MPS

University of Greater Manchester | University of Strathclyde Glasgow | University of Glasgow | The UK Caldicott Guardian Council

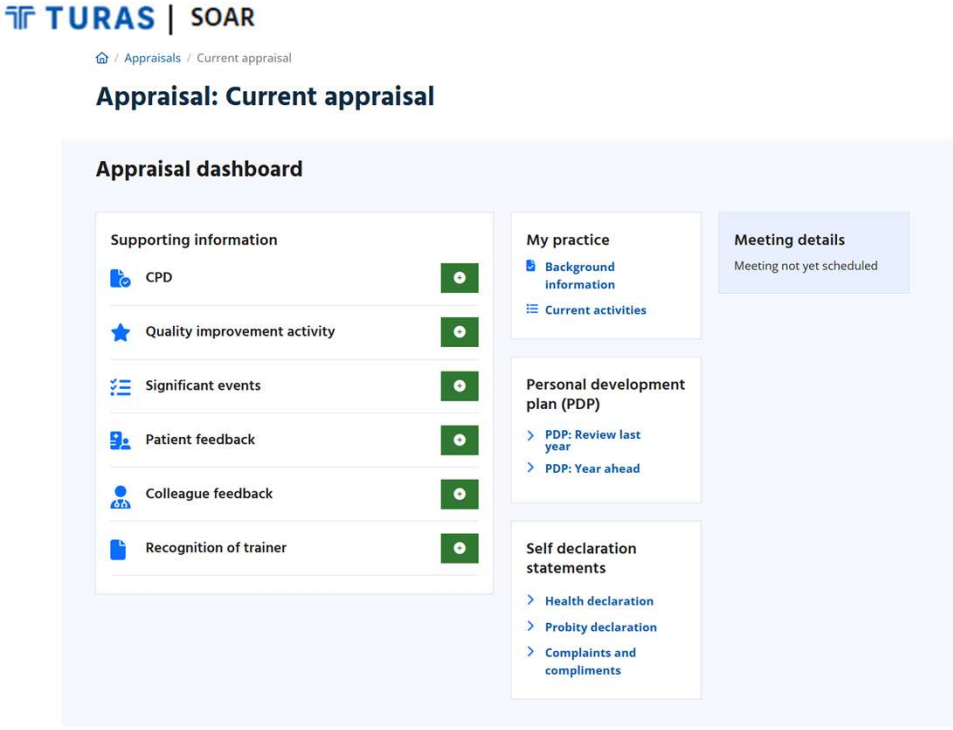
Centre for Contemporary Coronial Law

4

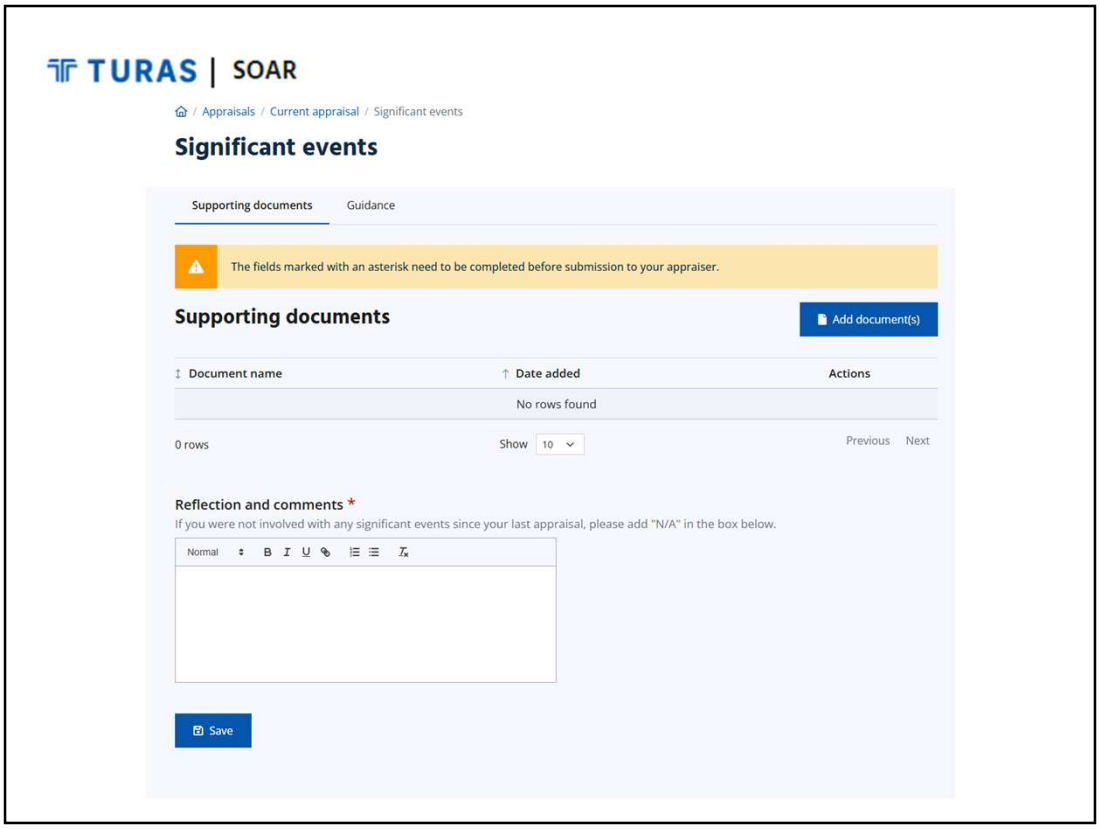
Routes of Accountability

- Complaints
- Ombudsman
- GMC
- Negligence Claims
- CI and FAI
- Criminal

5



6


TURAS | SOAR
Appraisals / Current appraisal / Significant events
Significant events
Supporting documents
Guidance
The fields marked with an asterisk need to be completed before submission to your appraiser.
Supporting documents
Add document(s)
Document name
Date added
Actions
No rows found
0 rows
Show 10
Previous
Next
Reflection and comments *
If you were not involved with any significant events since your last appraisal, please add "N/A" in the box below.
Normal
Save

7


General Medical Council
Significant events
Hide menu
The purpose of collecting and reflecting on significant events
To allow you to review and improve the quality of your professional work.
To identify any patterns in the types of significant events recorded involving your practice and consider what further learning and development actions you have implemented, or plan to implement to prevent such events happening again.
As a doctor, AA or PA you must be open and honest with patients, colleagues and your employers. The professional duty of candour guidance makes clear the need for honesty with patients after healthcare harm, and the importance of contributing to a learning culture to improve patient safety and make sure lessons are learned. You have a responsibility under the duty of candour to log incidents and events according to the reporting process within your organisation.
What is a significant event?
39. A significant event is any unintended or unexpected event, which could or did lead to harm of one or more patients. This includes incidents where the event should have been prevented.
40. Your organisation may use a different term for these events (for example serious incident, adverse event, serious adverse incident, or patient safety incident) or they may have defined the term more broadly to include learning events other than those that resulted in harm. To meet our requirements, you should focus on your learning from any events and incidents that have or could have harmed your patients.
41. Significant events should be collected routinely by your employer where you are directly employed or contracted by an organisation. If you are self-employed you should make note of any such events or incidents and review them.

8

General Medical Council

Our requirements

a. You must declare and reflect on every significant event you were involved in since your last appraisal. Involvement includes being a part of the team providing treatment where a significant event occurred.
b. Your discussion at appraisal should focus on those significant events that led to a change in your practice, and/or to system improvements, or which demonstrate your insight and learning. You should discuss your participation in logging any incidents and events, and in clinical governance meetings where incidents or events and learning are reviewed.
c. Your reflection and discussion should focus on the insight and learning from the event or incident, rather than the facts or the number you have recorded. You must be able to explain to your appraiser, if asked, why you have chosen these events or incidents.
d. If you have not been involved in any significant events you must declare this fact. You should either reflect on your local significant event or serious incident process or what you have been doing to mitigate the risk of an event or incident occurring.

Reflecting on significant events

42. You should be able to show that you are aware of any patterns in the types of incidents or events recorded about your practice. You should discuss the action you have taken and any changes made to your practice to prevent such events or incidents happening again.

9

TURAS | SOAR

Appraisals / Current appraisal / Complaints and compliments

Complaints and compliments

Please see Good Medical Practice, paragraphs 45-47

Declaration | Supporting documents

For compliments or particular pieces of positive feedback received, please document these separately and upload to the supporting documents section.

The fields marked with an asterisk need to be completed before submission to your appraiser.

Since your last appraisal, have you been the subject of a formal complaint or critical incident report? *

- Yes
- No

Acceptance and declaration *

- [ ] All the information relating to complaints and critical incidents is true to the best of my knowledge.

Save

10

General Medical Council

Being open if things go wrong

45 You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you must follow our guidance on *Openness and honesty when things go wrong: the professional duty of candour*, and you should:

a. put matters right, if possible

b. apologise (apologising does not, of itself, mean that you are admitting legal liability for what's happened)

c. explain fully and promptly what has happened and the likely short-term and long-term effects

d. report the incident in line with your organisation's policy so it can be reviewed or investigated as appropriate – and lessons can be learnt and patients protected from harm in the future.

46 You must respond promptly, fully and honestly to complaints. You must not allow a patient's complaint to adversely affect the care or treatment you provide or arrange.

47 You should only end a professional relationship with a patient when the breakdown of trust between you and the patient means you can't continue to provide good clinical care to them. You must follow our more detailed guidance on *Ending your professional relationship with a patient*.

11

The NHS Scotland Complaints Handling Procedure

Scottish Government
Riaghaltas na h-Alba
gov.scot

SPSO Scottish Public Services Ombudsman

12

What is a complaint?

[The organisation's] definition of a complaint is:

'An expression of dissatisfaction by one or more members of the public about the organisation's action or lack of action, or about the standard of service provided by or on behalf of the organisation.'

A complaint may relate to:

- care and/or treatment;
- delays;
- failure to provide a service;
- inadequate standard of service;
- dissatisfaction with the organisation's policy;
- treatment by or attitude of a member of staff;
- scheduled or unscheduled ambulance care;
- environmental or domestic issues;
- operational and procedural issues;
- transport concerns, either to, from or within the healthcare environment;
- the organisation's failure to follow the appropriate process;
- lack of information and clarity about appointments; and
- difficulty in making contact with departments for appointments or queries.

This list does not cover everything.

13

Scenario A (primary care) *(1/3)*

What happened?

- Patient believed a gynaecology referral had been made.
- A follow-up GP appointment was required before referral.
- An address-check phone call was misunderstood as confirmation that the referral was progressing.
- The appointment was not booked, so the referral was not completed.

14

Scenario A (primary care) *(2/3)*

Why did it happen?

- Several staff members were involved in communicating the next steps.
- Clinically sensitive instructions were passed through non-clinical staff.
- Responsibility for follow-up was not explicitly confirmed.
- The patient's understanding was not checked.

15

Scenario A (primary care) *(3/3)*

What happened next?

- Appraisee reflected and wrote the complaint as SEA
- SEA (learning) shared
- Change in practices

16

Scenario B (secondary care) *(1/2)*

Complaints discussion

- Complaints reviewed over an 18-month period: 12 submitted, 5 upheld, of which:
- Three concerned treatment or procedure delays outside appraisee's control.
- Two concerned appraisee's communication leading to delayed treatment.
- An internal grievance is also ongoing.
- No SAER and unaware of any Datix
- Appraisee failed to reflect:
  - *Nothing to do with me*
  - *I am who I am*
  - *That's a manager's job – I'm a doctor*

17

Scenario B (secondary care) *(2/2)*

What happened next?

- Appraiser flagged concerns to Appraisal Lead
- Form 4 should be factual and non judgemental
- As nothing new was disclosed; and
- Line management aware
- Nothing further needs to be done from appraisal standpoint

18

In the breakouts

- How does your own experience compare?
- What might you do differently?
- 15 mins

https://www.appraisal.nes.scot.nhs.uk/s/confinfo/complaints/

19

Your thoughts / reflections

- Word cloud
- Raise hand and come on screen/mic

20

Questions submitted before conference session

I had an appraisee who had to deal with a complaint from much earlier in their training before becoming a consultant. Their attitude was that this was frivolous, a waste of time, an annoyance. I tried to make it a learning experience, but any suggestions?

How to approach someone who is not open to reflection or feedback on this. How to support someone who you think may need more support from their line manager and is not receiving it

How would you raise the issue where you knew of a complaint against the doctor, but they didn't disclose this voluntarily at interview, and ticked the box to say no complaints?

Individual complaints - how to support doctors going through this

What is the process and how can we signpost colleagues for help

21

Please clarify the main purpose/aim in discussing complaints & how we ensure aims are met e.g. to show reflection and learning? or do we want them to highlight patterns, do we want them to have a chance to vent and make sure they are mentally OK?

What do you consider is the primary purpose of discussing complaints at appraisal. What does a good outcome from such a discussion look like?

If questions are raised around the support of the person within the team structure or the ongoing work environment they are working when discussing the complaint, how do you demonstrate support for them?

When and how do we need to escalate complaints?

How can appraisers discuss and record complaints in Form 4 in a fair, proportionate way that captures reflection and learning, avoids judgement or collusion, and distinguishes closed, unresolved and resurfacing complaints?

22

Should we expect a written reflection?

How to deal, if appraisee complaints about rude or patronising behaviour of appraiser?

Appraisees are often reluctant to see their reflections documented in the Form 4, but ROs do need to be able to see evidence of reflection. Where does the balance sit?

It is important to address specific complaints relating to the appraisee. But what if there are no complaints reported in the appraisal year?

How much detail should we expect the appraisee to provide regarding the complaint? e.g. copy of anonymised complaint letter and response, or a brief summary from the appraisee's perspective?

How would you approach a situation where an appraisee is reflecting on a complaint but you detect that the complaint seems quite justified and the colleague displays a lack of insight?

23

Keep in touch

w: https://www.healthcareimprovementscotland.scot/inspections-reviews-and-regulation/death-certification-review-service-dcrs/

e: his.dcrs@nhs.scot

t: 0300 123 1898

Healthcare Improvement Scotland
Death Certification Review Service

Delta House | 50 West Nile Street | Glasgow G1 2NP

24