GP Health Service
Practitioner Health Programme

# *DRAFT FOR COMMENT*

## Code of Practice for Complaints for NHS staff

This draft document has been prepared by the Practitioner Health Service to try and minimise the harm caused by an already stressful complaints process. It would also ensure that there is a timely and fair response for all parties, and a balance between the rights of patients and those of doctors. If you have any comments do let us know: email – gp.health@nhs.net

## A Code of Conduct for Complaints should include

1. **Clarity as to what the complaint is, what is it about, who has made it and who else, if anyone, is involved.**
2. This also includes standardization of who within the organization sends the complaint to the doctor. Ideally, a member from the Human Resource department should lead on all complaints, including being the point of contact for the doctor receiving the complaint and other internal or external stakeholders.
3. **A right to have the terms of reference or the parameters of the complaint made clear.**
4. **A right to access independent legal or other advice before responding**
5. What tends to happen now is that the doctor is told to first apologise to the patient, then to write a statement – usually immediately after they are made aware of the

complaint. Doctors may also be forced to use the Trust legal team, even where there might be a conflict of interest. For example, a doctor might be involved in a complaint which is also a complaint against the hospital itself (for example, the death of a patient). It is common practice, where the doctor does not have their own defence organisation and are covered under Crown Immunity, for the doctor to have to use the same team who might be also acting for the Trust. The views of the individual doctor and the Trust might differ and be conflicted.

6. **A right to not be interviewed under duress.**

7. They might also be summoned to a meeting/interview in order to explain themselves/give a statement before understanding the implications of what this statement might mean further down the track (for example, admitting to culpability where there is none). There are many examples where doctors are forced to attend meetings very soon after the event – sometimes even (if on a night shift) the following morning. They are given very little notice, are not told of the reason for the meetings, its status, outcomes or who will be present.

8. **A right to access all relevant information, including clinical or other records, to produce a defence.**

9. In many cases, doctors are refused access to the relevant case notes and/or not given the time to read them. Sometimes they are even refused access to the hospital or GP surgery completely and can only produce reports from memory. In this scenario, the doctor has no access to the necessary information for either writing their own account or for substantiating any reports written by third parties, including experts, until much further down the track (if the case ends up going to GMC, court, litigation).

10. **A right to a period of reflection before being required to give statements or explanations**
11. What this means is that whilst it might be important for the doctor to document their own version as soon as possible after the event, this version should not be used as evidence against the doctor as it might, in aftermath of the event, be significantly skewed by emotion and hence inaccurate. It is common, for example, for doctors to 'over-admit' to their failings; to not take into account all factors in the case; to over-disclose and even to embellish their own failings due to overdeveloped guilt, shame and fear.
12. **A right to workplace support and/or advice.**
13. Best practice might involve providing the doctor with a named 'buddy' to support them during the complaints process.
14. **A right to appropriate confidential health support.**
15. Many trusts do provide information about where to access help, including occupational health. This should be standard practice.
16. **A right to attend meetings with a colleague or other representation.**
17. **A right to review and comment on disclosures made about them with respect to the complaint.**
18. **A right to be seen to be innocent until proven guilty**
19. This must also include a right to be treated in a no-blame culture.
20. **A right to have sufficient time to respond to the complaint and any secondary allegations made against them.**
21. It is not unusual following a complaint/SUI against an index issue (e.g. serious complication) for other factors to be taken into account and for a fishing exercise to

happen, whereby many people not involved with the case at hand are contacted to comment on the doctor's performance/behaviour. The doctor then has to respond to each of these, whilst still having to meet the deadline laid down for the index complaint. The doctor by now is most likely distressed, might be unable to focus or sleep, and may begin to suffer from anxiety or even depression. The doctor would also have to attend endless meetings with the Trust/NHSE/Police/NHSL and so on, making deadlines increasingly difficult to meet.

22. **A right to a proportionate response by their employer, during and after the period of investigation.**
23. **A right to be kept up to date with respect to the progress of an investigation.**
24. **A right to be provided with the information given to the complainant/relevant third party which relates to their (the doctor's) involvement.**
25. It is not unusual for NHS Trusts/GP Practice s to send complainants/others responses or statements which make reference to the doctors involved without the doctors ever seeing this in draft. Often the letters contain inaccuracies which can be prejudicial, and it is very difficult to correct these. Doctors should be provided with such documents in draft before they are finalized and distributed.
26. **A right to support after the complaints process. If exonerated, this must be communicated to relevant parties.**
27. **A right to have sick leave or illness taken into account when providing a statement.**
28. A doctor may be having to make a statement when unwell in order to ensure a timely response for all parties, but they should have an opportunity to reconsider the response they have given when well again.