ST AUSTELL HEALTHCARE

Version 5.0
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PATIENT COMPLAINT FORM

If you have a complaint or concern about the service you have received from the doctors or any of the personnel working in this practice, please let us know. We operate a practice complaint procedure as part of an NHS complaints system, which meets or exceeds national criteria.

HOW TO COMPLAIN

We hope that we can sort most problems out easily and quickly, often at the time they arise and with the person concerned. If you wish to make a formal complaint, please do so AS SOON AS POSSIBLE - ideally within a matter of a few days. This will enable us to establish what happened more easily. If doing that is not possible your complaint should be submitted within 12 months of the incident that caused the problem; or within 12 months of discovering that you have a problem.

You should address your complaint in writing to the Complaints Manager, St Austell Healthcare, Wheal Northey, 1 Wheal Northey, St Austell, Cornwall PL25 3EF or email complaints.sahc@nhs.net (you can use the attached form). If you are unable to make a complaint in writing, a telephone call or in person meeting can be arranged. You should be as specific and concise as possible when making a complaint.

If you feel too uncomfortable to complain to us directly then you can make a complaint to the NHS England, PO Box 16738, Redditch B97 9PT, telephone 0300 311 22 33 or via email england.contactus@nhs.net please ensure you state 'For the attention of the Complaints Manager' in the subject line.

COMPLAINING ON BEHALF OF SOMEONE ELSE

We keep strictly to the rules of medical confidentiality. If you are not the patient, but are complaining on their behalf, you must have their permission to do so. An authority signed by the person concerned will be needed, unless they are incapable (because of illness or infirmity) of providing this. A Third Party Consent Form is provided below.

WHAT WE WILL DO

We will acknowledge your complaint within 3 working days and aim to have it fully investigated within 28 days of the date it was received. If you submit your complaint by email you will receive an automatic acknowledgement of receipt, please check your spam folder if this is not received. If we expect it to take longer we will explain the reason for the delay and tell you when we expect to finish. When we look into your complaint, we will investigate the circumstances; make it possible for you to discuss the problem with those concerned; make sure you receive an apology if this is appropriate, and take steps to make sure any problem does not arise again.

You will receive a final letter setting out the result of any practice investigations

TAKING IT FURTHER

If you remain dissatisfied with the outcome you may refer the matter to:
The Parliamentary and Health Service Ombudsman, Millbank Tower, 30 Millbank, London, SW1P 4QP, tel 0345 0154033, www.ombudsman.org.uk.

The Complaint Form is on the next page >>>

COMPLAINT FORM

Patient Full Name: ....

Date of Birth: ....

Address: ....
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Complaint details: (Include dates, times, and names of practice personnel, if known)

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(Continue overleaf if necessary)

Signed……………………………………….Print name…………………………..…………………

Date……………………………………….

PATIENT THIRD-PARTY CONSENT

PATIENT'S NAME: ____

TELEPHONE NUMBER: ____

ADDRESS: ____

____

ENQUIRER / COMPLAINANT NAME: ____

TELEPHONE NUMBER: ____

ADDRESS: ____

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IF YOU ARE COMPLAINING ON BEHALF OF A PATIENT OR YOUR COMPLAINT OR ENQUIRY INVOLVES THE MEDICAL CARE OF A PATIENT THEN THE CONSENT OF THE PATIENT WILL BE REQUIRED. PLEASE OBTAIN THE PATIENT'S SIGNED CONSENT BELOW. THIS CONSENT WILL NEED TO BE WITNESSED BY A STAFF MEMBER, WHO WILL NEED TO CONFIRM THAT ID DOCUMENTATION HAS BEEN SEEN.

I fully consent to my Doctor releasing information to, and discussing my care and medical records with the person named above in relation to this complaint only, and I wish this person to complain on my behalf.

This authority is for an indefinite period / for a limited period only (delete as appropriate)

Where a limited period applies, this authority is valid until…………………….. (insert date)

Signed: ……………………………………… (Patient only)

Date: …………………………………………..

To be completed by SAH staff member:-

Name of patient's photo ID Documentation seen ______________________________

Date seen _____/_____/_____

Staff Members Initials __________