

Sheen Surgery Procedure for Comments and Complaints

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 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. Formal complaints can be made verbally, in writing or electronically. Where the complaint is made verbally Sheen Surgery will make a written record of the complaint and provide a copy to the complainant. Complaints submitted in writing or electronically should be addressed to the Practice Manager, Alice Reilly (you can use the attached form). She will make sure that we deal with your concerns promptly and in the correct way. You should be as specific and concise as possible.

Alternatively you can complain to the commissioner of the service which is the Integrated Care Board (ICB). You can do this by calling them on 0800 026 6082 or via email at contactus@swlondon.nhs.uk

How to give feedback or make a complaint about NHS Services

For help making a complaint or to provide feedback, please see information at the link here:

NHS England » Feedback and complaints about NHS services

COMPLAINING ON BEHALF OF SOMEONE ELSE

We keep strictly to the rules of medical confidentiality (a separate leaflet giving more detail on confidentiality is available on request). 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 fully investigated within 20 working days of the date it was 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
Millbank
London
SW1P 4QP
Tel 0345 0154033 www.ombudsman.org.uk The
NHS Complaints Advocacy Service is an
independent, free and confidential service that
offers support to complainants and patients when
raising NHS complaints and can be contacted on
0300 330 5454.

COMPLAINT FORM

Patient Full Name: (PLEASE PRINT)

Date of Birth:

Address:

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

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SIGNED

PRINT NAME

PATIENT THIRD-PARTY CONSENT

PATIENT'S NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

ENQUIRER / COMPLAINANT NAME: _____

RELATIONSHIP TO PATIENT: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

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.

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, 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: