Lingwell Croft Surgery

LINGWELL CROFT SURGERY
PATIENT COMPLIMENT/ COMPLAINT FORM

If you have a compliment or complaint /concern about the service you have received from the doctors or any of the personnel working in this practice, please let us know.
We welcome feedback from good experiences as well as bad, although we realise that people usually only make comments about bad experiences.
We operate a practice complaints procedure as part of an NHS complaints system, which meets national criteria in line with the 2009 regulations.

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 can give us your complaint verbally or you can submit your complaint in writing to the Complaints Manager (you can use the attached form); to make sure that we deal with your concerns promptly and in the correct way, you should be as specific and concise as possible. You can also submit a complaint online via our website www.lingwellcroft.co.uk
You can alternatively choose to complain to:

NHS West Yorkshire Integrated Care Board
Primary Care Complaints Function
White Rose House
West Parade
Wakefield WF1 1LT
Email: wyicb.complaints@nhs.net
Visit: www.wypartnership.co.uk
Telephone: 01924 552150

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 (3rd party consent form is at the bottom of this page), unless they are incapable (because of illness or infirmity) of providing this. Parents may complain on behalf of children under the age of 16.

WHAT WE WILL DO

We will acknowledge your complaint within 3 working days and will agree with you a reasonable length of time to investigate and send you a full response.

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.

If you need support with a complaint there is a free advocacy service in Leeds, 'Advonet' who can be contacted on 0113 244 0606.

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

COMPLAINT/ COMPLIMENT FORM

Patient Full Name:
Date of Birth:
Address:
Today's date:
Complaint/compliment details: (Include dates, times, and names of practice personnel, if known)

.....
....

.....
....

.....
....

.....
....

.....
....

.....
....

……
…..

……
…..

.....
....

.....
....

.....
....

.....
....

.....
....

.....
....

.....
....

.....
....

.....
....

.....
....

.....
....

SIGNED…….Print name……
(Continue overleaf if necessary)
Return to Lingwell Croft Surgery or email: info.lingwellcroft@nhs.net
PATIENT THIRD-PARTY CONSENT FORM

PATIENT'S NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

_____

ENQUIRER / COMPLAINANT NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

_____

IF YOU ARE COMPLAINING ON BEHALF OF A PATIENT OR YOUR COMPLAINT OR INQUIRY INVOLVES THE MEDICAL CARE OF ANOTHER PATIENT THEN THE CONSENT OF THAT 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: ……..