

COMPLAINTS PRO-FORMA

BEFORE COMPLETING THE COMPLAINTS PRO-FORMA PLEASE READ THE GUIDANCE NOTES BELOW:-

SECTION 1

PATIENT DETAILS

- Please ensure all patient details are recorded as fully as possible.

SECTION 2

PERSON MAKING COMPLAINT

- Please ensure all details are recorded as fully as possible.
If you are **not** the patient we will require the consent form to be completed (see page 5). This will provide the Trust with authority to reply to the person who is making the complaint as well as providing consent to access the patient's health records and other relevant clinical information to enable the Trust to investigate the complaint. If the complaint relates to someone who has died or the patient is incapacitated and has a debilitating illness that prevents them from providing their consent then we will require their named next of kin or advocate with Power of Attorney for Health and/or Executor of their estate to complete and sign the form.

SECTION 3

DETAILS OF INCIDENT/COMPLAINT(S)

- Please ensure all details are recorded as fully as possible.

SECTION 4

ITEMISE COMPLAINTS

- This will enable us to focus on the specific issues you have raised.
For example:-
a) Attitude of staff b) Waiting time c) Lack of care/treatment d) Food/cleanliness

SECTION 5

SUPPLEMENTARY INFORMATION

- This section provides you with the opportunity to provide additional information, which is relevant in support of your itemised complaint/s. Where possible please provide dates, times and names.

SECTION 6

SIGNATURE

- This will enable us to identify if the complainant is the patient or a third party.

SECTION 7

WHERE DO YOU SEND YOUR COMPLAINT TO?

- Once you have completed this form it can either be handed to a member of staff on the ward/department you are attending, alternatively it should be posted to the Chief Executive at the address provided on page 4.

SECTION 8

ADVICE/ASSISTANCE

- You have the right to request advice/assistance when making an NHS complaint from the appropriate Advocacy Service; contact details for your area on page 4.

PLEASE DETACH AND RETAIN THIS SHEET FOR YOUR OWN INFORMATION

COMPLAINT PRO-FORMA

SECTION 1

PATIENT DETAILS:

Hospital No (if known): Inpatient/Outpatient/Ward/Department/Other
(Please circle as appropriate)

Forename: Surname:

Title: **MR / MRS / MISS / MS / OTHER** Date of Birth:
(Please circle as appropriate)

Address:
.....
..... Postcode:

Telephone No: (daytime)(evening)

Mobile Telephone No: E-mail address:

SECTION 2

DETAILS OF PERSON MAKING COMPLAINT

(If NOT the patient):

Forename: Surname:

Title: **MR / MRS / MISS / MS** (Please circle as appropriate)

Address:
.....
..... Postcode:

Are you the designated next of Kin? **YES/NO** (Please circle as appropriate)

Relationship to the Patient:

Telephone : (daytime)(evening)

Mobile Telephone No: E-mail address:

SECTION 3

DETAILS OF INCIDENT/COMPLAINT/S:

Date/s of Incident: Time/s of Incident:

Location:

Name of staff/designation involved (if known):
.....

.....
.....
.....
PLEASE CONTINUE ON A SEPARATE SHEET(S) IF REQUIRED

SECTION 6

SIGNATURE:

Signed by: Date:

SECTION 7

ADDRESS YOUR COMPLAINT TO:

**Ms Ann Marr
Chief Executive
St Helens & Knowsley Teaching Hospitals NHS Trust
Whiston Hospital
PRESCOT
Merseyside, L35 5DR
Telephone No: 0151 430 1242
E-mail address: ann.marr@sthk.nhs.uk**

On receipt of this form your complaint will be acknowledged and an investigation will be instigated.

SECTION 8

ADVOCACY DETAILS:

If you require advice/support you have the right to contact the advocacy service in your area as follows:-

Liverpool residents please contact: Tel No: 03007777007, or email: enquiries@healthwatchliverpool.co.uk

Knowsley residents please contact: Advocacy Together Hub Knowsley, Tel No: 0151 426 3174, Mobile: 07484935748, or email: Knowsley-advocacy@together-uk.org

St Helens residents please contact: Healthwatch St Helens, Tel No: 0300 111 0007, or email info@healthwatchsthelens.co.uk

Halton residents please contact: Healthwatch Halton, Tel No: 0151 347 8183, or email advocacy@weareecs.co.uk

Warrington residents please contact: Healthwatch Warrington, Tel No: 01925 246893, or email contact@healthwatchwarrington.co.uk

CONSENT FORM
(REFER TO GUIDANCE NOTES – SECTION 2)

I hereby authorise Ms Ann Marr, Chief Executive or her agents to divulge details of the hospital care of:

Name of Patient:
(Please insert patient's name)

to
Complainant:
(Please insert complainant's name)

I hereby authorise Ms Ann Marr, Chief Executive or her agents to have Access to the Health Records and any other relevant clinical information of:

Name of Patient:
(Please insert patient's name)

for the sole purpose of investigating the complaint. I understand that all Trust staff are governed by patient confidentiality and that In order to complete a full investigation into the complaint it may be necessary to allow suitably authorised NHS professionals access to relevant health records.

I mark and date this authorisation in my capacity as:

***The patient (if over 18):**

***The patient's parent or guardian (if under 16):**

***The patient's named next of kin if unable to give consent (see below):**

(*Please delete as necessary)

Mark

Date

Reason for incapacity.....

If you are not the patient this form **must** be signed by the named next of kin as recorded on the Trust's hospital records system/s. If the complaint relates to a patient who has died or they have a debilitating illness that prevents them from providing consent then we will require their named next of kin or advocate with Power of Attorney for Health & Welfare and/or Executor of their estate to complete and sign the form; evidence to confirm their status will be required. Please contact the Patient Advice & Liaison Service (PALS) on 0151 430 1376 or the Central Complaints Team on 0151 430 1167 should you require assistance to complete this form.