 

If you need help to make a complaint and are unable to complete this form, see Appendix 3

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| **Feedback Form** |
| **Date** |  |

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| **I wish to (please tick)** |
| Complain |  | Concern |  |
| Enquire |  | Compliment |  |
| **On behalf of (please tick)** |
| Self  |  |
| Patient  |  | Relationship to Patient |  |
| Other  |  | Please Specify (e.g MSP, Advocate, interpreter) |  |

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| **I need help with communication (please tick)** |
| Not Applicable to me  |  | British Sign Language  |  |
| Community Language (please state below what language you speak) |  | Hard of Hearing / Deaf / Deafened / Lip Reader  |  |
| Deaf Blind  |  | I use communication support aids such as Talking Mats  |  |
| I need my information made more accessible or translated (Community languages, Easyread Formats, BRAILLE, Large Print, Audio) Please state below |  | Other  |  |
| We work with Fife Council Deaf Communication Service and can provide appropriate, for example; Electronic Notetakers, and lip-speakers. |
| Please provide additional information here, specific to your requirements. If you need additional space this can be found on Appendix 1 and more information about accessible communication support can be found at the end of the form. |

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| **Hospital / Clinical Area** | **please tick** | **Hospital / Clinical Area** | **please tick** |
| Victoria  |  | Adamson |  |
| Queen Margaret |  | Lynebank |  |
| St Andrews |  | Randolph Wemyss |  |
| Glenrothes |  | Stratheden |  |
| Cameron |  | Whytemans Brae  |  |
| Other  |  | Please specify: |
| Ward / Department (if known) |  |  |
| Staff Member (if known / applicable) |  |  |

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| **GP Surgery**  | **please tick** | **GP Surgery** | **please tick** |
| Linburn Road Health Centre  |  | High Valleyfield Medical Practice |  |
| Kinghorn Medical Practice  |  | The Links / Masterson Health Centre, Burntisland |  |
| Staff Member (if known / applicable) |  |  |
| The above GP Surgeries are managed by NHS Fife. All other GP Surgeries in Fife are independent contractors and therefore please contact the Practice Manager of the surgery to raise your concerns. |

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| **Your Details**  |  |
| Title |  |  |
| Full Name  |  |  |
| Preferred Name |  |  |
| Date of Birth / Hospital Number (if known) |  |  |
| Address  |  |
| Postcode  |  |  |
| Telephone Number |  |  |
| Email Address |  |  |
| Would you be happy for us to contact you to discuss your feedback, if required? Y/N Tell us more in the box below  |  |  |
| If YES, when would be best to contact you and how would you like us to do this? (between the hours of 9.00am-4.30pm Monday to Friday) |  |  |

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| **Patient / Service User Details (if different from above)** |  |
| Title |  |  |
| Full Name  |  |  |
| Preferred Name |  |  |
| Date of Birth / Hospital Number (if known) |  |  |
| Address  |  |
| Postcode  |  |  |
| Telephone Number |  |  |
| Email Address |  |  |

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| **Consent** |  |
| If you are raising concerns on behalf of another person you will need to provide confirmation that they have agreed for you to act on their behalf (this also applies to children and young adults over the age of 12).

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**If able to do so, please print and return the consent form (Appendix 2). If you are unable to print this please tick here and we will send you the form by post.** *Alternatively, if the patient is able to do so, they can contact Patient Relations directly to provide their verbal consent (contact details below)* |

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| **Your Feedback**  |
| Please detail your feedback below and provide a summary of what happened, including any exact or approximate dates of when the event happened. If you need additional space this can be found on Appendix 1:**Summary:** |

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| **Your Desired Outcome**  |
| If applicable, consider the outcome you are looking for in sharing your feedback with us. For example, what do you feel NHS Fife can do to resolve matters for you? **Or** what you would consider to be a satisfactory outcome (i.e. an apology, an explanation, for it not to happen again)?When detailing your desired outcome below, please also include:* Any specific questions you wished addressed

If you need additional space this can be found on Appendix 1.**Desired Outcome:** |

 **Appendix 1**

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| **Additional Space**  |
| Please use this section as required for any additional comments or information: |
| **Obtaining Your Feedback** |
| We may contact you about the Feedback Process |
| Would you be happy to provide your feedback? Y/N  |  |

 **Appendix 2**

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**Consent Form**

**Before confidential information can be disclosed to a third party, this form needs to be completed and returned by the patient (aged 12 and over) or their Next of Kin (NoK)/Welfare Power of Attorney (WPOA), if the patient is unable to give their consent.**

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| **Section 1 – Patient Details (PLEASE PRINT)** |
| Title |  |
| Name |  |
| Address |  |
| Telephone Number |  |
| Email Address |  |
| Date of Birth |  |

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| **Section 2 – Details of whom disclosure is to be made (PLEASE PRINT)** |
| Title |  |
| Name  |  |
| Address  |  |
| Telephone Number |  |
| Email Address |  |
| Relationship to patient |  |

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| **Section 3 - Statement by the Patient (A) or the NoK/WPOA (B), where patient is unable to consent. Please tick and complete A or B as appropriate** |
| **A -** I am aware that the person detailed in **Section 2** has requested a response from NHS Fife, which requires the review and disclosure of my personal details (i.e. name, address(es), email address), details of a complaint I have made to NHS Fife and confidential information relating to my healthcare. Accordingly, I hereby give my consent for the disclosure of this information for the purposes of replying to a complaint. |  |
| **Patient’s signature**  | **Date**  |
| **B -** I am the patient’s NoK/WPOA. The patient is unable to give consent. |  |
| NoK/WPOA Name (PLEASE PRINT) |  |
| **NoK/WPOA Signature** | **Date** |
| Relationship to Patient |  |
| Reason Patient cannot provide consent |  |

Please enclose a copy of the Welfare Power of Attorney or Guardianship if relevant.

**Please return to:** NHS Fife Patient Relations, Level 1, Hayfield House, Hayfield Road, Kirkcaldy, Fife, KY2 5AH or by email to fife.patientrelations@nhs.scot

 **Appendix 3**

**Please return your completed forms to Patient Relations**

*Please note: the data will be stored in accordance with General Data Protection Regulation (GDPR). For a copy of NHS Fife’s Data Protection Policy, please visit NHS Fife’s website*

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| **By Post:**Patient Relations DepartmentLevel 1Hayfield HouseHayfield RoadKirkcaldyFifeKY2 5AH | **By Email:**fife.patientrelations@nhs.scot **In Person:**Phase 3 Reception, Victoria Hospital, Kirkcaldy |

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| **For issues with this form:** | **For help completing this form:** |
| You can contact Patient Relations by emailing us on the above email address or on 01592 648153, between 9.00am and 4.30pm Monday to Friday. | Patient Advice & Support Service (PASS) provides free, confidential, and independent advice and support for patients of the NHS in Scotland. They can support you in writing and submitting your feedback. You can contact them on 0800 917 2127, visit them at your local Citizen’s Advice Bureau or chat with them or submit an email online at [www.cas.org.uk/pass](http://www.cas.org.uk/pass) Circles Advocacy Network provides advocacy for people across Scotland, mostly over the age of 16 who are affected by disability, chronic long term illness, mental ill health, learning, physical and sensory difficulties, brain injury, autism and personality disorder.You can contact them on 01592 645360 |

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| **If you require Accessible Communication Support:** |
| For additional information on communication, you can contact our Equality and Human Rights Team 01592 729130 or by emailing them at:fife.EqualityandHumanRights@nhs.scotFor patients who are Deaf or Hard of Hearing you can use the **NHS Fife SMS Text Service** on 07805 800 005 (the service is monitored between 9.00am to 5.00pm, Monday to Friday.To register to use this service, please send a text to: 07805 800 005\*\*Important\*\* This text service is NOT for emergencies |