**QUALITY ASSURANCE FORM (QAF)**

**FOR CARE AND SUPPORT SERVICES DELIVERED BY COMMISSIONED PROVIDERS**

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| **This feedback form should be used to advise the Contract Management and Provider Improvement Team of any quality issues about the services being delivered. Under no circumstances is this form to be used to refer adult safeguarding issues, these should always be referred through the normal process at 0800 561 0015.** |

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| **WHO ARE YOU?** | |
| **Reporting Organisation (if any)** |  |
| **Your name** |  |
| **Your job title** |  |
| **Your contact number** |  |
| **Your email address** |  |
| **Do you wish to remain anonymous?** |  |

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| **WHERE DID IT TAKE PLACE AND WHO DID IT AFFECT?** | | | | | | | | | | | | | |
| **Name of Provider/ Service** |  | | | | | | | | | | | | |
| **Type of Service** | **Residential / Nursing Care** | **Domiciliary Care** | | | | **Supported Living** | | **Extra Care** | | | **Day Provision** | | **Voluntary Organisations** |
| **Other (please state)** | | | | | | | | | | | | | |
| **Service User Name**  **(If applicable)** |  | | | **LAS Number**  **(If known)** | | | | |  | | | | |
| **Service User Address:**  **(if applicable)** |  | | | | | | | | | | | | |
| **Service User Primary Need** | **Older Person** | | **Mental Health** | | **Physical Disability** | | **Learning Disability** | | | **Sensory Impairment** | | **Cognitive Impairment** | |
| **Other (please state)** | | | | | | | | | | | | | |

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| **REASON FOR FEEDBACK.**  **Please tick the relevant box(s) and provide as much information as possible below.** | | | | | | |
| **Quality of Service Provided** | |  | **Breach of Confidentiality** | | |  |
| **Delay in the provision of agreed service** | |  | **Standard of Care & Support** | | |  |
| **Reliability of service provision** | |  | **Health & Safety Concern** | | |  |
| **Professional practice by workers** | |  | **Communication with service user / relatives/ other professionals** | | |  |
| **Missed / Late /Short calls** | |  | **Not following the Care Plan** | | |  |
| **Financial arrangements of service user** | |  | **Other** | | |  |
| **Please provide details on what took place?** | | | | | | |
| **Please indicate what action(s) have been taken to date to try and resolve the issues with the provider. If the issues have not been raised with the provider please state why.** | | | | | | |
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| **Where applicable have you informed the service user or relatives that you have submitted feedback about the services / provider they receive?**    **Yes No** | | | | | | |
| **If not, please state why;** | | | | | | |
| **If the Contract Management and Provider Improvement Team investigate and take any action, would you like feedback. (If yes, please provide preferred contact details below).** | | | | | | |
| **Name** |  | | | **Date** |  | |
| **Organisation (if any)** |  | | | **Direct Contact Number** |  | |
| **Location/ Address** |  | | | **Email Address** |  | |

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| **Please return this form to: Contract Management and Provider Improvement Team,**  **Floor 2, Civic Centre,**  **Glebe Street,**  **Stoke on Trent,**  **ST4 1RJ**  **Or email:** [**quality.assurance@stoke.gov.uk**](mailto:quality.assurance@stoke.gov.uk) |