Policy Number	HM04	
Approval date	May 2021	
Review date	May 2024	
Policy Title	Concerns and Complaints Policy	Responsibility of the Executive Management Team
Name of author and job title	Vikki Harding, CEO & Natalie Webb, Director of HR	**(Signature)**
Executive Director approval	Linda Coffey Director of Care	**(Signature)**
CEO approval	Vikki Harding	**(Signature)**
Requires Trustee approval	Yes	
Trustee approval	Jan Stanton	**(Signature)**
Related policies & procedures	IG01 Data Protection Policy HR04 Whistle Blowing Policy H&SP008 Incident Reporting Policy H&SP009 Personal Safety Policy HR10 Disciplinary & Suspension Policy PTC67 Duty of Candour Policy PTC68 Consent Policy	
Version number	10	

1.	**'At a glance' key message summary of policy**
	This policy outlines the responsibilities in respect of any concerns and complaints received from service users, stakeholders, supporters or the general public. It also outlines the management of persistent, and/or aggressive complainants.
2.	**Assurance statement**
	The Organisation aims to ensure that every patient and family receives the best possible care and quality of service. It also aims to provide a good experience to supporters, stakeholders and service

	users at all times. As part of this process, it seeks to listen and to be responsive to feedback received, whether complaining, or raising concerns. The Organisation aims to provide an accessible, effective and fair concerns and complaints handling and management process in line with statutory requirements and maintaining best practice to stakeholders. This is to ensure a system that achieves an open and just outcome for people wishing to provide feedback for improvement or raise concerns relating to the services of the Organisation, in accordance with the Francis Report, February 2013. All processes within this policy are in place to ensure compliance with the Organisation's governance arrangements and in line with the Charity Commission, Department of Health, Care Quality Commission, and National Patient Safety Agency guidelines.
3.	**Aims, objectives and scope of policy**
	This policy applies to all concerns and complaints received from service users, stakeholders, supporters, or the general public. Complaints from staff and volunteers will be managed through the HR policies. The aim of this policy is to provide a robust framework for all staff and volunteers for the investigation, management of concerns and complaints. This ensures that anyone raising a concern or complaint is listened to, ensuring complaints are resolved quickly and appropriately, in line with the Duty of Candour policy. This policy provides a customer-centred approach to concerns and complaints management and is a flexible and negotiated process which is designed to ensure that each concern or complaint is dealt with in a way that is tailored to the needs of the individual and the circumstances of the issues raised.
4.	**Who should read this policy**
	All staff and volunteers, including all permanent, contracted, temporary/bank/locum, apprentices, and students. For the purposes of this policy the term "staff" will encompass staff and volunteers, including all permanent, contracted, temporary/bank/locum, apprentices, and students.
5.	**Definitions and terms**
	Care Quality Commission (CQC): The independent regulator of health and social care in England **Complainant:** is the person raising the concern or complaint **Complex complaint:** For the purposes of this policy this term is used to incorporate persistent, excessive and/or aggressive complaints. **Investigating Officer (IO):** is the person undertaking the investigation into the complaint raised. **Local Resolution:** is when informal concerns or complaints have been raised which have been managed locally within the service/department and the Complainant does not wish the concern to be upgraded to a formal complaint. **SI:** Serious Incident.
6.	**Policy**

6.1	**Introduction** A complaint is defined as "expression of dissatisfaction or concerns made to an Organisation related to its products or services." The Care Quality Commission (CQC) fundamental standards state that the general public must be able to complain about their care and treatment, and as a provider of care, the Organisation must have a system in place to handle and respond to any complaints or concerns raised. All complaints must be dealt with under the Being Open, Honest and Duty of Candour principles as outlined in the Organisation's Duty of Candour policy PTC7. The Organisation's 'Comments, Compliments and Complaints' leaflet and poster must be made available in all service user, patient and reception areas, as it includes advice and instructions for making a complaint (see Appendices 1 and 2). Complaints can be made verbally, either face-to-face or over the telephone, to a member of staff, or in writing via letter, or email. All complaints raised must be taken seriously and can be managed via an informal or formal process. Where a concern/complaint is made in relation to care provided to a patient, the concern/complaint can be raised by the patient or their representative. Where requested and/or necessary the Complainant should be given support in using the complaints procedure. This may be through use of interpreters, advocacy services or patient representatives. **Informal Complaints/Concerns Process**
6.2	Wherever possible the manager of the service or department or senior staff member must attempt to resolve the complaint informally as soon as possible. In most cases informal complaints will be face-to-face or over the telephone with the Complainant. If the Complainant raises a complaint directly, the member of staff must refer the Complainant to the manager (or most senior member of staff on duty in the manager's absence); if this is out of hours this will be the clinical manager on call. If the complaint is received in writing the manager must contact the Complainant to attempt to resolve the complaint informally. When contacting a Complainant this should only be done via the means the Complainant has given you access to, in line with data protection, eg: if a Complainant writes and includes an email address or telephone number it is acceptable to contact them via these means. If, however, they have only included their address it is not acceptable to contact them by telephone or email. Once the person has aired their complaint, a sincere apology must be given to the Complainant. This is not admitting fault but apologising for the Complainant's experience. The manager or senior staff member must also: • Inform the Complainant what action will be taken. • If an investigation needs to take place, the Complainant must be informed, and a date provided when this will be concluded. • Agree a follow up plan with the Complainant. • Thank the Complainant for raising the concern/complaint. The manager or senior staff member must document on the Infoflex incident the following:

	• Nature of the complaint (including date and time). • Name of person receiving the concern/complaint (including job title and department). • Details of the Complainant (including name, address and contact number). • Action taken. • If the complaint was resolved informally. • If not, was the Complainant informed of how to make a formal complaint. For any fundraising complaint, the specific Institute of Fundraising Code of Practice that is believed to have been breached should be recorded. If the complaint cannot be resolved informally in discussion with the Complainant, the Complainant must be advised of the formal complaints process (see section 6.3).
6.3	**Formal Complaints Process** All staff are required to adhere to the formal complaints handling process and to demonstrate the Organisation listens and responds to complaints that are raised by patients, service users, their families or carers. If the complaint cannot be resolved informally the manager of the department or service will discuss with their line manager and agree who will be appointed as Investigating Officer (IO). The IO must be competent in managing and investigating complaints. Best practice suggests that the IO should be somebody outside of the service/department; however, where this is not feasible the IO must not have had any personal involvement in the circumstances leading to the complaint being raised. The IO will then be briefed by the manager with regard to the complaint made, and they will be allowed access to all staff and volunteers, and documentation relevant to the complaint. The investigation must be handled in a manner that acknowledges being subject to a complaint can be a stressful and anxious time for staff or volunteers. The Executive Administrator, with direction from the IO, will provide a written acknowledgment letter to the Complainant within five working days of the formal complaint being raised, acknowledging receipt of the complaint, and attaching a copy of the Complaints Policy. The IO must carry out and conclude the investigation within 18 working days and send the investigation report, along with the first response letter with the findings, lessons learnt and actions to be taken to the CEO and Executive Administrator. Where the investigation is still in process after 20 days, a letter explaining the reason for the delay must be sent to the Complainant by the Executive Administrator with direction from the IO and a date for the completion to be advised. The CEO will review and finalise the 1st response letter and will send to the Executive Administrator for sending to the Complainant. The 1st response letter must be sent to the Complainant within 20 working days of the formal complaint being raised. The 1st response letter must include information of what the Complainant can do if they are not satisfied with the 1st response and action taken and will advise that if the Organisation is not contacted by them within 14 days of receiving the 1st response letter the complaint will be closed and a closing letter will be sent. Following the 1st response letter being sent, if the Complainant does not respond within 14 days of the 1st response being sent or informs the Organisation they are satisfied with the outcome, a closing letter will be sent to them by the Executive Administrator stating the complaint has been closed (see Appendix 3 for the Complaints Process flowchart).

If the response is not satisfactory to the Complainant, she/he can write to the Chair of Trustees within 14 days of the 1st response being received. An independent review may be conducted by the Board of Trustees. If the Chair of Trustees' response is also unsatisfactory, the Complainant may raise the complaint with an overseeing body (see Appendix 4 for details of Ombudsman).

Documentation

When a complaint is raised this must be documented on the electronic incident reporting system (Infoflex) by the staff member who received the complaint in line with the Organisation's Incident Reporting Policy.

All letters sent to the Complainant, the investigation report together with any action plans, or other relevant documentation must be attached to the Infoflex incident.

Following the outcome report of the investigation any action plans must be written by IO in collaboration with the manager of the service/department and include timelines and person responsible for each action.

Subject to the need to record information which is strictly relevant to the patient's health or care, no references to the complaint must be made in the health records.

Complex Complaints

There are occasions when complaints are persistent, excessive, or aggressive and are challenging for staff to handle. The Organisation has termed these type of complaints as "complex complaints".

Identifying a Potential Complex Complaint

6.4 Complaints can arise for a variety of reasons and can include:

- The Complainant acting out of character at times of stress, anxiety, or distress.
- The Complainant has a medical or mental health illness which makes effective communication difficult without giving the impression of being aggressive.
- The Complainant has used prescription or other drugs which can cause similar effects to the above.
- The Complainant has a learning difficulty which hinders positive formal social communication.

Staff must make reasonable allowances for a Complainant's behaviour and understand that it does not mean that a complaint is unjustified.

There are, however, a small minority of people who make complex complaints which are persistently unreasonable, make complaints for reasons other than a genuine wish to resolve a concern and some that act in a manner which, even after making allowances for their behaviour, is inappropriate and unacceptable.

6.5 Staff must be careful to distinguish between Complainants who are raising genuine concerns and those who are complex Complainants. This can be recognised by the following:

6.5.1	• Every complaint must be considered on its merits and, even if someone has made a complex complaint in the past, it must not be assumed that any other complaint will be a complex complaint. • Complainant may often be aggrieved, frustrated, or have other reasons for their behaviour and therefore, the focus must be on careful consideration of the merits of the case rather than the attitude of the Complainant. If staff feel a complaint maybe a complex complaint, they must escalate this to the relevant Director via their line manager giving their reasons. **Decision Making for Complex Complaints** The handling and management of complex complaints can be very time consuming and stressful for staff. The decision of whether a complaint is a complex complaint must only be made by the relevant Director of the department/service against which the complaint is made. A complaint could be deemed a complex complaint for the following reasons: • The Complainant seeks to prolong contact by continually changing the substance of the complaint or by continually raising further concerns or questions whilst the complaint is being addressed. • The Complainant fails to clearly identify the substance of the complaint or the precise issues which may need to be investigated, despite reasonable efforts by the Organisation to assist the Complainant to do so. • The Complainant complains solely about trivial matters to an extent which is out of proportion to their significance. • The Complainant makes excessive contact with the Organisation or seeks to impose unreasonable demands or expectations on resources or the outcome. • The Complainant is perceived by staff to be threatening, or abusive despite allowances being made whilst the complaint is being investigated. The designation of a complex complaint must not be exercised lightly or frequently. In the event a complaint is deemed a complex complaint the Complainant must be informed in writing of the decision and advised that the department/service staff will not enter into any further correspondence about the matter and all communication will be by the relevant Director. Should a Director deem a complaint as a complex complaint they must inform the CEO who will inform the Chair of the Trustees. The Clinical Commissioning Group (CCG) and the CQC must also be informed.
6.5.2	In such cases the Organisation may seek and independent IO or request the complaint is investigated by the Clinical Commissioning Group (CCG). This decision will be made by the CEO in collaboration with the relevant Director. **Disruptive Telephone Complaints** If a Complainant persistently calls or emails to discuss a complaint or to make further complaints, and it is proving disruptive or excessive, it is reasonable for staff to ask the Complainant to put their concerns or complaints in writing. If a Complainant displays an unacceptable level of verbal abuse or aggression during a telephone call it is acceptable for a staff member to terminate the call.

	In either scenario staff must remain calm and polite and wherever possible and provide the Complainant the opportunity to modify their behaviour by informing them that unless they do so the call will be terminated. If a staff member terminates a call to a Complainant due to verbal abuse or aggressive behaviour, they must escalate this to their line manager and complete an incident in the electronic incident reporting system in line with the Organisation's Incident Reporting Policy. With the consent of the relevant Director the Complainant maybe informed in writing that staff will no longer accept telephone calls from them and will only communicate with them in writing. **Abusive Complainants** People under stress or who feel angry or upset may react in an abusive or aggressive way to staff. There must be a balance between the ability to assist the complaint and what can be reasonably achieved in these circumstances. The Organisation is committed to maintaining a working environment for staff in which threatening, abusive, humiliating, or offensive behaviour is not tolerated in line with the Organisation's Personal Safety Policy. The personal safety of staff must never be compromised. Meetings can be brought to an end in circumstances where the Complainant becomes aggressive, abusive or displays threatening behaviour. Staff must remain calm and polite and wherever possible provide the Complainant the opportunity to modify their behaviour by informing them that unless they do so the meeting will be terminated.
6.5.3	When a meeting with a Complainant is terminated the staff member must explain politely and calmly the reason so that the Complainant does not feel their complaint is being dismissed or ignored. If it is deemed that the complainant's behaviour is abusive and threatening or aggressive and they continue with this behaviour after the staff member has informed them the meeting is terminated. Staff can request the Complainant to leave the premises in line with the Organisation's Personal Safety Policy If a staff member terminates a meeting with a Complainant due to abusive threatening or aggressive behaviour, they must escalate this to their line manager and complete an incident on the electronic incident reporting system. (Infoflex) incident in line with the Organisation's Incident Reporting Policy. With the consent of the relevant Director the Complainant may be informed in writing that personal contact between the Organisation and the Complainant is to be discontinued and the complaint may only be pursued further by written correspondence. If the Complainant is a visitor to a patient on the Inpatient Ward, the Director of Care and CEO will make the decision if the Complainant will be allowed to continue to attend the Hospice to visit the inpatient. The Director of Care must inform the Complainant of this in writing. If this decision is made, the CEO must inform the Chair of the Trustees. The Clinical Commissioning Group (CCG) and the CQC must also be informed.
6.5.4	

6.6	**Joint Complaints Managed Between Organisations** In the event a complaint is received by the Organisation but involves other external Organisations, the Executive Administrator with direction from the CEO, will seek consent from the Complainant to send the complaint to the other Organisations involved. On receipt of consent, a copy of the complaint letter will immediately be sent by the Executive Administrator to the other Organisations involved in the complaint and a discussion between parties involved will be undertaken to agree which Organisation should be the lead and the process to be followed. **Learning Lessons from Complaints** The Organisation values all feedback as it provides vital information for service improvements. The manager will discuss lessons learnt and any action plans from complaints regarding the service/department at team meetings and discussions will be documented in the minutes. If as part of the complaint action plan, training for staff is required the following actions must be taken: • The manager of the service/department must develop a training plan and method of delivery for the training. Assistance with this can be sought from the Education Department, Professional Development Lead (if clinical training) or the relevant senior Executive Director. • The manager of the service/department is responsible for ensuring relevant staff attend this training. • The manager of the service/department is responsible for auditing the effectiveness of the training following completion. Learning from complaints must be cascaded to the relevant Organisational staff to ensure improvements to prevent re-occurrence and improve the quality of services embedded across all relevant department/services. Should any disciplinary action need to be followed regarding the conduct or behaviour of any staff members, following the investigation of the complaint then the Organisation's Disciplinary policy will be followed. The following process for cascade must be followed: **Organisational or Non-Clinical Formal Complaints** Learning must be discussed at: • EMT meetings • SMT meetings • Department/service/team meeting and/or training sessions if relevant. **Clinical Formal Complaints** Learning must be discussed at: • EMT meetings • Clinical Leadership Team (CLT) meetings

6.7	• Department/service/team meeting and/or training sessions if relevant
	Legal Action and Disciplinary Procedures Where a complaint is received in a situation where legal action may be taken or should be taken, or where the police or counter-fraud investigators are involved, the relevant Director must be informed, and discussions will take place with the relevant authority (as progressing the complaint might prejudice subsequent legal or judicial action). If this is the case, the complaint will be put on hold and the Complainant will be advised. If this is not the case, the investigation should be undertaken as quickly as possible to allow urgent action to be taken to prevent similar incidents arising. In situations where a complaint is received where legal action is or may be taken the Organisation's Insurers must be informed (see Appendix 5 for criteria and timescales). The Organisation's Insurers will be notified by the Head of Governance, Compliance & Projects or in their absence the Director of Finance & Resources. Litigation should not be a barrier to investigating or progressing a complaint. However, the Complainant should be offered the option of suspending the litigation process until the Complainant has received the outcome of the investigation. This will be the Complainant's decision to make, and the Organisation should regard the complaint and ligation processes separately. **Reporting to External Bodies** There are some specific circumstances where other external bodies must be informed of a formal complaint (see Appendix 4 for the complete list of circumstances and time frames). **Monitoring of Complaints**
6.7.1	Progress with the action plan must be monitored by the manager of the service/department and their line manager. All complaint action plans will be monitored by the service/department managers at department/service meetings.
6.7.2	Updates must be provided on a monthly basis by the relevant service/department managers to the Organisation's Governance and Compliance Panel (see process in Appendix 5). If requested the relevant service/department managers will be invited to the Governance and Compliance Panel meetings to provide a verbal update. The action plan must also be tabled at the relevant Trustee Committee Meeting for discussion and assurance for the Board (see process in Appendix 6). **Closure of Complaints**
6.8	Prior to final closure of all formal complaints the following must have taken place: • The final letter must have been sent to the Complainant.

	• On receipt of the final letter no further action is required by the Complainant or no response has been received within 14 days of the letter being sent • All actions on the action plan have been completed. • The lessons learnt have been cascaded. • The Organisation's Governance and Compliance Panel have recommended sign off. The process for final closure of a formal complaint, and sign-off of any action plans, is documented in the Incident & Complaint Action Plan Closure Flowchart (Appendix 6) of this policy.
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6.10	
6.11	

7.	References
	Frivolous, Vexatious and Abusive Complaints Policy (Health & Care Professional Council 2014) Francis Report (2013)
8.	**Consent**
	Suitability to represent a patient normally depends on the patient's knowledge and consent that a specific person may act on their behalf. In these cases, consent needs to be obtained from the patient for the release of potentially confidential information. Where the patient has died or is unable to give consent, it is necessary to establish in these circumstances that the Complainant is suitable to represent the patient (please refer to the Organisation's PTC68 Consent Policy.
9.	**Training**
	Training must be provided for all staff in the Organisation at Departmental induction and at regular intervals thereafter. Training for managers and senior staff members must be provided and include: • What is a complaint? • How to receive, investigate and administer a complaint. • How to deal with someone making a complaint. • The complaints process, both informal and formal.
10.	**Roles and responsibilities**
	Chief Executive Officer (CEO) The CEO is responsible for assuring the Board of Trustees that policies, procedures and guidelines are being implemented and monitored for effectiveness and compliance. **Authors of Policies** The author of the policy is responsible for ensuring newly approved policies are sent to the Executive Assistant, for them to be included in the Organisation's staff communication updates. **Line Managers** Line managers are responsible for ensuring that: • This policy is made available to all staff within their department. • That staff they are responsible for implement and comply with the policy. • That staff are updated of any change to this policy. • In teams/services where this policy is of particular relevance, this policy is placed on team meeting agendas for discussion, any outstanding training needs identified and actions to address put in place. **Staff** All staff and volunteers, including all permanent, contracted, temporary/bank, apprentices, and students should familiarise themselves with this policy and ensure that the policy is fully implemented.
11.	**Equality statement**
	We recognise that some groups of the population are more at risk of discrimination or less able to access services than others and that services can often unintentionally put barriers in place that can limit or prevent access. This policy reflects the Organisation's determination to ensure that all parts of our community have equality of access to services and that everyone receives a high standard of service as a service user, carer or employee. This policy anticipates and encompasses

	the Organisation's commitment to prevent discrimination on any illegal or inappropriate basis and recognise and respond to the needs of individuals based on good communication and best practice.
12.	**Implementation and monitoring process**
	In teams/services where this policy is of particular relevance discussion of this policy must be included in the team/service induction for all staff and volunteers. A report including incidents and complaints must be submitted quarterly to the Care and People Committees for monitoring who will escalate issues to the Board. An annual audit of complaints will be carried out by the Head of Governance, Compliance and Projects. The results of which will be shared with the Executive and senior management team and the Board of Trustees.

JANUARY 2021

IF YOU STILL FEEL WE HAVE NOT ADDRESSED YOUR COMPLAINT

We recommend that you contact:

The Charity Commission
The Charity Commission, P.O. Box 1227, Liverpool, L69 3UG
www.charity-commission.gov.uk
Tel: 0845 600 8000

The Fundraising Regulator
2nd floor, CAN Mezzanine Building, 49-51 East Road,
London, N1 6AH
Tel: 0300 999 3407
Email: complaints@fundraisingregulator.org.uk

Care Quality Commission

Tel: 03000 616161
Email: enquiries@cqc.org.uk

Kent & Medway CCG, Complaints Manager
Tel: 01634 335177
Email: kmccg.complaints@nhs.net

COMMENTS, COMPLIMENTS, COMPLAINTS AND CONCERNS

We value your comments, compliments, concerns or complaints. **ellenor** aims to provide the highest standards of service to you, your family and carers and to our supporters and customers. We hope that you will be happy with every aspect of our care and service.

COMMENTS

Any suggestions on how our services might be improved are welcome. Please speak with a member of staff or complete a comments card which can be found near reception.

COMPLIMENTS

It is very reassuring and motivating for us to know that we are meeting the high standards of care and service that we set ourselves. If you are particularly pleased with the service you receive, we would be delighted if you would tell us.

Please send us an email to yourvoice@ellenor.org or write to us at:
ellenor, Coldharbour Road, Gravesend, DA11 7HQ.

COMPLAINTS – WHAT SHOULD I DO FIRST?

We recognise we don't always get things right. If you are unhappy about the care or service you have received, please speak to a member of staff who will try to deal with your concerns immediately.

WHAT IF I AM NOT HAPPY WITH THE RESPONSE TO MY COMPLAINT/CONCERN?

Please ask to speak with a member of the Senior Management Team or, if this is related to patient care, you can contact the Director of Care at:
ellenor, Coldharbour Road, Gravesend, DA11 7HQ.

All complaints are taken seriously and fully investigated. You will receive a written acknowledgement explaining the process within two working days of receipt and a full written response within 20 working days.

WHAT CAN I DO IF I AM NOT HAPPY WITH THE OUTCOME OF THE INVESTIGATION?

Please contact the Chief Executive Officer at **ellenor**, Coldharbour Road, Gravesend, DA11 7HQ.

ellenor improves services by listening to and learning from feedback.

You can email on yourvoice@ellenor.org if you wish to provide any feedback.

COMMENTS, COMPLIMENTS, COMPLAINTS AND CONCERNS

ellenor aims to provide the highest standards of service to you, your family and carers and to our supporters and customers. We hope that you will be happy with every aspect of our care and service. We value your comments, compliments, complaints and concerns. Any suggestions on how our services might be improved are welcome.

If you are particularly pleased with the service you receive, we would be delighted if you would tell us.

However, we recognise we don't always get things right. Please feel confident to speak to a member of staff who will try to deal with your concerns immediately who will support you if you wish to make a complaint. If you are not happy with the response, please ask to speak with a member of the Senior Management Team or, if this is related to patient care, the Director of Care on 01474 320007.

All complaints are taken seriously and fully investigated. You will receive a written acknowledgement explaining the process within two working days of receipt. A full response following investigation will be within 20 working days. Where this is not possible, you will be notified of the reasons. A copy of the complaints leaflet is available.

IF YOU STILL FEEL WE HAVE NOT ADDRESSED YOUR COMPLAINT

We recommend that you contact:

The Charity Commission
The Charity Commission, P.O. Box 1227,
Liverpool, L69 3UG
www.charity-commission.gov.uk
Tel: 0845 600 8000

The Fundraising Regulator
2nd floor, CAN Mezzanine Building, 49-51 East
Road, London, N1 6AH
Tel: 0300 999 3407
Email: complaints@fundraisingregulator.org.uk

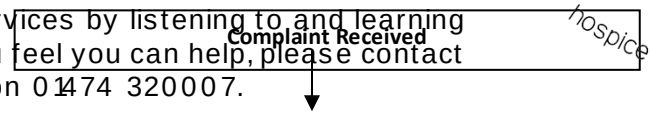
Care Quality Commission
Tel: 03000 616161
Email: enquiries@cqc.org.uk

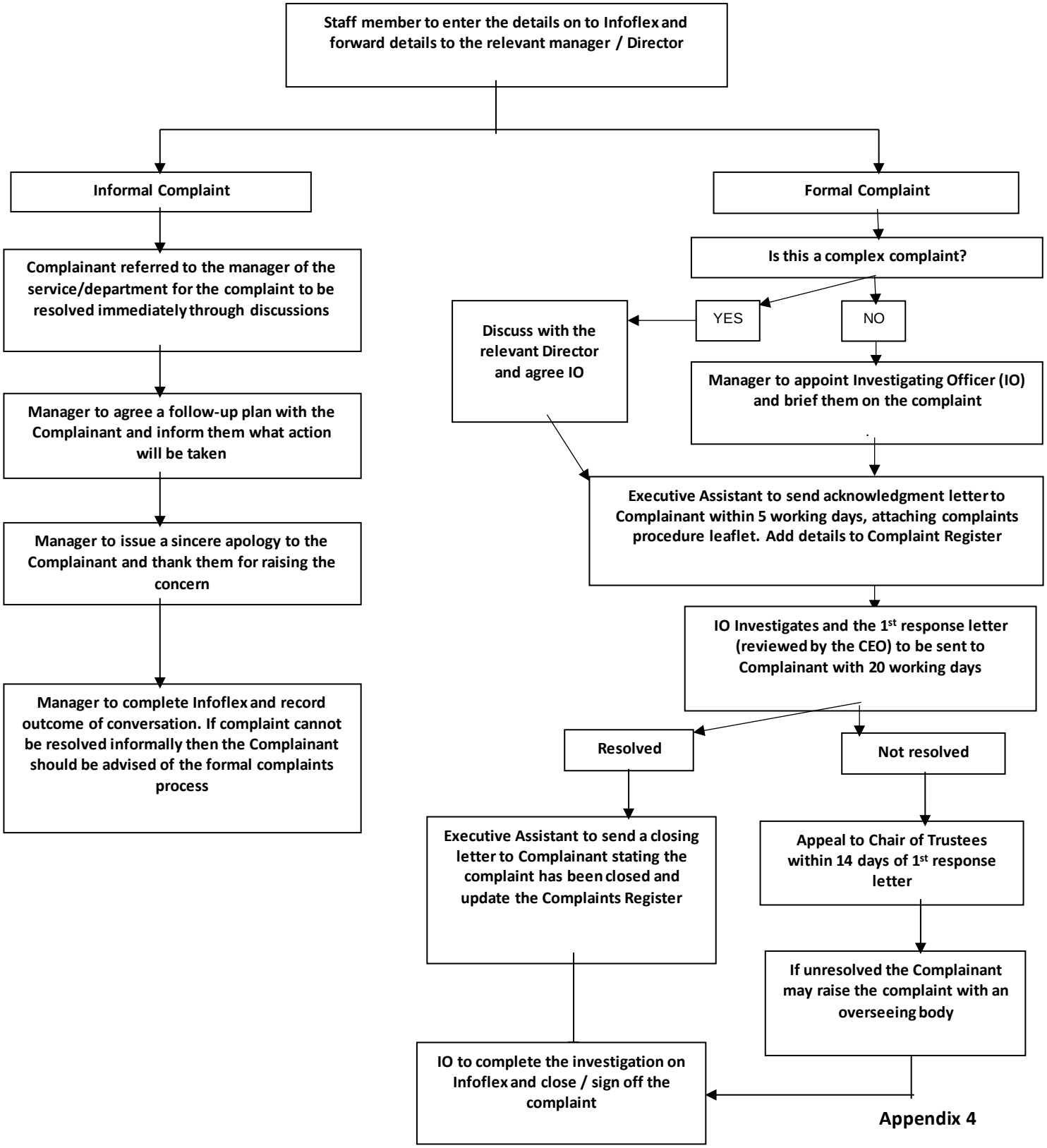
Kent & Medway CCG, Complaints Manager
Tel: 01634 335177
Email: kmccg.complaints@nhs.net

Making a complaint will not prejudice your care in any way. All complaints will be dealt with in a confidential manner.

ellenor improves services by listening to and learning from feedback. If you feel you can help, please contact a member of staff on 01474 320007.

COMPLAINTS PROCEDURE FLOW CHART





Appendix 4

LIST OF OMBUDSMEN AND OVERSEEING BODIES

The Charity Commission

The Charity Commission, P.O. Box 1227, Liverpool, L69 3UG

www.charity-commission.gov.uk
Tel: 0845 600 8000

The Fundraising Regulator
2nd Floor, CAN Mezzanine Building, 49-51 East Road, London, N1 6AH
Tel: 0300 999 3407
Email: complaints@fundraisingregulator.org.uk

Care Quality Commission
Tel: 03000 616161
Email: enquiries@cqc.org.uk

Kent & Medway CCG, Complaints Manager
Tel: 01634 335177
Email: kmccg.complaints@nhs.net

INFORMING EXTERNAL ORGANISATIONS OF FORMAL COMPLAINTS

LEGAL OBLIGATION		LOCAL REQUIREMENT		INTERNAL REQUIREMENT	
Care Quality Commission (CQC)	All SI's	CCG	All SI's	Chair of Trustees & Chair of relevant Committee	All SI's that the Organisation feels may become a claim &/or create reputational damage &/or negative media interest
Information Commissioners Office (ICO)	All Serious data breaches where the persons affected are not RIP	Organisation's Insurers	All SI's that the Organisation feels may become a claim		
		Police	All SI's that involve criminal acts		
Health, Safety Environment (HSE)	RIDDOR	Counter Fraud	All SI's that involve fraudulent acts	Internal Head of Marketing & Communications	All SI's that may lead to negative media interest
Charity Commission	• Harm to people who come into contact with your charity through its work: • Loss of money or assets; • Damage to charity's property; • Harm to your charity's work and reputation.				
Organisation's Auditors	Any reported to Charity Commission above			ICO	All Serious data breaches where the persons affected are not RIP

ellenor Incident Action Plan Flowchart