SPSO decision report

Case: **201901364, Fife NHS Board**
Sector: Health
Subject: complaints handling
Decision: upheld, recommendations

Summary

C attended the minor injuries unit at Queen Margaret Hospital and was unhappy with the way they were dealt with by a member of staff in the reception area. C considered that the board's investigation of their subsequent complaint was incompetent and lacked professionalism.

We found that the board failed to take timely and robust action to investigate and respond to C's complaint. The complaint was initially dealt with as a concern at C's request, however, we considered it should have been dealt with as a formal complaint investigation from the outset, or at least immediately upon C expressing dissatisfaction with the response to their concern. It was not logged as a complaint until the board met with C a few weeks later. The timescale for responding to C's complaint was excessively beyond the 20 working day target timeframe.

There was ongoing confusion as to the identity of the individual C's complaint was about, which was never resolved. The board did not take robust steps to try to identify and obtain written statements from the individuals present. By the time they requested CCTV footage of the incident, it was no longer available. C continued to seek answers and had two post-complaint meetings. We found that there was a failure to adequately follow up on agreed actions points from the first of these meetings. Overall, we concluded that the board's handling of the complaint was unreasonable and we, therefore, upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to take timely and robust action to investigate their complaint, including the failure to treat the complaint as a complaint from the outset and quickly pursue relevant evidence; the failure to respond to the complaint within the required timescale; and the failure to adequately follow up on agreed action points from a post-complaint meeting. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- The board should ensure complaint investigations conform to the NHS Model Complaints Handling Procedure, particularly in terms of timeliness, thoroughness, and how to deal with complaints where a person states they do not wish to complain.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.