

THE INDEPENDENT ADVICE AND SUPPORT SERVICE
AN ANALYSIS OF PATTERNS OF ACTIVITY, USAGE AND
CLIENT PROFILES PREPARED FOR CITIZENS' ADVICE
SCOTLAND

FINAL REPORT

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Executive summary

Introduction and Background

- A national framework for an Independent Advice and Support Service (IASS) was launched in March 2006 (HDL (2006) 13). The service, which is funded by local NHS Boards and provided through Citizens Advice Bureaux in Scotland, has two core aims: to assist people to identify and explore options about raising a concern or making a complaint if they are dissatisfied with some part of their health care or treatment; and to access information and advice to help people maintain or improve their health and well-being.
- The implementation of the service has been incremental, but there is now an IASS in all 14 territorial Health Board areas.

Objectives and methods

- The objectives of the study were to: indicate the number and nature of complaints and concerns being raised and the actions and strategies undertaken by IASS caseworkers in response; and illustrate the socio-demographic characteristics of the people using the service, including indicators of equality and diversity.
- The study comprised three methods. First, a quantitative analysis of the patterns of complaints and concerns over a 12-month period dealt with by IASSs in four NHS Health Board areas, together with information on client characteristics in these areas. The areas selected included two rural, one city and one mixed urban and rural area. The information collected by IASS on complaints, concerns and activities/strategies is categorised according to standard categories also used by ISD. Second, a quantitative analysis of all client and complainant data collected across IASSs over the period 1 September 2006 to 31st August 2008. This includes data from IASSs that have not been operational over this entire period. The data were drawn from three sources of client information: A client record form; a complainant profile and an equalities and diversity form. The third method was an analysis of case examples submitted by IASS caseworkers to identify themes in the pattern of concern

and complaints, to illustrate IASS caseworker activity and identify and draw attention to some wider emerging issues.

- The data do have limitations. The analyses raised questions concerning the completeness and consistency in relation to the quantitative data. This is particularly the case in relation to client related information, where there is risk that the experiences of some groups of people are consistently under-recorded.
- In addition the case examples although illustrative cannot be treated as a representative or random sample.

Analysis of Four Sample Area IASSs

- Where client information was available the data from the four sample area IASSs suggest that a comparatively high proportion of users were lone adults, living on low incomes, reliant on some form of benefit or retirement pension, living in accommodation rented from social landlords or in owner occupied properties. Across the four sample areas somewhere in the region of two-thirds had some form of health problem.
- The great majority of people, particularly outwith the city area were UK nationals for whom English was their first language. In the city area, however there were a small number of non-white clients and people who required an interpreter. All but one of those providing a response described themselves as heterosexual/straight. One person described herself as a lesbian/gay woman.
- The majority of people self-referred to the IASS, but a significant proportion came via other sources, predominantly, but not exclusively, in relation to issues relating to their own care or treatment.
- Across the sample areas the four complaints or concerns most frequently raised were: clinical treatment (all aspects), staff attitudes and behaviour, staff communication (particularly oral) and staff competence. The distribution is not dissimilar to the Scotland-wide pattern for NHS complaints recorded by ISD.

- 'Medical staff' were the single largest staff group and hospital acute in-patient and outpatients services the two service areas generating the greatest proportion of complaints.
- In responding to these complaints and concerns the IASS case workers across the four areas drew on a broadly similar repertoire of activities: drafting a letter with the client to send on the client's behalf; drafting a letter with the client, for the client to send; giving the client information to take away; and informal contact with NHS staff. There may however be some difference in emphasis between areas: with some IASSs perhaps adopting a more 'hands on' approach than others. This may reflect the substance of the concerns and complaints as well as the preferences of the clients themselves.
- Over one-third of issues were resolved and in over one-fifth of cases further action was taken. The apparent intractability of the problems raised though is also suggested by the finding that 22% of cases were not resolved and no action was taken. What also emerges is the frequency with which the outcome is 'no further contact from client'.
- In three of the four areas there was an apparent increase in new issues relating to sickness benefit and disability benefit dealt with by the CABX over the period that the IASSs became operational. This may begin to suggest that locating the IASSs within CABx helps to generate other outcomes for clients.

Analysis of national client profile

- To illustrate the wider client profile available data from IASSs from across Scotland collected between Sept 2006 and August 2008 (including from the four study areas described above) were analysed. Not all IASSs had been operational over this period and there are, as already noted, questions about the consistency and completeness of the data.
- Similar patterns emerge from this larger data set as was found from the analysis of data from the four study areas. Complainant Profile data, for example, suggest again that single adults comprised the largest single group of clients, followed by couples without children. People were predominantly living in social landlord or private rented accommodation followed by those in

owner occupied housing. Where information was available the majority of people were either retired or unable to work, with the minority in paid full-time or part-time employment. Nearly two-thirds had a health problem which for many was of a long-term nature. Available information suggests a considerable proportion were on low incomes, either reliant on benefits or retirement pensions.

- The client record data again suggests high rates of self-referral to IASS, but with some referred by other sources. Approximately two-thirds were raising issues about their own care or treatment, with one-third coming on behalf of a family member or spouse or/partner, including someone who had died. Around 9% of complainants needed assistance to raise concerns, either on the basis of age, mental health, mobility issues or language issues.
- Incomplete data makes it difficult to determine the extent to which the different 'equalities' groups are proportionately represented among users of the IASS. Where data are available it suggests higher proportions of women than men use the service. Although the majority of users are white/white Scottish some people who identify as from different ethnic groups and/or for whom English is not their first language are seeking access to the service. Two people identified as transgender, while, in terms of sexual orientation, one person identified as a lesbian/gay woman. This may tentatively suggest that the IASS is being accessed by people who, historically, might have felt excluded.

Case example analysis

- A number of cases examples selected by IASS caseworkers were drawn upon to illustrate the range of concerns and complaints people raise and the broad range of activities the caseworkers are involved in which include but extend beyond dealing with the complaint.
- The complaints and concerns described in the case examples fall into eight broad categories: inadequate information provided to the complainant; delayed or mis-diagnoses; medical accidents; issues around treatment; delays in receiving treatment; care plans which override people's wishes; perceived attitudes and behaviours of professions; and issues relating to policies,

procedures and practices. In some cases what is also suggested is the possibility of people experiencing not just indirect but potentially direct discrimination on the basis of, for example, having a mental health problem.

- In responding to these concerns and complaints, the case examples suggest the IASS caseworkers perform three core roles: acting as a conduit for an extensive knowledge base; providing advice and acting in a mediatory capacity between clients and different agencies and professionals; and providing one-to-one independent support. IASS workers act as advocates, in the broadest sense, supporting and acting on behalf of people who may be vulnerable or upset or who feel powerless in the face of statutory services. But these roles do not just relate to supporting people to deal with complaints and concerns. What may be initially presented as a complaint may turn out to be just the tip of an iceberg of complex health and welfare problems the client is experiencing requiring the caseworker to engage with a wide range of agencies and services on the client's behalf.
- A number of broader issues arose from the case examples. These included clients' fears of complaining in case this impacted negatively on the services they received. Other issues related to the potential for discrimination, procedural barriers and areas where there is a lack of clarity as to where responsibility for action in redressing complaints lies.
- What the case examples also reveal is the role of the IASS in supporting people to take their complaints beyond the NHS complaints system, for example to the Scottish Public Services Ombudsman or Mental Welfare Commission.

Conclusions

- There are limitations to the data that mean that the findings are indicative rather than definitive. To improve the quality and consistency of the data CAS is anticipating introducing a new electronic case management system. This overview also suggests that there may also be a value in streamlining and simplifying the client/complainant data to enhance consistency and completeness, even if at the cost of some of the detail. In

spite of some of the limitations of the data a number of conclusions emerge from the analysis.

- Analysis of the patterns of concerns and complaints recorded by IASSs in four 'sample' health board areas suggests the pattern is comparable with the Scotland-wide pattern for NHS complaints as recorded by the ISD. While outwith the scope and remit of this report this may suggest areas for continuous learning by Health Boards and Family Health Services.
- The actions and strategies deployed by IASS caseworkers will be related to the nature of the complaints and concerns presented. But the data also begin to suggest there may be different 'styles' of activity in different areas with more 'hands on' activity in some areas compared with those where the clients appear more active in following through the advice. This may reflect the substance of the concerns and complaints, the preferences of the clients themselves and also, perhaps clients' level of confidence in dealing with statutory organisations.
- In terms of 'outcomes' the quantitative data suggest a very mixed picture. Over one-half of cases were resolved or further action taken. But what also emerges is the apparent intractability of some of the problems raised. Further, the 'outcome' in around 17% of cases was that the client made no further contact. The intractability and 'drop out' rate may be issues for further consideration by both IASS and Health Boards.
- What cannot be established from the broad-brush figures is whether and in what ways IASS performs a 'preventative' role.
- In addition, however, are the 'outcomes' in terms of welfare benefits and/or links made with other services that the caseworkers facilitate for clients. This is suggested very crudely from the CABx data on new issues raised in relation to disability and sickness benefits. But it is the case examples which illustrate how by being integral to CABx the IASS caseworkers are able to 'add value' by providing an 'holistic' service which includes, but extends beyond support for a concern or complaint about health services.
- The analysis of client characteristics suggests a population on a comparatively low-income, living on their own, a high proportion of whom have physical or mental health problems. The

equalities and diversity data are perhaps the most problematic due to the high levels of non-response, but do suggest that IASS is being accessed by people who historically may have felt excluded, for example on the basis of their sexuality or gender.

- The data suggest the IASS has a role in supporting people who by virtue of poverty, disability and or/health problems or being alone may experience barriers to obtaining assistance and whose previous experiences of statutory agencies may not have been positive. The support of an empathetic worker, and one independent from the different statutory agencies may be particularly salient in those contexts where people feel that they have been 'brushed off' or have experienced direct or indirect discrimination.
- What also became apparent from the case examples was the extent to which clients were inhibited from raising concerns because of a fear of recrimination on the part of service providers. The IASS service by providing an independent source of advice, acting in a mediatory role, and providing one-to one support for people, who may, for a variety of reasons be vulnerable clearly has a role to play not only in supporting people to obtain redress but also has the potential to help to challenge some of the power imbalances that people may feel or experience.

List of abbreviations

AA	Attendance Allowance
A & E	Accident and Emergency Department
ASBO	Anti Social Behaviour Order
AvMA	Action for the Victims of Medical Accidents
CABx	Citizens Advice Bureaux
CAS	Citizens' Advice Scotland
DLA	Disability Living Allowance
GP	General Practitioner
IASS	Independent Advice and Support Service
ISD	NHS Scotland Information and Statistics Division
MWC	Mental Welfare Commission
SAMH	Scottish Association for Mental Health
SPSO	Scottish Public Services Ombudsman

1. Introduction and background

In November 2005, the then Minister for Health and Community Care indicated that NHS Boards should fund an Independent Advice and Support Service (IASS) for patients, carers and public across their local area.

A national service framework for the IASS was launched in March 2006 (HDL(2006)13). This set out the aims, scope, principles and standards of the service and the responsibilities of NHS Boards.

The two core aims of IASS are to assist, patients, carers, service users and members of the public to:

- Identify and explore options about raising a concern or making a complaint when they are dissatisfied with aspects of their treatment or care provided by them, by, or on behalf of, the NHS Board; and
- Access information and advice on issues that they regard as being important to help them to maintain or improve their health and well-being.

Funded by local NHS boards the service is part of the Citizens Advice Service in Scotland (CABX).

Although implementation since the launch in 2006 has been incremental, local bureaux across the 14 Health Boards now offer this service, with the support in the majority of areas of specialist case workers¹ (see Appendix 1).

The initial contract between the IASS provider and the NHS Board is for three years. Those bureaux who were among the first to provide the service may now be moving toward the end of the first three years. It is therefore timely for Citizens Advice Scotland to review the range of activity the IASS is undertaking, the outcomes being achieved for clients, and the profiles of people using the service, both to demonstrate what has been achieved but also to identify issues arising both for IASS and of wider concern.

¹ In Western Isles this service is provided by the four bureau managers

2. Objectives and Methods

Objectives

An earlier evaluation was commissioned by Citizens Advice Scotland (CAS) with the aim of identifying, through interviews with the range of stakeholders and a sample of clients, together with an analysis of data, the extent to which the service was effective in meeting its service and strategic objectives (Lacey and Lavery, 2008²).

The aims of this smaller scale study were to draw on quantitative data from IASS services in a sample of four NHS health boards, available quantitative data from across all IASS on client characteristics, including equality and diversity data, and qualitative case example data in order to illustrate:

- The pattern of complaints and concerns raised and in relation to which staff groups
- Actions/Strategies undertaken by IASS
- Outcomes of actions in relation to concerns or complaints
- Client characteristics, including:
 - Sources of referral to IASS, on whose behalf acting, special needs etc
 - Socio-demographic characteristics including income sources, benefits received, economic and caring status etc.
 - Equality and diversity indicators

Methods

Reflecting the different data sources the analysis comprised a three-pronged approach:

Quantitative analysis of patterns of complaints and concerns raised

To obtain a picture of the pattern of usage, activity and the outcomes of the IASS, quantitative data collected in four NHS Health Board areas have been analysed. This approach was chosen because IASS across

² Lacey, M. and Lavery, T. (2008) *Evaluation of the IASS: Final Report*, Edinburgh: Citizens Advice Scotland

Scotland have been set up at different rates. To use global data from across the services would therefore not have given an accurate picture of the pattern of activity. Four areas were therefore selected which had complete data for a 12-month period. In addition they represented areas with different socio-demographic profiles including urban, rural and mixed urban/rural communities. It was not possible, however, to cover the same 12-month period for each of the four areas. Table 2.1 indicates the four areas and the 12-month periods covered by the data analysis

NHS Health Board Area IASS	12-month period covered by the data analysis
Rural area 1	01/09/07 - 31/08/08
Rural area 2	01/07/07 - 30/06/08
City area	01/05/07 - 30/04/08
Mixed city and rural area	01/06/07 - 31/05/08

Quantitative data on 'contacts' provided by these sample services were analysed to indicate:

- Client/complainant profiles including socio-economic and equality and diversity indicators

Numbers of complaints and concerns by:

- Type of complaint
- Staff group
- Service Area
- Action/strategy taken
- Outcomes of action to address concerns/complaints

Quantitative analysis of client characteristics

Using data provided by all IASS the second element comprised a quantitative analysis of client characteristics. The analysis is based on the three forms completed by local IASS in relation to clients using the service: a client record form; a complainant profile form and an equalities and diversity form (Word copies attached at appendix 2). This data was analysed to identify:

- Sources or referral to IASS, on whose behalf acting, special needs etc.
- Socio-demographic characteristics including income sources, benefits received, economic and caring status etc.
- Equality and diversity indicators.

Because of the different start up dates and the incompleteness of some of the data this analysis will be illustrative, rather than definitive, providing a very broad overview of the characteristics and needs of clients referred to IASS across the health board areas.

Qualitative analysis of a sample of cases

Drawing on a sample of cases selected by IASS workers, this component had three objectives. First, an analysis of the material to identify any common themes in terms of complaints/concerns, actions and outcomes; second, to use these case examples to illustrate the nature of IASS activity at client level; third, to identify social policy issues raised by the nature of the complaints/concerns and outcomes.

Limitations of the data

Quantitative analysis of patterns of complaints and concerns

The codes and categories used for recording complaints and concerns are the same as those used to record NHS complaints by the Information and Statistics Division (ISD). However, in most bureaux, the current system for recording information about clients and their issues is on paper files, with some basic information on the issue and some of the actions taken being additionally entered into an ACCESS database. This limits the detail that can be recorded about any particular case. Some of the data is also incomplete and there may be a degree of variation in the interpretation of the categories and codes, particularly given the complexity and multi-dimensional nature of some of the cases with which the IASS deals.

It is important to underline that on their own the quantitative data can only describe the patterns of activity, but cannot fully explain them. Further, the complexity of outcomes and the quality of the service (as well as the quantity) cannot be fully captured.

Over the next three years Citizens Advice Scotland will roll out a new electronic case management system to all bureaux. This combined with more comprehensive advice codes (which will cover many more areas of advice and clients' issues) means that bureaux and CAS will be able to report in much greater detail on the clients using the service; the issues that they raise; the work being done by bureaux to assist clients; and the outcomes for clients.

Client data

In relation to client data the analysis was limited by both the incompleteness and the inconsistency of the material. In relation to a number of questions, around income and age, for example, clients often appeared reluctant to provide the information. While difficult to overcome this does raise a risk of systematic bias creeping in, with the experiences of some groups of people being consistently under-recorded. In addition, there may be a question about the consistency with which the data are collected and recorded. Variations between, for example client record sheet data, complainants profile data and equality and diversity data, make it difficult to ascertain whether the data refer to the same individuals and/or whether within and across CABx this data is being collected in different ways. It would, for example, be helpful to determine whether the data refer to clients or individual episodes, or even contacts made within an episode - that is whether one client and/or complainant appears a number of times. Further, it is not clear whether the distinction between 'client' and 'complainant' consistently understood and applied.

Case examples

The cases, described in chapter 5 were not randomly selected, but have been selected from anonymised examples submitted by different IASSs in response to a call from the CAS Health Support Unit Co-ordinator. As a result they can not be regarded as representative of the range or type of work the IASS undertakes. The amount of information provided in relation to each case was also variable. Again, however, this data provides a snapshot of the types of activities being undertaken - giving more qualitative substance to the quantitative data.

3. Analysis of Four Sample Area IASSs

Given the incremental implementation of the IASS across Scotland, the data from services provided in four health board areas which had been running for at least 12-months were analysed to provide an indicator of patterns of usage.

It must be emphasised at the outset that it is not intended here to use these four areas as in any way benchmarks for performance or activity, they have been selected just to provide an illustration of the range and type of activities undertaken and the needs of clients seeking assistance.

The following summarises the patterns of activity across the four areas. The data for the individual areas are presented in appendix 3.

Client/Complainant profiles

A national analysis of client/complainant profiles will be discussed in the next chapter. Here the aim is to give some sense, however incomplete, of the characteristics of the people who used the IASSs in the four sample areas. Clearly the different population sizes, and, by extension the absolute numbers for whom information is available will be reflected in some of the patterns.

The complainant profile suggest that single adults may be among the highest users of the IASSs: in the city area they comprised one-half of the sample for whom data on household type were available. Couples with and without children and lone parents appear to comprise the next largest groups.

In terms of accommodation type the sample was predominantly comprised of people living in owner-occupied accommodation or renting from social landlords. The balance between these two varied between Health Board areas, in two areas (one rural and one mixed) there were more owner-occupiers than people renting from social landlords (though based on small numbers), this was reversed in the other two areas (one urban and one rural area).

The majority did not appear to have caring responsibilities. Where they did this was predominantly for children.

Data on sources of income, including benefits were incomplete and highly variable, but among those providing data there were higher numbers of people in three of the areas who were retired or unable to work due to illness than there were people in full or part time employment. This may be an area where the 'declined to answer' responses may have a significant affect on the pattern.

Where information was provided, it is evident that people were drawing on and in some cases reliant on benefits. In one city area, this was the case for 40% of people providing this information. What is also notable is that in the three areas where some information was provided some people were on client or household incomes of less than £10,000. In the city, this comprised two-thirds of people answering this question (41 out of 61).

In each of the four areas there were significant numbers of people with health problems - whether long term, short term or mental health issues: in fact a crude estimate across the four areas suggests that nearly two thirds had a health problem.

The data on transport usage is too incomplete (including no responses from one area) to draw out conclusions, but clearly there are a substantial minority who are unable to use buses and/or need help with travel.

In one rural health board area no-one was prepared to answer the question on the need to use drugs and alcohol on a daily basis to function and in the mixed area people either indicated that they did not need drugs or alcohol or refused to answer. In the city area two of the 91 people responding indicated that they did need to use drugs or alcohol as did four of the eight people in one rural area³

The Client Record data suggest that in two of the health board areas (one rural and one mixed area) the majority of people self-referred to the IASS. In another rural area the converse was the case, with the majority referred from 'other' sources. In the city area two-thirds self-referred, the majority of the remainder also being referred from 'other' sources. However, according to the responses to a later question on the client record sheet the vast majority in all four areas had not sought help with the complaint elsewhere.

³ The comparatively high proportion of people in one area disclosing a need to use alcohol or drugs on a daily basis may reflect people's experience, it is possible, however, that people were interpreting 'drugs' to mean prescribed medication.

In the two rural areas the majority were raising an issue about their own treatment. In the city and mixed areas, 30% and 50% respectively of people about whom information was available were attending on behalf of someone else, including people who had died.

Complainants needed to be represented because of age, mental health, language or for mobility-related reasons.

Insufficient data were available to develop or compare age profiles. But the data do suggest a comparatively high proportion of older people - in the city area for example, where one quarter of clients were aged 65 years and over. In this area too, however, a small number of complainants were younger people including three aged 15 years or under.

In three of the areas a small number of people were subsequently referred on; none were in the fourth area.

Client equality and diversity data were provided by three of the four areas. The following summarises the available information, however, as noted in chapter 2, much of the data was incomplete, and perhaps even more than the client record and complainant profile, may raise concerns about systematic under-recording.

In two of the areas women outnumbered men, in the city area there were almost equal proportions of men and women.

Age information was consistently under-recorded to the extent that it is not feasible to indicate an across-area pattern

In the city and mixed areas there were a small number of people using the service who were not UK nationals. In the city area two people were from the Indian sub-continent and preferred to speak in either Urdu or Punjabi and required an interpreter to communicate. In the mixed area one person was from Poland and although the language they preferred to speak in was Polish did not indicate that they needed an interpreter.

In the two areas for which information on religion was available only in the city area did two people indicate their religion as other than Christian or 'none'. These two people were both Muslim.

Only one person indicated that they were a lesbian/gay woman, the remainder (of those prepared to answer) were 'heterosexual/straight'.

In two of the areas significant numbers of those responding had long term health conditions: seven out of nine in one area and 18 out of 43 in the city area. Insufficient people responded in the third area to make a meaningful comparison.

In terms of ethnicity, the majority of those responding described themselves as white or in one area white Scottish. In this city area one person described themselves as 'mixed' and three people as 'Pakistani'.

Of those prepared to provide the information, the IASS client profile would seem to indicate a comparatively high proportion on low incomes, reliant on some form of benefit or retirement pension, many of whom lived in lone households. Outwith the city area those responding to the equality and diversity questions were predominantly white, UK nationals for whom English was their first language. Only in the city area were there a small number of non-white clients. All but one of the people prepared to answer the question on sexual orientation described themselves as heterosexual/straight. Where information was available significant numbers had long-term health problems.

Concerns and Complaints

Table (3.1) summarises the 'top three' concerns and complaints across the four areas. This suggests that the four issues consistently raised relate to clinical treatment all aspects, staff attitudes and behaviour, staff communication (particularly oral) and staff competence. The pattern is comparable with the Scotland-wide pattern for NHS complaints as recorded by the ISD.

Table 3.1 Comparison of top three concerns and complaints across four areas

IASS Health Board Area	'Top Three' concerns and complaints						
	1	No. (%)	2	No. (%)	3	No. (%)	Total-All complaints concerns (%)
Rural 1	Clinical treatment (all aspects)	19 (22.9)	Staff Competence	18 (21.7)	Staff attitude and behaviour	17 (20.5)	83 (100)
Rural 2	Staff attitude and behaviour	27 (23.9)	'Other'	19 (16.8)	Staff-communication (oral)	15 (13.3)	113 (100)
City	Staff attitude and behaviour	43 (22.5)	Staff Competence	42 (22.0)	Clinical treatment (all aspects)	23 (12.0)	191 (100)
Mixed	Clinical treatment (all aspects)	18 (26.9)	Staff attitude and behaviour	13 (19.4)	Staff communication (oral) Staff competence	9 (13.4) 9 (13.4)	67 (100%)
Scotland¹ (Hospital and community health services) 07-08	Clinical Treatment (all aspects)	1229 (15.5)	Staff attitude/behaviour	1167 (16.0)	Communication oral	650 (8.9)	7294 (100)

¹Source: ISD Hospital and community health services: number of complaints by issue raised. Scotland 02/03 - 07/08 (<http://www.isdscotland.org/isd/4418.html>). This does not include family health services (medical, dental and optical) which comprise a different data set.

Reflecting this pattern of concerns and complaints, the single staff group generating the most concerns and complaints was medical staff - accounting for between 60 - 70% across the four areas.

Hospital acute in-patient services also generated the most complaints and concerns in three of the areas, followed by Hospital acute out-patients in two of the areas. Psychiatric/learning disability outpatient and community based services also featured in two areas, as did 'community services-not elsewhere'. As a result Health Boards were the main NHS area although in the mixed area GPs were the focus of 20% of the complaints and concerns.

Actions and Strategies

The three most frequent responses to the range of complaints and concerns are summarised in table 3.2 (appendix 4 presents data for all the complaints and concerns in each area). Clearly, the actions and strategies will be related to the nature of the complaints and concerns presented, and although as table 3.1 suggests, in very broad terms similar categories of issues were being raised across the four areas, the specifics may generate a quite different set of responses. Two features are, however suggested by table 3.2. First, that the actions/strategies most frequently resorted to are for the adviser to draft a letter and either send this on the client's behalf or to give it to the client to send and come back if necessary, or to give the client information to take action on their own behalf. Informal contact by the adviser with NHS staff also featured in two areas. This suggests a second possible theme, different 'styles' of activity in different areas. In the city area, for example, there appears to be more 'hands on' activity than perhaps in the mixed area where the clients appear more active in following through the advice. This may as suggested above, reflect the substance of the concerns and complaints as well as the preferences of the clients themselves.

Table 3.2 The 'Top Three' actions/strategies across four areas

IASS Health Board Area	'Top Three' actions/strategies						
	1	No. (%)	2	No. (%)	3	No. (%)	Total - all Actions/strategies (%)
Rural 1	Formal complaint letter drafted adviser to send on client's behalf	42 (45.2)	Formal complaint letter drafted with client. Client to send and come back if necessary	25 (26.8)	Client is given information, to take action on own behalf	13 (13.9)	93 (100)
Rural 2	Informal contact made by telephone/letter with NHS staff	36 (34.6)	Formal complaint letter drafted adviser to send on client's behalf	21 (20.2)	Client is given information, to take action on own behalf	19 (18.3)	104 (100)
City	Formal complaint letter drafted adviser to send on client's behalf	63 (53.8)	Informal contact made by telephone/letter with NHS staff	18 (15.4)	Formal complaint letter drafted with client. Client to send and come back if necessary	12 (10.3)	117 (100)
Mixed	Client is given information to take action on own behalf	29 (43.3)	Formal complaint letter drafted with client. Client to send and come back if necessary	13 (19.4)	Client wants to remain anonymous but raise concerns with NHS	10 (14.9)	67 (100)

Outcomes

Table 3.3 summarises the three main outcomes in relation to complaints and concerns in the four health board areas (appendix 4 presents information on all outcomes in these areas).

Table 3.3 The 'Top Three' outcomes across four areas

IASS Health Board Area	'Top Three' outcomes						
	1	No. (%)	2	No. (%)	3	No. (%)	Total Outcomes (%)
Rural 1	Further action taken	27 (45%)	Issue not resolved - no further action taken	12 (20.0)	No further contact from client	11 (18.3)	60 (100)
Rural 2	Issue not resolved - no further action taken	39 (61.0)	Issue resolved	16 (25.0)	No further contact from client	5 (7.8)	64 (100)
City	Issue resolved	64 (60.4)	Further action taken	17 (16.0)	No further contact from client	11 (10.4)	106 (100)
Mixed	No further contact from client	20 (40.0)	Issue resolved	10 (20.0)	Social policy form completed and issue raised anonymously	9 (18.0)	50 (100)

The pattern of outcomes is ambiguous: clearly 'no further contact from client' features quite significantly in all the areas, and particularly in the mixed area (which, as suggested above, had more client progressed actions). The city area appears to have generated the most outcomes where the issue was resolved, and or further action was taken. But in other areas difficulties of resolving actions, or the need for further action are highlighted.

Impacts on CABx

As a crude indicator of impacts of IASS on CABx activity, the number of new issues relating to Sickness Benefit, Disability Benefit and 'Any Health' referred to CABx in the four areas over the two years 2006 - 2007 and 2007- 2008 were analysed. It is important to note that 'Any Health' ***includes*** IASS activity. On the basis of the data as provided it appears that in all but Rural Area 2, new issues relating to sickness benefit and disability benefit increase to some extent. The pattern in Rural Area 2 may reflect other changes within the CABx in the area, rather than being specifically related to the IASS. As would be

expected, 'Any Health', which includes IASS activity increases over this period.

Table 3.4 Percentage change in new issues over two years in four areas

	% Change over the period 06-07 and 07-08 in new issues		
	Sickness benefit	Disability benefit	Any Health
Rural 1	+17	+11	+300
Rural 2	-4	-17	+92
City	+11	+4	+217
Mixed	+8	+7	+84

What the overview of complaints, concerns, actions, strategies outcomes and organisational impacts begins to suggest is a similarity in the pattern of complaints and concerns being raised by people, and the staff groups and areas which are the focus of these concerns. This may suggest areas for continuous improvement on the part of Health Boards and Family Health Services.

Although the detail of the complaints and concerns is not captured here, the data do suggest different possible 'styles' of response on the part of IASS. But also the proportions of clients (comprising around 17% of all outcomes across all four areas) not making further contact, may pose questions for IASSs. Without, however, undertaking a more evaluative study the reasons for this cannot be assumed.

What the data also suggest is the apparent intractability of the problems raised - out of a total of 290 complaints and concerns across the four areas 22% were not resolved and no further action was taken. More positively, an issue being resolved comprised over one-third (35.3%) of the outcomes and in a further one-fifth (19.5%) further action was taken. In addition there are a small number of cases, four in total, in which IASS were involved in appeals - two of which resulted in cases being partially upheld.

4. Analysis of national client profile

This summary of client profile data is based on clients for whom data was available across IASSs between 1st September 2006, when the first services became operational and 31st August 2008. This includes data from the four study areas described in chapter 3. Not all services have been running over this time so the following can only be regarded as illustrative of the clients using the service across the country.

Again this analysis draws on the three forms completed by local IASS in relation to clients using the service: the client record form; a complainant profile form and an equalities and diversity form (see Appendix 2). As noted in chapter 2, there are limitations to this data, in particular the different numbers of clients for whom the forms are completed and the high levels of missing data, largely due to people declining to answer questions.

Complainant Profile

Complainant profile data were provided for around 241 people.

Of the 207 people who provided information on their 'household type', the largest group were single adults, who comprised nearly one half (47%) of the complainants (figure 3.1). The next largest group were couples who made up around 29% of the sample and couples with dependent children (18 complainants) and lone parents (13 people). Seven people were couples without dependent children.

Household Type

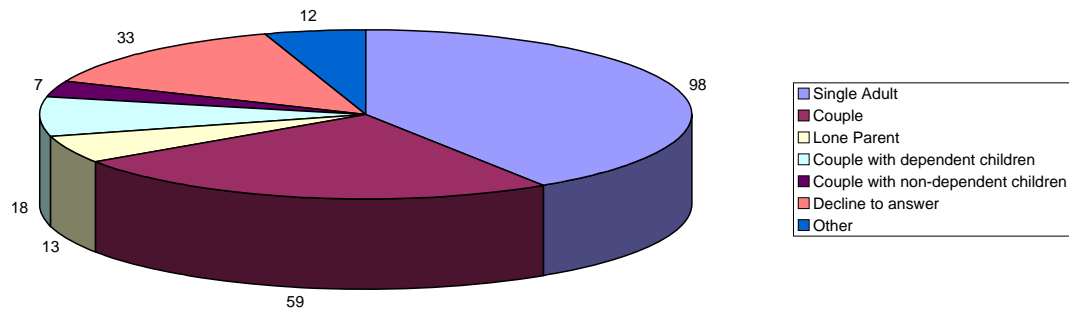


Figure 3.1 Household Type

Over one-half of people providing information on housing (203 complainants) were living in property rented from a social landlord. The next largest group were owner-occupiers who comprised 35% of the sample. Small numbers were living in private rented or were “not householder” (eight and seven people each). One person was living in temporary housing at the time.

Nearly three-quarters of the 203 complainants did not have caring responsibilities, with one-fifth caring for children. A small number were caring either for a partner or an elderly person (seven and six complainants respectively).

Fifty complainants did not disclose their economic status. Of those who did, the picture is very mixed (figure 3.2). Over 30% were retired and a further 27% unable to work due to illness or disability. Of those able to work 31 people (16%) were in full-time employment, 14 in part-time employment and 16 unemployed.

Economic Status

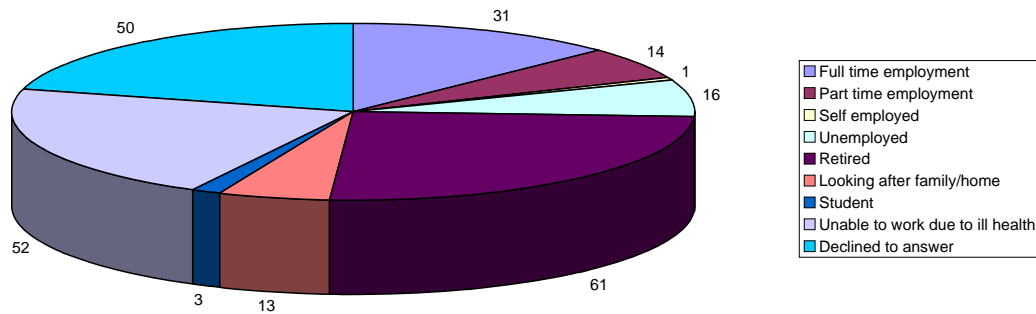


Figure 3.2 Economic Status

The comparatively high proportion of people who were unable to work due to illness/disability highlighted in relation to economic status, is reflected further in responses to the question on health status. Although one-third (out of 201 providing data) described their health as OK nearly two-thirds were experiencing a health problem or disability (figure 3.3). The majority (43% of the sample) had a long-term illness or health problem, 12% had a short-term illness/health problem and over 10% (21 people) had mental health issues. In addition one person had a learning disability.

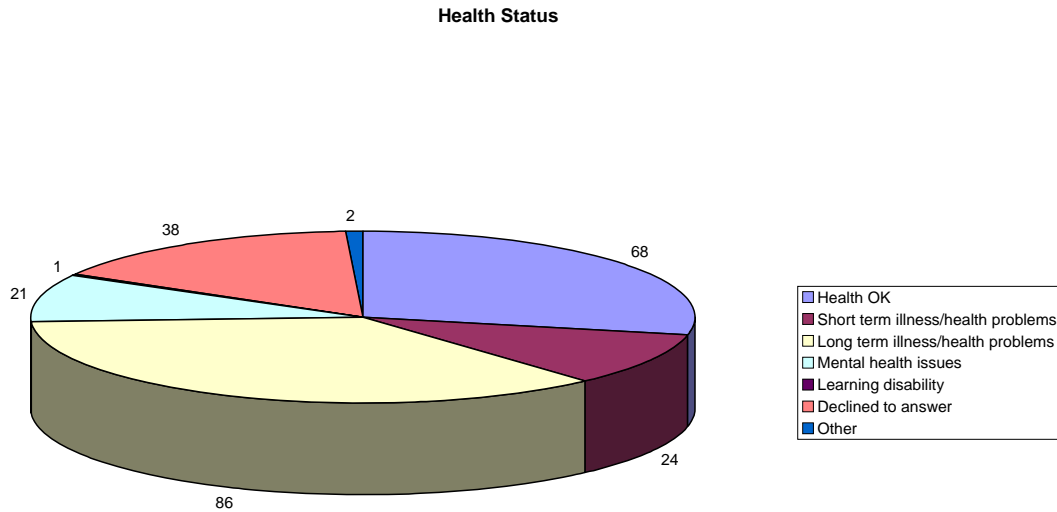


Figure 3.3 Health Status

Like age, data on income were incomplete, with only 140 people out of 241 prepared to provide information: again this raises concerns about the systematic bias built into the data. Where information is available, it suggests that the majority were on some form of benefits or retirement income. Only 15% (21 people) were reliant on income alone, compared with 45% reliant solely on benefits and a further 16% drawing on benefits and income. Reflecting what is suggested of the age profile, 19% of people were living on their pensions.

People drew on the range of benefits (the one benefit not being claimed was AA low), including those reflecting the health status of the many of the sample, including incapacity benefit (22 people), AA high (three people), DLA mobility high and DLA mobility low (17 and five people), DLA care high, middle and low (seven, 10 and eight people respectively).

Only 85 complainants were prepared to give information on their own or their household income. Of these nearly three-quarters (62 people) had an income of less than £10,000.

The questions on car ownership, use of buses and help with travel were not completed by significant numbers of the sample of 241 people. Again, where data is available it reflects the health and benefits profiles of many users. Of the 155 providing data 60% did not have access to a car, over one fifth (22% of 141) could not use buses and the same proportion needed assistance with travel (22 % of 140).

Only 140 people answered the question on whether they needed to use drugs or alcohol on a daily basis to function. Just under 10% of those responding (13 people) indicated that they did need to use drugs or alcohol daily.

As noted throughout, it would be erroneous to draw firm conclusions due to the different population sizes between the three forms, as well the high levels of non-response for a number of questions. But the pattern that does again emerge (as in chapter 3) is of a comparatively low-income population, on their own, with high levels of physical or mental health problems. The equalities and diversity data is perhaps the most problematic due to the high levels of non-response, but does suggest that women tend to be higher users of the service. Although the majority of users are white/white Scottish some people who identify as from different ethnic groups and or for whom English is not their first language are seeking to access the service. In terms of sexual orientation, one person identified as lesbian/gay woman, and two as transgender, which given the high non-response rates, again suggests that IASS is being accessed by people who historically may have felt excluded on the basis of their sexuality or gender.

People were largely self-referring to the IASS with issues mainly, but not exclusively, relating to their own treatment or that of a family member of spouse/partner. Other sources of assistance had been sought including from other CABx. The finding that over one-quarter of complainants needed assistance with taking their issues up again reflects the health and disability profile of the samples. The majority were dealt with by the IASS and not referred on.

Client Record Form data

Client Record Form data were available for around 353 people – but incomplete for some questions.

Of the 305 people for whom information was available, nearly 70% (212) self-referred, with 'other' sources of referral comprising just under 28%. These 'other' sources include other CABx, voluntary agencies and Advocacy Services. NHS complaints services and GPs each referred three people, and health visitors and Macmillan Services one each.

Just under 14% of 353 had sought help from another source before approaching IASS. Of this group of 48 people help had been sought predominantly from another CAB (19 people) or an 'other' source, but with some speaking to a solicitor and/or advocacy organisation (six and five people respectively) and three approaching an MSP or MP.

Out of 353 people, 6.5% (23 people) were subsequently referred on by the IASS, including to 'other' resources in 15 cases and a solicitor in eight. One person was referred to CAB money advice.

The split between those with an issue about their own treatment and those coming on behalf of someone else was roughly two-thirds and one third respectively. Of those coming on behalf of someone else this was either in relation to a family member (62 people) or a spouse/partner (32 people). In 40 cases (out of 353) concerns were being raised in relation to the treatment of a person who was deceased.

Just over 9% of complainants (out of 353) needed some form of assistance to help them raise their concerns. The reasons for needing assistance included 'age' and 'other' reasons (12 people) mental health issues (11 people) and mobility (7 people) (people could indicate more than one reason for needing assistance). One person needed assistance because of an issue relating to language.

Age data was available for only one third of the sample. As indicated elsewhere this may result in the systematic under-recording of some groups. Of the 110 who did provide this data, just over one-third were aged 65 years and over, including people aged 80 years and over. People aged 25 – 44 years comprised just under 30% and a further 17% were aged between 45 – 59 years. Less than one percent were aged 16 – 17 years.

Equality and Diversity

Equality and Diversity information was collected in relation to **171** clients - although there are high levels of missing data. As suggested in chapter 2, the concern is that far from being random, the missing data may result in some groups being systematically under-represented in the monitoring data. For example, only 43 people out of 171 gave an indication of their age. What is not known is whether certain groups of people consistently chose not to give their age. Similarly 100 people declined to indicate their religion and 59 their sexual orientation. This may not be significant or it could reflect in each case a reluctance to disclose information on the part of groups at risk of discrimination. Further the incomplete data makes it difficult to determine the extent to which the different 'equalities' groups, of age, gender, ethnicity, religion or belief, sexual orientation and disability are proportionately represented among clients of the IASS.

What the data do reveal is that just under 60% of those for whom equality and diversity information was available were women.

Getting an indication of the age range of users of the IASS is, as suggested more problematic - of the 171 cases, only 43 were prepared to give their age, of whom those aged 25 - 44 years comprised the largest single group (16 people) and people aged 65 years and over the next largest (10 people).

Of the 150 people providing information on national identity, the vast majority were from the UK, but with two people using the service from the Indian subcontinent, one from the middle-east and one from Poland. As a result, for all but six people answering the question, English was their preferred language. Two people preferred to speak in Gaelic, and one each in Arabic, Urdu, Punjabi and Polish.

Similarly, the majority of the 130 answering the question, indicated their ethnic group as either white Scottish (109) or white English (14), white 'other' (one person). One person each considered themselves to be of 'mixed' ethnicity, Irish or 'other'. Three people described themselves as Pakistani.

Only 71 people were prepared to indicate their religion, of whom 54 described themselves as Christian, two as Muslim, one as 'other' and four as 'none'

Of the 112 people indicating their sexual orientation all but one described being Heterosexual (straight). One person indicated that they were a lesbian/gay woman. Two people considered themselves to be transgender.

Given the nature of the IASS over one-half (55%) of the 108 providing this information had a health condition or disability. Of the total of 69 conditions or disabilities people indicated, long-term illness and physical disability comprised the largest two categories, comprising 35% and 38% of the types of condition. Mental health conditions comprised the third largest group constituting 22% of conditions experienced.

5. Case example analysis

A number of cases were identified by IASS workers to illustrate the range and complexity of issues people were bringing to the service. Clearly, as noted in chapter 2, these are not a 'random' or representative sample but are intended to give a better sense of the needs of clients and the activities of IASS caseworkers in response, than the quantitative data alone can provide. The case examples were provided following a request to IASSs across Scotland from the CAS Health Support Unit co-ordinator. The format for the response was left to the individual IASSs, as a result the levels of detail (including on the outcomes to date), were not consistent across the case examples. Because of the unsystematic way in which the case examples were selected, no attempt is made to quantify the concerns and complaints nor to extrapolate from these to indicate the overall pattern of complaints and concerns.

5.1 Concerns and complaints: Key themes

The case examples illustrate not just the range of concerns and complaints people had but also the direct impact of these issues on their own lives and that of their families.

Although not a 'random' selection the complaints and concerns raised in the case examples fall roughly into eight groups.

1. Inadequate information

In a number of the case examples the main concern was the perceived inadequacy of information they had been given. This may have caused needless anxiety, where, for example, it left people feeling that the situation was more serious than it was (case example 1) or conversely not being informed that someone's condition was more serious than assumed. In one case, for example, concerns were raised that neither the client nor her late partner's family were made aware of the seriousness of her partner's condition and that his death was imminent.

In several cases people were concerned that their opticians were not only not informing them that they had cataracts, but were prescribing and requiring people to pay for unsuitable glasses.

Case Example 1

After several years of unsuccessful treatment a seven year old was referred to a children's hospital where their condition was identified. When diagnosed the parents were not given information on their child's condition. While waiting for the operation the client found information on the internet regarding their child's condition which suggested that "If left untreated brain damage and death could follow". The client was very concerned that unless immediate treatment was accessed then her child would die. The client contacted her local Citizens Advice Bureau for assistance who contacted IASS.

Action Taken

IASS telephoned the complaints officer who agreed that she would arrange an appointment with a specialist nurse who would inform client of her son's condition and address any concerns.

Outcome

Client and her husband met with the specialist nurse, who discussed the condition and answered questions raised by the client and her husband. The nurse highlighted that their son's condition did not require immediate surgery; his life was not in danger. Although the information accessed was about the same condition it was not relevant in their son's case. The client was then happy to wait for a date for her son's surgery.

2. Mis/missed/delayed diagnoses

In a number of the case examples clients were raising concerns about delayed diagnoses, either because people were initially mis-diagnosed and/or the problem was missed. In two cases the concern was raised in relation to someone who had died. In one of these cases the person had been seeing a GP for two years and been diagnosed as having a chest infection. Subsequently he was found to have a cancerous tumour. In another case a client's son subsequently died of testicular cancer which was not picked up by either a GP or an A and E department. In a further two cases the clients wished to bring complaints against GPs for missing cancer. The fifth case, however, was of a different nature, involving a client who wished to challenge a mental health diagnosis (case example 2).

Case Example 2

Over the years the client had been seen by various psychiatrists and psychologists. Client has detailed in her medical notes that she was diagnosed with a mental illness which the client strongly believes was suggested by ex-husband. As client is seeking medical help by her GP, including referral to a psychologist and with details of her previous mental health issues, the Child Protection Team has informed the client that her two young children have been placed on the 'At Risk Register'. Client is waiting to have another mental health assessment. Client has complained to local NHS Feedback Team and is not satisfied with the response. Client would like name cleared and an investigation into her medical history.

Action Taken

Advised client that as client has been through the local NHS complaint's procedure she could contact the SPSO (Scottish Public Services Ombudsman) for an independent investigation into her case. Contact details given to client.

Also suggested to client she could contact AvMA (Action for the Victims of Medical Accidents) who would advise her if she has a legal case against the NHS regarding the alleged diagnosis.

Also suggested to client she could contact the Law Society of Scotland who would be able to recommend a solicitor who may be able to take her case forward and whether she would be entitled to legal aid.

3. Medical accidents

In two cases, people raised concerns about medical errors that resulted in additional surgery, with, in at least one case additional financial implications as a result of having to take further time off work (case example 3). In several other cases the focus seemed more on care following treatment, one person, for example, wished to complain that they were required to wait in A & E for six hours although in pain when a wound from a hysterectomy became infected.

Case Example 3

Client was admitted to hospital for relatively straight-forward surgical procedure but an error resulted in the client having a colostomy fitted. A successful reversal is not guaranteed.

The length of time off work to cope with the effects of surgery and in the prospect of lengthy absence expected following corrective surgery also resulted in employment and income issues.

Action taken

Client received intensive support from the IASS service in accessing Medical and other records and in making a comprehensive complaint to the NHS.

The NHS offered a meeting between the client and clinical staff involved in the original incident, which was taken up. Despite the client's initial reluctance to meet the individual responsible for the error, with the presence and support from IASS, the client was able to directly tell NHS staff of their shortcomings and elicit a personal apology, whilst at the same time seeking the reassurance that the NHS will learn from these experiences and the same thing will not occur again. In addition, some essential information was obtained which allowed the client to consider further options.

4. Issues around treatment

In addition to the several cases described above of opticians prescribing unsuitable lenses and one case of a client who, despite a number of complaints to his dentist, had not been able to get his dentures altered adequately, several further cases related to the delivery or withdrawal of treatment. In one case the IASS caseworker was in discussion with an advocacy worker contacted by the client, to identify someone to represent them at a meeting with a rehabilitation service to discuss a difference of opinion between the service and the client. In another case a patient with a particular condition who had been prescribed medication not licensed in relation to her condition, but which she found beneficial, had this withdrawn when her GP retired and was replaced by a new doctor. The client was not only concerned that the new GP appeared to be neglecting or ignoring her views and feelings, but that also she had been told she could not change to another GP practice because she was already registered with a GP in the city. The actions by the IASS worker included:

- Researching and printing off client information with regard to the drug trial in relation to her condition
- Giving the client information on changing doctors

- Providing information on treatment from a GP, medication, second opinions and the Practitioner Services Department.

5. *Delays in receiving treatment*

In at least three cases the concern related to a delay in receiving treatment. In one case a letter with a date for surgery had been sent to the GP, but the GP had not informed the client, who only found out after the fact. In a further case the client was concerned about a perceived delay and subsequent postponement in receiving heart surgery. Contact with the hospital by the IASS caseworker to request, on behalf of the client, information on a date for the operation generated what the case example summary describes as "an unhelpful and defensive response". However, a few days later the client was notified of the date for the operation. The client felt that the intervention by IASS may have helped her to obtain a date.

In a third case (case example 4) delays in receiving treatment had had significant financial implications for the client who had not been able to return to work and for his family. The IASS worker supported the client to obtain an apology for the delay. In addition to tackling the complaint, the IASS worker was also able to assist the client to obtain working tax credits and apply for incapacity benefit.

Case example 4

Client was attending a specialist clinic within a local hospital. He was advised that a referral to another hospital for additional treatment would be necessary. After several months no appointment had been received. As the treatment was not completed he was unable to return to work increasing the financial burden on the family. On making enquires to the clinic about the delay in his treatment he was advised that the referral had not been made. An apology was given and the client informed that they would fax the referral that day as urgent.

Eager not to endure any further delays the client contacted his local CAB who then referred him to an IASS caseworker.

Action Taken

Explained the NHS complaints procedure and the role that IASS has within this, also what assistance the IASS caseworker could provide. Offered to write a letter for the client to address his concerns and hopefully minimise any further delays. Client was happy for this action to be taken and a letter was sent to the hospital.

As the client's main concern was of a financial nature the IASS case worker undertook a benefits check to identify possible ways of maximising the family income. The check revealed that working tax credits could now be payable. The tax credit helpline was contacted to reflect a change in circumstances.

Outcome

A reply was received in the form of an apology in writing by the consultant involved with the referral made for further treatment, which the client has now completed.

Tax credits amounting to £4503.27 were also generated for this client and assistance given to enable the client to access incapacity benefit.

6. Care plans which override people's wishes

In two cases the concern was with discharge or care planning procedures which seemed to override the wishes of the people concerned. In one case the client wanted to challenge the decision made to discharge his son to sheltered housing with which neither were happy. In addition the client wanted advice on financial help if they obtained private rented accommodation. The IASS caseworker provided advice on the different routes for challenging the decision and making a complaint, as well as the range of welfare benefits they may be entitled to receive.

In the second case plans to discharge a patient to a local community hospital while adaptations were made to her home, were changed by

NHS staff at short notice, and an alternative community hospital proposed, with which neither the patient nor her family were happy. The family were told by NHS staff that because the person would continue to receive in-patient care in another health board area they could not initiate the review procedure. The IASS worker in this case gave the client advice on the NHS complaints procedure as well as providing information on assessment and provision of community care services. In addition the IASS worker requested a complaints resolution meeting on the client's behalf, which they attended and also to which they submitted written questions. The outcome in this case was the reinstatement of the original discharge plan.

7. *Attitudes/Behaviours*

In a number of cases it is the attitudes or behaviours of professionals that cause the most concern, particularly it appears in relation to certain groups of people, such as people with mental health problems or older people. One IASS caseworker, for example, describing the response to complaints by a client with mental health problems following a period of admission for psychiatric assessment made the comment that a dismissive approach "reflects a not untypical reaction to those with mental health issues". In another case a client with mental health problems was concerned with the attitude of his dentist (case example 5).

Case Example 5

Client contacted IASS requesting IASS caseworker draft a letter/act on his behalf to make complaint against NHS dentist.

Client informed IASS he is diagnosed with a mental health problem and is in receipt of Income Support and Disabled Living Allowance. He had an appointment to see the dentist and on three visits got different dentists. The client wanted to raise a complaint about the attitude and abrupt manner shown by the second dentist. No treatment was carried out that day and the following two appointments were cancelled.

The client wanted a written apology and explanation as to why no treatment was carried out and why further appointments were cancelled.

Action taken

The IASS caseworker explained NHS complaints procedure to the client.

The caseworker explained that they could draft a letter of complaint on the client's behalf. The client would be sent a consent mandate and data protection form to sign.

Once drafted the letter was approved by the client and sent by the IASS worker to the dental practice.

Outcomes

The client received an apology from the dentist and an assurance that he would receive the dental treatment he needed.

The client did not feel confident about contacting the dentist to make an appointment and asked the IASS worker to arrange the appointment. On the client's request IASS maintained contact with the client to provide support until his dental treatment had finished.

In a further case, the client and her father (for whom tests for dementia were being considered) wanted to raise a complaint through IASS in relation to what they perceived to be the inappropriate attitude and manner of a GP.

In several cases it was the feeling of not being listened to that generated concerns on the part of clients. In one instance despite feeling unwell for a year, the client was concerned that nothing was being done to relieve her symptoms or take her seriously. In another case it was the attitudes of care staff, and in particular their lack of respect for her privacy while home care staff were present, that was the source of concern. Although raising the issue herself the client felt that her complaints had been "brushed off somewhat". In this

instance, however, the client did not want the IASS to pursue her complaint because she was fearful that it would affect her future care. This fear of the complaint having a negative impact on on-going care or treatment was raised in a number of case examples and will be returned to below.

8. *Policies, procedures and practices*

In amongst the case examples were a range of procedural or practice issues that caused difficulties for people, and, as in the examples of people with mental health problems, may potentially disadvantage some groups.

These included, for example, the difficulties experienced by an elderly patient of a GP practice whose appointment system made it difficult to make appointments in advance and the automated appointment system was difficult for a person with a hearing impairment to understand. This was resolved following the IASS caseworker's discussion with the practice manager. This resulted in the client being able to make an appointment a week in advance. It also includes the case of a dentist charging when an elderly resident of a nursing home had to cancel an appointment at short notice because he was taken unwell. The IASS worker advised the Nursing Home matron, who was complaining on the client's behalf of the procedure for making complaints. In a further case, the IASS worker was instrumental in getting agreement for a client in a nursing home to receive an assessment to identify her needs, including her communication needs. This was prompted by finding (in the course of visiting the client in the home) that although the client had been in the home for 18 months no provision had been made to aid her to communicate, despite the fact that she had a speech impairment.

Among other process or practice issues which the case studies revealed were the difficulties people had trying to change GPs. In these cases IASS workers were instrumental in providing people with information on their rights and the procedures for moving practices. In another case the IASS was active in writing a letter to the Scottish Ambulance Service on behalf of residents of a [residential] home for whom hospital transport was consistently not arriving to take people to out-patient appointments.

In other cases the formal processes presented obstacles for clients. This includes, for example, notice of appeal forms for Incapacity

Benefit, which do not allow space for indicating the grounds for the appeal, or which appear to erroneously suggest that someone on the low rate DLA is not eligible for a bus pass.

This brief overview of case examples illustrates the breadth and depth of the work of the IASS. In addition it serves to illustrate the range of disabilities and health problems that people experience. In some cases what is also suggested is the potential for indirect discrimination, for example in the ways services are delivered. But there is also the potential for people to experience more direct discrimination, as suggested in the case examples of people with mental health problems.

5.2 The role of IASS support workers

The range of different concerns and complaints clearly generates a range of different responses on the part of the IASS caseworkers. This is reflected in the number and complexity of the tasks involved. Also in the extent to which the worker is directly involved in a 'hands on' way by attending meetings, contacting NHS complaints officers or drafting letters on behalf of clients or more 'hands off', in the sense of providing the information which clients can then take forward if they choose. Clearly both are required to respond to the different concerns and complaints, but also the needs of the clients.

From the case examples it appears that IASS caseworkers perform three core roles: a conduit drawing on an extensive knowledge base; providing advice and acting in a mediatory role; and providing one-to-one independent support.

A conduit for an extensive knowledge base

The knowledge that IASS support workers draw on includes not just an understanding of the NHS complaints system, but of the systems beyond the NHS for seeking, or obtaining advice on seeking redress including the Scottish Public Service Ombudsman (SPSO) and the SPSO watchdog, the Law Society, Mental Welfare Commission (MWC), MPs/MSPs, General Optical Council and Optical and Dental Consumer Complaints Services, Action for the Victims of Medical Accidents, Trade Union Safety Representatives and Advocacy Services. It also includes an understanding of the different organisational structures - primary and secondary care and also local authority - which enable the

caseworkers to advise on, or to make direct contact with the appropriate people. Importantly, however, by being integral to CABx the caseworkers have a knowledge base and access to a much wider range of information and advice, including in relation to benefits, but also for other sources of assistance that might arise from a contact that may have a health component, for example, bereavement counselling or information on the provision and assessment of community care services.

Providing advice and acting in a mediatory capacity

Clearly a key component of the role is to advise clients on the appropriate procedures and routes for making complaints or raising concerns, but also how to manage the process e.g. keeping notes of all contacts made with medical services, or how to conduct themselves in any meetings with the Hospital Board if they choose to go on their own. It may also involve looking over a letter a client has written and providing advice on its contents.

But in addition, a key role of the workers is that of being able to mediate between the clients and the different agencies, including, but extending beyond contact with NHS Complaints Officers. This might, at one level, comprise making a telephone call on a client's behalf to a practice manager to see if it was possible for the appointment system to be flexible enough to enable someone to make an appointment in advance; or making a telephone call to a consultant's secretary to obtain an indication of the likely date of a client's operation; or it might be writing a letter of complaint to a GP practice in response to a delay in making a diagnosis of cancer, or to a dental practice on behalf of a client whose appointments were cancelled without explanation. At another level, the role might involve contacting and undertaking a joint visit with an advocate, together with a client, to see a client's wife in her nursing home. At a further level, it may involve requesting and attending a complaints resolution meeting and submitting written questions.

An initial complaint or concern may, however, also reveal a range of other problems that a client may be experiencing, which require the IASS caseworker to engage with a wide range of agencies and service providers to assist the client to receive the care, treatment or support that they need. Case example 6, for example, illustrates how an initial concern about a GP practice, became a much more extensive task of

helping the client to receive a comprehensive care package, welfare benefits and make an application for sheltered housing.

Case Example 6

The initial contact with IASS was to make a complaint, on behalf of a woman in her late 70's who, it was felt, was receiving poor treatment from her GP.

A home visit by the IASS caseworker revealed that the client was experiencing a range of problems that required to be addressed. These included being unable to use the toilet unassisted, wash herself or change her nightwear. In addition she was unable to cook for herself or administer her own medication. Being housebound she was unable to go shopping.

Action Taken

The IASS caseworker liaised with the Social Work Department, Home Care Co-ordinator, Home Care Area Manager and Local Council to establish if any care packages were in place.

The worker also assisted the client to apply Attendance Allowance.

The client asked for advice on the criteria for admission to Very Sheltered Housing. The IASS worker found an appropriate local Sheltered Housing complex with a vacancy and assisted the client to fill in the 32-page application form.

Outcomes

The IASS caseworker was able to secure three visits a day from the local social care and support service to undertake shopping and housework and also arranged for a tuck in service.

In addition the IASS caseworker arranged for a social worker to visit to carry out a review of the client's needs.

As a result the client is now in receipt of Attendance Allowance and awaiting the outcome of her housing application

The initial NHS complaint was also processed by the IASS caseworker

Providing one-to-one independent support

In some respects IASS workers are acting as advocates (in the broadest sense of the word), to ensure that people's rights are respected and that they receive the services they need. In case example 7, for example, the IASS caseworker enabled a client to obtain her medical records to help her to progress her complaint against her GP, but also assisted her to appeal against a DLA and

Community Care grant decision and to obtain a community care assessment.

Case Example 7

A woman in her 60s with physical and mental health problems looking after her grandson wanted to make a complaint against her GP. At the same time, the client had made a claim for DLA and also for a Community Care grant, both of which had been rejected.

Action taken

The IASS caseworker made an application for GP records. The client's practice advised there was a £50.00 fee, despite guidelines recommending a maximum of £10.00. The practice was forwarded a copy of the guidelines and the fee was reduced to £30.00. A breakdown of charges was requested. The fee was reduced to £10.00.

The IASS case worker assisted the client to appeal against the DLA and Community Care grant decisions. The worker also provided the client with information on the availability of Community Care services and requested a Community Care Assessment. They also requested an occupational therapist assessment to facilitate disability adaptations.

In addition to what IASS caseworkers know and the actions they take is the support they are able to provide people. In several examples the case studies refer to people being upset. One person whose partner had died became distraught in the course of an initial meeting with the IASS caseworker, who arranged for her to return the following week to give her a chance to recover. In another instance someone whose dental appointments had been cancelled without explanation and who had experienced one dentist acting in an abrupt manner was described as 'upset'. Although the case examples here are largely 'secondary' rather than primary data involving interviews with clients themselves the available information on the characteristics of the client group and the nature of their concerns means that this more qualitative 'outcome' - the support of an empathetic worker, and one independent from the different statutory agencies, prepared to listen to them and help them find solutions that meet their needs - should not be overlooked. It also has the potential to help to redress some of the power imbalances that people who are, for a range of reasons and in different ways vulnerable, may feel or experience⁴.

⁴ For the views of clients see also the evaluation report produced by Lacey and Lavery, 2008 (see footnote 1 above)

5.3 'Social policy' issues.

IASS workers record what they regard as 'social policy' issues arising from the cases they handle. These are issues that they feel go beyond the specifics of a case to raise wider questions of processes or procedures. From a brief analysis of some of the concerns raised in the course of the case examples these can be categorised into three types of issue: the fearfulness client's have of complaining; issues around patient's rights; and opportunities to enable people to progress their complaints beyond the NHS complaints system.

Fearfulness of complaining

In a number of the case examples, people expressed a concern about taking their complaints further in case it affected their on-going or future treatment. In several cases clients did not want to provide any contact details, and, in one of these would give no more information than their first name⁵. A reluctance to raise issues for fear that this will impact negatively on the services they receive is clearly a significant barrier and while not easily overcome, does underline the importance of independent avenues for seeking redress.

Patient's rights

A number of cases, in different ways, raise issues of patient's rights and also of the need to tackle potentially discriminatory practice. These include:

- Procedural issues including barriers to accessing medical records by family members who may have a wider caring role but who are not identified as next of kin. But also the apparent procedural barriers to local review procedures if, for example a patient is transferred from one in-patient unit to another in a different health board - where the transfer itself is the subject of the complaint.
- Cases which draw attention to areas where there is a lack of clarity as to where responsibility for action in redressing complaints lies, for example between the concerns and issues being an issue of

⁵ Although the number of cases in which this occurs is not quantifiable, it is a further contributory factor to the level of missing client information data indicated in chapters 3 and 4.

professional competence, an NHS responsibility or a consumer issue. This is particularly the case in relation to optical and dental services.

- Attitudes towards people with mental health problems receiving health care, but also a perceived failure to take their complaints seriously when they are raised. Case example 8 both illustrates the role of the IASS in addressing perceived discrimination on the part of a health care professional, but also the role of the caseworker in linking the client in with resources and services to assist him deal with a range of additional problems he was experiencing. Again this indicates the 'added value' of the work of IASS.

Case Example 8

A client sought help with his mental health problems from his GP but did not feel he was given support or medical help. The client felt he was being discriminated against by his doctor due to an ASBO and drug and alcohol problems and felt he was not receiving appropriate care or treatment to help him re-build his life. The local CAB referred the client to the IASS caseworker.

Action taken

The caseworker explained the NHS complaints procedure in relation to GPs and the role of the IASS within that.

The caseworker wrote a letter to the GP on behalf of (and signed by) the client with a covering letter from the IASS to ask the GP for an explanation as to why he had not referred the client to specialist psychiatric or counselling services.

The IASS caseworker also suggested to the client other organisations that offer support with drinking problems and also, with the client's agreement, contacted appropriate organisations on his behalf. The caseworker also referred the client to an independent advocacy service to obtain assistance with an impending court case and also gave him information about SAMH.

Outcomes

The client received a letter of explanation from the GP asking the client to ensure he always sees the same doctor.

The client was contacted and assisted by relevant agencies to support his alcohol problems and court case.

The client is now successfully following a college course.

Enabling people to progress complaints and concerns further

The IASS also has a role in supporting people to take their complaints outwith the NHS system to the Scottish Public Services Ombudsman, to enable them not just to seek redress, but also to help draw attention to any instances where there have been process or systemic failures from which there can be more generalised learning. Although no specific reference is made to the role of the IASS a caseworker was instrumental in supporting a client make a complaint to the Scottish Public Service Ombudsman (SPSO) for being advised by a consultant that her cancer had been removed and that she was cured, when in fact the cancer did subsequently recur. The SPSO recommended to the Board that the client receive an apology (SPSO case 200703087: Lanarkshire NHS Health Board. November 2008).

6. Conclusions

Based on routine monitoring data, supplemented by case examples selected by IASS caseworkers the report has aimed to give a very broad brush indication of the levels and types of work undertaken by the IASS and the characteristics of the clients and complainants who use the service. This was not an evaluation of the service, but aimed to supplement and add to the earlier research undertaken by Lacey and Lavery (2008) (see footnote 1).

There are limitations to the data that mean that the findings are indicative rather than definitive. As noted in chapter 2, CAS is anticipating introducing a new electronic case management system. This, together with more accurate advice codes may help to 'clean' up the data. This overview also suggests that there may also be a value in streamlining and simplifying the client/complainant data to enhance consistency and completeness, even if at the cost of some of the detail. This might include reducing the number of forms from the current three.

Notwithstanding the limitations, a number of conclusions do emerge from the analysis.

Analysis of the patterns of concerns and complaints recorded by IASSs in four 'sample' health board areas suggests that the four issues consistently raised relate to: clinical treatment (all aspects); staff attitudes and behaviour; staff communication (particularly oral); and staff competence. This pattern is comparable with the Scotland-wide pattern for NHS complaints as recorded by the ISD. While outwith the scope and remit of this report, this may suggest areas for consideration by Health Boards and Family Health Services.

The actions and strategies deployed by IASS caseworkers will be related to the nature of the complaints and concerns presented. What the data suggest is that in broad terms the actions/strategies most frequently resorted to are for the caseworker to draft a letter and either send this on the client's behalf or to give it to the client to send and come back if necessary, or to give the client information to take action on their own behalf. The data also begin to suggest there may be different 'styles' of activity in different areas. In the city area, for example, there appears to be more 'hands on' activity than perhaps in the mixed area where the clients appear more active in following through the advice. This may reflect the substance of the concerns and complaints, the preferences of the clients themselves and also,

perhaps clients' level of confidence in dealing with statutory organisations.

In terms of 'outcomes' in relation to 290 of the complaints/concerns for which an outcome was recorded across the four sample health board areas the issue was resolved in over one-third (35.3%) and in relation to a further one-fifth (19.5%) further action was taken. In addition there were a small number of cases, four in total, in which IASS caseworkers were involved in appeals - two of which resulted in cases being partially upheld. What also emerges, however, is the apparent intractability of some of the problems raised - out of the total 22% were not resolved and no further action was taken. Further the 'outcome' in around 17% was that the client made no further contact. Both the intractability and 'drop out' rate cannot be accounted for without undertaking a more detailed evaluative study but may be issues for further consideration by both IASS and Health Boards. What also cannot be established from the broad brush figures is whether and in what ways IASS performs a 'preventative' role, that is tackling issues early enough on to prevent them becoming the subject of more formal procedures.

What is also less easily captured by current recording systems are the 'outcomes' in terms of welfare benefits and/or links made with other services that the caseworkers facilitate for clients. Very crude data suggests that in three of the sample areas the level of new issues raised in relation to disability and sickness benefits may have risen since the start of the IASS services in these areas. But it is the case examples described in chapter 5 that perhaps better illustrate how what may start as a complaint or concern in relation to some aspect of NHS care, treatment or delivery, may require the caseworker to draw on their knowledge not only of the welfare benefits (and appeals) system but of local statutory (and non-statutory) services. Being integral to CABx the IASS caseworkers are able to 'add value' by providing an 'holistic' service which includes, but extends beyond support for a concern or complaint in relation to health services.

The analysis of client characteristics suggests a population on a comparatively low-income, living on their own, a high proportion of whom have physical or mental health problems. The equalities and diversity data are perhaps the most problematic due to the high levels of non-response, but do suggest that women tend to be higher users of the service. Although the majority of users are white/white Scottish some people who identify as from different ethnic groups and or for whom English is not their first language are seeking to access the

service. In terms of sexual orientation, one person identified as lesbian/gay woman, and two as transgender, which given the high non-response rates, again suggests that IASS is being accessed by people who historically may have felt excluded on the basis of their sexuality or gender.

The data suggest the service therefore has a role in supporting people who by virtue of poverty, disability and or/health problems or being alone may experience barriers to obtaining assistance and whose previous experiences of statutory agencies may not have been positive. The support of an empathetic worker, and one independent from the different statutory agencies, prepared to listen to them, to help them find solutions that meet their needs and to mediate with different organisations on their behalf - is a further 'outcome'. This may be particularly salient in those contexts where people feel that in terms of the way care or treatment has been delivered, or in the formal responses to their complaints or concerns they have been 'brushed off' or have experienced direct or indirect discrimination.

What also became apparent from the case examples was the extent to which clients were discouraged from raising concerns because of a fear of recrimination on the part of service providers. The IASS service by providing an independent source of advice, acting in a mediatory role, and providing one-to one support for people, who may, for a variety of reasons be vulnerable clearly has a role to play not only in supporting people to obtain redress without fear of recrimination, but as suggested in chapter 5 also has the potential to help to challenge some of the power imbalances that people may feel or experience.

Appendix 1

IASS services by NHS Health Board

Ayrshire & Arran

One FTE post based at Saltcoats and Kilmarnock

Borders

Since October '08, one 18 hour post based at Peebles, prior to that two p/t time posts (5 hours each per week) based at Peebles & Galashiels

Dumfries & Galloway

One FTE post based at Dumfries

Fife

Two p/t workers (1 FTE) based at Methil provide support only to people raising NHS concerns or complaints

Forth Valley

One FTE post based at Alloa

Grampian

3 p/t workers (1.2 FTE) based at Aberdeen, Moray and Peterhead

Greater Glasgow & Clyde

3p/t workers (1.6 FTE) based at Bridgeton, Barrhead and Kirkintilloch

Highland

4 p/t workers (2 FTE) based at Alness, Lochgilphead, Fort William and Inverness

Lanarkshire

2 p/t workers (1FTE) based at Coatbridge and Lanark

Lothian

1 FTE post based at Edinburgh

Orkney

One 5 hr post based at Kirkwall

Shetland

One 7 hour post based at Lerwick,

Tayside

3 p/t posts (1.2 FTE) based at Montrose, Dundee and Perth

Western Isles

4 x 2 hour posts based on Barra, Harris, Lewis and Uist

Appendix 2 - Client Data Form (Word version)

IASS Client Record Sheet

Bureau name:

Client Ref

Please complete questions 1 to 11, tick the appropriate box where relevant and always specify where 'other' is selected. Note: Complainant profile questions relate to the person who is the subject of the complaint not the client if acting as a representative.

Q1 – Client's postcode
(not last 2 letters)

Q2 – Client referred by?

Self referral

NHS Complaints Staff

GP

Community nurse

Health Visitor

Macmillan

Other (please specify)

Q3 – Is the client raising
an issue about?

Their own treatment (go to Q8)

Or on behalf of another

(go to Q4)

Q4 – If on behalf of another person, the client
is?

Spouse or partner

Family member

Carer

Friend

Third party

Other (please specify)

Q5 – Is the subject of the

complaint deceased?

Yes

No

If No go to Q6

If Yes complete Q8, Q9 & Q10

Q6 – Is the person being represented because they have a special need?

Yes

No

If Yes go to Q7

Q7 – Why is help needed? Issues with?

Age

Hearing

Sight

Mobility

Mental health

Language

Learning disabilities

Other (please specify)

Q8 – Date of birth of complainant?

(dd/mm/yyyy)

Q9 – Postcode of the subject of the complaint if not the client?

If no longer living please give details of last postcode (not last 2 letters)

Q10 – Has help with the complaint been sought

from another source?

Yes

No

If Yes where?

Another CAB

Advocacy organisation

Solicitor

MSP/MP

Other (please specify)

Q11 – Referred on (to be
Completed by CAB)

Yes

No

If Yes where?

CAB Money Advice

CAB Tribunal Rep

CAB Employment Rep

Solicitor

Macmillan

Other (please specify)

Appendix 2 (continued)

Complainant Profile

Client Reference No.

(select one)

1. Household type

Single adult

Couple

Lone parent

Couple with dependent children

Couple with non-dependent children

Declined to answer

Other (please specify)

(select one)

2. Housing

Owner occupier

Rent - social landlord

Rent - private

Not householder

Temporary

Nowhere to stay

Declined to answer

Other (please specify)

(select one)

3. Caring Responsibilities

None

Children

Partner

Elderly person

Declined to answer

(select one)

4. Economic status

Full time employment

Part time employment

Self employed

Unemployed

Retired

Looking after

family/home
Seeking work
Student
Unable to work due to
illness/disability
Declined to answer

(select one)

5. Health status

Health Ok
Short term illness/
health problem
Long term illness/health
problem
Mental health issues
Learning disability
Cancer
Declined to answer
Other (please specify)

(select one)

6. Income

Benefits only
Income + benefits
Income only
Pension
Declined to answer
Other (please specify)

(can select more than one)

7. Benefits: At first visit

AA high
AA low
Carer's Allowance
Council Tax Benefit
DLA Mobility high
DLA Mobility low
DLA Care high
DLA Care middle
DLA Care low
Incapacity Benefit
Income Support
Housing Benefit

Child Tax Credit
Working Tax Credit
Pension Credit –
Guarantee
Pension Credit – Savings
Declined to answer

(select one)

8. Income level
Please indicate whether
applies to client or
household

Client income
Household income

(select one)

Less than £4,999
£5,000 - £9,999
£10,000 - £19,999
£20,000 - £29,999
More than £30,000
Declined to answer

(complete all questions)

9. Transport
Access to own car
Yes
No
Declined to answer

Can client use buses
Yes
No
Declined to answer

Does client need help with
travel?
Yes
No
Declined to answer
Other (please specify

(select one)

10. Drugs or alcohol needed daily to function?

Yes

No

Declined to answer

Appendix 2 (continued)

Equality & Diversity Questionnaire

1. Are you male or female?

Male

Female

Prefer not to answer

2. DOB

Prefer not to answer

3. National identity, (refer to the code list provided)

Prefer not to answer

4. What language do you prefer to speak in? (refer to the code list provided)

Prefer not to answer

Do you need an interpreter or help to communicate?

Yes

No

Prefer not to answer

If yes, what type of help do you need? (refer to the code list provided)

5. What religion are you?

None

Buddhist

Christian

Hindu

Muslim

Jewish

Sikh

Other (if other, please tell us)

Prefer not to answer

6. What is your sexual orientation?

Bisexual
Gay man
Heterosexual (straight)
Lesbian / Gay woman
Other (if other, please tell us)
Not applicable e.g. child
Prefer not to answer

7. Do you consider yourself to be transgender? (For example, have you considered, or do you plan to have, surgery to change your sex.)

Yes
No
Prefer not to answer

8. Do you have a health condition or disability that has lasted, or is expected to last, 12 months or more, which makes it difficult for you to do day-to-day activities?

Yes
No
Prefer not to answer

If yes, please tick as many of the following which apply to you.
Long-term illness (for example, cancer, diabetes, HIV, heart disease)
Physical disability (for example, you use a wheelchair, or you have difficulty using your arms or hands)
Sensory disability (for example, you are registered blind or deaf)
Mental health condition (for example, depression or schizophrenia)
Learning disability (for example, Down's syndrome)
Other (if other, please tell us)

9. What is your ethnic group?

Choose one section from A - E. Then tick the box in this section which describes your ethnic background.

A. White
Scottish Irish English Welsh
Any other White background (please tell us)

B. Mixed

Any Mixed background (please tell us)

C. Asian, Asian Scottish, Asian British

Indian Pakistani Bangladeshi Chinese

Any other Asian background (please tell us)

D. Black, Black Scottish, Black British

Caribbean African

Any other Black background (please tell us)

E. Other

Any other background (please tell us)

Prefer not to answer

10. What are the first 5 digits of your postcode?

Prefer not to answer

Appendix 3 Data on usage, issues, actions, outcomes and impacts for each IASS in four sample Health Board areas

A3.1 Rural Area 1

Within rural area 1, the IASS service to the four CABx within the Health Board area is supported by one 18-hour post based located within one of the CABx.

Who is using Rural Area 1 IASS?

Who is the complainant, what is help needed with and referral patterns

Client record sheet data was provided for 15 - 17 people. Of the 17, 13 had been referred to the IASS by an 'other' source, and three were self-referrals. 'Other' sources of referral included other CABx/CAB advisors and a relative. One person was referred by NHS complaints staff. The majority were raising an issue about their own treatment, three on behalf of family members. None of the complainants appear to be being represented because of a special need.

Information was only provided on the age range of six complainants, of whom half were aged 65 - 79 years and one aged 80 years or over.

Only one person out of 17 had previously sought help from another source. Although from the client record sheet it appears that none were subsequently referred on by the CAB, data on actions/strategies suggest that three people were referred on.

Complainant profiles

Of the eight people for whom a complainant's profile was completed five were single adults, and two lone parents with one couple with non-dependent children. Half of the eight complainants lived in properties rented from a social landlord, the remainder equally split between owner-occupiers and private rented. The majority had no caring responsibilities.

Of the eight people, four were retired and two unable to work because of illness or disability. The remaining two comprised one person who was unemployed and one who was a student.

Reflecting this economic status, pensions were the main source of income for three complainants, a further two people relied solely on benefits and one person's income comprised both benefits and income (two people declined to answer this question). The two people providing information indicated the range of benefits received including carers allowance, DLA care low, income support, housing benefit, council tax benefit and pension credit. Income levels for the two people providing the information including one person with an income of less than £5,000.

Five people indicated that they had some form of health problem, including three with a long-term illness and one with a mental health problem (two felt their health was OK and one person declined to answer). Four people also indicated that they needed drugs or alcohol daily in order to function.

Only three (out of seven providing a response) had access to their own car, while five could use buses. Four people, however, needed help with travel.

Equality and diversity data were not available for Rural Area 1.

Concerns and Complaints brought to Rural Area 1 IASS

Of the 83 concerns and complaints raised the 'top three' were

Concerns about all aspects of treatment	19 (22.9)
Staff competence	18 (21.7)
Staff attitude and behaviour	17 (20.5)
Total concerns and complaints	83 (100)

The remainder generated five or fewer concerns or complaints. This includes four complaints relating to patient status/discrimination and three to patient privacy and dignity.

The great majority of complaints and concerns were addressed to the medical staff group - accounting for 59 (71.1%) of the 83 complaints or concerns. Nursing, midwifery and health visiting, dentists, and professions allied to medicine each generated five complaints or concerns.

In terms of 'service area': 20 complaints related to Hospital acute services -Inpatient - the single highest category. Hospital Acute services for outpatients and A & E each generated 10 concerns or complaints. Psychiatric/learning disabilities services in the community which generated eight concerns or complaints while psychiatric/learning disability inpatient services were the basis of four complaints or concerns.

Not surprisingly, 52 of the 83 complaints and concerns were in relation to the local NHS Board activity, with an additional seven relating to an adjacent city NHS Board. GP/primary health care was the focus of 10 complaints/concerns and three complaints were directed toward the Scottish Ambulance Service.

Actions/strategies undertaken by Rural Area 1 IASS

Table A3.1 indicates the pattern of activities undertaken by IASS by most frequent activity. Of the 93 activities, 45% (42 activities) comprised IASS drafting and sending a formal complaint letter on behalf of the client. Just over one-quarter of activities (26.8% (n=25)) involved IASS drafting a letter for the client to send. Giving the client information to take action on their own behalf comprised 14% of actions/strategies.

Table A3.1 Actions/Strategies undertaken by Borders IASS

Action/strategy	Number
Formal complaint letter drafted adviser to send on client's behalf.	42
Formal complaint letter drafted with client. Client to send and come back if necessary	25
Client is given information, to take action on own behalf	13
Informal contact made by telephone/letter with NHS staff	5
Client assisted to access and review medical records	3
Client referred to other organisation	3
Client wants to remain anonymous but raise concern with NHS	2
Total	93

Outcomes of Rural Area 1 IASS activity

Table A3.2 indicates the outcomes for 60 of the concerns and complaints. As this suggests, 45% (n=27) of these resulted in further action being taken, while in a further 20 % (n=12) the issue was not resolved but no further action was taken. In relation to nine concerns and complaints the issue was resolved.

Table A3.2 Outcomes for Rural Area 1

Outcome	Number
Further action taken	27
Issued not resolved- no further action taken	12
No further contact from client	11
Issue resolved	9
Social policy form completed and issue raised anonymously	1
Total	60

Impacts on CABx activity

As a very crude indicator of the impact of IASS on CABx activity overall, new issues brought to bureaux in relation to Sickness Benefit, Disability Benefit and 'Any Health' have been compared for the two years 2006 - 2007 and 2007 - 2008.

Data for Borders are indicated in table A3.3 below

Table A3.3 Total New Issues: Rural Area 1 CABx/IASS

	Total new issues by type			Health Board Population ²
	Sickness Benefit	Disability Benefit	Any Health ²	
2006 - 2007	290	425	146	110,247
2007 - 2008	339	474	583	111,430
% change	+16.9	+11.5	+299.3	+1.1

²'Any Health' *includes* IASS activity

²GROS mid-year estimates 2006 and 2007

Table A3.3 suggests that there have been increases in queries relating to sickness benefit and disability benefit. The three times increase in the level of activity in relation to 'any health issues' includes IASS activity.

A3.2 Rural Area 2

The IASS in Rural Area 2 is supported by one full time post.

Who is using the Rural Area 2 IASS?

Who is the complainant, what is help needed with and referral patterns

Client record sheet data was provided for 29 people. Of these, 20 people had self-referred, and six were referred by an 'other' source, including a local advocacy organisation and SACRO. The majority - 19 were raising issues about their own treatment, but for a significant minority the concern was being raised on behalf of another person: in four cases a spouse or partner and a family member in six cases. In one case was the complainant deceased. The majority of clients - 26 had no special needs, but where help was needed this was on the basis of age and mobility and 'other' reasons. Data on age was only available in relation to two people - both aged between 45 - 59 years.

Only two people had sought help from another source: an advocacy organisation and an 'other' resource. Only one person was subsequently referred on to another agency.

Complainant profiles

Of the 34 people for whom a complainant profile was completed 10 were single adults, there were eight couples, three each of lone parents and couples with dependent children. 10 people declined to answer and two indicated 'other' household types. Of the 28 people who provided information 17 were in owner occupied accommodation and 10 in social landlord housing and one in private rented accommodation. The majority for whom information was available did not have caring responsibilities, three, however, were responsible for caring for children and two for an elderly person.

A significant number (15) declined to provide information on their economic status. Of those who made this information available six each were retired or unable to work due to illness/disability, three

were in full-time and one in part-time employment. Two people were looking after family/home and one was unemployed.

Data on income and income level are problematic, since 28 and 29 people respectively declined to provide this information. 20 people also declined to answer questions on benefits received. Those who did provide this information were in receipt of a range of benefits, including DLA mobility High (six people) council tax, housing tax and incapacity benefits, as well as child tax and working tax credits and pension credits.

Of the 28 people who provided information on their health status, 13 had a long-term illness/health problem, two people had mental health issues and two were experiencing a short-term illness/health problem. 11 people felt their health was OK. All declined to give information on daily drug and alcohol usage.

The great majority also declined to provide information relating to transport.

Equality and Diversity Profiles

Some information on equalities and diversity was available for 17 people - though the data is incomplete. Of the 17, 11 were women, 15 indicated their national identity as "UK" (two chose not answer) and all 17 preferred to speak in English. 15 people described themselves as Christian, and one as having no religion (one refusal). All 17 described themselves as heterosexual.

Of the nine people who provided an answer, seven people considered themselves as having a long-term (12 months or more) health condition or disability: including a long-term illness (three people) and/or a physical disability (four people).

In terms of ethnic group, nine people described themselves as white Scottish. The remainder chose not to answer.

Concerns and Complaints brought to Rural Area 2 IASS

Of the 113 concerns and complaints raised the 'top three' were:

Staff - Attitude/behaviour	27 (23.9%)
'Other'	19 (16.8%)
Staff - Communication (oral)	15 (13.3%)
Total concerns and complaints	113 (100%)

In addition, 13 complaints and concerns related to 'Staff- competence' and 10 to 'Staff - communication (written)'. 'Clinical Treatment (all aspects)' generated seven concerns and complaints. Issues relating to 'Consent to Treatment' and to 'Patient Status/Discrimination' were each the focus of four complaints/concerns.

The medical staff group were the focus of nearly 60% (66) of the 113 complaints/concerns, followed by nursing, midwifery and health visiting (16.8% (19)) and professions allied to medicine (8.0% (9)).

'Community services - not elsewhere specified' were the service area which generated the highest number of complaints or concerns - 21 (18.5%) out of 113. This was followed by 'Hospital acute services - in patient' which were the focus of 14 complaints or concerns and psychiatric/learning disabilities - outpatients, 10. Other Hospital acute services which generated a number of concerns include outpatient (8), Accident and Emergency (8). 'Unscheduled care' and 'Care of the elder - community' also each generated (8) concerns. Reflecting this pattern, 93 (out of 111) complaints and concerns related to the NHS Board covering Rural Area 2.

Actions/Strategies undertaken by Rural Area 2 IASS

Table A3.4 indicates the pattern of activities undertaken by IASS by most frequent activity. Of the 104 activities for which information is available, just over one-third (36) involved IASS making informal contact with NHS staff. Drafting a formal letter of complaint and sending it on the client's behalf comprised a further 20% (21), closely followed by giving the client information to take action on their own behalf. Other activities, although proportionately small in number suggest quite intensive levels of activity, for example, assisting with appeals or attending meetings with clients.

Table A3.4 Actions/strategies undertaken by Rural Area 2 IASS

Action/Strategy	Number of Concerns/Complaints
Informal contact made by telephone/letter with NHS staff	36
Formal complaint letter drafted, adviser to send on client's behalf	21
Client is given information to take action on own behalf	19
Client assisted with raising issue though not against NHS	5
Client wants to remain anonymous but raise concerns with NHS	4
Formal complaint letter drafted with client. Client to send and come back if necessary	4
Client assisted with letter to SPSO	4
Client assisted to access and review medical records	3
Client withdraws issue/complaint	3
Client assisted with appeal against discharge	2
Client assisted with meeting with NHS staff	1
Client assisted with letter to professional regulatory body	1
Client referred to other organisation	1
Total	104

Outcomes of Rural Area 2 IASS activity

The outcomes of IASS activity are indicated in Table A3.5. This suggests that in just over 60% of cases it was not possible to resolve the issue and no further action was taken. In 16 cases (25%), however the issue was resolved, and action was taken in a further four.

Table A3.5 Outcomes of Rural Area 2 Activity

Outcome	Number
Issue not resolved - no further action taken	39
Issue resolved	16
No further contact from client	5
Further action taken	4
Total	64

Impacts on Rural Area 2 CAB activity

Looking at potential impacts of the IASS on the wider activity of Rural Area 2 CAB, table A3.6 indicates the pattern of issues relating to sickness benefit, disability benefit and 'any health' over a two-year period. This suggests a *drop* in sickness benefit and disability benefit issues. This may be the result of other factors related to the operation of the CAB but un-related to the IASS. The increase of almost 100% in 'Any Health issues' includes IASS activity.

Table A3.6 Total New Issues: Rural Area 2 CAB/IASS

	Total new issues by type			
	Sickness Benefit	Disability Benefit	Any Health¹	Health Board Population²
2006 - 2007	874	2313	143	148,030
2007 - 2008	842	1916	275	148,300
% change	-3.7	-17.2	+92.3	+0.2

¹'Any Health' *includes* IASS activity

²GROS mid year estimates 2006 and 2007

A3.3 City Area

The IASS service for the City comprises three part-time workers (1.6 FTE) based across three CABx.

Who is using City Area IASS?

Who is the complainant, what is help needed with and referral patterns

Client record sheet data was available for between 129 - 133 people.

Of 128, two-thirds (87 people) self-referred to the service, an additional 40 were referred by an 'other' resource. 'Other' sources of referral included other CABx or CAB advisors, advocacy agencies, social work/social care staff/care services, a solicitor and a local councillor. The 'Ombudsman' referred one person. Friend and 'word of mouth' were also identified as sources of referral, as was "other IASS client", suggesting the value of informal social networks in extending

the reach of the service. NHS complaints staff had referred two clients. Over 70% (92 people) were raising issues about their own treatment. 25 people were raising an issue on behalf of a family member, and 11 about a spouse or partner. Of the complainants 17 were deceased, and 11 were being represented because they had a special need: including age-related (six people); mobility and mental health (two people each) and for 'other' reasons (five people), including because the 'complainant' was a child or in hospital.

Of the 67 complainants for whom information on age was available three were aged 15 years or less; around one-half were aged 25 - 59 years, and 27% (18 people) aged 65 years and over.

Around one-quarter had sought help with the complaint from another sources, including another CAB (14 people), an advocacy organisation (two people), solicitor (four people) and 'other' sources (12 people). Eleven people were subsequently referred on by the CAB including to 'Other' resources (seven people), Solicitor (four people) and one to CAB money advice.

Complainant profiles

Single adults comprised around one-half and couples just under one quarter of the 111 people who provided household type information was available. A further 11 people were couples with dependent children. In terms of housing data, of the 99 for whom information was available, the majority were either renting properties from social landlords (63.6; 63 people) or owner-occupiers (33.3; 33 people). Five people were not 'householders' and one person was living in temporary accommodation.

Reflecting household type, nearly 70% (79) of 99 complainants had no caring responsibilities, just under one-quarter (23.6; (27)) were caring for children, four for a partner and two for an elderly person.

The economic status of the 99 complainants providing information, was very mixed: including 33 people (33.3%) who were retired, around 30% who were unable to work due to illness/disability and around one-fifth who were in full time employment. A further 10 people were looking after a family/home and eight people were self-employed.

Of the 89 people who indicated their source of income, over one-half relied solely on benefits compared with only 11% relying on income

only. 16 people received both benefits and income and 14 people were on a pension.

In terms of benefits at first visit, 55 people declined to provide this information. The information provided by those who did respond reflects the high proportion of people overall reliant on benefits as a source of income. These include council tax benefit (24 people), DLA mobility High (25 people), Housing Benefit (23 people), Incapacity benefit (14 people) and income support (12 people).

Again, a significant number chose not provide information on client or household income. What is evident is that 41 people/households, that is 77% of the 61 people who responded received an income of less than £10,000.

107 people provided information on their health status. Of these 44% (47 people) had a long-term illness/health problem and a further 15 people (14.0%) had a short term illness or health problem. Mental health issues were experienced by nine people. For just under one-third their health was OK. Only two people suggested they needed to use drugs or alcohol on a daily basis to function, of the remainder, 89 said they did not and 23 declined to answer.

Over two-thirds (out of 102) did not have access to a car; just under 80% (out of 98) could, however use buses and over three-quarters did not need help with travel. This suggests, however, that one-fifth to one-quarter of clients had difficulties of some sort accessing transport.

Equality and Diversity profiles

Equality and diversity data appears to have been completed, at least partially by 54 people. Of these just over one-half were women (excluding three people who preferred not to say). 29 people declined to give their age. Of those who did, five were aged between 18 - 24 years, and three aged 60 years and over. The remainder aged between 25 - 59.

Two of the 52 people who provided information on their national identity described themselves as from the Indian Sub-Continent. The remainder were from the UK. This is mirrored in the language people preferred to speak with one person preferring to speak in Punjabi and one in Urdu, the remainder preferring to speak in English. Two people

also indicated that they needed an interpreter to assist them communicate.

Of the 36 people indicating their religion, 26 described themselves as Christian, two as Muslim and eight as having no religion.

In terms of sexual orientation, 38 people identified themselves as heterosexual and one a lesbian/gay woman. No-one indicated that they considered themselves to be transgender.

18 people out of the 43 responding indicated they had a long-term health condition or disability. This included a physical disability (8 people), long term illness (five people) and a mental health condition (seven people).

The majority described their ethnic identity as white Scottish (46 people), one person as mixed background and three people Pakistani.

Concerns and Complaints brought to City Area IASS

Around 191 concerns and complaints were raised. Of these the 'top three' were

Staff attitudes and behaviour	43 (22.5%)
Staff competence	42 (22.0%)
Clinical treatment (all aspects)	23 (12.0%)
Total concerns and complaints	191 (100%)

Staff communication (oral) and (written) feature among the next highest generating 16 and 12 concerns and complaints respectively. Failure to follow agreed procedure (eight concerns) and policy and decisions of NHS boards (seven concerns) also feature.

Nearly three-quarters (141 out of 192) of the concerns and complaints were directed toward the medical staff group. The next highest group, nursing, midwifery and health visiting generated only 7.0% of concerns and complaints.

This is reflected in the service areas in relation to which concerns and complaints were raised: with 77 (around 40%) of issues being raised in relation to inpatient hospital acute services and Hospital acute outpatient services (22 complaint or concerns). In-patient care of the elderly raised 12 concerns, and community based psychiatric/learning disabilities services generated 10.

Of the 186 complaints or concerns where an NHS area is indicated, the vast majority relate to the City Area Health Board, with a total of nine relating to other health boards or Special Health Boards. GPs and dentists only raised four and one complaints and concerns respectively.

Actions/strategies undertaken by City Area IASS

Table A3.7 describes the responses by IASS by most frequent activity/strategy. Out of a total of 117 actions/strategies, the largest - constituting nearly 54% of actions, was the preparation of a formal letter of complaint to be sent on the client's behalf. Informal contact with NHS staff was adopted as a strategy in 18 cases (15.4%), and a letter drafted for action by the client in 10% of cases.

Table A3.7 Actions/Strategies undertaken by City Area IASS

Action/strategy	Number
Formal complaint letter drafted adviser to send on client's behalf.	63
Informal contact made by telephone/letter with NHS staff	18
Formal complaint letter drafted with client. Client to send and come back if necessary	12
Client is given information, to take action on own behalf	10
Client referred to other organisation	6
Client assisted to access and review medical records	3
Client assisted with meeting NHS staff	3
Client assisted with raising issue though not against NHS	1
Client withdraws Issue/complaint	1
Total	117

Outcomes of City Area IASS Activity

The outcomes of these activities are indicated in table A3.8 In relation to over 60% of the concerns and complaints the issue was resolved while further action was taken in relation to 16%. In just 10 (9.4%) cases was it not possible to resolve the issue and no further action could be taken. In a small number (four concerns or complaints) the issues raised triggered the completion of a CAS social policy form.

Table A3.8 Outcomes of Concerns and Complaints to City Area IASS

Outcome	Number
Issue resolved	64
Further action taken	17
No further contact from client	11
Issue not resolved - no further action taken	10
Social Policy form completed and issue raised anonymously	4
Total	106

Impacts on City Area CABx Activity

Table A3.9 compares total new issues raised across the City Area CABx in relation to sickness benefit, disability benefit and 'Any Health' over the two years 2006 - 2007 and 2007 - 2008. This reveals increases in new issues in relation to sickness benefit and, to a lesser extent disability benefit. The two-fold increase in 'Any Health' issues includes IASS activity.

Table A3.9 Total New Issues: City Area CAB/IASS

	Total new issues by type			Health Board Population ²
	Sickness Benefit	Disability Benefit	Any Health ¹	
2006 - 2007	2633	3545	672	1,191,584
2007 - 2008	2934	3685	2134	1,192,419
% change	+11.4	+3.9	+217.5	+0.1

¹'Any Health' *includes* IASS activity

²GROS mid-year estimates for 2006 and 2007

A3.4 Mixed Area IASS

The Mixed area IASS is provided by three part time posts (1.2 FTE) based across three Bureaux.

Who is using the Mixed Area IASS?

Who is the complainant, what is help needed with and referral patterns

Client record sheet data was provided for 35 - 37 people. The majority (30 out of 35) self-referred to IASS, four were referred via an 'other' source and a GP referred one person. 'Other' sources of referral included voluntary and advocacy agencies and a local councillor. Of 35 people, 20 were raising an issue about their own treatment and 15 were acting on someone else's behalf - either a spouse or partner (8 people), family member (six people) or, in one case a member of their community. The subject of the complaint was deceased in 10 out of 37 cases. Five people were being represented because they had a special need including a mental health problem in two cases, age, language or 'other' (one case each).

Only nine people gave information on age: of these five were aged 65 - 79.

None had sought help elsewhere and the majority - 33 out of 37 - were not referred on elsewhere. Three people were referred on to a solicitor and one to an 'other' source of help.

Complainant profiles

Of the 10 people for whom a complainants profile was completed, four were single adults, two were part of a couple with dependent children and one was a couple (three people declined to answer). Of the seven people providing housing information, four were owner-occupiers and three lived in accommodation rented from a social landlord. Four people had no caring responsibilities, three were responsible for children (three declined to answer).

Only five out of 10 people provided information on their economic status: split between full time employment and retired (two people each) and unable to work because of illness/disability. Only four people provided information on income (three relied on income only

and one on benefits only) and benefits at first visit and none provided information on income level.

Of the eight people providing information on health status, health was OK for four, two people experienced mental health issues, and one person each experienced a short or long-term illness/health problem. None of the five people answering the question needed drugs or alcohol to function daily.

Five of the 10 clients declined to answer the questions relating to transport. The remaining five people were able to use buses and did not need help with travel.

Equality and diversity

Some data on issues of equality and diversity were provided for 20 clients. Of these 15 were women. Only two people, however, provided information on date of birth. Of the 16 prepared to provide information on national identity, one was Polish, the others were from the UK. None of the 15 answering the question needed an interpreter to communicate.

No-one indicated what religion they were.

Half of the 20 described their sexual orientation as heterosexual, the remainder refused to answer. No-one considered themselves to be transgender (eight people declined to answer).

Two people indicated they had a long term health condition or disability (one each with long term illness or mental health condition), but 11 people refused to answer this question.

All of the 14 people answering the question on ethnic group described themselves as white (13 white Scottish).

Concerns and Complaints brought to Mixed Area IASS

Of the 67 concerns and complaints raised, the 'top three' were:

Clinical treatment (all aspects)	18 (26.9%)
Staff - Attitude/Behaviour	13 (19.4%)
Staff Communication (oral)	9 (13.4%)
Staff Competence	9 (13.4%)
Total concerns and complaints	67 (100%)

The remainder generated four or fewer complaints or concerns.

Of 64 concerns and complaints for which information on staff group was available, Medical Staff accounted for 62.5% (40), the next largest group being 'Other' categories (13 complaints/concerns).

The service areas that generated the highest proportion of the 67 complaints and concerns were Hospital acute services - inpatient and Community services - not elsewhere specified - each of which were the focus of over one quarter of complaints (26.8%: 18 complaints), and 'Other' (15.0%; 10 complaints) Hospital acute outpatient and accident and emergency services each accounted for five complaints and concerns.

The data suggests that 42 (65%) of the 65 complaints and concerns for which information was available were in relation to activity within the Mixed Health Board area; two other Health Boards accounted for four and one complaints or concerns respectively and GPs 13 (20%).

Activities undertaken by Mixed Area IASS

Table A3.10 indicates the pattern of actions and strategies undertaken by the Mixed Area IASS by most frequent action/strategy. This suggests that the most frequent actions were to give the client information to take action on their own behalf - accounting for 43% of actions, followed by just under one-fifth of actions which involved drafting a formal letter with the client for the client to send and come back as necessary. In 10 cases (15%) the client wanted to raise a concern anonymously. In a small number of cases the service assisted the client at meetings or had informal contact with NHS staff on the client's behalf.

Table A3.10 Actions/Strategies undertaken by Mixed Area IASS

Action/Strategy	Number of complaints/concerns
Client is given information to take action on own behalf	29
Formal complaint letter drafted with client. Client to send and come back if necessary	13
Client wants to remain anonymous but raise concern with NHS	10
Formal complaint letter drafted, adviser to send on client's behalf	6
Client assisted to access and review medical records	2
Client assisted with meeting NHS staff	2
Client assisted with raising issue though not against NHS	2
Informal contact made by telephone/letter with NHS staff	1
Client assisted with letter to SPSO	1
Client referred to other organisation	1
Total	67

Outcomes of Mixed Area IASS Activities

Table A3.11 describes the outcomes in 50 cases. In 40% of cases there was no further contact from the client (this perhaps reflects the pattern of activities indicated in table A3.10 above), and in 20% of cases the issue was resolved. However, again reflecting the actions/strategies, in nine cases (18%) the IASS completed a social policy form and raised the issue anonymously.

Although not directly evident from the action/strategy data, the outcome data suggests that the IASS was involved in assisting a client with appeals: in two cases the appeal/case was partially upheld, and in one the appeal was lost.

Table A3.11 Outcomes of Mixed Area IASS activity

Outcome	Number
No further contact from client	20
Issue resolved	10
Social Policy form completed and issue raised anonymously	9
Further action taken	7
Appeal/case partially upheld	2
Issue not resolved - no further action taken	1
Appeal lost	1
Total	50

Impacts on CABx Activity

Comparing new issues presented to the Mixed Area CABx over the period 2006 - 2007 and 2007 - 2008 the data suggest that there were increases of under 10% in new issues relating to sickness benefit and disability benefit, but an 85% increase in 'Any Health' issues (table A3.12). 'Any Health' includes IASS activity.

Table A3.12 Total New Issues: NHS Tayside CAB/IASS

	Total new issues by type			
	Sickness Benefit	Disability Benefit	Any Health ¹	Health Board Population ²
2006 - 2007	932	1582	414	391,639
2007 - 2008	1010	1696	764	394,534
% change	+8.4	+7.2	+84.5	+0.7

¹'Any Health' ***includes*** IASS activity

²GROS mid-year estimates 2006 and 2007

Appendix 4

Comparison of actions/strategies and outcomes by sample area

Actions/strategies by sample area

Action/Strategy	Sample Area number of cases			
	Rural 1	Rural 2	City	Mixed
Client wants to remain anonymous but raise concern with NHS	2	4	0	10
Client is given information, to take action on own behalf	13	19	10	29
Informal contact made by telephone/letter with NHS staff	5	36	18	1
Formal complaint letter drafted with client. Client to send and come back if necessary	25	4	12	13
Formal complaint letter drafted, adviser to send on client's behalf	42	21	63	6
Client assisted to access and review medical records	3	3	3	2
Client assisted with meeting NHS staff	0	1	3	2
Client assisted with letter to SPSO	0	4	0	1
Client assisted with letter to professional regulatory body	0	1	0	0
Client assisted with appeal against discharge from medical care	0	2	0	0
Client assisted with raising issue though not against NHS	0	5	1	2
Client withdraws issue/complaint	0	3	1	0
Client referred to other organisation	3	1	6	1
Total	93	104	117	67

Appendix 4 continued

Outcomes by sample area

Outcome	Sample Area Number of cases			
	Rural 1	Rural 2	City	Mixed
Social policy form completed and issue raised anonymously	1	0	4	9
No further contact from client	11	5	11	20
Issue resolved	9	16	64	10
Further action taken	27	4	17	7
Issue resolved - no further action taken	12	39	10	1
Appeal/case upheld	0	0	0	0
Appeal/case partially upheld	0	0	0	2
Appeal lost	0	0	0	1
Total	60	64	106	50