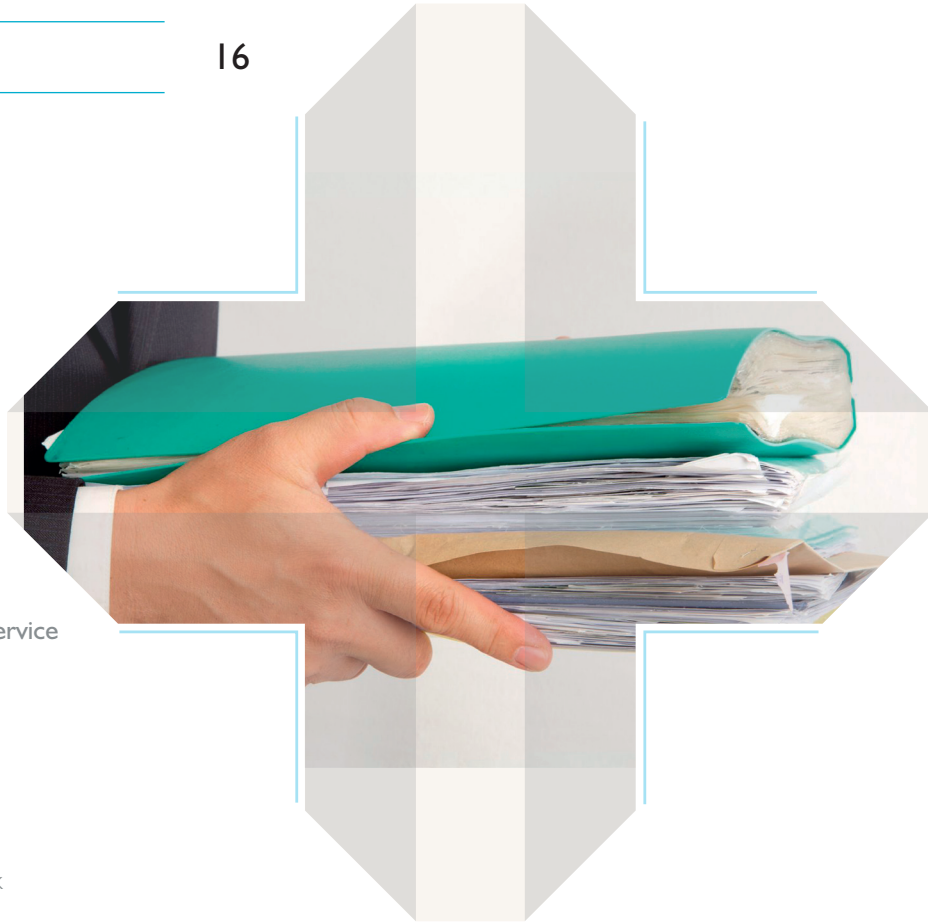
ISCAS
INDEPENDENT SECTOR
COMPLAINTS ADJUDICATION SERVICE

ANNUAL REPORT 2013

Adjudicating Complaints for the Independent Healthcare Sector

ISCAS
INDEPENDENT SECTOR
COMPLAINTS ADJUDICATION SERVICE

Contents



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Foreword

by Sally Taber, Director of ISCAS

This is the 13th year of the Independent Sector Complaints Adjudication Service, ISCAS, which we formed in response to a report by the Health Select Committee. Essentially derived from best practice of the members of the trade association serving independent acute hospitals, it added the element of external adjudication by an independent body, which enabled both complainants and providers to find closure of otherwise intractable complaints under a code of practice which is equitable and fair. Free to consumers, the adjudication process fosters a culture of learning, and assures the consumer that the complaint has a positive result.

The ISCAS Annual Report goes to subscribing members of ISCAS, government, professional and system regulators, the Parliamentary and Health Service Ombudsman and the general public via its website. It has been my endeavour to put best practice in handling complaints into the forefront of our subscribing member's minds, and to this end we have in 2013 revised and reformed the Code of Practice and expect our members to further develop their complaints management procedures to reflect these improvements.

During this year, a review of cosmetic interventions by Sir Bruce Keogh recommended that all private healthcare complaints in England should be handled by the Parliamentary and Health Service Ombudsman. The report adduced no evidence that ISCAS (to which over 90% of independent acute hospitals in England belong) was failing consumers. We believe that a public funded agency would be ill-suited to the independent healthcare sector, and have therefore put forward to government the successful ISCAS model as the foundation of a complaints management code to be mandated for the whole independent healthcare sector. This would be regulated by the Care Quality Commission in England, Healthcare Inspectorate Wales in Wales, Healthcare Improvement Scotland in Scotland and the Regulatory and Quality Improvement Authority (RQIA) in Northern Ireland.

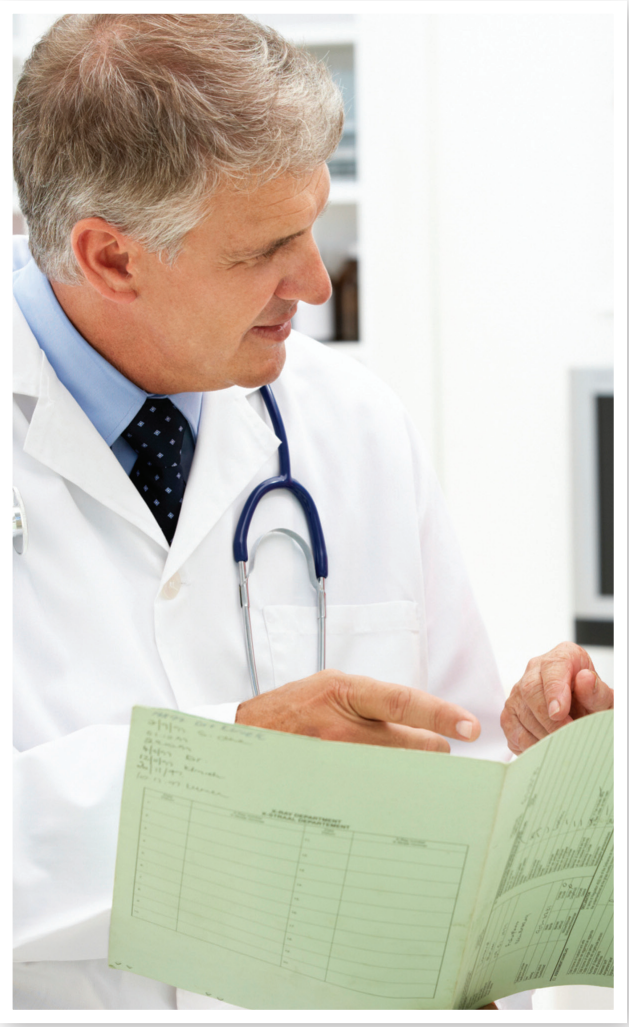
We do recognise that ISCAS serves only the healthcare providers already committed to high standards of consumer service. There are many healthcare providers who will have no recognised independent review process and this undoubtedly gives rise to difficulties. During recent years we have extended the reach of ISCAS in conjunction with the Independent Doctors Federation, whose fast growing membership encompasses doctors who are in independent practice. Patients of such doctors who need to complain now have a recognised route to resolution. In other cases we have invited new clinics to adopt the ISCAS Code – specifically the Private Ambulance Service and BCAM (British College of Aesthetic Medicine), thus extending its protection further to patients.

With our codes' recognition as suitable for the organisations they inspect, we believe that the CQC could do more to require other clinics to adopt the ISCAS Code, for the ultimate benefit of patients. Be it noted, ISCAS is not toothless, removing from membership more than one provider who has failed to abide by the Code; and reporting to the professional and system regulators instances of concern.

ISCAS is built upon the principle of openness, appropriately in this era of the increasingly well-informed patient.

Introduction

The Independent Sector Complaints Adjudication Service (ISCAS) operates the well-established, and recently revised, independent healthcare sector's Complaints Code of Practice (Code) and provides independent adjudication for complaints made against ISCAS members. The 2013 Code continues to focus on local resolution, first directly with the service provider (stage 1) and then at a corporate level (stage 2). The Code sets out the standards that ISCAS members agree to meet when handling complaints about their services. Each year ISCAS sees the vast majority of complaints amongst its members are being resolved at either stage 1 or stage 2.



Adjudication with ISCAS is the stage 3 independent review process for complaints that an ISCAS member has not been able to resolve at stages 1 and 2. It is the only complaints Code offering this level of independence operating in the independent healthcare sector.

The healthcare sector is facing increased regulation from system regulators such as the Care Quality Commission and scrutiny of quality following both the Francis Report, the Review of the Regulation of Cosmetic Interventions, conducted by Professor Sir Bruce Keogh, and also the Winterbourne View report. Fundamental to the drive for quality is ensuring that the best procedures are in place for managing disputes.

ISCAS is already recognised by major regulators, including the Care Quality Commission (CQC), Health Inspectorate Wales (HIW), Healthcare Improvement Scotland (HIS) and the Regulation and Quality Improvement Authority (RQIA). CQC and HIW even signpost complainants to the service where appropriate.

Over the year ISCAS saw a small increase in membership from 68 organisations to 71. Of note many organisations have a large number of hospital services in their corporate membership of ISCAS, for example the largest has 68 hospitals.

ISCAS Complaints Code of Practice

The Complaints Code is the cornerstone of ISCAS and the review of the Code has been the focus of development work over the year. The new Code has a different approach and look, providing clear standards of what to expect for everyone that uses it. The effective 3 stage approach has been retained as it affords greater opportunity for local resolution.

The review of the Code included a consultation with the ISCAS Governance Board, ISCAS members and then a wider external consultation. This latter phase ensured ISCAS engaged with regulatory bodies, medical defence organisations and importantly with patient groups. The patient groups largely welcomed the changes to the Code but wanted ISCAS to be much clearer about the interface between complaints and clinical negligence, which led to further changes. It is important to reduce barriers for complainants as they work their way through a complaints process and the new Code strives to achieve this.

The Code has retained the prescribed timescales unlike the NHS framework, as these have proven helpful in managing complaints for both ISCAS members and complainants. A major change is how the Code takes account of potential clinical negligence issues within individual heads of complaint. Under the previous Code, complaints that involved potential clinical negligence, and in particular if a legal claim had been made, would have halted the whole complaints process. This is no longer the case with the new Code and ISCAS recommends that the complaints procedure, including stage 3, continues even if a complaint relates to matters that may give rise to a potential claim.

ISCAS also responded to feedback to increase the time a complainant has to escalate their complaint at each stage. Complainants now have up to six months to escalate complaints at each of the three stages. The Code was published in June 2013 and members had until September 2013 to comply with the changes.

ISCAS Secretariat and Complaint Activity

by Andrew Wilby

Table 1: How people hear about ISCAS

329 people contacted ISCAS about their complaint over the reporting year in addition to complainants referring their case for adjudication. Table 1 shows how people were signposted to ISCAS however, 43% of all contacts could not recall, or were unsure where they learnt about ISCAS. From the remainder, the vast majority (21%) were using the internet and found the ISCAS website, which demonstrates the importance of continued development of this information resource. Fewer people were relying on the patient leaflet than has been the case previously.

Table 1: How people hear about ISCAS, Referral Source.

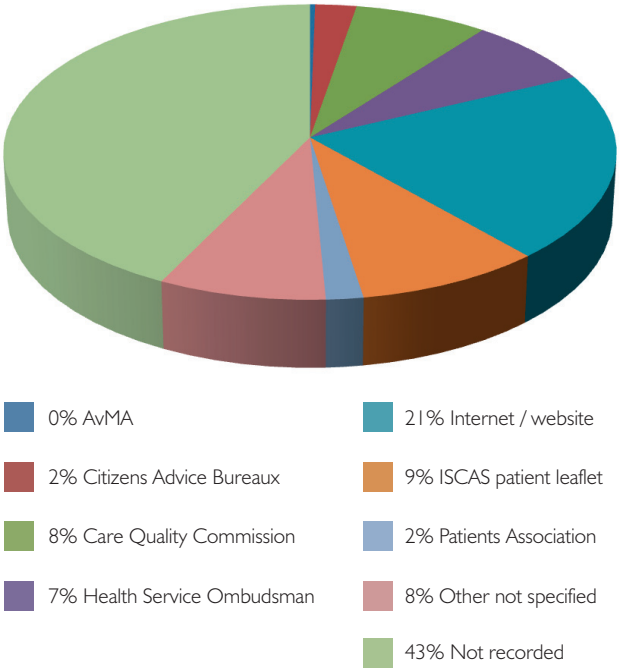


Table 2 clearly shows that most of the people contacting ISCAS had a complaint in relation to cosmetic surgery, followed by complaints about consultant care.

Table 2: Complaint by type for all contacts at stages 1 and 2

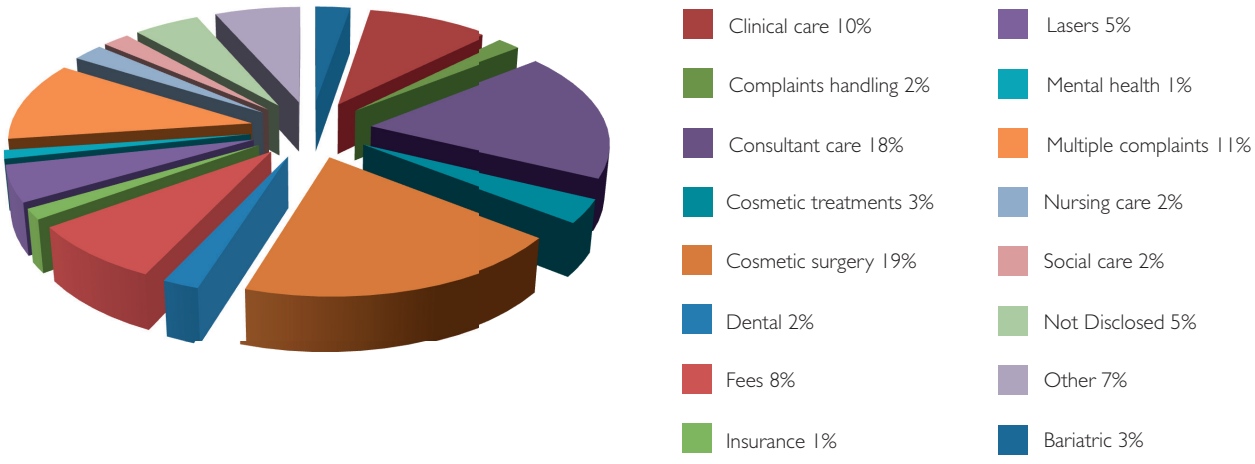


Table 3: Complaint by type for ISCAS members

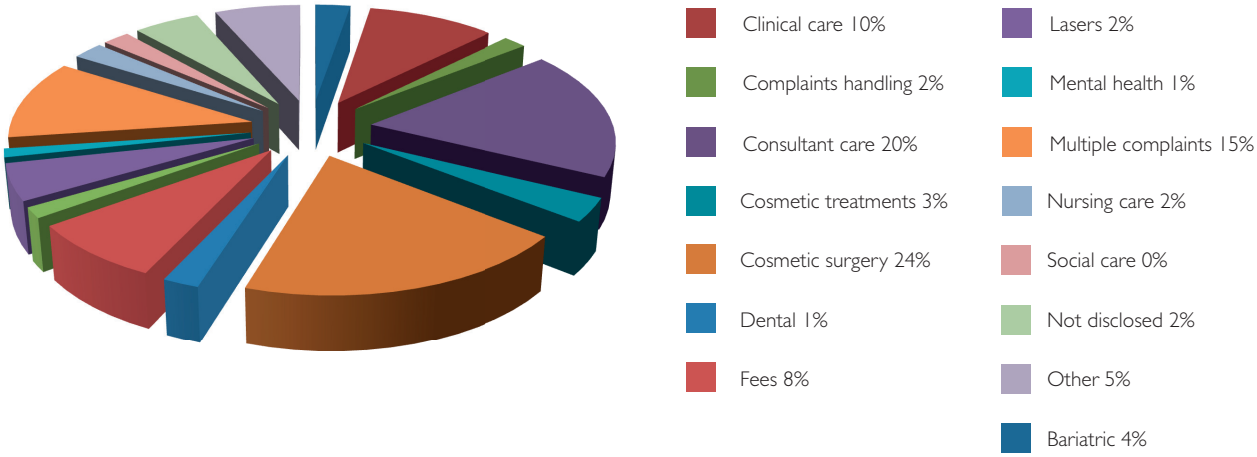
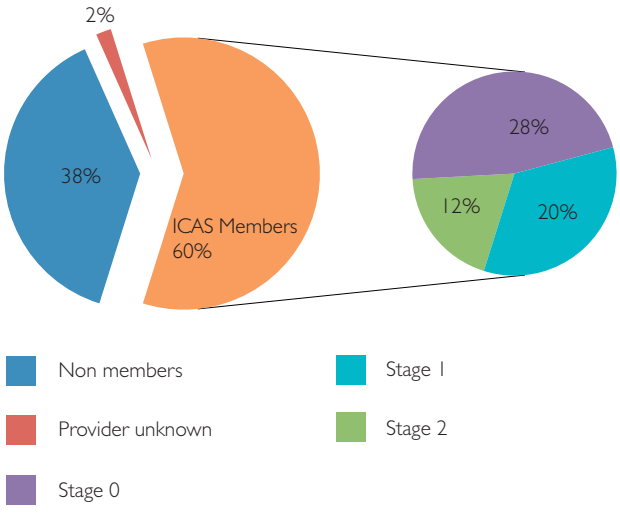


Table 4: Breakdown of complaints by each stage for ISCAS members

Table 4 also shows the stage that the complaint had reached when people contacted ISCAS.



Some people contact ISCAS before embarking upon the complaints process (28%), which reflects that in some cases the ISCAS member has not publicised their complaints information effectively. Some people seek assurance about how the complaint process is working.

ISCAS had a significant increase in complaints about non-members: 38%, compared with 25% last year. This includes people seeking to complain about NHS Private Patients Units, which do not currently subscribe to ISCAS. The remit of the Health Service Ombudsman does not extend to complaints about these units, leaving users of these services with limited redress and no avenue for independent review of their complaint. This is a matter the ISCAS Governance Board continues to raise with Ministers.

The majority of people contacting ISCAS about a member are at stage 1 of the process. Some are seeking advice about next steps and confirmation that the ISCAS member is following the right procedure. In some cases, there is a wish to escalate a complaint before stage 2 has begun. A significant amount of ISCAS time is committed to helping people work through the complaints process ahead of adjudication and to advising about alternative ways to pursue complaints about non-members. This is equally important to ISCAS, as unfortunately these complainants have used a service that has no commitment to a full complaints process with an independent review stage.

ISCAS Governance Board

Over the year, the Board has ratified the membership and focused on increasing its patient representation, including engagement with Action against Medical Accidents (AvMA) and the Private Patients Forum. The Board agreed a number of ISCAS developments to take forward:

- **Revision of the Code**
- **Seeking feedback from complainants about the service**
- **Improving the monitoring of member's compliance to the Code**
- **Reporting on ISCAS activity and adjudication outcomes**

ISCAS discontinued membership of one organisation due to continued non-compliance with the Code and providing a poor complaint service to its patients. This was an exceptional decision for the Board to make.

The Board's role in agreeing decisions about non-compliance is an important aspect of ensuring independence in the governance of the Code and demonstrating publically that membership of ISCAS means complainants are treated and responded to properly.

Baroness Fiona Hodgson, CBE, ISCAS Governance Board Chair

It has been my pleasure to chair the ISCAS Governance Board since its inception at its first meeting in March 2012.

This past year has seen the ISCAS Governance Board become well established. Getting the right balance on the Board has been an important concern. Coming from a patient background myself, I am always mindful about the importance of ISCAS engaging with patient representatives. During the past year we have invited in AvMA and the Private Patients Forum (PPF) in to talk to us about their work. We already have representation from the Patients Association and have been fortunate to have a patient representative from the Private Patients Forum.

Much work, and extensive consultation, has been put into the review of the Complaints Code of Practice. This has proved to be a challenging task which has meant that it has taken slightly longer to produce than originally anticipated. However, the new Code has been launched and I hope will be well received. I would like to thank Andrew Wilby and the ISCAS staff for all their hard work during the past year. Having such an excellent team has really helped the Governance Board enormously and we look forward to the challenges of the year ahead!

Baroness Fiona Hodgson, CBE

Independent Adjudication

Since reporting last year on the appointment of Sally Williams, ISCAS has been successful in confirming a second adjudicator, Fiona Freedland.

Fiona Freedland is a solicitor who specialises in the field of medical law. She played an active role in the Shipman Inquiry and in policy work regarding the regulation of healthcare professionals.

For many years, Fiona worked in the field of law and healthcare policy as Legal Director for AvMA, a national charity for patient justice. In addition to her work for ISCAS, Fiona is an Adjudicator for the Solicitor's Regulation Authority and sits as a Chair of the Nursing and Midwifery Council Fitness to Practice Panels. She is a lay assessor for the National Clinical Advisory Service (NCAS). Fiona has a masters degree in Medical Law and Ethics and she undertakes several public speaking roles on the subject of Medical Law and Ethics which is a particular interest of hers. She is an accredited mediator with CEDR.

Learning from Complaints During 2012-2013

Sally Williams, Adjudicator

An important and valued outcome of the complaints handling process is taking action to improve services and prevent the same problems happening again. Whenever an independent adjudicator reaches a decision on a complaint, they send a decision letter to the complainant and copy this to the ISCAS member the complaint was about.

The letter to the ISCAS member usually contains advice on how the organisation could improve its complaints handling. Often ISCAS members are asked to report back to ISCAS about actions they are taking as a consequence of this advice. In this way, independent adjudication seeks to be part of a circle of learning from complaints.

Where themes arise in the advice given to ISCAS members about specific complaints, these are shared with all ISCAS members through the Adjudicator's Monthly Message (this can be found at www.iscas.org.uk in the news section). Over the last year the monthly message has touched upon a broad range of issues. These include the thorny issue of complaints and clinical negligence. It is not uncommon for complaints to reach the adjudicator that stray into the field of clinical negligence, however ISCAS members often express uncertainty over whether the complaints procedures can continue where a complaint appears to have arisen as a result of possible clinical negligence and compensation is sought. The new ISCAS Code, published in June 2013, seeks to be clearer on this point and reflects practice in NHS complaints handling. It states: 'Even if independent advice is being sought about possible clinical negligence the ISCAS Code recommends that the complaints procedure and ultimately stage 3 adjudication is continued.'

Other themes from the year include the following:

1. Handling complaints received by email, including establishing a clear process for managing email interactions with complainants. This includes introducing timeframes that remove the pressure to give an immediate and, sometimes less considered, response and implementing a single database to log emails from the complainant and any organisational responses.

2. Demonstrating caution about what is contained in emails about complaints, which comprise an increasing proportion of complaints files and are potentially disclosable under the Data Protection Act. The informality of email can lure users into disregarding rules about confidentiality and the transfer of sensitive information. In reality, the risk of confidentiality breaches of personal information is much greater.

3. Ensuring that protocols governing the storage of patient records are adhered to by consultants with practising privileges and that information sharing happens to support complaints handling. Missing records make it much harder to establish the facts of a case and can create suspicion of a cover-up. Gaps often occur around consultant's clinical notes or photographs and imaging taken by consultants.

4. The use of experts to advise on the clinical aspects of complaints, including the importance of independence and the absence of any conflict of interest, having a clear documentation trail, and transparency over the identity of the expert and the opinion they provide.

5. Managing complaints that involve third parties, such as clinical negligence lawyers or a professional regulatory body, including whether there are elements of the complaint that the organisation should answer regardless of whether other parties are involved, what purpose will be served by halting a complaints process while third party investigations take place, and how the interests of the complainant and those complained about are best served.

6. The potential to resolve complaints more swiftly by offering to meet with complainants early on. This can be helpful in resolving complaints in a collaborative way.

7. Greater use of templates to ensure that responses to complaints routinely contain the right information.

Goodwill Payments, Anonymised Vignette

When a complaint reaches stage 3, the independent adjudicator is able to consider a wide range of remedies, of which one is to award a goodwill payment. Under the new code a goodwill payment can be awarded 'in recognition of shortfalls in the complaint handling, inconvenience, distress, or any combination of these, up to a limit of £5,000'. Often the award of a goodwill payment reflects all of these things, but issues have arisen over what the phrase 'shortfalls in the complaint handling' means in practice.

One case that illustrates this point concerns a complainant who underwent major surgery. Pre-operatively, the patient had been assessed as having three factors that increased her risk of Venous Thromboembolism (VTE) and identified her as needing anti-embolic (TED) stockings from admission until she was fully mobile. However, when she arrived at hospital, stockings in this patient's size were not available. Alternative mechanical prophylaxis was used to assist the prevention of VTE, but this was for only 24 hours and she was discharged from hospital without any support stockings. On two occasions after discharge home, the patient complained to hospital nursing staff about pain in her upper legs; these concerns were not escalated to her consultant. When she saw the consultant, he diagnosed bilateral deep vein thrombosis (DVT) and she later developed a pulmonary embolism (PE).

It was beyond the scope of the complaints procedures to establish whether the absence of support stockings caused, or contributed, to the development of this patient's DVTs and, subsequently, the PE. The adjudicator instead focused on how the hospital responded to the issues raised by the complainant, and found that the hospital did not respond adequately regarding its failure to provide the stockings that the patient had been identified as needing, that there was no evidence that consideration was given to postponing the procedure, and that it was not clear why stockings were not provided for use post discharge. The adjudicator also found that this patient was not well served during interactions with nursing staff post-discharge.

Positively, the handling of this complaint had been within the timeframes set out in the code and the adjudicator did not uphold heads of complaint that related to specific aspects of complaint handling. However, complaints handling covers the whole process, from responding to complaints within timeframes, the investigation and inquiry, as well as the remedies offered to the complainant. The adjudicator considered that as part of remedying the core complaint as set out above, the hospital should have made a gesture of goodwill.

The hospital considered the goodwill award made by the adjudicator – which fell into the category of 'very serious' – to be 'excessive'. It was concerned that the adjudicator had implied causality between the care delivered by the hospital and the complications the patient had experienced, and thought this was reflected in the goodwill payment awarded. The hospital was concerned that in paying the award, it risked implying acceptance of causality should the patient proceed to litigation.

The adjudicator responded that the size of the award reflected the seriousness of the issues and the distress caused to the complainant and her spouse. Paying it need not imply any acceptance of causality and appropriate caveats could be attached, such as expressly stating that it was made on an ex gratia basis, without prejudice and without any admission of liability. It was therefore incorrect to suggest that it would prejudice any clinical negligence claim in the event that the complainant decided to pursue this avenue.

This case highlighted the difficult path that ISCAS members and adjudicators often tread when handling complaints about issues that could potentially give rise to a clinical negligence claim. It also exposed a lack of transparency about the basis for determining the size of an award. This is something that the team of adjudicators are planning to address with ISCAS by developing guidance on the type of circumstances in which an award may be appropriate and the factors to consider in deciding the level of award. Such guidance can only be indicative, as each case must be considered on its own merits, but it should help to increase transparency of the formulation of awards.

Adjudication, Facts and Figures

The number of heads of complaint has risen since last year and may, in part, explain the increasing complexity of many of the cases that come to adjudication (Table 5). Last year, for the first time, adjudication saw more complaints about nursing and a decrease in medical complaints. This year there was a return to a higher number of medical complaints, as seen in table 5. It is important to note that these are complaints that are not resolved at stages 1 and 2; they do not necessarily reflect the scope of complaints received at those earlier stages by ISCAS members.

Complaints relating to administration, which includes complaints handling, have always been significant, however they have increased this year following a slight decrease last year. This has implications for how members comply with the code, which has led to the adjudicators recommending that ISCAS has oversight of actions taken by members organisations to improve complaints.

Table 5: Total heads of complaint year on year

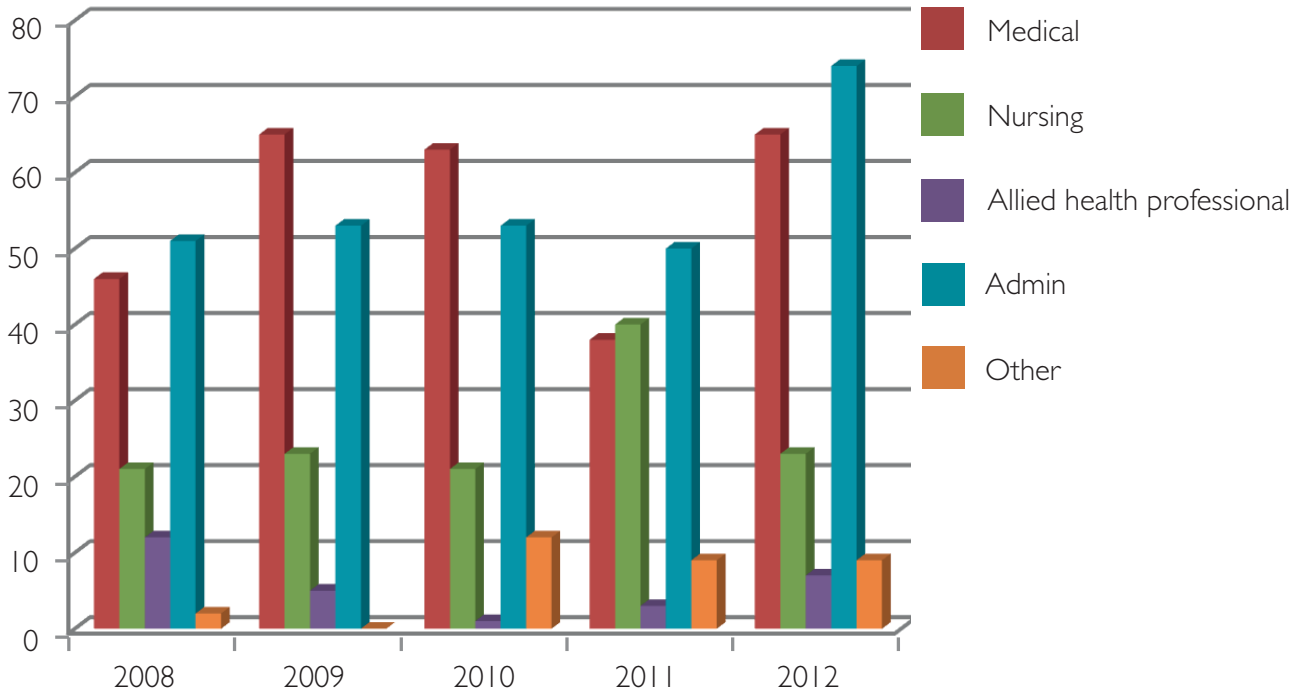


Table 6: Heads of complaint upheld by Independent Adjudication

48% heads of complaint were upheld under Independent Adjudication:	
Medical	33% of all medical complaints were upheld
Nursing	43% of all nursing complaints were upheld
Allied health professional	42% of all AHP complaints were upheld
Administrative	66% of all administrative

Expert Clinical Advice

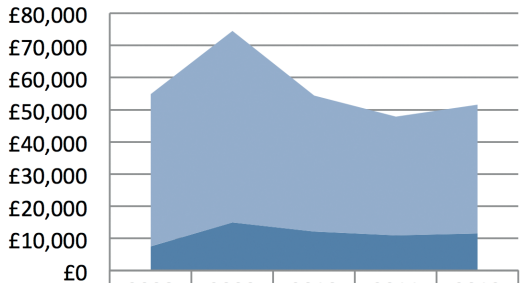
The use of expert advice is essential when a case involves a clinical matter that an Adjudicator needs to make a decision about, and demonstrates to the complainant the evidence and rationale the Adjudicator has relied upon. This year saw a rise in the number of cases requiring expert clinical advice from just 1 of the 28 cases last year to 8 of the 38 cases in 2012/13. The total costs associated with the expert advice came to £6,646.

Costs of adjudication

Since 2009 the cost of adjudication has reduced. However, during 2012 the overall cost rose slightly, which is shown in Table 7. There are a number of reasons for this. There has been an increase in the total number of cases coming to adjudication (Table 7). As noted previously, the cases coming to stage 3 adjudication are increasingly complex in nature, which has resulted in an increase in the resource required to complete an adjudication. ISCAS had for five years made no increase in the fees paid to the adjudicators and 2012 saw a reasonable increase in these fees. Such costs are met by the ISCAS members and adjudication remains free to complainants, as is the case with the Health Service Ombudsman.

Table 7: Year on year adjudication costs

The Code has a focus on learning and improving from complaints although it does allow the Independent Adjudicator to make a goodwill payment in recognition of inconvenience and distress. Table 9 shows there has been a slight decrease in the number of cases where a payment was made (down from 57% to 50%). The average cost of a payment was higher in 2012 compared with 2011, but was less than in previous years. The maximum payment that can be awarded is £5000, although the majority of cases that attract the payment are between £150 to £500. The maximum awarded for a single adjudication case was £3000.



	2008	2009	2010	2011	2012
Adjudication	£47,270	£59,485	£42,203	£36,950	£40,103
Ex Gratia Awards	£7,540	£15,000	£12,150	£10,906	£11,500

Table 8: Goodwill payments

Goodwill payments made	2008	2009	2010	2011	2012
Cases in which payments made	14	21	17	16	19
% of cases attracting a payment	72%	78%	77%	57%	50%
Total cost payment £	7,450	15,000	12,150	10,906	11,500
Averrage cost payment £	573	714	714	390	605

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The Year Ahead

Over the next year we will be reviewing the governance of ISCAS to continually improve the service. The governance arrangements of the Board will be further developed, including a commitment to increase the patient and public representation. ISCAS is seeking to raise its profile in the healthcare sector, firstly with a formal launch event of the ISCAS Code to sector stakeholders. ISCAS members are also likely to experience increased monitoring of their compliance with the Code as an integral part of membership application and renewal.

Management Accounts for 2012 - 2013

ISCAS	To 30/04/13
Subscriptions (£)	52,714
	52,714
Direct expenses	38,455
Gross profit /(loss)	14,259
Overheads	20,735
Net profit / (loss)	(6,476)

ISCAS is a not for profit scheme that reviews member subscriptions on an annual basis, with the intention that member subscriptions will cover the ISCAS operating costs.

Appendix I

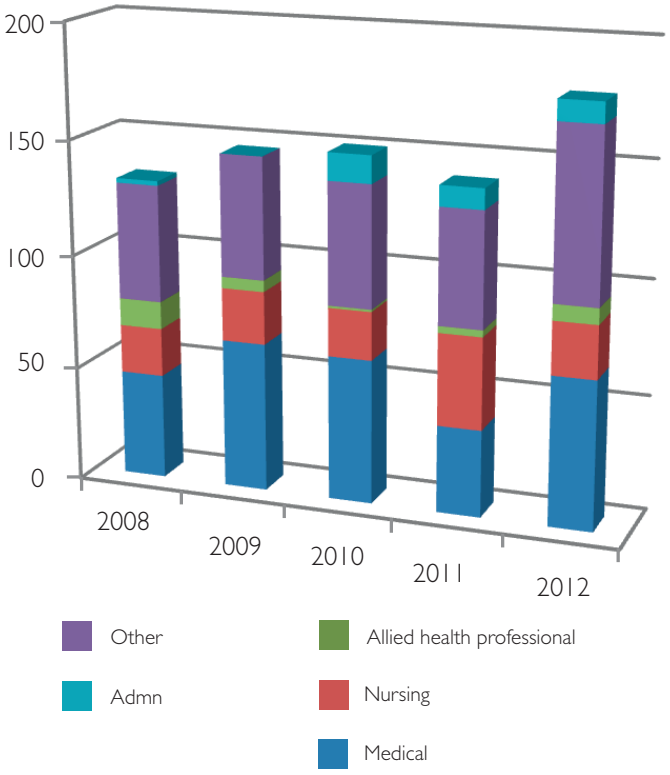
Table 9: Total number of complaints and by complainant type

	2008	2009	2010	2011	2012
Total number of complaints adjudicated	18	27	22	28	38
Total heads of complaints	132	146	150	140	178
% Female complainants	72%	63%	82%	64%	66%
% Male complainants	28%	37%	18%	36%	34%
Adjudication panels held	0	0	1	0	0

Table 10: Heads of complaint year on year

	2008	2009	2010	2011	2012
Total heads of complaint	132	146	150	140	178
Medical	46	65	63	38	65
Nursing	21	23	21	40	23
Allied health professional	12	5	1	3	7
Admin	51	53	53	50	74
Other	2	0	12	9	9
Total heads ofcomplaint not upheld	106 53%	77 61%	89 59%	73 52%	95 53%
Medical	38	34	36	24	43
Nursing	15	11	12	15	13
Allied health professional	12	3	1	1	4
Admin	39	29	32	30	27
Other	2	0	8	3	8
Total heads of complaint upheld	26 20%	69 47%	61 41%	68 48%	83 47%
Medical	8	31	27	14	22
Nursing	6	12	9	25	10
Allied health professional	0	2	0	2	3
Nursing	12	24	21	20	47
Other	0	0	4	7	1

Table 11: Nature of heads of complaint coming to Independent Adjudication



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ISCAS Members

- Aspen Healthcare Group
- Ayr Partnerships in Care
- Benenden Hospital Trust
- BMI Healthcare
- Bupa Cromwell Hospital
- Cambian Group
- Castle Craig Alcohol & Drug Rehab Clinic
- Castlebeck Care (Teesdale) Ltd
- Circle Partnership UK
- Clock House Healthcare Limited
- Destination Skin
- Linia
- Fairfield Independent Hospital
- Glenside Hospital
- HCA International
- Huntercombe Hospital - Edinburgh
- Independent Doctors Federation
- King Edward VII Hospital Sister Agnes
- Lighthouse Phoenix House, Welshpool
- Llanarth Court Partnerships in Care
- Ludlow Street Healthcare
- Make Yourself Amazing
- Marie Stopes International
- Mental Healthcare UK Ltd
- NE Oasis
- New Life Clinic
- New Victoria Hospital
- Newport Cardiac Centre
- North West Independent Hospital
- Nucleus Healthcare (now closed)
- Nuffield Health
- Ophthalmic Surgery Centre (North London) Ltd
- Ramsay Health Care UK
- Rushcliffe Care Group
- Sancta Maria Hospital
- Scottish Epilepsy Centre (Quarriers)
- SERCO Health
- Sk:n Ltd
- Spencer Private Hospitals
- Spire Healthcare Ltd
- St. Joseph's Private Hospital
- Surehaven Glasgow
- The Alexander Clinic
- The French Cosmetic Medical Company
- The Horder Centre
- The Hospital Group
- The Hospital of St John and St Elizabeth
- The London Clinic
- The Medical Chambers Kensington Limited
- The Priory Group of Companies
- The Raphael Medical Centre
- The Royal Hospital for Neurodisability
- Transform Medical Group
- UK Specialist Hospitals
- Ulster Independent Hospital
- UME Diagnostics
- Vale Healthcare Ltd
- Your Excellent Health Service