ANNUAL REPORT 2015

ISCAS

INDEPENDENT HEALTHCARE SECTOR
COMPLAINTS ADJUDICATION SERVICE

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The Independent Sector Complaints Adjudication Service (ISCAS) is the recognised complaints management framework for the independent healthcare sector. The actual Adjudication Service is the third stage of the complaints process.

ISCAS is a voluntary membership scheme that represents the vast majority (95%) of all independent healthcare providers across the UK.

The ISCAS Complaints Code of Practice sets out the standards that ISCAS members agree to meet when handling complaints from privately funded patients about their service.

Chair's Report

by Baroness Fiona Hodgson CBE, Chair of the ISCAS Governance Board

Two major changes have taken place this year. Representation of patient interests on the ISCAS Governance Board has been increased, and the Board approved the move of the service to the Centre for Effective Dispute Resolution (CEDR).

Last year in this Report I asked for further representation of patient interests and I am pleased to report that we have been joined by Lindsay Mitchell, who as a lay member chairs the patient information group set up by the Royal College of Surgeons to tackle the issue of communication with patients who are wishing for further information prior to considering Cosmetic Surgery. Another new member of the Board, Stephen Barasi, who has Welsh connections, is a lay member of the General Medical Council patient reference group and has contributed robustly to the review of the Code and the Patient leaflet. Patient representation provides a very valuable contribution to ISCAS and I welcome these additions.

During the year ISCAS moved from its former hosting with AIHO, where it had been since inception, and has set up with the Centre for Effective Dispute Resolution. CEDR has vast experience of all methods of dispute resolution, and the connection will, we believe, add to ISCAS's learning and in the long run enhance the patient experience when seeking redress.

We are examining whether the long-existing ISCAS template for adjudicating complaints can be improved by introducing alternative mediation and arbitration routes in addition where appropriate, and in particular for smaller organisations. Along with this, we will be examining possibilities for obtaining improved value for money.

In the last months of 2015 and continuing so far this year we have seen a notable increase in the number of complaints reaching the adjudication stage.

I want to thank Charlie Evans and Disa Young for their diligence during the year and for their help in the transfer of business to the CEDR offices at the end of January 2016. The Director's report will formally welcome the new ISCAS team.

Director's Report

by Sally Taber, Director of ISCAS

The Independent Healthcare Sector Complaints Adjudication Service (ISCAS) has moved. ISCAS is now located with the Centre for Effective Dispute Resolution (CEDR) at 70 Fleet Street, London EC4Y 1EU. Given the increasing scale of complaints referred to ISCAS, CEDR has been settled on as the organisation best suited to provide operational services under contract. It was responding to the requests of ISCAS Members from across the independent healthcare sector, and to the Association of Independent Healthcare Organisations (AIHO) representing private hospital operators, for the ISCAS service to be demonstrably separate from the influence of AIHO.

CEDR is now operating the dispute adjudication services in the name of ISCAS to a remit set by the ISCAS Governance Board. Both the ISCAS Governance Board and CEDR expect the service for providers and patients to be maintained and improved by the experienced CEDR, which already gives similar support to many other sectors including ABTA and the water supply industry.

The ISCAS Governance Board is pleased to confirm that the panel of independent experts who are retained to adjudicate in the resolution of Stage 3 disputes have all agreed to continue to provide their services. ISCAS intends no change to the ISCAS Code for the handling of complaints by healthcare providers. This allows for three stages for resolution of disputes between patients and healthcare operators:

Stage 1 - Local Resolution

Stage 1 is usually dealt with by the Manager of the hospital or clinic.

Stage 2 - Complaint Review

Stage 2 is usually dealt with by the Chief Executive of the Hospital Group or by a non-executive director/ member of the Board in the case of an individual hospital.

Stage 3 - ISCAS Independent External Adjudication

Stage 3 is conducted by an ISCAS Independent Adjudicator.

Members of ISCAS have reconstituted the Board of ISCAS to include three non-executive Directors. Alongside myself as the current Director I am joined by Stephen Collier who has a background as a lawyer and then his career with BMI Healthcare and Karen Harrowing, who is a pharmacist with expertise in Quality Governance together with experience with professional and system regulators.

It is the intention of the ISCAS Governance Board to review the present method of charging Members of ISCAS to both reduce annual charges and align costs more closely with usage of the adjudication stage of dispute resolution.

The Board of ISCAS will oversee the impartiality of the disputes resolution system in the independent healthcare sector, which is important to the reputation of all companies providing healthcare. I expect the new arrangements to support this aim, and to provide a more efficient and patient-responsive service. I welcome the association with CEDR, and the invaluable continued support of our expert panel of adjudicators.

Introducing the ISCAS Team

GRAHAM MASSIE, ISCAS Company Secretary

Graham Massie is CEDR's Chief Operating Officer, Company Secretary and Chief Financial Officer, a role he also performs for ISCAS. A Chartered Accountant and professional mediator by background, Graham has over 20 years' experience in the conflict management field and is regularly approached by businesses and public sector organisations to act as an independent chair for strategic discussions and deal-making negotiations. He also works with organisations to develop their in-house negotiation skills and conflict management systems, and he leads CEDR's research projects on the cost of conflict.

JOHN MUNTON, ISCAS Manager

John has been working in dispute resoltuion services for over 25 years and prior to joining CEDR he was the Senior Practice Manager at Keating Chambers where he worked with clients all over the world on the provision of barrister services for disputes related to construction & engineering, energy & natural resources and ICT projects. His extensive experience working with the construction industry is put to good use at CEDR operating our Construction Adjudication Service. In addition to his work with CEDR, John works as a Project Manager for his local hospice giving him an insight into the healthcare industry.

JEAN-MARIE SADIO, ISCAS Senior Adviser

Jean-Marie has many years of experience as a case administrator at CEDR, providing advice and assistance to consumers across a range of dispute resolution services and schemes. Jean-Marie is an associate of the Chartered Institute of Arbitrators (CIArb). As the ISCAS Senior Adviser, Jean-Marie will act as the first point of contact for patients and providers alike.

Creating a Blueprint for Good Complaints Handling for Independent Healthcare

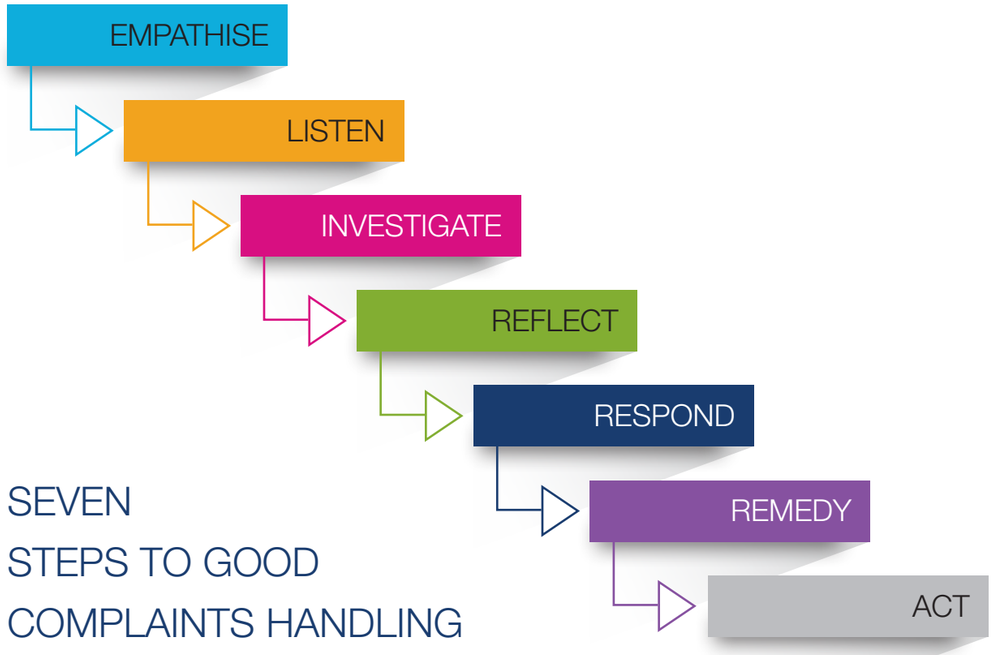
by Sally Williams, Lead Adjudicator

The Independent Adjudicators (IAs) have a unique vantage point over the complaint process. Complaints that reach Stage 3 adjudication have already passed through Stages 1 and 2 of the three-stage process. This means we are well placed to identify learning arising at local level (usually the hospital or clinic the complaint relates to) and also with regard to the review conducted by the provider (head office or, for larger organisations, at regional level).

Of course, we only see complaints that have not been resolved satisfactorily at the earlier stages, and not those that have been remedied swiftly or effectively at a local level.

Nevertheless, the learning we identify in the course of adjudications should be of relevance to all providers - even those able to resolve complaints effectively at an early stage.

The learning arising from Stage 3 adjudications has given rise to seven steps for good complaints handling. This is not a definitive or necessarily comprehensive set of steps, and we would invite ISCAS members and other interested parties to contact ISCAS regarding additional steps. It is our intention that these steps should provide the independent healthcare sector with a blueprint for good complaints handling.



SEVEN STEPS TO GOOD COMPLAINTS HANDLING

An efficient complaints process demonstrates confidence in the service offered and a commitment to the highest standards of practice.

1

step 1 > EMPATHISE

The starting point for anyone on receipt of a complaint should be one of empathy. This reflects the context in which complaints are made. We see complaints from people who are recovering from surgery, who are midway through their treatment, or who are beset with ill-health. Some complaints are from people mourning, and trying to make sense of, the loss of a loved one. These factors add to the complexity of complaints about healthcare and the need for sensitivity in the way in which complaints are managed.

According to the Parliamentary and Health Service Ombudsman (PHSO), more than half (54%) of those who want to complain do not do so (Mellor, 2014). More than a quarter (26%) worry about being labelled a 'troublemaker', and 11% fear it could have a negative impact on their ongoing care. Complainants pursuing Stage 3 adjudication also frequently highlight the toll of complaining on their health and wellbeing.

Complaining about healthcare often takes a degree of courage and, once begun, pursuing a complaint can take resilience. When people make a complaint, they are often under stress, and this can affect the way they express themselves. It can be made worse by challenges in navigating the system in order to find answers. It underlines the importance of having clear, coherent and robust processes in place, and for those who operate those processes to do so from a starting point that recognises how hard it can be to complain about healthcare.

Demonstrating empathy means approaching the situation from the complainant's perspective.

It might involve reassuring the complainant that their ongoing treatment will not be affected by their complaint, or acknowledging the impact of the events complained about on the complainant. Sometimes an empathic approach will involve expressing sympathy with the trouble or suffering the complainant reports experiencing.

2

step 2 > LISTEN

Too often it seems we do not listen with the intent to understand fully what the complainant has to say.

In practice, this means climbing into the complainant's shoes and developing an understanding of their experience from their perspective.

The PHSO states that when someone complains, the first question asked should be: How can this be put right? In some cases, it might be as simple as acknowledging that something went wrong and apologising for that. Dame Julie Mellor, the PHSO, has said: *'The sooner any mistakes are identified and acknowledged, the more satisfied the complainant is likely to be'.* (Mellor, 2014).

If the complaint cannot be resolved on the spot, then one of the most helpful things is to offer to meet with complainants. The complaints that come to the IAs at Stage 3 indicate that meetings with complainants are not offered anywhere near enough. This is a missed opportunity as meetings can offer a number of benefits to all parties, from showing that the complaint is taken seriously, to demonstrating that the organisation is in listening mode and wants to fully understand their concerns.

A meeting can provide an opportunity to resolve concerns early on, and it can build rapport and trust, which is particularly important for complex complaints that cannot be resolved swiftly.

If arranging a meeting face to face is difficult, then a telephone conversation is one alternative option - but again, our experience is that telephone discussions rarely happen in the cases that reach Stage 3 adjudication. It may be the case that complaints are less likely to progress to Stage 3 where meetings or telephone calls are offered. One provider has made it mandatory for its units to offer to meet with the complainant at the outset of Stage 1. If the offer of a meeting is declined, this provider requires that this is recorded, and any meetings that take place have to be minuted.

As IAs, an important step of the process we introduced in 2014 was a letter setting out the key heads of complaint. This is where we play back to complainants our understanding of the main aspects of their complaint. It is also at this point that we make clear the scope of the investigation, including any limitations, and encourage the complainant to think about the outcome they seek from complaining. Any extension in the time spent preparing the ground before the adjudication can begin is outweighed by gains made in avoiding situations where an important element of a complaint is overlooked. It also helps complainants to focus on the main elements of their complaint that remain unresolved. We advocate the use of this approach at Stages 1 and 2.

3

step 3 > INVESTIGATE

One of the biggest pitfalls in complaints handling that the IAs have observed during the last year has been around investigations. Too often, the investigation is insufficient - too cursory to enable an understanding of what happened - and sometimes the most basic things are overlooked, like establishing a chronology of events or asking relevant staff to provide their account. It results in responses that fail to get to the heart of the matter and do not provide complainants with the much-needed answers they seek.

Where investigation is done well, it gets underway swiftly. The sooner that staff are asked what happened, the easier it is for them to describe what occurred.

Good investigations have a clear structure and defined scope.

There is also a sense of momentum and defined end point. Importantly, all relevant parties are asked to input into the investigation, particularly clinicians. As IAs, we are often surprised at how frequently responses are made to complaints relating to clinical issues without seeking clinical input, particularly from the consultant overseeing that patient's care. The Code is very clear about the expectations on providers in terms of ensuring that clinicians with practising privileges co-operate with the complaints procedure.

Another marker of a good investigation is that conflicts of evidence are reconciled. In other words, any inconsistencies between staff statements, or between what is recorded in the notes and what staff say happened, are bottomed out. Sometimes it means interpreting the clinical opinion given by consultants or other staff for complainants to understand its relevance and the implications for their complaint.

Investigations about clinical issues will usually require, as a minimum, a review of the patient's clinical records. Obtaining the medical records made by clinicians with practising privileges appears to be an issue for some complaints. Accessing records made in outpatient clinics can be a particular stumbling block. Some Stage 3 adjudications have highlighted lapses in record keeping by hospital or clinic staff, especially when it comes to contact with the patient after they have been discharged. A good investigation will acknowledge and confront these gaps, not try to sweep them under the carpet.

Ultimately, the better the investigation, and the more clearly and comprehensively it is recorded, the easier the next steps should be.

4

step 4 > REFLECT

The element that often seems to be missing, or at least is not visible in the responses that are made at Stages 1 and 2, is reflection. By this, we mean making sense of the evidence that has been amassed and the outcome of the investigation.

Questions that healthcare providers may wish to ask include:

- Has the investigation got to the bottom of what occurred?
- What further steps, if any, are necessary before a full response can be made?
- Which aspects of the complaint, if any, should be upheld?
- How can we learn from this?
- How can we prevent the same problems from happening again?
- How well have we managed this complaint?
- What might we do differently if a similar situation were to recur?

These questions could also be asked at Stage 2 as part of the review of the handling of the complaint at Stage 1.

5

step 5 > RESPOND

Firstly, this means responding to the complaint within the timeframes set out in the Code, or giving reasons why this is not possible and setting out when a full response will be made.

Secondly, it is about being clear what the organisation has found. A common mistake is to say what usually happens, whereas complainants want to know what happened in the specific instance when they or their loved one received care.

It should go without saying that it is crucial to demonstrate candour regarding any failings, to be explicit about deficiencies and what should have happened, and to explain any steps taken to prevent the same thing happening again. Complainants want to know how the organisation has learnt from their experience and about actions to avoid other people going through the same experience (e.g. staff training or changes in policy).

Responding to complaints also means being clear whether or not the complaint is upheld, and what that means. This is often not articulated, even where failings are acknowledged, leaving complainants' unclear as to the status of their complaint.

6

step 6 > REMEDY

Complainants seek a range of remedies, from financial redress to an apology and assurances that steps will be taken to avoid the same problems happening again. It is important to acknowledge the remedy that the complainant seeks and whether or not the organisation is prepared to grant it. For example, if a complainant seeks a financial award and a decision is made not to make a financial award, the onus is on the provider to give a well-reasoned explanation as to why this decision was taken.

The PHSO states: *'Wherever possible, the response to a complaint should try to return the complainant to the position they would have been in if the events concerned had not happened'* (Mellor 2014). This may mean giving the complainant a financial sum that will enable them to receive the care they need from another provider where the organisation is unable to provide revision treatment, for example, in a timely way.

Some of the complainants at Stage 3 express frustration that they have not received a genuine apology from the organisation, even where failings are acknowledged. Sorry still seems to be the hardest word and some of the apologies made are meaningless or insincere (e.g. *'I apologise that you feel this way'*). This is despite doctors' defence organisations and others repeatedly giving assurances that apologising is not the same as admitting legal liability.

ISCAS members should feel unencumbered about saying sorry where it is the right thing to do, and should avoid giving heavily qualified apologies.

'If something went wrong, the apology should be clear and unequivocal', according to the PHSO (Mellor 2014).

Where a goodwill payment is made, it is helpful to be as clear as possible about the reasons for reaching the level of award made. This is something the IAs have given attention to during 2015 and we will be issuing new guidance on goodwill payments that seeks to differentiate better the tiers of award, and the reasons for deciding where a complaint sits within each tier (i.e. at the bottom, middle or upper end).

7

step 7 > ACT

Greater attention is needed to close the loop on complaints. By this, we mean ensuring that change happens and that the outcome is communicated to complainants.

For some of the cases that reached Stage 3 over the previous year, actions were alluded to but a lack of detail made it impossible to understand how the actions could prevent a recurrence of the problems experienced. Sometimes it was unclear whether actions that were mentioned in responses had been implemented.

The PHSO advocates action plans '*to describe what has been done to learn lessons after things went wrong and what will be done to prevent the same mistake from happening again'* (Mellor 2014).

Closing the loop is important not only for complainants but also for health systems regulation. The Care Quality Commission (CQC) receives details of all Stage 3 adjudications for complaints about registered services in England, and there have been instances during the last year where CQC visitors have asked hospitals and clinics about changes made in responses to complaints. ISCAS has similar information sharing agreements in Scotland and Wales, and is working to reach an agreement in Northern Ireland.

REFERENCES

Dame Julie Mellor (2014). Feedback, concerns and complaints: designing good together. Patient experience conference. Parliamentary and Health Service Ombudsman. Available at: http://www.slideshare.net/phsombudsman/20140121-phso-patient-experience-conference-slides (accessed 22 December 2015).

Good complaints handling at a glance

1. Make empathy your starting point
2. Listen and replay what you hear
3. Investigate - leave no stone unturned
4. Reflect - identify areas of learning and targeted action
5. Respond - humanely, and with candour
6. Remedy - including a sincere apology (where appropriate)
7. Act - turn learning into measurable change and close the loop

ISCAS Activity, Facts and Figures

A significant amount of ISCAS time is committed to helping people work through the complaints process ahead of and during the independent adjudication process, and to advising about alternative ways to pursue complaints about non-members.

Referrals to ISCAS

At the Independent Adjudication stage, the vast majority of complainants are now referred to ISCAS by ISCAS members. Table 1 shows how people were signposted to ISCAS before their complaint has reached independent adjudication. 97% of all referrals came from four sources.

Table 1: How people hear about ISCAS prior to Independent Adjudication

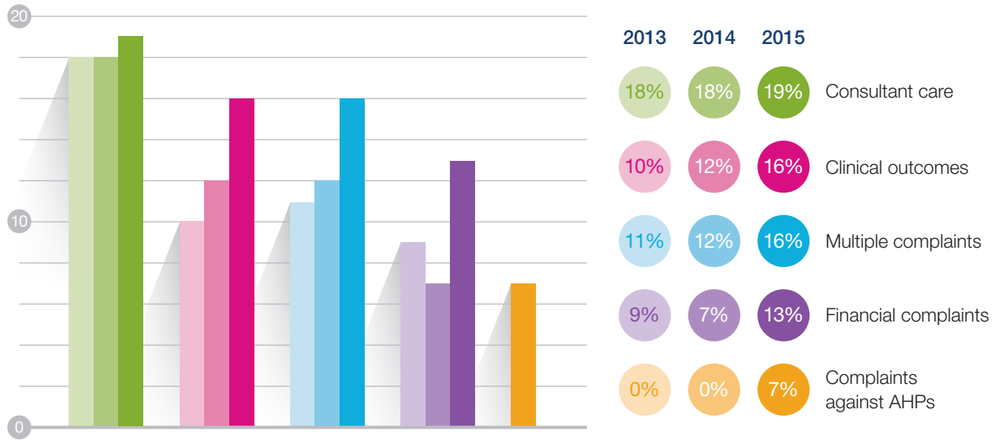
53%	ICAS member information
23%	ICAS website
17%	Health Service Ombudsman
4%	Care Quality Commission

Complaints managed by ISCAS

During 2015 a total of 237 complainants contacted ISCAS with a concern via telephone, email or letter. This was in addition to the 54 complainants whose complaints were adjudicated on. There were a further two complainants who began the ISCAS Adjudication process but settled their cases with the provider instead of progressing to Independent Adjudication.

Of the 237 complainants that contacted ISCAS with a concern, 76% (180) of the contacts related to ISCAS members. In all these cases, the complainant had not completed the local resolution stages and was therefore referred back to the ISCAS member. The remaining 24% of contacts relating to non-ISCAS members were signposted to other organisations where possible.

Table 2: Five largest categories of complaints about ISCAS members prematurely referred to ISCAS



The ISCAS Management Team has an important role in managing complainant expectations, particularly when they are considering progressing to Independent Adjudication. Some complainants have unrealistic expectations about the possible outcomes of adjudication - seeking a refund, revision surgery and/or financial compensation.

Adjudication facts and figures

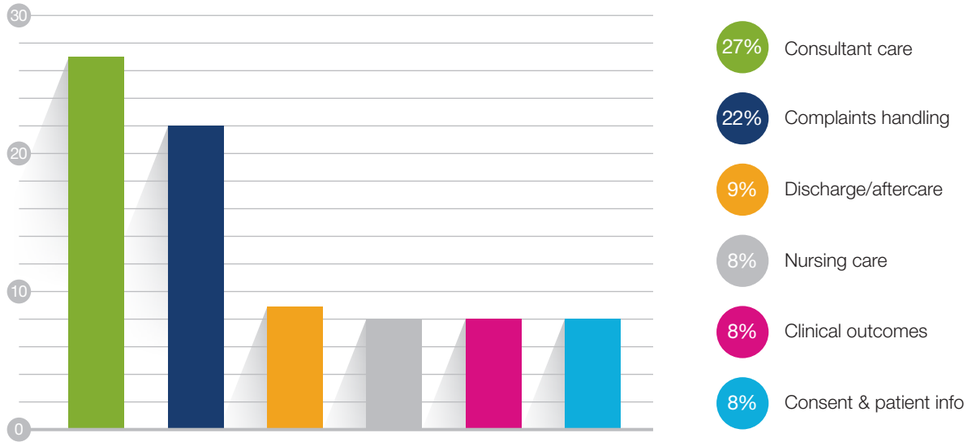
Across the 54 complaints adjudicated on, adjudicators identified 161 Heads of Complaint.

Table 3: Total number of adjudicated complaints and heads of complaint

	2010	2012	2014	2015
Total number of complaints adjudicated	22	38	40	54
Total heads of complaints	150	178	151	161

The following table shows the six largest categories of Heads of Complaint.

Table 4: Type of Heads of Complaint at Independent Adjudication



- 27% Consultant care
- 22% Complaints handling
- 9% Discharge/aftercare
- 8% Nursing care
- 8% Clinical outcomes
- 8% Consent & patient info

In each decision report, adjudicators either: 'uphold', 'partially uphold' or 'do not uphold' a particular head of complaint. The following table illustrates that the majority of complaint heads are either 'upheld' or 'partially upheld' by adjudicators.

Table 5: Heads of complaint upheld at the Independent Adjudication stage

- 35% Upheld
- 36% Partially upheld
- 29% Not upheld

Adjudication costs

Individual ISCAS members bear the cost of adjudications. The average cost of an adjudication case in 2015 was £5,441.

Table 6: Overall Independent Adjudication costs in 2015

	£
Adjudicator costs	£100,509
Goodwill payment costs	£29,263
Clinical expert costs	£16,300

Goodwill payments were made in 83% of cases and the average size of a payment was £714.

Table 7: Goodwill payments

	2010	2012	2014	2015
Cases in which payments made	17	19	34	45
% of cases attracting a payment	77%	50%	85%	83%
Total costs	£12,150	£11,500	£16,300	£29,263
Average award	£714	£605	£479	£714

Expert clinical advice

Adjudicators may require the use of expert clinical advice to determine if the clinical care provided by an ISCAS member fell short of reasonable expectations. Clinical reports are made available to complainants and providers when the adjudicator issues their decision.

26% of cases required expert clinical advice. The total costs associated with expert clinical advice came to £16,300.

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