Finance Committee

Meeting Venue:
Committee Room 3 - Senedd

Meeting date:
Wednesday, 4 February 2015

Meeting time:
09.00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:
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Agenda

1 Introductions, apologies and substitutions (09:00)

2 Papers to note (09:00-09:05) (Pages 1 - 3)

3 Welsh Tax Forecasts: Evidence Session 1 (09:05-09:45) (Pages 4 - 18)

Robert Chote - Chairman, Office of Budget Responsibility

FIN(4)-02-15 Paper 1 - December 2014 Welsh tax forecast
Research Brief

(Break - 09:45-10:00)

4 Consideration of Powers: Public Services Ombudsman for Wales: Evidence Session 2 (10:00-10:45) (Pages 19 - 23)

Jim Martin - Scottish Public Services Ombudsman

Transforming Scotland's Complaints Culture

Research Brief

5 Consideration of powers: Public Services Ombudsman for Wales: Evidence Session 3 (10:45-11:45) (Pages 24 - 57)

Simon Rogers - Chair, Welsh Independent Healthcare Association
Sally Taber - Director of Independent Healthcare Advisory Services, Welsh Independent Healthcare Association

FIN(4)-02-15 Paper 2 - Independent Sector Complaints Adjudication Service
FIN(4)-02-15 Paper 2a - Welsh Independent Healthcare Association Credentials 2013-2014
Research Brief

6 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business: (11:45)

Item 7, 8 and 9

7 Consideration of powers: Public Services Ombudsman for Wales: Discussion of evidence (11:45-12:00)

8 Consideration of Scoping Papers (12:00-12:20) (Pages 58 - 66)

FIN(4)-02-15 Paper 3 - Potential scope of a Future Funding Inquiry
FIN(4)-02-15 Paper 4 - Collection of devolved taxes

9 Consideration of Paper on Assembly Week 2015 (12:20-12:30) (Pages 67 - 69)

FIN(4)-02-15 Paper 5 - Assembly Week 2015

Finance Committee

Meeting Venue:	**Committee Room 2 – Senedd**
Meeting date:	**Wednesday, 21 January 2015**
Meeting time:	**09.00 – 11.40**

This meeting can be viewed on Senedd TV at:
http://senedd.tv/en/2649

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Concise Minutes:

Assembly Members:	**Jocelyn Davies AM (Chair)** **Peter Black AM** **Christine Chapman AM** **Mike Hedges AM** **Alun Ffred Jones AM** **Ann Jones AM** **Julie Morgan AM** **Nick Ramsay AM**
Witnesses:	**Nick Bennett** **Katrin Shaw, Public Service Ombudsman for Wales Office** **Susan Hudson, Policy and Communication Manager**
Committee Staff:	**Bethan Davies (Clerk)** **Leanne Hatcher (Second Clerk)** **Tanwen Summers (Deputy Clerk)** **Joanest Varney-Jackson (Legal Adviser)** **Richard Bettley (Researcher)**

1 Introductions, apologies and substitutions

1.1 The Chair welcomed Members to the meeting.

1.2 There were no apologies.

2 Papers to note

2.1 The papers were noted.

3 Consideration of powers: Public Services Ombudsman for Wales: Evidence Session 1

3.1 The Committee took evidence from the Ombudsman on its inquiry.

3.2 The Ombudsman agreed to provide the following:

- Follow up examples of where own-initiative powers have been used well in other countries.
- To outline what the precise relationship is between the complaints authority and the rest of the Scottish Ombudsman's office.

4 Motion under standing order 17.42 (vi) to resolve to exclude the public from the remainder of the meeting

4.1 The motion was agreed.

5 Consideration of powers: Public Services Ombudsman for Wales - Discussion of evidence

5.1 The Committee considered the evidence received.

6 Best Practice Budget Process: Key Issues

6.1 The Committee considered the key issues of the Best Practice Budget Process report.

7 Report on the Wales Audit Office Fleet Car and Travel and Subsistence: Consideration of Draft Report

7.1 Members agreed the draft report subject to the inclusion of some additional information.

8 Initial Consideration of Qualifications (Wales) Bill

8.1 The Committee considered the financial implications of the Qualifications (Wales) Bill.

9 Initial consideration of Safe Nurse Staffing Levels (Wales) Bill

9.1 The Committee considered the financial implications of the Safe Nurse Staffing Levels (Wales) Bill.

10 Consideration of Planning (Wales) Bill Letter

10.1 The Committee considered the letter.

December 2014 Welsh tax forecast

The material in this note has been taken from the Devolved taxes forecast document published alongside the December 2014 Economic and fiscal outlook.
http://cdn.budgetresponsibility.independent.gov.uk/Devolved_taxes_Dec2014-web519.pdf

Introduction

1.1 The Command Paper: Wales Bill: Financial Empowerment and Accountability – published alongside the Wales Bill in 2014 – required us to begin to forecast Welsh taxes alongside Autumn Statement 2014 and twice a year thereafter. This will initially include forecasts for stamp duty land tax, landfill tax, aggregates levy and the Welsh rate of income tax. Our forecasts will reflect any Welsh replacement taxes – as with Scotland's land and buildings transactions tax – when details of any changes become sufficiently clear. The Treasury will notionally assign these forecast receipts to the Welsh Budget to show how much of what is currently grant funding would be replaced by tax. Again, the Welsh Budget will not be varied in line with fluctuations in tax receipts until the devolution of these taxes has been fully implemented.

1.2 We published a methodology note in March 2012 that described how we planned to forecast Scottish tax receipts. It explained that it is not possible to replicate in full the methodology we use to produce our UK-wide forecasts. In particular, the macroeconomic data that we would need to produce a Scottish macroeconomic forecast and economic determinants were generally not available at a Scottish level or were only available with a long lag. That is also the case for Wales. We are therefore not able to produce a Welsh macroeconomic forecast to drive the Welsh tax forecast.

1.3 Given these challenges, the methodologies we use are generally based on estimating and projecting Welsh shares of relevant UK tax streams. We typically assume that the shares will continue at recent average levels, unless available evidence suggests we should adjust those assumptions to ensure our forecasts are central. For example, if a newly announced policy can be expected to have a disproportionate impact on the Welsh share of a particular tax, or there is evidence pointing to different trends in an underlying tax base.

1.4 As with our UK forecasts, the methodology and the forecasts represent the collective view of the three independent members of the OBR's Budget Responsibility Committee (BRC). The BRC takes full responsibility for the judgements that underpin them.

1.5 We consider these methodologies to remain work-in-progress. The OBR's role in forecasting has started well ahead of the initial devolution of these taxes in Wales. This will

allow us to develop and improve forecasts in light of experience and the availability of new information sources.

Forecast process

1.6 The process for producing the devolved tax forecasts has been as follows:

- HMRC officials produced a draft Welsh tax forecast using a near-final pre-measures UK economic and fiscal forecast. The BRC and OBR staff discussed these forecasts with HMRC and Welsh Government officials on 19 November; and
- in the final week before the Autumn Statement, HMRC officials provided us with a final set of Welsh forecasts using our final post-measures UK economic and fiscal forecasts, and taking into account Autumn Statement policy measures. Due to the confidentiality of the measures, we were unable to involve the Welsh Government in this stage of the process.

Table 1.1: Summary of December 2014 Welsh tax forecasts

	£ million					
	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Income tax	1930	1981	2092	2229	2364	2510
SDLT	165	168	190	211	231	246
Landfill tax	54	51	48	48	50	53
Aggregates levy	26	25	25	26	26	27
Total	2175	2225	2356	2514	2670	2836

Welsh rate of income tax

1.7 The Wales Bill includes provision for a referendum to determine whether the Welsh Assembly will be able to introduce a Welsh rate of income tax. The income tax levied by the UK Government would be reduced by 10p in the pound for those individuals defined as Welsh taxpayers. The Welsh Assembly would then levy separate Welsh rates for each band of income tax. The new Welsh income tax rates would need to be set every year by the Welsh Assembly. The block grant from the UK Government to Wales would then be reduced to reflect the fiscal impact of the devolution of these tax-raising powers.

1.8 The Autumn Statement 2014 forecasts assume that the referendum results in the implementation of a Welsh rate of income tax and that the Welsh Assembly then levies a 10p rate across all the income tax bands in every year.

1.9 We generate a UK forecast for non-savings, non-dividend income tax liabilities from the full UK income tax receipts forecast published in our EFO. The key components of the UK forecast are:

- total pay-as-you-earn (PAYE) liabilities;

- self-assessment (SA) liabilities on non-savings, non-dividend income. The forecast for SA in the EFO is on a receipts basis (i.e. when the cash is received). This is adjusted to be on a liabilities basis (i.e. when the activity occurred) and to exclude the savings and dividend elements of SA; and

- PAYE repayments and repayments to pension providers, from our income tax repayments forecast.

1.10 We then apply the latest estimated Welsh share to the UK total of these forecast components. We then include deductions in respect of the Welsh shares of Gift Aid repayments. Finally, we add estimates of the Welsh element of policy measures announced in Autumn Statement 2014.

1.11 Information on the share of UK income tax in Wales is derived from the Survey of Personal Incomes (SPI), an annual survey based on a sample of about 700,000 individuals in contact with HMRC during the course of the year through the PAYE, SA or repayment claim systems. This is only available with a long lag, with data currently only available up to 2011-12. An estimate for 2012-13 will be available for our next forecast. The Welsh share can be affected by a number of factors. These include:

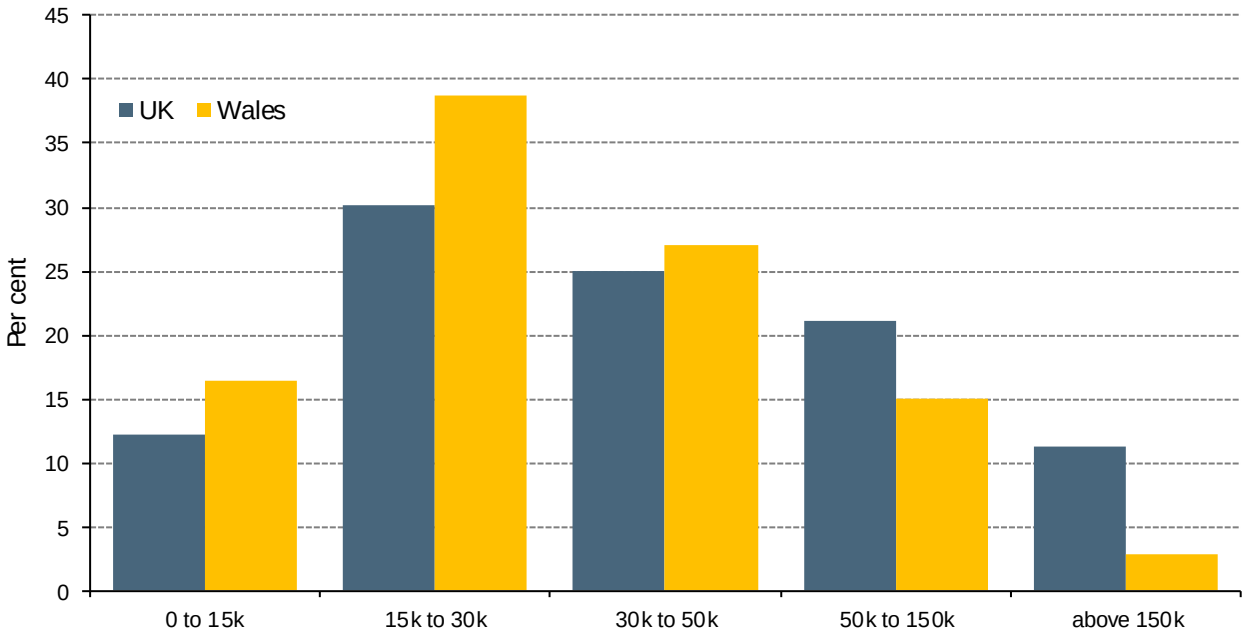
- different economic trends between Wales and the UK as a whole;

- different movements in the income distribution between Wales and the UK; and

- different effects of policy measures.

1.12 Wales has a different distribution of taxpayer income from the UK as a whole. Chart 1.X shows that the proportion of taxpayer income generated from individuals with incomes below £30,000 is substantially higher in Wales than for the UK as a whole. In recent years, revenue-raising policies have generally affected the top end of the income distribution. These include the additional rate of income tax for incomes over £150,000, the withdrawal of personal allowances over £100,000, freezes in the basic rate limit and higher rate thresholds and anti-avoidance measures. In contrast, tax reductions such as raising the personal allowance have been concentrated at the lower end of the income distribution.

Chart 1.1: Proportion of total taxpayer income by income bands (2011-12)



Source: HMRC

1.13 Table 1.2 shows our forecast for the Welsh share of income tax. The asymmetric effect of policy measures over recent years is expected to reduce the Welsh share in the first half of the decade. We have not made any further adjustments.

Table 1.2: Welsh share of income tax

	Per cent of UK total of non-savings, non-dividend liabilities								
	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
December 2014	1.37	1.36	1.29	1.29	1.28	1.28	1.28	1.28	1.29

1.14 Table 1.3 provides a forecast for Welsh income tax liabilities on non-savings, non-dividend income. These are the liabilities specifically for the Welsh rate. It assumes that a 10p rate is implemented by the Welsh Assembly. Matching the UK forecast, we expect more rapid growth in tax liabilities from 2016-17 onwards. With income more skewed to the bottom end of the income distribution in Wales, the raising of the personal allowance to £10,600 has a slightly larger than proportionate effect on Welsh income tax liabilities than in the rest of the UK

Table 1.3: Welsh income tax forecast

	£ million							
	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Welsh income tax liabilities (pre-measures)	1902	1874	1930	1991	2098	2234	2370	2517
Autumn Statement 2014 measures	0	0	0	-10	-5	-5	-6	-7
Welsh income tax liabilities (post-measures)	1902	1874	1930	1981	2092	2229	2364	2510

Welsh SDLT

1.15 The Wales Bill provides for SDLT to be fully devolved to Wales in April 2018. The Welsh Assembly has not yet announced any change from the UK system. Until any announcements are made and sufficient detail is available, our Welsh forecast will assume that the new UK SDLT system would remain after the tax is fully devolved.

1.16 The Welsh SDLT forecast is based on a constant share of the UK SDLT forecast. The Welsh share of residential SDLT has drifted down over the past four years, primarily because of the strength of the London housing market. We assume that rises in house prices will be more evenly distributed across the UK over the rest of the forecast period. As a result, we hold the Welsh share constant at 1.4 per cent throughout the forecast period. The Welsh share of commercial SDLT is more volatile, so we use a three-year average and project this forward. A share of 2.3 per cent has been used across the forecast period.

1.17 We then included the assumed Welsh share of SDLT measures in order to produce the final post-measures forecast. It has been estimated from administrative SDLT data that the policy to change the UK SDLT regime will have a disproportionately large impact on Welsh receipts. This is because the distribution of house prices in Wales is skewed towards lower prices, where transactions will face lower tax rates under the new system. We assume this reduces the Welsh share of SDLT to 1.06 per cent from 2015-16 onwards. The Welsh share in 2014-15 has been adjusted down to 1.2 per cent from 1.4 per cent to reflect that the new SDLT regime will only be in place from 4 December.

Table 1.4: Welsh SDLT forecast

	£ million						
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Residential SDLT	90	106	107	124	142	158	171
Commercial SDLT	60	59	61	65	69	73	75
Total SDLT	150	165	168	190	211	231	246

Landfill tax

1.18 The Wales Bill provides for landfill tax to be fully devolved from April 2018. As with SDLT, we assume that the Welsh Assembly will implement the UK regime and forecast landfill tax on that basis. We will update this assumption when sufficient detail about any replacement tax is available.

1.19 The Welsh landfill tax forecast is produced by applying an assumption about the path of the Welsh share of landfill tax to the UK forecast.

1.20 UK forecast is compiled using a forecast for the tonnage of waste sent to landfill, which is multiplied by the appropriate tax rate. The tonnage forecast is generated from separate Department of Food, Environment and Rural Affairs (DEFRA) projections of municipal solid waste, and commercial and industrial waste, sent to landfill. The amount of municipal waste

going into landfill is determined by comparing the cost of alternative waste treatment options. DEFRA's models cover England, so are scaled up to get to a UK-wide forecast. The split between standard and lower tax rates is based on historical trends. The tax rates are assumed to be uprated in line with inflation in the absence of announced policy.

1.21 Prior to devolution, there is no directly available data on the Welsh share of landfill tax, since landfill operators provide data returns that cover sites throughout the UK. The Welsh share is calculated using data on the amount of waste sent to landfill available from the Environment Agency.

1.22 The proportion of Welsh waste sent to landfill has remained fairly constant over the last five years. We have assumed that the Welsh share will remain constant at 4.4 per cent over the forecast period. There are no relevant policy measures to be added to the forecast.

Table 1.5: Welsh Landfill tax forecast

	£ million						
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
December 2014	52	54	51	48	48	50	53

Aggregates levy

1.23 The Government has committed to keeping the devolution of aggregates levy to Wales under review. It intends, subject to the resolution of a legal challenge in the European courts, to devolve this tax in the future. In the interim, the Treasury will assign aggregates levy receipts to Wales.

1.24 The UK forecast is generated from a projection of the tax base multiplied by the tax rate. An econometric model relates the sales of primary aggregates to construction sector growth. The model also allows for the usage of recycled aggregates to increase over time and for the substitution away from the extraction of primary aggregates. The tax rate is assumed to be uprated in line with inflation in the absence of announced policy.

1.25 To produce Welsh aggregates levy forecasts, we apply our assumptions of their respective share to the UK forecast. Data on the Welsh share of aggregates production is taken from the United Kingdom Mineral Yearbook 2013.

1.26 The Welsh share of aggregates tonnage has remained fairly constant over the past five years. We assume that the Welsh share will remain constant at 8.1 per cent over the forecast period. There are no relevant policy measures to be added to the forecast.

Table 1.6: Welsh Aggregates levy forecast

	£ million						
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
December 2014	24	26	25	25	26	26	27

Document is Restricted

Agenda Item 4

Document is Restricted

Agenda Item 5

National Assembly for Wales

Finance Committee

Consideration of Powers

Public Services Ombudsman (PSO) for Wales

January 2015

Submission from

ISCAS
INDEPENDENT HEALTHCARE SECTOR COMPLAINTS ADJUDICATION SERVICE

Independent Sector Complaints Adjudication Service
1 King Street, London
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www.iscas.org.uk

Contents

1. Executive Summary

2. The Independent Sector Complaints Adjudication Service (ISCAS) has operated the well-established Complaints Code of Practice across the UK independent healthcare sector for over 13 years.

3. The ISCAS three-stage complaints process has been running effectively throughout the 13 years and has been periodically reviewed. ISCAS operates a three stage process which reinforces local resolution. The stages are: Stage 1, *Local* Resolution; Stage 2, O*rganisational/corporate* Level Resolution; Stage 3, Independent Adjudication. ISCAS manages Stage 3 on behalf of its membership.

4. ISCAS does not support the Ombudsman's proposal to extend his jurisdiction to include private healthcare services on the basis that a mechanism for independent review of independent sector complaints already exists at no cost to the taxpayer. ISCAS would request a full discussion of any proposed levy for independent sector providers to come under the Ombudsman's scheme and would highlight a quote in the Ombudsman's own submission that "*The suggestion of a levy would … be very challenging to put into practice"* [2.4(e).

5. Furthermore, ISCAS would welcome the opportunity to enter into an information sharing agreement with the Ombudsman to jointly address the type of complaint that crosses between the NHS and independent sector, as referred to by the Ombudsman in his submission [2.4 (b)].

6. ISCAS has an Operating Protocol with Health Inspectorate Wales (HIW) and the Care Quality Commission (CQC) in England. Since April 2014 ISCAS has shared the outcomes of adjudications with the CQC in the same way the Parliamentary and Health Service Ombudsman shares its information. HIW has indicated its desire for ISCAS to similarly share the outcomes of any adjudication cases relating to independent healthcare providers in Wales.

7. ISCAS is aware of the proposals from the Department of Health Review of the Regulation of Cosmetic Interventions that the Parliamentary and Health Services Ombudsman covers all independent healthcare complaints **in England.** Unfortunately ISCAS believes that this is likely to have a detrimental impact in terms of delivering a timely outcome and ensuring all **English** complainants can access independent review and submitted a representation to the UK Parliament Health Committee to put forward this view.

8. By way of context, the independent healthcare sector in Wales is small and represents a tiny proportion of total healthcare provision across Wales. ISCAS represents all the six acute general hospitals and the two large specialist cosmetic providers in Wales. (ISCAS is aware that the six mental health providers that are members of the Welsh Independent Healthcare Association [WIHA] are entirely NHS-funded, meaning that all their patients already have access to the Public Services Ombudsman.) There are two further independent mental health providers that are not members of WIHA: Mental Health UK and Pastoral Healthcare.

9. The latest WIHA Credentials document[1] shows that the number of complaints made in WIHA acute hospitals represented less than 0.1 percent of all attendances – the actual figure being 159 complaints received at Stage 1.

10. ISCAS notes that the Ombudsman has put forward £180k-£270k as the total costs per annum for his proposals (*"dependent on the policy choice re the levy"* [3.4]). ISCAS would question that accepting oral complaints would have no associated costs for the Ombudsman as detailed in his submission to the Committee on 21 January 2015. In addition, there would surely be an associated cost with the required legislation change to Schedule 3 of the PSOW (Wales) Act that has not been accounted for.

11. ISCAS would like to draw the Committee's attention to the predicament of private patients treated within the NHS who have no ability to complain to any external body about their treatment**.** The Public Services Ombudsman does not include these complainants and NHS Private Patient Units (PPU)/private beds are not members of ISCAS and therefore have no access to an independent complaints adjudication process.

[1] Download the WIHA 2013/2014 Credentials document.

12. Introduction

13. The Public Services Ombudsman (PSO) for Wales has asked that his powers be reviewed and has submitted proposals to the Finance Committee around five key areas of change. Of particular relevance to ISCAS is the Ombudsman's proposal to extend and reform his jurisdiction to cover independent healthcare and our submission focuses on this proposal.

14. The ISCAS Complaints Code sets out clear standards for member healthcare organisations to abide by and improve the experience of complainants ensuring that all unresolved complaints have access to independent adjudication. In view of the recommendation to steer all complaints to the Ombudsman in future, the Finance Committee is asked to consider the experience and service of ISCAS.

15. It is questionable that public funds should be used for the independent healthcare sector when there is the voluntary ISCAS Complaints Code (Code) in operation with costs met by the independent healthcare sector that already covers all the significant independent healthcare providers in Wales.

16. Background of ISCAS

17. For over 13 years, patients using the services of the independent healthcare sector have had the benefit of an effective complaints resolution procedure from organisations signed up to the ISCAS Code and the independent adjudication service.

18. The Code was established following the work of the Health Select Committee (in England) in 1999 and has been revised a number of times, most recently in May 2013. The Code will be reviewed again in the first half of 2015. Overall the Code has a clear customer focus and is supported by the Medical Defence Organisations.

19. How ISCAS works

20. ISCAS is a not for profit company limited by guarantee, set up as a member-owned co-operative with a Governance Board and Management Team. ISCAS operates the Code including the third stage of the complaints resolution:

    Stage 1 - Local resolution (hospital/clinic level)
    Stage 2 - Internal review (CEO/Board of Trustees)
    Stage 3 - Independent Adjudication

21. ISCAS membership[2] comprises of corporate members across the healthcare industry in all four countries of the United Kingdom. ISCAS members share knowledge, experience and understanding on the effective management of complaints. The Code means complainants can raise a complaint about any aspect of service provided within the healthcare facilities of an ISCAS member.

[2] Membership listings can be found at www.iscas.org.uk following links to the membership directory

22. The three stages are essential in managing complaints and achieving resolution for the vast majority without accessing the final adjudication stage. The second stage allows an organisation to review a complaint outcome at senior level and is one step removed from day to day management to ensure all options have been exhausted to resolve the complaint.

23. Below are examples from two different ISCAS members about the number of local complaints and the number escalating to Stage 3 Adjudication:

24. Corporate cosmetic surgery provider (UK wide):
    Total complaints for year 2012/2013

Number of complaints at Stage 1	1288
Number of complaints at stage 2	45
Number of complaints escalated and to stage 3	4

    Organisation information: turnover of £37.5m (July 2011)

25. Two large corporate providers of acute hospitals (UK wide):
    Total complaints for year 2012/2013

	Provider A	Provider B
Number of complaints at stage 1	1943	1604
Number of complaints at stage 2	111	35
Number of complaints escalated to stage 3	9	3

    Organisation information:
    Provider A - Turnover of £821.5m (September 2012) with 2,761 beds
    Provider B - Turnover of £739m (December 2012) with 1857 beds

26. In Wales, four of the six acute general hospitals and the two large specialist cosmetic providers are all part of a wider corporate structure, with their head offices registered and operating out of England. For these providers Stage 2 Corporate Level complaints resolution currently happens at the corporate head offices.

27. Adjudication

28. The purpose and outcome of adjudication is principally to offer answers and then, if possible, to put things right in the most appropriate way.

29. The complainant benefits by not only being offered a deeper insight into the issues raised but may also receive a financial award in recognition of any failings. The Adjudicator reviews the case by reference to the documentary evidence of all correspondence and clinical records. The Adjudicator produces a comprehensive report of the case in the decision letter to the complainant.

30. Independent adjudication has a high success rate in resolving the more difficult or intractable complaints. The main aim of adjudication is to leave all the parties with a better understanding and insight into the issues that have been raised, which leads to a greater focus on the lessons learnt.

31. The outcomes include a wide range of remedies for example: a sincere apology, a goodwill payment and recommendations being made to the ISCAS member. Goodwill payments (with a maximum set at £5000) can be awarded by the Adjudicator and can help reduce litigation, and in fact become a viable alternative - especially for service complaints. Medical Defence Organisations acknowledge the benefits that this system has brought.

32. Further information about ISCAS can be found in the Annual Report at www.iscas.org.uk

33. **Extending the Ombudsman's jurisdiction to include private health services**

34. ISCAS does not support this proposal on the basis that a mechanism for independent review of complaints already exists at no cost to the taxpayer. Furthermore, ISCAS would welcome the opportunity to enter into an information sharing agreement with the PSO for complaints that cross between the NHS and independent sector.

35. ISCAS and adjudication costs:

36. Importantly, for complainants, there is no cost to them through participation and, therefore, no risk involved. Additionally, the decision to engage in the adjudication process does not preclude the complainant from pursuing litigation at a later stage.

37. ISCAS members pay an annual subscription to cover the management resource. This base cost is shared across all members on a sliding scale according to company size.

38. An individual ISCAS member meets the costs of the Adjudicator's case fee, any goodwill payment awarded and any associated clinical expert witness costs. In 2014, ISCAS Adjudicators reported on 40 complaints from across the UK. The average cost of an ISCAS Stage 3 Adjudication in 2014 was £2,430.

	2014
Ex Gratia Awards	£16,300
Adjudication	£64,115
Clinical Expert	£16,096

39. Compliance built into the ISCAS system:

40. Compliance with the ISCAS Code and the Stage 3 Independent Adjudication scheme is a criterion of membership of ISCAS.

41. When producing the Stage 3 Independent Adjudication report, the adjudicator also writes personally to the Chief Executive Officer of the ISCAS member to highlight any recommendations to practice and to require a report back to ISCAS to monitor compliance with the Code. The ISCAS Management Team also undertakes regular compliance checks on members.

42. The ISCAS Governance Board ensures the overall effective implementation of the Code of Practice. The Board has an independent Chair, Baroness Fiona Hodgson CBE, as well

as representation from the Patients Association, the Action against Medical Accidents (AvMA), a patient representative and ISCAS member representation. Outcomes and themes of adjudications are reported, as well as ISCAS activity and member compliance.

43. ISCAS has an Operating Protocol with Health Inspectorate Wales (HIW) and the Care Quality Commission (CQC) in England. Since April 2014 ISCAS has shared the outcomes of adjudications with the CQC in the same way the Parliamentary and Health Service Ombudsman shares its information. HIW has indicated its desire for ISCAS to similarly share the outcomes of any adjudication cases relating to independent healthcare providers in Wales. Furthermore, ISCAS is working with the Regulation and Quality Improvement Authority in Northern Ireland and Healthcare Improvement Scotland on a similar approach. The Operating Protocol also means that complainants are signposted to ISCAS.

44. For information, the ISCAS Director, Sally Taber, is a board member on the newly formed HIW Advisory Board.

45. ISCAS membership covers 98% of the acute hospital sector and other independent healthcare providers across the United Kingdom. However there remain a proportion of smaller independent healthcare providers that have not yet subscribed to ISCAS in the independent sector. If Healthcare Inspectorate Wales had the authority to require organisations to participate in an independent complaint review stage this would change the complaints experience for a complainant significantly and ensure all independent sector providers subscribed to ISCAS or an equivalent process. Indeed, ISCAS is seeing a movement towards this in England, where the CQC has started asking new registrants exactly this question.

46. The Ombudsman and NHS Private Patient Units/private beds

47. ISCAS has a particular concern about private patients using services within an NHS Trust such as Private Patient Units (PPUs)/private beds. In these services patients have no access to an independent review as the Ombudsman does not include these complainants and NHS-run PPUs cannot subscribe to ISCAS. ISCAS has escalated this issue a number of times to the Department of Health (England). Last year Baroness Fiona Hodgson CBE, Chair of the ISCAS Governance Board, raised the issue with the Secretary of State for Health Jeremy Hunt MP. Dr Dan Poulter MP replied on behalf of Jeremy Hunt and ISCAS continues to raise the issue of NHS-run PPUs not offering any independent review stage for complainants as there has been no change in this position to afford a better experience for those complainants.

48. The Ombudsman's proposals around four further areas of change

49. **Own-initiative investigation powers** – ISCAS is broadly supportive of this proposal in line with developments in complaints management across the UK. However, ISCAS agrees that *"it would be important to frame any changes in such a way as to ensure that the power would be used only where appropriate and cases could be referred to regulators or commissioners where this was a more suitable alternative"* [Ombudsman submission to the Finance Committee, 21 January 2015].

50. **Oral complaints** – again ISCAS supports this proposal and agrees that requiring complainants to submit evidence in writing is a barrier to the service and is out of touch with the electronic age. The ISCAS Code requires that members have a policy on complaints that are made by email, text or on social media. This is particularly relevant in the area of cosmetic surgery where the typical patient is young and tends to make use of social media to complain about services.

51. ISCAS is currently reviewing its Code of Practice and will be reviewing the Stage 3 Adjudication requirement for "*complainants to clarify* [their complaint] *in writing*" and its current practice is already to accept complaints via email through the ISCAS website or following a telephone call with a member of the Management Team.

52. Patient confidentiality, data protection and good information governance practices are important considerations when dealing with oral and electronic complaints.

53. ISCAS would question the Ombudsman's submission that accepting oral submissions would have no associated costs [Ombudsman submission to the Finance Committee, 3.2]. ISCAS believes that there would surely be an associated staff and time cost. Accepting telephonic complaints would require skilled staff to capture the complaint correctly, particularly as complaints referred to the Ombudsman tend to be of a complex nature. Furthermore, opening up the option of oral complaints will increase the number of complaints being self-referred to the Ombudsman.

54. **Complaints handling across public services** – while this proposal is not directly relevant to independent healthcare, ISCAS considers this to be an excellent proposal. ISCAS operates in a similar manner for ISCAS members by producing model complaints policies for members; sharing learning and best practice with members through a quarterly e-Newsletter; and hosting annual training seminars for members on complaints handling and learning from complaints. Data from the soon-to-be-published 2014 ISCAS Annual Report shows that complaints handling remains a key area of complaints against healthcare services.

55. **Links with the courts** – ISCAS supports the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review. ISCAS already offers such an option for complainants in the independent sector.

56. Under the ISCAS Code, ISCAS reminds complainants of their right to seek independent legal advice where any aspects of their claim might give rise to a clinical negligence claim. Even if independent legal advice is being sought about clinical negligence or might be sought in the future pending the outcome of the adjudication process, the Code recommends that the complaint can be considered under the complaints procedure and ultimately Stage 3 Adjudication.

57. The outcomes of Stage 3 Adjudication include a wide range of remedies for example: a sincere apology, a goodwill payment and recommendations being made to the ISCAS member. Goodwill payments (with a maximum set at £5000) can be awarded by the Adjudicator and can help reduce litigation, and in fact becomes a viable alternative - especially for service complaints. Medical Defence Organisations acknowledge the benefits that this system has brought.

58. ISCAS notes the Ombudsman's point at 2.5(a) that the *"bar should be set aside entirely, so that complainants can choose which is the more appropriate route for them."* It would seem that it is proposed that complainants would be forced to choose one particular route when ISCAS Adjudication allows complainants to pursue both avenues if they so choose. In addition, ISCAS would question whether all complainants are able to make an informed choice about which route is most appropriate for them, particularly vulnerable complainants.

59. Conclusion

60. In conclusion, ISCAS does not support the Ombudsman's proposal to extend his jurisdiction to include private healthcare services in Wales on the basis that a mechanism for an independent review of independent sector complaints already exists at no cost to the taxpayer and no requirement for legislative change.

61. ISCAS would welcome the opportunity to enter into an information sharing agreement with the PSO for any complaints that cross between the NHS and independent sector.

62. ISCAS is working closely with Healthcare Inspectorate Wales to formalise the process of sharing the outcomes of ISCAS adjudication cases in the same way that it already does with the Care Quality Commission.

63. If Healthcare Inspectorate Wales had the authority to require that independent healthcare providers participate in an independent complaint review stage, this would ensure that all providers would subscribe to ISCAS or an equivalent process. As detailed above, ISCAS has already noted the Care Quality Commission requiring this of independent sector providers in England.

Appendix I

Complaints Code of Practice

May 2013

Independent Sector Complaints Adjudication Service
1 King Street
London EC2V 8AU

Tel: 020 3713 1746

Website: www.iscas.org.uk

About this Code

Independent healthcare organisations (hospitals, clinics and doctors working privately) want to give all patients an excellent service. However, there may be times when they get it wrong. When this happens, they want to respond to complaints swiftly and, where they can, try to put things right.

This Code sets out the necessary standards that all independent healthcare organisations which are members of the Independent Sector Complaints Adjudication Service (ISCAS), have agreed to meet when handling complaints about their services.

This document describes the minimum standards for complaints handling. It also includes an explanation of adjudication arrangements, an independent way of resolving disputes with those independent hospitals and clinics that are members of ISCAS.[3] The costs associated with adjudication are met by the organisation and not by the complainant.

This Code applies to patients treated privately in an ISCAS member hospital or clinic, whether or not they paid for their care directly or through an insurance scheme. Complaints from NHS funded patients treated in an ISCAS member hospital or clinic should be handled according to the NHS Complaints Procedure. Sometimes this may mean ISCAS members handling complaints from NHS patients under this Code as part of the investigation under the NHS procedures (this does not include private patients in NHS Trusts).

The Code applies to complaints about doctors and other healthcare professionals working within member hospitals and clinics, even where they are not employed by the clinic and have practising privileges (this means they agree to provide certain services within the hospital or clinic as independent practitioners).

The Care Quality Commission (CQC) in England is the regulator for health and adult social care including independent healthcare services. It does not handle complaints[4], nor does it provide an arbitration service. However, it collects information about how independent healthcare services meet the regulations and standards it sets, and will take action where any offences have been committed. The Healthcare Inspectorate Wales (HIW), Health Improvement Scotland (HIS) and the Regulation and Quality Improvement Authority (RQIA) (Northern Ireland) regulate independent healthcare services in their respective countries. The regulators of each country recognise and signpost complainants to ISCAS.

[3] A full list of healthcare organisations that are members of ISCAS is available at www.iscas.org.uk

[4] The only exceptions to this are complaints from people whose rights are restricted under the Mental Health Act, or their representatives, about the way staff have used their powers under the Act.

Learning from complaints

Underpinning this Code is a commitment to value complaints for the feedback they provide about independent healthcare services, and to bring about quality improvements. In addition to acknowledging mistakes and apologising where it is appropriate, ISCAS members will inform a complainant about how the complaint was investigated, the lessons learned from their complaint and the actions they have taken as a result. This might include changing guidance to staff, or a policy, or it might mean providing new or different services.

Sometimes finding a remedy for a complaint requires more than this. ISCAS members will consider a range of remedies, which may include a goodwill payment in recognition of any shortfall in complaint handling, inconvenience, distress, or any combination of these. This Code also provides for the Independent Adjudicator (the final stage of the complaints handling process) to review a goodwill payment to the complainant.

The Independent Adjudicator (the final stage of the complaints handling process) can review or award a goodwill payment of up to £5,000. This is not designed to be compensation. If a complaint potentially appears to have arisen as a result of clinical negligence and compensation is sought, and/or might be awarded if a clinical negligence claim is successfully pursued, it may be appropriate to seek legal advice.

Principles

This Code reflects the *Principles of Good Complaint Handling* identified by The Parliamentary and Health Service Ombudsman. Good complaint handling means:

1. **Getting it right**
   Quickly acknowledging and putting right cases of maladministration or poor service that led to injustice or hardship. Considering all the factors when deciding the remedy with fairness for the complainant and where appropriate others who also suffered
2. **Being customer focused**
   Apologising and explaining, managing expectations, dealing with people professionally and sensitively and remedies that take into account individual circumstances
3. **Being open and accountable**
   Clear about how decisions are made, proper accountability, delegation and keeping clear records
4. **Acting fairly and proportionately**
   Fair and proportionate remedies, without bias and discrimination
5. **Putting things right**
   Consider all forms of remedy such as apology, explanation, remedial action or financial offer

6. **Seeking continuous improvement**
   Using lessons learned to avoid repeating poor service and recording outcomes to improve services.

ISCAS members are not public bodies, and ISCAS does not provide a public service[5]. However, these principles can be reasonably applied to independent healthcare hospitals and clinics. Therefore, ISCAS members are expected to have complaints handling procedures that are proportionate and reflect these principles.

Further details of these principles can be found at www.iscas.org.uk

The standards

The Code sets out a three stage process for handling complaints. All complaints should be raised directly with the hospital or clinic in the first instance (stage 1). Complaints should normally be made as soon as possible and within 6 months of the date of the event complained about, or as soon as the matter first came to the attention of the complainant. The time limit can sometimes be extended (so long as it is still possible to investigate the complaint). An extension might be possible, such as in situations where it would have been difficult to have complained earlier, for example, when someone was grieving or undergoing trauma.

In the event that the complainant is unhappy with the response to their complaint, they can escalate their complaint by asking the hospital or clinic to conduct a review of its handling (stage 2). Finally, if the complainant remains dissatisfied they can request independent external adjudication of their complaint (stage 3).

Stage 1: Local Resolution

ISCAS members will:

1. Have a written procedure on the handling of complaints. This should be concise, easy to understand and only contain relevant information about complaints handling. The procedure should be kept up-to-date and as a minimum include information about:
   - The process for handling complaints, including clinical governance arrangements within the hospital or clinic for investigating complaints, including where a clinical negligence matter may have arisen
   - The steps the ISCAS member will take to investigate the complaint which are thorough yet proportionate[6]
   - The timeframes the ISCAS member will work to in trying to resolve the complaint (see standards 9 and 10)
   - How complaints can be made, including how complaints submitted by email or text or using other media will be handled.

[5] The Court of Administration confirmed that ISCAS provides a private service and not a public service, as a result of an application for a Judicial Review of ISCAS in 2011.
[6] CQC: Essential standards of quality and safety, outcome 17

2. Ensure that the procedure on complaints handling is well-publicised and easily available to complainants. For example, ISCAS member websites should include information on 'how to complain' and confirm their membership of ISCAS. Complainants should be provided with a copy of the complaints procedure when they first raise concerns about any aspect of the service they have received.

3. Ensure that the ways in which complaints are accepted does not deter or disadvantage patients or their relatives from making complaints[7]. Reasonable assistance should be available to anyone needing help to make a complaint (for example, whose first language is not English or who may have a disability).

4. Offer complainants a face to face meeting to talk through their concerns and try to resolve the complaint early on.

5. Remind complainants of their right to seek independent or legal advice where any aspect of their complaint might give rise to a clinical negligence claim. 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.

6. Agree with clinicians who hold practising privileges that co-operation with the complaints procedure is a condition of working within the hospital or clinic, described in the Independent Healthcare Advisory Services (IHAS) Practising Privileges Model Policy.

7. Keep confidential all details relating to the complaint and its investigation, and seek appropriate consent from the complainant (or someone acting as their proxy) in circumstances where the investigation of their complaint requires the release of their medical records or sharing their information with other relevant parties.

8. Respond in writing to written complaints, whether made by letter, email or text. Any face to face or telephone discussions with a patient about concerns with the service they have received should be recorded in writing and normally be followed up in writing to the complainant.

9. Provide a written acknowledgement to complainants within 2 working days of receipt of their complaint (unless a full reply can be sent within 5 days).

10. Provide a full response to the complaint within 20 working days or, where the investigation is still in progress, send a letter explaining the reason for the delay to the complainant, at a minimum, every 20 working days.

[7] A communication constitutes a complaint when the issue requires investigation and a formal response.

11. Consider a wide range of appropriate and proportionate responses, including:

- Acknowledging when things have gone wrong
- Giving the complainant an apology, where appropriate
- Taking action to put things right
- Sharing details of how the organisation has investigated and has learnt from the complaint including any changes made as a result
- Making a gesture of goodwill offer, where appropriate.

12. Signpost complainants to the next stage of the complaints procedure, in the event that they are dissatisfied with the response to their complaint. This means an explanation to the complainant of the option to proceed to the stage 2 review of their complaint and what that entails. Complainants should also be informed that, should they wish to escalate their complaint to stage 2, they must do so in writing, within 6 months of the final response to their complaint at stage 1.

Stage 2: Complaint Review

ISCAS members will

13. Have arrangements in place by which to conduct a review of the complaint. Normally this will mean that a senior member of staff within the organisation, who has not been involved in handling the complaint at Stage 1 and is removed from the hospital or clinic that the complaint is about, will review all of the documentation and may interview staff involved, to form an independent view on the handling of the complaint.

14. In the case of smaller organisations there is a need to demonstrate processes that allow for an objective assessment of the complaint at stage 2.

15. Provide a written acknowledgement to complainants within 2 working days of receipt of their complaint at stage 2 (unless a full reply can be sent within 5 working days).

16. Provide a full response on the outcome of the review within 20 working days or, where the investigation is still in progress, send a letter explaining the reason for the delay to the complainant, at a minimum, every 20 working days.

17. Signpost complainants to the next stage of the complaints procedure, which means explaining their right to an independent external adjudication of their complaint, and the timescales for doing this. Requests for independent external adjudication should be made to ISCAS, in writing, within 6 months of receipt of the stage 2 decision letter. Requests for independent external adjudication will be allowed outside this timeframe only in exceptional circumstances.

Stage 3: Independent External Adjudication

ISCAS will

18. Have a written document that explains the Independent External Adjudication Process. This should be concise, easy to understand, and kept up-to-date. This document should be available on the ISCAS website and a hard copy sent to complainants on request.

19. Provide a written acknowledgement to complainants of their request for independent external adjudication within 2 working days of receipt of the request.

20. Check with the ISCAS member hospital or clinic that the processes for local resolution and stage 2 review have already been exhausted and obtain a response within 2 working days.

21. Refer complainants to the ISCAS member that their complaint is about, where the complaint has not been through local resolution stages 1 and 2.

22. Ask complainants to clarify in writing which aspects of their complaint they wish to refer for adjudication and consent to the ISCAS process and release of relevant case records from the ISCAS member.

23. Assign an Independent Adjudicator to consider the complaint. The adjudicator will be entirely independent of the ISCAS member organisation, and will have the necessary skills and experience to perform this role.

24. Ensure that complainants understand the binding nature of the independent external adjudication. In order for a complaint to proceed to Independent External Adjudication, the complainant must accept:

- The finality of the decision by the Independent External Adjudicator;
- That any decision and/or goodwill payment awarded by the Independent External Adjudicator brings the complaint process to a close;
- That the Independent Adjudicator's decision is binding on the ISCAS member. However, for the avoidance of any doubt (subject to paragraph 24 below), any award of a goodwill payment recommended by the adjudicator does not preclude a complainant from seeking any additional legal remedy; monetary or otherwise.

25. Remind complainants of their right to seek independent legal advice where any aspects of their complaint might give rise to a clinical negligence claim. Even if independent legal advice is being sought about clinical negligence or might be sought in the future pending the outcome of the adjudication process the ISCAS Code recommends that the complaint can be considered under the complaints procedure and ultimately stage 3 adjudication.

The Independent Adjudicator will

26. Accept complaints for adjudication, unless:

- It is reasonable to consider that the complaint has been resolved, or
- The ISCAS member has genuine and reasonable grounds for considering that the complaint can be resolved locally and takes active steps to achieve this, or
- The complaint is outside the remit of the Code for complaints handling, or
- It is reasonable to consider that the complaint is vexatious, or
- In exceptional circumstances a reasonable and acceptable request has been made by the ISCAS member hospital or clinic that the case should be deemed closed at stage 2 and not proceed to stage 3.

27. Provide a written acknowledgement to complainants within 2 working days of receiving from ISCAS, documentation relating to their complaint.

28. Provide a full adjudication decision within 20 working days or send a letter explaining the reason for the delay to the complainant, at a minimum, every 20 working days.

29. Consider a wide range of remedies, including asking the ISCAS member:

- to provide an explanation and apology, where appropriate
- to take action to put things right
- to share details of how the organisation has learnt from the complaint and any changes made as a result
- to offer a goodwill payment in recognition of shortfalls in the complaint handling, inconvenience, distress, or any combination of these, up to a limit of £5,000. Any goodwill payment awarded by the Independent External Adjudicator should take account of any claim that the ISCAS member has against the complainant (e.g. for unpaid hospital fees). Acceptance of the goodwill payment by the complainant will bring all matters that are subject to the complaint to a close.

30. Consider using appropriate resources to assist the adjudicator in his/her determination. Such resources may include the commissioning of clinical and technical reports from external experts[8], and or requests for further documentation or clarification from the complainant or the ISCAS member. In some cases, the Adjudicator may need to speak with the complainant or the ISCAS member, in order to decide how best to resolve the complaint.

[8] ISCAS uses experts from a reputable and recognised source ensuring there is no conflict of interest

Breaches of the Code

ISCAS members will

31. Undertake an annual self assessment of compliance against the standards set out in the Code. They are required to declare the outcome of this assessment to ISCAS, together with an action plan that sets out how they will meet standards with which they have not been compliant.

32. Cooperate with ISCAS to address areas of non-compliance.

ISCAS will

33. Publish an annual report on how ISCAS members are performing against the standards set out in the Code. This will be based on the self-assessments conducted by ISCAS members, themes arising from Independent External Adjudication and other ISCAS activity in the reporting year.

34. Undertake a performance assessment of ISCAS members that repeatedly fail to meet the Code's standards.

35. Take steps to remove the membership of any ISCAS member that persistently fails to meet the Code's standards and does not engage with ISCAS to improve its complaints handling.

Complaints about ISCAS or the Independent Adjudicator

Complaints about the way ISCAS has handled a complaint at stage 3, or about the Independent Adjudicator, should be made in writing to the Director, ISCAS. A complaint can only be made if the complainant believes that ISCAS and or the Adjudicator have failed to carry out the process of adjudication properly.

THE ISCAS DIRECTOR will

I. Acknowledge receipt of the complaint within 2 working days.

II. Invite the complainant to meet to help resolve the complaint, where this may be helpful.

III. Investigate and respond to the complaint in full within 20 working days.

IV. Refer the complaint to the independent Chair of the ISCAS Governance Board if the complaint cannot be resolved after 20 days and notify the complainant accordingly. The Chair will consider the complaint about ISCAS and may hold a small panel to consider a case. A response will be made within 20 working days.

V. Report all complaints about ISCAS to the Governance Board and publish information about feedback from those who use the service.

Dealing with abusive or vexatious complaints

ISCAS members should have a policy in place to handle situations where people pursue their complaint in a way that can impede its investigation, can cause significant resource issues for the organisation, or which involves unacceptable behaviour (such as leaving multiple voicemails or emails, or using abusive language). The policy should set out how the organisation will decide which complainants will be considered vexatious or unreasonably persistent, and how the organisation will respond in those circumstances.

ISCAS has its own policy for handling vexatious complaints and provides guidance to members on its application.

Welsh Independent Healthcare Association
Cymdeithas Gofal Iechyd Annibynnol Cymru

High quality patient care
Working in collaboration
Investment in local economy

2013/2014 CREDENTIALS DOCUMENT

Gofalu am Gleifion dros Gymru

Investment in the latest equipment is essential for the care of our patients

The Mental Health sector provided **85,000** patient bed days in 2013-2014

The acute sector provided over **16,500** in-patient/day case episodes in 2013-2014

The Learning Disability Services provided over **21,700** bed days in 2013-2014

WIHA members ensure their staff receive high quality training and development to ensure continuing high levels of care

Introduction

The past year has seen a number of changes in the independent sector, both in terms of acute provision and mental health regulation. Nevertheless, and despite the challenging economic climate, many thousands of patients have used the services and treatments provided by independent hospitals in Wales.

We employ almost 2,000 people and treat tens of thousands of patients every year, either as inpatients or on an outpatient basis, and across a range of general health services but increasingly in particular areas of more specialist care and treatment.

We are working more and more closely in an advisory and collaborative way with both the Welsh Government and Health Boards to improve alignment with our common objectives of the highest standards of patient safety and quality. We believe there is more scope to develop shared learning and ideas in healthcare innovation and improvement by working in a more collaborative manner.

As local employers often in areas with higher than average levels of unemployment, we also provide opportunities for employment across a range of disciplines and areas. We seek to promote good practice in our employment practices and by doing so to demonstrate our commitment to Corporate Social Responsibility.

The Welsh Independent Healthcare Association (WIHA) was formed several years ago and aims to provide a single co-ordinated voice to facilitate consultation and share practice across the sector, helping to streamline communication and avoid repetition and engagement with a multiplicity of individual organisations.

We have compiled this booklet to provide some key facts and figures about the independent healthcare sector in Wales. A detailed summary is available of the result of the audit.

I hope you find this booklet helpful and please do contact me if you would like more information about the WIHA, its members, or the work of the independent health sector in Wales.

Thank you.

Simon Rogers,
Chairman WIHA

Telephone: 01443 449292

Email: simon.rogers@nuffieldhealth.com

About the Independent Health Sector

The WIHA is made up of:

- 6 acute hospital organisations
- 6 mental health organisations (comprising 23 units)
- 2 organisations providing learning disability services

All of these hospitals collaborate with a wide range of stakeholders, including patients, consultants and their professional associations, regulatory bodies, intermediaries, Local Health Boards, GPs and community health services.

The six acute independent hospital organisations which took part in this audit:

- Treated more than 16,500 inpatient/day cases in the period 2013-14.
- Managed more than 23,000 bed days in the same period.

The six mental health organisations:

- Managed more than 85,000 bed days, again in the same period
- All of the NHS funded bed days.

The learning disability units:

- Managed over 21,700 bed days, in the same period
- All of them NHS funded beds.

All WIHA members have a commitment to quality assurance as a key part of the delivery of safe and effective services to patients, and they have systems in place to identify the central cause of any issues raised which help to ensure that problems do not recur.

In addition, the sector makes a sizeable contribution to both Welsh employment and the Welsh economy by providing employment for a large number of people, while the vast majority of the goods and services are bought locally.

These include areas such as foodstuffs, supplies, engineering support, grounds maintenance, building and construction.

Our patients rate the level of care they receive extremely highly


Total staff in sector
1,928
Acute inpatients discharges
16,901
Acute outpatient attendance
143,296

Ensuring the Quality of Clinical Care

Patients in the independent sector receive high standards of clinical care, and are treated in high-quality facilities by leading consultants using some of the latest technology.

WIHA members have stringent measures in place to combat Methicillin Resistant Staphylococcus Aureas (MRSA) and other hospital acquired infections.

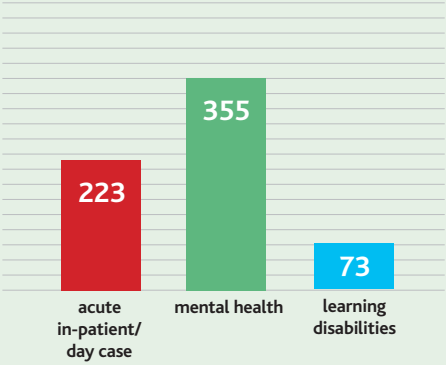
As a result, no incidences of hospital acquired MRSA Bacteraemia and only 1 case of Clostridium Difficile were recorded in the WIHA acute hospitals completing the questionnaire in 2013/2014, and they managed a total of 23,134 bed days.

99%

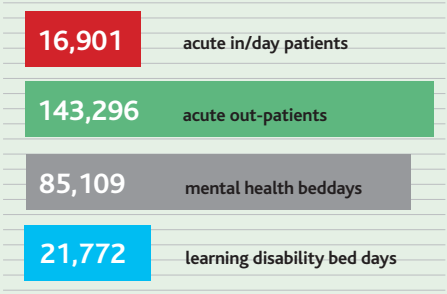
of patients would recommend our hospitals to others

Summary of results of the audit

number of beds



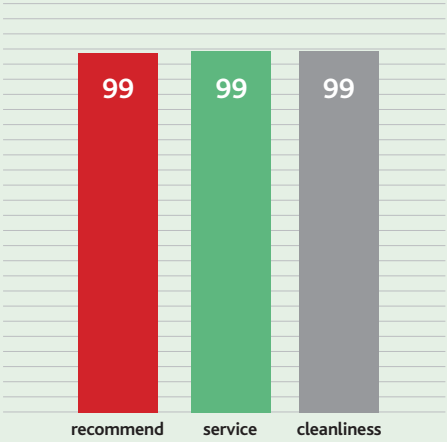
number of patients treated



levels of patient satisfaction and complaints

All the independent sector organisations in the audit have high rates of patient satisfaction. The average results in 2013/14 for the WIHA group were:

- **99%** of patients surveyed would recommend our hospitals to others
- **99%** of patients rated the service as either excellent, very good, or good.
- **99%** of patients rated the cleanliness of the facility as excellent, very good or good.



Quality assurance

The independent health sector receives very few complaints.

- In the mental health hospitals complaints represented just 0.04 per cent of patient days.
- The number of complaints made in the acute hospitals represented less than 0.1 per cent of attendances.

99% rated the cleanliness of our hospitals as excellent, very good or good

Complaints across the sector represented less that 0.1% of all patient activity

Organisations who are members of WIHA and supplied data for this document:

Acute Surgical:

- BMI Werndale Hospital, Carmarthen
- Nuffield Health Cardiff & Vale Hospitals, Cardiff and Vale of Glamorgan
- Sancta Maria Hospital, Swansea
- Spire Cardiff Hospital, Cardiff
- Spire Yale Hospital, Wrexham
- St Josephs Hospital, Newport

Mental Health:

- The Cambian Group
- Lighthouse Healthcare, Phoenix House
- Ludlow Street Healthcare
- Partnership in Care, Llanarth Court Hospital, Raglan
- Priory Group
- Rushcliffe Independent Hospital

Learning Disabilities:

- Ludlow Street Healthcare
- Priory Group

Organisations not participating are Mental Health UK and Pastoral Healthcare

Produced by Welsh Independent Healthcare Association with grateful thanks to Lene Gurney, Association of Independent Healthcare Organisations (AIHO) Independent Healthcare Advisory Services (IHAS) Division (lene.gurney@aiho.org.uk).

Further information about the WIHA can be found at
www.independenthealthcare.org.uk/wiha

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Agenda Item 9

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