HOSPITAL AND COMMUNITY HEALTH SERVICES
INDEPENDENT REVIEW BODY
(Bing Aavriwnyssyn Neuchroghagh)

REPORT FOR THE PERIOD 1 APRIL 2014 – 31 MARCH 2016

PURPOSE: The Independent Review Body (IRB) exists to investigate complaints made in relation to the National Health Service (NHS) which have not been dealt with to the Complainants' satisfaction by the Service Providers' own local resolution procedure. Such complaints can relate to Noble's Hospital or a Practitioner (i.e. a G.P., Pharmacist, Dentist or Optometrist). Equally, complaints can relate to purely process or procedural matters such as traffic management at the Hospital, Clinic organisation OR to Medical Practice, competence or any other aspect of care which fails to meet a service user's expectation. According to the IRB's statutory purpose and obligation, it is entitled to investigate all matters that relate to a health service complaint that are unresolved.

MEMBERSHIP: Andrew Guy (Convenor and Chairman - appointed by IRB Membership to oversee business matters), Francis Masserick (Convenor and Deputy Chairman - similarly appointed), Colin Brown (Convenor), Brian Holt, (Convenor), Chris Barr (Lay Member), Harry Messenger (Lay Member). Vivienne Hare (Convenor), having completed her first term of office, attended her last meeting on 13 October 2015. Andrea Roberts is Clerk to the IRB.

MODE OF OPERATION: The way in which the IRB functions has been adjusted to provide continuity in operation. An additional Convenor was appointed so that the original procedural intention could be fulfilled. Thus Andrew Guy (and his successors) now takes on the role of Chair to all Hearings as well as acting as a consultant/adviser to the Convenors but does not take new cases as Convenor.

The intention is that members of the IRB are initially appointed as Lay Members and, after training and shadowing existing Convenors, become Convenors in their own right.

The Members of the Independent Review Body meet on a quarterly basis to transact any formal business and discuss, for training purposes, Convenors' and Panel decisions in respect of matters which have been concluded. The individual Convenors and Lay Members are required to read through, in their own time, often extensive medical records and complaint management files in connection with issues into which they are enquiring.

The IRB operates on the basis that one Convenor reviews the initial complaint and, if appropriate, seeks qualified medical advice. Such medical advice is provided by a Department appointed clinician. The options open to the Convenor include calling a full Panel Hearing to investigate further, declining to hold a Hearing whilst upholding the complaint and making a number of recommendations (although these may not include a recommendation of financial awards nor disciplinary action by the NHS but may include a referral of an individual to an appropriate professional body if the Panel deems it necessary), or turning down the request for a Hearing without making any recommendations (rejecting the complaint). Finally, the Convenor has the power to refer the matter back for a further attempt at local resolution, if it is felt this is the most likely way to resolve the issue or where it is clear that local resolution was not adequately carried out in the initial phase.

Procedure on appeal of a Convenor's decision: If the Complainant is not satisfied with the decision of the first Convenor, an appeal can be made to a second Convenor. This person then has access to all the documentation produced in the case to date but not the report of the first Convenor; thus an appeal requires a second, independent, investigation. Should the second Convenor also turn down the request for a full Panel Hearing then that completes the complaints procedure and no further action may be taken by the Complainant.

Should either the first or second Convenor decide to call a Panel Hearing this Member sits on the Panel and produces the final report, but the Hearing is chaired as set out above. Any other one of the Members completes the Panel. The Complainant is invited to attend the Hearing, as are other individuals whose presence is thought to be helpful to the investigation. If the complaint involves a medical issue, independent assessors from the UK are engaged to attend the Hearing, advise the Panel Members, and then submit a separate or joint report. These form the basis of the Panel's own final report which is circulated to all parties, including the Department of Health and Social Care (DHSC), or other appropriate Body.

STATISTICS: Number of complaints: As will be appreciated, arrangements for investigating complaints are ongoing and do not fall neatly into a yearly cycle. Complaints made or received in one year may not always be resolved within that year and so year on year comparisons are rarely easily made. Similarly, IRB data may not be easily comparable with records kept by NHS Units for similar reasons.

(a) During the year 2014-2015, 18 complaints were received and can be summarised as follows:

Six complaints were reviewed by a Convenor, who considered a Panel Hearing was not required but, in some cases, recommendations were made to the Service Provider for the improvement of arrangements;

One complaint was halted before the Convenor's report had been issued because legal proceedings were instigated;

Two complaints were reviewed by a Convenor and referred back for further local resolution;

Four complaints were referred for a Panel Hearing;

Five complaints are in the process of being investigated.

(b) During the year 2015-2016, 11 complaints were received and can be summarised as follows:

One complaint was reviewed but Complainant chose not to proceed;

Two complaints were reviewed by a Convenor, who considered a Panel Hearing was not required but, in some cases, recommendations were made to the Service Provider for the improvement of arrangements;

Three complaints were reviewed by a first Convenor and, on appeal, referred to second Convenors to provide a second independent investigation. It was concluded that a Panel Hearing was not required but, in some cases, recommendations were made to the Service Provider for the improvement of arrangements;

Two complaints were reviewed by a Convenor and referred back for further local resolution;

Three complaints are in the process of being investigated.

To assist in understanding, the cases completed during the period are listed in the Appendix to this report.

OBSERVATIONS:

1. DEPARTMENT OF HEALTH AND SOCIAL CARE (DHSC): Over the period in question there have been considerable and ongoing changes to the mode of operation of the DHSC in general and noticeably the Health Services. There has been some upheaval in staff structure and organization which has been reflected in the review of complaints.

Members of the management team have been invited to meet with the IRB to discuss the areas of interest and concern. This has resulted in the introduction of a regular update each quarter to Members on Health Service strategy, policy and procedures.

2. ACCESS TO SHARED AREA ON GOVERNMENT SITE: To provide a secure area for communication and enable access to Meeting documentation, Members were issued with a Government laptop in December 2015. There have been ongoing problems with usage which are being addressed by DHSC Staff.

3. NATIONAL HEALTH AND CARE SERVICE ACT: It is understood that the IRB will be invited to contribute to the drafting of any secondary legislation (scheme) which will be put in place to support delivery of a cohesive and comprehensive complaints resolution function and that such drafting will be commenced at the end of 2016/beginning 2017.

4. ROLE OF IRB/ADVISORY BODIES: There did appear to be some areas where NHS personnel were somewhat confused about the role and nature of the IRB. It was not fully understood that the IRB is the Body to which Complainants, dissatisfied with local resolution, can make an ultimate appeal (witness the Ombudsman in the U.K.). The IRB has a statutory function to investigate and is required to provide an independent objective review of a complaint neither favouring the Complainant nor the Service Provider. It cannot alter the requirements of Statute.

At one stage, the IRB was quoted alongside Age Isle of Man and the Isle of Man Health and Care Association which caused some confusion for Complainants. Whilst it is appreciated that these Bodies provide a useful charitable advisory service to assist individuals, they have no formal standing as regards investigating matters which rests, in the first instance, with the relevant NHS Governance Manager and, secondly, the IRB.

However, in recent months, at the instigation of IRB Members, the Chair has been invited to give presentations at a GP Educational Afternoon, the Noble's Executive Team and the Patient Safety Forum. Similarly, Members have attended Presentations regarding Quality Strategy, Patient Safety Conference and, alongside staff, have participated at Patient Safety Educational Modules.

It is therefore hoped that such interaction will result in a greater understanding of the IRB's role as well as an appreciation by Members of the challenges being encountered by DHSC staff.

5. NATURE OF COMPLAINTS:

(a) Tertiary Care: Recent complaints have included reference to the arrangements by which care is supplied for Island residents in UK Hospitals/Units. There does not appear to be a central strategy for monitoring such arrangements which is of some concern to the IRB. In the view of the Members, this apparent lack of co-ordination/control can lead to additional 'loopholes' in service and resultant dissatisfaction by service users.

(b) Non-Hospital Services: The number of complaints about services outside the Hospital has grown significantly over recent years. In particular, the IRB has seen a number of complaints about Mental Health Services and Dentistry. Complaints about GP services remain extremely low.

In dealing with dentistry complaints it has become apparent that the standard of local resolution is often low and there is a lack of clarity over responsibility for service quality at both the practice level and at the central management level. This is of some concern and will need to be resolved over the coming period.

6. COMPLAINANTS: It has been noted that more recently Complainants have become pro-active and concerned that any IRB recommendations to improve service provision are fully actioned. The detailed plans to progress arrangements as provided by the Service Provider are scrutinised in depth, not only by the IRB, but also the Complainant, who on occasion will raise issues which it is felt have not been fully addressed.

In general, the IRB goes to some length to include the Complainant in the review process and recommendations are often set to encourage such inclusion.

7. CONSULTANTS' CONTRACTS & OBLIGATIONS: In the previous report, the IRB noted that it was aware that the Manx Health Service contracts for medical and nursing staff do not expressly require them to cooperate fully with an IRB investigation or to attend a panel hearing. However, for those registered with the

General Medical Council, the IRB has been informed that failure to fully cooperate runs contrary to the GMS principles.

Due to the recent substantial changes to NHS management, departmental restructuring and a new ministerial appointment, the IRB has been unable to address this issue but a resolution will need to be found in the coming period to prevent any further difficulty. The IRB believes that the recent draft Bill and review of all attending contracts, structures and regulation could simply deal with this issue and prevent damage to the reputation of the NHS.

Andrew Guy
Chairman
Independent Review Body

October (Dec) 2016

Appendix

Independent Review Body (IRB) Complaint investigation reports issued 1 April 2014 – 31 March 2016

IRB ID	Date received IRB	DHSC Division(s)	Convenor/Panel	Report issued
IRB 123	14.02.13	Noble's	Panel Hearing	14.07.14
IRB 125	26.06.13	Noble's	Panel Hearing	21.10.14
IRB 126	11.08.13	Noble's	2nd Convenor A Guy	09.06.14
IRB 127	16.08.13	MHS	1st Convenor A Guy	15.06.15
IRB 129	29.09.13	Noble's	Panel Hearing	15.12.14
IRB130	27.09.13	Noble's	1st Convenor A Guy	13.06.14
IRB 131	10.10.13	MHS	Panel Hearing	12.01.15
IRB 134	18.02.14	Noble's	1st Con. F Masserick	10.05.15
IRB 136	17.04.14	Noble's	Panel Hearing	29.05.15
IRB 139	26.05.14	Noble's	1st Convenor V Hare	20.08.14
IRB 141	12.07.14	Noble's	1st Convenor V Hare	30.03.15
IRB 142	15.07.14	Noble's/GP	1st Convenor A Guy	19.10.15
IRB 144	22.07.14	Noble's	1st Convenor V Hare	04.03.15
IRB 147	07.08.14	MHS	1st Convenor V Hare	16.01.15
IRB 149	15.08.14	Noble's	1st Con. F Masserick	07.03.15
IRB 150	27.12.14	Noble's	1st Convenor A Guy	12.06.15
IRB 151	26.01.15	Noble's	Panel Hearing	29.07.15
IRB 153	12.03.15	Noble's	1st Convenor A Guy	12.06.15
IRB 154	13.04.15	Noble's/GP	1st Convenor B Holt 2nd Convenor C Brown	28.10.15 19.01.16
IRB 156	27.05.15	Speech&Language	1st Convenor C Brown 2nd Convenor B Holt	23.09.15 25.02.16
IRB 157	05.06.15	Ambulance	1st Convenor B Holt	17.07.15

IRB ID	Date received IRB	DHSC Division(s)	Convenor/Panel	Report issued
IRB 158	24.08.15	MHS	1st Convenor B Holt 2nd Con. F Masserick	20.11.15 09.03.16
IRB159	07.09.15	MHS	1st Convenor C Brown	25.02.16
IRB 160	8.10.15	MHS	1st Convenor B Holt	23.03.16
IRB 161	10.11.15	Therapy Services	1st Convenor C Brown	23.03.16