Independent Review into Safeguarding and Care at Dunmurry Manor Care Home

Full Review Terms of Reference and Methodology
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Introduction

1. The review has been commissioned to provide the Department of Health and the wider Health and Social Care System with an analysis and insights into how the system responded to the issues at DMCH. Necessarily, this will examine the decisions made by relevant HSC bodies and the systems within which those decisions were made. Ultimately this will enable the Department to understand if failings were the result of flaws in systems, their operation or a combination of both and to identify learning for future improvements.
2. A *rapid review* was undertaken prior to the release of the Commissioner for Older People for Northern Ireland (COPNI) report *Home Truths: a report on the Commissioner's investigation into Dunmurry Manor Care Home,* which among other things, gave the Department of Health (DH) assurance and advice about the current quality and safety of services at DMCH.
3. The terms of reference below do not seek to duplicate COPNI's approach.
4. In commissioning this review the DH have been clear that the issues at DMCH create a requirement for action. The fundamental questions for this review are: *why did people in the system make the decisions they did and what could be done differently in the future*?
5. In announcing this review, the DH said: *The Department of Health has commissioned an independent review into care failings at Dunmurry Manor Care Home, focussing on the actions of the Health and Social Care (HSC) system. The review will consider HSC responses to issues at Dunmurry Manor and identify lessons to be learned for the future.*

   > *A Departmental spokesperson said: "As the Permanent Secretary has made clear, the Department of Health takes very seriously the issues which have emerged from Dunmurry Manor. This independent review, which we have commissioned CPEA to carry-out, will give us a clear picture of how these care failings came about and, crucially, how we can put systems in place to prevent them occurring again."*

   It is part of a range of actions announced by the Department of Health on 27 June 2018.[1]

Proposed Terms of Reference

6. Taking a whole system approach, the review must consider how the following interacting sub-systems impacting on the lives of residents at DMCH work:
   a) **Case management** with vulnerable adults' people who require residential accommodation for personal support, safety, care and/or nursing including how placements are chosen and the extent to which care reflects individual choices, preferences and lifestyle and how effectively safeguarding concerns are responded to.
   b) **Commissioning** of nursing and residential care including how effectively care provided meets assessed needs, how the quality of what is commissioned is monitored on an ongoing basis and by whom

[1] See https://www.health-ni.gov.uk/news/department-commissions-independent-review-actions-around-dunmurry-manor-care-home (Accessed 18th July 2018)

c) **The Service provider** including the values and culture of the organisation, the effectiveness of its working relationships with other organisations including HSC Trusts, the adequacy of its leadership and management arrangements, the quality of care provided and the operation of its complaints processes. The review will also consider any issues arising from a single provider operating a number of homes specifically considering the relevance of unsatisfactory performance of one or more homes for the providers overall portfolio.

d) **The quality assurance system** considering the remits and responsibilities of regulators, commissioners and providers to ensure quality and robust governance for the provision of care, how well these are understood by different parts of the system and how well they are discharged.

Methodology

7. It is proposed that a small oversight/reference group is put in place to work with CPEA Ltd. This should be made up of the safeguarding leads of each Health and Social Care Trust (HSCT), Social Work and Nursing Directors, the RQIA, NMC and the NISCC as well as the DH. This should provide the CPEA Team with information and evidence concerning the context of policies, procedures and resources.
8. The group would: (i) provide local knowledge and context; (ii) identify and provide access to information required to complete the review; (iii) identify relevant people for the review team to interview; (iv) work with CPEA to help focus the review on the key issues; and (v) take any relevant immediate action emerging from the review.
9. The CPEA Team will carry out both a wide-ranging desktop review of documents. The Team will similarly seek early meetings with families, key staff at all levels and across all parts of the system as required to undertake the review.
10. It is expected to seek an early meeting with the COPNI to clarify the approach of the review and to ascertain the extent he wishes to be involved, engaged and informed by the process. It is hoped that the COPNI will be able to assist and advise on how the status and quality of care and nursing homes may be improved, ways of routinely involving families and on public expectations of accountability and candour.
11. CPEA's *rapid review* ascertained that long-standing members of staff at DMCH were not interviewed by the COPNI. The review will place their views on record. It is not known how much Runwood has been involved and/or contributed to the COPNI report, but we would like to extend the review to include the perspectives of the Chief Executive, the Chief Operating Officer and the Director of Operations for Northern Ireland. The current Registered Manager has already contributed to the *rapid review* but it possible some of her predecessors may remain with the company in other capacities and have useful perspectives.