The Isle of Wight Safeguarding Adults Board (IWSAB) has today published an independent Safeguarding Adults Review into the death of Mrs X.

In the case of Mrs. X it is clear that the circumstances of her death and the history of Safeguarding alerts, gave rise to serious concerns. In responding to these concerns, initially raised by the Coroner, and agreeing that an Independent Safeguarding Adults Review should be commissioned; Board members appreciate the family's loss and have been concerned to achieve as thorough a review as possible into the circumstances of Mrs X's death.

In the report, the Independent Review team identify that the home had too few staff to deal with the emergency situation that arose, whilst also attending to the needs of other residents. Work has been undertaken to improve the capacity within the home to deal with this kind of situation should it happen again.

The Review Panel's report highlights the lessons which should be learned from Mrs X's experience and the responses listed below are the basis of an initial Action Plan agreed by the Safeguarding Adults Board to improve practice and procedures and address the issues raised by the report.

Summary of initial responses:

- A review of the present arrangements for Safeguarding Adults within the Local Authority is currently being undertaken. Any new proposals will be brought to the Safeguarding Adults Board for consultation before they are introduced. This is important as the Local Authority has a lead role in co-ordinating the multi-agency response to Safeguarding Adults on the Isle of Wight. Adequate arrangements for training in any new processes and promoting awareness of the Safeguarding Adults procedures will need to be introduced alongside of any new organisational structures. The Board will request up-dates on progress at each Board meeting.
- The Local Authority's Adult Social Care service will put in place a single point of commissioning team a part of whose role will be to develop and implement a more proactive quality monitoring of care provision on the island. The Board will review progress on this over the next year with an expectation that quality monitoring will have improved significantly over this period and that the Local Authority work in this area will be adequately linked with the relevant Health services.
- There is recognition on the Isle of Wight that more nursing places are needed. Health and Social Care Commissioners are aware of this need and are seeking to support existing care providers to increase the number of nursing places within their services. The Safeguarding Board will regularly review progress on this intention.
- The Safeguarding Review panel in the case of Mrs X found evidence to suggest that the pressure sores identified shortly before her death were most likely to be attributable to internal psoriasis – a serious skin condition for which she had been receiving treatment. The Health Trust are now regularly monitoring the incidence of pressure sores in nursing homes on the Isle of Wight with a view to ensuring any issues are identified quickly and responded to effectively. This work is ongoing – the Board will receive regular reports on any findings.

- New I.T. systems are being introduced for the District Nurse service across the Isle of Wight which should be embedded by January 2016.
- New leadership is now in place for District Nurses and attention will be given to achieving a workload arrangement which improves the existing capacity of District Nurses. The Board will request a report by March 2016 about the workload of district nurses. This will include information on the number of cases etc. being managed by District Nurses on the Isle of Wight.
- There is a commitment from both Health and Social Care services on the Isle of Wight to providing more person-centred services. The Adult Safeguarding Board will consider how best to monitor progress towards more person-centred services so that individuals do not feel 'stranded' in one service, or moved from one to the other in ways that pay little attention to the whole of their needs. A method for monitoring progress towards more person-centred approaches should be agreed by March 2016 and actioned after that date. This monitoring will include an overview of the new locality work and its links to the Vanguard initiative, which seeks to involve individuals more in decision making about their health and social care needs.