Mr W

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

In the case of Mr W, the Review clearly highlights issues about self-neglect, mental capacity and communication both between services and with Mr W about his background and interests. Sadly, despite a number of agencies being involved in his life, the individual in this case found himself alone, confused and not wanting to continue after the death of his sister.

The independent reviewer has highlighted a number of lessons to be learned from this Review and the Safeguarding Adults Board have identified a range of responses which will form the basis of an Action plan aimed at improving future practice.

- 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.

- In reviewing Adult Safeguarding arrangements a focus will be given to effectiveness of multi-agency work and the need for earlier multi-agency meetings in order to agree core plans for individuals whose needs require services to act together. In reviewing progress on the changes to Adult Safeguarding processes the Board will have a specific focus on how these changes improve communication between services, ensure earlier multi-agency working as necessary, and a shared approach to risk assessment.

- 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 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 health.

- 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 on the average number of cases being managed by District Nurses on the Isle of Wight.

- Since the SCR the Safeguarding Adults Board manager has met with the Mental Health Service's lead and received reassurances that responses to requests for information in the future will be promptly responded to. The Health Trust, who oversee this work, have also recently formed a small safeguarding team who will be routinely informed of any Safeguarding Reviews and will be in a position to ensure that any services linked to the Trust respond to these requests.

- There will be a continued focus on improving training and practice in respect of mental capacity assessment work amongst practitioners on the Isle of Wight. The Board has been supporting the promotion of Mental Capacity Act training in 2014/15 and will look to services to place a fresh emphasis on this during the course of the year. The Board will support additional training for practitioners in improving identification of self-neglect and the response to it. Adults with mental capacity have the right to make their own lifestyle choices and when this involves what others view as self-neglect it presents real difficulties for practitioners but support might still be improved.

- 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 review 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.