Adult Safeguarding Policy and Procedures 2018

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Part 1: Policy

1 Purpose and scope

This policy, and any procedures or guidance that accompany it, set out how Surrey Safeguarding Adults Board ('SSAB' or 'the Board') will meet the objective required of it in section 43 of the Care Act 2014 ('the Care Act') of co-ordinating and ensuring the effectiveness of what each of its members does to help and protect adults in Surrey its area in cases where

- The adult has care and support needs; and
- They are experiencing, or are at risk of, abuse or neglect; and
- They are unable to protect themselves from the abuse or neglect, or the risk of it, as a result of those care and support needs

In such cases, there is a duty under section 42 of the Care Act to ensure there is a safeguarding adults enquiry. Paragraph 14.6 of the Care and Support Statutory Guidance ('the guidance') says this duty will be on

- The prison governor, where the adult is in prison
- Her Majesty's Prison and Probation Service (HMPPS) where the person is in approved premises
- Surrey County Council's Adult Social Care services in all other cases

Those organisations will have their own arrangements for how they meet this duty. This policy, and any procedures of guidance that accompany it, set the multi-agency context for those enquiries.

2 Principles

This policy has been written in line with the following principles. The Board expects its member agencies to adopt these principles in their own adult safeguarding policies, procedures and guidance.

2.1 Avoiding duplication

There is an expectation that reader of this policy will be familiar with the Care Act and the guidance, so if a matter is covered in those it will not be covered here unless there is good reason such as

- It being necessary for clarity
- It is a matter that bears repetition because, for example, it relates to a frequently misunderstood area of practice or an issue of high risk

2.2 Minimising redundancy

Safeguarding adults concerns cover a wide variety of issues and contexts. In attempting to reflect this policies, procedures and guidance in this area risk attempting to cover so much ground that the substantive content gets lost. We aim to focus on the material that will be of most use in practice.

2.3 Describe good practice

Safeguarding adults policy and procedures should do more than set out what is required for compliance. They should describe what makes for good practice.

2.4 Allow requisite variety of response

Safeguarding adults policy and procedures should allow space for professional judgement. With the variety of issues that adult safeguarding work covers there has to be scope for those dealing with a matter to determine the best way to apply the good practice principles to it.

3 Roles in adult safeguarding enquiries

Safeguarding adults enquiries will often involve collaboration by a significant number of people who may be in a number of different organisations. It can be helpful to have a shared language to describe who does what. The Board has adopted the following terms to describe key roles in adult safeguarding enquiries where Surrey County Council has the duty under section 42 of the Care Act.
These terms relate to roles in an enquiry, and are not job titles.

3.1 Safeguarding Adults Enquiry Decision Maker ('SAD')

This is the person with responsibility for making the decisions required by s42 Care Act on behalf of the local authority, which are

- Is there a duty to have an enquiry?
- What will the enquiry consist of?
- Has the enquiry been completed?
- In light of the enquiry what actions, if any, are required and who by?

There is only one person in the SAD role at any one time, though the role may pass from one person to another as the work progresses.

3.2 Safeguarding Adults Enquiry Manager ('SAM')

This is the person who carries out day-to-day management of the adult safeguarding enquiry. This will include

- Allocating resources to enquiry
- Ensuring communication takes place and feedback is given at the end of an enquiry
- One person can act as both SAD and SAM
- In some contexts there may be an expectation that different people hold the SAD and SAM roles.
- In other settings a decision will be made case-by-case whether to have separate SAD and SAM. Indictors of when this might be useful include
    - Where the concern relates to operational work in sphere of SAM's responsibilities, and a degree of independent oversight may be required
    - Where there are risks or issues which make it useful to escalate the seniority of the person in the SAD role

If the SAD and SAM roles are held by different people

- The SAM will escalate to SAD at the key points where a decision is required that falls within section 42 of the Care Act
- At those times, the SAM will make a recommendation to SAD on the decision

There is only one person in the SAM role at any one time, though the role may pass from one person to another as the work progresses.

3.3 Lead Enquiry Office ('LEO')

The Lead Enquiry Officer leads the carrying out of an adult safeguarding enquiry
Their tasks in this are

- Applying "Making Safeguarding Personal" objectives
- Ensuring communication happens
- Implement enquiry plan
- Coordinate contributions from others
- Produce an enquiry report that brings together information from all sources and makes judgements and recommendations on the questions
    - Has there been abuse and neglect, or clear risk of these?
    - If so, why? This will include root cause analysis.
    - What actions may be needed?
- Ensuring there is appropriate record of the enquiry

There is only one person in the LEO role at any one time, though the role may pass from one person to another as the work progresses.

3.4 Safeguarding Adults Enquiry Contributor(s) ('SAEC')

This term refers to all people who contribute to Safeguarding Adults Enquiry from a range of organisations, they will

- Provide the LEO with support and information in line with the enquiry plan
- Makes use of expertise to provide LEO with planning the enquiry and with analysis, judgements and recommendations
- Ensures their own agency or service cooperates with the enquiry
- Ensures their own agency or service acts on the enquiry findings

3.5 Who undertakes these roles?

Surrey County Council's Adult Social Care policies and procedures set out how the SAD is identified for a safeguarding adult's enquiry. The SAD will identify and allocate SAM and LEO roles. The SAEC(s) will be identified during enquiry planning in partnership with relevant organisations.

4 Applying the Care Act in Surrey

The definitions below aim to clarify elements of the Care Act that can cause difficulty in practice. It may be that case law will develop on these areas, which would supersede the relevant section here.
On any given case it will fall to the organisation with the duty under section 42 of the Care Act to make the final determination of how to apply these definitions in that case.

4.1 The meaning of "care and support needs"

The Care Act says adult safeguarding duties apply to adults with care and support needs, but does not define what it means by these. Guidance from the Social Care Institute of Excellence (SCIE) can help address this, as can the regulations that accompany the Act.

4.1.1 SCIE guidance

In its "Adult safeguarding practice questions" (March 2015) SCIE wrote

"An adult with care and support needs may be:

- *an older person*
- *a person with a physical disability, a learning difficulty or a sensory impairment*
- *someone with mental health needs, including dementia or a personality disorder*
- *a person with a long-term health condition*
- *someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living.*

This is not an exhaustive list … There may be times when a person has care and support needs and is unable to protect themselves for a short, temporary period – for example, when they are in hospital under anaesthetic."

The position of the Board is that "an older person" should not be taken to mean that age alone means a person has care and support needs, but is a recognition that older people are at higher risk of some conditions that can lead to care and support needs developing.

4.1.2 The cause of the need

The Care and Support (Eligibility Criteria) Regulations 2014 say that an eligible care and support need is one that

1. Arises from or is related to a physical or mental impairment or illness;
2. Results in the adult being unable to achieve two or more of the outcomes specified in the regulations; and
3. Which has, or is likely to have, a significant impact on the adult's well-being

Items (2) and (3) relate to the degree of the need, which is not relevant to determining whether a duty arises under section 42 of the Care Act, but item (1) relates to the nature of the need.

4.1.3 The impact of the need

The regulations go on to say that care and support needs have an impact on the following outcomes:

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Managing toilet needs
- Being appropriately clothed
- Being able to make use of the home safely

- Maintaining a habitable home environment
- Developing and maintaining family or other personal relationships
- Accessing and engaging in work, training, education or volunteering
- Making use of necessary facilities or services in the local community including public transport and recreational facilities or services
- Carrying out any caring responsibilities the adult has for a child

In the context of adult safeguarding, any impact on one or more of these outcomes may be relevant. There is no threshold of it being a significant impact.

Unless and until the statutory guidance or case law say otherwise, the position of the Board is that a starting point for understanding care and support needs in the context of adult safeguarding issues is:

- The adult falls within the examples given in the SCIE guidance or has needs arising from or are related to a physical or mental impairment or illness (Care and Support (Eligibility Criteria) Regulations 2014); and
- The adult has needs which impact on one or more of the outcomes listed at 4.1.3.

4.2 The meaning of "is experiencing, or is at risk of, abuse or neglect"

Section 42 (1) (b) of the Care Act says that one of the tests to determine whether there is a duty for there to be a safeguarding adults enquiry is that the person "is experiencing, or is at risk of, abuse or neglect".

In practice, some difficulties can arise because this is written in the present tense. For example a concern may arise that a person is at risk of abuse, and a decision is made to refer this to the local authority. In the time taken to pass the concern to the local authority, and for the concern to reach the appropriate decision maker in the local authority, the circumstances may have changed. For example, the person may have died. The person in the local authority making a decision whether there must be an adult safeguarding enquiry faces a dilemma.

- Should they apply the test in s42 as per the circumstances on the day the concern arose, in which case the test is met
- Should they apply the test in s42 as per the circumstances today, in which case the test is not met

The position of the Board is:

- Unless and until there is case law that clarifies this, there will be uncertainty on this matter and a need for sound professional judgement
- The starting point should be that if the tests in s42(1) were met at any point during the period from when the abuse occurred or the risk of it arose to when the decision is being made then the presumption should be that there will be an adult safeguarding enquiry
- Factors that would strengthen this presumption might include there being risks to other adults with care and support needs, there being some public interest in the

matter leading to an adult safeguarding enquiry, and an adult safeguarding enquiry being likely to promote public confidence in the services involved
- Factors that may lead to a reversal of the presumption might include that there were no apparent risks to others, no questions to be addressed about the actions of any agencies involved, or if there was going to be another process that might provide sufficient scrutiny such as a Safeguarding Adults Review, taking account that the aims of an Enquiry and Review are different.

4.3 The meaning of "at risk of abuse or neglect"

The position of the Board is that, in applying section 42 of the Care Act in Surrey, "risk" means some clear and present risk. It must be more than simply a theoretical risk.

4.4 The meaning of "unable to protect himself or herself"

For the duty to have an adult safeguarding enquiry to apply, the person with care and support needs must be unable to protect himself or herself against the abuse and neglect because of the care and support needs they have.
This requires there to be a causal link between the care and support needs and the inability to protect themselves.

4.5 Consent and adult safeguarding concerns

The Care Act does not require consent for adult safeguarding work, so absence of consent is not a barrier to such work. However, the person should be informed before referring an adult safeguarding concern to the local authority, unless to do so creates disproportionate risk.
There is a link between sections 42, 9 and 11 of the Care Act 2014 which has an implication on this matter.

- Section 42 relates to when there is a duty on the local authority to ensure there is an adult safeguarding enquiry. One of the tests is that the person must have care and support needs. There is no requirement for the person to consent for the enquiry duty to be met.
- Section 9 relates to the duty on the local authority to assess the care and support needs of a person. The test is that there is a reasonable belief that the person has care and support needs, therefore people falling under section 42 of the Care Act will also fall under section 9 of that Act.
- Section 11 says that adults can decline to have their care and support needs assessed except when
    - They lack the mental capacity to make that decision and the local authority believes the assessment is in their best interests; or
    - Where there is a concern that the person is experiencing or is at risk of abuse or neglect

This means that where there is a requirement for there to be an adult safeguarding enquiry, there is likely to be a requirement for the local authority to assess the person's care and support needs, and the person cannot decline this assessment due to the concern that they are experiencing or at risk of abuse or neglect.

Also, it should be noted that section 11 does not require the person to be unable to protect themselves Section 9 and 11 of the Care Act 2014 can apply to a person with care and support needs who is experiencing or at risk of neglect but who does not fall within s42 Care Act because they are able to protect themselves. In such a case, the duty to assess the person's care and support needs applies, but the duty for there to be an adult safeguarding enquiry does not.

Paragraph 6.20 of the guidance says

> *"An adult with possible care and support needs or a carer may choose to refuse to have an assessment. The person may choose not to have an assessment because they do not feel that they need care or they may not want local authority support. In such circumstances local authorities are not required to carry out an assessment. However, where the local authority identifies that an adult lacks mental capacity and that carrying out a needs assessment would be in the adult's best interests, the local authority is required to do so. The same applies where the local authorities identifies that an adult is experiencing, or is at risk of experiencing, abuse or neglect. Where the adult who is or is at risk of abuse or neglect has capacity and is still refusing an assessment, local authorities must undertake an assessment so far as possible and document this. They should continue to keep in contact with the adult and carry out an assessment if the adult changes their mind, and asks them to do so."*

4.6 Requirement to report concerns

4.6.1 Paragraph 14.43 of the guidance says

> *"No professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. If a professional has concerns about the adult's welfare and believes they are suffering or likely to suffer abuse or neglect, then they should share the information with the local authority and, or, the police if they believe or suspect that a crime has been committed."*

Paragraphs 14.199 – 200 of the guidance say

> *"It is not for front line staff to second-guess the outcome of an enquiry in deciding whether or not to share their concerns. There should be effective and well-publicised ways of escalating concerns where immediate line managers do not take action in response to a concern being raised.*
>
> *Concerns about abuse or neglect must be reported whatever the source of harm is. It is imperative that poor or neglectful care is brought to the immediate attention of managers and responded to swiftly, including ensuring immediate safety and well-being of the adult."*

The Board's position is that in combination these provisions show it is the policy of central government that adult safeguarding concerns should be referred to the local authority irrespective of whether the person has consented to this or not, though that does not mean that consent should not be sought, and the person should be told that a referral may be made even without their consent.

This can raise complex legal, ethical and practice issues where a person does not consent to these processes which may have to proceed irrespective of their consent, and guidance

may need to be sought from adult safeguarding specialists within the organisation or the local authority.

If there is adult safeguarding work to be done though the person is not consenting to it, this does not overturn the expectation that the work itself is done in line with person-centred principles and in line with Making Safeguarding Personal.

4.7 The meaning of "adult safeguarding enquiry" and "Safeguarding or Protection Plan"

The duty under s42 Care Act 2014 requires the local authority to

- Determine if the person is one that the duty applies to;
- Make, or cause to be made, whatever enquiries it thinks are necessary; and
- Decide whether any action should be taken and, if so, what and by whom

An adult safeguarding enquiry is the aggregation of the separate strands that make up whatever enquiries the local authority thinks are necessary.
The Safeguarding Plan or Protection Plan (the statutory guidance uses both terms interchangeably) is made up of the actions the local authority decide should be taken.

In Surrey we shall use the terms

- "**Enquiry Plan**" to mean the plan for the enquiries that the local authority will make or cause to be made
- "**Safeguarding Plan**" to mean the plan for the actions the local authority decides should be taken as a result of an adult safeguarding enquiry

4.8 Powers to carry out an adult safeguarding enquiry

S42 Care Act 2014 does not create powers to undertake the enquiry so the local authority, and any other partner involved with the case, will need to determine for themselves what powers and duties they are exercising when making enquiries or carrying out actions.
As noted above, for the local authority some or all of the enquiries it makes as part of an adult safeguarding enquiry will be carried out under s9 of the Care Act.

4.9 Duty to cooperate

Where the local authority makes a request of another organisation to make enquiries as part of an adult safeguarding enquiry, or to carry out an action as part of a Safeguarding Plan arising from an adult safeguarding enquiry, and that other organisation is a "Relevant Partner" as per s6 Care Act 2014, then the request should be treated as a request for co-operation under s7 Care Act 2014.

The partner organisation must comply with the request unless it considers that doing so

- would be incompatible with its own duties, or
- would otherwise have an adverse effect on the exercise of its functions.

If a Relevant Partner decides not to comply with such a request it must give the person who made the request written reasons for the decision.

5 Applying the Care and Support statutory guidance in Surrey

5.1 Self-neglect

The Care and Support statutory guidance gives leeway as to whether concerns regarding self-neglect and hoarding should lead to an adult safeguarding enquiry under section 42 of the Care Act. This will be a matter for professional judgment case-by-case.

Where a situation is presented as a matter of self-neglect, consideration should be given as to whether or not there is also a concern about some other form of abuse or neglect present. If there is, then the situation may meet the section 42 Care Act threshold on the basis of those other issues alone. Factors which sometimes can occur alongside self-neglect include

- There is a concern that there have been failures by agencies or professionals to work together to assess and manage risks effectively
- The person is at risk because care or access to facilities is being prevented by another person

In Surrey, the starting point will be an assumption that an adult safeguarding enquiry is not the best response to a concern about self-neglect or hoarding. However, this assumption can be overturned by the person in the role of SAD if they are of the view that a safeguarding adults enquiry is the most effective way of addressing the issues.

Conditions that make it more likely to overturn this assumption on a particular case include, but are not limited to the presence of factors such as

- There is a concern that the person is unable to protect themselves by controlling their own behaviour
- The person lacks mental capacity and is unable to understand the risks and control the situation.
- Self-neglect where there is significant risk associated with
    - Wellbeing is affected on a daily basis
    - Care, treatment or some other intervention is being refused
    - The person refuses to engage with necessary services
    - Hygiene is poor and causing other risks such as skin problems
    - Hoarding where there is significant risk associated with a risk of fire
    - Urgent health and safety risks
    - Pending enforcement action creating risk of losing home
    - A vulnerable person living where facilities have been disconnected

5.2 Carers and adult safeguarding

Section 42 of the Care Act 2014 applied only to adults with care and support needs. For the purposes of the Care Act, carers are people with support needs and so are not covered under section 42 of the Care Act.

Where there is a concern about a carer being at risk of abuse and neglect, the matter should be responded to as set out in paragraph 14.48 of the Care and Support statutory guidance. There will be exceptions in those cases where a person in a caring role

happens to also have their own care and support needs and the tests in s42 of the Care Act are met in regard to that person.

5.3 Care and support needs in particular contexts

The guidance says that abuse and neglect includes people who are victims of sexual exploitation, domestic abuse and modern slavery. In its "Adult safeguarding practice questions" (March 2015) SCIE wrote

> *"These are all largely criminal matters, however, and safeguarding duties would not be an alternative to police involvement, and would only be applicable at all where a person has care and support needs that mean that they are not able to protect themselves."*

5.4 Understanding the prevalence of abuse and neglect

The guidance says that each Safeguarding Adults Board should

> *"establish ways of analysing and interrogating data on safeguarding notifications that increase the SAB's understanding of prevalence of abuse and neglect locally that builds up a picture over time" (Care and Support statutory guidance, paragraph 14.139)*

This will require those undertaking adult safeguarding enquiries in Surrey to consider within those enquiries whether the facts established show that the person experienced or was at risk of abuse or neglect, and that there are recording systems in place that can capture this information and supply it to the Board to inform practice and learning.

6 Making Safeguarding Personal

The Board are committed to the Making Safeguarding Personal approach which means adult safeguarding work that

- is person-led
- is outcome-focused
- engages the person and enhances involvement, choice and control
- improves quality of life, wellbeing and safety

The Board are committed to delivering Making Safeguarding Personal by applying the principles of adult safeguarding set out in the guidance:

- **Empowerment**. We ask people what outcomes they want as a result of the safeguarding adults process and these directly inform what happens. This means all staff and professionals from all organisations will routinely ask people about outcomes at the point of concern and record this information. This is recorded and analysed so that the safeguarding adults board can see the extent of partner engagement in Making Safeguarding Personal and mobilise advice and support where this is needed.

- **Protection**. We help and support people to report abuse. We support people to be involved in the safeguarding adults process to the extent to which the adult wants.
- **Prevention**. We can effectively identify and appropriately respond to signs of abuse and suspected criminal offences and take action before harm occurs. We make everyone aware, through provision of appropriate training and guidance, of how to recognise signs and take any appropriate action to prevent abuse occurring.
- **Proportionality**. We work in the best interests of the adult and undertake the least intrusive response appropriate to the risk that is presented.
- **Partnership**. We will work together to place the welfare of individuals above organisational boundaries. We have effective local information-sharing and multi-agency partnership arrangements in place and staff understand these.
- **Accountability**. The roles of the agencies are clear, together with the lines of accountability. Staff understand what is expected of them and others. Agencies recognise their responsibilities to each other, act upon them and accept collective responsibility for safeguarding arrangements.

7 The use of language in safeguarding adults work

The ways we talk about abuse and neglect have an impact on how effective our response to safeguarding concerns will be.

- The way we use language can shape the way we think about things. Some ways of expressing things will help us think about matters in more useful ways than others.
- The language we use may have connotations for others that we don't intend, and which creates barriers.
- Inconsistent use of language across organisations can lead to confusion, misunderstanding and can be the cause of failings in safeguarding work.

Here are some examples of how the language we use about safeguarding adults matters can be unhelpful, and what can be done differently.

7.1 Using "safeguarding" as a stand-alone noun

7.1.1 Examples

- "We have had four safeguardings this week"
- "This is not a safeguarding"

7.1.2 What effect this has

Using the word "safeguarding" in this way can lead to miscommunication. It can be used to refer to

- A safeguarding concern, about which a decision is needed as to whether there will be a safeguarding enquiry
- A safeguarding enquiry
- An instance of abuse or neglect

Using the same words to describe different things will lead to miscommunication. One person will understand a phrase to mean one thing and someone else will understand it to mean another. It is possible, likely even, that they won't realise they mean two different things, and there can be unintended consequences.

An example can illustrate this:

- A person has a worry about abuse and neglect: there is a safeguarding concern.
- On looking into the matter, it is established there hasn't been any abuse or neglect.
- The person who looked into it says "This is not a safeguarding", by which they meant there wasn't evidence that a person has experienced or has been put at risk of abuse or neglect.
- The meaning the person who had the concern takes from this hears "This is not a safeguarding" is that they were mistaken to have raised the concern. They remember this the next time a concern arises, which causes them to fail to take the action they should.

7.1.3 What to say instead

- "We have received four safeguarding concerns this week"
- "This safeguarding concern won't lead to a safeguarding enquiry"

7.2 "Against"

7.2.1 Examples

- "We've had a safeguarding concern against us"
- "There have been five safeguarding referrals against this care home this year"

7.2.2 What effect this has

Talking this way sets up safeguarding enquiries as oppositional and confrontational, when what is needed is a collaborative approach. To say a safeguarding concern is "against" suggests the existence of the concern is problematic, whereas safe, vigilant systems should recognise and act on concerns.

7.2.3 What to say instead

- "There is a safeguarding concern about …"
- "There have been five safeguarding concerns regarding this care home this year"

7.3 Using quasi-judicial language

7.3.1 Examples

- "I carried out a disclosure interview" (when said by a Social Worker)
- "the evidence tells us"

7.3.2 What effect this has

It can be off-putting for the person at risk and their friends and family. It can get in the way of collaborative working.

Language like this can give the impression that the local authority has powers that it does not have, or the safeguarding adults enquiry has a status that is does not have. It can escalate the emotional temperature, which can have the perverse consequence of people doing less than they should as they fear the consequences of doing something wrong as they perceive the stakes to be high.

7.3.3 What to say instead

- "I spoke with the person"
- "The information gathered during the enquiry shows …"

7.4 Confusing findings with outcomes

7.4.1 Example

"The outcome of the enquiry is 'substantiated'"

7.4.2 What effect this has

An enquiry may make a finding of whether or not there was abuse or neglect, or the risk of these. But this is not the same as the outcome. The key outcomes for a safeguarding enquiry are whether or not it has achieved what the person at risk wanted from the process.

7.4.3 What to say instead

"The information gathered during the enquiry shows that there had been abuse. The person at risk said at the beginning of the process that the outcomes they wanted were for the abuse to stop, and for them to be able to report the matter to the police. Both of these have happened."

7.5 "Alert" or "Concern"

Before the Care Act came in to force in April 2015 it was commonplace to talk of adult safeguarding alerts. The Care and Support statutory guidance introduced the term "concern". In Surrey we use the term "concern" in preference to "alert" and defined and adult safeguarding concern as

> "any concern that an adult is experiencing, or is at risk of, abuse or neglect which they are unable to protect themselves from because of their care and support needs."

7.6 "Allegation", a "concern about the quality of care or practice", and a "complaint"

Paragraph 14.120 of the guidance requires adult safeguarding policies to make a clear distinction between an allegation, a concern about the quality of care or practice or a complaint. In Surrey we take these to mean

- An allegation: This is a safeguarding concern relating to a staff member or volunteer as the source of the risk

- A concern about the quality of care or practice: This can arise when someone has experienced or seen poor care
- A complaint: This is an expression of dissatisfaction from someone using services or their representative

A single issue may fall in to more than one category. Where there is an adult safeguarding concern, an adult safeguarding enquiry can be an effective means of coordinating the different strands.

7.7 Safeguarding Adults Work and Safeguarding Adults Enquiries

The term “Safeguarding Adults Enquiry” is often used interchangeably to refer to either

- the phase of the work related to the task in s42 of the Care Act 2014 of Surrey County Council to “make (or cause to be made) whatever enquiries it thinks necessary”; or
- the totality of the response by the County Council to an adult safeguarding concern

This can cause confusion in practice as, for example, “ending the enquiry” can be taken to mean both completing one phase of the work or the completion of all the work.

To avoid confusion, in Surrey we will distinguish between

- A piece of **adult safeguarding work**: This is the totality of the work in response to an adult safeguarding concern. It will involve deciding if an adult safeguarding enquiry is required, planning that enquiry, carrying it out and, on completion of the enquiry, deciding if a Safeguarding Plan is needed and, if so, what it will say;
- An **adult safeguarding enquiry**: The enquiry phase of a piece of adult safeguarding work which does the work of establishing the facts, ascertaining the wishes of the adult and assessing their needs

8 Natural justice and safeguarding adults

The Board is committed to applying the principles of natural justice to the responses to adult safeguarding adults, in particular the principles that

- No-one should be judge in their own cause: There should be no actual bias, or the appearance of possible bias. This is sometimes summed up as “Justice must not only be done, but must be seen to be done”
- Hear the other party too: No-one should be judged without a fair process, in which they get to hear and respond to the evidence against them

In most instances it will be straightforward to ensure these principles are taken into account of when planning the safeguarding enquiry. This would be done by making sure that:

- The enquiry is carried out by someone who will not be seen by others as possibly being biased. There should not be any concern that their actions, non-actions or decisions may have contributed to any actual or risk of abuse or neglect that the enquiry is considering

- The person or organisation that may have caused the abuse or neglect, or created the risk of these, is properly involved in the enquiry. Unless there are good enough reasons not to, they should know what the concern about them is, and they should be given reasonable opportunities to give their account. This might involve them having support or advocacy to do this. The planning of the enquiry from the earliest stages should take account of how this will be done.

9 The Mental Capacity Act in adult safeguarding work

Consideration should be given to whether the person can make a decision about "what should I do to protect myself from the abuse or neglect, or the risk of these that I am facing". If there is a belief that they may not be able to then an assessment of capacity and, if required, a best interest decision may be required in relation to this decision in line with the requirements of the Mental Capacity Act 2005.

A best interest decision in the context of an adult safeguarding enquiry might require consultation with the person who is the source of risk, if they are required to be consulted with under section 4 of the Mental Capacity Act 2005.

Part 2: Procedure

10 Adult safeguarding policies and procedures

Paragraph 14.52 of the guidance says “In any organisation, there should be adult safeguarding policies and procedures.” The Board will produce guidance on producing adult safeguarding policies and procedures which organisations in Surrey can use either as a template for producing their own or as a tool to check their existing policies and procedures against.

11 Who needs to know about an adult safeguarding concern?

If there is an adult safeguarding concern, it should be referred to Surrey County Council’s Adult Social Care Services via the Multi-Agency Safeguarding Hub (MASH).
During office hours contact the Multi Agency Safeguarding Hub (MASH) by phone or email in the first instance, if these fail, contact can be made by fax.

- Tel: 0300 470 9100
- Email: ascmash@surreycc.gov.uk
- Fax number: 01483 519862

Out of hours:

- Call the Adult Social Care Emergency Duty Team on: 01483 517898

In an emergency:

- Dial 999 for the emergency services

If the adult is in prison or in approved premises, those services will have their own arrangements for dealing with adult safeguarding concerns and those local arrangements should be followed.

12 Responsibilities for reporting adult safeguarding concerns

The Care and Support Statutory Guidance says

“Early sharing of information is the key to providing an effective response where there are emerging concerns … To ensure effective safeguarding arrangements:

1. *All organisations must have arrangements in place which set out clearly the processes and the principles for sharing information between each other, with other professionals and the SAB; this could be via an Information Sharing Agreement to formalise the arrangements.*
2. *No professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. If a professional has concerns about the adult’s welfare and believes they are suffering or likely to suffer abuse or neglect, then they should share the information with the local authority and, or, the police if they believe or suspect that a crime has been committed.”*

(Care and Support Statutory Guidance paragraph 14.43)

And

"It is not for front line staff to second-guess the outcome of an enquiry in deciding whether or not to share their concerns. There should be effective and well-publicised ways of escalating concerns where immediate line managers do not take action in response to a concern being raised.
Concerns about abuse or neglect must be reported whatever the source of harm is. It is imperative that poor or neglectful care is brought to the immediate attention of managers and responded to swiftly, including ensuring immediate safety and well-being of the adult."

(Care and Support Statutory Guidance paragraph 14.199 - 200)

13 What happens next?

Surrey County Council's Adult Social Care Services will make a decision whether there will be an adult safeguarding enquiry. If they have reason to suspect that an adult in Surrey is experiencing, or is at risk of, abuse or neglect which they are unable to protect themselves from because of their care and support needs, then they have a duty to undertake an adult safeguarding enquiry or cause someone else to do this.

14 What is an adult safeguarding enquiry?

An enquiry is the action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place. The purpose of the enquiry is to decide whether or not the local authority or another organisation, or person, should do something to help and protect the adult.

The Care Act does not create any powers to undertake the enquiry, so the actions taken in an enquiry are simply the agencies involved using their usual processes to meet the objectives of the enquiry. It is the coordination of these activities by the local authority and their focus on the concern about abuse and neglect that distinguishes an enquiry.

The guidance says that the objectives of an enquiry are to

- establish facts
- ascertain the adult's views and wishes
- assess the needs of the adult for protection, support and redress and how they might be met
- protect from the abuse and neglect, in accordance with the wishes of the adult;
- make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect
- enable the adult to achieve resolution and recovery

A carer, family member or advocate should support the completion of the enquiry by helping the person with care and support needs communicate their wishes or views on those occasions where the person is not able to do this independently.

15 How might the objectives of the enquiry be met?

Objective	How it may be met
Establish facts	The enquiry involves • Generating hypotheses • Gathering information • Analysis of information to test hypotheses • Making a judgement about what has happened and why This will include hearing from the person or organisation thought to be the source of risk
Ascertain the adult's views and wishes	Speaking with the person or their representative Use of advocacy where appropriate
Assess the needs of the adult for protection, support and redress and how they might be met	Assessment of care and support needs under s9 Care Act 2014 Other assessments Securing redress through processes such as • Complaints processes • Criminal justice processes • Restorative justice
Protect from the abuse and neglect, in accordance with the wishes of the adult	Developing a safeguarding plan informed by the analysis and judgements made and assessment of care and support needs. Protection might include • Changes to service provision • Developing skills • Changing financial arrangements • Change of accommodation It may also include protective measures for other people that may be affected by the issue.
Make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect	Developing a safeguarding plan informed by the analysis and judgements made and assessment of care and support needs Follow-up action might include • Action by an employer • Action by a contract holder • Action by a regulator • Referral to a professional body • Application to a Court • Criminal justice process
Enable the adult to achieve resolution and recovery	Developing a safeguarding plan informed by the analysis and judgements made and assessment of care and support needs

16 Surrey Safeguarding Adults Enquiries Method (SSAEM)

The Method is intended to support good practice in adult safeguarding enquiries while enabling case-by-case flexibility about how a concern is responded to. Using the Method helps to

- Ensure enquiries are well planned in ways which help avoid confirmation bias and groupthink leading to prematurely closing lines of enquiry
- Risks are identified and managed, using standardised risk assessment tools where possible, to help avoid optimism bias

The detail of how the Method is applied in practice will be in Surrey County Council Adult Social Care's policy and procedure

16.1 Overview of the SSAEM

The Method involves four phases

1. **Decide**
    a. Manage immediate risks.
    b. Apply the s42 threshold to decide if there will be an enquiry
2. **Plan**
    a. Establish what we want to achieve
    b. Decide what the enquiry will involve
3. **Do**
    a. Carry out the enquiry
    b. Analyse what has been learned and make judgements
        i. What happened?
        ii. Why did it happen?
        iii. What do we need to do as a consequence?
4. **Review**
    a. Ensure that what needs to be done will happen
    b. Consider whether a Safeguarding Adults Review is needed

16.2 SSAME and roles in adult safeguarding work

Safeguarding Adults Decision Maker (SAD)	Safeguarding Adults Manager (SAM)	Lead Enquiry Officer (LEO)	Safeguarding Adults Enquiry Contributors (SAECs)
Decides there will be an adult safeguarding enquiry			
If no enquiry, decides what other action may be needed and / or feedback given. End of Safeguarding work.			
Decides what the enquiry will involve. Appoints a SAM	Appoints LEO and allocates resources		
	Day to day management of the enquiry	Leads the carrying out of the enquiry. Produces an enquiry report.	Provides information, advice and support.
Decides whether the enquiry is completed. If it is, decides if a Safeguarding Plan is required and if so, whether any review process is needed for that plan.	Implements Safeguarding Plan.	Implements Safeguarding Plan.	Implements Safeguarding Plan.
Decides if a referral to the SSAB for a Safeguarding Adults Review (SAR) is needed.			
End of Adult Safeguarding work.			

General Process for adult safeguarding work

Key:

Decide
Plan
Do
Review

17 Timeliness

The “Decide” phase should be completed by the end of the next working day after the adult safeguarding concern was referred to the local authority

The “Plan” phase should result in an initial plan immediately after a decision has been made that there is a duty for a section 42 enquiry. The planning phase itself may need to last longer if there are iterations of the plan needed, such as following consultation with the adult with care and support needs

The timescales for the “Do” and “Review” phases will be decided on a case-by-case basis as part of the “Plan” phase. However, a model of what the proportion of concerns will lead to work taking a particular length of time can be derived and can be used to monitor timeliness.

Weeks since concern	Proportion of cases open at end of period
0	100%
4	50%
8	40%
12	30%
16	25%
20	20%
24	15%
28	12%
32	10%
36	7%
40	5%
44	3%
48	1%
52	0%

17.1 Monitoring timeliness

All partner agencies should have processes in place to monitor that they are taking actions on Enquiry Plans and Safeguarding Plans to the expected timescales, and to take action when these are being missed.

This monitoring should be at individual case level and at aggregated performance level across organisations.

Organisations that manage adult safeguarding enquiries should have systems that allow them to report on reasons for delays and which organisations involved in the work are responsible for these.

17.2 Principle of "No delay"

Where there is risk of harm or abuse, swift action must be taken and an effective response made. If it appears that the person is experiencing, or at risk of, abuse or neglect, a safeguarding enquiry must be carried out to determine with the person what action, if any, is necessary and by whom. This procedure adopts the principle of 'No delay' so that the safeguarding response is made in a timely fashion with due consideration to the level of presenting risk. In practice, this means that the pace of the process is determined by presenting circumstances and professional judgments about risk. Decisions about timeliness should take account of a range of factors such as the degree of risk, complexity of the case or to work in a way that is consistent with the needs and wishes of the adult.

18 Who carries out the enquiry?

The planning phase will identify who will do what. Where existing processes are being used to form all or part of the enquiry it may be clear who the owner of those processes is and therefore who will take those actions.

While Surrey County Council can cause an enquiry to be undertaken by others it cannot delegate this function entirely. The overall decision making, or the need to ensure the enquiries and actions have been undertaken, remains with the council. The council will be responsible for ensuring that when it causes an enquiry, or part of an enquiry, it is referred to the right place and is acted upon. This will include:

- clearly communicating the request to complete an enquiry, or part of an enquiry, to an accountable person in the organisation, including an explanation of why they are best placed to do this
- being satisfied that the organisation undertaking the enquiry is competent to do so and that there is no conflict of interest in this organisation (or person) undertaking this role
- confirming the legal context of the request, including the statutory nature of the duty to co-operate under S6 or section 7 of the Care Act if relevant, and the duty of candour under S81 of the Care Act 2014
- agreeing the timescale within which the enquiry should be completed
- agreeing the actions that should be undertaken
- confirming how the enquiry outcomes will be fed back to the council, and who to
- recording the actions agreed

18.1 Adult safeguarding enquiries in regulated services

The Care and Support statutory guidance says, in relation to adult safeguarding enquiries in regulated services, that

> *"The employer should investigate any concern (and provide any additional support that the adult may need) unless there is compelling reason why it is inappropriate or unsafe to do this. For example, this could be a serious conflict of interest on the part of the employer, concerns having been raised about non-effective past enquiries or serious, multiple concerns, or a matter that requires investigation by the police."*

(Care and Support statutory guidance, paragraph 14.70)

18.2 Responsibilities of Surrey County Council

If Surrey County Council causes enquiries to be made by asking another organisation to contribute to some or all of the actions on an Enquiry Plan then it must monitor that those actions are completed on schedule and address this with that organisation if they are not

When the actions are completed Surrey County Council must satisfy itself the process used and the outcome of that work is satisfactory. If it is not it must either

- Request that organisation to remedy the situation; or
- Take on the actions itself

18.3 Fairness, independence and natural justice

Where an adult safeguarding concern relates to risks of abuse or neglect within a service provision, getting the balance right of the responsibility of that service to respond to the concerns against the need to have due rigour and independence of the enquiry.

The Care and Support statutory guidance sets out some expectations for when this arises in regard to regulated health and social care settings, which can apply in other settings. It says

> "The employer should investigate any concern (and provide any additional support that the adult may need) unless there is compelling reason why it is inappropriate or unsafe to do this.
>
> For example, this could be
>
> - a serious conflict of interest on the part of the employer,
> - concerns having been raised about non-effective past enquiries or
> - serious, multiple concerns, or
> - a matter that requires investigation by the police."
>
> (Care and Support statutory guidance, paragraph 14.70)

The local authority has to take in to account natural justice principles when deciding who will carry out the enquiries that contribute to a s42 Care Act enquiry. Particular weight should be given on this matter to the views of the adult or their representative, and the person or organisation that may be the source of risk. In doing so, they might consider

- In applying the "No-one should be judge in their own cause" principle, whether the arrangements would result in actual bias, or the appearance of possible bias
- In applying the "Hear the other party too" principle, whether those with an interest in the matter will consider that the arrangements proposed amount to a fair process.

The local authority, when deciding how the enquiry should be carried out, should be mindful of not using too high a threshold when determining what might amount to a "compelling reason". Some local authorities have come in for criticism for doing so. For example

- A Safeguarding Adults Review was critical of a local authority that asked a care home to carry out enquiries when a person living there was seriously injured. The

local authority did not ensure that the police investigated and asked the Area Manager for the care home provider to enquire into the matter. The Area Manager delegated this to the manager of the care home where the injury happened, and the local authority did not challenge this.

- A patient in an NHS hospital died in circumstances where there may have been abuse or neglect. The local authority asked the Hospital Trust to use its Serious Incident process as the way of carrying out the adult safeguarding enquiry. A Coroner's Court was critical of a local authority for not ensuring that the Serious Incident investigation was carried out by someone independent of the Trust

If there are concerns over these issues, ways of addressing them might include

- Resolution through negotiation between the parties involved. If this is problematic it may need escalation within or between any organisations involved;
- Where the matter involves organisations that are "Relevant Partners" as per s6 of the Care Act 2014, the local authority may make the request to the other organisation under s7 of the Care Act which places the other party under some obligations about their response to the request;
- The matter may need to be drawn to the attention of Surrey Safeguarding Adults Board

19 The Safeguarding Plan

If, at the conclusion of the enquiry, the SAD has decided that actions are required these will form the Safeguarding Plan.
The purpose of a Safeguarding Adults Plan is to formalise and coordinate the range of actions to protect the adult and to support them to recover from the experience of abuse or neglect. Safeguarding Adults Plans should be individual, person-centred and outcome-focused and should set out:

- what steps are to be taken to help ensure the person's safety in future
- the provision of any support, treatment or therapy, including on-going advocacy
- any modifications needed in the way services are
- how best to support the adult through any action they take to seek justice or redress
- any ongoing risk management strategy as appropriate
- any action to be taken in relation to the person or organisation that has caused the concern

A Safeguarding Plan may not always be required. The outcome of the enquiry may be that no further steps are required, or that ongoing risks can be managed or monitored through single agency processes, for example, assessment and support planning processes, community policing responses or health service monitoring. Where no Safeguarding Plan is required, the safeguarding process will end and the agreed outcomes will be recorded.
A Safeguarding Plan is more likely to be required in the following situations:

- where the risk of abuse or neglect is ongoing, complex and unstable;
- where the risk of harm to the adult or others is significant;
- where other factors such as coercion, undue influence or duress add to the complexity and uncertainty of the risk; and
- where the risk cannot be managed appropriately or adequately by other processes

These types of situations will often require a greater level of scrutiny and review, usually within a multi-agency context.
The Safeguarding Plan will set out whether and how the provisions in the plan will be monitored and reviewed. Where monitoring or review is needed, this might be done through business-as-usual processes, or a bespoke arrangement for reviewing a particular plan. The SAD will be responsible for ensuring the Safeguarding Pan sets out the appropriate arrangements and responsibilities.

20 Ending the adult safeguarding work

Safeguarding adults work can be concluded when the SAD has decided this is appropriate such as when

- The Enquiry has been completed and no Safeguarding Plan is required
- The Safeguarding Adults Plan is no longer required because
    - The adult is no longer at risk of abuse or neglect, or
    - Risks have reduced to the level that they can adequately and appropriately be managed or monitored through single agency processes, such as assessment and support planning processes, community policing responses or health service monitoring.

21 Allegations in the workplace

This section applies to allegations about anyone working, in either a paid or unpaid capacity, with adults with care and support needs in Surrey. Where concerns are raised about someone who works with adults with care and support needs (which, for the purposes of this section, includes volunteers and students), the employer (which, for the purposes of this section, includes student body or voluntary organisation) must assess any potential risk to adults with care and support needs who use their services, and, if necessary, to take action to safeguard those adults.

Examples of such concerns could include allegations that relate to a person who works with adults with care and support needs who has:

- behaved in a way that has harmed, or may have harmed an adult or child
- possibly committed a criminal offence against, or related to, an adult or child
- behaved towards an adult or child in a way that indicates they may pose a risk of harm to adults with care and support needs

Concerns could also arise from the person's home / personal life, as well as within their work and may include situations such as:

- A person has behaved (or is alleged to have behaved) towards another adult in a way that indicates they may pose a risk of harm to adults with care and support. For example, this may include situations where a person is being investigated by the police for domestic abuse to a partner, and undertakes voluntary work with adults with care and support needs.
- A person has behaved (or is alleged to have behaved) towards children in a way that indicates that they may pose a risk of harm to adults with care and support need. For example, this may include situations where a person is alleged to have abused a child, and is a student undertaking professional training to work with adults with care and support needs.
- A person is the subject of a safeguarding enquiry into allegations of abuse or neglect which have occurred in one setting. However, there are also concerns that the person is employed, volunteers or is a student in another setting where there are adults with care and support needs who may also be at risk of harm.

When a person's conduct towards an adult may impact on their suitability to work with or continue to work with children, this must be referred to the local authority's designated officer.

21.1 Responsibilities of the employer

Organisations in Surrey that employ people who work with adults with care and support needs should

- Establish a clear internal allegations management procedure setting out the process, including timescales, for investigation and what support and advice will be available to individuals against whom allegations have been made.
    - Paragraph 14.112 of the guidance says "When a complaint or allegation has been made against a member of staff, including people employed by the adult, they should be made aware of their rights under employment legislation and any internal disciplinary procedures."
    - Where allegations have been made in relation to an employee, volunteer or student, the employer must assess the risk in the context of their service and consider appropriate risk management arrangements, taking into consideration their own internal policies and procedures and employment law. This may include actions, such as changes to their working arrangements or suspension
- Ensure their staff and managers have access to expert advice and guidance to enable them to fulfil their responsibilities when responding to allegations.
- Respond promptly to allegations regarding their staff and for undertaking all necessary action in line with their internal process and agreed timescales.
    - If the concerns involve possible criminal offences to either an adult or child, liaise with the police about the need for possible criminal investigation
    - Where the concerns involve a person working in a commissioned service, inform the relevant commissioning/contracts team.
    - If the person may pose a risk of harm to his/her own children, or other children/young people in the course of their private life, children services should be informed without delay.

    - If the person may pose a risk to children/young people in the course of their work, paid or unpaid, the Local Authority Designated Officer (LADO) should be informed without delay.
- Monitor the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.
- Ensure appropriate systems are in place to support and provide regular updates to the employee in respect of the investigation.
- Make prompt referrals to the Disclosure and Barring Service (DBS) and/or Professional Registration Bodies, as relevant.
- Ensuring appropriate recording systems are in place and that these provide a clear audit trail about the decision making process and any learning arising from the response to the allegation and subsequent actions.
- Ensuring the control of information in respect of individual cases is in accordance with accepted data protection and confidentiality requirements.
- Maintain records of the number and nature of allegations made and using this data to inform service improvement and development.

21.2 Relationship to adult safeguarding enquiries

Where the allegations are being responded to within a section 42 safeguarding enquiry, this might include:

- An assessment and management of risk posed by a 'person in a position of trust' to be considered in the initial safeguarding planning and subsequently kept under review
- Any action taken in respect of a person to be included in the safeguarding enquiry report
- Further actions to safeguard or manage risk should be included in the safeguarding plan

Where the concerns have not met the test in s42 Care Act, the process for responding to the concerns might include having discussions or convening a meeting to assess and determine the actions required to manage the risk posed by a 'person in a position of trust'. Those involved in this might include

- For the employer
    - The person's line manager
    - The organisation's safeguarding lead
    - HR and / or legal advisors
- Care Quality Commission
- Commissioners or contract managers
- Police
- LADO if there are also risks to children

The purpose is to undertake a collaborative assessment of the level of risk posed by the person about whom concerns have been raised and to clarify what actions will be taken based on an assessment of the potential or actual harm to adults or children at risk.

21.3 Responsibilities of organisations receiving information about employees of another organisation

Where an organisation is the first to learn of concerns about someone employed by another organisation who works with adults with care and support needs which indicates they may be a risk to those adults, that organisation will need to determine what, if any, information it will share with the employer.

If the information first comes to the police, they will

- Consider whether they will make a disclosure to employers under their common law disclosure powers or to any other body such as commissioners, regulators or professional registration bodies;
- Consider whether they will refer the matter to the local authority as an adult safeguarding concern

If the information first comes to Surrey County Council Adult Social Care, they will

- Consider what information, if any, they will disclose to the employer or to any other body such as commissioners, regulators or professional registration bodies;
- Consider whether there is a duty for an adult safeguarding enquiry under s42 Care Act 2014
- Liaise with the police about the need for possible criminal investigation if the concerns involve possible criminal offences to either an adult or child

If the information first comes to any other organisation, they will

- Consider what information, if any, they will disclose to the employer or to any other body such as commissioners, regulators or professional registration bodies;
- Consider whether they will refer the matter to the local authority as an adult safeguarding concern
- Liaise with the police about the need for possible criminal investigation if the concerns involve possible criminal offences to either an adult or child

21.4 Information sharing with an employer regarding allegations about their employee

Decisions on sharing information must be justifiable, proportionate and based on the potential or actual harm to adults or children at risk. The rationale for decision-making should always be recorded. When sharing information between agencies about adults, children and young people at risk it should only be shared:

- Where relevant and necessary, not simply sharing all the information held;
- With the relevant people who need all or some of the information; and
- When there is a specific need for the information to be shared at that time.

In deciding whether the information should be shared, it is necessary to consider the key question of whether the person has behaved or may have behaved, in a way that means their suitability to undertake their current role or to provide a service to adults with care and support needs should be reviewed.

Unless it puts the adult at risk or a child in danger, the person should be informed an allegation against them has been made and that it will be shared with their employer. They should be offered a right to reply.

If possible, there should be discussion with the person's consent to advise them what information will be shared, how and who with. Each case must be assessed on its own individual merits as there may be cases where informing the person about details of the allegation increases the risks to a child or adult at risk.

The person should be given the opportunity to inform their employer themselves, though sometimes the immediacy and nature of the risk won't allow for this. If they are given this opportunity, the organisation should check appropriate information has been shared with the employer to enable them to assess risk, and review the suitability of the person continuing to work and any other actions required.

21.5 Responsibilities of commissioners of services for adults with care and support needs

Commissioning organisations should build reporting requirements into their procurement, commissioning and contract arrangements to

- promote the implementation of safe working procedures, including the management of allegations, within the organisations that they commission
- ensure that provider organisations promptly share information about incidents falling within the remit of this section with their commissioners

22 NHS Serious Incidents and Safeguarding Adults Work

The coordination of serious incident investigations / safeguarding enquiries requires shared understanding of each organisations statutory and legal responsibilities, effective communication, transparency, learning and co-operation across the multi-agency safeguarding adults partnership.

Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant investigating under the Serious Incident process. Serious incidents can be isolated, single events or multiple linked or unlinked events signalling systemic failures within a commissioning or health system.

A number of events that are reported as a serious incident are often safeguarding concerns too (for example, neglect or poor care in a health setting). Whilst such incidents should always be a serious incident and reported as serious incidents they are also a safeguarding concern and a notification must also be raised in line with these procedures.

As the focus of the safeguarding enquiry is different to the Serious Incident investigation, the findings of one do not in itself determine the conclusions of the other. The Lead Enquiry Officer for the safeguarding enquiry and the lead undertaking the

serious incident investigation must plan and co-ordinate the approach and tasks within both these processes.

23 Criminal investigations and Safeguarding Adults Work

Everyone is entitled to the protection of the law and access to justice. Behaviour which amounts to abuse and neglect also often constitutes criminal offences. Effective, efficient and continual co-operation and communication between health and social care services and the police is required to understand whether criminal offences have taken place.

Communication is required in both directions:

- If the police are investigating an offence and have concerns that the victim has experienced abuse or neglect due to their care and support needs, they must ensure that the local authority are aware and have been notified. This can be done by completing an adult referral (via Single Combined Assessment of Risk Form (SCARF)) or on those occasions where immediate action is required, through direct contact with the locality team.
- If any health or social care worker notices or is made aware of unexplained injuries to an adult at risk, the police must be made aware immediately by calling 101. This will ensure all details and decisions are fully recorded and where appropriate an Investigating Officer is assigned to be part of the planning for safeguarding enquiry.

The timing of information sharing with the police is crucial in order not to miss forensic opportunities relating to a crime scene. A criminal investigation by the police takes priority over all other enquiries, although a multi-agency approach should be agreed to ensure that the interests and wishes of adults are considered throughout, even if they do not wish to provide any evidence or support a prosecution.

24 Quality of service issues and adult safeguarding concerns

The care provider needs to consider whether any incident or concern should be referred as a safeguarding concern to the Local Authority, and to other organisations such as their regulator (CQC), and commissioners. The care provider will also need to consider if it does not raise an incident/concern as a safeguarding concern how that will be recorded, and who this incident needs to be reported to.
Incident procedures cover a wide range of issues including minor incidents that may happen as a result of issues to do with practice or the quality of care provided. It is the provider manager's responsibility to ensure these are addressed proactively and effectively through internal processes and to ensure the service they provide meets the required standards of care.
Managers and staff are responsible for taking appropriate action in line with their own policy and procedures for incident reporting. This should reflect the Care Quality Commission's Compliance to Essential Standards of Quality and Safety.

Consideration should also be given, depending on the nature of the incident, as to whether it may be necessary to notify relevant parties such as relatives, or any external agencies or organisations due to contractual or regulatory requirements.
Where an incident occurs where abuse or neglect is suspected a safeguarding concern should be raised.

24.1 Missed home care visits, missed medication and medication errors

These are areas that have caused challenges to services in determining whether and how they relate to adult safeguarding enquiries.

Decision making about this has sometimes been based on issues such as degree of harm or whether they are part of a pattern. These are not relevant issues for deciding whether a matter is a safeguarding concern or whether there is a duty to have an adult safeguarding enquiry. Presence, absence or scale of harm is irrelevant in the context of s42 of the Care Act. The test in s42 applies even where there is only risk of abuse or neglect, so there does not need to be any actual harm. 14.17 and 14.18 of the Care and Support statutory guidance have neither a harm test nor a distinction between minor or major incidents. One-off incidents are specifically included.

These issues can, however, be very relevant in deciding what an adult safeguarding enquiry will involve and what actions will be required.

The expectation of the Surrey Safeguarding Adults Board is that a safeguarding concern should be raised on those occasions when it is considered the person has been at risk of abuse or neglect due to the visit being missed, medication being missed or a medication error occurring.

Where there is an adult safeguarding concern about such issues, the provider of the service should act in line with paragraphs 14.68 – 14.75 of the Care and Support statutory guidance.

The employer should review the concern against their own organisational policies and procedures and escalate to the LA where the criteria is met.

25 Safeguarding Adults Reviews

The Safeguarding Adults Review (SAR) Sub Committee of the Board is responsible for

- Reviewing requests to the Board to consider commissioning a Safeguarding Adults Review (SAR) under S44 of the Care Act 2014 and deciding whether the duty for a SAR has been met or to exercise the discretionary power to arrange for a SAR
- Setting the terms of reference and determining the method for those SARs
- Overseeing the progress of SARs
- Monitoring that recommendations from SARs and associated actions have been addressed by the multi-agency partnership and individual agencies.

- Providing assurance to SSAB on the progress of SARs that are underway and the implementation of action plans for completed SARs
- Advising SSAB on the learning from SARs carried out in other areas, and any early learning from SARs underway in Surrey that can be identified in advance of the completion of those SARs

The Chair of the SAR subgroup has discretion to take actions on behalf of the group where this is needed for matters of expediency. When doing so the Chair will make reasonable efforts to consult with members of the subgroup and the Chair of the Board before taking action.

25.1 The purpose of SARs

A SAR is a multi-agency process that considers and uses the learning that enables the Board to improve services and prevent abuse and neglect in the future. They provide an opportunity to improve inter-agency working, the sharing of best practice and ultimately better safeguarding of adults at risk of abuse and neglect. A SAR will be focused on ensuring learning and improvement of practice and is explicitly not about blaming any agency, service or individual.

Agencies will have their own internal procedures to review practice and raise standards, such as complaints, audits and serious incident investigations; a SAR is not intended to duplicate those processes, or to investigate allegations of abuse or neglect. Rather, the focus is on multi-agency learning through consideration of how agencies worked together, with the intention of improving how they do so in the future.

SARs are not enquiries into how an adult with care and support needs died or who is culpable. That is a matter for Coroners or Criminal Courts to determine, as appropriate.

25.2 Choosing the methods for a SARs

The Care Act is not prescriptive about how a SAR will be carried out. Some options for methods are set out below. This list is not exhaustive, and the SAR Sub group will use its collective experience and knowledge to recommend the most appropriate learning method of the case under consideration.

25.2.1 Traditional SCR approach

This typically involves

- Appointment of SAR panel, including chair (usually independent) and core membership which oversees process
- The Chair may take on the role of report author, or an independent report author could be appointed
- Involved agencies produce Individual Management Reports (IMRs), outlining involvement and key issues
- Chronologies of events
- Overview report with analysis, lessons learnt and recommendations
- Relevant agencies produce action plans in response to the lessons learnt
- Formal reporting to the Safeguarding Adults Board and monitoring implementation across partnerships

Advantages of this approach include

- More familiar to SAB/stakeholders, who may consider it robust and objective

Disadvantages of this approach include

- It can have considerable bureaucratic overheads
- It can involve a protracted process so implementation of lessons learnt/ recommendations not sufficiently responsive
- It can be costly, and not clear value for money
- Often experienced as punitive and attributing blame
- Frontline staff are often precluded, so disengaged from the process and subsequent learning

It may be useful

- Where public/political confidence may only be upheld via a tried and tested approach
- Where there is multiple abuse

25.2.2 Action learning approach

This option is characterised by reflective or action learning approaches, which do not seek to apportion blame, but identify both areas of good practice and those for improvement. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments.

There is flexibility within this option as to the scale and costs. The process can be adapted to the individual circumstances of the case, and the requirements and preferences of the SAR subgroup. For instance, the involvement of external agency/consultancy can vary from not at all to a full role in documentation review, staff interviews and report production.

The broad methodology is:

- Scoping of review/terms of reference: identification of key agencies/personnel, roles; timeframes for completion of the SAR and for the period being reviewed; specific areas of focus/exploration
- Appointment of facilitator and overview report author
- Production/review of relevant evidence, the prevailing procedural guidance, via chronology, summary of events and key issues from designated agencies
- Material circulated to attendees of learning event; anticipated attendees to include members from SAB; frontline staff/line managers; agency report authors; other co-opted experts (where identified); facilitator and/or overview report author
- Learning event(s) to consider what happened and why, areas of good practice, areas for improvement and lessons learnt
- Consolidation into an overview report, with analysis of key issues, lessons and recommendations
- Event to consider first draft of the overview report and action plan
- Final overview report presented to Safeguarding Adults Board, agree dissemination of learning, monitoring of implementation
- Follow up event to consider action plan recommendations
- Ongoing monitoring via the Safeguarding Adults Board

Advantages of this approach include

- There is some evidence that this approach is more efficient
- It can be a shorter process than the traditional approach so learning can be arrived at more quickly and with lower costs incurred
- Action learning approach enhances partnership working, mutual recognition of alternative partner perspectives and collaborative problem solving
- Readily allows involvement of both frontline staff/senior managers, securing both strategic and operational perspectives
- Captures the perspective of staff involved in the case, and can reflect on the systems operating at the time
- Allows for identification of system strengths/positive practice
- Learning takes place through the process which can give enhanced commitment to its dissemination

Disadvantages of this approach include

- Methodology less familiar to many

25.2.3 Peer review approach

This option is characterised by peer reviews and accords with increasing sector led reviews of practice. In this option peers can constitute professionals/agencies from within the same safeguarding partnership, for instance a Safeguarding Adults Board members or one or more agencies from another area.

Peer led reviews provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice. They can be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice. Such reviews can be cost effective and spread learning.

Although peer reviews tend to be wholly undertaken by one external team, there can be flexibility within this option regarding the balance of peer team, for instance from one authority area, to a range of different people across various agencies to maximise identified expertise.

Advantages of this approach include

- Objective, independent perspective to particular case/aspects of safeguarding practice
- Usually via trusted sources sharing common experiences/understanding
- Can be part of reciprocal arrangements across/between partnerships
- Very cost effective, usually no fees incurred

Disadvantages of this approach include

- Capacity issues within partner agencies may restrict their availability or responsiveness to engage with a peer review

When this approach may be useful

- If the SAR has been preceded by a thorough s42 enquiry, and a light touch review with a degree of independence may be proportionate

When this approach might not be useful

- Cases that are high profile or have particular sensitive issues may be better managed with local oversight

25.3 Escalation of disputes

Where appropriate/possible, the subject of the SAR, their family or representative, will be involved throughout the review process. Their views and wishes will be captured and used to inform the terms of reference for the SAR and they will be kept updated as the review progresses. Prior to the final SAR report being signed off, the subject or their family will have an opportunity to read and comment on the review.

If at any point the family disagree with the SAR, either the process employed or the findings, concerns should be raised to the Manager of Surrey Safeguarding Adults Board who will lead efforts to resolve the issue. If the matter cannot be resolved the Manager of the Board will raise this with the Chair of the Board.

25.4 Relationship to other processes

It may be necessary to consider whether the circumstances that led to the Safeguarding Adults Enquiry also might lead to other investigations and reviews. This might include:

- Criminal and Coroner's Investigation:
- Serious Case Reviews concerning children
- Domestic Homicide Reviews
- Mental Health Homicide Review
- MAPPA Serious Case Review
- NHS Serious Incident investigation

The planning of the enquiry should ensure it works with these other processes to minimise duplication and maximise effectiveness and to ensure it does not prejudice criminal or judicial proceedings. For example, where there is also a Coroner's Inquest to take place the enquiry should not address the issue of cause of death.

25.5 The importance of sharing learning

One of the core roles of the SAB is to ensure that safeguarding practice is continuously improving and enhancing the life of adults with care and support needs. This is done by reviewing practices and sharing the learning from safeguarding enquiries and safeguarding adult reviews. The purpose of SARs is described very clearly in the statutory guidance as to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

26 Non-recent abuse allegations

The framework for the response to non-recent abuse allegations will depend on the age of the person at the time of the abuse or neglect.

26.1 If the person was under 18 years old

The response by all agencies to allegations by an adult of abuse experienced as a child must be of as high a standard as a response to allegations of current abuse because:

- There is a significant likelihood that a person who abused a child in the past will have continued and may still be doing so;
- Criminal prosecution remains a possibility, if sufficient evidence can be carefully collated;
- Any potential victims should have the opportunity to be listened to.

An adult safeguarding enquiry cannot be used as the response to abuse that occurred when the person was under 18 years old. The framework for the response will be the Surrey Safeguarding Children Partnership Procedures.

If the person has care and support needs today arising from their experience of abuse as a child there may be a role for health, social care or other services to respond to these. If the person experienced abuse in Surrey but now lives elsewhere, it may be the services in that area are the ones that would provide the support they need.

26.2 If the person was 18 years old or over

An adult safeguarding response will be appropriate, unless the concerns have already been looked in to.

If the concerns have already been looked in to and the person is dissatisfied with the response to those concerns this should be brought to the attention of the person responsible for managing the service that gave the response, who can consider if there is any action required such as use of a complaints process.

27 Prisons and approved premises

27.1 Adult safeguarding in prisons and approved premises under the Care Act 2014

Section 42 of the Care Act 2014 says it is the duty of the local authority where the adult with care and support need is to determine

- Whether the duty to have an adult safeguarding enquiry has been met
- If so, what that enquiry will involve
- At the completion of that enquiry what actions, if any, are required and who by

The Care and Support statutory guidance says

> "Local authority statutory adult safeguarding duties apply equally to those adults with care and support needs regardless of whether those needs are being met, regardless of whether the adult lacks mental capacity or not, and regardless of setting, other than prisons and approved premises where prison governors and National Offender Management Service (NOMS) respectively have responsibility. However, senior representatives of those services may sit on the Safeguarding Adults Board and play an important role in the strategic development of adult safeguarding locally. Additionally, they may ask for advice from the local authority when faced with a safeguarding issue that they are finding particularly challenging." (Care and Support statutory guidance, paragraph 14.6)

27.2 Prisons and Safeguarding Adults Boards

Many of the systems and processes used by prisons are standardised ones that prisons are required to use nationally. These do not reflect the Care Act arrangements which means

- Prisons will not have stand-alone processes for undertaking adult safeguarding enquiries. Their usual process for responding to incidents and issues will be the vehicle for meeting the objectives of adult safeguarding enquiries.
- The recording and reporting systems for these processes have not been designed to identify when the prisoner concerned has care and support needs, so it is not possible for prisons to report on their adult safeguarding activity in an analogous way to local authorities

This creates a particular set of challenges for prisons when giving assurance to Safeguarding Adults Boards about their adult safeguarding work. Unless and until the national systems change, it will be a matter of best endeavours using the current systems.

27.3 Assurance to the Board

Surrey Safeguarding Adults Board will agree arrangements with the prisons in Surrey on how they will give assurance to the Board about their adult safeguarding work.

28 Information Sharing

Information sharing is a necessary part of effective safeguarding but it is acknowledged that the landscape and decision making can be complex. Privacy law does not prevent the sharing of information, but rather sets out a legal expectation in how it must be conducted. There will be a significant number of circumstance within Safeguarding Processes when private and confidential information may and should be shared. The Care Act 2014 emphasises the need to empower people, to balance choice and control for individuals against preventing harm and reducing risk, and to respond proportionately to safeguarding concerns.

The Fifth Caldicott Principle states everyone with access to personal confidential data should be aware of their responsibilities whilst the Seventh makes clear that the duty to share information can be as important as the duty to protect confidentiality.

When sharing people's information, recognise that:

- Health and social care organisations should apply the Caldicott principles when using personal confidential data in the context of adult safeguarding work. The Fifth Caldicott Principle states everyone with access to personal confidential data should be aware of their responsibilities whilst the Seventh makes clear that the duty to share information can be as important as the duty to protect confidentiality.
- Adults have a general right to independence, choice and self-determination including control over information about themselves and their privacy. In the context of adult safeguarding these rights can be overridden in certain circumstances.
- Emergency or life-threatening situations may warrant the sharing of relevant information with the relevant emergency services without consent

- The law does not prevent the sharing of sensitive, personal information within organisations. If the information is confidential, but there is a safeguarding concern, sharing it may be justified
- The law does not prevent the sharing of sensitive, personal information between organisations where the public interest served outweighs the public interest served by protecting confidentiality – for example, where a serious crime may be prevented
- The General Data Protection Regulation sets out a framework to enable the lawful sharing of information.
- There should be a local agreements or protocols in place setting out the processes and principles for sharing information between agencies
- An individual employee cannot give a personal assurance of confidentiality
- Frontline staff and volunteers should always report safeguarding concerns in line with their organisation's policy. This is usually to their line manager in the first instance except in emergency situations
- It is good practice to try to gain the person's consent to share information, but only where this is relevant. Under the General Data Protection Regulations consent will not likely be the legal basis for processing information by public authorities but is an important mechanism of empowering people with choice and control.
- As long as it does not increase risk, practitioners should inform the person if they need to share their information without consent
- Organisational policies should have clear routes for escalation where a member of staff feels a manager has not responded appropriately to a safeguarding concern
- All agencies must have a whistleblowing policy
- The management interests of an organisation should not override the need to share information to safeguard adults at risk of abuse
- All staff, in all partner agencies, should understand the importance of sharing safeguarding information and the potential risks of not sharing it
- All staff should understand when to refer an adult safeguarding concern to the relevant local authority
- The six safeguarding principles should underpin all safeguarding practice, including information sharing.

28.1 Setting expectations before there is a concern

Many potential information sharing problems can be avoided by being open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

28.2 Referring to the Disclosure and Barring Service

The Safeguarding Vulnerable Groups Act (2006) places specific duties on those providing 'regulated' health and social care activities. They must refer to the Disclosure and Barring Service (DBS) anyone who has been dismissed or removed from their role because they are thought to have harmed, or pose a risk of harm to, a child or

adult with care and support needs. This applies even if they have left their job and regardless of whether they have been convicted of a related crime. The DBS has powers to require information to be shared with it.

28.3 Professional codes of practice

Many professionals, including those in health and social care, are registered with a body and governed by a code of practice or conduct. These codes often require those professionals to report any safeguarding concerns in line with legislation. The statutory guidance to the Care Act 2014 requires all organisations in contact with people with care and support needs to have in place an allegations management process that enables referrals of individual employees to regulatory bodies are made promptly and appropriately.

The Health Care Professions Council (HCPC) is the Professional Body that regulates social workers and allied health professionals. HCPC professional standards were amended in Jan 2016 to require all those registered with that body to comply with a professional DUTY to take appropriate action to address and report concerns about safety or wellbeing of people using services, follow up concerns and be open and honest if things go wrong.

28.4 Duty of Candour

The Duty of Candour requires all health and adult social care providers registered with CQC to be open with people when things go wrong. The regulations impose a specific and detailed duty on all providers where any harm to a service user from their care or treatment is above a certain harm threshold.

The Duty of Candour is a legal requirement and CQC will be able to take enforcement action when it finds breaches. The Duty requires providers to offer an apology and state what further action the provider intends to take in this situation. In practice, this means that care providers are open and honest with patients when things go wrong with their care and treatment.

If the provider fails to comply with the Duty, CQC can move directly to prosecution without first serving a warning notice. This policy embraces this Duty in relation to safeguarding adults, and all Section 42 enquiries and safeguarding processes where this is relevant should involve checking that this Duty has been fulfilled.

The regulations also include a more general obligation on CQC registered providers to "act in an open and transparent way in relation to service user care and treatment". This means that the default position should be to be open, honest and candid, unless there are justifiable reasons for not being so – for example because the service user actively says that they do not want further information about the incident. However, these circumstances should be the exception rather than the norm.

28.5 Commissioners

Those commissioning services should consider whether contracts should place an obligation on service providers to share safeguarding information. Any specifications would need to be in line with policy, regulation and the law.

29 Appendix 1 Pressure Ulcers and Adult Safeguarding Enquiries

29.1 Using professional judgement

The Decision Guide assessment process should not be a barrier to referring adult safeguarding concerns to the local authority. If a professional makes a judgement that the tests in s42 of the Care Act have been met then the matter ought to be referred to the local authority irrespective of the outcome of a Decision Guide assessment, or whether a Decision Guide assessment has been completed or not.
In exercising professional judgement on this matter due regard will be given to issues such as whether there is a public or vital interest in making the referral.

29.2 Matters crossing organisations

The Pressure Ulcer Protocol says

> "If the person's care has recently been transferred, this may require contact being made with former care providers for information, to seek clarification about the cause and timing of the skin damage. This is the responsibility of the organisation raising the concern"
>
> Pressure Ulcer Protocol (2017), Department of Health, page 14

It is possible that this may cause difficulties in some cases, such as

- Health and social care providers would not want to put themselves in a position where they might be investigating one another outside of any proper framework to do so
- There may be reasonable limitations in what some organisations are able to share with others

Where problems arise because of issues cutting across organisations consideration should be given to

- Bringing forward the decision about whether a safeguarding referral should be made to the local authority, rather than spending an extended period attempting to resolve problems bilaterally
- Make a presumption to refer the safeguarding concern to the local authority on the grounds of professional judgement, irrespective of the outcome of the Decision Guide assessment

29.3 The relationship between internal investigation and s42 Care Act enquiries

The Pressure Ulcer Protocol says

> "The decision as to whether there should be a section 42 enquiry will be taken by the local authority, informed by a clinical view. A summary of the decision should be recorded and shared with all agencies involved.
> Where an internal investigation is required, this should be completed by the organisation that is taking care of the individual, such as the District nurse team lead, ward manager or nursing home manager, in line with the local policies, such as pressure ulcer or risk management policies.

> The local authority needs to decide/agree post completion of the internal investigation if a full multi-agency meeting or virtual (telephone) meeting needs to be convened to agree findings, decide on safeguarding outcome and any actions."
>
> Pressure Ulcer Protocol (2017), Department of Health, page 14

In such circumstances the internal investigation is a strand of the s42 adult safeguarding enquiry that the local authority has caused to be made by the organisation. It is not being done instead of or separate from the adult safeguarding enquiry.

29.4 Timeliness

The Pressure Ulcer Protocol says

> "The adult safeguarding decision guide should be completed immediately or within 48 hours of identifying the pressure ulcer of concern. In exceptional circumstances this timescale may be extended but the reasons for extension should be recorded."
>
> Pressure Ulcer Protocol (2017), Department of Health, page 14

In Surrey we take this to mean

- The "No Delay" principle should be applied in carrying out the Decision Guide assessment and subsequent decision whether to refer the adult safeguarding concern to the local authority
- Where practicable this should be done immediately. Where this is not possible, a decision should be reached within 48 hours (or by the end of the next working day, where there are non-working days involved)
- In considering if there are exceptional circumstances under which the timescale may be extended, there should be a presumption that it won't be extended and that where there is uncertainty the safeguarding concern should be referred to the local authority as a precautionary step

29.5 Supporting good practice in adult safeguarding enquiries

Appendix 1 of the Pressure Ulcer Protocol can be used as a useful checklist for

- The SAD and / or SAM when
  - requesting an organisation carry out some or all of an adult safeguarding enquiry where there is a concern about a pressure wound
  - quality assuring an adult safeguarding enquiry report regarding a concern about a pressure wound
- A person completing contributing to an adult safeguarding enquiry where there is a concern about a pressure wound

Surrey Safeguarding Adults Board Pressure Ulcer Protocol (updated August 2020)

- Appendix 3: Adult Safeguarding Decision Guide for individuals with severe pressure ulcers
- Appendix 4: Body Map
- Appendix 5: Adult Safeguarding Concern Proforma regarding Pressure Ulceration

30 Glossary

DBS	Disclosure and Barring Service
CQC	Care Quality Commission
HCPC	Health Care Professional Council
HMPPS	Her Majesty's Prison and Probation Service
HR	Human Resources
IMRs	Independent Management Reports
LADO	Local Authority Designated Officer
LEO	Lead Enquiry Officer
MAPPA	Multi-agency public protection arrangements
MASH	Multi-Agency Safeguarding Hub
NHS	National Health Service
NOMS	National Offender Management Service
SAB	Safeguarding Adults Board
SAD	Safeguarding Adults Enquiry Decision Maker
SAEM	Safeguarding Adults Enquiry Contributor(s)
SAM	Safeguarding Adults Enquiry Manager
SAR	Safeguarding Adults Review
SCARF	Single Combined Assessment of Risk
SCIE	Social Care Institute of Excellence
SCR	Serious Case Review
SSAB or the Board	Surrey Safeguarding Adults Board
SSAEM	Surrey Safeguarding Adults Enquiries Method
The Care Act	Care Act 2014
The Guidance	Care and Support Statutory Guidance

31 Version Control

Date	Version	Comments
14.09.2020	V5	Document reviewed to meet Website Accessibility standards September 2020
02.12.2020	V5.1	Appendix 1 (29) Pressure Ulcer Protocol updated (by CCG) and added. Previous protocol and executive summary removed. Appendix 3,4 and 5 added as word documents.