HAMPSHIRE COUNTY COUNCIL

Decision Report

Decision Maker:	Cabinet
Date:	12 December 2023
Title:	Annual Safeguarding Report – Adults' Health and Care 2022-23
Report From:	Director of Adults' Health and Care and Deputy Chief Executive

Contact name: Jess Hutchinson, Principal Social Worker and Assistant Director, Younger Adults

Email: Jessica.hutchinson@hants.gov.uk

Report purpose

1. The purpose of this report is to provide an annual update in respect of the local authority statutory duty to safeguard vulnerable adults.

Recommendations

2. It is recommended that Cabinet:

   - Notes the positive progress and strong performance of the Directorate to keep adults at risk safe from abuse and/or neglect, whilst acknowledging ongoing risks to fulfilling statutory safeguarding duties, including as a result of increased numbers of safeguarding concerns being reported.
   - Notes the commitment of a wide range of Adults' Health and Care staff, and wider partner agencies, to delivering robust safeguarding arrangements in Hampshire.
   - Notes the contribution of the Hampshire Safeguarding Adults Board (HSAB) to safeguarding strategy, assurance, and the development of policy across the four local authority areas of Hampshire, Portsmouth, Southampton, and the Isle of Wight.

Executive Summary

3. This report provides an update on the work of the Adults' Health and Care Directorate, and of the Hampshire Safeguarding Adults' Board respectively, to safeguard vulnerable adults.

4. The Directorate has seen an increasing number of reported safeguarding concerns, which is a trend seen elsewhere nationally. An extensive programme of safeguarding practice improvement has served to ensure section 42 enquiries are undertaken and recorded to confirm that risks are

managed, and people are kept safe. Hampshire's section 42 enquiry rates are now within similar parameters of comparator local authority areas. Safeguarding practice has also been further strengthened through an enhanced training offer, continued development of the Senior Social Worker role, continued use of a safeguarding practice audit tool (QAF) and a safeguarding activity dashboard to enable trends to be identified and highlighting opportunities for further development.

5. Improvement actions are implemented in response to key learning from Safeguarding Adult Reviews and serious incidents. In the past year this has included:

    a. Increased delivery of direct practice support from the Strategic Safeguarding Team to identified community teams.

    b. Further development of the Risk Assessment and Escalation Framework.

    c. Design of new safeguarding recording format in CareDirector to support good practice, and the launch of pro-forma ahead of CareDirector rollout to replicate this improved format.

6. The Directorate has continued to work with wider partners to undertake Large Scale Safeguarding Enquiries, with six opened by the Directorate in the 12 months to September 2023.

7. The government has announced an indefinite delay to implementation of the Liberty Protection Safeguards (2019). Local partnerships have shifted focus to streamlining and strengthening the current safeguards. In the absence of new safeguards, a large waiting list is likely to remain; this is in keeping with other local authorities of a similar size and demographic.

8. The Client Affairs Service continues to operate an effective service to its 1,000 clients and deliver services on behalf of Southampton City Council.

9. In keeping with the County Council's Modern Slavery Statement, the Directorate has continued to progress actions to raise awareness of modern slavery, including through the delivery of training and guidance for staff.

10. There is a continued focus on Domestic Abuse, with new guidance published and training commissioned.

11. In line with its statutory duty under the Care Act, the Hampshire Safeguarding Adults Board (HSAB) published its 2022-23 Annual Report setting out key areas of progress and achievements against its 2022 – 2025 Strategic Priorities. The Board developed an Operational Plan to support delivery of the strategic priorities. The Annual Report covers the first-year delivery of this plan. The HSAB also responded to further growth in the number of Safeguarding Adult Review referrals and commissions.

12. As part of its assurance and oversight of adult safeguarding activity, HSAB continues to review and update its Risk Register. The Board continues to scrutinise and seek assurance regarding the performance of the South-Central Ambulance Service following CQC inspection of the service's

Emergency Operations Centre. The Risk in relation to The Gosport War Memorial Hospital has been removed following Board approval.

Contextual information

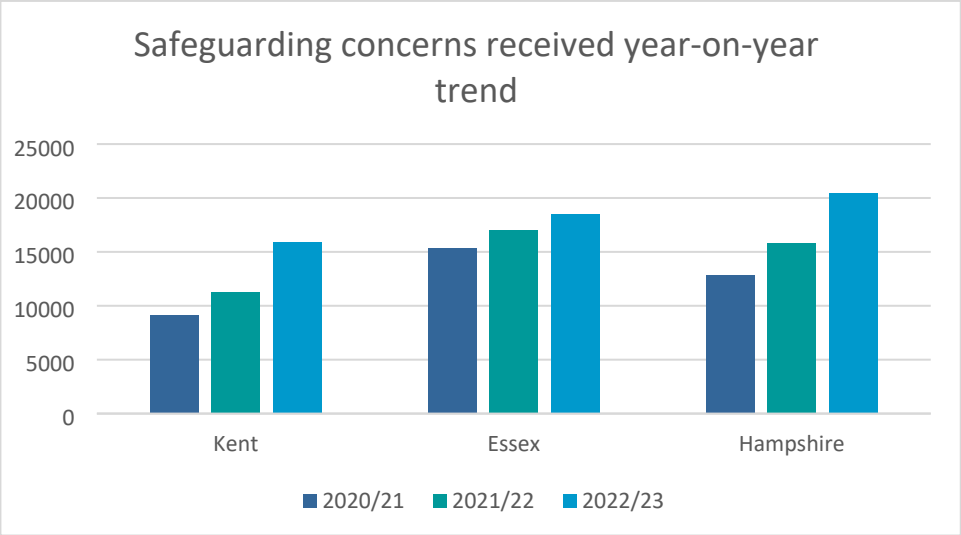
13. This report provides an update on the work of the Adults' Health and Care Directorate, and of the Hampshire Safeguarding Adults Board respectively, to safeguard vulnerable adults.

14. The main statutory safeguarding responsibilities for local authorities, Police and the NHS are covered by the Care Act 2014 and subsequent statutory guidance. The Care Act 2014 Statutory Guidance defines safeguarding as 'protecting an adult's right to live in safety, free from abuse and neglect'. A person with care and support needs living in Hampshire who is at risk of, or experiencing, abuse or neglect, and is unable to protect themselves, can access safeguarding support irrespective of their eligibility for services. A safeguarding concern is raised where there is reasonable cause to suspect that an adult who has, or may have, needs for care and support is at risk of, or experiencing, abuse or neglect (Care Act 2014, Section 42 (1) (a) and (b)).

15. Statutory responsibility for oversight of Hampshire's local system safeguarding arrangements rests with the Hampshire Safeguarding Adults Board (HSAB). The main objective of the HSAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet safeguarding criteria. The HSAB achieves this by working closely with wider Adults' and Children's Safeguarding Partnerships.

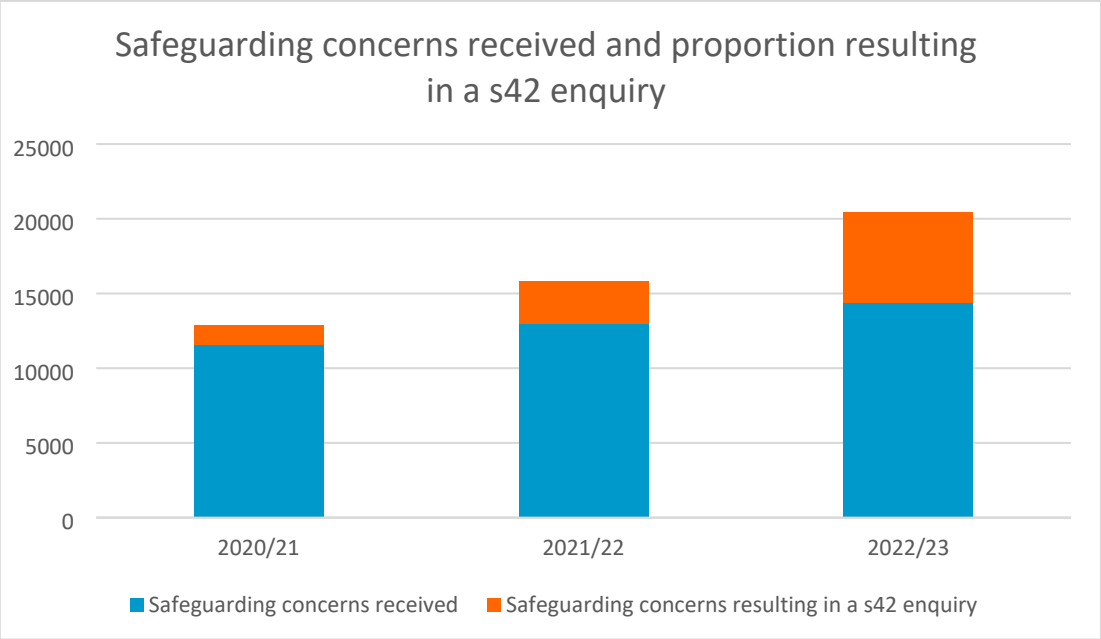
Safeguarding Improvement

16. Under the leadership of the Principal Social Worker, the Strategic Safeguarding Team has continued a programme of safeguarding practice improvement started in 2021/22. Throughout this period, there have been increasing numbers of safeguarding concerns received by the Directorate, which is a trend also being observed in comparator local authorities. Safeguarding concerns were most often received by the Multi-Agency Safeguarding Hub (MASH) but some also came directly to hospital and community teams.



17. A two-year programme commenced in 2022 to support continued safeguarding practice improvement included a requirement for all operational staff to complete relevant training to ensure their knowledge is fully up to date. At this midway point, 45% of staff in scope have completed their training, 6% have partially completed their training, and 11% have booked their training, with the remainder still to book and complete their training. A training dashboard enables managers to see clearly which staff have attended individual training courses.

18. The safeguarding practice improvement programme has successfully addressed a key priority to respond to more safeguarding concerns through formalised section 42 enquiries to manage risks and keep people safe. This has seen the total number of section 42 enquiries commenced rising to 540 per 100,000 adults in Hampshire (an increase of 119 in 2020/21;420 per 100,000). This reflects a continued focus on professional practice alongside the increased identification of concerns being seen nationally. This combination of increased safeguarding concerns and increased section 42 enquiries nonetheless places additional pressure on the Multi-Agency Safeguarding Hub and community teams.



19. SAR learning highlights that working with acute or complex risk can be one of the most challenging areas of practice. In response, the Directorate introduced an improved Risk Assessment and Escalation Framework which has been in place since September 2022. The framework ensures that practitioners are supported with shared decision-making for the most complex risks, drawing on relevant expertise as needed across the Directorate. The most complex risks are reviewed at Risk Escalation Panel, with representation from senior managers within the Directorate. Since its introduction, risks for 19 adults have been discussed at Risk Escalation Panel and seven have been discussed on multiple occasions due to severity and complexity of risk. Complex considerations relating to mental capacity, hoarding and environmental risks, domestic abuse, self-harm, malnutrition, engagement with services and substance misuse have been recurring themes in risks escalated to panel. The panel has been well-received by practitioners and operational managers as an effective way to achieve progress in the most complex situations. 'Working with Risk' training and guidance has been launched to complement the Risk Assessment and Escalation Framework.
20. The Strategic Safeguarding Team works to continuously improve safeguarding practice through delivering expert guidance and support to practitioners and managers across a broad range of safeguarding practice matters. They also advise on the development and implementation of safeguarding guidance. Six new safeguarding-related guidance topics have been published over the past year, and 13 safeguarding-related guidance topics have been reviewed.
21. Senior Social Workers lead excellent social work practice within their teams, the wider organisation and with multi-agency partners There are currently over 30 Senior Social Workers with a safeguarding specialism who provide practice expertise within their own, more complex, caseloads and guide, advise and supervise team members. Monthly sessions for this Senior Social

Worker group are facilitated by the safeguarding consultants to support the development of safeguarding practice, create and share resources, and for expertise and insights to be shared across teams.

22. Excellent safeguarding practice continues to be supported through the Safeguarding Adult Quality Assurance Framework (QAF). The QAF is an online questionnaire designed to help practitioners, team managers and senior managers celebrate good practice and identify opportunities for improvement. Practitioners working in safeguarding are expected to have their safeguarding practice audited using the QAF tool at a minimum of once a year. The QAF supports recording within the Directorate's client record system that accurately reflects activity undertaken under our statutory responsibilities. It also includes measures in response to learning from Safeguarding Adult Reviews, such as robust application of section 42 criteria in the area of self-neglect.

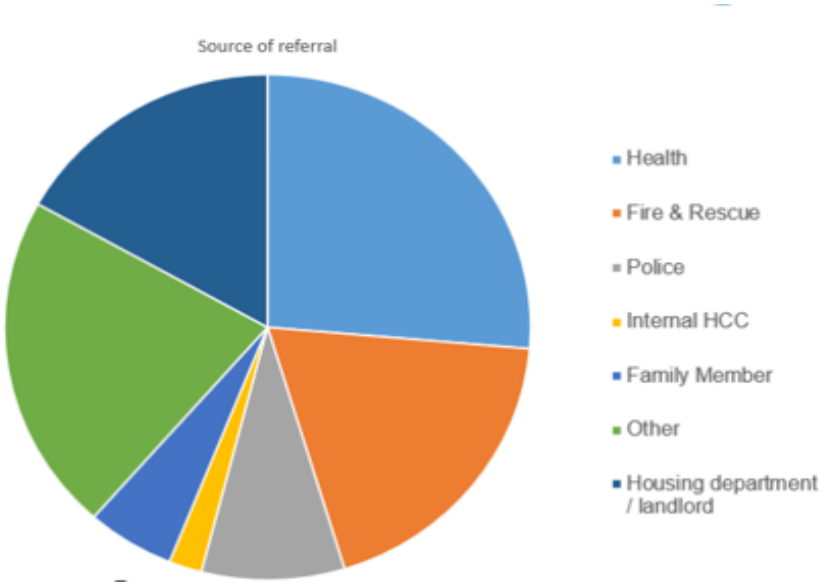
23. Improvement actions are identified and implemented in response to key system learning from Safeguarding Adult Reviews (SARs). Adults' Health and Care have taken a systematic approach to developing learning from the SARs that have been published since 2020. This is managed through a comprehensive SAR action plan that ensures all learning for the Directorate is progressed and tracked. Notification of SARs publications are circulated to teams across the Directorate and published SARs are available to practitioners via the Social Care Practice Manual. In addition, over the past 12 months, a framework to take learning from serious incidents and apply it to practice improvement in a timely way has been launched with the development of regular Practice Improvement Panels.

Enhanced Support Work project

24. Adults' Health and Care initially commissioned a six-month pilot with two providers to test a new service using Enhanced Support Workers to engage with individuals where there are safeguarding concerns primarily in relation to self-neglect (which may include hoarding), or the person is at risk of experiencing home loss. These individuals may present with recurring multiple co-morbidities, including Mental Health issues, Autism, other disabilities, undiagnosed health needs, substance misuse, or chaotic social circumstances and limited social support networks. People referred to the service are often classified as 'hard to reach'. The pilot was undertaken in response to learning from the thematic self-neglect SAR and escalating numbers of people supported by AHC due to self-neglect.

25. Due to the success of the Enhanced Support Work project in achieving positive outcomes for individuals, continuation of the project was secured until March 2024. Referrals to Enhanced Support Workers were originally via the MASH hub from external partners. The service now accepts referrals from community teams too. The complexity of this work presents a challenge for community teams due to the time-intensive nature of interventions required to successfully address the issues present. The availability of the Enhanced

Support Work project provides practical support to help ensure these complex needs continue to be addressed. Referrals to the project are received through a range of channels:



Transformation of the Multi-Agency Safeguarding Hub

26. The Directorate continue to develop and implement a new and improved way of working within MASH with the aim of becoming a centre of excellence for safeguarding practice, retaining a particular focus in supporting residents with the most complex risks, such as hoarding and self-neglect. Previously, all safeguarding contacts were handled by the social care contact centre. Now contacts are channelled through a new Safeguarding Contact Team made up of experienced caseworkers. Their responsibility is to manage all safeguarding contacts and ensure detailed and relevant information is gathered. This new process focuses on “think safeguarding first” and Making Safeguarding Personal as well as effective risk assessment and use of advocacy.

27. Alongside this, a new **Safeguarding Enquiry Team** consisting of the current MASH team with additional social workers and senior case workers, manage all complex cases, complete enquiries, and visit and work with community partners to manage safeguarding risks. The new model will deliver high quality and timely safeguarding interventions at the front door, a consistent approach to managing safeguarding concerns, increased and consistent feedback to referrers and vulnerable adults from MASH and an upskilled workforce to manage safeguarding concerns through training.

28. In the context of increasing safeguarding referrals being made to Adults’ Health and Care, work is being undertaken to help ensure referrals received are appropriate. This includes focused work with key stakeholders to build on mutual understanding of referral criteria. Furthermore, HSAB and MASH are working in partnership to further develop Hampshire’s online safeguarding referral form.

29. The impact of the Directorate's continuous practice improvement is monitored via a monthly safeguarding dashboard that generates insights into safeguarding activity, trends and potential areas for development. This is used by both operational and strategic staff to influence practice and improvement activity. The development of a new client records system (CareDirector) for the Directorate has provided opportunities to improve on the existing safeguarding recording format and the measures it generates for governance and assurance. Benefits this will offer include more refined reporting on safeguarding concerns received and rationale for decision-making on actions to be taken in response. This will inform improved reporting of safeguarding activity both internally and for national reporting requirements. The new system is due for rollout in November 2023.

Large Scale Section 42 Safeguarding Enquiries

30. Large Scale Section 42 Safeguarding Enquiries (LSSE) are a co-ordinated multi-agency response to protect adults with care and support needs from organisational abuse. LSSE is part of the continuum of potential responses to safeguarding concerns in a provider setting. An LSSE may be triggered where there are safeguarding concerns about more than one adult, there is a place or network that facilitates abuse, or there is a provider who fails to protect adults from abuse. LSSEs are often complex, requiring significant resource from multiple partners. Over the course of the last year, six LSSEs were opened by the Directorate. At time of writing, there were two open LSSEs, with work continuing to safeguard the individuals and make improvements.

Deprivation of Liberty Safeguards (DoLS)/Liberty Protection Safeguards (LPS)

31. The Local Authority acts as the 'supervisory body' under the Mental Capacity Act 2005 for Deprivation of Liberty Safeguards (DoLS). DoLS is the legal framework applied when someone has care and support needs and for their own safety and welfare their liberty is deprived. Care homes and hospitals ('managing authority') must make an application to the local authority if they believe someone in their care, who lacks mental capacity, is deprived of their liberty because of care arrangements in place. These arrangements are necessary to ensure that no-one is deprived of their liberty without independent scrutiny and outside of the appropriate legal framework.

32. The Government had planned to replace DoLS with the Liberty Protection Safeguards, which were introduced through the Mental Capacity (Amendment) Act 2019[1] and originally due to come into force in October 2020. This was delayed to April 2022 due to the Covid-19 pandemic. In April

[1] Mental Capacity (Amendment) Act 2019 (legislation.gov.uk); Mental Capacity (Amendment) Act 2019 (legislation.gov.uk)

2023 the Government announce the safeguards would not be implemented within the lifetime of this parliament. This has left some doubt as to whether they will be implemented at all.

33. The prevailing view from the National Mental Capacity Forum (NMCF) and the Association of Directors of Adult Social Services (ADASS) is that local authorities should refocus their efforts from preparation for the new safeguards. Resources will be more effectively deployed strengthening and streamlining assessments under the current scheme. It is however common ground that without the offered solution of the new framework, statutory obligations will continue to outweigh the available resource. This is reflected in all Local Authorities and results in large waiting lists that require constant re-triage and risk management. In light of the above decision, the multi-agency implementation Steering Group co-chaired by AHC and the Hampshire and Isle of Wight Integrated Care Board will be stood down until further announcements upon implementation are made.

Client Affairs Service (CAS)

34. The Client Affairs Service (CAS) operates to manage the property and financial affairs of people who lack the mental capacity to do this for themselves. People supported by the service have no family willing or deemed suitable to do this on their behalf.

35. The CAS continued to operate an effective service to its 1,000 clients during the pandemic and deliver services on behalf of Southampton City Council (SCC). 'Sold service' activities were further developed through previous agreements with Guernsey and with the Integrated Commissioning Board (ICB).

36. The service is currently undertaking a systematic review of its processes and practices. This is to ensure that it remains a high performing team that is fit for the future and can manage the increase in demand that is being see. The review is focused on ensuring that full advantage is made of online and digital solutions.

Modern Slavery

37. Adults' Health and Care continue to progress actions to deliver on the County Council's commitment to preventing slavery and human trafficking across its business activities and supply chains. A key focus over the last year has been to raise awareness across Adults' Health and Care and the wider organisation. Key developments include:

- The Directorate remains involved with the Hampshire Modern Slavery Partnership and has inputted into the development of the Office of Police and Crime Commissioner's three-year strategy.
- The Directorate continues to promote the Hampshire Modern Slavery Partnership eLearning training to key cohorts of Adults' Health and Care staff.

- Regular review and updates of Social Care Practice Manual modern slavery guidance and the Directorate's internal Equality and Inclusion web pages.
- Attendance at national sessions provided by the Shiva Foundation on modern slavery to improve and embed understanding of modern slavery and its impact.

Domestic Abuse

38. The Hampshire Domestic Abuse Partnership is formed by a variety of statutory and voluntary sector agencies working together to tackle the issues of domestic abuse. The Partnership includes the Hampshire Domestic Abuse Partnership Board which operates through several sub-groups that AHC participate in.

39. Operational guidance relating to Domestic Abuse has been developed for Adults' Health and Care staff, including resources on the Social Care Practice Manual pages.

40. As a result of a staff survey, Domestic Abuse training has been commissioned regarding identifying and supporting adults at risk of or experiencing domestic abuse in our service user groups. Domestic Abuse has been a priority feature of Social Work conferences held over the last year. It is also a subject that has been and will continue to be covered in the safeguarding lead Senior Social Work forums as a means of ensuring current and detailed learning is disseminated to teams. Training offered by the Hampshire Safeguarding Children's Partnership is also promoted to practitioners and managers in Adults' Health and Care.

Hampshire Safeguarding Adults Board (HSAB)

41. The HSAB continues to be a well-established, strategic board whose membership includes all key multi-agency partners. The Board is chaired by the Director of Adults' Health and Care, and an Independent Scrutineer provides critical challenge and support to ensure the Board fulfils its core statutory responsibilities. Additionally, a new post of SAR co-ordinator has been recruited to the Board team, supporting the increased number of SAR referrals received.

42. In line with its statutory duty under The Care Act, the HSAB published its 2022- 23 Annual Report setting out key areas of progress and achievements against its 2022-25 Strategic Plan. Highlights of year one include:

    - Safeguarding Adult Reviews and sustained growth in the volume of SAR referrals.
    - Holding four round the table discussions on key issues identified from SARs and partner engagement on safeguarding concerns, ethnic diversity, advocacy, and self-neglect.
    - Hampshire, IoW, Portsmouth and Southampton Local Safeguarding Adults Boards (4LSAB) System Improvement and Learning Framework

working group has been established to support evidence-based decision making.

- Collaborating with Safeguarding Adults Board for Portsmouth, Southampton, and the Isle of Wight to produce joined-up guidance on Multi-Agency Risk Management Framework (MARM), Multi-Agency Escalation protocol, 4LSAB Safer Recruitment Guidance and a refresh of the 4LSAB Multi Agency Safeguarding Policy and Guidance. The Board continues to work through several sub-groups across the 4LSAB areas to reduce duplication and maximise its effectiveness.
- Delivering multi-agency training events, engaging over 70 people at each event.
- Contributing to three Family Approach training events run by the Hampshire Safeguarding Children's Partnership.
- Raised awareness during National Safeguarding Week, reaching 15,417 people via social media.

43. The Board continued to deliver on it's 2022-25 Strategic Priorities , which form the basis of the HSAB forward operational work programme. These priorities are to:
    - Foster a shared understanding of what a 'safeguarding concern' is, who to take concerns to and what will happen next.
    - Empower people and those who help them to draw on their knowledge and expertise to make safeguarding personal, listening and acting on people's insights and lived experiences.
    - Support the effective identification, assessment and coordinated management of risk in a way that balances different perceptions of risk whilst preventing or reducing the impact of harm.

Safeguarding Adult Reviews

44. A key statutory duty of the HSAB is to conduct Safeguarding Adult Reviews (SARs) as appropriate under Section 44 of the Care Act. The purpose of a SAR is to learn from events to drive whole system improvement, leading to better outcomes for adults at risk of abuse and /or neglect.
45. Referrals are considered by the HSAB Learning and Review sub-group which determines whether the circumstances of the case fit the requirements for a SAR and if so, what type of review process would promote the most effective learning and improvement action to reduce the likelihood of future deaths or serious harm occurring. The SAR collates and analyses findings from multi-agency records and frontline practitioners and managers involved with the case. It provides a detailed overview of the interfaces involved and, where necessary, makes recommendations for practice improvement.
46. In 2022/23, the HSAB received 29 SAR referrals, which is an increase from the 17 received in 2021/22. Data received over the first two quarters of 2023

indicates significantly increased volumes, with 19 referrals received so far and two new SAR commissions. Two SARS were commissioned during 2022/23: 'Gillian' SAR and a thematic Self-Neglect Gap Analysis. Gillian SAR was published in September 2023 and the thematic Self-Neglect Gap Analysis is scheduled to be published during Q3 2023.

Key areas of risk and system oversight

47. Pressure is caused by increasing numbers of safeguarding referrals and section 42 safeguarding enquiries within both the MASH and community teams. This pressure is due to the increased demand of safeguarding concerns raised, and increased numbers of safeguarding enquiries required in response. This presents a risk to managing that increased demand while ensuring safeguarding concerns are addressed in an effective, person-centred and timely way.

48. As part of its assurance and oversight of adult safeguarding activity the HSAB continues to review and update its Risk Register. The Board continues to scrutinise and seek assurance regarding the performance of the South Central Ambulance Service following CQC inspection of the service's Emergency Operations Centre. A previous risk in relation to The Gosport War Memorial Hospital has been removed following Board approval.

49. An increasing number of SAR referrals and the complex nature of the work involved is putting pressure on agencies' ability to commission and complete reviews within statutory timescales. In mitigation, the SAR co-ordinator works closely with Adults' Health and Care and partner agencies to monitor referrals and progress of reviews, and to ensure completion of reviews.

Looking ahead

50. Over the next twelve months, the Directorate will prioritise the following to strengthen further its approach to safeguarding adults:

    - Practitioner and manager training, guidance and support to embed new safeguarding recording formats in CareDirector.
    - Further develop monitoring and reporting of safeguarding activity, maximising the benefits of the new CareDirector system, to help inform strategic priorities.
    - Develop further its work to mitigate safeguarding risks associated with cuckooing, incorporating learning to come from cuckooing thematic SAR review, through practice guidance development and multi-agency work.
    - Develop improved safeguarding online referral form to support the quality and consistency of incoming safeguarding referrals and efficiency of work in the MASH.
    - Contribute to the development of service user and carer feedback form to ensure the experiences of people subject to safeguarding enquiries are understood and used to inform further practice improvements.

- Further development of Practice Improvement Approach to ensure learning from serious incidents is used to inform practice change in a streamlined and timely way.
- Introduction of mandatory policy and guidance updates to ensure staff are briefed on essential local and national developments within safeguarding and wider social care.
- Continued development of safeguarding practice guidance to include new topics on:
    - Supporting people at risk of choking
    - Self-neglect
    - Mate Crime and Hate Crime
    - Cuckooing
    - Self-harm
- Continue to respond effectively to the sustained, high levels of SAR referrals and commissions, and seek to evidence the impact of improvement actions.
- Collaborate with its HSAB partners to implement the operational plan and deliver on the HSAB Strategic Priorities.

Climate change impact assessment

51. This annual report references a wide range of services and activities which serve to fulfil the County Council's statutory duty with respect to safeguarding adults from abuse and/or neglect. Specific projects and initiatives, and the climate impacts of these, are overseen by internal governance arrangements and are not covered in this overarching report.

52. In the main, strategic safeguarding roles require limited travel and are predominantly home based. However, the Directorate also recognises the importance of in-person, physical meetings to safeguarding vulnerable adults and believes the benefit of these outweighs the climate change impact of car travel. To contribute to balancing this, the Directorate is exploring an expansion of its use of electric vehicles.

Conclusion

53. This report demonstrates that the Directorate continues to fulfil its safeguarding remit and continues to seek to improve safeguarding practice, working effectively with partner agencies. The HSAB also delivered on its statutory duties to oversee the local safeguarding system**.**

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
People in Hampshire enjoy being part of strong, inclusive communities:	Yes

Other Significant Links

Links to previous Member decisions:	
Title	Date
Direct links to specific legislation or Government Directives	
Title	Date
Care Act	2014

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. Equality Duty

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. Equalities Impact Assessment:

The Multi-Agency Policy, Guidance and Toolkit referenced in the main body of the report has its own Equality Impact Assessment. The local authority approach to safeguarding is applicable across all communities. As this is an annual overview report, no individual Equalities Impact Assessment has been undertaken.