HAMPSHIRE COUNTY COUNCIL

Decision Report

Decision Maker:	Cabinet
Date:	13 December 2022
Title:	Annual Safeguarding Report – Adults' Health and Care 2021-22
Report From:	Director of Adults' Health and Care and Deputy Chief Executive

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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 Department to keep adults at risk safe from abuse and/or neglect, whilst acknowledging ongoing risks to fulfilling statutory safeguarding duties.
   - 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 Department, and of the Hampshire Safeguarding Adults' Board respectively, to safeguard vulnerable adults.
4. The Department has undertaken an extensive programme of safeguarding practice improvement which has served to increase the number of safeguarding concerns raised with the Department and recorded Section 42

Enquiries, this sees Hampshire within the same parameters of similar sized county areas. Safeguarding practice has also been further strengthened through an enhanced training offer, introduction of the Senior Social Worker role, development of a new Safeguarding Adult Quality Assurance Framework and a new data dashboard to enable trends to be identified, highlighting opportunities for preventative action.

5. Improvement actions have also been implemented in response to key learning from Safeguarding Adult Reviews. These included piloting the introduction of a new service offer using Enhanced Support Workers to engage people where there are safeguarding concerns relating to self-neglect and homelessness, introducing a new Risk Assessment and Risk Escalation panel, and delivering an improved way of working within the Multi-agency Safeguarding Hub.

6. The Department has continued to work with wider partners to undertake Large Scale Safeguarding Enquiries, with seven opened by the Department in the 12 months to September 2022.

7. The Department has continued to work closely with Health partners to plan for the Government's introduction of Liberty Protection Safeguards, which is due to replace the current Deprivation of Liberty Safeguards scheme.

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 Department has continued to progress actions to raise awareness of modern slavery, including through the rollout of training to staff and updated guidance.

10. The Domestic Abuse Partnership commenced work to develop a domestic abuse needs assessment to inform a revised strategy from 2023.

11. In line with its statutory duty under The Care Act, the HSAB published its 2021-22 Annual Report setting out key areas of progress and achievements against its 2019-20 Business Plan. The Board also ran a series of development days engaging a breadth of stakeholders to co-produce a revised set of Strategic Priorities. The HASB also responded to growth in the number of Safeguarding Adult Review commissions.

12. The HSAB reviewed and updated its Risk Management Framework and is in the process of refreshing its Risk Register. As part of this, the Board continued to scrutinise and oversee the response to The Gosport War Memorial Hospital Inquiry Report and to seek assurance regarding the performance of the South Central Ambulance Service following CQC inspection of the Service's Emergency Operations Centre.

Contextual information

13. This report provides an update on the work of the Adults' Health and Care Department, 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. 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.

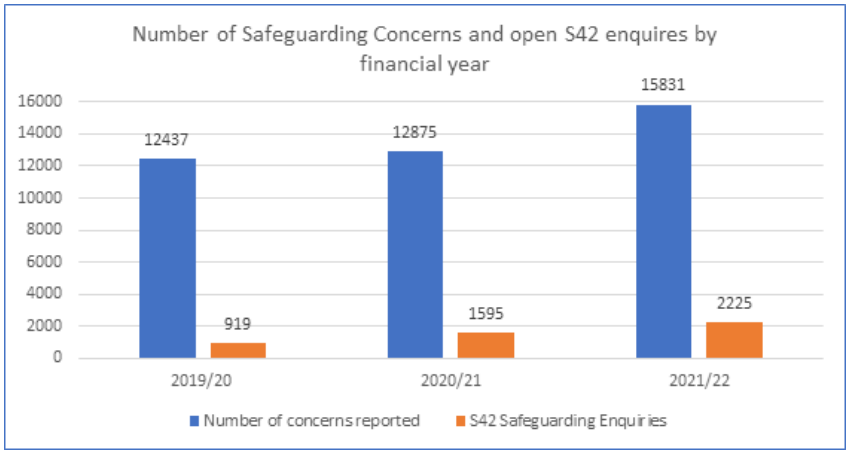
Safeguarding improvement

16. Under the leadership of the Principal Social Worker, the Strategic Safeguarding Team has undertaken an extensive programme of safeguarding practice improvement to address areas highlighted by data and wider evidence. A key area of focus was on increasing the number of adult safeguarding concerns referred to the local authority, alongside growth in the volume of Section 42 Enquiries. This has seen the total number of Section 42 Enquiries commenced rising to 259 per 100,000 adults in Hampshire (an increase from 84 in 2019-2020). This development enables more concerns to be formally managed and successfully resolved.

17. Actions to increase the level of Section 42 Enquiries included requiring all operational staff to complete appropriate training over the next two years, increased vigour in the recording within the Department's client management system to better reflect the activity undertaken, and practice improvement in response to the findings of Safeguarding Adult Reviews, such as measures to ensure that practitioners apply the Section 42 criteria robustly in the area of self-neglect.

18. The impact of these initiatives is reflected in the data (alongside the re-opening of services following national restrictions and lockdowns in the preceding period). In September 2021, 1,251 safeguarding concerns were received into the Department. In September 2022, there were 1,858 concerns received, which demonstrated an increase of 31%. In this 12-month period, the highest level of monthly safeguarding concerns received was 2,129 in August 2022. Safeguarding concerns were most often received by the Multi Agency Safeguarding Hub (MASH) but some also came directly to hospital

and community teams. The number of recorded Section 42 Enquiries also increased by 283% over the twelve months to September 2022 (from 122 to 467). Again, this increase not only reflects a continued focus on professional practice and wider community awareness, but also a consequence of restrictions easing in our communities and greater identification of concerns as a consequence.



19. The Strategic Safeguarding Team has also worked to continuously improve safeguarding practice through delivering guidance and expert support to practitioners across the breath of safeguarding practice. This was achieved in part through the introduction of Senior Social Workers; practice leaders who champion excellent social work practice within their teams and the wider organisation, as well as with other professionals. They have the skills and experience to provide practice expertise within their own, more complex, caseloads and to guide, advise and supervise team members. There are currently over 30 Senior Social workers with a Safeguarding specialism. Monthly sessions facilitated by the Safeguarding consultants are in place to support the development of safeguarding practice, create and share sources in order for greater knowledge and insights to be shared within teams.

20. Excellent practice was further supported through the introduction of the Safeguarding Adult Quality Assurance Framework (QAF). This was developed and introduced for all practitioners who undertake practice in relation to Safeguarding Adults. The QAF is an online questionnaire designed to help practitioners, team managers and senior managers identify opportunities for improving the quality of safeguarding adults' practice.

21. Improvement actions were also identified and implemented in response to key system learning from Safeguarding Adult Reviews (SARs). Adults' Health and Care (AHC) took a systematic approach to developing learning from the SARs that have been published since 2020. This included developing a SAR action plan to ensure that all specific learning for AHC individually with partners is progressed and tracked. Four examples of responses taken in response to the SARs are:

    - **Enhanced support worker** – AHC commissioned a six-month pilot with two providers to test a new service offer 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 and / or other disabilities, have undiagnosed health needs, use substances, or have chaotic social circumstances and limited social support networks, and may be people who could be classified as 'hard to reach' or resistant to intervention. The pilot is being undertaken in response to learning from the thematic Self-neglect SAR and the escalating numbers of people AHC are supporting due to self-neglect.

- **Risk Assessment and Risk Escalation panel –** SAR learning highlighted that working with acute or complex risk can be one of the most challenging areas of practice. In response, the Department put in place a Risk Assessment and Escalation Framework which is designed to ensure that practitioners are supported with shared decision-making for the most complex risks, drawing on relevant expertise as needed across the Department.
- **Transformation of the Multi-agency Safeguarding Hub –** the Department implemented a new and improved way of working within MASH with the aim of becoming a centre of excellence for safeguarding practice, with 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 as much detailed and relevant information is gathered, in line with our new processes. The new process focuses on “think safeguarding first” and Making Safeguarding Personal as well as effective risk assessment and use of advocacy.
- Alongside this, a new **Safeguarding Enquiry Team**, consist of the current MASH team with additional Social Workers and senior case workers, manages 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.

22. The impact of the Department’s continuous practice improvement model is being tracked and monitored, in part, through a new dashboard that allows relevant data to be appropriately accessed by both operational and strategic staff. This is generating insights in to Safeguarding activity, trends, and potential areas for preventative work.

Large Safeguarding Enquiries

23. The Department's Large Safeguarding Enquiries (LSE) Policy and associated processes are intended to be used in the most serious circumstances where there is a high level of risk and complexity. LSE response is part of the continuum of a whole system's approach to safeguarding activity that may be an appropriate response to safeguarding concerns in a provider setting. Between September 2021 and September 2022, there have been seven LSEs opened by AHC. Five of those opened were in relation to Older Adults providers and two Younger Adult providers. Five of these Enquiries opened in the last six months. LSEs are often complex requiring significant resource from multiple partners. Currently there are two open LSEs, where work continues with the provider to safeguard the individuals within the setting and make improvements. Out of the five LSEs that have closed to the LSE process, two homes have ceased operating, two services have made improvements and are now being monitored through other frameworks and one service has made all the necessary improvements and the action plan has been completed.

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

24. 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.

25. The Government is replacing DoLS with a Liberty Protection Safeguards, which was 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 and was postponed further in December 2021 (in advance of the April'22 date). At present, the introduction of LPS is not expected before October 2023, although it is expected that some provisions covering new roles and training will come into force ahead of full implementation.

26. In March 2022, the Government consulted on its draft LPS Code of Practice, alongside six sets of draft regulations for England. Adults' Health and Care worked closely with its partners to develop a joined-up response to the consultation and continues to play a central role in coordinating partners' implementation plans. This includes through co-chairing a multi-agency implementation Steering Group with the Designated LPS Lead for the Hampshire and Isle of Wight Integrated Care Board.

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

Client Affairs Service (CAS)

27. 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.

28. 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 Clinical Commissioning Groups (CCGs).

Modern slavery

29. Adults' Health and Care continued 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. This has been achieved through:

    - Awareness raising sessions delivered in partnership with the charity Unseen
    - The rollout of Hampshire Modern Slavery Partnership eLearning training to key cohorts of Adults' Health and Care staff.
    - Improving staff guidance on the Social Care Practice Manual and the Department's internal Equality and Inclusion web pages.

Domestic Abuse for adults at risk

30. 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.

31. Over the past year, the Domestic Abuse Health subgroup focused on improving the capabilities of the health settings' workforce, strengthening pathways from health services to specialist domestic abuse services, and maintaining Health's engagement with Multi-Agency Risk Assessment Conferences (MARAC) and High-Risk Domestic Abuse (HRDA) – a local multi-agency, whole family focused process where information is shared on the highest risk cases of domestic violence.

32. The Safe Accommodation subgroup worked to deliver five strategic objectives:

    - **Improve measurable and purposeful local information and data collection, collation and analysis processes including vulnerable groups and from different intersectionalities.** Data will be used to provide a more accurate picture of Hampshire in national data returns,

and to inform the commissioning of services locally. Work on this priority has recently commenced.

- **Improve intelligence on the needs of 10-25 year olds** which, following the Safer Accommodation Needs Assessment, has been identified as a gap nationally. Hampshire is considering what types of accommodation are required going forward in recognition that the needs of this cohort are often complex and more 'traditional' services, which might be offered in a crisis, are not always appropriate.
- **Improve prevention, identification, and the effective and efficient use of the safe accommodation referral pathways.** This work is being led by the Hampshire Domestic Abuse Partnership (HDAP) and will develop the existing referral pathway to improve the offer to those experiencing domestic abuse. For example, Hampshire Hospitals Foundation Trust has Domestic Abuse Advocates in their hospitals who provide training to staff on the early identification of domestic abuse and how to refer to specialist services. Work is underway to develop these areas in education, including a training plan for colleagues working in education.
- **Establish the Whole Housing Approach to ensure range of safe accommodation and support is available.** Housing teams have begun to develop specialist domestic abuse posts to improve pathways for people living with domestic abuse who use housing services. Some District and Borough councils have recently accessed funding to also employ these specialists, although this model is not available across the whole of Hampshire. Work is also underway to look at the creation of specialist posts within GP primary healthcare. A range of accommodation options are under consideration.
- **Establish a robust expert by experience (adult and children and young people survivor and perpetrator) mechanism and feed this into future domestic abuse strategies.** It is anticipated that a three-year contract will be made available at the end of 2022 to establish community engagement mechanisms by building networks, especially reaching underserved populations with Hampshire. This will then be used in further strategies and commissioning of specialist services.

33. A domestic abuse needs assessment is being developed to inform the Domestic Abuse Strategy from 2023 and will incorporate the Domestic Abuse Act 2021 Part 4 Safe Accommodation element to build on achievements gained from the 2021-2023 Domestic Abuse Safe Accommodation Strategy. The needs assessment will also consider what mental health support is available for those experiencing domestic abuse, as well as recent systemwide reviews of prevention and intervention responses to perpetrators and the roles and responsibilities of probation and prison in reducing harm when perpetrators leave their services.
34. Operational guidance is under development for Adults' Health and Care staff, including an update to the Social Care Practice Manual pages. Furthermore, a revised Adults' Health and Care training strategy is also under development

following a review of frontline staff in addition to the promotion of the current training offer from the Hampshire Safeguarding Children's Partnership.

Hampshire Safeguarding Adults Board

35. 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.

36. In line with its statutory duty under The Care Act, the HSAB published its 2021-22 Annual Report setting out key areas of progress and achievements against its 2019-20 Business Plan. Highlights include:

    - Publishing three Safeguarding Adult Reviews and responding to sustained growth in the volume of SAR referrals.
    - Delivering a whole system workshop on adult safeguarding and homelessness, resulting in a discussion paper exploring experiences of homelessness and highlighting the importance of trauma-informed, joined-up responses.
    - Developing the Board's approach to quality assurance, including development of a new System Improvement and Learning Framework 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 modern slavery, human trafficking, a new multi-agency fire safety framework and information on transitional safeguarding. The Board continues to work through several sub-groups across the four LSABs to reduce duplication and maximise its effectiveness.
    - Delivering 17 multi-agency training events, engaging 1,183 people.
    - Contributing to three Family Approach training events run by the Hampshire Safeguarding Children's Partnership.
    - Reviewed and re-launched the See it Stop it App.
    - Raised awareness during National Safeguarding Week, reaching 37,540 people via social media.
    - Secured increased partner contributions to support and sustain the work of the Board.

37. The Board also ran a series of development days engaging a breadth of stakeholders to co-produce a revised set of Strategic Priorities, which form the basis of the HSAB forward work programme. These 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

38. 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.

39. 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.

40. Between January and December 2021, the HSAB received 10 SAR referrals, which is a reduction from the 22 received in 2020 and more akin to that of 2019 (11). However, whilst the number of referrals reduced, a significantly higher proportion (60%) of those referrals met SAR criteria resulting in a continuing high level of SAR commissions. Data received over the first three quarters of 2022 indicates significantly increased volumes, with 26 referrals received between January and September, and three new SAR commissions.

41. During 2020-21, the HSAB published three SARs: Vicky, The Self Neglect Thematic SAR, and Sam. These are summarised in the HSAB 2020-21 annual report. Action plans are in place to respond to the recommendations and the board has received assurance on implementation of the agreed improvements. A further SAR has been concluded and is awaiting publication due to an ongoing court case and a further two SARs are in progress.

Key areas of risk and system oversight

42. The Safeguarding Board reviewed and updated its Risk Management Framework and is in the process of refreshing its Risk Register. As part of this, the Board continued to scrutinise and oversee the response to The Gosport War Memorial Hospital Inquiry Report. The report revealed that at Gosport War Memorial Hospital, the lives of many patients were shortened by the prescribing and administering of 'dangerous doses' of a hazardous combination of medication not clinically indicated or justified.

43. Ongoing oversight of the Gosport War Memorial Response is provided through the Hampshire and Isle of Wight Integrated Care System Quality Group. The Group enables a system-wide approach, aligning the Inquiry Report recommendations with themes and areas for improvement also noted

in other independent HIOW and national investigations and reviews. This includes the recurrent theme of patient and carer experience, with insight data and information triangulated and shared at system level. Ongoing review of outstanding actions are assured through four local place-based assurance Quality Committees, escalating by exception to the System Quality Group. Alongside this, the HSAB maintains a scrutiny role to oversee the response to the Inquiry Report and to gain assurance that lessons are being implemented across the relevant agencies involved. There is an ongoing police investigation led by Essex and Kent Constabularies into the historic issues at GWMH which is yet to conclude.

44. The HSAB also continued to seek assurance regarding the performance of the South Central Ambulance Service following CQC inspection of the Service's Emergency Operations Centre, which resulted in a rating of Requires Improvement. An update report will be provided by the Hampshire and Isle of Wight Integrated Care Board on a quarterly basis to the four Safeguarding Adults Board detailing improvement progress.

Looking ahead

45. Over the next twelve months, the Department will prioritise the following to strengthen further its approach to safeguarding vulnerable adults:

    - Develop further its work to mitigate safeguarding risks associated with self-neglect, including through developing practice guidance and resources and through multi-agency work.
    - Focus further improvement on the application of Making Safeguarding Personal, thereby ensuring the voices of those at risk are heard even more clearly.
    - Strengthen the use of advocacy to support people to engage in Section 42 Enquiries and direct support to hospital teams who coordinate Enquiries.
    - Continue to drive consistency of safeguarding recording across all areas, including through the development of Care Director (a new case management system).
    - Undertake detailed planning to ensure the successful implementation of Liberty Protection Safeguards.
    - Produce a domestic abuse needs assessment and revised Domestic Abuse Strategy.
    - 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 work programme and deliver on the HSAB Strategic Priorities.

Climate change impact assessment

46. 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.

47. In the main, strategic safeguarding roles require limited travel and are predominantly home based. However, the Department 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 Department is exploring an expansion of its use of electric vehicles.

Conclusion

48. This report demonstrates that the Department 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 and worked collaboratively to co-produce a revised set of Strategic Priorities.

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:

0. **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.

1. **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.