

Bolton Safeguarding Adults Board

Annual Report
2024 — 2025



“We are committed to continuous improvement, learning from experience, and enabling adults at risk of neglect and abuse to have a voice”

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Message from the Independent Chair



I am pleased to present this year's annual report, which offers assurance that the Bolton Safeguarding Adults Board (BSAB) continues to demonstrate strong leadership, effective multi-agency collaboration, and a shared commitment to continuous learning and improvement in safeguarding adults at risk.

Publishing an annual report is a statutory requirement for all Safeguarding Adults Boards, and this document serves as a valuable tool for reflecting on our achievements and measuring our progress against the Board's strategic plan. It also provides an opportunity to identify our priorities for the year ahead. This report outlines the extensive work delivered over the past 12 months by the BSAB and our partner agencies.

We continue to operate in a challenging landscape, with increasing demand on services and complex needs within our communities. I want to acknowledge the unwavering dedication and engagement of our partners throughout this year, particularly the leadership provided by our three statutory agencies: Greater Manchester Police, Bolton Council, and the NHS Greater Manchester Integrated Care Board.

As Independent Chair, I have remained actively involved in regional and national safeguarding networks. This wider engagement ensures that Bolton's voice influences emerging national policy and practice, while also allowing us to bring best practice and new thinking back to our local system.

We have continued to strengthen our relationships with both the Bolton Safeguarding Children Partnership and the Bolton 'BeSafe' Community Safety Partnership. Together, we are aligning our strategies to address cross-cutting themes such as domestic abuse and community safety in a more joined-up and impactful way.

A key strength of the BSAB is our culture of constructive challenge and mutual accountability. We are committed to scrutinising the effectiveness of our systems, policies, and practices to ensure that safeguarding is not only effective, but also equitable and person-centred. Our approach empowers all agencies to raise concerns in a safe environment, confident that they will be heard and acted upon appropriately.

This year, we have further strengthened our quality assurance processes, with particular focus on our Safeguarding Effectiveness Subgroup. By combining data, intelligence, and professional insight, we are improving our ability to anticipate safeguarding trends and respond proactively to emerging risks.

We have also overseen several Safeguarding Adult Reviews (SARs), each of which has provided important learning. These reviews remain a core function of the Board, helping us to identify where systems can improve and ensuring that those lessons are embedded in everyday frontline practice.

Looking ahead, the BSAB will be guided by a new three-year strategic plan that sets out clear priorities and a robust delivery framework. We will adopt a sharper focus on evidence, assurance, impact, and learning, making sure that our work reflects the outcomes that matter most to adults at risk, their carers, and the wider safeguarding workforce.

Finally, I would like to extend my sincere thanks to all those working across the adult safeguarding system in Bolton. Your professionalism, dedication, and collaborative spirit ensure that our most vulnerable residents are supported to live lives that are free from harm, abuse, and neglect.

Neil Smith

Independent Chair

1. What is the Safeguarding Adults Board?

The Bolton Safeguarding Adult Board (BSAB) is established in line with the duties set out in Section 43 of the Care Act 2014, as the statutory mechanism for agreeing how partner agencies cooperate to protect adults at risk, prevent abuse and neglect and promote the wellbeing of adults in its area.

The Board meets on a bi-monthly basis.

Statutory Partners

The Care Act places a duty on three statutory safeguarding partners: Bolton Council, the Police, and the NHS Greater Manchester Integrated Care Board to work together with other relevant agencies to safeguard adults at risk.

In Bolton the membership of the board is:

- Bolton Council – Adult Social Care, Community Safety and Housing and Public Health
- Bolton CVS (Community and Voluntary Services)
- Bolton NHS Foundation Trust
- Department for Work and Pensions
- Greater Manchester Fire and Rescue Services
- Greater Manchester Mental Health Trust
- Greater Manchester Police
- Healthwatch
- National Probation Service
- NHS Greater Manchester Integrated Care Board
- Northwest Ambulance Service NHS Trust

There is also a legal adviser to the board.

Leadership and Independent Chair

The Independent Chair provides the support and additional reassurance that the Board has independence from the local authority and other partner organisations. The chair has an important role to lead, advise, encourage and support the board, as well as constructively challenging and holding member agencies to account. The Chair will also act as the spokesperson for the Safeguarding Adults Board when required.

Partnerships

Bolton Safeguarding Adults Board has a strong and effective partnership. Our governance structure ensures that our safeguarding arrangements provide strong collaboration, scrutiny, assurance, accountability and drive safeguarding across the whole system.

Safeguarding is everyone's responsibility – but different organisations and professionals have specific roles in relation to safeguarding adults at risk of harm. All our members have a role to play and actively contribute to the work of the Board.

Vision of the BSAB

Our vision is for the people of Bolton to live free from harm, abuse and neglect, with all partners working together effectively to enable and promote safeguarding as everybody's responsibility.

To achieve this vision, the Bolton Safeguarding Adult Board will:

Ensure, the voice of adults and their carers is at the centre of all we do, creating a culture where safeguarding is everybody's business, and good safeguarding practice is a priority.

In doing so, the six safeguarding principles will be actively promoted through the partnership work.

The six safeguarding principles

1. Empowerment Supporting and encouraging people to make their own decisions with informed consent.

2. Prevention It is better to take action before harm occurs, working together on any new or emerging safeguarding issues, themes, and trends.

3. Proportionality The least intrusive response appropriate to the risk presented.

4. Protection Supporting and providing representation for those in the greatest need.

5. Partnership Working with all agencies and the Bolton community in recognition that safeguarding is everyone's business. Communities have a part to play in preventing, detecting, and reporting safeguarding issues.

6. Accountability Accountability and transparency by ensuring the effectiveness of safeguarding practice across all single agency members of the BSAB and wider organisations working with adults at risk, and their carers, and as a Board seeking assurance in how we are currently performing in meeting our statutory duties, with a sharp focus on real time learning and embedding a learning and improvement culture.

Making Safeguarding Personal

In addition to the safeguarding principles, we are committed to being person-centred in our approach to safeguarding. Being person-centred means focusing on the person, not the process, listening to the adult and what they want to happen and taking their wishes and feelings into account wherever possible.

Core duties of the Board

The BSAB has the following core functions under the Care Act:

- **To develop and publish a strategic plan:** Within this plan, we set out our safeguarding adults' objectives, showing what we need to do to achieve these, and how we plan to do it. Our objectives are informed by continuous monitoring of local, regional and national themes and issues; we have a new system in place to identify local risks as they develop. We also use data from our partners and have been improving our quality, effectiveness, assurance and monitoring processes in recent years to support best safeguarding adults' practice.
- **To carry out and publish Safeguarding Adults Reviews (SARs):** These consider how agencies have worked together when a person has died or been at risk of or seriously injured. A review produces recommendations and key learning for the agencies involved to try to prevent these events from happening again. Responding to the learning is a key pillar of our approach.
- **To publish an annual report:** This public report shows how we have all worked together to deliver the objectives within this strategic plan over each year, using evidence from our business delivery plan, local data, and contributions from a range of partners.

2. The safeguarding landscape

What we know about our community

Bolton has a population of 302,383 with 9,538 adults receiving care and support from the local authority and 4,520 adults receiving long-term support. Of those accessing long-term support, 6% are in receipt of nursing care, 17% residential care and 77% are receiving care in the community.

We know that 18% of over 16s have a disability and 9% of those have a long-term health condition or disability which limits their day-to-day activities. 9.4% (this is similar to England and Wales according to Carers UK¹) of the Bolton population provide some form of unpaid care, with 33% of carers providing 50 or more hours per week of care.



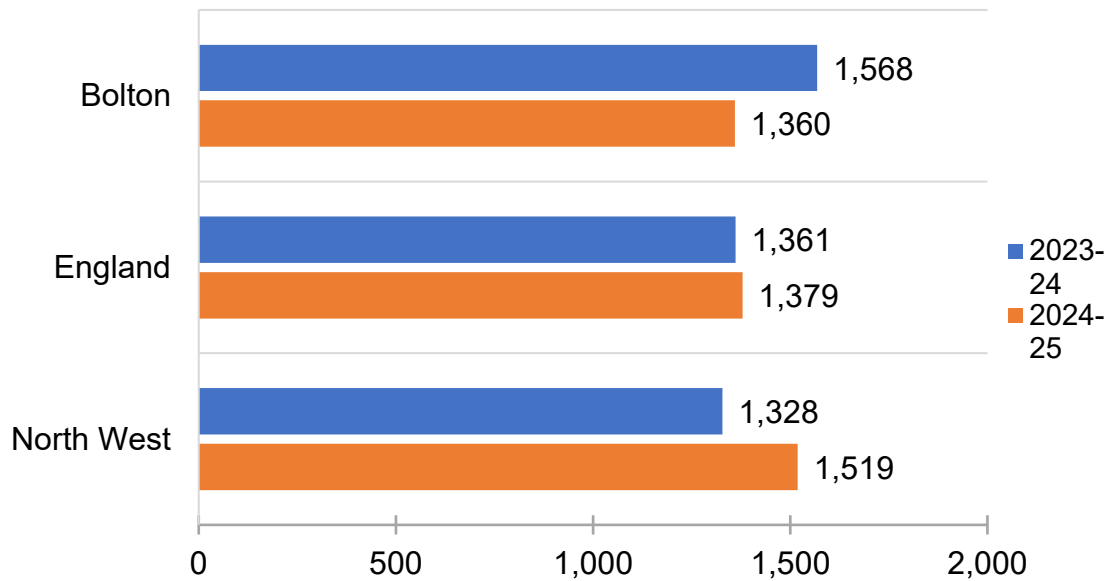
¹ [facts-about-carers-october-2025.docx](#)

Safeguarding Adults Collection Data 2024-25

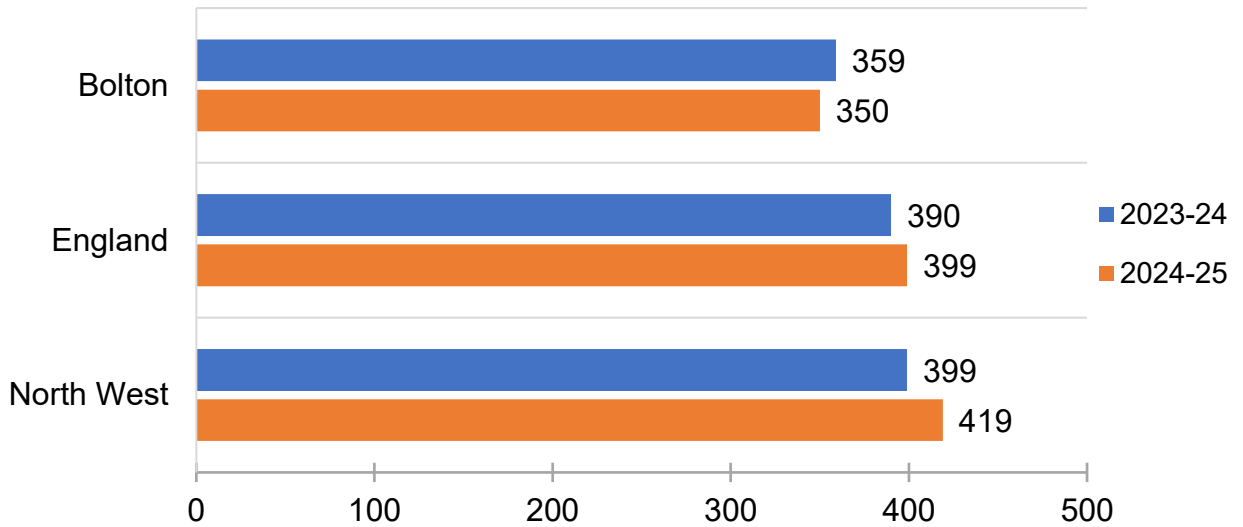
Safeguarding Concerns and Enquiries

During 2024-25, Adult Social Care received 3190 safeguarding concerns. This was 360 less than the previous year (3550 safeguarding concerns received in 2023-24). When we look at this data per 100,000 adults, it equates to 1,360 concerns in the last 12 months. The chart below shows that in the last 12 months, Bolton received fewer safeguarding concerns than the North West Average and was slightly lower than the England average.

Safeguarding Concerns per 100,000 Adults - Comparators

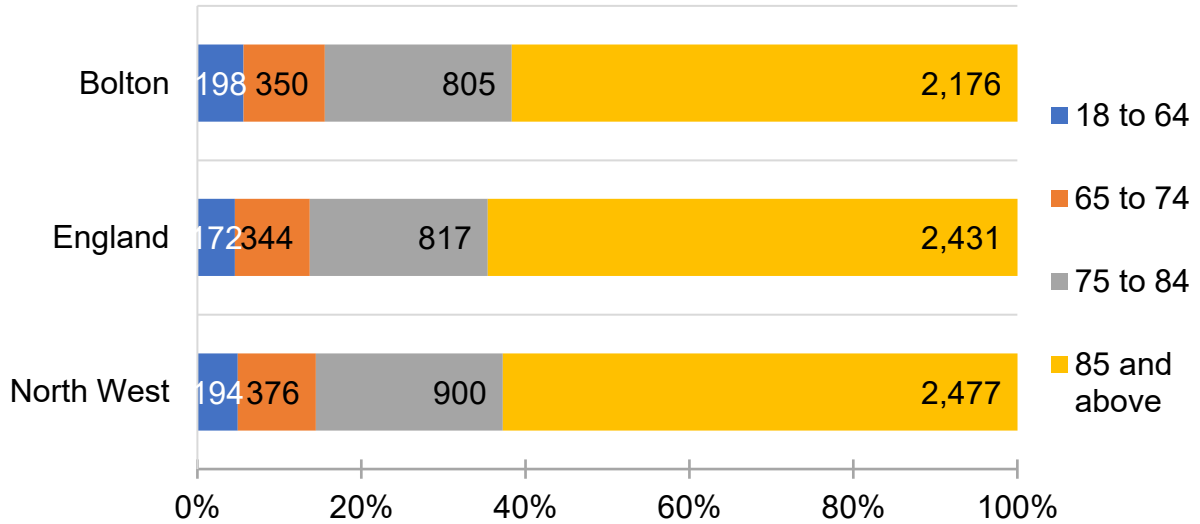


Section 42 Enquiries Commenced per 100,000 Adults - Comparators



In the year 2024-25, 350 Safeguarding Enquiries per 100,000 adults were commenced under Section 42 (of the Care Act 2014). This is slightly less than last year and less than the North West and England averages.

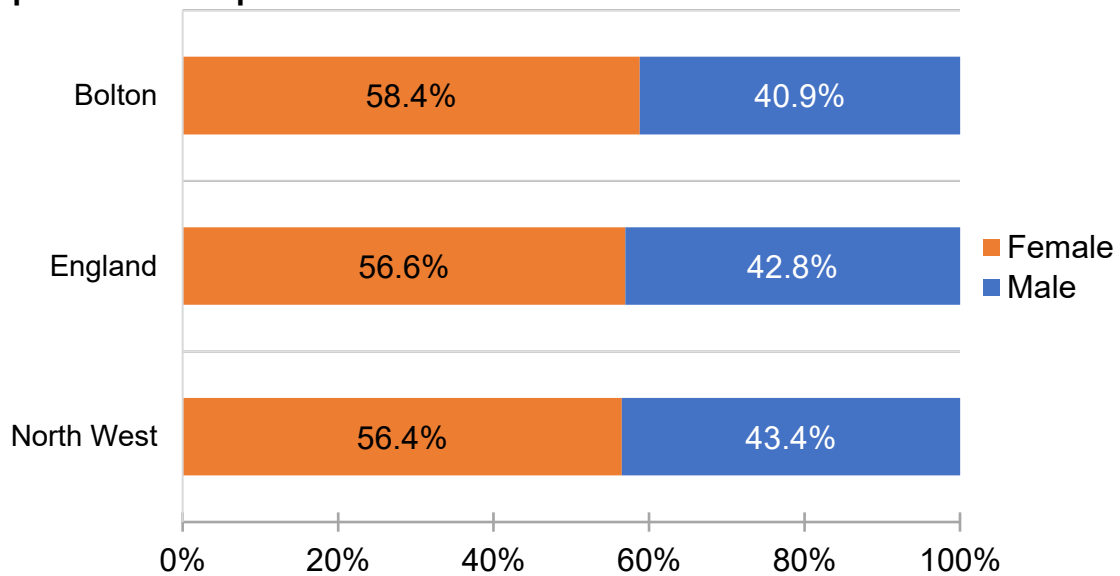
Individuals Involved in Section 42 Enquiries per 100,000 Adults by Age Group - Comparators



The chart above shows that the majority of people involved in safeguarding enquiries were aged 75 or older. This is similar to the North West and England data.

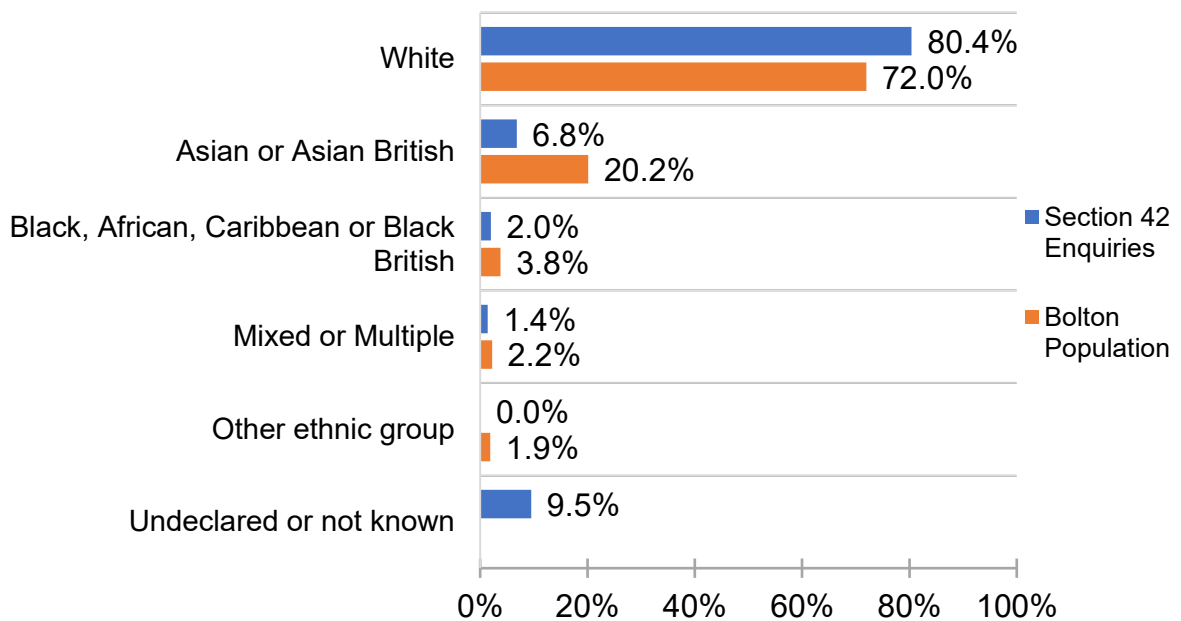
Demographics

Proportion of Section 42 Enquiries by Gender Compared to Population - Comparators



The chart above shows that slightly more safeguarding enquiries were completed in relation to females than males. This is slightly higher than North West and England data.

Proportion of Section 42 Enquiries by Ethnicity Compared to Bolton Population

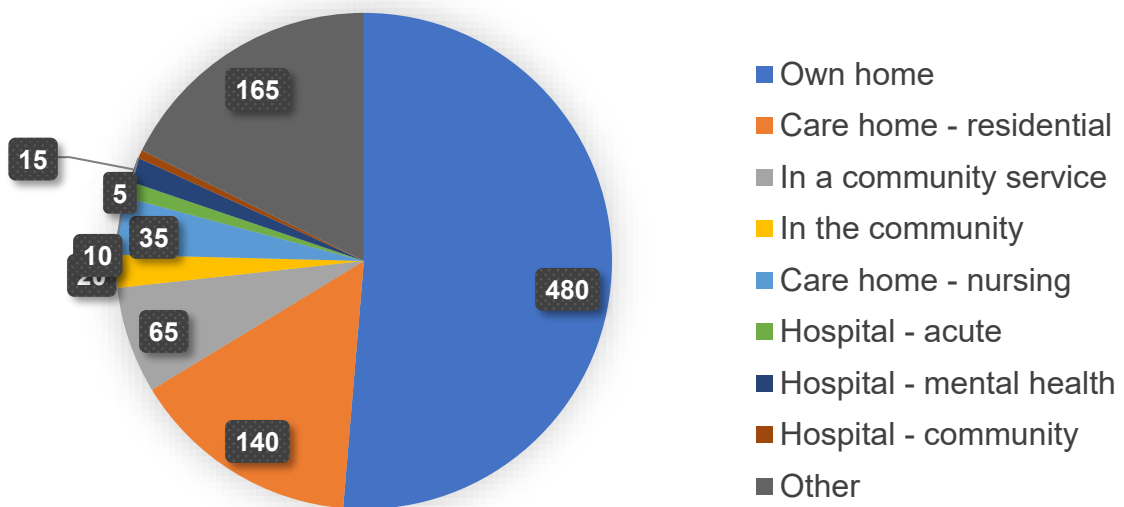


The chart above shows the proportion of safeguarding enquiries by ethnicity and compares this to the Bolton population. 80.4% of enquiries were in relation to people who were white.

This is higher than the proportion of the Bolton population who are white (72%). Enquiries involving Asian / Asian British people (6.8%) was much less than the population (20.2%).

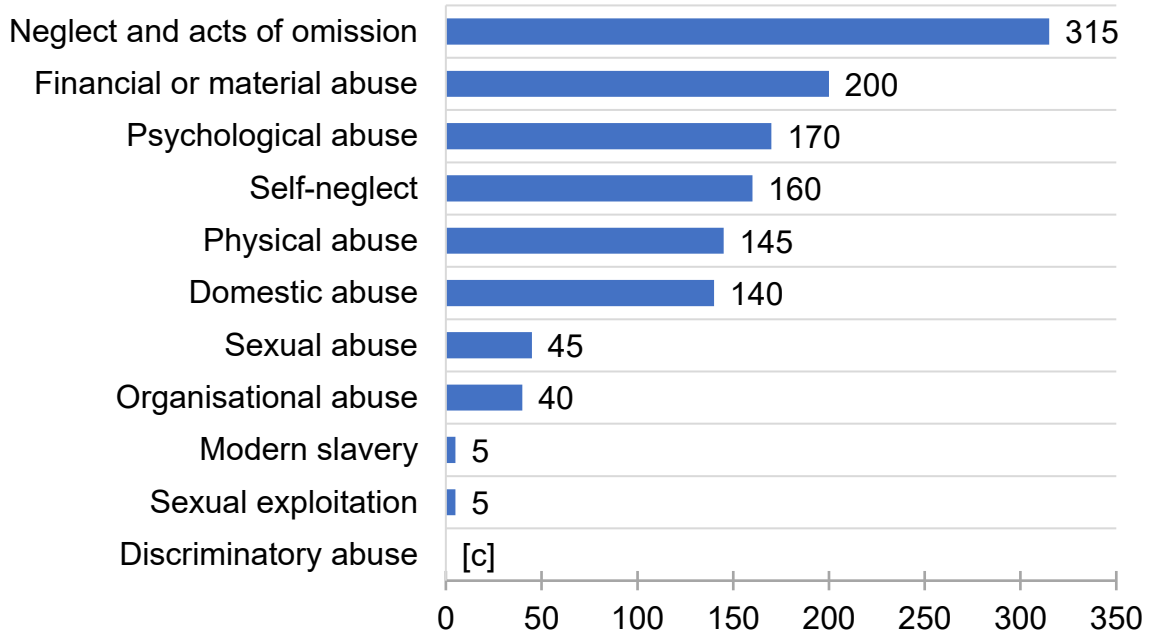
Location and Types of Abuse

2024-25 Location of risk in safeguarding enquiries



In over half of all safeguarding enquiries, the location of the alleged abuse took place the person's own home.

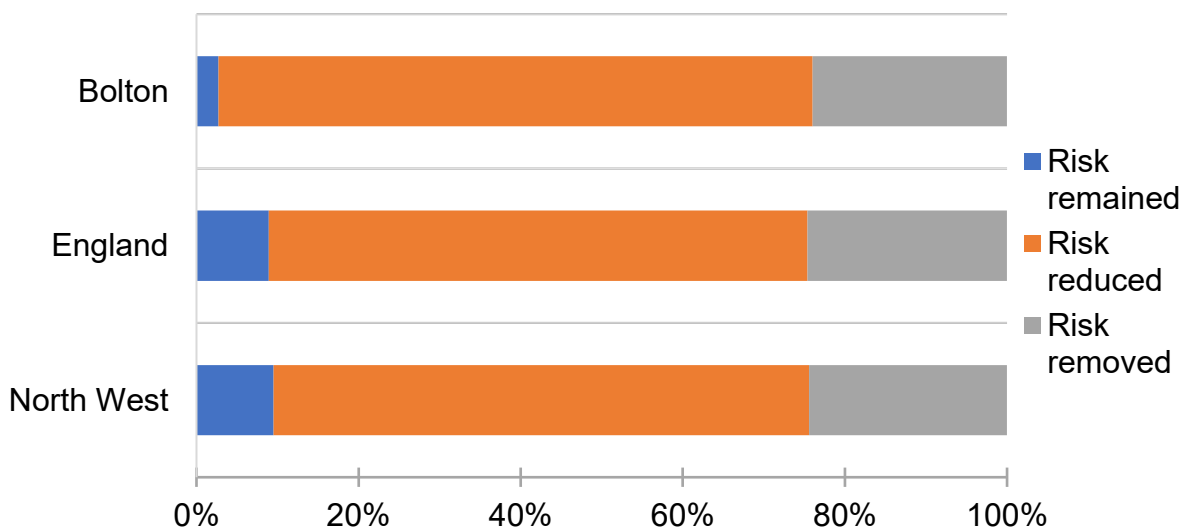
Types of abuse



The chart above shows that the most frequent type of abuse recorded was neglect and acts of omission, followed by financial and material abuse, psychological abuse and self-neglect. Often, people will often experience multiple types of abuse alongside each other.

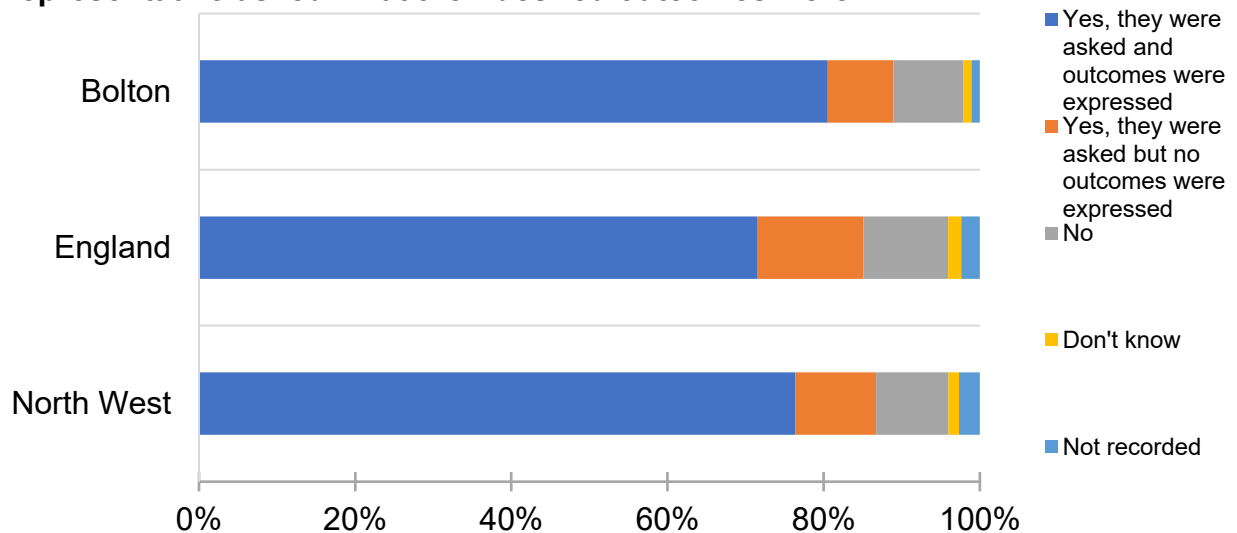
Outcomes of Safeguarding Enquiries

Where a risk was identified, what was the outcome / expected outcome when the case was concluded?



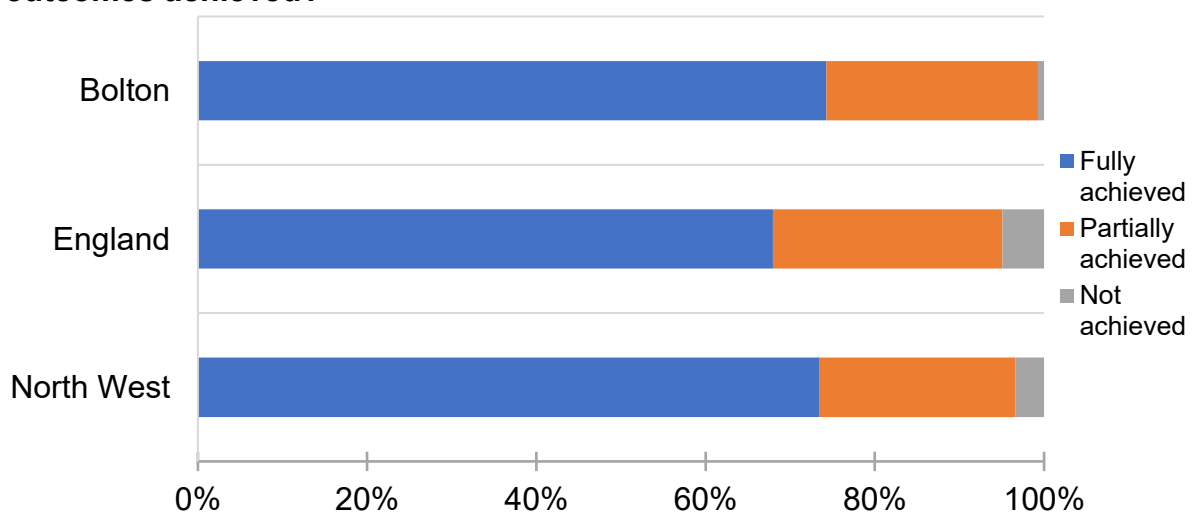
The chart above shows that the outcome / expected outcome that the risk was either reduced or removed in almost all cases. The proportion of cases where the risk remained was very low in Bolton, and this was lower than the reported figures for the North West and England.

For each concluded enquiry, was the individual or individual's representative asked what their desired outcomes were?



The chart above shows that in the majority of safeguarding enquiries, people were asked about their desired outcomes. This is slightly higher for Bolton than the North West and England data.

Of those asked what their desired outcomes were, were these outcomes achieved?



In the majority of cases where people were asked about their desired outcomes with regards to safeguarding enquiries, this was fully or partially achieved. This was higher for Bolton than the North West and England.

3. Our priorities

In 2024, BSAB produced a new [strategic plan for 2024-27](#) which identifies three key priority areas that underpin the work of the partnership in delivering the vision for the people of Bolton. The 3 priorities are set out below:

Proactive and Preventative

- Collaborate with Bolton residents and strategic partners to develop prevention strategies, focusing on key issues like domestic abuse and suicide prevention.
- Enhance engagement and representation of the VCSE and Faith sectors to ensure they understand and can contribute to the Safeguarding Adults Board's role in safeguarding adults.
- Identify and develop key awareness campaigns with accessible information and guidance, ensuring effective learning and development opportunities are shared across the sector.

Managing and Responding: effective practice

- Collaborate to create effective safeguarding policies, procedures, guidance, and training, adapting to legislative changes, national policy, best practices, and local intelligence.
- Implement a Quality and Effectiveness Framework with a fully functional Safeguarding Effectiveness Subgroup reporting to the Adults Safeguarding Board.
- Enhance the multi-agency data dashboard to analyse safeguarding data, understand demand, identify risks, and assess data and referral quality.

Voice and Learning Lessons: shaping future practice

- Create a co-production framework to enhance engagement with Bolton citizens, communities, and those with lived experience, shaping strategies, policies, and practices.
- Translate learning from Safeguarding Adults Reviews (SARs), local reviews, and national insights into effective training for organisations and staff, utilising learning circles.
- Develop a workforce skilled in safeguarding prevention, identification, and intervention.

4. Progress against our strategic priorities

Pro-active and preventative

- A suite of communications materials has been produced to raise awareness of safeguarding. This includes posters, leaflets and Z-cards (credit card size, fold out cards with basic safeguarding information). There are also pop-up banners and posters with information about reporting concerns regarding people in positions of trust. These materials will be utilised and distributed in 2025-26.
- Work has begun to develop a new website for Bolton Safeguarding Adults Board. This will be completed and launched in 2025-26 and will significantly enhance the information available about the board to both professionals and the public.

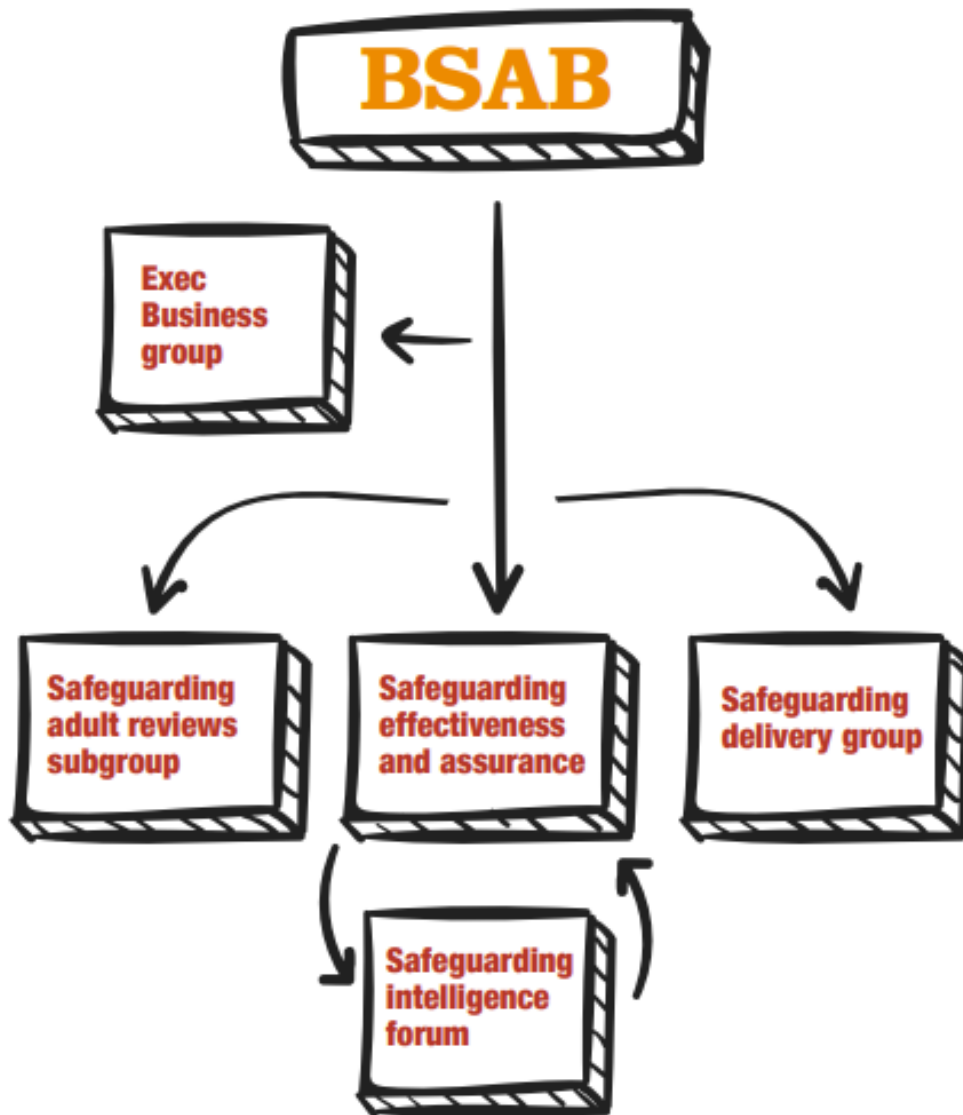




Managing and Responding

- The BSAB Constitution has been updated and signed by all members.
- The BSAB structure was reviewed and sub-groups streamlined to create a Safeguarding Effectiveness Sub-group (SEG), Safeguarding Adult Review (SAR) Sub-group and a Safeguarding Delivery Group with new sub-group chairs appointed. Terms of Reference for the SEG and SAR Sub-groups were reviewed and refreshed. The new sub-group structure is shown on the diagram below.
- The BSAB Multi-agency Safeguarding Policy has been updated and published on the Bolton Council website.
- The Safeguarding Adult Review Protocol was also updated and published on the website.
- The BSAB Independent Chair is also Chair of the Greater Manchester Chairs and Business Manager's Network. Both the Chair and Business Manager attend the national networks to ensure that BSAB can influence the national agenda as well as drawing on good practice from other areas.
- The SEG has developed and begun to implement a new [Quality and Effectiveness Assurance Framework](#) and [Safeguarding Effectiveness Toolkit](#). It is the role of the SEG to analyse available data to understand demand, ensure effectiveness and identify emerging risks and trends.
- A new exceptions report has been introduced which members complete ahead of each meeting. This includes information on emerging themes, trends or risks and any action being taken in response. Any issues identified can be addressed or escalated to the BSAB where necessary.
- Work has been ongoing to develop data dashboard for the SEG.

Diagram – BSAB Subgroup Structure



Voice and Learning Lessons: shaping future practice

- SAR Nancy was completed and published in May 2024; a learning event was held to share learning from SAR Nancy. The event was presented by the review author Paul Nicholls and Karl Mason, a Senior Lecturer in Social Work and member of the Local Government Association (LGA) Partners in Health and Care Subgroup Discriminatory Abuse Advisory Group.
- Several workshops were held in the Autumn 2024.
 - The first of these was held in September and this focused on Understanding Discriminatory Abuse and Intersectionality.
 - This was followed by Multiple Exclusion Homelessness and Safeguarding in October.
 - A third workshop was held in November (during Safeguarding Adults Week) on Discriminatory Abuse, Hate Crime and Safeguarding Adult Reviews.
 - 78 people attended these sessions.
- Safeguarding Adults Week led by the Ann Craft Trust is held in November each year. During Safeguarding Adults Week, several external speakers were commissioned to present training / learning sessions. These included:
 - Learning from Safeguarding Adult Reviews (23 attendees)
 - Supporting Suicide Prevention in the workplace (10 attendees)
 - Self-neglect and safeguarding (32 attendees)
 - Transitional Safeguarding (12 attendees)
 - Practical Approaches to handling pressure sores (17 attendees)
 - Transitional Safeguarding (14 attendees)
 - Self-neglect and complex issues (31 attendees)
 - Discriminatory abuse, hate crime and safeguarding adult reviews (35 attendees)
- The Independent Chair conducts one to one meetings with partner leads to review how learning opportunities are operationalised into practice.

5. How our partners have contributed

Bolton Integrated Care Board (ICB)

As a statutory partner of BSAB, the Greater Manchester Integrated Care Board (ICB) at the Bolton locality is fully committed to the Board's priorities. Our Designated Safeguarding Adult Professional and Associate Director of Quality (ADQ) represent the ICB at BSAB and its subgroups. The ICB is also a member of the Bolton Domestic Abuse Board, helping to shape Bolton's response to domestic abuse with a strong focus on prevention.

One key piece of work from the Domestic Abuse Workstream involved an in-depth review of thematic Safeguarding Adult Reviews (SARs), with a particular focus on contextual suicide. Reviews revealed that child removal, often influenced by complex issues like domestic abuse, can lead to deep emotional distress and increased suicide risk for parents, especially when post-removal support is lacking. Greater Manchester Delivery Groups are now identifying and sharing best practices across the region and nationally with the goal being to establish a more coordinated, trauma-informed response.

The ICB undertakes a range of activity which includes:

- Active promotion of suicide prevention through staff briefings and newsletters.
- Championing the Making Safeguarding Personal (MSP) approach across the local health system, including ensuring safeguarding responses are person-led, outcome-focused, and respectful of the individual's choices and experiences.
- Health providers actively participate in safeguarding enquiries by offering clinical expertise, providing timely and accurate information, supporting a coordinated multi-agency response that recognises and incorporates the adult's lived experience.
- Supports multi-agency safeguarding training, supervision models, access to expert advice, thematic learning sessions and discussion forums.
- Facilitates learning across the health system in several ways which includes through:
 - the **Safeguarding Health Collaborative** where learning is shared during meetings and through the distribution of resources such as 7-minute briefings. Discussions explore the implications of findings for local providers.
 - **Designated Nurses:** Act as conduits between the Greater Manchester Designated Group (DG) and localities, ensuring learning and guidance are shared consistently.

- **Named GPs:** Are linked in as resources and provide updates to Clinical Leads
- Commissions training on specialist topics such as Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), Coroner's Court, including statement writing and court preparation, Safeguarding conferences and masterclasses. Training is regularly reviewed to reflect new learning from statutory reviews, changes in national policy, and emerging safeguarding issues.
- All ICB staff with clinical responsibilities are now required to complete the Oliver McGowan Mandatory Training on Learning Disability and Autism, including a one-day, face-to-face session.
- The ICB monitors provider safeguarding training compliance through contractual standards, which are being updated for the 2025/26 framework.
- Greater Manchester Integrated Care Board (ICB) has introduced a new digital safeguarding review platform, a first-of-its-kind system designed to improve oversight and learning from statutory safeguarding reviews across all localities. This innovative platform enables each locality to upload, update, and monitor reviews, helping to identify emerging themes, trends, and cross-cutting learning that can be shared both locally and regionally.

Adult Social Care

In November 2024, Adult Social Care (ASC) implemented a new professional safeguarding online referral portal. The primary objective was to enhance the quality of information submitted at the referral stage, supporting timelier and more effective triage, and reducing the need to request additional information from referrers.

Since its introduction, the portal has led to significant improvements in the quality and completeness of referral information. This has enabled the safeguarding team to triage cases more efficiently and proactively signpost individuals to appropriate teams and services, ensuring more effective support. A review of the referral form is planned to further improve this.

Over the past year, ASC has embedded the Safeguarding Adults Board Persons in Positions of Trust (PiPoT) framework. The adult safeguarding team manages PiPoT referrals and investigations in line with the framework. We have designed and fully integrated the process within our care record system, enabling secure, centralised recording and investigation of staff where safeguarding concerns arise, and facilitating cross-referencing across organisations. This supports the identification of patterns and enhances oversight.

Additionally, the co-located Multi Agency Safeguarding Hub (MASH) facilitates daily referral huddles with police colleagues and, where appropriate, Children's Social Care. These meetings enable the early identification of risk, the development of robust support plans, and effective signposting to other services. This proactive, partnership-driven model helps to minimise risks and ensures that safeguarding interventions are both timely and effective.

ASC safeguarding management team continue to play an active role in supporting Bolton's multi-agency response to domestic abuse through regular participation in the weekly Multi-Agency Risk Assessment Conference (MARAC).

ASC has worked closely with partners, to review the multi agency safeguarding policy and Safeguarding Adults Review protocol.

ASC staff have been instrumental in developing and supporting the ongoing work to enhance the multi-agency data dashboard, with the primary aim of enabling more sophisticated analysis of safeguarding data which is being overseen by the Safeguarding Effectiveness Sub-group (SEG). The group monitors the quality of safeguarding practice and is driving continuous improvement through shared learning and reflective practice.

As part of ASC role within the BSAB Delivery Group, we are leading the development of a multi-agency risk management framework. This initiative is designed to support system partners in effectively managing cases where individuals present a high risk to themselves or others, and where standard case management processes have been exhausted. The framework will provide clear guidance for escalation to system leaders, ensuring that complex cases receive coordinated oversight and timely intervention across the partnership.

Adult Social Care remains committed to ensuring that the voice of adults at risk is central to all safeguarding activity. A Council co-production framework has been developed to enhance engagement with Bolton citizens, communities, and individuals with lived experience. This framework ensures that adults are actively involved in shaping service delivery. Regular engagement events and feedback mechanisms have been established, enabling Adult Social Care to listen to and act upon the views of those with lived experience.

ASC recognises that continuous learning and development are essential to delivering high-quality services. All social work teams are required to complete statutory training, including Deprivation of Liberty Safeguards (DoLS), Safeguarding, and the Mental Capacity Act (MCA), with compliance monitored by Managers to ensure all staff remain up to date.

In 2024–2025, additional training was provided on domestic abuse, modern slavery, co-production, and strengths-based practice. These initiatives are supporting staff to be well-equipped to manage Section 42 safeguarding enquiries and respond effectively to the evolving needs of the community and recognise adults at risk earlier stage to offer preventive measures and services to reduce risks.

Greater Manchester Police (GMP)

A dedicated Domestic Abuse Unit was implemented in late 2024 to specialise in targeting high risk offenders and repeat offenders. The team identify a rolling top ten priority offenders for intensive work around enforcement. Alongside this, the victims of this group are engaged and supported through judicial processes.

Multi-Agency Tasking and Co-ordination (MATAC) Officers have also been implemented. Their role is to identify the most harmful and serial domestic abuse offenders and use multi-agency intervention and approaches to prevent re-offending. MATAC officers will support, divert, prevent and enforce using a range of criminal justice sanctions and other interventions.

Arrests for domestic abuse have increased significantly and the use of Domestic Violence Protection Orders has also increased. Daily triage with partners is carried out to look for opportunities to protect victims and their families.

Fortalice (a local domestic abuse charity) has worked closely with police officers and has resulted in better engagement from victims. The MATAC officer along with a dedicated Fortalice worker review all domestic abuse incidents where officers have an appointment to attend. The Police Officer will be accompanied by a Fortalice worker to engage the victim, giving them several options both inside and outside of the criminal justice system.

The District Intelligence Unit supported by the Neighbourhood team, Programme Challenger (Organised Crime Team) and partners continue to identify individuals that are at risk of exploitation by actively preventing and investigating instances of 'Cuckooing' also known as home takeover (where an offender takes over a vulnerable person's home, usually for criminal purposes). The next 12 months will see us strengthen our intelligence collection and sharing between partners and the voluntary sector.

Bolton CVS

Bolton Community Voluntary Sector (CVS) work alongside Bolton's Voluntary, Community and Social Enterprise (VCSE) sector, supporting them to fulfil their roles and responsibilities effectively.

Bolton CVS has continued to promote the need to safeguard adults at risk across the sector, providing basic level training throughout the year to different organisations. They have continued to promote the need for safe recruitment, appropriate policies training, risk assessment and volunteer management with our safeguarding in the VCSE sector session and by using the organisational health check which forms part of the Bolton Mark. Where required, individual support for groups is provided and provides tailored advice on how organisations can be well-run, safe and sustainable.

Bolton NHS Foundation Trust

Bolton Foundation Trust has undertaken a range of activities to strengthen safeguarding within the trust and across the multi-agency partnership. The Trust has reshaped their Safeguarding Committee framework and membership which now includes BSAB Independent Chair as a core member. There has been a clear step change in system issues being identified early and evidence of a joined-up response.

- As part of our assessment processes within Emergency Department and Maternity, information relating to Domestic Abuse is captured and audited. The maternity audit highlighted further training to upskill of midwives to signpost and offer relevant support during pregnancies.
- As part of Safeguarding Adults' Awareness week, we had one day focused on Domestic Abuse. This was well received by both visitors and staff.
- Over the past year, we have strengthened our commitment to supporting staff affected by Domestic Violence and Abuse (DVA) by working closely with ward managers to ensure consistent and compassionate application of the Trust's Domestic Violence and Abuse Policy. This has led to increased confidence among ward managers in handling disclosures and enhanced support for staff members affected.
- We have worked in close partnership with the local authority to co-develop and refine our process and guidance documents around safeguarding enquiries and the Deprivation of Liberty Safeguards (DoLS) Policy, to ensure our processes complement one another.

- 7-minute briefings have been used to cascade key messages to frontline staff through divisional leadership structures, with assurance being sought through Trust Safeguarding committee
- Safeguarding Adults and Prevent Training is part of the mandatory training suite.
- The Safeguarding team continues to build expertise through specialist training in Mental Capacity Act, Mental Health, and DoLS.
- A new Level 3 Adult Safeguarding Training e-learning package was developed in 2025 to run alongside face-to-face training. This was designed to encourage staff to reflect on poor safeguarding practices and to improve responses and accountability.

Bolton Council Community Housing

Community Housing Services provide a range of services and interventions to support vulnerable adults and their families at key points such as when they are at risk of or experiencing homelessness. As well as providing emergency interventions to alleviate homelessness, the services provide a range of interventions to prevent people losing their homes and to improve their living circumstances – where home circumstances may adversely affect people’s health and well-being.

Rough Sleeping and Multiple Disadvantage

The Rough Sleeping team is a virtual team co-ordinated by the Council’s outreach service involving nurses, addiction and mental health professionals as well as supported housing partners and the voluntary sector. During 2024-25, 351 people were assisted into emergency respite accommodation to either support them from the street or prevent them from rough sleeping. The people experiencing rough sleeping present a great deal of complexity with over a third of the cohort demonstrating a combination of three or more elements of multiple disadvantage. The current target priority group, comprising 25 people, had been sleeping rough in two or more years out of the last three and in 2 or more months in the last twelve.

Work has been undertaken to develop positive social circles for people to support longer term recovery when exiting rough sleeping and associated complex challenges. Ongoing development of the Genesis project in partnership with Urban Outreach is seeing the building of a supportive community providing opportunities for meaningful engagement and activity. This work is feeding into other work programmes such as Changing Futures, with the client group being central to developing further co-production, lived experience and potential emerging peer support opportunities.

Housing Vulnerable Adult Social Worker Role

One key area of development of the team has been the securing of a permanent Housing Vulnerable Adult Social Worker role which is fully embedded within the Rough Sleeping and Housing Options team. Whilst several Council's do have strong linkages across rough sleeper work and Adult Safeguarding Social Work, this dedicated role appears to be the first of its kind. The intention is to embed the role and influence of professional social work curiosity within our approach to one of the most vulnerable and excluded groups in our community.

A key focus will be developing our understanding and deployment of mental capacity and executive functioning assessment and effective support interventions learning from ground-breaking rough sleeper intervention work currently being undertaken in Manchester. The role is intended to deliver true connectivity across housing, homelessness and rough sleeping and professional social work enquiry, Care Act interventions, and embed Adult Safeguarding influence across the functions of housing need.

Homelessness and Vulnerable Adults

The Housing Options service provide homelessness assessment and prevention, securing temporary accommodation for 695 households of which 212 single people were assessed as 'vulnerable' within the scope of part VII Housing Act 1996 during 2024/25. In addition, the service secured a 'place of safety' for 89 households fleeing domestic abuse during the year. Homelessness assistance was provided to 126 people leaving institutions / prisons and providing hospital discharge support to a 100 people leaving mental health wards.

Accessible Accommodation

Access to suitable social housing is critical especially where it relates to those with an adapted or accessible accommodation need. There were 562 households accepted onto the Adapted Housing Register at the end of 2024/25, with a further 106 having been secured accommodation to meet their needs during the year.

Community Safety

Community Safety continues to play a central leadership role in Bolton's response to domestic abuse, led by the Domestic Abuse Strategic Lead and supported by the Domestic Abuse Safeguarding Officer. Together, they provide strategic oversight, policy development, and project coordination through the Domestic Abuse Partnership Board and the newly established Domestic Abuse Operations Group.

Key highlights of this work include:

Safe Accommodation: Under Part 4 of the Domestic Abuse Act 2021, Bolton has implemented provision of new safe accommodation, commissioned contracts that meet statutory requirements and services that are trauma-informed, accessible, and responsive to the diverse needs of victims and survivors.

Embedding Lived Experience: Bolton was selected as a pilot site in partnership with SafeLives to embed lived experience into the local coordinated community response. This includes establishing survivor engagement mechanisms, such as the development of the Survivors Forum, to ensure that lived experience informs commissioning, policy, and practice.

Perpetrator Intervention: Through GMCA perpetrator funding, targeted interventions such as the Inner Strength and Inner Peace programmes are delivered via commissioned providers. These initiatives support behavioural change and accountability. Additionally, the new MATAC (Multi-Agency Tasking and Coordination) function addresses high to medium risk repeat perpetrators.

Strategic Action Plan Implementation:

- The partnership is actively delivering Bolton's four-year Domestic Abuse Strategic Action Plan, which includes 38 actions.
- Immediate priorities include launching the "Voices Against Domestic Abuse" community brand, revising the Domestic Abuse Toolkit, hosting the Domestic Abuse Annual Event, and reviewing MARAC (Multi-Agency Risk Assessment Conference) processes.
- Future phases will introduce Healthy Relationship Education in Schools, Bystander Awareness Training, and the Human Library Campaign to amplify survivor stories.

Multiagency action plans are informed by learning from Domestic Abuse Related Death Reviews (formerly Domestic Homicide Reviews), ensuring continuous improvement in practice. Long-term impact metrics and stakeholder engagement strategies are being developed to sustain progress.

Changing Futures Programme

In quarter 4, Bolton's newly funded Changing Futures programme, working in partnership with Revolving Doors, hosted a series of three codesign/coproduction consultations with adults accessing services, residents and other stakeholders. The aim of these workshops was to gain insights into people's experiences of multiple disadvantage that could be used to shape future practice and inform the delivery of the Changing Futures programme as it gets fully underway in 2025-26.

Work such as this represents a renewed and strengthened commitment from Bolton Council towards ensuring the voices of adults at risk and those experiencing multiple disadvantage continue to be heard and are used to influence policy and practice. To help drive this work forward, the council recruited a dedicated Changing Futures Programme Manager, whose focus will be on building and establishing the programme in Bolton, as well as contributing to a longer-term, system-wide approach to improving access, support and outcomes for people experiencing multiple disadvantage and other at-risk adults.

When the Changing Futures programme launches fully in 2025-26, it will have its own its coproduction framework, including regular feedback and design spaces with adults accessing services and community members, that will help shape the programme.

Changing Futures will also explore partnerships with lived experience organisations to provide training for practitioners around multiple disadvantage and how best to use a person-centred, trauma-informed approach, making an important contribution to workforce development and upskilling. As the programme progresses, there will also be voluntary and paid employment opportunities for people with lived experience of multiple disadvantage, supported in partnership with Bolton's strong VCSE sector.

Greater Manchester Fire and Rescue Service (GMFRS)

GMFRS continues to strengthen internal safeguarding arrangements so that all our staff and volunteers are best equipped to identify and refer safeguarding concerns for members of the community and our own personnel. The service has commissioned a suite of online training courses to help staff and volunteers gain a more in-depth understanding of specific safeguarding themes, such as Modern Slavery, Domestic Abuse and Adult Neglect.

GMFRS has made system improvements so that all safeguarding activity is recorded digitally. Quality assurance is a key focus for future development and the service will be investing additional resources to ensure that referrals and information submitted to safeguarding partners is of a good standard.

The GMFRS Prevention Manager continues to act as the single point of contact for safeguarding partners in these areas and remains an active member of BSAB and various subgroups.

Healthwatch

Healthwatch's remit is to listen to the community about their experiences of using health and social care services. They also provide information, advice and signposting to the public.

Healthwatch Bolton is working more closely with the BSAB to share intelligence about people's experiences of using health and care services. This assists the BSAB to have a wider picture of what people are experiencing in Bolton, and to provide assurance that health and care services are meeting the needs of the community. Activity during the last year has included:

- Escalation of safeguarding concerns in a timely manner to the relevant departments.
- Identified themes of concern, including dignity in care, continuity of care, and access to advocacy.
- Supported the promotion and distribution of safeguarding literatures within the community to raise awareness of how to identify safeguarding risks.
- Conducted regular review of Safeguarding policies and processes.
- Attended the Safeguarding Effectiveness sub-group meetings where feedback from the public / our intelligence is shared.
- Attended safeguarding collaborative meetings to share intelligence with partners.
- Attended Bolton Quality System (multi-agency meeting).
- A summary of issues is provided as part of regular feedback to Healthwatch Board and BSAB.

Greater Manchester Mental Health Trust (GMMH)

GMMH has an established safeguarding structure led by the Chief Nurse as the Executive Lead for Safeguarding. Strategic and operational safeguarding arrangements are delivered and supported by the Corporate Safeguarding Team and locality Safeguarding Leads.

In the last year, GMMH has undertaken a range of activity to strengthen safeguarding in the trust and within the Bolton locality:

- Safeguarding alert functionality was reviewed and improved on the clinical record system to ensure alerts are visible in relation to domestic abuse and exploitation.
- Several briefings were completed during 2024-25 in response to key learning and themes emerging from internal and external multi-agency reviews. This has included self-neglect and Mental Capacity Act, care leavers, prevent and radicalisation, domestic abuse, policy and resources, professional curiosity, distressed behaviours and others.
- A new network has been established for identified 'Champions', facilitated by the Corporate Safeguarding Team.
- A new Suicide Prevention Strategy for 2025-29 has been approved
- A review of the governance arrangements for safeguarding across the Trust was undertaken and a new monthly meeting sequence introduced to strengthen oversight, scrutiny and assurance in relation to safeguarding.
- A Learning from Reviews Group was established to ensure improved oversight of reviews and action plans.
- The Trust has a comprehensive suite of safeguarding policies, procedures, and practice guidance, alongside the multi-agency procedures, which support staff to identify and respond to safeguarding concerns.
- Safeguarding care documentation was rolled out in the Bolton Division which will ensure improved data capture.
- Introduction of quality visits across service areas which includes a safeguarding subject matter expert and adults with lived experience.
- Inclusion of adults using services representative on the interview panel for Safeguarding Lead roles.
- In Q3 2024/25, new bitesize learning sessions were introduced in response to key themes from learning: this included sessions on Wilful Neglect – legalities/roles/responsibilities, Domestic Abuse Policy re-launch and Section 117 [of the Mental Health Act 1983] which relates to duties in relation to providing aftercare to some people detained for treatment under the act.
- Trust wide Professional Curiosity Learning Event co-developed and co-delivered by the Corporate Safeguarding Team in Q4 2024/25.

- The Trust also delivers Levels 1-3 Safeguarding Adult Training. Level 3 is facilitated by a Safeguarding Trainer. Training is also delivered on Safeguarding Enquiries (under Section 42 of the Care Act 2014), Mental Capacity Act 2005 and Chairing Safeguarding Enquiries on a regular basis.
- Let's Talk about Domestic Abuse' Training was co-developed and co-delivered by an adult with lived experience.

Public Health

Public Health promote positive emotional, mental and physical health across the population and share details of how to 'be well' and 'stay well'. This includes providing information on where to get support, how to access advice, information, training and resources with the aim of preventing an escalation of poor health and associated crisis. More information can be found at [Let's Keep Bolton Moving - Activities, Health, Fitness, and Community Wellbeing in Bolton](#).

The team work closely with the local voluntary, community, faith and social enterprise sector (VCFSE) to promote the **5 Ways to Wellbeing** and have also commissioned work with the sector to increase awareness of the impact of **ACEs (Adverse Childhood Experiences) and Trauma** among our communities and partners.

More recently the department has developed and launched the **[Bolton Prevention Framework](#)** which will support a shift in thinking when developing our approaches to a wide range community developments, community assets, local strategies, plans and policies, service offers and our system workforce.

Public Health continue to collate data, intelligence and evidence to inform system developments, identify gaps, risks and challenges to inform our ever evolving **[Joint Strategic Needs Assessment](#)**. This includes:

- Information on drug and alcohol related deaths, near miss overdoses and suicide deaths.
- Suicide verdict information which contributes to the local **Suicide Audit**.
- Local real-time suicide surveillance data, enabling early identification of emerging trends

Public Health contributes to the Safeguarding Effectiveness sub-group and are considering what data and intelligence can be contributed to the development of the multi-agency safeguarding data dashboard.

Public Health have played a key role in developing and number of local strategies including:

- Suicide prevention strategy which has been co-designed with various key partners and will be launched in Autumn 2025.
- [**Bolton's Age Friendly Strategy 2025-2028**](#) which includes understanding the prevalence of Dementia, risk around falls and deprivation of income. The strategy developments have been co-produced with older people from across Bolton.

In the last year, Public Health have reviewed the quality and effectiveness of our Public Health commissioning processes and service contracts as part of our wider commissioning plan. Work has included:

- Working closely with key partners and in line with **Changing Futures Programme** to define a way of evaluating work around multiple disadvantage and ensure that services / systems respond effectively to adults with these more complex needs.
- Facilitated the growth of a strong recovery network '**Next Steps**' which is built on **lived experience** and is closely linked to the drug and alcohol service provision in Bolton. It also links to the **Bolton Alcohol, Drugs and Gambling Alliance**, which brings together key stakeholders.
- Utilising additional grant funding to enable **Rough Sleepers** better access to drug and alcohol treatment where needed.
- Commissioning the specialist drug and alcohol treatment service **Achieve** which contributes to a multi-disciplinary workforce with partner agencies that provides specialist services such as neuropsychology, psychology, access to psychiatry and dual diagnosis case management to better support some of our most vulnerable and complex residents.
- We require our providers to achieve expected levels of compliance with the training of staff to Safeguarding level 3 and which is monitored via contract review and reporting processes.

We have also worked in partnership to develop or commission a range of training programmes which included mental health training, different conversations, Adverse Childhood Experiences (ACEs)/Trauma Awareness Training and understanding alcohol dependency and engaging change resistant drinkers.

Probation

Building upon the solid foundations and successes of the past 12 months, 2025/26 has been labelled the Year of Quality within the Probation Service and addressing safeguarding and domestic abuse is an integral part of the drive to continue to improve quality in practice. There has been a particular focus on ensuring relevant information is incorporated into good assessments and this is then evidenced in the management of each case.

Some of our achievements over the past year include:

- A range of case auditing has now been established. This is undertaken at a local, regional and national level. A process has been established to ensure that any learning is shared promptly with the case holder.
- A domestic abuse support officer has been appointed to support practitioners address obstacles in the management of cases. An input was given to the workforce in October 2024.
- In December 2024, Controlling Coercive Behaviour (CCB) Guidance was issued to the Bolton workforce.
- Guest speakers from the VCSE and faith sector have been invited to provide information and training to the workforce with the aim of raising awareness of services that exist to meet local community need.
- As and when appropriate, representatives from the faith sector have been invited to attend MAPPA (Multi-Agency Public Protection Arrangements) meetings to enable them to contribute to the management of risk and ensure religious needs are met.
- All staff are required to complete suicide awareness training and there is a dedicated representative attends regional meetings and cascades information as required.
- Greater Manchester Audit and Assurance Unit established
- Bolton Implementation and Embedding Meeting has been established to allow dedicated reflective time to consider how public protection practice can be improved, including how learning from reviews such as safeguarding adult reviews can be embedded into practice.
- A number of checklists have been introduced to support probation practitioners/officers to ensure that key areas such as risk management planning, sentence planning, child safeguarding and domestic abuse are covered and all necessary measures in place.
- Actively driven improvements in use of flags to highlight issues on the case management system such as vulnerabilities, 'cuckooing' also known as home take over and mental health.
- Annual 'Your Voice Matters' Survey was completed with 71 respondents.

- A Person on Probation recognition scheme launched to recognise and reward people on probation who have performed well and made significant changes.
- Engaging People on Probation Forum (EPOP) is firmly established and brings together lived experience of people on probation with probation staff, enhancing the quality of provisions and practice. Bolton Probation was the first region to set up its own EPOP newsletter which was launched in Spring 2025.

North West Ambulance Service (NWAS) NHS Trust

North West Ambulance Service operates across the Northwest region, an area covering 5400 square miles and covering Cumbria, Lancashire, Greater Manchester, Merseyside, Cheshire and Glossop (Derbyshire). Services include emergency response, patient transport provision, the NHS 111 urgent care and advice providers.

A designated safeguarding practitioner from NWAS is assigned to the Bolton area to engage and contribute to Safeguarding Adult Reviews (SAR) and Domestic Abuse Related Death Reviews (DARDR) formerly called Domestic Homicide Reviews (DHR) processes. Any organisational learning or recommendations from these processes is considered internally and action taken or learning cascaded accordingly.

NWAS clinicians' complete level 3 safeguarding mandatory training. Promoting increased professional curiosity for our workforce is a focus of current and future safeguarding educational delivery.

Department for Work and Pensions (DWP)

The Department of Work and Pensions have sustained its proactive and preventative work through presentations and training its staff across Greater Manchester (DWP wide), including Jobcentres, Service Centres and Retirement Services. Training has included Professional Curiosity, Prevent and Professional Boundaries.

The DWP is committed to ensuring effective safeguarding arrangements by attending Safeguarding Boards and other multi-agency meetings and contributing to Safeguarding Adult Reviews when required. This enables us to ensure that findings/outcomes from reviews are fed through to National DWP teams for learning and quality improvement in service delivery.

To ensure the voice of the adult at risk is heard and used to inform safeguarding activities, we have sustained existing processes, and we look forward to strengthening processes that would ensure staff across regions are upskilled and kept informed of localised plans in order to best support citizens and attend to their concerns

Currently, there is an on-going upskill of our Partnership Management Teams, Disability Employment Advisers and DWP workforce as a whole across Greater Manchester via bitesize modules, face-to-face workshops, case conferencing, peer mentoring and ongoing input from our Advanced Customer Support Directorate

Part of our forward plan is to utilise the Mobile Jobcentre Bus service to provide further support in local communities.

6. Safeguarding Adults Reviews (SARs)

Safeguarding Reviews (SARs) play a critical role in identifying systemic gaps and opportunities for improvement within safeguarding practices. Mandated under Section 44 of the *Care Act 2014*, SARs must be conducted when an adult with care and support needs suffers serious harm or has died as a result of abuse or neglect, and there are concerns with regards to how agencies worked together to protect the adult from abuse or neglect. Safeguarding Adult Reviews are not intended to hold any individual or organisation to account, but aim to promote a culture of continuous learning, ensuring that safeguarding practices are robust and person-centred.

Under the Care and Support Statutory Guidance, the Board is required to provide information on Safeguarding Adult Reviews, including those which are ongoing.

In 2024-25, a revised [Safeguarding Adult Review Protocol](#) was published.

In 2024-25, there were:

- One mandatory SAR Completed – SAR Nancy
- Three SARs in progress (two mandatory and one discretionary)
- Two referrals received, one which became a mandatory SAR and one a joint SAR / Domestic Abuse Related Death Review
- A referral to a neighbouring local authority for a SAR in relation to a female who died in Bolton.

Domestic Abuse Related Death Reviews (formerly known as Domestic Homicide Reviews) are a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

- (a) a person to whom he was related or whom he was or had been in an intimate personal relationship, or
- (b) a member of the same household as himself, held with a view to identifying the lessons to be learned from the death.

Domestic Abuse Related Death Reviews are a statutory function of Community Safety Partnerships.

Emerging themes

SAR Nancy

This review identified several learning areas. These were:

- Effective communication needs to take place and an identified lead professional where several agencies are involved in delivering care to a person in the community
- Mental Capacity Assessments need to be undertaken where there are concerns regarding a person's mental capacity to make a specific decision. The Mental Capacity Act 2005 provides a framework to support adults to make decisions for themselves where possible for them to do so, and for making decisions where they are unable to. Mental capacity assessments should consider a person's executive functioning.
- The need to engage carers and complete carer's assessments.
- The need to review the care plan and risk assessments at critical moments in time.
- Processes need to be followed to ensure that any changes to home care packages are managed.
- Discriminatory abuse – Nancy was an older woman with disabilities whose home was burgled twice whilst she was in hospital. The reviewed questioned whether Nancy had been targeted due to her vulnerabilities.

Ongoing SARs

Several ongoing SARs involve adults with multiple and complex needs. These include mental and physical ill health, alcohol and/or substance use and a history of adverse childhood experiences and trauma.

In at least two reviews, there is evidence of exploitation, 'cuckooing' or home takeover, physical and financial abuse.

One review is focused on mental health care and the transition from Children's to Adult Services.

Identified learning themes include:

- Multi-agency information sharing and co-ordination
- Mental capacity, unwise decisions and executive function
- Learning around exploitation including home take over
- Supporting adults who are particularly challenging due to their complexity, fluctuating mental capacity and high levels of risk.

7. How some of our partners have implemented learning from SARs

Adult Social Care

Learning has been shared across the directorate through the dissemination of BSAB 7-minute briefings. Reflective sessions on SAR Nancy (and other previous SARs) have been held for all Adult Social Care frontline staff, focusing on learning and future risk prevention.

Audit and moderation work in 2024/25 has focused on highlighting and improving quality of practice covering key themes identified in these SARs, including, partnership working, recording, and mental capacity.

Bolton Foundation Trust

As part of the Safeguarding Adults Review (SAR) toolkit, key learning materials were shared at the Safeguarding Committee. Senior representatives were tasked with cascading this information to respective wards and departments to ensure lessons are embedded in practice.

ICB

The ICB has played an active role in embedding learning from local Safeguarding Adult Reviews (SARs), including the case of Nancy. We are committed to making sure that lessons identified from these reviews inform and improve practice across the health system.

Learning from SARs is shared in a structured and targeted way to reach all relevant staff and services and includes:

- 7-minute briefings, tailored to highlight key issues for health commissioners and providers
- GP safeguarding newsletters, where summaries and practice reflections are circulated

- The Safeguarding Health Collaborative, which brings together safeguarding leads from health organisations across Bolton to reflect on key learning and drive improvement
- We also share learning from GM delivery groups via the same systems at locality.

The ICB also works closely with Bolton Safeguarding Adults Board to ensure SAR learning is integrated into system-wide improvement plans. This includes identifying themes for quality assurance audits and aligning learning to strategic priorities such as Making Safeguarding Personal and early intervention.

GMMH

Learning from reviews is shared via several mechanisms which include safeguarding briefings, Patient Safety newsletters, learning events and bitesize training sessions.

Probation

Any relevant learning from reviews is now discussed and cascaded via the Probation Delivery Unit (PDU) Development Group. It is also shared by the Head of the PDU in monthly all staff calls and in staff newsletters.

Following learning from a recent Domestic Homicide Review (now called a Domestic Abuse related Death Review), a real emphasis has been placed upon the need for staff to improve communication and work more collaboratively with partners. On a regular basis instructions have been issued reminding all staff of the importance and need for liaison between Probation staff, named professionals, voluntary and /or faith groups in the management of a case. This message has been reiterated in team meetings, individual supervision and all staff events.

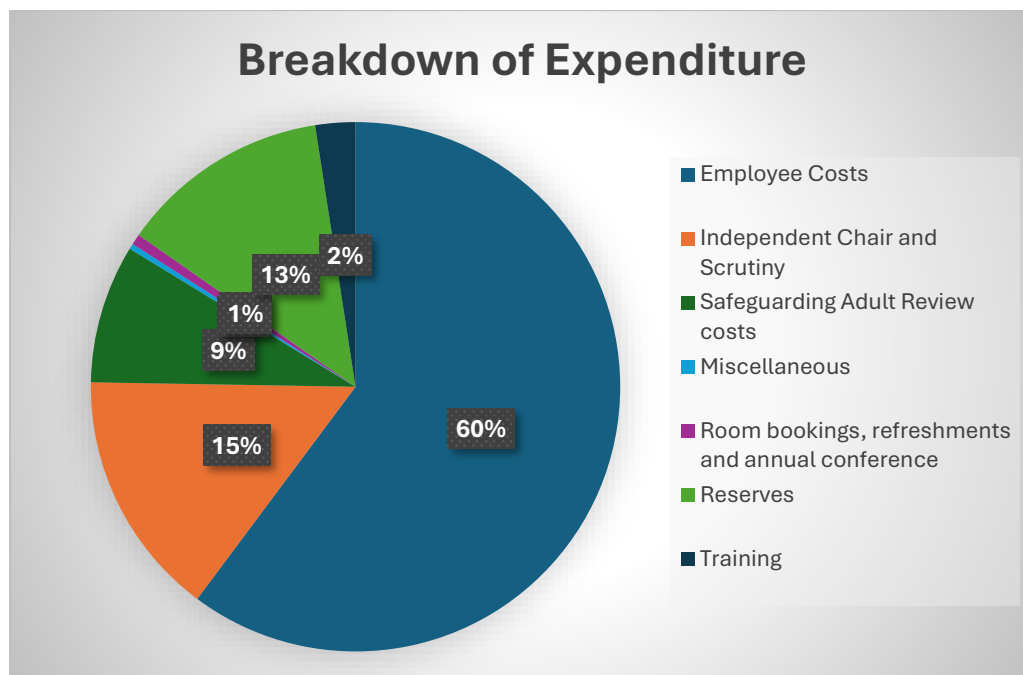
8. Financial summary

The Local Authority, Greater Manchester Police and NHS Greater Manchester Integrated Care Bolton Locality have continued to fund the BSAB with contributions for the year amounting to £124,951.

Other organisations have contributed 'in kind' to the board, by allowing access to venues free of charge, and contributing to the Board's sub-groups, recognising that the board continues to operate on a relatively small and carefully managed budget.

Staffing costs were slightly lower than projected for the last financial year due the BSAB Manager post being vacant for part of the year. This post has now been permanently recruited to and the new BSAB Manager begun in post in April 2025.

The chart below shows the breakdown of expenditure in 2024/25.



9. Future plans

Work is ongoing to deliver on the priorities as set out in the strategic plan which includes strengthening links with the voluntary and community sector.

The **Safeguarding Delivery Sub-group** has now been established and a number of workstreams identified. These are:

- Policy, procedure and guidance which will focus on reviewing and updating existing policies as well as developing new policies, procedures and guidance where a need is identified through SARs, audits or other mechanisms. The group is currently developing the Bolton Adult Risk Management Framework.
- Communication, Engagement and Voice will oversee the distribution of communications materials to raise awareness of safeguarding, the board's new website and building mechanisms to obtain feedback from adults with lived experience.
- Training and Workforce Development are currently developing a programme of activity that will take place on or around Safeguarding Adults Week in November 2025. This will include learning from Safeguarding Adult Reviews. The group will also be developing a plan for training and workforce development activity moving forward.

The **Safeguarding Adults Review Sub-group** will oversee the SAR process, ensuring that SARs are undertaken where required and done so effectively and efficiently. It will ensure that learning from SARs is shared widely and with the other sub-groups so that they can progress actions and monitor implementation of any learning.

The **Safeguarding Effectiveness Sub-group** will continue to build on and strengthen the range of information that comes to the sub-group to improve oversight of emerging risks, mitigation and safeguarding across the system. It will develop a multi-agency audit programme to ensure that the response to issues identified and learning from SARs is robust.

For further information about the arrangements, to share your experiences of Safeguarding in Bolton get in touch via our website:



www.bolton.gov.uk



or call

01204 337000

