Bolton NHS Foundation Trust

Safeguarding Adult, Children

and

Looked After Children Annual Report 2021/22

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1. Introduction

This 2021/22 Safeguarding Annual Report provides an opportunity to reflect on the achievements of 2021/22 and focus on priorities for 2022/23. This year's Annual Report will focus on the activity of adults, children and Looked After Children during 2021/22 and update on key priorities aligned to statutory and regulatory requirements.

In 2021/22 there has been no significant changes to statutory requirements for safeguarding adults and children, and the Trust continues to work within the same statutory guidance for both children and adults. The Domestic Abuse Act was published in 2021 and the report will provide an overview of the key changes.

We continue to see the impact of Covid-19 on our patients and service users, but we are pleased to provide continued assurance that we prioritise our most vulnerable to ensure they are protected, and their health needs are met.

2021/22 has seen some challenges in both the children and adults safeguarding teams with a period of time when there was no adult safeguarding lead in post following a retirement. This has now been resolved and an experienced safeguarding adult lead has been recruited who is building the safeguarding adult team and benchmarking the needs of the Trust against safeguarding adults' requirements. However, both teams continue to be challenged but work exceptionally hard to ensure the Trust meets is statutory requirements and patients are safeguarded.

The Executive team, safeguarding leads and all managers across the Trust remain committed to ensuring that the safety and protection of our patients and services users and staff remains a key Trust priority. The Trust Safeguarding Committee has refocussed in order to ensure assurance is received from all Divisions in line with CQC Regulation 13, Contractual Safeguarding requirements and in line with The Children Act (1989/2004) and the Care Act (2014).

This report will provide an update that the Trust is fulfilling its duties and responsibilities in relation to promoting the welfare of children, young people, adults and their families or carers who come into contact with our services. This is in line with the Trusts statutory responsibilities and required regulatory and contractual standards.

2. Safeguarding Frameworks

2.1 Legislation

The duties of NHS providers to ensure any person in our care and who use our services are safeguarded is outlined in the NHS England - Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (NHSE August 2019). Whilst safeguarding shares the same responsibilities and principals for adults and children, there are significant differences in the laws and policies that underpin practice. The overarching objective for both is to enable children and adults to live a life free from harm, abuse or neglect. The two key pieces of legislation governing safeguarding adults and children remain –

Children Act 1989/2004 (Children)	Care Act 2014 (Adults)

Trust safeguarding policies, procedures and training are underpinned by this legislation and include definitions and arrangements as to how Bolton NHS FT discharges its statutory safeguarding duties and a comprehensive list of the legislation can be found in **Appendix 1**.

2.2 Local Partnership Arrangements

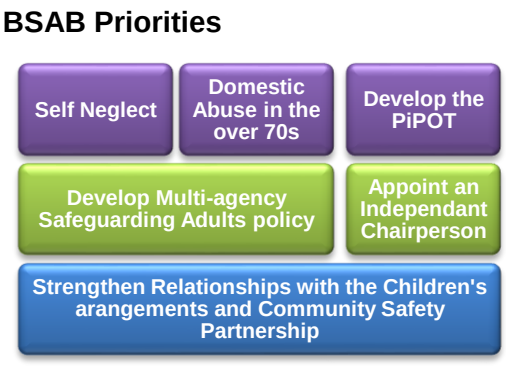
The Children and Adult Safeguarding Teams contribute to the local Safeguarding Partnership arrangements representing the Trust on a range of groups and committees. The team also provide assurance to the Clinical Commissioning Group (CCG) declaring compliance against NHS England Safeguarding Standards (Standard NHS Contract for All Services: Schedule C, Part 7.2). **As this report covers the period from April 2021 – March 2022, the CCG was still in operation.**

2.3 Bolton Safeguarding Adults Board (BSAB)

Diagram 1: Bolton Safeguarding Adults Board

The Trust is represented on Bolton Safeguarding Adults Board (BSAB) by the Associate Chief Nurse who ensures the priorities of the Board are reflected in the Trust safeguarding adult's agenda.

The BSAB coordinates the delivery of Adult Safeguarding across agencies ensuring that local safeguarding arrangements and partners act to protect adults who are at risk of abuse or neglect.

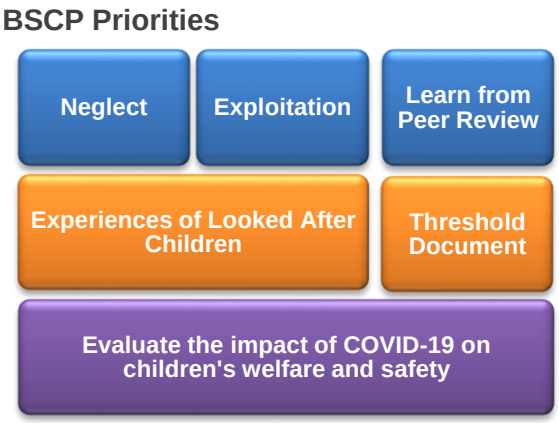


2.4 Bolton Safeguarding Children Partnership's (BSCP)

Diagram 2: Bolton Safeguarding Children Partnership

The Trust is represented on the BSCP by the Chief Nurse. The BSCP vision is to give all our children the best possible start in life, so that they have every chance to succeed, be safe and be happy.

The BSCP is led by the three statutory partners (Bolton Council, Bolton Clinical Commissioning Group and Greater Manchester Police). The partnership, supports and enables local organisations and agencies to work together to safeguard and protect children.



3. Governance Arrangements for Safeguarding

Bolton NHS FT has robust governance processes in place to ensure that culture in which safeguarding children and adults is everyone's responsibility across the Trust and all staff regardless of role who identity concerns, ask for advice and guidance when a safeguarding concern arises.

The Trust Board Executive lead for safeguarding children, Looked After Children and adults at risk is the Chief Nurse. The Trust Safeguarding Teams provide an integrated and consistent approach to safeguarding and the Trust Safeguarding Committee meets monthly to ensure there are robust arrangements in place and these are regularly reviewed.

The Committee provides challenge and assurance on the safeguarding arrangements within the Trust, and monitors compliance and benchmarking against regulatory standards and key clinical effectiveness indicators (including Care Quality Commission (CQC) outcomes). The Committee reports, advises and acts on findings to address any gaps in service. The Safeguarding Committee reports to the Quality Assurance Committee on a quarterly basis which informs the Trust Board.

See Appendix 2 for team structure

2.1 Governance Reporting Structure

Diagram 3: Trust reporting structure

As per statutory and regulatory requirements for Safeguarding there is a clear line of sight from floor to Board. With the Chief Nurse being Executive lead for safeguarding children, looked after children and adult safeguarding.

3.2 Named and Specialist roles

It is a Statutory requirement that there are staff in key safeguarding roles within health organisations. In line with the intercollegiate guidance, Bolton FT has in place named professionals with responsibility for adults, children and LAC.

During 2021/22 the Named Midwife was a combined role with an Enhanced Midwifery Team Leader post. Given the size and acuity of Maternity services, this has been reviewed and supported to become a stand-alone post as per Intercollegiate Guidance.

3.3 Reporting

The Trust Safeguarding Committee has adopted Signs of Safety approach within all assurance and reporting arrangements to the Committee to support a reflective approach to safeguarding across all Divisions and services. Therefore, all reports identify –

What's Working well	What is not working well	What needs to happen

Reports are submitted on a quarterly basis which provide assurance against our responsibilities against CQC Regulation 13, Contractual Safeguarding requirements and in line with The Children Act (1989/2004) and the Care Act (2014).

3.4 Risk register

A number of safeguarding risks have been on the Risk Register within the timeframe of this report. These have been reported to the Trust Safeguarding Committee and updated regularly to reflect the actions taken and revised level of risk identified.

The risks include:

Diagram 4: Risks

- Safety of staff visits to a known site following police information
- Vulnerable children not linked to appropriate services or who are unseen
- Managing young people admitted to adult wards (16- and 17-year-olds) where there are mental health concerns.
- Managing complex young people who access Trust services from Specialist Care Placements (eating disorders)
- Workload and capacity of Safeguarding teams
- Identified gaps in working with Domestic Abuse and Complex Safeguarding.
- Knowledge and skills to accurately undertake DoLs and mental capacity assessments.

3.5 Audit

During 2021/22 a number of multi-agency and Trust wide audits were undertaken with findings, learning and recommendations reported to individual staff members and managers and the Trust Safeguarding Committee. Some of the audits are part of GM or local multiagency audits while others are in response to local and national vase reviews or internal reviews. Audits are presented to the safeguarding committee for assurance purposes and to ensure that the relevant learning is disseminated across divisions.

3.5.1 Audit Activity by the Safeguarding Children Team from April 2021 to March 2022

The safeguarding team have undertaken a number of audits in 2021/22. Findings from audits are shared with services involved to improve or change practice.

The table below shows the audits undertaken in 2021/22 by the safeguarding children team

Table 1: Audit activity undertake by safeguarding children team

Observations of Case Conferences	**• For consistency in health attendance & effective contributions and information sharing.**
LAC Health Assessments	**• To audit quality and LAC health plan**
MASSS Heath Referrals	**• To audit approriateness of health referals for child protection**
0-19 Observation of duty team	**• To monitor effectivenees and consistency of safeguarding advice given.**
GM Complex Safeguarding Auidt and Pre-audit	**• Contribution to a wider piece of work across GM**
Routine Enquiry in Maternity	**• To inform the work of the Enhancing Midwifery Team**
Health Referrals to Social Care	**• To monitor quality and appropriateness**
16 and 17 year olds on adult ward	**• To ensure their needs are met under the Children Act**

4. Impact of COVID-19 on Safeguarding

Safeguarding has been 'business as usual' at Bolton FT, throughout COVID-19 with all staff ensuring that safeguarding was prioritised. The safeguarding service has continued to provide advice and support in both acute and community. In 2021/22 the impact of Covid-19 on our patients and services users is ongoing and this included increased vulnerabilities.

The impact of Covid-19 on vulnerable children and adults and has continued into 2021/22 and resulted in increased referrals to Social Care and Police, with a significant increase in incidents of domestic abuse and violence during this period. The need to keep vulnerable adults and children safe is a core priority of our frontline teams however, Covid-19 put huge strain on the workforce and made previous home visiting and monitoring more challenging.

Issues have emerged during the pandemic and lockdown including

Table 2: Emerging issues

Children	Adults
• **Unseen vulnerable children**	• **Increase in domestic abuse by partners/family members**
• **Increased domestic abuse,**	• **Increase in Domestic abuse in over 70s**
• **Increased gang activity and criminal exploitation**	• **Increased Mental Health problems in women compared to men.**
• **Increased cases of neglect and emotional abuse**	• **Older people and disabled experienced depression and anxiety**
• **Child Exploitation/Sexual Exploitation**	• **Over 75s and disabled digitally excluded**
• **High school closures**	• **Increase In A/E attendances with Dementia**
• **Increase in self harm**	• **Increase in S42 Safeguarding adult enquiries for over 85s**
• **Low socio-economic families digitally excluded**	• **Impact on care home residents**

The safeguarding team have revised their training programmes to highlight these themes for frontline staff.

5. Safeguarding Children in Bolton

5.1 Priorities

In 2021/22 four practice areas were identified by the Safeguarding Children Team to be high priority which will continue into 2021/22 in line with GM and Bolton Children's Services strategic objectives.

These include:

1. Domestic Abuse

2. Mental Health presentations of CYP

3. Complex Safeguarding

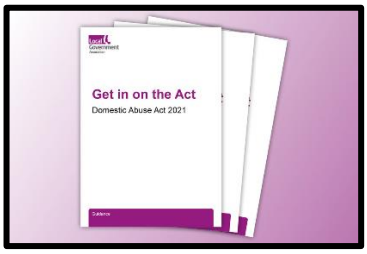
4. CYP - victims and perpetrators of crime

5.1.1 Priority 1 - Domestic Abuse

Diagram 5: Domestic Abuse

There has been increased demand across the region since the start of COVID-19 with lockdowns considerably contributing to the rise in cases.

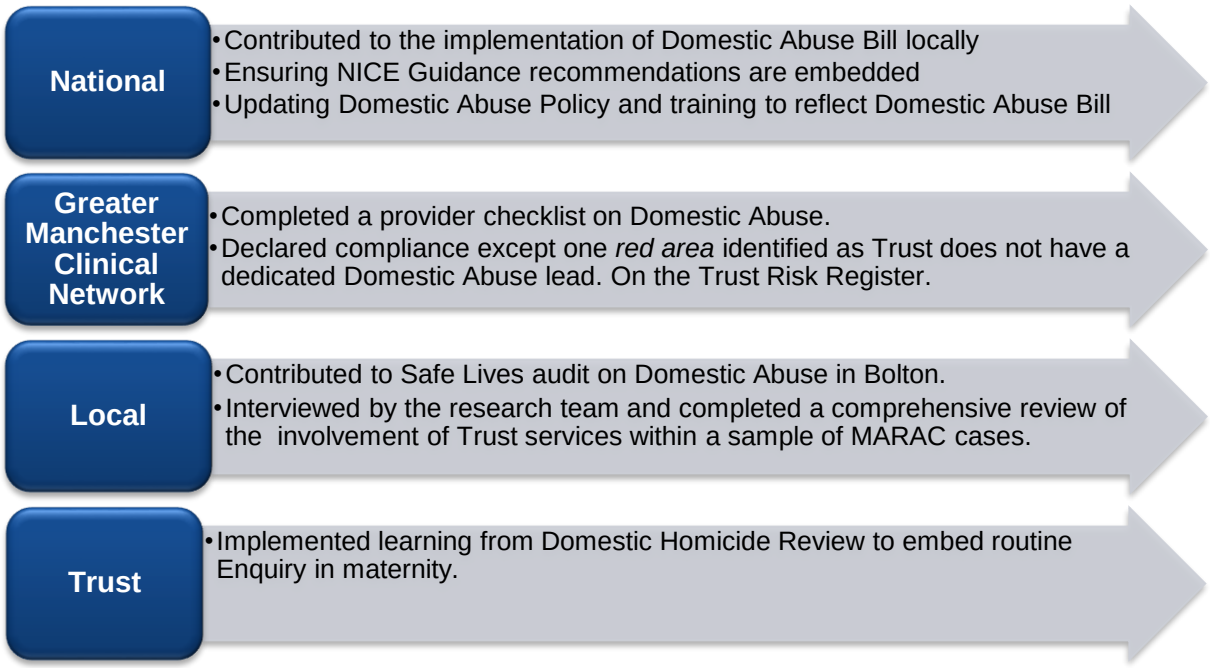
The Government during COVID-19 reported domestic abuse in households as "pressure cooker families" requiring increased vigilance and intervention.



Published in 2021 the Domestic Abuse Act legislation outlined a number of changes in legislation which included -

- Requirement to set up a Domestic Abuse Partnership Board
- Inclusion of new offences
  - Non-fatal strangulation,
  - Revenge porn
  - Threats to share intimate images.
- The definition of coercive control was updated.
- There are plans for Clare's Law to become statutory.

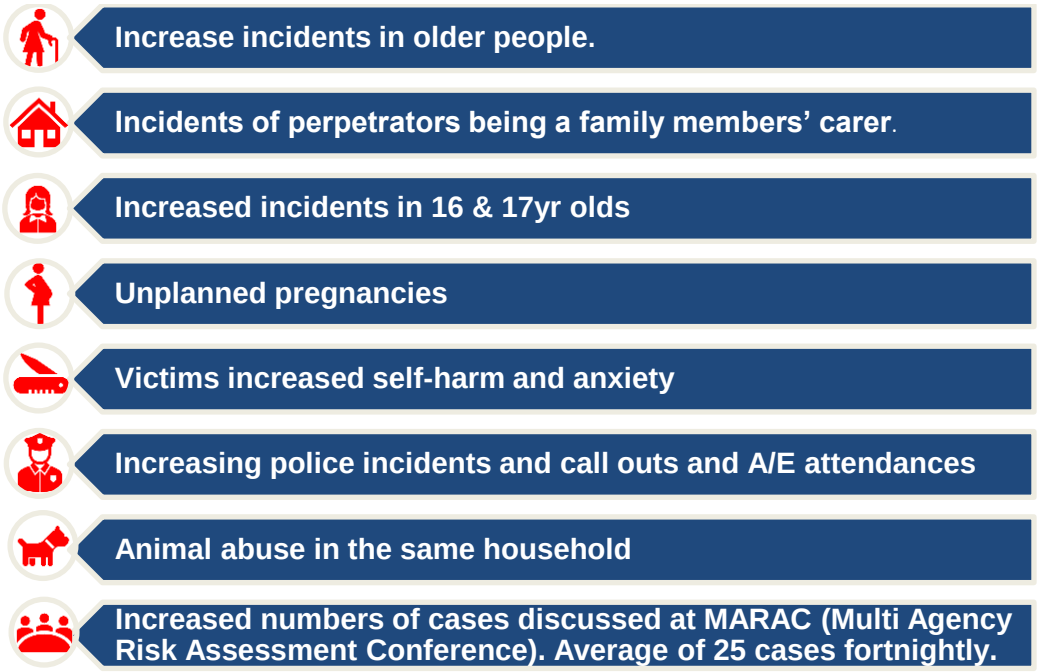
Diagram 6: Overview of work on Domestic Abuse undertaken by Safeguarding Team in 2021/22



Impact of Domestic Abuse

The safeguarding team in Bolton has supported staff across the Trust who have seen increased prevalence in the areas described below across the Trust.

Diagram 7: Impact of abuse



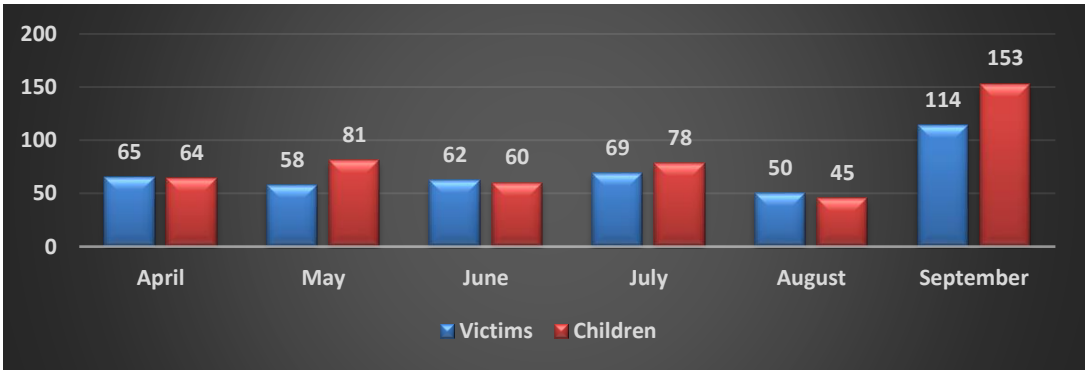
MARAC (Multi Agency Risk Assessment Conference)

The chart below shows the increase in the numbers of MARAC cases discussed in Quarter 1 and 2 (April to September 2021). The data shows the volume of children affected in Bolton in cases heard at MARAC. These are high level Domestic Cases whereby interventions are needed to prevent serious injury or Domestic Homicide.

Safeguarding Children's Nurse represents the Trust at MARAC and has seen meeting frequency increased to fortnightly from monthly due to increase in referrals.

These figures do not include routine callouts by police or individual disclosures to health staff.

Chart 1: MARAC referrals Q1 and Q2



Domestic Abuse Audit

In response to learning from a DHR published in 2021/22 the safeguarding team undertook a maternity records audit was undertaken in July 2021 to support embedding routine enquiry about Domestic Abuse in pregnancy is standard practice across maternity services.

The results were as follows :

68 patients were involved

Table 2: Audit findings

Audit Question	Yes	No	No answer	Total	Findings
Seen alone at booking	**61**	**1**	**6**	**68**	- Women were seen alone to support a discussion about Domestic Abuse at booking. - Direct questions were not used at later in pregnancy or postnatally. - **Questions can't be asked when suspected perpetrator present.** - **Women may not be ready to disclose Domestic Abuse.**
Seen alone further appts	**1**	**0**	**67**	**68**	
Routine enquiry booking	**62**	**0**	**6**	**68**	
Routine enquiry further	**1**	**0**	**67**	**68**	
Domestic Abuse Disclosed	**2**	**59**	**7**	**68**	

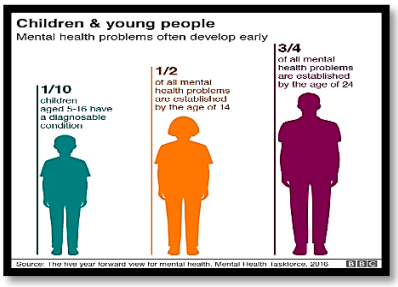
Key messages were shared with maternity services following audit :

- Expectations of NICE Guidance (supporting disclosures of domestic abuse).
- Evidence regarding increasing likelihood of Domestic Abuse escalation in pregnancy to support direct questions being asked.

5.1.2 Priority 2 - Mental Health Presentations of Children and Young People (CYP)

COVID-19 has caused unprecedented disruption in children's lives, affecting emotional, cognitive and social development. Known risk factors have intensified, e.g. socioeconomic, social isolation and bereavement.

Access to sources of support has reduced e.g., friends, schools and activities. There is substantial concern that the pandemic may have long-lasting negative impacts on child mental health.



There has been work across GM to standardise and strengthen the response to children and young people considered to be in crisis.

GM procedures – Child and Young People in crisis support and escalation framework is still being developed but has already been adopted in part in some areas.

Bolton FT

The Safeguarding Children Team and colleagues in Mental Health Services and Children's Social Care all have a part to play in managing risk and providing support to children and their families. In 2021/22 the team have supported an increase in presentation of CYP to A/E the main presentations have been :

Self- harm	Suicidal ideation	Overdose

In addition, in 2021/22 has seen an increase in A/E attendances for young people with eating disorders not previously known to services and requiring medical review or admission has increased. All complex cases require escalation where there are difficulties in arranging discharge from hospital once medically fit.

Learning from Mental Health Local Review

The sad death in 2020 of a 16-year-old patient with mental health issues had a profound effect on the Trust and all the staff involved. As a result, extensive learning and changes in

practice have taken place to ensure that 16 and 17-year-olds with mental health presentations are managed appropriately and safely when admitted.
Although immediate changes were implemented in 2020, additional changes have been implemented during 2021/22 which aligned with the internal Serious Incident recommendations and 4 recommendations out of 28 for Bolton FT from a multi-agency Child Safeguarding Practice Review, these included :

Diagram 8: Learning from reviews

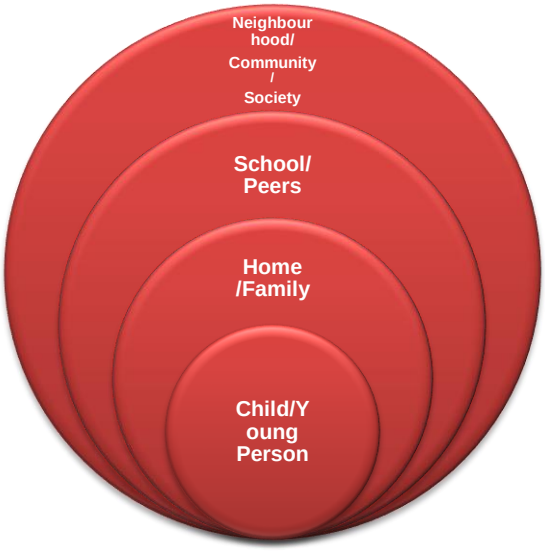
- **SBAR** (Situation, Background, Assessment, Recommendation) for 16- and 17-year-olds admitted to adult wards.
- **Documentation** - Safeguarding team notes available on EPR (Electronic Patient Record).
- **Standard Operating Procedure** (SOP) - For Management of 16- and 17-year-olds.
- **Admission** - Adjusted admission documents to capture needs of 16–17-year-olds on adult wards.
- **Database** - Live database 16- and 17-year-olds available
- **Discharge** - Focus on delayed discharge and external escalation when medically fit for discharge.
- **Audit** - To identify baseline and monitor progress of actions embedded.
- **Training** - We Can Talk and Suicide Awareness training for staff
- **Policy** - Merged Missing Policy for adults and children in to one all age documents.

5.1.3 Priority 3 - Complex and Contextual Safeguarding

In Greater Manchester Complex Safeguarding is used to describe Criminal Activity (often organised), or behaviour associated to criminality, involving vulnerable children/young people, where there is exploitation and/or a clear implied safeguarding concern.

Diagram 9 &10: Complex safeguarding

Complex Safeguarding requires focus on contextual safeguarding which differs to our current traditional model of safeguarding which focuses largely on the risks to the child within the family.



A contextual approach focuses on those external 'contextual risks' that our children also face within the community, schools, public spaces, transport, peer group and online and considers interventions to change the systems and conditions in which this type of abuse occurs.

In 2021/22 the safeguarding team have seen an increase in Complex Safeguarding cases and have worked hard to ensure that frontline practitioners are supported to recognise and responding to the many facets of Complex Safeguarding.

This year training has been updated to ensure it captures emerging themes across Bolton and nationally. The team also represents the Trust at Bolton's CSE and Missing Steering Group (CEAM). As this work is complex and ongoing, the team will continue to prioritise this in 2022/23.

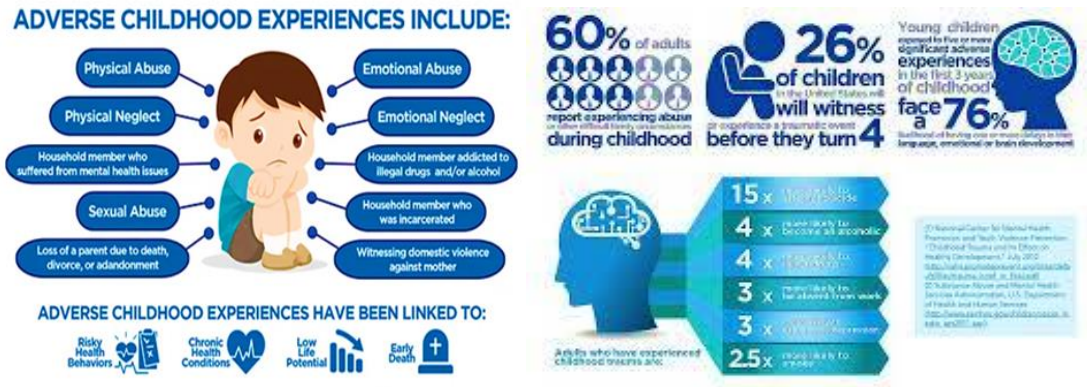
Adverse Childhood Experiences (ACEs)

The continued and growing recognition of ACEs (Adverse Childhood Experiences) and their links to both Complex and Contextual Safeguarding is significant for children and young people in all the practice areas and particularly in CSE and CCE.

In 2021/22 a local prevalence study took place in Bolton to highlight the impact of that ACEs can have on children. This study found that increased ACEs lead to vulnerabilities, exploitation, violent behaviour and abuse.

In 2021/22 the Safeguarding team have continued to embed the recognition of ACEs across all areas of practice, and this will develop further in 2022/23.

Diagram 10: ACEs



Trauma Informed Practice

The focus on Trauma Informed Practice, supports an approach where staff see safeguarding concerns not as isolated problems but as part of a wider picture of causes and needs where support and interventions are required.

Diagram 11: Trauma informed practice

5.1.4 Priority 4 - Child Criminal Exploitation (CCE)

While staff have developed knowledge and skills in working with children and young people at risk of Child Sexual Exploitation (CSE) there has been less working knowledge of Child Criminal Exploitation (CCE).

Diagram 11: Child Exploitation

Known direct targets CYP	
• No strong support networks • No previous criminal record • Unlikely to be stopped by police • Emotional, mental ill-health or learning disabilities • Non-UK citizens or do not have immigration status • Looked after in children's homes or out of area • May be living in poverty	

There is growing evidence that vulnerable children and young adults are specifically targeted for criminal purposes, although any child can be at risk.

Diagram 12: Child Exploitation

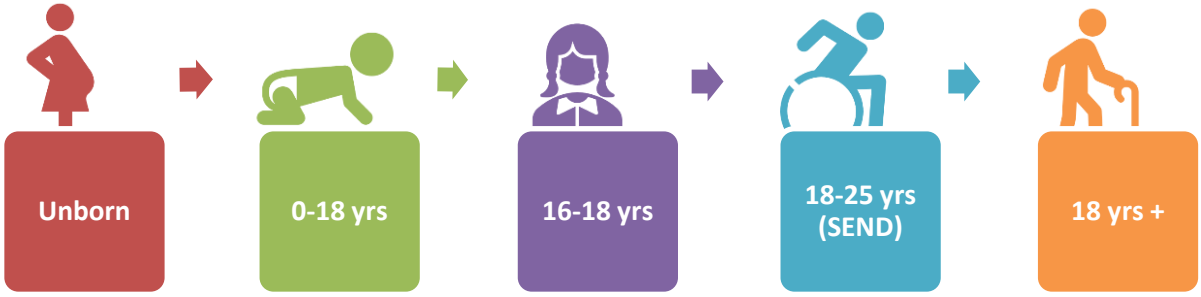
Bolton FT have no dedicated resource for the growing demands of CSE and CCE to provide a health offer to children and young people who are victims. This is included on the Trust Risk Register. To mitigate, the Specialist Safeguarding Nurse in the 0-19 Adolescent service supports the local CEAM meeting (Child Exploitation and Missing meeting). However, this is in addition to the day to day safeguarding work.

Children and young people who are victims or perpetrators of violent crime

This has been recognised across agencies as a concern locally in Bolton. The Tackling Serious Youth Violence project in Bolton includes a number of services and providers including the Navigator project. The Safeguarding Children team work closely with the Navigator project workers to implement processes where children and young people who attend A&E with injuries from violent crime can be referred to the project. The Safeguarding Children Team make referrals to Navigator if these have not been completed in A&E.

6. Safeguarding Activity

Safeguarding remains a complex and changing area of practice. The remit of the Safeguarding Children Team extends beyond children under the age of 18. This includes



Abuse and harm to children and young people can happen in a variety of contexts and can take many forms, some of which are not obvious or easily identified.

In Bolton the Continuum of Help and support is use as a framework for intervention to ensure the correct help at the

right level is available to children and families across Bolton.

6.1 Developments in Bolton Partnership in 2021/22

- **Integrated Front Door**
  - In July 2021 the MASSS (Multi-Agency Safeguarding Screening Service) in Bolton was replaced by the IFD (Integrated Front Door).
  - This provides x a single point of contact to the Social Work assessment team, working alongside the Early Help access point.
  - The Police and a Specialist Safeguarding Nurse who is part of the Trust Safeguarding Children Team, are co-located with the IFD.

- **Framework for Action (FFA)**
  - The threshold document for all agencies across Bolton. was revised and launched in July 2021
  - This ensures that children that require help and support receive this at the appropriate level

6.2 Bolton NHS FT Safeguarding Activity

The Trust safeguarding team undertake a range of safeguarding activities that support staff and improve outcomes for vulnerable children and young people. Advice and guidance is provided by all members of the safeguarding children team on a daily basis and contacts are made by phone or email. There may be a number of discussions about the same child or family.

6.2.1 Daily duty response to referrals from A&E

The Paediatric Emergency Department (PED) see vulnerable children on a daily basis. The Safeguarding team undertake an annual review with PED of cases that require an internal referral to the Safeguarding Children team and criteria are jointly agreed and shared with all staff, this happens bi-monthly and is co-ordinated by an A&E Consultant and Specialist Safeguarding Children Nurse.

The majority of referrals from A&E to the Safeguarding Children team do not result in onward referrals to Children's Social Care, however actions are taken to support the assessment of risk and identify support for the child or family.

In 2021/22 the Safeguarding Children Team received daily referrals for

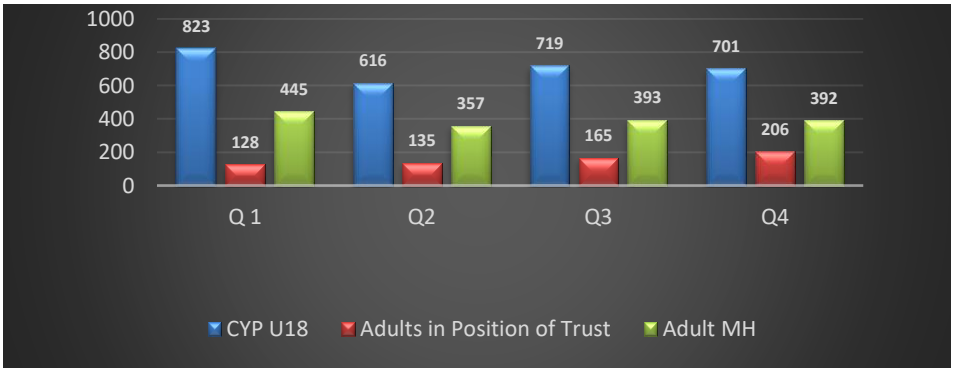
Diagram 13: A&E safeguarding referrals

6.2.2 Safeguarding Team Referral Data 2021/22

Table 3: Safeguarding children referral data

Month	Children (under 18)	Adults who are parents/carers or in a position of trust	Mental Health (adults who are carers and children)
Q1 Total	823	128	445
Q2 Total	616	135	357
Q3 Total	719	165	393
Q4 Total	701	206	392

Chart 2: Safeguarding children referral data



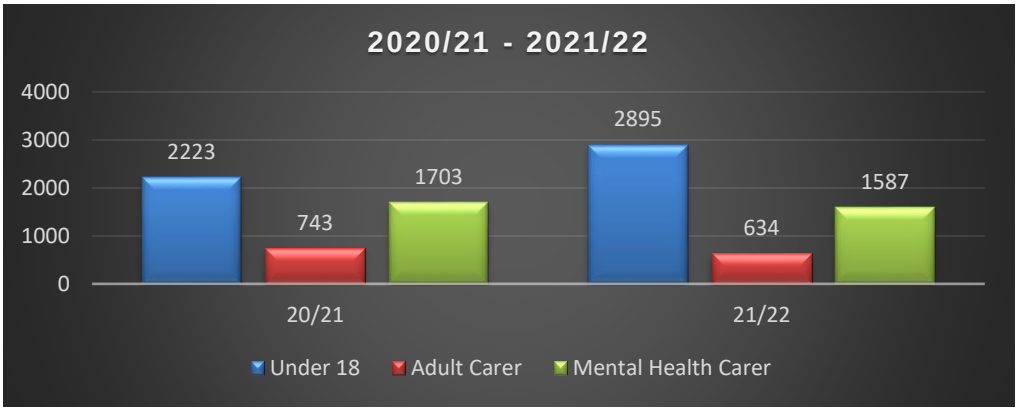
6.2.3 Total Referral in 2021/22 in comparison to 2020/21

The figures below demonstrate a 22% increase in children referrals in 2021/22 compared to the previous year and decrease in the number of referrals regarding persons in a position of trust.

Table 4 : Referral comparison data

23% **increase in all categories of abuse from 2020 - 2021**	**34%** **increase in all categories of abuse from 2019 - 2021**	**31%** **increase in Neglect from 2019 - 21**
38% **increase in Emotional abuse from 2019 – 21**	**27%** **increase in Sexual abuse from 2019 - 2021**	**30%** **increase in Physical abuse from 2019 – 2021**

Chart 3: Referral comparison data



6.2.4 Bolton Child Protection Data

The following chart shows a 3-year comparison of the categories of abuse that children in Bolton are subject to a **Child Protection Plan (CPP)** to protect them.

Table 5: Children subject to CPP

Child Protection Plan at 31st October 2021		Category of Abuse				
Year	**Total CPP**	**Neglect**	**Physical**	**Sexual**	**Emotional**	**Multiple**
2021	494	214	30	33	205	12
2020	381	180	20	28	136	17
2019	325	147	21	24	126	7

There is a year-on-year increase in the number of children subject to a CPP in Bolton as outlined below.

6.2.5 Analysis

- Over 100 more children subject to Child Protection plan in Bolton in 2021 compared with 2020.
- Highest increase in Neglect and emotional abuse which links with increased domestic abuse.
- Significant increase in the number of under 18 referrals to the safeguarding team in 2021/22 compared to 2020/21. New data collection by the safeguarding children team has identified the following themes and trends:
    - Increase in the attendance of children who don't live in Bolton
        - Information sharing for out of area children time consuming and at times problematic. This includes identifying the lead professional for the family and who to escalate concerns to if there are actions required.
    - Further information is often required to identify the level of risk to the child due to limited details on the referral.
        - This includes gathering information on the wider family including parents and siblings. Information given in A/E may not have been gathered or recorded and in some cases incorrect or misleading information has been provided to A/E staff.
    - The Safeguarding Team supports multi-agency meetings to discuss a child or family in more complex cases (for example strategy meetings, discharge planning meetings, Professionals meetings, Best Interest meeting).
        - These are often arranged for the same day/next working day, impacting on the day-to-day work of a small team.
    - The Safeguarding Team is a point of contact for Social Workers on a daily basis to enquire about A/E attendances of children who are subject to a Child Protection Plan or who are Looked after Children who have flagged on the a CP-IS alerts.
    - In a small number of cases concerns identified in A/E have not been shared with Social Care while the child is in A&E, this relies on the duty safeguarding nurse undertaking this, again impacting on the day-to-day work of a small team.
    - Presentation of numbers of younger children with emotional/mental health or significant behavioural concerns impact on the work of the team.

7 Safeguarding Reviews

The safeguarding children team have contributed to a number of statutory reviews within the time frame of the annual report. This includes providing reports based on agreed terms of reference regarding children and adults in the family home and their contact with Trust services. There is also a requirement to attend panel meetings, practitioner learning events, sign off panels to agree final reports and meetings about publication and publicity arrangements. All reviews include children and families that reside in Bolton and also those who live in other areas but who have accessed Bolton FT services.

In addition to writing reports there is a requirement to meet with staff who have provided services to the child and family. It is to be remembered that often a serious injury or death has prompted the review and staff need to be updated about identified learning and offered support.

7.1 Domestic Homicide Reviews (DHR)

A DHR is convened by the Community Safety Partnership as a multi-agency review into the circumstances of the death of a person over the age of 16 as a result of violence, abuse or neglect by a person to whom they were related or who they have been in an intimate relationship with or another family or household member.

There have been two DHRs within the timeframe of this report. These reports have not yet been completed or published.

- One was in relation to the death of a female in Bolton
- Second the death of a female out of area.

7.2 Rapid Reviews and Child Safeguarding Practice Reviews

These are held to consider serious child safeguarding cases where a child has died or has suffered serious harm as a result of abuse or neglect.

A number of reviews were in progress within the timeframe of the annual report including reviews for children out of area who had accessed services provided by the Trust.

The following is an overview of the Rapid Reviews and Child Safeguarding Practice Reviews that have taken place in 2021/22. All names and initials anonymised.

In summary in 2021/22 the safeguarding team on befall of the trust has contributed to the following reviews:

Diagram 13: Number of safeguarding reviews

7.2.1 Overview of Reviews

Table 6: Details of reported reviews

Identifier	Type of Review	Overview
AS	**Rapid Review**	**Death of an infant found to be co-sleeping where there were parental risk factors in place.** • Included in the thematic review of 3 infant deaths outlined below. • Specific learning in relation to parental alcohol use.
OE	**Rapid Review**	**Death of an infant of natural causes.** • Subject to an internal SI and included in the review of 3 infant deaths below. • Specific learning in relation to child neglect, un-booked pregnancy and working with resistant families.
Male infant out of area	**Rapid Review**	**Near drowning of a 9-month-old in the family home.** • Child sustained significant long term health condition as a result. • Consideration and implications for this child and sibling.
Female infant out of area	**Rapid Review**	**Death by drowning of a 2-year-old outside the family home.** • Police investigation is on-going. • Considered to be abuse or neglect at the time of death.
"Sarah"	**Child Safeguarding Practice Review**	**Death of 16-year-old from suicide.** • Learning on management of metal health admissions for 16 and 17-year-olds. • Findings from the review were submitted to Ofsted by LA. • Presentation to the Trust Safeguarding Committee to highlight learning and recommendations.
3 Infant deaths	**Thematic Review**	**Completed in September 2021 to review the deaths of 3 infants where vulnerability factors and safe sleeping factors were identified**. • Attended by 0-19 service, Maternity and Trust Safeguarding Children team representatives. • Final report including recommendations from the National Child Safeguarding Practice Panel to be shared with key services.
3 reviews including Child R	**Local Safeguarding Reviews**	**14-year-old who died as a result of a stabbing and two young people were charged with murder.** • Need to understand the child's lived experience, Adverse Childhood Experiences and their impact on learning, behaviour and school absence. • Requirement for robust assessments and plans • Children in families who experience domestic abuse
Family G	**Serious Case Review**	Completed in 2019 but publication delayed due to Coronial Process. • Inquest in January 2021 into the deaths of the 2 children • Local and national media interest. Final report published following conclusion of the Coronial Process.
DHR from a historical case	**Domestic Homicide Review**	Adult male death – the criminal case has concluded. • No recent contact with adults or children in the family by Bolton FT services. • Report provided based on KLOE and historic information.
DHR "Laura"	**Domestic Homicide Review**	Adult female death. Child in the care of the perpetrator at the time of 'Laura's' death. • Report and representation at the Panel provided by the Safeguarding Children Team

7.3 Learning from National Reviews

National reviews into the tragic deaths of Arthur Labinjo-Hughes and Star Hobson in 2020, both murdered as a result of sustained abuse and neglect by their caregivers, was reported nationally and details of the circumstances surrounding their deaths were published in 2021. There is learning for all agencies from both tragic cases as follows:

Table 7: Learning from National Reviews

Professionals and family members had previously thought their parents capable of providing good care to them. History of domestic abuse in both cases.
Lack of information sharing, professional challenge , risk assesment and decision making across agencies.
Escalating concerns from family members to professionals and evidence of physical abuse not acted on.
Understanding the daily lived experience of the child and engagement with reluctant parents

7.4 Achievements of staff in Specialist and Named roles

The Team have maintained a supportive advice and guidance on site service throughout Covid restrictions and the following are achievements in 2021/22. Despite being a small team, the safeguarding children team has provided support across the Trust to all staff, been active and effective at partnership meetings and have aligned with GM procedures.

Table 8: Team achievements

Safeguarding Team Achievements 2021/22	
Effective and continued engagement with partners and for high-risk panels – • MARAC (Multi-Agency Risk Assessment Conference), • MAPPA (Multi-Agency Public Protection Arrangements), • Channel • CEAM (Child Exploitation and Missing)	✓
Effective and timely response to all requests for support including – • Social Workers requesting a Child Protection medical • Initial Health Assessment (IHA) is required because a child has become LAC. • Mental Health admissions for under 18s	✓
Effective joint working with colleagues in MHLT (Mental Health Liaison Team) to ensure processes of escalation and support are in place and understood.	✓

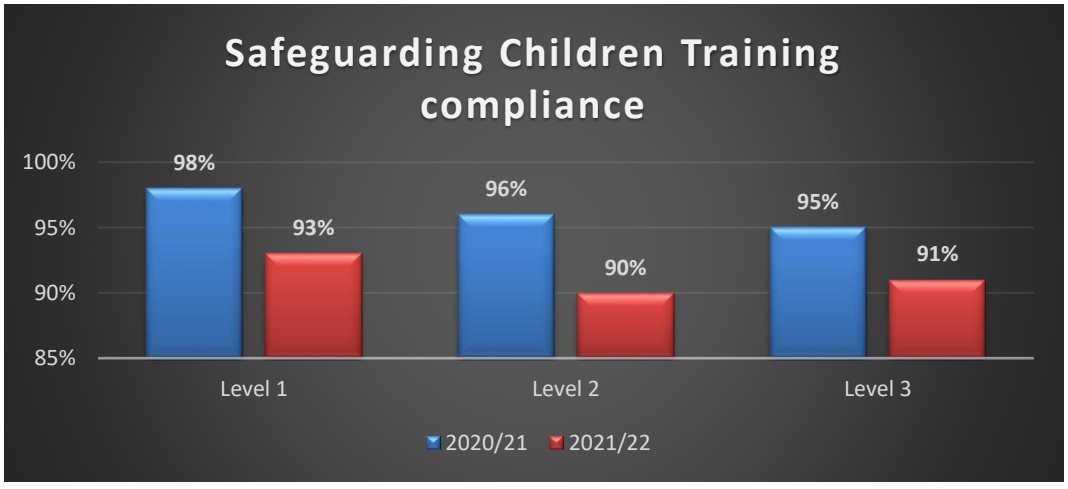
Supported safe discharges from hospital where children and young people are medically fit but have emotional health and wellbeing ongoing concerns.	✓
Effective Peer Review and attendance at A&E Safeguarding meetings as a supportive learning environment	✓
Contribution to the multi-agency Neglect Strategy and group across the Bolton Partnership.	✓
Named Nurse is chair of the Child Safeguarding Practice Review Group	✓
Contributed and represented the Trust on a range of safeguarding reviews.	✓

7.5 Compliance with Safeguarding Children Training

Due to Covid restrictions, all training in 2021/22 was via E-learning. This was as advised by NHS England. Compliance feel in 2021/22 across all levels, however in 2022/23 work will be undertaken across all Divisions to complete a Training Needs analysis to ensure all staff are undertaking training at the correct level to meet the competencies set out in the Intercollegiate Guidance Safeguarding children and young people - roles and competencies The Trust Compliance for Statutory Safeguarding training is 95%.

The chart below shows 201/22 compliance as compared with 2020/21. It should be noted that L3 compliance is based on Family Care Division where all clinical staff band 5 and above will require Level 3 training, these figures include medical staff.

Chart 4: Safeguarding Children compliance



8. Looked after Children (LAC) and Care Leavers

The majority of children and young people who become looked after in Bolton are victims of abuse or neglect. However nationally in recent years there has also been an increase in the number of Unaccompanied Asylum-Seeking Children (UASC), and children who have been trafficked and/or exploited entering the care system.

In Bolton in 2021 **617** children were looked after, a rate of **90 for every 10,000 children**. This is lower than North West region (97 per 10,000) and is higher than England (67 per 10,000).

Looked after children have many of the same health risks and problems as their peers but the extent of those issues is often exacerbated by their experiences of poverty, abuse and neglect.

Table 9: LAC and Care Leavers health risks

Looked After Children (LAC) and Care Leavers	**Emotional and mental health problems is between 45% and 72% compared to 10% in non-LAC peers.**
	Higher levels of teenage pregnancy, drug and alcohol abuse
	Significantly over represented in the criminal justice system.
	Two thirds found to have developmental and physical health issues such as speech and language problems, continence issues, coordination difficulties and sight problems.
	11% have been found to be on the autism spectrum.
	Health and wellbeing of young people leaving care has consistently been found to be poorer than that of young people who have never been in care.
	Special Educational Needs and Disability (SEND), over represented in the care system
	9 times more likely to have an Education and Health Care Plan, (EHC plan) than the general pupil population

8.1 Looked After Children workforce

The Trust arrangements for named professionals for LAC and staff in a specific LAC role is not fully aligned to Intercollegiate Guidance with the Named Nurse for Safeguarding Children undertaking the Named Nurse for LAC role, where a separate role is required to meet

statutory and regulatory requirements. This arrangement is subject to review; however, Bolton is not an outlier with regard to LAC staffing and other organisations across Greater Manchester have similar arrangements. Regular review is based on clinical workload and capacity of those in a specific role to continue to offer detailed oversight of Trust services to Looked after Children.

Named professionals contribute to multi-agency working as medical advisors to the adoption and fostering panels and are linked to the Corporate Parenting Board and Permanency Panel and health economy wide meetings and forums. The Trust LAC group has a distinct action plan based on the safeguarding standards and this feeds into the Trust Safeguarding Committee.

8.2 Looked After Children data

Monthly LAC data is gathered to monitor compliance with timescales for statutory health assessments for children in care which is reviewed within the Trust prior to submission to the Commissioner. The timeliness and quality of statutory health assessments requires scrutiny and prompt action if concerns arise. Compliance data provides evidence of the effectiveness of agreed LAC pathways. On a monthly basis actions are taken where barriers are identified.

Most children who are looked after in Bolton are Bolton residents, however there are children who are placed in Bolton from other areas and responsibility for the provision of health assessments for these children lies with the Trust. The numbers of children who require statutory health assessments varies widely every month depending on the circumstances and number of children entering the care system. The continued fluidity of the LAC population is challenging in practice due to fluctuating numbers which require health assessments this also includes children with complex health needs or at high risks.

8.2.1 Initial Health Assessments (IHA)

These should be completed within 20 days of becoming looked after with an expected compliance of 95%.

Table 10: IHA completion

Total Initial Health Assessments due	**153**
Number completed within 20 working days	**106 (69%)**
Number of additional IHA completed within the month but outside timescales	**47 (31%)**

Reasons for non-completion within time scales

Diagram 14: Reasons for none completion

• 80% due to a delay in Social Care providing statutory paperwork in a timely manner. • Delay in notification by Social Care, • Part A of the statutory paperwork not completed by Social Worker. • Parental consent not available or late.	• Children were not brought to the appointment. • Cancelled by Carer, • Cancelled by young person, • Unable to engage with young person, • Health staffing/capacity/staff sickness.

As a flexible and timely response to support completion of IHA, the Named Doctor for LAC aims to see children within the month that they become LAC for their IHA. This means scheduling additional appointments, however attendance and completion of the IHA is consistently over 90%. This demonstrates a continued priority for administrative and medical staff of the importance of assessment of health needs of children entering care.

8.2.2 Review Health Assessments (RHA)

RHA are completed by community-based nurses (Health Visitors, School Nurses, Special School Nurses, Specialist Nurse LAC) either every 6 months for children under the age of 5 or annually for children over the age of 5. There has been an improved annual compliance with statutory timescales noted with health assessments completed within month providing evidence of the priority and flexible provision to Looked after Children.

Table 11: RHA completion.

Total Review Health Assessments due	**550**
Number completed within timescales (6 monthly Under 5s, annually over 5s)	**461 (84%)**
Number of additional RHA completed within the month but outside timescales	**89 (16%)**
Total % on time /within month	**88%**

The completion of RHAs in 2021.22 were affected by school closures as many RHA are undertaken in schools and nurseries.

8.3 LAC Quality Assurance process and audit

Audit arrangements are in place to monitor the quality of health assessments for LAC. All new staff are required to have 10 RHAs quality assured through annual management reviews. For other staff, dip sample audits are carried out twice a year. The aim of all audit

activity is to show continuous learning and improvement to support better outcomes for children rather than being purely a focus on compliance with timescales.

8.3.1 2021/22 Dip sample audit

Two audits were completed in April 2021 and November 2021. The results highlighted the following -

- Quality of EHA health assessments were good with some excellent examples of holistic health assessments.
- Good practice was evident including
    - The use of appropriate language in completing the health assessments,
    - Enquiring about and recording significant relationships
    - Evidence of excellent communication with a young person who was reluctant to engage but did complete the health assessment.

CCG colleagues were part of the audit team and provided the following comments -

"It was a pleasure to read such quality health assessments and share the child/young person's journey. I was able to understand what life was like for the child. It is testament to the ongoing training, support and quality assurance measures that the Trust have in place and I thank everyone for their valued contribution in making this happen"

8.4 Health Profile Tool

There is a requirement to collect data on the health needs of Looked after Children as part of annual Safeguarding and LAC standards. Building a health profile supports better understanding of the needs of LAC in order to provide responsive services, identify themes and trends, provide data to evidence complexity and to support the tracking of children considered to be high risk.

The Health Profile pro-forma is used for every child who enters care. A RAG rating supports children and young people who require an urgent review or follow up.

The assessment information considered in the health profile included eight domains of concern

Table 12: Domains of concern

1. Physical health including dental	**2. Mental/emotional health or behaviour**	**3. Substance use**	**4. Exploitation / risk**
5. Opportunities for Education / Employment/Training	**6. Age appropriate – development/independent living skills**	**7. Impact of neurodevelopmental disorder or communication issues**	**8. Factors individual to the child e.g. unaccompanied asylum seekers**

8.4.1 Bolton Health Profile

In 2021/22 **153** IHA were completed, and a health profile was completed on all of these reviews which showed the following -

- **41 (27%)** Children had **0-1 domains** - **Low areas of concern requiring action**
- **82 (54%)** Children had **2-4 domains** – **Medium areas of concern requiring action**
- **30 (19%)** Children had **4-8 domains** – **High areas of concern requiring action**

The number of **medium** and **high** variances/areas of concern demonstrates the complex picture and needs of children entering care in Bolton.

Diagram 15: The highest level of variance / areas of concern was found in the following domains

The plan for 2022/23 is to add the health profile on to EPR so that all services can access this information to ensure the best outcome for the child/ young person.

8.5 New care homes and placements.

The CCG and Specialist Nurse for LAC continue to visit all care home placements on an annual basis to safeguarding and senior staff. All cases are managed on an individual basis depending on needs and concerns about the child or young person.

The numbers of private care home placements in Bolton for very complex children and young people has risen, with the majority of residents from out of area so not known locally to Trust services. These placements support children and young people with complex and long-standing issues including eating disorders, mental health and behavioural difficulties.

The safeguarding team will continue to work with partners to support the LAC agenda and ensure a high-quality health service is delivered for our young people to achieve best possible outcomes.

9. Safeguarding Adults

It is every member of staff's responsibility to ensure the safety and protection of all vulnerable adults in our care and who use our services. All organisations have a responsibility to ensure that there is a culture which takes all concerns seriously, ensures transparency and escalates concerns appropriately as outlined in the Care Act 2014. The Care Act is the key legislation that underpins all adult safeguarding work.

9.1 Key Principles of Safeguarding Adults

The Care Act 2014 emphasises six key principles:

9.2 Categories of abuse as described by The Care Act 2014 *(diagram 16)*

9.3 Making Safeguarding Personal (MSP)

Making Safeguarding Personal (MSP) is about having conversations with people on how to respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

The Care Act advocates a person-centred rather than process-driven approach. This is a key requirement of the Care Act and a priority for the adult safeguarding team in 2022/23 when the new safeguarding lead is in post and has a team to support.

MSP is essential to ensure that any support offered and/or provided is person centred and tailored to the needs, wishes and the outcomes identified by the adult. The person at risk at the centre of any Safeguarding process must stay in control of decision making as much as possible.

9.4 Bolton Adult Safeguarding Board

Bolton Safeguarding Adults Board (BSAB) has a statutory responsibility or legal duty to ensure that Bolton has an effective multi-agency response to safeguard our most vulnerable adults that fall into the criteria of the Care Act 2014 and ensure measures are in place to prevent abuse. The board is also legally responsible for carrying out reviews of serious cases to ensure that lessons are learnt and to ensure a more joined up partnership approach to safeguarding issues.

9.4.1 Bolton Safeguarding Adult Board Strategic priorities 2020-2023

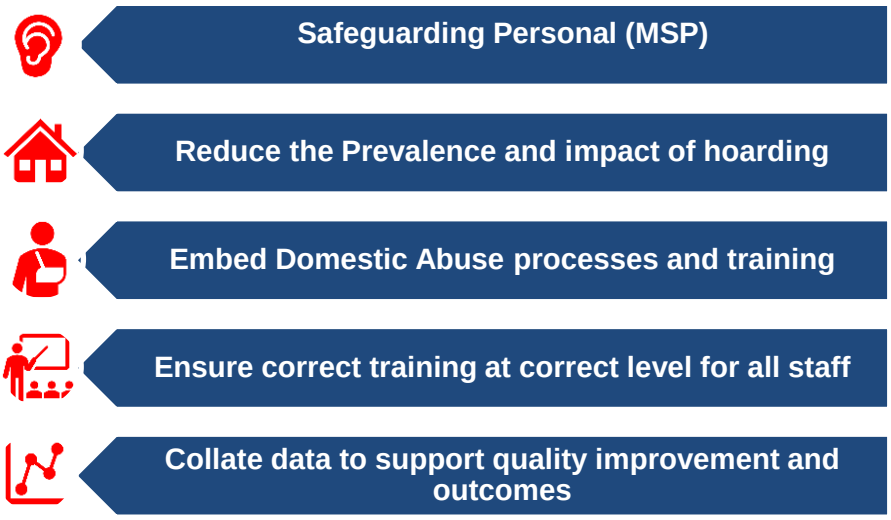
Bolton FT safeguarding adult's agenda reflects the priorities of Bolton Safeguarding Adult Board. While there has been challenges with a limited team in 2021/22, the new team is developing and will align with the BSAB priorities in 2022/23.

In addition, the team will work to ensure that the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) is embedded and well understood across the Trust to ensure that patients in our care are not detained illegally.

Another priority will be to work closely with the safeguarding children team on a 'Think Family' approach to safeguarding and in particular in relation to Domestic Abuse.

9.4.2 Bolton Safeguarding Adult Priorities

Diagram 17: BSAB priorities



9.5 Safeguarding Adult Statistics

9.5.1 National data

- In 2021/22 there was an estimated **541,535** concerns of abuse raised, **an increase of 9%** on the previous year.
- **Section 42 enquiries** (safeguarding adult enquiries) **increased by 6% to an estimated 161,925 and involved 129,685 individuals.**
- Other safeguarding enquiries where there may not be reasonable cause to suspect that statutory Section 42 criteria are met but where local authorities use other powers to make enquiries, is reported to be **22,590.**
- The most common type of risk in Section 42 enquiries that concluded in 2021/22 was **Neglect and Acts of Omission, accounting for 31% of risks**,
- The **most common location** of the risk was the **person's own home at 48%.**

9.6 Bolton Safeguarding Adult data

Number of adults in Bolton aged 18 and over - 219,317

Table 13: Age profile

Age profile	Bolton	England
Percentage of population who are adults aged 65+	**17.4%**	**18.5%**
Percentage of population who are adults aged 18-64	**58.7%**	**60.1%**

The following chart provides a comparison with the number of safeguarding adult concerns in Bolton, North West and England before, during and as we emerge from the Covid-19 Pandemic.

9.6.1 Figures show the year on year increase nationally *(Table 14)*

Concerns/S42	2019/20	2020/21	2021/22		
	England	England	England	North West	Bolton
Number of Concerns raised	475,560	498,260	**541,535**	**64,880** (12% of national concerns raised)	**3265** (5% of NW concerns raised)
Number of Section 42 Investigations	161,910	152,270	**161,925**	**21,585** (13% of national S47)	**790** (4% of NW S47)

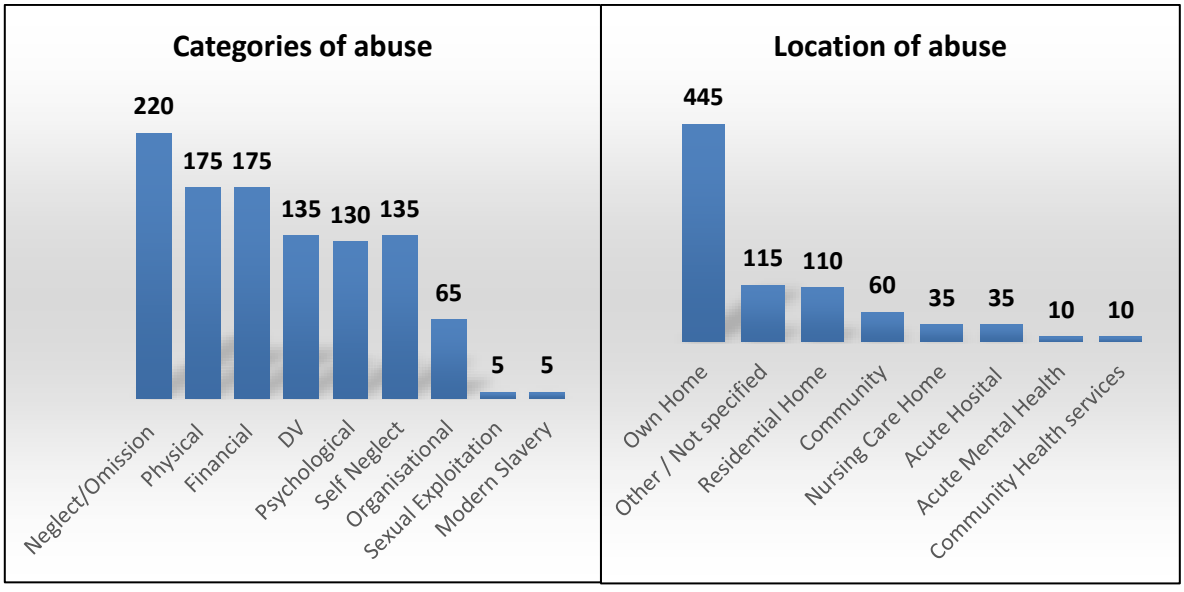
9.6.2 Section 42 Categories of Abuse in Bolton *(Table 15)*

Category of Abuse	Number	Category of Abuse	Number
Neglect / Omission	220	Organisational	65
Physical	175	Domestic Violence	135
Financial	175	Sexual Exploitation	5
Psychological	130	Modern Slavery	5
Self-Neglect	135		

9.6.3 Places where Abuse occurred in Bolton (when documented) *(Table 16)*

Place	Number	Place	Number
Own Home	445	Acute Trust	35
Community	60	Acute Mental Health Unit	10
Nursing Care Home	35	Community Health	10
Residential Home	110	Other	115

Chart 5:Categories and location of abuse



9.6.4 Analysis of data

- Increased referrals year on year also reflected in Bolton
- Increased numbers meeting the criteria for S42 statutory Enquiry
- Most abuse happens in a person's own home although abuse can occur anywhere
- **Top 3 areas of highest concern in Bolton are as follows** –

9.7 Safeguarding Referral data

Through both the first and second wave of the Pandemic, the Trust witnessed a significant increase in safeguarding adult referrals.

In 2021/22 there was an average of **247** referrals per month to the safeguarding adult team compared with **180** per month pre-pandemic, **a 37% increase.**

9.8 Safeguarding Adult Training compliance

The adult Intercollegiate Guidance - Adult Safeguarding: Roles and Competencies for Health Care Staff (2022) is the framework for safeguarding. As with children's training, safeguarding adults training was delivered via eLearning in 2021/22. There has been a gap in Level 3 training as there was issues in embedding the Level 3 eLearning and obtaining data. However, plans to reconvene level 3 face to face training in 2022/23 and refresh the training content will help with compliance.

Chart 6: Adult safeguarding training

9.9 Impact of Covid-19 on Adult Safeguarding

Throughout 2021/22 there were still Covid-19 national restrictions which impacted vulnerable people. As with children's safeguarding, Domestic Violence cases connected to Covid-19 lockdowns feature in the concerns raised. From a safeguarding perspective, regardless of the pandemic, the Trust has continued to provide a Trust wide, safeguarding service, supporting all services in both the community and bed-based services. The Trust has been able to continue to provide face to face support for vulnerable patients especially within the Emergency Department and Community settings.

9.10 Prevent

Prevent safeguards vulnerable people from becoming terrorists or supporting terrorism, by engaging with vulnerable people and protecting those being targeted by terrorist recruiters.

Prevent deals with all forms of terrorism, including Islamist and extreme right wing, and does not focus on any one community.

Prevent is about working in areas where there are risks of radicalisation and offers support predominately through local community partnerships.

Through Prevent, vulnerable individuals who are at risk of radicalisation can be safeguarded and supported.

9.10.1 Prevent duty

The Prevent duty came into force as part of the Counterterrorism and Security Act 2015 and ensures that specified authorities have a duty to prevent people from being drawn into terrorism. It covers schools, colleges, universities, health, local authorities, police, and prisons.

9.10.2 Channel

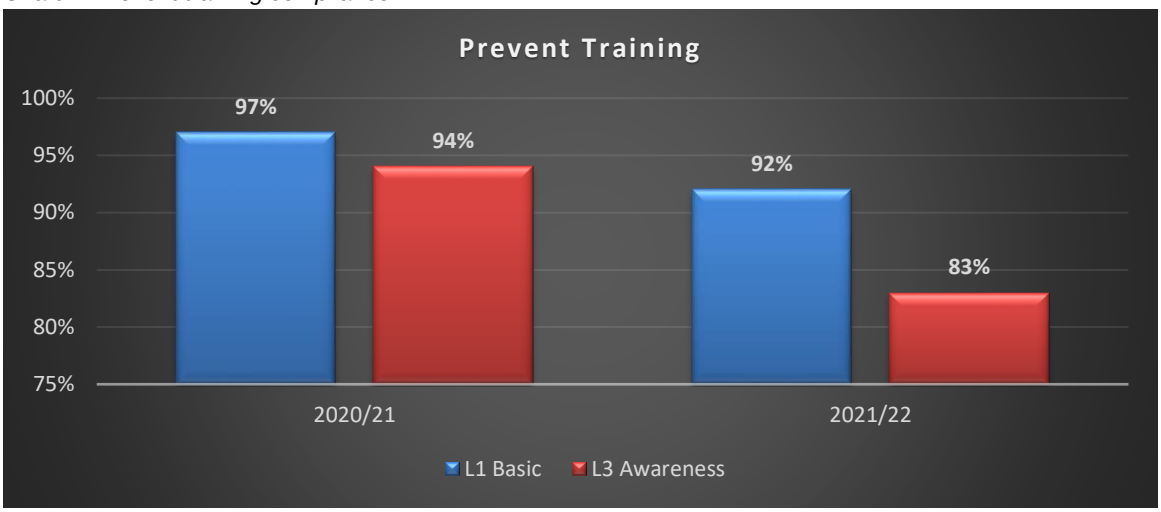
Since 2012, the Channel programme has helped more than 1,500 people who were considered to be vulnerable to exploitation from terrorist influences. It provides tailored support for a person vulnerable to being drawn into terrorism. A referral can come from anyone who is concerned about any person who may be at risk. All referrals are carefully assessed for suitability for Channel. For cases where there is a risk of radicalisation, a multi-agency **Channel Panel** chaired by the local authority will meet to discuss the referral and decide on

what tailored package of support can be offered to the individual. The safeguarding team represent the Trust at Channel Panel.

9.10.3 Bolton FT Prevent Training data

The chart below shows a reduction in both Level 1 and 3 training compliance in 2021/22 compared with 2020/21. Work is underway to review how Prevent training is delivered to ensure compliance increases.

Chart 7: Prevent training compliance



9.10.4 Bolton FT Position on Prevent

- On a quarterly basis, Prevent activity undertaken by the Trust is reported to NHS England.
- The Safeguarding Team provide advice and support for staff reporting Prevent cases and liaising with Counter Terrorist Police to share information for CHANNEL or high-risk cases.
- Bolton FT is represented on the Channel Panel by the safeguarding team
- Home Office Level 1 Prevent training and Prevent Level 2 training across the Trust.

10. Adults - Learning from Reviews

The Safeguarding Adults Board (SAB), under the Care Act 2014, commissions Safeguarding Adult Reviews (SAR) when a person with needs for care and support has died, and it is suspected that the death is a result of abuse or neglect, and there are concerns around how partner agencies worked together to safeguard that person.

In 2021/22 – 0 SAR were commissioned by the SAB.

10.1 Learning from Previous Reviews

Between 2019 and 2021, the safeguarding adult team has contributed to the following reviews –

1 joint Safeguarding Adult Review/Domestic Homicide Review and

1 stand-alone Safeguarding Adult Review.

Recommendations from both reviews include:

Diagram 18: Recommendations from learning reviews

These actions will form key priorities for the Trust safeguarding adult team in 2022/23.

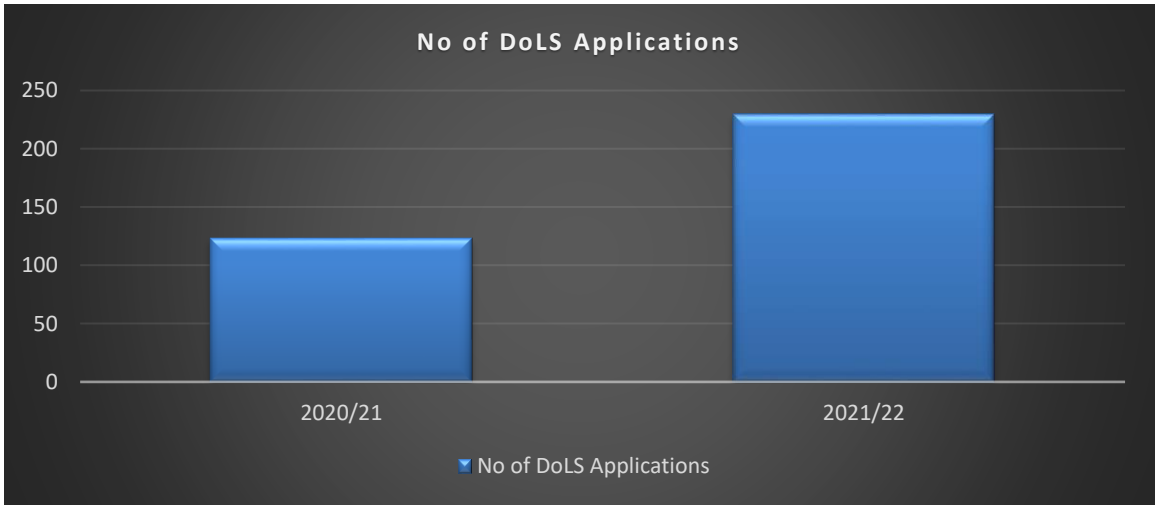
11. Mental Capacity Act 2005 and Deprivation of Liberty Safeguards DoLS

The safeguarding adult team supports the MCA/DoLS agenda as there is no dedicated MCA/DoLS lead for the Trust, this includes providing training and support to staff and ensuring policy reflects statutory requirements. The team support staff in ensuring that correct processes are in place for any patient who lacks capacity to make decisions to ensure they are not illegally detained by the Trust and have a DoLS in place.

11.1 Deprivation of Liberty safeguards (DoLS)

In 2021/22 there has been an increase in the number of DoLS applications made by Bolton FT compared to 2020/21. During COVID, there was very limited capacity within social care to assess DoLS applications due to home working. As COVID restrictions have lifted, the volume of DoLS has increased.

Chart 8: Number of DoLS applications



In 2022/23 The safeguarding team will drive forward this agenda through training, audit and support to increase awareness of staff on their statutory duty and ensure that no patient is illegally detained in the Trust and those that are subject to a DoLS have least restrictive restraint in place.

It is acknowledged that further education and support is required across our workforce to ensure that we are fully compliant with the legislation around DoLS. Over the last 12 months we have redefined our processes to capture the accurate recording of DoLS applications and monitoring these with the local authority. This is an area that still requires further improvement and is a key objective for 2022- 2023.

11.2 Liberty Protection Safeguards (LPS) Update

The LPS were originally due to be implemented in October 2020, but were then delayed to a target of April 2022 because of the pandemic. However, at the end of last year, the government announced a further delay but without specifying a new implementation – a position that still holds. As a Trust we continue to prepare for the implementation of LPS.

12. Conclusion

Safeguarding is often described as a 'golden thread' that weaves through every service and touches every area of practice and practitioner at some stage in a career. This annual report has highlighted the diversity of the adult, children and LAC safeguarding agenda and provides assurance that the Trust is meeting its statutory requirements and that thread is very clearly embedded across the Trust.

The report highlights the impact that the pandemic has had on all aspects of safeguarding and the challenges faced by the teams and wider Trust not just as a result of the pandemic but also due to significant staffing issues in all teams. This has impacted on the ability to further develop safeguarding as the need to be reactive rather than proactive has had to take precedence.

The teams look forward to 2022/23 where they will work more cohesively on a Think Family approach and re-establish face to face training which will greatly impact and support frontline staff.

The wider safeguarding agenda continues to be challenging for all health agencies and multi-agency partners, the Trust continues to actively respond and contribute to regional and national developments. However, we recognise there is much more to achieve and to this end the development and delivery of the future priorities will help ensure that the Trust is fully engaged in the effective prevention of and response to safeguarding concerns.

This Annual Report demonstrates that safeguarding vulnerable people remains a significant priority for the Trust and offers assurance that the priorities for 2022/23 align with the partnership strategic objectives to ensure the people of Bolton are afforded the best care and protection when in our care.

13. Next steps 2022-2023

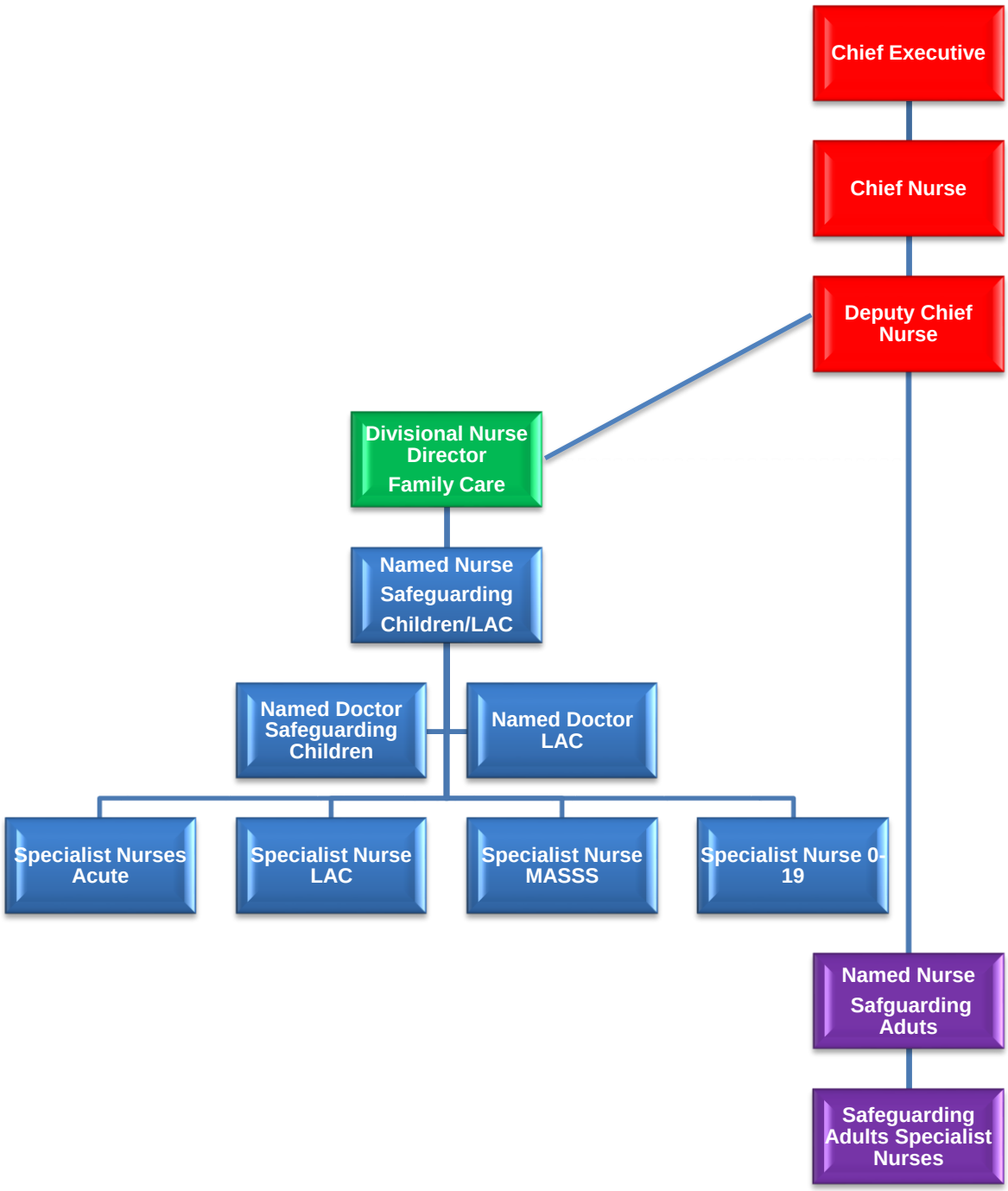
Safeguarding activity and protecting our vulnerable patients and service users remains a key focus for the trust in 2022-2023. In line with the priorities from Bolton Safeguarding Childrens Partnership (SCP) and Bolton Safeguarding Adults Board (SAB) our focus for the next 12 months are:

- Further strengthen and develop reporting through the Trust Committee structures and to SAB and SCP.
- Undertake a full review of the safeguarding teams the service and our processes in line with the guidance in the intercollegiate document.
- Develop further relationships with the local authority and our partners to deliver services that met our populations needs.
- Strengthen our systems and processes for DoLS and MCA working in collaboration with GMMH and the local authority.
- Review safeguarding training across the locality in line with SAB to ensure the training we provide is continually reviewed to meet relevant guidance and also address areas of concern within the local population and area.
- To work towards an integrated safeguarding team enabling smoother transition for patients and a seamless all age service

Appendix 1

Underpinning Legislation /Statutory Guidance
• Children Act 1989/2004
• Working Together (2018) Statutory Guidance
• Promoting the Heath of Looked After Children (2015) Statutory Guidance
• Safeguarding Children and Young People Roles and Competencies for Health Care staff (2019)
• Safeguarding Adults Roles and Competencies for Health Care staff (2019)
• Looked After Children, Skills and Competencies for healthcare Staff (2015)
• Health and Social Care Act 2008 (Regulated Activities) Regulations (2014)
• Lampard Inquiry (2015)
• Children Act 1989/2004
• Working Together (2018) Statutory Guidance
• Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)
• General Data Protection Act 2018 (GDPR) and the Data Protection Act 2018.
• Working Together (2018)
• Children Act 1989/2004
• Working Together (2018) Statutory Guidance
• Female Genital Mutilation Act 2003
• Mental Capacity Act 2005
• Serious Crime Act 2015
• Mental Health Act 2007
• Children and Families Act 2014
• Modern Slavery Act 2015
• The Crime and Disorder Act 1998
• Sexual Offences Act 2003
• Domestic Abuse Act 2021

Appendix 2 – Team Structure



Appendix 3 – Definitions

Child	Having not reached 18 years, up to 19/25 years if SEND (Special Educational Needs and Disability)
Safeguarding Children	Protection from maltreatment, preventing impairment of health or development; growing up with safe, effective care to enable best outcomes.
Child Protection	Part of safeguarding refers specifically to children who are suffering, or at risk of significant harm.
Looked After Child	In the care of the Local Authority for more than 24 hours. Also often referred to as children in care
Adult Safeguarding	Protecting an adult's right to live in safety, free from abuse and neglect, while at the same time making sure that the adult's wellbeing is promoted and having regard to their views, wishes, feelings and beliefs
Deprivation of Liberty Safeguards (DoLS)	DoLS is part of the MCA and is a legal framework for individuals over 18 years who lack the capacity to consent to be accommodated in a hospital or care home in order to receive care and treatment
The Mental Capacity Act (MCA)	The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.