Primary Care Safeguarding Annual Review

Safeguarding forum 25th March 2026

Primary Care Safeguarding Annual Review 25/26

Assurance and Quality Review

Aim: To support practice engagement and quality improvement
Objective: Identify and share areas of good practice, and identify areas for development at both practice and support at ICS level

Section 11 of the Children Act 2004 and the **Care Act 2014** places a statutory duty on agencies, including GP practices, to ensure that they have regard to the need to safeguard and promote the welfare of children and vulnerable adults.

This assessment tool has been designed to allow opportunity to highlight areas of strength and to identify areas for development in respect of duties and responsibilities.

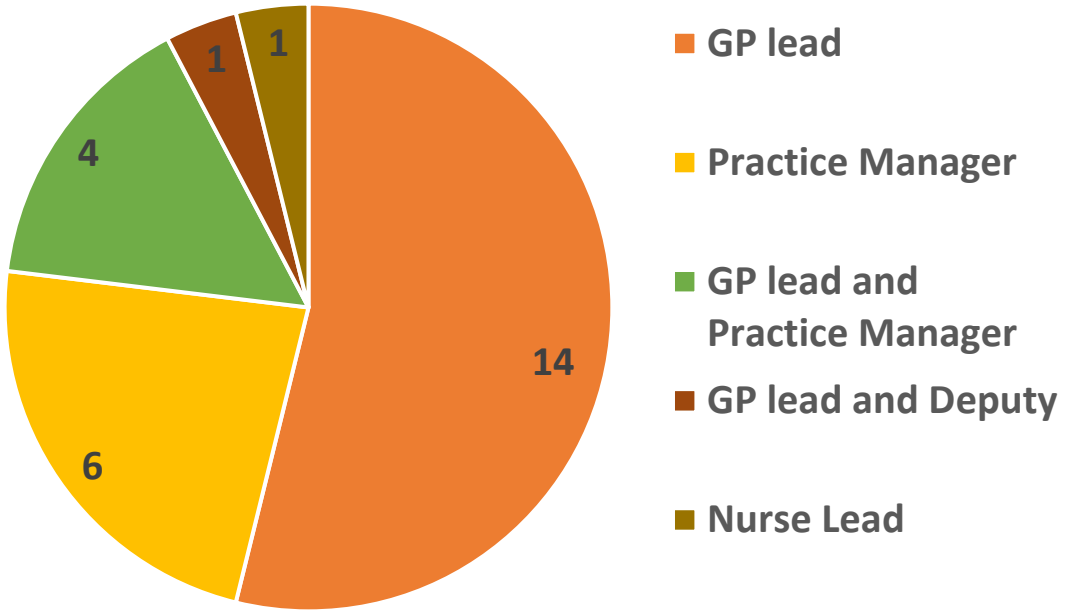
This tool assists the ICS- Southwark borough safeguarding team to identify where to target support, in order to drive safeguarding standards upwards.

Practice Policy and Process
Training
Frontline safeguarding
Looked After Children and Care Leavers

SG

Primary Care Safeguarding Annual Review Practice Policy and Process

25/31 practices + Care Home Team completed (81%) -thank you!



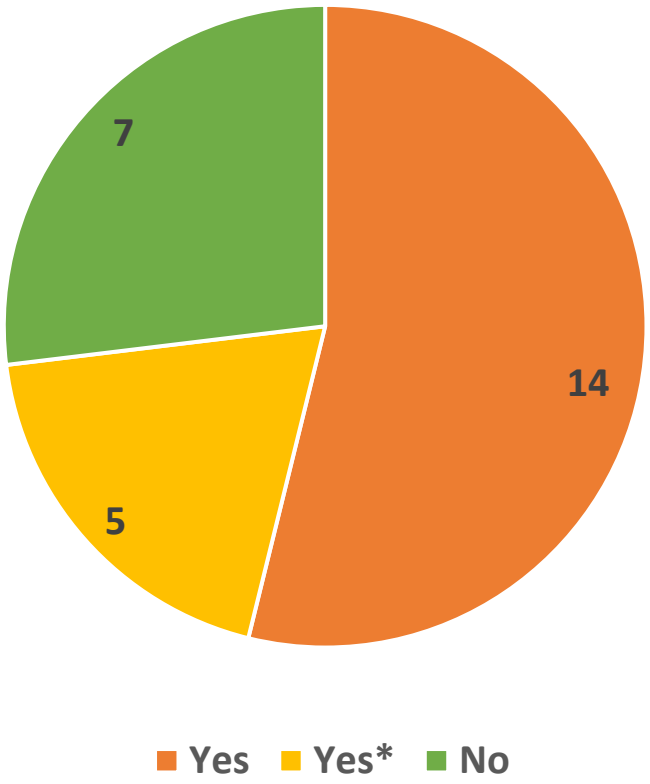
Within the last 24 months:

- Safeguarding lead changed in 3/26 practices
- Practice policies updated in all practices, 16 in the last 12 months

Reasonable adjustments for Learning Disability
New contact details for SEL team
Domestic abuse policy
Online referral portal links
DoLs Guidance | Locums
Appendix with added on using Ardens searches
Local referral pathways
Online access
Escalations | Flowcharts

SG q8-11

Does your Safeguarding Lead have protected time for the role?



Protected time as and when needed

Within protected admin time

Time for forums and PLTs

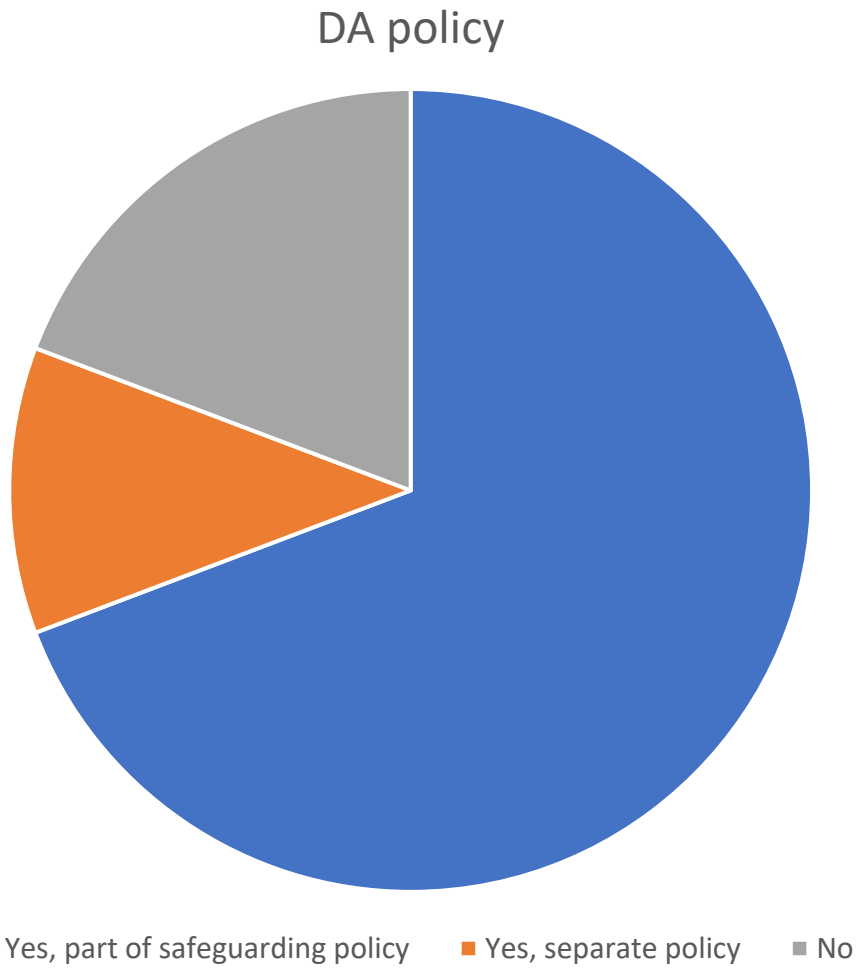
30mins, 2 hours, 3hours, 1 session per month

Unfunded- try to fit in with all other work.

**Have you signed up for the NHS SEL Safeguarding LIS?*

SG10-11

Do you have a separate domestic abuse policy?



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References useful in updating your domestic abuse policy

Domestic Abuse Act 2021
And
Home Office Domestic Abuse Statutory Guidance document dated July 2022
(for legal aspects)

RCGP Safeguarding Toolkit Part 2B: Domestic Abuse (very good for understanding the concept of routine enquiry, approaching questions about domestic abuse, and responding to disclosures making a BRIEF risk assessment. Also specific guidance on how to document in records)

Safe Lives (another helpful resource library – but whilst knowledge that there is a DASH risk assessment toolkit is helpful, it is NOT expected or recommended that GPs/primary care staff try to use this in their consultations so do not write this into your policies.)

Domestic abuse | Southwark Council

Bede Women's Safety Alliance (new Southwark domestic abuse incorporating also a broader violence against women and girls (VAWG) service – referral form on DXS – replaces Refuge/IRIS

Southwark MASH (to ensure all children in household are safeguarded)

MARAC – for high risk cases – can refer directly (form on DXS) or when passing to an IDVA a full risk assessment will be made and decision made whether to escalate to MARAC

Respect Charity to Help Domestic Abuse Perpetrators | Respect Phoneline UK

24Hr Domestic Abuse Helpline 0808 2000 247

New Southwark Domestic Abuse service since 7th Feb 2026:

New provider (Bede House), Broader service

The service is available to all those living in Southwark who have experienced, or are at risk of, gender-based abuse VAWG crimes listed below:

- Domestic abuse
- Rape
- Sexual assault
- Sex industry
- Trafficking for sexual exploitation
- Up-skirting
- Voyeurism
- Stalking and harassment
- Female genital mutilation (FGM)
- Forced marriage
- Honor based abuse
- Digital stalking
- Exposure
- Spiking

The **Women's Safety Alliance** will support people impacted by domestic abuse (within intimate or ex-intimate partner and family relationships) and Public Space gender-based abuse such sexual assault, stalking, and harassment.

Submit completed forms (available on DXS) to:

wsa@bedehouse.org

Duty Number: 020 7232 0860

<u>The support offer by Womens Safety Partnership (Bede) includes the following services</u>:

- **Independent Gender-Based Violence Advocates (IGVAs)** – Engage with individuals aged 16+ who have experienced or are concerned about violence against women and girls (VAWG) in public or community spaces. Provide support across all levels of risk – high, medium, and standard – offering information, advice, guidance, effective case management, and intensive advocacy for survivors of gender-based violence and abuse.

- **Housing** – Providing support to survivors of domestic abuse who require assistance with housing-related issues, including accessing safe accommodation and navigating housing services.

- **Home Safety and Sanctuary Scheme** – Support households, families, and individuals to make their homes safer through practical security measures, aiming to reduce repeat incidents and increase personal safety.

- **Police** – Support clients who require advocacy and guidance when navigating the criminal justice system, ensuring their experiences and needs are represented and understood.

Counselling - 12 to16-week 1-2-1 counselling programme for survivors of Domestic and Non-relationship VAWG crimes /or Sexual abuse. The service is for Southwark Residents 16 years and over.

Children's Therapeutic Support - one to one, 12 week talking, play and arts based therapeutic intervention to children and young people who have witnessed Domestic Abuse or VAWG Crimes. Age range 5-17 years old.

Survivor Group Work Programme – The Freedom Programme: A domestic abuse group for women, supporting survivors to identify the characteristics and tactics of perpetrators, understand the different forms and strands of domestic abuse, and build confidence and skills to regain control and empowerment over their lives.

Accessing Advice and Making Referrals

Has the team experienced any difficulties in accessing advice and making referrals with social care for child at risk of significant harm of abuse? - No 96%

Has the team experienced any difficulties accessing advice and making referrals with social care for vulnerable adults at risk of abuse? - No 85%

The challenge is sometimes resources and when we have referred vulnerable adults if they have struggled to engage with them, they have signposted them back to us.

We do follow up our patients and many times it becomes difficult to see which decisions have been taken related to that case. Especially with adults, not children, the communication between Adult Social Care and GPs is extremely poor - we have to chase emails/referrals that we have sent several times.

We have highly dependent adults who have been moved into supported housing. Many are very vulnerable. We've found it difficult to get answers from Adult Social care as to the status of referrals - e.g. is their listed NOK a known perpetrator of financial abuse? Can the client be supported to pay important bills? Do not always get update on outcome from Social Services - have to chase .

HV-GP liaison meetings mean regular information sharing on under 5s . There is a gap in information sharing for school age children as little/no contact with school nurses.

We have had some occasions where it was difficult to get social services to accept referrals for a child especially where we would expect them to liaise with the child safeguarding team at another borough.

Timely communication regarding any changes to local safeguarding processes or contacts would be beneficial.

SG Q16-17

Using the new online referral portals

Prefer pre-populated forms – saves time – online forms add to workload – mentioned by 8 practices

Harder to include clinical notes in referral

MASH- font reportedly too large for small box- hard to include enough detail

Very straightforward and no challenges so far – 5 practices

It is a shame to spend additional time on essentially data entry for demographics

Hard to include "vague" detail- sometimes things are unclear, and opting for a binary selection seems risky

Better since online so overall is beneficial

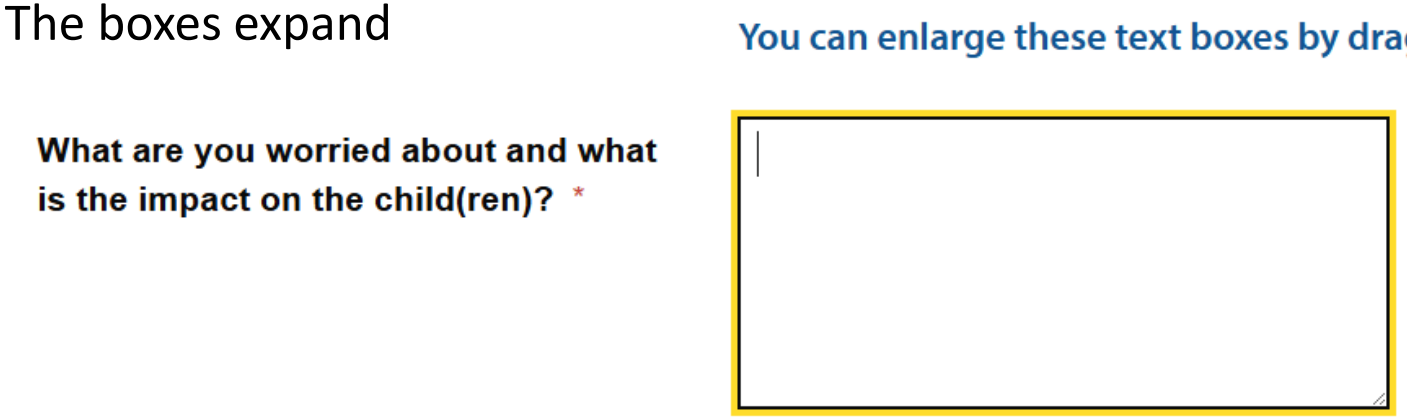
Overall, the portals support timely and appropriate referrals, with ongoing improvements and updates welcomed.

we have to manually save a copy into the patient's records which is time consuming as well as increasing the risk that information might get lost.

It is helpful to be able to upload document at the end, I wonder that it may be helpful to advise of this at the beginning of the process

Responding to some concerns:

- Online portals are part of a London wide Social Care implementation, allowing for additional function beyond an ‘email inbox’ – making for more accurate and faster processing of referrals
- DXS form still accepted for Adult Safeguarding referrals for the time-being (your feedback has been passed to the ASC team developing the portal)
- If using online portal for Adult Safeguarding Concern, no longer need to decide which team to email – ASC now do this at point of referral – more straightforward
- They are designed for multi-agency use - Health, Schools, Police, Voluntary Sector all with wide and varied systems – so as such not possible to integrate into our EMIS/DXS system unfortunately
- Parents/Carers/ Significant Adults, Sibling(s)’ details did not integrate in the emailed form previously, this is no different
- The boxes expand



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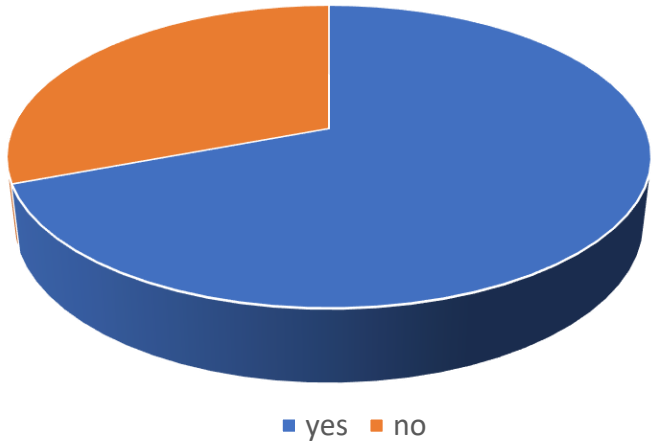
Safeguarding Audits/Practice Development projects - 18/26 practices (69%)

several practices said they had regularly reviewed their safeguarding registers and vulnerable adults lists, and updated them accordingly, discussing active cases at practice MDTs.



Other examples of quality improvement projects included…….

clinical audit report concerning the **recommendation from the domestic homicide review**, which emphasizes the necessity for our GP surgery to carry out routine **domestic abuse enquiries for all pregnant women** (antenatal and postnatal)

Audit on **missed appointments for children** – this has informed the revision of our WNB/DNA policy

Checked that **alerts were placed on household members of all children on safeguarding register** to advise of a potential safeguarding risk (2 practices)

Reviewed the Children's Safeguarding Register **to identify any concerns such as repeated appointment DNAs, missed vaccinations, and any emerging risks.**

correcting coding in patients notes to reflect current status of safeguarding concerns

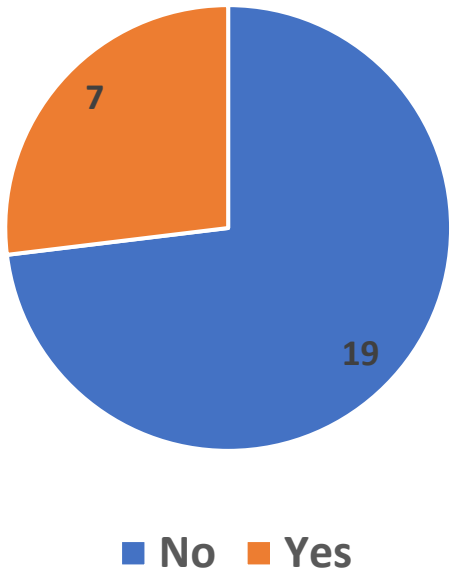
A review of adults with **legacy child safeguarding codes** still on record as current problem

We found some newly registered patients with **historic codes** from previous practices needed review. We worked with Healthtech- our patient **registration team**- to review questions for children, to ensure we asked if **child looked after** or **known SW**. Also the **exact relationship of the person registering.**

Flowchart produced for admin team members on what to do when a request for information in respect to safeguarding is received.

Our paramedic has contacted adult safe guarding patients to **see if any help is still needed or ongoing**

Has the practice experienced any difficulties/significant events in relation to prospective patient/child proxy online access to medical records and safeguarding?

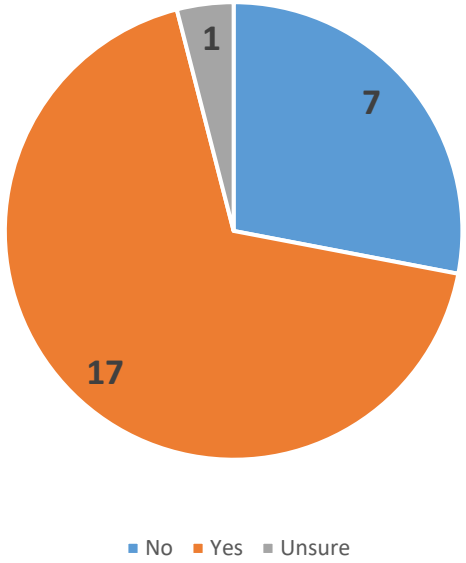


- **Complex and time consuming**. No significant events but real concern about risk of incorrectly having information shared with family members.
- Challenges - particularly when children reach the **age** of 13.
  - At this stage, their right to confidentiality changes, and parents sometimes request continued access to their child's medical records without the young person's consent. This has occasionally led to difficult conversations where parents were unaware of the legal and safeguarding requirements that govern access at this age.
  - Staff have had to explain the rules around capacity, confidentiality, and safeguarding, which can be challenging when expectations differ.
  - Highlights a need for increased awareness among parents about how access changes as their child gets older, as well as continued training and support for practice staff to confidently handle these discussions.
- There was a **parental dispute** with relationship breakdown between parents going through the courts. Father requested access to children's notes, it was given. Mother made a complaint however father had parental responsibility and there were no court documents denying him access.

- Access requests are reviewed on a **case-by-case basis** in line with safeguarding guidance, with clinical oversight to ensure access is appropriate and does not pose a risk to the patient or child. Where concerns are identified such as parental conflict or safeguarding flags, access is restricted or declined, and decisions are clearly documented. Staff remain vigilant and follow established safeguarding and information-sharing procedures.
- We are strict on this and follow our policy Patient Access & the NHS App on our portal . Issues tend to arise when a parent (usually estranged or fighting) does a SAR and then we release redacted documents which they then challenge why redacted . This takes up a lot of time checking and rechecking and dealing with the dispute .

SG 22-23

With the transition to increased GP patient registrations via the NHS app and wider online providers is the practice taking any additional steps to identify vulnerable families and adults at, or just after registration?



- *Once national registration form completed- family directed to Healthtech form- safeguarding, vulnerability flagged to registration team, onward practice MDT discussion*
- *CP-IS*
- *Registration Policy*
- *All new registrations screened*
- *Run searches monthly*
- *New patient health check*
- *Work closely with HV to identify vulnerable families*
- *This something we need to look at improving*

SG 24-25

Child Protection Information Sharing (CP-IS) service

Overview of Child Protection Information Sharing (CP-IS) service

A national system that connects local authorities' child social care IT systems with those used by NHS unscheduled care settings (e.g., Emergency Departments) in England, to provide better care and earlier intervention for children who are considered 'vulnerable and at risk'

NHS unscheduled care settings

- emergency departments
- emergency dental services (when connected to and emergency department in a hospital)
- walk in centers
- ambulance services
- GP out of hours
- paediatric wards
- maternity units
- 111 services

NHS England

cpis.operations@nhs.net

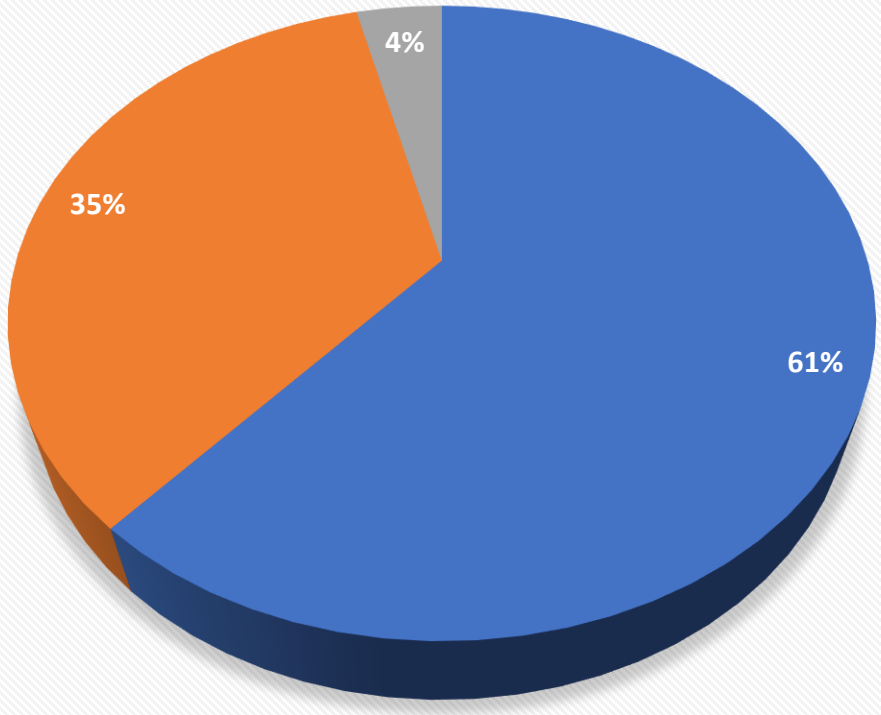
Child Protection Information Sharing

https://digital.nhs.uk/developer/api-catalogue/child-protection-information-sharing-mesh

Phase 2 – roll out in GP –Primary Care

Suggest registration suitable junction- check if child/unborn subject to plan or Looked After Child

Does the team feel confident in identifying and responding to needs to victims of domestic abuse?



- Yes- e.g., we have a clear robust system, including regular referral to IDVA services (IRIS/Refuge), we regularly undertake routine enquiry during consultations including ante- and postnatal appointment, we regularly discuss cases at our safeguarding meeti
- Mostly Yes- e.g., on reflection we need to further embed routine enquiry and review our referral rates and ensure we discuss such cases on a regular basis.
- Mostly No- e.g., we recognise this as an area we would value additional support

Feedback on access to domestic abuse training

There is **plenty of training available** . The IDVA service is good and we always recommend and signpost clients . I am unsure how many clients use the service as it is self-referral and they may choose not to do so, or face barriers /fear to engage

Training organised for the whole practice

we have a **clear robust system**, including regular referral to Southwark Domestic Abuse Services (SDAS), we regularly undertake routine enquiry during consultations including ante- and postnatal appointment, we regularly discuss cases at our safeguarding meeting

Use of online resources. We also recently had an online meeting with the **lead doctor at The Havens give a talk** to our practice 4-6 weeks ago.

Part of **GP lead forums and PLTs**

Staff have Domestic Abuse level 1 training on **Bluestream**

training has felt too basic, and lengthy. We have tended to avoid repeats, as worried we would just go over the same ground again

we might **need to receive more training** on that

We are speaking with our **IRIS** Advocate Educator to arrange domestic abuse training for our admin/reception team.

Feedback on access to domestic abuse training

The practice has access to domestic abuse training through statutory safeguarding training, online learning, and local ICB/borough-led updates. Staff are supported to identify and respond to domestic abuse concerns and are aware of local referral pathways and advocacy services (e.g. IDVA services). Information on domestic abuse support is available within the practice, and safeguarding leads provide advice, signposting, and escalation support when required. **Opportunities for further specialist training and enhanced access to advocacy services would be welcomed to strengthen staff confidence and patient support.**

We feel that **training is accessible**

Iris training & **bluestream training available to all staff**

Practice is aware of **training module on elfh**

Yes, we feel we provide an effective service and have patients from a refuge closeby

we had a PLT with discussion around what is available locally for victims of domestic abuse . **presentations from Refuge and before that solace**

Domestic abuse training for Southwark Primary Care going forward:
A new era with a new Domestic Abuse service provider – **Bede**

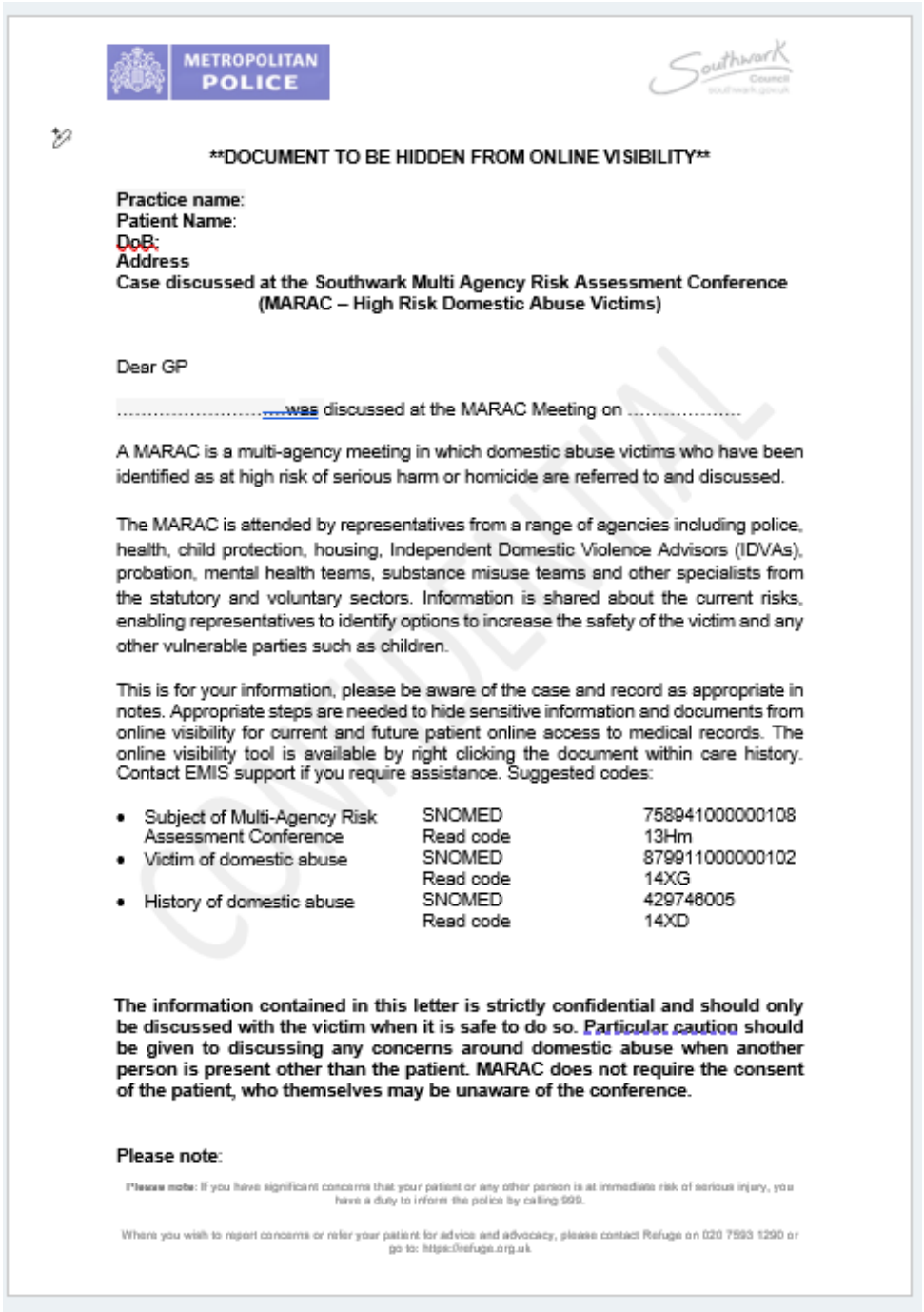
Will retain the ability of the IDVA to come to practices to see patients if this is the patient's preference

Will remain the provider for 10 yrs (providing continuity, avoiding uncertainty in referral pathways)

HAVE YOUR SAY! – new providers eager to tailor training to the needs of our primary care workforce…… you will be emailed shortly to ask for ideas. No longer need to adhere to rigid IRIS model

The form of the training is a work in progress – responding to previous annual review responses the aim will be to

1. provide separate specific training relevant to admin staff as well as Southwark-specific clinical training
2. be available in bitesize recorded live webinars (which can be played back and viewed when convenient)
3. Building on basic level of knowledge about domestic abuse (trying to avoid too much repetition from e-learning)
4. Providing an option of face to face training where resource allows



METROPOLITAN POLICE

Southwark Council

****DOCUMENT TO BE HIDDEN FROM ONLINE VISIBILITY****

Practice name:
Patient Name:
DoB:
Address
Case discussed at the Southwark Multi Agency Risk Assessment Conference (MARAC – High Risk Domestic Abuse Victims)

Dear GP

……was discussed at the MARAC Meeting on ……

A MARAC is a multi-agency meeting in which domestic abuse victims who have been identified as at high risk of serious harm or homicide are referred to and discussed.

The MARAC is attended by representatives from a range of agencies including police, health, child protection, housing, Independent Domestic Violence Advisors (IDVAs), probation, mental health teams, substance misuse teams and other specialists from the statutory and voluntary sectors. Information is shared about the current risks, enabling representatives to identify options to increase the safety of the victim and any other vulnerable parties such as children.

This is for your information, please be aware of the case and record as appropriate in notes. Appropriate steps are needed to hide sensitive information and documents from online visibility for current and future patient online access to medical records. The online visibility tool is available by right clicking the document within care history. Contact EMIS support if you require assistance. Suggested codes:

• Subject of Multi-Agency Risk Assessment Conference	SNOMED Read code	758941000000108 13Hm
• Victim of domestic abuse	SNOMED Read code	879911000000102 14XG
• History of domestic abuse	SNOMED Read code	429746005 14XD

The information contained in this letter is strictly confidential and should only be discussed with the victim when it is safe to do so. Particular caution should be given to discussing any concerns around domestic abuse when another person is present other than the patient. MARAC does not require the consent of the patient, who themselves may be unaware of the conference.

Please note:

Please note: If you have significant concerns that your patient or any other person is at immediate risk of serious injury, you have a duty to inform the police by calling 999.

Where you wish to report concerns or refer your patient for advice and advocacy, please contact Refuge on 020 7953 1290 or go to: https://refuge.org.uk

CONFIDENTIAL

The Multi-Agency Risk Assessment Conference (MARAC) and ICB safeguarding team facilitate GP practice case notifications –

How does your practice respond and process these?

MODEL PROCESSING OF MARAC NOTIFICATION:

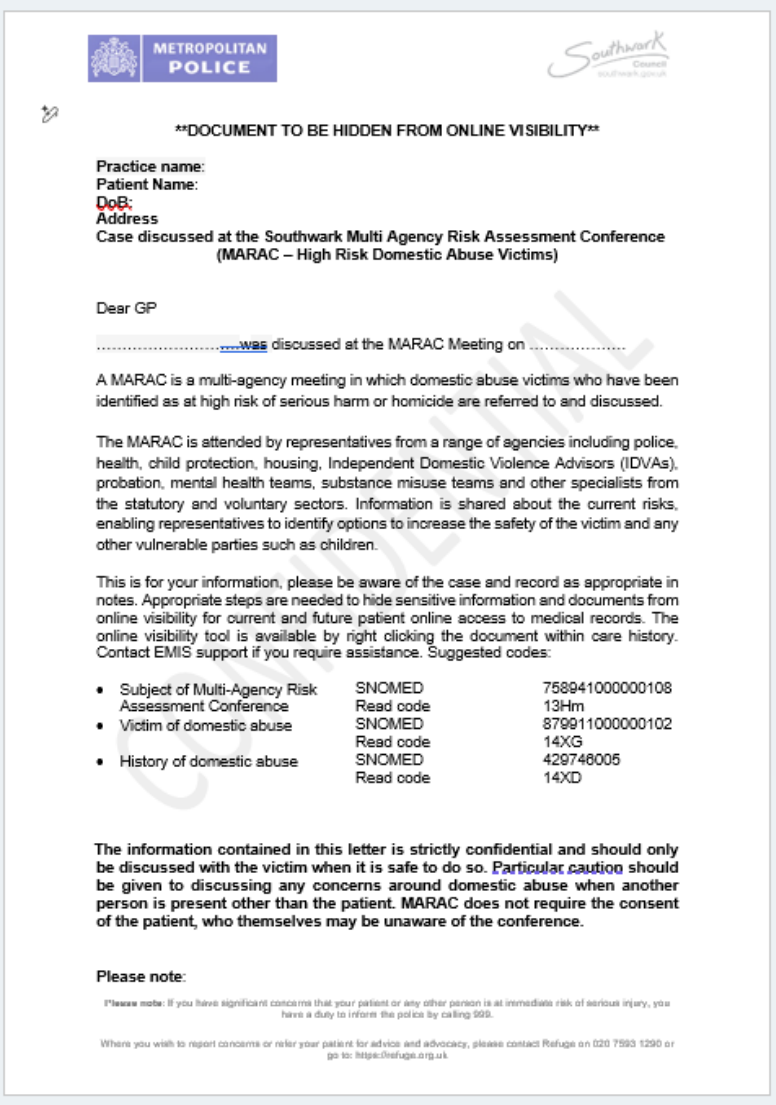
HIDE FROM ONLINE VISIBILITY/LOCK

CODE AS ADVISED ……..(this should ensure team is particularly alert to potential influence of coercion and be hypervigilant of confidentiality in information sharing)

INFORM SAFEGUARDING LEAD/ CARE CO-ORDINATOR, & DISCUSS AS A TEAM

CONSIDER IMPACT ON FAMILY AND PLAN ANY PROACTIVE CARE AS A RESULT

" I find a notification they were discussed at MARAC by itself not particularly helpful. We should be receiving a report of the details of the meeting "



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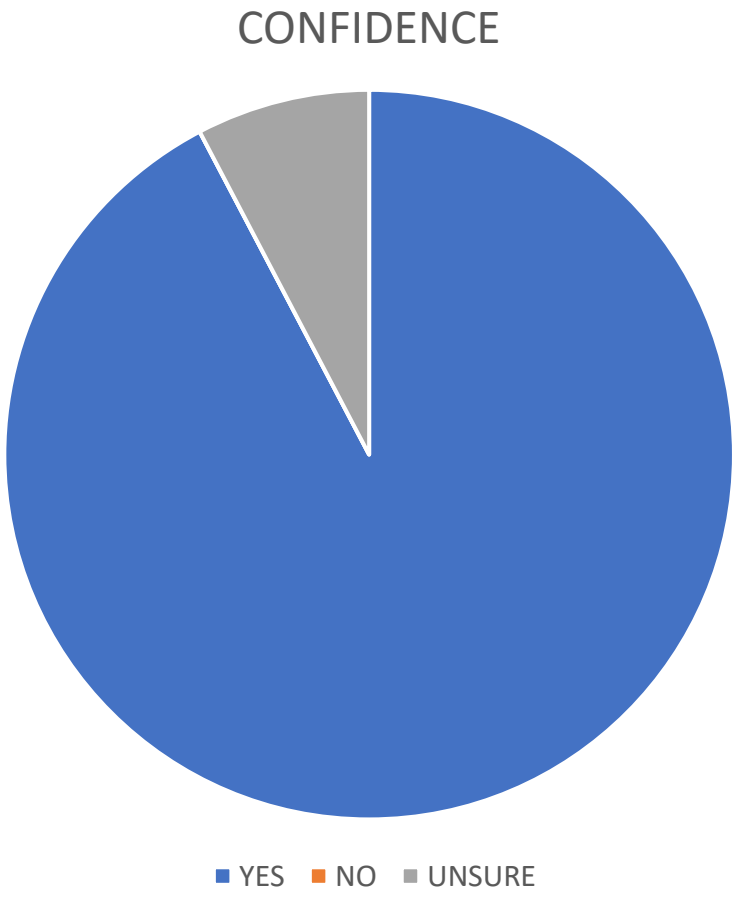
- Designed to be deliberately brief and avoiding detail for variety of reasons:

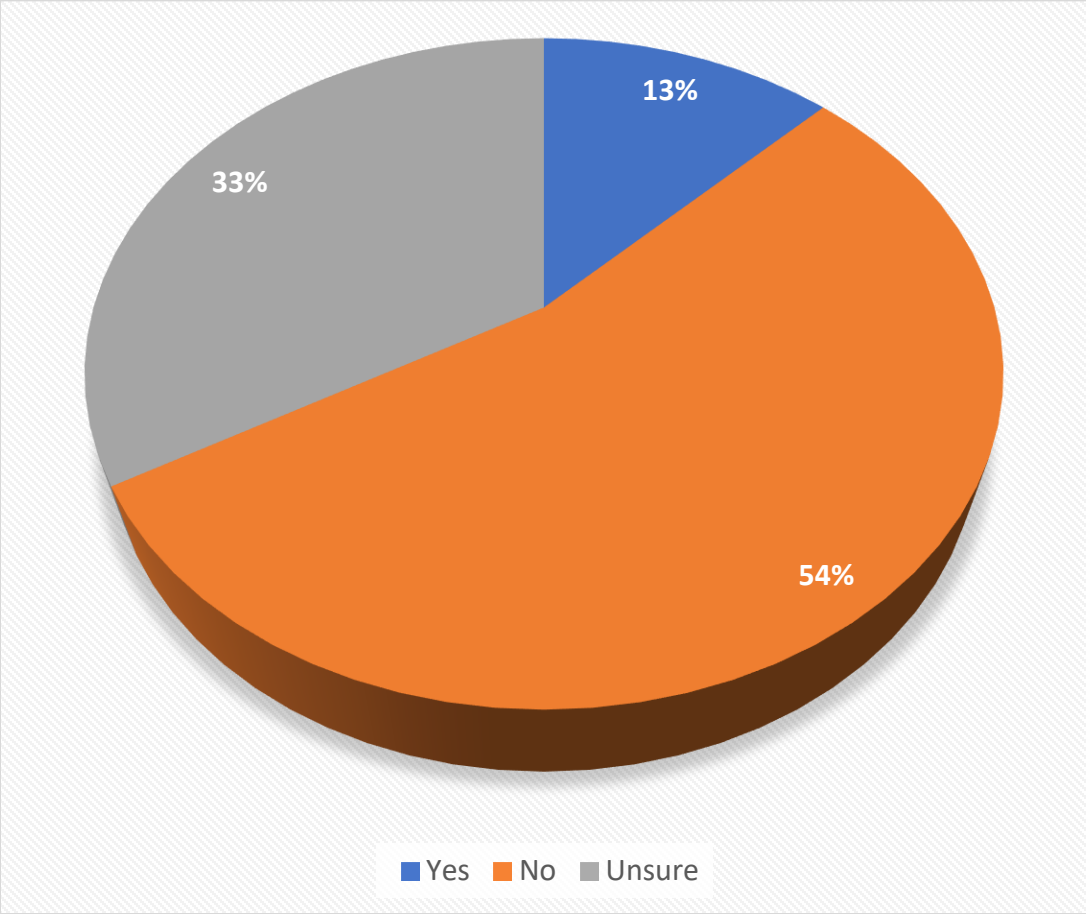
1. information is of highest sensitivity level & must not be inadvertently filed clumsily, which could put patients at risk (keeps message clear and to point)
2. Speeds up process of notification and allows process at practices to remain consistent and clear as uses a recognisable template format
3. Avoids confusion about what to do with 3rd party information – it would be a serious risk to file information from MARAC in perpetrators records.
4. Practices wishing to have more detail can write to MARAC to request it if required

Are clinical staff confident about when to seek consent and when they can share information without consent to safeguard children and vulnerable adults?



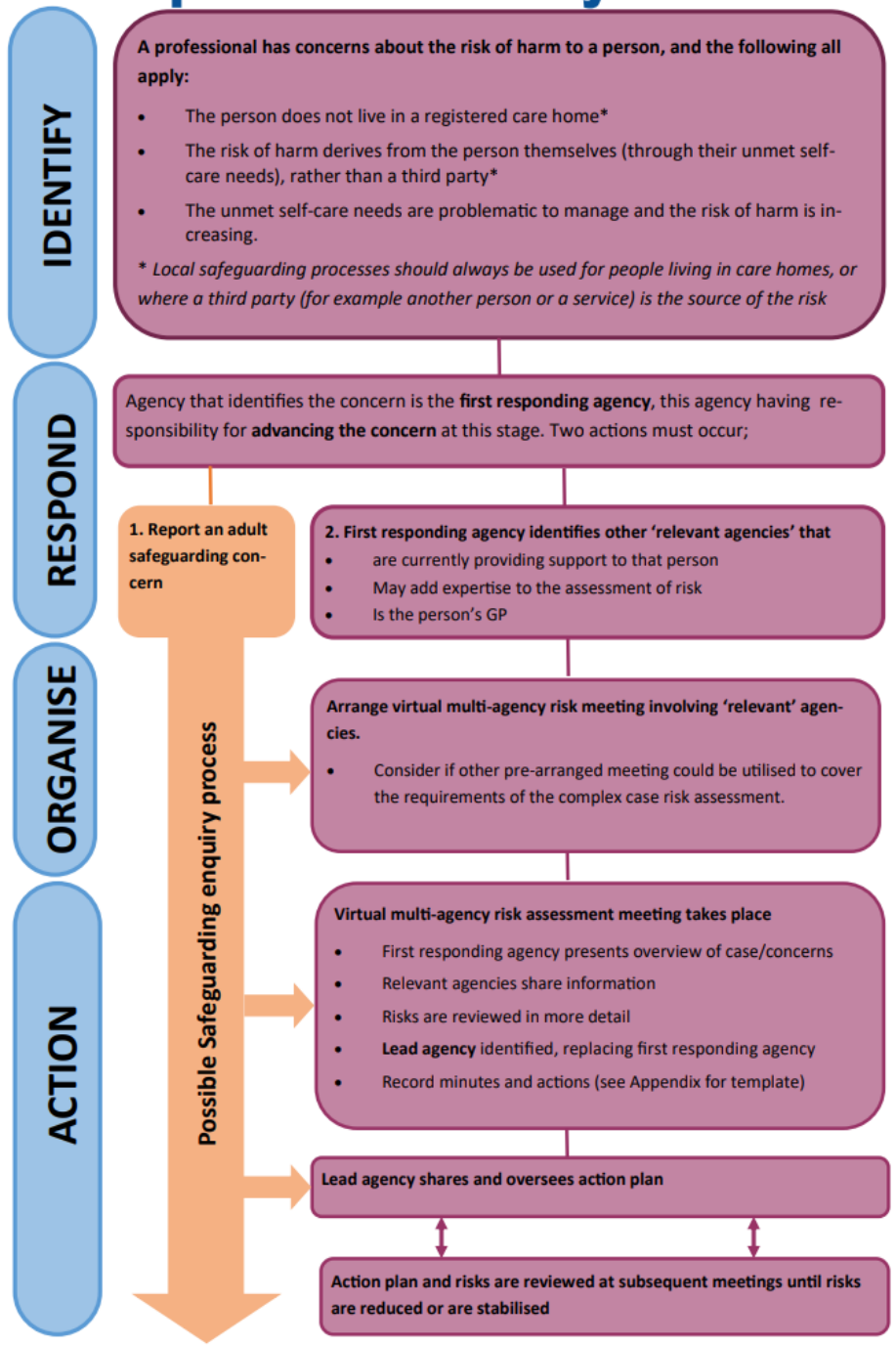
- “To obtain consent is a big issue”

Has your practice had experience in following the **“Complex case pathway”** which was brought out as Southwark Safeguarding Adults Board guidance in 2021/22? [Safeguarding The London Borough of Southwark • Resources]



- Well done to practices who have attempted to use it
- Not well embedded across agencies and has been under review for a number of years – thank you for your honesty
- Useful to have feedback to strengthen argument for scrapping process and starting again!

Complex Case Pathway/Framework



Feedback on use of the Complex Case pathway

- Our practice has not formally used the Southwark Safeguarding Adults Board “Complex Case Pathway” (2021/2022). However, we regularly manage complex adult safeguarding cases through internal MDT discussions and multi-agency working. These processes mirror the principles of the pathway, but we have no documented instance of following the specific formal pathway itself.
- I have not personally used the Southwark Safeguarding Adults Board Complex Case Pathway to date. My understanding is that it is intended to support adults with complex, ongoing risks that fall outside Section 42 safeguarding thresholds. Feedback from wider safeguarding learning suggests it can support improved multi-agency coordination and shared planning, though it can be time-intensive and require clear ownership across services. I would welcome further practical guidance or case-based examples to support confident use in future practice.
- Unsure of what this is. We could do with an update of information.
- We have concerns that we do not have capacity to arrange meeting and facilitate. It also does not offer us additional support to manage this complex cohort of patients.

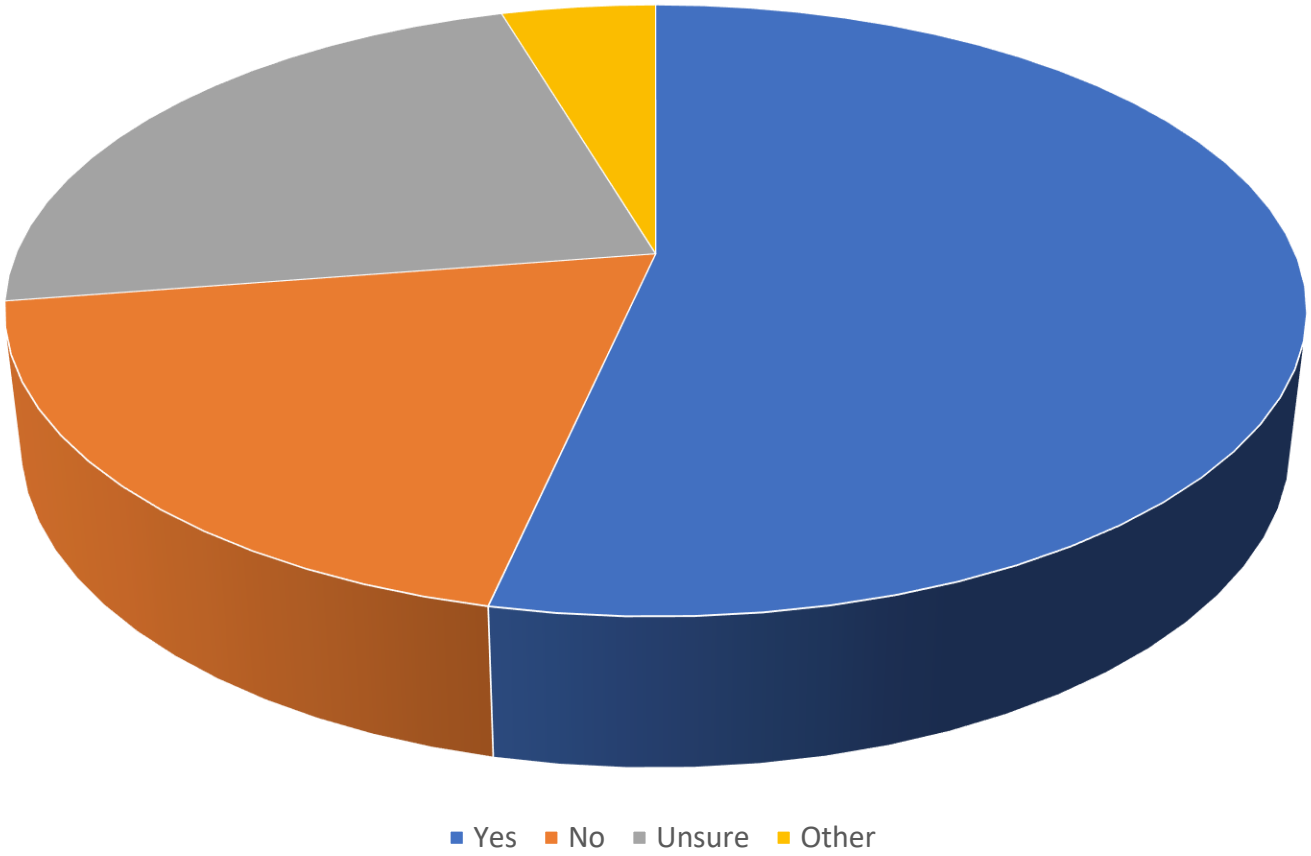
TAKE HOME MESSAGES on the Complex Case Pathway:

IT IS GUIDANCE, NOT A PATHWAY- The principle is to try to have a multi-agency meeting when you have a complex patient – something that at least one practice identifies they are doing already – and I expect several of you are – continue to strive to do this (whether following the pathway or not)

Do not worry if you are not using it – you are not alone, and it is likely to be changing soon.

WATCH THIS SPACE: Myself and the new Principal Social Worker for Adult Social Care (very supportive in recognising this is not a particularly helpful system) have called a new steering group to establish a safer and more robust plan that is likely to involve Adult Social Care as the lead agency in such cases, and stem from making a safeguarding referral.

Has your practice switched on the Ardens “Vulnerability factor” alert which highlights adults who may be vulnerable to abuse or neglect?



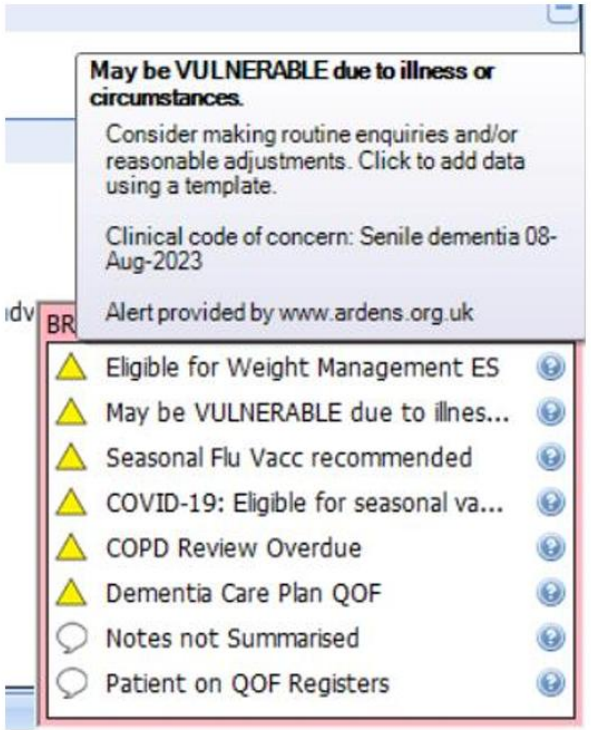
Feedback

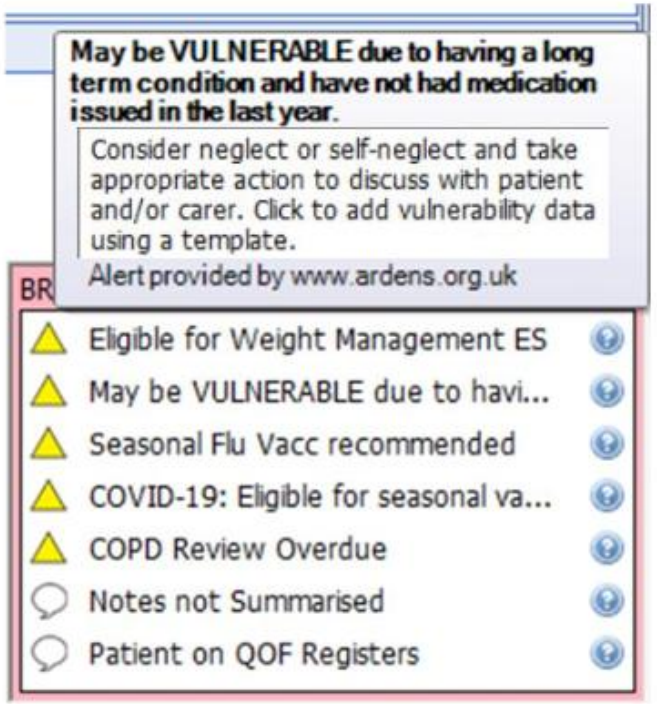
- **Useful**
- **Generally helpful** alert- as it makes you scrutinise the records and patient story more closely
- it **works well** at the moment
- The Arden's Vulnerability Factor alert is a **useful prompt** to highlight adults who may be vulnerable to abuse or neglect and supports early identification during clinical interactions. It helps clinicians remain alert to safeguarding risks and supports consistent recording and follow-up**. Suggested improvements include clearer guidance on trigger thresholds**, **alignment** with local safeguarding pathways, and **greater integration with existing safeguarding alerts** to reduce **alert fatigue**.
- **lots of patients flagged up**
- we are still learning on how to use this feature.
- New to me. We use the frailty one, and there's probably some overlap
- We are in the process of doing this exercise. We have an Ardens expert discussing with the team in February 2026

Collaboration with Named GPs across SEL ICB and Ardens

Designed to highlight codes in pt's history considered adversity factors (both current and historic) which may make them more vulnerable to mental health difficulties, abuse, neglect, and/or self-neglect.

Not designed to create any more work but to help a clinician think in a more trauma-informed way whilst consulting



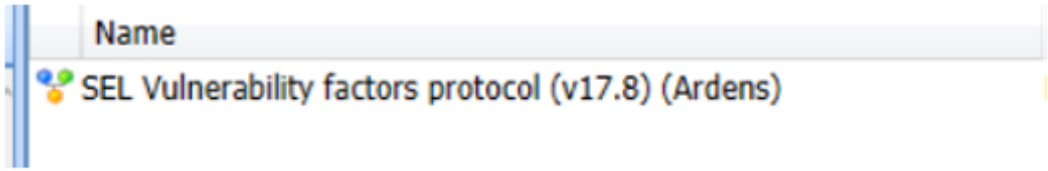


Alert tool will also flag if someone has a long term condition and has not had their medication issued in the last year

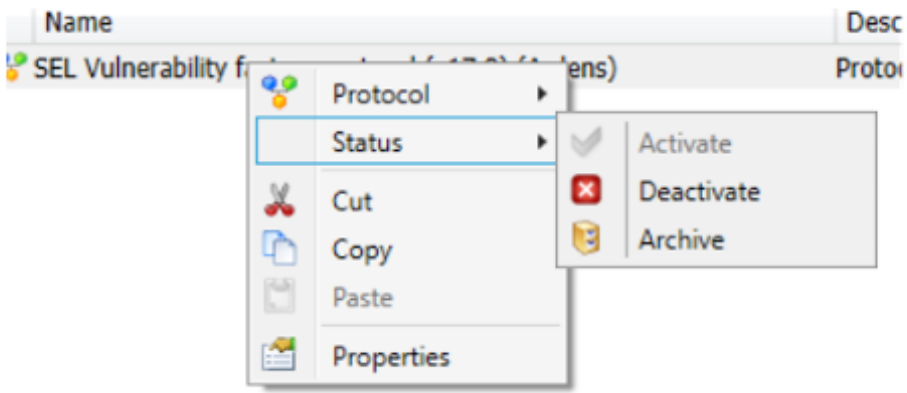
This is a soft indicator of possible neglect/self neglect, and may be difficult to spot otherwise

Making the alert active on your practice systems:

- Use the search function in Resource Publisher to identify the alert



- Right click and then activate (it will not be greyed out):



Training

Level 3 children	All GPs in 76% of ***practices** All Practice Nurses in 81% of practices All practice based (directly employed) Pharmacists 92% of practices All Health Care Assistants in 88% of practices
Level 3 adults	All GPs in 76% of practices All PNs 86% of practices All practice based (directly employed) pharmacists 83% of practices All Health Care Assistants in 88% of practices
Practice based ANPs, Physician's Associates and Paramedics were 100% trained across the board	
Level 2 children	All non-clinical staff are trained in 57% of practices
Level 2 adults	All non-clinical staff are trained in 62% of practices
Prevent	All staff are trained in 45% of practices

*Figures given as % of responding practices

SG26-42

Experiential Learning and Dissemination

The Intercollegiate Documents, which set guidance for health care roles, competencies and training for safeguarding children/adult was updated in 2019 to include experiential learning as part of safeguarding training.

(e.g. case-based personal reflection, scenario-based discussions, multi-professional meetings)

Regular staff appraisals are reported in 100% of responding practices
Resources from GP forums shared in 96% of responding practices
Case discussions during clinical and practice meetings | Significant event meetings also event analysis and learning event feedback | Complaints meetings | Safeguarding forums | Online learning | Day to day conversations with colleagues- Real time reflective practice | Standing item on weekly practice meeting | Rooted in daily practice | Complex referrals discussed with safeguarding leads | Reflective experiential sessions (mostly LD patients) | MDT- HV | Post- incident debriefs | Wider multi-site supervision

SG 43-46

Frontline Safeguarding -managing information requests

Named GPs are receiving escalation notifications when inappropriate medical information is shared with Quality Assurance Unit (the team managing Child Protection Conferences).

Please outline practice process for managing requests for safeguarding information, sharing details of process for producing reports e.g. standard proforma/ report prepared by admin for clinical staff to review/ prepared on case-by-case basis by GP or equivalent?

Receipt->
Administrator review of urgency | Administrator checking if S17/47/42 and for relevant consent | processed same day | | Dedicated Safeguarding administrator | Practice manager triages and assigns

Response->
Proforma/Standard Report |Guiding template- contains prompts | Ardens/EMIS template – not mentioned this time| Copying request and report into notes once all completed | Template, which includes prompts within free text boxes | Report signed | Report prepared on case by case basis| Draft prepared by GPA/ Admin and checked by GP

Follow up->
Specific codes applied to report | Report saved with restricted view, Documents saved to children and parents | Safeguarding requests logged in spreadsheet | Named added to clinical meeting

Flow chart / SOP

SG 55

Proformas and responses

- Every request for information should contain brief details on concern

- Context beyond medical summary
  - do not simply sent a medical summary, risk breeching confidentiality, unlikely to help assessment

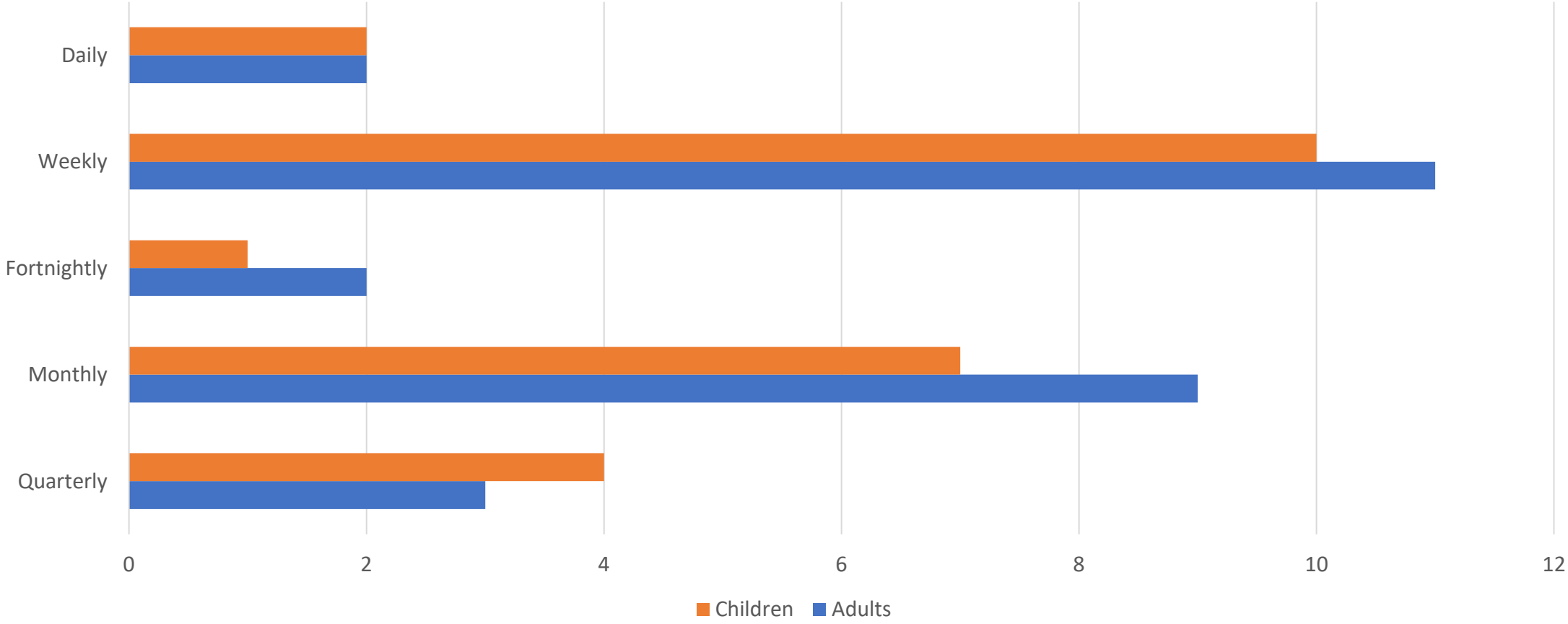
- Strengths ‘what’s going well’ and area of potential concern

- Child’s health and development,
- ‘Was not brought’, A&E/Hospital appointments,
- Impact of medical conditions
- Identified wider needs
- Factors impacting parenting capacity
- Known protective/supportive factors
- Avoid medical jargon

Information sharing advice for safeguarding practitioners - GOV.UK (www.gov.uk)

Factors with potential to affect parenting capacity

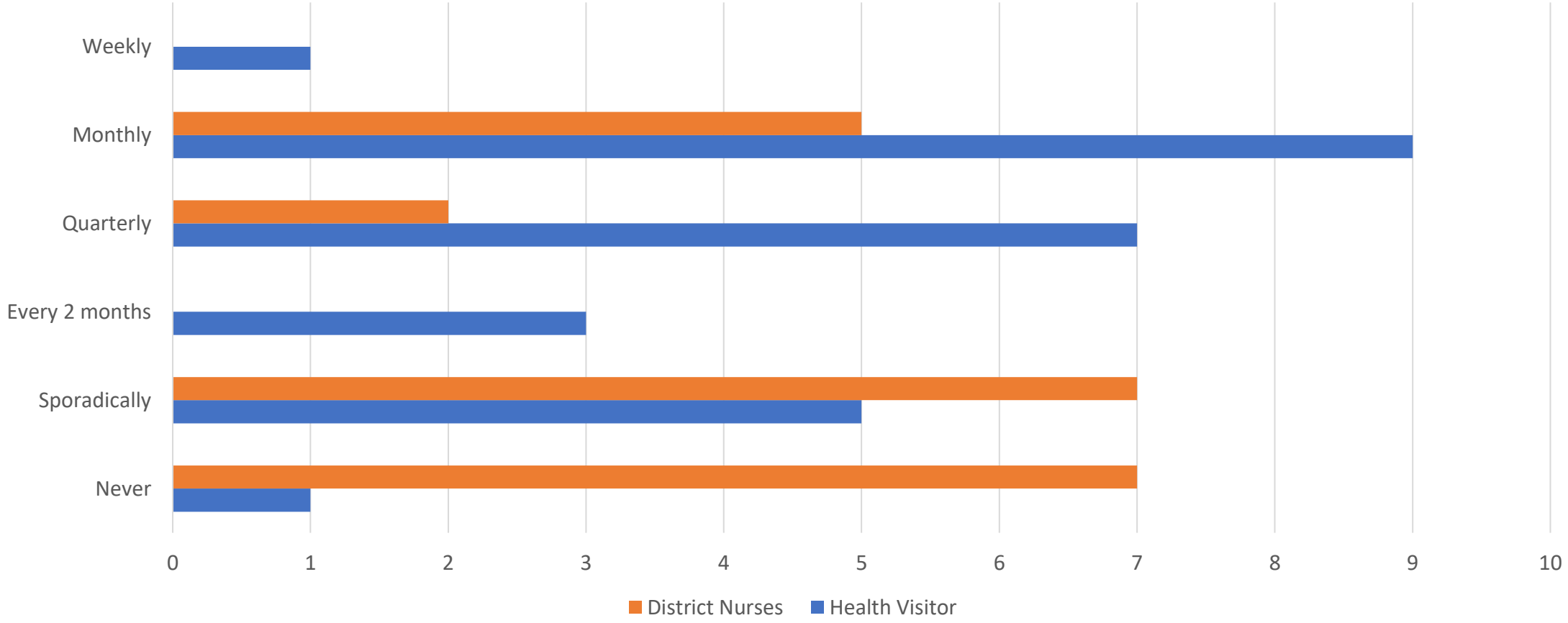
How often do you/are you able to meet as a practice team to discuss current safeguarding cases?



Several practices pointed out additional adhoc and urgent meetings as needed with clinicians and non- clinical staff

SG 56-59

How often do you/are you able to meet with community colleagues to discuss cases of concern?



A couple of practice reflected on having an open door policy
A number of practices reported difficulty engaging with community colleagues

SG 56-59

What are you most proud of in relation to you safeguarding work as a practice team?

Reflect on any families/individuals you've supported/safeguarded, approaches to safeguarding as a team, use of local resources, engagement with a wider safeguarding audit/ review, partnership work. Reflect on impact on practice process, policy or culture, any internal training

Efficient processes and **effective** and timely support for any vulnerable patients

We are proud of our supportive and **personal approach** to supporting our vulnerable patients. Continuity of care is central to this, we know our patients and they know us.

We are proud of our open, no-blame **safeguarding culture** where all staff—including trainees, ARRS pharmacists and newly qualified GPs—feel confident to raise concerns. We meet weekly and support each other with complex cases.

One of the things I am most proud of is the invaluable work of our **care coordinators**. Over time, we have expanded the scope of this team significantly. Our care coordinators reach out to families and individuals, offering consistent support and building trust within a fragmented system. fostering a culture of thorough and compassionate care.

The practice is proud of its **proactive**, team-based approach to safeguarding, with early identification, timely escalation, and strong multi-agency working to support vulnerable children, families, and adults. Reflective case discussions, use of local resources, and internal training have strengthened safeguarding awareness, consistency, and culture across the practice.

Our team is **highly diverse** in terms of cultural background, religion, race, and language. This diversity provides a meaningful advantage when working with vulnerable families, especially given that our current patient population is also very diverse. It allows us to better understand and sensitively discuss aspects of patients' lives, values, and cultural practices.

Interface with **SPLW** and the very real support we can offer individuals with our SPLW support. I'm proud the the whole team approach. We aim to keep abreast of new local teams and share details. I'm proud of our records keeping and aiming to follow up all information requests and ensure medical records are as accurate as possible

SG 60

What are you most proud of in relation to you safeguarding work as a practice team?

Reflect on any families/individuals you've supported/safeguarded, approaches to safeguarding as a team,

Recently, we supported a very elderly patient who was not collecting her pension or benefits and appeared to be in financial rent arrears. When she attended the practice we ensured she was seen, and information from a local resident helped us understand her vulnerability. We contacted her son, identified memory concerns, and the GP is now supporting her with her memory, social issues and safety. Her case is discussed regularly to ensure ongoing, coordinated support.

We were able to support a patient whose mental health issues had led to their child being put into foster care after a MASH referral. The patient was supported by the practice and a private psychiatrist which has eventually led to them being able to reunite with their child.

One of our Nurses was able to identify a patient who was going through domestic abuse. She promptly discussed with the safeguarding lead, and an appropriate referral was made. The patient got the right help and was removed from the abuser. I appreciate the fact that both clinicians and non-clinicians at the practice feel comfortable to raise concerns.

SG 60

What are you most worried about?

Reflect on challenges facing vulnerable families and adults in your locality, any identified new issues or concerning trends. Reflect on any recurring systems issues?

Continuity and consistent service when referring patients. **Resource challenges** and sometimes signposted back to the practice when we have exhausted everything.

Proxy access for children. Concern about subject access requests for safeguarding records

Safeguarding records – outcomes from reports and referrals, consistent coding in the practice

Workload, capacity, insufficient time, resources

Increasing number of vulnerable adults—particularly elderly patients—who are **not engaging with services** or are unable to access support - which creates significant safeguarding concern. Non-engagement, social isolation, memory problems and difficulty accessing benefits or essential services are becoming more common trends in our locality. These system issues make it harder to intervene early, and we continue to monitor these cases closely in our weekly meetings

Increasing complexity of need among vulnerable families and adults, including mental health, domestic abuse, housing insecurity, and service capacity pressures, which can delay timely support and multi-agency responses.

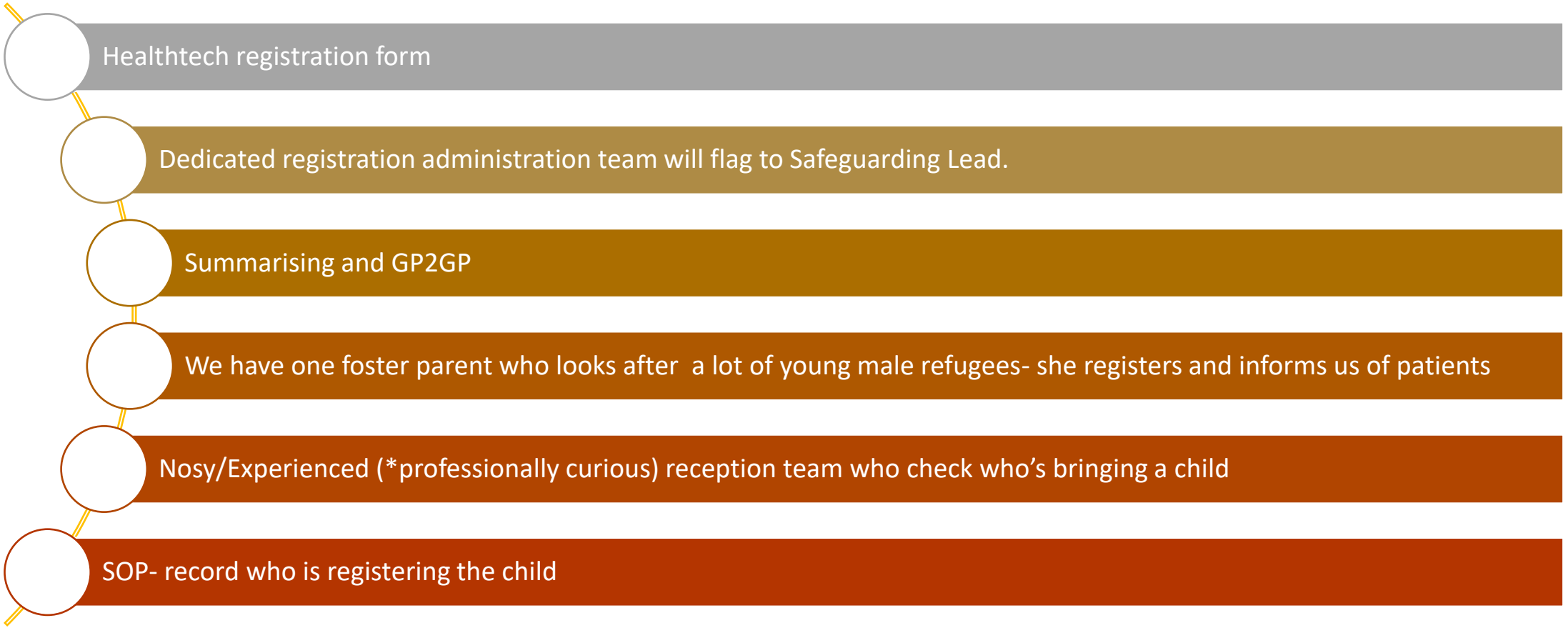
The impact of **the housing crisis**. Vulnerable patients in temporary accommodation are often moved to areas far away, making it difficult to provide consistent support and services. Frequently, appointments are missed or referrals are rejected because the client has been relocated out of the area. This fragmented system poses a significant challenge, as there are so many gaps through which these clients can fall. It is increasingly difficult to support them consistently

Worsening complexity and level of **exploitation**s faced by some young people and the adolescents about to enter young adulthood. I am concerned about widening inequality.

NFA and safeguarding. **Inverse care law** applies here. Also vulnerable adults coming out of prison who are NFA and often addicted or mentally unwell. Adults w LD- nothing to do, so little available on a weekly basis, unless the parents are like tigers, and prepared to travel.

SG 61

Please outline how you currently identify Looked After Children (children in foster care) at registration?



SG 62

Not currently a question on the NHS app registration process- consider practice base/website registration form with the questions

Do you have any practice process for supporting your looked after children cohort specifically, please outline?

- By providing coordinated support, focusing on their emotional wellbeing ,ensuring access to health services, and building partnerships with families
- Appropriate coding and alerts on the clinical system, and close liaison with social care, foster carers, and health professionals.
- Looked After Children are prioritised for health assessments, immunisations, and reviews, with information shared appropriately and follow-up arrangements documented to ensure continuity of care.
- New patient face to face review with carer and identification of needs
- Allocation of a named GP to support continuity of care wherever possible.
- The team recognises that Looked After Children should be easily identified from records, due to the potential for additional vulnerabilities.
- 9 responses- no additional process

SG 63

Next Steps- Practice Action Plan

- ? Review your Safeguarding and Domestic Abuse Practice Policy
- ?Set up HV meetings and escalate to Named GP if you're experiencing difficulty
- ? Check multi-agency contacts- e.g. New Domestic Abuse provider
- ? Review child proxy access protocol
- How are you sharing updates in the practice?