National Safeguarding Team (NHS Wales)

Primary Care Team (Public Health Wales)

Guidance for Safeguarding Children and Adults at Risk in Community Pharmacy Practice

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Contents Page No.

1. Introduction 1

2. Definitions 2

2.1 What is a safeguarding issue? 2

2.2 Definition of a Child at Risk 2

2.3 Definition of an Adult at Risk 2

2.4 Definitions of Abuse and Neglect 3

2.4.1 Abuse and Neglect of Children and Young People 3

2.4.2 Adults at risk 4

3. Roles and responsibilities 5

3.1 Pharmacy owners and superintendent pharmacists 5

3.2 Pharmacy professionals 5

3.3 Provision of a safe and appropriate environment 6

3.4 Safe recruitment practice 6

3.5 Safe working practice 8

3.5.1 Allegations of professional abuse and whistle blowing 8

3.5.2 Safeguarding training 8

4. Reporting Concerns 10

5. Confidentiality, Information Sharing, Consent, and 12

5.1 Confidentiality and Information Sharing 12

5.2 Consent 13

5.3 Capacity 14

6 Domestic Abuse and Family violence 16

6.1 Domestic Abuse and children 17

6.2 Young people - family violence and domestic abuse 17

6.3 Adults – family violence and domestic abuse 17

6.4 Ask and Act 18

6.5 Multi Agency Risk Assessment Conference (MARAC) 18

7 Substance Misuse 20

7.1 Adults at Risk: substance misuse. 20

7.2 Substance misuse impacting on parenting or caring 20

7.3 Information and Support 21

8 Sexually active young people and adults at risk 22

8.1 Sexually Active Young People 22
8.1.1 Children under 13 years old..... 22
8.1.2 Children aged 13 to 16 years old..... 23
8.1.3 Young People aged 17 to 18 years old 24
8.1.4 Child Sexual Exploitation..... 24
8.2 Sexual Activity in Adults at Risk 25

9 Female Genital Mutilation.....27

9.1 FGM: Mandatory Reporting 27

10. Prevent – What does this mean in Primary Care?.....29

11. References 31

Appendix 1: The Welsh Government Health and care standard on safeguarding children and safeguarding adults at risk 35

Appendix 2: Contact details and document links.....36

Appendix 3: Definitions of child abuse 37

Appendix 4: Different types of adult abuse 39

Appendix 5: Safeguarding referral flowchart 42

Appendix 6: The seven golden rules of sharing information.....43

Appendix 7: Flowchart of when and how to share information 44

Appendix 8: The Mental Capacity Act 2005 45

Appendix 9: Indicators of potential domestic abuse 46

Appendix 10: Drug-using parents with dependent children 49

Appendix 11: Child sexual exploitation 50

Appendix 12: Indicators of FGM.....52

Appendix 13: Reviewers and contributors 53

Abbreviations

CRB	Criminal Records Bureau
CSE	Child sexual exploitation
DBS	Disclosure and Barring Service
EDT	Local Authority Social Services Emergency Duty Team
FGM	Female genital mutilation
ICD	Intercollegiate document
GPhC	General Pharmaceutical Council
LHB	Local health board
MARAC	Multi Agency Risk Assessment Conference
MUR	Medicines Use Review
NSPCC	National Society for the Prevention of Cruelty to Children
POVA	Protection of adults at risk
SERAF	Sexual Exploitation and Risk Assessment Form
WCPPE	Wales Centre for Pharmacy Professional Education
WRAP	Workshop to Raise Awareness of Prevent

Glossary

General Pharmaceutical Council (GPhC)	The independent regulator for pharmacists, pharmacy technicians and pharmacy premises in Great Britain.
Pharmacy professionals	Pharmacists and pharmacy technicians registered with the General Pharmaceutical Council,

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Foreword

There have been significant changes in safeguarding knowledge, priorities, practice and legislation since 'A guide for Safeguarding Children and Vulnerable Adults in community pharmacy practice was first published by Public Health Wales in 2013. As a consequence safeguarding has evolved. The greatest changes are due to the Social Services and Well-being (Wales) Act 2014 which came into effect in April 2016. The Act will have a significant impact on the safeguarding of children, young people and adults.

The original guidance was devised mainly for safeguarding children with only some parts looking at adult safeguarding, whereas currently there is a move to safeguarding across all ages.

In safeguarding children and young people the themes of suicide and self harm, child sexual exploitation, female genital mutilation, domestic abuse, and internet and technology based abuse have become much more prominent.

The safeguarding of adults at risk (formerly vulnerable adults) has become a much larger priority, particularly within healthcare. There are now Adult Safeguarding Boards similar to the Regional Safeguarding Children Boards in Wales, with the likelihood of children's and adult boards merging in the future.

A National Safeguarding Board was set up in April 2016 that looks at safeguarding across Wales, across all ages and across all public service agencies. Local health boards and NHS trusts in Wales have also moved to a safeguarding structure where they have merged many aspects of children's and adult safeguarding.

The Social Services and Well-being (Wales) Act 2014 has made it a duty to report all adults at risk, as well as children, to the relevant local authority department. The Mental Capacity Act and deprivation of Liberty Standards are having a huge impact on adults in nursing homes and residential care and hence on primary care.

As a consequence of this we have undertaken to rewrite the guidance in full.

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1. Introduction

There is an expectation that there is good safeguarding practice in place for children, young people and adults at risk within any healthcare setting. Pharmacists and their support staff should fully understand their duties in protecting the welfare of these population groups.

Pharmacy professionals and relevant support staff, have a statutory duty of care to their patients and clients. This duty extends to ensuring safeguarding arrangements are in place to promote the health of, and protect, the most vulnerable members of society.

The Social Services and Well-being (Wales) Act 2014 which came into effect in April 2016 sets out what must and should be done to safeguard children and adults. The intention of the Act is to strengthen and build on existing practice. This reiterates a duty to safeguard the welfare of children and young people and to report when they have a reasonable cause to suspect that a person is an adult or a child at risk.[1]

The General Pharmaceutical Council (GPhC) standards for registered pharmacies require that *Staff are empowered and competent to safeguard the health, safety and wellbeing of patients and the public*.[2]

Pharmacists and their staff are in a key position to become aware of safeguarding concerns at an early stage given their relationship with individual patients/clients, their families and communities. Professional developments in community pharmacy practice mean that pharmacy teams are increasingly likely to come into contact with children, young people and adults at risk during the course of their work who are in need, or in need of protection. Therefore pharmacy teams should:

- Be alert to the potential indicators of abuse and neglect,
- Be familiar with local procedures for promoting and safeguarding the welfare of children, young people and adults at risk, and
- Understand the principles of patient confidentiality and information sharing.

The Welsh Government's Heath and Care Standards includes Standard 2.7; *Safeguarding children and safeguarding adults at risk* [3] which requires that:

Standard 2.7 *Safeguarding Children and Safeguarding Adults at Risk*

Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

See Appendix 1 for further details.

This guidance aims to support community pharmacy teams in establishing and maintaining safeguarding arrangements for children, young people and adults at risk that they come into contact with during the course of their work.

2. Definitions

2.1 What is a safeguarding issue?

Safeguarding means preventing harm and acting to protect children and adults at risk from actual or potential abuse, neglect or exploitation and ensuring they receive proper care that promotes health and welfare.

Safeguarding concerns can arise within almost all areas of practice. It is important that all members of staff have an appropriate level of understanding of the signs and presentations of abuse and neglect and are able to implement the All Wales Child Protection[4] or Protection of Vulnerable Adults (POVA) procedures.[5,6]

2.2 Definition of a Child at Risk

The Social Services and Well-being (Wales) Act 2014, defines a child as being a person under 18 years old.[1] The term "child" includes children and young people. The fact that a child has reached 16 years of age, is living independently, is in further education, is a member of the Armed Forces or is in hospital, prison or a young offender's institution does not change their status or their entitlement to services or protection under the Children Act 1989.[4]

A "child at risk" is defined in the Social services and well-being (Wales) Act 2014, as a child who:[1]

(a) is experiencing or is at risk of abuse, neglect or other kinds of harm, and

(b) has needs for care and support (whether or not the [local] authority is meeting any of those needs).

2.3 Definition of an Adult at Risk

The Social Services and Well-being (Wales) Act 2014, defines an adult as being a person aged 18 years old or over.[1]

An "adult at risk" is defined in the Act as an adult who:

(a) is experiencing or is at risk of abuse or neglect,

(b) has needs for care and support (whether or not the [local] authority is meeting any of those needs), and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

In general terms, an adult can be considered to be at risk when they are receiving one of the following services:[7]

- Continuing health care;
- Relevant personal care;
- Social care work;
- Assistance in relation to general household matters by reason of age, illness or disability;
- Relevant assistance in the conduct of their own affairs; or
- Assistance with communication that may be due to age, illness, disability in some circumstances or where English is not their first language.

People with learning disabilities, mental health problems, older people and disabled people may fall within this definition, particularly when their situation is complicated by additional factors such as physical frailty, chronic illness, sensory impairment, challenging behaviour, lack of mental capacity, social and emotional problems, poverty, homelessness or substance misuse.

2.4 Definitions of Abuse and Neglect

Abuse is a violation of an individual's human rights and is a criminal act. It may be a single or repeated incident of neglect or abuse. It may be physical, sexual, psychological, emotional or financial abuse and includes abuse taking place in any setting, whether in a private dwelling, an institution or any other place. It can be an act of neglect or omission to act, or be the unintended result of a person's actions.[1]

Neglect means a failure to meet a person's basic physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being.[1] Self-neglect or self-abuse is a failure to provide for oneself, through inattention or inappropriate diversion of resources.

Harm in relation to a child, means abuse or the impairment of:

(a) physical or mental health, or

(b) physical, intellectual, emotional, social or behavioural development,

and where the question of whether harm is significant turns on the child's health or development, the child's health or development is to be compared with that which could reasonably be expected of a similar child.[1]

The Named Doctor and Named Nurse for Child Protection/Safeguarding Children, and the Professional Lead for Protection of Adults at Risk/Safeguarding Adults for each local health board are available to provide guidance for specific concerns about individual cases and for general safeguarding advice.

See Appendix 2 for internet links to lists of contacts for support and guidance.

2.4.1 Abuse and Neglect of Children and Young People

In safeguarding children and young people, there are four recognised forms of abuse.

- Physical Abuse
- Emotional Abuse
- Sexual Abuse
- Neglect

See Appendix 3 for definitions of types of child abuse and some examples.

A child is abused or neglected when somebody inflicts harm or fails to act to prevent harm. Abuse may take place within the family or in an institutional or community setting by those known to them or more rarely by a stranger. Signs and symptoms will vary but may be indicated through injury, the child's presentation or the behaviour of parents or carers. Significant factors in parents and carers that lead to safeguarding concerns for children and young people are; domestic abuse, substance misuse, and mental health problems.

Female genital mutilation, trafficking, child sexual exploitation, enforced marriages and honour based violence are amongst other safeguarding concerns of which pharmacists and their staff should be aware.

Any observations or comments that lead to concerns or uncertainty about abuse or neglect should be acted upon by implementing the All Wales Child Protection Procedures[4] or by seeking advice and guidance.

2.4.2 Adults at risk

Seven discrete but related forms of abuse have been identified for adults at risk:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect and acts of omission
- Financial abuse
- Discriminatory abuse
- Institutional abuse

There is often considerable overlap between these categories e.g. domestic abuse is often a combination of physical, emotional, financial and sexual abuse.

See Appendix 4 for definitions of types of adult abuse and some examples.

Suspicions of abuse, neglect or exploitation of adults at risk may also be triggered by observations of the patient's presentation or by concerns or comments about the lack of appropriate care at their home or in a community or residential placement.

Pharmacists and their staff are well placed to identify the risks to general health and well-being that are associated with inadequate care, both in the short and long-term.

3. Roles and responsibilities

Pharmacists and relevant staff, should be aware of and comply with child and adult protection procedures, have safe recruitment practice and receive relevant training. They should also know how to respond if they are concerned for the health and well-being of children, young people and adults at risk who are their patients or clients; or if they hold concerns for children, young people or adults at risk who accompany patients or clients.

Pharmacists should be aware of the Welsh Government's *Clinical governance requirements for community pharmacies in Wales* *Section 4.8* Safeguarding Children.[8]

The health board Named Doctor and Named Nurse for Child Protection and the Professional Lead for Protection of Adults at risk are available to provide guidance for specific concerns about individual cases and for general safeguarding advice.

See Appendix 1 for internet links to lists of contacts for support and guidance.

3.1 Pharmacy owners and superintendent pharmacists

Pharmacy owners and superintendent pharmacists are responsible for ensuring that the General Pharmaceutical Council's (GPhC) Standards for registered pharmacies are met.[2] They must are also make sure that all staff, including non-pharmacists, involved in the management of pharmacy services are familiar with the standards[2] and understand the importance of their being met.

3.2 Pharmacy professionals

Pharmacy professionals have a duty to safeguard but are not expected to be experts in safeguarding or deal with all safeguarding issues. Pharmacy professionals are expected to use their professional judgement and raise concerns where necessary.

Pharmacy professionals and relevant staff should be:

- Trained in safeguarding to an appropriate level,
- Familiar with local and national policies and procedures to safeguard children, young people and adults at risk, and
- Aware of who to contact locally in the health service, social services and the police in the event of a safeguarding concern.

Pharmacy professionals should be familiar with the following standards and guidance relevant to safeguarding produced by the GPhC:[2,9-14]

- *Standards for registered pharmacies*[2]
- *Standards of conduct, ethics and performance*[9]

  The GPhC plans to publish new *Standards for pharmacy professionals* in 2017 which will replace Standards of conduct, ethics and performance.

  The GPHC will also be revising the guidance material in support of the new *Standards for pharmacy professionals*. Pharmacy professionals should make themselves familiar with the new Standards and supporting guidance when published. At the time of writing, supporting guidance relevant to safeguarding includes:

  - *Guidance for responsible pharmacists*[10]

- *Guidance on raising concerns*[11]
- *Guidance on consent*[12]
- *Guidance on maintaining clear sexual boundaries*[13]
- *Guidance on patient confidentiality*[14]

Although responsibility for meeting the standards lies with the pharmacy owners and superintendant pharmacists, pharmacy professionals have a professional responsibility to raise concerns if they believe the GPhC standards are not being met.

3.3 Provision of a safe and appropriate environment

Pharmacy owners and superintendant pharmacists are expected to ensure that they have adequate governance arrangements in place to protect and maintain the health, safety and well-being of patients and the public; and specifically safeguarding children, young people and adults at risk.[2]

It is important that community pharmacy premises are suitable for the services that are being offered to patients and the public. The GPhC's Standards for registered pharmacies[2] are intended to create and maintain the right environment, both organisational and physical, for the safe and effective practice of pharmacy.

Community pharmacies should therefore provide a safe and appropriate environment. This is particularly important where children are concerned. Parents or carers should be encouraged to remain with their child, patient or client that they are accompanying at all times. Where this is not possible, or where a young person or vulnerable adult wishes to attend the consultation area alone, then a second member of the pharmacy team should be present to act as a chaperone for the person and to support the member of staff. Such safe practice should also apply if services are provided in settings outside community pharmacy premises.

3.4 Safe recruitment practice

Employers must ensure that all staff engaged to work with children, young people and adults at risk are suitable to do so. All reasonable steps must be taken in the employment process including:

- Availability of a full employment history with satisfactory explanations for any gaps in employment history.
- Qualifications and professional registration are checked.
- Proof of identity is checked (birth certificate and passport).
- References are properly validated.
- A disclosure and barring check where appropriate.

If assistance is needed to decide who should have a check and at what level that should be with this or have any questions, the Disclosure and Barring Service (DBS) operates a helpline:

Telephone ☎ 0300 0200 190 Welsh ☎ 0300 0200 190

or email 💻 customerservices@dbs.gsi.gov.uk

See Appendix 2 for contact details regarding DBS checks required by health boards in Wales prior to providing community pharmacy specific service(s).

Candidates should be clear that failure to disclose previous and any new convictions is a disciplinary issue.

It is a criminal offence to knowingly appoint a person or continue to allow a person who is unsuitable to work with children and/or adults by virtue of a previous relevant conviction. (This offence carries a prison sentence). Not knowing is not considered a defence if suitable pre-employment checks and suitable checks thereafter were not undertaken.

Employment appointments should be subject to all the above being in place. If the checks are not fully completed, the appointing officer will need to make a decision on the appointment date and whether it is suitable for the appointee to begin work but with no unsupervised contact with children or adult at risks. No employee should be given unsupervised access to children or adult at risks without all satisfactory recruitment checks having been made.

If temporary staff are recruited from an agency then the community pharmacy practice should be assured that appropriate checks have been made.

Under the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975[15] and the Rehabilitation of Offenders Act 1974 (Exclusions and Exceptions) (Scotland) Order 2003[16], pharmacy professionals are exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974. Therefore pharmacy professionals are not entitled to withhold information about convictions which for other purposes are spent under the provisions of the Act and failure to disclose such convictions could result in disciplinary action.[17]

Clarification on recruitment policy in relation to safeguarding can be sought from the Named Professionals for Safeguarding within health boards in Wales, or the Designated Professionals/Safeguarding Children Service for Public Health Wales.

A DBS check may be needed for certain jobs relating to healthcare, and where required, they must be carried out in line with current legislation. It is a criminal offence for an employer to knowingly allow a barred person to work in regulated activity.[17]

Pharmacy professionals are required to disclose to the GPhC if they have been barred from regulated activity.[18] The Home Office provides further details about regulated activity, disclosure and barring, and the duty to refer to the DBS.[19]

In relation to the community pharmacy contractual framework for England and Wales:

Essential services: There is currently no NHS regulatory requirement to undertake DBS checks on pharmacy professionals or their support staff providing essential services.

Advanced services: There is currently no NHS regulatory requirement to undertake DBS checks on pharmacy professionals providing advanced services. However, health boards in Wales potentially may require DBS checks as a pre-condition of providing an advanced service in certain circumstances e.g. if carried out the patient's home or within care homes.

Enhanced services: Health boards in Wales require DBS checks as a pre-condition of providing the National Enhanced Service for *Provision of Emergency Hormonal Contraception*.

3.5 Safe working practice

Pharmacists and their staff do not expect allegations of abuse to be made against them, but it is important they acknowledge such a possibility may exist. It is important that all staff in contact with any patient or the public always act in a professional manner and in ways in which their behaviour cannot be misinterpreted or lead any reasonable person to question their suitability to work with children, young people or adults at risk.

Pharmacists and their staff should also be aware that behaviour in their personal lives and actions of their partner or other family members drawn to the attention of other agencies may raise questions about their suitability to work with children, young people and adults at risk. Pharmacy professionals must meet accepted standards of personal and professional conduct.[9]

3.5.1 Allegations of professional abuse and whistle blowing

Pharmacy professionals should be familiar with the GPhC's guidance on raising concerns.[11]

Any allegations of abuse of children or adults at risk by a member of staff should be taken seriously and managed in accordance with the *All Wales child protection procedures*[4] or relevant procedures for safeguarding adults at risk.

If someone is dismissed or removed from regulated activity, or they would have been had they not already left, because they harmed or posed a risk of harm to vulnerable groups including children, the employer is legally required to forward information about that person to the DBS.[17] It is a criminal offence not to do so. If the person is believed to have committed a criminal offence, the DBS strongly advise that the information is shared with the police.[17] The employer should also make a referral to the GPhC if the person is a Pharmacy Professional.

The health board Named Doctor or Named Nurse for Child Protection, or the Professional Lead for Protection of Adults at Risk should be contacted for advice and support when concerned about professional abuse. The Designated Doctor or Nurse for Safeguarding, Public Health Wales, can provide further sources of advice and support.

See Appendix 2 for internet links to lists of contacts for support and guidance.

3.5.2 Safeguarding training

Pharmacists and relevant support staff must clearly understand their responsibilities and should be supported by their employing organisation and health board to fulfil their duties. To fulfil these responsibilities, the pharmacy team should have access to appropriate safeguarding training, learning opportunities, and support to facilitate their understanding of aspects of child welfare and adult protection relevant to individuals' roles, including information sharing.

The intercollegiate document (ICD) *Safeguarding Children and Young people: roles and competences for health care staff* [20] states that in order to protect children and young people from harm all healthcare staff must have the competences to recognise child maltreatment and to take effective action as appropriate to their role. It details competences at various levels that specific healthcare staff are required to meet. The relevant levels for community pharmacy practice are Levels 1 and 2.

- **ICD Level 1:** All relevant staff must complete, safeguarding training at level one.
- **ICD Level 2:** All pharmacists are required to attain the competences at level 2

Training should be updated every three years, but only at the higher level for the individual's role. Individuals updating previous level 2 training are not required by the ICD to update previous level 1 training.

There is currently no ICD equivalent for training regarding safeguarding adults at risk. However it is equally important and it would be prudent, for pharmacists and relevant support staff to ensure that they are up to date on adult safeguarding issues in a similar way to safeguarding children's issues.

Safeguarding training via e-learning can be accessed through the Welsh Centre for Professional Pharmacy Education (WCPPE). There is also e-learning available on Learning@NHSWales. To request an e-Learning account, please complete the form appropriate to your workplace. If you encounter any problems please e-mail elearning@wales.nhs.uk.

In addition to this level of training, pharmacy professionals should ensure that they keep up to date with safeguarding developments.

An up-to-date record should be kept of the safeguarding training undertaken by all relevant pharmacy staff.

Case studies

The GPhC published an article *Focus on safeguarding children and vulnerable adults* in its online registrant newsletter *Regulate* in June 2016. The article includes a number of case studies in relation to safeguarding in community pharmacy practice.

4. Reporting Concerns

What to do if you identify or suspect abuse or neglect

Pharmacy professionals have a duty to share concerns and take action to safeguard the welfare and safety of a child, young person and/or adult at risk.

Anyone who detects possible signs of neglect or abuse in a child or adult should take immediate action as below.

Listen and Observe

- Note factual signs and symptoms of potential or suspected abuse or neglect without alarming the patient or alerting a possible abuser.
- If appropriate, listen sympathetically to what a child or adult at risk tells you (as they are often ignored) but do not agree not to tell anyone.

Imminent Danger

- Where you are concerned that the child, young person or adult at risk is in immediate danger you must contact social services at the appropriate local authority straight away. Outside office hours you should contact their social services Emergency Duty Team. If there are severe injuries requiring medical treatment a 999 call for police and ambulance should be made and then social services contacted

Share Concerns

- Alert and discuss your concerns with your manager, senior professional or designated staff member depending on your pharmacy procedure.
- If necessary seek advice from the local health board and/or local authority Safeguarding Team.
- Consider and agree whether it is appropriate to seek agreement to the referral from the child, young person or adult at risk and/or the parent/carer, or for them to be informed of the referral. You need to consider whether doing so would place the child, young person or adult at risk at increased risk of suffering significant harm.

Report

- If after consideration and discussion you feel that a safeguarding report is appropriate you should contact social services by telephone to inform them of your concerns.
- This should be followed up within 48 hours with a written report. Social services will usually send a copy of their local referral form by fax/e-mail for completion. These forms can be long and ask for information that is not available to you or your team. You should endeavour to complete those parts for which you are able to provide information.
- When reporting information, reports should be restricted to the nature of the injury, suspicious behaviour or concern facts to support the possibility that the injuries or concerns are suspicious.
- Agree with recipient of the report what the patient and relatives/carers will be told, by whom and when (and note this).
- You should receive confirmation of referral within one working day

- If you have not had confirmation within three working days you should contact social services again.

Reporting not appropriate

- You should consider whether the child, young person or adult at risk would still benefit from support or help from social services or another appropriate agency.
- If you feel that this is appropriate you should seek consent from the child, young person, adult at risk or their parent/carer to make this referral.
- If consent is refused you should contemplate whether this would alter your decision about a safeguarding referral.

Record

- You must ensure that all observations, advice sought/received, including from whom and all actions taken are recorded. You should justify any actions you have taken and also give reasons where you have decided not to take any action.
- You must ensure that these records as well as any reports, such as written referrals to social services, are stored confidentially in a secure place.

Review

- You should look to review the case and/or patient whether you took any action or not. This affords the opportunity to re-evaluate the situation and to confirm that any actions needed have been followed up. There may also be new information available.
- If on review or re-evaluation you still have concerns or there are new concerns, you should reconsider your decision about referral to social services or inform social services of this additional information.
- When providing further information it is important to do this by using the same process as for a referral to ensure that this information is incorporated into social services system. Again record and justify any decisions made.
- You may then decide to continue to monitor and review the case or to close it.

See appendix 5; *Safeguarding Vulnerable Groups Flowchart* for actions to be taken when there are safeguarding concerns.

Note: You should also refer to the All Wales Child Protection[4] and the Protection of Vulnerable Adults[5,6] Procedures.

5. Confidentiality, Information Sharing, Consent, and Capacity

5.1 Confidentiality and Information Sharing

> Pharmacy professionals have a duty to share concerns and take action to safeguard the welfare and safety of children, young people and adults at risk.
>
> Fears about sharing information cannot be allowed to stand in the way of the need to safeguard.[21]

The revised Caldicott Principle 7 states that "the duty to share information can be as important as the duty to protect patient confidentiality".[22]

Sharing of information between healthcare professionals and relevant agencies is essential for effective identification, assessment, risk management and service provision. Many 'Serious Case Reviews' into serious harm or death in children cite information sharing concerns as a contributory factor.[23,24] Legislation and professional guidance concerned with confidentiality protects individual patients, but they are not intended to prevent exchange of information between the professionals and agencies that have a responsibility for ensuring the protection of children, young people and adults at risk, and the general public in certain instances e.g. terrorist activity and threats of serious harm such as murder or rape.

In cases where there are safeguarding concerns, there is a legal duty to share all relevant information with the relevant professionals and agencies.[1] This may include disclosing information to other professionals who need access to that information for the purposes of safeguarding; with or without the permission of the child, young person, adult at risk, parents or carers. You do not need to be certain that a person is at risk of significant harm to take this step. If a child, young person or adult is at risk of, or is suffering abuse or neglect, the possible consequences of not sharing relevant information will, in the overwhelming majority of cases, outweigh any harm that sharing your concerns with an appropriate agency might cause.

In sharing concerns about possible abuse or neglect, you are not making the final decision about how best to protect a person. That is the role of the local authority and, ultimately, the courts. Even in the event that the person is not at risk of, or suffering, abuse or neglect, sharing information will be justified as long as your concerns are honestly held and reasonable, you share the information with the appropriate agency, and you only share relevant information.

While the Data Protection Act 1998 places duties on organisations and individuals to process personal information fairly and lawfully, it is not a barrier to sharing information where the failure to do so would result in a child, young person or vulnerable adult being placed at risk of harm. It does not prohibit the collection and sharing of personal information but provides a framework to ensure that personal information about an individual is shared appropriately. Similarly the common law duty of confidence and human rights concerns, such as respecting the right to a private and family life, would not prevent sharing where there are real safeguarding concerns.

Confidentiality is an important duty, but it is not absolute. There are circumstances when it may be appropriate to disclose confidential patient information. These are:[14]

- when you have the patient's consent, or
- when the law says you must, or
- when it is in the public interest to do so.

Children, young people and adults at risk are entitled to the same duty of confidence as any other person provided that they have the ability to understand their choices and the consequences of any actions.

A complete record of what has been shared should always be kept.

The most important consideration is whether sharing information is likely to safeguard.

Further information on making decisions about sharing safeguarding information on a case by case basis is available in Appendices 6 and 7.

Appendix 6 *The Seven Golden Rules for Information Sharing*21

Appendix 7 *Flowchart of when and how to share information*[21]

5.2 Consent

Seeking a patient's/client's consent to disclosure of information shows respect, and is part of good communication. Wherever possible, you should seek consent and be open and honest with the individual (and/or where appropriate, their family or carers) from the outset as to why, what, how and with whom, their information will be shared.

In safeguarding the child, young person or adult at risk may not have the capacity to give consent (see below for details about capacity). If you believe that a patient/client may be a victim of neglect, physical, sexual, financial or emotional abuse, that they lack capacity to consent and where you believe that the disclosure is in the patient's/client's best interests or necessary to protect others from a risk of serious harm, you must give information promptly to an appropriate responsible person and the local authority. The responsible person may be the patient's parent, family, carer or an advocate.

If, for any reason, you believe that disclosure of information is not in the best interests of a neglected or abused patient/client, you should discuss the issues with an experienced safeguarding colleague. If you decide not to disclose information, you should document your discussions and the reasons for deciding not to disclose. You should only withhold information where there is significant justification and you should be able and prepared to justify your decision.

You do not necessarily need the consent of the patient/client or their parent/carer to share their personal information. It is still possible to share personal information if it is necessary in order to carry out your role, or to protect the vital interests of the individual.

Working in partnership with families is essential to promoting the welfare of children and adults at risk. When making a safeguarding referral, it is good practice to inform the parents or carers. There may be occasions when it is believed that informing the parents or carers may place the individual at further

or additional risk. In such circumstances consent should not be sought and the parent or carer should not be informed of the referral.

If consent is withheld by a parent or carer to share information further advice should be sought, as the refusal to consent may increase concerns.

You would also not need to seek consent if it was unsafe to do so because of a risk of harm to pharmacists or their staff. In the process of any subsequent investigations by the police and social services it should be expected that the referral and its source will be made known to parents or carers. Therefore any concerns about the impact of this on pharmacists and/or their staff should be shared with the police or social services at the time of referral.

The Carlile review, *Too serious a thing: review of safeguards for children and young people treated and cared for by the NHS in Wales*, stated:[25]

"*There is nothing within the Caldicott Report, the Data Protection Act 1998, or the Human Rights Act 1998, which should prevent the justifiable and lawful exchange of information for the protection of children or prevention of serious crime*".

Therefore while consent is desirable it is not necessary for safeguarding referrals.

Safeguarding is dependent on raising concerns and on sharing information appropriately. However, healthcare professionals are frequently uncertain as to whether their concerns reach a threshold for action. In these circumstances advice should be sought from a professional with expertise in safeguarding. The health board Named Doctor and Nurse for Child Protection and Professional Lead for Protection of Adults at risk are available to provide guidance for specific concerns about individual cases and for general safeguarding advice.

Community pharmacy professionals must also be aware of the GPhC's *Guidance on consent*.[12]

See Appendix 2 for internet links to lists of contacts for support and guidance.

5.3 Capacity

Every adult and young person aged 16 to 17 is presumed to have the capacity to make their own decisions and to give consent unless there is enough evidence to suggest otherwise.

For consent to be valid the person/patient must:[12]

- Have the capacity to give consent.
- Be acting voluntarily – they must not be under any undue pressure from you or anyone else to make a decision.
- Have sufficient, balanced information to allow them to make an informed decision.
- Be capable of using and weighing up the information provided.

You must **not** assume that a patient/client lacks capacity based just upon their age, disability, beliefs, condition and behaviour or because they make a decision you disagree with. You must base an assessment of capacity on an individual basis taking into account the patient's/client's ability to make a specific decision

at the time it needs to be made, as well as the complexity and importance of that decision. At any time a person may be capable of making some decisions but not others.

In the case of adults at risk reference should be made to the Mental Capacity Act 2005 and its Code of Practice.[26]

See Appendix 8 for further information.

Children under 16 years old are not presumed to have the capacity to consent; they must demonstrate their competence. A child can give consent if you are satisfied that the treatment or action is in their best interests and that they have the maturity and ability to fully understand the information given and what they are consenting to.

The Mental Capacity Act 2005 does not generally apply to children under 16 years old. However the principles of assessing capacity are the same. The Fraser Guidelines are often used to assess capacity in children under 16 years old, although they were originally intended for the prescribing of contraception to this age group. Consideration should always be given to getting consent from a child under 16 years old where they are felt to be competent. In this case you do not also need consent from a person with parental responsibility.

For your information, the guidance for Registered Medical Practitioners on lack of capacity to consent states:[27]

When making decisions about whether to disclose information about a patient who lacks capacity, you must:

(a) Make the care of the patient your first concern

(b) Respect the patient's dignity and privacy, and

(c) Support and encourage the patient to be involved, as far as they want and are able, in decisions about disclosure of their personal information.

6 Domestic Abuse and Family violence

Domestic abuse has a profound effect on all those who experience it, resulting in short and long term consequences for the individual's mental health and wellbeing, an increased risk of physical injury and in some cases, death. The consequences of abuse can lead to homelessness, isolation and long term social exclusion.

The definition of domestic abuse has recently been changed so that it now includes 'coercive control' and encompasses young people under 18 years old.

The new definition of domestic violence is:[28]

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional"

Where:

Controlling behaviour: is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour: is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

This definition of domestic violence and abuse is not a legal definition, but is used by government departments for the purposes of, for example, targeting support services.

The abuse experienced can vary from emotional abuse, to physical, sexual, financial, psychological abuse and neglect. Many victims will often experience a combination of these behaviours. Domestic abuse has the highest rate of repeat victimisation of all violent crimes.

Domestic abuse, like child abuse is often referred to as a 'hidden' harm because victims of abuse are often afraid to report the abuse for fear of repercussions by the abuser. Perpetrators of abuse will attempt to reassert their control over the victim if they sense a change in behaviour. Victims often stay in a relationship because they are afraid of what the perpetrator may do to them or other family members should they attempt to leave. Many victims of abuse also feel a sense of relief during the times where the abuse stops and hope that their circumstances will improve and the pattern of abuse will stop.

The risk of death peaks at the point victims try to leave the abuser and for a period after separation.

6.1 Domestic Abuse and children

Domestic abuse and family violence has a profound effect on children and young people who experience it within their family. Research shows that children experiencing domestic abuse can be affected in every aspect of their functioning; safety, health, school attendance, educational achievement, economic well-being and emotional and social development. In the most extreme cases children are at risk of serious injury or death.

It is a major factor in Child Protection cases and one of the commonly recurring features in Serious Case/Child Practice Reviews. Children are put at risk of experiencing physical harm from the perpetrator or by being caught up or trying to intervene in arguments and fighting between family members. Children are hugely affected by the fear of abuse as well as seeing and hearing abuse within their family.

The link between domestic abuse and child abuse is so strong that it is usual practice to always make a referral to Social Services in cases where there are children dependent on the perpetrator or victim.

This is true even where the adult victim has capacity and declines referral for themselves. The children do not have to be present at the time of the incident triggering concern; the nature of domestic abuse is such that there has often been a long period of abuse before there is a disclosure or revelation. In these circumstances the healthcare professional making the referral is acting as an advocate for the child who normally cannot make an informed choice about reporting the abuse they are suffering.

6.2 Young people - family violence and domestic abuse

The British Crime Survey 2009/10[29] found that 16-19 year olds were the group most likely to suffer abuse from a partner and this has prompted the change in the definition of domestic abuse.

Young people can also be perpetrators of abuse towards their parents or carers. This can include physical violence, damage to property, emotional and financial abuse.[30] For young people 16 years old and over, this meets the definition for domestic abuse. However, adolescent to parent violence and abuse can also involve children under 16 years old.

6.3 Adults – family violence and domestic abuse

The prevalence of physical assaults from a partner or adult family member is higher among heterosexual women than among heterosexual men. Heterosexual women experience more repeated physical violence, more severe violence, more sexual violence, more coercive control, more injuries and more fear of their partner.[31] There is under-reporting of domestic abuse and sexual violence from black and minority ethnic and lesbian, gay, bisexual and transgender communities.

It is important to remember that violence and abuse which meets the definition of domestic abuse are also experienced by other adults, within family settings and relationships. This includes in same sex relationships, in the elderly between partners and from their children, between other family members and by men who are abused by women. Recognising, responding and supporting victims should be about an inclusive approach for all potential victims, providing effective responses to all.

6.4 Ask and Act

Following the *Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015* [32] all healthcare staff have a role in providing an effective response to those experiencing violence against women, domestic abuse and sexual violence.

Ask and Act is a process of targeted enquiry that recognises that there are indicators of potential violence against women. These should be used as a prompt for healthcare professionals to ask patients whether they have been affected by any of these issues. The implementation of *Ask and Act* should acknowledged that women disproportionately experience domestic abuse, sexual violence and other abuse, such as forced marriage and female genital mutilation

Violence against women, domestic abuse and sexual violence require a Public Service response. Professional confidence to identify these issues, to ask about them and to respond effectively is fundamental for good clinical practice.

There are various indicators for domestic abuse that suggest an Ask and Act targeted enquiry is appropriate.

See Appendix 9 for indicators of potential domestic abuse.

6.5 Multi Agency Risk Assessment Conference (MARAC)

Working in a multi-agency partnership is the most effective way to approach domestic abuse at both an operational and strategic level. The MARAC is a process to address the safety and protection of those most at risk from serious assault or murder as a result of domestic abuse.

In many high risk situations, victims may adopt an increasingly passive stance and an acceptance of their situation without the possibility of change, leading to them being unlikely to seek help. The MARAC is a vital tool in addressing their safety and is a way of moving the responsibility for addressing domestic abuse from the victim to a broad group of agencies.

Effective protection of victims and their children is a multi agency responsibility. This meeting combines up to date risk information with a comprehensive assessment of a victim's needs linking those directly involved to the provision of appropriate services for the victim, children and perpetrator.

Healthcare professionals may be asked to attend, or provide information for, the MARAC. The duty of responsibility to co-operate with this process is the same as for Child Protection Case Conferences.

The aims of the MARAC are to:

- Share information to enhance the safety, health and well being of victims, adults and their children;
- Raise awareness of the impact of domestic abuse on children;
- Agree and implement a risk management plan;
- Reduce repeat victimisation;
- Determine whether the perpetrator poses a significant risk to any particular individual or to the general community;
- Reduce domestic homicide and abuse;
- Prevent child abuse;

- Ensure agency accountability;
- Provide support for staff members and professionals involved in high risk domestic abuse cases.

The MARAC may recommend a referral to social services. Similarly at any point in a social service assessment process a MARAC may be recommended and arrangements must be in place to share information between the two processes.

MARAC partner agencies recognise the overlap between domestic abuse and the abuse of children. The legal definition of harm to children has been extended to include those living in households where domestic abuse is taking place through the Adoption and Children Act 2002, Section 120 (Amendment).[33]

7 Substance Misuse

The Welsh Government's ten year substance misuse strategy, *Working Together to Reduce Harm, 2008 – 2018*, has four key priority areas for action including:[34]

Supporting families: *reducing the risk of harm to children and adults as a consequence of the substance misusing behaviour of a family member.*

7.1 Adults at Risk: substance misuse.

Substance misuse (drugs and/or alcohol) in adults could mean that they prioritise obtaining and using drugs and/or alcohol above all other things in their lives. Such lifestyles and priorities can often lead people to be particularly vulnerable to abuse.

Where individuals with substance misuse problems also have co-existing mental health needs there is a potential for self-neglect. This may mean there is a decline in the way they manage their health, mismanage or omit prescribed medicines and/or fail to attend appointments. Communities, friends and families may notice changes in friendship groups as well as concerns about living conditions and who the adult is spending time with.

7.2 Substance misuse impacting on parenting or caring

Parental substance misuse can cause serious and significant harm to children of all ages, from conception to adulthood. The adverse consequences for children are typically multiple and cumulative and will vary according to the child's stage of development. They include failure to thrive; blood-borne virus infections; incomplete immunisation and otherwise inadequate health care; a wide range of emotional, cognitive, behavioural and other psychological problems; early substance misuse and offending behaviour; and poor educational attainment. It is estimated that between 2–3% of children under 16 years old in England and Wales have one or both parents dealing with a serious drug problem.[35]

The complex problems associated with substance misuse can significantly affect children and families. Safeguarding and protecting vulnerable children is a key theme of the Social Services and Well-being (Wales) Act 2014.[1] It recognises that children and young people are likely to be at greater risk of harm through their own substance misuse or parental substance misuse.

Children's and adults' health and social services need to continue working together, aiming for effective treatment and support for the adult, leading to major benefits, and improved outcomes for the child.

It is helpful to consider what it is that a parent is **not** doing for their child (age appropriate expectations) that you would be reasonably expecting a parent to do. In addition to the above information the following examples of concerns or behaviours would hopefully lead to discussion about whether support is in place or if a specific intervention is needed for a family or an individual.

- Failing to attend appointments, not bringing a child to an appointment;
- A child or young person not attending school or college;

- Noticing apparent neglect issues, examples such as lack of self-care in an adult or young person or neglectful care of a child;
- Parents associating with unsuitable or inappropriate adults can increase risks to children as they may be exposed to inappropriate activities and unsafe situations;
- Where income may be being spent on drugs or alcohol, there is a lack of money for food, clothes and essential amenities for the children.

In addition to the above information, the guidance for specialist drug misuse services on considerations during the assessment of drug-using parents may be helpful. (**See Appendix 10**).

7.3 Information and Support

Information about specific drugs and alcohol, the potential health risks and sources of support are available from the NHS Direct Wales website and the Wales Drug and Alcohol website dan 24/7.

The Wales Drug and Alcohol Helpline (part of dan 24/7) is a free and bilingual telephone drugs helpline providing a single point of contact for anyone in Wales wanting further information or help relating to drugs or alcohol.

The Wales Drug and Alcohol Helpline can be contacted on:

Freephone ☎ 0808 808 2234 or text DAN to 81066

8 Sexually active young people and adults at risk

8.1 Sexually Active Young People

Most children and young people under the age of 18 will have a healthy interest in sex and sexual relationships. Those working with children and young people need to be able to identify where those relationships may be abusive and the young people may need the provision of protection and additional services. The primary concern of anyone working with sexually active children and young people under the age of 18 years must be to safeguard and promote their welfare.

Where pharmacists are providing a sexual health service such as contraception to young people e.g. on prescription or under a Patient Group Direction (PGD) or sexual health advice, they have a responsibility to provide a confidential health service in which young people have trust but also have a duty to act to safeguard young people. Concern about confidentiality is the biggest deterrent to young people asking for sexual health advice.

Striking a balance between what, on the surface, appear to be conflicting needs can cause significant dilemmas for pharmacists. Consent should be sought whenever possible prior to disclosing patient information. The duty of patient confidentiality is not absolute and information may be shared if you judge on a case-by-case basis that sharing is in the young person's best interest.[36]

It is possible to seek advice from safeguarding professionals without disclosing identifiable details of a young person and breaking confidentiality – and that where there is a decision to share information, this should be proportionate.[36]

Note: It is illegal to pay for the sexual services of a young person under 18 years of age.

8.1.1 Children under 13 years old

The All Wales Child Protection Procedures (section 5.4.6.1) states:[4]

Under the Sexual Offences Act 2003, children under the age of 13 are of insufficient age to give consent to sexual activity.

Medicines, ethics and practice: the professional guide for pharmacists (section 3.5.14) states:[36]

Instances should be treated seriously with a presumption that the case should be reported to social services, unless there are exceptional circumstances backed by documented reasons for not sharing information.

A decision not to refer to social services should only be made following a discussion of the case, with a Named Lead for Child Protection within the local health board and/or a Designated Doctor/Nurse for Safeguarding Children at Public Heath Wales. When a referral is not made, the professionals and any agency concerned are fully accountable for the decision and the reasons for the decision must be clearly recorded.

The child may present again or information may be received which escalates potential risk to the child. In all cases, advice should be sought from the Named Lead for Child Protection within the local health board and/or a Designated Doctor/Nurse for Safeguarding Children. If following that discussion a decision

not to make a referral is arrived at, the professionals must be prepared to fully justify, record and make available for review if necessary, any decision not to make a referral to social services and the police.

The Welsh Assembly Government's guidance *Safeguarding children: working together under the Children Act 2004* (Chapter 8, paragraph 8.29)[37] reaffirms that the police should be notified as soon as possible when a criminal offence has been committed, or is suspected of having been committed, against a child – unless there are exceptional reasons not to do so.

Any offence under the Sexual Offences Act 2003 involving a child under 13 years old is very serious and should be taken to indicate a risk of significant harm. However, although the legislation is clear in respect of under 13's this group of children are still entitled to the right of confidential advice on contraception, condoms, pregnancy and abortion.

8.1.2 Children aged 13 to 16 years old

The Sexual Offences Act 2003 reinforces that, while mutually agreed, non-exploitative sexual activity between teenagers does take place and that often no harm comes of it, the age of consent should still remain at 16. This acknowledges that this group of young people can still be vulnerable, even when they do not view themselves as such. For children between 13 and 16 years the child's own views on their best interests are also a factor, which should be given a weight dependent on their maturity and understanding.

Providing advice and treatment to children under 16 years of age can be given under the Fraser guidelines without parental consent providing that the young person understands the advice being given and cannot be persuaded to inform or seek support from their parents. All decisions must be made within the best interest of the child balanced against the need to protect the rights and freedom of others. This could pose a major dilemma for pharmacists in that the Sexual Offences Act 2003 states that sexual activity under the age of 16 is illegal.

It is not in the best interests of the child or young person to have an automatic referral made to police or social services when knowledge about their sexual activity becomes known to a pharmacy professional. Once information has been shared with authorities it may remain on databases even if no convictions occur.

> The purpose of the Act is to safeguard the welfare of the young person in circumstances where the sexual activity suggests that that they are being exploited. The law is not intended to prosecute mutually agreed sexual activity between young people of a similar age, unless it involves abuse or exploitation.
>
> For children aged 13 to 16 the decision not to refer can be made by the pharmacist alone. The pharmacist must clearly record the decision taken and the reasoning behind it.

In all situations decisions would clearly be influenced by knowledge of power or age imbalances between the partners, suggestions of abuse of trust or the use of sexual favours. Possible power imbalances within a relationship can result from differences in size, age, material wealth and/or psychological, social and physical development. In addition gender, sexuality, race and any other diversity issues where levels of sexual knowledge can be used to exert power. Where a power imbalance results in coercion, manipulation and/or bribery and seduction, these

pressures can be applied to a young person by one or two individuals, or through peer pressure (i.e. group bullying).

Particular sensitivity must be employed when considering the needs of young people with learning disabilities, mental disorders or communication difficulties. Confidentiality cannot be absolute in these circumstances and sharing information without consent might be necessary in the above circumstances.

Action will also need to be taken when the young person's own behaviour places them at risk including vulnerability due to the misuse of drugs and alcohol, or denial or minimising concerns regarding their activity.

Any safeguarding concerns relating to any girl under the age of 16, who is pregnant, must be discussed with the Professional Lead for Safeguarding Children in the local health board.

8.1.3 Young People aged 17 to 18 years old

Although sexual activity in itself is no longer an offence over the age of 16, young people under the age of 18 are still offered the protection of Child Protection Procedures.

Consideration still needs to be given to issues of sexual exploitation through abuse of power or trust.

Young people can still be subject to offences of rape and assault and the circumstances of an incident may need to be explored with a young person.

It is an offence for a person to have a sexual relationship with a 16 or 17 year old if they are an adult in a position of trust or authority in relation to them or a family member as defined by the Sexual Offences Act 2003.

8.1.4 Child Sexual Exploitation

The Welsh Government and the All Wales Child Protection procedures definition of child sexual exploitation (CSE) is the coercion or manipulation of children and young people into taking part in sexual activities. It is a form of sexual abuse involving an exchange of some form of payment which can include money, mobile phones and other items, drugs, alcohol, a place to stay, 'protection' or affection. The vulnerability of the young person and grooming process employed by perpetrators renders them powerless to recognise the exploitative nature of relationships and unable to give informed consent.[38]

Those exploiting the child hold power over the child or young person (by virtue of age, gender, intellect, physical strength, money and/or other resources). CSE involves exploitative relationships as well as violence, intimidation and coercion and prays on the child's emotional or social or economic vulnerability[38]

In contrast to other forms of sexual abuse, children and young people who are sexually exploited may not recognise that they are being abused as they perceive the perpetrator as giving them something they need or want. This may change over time as the perpetrator's behaviour becomes more coercive, but fear of consequences may stop them from disclosing.[39]

Sexual exploitation results in children and young people suffering harm, and causes significant damage to their physical and mental health. Some young people may be supported to recover whilst others may suffer serious life-long

impairments which may, on occasion, lead to their death, for example through suicide or murder.[38]

There are different ways in which sexual exploitation may take place such as:

- An inappropriate relationship often characterised by a significant age difference - the perpetrator exercises power over the young person through giving them something they need in exchange for sexual activity.
- The 'boyfriend' model - the young person is groomed to view the person as a boyfriend but is then forced into performing sexual behaviours for others.
- Peer-on-peer exploitation - the young person is drawn into sexual activities by their peers e.g. as part of the ritual of belonging to a gang.

It should not be assumed that children aged 16 and 17 years are safe from CSE. A young person who has been subject to a complex pattern of life experiences including sophisticated grooming and priming processes that have brought them to a point where they are at risk of, or are abused, through CSE, are often not able to recognise the exploitative relationships and situations they are in. They may even present as being in control.[38]

Healthcare services have a role and responsibility in relation to prevention and recognition of CSE. Information sharing and multi-agency working is central to safeguarding and promoting the welfare of children and young people vulnerable to, at risk of and abused through child sexual exploitation.

See Appendix 11 for vulnerability and risk factors

8.2 Sexual Activity in Adults at Risk

The Sexual Offences Act 2003 does not intend to criminalise all sexual activity that someone with what the Act terms term a mental disorder i.e. an adult at risk, might engage in. It is also not intended to restrict the right of a person to engage in sexual relationships. It does however seek to protect vulnerable people when this sexual activity is founded on exploitation and abuse.

The sexual offences act splits into three categories the offences against those with a mental disorder. These are:

- Offences against a person with a mental disorder impeding choice. This covers individuals whose mental functioning is so impaired at the time of the sexual activity that they are unable to refuse.
- Offences against those who have the capacity to consent to sexual activity but have a mental disorder which makes them vulnerable to inducement, threat or deception.
- Offences by care workers against those with a mental disorder.

Sexual activity with adults who lack capacity is always illegal, as they can never legally give their consent. There should always be contact with the Police and a Referral made under the Safeguarding Adults Procedures in these circumstances.

For adults at risk there may be inducement, threat or deception similar to grooming and exploitation seen in child sexual abuse. This may lead to the

appearance of a victim having ‘agreed’ to the activity but the reality is that any apparent agreement will have been obtained by exploitation.

There is a very difficult balancing act when dealing with adults at risk who may have capacity to consent to sexual relationships. On the one hand to protect them against the consequences of potentially harmful and exploitative relationships and on the other to protect the right that every adult should experience respect for the most intimate and private parts of their lives.

Where the sexual relationship is considered consensual and not abusive, healthcare professionals should ensure that the adult at risk receives appropriate advice regarding sexual health and contraception.

9 Female Genital Mutilation

Female genital mutilation (FGM), sometimes called 'female circumcision' or 'cutting', refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. FGM comprises all procedures involving partial or total removal of the external female genitalia for non-medical reasons. The practice is illegal in the UK under the Female Genital Mutilation Act 2003.

FGM is a form of child abuse and violence against women. The health implications of FGM can be severe to fatal depending on the type of FGM carried out. Community pharmacy professionals need to be aware of the possibility of FGM.

Children: the All Wales Child Protection Procedures are supported by specific guidance on FGM.[40]

Adults: there is an All Wales FGM clinical pathway

The NSPCC operate the FGM helpline:

Telephone ☎ 0800 0283 550 or email 💻 fgmhelp@nspcc.org.uk

There are no health benefits to FGM. Removing and damaging healthy and normal female genital tissue interferes with the natural functions of girls' and women's bodies, causing both short and long term physical, emotional and psychological health problems. Simple descriptors and information about of FGM can be found on NHS Direct Wales Encyclopaedia - FGM.

FGM is carried out on girls aged anywhere from infancy to late teenage years, and seems to be more common before puberty. Girls may be taken to the family country of origin over the school holiday periods, where FGM takes place on the child. Increasingly, girls may have FGM performed in the UK.

See Appendix 12 for some indicators of FGM.

9.1 FGM: Mandatory Reporting

Pharmacy professionals must be familiar with the GPhC's guidance *Female genital mutilation: mandatory duty for pharmacy professionals to report*[41]

There is a mandatory legal duty to report FGM as part of the Female Genital Mutilation Act 2003, as amended by the Serious Crime Act 2015 (section 74).

The legislation applies to **all** registered health professionals in England and Wales. It requires them to report to the police, orally or in writing if they either:

- are informed by a girl under 18 that an act of FGM has been carried out on her; or
- observe physical signs indicating that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

For the purposes of the duty to report, the relevant age is the girl's age at the time of the disclosure/identification of FGM (i.e. it does not apply where a woman aged 18 or over discloses that she had FGM when she was under 18).

Complying with the duty does not breach any confidentiality requirement or other restriction on disclosure which might otherwise apply. The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred. The only exception to this is if you know that another individual from your profession has already made a report then there is no requirement to make a second referral.

The duty does not apply in relation to at risk or suspected cases or in cases where the woman is over 18. In these cases, you should follow local safeguarding procedures.

Where there is a risk to life or likelihood of serious immediate harm, professionals should report the case immediately to police, including dialling 999 if appropriate.

The GPhC's guidance *Female genital mutilation: mandatory duty for pharmacy professionals to report* states:[41]

The mandatory duty to report is the responsibility of the pharmacy professional and cannot be passed onto anyone else.

The mandatory duty to report will not apply:

- if a pharmacy professional can identify that another individual working in the same profession has already made a report to the police in connection with the same act of FGM
- to those at risk of FGM
- to suspected cases of FGM
- to women over 18, in which case their right to patient confidentiality must be respected if they do not wish any action to be taken

In these circumstances pharmacy professionals must apply local safeguarding protocols.

Further information regarding procedural information can be sourced by following this link to the Home Office guidance *Mandatory Reporting of female genital mutilation: procedural information.*[42]

10. Prevent – What does this mean in Primary Care?

Counter terrorism like safeguarding is everybody's responsibility. The **Prevent** Strategy[43] was published in 2011 and is part of CONTEST[44] the UK Government's counter-terrorism strategy. It is important that we know what role we can play and what the Prevent Strategy means to us both as healthcare professionals and as citizens.

The key components include:

- Recognising the vulnerability of someone being drawn into terrorism
- An awareness of how to respond to concerns
- Potentially referring onwards for further advice and support
- Balancing information sharing and managing issues of confidentiality

All providers of NHS services are covered by the Prevent strategy this includes community pharmacists and relevant support staff.

The intercollegiate guidance document, Safeguarding children and young people: roles and competencies for health care staff, now includes Prevent information and identifies competences for healthcare staff.[20]

The aim of Prevent is to stop people from becoming terrorists (often referred to as being radicalised) or supporting terrorism. Community pharmacy professionals are expected to be mindful of this as they work with vulnerable people in the community who may be targeted by extremists to radicalise in order to coerce them into committing acts of terrorism.

A member of the pharmacy team may have concerns relating to an individual's behaviour, which could indicate that they may be being drawn into terrorist activity. This may include:

- Graffiti symbols, writing or artwork promoting extremist messages or images
- Patients/staff accessing terrorist related material online, including through social network sites
- Parental/family reports of changes in behaviour, friendships or actions, coupled with requests for assistance
- Partner healthcare organisations', local authority services' and police reports of issues affecting patients in other healthcare organisations
- Patients voicing opinions drawn from terrorist related ideologies and narratives
- Use of extremist or hate terms to exclude others or incite violence

Workshop to Raise Awareness of Prevent (WRAP)

The Home Office has developed training on the Prevent Duty called the *Workshop to Raise Awareness of Prevent (WRAP)*. It has been developed to raise awareness of and explain Prevent within the wider safeguarding context and developing the ability of frontline staff to use their existing expertise and professional judgment to recognise vulnerable individuals who may need support.

Pharmacists should undertake WRAP training in addition to Level 2 safeguarding training.

The Home Office has developed an e-learning resource to raise awareness of Prevent. Available at: https://www.elearning.prevent.homeoffice.gov.uk/

Please note:

- This resource has been designed for those in the education sector.
- While the learning is applicable across all public sectors, the current content (for example use of case studies) and means for sharing concerns focuses on educational settings, so please bear this in mind while using this training.
- Home Office e-learning training for other sectors including healthcare are currently in development.

11. References

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Appendix 1: The Welsh Government Health and care standard on safeguarding children and safeguarding adults at risk

The Heath Standard on Safeguarding Children and Safeguarding Adults at Risk states that the health service will need to consider the following criteria for meeting the standard:

There is compliance with legislation and guidance to include:

- All Wales Child Protection and Adults at risk procedures.
- Mental Health Act 1983 in relation to persons liable to be detained, and the Mental Capacity Act 2005 regarding Deprivation of Liberty Safeguards.
- Assurance of safeguarding services and processes is evident across all levels of the organisation.
- Effective multi-professional and multi-agency working and co-operation are in place complying with the Social Services and Well-being (Wales) Act.
- Staff are trained to recognise and act on issues and concerns, including sharing of information and sharing good practice and learning.
- People are informed how to make their concerns known.
- Priority is given to providing services that enable children and adults at risk to express themselves and to be cared for through the medium of the Welsh language because their care and treatment can suffer when they are not treated in their own language. (They are recognised as a priority group in More than just Words).[46] Suitable arrangements are in place for people who put their safety or that of others at risk to prevent abuse and neglect.
- Risk is managed in ways which empower people to feel in control of their life.
- Arrangements are in place to respond effectively to changing circumstances and regularly review achievement of personal outcomes.

Appendix 2: Contact details and document links

Contact details for safeguarding professionals in Wales can be accessed through the Safeguarding Children Service section of the Public Health Wales internet site available at: http://www.wales.nhs.uk/sitesplus/888/page/67317

Safeguarding professionals' contact details

To find the following contact details go to the Safeguarding Children Service homepage and click on:

Or use the following internet links:

Safeguarding Professionals for Wales - October 2014

Children's Social Services and Emergency Duty Team's for Local Authorities across Wales

Adult Social Services for Local Authorities across Wales

Protection of Vulnerable Adults (POVA) Leads-NHS Wales Health Boards/Trusts 2015

Designated Professionals for Safeguarding Children Public Health Wales

Safeguarding Children Service: Guidance and Documents

Additional guidance and documents can be accessed from the Safeguarding Children Service homepage and clicking on:

Or use the following internet links:

http://www.wales.nhs.uk/sitesplus/888/page/67421

Safeguarding in Community Pharmacy Practice

Information to support the Guidance for Safeguarding Children and Vulnerable Adults in Community Pharmacy Practice can be accessed from the **Safeguarding Children Service: Guidance and Documents** homepage and clicking on:

Pharmacy guidance or use the following internet link:

http://www.wales.nhs.uk/sitesplus/888/page/66437

Disclosure and Barring Service (DBS) check contact:

NWSSP.CRB@wales.nhs.uk

Cwmbran House, Mamhilad Park Estate, Mamhilad, Pontypool, Gwent, NP4 0XS

Tel: 01495 332072/2327 (ophthalmic/pharmaceutical)

Appendix 3: Definitions of child abuse

Physical abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates or induces illness in a child whom they are looking after.

Physical abuse can lead directly to neurological damage, physical injuries, disability or at the extreme death. Harm may be caused to children both by the abuse itself and by the abuse taking place in a wider family or institutional context of conflict and aggression. Physical abuse has been linked to aggressive behaviour in children, emotional and behavioural problems, and educational difficulties. Violence is pervasive and the physical abuse of children frequently coexists with domestic abuse.

Emotional abuse

Emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill-treatment of a child, though it may occur alone.

There is increasing evidence of the adverse long-term consequences for children's development where they have been subject to sustained emotional abuse. Emotional abuse has an important impact on a developing child's mental health, behaviour and self-esteem. It can be especially damaging in infancy. Underlying emotional abuse may be as important, if not more so, than other more visible forms of abuse in terms of its impact on the child. Domestic abuse, adult mental health problems and parental substance misuse may be features in families where children are exposed to such abuse.

Sexual abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Disturbed behaviour including self-harm, inappropriate sexualised behaviour, depression and a loss of self-esteem, have all been linked to sexual abuse. Its adverse effects may endure into adulthood. The severity of impact on a child is believed to increase the longer abuse continues, the more extensive the abuse, and the older the child. A number of features of sexual abuse have also been linked with severity of impact, including the relationship of the abuser to the child, the extent of premeditation, the degree of threat and coercion, sadism, and unusual elements. A child's ability to cope with the experience of sexual abuse,

once recognised or disclosed, is strengthened by the support of a non-abusive adult carer who believes the child, helps the child understand the abuse, and is able to offer help and protection. The reactions of practitioners also have an impact on the child's ability to cope with what has happened, and his or her feelings of self-worth.

A proportion of adults who sexually abuse children have themselves been sexually abused as children. They may also have been exposed as children to domestic abuse and discontinuity of care. Sexual abuse on children can have an impact on future relationships and a proportion of children who have been sexually abused may go on to sexually abuse children themselves. However, it would be quite wrong to suggest that most children who are sexually abused will inevitably go on to become abusers themselves.

Neglect

Neglect means a failure to meet a person's basic physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being (for example, an impairment of the person's health or, in the case of a child, an impairment of the child's development).

It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

The severe neglect of young children has adverse effects on children's ability to form attachments and is associated with major impairment of growth and intellectual development. Persistent neglect can lead to serious impairment of health and development, and long-term difficulties with social functioning, relationships and educational progress. Neglected children may also experience low self-esteem, feelings of being unloved and isolated. Neglect can also result, in extreme cases, in death. The impact of neglect varies depending on how long children have been neglected, the children's age, and the multiplicity of neglectful behaviours children have been experiencing.

Appendix 4: Different types of adult abuse

Physical abuse

Physical abuse can be defined as the non-accidental infliction of physical force that results in bodily injury, pain or impairment. For example, hitting, pushing, pinching, shaking, misusing medication, scalding and the misuse or illegal use of restraint.

Emotional abuse

Emotional abuse is behaviour or actions that have a harmful effect on the emotional, health and/or development of an adult at risk.

This can include threats, deprivation of contact, shouting, ignoring, cruelty, bullying, humiliation, coercion, negating the right of the adult at risk to make choices and undermining self-esteem.

Sexual abuse

Sexual abuse is the direct or indirect involvement of the adult at risk in sexual activity or relationships, which they:

- Do not want or have not consented to
- Cannot understand and lack the mental capacity to be able to give consent to
- Have been coerced into because the other person is in a position of trust, power or authority (for example a care worker).

This includes indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or the witnessing sexual acts as well as rape.

Neglect and acts of omission

Neglect and acts of omission are the failure of any person, who has responsibility for the charge, care or custody of an adult at risk, to provide the amount and type of care that a reasonable person would be expected to provide. Neglect can be intentional or unintentional. For example, failure to provide for medical, social or educational needs, or withholding necessities such as food, drink and warmth, and a lack of protection from hazards.

Financial abuse

Financial abuse is the use of a person's property, assets, income, funds or any resources without their informed consent or authorisation. Financial abuse is a crime. It includes:

- Theft or fraud
- Exploitation
- Undue pressure in connection with wills, property, inheritance or financial transactions
- The misuse or misappropriation of property, possessions or benefits
- The misuse of an enduring power of attorney or a lasting power of attorney, or appointeeship

Discriminatory abuse

Discriminatory abuse occurs where there is abuse or unfair treatment motivated because by age, gender, sexuality, disability, religion, class, culture, language, and race or ethnic origin.

It can be a feature of any form of abuse of an adult at risk and often occurs when values, beliefs or culture result in a misuse of power that denies opportunity to some groups or individuals e.g. exploiting a person's vulnerability by treating them in a way that excludes them from opportunities they should have as equal citizens, for example, education, health, justice and access to services and protection.

Institutional abuse

Institutional abuse is the mistreatment, abuse or neglect of an adult at risk by a regime or group of individuals. It takes place in settings and services that adults at risk live in or use. It violates the person's dignity and is a lack of respect for their human rights.

Institutional abuse can occur when the routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice. It can take the form of an organisation failing to respond to, or address, examples of poor practice brought to their attention.

It can take place in day care, care homes, hostels, hospitals, sheltered and supported housing.

It can be difficult to identify the difference between a poor service and institutional abuse.

Where can abuse happen?

Anywhere including:

- in a person’s own home
- in a residential or nursing home
- in a hospital
- in the workplace
- at a day centre or educational establishment
- in sheltered or supported housing
- in the street.

Who can abuse?

The person responsible for the abuse is often well known to the person being abused, and could be:

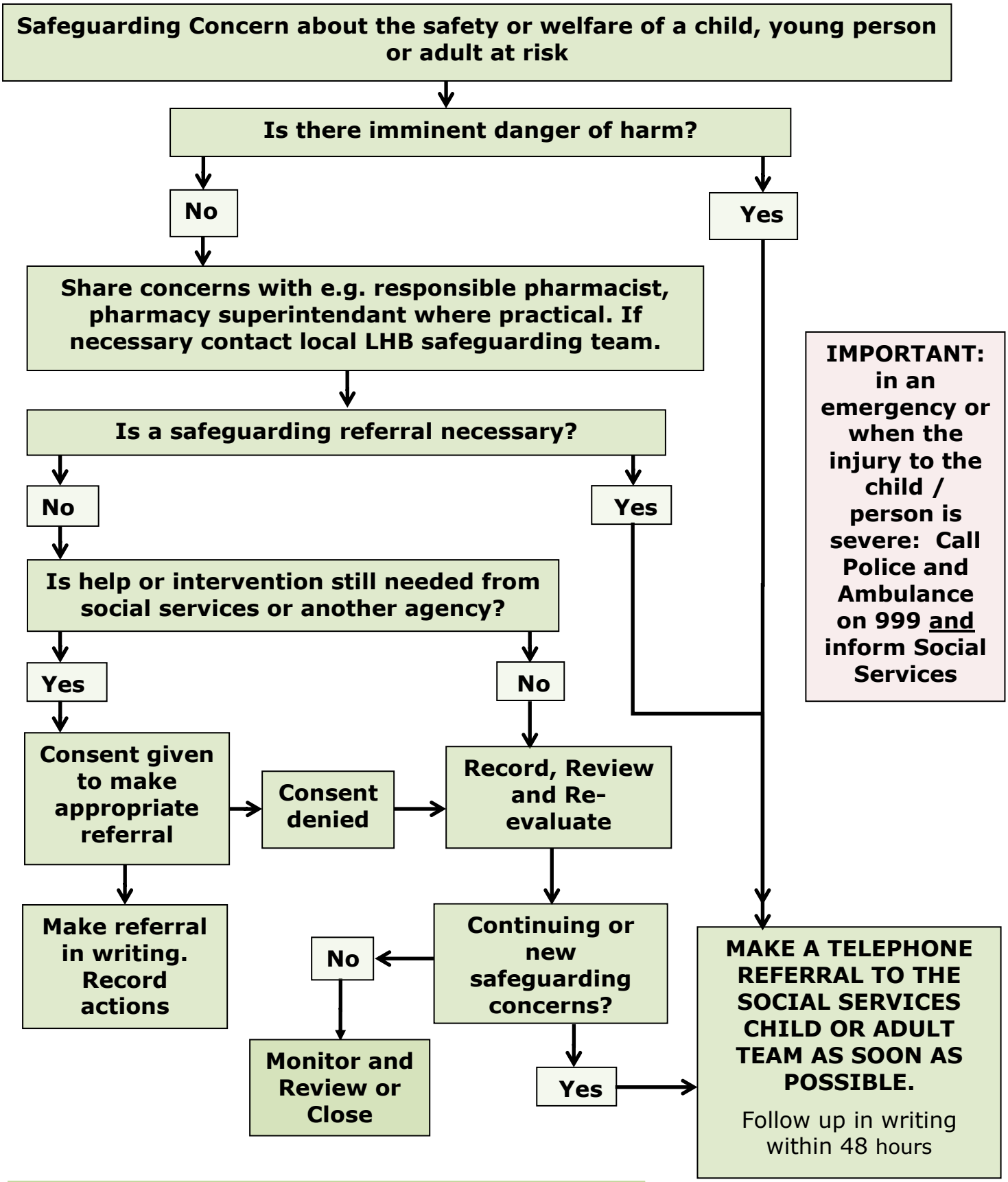
- a paid carer in a residential establishment or from a home care service
- a person employed directly by someone in their own home as a carer or a personal assistant
- a social care worker
- a health worker
- a relative, friend, or neighbour

- another resident or person using a service in a shared care setting
- someone providing a support service.

It can also be people who:

- befriend vulnerable people with the intention of exploiting them
- deceive people into believing they are from legitimate businesses, services or utility providers
- intimidate vulnerable people into financial transactions they do not want or cannot understand

Appendix 5: Safeguarding referral flowchart



Local Contact Details:

Children's Social Services .....

Adult Social Services .....

LHB Safeguarding Team .....

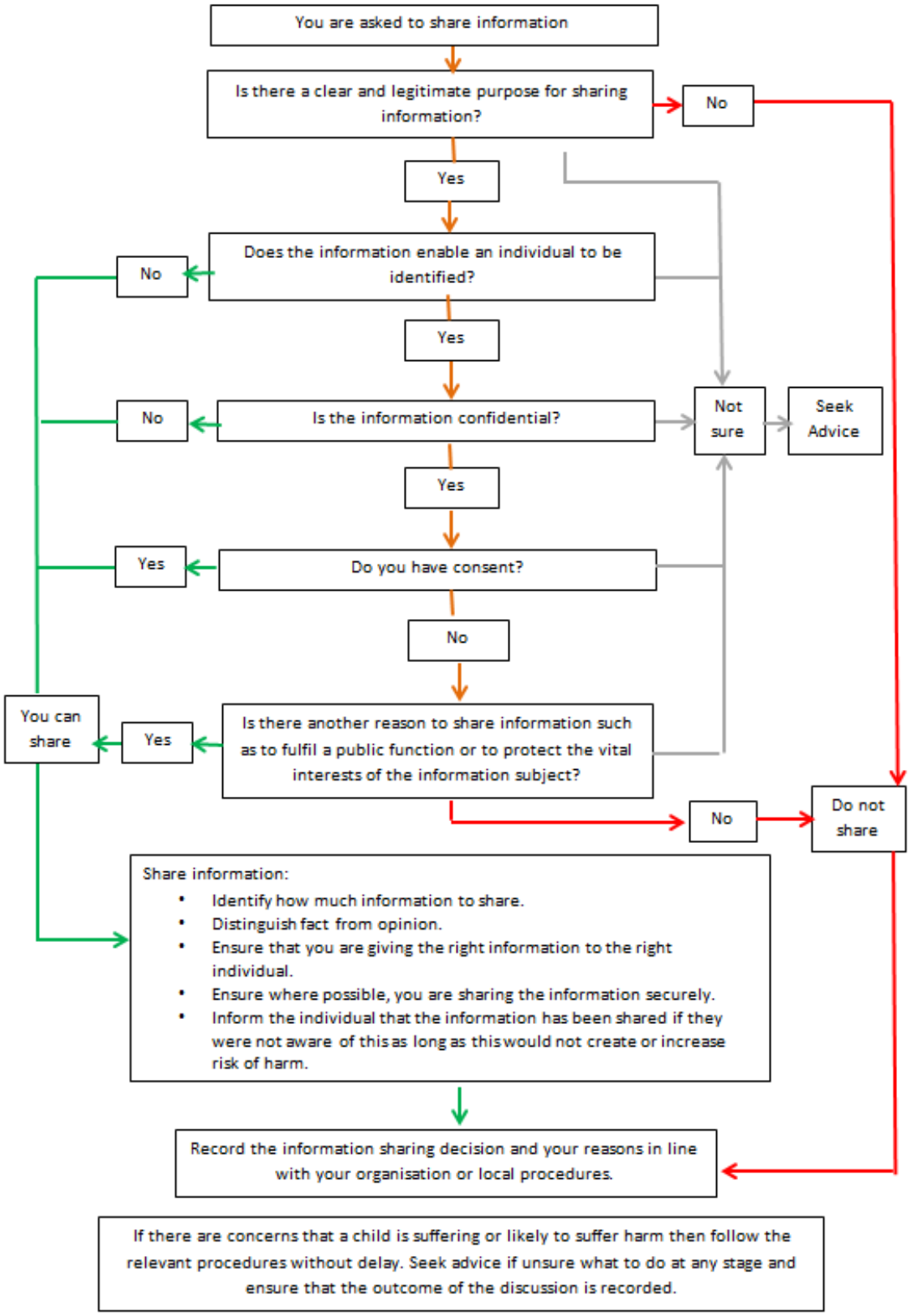
Record incident as soon as possible without delaying appropriate action

Appendix 6: The seven golden rules of sharing information

1.	Remember that the Data Protection Act 1998 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.
2.	Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3.	Seek advice from other practitioners if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.
4.	Share with informed consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, there is good reason to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be certain of the basis upon which you are doing so. Where you have consent, be mindful that an individual might not expect information to be shared.
5.	Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.
6.	Necessary, proportionate, relevant, adequate, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
7.	Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Source: *Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers*.[21]

Appendix 7: Flowchart of when and how to share information



Source: *Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers*.[21]

Appendix 8: The Mental Capacity Act 2005

The five statutory principles of the Mental Capacity Act:

1. A person must be assumed to have capacity unless it is established that they lack capacity.

2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

4. An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Assessing Capacity

Anyone assessing someone's capacity to make a decision for themselves should use the two-stage test of capacity.

1. Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent.)

2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Assessing ability to make a decision

• Does the person have a general understanding of what decision they need to make and why they need to make it?

• Does the person have a general understanding of the likely consequences of making, or not making, this decision?

• Is the person able to understand, retain, use and weigh up the information relevant to this decision?

• Can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful?

Assessing capacity to make more complex or serious decisions

• Is there a need for a more thorough assessment (perhaps by involving a doctor or other professional expert)?

Appendix 9: Indicators of potential domestic abuse

Signs:

The potential outward and physical signs someone is experiencing violence against women, domestic abuse and sexual violence will be both physical and linked to the demeanour and behaviour of the client. They may include attitudinal change or cultural signs:

- Changes in attitude or behaviour: becoming very quiet, anxious, frightened, tearful, aggressive, distracted, depressed etc.
- Constant accompaniment by partner, even where this seems supportive and attentive
- Partner exerting unusual amount of control or demands over interactions with service, including constant accompaniment
- Reliance on partner for decision making-lack of free will and independence
- Obsession with timekeeping
- Secretive regarding home life
- Worried about leaving children at home with partner or family
- Partner or ex-partner exerting unusual amount of control or demands over clients schedule
- Social isolation from family/friends signs
- Unexplained injuries
- Change in the pattern or amount of make-up used
- Change in the manner of dress: for example, clothes which do not suit the climate which may be used to hide injuries
- Substance use/misuse
- Fatigue/sleep disorders

Symptoms:

As the term would indicate it is expected the identification and subsequent enquiry based on symptoms will be rooted within clinical and medical practice. Symptoms which should trigger an enquiry include (this list is not exhaustive):

- Depression
- Anxiety
- Medically unexplained chronic pain
- Tiredness
- Alcohol or other substance use
- Self-harm
- Suicide attempts
- Eating disorders
- Medically unexplained chronic gastrointestinal symptoms

- Medically unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Gynaecological problems
- Medically unexplained genitourinary symptoms, including frequent bladder or kidney infections or other
- Repeated vaginal bleeding and sexually transmitted infections
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis or medically unexplained symptoms
- Intrusive or controlling partner in Consultations

Cues:

A cue describes either a piece of information or pattern of behaviour which merits enquiry. This could include taking an overview of a client's engagement with services over time and querying the reasons behind sporadic or crisis based engagement. It might also include information provided by a partner agency, based on referral or shared via use of local Information Sharing Protocols which indicates concern, suspicion or unsubstantiated intelligence the client might be experiencing violence against women, domestic abuse and sexual violence.

To "Ask and Act" is not to interrogate, but where a cue is observed or received a professional should make appropriate enquiry.

Settings:

There is evidence which suggests in some settings routine enquiry is appropriate as the reason for the patient's engagement within the setting is also a trigger for enquiry in relation to violence against women, domestic abuse and sexual violence.

Professionals working in the following settings should routinely ask all clients whether they are experiencing violence against women, domestic abuse and sexual violence due to the known co-occurrence of domestic abuse with the core purpose of the service they provide (mental health issues, pregnancy, child maltreatment):

Mental health settings

The risk of developing depression, post-traumatic stress disorder (PTSD), substance use issues or becoming suicidal is 3 to 5 times higher for women who have experienced violence in their relationships compared to those who have not.

Acknowledging mental health settings as an indicator for "Ask and Act" offers practitioners an opportunity to address these links pro-actively and offer care which addresses the co-occurring issues.

Maternal and post partum settings

Thirty percent of domestic violence starts in pregnancy and is associated with low birth weight and pregnancy complications including miscarriage and still-birth. A

process of “Ask and Act”, with additional training will further strengthen the existing maternity care pathway which uses an evidence based approach to asking all women about domestic abuse in the antenatal period.

Concerns about child maltreatment

Nearly three quarters of children on the child protection register live in households where domestic violence occurs and 52% of child protection cases involve domestic violence. Of the children exposed to domestic abuse, 62% are directly harmed.

There are missed opportunities to identify violence against women, domestic abuse and sexual violence and to identify risks to children.

Appendix 10: Drug-using parents with dependent children

The *Drug misuse and dependence: UK guidelines on clinical management* is currently being updated. The final guidelines are expected to be published in late 2017. The draft for consultation with stakeholders includes the following considerations during the assessment of drug-using parents with dependent children:[36]

Full or comprehensive assessment of drug-using parents

The following should be taken into consideration:

- Effect of drug misuse on functioning, for example, intoxication, agitation.
- Effect of drug seeking behaviour, for example, leaving children unsupervised, contact with unsuitable characters.
- Impact of parent's physical and mental health on parenting.
- How drug use is funded, for example, sex working, diversion of family income.
- Emotional availability to children.
- Effects on family routines, for example, getting children to school on time.
- Other support networks, for example, family support.
- Ability to access professional support.
- Storage of illicit drugs, prescribed medication and drug-using paraphernalia.

Appendix 11: Child sexual exploitation

Disclosure of this form of abuse is rare and there is a perception that CSE is a hidden form of abuse that takes place out of sight. However as quoted by a young victim of CSE to researchers from the University of Bedfordshire "It's not hidden, you just aren't looking".[47]

Almost all children and young people come into contact with primary care services and it is possible to reduce the risks associated with CSE at all levels of risk. Vulnerability and risk indicators of CSE are well established. So there is an opportunity to recognise those at risk and to involve other agencies in preventing abuse. Early identification and a timely response are central to effective safeguarding practice.[39]

Vulnerability factors for CSE

- Whilst generally more females than males suffer from CSE and the average age when concerns are first identified is 13-15 years old, no one is immune.
- Particular life experiences associated with increased risk of CSE are:
- Family dysfunction
- Prior (sexual) abuse or neglect
- Going missing / running away
- Substance misuse
- Disengagement from education
- Social isolation
- Low self-esteem
- Socio-economic disadvantage
- Learning difficulties / disabilities
- Peers who are sexually exploited
- Gang-association
- Attachment issues
- Homelessness
- Being in care

Possible warning signs of CSE (drawn from The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation In Gangs and Groups, interim report, 2012)[48] *I thought I was the only one*.

- Missing from home or care
- Physical injuries
- Drug or alcohol misuse
- Involvement in offending
- Repeated STIs, pregnancies and termination

- Absent from school
- Change in physical appearance
- Evidence of sexual bullying/vulnerability through the internet and/or social networking sites
- Estranged from their family
- Receipt of gifts from unknown sources
- Recruiting others into exploitative situations
- Poor mental health
- Self-harm or thoughts of or attempts at suicide

In Wales the Barnardo's Sexual Exploitation and Risk Assessment Form (SERAF) is the recommended tool to identify those at risk from CSE. Some research done in South Wales on the questions used in the SERAF has identified four questions that are the most important to ask. The wording used in these questions has been established in consultation with young people.

They are:

- Have you ever stayed out overnight or longer without permission from your parent(s) or guardian?
- How old is your partner or the person(s) you have sex with? (Is the age difference 4 or more years?)
- Does your partner stop you from doing things you want to do?
- Thinking about where you go to hang out, or to have sex. Do you feel unsafe there or are your parent(s) or guardian worried about your safety?

Appendix 12: Indicators of FGM

The following are some indicators of FGM. However this is not an exhaustive list and professionals should be vigilant at all times.

Indications that FGM may be about to take place include:

- The family comes from a community that is known to practice FGM e.g., Somalia, Sudan and other African countries. It may be possible that they will practice FGM if a female family elder is around.
- Parents state that they or a relative will take a girl out of the country for a prolonged period.
- A girl may talk about a long holiday to her country of origin or another country where the practice is prevalent, including African countries and the Middle East.
- A girl may confide to a professional that she is to have a 'special procedure' or to attend a special occasion.
- A professional hears reference to FGM in conversation, for example a girl may tell other children about it.
- A girl may request help from a teacher or another adult.
- Any girl born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family.
- Any girl who has a sister who has already have undergone FGM must be considered to be at risk, as must other female children in the extended family.

Indications that FGM may have already taken place include:

- A girl may spend long periods of time away from the classroom during the day with bladder or menstrual problems if she has undergone Type 3 FGM.
- There may be prolonged absences from school if she has undergone Type 3 FGM.
- A prolonged absence from school with noticeable behaviour changes on the girl's return could be an indication that a girl has recently undergone FGM.
- Professionals also need to be vigilant to the emotional and psychological needs of children who may/are suffering the adverse consequences of the practice e.g. withdrawal, depression etc.
- A girl requiring to be excused from physical exercise lessons without the support of her GP.
- A girl may ask for help.

Adapted from: Female genital mutilation risk and safeguarding: guidance for professionals.[49]

Appendix 13: Reviewers and contributors

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