

Safeguarding Response to Obesity when Neglect is an Issue

Introduction

Obesity in childhood is a significant public health issue. Childhood obesity is more than a cosmetic problem as there is incontrovertible evidence that it is linked to adult obesity, which is a major cause of cardiovascular disease and diabetes.¹ There is a strong case for early help to support people to maintain a healthy weight as evidence suggests that future lifestyles are determined by early life experiences. Food preferences, activity levels and leisure activities as adults are all influenced by parenting and the home environment in the first years of life.

In addition to impacting significantly on the quality of life of the individual, obesity leads to increased health and social care costs for society. Obesity is a priority area for Government, the Government's "Call to Action" on obesity in 2011 included national ambitions relating to excess weight in children.² Obesity has also been identified as a priority locally, with the Norfolk Health and Wellbeing Board identifying it as one of their three priorities for the Norfolk Health and Wellbeing Strategy 2011-15.

Data from the National Child Measurement Programme (NCMP) is used to track trends in childhood obesity and identify areas with higher need of services aimed at encouraging healthy weight. The height and weight of children is measured in Reception Year and then again in Year Six of primary school. The latest data from 2012/13 shows that nationally:

- 22% (nearly a quarter) of children aged 4-5 are overweight (with 9% obese).
- 33% (or one third) of children aged 10-11 are overweight (19% obese).

In 2012/13 Norfolk was broadly in line with national statistics. See **Table 1**:

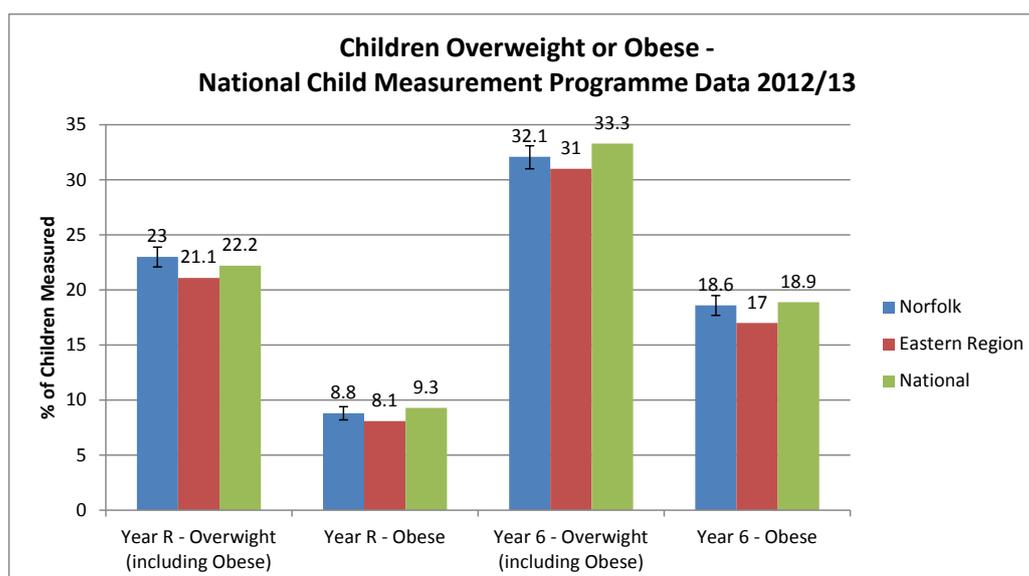


Figure 1

¹ Rudolf, M (2010) *Tackling Obesity through the Healthy Child Programme: A framework for action*. National Obesity Observatory

² HM Government (2011) *Healthy Lives, Healthy People: A call to action on obesity*. HM Government

For more data on the National Child Measurement Programme (NCMP) go to: <http://fingertips.phe.org.uk/profile/national-child-measurement-programme/data>

Importantly childhood obesity is a significant health inequality with higher rates amongst children in disadvantaged areas and some ethnic groups.³ In Norfolk there are a third more obese children in the most deprived areas than in the least deprived (the percentage of children aged 4-5 is 38 percent higher in the most deprived quintile and 31 percent higher for children aged 10-11). See **Table 2:**

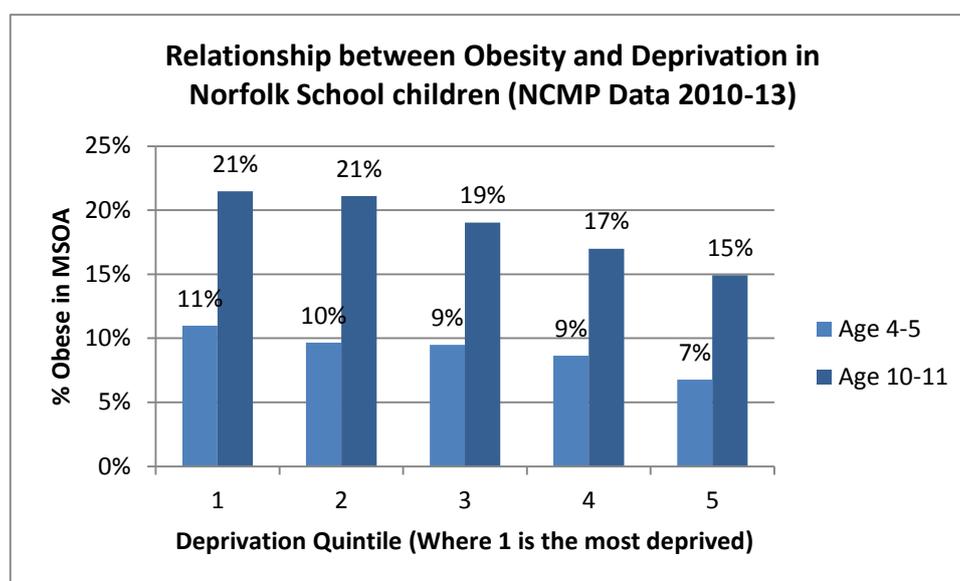


Figure 2

Tackling obesity is one of the Norfolk Health & Wellbeing Board's top priorities. The physical risks and implications of obesity are well documented (see Appendix 1), but the links to safeguarding are harder to define.

When does obesity become a safeguarding issue?

In July 2010, the British Medical Journal published an article by Dr Russell Viner from the UCL Institute of Child Health in London⁴, in which he and a group of child health experts, set out to review existing evidence and propose a framework for practice and is the source that links some obesity cases to safeguarding.

Childhood obesity alone is a concern, but not usually a child protection concern — A consultation with a family with an obese child should not raise child protection concerns if obesity is the only cause for concern. The root causes of obesity are complex that it is untenable to institute child protection actions relating parental neglect to the cause of their child's obesity. However, professionals working with obese children should be mindful of the possible role of abuse or neglect in contributing to obesity. Older children and

³ HM Government (2011) *Healthy Lives, Healthy People: A call to action on obesity*. HM Government

⁴ Russell Viner, British Medical Journal, 21 August 2010, Volume 341

adolescents should be offered the chance to talk apart from their parents to explore their understanding of their weight issues.

Failure to reduce overweight alone is not a child protection concern — The outcomes of weight management programmes for childhood obesity are mixed at best, with the body mass index of some children falling substantially and that of others increasing despite high family commitment. As obesity remains extremely difficult for professionals to treat, it is untenable to criticise parents for failing to address it successfully if they engage adequately with treatment.

Consistent failure to change lifestyle and engage with outside support can indicate neglect, particularly in younger children — Parental failure to provide their children with adequate treatment for a chronic illness (asthma, diabetes, epilepsy, etc) is a well accepted reason for a child protection registration for neglect. Childhood obesity only becomes a child protection concern when parents behave in a way that actively promotes treatment failure in a child who is at serious risk from obesity and when the parents or carers understand what is required, and are helped to engage with the treatment programme. Parental behaviours of concern include:

- consistently failing to attend appointments;
- refusing to engage with various professionals or with weight management initiatives; or
- actively subverting weight management initiatives.

These behaviours are of particular concern if an obese child is at imminent risk of comorbidity—for example, obstructive sleep apnoea, hypertension, type 2 diabetes, or mobility restrictions. Clear objective evidence of this behaviour over a sustained period is required, and the treatment offered must have been adequate and evidence based.

Obesity may be part of wider concerns about neglect or emotional abuse — Obesity is likely to be one part of wider concerns about the child's welfare — for example, poor school attendance, exposure to or involvement in violence, neglect, poor hygiene, parental mental health problems, emotional and behavioural difficulties, or other medical concerns. It is essential to evaluate other aspects of the child's health and wellbeing and determine if concerns are shared by other professionals such as the family general practitioner or education services. This will require a multidisciplinary assessment, including psychology or other mental health assessment. If concerns are expressed, a multi-agency meeting is appropriate.

Assessment should include systemic (family and environmental) factors — As with any childhood behaviour, understanding what maintains a problem involves understanding factors within the child and their context. Assessment of parental capacity to respond to that particular child's needs is central to this, such as parent(s) struggling to control their own weight and eating, but they are not the only factors. For example, a child who lives in an area where it is unsafe to play outdoors is inevitably at greater risk. Admission to hospital or other controlled environment may be useful because it allows a more detailed assessment of behaviours and parent-child interactions. However,

admission removes a child from his or her wider familiar environment as well as from parents so weight loss in a controlled environment is not evidence of neglect or abuse.

It is envisaged that only a very small number of children will reach the safeguarding threshold in relation to obesity linked to neglect. There are a number of definitions of childhood obesity, and even the most conservative — the International Obesity Taskforce thresholds — are too inclusive to be useful as a guide to child protection concerns, encompassing a significant percentage of current Norfolk children (see Table 1 above).

This policy recognises that weight management is an emotive issue and many families struggle to maintain a healthy diet and take the recommended amount of physical activity. Wherever possible, it is important to work with families to understand potential risks and signs of safety. Morbid obesity can affect a child's outcomes in a number of ways, including academic achievement and emotional wellbeing; in a very small minority of cases, obesity can be life threatening. It is imperative that any parent or carer who is trying to manage their child's weight understands the risks and has access to appropriate support and guidance.

As in all areas of child health, we have a duty to be open to the possibility of child neglect or abuse in any form. When assessing such children, a comprehensive picture of the child's functioning from a health, psychological, and educational perspective is necessary.

This policy should be read with reference to the NSCB Neglect Strategy.

The Child & Family

Obesity is the most common nutritional disorder affecting children, and is much more common in families living in poverty and those from some ethnic minorities. For more detail visit the National Obesity Observatory website: <http://www.noo.org.uk/>

NB Consideration must be given to cultural and ethnic influences when considering obesity as a potential harm in safeguarding children. In particular an understanding of varying approaches to what constitutes; healthy foods, food preparation, exercise and a healthy weight must be explored in the cultural context of the family. It is important not to make assumptions about, or stigmatise, certain cultural beliefs in regard to weight nor the belief system which sits behind those values. This may require some education and wider consultation to be undertaken by the practitioner when working with culturally diverse groups thus ensuring a parity of approach and assessment of risk.

Being overweight or obese in childhood has both short-term and longer-term consequences for health. Moreover, once severe, obesity is very difficult to treat effectively.

In addition to the physical consequences of obesity, children experience significant emotional and psychological distress. Teasing and discrimination is not uncommon, with resultant low self-esteem anxiety and depression.

When severe, (morbid obesity), it may have serious health implications for the child (see Fig.1, Appendix 1). The health risks increase with duration and severity of obesity and in rare instances may have a fatal outcome.

For the most part, childhood obesity is so called “simple obesity”, arising from a chronic imbalance between energy intake and activity. Often this reflects the family environment, and one or both parents is commonly overweight or obese. Obese children are more often ill, experience more day-to-day health issues (e.g. breathlessness, discomfort, fatigue, etc), have greater school absence, healthcare attendances and hospital admissions. Obesity in childhood is often the harbinger of adult obesity, with greatly increased risks of disability, chronic ill-health and premature death.

Obesity may be part of a more complex health problem, which further jeopardises a child’s wellbeing. Examples include obesity:

- In a child with a genetic condition, such as Prader-Willi Syndrome,
- In a child with autism or learning difficulties,
- Associated with other health problems, such as blindness or arthritis which hamper mobility,
- From treatment with steroids or other treatment known to increase risk of obesity,
- Complicated by asthma, obstructive sleep apnoea, Type 2 Diabetes or other obesity-related illness.

Some families and even professionals working with the family will use the attendant health issues to justify, explain or excuse the child’s obesity. However the dual diagnosis of obesity and another health condition strains a family’s ability to cope, and amplifies the risks to the individual child. It is this group of children in whom obesity most commonly becomes a safeguarding concern. There are of course exceptions, for example, a child on long term steroids particularly in a high dose will be obese and even the most attentive parent will struggle to address this. Therefore it is imperative to use professional judgement when considering each case.

Legal Framework, 1989 Children Act

Where there is clear medical advice that the child is likely to suffer or is suffering significant harm from health conditions, specifically obesity and/or obesity related issues, as well as evidence that the care givers are unable or unwilling to engage in a plan that will realistically lead to improvements for that child, then the case requires action under Section 47 of the Children’s Act.

Where there is medical advice that the child is unlikely to achieve /maintain a reasonable standard of health/well being, but parents are engaging and/or there is no immediate risk of significant harm, then the case requires action under Section 17 of the Children’s Act.

For the purposes of this document, ‘immediate’ can be defined as risks escalating significantly within 12 months. Case management should be

regularly reviewed to ensure that the risks to the child's health and wellbeing are monitored carefully to ensure appropriate and timely actions are taken under the legal framework.

Safeguarding Trigger Points.

All trigger points need to be understood in terms of managing lifestyle, including healthy eating, physical activity and behaviour change, linked to the child's overall health, safety and wellbeing.

Lack of capacity to engage

- parents/carers unable to effectively provide for the child's health needs due to additional family factors, such as learning difficulties, socio-economic issues, unmet parental needs
- unable to attend appointments and make necessary changes to lifestyle
- weight continues, or appears to continue, to increase/or not to decrease.

Unwilling to engage

- not attending appointments
- unwilling to make any changes to child's lifestyle even with appropriate support and intervention by agencies.
- parent/carer refusing, rejecting or ignoring professional advice regarding ongoing significant health risks to their child if the weight continues to increase.
- transient or intermittent engagement
- actively frustrating efforts of professionals or child to reduce weight gain.
- oppositional behaviour: parents/carers unable/unwilling to set and maintain boundaries with child to manage lifestyle changes and allow further weight gain

Deceptive Compliance

- parents/carers appear to follow advice, but are not making any changes to lifestyle which would make a significant difference to the child's well being.
- parents/carers unwilling/unable to model appropriate behaviour to facilitate lifestyle changes

Parents/carers playing one professional off against another.

- agencies need to be aware of how parents/carers can distract professionals both within one agency and across agencies from focusing on the child by favouring one agency/professional over another. Behaviours can include:
 - appearing helpless and/or overwhelmed
 - being aggressive and/or confrontational
 - using media and/or politicians and/or legal advisers to challenge the professionals

- over sensationalise particular comments/issues to detract from the significant harm being experienced by the child/young person.
- parents/carers may use medical diagnoses to justify their inability to adhere to recommended advice. Professionals need to be cognisant of the child's needs and be prepared to challenge both parents and other practitioners working with the child/family.

Identifying Children where there are Safeguarding Concerns

There are number of warning signs and indicators that will support practitioners working with children and young people to **identify safeguarding concerns for children who are visibly overweight**. The following list should be considered in the context of the child's overall presentation and not in isolation:

- Sleep deprived and/or sleep apnoea: effects of inadequate rest affecting day to day functions
- Incontinence
- Inability/unwillingness to participate in physical activity
- Requires medical assessment to manage weight
- Avoidance of school weight/height measurements (National Child Measurement Programme)
- A & E attendance with mobility related injuries
- Co-morbidity, i.e. presence of one or more additional disorders (or diseases), whether related to obesity or not (see Appendix 1 for obesity related co-morbidities)
- Continuous and persistent weight gain after obesity diagnosed
- Unkempt appearance
- Depression
- Low self-esteem
- Self-harm
- Poor or non school attendance
- Socially isolated
- Parents/carers not engaging in weight management programmes
- Parents/carers poor mental health
- Family identity linked to obesity/intergenerational weight issues
- Any other feature of neglect

The list above is not exhaustive and need to be considered in line with safeguarding trigger points.

The role of the LSCB & Individual Organisations

Chapter 1 of *Working Together 2013*⁵ sets out the need for organisations, working together, to take a coordinated approach to ensure effective safeguarding arrangements. This is supported by the duty on local authorities

⁵ HM Government, Working Together to Safeguard Children, A Guide to Interagency Working to Safeguard and Protect the Welfare of Children, March 2013

under section 10 of the Children Act 2004 to make arrangements to promote cooperation to improve the wellbeing of all children in the authority's area.

In Chapter 2, the guidance provides more specific guidance on the range of individual organisations and professionals working with children and families, outlining their specific statutory duties to promote the welfare of children and ensure they are protected from harm. The child's welfare is paramount. Both professionals and the public should be aware that obesity becomes a safeguarding issue when there are wider concerns about **neglect** and/or **emotional abuse**. The children's workforce must be alert to these children, who may be isolated and/or not accessing universal services, and ensure that the risks are recognised and assessed appropriately.

Professionals and the public need to recognise that safeguarding is everybody's responsibility. However, when dealing with complex issues such as obesity there are specific contributions that can be and should be made by different agencies and these interventions and assessments need to be child focused, co-ordinated and shared appropriately.

Paediatricians It is important that the child's health needs are properly assessed, including, where possible, assessment of any environmental factors that are having a negative impact on their weight gain or loss. This will enable close monitoring of the parents'/carers' ability to support the child to maintain a healthy weight and active life style.

Where an obese child is on a Child Protection (CP) Plan, there are two key practice points to follow:

- The CP Plan should ensure that a paediatric assessment takes place where obesity is presenting as a safeguarding issue
- The Paediatrician should attend all child protection conference reviews and, where, appropriate core group meetings, so that the effectiveness of the weight management programme can be reviewed in line with ongoing parenting capacity monitoring

In identified safeguarding cases, consideration should be given to appointing the paediatrician as medical lead for all the child's presenting conditions. There should be regular communication with the child's GP to assess whether or not any other arising health concerns are considered in light of concerns over his/her health. This principle should be applied for any health professionals responsible for primary care, such as school nurses or health visitors, to ensure that the paediatrician maintains a holistic overview of the risks.

Other Health Professionals

Other health professionals including GPs, school nurses, health visitors and paramedics, should be mindful of the delineation between obesity as a health issue and a safeguarding concern, using the indicators above. Most cases of obesity will be managed by health, working with parents, however when the lifestyle challenges trigger failure to thrive concerns safeguarding referrals

should be considered. When the health professional recognise that their interventions alone are not having any impact on the weight management and the health risks are escalating, they need to ensure that their concerns are shared with the wider children's workforce.

Education

Schools who have concerns about a child's weight must establish that the child's health is being managed and, with parents' consent, confirm with health colleagues that an appropriate weight management programme is in place. If consent is not gained, the school should clearly record its concerns and keep a log to monitor the weight, how it is being managed and whether the parents are supporting the child to exercise and eat healthily.

The school is in the strongest position to monitor the day to day impact of persistent weight gain and the parents' ability to manage the child's weight and **should not rely solely on the health professionals' interventions**. If the child's weight continues to increase and the indicators noted above are identified, a referral to social care should be made (see Referral and Risk Assessment below). Challenges need to be recorded clearly.

Schools should be prepared to challenge any barriers presented by parents in addressing lifestyle changes such as not allowing the child to participate in physical activities. All concerns should be recorded and where appropriate shared with partners to better assess the risks.

Schools involved in child protection conferences and/or core groups should ensure that they record on a regular basis any information that the child gives them regarding their eating patterns so that they can report on whether or not parents are being compliant with the CP Plan. Consideration should be given to the impact of obesity on the child's emotional well being and the school should record observations on any signs of emotional harm, such as depression, isolation or bullying. Any activities that the child cannot engage with due to their weight should be noted in terms of the impact of social isolation as well as affecting educational attainment. This should be recorded in the log.

Social Care

Social workers - including frontline staff, their Managers, and Conference Chairs - with case loads of children with obesity related safeguarding concerns should be aware of the safeguarding warning signs and indicators noted above. As safeguarding leads, they should ensure that all aspects of non compliance with the CP Plan are communicated to all core group members as and when this occurs, and not wait until reporting the incidences at the next core group. This will enable any patterns to be identified, and where the parent/carer fails to comply with a particular agency/agencies to be identified quickly and challenged. Parents/care givers and young people will need to be informed that this will happen and the reasons why.

Non compliance includes:

- not attending school
- missing medical appointments
- not participating in physical activity unless there is clear medical evidence which is signed off by the Paediatrician overseeing the child's health plan
- parents/carers intervening to prevent their child from participating in physical activity
- parents/carers consistently providing inappropriate lunches/snacks .

Independent Reviewing Officers working with Looked After Children who are obese should challenge any lack of progress to reduce/manage weight within the care plan. Carers need to be supported to understand the risks and ensure that the child in their care makes appropriate progress.

Police

Childhood Obesity per se should be managed primarily by parents and carers with incremental support from Health and Children's Social Care.

The police may well engage in multi-agency strategy discussions in cases where a child is considered likely to suffer significant harm (Section 47 of the Children Act 1989) where their obesity is cited as a primary factor. However, the role of the police within the Child Safeguarding partnership is to investigate and prosecute criminal offences. To that end any neglect or ill-treatment of a child would ordinarily be considered under Section 1(1) of the Children and Young Persons Act 1933 which states:

If a person who has attained the age of sixteen years and has responsibility for a child or young person under that age, wilfully assaults, ill-treats, neglects, abandons, or exposes him, or causes or procures him to be assaulted, ill-treated, neglected, abandoned, or exposed, in a manner likely to cause him unnecessary suffering or injury to health (including injury to or loss of sight, hearing, limb, or organ of the body, and any mental derangement), that person is guilty of a misdemeanour

Any police involvement must be determined by the facts presented. There has to be a very distinct line drawn where the potential harm is directly attributable to wilful acts or omissions by the parent or carer.

In any event the police involvement will be very reliant on the combined information of the agencies engaged with the child and information sharing will be crucial to any action taken by police.

Whilst not prescriptive, the below should be considered as the threshold to police involvement.

1. The child is Obese and their weight is continuing overall to increase disproportionately to age **OR** is not reducing in line with a realistic and achievable health plan

AND

2. Paediatric examination shows that this is leading to co-morbidity factors (other medical factors as a direct result of the obesity)

AND

3. the parents or carers are aware of the risks and have the capacity and capability to engage in their child's treatment

AND

4. they are frustrating, or unnecessarily failing to engage in, a coordinated plan to improve the child's health

AND

5. the child is likely to be caused unnecessary suffering or injury to health

It will be important to be able to discern cases where the parents or carers require significant support in the management of their child's obesity. Such cases may include genetic conditions (e.g. Praderwilli Syndrome) or perhaps cases where the parents or carers do not have the ability to properly manage these more complex needs. Except in exceptional circumstances these cases will be managed by Health and Children's Social Care.

Referrals and Risk Assessment

It can be difficult to discuss obesity with parents who may be hostile, unreceptive or who lack capacity to recognise the safeguarding implications. Regardless, the protection and welfare of the child is the priority and it is everyone's responsibility to act on their concerns.

All referrals should go through the Multi-Agency Safeguarding Hub, (MASH) using the NSCB1 referral form, with the parents'/carers consent unless there are significant safeguarding concerns (see Legal Framework above). Any professional considering referring a child where the safeguarding concerns are linked to obesity should consider the contents of this policy before making the referral, specifically safeguarding indicators and triggers.

A proper balanced assessment will depend on both the medical and social assessments of the child. Most referrals will likely come from a single agency viewpoint. To this end each child that meets the threshold should be referred to the missing element to ensure that a holistic picture is properly formed.

To aid professionals in making this decision an analysis tool has been developed and is attached as Appendix 2, health professionals/clinicians and Appendix 3 for all other children's workforce staff. This information should be included as an addendum to the NSCB1 and/or the contents included on the referral form.

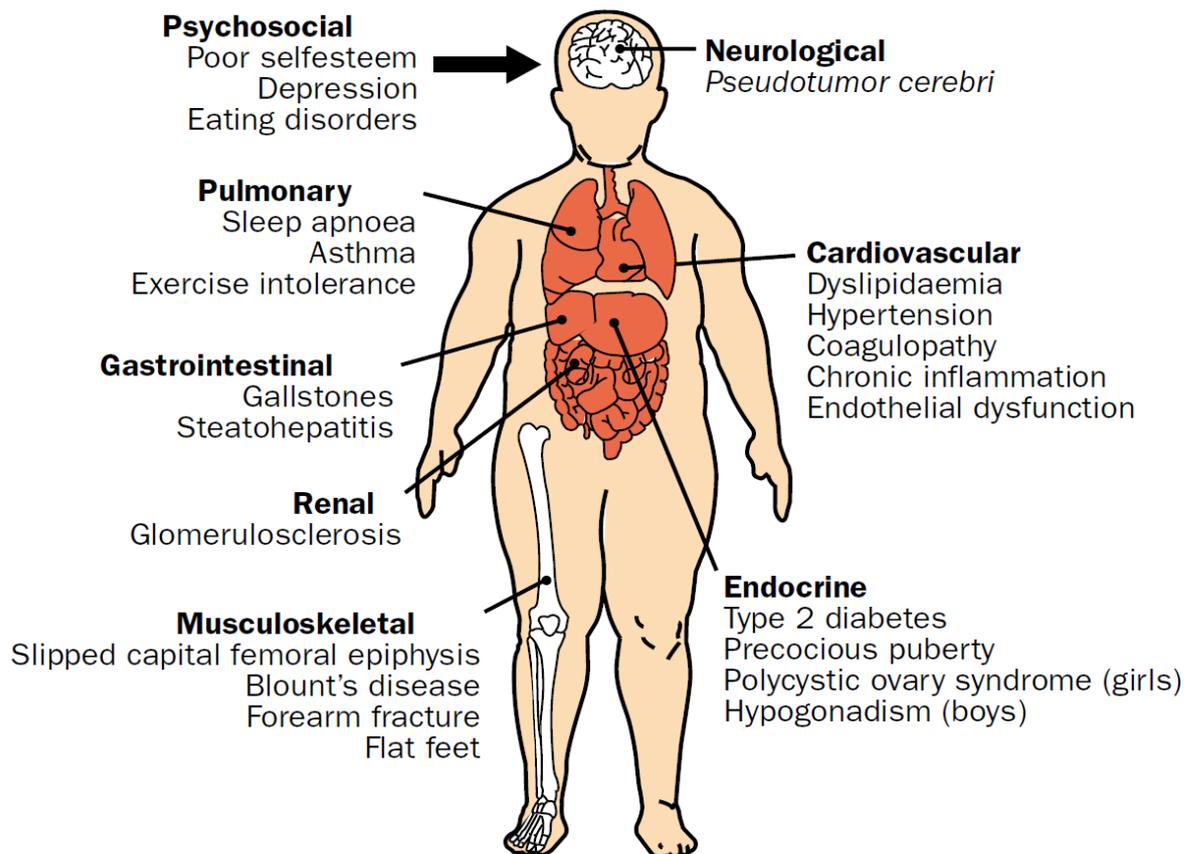
We also include an intervention scale to assist the decision makers in agreeing actions at Appendix 4.

Appendices

Appendix 1

Childhood overweight and obesity is a critical risk factor for a range of health and social consequences summarised

Figure 1: Health risks associated with childhood overweight and obesity
Ebbeling CB, Pawlak DB, Ludwig DS. Childhood obesity: public-health crisis, common sense cure. *Lancet* 2002;360:473-82.



Appendix 2 – Analysis Tool for Health Professionals – Addendum to NSCB1



**ANALYSIS TOOL: IMPACT OF OBESITY ON SAFEGUARDING
(Health Practitioner/Clinicians)**

Name Of Referrer							
Referrers agency							
Name of Child							
School/Other Education (please specify)							
General				Response			
Are the parents / carers aware of this referral?					YES	NO	
Are the parents likely to be receptive to support?					YES	NO	
Identifying Obesity				Response			
Has the child been formally diagnosed as Clinically Obese?					Yes	No	Not Known
Are you or your agency actively recording the child's weight and height?					YES		NO
If not please detail your concerns about the child's obesity?							
Is the child currently engaged with Children's Services?					Yes	No	Not Known
Is the child on a weight management plan?					Yes	No	Not Known
Has the child made any progress on the plan?					Yes	No	Not Known
Are there any other Child Safeguarding Concerns?					Yes	No	Not Known
Co-Morbidity Factors				Prognosis			
Are you aware of any co-morbidity factors?							
Asthma							
Sleep apnoea							
Joint problems							
Weight related injuries (Sprains, Breaks etc)							
Incontinence							
Skin conditions							
Diabetes							
Other (Please Specify)							
General Observations on Safeguarding Triggers					Comments and details		
Parents/carers lack capacity to engage	Y	N	Not Known				
Parents/carers unwilling to engage	Y	N	Not Known				
Concerns about Deceptive Compliance	Y	N	Not Known				
Parents/carers play one professional off against another.	Y	N	Not Known				
Child's outcomes are compromised by weight gain, e.g. social presentation/interaction with peers/educational attainment	Y	N	Not Known				
Concerns escalating over time (Specify time period)	Y	N	Not Known				

Appendix 3 – Analysis Tool for Non-Health Professionals – Addendum to NSCB1



ANALYSIS TOOL: IMPACT OF OBESITY ON SAFEGUARDING (Non-Health Professionals/Practitioners)

Name Of Referrer						
Referrers agency						
Name of Child						
School/Other Education (please specify)						
General				Response		
Are the parents / carers aware of this referral?				YES	NO	
Are the parents likely to be receptive to support?				YES	NO	
Identifying Obesity				Response		
Has the child been formally diagnosed as Clinically Obese?				Yes	No	Not Known
Are you or your agency actively recording the child's weight and height?				YES		NO
If not please detail your concerns about the child's obesity?						
Is the child currently engaged with Health Services in relation to their weight management?				Yes	No	Not Known
Is the child gaining weight and, if so, over what period?				Yes	No	Not Known
Are there any other Child Safeguarding Concerns?				Yes	No	Not Known
Co-Morbidity Factors				Comments on presentation		
Can you detail any co-morbidity factors?						
Asthma						
Sleep apnoea						
Joint problems						
Weight related injuries (Sprains, Breaks etc)						
Incontinence						
Skin conditions						
Diabetes						
Other (Please Specify)						
General Observations on Safeguarding Triggers					Comments and details	
Parents/carers lack capacity to engage	Y	N	Not Known			
Parents/carers unwilling to engage	Y	N	Not Known			
Concerns about Deceptive Compliance	Y	N	Not Known			
Parents/carers playing one professional off against another.	Y	N	Not Known			
Child's outcomes are compromised by weight gain, e.g. social presentation/interaction with peers/educational attainment	Y	N	Not Known			
Concerns escalating over time (Specify time period)	Y	N	Not Known			

Appendix 4 – Intervention Scale

Obesity Intervention Scale
Engagement & Early Help
<ul style="list-style-type: none"> • Parent / Carer engagement • Consents to communicate with GP • Share information on health, lifestyle and concerns between School, GP and Parents • Supported through the Healthy Child Programme, including health visitors and school nurses
Referral
Health Referral or Social Referral (School, Children’s Services etc)
Multi Agency Assessment (MASH)
<p>Referral from Health Professional</p> <ul style="list-style-type: none"> • What are the medical concerns? • What are the issues with lifestyle and care that are impacting on the child’s health? • What is the background to this (Multi Agency)? • Are School or Children’s Services engaged? • Is there a need for a co-ordinated approach to information sharing? • Is this single agency approach (Health) able to deliver improvements to the child’s overall health? <p>Referral from Social Perspective</p> <ul style="list-style-type: none"> • Background checks • Does this child appear to be socially disadvantaged • Could the physical impacts described amount to S.17 / S.47? • Is the referrer engaged with health? • What is the health perspective? – Is there one? Should there be one?
Action
<ul style="list-style-type: none"> • Key agency personnel need to be identified at the earliest stage • Live information sharing should be employed between the key people. Absences from school, GP visits, Parental comments etc must all be taken in context between agencies. • Medical Management - Consider agreeing a paediatrician to lead on medical matters. This will ensure that all health information from GP and other medical sources assessed holistically by one expert to be able to give the most accurate picture of harm in a potentially fast changing environment. For example, visits to GP outside of the Paediatric appointments. • School, Children’s Services, Dieticians, Health visitors etc to be identified to ensure that all facets of the child’s life are taken into account. • Risks of Social isolation, bullying etc • Is there a need for a S.47 Strat?