Trafford Strategic Safeguarding Partnership

GREATER MANCHESTER POLICE

NHS
Trafford
Clinical Commissioning Group

TRAFFORD COUNCIL

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Contents

Introduction

This is a multi-agency policy to support professionals when working with children and young people when it is considered that a child's obesity may be related to neglect.

Please note that this policy is to be read with reference to the TSSP Threshold of Need and TSSP Neglect Toolkit.

The management of obesity is complex and challenging. Obesity in childhood is a significant public health issue. 34% of children measured at year 6 were either overweight or obese in England in 2016. Obesity is the greatest risk factor for Type 2 diabetes and the rates for Type 2 diabetes have risen significantly over the last decade. Obesity is also a risk factor for cardiovascular disease and cancer.

Body mass index (BMI) is the recommended method to assess the weight status of children aged 2 years or more. The following categories are used:

BMI ≥ 2nd centile < 91st centile	healthy weight
BMI > 91st centile	Overweight
BMI > 98th centile	obese (very overweight)
BMI > 99.6th centile	severely obese
BMI > +3.33 SD	morbidly obese

There is no agreed definition of obesity for children under the age of 2. Health professionals need to make an assessment based on length and weight centiles.

The World Health Organisation recognises obesity as a disease. The root causes of obesity are complex and obesity remains difficult for professionals to treat once established. Obesity is caused generally by a long term positive energy balance related to changes to modern diets and a reduction in the level of activity.

The National Institute for Health and Care Excellence (NICE) produced guidance in 2014 (NICE Guidelines[1]) and an updated population-level approach to prevention in 2015 (NICE Prevention Information[2]).

Weight management is an emotive issue and many families struggle to maintain a healthy diet and take the recommended amount of physical activity. This is on a background of a modern lifestyle with diets high in processed food and sugar, availability of sugary drinks, food advertising and sedentary activities resulting in reduced 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. The Trafford Healthy Weight Pathway has been developed to detail the assessment and

[1] Obesity: identification, assessment and management https://www.nice.org.uk/guidance/cg189/chapter/1-recommendations
[2] Obesity prevention https://www.nice.org.uk/guidance/CG43

management of children where overweight and obesity has been raised as an issue. (See also Appendix 5 - Obesity Guidelines).

However, professionals working with obese children should be mindful of the possible role of abuse or neglect in contributing to obesity. When assessing such children, a comprehensive picture of the child's functioning from a health, psychological, and educational perspective is necessary and older children and adolescents should be offered the chance to talk apart from their parents to explore their understanding of their weight issues (Framework for practice). This should be as for any clinical condition which is having a significant impact on health and wellbeing of a child.

The child and 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. 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.

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, depression, and may lead to disordered eating.

Obese children are more often ill, experience more day-to-day health issues (e.g. breathlessness, discomfort, fatigue), have greater school absence, healthcare attendances and hospital admissions. Obesity in childhood is often the harbinger of adult obesity. 79% of adolescents who are obese are likely to remain obese as adults. Being overweight or obese in childhood has both short-term and longer-term consequences for health, with greatly increased risks of disability, chronic ill-health and premature death. Moreover, once severe, obesity is very difficult to treat effectively. Obesity can be a result of an eating disorder that requires management through child and adolescent mental health services.

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

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 and whilst a medical condition may be an additional challenge it should be considered in the context of the parent's engagement. The dual diagnosis of obesity and another health condition may place additional strains on 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 and it is imperative to use professional judgement when considering these cases.

Legal Framework, 1989 Children Act

Where there is clear medical advice that the child is likely to suffer or is suffering significant harm as a result of 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 evidence that the child is unlikely to achieve/maintain a reasonable standard of health/wellbeing, 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.

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, to recognise where escalation is appropriate and to guard against case drift.

When does obesity become a safeguarding issue?

Childhood obesity alone is not a safeguarding concern. The causes of obesity are so complex that obesity in a child does not mean the parents or carers have been neglectful. However, the possible role of neglect and abuse in contributing to obesity should be considered. Older children and young people should be offered the chance to talk away from their parents or carers to explore their understanding of their weight issues. Childhood obesity is challenging to treat, particularly in older children and young people. Even when families and carers have a high level of commitment to weight management they may struggle to bring about a positive change to weight status.

Childhood obesity can become a child protection concern if parents fail to provide their child adequate treatment or when parents behave in a way that actively promotes treatment failure, as with any chronic illness in a child. Russell Viner in an article published in the British Medical Journal (21.8.10, Volume 341) proposed a framework for practice.

Parental behaviours of concern include:

- Consistently failing to attend appointments;
- Refusing to engage with various professionals or with weight management initiatives; or
- Actively not follow 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 therefore 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 multi-agency collaborative assessment, including psychology or other mental health assessment. If concerns are expressed, a multi-agency meeting is appropriate.

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. Admission to hospital or another 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 needs to be evaluated carefully and although on its own is not evidence of neglect or abuse does indicate the potential for the child to be able to avoid gaining weight.

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.
- Child continues to become more overweight (BMI increasing upwards through centiles)

Unwilling to engage

- Not attending appointments.
- Transient or intermittent engagement.
- 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 on going significant health risks to their child if they continue to become more obese.
- Actively frustrating efforts of professionals or child to work towards weight management.
- Oppositional behaviour: parents/carers unable/unwilling to set and maintain boundaries with child to manage lifestyle changes and allow further weight gain.

Disguised 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 wellbeing.
- 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 prepared to challenge both parents and other practitioners working with the child/family.

Measuring progress with weight management

Assessing progress with weight management should not be based purely on BMI/weight change as this could promote inappropriate dieting rather than the evidence based lifestyle approach. Weight and BMI change need to be part of the assessment, however, the support given to the child by parents to make lifestyle changes is as important as this will promote longer term weight management.

Whether a child needs to lose weight or limit weight gain as they grow in height will depend on the level of obesity and the child's age. Health services should advise on the appropriate outcomes expected from weight management programmes. If a child is found to have disordered eating or an eating disorder, weight change may not be an initial outcome to treatment but rather establishing a more normal relationship with food.

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
- Poor dental health
- 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 TSSP and individual organisations where there are safeguarding concerns identified

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 business. 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 lifestyle. It is important that the paediatrician ensures health provision is well co-ordinated and there is good communication between those involved.

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 or a representative should aim to 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 on-going 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. Please see Appendix 9

Other health professionals

All other health professionals who are involved in caring for a child should be mindful of the differences 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 a health professional recognises 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 continue monitor the situation, how weight 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 FIRST RESPONSE should be made. 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 wellbeing 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.

Children's Social Care

Social workers – including frontline staff, their managers, and conference chairs – with caseloads 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/drinks.

Independent Reviewing Officers working with Children in Care 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 but cases that feature potential harm that is directly attributable to wilful acts or omissions by the parent or carer will be cases they wish to consider. In any event the police involvement will be 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.

- The child is obese and they are continuing to become more obese OR is not meeting outcomes in line with a realistic and achievable health plan; and
- Paediatric examination shows that this is leading to co-morbidity factors (other medical factors as a direct result of the obesity); and
- The parents or carers are aware of the risks and have the capacity and capability to engage in their child's treatment; and

- They are frustrating, or unnecessarily failing to engage in, a coordinated plan to improve the child's health; and
- The child is likely to be caused unnecessary suffering or injury to health.

It will be important to be able to distinguish 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. Prader-Willi 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. It is likely that professionals will have attempted to engage families over a period of time.

All referrals should go through the Trafford Children's First Response Team, using the appropriate referral form, with the parents'/carers consent unless there are significant safeguarding concerns (see above and refer to the TSSP Levels of Need Guidance).

Any professional considering referring a child where the safeguarding concerns are linked to obesity should consider the contents of this policy (especially safeguarding indicators and triggers) and refer to the Threshold Guidance before making the referral.

To aid professionals in making this decision an analysis tool has been developed and is attached: see **Appendix 2 for Health Care Professionals/Clinicians and Appendix 3 provides guidance on how to use the analysis tool**, all other children's workforce staff should refer to **Appendix 4.**

This information should be included as an addendum to the FIRST RESPONSE referral and/or the contents included on the referral form.

Resolving professional disagreement

Effective working together depends on resolving disagreements to the satisfaction of workers and agencies, and a belief in a genuine partnership and joint working to safeguard children. Agencies should work to the principle of restoring relationships and disagreements at the lowest possible level so that each agency is satisfied both that their concerns have been listened to and with the outcome for children and families

Within Trafford we utilise professional thinking time to support such discussions….

Trafford works in partnership across Greater Manchester to produce the Greater Manchester Safeguarding Children Procedures Manual in which Resolving Professional Disagreements/ Escalation Policy can be reviewed to support further discussions.

Appendix 1

Effects of childhood obesity

Childhood overweight and obesity has both immediate and long-term health outcomes. Increasingly, obese children are being diagnosed with a range of health conditions previously seen almost exclusively among adults. Childhood unhealthy weights may result in serious medical problems in childhood such as:

- type 2 diabetes
- high blood pressure and elevated blood cholesterol
- liver disease
- bone and joint problems
- respiratory problems such as asthma
- sleep disorders such as difficulty breathing while asleep (sleep apnoea)
- earlier than normal puberty or menstruation
- eating disorders such as anorexia or bulimia
- skin infections due to moisture from sweat being trapped in skin folds
- fatigue

Overweight or obesity in childhood can also result in serious psychological difficulties. Overweight or obese children:

- are more likely to be teased and bullied
- are more likely to bully others
- may have poor self-esteem and may feel socially isolated
- may be at increased risk for depression
- may have poorer social skills
- may have high stress and anxiety
- may have behaviour and/or learning problems as a result of psychological difficulties related to childhood obesity

Unfortunately most obese children and youth do not outgrow their weight problem. In fact, most people continue to gain weight as they age. Obesity in adulthood leads to:

- high blood pressure
- strokes
- certain types of cancer (endometrial, breast and colon among others)
- heart disease
- liver disease
- type 2 diabetes
- dementia

Appendix 2

Safeguarding Analysis Tool in the Context of Obesity (for health practitioners and clinicians):

Name:	**OBESITY ANALYSIS TOOL**	Date:
Date Of Birth:	***Always consider the potential of neglect when assessing obesity and refer to Graded Care Profile 2 (GCP2)***	School:
NHS NO:		

	Yes	**No**	**Comments**
Is the child currently engaged with Children's Services or any other Services (e.g. School, HV, GP, CAMHS, Early Help, CWMS etc.)			
Is the child obese (on or above 98th centile)? *Attach centile chart to show BMI trajectory if weight history known*			
Has the family had weight management support including a weight management plan?			
Has the family made any progress with weight management for the child?			
Are there any other Child Safeguarding Concerns? (incl. other indicators of abuse/neglect)			
Has a medical professional informed the family of the significance of their child's weight and the health risks involved?			
Do parents/carers understand the concerns around their child's weight?			
Are parents/carers willing to engage?			
Does the child have any concerns about their weight?			
Is the child willing to engage?			
Are there concerns of 'Disguised Compliance'?			
Are the concerns escalating over time?			
Are there concerns about the child's food intake and activity level, e.g. Poor Quality Consideration of meal times Portion sizes Sedentary behaviour/ screen time			

BMI = $\frac{\text{weight}}{\text{Height}^2}$
(weight in kg/ height in cm)
Centile =

What is the impact of obesity on the child's health and wellbeing
(10 appropriate lifestyle and 0 severely impacted & will lead to serious harm or death)- please circle

10
9
8
7
6
5
4
3
2
1
0

Are parents modelling healthy behaviours as part of a family approach?				

Child Health Factors	Comments
PHYSICAL PROBLEMS conditions…….. ☐ Joint pain/problems ☐ Fatigue, exhaustion ☐ Difficulties with self-care/ dress ☐ Hygiene ☐ Appearance/ ill-fitting clothes ☐ Unable to walk to and from school ☐ Enuresis / incontinence ☐ Constipation/ diarrhoea ☐ Shortness of breath ☐ Sleep apnoea / snoring ☐ Type II Diabetes ☐ Asthma ☐ Raised BP ☐ Raised Cholesterol ☐ Is there a diagnosis of any health ☐ Is the child on any medication **EMOTIONAL PROBLEMS** ☐ Low self-esteem ☐ Loneliness or isolation ☐ Sadness or depression ☐ Worry, fear or anxiety ☐ Feelings of insecurity ☐ Anger or frustration ☐ Teasing/bullying/social discrimination ☐ Reclusive/ uncomfortable to go out ☐ Trigger (bereavement, accident, separation)	
Parent and Family Factors	
☐ Absence of meal routines/ meals unplanned ☐ Are parents or siblings obese or overweight? ☐ Are parents/carers unsure of what child is eating ☐ Has a whole family approach been considered? ☐ Does child go to bed after parents/carers ☐ Are they receiving DLA for this child ☐ Does the parent see any of the above as a problem? ☐ Is the child LAC /CPP/CIN …… ☐ Does parent agree child is overweight? ☐ Social Worker…….……..	

☐ Does parent enable child to attend health appointments ☐ Does parent accept health advice? and comply with treatment?	

What are we worried about?	Worry Statement	What needs to happen now and timescales	What would we want the outcome to look like?

Evidence of Child's wishes and feelings (include the child's view of their weight):

Staff name and Role: **Contact details (email/number):**	Date:

Next Steps:

Refer to Trafford's Level of Need Document to determine the most proportionate level of support.

Appendix 3:

Safeguarding Analysis Tool in the Context of Obesity

OBESITY ANALYSIS TOOL– How to use the Tool

The aim of this tool is to support practitioners to develop a holistic assessment of a child where obesity is identified as a significant concern.

Introduction and Context

In the context of obesity as a safeguarding concern the following need to be considered

- For some children, their obesity is one aspect of widespread concerns about neglect
- For other children obesity maybe an indicator and response to abuse and neglect
- For some children, obesity maybe the presenting factor that alert professionals to safeguarding concerns and neglect of children

This tool focuses on how the obesity affects the child's health and wellbeing. There will be other factors that will impact and so an assessment to identify all aspects of the child health and emotional wellbeing is essential to determine the level of safeguarding and if the threshold is met that the child is at risk of significant harm or at risk of suffering harm.

Guidance in using this tool

- This tool is to be used on any child on or above the 98th centile.
  It can also be used with any overweight child (above the 91st centile) at the discretion of the health professional.

- The tool should be completed with the consent and involvement of parents/carers and the young person where appropriate. However if attempts have been made to engage the family and are unsuccessful, the risk of significant harm should be considered. The tool can then be used to clarify safeguarding concerns and inform management and safeguarding plan without family involvement.

- By completing the whole tool it will evidence the level of concern and determine the impact of the obesity on the child by identifying all the indicators.

- There is an expectation that all the questions will have been asked and where the box has not been ticked this would imply that this is not an issue therefore does not apply to the child. However – there is the option to add additional comments relating to the child health factors as necessary.

- The tool should be completed from conversation with the young person, parents/carers, multi-agency information sharing (school, GP, Child Weight Management Service (CWMS) & paediatrician etc.) and a review of the child health records.

- On completion the health professional will need to make a weight management assessment and plan on to how to manage the case going forward.

- Following the completion of the tool the health professional will be able to complete the danger scoring through assessment of child health and parental family factors.

- The scoring will be between 0-10 on 'What is the impact of obesity on the child's health and wellbeing?' The same principles apply in scoring following the Signs of Safety model, with a score of 10 would imply appropriate lifestyle down to a score of 0 implying the severely impacted & will lead to serious harm or death.

- Danger statement should be specific to each child, clearly identifying the risk from the completed Obesity Analysis Tool. The severity of physical and emotional problems identified will help identify the risk of significant harm or if interventions can be put in place at an earlier level.

The following page provides a series of prompts to promote enquiry when using the tool, alongside suggested services to refer to for support.

Page 1	Prompts to promote enquiry and services to refer to for support
Is the child currently engaged with Children's Services or any other Services (e.g. School, HV, GP, CAMHS, Early Help etc.)	• Any other health needs – hearing, vision, podiatry, physio, occupational therapy etc. • Any professionals or community services involved such as Youth workers, groups through mosque/church/synagogue. • Children's Services - Early Help/ allocated social worker.
Is the child obese (on or above 98th centile)? *Attach centile chart to show BMI trajectory if weight history known*	• If no up to date, centile chart in records complete with measurements available in records • Use RCPCH centile charts only: https://www.rcpch.ac.uk/sites/default/files/2018-03/boys_and_girls_bmi_chart.pdf
Has the family had weight management support including a weight management plan?	• Professional or service worked with, when and duration. • Resources used. • Advice given.
Has the family made any progress with weight management for the child?	• Look at past results include if lost and regained.
Are there any other Child Safeguarding Concerns? (incl. other indicators of abuse/neglect)	• Domestic Violence • Lack of school attendance • Non-attendance of health appointments. • History of input with Children's Services. • Non-compliance with health advice • Discussion at supervision.
Has a medical professional informed the family of the significance of their child's weight and the health risks involved?	• If family informed – who by (GP, school nurse, CWMS, other HCP). • If answer no inform family of health risks. • Include reaction of family.
Do parents/carers understand the concerns around their child's weight?	• Ask what their concerns are? • Ask them to tell you what their child is at risk of.
Are parents/carers willing to engage?	• Discuss how can engage- attend appointments/sessions/meetings. • Completion of food/ activity diaries. • Evidence of any advice followed.
Does the child have any concerns about their weight?	• Ask them what their concerns are. • Ask them to tell you what they are at risk of.
Is the child willing to engage?	• Discuss how can engage - attend appointments/ sessions/meetings. • Completion of food/ activity diaries. • Evidence of any advice followed.
Are there concerns of 'Disguised Compliance'?	• Have appointments been attended but no changes noted? • Is there evidence of parents/child reporting following advice but observed not to be?
Are the concerns escalating over time?	• Include information from records/ services/ other professionals e.g. education/ social care/ medical staff

Page 2 - PHYSICAL PROBLEMS	Prompts to promote enquiry and services to refer to for support
Joint pain/problems Fatigue, exhaustion Not participating in PE Unable to walk to and from school Difficulties with self-care/dress Hygiene Appearance/ill-fitting clothes Enuresis / incontinence Constipation/diarrhoea Shortness of breath Asthma Sleep apnoea / snoring	• Note observations of child- e.g. difficulty in standing up from floor/ rubbing of joints/ mobility issues/appears tired/smell – may need referral to GP/physio/podiatry/continence team. • Observations about body language. • Ask about medication - some do have side effects of weight gain. Record medication and dose. • Have they been reviewed by community paeds/endocrinology if severely obese – if not may need referral. • Check with school for concerns, e.g. participation in PE, appearance at school • Consider consultation with relevant medical specialists to identify short and long term health implication of diagnosis and current engagement with treatment • Consider severity of physical problem and the impact of risk of harm on the child's on health and wellbeing. See Appendix 1
EMOTIONAL PROBLEMS	**Prompts to promote enquiry and services to refer to for support**
Low self-esteem Loneliness or isolation Sadness or depression Worry, fear or anxiety Feelings of insecurity Anger or frustration Teasing/bullying/social discrimination Reclusive/ uncomfortable to go out Trigger (bereavement, accident, separation)	• Observations about body language. • Check with school for concerns, e.g. participation in PE, bullying, absences. • Always ask 'how do you feel about self/ school/ weight/ friendships?' • Can also use Strengths and Difficulties Questionnaire to assess emotional health. • May need referral to GP/ CAMHS referral/ school counsellor.
PARENTING	**Prompts to promote enquiry and services to refer to for support**
Absence of meal routines/ meals unplanned Are parents/carers unsure of what child is eating Does child go to bed after parents/carers Does the parent see any of the above as a problem? Does parent agree child is overweight? Does parent enable child to attend health appointments & comply with treatment? Does parent accept health advice? Are parents or siblings obese or overweight? Has a whole family approach been considered? Are they receiving DLA for this child	• Consider using a Culturagram (School Health Shared Drive) to initiate a discussion of health beliefs, attitudes to professionals and attitude to family relationships. • Consider referral to Early Help Parenting Courses or School-led Parenting Courses, Family Support Worker at School • Consider wider indicators of neglect – if present consider use of Graded Care Profile 2

From completion of the tool you should be able to answer the following questions:

Is there consistent failure on the part of parent to change lifestyle and address concerns regarding pattern of behaviour underpinning obesity
Is there a lack of acceptance of professional advice
Is there complete parental inability to take reasonability for their part in the problem and willingness to create change?
Does the parent blame the child completely for the problem and is negative and denigrating of the child?
Is there a lack of attendance of appointments or poor compliance with treatment regimes?
Are there any existence of co-morbidity factors (such as asthma, sleep apnoea, joint problems)

Answers to the above questions will inform you're scoring in identifying if the child's outcomes are being compromised by obesity
Consider also **'Have these concerns been escalating over time?'**

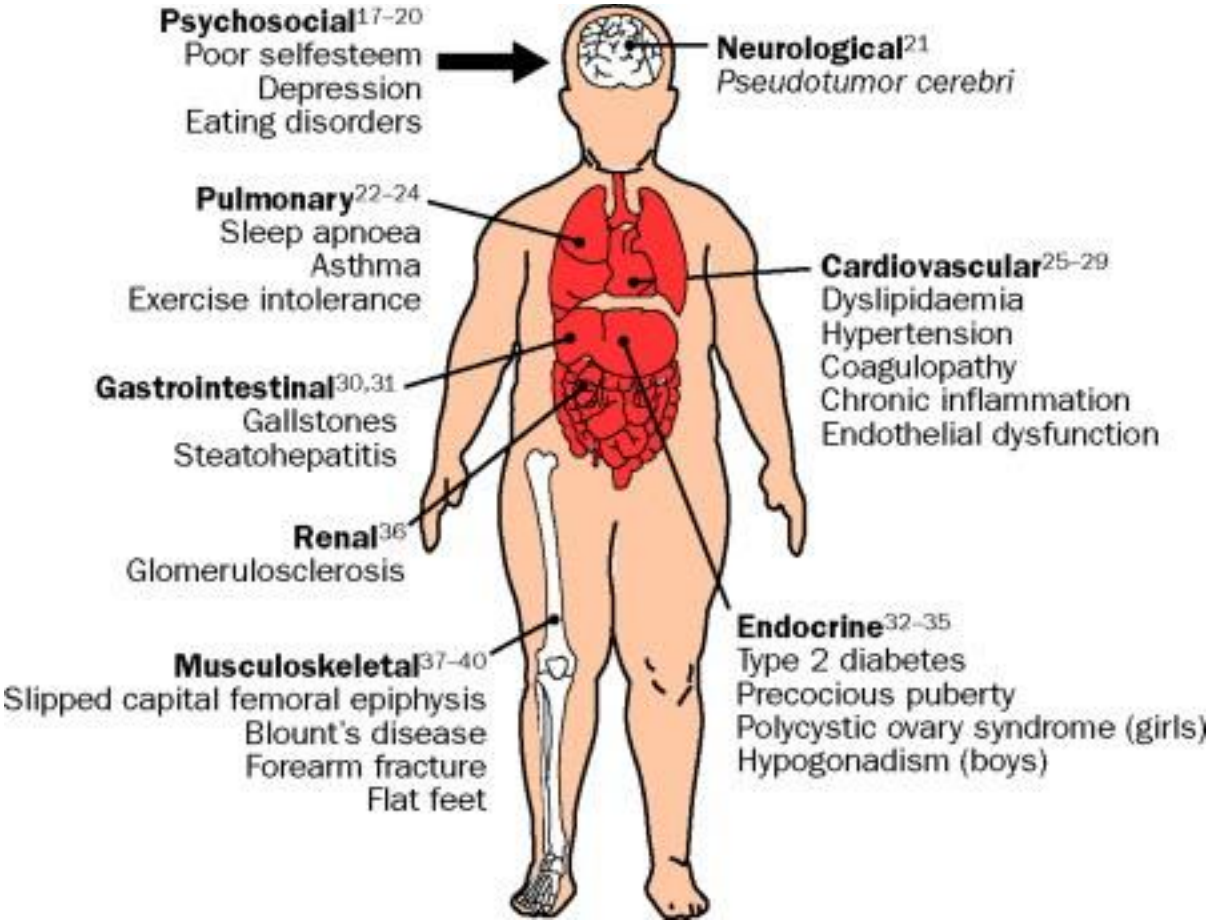
References;

- Manchester Safeguarding Board Serious Case Review Child F1 SCR (published May 2018) available at https://www.manchestersafeguardingboards.co.uk/resource/serious-case-reviews/

- Norfolk Safeguarding Board Safeguarding Response to Obesity when Neglect is an Issue available at Safeguarding Response to Obesity when Neglect is an Issue https://www.norfolklscb.org/wp-content/uploads/2015/04/Safeguarding-Response-to-Obesity-when-Neglect-is-an-Issue-Guidance.pdf

- Viner, R. M., Roche, E., Maguire, S. A., & Nicholls, D. E. (2010). Childhood protection and obesity: Framework for practice. British Medical Journal (BMJ), 341(c3074), 375-377 https://orca.cf.ac.uk/27859/1/Viner%202010.pdf

Complications of Childhood Obesity



Ebbeling, C. B., Pawlak, D. B. & Ludwig, D. S. (2002). Childhood obesity: public-health crisis, common sense cure. The Lancet, 9331, 473-482

Appendix 4

Safeguarding Analysis tool in the Context of Obesity (for non-health professionals/practitioners):

Name:	**OBESITY ANALYSIS TOOL**	Date:
Date Of Birth:	***Always consider the potential of neglect when assessing obesity and refer to Graded Care Profile 2 (GCP2)***	School:
NHS NO:		

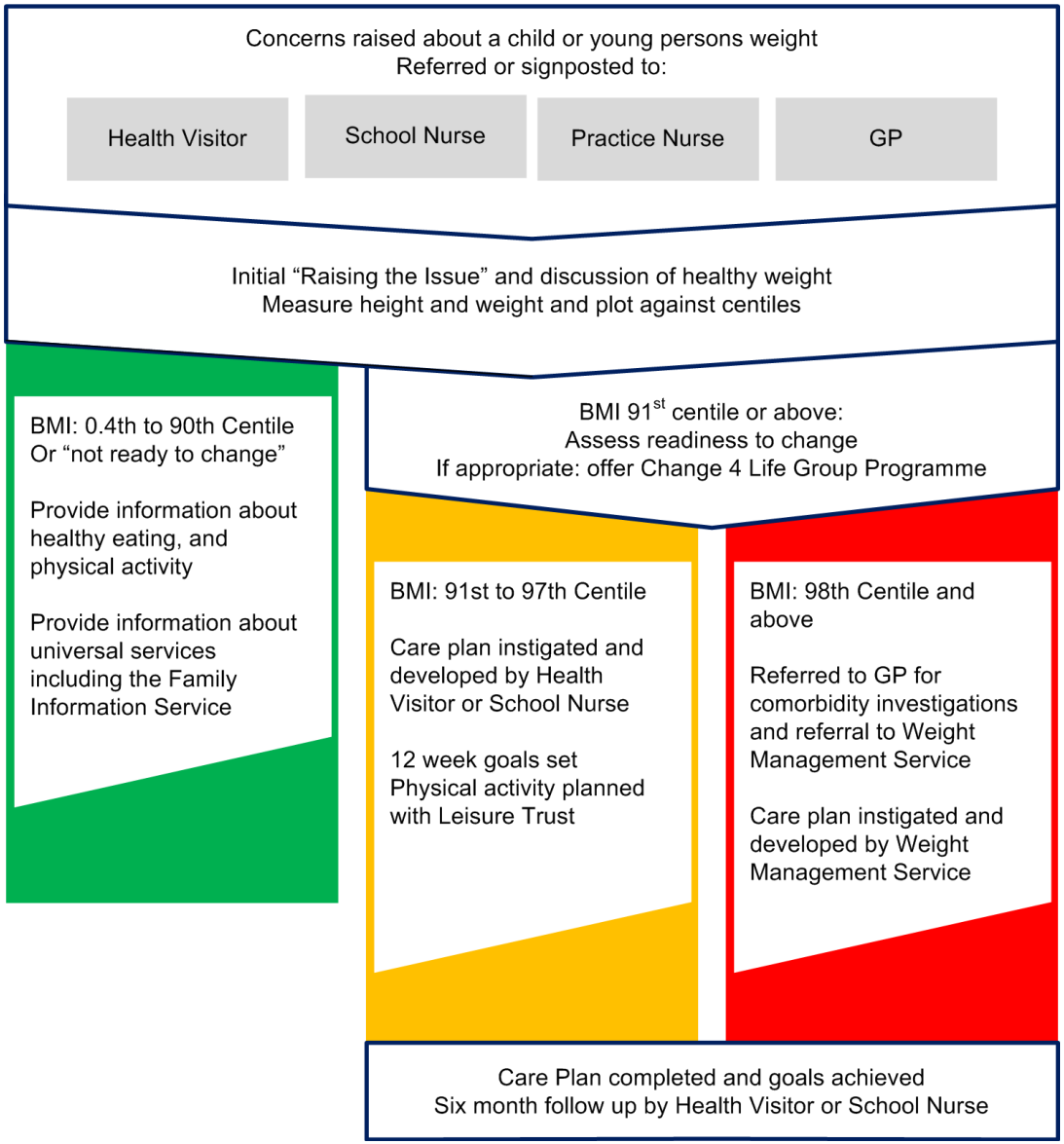
	Yes	No	Comments
Is the child currently engaged with Children's Services or any other Services (e.g. School, HV, GP, CAMHS, Early Help,CWMS etc.)			
Is the child obese (on or above 98th centile)? *Attach centile chart to show BMI trajectory if weight history known*			
Has the family had weight management support including a weight management plan?			
Has the family made any progress with weight management for the child?			
Are there any other Child Safeguarding Concerns? (incl. other indicators of abuse/neglect)			
Has a medical professional informed the family of the significance of their child's weight and the health risks involved?			
Do parents/carers understand the concerns around their child's weight?			
Are parents/carers willing to engage?			
Does the child have any concerns about their weight?			
Is the child willing to engage?			
Are there concerns of 'Disguised Compliance'?			
Are the concerns escalating over time?			
Are there concerns about the child's food intake and activity level, e.g. Poor Quality Consideration of meal times Portion sizes Sedentary behaviour/ screen time			

Are parents modelling healthy behaviours as part of a family approach?			
Child Health Factors			**Comments**
PHYSICAL PROBLEMS ☐ Is there a diagnosis of any health conditions…….. ☐ Joint pain/problems ☐ Is the child on any medication ☐ Fatigue, exhaustion ☐ Difficulties with self-care/ dress **EMOTIONAL PROBLEMS** ☐ Hygiene ☐ Low self-esteem ☐ Appearance/ ill-fitting clothes ☐ Loneliness or isolation ☐ Unable to walk to and from school ☐ Sadness or depression ☐ Enuresis / incontinence ☐ Worry, fear or anxiety ☐ Constipation/ diarrhoea ☐ Feelings of insecurity ☐ Shortness of breath ☐ Anger or frustration ☐ Sleep apnoea / snoring ☐ Teasing/bullying/social discrimination ☐ Type II Diabetes ☐ Reclusive/ uncomfortable to go out ☐ Asthma ☐ Trigger (bereavement, accident, separation) ☐ Raised BP ☐ Raised Cholesterol			
Parent and Family Factors			
☐ Absence of meal routines/ meals unplanned ☐ Are parents or siblings obese or overweight? ☐ Are parents/carers unsure of what child is eating ☐ Has a whole family approach been considered? ☐ Does child go to bed after parents/carers ☐ Are they receiving DLA for this child ☐ Does the parent see any of the above as a problem? ☐ Is the child LAC /CPP/CIN …… ☐ Does parent agree child is overweight? ☐ Social Worker……..…….. ☐ Does parent enable child to attend health appointments and comply with ☐ Does parent accept health advice? treatment?			

What are we worried about?	Worry Statement	What needs to happen now and timescales	What would we want the outcome to look like?
Evidence of Child's wishes and feelings (include the child's view of their weight/obesity):			
Staff name and Role: Contact details (email/number):			Date:
Next Steps: Refer to Trafford's Level of Need Document to determine the most proportionate level of support.			

Appendix 5

Trafford Healthy Weight Pathway and Children's Weight Management Service (CWMS)



Appendix 6

Obesity - Guideline for the Identification and Management in Children and Young People in Trafford for Health Practitioners

Introduction

Overweight and obesity are an increasing health and social problem in childhood

It is likely that obesity in childhood is associated with later cardiovascular risk although the evidence for this is poor quality and contradictory

Quality evidence on effective management strategies is scarce

Early onset obesity (pre-school) is a concern for a number of reasons

The most important management strategy in controlling weight is affecting change of behaviour of both the child and the family

Other psychosocial morbidities (eg self harm, low self esteem and substance misuse) are associated with obesity in young people

1.2 Purpose of the Guideline

The aim of this guideline is to help clinicians working in secondary paediatric care and community settings:

Identify overweight and obese children

Make an assessment of the likelihood of secondary obesity and current cardiovascular risk factors

Initiate behaviour change

Identify children and young people who require specialist care

This guideline will form part of the Trafford Healthy Weight Pathway and Children's Weight Management Service (CWMS) (Appendix 5).

1.3 Identifying Obese and Overweight Children

Not all children who attend hospital/community clinics (for non-weight reasons) have their BMI calculated.

All children with a weight centile which is two or more centile above their height centile should have their BMI calculated and their centile plotted

All children with a weight on the 98th centile or above should have their BMI calculated and centile plotted

Check that the child looks obese (as opposed to increased lean mass)

Pay more attention to children with abdominal adiposity and rapid weight gain in infants and toddlers

Body Mass Index

Body Mass Index (BMI) is currently the most appropriate measure of adiposity in children.

BMI is calculated by dividing the weight (kg) by height squared (m^2) [weight (kg)/ height (m^2)]. However, calculated BMI values need to be compared with age and sex reference standards due to BMI changes that occur in normal growth.

You can use an online BMI Calculator

It should then be plotted on an appropriate BMI Centile Chart.

Overweight: Overweight is defined as a BMI greater than the ≥91st percentile.

Obesity: Obesity is defined as a BMI greater than the ≥98th percentile.

1.4 History and Examination

Plot the "obesity trajectory"	Consequences of obesity	Family Risk Profile
Birth weight Early feeding history Whether onset of obesity was sudden or gradual and age of onset of obesity Whether progression of obesity was gradual or rapid Whether there have been any periods of very rapid weight gain, particularly recently	**Medical** Slipped Upper Femoral Epiphysis Exercise tolerance/asthma Snoring and symptoms of obstructive sleep apnoea Skin problems eg genital or axillary candidiasis, acanthosis nigricans	To place the child in the appropriate risk category it is useful to ask about family history (in first and second generations) of components of the insulin resistance syndrome (IRS), e.g.: 1. Extreme obesity 2. Type 2 diabetes 3. Hypertension 4. Dyslipidaemia 5. Polycystic ovarian syndrome (PCOS)

Whether there have been any periods of weight loss (and why and how) Who else in the family is obese or has trouble controlling their weight	Features of insulin resistance eg acanthosis nigricans; hirsuitism, acne and irregular periods (PCOS) in girls; type 2 diabetes **Psychological** Adolescent HEADSSS assessment (Appendix1) Self esteem/image Bullying School problems/refusal	6. Early cardiovascular disease (defined as relatives who developed cardiovascular disease in the fifties or earlier) 7. Ethnicity

Examination

Distribution of fat

For example, whether generalised or abdominal or other pattern. The presence or absence of the "buffalo hump" is a poor sign of Cushing's syndrome, as a prominent nuchal fat pad is common in simple obesity

Acanthosis nigricans

Acanthosis nigricans, the presence of velvety thickening of the skin around the neck and in skin creases, is suggestive of hyperinsulinism but is neither sensitive or specific

Accurate blood pressure

Using an appropriate size cuff (two readings, lying and sitting) – see hypertension guideline for age appropriate blood pressure values

Pubertal and growth assessment

Those obese before 2 years are tall for age. Many obese girls develop early in puberty. Pubertal and growth assessment is particularly important to assess whether weight maintenance (i.e. growing into their weight) is a viable option for treatment

Signs of hypothyroidism

Short stature, goitre, yellowish skin, dry skin and hair

Signs of Cushing's syndrome or polycystic ovarian syndrome (PCOS)

Glucocorticoid and androgen excess in Cushing's syndrome produce striae, acne, telangiectasia, hirsutism, and virilisation. The androgen excess in polycystic ovarian syndrome (PCOS) in girls produces hirsutism and acne. However, striae are almost universal in obese children and adolescence and we have not found that the distribution or colour of the striae can help distinguish between the extremely common simple obesity and the extremely rare Cushing's syndrome. Obesity by itself is practically never the presenting sign of Cushing's syndrome. Children with Cushing's will have reduced height velocity.

Signs of genetic obesity syndromes

For example, Prader Willi, Bardet Biedl, leptin deficiency, melanocortin 4 receptor (MC4R) deficiency and other monogenic forms of obesity. Monogenic forms of obesity remain a very rare cause of obesity in the general population, although such syndrome should be considered in those who have very early onset of extreme obesity.

1.5 Addressing the Issue

The issue of obesity as an important health concern is often not addressed in the clinical setting. Once you have noted that the child is overweight/obese you may address the issue using the following approach

Do no harm! Approach with respect but address the issue!

Assess child and parent's perceptions of the issue - do they even see it as a concern? - do they have differing awareness/concerns?

Highlight the issue of weight in the context of health - show the growth chart to the family and explain what the healthiest weight for their child would be; explain they are still growing in height, so probably do not need to actually lose weight they need to grow into their weight

Ask what they think they could do and possibly suggest some behaviour change ideas (see below)

Parental Perception

We know that approx 50% of parents of obese children do not perceive that their child is overweight. It is therefore useful to gauge their opinion and experience of this issue as this can shape the ensuing discussion eg 'What do you think about Sarah's weight?'

They (and she!) may respond that they are aware and concerned about the issue. This is when you can discuss specific behaviour changes (see below) and arrange referral.

They may instead state that they think her growth is fine. Then your goal is to raise their awareness of the health issues, not necessarily to solve the problem!

Frame discussion of overweight in terms of health -talk about 'the healthiest weight for Sarah'.

You could respond:

'Let's take a look at where Sarah should be on the weight for height chart and I can explain why I am concerned. At 5, Sarah is the weight of an average 8 yr old. This has implications for her future health. We need to slow the rate at which Sarah is putting on weight, and help her grow into her weight'

1.6 Behaviour Change

Some behaviour change ideas you can discuss with families in clinic:

Physical activity

Any increase in activity is an improvement but recommendations are at least 60 mins of moderate – vigorous activity/ day. Activity can be in 1 session or several lasting ≥ 10 mins. Overweight children may need to do > 60 mins a day

Aim for 'lifestyle' exercise: using the stairs, walking or cycling to school, walking the dog

Involve the whole family (everyone can benefit regardless of weight status) e.g. going to the park, swimming

Use after school time to get outdoors and be active

Encourage participation in sports & exercise opportunities at school

Have bikes, helmets and balls ready to go by the door!

Decrease sedentary behaviour e.g. screen based activities (TV, Computer, video games)

It is recommended to reduce to < 2 hrs/d on average or equivalent of 14 hrs/ wk

Nutrition - and don't forget drinks!

Importance of breakfast, regular meals and healthy snacks, in a sociable environment with no distractions

Parents should eat with children & all members eat the same foods

Separate eating from other activities such as watching TV or doing schoolwork

Offer a healthy balance from the food groups as shown in the eat-well plate. This can include one small portion from the fatty/sugary food group each day.

Encourage the child to listen to internal hunger cues and to eat to appetite. Eat slowly so you can register fullness in time

Serving sizes (does the 5 yr old get served as much as Mum or Dad?)

Instead of offering food as a reward, try alternatives e.g. stickers, going to the cinema, new book or toy, or having a friend to stay overnight

Comfort with attention, listening and hugs instead of food

Keep foods that the child should be avoiding out of the house e.g. crisps, sweets

Avoid classifying foods as good or bad

The approach a parent takes to a child's behaviour should always be consistent

Water is the best drink: cut out squash, fizzy drinks. Fruit juice can be drunk once a day with a meal and is ideally diluted 50:50 with water.

Semi skimmed milk is preferred for children over 2 years of age

Basic food label reading and awareness of the 'traps' ie 'no fat' might mean large amounts of sugar and therefore the same number of calories

Planning ahead, avoiding regular take-away

The whole family need to be involved within nutrition change

Ask for help from friends and family in supporting behaviour change

Behavioural interventions for children should include, as appropriate:

Stimulus control

Self monitoring

Goal setting

Rewards for reaching goals

Problem solving

Setting Change of Activity and Nutrition goals

Set some simple and achievable lifestyle goals for the next visit.

Ask the young person/family to keep a 5 a day food and activity diary (preferably including a weekend). You can use this as a focus for discussion at the next visit

Cheer on successes – no matter how small!

Identify areas of change and suggest alternatives

Emphasise weight maintenance in growing children

Early follow up (weeks) is required if you are to help maintain motivation

1.7 Providing information and further support

Provide the young person/family with some written information to support your advice or direct them to recommended websites for further reading. These include:

http://www.nhs.uk/Livewell/Goodfood/Pages/the-eatwell-guide.aspx

http://www.nhs.uk/change4life/Pages/change-for-life.aspx

Local Activity and Lifestyle Schemes

For pre-school children refer to the Health Visitor otherwise to the School Nurse for weight management advice and support. Children out of education should be referred to the Practice Nurse.

If the child is significantly obese then consider referral to **Children's Weight Management Service (CWMS) (Appendix 2)**

1.8 Investigation

If the child has simple or primary obesity with no family or personal risk factors for the insulin resistance syndrome no investigations are required.

However, in cases of simple or primary obesity with

family history of Insulin Resistance Syndrome (IRS - see table in history section)

signs of IRS - acanthosis nigricans, PCOS

marked abdominal obesity

extreme obesity BMI >>98th Centile

Consider:

Fasting lipids (total and HDL cholesterol, triglycerides)

LFT

TFT

Oral glucose tolerance test (OGTT)

Liver USS (Steatosis)

If there are significant symptoms to suggest obstructive sleep apnoea (snoring, difficult to wake, nightmares, and daytime somnolence) consider referral to ENT for a sleep study to exclude other causes of obstructive sleep apnoea.

Suspected secondary obesity

If there are signs or symptoms suggestive of secondary obesity then as well as above tests consider genetic tests and cortisol levels.

In children with early onset (pre-school) of extreme obesity consider DNA screening for monogenic forms of obesity.

Consider referral to Paediatric Endocrinologist.

Referrals

Only a small minority of overweight/obese children and young people will require onward referral. The success of weight management is usually dependent on the motivation of the child/family and not on the number of referrals made.

Paediatric Endocrinologist – children or young people with insulin resistance syndrome or evidence of a secondary cause for their obesity (see flow chart)

Dietician – children or young people with BMI ≥ 98th centile who would benefit from education and support to make changes to their diet and lifestyle.

CAMHS – motivated children and young people with significant psychosocial or psychological co-morbidities.

1.9 Flow Chart

2.0 References

NICE, 2006. Obesity –guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE clinical guideline 43. www.nice.org.uk

Assessment of Childhood Obesity in Secondary Care: OSCA consensus statement. Russel M Viner et al. Arch Dis Child Educ Pract Ed 2012; 97:98-105

Author: Dr RM Nawaz Paediatric Consultant Trafford

2.1 Acknowledgements

Judith Williams

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Seymour Grove Health Centre

Manchester. M16 0LW

Dr Mars Skae

Consultant Paediatric Endocrinologist

Royal Manchester Children's Hospital

Department of Paediatric Endocrinology.

Appendix 7

Adolescents and the HEADSSS Assessment

Communication with teenagers can be challenging. This guideline provides some guidance on specific consultation skills that should be employed when seeing young people.

Effective communication with teenagers requires empathy, mutual trust and respect. Confidentiality is greatly valued by teenagers who are in contact with health care professionals. Paediatricians rarely feel comfortable discussing sex, smoking and drug use with patients. The **HEADSSS assessment**, which is now used throughout the world, helps to address these issues.

Psychosocial morbidities (such as obesity, smoking and risky sexual behaviour) often co-exist in young people. Young people with chronic illness are more at risk of psychosocial morbidity than their healthy peers.

Meeting the Teenager and their Family for the First Time

It is important to concentrate on building a rapport from the outset of the consultation. The way in which you approach the young person may set the tone for the rest of the consultation.

It is helpful to meet the young person outside the consultation room

- Greet the adolescent first (remember to shake their hand)
- Ask the young person to introduce the rest of the family
- Begin by seeing the young person on their own and then bring in the family.

A major advantage of seeing young people on their own is that increases the chance that they may talk to us. In some circumstances it may be appropriate to see the teenager with their parents/carers first and then to see the young person alone. Rarely, you might need to speak with the parents alone before speaking to the young person. In such cases ensure the teenager understands why this is necessary.

Assuring Confidentiality

It is essential to assure young people that the content of your conversation will remain confidential, and that you will not discuss things with their parents without permission. It is important to state that confidentiality cannot be assured if the young person is at risk of harm (eg physical/sexual abuse or self harm) or if others would be at risk of serious harm.

"Anything we talk about today is confidential. That means I cannot tell others, including your parents, about it without your permission. The only exceptions would be if I thought you, or someone else, was at risk of serious harm. In that case I would need to tell someone else."

Building rapport

This can be done by:

- Asking **developmentally appropriate questions** and avoid medical jargon
  - Open ended questions for older adolescents
  - Give alternatives for younger teenagers (eg which do you prefer maths or PE)
- Start with **non-threatening topics** (for example, if self harm is the presenting problem start with some questions about home or school)
- **Listening** to the teenager and giving them the chance to tell their story (resist the urge to jump in too soon to clarify)
- **Take their concerns seriously** – do not minimise their concerns

- Avoid lecturing teenagers – criticise the activity not the young person
- Minimise note-taking during the consultation
- Try not to make assumptions based on limited evidence (for example, that a sexual partner is of the opposite sex)

The *HEADSSS* Assessment

Home and relationships

Who lives at home with you? Do you have your own room?

Who do you get on with best/fight with most? Who do you turn to when your feeling down?

Education and employment

Are you in school/college at the moment? Which year are you in?

What do you like the best/least at school/college? How are you doing at school?

What do you want to do when you finish?

Do you have friends at school? How do you get along with others at school?

Do you work? How much?

Activities and hobbies

How do you spend your spare time? What do you do to relax?

What kind of physical activities do you do?

At this stage - reassure about confidentiality

Drugs, alcohol and tobacco

Does anyone smoke at home?

Lots of teenagers smoke. Have you been offered cigarettes? How many do you smoke each day?

Many people start drinking alcohol as teenagers. Have you tried or been offered alcohol? How much/how often?

Some young people use cannabis. Have you tried it? How much/how often?

What about other drugs, such as ecstasy and cocaine?

If the teenager says yes to the above you may should ask questions which assess their understanding of the harms/risks and their motivation to change their behaviour. See the guideline on smoking cessation.

Sex and relationships

Are you seeing anyone at the moment? Are they a boy or girl?

Young people are often starting to develop intimate relationships? How have you handled that part of your relationship?

Have you ever had sex?

What contraception do you use?

Self-harm, depression and self-image

How is life going in general?

Are you worried about your weight?

What do you do when you feel stressed? Do you ever feel sad and tearful?

Have you ever felt so sad that life isn't worth living? Do you think about hurting or killing yourself? Have you ever tried to harm yourself?

Safety and abuse

You may not need to ask every young person about this, however it is important in young people who self-harm, have established substance misuse or emotional/behavioural problems.

Is anyone harming you?

Is anyone interfering with you or making you do things that you don't want to?

Examination

Ask the teen whether they would like a parent present. Consider whether you need a chaperone.

Remember to ensure privacy for the teenager during the examination

Remember to:

- Plot height/weight and BMI

- Make an assessment of pubertal development
- Explain what you are going to do before you do it

Appendix 8 – Healthy Weight Pathway including safeguarding

Safeguarding and obesity pathway

Concerns re: excess weight identified (any professional)

N.B. Check referral to secondary care complete therefore no medical reason for not achieving outcomes

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CONSIDER SAFEGUARDING ACTION

Appendix 9 Pathway for Medical and Further Assessments for Children with Obesity

Child identified with BMI >98th centile (source NCMP, GP, school nurse, health visitor, Children and YP Weight Management Service)

GP alerted to ensure family assessment of obesity risk undertaken

GP - Community assessment of comorbidities risk should be undertaken:

- Genetic risk - early onset < age 5 years
- Respiratory risk – snoring and symptoms of obstructive sleep disorder
- Metabolic risk – presence of acanthosis nigricans
- Family history of metabolic complications – hypertension, heart disease, stroke, Type 2 DM, ethnicity
- Physical risk – mobility issues
- Psychological risk – depression, low self esteem
- Ensure engagement with community weight management services
- Engagement with relevant adult services for parents if appropriate

Referral to secondary care paediatrics if any of following:

- Genetic, respiratory, metabolic, physical and psychological risk factors identified,
- BMI +3.33 SD – morbid obesity
- No improvement to weight status (reduction in BMI centile) with community interventions

Paediatric Consultant - Secondary care assessment:

- Retake history, establish possible additional reasons for failure to achieve no improvement to weight status (reduction in BMI centile)
- Assess children for syndromic/genetic cause of obesity (dysmorphism, learning difficulties, hyperphagia)
- Reassess growth parameters – is the child short and obese (indicative of a hormonal cause of obesity)
- Undertake basic metabolic testing: Blood pressure, HbA1C, LFT, TFT, OGTT and fasting insulin (if acanthosis nigricans noted), Fasting lipids
- Ensure engagement with community weight management services

Referral to tertiary obesity service (Endocrinology, Manchester Royal Children's Hospital) if any of following:

- Multiple obesity related comorbidities found
- Genetic cause of obesity suspected
- Hormonal cause of obesity suspected or confirmed
- No improvement to weight status (reduction in BMI centile) despite significant community intervention

Appendix 10 Pathway for medical and further Assessments for Children with Severe Obesity

Child identified with BMI>95th centile (source NCMP, GP, school nurse)

Referral to:
- Preschool age – health visitors (for preschool children)
- School age - community weight management service (ABL Health for assessment) / school nursing

GP alerted to ensure family assessment of obesity risk undertaken and appropriate engagement with relevant adult services for parents is undertaken.

Community assessment of comorbidities risk should be undertaken:
- Genetic risk - early onset < age 5 years
- Respiratory risk – snoring and symptoms of OSA
- Metabolic risk – presence of acanthosis nigricans
- Family history of metabolic complications – hypertension, heart disease, stroke, Type 2 DM, ethnicity
- Physical risk – mobility issues
- Psychological risk – depression, low self esteem

Referral to secondary paediatrics if:
- No weight maintenance observed with community interventions
- Genetic, respiratory, metabolic, physical and psychological risk factors identified

Secondary care assessment:
- Ensure engagement with community weight management service
- Retake history, establish possible additional reasons for failure to achieve weight maintenance or BMI centile loss
- Assess children for syndromic/genetic cause of obesity (dysmorphism, learning difficulties, hyperphagia)
- Reassess growth parameters – is the child short and obese (indicative of a hormonal cause of obesity)
- Undertake basic metabolic testing:
- Consider need for referral to social care if complex social history, non-compliance or disguised compliance noted

Blood pressure, HbA1C, LFT, TFT, OGTT and fasting insulin (if acanthosis nigricans noted), Fasting lipids

Referral to tertiary obesity service (in endocrinology) if:
- Multiple obesity related comorbidities found
- Genetic cause of obesity suspected
- Hormonal cause of obesity suspected or confirmed
- No weight maintenance achieved despite all community (weight management, school nursing measures, GP) interventions have been instigated.