SAFEGUARDING CHILDREN LIVING WITH COMPLICATIONS OF EXCESS WEIGHT (CEW)

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The Complications of Excess Weight (CEW) teams across the country use a holistic approach to treating conditions related to children and young people (CYP) living with obesity.

The three aims of the service are:

- **Identify** the factors involved in the development of severe obesity. Assessment should be holistic with equal consideration for mental health, physical health, and social needs.
- **Treat complications** associated with severe obesity and coordinate / refer to other services when required.
- **Individualised holistic plan** that aims to address health inequalities by considering culturally appropriate factors and a personalised approach.

Children will receive person-centred care packages developed with their family which could include mental health treatment, coaching, and advice around healthy living.

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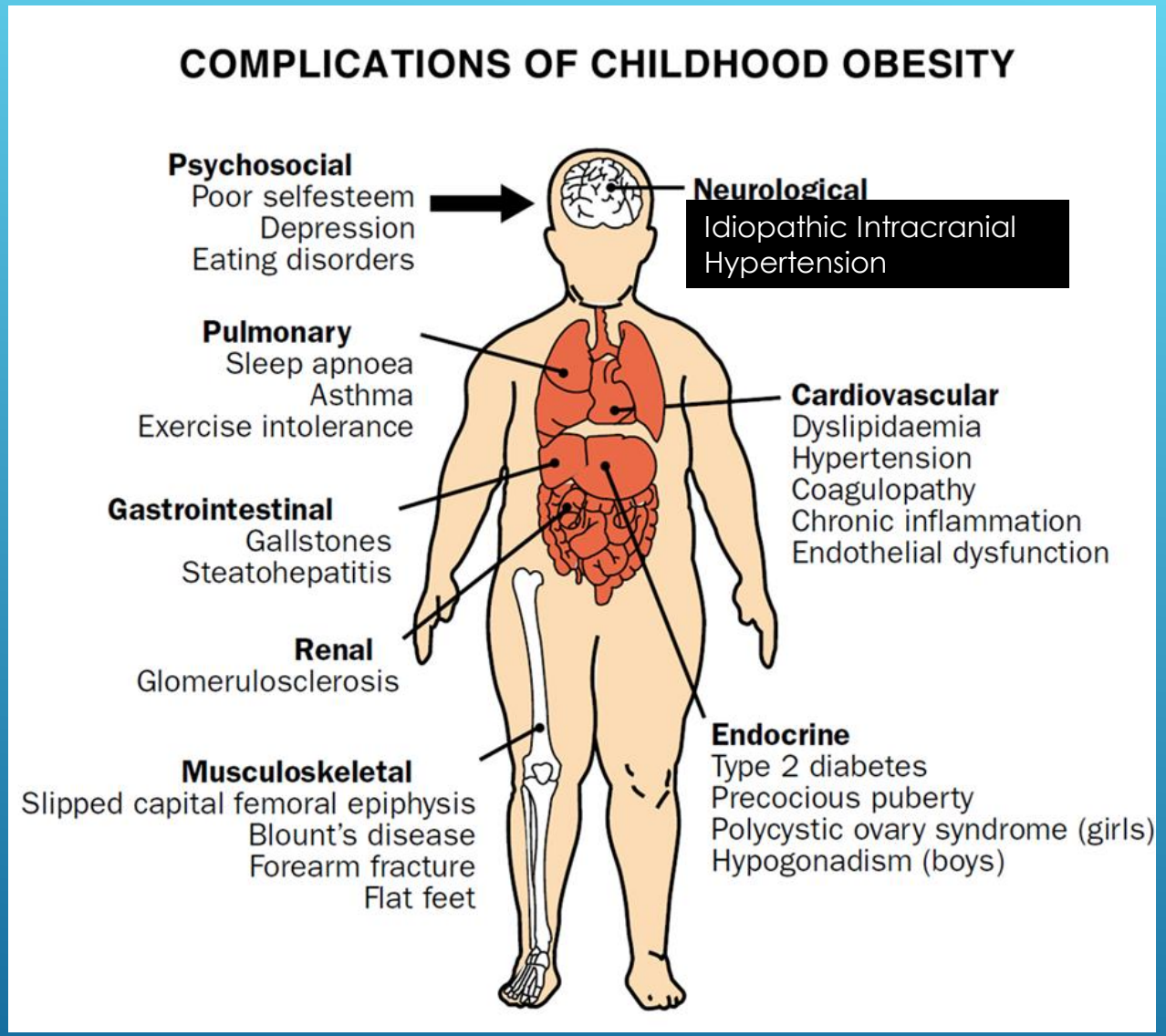
- Obesity in children has transformed from a sign of wealth and health to a disease that according to the WHO is "one of the most serious challenges of the 21st century"[1]
- Obesity affects one in four children in the UK with 1.22 million children in England meeting criteria for treatment according to NICE guidance[2]
- Living with severe obesity increases the likelihood of a child developing serious health issues such as Type 2 diabetes, liver disease, hypertension, and early heart disease.
- They may also develop difficulties with breathing, sleep, and mental health problems, which dramatically impacts their quality of life.
- Type 2 diabetes is increasingly prevalent in adolescents and young adults who have had obesity during childhood. When it is diagnosed in young individuals, the morbidity and mortality rate is higher than when it occurs later in life, and more dangerous than Type 1 diabetes[3]
- A child living with severe obesity (BMI SDS of 3.5) at the age of 4, who doesn't subsequently lose weight, has a life expectancy of 39 years[4]


COMPLICATIONS OF CHILDHOOD OBESITY
Psychosocial
Poor selfesteem
Depression
Eating disorders
Neurological
Idiopathic Intracranial Hypertension
Pulmonary
Sleep apnoea
Asthma
Exercise intolerance
Cardiovascular
Dyslipidaemia
Hypertension
Coagulopathy
Chronic inflammation
Endothelial dysfunction
Gastrointestinal
Gallstones
Steatohepatitis
Renal
Glomerulosclerosis
Endocrine
Type 2 diabetes
Precocious puberty
Polycystic ovary syndrome (girls)
Hypogonadism (boys)
Musculoskeletal
Slipped capital femoral epiphysis
Blount's disease
Forearm fracture
Flat feet

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Challenges

- Complexity of patients and families – identifying the barriers to change / social risk factors
- High levels of Safeguarding
- High percentage of Neurodiversity
- Finding / accessing resources to support families living in deprivation
- Multi-agency understanding of patient's health implications
- Identifying and evidencing Neglect / Disguised Compliance
- Terminology – when Neglect is suspected

SOCIAL RISK FACTORS IDENTIFIED IN CASES OF OBESITY FOR BOTH CHILD AND FAMILY

CEW Portsmouth Cases – identified at first MDT appointment

- Deprivation / poverty / financial pressure including access to services
- Parental / CYP mental health / learning needs
- Parental / CYP bereavement
- Experience of ACEs for parent or CYP - ↑ACEs = ↑ risk of obesity[5]
- Bullying resulting in social isolation / social anxiety
- Disguised compliance
- Parental unhealthy relationship with food / living with obesity
- Single parent family / Parental separation / Ineffective co-parenting
- Poor home conditions / hoarding / lack of bed for CYP
- Non-acceptance or lack of understanding of the impact on health outcomes
- Siblings with health needs
- 'Locked in' children
- Comorbidities – ASD, ADHD with strong preferences

All sit in line with national consensus and research evidence

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FURTHER RISK FACTORS IDENTIFIED FOR BOTH CHILD AND FAMILY DURING THEIR JOURNEY

- History / Current domestic violence
- Significant social care input
- Poor school attendance
- Lack of support system
- Siblings with additional needs
- Substance / alcohol use
- Close family member incarceration
- Caregiver loss of employment
- Multiple pets in household
- Homelessness
- Limited access to green space
- Limited access to supermarkets

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Safeguarding a child living with complications of excess weight does not always mean a referral to Children's Services

Childhood-Obesity-deep-dive-learning-summary.pdf

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When identifying neglect, the important factor is the caregiver's response to the management of the obesity rather than what caused it.

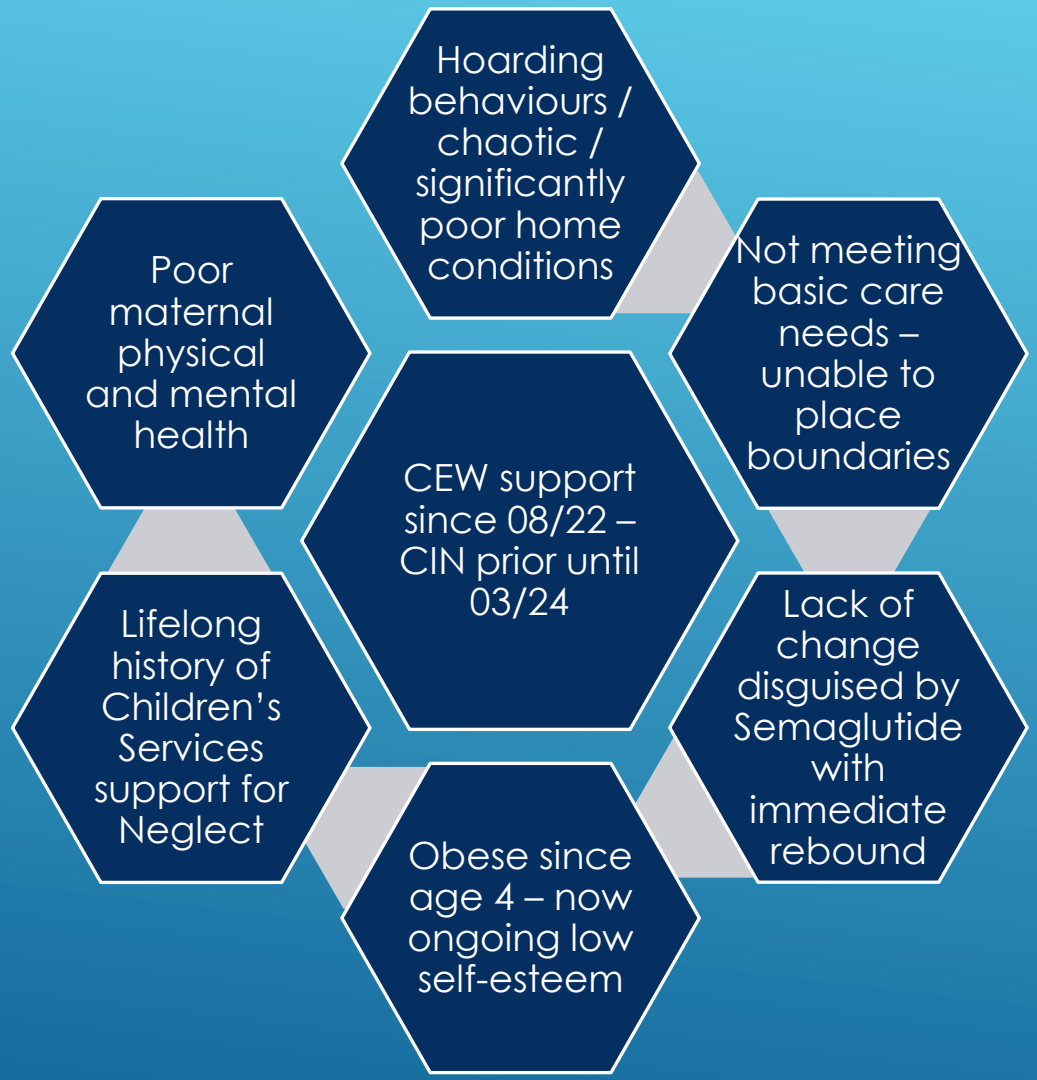
RED FLAGS

- Locked in children (regardless of engagement with MDT)
- BMI consistently not improving – despite MDT input (education, support, advice)
- Disguised compliance / Sabotaging behaviours / Exaggeration of symptoms
- Be aware of parental distraction between professionals
- Consistent non-engagement including WNB
- Identified social risk factors increasing / new risk factors identified

WHY BUILDING TRUST AND RAPPORT ARE IMPORTANT

Peeling back the layers and how social issues represent periodically.

Case study, 12-year-old girl



- Aged 10 years – 83.10kg with Metabolic Syndrome Associated Fatty Liver Disease and Insulin Resistance
- 02/23 Semaglutide - 88.05kg
- 01/24 – achieved remission – 90.20kg
- 04/24 – weight ↑ 7.6kg – 97.8kg
- 05/24 – IACF = CIN
- 08/24 – ED IACF – admitted (OSA noted) = CIN
- 08/24 – Hypertension (ECHO, ECG, Eyes, and treatment (significant non-compliance)
- 09/24 – 107.6kg – restart Semaglutide
- 09/24 – Supervision = escalation
- 09/24 – Mum interviewed by police for Neglect (charges considered)
- 10/24 – CP
- 01/25 – Proteinuria, non-compliant with medication
- 01/25 – weight gradually reducing - BH 4 weeks – d/c wt = 98.6kg
- 05/25 = PLO

Case study, 10-year-old girl

- Aged 10 years – T2DM, Insulin resistance, and dyslipidaemia.
- 10/24 - 136.55kg (21st 7lb)
- 11/24 - Hypertension with proteinuria & ↑ ALBC - consideration of IACF.
- 11/24 - Consider Semaglutide due to ↑ risk
- 12/24 - 141.7kg (22st 5lb)
- 12/24 - Developed fatty liver – start Semaglutide
- 01/25 - Supervision ? Admission ? IACF
- 01/25 - Home visit to discuss IACF
- 01/25 - Blood pressure worryingly high – assessment and medication started
- 02/25 - 137.7kg (21st 10lb) – HbA1c 39 (54)
- 02/25 - Still hypertensive - ↑ Telmisartan
- 03/25 - Supervision
- 04/25 - Moved out of hostel to new home – slight ↑ 05/25 (1.25kg)

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HOW CAN WE SUPPORT CHILDREN, YOUNG PEOPLE AND FAMILIES TO HELP REDUCE OBESITY AND RELATED HEALTH RISKS

ADOPTING A WHOLE SYSTEM APPROACH – SUSTAINED SUPPORT TO MAINTAIN EFFECT

RECOGNISING THE RISKS - PREVENTING SIGNIFICANT HARM – OBJECTIVE EVIDENCE OF HARM OR CHANGE

Leadership, knowledge, expertise and supervision, advocacy
Toolkits, guidelines and pathways, thresholds for escalation to appropriate services
Multi-agency collaborative working

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Responding to challenges

- Appropriate and timely communication with multi-agency to ensure collaborative working – Champions
- Utilise toolkits for the right terminology when harm / neglect is suspected
- Provide education for multi-agency colleagues on health impacts of obesity
- Use of objective evidence when referring to other agencies
- Identify and understand social risk factors and their impact on effecting change
- Working with local communities and services to offer families activity options

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References:

1. World Obesity Federation. Taking action on childhood obesity. World Health Organisation, 2018. www.worldobesity.org
2. NHS England. Complications from Excess Weight (CEW) clinics for children. www.england.nhs.uk
3. Journal of internal medicine, 2022. Paediatric obesity – long-term consequences and effect of weight loss.
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5. The early effects of cumulative and individual adverse childhood experiences on child diet: Examining the role of socioeconomic status, 2021. 10.1016/j.ypmed.2021.106447
6. Children's Wellbeing and Schools Bill 2024: policy summary - GOV.UK