Request for information under the Freedom of Information Act – 2019.216
Released – 16 August 2019

Thank you for your email received 31 July 2019 requesting information regarding weight of infants.

Please find detailed below a summary of your request, together with our response.

Summary of your original request:
I am looking into the weight of infants.

I am sending this email in the hope that someone will be able to provide me with the Health Visitor Growth policy for Kent.

Please see attached a copy of the Kent Community Health NHS Foundation Trust's guidance for Weighing, measuring and weight management of children, Age 0 to 5 years.

Kent Community Health
NHS Foundation Trust

Clinical Guidance for Public Health: Health Visiting Service

Weighing, measuring and weight management of children Age 0 to 5 years

Document Reference No.	CF030
Status	Final
Version Number	1.0
Replacing/Superseded policy or documents	Growth Measurement Guidance (Clinical Protocol, Eastern and Coastal Kent Community Services (February 2010) (CF005) Guidance for weighing and measuring of children Age 0 to 19 years, Kent Community Health NHS Foundation Trust (2014) (CF021)
Number of Pages	19
Target audience/applicable to	Public Health –Health Visiting service
Authors	HV Practice Teacher Locality Clinical Manager
Acknowledgements	Team Co-ordinator, BFI Lead
Contact Point for Queries	Locality Clinical Manager
Date Ratified	16 April 2019
Date of Implementation/ distribution	May 2019
Circulation	Children and Young People Public Health Services
Review date	April 2022
Copyright	Kent Community Health NHS Foundation Trust

Governance Arrangements

Governance Group responsible for developing document	Public Health Governance Group
Circulation group	Intranet, Policy Distribution
Authorised/Ratified by Governance Group/Board Committee	0-5 Yrs Health Visiting Service Governance Group Public Health Governance Group Patient Safety and Clinical Risk Group Quality Committee
Authorised/Ratified On	16 April 2019
Review Date	3 years from ratification
Review criteria	This document will be reviewed prior to review date if a legislative change or other event dictates.

Key References

NICE 2015; Post Natal Care up to eight weeks after birth: CG37
NICE 2015; Obesity: prevention and lifestyle weight management in children and young people. Quality Standard 94
DH, 2013; NHS New-born and Infant Physical Screening Programme
RCPCH (April 2012); Consideration of issues around the use of BMI centile thresholds for defining underweight, overweight and obesity in children age 2 – 18 years in the UK.
DH, 2009; Healthy Child Programme DH 0-4years
DH(2009); World Health Organization, Growth Charts Resource Pack
Child Growth Foundation (2012) Recommended growth Monitoring.
Mary Rudolf 2009b. Tackling Obesity through the Healthy Child Programme*;* a framework for action. Available at: http://www.noo.org.uk/uploads/doc/vid_4865_rudolf_TacklingObesity1_210110.pdf
Department for Health (2017), Childhood Obesity: A plan for Action
NICE 2017: Faltering Growth : recognition and management of faltering growth in children

Related Policies, Procedures and Guidance

Title	Reference
KCHFT Transition to Parenthood Pathway	CF026
KCHFT Infant Feeding Policy	CF022
KCHFT Equality and Diversity Policy	KCHFT HR012
KCHFT Healthy Child Clinic Guidelines	No ref.
KCHFT Infection Prevention and Control, Standard Precaution Policy	IPC020
KCHFT Safeguarding Operational Manual	March 2019

Document Tracking Sheet

Version	Status	Date	Issued / Approved to	Comments/Summary of Changes
0.1.0	DRAFT	January 2017	SN Professional Lead/ HV Practice Teachers/ C&YP AD	Divide document from 0-19 years to 0-5 years and add weight management guidance
0.2.5	DRAFT	April 2017	Team Co-ordinators, Baby Friendly Leads and HoS.	Changes to frequency of weighing and BFI ethos incorporated.
0.2.6	DRAFT	May 2017	LCMs, Professional Lead and TC`s for comments.	Changes to weighing within first weeks of birth and link document to 5-19 agenda
0.3.0	DRAFT	July 2017	Released to staff for operational Trial; live document format.	Changes to clinical practice
0.3.3	DRAFT	Jan 2018	Seniors Managers meeting	Flow charts amended. Separate Care pathway
0.3.3	DRAFT	June 2018	Service Governance meeting	Approved
0.3.4	DRAFT	July 2018	IG Assurance Lead	Formatting tidied, version control corrected (first published version to be 1.0, previous versions 0.1, 0,2, etc. mandatory information added)
1.0	FINAL	April 2019	Ratified at: Public Health Governance Group; Patient Safety & Clinical Risk Group and Quality Committee. Published for implementation	Updated front sheet, version & date

CONTENTS

1.0 INTRODUCTION

1.1 Growth is a sensitive indicator of health in childhood, as normal growth can only occur if a child is healthy, adequately nourished and emotionally secure. Poor growth in infancy is associated with high childhood morbidity and mortality.

1.2 Poor nutrition in childhood is associated with childhood malnutrition/obesity and adulthood morbidities such as cardiac related illness and mental well-being.

1.3 A screening procedure is applied to a population who have no manifestations of a disorder to separate out those at higher risk from those at lower risk. With the possible exception of single height measurements, weighing and measuring children cannot be regarded as screening and therefore the term Growth Monitoring is adopted (Hall; 2006).

1.4 Growth monitoring forms part of the Health Visiting service and must be viewed in the context of a holistic approach with normal growth as a good indicator of wellbeing. Children need to be considered within their family and community background. Additional Growth monitoring aims to identify children with less obvious but treatable growth disturbances such as Growth Hormone Insufficiency, Turners Syndrome, and Hypothyroidism.

1.5 Serious Case Reviews highlight the importance of assessing growth and/or weight in the context of a baby's, a child's or young person's wider environment.

1.6 Growth monitoring includes taking measurements of the head circumference, length/height or weight and plotting the result on the appropriate growth chart. An assessment of an infant/child`s growth will involve: a visual assessment, accurate measurements when appropriate, interpretation and explanation of these measurements in relation to any earlier growth measurements.

1.7 BMI centile charts are among the most common height and weight charts used by medical professionals and this tool can be used from age 2 years. The primary purpose is to determine whether the child is within a normal weight range for height, or if they are underweight or overweight.

1.8 **Universal Service** - Individual health screening contacts as part of the Healthy Child Programme: New Birth, 6- 8 weeks; 9 months; 24-30 months. The aim being early identification, prompt investigation and early treatment for growth concerns.

1.9 **Universal Plus** - Within the Healthy Child Programme; children with an unhealthy growth/weight concern as identified by professionals or parents are entitled to an offer of an assessment from the Health Visiting team.

1.10 **Universal Partnership Plus** – when a child has been identified as having growth concerns identified through assessment, then in partnership with health partners, and other agencies, intervention and support should be offered; to safeguard and to support further medical exploration.

2.0 SCOPE

2.1 This document covers clinical staff working within the 0-5 year's universal public health service.

3.0 PURPOSE

3.1 The purpose of this document is:

3.2 To assist staff with ensuring a standardised approach to weighing and measuring children age 0 –5 years.

3.3 To assist staff with identifying early indicators for childhood excess weight and ensure a standardised approach for early intervention.

3.4 To assist staff with identifying early indicators for faltering growth and standardising referral pathways.

3.5 To raise awareness within health visitor service of current national guidance for frequency of weight, length, height and head circumference measurements.

3.6 To promote competency in measuring children and plotting these measurements accurately on centile charts, and the appropriate recording in professional client records and patient held records.

3.7 To ensure measuring equipment is serviced and maintained in accordance with manufacturing guidelines, and in a timely manner, to allow for accuracy of measurement.

3.8 To provide a framework for safe clinical practice and onward referral.

4.0 ROLES AND RESPONSIBLITIES

4.1 The management structures within Health Visiting will ensure that the clinical guidance is implemented and adhered to through performance management.

4.2 Health visiting staff to be compliant with clinical guidance when measuring or monitoring growth and ensure that safe practices are in place to prevent unnecessary distress to children and families.

4.3 All clinical staff to ensure sensitivity in weight management, early intervention and the promotion of healthy family lifestyles.

5.0 TRAINIING

5.1 All staff members who are responsible for growth measurements within the health visiting service are required to update their knowledge and skills three yearly inclusive of a practical assessment.

5.2 The practical assessment is to be undertaken by a staff member qualified to assess competence.

5.3 All staff to be trained once in one of the below:
- Motivational Interviewing
- Behavioural change management techniques
- Crucial conversation techniques.

6.0 GROWTH CHARTS: WHAT DO CENTILES MEAN?

6.1 The centile charts indicate a child's size compared with children of the same age and maturity, who have shown optimum growth, and how quickly the child is growing. (WHO; 2009)

6.2 Children are different shapes and sizes but 99 out of 100 who are growing optimally will be between the 0.4th and 99.6th centiles. Half will lie between the 25th and 75th centile.

6.3 There is no single threshold below which a child's weight or height is definitely abnormal. However 4 out of 1000 children who are growing optimally are following below the 0.4th centile. (DH, 2009)

6.4 Following a holistic assessment, and when over 25 months, BMI Centile will be calculated and recorded on electronic records.

6.5 Measurements need to be interpreted in relation to family environment, length, growth potential and any earlier measurements of baby, child or young person.

6.6 For pre-term babies born between 32 and 36 weeks and six days gestation the preterm section of the UK-World Health Organisation growth chart could be used. There is also a 23 to 42 weeks gestation Neonatal and Infant Close Monitoring Growth Chart for use from 23 weeks to 2 years corrected age, (RCPCH, 2018). Use the relevant chart in liaison with partner agencies.

6.7 In the Personal Child Health Record, (Red Book); children 0 – 4 years height and weight will be plotted on the UK-World Health Organisation 0- 4 years growth chart. The chart provides a description of optimal growth and will help to establish breast feeding as the norm and support parents to understand the growth expectation of their baby or toddler.

7.0 WHEN TO WEIGH AND MEASURE

7.1 New-born / Neonate

7.1.1 Where there is a clear growth or health/feeding indication following holistic assessment babies should be weighed at the New Birth Visit .This should be, weigh naked using class III electronic scales.

7.1.2 Some degree of weight loss is common in the first week but 80% of infants will have regained this by 2 weeks of age. Recovery of birth weight by 2 weeks is suggestive that feeding is effective and that the baby is well. Future weighing by Health Visiting service should be dictated by child health need and in discussion with parents or if concerns about weight are raised.

7.1.3 Weight loss or slow weight gain may indicate a feeding problem or underlying medical problem. If weight loss is equivalent to, or greater than 10% of their birth weight, perform a detailed feeding assessment, assess for evidence of dehydration or an illness that might account for the weight loss and consider direct feeding observation (NICE, 2017). Referral to paediatrician must be considered and review of their weight arranged (NICE, 2008, updated 2015). In cases of concern, all measurements must be documented on a large UKWHO Growth chart at each contact and attached uploaded to the electronic record.

7.1.4 Following visual assessment or medical indication head circumference measurements should be recorded at new birth contact. (NICE, 2017) However, measurements of head circumference and length at birth are not an accurate interpretation of growth patterns. The birth head circumference measurement is affected by moulding. Similarly, the length measurement at birth is incompatible with later supine measurements (HCP 2009).

7.1.5 Baseline head circumference and length for healthy new-borns with no concerns can be achieved during the 6 -8 weeks of age.

7.1.6 **DO NOT** measure babies at the New Birth contact if there is a first degree family history of hip dysplasia in early life (i.e. mother, sister or brother) who had a hip problem that started as a baby or young child, that require treatment with splint, harness or operation.

7.1.7 **DO NOT** measure if the baby was a breech presentation at, or after 36 weeks gestation, irrespective of delivery mode. Nor if a breech delivery under 36 weeks gestation.

7.1.8 **DO NOT** measure a baby girl's length at new birth contact or subsequent visits; if birth weight is over 4 kg. Hip scan must be completed and the infant medically discharged before measuring.

7.2 Infant and toddlers under 2 years of age

7.2.1 After the neonatal period and once feeding is established, infants and children are weighed and measured at Universal contacts (DH, 2009b) and when there are clear growth or health indications.

7.2.2 The Child Growth Foundation (2012) highlights health professional contact should allow early identification of any unhealthy growth, thereby ensuring timely interventions to optimize the health of children. **Public Health staff should use professional judgment and parental concern to measure growth.**

7.2.3 Measurements need to be interpreted in relation to length, growth potential and any earlier measurement. All measurements raising concerns require careful assessment. This will include a full review of measurements i.e. weight, length and head circumference (HCP 2009).

7.2.4 If there is increased weight concern use professional judgment to monitor growth, as weights measured too closely together i.e. weekly are often misleading and raise parental anxiety. Always consider a primary care referral to rule out any medical conditions. Follow Healthy weight universal pathway. (Appendix 1)

7.2.5 Short video clips of correct measuring technique are available from The Royal College of Pediatricians and Child Health – www.growthcharts.rcpch.ac.uk
also Healthy Child Programme e-learning modules 08-07,08-08,08-09

8.0 GENERAL PROCEDURES FOR TAKING MEASUREMENTS 0 – 5 YEARS

A duplicate centile chart is required for any child identified as faltering growth or Child Protection. This will assure accuracy and act as a reference point if the Red book is not available or lost.	
Weight	Calibrated scales to be placed on a firm level surface. Babies should be weighed naked and in a warm environment. If it is not possible to weigh naked (e.g. due to a splint) this should be recorded alongside the measurements. Babies to be placed lying down on the scales until able to sit unsupported in the scales. Whenever the accuracy of a measurement is questionable, it should be repeated.
Length/ Height	**Under 2 years:** Babies and Infants can be measured supine and naked up to 2 years of age though definitely recommended naked up to 1 year. If it is not possible to measure naked (e.g. due to a splint) The items worn should be recorded alongside the measurements The appropriate length measuring mat should be used, and two people are required to measure accurately. **2 years onwards:** Children should be measured standing, without shoes and without bulky outdoor clothing. The child must be able to stand unaided. The child should be measured using a Leicester height measure correctly installed. **To measure accurately:** Ensure the child stands on the height measure with their feet flat on the floor, heels together and back of their heels touching the base of the vertical measuring column The child's arms should be relaxed, and their bottom and shoulders should touch the vertical measuring column To obtain the most reproducible measurement, the child's head should be positioned so that the Frankfurt Plane is horizontal; The measuring arm of the height should be lowered gently but firmly on to the head before the measurer positions the child's head in the Frankfurt Plane. Ideally, the parent or carer will ensure the child maintains the correct position while the member of staff reads the

	measurement. Whenever the accuracy of a measurement is questionable, it should be repeated
Head Circumference /Occipital Frontal Circumference	Use the recommended narrow paper or plastic tape – not a tailors measuring tape. The measurement should be taken around the head where the circumference is widest, best practice advises taking three measurements and using the average. Record measurement in centimeters to the nearest millimeter e.g. 38.4 centimetres. Whenever the accuracy of a measurement is questionable, it should be repeated.

9.0 BODY MASS INDEX CHARTS

9.1 **An adult BMI is not appropriate for children. Use BMI centiles.**

9.2 **Why do we use BMI Centiles?**
BMI centile indicates how heavy a child is relative to his or her height and is simplest measure of thinness and fatness from the age of 2 years, when height can be measured fairly accurately (UK WHO - 2009).

9.3 **Interpretation of BMI**
Assessing the BMI centile of children is more complicated than for adults. The BMI changes as a child grows and matures. In addition, growth patterns between boys and girls differ. In a child over 2 years of age, the BMI centile is a better indicator of overweight or underweight than the weight centile alone.

A child whose weight is average for their height will have a BMI between the 25th and 75th centile. A child or young person on or above the 91st centile is classified as overweight. A BMI Centile below the 2nd centile is unusual and may reflect under nutrition (UK WHO, 2009. RCPCH, 2012).

9.4 **For children age 2 – 4 years** use the weight – height to BMI centile conversion chart on the UK –WHO 0-4 year growth chart.

9.5 Children with some conditions may require specific growth monitoring centile charts in this instance liaise with the appropriate Paediatric services.

10.0 REFERRAL CRITERIA: 0 – 5 YEARS

10.1 Referral pathway via GP or Community Paediatrician as local practice dictates

10.2 New-borns / Neonates

- Babies who have lost more than 10 -12% birth weight.
- Any baby that does not regain birth weight by 3 weeks.
- Any measurement falling below 0.4th centile or that is outside of normal parameters as identified by UK-WHO growth Charts.
- Preterm babies will be monitored on an individual basis. (<37 wks gestation)

10.3 Slowing Weight

- Weight that has fallen two or more centiles in 6 months or less
- There is a concern regarding general health
- There is a concern regarding social circumstances in relation to health. Consider whether parents have followed previous advice and are appropriately concerned.

10.4 Unhealthy weight / Obesity definition:

< 2nd BMI centile
Low weight

2nd – 91st BMI centile
Healthy weight

> 91st BMI centile
Overweight

10.5 Use Healthy Weight (HW) discussion tool to assess in conjunction with professional judgement for referrals and package of care following outcomes of assessment. (Appendix 2 and Appendix 3 Healthy Weight package of care.)

10.6 Children 4-5 years old entering School within one month of a weight concern being raised will come under the National Child Measurement Programme.

11.0 HEALTHY WEIGHT PATHWAY

11.1 Support behavioural change and encourage positive parenting skills to include problem solving. (Appendix 3)

11.2 Emphasis should be on encouraging all family members to participate, including eating healthily and being physically active, NICE Guidelines (2015).

11.3 Follow Parent Education: Healthy weight guidance.

12.0 EQUALITY, DIVERSITY AND INCLUSION

12.1 Communication and the provision of information are essential tools of good quality care. To ensure full involvement and understanding of the patient and their family in the options and decision making process about their care and treatment, all forms of communication (e.g. sign language, visual aids, interpreting and translation, or other means) should be considered and made available if required. These principles should be enshrined in all formal documents.

12.2 Kent Community Health NHS Foundation Trust is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is not recommended to use relatives to interpret for family members who do not speak English. There is an interpreter service available and staff should be aware of how to access this service.

12.3 The privacy and dignity rights of patients must be observed whilst enforcing any care standards e.g. providing same sex carers for those who request it. (Refer to Privacy and Dignity Policy).

12.4 Kent Community Health NHS Foundation Trust is committed to ensuring that information is provided in accessible formats and communication support is met for people (patients, carers, parents/guardians) with a disability, impairment or sensory loss. The Accessible Information Standard (AIS) is a legal requirement of the Equality Act 2010 which applies to all organisations included within the Health and Social Care Act. https://www.england.nhs.uk/ourwork/patients/accessibleinfo/. Guidance on professional support services for the Trust is available in the Accessible Information Policy.

12.5 Staff must be aware of personal responsibilities under Equality legislation, given that there is a corporate and individual responsibility to comply with Equality legislation. This also applies to contractors when engaged by the Trust, for NHS business.

13.0 SAFETY OF MEASURING EQUIPMENT

13.1 Seca Scales are to be calibrated annually.

13.2 Leicester Height measures to be checked prior to use for breakage. Do not use if components are broken.

13.3 Detergent wipes / hand lotion sanitizer lotion should be carried in the scales carrying case.

14.0 CARE OF EQUIPMENT

14.1 Care of the equipment – please see Appendix 4

15.0 EQUALITY ANALYSIS

15.1 Kent Community Health NHS Foundation Trust is committed to promoting and championing a culture of diversity, fairness and equality for all our staff, patients, service users and their families, as well as members of the public.

15.2 Understanding of how policy decisions, behaviour and services can impact on people with 'protected characteristics' under the Equality Act 2010 is key to ensuring quality and productive environments for patient care and also our workforce.

15.3 Protected Characteristics under the Equality Act 2010 are:

- Race
- Disability
- Sex
- Religion or belief
- Sexual orientation (being lesbian, gay or bisexual)

- Age
- Gender Re-assignment
- Pregnancy and maternity
- Marriage and civil partnership

15.4 An equality analysis should be completed whilst a policy is being drafted and/or reviewed in order to assess the impact on people with protected characteristics. This includes whether additional guidance is needed for particular patient or staff groups or whether reasonable adjustments are required to avoid negative impact on disabled patients, carers or staff.

15.5 The Equality Analysis for this policy is available upon request by contacting the Engagement Team via kchft.equality@nhs.net.

16.0 MONITORING COMPLIANCE AND EFFECTIVENESS OF THIS GUIDANCE

16.1 Monitoring matrix:

What will be monitored?	How will it be monitored?	Who will monitor?	Frequency
Babies are weighed according to recommendation.	Supervision/ Audit	District Managers(DMs) / Audit Lead	6 Weekly/ As required
Scales are regularly calibrated and used as recommended.	I-Leader	DMs	Annually
Referrals are made using recommended pathways.	Record keeping audit	DMs / Audit Lead	Annually
Healthy Weight (HW) discussion tool for assessment and management is used.	Documented in client records	Audit Lead	In supervision
Staff to update their knowledge and skills three yearly including a practical assessment.	Appraisals	DMs	3 Yearly

17.0 EXCEPTIONS

17.1 Any exceptions to the Standard Operating Procedures should be clearly rationalised in the client's documentation by practitioners. This may include elements declined by the client or where family priorities have changed the course of the contact.

17.2 Issues of capability, performance or capacity should be addressed by District Manager in the first instance and may need to involve Senior managers.

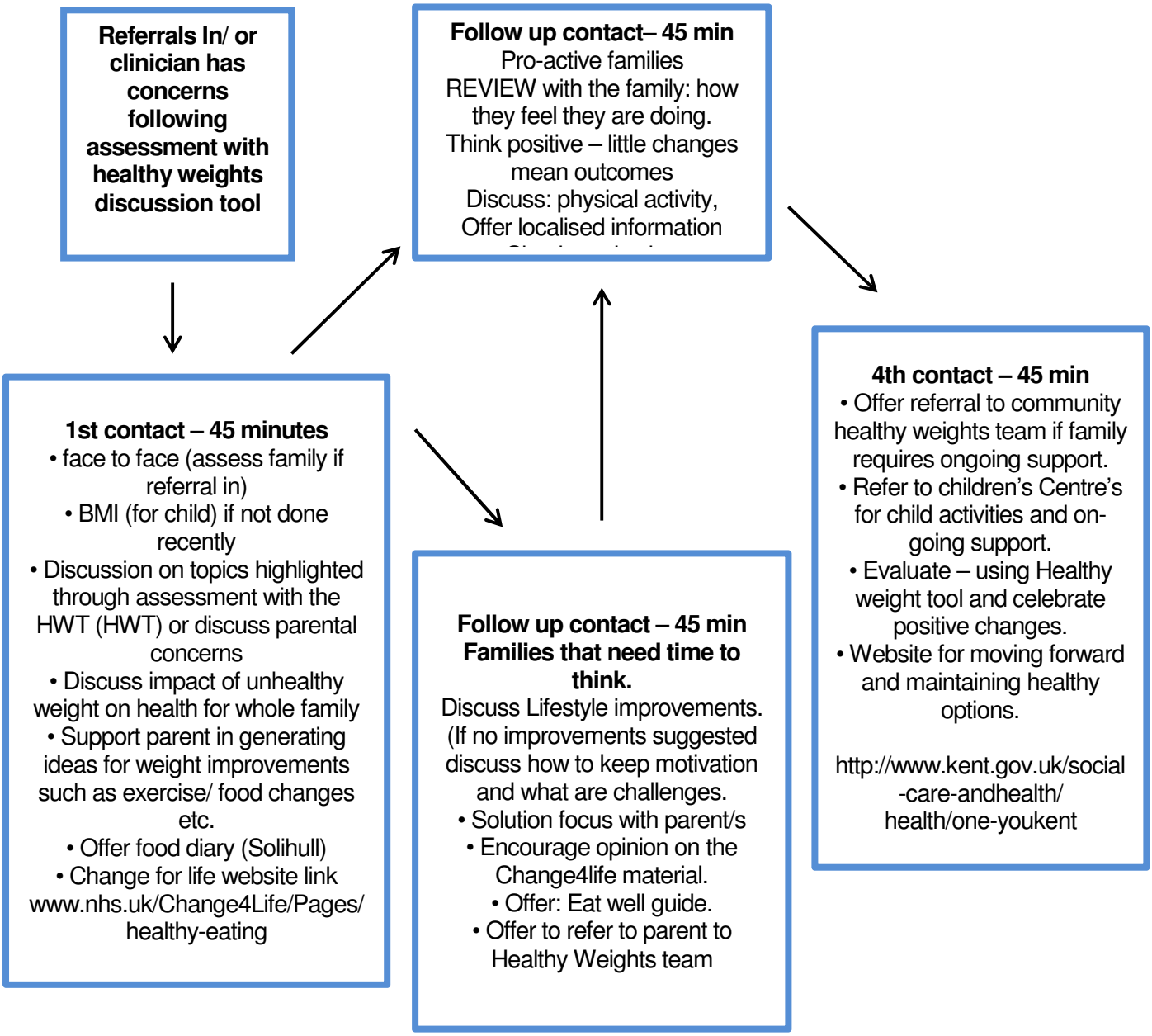
17.3 Exception reporting due to service capacity should be supported by a risk assessment and action plan.

18.0 GLOSSARY AND ABBREVIATIONS

Abbreviation	Meaning
KCHFT	Kent Community Health NHS Foundation Trust
SOP	Standard Operating Procedure
DM	District Manager

APPENDIX 1

Universal Plus - Healthy Weight Care Package
(25 month - 5 Years including support for parental change)

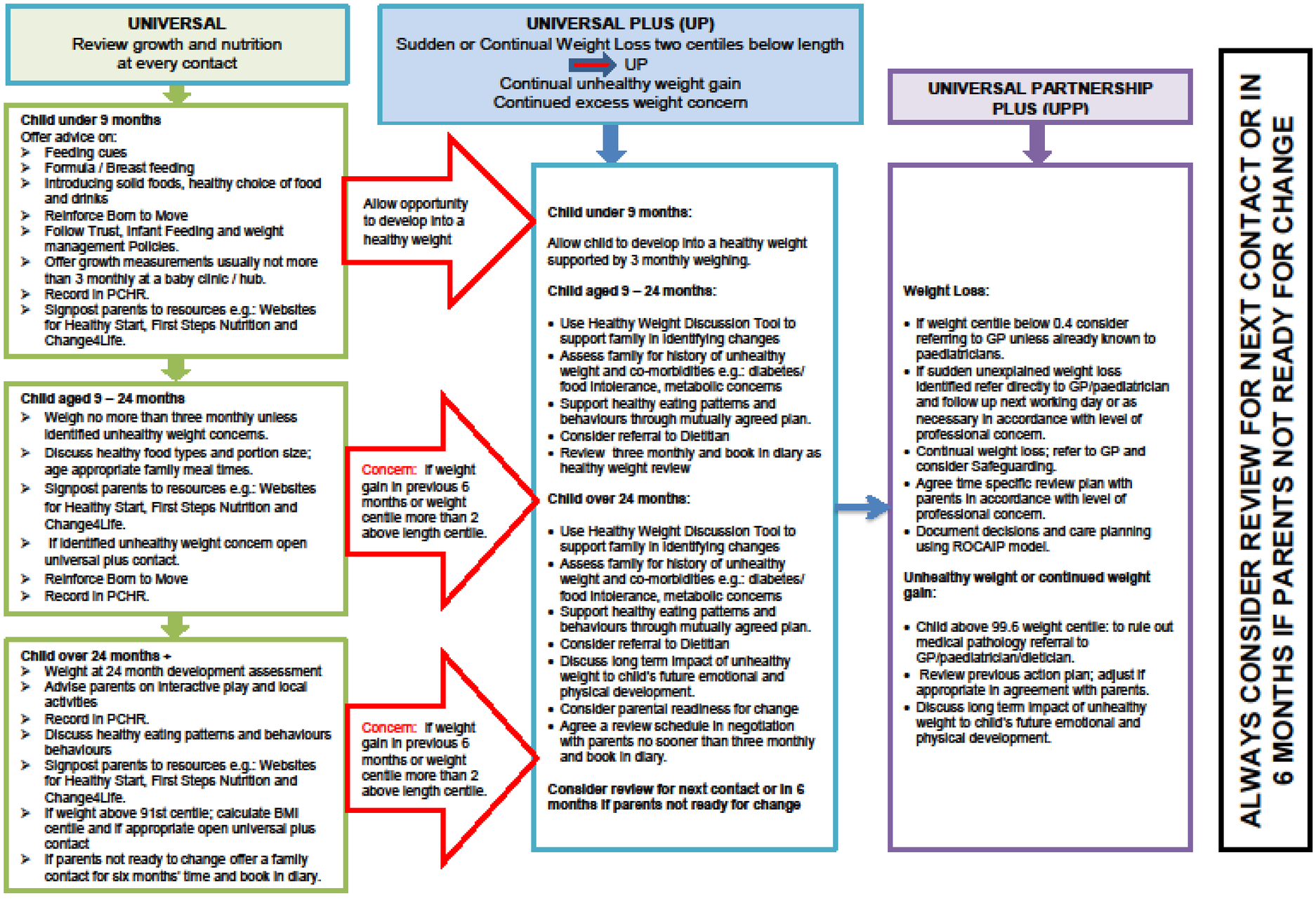


Training: Motivational Intervention, Understanding Behavioural Change, HCP online training

Outcome: Smart goal, parent led

Resources: Solihull Food Diary, Change for Life materials, Health Weight Assessment Tool, Henry Programme

APPENDIX 1


UNIVERSAL
Review growth and nutrition at every contact
Child under 9 months
Offer advice on:
Feeding cues
Formula / Breast feeding
Introducing solid foods, healthy choice of food and drinks
Reinforce Born to Move
Follow Trust, Infant Feeding and weight management Policies.
Offer growth measurements usually not more than 3 monthly at a baby clinic / hub.
Record in PCHR.
Signpost parents to resources e.g.: Websites for Healthy Start, First Steps Nutrition and Change4Life.
Child aged 9 – 24 months
Weigh no more than three monthly unless identified unhealthy weight concerns.
Discuss healthy food types and portion size; age appropriate family meal times.
Signpost parents to resources e.g.: Websites for Healthy Start, First Steps Nutrition and Change4Life.
If identified unhealthy weight concern open universal plus contact.
Reinforce Born to Move
Record in PCHR.
Child over 24 months +
Weight at 24 month development assessment
Advise parents on interactive play and local activities
Record in PCHR.
Discuss healthy eating patterns and behaviours behaviours
Signpost parents to resources e.g.: Websites for Healthy Start, First Steps Nutrition and Change4Life.
If weight above 91st centile; calculate BMI centile and if appropriate open universal plus contact
If parents not ready to change offer a family contact for six months' time and book in diary.
Allow opportunity to develop into a healthy weight
Concern: If weight gain in previous 6 months or weight centile more than 2 above length centile.
Concern: If weight gain in previous 6 months or weight centile more than 2 above length centile.
UNIVERSAL PLUS (UP)
Sudden or Continual Weight Loss two centiles below length
UP
Continual unhealthy weight gain
Continued excess weight concern
Child under 9 months:
Allow child to develop into a healthy weight supported by 3 monthly weighing.
Child aged 9 – 24 months:
Use Healthy Weight Discussion Tool to support family in identifying changes
Assess family for history of unhealthy weight and co-morbidities e.g.: diabetes/ food intolerance, metabolic concerns
Support healthy eating patterns and behaviours through mutually agreed plan.
Consider referral to Dietitian
Review three monthly and book in diary as healthy weight review
Child over 24 months:
Use Healthy Weight Discussion Tool to support family in identifying changes
Assess family for history of unhealthy weight and co-morbidities e.g.: diabetes/ food intolerance, metabolic concerns
Support healthy eating patterns and behaviours through mutually agreed plan.
Consider referral to Dietitian
Discuss long term impact of unhealthy weight to child's future emotional and physical development.
Consider parental readiness for change
Agree a review schedule in negotiation with parents no sooner than three monthly and book in diary.
Consider review for next contact or in 6 months if parents not ready for change
UNIVERSAL PARTNERSHIP PLUS (UPP)
Weight Loss:
If weight centile below 0.4 consider referring to GP unless already known to paediatricians.
If sudden unexplained weight loss identified refer directly to GP/paediatrician and follow up next working day or as necessary in accordance with level of professional concern.
Continual weight loss; refer to GP and consider Safeguarding.
Agree time specific review plan with parents in accordance with level of professional concern.
Document decisions and care planning using ROCAIP model.
Unhealthy weight or continued weight gain:
Child above 99.6 weight centile: to rule out medical pathology referral to GP/paediatrician/dietician.
Review previous action plan; adjust if appropriate in agreement with parents.
Discuss long term impact of unhealthy weight to child's future emotional and physical development.
ALWAYS CONSIDER REVIEW FOR NEXT CONTACT OR IN 6 MONTHS IF PARENTS NOT READY FOR CHANGE

APPENDIX 2

Healthy Weight Discussion Tool To be carried out by a member of the Health Visiting Team pre-post intervention.

Name…….. **Completed by**…….. **Date**……

Age……**Weight Centile**:…… **Height Centile**:…… **BMI Centile** (24/12+)……..

Please indicate: N = No Y = Yes	**Consider parental readiness for change.**			
Unhealthy weight predictors:	Bottle feeding, particularly with formula (16)		Family History of maternal weight gain, pre-pregnancy or during pregnancy (10)	
	Early weaning, before 6/12, not baby-led, self-feeding (2,3)		Socioeconomic factors (8)	
	Consider parents' lifestyle and food/fluid choices (4; 14)		Consider language/cultural/literacy barriers.	
Present Factors:	Underweight-2centiles below length. Overweight – 2 centiles above length (4)		Overweight or obese on **BMI centile chart** if age 24 months or over. Use BMI centile chart if weight is on 91st or 98th centile (11)	
	Recent rapid weight gain of infant, in last 6 months (4)		Raised parental BMI (13)	
Intervention advice / discuss with parents:	Hunger/full cues (3)		Family mealtimes & Role modelling (9); 3Ss: Sitting down, Slowly, Sociable (15)	
	Portion sizes (7)		Active play, 2-3 hrs daily (5; Born to Move); Reduce screen time (1,6)	
	Discuss sleep pattern (6,12))		Parenting approach: 'Parent provides, child decides' (15)	
Next steps agreed with parents;	Signpost to websites: Change4life; Healthy Start; First Steps Nutrition; NHC choices.		Growth review in clinic. Date: Age……..Wt……..Ht……BMI %……..	
Referral:	See 0-2yrs healthy weight pathway		HV to consider referral to community dietician if no change after review	
	HV to send copy to GP with consent to inform		Document in PCHR	
Review:	What has parent found useful? What was implemented? What is the outcome?		Growth reviews in clinic. Date: Age……..Wt……..Ht……BMI %…….. Age……..Wt……..Ht……BMI %…….. Age……..Wt……..Ht……BMI %……..	

APPENDIX 3

Care and Cleaning of height, weight & measuring equipment

Scales

Care of Equipment
Recorded on I-Leader/Equipment Database.

↓

Assemble equipment correctly
Check wired connections & Batteries
Ensure Level is adjusted as required
Ensure spare batteries are carried in the case
Clean thoroughly on completion of session
Not to be stored in cars in inclement weather.

↓

Calibration
To be calibrated annually
Calibration to be recorded on I-Leader/equipment database

↓

Cleaning
Wipe Surfaces appropriately with detergent wipes
NCMP after approx. every 20 children (where children present with bare feet clean immediately after use)
HV after every baby/child
Dry surface if required before proceeding
Clean on completion of each session

Leicester height meansures

Care of Equipment
Recorded on I-Leader/Equipment Database.

↓

Assemble in correct numerical order
Check all parts for wear & tear
Ensure situated appropriately
Do not mix equipment parts- replace with correct new equivalent.
Store correctly in equipment case
Do not place other items in equipment cases

↓

Calibration
None required – however equipment should be checked for:
Numbers clearly visible
Head plate slides freely
Posts slot together correctly

↓

Cleaning
Wipe foot plate appropriately with detergent wipes
NCMP after approx. every 20 children with detergent wipes
Where children present with bare feet clean immediately after use
HV after every baby/child
Dry surface if required before proceeding
Clean on completion of each session including upright parts

Measure Mat

Check all parts for wear and tear, ensure numbers are clearly visible
Ensure positioned on a firm flat surface

↓

Cleaning
Wipe with a detergent wipes after use
Clean thoroughly on completion of session inclusive of upright parts

APPENDIX 4

References

1) Braithwaite, I., Stewart, A., Hancox, R., Beasley, R., Murphy, R. and Mitchell, E., (2013) 'The worldwide association between television viewing and obesity in children and adolescents: cross sectional study', *PLoS ONE*, 8(9), p. e74263.
2) Brown, A. and Lee, M. (2012) 'Breastfeeding during the first year promotes satiety responsiveness in children aged 18-24 months', *Paediatric Obesity*, 7, pp.382-390.
3) Brown, A. and Lee, M. (2013) 'Early influences on child satiety-responsiveness: The role of weaning style', *Paediatric Obesity*, 10(1), pp.57-66.
4) Department of Health (2009) *Using the new UK-World Health Organization 0-4 years growth charts; Information for healthcare professionals about the use and interpretation of growth charts.* Available at: www.dh.gov.uk/publications
5) Department of Health (2011) *UK Physical Activity Guidelines*. Available at: https://www.gov.uk/government/publications/uk-physical-activity-guidelines (Accessed 15 August 2016).
6) Epstein, L., Roemmich, J., Robinson, J., Paluch, R., Winiewicz, D., Fuerch, J. and Robinson, T., (2008) 'A randomized trial of the effects of reducing television viewing and computer use on body mass index in young children', *Arch Pediatric Adolesc Med*, 162(3), p.239.
7) First Steps Nutrition Trust (2016) Available at: http://firststepsnutrition.org/.
8) Gibbs, B.G. and Forste, F. (2013) 'Socioeconomic status, infant feeding practices and early childhood obesity', *Paediatric Obesity*, 9, pp.135-146.
9) Gillman, M. (2000) 'Family dinner and diet quality among older children and adolescents', *Archives of Family Medicine*, 9(3), pp.235-240.
10) David M. B. Hall and David Elliman (2006) Health for All Children, Oxford University Press. London
11) Hillier, T., Pedula, K., Vesco, K., Oshiro, C. and Ogasawara, K. (2016) 'Impact of maternal glucose and gestational weight gain on child obesity over the first decade of life in normal birth weight infants', *Maternal and Child Health Journal*, 20(8), pp.1559-1568.
12) Kent Community Health Foundation Trust (2014) *Guidance for weighing and measuring of children age 0-19 years.* Children and Young People Services.
13) Magee, C., Caputi, P. and Iverson, D., (2013) 'Lack of sleep could increase obesity in children and too much television could be partly to blame', *Acta Paediatrica*, 103(1), pp. e27-e31.
14) National Obesity Observatory (2011) A simple guide to classifying body mass index in children. Available at: http://www.noo.org.uk/NOO_about_obesity/maternal_obesity_2015.
15) National Institute for Health and Care Excellence (2015) Available at: https://pathways.nice.org.uk/pathways/maternal-and-child-nutrition.
16) Royal College for Paediatrics' and Child Health (2018) https://www.rcpch.ac.uk/resources/uk-who-growth-charts-neonatal-infant-close-monitoring-nicm
17) Russell, C., Taki, S., Laws, R., Azadi, L., Campbell, K., Elliott, R., Lynch, J., Ball, K., Taylor, R. and Denney-Wilson, E., (2016) 'Effects of parent and child behaviors on overweight and obesity in infants and young children from disadvantaged backgrounds: systematic review with narrative synthesis', *BMC Public Health*, 16(1).