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OBESITY IN YOUNG PEOPLE WITH SPECIAL EDUCATIONAL NEEDS – AN AUDIT OF CURRENT PRACTICE

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Objectives Obesity is a major public health concern for children and young people. The prevalence of obesity has increased significantly in recent years and currently affects one in four children living in England.¹ Obesity disproportionately affects children and young people with chronic health conditions, including those with learning disabilities.² However, there is limited UK data on rates of obesity in young people with neurodevelopmental disorders. This audit aimed to identify the prevalence of obesity amongst young people within a special educational needs setting and to compare current practice against national guidance.

Methods Methods included retrospective review of clinic notes for young people attending a special educational needs secondary school between August 2021 and March 2022. Body mass index (BMI) was calculated using the most recent growth measurements and classified by centile using UK-WHO growth charts. In cases where BMI was above the 91st centile for age, data was audited against NICE guidance on the identification, assessment and management of obesity (CG189).

Results 38 adolescents were identified. Mean age at time of audit was 14.6 years (range 12–20 years) with a male predominance (97%, n=37). All patients had a diagnosis of autistic spectrum disorder (ASD) and 52% (n=20) had diagnosed learning disability (LD). Weight and height were documented for the majority of patients (95%; n=36). BMI was not documented in the clinic letter for any of the cohort. 50% patients were overweight (BMI 91st–98th centile; n=2), obese (BMI 98th–99.6th centile; n=4) or severely obese (BMI >99.6th centile; n=13). For the overweight and obese cohort, excess weight was acknowledged in the majority of cases (79%, n=15) and dietary and lifestyle advice provided. Blood pressure was recorded for 58% patients (n=11). No patients completed the blood investigations recommended by NICE. One patient was referred to a dietician.

Conclusions Adolescents with ASD are at increased risk of being overweight and obese compared to the general population, as evidenced by our audit. Whilst recognition of excess weight was well-documented, BMI was not routinely measured and blood investigations were rarely undertaken. We suggest implementing a local guideline to standardise the assessment and management pathway and creating a family information leaflet tailored specifically for young people with neurodevelopmental conditions.

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CHARACTERISING A PAEDIATRICIAN LED ADOLESCENT EATING DISORDER SERVICE

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Objectives To describe a Paediatrician-led Eating Disorder Service (P-EDS) model. We present an evaluation of the service, characterising the caseload and service outcomes to inform the conversation around incorporating specialist Paediatrician input into routine care.

Methods Retrospective Observational Service Evaluation of a P-EDS located at a District General Hospital in the South West of England. Data collected from all adolescents (10–17 years) referred by Child and Adolescent Mental Health Services or their GP due to concerns around their physical risk secondary to an eating disorder. The study quantifies the number of patients referred and cared for in the P-EDS, the diagnoses, number of appointments, length of time spent in the service, % median Body Mass Index (BMI) at assessment and discharge as well as need for local and tier 4 admission.

Results 244 patients were referred to the P-EDS between April 2016–2020. Of these, 81% were accepted beyond initial assessment. Half of referrals were classified as Eating Disorder Not Otherwise Specified (EDNOS) and just over a quarter as Anorexia Nervosa (AN), the remaining cohort consisted of Bulimia Nervosa, Other Mental Health (MH) Disorders and Avoidant-Restrictive Food Intake Disorder (ARFID). The number of patients diagnosed with ARFID and ED secondary to other MH disorder climbed yearly.

The median length of time spend in the service was 3.5 months (IQR 1.2–8.6), and patients had a median of 4 appointments each (IQR 2–9). However, this varied considerably by diagnosis with AN patients spending substantially longer in the service than EDNOS and ARFID patients (median 9m/10appts vs 2.5m/4appts and 3.4m/4appts respectively). For patients with a diagnosis of AN, the average increase in % median BMI between assessment and discharge was 10.1%.

The vast majority of patients (205 patients (84%)) required less than 1 year of P-EDS input, and 95% (233 patients) were discharged prior to two years. The likelihood of needing tier 4 referral increased the longer a patient remained in the service.

Conclusions The number of referrals demonstrates the significant demand for specialist medical (Paediatrician) involvement in the care of adolescents with eating disorders. This is likely a reflection of the overlap that EDs present between mental and physical health and the lack of time and training that GPs receive.

Patients who present at a higher % median BMI require less clinician input supporting the argument that early intervention improves outcomes. Adolescents with Anorexia gained a significant amount of weight whilst under the P-EDS thus decreasing their physical risk and reducing pressure on stretched tier 4 services.

The number of patients diagnosed with ARFID and an ED secondary to another MH disorder rose yearly, this may be secondary to the introduction of ICD-11 with its superior diagnostic specificity. This should enable better recognition of the triggers leading to disordered eating, and thus to improved treatments and outcomes.

As far as the authors are aware this is the first comprehensive service evaluation of a P-EDS published. Further studies on Day-case models, nurse led initiatives and tertiary level inpatient care will enable the development of best practice based on objective evaluation.