OBESITY CARE PATHWAY

Support Package

CHILD OBESITY Workbook



PHAST Public Health Action Support Team
Community Interest Company: A Social Enterprise Organisation

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OBESITY CARE PATHWAY
Support Package

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OBESITY CARE PATHWAY Support Package

What is the support package?

Public Health Action Support Team (PHAST) has developed a new interactive resource to support Primary Care Trusts (PCTs) to develop, implement, and evaluate effective obesity care pathways. The new resources, commissioned by the Regional Public Health Group for London (RPHG), focus on adults, child and maternal obesity.

The support package aims to:

- Guide users through a systematic process of developing, implementing and evaluating obesity care pathways to ensure they are robust, evidence based and focused on local needs.
- Assist users with reviewing and strengthening existing pathways.
- Provide opportunities to learn from the experiences of other London PCTs in the form of case studies.

The support package is made up of the following components:

- Three workbooks: adult, child, and maternal obesity.
- One interactive video providing a step-by-step guide to developing obesity care pathways. The workbooks and interactive video complement each other and at appropriate stages within the video, users are asked to refer to the relevant sections within the workbooks.
- Downloadable templates with editable regions, which users can populate with local information.
- Case studies from London PCTs are used throughout the workbooks and video to illustrate important issues.

This document represents the workbook for child obesity care pathways. It is one part of the support package that you can download and use alongside the interactive video, which walks and talks you through the key stages in generating your pathways.

The target audience: the support package is intended as a practical and concise resource to help those working at a local level who are responsible for developing and reviewing obesity pathways, and commissioning associated weight management services. It is primarily for those working in PCTs although local partners who are involved in the process (e.g. leads in acute trusts and local authorities) will also benefit from using the package.

To view the interactive video and download an electronic workbook and copies of templates, please go to www.healthknowledge.org.uk

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Why has the support package been produced?

Obesity is a significant public health challenge facing the UK. It is estimated that currently two-thirds of adults and a third of children are either overweight or obese and unless effective action is taken the rates will continue to escalate with almost nine in ten adults and two-thirds of children predicted to be overweight or obese by 2050[i]. Without action, obesity-related diseases will cost an extra £45.5 billion per year.

Primary Care Trusts (PCTs) are expected to develop strategies that include both preventative measures and services that manage those that are already overweight and obese. In particular, there is a need for the identification of overweight and obese children and adults and subsequent management including referral into weight management services.

A care pathway is often defined as a way of ensuring care or support:

- for the right people;
- in the right place;
- at the right time;
- by doing the right thing;
- with the right outcomes; and
- focused on the needs of the child and family/adult.

(Healthy Weight Healthy Lives: Commissioning weight management services for children and young people, 2008)[ii]

An effective obesity care pathway is therefore a framework or tool that should achieve the following:

- ensure local implementation of national guidance and evidence;
- ensure that services are aligned with local need;
- reduce variations in the quality of care;
- provide an equitable service for all users; and
- provide a framework for ongoing monitoring and evaluation of the weight management services and whole-system of obesity services.

Effective obesity care pathways (adult, child and maternal) are therefore required within local areas in order to improve the delivery of services for adults (including pregnant women) and children who are overweight and obese.

Use of the support package by PCTs will improve consistency and standardisation of pathways and the pathway generation process across London, and increase effectiveness and efficiency by reducing pressure on financial and human resources.

Obesity Care Pathway Cycle of Phases

There are four key phases involved with the systematic method of generating obesity care pathways:

- Phase 1: Initiation
- Phase 2: Development
- Phase 3: Implementation
- Phase 4: Evaluation

Within each of the phases there are key steps as illustrated in the cycle of phases. The process should not be considered linear and often two or three steps will need to take place in parallel. The workbook will work through each of the steps systematically and in a logical order, whilst highlighting when steps should be considered and completed at the same time as each other.

A timeline has also been put together to provide an overview of the obesity care pathway process. This provides estimated delivery times and should be considered as a guide.

Both the cycle of phases and timeline are generic and should be used in the generation of any of the obesity care pathways: adult, child or maternal.

In addition, generation of a pathway relies upon effective 'Stakeholder Engagement'. A detailed section on stakeholder engagement is, therefore, provided within the support package.

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Obesity Care Pathway Cycle of Phases

Stakeholder Engagement

Phase 1: Initiation – starting up the process of generating the pathway by specifying the aim and objectives, and agreeing key resources, taking into account the national and local situation.

Phase 2: Development – drafting and finalising the obesity care pathway based on need, demand and supply.

Phase 3: Implementation – applying and putting into practice the finalised obesity care pathway.

Phase 4: Evaluation – judging the value of the pathway and assessing to what extent it achieved what it set out to do and benefited the overweight and obese local population.

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Obesity Care Pathway Timeline

Timeline is an estimate and is dependent upon the local situation of each PCT.

PHASE AND STEP	MONTH																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Phase 1: Initiation																		
Step1 Identify a strategic lead and a project Lead																		
Step 2 Summarise key national and local policy drivers																		
Step 3 Estimate local need for obesity services																		
Step 4 Estimate local costs of obesity																		
Step 5 Agree key resources																		
Stakeholder Engagement																		

PHASE AND STEP	MONTH																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Phase 2 Development*:																		
Step1 Map current service provision (supply)																		
Step 2 Review the evidence-base and best practice																		
Step 3 Review need, supply and demand (comparative analysis)																		
Step 4 Reconfigure services to meet the need																		
Step 5 Draft and finalise pathway																		
Step 6 Identify training requirements																		
Step 7 Sign off pathway																		

* The length of time for development is highly dependent upon the results of the local needs analysis and the degree of service reconfiguration that needs to take place i.e. whether commissioners decide to commission new services, develop existing services, or both. The procurement process can vary from a few weeks to 12 months depending on the scale and complexity of the intervention or services being procured.

PHASE AND STEP	MONTH																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Phase 3: Implementation																		
Step1 Plan and organise launch and training events																		
Step 2 Design and print pathway																		
Step 3 Launch final pathway																		
Phase 4: Evaluation																		
Step 1 Monitor and evaluate pathway																		
Step 2 Revise and improve pathway																		
Step 3 Disseminate the findings																		
Step 4 Continue to monitor																		
Step 5 Make plans to sustain pathway																		

Phase 1: Initiation

Definition: the initiation phase is the first phase in the obesity care pathway process. It involves starting up the process of generating the pathway by specifying what the process aims to accomplish and how it will achieve the objectives, by taking into account the current national and local situation.

During the initiation phase, the project initiator (usually the PCT obesity lead) will summarise the key policy drivers, estimate local health need, make the case for funding and resources, and designate the obesity care pathway lead. It is crucial to conduct the key steps in this phase prior to beginning to develop the pathway.

There are five steps within this phase:

1. Identify a strategic lead and a project lead
2. Summarise key national and local policy drivers
3. Estimate local need for obesity services
4. Estimate local costs for obesity
5. Agree key resources

Step 1: Identify a strategic lead and a project lead

Strategic lead

The obesity care pathway process requires a multi-agency approach with all key stakeholders engaging and working together effectively. In order to coordinate activity successfully across a range of sectors it is advisable to identify a strategic lead that will have overall leadership of the project, for example, the Assistant/Associate Director of Public Health or PCT Obesity Lead. The strategic lead will act as an advocate and should help to ensure that all stakeholders commit to the process. High-level buy-in is therefore required to get cooperation from resistant stakeholders, to help sign off the pathway, ensure recommendations are carried out in practice, and it is helpful if the strategic lead chairs the obesity care pathway group meetings.

Project lead

Designate an obesity care pathway project lead who will complete all of the phases and steps within the care pathway process with support from the stakeholders. The obesity care pathway project lead will need to understand the broader national obesity policy agenda and the local context in which the pathway is being developed and implemented. They will, therefore, need the necessary knowledge, skills and expertise to coordinate the successful delivery of the project.

Step 1

The obesity care pathway project lead may be an internal or an external person. An internal project lead is an existing employee of the PCT in a post that has a remit to undertake obesity related projects and programmes, for example, the PCT Obesity Lead or a junior member of the obesity team. In comparison, an external project lead is not an existing employee and is usually appointed specifically to complete the obesity care pathway project on a time-limited contract. There are advantages and disadvantages to identifying an internal or external obesity care pathway lead to undertake the project as outlined in table 1.1 below.

Table 1.1: Advantages and Disadvantages of an Internal and External Project Lead

Lead	Advantages	Disadvantages
Internal	• An understanding of the organisational context already exists. • Organisational relationships already established. • No additional financial resources required to fund the post.	• Potential lack of necessary internal skills, expertise and techniques in developing obesity care pathways. • Lack of internal capacity for undertaking the project and opportunity costs with other work. • May be undertaking the work as part of another role – competing work priorities. • May be viewed as biased when trying to initiate change.
External	• Brings breadth and depth of expertise in skills, knowledge and techniques in generating obesity care pathways which are not available within the organisation. • Provides additional capacity for the project for organisations with a lack of available human resources. • May have access to a broad range of expertise and resources in addition to that which they themselves can offer. • Detached objectivity to change process as may be seen as unbiased when trying to initiate changes in service delivery.	• Lack of understanding of organisational context and time required to understand this and build relationships. • Need to recruit or commission the post and allow the lead to demonstrate the transferability of their skills and experience – longer time period before work commences and ensuring the right person is employed. • Financial resources required to fund the post.

If an external obesity care pathway lead is recruited or commissioned to undertake the project, a number of issues need to be taken into consideration.

1. An external lead will need good internal support mechanisms and to be linking closely to the senior management responsible for the delivery of the work programme in particular a named internal lead, who is preferably at a senior level.
2. Ensure that a project brief is agreed for the role they are to undertake with clear aims, objectives and timescales.
3. Plan an exit strategy for when the project is complete. This should involve a hand over of responsibilities and transfer of knowledge to ensure that the obesity care pathway work is maintained.

Step 2: Summarise key national and local policy drivers

It is advisable to produce a summary of the key national and local publications, polices, and guidance, including targets, that relate to obesity. This will be used in reports and papers outlining the case for additional or ongoing resources (human and financial). The resources section of the workbook includes a list of websites for key organisations which may provide useful information.

Step 3: Estimate local need for obesity services

There are a number of sources of data that should be collated in order to estimate the local prevalence (need) for obesity services. This is particularly important for making the case for the generation of obesity care pathways. Table 1.3 outlines the data sources that should be used to estimate the local prevalence and local need. Produce a summary report outlining the current prevalence of childhood obesity in your borough and make comparisons with other boroughs and national rates.

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Step 3

Table 1.3: Data Sources for Childhood Obesity

Source	Description	Data
National Child Measurement Programme (NCMP) for 2005/6, 2006/7, 2007/8, 2008/9	NCMP annually measures and weighs children aged 4–5 (reception) and 10–11 (year 6) in maintained schools in England. The NCMP began in 2005 and is now in its fifth year of data collection. It provides the most robust source of childhood obesity data in England. Measured height and weight are classified using the 'population monitoring' thresholds of the 85th and 95th percentiles of the British 1990 growth reference population (UK90) to classify children as overweight or obese. In clinical settings the 91st and 98th percentiles tend to be used. Data on child's ethnicity and geography are also collected.	Percentage of children participating in NCMP. Percentage overweight and obese in Reception Year. Percentage overweight and obese in Year 6. Further local analysis, for example, by geographical area or ethnic group. Further analysis of data on the prevalence and determinants at PCT and LA level using the NOO e-atlases.

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Table 1.3: Data Sources for Childhood Obesity (continued)

Source	Description	Data
Health Survey for England (HSE)	The HSE is an annual survey undertaken since 1991. Since 1995 the survey has also covered children aged 2–15 years and children under 2 since 2002. It provides estimates of the underlying population figures on a small sample size so figures should be treated with caution and SHAs are the lowest geographical area for which figures are available. Measured height and weight data are recorded as part of a core data set (which also includes general health, smoking, drinking, fruit and vegetable consumption, blood pressure measurements, blood and saliva samples) and topic specific health indicators. Child weight status is classified using the 'population monitoring' thresholds of the 85th and 95th percentiles of the British 1990 growth reference population (UK90) to classify children as overweight or obese. In clinical settings the 91st and 98th percentiles tend to be used. Level of physical activity and trends in purchases and consumption of food and drink and energy intake, and health outcomes of being overweight and obese relative risks of diseases, deaths, Hospital Episode statistics, prescribing, financial costs) are also included in reports produced by the NHS Information Centre.	Prevalence of overweight and obesity in children (estimates for each area).
Local data on breastfeeding initiation rates and 6-8 weeks breastfeeding rates	Each Primary Care Trust (PCT) is required to submit: • quarterly data on the number of maternities, the number of mothers initiating breastfeeding and the number of mothers not initiating breastfeeding. • data on the number of infants due a 6–8 week check during the quarter, number of infants being totally breastfed at 6–8 weeks, number of infants being partially breastfed (receiving both breast milk and infant formula) at 6–8 weeks, and number of infants being not at all breastfed at 6–8 weeks during the quarter.	Percentage initiating breastfeeding. Percentage breastfeeding at 6–8 weeks.

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Electronic mapping tools

The National Obesity Observatory (NOO) e-atlases are interactive mapping tools for the analysis of data on the prevalence of obesity and its determinants at PCT and LA level in England. The child e-atlases enable users to view and compare data at PCT and LA level, for both single and dual maps:

- **Single** – view data on the prevalence of child obesity for PCTs or LAs in England and compare to regional and national figures e.g. local area deprivation score.
- **Dual** – examine the association between prevalence and determinants of adult obesity for LAs in England.

An electronic ready-reckoner for estimating obesity prevalence can be found at www.fph.org.uk/Obesity_Ready_Reckoner. This tool can be used to estimate the number of adults (aged 16 and above) or the number of children aged 1–15 years within a PCT who are obese or overweight. The tool does not take account of local factors such as ethnicity, deprivation or other factors that might affect overweight and obesity prevalence.

It may also be of benefit to review the DH social marketing insight work. The purpose of this research was to understand better the behaviours that can lead to obesity (diet and activity), and so future ill health, and to understand which behaviours are common within different groups or clusters in society. This 'segmentation' analysis showed that children aged 2-11 years and their families could be divided into six clusters based on their behaviours. Of these, three clusters were found to be most 'at risk' of developing obesity (Cluster 1: 'Pressured Parents', Cluster 2: 'Inexperienced Parents', and Cluster 3: 'Treater Parents') and these three clusters were found to have the highest rates of adult and child obesity. As a result of the research, these three groups have been prioritised for national action within the national social marketing programme. The three 'at risk' clusters can also be used by local areas to better target interventions to promote healthy weight, leading to more effective interventions and use of public resources.

Step 4: Estimate local costs of obesity

It is also important to estimate local costs of obesity to the NHS. A tool within *Healthy Weight Healthy Lives: A toolkit for developing local strategies (2008)*[iii] (page 95) provides estimates of the annual costs to the NHS of diseases related to overweight and obesity and obesity alone, broken down to PCT level. The estimated costs have been based on a disaggregation of the national estimates calculated by Foresight (for selected years 2007, 2010, and 2015). The estimates can be used for understanding the problem in your PCT, providing support for the case for funding, supporting evaluation and monitoring in particular acting as a baseline figure for monitoring interventions relating to reducing costs in the NHS.

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Step 5

Step 5: Agree key resources

The resources required for the obesity care pathway process will be different for each of the phases. Table 1.4 provides a summary of the resources required at each phase. It is critical to address fundamental resource issues at the initiation phase of the project although the level of financial resource will in part depend upon the results of the mapping of current service provision during the development phase. Produce a summary spreadsheet using the template provided (see *Appendix A*) and update this as you progress through each phase of the obesity care pathway process.

Table 1.4: Summary of key resources required during each phase

Development Phase	• **Personnel** This includes both the capacity and capability of human resources. Personnel will include the obesity care pathway project lead (see section on identifying an obesity care pathway project lead) and the time contributed by all of the stakeholders engaged in the process. • **Investment in service provision** Financial resources will depend upon the current service need, supply and demand. Estimated need was already completed during Step 2 of the initiation phase and estimating demand and supply will be completed during the development phase. The results will identify whether additional funding is required for the commissioning of new services or provider development of existing services or whether funds can be obtained from the de-commissioning of an existing service. Investment at this stage may be difficult to estimate.
Implementation Phase	• **Personnel** Personnel during the implementation phase will be similar to those involved at the development phase. The time contributed by each stakeholder will vary depending on his or her level of contribution. For example, those stakeholders who assist with training and hosting the launch events will be significantly involved at this phase compared to other stakeholders. • **Training** The amount of resources required for training will depend upon the level of training required for successful implementation and whether an external training provider is commissioned or if the training is delivered 'in-house' (see section training requirements for implementation). All training and launch events will require trainers, a venue, refreshments, and printed resources.

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Step 5

Table 1.4: Data Sources for Adult Obesity (continued)

Implementation Phase (cont)	• **Marketing and advertising** Financial resources are required for marketing and advertising the pathway. Links should be established with communications departments to ensure that the pathway and associated weight management services are featured in PCT and LA newsletters. • **Publications** This includes the design and printing of pathways and supportive resources. Financial costs could be reduced or eliminated by designing or printing 'in-house'. • **Equipment** It might be necessary to purchase new equipment for weighing and measuring children although these should have been purchased as part of rolling out the NCMP.
Evaluation Phase	• **Personnel** The time required to complete this phase will depend upon the methods chosen to evaluate the pathways, the availability of data and internal support offered within the PCT (e.g. data analysis by health information team). Additional costs will be required if the PCT decides to commission an external evaluator to conduct a formal evaluation. See section on monitoring and evaluation. Personnel time will also be necessary for continued marketing and advertising, support for health and non-health care professionals using the pathway, reviewing and revising the pathway (links to the evaluation phase). • **Training** This is required for those frontline staff who are using the pathway. It will depend upon the turnover of staff as a high turnover will require frequent training days to ensure all new staff are trained in using the pathway and conducting a brief intervention. Top up training is necessary for those frontline staff that have already attended a previous training event but need a refresher course. It seems sensible to consider providing some form of annual top up training or rolling training programme. • **Publication** Improvements and revisions to the pathway will mean that updated versions of the pathway will need to be printed.

Step 5

Box A identifies the potential barriers that PCTs may encounter when generating obesity care pathways. It is helpful to be aware of any potential barriers that can arise because being aware of the barriers means that preventative measures can be put in place prior to the issue arising or known actions can be taken to alleviate the problem.

Box A: Potential barriers and methods to alleviate the problems that can arise when generating obesity care pathways include:

Inadequate Funding

Inadequate funding to cover the financial resources required during the development, implementation, and monitoring and evaluation phases will prevent delivery of the pathways. Ensure that financial resources are discussed and agreed during the initiation phase and after the comparative analysis has been conducted during the development phase. Firstly, make the case for generating the pathways (see Initiation Phase) and make the case for additional funding, if necessary (see Development Phase). If funding is limited, however, there are a number of areas where financial resources can be restricted: agree an internal project lead, design and print the resources 'in-house', and provide training 'in-house'. Prioritise funding for the commissioning and delivery of obesity services and consider de-commissioning and commissioning services for a more efficient use of limited funds.

Insufficient Service Provision

Insufficient obesity services need to be counteracted by the commissioning of new services or redesign of existing services. Review the effectiveness and cost-effectiveness of existing services and identify whether de-commissioning a particular service may enable a more cost-effective service to be implemented. In addition, during the mapping exercise, unknown existing services may be identified that can be utilised more effectively and included within the pathway.

Limited Capacity or Capability of Staff

If internal staff have limited capacity and capability and funding is available consider employing an external project lead to complete the project. If funding is not available internal staff will need to be drawn on but expect that the project may take longer to deliver. The internal project lead may need more support from senior members of staff (e.g. Assistant/Associate Director of Public Health) and it may be helpful for them to draw on the expertise of other PCTs/LAs that have successfully developed and implemented their own pathways.

The workforce capacity and capability of frontline staff involved in the implementation of the pathways may also be highlighted as a problem, for example, by the Head of School Nursing or Head of Health Visiting. Ensure that training is organised for all relevant frontline staff to enable them to feel confident at identifying and treating overweight and obese children and families (see Step 6: Training requirements). The increasing need to work with and provide support for families with weight problems will impact on capacity and it may be necessary to discuss these issues within workforce development commissioning.

continued

Step 5

Box A: Potential barriers and methods to alleviate the problems that can arise when generating obesity care pathways include (cont):

Inadequate Senior Level Support

Lack of support at the senior level can impact negatively on the process because senior members of staff help agree funding streams, increase the profile of obesity and the pathway, and engage stakeholders (especially those that resist being involved). Ensure that a senior strategic lead, who is motivated about tackling the obesity agenda, is identified and assists with overcoming obstacles.

Resistance by Stakeholders

Some stakeholders might resist being involved with the obesity care pathway project. Although senior level support can assist with trying to engage all stakeholders, some health and non-health care professionals may not contribute to the pathway generation process. In such cases it is helpful to identify an advocate for the work who may have a considerable impact on those stakeholders who are not contributing to the process. For example, a GP who is committed to the obesity agenda should be significantly involved in the process of pathway generation as they are respected by other GPs and are therefore able to reduce any resistance and increase GP involvement.

It is inevitable that each PCT/LA will encounter other barriers that have not been mentioned above. It is helpful to share this learning with other local areas by recording and disseminating the barriers and lessons learnt.

Phase 2: Development

Definition: the development phase is the second phase in the obesity care pathway process. It involves drafting and finalising the obesity care pathway based on need, demand and supply.

During the development phase, the obesity care pathway lead will assess the current service provision whilst reviewing the evidence, and analyse the information in order to identify gaps and duplications of services. This information will then be used to agree service reconfiguration in the form or future commissioning/de-commissioning or provider development of existing services. The final version of the pathway needs to be signed off and training requirements for successful implementation of the pathway need to be discussed.

There are seven steps within this phase:

1. Map current service provision (supply)
2. Review the evidence-base and best practice
3. Review need, supply and demand (a comparative analysis)
4. Reconfigure services to meet service need
5. Draft and finalise the pathway
6. Identify training requirements
7. Sign off the pathway

Before each of the above seven steps are outlined in more detail there is a short section on stakeholder engagement.

Stakeholder Engagement

Stakeholder engagement is critical at a number of steps within the initiation, development, implementation, and evaluation phases of the obesity care pathway cycle. The following section covers four key components of stakeholder engagement:

- Who to engage;
- When to engage;
- Method of engagement; and
- Key questions to ask when engaging.

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Who to engage

Begin the stakeholder engagement process by mapping the key internal and external stakeholders – identify all those people and organisations that have something to gain or lose through the outcomes of the obesity care pathway project. The stakeholders identified will depend upon the pathway that you are generating and although some stakeholders will be common across all three pathways (adult, child and maternal), a number of stakeholders are specific to only the child pathway.

Children's obesity care pathways will include children aged between 0 to 18 years. There are a number of health and non health care professionals involved with a child throughout this time period, and it may be helpful to classify stakeholders within three age brackets and settings:

- 0–4 years (early years)
- 5–11 years (primary school)
- 12–18 years (secondary school)

Table 2.1 provides a summary of key stakeholders classified by the three age brackets. This should not be considered an exhaustive list as each PCT may identify other key stakeholders and need to tailor the checklist to their local area.

The table demonstrates that some of the key stakeholders are common to all three age groups (e.g. Assistant Director of Public Health and Dietitian) whilst others are specific to one age range (e.g. Head of Health Visiting for the 0 – 4 years and Head of School Nursing for both the 5–11 and 12–18 years). In addition, there is a broad range of stakeholders ranging from senior/strategic staff to local frontline staff, commissioners and providers, community/primary and acute-based.

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Table 2.1: Key Stakeholders for Children's Obesity Care Pathways

0 – 4 years (Early Years)	5 – 11 years (Primary School)	12 – 18 years (Secondary School)
PCT Obesity Lead	PCT Obesity Lead	PCT Obesity Lead
Assistant/Associate Director of Public Health	Assistant/Associate Director of Public Health	Assistant/Associate Director of Public Health
Public Health Strategists – Children and Young People	Public Health Strategists – Children and Young People	Public Health Strategists – Children and Young People
Head of Health Intelligence/Information	Head of Health Intelligence/Information	Head of Health Intelligence/Information
Director of Children's Services	Director of Children's Services	Director of Children's Services
Head of Health Visiting	Head of School Nursing	Head of School Nursing
Head of Maternity Services		
Head of Dietetics	Head of Dietetics	Head of Dietetics
Paediatric Dietitian	Paediatric Dietitian	Paediatric Dietitian
Clinical Psychologist/CAHMS	Clinical Psychologist/CAHMS	Clinical Psychologist/CAHMS
Community Paediatrician	Community Paediatrician	Community Paediatrician
Paediatrician	Paediatrician	Paediatrician
Physiotherapist	Physiotherapist	Physiotherapist
Children's services commissioning lead	Children's services commissioning lead	Children's services commissioning lead
Infant Feeding Coordinator	Healthy Schools Programme Manager	Healthy Schools Programme Manager
Community Food Team Manager	School Sports Partnership Manager	School Sports Partnership Manager
General Practitioner	General Practitioner	General Practitioner
Professional Executive Committee (PEC) representatives	Professional Executive Committee (PEC) representatives	Professional Executive Committee (PEC) representatives
Practiced Based Commissioning (PBC)	Practiced Based Commissioning (PBC)	Practiced Based Commissioning (PBC)
Practice Nurses	Practice Nurses	Practice Nurses

continued

Table 2.1: Key Stakeholders for Adult Obesity Care Pathway (continued)

0 – 4 years (Early Years)	5 – 11 years (Primary School)	12 – 18 years (Secondary School)
Physical activity coordinator	Physical activity coordinator	Physical activity coordinator
(Local Authority/Sport and Leisure Provider)	(Local Authority/Sport and Leisure Provider)	(Local Authority/Sport and Leisure Provider)
Managers of specific local obesity programmes	Coordinators of specific local obesity programmes	Coordinators of specific local obesity programmes
PCT Social Marketing lead	PCT Social Marketing lead	PCT Social Marketing lead
Public health dental health consultant/ strategist	Public health dental health consultant/ strategist	Public health dental health consultant/strategist
RPHG obesity lead	RPHG obesity lead	RPHG obesity lead
External providers of obesity services	External providers of obesity services	External providers of obesity services
Head/Director of Procurement	Head/Director of Procurement	Head/Director of Procurement
Head/Director of Finance	Head/Director of Finance	Head/Director of Finance
Other stakeholders (please specify)	Other stakeholders (please specify)	Other stakeholders (please specify)

Please note that it may also be useful to engage with service users (e.g. overweight and obese children and their parent/carers) who will be able to provide feedback on their experiences of existing service provision and recommendations for the development of any new services/adaptations to existing services.

Turn to the stakeholder checklist template (*Appendix B*) and complete it for your area. Place the name of the stakeholder in your area next to the stakeholder title. It may be necessary to populate this table with the help of other stakeholders during the engagement process. Furthermore, whilst you are engaging with stakeholders you may find that additional stakeholders are identified.

Stakeholder analysis is a technique used to identify and assess the influence and importance of key stakeholders.

- **Influence:** the power which stakeholders have over a project – to control what decisions are made, facilitate its implementation, or exert influence which affects the project negatively. Examples include: the command and control of budgets, authority or leadership, or possession of specialist knowledge.
- **Importance:** the priority given to satisfying stakeholders' needs and interests through the project, especially those stakeholder interests that converge most closely with the project objectives.

A matrix is constructed on which each stakeholder is plotted relative to his or her influence and importance in relation to the obesity care pathway process. The level of influence and importance of each stakeholder may change throughout the process and at different phases of the project. See *Appendix C* for four stakeholder analysis templates; one for each phase. Complete these for your local area.

When to engage

Engagement with stakeholders is required throughout all stages of the pathway process; it should be considered cyclical and NOT a linear process. The cycle of phases at the start of the document highlights that stakeholder engagement is critical at all phases and steps.

Method of engagement

Stakeholder engagement is the process of effectively eliciting the knowledge, expertise, views, and recommendations of all stakeholders throughout the obesity care pathway process. There are a number of different methods that can be used; some methods will be more appropriate for certain stakeholders and other methods will be more appropriate for different phases of the pathway process. A summary of engagement methods and the advantages and disadvantages of each method are outlined in table 2.2. As you progress down the table the engagement methods become less intense and time-consuming.

Initially, it is advisable to set up an **Obesity Care Pathway Group**. From this point onwards the group will be referred to as a steering group to ensure consistency of terminology but local areas may choose to use different terminology such as 'working' or 'advisory' group. The steering group should include all of the key stakeholders although it is likely that not all of the stakeholders will be able to attend the steering group meetings and other methods of engagement will be necessary.

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Table 2.2: Methods of Stakeholder Engagement

Method of engagement	Advantages	Disadvantages
Steering group meetings	• Less time consuming than individual meetings. • The opinion of one stakeholder may trigger ideas from another stakeholder. • Able to run group creativity sessions to generate a large number of ideas for a solution to problems encountered. • Able to reach agreement on actions and next steps for each stakeholder (minutes can be produced as a record).	• Not all stakeholders will be able to attend the meetings. • The level of contribution from each stakeholder will depend upon the group dynamics and an imbalance can result in 'group think' or alternatively high-level conflict. • Need to maintain focus in order for actions to be agreed.
Small group meetings (e.g. sub-groups of the steering group)	• More likely all members of the groups to be able to attend. • Able to discuss and work through specific issues. • Likely to be more focused than the steering group meetings.	• Disagreement across small groups. • Poor communication leading to misunderstandings.
One-to-one meetings (either face-to-face or over the telephone). NB In both cases stakeholders should be able to view a copy of the draft pathway throughout the conversation.	• Good for obtaining a detailed understanding of each stakeholder's involvement (i.e. mapping of services) and recommendations for the layout of the pathway. • Able to understand specific issues and recommendations • Builds rapport and commitment with each of the stakeholders	• Time consuming for both the obesity pathway lead and the stakeholder. • Conflicting views. • Lack of cohesion. • The final decisions made may not reflect those of all stakeholders and therefore cause disaffection.
Emailing	• Good for circulating drafts of the pathway to all stakeholders and keeping everyone informed. • Can be kept as records of the pathway process.	• Non-response by stakeholders when requesting feedback. • Lack of total commitment due to other pressures. • Unable to build rapport and potential for misunderstanding.

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It is acknowledged that certain stakeholders may choose not to engage in the pathway generation process. Every effort should be taken to contact and involve everyone using a variety of methods but should stakeholders be unwilling to be included (for example, due to time constraints) a colleague should be identified to cover the stakeholder (e.g. Deputy Head of Dietetics covering the Head of Dietetics). In addition, it is advisable to identify a senior level champion for childhood obesity, for example the Assistant/Associate Director of Public Health. This is beneficial for improving engagement, raising the profile, assisting with overcoming barriers and driving the project forward (see Phase1: Initiation – Step 1: Identifying a Strategic Lead).

Key questions to ask when engaging with stakeholders

The type and number of questions to discuss will vary with each individual stakeholder and at which stage of the process the stakeholder is contacted. *Appendix D* provides a generic topic guide of key questions. Please note that not all of the questions will be relevant for all of the stakeholders; questions may need to be omitted or adapted.

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Step 1: Map current service provision (supply)

The mapping exercise involves conducting an audit of local obesity services, programmes and projects. The care pathway will extend across the community, primary, secondary and tertiary care, and thus a broad range of services involving a number of different health and non-health care professionals need to be recorded.

In order to accurately map the services, complete the following:

1. Stakeholder engagement – consultation with the stakeholders identified during the stakeholder mapping exercise is crucial for this part of the process. See *Appendix D* for the key questions that can be asked in order to extract the relevant information.
2. Identify and obtain copies of local strategy documents (e.g. obesity, food, physical activity, breastfeeding and weaning, and social marketing), service level agreements (SLAs), and quarterly monitoring reports from provider services. This will provide some information on existing services but stakeholder engagement will still need to be conducted to confirm the accuracy (strategies and SLAs are often out-of-date) of the information, obtaining their views on the effectiveness of current service provision, and recommendations for future commissioning and service re-design for the future pathway. Furthermore, data may be able to be extracted from provider databases to assist with assessing the effectiveness of existing services.
3. Conduct a more detailed evaluation of any existing services, where necessary. This may be required when there are existing services in place and evidence of their effectiveness needs to be assessed (particularly for decisions around future funding).

The information gathered should be recorded – see *Appendix E* for a template for mapping the current service provision.

Step 2: Review the evidence-base and best practice

Although the current evidence for the effective prevention and management of obesity is limited new research is continually being published. In order to obtain a summary of relevant guidance and evidence the following should be reviewed:

- National Institute for Health and Clinical Excellence (NICE) – one evidence-based clinical guideline for the prevention, identification, assessment and management of overweight and obesity in children and adults (NICE, 2006)[iv] currently exists in England. The guidance includes two generic clinical care pathways: one for adults and one for children. There are a number of other NICE guidelines that relate to obesity and are worth reviewing (see resources section).

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- Guidelines from outside of England: Scottish Intercollegiate Guidelines Network (SIGN) (2010) for Scotland[v], Royal College of Paediatrics and Child Health and National Obesity Forum (2002) for United Kingdom[vi] and National Health and Medical Research Council (2003) for Australia[vii].
- The Department of Health has also developed evidence-based guidance for use in England (2006)[viii]. This has been produced to support primary care clinicians to identify and treat children, young people and adults who are overweight or obese. It has recently been updated and is currently being revised.
- Conduct a literature review to identify relevant published articles. The National Library for Public Health (search using 'obes* OR overweight') is helpful to use at this stage **www.library.nhs.uk/publichealth**
- Obtain copies of examples of existing obesity care pathways. When constructing your own local pathway it can be helpful to review existing pathways that have been developed by other PCTs. It may also be helpful to obtain information on the obesity budgets for local PCTs and the allocation of funds between prevention versus treatment, and adults versus children. This will allow you to conduct some degree of benchmarking.

Step 3: Review need, supply, and demand (a comparative analysis)

At this stage, it is helpful to return to the estimation of need that was conducted in the initiation phase. Estimate the number of overweight and obese children that 'need' obesity services in your borough and compare with the number of children that can receive ('supply') the service. Evidently, need is likely to exceed supply and demand must also be taken into account when planning health services.

A comparative analysis is conducted once the mapping process and review of the evidence base are complete. It involves comparing the current service provision with the evidence base (for example, NICE obesity guidance 2006 and other reviews that may have been obtained such as The Cochrane Review on Intervention for treating obesity in children 2009). This process identifies the gaps (and duplications) in service provision and will facilitate the identification of under-provision, adequate, or over-provision of services. The level of priority can then be assigned to each gap and future investment can be prioritized according to local needs and service requirements.

Appendix F provides a template for conducting the comparative analysis. This has been produced in a format that reflects the levels required within an obesity care pathway. During the analysis it is also helpful to begin to map in a diagrammatic format the referral routes between and across the services at all levels of care (i.e. community, primary, secondary and tertiary care).

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At this stage it is advisable to use the good-quality local intelligence that has been gathered to produce a local report or paper for discussion, which summarises the mapping of current obesity services, the gaps and duplications in service provision, and recommendations for future service provision (consider adding the populated templates for mapping and comparative analysis as appendices). This can be used for agreeing additional funding if required. The report should be taken to the strategic lead and steering group for discussion.

Step 4: Reconfigure services to meet service need

This section involves agreeing the next steps required to fill the gaps and remove the duplications in service provision in order to provide an adequate and equitable provision of services at all stages of the pathway of care for overweight and obese children. This will depend upon the local situation; some areas may choose to redesign or expand existing services whilst other areas may choose to commission new services (and de-commission existing services). Two case studies are provided within this section to illustrate two different approaches to the development of children's obesity care pathways. In both cases the aim is to assist with achieving their local targets to reduce the levels of obesity and overweight among children.

Commissioning and Procuring New Obesity Interventions and Services

Local areas can commission a range of weight management services to meet different needs. The use of independent and third sector providers to provide NHS-funded services is becoming more and more widespread and PCT commissioners are expected to select and use providers who are best placed to deliver cost-effective and high-quality services. It may be necessary, therefore, to consider commissioning new obesity interventions for any stage/tier of the pathway. The choice of programme will depend upon a number of factors including: the age-range of the pathway, stage/tier of the pathway, feasibility of implementation within the borough, and resources available.

Once the obesity lead and the strategic lead (and stakeholders who will include representatives from the local authority and other partners) are clear on the intervention(s)/service(s) that need to be commissioned the next step is to procure those interventions and services.

For any procurement route, there are three key stages of procurement as outlined in table 2.3. The time required to undertake a procurement can vary greatly depending on the size and complexity of the intervention or service being procured (from a few weeks to 12 months for larger scale procurements).

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Step 4

Stage 1: Pre Procurement	Stage 2 : Procurement	Stage 3 : Contract Management
• Health needs assessment and planning	Procurement strategy and plan	Service transition and mobilisation
• Development of service specifications	Advertise	Full service commencement
• Consultation	Prequalification Questionnaire (PQQ)	Ongoing contract management (including performance management of providers)
• Stimulate market	Memorandum of Information	
• Strategic/outline business case including affordability exercise	Issue ITPD/ITT tenders	
• Build a project team	Dialogue/negotiations Select preferred providers Sign contract	

Table 2.3: Three Key Stages of Procurement

DH previously produced a guide to support local areas in commissioning weight management services for children and young people in recognition that local areas are increasingly commissioning these services to provide support to overweight and obese individuals in moving towards and maintaining a healthier weight, as part of broader healthy weight strategies.

The guide aims to help commissioners improve health outcomes for children and young people. It will also support commissioners towards achieving the world class commissioning competencies. See *Healthy Weight Healthy Lives: Commissioning weight management services for children and young people (2008)*[ii].

The guide summaries the three overarching stages or phases of activity:

Phase 1: Needs assessment and strategic planning;

Phase 2: Shaping and managing the market; and

Phase 3: Improving performance, monitoring and evaluating.

Tools are included in the guide and are grouped under the three phases outlined above. For example, phase 2 includes a tool designed to support local areas in developing service specifications for weight management services for children and young people.

In addition to this guide, the Cross-Government Obesity Unit developed further support for local areas in commissioning weight management services for children and young people in the form of a list of 'pre-qualified' providers from which PCTs are able to call off services quickly and easily. *Healthy Weight, Healthy Lives: Child weight management*

programme and training providers framework (2009)[ix]. The list – or 'framework' – of providers covers providers that can offer the following package of services in England:

- an approach to weight management for overweight and/or obese children and young people;
- training for local staff to enable them to deliver that approach to weight management to children, young people and families; and ongoing support to local staff who have completed the training.

The national procurement process to develop this list of providers began in August 2008. The decision to develop this framework of providers was based on feedback from local areas on how national-level support could best be provided, including by: setting standards for provision of weight management services; increasing the range of choice available to commissioners; and ensuring that providers are able to tailor their services to meet local needs better.

Consultation showed that there is a strong preference among commissioners and obesity leads for local-level organisations to deliver weight management services to children, young people and families. These delivery partners may be from a range of organisations, so the idea was to ensure that providers on the framework are able to adapt their training to meet different needs and reflect different levels of experience.

It is not mandatory to use the framework and PCTs are able to commission providers outside of the list of providers or without using the list of providers. In addition, a number of PCTs and LAs have developed their own 'home grown' initiatives, for example, 'Healthy Lifestyles' in City and Hackney, 'Alive 'n' Kicking' in Sutton and Merton, and 'Kickstart' in Westminster, to name just a few. It is advisable to contact obesity leads within PCTs should the steering group/project lead become aware of a local programme that has the potential to be delivered across another borough. *'Schemes to promote healthy weight among obese and overweight children in England'*[x] is a useful publication, which lists childhood obesity interventions that are being provided or have been provided recently.

It is important to remember that weight management services should be commissioned in the context of a whole care pathway.

CASE STUDY

NHS CAMDEN: Commissioning Children's Weight Management Services

See Case Studies

De-commissioning existing obesity interventions and providers

Commissioners may need to consider de-commissioning specific services. De-commissioning is the process of ending the provision of activities/interventions that are no longer required or appropriate. This may be necessary as part of service redesign or the movement of investment to meet new priorities. For example, an existing service

may only provide a healthy eating component to tackling obesity and the investment in this programme could be spent better by de-commissioning the existing service and commissioning a multi-component weight management service. Please note that guidance by NICE on the commissioning of weight management services states that interventions for children should be multi-component (include healthy eating, physical activity and behaviour change) and should involve parents and carers.

Service and provider development

Instead of, or in addition to, commissioning and de-commissioning services, there may be a need to redesign existing services and interventions by supporting service and provider development. This may be necessary if the mapping of services has identified a number of issues with the existing service provision as outlined below:

- **Under-provision** – the service is performing effectively and efficiently but there is inadequate supply for the need (and demand).
- **Over-provision** – the service is performing effectively and efficiently but there is excess supply for the need (and demand). This may occur if services do not exist at the lower tiers of the pathway and therefore individuals are referred directly to services in the higher tiers. Establishing new services at the lower tiers will therefore reduce the need for services in the higher tiers.
- **Inappropriate provision** – the target groups are not being reached (in terms of age, ethnicity, socioeconomic status, geographical area, and degree of obesity). Adapt the service to align it with local need and ensure that there is equitable service provision.
- **Duplication in provision** – two services exist and are targeting the same groups (i.e. they have the same referral criteria).
- **Out-of-date provision** – existing services may need to be adjusted in response to the publication of new evidence and guidance.
- **Insufficient capacity and capability** – frontline staff (health and non-health care professionals) may need to have their skills and knowledge supplemented and strengthened to ensure they can appropriately identify and manage overweight and obese patients.
- **Inadequate output and outcome data** – evidence to demonstrate effectiveness and cost effectiveness of the service may be insufficient or not aligned with national guidelines, or unable to be compared across services. This will depend upon the data collection, collation and storage protocols of each service.

Service and provider development is particularly important for interventions that have been commissioned previously. During monitoring and evaluation of the services ensure that they are meeting local need, aligned with the latest evidence, and that there is no excess demand or supply for the service.

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CASE STUDY
NHS Tower Hamlets: Provider development of Children's Weight Management Services
See Case Studies

Step 5: Draft and finalise the pathway

Developing the care pathway involves agreeing a number of critical steps:

- positioning each service at the appropriate tier within the pathway;
- agreeing entry thresholds/referral criteria/inclusion and exclusion criteria for each service and tier along the pathway;
- agreeing exit thresholds/discharge criteria for each service and tier along the pathway;
- establishing referral routes (including self referral) which can assist in ensuring that the service is reaching as many people within its target population as possible;
- establishing routes back through the pathway (i.e. children returning from a higher tier to a lower tier. For example, a child who is obese but found to have no co-morbidities may move down from level 3 to level 2);
- establishing the definitions for successful/unsuccessful at each level of the pathway and criteria for referral on through the pathway;
- agreeing the transition into/out of and service provision for weight maintenance. This includes the criteria for entering weight maintenance and how long the individual remains in weight maintenance;
- identifying the frontline staff (health and non-health care professionals) who need to be involved at each tier, and their capacity and capability;
- identifying sources of support which can be offered by various organisations; and
- agreeing outputs and outcome measures to be collected at various points along the pathway for monitoring and evaluation (baseline and follow-up).

There are many different ways of presenting pathways. The chosen approach will depend largely on the target audience viewing the pathways. It is likely that it will be necessary, and helpful, to produce the pathway in a few different formats, all of which will display the same information but use a different framework. The following three frameworks have been provided here as examples.

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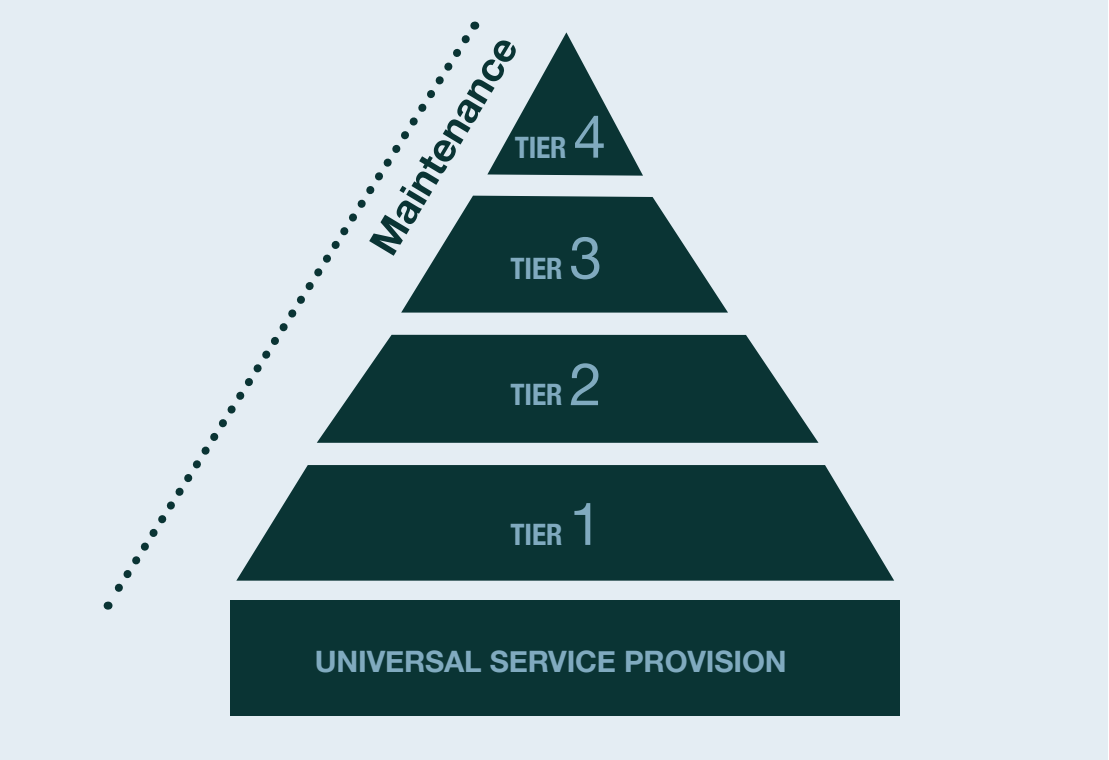
Step 5

1. Triangle approach
2. Referral pathway approach
3. Care pathway approach

Triangle approach



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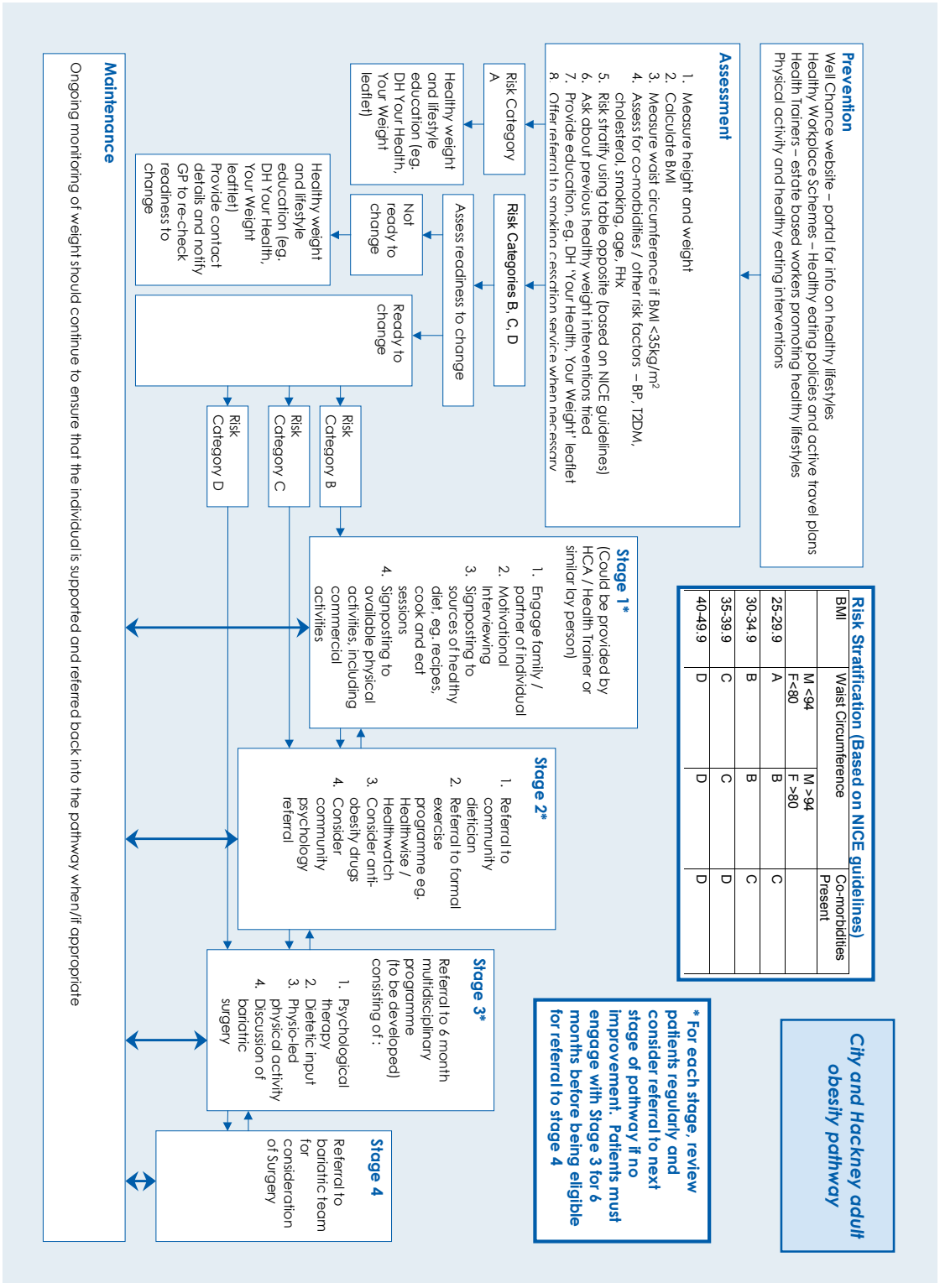
Step 5

Referral pathway approach

Example of an Adult Obesity referral pathway from NHS City and Hackney. Please note that the referral pathway is currently in draft format.



Step 5

Care pathway approach

Example of a Child Obesity (5–11 year old – primary school) care pathway from NHS Camden (this is one of three child obesity care pathways – early years, primary school and secondary school). Please note that the care pathway is currently in draft format.

Healthy Weight Healthy Lives Care Pathway – Primary School (5-11 years)

Pre-assessment

1 Opportunistic
2 Existing Disease
3 Health Monitoring at Reception Year and Year 6 as part of the National Child Measurement Programme
4 Seeking Advice (parent/carer or child)

Health and non-health care professionals involved: school nursing team, primary care team, community paediatricians, dietetians, psychologists, physiotherapists, secondary care clinicians, dental health teams, community food team, school improvement service (healthy schools, extended services), schools sports coordinators, teachers, and staff from leisure services, physical activity initiatives, community and voluntary organisations

Assessment and Classification

1 Use clinical judgment to decide when to measure height and weight to calculate BMI. $BMI = \frac{Wt(kg)}{Ht(m^2)}$
2 Relate to UK 1990 BMI charts to give age and gender specific information.
91st centile or above – Overweight
98th centile or above – Obese
3 Record child's history and family history of overweight, obesity, comorbidities and complex needs.

Risk factors, comorbidities and complex needs associated with obesity

- Metabolic syndrome and cardiovascular risk
- Type 2 diabetes or pre-diabetic states
- Exacerbation of Asthma
- Psychosocial difficulties (e.g. low self-esteem, depression, eating disorders)
- Any joint or mobility problems
- Developmental delay
- Educational and learning difficulties
- Being looked after and having other special needs

See resource pack for a more comprehensive list

4 Raise the issue of weight
5 Assess child's and family's willingness and motivation to change.

Health professionals involved: school nursing team, primary care team, community paediatricians, dietetians, psychologists, physiotherapists, and secondary care clinicians

Children aged 5-11 years classified as overweight or obese

NOT MOTIVATED	MOTIVATED	
	NO COMORBIDITY OR COMPLEX NEEDS	COMORBIDITY OR COMPLEX NEEDS
	Overweight 91st centile or above / Obese 98th centile or above	Overweight 91st centile or above / Obese 98th centile or above
• Provide information about the benefits of achieving a healthy weight, healthy eating and physical activity. • Provide contact details of a relevant health care professional e.g. school nurse or practice nurse. • Raise the issue of weight again in 3-6 months.	Refer to Tier 1 with school nursing team or primary care team. Refer to Tier 2 only after follow up. / Refer to Tier 2 Child Weight Management Service.	Refer to specialist Tier 3 services Child Weight Management Service. / Refer to specialist Tier 3 services Child Weight Management Service.

NHS Camden

Healthy Weight Healthy Lives Care Pathway – Primary School (5-11 years)

Tier 1

Brief first-line advice intervention: healthy eating, physical activity and behaviour change.
1 **Explore** current lifestyle, diet and levels of physical activity.
2 **Encourage** healthy eating, increased physical activity, and improved behaviour around eating and activity.
3 **Supply supportive resources** e.g. Change4Life *Top Tips for Top Kids*
4 **Set SMART goals** and a realistic healthy weight plan tailored to the individual.
5 **Signpost** to local healthy eating and physical activity initiatives.
6 **Set-up referral** to other health care professionals where necessary via specialist clinician for Child Weight Management Service.
7. **Review** weight and BMI change at least once a month for 3 months and aiming for weight maintenance producing BMI reduction with growth.

Monitoring criteria at 3 months:
Child classified as successful - refer to maintenance
Criteria:
- achieves a healthy weight (below 91st centile), **or**
- remains overweight (≥91st centile) but there is a reduction in BMI centile.

Child classified as unsuccessful - refer to Child Weight Management Service
Criteria:
- remains overweight (≥91st centile) and there is no reduction in BMI centile or an increase in BMI centile, **or**
- increases to obese (≥98th centile).

Health professionals involved:
school nursing team or primary care team

Maintenance

A 9 month step-down support for children (and families) who have achieved a successful BMI reduction (related to age and gender).

The level of support depends on which tier the child has successfully completed prior to entering maintenance.

Tier 1 children receive:
- Follow-up measures by school nursing and primary care teams (at 3, 6 and 9 months after they have entered maintenance)
- Signposting to local community-based healthy eating and physical activity initiatives using the CWMS Activity Directory

Tiers 2 and 3 children receive:
- Follow-up measures by the CWMS (at 3, 6 and 9 months after they have entered maintenance)
- Signposting to local community-based healthy eating and physical activity initiatives using the CWMS Activity Directory
- Free physical activity sessions for children and families held at a variety of times and venues across Camden
- MEND World support

Children who relapse in weight maintenance are referred back into the pathway.

Child Weight Management Service
SPECIALIST CLINICIAN

Tier 2

MEND - multicomponent weight management programme

Tier 3

- Paediatric Dietetics
- Psychology
- Specialist physical activity / physiotherapy
- Community paediatrics for children with complex needs

Tier 4

UCLH Child & Adolescent Weight Management Clinic
- Specialist Lifestyle Modification
- Specialist Medical and Behavioural Treatment

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Step 5

All three approaches are based on guidance and evidence as well as case studies from local areas. They all use tiers to illustrate the different levels of care that are provided for overweight and obese individuals, as described in more detail below.

Universal services

This level covers core preventative services that all children and young people and their families should have access to – providing universal healthy eating, physical activity programmes and support. This can include the Child Health Promotion Programme delivered through health visitor-led teams, Children's Centres, Healthy Schools, and primary care. Services at this level may also play an important role in providing weight maintenance support for those wanting to maintain a healthy weight.

Tier 1 – targeted brief intervention

This level covers brief intervention by frontline staff such as school nursing ad health visiting teams. The service is usually conducted 1:1 with the child and parent or carer (depending on their age). This service takes place in a community setting.

Tier 2 – targeted multi-component weight management programmes

Services provided at this level typically take the form of multi-component (nutrition, physical activity, and behavioural change) family-based weight management programmes, often taking place in community settings and run by non-health care professionals. This level of intervention is often aimed at children or young people with a BMI above the 91st and 98th centile, but without a co-morbidity or complex need (e.g. learning disability).

Tier 3 – targeted specialist multi-disciplinary weight management interventions

Services provided at this level often require more intensive and specialist clinical input than tier 2 services. Specialists include dietitians, psychologists, and physiotherapists/physical activity specialists. The service is usually in community settings. This level of intervention is often aimed at children or young people with a BMI greater than 98th centile plus a medical cause of obesity co-morbidity, or complex needs (e.g. learning disability).

Tier 4 – targeted highly specialist multi-disciplinary weight management service

Services provided at this level often require more intensive and highly specialised clinical input than tier 2 and 3 services. Specialists will include similar professionals to those provided within tier 3 (e.g. dietitians, psychologists, and Physiotherapists) as part of specialist clinics with paediatricians. The service will also be acute based. The prescribing of pharmacotherapy and pre-assessment for bariatric surgery for young people will take place at this stage. This level of intervention is often aimed at children or young people with a BMI greater than or equal to the 99.6th centile, plus a medical cause of obesity, significant co-morbidity, or complex needs (e.g. learning disability).

Maintenance

This is a variety of services provided via existing (e.g. free swimming etc) or new services within the borough (e.g. structured physical activity sessions specifically for children that have completed at least one tier of the pathway and have been defined as successful)

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to ensure individuals maintain or achieve their healthy weight, and maintain their healthy eating and exercise behaviours. This should include follow-up measurements (e.g. BMI centile or z-score).

It is important to remember that children will be either unsuccessful or successful at each tier and will either be referred into the higher tier (i.e. when they are unsuccessful) or referred into maintenance (i.e. if they are successful).

The referral and care pathway approaches also include the identification, and assessment and classification of overweight and obese children and young people. For example, the National Child Measurement Programme is a method for identifying overweight and obese children in reception year and year 6.

The care pathway for children can be considered as one pathway for children aged 0–18 years or as three separate care pathways broken into different age brackets and settings such as, 0–4 years (early years), 5–11 years (primary school), 12–18 years (secondary school). The latter recognises that a different group of interventions is required for a 6-year old compared with a 16-year old. Whilst the actual interventions offered in each level may be different for different age groups, the overall care pathway and the tiered structure should remain consistent.

Whilst developing the pathway, it is also necessary to identify other relevant programmes and services that are taking place or set up in the local area, which although not specifically focused on obesity, are likely to bring frontline staff in contact with children and families with weight problems. Examples for children and young people, include the Family Nurse Partnership. The interface with these other programmes and care pathways needs to be established.

A number of versions of the pathway (whichever framework approach is used) will need to be produced and circulated for comments. Ensure that all stakeholders review the drafts and provide feedback as this will assist with the implementation process. It may also be helpful to begin to draft the care pathways prior to commissioning and procuring new services i.e. the pathway will include some services that are already in place, some that are currently being commissioned and some that require business cases to fund new services. The draft care pathways can be used in all of these situations i.e. they can be attached as appendices to service specifications for new services, and to business cases, and used in presentations to senior management when trying to agree additional funds or the reallocation of resources. A number of iterations of the draft pathway will be produced before it is signed off and finalised in Step 7, and even then the pathway may be revised following monitoring and evaluation.

At this stage, it is also beneficial to consider whether to produce resource packs that support the pathways. These support packs should contain detailed information about all stages of the pathway (e.g. identification, classification, management at different tiers, follow up and maintenance) and tools/resources for use by all the frontline staff involved with the whole of the pathway (i.e. across all of the tiers). They provide a record and

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resource that staff can refer to whilst using the pathway and contain detailed information that is unable to be included on the pathways.

Step 6: Identify training requirements

During implementation, training days and events will be needed both to launch the pathway and to ensure that everyone has the capability to implement the pathway effectively.

Local areas need to make sure that all health and non-health care professionals are equipped and feel confident raising the issue of weight, assessing the weight status of children (and parents/carers), providing healthy eating and physical activity advice using behaviour change techniques (brief intervention training including facilitation of groups), supplying supportive literature and resources, signposting to local initiatives, and referring into associated weight management services. The specific training requirements will be different for each individual PCT. Local needs should be identified during stakeholder engagement, mapping of existing services, and drafting of the pathway.

A generic outline of potential training needs is outlined in table 2.4. Please note that the resources available for training must be taken into consideration (see Initiation Phase – Step 5: Agree key resources). PCTs should also consider establishing an annual rolling training programme that takes account of top-up/refresher training and staff turnover.

Table 2.4: Generic Outline of Potential Training Needs

Level	Training Content
Level 1	**Understanding and implementing the pathway** • Launch the pathway • Presentation explaining and talking through the pathway • Questions and answers on the pathway to ensure all delegates understand the pathway The training should take place over a short session (e.g. lunch breaks) or could be lengthened to half a day by including a brief exercise/group work on a case study. This level of training is ideal for frontline staff who need to be aware of the pathway and understand how and where to refer children within the pathway but may not need to conduct detailed assessments or manage overweight or obese individuals or they already have the required skills (for example, GPs, dietitians, psychologists, and paediatricians).

continued

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Step 6

Table 2.4: Generic Outline of Potential Training Needs (continued)

Level	Training Content
Level 2	**Assessment and management of overweight and obese children** • Launch the pathway • Presentation explaining and talking though the pathway • Questions and answers on the pathway to ensure all delegates understand the pathway • Interactive session on breastfeeding and weaning advice (may be only necessary for the 0–4 year olds pathway) • Interactive session on raising the issue of weight and assessing/exploring motivation to change using role-plays. • Practical session on measuring height, weight, calculating BMI (and relating it to the UK 1990 Growth Charts for children). • Practical session on conducting a 'brief intervention' – providing healthy eating and physical activity advice, agreeing SMART goals and a realistic weight management plan and follow up. • Exercise/group work using case studies • Referral into associated weight management services within the pathway. Role plays and case studies should recognise that when tackling childhood obesity, the child and parent/carer will be involved. The training should ideally take place over one day with regular breaks throughout the day. It is ideal for frontline staff who will be conducting detailed assessments and managing overweight and obese children (for example, school nurses, practice nurses, health trainers, and health visitors). Frontline staff who are involved with tier 3 weight management services (e.g. dietitians, psychologists, physiotherapists/specialist physical activity professionals) may be able to play a role in delivering the level 2 training and providing ongoing support to frontline staff at tiers 1 and 2.
Level 3	**Behaviour change and motivational interviewing** Two days and training on behavioural change techniques.

PCTs that decide to launch child, adult (and maternal) obesity care pathways simultaneously, should consider coordinating training events. This would demonstrate a systematic provision of care for overweight and obese individuals across the life-course. Coordinated training events are likely to improve partnership working across groups of health and non-health care professionals.

See *Appendix G* for a Training needs gap analysis template.

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Step 7: Sign off the pathway

Once the pathway has been agreed by the Obesity Care Pathway Steering Group, they will need to be taken to a number of key groups for sign off. These include:

1. PCT Public Health/Health Improvement Senior Management Team (SMT)
2. PCT Professional Executive Committee (PEC)
3. PCT Commissioning Executive/Board
4. Children and Young People's Strategic Partnership under the Local Strategic Partnership (LSP)

There may be other senior groups and committees that need to sign off the pathway but these are individual to each PCT.

A paper will need to be produced (with the pathways attached as appendices) and circulated in advance of the board and committee meetings.

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Phase 3: Implementation

Definition: the implementation phase is the third phase in the obesity care pathway process. It involves applying and putting into practice the finalised obesity care pathway.

During the implementation phase, the obesity care pathway lead will plan and co-ordinate launch and training events in combination with designing and printing, and marketing and advertising the pathways.

There are three steps within this phase:

1. Plan and organise the launch and training events
2. Design and print the pathway
3. Launch the final pathway

Step 1: Plan and organise launch and training events

The training needs of frontline staff should have been identified during the development phase (see Development Phase – Step 6: Identify Training Requirements). Once the training needs have been agreed, training events must be planned and organised. The training events may be able to be provided 'in-house' using internal staff and venues or in some cases, it may be necessary to commission training packages. *Healthy Weight, Healthy Lives: Directory of Obesity Training Providers* (April 2009)[xi] lists training courses, and acts as a resource for commissioning training on the prevention and management of obesity. The directory is an update of the one published in 2005. There are no quality assurance criteria for the listings and, as such, inclusion in this directory does not indicate approval or accreditation by the Department of Health or Dietitians in Obesity Management UK (DOM UK). The resource should, however, still be considered a useful guide for PCTs identifying training providers to support the implementation of the pathway.
See *Appendix G – Training needs gap analysis by staff group*
See *Appendix H – Training event check list*

Step 2: Design and print the pathway

The final pathway should have been agreed and signed-off during the development phase (see Step 5: Draft and finalise the pathway and Step 7: Sign off the pathway). Depending on financial resources, the pathways and training materials can either be printed 'in-house' or by a professional publisher/printer. Estimate the number of health and non-

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health care professionals that will be using the pathway, for example, health trainers, practice nurses, GPs, dietitians, psychologists, pharmacists, specialist physical activity professionals, consultants. Ensure that enough copies of the pathway are produced so that all staff are able to have their own copy.
See *Appendix G – Training needs gap analysis by staff group*

Step 3: Launch the final pathway

The pathway needs to be launched across the borough for successful implementation to take place. Launching will take place both through marketing and advertising, and the training and launch events. Ensure that the pathway is an agenda item on all related steering groups/partnership meetings/networks, such as, Breastfeeding Partnership Group, and Children's and Young People Steering Group. A number of stakeholders who have been involved with generating the pathway will be part of these steering groups, but presenting at each of these specific groups will ensure that the pathway is fed down and across to all relevant strategic and delivery staff.

Market and advertise the pathway

Engage all stakeholders and disseminate the pathway through all of their routes via email, post and short presentations. Coordinate with communications departments and produce articles featuring the pathway and associated weight management services and advertise the training events in local PCT and LA newsletters and circular emails. Consider producing a letter from the strategic lead and other key stakeholders (e.g. Head of Health Visiting/School Nursing or GP) that launches the pathway because this can be used when disseminating copies of the pathway to various settings (e.g. GP practices, children's centres, schools). It is a good idea to follow up on postal distributions to see if frontline staff have received the pathways.

Coordinate training events

The training sessions should have been planned and organised (see Implementation Phase – Step 1: Plan and organise training events) by this point. Confirm the dates, venues, refreshments, trainers and continue advertising so that a high percentage of delegates attend the sessions. It is unlikely that all health and non-health care professionals will be able to attend the events but the more events, distributed in various venues across the borough, and on different days of the week, the higher the attendance rate.
See *Appendix H – Training events checklist.*

A launch and training events log (*see Appendix I – Launch and training events log)* should be completed and kept up-to-date.

Phase 4: Evaluation

Definition: the monitoring and evaluation phase is the fourth phase in the obesity care pathway process. It involves judging the value of the obesity care pathway and assessing to what extent it has achieved what it set out to do, met any funding conditions, and benefited the target group (overweight and obese local population). The results will indicate what was successful as well as what could be improved. Monitoring and evaluation is particularly important because the obesity care pathway must be sustained, and will result in the continuous improvement of the pathway over time.

During the monitoring and evaluation phase, the obesity care pathway lead will coordinate the monitoring and evaluation of the pathway and use the findings to inform improvements in the pathway. This is key for sustaining the pathway. Any formal evaluation conducted at this stage may be carried out by an external organisation and not necessarily the obesity care pathway lead.

There are five steps within this phase:

1. Monitor and evaluate the pathway
2. Revise and improve the pathway
3. Disseminate the findings
4. Continue to monitor and evaluate
5. Make plans to sustain the pathway

Step 1: Monitor and evaluate the pathway

The importance of monitoring and evaluation

Care pathways are frameworks that should be regularly reviewed and improved to drive up system quality and highlight any weaknesses. At present there is a lack of evidence to demonstrate the effectiveness of obesity care pathways and associated weight management interventions. Monitoring and evaluation of obesity care pathways is therefore necessary for a number of reasons including:

- To revise and continually improve the pathway (see Step 5 – Make plans to sustain the pathway);
- To provide evidence of effectiveness and cost-effectiveness, (particularly important for supporting requests for further funding); and
- To expand the evidence-base and develop models of good practice that can be shared with other PCTs.

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Step 1

Evaluating a pathway is often forgotten, particularly as the focus is centred on actually developing and implementing the pathway. Although it is positioned in the fourth quarter of the cycle of phases, it should not be considered a stand-alone activity that should only occur at the end of the pathway development and implementation phases. Evaluation is an integral part of the process and should be considered during the initiation phase (see Step 5: Agree key resources) and development phase (see Step 4: Reconfigure services to meet need and see Step 5: Draft and finalise the pathway). It should be closely linked to the objective setting and setting of key output and outcome measures (key performance indicators) for each of the services within the pathway.

Conducting monitoring and evaluation

A national Standard Evaluation Framework (SEF) has been developed by the National Obesity Observatory (2009)[xii] to support high quality, consistent evaluation of weight management interventions. The guidance lists criteria divided into two parts: essential and desirable. Essential criteria are presented as the minimum recommended data for evaluating a weight management intervention. Desirable criteria are additional data that would enhance the evaluation. Although the guidance is specifically for the evaluation of weight management interventions, it can be used more widely for supporting the evaluation of the whole care pathway.

Monitoring is a continuous process carried out throughout the whole project and is used to check the extent to which the project is proceeding according to plan. For example, the commissioner may review quarterly monitoring reports from providers to see if recruitment and attendance rates are achieving the target. Results of the monitoring process can change the development and implementation of the pathway (e.g. a sudden decrease in attendance rates can be rectified by establishing a recruitment drive, changing the location of the service). Monitoring should not be considered a substitute for a full evaluation.

Evaluation is assessed at a particular point in time to measure the extent to which the project has achieved its objectives. Evaluation can measure process, output, impact and outcome measures. Process evaluation focuses on the process used throughout the development and implementation of the pathway: it aims to see why the pathway meets or does not meet its aims and objectives; what went right and what went wrong; what can be learnt for future pathway development projects. Output, impact and outcome focus on whether the pathway development and implementation project met its aims and objectives. This might be in terms of health impacts (e.g. change in health behaviours around eating and physical activity) or outcomes (e.g. change in body mass index). It is also helpful to record the inputs (resources used to conduct the work e.g. financial, material and human).

It is advisable to allocate a budget and resources (personnel and funding) and agree plans for the monitoring and evaluation phase prior to developing the obesity pathway (see Initiation phase – Step 5: Agree Key Resources). There is no general consensus on the level of funding required for evaluations although the World Health Organisation (WHO) suggests at least 10% of the total budget. In addition, during the initial start up phase make sure you confirm your SMART (Specific, Measurable, Achievable, Relevant, Time-limited) objectives, and expected outputs and outcomes.

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Step 1

The next step is to establish and set core measures (performance indicators), which uses information that indicates that an objective has been met (i.e. a measure of something which demonstrates a change in a particular outcome following the pathways implementation). The core measures or performance indicators can be quantitative and qualitative (these are different ways data can be used to inform evaluations):

- **Quantitative indicators** give numerical results that can be analysed using statistical methods. Quantitative methods are most often used to assess outcomes.
- **Qualitative indicators** use narrative or descriptive data rather than numbers. Qualitative methods are most often used to assess service user and service provider needs and views.

Table 4.1 provides examples of quantitative and qualitative indicators.

Table 4.1: Examples of quantitative and qualitative indicators

Indicator	Example
Quantitative	**Percentage of individuals who have completed the tier 2 weight management intervention and reduced their BMI taking into account age and gender (ie centile/z-score).** **Percentage of individuals who have maintained BMI reduction taking into account age and gender or centile/z-score at 6 months after completing the weight management intervention.** **Prevalence of obesity among primary school age children in Reception and Year 6.** NOTE: The effects of introducing a pathway are likely to have a time lag so a local change in childhood obesity prevalence will be greater in years two and three than year one[ix].
Qualitative	**Semi-structured interviews with health care professionals (e.g. school nurses)** to assess their thoughts and feelings about using the pathway (e.g. effectiveness, barriers to implementation, factors to facilitate implementation). **Focus group with service users** to assess their experiences of being identified and assessed by primary care, referred into the tier 2 weight management intervention and recommendations for how it can be improved (e.g. assessment, referral process, length of time for referral, length or programme, timing, location, and content of programme).

It is important to be realistic about the impact of the pathway on the key indicators and to agree a range of indicators. SEF recommends considering using a 'Logic Model', which describes the relationships between elements in a project or intervention, and the likely direction of change.

Step 1

The following step is to identify how and when to collect the data required for each core measure. Performance indicators can be existing indicators or new indicators. For example, many areas will already be collecting data on the prevalence of obesity in children and is therefore a useful existing indicator whilst the percentage of children that have a reduced BMI z-score during the 12-week programme would be a new indicator that requires identifying a data collection method. Some data will be objective and easy to collect (e.g. height and weight at the start and end of the intervention) and some data will require indirect methods (e.g. questionnaire on physical activity). SEF outlines some validated tools for measuring physical activity. Qualitative data will usually be collected through semi-structured face-to-face or telephone interviews, or focus groups. When designing questionnaires and considering conducting semi-structured interviews or focus groups, it is important to seek help from someone experienced in quantitative and/or qualitative methods. It is also important to confirm baseline data and levels against which performance can be measured i.e. compare outcome data with baseline data.

At all stages of agreeing the data sets and information that shall be collected at each stage of the pathway, refer to and cross-reference with the SEF to ensure that the indicators, service specifications, SLAs are all aligned with SEF.

Finally, once the data have been collected, they need to be analysed at pre-agreed points throughout the project. For the pathway, this could be annually although interim reports on individual components of the pathway (e.g. each weight management intervention) should be monitored on a more regular basis (e.g. quarterly). The type of analysis will depend on the performance indicator, data, and data collection method. For example, quantitative data will require the appropriate statistical test and quantitative data will require the appropriate analytical analysis method.

Table 4.2 provides examples of monitoring and evaluation questions and data collection methods (see following page).

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Table 4.2: Examples of monitoring and evaluation questions and methods that can be used for evaluating obesity care pathways

Performance Indicator	Monitoring and Evaluation methods
Outputs **1. Numbers and sources of referrals** Number and % of patients referred and by source (for each weight management programme) **2. Attendance/drop-out at first session** Number and % of patients attending and failing to attend first session (for each weight management programme) **3. Retention rates** Number and % of patients who fail to attend a session (for each weight management programme) **4. Completion rates** Number and % of patients that complete the tier 2 weight management intervention (i.e. attended 75% of the sessions) (for each weight management programme) **5. Referral onto appropriate tier** – Number and % of patients that are unsuccessful at tier 2 and referred on to tier 3 (or tier 3 to tier 4). **Impacts and outcomes** **1. BMI change related to age and gender on completion** No. and % of patients that complete the weight management programme (i.e. attends 75% of the sessions) and achieve a reduction in BMI related to their age and gender, centile/z-score (for each weight management programme). **2. Weight maintenance and follow-up at 9 months post completion (12 months from baseline)** No. and % of completers/ patients achieving no increase in BMI related to their age and gender, centile/z-score (9 months) after completing the programme (for each weight management programme).	Quantitative – quarterly reporting/ data extraction followed by statistical analysis.
Service user feedback **1. Participants satisfaction with service** Strengths, weaknesses, likes, dislikes, self-reported programme impacts (for each weight management programme) referral process into the service, discharge from the service, follow-up.	Qualitative – focus group
Service provider feedback **1. Participants satisfaction with service** Strengths, weaknesses, problem areas, recommendations (for each weight management programme) and views on using the care pathway (from all frontline staff e.g. primary care teams, school nursing teams, health visiting teams).	Qualitative – semi-structured interviews (face-to-face or telephone)

Please note that these are examples and should not be considered an exhaustive list. See the SEF essential and desirable criteria. Work through each step of the pathway and consider whether it is possible to set an appropriate performance indicator and how the data will be collected for each core measure. It is also helpful to identify which service or

frontline staff will collect the data and how it will be reported to the commissioner.
See Appendix J for a template for monitoring and evaluating the pathway.

Tackling obesity requires action across a range of areas, and individual initiatives, such as generating pathways, are only one of the actions involved with decreasing the prevalence of obesity. Therefore, it is advisable to monitor progress made by measures that are associated with the outcome measure and agree on a combination of quantitative and qualitative methodologies for monitoring and evaluating the obesity care pathway.

Step 2: Revise and improve the pathway

The results of monitoring and evaluation should be fed back into the planning and revisions to the pathway.

Step 3: Disseminate the findings

The results of the evaluation should be disseminated widely in a number of formats, for example, a final report, short written summaries, steering group meetings and seminars or workshops. All PCTs should consider producing a journal article, for a peer-reviewed publication, to increase the evidence and support other PCTs undertaking similar evaluations.

Step 4: Continue to monitor and evaluate

As mentioned in 'Step 1: Monitor and Evaluate the Pathway', monitoring is a continuous process carried out throughout the lifetime of the project. Once again, the results of monitoring and evaluation of the desired outcomes should be used to revise the pathway.

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Step 5

Step 5: Make plans to sustain the pathway

The extent to which an intervention may be continued beyond its initial development, implementation and evaluation will depend upon the effectiveness of the programme effectiveness and whether there is a continued source of funding. See 'Initiation phase – Step 5: Agree key resources' for an outline of the specific activities that will require continued funding. It is therefore crucial that key indicators are put in place to evaluate the pathway and the results are used to make improvements in order to increase its reported effectiveness.

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Resources

Websites

Change4Life (including Start4Life and Adult Change4Life)
www.nhs.uk/change4life/Pages/Partners.aspx

Department of Health – Obesity
www.dh.gov.uk/en/Publichealth/Healthimprovement/Obesity

Department of Health – Physical Activity
www.dh.gov.uk/en/Publichealth/Healthimprovement/PhysicalActivity

Department of Health – Change4Life
www.dh.gov.uk/en/MediaCentre/Currentcampaigns/Change4Life

National Institute for Health and Clinical Excellence (NICE)
www.nice.org.uk

National Obesity Observatory (NOO)
www.noo.org.uk

Obesity Learning Centre
www.obesitylearningcentre-nhf.org.uk

Publications

Change4Life Marketing Strategy – In support of Healthy Weight, Healthy Lives (April 2009)

Change4Life: One Year On (February 2010)

Chief Medical Officer Report – At least five a week: Evidence on the impact of physical activity and its relationship to health (April 2004)

Foresight – Tackling Obesities – Future Choices Project (October 2007)
This project looked at how we can respond sustainably to the prevalence of obesity in the UK over the next 40 years.

How to set and monitor goals for prevalence of child obesity: guidance for Primary Care Trusts (PCTs) and local authorities – initial guidance (February 2008) and updated guidance (February 2009)

British Heart Foundation Detailed Local Area Costs of Physical Inactivity by Disease Category

Tackling obesity through the Healthy Child Programme: a framework for action (2010)

Operating Framework for the NHS in England 2010/11 (December 2009)

National Institute for Health and Clinical Excellence (NICE)

- Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children (December 2006)
- Behaviour Change (October 2007)
- Physical Activity and the environment (January 2008)
- Promoting physical activity for children and young people (January 2009)
- Promoting physical activity in the workplace (May 2008)
- Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling (March 2006)

DH Obesity Care Pathway (2006)

Package of materials for health care professionals as well as information to be given to patients. It includes obesity care pathways for adults and children and a supporting booklet with detailed information for health professionals. In addition, there are tools to help GPs raise the rather sensitive issue of weight opportunistically with both adults and children.

National Obesity Observatory Standard Evaluation Framework for weight management interventions (March 2009)

The aim of the SEF is to support high quality, consistent evaluation of weight management interventions in order to increase the evidence base. The SEF provides introductory guidance on the principles of evaluation, and lists 'essential' and 'desirable' criteria. Essential criteria are presented as the minimum recommended data for evaluating a weight management intervention. Desirable criteria are additional data that would enhance the evaluation. The supporting guidance describes why particular criteria have been categorised as essential or desirable, and gives further information on collecting data.

Department of Health – NHS LifeCheck (NHS Baby LifeCheck, and NHS Teen LifeCheck)

www.dh.gov.uk/en/Publichealth/Healthimprovement/NHSLifeCheck

Documents previously produced by the Department of Health to support local work on obesity may also be of use:

Healthy Weight, Healthy Lives: Child weight management programme and training providers framework (March 2009)

A framework agreement with nine provider organisations to support the local commissioning of weight management services for children and young people. The providers all offer training in the delivery of specific approaches to weight management in at risk, overweight and obese children and young people.

Healthy Weight, Healthy Lives: Directory of obesity training providers (April 2009)

The directory lists training providers running courses on the prevention and management of obesity.

Healthy Weight, Healthy Lives: A Toolkit for Developing Local Strategies (October 2008)

This toolkit is to help primary care trusts and local authorities plan, coordinate and implement comprehensive strategies to prevent and manage overweight and obesity.

Healthy Weight, Healthy Lives: Commissioning weight management services for children and young people (November 2008)

A guide developed to support local areas in commissioning weight management services for children and young people. It is designed to reflect the move towards world class commissioning and joint commissioning of children's services.

Healthy Weight Healthy Lives: Consumer Insight Summary (November 2008)

Summary of the results of research carried out for the Department of Health into families' attitudes and behaviours relating to diet and activity.

Appendices

Appendix A: Summary spreadsheet for key resources required for obesity care pathway process

Estimated Costs for Obesity Care Pathway	Cost (£)
Phase 1: Initiation	
Personnel – Obesity Care Pathway Project Lead (external)*	
Phase 2: Development	
Personnel – Obesity Care Pathway Project Lead (external)*	
Investment in service provision:	
Identification and Assessment	
Tier 1	
Tier 2	
Tier 3	
Tier 4	
Maintenance	
Phase 3: Implementation	
Personnel – Obesity Care Pathway Project Lead (external)*	
Trainers (launch and training events) (e.g. dietitians, psychologists, physiotherapists/physical activity specialists – internal or external)	
Venues (launch and training events)	
Refreshments (launch and training events)	
Marketing and advertising	
Design and printing resources (e.g. pathways and supportive resources)	
Equipment (e.g. scales, tape measures)	
Phase 4: Evaluation	
Personnel – Obesity Care Pathway Project Lead (external)*	
External evaluators (e.g. to complete the whole evaluation or sections such as focus groups with service users and interviews with commissioners)	
Rolling training programme/top-up training	
Design and printing costs (once revisions to the pathway)	
Total estimated cost	

** It may be also helpful to estimate the hours that all internal project leads will have to dedicate to the project*

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Appendix B: Who are your stakeholders?

0 – 4 years Early Years	Name of local stakeholder
PCT Obesity Lead	
Assistant/Associate Director of Public Health	
Public Health Strategists – Children and Young People	
Head of Health Intelligence/Information	
Director of Children's Services	
Head of Health Visiting	
Head of Maternity Services	
Head of Dietetics	
Paediatric Dietitian	
Clinical Psychologist/CAHMS	
Community Paediatrician	
Paediatrician	
Physiotherapist	
Children's services commissioning lead	
Infant Feeding Coordinator	
Community Food Team Manager	
General Practitioner	
Professional Executive Committee (PEC) representatives	
Practiced Based Commissioning (PBC)	
Practice Nurses	
Other	

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5 – 11 years Primary School	Name of local stakeholder
PCT Obesity Lead	
Assistant/Associate Director of Public Health	
Public Health Strategists – Children and Young People	
Head of Health Intelligence/Information	
Director of Children's Services	
Head of School Nursing	
Head of Dietetics	
Paediatric Dietitian	
Clinical Psychologist/CAHMS	
Community Paediatrician	
Paediatrician	
Physiotherapist	
Children's services commissioning lead	
Healthy Schools Programme Manager	
School Sports Partnership Manager	
General Practitioner	
PEC representatives	
Practiced Based Commissioning (PBC)	
Practice Nurses	
Other (please specify)	

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Appendix B

12 – 18 years Secondary School	Name of local stakeholder
PCT Obesity Lead	
Assistant/Associate Director of Public Health	
Public Health Strategists – Children and Young People	
Head of Health Intelligence/Information	
Director of Children's Services	
Head of School Nursing	
Head of Dietetics	
Paediatric Dietitian	
Clinical Psychologist/CAHMS	
Community Paediatrician	
Paediatrician	
Physiotherapist	
Children's services commissioning lead	
Healthy Schools Programme Manager	
School Sports Partnership Manager	
General Practitioner	
PEC representatives	
Practiced Based Commissioning (PBC)	
Practice Nurses	
Other (please specify)	

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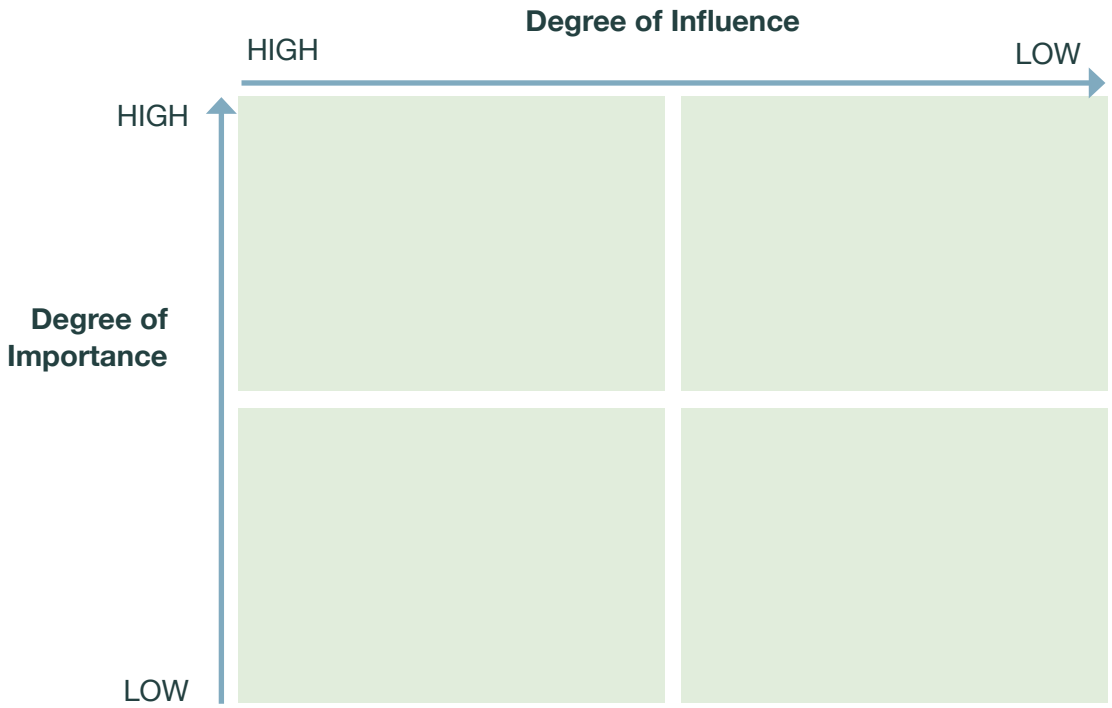
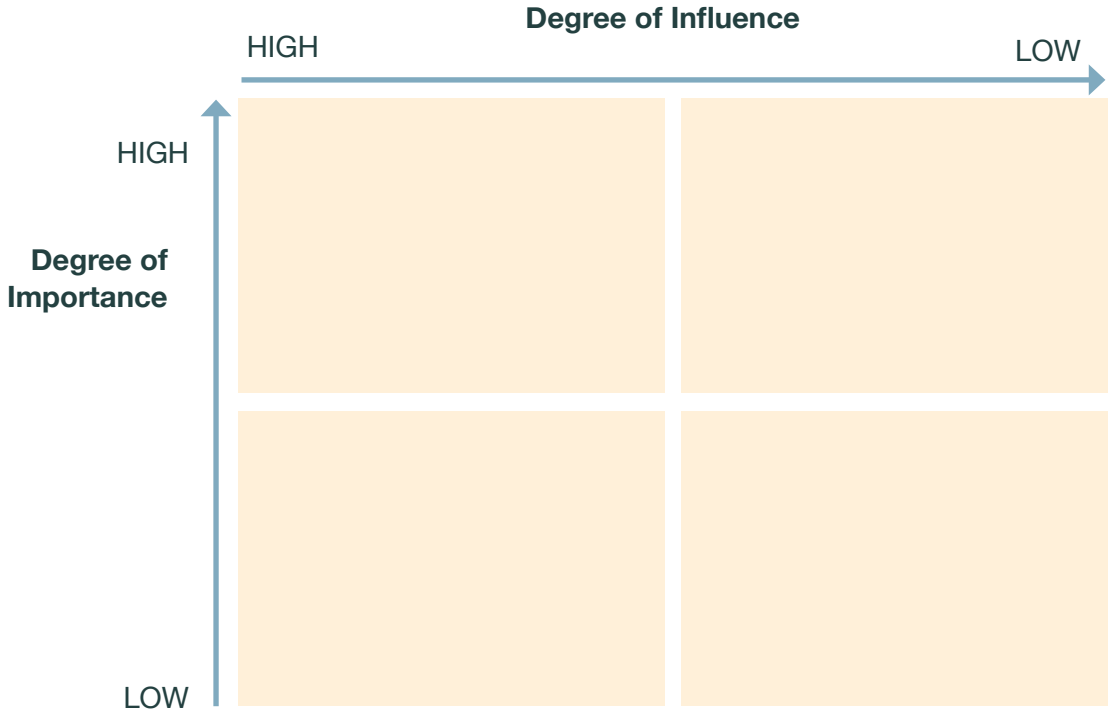
Appendix C: Stakeholder analysis

PHASE 1 – Initiation

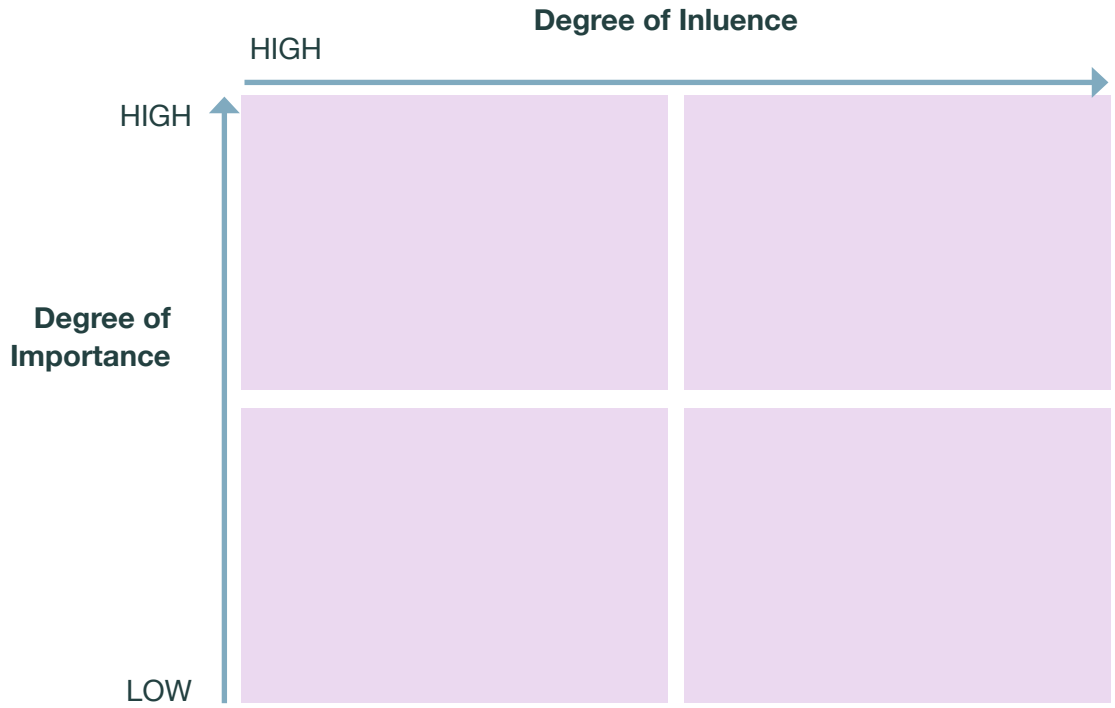


PHASE 2 – Development

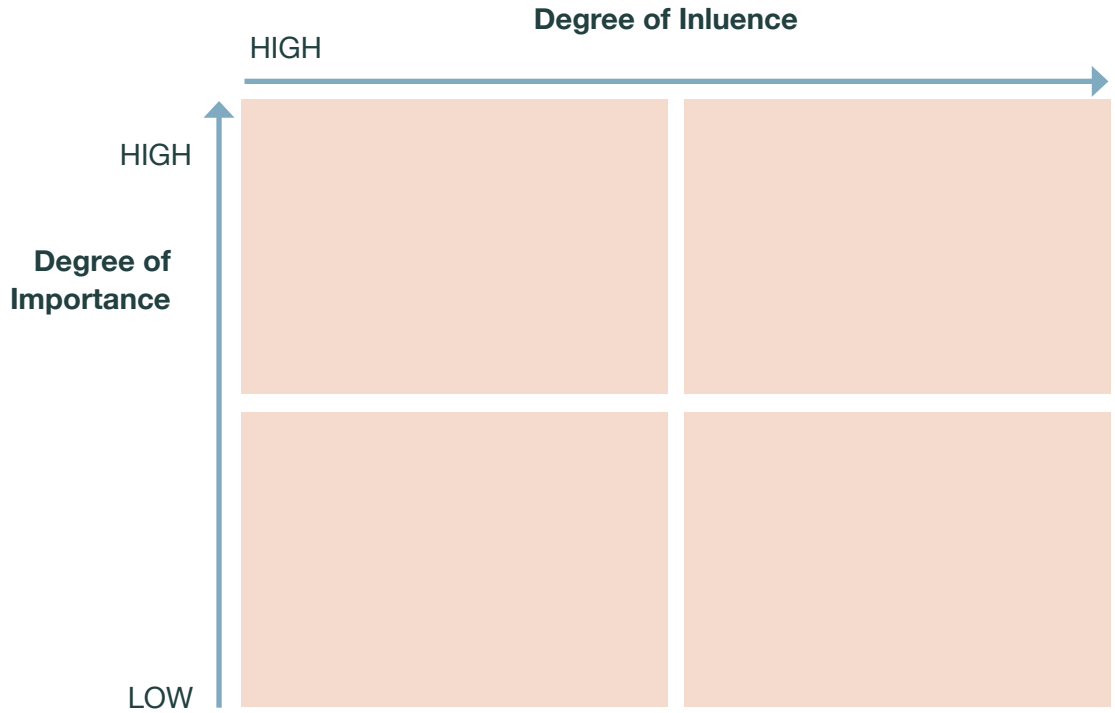


Appendix C

PHASE 3 – Implementation



PHASE 4 – Evaluation



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Appendix D: Topic guide of key questions for stakeholders

Introduction

1. Record their name, job title, and contact details.
2. How does your role contribute to tackling childhood obesity?

Mapping current service provision

1. Has any type of mapping exercise/needs assessment of childhood obesity services been conducted as yet?
2. How does your service identify and classify overweight and at-risk children as well as those who are obese?
3. What does your service provide/commission for those children that are overweight and obese? For each of the services obtain information on the following areas:
   - **a.** Detailed outline of the service content (e.g. nutrition, physical activity and/or behaviour change components)
   - **b.** Provided by which health care professionals
   - **c.** Setting for the service
   - **d.** Referral and eligibility criteria for the service (e.g. BMI/Centile, age, co-morbidities)
   - e. Referral routes (to AND from the service)
   - **f.** Number and source of referrals to the service?
   - **g.** Under-provision, adequate or over-provision of services i.e. is there a long waiting list?
   - **h.** Demographic, outcome, output data on effectiveness/cost effectiveness of the service (compare with SEF)
   - **i.** Length of the programme/number of appointments
   - **j.** Follow up of children
   - **k.** Resources/funding available for the service (continuous or fixed term)
   - **l.** Borough wide or confined to specific geographical locations
4. Breaking down by profession, how many health care professionals are there within the department e.g. how many health visitors, school nurses, dietitians, psychologists, physiotherapists, paediatricians etc?
5. To what extent are health visitors, school nurses etc involved with tackling obesity?
6. How many staff specifically have childhood obesity work within their contracts?
7. What settings have been used to treat childhood obesity?
8. How many schools, children's centres, leisure centres, health centres, GP practices (plus any other settings identified in the previous questions) are there in the borough and where are they distributed?

Appendix D

Prompt the current stakeholder for other obesity services and health care professionals to contact.

9. Are there any other childhood obesity services of which you are aware?
10. Can you recommend anyone else that it would be helpful to speak to that may be able to provide further useful information?

Data sources

1. What are the results of the National Child Measurement Programme? (reception year and year 6)
2. What are the breastfeeding rates? (percentage initiating breastfeeding and percentage breastfeeding at 6-8 weeks)
3. What are the results of the National Healthy Schools Programme (NHSP)? (percentage of all schools participating in NHSP and percentage of all schools achieving NHSS) and Enhanced Healthy Schools Programme.

Providing recommendations for gaps and duplication in service provision

1. Where do you feel there are gaps and duplications in the service provision?
2. Is the current service able to be expanded in order to assist with treating overweight and obese children (it may require additional resources)?
3. Are there examples of good practice that you feel should be mainstreamed?
4. Are you aware of any examples of good practice outside the borough that should be implemented?
5. Do you have any other recommendations for the pathway?

Have a copy of a pathway from another area or a mapping of your existing services.

Identifying training needs

1. Do you think that the workforce directly involved with childhood obesity (e.g. school nurses, health visitors, practice nurses) has sufficient capacity and capability to conduct obesity interventions?
2. Has any training been conducted for frontline staff on identifying and managing obese children? If yes, what type of training has been conducted, for which health care on non-health professionals and how many have been trained?

Comments on draft versions of the pathway

1. What are your initial thoughts on the layout of the pathway?
2. Could the pathway be realistically implemented within the borough?

Implementing the pathway

1. Are you aware of any barriers to implementing the pathway?
2. Are you able to support the implementation of the pathway (for example, assisting with training days, marketing and distributing the pathway)?

Appendix E: Mapping of current service provision

Stakeholder	Summary of Service	No. & type of Staff	Referral Criteria	Referral Routes	Setting & time(s)	Capacity of service	Output data (e.g. recruitment, attendance)	Outcome data (e.g. z-score change*)	Funding & Cost (£) (resources)	Systems (e.g. database)
Community services										
Voluntary services										
Children's Centres										
Schools and Colleges										
Youth Services										
Leisure services										

** All output and outcome measures should be broken down by gender, ethnicity, socio-economic group.*

continued

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Stakeholder	Summary of Service	No. & type of Staff	Referral Criteria	Referral Routes	Setting & time(s)	Capacity of service	Output data (e.g. recruitment, attendance)	Outcome data (e.g. z-score change*)	Funding & Cost (£) (resources)	Systems (e.g. database)
Tier 1										
Primary Care Teams (e.g. GPs, Practice Nurses, Health Care Assistants)										
School Nursing Teams										
Health Visiting Teams										
Tier 2										
Multi-component weight management programme										

** All output and outcome measures should be broken down by gender, ethnicity, socio-economic group.*

continued

Appendix E

Stakeholder	Summary of Service	No. & type of Staff	Referral Criteria	Referral Routes	Setting & time(s)	Capacity of service	Output data (e.g. recruitment, attendance)	Outcome data (e.g. z-score change*)	Funding & Cost (£) (resources)	Systems (e.g. database)
Tier 3										
Dietetics										
Psychology/ CAHMS										
Specialist Physical Activity										
Community Paediatricians										

** All output and outcome measures should be broken down by gender, ethnicity, socio-economic group.*

continued

Appendix E

Stakeholder	Summary of Service	No. & type of Staff	Referral Criteria	Referral Routes	Setting & time(s)	Capacity of service	Output data (e.g. recruitment, attendance)	Outcome data (e.g. z-score change*)	Funding & Cost (£) (resources)	Systems (e.g. database)
Tier 4										
Secondary & Tertiary Care										
Specialist obesity clinics										
Private providers										

** All output and outcome measures should be broken down by gender, ethnicity, socio-economic group.*

Pathway Level	Evidence and Best Practice	Need	Current Service Provision (supply)	Gap Analysis*	Priority**
Identification	Service provided by all frontline staff				
Assessment and Classification	Service provided by primary care health professionals (e.g. practice nurses, health care assistants, and GPs), school nursing teams, health visiting teams and other frontline staff. NICE (2006) - Identify, assess and classify overweight and obese children using BMI related to 1990 BMI charts (age- and gender- specific). Assess lifestyle, co-morbidities and willingness to change.				
Tier 1	Brief intervention provided by frontline staff, (such as, practice nurses, health care assistants, school nurses, health visitors) providing brief interventions.				

continued

Key:
*Gap Analysis (based on need, demand, and supply)
Red = no service provision
Amber = limited service provision
Green = complete service provision

**Priority (based on need, demand, supply, and funding)
Red = high priority
Amber = medium priority
Green – low priority

Appendix F: Comparative analysis

Appendix F

Pathway Level	Evidence and Best Practice	Need	Current service Provision (supply)	Gap Analysis*	Priority**
Tier 2	Multi-component (nutrition, physical activity and behavioural change) weight management interventions. Community based setting. NICE (2006) - Offer multi-component interventions to encourage: • increased physical activity • improved eating behaviour • healthy eating Include behavioural change strategies that may involve stimulus control, self-monitoring, goal setting, rewards for reaching goals, problem solving. Provide tailored and targeted advice with parent/ carer involvement.				
Tier 3	Specialist multi-disciplinary service (dietetics, psychology, physiotherapy/specialist physical activity, specialist nurse, community paediatrics). Community based setting. NICE (2006) – Referral to an appropriate specialist should be considered for children who are overweight or obese and have significant co-morbidity or complex needs (for example, learning or educational difficulties).				

continued

Pathway Level	Evidence and Best Practice	Need	Current service Provision (supply)	Gap Analysis*	Priority**
Tier 4	Specialist paediatric clinics within tertiary setting NICE (2006) – Drug treatment is not generally recommended for children younger than 12 years. In children younger than 12 years, drug treatment may be used only in exceptional circumstances, and treatment should be started in a specialist paediatric setting, by multidisciplinary teams with experience of prescribing in this age group. Drug treatment should be considered only after dietary, exercise and behavioural approached have been started and evaluated. NICE (2006) – Surgical intervention is not generally recommended in children or young people. Bariatric surgery may be considered for young people only in exceptional circumstances, and if they have achieved or nearly achieved physiological maturity. Surgery for obesity should be undertaken only by a multidisciplinary team that can provide paediatric expertise.approaches have been started.				
Maintenance	Variety of services provided via existing or new services within the borough (e.g. free swimming etc) to ensure individuals maintain/achieve their healthy weight, and maintain their healthy eating and exercise behaviours. This should include follow-up measurements (e.g. BMI z-score).				

Appendix G: Training needs gap analysis by staff group

For each staff group, a list of all staff will need to be obtained and their individual training needs identified in order to complete a full training needs gap analysis.

Staff group	Estimate number of staff by staff group	Level of training required for each staff group – see table 2.4		
		1	2	3
Primary Care Teams • GP • Practice nurses • Health Care Assistant				
Health Trainers				
Schools Nursing Teams				
Health Visiting Teams				
Midwifery teams (community and acute)				
Dietetics				
Psychology				
Physiotherapy				
Physical Activity Specialist				
Community Paediatrics				
Paediatrics				
Pharmacy				
Allied Health Professionals				
Leisure Centre Staff				
Healthy Schools Team and Schools Sports Coordinators				
Pastoral Care Teams				
Total number of staff				

The above list should not be considered exclusive; further staff groups are likely to be identified by local areas.

Appendix H: Training event checklist

Checklist	Tick once complete
Budget confirmed	
Agenda and content	
Agree trainers	
Venue	
I.T. equipment, flipcharts etc	
Refreshments/catering	
Advertising and marketing (incl flyer)	
Registration process (related to training needs gap analysis)	
Training materials (e.g. scales, tape measures, centile charts)	
Attendance sheet	
Evaluation forms	

Appendix I: Launch and training events log

Training or launch event (incl date of event)	Level of training (e.g. 1,2 or 3)	Trainers	Venue	Attendance by staff group	Evaluation feedback

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Appendix J: Monitoring and evaluating the pathway

Some examples have been provided within the template to provide some ideas of possible indicators and to assist with completing the template in full.

Pathway Level	Performance Indicator – quantitative or qualitative (output, impact and outcome measures)	Method of Data Collection	Timing of collection (e.g. end of programme, quarterly, annual	Who will collect the data and how it will be reported to the commissioner
Prevention	*e.g. % uptake in physical activity participation*			
Identification, Assessment and Classification	*e.g. % of overweight and obese children in the borough*			
Tier 1	*e.g. % of primary care staff conducting brief interventions* *e.g. numbers of frontline staff attending obesity care pathway training* *e.g. qualitative feedback (interviews or survey) of frontline staff views on using pathway*			

continued

Pathway Level	Performance Indicator – quantitative or qualitative (output, impact and outcome measures)	Method of Data Collection	Timing of collection (e.g. end of programme, quarterly, annual	Who will collect the data and how it will be reported to the commissioner
Tier 2	*e.g. % of patients referred (and referral source) to the service* *e.g. % of inappropriate and appropriate referrals (appropriateness of referrals should increase over time)* *e.g. % of patients achieving 5% weight loss at 3 months (adult)*			
Tier 3	*e.g. % of patients with improved self-esteem (using a validated questionnaire)* *e.g. % of patients with improved resting and recovery heart rate*			

continued

Appendix J

Pathway Level	Performance Indicator – quantitative or qualitative (output, impact and outcome measures)	Method of Data Collection	Timing of collection (e.g. end of programme, quarterly, annual	Who will collect the data and how it will be reported to the commissioner
Tier 4	*e.g. % of patients referred from tier 3 to tier 4 (i.e. unsuccessful at tier 3) (instead of directly to tier 4.*			
Maintenance	*e.g. % of completers who are referred into maintenance and do not increase BMI/weight after 3 months*			

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