



National Clinical Programme for Obesity



ROYAL COLLEGE OF PHYSICIANS OF IRELAND



# Model of Care for the Management of Overweight and Obesity



Clinical Design & Innovation  
*Person-centred, co-ordinated care*



Healthy Eating Active Living Programme

# NATIONAL CLINICAL PROGRAMME FOR OBESITY WORKING GROUP

A multidisciplinary working group supports the planning and delivery of the work of the National Clinical Programme for Obesity in line with agreed programme plans.

## WORKING GROUP MEMBERS

Prof Donal O'Shea (Chair)	HSE National Clinical Lead for Obesity
Ms Karen Gaynor	Programme Manager, National Clinical Programme for Obesity
Dr Brendan O'Shea	General Practitioner, Chair RCPI Clinical Advisory Group
Dr Cathy Breen	Specialist Weight Management Service, St. Columcille's Hospital
Dr Eirin Carolan	Consultant Endocrinologist CHI Crumlin
Dr Fionnuala Cooney	Public Health Representative
Dr Jean O'Connell	Consultant Endocrinologist IEHG
Dr Orla Walsh	Adolescent Medicine CHI Temple St.
Ms Sarah O'Brien	National Lead, Healthy Eating and Active Living Programme
Prof Helen Heneghan	Consultant Surgeon, Bariatric Surgery
Ms June Boulger	National Lead, Patient and Public Involvement
Ms Margaret O'Neill	National Dietetic Lead
Ms Marian McBride	Project Dietitian
Ms Michelle Lynch/Ms Caroline Peppard	Self-Management Support Co-ordinators Representative (Joint)
Ms Roisin Doogue	Irish Practice Nurses Association Representative
Ms Sheila Cahalane	Director of the NMPD Dublin, Kildare and Wicklow -ONMSD
Ms Susie Birney	ICPO Patient Representative
Ms Mary Francis Blaney	ICPO Patient Representative
Prof Francis Finucane	Consultant Endocrinologist – Saolta/NUIG
Dr Grace O'Malley	W82Go, CHI Temple St./ISCP Representative
Ms Martina Stanley	Medical Social Work Representative
Dr Norah Jordan	Clinical Psychologist W82Go, CHI Temple St.
Dr Rita Lawlor	Professional Development Co-ordinator for Practice Nurses
Dr Sean Manning	Consultant Physician
Dr Colin Davenport	Consultant Endocrinologist
Ms Gracia Gomez Kelly/ Ms Niamh Van den Berg	AOTI Representative (Joint)
Dr Michael Crotty	GP specialist in Weight Management & Bariatric Medicine

# RCPI OBESITY CLINICAL ADVISORY GROUP MEMBERSHIP

A multi-specialist clinical advisory group (CAG) provides clinical expertise and support to the programme. The CAG was established by the RCPI with membership nominated from faculties across all medical training colleges and is chaired by Dr Brendan O'Shea (2017-present). Membership includes physicians and surgeons from community, hospital and research settings as well as other organisations across Ireland.

## CURRENT AND PREVIOUS CAG MEMBERS

Dr Eirin Carolan	Consultant Paediatric Endocrinologist
Prof Chris Collins	Consultant Bariatric Surgeon
Dr Catherine Conlon	Director of Human Health and Nutrition, Safefood
Dr Laurence Conway	Sports and Exercise Medicine Physician
Dr Colin Davenport	Consultant Endocrinologist
Prof Francis Finucane	Consultant Endocrinologist
Dr Cliodhna Foley Nolan	Public Health Specialist (2017-2019)
Dr Joe Gallagher	ICGP HSE Primary Care Lead for CVD Integrated Care Programme
Prof Catherine Hayes	Associate Professor and Specialist in Public Health
Prof Helen Heneghan	Consultant Bariatric Surgeon
Prof Carel LeRoux	Professor of Experimental Pathology
Dr Sean Manning	Consultant Endocrinologist
Prof Fionnuala McAuliffe	Consultant Obstetrician & Gynaecologist
Dr Brendan McCormack	Consultant Psychiatrist
Dr Ronan Mullaney	Consultant Psychiatrist
Dr Sinead Murphy	Consultant Paediatrician
Dr Brendan O'Shea (Chair)	Assistant Adjuvant Professor in Primary Care and Public Health
Prof Donal O'Shea	HSE National Clinical Lead for Obesity
Dr Jean O'Connell	Consultant Endocrinologist
Prof Clodagh O'Gorman	Consultant Paediatrician
Prof Gregory Pastores	Consultant Physician, Clinical Genetics
Prof Edna Roche	Consultant Endocrinologist
Dr Alison Sigrist	Occupational Health Physician
Prof Michael Turner	Consultant Obstetrician & Gynaecologist
Dr Jenny Walsh	Consultant Obstetrician & Gynaecologist
Dr Conor Woods	Consultant Endocrinologist

# FOREWORD BY THE HSE NATIONAL CLINICAL LEAD FOR OBESITY

This model of care is for people in Ireland and their families who are living with obesity every day and coping with the associated stigma, judgement and misunderstanding from society and the health care service. The model was written by the Working Group of the National Clinical Programme for Obesity. It sets out how the care of people living with overweight and obesity should be organised and resourced now and in the future.

The National Clinical Programme for Obesity was set up as a joint initiative by the HSE Health and Wellbeing Division and the Royal College of Physicians of Ireland (RCPI) in 2017. The working group, established in 2019, is multidisciplinary, including nominees from different groups involved in the care of people with overweight and obesity. It includes individuals from specialist treatment centres for children, young people and adults, nominees from primary care and community services, nursing, health and social care professionals involved in obesity care, HSE Healthy Eating and Active Living Programme and representatives from patient groups.

The priority of the working group was to develop a model of care to outline national services for the care of people with overweight and obesity. A model of care writing group was established and reviewed national and international data and evidence relating to services for overweight and obesity in children, young people and adults. Consideration was given to the planned health and social care service reform under Sláintecare and the priority was to develop the right care, in the right place, at the right time. Following several rounds of review by the Programme Working Group and Clinical Advisory Group, the model of care was then sent out for broad consultation as outlined in Appendix 8 and robust and positive feedback was received from 46 stakeholders.

People with obesity are a highly stigmatised and vulnerable group, and 'calls to action' can potentially increase stigmatisation. The working group was keen to outline clinical services for overweight and obesity that take the wider drivers of obesity such as genetics, environment and socioeconomic status into account. Clinical services in Ireland must exist within a broader multi sectoral strategy that actively targets the social and commercial determinants of obesity.

The document was also developed in close liaison with the Healthy Eating and Active Living Programme (HSE Health and Wellbeing Division), the RCPI National Clinical Programme for Paediatrics and the Office of the NCAGL for Chronic Disease. This final document has been approved by members of the RCPI Obesity Clinical Advisory Group and the National Clinical Programme for Obesity Working Group. The membership of these groups is set out in pages 2-3. The model of care was presented to and approved by Dr. Orlaith O'Reilly, National Clinical Advisor and Group Lead for Chronic Disease and the HSE Clinical Forum of the Office of the Chief Clinical Officer. The clinical programme will continue to advocate for greater understanding and better services to support and manage individuals living with this complex chronic disease.

National Clinical Programme for Obesity Working Group

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## EXECUTIVE SUMMARY

This model of care for the management of overweight and obesity in children, young people and adults will ensure that an end-to-end approach is adopted, defining the way health services are developed across the lifespan. Through the implementation of this model of care, the Irish health service will ensure that the right care is delivered to individuals with overweight and obesity at the right time and in the right place. The approval of this model of care is timely given the priority being given to operationalising Sláintecare and the COVID-19 environment we now work in, which demands new ways of working including enhanced integration across all health and social care settings and the incorporation of digital technology. The model of care for adults is aligned with the National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland. The model of care for children and young people is aligned with the Model of Care for Paediatric Healthcare Services in Ireland.

More than one in five children and 60% of adults living in Ireland have overweight and obesity, and these figures are higher in deprived areas. For many people, body weight is not a choice and a new approach is required to effectively address the complex nature of obesity. Treatment of overweight and obesity is not simply a case of “eat less, move more” but requires multidisciplinary, holistic treatment strategies. Overweight and obesity are associated with multiple complications including type 2 diabetes, cardiovascular disease, respiratory disease, several types of cancer, pain, musculoskeletal disorders and poorer quality of life. People with obesity are also particularly vulnerable to the effects of COVID-19 and obesity has been officially listed amongst medically vulnerable high-risk groups by the European Centre for Disease Prevention and Control and the European Commission as part of the EU COVID recovery programme. Funding and implementing this model should be prioritised because there is strong evidence that actively managing overweight and obesity will improve health, quality of life and overall mortality while reducing healthcare costs.

The model of care takes a population health approach to the management of overweight and obesity. It aims to improve the health of the entire population and to reduce health inequalities among population groups. It recognises the higher prevalence of obesity among socially disadvantaged groups and the urgent need for obesity treatment services within the Irish public health system. Specific population groups including women before, during and after pregnancy, older people, individuals with eating disorders, mental illness and those with intellectual and physical disabilities are at high risk of developing overweight and obesity. It is a priority for the National Clinical Programme for Obesity to work with the relevant national clinical programmes responsible for these groups to ensure obesity treatment pathways are resourced appropriately and integrated into these settings. The delivery of the services that emerge from the implementation of this model of care will need to be supported by the development of national and local clinical guidelines and clear patient pathways.

This model of care is guided by international best practice and outlines the spectrum of health services required to manage overweight and obesity in general practice and primary care, community and hospital settings. The HSE Healthy Eating and Active Living (HEAL) Programme, part of HSE Health and Wellbeing, co-ordinates initiatives that support individuals with healthy behaviours that can impact on weight and chronic disease.

In the model of care for adults with overweight and obesity there are five defined levels of care, in line with the National Framework for the Integrated Prevention and

Management of Chronic Disease in Ireland. In the model of care for children and young people there are four levels of care in line with the National Model of Care for Paediatric Healthcare Services in Ireland. Each level brings more intensive intervention to individuals with increasing needs, across the levels of service delivery. Services are aligned to Community Healthcare Networks (CHNs), Chronic Disease Specialist Hubs, Community Health Organisations (CHOs) or Regional Health Areas (RHAs) and Hospital Groups. These levels are not distinct cohorts, individuals will move between levels as the complexity of their obesity changes. The key elements of the model are set out in detail in chapter three. For the purpose of this document, the term healthcare professional (HCP) includes the broad range of professionals involved in delivering clinical services across all health and social care settings. This includes but is not limited to medical, surgical, nursing and midwifery, and health and social care professionals (HSCPs). Here follows a brief summary of the role each level will play in the model of care.

## ADULT LEVEL 0 LIVING WELL WITH OVERWEIGHT AND OBESITY

This level involves a range of initiatives that will be available locally to enable a supportive healthy environment for people with overweight and obesity. These initiatives will support healthy decision making in home, work and social environments.

By 'Making Every Contact Count' brief advice and brief interventions, HCPs can provide support to individuals to manage health behaviours that contribute to stabilising weight in a self-compassionate and de-stigmatising manner while respecting patient autonomy. People will have the opportunity to develop self-management skills by participating in tailored programmes within their locality. Across all levels of service there will be shared care pathways developed for high risk groups.

## ADULT LEVEL 1 GENERAL PRACTICE AND PRIMARY CARE TEAM

Most adults with overweight or obesity will present initially to primary care. The General Practitioner (GP), General Practice Nurse (GPN), and the wider multidisciplinary primary care team are the key health care professionals within this setting. They lead on early identification of overweight, obesity and complications, brief advice, initial management, signposting or onward referral to specialist services within community care hubs, with scheduled follow ups for ongoing support. They have a central role in ensuring an integrated, person-centred approach to support individuals to manage their own condition.

## ADULT LEVEL 2 COMMUNITY SPECIALIST AMBULATORY CARE

Level 2 ambulatory care hubs will provide specialist support to GPs in managing patients with obesity, preventing disease progression and the development of obesity related complications. This care provided in community specialist hubs builds on the level 1 services to provide enhanced support.

This level involves provision of structured, multicomponent weight management services in the community for adults with obesity and complications. These services will be aligned with the National Diabetes Prevention Programme (currently in development), the Chronic Disease Management Programme introduced as part

of GP Contractual Reforms 2019 and the National Framework for the Integrated Prevention and Management of Chronic Disease.

### ADULT LEVEL 3 ACUTE SPECIALIST AMBULATORY CARE

Physician led multidisciplinary team (MDT) services will be available initially in every RHA, co-located in hospital sites, to provide care for adults with severe and complicated obesity including assessment for consideration of referral to regional Level 4 services as part of a comprehensive treatment pathway. Subsequent implementation phases will focus on building capacity nationally to meet local demand by developing additional Community Specialist Obesity MDTs within the community specialist hubs.

### ADULT LEVEL 4 SPECIALIST HOSPITAL CARE

Level 4 specialist hospital care describes the services required in secondary care for individuals with severe and complex obesity that are referred from level 3. While this will involve access to in-patient rehabilitation and palliative care services, this level mainly refers to access to bariatric surgical services. There is a need for an adult bariatric surgery centre in each of the six RHA's with a recognition that these will need to be introduced on a phased basis.

### CHILDREN AND YOUNG PEOPLE LEVEL 0 HEALTH PROMOTION AND COMMUNITY PROGRAMMES

This level applies to all families, children and young people. There will be community based, family orientated programmes aimed at children and young people who are identified with overweight and obesity. These programmes will support families with healthy behaviours and self-management skills and will be delivered within CHNs.

### CHILDREN AND YOUNG PEOPLE LEVEL 1A GENERAL PRACTICE AND PRIMARY CARE

Children are typically identified with overweight or obesity in primary care by the Public Health Nurse, Community Medical Doctor, in General Practice or by other HSCP's opportunistically or through routine growth measurement programmes. Once identified as having overweight or obesity there will be signposting either to enhanced parenting programmes or referral to primary care HSCPs.

### CHILDREN AND YOUNG PEOPLE LEVEL 1B COMMUNITY SPECIALIST OBESITY MDTs

The role of the Community Specialist Obesity MDT is to provide additional support to general practice and primary care in the management of children and young people with obesity. Medical oversight will be provided by the lead GP or CMD depending on the locality.

## CHILDREN AND YOUNG PEOPLE LEVEL 2 HOSPITAL SPECIALIST OBESITY MDTs

There will be paediatrician led specialist MDTs in each local paediatric unit. These are integrated with the community MDTs to provide further assessment and treatment to children and young people with obesity with onward referral to tertiary care where appropriate.

## CHILDREN AND YOUNG PEOPLE LEVEL 3 TERTIARY CARE MDT

There will be one national centre for children and young people within Children's Hospital Ireland. This will be a consultant led MDT for complex case management, assessment and approval for bariatric surgery and comprehensive pre, peri and post-operative education and support. A major role will be supporting young people in the transition to appropriate adult services.

## KEY ENABLERS

Overweight and obesity is a highly stigmatised condition, having a profound negative effect on how care is delivered and experienced. In all health and social care settings, staff will be trained to deliver weight management interventions appropriate to that setting. Each level of service will require robust information and communications technology (ICT) systems for secure data collection, information sharing and communication across settings and services. National surveillance systems to monitor population prevalence of overweight, obesity and associated complications are also required. By 2025, this model envisages that routine measurement will be established, recording and reporting on overweight and obesity across all care settings to enable surveillance at population level. Healthcare professionals will be adequately trained to do this in a non-stigmatising, patient-centred way that respects patient autonomy and individual needs. Services at each level will need to be developed and evaluated in parallel to ensure the provision of integrated end-to-end care for individuals living with overweight and obesity for the first time in the history of the state.

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Working Group

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# 1.

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# INTRODUCTION

A model of care defines the way health services are delivered and describes best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event (NSW Agency for Clinical Innovation, 2013).

This model of care defines the way in which health care services for overweight and obesity are delivered. It describes the service required, who should provide it and outlines where the service or care should be delivered from a whole health system perspective.

Providing effective, comprehensive obesity management in an unhealthy environment influenced by social, economic and political factors is a challenge. The model of care needs to be supported by cross-governmental and cross-sectoral policies and initiatives which address the effects of the range of social and commercial determinants of health through meaningful legislative change and societal factors.

The implementation process for the model of care will be underpinned by a detailed implementation plan and effective change management approach to ensure sustainability. It will leverage synergies in areas such as ICT, telemedicine, chronic disease management and prevention initiatives across all clinical service development and design, including the development of an effective integrated electronic medical record. Shared care with general practice requires a shared electronic health record which will also be important for gathering data on the effectiveness and quality of the service as it progresses. It will require strong leadership, stakeholder commitment, system and staff capacity, along with a clearly communicated implementation plan, especially in the new COVID 19 environment. Given the scale of change and service developments needed, prioritisation of resources will be required.

## 1.1 STRATEGIC BACKGROUND

In 2017, a National Clinical Programme for Obesity was established by HSE Health and Wellbeing partnering with RCPI with the explicit objective of designing a model of care for children, young people and adults to enhance the accessibility, appropriateness and quality of services for people with overweight and obesity. The organisational structure of the National Clinical Programme for Obesity is outlined in Appendix 2.

The Healthy Ireland Framework 2013-2025 is the national cross-governmental framework for improving health and wellbeing and reducing chronic disease. The implementation of the Healthy Ireland Framework, under the oversight of the Cabinet Sub-Committee on Social Policy, is co-ordinated by Department of Health.

Healthy Weight for Ireland Obesity Policy and Action Plan 2016-2025 sets out the strategic approach to tackling obesity in Ireland and is a key policy within the Healthy Ireland Framework. The development of this model of care is a key action to be delivered by HSE in the first phase of Healthy Weight for Ireland implementation. It focuses specifically on the significant cohort of children, young people and adults with overweight and obesity, whose health and quality of life are dependent on equitable access to effective clinical treatment and weight management. It guides stakeholders to resource the health services to provide better care. It shapes the training, education and regulation of all HCPs and standards of care in the delivery of obesity care in Ireland.

The Sláintecare Report of the Oireachtas Committee on the Future of Healthcare (2017) sets out the ten-year vision for the health service in Ireland and identified the

nine elements that will underpin the ten-year reform programme (figure 1), through the creation and implementation of a Citizen Care Masterplan. A key element of the Citizen Care Masterplan is service redesign based on population health planning, knowledge of current levels of service delivery and configuration and the principle of collaboration with partners. There will be a comprehensive range of primary, acute and social care services at no cost or reduced cost, with the majority of care provided in community settings. The alignment of this model of care to the Sláintecare model of care principles is set out in section 3.1



Figure 1: Sláintecare Model of Care Principles (Sláintecare, 2019)

The World Health Organisation (2017) recommends that prevention of obesity in very young children is essential, because development of overweight and obesity in early life increases exposure to obesity and complications. The Healthy Weight for Children Framework 0-6 years (HSE, 2018) provides strategic direction for a national and sustainable approach to facilitating healthy weight and prevention of obesity in early childhood. A priority action of the framework is to build knowledge and skills in the workforce to support families to better prevent and treat overweight and obesity, in line with this model of care.

The National Model of Care for Paediatric Healthcare Services in Ireland (2018) describes the optimal way to provide paediatric services now and into the future in Ireland. The paediatric services outlined in this document to support children and young people with obesity align with the guiding principles and approach set out by the National Clinical Programme for Paediatrics and Neonatology.

In forecasting the future capacity requirements in acute hospitals, community and in services for older persons in Ireland, the Health Service Capacity Review (2018) recommends the development of specialist services for the treatment of obesity in line with those in place for the management of other chronic diseases (Department of Health, 2018). The National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland 2020-2025 (2020) demonstrates how end-to-end care for chronic disease will be provided within the Irish health services. Each of the National Clinical Programmes for Chronic Disease (The National Heart Programme and the National Clinical Programmes for Respiratory and Diabetes) have adapted this to develop models of care detailing end-to-end care for heart failure, chronic obstructive pulmonary disease, asthma and type 2 diabetes mellitus. As obesity is now widely recognised as a chronic disease, the model of care for obesity management will also align to this framework (figure 2) to offer a spectrum of preventive, diagnostic, care and support services which are integrated, collaborative, person-centred and provided as close to home as possible.

**National Clinical Programme for Obesity Working Group**

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Figure 2: Model of Care for the Integrated Prevention and Management of Chronic Disease (Integrated Care Programme for the Prevention and Management of Chronic Disease, 2020).

The HSE Corporate Plan (2020) sets out a number of service-related objectives and key actions the HSE will take over 2021-2024 to improve the health service and the health and wellbeing of people living in Ireland. Development of this plan included consultation from public, staff and partners on areas of improvement. Implementation of this model of care will clearly support two key objectives within the corporate plan:

1. Enhance primary and community services and minimise hospital attendance and
2. Prevention and early intervention on children's health, obesity and alcohol.

The HSE is committed to fully implementing this plan and driving demonstrable improvements over 2021 to 2024.

## 1.2 AIM AND OBJECTIVES OF THE MODEL OF CARE FOR OBESITY

### Aim:

The aim of this model of care is to outline the spectrum of best practice care and services for overweight and obesity management in Ireland, ensuring the right care, in the right place at the right time.

### Objectives:

To define specific services for the effective management of obesity and overweight in children, young people and adults across the life course incorporating prevention, early identification and treatment to prevent progression of disease and complications.

To ensure effective integration and support across levels of services, across the lifespan and with services for high risk groups.

### Scope:

The scope of this model of care is to define the services required to support the general population of children, young people and adults in the management of overweight and obesity. It includes health services operated and funded by the HSE and includes community-based services as well as hospital-based secondary and tertiary care services. This model of care is guided by national and international best practice. It is not intended to be a stand-alone clinical guideline. It acknowledges that specific health and social care settings, high risk and vulnerable groups will require additional interventions and support. Working with the relevant national clinical programmes and services, this model of care will inform the future development of shared pathways, policies, strategies and services to improve health outcomes in these settings.

This model of care acknowledges and supports the range of services and activities external to the HSE such as schools and voluntary agencies that play a vital role in prevention and treatment but does not include these settings. While the National Clinical Programme for Obesity advocates for policy, legislation and cross-sectoral action to support healthy environments for all, this model of care does not apply to population-based policy or legislation.

The Healthy Childhood Programme including the Healthy Weight for Children (0-6 years) Framework will be implemented fully to provide a national and sustainable approach to facilitating healthy weight and the prevention of obesity in children. This framework sets out the key actions around governance, training, communications, interventions, monitoring and data collection aimed at facilitating healthy weight and prevention of obesity in early childhood.

## 1.3 KEY PRINCIPLES OF THE NATIONAL CLINICAL PROGRAMME FOR OBESITY

Obesity is a complex, chronic, multifactorial disease that requires a comprehensive multidisciplinary, approach to care across the lifespan.

Appropriate and equitable treatment for overweight and obesity is required in addition to public health prevention measures.

Weight-based stigma and obesity discrimination will not be tolerated in the healthcare system.

Academic institutions, professional bodies, and regulatory agencies will ensure that formal teaching on the causes, mechanisms, and treatments of obesity are incorporated into standard training programmes.

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## 1.4 DEFINITION OF OVERWEIGHT AND OBESITY

Overweight and obesity is defined as “abnormal or excessive fat accumulation that presents a risk to health” (World Health Organisation, 2017). It is a progressive, chronic and complex disease affecting all ages and genders. It is disproportionately greater in disadvantaged groups. Many HCPs have been trained to believe that overweight and obesity is simply caused by too much eating and too little exercise. This may explain the emphasis on “eat less and exercise more” as the solution to obesity. This approach ignores a wealth of scientific data confirming that energy balance is influenced by a complex and multifaceted system of determinants. At the heart of this system lies a homeostatic biological system, struggling to adapt to the rapid changes in our environment.

## 1.5 CLASSIFICATION OF OVERWEIGHT AND OBESITY

Body mass index (BMI), defined as weight in kilograms divided by the square of height in meters ( $\text{kg}/\text{m}^2$ ), is considered to be the best available population marker for monitoring trends in overweight and obesity in adults, children and young people over time. Direct assessment of body fat is not readily available in clinical settings. Therefore, BMI is the most widely used measure of obesity in clinical practice. Waist circumference can be used alongside BMI to assess risk for developing obesity-related complications. While BMI and waist circumference have a direct relationship with morbidity and mortality, they should not be the only measures used to classify obesity when assessing an individual patient. Several factors, such as cardiorespiratory fitness and presence of other obesity related complications substantially modify the risk associated with excess body fat.

The World Health Organisation (WHO) classifications of BMI for adults are below. The criteria are the same for all ages and genders. BMI measurement has some limitations, including overestimating body fat in athletic or muscular individuals, underestimating body fat in older or frail people, and less accuracy in certain ethnic groups. Individuals from Black, Asian and other minority ethnic groups are at an equivalent risk to type 2 diabetes, other health conditions or mortality, at a lower BMI than the white European population. It is therefore recommended that lower thresholds (BMI  $23\text{kg}/\text{m}^2$  instead of  $25\text{kg}/\text{m}^2$  for overweight and  $27.5\text{kg}/\text{m}^2$  instead of  $30\text{kg}/\text{m}^2$  for obesity) are used to trigger action to prevent type 2 diabetes among South Asian, Black African, Black Caribbean and Chinese populations (NICE, 2013).

**TABLE 1:**  
**WHO CLASSIFICATIONS OF BMI FOR ADULTS**

Classification	BMI ( $\text{kg}/\text{m}^2$ )
Underweight	<18.5
Ideal range	$\geq 18.5$ and $< 25.0$
Overweight	$\geq 25.0$ and $< 30.0$
Obesity	$\geq 30.0$
Obesity, class I	$\geq 30.0$ and $< 35.0$
Obesity, class II	$\geq 35.0$ and $< 40.0$
Obesity, class III	$\geq 40.0$

As children and young people grow, their bodies undergo several physiological changes during which body fat content changes with significant differences between boys and girls. Therefore, the BMI cut-off points for children and young people are different to adults and vary according to age and sex. For children over two years, age and sex-specific growth reference percentile charts (e.g. UK-WHO) are used from which their BMI can be categorised using internationally agreed thresholds for the child's age.

Population monitoring BMI thresholds are used for most published obesity and overweight prevalence figures and clinical BMI cut-offs are recommended for use in clinical settings with individual children (Table 2).

**TABLE 2:**  
**RECOMMENDED BMI THRESHOLDS FOR POPULATION MONITORING AND CLINICAL ASSESSMENT IN CHILDREN (NATIONAL OBESITY OBSERVATORY, 2011)**

Category	BMI Threshold
Underweight:	2nd centile for population monitoring and clinical assessment
Overweight:	85th centile for population monitoring, 91st centile for clinical assessment
Obesity:	95th centile for population monitoring, 98th centile for clinical assessment

## 1.6 PREVALENCE OF OVERWEIGHT AND OBESITY

In the absence of comprehensive national surveillance data on overweight and obesity, prevalence of overweight and obesity is derived from population level surveys and longitudinal studies such as Healthy Ireland, Growing Up in Ireland, Childhood Obesity Surveillance Initiative (COSI) and The Irish Longitudinal Study on Ageing (TILDA). Prevalence in Ireland is outlined in Table 3. This is amongst the highest in Europe and internationally.

### Key considerations:

- At least one in five children aged 5 years (ESRI, 2017) and at least one in four young people age 17-18 years are living with overweight or obesity (ESRI, 2019).
- While overall prevalence seems to be stabilising in children, prevalence of overweight and obesity is relatively higher in older than younger primary school age children (COSI, 2020).
- Overweight and obesity is more prevalent in girls (particularly in first and second class) and in disadvantaged schools (COSI, 2020).
- There is double the rate of overweight and obesity in children attending Delivering Equality of Opportunity in Schools (DEIS) programme schools compared to other schools and this gap is widening. Prevalence in sixth class children is 38% vs 19% in other schools (COSI, 2020).
- It is estimated that 60% of adults in Ireland are living with overweight and obesity, this has been relatively stable since 2015 (Healthy Ireland Survey, 2019).
- Obesity prevalence is higher in older people, in areas of social deprivation (Healthy Ireland Survey, 2019), in individuals with intellectual disabilities (Melville

et al. 2005, IDS-Tilda, 2017) and in individuals with mental health problems (Rajan and Menon, 2017).

- Individuals living in deprived areas are more likely than those living in affluent areas to have overweight or obesity (65% and 55% respectively) (Healthy Ireland Survey, 2019).
- The levels of extreme obesity are 1.7% overall in Irish schools, and significantly higher in disadvantaged schools (3.2%) (Bel-Serrat et al, 2018).
- Among adults aged > 50 years, 8% (92,573 people) meet criteria for bariatric surgery (BMI >40kg/m<sup>2</sup> with at least one comorbidity). This number is likely to be higher when the entire population of adults is considered (O'Neill et al, 2017).

**TABLE 3:**  
**PREVALENCE (%) OF OVERWEIGHT AND OBESITY ACROSS THE LIFESPAN**

Age	Overweight	Obesity	Reference
3 years	19%	5%	ESRI, 2017
5 years	15%	5%	ESRI, 2017
7/8 years	15%	5%	ESRI, 2017
13 years	20%	6%	ESRI, 2012
17-18	20%	7%	ESRI, 2019
20 years	24%	12%	ESRI, 2019
15-24	19%	9%	HI Survey, 2019
15-65+	37%	23%	HI Survey, 2019
Over 50	43%	36%	Leahy et al, 2014

In 2016, there were an estimated 1,220,907 children under 18 living in Ireland. This accounted for about a quarter (26.1%) of the total population of Ireland. When applied to Irish population figures (Central Statistics Office, 2016), prevalence equates to the following numbers per Regional Health Area (RHA), Community Healthcare Network (CHN) and nationally.

**TABLE 4:**  
**APPROXIMATE NUMBER OF PEOPLE WITH OVERWEIGHT AND OBESITY BASED ON 2016 CENSUS DATA (CSO, 2016).**

	Per CHN (~50,000) (total number <sup>2</sup> )	Per Ambulatory Care Hub (~150,000) (total number <sup>2</sup> )	Per RHA (~600,000) (total number <sup>2</sup> )	Nationally <sup>1</sup> (4,761,865) (total number <sup>2</sup> )
Children < 18 with overweight <sup>3</sup>	1,950 (13,000)	5,850 (39,000)	23,400 (156,000)	187,769 (1,251,796)
Children < 18 with obesity <sup>4</sup>	650 (13,000)	1,950 (39,000)	7,800 (156,000)	62,589 (1,251,796)
Adults with overweight <sup>5</sup>	13,690 (37,000)	41,070 (111,000)	164,280 (444,000)	1,359,750 (3,510,069)
Adults with obesity <sup>6</sup>	8,510 (37,000)	25,530 (111,000)	102,120 (444,000)	807,315 (3,510,069)

Notes: <sup>1</sup> based on Central Statistics Office Census of Population 2016 data (CSO, 2016) <sup>2</sup> based on 26% of total population of Ireland is < 18 years (CSO, 2016) <sup>3</sup> based on primary school age overweight prevalence (15%) <sup>4</sup> based on primary school age obesity prevalence (5%) <sup>5</sup> based on 15-65+ overweight prevalence (37%) <sup>6</sup> based on 15-65+ obesity prevalence (23%)



## 1.7 IMPACT OF OVERWEIGHT AND OBESITY

There are significant impacts on health and quality of life associated with overweight and obesity.

- Up to 70% of children with obesity present with multiple complications of obesity (Table 5).
- It is estimated that 55% of children with obesity will have obesity into adolescence and that 70% of adolescents with obesity will have obesity over the age of 30 (Simmonds et al., 2016).
- Quality of life is affected by a range of psychosocial factors associated with obesity, including stigma, social exclusion, bullying, poor self-concept, mood and anxiety difficulties, increased risk of disordered eating.
- Obesity and overweight can be a consequence of eating disorders such as bulimia nervosa and binge eating disorder. Individuals with both eating disorders and obesity are at high risk of severe physical and mental health consequences.
- Focusing obesity reduction strategies solely at children may not substantially reduce the overall burden of adult obesity. Seventy percent of adults with obesity did not have obesity in childhood or adolescence (Simmonds et al., 2016).
- Obesity is associated with more than 195 other adverse health conditions in adults, the most common conditions include obstructive sleep apnoea (OSA), cardiovascular disease (CVD), hypertension (HTN), Type 2 diabetes, liver disease, certain cancers and osteoarthritis (Yuen et al., 2016).
- Obesity in preconception and pregnancy is associated with an increased risk of pregnancy complications such as gestational diabetes, pre-eclampsia, stillbirth and operative delivery (Heslehurst et al, 2008) and is associated with a higher risk of overweight and obesity in children (Catalano and Ehrenberg, 2006).

**TABLE 5:  
COMPLICATIONS OF OBESITY IN CHILDREN AND YOUNG PEOPLE**

Complications of Obesity in Children and Young People	
Asthma	Hypertension
Musculoskeletal (movement) disorders	Sleep Apnoea
Pain	Non-alcoholic fatty liver disease (NAFLD)
Depression	Gallstones
Type 2 Diabetes	Reflux
Depression and Anxiety	Impaired quality of life
Eating disorders	Dyslipidaemia
Poor self esteem	Polycystic Ovary Syndrome (PCOS)
Insulin resistance	

The lifetime costs of childhood obesity, which includes direct health care and societal costs, is €4.6 billion in Ireland. Direct healthcare costs associated with childhood obesity is estimated at €1.7million. Annual estimated costs of adult obesity are €1.13 billion, of which a third are direct healthcare costs such as hospital care and medication costs. The remainder are indirect costs including productivity losses from absenteeism and premature mortality (Safefood, 2012). The annual healthcare costs of people with a BMI at 40 kg/m<sup>2</sup> are estimated to be double that of those with a BMI 20-21kg/m<sup>2</sup>, for both men and women (McCombie, 2015). Given that the proportion of the Irish population over the age of 65 is increasing rapidly, the combination of an ageing population and an increasing prevalence of obesity and related comorbidities across the lifespan will considerably impact future health service capacity.

Misconceptions of obesity are prevalent in the media, society and scientific literature. Weight bias and stigma means that people with obesity are viewed as lazy, unhealthy and unmotivated individuals. Many people, including healthcare practitioners, believe that obesity is a lifestyle choice which is due to poor self-discipline and lack of motivation. Weight stigma in healthcare can prevent HCPs from providing supportive and non-judgemental consultations with patients, which can result in a lack of diagnosis, and low efficacy of interventions for weight management. Experiences of judgement and shame in healthcare settings prevents people with obesity from seeking help. Weight stigma can also lead to the unrecognition, delayed screening and lack of monitoring for development of eating disorder symptoms. Stigmatisation is associated with greater psychological distress and can cause people to engage in behaviours that make obesity worse. In this way, experience of stigma has been shown to be associated with increased risk of weight gain and weight regain. On a wider level, weight stigma can result in ill-informed clinical decisions, inaccurate public health recommendations and unproductive allocation of limited research resources.

### Lessons from the COVID-19 Pandemic

COVID-19 has highlighted the vulnerability of people living with obesity. When a large proportion of the population have undiagnosed and unmanaged obesity, society as a whole is more vulnerable to the impact of COVID-19. A review of published evidence found that people with obesity who contract COVID-19 had a greatly increased risk of hospitalisation (113%), were more likely to be admitted to intensive care (74%) and had a higher risk of death (48%) from the virus (Popkin et al., 2020). Data from confirmed cases of COVID-19 in Ireland substantiates this observation (Health Protection Surveillance Centre, 2020). Furthermore, the measures that have been taken to disrupt the spread of COVID-19 create physical and mental health challenges for the management of obesity. Social isolation and enforced physical inactivity can have a significant impact on many weight related behaviours. Prioritisation of healthcare services, physical distancing measures and strategies to alleviate strain on health services have left people living with overweight and obesity with minimal access to management, support and treatment.

Sláintecare policy requires that services be focused primarily in the community. The COVID-19 pandemic has further emphasised the importance of this to protect vulnerable groups by avoiding care in congregated settings as much as possible. Opportunities have arisen from the uptake of virtual consultations, telemedicine and the use of digital tools that have been increasingly used to substitute face to face, physical care and management during the pandemic. For example, transportation may be a barrier for attending clinics for some people living with obesity, which virtual care solutions can address. Implementation of the obesity management model of care would further support early intervention and increased access to weight management services in the community.

## 1.8 OBESITY PREVENTION AND TREATMENT

There are many factors that put people at risk of overweight and obesity. Most research interventions and public health initiatives have focused on nutrition and physical activity. There are other modifiable factors such as sleep, stress, medications, other chronic conditions or smoking that can also influence weight. Other factors which are more difficult to modify include age, genetics, income, physical environment, socio-political environment and adverse childhood events, including abuse and neglect. There is a historic belief that obesity is caused by individual behaviour and weight management is the responsibility of the individual. Focusing treatment and prevention strategies on diet and exercise does not address the complex nature of obesity or recognise the need for a holistic, integrated approach.

Where a child has been identified as gaining weight outside of normal growth levels, early intervention is key to prevent progression of overweight and obesity at this early age. While regular childhood growth monitoring is essential, evidence on screening for obesity in children is still evolving and requires ongoing evaluation to ensure it is effective and does not cause harm or increase weight stigma. Referral pathways that arise from screening also need careful consideration, given that stigma can negatively impact treatment uptake. The consensus among clinical experts in this field is that the precautionary principle should be invoked, and these interventions are deployed on the basis that they are likely to do significantly more good than harm.

The UN Committee on the Rights of the Child (UN CRC) recommends that a child diagnosed with a health condition (such as obesity) with complications should have access to health care irrespective of whether that condition developed due to genetic, biological, social or environmental factors. Care for overweight and obesity needs to reflect this and align to other paediatric chronic care models which emphasise the need for accessible, ongoing comprehensive care in the community, coordinated and co-managed with specialist obesity treatment provided by a multidisciplinary team in community and hospital settings.

Treating overweight and obesity significantly improves complications, reduces hospital admissions and length of stay. Reductions in body weight between 3-15% can improve complications of obesity such as type 2 diabetes, hypertension, dyslipidaemia, non-alcoholic fatty liver disease, obstructive sleep apnoea and osteoarthritis (Cefalu, 2015). On a population level, it is estimated that a 1% reduction in BMI would lead to a €270 million saving (SafeFood, 2017) and 26-28 fewer cases of chronic disease per 1,000 men and women respectively (Kearns et al., 2014). Without non-judgemental support and appropriate signposting individuals with obesity will not access treatment for obesity. Delayed treatment causes deterioration in health, increases the prevalence of obesity across the lifespan and increases progression to severe obesity with complications. It increases the risks of undergoing surgery, which could increase post-operative morbidity and decrease the clinical and cost effectiveness of surgical treatment.

### Primary Prevention

The aim of primary prevention is to prevent overweight and obesity from developing. Brief opportunistic interventions delivered by health care professionals are acceptable to patients and can be an effective way to support self-management of the behaviours that can impact on weight, such as eating, activity, sleep and stress. Common population level primary prevention strategies include unhealthy food

and drink taxation, calories on menus, limiting food and beverage advertisement, affordable physical activity options, improving the built environment and addressing social determinants of health. While the importance of these must be emphasised, the defining and implementation of these population level measures are beyond the scope of this document. There is a critical and urgent need for cross-governmental and cross-sectoral policies and initiatives which will address the effects of the unhealthy environment through meaningful legislative change and societal factors.

### Secondary Prevention

Secondary prevention aims to reduce the impact of overweight and obesity on individuals' health and quality of life. It includes early identification and management to prevent progression to more severe obesity with complications. In this model of care, secondary prevention relates to early intervention in the form of regular screening and optimising health and wellbeing. The aim is to support the health behaviours that contribute to stabilising weight, such as adequate nutrition, regular physical activity, and stress and sleep management, in people with overweight and uncomplicated obesity, and provide further assessment for complications of obesity for those that require it. This is a key role for general practice and primary care teams. There is substantial variation in the health profiles observed between individuals with the same body mass index (Wharton, 2020). To avoid further stigmatisation of individuals with overweight and obesity, it is important that early intervention should not be solely focused on weight and weight loss advice, but a collaborative conversation with individuals about the health behaviours that contribute to overall health, wellbeing and weight, with support offered when required.

### Tertiary Prevention

Tertiary prevention aims to support people to manage long-term, complex health problems to improve their ability to function, their quality of life and their life expectancy. In this model of care, this includes the weight management services across primary, secondary and tertiary care including structured education programmes, multidisciplinary behavioural interventions, pharmacotherapy and bariatric surgery.

## 1.9 SPECIFIC SETTINGS AND HIGH-RISK GROUPS

In outlining services for overweight and obesity, specific attention must be given to the groups of individuals and specific settings that are at higher risk of developing overweight and obesity. Screening and prevention interventions should be prioritised for high-risk populations and life stages associated with weight gain, such as women pre-pregnancy, in pregnancy or postpartum, smoking cessation, cancer treatments, initiating medications associated with weight gain, menopause and young adults (Wharton et al., 2020). The National Clinical Programme for Obesity will work collaboratively with the relevant national clinical programmes and services to develop shared pathways of care to meet the needs of individuals with or at risk of overweight and obesity. The following sets out the key groups for consideration.

## 1.9.1 MENTAL HEALTH SETTINGS AND INDIVIDUALS WITH MENTAL ILLNESS

The life expectancy of those with mental illness is 20% lower than the general population and obesity is one of the key contributory factors (RCPI, 2015). There is significant overlap between these two conditions. Obesity can have a negative effect on mental health and treatment for mental health problems can result in overweight, obesity and development of complications (Scott et al, 2008). Individuals with both obesity and mental illness experience bias and stigmatisation independently, and when these conditions are combined, the effects of stigma are multiplied. Rates of overweight and obesity have been reported as 25%–60% for bipolar disorder, 30%–70% for schizophrenia and 20–50% for depression. Links have also been made between overweight and obesity and binge eating disorder, attention deficit disorder and post-traumatic stress disorder (Wharton, 2020). Eating disorders can present at any point along the BMI continuum and are often mis-diagnosed when presented in combination with overweight or obesity. Antipsychotics, medications used in the treatment of bipolar disorder, major depressive disorder and anxiety have all been shown to be associated with significant weight gain (Wharton, 2020).

Body image concerns are impacted by public opinion and beliefs about food, eating and weight. Public health campaigns about overweight and obesity and early interventions can have unintended negative impacts by increasing risk factors such as preoccupation with weight and shape or restrictive eating. Public health campaigns and training for HCPs across all health and social care settings must avoid adding to stigma and body dissatisfaction by focusing on health, wellbeing and behaviours that contribute to weight, rather than weight and size alone.

Given the interaction between the two conditions, addressing the physical and mental health needs of this group should be considered a priority. Those attending mental health services require a targeted approach to support vulnerable people in maintaining healthy weight – this is best delivered by skilled mental health dietitians working as integrated members of the mental health team. An integrated collaborative approach from both obesity, mental health and eating disorder specialities is required in the development of standardised screening approaches, clear clinical pathways and accessible weight management interventions.

## 1.9.2 INTELLECTUAL AND PHYSICAL DISABILITIES

People with physical disability have a higher prevalence of overweight and obesity compared to the general population. People with mild to moderate levels of intellectual disability have higher levels of overweight and obesity at 85% and 72% respectively (TILDA-IES, 2014) and experience increased difficulty accessing services due to marginalisation, stigma and other inequalities. There is significant overlap between physical disability and overweight and obesity in children, young people and adults. Patients with inborn errors of metabolism represent a particularly vulnerable group and there is increasing recognition that as adults, they are at increased risk of obesity and metabolic syndrome.

Risk factors for developing overweight and obesity among people with a disability include changes in body composition, the use of medications and changes in energy expenditure and overall levels of physical activity. Obesity can also lead to the development or worsening of physical disabilities (RCPI, 2015).

Health care services mainly focus on the primary disability rather than on the prevention or management of other conditions such as overweight and obesity. Weight management services across all levels of care need to engage with local disability services (residential, day or community) to provide specialist knowledge and skills when engaging with adults, children and young people with disabilities. All overweight and obesity prevention, treatment and management services should be equally accessible and available to people with intellectual or physical disabilities. For example, accessible examination and treatment spaces and literacy-friendly resources and supports. Collection of BMI data as part of the National Intellectual Disability Database and the National Physical and Sensory Database needs to be explored (RCPI, 2015). An integrated collaborative approach from both obesity, intellectual and physical disability specialities is required in the development of standardised, adapted screening approaches, clear clinical pathways and accessible weight management interventions from this model of care.

### 1.9.3 OLDER PEOPLE

Seventy-nine percent of adults over 50 in Ireland have overweight or obesity alongside multiple chronic diseases. The proportion of people in Ireland over the age of 65 is predicted to double from 11% in 2006 to 22% in 2041, increasing numbers within this vulnerable group (TILDA, 2014). Obesity with low skeletal muscle function and mass is termed sarcopenic obesity. It can be caused by ageing as well as other factors and may lead to a higher risk of adverse outcomes such as frailty, disability, and increased morbidity and mortality (Stenholm et al, 2008). Greater awareness is needed to identify, assess, prevent and treat sarcopenic obesity particularly in older people. Other issues specific to older adults with obesity include quality of life and function, osteoporosis and nutritional deficiencies (RCPI, 2015). An integrated collaborative approach from both obesity and geriatric specialities is required in the development of standardised, adapted screening approaches, clear clinical pathways and accessible weight management interventions from this model of care, and partnership working with the Integrated Care Programme for Older People Specialist Teams to support an integrated service for older people with obesity and complex chronic disease.

### 1.9.4 WOMEN PRE-PREGNANCY, IN PREGNANCY AND POST-NATAL

Obesity has become the most common medical condition in women of reproductive age. Approximately 20% of women between the age of 25-44 in Ireland have obesity (Healthy Ireland, 2019). Obesity affects fertility and increases risks during pregnancy and childbirth. While the causes are multifaceted, HCPs across all health and social care settings have a role to play in preventing and managing obesity for women before, during, and after pregnancy as part of routine and specialist care.

The HSE/ICGP published Healthy Weight Management Guidelines for before, during and after pregnancy in 2017 (Appendix 3). More recently, the International Federation of Obstetricians and Gynaecologists (FIGO) Committee Guideline for the Management of Pre-pregnancy, Pregnancy, and Postpartum Obesity have outlined specific guidance (McAuliffe et al., 2020). This sets out recommendations for screening for overweight and obesity in all women in primary care, with further assessment for complications such as sleep apnoea and other conditions that could affect health during pregnancy as indicated. Advice on health behaviours that can impact weight should be provided, with permission, during periodic health examinations, preconception counselling, contraceptive consultations, or other gynaecologic care prior to pregnancy, with signposting or referral to appropriate weight management services for support. Women with previous bariatric surgery require closer screening and monitoring.

In pregnancy, gestational weight gain should be monitored, and support provided as part of routine antenatal care practices. All antenatal healthcare facilities should have well defined multidisciplinary pathways for the clinical management of pregnant women with obesity including the identification and treatment of pregnancy related complications. All complications such as gestational diabetes should receive appropriate postnatal follow-up in line with local resources, care pathways, and in response to the individual health requirements of each woman and her children. Women with obesity should be screened for postpartum mental health disorders such as depression and anxiety. Support should be provided on breastfeeding initiation and maintenance.

Obesity in pregnancy should be considered in the context of a life course approach, linking with preconception, antenatal and postpartum services to prevent excess weight gain before and during pregnancy (Hanson et al., 2020). Development of national evidence-based, guidance on the management of overweight and obesity in women in line with local needs, practices, policies, and available resources need to be developed through collaboration between the Obesity and Obstetrics and Gynaecology clinical programmes and specialist services.

### 1.9.5 SOCIALLY EXCLUDED AND DISADVANTAGED GROUPS

Socially excluded groups have complex health needs and experience poorer health outcomes. These groups include people who are homeless, people with substance use disorders, Travellers, asylum-seekers, prisoners and survivors of institutional abuse. Children who grow up in these families can experience poorer health outcomes as a result of adverse childhood experiences. In total, 22.5% of the population (1,072,707 people) are exposed to disadvantage; these numbers have increased between 2011 and 2016 by 9.1% while those living in extreme disadvantage increased by 9.8% (CSO, 2016). Healthy Ireland survey (2019) shows that adults living in deprived areas are more likely than those living in affluent areas to have overweight or obesity (65% and 55% respectively). Prevalence of chronic illness is also higher in more deprived areas. The Institute of Public Health in Ireland has calculated that the incidence of stroke is 2.2 times higher, and coronary heart disease (CHD) is 2.5 times higher in the most deprived Local Health Office (LHOs) areas compared to the least deprived LHOs. In addition, diabetes prevalence in the most deprived LHOs is 1.4 times than in the least deprived LHOs (Balanda et al, 2010). Planning and implementation of services for overweight and obesity must ensure equal access to quality care, with a focus on socially excluded and disadvantaged groups.

National Clinical  
Programme  
for Obesity  
Working Group

RCPI  
Obesity Clinical  
Advisory Group  
Membership

Foreword  
by the HSE  
National  
Clinical Lead  
for Obesity

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# 2.

## CURRENT SERVICE OVERVIEW

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The HSE/ICGP Weight Management Treatment Algorithms were developed in 2011 by multidisciplinary working groups as a blueprint for general practice and primary care teams to assist in the prevention, detection and management of children over 2 years, young people and adults with overweight and obesity (Appendix 3). The child and adolescent guidelines were based on a consensus statement from the Obesity Services for Children and Adolescents Network (OSCA) (Viner et al., 2012), adapted for the Irish setting by the HSE Subgroup on Obesity and approved by the ICGP. No dedicated resourcing was aligned to enable implementation of the algorithms, which are now due to be reviewed. The prevalence of obesity has continued to increase in Ireland (Healthy Ireland, 2019), yet the provision of weight management services and obesity treatment remains disjointed, geographically inequitable and limited in comparison to other European countries (Borisenko, 2015).

## 2.1 PRIMARY AND COMMUNITY CARE

Services in community for overweight and obesity in children, young people and adults vary greatly across the country. While general practice and primary care teams operate at a population level, it is unknown if there is adequate capacity for general practice and primary care teams to systematically engage in prevention, early identification and initial management of overweight and obesity. Numbers of GPs and GPNs per capita in Ireland are substantially lower than comparative healthcare systems internationally. Staffing levels for primary care are presently determined on a flat line basis exclusively relating to population levels and do not account for levels of deprivation and health inequalities. Overweight and obesity are often not identified in primary care until complications develop, and treatment of obesity related complications is prioritised via existing models of care rather than treating obesity itself.

Identification of overweight and obesity in children under two years is carried out by the Public Health Nurse (PHN) and in some areas, the Community Medical Doctor (CMD). From age two to six, weight is checked as per the PCRS Under 6 Contract by the GP or Practice Nurse within general practice. After age six, there are no further formal growth monitoring or health and weight checks for children or young people. Once overweight or obesity is identified, limited availability of services to refer to results in people waiting months to access appropriate care through designated services. Practice varies locally, with some HCPs referring to local community dietitians, commercial programmes or other local initiatives. These services can be difficult to access and may not be resourced to provide effective treatment interventions. Some services are unable to accept referrals for obesity from secondary care level paediatrics, mental health services or disability services. Typical primary care adult intervention is brief intervention and referral to a community-based group weight management programme if available, most services also offer individual appointments with the dietitian. Primary care interventions for children and young people are generally individual appointments with the dietitian. In the absence of treatment programmes, individuals may be referred or signposted to prevention or health promotion programmes which do not meet the requirements of obesity treatment programmes.

In addition to lack of resourcing, there are several barriers which further impact on effective clinical management. These include a lack of disease understanding among HCPs leading to misperceptions and bias towards people with obesity, poor communication between the HCP and patient, limited availability and adoption of treatment options and insufficient reimbursement of pharmacotherapy for obesity management (Obesity Policy and Engagement Network, 2019).

A survey in February 2020 of HSE Community Dietitian Managers highlighted the following challenges:

- Overweight and obesity are not coded as a separate condition on referral systems, therefore it is difficult to identify the need for services.

- Lack of staffing, backfill and maternity cover means only high priority referrals can be seen, and some areas have no primary care dietetic service.
- There are no dedicated weight management dietitian posts in community and mental health services in many areas do not have access to dietetics.
- Limited resourcing to attend training in obesity management.
- Due to long waiting lists and obesity not being classed as priority referral, primary care teams tend not to refer people with obesity because they perceive the services do not exist.
- Inadequate resourcing to deliver training or education to primary care staff.
- Limitations of single discipline interventions (e.g. dietetics), as obesity requires multidisciplinary support.
- The facilities, equipment and environment are often not safe or appropriate for individuals with severe and complex obesity e.g. weighing scales, chairs, accessibility.
- Very limited or absence of service for the increasing number of individuals that have had bariatric surgery, either in Ireland or abroad.

Initiatives currently available in community and primary care include but are not limited to:

### Children and Young People

- Cavan/Monaghan Healthy Families (HSE/Local Authority), an eight-week community-care based group programme for families to make healthy lifestyle changes. This is a mixed weight group not specifically aimed at children with overweight or obesity. Four programmes are run annually across Cavan and Monaghan.
- W82Go paediatric weight management programme (HSE): a six-week community-based group MDT weight management programme for children with obesity aged 5-12 years. One programme is run annually in Dublin South West area.

### Adults

- PHEW (Programme for Healthy Eating and Weight Management) (HSE): a six-week community-based group weight management programme for adults with a BMI of 28kg/m<sup>2</sup> or above delivered by HSE community dietitians. Originally developed in Dublin Mid-Leinster and now available in many areas, although consistent delivery of programmes is limited by availability of staffing.
- Croí CLANN (Changing Lifestyle with Activity and Nutrition) (Saolta HG/Croí the West of Ireland Cardiac and Stroke Foundation) is a 10 week community based group weight management programme for adults with a BMI of >40kg/m<sup>2</sup> (or 35kg/m<sup>2</sup> with a comorbidity) available to individuals referred from the bariatric programme at Galway University Hospital. Participants avail of a 1:1 pre-programme assessment with a specialist nurse, physiotherapist and dietitian in addition to the group-based sessions. Since Covid-19, the Croí CLANN programme has adapted and been developed into an online programme.
- Eating for Health (HSE): An experiential group education workshop for adult weight management with follow up with social prescribing supports in the community. Delivered by community dietitians in Carlow/Kilkenny.
- Better LIFE: A six-week education and 12-month exercise MDT programme, including dieticians, physiotherapists, occupational therapists and public health nurses delivered in primary care in North Louth since 2011.

## 2.2 SECONDARY AND TERTIARY HOSPITAL CARE

Treating severe and complex obesity requires specialist MDTs for assessment, management and optimising health outcomes, which are delivered mainly in secondary and tertiary care settings in Ireland. Secondary and tertiary care services have been affected by lack of dedicated and consistent resourcing. This results in inequitable access, long waiting lists, exacerbation of obesity and complications, difficulties in delivering quality services, individuals travelling long distances at considerable expense to access care or declining care based on the distance and cost. Specialist services are required to assess and refer for bariatric surgery, therefore limited capacity in these services has a direct impact on access to bariatric surgery.

### Children and Young People

Children and young people are classified as overweight or obese based on growth measurement at intervals of six months by their GP, GPN, School Nurse, PHN, CMD or other HCP. After plotting BMI on age and gender adjusted growth charts the HCP discusses the measurements with the parent and/or child and decides whether onward referral is necessary for further assessment or treatment. Further assessment could be undertaken by the paediatric community team or in secondary care by general paediatrics or other paediatric specialists. After assessment, appropriate treatment may be required based on the needs of the child or young person. While all children and young people have access to general paediatrics in secondary care, they often wait for long periods to be seen and then may not receive multidisciplinary treatment. Currently, specialist multidisciplinary services for children and young people with severe and complex obesity are delivered formally in one tertiary care setting. Children's Health Ireland at Temple Street is a member of the European Association for the Study of Obesity (EASO) 'Collaborating Centres for Paediatric Obesity Management' (COMs) initiative, which is a network of accredited multidisciplinary treatment centres across Europe. The service in CHI at Temple Street has treated over 1500 children and young people (2004-2020) and has capacity to see 120 new referrals each year in addition to approximately 200 review patients. The service is led by a Clinical Specialist HSCP in Paediatrics and accepts referrals from hospital consultants working in the CHI group for children and young people with BMI > 98th centile. Thereafter, patients are either referred to a paediatric primary care team or offered treatment delivered via group or individual intervention. On average, people wait for over 24 months from GP referral to review by general paediatrics and onward referral for initial assessment by the MDT. As of June 2020, there are 108 new patients currently awaiting assessment and 94 awaiting review. There is currently no funding for an MDT to provide surgical services for eligible young people.

### Adults

As of 2020, there are two consultant led multidisciplinary weight management services which deliver both medical and surgical treatments for adults with severe and complex obesity in secondary care settings: IEHG (St. Columcille's Hospital/ St. Vincent's University Hospital) and Saolta HG (University Hospital Galway). Both services are members EASOCOM's network.

The medical service in IEHG consists of a 12-month individual multicomponent intervention delivered to adults with BMI > 40kg/m<sup>2</sup> or BMI > 30kg/m<sup>2</sup> with complications as outpatients at St. Columcille's Hospital. The service triages approximately 500 individuals per year, according to the complexity of their obesity, with approximately 300 individuals in active treatment at any one time. It receives approximately 50 referrals per month from all HCPs and has a waiting list of approximately 1800. People attending the service can also access supports including cookery demonstrations, exercise classes, psychology groups and weight check clinics.

If eligible, people attending the service are referred to the bariatric surgery service and/or an Inpatient Weight Management Programme. The Inpatient Programme is a 6-week multidisciplinary rehabilitation programme that includes a medically supervised in-patient exercise programme, low calorie liquid diet, psychology and nursing support. To date, the programme has treated approximately 106 individuals, with capacity to see up to 16 individuals per year. There are currently over 30 people waiting to access the programme. The bariatric surgery service is delivered across three sites, all part of the Ireland East Hospital Group. Pre-operative assessment and post-operative support is delivered in St. Columcille's Hospital, surgical procedures are carried out in St. Vincent's University Hospital and St Michael's Hospital. The surgical service is funded to deliver 30 surgeries with MDT support per year, with additional 50 procedures funded via NTPF. The current surgical waiting list is approximately 200 individuals.

The bariatric medicine service in Galway University Hospital was launched in 2011. Approximately 500 adults with BMI >40kg/m<sup>2</sup> or BMI >35kg/m<sup>2</sup> with comorbidities are treated each year within the service, approximately 60 referrals are received per month. Patients attending the service are assessed and are offered different bariatric care options including structured weight management groups, psychological and surgical assessment, meal replacement programmes and pharmacotherapy. The delivery of the structured weight management programme (Croí CLANN) is contracted out to Croí; a registered charity. As of July 2020, there is no senior dietitian or physiotherapist and 456 individuals are waiting to access the service. Five hundred individuals are awaiting psychological and surgical assessment and there is inadequate space to provide a safe multidisciplinary clinical service. The bariatric surgery service is delivered to a very limited extent in University Hospital Galway and more recently Letterkenny University Hospital. As of June 2020, there are 700 individuals waiting for bariatric surgery in University Hospital Galway.

Despite the unequivocal clinical evidence supporting bariatric surgery, the rate of operations for adults in Ireland is extremely low. In 2019, 80 surgeries were carried out in IEHG and 14 surgeries were carried out in Saolta HG. This equates to 18 per million of the population, compared with European averages which range from 72 to 928 per million (Borisenko et al, 2015). At current rates of 80 per year nationally, adults with severe and complex obesity that have been assessed and suitable for surgery must wait over 4 years (and even longer in Galway) to undergo their procedure.

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This model of care describes clinical services aligned with the best existing evidence to address the real world practical care of individuals with overweight and obesity. The right service design is one where the population is actively engaged in prevention, health behaviour improvement and self-management support with timely access to relevant and necessary treatment based on their individual needs.

The treatment goals of obesity care are:

- To treat with behavioural interventions/pharmacotherapy/bariatric surgery to eliminate or ameliorate weight-related physical, functional and psychosocial complications and prevent disease progression.
- To prevent future weight gain and development of weight related complications in individuals with overweight or obesity.

Using a population-based approach, it is possible to define groups of people with chronic disease within a given catchment area according to their care requirements and provide the most appropriate services to meet their needs. The aim is to provide early identification and intervention before overweight or obesity progresses, rather than intervening later. It is used to stratify patient groups into levels of risk, with different interventions provided at each level to maintain health. A population health approach for chronic disease, which this model of care is based on, is shown in Figure 3.

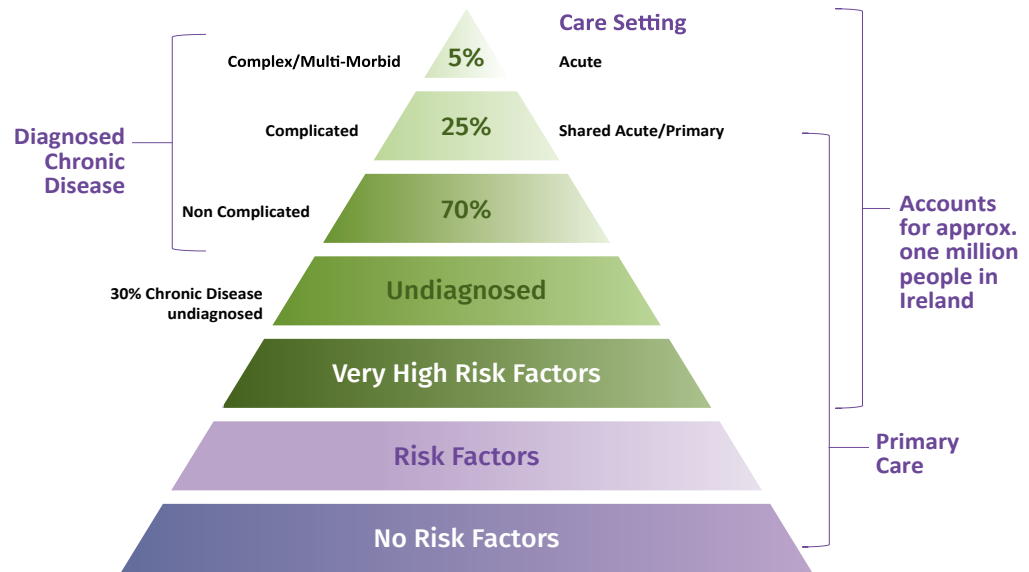


Figure 3: Population health approach for chronic disease

Figure 4 shows the full spectrum of services required to provide end-to-end care for chronic disease in Ireland and the settings where they should occur. Community and primary care services cover many of the health and social care services outside of the hospital setting. Primary care can be defined as the first level of contact for the population with the health care system, bringing health care as close as possible to where people live and work. Primary care includes services provided by general practice teams as well as other health professionals such as nurses, HSCPs, pharmacists and community health workers. The aim of the primary care team is to provide services that are accessible, integrated, of a high quality and which meet the needs of the local population within the Community Healthcare Network (CHN).

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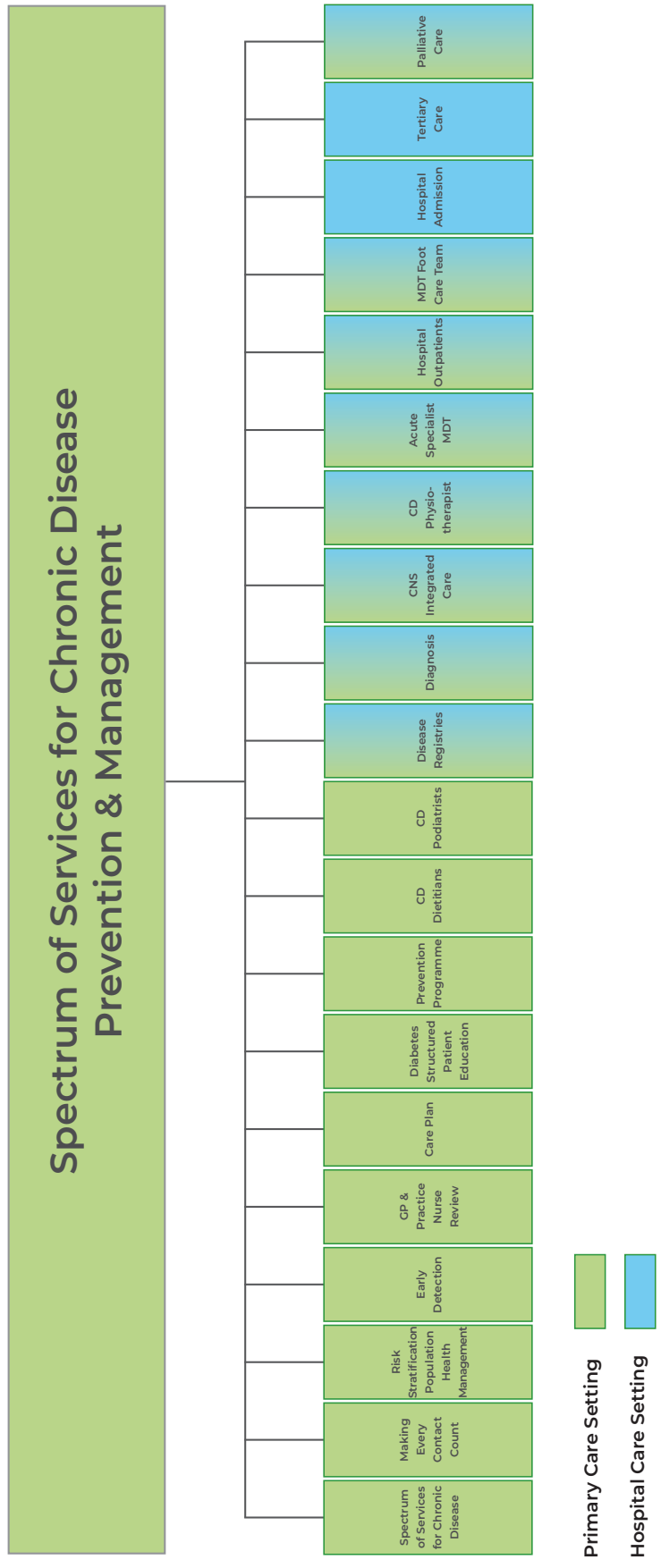


Figure 4: Spectrum of services for people living with or at risk of chronic disease (Integrated Care Programme for the Prevention and Management of Chronic Disease, 2020)

As part of implementing Sláintecare and improving how health services are delivered, six new health regions for Ireland have been developed as outlined in Figure 5. The aim of the new regions is to enable planning and provision of better healthcare, with a shared budget to care for the people living in each region. This model of care sets out national services for people with overweight and obesity which align to proposed CHNs, Ambulatory Care Hubs and RHAs to support integrated care delivery across community, primary and hospitals.

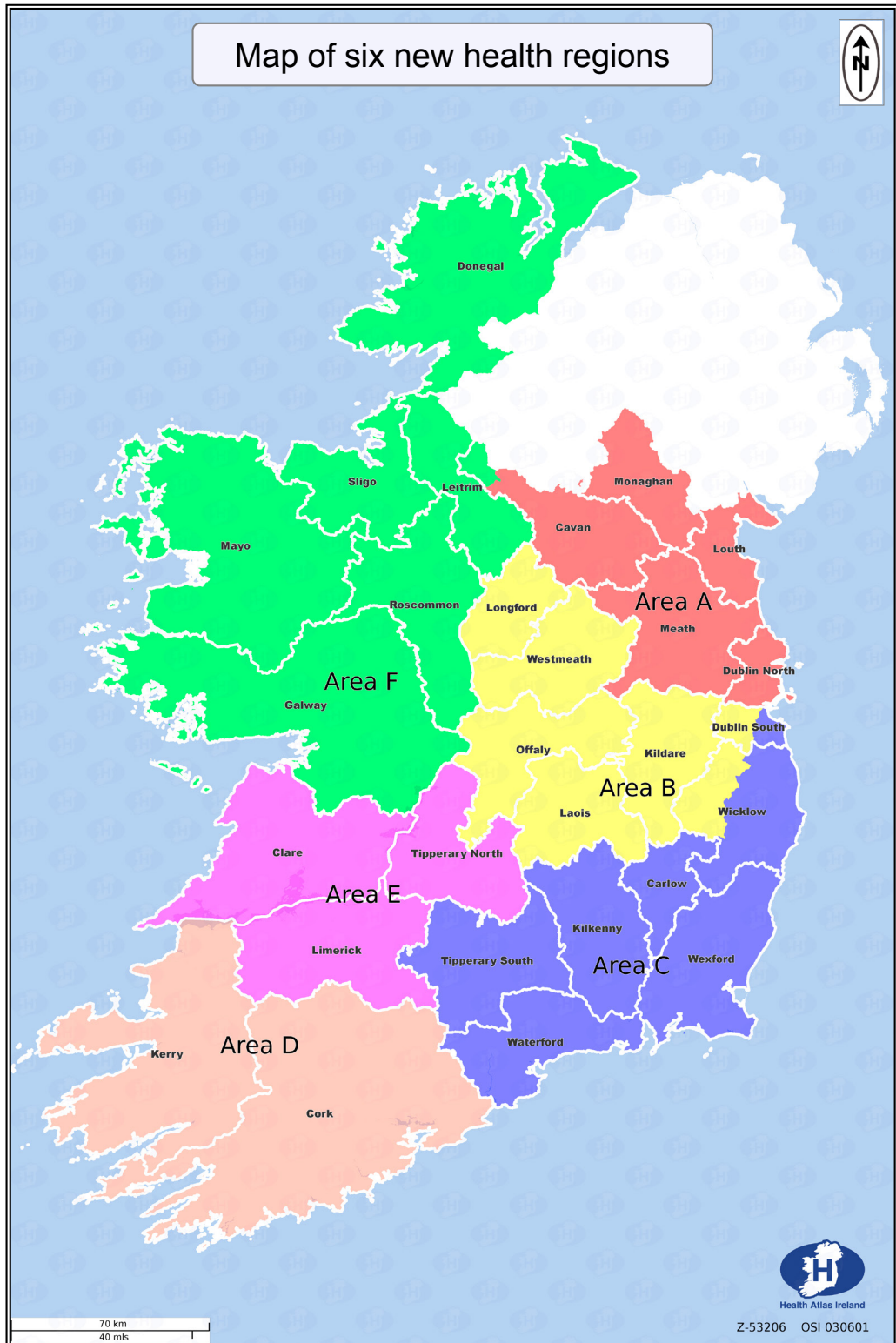


Figure 5: Map of six new Regional Health Areas (RHAs).



### 3.1 SLAINTECARE PRINCIPLES

This model of care aligns to the Sláintecare principles as outlined as follows:

#### Population Health Perspective

The model is based on the population health pyramid set out in Figure 3. Within the population, children, young people and adults will experience different levels of disease complexity or risk and therefore, have different requirements for healthcare services. Many people will be managed within primary care. Prevention of disease progression and development of complications occurs at every level. Unless actively managed, individuals will progress up the pyramid to develop severe and complex obesity. Collaboration with the relevant National Clinical Programmes is essential to address overweight and obesity in service design and delivery. These include but are not limited to paediatrics, anaesthesia, critical care, acute medicine, emergency medicine, acute and elective surgery, palliative care, transport medicine, mental health (eating disorders, early intervention in psychosis, ADHD in adults). There is also an opportunity for collaboration with services and agencies in Northern Ireland to develop an all-island approach to overweight and obesity care.

#### Person-centred Care

Services will be developed to provide the right care, in the right place, at the right time and built around the needs of the individual. Use of an evidence-based classification system that considers complications of obesity and functional status is recommended to improve the use of resources and help direct individuals to the most suitable service. The Edmonton Obesity Staging Systems for children and adults are appropriate tools for this purpose (Appendix 4 & 5). Negative and stigmatising attitudes amongst health care professionals can leave people with obesity feeling embarrassed or ashamed and have a profound negative effect on care, including avoidance of healthcare interactions in future. In all health and social care settings, management of overweight and obesity is underpinned by respectful, non-judgemental and non-stigmatising conversations with all healthcare professionals. Individuals should not be discriminated against based on body size. A suite of individualised treatment options and supports will be available and offered with permission and in collaboration with patients, with continued follow up for support.

#### Health and Wellbeing

Prevention of disease progression and development of complications is central to all levels of service delivery. Advances in the epidemiology, determinants, pathophysiology, assessment, prevention and treatment of obesity has changed the focus of obesity management away from weight loss alone and towards improving patient-centred health outcomes, living well and achieving 'best weight' rather than 'ideal weight'. Local service co-ordinators within Health and Wellbeing will work to integrate and map community based programmes, initiatives and programmes, develop standardised pathways and procedures to support people to self-manage the health behaviours (eating, activity, sleep, stress, etc) that can impact weight. The National Clinical Programme for Obesity will work with Health and Wellbeing to develop guidance for community based self-management support programmes.

#### Co-ordination of Care

HCPs across all health and social care settings will be encouraged and supported to provide earlier identification and management of overweight and obesity. Lifelong support is required for obesity, as with any other chronic disease. A full spectrum of services across all levels of care will be required to ensure continuity of care through integrated care pathways. Secondary and tertiary care services are integrated with

primary care, facilitated by clinical coordinators and supported by community-based programmes and self-management support depending on complexity. Standardised referral guidelines, pathways and processes will be developed to ensure timely access to patient-centred, cost efficient, integrated care between health professionals and across all health and social care settings.

### Equity

Services are underpinned by the principle of equity in recognition of the distribution of obesity among socially disadvantaged groups, long waiting lists for access to specialist services and lack of capacity in primary care. There are a number of identified groups with or at risk of overweight and obesity that require additional interventions and supports due to the sociodemographic setting, presence of other complications, age, gender or ethnic group including people of African, African-Caribbean, Asian descent, members of Travelling Community. Services will be targeted and accessible to higher risk groups and shared pathways will be developed with external services to meet the needs of individuals requiring additional supports. An equitable service would be a tailored approach in which this group could access weight management services with additional support from skilled HSCPs within their relevant teams e.g. mental health, eating disorders, chronic disease, older people, women with obesity in pregnancy. Key enablers of this include shared electronic medical records, communication and standardised referral pathways across the services (through Healthlink or similar platforms), and population risk stratification for overweight and obesity through improved ICT systems for compiling data at a national level.

### Self-care and Self-management

This model of care is underpinned by the HSE's Self-Management Support Framework (2017) and the Making Every Contact Count Frameworks (Appendix 6) for the prevention and management of chronic disease. Individuals will be supported with knowledge and skills to self-manage their condition and access support services in the locality.

### Top of Licence Practice and Teamwork

Changing care for people living with obesity requires changes in healthcare professionals' knowledge, skills and practice, improved organisation of care and new ways of working together to best support individuals across all health and social care settings. To achieve consistent, high-quality, cost effective, person-centred care, advanced practice and clinical specialist roles should be developed within specialist services for obesity, nursing and HSCPs. Team members have clear roles and responsibilities and are committed to maintain continuity of care through communication and record keeping where personal continuity is not possible.

### Supported by Technology

A national health information and communications technology infrastructure, including electronic health records, is essential for integrated services to improve communication and sharing of clinical information between HCPs and across service settings. Services will require technological support to enable clinical data sets to be collected and analysed for quality improvement and service planning. Information, communication and self-management support will be provided via online platforms. Services will be designed and resourced to be flexible in delivery: face-to-face, online and blended service delivery models will be designed to best support individuals. The COVID-19 pandemic has presented opportunities to move towards virtual and digital models for certain aspects of care which may better suit some people living with obesity.

## Quality and Safety

Clear and robust governance structures to support accountability and the delivery of high-quality, safe, patient-centred, integrated care are a key in the development of services for overweight and obesity. Services will be developed and constantly reviewed in collaboration with persons with living experience of overweight and obesity. Interventions are delivered by a team of trained, experienced and competent HCPs with appropriate staffing levels. New ways of working will require governance and oversight at local, regional and national levels. Robust measurement and evaluation processes will be developed to support this model of care. Quality will be measured by reported patient experience to include, defined outcome measures, key performance indicators, regular and standardised service monitoring and reporting, audit and evaluation. This will be facilitated by standardised data collection processes and integrated electronic medical records. Services should have dedicated space and be appropriately equipped for all service users in line with National Guidelines on Accessible Health and Social Care Services (NAU/HSE, 2014).

### 3.2 THE MULTIDISCIPLINARY TEAM FOR CARE OF OVERWEIGHT AND OBESITY

Overweight and obesity will be delivered by different members of the MDT depending on the level of service. Assisting people with overweight and obesity to build confidence and skills in self-management through self-monitoring, goal setting, problem solving, education and empowerment should be a key function of all HCPs. The various members of the MDT for all levels of care and description of roles are outlined in Appendix 7.

### 3.3 SERVICES FOR CHILDREN AND YOUNG PEOPLE

All children and young people should be able to access safe, high quality services for overweight and obesity in an appropriate setting, within an appropriate timeframe, irrespective of their geographical location or social background. This requires the development of an integrated network of paediatric services nationally. Integration means healthcare that is seamless, smooth and easy to navigate for the child and their family, a coordinated service which minimises the number of separate healthcare visits. Family-centred care includes parents, carers and those who provide support to individuals who live with assistance but who may not be direct family members. The cornerstone of both the model of care for paediatrics and this model of care for obesity are pathways that enable children and young people to move between primary, secondary or tertiary care as required. Integration of initiatives and supports for healthy behaviours for children and families in the community is also essential. Services should also be linked with specialist services across social care, mental health, eating disorders, disabilities to provide specialist input for children and young people at high risk.

Obesity is a condition that can track from childhood to adulthood. Transition services need to be developed to support young people in their obesity care and treatment through each life stage. While children and young people will access services for overweight and obesity in primary care for the most part, specialist services will be available in community and hospital settings for the assessment and treatment of obesity. Children and young people that require care, will have access to multidisciplinary medical assessment and treatment services including pharmacotherapy and onward referral to bariatric surgery services. Bariatric surgery, inpatient rehabilitation and additional specialist services will be provided in the national tertiary care centre.

Anthropometric measures do not always accurately and reliably identify children and young people with obesity-related health risks or complications. For the

purposes of this document, overweight and obesity in children is broadly categorised based on the Edmonton Obesity Staging System – Paediatric (EOSS-P) (Hadjiyannakis et al., 2016) which is outlined in Appendix 4. The EOSS-P can be used to classify individuals according to the severity of their comorbidities and barriers to weight management into four graded categories. It is based on common clinical assessments that are widely available and routinely completed by clinicians and can help evaluate and guide signposting and referral of children and young people to the appropriate services for management of overweight and obesity. Table 6 outlines the suggested level of service, based on degree and severity of overweight and obesity. Standardised referral criteria, integrated service pathways and service specifications will be developed by the National Clinical Programme for Obesity during the implementation phase of the model of care.

**TABLE 6:  
SUGGESTED SERVICES FOR CHILDREN AND YOUNG PEOPLE**

	BMI	Presence of complications	Suggested services
<b>Overweight</b>	BMI > 91 <sup>st</sup> centile with	No identified complications	Level 0-1a Early identification and brief advice Enhanced parenting programmes Self-management supports
<b>Obesity</b>	BMI > 98 <sup>th</sup> centile with	No obesity related metabolic, mechanical, psychopathology or parental, familial or social environment concerns	Level 0-1a Early identification and brief advice Enhanced parenting programmes Primary care team HSCP interventions
	BMI > 98 <sup>th</sup> centile with	Mild metabolic abnormalities, bio-mechanical complications, psychopathology, minor social environment concerns	Level 0-1b Community Specialist Obesity MDT with medical oversight from GP or CMD
	BMI > 98 <sup>th</sup> centile with	Moderate metabolic complications requiring pharmacotherapy, moderate bio-mechanical complications, moderate mental health issues or problems in relationships and social environment	Level 2 Assessment by an identified lead Paediatrician in local hospital unit with treatment in Community Specialist Obesity MDT or onward referral to tertiary care
<b>Severe and complex obesity</b>	BMI > 99.5 <sup>th</sup> centile OR BMI > 98 <sup>th</sup> centile with	Uncontrolled metabolic complications, bio-mechanical complications requiring treatment, limited mobility, shortness of breath, uncontrolled psychopathology, school refusal, eating disorders, severe problems in relationships and severe environmental concerns	Level 3 Tertiary based MDT

Key enablers of this model of care will be agreed with standardised clinical guidelines, outreach from secondary and tertiary centres to primary care and community services, organisation of care on a regional basis with integrated care pathways and the implementation of a national electronic health record linking all care settings. Children, young people and families are highly vulnerable to weight bias and discrimination within society and the health services. All HCPs involved in the care of overweight and obesity require training and support to provide high quality, evidence-based interventions in a non-stigmatising, collaborative, compassionate manner that respects the autonomy of children, young people and families. Figure 6 outlines the levels of care provided for children and young people using a population-based health approach.

### EXAMPLES OF SERVICES

#### Tertiary Care Obesity MDT

- Specialist MDT assessment and interventions
- Bariatric surgery (pre and post-operative support)
- Inpatient management

#### Hospital Specialist Obesity MDT

- Lead paediatrician, CNS and dietitian assessment and treatment in local paediatric unit
- Pharmacotherapy
- Onward referral to tertiary care or community team as required

#### Community Specialist Obesity MDT

- MDT 1:1, group and online interventions with medical oversight from GP or CMD

#### General Practice & Primary Care Team

- Early identification, brief advice & follow up by GP, GPN, PHN, CMD
- Primary care team HSCP interventions

#### Health Promotion & Community Programmes

- Self management supports
- Enhanced parenting programmes

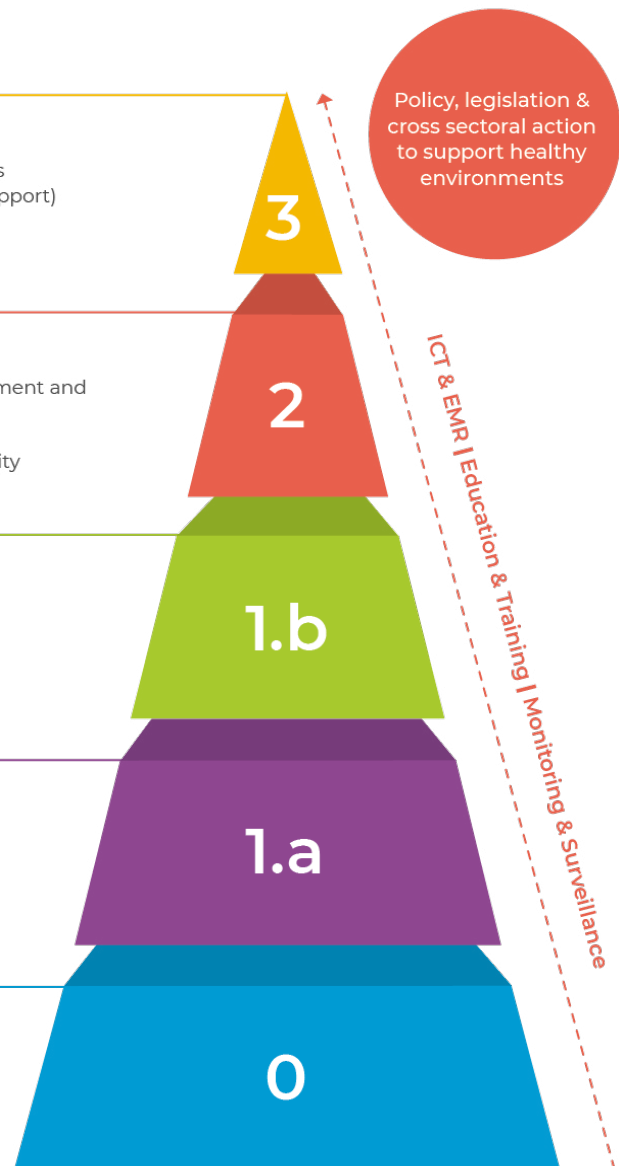


Figure 6: A population health approach to services for overweight and obesity for children and young people

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### 3.3.1 LEVEL 0 HEALTH PROMOTION AND COMMUNITY PROGRAMMES

Health promotion and community programmes underpin all levels of service. They encompass all the supports required at local level for children, young people and families to manage healthy behaviours that can impact on weight. It includes community programmes, online resources and brief advice provided during routine and opportunistic consultations with healthcare professionals. The Healthy Weight for Children Framework (2019) outlines a broad range of community initiatives, to support prevention of overweight and obesity.

Enhanced parenting programmes are holistic, healthy behaviour focused, evidence-based parenting programmes with specific interventions for children and families with overweight or obesity. These will be integrated into the suite of existing parenting supports offered by the TUSLA Prevention Partner and Family Support (PPFS) programme nationally. This suite should include general parenting programmes for all families, a 1-1 peer family visiting programme for vulnerable families as a component of the PPFS programme (such as Preparing for Life) and lifestyle focused parenting programmes such as Triple P lifestyle. The recommended staffing requirements for implementation of enhanced parenting programmes within the CHN are outlined in table 7. Community programmes will be tailored to the needs of the local population and open to self-referrals. They will be accessible to all, including those in high risk groups such as mental health, eating disorders, disabilities and ethnic minorities. They will have a focus on lower socio-economic groups which are at higher risk of overweight and obesity. Integration of services will be facilitated by local service coordinators on a few levels:

- Integration of community health and wellbeing services.
- Integration with primary, secondary and tertiary care services.
- Integration and partnership between HSE and local authorities, Children & Young People's Services Committees, local sports partnerships and trained exercise professionals, schools and the voluntary sector.

#### KEY ELEMENTS OF CARE PROVIDED WITHIN EACH COMMUNITY HEALTH NETWORK (APPROXIMATELY 50,000 POPULATION):

- Brief advice and signposting to community care supports during routine and opportunistic contacts with healthcare professionals.
- Self-management support programmes including general parenting programmes and enhanced parenting programmes supporting behavioural change.

**TABLE 7:  
RECOMMENDED ENHANCED PARENTING PROGRAMME STAFFING (PER 50,000 POPULATION)**

Discipline	WTE	Suggested Grade
Service Coordinator	0.3	Grade VII or equivalent clinical grade
Programme Facilitator	1	Grade VI
Administration	0.3	Grade IV

**Other programmes and initiatives that are relevant at this level:**

- Community cooking programmes: Healthy Food Made Easy.
- Breastfeeding groups supports and weaning workshops.
- Physical activity programmes and initiatives for children and families.
- Stress management and counselling programmes.
- 1-1 family visiting programme for vulnerable families: Preparing for Life/Community Mothers.
- Safefood Community Food Initiative: a programme that positively influences the eating habits of families with children in low-income communities.
- START programme: the public health awareness campaign from Safefood, the HSE and Healthy Ireland; to support families to take small steps towards eating healthier food and becoming more active.
- NURTURE programme and MyChild resources and supports.
- Health promotion campaigns raising awareness of overweight and obesity, weight stigma, healthy behaviours, healthy relationships with food and bodies that avoid unintended negative impacts such as preoccupation with weight and shape or restrictive eating.

**Training requirements at this level:**

To support access to these programmes, training will be available to all HCPs on providing brief assessment, brief advice and onward signposting for children, young people, families and carers as follows;

- Brief intervention training for overweight and obesity management in children and young people for HCPs across all health and social care settings. This provides the knowledge and skills to identify overweight and obesity and provide information that is evidence based, non-stigmatising, collaborative, compassionate and respects patient autonomy.
- Training, education and guidance for those involved in developing and delivering health promotion campaigns to ensure that they are evidence-based, non-stigmatising and avoid reinforcing misconceptions about overweight and obesity.

**3.3.2 LEVEL 1A GENERAL PRACTICE AND PRIMARY CARE TEAMS**

Healthcare professionals within general practice teams and in primary care teams are ideally placed to provide early identification and brief interventions for overweight and obesity in children through routine and opportunistic contacts. This model of care supports the extension of access to GP care without fees, on a phased basis, to all children of primary school age as outlined in the GP Contract (2019) to support early identification and brief advice provided to children and young people over 6 years old. These interactions provide an opportunity to identify overweight and obesity at the earliest opportunity, provide brief advice on healthy behaviours and onward referral as necessary, with regular follow up support and monitoring.

In addition to facilitating early identification of overweight and obesity, regular assessment of growth in childhood may help early diagnosis of conditions such as hypothyroidism, coeliac disease, growth hormone deficiency and Turner Syndrome. It also provides essential population level data for services planning and delivery (RCPI, 2015).

#### Specific opportunities for early identification and brief advice include:

- Growth monitoring and brief interventions by PHN or CMD as part of the National Healthy Childhood Programme.
- Growth monitoring and brief interventions by GP and GPN at age 2 and 5 as part of the Primary Care Reimbursement Service (PCRS) GP Under 6 Contract.
- Brief interventions during routine Health and Social Care Professionals (HSCP) interventions in primary care for conditions related to overweight and obesity.

### KEY ELEMENTS OF CARE PROVIDED WITHIN EACH COMMUNITY HEALTH NETWORK: (APPROXIMATELY 50,000 POPULATION)

- PHN and CMD growth monitoring, brief intervention and referral and signposting as needed.
- GP and GPN growth monitoring, brief intervention and referral and signposting as needed.
- Further clinical assessment by GP or CMD as required (physical exam, laboratory assessment, diagnostics and eating disorders screening).
- Identification of high-risk populations and appropriate management in line with agreed shared care pathways. For example, children and young people living with eating disorders or a mental health diagnosis, and those taking medications associated with weight gain; children and young people living with intellectual or physical disabilities.
- Routine HSCP interventions in primary care provided by HSCPs with defined resource from paediatric dietetics (based on local obesity prevalence).
- Existing weight management interventions in primary care.

#### 3.3.3 LEVEL 1B COMMUNITY SPECIALIST OBESITY MDT

The majority of children and young people with overweight and obesity can be managed in community settings by general practice and primary care teams. The function of the Community Specialist MDT is to provide additional specialist support for children and young people with obesity and complications. Medical oversight is a crucial component and can be provided by the GP or Community Medical Doctor depending on age or geographical location. Interventions are evidence based and provided in individual, group and telehealth settings including structured transition pathways to adult services.



The Community Specialist Obesity MDT can also provide specialist treatment to children and young people attending level 2 hospital-based team as required. The recommended staffing for these teams is outlined in table 8. Staffing and geographical location will be weighted to local population prevalence, where higher obesity prevalence is observed in socially disadvantaged areas.

**TABLE 8:  
RECOMMENDED LEVEL 1B COMMUNITY SPECIALIST OBESITY MDT  
STAFFING (PER 500,000-600,000 POPULATION INITIALLY)**

Discipline	WTE	Suggested Grade
Service Coordinator	1	G VII or equivalent clinical grade
Nursing	1	Obesity Clinical Nurse Specialist
Dietetics	2	Clinical Specialist x 1 Senior x 1
Physiotherapy	2	Clinical Specialist x 1 Senior x 1
Occupational Therapy	2	Clinical Specialist x 1 Senior x 1
Psychology	2	Senior x 1 Staff grade x 1
Medical Social Worker	0.5	Senior
Administration	1	G IV

Children and young people identified with obesity and related complications attending other services such as Child and Adolescent Mental Health Services (CAMHS), Specialist Eating Disorders Services or Children's Disability Network Teams will receive appropriate support and treatment from the most appropriate service to meet their needs. Access criteria and pathways will be developed and agreed with these services.

**Training requirements:**

- Undergraduate, postgraduate and continuing education to build skills, knowledge and attitudes necessary to confidently and effectively support people living with overweight and obesity.
- The skills and competencies should be relevant to the level of service provided, with an opportunity for HSCPs and nursing to develop clinical specialist and advanced roles in obesity care.
- Training and supports to develop special interest in obesity for Community Medical Doctors, GPs and Community Paediatricians.

**3.3.4 LEVEL 2 HOSPITAL SPECIALIST OBESITY MDT**

Referral to secondary care should be guided by degree of obesity, presence or likelihood of complications (e.g. family history) or where secondary or genetic causes of obesity is suspected (Viner et al, 2012, Hadjiyannakis et al., 2016). Secondary care teams are based in paediatric units, led by a Consultant Paediatrician with specialist support from nursing and dietetics. They provide further assessment and investigations, management of comorbidities, pharmacotherapy and refer to tertiary care and bariatric surgery as required. They also include structured transition pathways to support young people accessing adult services. The recommended staffing at a regional level for these teams is outlined in table 9. Staffing and geographical location will be weighted to local population prevalence, where higher prevalence is observed in socially disadvantaged areas. Paediatric units are outlined in Appendix 9.

**TABLE 9:  
RECOMMENDED LEVEL 2 LOCAL/REGIONAL HOSPITAL UNIT SPECIALIST OBESITY MDT STAFFING (PER LOCAL/REGIONAL PAEDIATRIC HOSPITAL UNIT)**

Discipline	WTE	Suggested Grade
General Paediatrician	0.5	Consultant lead for obesity
Nursing	0.5	Clinical Nurse Specialist
Dietetics	0.5	Clinical Specialist
Administration	0.5	G IV

**Key elements of care provided within local hospital units:**

- Comprehensive clinical assessment and treatment provided by General Paediatrician lead for obesity with support from hospital and community MDT as required.
- Clinical Nurse Specialist and Clinical Specialist Dietitian to support the Paediatrician in providing comprehensive assessment and treatment.

- Adjunctive use of approved pharmaceutical medications as appropriate for children and young people.
- Assessment and treatment for complications of obesity and referral to specialist services as required e.g. liaison psychiatry.
- Initial assessment for bariatric surgery and onward referral to tertiary care as required.
- Integration with primary care and tertiary care services with severe and complex obesity for support and case management as required.
- Shared care pathways with relevant specialities for the assessment and management of obesity related complications e.g. cardiology, respiratory, endocrinology and orthopaedics.
- Shared care pathways with specialist services for high risk groups including CAMHS, eating disorders and disability services.
- Assessment, planning and completion of structured transition programme for young people transferring into adult services.

### 3.3.5 LEVEL 3 TERTIARY CARE SPECIALIST OBESITY MDT

One tertiary care multidisciplinary child and adolescent obesity service is required for every one million children and young people (Welbourn, 2018). Children and young people with adiposity, obesity with severe complications, secondary causes of obesity, and syndromic obesity who cannot be adequately managed in primary or secondary care should be referred to a specialist multidisciplinary service i.e. tertiary care. (Viner et al, 2012). Children and young people can be referred by the hospital specialist obesity MDT in local units, the GP, Community Medical Doctor, Community Paediatrician or other Physician as relevant for assessment in the specialist multidisciplinary service at the Children's Health Ireland (CHI), which is under the clinical governance of a Consultant Paediatrician of relevant specialty. The service provides inpatient and outpatient non-surgical treatment and bariatric surgical services. Recommended staffing is outlined in table 10.

**TABLE 10:  
RECOMMENDED LEVEL 3 TERTIARY CARE SPECIALIST OBESITY MDT STAFFING**

Discipline	WTE	Suggested Grade
Consultant Bariatric Surgeon	0.5	Consultant
Consultant Anaesthetist	0.5	Consultant
Consultant Paediatrician (relevant specialty)	0.5 Paediatrician 0.5 Paediatric Endocrinologist 0.5 Adolescent Paediatrician to support transition service 0.5 Paediatric Psychiatrist	Consultant

Discipline	WTE	Suggested Grade
NCHD*	1	Registrar
Service/Transition Coordinator	1	G VII or equivalent clinical grade
Nursing	1	Clinical Nurse Specialist
Dietetics	1.5	Senior – Clinical Specialist
Physiotherapy	1.5	Senior – Clinical Specialist
Occupational Therapy	1	Senior – Clinical Specialist
Medical Social Work	1	Senior
Clinical/Counselling Psychology	1.5	Entry level-Senior
Administration	1.5	G IV

*\*Can include nursing or HSCP advanced practitioner grade at this level.*

#### Elements of care provided at this level include:

- Multidisciplinary medical assessment and evidence-based treatment for severe and complex obesity in children and young people.
- Assessment for complications of obesity and referral to other specialist services as relevant.
- Genetic testing to assess for non-syndromic and syndromic obesity.
- Multidisciplinary assessment, planning and provision of bariatric surgical procedures including pre-, peri- and post-operative care.
- Adjunctive use of approved pharmaceutical medications as appropriate for children and young people.
- Respiratory and neurodevelopmental rehabilitation interventions.
- Integrated care pathways to ensure access to appropriate health and social care supports for children with additional complex needs.
- Assessment, planning and completion of structured transition programme for young people transferring into adult services led by an adolescent Paediatrician and integrated with local adult level 3 and 4 services, to ensure an optimal transition of young persons with obesity to appropriate services, in a timely manner.
- Links between the Young People level 4 service, adolescent and adult services for those over 16 years need to be clearly established to avoid this group waiting until they deteriorate sufficiently to meet level 4 service provision.

- A dedicated level 4 service for young people over 16 years with obesity and comorbidities.
- It is essential that a well-defined transition service exists between the level 3 adolescent service, based at CHI and the dedicated level 4 service for young people.

### 3.3.6 TRANSITION SERVICES

Adolescence is a unique developmental period when young people experience pivotal biological, psychological, social and cognitive changes as they transition from child to adulthood. The transition from childhood to adulthood for young people with obesity is challenging and there is a risk of attrition in the absence of continuity of care.

Paediatrics should be developmentally focused, addressing periods of high burden of disease. There is a significant gap in the current healthcare system (depicted in figure 7 below) between the ages of 16; the cut off for paediatric services, and 18; the start of adult services. Therefore, the healthcare system fails to meet the significant health needs of this population. This results in disease progression and development of complications and subsequent intergenerational effects. This is further compounded by the differences between paediatric and adult services, location of these services and waiting times to access services. It also fails to reflect that people mature at different ages and that 16 is an arbitrary age at which to withdraw more intensive services with family involvement (Zhou et al, 2016). Due to major societal changes including the greater uptake of post-secondary education, there has been a major demographic transition in Ireland in recent decades resulting in a significantly longer adolescent and young adult period.

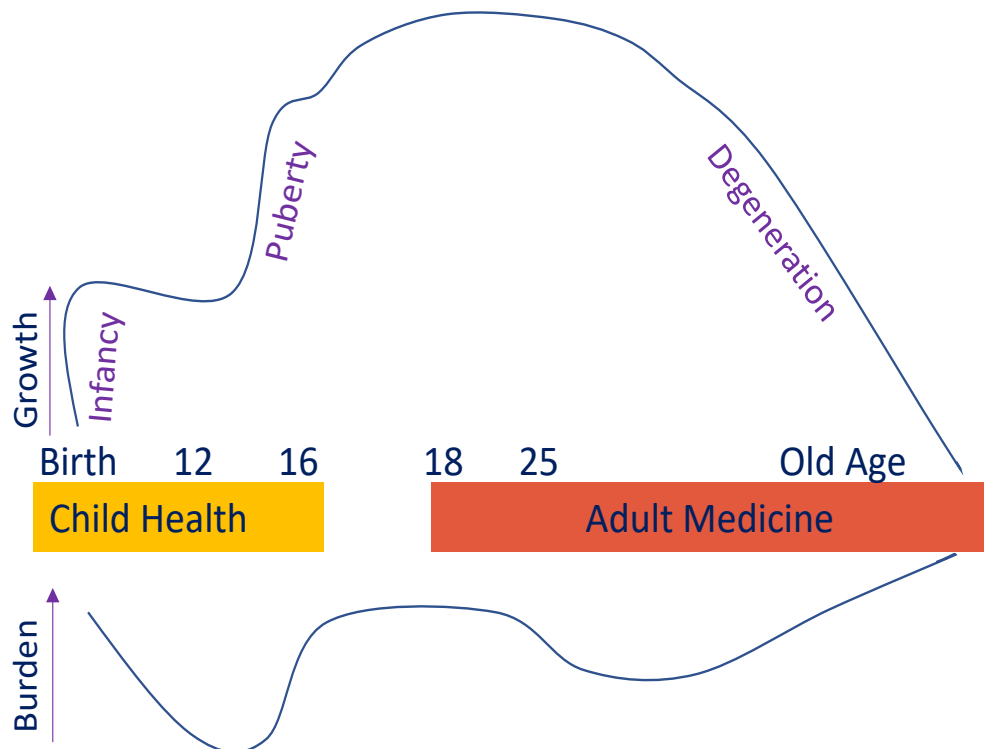


Figure 7: Current gaps in adolescent care

Poorly planned transition is associated with an increased risk of non-adherence to treatment, a lack of follow up and the development of more serious comorbidities which will cause further morbidity in adulthood. This is associated with anxiety and psychological distress which can affect their social and educational outcomes, as well as increased morbidity and mortality as adults (Zhou et al, 2016). Structured multidisciplinary transition programmes can improve health outcomes. Transition to adult care should be planned and managed appropriately through defined patient pathways with clear governance and ongoing support. Continuity of care must be ensured; young people transitioning to adult services should not be placed on a waiting list. The timing of transition ranges from late teens to early twenties, young people should transition according to their developmental stage and self-management abilities ('readiness to transition'), rather than according to chronological age. Consideration should also be given to transition issues that arise in adjunct services such as mental health and disability services.

### Key recommendations for transition services for young people:

Young people with overweight and obesity are prioritised with a dedicated adolescent service regionally, which could be developed within the level 2 Hospital Specialist MDTs.

Young people are eligible to attend Community Specialist MDTs until they are 18 years old.

Priority is given to young people between 16 and 20 years of age who are referred to adult specialist services.

Structured transition programmes within primary, secondary and tertiary care services are available for young people leaving the paediatric service and being transferred to adult services. This transition usually occurs at age 16, following a period of transition preparation via a transition programme.

Transition programmes include a transition coordinator, self-management skill training and assessment of readiness to transition to adult services.

Adult services are trained and adapted to ensure service delivery is flexible to the needs of young people transitioning from paediatric services.

Transition arrangements are in place with adult services for young people that have had bariatric surgery in Children's Health Ireland for long term follow up and support.

### 3.3.7 PATHWAYS OF CARE FOR CHILDREN AND YOUNG PEOPLE

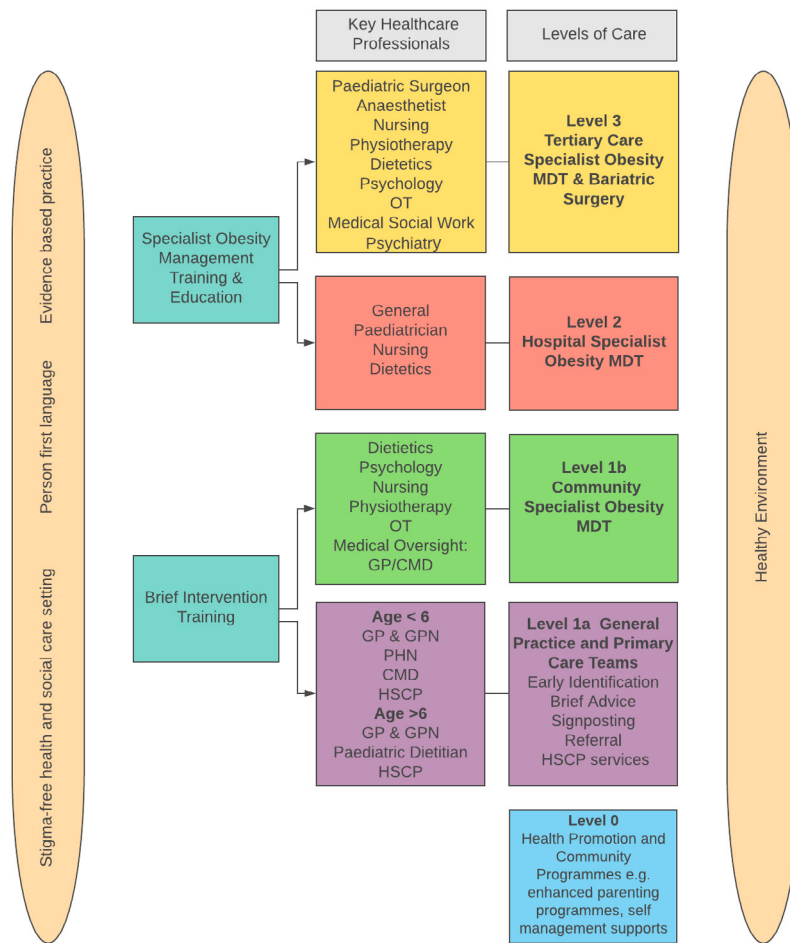


Figure 8: Suggested pathways of care for children and young people with overweight and obesity

### 3.4 SERVICES FOR ADULTS

Obesity is a complex, chronic disease, where management addresses both body weight and related complications to improve overall health and quality of life. The goal of treatment should not solely be restricted to weight reduction, it should also focus on preventing and reducing the impact of complications associated with obesity. The presence and severity of weight-related complications should be the primary determinants for treatment selection as part of a ‘complications-centric’ approach, with the primary therapeutic endpoint being improvement in complications and psychosocial outcomes, not a preset reduction in body weight (AACE/ACE Obesity CPG, 2016).

Obesity can be classified using the Edmonton Obesity Staging System (2009) (Appendix 4) which ranks severity of obesity based on a comprehensive assessment of weight-related health problems, mental health and quality of life in addition to BMI (Sharma and Kushner, 2009). A tiered approach to treatment should be available based on the complexity and progression of obesity, in consultation with the patient.

For the purposes of this document, obesity in adults can be broadly categorised as follows (adapted from EOSS (Sharma and Kushner, 2009), Appendix 5

**TABLE 11:  
 SUGGESTED SERVICES FOR ADULTS**

	BMI	Presence of complications	Suggested services
Overweight and non-complex obesity	BMI > 25kg/m <sup>2</sup>		Level 0-1  Early identification and brief advice  Online resources  Commercial programmes  Self-management supports
	BMI > 30kg/m <sup>2</sup>	No sign of obesity related risk factors, no physical or psychological symptoms, or functional limitations.	Level 0-1  Early identification and brief advice (GP Chronic Disease Contract)  Primary care team HSCP interventions
	BMI > 30kg/m <sup>2</sup>	Obesity related sub clinical risk factors, mild physical symptoms (not requiring medical treatment) and mild obesity related psychological symptoms and/or impairment of well being	Level 0-1  Early identification and brief advice (GP Chronic Disease Contract)  Primary care team HSCP interventions
	BMI >30kg/m <sup>2</sup> with:	Established but controlled obesity related co-morbidities requiring medical intervention (hypertension, type 2 diabetes, sleep apnoea, polycystic ovarian syndrome, osteoarthritis) OR  Moderate but controlled obesity related psychological symptoms (depression, eating disorder, anxiety disorder)  Moderate functional limitations in daily activities	Level 2-4  Dietitian led behavioural weight management programmes
Severe and complex obesity	BMI >30kg/m <sup>2</sup> with:	Significant/severe/uncontrolled obesity related end organ disease  Significant/severe obesity/uncontrolled related psychological symptoms  Significant/severe/uncontrolled functional limitations  Significant/severe/uncontrolled impairment of well being	Level 3-4  Specialist Obesity MDT  Bariatric Surgery MDT

National Clinical Programme for Obesity Working Group

RCPI Obesity Clinical Advisory Group Membership

Foreword by the HSE National Clinical Lead for Obesity

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While most people will access services for overweight and obesity in primary care, specialist ambulatory care services for the assessment and treatment of severe and complex obesity can be in community or acute settings. People with severe and complex obesity will have access to multidisciplinary medical assessment and treatment services including inpatient treatment, pharmacotherapy and holistic assessment for onward referral to bariatric surgery services. Bariatric surgery, inpatient rehabilitation and additional specialist services will be provided in a hospital setting. Figure 9 outlines the levels of care provided for adults using a population-based health approach.

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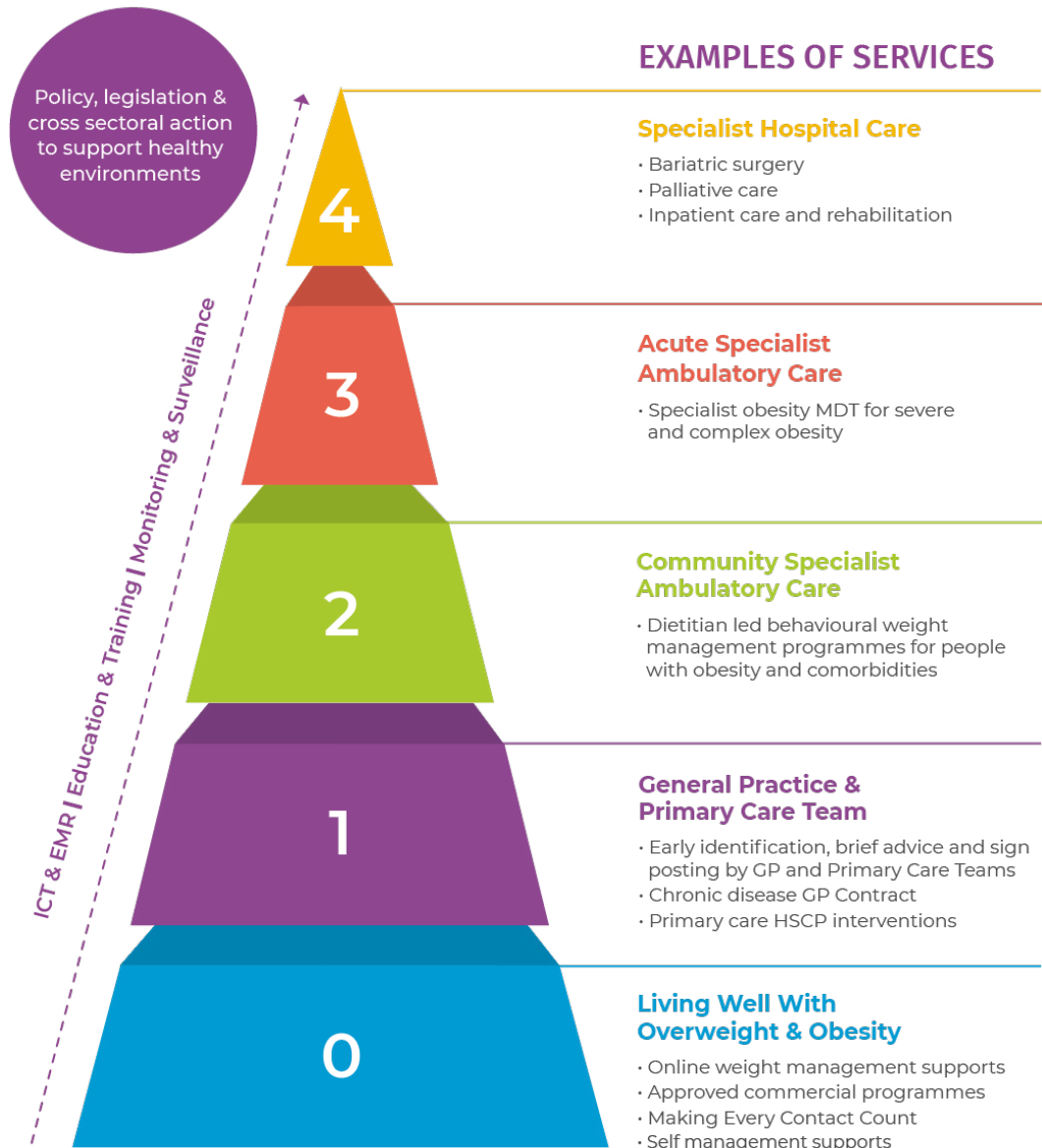


Figure 9: A population health approach to services for overweight and obesity in adults

### 3.4.1 LEVEL 0 LIVING WELL WITH OVERWEIGHT AND OBESITY

Individuals living with overweight and obesity, with their family and carers, will be supported to make the best decisions for their health through programmes and initiatives to increase knowledge and skills in weight management and healthy behaviours. Self-management support encompasses a broad range of interventions that aim to increase patients' knowledge, skills and confidence in managing their health (HSE, 2017). Interventions to support self-management are varied and can include education sessions, online resources and support, counselling or peer-support groups, physical activity and cooking skills courses. Resources for and availability of these programmes will be prioritised and targeted to high-risk groups with overweight and obesity.

Policy, legislation and cross sectoral action to support healthy environments for all are led by the Department of Health. The suite of preventive measures aimed at improving the food and physical activity environment for the whole population across health services is coordinated by the Healthy Eating and Active Living (HEAL) Programme.

Through 'Making Every Contact Count' (MECC) brief advice and brief interventions, HCPs can support individuals to make healthier choices during routine contacts to help prevent and manage chronic diseases. MECC focuses on health behaviours that are known to impact chronic disease (healthy eating, physical activity, tobacco use and alcohol consumption). A MECC training module for weight management will be developed to support non-specialist health care professionals with knowledge and skills in brief interventions for overweight and obesity.

#### Key elements at this level include:

Making Every Contact Count.

Online weight management resources and support via HSE.ie and Safefood Weigh2Live.

Self-management support programmes and activities such as:

- 'Living Well with a Chronic Condition' programmes
- Healthy Food Made Easy programme
- Physical activity programmes and initiatives
- Stress management and counselling programmes
- Patient advocacy groups for people living with obesity and other chronic disease

Approved evidence based commercial weight management programmes which align with the principles of the model of care.

Health promotion campaigns addressing weight stigma, healthy behaviours and providing accurate information on overweight and obesity.

#### Training requirements at this level:

- MECC training for overweight and obesity management people will support staff in community care across all health and social care settings with the knowledge and skills to effectively screen and support individuals with overweight and obesity, relevant to the level of service provided.

- Provide training, education and guidance to health and wellbeing staff in developing and delivering health promotion campaigns that are evidence-based, non-stigmatising and avoid reinforcing misconceptions about overweight and obesity.

### 3.4.2 LEVEL 1 GENERAL PRACTICE AND PRIMARY CARE TEAM

Overweight and obesity are embedded in many different clinical presentations and the first contact for any medical treatment or other issues is mostly with general practice teams. The GP and GPN play a critical role in identifying individuals who could benefit from and who are ready for weight loss support as well as onward referral to suitable interventions. Individuals with overweight and obesity also access HSCPs in primary care across all health and social care settings as part of the management of other conditions. All HCPs have a key role to play in early identification, brief assessment, brief advice and signposting to further support. Changing primary care for people living with overweight and obesity to achieve consistent, high-quality, person-centred care will require changes in HCP knowledge, skills and practice in conjunction with improved organisation of overweight and obesity care.

#### Chronic Disease Management Programme in General Practice

A Chronic Disease Management Programme (CDM) for individuals with General Medical Scheme (GMS) or GP Visit Cards commenced in 2020 for individuals over the age of 70 years who have a GMS or Doctor Visit card and will be rolled out to all adult patients with a GMS or Doctor Visit Card over a four-year period (DOH, HSE, IMO, 2020). The Programme includes opportunistic case finding, an annual preventive programme for patients at high risk of cardiovascular disease or diabetes and a structured treatment programme for those diagnosed with the one of the chronic diseases included in the programme (cardiovascular disease (CVD), chronic obstructive pulmonary disease (COPD), asthma and/or type 2 diabetes). This includes screening for overweight and obesity through measurement of height, weight, BMI and waist circumference for eligible individuals. Those with risk factors for CVD or type 2 diabetes will receive an annual preventive GP and GPN visit and those diagnosed with CVD, COPD, asthma or diabetes will be referred to structured treatment interventions.

#### Overweight and Obesity Management in General Practice and Primary Care

Height, weight, BMI and waist circumference can be used to identify individuals with increased adiposity where more intensive assessments may be indicated. Regular screening can identify individuals at risk of developing obesity and initiate preventative supports. HCP's in general practice and primary care teams can screen, assess and manage people living with overweight and obesity using a framework such as the 5A's of obesity management (Wharton et al, 2020). This is essential to reduce progression of overweight and obesity and development of complications, to challenge stigmatisation and to support well-being, positive body image and self-esteem. Weight loss is not considered the first priority (Schutz et al, 2019). Management of overweight and obesity at this level includes asking permission to discuss weight, assessing the causes of overweight and obesity and related complications, providing advice on the treatment options and supports available across levels 0 to 4, arranging onward referral and scheduled follow-up to review the treatment plan.

**Elements of care provided at this level includes:**

All primary care HCPs in general practice and CHNs can, with permission, initiate patient-centred and non-judgemental conversations about overweight and obesity, undertake basic anthropometric screening, provide brief advice and signposting to relevant services as part of Making Every Contact Count programme in the course of their routine clinical interventions.

Routine and regular measurement of height, weight, BMI and waist circumference obesity will be recorded in general practice as part of the Chronic Disease GP Contract, Making Every Contact Count and Maternity Care Programme.

Based on screening, comprehensive clinical assessment may be required which includes physical exam, laboratory assessment and other diagnostics to identify psychosocial, mechanical and metabolic comorbidities and complications of overweight and obesity.

Identification of high-risk population groups and appropriate management in line with agreed care pathways, for example:

- Women living with obesity pre-pregnancy, in pregnancy and post pregnancy
- Women with gestational diabetes
- Individuals living with eating disorders or a mental health diagnosis, and those taking medications associated with weight gain
- Individuals living with intellectual or physical disabilities
- Sarcopenic obesity in older adults
- Ethnic population groups

Advice on overweight and obesity, treatment expectations and treatment options.

Obesity medications prescribed as appropriate in conjunction with behavioural interventions.

Review of individuals that have undergone bariatric procedures outside of Ireland or are not under the care of a bariatric surgeon, with onward referral to specialist services (level 3 or Level 4) as appropriate.

Signposting or onward referral to community self-management supports (level 0), and structured weight management education programmes (level 2) or specialist MDT services and bariatric surgery (levels 3-4) for overweight and obesity.

Access to existing evidence based HSCP led weight management interventions in primary care (e.g. PHEW).

Access to HSCP treatment and supports across all health and social care settings for single component interventions or obesity related complications e.g. psychology, occupational therapy or physiotherapy.

Onward referral to relevant specialist services for management of any identified complications or comorbidities.

Scheduled follow up visits for review.

Individuals with overweight and obesity may also access Community Network HSCPs at this level for treatment and support of obesity related complications e.g. community psychological services, occupational therapy, physiotherapy or pharmacy.

**Training requirements at this level:**

- Making Every Contact Count for weight management in primary care will support HCPs in general practice and across all health and social care settings with the knowledge and skills to effectively screen and support individuals with overweight and obesity.
- Undergraduate, graduate and continued education for HCPs across all health and social care settings should provide education and training to address skills, knowledge and attitudes necessary to confidently and effectively support people living with overweight and obesity. The skills and competencies addressed in the training should be relevant to the level of service provided.

**3.4.3 LEVEL 2 COMMUNITY SPECIALIST AMBULATORY CARE**

Government policy on healthcare reform as outlined in Sláintecare sets out the need to develop community services using evidence based clinical care models and ensuring integration of services across all health and social care settings. Following permission, screening, assessment and brief advice by the general practice or primary care team, appropriate individuals with obesity and two established obesity related complications may be referred to multi-component interventions with personalised obesity management strategies in primary care, if necessary. Multi-component interventions lead to greater weight loss, whereas single component interventions are more effective in improving the targeted behaviour, for example, nutrition or physical activity (Wharton et al, 2020).

The objective of community specialist ambulatory care hub for chronic disease management as outlined in the National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland (2020) is to provide GPs in the community with access to diagnostics and HSCP specialist supports, to assist the management of patients with chronic disease, as well as providing individuals with high-quality care close to home. For individuals with overweight and obesity, there is a gap in the evidence to define the optimal structure, providers, setting, format and content of community-based weight management services due to heterogeneity in the literature. International guidelines including NICE (2014), Scottish Intercollegiate Guidelines Network (2010), American College of Cardiology/American Heart Association, The Obesity Society Guidelines (2011) and Canadian Clinical Practice Guidelines (2020) outline the core components that should be included. Ongoing research and evaluation are required at this level, to ensure the best services are put in place so overweight and obesity is addressed early, effectively and continually in community, and provide capacity to manage overweight and obesity on a larger scale.

**Elements of care provided at this level includes:**

Access to community specialist weight management programmes for people with obesity and two established obesity related complications delivered via groups or individually and supported by telehealth, which include the following components:

Developed by a multidisciplinary team, addressing nutrition, physical activity and health-related behaviour change.

- Focus on realistic, personalised and long-term behaviour changes.

- Include individualised treatment goals based on prevention of obesity progression and management of obesity related complications.
- Delivered alone or in conjunction with pharmacotherapy.
- Include regular sessions, scheduled follow up and telehealth.
- Tailored and targeted where possible to reduce health inequalities and target specific ages, genders, communities and ethnic groups.
- Accessible to high-risk groups including those with mental health, eating disorders, intellectual and physical disabilities, older adults and women with obesity pre-pregnancy, pregnancy and after pregnancy.
- Have defined core outcomes and core processes that will be measured and reported to inform ongoing development of the intervention.

Access to community diagnostics such as phlebotomy, x-ray, echocardiography to support comprehensive clinical assessment of obesity.

Access to other specialist chronic disease self-management support services including cardiac rehabilitation, pulmonary rehabilitation, foot protection services, diabetes structured education and diabetes prevention.

Shared care pathways for high risk groups including intellectual and physical disability services (residential, day, community), mental health and eating disorders specialist services, maternity services which are integrated with obesity services as appropriate.

### 3.4.4 LEVEL 3 ACUTE SPECIALIST AMBULATORY CARE

Many of the needs of the population with overweight and obesity can be managed with services provided in general practice, primary care and community ambulatory care hubs. However, individuals with severe and complex obesity including those suitable for bariatric surgery require access to acute specialist ambulatory care and individualised, multidisciplinary assessment and treatment.

Currently these services are delivered in secondary care but in future should be integrated and delivered in the community with the appropriate staffing, governance structures, equipment and facilities in place. In the initial phase of implementation, there will be one physician-led multidisciplinary team per RHA, co-located on a hospital site providing care with a single point of access that includes comprehensive assessment and specialist MDT treatment. In time, as community specialist hubs for chronic disease become established the demand for additional level 3 services will be quantified through robust monitoring systems. It is intended that additional services at this level will be provided through the community specialist hubs for chronic disease, which is in line with international evidence (Hazlehurst et al, 2020). The lead clinician can be from a range of specialities including, but not limited to, general practice, diabetes and endocrinology, respiratory medicine or cardiovascular medicine. Table 12 outlines the recommended staffing for the Level 3 Specialist Obesity MDT.

**Elements of care provided at this level include:**

Access to a level 3 physician-led multidisciplinary obesity specialist team.

Detailed clinical assessment including screening for underlying causes and consequences of obesity. This should include assessment and review of existing complications and screening for additional complications.

Detailed, evidence-based, multidisciplinary and individualised clinical assessment and interventions for severe and complex obesity which can be delivered to individuals, groups or via telehealth:

Medical and pharmacotherapy interventions including:

- Nursing interventions
- Nutrition and dietetic interventions
- Physical activity and physiotherapy interventions
- Psychological and behavioural interventions
- Occupational therapy interventions

Re-screening and treatment or onward referral for eating disorders, trauma and chronic mental health conditions.

Interventions and support for individuals not suitable for bariatric surgery.

Onward referral for additional interventions prior to bariatric surgery e.g. cardiology, respiratory, anaesthesia.

Development of specific accelerated pathways for individuals with complex health needs requiring weight management prior to other medical interventions or diagnostics. This may include individuals awaiting transplant surgery, cancer surgery, orthopaedic surgery etc.

**TABLE 12:**  
**RECOMMENDED LEVEL 3 SPECIALIST OBESITY MDT (PER 500,000-600,000 POPULATION INITIALLY)**

Discipline	WTE	Suggested Grade
Obesity Medical Specialist	1	Consultant (relevant speciality) or General Practitioner
NCHD*	1	Registrar
Clinical Service Coordinator	1	G VII or equivalent clinical grade
Nursing	1	Obesity Clinical Nurse Specialist
Dietetics	2	Clinical Specialist x 1 Senior x 1
Physiotherapy	2	Clinical Specialist x 1 Senior x 1
Occupational Therapy	2	Clinical Specialist x 1 Senior x 1
Psychology	2	Senior x 1 Staff grade x 1
Administration	1	G IV

*\*Can include advanced practitioner nursing or HSCP at this level*

**Training requirements to support this level:**

- The skills and competencies addressed in the training should be relevant to the level of service provided, with an opportunity for HSCPs and nursing to develop clinical specialist and advanced roles in obesity care.
- Training and supports to develop subspecialty in obesity for GPs and physicians.

**3.4.5 LEVEL 4 SPECIALIST HOSPITAL CARE**

Level 4 specialist hospital care describes the services required in secondary care for individuals with severe and complex obesity that are referred from level 3 because the degree of complexity of their obesity cannot be adequately managed in primary care. While this will involve access to inpatient rehabilitation and palliative care services, this level refers mainly to access to bariatric surgical services.

There is now very strong evidence that bariatric surgery in conjunction with behavioural interventions achieves superior outcomes and improved quality of life for people living with severe and complex obesity compared with medical and behavioural interventions alone. Bariatric surgery also leads to substantial cost savings. Level 4 bariatric surgery services will provide accessible, appropriate, quality assessment on suitability for surgical management for people living with severe and complex obesity that are referred from level 3 services. Table 13 outlines the recommended staffing for the hospital based bariatric surgery MDT. The National Clinical Programme for Obesity will work with the National Clinical Programme for Surgery to develop clinical pathways and guidelines including service delivery and minimum standards for bariatric surgery centres.

**Key elements of care provided at this level:**

Consultant led, multidisciplinary assessment and approval for bariatric surgery with pre, peri and post-operative support.

Pre-operative MDT education and support.

A range of surgical options and peri-operative MDT input.

Post-operative follow-up: medicines management, complications and weight regain management, nutritional assessment and management of identified deficiencies, assessment of mental health and psychological adjustment, pregnancy advice.

Post-operative review and follow up for individuals that have undergone bariatric surgery procedures outside of Ireland or are not under the care of a bariatric surgeon and treatment as required.

Post-operative assessment by plastic surgeon once weight stable for clinically significant redundant skin folds which impact on quality of life and pose risk of infection.

Annual review (shared care with GP as appropriate).

Inpatient rehabilitation for individuals with severe and complex obesity that are not suitable for ambulatory care interventions.

Palliative care for individuals with end stage obesity syndrome.



**TABLE 13:**  
**RECOMMENDED LEVEL 4 BARIATRIC SURGERY MDT STAFFING (PER 500,000-600,000 POPULATION)**

Discipline	WTE	Suggested Grade
Bariatric Surgeon	1	Consultant
Surgical NCHD	1	Registrar
Anaesthetist	0.5	Consultant
Plastic Surgeon	0.5	Consultant
Obesity Medical Specialist	1	Consultant (relevant speciality) or General Practitioner
Medical NCHD*	1	Registrar
Clinical Service Coordinator	0.5	G VII or equivalent clinical grade
Nursing	0.5	Clinical Specialist
Dietetics	1.5	Clinical Specialist
Physiotherapy	1.5	Clinical Specialist
Occupational Therapy	1.5	Clinical Specialist
Psychology	1.5	Senior
Administration	1.5	G IV

*\*Can include advanced practitioner nursing or HSCP at this level*

**Training requirements to support this level:**

- The skills and competencies addressed in the training should be relevant to the level of service provided, with opportunity for HSCPs and nursing to develop clinical specialist and advanced roles in obesity care.
- Training and supports to develop subspecialty in obesity for GPs and physicians.

### 3.4.6 PATHWAYS OF CARE FOR ADULTS

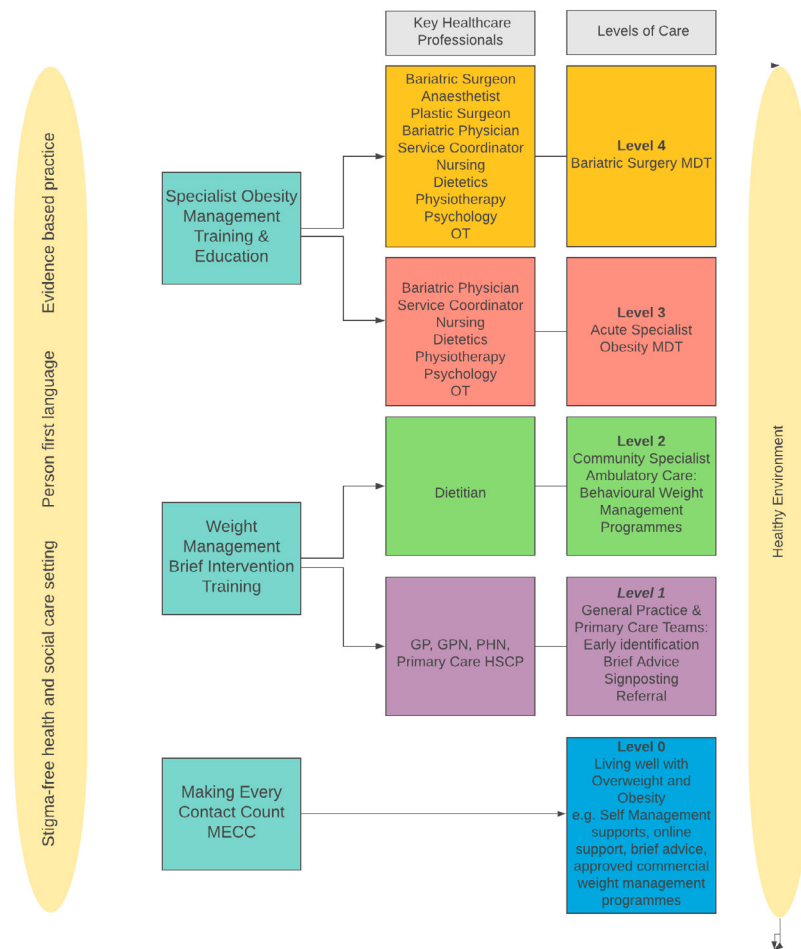


Figure 10: The suggested pathways of care for adults with overweight and obesity.

### 3.5 IMPLEMENTATION

To realise the benefits, in health and economic terms at individual patient, health service and societal level, full implementation of the model of care within a ten-year time frame is necessary. The approach acknowledges the challenge of providing effective, comprehensive obesity management in an unhealthy environment given the wide ranging social and commercial determinants of health. Implementation of the model of care should be in parallel with a sustained effort to address the environment through cross-government and cross-sectoral policies, initiatives and meaningful legislative change. There must also be investment in enhanced health service delivery to provide the right care in the right place at the right time, with resourcing tailored and targeted to higher risk areas of deprivation and health inequalities. The models of care for adults and children and young people should be implemented as part of the National Framework for the Integrated Prevention and Management of Chronic Disease and the Model of Care for Paediatrics respectively.

In proposing the current implementation, the programme is cognisant of numerous factors to be achieved, in the short to medium term. This will involve being flexible about changing demand in the longer term as efforts at prevention gain traction, new treatments become available, the population ages and more people look to access care.

This proposed phased implementation plan for services aims to develop a spectrum of services nationally, and outlines minimum recommendations based on best available knowledge. It does not account for population growth, increased disease complexity, and the rapidly ageing population placing added pressure on services nationally.

**Implementation phases:**

Phase 1	Phase 2	Phase 3
2021 - 2024	2024 - 2027	2027 - 2031

**General requirements to deliver services:**

Team size will vary as they will require staffing level proportionate to local population needs.

Training and education will be required to support the development of paediatric obesity specialist posts for hospital and community staff.

There are currently no dedicated specialist community services for people with overweight and obesity, additional funding and resourcing will be required.

Local service implementation groups will be required to support the delivery of services in line with local needs.

Dedicated facilities including clinical rooms and group education rooms with appropriate equipment will be required including furniture (seating, toilets, plinths, hoists, slings, theatre gowns, bariatric trolleys and beds), mobility aids and basic equipment (weighing scales, stadiometers and blood pressure cuffs).

IT infrastructure will be required to support monitoring, evaluation and telemedicine interventions.

Dedicated equipment, theatre space and inpatient beds will be required for bariatric surgery services.

Defined metrics including structural, service procedures, processes and outcomes will be developed for each level of service.

Patient reported experience and outcome measures.

Key performance indicators which reflect the success of the service as defined by the National Clinical Programme for Obesity in collaboration with services.

Robust and sustainable data monitoring and collection systems in place to record and analyse service performance and delivery of safe and effective care.

### 3.5.1 CHILDREN AND YOUNG PEOPLE

- As part of level 0, Health Promotion and Community Programmes and Enhanced Parenting Programmes will be established in every CHN to support healthy behavioural change.
- In line with the GP Under 6 contract and Child Health Programme, it is anticipated that GPs, general practice nurses, public health nurses and Community Medical Doctors will work together with primary care teams at CHN level to provide early identification, brief advice and signposting or referral to services as required. This will be supported by the provision of **0.5 WTE senior paediatric dietitian** per network.
- It is recommended that **Community Specialist Obesity MDTs** are established in a phased approach, subject to local needs and ongoing monitoring and evaluation.
- It is recommended that **6 Community Specialist Obesity MDTs** are established nationally in phase 1, subsequent implementation phases will focus on building capacity nationally to meet local demand.
- The **Community Specialist Obesity MDTs** will be closely linked to general practice and primary care networks, with the Hospital Specialist Obesity MDT in local and regional paediatric units and with local specialist services for high-risk groups e.g. mental health, eating disorders and disabilities services.
- It is recommended that a **Hospital Specialist Obesity MDT** is established in all 18 of the 19 local and regional paediatric units nationally.
- It is recommended that one national **Tertiary Care Specialist Obesity MDT** be fully resourced within Children's Health Ireland.

**TABLE 14:**  
**PROPOSED OUTLINE IMPLEMENTATION PLAN FOR SERVICES FOR CHILDREN AND YOUNG PEOPLE**

Level	Key Services	Setting	Number of programmes/ teams nationally	Phase 1 2021-2024	Phase 2 2024-2027	Phase 3 2027-2031
0. Health Promotion and Community Programmes	Enhanced parenting programmes	Community Health Network	96 programmes	18	36	42
1a. General Practice and Primary care	0.5 WTE Senior Paediatric Dietitian	Community Health Network	48 WTE (1 WTE per 6000 children/young people with overweight/obesity)	9	18	21
1b. Community Specialist Obesity MDT	Community Specialist Obesity MDT	Regional Health Authority	6 MDTs (1 per RHA) in phase 1*	6	to be developed	to be developed
2. Hospital Specialist Obesity MDT	Hospital Specialist Obesity MDT	Paediatric Hospital Units	18 MDTs	6	6	6
3 Tertiary Care Specialist Obesity MDT	Medical & bariatric surgery service	National Tertiary Care Centre	1	1		

\*Medical oversight provided by Community medical doctor or GP

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### 3.5.2 ADULTS

- To support level 0 Living Well with Obesity Services, Making Every Contact Count Weight Management Module will be developed and provided as part of the MECC Implementation Plan (HSE, 2016). Individuals with overweight and obesity can also access self-management supports provided through implementation of the 'Living Well with a Chronic Condition: National Framework and Implementation Plan for Self-management Support for Chronic Conditions: COPD, Asthma, Diabetes and Cardiovascular Disease' (HSE, 2017).
- In line with the Integrated Care Programme for Chronic Disease (2020) it is anticipated that GPs and primary care team staff will work together as integrated multidisciplinary teams at CHN level to provide early identification, brief advice and signposting or referral to services as required. The GP Contract supports the achievement of this vision by setting out the activities required of GPs and GPNs in the prevention and management of chronic disease.
- To support GPs and GPNs, there will be access to dietitian led behavioural weight management programmes at ambulatory care hub level. Implementation of these programmes will align to the chronic disease framework implementation plan.
- Timely access to Level 3 and level 4 treatment services for severe and complex obesity is required nationally as a priority.
- Level 3 Specialist Obesity MDTs can be in hospital or community settings with access to appropriate diagnostics and facilities. Currently these services are delivered in hospitals, therefore it is recommended that six Acute Specialist Obesity MDTs should be established (one per RHA) in phase one of the implementation of this model of care.
- Subsequent implementation phases will focus on building capacity nationally to meet local demand by developing additional Community Specialist Obesity MDTs within the community specialist hubs.
- It is recommended that six Bariatric Surgery MDTs are established (one per RHA) implemented on a demand dependent, phased basis.

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**TABLE 15:**  
**PROPOSED OUTLINE IMPLEMENTATION PLAN FOR SERVICES FOR ADULTS**

Level	Key Services	Setting	Number of programmes/ teams nationally	Phase 1 2021-2024	Phase 2 2024-2027	Phase 3 2027-2031
2. Community Specialist Ambulatory Care	Dietitian led behavioural weight management programmes	Ambulatory Care Hubs	48 WTE dietitians delivering programmes across 32 chronic disease hubs	18 <sup>1</sup>	14 <sup>1</sup>	-
	Specialist Obesity MDT	Community Specialist Hubs	to be developed	-	to be developed	to be developed
3. Acute Specialist Ambulatory Care <sup>2</sup>	Specialist Obesity MDT	Regional Hospital Groups: (IEHG, DML HG, S/SW HG, RCSI HG, UL HG, Saolta HG)	6 (1 per Hospital Group) in phase 1	6	-	-
4. Specialist Hospital Care	Bariatric MDT	Regional Hospital Groups	6 (1 per Hospital Group)	3	2	1
		(IEHG, DML HG, S/SW HG, RCSI HG, UL HG, Saolta HG)				

<sup>1</sup> Implementation in line with Integrated Care Programme for Chronic Disease

### 3.6 GOVERNANCE

The National Clinical Programme for Obesity is jointly governed by the Health and Wellbeing division of the HSE and the Office of the National Clinical Advisor and Group Lead (NCAGL) for Chronic Disease, with clinical governance from the RCPI Clinical Advisory Group (Appendix 2). The programme is closely linked to the Healthy Eating and Active Living Programme within Health and Wellbeing and the NCAGL for Chronic Disease within Clinical Design and Innovation. This allows the programme to officially and effectively communicate with the Office of the Chief Clinical Officer via the Clinical Forum.

### 3.6.1 NATIONAL GOVERNANCE

The role of the National Clinical Programme for Obesity is to provide leadership and governance for the development and delivery of health services for the management of overweight and obesity. This will encompass the principle that quality services are delivered in a timely manner with ongoing monitoring and evaluation by the National Clinical Programme for Obesity and reporting to all agencies and services operating throughout the model of care.

Specific national governance functions of the National Clinical Programme for Obesity include:

Facilitating the implementation of local services and ensuring they are in line with the model of care.

Providing national leadership on obesity care.

Developing accredited training programmes.

Developing national patient education programmes.

Developing appropriate key performance indicators, minimum service standards and reporting processes in the implementation of each level of service.

Developing standardised monitoring and evaluation of current service provision to ensure services are effective in terms of providing quality care balanced with cost effectiveness.

Providing a centralised resource of up-to-date information for healthcare professionals, patients, the media and the general public.

Fostering key relationships with patient advocacy groups (ICPO) and other key stakeholders.

### 3.6.2 CLINICAL PROGRAMME KEY COLLABORATIONS

The National Clinical Programme for Obesity will collaborate at a national level with a number of national programmes as outlined in figure 11 in the promotion of best practice, quality improvement and integrated service pathways for people with overweight and obesity as well as training programmes and resources for patients and healthcare staff.



*Figure 11: Key collaborations between the Obesity Management Clinical Programme and National Clinical Programmes (NCP), Integrated Care Programmes (ICP) and National Policy Priority Programmes*

### 3.6.3 LOCAL GOVERNANCE

At local level, implementation groups will be formed to include key management, clinician and patient stakeholders across community, primary care and hospital settings as relevant to the level of service. These groups will work closely with the National Clinical Programme for Obesity. The functions of the local group are to:

- Ensure a locally driven focus on the development of services built around the needs of local populations of children, young people and adults with overweight and obesity.
- Ensure appropriate leadership at the clinical and operational levels to develop and design services and to support the prioritisation and resourcing of these services.
- Ensure local evaluation services are in place to drive service improvement feeding into national evaluation.
- Ensure local care pathways continue to be developed and implemented to support the delivery of integrated care at a local level.

Dedicated services improvement leads will be identified at a local level for development of specialist services in community and hospitals for children, young people and adults to:

- Support service design including development of standard operating procedures, quality and audit standards and tools, data reporting and monitoring process.
- Work with Heads of Service in primary care and Hospital Groups to establish services.



- Develop, deliver and support staff training on standard operating procedures, quality and audit processes, data reporting and monitoring.
- Input to the review and evaluation of services and translate learnings into continuous quality improvement and service design.

### 3.6.4 CLINICAL GOVERNANCE

The clinical governance relating to specific services for children, young people and adults is outlined below:

#### Services for Children and Young People

- Level 1a governance with referrer.
- Level 1b MDT governance with medical lead from GP or CMD.
- Level 2 secondary care and level 3 tertiary care hospital services for children and young people with obesity are under the clinical governance of the relevant Consultant Paediatrician or Surgeon.

#### Services for Adults

- Level 1 (general practice and primary care) and level 2 community based HSCP services and community specialist weight management programmes are under the clinical governance of the GP.
- Level 3 specialist MDT services co-located in hospital or community settings are under the clinical governance of the Consultant Physician.
- Level 4 bariatric surgery services in hospital settings are under the clinical governance shared by the lead consultants.

#### Clinical governance must adhere to:

1. The HSE Code of Governance (2015)  
<https://www.hse.ie/eng/about/who/directoratemembers/codeofgovernance/hsecodeofgovernance2015.pdf>
2. The HSE Patient Safety Strategy 2019-2024  
<https://www.hse.ie/eng/about/qavd/patient-safety/hse-patient-safety-strategy-2019-2024.pdf>

### 3.6.5 PROFESSIONAL GOVERNANCE

Professional governance for each disciplinary group within the multidisciplinary teams will be through their existing community or acute clinical line managers.

## 3.7 EDUCATION AND TRAINING

Currently, training in management of overweight and obesity is very limited for health care professionals in Ireland, and most practitioners feel ill-equipped to effectively communicate with patients and provide appropriate diagnosis and treatment. Obesity is not recognised as a medical speciality. Considering the prevalence of obesity and complications, there are relatively few healthcare practitioners who have specialist training and appropriate experience in obesity management.

Healthcare is a setting in which weight stigma is particularly pervasive, even among HCPs specialising in obesity-related illnesses. This stigma has direct consequences for the quality of services provided to people living with obesity and increases the likelihood that people with obesity will avoid accessing healthcare. There is a wealth of evidence identifying weight stigma as part of a positive feedback loop, increasing the risk of weight gain and weight regain. Stigma is a negative emotional experience that causes significant stress. This stress is associated with adverse physical and psychological effects including increased cortisol, reduced executive function and self-regulation. In simple terms, stigma experiences are associated with increased caloric intake and reduced physical activity. Multiple biobehavioural mechanisms lead to further weight gain, and then further stigmatising experiences continue the cycle. These mechanisms also act as a potent barrier to people accessing essential medical care at all levels of service. When an individual with obesity begins to internalise and believe these negative labels or values about themselves, it compounds the negative impact of obesity on the health of the individual.

The pervasiveness of the “personal responsibility” belief plays a key role in stigmatisation. Explicit and implicit bias, that weight is an individual’s responsibility and that obesity can be treated through ‘eating less and moving more’, has a strong influence on interactions between HCPs and patients, and on the focus of public health campaigns. Health professionals need training in the complexity of obesity, including knowledge of the genetic, biological, socioeconomic, psychological and environmental determinants of obesity. Many health professionals will struggle to care for people with obesity in a non-judgemental and supportive manner without this knowledge. Addressing weight bias and stigma should be a core part of all education and training programmes listed below.

Education and training requirements to successfully implement this model of care:

### 3.7.1 REQUIREMENTS FOR ALL HEALTHCARE PROFESSIONALS

Core elements of overweight and obesity, including aetiology, assessment, brief intervention and treatment and weight stigma. This should be provided at undergraduate, postgraduate and in-service levels.

Making Every Contact Count module for adult weight management and brief intervention training for managing overweight and obesity in children and young people should be provided at undergraduate, postgraduate and in-service levels where appropriate.

All HCPs involved in providing information on obesity should ask permission, use preferred terminology (“person-first” or other), avoid judgemental language, communicate clearly and be aware of health literacy issues during their daily work with individuals.

HCPs should receive training in bariatric manual handling for HCPs across all relevant health and social care settings.

### 3.7.2 REQUIREMENTS FOR SPECIALIST TEAMS

- All members of the obesity MDT should be trained in the necessary knowledge and skills to provide obesity services, including communication skills and behavioural change strategies for weight management.
- Specific training should be developed and provided in all high-risk health and social care settings e.g. mental health services, eating disorder services, disability services, maternity settings, older persons services and teams delivering transition services to young adults.
- Accredited training programmes include those programmes accredited by The Association for the Study of Obesity in Ireland (ASOI), The European Association for the Study of Obesity (EASO), and the National Clinical Programme for Obesity, including SCOPE certification, Obesity Canada Advanced Obesity Management Programme, EASO Task Force Programmes on Childhood Obesity, Obesity Management and Prevention & Public Health, as well as behaviour change training such as the HSE Making Every Contact Count programme (Appendix 6).

### 3.7.3 RECOMMENDATIONS FOR RELEVANT TRAINING BODIES

- Develop training leads for obesity in medical training bodies RCPI, RCSI, COA and ICGP, to lead and develop educational programmes and incorporate weight management into future curricula, in consultation with the National Clinical Programme for Obesity.
- GP and other relevant medical specialities should have access to specialist training, continuous medical education and mentorship schemes within specialist services to develop lead obesity roles within group practices, GP training schemes, academic departments and continuing medical education training structures.
- Training pathways for obesity clinical specialist and advanced practitioner posts should be introduced for HSCPs and nursing and midwifery.
- Obesity rotations in specialist centres should be included in GP post graduate training schemes and relevant higher medical specialist training schemes e.g. Endocrinology and Diabetes, Gastroenterology, Respiratory Medicine, Public Health, Occupational Health, Nursing and HSCP roles.

### 3.7.4 RECOMMENDATIONS FOR PUBLIC HEALTH

- Relevant governmental and non-governmental departments, agencies and organisations also need education, to increase understanding of obesity and improve public health campaign design and delivery and ensure a coordinated approach to service delivery.

# 3.8

## METRICS AND EVALUATION

### 3.8.1 COMMUNITY AND HOSPITAL SETTINGS

Health services should be resourced and supported to establish routine measurement, recording and reporting of overweight and obesity for children and adults across all care settings to enable surveillance at a population level.

**Key elements include:**

- The GP Contract (2019) clinical data repository will have data on BMI, waist circumference and comorbidities. At present this is only for over 70s but will be rolled out to all GMS adult population.
- Growth measurements are included as part of the GP Under 6 health and wellbeing checks at age two and five years. This should be captured, analysed and reported at national level.
- Development of an integrated electronic medical record system.
- Overweight and obesity should be accurately measured and coded in HIPE hospital admission systems, PCRS and EMR data sets.

### 3.8.2 SPECIALIST TEAMS IN COMMUNITY AND HOSPITAL SETTINGS

The current lack of access to treatment services for obesity make it difficult to conduct proper economic analyses. Cost-effectiveness and cost-benefit analyses of comparative treatment options should be undertaken to inform planning of the healthcare services. Economic analysis on specific interventions for high-risk individuals is also required. The model of care recommends that all services engage in continuous service improvement initiatives, clinical outcome evaluation and audit as part of standard practice. This will support ongoing research into the effectiveness of intervention strategies and the management of obesity within the health system. To ensure cost efficiency, only evidence-based, outcome focused programmes will be adopted, and existing programmes may be restructured to incorporate elements of proven effectiveness.

**Key elements include:**

- Patient reported experience and outcome measures.
- Core process outcomes (referrals, attendance and waiting list data).
- Key measured clinical outcomes (anthropometrics and other mental, functional and clinical indicators).

### 3.8.3 NATIONAL LEVEL SURVEILLANCE

This model of care recommends the development of the following registries at national level:

- A national database for growth measurements for children and young people.
- A national register for obesity-related data for adults.
- A national bariatric surgery register.

# 4

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## APPENDIX 1 - LIST OF ABBREVIATIONS

<b>ADHD</b>	Attention Deficit/Hyperactivity Disorder
<b>AOTI</b>	Association of Occupational Therapists of Ireland
<b>BMI</b>	Body Mass Index
<b>CAG</b>	Clinical Advisory Group
<b>CDM</b>	Chronic Disease Management
<b>CHI</b>	Children's Health Ireland
<b>CHN</b>	Community Healthcare Network
<b>CHO</b>	Community Healthcare Organisation
<b>CMD</b>	Community Medical Doctor
<b>COA</b>	The College of Anaesthetists
<b>COPD</b>	Chronic Obstructive Pulmonary Disease
<b>COSI</b>	Childhood Obesity Surveillance Initiative
<b>CVD</b>	Cardiovascular Disease
<b>CYP</b>	Children and Young People
<b>DCYA</b>	Department of Children and Youth Affairs
<b>DEIS</b>	Delivering Equality of Opportunity in Schools
<b>DES</b>	Department of Education and Skills
<b>DSP</b>	Department of Social Protection
<b>EMR</b>	Electronic Medical Record
<b>EOSS-P</b>	Edmonton Obesity Staging System - Paediatric
<b>ESRI</b>	The Economic and Social Research Institute
<b>FIGO</b>	International Federation of Gynaecology and Obstetrics
<b>GP</b>	General Practitioner
<b>GPN</b>	General Practice Nurse
<b>GMS</b>	General Medical Scheme
<b>HEAL</b>	Healthy Eating and Active Living Programme
<b>HIPE</b>	Hospital Inpatient Enquiry
<b>HSCPs</b>	Health and Social Care Professionals
<b>HTN</b>	Hypertension
<b>ICGP</b>	Irish College of General Practitioners
<b>ICT</b>	Information and Communications Technology
<b>MDT</b>	Multidisciplinary Team
<b>MECC</b>	Making Every Contact Count
<b>MI</b>	Myocardial Infarction
<b>NAFLD</b>	Non-alcoholic Fatty Liver Disease
<b>NICE</b>	The National Institute for Health and Care Excellence
<b>OSA</b>	Obstructive Sleep Apnoea
<b>OSCA</b>	Obesity Services for Children and Adolescents Network
<b>PCOS</b>	Polycystic Ovarian Syndrome
<b>PCRS</b>	Primary Care Reimbursement Service
<b>PHN</b>	Public Health Nurse
<b>RCPI</b>	Royal College of Physicians of Ireland
<b>RCSI</b>	Royal College of Surgeons of Ireland
<b>RHA</b>	Regional Health Area
<b>RICO/ RICA</b>	Regional Integrated Community Organisation/Area
<b>SIGH</b>	Scottish Intercollegiate Guidelines Network
<b>TILDA</b>	Irish Longitudinal Study on Ageing
<b>TUSLA-PPFS</b>	Tusla Prevention Partner and Family Support Programme
<b>WHO</b>	World Health Organisation

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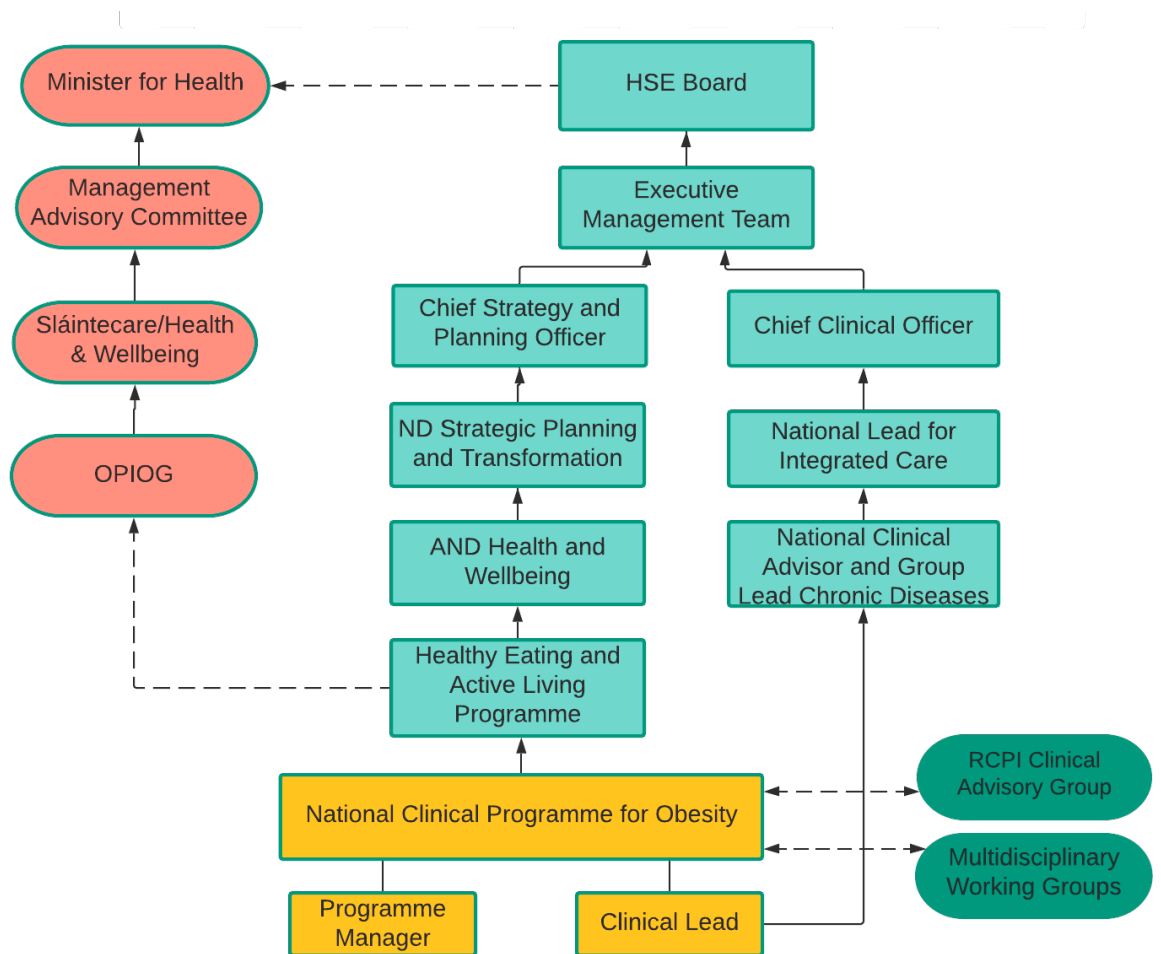
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**Organogram for National Clinical Programme for Obesity**



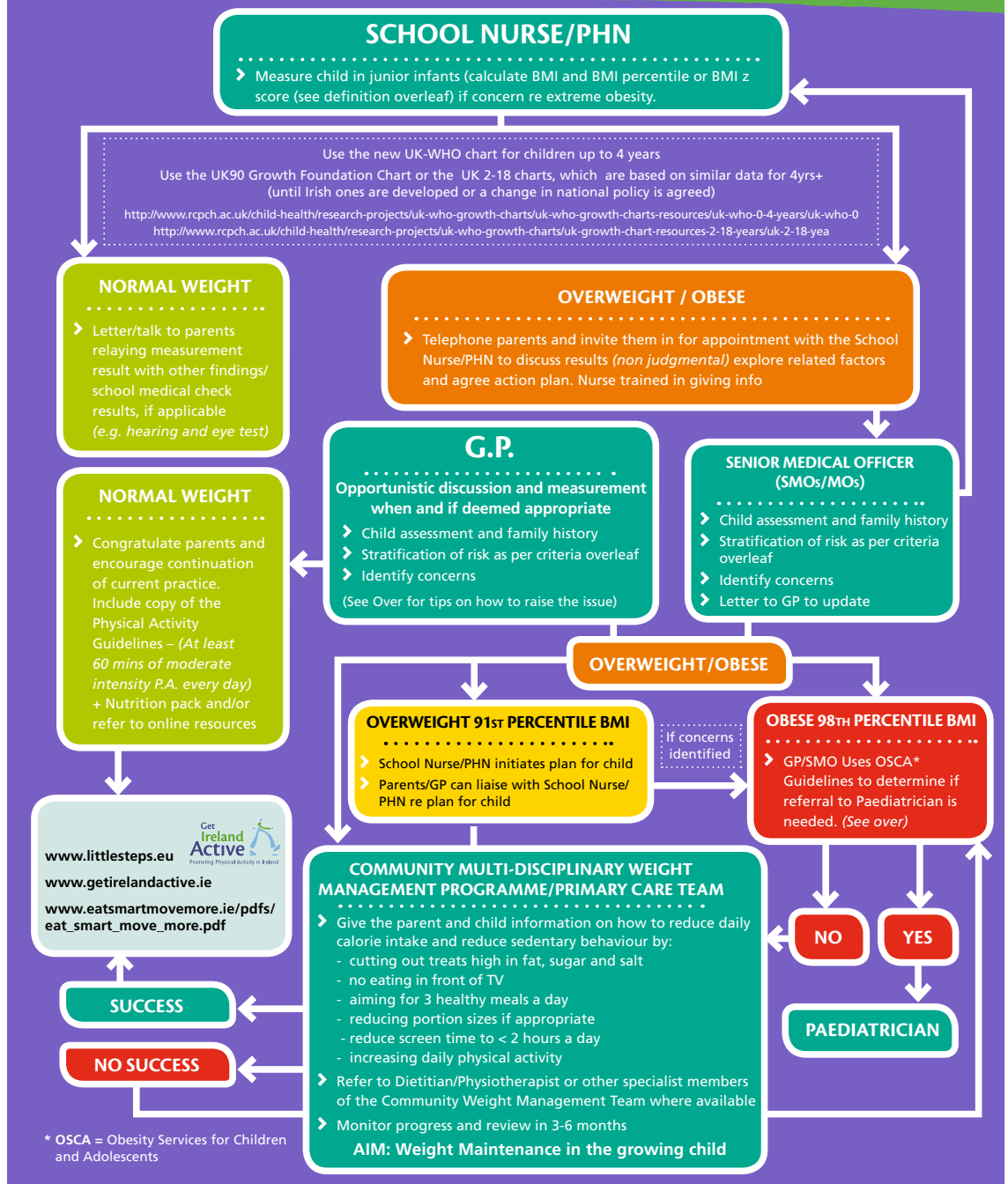
## APPENDIX 3 - HSE/ICGP WEIGHT MANAGEMENT TREATMENT ALGORITHMS FOR CHILDREN

### Weight Management Treatment Algorithm for Children



#### A Quick Reference Guide For Primary Care

(See [www.icgp.ie/weightmanagement](http://www.icgp.ie/weightmanagement) or [www.hse.ie](http://www.hse.ie) for the Weight Management Treatment Algorithms for both Adults and Children, an adult BMI chart plus additional support online resources.)



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### SPEAKING TO A CHILD ABOUT THEIR WEIGHT

- ▶ Don't have a "big talk" with them about it.
- ▶ Instead, look out for a good opportunity to discuss e.g. if they are struggling in P.E. classes, are left out of a group activity, are out of breath easily, are teased because of their weight.
- ▶ The easiest way to approach the subject is to ask them what is happening, how it makes them feel and why they think it is happening. Ask them to describe a typical day.
- ▶ Focus on the behaviours that have led to their weight gain.
- ▶ Highlight that these are behaviours, and behaviour can be changed.
- ▶ Be empathetic and try to understand how they are feeling.
- ▶ Highlight all the positive aspects of being a healthy weight – not just physical

Be careful not to assume you know how the child is feeling – make sure that you ask them if they would like your support and how they would like you to help.

### SPEAKING TO PARENTS ABOUT THEIR CHILD'S WEIGHT

There are common worries about speaking to a parent about their child's weight but they shouldn't be a reason to stop you from talking to them. The key is to build up a positive relationship with the parent. If you do not have a good relationship with the parent then you are most likely not the right person to be raising the issue with them.

In speaking to children and parents about weight issues you shouldn't actually be doing a lot of the talking. They should. It is their opportunity for someone to listen to their concerns. It is imperative that:

- ▶ you are realistic and explain that long term changes need to be made regarding the child's diet and lifestyle, and that returning to a healthy weight will be a slow process.
- ▶ if you are unsure how to answer their questions then be honest about this, but offer to help them find out by signposting them to the right service/ programme/online supports for their family. (see overleaf)

### IF THEY DON'T WISH TO ENGAGE

If the parent and/or child choose not to acknowledge that there is a weight issue or don't want to discuss it you must:

- ▶ respect their wishes.
- ▶ do not ask any more questions.
- ▶ let them know you are there if they would like to speak to you at any point.
- ▶ offer them the opportunity to speak to another Healthcare Professional e.g. practice nurse etc.

**However clinical judgement and duty of care may override the above depending on degree of obesity and/or risk of comorbidities**

### ASSESSMENT AND CLASSIFICATION OF OVERWEIGHT AND OBESITY IN CHILDREN

#### Determine degree of overweight or obesity

- ▶ Measure weight and height, particularly if weight may be a factor in the reason they made the appointment.
- ▶ Use BMI; relate to UK 1990 BMI charts (for 4yrs+) to give age and gender specific information. (See over for web link)
- ▶ Discuss with the child and family.

#### Consider intervention or assessment

- ▶ Consider tailored clinical intervention if overweight with BMI at 91st centile or above.
- ▶ Consider assessing for comorbidities if obese with BMI at 98th centile or above.

#### Assess lifestyle, comorbidities and willingness to change, including:

- ▶ presenting symptoms and underlying cause of overweight or obesity.
- ▶ willingness and motivation to change.
- ▶ comorbidities (such as hypertension, hyperinsulinaemia, dyslipidaemia, type 2 diabetes, psychosocial dysfunction and exacerbation of asthma) and risk factors.
- ▶ psychosocial distress such as low self-esteem, teasing and bullying.
- ▶ family history of overweight and obesity and comorbidities.
- ▶ lifestyle – diet and physical activity
- ▶ environmental, social and family factors that may contribute to overweight and obesity and the success of treatment.
- ▶ growth and pubertal status.

Source: Adapted from National Institute for Health and Clinical Excellence (NICE), 2006

#### Note:

The GP/SMO should refer to a Paediatrician if Specific Concerns or if:

1. Extreme obesity (See below) or
2. BMI > 98th centile and  
A child or family is seeking help/ treatment PLUS one or more of the following risk factors  
For current or future morbidity.....  
(A) Pathology.....  
\* Short stature for genetic potential/parents  
\* Dysmorphic features  
\* Learning difficulties  
OR  
(B) Future morbidity or risk factors  
\* Adverse family history  
\* Symptoms/signs from clinical assessment  
\* Abnormalities on investigation

#### Definitions of extreme Obesity (BMI)

Years	Male (BMI)	Female (BMI)
2 yrs	22.7	22.7
5 yrs	22	23.5
10yrs	32	33
15yrs	38	38
18yrs	40	40

Source: OSCA Consensus statement on the assessment of obese children & adolescents for paediatricians. (For additional information if required see <http://lep.bmj.com/content/97/13/98.full>)

#### Body Mass Index z-scores:

Body mass index z-scores, also called BMI standard deviation (S.D.) scores, are measures of relative weight adjusted for child age and sex.

Source: Must A, Anderson S E. Body mass index in children and adolescents: considerations for population-based applications. *International Journal of Obesity* 2006 30, 590-594. doi:10.1038/sj.ijo.0803300

BMI z scores are used here to identify those with extreme obesity which is considered  $\geq 3.5$  Standard Deviations (SDs) and broadly corresponds to the values shown in the table above. Obesity is defined as  $> 98$ th percentile. The Z score gives an indication of how much above the 98th percentile the child is.

See <http://www.phsim.man.ac.uk/SDSCalculator/> For an SDS Individual Calculator for British 1990 Growth Reference Data.

## APPENDIX 3 - HSE/ICGP WEIGHT MANAGEMENT TREATMENT ALGORITHMS FOR ADULTS

# Weight Management Treatment Algorithm

**HSE** Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive



### A Quick Reference Guide For Primary Care

(See [www.icgp.ie/weightmanagement](http://www.icgp.ie/weightmanagement) or [www.hse.ie](http://www.hse.ie) for additional online resources)



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**Physical Activity (P.A.) Guidelines**  
[www.getirelandactive.ie](http://www.getirelandactive.ie)

Suggest starting with **small, regular, planned** bouts of P.A. (10 minutes or less). Build to target time over months.

**Weight maintenance**

- Suggest 30 – 60 minutes moderate intensity P.A. between 5 to 7 days a week (> 150 mins per week)
- 60 minutes of moderate or 30 minutes of vigorous activity per day
- This can be broken up into smaller cumulative blocks (e.g. 15 mins x 5, 25 mins x 3, 35 mins x 2)

**To lose weight**

- Suggest 60 – 75 minutes of moderate intensity P.A. per day between 5 to 7 days a week (> 250 mins per week)

BMI < 18.5 Refer if appropriate	BMI 18.5 – 25 <b>Healthy Weight</b>	BMI 25 – 30 <b>Overweight</b>	BMI 25 – 30 + Co-morbidities <b>Overweight</b>	BMI 30 – 35 <b>Grade I Obesity</b>	BMI 35 – 40 <b>Grade II Very Obese</b>	BMI > 40 <b>Grade III Severe Obesity</b>
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**SOUTH ASIAN POPULATION REFERENCE POINTS**

Underweight (<18.5 kgs/m <sup>2</sup> )	Healthy weight (18.5 - 22.9 kgs/m <sup>2</sup> )	Over-weight (23.0 - 24.9 kgs/m <sup>2</sup> )	Obese (25.0 - 34.9 kgs/m <sup>2</sup> )	Very Obese (> 35 kgs/m <sup>2</sup> )
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Source: Deurenberg P, YAP N, Van Staveran WA: Body Mass Index and % body fat: a meta analysis among different ethnic groups. International Journal Obes Relat Metab Disord 22:1164-1171. 1998

World Health Organisation: WHO Recommendations: Obesity: Preventing and Managing the Global Epidemic. Geneva. WHO, 2000. (Tech, no 894)

“Stress that consistent weight loss of 0.5 -1kg (1-2lbs) per week will result in reaching the target weight of 10% weight loss.”

**Subsequent visits / referral options**

- Recheck BMI and assess trend
- Assess the food & exercise diary - identify & agree areas for improvement ([www.icgp.ie/weightmanagement](http://www.icgp.ie/weightmanagement)). Reset target.
- Explore any contributing factors i.e. medical & social, family & environmental factors.
- Consider referral to a Dietitian, Physiotherapist/Physical Activity Specialist or Psychologist. Referrals where possible should be within the Primary Care Team/Network to maximize multidisciplinary management.
- Refer to the GP Exercise Referral Programme/Green Prescription, if available in your area, or advise re regular, planned exercise. Emphasise self-monitoring of time involved (minutes per week). Use Physical Activity Diary. ([www.icgp.ie/weightmanagement](http://www.icgp.ie/weightmanagement))
- Reweigh & explain that weight loss may be slow (or absent) in initial weeks but persistence will achieve results. Explore reasons for lack of weight loss.
- Consider referral to commercial, self-help & community organisations e.g. Weight Watchers & Unislim, as well as the online resource [www.safefood.eu/weigh2live](http://www.safefood.eu/weigh2live) all of which are evidence based.
- Agree regular follow up – ideally every 4 weeks.
- Once 10% weight loss is achieved encourage weight maintenance for 6 months
- Consider other options e.g. pharmacotherapy (see box), bariatric surgery (hospital referral for BMI >40) ([www.icgp.ie/weightmanagement](http://www.icgp.ie/weightmanagement))

**Pharmacotherapy**

Only one agent is currently licensed for the treatment of obesity – Orlistat. It is hoped that other agents will become available soon.

**Orlistat**

- Prescribe only as part of an overall plan for managing obesity in adults who have:
  - BMI of 28.0 kg/m<sup>2</sup> or more with associated risk factors,
  - Or
  - BMI of 30.0 kg/m<sup>2</sup> or more.
- Continue treatment for longer than 3 months only if the person has lost at least 5% of their initial body weight since starting drug treatment (less strict with type 2 diabetics).
- Continue for longer than 12 months (usually for weight maintenance) only after discussing potential benefits and limitations with the patient.

**Contraceptive renewal**

- Advise patient that oestrogen containing contraceptives are not advised with BMI > 39 due to increased CV & thromboembolic risk.
- For BMI 30 – 39 advise patient of importance of weight loss, both for reduced cardiovascular risk and improved fertility.
- Consider alternatives & record.

**APPENDIX 3 - HSE/ICGP HEALTHY WEIGHT MANAGEMENT GUIDELINES BEFORE, DURING AND AFTER PREGNANCY**

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# Healthy Weight Management Guidelines Before, During and After Pregnancy



## A Quick Reference Guide for Primary Care

(see [www.icgp.ie/weightmanagement](http://www.icgp.ie/weightmanagement) or [www.hse.ie](http://www.hse.ie) for additional online resources)

### PRE-PREGNANCY

#### BODY WEIGHT AND CONCEPTION

- Women who have a BMI > 29.0kg/m<sup>2</sup> who are not ovulating should be informed that they are likely to take longer to conceive and losing weight is likely to increase their chance of conception
- Women should be informed that participating in regular physical activity and following dietary advice leads to more pregnancies than weight loss via dietary advice alone
- Women with a BMI < 19.0kg/m<sup>2</sup> and who have irregular menstruation or are not menstruating should be advised that increasing body weight is likely to improve their chance of conception

Source: NICE Clinical Guideline II Fertility: assessment and treatment for people with fertility problems. Feb. 2004.

- Height, Weight taken and Body Mass Index calculated on all women who are planning a pregnancy
- If BMI < 18.5kg/m<sup>2</sup> consider appropriate referral to dietician
- For women who are overweight advise a weight loss programme of 5 – 10% weight loss over a 3 – 6 month period before becoming pregnant consider referral to dietician
- Consider referral to commercial self-help and community organisations e.g. Weight Watchers and Unislim as well as the online resource [www.safefood.eu/weight2live](http://www.safefood.eu/weight2live) all of which are evidence based
- Once 5 – 10% weight loss is achieved encourage ongoing weight maintenance
- Use the Weight Management Treatment Algorithm to support health behaviour change and to discuss current eating habits and physical activity levels – see [www.icgp.ie/weightmanagement](http://www.icgp.ie/weightmanagement)
- Additional training for health professionals in achieving behaviour change in physical activity is available as an e learning module on <http://www.icgp-education.ie/physical-activity/>
- An oral glucose tolerance test (OGTT) is performed for women with a BMI > 30kg/m<sup>2</sup> and all women who have had Gestational Diabetes Mellitus (GDM) in a previous pregnancy or who have gained considerable weight since their previous post natal check
- Higher doses of folate (5mg) and Vitamin D (10ug) should be prescribed pre pregnancy for women of a BMI > 30.0kg/m<sup>2</sup>

*There are certain life stages and events that can trigger weight gain, these include Pregnancy and child rearing*

#### BODY WEIGHT AND ASSISTED REPRODUCTION

- BMI should ideally be in the range 19.0 – 30.0 kg/m<sup>2</sup> before commencing assisted reproduction
- Female BMI outside this range is likely to reduce the success of assisted reproduction procedures

Source: NICE Clinical Guideline II Fertility: assessment and treatment for people with fertility problems. Feb. 2004.

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### NATIONAL PHYSICAL ACTIVITY GUIDELINES

[www.getirelandactive.ie](http://www.getirelandactive.ie)  
Suggest starting with **small, regular, planned** bouts of Physical Activity (10 minutes or more). Build to target time over months.

#### To lose weight

- Suggest 60 – 75 minutes of moderate intensity Physical Activity per day between 5 to 7 days a week (> 250 mins per week)

#### Weight maintenance

- Suggest 30 – 60 minutes moderate intensity Physical Activity between 5 to 7 days a week (>150 mins per week)
- 60 minutes of moderate or 30 minutes of vigorous activity per day
- This can be broken up into smaller bouts (e.g. 15 mins x 5)



**BMI > 40 Grade III**  
- Severe Obesity  
- High Risk  
- Specialist Referral Indicated

**BMI > 30 Obese or Very Obese**  
- Combination of Diet, physical activity, psychology + or - pharmacotherapy (pre or post pregnancy only)

**BMI > 25-30 with co-morbidities**  
- Advise patient re health risks  
- Highlight need for lifestyle change to revert to a healthy weight

**BMI > 25 patient overweight or obese**  
- Assess readiness to change and proceed

Calculate BMI regularly and advise patient accordingly

BMI < 18.5 Refer if appropriate	BMI 18.5 – 25 Healthy Weight	BMI 25 – 30 Overweight	BMI 25 – 30 + Co-morbidities Overweight	BMI 30 – 35 Grade I Obesity	BMI 35 – 40 Grade II Very Obese	BMI > 40 Grade III Severe Obesity
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#### SOUTH ASIAN POPULATION REFERENCE POINTS

BMI Underweight (<18.5 kg/m <sup>2</sup> )	BMI Healthy weight (18.5 – 22.9 kg/m <sup>2</sup> )	BMI Overweight (23.0 – 24.9 kg/m <sup>2</sup> )	BMI Obese (25.0 – 34.9 kg/m <sup>2</sup> )	BMI Very Obese (> 35 kg/m <sup>2</sup> )
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Source: Deurenberg P, YAP N, Van Staveren WA: Body Mass Index and % body fat: a meta analysis among different ethnic groups. *International Journal Obes Relat Metab Disord* 22:1164-1171. 1998  
World Health Organisation: WHO Recommendations: Obesity: Preventing and Managing the Global Epidemic. Geneva. WHO, 2000. (Tech, no 894)

## DURING PREGNANCY

- During the initial visit to confirm pregnancy height and weight should be taken and BMI recorded
- Discuss recommended weight gain (Institute of Medicine) Minimum weight gain advised up to 20 weeks, average weight gain of 1lb per week advised from 20 weeks to term. Weight should be recorded at each ante natal visit and at regular intervals
- Discuss eating habits and physical activity levels, suggest monitoring these using the food and exercise diaries see [www.icgp.ie/weightmanagement](http://www.icgp.ie/weightmanagement)
- Avoid 'dieting' to reduce weight in pregnancy but encourage healthy eating using the 'healthy eating in pregnancy booklet' [www.healthpromotion.ie](http://www.healthpromotion.ie)
- Advise that moderate intensity physical activity is beneficial. At least 30 minutes per day of moderate intensity activity is recommended. Recommend the site [www.getirelandactive.ie](http://www.getirelandactive.ie) for further advice and information about physical activity
- All women with a BMI > 30 should have an oral glucose tolerance test (OGTT) performed at 24-28 weeks in line with HSE / ICGP guidelines "A practical guide to integrated type 2 diabetes care" available at [www.hse.ie](http://www.hse.ie)
- A community ante natal class offered in early pregnancy through primary care teams which will advise on healthy eating, physical activity, breastfeeding and health behaviour change should be developed and offered where appropriate
- Encourage the mother to breastfeed her baby and enquire as to the support available from partner and family
- Assess psychological history if relevant – history of depression, anxiety or eating disorders see [www.icgp.ie/weightmanagement](http://www.icgp.ie/weightmanagement) for screening tools

## BREASTFEEDING

A 15-30% reduction in adolescent and adult obesity rates has been found if any breastfeeding occurred in infancy compared with no breastfeeding. Children breastfed for 3 to 6 months have a 38% less risk of obesity at age 9. Breastfeeding for more than 6 months leads to a 51% reduction (McCrory and Layte, 2012)

## POST PREGNANCY

- At the initial Public Health Nurse/GP visit, encourage maintenance of breastfeeding and reinforce benefits of breastfeeding for mother and child
- At the 6 week postnatal check consider measuring height and weight and calculate BMI. Advise woman with BMI > 25 to aim for a gradual 5 – 10% weight reduction using food and exercise diaries for monitoring her progress see [www.icgp.ie/weightmanagement](http://www.icgp.ie/weightmanagement)
- Encourage healthy eating and resumption of mild activities such as daily walking (see physical activity box)
- An oral glucose tolerance test (OGTT) should be taken for those women who had Gestational diabetes mellitus (GDM) at 6 – 12 weeks post partum followed by reinforcement of lifestyle change as appropriate
- Remind all mothers who have had GDM that they should attend for diabetic screening annually from now on

## APPENDIX 4 - EDMONTON OBESITY STAGING SYSTEM FOR PAEDIATRICS

From S Hadjiyannakis et al. (2016)

EOSS-P Edmonton Obesity Staging System - Paediatric Staging Tool	Stage	Criteria
	Stage 0	<b>Metabolic:</b> No metabolic abnormalities <b>Mechanical:</b> No functional limitations <b>Mental:</b> No psychopathology <b>Milieu:</b> No parental, familial or social environment concerns
	Stage 1	<b>Metabolic:</b> Mild metabolic abnormalities (ie IGT, pre-hypertension, mild lipid abnormalities, mild fatty infiltration of liver/elevation in transaminases) <b>Mechanical:</b> Mild bio-mechanical complications (ie OSA not requiring POP therapy, mild MSK pain not interfering with ADL, GERD) <b>Mental:</b> Mild psychopathology, ADHD, LD, mild body image preoccupation, occasional emotional/binge eating, bullying, mild developmental delay <b>Milieu:</b> Minor problems in relationships, minor limitations in caregivers ability to support child's needs
	Stage 2	<b>Metabolic:</b> Moderate metabolic complications requiring pharmacotherapy (ie Type 2 Diabetes, hypertension, lipid abnormalities, PCOS, moderate to severe fatty infiltration of liver) <b>Mechanical:</b> Moderate bio-mechanical complications (ie OSA requiring PAP therapy, GERD, MSK pain limiting activity, moderate limitations in ADLs) <b>Mental:</b> Moderate mental health issues (ie major depression, anxiety, frequent bingeing, significant body image disturbance, moderate developmental delay) <b>Milieu:</b> Moderate problems in relationships, significant bullying at home or at school, significant limitations in caregivers ability to support child's needs
	Stage 3	<b>Metabolic:</b> Uncontrolled metabolic complications (T2DM (+complications/not meeting glycemic targets), uncontrolled hypertension, FSGS, markedly elevated liver enzymes and/or liver dysfunction, symptomatic gall stones, marked lipid abnormalities) <b>Mechanical:</b> OSA requiring PAP therapy and supplemental oxygen, limited mobility, shortness of breath sitting/sleeping <b>Mental:</b> Uncontrolled psychopathology, school refusal, daily binge eating, severe body image disturbance <b>Milieu:</b> Severe problems in relationships, caregivers unable to support child's needs (may include exposure to family violence), dangerous environment (home, neighbourhood or school)

### The Edmonton Obesity Staging System for Pediatrics and stage-based management plan\*

Stage	Management plan
0	Ongoing monitoring of obesity-related risk factors and healthy lifestyle/behavioural counselling by the primary health care provider at regular visits.
1	Ongoing monitoring of obesity-related risk factors and healthy lifestyle/behavioural counselling by primary health care provider in conjunction with dietitian/mental health provider depending on individual needs.
2	Referral to multidisciplinary paediatric obesity clinic for comprehensive assessment; receive more intensive, family-centred counselling and lifestyle/behavioural intervention; plan regular follow up clinical appointments.
3	Referral to tertiary level, multidisciplinary paediatric obesity clinic for comprehensive assessment, which may include subspecialty care to manage comorbidities; receive more intensive, family-centred counselling and lifestyle/behavioural intervention; consider complementary, intensive therapeutic options (eg: bariatric surgery); plan regular follow up clinical appointments.

\*Persistence in stage 1,2 pr 3 over an extended period (eg: 12 months) should result in intensification of management strategy after the exclusion of nonmodifiable risk factors.

**APPENDIX 5 - EDMONTON OBESITY STAGING SYSTEM FOR ADULTS**

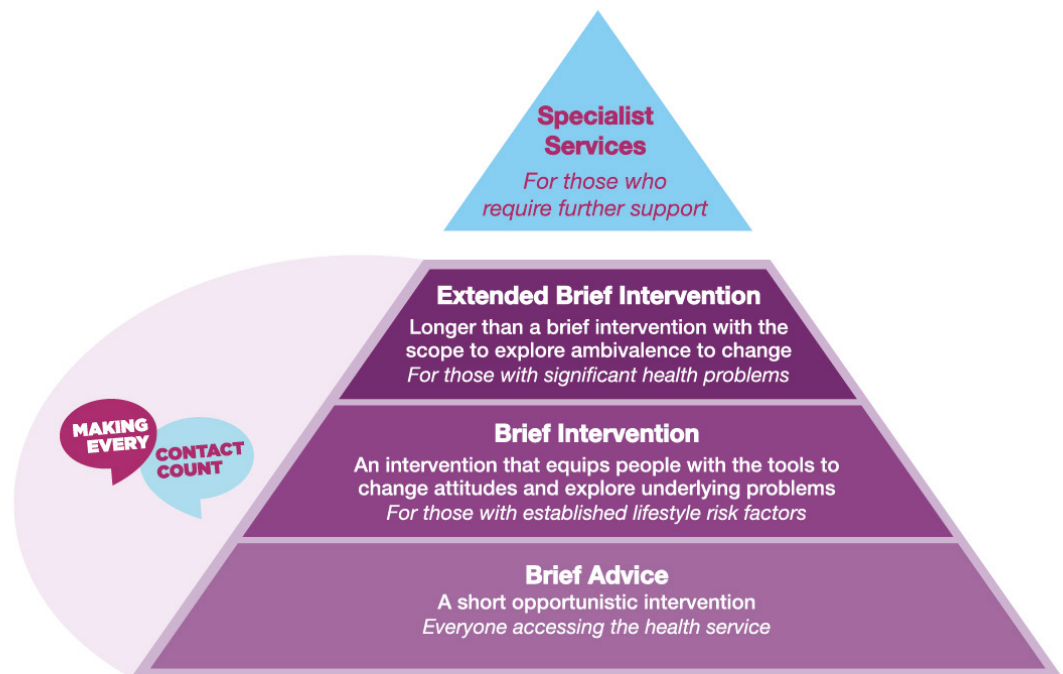
From Sharma and Kushner (2009)

<b>Stage</b>	<b>Description</b>	<b>Management</b>
0	No apparent obesity-related risk factors (e.g., blood pressure, serum lipids, fasting glucose, etc. within normal range), no physical symptoms, no psychopathology, no functional limitations and/or impairment of well being	Identification of factors contributing to increased body weight. Counseling to prevent further weight gain through lifestyle measures including healthy eating and increased physical activity.
1	Presence of obesity-related subclinical risk factors (e.g., borderline hypertension, impaired fasting glucose, elevated liver enzymes, etc.), mild physical symptoms (e.g., dyspnea on moderate exertion, occasional aches and pains, fatigue, etc.), mild psychopathology, mild functional limitations and/or mild impairment of well being	Investigation for other (non-weight related) contributors to risk factors. More intense lifestyle interventions, including diet and exercise to prevent further weight gain. Monitoring of risk factors and health status.
2	Presence of established obesity-related chronic disease (e.g., hypertension, type 2 diabetes, sleep apnea, osteoarthritis, reflux disease, polycystic ovary syndrome, anxiety disorder, etc.), moderate limitations in activities of daily living and/or well being	Initiation of obesity treatments including considerations of all behavioral, pharmacological and surgical treatment options. Close monitoring and management of comorbidities as indicated.
3	Established end-organ damage such as myocardial infarction, heart failure, diabetic complications, incapacitating osteoarthritis, significant psychopathology, significant functional limitations and/or impairment of well being	More intensive obesity treatment including consideration of all behavioral, pharmacological and surgical treatment options. Aggressive management of comorbidities as indicated.
4	Severe (potentially end-stage) disabilities from obesity-related chronic diseases, severe disabling psychopathology, severe functional limitations and/or severe impairment of well being	Aggressive obesity management as deemed feasible. Palliative measures including pain management, occupational therapy and psychosocial support.

## APPENDIX 6 - MAKING EVERY CONTACT COUNT

The Making Every Contact Count (MECC) programme is a key action in supporting the implementation of Healthy Ireland, a National Framework for Improved Health and Wellbeing. 80% of GP consultations and 60% of hospital bed days relate to chronic diseases. By Making Every Contact Count health professionals can encourage people during routine consultations to empower and support people to make healthier choices to achieve positive long-term behaviour change.

The model for MECC is presented as a pyramid with each level representing an intervention of increasing intensity with the low intensity interventions at the bottom of the pyramid and the specialised services at the top. Implementing the Making Every Contact Count approach seeks to begin the process at the basic level of brief advice and brief intervention.



The Making Every Contact Count training programme is available to all HCPs in Ireland. It was developed in consultation with HCPs and service users in order to provide effective tools and knowledge to carry out a brief intervention. The e-learning training programme consists of 6 x 30-minute e-learning modules.

### The Making Every Contact Count training modules include:

- Introduction to behaviour change provides a foundation in behaviour change theory and techniques including the underlying principles of a patient-centred approach.
- Four topic modules on smoking, alcohol and drugs, healthy eating and active living.
- A Skills-Into-Practice module demonstrates the skills of how to carry out a brief intervention across a range of topics through a suite of video scenarios using real-life HCPs.

- Following completion of the online module there will be an opportunity to complete a classroom-based 'Enhancing your brief intervention skills' workshop.

**MECC complements existing engagement approaches by:**

- Supporting HCP's to have a concise supportive conversation if doing your consultation by telephone or online.
- A MECC interaction takes a matter of minutes and is not intended to add to existing busy workloads.
- CPD points awarded for nursing staff and endorsed by HCP bodies.
- Supports individuals in managing their own health.

Every day, people with chronic health conditions, their family members and carers will make decisions, take actions and manage a broad range of factors that contribute to their health. Self-management support acknowledges this and supports people to develop the knowledge, confidence and skills they need to make decisions and take actions in relation to their health conditions. The National Framework and Implementation Plan for Self-management Support for Chronic Conditions (HSE, 2017) provides an overview of self-management support and offers recommendations for implementation of self-management support in Ireland, along with a plan for implementation and priorities for early implementation.

Extended brief interventions will be conducted by health professionals with greater capacity to carry out this lengthier intervention, because of their specialist role or due to the specific service that they work in. This intervention should be delivered to individuals requiring more intensive support in their behaviour change efforts and/or who may be self-managing an existing chronic disease. The specialist services are delivered by practitioners who use specialised or advanced approaches to support individuals to change behaviour. These services include care delivered by HCPs specifically trained in delivering weight management interventions.

## APPENDIX 7 - THE MULTIDISCIPLINARY TEAM FOR OVERWEIGHT AND OBESITY CARE

Team Member	Role in Management of Overweight and Obesity
<b>GP</b>  RCPI Obesity Clinical Advisory Group Membership  Foreword by the HSE National Clinical Lead for Obesity  Executive Summary	<p>Key role in supporting infants, children, young people and adults at all levels of service through prevention, growth monitoring/nutrition screening, early identification, brief interventions, initial management and referring/signposting to services as appropriate.</p> <p>Management of obesity related complications including chronic diseases such as diabetes or hypertension, functional and psychological complications.</p> <p>Ongoing support to children, young people and adults accessing weight management services.</p> <p>Provides maternity care under the Maternity and Infant Care Scheme and Under 6 Health and Wellbeing checks at 2 years and 6 years.</p> <p>Essential to safeguarding processes.</p>
<b>Obesity Lead GP</b>	<p>GP with additional training and experience in obesity. Acts as a lead for obesity within a defined group of GP practices, GP Training Schemes, academic departments and GP education. Dedicated specialists within primary care who can evaluate individuals with obesity related complications, coordinate care, act as an advocate and liaise with multiple services to improve the provision of patient care and follow up.</p> <p>Can provide combined/shared care with the secondary/tertiary services, for long term care of people with complex obesity or following bariatric surgery.</p>
<b>General Practice Nurse</b>	<p>Works with GP, supporting infants, children, young people and adults with overweight and obesity through prevention, growth monitoring/nutrition screening, early identification, brief interventions, initial management and referring/signposting to services as appropriate. Also provides regular reviews of obesity related complications including chronic diseases such as diabetes or hypertension and clinical assessments including weight, blood pressure, respiratory and diabetes checks as required. Provides care under Maternity and Infant Scheme and Under 6 Health and Wellbeing Checks. Provides education and advice on implementing behaviour changes in accordance with MECC.</p> <p>Can provide combined/shared care with the secondary/tertiary services, for long term care of people with complex obesity or following bariatric surgery.</p>
<b>Public Health Nurse</b>	<p>Assessment of growth and development for children from birth to school age, provides brief advice/education and referral/signposting to health and social care services as appropriate.</p>
<b>Community Medical Doctor</b>	<p>In some areas, provides assessment of growth and development for pre-school children, provides brief advice/education and referral/signposting to health and social care services as appropriate as part of first tier model. Receives referrals from PHNs, GPs, Community Paediatricians and other HCPs for detailed developmental assessment providing a co-ordinated child health service. Could develop special interest in obesity and provide medical assessment and management as part of enhanced primary care services.</p>
<b>School Nurse</b>	<p>Assesses growth for children in junior infants, provides brief advice to parents and referral/signposting to health and social care services as appropriate.</p>

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<p><b>Clinical Nurse Specialist</b></p>	<p>Work within the MDT at level 3 and 4 weight management and bariatric service for infants, children, young people and adults. Interventions are delivered individually, in groups and using telehealth platforms.</p> <p>Provides assessment, information, education and support for type 2 diabetes, hypertension, lymphoedema, incontinence and other obesity related complications.</p> <p>Within the MDT, facilitates evidenced based management of individuals, providing nursing assessments, assessment and advice on management of pharmacotherapy, identification and management of complications and supporting self-monitoring and behaviour changes.</p> <p>Contributes to pre-screening and patient measurement.</p> <p>Provides case management and support for the on-going care of specific patients in collaboration with GP, Sleep Laboratory, Community OT, Community Intervention team, Consultants and the wider MDT.</p> <p>Coordinates patient pathway in level 3 and level 4 services, triaging and prioritisation of patients and management of waiting lists.</p> <p>As a member of the MDT provides pre and post bariatric surgery care including guidance on obstructive sleep apnoea, use of thromboprophylaxis, the management of diabetes and safe use of bariatric-friendly equipment, coordination of services around inpatient hospital stay, facilitation of discharge and post-operative support.</p> <p>Key role in education of patient, family, staff and others including health promotion, self-care and self-management.</p> <p>Nurse Specialist is key in coordination of care link to other disciplines-development of patient pathways and journey.</p>
<p><b>Health Care Assistant</b></p>	<p>Support levels 1-4 services in clinical assessment and patient care.</p>
<p><b>Physiotherapist</b></p>	<p>Work within the MDT at all levels of weight management and bariatric service for infants, children, young people and adults. Interventions are delivered individually, in groups and using telehealth platforms. Key roles include:</p> <p>Clinical Assessment: physical function; musculoskeletal; neurodevelopmental; gait, mobility, postural and balance; physical activity behaviour, sleep behaviour and sleep apnoea triage; functional health, self-care, continence screening and occupational health; participation in activities of daily living and quality of life.</p> <p>Clinical Intervention/Treatment: education and advice; behaviour change skills and training; pain management; musculoskeletal rehabilitation; cardio-pulmonary rehabilitation; neurodevelopmental therapy; exercise therapy/strength/conditioning training; individual and group kinesiology and hydrotherapy; manual therapy; prescription of orthoses, gait/mobility aids.</p>
<p><b>Physiotherapist</b></p>	<p>Tailored physical activity prescription: sleep &amp; CPAP management, sleep training and sleep hygiene; functional training; lymphoedema management including compression wrapping and tailored garments or referral to specialist clinic.</p> <p>Communication and Education: interaction between health professionals, schoolteachers, patients, carers, social-care teams and TUSLA; education and advice resources to other HCPs, structured education of weight management skills to other HCPs and students.</p>

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<p><b>Dietitian</b></p>	<p>Work within the MDT at all levels of weight management and bariatric service infants, children, young people and adults. Interventions are delivered individually, in groups and using telehealth platforms.</p> <p>Clinical assessment includes: Anthropometric assessment , nutrition focused physical findings (appetite, mastication and GI function), nutritional requirements, obesity complications requiring specialised nutritional interventions e.g. sarcopenia, liver disease, kidney disease and binge eating disorder, nutritional deficiencies, food and nutrient intake using a variety of methods including dietary recalls, questionnaires and self-monitoring records, bariatric surgery assessment in relation to eating and dietary behaviours, eating behaviours (cultural and personal preferences, barriers and facilitators).</p> <p>Clinical Interventions include provision of evidence based tailored nutrition education using behaviour change skills, individualised reduced calorie diets for obesity complicated by sarcopenia, type 2 diabetes, hypertension, liver disease, kidney disease, disordered eating, binge eating disorder etc., ensuring nutritional adequacy of diet, treatment of nutritional deficiencies, meal replacement and very low energy diets, dietary advice for pharmacotherapy, pre- and post-bariatric surgery dietary advice and support, adaptation of dietary plans to personal and cultural preferences.</p> <p>Communication and Education includes interaction between health professionals, schoolteachers (paediatrics), patients, carers, social-care teams and TUSLA (paediatrics); developing weight management resources and delivering training to HCPs and students.</p>
<p><b>Clinical or Counselling Psychologist</b></p>	<p>Works within the MDT across levels 2,3 and 4 of weight management and bariatric services, providing clinical assessment, intervention, care and support to children, young people, families and adults, delivering group and 1:1 intervention.</p> <p>Key aspects of psychology input include: Clinical assessment and screening for mental health, learning or behavioural difficulties, family-based interventions, range of psychotherapeutic models (e.g. cognitive behavioural therapy, systemic therapy),</p> <p>Pre-operative psychology assessment and post-operative support.</p>
<p><b>Paediatrician Physician-Bariatric Medicine</b></p>	<p>Works within the MDT across levels 2,3 and 4 of weight management and bariatric services. Relevant specialist within paediatric medicine such as an endocrinologist, with sub-specialty interest and experience in obesity/bariatric medicine who is based in secondary and tertiary care and provides: clinical assessment of obesity and related complications; screening for other underlying conditions; treatment; care; and support for children and their families and advocates for CYP in liaison with health and social care supports. Provides referral to primary care services or to those based in secondary and tertiary care, prescribes and monitors medications, advocates for CYP safeguarding and refers to additional specialties as needed.</p>
<p><b>Bariatric Surgeon</b></p>	<p>Works within the MDT across levels 3 and 4 of weight management and bariatric services.</p>
<p><b>Administrative support</b></p>	<p>Works within the MDT across all levels of weight management and bariatric services Provides support to staff for administrative functions, including communicating with patients in specific service areas and medical typing. The role supports the team to deliver the clinical service, maintain local registers, scheduling appointments, facilitating communication and collecting minimum data sets.</p>

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<b>Service Coordinator</b>	Works within the MDT across all levels of weight management and bariatric services. Manages patient care across the spectrum of services and supports integrated care.
<b>Medical Social worker</b>	<p>Works within the MDT across levels 3 and 4 of weight management and bariatric services, providing counselling, support and practical assistance to children, young people, family and adults. Interventions are delivered through individual, group and family work.</p> <p>Clinical Interventions include psychosocial assessment of personal and family situations to aid in the effective delivery of care to patients. Assist patient and families to recognise strengths, coping strategies and challenges in coping with illness in their lives. Assist patients with accessing practical supports and services required to help them achieve healthy lifestyle.</p> <p>Provides education, consultation and assessment to MDT, patient and families around the possible Child Protection/ Child welfare impact of obesity.</p>
<b>Occupational Therapist</b>	<p>Occupational Therapists work within the MDT at all levels of the overweight and obesity pathways of care from the early intervention of school age children, young adults and adults. OTs deliver 1:1 and group interventions and practice in a range of care contexts such as Acute, Community, Social Care (disability and the older person) and Mental Health (children, adolescents and adults).</p> <p>The interventions provided include clinical assessment, treatments and intervention strategies, energy conservation, education, wellbeing, environmental access, technology development, specialised equipment assessment, advice and provision of advocacy. The key occupational focus is on performance, justice, deprivation, occupational balance and health promoting occupations.</p> <p>The patients' goals are achieved by addressing engagement and participation in daily tasks such as showering, dressing, household and community mobility, promoting access, shopping, cooking, environmental medication and promoting engagement and participation in occupational roles.</p>
<b>Community Pharmacy</b>	Can provide support to individuals with overweight and obesity through early identification, brief advice and signposting. Provide support and advice on medicines management for obesity and related complications.

## APPENDIX 8 - CONSULTATION PROCESS

This document was developed by the National Clinical Programme for Obesity in 2020. A broad consultation period, open to both internal and external stakeholders was conducted from 5th August 2020 to 4th September 2020. Consultation with internal and external key stakeholders was important in order to better inform the development process. Wide participation increases the legitimacy of decision-making, improves knowledge and awareness of the development process amongst key stakeholders and helps the clinical programme to make better decisions about how services are defined and implemented. The document approval pathway is outlined in figure 12.



Figure 12: The model of care approval pathway

The document was circulated to 78 individual stakeholders, who were each invited to disseminate amongst their stakeholder group and complete a feedback template. Extensive consultation and review took place with the office of the NCAGL for Chronic Disease and the National Clinical Programme for Paediatrics. Stakeholders included but were not limited to:

- HSE Executive Management Team
- HSE Senior Leadership Team
- Individual HSE divisions
- HSE Hospital Group and Community Health Organisation leads
- Irish College of General Practitioners - Quality and Safety Committee
- All National Clinical Leads and Clinical Programme Managers
- The National Health and Social Care Professional Office and professional bodies
- All relevant professional bodies representing General Practitioners, Nursing and Midwifery, relevant medical and surgical specialities
- Patient advocacy groups for obesity and chronic disease
- Department of Health divisions including Sláintecare and members of the Obesity Policy and Implementation Oversight Group (OPIOG)

A total of 46 responses were received, from a combination of individual and group stakeholders. Each feedback response was considered by the model of care writing group, chaired by Professor Donal O'Shea. Feedback was categorised as follows:

- Incorporated into the final document
- Not incorporated into the final document
- No action required. Reasons for no action included but were not limited to, outside the scope of the document, not relevant to the final version of the document, included in the implementation plan or other supporting documents, policies, procedures and guidelines to be developed by the programme.

Following assessment of and response to the feedback received from the consultation, change requests were made and the final document was developed. On the 27th August 2020, the National Clinical Programme for Obesity hosted an online Obesity Summer School event, which was attended by over 400 healthcare professionals and members of the public. The Model of Care was further socialised at this event through the presentation of key elements and a live panel discussion.

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**APPENDIX 9 - PAEDIATRIC UNITS (2020)**

Hospital	Hospital Classification
Crumlin	CHI
Temple Street	CHI
Tallaght	CHI
Limerick	Regional
UCHG	Regional
CUH	Regional
Drogheda, OLOL	Local
Waterford	Local
Mayo	Local
Sligo	Local
Letterkenny	Local
Portlaoise	Local
Wexford	Local
Cavan	Local
St Luke's Kilkenny	Local
Kerry	Local
Portiuncula	Local
South Tipperary	Local
Mercy	Local

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