PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Barriers and facilitators to the implementation of a community-based, multidisciplinary, family-focused childhood weight management programme in Ireland: A qualitative study
AUTHORS	Kelleher, Emily; Harrington, Janas; Shiely, Frances; Perry, Ivan; Mc Hugh, Sheena

VERSION 1 - REVIEW

REVIEWER	Gemma Enright The George Institute for Global Health, Australia
REVIEW RETURNED	07-Mar-2017

GENERAL COMMENTS	Review of paper: “Implementation of a community-based, multidisciplinary, family-focused childhood weight management programme: Barriers and facilitators for success” General comments: A highly relevant and useful study to build much-needed evidence around implementation challenges in translating multidisciplinary weight management programs for families into the community setting. Whilst the paper describes barriers and facilitators from a wide range of stakeholders involved in implementation, there is no direct feedback from participants of the W82GO-community pilot or hospital version themselves (i.e. those receiving the intervention). In the DISCUSSION authors refer to low program uptake by patients as a key barrier, and follow with some speculations on patient behaviour being linked to perceived social norms, however these patient perceptions are based on anecdotal feedback from the stakeholders supported by the current literature. The authors do justify the focus of the process evaluation being on stakeholders and implementation (in Background, line 8/9 and ref [11]), however they might like to consider acknowledging where the comments about patients’ attitudes are mainly coming from (e.g. the local level program managers, nurses etc.)? ARTICLE SUMMARY/ Article focus • Line 1: sentence “International agencies recommend multi-component programmes to treat and manage childhood obesity” – Would ‘reduce’ be a better fit than ‘treat’? BACKGROUND • Line 2 – separate “Internationalrecommendations”

	METHODS Intervention context • Suggest caution around linking the W82GO-community pilot program to “universal” upscaling and translation? Line 3/4 – “In an attempt to provide universal treatment the Irish Health Service Executive (HSE) planned to pilot the W82GO-community programme in two communities with the intention of rolling the programme out nationwide after pilot programme completion”. Has W82GO- community been measured for BMI outcomes and compared to the hospital version? The authors might want to reiterate in the DISCUSSION or CONCLUSION that a one size fits all approach may not be appropriate, as verbalised by stakeholders (i.e. the suggested tier approach). There may be a need for further qualitative research to investigate what works for whom, in what context and why, and use BMI outcome measures as a basis (maybe over time) before we can make recommendations about up-scaling in the community? Data analysis • Line 2/3 – “Similarities and differences between the coding labels and definitions were discussed and the coding framework was refined and applied to the remaining interviews” –How many interviews were remaining and did this mean that earlier interviews were not aligned in terms of coded themes with the later interviews? • Line 6 – “tailored-based” – do the authors mean “tailor-based”? • Line 9 – “Interviews continued until data saturation was reached…” – earlier in the paragraph, and below under RESULTS it is reported that all 38 stakeholders were contacted (with a 76% response rate), which suggests that all who responded were interviewed? RESULTS The innovation • Line 7 – in the quote there may be a word missing after “you’d”? • Line 10 – separate “Inaddition” Individual professional • Line 12 – suggest revising the sentence slightly to make sense: “As one stakeholder described, post motivational interviewing training she wasn’t “frightened of dealing with them at all. It’s kind of second nature to me now...” • Line 13 – is “alien” a word the stakeholders used? Perhaps reference the quote or use “” as in “naivety” in the paragraph under Social context to keep consistency. Patient • To the earlier point, it would be useful to get some direct feedback from the patients themselves to support your work with the stakeholders – e.g. why they chose not to participate in the community program, and their perceptions on obesity and social norms. • Line 7 – separate “phonecalls” Social context • Line 5 – separate “groundand” • Line 8 – is “if” supposed to be “is” in the quote? External environment • Line 1 – separate “duringour” • Line 7 – who were the parents giving feedback to? (which stakeholders?)

	DISCUSSION • Line 8 – separate “intheir” Limitations • Line 2- suggest a wording change to “However, we do not believe this to be the case…”. Suggestion to add clarity: “However, we do not believe this bias had an effect as stakeholders….” CONCLUSIONS • Might be worth linking back to the issue outlined in the Background – that the study builds the currently lacking evidence base for barriers and enablers to translating family-based weight management programs in community settings.

REVIEWER	Dr Paula Watson Liverpool John Moores University, UK
REVIEW RETURNED	10-Mar-2017

GENERAL COMMENTS	GENERAL COMMENTS This paper reports on the barriers and facilitators to implementation of a family-focussed child weight management programme in the community (that was previously delivered in a hospital setting). The paper provides some valuable data and methods are generally sound. However the authors need to provide more detail of the community-based intervention (i.e. target population, recruitment, content and structure, professional roles and responsibilities) for the reader to make sense of the data that is presented. The authors are urged to consider the TIDieR checklist to ensure transparent reporting of intervention components. Consideration also needs to be given to how responses between professional groups compared and the implications of this for practice. The article is generally well-written but authors need to proof-read the work for grammatical errors, some use of “i” in lower case (table 3), plus inappropriate use of abbreviations in one or two places (e.g. didn’t). References would be clearer if they were numbered in the order they appear in the script (i.e. first reference mentioned should be [1]) SPECIFIC COMMENTS Page 3 strengths & limitations – the authors mention only strengths. Please add details of limitations. INTRODUCTION Page 4, reference 7 (line 3) – it would be better to refer to NICE guidance 47 (2013), which focusses specifically on lifestyle approaches to child weight management. Note also, although NICE draws on international literature in its reviews, the guidance is targeted at those working in health and social care in the UK. Therefore sentence either needs re-wording or additional examples of international guidance need to be added. METHODS Intervention and context Page 5 – further details about the W82GO intervention are needed

	(see specific queries below also). The authors might wish to use the TIDieR checklist to ensure the intervention is reported in sufficient detail (see Hoffman TC, Glasziou PP, Boutron I, et al. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. BMJ 2014;348:g1687). Use of the TIDieR checklist will allow comparison between interventions and will provide the reader with the necessary detail to make sense of the data presented. The authors may wish to review the value of the TIDieR checklist in an example documenting implementation of a community-based childhood obesity intervention (see Watson, P. M., Dugdill, L., Pickering, K., Owen, S., Hargreaves, J., Staniford, L., Murphy, R., Knowles, Z. & Cable, T. (2015). Service evaluation of the GOALS family-based childhood obesity treatment intervention during the first three years of implementation. BMJ Open, 5, e006519 DOI: 10.1136/bmjopen-2014-006519.) Page 5, lines 9-17 - What population was W82GO aimed at? (e.g. age of child, obesity prevention or treatment, did family members take part?) Page 5, lines 46-50 – given the focus of this paper, it is important to include more detail about the specific role of each practitioner within the intervention. Were any of the professionals recruited to specifically run the W82GO programme? Or were they all contributing as part of their existing roles (in which case competing pressures and priorities become an issue). Were all professionals trained to deliver the same content, or did certain professions have different responsibilities from others? Were they all actively delivering the programme, or were some involved only through referring in or commissioning? Did staff work in teams (and who led the teams)? How many staff were present with each group of families at one time (i.e. what was the staff to family ratio)? Page 6, lines 10-12 – it is noted that stakeholders who "were involved in implementing" the W82GO programme were invited. How are the researchers defining implementation? It seems the list of stakeholders goes beyond those previously identified as being involved in the delivery of the programme. Some clarification would be useful. Page 6, lines 31-41 – were interview topics the same for all stakeholders? If so, how did you account for the different roles (in terms of implementation)? Page 6, lines 52-55 & results page 7, lines 54-57 – it is noted interviews continued until data saturation was reached, but it seems all participants who responded to the invite were interviewed (suggesting more of a convenience sampling approach). Please clarify further – how was it possible for both these situations to occur? RESULTS Throughout - One of the values of collecting data from multiple stakeholders is to explore the extent to which they are in agreement (or indeed differ). How did findings compare between different stakeholders? Participant identifiers need to give details of the respondent's profession and the authors are urged to give some consideration to the comparisons between stakeholders. If there were no noticeable differences explicitly state this for the reader.

	DISCUSSION Page 13, reference 19 (line 29) – check reference and sentence wording. The Bleich et al. study focusses on childhood obesity prevention studies but the sentence refers to child weight management. Given W82GO project is a childhood obesity treatment intervention, it might be better to refer to a treatment (rather than prevention) review. Page 15, lines 19-22 – this information about the researcher's role /relationship with participants needs to go in the methods. Page 15, lines 19-30 – consideration needs to be given to the potential limitations associated with the convenience sampling method and make-up of stakeholders within the group (e.g. some professional groups were represented by a single participant, compared with nine participants for other groups). As noted above, consideration needs to be given in the discussion to how stakeholder views compared. The authors may wish to consider the findings of Staniford LJ, Breckon JD, Copeland RJ, et al. Key stakeholders' perspectives towards childhood obesity treatment: a qualitative study. J Child Health Care 2011;15(3):230-44. Consideration needs also to be given in the discussion to the challenges that were reported of translating a hospital programme to a community programme. The points about the lifestyle programme being overly-medicalized are particularly relevant, and something that has come up elsewhere – see supplementary online resource 1 in the Watson et al. (2015) reference provided above (DOI: 10.1136/bmjopen-2014-006519). The authors may be interested to read this since it provides a very practical insight into the challenges and lessons learned during implementation of a childhood obesity intervention (during which we moved from assessments with the paediatrician for all children, to a simple self-disclosure form). TABLE 3 - Participant identifiers need to identify which professional the quote is from. This is important given the focus on multiple stakeholders. - What is the reason for three quotes illustrating the same thing in the "parental resistance" theme? Suggest presenting one quote only to be consistent with the rest of the table. COREQ CHECKLIST The reader is referred to "page 1" (i.e. title page) for several of the details about the researcher. It would be more transparent for the reader (and thus enhance the quality of the paper) if the authors gave explicit consideration to these items within the methods section.

REVIEWER	Dr Penny Love Deakin University, Australia
REVIEW RETURNED	13-Mar-2017

GENERAL COMMENTS	Informed consent is mentioned, however, ethics approval is not stated.Strengths and limitations (wthin the summary and paper) as cuRrently written is rather ad hoc and needs more structure.The decision to use the Grol and Wensing framework (rather than other

	more contemporary frameworks eg: CFIR) needs elaborating.

VERSION 1 – AUTHOR RESPONSE

Response to Referee 1:
R: A highly relevant and useful study to build much-needed evidence around implementation challenges in translating multidisciplinary weight management programs for families into the community setting.

A: Thank you for taking the time to read this manuscript and for this comment, it is much appreciated. We have addressed your individual comments below. Many of the grammatical errors such as 'internationalrecommendations' do not appear in our Word Document and so may have occurred during the uploading process; we apologise for an inconvenience this caused when reviewing the manuscript.

R: Whilst the paper describes barriers and facilitators from a wide range of stakeholders involved in implementation, there is no direct feedback from participants of the W82GO-community pilot or hospital version themselves (i.e. those receiving the intervention). In the DISCUSSION authors refer to low program uptake by patients as a key barrier, and follow with some speculations on patient behaviour being linked to perceived social norms, however these patient perceptions are based on anecdotal feedback from the stakeholders supported by the current literature. The authors do justify the focus of the process evaluation being on stakeholders and implementation (in Background, line 8/9 and ref [11]), however they might like to consider acknowledging where the comments about patients' attitudes are mainly coming from (e.g. the local level program managers, nurses etc.)?

A: This is an important point and we have now addressed it in the discussion. We have amended the following in the discussion section (pg14);

"A key barrier to the implementation of W82GO-community was perceived parental resistance which occurred at the patient level but is also intrinsically linked to the external environment where the increasing normalisation of overweight and obesity coexists with a stigma that surrounds the issue. Stakeholders delivering the programme described parental resistance occurring at every stage of the implementation process and suggested that parents did not appear to recognise the issue in their own children.

As a result stakeholders believed that parents did not see the need for treatment or refused to accept that their child was carrying excess weight. While parental attitudes reported in this study were based on the perceptions of staff, a lack of parental awareness regarding their child's weight and resistance towards discussing weight issues has been documented in previous research [19-23]."

We also include this as a limitation of this research and highlight that research is ongoing with parents and children to understand their perspective and the factors underlying attendance (pg16).

"It is important to note that parental attitudes reported in this study were based on the perceptions of staff delivering the programme. Other studies have identified differences between parents, staff and children in terms of their attitudes towards childhood obesity treatment [34]. We are conducting further research with parents and children to understand the factors influencing their decisions to engage or disengage with obesity treatment."

R: ARTICLE SUMMARY/ Article focus
Line 1: sentence "International agencies recommend multi-component programmes to treat and

manage childhood obesity" – Would 'reduce' be a better fit than 'treat'?

A: Thank you for this suggestion. The sentence now reads "International recommendations agree that initiatives to reduce and manage childhood obesity should be family-focused and combine healthy eating, physical activity and behavioural components [5, 7, 8]."

R: BACKGROUND
Line 2 – separate "Internationalrecommendations"

A: This has been corrected

R: METHODS
Intervention context
Suggest caution around linking the W82GO-community pilot program to "universal" upscaling and translation? Line 3/4 – "In an attempt to provide universal treatment the Irish Health Service Executive (HSE) planned to pilot the W82GO-community programme in two communities with the intention of rolling the programme out nationwide after pilot programme completion". Has W82GO- community been measured for BMI outcomes and compared to the hospital version? The authors might want to reiterate in the DISCUSSION or CONCLUSION that a one size fits all approach may not be appropriate, as verbalised by stakeholders (i.e. the suggested tier approach). There may be a need for further qualitative research to investigate what works for whom, in what context and why, and use BMI outcome measures as a basis (maybe over time) before we can make recommendations about up-scaling in the community?

A: Thank you for this suggestion. In the absence of a treatment programme designed specifically for the community setting, national stakeholders and policy makers expected that the W82GO programme, which had demonstrated effectiveness in the hospital setting, could be transferred to the community with similar results. The original plan was to test the effectiveness of the community based programme by monitoring BMI and then to scale up the programme, presuming improvements in outcomes. However due to problems of recruitment and retention, this evaluation was no longer possible and a process evaluation became a priority. We have tried to capture this context more accurately in the Methods section (pg4):

We have now changed the wording of this sentence to; "In an attempt to identify a universal treatment the Irish Health Service Executive (HSE) planned to pilot the W82GO-community programme in two communities. This programme had previously demonstrated effectiveness in the hospital setting [14]. Its effectiveness in the community setting was to be assessed with the intention of nationwide rollout should the programme demonstrate a positive impact on body mass index (BMI)."

We have also included some information in the discussion on staff recommendations for the future. The following paragraph has been added to pg 16 which will also complement a suggestion from reviewer 2;

"Finally, an important finding from this research was the inherent problems in a 'one size fits all' approach to community-based treatment. Stakeholders in our study suggest a tiered approach may be more suitable, beginning with a brief intervention which intensifies based on a child's degree of obesity, the family's motivation, and the capacity of the community and/or healthcare provider. This finding is in line with a suggestion from Staniford et al. who suggest that future interventions should tailor treatment according to participants' age, degree of obesity and their readiness or confidence to change [35]. In addition to tailoring a programme to the individual, programmes need to be adapted for the community setting. Stakeholders in our study raised concerns that the W82GO programme, having been developed in a hospital setting, was too medicalised for community practice. In

particular, the lengthy assessment process which in some cases involved blood tests and the presence of medically trained doctors, was unnecessary for a community-based lifestyle programme. This finding is consistent with previous research conducted by Watson et al. who evaluated a family-based childhood obesity treatment intervention and found they needed to modify the assessment process by replacing community pediatrician assessments with parent/carer self-completion forms for reasons of time and cost [36]. To develop a full picture of treatment, future research should examine what aspects of the programme work, for whom, in what context and why."

R: Data analysis
Line 2/3 – "Similarities and differences between the coding labels and definitions were discussed and the coding framework was refined and applied to the remaining interviews" –How many interviews were remaining and did this mean that earlier interviews were not aligned in terms of coded themes with the later interviews?

A: This process was conducted at an early stage of the analytical process, after open coding of 2 interviews, to ensure the comprehensiveness of the coding framework. However, the coding process was iterative and emergent codes were added to the framework contributing to the development of themes across the interviews. We have now added this explanation to the methods section on pg7; "While this process was conducted at an early stage of the analysis, the coding process was iterative; emergent codes were added to the framework and contributed to the development of themes across the interviews."

R: Line 6 – "tailored-based" – do the authors mean "tailor-based"?

A: Thank you for pointing this out. We have made this change.

R: Line 9 – "Interviews continued until data saturation was reached…" – earlier in the paragraph, and below under RESULTS it is reported that all 38 stakeholders were contacted (with a 76% response rate), which suggests that all who responded were interviewed?

A: When conducting data analysis, we judged that data saturation was reached at around interview 20-25 however during ongoing recruitment, other stakeholders had expressed an interest in sharing their experience and so they were given the opportunity to participate. These data added to the consistency within the themes, provided more examples of recurring phenomena and we believe strengthened the overall findings.

This information has now been added in the section entitled 'data collection' on pg 7; "Data collection and analysis was iterative. Data saturation was judged to have been reached between interviews 20 and 25. However during recruitment, other stakeholders had expressed an interest in sharing their experience and so were given the opportunity to participate. The data from these interviews overlapped with the existing coding framework and thus contributed to the main themes."

R: RESULTS
The innovation
Line 7 – in the quote there may be a word missing after "you'd"?

A: This is a direct quote from a respondent which maintains their original language. We have now edited the quote, it reads "You've a very different kind of child coming into the hospital than you do in the general community. You've a very different kind of parent. Even if you had a parent who was resistant to hearing about their child being overweight, if they are attending hospital appointments regularly they are obviously already engaged about their child's health... so I believe that's a major barrier straight away that they possibly didn't have to face in the hospital you know?", W82GO010.

R: Line 10 – separate “Inaddition”

A: Corrected

R: Individual professional

Line 12 – suggest revising the sentence slightly to make sense: “As one stakeholder described, post motivational interviewing training she wasn’t “frightened of dealing with them at all. It’s kind of second nature to me now...”

A: Thank you for pointing this out. Again this is a direct quote from a respondent which maintains their original language. We have added in the word ‘parents’ to let the reader know who ‘them’ are. The sentence now reads, “As one stakeholder described, post motivational interviewing training she wasn’t “frightened of dealing with them [parents] at all”, It’s kind of second nature to me now... I know the buzz words, I know exactly what to say to them. And body language, the whole lot”, W82GO002.”

R: Line 13 – is “alien” a word the stakeholders used? Perhaps reference the quote or use “” as in “naivety” in the paragraph under Social context to keep consistency.

A: Yes it was a word a stakeholder used. We have made this change.

R: Patient
To the earlier point, it would be useful to get some direct feedback from the patients themselves to support your work with the stakeholders – e.g. why they chose not to participate in the community program, and their perceptions on obesity and social norms.

A: Our next paper is dedicated to patient’s perspectives and motivations for referral etc. and a line has been added to the discussion section on pg 16 to reflect the need for this feedback. “It is important to note that parental attitudes reported in this study were based on the perceptions of staff delivering the programme. Other studies have identified differences between parents, staff and children in terms of their attitudes towards childhood obesity treatment [34]. We are conducting further research with parents and children to understand the factors influencing their decisions to engage or disengage with obesity treatment”

R: Line 7 – separate “phonecalls”

A: Thank you for this suggestion. We have made this change.

R: Social context
Line 5 – separate “groundand”

A: Corrected

R: Line 8 – is “if” supposed to be “is” in the quote?

A: Thank you for spotting this. The sentence now reads “Furthermore, stakeholders felt that because of the multidisciplinary approach of the programme “you needed someone on the ground”; if they didn’t have a local lead “pulling all those people and bits together, it wouldn't have worked because running something like this with people dispersed across a whole county and city is difficult”, W82GO005.”

R: External environment
Line 1 – separate "duringour"

A: Corrected

R: Line 7 – who were the parents giving feedback to? (which stakeholders?)

A: This was stakeholder's own perception. We have changed the sentence to reflect this, it now reads "Additionally, staff felt that the stigma surrounding childhood obesity and weight management programmes created a significant barrier to programme implementation as they believed many parents were reluctant to attend or even talk about the issue of weight for fear of singling out or 'labelling' their child."

R: DISCUSSION
Line 8 – separate "intheir"

A: Corrected

R: Limitations
Line 2- suggest a wording change to "However, we do not believe this to be the case…". Suggestion to add clarity: "However, we do not believe this bias had an effect as stakeholders…."

A: Thank you for this suggestion. We have made that change.

R: CONCLUSIONS
Might be worth linking back to the issue outlined in the Background – that the study builds the currently lacking evidence base for barriers and enablers to translating family-based weight management programs in community settings.

A: Thank you for this useful suggestion. We have now included the following line as the beginning of the conclusion, "In light of the dearth of knowledge available on the translation of multi-component childhood weight management programmes to community settings, this study highlights the barriers and facilitators to implementing such programmes from a wide range of community healthcare and admin perspectives."

Response to Referee 2:

R: GENERAL COMMENTS
This paper reports on the barriers and facilitators to implementation of a family-focussed child weight management programme in the community (that was previously delivered in a hospital setting). The paper provides some valuable data and methods are generally sound. However the authors need to provide more detail of the community-based intervention (i.e. target population, recruitment, content and structure, professional roles and responsibilities) for the reader to make sense of the data that is presented. The authors are urged to consider the TIDieR checklist to ensure transparent reporting of intervention components. Consideration also needs to be given to how responses between professional groups compared and the implications of this for practice.

A: Thank you kindly for your time and feedback. We have taken on board your queries and have addressed each comment separately below.

R: The article is generally well-written but authors need to proof-read the work for grammatical errors, some use of "i" in lower case (table 3), plus inappropriate use of abbreviations in one or two places

(e.g. didn't).

A: Thank you for spotting this – We have made those changes.

R: References would be clearer if they were numbered in the order they appear in the script (i.e. first reference mentioned should be [1])

A: We have now taken out the references from the strengths and limitations section and so references begin at number 1 and are ordered numerically from the background section on.

R: SPECIFIC COMMENTS: Page 3 strengths & limitations – the authors mention only strengths. Please add details of limitations.

A: Thank you for this suggestion. We have now added the following important limitation:"Using a preconceived framework runs the risk of prematurely excluding other ways of organising the data. However, data was analysed inductively first before mapping onto the Grol and Wensing Framework."

R: INTRODUCTION
Page 4, reference 7 (line 3) – it would be better to refer to NICE guidance 47 (2013), which focusses specifically on lifestyle approaches to child weight management. Note also, although NICE draws on international literature in its reviews, the guidance is targeted at those working in health and social care in the UK. Therefore sentence either needs re-wording or additional examples of international guidance need to be added.

A: Many thanks for this suggestion. We have included the NICE CG47 reference as well as other international references.

R: METHODS
Intervention and context
Page 5 – further details about the W82GO intervention are needed (see specific queries below also). The authors might wish to use the TIDieR checklist to ensure the intervention is reported in sufficient detail (see Hoffman TC, Glasziou PP, Boutron I, et al. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide.

BMJ 2014;348:g1687). Use of the TIDieR checklist will allow comparison between interventions and will provide the reader with the necessary detail to make sense of the data presented. The authors may wish to review the value of the TIDieR checklist in an example documenting implementation of a community-based childhood obesity intervention (see Watson, P. M., Dugdill, L., Pickering, K., Owen, S., Hargreaves, J., Staniford, L., Murphy, R., Knowles, Z. & Cable, T. (2015). Service evaluation of the GOALS family-based childhood obesity treatment intervention during the first three years of implementation. BMJ Open, 5, e006519 DOI: 10.1136/bmjopen-2014-006519.)

A: This is a very useful suggestion. – We have included the TIDieR checklist as supplementary material and have referred to it in the main manuscript. The section Intervention and context (pg4) now reads, "The Template for Intervention Description and Replication (TIDieR) checklist [17] was used to specify the details of programme delivery and is included in Additional file 1. In summary..."

R: Page 5, lines 9-17 - What population was W82GO aimed at? (e.g. age of child, obesity prevention or treatment, did family members take part?)

A: The following information has been added to the main text on pg5. "Families were eligible for the programme if the child was between 5-7 years old; was obese (BMI ≥98th centile); had no limitations to engaging in physical activity; was not taking medication known to affect body weight; and had at

least one parent/carer who was able to attend each of the programme sessions. Siblings were also welcome to attend the sessions."

R: Page 5, lines 46-50 – given the focus of this paper, it is important to include more detail about the specific role of each practitioner within the intervention. Were any of the professionals recruited to specifically run the W82GO programme? Or were they all contributing as part of their existing roles (in which case competing pressures and priorities become an issue). Were all professionals trained to deliver the same content, or did certain professions have different responsibilities from others? Were they all actively delivering the programme, or were some involved only through referring in or commissioning? Did staff work in teams (and who led the teams)? How many staff were present with each group of families at one time (i.e. what was the staff to family ratio)?

A: Thank you for highlighting these important questions. I have now included the following information on pg5 to address these queries…"The programme was offered free of charge and was delivered by existing community health professionals including dietitians, psychologists, public health nurses, physiotherapists, health promotion officers, area medical officers and administrators. These health professionals were brought together as a team and asked to deliver this programme as part of their existing roles. Table 1 outlines their specific responsibilities during programme implementation. All staff were invited to take part in a training programme prior to programme commencement."Please also refer Table 1 which has been added to additional files.

R: Page 6, lines 10-12 – it is noted that stakeholders who "were involved in implementing" the W82GO programme were invited. How are the researchers defining implementation? It seems the list of stakeholders goes beyond those previously identified as being involved in the delivery of the programme. Some clarification would be useful.

A: We define implementation as the process of putting a plan or decision into effect and implementation science as the study of methods to promote the adoption and integration of these plans into routine public health practice. Therefore anyone involved in integrating W82GO-community into community practice was invited to take part in this study. The lists have now been expanded to reflect the same professionals involved and the sentence has been rephrased accordingly, it now reads "We adopted a purposive approach to sampling, inviting stakeholders with knowledge and experience of planning, coordinating or delivering of W82GO-community."

R: Page 6, lines 31-41 – were interview topics the same for all stakeholders? If so, how did you account for the different roles (in terms of implementation)?

A: Core topics were the same across stakeholders and particular probes were added for specific stakeholder groups depending on their role during programme i.e. public health nurses were asked about their specific experience of the referral process and what they felt were the main factors influencing non-attendance.

We have added this information to the document on pg7; "Core topics were the same across stakeholders and particular probes were added for specific stakeholder groups depending on their role during programme. For example public health nurses were specifically asked to report on the barriers and facilitators to referral."

R: Page 6, lines 52-55 & results page 7, lines 54-57 – it is noted interviews continued until data saturation was reached, but it seems all participants who responded to the invite were interviewed (suggesting more of a convenience sampling approach). Please clarify further – how was it possible for both these situations to occur?

A: At the recruitment stage our aim was to ensure we had representation from each stakeholder group across both sites. Given the small number of individuals in each group, we invited stakeholders involved in implementing the programme to take part at the outset as we did not expect such a high response rate. Data collection and analysis was conducted iteratively and we judged that data saturation was reached between interviews 20 and 25. However as other stakeholders had expressed an interest in sharing their experience, they were given the opportunity to participate in an interview and were included in the analysis.

We have made the following changes to the study design and sample section on pg 6 to provide clarification;

"A qualitative approach using semi-structured interviews was utilised. We adopted a purposive approach to sampling, inviting stakeholders with knowledge and experience of planning, coordinating or delivering of W82GO-community. Stakeholders included professionals from dietetics (n=5), clinical psychology (n=3), public health nursing (n=13), physiotherapy (n=4), health promotion (n=4), medicine (n=4), administration (n=2) as well as individuals from both national and local-level management (n=3). To ensure representation from each stakeholder group and given the small number of individuals in each, we invited all stakeholders to participate. All stakeholders were contacted by email in the first instance and followed up by telephone contact during which the researcher outlined the study aims and methodology."

We have made the following changes to the data collection section on pg 7; "Data collection and analysis was iterative. Data saturation was judged to have been reached between interviews 20 and 25. However during recruitment, other stakeholders had expressed an interest in sharing their experience and so were given the opportunity to participate. The data from these interviews overlapped with the existing coding framework and thus contributed to the main themes."

R: RESULTS
Throughout - One of the values of collecting data from multiple stakeholders is to explore the extent to which they are in agreement (or indeed differ). How did findings compare between different stakeholders? Participant identifiers need to give details of the respondent's profession and the authors are urged to give some consideration to the comparisons between stakeholders. If there were no noticeable differences explicitly state this for the reader.

A: Thank you for raising this point. While this paper describes barriers and facilitators from the perspective of a wide range of stakeholders and provides a thorough overview of the relevant issues, findings were consistent across all stakeholders groups which adds to the authority of the findings. This has been noted as a strength of the study on pg3, "While this paper describes barriers and facilitators from the perspective of a wide range of stakeholders and provides a thorough overview of the relevant issues, findings were consistent across all stakeholders groups which adds to the authority of the findings."

We have made it clear that we did look for differences between stakeholder groups in the data analysis section on pg7-8; "Themes were also analysed across stakeholder groups to identify similarities and differences across disciplines and positions."

Finally we acknowledged this finding at the beginning of the results section on pg9; "Views on the main barriers and facilitators to implementation were consistent across stakeholders; despite different disciplinary backgrounds, they had common experiences as implementers adding to the authority of the findings."

Information about stakeholder professions is potentially identifiable given the small number of

locations involved in the pilot and the inclusion of national managers who are the only individuals occupying these roles. Therefore we have to omit this information to protect the anonymity of our participants.

R: DISCUSSION
Page 13, reference 19 (line 29) – check reference and sentence wording. The Bleich et al. study focusses on childhood obesity prevention studies but the sentence refers to child weight management. Given W82GO project is a childhood obesity treatment intervention, it might be better to refer to a treatment (rather than prevention) review.

A: Thank you for this comment and advice. We have revised the discussion. It now reads "This study identifies the barriers and facilitators to implementing a community-based weight management programme from the perspective of stakeholders tasked with delivering such a programme. While community-based weight management programmes have become an important response to the obesity epidemic given their potential reach and accessibility for families, the majority are based on small, efficacy trials [2] and little is known about the factors influencing their implementation in real-world settings."

R: Page 15, lines 19-22 – this information about the researcher's role /relationship with participants needs to go in the methods.

A: We have now included a line in the methods to reflect this. It now reads "To ensure consistency all interviews were conducted by a single trained qualitative researcher (EK), using a semi structured topic guide. Participants knew the interviewer as an independent programme evaluator conducting this research as part of her PhD training."

R: Page 15, lines 19-30 – consideration needs to be given to the potential limitations associated with the convenience sampling method and make-up of stakeholders within the group (e.g. some professional groups were represented by a single participant, compared with nine participants for other groups).

A: To achieve our aim and to ensure we had representativeness from all stakeholder groups across both pilot sites we undertook a purposeful sampling approach and invited all stakeholders involved in the implementation and delivery of W82GO-community (n=38) to take part.

One professional group was represented by a single person because it was a national role and only one person was working within that role. Therefore we have included the total sample of that stakeholder group. This is the same for the stakeholder group at local level management (n=2). In all other stakeholder groups, we initially invited all individuals to participate and the response rate within each group was high;

Health Promotion Officers (n=4, total recruited=4)
Physiotherapists (n=4, total recruited =4)
Dietitians (n=5, total recruited=3)
Psychologists (n=3, total recruited=2)
Public Health Nurses (n=13, total recruited =9)
Local Manager (n=2, total recruited =2)
National Manager (n=1, total recruited =1)
Area Medical Officers (n=4. total recruited =2)

Administration (n=2, total recruited=2)

R: As noted above, consideration needs to be given in the discussion to how stakeholder views compared. The authors may wish to consider the findings of Staniford LJ, Breckon JD, Copeland RJ, et al. Key stakeholders' perspectives towards childhood obesity treatment: a qualitative study. J Child Health Care 2011;15(3):230-44.

A: There were no differences in opinions/views between stakeholder groups. This has been noted as a strength of the study on pg3, “While this paper describes barriers and facilitators from the perspective of a wide range of stakeholders and provides a thorough overview of the relevant issues, findings were consistent across all stakeholders groups which adds to the authority of the findings.”

We have made it clear that we did look for differences between stakeholder groups in the data analysis section on pg7-8; “Themes were also analysed across stakeholder groups to identify similarities and differences across disciplines and positions.”

Finally we acknowledged this finding at the beginning of the results section on pg9; “Views on the main barriers and facilitators to implementation were consistent across stakeholders; despite different disciplinary backgrounds, they had common experiences as implementers adding to the authority of the findings.”

R: Consideration needs also to be given in the discussion to the challenges that were reported of translating a hospital programme to a community programme. The points about the lifestyle programme being overly-medicalized are particularly relevant, and something that has come up elsewhere – see supplementary online resource 1 in the Watson et al. (2015) reference provided above (DOI: 10.1136/bmjopen-2014-006519). The authors may be interested to read this since it provides a very practical insight into the challenges and lessons learned during implementation of a childhood obesity intervention (during which we moved from assessments with the paediatrician for all children, to a simple self-disclosure form).

A: Thank you for this suggestion. We have now added the following information to the discussion to elaborate on the results and to further complement suggestions from Reviewer 1; “Finally, an important finding from this research was the inherent problems in a ‘one size fits all’ approach to community-based treatment. Stakeholders in our study suggest a tiered approach may be more suitable, beginning with a brief intervention which intensifies based on a child’s degree of obesity, the family’s motivation, and the capacity of the community and/or healthcare provider. This finding is in line with a suggestion from Staniford et al. that to move forward, future interventions should tailor treatment according to participants’ age, degree of obesity and their readiness or confidence to change [34]. Furthermore, stakeholders in our study raised concerns that the W82GO programme, having been developed in a hospital setting, was too medicalised for community practice. In particular, the lengthy assessment process which in some cases involved blood tests and the presence of medically trained doctors, was unnecessary for a community-based lifestyle programme. This finding is consistent with previous conducted by Watson et al. who evaluated a family-based childhood obesity treatment intervention and found they needed to modify the assessment process by replacing community pediatrician assessments with parent/carer self-completion forms for reasons of time and cost [35]. To develop a full picture of treatment, additional qualitative research will be needed to explore what works for families, in what context and why.”

R: TABLE 3

Participant identifiers need to identify which professional the quote is from. This is important given the focus on multiple stakeholders.

A: As mentioned above we feel by adding participant identifiers that identify participant professional role their anonymity will be taken away. For example at management level there are only three stakeholders all of whom have been interviewed in this study and so may be easily identifiable.

R: What is the reason for three quotes illustrating the same thing in the "parental resistance" theme? Suggest presenting one quote only to be consistent with the rest of the table.

A: Thank you for this suggestion. We have now deleted two of the quotes.

R: COREQ CHECKLIST
The reader is referred to "page 1" (i.e. title page) for several of the details about the researcher. It would be more transparent for the reader (and thus enhance the quality of the paper) if the authors gave explicit consideration to these items within the methods section.

A: Thank you, we have now made reference to several of these details about the researcher to the methods section pg6; "To ensure consistency all interviews were conducted by a single trained qualitative researcher (EK), using a semi structured topic guide. Participants knew the interviewer as an independent programme evaluator conducting this research as part of her PhD training."
Response to Referee 3:

R: Informed consent is mentioned, however, ethics approval is not stated.

A: This was included at the end of the manuscript under ethics declaration. We have now included a statement in the methods section under data collection heading.

R: Strengths and limitations (wthin the summary and paper) as cuRrently written is rather ad hoc and needs more structure.

A: Many thanks for this – We have now edited and re-structured the strengths and limitations section by first introducing the research and then highlighting specific strengths and limitations as they occur in the paper. It now reads;

"Strengths and limitations
• This is one of few qualitative studies, and the first in Ireland, that explored the factors that hampered and facilitated the implementation of a community-based, multi-component childhood weight management programme from a wide range of stakeholder perspectives.
• While interviewing a wide range of stakeholders provided a thorough overview of the relevant issues, the themes that emerged were relatively homogenous across disciplines which added to the authority of the findings.
• Data were analysed using a systematic approach and an adapted version of the recognised implementation model by Grol and Wensing was used to classify the barriers and facilitators into levels.
• Using a preconceived framework runs the risk of prematurely excluding other ways of organising the data. However, data was analysed inductively first before mapping onto the Grol and Wensing Framework."

R: The decision to use the Grol and Wensing framework (rather than other more contemporary frameworks eg: CFIR) needs elaborating.

A: The decision to use the Grol and Wensing framework was based on a desire to maintain the coherence of the findings and avoid imposing a predefined structure or terminology on participants' accounts. The aim of this study was not to test the applicability of a particular implementation framework but rather to use the framework as an analytical tool and provide coherence to our findings while also allowing us to stay as close as possible to the barriers and facilitators identified and named by our participants. This framework is one of the original determinant frameworks in implementation science and although it has since been incorporated into more recent synthesized frameworks such as CFIR it is still applied regularly to understand health service change;

- Busetto, L., J. Kiselev, K. Luijkx, et al., Implementation of integrated geriatric care at a German hospital: a case study to understand when and why beneficial outcomes can be achieved. BMC Health Services Research, 2017. 17(1): p. 180.
- Vlaeyen, E., J. Stas, G. Leysens, et al., Implementation of fall prevention in residential care facilities: A systematic review of barriers and facilitators. International Journal of Nursing Studies, 2017. 70: p. 110-121.
- Vandewalle, J., B. Debyser, D. Beeckman, et al., Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review. International Journal of Nursing Studies, 2016. 60: p. 234-250.

VERSION 2 – REVIEW

REVIEWER	Gemma Enright The George Institute for Global Health
REVIEW RETURNED	01-May-2017

GENERAL COMMENTS	General comments: Dear authors, I feel you have addressed all my previous comments. I think this is a very well-written and valuable paper and I look forward to reading your subsequent papers. On reading your revision I noticed a couple of minor things to quickly amend before publication: RESULTS • Page 9, Table 4 Perceived Barriers and Facilitators to the Implementation of W82GO in the Community – under The Innovation there is a reference missing for the second quote • Page 12 (last line) – you may need to clarify the age of the children in the community version of W82GO as on page 5, line 7 you mention the ages of the children in the hospital program are 5-7, then on page 12 you mention the age as being 4-6.

REVIEWER	Paula Watson Liverpool John Moores University, Liverpool, UK
REVIEW RETURNED	11-May-2017

GENERAL COMMENTS	Thank you for taking the time to respond in detail to the reviewer comments. All comments appear have been comprehensively addressed and, where recommendations were not possible to implement, the authors have provided a clear justification as to why this is not possible.

	The resulting paper is well-written, insightful and provides some practical and pertinent recommendations for the implementation of community-based child weight management interventions. MINOR COMMENTS TO ADDRESS (MOSTLY FORMATTING ISSUES) METHODS Intervention detail much better, thank you. Page 5, line 57 – full stop missing after "commencement" Page 6, line 34 – delete "of" Page 6, lines 35 to 42– suggest rephrasing as follows to make clear these were the stakeholders who were invited to take part in the research, not those who actually took part: (After sentence ending "…delivering W82GO-community.", line 35) "To ensure representation from each stakeholder group and given the small number of individuals in each, we invited all eligible stakeholders to participate (n=X, see table 1)". (Then continue with "All stakeholders were contacted by e-mail…") Then put "(n=X)" for each specific profession in the first column of table 1. Page 6, line 52 - because the reader does not yet know how many participants were in the final sample, it would be better to remove the n = 22 / n=7 from this sentence, then add a sentence in the "stakeholder characteristics" section on page 8 to explain how many face-to-face and how many telephone interviews were conducted. Page 7, line 19 - "the" programme. RESULTS Page 10, lines 24-26 – the quote for "Collaboration between national and local teams" is not self-defining and does not therefore provide sufficient evidence for this subtheme. Is there a different quote or some context that could be added to this to explain that this issue was down to poor collaboration between national and local teams? Alternatively, the authors may wish to re-name the subtheme. Page 12, line 8 – specify what "such an approach" is Page 12, line 54 – "had not" TIDieR CHECKLIST This is a very useful addition, thank you. Page 23, lines 19-28 – it would be useful to provide further detail about how the TTM & SCT were used to inform the intervention. Such detail is often omitted from studies but is crucial information for synthesising evidence. Page 24, line 5 - "while parents received an…" Page 25, section 8 – details of the 12 month final assessment seem

	to be missing

REVIEWER	Dr Penny Love Deakin University, Australia
REVIEW RETURNED	16-May-2017

GENERAL COMMENTS	Thank you for an improved version of this manuscript which will make an important contribution to the field of research translation, as well as the implementation of childhood weight management programs. One recommendation: As the external (outer) setting is regarded as vital for scalability and sustained implementation, it is recommended that the sections on the social (national level support) and organisational (resourcing) barriers be elaborated on further within your discussion. Eg: Are there existing policy frameworks at national level which can create the policital leverage required for the reallocation of resources etc so that childhood weight management programs can be prioritised? These specific barriers are probably the most important ones for program implementation to occur at a community-level.

VERSION 2 – AUTHOR RESPONSE

Response to Referee 1:

General comments:
R: Dear authors, I feel you have addressed all my previous comments. I think this is a very well-written and valuable paper and I look forward to reading your subsequent papers. On reading your revision I noticed a couple of minor things to quickly amend before publication:

A: Thank you for taking the time to read this manuscript again and for this comment, it is much appreciated. We have addressed your individual comments below.

R: Page 9, Table 4 Perceived Barriers and Facilitators to the Implementation of W82GO in the Community – under The Innovation there is a reference missing for the second quote.

A: Thank you for spotting this – We have added in the reference.

R: Page 12 (last line) – you may need to clarify the age of the children in the community version of W82GO as on page 5, line 7 you mention the ages of the children in the hospital program are 5-7, then on page 12 you mention the age as being 4-6.

A: We have now clarified the age group to 5-7 years of age.

Response to Referee 2:
R: GENERAL COMMENTS: The resulting paper is well-written, insightful and provides some practical and pertinent recommendations for the implementation of community-based child weight management interventions.

A: Many thanks for reviewing our manuscript again –your time and expertise is much appreciated.

R: Page 5, line 57 – full stop missing after “commencement”

A: Thank you for spotting this – we have added in the full-stop.

R: Page 6, line 34 – delete “of”

A: This has now been deleted.

R: Page 6, lines 35 to 42– suggest rephrasing as follows to make clear these were the stakeholders who were invited to take part in the research, not those who actually took part: (After sentence ending “…delivering W82GO-community.”, line 35) “To ensure representation from each stakeholder group and given the small number of individuals in each, we invited all eligible stakeholders to participate (n=X, see table 1)”. (Then continue with “All stakeholders were contacted by e-mail…”). Then put “(n=X)” for each specific profession in the first column of table 1.

A: Thank you for this suggestion. These changes have been made and the section now reads;

Table 1 Health professional roles during the implementation of W82GO-community

Health Professional	Role in implementation of W82GO-community
National Manager (n=1)	Overseeing implementation of W82GO-community in both community sites
Local Manager (n=2)	Overseeing implementation of W82GO-community at local level. Local manager in Site B was involved in referring to the programme.
Physiotherapists (n=4)	Involved in initial assessments and delivering programme material
Dietitians (n=5)	Involved in initial assessments and delivering programme material
Psychologists (n=3)	Involved in initial assessments and delivering programme material
Public Health Nurses (n=13)	Referral to the programme
Area Medical Officers (n=4)	Involved in initial assessments
Health Promotion Officers (n=4)	Delivering programme material
Administration (n=2)	Involved in contacting parents re programme sessions

Study design and sample

A qualitative approach using semi-structured interviews was utilised. We adopted a purposive approach to sampling, inviting stakeholders with knowledge and experience of planning, coordinating or delivering W82GO-community. To ensure representation from each stakeholder group and given the small number of individuals in each, we invited all eligible stakeholders to participate (n=38, see table 1). All stakeholders were contacted by email in the first instance and followed up by telephone contact during which the researcher outlined the study aims and methodology.

R: Page 6, line 52 - because the reader does not yet know how many participants were in the final sample, it would be better to remove the n = 22 / n=7 from this sentence, then add a sentence in the “stakeholder characteristics” section on page 8 to explain how many face-to-face and how many telephone interviews were conducted.

A: You are right. We have added this info to the stakeholder characteristics section.

R: Page 7, line 19 - “the” programme.

A: Many thanks for spotting this.

R: Page 10, lines 24-26 – the quote for “Collaboration between national and local teams” is not self-defining and does not therefore provide sufficient evidence for this subtheme. Is there a different

quote or some context that could be added to this to explain that this issue was down to poor collaboration between national and local teams? Alternatively, the authors may wish to re-name the subtheme.

A: We have used a different quote; “I did feel there was a very big gap once the decision had been made nationally to roll this out, there was a very big gap then us on the ground and them, there was no consultation or collaboration with people on the ground and I think that’s where the problem was”, W82GO003

R: Page 12, line 8 – specify what “such an approach” is

A: This line now reads; “While stakeholders both applauded and recognised the need for a multidisciplinary approach to the treatment of childhood obesity, it created significant barriers to programme implementation.”

R: Page 12, line 54 – “had not”

A: Thank you for pointing this out.

R: Page 23, lines 19-28 – it would be useful to provide further detail about how the TTM & SCT were used to inform the intervention. Such detail is often omitted from studies but is crucial information for synthesising evidence.

A: Under section 2 of the TIDIER Checklist we have now included the following; “Using the social cognitive theory the programmes aims to motivate children and their families to engage in positive behaviours that are achievable. The transtheoretical model is incorporated from initial contact, when the service is first introduced to the family and their level of interest is assessed.”

Furthermore, after describing the various phases of treatment (intensive phase and maintenance stage) in section 8 we have included the following line; “This model of implementation is in keeping with the transtheoretical model of behaviour change.”

R: Page 24, line 5 - “while parents received an…”

A: Many thanks for spotting this – change has now been made.

R: Page 25, section 8 – details of the 12 month final assessment seem to be missing

A: You are correct – we have now added the following line to the end of section 8; “Upon completion of the 12 month programme children and their parents/carer return for a final assessment lasting approx. one and half to two hours.”

Response to Referee 3:
R: Thank you for an improved version of this manuscript which will make an important contribution to the field of research translation, as well as the implementation of childhood weight management programs.

A: Thank you again for taking the time to read our revised manuscript.

R: As the external (outer) setting is regarded as vital for scalability and sustained implementation, it is recommended that the sections on the social (national level support) and organisational (resourcing) barriers be elaborated on further within your discussion. Eg: Are there existing policy frameworks at

national level which can create the policital leverage required for the reallocation of resources etc so that childhood weight management programs can be prioritised? These specific barriers are probably the most important ones for program implementation to occur at a community-level.

A: Thank you for this important comment. We have highlighted this conclusion in the abstract: “Our results suggest the assignment of clear roles and responsibilities, the provision of sufficient practical training and resources, and organisational support play pivotal roles in overcoming barriers to change.” We have also added some detail to the first paragraph in the discussion section: “In addition to their experience, the stakeholders we interviewed are keen to get involved in community-based weight management treatment provided the appropriate training and resources have been allocated. Within their 10 year framework for action, the Irish Government recognise the need for additional resources to be assigned and seek to “mobilise the health services to better prevent and address overweight and obesity through effective community-based health promotion programmes”[19] as well as providing training and skills development. Given this renewed commitment by the Irish Department of Health to empower community teams and communities, the road ahead looks promising.”

VERSION 3 – REVIEW

REVIEWER	Paula Watson Liverpool John Moores University, UK
REVIEW RETURNED	28-Jun-2017

GENERAL COMMENTS	Just a few minor points you might wish to consider for the final proof: 1. Page 10, lines 24 - 26 - there appears to be a typo in the revised quote. Should it be..."there was a very big gap between us on the ground and them"? 2. Page 8, line 35 (section title) and table 3 - sorry this wasn't something I commented on before, but I just wondered if the title "Stakeholder characteristics" explains clearly what is in this section and table? Would it be clearer to call the section "Participant characteristics" and label the table something like "Stakeholders recruited from each site"? 3. TIDieR checklist, section 2, line 6 - should read the "programme aims..." 4. TIDieR checklist, section 2 - The text about the social cognitive theory and transtheoretical model is still a little general. I do however appreciate there may be space limitations, therefore I wonder if it is worth alerting the readers how they might obtain further details of the theoretical components (e.g. with an author name and e-mail). Relevant detail might include, for example, what components of the social cognitive theory were drawn upon to enhance motivation, and how were participants treated differently depending on what stage of change they were at?

REVIEWER	Penny Love Deakin University Australia
REVIEW RETURNED	21-Jun-2017

GENERAL COMMENTS	Very informative research that will add to the implementation science field.

VERSION 3 – AUTHOR RESPONSE

Response to Referee 2:
General comments:
R: Thank you for addressing my previous comments and the clear response provided. I am happy all comments have been satisfactorily addressed. Just a few minor points you might wish to consider for the final proof.

A: Again thank you for your time and consideration. Your contribution to this paper is much appreciated.

R: Page 10, lines 24 - 26 - there appears to be a typo in the revised quote. Should it be..."there was a very big gap between us on the ground and them"?

A: You are right, thank you for spotting this. We have edited the quote now to read: "I did feel there was a very big gap once the decision had been made nationally to roll this out, there was a very big gap between us on the ground and them, there was no consultation or collaboration with people on the ground and I think that's where the problem was", W82GO003

R: Page 8, line 35 (section title) and table 3 - sorry this wasn't something I commented on before, but I just wondered if the title "Stakeholder characteristics" explains clearly what is in this section and table? Would it be clearer to call the section "Participant characteristics" and label the table something like "Stakeholders recruited from each site"?

A: This is a good suggestion and the section has been renamed 'Participant Characteristics' and the subsequent table has also been renamed 'Stakeholders recruited from Site A and Site B'.

R: TIDieR checklist, section 2, line 6 - should read the "programme aims..."

A: Thank you this has now been removed in line with the following query.

R: TIDieR checklist, section 2 - The text about the social cognitive theory and transtheoretical model is still a little general. I do however appreciate there may be space limitations, therefore I wonder if it is worth alerting the readers how they might obtain further details of the theoretical components (e.g. with an author name and e-mail). Relevant detail might include, for example, what components of the social cognitive theory were drawn upon to enhance motivation, and how were participants treated differently depending on what stage of change they were at?

A: Thank you for this suggestion. You are right in that space is limiting us however we would like to provide the reader with some more information on specific techniques used and so have added the following information to this section: "The W82GO-community programme is a family-focused programme grounded in behavioural change theory (transtheoretical model and social cognitive theory) and aims to reduce obesity in children with BMI ≥98th percentile, improve children's dietary intake, physical activity levels and weight status while also increasing children's quality of life and psychosocial health. During initial assessments the families' attitudes and behaviours related to health promotion are identified and specific and achievable goals are set. In attaining these goals, a number of sub-behaviours are promoted including self-efficacy, self-monitoring and self-management. At

every stage of the process the team aims to empower the family to recognise and make the necessary changes to bring about positive lifestyle changes and motivate them to maintain these changes.”

Response to Referee 3:

R: Very informative research that will add to the implementation science field.

A: Many thanks for reviewing our manuscript again and your kind words – we enjoyed this piece of work and hope that it will contribute to the field.