

## D.7 Key area G

### D.7.1 Service configuration (question number G.1)

Item	Details
Area in the scope	Design of services for the management of faltering growth.
Review question in the scope	What service configurations are effective for the management of faltering growth in infants and preschool children?
Review question for the guideline	In the management of infants and preschool children what is the most effective service configuration with regard to the configuration and working arrangements of multidisciplinary teams?
Objective	To identify the most effective service with regards to: <ul style="list-style-type: none"> <li>• how multidisciplinary teams are organised (including the role of midwives and health visitors)</li> <li>• the level of intensity and workload of the team with regards to the management and assessment of faltering growth (e.g. how many hours per week dedicated to this)</li> <li>• care in varied settings (including primary, secondary and tertiary but excluding neonatal intensive care units)</li> </ul>
Population and directness	Infants and preschool children with borderline or definite faltering growth. Exclude complex, severe malnutrition in World Bank low and middle income group countries, and infants and children in intensive care settings.
Intervention	<ul style="list-style-type: none"> <li>• multidisciplinary teams configuration (for example, including the role of midwives, health visitors, dieticians, community nurses and infant feeding specialists)</li> <li>• specialist services, for example, infant feeding teams or community teams</li> <li>• intensity and workload of the team with regards to the management and assessment of faltering growth (e.g. how many hours per week dedicated to this)</li> <li>• settings: primary care, community paediatric services, and secondary and tertiary care services</li> <li>• specialist packages of care (including combinations of settings, staff and approaches or mobile (i.e. roaming service without a fixed location))</li> </ul>
Comparison	The following possible comparisons will be included: <ul style="list-style-type: none"> <li>• any of above interventions versus usual care</li> <li>• any of above intervention versus any other of the above interventions (individually or in combination or in different settings)</li> </ul>
Outcomes	<ul style="list-style-type: none"> <li>• measurements of growth (weight gain, length/height, head circumference, mid-arm circumference) – resolution of faltering growth</li> <li>• health-related quality of life</li> <li>• parent or carer satisfaction</li> <li>• adherence to interventions</li> <li>• adverse effects of interventions (for instance, family dissatisfaction)</li> <li>• cognition and neurodevelopment - only restricted to IQ at school age if reported</li> <li>• admission and re-admission to hospital</li> <li>• resource use outcomes reported in studies included in the clinical evidence, will be extracted and presented in the health economic part of the review</li> </ul>

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Importance of outcomes	<p>Preliminary classification of the critical and important outcomes for decision making:</p> <p>Critical:</p> <ul style="list-style-type: none"> <li>• measurements of growth (resolution of faltering growth)</li> <li>• health-related quality of life</li> <li>• resource use</li> </ul> <p>Important:</p> <ul style="list-style-type: none"> <li>• All other specified outcomes</li> </ul>
Setting	<p>All settings in World Bank high income group countries excluding ICU settings. Primary care, community paediatric services, secondary and tertiary care service models will be compared, if there is available evidence.</p>
Stratified, subgroup and adjusted analyses	<p>Stratified analyses:</p> <ul style="list-style-type: none"> <li>• age / stage of feeding</li> <li>• neonates</li> <li>• age - (1 – 6 months, 6 months and older)</li> </ul> <p>Subgroups (in case of heterogeneity):</p> <ul style="list-style-type: none"> <li>• premature birth, including degree of prematurity</li> <li>• IUGR</li> <li>• type of intervention</li> <li>• children with a previous condition that caused the faltering growth but who are still not thriving once the condition has been controlled (e.g. treated cardiac condition that may have led to faltering growth but even after treatment growth is still not catching up)</li> <li>• different health care models/systems</li> <li>• baseline severity of faltering growth</li> <li>• socio-economic factors (parental income, parental education)</li> </ul> <p>Sensitivity analysis: (in the presence of heterogeneity) including and excluding studies with a high risk of bias.</p>
Language	<p>English</p>
Study design	<ul style="list-style-type: none"> <li>• Systematic reviews of RCTs or systematic reviews of comparative observational studies (if no RCT evidence for each comparison is found). It may be possible to incorporate the results of high quality systematic reviews (according to CASP SR checklist) into the evidence review (updating them if necessary)</li> <li>• Randomised controlled trials (RCTs)</li> </ul> <p>If no RCTs are available we will look for abstracts of RCTs and cohort studies. If non-randomised studies are included we would prioritise studies using multivariable analysis over univariate methods.</p>
Search strategy	<p>Sources to be searched: Medline, Medline In-Process, CCTR, CDSR, DARE, HTA, Embase.</p> <p>Limits (e.g. date, study design): Standard English language/animal studies exclusions will be applied where possible. RCT/SR filters will be applied where</p>

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	<p>possible.</p> <p>Supplementary search techniques: No supplementary search techniques will be used.</p> <p>See appendix E for full search strategies.</p>
Review strategy	<p>This review is not prioritised for dual weeding, as the GC are aware of relevant randomised trial evidence which should be straight forward to identify in the search results.</p> <p>Appraisal of methodological quality:</p> <ul style="list-style-type: none"> <li>• The methodological quality of each study will be assessed using quality checklists and the quality of the evidence for an outcome (i.e. across studies) will be assessed using GRADE</li> </ul> <p>Synthesis of data:</p> <ul style="list-style-type: none"> <li>• Meta-analysis will be conducted where appropriate (if there are RCTs). Otherwise ranges of values will be reported</li> <li>• Default MIDs will be used: 0.75 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes to assess imprecision</li> <li>• If studies only report p-values, they may still be downgraded one level due to unclear risk of imprecision</li> </ul>
Equalities	<p>Effective interventions to address should take into consideration parents' and carers' socioeconomic, cultural, religious and ethnic environment, and potential language barriers.</p> <p>Access to appropriate nutrition may also differ across socioeconomic groups. Certain groups may be at greater risk of developing faltering growth, including preterm infants and children, children and infants with intrauterine growth restriction, those with learning-disabled parents or carers, asylum seekers, and looked-after children.</p>
Notes/additional information	n/a