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# **Engaging patients, clinicians and health funders in weight management: The Counterweight Programme**

(Running title: integrating evidence based weight management into routine family practice)

**Authors: Counterweight Project Team**

(Names according to centre)

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## **Abstract**

**Background:** The Counterweight Programme provides an evidence-based and effective approach for weight management in routine primary care. Uptake of the programme however has been variable for practices and patients

**Aim:** To explore key barriers and facilitators of practice and patient engagement in the Counterweight Programme and to describe key strategies used to address barriers in the wider implementation of this weight management programme in UK primary care.

### **Methods:**

In depth interviews were conducted with purposeful sample of general practitioners (n=7), practice nurses (n=15) from 11 practices out of the 65 participating in the programme. A total of 37 patients participated through a mixture of in-depth interviews (n=18) and three focus groups. Interviews and focus groups were analysed for key themes emerging.

### **Results:**

Engagement of practice staff was influenced by clinician beliefs and attitudes, factors related to the way the programme was initiated and implemented, the programme content and organisational/contextual factors. Practice endorsement of the programme, clear understanding of the programme goals, structured proactive follow up and perception of positive outcomes all influenced patient engagement.

### **Conclusions:**

Having a clear understanding of programme goals and expectations, enhancing self efficacy in weight management and providing proactive follow up is important for engaging both patients and practices. The widespread integration of weight management programmes into routine primary care is likely however to require supportive public policy.

## **Background:**

The prevalence of obesity in the United Kingdom (UK) has almost trebled over the past 20 years. This has implications for individuals with increased risk of obesity related co-morbidities and decreased quality of life as Body Mass Index (BMI) increases<sup>1,2</sup>. The effect of this rise in obesity prevalence has greatly increased the burden on healthcare resources<sup>3,4</sup>.

Strategies for managing obesity need to be clinically effective and capable of dealing with large numbers of people. Primary care remains the public's preferred source of food and health information<sup>5</sup>. Patients' would value more assistance with weight management in primary care<sup>6,7</sup> with attitudes towards practice based lifestyle interventions being positive<sup>8,9</sup>. Yet weight management however is a low priority in family practice due to lack of time, training, teaching materials, staff support, and adequate reimbursement<sup>9</sup>.

There are few studies on the effectiveness of weight management interventions delivered in routine primary care<sup>10</sup>. Isolated training sessions for general practitioners (GPs) and Practice Nurses (PNs) have been shown to improve clinician knowledge and/or change clinician behaviour but do not result in weight loss<sup>11,12,13</sup>. Some GPs believe that obesity is the responsibility of the patient. It is recognized that many GPs believe that obesity does not belong within the medical domain<sup>14,15</sup>. Rather than a medical problem requiring a medical solution, GPs remain unconvinced that obesity is a problem requiring their clinical expertise<sup>16</sup> unless more effective interventions are developed.

The Counterweight Project was established to improve obesity management in primary care by implementing evidence-based weight management intervention that is practice focused. Counterweight works with the general practice team in raising awareness of barriers to obesity management. Changes to team behaviour are encouraged at a number of levels: clinical management of obesity, utilisation of

practice systems<sup>11</sup> and methods to ensure clinical efficiency. The intervention programme has been shown to produce clinically effective weight loss amongst all attenders with enhanced outcomes in patients considered high attenders i.e. attending 70% planned appointments<sup>17,18,19</sup>. Yet implementation outcomes from the pilot showed that after two years almost one-fifth of enlisted practices had never enrolled patients into the programme. Practices varied hugely in their ability to implement the programme and also recruit and maintain patients through the intervention.

In order to understand the reasons for the variable rates of patient and practice participation, an independent qualitative research study was commissioned. This paper will present the findings relating to the key barriers and facilitators of engagement, both at the patient and practice level. The paper will also describe key strategies used to enhance engagement as part of a wider implementation of the programme in UK primary care.

## **Methods**

The qualitative study was conducted by a team of three experienced independent social researchers, who were selected from three potential research teams. Firstly, a focus group was conducted with the Weight Management Advisers (WMAs) responsible for implementing Counterweight at the local level to explore their perception of the key facilitators and barriers of implementation for practices and patients. The qualitative study was conducted in 11 out of the total 65 practices who agreed to implement Counterweight. Practices were purposefully sampled based on key characteristics (rural or urban location, patient list size, number of partners, level of deprivation and degree of ethnic diversity) and the extent to which they had been successful in implementing the programme and recruiting patients. Attempts were made to secure interviews with the practice nurse (PN)(s) responsible for Counterweight and at least one general practitioner (GP) within each practice. Interviews focused on staffs' experience of implementing the programme including factors facilitating or inhibiting success.



To explore the patient experience the lead PNs for Counterweight sent letters to all or an initial subset of 25 counterweight patients (whichever number was fewest) with invitations to participate in an individual interview or focus group. If letters were sent to a subset, PNs were asked to include a range of patients in terms of their age, gender, starting BMI, attendance record and weight loss outcome. Interviews and focus groups explored patients' experience of being involved in the programme and issues relating to weight management in general.

Individual interviews with staff and patients lasted about an hour and focus groups lasted between 90 minutes and two hours. All interviews and focus groups were tape recorded with participants' permission and transcribed verbatim for analysis. Analysis involved reading the transcripts, identifying and coding key themes and issues. At various points throughout this process, emerging findings were explored and refined through discussion between the researchers and the Counterweight Project Team.

## **Results**

All Weight Management Advisers (n=7) participated in a focus group. In-depth interviews were conducted with 15 PNs, seven GPs across 11 practices out of the 65 participating in the pilot. A total of 37 patients took part in the qualitative study through a mixture of individual in-depth interviews (n=18) and three focus groups (n=4,6,9). Key themes relating to the engagement of practice staff and patients are presented in Tables 1 and 2 and key points are highlighted below.

### *Engaging Practice Staff – Barriers and Facilitators*

Key barriers identified to engaging practice staff related to clinician beliefs and attitudes, factors relating to the way the programme was initiated and implemented, and programme content (Table 1). These factors are further illustrated in case descriptions of a 'successful' and 'unsuccessful' practice (Box 1). Clinicians' belief that primary care was not an appropriate setting for weight management and

scepticism about the effectiveness of managing obesity in this setting were key barriers to initial engagement of practices.

*I think they [weight management programmes] are a good idea. I don't think that they are necessarily successful...we have had weight-reducing ideas and regimes in clinics and it always seems to be the same people who are going to them and over the umpteen years that they have been going they haven't really lost any weight (GP).*

The way the programme was initiated also influenced the engagement of practices. Successful practices were characterised by active GP participation and strong ownership usually with one or more staff members acting as a 'Counterweight champion'. In contrast in less successful practices, PNs responsible for implementing the programme were not involved in the decision to sign up to Counterweight; staff in these practices were often not fully aware of what the programme involved, hence ownership and commitment were poor. The credibility of the programme, its support mechanism, and materials were important in engaging the practices' interest initially. Yet there was uncertainty among some participating staff as to the most effective use of these resources and a lack of confidence in their ability to implement the programme with patients. Interviews with staff also highlighted variability in the amount and emphasis of PN training and support provided. Organisational factors were also important; less engaged practices reported the programme to be too time and resource intensive (in the absence of incentives) to support such an investment.

### *Engaging Patients*

For some patients, the fact that the programme was being conducted in their practice and endorsed by their practice was an important factor in their initial engagement.

*"When I first went there I thought this is great I am going to diet at my doctor's surgery. Knowing it was at my doctor's surgery gave me a big 'oof'.." (patient).*

Engaged patients identified the Counterweight brand, had a clear sense of having attended a structured personalised programme and identified positive outcomes from participating, even if weight loss was not achieved.

*“I am literally just a few pounds lighter than I was when I started Counterweight but I feel that I have got control over increasing, I am not increasing. (patient).*

In contrast a poor understanding of the programme goals and commitment required combined with unrealistic weight loss expectations appeared to contribute to patient drop out.

*“What they wanted was a quick fix, ...They want to lose pounds very quickly. And it doesn't happen...They don't want to alter their way of eating or exercise, so everyone comes and asks for slimming tablets”(GP).*

Low self efficacy was a major barrier to continued engagement of some patients. Patients were often veterans of weight loss programmes, having tried and failed to loss weight previously. A lack of strategies to deal with lapse and relapse in the programme compounded this problem.

## **Discussion**

These qualitative findings provide an important insight into some of the variability across the practices involved with counterweight. One of the key issues was to explore factors influencing how practices and patients become engaged in the Counterweight Programme. Our findings indicate that having a credible evidenced-based programme endorsed by the practice and a clear understanding of programme goals and expectations was important for both practices and patients. There is a large body of evidence detailing effective interventions in the treatment of overweight and obesity<sup>20</sup>. It is the delivery of Counterweight which is unique rather than the evidence base<sup>17,18,19</sup>. These findings support enhancing self efficacy and preventing relapse behaviour in patients, monitoring outcomes and creating a supportive environment for change as key facilitators to the ongoing engage practices and patients alike.

### *Continuous Improvement - Modifications to the Programme to enhance engagement*

In response to these findings and in line with our continuous improvement methodology, the Counterweight Project Team has modified aspects of the programme to enhance engagement and promote programme sustainability. Changes to the programme and general implications of our findings are discussed below in relation to engaging government and health service funders, practices and patients.

### *Engaging Practices*

As most individual general practices operate as independent contractors the decision to commission Counterweight lies with the members of the general practice team. In order to address the wide ranging barriers identified to engaging practices, a number of strategies are now being implemented by the Counterweight Project Team (Table 1). Clinicians' expectations of weight management outcomes are often over ambitious; this frequently leads to disappointment in terms of what is achievable, affordable or medically valuable. Early experiences with the Counterweight Programme appear to influence practice engagement. Expectations can best be managed by considering what is successful before embarking on a programme. Information is presented to interested practices on the clinical and costs effectiveness of the programme<sup>18,19,21</sup>, and on our findings related to the burden of obesity, in particular the impact of increasing BMI on GP and PN appointments<sup>3</sup>, prescribing burden<sup>4</sup>, and prevalence of co-morbidity<sup>2</sup>. Standardised information is also presented on the programme structure, requirements, key objectives and messages (Table 3). All staff are encouraged to be involved in the decision on whether to implement the programme. A member of the practice team is also identified as a lead for programme implementation to help promote ownership and ongoing engagement of the whole practice team.

Where GPs are convinced of the clinical value of weight management but consider the cost benefits occur at a higher level in primary care, the option of having a centralised service delivered out with general practice and funded from a central budget is given. With centralised services consideration

needs to be given to accessibility of the programme (as general practices are seen as 'one stop shops' for patient healthcare), time currently spent on weight management in practices and feedback mechanisms for relevant clinical information. A centralised service is being piloted in Lanarkshire in Scotland.

When weight management is seen as too labour/resource intensive, WMAs highlight the value of a structured treatment pathway which limits patient visits for weight intervention and encourages self efficacy and self monitoring . Reminding practices of the resources burden associated with obesity and facilitating links with outside agencies capable of providing help and support to suitable patients has also proved useful.

Finally a key factor for maintaining engagement with the staff is experience of success. Feedback is now provided at agreed intervals on

- 1) number of patients being referred to the programme
- 2) numbers commencing the programme
- 3) number of contacts
- 4) weight change outcomes for programme participants.

Outcomes are set against pilot data and compared with other local practices (anonymised) to assess progress. National codes have been agreed for data collection (READ codes) and this coding system is used across all UK practice clinical information systems so that a minimum data set of number of appointments attended and weight change is available for each patient starting the programme

The biggest barrier to general practice engagement in the UK at present lies with the General Medical Services (GMS) contract. At present there are 8 Quality Outcome Framework (QOF) points out of a total of 1000 are available for creation of the obesity register, just 0.8% of total points and 1.2% of clinical points (the rest are attributed to organizational, patient experience and additional service domains).

Until clarity and more rewards for having in-house weight management services is given, GPs have to decide between finding the resource for the service with the resulting clinical benefits versus the threats to practice resources where weight management is **not** provided.

### *Engaging Patients*

Data from the Counterweight showed that optimal attendance is crucial to successful weight loss and weight loss maintenance. In order to address barriers to patient engagement a number of strategies are now being implemented (Table 2). When identifying suitable patients to refer to Counterweight programme, the modified programme now has an increased emphasis on assessing their readiness to change, with specific resources developed for those ambivalent about lifestyle change. Initial discussion around weight management with patients often uncovers feelings of low self efficacy. This is often linked to unclear expectations of the programme and often unrealistic weight loss goals. Research shows that baseline weight loss expectations are independent cognitive predictors of attrition in obese patients entering weight management programmes<sup>22</sup>. Successful weight loss and healthy-weight management depend on sensible goals and expectations<sup>23</sup>. At the outset patients are provided with clear information on the programme structure (i.e. length and number of appointments, where and when sessions are to be held) and weight loss expectations are discussed and with the aim of agreeing on a 5-10% weight loss goal. The programme has also been modified to place a greater focus on barriers and facilitators to patients achieving lifestyle goals which may help facilitate weight loss. Earlier attention to lapse management will also allow the patient to understand positive outcomes which in turn increases self efficacy and patient empowerment. Finally programme branding has been enhanced to improve the visibility and profile of the programme in practices. Programme materials have also been revised to personalise and increase patient interaction and encourage self monitoring of outcomes. Tailored health education materials have been shown to be significantly more effective than non tailored materials at changing dietary behaviours associated with weight loss interventions<sup>24</sup>

### *Engaging Government and Health Service Funders*

The Counterweight Project Team engaged the Governments in England and Scotland in discussions on how to support the wider dissemination of the programme beyond the pilot phase which was funded by a short-term educational grant. Key issues when engaging governments' support for the programme were

presentation of data on the clinical and cost effectiveness of Counterweight, plans for publishing on-going work and a business plan for incorporating the programme into routine primary care practice. It was also important to understand differences in healthcare policy in England and Scotland which would influence how Counterweight could potentially be positioned. The Governments in the UK have taken different actions to tackle obesity. In Scotland management of adult obesity in the health service has been given a high priority, whereas in England management of childhood obesity is the main priority. In Scotland Counterweight was chosen by central Government as the main weight management intervention for the 'Keep Well' programme, an anticipatory care programme for the prevention of cardiovascular disease taking place in areas of high social deprivation. In England Primary Care Trusts (PCTs) have been engaged individually.

#### *Strengths and Limitations of the Findings:*

The interviews did not include practices that refused to participate in the programme and it is acknowledged that individuals who agreed to be interviewed may have felt more positive about the programme than those who refused. Interviews were however conducted with practices and patients who barely engaged with the programme. The themes identified in the study were also informed by multiple perspectives including GPs, PNs, Practice Managers, WMAs and patients.

#### **Conclusion:**

Having a clear understanding of programme goals and expectations, enhancing self efficacy in weight management and providing proactive follow up is important for engaging both patients and practices. Awareness of the above factors has informed Counterweight Programme refinement for implementation into routine NHS services. The widespread integration of weight management programmes into routine primary care is likely however to require supportive public policy.



**Table 1. Engaging Practice Staff: Key Barriers, Facilitators and Strategies**

Barriers	Facilitators	Strategies
<b>Clinician Beliefs &amp; Attitudes</b>		
<ul style="list-style-type: none"> <li>▪ Scepticism about the effectiveness of the programme and weight management in general</li> <li>▪ Belief that obesity should be managed outside of primary care (concern re over-medicalisation)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Experiences of patient success</li> <li>▪ Recognition of obesity as a health issue appropriate for management in primary care</li> <li>▪ Clinician interest in and commitment to addressing obesity</li> </ul>	<ul style="list-style-type: none"> <li>▪ Provide evidence of clinical and cost effectiveness.</li> <li>▪ Provide evidence of burden of obesity on number of visits, prescribing costs and co-morbidities.</li> </ul>
<b>Process of Implementation</b>		
<ul style="list-style-type: none"> <li>▪ Unclear expectations of the programme</li> <li>▪ Poor GP involvement and low rates of referral</li> <li>▪ High staff turnover and lack programme ownership</li> </ul>	<ul style="list-style-type: none"> <li>▪ Active GP participation and referral</li> <li>▪ Programme ownership</li> <li>▪ Staff champion</li> <li>▪ Targeting practice interests / priorities</li> </ul>	<ul style="list-style-type: none"> <li>▪ Standardised presentation of programme structure</li> <li>▪ Encourage all practice staff to be involved in decision to implement</li> <li>▪ Staff to agree on programme objectives and messages</li> <li>▪ Named person identified as the lead 'champion'</li> </ul>
<b>Programme Factors</b>		
<ul style="list-style-type: none"> <li>▪ Low self efficacy in managing the programme</li> <li>▪ Unclear about appropriate use of programme resources</li> <li>▪ Inappropriate patients targeted</li> </ul>	<ul style="list-style-type: none"> <li>▪ Credible programme offering treatment pathway for obesity</li> <li>▪ Support and high quality materials offered as part of the programme</li> </ul>	<ul style="list-style-type: none"> <li>▪ Increase interactive training component and provide more structured mentoring programme</li> <li>▪ Demonstrate deliver of programme by WMAs</li> <li>▪ Monitor achievement of core competencies</li> <li>▪ Streamline use of programme resources</li> </ul>
<b>Organisational / Contextual factors</b>		
<ul style="list-style-type: none"> <li>▪ Programme perceived to be too time and resource intensive</li> <li>▪ Weight management not included in GP contract</li> <li>▪ Lack of supportive environment for lifestyle changes</li> </ul>	<ul style="list-style-type: none"> <li>▪ Programme integrated into existing practice systems</li> <li>▪ Good practice links with external support services</li> <li>▪ Practice culture of prevention</li> </ul>	<ul style="list-style-type: none"> <li>▪ Emphasis structured treatment pathway</li> <li>▪ Provide evidence of burden of obesity on practice resources.</li> <li>▪ Facilitate practice links with external support services</li> <li>▪ Advocate for inclusion of weight management in GP contract</li> </ul>

**Table 2. Engaging Patients: Key Barriers, Facilitators and Strategies**

Barriers	Facilitators	Strategies
<b>Initial engagement</b>		
<ul style="list-style-type: none"> <li>▪ Lack of patient commitment</li> <li>▪ Low self efficacy</li> <li>▪ Poor GP involvement and low rates of referral</li> <li>▪ Inappropriate use of terminology (obese)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Program endorsed by practice and free</li> <li>▪ GP referral</li> <li>▪ Positive rapport with practice staff</li> <li>▪ Positive messages</li> </ul>	<ul style="list-style-type: none"> <li>▪ Engage GPs to actively refer and promote the programme</li> <li>▪ Increased focus on 'readiness to change assessment'</li> <li>▪ Resource develop for those ambivalent about lifestyle change</li> <li>▪ Agreement on 5-10% weight loss goal, explore patient weight loss expectations and past experience</li> <li>▪ Patient contract</li> </ul>
<b>Ongoing Engagement</b>		
<ul style="list-style-type: none"> <li>▪ Unclear expectations of the programme</li> <li>▪ Lack of identification with the programme</li> <li>▪ Lack of perceived success</li> <li>▪ Lack of strategies to deal with relapse</li> <li>▪ Lack of active follow up</li> </ul>	<ul style="list-style-type: none"> <li>▪ Clear understanding of programme goals and requirements</li> <li>▪ Clear sense of having attended a structured programme</li> <li>▪ Personalised approach</li> <li>▪ Perception of positive outcomes</li> <li>▪ Structured proactive follow up</li> </ul>	<ul style="list-style-type: none"> <li>▪ Programme structure clearly outlined at the outset.</li> <li>▪ Branding of programme materials to promote recognition</li> <li>▪ Patient booklets reviewed to personalise and increase interaction</li> <li>▪ Increased emphasis on lapse management early in the programme</li> <li>▪ Proactive follow up and Increased emphasis on monitoring outcomes</li> </ul>

**Box 1****Case Description – ‘successful practice’\***

Practice 1 is based near the centre of a small country town. It is a sizeable practice with four practice nurses as well as other nurses involved mainly in medical research trials. Within the practice there is a growing culture in respect of prevention (‘They are now beginning to think much more that if they can prevent things happening in the first place it is worth it’). Over the pilot period, this practice has treated more than 100 Counterweight patients mainly through group sessions. The majority of patients attended all the sessions assigned to them, especially following the initial ‘teething’ period and weight loss outcomes were good overall. At the time of interview Counterweight was well integrated into this practice, with patients being routinely referred by GPs and PNs as well as being encouraged to self-refer.

**Case Description – ‘unsuccessful practice’\***

Practice 2 is also a rural practice, but based in a large village. Two practice nurses, one part-time and one who works just enough hours a week to qualify as full-time have jointly been responsible for running Counterweight. Neither PN seemed particularly engaged with the programme and remarked on other competing (and higher priority) pressures on their time. GPs in the practice have not shown particular enthusiasm for the pilot. We were unable to secure an interview with a doctor and the PNs claimed to have had very few cases referred to them. Fewer than 15 patients have been through Counterweight since it was established and PNs reported that most of these failed either to complete the programme or to lose weight. At the time of interview no new patient had been signed up for some months and the programme was essentially moribund.

\* Successful practice – Practice which continued to enrol patients after 12 months

\* Unsuccessful practice – Practice which ceased to enrol new patients before 12 months

**Table 3. Counterweight Programme Key Messages**

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- 5-10% weight loss from baseline is medically valuable
  - Success in terms of >5% loss from baseline will occur in around 1 in 7 people commencing the programme
  - Each staff member should recruit around 25-30 patients per year to maintain confidence and competence without overwhelming workload
  - Patients need to consider the importance of weight loss to them in relation to the lifestyle changes needed to achieve weight loss
  - At three months patients will have a review session. Follow up from then on will depend on weight change outcomes and review of motivation
  - Prevention of weight gain has clear benefits in terms of cost avoidance
  - Health economic analysis of Counterweight concluded the programme to be cheaper and more clinically effective than no intervention
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