Engaging patients, clinicians and health funders in weight management: the Counterweight Programme

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**Background.** The Counterweight Programme provides an evidence based and effective approach for weight management in routine primary care. Uptake of the programme 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.** All seven weight management advisers participated in a focus group. In-depth interviews were conducted with purposeful samples of GPs (\(n = 7\)) and 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 that emerged.

**Results.** Engagement of practice staff was influenced by clinicians’ beliefs and attitudes, factors relating to the way the programme was initiated and implemented, the programme content and organizational/contextual factors. Patient engagement was influenced by practice endorsement of the programme, clear understanding of programme goals, structured proactive follow-up and perception of positive outcomes.

**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 practices and patients. The widespread integration of weight management programmes into routine primary care is likely to require supportive public policy.

**Keywords.** Patient-professional engagement, obesity management.

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Background

The prevalence of obesity in the UK has almost trebled over the past 20 years. This has implications for individuals with increased risk of co-morbidities related to obesity and decreased quality of life as body mass index (BMI) increases. This rise in obesity prevalence has greatly increased the burden on health-care resources.

Strategies for managing obesity need to be clinically effective and capable of dealing with large numbers of people. Primary care has been found to be the public’s preferred source of food and health information. Patients would value more assistance with weight management in primary care and attitudes are positive towards practice-based lifestyle management.

Weight management is a low priority in family practice due to lack of time, training, teaching materials, staff support and adequate reimbursement.

There are few studies on the effectiveness of weight management interventions delivered in routine primary care. Isolated training sessions for GPs and practice nurses (PNs) have been shown to improve clinicians’ knowledge and/or change clinician behaviours but do not result in weight loss. A prejudicial victim-blaming attitude exists with some GPs believing that obesity is the responsibility of the patient and that treatment is not a good use of their time and does not belong within the medical domain. GPs will remain unconvinced that obesity is a medical problem requiring a medical solution, i.e. a problem requiring their clinical expertise unless more effective interventions are developed.

The Counterweight Project was set up to establish and improve obesity management in primary care by implementing an evidence-based weight management intervention that is practice focused. It was developed using theoretical models of behavioural change and the best available methods from the published evidence. Initially, the Counterweight Programme aims to raise awareness of barriers to obesity management through discussion with the general practice team. Changes to team behaviour are encouraged at a number of levels e.g. clinical management of obesity, utilization of practice systems and methods to ensure clinical efficiency. The effectiveness of the Counterweight Programme was assessed with 1906 patients from 65 practices. Practices were chosen from those expressing interest; care was taken to provide a representative group of practices based on key practice characteristics such as size, geographical location and levels of social deprivation. When compared with other clinical and lifestyle interventions, the level of success achieved by Counterweight is considered positive.

The programme has been shown to produce weight loss maintained to 1 year, and it improved risk factors in around 30% of recruited patients followed up at 1 year. Enhanced outcomes are shown in patients considered high attenders i.e. attending ≥66% planned appointments. A key feature of the original design of the Counterweight Programme was to incorporate a ‘closed loop audit’ to evaluate and improve results, using continuous improvement methodology.

Despite the effectiveness of the programme, levels of uptake by practices and patients were variable. After 2 years, almost one-fifth of enlisted practices had never enrolled patients into the programme. Practices varied greatly in their ability to implement the programme and to 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 presents the findings relating to the key barriers and facilitators of engagement, both at the practice and patient 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.

The study was approved by the West Midlands Multi-Centre Research Ethics Committee. 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 to implementation for practices and patients (Table 1). The researchers then worked with a sample of the original 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 PNs responsible for Counterweight and at least one GP within each practice. Interviews focused on staffs’ experience of implementing the programme including factors facilitating or inhibiting success, as well as what would have improved their participation in the programme and patient recruitment levels (Table 2).

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
Integrating evidence-based weight management into routine family practice

Table 1  Topics for focus groups held with staff and patients participating in Counterweight

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Results

All WMAs (n = 7) participated in a focus group. In-depth interviews were conducted with 15 PNs and 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 and 9). Key themes relating to the engagement of practice staff and patients are presented in Tables 2 and 3 and key points are discussed below.

Engaging practice staff—barriers and facilitators

Key barriers identified to engaging practice staff related to clinicians’ beliefs and attitudes, factors relating to the way the programme was initiated and implemented, the programme content and organizational/contextual factors (Table 1 and Table 2). 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 characterized by active GP participation and strong ownership usually with one or more staff members acting as a ‘Counterweight champion’. In less successful practices, PNs responsible for implementing the programme were not involved in the decision to sign up to Counterweight; and 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. 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 by the WMAs. Organizational factors were also important; less engaged practices reported the programme to be too intensive in time and resource, in the absence of incentives.

Engaging patients—barriers and facilitators

Initial engagement of patients was influenced by the apparent endorsement of the programme by the medical practice they were registered with as well as the fact that the programme was being conducted within the practice by practice staff (Table 1 and Table 3).

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’.

(patients)

Engaged patients identified the Counterweight brand, had a clear sense of having attended a structured personalized 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)

The invaluable thing is the good practices you learn. (patient)

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

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 also a major barrier to continued engagement of some patients.

I do lack self confidence ... I do comfort eat. There is no doubt about it, I do. That just makes it worse because I am aware that I am doing it but I still do it. Intellectually I know that I am doing it and that I should stop ... but emotionally I just can’t find the motivation. (patient)

Patients were often veterans of weight loss programmes, having tried and failed to lose weight previously. A perceived lack of strategies to deal with lapse and relapse in the programme compounded this problem.

Discussion

It is the delivery of Counterweight which is unique rather than this evidence base. While there is a large body of evidence detailing effective interventions in the treatment of overweight and obesity, few studies have explored factors influencing the implementation of these evidence-based approaches in routine primary care. This qualitative study provides some important new insights into factors influencing how practices and patients became engaged with the Counterweight Programme. Our findings indicate that having a credible evidence-based programme endorsed by the practice and a clear understanding of the programme’s goals and expectations was important for both practices and patients. Enhancing self-efficacy and emphasizing strategies to prevent relapse behaviour in patients is paramount. Similarly, monitoring outcomes and creating a supportive environment for change are key facilitators to the ongoing engagement of patients and practices alike.

Continuous improvement—modifications to the programme to enhance engagement

In line with our continuous improvement methodology, the Counterweight Project Team has now 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 patients, practices and government and health service funders.

Engaging patients

Data from the Counterweight pilot have 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. When identifying suitable patients to refer to the Counterweight Programme, the modified programme now has an increased emphasis

Box 1  Box describing successful and unsuccessful practices in the Counterweight Programme

Case description—successful practice

Practice 1 is based near the centre of a small country town. It is a sizeable practice with four PNs 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 PNs, 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 patients before 12 months.
on assessing readiness to change, with specific resources enhanced 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 unrealistic weight loss goals. Research shows that baseline weight loss expectations and levels of self-efficacy are independent cognitive predictors of attrition in obese patients entering weight management programmes. Successful weight loss and healthy weight management depend on sensible goals and expectations. At the outset, patients are provided with clear information on the programme structure including length and number of appointments or group sessions and where and when sessions are to be held. Weight loss expectations are also discussed with the aim of agreeing on a 5–10% weight loss goal. The programme has 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. Programme branding has been strengthened to improve the visibility and profile of Counterweight in practices. Programme materials have been revised to personalize and increase patient interaction and encourage self-monitoring of outcomes. Tailored health education materials have been shown to be significantly more effective than uniform materials at changing dietary behaviours associated with weight loss interventions.

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 2). 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 cost-effectiveness of the programme and on our findings relating to the burden of obesity, in particular the impact of increasing BMI on GP and PN appointments, prescribing burden and prevalence of co-morbidity. All staffs 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 is given of having a centralized service delivered outside general practice and funded from a central budget. With centralized services consideration needs to be given to accessibility of the programme (as general practices are seen as ‘one stop shops’ for patient health care), time currently spent on weight management in practices and feedback mechanisms for relevant clinical information. A centralized 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 resource burden associated with obesity and facilitating links with outside agencies capable of providing help and support to suitable patients is also useful.

Finally, a key factor for maintaining engagement with staff is the experience of success. Practices are encouraged to collect data on their patients for discussion at agreed intervals on:

(i) Number of patients being referred to the programme
(ii) Numbers commencing the programme
(iii) Number of contacts
(iv) Weight change outcomes for programme participants.

Outcomes are set against pilot data and compared with other local practices (anonymized) 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 contract. At present, there are eight Quality Outcome Framework points out of a total of 1000 allocated for establishing an 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 greater rewards are provided for having an in-house weight management service, GPs will have to decide between finding the resource for the service with the resulting clinical benefits versus the risks to practice resources where weight management is not provided.
Engaging government and health service funders

The Counterweight Project Team have engaged in discussions with the Governments in England and Scotland (at present, there has been no contact with either the Welsh or Northern Irish Assemblies) on how to support the wider dissemination of the programme beyond the pilot phase which was funded by a short-term educational grant. Key strategies in engaging policymakers included presentation of data on the clinical and cost-effectiveness of Counterweight, plans for publishing ongoing work and a business plan for incorporating the programme into routine primary care practice. It was also important to understand the differences in health-care policy in England and Scotland which would influence how Counterweight could potentially be positioned. 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 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, monies have been provided from central funds to Primary Care Trusts who then have the option to engage with Counterweight individually.

Strengths and limitations of the findings

The themes identified in the study were informed by multiple perspectives including GPs, PNs, practice managers, WMAs and patients. Interviews were conducted with practices and patients who engaged well and those who barely engaged with the programme. The interviews did not include practices that refused to participate in the programme. Individuals who agreed to be interviewed may have felt more positive about the programme than those who refused.

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. Counterweight has been informed by the above factors and aided in continuous refinement of the programme for more successful implementation into routine services of National Health Service. The widespread integration of weight management programmes into routine primary care is likely to require supportive public policy.

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