

Research paper

Barriers and enablers to managing obesity in general practice: a practical approach for use in implementation activities

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ABSTRACT

Background In 2006, the National Institute of Health and Clinical Excellence (NICE) published guidelines for the prevention and management of overweight and obesity. To tailor the implementation of guidelines, information is needed about the prevailing barriers and enablers, and practical methods for identifying barriers and enablers.

Aim To uncover and describe barriers and enablers to implementing NICE's recommendations on the management of obesity in adults in general practice, using practical qualitative methods.

Methods A qualitative study involving semi-structured interviews with seven general practitioners, seven practice nurses and nine overweight or obese patients, exploring their views and experiences on the implementation of NICE guidelines on obesity. The interviews were undertaken and analysed by a health professional with support of a health service researcher; they were recorded and transcribed verbatim and analysed using a thematic

framework approach. The analysis described the reported barriers and enablers.

Results Barriers included: stigma, cost of private sector services, previous patient experience, practitioners not wanting to take responsibility for obesity management, lack of consistency in care, limited practitioner skills, perceived lack of NHS services and constraints imposed by commissioners. Trust between practitioners and patients, practitioners with the skills and confidence to raise the issue of obesity, practice-based procedures and weight management services being available were perceived as enablers to implementation.

Conclusion This pragmatic study found that there are many barriers to the implementation of NICE guidance on obesity, involving patients, practitioners and support services for primary care.

Keywords: adults, barriers, enablers, NICE guidelines, obesity, weight management

How this fits in with quality in primary care

What do we know?

Obesity is a complex issue of increasing importance. Adoption of the National Institute of Health and Clinical Excellence (NICE) obesity guidance may help to reduce the prevalence of adult obesity. However, many general practices in England are not fully implementing the guidance. Tailored interventions to overcome barriers to implementation of guidance can be effective; however, information is needed to identify the barriers and enablers. Previous studies have used complex methods to identify barriers and enablers, which may not be suitable for routine use in healthcare settings. Simpler, pragmatic methods are needed to identify barriers and enablers so that interventions can be tailored to enable the adoption of guidance.

What does this paper add?

We found that patients mentioned stigma, cost of private sector services and past experience of failed weight loss attempts as barriers, but highlighted that trust in their practitioner was an enabler. Practitioners denied responsibility, and reported that the lack of consistency in care and their limited skills hindered their implementation of the guideline. The perceived lack of NHS services, the cost of private services and restrictive commissioner policies were barriers reported by both practitioners and patients. These findings were found using a relatively simple and quick pragmatic method of identifying barriers and enablers to the implementation of guidance, albeit needing further validation. The findings from such investigations cannot provide generalisable findings, but can inform the development of local implementation interventions.

Introduction

The number of obese people in England is rising^{1,2} and the causes of obesity are complex, encompassing individual biology and behaviour. These are influenced by the local culture, social networks and the individual's environment¹ and this 'obeso-genic' environment plays its part in hindering sustained weight loss. Therefore, achieving change in exercise and eating behaviours and public attitudes is challenging. Although health services alone cannot achieve such change, health care does have a role in helping people avoid becoming obese and in helping those who become obese to lose weight. In England, the National Institute of Health and Clinical Excellence (NICE) has published guidelines for professionals on how to manage overweight and obese people. Preventative and curative measures that concentrate on attitudes, behaviour and short-term goals can be associated with significant health benefits.³ In general practice, in particular, detection of overweight or obesity followed by advice and support in making lifestyle changes, may help to reduce the prevalence of obesity.³ Guidelines, however, are not automatically adopted in practice.⁴ General practitioners (GPs) are soon to become lead commissioners in England⁵ and understanding how general practice can improve the management of obesity and potentially reduce healthcare costs would help towards meeting the planned £20 billion efficiency savings.⁶ However, at present, many general practices are not achieving full quality and outcomes framework points for

maintaining an obesity register,⁷ which is the first step in obesity identification and management.

The presence of barriers to, and enablers of, implementation may explain why guidelines are not routinely followed in clinical practice.⁸ Most previous research has focused on barriers rather than enablers, and they have been classified as either internal or external to physicians,⁹ as cognitive-behavioural, attitudinal, rational-emotional barriers. In another classification, professional barriers are described as embedded in the guidelines or arising from the evidence, with other barriers including patient barriers, lack of support or resources, and system and process barriers.¹⁰ Although various interventions including education, reminders or audit and feedback have been used to implement guidelines, no method is consistently effective.¹¹ A recent review of randomised trials indicated that implementation strategies tailored to address the prevailing barriers can be effective.¹² In order to tailor implementation strategies, information is needed on the barriers and enablers. If tailoring is to be used routinely, practical and efficient means of identifying barriers and enablers are required. Complex methods have been used¹⁰ to investigate barriers and enablers, but such methods are unlikely to be suitable for routine use in health care.

Previous research assessing practitioners' views of managing obesity in children found that limited time, lack of expertise or access to effective treatments presented barriers.¹³ In this study, undertaken in the context of a local guideline implementation initiative, we aimed to uncover and describe the barriers and

enablers to implementing NICE's recommendations for general practice teams on the management of obesity in adults.

Methods

Recruitment

We aimed to recruit healthcare professionals in three primary care trusts (PCTs) in the East Midlands, England. We used purposive sampling by asking the obesity leads in each PCT to identify five practices with different levels of commitment to obesity, indicated by different levels of recording of body mass index (BMI) from quality and outcomes framework data from each PCT. We sought a mix of rural and urban practices and set a provisional quota sample of 12 healthcare professionals (one GP and one practice nurse from each participating general practice) and 8–10 patients (one or two from each participating general practice who had experience of weight management from the practice) to enable us to capture a range of views, recognising that some practices would not participate.

From those practices agreeing to take part, health professionals were recruited by the researchers, and patients who had experienced weight management support from the practice were recruited by their healthcare professional.

Interviews

Interviews were conducted between December 2009 and March 2010 and lasted between 20 and 45 minutes each. The interview schedule was designed to be practical, being delivered and analysed by staff with relatively limited research expertise in order to reflect an approach feasible to replicate in routine practice. An interview schedule containing open-ended questions with prompts was developed by the research team to guide semi-structured interviews. Health professionals were asked what factors hinder or help them in identifying and managing patients who are overweight

or obese. Patients were asked about the barriers and enablers to obtaining support from the practice, and what services they were aware of to support them with their weight reduction. In addition to the interview questions, information on age, gender, marital status and duration of employment of practitioners were collected.

Participant information leaflets were provided prior to the interviews, and those giving consent to take part were interviewed individually at a place of their own preference. All health professionals were interviewed at their practices. Patients were interviewed either at their homes or at their local practice. Interviews were recorded, transcribed verbatim and entered into *Nvivo 8*¹⁴ for data management. The researchers took field notes during the interview to record any issues in need of further exploration.¹⁵ SG, a health professional, conducted 14 interviews and FG, a health services researcher, conducted nine.

Data analysis

Reflecting the practical nature of the study, a thematic framework approach was used to analyse the data (Box 1).¹⁶ The thematic framework was created, drawing from issues reported in the literature on barriers and enablers to the implementation of guidelines. SG and FG familiarised themselves with the data separately, identifying additional emergent themes and sub-themes which were coded. SG and FG coded, mapped and interpreted the data to provide explanations of the findings. To test the understanding of the data, the two researchers met to agree the final themes and sub-themes which were then tested through discussions with researchers at the university to agree codes that were subsequently incorporated, and to ensure appropriate methodology was adopted. Analyses revealed good agreement between the two researchers to develop the final model and they were content with the methods used.

Box 1 Five-step process to analysis (adapted from Pope and Mays 1999)¹⁶

- Identify a thematic framework by recognising all the key issues, concepts and themes by which the data can be examined and referenced.
- Familiarisation of the raw data.
- Index the data by applying the thematic framework systematically.
- Chart the data according to the appropriate part of the thematic framework to which they relate and form charts.
- Map and interpret the data by using the charts to define concepts, find associations between themes with the view to providing explanations of the findings.

Results

Nine general practices (Table 1) were recruited with a total of 14 health professionals (seven GPs and seven practice nurses; Table 2) and nine patients (Table 3) being interviewed. On average, health professionals had spent 10 years working in primary care. The major themes are summarised in Table 4 and presented below.

Barriers and enablers related to patients

For patients, stigma, the cost of private sector services and previous experience of trying to lose weight were barriers and perceived trust between practitioners and patients was a major enabler to the implementation of obesity guidelines. These all contributed in different ways to how the patient perceived support to reduce their weight.

Patient barriers

The stigma of obesity was an important influence on the patients' willingness to raise the issue of weight with their healthcare professional.

'I don't want to go out and ask for the help, because they are ashamed of what their size is and things like that.' (Patient 5)

Patients expressed concerns about the cost of private sector services. If they were recommended to use a service that charged a fee, they felt they could not afford it or saw little value in the service being offered.

'You got like Weight Watchers and Slimming World, you have to pay, you have to go, you have to pay, whereas you can't always afford to pay or go or whatever.' (Patient 5)

Patients also reported experiencing an endless loop of weight loss failure over many years, showing they have struggled with their weight.

'I have been on different diets, Weight Watchers, Weight Wise quite a few times. Though I got my weight down then it rocketed back up again ... I have been good over the years, but I do cheat quite a bit.' (Patient 6)

Table 1 Characteristics of participating practices

Practice ID	Practice population (patients aged 16 years and over)*	Locality	Index of deprivation (2007 IMD score)**	Number of obese/overweight adults (aged 16 years and over) who had BMI checked in last 15 months [†]	Number of adults who are obese (with a BMI \geq 30) who have been prescribed weight-loss medication in the last 15 months
Practice 1	10060	Town	11.5	1526	1327
Practice 2	5203	Town	10.3	722	633
Practice 3	7970	Rural	14.9	1259	1231
Practice 4	8693	City	41.2	1661	1478
Practice 5	7227	City	21.1	1506	1107
Practice 6	9306	Town	8.7	3133	2016
Practice 7	3322	City	12.4	862	739
Practice 8	7397	City	49.5	1648	1418
Practice 9	2759	City	32.7	775	398

Notes: Originally there were 10 practices but during the study one practice withdrew. * Population of practice patients (aged 16 years and over) from MiQuest data extraction in the period 2009/2010. ** An IMD (2007) score $>$ 34.32 equates to the 20% most deprived communities, an IMD (2007) score $<$ 8.32 equates to the 20% least deprived communities. [†] A proxy measure of the stage of adoption of obesity guidance.

Table 2 Characteristics of health professionals

Code	Health professional job title	Length of time working as a health professional (years)	Gender	Age group	Ethnicity
GP 1	General practitioner	7	M	31–40	South Asian
GP 2	GP partner	17	F	41–50	White
GP 3	GP partner	6	F	31–40	South Asian
GP 4	General practitioner	8	F	31–40	White
GP 5	GP partner	7	M	31–40	White
GP 7	General practitioner	17	M	51–60	Mixed
GP 10	General practitioner	10	M	51–60	South Asian
PN 1	Practice nurse	2	F	41–50	White
PN 2	Practice nurse	4	F	31–40	White
PN 3	Practice nurse	16	F	45–64	White
PN 4	Practice nurse	6	F	31–40	White
PN 5	Lead practitioner nurse	20	F	41–50	White
PN 7	Practice nurse	14	F	41–50	White
PN 9	Practice nurse	10	F	51–60	White

Patient enablers

Most patients felt that trust between them and the health professional was a key enabler in helping them to lose weight.

‘You need to trust someone. Sometimes you don’t get the same nurse and sometimes you don’t see the same person, I tried to stick with Doctor [x], she knows my history otherwise you have to explain everything over and over.’ (Patient 2)

Barriers and enablers related to practitioners

Practitioners expressed reluctance to take responsibility for implementing the guideline, reported lack of consistency in their weight management approaches and highlighted issues relating to consultations with

patients. Enablers included practitioner confidence, and practice policies and procedures.

Practitioner barriers

The NICE guideline on obesity was viewed by some practitioners as not for them to implement, as it was perceived to be the responsibility of local commissioners.

‘We’ve got enough to do, in terms of sorting and presenting the complaint and then sorting out the ongoing stuff and sorting out the critical health stuff and that’s quite enough for 10 minutes, thank you very much.’ (GP 2)

This was reinforced as obesity was viewed as a non-medical issue and therefore not necessarily the responsibility of medical professionals to deal with.

‘I don’t really see it as my job. I think by the time they get to me, they come with a specific problem or some

Table 3 Patient characteristics

Code	Gender	Age group (years)	Marital status	Weight (kg)	Height (m)	BMI	Occupation	Ethnicity
Patient 1	M	61 and over	Married	Not known	1.55	Not known	Retired	White
Patient 2	F	31–40	Married	126	1.62	48.01	Admin assistant	White
Patient 3	F	61 and over	Married	Not known	Not known	Not known	Retired	White
Patient 4	F	51–60	Married	82	1.57	33.27	Retired	White
Patient 5	F	61 and over	Married	81.4	1.63	30.64	Retired	White
Patient 6	F	61 and over	Married	81.4	1.63	30.64	Retired	White
Patient 7	F	20–30	Single	138	1.56	56.71	Unemployed	Mixed
Patient 8	F	51–60	Single	132.9	1.56	54.61	Child minder	White
Patient 9	F	20–30	Single	85	1.65	31.22	Teacher	South Asian

complexity associated with them and they have often seen the nurse. If I am interested and it hasn't been done, then I will do it, but I am not going to do it as a broad tool for everybody when I don't think there is a value to it.' (GP 2)

There were concerns from health professionals that there was a lack of consistency in the approach to overweight and obesity within the practice. This could lead to unequal provision of treatment and services.

'... so we just need to maximise everybody at every level and you can't do that unless you have a common consensus about where we are going. Actually, it is really hard to have a common consensus about everything because your time for education is not enough, is never enough.' (GP 2)

The practitioner and patient consultation is an important first step in implementing the NICE guideline on obesity. The main barriers were seen as time with patients, the lack of counselling skills and doubt that the consultation could make a difference.

'I think it's that we don't get any training on how to talk to people about their weight and how best to advise people to lose weight ... again there is obviously a time factor.' (GP 4)

'You can lead a horse to water but you can't stop it eating cream cakes.' (GP 5)

Practitioner enablers

On the other hand, a confident, knowledgeable practitioner would implement the guideline, weighing the patient and taking action if it was needed.

'I always ask them if they want to be weighed. It's up to them if they want to be weighed or not. I think you need a baseline to see how they are improving week on week.' (PN 3)

Having the NICE guideline on obesity embedded within the practice procedures was viewed by most practitioners as highly supportive. Practitioners felt that the guideline needed to be localised, that is, adapted to take account of local services.

'I think we created a template initially from the beginning thinking that it is a template which will help us in the future programmes, so from there I think we are measuring height, weight, BMI.' (GP 10)

Barriers and enablers related to primary care services

Practitioners and patients typically identified lack of available services as a major barrier, while having in-house practice clinics was thought to support implementation. Practitioners felt that the local commissioning process was placing unnecessary constraints

Table 4 A summary of barriers to and enablers of implementation of NICE guideline on obesity

	Theme	Barrier	Enabler
Patient	Motivation	Patient seeing the practice as a last resort	Family support, empowered patient, good relationship with health professional, feeling of time for the patient, patient recognising the issue, type of health professional
	Patient experience	Endless loop of failure	Patient requiring a trigger
	Stigma	View obesity as their own fault, in denial about being obese	
Practitioner	Cost of services	Cost of services	
	Consultation with patients	Lack of counselling skills, limited time with patients	
	Consistency of approach	Lack of consistency of approach across the practice, guideline as a guide not a rule	Guideline which is easy to follow and implement, having guideline built into the consultation process
	Not the practitioner's responsibility	Guideline does not support their patients, nothing would work to reduce obesity, helplessness in patients not interested, frustration by practitioners by lack of support, practitioners wanting patients to take responsibility, practitioners feeling that guideline should be implemented by primary care trust/strategic health authority	
	Confident practitioner	Practitioners not wanting to deal with the issue so passing it onto someone else, guidelines only used to check use of drugs, better support and education required, practitioner not wanting to raise the issue, limited knowledge of what to do and when	Practitioner being overweight or obese, trying to tackling co-morbidities, confidence brought action

Table 4 Continued

	Theme	Barrier	Enabler
Services	Commissioning process	PCT changing NICE guideline to suite themselves, referral process cumbersome, restriction on the use of drugs, time with patients, obesity not high on the agenda, red tape and bureaucracy, cross-boundary referrals	Embedding obesity into the quality and outcomes framework
	Support services	Lack of services (psychological, nutritional), lack of information on current services, guideline did not add any new services, consistency of services, difference in rural and urban, lack of progress of the patient when referred to services, no facilities to run their own services, services not meeting the needs of the local population	Peer support groups within a practice, supporting patients earlier, other agencies supporting the practice, multi-component one-stop shop, professional feeling confident to refer to services

on the development of obesity services in practices. Performance measures such as the quality and outcomes framework were seen as hindering care by some respondents, but as enabling care by others.

Available services were perceived by both practitioners and patients as not meeting local needs because they were not accessible, were restricted to patients meeting specific criteria or they did not have the capacity to deal with the potential demand if practitioners fully implemented the guideline.

'I also went to the gym; because I was too heavy they refused to take me. The doctor did try and put me down for the gym, but they said I was too heavy for it. I did go to the physiotherapist assistants ... it was only temporary because that's the way NHS works.' (Patient 1)

Shortfalls in available services included the lack of nutritional and psychological services.

'They have reduced the number of dietary services in the whole of [x], so it's very difficult to actually refer somebody, and they are all now based in [x], so if people don't drive, they are just not going to go, that is even if they have an appointment.' (GP 1)

Practitioners felt that the local commissioning process imposed a number of constraints. These included

restricting the use of drugs and not regarding obesity as an important issue. This was reinforced by the limited emphasis given to obesity in the quality and outcomes framework.

'So I feel constrained in what I can do. And we have even had the PCT [primary care trust] in checking on our Orlistat prescribing.' (GP 3)

Service level enablers

Conversely, the quality and outcomes framework had made other health professionals increasingly aware of obesity and encouraged improved recording of body mass index.

'With the introduction of QoF, we are increasingly aware of certain things we need to address ... obesity interacts with other co-morbidities, its part and parcel of a cardiovascular work up. So, you can't ignore it.' (GP 1)

Having small groups of overweight or obese patients who meet regularly within the practice was a strong theme that emerged both from patients and health professionals. Practitioners wanted to offer these services to patients as they felt having free and accessible

peer support modelled on the guideline would support patients with weight loss.

'I would prefer NHS [support] with small groups of 10–15 at a time, perhaps weigh them ... I just say I think coming regularly and meet and talk with people is important and trying to keep the cost down.' (Patient 1)

Discussion

Summary of main findings

This study was designed to identify the barriers and enablers to the adoption of the NICE guideline on obesity in general practice. Patients mentioned stigma, cost of private sector services and their past experience of failed weight loss attempts as barriers, but highlighted that trust in their practitioner was an enabler. Practitioners reported that it was not their responsibility. The lack of consistency in care, and the GPs' limited skills hindered their implementation of the guideline. The perceived lack of NHS services, the cost of private services and restrictive commissioner policies were barriers reported by both practitioners and patients.

The barriers and enablers found for both patients and practitioners were identified within three months with only part-time input from the research team. The simple, pragmatic methods used in this study, although resting on the collaboration between a health professional and a health services researcher and the need to be validated further, could be replicated in other healthcare settings by healthcare professionals with limited additional support to identify local barriers/enablers to guideline implementation.

Strengths and limitations of the study

We used a straightforward and relatively quick method for identifying barriers and enablers, employing semi-structured interviews and an analysis strategy that described broad fields relating to barriers and enablers (patients, practitioners and services). Although this approach may be applicable by health services in routine initiatives to implement guidelines, it does not provide evidence that can be generalised to other settings, practices or services, nor has the method been validated. The use of health professionals undertaking the field work and analysis, supported by experienced researchers may limit the observations found. Additionally, the sample was based on responses to invitations to participate, thus there may be a biased view of the guidance. Although suitable for informing a local implementation project, the barriers and enablers identified do not represent those faced by all patients

and professionals in England. Our sample did not allow us to describe in detail different views held by men and women, or between different ethnic groups or patients of different socio-economic status, yet the male view was very similar to that of the females in the study. Contrasts might exist, albeit undetected in this study,^{17–19} however, the findings were consistent with other studies.²⁰ The limitations are in part a consequence of our intention of using a practical method. Despite the methodological reservations, it was possible to use the findings to tailor implementation in a local guideline initiative.

Comparison with existing literature

Many of the findings from this study support the suggestion that implementing guidance is difficult.⁹ Empowerment of patients has been shown as an enabler to implementation,²¹ and for patients in this study, successful implementation required them to overcome the stigma associated with obesity and thus empowering patients may aid implementation. Trust between the patient and practitioner was critical in implementing treatments, a finding reported in other studies,^{13,22,23} emphasising the need to organise services to enable patients to develop trust over several consultations.²⁴ This could be seen as developing a relationship with the patient, to enable the discussion of overweight or obesity. However, the relationship itself could be a barrier, as health professionals may prioritise the relationship over obesity management.^{22,23,25} The cost of services was a barrier to patients wanting to take action and addressing these costs can support implementation.^{10,23} Therefore, services have to be of value to the patient to ensure they are used.

A synthesis of GP attitudes to guidelines¹⁷ suggests that clinicians are sometimes pessimistic about guidelines, and consider that implementation is not their responsibility, although others have stated that it was part of their role to tackle obesity and that primary care was a good setting in which to do this.¹³ Both of these views were expressed by the practitioners interviewed in this study, suggesting that there is diversity among practitioners in primary care with respect to their roles in prevention and public health, with implementation being dependent on the practitioner. Structures around practitioners, such as embedding the guideline into policies and procedures, were viewed as aiding implementation, an approach that has been suggested as improving implementation irrespective of the practitioner's own perspective.^{26,27}

Clinicians need to feel confident in raising the issue of weight with their patients,²⁴ but it appears that some of those in our study were not. Having an appropriately trained workforce who understand the delivery of

guidelines may improve implementation.²⁸ Additionally, practitioners reported that if they saw the effects on other co-morbidities and that successful implementation of guidelines led to health benefits, this encouraged them in the implementation of the guideline. Consequently, services that report the outcomes of patients referred to them can enable implementation.^{29,30} Some barriers may be difficult for practitioners or patients to overcome. Adoption of guidelines is more likely if relevant local services are available,³¹ nevertheless many of the practitioners and patients interviewed felt that there was a lack of services or were unaware of their availability.

Implications for policy clinical practice and future research

Our relatively straightforward and quick method succeeded in identifying barriers and enablers reported by patients and professionals, which were reported back to the PCT commissioners for action. The method involved simple semi-structured interviews devised from the available literature and an essentially pragmatic analysis. The findings were suitable for informing the development of an implementation intervention, highlighting the need for information on local services for obese people and for bringing practice teams together to reflect on their performance and discuss ways to improve. Other methods for identifying barriers are available, including questionnaires, focus groups and observation,⁸ but these may require more expertise than the interview of a pragmatically identified sample of professionals and patients. We believe our approach is replicable in other guideline implementation initiatives in routine health care, yet will need to be validated. The findings from such investigations cannot be generalised, but can inform the development of local implementation interventions. Methods to implement guidelines have costs,¹² and therefore should be kept within reasonable limits. Future studies should validate these methods and compare the costs of different methods as well as their success in identifying barriers and enablers.

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ETHICAL APPROVAL

In discussion with the research governance managers of the participating primary care trusts, this project was classified as a service evaluation. This followed checking the project protocol against the national research ethics criteria, and was accompanied by comprehensive service evaluation review by the trusts. In addition to these NHS procedures, we sought and received ethics approval from the University of Leicester Ethics Committee.

PEER REVIEW

Not commissioned; externally peer reviewed.

CONFLICTS OF INTEREST

None declared.

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