

# Addressing barriers for GPs in obesity management: The RCGP Nutrition Group

*Rachel Gillian Pryke, Carly Anna Hughes, Maxine Blackburn*

**Weight management in primary care remains an area of controversy owing to inadequate mechanisms to define roles and responsibilities and to fund work done in this area, as well as an uncertain evidence base for the effectiveness of management by primary care clinicians. However, there are clear areas in which weight management is closely related to primary care, including risk assessment and signposting to self-help and tiered weight management services, plus an evolving role in long-term follow-up after bariatric surgery. This article summarises some of the methods whereby GPs can support weight management in primary care and explores limitations and barriers to carrying out those responsibilities, as well as emerging solutions. It also outlines the work of the Royal College of GPs Nutrition Group in developing new resources to support training in obesity management for primary care clinicians.**

General practice holds the unique and challenging position of having no clinical boundaries. Anything might come a GP's way, yet the enthusiasms of the primary care team are as varied as the challenges, with wide variation in engagement with different clinical domains. Some of these, such as heart disease, diabetes and asthma, are considered bread-and-butter primary care, with payment mechanisms (via the Quality and Outcomes Framework [QOF]) to support them, whilst others remain contentious, with unclear expectations and inconsistent engagement across the profession. One such topic is obesity.

There is no dispute that obesity has a major influence on health and healthcare, or that it is a top public health priority. It is highly relevant to primary care and generates significant additional clinical burden for patients, drug budgets and chronic disease clinics. Its profile

has been raised further by recent NICE obesity guideline updates, confirming the potential for bariatric surgery to influence diabetes control (NICE, 2014). Controversy arises from the uncertain evidence for managing obesity in primary care and the difficulty of translating "advice" into behaviour change. GPs are well placed to raise the topic of weight in a sensitive way, but their role is not to be slimming group leaders. Evidence does not support GP-led, in-house obesity services (Jebb et al, 2011; Jolly et al, 2011) unless supported by an evidence-based programme such as Counterweight (Counterweight Project Team, 2008; McCombie et al, 2012), which would require commissioning as an additional service by local Clinical Commissioning Groups (CCGs).

Nonetheless, GPs can be very useful in helping patients to understand the link between their weight, fitness and nutritional

**Citation:** Pryke RG, Hughes CA, Blackburn M (2015) Addressing barriers for GPs in obesity management: The RCGP Nutrition Group. *British Journal of Obesity* 1: 9–13

## Article points

1. GPs are well placed to support weight management, as they have unique roles in conveying risk to their patients, can signpost them to appropriate support and often have a unique window into their circumstances.
2. The Royal College of GPs (RCGP) Nutrition Group has been established to improve nutritional health in the UK and, in particular, to increase GP engagement in obesity management.
3. In addition to its advocacy work, the group has developed a number of information and training resources, which are available at the RCGP website.

## Key words

- General practice
- Obesity management
- RCGP Nutrition Group

## Authors

Rachel Pryke is a GP, Winyates Health Centre, Redditch; Carly Hughes is Clinical Lead, Fakenham Weight Management Service, and GP Research Fellow and Honorary Lecturer, University of East Anglia, Norwich; Maxine Blackburn is a PhD student, University of Bath.

### Page points

1. Although GPs are well placed to treat and refer obese people, many are hesitant to do so, and they may have little reason to engage in the matter if local weight management services are unavailable.
2. The Royal College of GPs Nutrition Group has been formed to increase obesity engagement among GPs and to advocate for public health strategies.

status and other aspects of health, in particular those individuals with multimorbidity, where obesity is the most common shared risk factor. They have a unique role in conveying health risks to their patients and they have tools that other allied obesity clinicians do not, such as QRISK and Framingham calculators. They have an important role in signposting patients to appropriate support, which may require referral, and a duty to monitor the medication of people with comorbidities while they are in phases of successful weight reduction. They may also, as family doctors, have a unique window into the competing pressures that an obese individual may be facing, such as psychological pressures, social difficulties, physical limitations and relevant family factors, which allow them to bring holistic perspectives to the patient's weight context.

Conversations about obesity remain a challenge to many GPs not just because of time management and fears of causing upset but also because they may trigger lengthy discussion of dietary details but without practitioner confidence that the conversation might alter patient behaviour. Such discussions highlight the very blurred boundary at which social influences become health issues, and at what point along this scale a GP should get involved.

### Local service availability is key to promoting better GP engagement

The ability of GPs to raise awareness of a problem is compromised if local services to signpost patients towards are inadequate or even absent. NICE (2014) guidelines and NHS commissioning guidelines (NHS England, 2014a) clearly recommend initial referral to local community weight management services (described as Tier 2 services), which are widely available. However, provision of Tier 3 services (specialist non-surgical obesity support), which are recommended for those patients who require a multidisciplinary team approach or are being considered for bariatric surgery, is less established, with many areas yet to commission Tier 3 capacity.

Tier 3 services can be provided successfully in general practice if adequately resourced,

as was demonstrated by the award-winning Rotherham Institute of Obesity (Senior et al, 2013) and the Fakenham Weight Management Service (Jennings et al, 2014). Alternative models include clinics led by bariatric physicians from secondary care, sited either in the community or in a local general hospital (Morrison et al, 2012).

### RCGP Nutrition Group objectives

Although solutions are complex and difficult, they intertwine at every point with primary care, and greater engagement is the way forward. Hence the formation of the Royal College of GPs (RCGP) Nutrition Group, which has provided an enthusiastic GP presence contributing to the multidisciplinary obesity initiatives that are happening in many clinical and public health quarters. The group's remit extends across the spectrum of nutritional issues, including malnutrition. The group's origins within the RCGP has promoted dialogue with the RCGP Council to debate the boundaries of what GPs can and cannot do. Considering that the forces driving the high prevalence of obesity have their roots in economic prosperity, relating to the availability of alluring, cheap, calorie-dense food plus lack of necessity to be physically active in daily life, the group strongly supports action on the societal determinants of obesity and malnutrition and advocate for public health interventions for prevention.

The key objectives of the group are the following:

- To ensure that nutritional health is retained as a focus within RCGP policy and that the RCGP calls for strong leadership in this field from policy makers and government.
- To ensure that the RCGP commits to ongoing involvement in nutritional projects and developments by ensuring that a representative from the RCGP is sought and fielded when required.
- To ensure that the RCGP improves nutritional training for the GP trainee curriculum and for Continuing Professional Development for qualified GPs.

Hence, the RCGP Nutrition Group has focused on GP involvement (an opportunity to “put our own house in order”), with quite a wide clinical scope.

One starting point has been to look at the barriers that stop GPs from doing more. This has included looking at the sensitivity of raising the topic of obesity in consultations, for which we have produced a leaflet titled *GP Ten Top Tips: Raising the Topic of Weight* (available at: <http://bit.ly/1GkLlmW>). Sentences such as “How do you feel about your weight?” and “Is it OK if I ask you about your weight?” can safely introduce the topic without casting a sense of judgement or causing upset. GPs should take care to consider that an overweight person may already be addressing their lifestyle, and create an opportunity to listen to the patient’s story because a single glance at someone who is overweight will not convey their recent weight trajectory, which may be increasing, decreasing or static (Pryke and Docherty, 2008; Lewis, 2015).

Making clinical information more widely available is another of the group’s aims. The RCGP has now established an index of reference and guidance materials relating to a range of clinical topics, with obesity and malnutrition resources listed under Nutrition (available at: <http://bit.ly/1BAyheY>).

### Development of training resources

A further barrier to GP engagement has been a shortage of training materials on obesity and malnutrition, as both problems have only recently emerged as clinical topics in their own right and, historically, were barely mentioned in either undergraduate or postgraduate medical training. The Royal College of Physicians (2010) has defined core aspects of knowledge for healthcare professionals working in obesity, but development of training programmes for GPs has been slow to evolve, reflecting the uncertainties of the profession in general and the absence of clearly defined tasks or expectations of the GP role. Not uncommonly, obesity training has been poorly attended or cancelled altogether owing to lack of uptake, whereas study days for QOF-related

topics remain popular.

However, the tide is changing, with a much stronger focus on both preventing and tackling obesity outlined in Simon Stevens’ *Five Year Forward View* (NHS England, 2014b). More obesity training programmes are emerging; for example, specialist obesity training is available through Specialist Certification of Obesity Professional Education (SCOPE; available at: [www.worldobesity.org/scope](http://www.worldobesity.org/scope)), which provides internationally recognised training and accreditation.

In addition, the RCGP Nutrition Group has developed training for non-specialist staff by setting up the Introductory Certificate in Obesity, Malnutrition and Health, which involves completion of six e-learning sessions on the RCGP e-Learning platform (available at: <http://elearning.rcgp.org.uk>), plus attendance at a behaviour change study day. Each component of this training can be done independently. The group has developed an interactive workbook and slide set to enable obesity workshop sessions to be incorporated into local training days or multi-topic training events. Individual workshops or half- or full-day training could be commissioned through the group to provide local training for community and primary care staff.

The workshops are designed to equip healthcare professionals with the knowledge and skills to put behaviour change into practice, drawing on motivational interviewing techniques. They include topics such as working with people with severe and complex obesity, understanding tiered obesity care pathways, approaches to child obesity and the use of screening tools to assess malnutrition, plus an audit tool to support primary care follow-up after bariatric surgery.

A well-recognised concern relates to child obesity and how GPs can support local initiatives. The group has highlighted gaps in current provision of child obesity services, which are commonly hard to access or even absent in many areas, leading to a reluctance to raise the topic. It is demoralising to tell a family that they have a problem when there is no evident help to offer. More specifically,

### Page points

1. The Nutrition Group has provided a number of resources to improve GPs’ engagement with obese people during consultations, as well as resources to aid education, weight loss and weight maintenance.
2. Until recently, training for healthcare professionals on obesity has been sparse and poorly attended; however, specialist obesity training, as well as online e-learning courses, are now available.

### Page points

1. The long-term follow-up of patients after bariatric surgery is an emerging issue with the increased uptake of these procedures.
2. In conjunction with the British Obesity and Metabolic Surgery Society, the RCGP Nutrition Group has developed brief guidelines on the follow-up of these patients, including information on potential early and late complications and the need for nutritional supplementation.
3. The Nutrition Group would like to hear from GPs from any part of the UK who wish to further the primary care obesity agenda.

GP computer systems do not currently allow child growth data to link into the appropriate World Health Organization reference ranges, an essential facility if the data are to be interpreted meaningfully. This has been raised at a policy level, and there are now positive links with Public Health England and the National Child Measuring Programme in order to address these practical data-recording issues and explore how a variety of resources for family support can be expanded.

### Gearing up to share provision of long-term support after bariatric surgery

Further challenges lie ahead. An emerging issue is the longer-term follow-up of patients after bariatric surgery. Whilst impressive evidence of the clinical benefits of surgery (e.g. Sjöström, 2013) is driving increased uptake of bariatric procedures, this life-long procedure requires long-term metabolic surveillance, with several primary care audits (e.g. Harbottle, 2011) already demonstrating nutritional deficiencies in patients who end formal follow-up. The number of these at-risk patients is going to increase, as NHS surgical packages are obliged to provide follow-up for only 1 or 2 years, and some private procedures, such as those that take place abroad, are being carried out without any prospect of long-term monitoring.

The RCGP Nutrition Group, in conjunction with the British Obesity and Metabolic Surgery Society (BOMSS), have developed brief guidance for GPs on important aspects of monitoring patients after bariatric surgery. The printable short leaflet (available at: <http://bit.ly/1zzyfxp>) and longer versions (available at: <http://bit.ly/1wVfNl3>) are available on the RCGP Nutrition web pages. Additionally, there is a useful poster outlining the early and late complications to be aware of after surgery (available at: <http://bit.ly/1Ddt6yT>).

Until 2016, the commissioning of severe and complex obesity surgery will remain under the control of the NHS Commissioning Board, but there are suggestions that it may be devolved to CCGs thereafter. How this will impact on local capacity as well as the development of

Tier 3 obesity services is yet to emerge. These are new issues that are currently being debated, but there is no doubt that there are potential opportunities to develop shared-care protocols between primary care and Tier 3 obesity services to ensure that patients get the follow-up that they require.

### Conclusions

RCGP Nutrition Group meetings have enabled productive networking among GPs in England, Scotland and Wales, as well as feedback from all the members who have represented the group on other committees. We have developed an array of educational resources to support primary care's engagement in some aspects of weight management. There has been excellent networking with allied obesity organisations, plus support of NICE guidance development, and we aim to continue to develop these links further. We would like to hear from interested GPs from any part of the UK if they wish to get involved in pushing the primary care obesity and malnutrition agenda firmly forward. If you would like further information, please contact Rachel Pryke via [rpryke@nhs.net](mailto:rpryke@nhs.net). ■

Counterweight Project Team (2008) Evaluation of the Counterweight Programme for obesity management in primary care: a starting point for continuous improvement. *Br J Gen Pract* **58**: 548–54

Harbottle L (2011) Audit of nutritional and dietary outcomes of bariatric surgery patients. *Obes Rev* **12**: 198–204

Jebb SA, Ahern AL, Olson AD et al (2011) Primary care referral to a commercial provider for weight loss treatment versus standard care: a randomised controlled trial. *Lancet* **378**: 1485–92

Jennings A, Hughes CA, Kumaravel B et al (2014) Evaluation of a multidisciplinary Tier 3 weight management service for adults with morbid obesity, or obesity and comorbidities, based in primary care. *Clin Obes* **4**: 254–66.

Jolly K, Lewis A, Beach J et al (2011) Comparison of range of commercial or primary care led weight reduction programmes with minimal intervention control for weight loss in obesity: Lighten Up randomised controlled trial. *BMJ* **343**: d6500

Lewis E (2015) Why there's no point telling me to lose weight. *BMJ* **350**: g6845

McCombie L, Lean ME, Haslam D (2012) Effective UK weight management services for adults. *Clin Obes* **2**: 96–102

Morrison DS, Boyle S, Morrison C et al (2012) Evaluation of the first phase of a specialist weight management programme in the UK National Health Service: prospective cohort study. *Public Health Nutr* **15**: 28–38

NHS England (2014a) *Joined up Clinical Pathways for Obesity: Report of the Working Group*. NHS England, London. Available at: <http://bit.ly/RNNm7S> (accessed 23.02.15)

NHS England (2014b) *Five Year Forward View*. NHS England, London. Available at: <http://bit.ly/1rr78ja> (accessed 23.02.15)

NICE (2014) *Obesity: Identification, Assessment and Management of Overweight and Obesity in Children, Young People and Adults* (CG189). NICE, London. Available at: [www.nice.org.uk/guidance/cg189](http://www.nice.org.uk/guidance/cg189) (accessed 23.02.15)

Pryke R, Docherty A (2008) Obesity in primary care: evidence for advising weight constancy rather than weight loss in unsuccessful dieters. *Br J Gen Pract* **58**: 112–7

Royal College of Physicians (2010) *The Training of Health Professionals for the Prevention and Treatment of Overweight and Obesity*. RCP, London. Available at: <http://bit.ly/1DNmicy> (accessed 23.02.15)

Senior L, Carter D, Capehorn M (2013) Service evaluation of the Rotherham Institute for Obesity and comparison of 2010 and 2011 data. *Obes Facts* **6**(Suppl 1): 116

Sjöström L (2013) Review of the key results from the Swedish Obese Subjects (SOS) trial – a prospective controlled intervention study of bariatric surgery. *J Intern Med* **273**: 219–34

***“GPs can be very useful in helping patients to understand the link between their weight, fitness and nutritional status and other aspects of health, in particular those individuals with multimorbidity, where obesity is the most common shared risk factor.”***