Royal College of General Practitioners

RCGP Position Statement on Obesity and Malnutrition

1. Overview

Obesity and malnutrition relate strongly to generalist care, both having profound effects on health, health services, quality of life, life expectancy and multimorbidities. GPs and primary healthcare teams have important but quite specific roles in raising awareness of the impact of obesity and malnutrition on health and risk of illness, plus an important role in encouraging physical activity, signposting to appropriate support and undertaking some aspects of management. The RCGP Position Statement on Obesity and Malnutrition aims to clarify these roles.

The problem of obesity and malnutrition presents a common problem for all four countries in the UK as well as much of the developed world. In this paper mention is made of the role of Clinical Commissioning Groups (CCGs) in addressing the problem. These structures are unique to England, as is the 5 year forward view, and whilst this brings a particular perspective, the themes and general messages are common for the devolved countries of Scotland, Wales and Northern Ireland.

2. Scale of nutritional problems

The World Health Organisation have highlighted the global problems of chronic or non-communicable diseases (NCD), of which cardiovascular diseases account for most NCD deaths, or 17.3 million people annually, followed by cancers (7.6 million), respiratory diseases (4.2 million), and diabetes (1.3 million). (1) They share four risk factors: tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets. GPs already perceive a clear role in smoking cessation and alcohol intervention; there is equal merit in GP engagement to provide effective physical activity and dietary support.

Almost 60% of the UK population are now overweight or obese. (Fig 1) Excess body fat underlies almost two thirds of cases of type 2 diabetes in men and three quarters in women. It contributes to increased cancer risk, hypertension, dyslipidaemia, obstructive sleep apnoea, gallstones, non-alcoholic fatty liver disease, decreased fertility, dementia and depression. (2) Micronutrient deficiency may also co-exist with caloric excess.

Overweight and obesity now affects 28% of UK children aged 2-10 years and 34% of children aged 11-15 years. A third of our young population are now entering adulthood with a pre-existing weight problem. Whilst action to address both prevention and treatment of childhood overweight/obesity and weight-related co-morbidities involves primary care, effective approaches and treatment services have yet to be demonstrated.

At the other end of the nutritional spectrum, more than 3 million people in the UK are estimated to be at risk of malnutrition with most (93%) living in the community. (3) Up to 40% of patients on admission to a nursing home are at risk of malnutrition as shown by MUST score. Malnutrition predisposes to disease, adversely affecting its outcome and reducing the likelihood of independence, increasing risk of hospital admissions and readmissions, longer length of stay in hospital and greater health care needs in the community (more GP visits, care at home and antibiotics). Addressing

malnutrition and dehydration can improve nutritional status, clinical outcomes and reduce healthcare use. (4, 5)

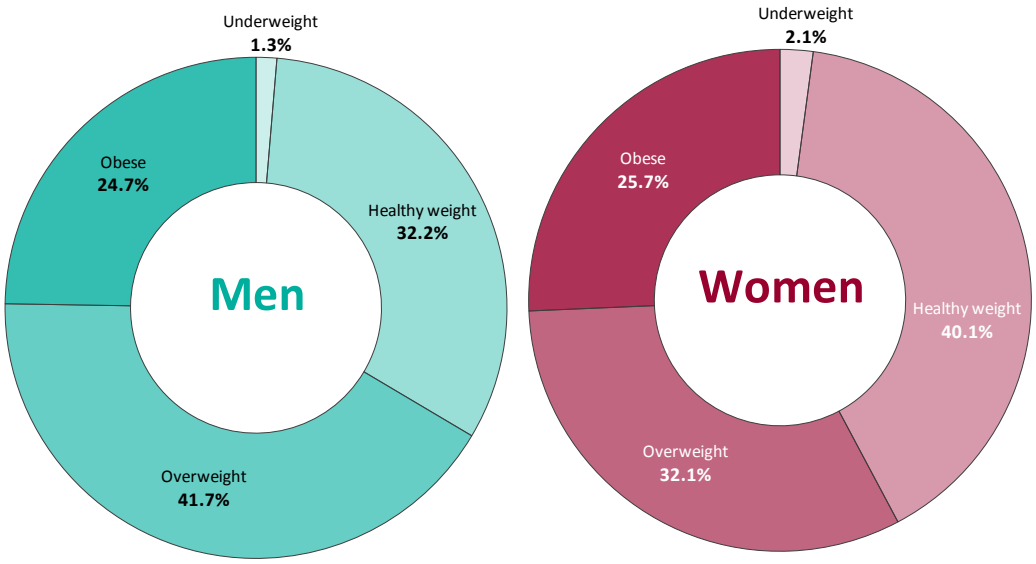

Figure 1: PHE Adult BMI status by Sex: Health survey for England 2010-2012

3. What role should the RCGP undertake?

The RCGP has an important role to support and influence public policy that aims to address obesity. Solutions require comprehensive societal steps to address the obesogenic environment and the major impact that the market economy has on lifestyle choices. The RCGP also has a clear role to include obesity and malnutrition in the postgraduate curricula and assessment processes.

Equally, avoiding malnutrition will impact significantly on the independence and health care needs of our ageing population with accompanying multi-morbidities, meaning that nutritional assessment will be an increasingly important aspect of community care. The RCGP can help by ensuring that any clinical initiatives make due reference to nutrition, e.g. care planning, cancer, dementia, end of life care, kidney care and rare diseases programmes. The RCGP should ensure representation at policy and project meetings that examine and influence aspects of malnutrition awareness and management.

The RCGP has an important role to:

- Support the call for national action on obesity in the NHS Five Year Forward View (6).
- Support the availability of evidence based interventions such as bariatric surgery to be available for GPs to refer patients for in all four of the countries of the UK
- Ensure that obesity and nutrition are covered in the MRCGP curriculum and assessment processes as well as being included as an important part of ongoing postgraduate continuing professional development.
- Support the Academy of Medical Royal Colleges working group on nutrition.
- Highlight the responsibility of Government to address the obesogenic environment through strategies such restricting the targeting of customers at checkouts with confectionery,

advertising high calorie foodstuffs to children, exploring a sugar tax, and the ending of BOGOF and similar price discounting schemes.

4. What is the role of Clinical Commissioning Groups?

- Develop mechanisms whereby the priorities highlighted in the NHS Five Year Forward View and by Public Health England can be actioned in localities.
- Ensure GPs are aware of availability of local services provided by public health and community groups, plus the access criteria and referral mechanisms. (7 8)

4.1 The role of GP members of Clinical Commissioning Groups:

- Raise with their GP commissioners and with their local Health and Wellbeing Board where local services to support overweight and obese patients are inadequate or absent.
- Engage with those people charged with developing services to ensure services are feasible, practical and costed for primary care.

5. What is the role for GPs in the management of obesity?

GPs are not in a position to accept responsibility for the increasing levels of obesity in our society. There are however useful contributions that GPs can make towards the health and wellbeing of people who are obese.

GPs have an important role in:

a) Helping individuals to understand the holistic impact of obesity on their health and to help with their prioritisation of interventions.

John is 39 years old he has a BMI of 33 and smokes 40 cigarettes a day. His GP has an important role in helping him to understand the impact that both of these factors have on his health, using a risk calculation tool where appropriate. For John the evidence would support him stopping smoking first even if this were to lead to an increase in his BMI.

b) Explaining to patients the link that obesity has with other comorbidities and helping people to understand the associated benefits that weight loss may bring with it.

Alice is 65. She has a BMI of 42 and has osteoarthritis of her knees for which she is contemplating surgery. She frequently consults about this and is on Co-codamol 30/500, Tramadol and Naproxen. Her GP has an important role in addressing the presenting complaint as well as highlighting the benefit that would accrue from weight loss, becoming more physically active, and signposting her to appropriate support to achieve behaviour change.

c) Understanding the role of brief interventions and brief messages.

Finn is 6 and comes with his mother because of constipation.
His GP has an important role to highlight the benefit of increasing dietary fibre and to signpost to a resource where the family can get further information, such as NHS Choices website.

d) Targeting efforts to help individuals most likely to benefit from weight loss e.g. those with known pre-diabetes (9, 10, 11) and women before, during and after pregnancy. (12)

Alma, 22, gained 4 stone in her first pregnancy, resulting in her BMI being 32.

Her GP has a role to explain the health benefits of losing her pregnancy weight even if she might be considering another pregnancy, but that this weight loss should be gradual. Signposting to a community slimming group may be appropriate.

e) Understanding the criteria and local referral arrangements for Tier 3 and Tier 4 obesity services, including bariatric referral criteria. (13,14, 15)

Norman, 43, was recently diagnosed with type 2 diabetes. He has tried many diets in the past without success and his BMI is 41.

His GP has an important role to explore whether bariatric surgery may be appropriate, particularly in view of his recent onset diabetes.

GPs have a valuable role in helping patients to access appropriate support at the interface between the social/lifestyle issues of weight management and the medical problems that can accompany obesity, (16) but they do not have a specific role to directly oversee active weight loss attempts. There is clear evidence that running in house weight management programmes are not an effective use of GP time and resources. (17, 18) There is also an escalating need to define the role of GPs in providing support for post-operative bariatric surgery patients. (19)

6. What is the role for GPs in the management of malnutrition?

Both malnutrition and dehydration are safeguarding issues and it is important for GPs to be able to identify vulnerable patients in their care who are at risk of malnutrition and dehydration as well to be able to identify relevant services (20, 21, 22)

In addition to investigating weight loss as a flag of potential underlying pathology, GPs are encouraged to consider treatment of malnutrition, particularly where there is likelihood of surgery, due to the evidence of benefit on length of hospital stay, wound healing and post-operative complications. (5)

7. Summary

The RCGP is committed to taking part in policy discussions about how the nutrition agenda develops in future, and particularly in support of societal and public health measures to address the obesogenic environment e.g. ‘junk-free checkouts’. (23)

The RCGP supports an awareness raising and signposting role for GPs in relation to obesity and malnutrition, particularly emphasising roles that are not undertaken by other health workers, such as risk assessment and conveying perspectives on other aspects of health (such as co-morbidities and anaesthetic risk). Evidence supports GP use of 'brief intervention' messages.

The RCGP supports inclusion of nutritional aspects of health in GP training, by inclusion in the relevant GP curriculum statements (24) and by development of educational materials.

Appendix 1

Evidence to support primary care engagement in obesity

There is a large body of evidence (summarised in Cochrane review table, Appendix and 11) showing that lifestyle change is worthwhile. Weight reduction from lifestyle modification is beneficial and evidence supports the identification of patients in primary care and their sign posting to evidence based behavioural interventions. The evidence base remains challenging due to the need to assess benefits over longer time-scales than many research projects examine and acknowledged difficulties in maintaining lifestyle change in the long term. However, whilst outcomes may be modest – between 5-10% weight reduction may be expected for around a third of attenders at a structured weight management programme, (15) this can translate to significant health gains across a population. Furthermore, many other health gains accrue from lifestyle change, but may be difficult to measure due to inadequate tools to demonstrate changes in fitness, falls risk, emotional well-being, cardiovascular health, cancer risk or dietary quality.

Examples of effective weight management approaches will usefully contribute to the developing evidence base in this area and case examples can be shared at http://www.noo.org.uk/sefsearch.php

There have been gradual changes in attitudes by the public as outlined in the NOO report - Knowledge and attitudes towards healthy eating and physical activity: what the data tell us. (16)

Its key findings show

- Obese and morbidly obese adults are significantly less likely to consider their diet to be very healthy and significantly more likely to report a desire to make healthy changes to their diet, than those of a healthy weight.
- The majority of adults say they would like to make improvements to their own diets. Obese adults are significantly more likely than healthy weight adults to consider this difficult to achieve.

Discussions about the relevance of weight to health are thus commonly welcomed by patients, providing the subject is sensitively and non-judgementally introduced and there is constructive exploration of the patient's perceived barriers to lifestyle change and signposting to appropriate help.

Educational resources

Nutrition web pages http://www.rcgp.org.uk/clinical-and-research/clinical-resources/nutrition.aspx
Six e-learning sessions on obesity and malnutrition http://elearning.rcgp.org.uk/course/info.php?id=147&popup=0
RCPCH child obesity and child growth e-learning sessions http://www.e-lfh.org.uk/programmes/healthy-school-child/access-the-e-learning/
Tackling Obesity through the Healthy Child Programme:- An evidence based framework for action on child obesity that relates to primary care http://www.noo.org.uk/Mary_Rudolf

Cochrane review evidence on obesity interventions
http://www.thecochranelibrary.com/details/collection/1417685/Treatment-of-obesity.html

Health issue	Recommended intervention	Quality of evidence
Women with PCOS, which affects 4-18% of reproductive-aged women	Current evidence suggests that following a healthy lifestyle reduces body weight and abdominal fat, reduces testosterone and improves both hair growth, and improves insulin resistance. There was no evidence that a healthy lifestyle improved cholesterol or glucose levels in women with PCOS.	Cochrane review – 6 RCTs
Interventions for treating obesity in children	This review showed that lifestyle programs can reduce the level of overweight in child and adolescent obesity 6 and 12 months after the beginning of the program. In moderate to severely obese adolescents, a reduction in overweight was found when either the drug orlistat, or the drug sibutramine were given in addition to a lifestyle program, although a range of adverse effects was also noted.	Cochrane review – 64 lifestyle studies and 10 on drug treatment
Obstructive sleep apnoea	Lifestyle modification, especially weight loss, sleep hygiene and exercise, are often recommended. These could help by relieving pressure on the upper airway, and increasing muscle tone in the airway. However, the review found no trials to assess the effects of these strategies, and more research is needed.	Cochrane review – insufficient evidence
Long-term non-pharmacological weight loss interventions for adults with prediabetes	In this review we found that dietary, physical activity, or behavioural interventions produced significant improvements in weight among persons with prediabetes and a significant decrease in diabetes incidence. Modest, but not statistically significant improvements were noted in the few studies that examined blood sugar control, blood pressure, and lipid levels.	Cochrane review 9 studies
Long-term non-pharmacological weight loss interventions for adults with type 2 diabetes mellitus	Weight loss strategies using dietary, physical activity, or behavioural interventions produced small between-group improvements in weight. These results were minimized by weight loss in the comparison group, however, and examination of individual study arms revealed that multicomponent interventions including very low calorie diets or low calorie diets may hold promise for achieving weight loss in adults with type 2 diabetes.	Cochrane review 22 studies
NAFLD	Weight reduction with different measures for treating non-alcoholic fatty liver disease (NAFLD) is recommended, though this is not evidence-based. There seemed to be some beneficial	Cochrane review 5 – insufficient evidence

	effects of lifestyle programme involving restricted diet and physical exercise for NAFLD patients. However, the data were sparse, and meta-analyses could not be performed.	
Weight reduction for primary prevention of stroke in adults with overweight or obesity	Obesity seems to be associated with an increased risk of stroke and it has been suggested that weight loss may lead to a reduction of stroke occurrence. However, this hypothesis is not based on strong scientific evidence resulting from randomised controlled clinical trials.	Cochrane review – Insufficient evidence
Exercise for overweight or obesity	The results of this review support the use of exercise as a weight loss intervention, particularly when combined with dietary change. Exercise has a positive effect on body weight and cardiovascular disease risk factors in people with overweight or obesity, particularly when combined with diet, and that exercise improves health even if no weight is lost.	Cochrane review 43 studies
Low glycaemic index (LGI) or low glycaemic load diets for overweight and obesity	Overweight or obese people on LGI lost more weight and had more improvement in lipid profiles than those receiving Cdiets (conventional diets). Body mass, total fat mass, body mass index, total cholesterol and LDL-cholesterol all decreased significantly more in the LGI group. In studies comparing ad libitum LGI diets to conventional restricted energy low-fat diets, participants fared as well or better on th LGI diet, even though they could eat as much as desired. Lowering the glycaemic load of the diet appears to be an effective method of promoting weight loss and improving lipid profiles and can be simply incorporated into a person's lifestyle.	Cochrane review 6 RCTs
Long-term effects of weight-reducing diets in hypertensive patients	In patients with primary hypertension, weight loss diets reduced body weight and blood pressure. It is not known whether weight loss reduces mortality and morbidity.	Cochrane review – 8 studies
Long-term effects of orlistat in hypertensive patients	Orlistat and sibutramine have been shown to modestly reduce weight. Orlistat also reduced blood pressure	Cochrane review – modified since sibutramine withdrawn
Psychological interventions for overweight or obesity	People who are overweight or obese benefit from psychological interventions, particularly behavioural and cognitive-behavioural strategies, to enhance weight reduction. They are predominantly useful when combined with dietary and exercise strategies. The bulk of the evidence supports the use of behavioural and cognitive-behavioural strategies.	Cochrane review 36 studies – NB new review currently being done
Long-term pharmacotherapy for obesity and overweight	Compared to placebo, orlistat reduced weight by 2.9 kg. Patients on active drug therapy were significantly more likely to achieve 5% and 10%	Cochrane review Sixteen orlistat (n = 10,631),

	weight loss thresholds. Placebo-controlled weight losses were consistently lower in patients with diabetes. Orlistat reduced diabetes incidence, improved total cholesterol, LDL-cholesterol, blood pressure, and glycaemic control in patients with diabetes but increased rates of gastrointestinal side effects and slightly lowered HDL levels.	
Surgery for weight loss in adults	Seven studies compared surgery with non-surgical interventions. One to two years following surgery, BMI was on average 6 units lower than in people who did not have surgery. Improvements in quality of life and diabetes were also found. No deaths occurred, reoperations in the surgical intervention groups ranged between 2% and 13%. Gastric bypass achieved greater weight loss up to five years after surgery compared with adjustable gastric band: the BMI at the end of the studies was on average five units less.	Cochrane review

Further evidence

Health issue	**Recommended intervention**	**Quality of evidence**
A comprehensive list of reviews and evidence briefings	http://www.noo.org.uk/Resources/Reviews	
Tackling Obesity through the Healthy Child Programme:- A clear framework for action on child obesity that relates to primary care	http://www.noo.org.uk/Mary_Rudolf	Comprehensive evidence is included
Managing overweight and obesity in adults – lifestyle weight management services	http://www.nice.org.uk/guidance/PH53 Point of relevance to GPs - Clinical judgement will be needed to determine whether different tier 2 services are suitable for people with conditions that increase the risk of, or are associated with, obesity or who have complex needs.	NICE guideline May 2014
Clinical and cost-effectiveness of long-term weight management schemes for adults: systematic review	http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0016/65311/FullReport-hta15020.pdf	NIHR Health Technology Assessment 2011
Targeting higher risk groups		
Adapting health promotion interventions to meet the needs of ethnic minority	http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0009/64764/FullReport-hta16440.pdf	NIHR Health Technology Assessment 2012

groups		
Evidence to support prevention and treatment of adult malnutrition		
Varied evidence demonstrates the health and cost benefits of managing malnutrition, guidance to improve appropriate prescribing of oral nutritional supplements and social support for patients at risk of malnutrition	https://www.evidence.nhs.uk/search?q=Prevention+and+treatment+of+adult+malnutrition%3A+appropriate+prescribing+of+oral+nutritional+supplements	NICE collation of evidence

Appendix 2

Important 'brief message' concepts
Modest 5-10% weight loss generates important health outcomes in improving CVD risk, hypertension and development of diabetes. (2)
Increasing exercise improves fitness, reduces falls risk, improves self-esteem and well-being, can support recovery from depression, improves diabetic control, reduces hypertension, and is important for weight maintenance after weight loss. BUT it only results in weight loss when accompanied by some degree of calorie restriction.
Improving dietary quality may help bloating, constipation, reduce anaemia and vitamin D deficiency, reduce dental caries, influence cancer risk and diabetic control, BUT, in order to support weight loss, will also require some degree of calorie restriction.
Recommend 'food structures' or a food hierarchy to guide daily decision making about what foods are appropriate for different settings and occasions. E.g. 'save rich treat foods to enjoy at picnics and parties'.
Reduce sugary drinks, which are a well-recognised source of 'empty calories' – ones that have no effect on fullness, but which contribute to weight gain
Any diet or weight management approach which involves calorie restriction could work – the determining step is whether people stick to it. Hence avoid regimes that are overly complex.
Reducing portion size helps weight reduction
Best evidence supports weight loss approaches that combine dietary, physical activity and a behavioural component
Improving lifestyle with improved fitness and dietary quality creates many health gains even if weight is not lost. Sedentary behaviour is an independent risk factor for cardiovascular risk.

References

1. A World Health Organisation Non-communicable diseases factsheet. March 2013 http://www.who.int/mediacentre/factsheets/fs355/en/
2. Avenell A, Broom J, Brown TJ *et al*. Systematic review of the long-term effects and economic consequences of treatments for obesity and implications for health improvement. *Health Technol Assess* 2004; **21**: 1–458
3. Malnutrition in older people statistics, NICE Evidence https://www.evidence.nhs.uk/search?q=malnutrition%20older%20people%20statistics
4. Elia M, Russell CA. Screening for malnutrition in sheltered housing. A Report from BAPEN with the Group on Nutrition in Sheltered Housing (GNASH). Redditch: BAPEN, 2009.
5. Elia M, Russell CA . Combating malnutrition; Recommendations for Action. A report from the Advisory Group on Malnutrition, led by BAPEN. Redditch: BAPEN, 2009
6. NHS Five Year Forward View http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
7. NICE Obesity: identification, assessment and management of overweight and obesity in children, young people and adults http://www.nice.org.uk/guidance/cg189
8. Treating adult obesity through lifestyle change interventions: a briefing paper for commissioners. Mar 2010 www.noo.org.uk/.../vid_5189_Adult_weight_management_Final_22021
9. Norris SL, Zhang X, Avenell A *et al*. Long-term effectiveness of lifestyle and behavioural weight loss interventions in adults with type 2 diabetes: a meta-analysis. *Am J Med* 2004; **117**: 762–774.
10. 13. Knowler WC, Barrett-Connor E, Fowler SE *et al*. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *N Engl J Med* 2002; **346**: 393–403.
11. 14. Tuomilehto J, Lindstrom J, Eriksson J *et al*. Prevention of type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance. *N Engl J Med* 2002; **44**: 1343–1349.
12. Weight management before, during and after pregnancy http://www.nice.org.uk/guidance/PH27
13. NICE Pathways http://pathways.nice.org.uk/pathways/obesity
14. RCGP nutrition pages http://www.rcgp.org.uk/clinical-and-research/clinical-resources/nutrition/obesity.aspx
15. Effective UK weight management services for adults L. McCombie, M. E. J. Lean, D. Haslam Clinical obesity, doi: 10.1111/j.1758-8111.2012.00049.x
16. . Knowledge and attitudes towards healthy eating and physical activity: what the data tell us www.**noo**.org.uk/uploads/doc/vid_11171_**Attitudes**.pdf
17. Jebb SA, Ahern AL, Olson AD,et al. Primary care referral to a commercial provider for weight loss treatment versus standard care: a randomised controlled trial. Lancet. 2011 Oct 22;378(9801):1485-92. Epub 2011 Sep
18. Jolly K, Lewis A, Beach J, Denley J, Adab P, Deeks JJ, Daley A, Aveyard P. 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. 2011 Nov 3;343:d6500. doi: 10.1136/bmj.d6500.
19. BOMSS Guidelines on peri-operative and postoperative biochemical monitoring and micronutrient replacement for patients undergoing bariatric surgery, Sept 2014 http://www.bomss.org.uk/wp-content/uploads/2014/09/BOMSS-guidelines-Final-version1Oct14.pdf

20. Care Quality Commission. Guidance about compliance. Essential standards of Quality and Safety – What providers should do to comply with the section 20 regulation of the Health and Social Care Act 2008. March 2010 http://www.cqc.org.uk/sites/default/files/documents/gac_-_dec_2011_update.pdf
21. Managing Adult Malnutrition in the Community http://www.malnutritionpathway.co.uk
22. Ftouh S, Thomas M; Acute kidney injury: summary of NICE guidance. BMJ. 2013 Aug 28;347:f4930. doi: 10.1136/bmj.f4930.
23. 20% 'Fat tax' needed to improve population health http://www.bmj.com/press-releases/2012/05/14/20-%E2%80%9Cfat-tax%E2%80%9D-needed-improve-population-health
24. RCGP curriculum statements http://www.rcgp.org.uk/gp-training-and-exams/gp-curriculum-overview.aspx