OBESITY CARE PATHWAY TOOLKIT
- Annexes 1 to 9

This care pathway and toolkit has been developed by a multi-disciplinary group of healthcare professionals for use by healthcare professionals

NOF EXPERT COMMITTEE 2005

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A patient-led NHS

A robust, weight management service should:
• be based on best evidence, where ever possible
• deliver a desired outcome for the user that will improve health
• be cost effective to the PCT or user
• be supported by primary care staff, particularly GP’s.

The service should offer options that meet the majority of people’s needs and one that they feel is appropriate, accessible and relevant to them. However, there will be specific target groups, such as learning or physical disabilities, black and ethnic minorities, low socio-economical groups, that will need additional services/planning.

It is essential that services be developed in consultation with the users and people who will be delivering them, working together as a multi-disciplinary group.

Training on weight management control, healthy eating and increasing physical activity to health professionals is necessary to ensure consistent, accurate and up to date messages are given to patients at all times.

Currently, very few NHS weight management services are monitored or audited, this will be a must in the future and needs to be built in at the planning stage. The feedback will result in improved services to patients.

We suggest that a weight management service should/could encompass the following (this list is not definitive, but is offered a suggestion, based on our experience):

• A choice of services at various locations should be available so people’s needs are met. These could be:
  o at GP practices, delivered by practice nurses, health care assistants or possibly community dietitians - practices could get together to form a “cluster group” as a way of sharing costs.
  o via Community pharmacists - it has been shown that this is a particularly good route to reach minority groups.
  o through community centres, healthy living zones and secondary care specialist services - most patients would be able to access and afford these type of services this way.
  o via commercial weight loss schemes such as Rosemary Conley, weight-watchers or slimming world - such schemes are funded by
some PCT’s, thereby reaching people in deprived areas who wouldn’t normally be able to afford these programmes.

- In order to be sustainable, healthy weight loss needs to be part of a programme that encourages a change in everyday behaviour. As will all behavioural-based interventions, patients will need to be supported through a range of services, dipping in and out as required.

- Ensure Patient and Public Involvement (PPI)

- Racial diversity awareness

- Disability Discrimination Act compliance. This means in all its forms:
  - ramps to get up to the clinics
  - scales which take patients over 120kg
  - tape measures which are long enough
  - awareness of sensitive issues such as small toilets/cubicle areas
  - training for all staff coming in contact with the patient

- Services should be tailored to ensure access to all regardless of racial or social background
**Referral from Tertiary care back to primary care**

This grouping encompasses a number of conditions for which weight loss is the primary treatment, these include:

- Fertility problems
- Sleep apnoea
- Patients whose BMI prevents them undergoing surgery

Note> active management of waiting lists - screening patients by BMI/waist circumference - ensuring where necessary patients’ enrols on a weight management programme should be encouraged.
Patient Motivation- are they ready?

It is preferable to use a qualitative tool to assess if the patient is ready to lose weight. The following tool is based on the work of Prochaska and Diclemente and has been used by the CounterWeight Programme.

Questions to ask the patient (can be given in the form of a questionnaire before calling patients into the clinics)

1. In the past month, have you been actively trying to lose weight?
   Y/N
2. In the past month, have you been actively trying to keep from gaining weight?
   Y/N
3. Are you seriously considering trying to lose weight to reach your goal in the next 6 months?
   Y/N
4. Have you maintained your desired weight for more than 6 months?
   Y/N

<table>
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<tr>
<th>Stage</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>These patients are not considering losing weight in the next 6 months. Discuss benefits of weight loss and risks of not changing. Reassess readiness to change at future appointments</td>
</tr>
<tr>
<td>Contemplation</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>This group includes those patients who are seriously considering losing weight. Refer to treatment algorithm</td>
</tr>
<tr>
<td>Action</td>
<td>Y</td>
<td></td>
<td>N</td>
<td>Patients who are actively trying to lose weight or who have been successful but for less than 6 months. Reinforce all changes &amp; encourage. Give additional support as required</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Y</td>
<td></td>
<td>Y</td>
<td>Patients who have successfully maintained their weight loss for at least 6 months. Reinforce all changes and encourage.</td>
</tr>
</tbody>
</table>
If the patient is at contemplation, action or maintenance position on the cycle of change he or she is appropriate for a weight management intervention.
Baseline Data

Primary prevention of chronic disease is a priority, rather than waiting for a coronary event to occur or type II diabetes to be diagnosed. Identification of candidates for chronic disease by increased waist circumference, coupled with raised markers: BP; glucose; and cholesterol, and proactively treating obesity is essential.

A 10% weight reduction has been shown to reverse the progression of type II diabetes in 50% of cases, reduce obesity-related mortality by 40% and reduce or minimise significant morbidities associated with obesity¹.

Critical essential measurements and investigations needed to assess a patient's risk
- BMI (weight & height)
- Waist circumference
- Blood Pressure
- Fasting blood glucose
- Fasting lipid profile
- Thyroid function

Useful baseline information

History
- Medical history including all other co-morbidities
- Ethnicity
- Family history of diabetes, CHD, stroke, endocrine disorder
- History of gestational diabetes
- History of infertility, Polycystic ovaries, hirsutism, dysfunctional uterine bleeding
- Contraceptive history
- Dietary history

Direct Questioning for symptoms of co-morbidities
- Polyuria, polydipsia
- Breathlessness on exertion
- Chest pain, palpitations
- Abnormal fatigue or daytime somnolence: snoring
- Intermittent claudication, peripheral vascular disease or symptoms or other circulatory disorders
- Menstrual disorders
- Erectile dysfunction
- Depression
- Hip & knee joint problems

¹ Scottish Intercollegiate Guidelines Network, 1996
Assess Readiness to Change, consider:
- Motivation to change behaviour
- Confidence to make the changes
- Barriers to change

Social history
- Fitness rating
- Alcoholism/smoking status
- Mental history-depression, low self esteem, psychosis, suicide ideation, anorexia, bulimia
- Drug use, especially 'slimming drugs/amphetamines, metformin, anti-inflammatory medication, diuretics.

Note> Drugs that may cause Weight Gain
- antipsychotics esp: olanzepine (Zyprexa)
- antidepressants : tricyclics, SSRI’s, MAOIs & mirtazepine (Zispin) and Lithium
- corticosteroids : all corticosteroids may promote weight gain by 2 mechansisms : fat redistribution causing truncal obesity, buffalo hump & moon face, and fluid retention via mineralocorticoid effects.
- OCP : progestogenic compounds
- β-blockers : not only do these agents cause weight gain, they may restrict physical activity due to fatigue.
- oral hypoglycaemins : Numerous agents shown to increase weight. Most sulphonylureas (except glimepiride) Glitazones.
- insulin
- anticonvulsants : weight gain has been documented with some agents (phenytoin sodium)
- valproate). Topiramate (topamax) is weight neutral or may cause weight loss.
- antihistamines : many antihistamines may cause weight gain though these effects are more pronounced with older agents.

Blood / urine tests
- FBC
- LFT for NASH
- HbA1c / glucose tolerance test if appropriate
- Microalbuminuria if indicated
- Hormone profile if indicated
- Sleep studies, CXR, ecg or other tests as indicated
Key Advice on Healthy Eating

Being overweight is usually a result of an imbalance between the energy taken in (food & drink) and energy used (activity). Typically this imbalance is only small (50-100 extra calories daily), but over time this leads to obesity.

Successful weight control (management) is about learning new healthy eating habits for life, not as a short-term solution. Managing your weight means developing new habits, and changing behaviour is the key.

Use of a food and activity diary should be encouraged as a simple way for patients to start really understanding what they doing well and where improvements to a healthier lifestyle could be made.

Healthy Eating Advice can be kept to a simple 3-point plan:
1. establish regular meals – including breakfast
2. balance food groups - all foods can be part of healthy eating, just keep to the right balance
3. reduce portion sizes – eating too much of any food group can lead to weight gain

Key messages:
- Eat a wide variety of foods and enjoy your meals
- Eat 3 regular meals a day
- Eat a balanced diet and include foods from the 5 food groups:
  - Have at least 5 portions of fruit and vegetables each day
  - Base your meals on starchy foods such as bread, other cereals and potatoes
  - Have 2-3 portions of milk and dairy foods each day
  - Choose moderate amounts of meat, fish and alternatives
  - Limit the amount of fatty and sugary foods and drinks
- Include fibre containing foods – wholemeal bread, beans & pulses, fruit & vegetables
- Be careful not to use too much salt
- Drink plenty of fluids – 6 to 10 cups or glasses a day
- Check food labels – complex/processed foods often contain high quantities of fat, sugar & salt putting these into the fats &

2 DH etc
sugars food group – meaning the amount eaten should be limited.

**Weight Loss Goals**
Aim for 5 to 10% weight loss in 3 to 6 months  
Set small, achievable goals each week

There is a lot of, often contradictory, information out there about diets and healthy eating. For example, considering the Glycemic Index (GI) of a food can be useful in helping maintain consistent energy levels throughout the day (unfortunately this concept can be complicated). **Initially it is better to keep to the simple 3-point plan – dealing with each in turn – to help a patient learn healthy eating habits** - if a patient is eating 6 pieces of toast each morning - changing to 6 slices of granary toast will not help, but reducing it to 2 slices will.

**Few tips to help you Eat Smart:**
- Try not to eat on the run (have regular meal times)  
- Drink a glass of water before starting a meal, this will help you feel full  
- Start meals with a low fat soup and/or salad to fill you up  
- Watch your portion sizes – use a smaller plate  
- Avoid second portions – it takes time for your brain to recognise your stomach is full  
- Eat slowly and take time to enjoy your meals  
- Clear the table after meals to avoid picking at leftovers

**Few tips to help you Shop Smart:**
- Learn to read food labels – choose foods that have no more than 3 – 5grams of fat per 100 grams of product  
- Use a shopping list, and don’t buy anything not on the list  
- Try noo shop when you are hungry  
- Buy low-fat alternatives, i.e. skimmed milk & lower fat cheeses  
- If eating margarine or butter – scrape it on thinly (use sparingly)  
- Fill your shopping trolley with plenty of vegetables, fruit, grains (pasta, rice), breads & cereals

**Few tips to help you Cook Smart:**
- Cut all visible fat off meat and remove skin from poultry before cooking  
- Use less cooking oil by using non-stick cookware  
- Bake, grill, steam, microwave or stir-fry – try not to fry  
- Use fewer creamy dressings or sauces – look for low-fat or oil-free dressings  
- Don’t prepare more than you need
Key Points on Physical Activity

Physical activity plays an important part in the prevention and management of obesity, but only if it is sustainable. **Adherence to physical activity over the life course is the goal** to which patients and professionals should aim. Following a short-term programme will have limited effectiveness in long term weight management. **Clients who increase their physical activity maintain their weight loss for longer**.3

Prescribing protocols highlight lifestyle management of obesity as a first line intervention, and behavioural interventions should be given a fair chance before decisions to prescribe medication are made. Practitioners should therefore ask themselves whether patients are being given a quality assured physical activity intervention.

What is a quality assured lifestyle intervention?
This can usefully be defined as one which:

- Clarifies the expectations of each professional in the care pathway, relative to other professionals. **For example, is a formalised assessment of readiness to change behaviour expected within a short opportunistic GP consultation, or is dedicated practice nurse or exercise professional time to be made available?**

- Is sufficient patient contact time given for the achievement outcome? **For example, negotiating a physical activity programme with the client, and discussing likely outcomes and expectations is likely to need dedicated time which may not be available during an opportunistic client visit**

- Is based on evidence of characteristics of effective interventions. **For example, how does an exercise referral scheme need to change to incorporate what we know about achieving client adherence over the longer term?** (See below)

- Has a clearly defined outcome measure and evaluation method that shows you whether or not you have achieved your aim. **For example pre programme and post programme fitness assessments may show changes in waist circumference but will not measure adherence over the longer term, which is an important goal. This could be recorded via a self reported or prompted physical activity diary or questionnaire**

3
• Influences the overall care pathway. For example, if the patient loses inches it should inform a clinical decision about whether to defer or avoid prescribing medication. Operating a physical activity intervention in isolation from the rest of the care pathway should be avoided

• Has a meaningfully recordable outcome that can be added to patient notes, either electronically or on paper. For example, being able to record, in real time, key elements of a physical activity action plan negotiated with a client during the consultation

• Can have its outcomes conveniently fed back to primary care staff to ensure systemic use and continuous review and refinement. For example, sharing data on client’s adherence and any physiological changes associated with increased physical activity during practice meetings to maintain the projects profile within a broader care pathway

**KEEPING people active over time – what works?**
Reflection on how schemes incorporate characteristics of known effective interventions may help increase longer-term adherence. Review level evidence of healthcare and community settings suggests that:

• Referral to an exercise specialist in the community can lead to longer term (>8 months) changes in physical activity
• Interventions based on behaviour change theories, which teach behavioural skills and are tailored to individual needs, are associated with longer term changes in behaviour than interventions without a theoretical base
• Interventions that promote moderate intensity physical activity, particularly walking, and are not facility dependent, are also associated with longer term changes in behaviour
• Studies that incorporate regular contact with an exercise specialist tend to report sustained changes in physical activity


The benefits of securing access to a physical activity practitioner, in much the same way as primary care currently refers to a dietitian, soon become apparent, particularly where specialist technical knowledge about exercise and adaptations to exercise are concerned.
Top tips for brief physical activity interventions

- Discuss the energy balance to help clients understand the role of physical activity in the context of obesity rather than as an isolated behaviour.
- Help the client assess their readiness to become more active using open questions such as “how ready do you feel to become more active, and why?”
- Work through the course of a client’s average day and ask them to identify opportunities where they could be more active.
- Encourage the client to start gently and build up gradually.
- Know the national recommendations for physical activity (5 x 30 minutes – can be broken into 10 or 15 minute bouts - of moderate intensity physical activity, defined as anything which makes you feel warm and breathe harder than normal for prevention of ill health; 60 minutes for weight loss).
- Know the limitations of the national recommendations – obese individuals may have low exercise tolerance and their small first steps are unlikely to produce significant weight loss.
- Ensure the client has realistic expectations, and pick up on any other positives which the client associated with physical activity besides weight loss.
- Anyone can (and should) advocate brisk walking, but formalised exercise programmes, should be left to exercise professionals who have experience and qualifications in working with “special” populations. Exercise professionals who are members of the Register of Exercise Professionals (REPS) have a means of demonstrating their competency in this area.
- People who wish to go back to organised or competitive sports, which carry an increased risk of injury associated with obesity, should be advised to start gradually and choose a relatively safe activity (such as walking). For example, an overweight or obese male who played squash in previous years and wants to return to the game could usefully be advised to lose weight and build cardiovascular fitness. The adage “get fit to play squash, don’t play squash to get fit” is equally applicable to a number of sporting activities for people carrying excess weight.
Examples of activity and energy expenditure

<table>
<thead>
<tr>
<th>Physical Activity</th>
<th>Energy expenditure Kcalories/hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awake, lying still</td>
<td>77</td>
</tr>
<tr>
<td>Dusting</td>
<td>150</td>
</tr>
<tr>
<td>Walking on level ground</td>
<td>200</td>
</tr>
<tr>
<td>Swimming</td>
<td>260</td>
</tr>
<tr>
<td>Walking upstairs</td>
<td>960</td>
</tr>
</tbody>
</table>

A simple place to start is to draw up a directory of local services designed to encourage an increase in physical activity. Some services will already exist that the patient can use, but adherence is more likely to occur if the patient chooses his or her activity, either from a list of known options or from their own experience/knowledge.
Integrated weight management programmes

Initial Review
After looking at baseline data, consider
- Level of motivation & position on cycle of change
- Integrated planning
- Healthy eating dietary advice, preferably written. Encourage an energy deficit of approx 500 kcals/day
- Physical activity programme
- Behavioural counselling. Encourage self monitoring of goals using a food and activity diary
- Local support network (family, friends)
- Community support network
- Use of commercial enterprises
- Need for pharmacotherapy
- Offer detailed advice regarding risk factors and co-morbidity

Refer if special considerations

<table>
<thead>
<tr>
<th>Special considerations</th>
<th>Refer to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Diabetes integrated care service</td>
</tr>
<tr>
<td>CHD</td>
<td>Check if patient is under care of cardiac specialist nurse</td>
</tr>
<tr>
<td>Poor mobility</td>
<td>Refer to physiotherapy or rheumatology clinics</td>
</tr>
<tr>
<td>Lack of exercise</td>
<td>Give general advice but also use exercise referral schemes, walking for health, green gym etc</td>
</tr>
<tr>
<td>Special dietary requirements/restrictions</td>
<td>e.g. renal disease, allergies, coeliac disease. Enlist specialist dietetic support</td>
</tr>
<tr>
<td>Psychological problems</td>
<td>Refer for counselling</td>
</tr>
<tr>
<td>Mental health problems</td>
<td>Refer to psychiatric service</td>
</tr>
</tbody>
</table>

Review 2
- Preferably within a month
- Review food & activity diary
- Discuss specific difficulties i.e. triggers etc
- Weight, waist circumference, Blood Pressure
- Use of patient held record cards
- Motivation and positive encouragement
- Behavioural and lifestyle changes
- Treatment plan changes
- Agree realistic goals for next visit
Ongoing Review

Continue with review/monitoring cycle. If successful, review every 6 months. If unsuccessful, consider

- Changing dietary emphasis e.g. more fibre, less fat, spreading meals
- Reducing triggers, e.g. different route to work, change time of eating, place meal is taken
- Re-emphasise health risks & relative risks
- Personalise diet plans
- Re-run motivation questionnaire, try to identify stumbling blocks
- Check medication (certain drugs can precipitate weight gain e.g. gliclazide)
- Re-check co-morbidity i.e. diabetes, CHD, heart failure, COPD, thyroid disease, hypertension, depression
- Consider anti-obesity drugs if not used before
- Enlist specialist dietetic support. Check times of clinic are suitable for the patient
- Enlist help of support groups i.e. family support, ‘buddy system’, commercial slimming groups
- Identify any problems with exercise- FITT programme, walk for life etc
- Make goals SMART!!
- Consider patient choice

If patients are gaining weight or have increased co-morbidity

- Enlist help of specialist weight management clinics
- Consider surgery
- Give clients the opportunity to re-enter the programme at any time.

Great patient leaflets to consider using:

- So you want to lose weight for good? – British Heart Foundation/Faculty of Public Health Obesity Toolkit
- Getting the balance right – British Meat Education Service
- Patient resources & leaflets – DOM UK
Running a successful weight management clinic

A few key tips on what differentiates a successful weight management clinic:

- Protected time for all involved to run the clinic
- GP & HCP understanding of and commitment to the care pathway, how pharmacotherapy is to be used
- Agreed strategy for who intervenes with the patient and how support is maintained
- Screening and patient selection
- GPs pivotal role in motivating and influencing patients
- Goals set for patient recruitment, with targets to reach
- Specific criteria set for how recruitment will occur
- Do not limit service only to those with long term, malignant obesity, recruit mixture of patients – the success of the clinic is significantly increased with progressive patient weight loss.
- Weight management seen as a priority to the whole practice
- Regular review of the progress, check if targets are being met
- Audit cycle- what could be improved or built upon? What could be done differently?
- Sharing best practice with other health care professionals
- Engaging the PCT and patient focus groups
## At Risk

<table>
<thead>
<tr>
<th></th>
<th>Satisfactory</th>
<th>Increased risk</th>
<th>High risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-asian males</strong></td>
<td></td>
<td>≥ 94 cm ≥ 25 kg/m²</td>
<td>&gt; 102 cm ≥ 28 kg/m² + comorbidities &gt; 30 kg/m²</td>
</tr>
<tr>
<td>&lt; 94 cm</td>
<td>&lt; 25 kg/m²</td>
<td>≥ 25-28 kg/m²</td>
<td></td>
</tr>
<tr>
<td>&lt; 25 kg/m²</td>
<td>≥ 28 kg/m²</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Asian males</strong></td>
<td>≥ 94 cm ≥ 25 kg/m²</td>
<td></td>
<td>&gt; 102 cm ≥ 28 kg/m² + comorbidities &gt; 30 kg/m²</td>
</tr>
<tr>
<td>&lt; 85 cm</td>
<td>&lt; 23 kg/m²</td>
<td>≥ 23-26 kg/m²</td>
<td></td>
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<tr>
<td>&lt; 23 kg/m²</td>
<td>≥ 26 kg/m²</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-asian females</strong></td>
<td></td>
<td>&gt; 80 cm &gt; 28 kg/m² + comorbidities &gt; 30 kg/m²</td>
<td></td>
</tr>
<tr>
<td>&lt; 80 cm</td>
<td>&lt; 25 kg/m²</td>
<td>≥ 25-28 kg/m²</td>
<td></td>
</tr>
<tr>
<td>&lt; 25 kg/m²</td>
<td>≥ 28 kg/m²</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Asian females</strong></td>
<td></td>
<td>&gt; 85 cm &gt; 26 kg/m² + comorbidities &gt; 28 kg/m²</td>
<td></td>
</tr>
<tr>
<td>&lt; 80 cm</td>
<td>&lt; 23 kg/m²</td>
<td>≥ 23-26 kg/m²</td>
<td></td>
</tr>
<tr>
<td>&lt; 23 kg/m²</td>
<td>≥ 26 kg/m²</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BMI categories The Lancet Vol 363 Jan 10 2004
Waist Circumference Diabetes Care Vol 26 No. 5 May 2003

### Obesity can be a risk factor in the following conditions:

- Diabetes
- Coronary heart disease
- Cardiovascular disease
- Hypertension
- Dislipidaemia
- Osteoarthritis
- Cancer including colon, breast, ovarian, prostate, liver, endometrial, renal and rectal
- Respiratory including sleep apnoea
- Fertility problems including PCOS
- Complications in pregnancy
- Gallstones
- Mental health – major depression & suicide
- Joint disorders including gout
- Possible link to Alzheimer’s

Please note this is not an exhaustive list.
Useful Contacts

(web pages /sites to be hyperlinked where available)

BHF National Centre for Physical Activity and Health  
www.bhfactive.org.uk
British Meat & nutrition education service  
www.meatandhealth.com
British meat Education Service  
www.bnesonline.org.uk
Cancer Research UK  
www.cancerresearchuk.org
Department of Health, England  
www.dh.gsi.gov.uk
Department of Health, Wales  
www.wales.gov.uk/subihealth
Diabetes UK  
www.diabetes.org.uk
DOM  
www.domuk.org
Food Standards Agency  
www.foodstandards.gov.uk
Health Education Board for Scotland  
www.hebs.scot.nhs.uk
Health Promotion Agency Northern Ireland  
www.healthpromotionagency.org.uk
Heart UK  
www.heart.org.uk
National Heart Forum  
www.heartforum.org.uk
National Institute for Health and Clinical Excellence (NICE)
  - orlistat guidance  
    www.nice.org.uk/pdf/orlistatguidance.pdf
  - sibutramine guidance  
    www.nice.org.uk/pdf/SIBUTRAME%2031%20GUIDANCE.pdf
  - obesity surgery  
    www.nice.org.uk/pdf/Fullguidance-PDF-morbid.pdf
  - Scope document for Obesity Clinical Guidelines  
NHS Direct  
www.nhsdirect.nhs.uk
Patient support programmes
  - MAP  
    www.xenicalmap.co.uk
  - Change for Life  
    www.changeforlifeonline.com
Ramblers Association  
www.walkingworld.com
Rosemary Conley  
www.rosemary-conley.co.uk
Slimming World  
www.slimming-world.com
SPORT ENGLAND  
www.sportengland.org
TOAST  
www.toast-uk.org.uk
Weight-watchers  
www.weight-watchers.co.uk