A Practical Resource Pack to Support Primary Care Practitioners in the Management of Overweight or Obese Patients

Production team:

Emma Davis—Health Improvement Practitioner Specialist

Jacqui Fox—Public Health Information Specialist

Editorial team:

Greg McGrath—Health Improvement Manager

Katie Needham—Public Health Consultant

Dr Jane S Carradine—Beech House Surgery, Knaresborough

North Yorkshire and York

Contents

Introduction	2
Quick Reference Pathway	3
Assessment	5
Level 1—Universal Service	8
Follow Up	12
Levels 2 and 3—Community and Specialist Services	13
Level 4—Morbid Obesity Surgery	16
Resources	17
References	19

Attachments:

- Readiness Ruler
- Integrated Weight Management Service Model for Adults
- Weight Management Signposting
- Weight Management Packages

December 2010 **Version 1.4**

Introduction

This resource pack is for health professionals including the GP, practice nurse, health visitor or pharmacists. This resource has been developed in North Yorkshire and York to enable health professionals to support, assess, advise, discuss, negotiate and signpost adult patients appropriately who are overweight and obese using evidenced based information and practical resources.

The proposed North Yorkshire and York integrated care pathway for adult weight management services identifies the different services that require planning, investment and commissioning along a care pathway, ranging from prevention through to treatment in accordance with NICE guidance. Implementing this pathway is currently challenging due to the significant investment required. This resource has been developed to support **Level 1 (universal and preventative services)** of this care pathway to improve overweight and obese patients' health and wellbeing. Primary Care colleagues who are considering investing or setting up Level 2 services in house or in the community.

Prevalence of overweight and obesity has trebled since the 1980s, and over half of all adults are either overweight or obese (Health Survey for England, 1995-2003)[1]. This equates to approximately 24 million adults, a high proportion of these will not have been identified and classified as overweight or obese.

Obesity is a complex disease and there are increasing demands being placed on primary care to identify and treat patients. General practice is however, where most obese and overweight individuals will come into contact with health services and it remains the publics preferred source of food and health information. It is therefore, the ideal opportunity to identify and manage obesity. In addition, general practices are encouraged to maintain an obesity database of all patients recorded as obese. Collecting data on the heights and weights (BMI) of patients within a practice allows the magnitude of the problem of obesity to be assessed within individual practices.

A list of community weight management packages have been collated, to guide health professionals to the most popular and well researched options for managing and treating overweight and obese patients, if resources were available at a practice or cluster level. Please note that this list is not exhaustive .

Identification may occur under one of four categories:

- **Opportunistic**
- **Existing Disease** (e.g. type 2 diabetes, coronary heart disease, hypertension)
- **Health Screening** i.e. NHS Health Checks
- **Patient Seeking Advice**

IDENTIFICATION

1. Opportunistic
2. Existing Disease
3. Health Screening
4. Seeking Advice

Health Professional

GP, Practice Nurse, Health Visitor, Pharmacist, Health Care Assistant

ASSESSMENT

1. Height and weight—BMI
   BMI = weight (kg)/height (m^2)
2. Waist circumference
3. Patient History
4. Raise issue of weight (DH)
5. Assess readiness and motivation to change

Classification	BMI (kg/m2)	Waist Circumference		Co-morbidities present
		Low Men < 94cm Women < 80cm	High Men > 94cm Women > 80cm	Type 2 diabetes Hypertension Cardiovascular Disease Dyslipidaemia Osteoarthritis Sleep Apnoea
Healthy weight	18.5-24.9			
Overweight	25.0-29.9			
Obesity I	30.0-34.9			
Obesity II	35.0-39.9			
Obesity III	> 40.0			

Level 1—General Advice on losing weight, healthy eating and physical activity (DH - *Why Weight Matters* card). Offer follow-up appointment.

Level 2—Diet and physical activity

Level 3—Diet and physical activity; consider drugs

Level 4—Diet and physical activity; consider drugs; consider surgery. (Only available in North Yorkshire and York BMI ≥ 50

Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. National Institute for Health and Clinical Excellence 2006[2]

LEVEL 1 UNIVERSAL

Lifestyle assessment by health professional to increase physical activity and healthy eating using behavioural change techniques.

ASSESS

Discuss current lifestyle, diet and levels of physical activity.

ADVISE

Advise on dietary, physical activity and lifestyle modifications.

AGREE

Establish individual goals and a realistic weight management plan (5-10% weight loss).

Negotiate the most effective method of managing weight loss/ maintenance.

ASSIST/ARRANGE

Signpost to local physical activity and healthy eating initiatives.

FOLLOW UP

Monitor weight loss: suggested minimum is 3 and 6 months, or more often if patient wanting active support.

Quick Reference Pathway

LEVEL 2 COMMUNITY

Community/Primary Care Services

- Pharmacology
  $\geq$ 28kg/m^2 with comorbidities or $\geq$ 30kg/m^2
- Specialist weight management clinics $\geq$ 30 kg/m^2

NOT CURRENTLY AVAILABLE IN NHS NORTH YORKSHIRE AND YORK

Please see community weight management packages for setting up your own weight management service

LEVEL 3 SPECIALIST

Specialist weight management services MDT

- Specialist nutritional advice
- Psychotherapy
- Pharmacotherapy
- Physiotherapy

GP Assessment

Pharmacotherapy

Orlistat

- >30 kg/m2
  >28 kg/m2 plus co-morbidity
- Continue treatment if 5% weight loss at 3 months (less strict goals may be appropriate for people with type 2 diabetes).
- Continue for longer than 12 months (usually for weight maintenance).

Alli

- Non-prescription weight loss aid needs comprehensive support to change eating habits.
- Ensure they follow a healthy, calorie controlled, low fat eating plan to effectively and safely promote weight loss and to avoid any side effects of Alli.

NOT CURRENTLY AVAILABLE IN NHS NORTH YORKSHIRE AND YORK.

LEVEL 4 SURGERY

Bariatric Surgery

NHS North Yorkshire and York Individual Funding Request Panel where specific exceptional circumstances apply.

- For patients
  > 50 kg/m2
  > 45 kg/m2 plus co-morbidity.
- Further assessment in hospital including a psychological assessment.

Clinicians must ensure that all other alternatives on the pathway (diet, physical activity and pharmacotherapy) have been tried before considering surgery.

MAINTENANCE

Ongoing monitoring of weight should take place to ensure that patients are supported and referred back into the pathway should they have a relapse in weight management.

Assessment

The best way to assess obesity and overweight and associated health risks in a patient is to use a combination of Body Mass Index, waist circumference, and patient history (co-morbidities). Table 1 assists with the accurate classification of patients and can be completed once BMI and waist circumference have been measured and patient history/co-morbidities have been assessed.

1 **Body Mass Index (BMI)** is used to measure the degree of overweight and obesity. The BMI is calculated by dividing a patient's weight in kilograms by the square of their height in metres.

$$\text{BMI} = \frac{\text{weight (kg)}}{\text{height (m}^2\text{)}}$$

Classification of Body Mass Index is outlined in Table 1.

- All patients should have their BMI recorded and changes monitored over time.
- Increasing weight in **Asian adults** is associated with a higher risk. Risk factors, therefore, may be of concern at lower BMIs.
- Clinical judgment is required when classifying **muscular patients** because BMI may overestimate the degree of fatness in these patients.

2 Waist Circumference

The World Health Organisation guidance recommends that waist circumference be measured using the midpoint between the lowest rib and top of the right iliac crest. The tape measure should sit snugly but not compress the skin. This is categorised as either high or low and different cut-off values are used for men and women.

	LOW	HIGH
Men	**< 94cm**	**> 94cm**
Women	**< 80cm**	**> 80cm**

3 Patient History and Co-morbidities

A patient history (including family history) is required to assess whether any co morbidities are currently present or whether further tests may be required for diagnosis in certain patients. NICE (2006)[2] states that the following co-morbidities should be recorded:

- type 2 diabetes
- hypertension
- cardiovascular disease
- dyslipidaemia
- osteoarthritis
- sleep apnoea.

Assessment

Table 1: Classification of adults

Classification	BMI (kg/m2)	Waist Circumference		Co-morbidities present
		Low Men < 94cm Women < 80cm	High Men > 94cm Women > 80cm	Type 2 diabetes Hypertension Cardiovascular Disease Dyslipidaemia Osteoarthritis Sleep Apnoea
Healthy weight	18.5-24.9			
Overweight	25.0-29.9			
Obesity I	30.0-34.9			
Obesity II	35.0-39.9			
Obesity III	> 40.0			

Level 1—General Advice on losing weight, healthy eating and physical activity (DH - *Why Weight Matters* card). Offer follow-up appointment.
Level 2—Diet and physical activity
Level 3—Diet and physical activity; consider drugs
Level 4—Diet and physical activity; consider drugs; consider surgery (only available in North Yorkshire and York BMI $\geq$ 50

Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. National Institute for Health and Clinical Excellence 2006[2]

This table can be used as a guide to identify the level of intervention suitable for that patient.

Tick the boxes to signpost you to the correct level of intervention.

Assessment

This stage needs to be handled carefully because many patients who are overweight or obese are sensitive about their weight.

Raising the Issue of Weight

Consider using the 'Raising the Issue of Weight in Adults'[3] card from the Your Weight, Your Health series, DH 2006 which provides helpful samples of dialogue for initiating a conversation about the patient's weight.

Assess Readiness and Motivation to Change

The Transtheoretical (Stages of Change) Model (Prochaska and DiClemente, 1982)[4] attempts to describe readiness to change and suggests that people move through a series of stages when attempting to change their behaviour.

The model has gained widespread popularity and has intuitive appeal to many practitioners. However, although it provides a useful framework for thinking about behaviour change, it has been criticised for being deficient in providing insight into how to negotiate/influence behaviour change.

Readiness can be understood and roughly assessed by enquiring about the importance of change to the patient and the degree of confidence the patient has in his/her ability to do so.

The stages are outlined below:

PRECONTEMPLATION
Not intending to make any changes (Patient not interested in losing weight)
CONTEMPLATION
Considering a change (Patient is thinking about trying to lose weight)
PREPARATION
Making small changes (Patient is making small changes/ developed a plan of action)
ACTION
Actively engaging in change (Patient is making changes to their lifestyle to try and lose weight)
MAINTENANCE
Sustaining change over time (Patient has lost weight and is maintaining)

Readiness Ruler

Another resource for assessing motivation to change is the Readiness Ruler[5]. When discussing lifestyle with an individual there are two main questions that provide a lot of information about readiness for change. Ask the individual:

1. How important is it for you to make a change?
2. How confident do you feel you can make changes to your lifestyle?

Ask individuals to indicate their best answer to each question. (Remember they may be at different stages of readiness to change for each lifestyle behaviour you may discuss.) Use the scale to help you quantify readiness.

Level 1

The aim of advice is to help a patient to:

- reduce calorie intake
- increase physical activity while reducing sedentary behaviours
- and increase self-awareness about day-to-day behaviours that affect intake and activity levels

Level 1 Universal and Preventative Services

Assess

1. **Assess dietary consumption** using a record of the patient's food , fluid intake and activity diary. This can be done in any form which is easy for the patient to report back and discuss with you their food and fluid intake.
2. **Assess physical activity levels** using the General Practice Physical Activity Questionnaire (GPPAQ).

The GP Physical Activity Questionnaire (GPPAQ)[6]

- The GPPAQ is used to measure a patient's (aged 16+) physical activity levels.
- It takes 30 seconds for a patient to complete.
- It takes between 1-2 minutes for the health practitioner to input data into an excel sheet and analyse result.

It should be recorded and updated:

- every year for patients at risk of CVD
- every five years for all other patients.

The questionnaire looks at how active the patient's daily life is , an algorithm is then used to create a score from their answers.

Sedentary	0 hours per week
Moderately	Less than 1 hour per
Moderately active	More than 1 hour per
Active	3 or more hours per week

Essentially it classifies patients as:

Please note, walking, housework; childcare, gardening and DIY are in the questionnaire. However, it is very important to note that these are **not** included in the result.

If your patient does not score an "active" rating but has answered the walking, housework, childcare, gardening and DIY category, please talk to them about whether this activity is **moderate** (in minimum of 10 minute blocks).

If you are convinced that their activity does classify as moderate, add this to the notes so that you can refer back to it on your next appointment.

If someone does not score an active rating (after you have talked to them about walking), you should discuss their activity levels using behavioural change techniques.

Advise

1 Discuss general healthy eating recommendations taking into consideration what they are eating and drinking at present. Consider using The Eat Well Plate model (below).

Advise to eat:

- Plenty of fruit and vegetables (fresh, frozen, chilled, canned, 100% juice and dried all count towards 5ADAY).
- Plenty of bread, rice, potatoes, pasta and other starch foods—advise wholegrain varieties.

The eatwell plate

Use the eatwell plate to help you get the balance right. It shows how much of what you eat should come from each food group.

Food Standards Agency The Eatwell Plate[7]

The eatwell plate makes healthy eating easier to understand by showing the types and proportions of foods needed to have a healthy balanced diet. The eatwell plate shows how much of what you eat should come from each food group. This includes everything you eat during the day, including snacks.

- Some milk and dairy foods.
- Some meat, fish, eggs, beans and other non-dairy sources of protein.
- Just a small amount of foods high in fat and/or sugar.

The balance doesn't have to be right at every meal, but over a whole day or even a week.

Healthy eating publications to download.

Level 1

8 eatwell messages:

- Base your meals on starchy foods.
- Eat lots of fruit and vegetables (5ADAY message).
- Eat more fish.
- Cut down on saturated fat and sugar.
- Try to eat less salt—no more than 6g a day (about 1 teaspoon full).
- Don't skip breakfast.
- Drink plenty of water.
- Get active.

Alcohol

Alcohol is high in calories and therefore contributes to weight gain and must be considered when trying to lose weight.

Regularly drinking above the recommended daily limits for lower risk drinking of 2-3 units for women and 3-4 units for men, significantly increases the risk of ill health. "Regularly" means drinking every day or most days of the week. You should also take a break for 48 hours after a heavy session to let your body recover.

2 Discuss physical activity (consider GPPAQ result) – promote 5 x 30mins (to gradually build up to accumulate 30 minutes of moderate physical activity on 5 or more days a week). However, in many people and in the absence of a reduction in energy intake, 45-60 minutes of activity each day may be needed in order to prevent the development of obesity. People who have been obese and who have lost weight may need to do 60-90 minutes of activity a day in order to maintain their weight loss. (CMO 2004[8])

It doesn't have to be all in one go, shorter bouts of 10 minutes throughout the day add up to the total amount. Moderate intensity should make you feel warm and slightly out of breath, e.g. brisk walking.

3 Providing Your Weight, Your Health booklet (DH) which combines information on healthy eating and physical activity. Consider providing relevant leaflets from the resources section.

Agree

Agree **SMART** goals in ***partnership*** with your patient:

Specific	"I will partake in 30 minutes of brisk walking 3 times a week".
Measurable	"I will eat 3 portions of fruit/vegetables every day".
Achievable	Negotiate goals that can be accomplished, e.g. losing 0.5 kg per week.
Relevant	Goals should meet the patient's expectations, e.g. if the patient enjoys walking, a goal based around walking would be relevant.
Timely	Negotiate a time-frame for achieving the goal that is specific and realistic. This could be an interim goal working towards a achieving a main goal.

The goals may be specific to healthy eating and/or physical activity.

Agree a target weight loss. Very small levels of weight loss produce health benefits but significant changes result after a 5-10% weight loss. This can be achieved over 3 to 6 months, representing a loss of 0.5-1.0kg per week.

Assist/Arrange

1. Signpost to local physical activity and healthy eating initiatives.
2. Provide information on electronic and paper resources.
3. Arrange referrals to programmes (e.g. Exercise Referral Scheme).

Follow Up

Weight loss needs to be monitored and recorded over time: the suggested minimum is 3-6 months but more often if the patient wants or requires active support.

3-month Review

> 5% = successful weight loss:

Continue with the ongoing treatment and support.

<5% = unsuccessful weight loss:

Reassess motivation and readiness to change, and identify any problems which may have impacted on the lack of success so far. Repeat Level 1 advice if the patient is still ready to change.

1. Repeat Level 1 advice – explore information and support the patient to increase their own knowledge around diet and physical activity.
2. Identify any problem areas – explore and work through them in partnership with the patient, moving towards a balanced healthier lifestyle.
3. Revise SMART goals.

Weight loss needs to be monitored and recorded over time

6-month Review

Repeat as at 3 months.

> 5% = successful weight loss :

Action as at 3 months or consider moving patient to maintenance phase.

< 5% = unsuccessful weight loss:

Reassess patient’s motivation to change and consider referral to in-house community weight management services if available, for a more comprehensive assessment for patients with co-morbidities.

Level 2 Community/ Primary Care Weight Management Services

The PCT currently does not commission Level 2 services; however some practices have started to develop their own in house services.

Please see community weight management packages for setting up your own weight management service.

What should Level 2 Community/Primary Care based services look like?

Intervention content

All interventions at Level 2 community should be multi-component and focus on diet and physical activity together, rather than attempting to modify either diet of physical activity alone.

Weight management interventions should include behaviour change strategies to:

- increase people's physical activity levels and/or decrease inactivity
- improve eating behaviour and the quality of the person's diet;
- reduce energy intake.

Many interventions have the potential to be delivered to families as well as to individuals. It is important that all interventions are tailored to the individual and provide on-going support.

Health professionals should discuss the range of weight management options with people. This might include a motivational interviewing approach if using appropriately trained staff.

Physical activity component

The physical activity component of interventions should focus on activities that fit easily into people's everyday lives (such as walking, cycling or dance) and are tailored to people's individual preferences and circumstances.

Interventions should aim to improve people's belief in their ability to change (for example, by verbal persuasion, modelling exercise behaviour and discussing positive effects).

Interventions aimed at people who have been obese and have lost weight should emphasise that it may be necessary to be active for 60–90 minutes a day to avoid re-gaining weight. Current physical activity recommendations suggest 30 minutes of activity on at least five days a week.

Dietary component

The dietary components of interventions should aim to improve diet and reduce energy intake, and should bring together a number of components such as dietary modification, targeted advice, family involvement and goal setting.

Levels 2 and 3

Dietary changes should be individualised, tailored to food preferences and allow for flexible approaches to reducing calorie intake. In the longer term, people should move towards eating a balanced diet, consistent with other healthy eating advice.

Diets that have a 600 kcal/day deficit (that is, they contain 600 kcal less than the person needs to stay the same weight) or that reduce calories by lowering the fat content (low-fat diets), in combination with expert support and intensive follow-up, are recommended for sustainable weight loss.

Low-calorie diets (1000–1600 kcal/day) may also be considered, but are less likely to be nutritionally complete. Very low-calorie diets (less than 1000 kcal/day) may be used for a maximum of 12 weeks continuously, or intermittently with a low-calorie diet (for example for 2–4 days a week), by people who are obese and have reached a plateau in weight loss. Low glycaemic index or load diets can be effective.

Any diet of less than 600 kcal/day should be used only under clinical supervision.

Behavioural component

Behavioural interventions for adults should include the following strategies tailored to the needs of the individual:

Self monitoring of behaviour and progress, stimulus control, goal setting, slowing rate of eating, ensuring social support, problem solving, assertiveness, cognitive restructuring (modifying thoughts), reinforcement of changes, relapse prevention and strategies for dealing with weight regain.

In addition to the above, Level 2 community services should consider Pharmacology ($\geq$28kg/m^2 with co-morbidities or $\geq$30 kg/m^2) and setting up specialist weight management clinics.

Level 3 Specialist Weight Management Services

The PCT currently does not commission Level 3 services.

What should Level 3 Specialist Services look like?

Level 3 specialist services should involve specialist nutritional advice, psychotherapy, pharmacotherapy and physiotherapy. Level 3 specialist services should consider using mutli-disciplinary teams.

GP Assessment

The GP acts as the gatekeeper for further treatment for patients if they have been unsuccessful in their attempts to lose weight and need additional assistance with weight loss. For example, certain patients may be referred to the GP for consideration for pharmacotherapy/bariatric surgery.

Pharmacotherapy

- Patients should be encouraged to attempt diet, physical activity and behaviour change before prescribing drugs.
- Consider for patients who have not reached their target weight loss or have reached a plateau on dietary, activity and behavioural changes alone.
- Drug therapy should always be considered as an addition, rather than an alternative, to lifestyle intervention.

Patients should be supported in their attempts to make behavioural changes (diet and physical activity) before prescribing drugs.

Orlistat is the only prescribed obesity drug available.

Orlistat

Orlistat inhibits the action of pancreatic lipase enzyme in the gastrointestinal system and must therefore be taken in conjunction with a low-fat eating plan.

Prescribe only as part of an overall plan for managing obesity in adults who have:

- a BMI of 28.0 kg/m^2 or more with associated risk factors, or
- a BMI of 30.0 kg/m^2 or more.
- Continue treatment for longer than 3 months only if the person has lost at least 5% of their initial body weight since starting drug treatment (less strict goals may be appropriate for people with type 2 diabetes).
- Continue for longer than 12 months (usually for weight maintenance) only after discussing potential benefits and limitations with the patient.
- Co-prescribing with other drugs for weight reduction is not recommended.

(NICE, 2006[2])

Alli is the only over the counter obesity drug.

Alli

This non prescription weight loss aid needs comprehensive support to change eating habits. This is to ensure they follow a healthy calorie controlled, low fat eating plan to effectively and safely promote weight loss, and to avoid any side effects of Alli.

Alli may have a role for some people for the first 6 months, as a helping hand towards modest, but beneficial weight loss. Alli specifies that if there is no weight loss within 12 weeks users should be referred on to healthcare professionals.

(BDA/DOM UK statement on OTC Alli[9])

Level 4

Level 4 Morbid Obesity Surgery Services

Bariatric Surgery

Bariatric surgery is generally only considered for patients who have tried all other interventions, for example, healthy eating and physical activity, and pharmacotherapy.

Bariatric surgery reduces gastric size and thus may result in malabsorption of ingested food. Patients will need to make life changes after surgery and will therefore continue to require dietetic support and support in becoming more physically active.

The current referral pathway operating in NHS North Yorkshire and York is that a request for approval occurs through the Individual Funding Request Panel. The Individual Funding Request Panel assesses requests based on the following criteria where specific exceptional circumstances apply:

- BMI ≥ 50 automatic approval for referral/surgery if clinically indicated
- BMI > 45 may be approved if other co-morbidities indicate severity/risk to health. These are assessed using a scoring system to identify risk.
- BMI < 45 not usually approved for bariatric surgery, but co-morbidities taken into account for risk factors.
- BMI < 40 not usually approved for bariatric surgery.
- Patients who are refused surgical intervention by the Individual Funding Request Panel are referred back to their GP or clinician for weight management and may be considered for drug therapy.

Clinicians must ensure that all other alternatives on the care pathway (diet, physical activity and pharmacotherapy) have been tried BEFORE considering surgery.

Maintenance

Ongoing monitoring of weight should take place and this will ensure that patients are referred back into the pathway should they have a relapse in weight maintenance. Consider setting goals to help them adhere to changes made in the weight loss phase.

(NICE, 2006[2])

Resources

The 'Your Weight, Your Health' series can be ordered from DH publications

The DH 'Your Weight, Your Health' publications are available free of charge: you can place an order by post, telephone, fax or email (quote the title and reference number).

Your Weight, Your Health – Raising the Issue of Weight in Adults (DH) (code 274543)

A card to assist health professionals with raising the issue of weight with patients.

Your Weight, Your Health – How to Take Control of Your Weight (DH) (code 274537)

A booklet for patients who are ready to think about losing weight.

Your Weight, Your Health – Why Weight Matters card (DH) (code 274538)

For patients who are not yet committed to losing weight. This card discusses the risks associated with being overweight, the benefits of modest weight loss, and practical tips for people to consider.

Your Weight, Your Health—Care Pathway for the Management of Overweight and Obesity (DH) (code 274539)

GP Physical Activity Questionnaire

5 A DAY

Booklet (code 301117) and z-card (code 289557) available from the DH.

DH Publications Orderline
Telephone: 0300 123 1002
Fax: 01623 72 45 24
Email: dh@prolog.uk.com

Food Standards Agency

Eatwell– 8 Tips for Making Healthier Choices

The Eatwell Plate

Your Guide to the Eatwell Plate

Telephone: 0845 606 0678

British Dietetic Association (BDA)

Food Fluid Intake and Activity Diary

British Heart Foundation (BHF)

Walking for Health

Walk more feel the difference leaflet

The Readiness Ruler. To access click here.

Integrated Weight Management Service Model for Adults. To access click here.

Signposting for adult weight management. To access click here.

Community weight management packages. To access click here.

To access the **online searchable database for services and activities**, click here.

Resources

Useful websites

NHS North Yorkshire and York - Staying Healthy
www.northyorkshireandyork.nhs.uk/StayingHealthy

Change 4 Life
www.change4life.co.uk

The British Dietetic Association
www.bdaweightwise.com

The National Obesity Forum
www.nationalobesityforum.org.uk

The British Heart Foundation
www.bhf.org.uk

The Food Standards Agency
www.food.gov.uk

Association for the Study of Obesity
www.aso.org.uk

Dietitians in Obesity Management
www.domuk.org

National Institute for Health and Clinical Excellence
www.nice.org.uk

The Pharmacy Health Link
www.pharmacyhealthlink.org.uk

NHS Choices
www.nhs.uk

References

1 Obesity among children under 11.
Health Survey for England 1995-2003
National Centre for Social Research, Department of Epidemiology and Public Health at the Royal Free and University College Medical School. Commissioned by Department of Health, in collaboration with the Information Centre for health and social care

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4109245

2 Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. National Institute for Health and Clinical Excellence 2006
www.nice.org.uk/nicemedia/pdf/CG43NICEGuideline.pdf

3 Your Weight, Your Health—Raising the Issue of Weight in Adults
Department of Health, 2006
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_078106.pdf

4 The Transtheoretical (Stages of Change) Model (Prochaska and DiClemente, 1982)

5 The Readiness Ruler
Healthy Living NHS Health Scotland, 2005

6 The GP Physical Activity Questionnaire
Department of Health, 2006
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063812

7 The Eatwell Plate
Food Standards Agency, 2007
www.food.gov.uk/multimedia/pdfs/publication/eatwellplate0210.pdf

8 At least five a week: Evidence on the impact of physical activity and its relationship to health.
Chief Medical Officer, Department of Health, 2004
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4080994

9 Press Release—BDA/DOM UK statement on OTC Alli
British Dietetic Association, 2009
www.bda.uk.com/news/090427alli.html

10 North Central London Adult Obesity Pathway and Resources Pack for the Management of Overweight and Obesity
Haringey Teaching Primary Care Trust, 2008