



Obesity Medications: including GLP-1 therapy Lifestyle and Physical Activity Considerations

Information and Guidance
Version 1, September 2026

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Leese



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1. What are GLP-1 Agonists?

1. What are GLP-1s?

- Glucagon-like peptide-1 (GLP-1) is one of two gut-derived incretin hormones, alongside glucose-dependent insulintropic polypeptide (GIP).
- These medications work by mimicking a natural hormone that helps regulate blood sugar and reduces appetite and slow stomach emptying.
- Gut-derived incretin hormone receptor agonists (mimics) were initially developed for the management of type 2 diabetes mellitus.
- These agents have been repurposed for weight management following consistent observations of clinically significant weight loss.
- STEP-5 trial found that weekly semaglutide (2.4 mg) resulted in a mean weight reduction of 15.2% over two years.
- SURMOUNT-1 trial, participants tirzepatide (brand name Mounjaro) achieved mean weight loss of 20.9% at 72 weeks, compared with 3.1% in the placebo group.

**NB: this information was accurate at time of production of these slides.



2. Current national context

The national context – the data

- Obesity is widely acknowledged as a major [public health issue](#), globally.
- [2023/24 Health Survey for England](#): 26.5% of adults were living with obesity (15% 1993), and 64.5% were either overweight or living with obesity.
- Most up-to-date obesity related [statistics on public health in England 2023](#) show:
 - 8,716 hospital admissions directly attributable to obesity, up 13% on the previous year.
 - Obesity is a major driver of long-term conditions: T2DM, CVD, cancer.

However:

Most people living with overweight or obesity do not receive the recommended level of support from weight management services ([Obesity Health Alliance Oct 2024](#)).

[NICE QS Aug 2025](#) aims to address stigma and bias from HCPs to improve patient care.

New pharmaceutical treatments have resulted in unprecedented public demand for services and added enormous pressure on already stretched community services.

There are major inequalities in the access to and delivery of obesity treatment, due to poor access on the NHS, and uneven national coverage.

National context – NICE Guidance

- NHS England currently prescribes obesity medications to patients living with obesity and/or type 2 diabetes (who meet specific NICE criteria).
- NHS England more recently announced a [3-year pilot phased roll-out](#) for tirzepatide to be available in primary care [NICE TA 2024 TA1026](#).
- Throughout the pilot, the [SURMOUNT-MMO Trial](#) will evaluate the real-world effectiveness of tirzepatide in weight loss, diabetes preventions, and prevention of obesity-related complications for adults with obesity.
- Commencing in Greater Manchester: [Greater Manchester plans to partner with industry on a new study to deepen understanding of a weight loss medication - The Health Innovation Network](#).

The national context – the access

- Demand has rapidly outstripped NHS provision, leading to widespread private sector prescribing.
- 7% of UK adults are using or have already used these medications, with a further 8% considering their use.
- Approximately [90% of UK patients](#) access GLP-1 medications through private, non-NHS channels.
- Oral formulations licenced for weight management have now been approved: Semaglutide and Orforglipron.



3. What are the obesity medications?

Obesity medications – the guidance

Drug name	Drug type	Approved for the NHS?	Can be used in primary care?
Orlistat	Lipase inhibitor	Yes	Yes
Liraglutide (Saxenda)	GLP -1	Yes	No
Semaglutide (Wegovy)		Yes	No
Tirzepatide (Mounjaro)	GLP-1 + GIP	Yes	Yes (NHS England pilot rollout June 2025-28)
Retatrutide	GLP-1 + GIP + GCG	Not yet	n/a
Orforglipron	GLP-1	Not yet	n/a



All obesity medications must be used alongside a **reduced calorie diet** and increased **physical activity**.

Obesity medications – the guidance

Weight Management services:

- Tirzepatide (Mounjaro®) is the first injectable obesity medication to which NICE has broadened access outside of specialist weight management.
- This means it can be delivered in primary care, providing additional diet and physical activity support services are implemented because the sophistication and capacity of current services varies widely.
- GLP-1 receptor agonists (Wegovy® and Saxenda®) can only be prescribed in Tier 3 and 4 specialist weight management services for the management of obesity.

Primary Care roll-out from March 2025 (3 years, 220,000 patients):

- A phased approach to service rollout within primary care settings.
- Initially tirzepatide (Mounjaro®) will only be available on the NHS to those with the highest clinical need, moving through 3 cohorts.

Cohort 1 (23/06/2025 onwards): BMI $\geq 40^*$ + ≥ 4 of the 5 eligible conditions.

Cohort 2 (23/06/2026 onwards): BMI $\geq 35^*$ + ≥ 4 of the 5 eligible conditions.

Cohort 3 (01/04/2027 onwards): BMI $\geq 40^*$ + ≥ 3 of the 5 eligible conditions.

*Lower BMI thresholds by 2.5 for people from South Asian, Asian, Chinese, Middle Eastern, black African or African-Caribbean family backgrounds due to high cardiometabolic risks at lower BMIs

Obesity medications – the guidance

What are the 5 eligible conditions for the phased rollout?

1. Type 2 diabetes and meeting the criteria for glycaemic control (NICE 2023, TA924) or weight management (NICE 2024, TA1026).
2. Hypertension requiring pharmacotherapy.
3. Established atherosclerotic cardiovascular disease.
4. Established obstructive sleep apnoea and treatment indicated, i.e. meets the criteria for CPAP or equivalent.
5. Dyslipidaemia, defined as: on lipid-lowering therapy; or with LDL ≥ 4.1 mmol/L; or HDL < 1.0 mmol/L in men, HDL < 1.3 mmol/L in women; or fasting (where possible) triglycerides ≥ 1.7 mmol/L.

Wrap-around care is required for all anti-obesity meds and is part of specialist weight management services.

People who receive tirzepatide in primary care should also have access to wrap-around care, which provides dietary, psychological and physical activity advice, although currently this is patchy in terms of access and availability.

Who is eligible?

Generic name	Brand	Used in WM specialist services	Prescribed in Primary Care	Eligibility	Length of time on Meds: (NB generally on case-by-case basis) ➤ 6 months is defined as long term
Semaglutide	Wegovy	Yes	No	- BMI >35* - OR - BMI 30-34.9* (+ risk factors and meets referral criteria for specialist weight services) - AND - at least 1 weight-related comorbidity	- Cannot be used longer than 2 years (likely to change once safety data is available to NICE) - Prescribed for obesity only in specialist WM services***
Liraglutide	Saxenda	Yes	No	- BMI >35* - OR - Prediabetes (HbA1c 42-47) - OR - at high risk of CVD	- Longer periods, all considered on a case-by-case basis - Prescribed for obesity only in specialist WM services***
Tirzepatide	Mounjaro	Yes	Yes	Eligibility will change over the 3-year phased roll-out - Current eligibility: BMI $\geq 40^*$ with ≥ 4 of the 5 eligible conditions** - From June 2026 onwards: it will include BMI $\geq 35^*$ with ≥ 4 of the 5 eligible conditions** - Eventually (March 2026) will be BMI ≥ 35 + ≥ 1 weight-related comorbidity	- Longer periods, all considered on a case-by- case basis - When authorised for use outside of specialist WM services***, this time restriction will not apply

*Lower BMI threshold by 2.5 for people from South Asian, Asian, Chinese, Middle Eastern, black African or African-Caribbean family backgrounds due to high cardiometabolic risks at lower BMIs

** Weight-related Comorbidity:

- ✓ Established atherosclerotic cardiovascular disease
- ✓ Hypertension
- ✓ Dyslipidaemia
- ✓ Obstructive Sleep Apnoea
- ✓ Type 2 Diabetes

***NB: NHS specialist WM services generally have max length of 2 yrs to support a patient, due to high demand.

GLP-1 not without side effects

But...

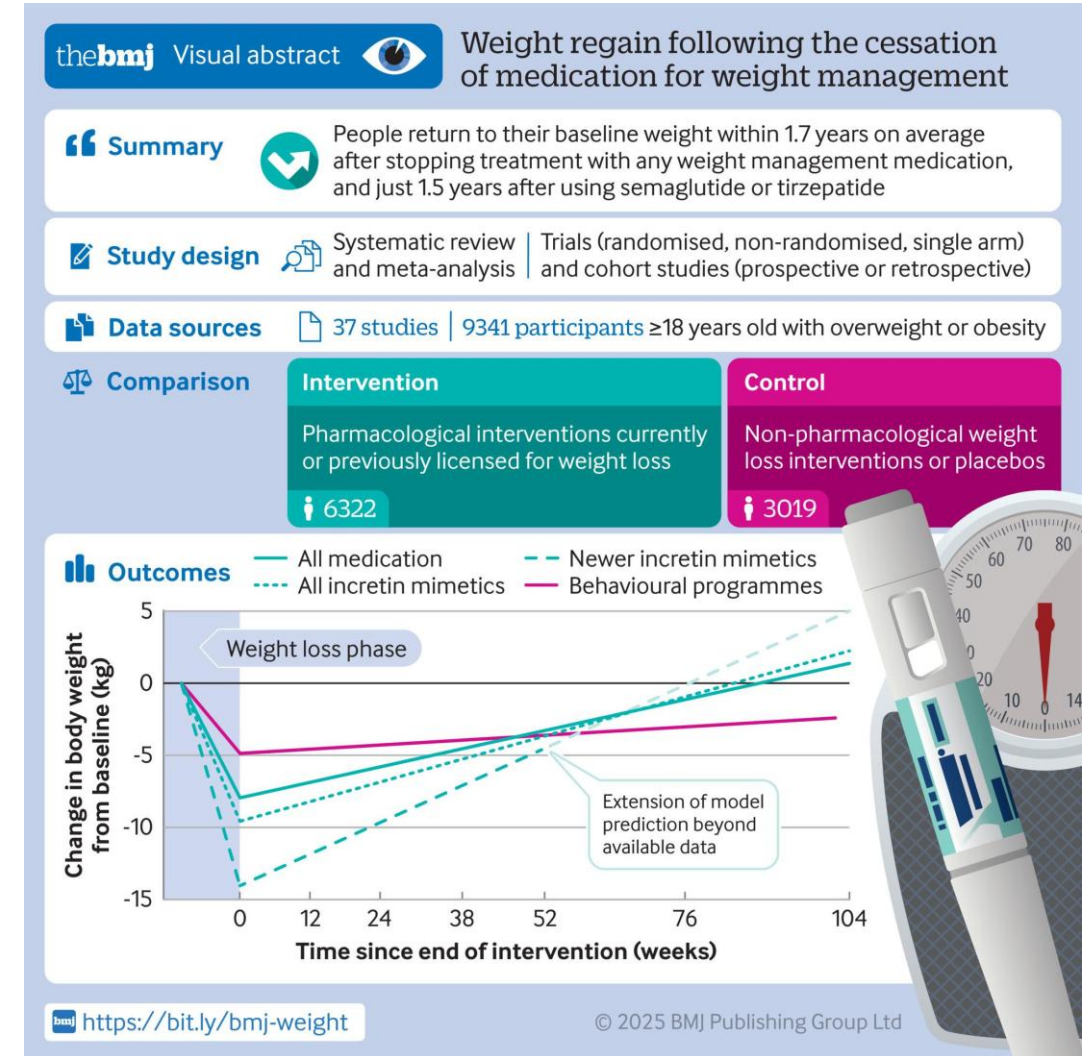
- **Long term adherence** is often low. This is due to side-effects, cost of accessing it privately or unmet expectations.
- **Rapid weight loss**, whether due to GLP-1s or lifestyle change, can lead to a higher proportion of fat-free mass (FFM) being lost (25–40%) (JAMA 2024;332:9).
- **Muscle mass loss** (referred to as sarcopenia) leads to a decrease in muscle size and strength.
 - In addition, muscle atrophy leads to a lower basal metabolic rate (BMR – the number of calories the body needs to function).
 - Impacting ability to regulate body temperature, physical function, brain health, metabolic health and weight regain.
- **Weight regain** is an issue:
 - People return to their baseline weight within 1.5 years on average after stopping treatment with semaglutide and tirzepatide (rate of 0.5-0.8kg/month).
 - That compares to 0.1/kg/month after weight lost through purely behavioural programs.
 - Reductions in HbA1c, fasting glucose, blood pressure, triglycerides and cholesterol progressively attenuated back to baseline within 12–18 months of stopping weight management obesity medication.

Weight regain

How much weight was lost during the intervention phase prior to stopping?

- Behavioural weight management program: 5.1kg
- All obesity medication: 8.3kg
- Tirzepatide and semaglutide: 14.7kg

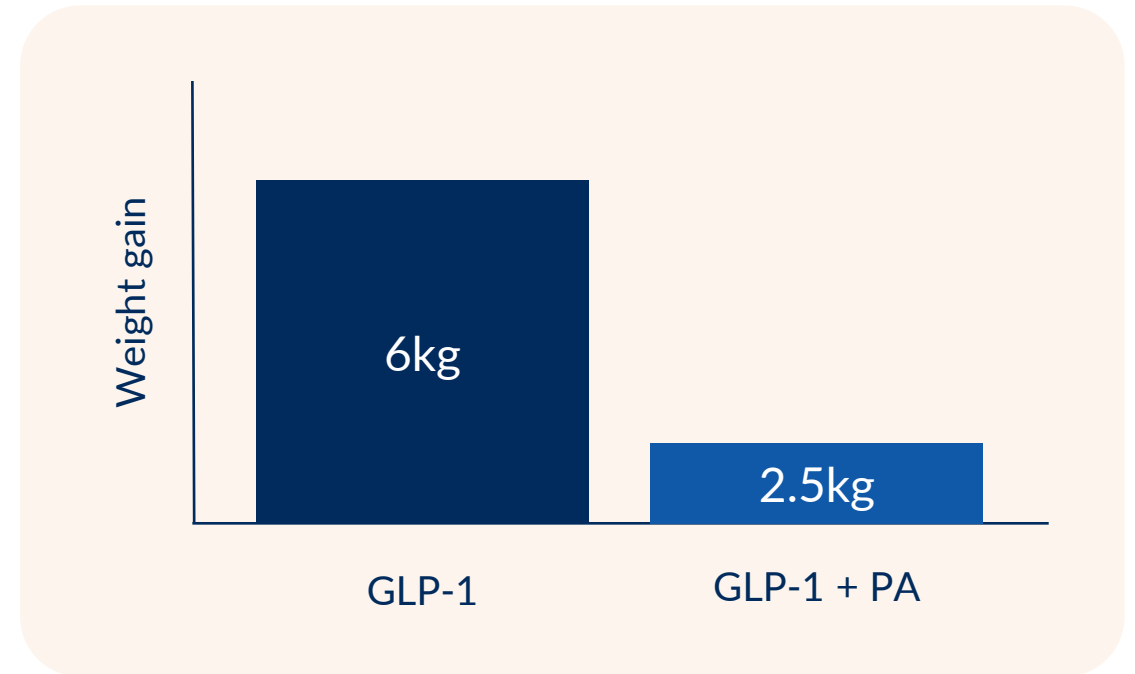
This study supports the view that obesity is a chronic, relapsing disease. The authors recommended we avoid short-term prescribing without a robust holistic maintenance plan, and we should discuss continuation/maintenance therapy, long-term follow-up, and integrated lifestyle support. We should set expectations early about rebound risk on treatment cessation.



Weight regain – Physical activity

In a [post-treatment analysis of a randomised control trial](#), it was found that those who engaged in a supervised exercise programme during their GLP-1 (liraglutide) treatment:

- achieved better weight loss and body composition compared vs GLP-1 treatment alone (-5.1kg, -2.3% body fat percentage)
- maintained that weight loss better after stopping the GLP-1.



Obesity medications: the importance of access to lifestyle support

A key aim of the treatment is to undertake significant lifestyle adaptation to improve outcomes during weight loss and maintenance phase.



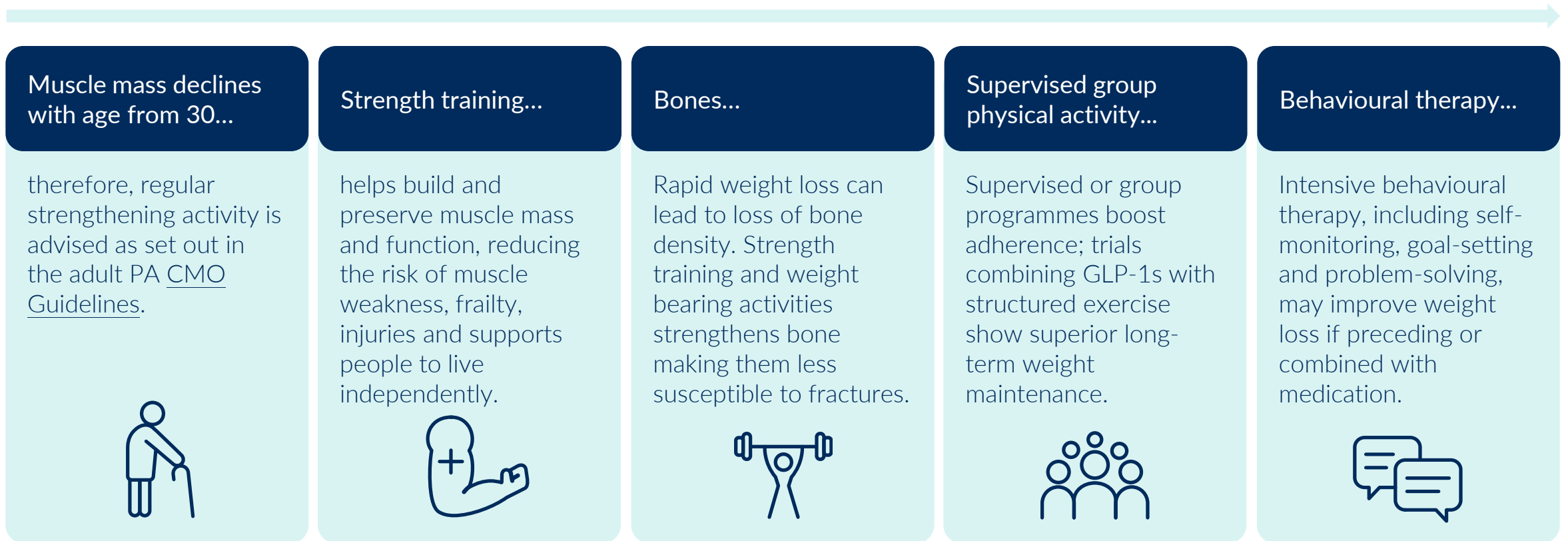
Those who receive obesity medications privately may not receive this support and weight regain is commonplace.





4. Why is strength training so important?

Strength training – the facts



Therefore, strength training needs to be a key part of wrap-around care.

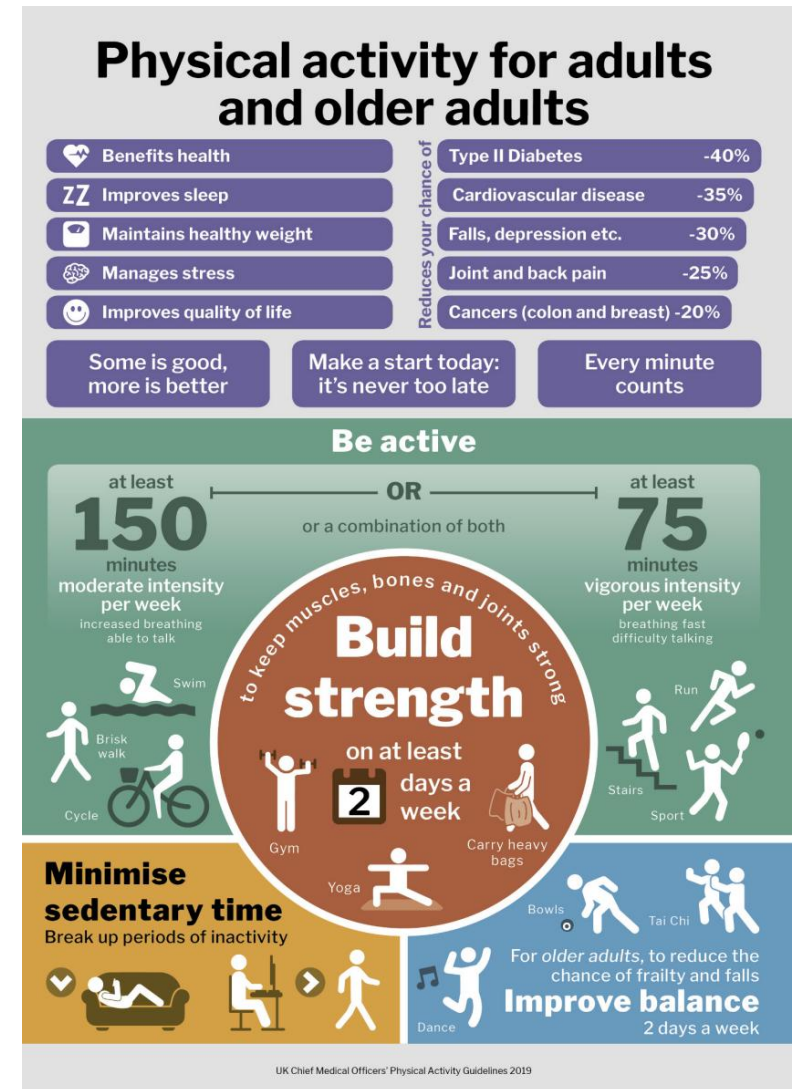


Remember! Strength training, regardless of weight loss ambitions, is an important part of PA guidance

The [UK Chief Medical Officers' Physical Activity guidelines](#) reinforce the need for:

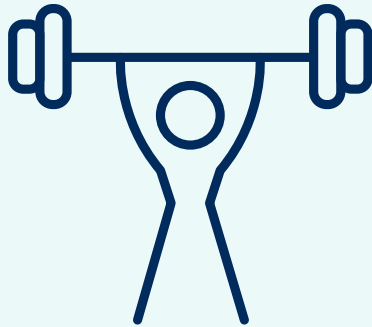
- Adults to include muscle-strengthening activities that work all the major muscle groups, at least 2 days a week, as well achieving at least 150 minutes of moderate intensity cardiovascular activity per week.
- Children and young people should engage in a variety of activities including muscle and bone strengthening exercises, at least 3 days a week.

To maximise the benefits of strength training, the principle of progressive overload should be applied, by increasing moderate or greater intensity or effort through increased resistance as well as reps.

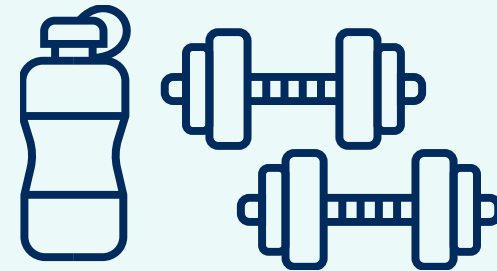


Key points

Strong muscles and bones are therefore essential for overall function.



Strength training does not just mean going to the gym – it can be done how and where you like!





5. Why is wrap-around care essential?

Wraparound care

- A whole system approach which provides the right level and type of intervention based on individual's circumstances and needs, with appropriate person-centred decision-making.
- Medicines should be prescribed after nutritional, physical activity and behavioural approaches have been started and evaluated.
- Weight management medicines are not generally recommended for children under 12 years (only in exceptional circumstances, if severe comorbidities are present).
- Advice should be given for maintaining changes and continued support for improving their health and wellbeing.
- Ensure that people stopping medicines or after completing a weight management intervention are provided with advice, including the benefits of **maintaining physical activity levels over the long term**.

NICE National Institute for
Health and Care Excellence



Overweight and obesity management

Quality standard
Published: 5 August 2025

www.nice.org.uk/guidance/qs212

Nutrition

Nutritional deficiencies:

- GLP-1s can result in significant reduction in appetite and energy intake, and caloric reductions of 16-39%.
- This large reduction can lead to insufficient intakes of essential vitamins and minerals. ([Nutritional priorities to support GLP-1 therapy for obesity. May 2025](#)).
- This can impact energy levels, skin flakiness or itching, muscle weakness, hair loss, poor wound healing and unusual bruising, and result in micronutrient deficiencies.
- Common deficiencies include:
 - Vitamin D and B12
 - Calcium, magnesium and iron
 - Essential fatty acids.

Because GLP-1-based therapies slow gastric emptying and reduce hunger, and may cause nausea or early satiety, many individuals struggle to tolerate normal meal volumes. As a result, protein intake can easily become inadequate.

Nutritional advice

Protein

- Lean protein sources aiming for 60-75 g/day, up to 1.5 g/kg body weight/day.
- Protein intake can come from oral nutrition supplementation as needed.

Meal types

- Small, nutrient dense meals, low fat meals reduce nausea.
- Prioritising fruits, vegetables, wholegrains to help satiety, sustained energy and reduced constipation ([JAMA 2025;185:1151](#)).

Micronutrients

- Supplementation may be required if diet quality is hard to improve.

Eating habits

- Avoid long periods without meals.
- Adequate fluids and minimal alcohol intake.

Physical activity advice



*Minimum: 2 sessions/week is helpful (updated CMO guidelines emphasises strength training for people who may be experiencing muscle loss associated with rapid weight loss, including those using GLP-1 weight-management medications). [Grosicki et al. \(2024\)](#) and [Mulcahy et al. \(2025\)](#) recommend a progressive resistance training programme starting with 10-15 repetitions of 8-10 exercises twice per week, progressing to 3 sets of 8-10 repetitions three times per week.

In the updated CMO physical activity guidelines there is increased emphasis on the importance of strength and balance activities, particularly for healthy ageing and for people who may be experiencing muscle loss associated with rapid weight loss, including those using GLP-1 weight-management medications.

Supporting movement during treatment

Gastrointestinal symptoms, appetite suppression and rapid weight loss create specific considerations for maintaining and optimising physical activity.

Gastrointestinal side effects

- Avoid moderate–vigorous exercise within 60–90 minutes of eating.
- Encourage smaller, lower dietary fat, protein-focused meals.
- Trial lower-intensity sessions until treatment dose has stabilised.
- Hydration optimisation (particularly if vomiting or diarrhoea occur).

Low energy and fatigue

- Ensure carbohydrate adequacy around longer or higher-intensity sessions.
- Deliver session not purely based on their pre-treatment fitness but considering prolonged energy deficit.
- Monitor symptoms of low energy availability (fatigue, dizziness, reduced performance, tachycardia).

In individuals with type 2 diabetes on insulin or sulfonylureas, exercise-related hypoglycaemia remains a consideration, though GLP-1 monotherapy rarely causes hypoglycaemia.

Supporting movement during treatment

Light-headedness/dizziness

- Slow positional changes.
- Ensure well hydrated.
- Check and track heart rate if concerns.
- Caution with hot environments or prolonged endurance sessions.

Psychological reframing

Many will be frustrated that they won't be as energetic, strong or fit during treatment.

- Disappointment if performance drops.
- Concern about muscle loss.
- Reduced drive due to caloric deficit.

Reframe:

Weight loss phase = metabolic recalibration

Training goal = preservation and function

Performance peaks can follow stabilisation

Monitoring and review

Strength progression

- Record baseline loads or resistance level for key functional movements.
- Track repetitions in reserve (RIR) or perceived exertion to ensure progressive overload without excessive fatigue.
- Progression may not be possible given a calorie deficit depending on pre-treatment routine.
- Monitor weekly volume (sets × reps × load) to ensure stability during dose escalation phases.
- Flag sustained regression (>2–3 weeks) which may indicate rapid weight loss, inadequate protein intake, low energy availability or excessive side effects.

Functional Tests

(Simple, low-burden measures suitable for primary care or community settings).

Sit-to-stand (30-second or 5-repetition test):

- Perform at baseline and every 8–12 weeks.
- Record total repetitions (30-second test) or time to complete 5 rises.
- Useful marker of lower limb strength and fall risk.
- Decline may signal muscle loss or deconditioning.

Grip strength (hand dynamometer):

- Take best of three attempts per hand.
- Track absolute value and change over time.
- Decline can indicate lean mass loss or inadequate protein intake.
- Particularly valuable in older adults or those at sarcopenia risk.

Monitoring and review

Body Composition

- Establish baseline measurement (BIA, DEXA, or validated device where available).
- If not available, use weight-height ratio as per [NICE 2025 guideline](#).
- Focus on trends rather than single data points.
- Monitor proportion of weight loss from lean mass vs fat mass (recognising device limitations).
- Flag disproportionate lean mass reduction (>30–40% of total loss may warrant review of training/protein).
- Ensure privacy and respect when assessing.

Method	Key Points	Limitations
Skinfolds	Low cost, portable	Poor accuracy in obesity
BIA	Most practical tool	Affected by hydration Wide range of quality
DEXA	High accuracy	Cost, access, radiation
BodPod	Non-invasive	Limited availability
CT/MRI	Gold standard	Not suitable routinely

Monitoring and review

Symptom Diary During Titration

Encourage patients to log:

- Nausea severity (0–10 scale).
- Reflux, bloating, bowel habit changes.
- Fatigue levels.
- Dizziness or orthostatic symptoms.
- Exercise tolerance (e.g. “completed session”, “reduced intensity”, “missed session”).

Food is medicine models

An [expert group in America noted](#) that social determinants (food insecurity, health literacy) greatly affect success.

Addressing these (e.g. via food vouchers or community resources) is part of comprehensive nutritional support.

Consider how:

- you can support users to access nutritious affordable food
- you can act as an advocate for a healthier environment in your local area.

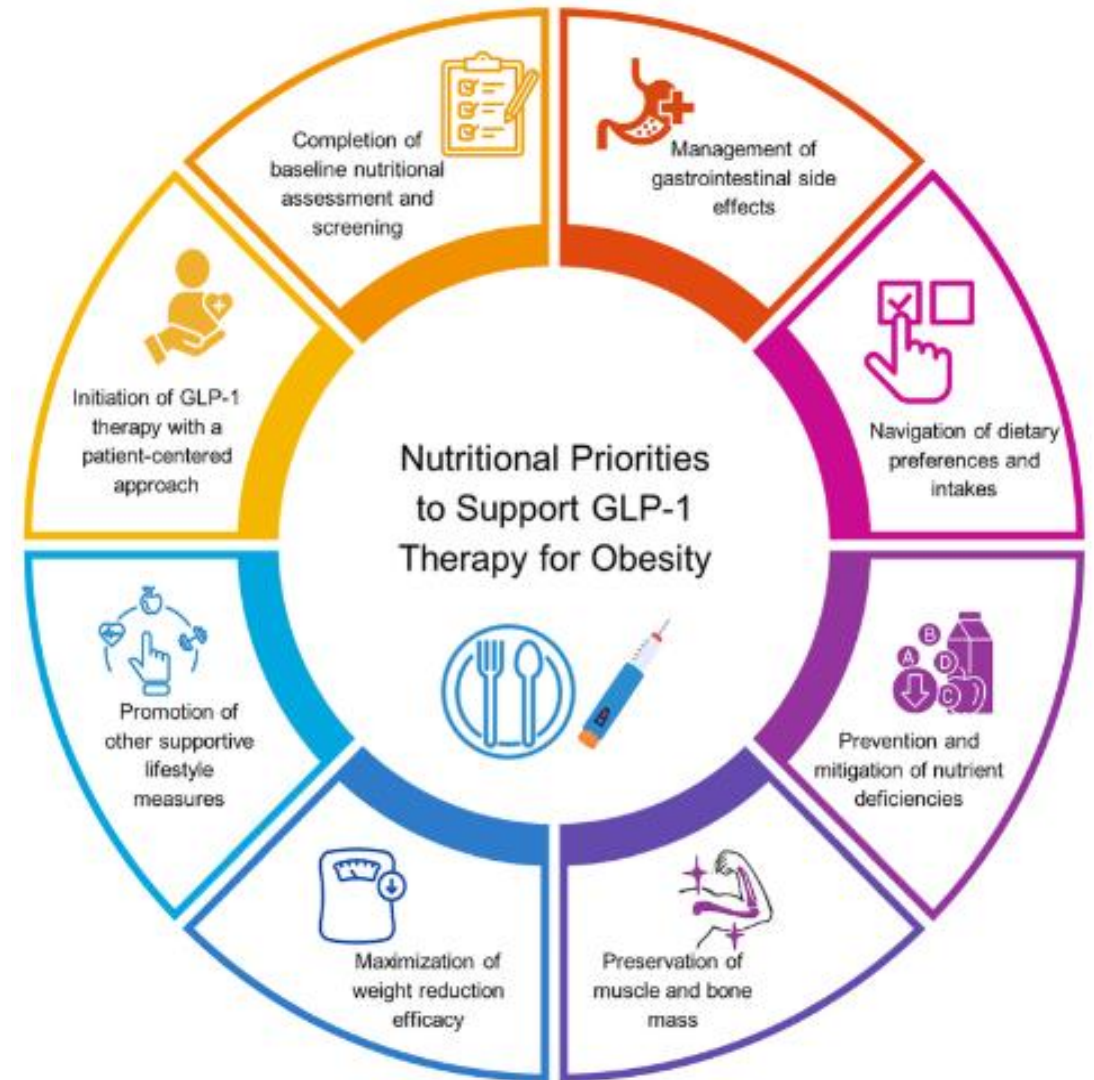
[Nutritional priorities to support GLP-1 therapy for obesity. May 2025](#)



Wrap-around care – a multi-disciplinary team approach

The wraparound support should be implemented ensuring a person-centred approach.

- It is not just the job for one sector.
- Our Active Partnerships network can maximise this opportunity to promote PA as a key cornerstone of the lifestyle support that's needed and support a coordinated multi-disciplinary approach.
- This will help to ensure weight-loss care is safe, sustainable and equitable.





6. Current context across our network

Current context across our network

Active Devon

'We've approached our ICB and more specifically Weight Management leads who have indicated interest in how we can support those receiving WM Services (mainly through Xyla who run the Diabetes prevention programme) and those receiving Tirzepatide GLP receptor related medications.

We are convening a conversation on this with Leisure service leads and providers through the Devon Leisure Network which we co-ordinate, and with ICB LTHC lead.'

Active Dorset

'We are working with our ICB colleagues and a wider steering group of services that are involved with the weight loss injections roll out in Dorset in September. Our role, as you might imagine, is ensuring physical activity is a part of any services to support people who do/don't get prescribed the medication.

We are working with our integrated lifestyle service, physical activity providers, GPs and ICB to provide advice and guidance on physical activity and weight loss medication.'

GM Moving

'We supported Obesity Reimagined, which is a project looking at the weight management pathways for the treatment of obesity with weight loss drugs/medications. We have been invited by the ICB to work with the Food and Healthy Weight Leads on current programmes, approaches, and strategies across the city-region and how we use the ambitions in the NHS 10-year plan to think about a GM approach to 'Halt the Rise in Obesity'. Oldham Leisure staff have undergone training on working with people taking weight loss medications, and Tameside Active staff have signed up to complete training too.'

Active Surrey

'We are in discussions with the lead for weight loss meds in our ICB, who is also Surrey's deputy CMO. We have agreed to her request to fund a place on the Red Whale course for one GP in each PCN in Surrey and are continuing discussions on how we can help embed PA in a patient's weight loss journey.'



7. Opportunities for our Active Partnership network

Scale of the opportunity

- 3.4m people are eligible for anti-obesity medication in primary care but estimated that 2.8m will take up the offer – estimated at 70% take up rate.
- 1 in 5 GP appointments would be needed to manage patient uptake.
- 220,000 patients to be supported through the pilot phase alone.

Therefore, the scale of this opportunity for our network to influence the importance of physical activity and be a cornerstone of that wraparound care, is of enormous magnitude!



A massive opportunity for our network

“Obesity medicine is evolving rapidly, and the need to tackle this epidemic is urgent. Growing investment creates a real opportunity to embed physical activity into clinical care, because durable weight and health outcomes require more than a prescription alone. We must move beyond simply telling people with obesity to “move more” and instead provide personalised support that helps them use movement to improve health and achieve lasting weight loss; through behaviour-change techniques, ongoing coaching and close collaboration with physical-activity providers. Active Partnerships can serve to help to promote and nurture relationships between these sectors”.

Dr Hussain Al-Zubaidi Instagram: [@irondoctorhaz](#)



[Dr Hussain Al-Zubaidi](#)

- RCGP Lifestyle & Physical activity champion
- ITV Obesity medicine expert
- Red Whale Medical Education Obesity and Lifestyle lead
- Leamington PCN NHS Personalised care and social prescribing lead
- Parkrun Health Partnerships Lead
- ThinkActive CSW Trustee

Summary

- ✓ Obesity is a chronic, relapsing complex condition
- ✓ Physical activity reduces and prevents many of the risk factors for obesity related diseases
- ✓ Physical activity is beneficial **even if no weight is lost**
- ✓ **Muscle strengthening** is very important
- ✓ GLP-1 analogues provide a great opportunity for **behaviour change and influencing physical activity levels**
- ✓ The aim of treatment is **health gained**, rather than simply weight loss



For Active Partnerships

“This will be a great document to talk through with Public Health and Social Care colleagues, as well as lifestyle service leads”.

Active Partners Trust



8. Resource Hub

Resource Hub

- [NHS England Obesity](#)
- [Behavioural overweight and obesity interventions. NICE 2025](#)
- [Treatment of Overweight and Obesity Position Statement & Evidence Review](#); Obesity Health Alliance Oct 2024
- [Tirzepatide for reduction of morbidity and mortality in adults with obesity](#) June 2025
- [Quality standards | NICE Wrap around care alongside Obesity medicines](#) Aug 25
- [NICE_Behaviour Change_Individual Approaches 2014](#)
- [CSP Stronger My Way](#)
- [RCGP helping our patients build back stronger - 'stronger my way'](#)
- [CMO's PA Guidelines 2019](#)
- [GLP-1 medicines for weight loss and diabetes: what you need to know - GOV.UK](#)
- [ukactive and CIMSPA support for the PA sector](#)
- [ukactive GLP-1 News Article](#)

- [We Are Undefeatable Ways to Move](#)
- [NHS: How to improve strength and flexibility](#)
- [Stronger at Home](#)
- [Resistance Training Variables for Optimization of Muscle Hypertrophy: An Umbrella Review](#)

Available training courses, which include focus on PA and other lifestyle measures (course cost details are available via links, if applicable)

- [Future Fit Physical Activity Professional Training](#)
- [Future Fit Physical Activity Organisation Training for Staff](#)
- [Red Whale Healthcare Professional Training](#)

Resource Hub



I'M GETTING STRONGER MY WAY TO DO THE THINGS I LOVE

STRONGER MY WAY

A year after my stroke I could feel myself getting stronger and stronger. It was really encouraging and motivating having to keep going.

— ANDY

STRONGER MY WAY

SPORT ENGLAND

THE CHARTERED SOCIETY OF PHYSIOTHERAPY

FIND YOUR STRENGTH WITH PHYSIO-APPROVED RESOURCES AT [CSP.ORG.UK/STRONGER](https://csp.org.uk/stronger)

[Stronger My Way CSP Posters](#)

Turn your living room into your own personal gym.

People of all ages and abilities will benefit from getting STRONGER.

People who are STRONGER, are more active.

The short-term benefits of becoming STRONGER and more active include better glucose regulation, improved mood, increased energy, and better sleep. Long-term, we see people living better for longer, STRONGER and more resilient bones, muscles and joints, and a risk reduction of cognitive decline, dementia, type 2 diabetes, cardiovascular disease, and even some forms of cancer.

We know that everyone will have their own starting point, that's why we include exercises for those who are just starting out as well as for those who are ready to take the next step in their strength training journey.



[Stronger at home](#)

[Stronger My Way promotional resources | The Chartered Society of Physiotherapy](#)

Why focus on strengthening?



Strength helps maintain function, bone density and balance

This can mean your patient can live independently and not become reliant on support.



Strength helps manage long-term conditions

This makes people feel more in control by managing the condition or its symptoms, which can improve confidence to do even more.



Strength enables aerobic activity

This can simply mean ability to complete daily activities and do more of the things that matter. Finding an emotive ambition can be a powerful motivator.



Over 15 million people in England live with a long-term health condition. Less than half of people living with a long-term health condition or disability are meeting the CMO Physical Activity recommendations.¹

ACTIVE LIVES SURVEY, SPORT ENGLAND, 2021



How to talk about strengthening

The CSP, supported by Sport England and the Centre for Ageing Better, conducted multiple rounds of interviews and focus groups with people living with long term conditions and healthcare professionals. The findings from this work will help you deliver care to your patients.

Suggest choosing from approved exercises to get started.

Say 'gradually increase', not 'gently increase'. This allows control over the activity and feels more accessible.

Talk about 'maintaining' and 'improving' strength, not one or the other.

Use simple language and avoid jargon, technical words and patronising terms. For example, say 'raising your leg' instead of 'calf raises'.

Convey that strengthening can be easy and accessible, don't explicitly say it is. For example, it can be done at home with no special equipment.



9. Glossary

Glossary

AP	Active Partnership
APNO	Active Partnership National Organisation
BMI	Body mass index
BMR	Basal metabolic rate
BSLM	British Society of Lifestyle Medicine
CIMSPA	Chartered Institute for the Management of Sport and Physical Activity
CMO	Chief Medical Officer
CVD	Cardiovascular disease
FFM	Fat free mass
GLP-1	Glucagon-like Peptide-1
GP	General practitioner
HCP	Health care professional

ICB	Integrated Care Board
LTHC	Long term health condition
NHS	National Health Service
NHSE	National Health Service - England
NICE	National Institute for Health and Care Excellence
NICE QS	National Institute for Health and Care Excellence Quality Standard
PA	Physical activity
PCN	Primary Care Network
RT	Resistance training
WAU	We Are Undefeatable campaign
WM	Weight management



10. Acknowledgements

Active
Partnerships

 
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RC
GP

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- British Society of Lifestyle Medicine (BSLM)
- Royal College of General Practitioners (RCGP)



Royal College of General Practitioners
www.rcgp.org.uk

Active Partnerships National
Organisation
www.activepartnerships.org

Sport England
www.sportengland.org

with expert oversight from
Dr Hussain Al-Zubaidi

