Dietary guidelines for obesity uk

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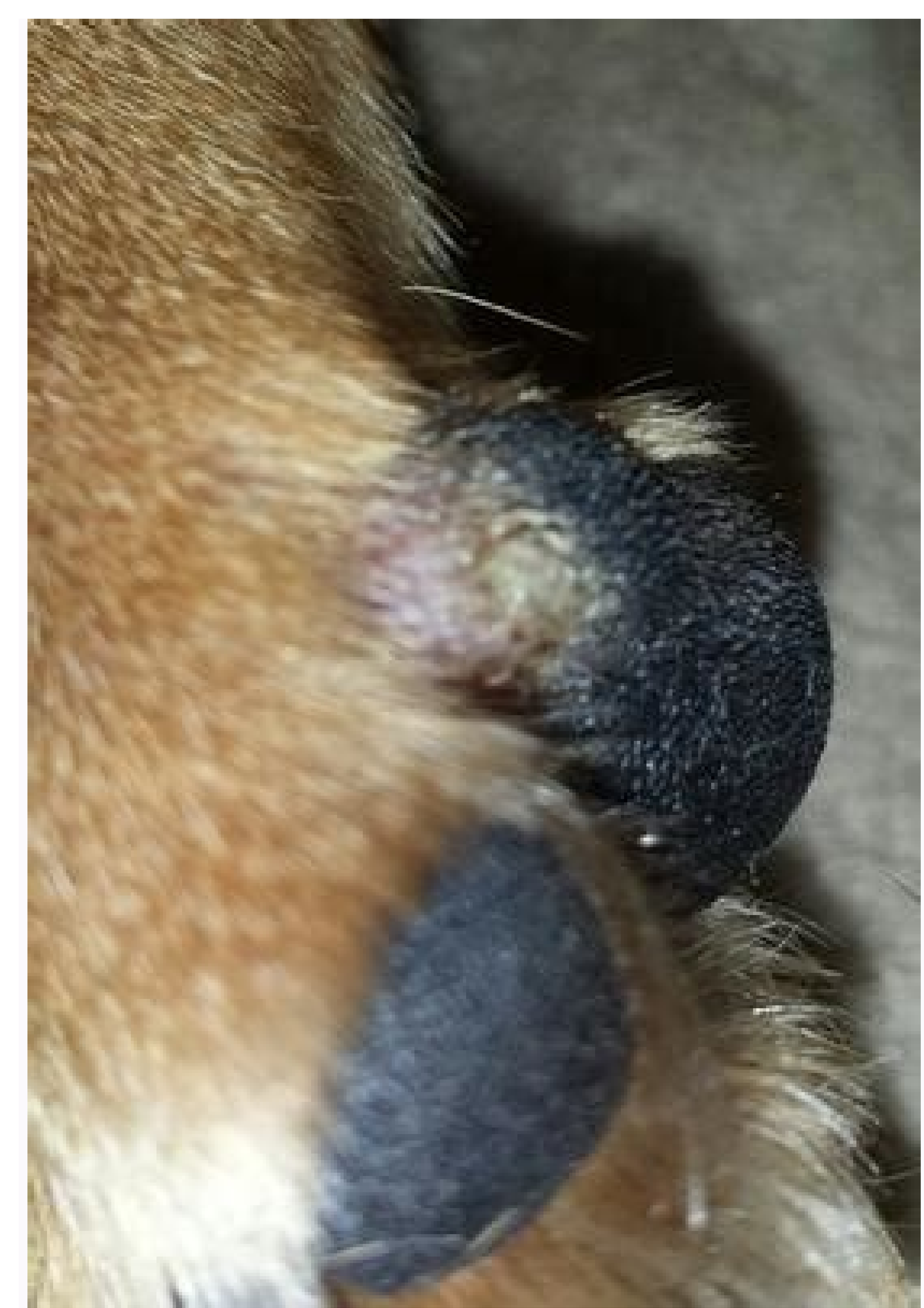

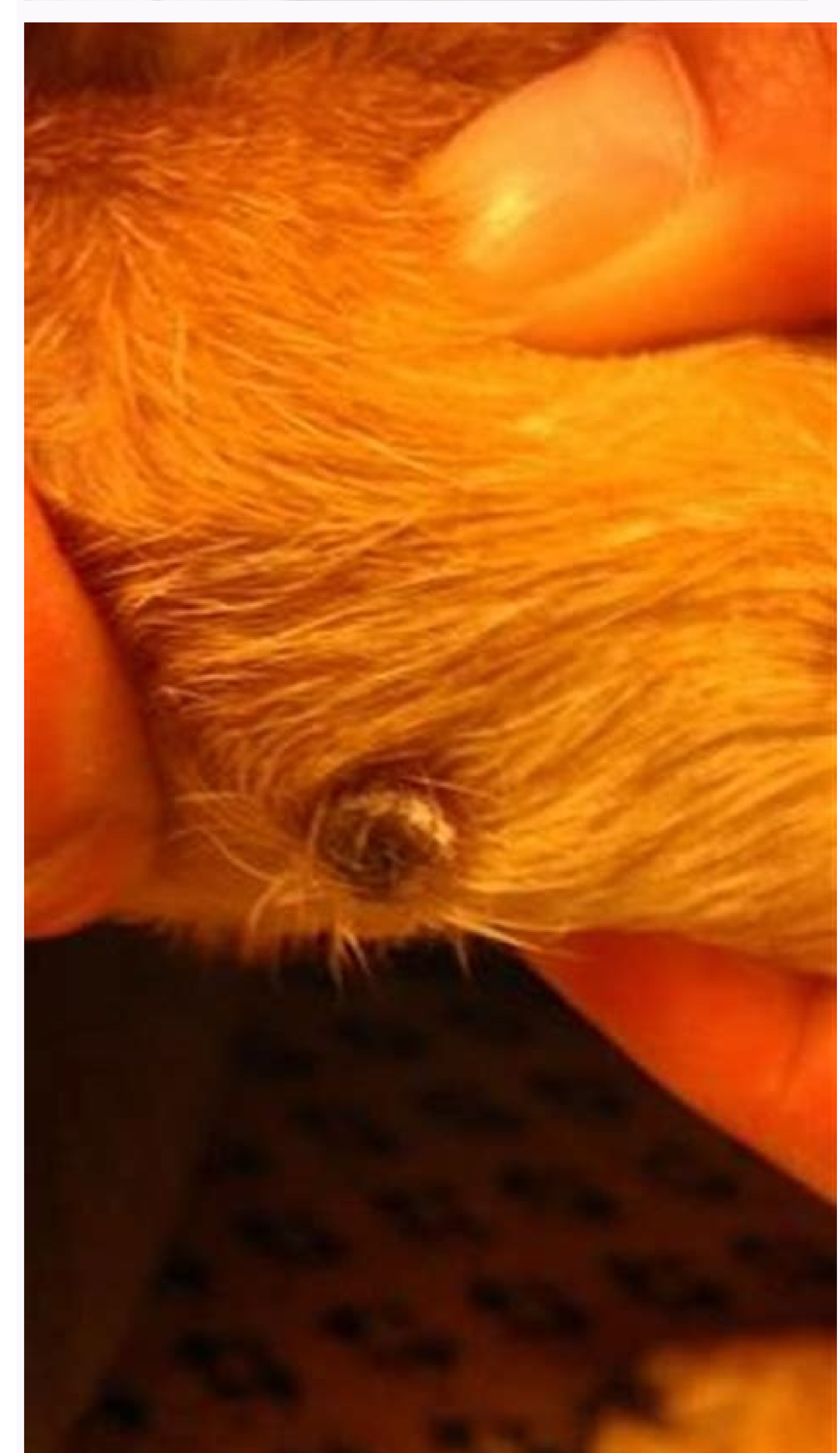

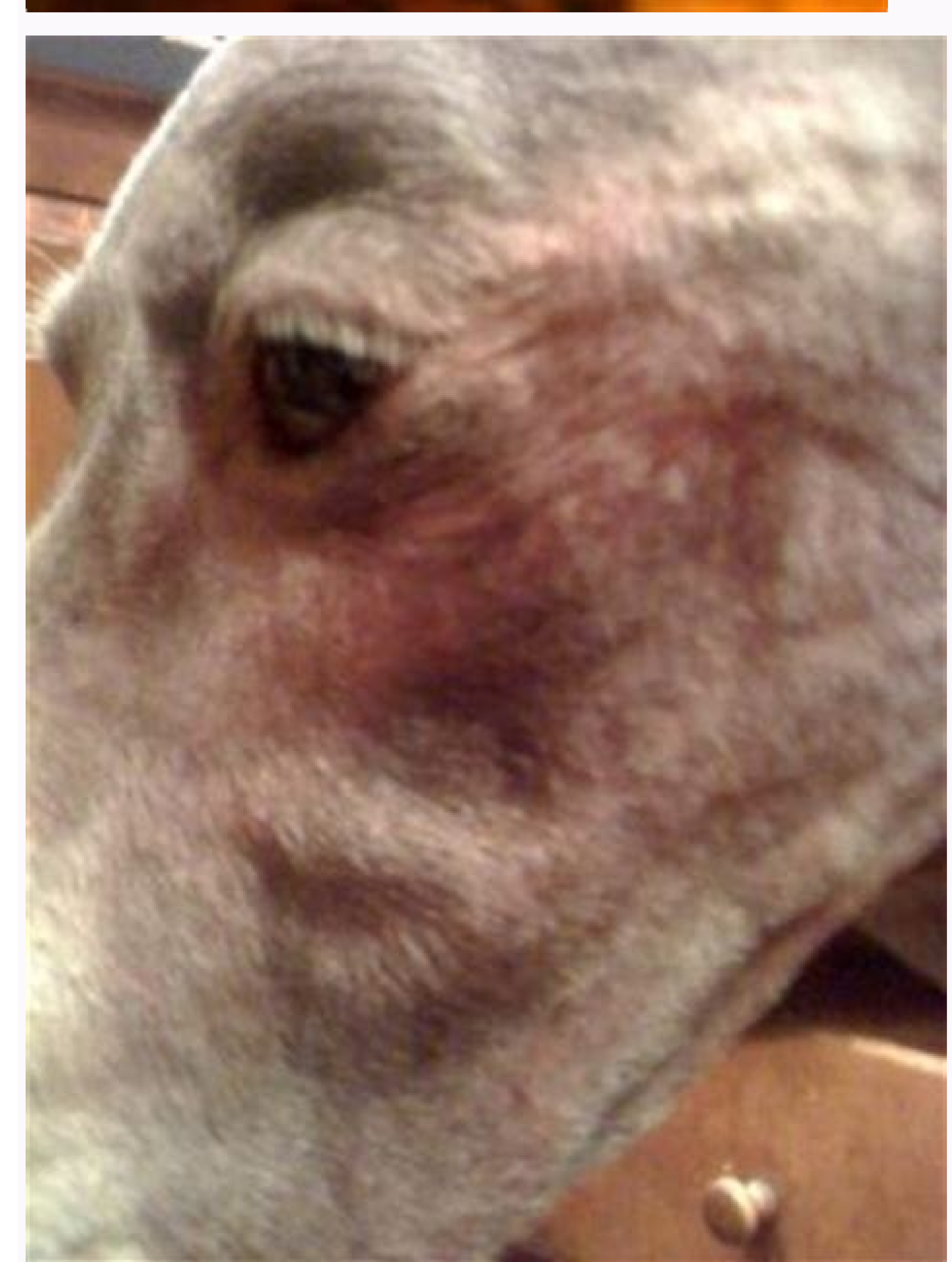

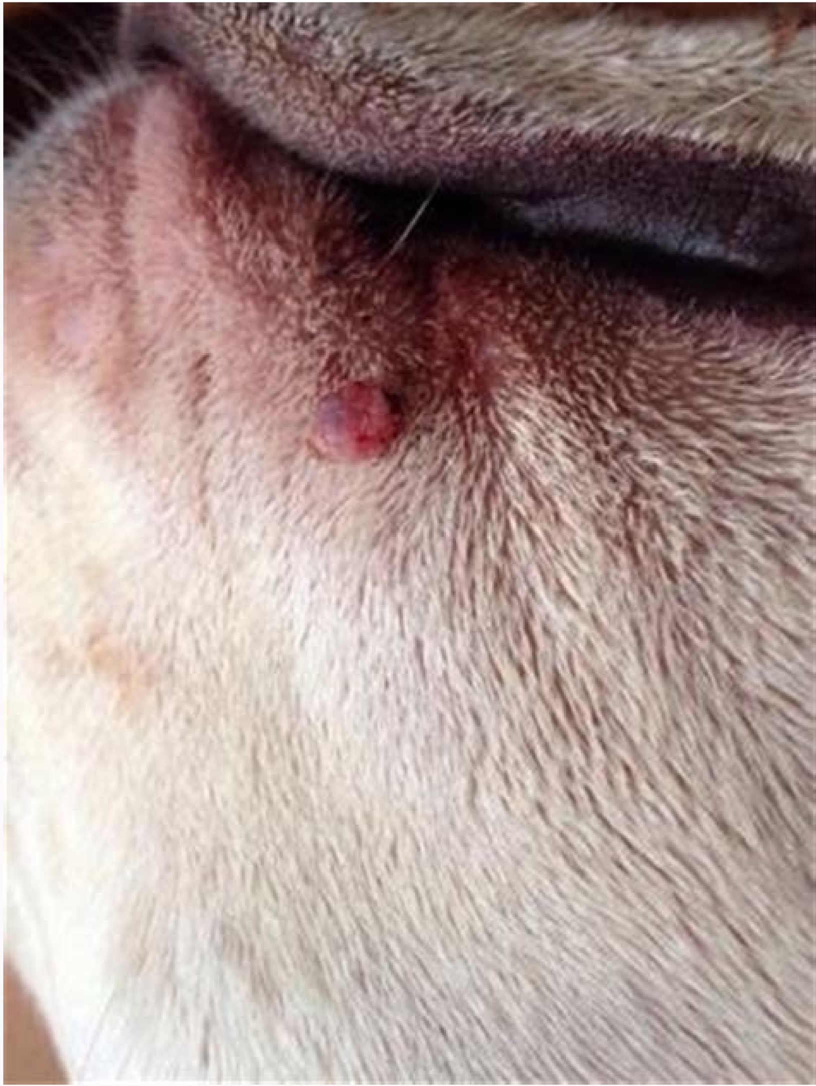

Obesity guideline.

This Guidelines summary covers NICE's recommendations regarding identification, assessment, and management of obesity. Included are recommendations concerning: generic principles of care identification and classification of overweight and obesity assessment lifestyle and behavioural interventions physical activity dietary interventions pharmacological interventions continued prescribing and withdrawal. This guideline partially replaces CG43, and is the basis of QS127. Adults Discuss the choice of interventions for weight management with the person. The choice of intervention should be agreed with the person. Tailor the components of the planned weight management programme to the person's preferences, initial fitness, health status and lifestyle. Children Coordinate the care of children and young people around their individual and family needs. Comply with the approaches outlined in the Department of Health's A call to action on obesity in England. See also NICE's guideline on weight management: lifestyle services for overweight or obese children and young people. Aim to create a supportive environment that helps a child who is overweight or who has obesity, and their family, make lifestyle changes. (The GDG noted that 'environment' could include settings other than the home, for example, schools.) Make decisions about the care of a child who is overweight or has obesity (including assessment and agreeing goals and actions) together with the child and family. Tailor interventions to the needs and preferences of the child and the family. Ensure that interventions for children who are overweight or have obesity address lifestyle within the family and in social settings. Encourage parents (or carers) to take main responsibility for lifestyle changes in children who are overweight or obese, especially if they are younger than 12 years. Take into account the age and maturity of the child, and the preferences of the child and the parents. Adults and children Offer regular, non-discriminatory long-term follow-up by a trained professional. Ensure continuity of care in the multidisciplinary team through good record keeping. Use clinical judgement to decide when to measure a person's height and weight. Opportunities include registration with a general practice, consultation for related conditions (such as type 2 diabetes and cardiovascular disease) and other routine health checks. Use BMI (adjusted for age and gender) as a practical estimate of adiposity in children and young people. Interpret BMI with caution because it is not a direct measure of adiposity. Where available, BMI z-scores or the Royal College of Paediatrics and Child Health UK-WHO growth charts may be used to calculate BMI in children and young people. The childhood and puberty close monitoring (CPCM) form may be used for longitudinal BMI monitoring in children over 4. Waist circumference is not recommended as a routine measure. Use it to give additional information on the risk of developing other long-term health problems. Do not use bioimpedance as a substitute for BMI as a measure of general adiposity. Define the degree of overweight or obesity in adults using the following classifications: Healthy weight – BMI 18.5 kg/m2 to 24.9 kg/m2 Overweight – BMI 25 kg/m2 to 29.9 kg/m2 Obesity I – BMI 30 kg/m2 to 34.9 kg/m2 Obesity II – BMI 35 kg/m2 to 39.9 kg/m2 Obesity III – BMI 40 kg/m2 or more. Interpret BMI with caution in highly muscular adults as it may be a less accurate measure of adiposity in this group. Some other population groups, such as people of Asian family origin and older people, have comorbidity risk factors that are of concern at different BMIs (lower for adults of an Asian family origin and higher for older people).[C] Use clinical judgement when considering risk factors in these groups, even in people not classified as overweight or obese, using the classification above.Further information on the use of BMI and waist circumference can be found in NICE's guideline on BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups. Base assessment of the health risks associated with being overweight or obese in adults on BMI and waist circumference as follows: BMI classificationWaist circumference Low High Very high Overweight No increased risk Increased risk High risk Obesity 1 Increased risk High risk Very high risk For men, waist circumference of less than 94 cm is low, 94–102 cm is high and more than 102 cm is very high. For women, waist circumference of less than 80 cm is low, 80–88 cm is high and more than 88 cm is very high. Give adults information about their classification of clinical obesity and the impact this has on risk factors for developing other long-term health problems. Base the level of intervention to discuss with the patient initially as follows: BMI classificationWaist circumferenceComorbidities present Low High Very high Overweight 1 2 2 3 Obesity I 2 2 2 3 Obesity II 3 3 3 4 Obesity III 4 4 4 4 1 General advice on healthy weight and lifestyle 2 Diet and physical activity 3 Diet and physical activity; consider drugs 4 Diet and physical activity; consider drugs; consider surgery The level of intervention should be higher for patients with comorbidities, regardless of their waist circumference. Adjust the approach as needed, depending on the person's clinical need and potential to benefit from losing weight. Relate BMI measurement in children and young people to the UK 1990 BMI charts to give age- and gender-specific information.Where available, BMI z-scores or the Royal College of Paediatrics and Child Health UK-WHO growth charts may be used to calculate BMI in children and young people. The childhood and puberty close monitoring (CPCM) form may be used for longitudinal BMI monitoring in children over 4. Tailored clinical intervention should be considered for children with a BMI at or above the 91st centile, depending on the needs of the individual child and family. Adults and children Make an initial assessment, then use clinical judgement to investigate comorbidities and other factors to an appropriate level of detail, depending on the person, the timing of the assessment, the degree of overweight or obesity, and the results of previous assessments. Manage comorbidities when they are identified; do not wait until the person has lost weight. Offer people who are not yet ready to change the chance to return for further consultations when they are ready to discuss their weight again and willing or able to make lifestyle changes. Give them information on the benefits of losing weight, healthy eating and increased physical activity. Recognise that surprise, anger, denial or disbelief about their health situation may diminish people's ability or willingness to change. Stress that obesity is a clinical term with specific health implications, rather than a question of how people look; this may reduce any negative feelings. During the consultation: Assess the person's view of their weight and the diagnosis, and possible reasons for weight gain. Explore eating patterns and physical activity levels. Explore any beliefs about eating, physical activity and weight gain that are unhelpful if the person wants to lose weight. Be aware that people from certain ethnic and socioeconomic backgrounds may be at greater risk of obesity, and may have different beliefs about what is a healthy weight and different attitudes towards weight management. Find out what the person has already tried and how successful this has been, and what they learned from the experience. Assess the person's readiness to adopt changes. Assess the person's confidence in making changes. Give people and their families and/or carers information on the reasons for tests, how the tests are done, and their results and meaning. If necessary, offer another consultation to fully explore the options for treatment or discuss test results. Adults Take measurements (see the recommendations in the section, Identification and classification of overweight and obesity) to determine degree of overweight or obesity and discuss the implications of the person's weight. Then, assess: any presenting symptoms any underlying causes of being overweight or obese eating behaviours any comorbidities (for example type 2 diabetes, hypertension, cardiovascular disease, osteoarthritis, dyslipidaemia and sleep apnoea) any risk factors assessed using lipid profile (preferably done when fasting), blood pressure measurement and HbA1c measurement the person's lifestyle (diet and physical activity) any psychosocial distress any environmental, social and family factors, including family history of overweight and obesity and comorbidities the person's willingness and motivation to change lifestyle the potential of weight loss to improve health any psychological problems any medical problems and medication the role of family and care workers in supporting individuals with learning disabilities to make lifestyle changes.See also NICE's guideline on weight management: lifestyle services for overweight and obese children and young people. Consider referral to tier 3 services if: the underlying causes of being overweight or obese need to be assessed the person has complex disease states or needs that cannot be managed adequately in tier 2 (for example, the additional support needs of people with learning disabilities) conventional treatment has been unsuccessful drug treatment is being considered for a person with a BMI of more than 50 kg/m2 specialist interventions (such as a very-low-calorie diet) may be needed surgery is being considered.For more information on tier 3 services, see NHS England's report on joined up clinical pathways for obesity. Children Assessment of comorbidity should be considered for children with a BMI at or above the 98th centile. Take measurements to determine degree of overweight or obesity and raise the issue of weight with the child and family, then assess: presenting symptoms and underlying causes of being overweight or obese willingness and motivation to change comorbidities (such as hypertension, hyperinsulinaemia, dyslipidaemia, type 2 diabetes, psychosocial dysfunction and exacerbation of conditions such as asthma) any risk factors assessed using lipid profile (preferably done when fasting) blood pressure measurement and HbA1c measurement psychosocial distress, such as low self-esteem, teasing and bullying (See also NICE's guideline on weight management: lifestyle services for overweight or obese children and young people) family history of being overweight or obese and comorbidities the child and family's willingness and motivation to change lifestyle lifestyle (diet and physical activity) environmental, social and family factors that may contribute to being overweight or obese, and the success of treatment growth and pubertal status any medical problems and medication the role of family and care workers in supporting individuals with learning disabilities to make lifestyle changes. Consider referral to an appropriate specialist for children who are overweight or obese and have significant comorbidities or complex needs (for example, learning disabilities or other additional support needs). In tier 3 services, assess associated comorbities and possible causes for children and young people who are oberweight or who have obesity. Use investigations such as: blood pressure measurement lipid profile, preferably while fasting fasting insulin fasting glucose levels and oral glucose tolerance test liver function endocrine function.Interpret the results of any tests used in the context of how overweight or obese the child is, the child's age, history of comorbidities, possible genetic causes and any family history of metabolic disease related to being overweight or obese. Make arrangements for transitional care for children and young people who are moving from paediatric to adult services. Adults and children Multicomponent interventions are the treatment of choice. Ensure weight management programmes include behaviour change strategies to increase people's physical activity levels or decrease inactivity, improve eating behaviour and the quality of the person's diet, and reduce energy intake. When choosing treatments, take into account: the person's individual preference and social circumstance and the experience and outcome of previous treatments (including whether there were any barriers) the person's level of risk, based on BMI and, where appropriate, waist circumference any comorbidities. Document the results of any discussion. Keep a copy of the agreed goals and actions (ensure the person also does this), or put this in the person's notes. Offer support depending on the person's needs, and be responsive to changes over time. Ensure any healthcare professionals who deliver interventions for weight management have relevant competencies and have had specific training. Provide information in formats and languages that are suited to the person. Use everyday, jargon-free language and explain any technical terms when talking to the person and their family or carers. Take into account the person's: age and stage of life gender cultural needs and sensitivities ethnicity social and economic circumstances specific communication needs (for example because of learning disabilities, physical disabilities or cognitive impairments due to neurological conditions). Praise successes – however small – at every opportunity to encourage the person through the difficult process of changing established behaviour. Give people who are overweight or obese, and their families and/or carers, relevant information on: being overweight and obesity in general, including related health risks realistic targets for weight loss; for adults, please see NICE's guideline on managing overweight and obesity in adults the distinction between losing weight and maintaining weight loss, and the importance of developing skills for both; advise them that the change from losing weight to maintenance typically happens after 6 to 9 months of treatment realistic targets for outcomes other than weight loss, such as increased physical activity and healthier eating diagnosis and treatment options healthy eating in general (more information on healthy eating can be found on the NHS website) medication and side effects surgical treatments self-care voluntary organisations and support groups and how to contact them.Ensure there is adequate time in the consultation to provide information and answer questions. If a person (or their family or carers) does not feel this is the right time for them to take action, explain that advice and support will be available in the future whenever they need it. Provide contact details so that the person can get in touch when they are ready. Adults Encourage the person's partner or spouse to support any weight management programme. Base the level of intensity of the intervention on the level of risk and the potential to gain health benefits. Children Be aware that the aim of weight management programmes for children and young people can vary. The focus may be on either weight maintenance or weight loss, depending on the person's age and stage of growth. Encourage parents of children and young people who are overweight or obese to lose weight if they are also overweight or obese. Adults and children Deliver any behavioural intervention with the support of an appropriately trained professional. Adults Include the following strategies in behavioural interventions for adults, as appropriate: 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 strategies for dealing with weight regain Children Include the following strategies in behavioural interventions for children, as appropriate: stimulus control self-monitoring goal setting rewards for reaching goals problem solving. Give praise to successes and encourage parents to role-model desired behaviours. Adults Encourage adults to increase their level of physical activity even if they do not lose weight as a result, because of the other health benefits it can bring (for example, reduced risk of type 2 diabetes and cardiovascular disease). Encourage adults to meet the recommendations in the UK Chief Medical Officers' physical activity guidelines for weeky activity. Advise that to prevent obesity, most people may need to do 45 to 60 minutes of moderate-intensity activity a day, particularly if they do not reduce their energy intake. Advise people who have been obese and have lost weight that they may need to do 60 to 90 minutes of activity a day to avoid regaining weight. Encourage adults to build up to the recommended activity levels for weight maintenance, using a managed approach with agreed goals. Recommend types of physical activity, including: activities that can be incorporated into everyday life, such as brisk walking, gardening or cycling (see also NICE's guideline on walking and cycling) supervised exercise programmes other activities, such as swimming, aiming to walk a certain number of steps each day, or stair climbing. Take into account the person's current physical fitness and ability for all activities. Encourage people to also reduce the amount of time they spend inactive, such as watching television, using a computer or playing video games. Children Encourage children and young people to increase their level of physical activity, even if they do not lose weight as a result, because of the other health benefits exercise can bring (for example, reduced risk of type 2 diabetes and cardiovascular disease). Encourage children to meet the recommendations in the UK Chief Medical Officers' physical activity guidelines for daily activity. Be aware that children who are already overweight may need to do more than 60 minutes' activity. Encourage children to reduce inactive behaviours, such as sitting and watching television, using a computer or playing video games. Give children the opportunity and support to do more exercise in their daily lives (for example, walking, cycling, using the stairs and active play; see also NICE's guideline on walking and cycling). Make the choice of activity with the child, and ensure it is appropriate to the child's ability and confidence. Give children the opportunity and support to do more regular, structured physical activity (for example football, swimming or dancing). Make the choice of activity with the child, and ensure it is appropriate to the child's ability and confidence. Adults and children Tailor dietary changes to food preferences and allow for a flexible and individual approach to reducing calorie intake. Do not use unduly restrictive and nutritionally unbalanced diets, because they are ineffective in the long term and can be harmful. Encourage people to improve their diet even if they do not lose weight, because there can be other health benefits. Adults The main requirement of a dietary approach to weight loss is that total energy intake should be less than energy expenditure. 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. Consider low-calorie diets (800–1600 kcal/day), but be aware these are less likely to be nutritionally complete. Do not routinely use very-low-calorie diets (800 kcal/day or less) to manage obesity (defined as BMI over 30). Only consider very-low-calorie diets, as part of a multicomponent weight management strategy, for people who are obese and who have a clinically-assessed need to rapidly lose weight (for example, people who need joint replacement surgery or who are seeking fertility services). Ensure that: the diet is nutritionally complete the diet is followed for a maximum of 12 weeks (continuously or intermittently) the person following the diet is given ongoing clinical support. Before starting someone on a very-low-calorie diet as part of a multicomponent weight management strategy: Consider counselling and assess for eating disorders or other psychopathology to make sure the diet is appropriate for them Discuss the risks and benefits with them Tell them that this is not a long-term weight management strategy, and that regaining weight may happen and is not because of their own or their clinician's failure Discuss the reintroduction of food following a liquid diet with them. Provide a long-term multicomponent strategy to help the person maintain their weight after the use of a very-low-calorie diet. Encourage people to eat a balanced diet in the long term, consistent with other healthy eating advice.More information on healthy eating can be found on the eat well pages of the NHS website. Children A dietary approach alone is not recommended. It is essential that any dietary recommendations are part of a multicomponent intervention. Any dietary changes should be age appropriate and consistent with healthy eating advice. For overweight and obese children and young people, total energy intake should be below their energy expenditure. Changes should be sustainable. Adults Consider pharmacological treatment only after dietary, exercise and behavioural approaches have been started and evaluated. Consider drug treatment for people who have not reached their target weight loss or have reached a plateau on dietary, activity and behavioural changes. Make the decision to start drug treatments after discussing the potential benefits and limitations with the person, including the mode of action, adverse effects and monitoring requirements, and the potential impact on the person's motivation. Make arrangements for appropriate healthcare professionals to offer information, support and counselling on additional diet, physical activity and behavioural strategies when drug treatment is prescribed. Provide information on patient support programmes. Children Drug treatment is not generally recommended for children younger than 12 years. In children younger than 12 years, drug treatment may be used only in exceptional circumstances, if severe comorbidities are present. Prescribing should be started and monitored only in specialist paediatric settings. In children aged 12 years and older, treatment with orlistat is recommended only if physical comorbidities (such as orthopaedic problems or sleep apnoea) or severe psychological comorbidities are present. Treatment should be started in a specialist paediatric setting, by multidisciplinary teams with experience of prescribing in this age group.In October 2014, this was an off label use of orlistat. See NICE's information on prescribing medicines. Do not give orlistat to children for obesity unless prescribed by a multidisciplinary team with expertise in: drug monitoring psychological support behavioural interventions interventions to increase physical activity interventions to improve diet. Drug treatment may be continued in primary care for example with a shared care protocol if local circumstances and/or licensing allow. Adults and children Pharmacological treatment may be used to maintain weight loss rather than to continue to lose weight. If there is concern about micronutrient intake adequacy, a supplement providing the reference nutrient intake for all vitamins and minerals should be considered, particularly for vulnerable groups such as older people (who may be at risk of malnutrition) and young people (who need vitamins and minerals for growth and development). Offer support to help maintain weight loss to people whose drug treatment is being withdrawn; if they did not reach their target weight, their self-confidence and belief in their ability to make changes may be low. Adults Monitor the effect of drug treatment and reinforce lifestyle advice and adherence through regular review. Consider withdrawing drug treatment in people who have not reached weight loss targets. Rates of weight loss may be slower in people with type 2 diabetes, so less strict goals than those for people without diabetes may be appropriate. Agree the goals with the person and review them regularly. Only prescribe orlistat as part of an overall plan for managing obesity in adults who meet one of the following criteria: a BMI of 28 kg/m2 or more with associated risk factors a BMI of 30 kg/m2 or more. Continue orlistat therapy beyond 3 months only if the person has lost at least 5% of their initial body weight since starting drug treatment. (See above for advice on targets for people with type 2 diabetes.) Make the decision to use drug treatment for longer than 12 months (usually for weight maintenance) after discussing potential benefits and limitations with the person. The co-prescribing of orlistat with other drugs aimed at weight reduction is not recommended. Children If orlistat is prescribed for children, a 6–12-month trial is recommended, with regular review to assess effectiveness, adverse effects and adherence.In October 2014, this was an off label use of orlistat. See NICE's information on prescribing medicines. © NICE 2021. Obesity: identification, assessment and management. Available from: www.nice.org.uk/guidance/CG189. All rights reserved. Subject to Notice of rights. NICE guidance is prepared for the National Health Service in England. All NICE guidance is subject to regular review and may be updated or withdrawn. NICE accepts no responsibility for the use of its content in this product/publication. 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