Diabetes & Primary Care

Volume 28 | Issue 4 | 2026
Sponsored supplement

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CHORD
Campaign for Health in Obesity-Related Disease

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Striking the right CHORD: A primary care perspective on tackling obesity in the UK

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Citation: Capehorn M, Ali K, Bell H, Kanumilli N, Lamba A, Malik N, Milne N, Woodhouse M (2026) Striking the right CHORD: A primary care perspective on tackling obesity in the UK. *Diabetes & Primary Care* **28**(Suppl 1): S1–23

Key words
– Obesity
– Obesity assessment
– Overweight
– Weight loss
– Weight management
– Clinical guidance
– Primary care
– Education

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Obesity is a growing public health crisis in the UK. Many adults are living with overweight and obesity, and the number is expected to increase over the next decade. Tackling the obesity epidemic is a key priority for UK healthcare professionals working in primary care. Obesity is associated with significant risks of developing many other medical and mental health conditions, including various types of cancer, cardiovascular disease and type 2 diabetes, and even small amounts of weight loss can help to reduce the risk of such conditions. Primary care is an ideal setting for the management of obesity, including early identification of people at risk of developing obesity. With permission from the individual, short, consistent messages and motivational discussions about healthy living and prevention of obesity and associated conditions can be delivered at each contact. In addition to existing non-pharmacological interventions and the ability to refer appropriate people for higher tier weight management services, the relatively recent approval of newer pharmacological weight-loss treatments has given healthcare professionals more options for treating people living with severe and complex obesity and comorbid conditions.

The Campaign for Health in Obesity-Related Disease (CHORD) steering committee is a multidisciplinary group of UK healthcare professionals that aims to help educate and provide clarity to primary care professionals working with adults living with obesity. In this article, the committee outlines its recommendations for effective assessment and management of obesity in primary care, including practical tools to support healthcare professionals in their day-to-day weight management activities.

What this paper adds

This narrative review article summarises the latest obesity research and proposes practical advice that primary care healthcare professionals can use in their work with adults living with overweight and obesity. The supplementary information includes an interactive pathway tool and summaries of key information for use during consultations.

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The role of the CHORD steering committee

The Campaign for Health in Obesity-Related Disease (CHORD) steering committee is a multidisciplinary group of UK healthcare professionals that aims to help educate and provide clarity to primary care professionals working with adults living with obesity. This consensus document has been developed as a practical, evidence-based guide to the management options available and the factors to consider when assessing, advising and treating people living with overweight and obesity.

This article is based on previously conducted studies and does not contain any studies with human participants or animals conducted by any of the authors.

Obesity: a growing public health crisis in the UK

Obesity and overweight represent a growing global public health crisis, with the 2024 Health Survey for England figures suggesting around two-thirds of adults (66%) are classed as being above a healthy weight and 30% of all adults are living with obesity. [**NHS England Health Survey for England 2024**] In Scotland, Wales and Northern Ireland, the figures are similar, with 62–66% of adults in the overweight or obese category and 25–31% of all adults living with obesity. [**Scottish Gov. Health Survey 2024, Welsh Gov National Survey for Wales 2024–5, NI DoH Health Survey Northern Ireland 2024–5**]

Obesity costs the NHS an estimated £12.6 billion every year, and when added to wider costs such as lost productivity, the figure is estimated at £126 billion. [**Frontier Economics & Nesta 2025**] Preventing and treating obesity is a national priority. The NHS's *Fit for the future: 10 year health plan for England* [**Dept Health and Social Care 2025**] had a strong obesity focus, pledging to take action to prevent obesity in children and to deliver high-quality obesity care to people from all socioeconomic backgrounds.

As with adults, obesity in children is an important and concerning issue, but approaches to obesity management are quite different between these age groups. In this paper, we focus on adults living with obesity.

Obesity is a disease in its own right

The committee agrees with multiple bodies, including the Royal College of Physicians (RCP), European Association for the Study of Obesity (EASO), World Health Organization (WHO), Canadian Medical Association (CMA) and American Medical Association (AMA) that obesity should be considered a chronic, progressive, relapsing disease in its own right, rather than a risk factor for other conditions. [**RCP 2025, Frühbeck 2019, WHO 2022, Schumacher 2023, Obesity Canada 2025**]

WHO defines chronic diseases as long-term, slowly progressing, non-communicable diseases caused by a combination of genetic, physiological, environmental and behavioural factors. [**WHO 2025 Noncommunicable disease**] Obesity meets these criteria and, like other long-term conditions such as type 2 diabetes and hypertension, further health risks are reduced when obesity is well managed. [**Haase 2021, Blüher 2025**]

In the 2025 *WHO guideline on the use of glucagon-like peptide-1 (GLP-1) therapies for the treatment of obesity in adults* [**WHO 2025 GLP-1**] obesity is defined as 'a chronic complex disease that requires lifelong care beginning with clinical assessment and early diagnosis'.

Obesity is a complex condition, with environmental, behavioural, genetic, psychological and socioeconomic drivers. [**Government Office for Science 2007, WHO 2025 GLP-1**] People living with obesity who achieve weight loss often experience relapse. [**Hall 2018**] This may be caused by homeostatic adaptation – pathophysiological processes that attempt to return the body to its previous weight, including decreased energy expenditure, reduced resting metabolic rate, hormonal changes and increased appetite. [**Hall 2018**] Not recognising obesity as a disease in its own right may shift the blame towards people living with obesity and contribute to the already significant stigma they feel. There is not the same debate about the disease status of other conditions with a considerable behavioural component, e.g. type 2 diabetes. [**Rubino 2025**]

There is an argument that classifying obesity as a disease increases the focus on pharmacological or surgical interventions, rather than prioritising healthy living and public health policies. It may also lead to more aggressive treatment of people who are living with obesity, some of whom do not yet experience obvious associated health problems. [**Luli 2023**] However, the CHORD committee believes recognising obesity as a disease in its own right will produce wider societal benefits, such as reduced stigma, new initiatives to improve obesity prevention, changes in the food industry and increased access to interventions that promote healthy living and pharmacological treatments.

Considering obesity as a chronic disease requires a shift in obesity management, treating it in a similar way to other long-term conditions such as type 2 diabetes or hypertension. This includes the understanding that the condition is unlikely to improve without treatment, and that obesity management interventions or lifelong management strategies will likely be needed for the rest of the person's life. As with other

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Table 1. Estimated relative risk of various conditions among people living with obesity, compared with those at a healthy weight. Pooled results from meta-analysis of multiple studies. Adapted from Guh DP et al. [Guh 2009]

Condition		Measure	Relative risk (95% CI)	
			Females	Males
Cardiovascular, renal and metabolic conditions	Type 2 diabetes*	BMI	12.41 (9.03–17.06)	6.74 (5.55–8.19)
		WC	11.10 (8.23–14.96)	5.13 (3.81–6.90)†
	Hypertension*	BMI	2.42 (1.59–3.67)	1.84 (1.51–2.24)
		WC	1.90 (1.77–2.03)	N/A
	Coronary artery disease*	BMI	3.10 (2.81–3.43)	1.72 (1.51–1.96)†
		WC	2.69 (2.05–3.53)	1.81 (1.45–2.25)†
	Congestive heart failure*	BMI	1.78 (1.07–2.95)†	1.79 (1.24–2.59)
	Stroke	BMI	1.49 (1.27–1.74)†	1.51 (1.33–1.72)†
	Pulmonary embolism	BMI	3.51 (2.61–4.73)	3.51 (2.61–4.73)
Cancer	Postmenopausal breast cancer	BMI	1.13 (1.05–1.22)	N/A
	Colorectal cancer	BMI	1.66 (1.52–1.81)	1.95 (1.59–2.39)
	Endometrial cancer	BMI	3.22 (2.91–3.56)	N/A
	Oesophageal cancer	BMI	1.20 (0.95–1.53)	1.21 (0.97–1.52)
	Kidney cancer	BMI	2.64 (2.39–2.90)	1.82 (1.61–2.05)
	Ovarian cancer	BMI	1.28 (1.20–1.36)	N/A
	Pancreatic cancer	BMI	1.60 (1.17–2.20)	2.29 (1.65–3.19)
	Prostate cancer	BMI	N/A	1.05 (0.85–1.30)
Other	Asthma	BMI	1.78 (1.36–2.32)†	1.43 (1.14–1.79)†
	Gallbladder disease*	BMI	2.32 (1.17–4.57)‡	1.43 (1.04–1.96)‡
		WC	N/A	2.38 (2.06–2.75)†
	Osteoarthritis	BMI	1.96 (1.88–2.04)†	4.20 (2.76–6.41)
	Chronic back pain	BMI	2.81 (2.27–3.48)†	2.81 (2.27–3.48)†

BMI=body mass index; CI=confidence interval; WC=waist circumference.
*WC was considered by the authors to better predict risk than BMI.
Relative risks were calculated from incidence rate ratios (IRRs) except those marked †, which were calculated from ratios of proportions (RR-Ps); ‡ Calculated using both RR-Ps and IRRs.

long-term conditions, we believe obesity should be managed in primary care or in the community, and that people living with overweight or obesity should have increased access to psychosocial support services to improve outcomes.

Health inequalities

Obesity in the UK shows considerable health inequalities, with deprivation being a key factor affecting obesity prevalence. Adults in the most deprived areas have substantially higher overweight and obesity rates and obesity-related hospital admissions than those in the least deprived areas, particularly in women, and the gap between the most and least deprived areas has widened in recent years. [**Stiebahl, 2025, NHSE Obesity stats 2021, NICE NG246, NICE health inequalities 2023**] People living in more deprived areas may experience barriers to healthy eating and regular physical activity, [**NICE health inequalities**] for example the cost of fresh, healthy food and access to organised fitness activities. Socioeconomic factors can also affect availability of, and access to, weight management services, with people from more deprived areas less likely to complete weight management programmes. [**NICE health inequalities**]

People from South Asian, Chinese, other Asian, Middle Eastern, Black African and African-Caribbean backgrounds have increased risks for central adiposity, cardiometabolic risk factors and weight-related health conditions, so lower body mass index (BMI) thresholds are required for these populations. [**NICE NG246**] Many people are not aware of these increased risks, and healthcare professionals can help to raise awareness as part of routine consultations, using it as an opportunity to measure and record height, weight and waist circumference, helping to highlight people at risk of developing obesity in the future.

Obesity shortens life expectancy and is associated with over 200 separate conditions

Overweight and obesity are associated with over 200 physical and mental health conditions, affecting almost all body systems. [**Yuen 2021**] It is thought excess weight contributes to these conditions by various mechanisms, including chronic inflammation, oxidative stress, impaired immunity, insulin resistance, endothelial dysfunction, overactivity in the renin-angiotensin-aldosterone system or sympathetic nervous system, alterations in sex hormones or brain structure, and mechanical effects of excess body fat, either through excess load on the body or infiltration of fat cells into organs. [**Yuen 2021, Rubino 2021, Tsai 2019, Sarma 2021**]

As well as the more obvious links to cardiovascular-renal-metabolic conditions, such as type 2 diabetes, hypertension and

cardiovascular disease, obesity has been linked to many types of cancer. Some US estimates suggest 20% of all cancers are linked to obesity, [**Wolin, 2010**] including endometrial, breast, ovarian, prostate, oesophageal, liver, gallbladder, kidney and colon cancer. [**Ackerman 2017, Wolin, 2010**] Other obesity-related conditions include obstructive sleep apnoea, gallbladder disease, osteoarthritis and respiratory problems. [**Jensen 2014**]

Compared with people at a healthy weight, individuals living with obesity are more likely to develop a number of conditions, particularly type 2 diabetes (see *Table 1*, previous page). [**Guh 2009, Kivimaki 2022, Grant 2025**]

It is thought obesity shortens life expectancy by 6–14 years, [**Whitlock 2009, Fontaine 2003, Grover 2015**] although figures suggest mortality rates among people living with obesity have been declining. Between 2004 and 2019, UK healthcare database records showed an average annual rate reduction of 3% in all-cause mortality and 4–7% reduction in cardiovascular mortality for people in the obese category. [**Sophiea 2024**]

Obesity has also been shown to reduce a person's number of disease-free years. [**Grover 2015, Nyberg 2018**] Longitudinal evidence pooled from multiple European cohort studies suggests severe obesity is linked to a substantial reduction in disease-free years. Between the ages of 40 and 75, people with severe obesity had fewer estimated disease-free years (8.5 years in males, 7.3 years in females) compared with those at a healthy weight. [**Nyberg 2018**]

Encouragingly, even modest weight loss can produce clinically meaningful improvements in health outcomes, particularly risk factors for cardiovascular disease and type 2 diabetes. [**Jensen 2014, Hartmann-Boyce 2023**] A systematic review and meta-analysis of behavioural weight management programme trials suggested health benefits seen with weight loss could continue for up to 5 years after programme completion, even in people who subsequently regained weight. [**Hartmann-Boyce 2023**]

A 5–10% decrease in initial body weight has been shown to reduce the risk of cardiovascular disease, type 2 diabetes and other obesity-related complications, and to improve lipid profiles, blood glucose and HbA_{1c}. [**Obesity Canada – Canadian guidelines 2020**] A systematic review of studies with a combined total of over 18,000 people who lost under 5% of their body weight suggested 87% of people experienced improvements in at least one health marker. [**Dhar 2025**] In addition, even in the absence of weight loss, healthy eating and increased physical activity can contribute to improvements in quality of life, mental health, strength, stamina and confidence. *Figure 1* highlights some examples of health outcome improvements at increasing levels of weight loss.

Current obesity guidelines and their overlap with other cardiovascular-renal-metabolic conditions

In writing this review, the committee considered and reviewed current global obesity guidelines. [**NICE NG246, Busetto 2024, Jensen 2014, Garvey 2016, Wharton 2020, Rubino 2025, Durrer Schutz 2019, WHO GLP-1 2025, McGowan 2025 EASO**] There is considerable

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0–5% weight loss	>5% weight loss	>10% weight loss	>15% weight loss
• Improved glycaemic control **[Ryan]** • Reduced hypertension **[Mariam]** • Improved asthma control **[Johnson]** • Reduced chronic kidney disease (after 10 years) **[Mariam]** • Improved ovulatory function and subsequent pregnancy in patients with polycystic ovary syndrome and infertility **[Ryan]**	• Reduced risk of obesity-related cancer **[Luo]** • Improved knee pain and function in people with osteoarthritis **[Ryan]** • Slowed ageing-associated mobility decline **[Ryan]** • Reduced urinary incontinence **[Ryan]** • Reduced sexual dysfunction **[Ryan]** • Decreased hospitalisation rate in people with type 2 diabetes **[Ryan]**	• Reduced major cardiovascular outcomes **[Ryan]** • Improved metabolic dysfunction-associated steatohepatitis activity score **[Ryan]**	• Reduced all-cause and cardiovascular mortality **[Ryan]**

Figure 1. Health outcome improvements with increasing levels of weight loss. ***[Ryan 2017, Mariam 2021, Johnson 2022, Luo 2019]***

"Advances in obesity treatment, including recently approved medications and new formulations in development, are expected to have a considerable effect on obesity levels in the UK. However, the already stretched NHS is unlikely to have the capacity and funding to deal with prescribing weight management medications to everyone who needs them."

overlap between recommendations and a lot of crossover between the obesity guidelines and those for other cardiovascular-renal-metabolic conditions, with common goals such as reduction in weight, blood pressure and blood glucose. [**NICE NG28, NG49, NG136, NG203**] In future, it may be possible to create integrated cardiovascular-renal-metabolic guidelines that encompass obesity as part of the wider cluster of conditions that also includes hypertension, type 2 diabetes, cardiovascular disease, chronic kidney disease and metabolic dysfunction-associated steatotic liver disease (MASLD). Recently, the acronym CARDIAL-MS has been proposed to incorporate all of these conditions: CArdio-Renal-DIAbetes-Liver-Metabolic Syndrome. [**Godoy-Matos 2025**]

Changes in the obesity treatment landscape

Advances in obesity treatment, including recently approved medications and new formulations in development, are expected to have a considerable effect on obesity levels in the UK. However, the already stretched NHS is unlikely to have the capacity and funding to deal with prescribing weight management medications to everyone who needs them. [**NHSE commissioning guidance 2026, NHS Scotland Consensus statement 2025**] There are also uncertainties around the long-term effects of weight management medications, the impact of medication on behavioural change and what happens when drug treatment is stopped. [**McKinsey 2025**]

UK tiered weight management structure

Weight management is typically organised into a four-tier structure in England and Scotland (see *Figure 2*) although the most recent NICE obesity guidelines appear to be moving away from a strict tier system towards a more individualised, patient-centred model of care. [**NICE NG246, NHS England interim commissioning guidance**] Tier 1 includes general healthy living advice and is carried out in primary care. Tier 2 is also managed in primary care and includes referral to community-based weight management programmes including exercise classes at local leisure centres, and commercial programmes such as WW (formerly Weight Watchers) and Slimming World. Where available, dietitians based in primary care or the community can provide tailored advice and appropriate primary care health professionals can prescribe some weight management medications for appropriate people. Tier 3 involves specialist weight management services, usually managed by a multidisciplinary team, where interventions can include specialist-only weight management medications, very-low-calorie diets and assessment for referral for bariatric surgery. Tier 4 covers specialist complex obesity services, including bariatric surgery. [**Gupta 2023**] There are currently no structured weight management services in Northern Ireland.

Tier 3 and 4 weight management services have produced good results [**Jennings 2014**] but are not available in all areas. Where

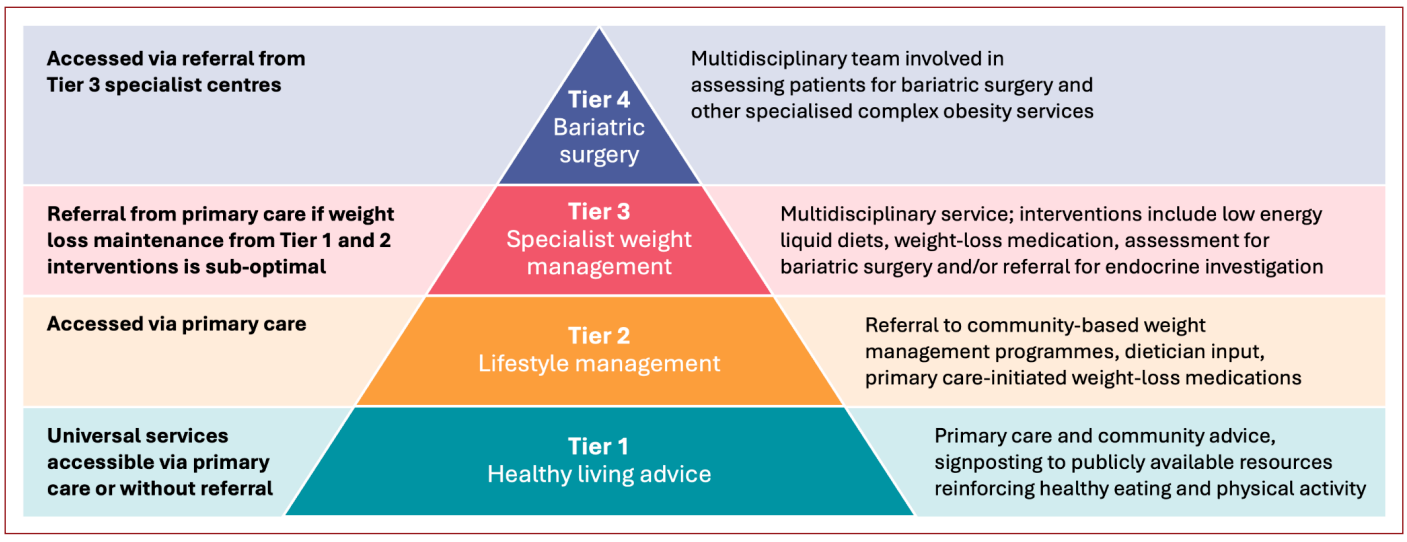

Figure 2. The four-tier weight management structure in England and Scotland (Adapted from Gupta and Chen, 2023). ***[Gupta 2023]***

they do exist, waiting lists are often long. [**Spaltro 2025**] In the future, some Tier 1–3 weight management services could be remotely delivered to help relieve the pressure on in-person services. [**Spaltro 2025**] Most private providers of weight management medication are fully remote, and it may be possible for the NHS to provide a similar service. Another alternative to separate Tier 3 services could be to incorporate obesity into cardiovascular-renal-metabolic or multiple long-term condition clinics, adding expertise from obesity specialists to existing multidisciplinary teams.

Because of the increased number of contacts primary healthcare professionals have with people at risk of obesity, they are well placed to recognise early signs of overweight and obesity, talk to people about their concerns and provide information about healthy living and available services. If pharmacological treatment is necessary, some options can be initiated in primary care. Prioritising early diagnosis and intervention could help prevent development or worsening of obesity and related conditions, improving quality of life and reducing healthcare expenditure. However, significant workload pressures in primary care, including resource shortages and increasingly complex caseloads mean delivery of weight management services requires an efficient, low-cost approach. Sufficient funding, infrastructure and training is essential for effective primary care weight management.

Opportunistically talking about weight, ensuring BMI and other anthropometric results are up to date and providing information about available local services and treatment options can be done effectively in primary care, in short consistent conversations over multiple appointments if necessary. Allied and non-medical healthcare professionals in primary care, including dietitians, health and wellbeing coaches, healthcare assistants, and social prescribers could manage some of the primary care weight management conversations and interventions, possibly allowing longer appointment durations and freeing up GP time.

Obesity management pathway

The CHORD committee has proposed two pathways for identification, assessment and treatment of people living with obesity. The first, a 'realistic pathway', takes into account the limitations and constraints primary care management of obesity is under (*Figure 3*). Another 'ideal pathway' contains steps that could be included with sufficient investment, resource and time (*Figure 4*). This pathway requires more detailed cost–benefit analysis, but could be adapted to take into account local needs and available resources. In either pathway, individualised treatment and shared decision-making applies at all stages.

Assessment and diagnosis of obesity

Assessment of obesity in primary care can be difficult in the short time healthcare professionals have with each individual. People rarely visit their primary care practice to discuss their weight, and if it is mentioned, it may be as an afterthought at the end of a consultation. People can be reluctant to discuss their weight and may feel self-conscious about mentioning it. Some healthcare professionals can also hold negative views about people living with obesity, and may use unsupportive language.

As healthcare professionals, it is important not to add to the stigma already faced by people living with overweight and obesity, and to use positive, inclusive and supportive language (for some useful advice for sensitive discussions, see *Box 1, supplementary information*). [**Obesity UK Language Matters**]

Introducing the topic of weight

Healthcare professionals should always ask for permission to discuss weight. [**Obesity UK Language Matters**] If the person doesn't want to talk about weight that day, a note should be placed on their file to ask again at a future appointment.

It can help to introduce the topic indirectly, for example by asking if the person has any health concerns. In many cases, the condition(s) they mention will have a link to obesity, and key statistics can be introduced to help sensitively move the conversation towards weight. Healthcare professionals should take care not to engage in 'diagnostic overshadowing' where a person presents with a different condition and weight is discussed immediately. [**NICE NG246**] The presenting condition should be considered first, but could be used as a starting point for

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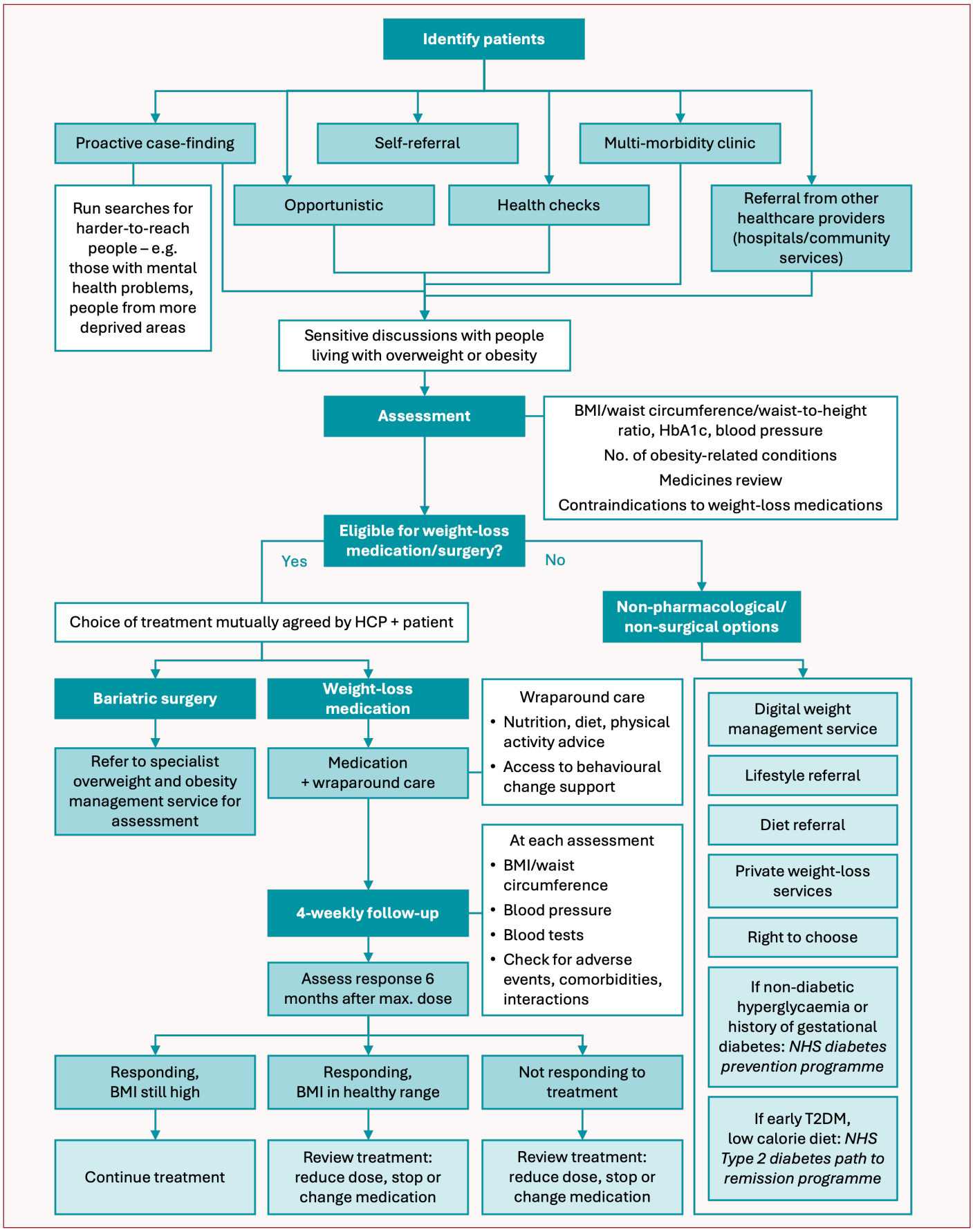

Figure 3. The 'realistic' CHORD obesity management pathway.
BMI: body mass index; HCP: healthcare professional; T2DM: type 2 diabetes mellitus. **Please note:** Resources and access to tools such as online support programmes varies between locations. For example, while digital remission of diabetes and prevention programmes have recently been introduced in Scotland, fewer resources are available in Northern Ireland and Wales.

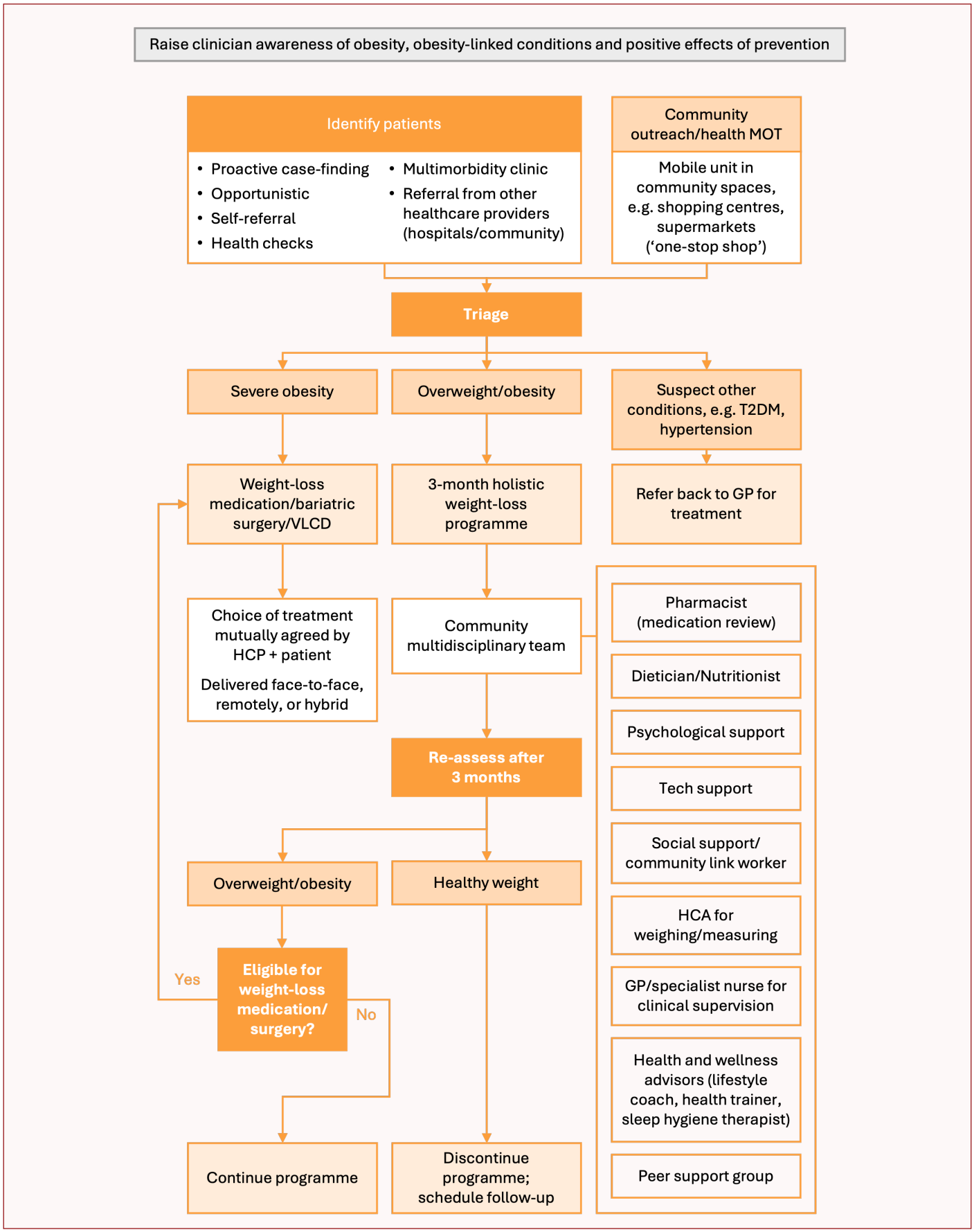

Figure 4. The 'ideal' CHORD obesity management pathway.
HCA: healthcare assistant; HCP: healthcare professional; T2DM: type 2 diabetes mellitus; VLCD: very-low-calorie diet.

"Healthcare professionals are encouraged to measure weight, height and waist circumference at suitable opportunities, after obtaining permission. This could include GP registration, consultations for long-term conditions and other routine health checks."

weight-based discussions later in the consultation, with permission.

Opportunistic weight measurement

Healthcare professionals are encouraged to measure weight, height and waist circumference at suitable opportunities, after obtaining permission. This could include GP registration, consultations for long-term conditions and other routine health checks. [**NICE NG246**] People living with obesity, especially those without diagnosed long-term conditions, may only have had their BMI and other measurements taken when they first joined the practice. Keeping these data regularly updated could help identify people at risk of developing obesity and allow earlier intervention.

Is body mass index still the most useful tool for measuring obesity?

Body mass index (BMI) has long been widely used as a proxy measure for overweight and obesity, [**Ashwell 2012**] and is the measure most commonly used in clinical research, obesity guidelines and eligibility criteria for treatment. However, BMI has some limitations. For example, it does not take into account differences in gender, body composition or age, and does not always correlate with excess body fat. Among people with the same BMI, body fat percentage can vary considerably. [**Romero-Corral 2008**] (see *Box 2, supplementary information*). Guidelines suggest combining BMI with another measure, e.g. waist-to-height ratio, to give a better picture of a person's level of risk, particularly in people with BMI <35 kg/m^2. [**NICE NG246, Busetto 2024**] People with BMI >35 kg/m^2 are likely to have a high waist-to-height ratio, so waist measurements in this group are not as useful. [**NICE NG246**] Bioelectrical impedance analysis can be useful for estimating body fat percentage, but its use is discouraged in the NICE obesity guidelines [**NICE NG246**] and it is not widely available in primary care settings.

Primary healthcare professionals are well placed to use their experience to recognise signs of problematic weight gain in the people they see, and prioritise measurements and weight-based discussions for the people they are most concerned about.

It is important to ensure the correct equipment is available for measuring people of all weights and sizes, without needing to make special adjustments. This includes chairs without arms, weighing scales suitable for all weights, and large blood pressure cuffs. [**NICE NG246**]

Holistic evaluation

As well as anthropometric measurements, healthcare professionals should take a detailed history once given permission to discuss weight. Open-ended questions should be used to ascertain the person's feelings about their weight. [**Obesity UK Language Matters**] Questions about family history, lifestyle, working patterns, sleep and important life events can highlight other possible contributions to weight gain, including psychological eating and socioeconomic factors. Possible barriers to treatment can also be identified.

Validated mental health assessment tools can be used to help ascertain whether weight gain is linked to psychological eating, and to indicate whether further intervention or referral is needed. These include the Generalised Anxiety Disorder-7 (GAD-7), SCOFF questionnaire, [**Morgan 1999**] Binge Eating Scale (BES) [**Gormally 1982**] or 7-item Binge-Eating Disorder Screener (BEDS-7). [**Herman 2016**]

Consideration should also be given to women's health and how obesity can affect the various stages of a woman's reproductive life, including fertility, pregnancy planning, pregnancy and breastfeeding. EASO published a position statement in 2025, providing useful information on diagnosis and management of obesity at each stage, along with considerations for counselling, communication and psychological support. [**Filippi-Arriaga 2025**]

Figure 5 gives a suggested structure for discussions about weight, based on the existing 5 As and 7 As frameworks for behavioural change. This structure is based on shared decision-making, with the healthcare professional listening to the priorities and goals of the person living with obesity and providing information, advice and encouragement, rather than dictating what they must do. If the healthcare professional feels unsure of how to perform any step, or has not had suitable training, they can assign the person living with obesity to colleagues with the right experience.

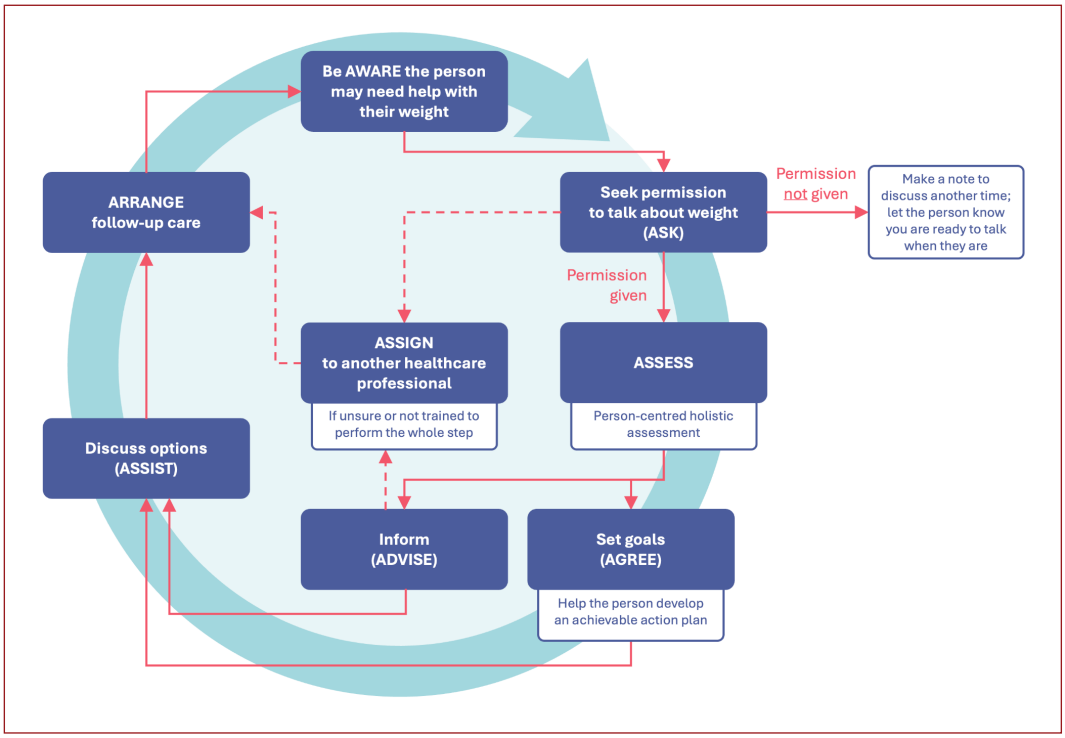

Figure 5. A suggested model for obesity consultations, adapted from the 5 As and 7 As models.
Adapted from **Diabetes UK** and **Sturgiss 2017**.

Goal setting

Personalised goals should focus on improving quality of life rather than weight loss. They should be realistic and meaningful to the person living with obesity, for example better mobility or being able to breathe more easily when climbing stairs. [**NICE NG246, Busetto 2024, Durrer Schutz 2019, Mallik 2023**]

Management options

Obesity management requires a holistic approach, involving shared decision-making. The primary goal should be to improve health and quality of life, rather than a fixed weight-loss target. [**Garvey 2016**] Small changes can make a big difference, and in people whose weight is continuing to increase, weight maintenance rather than loss is a positive outcome.

Non-pharmacological obesity management

Comprehensive healthy living interventions are the foundation of obesity management, with or without additional pharmacological treatment. The CHORD committee recommends using positive language around 'nutrition, movement and recovery' to help discuss non-pharmacological healthy living interventions with people living with obesity (*Figure 6*). This moves away from potentially stigmatising or restrictive language such as 'diet', and is general advice that can be given to everyone, regardless of their weight.

Reviewing obesogenic medications

Some medications can contribute to weight gain. [**Apovian 2015, Domecq 2015**] Before beginning any weight-loss intervention, healthcare professionals should conduct a medicine review and suggest weight-neutral alternatives, where appropriate. Obesogenic medications may include corticosteroids, hormones, antipsychotics, anti-hyperglycaemic agents (e.g. insulin, sulphonylureas, thiazolidinediones), antiepileptics, antidepressants and some analgesics. [**NICE 2025 implementation support, Ibrahim 2025**]

The effects of sleep on weight

People living with obesity might not be aware of the effects of sleep deprivation on weight. Sub-optimal sleep has been shown to produce lower levels of leptin (a hormone involved in satiety signalling), higher levels of ghrelin (the 'hunger' hormone) and increased insulin resistance. [**Taheri 2004**] Lack of sleep is also

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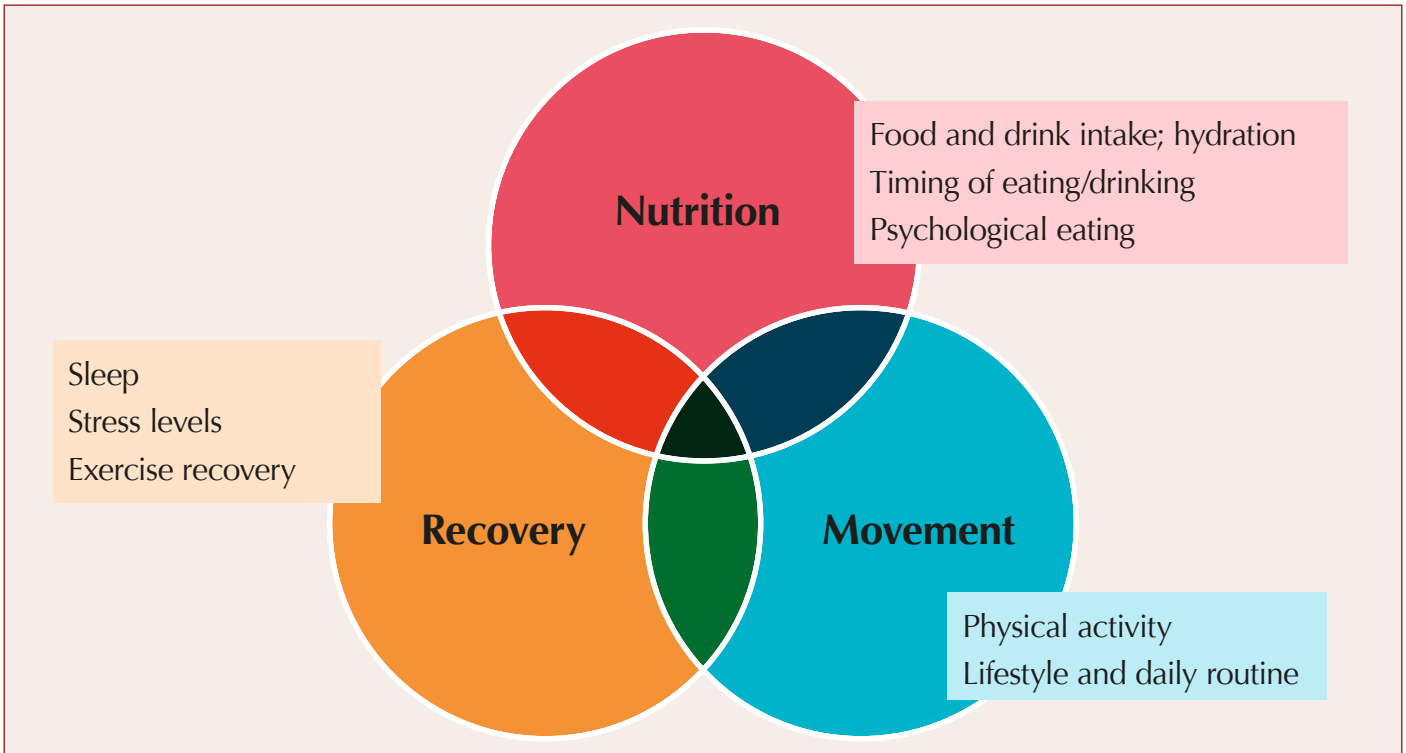
related to higher cortisol and increased tiredness, which are both thought to increase appetite and the preference for energy-dense foods. Tiredness can reduce physical activity levels, and being awake for longer gives people more opportunity to eat. One 2004 study of over 1,000 volunteers predicted that people who had 5 hours of sleep per night would have a 14.9% increase in ghrelin, a 15.5% decrease in leptin, and a 3.6% increase in BMI, compared with those who had 8 hours of sleep per night. [**Taheri 2004**]

The suggested optimum duration of sleep is 7–8 hours; sleeping longer than 8 hours is also associated with increased BMI. [**Taheri 2004, Gresser 2025**]

When assessing a person living with overweight or obesity, healthcare professionals should ask about sleep patterns and quality of sleep; for example, whether the person does shift work or uses screens late at night. [**Mallik 2023**] Helping a person to improve their sleep could enhance the effects of any weight management interventions.



Nutrition	Movement	Recovery
• Follow healthy eating guidelines, e.g. eating a balanced diet and reducing intake of ultra-processed food **[Karam 2023]** • Stay well hydrated by drinking 6–8 cups of water or other drinks per day • Timing of eating and drinking • If psychological eating is involved, it may be possible to refer to a psychologist, or NHS Talking Therapies services	• Aim for at least 150 minutes of moderate-intensity activity per week (e.g. 30 minutes, 5 times a week) **[UK Gov CMO activity guidelines, 2019]** • Any activity is better than none **[UK Gov CMO activity guidelines, 2019]** • If possible, incorporate strength training, e.g. strenuous gardening, carrying heavy shopping bags or weight or resistance exercises **[UK Gov CMO activity guidelines, 2019]** • Try small manageable swaps, e.g. taking the stairs instead of the lift • Continue physical activity even if there are no visible results; it has many other physical and mental health benefits **[NICE NG246]**	**Sleep [Taheri 2004, Taheri 2006, Steven 2022, Brown 2025 - SPAN]** • Aim for 7–8 hours per night • Follow sleep hygiene guidelines, e.g. try to go to bed and wake up at the same time every day, stop screen use an hour before bed **Stress reduction [NHS stress busters 2022]** • Follow stress reduction advice, e.g. taking regular exercise, spending time with family or friends, making time for yourself **Exercise recovery** • Plan to do lighter activity the day after a more intense exercise session, to help the muscles recover and reduce the risk of injury
British Heart Foundation – DASH diet NHS Talking Therapies for anxiety and depression	UK Government – physical activity guidelines	NHS tips to reduce stress

Figure 6. Non-pharmacological obesity management.

Stress and psychological eating

Stress can both increase and decrease appetite through various mechanisms, depending on the individual. [**Rabasa 2016**] Stress can have many negative effects, including reduced sleep duration, irregular timing of eating and lack of interest or ability to participate in physical activity. These factors could increase the risk of weight gain, so people at risk of developing obesity may benefit from stress management interventions.

Psychological eating has been reported in over half of people referred to a specialist weight management service, [**Wong 2020**] and can develop as a coping mechanism for states such as stress, depression, loneliness, boredom or tiredness. [**Ibrahim 2025, Durrer-Schutz 2019**] Techniques such as identifying and managing triggers and practising mindful eating can help people who experience psychological eating. People with significant psychological eating or disordered eating patterns could be referred to a psychologist for treatment, for example cognitive behavioural therapy (CBT), if available.

Healthy living support programmes

People living with overweight and obesity may be interested in participating in a support programme promoting healthy living. There are a number of options, many of which are of low or no cost to the person (see *Box 3, supplementary information*). Availability varies around the country, and practices should maintain an up-to-date list of available local services that can be offered to eligible people. [**NICE NG246**]

Efficacy of non-pharmacological obesity interventions

Even small changes towards healthier behaviours could help to decrease mortality risk. An analysis of over 59,000 people from the UK Biobank study suggested that small daily improvements in sleep and physical activity duration and quality of nutrition could markedly reduce mortality risk. Modelling using mortality data from the study suggested a person who usually sleeps for 5.5 hours and does 7.3 minutes of physical activity per day, and whose diet scores 36.9% on a diet quality score, could reduce their mortality risk by 10% by increasing their sleep by 15 minutes and their physical activity by 1.6 minutes per day, along with a 5% improvement in diet quality. The model showed similar risk reduction could be achieved by improving just one of the three variables, but a greater change would be needed to produce an equivalent risk reduction. [**Stamatakis 2025**]

Non-pharmacological weight management interventions have been shown to improve healthy behaviours and produce modest weight loss. A 2022 systematic review and meta-analysis of randomised controlled trials of primary care non-pharmacological weight management interventions showed a mean 3.7 kg weight loss and 3.7 cm reduction in waist circumference in the intervention group after 12 months. In the comparator group (no or minimal intervention, or attention control), average weight loss over the same time period was 1.4 kg, with a 1.3 cm waist reduction. At 24 months, the difference in weight loss between the two groups was smaller, with a 1.8 kg greater weight loss in the intervention group than the comparator group. [**Madigan 2022**] Interventions run by non-medical professionals were as effective as those run by GPs or nurses, and ≥12 annual in-person or remote contacts between the professional and the person living with overweight or obesity was associated with greater weight loss than interventions with fewer contact points. [**Madigan 2022 (suppl info)**]

As mentioned earlier, although these reductions in weight are relatively small, the benefits of adopting healthier behaviours extend beyond weight loss. Modest weight loss has been linked to improvements in multiple measures, including cardiovascular, metabolic, renal and hepatic markers, and quality of life. [**Wing 2011, Dhar 2025**]

Pharmacological obesity management

For most people, healthy living interventions should be trialled for at least three months before considering medication. If there has been little or no improvement after three months and the person meets the eligibility criteria, they can be offered weight management medication. This should be a shared decision, and healthcare professionals need to provide clear information about the available options so the person living with obesity can decide their preferred treatment. Diet and physical activity improvements must be continued alongside medication.

"Even small changes towards healthier behaviours could help to decrease mortality risk. An analysis of over 59,000 people from the UK Biobank study suggested that small daily improvements in sleep and physical activity duration and quality of nutrition could markedly reduce mortality risk."

"Other wraparound care similar to that used in trials of weight management medication may help improve the effectiveness of pharmacological interventions. This could include education about diet and physical activity, medicines review (e.g. concomitant medications may need adjustment after initial weight loss) and psychological support, if needed."

In the committee's opinion, people at very high risk of obesity-related conditions, e.g. those with BMI ≥40 kg/m^2 with multiple obesity-related conditions, should be offered weight management medications without first having to complete a three-month trial of healthy living interventions, if national and local prescribing guidelines allow. Lifestyle changes including healthy eating, increased physical exercise and improved sleep quality are still crucial for this population, but should be initiated alongside, rather than before, medication.

There are four weight management medications currently licensed for use in the UK (see *Table 2*). Orlistat is a lipase inhibitor that prevents breakdown and absorption of dietary triglycerides. Semaglutide and liraglutide are glucagon-like peptide-1 receptor agonists (GLP-1 RAs) that mimic GLP-1 in the body and have effects on satiety and glucose levels. Tirzepatide is a dual agonist, acting both as a GLP-1 RA and a glucose-dependent insulinotropic polypeptide (GIP) agonist, with additional effects on insulin sensitivity and fat metabolism. Primary care healthcare professionals can prescribe orlistat, and a lower dose is also available over the counter. At the moment, tirzepatide is the only incretin-based weight management medication that can be prescribed in primary care. Semaglutide and liraglutide can only be prescribed for weight management by specialist overweight and obesity management services (see *Table 3*).

Efficacy of weight management medications

These treatment options have been shown to produce weight loss versus placebo, [**Bergmann 2022, le Roux 2017, Jastreboff 2022, Sjöström 1998**] but the magnitude of weight loss varies between treatments. [**McGowan 2025 meta-analysis**]

There are limited head-to-head trials between active treatments, but network meta-analyses can provide some information about the relative efficacy of each treatment. One network meta-analysis suggested the weighted mean difference in percentage total body weight loss compared with placebo after 12 months of treatment is 2.14% for orlistat, 6.81% for liraglutide, 12.07% for semaglutide and 14.77% for tirzepatide. [**McGowan 2025 meta-analysis**]

EASO guidelines suggest tailoring the choice of weight management medication to the individual, taking into account comorbid conditions. The guidelines include advice on the most appropriate medications for people with conditions including non-diabetic hyperglycaemia, type 2 diabetes, cardiovascular disease and metabolic dysfunction-associated steatotic liver disease (MASLD). [**McGowan 2025 EASO**]

Wraparound care

Weight management medications are licensed to be used alongside other weight management support, including a reduced-calorie diet and increased physical activity. Other wraparound care similar to that used in trials of weight management medication may help improve the effectiveness of pharmacological interventions. This could include education about diet and physical activity, medicines review (e.g. concomitant medications may need adjustment after initial weight loss) and psychological support, if needed. [**NICE TA1026**]

It is very important to discuss the potential for sarcopenia with people taking incretin mimetics. Adequate protein and micronutrient intake, and weight-bearing and resistance exercise can help to reduce muscle mass during weight loss. [**Mechanick 2024, Brown 2025 – muscle**]

Health inequalities

While obesity is most prevalent in areas with higher deprivation, access to weight management medications through the NHS is currently limited to people with the highest levels of obesity and additional risk factors. [**NICE implementation support 2025**] Private prescriptions for weight management medications are available for people who meet the criteria for treatment and have the ability to pay. According to WHO, "There is an urgent need for global guidance that ensures the appropriate, safe and inclusive use of these therapies across diverse health systems." [**WHO GLP-1 guidelines 2025**]

Bariatric surgery

Bariatric surgery is a treatment option for people in England, Scotland or Wales with severe or complex obesity for which other treatments have not been effective. People from European backgrounds can be referred for assessment by a bariatric surgery service if they have a

Table 2. Weight management medications: Key information

	Tirzepatide [Tirzepatide SmPC; NICE practical guide 2025]	**Semaglutide [Semaglutide SmPC; NICE practical guide 2025]**	**Liraglutide [Liraglutide SmPC; NICE practical guide 2025]**	**Orlistat (60 mg: pharmacy; 120 mg: prescription-only) [Orlistat SmPC]**
Class	GLP-1 receptor agonist/GIP agonist	GLP-1 receptor agonist	GLP-1 receptor agonist	Lipase inhibitor
Indication	As an adjunct to a reduced-calorie diet and increased physical activity Weight management, including weight loss and weight maintenance for adults with an initial BMI of: • ≥30 kg/m² (obesity); or • ≥27 kg/m² to <30 kg/m² (overweight) in the presence of at least one weight-related comorbidity	As an adjunct to a reduced-calorie diet and increased physical activity Weight management, including weight loss and weight maintenance, for adults with an initial BMI of: • ≥30 kg/m² (obesity), or • ≥27 kg/m² to <30 kg/m² (overweight) in the presence of at least one weight-related comorbidity	As an adjunct to a reduced-calorie diet and increased physical activity Weight management for adults with an initial BMI of: • ≥30 kg/m² (obesity); or • ≥27 kg/m² to <30 kg/m² (overweight) in the presence of at least one weight-related comorbidity	**60 mg:** In conjunction with a mildly hypocaloric, lower-fat diet Weight loss for adults who are overweight (BMI ≥28 kg/m²) **120 mg:** In conjunction with a mildly hypocaloric diet. Treatment of people living with: • Obesity, with a BMI ≥30 kg/m²; or • Overweight (BMI ≥28 kg/m²) with associated risk factors
Dose	**Available doses:** 2.5 mg, 5 mg, 7.5 mg, 10 mg, 12.5 mg, 15 mg, once weekly **Starting dose:** 2.5 mg once weekly	**Available doses:** 0.25 mg, 0.5 mg, 1 mg, 1.7 mg, 2.4 mg, once weekly **Starting dose:** 0.25 mg once weekly	6 mg/mL solution; variable dose between 0.6–3.0 mg once daily **Starting dose:** 0.6 mg once daily	60 mg or 120 mg up to three times per day
Administration	Solution for subcutaneous injection in single-use pre-filled pen	Solution for subcutaneous injection in multi-use pre-filled pen	Solution for subcutaneous injection in multi-use pre-filled pen	Oral capsule taken with water just before, during or up to one hour after each main meal
Contraindications, warnings and precautions	Contraindicated in people with hypersensitivity to tirzepatide or any of the excipients. Should not be used during pregnancy; not recommended in women of childbearing potential not using contraception; discontinue treatment ≥1 month before planned pregnancy due to tirzepatide's long half-life. Use with caution in people with a history of pancreatitis, severe gastrointestinal disease (including severe gastroparesis), diabetic retinopathy, severe renal or hepatic impairment. Increased risk of hypoglycaemia in people with type 2 diabetes; adjust dose of anti-hyperglycaemic medication if necessary. Potential risk of metabolic acidosis in people with hepatic or renal impairment. Risk of residual gastric content due to delayed gastric emptying should be considered before surgery under general anaesthesia or deep sedation. Discontinue if acute pancreatitis is suspected. If confirmed, do not restart tirzepatide. Limited data in people aged ≥85 years and children <18 years.	Contraindicated in people with hypersensitivity to semaglutide or any of the excipients. Should not be used during pregnancy; not recommended in women of childbearing potential not using contraception; discontinue treatment ≥2 months before planned pregnancy due to semaglutide's long half-life. Not recommended for those who are breastfeeding. Use with caution in people with a history of pancreatitis. Increased risk of hypoglycaemia in people with type 2 diabetes; adjust dose of anti-hyperglycaemic medication if necessary. Semaglutide has been associated with an increased risk of diabetic retinopathy complications in people taking insulin and semaglutide. People with diabetic retinopathy should be closely monitored and treated to clinical guidelines. Risk of residual gastric content due to delayed gastric emptying should be considered before surgery under general anaesthesia or deep sedation. Discontinue if acute pancreatitis is suspected. If confirmed, do not restart semaglutide. Limited data in people aged ≥85 years or with class IV congestive heart failure. Not recommended for people with end-stage renal disease. Use with caution in people with severe hepatic impairment.	Contraindicated in people with hypersensitivity to liraglutide or any of the excipients. Should not be used during pregnancy; discontinue before planned pregnancy or when pregnancy occurs. Increased risk of hypoglycaemia in people with type 2 diabetes; adjust dose of anti-hyperglycaemic medication if necessary. Risk of residual gastric content due to delayed gastric emptying should be considered before surgery under general anaesthesia or deep sedation. Discontinue if acute pancreatitis is suspected. If confirmed, do not restart liraglutide. Not recommended for people: • Aged ≥75 years • With NYHA class IV congestive heart failure • Treated with other weight management medications • With obesity secondary to endocrinological or eating disorders, or medication • With severe renal impairment • With severe hepatic impairment • With inflammatory bowel disease or diabetic gastroparesis • Who are breastfeeding Use with caution in people with mild or moderate hepatic impairment, thyroid disease.	Contraindicated in people with hypersensitivity to orlistat or any of the excipients, chronic malabsorption syndrome, cholestasis, and in those who are breastfeeding. Limited data in children and the elderly, and people with hepatic or renal impairment. May be associated with hyperoxaluria and oxalate nephropathy, which can lead to renal failure. The risk is increased in people with underlying chronic kidney disease and/or volume depletion. Rarely, hypothyroidism and/or reduced control of hypothyroidism may occur. Use with caution in pregnant women.

Table 2. Weight management medications: Key information (continued)

	Tirzepatide [Tirzepatide SmPC; NICE practical guide 2025]	Semaglutide [Semaglutide SmPC; NICE practical guide 2025]	Liraglutide [Liraglutide SmPC; NICE practical guide 2025]	Orlistat (60 mg: pharmacy; 120 mg: prescription-only) [Orlistat SmPC]
Interactions	Should not be used in combination with any other GLP-1 receptor agonist. Potential impact on absorption of oral medicines due to delayed gastric emptying. Most likely at tirzepatide initiation. No dose adjustments expected to be needed for most concomitant oral medications. Monitoring of people taking oral medicines with a narrow therapeutic window, e.g. warfarin or digoxin, is recommended, especially during tirzepatide initiation and after each dose increase. Consider possible delayed effects or reduced efficacy for medicines where speed of onset is important. Suggest non-oral or barrier contraception for 4 weeks after tirzepatide initiation and each dose escalation. DPP-4 inhibitors should be discontinued before starting treatment.	Should not be used in combination with any other GLP-1 receptor agonist. Potential impact on absorption of oral medicines due to delayed gastric emptying; no dose adjustment is needed for concomitant oral medications. Frequent monitoring of INR in people taking warfarin or other coumarin derivatives is recommended. DPP-4 inhibitors should be discontinued before starting treatment.	Should not be used in combination with any other GLP-1 receptor agonist. Potential impact on absorption of oral medicines due to slightly delayed gastric emptying; no dose adjustment is needed for concomitant oral medications. Frequent monitoring of INR in people taking warfarin or other coumarin derivatives is recommended. DPP-4 inhibitors should be discontinued before starting treatment.	Avoid concomitant administration of acarbose. Not recommended in people taking ciclosporin. The absorption of various medications may be decreased: • Oral anticoagulants; additional INR monitoring may be required. • Antiepileptic medications; monitor for possible changes in frequency and/or severity of convulsions. • Antiretrovirals for HIV. • Amiodarone; increase clinical and ECG monitoring. • Antidepressants, antipsychotics (including lithium) and benzodiazepines; only initiate orlistat in people taking these medicines after careful consideration of possible impact. Possible impaired absorption of fat-soluble vitamins (A, D, E and K). If severe diarrhoea occurs, this may affect the efficacy of oral contraceptives. Suggest non-oral or barrier contraception to women of childbearing age with severe diarrhoea.
Very common side-effects (seen in ≥10% of people)	• Hypoglycaemia if used with insulin or sulphonylurea in people with type 2 diabetes • Nausea • Diarrhoea • Vomiting • Constipation • Abdominal pain	• Headache • Vomiting • Diarrhoea • Constipation • Nausea • Abdominal pain • Fatigue	• Headache • Nausea • Vomiting • Diarrhoea • Constipation	• Headache • Upper respiratory infection • Abdominal pain/discomfort • Oily spotting from the rectum • Flatus with discharge • Faecal urgency • Fatty/oily stool • Flatulence • Liquid stools • Oily evacuation • Increased defaecation • Rectal pain/discomfort • Hypoglycaemia (in people with type 2 diabetes) • Influenza
Useful patient information	• Symptoms of pancreatitis to look out for and how to report • Advice on preventing dehydration from GI side-effects • Proper injection technique, including rotation of injection sites • How to manage missed doses and changing administration day • Contraception advice for women of childbearing age	• Advice on preventing dehydration from GI side-effects • Proper injection technique, including rotation of injection sites • How to manage missed doses and changing administration day • Remind people living with diabetes who take insulin not to use semaglutide as a substitute for insulin • If dizziness occurs (mainly seen during the dose escalation period) use caution when driving or using machinery • Contraception advice for women of childbearing age	• Symptoms of pancreatitis, cholelithiasis and cholecystitis, and increased heart rate to look out for and how to report • Advice on preventing dehydration from GI side-effects • Proper injection technique, including rotation of injection sites; information on the possibility of amyloid deposits if injection site is not rotated • How to manage missed doses • Remind people living with diabetes who take insulin not to use liraglutide as a substitute for insulin, and that doing so can cause diabetic ketoacidosis • If dizziness occurs (mainly seen during the first 3 months of treatment) use caution when driving or using machinery • Contraception advice for women of childbearing age	• Explain how the medicine works to prevent digestion of dietary fat; advise that faecal fat will increase as early as 24–48 hours after the first dose • Nutritional directions: mildly hypocaloric, nutritionally balanced diet, rich in fruit and vegetables, with ~30% of calories from fat; daily intake of fat, carbohydrate and protein intake to be balanced across three daily meals • If a meal is missed or contains no fat, the dose should be omitted • With very high fat meals, the risk of gastrointestinal adverse effects may increase • How to manage missed doses • To look out for and report important symptoms including rectal bleeding
How to up- or down-titrate	Increase weekly dose by 2.5 mg after ≥4 weeks at the previous dose, up to a maximum of 15 mg once-weekly **Recommended maintenance doses:** 5 mg, 10 mg, 15 mg	Increase weekly dose after ≥4 weeks at the previous dose, up to a maximum of 2.4 mg once-weekly	Increase weekly dose by 0.6 mg after ≥1 week at the previous dose, up to a maximum of 3.0 mg once-daily	N/A
When to stop	Consider discontinuing after 6 months at the highest tolerated if weight loss is <5% of initial body weight No time limit for administration if effective	Consider discontinuing after 6 months at the highest tolerated if weight loss is <5% of initial body weight Can be given for maximum 2 years	Discontinue after 12 weeks of 3.0 mg/day dose if weight loss is <5% of initial body weight No time limit for administration if effective	Discontinue after 12 weeks if weight loss is <5% of initial body weight No time limit for administration if effective

DPP-4=dipeptidyl peptidase-4; GIP=glucose-dependent insulinotropic polypeptide; GLP-1=glucagon-like peptide-1; INR= international normalised ratio. See the manufacturers' Summaries of Product Characteristics for full details.

Table 3. Weight management medications: UK prescribing guidance

	Tirzepatide	Semaglutide	Liraglutide	Orlistat (60 mg: pharmacy; 120 mg: prescription-only)
Initiation in primary care (NHS)?	Yes, in defined patient population	No, specialist weight management service only	No, specialist weight management service only	Yes
NICE eligibility criteria for adults	• Initial BMI ≥35 kg/m²* **and** • ≥1 weight-related comorbidity **and** • The company provides the product according to the commercial arrangement • Recommended alongside a reduced-calorie diet and increased physical activity **[NICE TA1026]**	• ≥1 weight-related comorbidity **and** – Initial BMI ≥35 kg/m²* **or** – Initial BMI >30 to ≤35 kg/m²* and meets the criteria for referral to specialist overweight and obesity management services** **and** • The company provides the product according to the commercial arrangement • Can be used for maximum 2 years • Recommended alongside a reduced-calorie diet and increased physical activity **[NICE TA875]**	• Initial BMI ≥35 kg/m²* **and** • Non-diabetic hyperglycaemia: – HbA_{1c} 42–47 mmol/mol (6.0–6.4%) **or** – Fasting plasma glucose 5.5–6.9 mmol/L **and** • High CVD risk based on factors such as hypertension and dyslipidaemia **and** • The company provides the product according to the commercial arrangement • Recommended alongside a reduced-calorie diet and increased physical activity **[NICE TA664]**	No NICE technology appraisal available **[NICE Implementation support, 2025]**
Eligibility criteria England	Phased introduction over up to 12 years. June 2025 to ~June 2026: • Initial BMI ≥40 kg/m²*; and • ≥4 weight-related comorbidities June 2026 to ~March 2027: • Initial BMI ≥40 kg/m²*; **and** • 3 weight-related comorbidities **[NICE TA1026]**	As NICE guidance	As NICE guidance	No specific advice
Eligibility criteria Scotland	Adults with BMI ≥30 kg/m²* and ≥1 weight-related comorbidity **[SMC2653]**	Specialist weight management service only BMI ≥30 kg/m²* and ≥1 weight-related comorbidity **[SMC2497]**	Specialist weight management service only • BMI ≥35 kg/m²* **and** • Non-diabetic hyperglycaemia: – HbA_{1c} 42–47 mmol/mol (6.0–6.4%) **or** – Fasting plasma glucose 5.5–6.9 mmol/L **and** • High risk of CVD: – Total cholesterol >5 mmol/L **or** – HDL <1.0 mmol/L for men; <1.3 mmol/L for women **or** – Systolic blood pressure >140 mmHg **[SMC2455]**	No SMC advice
Eligibility criteria Wales	Not commissioned for prescribing or monitoring in general practice Hospital-only, prescribed by specialist weight management services GPs should not initiate or monitor GLP-1 analogues for weight loss **[BMA 2025 GLP-1 in Wales]**	Hospital-only, prescribed by specialist weight management services GPs should not initiate or monitor GLP-1 analogues for weight loss **[BMA 2025 GLP-1 in Wales]**	Hospital-only, prescribed by specialist weight management services GPs should not initiate or monitor GLP-1 analogues for weight loss **[BMA 2025 GLP-1 in Wales]**	No specific advice
Eligibility criteria Northern Ireland	Will be introduced using a phased approach over a number of years. Not currently available for prescribing in primary care At present no GLP-1 analogues can be prescribed under the NHS in Northern Ireland because there are no specialist weight management services **[Northern Ireland Formulary 2025]**	At present no GLP-1 analogues can be prescribed under the NHS in Northern Ireland because there are no specialist weight management services **[Northern Ireland Formulary 2025]**	At present no GLP-1 analogues can be prescribed under the NHS in Northern Ireland because there are no specialist weight management services **[Northern Ireland Formulary 2025]**	No specific advice

*Use a lower BMI threshold (usually reduced by 2.5 kg/m²) for people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic backgrounds. **[NICE NG246]**

These criteria include: underlying causes of overweight and obesity need to be assessed, complex disease states or needs, less intensive management has been unsuccessful, specialist interventions may be needed, surgery or certain medicines are being considered. **[NICE NG246]

"Any obesity management intervention requires regular review and follow-up, usually starting with more regular appointments and extending the intervals between visits once interventions are better established."

BMI of ≥40 kg/m², or 35–39.9 kg/m² with a significant health condition that could be improved with weight loss. For people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean backgrounds, the BMI thresholds for referral are ≥37.5 kg/m², or 32.5–37.4 kg/m² with a significant health condition. Significant obesity-related health conditions include cardiovascular disease, hypertension, idiopathic intracranial hypertension, non-alcoholic fatty liver disease with or without steatohepatitis, obstructive sleep apnoea or type 2 diabetes. [**NICE NG246**] In Northern Ireland, bariatric surgery is not available on the NHS. [**Dept of Health NI 2025**]

People considering bariatric surgery should be advised it is a major procedure performed under general anaesthetic that is often non-reversible. They must also commit to annual reviews, adhering to a strict diet and taking nutritional supplements for the rest of their lives. [**NICE NG246**] After the initial postoperative period, primary care professionals are normally involved in the follow-up and review of people who have had bariatric surgery. [**Yanovski 2024**]

Bariatric surgery is not suitable for everyone; for example, psychological eating may result in poorer outcomes. It is possible for easily digestible calorie-dense food, such as chocolate, cake and alcohol, to pass through the stomach after surgery without making the person feel full. Lack of motivation to follow strict nutritional guidelines and smaller portion sizes can affect the degree of weight loss. Bariatric surgery can result in an average total weight loss of 23–31% after 1 year and 19–27% after 5 years, with different success rates for the different surgical procedures. [**Courcoulas 2023**] It has been suggested that bariatric surgery could increase overall life expectancy by 3 years and reduce mortality from cardiovascular disease by 30% and cancer by 23%. [**Carlsson 2020**]

Review and monitoring

Any obesity management intervention requires regular review and follow-up, usually starting with more regular appointments and extending the intervals between visits once interventions are better established. For example, with interventions promoting healthy living, it might be useful to see the person after 3 and 6 months, moving to annual check-ups if things are going well. This will be different for each individual, and people who need more support should have more regular contact with their primary care team.

With orlistat, follow-up is typically every three months for the first year, followed by 6- to 12-monthly visits if treatment is well tolerated and effective. People starting incretin mimetics for weight loss will need healthcare professional contact every 4 weeks for dose titration. After they reach their maximum tolerated dose, follow-up intervals can be increased as needed. [**NICE practical guide 2025**] People who have had bariatric surgery will normally be followed up by the surgical team for the first two years. After this, care transfers to primary care, where they will be seen at least annually to monitor nutritional status and the need for dietary supplements.

Alongside GPs, other healthcare professionals, such as nurses, pharmacists, healthcare assistants, nutritionists and dietitians, can run follow-up and monitoring appointments. These appointments should be tailored to the individual but can include comorbidity monitoring, taking anthropometric measurements, reviewing progress, setting goals, medicines review, providing information such as healthy living advice, psychological assessment, signposting and referral to local services, and answering questions. These appointments can be an opportunity to discuss changes in non-weight health measures, like blood pressure or lipids, and practical aspects, such as being able to climb stairs without becoming breathless or participating in activities that weren't previously possible. Discussing such improvements may help motivate people to continue with their weight management intervention, particularly if they are not losing as much weight as they were hoping.

How to stop weight management medications

If a person living with obesity has intolerable side-effects from a weight management medication, it can be stopped immediately without any need to down-titrate. Healthcare professionals should report any side-effects using the MHRA Yellow Card reporting site (https://yellowcard.mhra.gov.uk/) and notify the marketing authorisation holder. Weight

management medications must also be stopped during pre-conception planning and pregnancy.

Some people do not experience sufficient weight loss with weight management medications, and it is recommended that treatment is discontinued after a defined time period in such cases. If, at the maximum tolerated dose, total body weight loss is <5% after 12 weeks of orlistat or liraglutide treatment or 6 months taking semaglutide or tirzepatide, treatment should be stopped. [**Orlistat SmPC, Liraglutide SmPC, Semaglutide SmPC, Tirzepatide SmPC**] Next steps after discontinuation should be tailored to the individual, but could include a trial of a different weight management medication, referral to a healthy living programme or referral to a higher tier specialist weight management service.

In people who do respond to weight management medications, the risks and benefits of continuing treatment should be reviewed once the person's target weight has been reached. If, with the person's agreement, it is decided to stop treatment, healthcare professionals should discuss with them the possible outcomes of discontinuation. With any weight management intervention there is a risk of weight regain over time or once treatment is stopped. [**Horn 2026, Maya 2025, Wilding 2022, Berg 2025**] A recent systematic review of weight management medication trials suggested an overall trend for weight gain after stopping treatment with any weight management medication. Across the studies examined, participants had an average weight gain of 0.4 kg per month, returning to their baseline weight after an average of 1.7 years from medicine discontinuation. [**West 2026**]

To minimise weight regain and weight cycling, it is crucial that people living with obesity follow advice for healthy living alongside any treatment, and to continue this after treatment is discontinued. Primary care teams should support people to maintain their healthy living habits by conducting regular feedback and monitoring for at least a year after discontinuation of a weight management intervention. [**NICE QS212**] It is important to reassure people living with obesity who have stopped a weight loss intervention that weight regain is likely, and does not indicate failure by the individual. [**NICE NG246**] The CHORD committee's recommendation is to restart weight management medication in someone whose weight has begun to increase again after stopping treatment. After returning to their target weight, the person can discontinue medication again, while continuing to follow healthy living advice.

Monitoring privately prescribed weight management medications

There has been an increase in the number of people obtaining private prescriptions for weight management medications. [**BMA tirzepatide guidance**] These are often obtained remotely without a face-to-face consultation and can be issued by any independent prescriber, including doctors, nurse prescribers and pharmacist independent prescribers. Weight management medicines that can only be prescribed in secondary care in the NHS, including semaglutide and liraglutide, can be supplied by private prescribers.

In February 2025, the General Pharmaceutical Council published updated guidance for remote prescribing. Consultations for weight management medications, and medicines that are part of the black triangle scheme, cannot be conducted by online questionnaire alone. Prescribers must independently verify weight, height and BMI information provided by the person having the consultation, via video consultation, in person, from medical records or by asking another healthcare professional, such as the person's GP. [**General Pharmaceutical Council 2025**]

NHS GP surgeries are often asked to provide patient information to private providers. The British Medical Association (BMA) has published guidance for GPs in England and Wales for responding to patient information requests from private weight management medication providers. [**BMA 2025 (England), BMA 2025 (Wales)**] Supplying patient information to private providers is not an essential service, nor is it covered under the General Medical Services Contract. The increasing number of these requests and the reduced capacity in general practice mean it is not always feasible to reply in full. The BMA recommends encouraging people to share their online medical records with the private provider, and has provided a letter template that can be embedded into the

"In people who do respond to weight management medications, the risks and benefits of continuing treatment should be reviewed once the person's target weight has been reached. With any weight management intervention there is a risk of weight regain over time or once treatment is stopped."

practice's electronic medical record system to help facilitate this. [**BMA 2025 (template letter)**]

However, if a GP becomes aware of someone in their care starting a weight management medication supplied by a private provider, they have a duty of care to check for and act on any contraindications or drug interactions, and add the external prescription to the patient record. [**BMA 2025**] Healthcare professionals should ask whether weight management medications have been obtained from private providers during relevant discussions, for example at annual medication reviews for women taking hormonal contraception or hormone-replacement therapy, [**BMA 2025**] or for people taking oral medications with a narrow therapeutic range.

Table 4. Summary of recommendations.

Assessment	
1	Recognise obesity as a chronic, progressive, relapsing disease requiring lifelong management, similar to other long-term conditions like type 2 diabetes or hypertension
2	Use positive, inclusive and supportive language when discussing weight
3	Always seek explicit permission before discussing weight; if declined, note to revisit at the next appointment
4	Avoid diagnostic overshadowing – address the presenting condition first before introducing weight-related discussions
5	Opportunistically measure weight, height, and waist circumference during routine checks, after obtaining permission
6	Combine BMI with waist-to-height ratio for better cardiometabolic risk assessment in people with BMI <35 kg/m²
7	Apply lower BMI thresholds for people from South Asian, Chinese, Middle Eastern, Black African, and African-Caribbean backgrounds due to higher cardiometabolic risk
8	Conduct a comprehensive history, including family history, working patterns, sleep, psychological eating, and socioeconomic factors to identify contributors to weight gain
9	Ensure appropriate equipment is available (chairs without arms, scales for all weights, large BP cuffs)
10	Screen for psychological issues using validated tools (PHQ-9, GAD-7, SCOFF, BES) and assess socioeconomic barriers; signpost to Citizens Advice or social prescribing link workers
11	Ask about sleep patterns
Non-pharmacological management	
12	Initiate management with a three-month trial of healthy living interventions for most people, using positive language around 'nutrition, movement and recovery'
13	Set personalised, realistic goals focused on improving quality of life (e.g. mobility, lung capacity) rather than fixed weight targets
14	Recognise that small, concurrent improvements in sleep, physical activity, and diet quality can substantially reduce mortality risk
15	Maintain an up-to-date list of local healthy living support programs and offer these to eligible people
Pharmacological interventions	
16	Review medications that may contribute to weight gain and suggest weight-neutral alternatives before starting weight-loss interventions
17	Consider weight management medication after a three-month healthy living intervention trial if criteria are met, or initiate immediately for very high-risk people (BMI ≥40 kg/m² with multiple obesity-related comorbidities)
Bariatric surgery	
18	Refer people for bariatric surgery assessment if BMI ≥40 kg/m² (or ≥37.5 kg/m² for higher-risk groups), or BMI 35–39.9 kg/m² (or 32.5–37.4 kg/m² for higher-risk groups) with significant comorbid conditions
Review and monitoring	
19	Conduct regular follow-up for all weight management interventions, starting with more frequent reviews and moving to annual check-ups; this should include anthropometric measurements, nutrition, movement and recovery advice
20	Monitor for side-effects in people taking weight management medications and report any adverse events using the MHRA Yellow Card reporting site
21	Discontinue medication in non-responders and suggest alternative treatments or weight management programmes
22	Support healthy habits during and after treatment discontinuation to minimise weight regain; monitor for at least one year post-intervention
23	Check whether any weight management medication is being privately prescribed, and if so monitor for contraindications or drug interactions and add prescriptions to electronic patient records; encourage people to share their online medical records with private providers as supplying this is not an essential NHS service

Conclusion

Obesity is a growing problem in the UK, and initiating weight loss interventions in people living with obesity is only a small part of the solution. Widescale societal changes are needed to slow the upward trend in obesity, addressing food production and advertising, healthy living education for children, provision of local services and minimising health inequalities. Primary care professionals play a crucial role in identifying people living with, or at risk of, obesity, and initiating weight management interventions.

Every body is different, and treatment of obesity must be individualised, taking into account lifestyle, goals and level of motivation. But it is challenging to comprehensively assess and manage obesity in primary care with increasingly stretched services and short appointment times. In this article, we have outlined the committee's recommendations (see *Table 4*) for the effective management of obesity in primary care, including practical tools that can be used in consultation by busy primary care health professionals. ■

Supplementary material

An interactive information tool based on this review is also available

Click here to access

Acknowledgements

Funding

This initiative is independently sponsored by Eli Lilly and Company. Eli Lilly and Company have had no involvement in the content or outputs of this initiative.

Sponsorship and article processing charges for this study were funded by Eli Lilly and Company Limited. All authors had full access to all of the data in this study and take complete responsibility for the data and the accuracy of the data analysis.

Medical writing

Medical writing services were provided on behalf of the CHORD committee by Fiona Millard for LKOTT Consulting Limited and project management support was provided by Lisa Kelly at OmniaMed Communications. Support for this assistance was funded by Eli Lilly and Company Limited.

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"Every body is different, and treatment of obesity must be individualised, taking into account lifestyle, goals and level of motivation."