

NICE guidance mapping:

Where Physical Activity,
exercise and community
rehabilitation appear in
condition specific NICE
Clinical guidance, NICE
guidance and quality
standards.

Updated October 2025

This document is the second document in the NICE guidance mapping findings. It should be read in conjunction with the NICE mapping PowerPoint slides that provide the headline findings.

It sets out the details of where physical activity, exercise and community rehabilitation (for example phase 4 cardiac rehabilitation, pulmonary rehabilitation in leisure settings etc.) appear in condition specific NICE Clinical guidance, NICE quality standards, NICE guidelines, NICE Public Health guidelines and NICE Indicators.

The NICE Clinical guidance, NICE quality standards, NICE guidelines, NICE Public Health guidelines and NICE Indicators set out in this document are © NICE 2002–2025. Available from www.nice.org.uk/guidance. 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 All NICE guidance is subject to regular review and may be updated or withdrawn.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 or the use of its content in this product/publication.

Although Sport England has made every effort to ensure the accuracy of this document as at the date of its publication (October 2025), we strongly recommend that readers refer to the full NICE source documents (available via the links provided) for the full guidance and context and to access the most up-to-date versions.

The content of this document is provided for general information only. It is not intended to amount to specific advice for your organisation on which you should rely. Sport England does not make any representations, warranties or guarantees that the content of this document is accurate, complete or up to date. Sport England is not responsible or liable to any person in respect of any loss, damage or costs of any nature arising directly or indirectly from reliance placed on the information in this document.

Sport England is not responsible for the content or reliability of linked websites. Linking should not be taken as endorsement of any kind. We cannot guarantee that the links provided will work all the time and we have no control over availability or content of linked pages.

Table of Contents

Clinical Guidelines	14
Cardiovascular Disease	15
Familial hypercholesterolaemia: identification and management Clinical guideline [CG71] Published: 27 August 2008 Last updated: 04 October 2019	15
Stable angina: management Clinical guideline [CG126] Published: 23 July 2011 Last updated: 25 August 2016	16
Varicose veins: diagnosis and management Clinical guideline [CG168] Published: 24 July 2013. Last reviewed February 2016.	17
Mental Health (Adults)	18
Depression in adults with a chronic physical health problem: recognition and management Clinical guideline [CG91] Published: 28 October 2009 Last updated: May 2024	18
Generalised anxiety disorder and panic disorder in adults: management Clinical guideline [CG113] Published: 26 January 2011 Last updated: 15 June 2020	20
Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services Clinical guideline [CG136] Published: 14 December 2011 Last reviewed: January 2021	21
Psychosis and schizophrenia in adults: prevention and management Clinical guideline [CG178] Published: 12 February 2014 Last updated: 01 March 2014 Last reviewed: 29 July 2025	22
Mental Health (Children & Young People)	23
Psychosis and schizophrenia in children and young people: recognition and management Clinical guideline [CG155] Published: 23 January 2013 Last updated: 26 October 2016. Last reviewed: 21 May 2024	23
Respiratory	24

Idiopathic pulmonary fibrosis in adults: diagnosis and management Clinical guideline [CG163] Published: 12 June 2013 Last updated: 23 May 2017. Last reviewed: 29 September 2024	24
Cancer	25
Advanced breast cancer: diagnosis and treatment Clinical guideline [CG81] Published: 23 February 2009 Last updated: 19 February 2025 Some further updates underway following January 2023 review.....	25
Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer Clinical guideline [CG164] Published: 25 June 2013 Last updated: 14 November 2023	26
Musculoskeletal Conditions and MSK health	27
Spasticity in under 19s: management Clinical guideline [CG145] Published: 25 July 2012 Last updated: 29 November 2016	27
Children and Young People	28
Constipation in children and young people: diagnosis and management Clinical guideline [CG99] Published: 26 May 2010 Last updated: 13 July 2017 Last reviewed: June 2018	28
Autism spectrum disorder in under 19s: support and management Clinical guideline [CG170] Published: 28 August 2013 Last updated: July 2024: planned updated on psychosocial interventions Last reviewed: 5 September 2025	29
Fertility, maternity, postnatal and menopause	31
Fertility problems: assessment and treatment Clinical guideline [CG156] Published: 20 February 2013 Last updated: 06 September 2017	31
Other conditions	32
Drug misuse in over 16s: opioid detoxification Clinical guideline [CG52] Published: 25 July 2007 Last reviewed: 9 December 2024.....	32
Irritable bowel syndrome in adults: diagnosis and management Clinical guideline [CG61] Published: 23 February 2008 Last updated: 30 April 2025.....	33

Autism spectrum disorder in adults: diagnosis and management Clinical guideline [CG142] Published: 27 June 2012 Last updated: 14 June 2021 Last reviewed: 5 September 2025	34
Cardiovascular Disease	35
Stroke in adults Quality standard [QS2] Published: 29 June 2010 Last updated: 12 April 2016	35
Chronic heart failure in adults Quality standard [QS9] Published: 29 June 2011 Last updated: 3 September 2025	37
Secondary prevention after a myocardial infarction Quality standard [QS99] Published: 04 September 2015	39
Cardiovascular risk assessment and lipid modification Quality standard [QS100] Published: 04 September 2015 Last updated: 23 July 2025	40
Diabetes in children and young people Quality standard [QS125] Published: 14 July 2016 Last updated: 31 March 2022.....	42
Type 2 diabetes in adults Quality standard [QS209] Published: 02 March 2023	44
Weight Management & Obesity	45
Overweight and obesity management Quality standard [QS212] Published: 05 August 2025	45
Musculoskeletal Conditions and MSK Health	47
Falls in older people Quality standard [QS86] Published: 25 March 2015 Last updated: 29 April 2025.....	47
Osteoarthritis in over 16s Quality standard [QS87] Published: 11 June 2015 Last updated: 19 October 2022.....	49
Low back pain and sciatica in over 16s Quality standard [QS155] Published: 27 July 2017.....	53
Joint replacement (primary): hip, knee and shoulder Quality standard [QS206] Published: 29 March 2022.....	56
Neurological conditions	59

Multiple sclerosis Quality standard [QS108] Published: 14 January 2016.....	59
Mental Health (Adults)	61
Depression in adults Quality standard [QS8] Published: 29 March 2011 Last updated: 29 June 2023	61
Psychosis and schizophrenia in adults Quality standard [QS80] Published: 12 February 2015	63
Bipolar disorder in adults Quality standard [QS95] Published: 23 July 2015 Last updated: 18 February 2016	65
Mental wellbeing and independence for older people Quality standard [QS137] Published: 05 December 2016.....	67
Mental Health (Children & Young People)	69
Bipolar disorder, psychosis and schizophrenia in children and young people Quality standard [QS102] Published: 15 October 2015	69
Respiratory	71
Chronic obstructive pulmonary disease in adults Quality standard [QS10] Published: 28 July 2011 Last updated: 19 September 2023	71
Idiopathic pulmonary fibrosis in adults Quality standard [QS79] Published: 29 January 2015	73
Dementia.....	75
Dementia Quality standard [QS184] Published: 28 June 2019	75
Fertility, maternity, postnatal and menopause	77
Postnatal care Quality standard [QS37] Published: 16 July 2013 Last updated: 27 September 2022.....	77
Other	79
Lower urinary tract symptoms in men Quality standard [QS45] Published: 18 September 2013	79
Physical activity: for NHS staff, patients and carers Quality standard [QS84] Published: 25 March 2015.....	81
Liver disease Quality standard [QS152] Published: 29 June 2017	82

Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups Quality standard [QS167]	
Published 11 May 2018.....	84
Physical activity: encouraging activity in the community Quality standard [QS183] Published: 06 June 2019	88
Learning disability: care and support of people growing older Quality standard [QS187] Published: 24 July 2019	89
NICE Guidelines	91
Cardiovascular Disease	92
Diabetes (type 1 and type 2) in children and young people: diagnosis and management NICE guideline [NG18] Published: 01 August 2015 Last updated: 11 May 2023	92
Type 1 diabetes in adults: diagnosis and management NICE guideline [NG17] Published: 26 August 2015 Last updated: 17 August 2022 Last reviewed: 19 September 2024.....	94
Type 2 diabetes in adults: management NICE guideline [NG28] Published: 02 December 2015 Last updated: 29 June 2022 Last reviewed: 23 December 2024	95
Chronic heart failure in adults: diagnosis and management NICE guideline [NG106] Published: 12 September 2018 Last reviewed: 3 September 2025.....	96
Hypertension in adults: diagnosis and management NICE guideline [NG136] Published: 28 August 2019 Last updated: 18 March 2022 Last reviewed: 27 November 2024	97
Abdominal aortic aneurysm: diagnosis and management NICE guideline [NG156] Published: 19 March 2020	98
Acute coronary syndromes NICE guideline [NG185] Published: 18 November 2020 Last reviewed: 19 December 2024	99
Stroke rehabilitation in adults NICE guideline [NG236] Published: 18 October 2023	101

Cardiovascular disease: risk assessment and reduction, including lipid modification NICE guideline [NG238] Published: 14 December 2023 Last reviewed 2 September 2025.....	103
Weight management/Obesity	105
Overweight and obesity management NICE guideline [NG246] Published: 14 January 2025	105
Maternal and child nutrition: nutrition and weight management in pregnancy, and nutrition in children up to 5 years [NG247] Published: 15 January 2025	123
Respiratory	126
Cystic fibrosis: diagnosis and management NICE guideline [NG78] Published: 25 October 2017 Last reviewed: 19 December 2024	126
Chronic obstructive pulmonary disease in over 16s: diagnosis and management NICE guideline [NG115] Published: 05 December 2018 Last updated: 26 July 2019 Last reviewed: 12 January 2022.....	127
Dementia.....	131
Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset NICE guideline [NG16] Published: 20 October 2015.....	131
Dementia: assessment, management and support for people living with dementia and their carers NICE guideline [NG97] Published: 20 June 2018 Last reviewed: 26 September 2023	133
Musculoskeletal Conditions and MSK health	134
Low back pain and sciatica in over 16s: assessment and management NICE guideline [NG59] Published: 30 November 2016 Last updated: 11 December 2020	134
Spondyloarthritis in over 16s: diagnosis and management NICE guideline [NG65] Published: 28 February 2017 Last updated: 02 June 2017 Last reviewed: 4 March 2025.....	135
Rheumatoid arthritis in adults: management NICE guideline [NG100] Published: 11 July 2018 Last updated: 12 October 2020 Last reviewed 19 November 2024.....	136

Joint replacement (primary): hip, knee and shoulder NICE guideline [NG157] Published: 04 June 2020 Last reviewed: 19 December 2024	.137
Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain NICE guideline Published: 7 April 2021	139
Rehabilitation after traumatic injury NICE guideline [NG211] Published: 18 January 2022	140
Osteoarthritis in over 16s: diagnosis and management NICE guideline [NG226] Published: 19 October 2022	143
Falls Prevention	146
Falls: assessment and prevention in older people and in people 50 and over at higher risk [NG249] Published: 29 April 2025	146
Neurological Conditions	150
Motor neurone disease: assessment and management [NG42] Published: 24 February 2016 Last updated: 23 July 2019 Last reviewed: 27 November 2024	150
Parkinson’s disease in adults NICE guideline [NG71] Published: 19 July 2017 Last reviewed: 19 December 2024	151
Cerebral palsy in adults NICE guideline [NG119] Published: 15 January 2019	152
Multiple sclerosis in adults: management NICE guideline [NG220] Published: 22 June 2022	154
Rehabilitation for chronic neurological disorders including acquired brain injury [NG252] Published: 15 October 2025	155
Cancer	159
Bladder cancer: diagnosis and management NICE guideline [NG2] Published: 25 February 2015 Last reviewed: 17 September 2025	159
Non-Hodgkin’s lymphoma: diagnosis and management NICE guideline [NG52] Published: 20 July 2016	160
Brain tumours (primary) and brain metastases in over 16s NICE guideline [NG99] Published: 11 July 2018 Last updated: 29 January 2021	161

Early and locally advanced breast cancer: diagnosis and management NICE guideline [NG101] Published: 18 July 2018 Last updated: 14 April 2025	162
Colorectal cancer NICE guideline [NG151] Published: 29 January 2020 Last updated: 15 December 2021 Last reviewed: 27 August 2025	164
Mental Health (Adults)	165
Preventing suicide in community and custodial settings NICE guideline [NG105] Published: 10 September 2018	165
Rehabilitation for adults with complex psychosis NICE guideline [NG181] Published: 19 August 2020 Last reviewed: 16 August 2024....	166
Mental wellbeing at work NICE guideline [NG212] Published: 02 March 2022	169
Depression in adults: treatment and management NICE guideline [NG222] Published: 29 June 2022	170
Mental Health (Children and Young People)	171
Depression in children and young people: identification and management NICE guideline [NG134] Published: 25 June 2019.....	171
Fertility, maternity, postnatal and menopause	172
Diabetes in pregnancy: management from preconception to the postnatal period [NG3] Published: 25 February 2015: Last updated: 16 December 2020 Last reviewed: 30 April 2025.....	172
Menopause: identification and management NICE guideline [NG23] Published: 12 November 2015 Last updated: 07 November 2024.....	176
Postnatal care NICE guideline [NG194] Published: 20 April 2021.....	177
Antenatal care NICE guideline [NG201] Published: 19 August 2021 Last reviewed: 27 December 2024	179
Other	180
Workplace health: management practices NICE guideline [NG13] Published: 24 June 2015 Last updated: 24 March 2016	180

Older people with social care needs and multiple long-term conditions NICE guideline [NG22] Published: 04 November 2015.....	181
Older people: independence and mental wellbeing NICE guideline [NG32] Published: 17 December 2015.....	182
Non-alcoholic fatty liver disease (NAFLD): assessment and management NICE guideline [NG49] Published: 06 July 2016 Last reviewed: 24 October 2024 and update underway.....	183
Multimorbidity: clinical assessment and management NICE guideline [NG56] Published: 21 September 2016.....	184
Physical health of people in prison NICE guideline [NG57] Published: 02 November 2016	185
Attention deficit hyperactivity disorder: diagnosis and management NICE guideline [NG87] Published: 14 March 2018 Last updated: 13 September 2019 Last reviewed: 7 May 2025.....	187
Care and support of people growing older with learning disabilities NICE guideline [NG96] Published: 11 April 2018	188
Diverticular disease: diagnosis and management NICE guideline [NG147] Published: 27 November 2019	189
Behaviour change: digital and mobile health interventions NICE guideline [NG183] Published: 07 October 2020.....	190
Chronic kidney disease: assessment and management NICE guideline [NG203] Published: 25 August 2021 Last updated: 24 November 2021 Last reviewed: 19 August 2025.....	191
Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management NICE guideline [NG206] Published: 29 October 2021 Last reviewed: 24 January 2025	193
Pelvic floor dysfunction: prevention and non-surgical management NICE guideline [NG210] Published: 09 December 2021	201
Subarachnoid haemorrhage caused by a ruptured aneurysm: diagnosis and management NICE guideline [NG228] Published: 23 November 2022	202
NICE Public Health Guidelines	203

Cardiovascular Disease	204
Cardiovascular disease prevention Public health guideline [PH25] Published: 22 June 2010	204
Type 2 diabetes prevention: population and community-level interventions Public health guideline [PH35] Published: 10 May 2011 Last reviewed: 28 March 2018	206
Type 2 diabetes: prevention in people at high risk Public health guideline [PH38] Published: 12 July 2012 Last updated: 15 September 2017 Last reviewed: 28 March 2018	215
Children & Young People	221
Unintentional injuries: prevention strategies for under 15s Public health guideline [PH29] Published: 24 November 2010 Last reviewed 10 October 2019	221
Cancer Service Guidelines	223
Improving outcomes in breast cancer Cancer service guideline [CSG1] Published: 28 August 2002 Last reviewed: 31 December 2014	224
NICE Indicators	225
Hypertension: assessment of physical activity NICE indicator IND95 Published: 1 August 2011 Last updated: 4 November 2020	226
Hypertension: brief intervention to increase physical activity NICE indicator IND96 Published: 1 August 2011 Last updated: 4 November 2020	227
Cardiovascular disease prevention: primary prevention with lifestyle changes NICE indicator IND228 Published: 23 August 2022 Last updated:5 June 2023	228

Clinical Guidelines

Cardiovascular Disease

Familial hypercholesterolaemia: identification and management Clinical guideline [CG71] Published: 27 August 2008 Last updated: 04 October 2019

1.3 Management

1.3.2 Lifestyle interventions

Physical activity

1.3.2.8 Healthcare professionals should advise people with FH to undertake physical activity in line with national guidance for the general population (see the UK Chief Medical Officers' physical activity guidelines for more information). [2008]

1.3.2.9 Healthcare professionals should encourage people who are unable to perform moderate-intensity physical activity because of comorbidity, medical conditions or personal circumstances to exercise at their maximum safe capacity (see the UK Chief Medical Officers' physical activity guidelines for more information). [2008]

1.3.2.10 Recommended types of physical activity include those that can be incorporated into everyday life, such as brisk walking, using stairs and cycling (see the UK Chief Medical Officers' physical activity guidelines for more information). [2008]

© NICE 2025 *Familial hypercholesterolaemia: identification and management Clinical guideline [CG71]* Available from <https://www.nice.org.uk/guidance/CG71> All rights reserved. Subject to [Notice of rights.](#)

1.2 Information and support for people with stable angina

1.2.6 Assess the person's need for lifestyle advice (for example about exercise, stopping smoking, diet and weight control) and psychological support, and offer interventions as necessary.

1.3 General principles for treating people with stable angina

Preventing and treating episodes of angina

1.3.3 Offer a short-acting nitrate for preventing and treating episodes of angina. Advise people with stable angina:

- how to administer the short-acting nitrate
- to use it immediately before any planned exercise or exertion
- that side effects such as flushing, headache and light-headedness may occur
- to sit down or find something to hold on to if feeling light-headed.

Varicose veins: diagnosis and management Clinical guideline [CG168]

Published: 24 July 2013. Last reviewed February 2016.

1.1 Information for people with varicose veins

Give people who present with varicose veins information that includes:

- Advice on:
 - weight loss (for guidance on weight management see the NICE guideline on obesity prevention)
 - light to moderate physical activity
 - avoiding factors that are known to make their symptoms worse if possible
 - when and where to seek further medical help.

© NICE 2025 *Varicose veins: diagnosis and management Clinical guideline [CG168]*. Available from <https://www.nice.org.uk/guidance/CG168> All rights reserved. Subject to [Notice of rights](#).

Mental Health (Adults)

Depression in adults with a chronic physical health problem: recognition and management Clinical guideline [CG91] Published: 28 October 2009

Last updated: May 2024

1.4 Step 2: recognised depression in primary care and general hospital settings – persistent subthreshold depressive symptoms or mild to moderate depression.

1.4.1 General measures

Sleep hygiene

1.4.1.2 Offer patients with depression and a chronic physical health problem advice on sleep hygiene if needed, including:

- establishing regular sleep and wake times
- avoiding excess eating, smoking or drinking alcohol before sleep
- creating a proper environment for sleep
- taking regular physical exercise where this is possible for the patient.

1.4.2 Low-intensity psychosocial interventions

1.4.2.1 For patients with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem, and for patients with subthreshold depressive symptoms that complicate the care of the chronic physical health problem, consider offering one or more of the following interventions, guided by the patient's preference:

- a structured group physical activity programme
- a group-based peer support (self-help) programme
- individual guided self-help based on the principles of cognitive behavioural therapy (CBT)

Delivery of low-intensity psychosocial interventions

1.4.2.2 Physical activity programmes for patients with persistent subthreshold

depressive symptoms or mild to moderate depression and a chronic physical health problem, and for patients with subthreshold depressive symptoms that complicate the care of the chronic physical health problem, should:

- be modified (in terms of the duration of the programme and frequency and length of the sessions) for different levels of physical ability as a result of the particular chronic physical health problem, in liaison with the team providing care for the physical health problem be delivered in groups with support from a competent practitioner
- consist typically of 2 or 3 sessions per week of moderate duration (45 minutes to 1 hour) over 10 to 14 weeks (average 12 weeks)
- be coordinated or integrated with any rehabilitation programme for the chronic physical health problem.

© NICE 2025 *Depression in adults with a chronic physical health problem: recognition and management [CG91]* Available from <https://www.nice.org.uk/guidance/cg91> All rights reserved. Subject to [Notice of rights.](#)

**Generalised anxiety disorder and panic disorder in adults: management
Clinical guideline [CG113] Published: 26 January 2011 Last updated: 15
June 2020**

Step 2 for people with panic disorder: offer treatment in primary care

The recommended treatment options have an evidence base: psychological therapy, medication and self-help have all been shown to be effective. The choice of treatment will be a consequence of the assessment process and shared decision making.

1.4.12 The benefits of exercise as part of good general health should be discussed with all people with panic disorder as appropriate. [2004]

© NICE 2025 *Generalised anxiety disorder and panic disorder in adults: management [CG113]* Available from <https://www.nice.org.uk/guidance/cg113> All rights reserved. Subject to [Notice of rights](#).

Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services Clinical guideline [CG136] Published: 14 December 2011 Last reviewed: January 2021

1.6 Hospital care

1.6.9 Ensure that service users in hospital have access to a wide range of meaningful and culturally appropriate occupations and activities 7 days per week, and not restricted to 9am to 5pm. These should include creative and leisure activities, exercise, self-care and community access activities (where appropriate). Activities should be facilitated by appropriately trained health or social care professionals.

© NICE 2024 *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services [CG136]* Available from <https://www.nice.org.uk/guidance/cg136> All rights reserved. Subject to [Notice of rights](#).

1.1.3 Physical health

1.1.3.1 People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider.

Our 2019 review of the STEPWISE trial did not change this recommendation. [2019]

1.3.3 Assessment and care planning

1.3.3.1 Carry out a comprehensive multidisciplinary assessment of people with psychotic symptoms in secondary care. This should include assessment by a psychiatrist, a psychologist or a professional with expertise in the psychological treatment of people with psychosis or schizophrenia. The assessment should address the following domains:

- psychiatric (mental health problems, risk of harm to self or others, alcohol consumption and prescribed and non-prescribed drug history)
- medical, including medical history and full physical examination to identify physical illness (including organic brain disorders) and prescribed drug treatments that may result in psychosis
- physical health and wellbeing (including weight, smoking, nutrition, physical activity and sexual health)
- psychological and psychosocial, including social networks, relationships and history of trauma
- developmental (social, cognitive and motor development and skills, including coexisting neurodevelopmental conditions)

© NICE 2025 *Psychosis and schizophrenia in adults: prevention and management [CG178]* Available from <https://www.nice.org.uk/guidance/cg178> All rights reserved. Subject to [Notice of rights](#)

Mental Health (Children & Young People)

**Psychosis and schizophrenia in children and young people: recognition and management Clinical guideline [CG155] Published: 23 January 2013
Last updated: 26 October 2016. Last reviewed: 21 May 2024**

Assessment and care planning in secondary care

1.3.4 Ensure that children and young people with first episode psychosis receive a comprehensive multidisciplinary assessment. The assessment should address the following domains:

- physical health and wellbeing (including weight and height, and information about smoking, diet and exercise, and sexual health)

Hospital care

1.5.11 Ensure that children and young people in hospital continue to have access to a wide range of meaningful and culturally appropriate occupations and activities 7 days per week, and not restricted to 9am to 5pm. These should include creative and leisure activities, exercise, self-care and community access activities (where appropriate). Activities should be facilitated by appropriately trained educational, health or social care professionals. [2013]

1.5.13 Promote good physical health, including healthy eating, exercise and smoking cessation. [2013]

© NICE 2025 *Psychosis and schizophrenia in children and young people: recognition and management [CG155]* Available from <https://www.nice.org.uk/guidance/cg155> All rights reserved. Subject to [Notice of rights](#).

Respiratory

Idiopathic pulmonary fibrosis in adults: diagnosis and management
Clinical guideline [CG163] Published: 12 June 2013 Last updated: 23 May 2017. Last reviewed: 29 September 2024

1.5 Management

Pulmonary rehabilitation

1.5.3 If appropriate after each assessment, offer pulmonary rehabilitation including exercise and educational components tailored to the needs of people with idiopathic pulmonary fibrosis in general.

1.5.4 Pulmonary rehabilitation should be tailored to the individual needs of each person with idiopathic pulmonary fibrosis. Sessions should be held somewhere that is easy for people with idiopathic pulmonary fibrosis to get to and has good access for people with disabilities.

© NICE 2024 *Idiopathic pulmonary fibrosis in adults: diagnosis and management [CG163]* Available from <https://www.nice.org.uk/guidance/cg163> All rights reserved. Subject to [Notice of rights](#).

Cancer

Advanced breast cancer: diagnosis and treatment Clinical guideline [CG81] Published: 23 February 2009 Last updated: 19 February 2025 Some further updates underway following January 2023 review.

1.5 Managing complications

Lymphoedema (2014 recommendations)

Recommendations in this section have been stood down as they have been superseded by the February 2025 update on lymphoedema early identification, risk reduction and management in the [NICE guideline on early and locally advanced breast cancer: diagnosis and management](#).

Cancer-related fatigue

1.5.10 Provide information about and timely access to an exercise programme for all patients with advanced breast cancer experiencing cancer-related fatigue. [2009]

© NICE 2025 *Advanced breast cancer: diagnosis and treatment [CG81]*
Available from <https://www.nice.org.uk/guidance/cg81> All rights reserved.
Subject to [Notice of rights](#).

Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer Clinical guideline [CG164] Published: 25 June 2013 Last updated: 14 November 2023

1.7 Risk reduction and treatment strategies

Weight and physical activity

1.7.19 Women should be advised about the potential benefits of physical exercise on breast cancer risk. [2004]

© NICE 2025 *Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer [CG164]* Available from <https://www.nice.org.uk/guidance/cg164> All rights reserved. Subject to [Notice of rights](#).

Musculoskeletal Conditions and MSK health

Spasticity in under 19s: management Clinical guideline [CG145]

Published: 25 July 2012 Last updated: 29 November 2016

1.2 Physical therapy (physiotherapy and/or occupational therapy)

General principles

1.2.1 All children and young people with spasticity referred to the network team should be promptly assessed by a physiotherapist and, where necessary, an occupational therapist.

1.2.14 Direct muscle-strengthening therapy towards specific goals using progressive repetitive exercises performed against resistance.

© NICE 2024 Spasticity in under 19s: management Clinical guideline [CG145] Available from <https://www.nice.org.uk/guidance/cg145> All rights reserved. Subject to [Notice of rights](#).

Children and Young People

**Constipation in children and young people: diagnosis and management
Clinical guideline [CG99] Published: 26 May 2010 Last updated: 13 July
2017 Last reviewed: June 2018**

1.5 Diet and lifestyle

1.5.6 Advise daily physical activity that is tailored to the child or young person's stage of development and individual ability as part of ongoing maintenance in children and young people with idiopathic constipation.

© NICE 2024 Constipation in children and young people: diagnosis and management [CG99] Available from <https://www.nice.org.uk/guidance/cg99> All rights reserved. Subject to [Notice of rights](#).

1.1 Interventions for coexisting problems

Interventions for sleep problems

1.7.4 If an autistic child or young person develops a sleep problem offer an assessment that identifies:

- what the sleep problem is (for example, delay in falling asleep, frequent waking, unusual behaviours, breathing problems or sleepiness during the day)
- day and night sleep patterns, and any change to those patterns
- whether bedtime is regular
- what the sleep environment is like, for example:
 - the level of background noise
 - use of a blackout blind
 - a television or computer in the bedroom
 - whether the child shares the room with someone
- presence of comorbidities especially those that feature hyperactivity or other behavioural problems
- levels of activity and exercise during the day
- possible physical illness or discomfort (for example, reflux, ear or toothache, constipation or eczema)
- effects of any medication
- any other individual factors thought to enhance or disturb sleep, such as emotional relationships or problems at school
- the impact of sleep and behavioural problems on parents or carers and other family members.

© NICE 2025 *Autism spectrum disorder in under 19s: support and management [CG170]* Available from <https://www.nice.org.uk/guidance/cg170> All rights reserved. Subject to [Notice of rights](#).

Fertility, maternity, postnatal and menopause

Fertility problems: assessment and treatment Clinical guideline [CG156]

Published: 20 February 2013 Last updated: 06 September 2017

1.2 Initial advice to people concerned about delays in conception

1.2.6 Obesity

1.2.6.3 Women should be informed that participating in a group programme involving exercise and dietary advice leads to more pregnancies than weight loss advice alone. [2004]

1.5.1 WHO Group 1 ovulation disorders

1.5.1.1 Advise women with WHO Group 1 anovulatory infertility that they can improve their chance of regular ovulation, conception and an uncomplicated pregnancy by:

- increasing their body weight if they have a BMI of less than 19 and/or
 - moderating their exercise levels if they undertake high levels of exercise.
- [new 2013]

© NICE 2025 Fertility problems: assessment and treatment [CG156]
Available from <https://www.nice.org.uk/guidance/cg156> All rights reserved.
Subject to [Notice of rights](#).

Other conditions

Drug misuse in over 16s: opioid detoxification Clinical guideline [CG52]

Published: 25 July 2007 Last reviewed: 9 December 2024

1.1 General considerations

1.1.1 Providing information, advice and support

1.1.1.3 Service users should be offered advice on aspects of lifestyle that require particular attention during opioid detoxification. These include:

- a balanced diet
- adequate hydration
- sleep hygiene
- regular physical exercise.

© NICE 2025 Drug misuse in over 16s: opioid detoxification [CG52] Available from <https://www.nice.org.uk/guidance/cg52> All rights reserved. Subject to [Notice of rights](#).

Key priorities for implementation

1.2 Clinical management of IBS

1.2.1 Dietary and lifestyle advice

1.2.1.1 People with IBS should be given information that explains the importance of self-help in effectively managing their IBS. This should include information on general lifestyle, physical activity, diet and symptom-targeted medication. [2008]

1.2.1.3 Healthcare professionals should assess the physical activity levels of people with IBS, ideally using the General Practice Physical Activity Questionnaire (GPPAQ; see appendix J of the full guideline). People with low activity levels should be given brief advice and counselling to encourage them to increase their activity levels. [2008]

1.3 General principles of care Principles for working with autistic adults and their families, partners and carers

1.1.9 All health and social care professionals providing care and support for autistic adults should:

- be aware of under-reporting and under-recognition of physical disorders in autistic people
- be vigilant for unusual likes and dislikes about food and/or lack of physical activity
- offer advice about the beneficial effects of a healthy diet and exercise, taking into account any hyper- and/or hypo-sensory sensitivities; if necessary, support referral to a GP or dietician.

Cardiovascular Disease

Stroke in adults Quality standard [QS2] Published: 29 June 2010 Last updated: 12 April 2016

Quality statement 2: Intensity of stroke rehabilitation Quality statement
Adults having stroke rehabilitation in hospital or in the community are offered at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week. [2010, updated 2016]

Rationale Higher-intensity stroke rehabilitation therapies can improve the quality of life for adults who have had a stroke. The improvements that an adult with stroke should expect to achieve will depend on their health and abilities before and after the stroke, the severity of the stroke and the intensity of the rehabilitation therapy. The intensity of stroke rehabilitation should be suitable for the person, so that they are able to participate and make progress towards their functional goals.

Process

b) Proportion of adults having stroke rehabilitation in the community who receive at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week.

What the quality statement means for different audiences Service providers (such as secondary care providers and community care providers) ensure that adults having stroke rehabilitation are offered at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week. Health and social care practitioners offer adults having stroke rehabilitation at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week. Commissioners ensure that they commission services in which adults having stroke rehabilitation are offered at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week. Adults having rehabilitation therapy after a stroke are offered at least 3 hours of rehabilitation therapy that they need on at least 5 days a week. Rehabilitation therapy is long-term support to help people

regain their independence and cope with any remaining disabilities after a stroke. It may involve many different specialists, such as physiotherapists, occupational therapists and speech and language therapists. They can help people who have problems with their memory and concentration; speaking, reading and writing; emotions and feelings; sight; swallowing and eating; strength, balance and movement; and shoulder pain. They also include help to encourage physical activity and independent living.

Quality statement 6: Cardiac rehabilitation

Quality statement

Adults with chronic heart failure receive a personalised programme of cardiac rehabilitation. [2011, updated 2023]

Rationale

A personalised programme of cardiac rehabilitation delivered by an appropriate method, preceded by an assessment to ensure that it is suitable, can help to extend and improve the quality of a person's life. Cardiac rehabilitation uses monitored exercise, psychological support and education about lifestyle changes to reduce the risks of further heart problems. It can also reduce uncertainty and anxiety about living with chronic heart failure. Through better management of their condition, the person may have greater opportunities to return to normal activities.

Proportion of adults with chronic heart failure who have a record of referral to a personalised programme of cardiac rehabilitation.

Proportion of adults with chronic heart failure who receive a personalised programme of cardiac rehabilitation.

Outcome

Rates of people with chronic heart failure completing programmes of cardiac rehabilitation.

What the quality statement means for different audiences

Service providers (GP practices, community nursing teams and hospitals) ensure that referral pathways to personalised programmes of cardiac rehabilitation that include a monitored exercise, a psychological component and an educational component are available for adults with chronic heart failure.

Healthcare professionals (such as GPs, cardiac rehabilitation nurses and specialists in cardiac care) ensure that they refer adults diagnosed with

chronic heart failure to a personalised programme of cardiac rehabilitation, once they are well enough to take part.

Commissioners (integrated care systems and local authorities) ensure that they commission services in which personalised cardiac rehabilitation programmes that include a monitored exercise, a psychological component and an educational component are available for adults with chronic heart failure.

Adults with chronic heart failure are offered a personalised programme of cardiac rehabilitation if it is suitable for them, once they are well enough to take part. This programme includes help and support with taking exercise, help with understanding their condition, support with their thoughts and feelings around the condition, and help with how to look after themselves

Personalised programme of cardiac rehabilitation

This is an exercise-based programme of rehabilitation designed for people with chronic heart failure that includes a psychological and educational component. It should be accompanied by information about support available from healthcare professionals. The information should be provided in a format and setting (at home, in the community or in the hospital) that is easily accessible. It should be suited to the person, their condition, and their needs. [Adapted from NICE's guideline on chronic heart failure in adults, recommendation 1.9.1]

Secondary prevention after a myocardial infarction Quality standard [QS99] Published: 04 September 2015

[Statement 2](#) Adults admitted to hospital with an MI are referred for cardiac rehabilitation before discharge.

[Statement 4](#) Adults referred to a cardiac rehabilitation programme after an MI have an assessment appointment within 10 days of discharge from hospital.

[Statement 5 \(developmental\)](#) Adults referred to a cardiac rehabilitation programme after an MI are offered sessions during and outside working hours and the choice of undertaking the programme at home, in the community or in a hospital setting.

Quality statement 2: Diet and lifestyle advice for primary prevention

Adults with a 10-year risk of cardiovascular disease of 10% or more receive tailored advice on diet and lifestyle changes within 3 months of their cardiovascular disease risk assessment score being recorded. [2015, updated 2025]

Making improvements to diet, stopping smoking, increasing physical activity, managing weight and reducing alcohol consumption can reduce the risk of cardiovascular disease (CVD). Healthcare professionals should offer advice to adults with a 10-year CVD risk score of 10% or more after a full formal risk assessment, based on their individual needs, preferences and circumstances.

What the quality statement means for different audiences

Service providers (such as primary care services) ensure that systems are in place for adults with a 10-year risk of CVD of 10% or more to be given advice on diet and lifestyle changes within 3 months of their cardiovascular risk assessment score being recorded.

Healthcare professionals (such as GPs, nurses, healthcare support workers, and pharmacists) give advice on diet and lifestyle changes for the primary prevention of CVD to adults with a 10-year risk of CVD of 10% or more within 3 months of their cardiovascular risk assessment score being recorded. They take the person's individual needs, preferences and circumstances into account when giving advice.

Commissioners ensure that they commission services that can deliver diet and lifestyle advice to adults with a 10-year risk of CVD of 10% or more within 3 months of their cardiovascular risk assessment score being recorded.

Adults with a 1 in 10 chance or more of developing CVD in the next 10 years (a 10-year risk of 10% or more) are given advice on diet and lifestyle changes, such as stopping smoking, losing weight, eating a healthy diet and exercising when they are found to be at risk. These changes may help

to reduce their chances of having a heart attack or stroke in the future. The advice reflects their needs, preferences and circumstances

Diet and lifestyle changes Diet and lifestyle changes include:

- stopping smoking
- healthy eating
- reaching and maintaining a healthy weight
- increasing physical activity
- reducing alcohol consumption.

[NICE's guideline on cardiovascular disease: risk assessment and reduction, including lipid modification, recommendations 1.3.1 to 1.3.11]

Quality statement 2: Education and information

Quality statement

Children and young people with type 1 or type 2 diabetes are offered a programme of diabetes education from diagnosis that is updated at least annually.

Rationale

Education is essential in enabling self-management of diabetes and reducing the chance of complications. It should start at diagnosis and continue throughout a person's life. It is important to focus education on core topics and tailor it to the individual needs and learning styles of the child or young person and their family members or carers (as appropriate).

Process

- a) Proportion of children and young people with type 1 diabetes who are offered a programme of diabetes education from diagnosis that is updated at least annually.
- b) Proportion of children and young people with type 2 diabetes who are offered a programme of diabetes education from diagnosis that is updated at least annually.

Programme of diabetes education (type 1 diabetes)

A continuing programme of education that is age appropriate, tailored to need and revisited at least annually. The following core topics should be included from diagnosis:

- insulin therapy, including its aims, how it works, how to take it and how to adjust the dosage
- blood glucose monitoring, including continuous glucose monitoring, blood glucose and HbA1c targets, and time-in-range targets

- how diet, physical activity and intercurrent illness affect blood glucose levels
- managing intercurrent illness ('sick-day rules', including monitoring of blood ketones [beta-hydroxybutyrate])
- detecting and managing hypoglycaemia, hyperglycaemia and ketosis
- the importance of good oral hygiene and regular oral health reviews for preventing periodontitis.

Programme of diabetes education (type 2 diabetes)

A continuing programme of education that is age appropriate, tailored to need and revisited at least annually. The following core topics should be included from diagnosis:

- the importance of managing glucose levels, including achieving and maintaining glucose and HbA1c targets
- how and when to take capillary blood glucose measurements (self-monitoring)
- how diet, increasing physical activity and reducing body weight can reduce the symptoms of type 2 diabetes and lead to remission
- how diet, physical activity, body weight and intercurrent illness affect blood glucose levels
- how metformin can help, and its possible adverse effects
- the complications of type 2 diabetes and how to prevent them.

© NICE 2024 *Diabetes in children and young people [QS125]* Available from <https://www.nice.org.uk/guidance/qs125> All rights reserved. Subject to [Notice of rights](#).

Type 2 diabetes in adults Quality standard [QS209] Published: 02 March 2023

QS 1 Adults at high risk of type 2 diabetes are offered a referral to the NHS Diabetes Prevention Programme.

QS 2 Adults with type 2 diabetes are offered a structured education programme at diagnosis. **[2011, updated 2023]**

What the quality statement means for different audiences

Service providers (such as local authorities who provide the NHS Health Check programme) ensure that systems are in place for adults at high risk of type 2 diabetes to be offered a referral to the NHS Diabetes Prevention Programme.

Health and public health professionals (such as GPs, pharmacists and people carrying out diabetes risk assessments and other health checks) ensure that they offer a referral to the NHS Diabetes Prevention Programme to adults at high risk of type 2 diabetes. They should ensure adults with type 2 diabetes are given clear information on the NHS Diabetes Prevention Programme and help to access it. Health and public health professionals should recognise when offering a behaviour change intervention may not be appropriate due to personal circumstances.

Integrated care systems ensure that they identify adults at high risk of developing type 2 diabetes and refer them to the NHS Diabetes Prevention Programme.

Adults who have been told they are at high risk of getting type 2 diabetes are offered a programme that will help them change their lifestyle to reduce their risk. This includes support to become more physically active and improve their diet. They receive clear information on the programme and are helped to access it.

© NICE 2025 *Type 2 diabetes in adults [QS209]* Available from <https://www.nice.org.uk/guidance/qs209> All rights reserved. Subject to [Notice of rights](#).

Weight Management & Obesity

Overweight and obesity management Quality standard [QS212]

Published: 05 August 2025

Quality statement 6: Wraparound care alongside medicines for weight management

Quality statement

People living with overweight or obesity who are prescribed medicines for weight management receive wraparound care focusing on diet, nutrition and increasing physical activity. [new 2025]

Rationale

Medicines for weight management are recommended as options for people with relevant clinical criteria (specific to the medicine). The decision to start medicines should be made after discussion, and providing information, support and counselling on additional dietary, physical activity and behavioural strategies

What the quality statement means for different audiences

Service providers (specialist overweight and obesity management services, primary care) ensure that protocols are in place for providing information, support and counselling on additional dietary, physical activity and behavioural strategies alongside prescription of medicines for weight management.

Health and social care practitioners (GPs, overweight and obesity management service staff) ensure that they provide and record any outcomes of information, support and counselling on additional dietary, physical activity and behavioural strategies alongside prescription of medicines for weight management.

Commissioners ensure that any services able to prescribe medicines for weight management have protocols in place to ensure that information, support and counselling on additional dietary, physical activity and behavioural strategies are provided alongside them.

People living with overweight and obesity receive support with making changes to what they eat and how active they are when they are given medicines to manage their weight.

Musculoskeletal Conditions and MSK Health

Falls in older people Quality standard [QS86] Published: 25 March 2015 Last updated: 29 April 2025

Quality statement 3: Interventions to reduce the risk of falls

Quality statement

People aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over have tailored interventions that address their individual risk factors if they need comprehensive falls management to reduce their risk of falling. [2017, updated 2025]

Rationale

A comprehensive falls assessment allows a person's risk factors to be identified. In a comprehensive falls management approach, interventions to reduce the risk of falls are tailored to address the person's individual risk factors.

What the quality statement means for different audiences

Service providers (such as specialist services, primary care services, community teams) ensure that systems and governance structures are in place to provide tailored interventions that address people's risk factors when they are identified through comprehensive falls assessment; to coordinate interventions across different professionals and settings; and to ensure that appropriate staff perform the interventions.

Healthcare professionals (such as consultant geriatricians, nurses, physiotherapists, occupational therapists, pharmacists and primary care practitioners) identify interventions that address a person's multiple risk factors established through a comprehensive falls assessment; discuss the interventions with the person and how they can be tailored to their needs; deliver the interventions; and document them in the patient's record.

Commissioners ensure that they commission services so that adults who are assessed as being at increased risk of falling receive tailored interventions based on comprehensive falls assessment.

People aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over who have had an assessment that shows they are at increased risk of falling develop a plan with a healthcare professional tailored to their individual needs to reduce their risk of falling. This plan may include treating health problems, making changes at home, exercises, having their eyes checked and looking at whether any medicines they take should be changed.

Tailored interventions

Comprehensive falls management involves using interventions tailored to address the person's individual risk factors identified in a comprehensive assessment. Individual interventions may be directly carried out by 1 or more health professionals in a specialist service (for example, a medication review by the team pharmacist or a home hazard modification by the team occupational therapist) or by referrals for further action (for example, a referral to ophthalmology for consideration of cataract surgery) and may vary depending on setting. Comprehensive falls management interventions may include:

- a structured medication review with modification or withdrawal, in particular, of psychotropic medicines
- advice about vitamin D supplements
- home hazard assessments and interventions
- surgical interventions for cataracts or cardiac pacing
- falls prevention exercise programmes
- cognitive behavioural approaches
- advice about physical activity and exercises.

© NICE 2025 Falls in older people [QS86] Available from <https://www.nice.org.uk/guidance/qs86> All rights reserved. Subject to [Notice of rights](#).

Quality statement 3: Information and support

Quality statement

Adults with osteoarthritis are given information about their condition and its management

at diagnosis and follow-up appointments

Rationale

Providing information and advice about osteoarthritis and its management supports adults to develop a greater understanding of the condition, its development over time and how to manage it. Tailored information on management, based on the person's symptoms and physical function, and taking into account any other long-term or ongoing conditions, can also support shared decision making and self-management strategies. Adults with osteoarthritis can also use advice on how to access additional sources of information after the consultation to provide ongoing support. Information can help them to actively participate in their care, and improve patient experience.

What the quality statement means for different audiences

Service providers (GPs and community healthcare providers) ensure that processes are in place so that adults with osteoarthritis are given tailored information to support self-management strategies. This should comprise information and advice about the condition, how it changes over time, core treatments, where to access further information on topics such as managing symptoms and specific types of exercise, and how to access additional sources of information.

Healthcare professionals give adults with osteoarthritis tailored information and advice to support self-management strategies. This should cover the condition, how it changes over time and of core treatments, where to access further information on topics such as managing symptoms and

specific types of exercise, and how to access additional sources of information.

Quality statement 4: Therapeutic exercise

Quality statement

Adults with osteoarthritis are advised to do tailored therapeutic exercise.

Rationale

Therapeutic exercise is a core treatment for osteoarthritis that will help manage and reduce symptoms and improve or maintain physical function. It is important that people are advised to undertake specific exercise that is relevant for their condition, and that it is tailored to their needs, for example, muscle strengthening that targets affected joints and general aerobic fitness. Healthcare professionals will need to make a judgement about the best way to support people to exercise, because this will vary for each person depending on their needs, circumstances and self-motivation, and may change over time.

Process

a) Proportion of adults newly diagnosed with osteoarthritis who receive advice on tailored therapeutic exercise.

What the quality statement means for different audiences

Service providers (GPs and community healthcare providers) ensure that processes are in place so that adults with osteoarthritis are advised to do therapeutic exercise tailored to their needs, such as local muscle strengthening and general aerobic fitness. Advice is given at both diagnosis and follow-up appointments. Service providers may compile information about local exercise classes, groups and facilities, so that people can be given information about any that are suitable.

Healthcare professionals ensure that they advise adults with osteoarthritis at both diagnosis and follow-up appointments to do therapeutic exercise. This is tailored to the person's needs, and may involve local muscle strengthening and general aerobic fitness, and information on suitable local exercise classes, groups and facilities.

Commissioners ensure that they commission services in which adults with osteoarthritis are advised at both diagnosis and follow-up appointments to do therapeutic exercise which is tailored to their needs, such as local muscle strengthening and general aerobic fitness.

Tailored therapeutic exercise

Exercise tailored to the needs of adults with osteoarthritis, such as local muscle strengthening and general aerobic fitness, to reduce their symptoms and improve or maintain physical functioning over the long term. Therapeutic exercise should be offered to adults with newly diagnosed osteoarthritis and at follow-up appointments, along with information and support. [Adapted from NICE's guideline on osteoarthritis in over 16s, recommendation 1.3.1, rationale and impact section; and expert opinion]

Quality statement 7: Core treatments before referral for consideration of joint surgery

Quality statement

Adults with osteoarthritis are supported with non-surgical core treatments for at least 3 months before any referral for consideration of joint surgery.

Rationale

Core treatments for adults with osteoarthritis are verbal and written information to support a better understanding of the condition, tailored therapeutic exercise and weight management for people who are also living with overweight or obesity. Core treatments support the person to self-manage their condition and help to relieve symptoms. It is therefore important that these treatments are tried before a surgical solution is explored. Ensuring that core treatments are tried first will help to reduce unnecessary referrals. People who do go on to have surgery are likely to have improved outcomes if core treatments are undertaken pre-operatively

Equality and diversity considerations

All adults with osteoarthritis should be encouraged to exercise. If age, comorbidities, pain severity or disability are seen as a barrier, the person may need specific advice and support (such as supervised therapeutic exercise) to encourage participation, and should be advised that exercise may improve their symptoms.

Low back pain and sciatica in over 16s Quality standard [QS155]

Published: 27 July 2017

Quality statement 3: Self-management

Quality statement

Young people and adults with low back pain with or without sciatica are given advice and information to self-manage their condition.

Rationale

Low back pain and sciatica are common and recurrent conditions that can be long term. It is therefore important that the person learns how to manage their symptoms to reduce their pain and distress and improve their functioning and quality of life. Healthcare professionals can support the person's ability to self-manage their condition by giving reassuring advice about the benign nature of the condition, the high probability of a rapid improvement in symptoms and the importance of early return to normal life activities. These include returning to work where applicable, physical activity and exercise.

Process

Proportion of young people and adults with low back pain with or without sciatica who are given advice and information to self-manage their condition.

Outcome

a) Number of repeat GP appointments for young people and adults with low back pain with or without sciatica.

Data source: Local data collection, for example, audit of patient notes.

b) Levels of satisfaction amongst young people and adults with the management of their low back pain with or without sciatica.

Data source: National Pain Audit 2012 and local data collection.

What the quality statement means for different audiences

Service providers (such as GP practices) ensure that staff have the knowledge and information needed to support young people and adults with low back pain with or without sciatica to self-manage their condition. This can include having the expertise to give verbal information, providing leaflets or giving information about access to exercise schemes such as walking support groups.

Healthcare professionals (such as GPs, nurses and physiotherapists) advise and provide information to young people and adults with low back pain with or without sciatica to help them self-manage their condition. This can include verbal information provided by a healthcare professional, leaflets, or information about access to exercise schemes such as walking support groups.

Commissioners (such as clinical commissioning groups and NHS England) ensure that the services they commission employ healthcare professionals with the expertise to give verbal information, provide leaflets or give information about access to exercise schemes such as walking support groups for young people and adults with low back pain with or without sciatica to self-manage their condition.

Young people and adults with low back pain with or without sciatica are given advice and information to manage their condition themselves. The information can cover the importance of continuing with normal activities and, where applicable, returning to work and access to exercise schemes such as walking support groups.

Advice and information to self-manage their condition

People are provided with advice and information, tailored to their needs and capabilities, to help them self-manage their low back pain with or without sciatica, at all steps of the treatment pathway. It includes:

- information on the nature of low back pain and sciatica
- encouragement to continue with normal activities and access to exercise schemes.

© NICE 2024 *Low back pain and sciatica in over 16s [QS155]* Available from <https://www.nice.org.uk/guidance/qs155> All rights reserved. Subject to [Notice of rights](#).

Joint replacement (primary): hip, knee and shoulder Quality standard [QS206] Published: 29 March 2022

Quality statement 1:

Preoperative rehabilitation advice for hip and knee replacement Quality statement Adults who will have hip or knee replacement are given advice on preoperative rehabilitation when they are listed for surgery.

Advice on preoperative rehabilitation

This includes advice on:

- exercises to do before and after surgery that will aid recovery
- lifestyle, including weight management, diet and smoking cessation
- information on preparing for surgery, including steps people can take to optimise their recovery
- wellbeing, including physical and mental health, and emotional wellbeing (see NICE's guidance on lifestyle and wellbeing)
- maximising functional independence and quality of life before and after surgery
- information about what to expect before, after and during surgery, including length of hospital stay, recovery and rehabilitation.

Statement 5: Postoperative rehabilitation

Quality statement

Adults who have had hip, knee or shoulder replacement are given advice on postoperative rehabilitation before discharge.

Rationale

Discussion with a member of the physiotherapy or occupational therapy team before discharge from hospital allows people to get personalised advice on postoperative rehabilitation to help optimise their recovery.

Advice may also include how to do self-directed rehabilitation at home, or arrangements for supervised group or individual

outpatient rehabilitation depending on operation type and the person's specific needs.

Definitions of terms used in this quality statement

Advice on postoperative rehabilitation

Postoperative rehabilitation needs are assessed through a discussion during the hospital stay. This is led by physiotherapy and occupational therapy teams but supported by the whole multidisciplinary team.

The type of rehabilitation offered should be based on the outcome of this discussion and reflect adults' clinical and personal circumstances, as follows:

- Adults who have had hip or knee replacement are given advice on self-directed rehabilitation.
- Adults who have had shoulder replacement are given advice on:
 - self-directed rehabilitation or
 - supervised group rehabilitation or
 - individual rehabilitation.
- Supervised group or individual outpatient rehabilitation is offered to adults who have had hip, knee or shoulder replacement who:
 - have difficulties managing activities of daily living or
 - have ongoing functional impairment leading to specific rehabilitation needs or
 - find that self-directed rehabilitation is not meeting their rehabilitation goals.

The advice is given before discharge from hospital and should consider the needs of adults with cognitive impairment, for whom supervised group or individual outpatient rehabilitation should be considered.

Advice on self-directed rehabilitation includes:

- a clear understanding of rehabilitation goals and the importance of doing the exercises prescribed to achieve these goals
- a point of contact for advice and support.

Neurological conditions

Multiple sclerosis Quality standard [QS108] Published: 14 January 2016

Quality statement 4: Physical activity

Quality statement

Adults with multiple sclerosis (MS) who have problems with mobility or fatigue are offered support to remain physically active.

Rationale

Remaining physically active can improve mobility and fatigue, which are common problems experienced by adults with MS. It can also help to reduce the secondary complications of inactivity, such as pressure sores, and help adults with MS to regain or maintain their strength.

Process

Proportion of adults with MS who are offered support to remain physically active.

What the quality statement means for different audiences

Service providers (GPs, community health teams and neurology services) ensure that adults with MS who have problems with mobility or fatigue are offered support to remain physically active. It may be useful to compile information about local exercise classes, groups and facilities, so that people can be given information about any that are suitable.

Healthcare professionals (members of the multidisciplinary team) ensure that they offer adults with MS who have problems with mobility or fatigue support to remain physically active.

Commissioners (NHS England, integrated care systems and clinical commissioning groups) ensure that they commission services in which adults with MS who have problems support to remain physically active

Healthcare professionals should discuss the potential benefits of exercise with adults with MS who have problems with mobility or fatigue. Programmes or courses of exercise therapy should be supported by a

competent professional, such as a physiotherapist with expertise in MS, who can suggest the most suitable exercises and monitor the effects.

Types of suitable physical activity may include the following:

- aerobic, resistive and balance exercises, including yoga and pilates
- a combination of a programme of supervised aerobic and moderate progressive resistance activity and cognitive behavioural techniques for people with MS with moderately impaired mobility (an EDSS [Expanded Disability Status Scale] score of greater than or equal to 4)
- supervised exercise programmes involving moderate progressive resistance training and aerobic exercise
- exercise referral schemes.

People with MS should also be encouraged to keep exercising after programmes end for longer term benefits.

Mental Health (Adults)

Depression in adults Quality standard [QS8] Published: 29 March 2011

Last updated: 29 June 2023

Quality statement 1: Assessment

Quality statement

Adults with suspected depression have a comprehensive assessment.

[2011, updated 2023]

Rationale

Recognition of suspected depression is based on clinical suspicion or responses to questions used to initially identify depression. A comprehensive assessment includes discussion of factors affecting the development, course and severity of depression and enables confirmation of a diagnosis of depression. The assessment may also identify other mental health conditions that share similar symptoms, such as bipolar disorder and posttraumatic stress disorder. If the adult has additional needs affecting language and communication, these should be identified and the assessment adjusted to enable participation. Establishing a diagnosis of depression is an essential first step in the care of adults with depression, leading to appropriate treatment at the earliest opportunity.

Comprehensive assessment

A comprehensive assessment should include:

- severity of symptoms
- previous history, duration and course of illness
- degree of functional impairment or disability, or both.

The assessment should include discussion of how the following factors may have affected the development, course and severity of their depression:

- any history of depression and coexisting mental health or physical disorders

- any history of mood elevation (to determine if depression may be part of bipolar disorder; see the NICE guideline on bipolar disorder)
- any past experience of, and response to, previous treatments
- personal strengths and resources, including supportive relationships
- difficulties with previous and current interpersonal relationships
- current lifestyle (for example, diet, physical activity and sleep)
- any ongoing, recent or past experience of stressful or traumatic life events, such as early adversity (including physical abuse, sexual abuse or bullying), redundancy, divorce, bereavement, or trauma (see the NICE guideline on post-traumatic stress disorder)
- living conditions, drug (prescribed or illicit) and alcohol use, debt, employment situation, loneliness and social isolation.

© NICE 2024 *Depression in adults [QS8]* Available from <https://www.nice.org.uk/guidance/qs8> All rights reserved. Subject to [Notice of rights](#).

Quality statement 7: Promoting healthy eating, physical activity and smoking cessation

Quality statement

Adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes, and help to stop smoking.

Rationale

Rates of obesity and type 2 diabetes in adults with psychosis or schizophrenia are higher than those for the general population. Rates of tobacco smoking are also high in people with psychosis or schizophrenia. These factors contribute to premature mortality. Offering combined healthy eating and physical activity programmes and help to stop smoking can reduce these rates and improve physical and mental health.

Structure

- a) Evidence of local arrangements to ensure that adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes.

Process

- a) Proportion of adults with psychosis or schizophrenia who received combined healthy eating and physical activity programmes within the past 12 months.

Numerator – the number in the denominator who received combined healthy eating and physical activity programmes within the past 12 months.

Denominator – the number of adults with psychosis or schizophrenia.

What the quality statement means for different audiences

Service providers (mental health services) ensure that systems are in place for adults with psychosis or schizophrenia to be offered combined

healthy eating and physical activity programmes, and help to stop smoking.

Health and social care practitioners ensure that they are aware of local healthy eating and physical activity programmes and offer these to adults with psychosis or schizophrenia. They should also offer them help to stop smoking if they smoke.

Commissioners (such as NHS England local area team and local authorities) ensure that they commission services that make sure adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes, and help to stop smoking.

Adults with psychosis or schizophrenia are offered help with healthy eating and physical activity to help prevent weight gain, diabetes and other health problems that are common in adults with psychosis or schizophrenia and often related to treatment. Smoking is also common in adults with psychosis or schizophrenia and those who smoke should be offered help to stop smoking.

© NICE 2025 *Psychosis and schizophrenia in adults [QS80]* Available from All <https://www.nice.org.uk/guidance/qs80> rights reserved. Subject to [Notice of rights](#).

Quality statement 7: Assessing physical health

Quality statement

Adults with bipolar disorder have a physical health assessment at least annually.

Rationale

Life expectancy among adults with bipolar disorder is estimated to be 15 to 20 years lower than for the general population. Causes contributing to high morbidity and premature mortality among adults with bipolar disorder include cardiovascular disease, respiratory disease, diabetes and obesity. Assessing physical health allows healthcare professionals to identify early signs and symptoms of poor health and take action to address them.

Process

- b) Proportion of adults with bipolar disorder who receive an annual physical health assessment.

Physical health assessment

A physical health assessment for adults with bipolar disorder should include:

- weight or BMI, diet, nutritional status and level of physical activity
- cardiovascular status, including pulse and blood pressure
- metabolic status, including fasting blood glucose or glycosylated haemoglobin (HbA1c), and blood lipid profile
- liver function
- renal and thyroid function, and calcium levels, for adults taking long-term lithium.

© NICE 2025 *Bipolar disorder in adults [QS95]* Available from All <https://www.nice.org.uk/guidance/qs95> rights reserved. Subject to [Notice of rights](#).

Quality statement 2: Physical activity for older people

Quality statement

Statement 2: Older people most at risk of a decline in their independence and mental wellbeing are offered tailored, community-based physical activity programmes.

Structure

Evidence of local arrangements to ensure tailored, community-based physical activity programmes are in place for older people most at risk of a decline in their independence and mental wellbeing.

Process

Proportion of older people most at risk of a decline in their independence and mental wellbeing who take part in tailored, community-based physical activity programmes.

Outcome

- a) Change in physical activity among older people.
- b) Incidence of mental health conditions among older people identified as being at risk of decline.
- c) Incidence of admission to supported care facilities among older people identified as being at risk of decline.

What the quality statement means for different audiences

Service providers (such as local authorities, local NHS providers and voluntary organisations) ensure that tailored, community-based physical activity programmes are in place for older people most at risk of a decline in their independence and mental wellbeing.

Health, public health and social care practitioners (such as GPs, community nurses and occupational therapists) are aware of, and offer,

tailored community-based physical activity programmes for older people most at risk of a decline in their independence and mental wellbeing.

Commissioners (such as local authorities) commission community-based physical activity programmes tailored for older people most at risk of a decline in their independence and mental wellbeing.

Older people most at risk of a decline in their independence and mental wellbeing are offered community-based physical activity programmes that reflect their preferences to improve their physical and mental wellbeing

Mental Health (Children & Young People)

Bipolar disorder, psychosis and schizophrenia in children and young people Quality standard [QS102] Published: 15 October 2015

Quality statement 5: Healthy lifestyle advice

Quality statement

Children and young people with bipolar disorder, psychosis or schizophrenia are given healthy lifestyle advice at diagnosis and at annual review.

Process

- a) Proportion of children and young people with bipolar disorder, psychosis or schizophrenia who receive healthy lifestyle advice at diagnosis.
- b) Proportion of children and young people with bipolar disorder, psychosis or schizophrenia who receive healthy lifestyle advice at their annual review.

Outcomes

- c) Obesity rates in children and young people with bipolar disorder, psychosis or schizophrenia
- d) Physical activity in children and young people with bipolar disorder, psychosis or schizophrenia.

What the quality statement means for different audiences

Service providers (such as GP surgeries, community health services, child and adolescent mental health services and early intervention in psychosis services) ensure that processes are place for children and young people with bipolar disorder, psychosis or schizophrenia to receive age-appropriate healthy lifestyle advice at diagnosis and at annual review.

Healthcare professionals (such as GPs, psychologists and mental health nurses) offer age-appropriate healthy lifestyle advice to children and

young people with bipolar disorder, psychosis or schizophrenia at diagnosis and at annual review.

Commissioners (such as clinical commissioning groups and NHS England) commission services that offer age-appropriate healthy lifestyle advice to children and young people with bipolar disorder, psychosis or schizophrenia at diagnosis and at annual review.

Children and young people with bipolar disorder, psychosis or schizophrenia should be offered advice that is suitable for their age at diagnosis and at annual review on healthy eating, how to make sure they get enough exercise, practising safe sex and the importance of avoiding drug and alcohol misuse and smoking. If they smoke, they should be given advice on how to stop.

© NICE 2025 *Bipolar disorder, psychosis and schizophrenia in children and young people [QS102]* Available from All <https://www.nice.org.uk/guidance/qs102#:~:text=This%20quality%20standard%20covers%20recognition,in%20priority%20areas%20for%20improvement.> rights reserved. Subject to [Notice of rights](#).

Respiratory

Chronic obstructive pulmonary disease in adults Quality standard [QS10] Published: 28 July 2011 Last updated: 19 September 2023

Quality statement 4: Pulmonary rehabilitation for stable COPD and exercise limitation

Quality statement

People with stable chronic obstructive pulmonary disease (COPD) and a score of 3 or above on the Medical Research Council (MRC) dyspnoea scale are referred to a pulmonary rehabilitation programme. [2011, updated 2023]

Rationale

People with stable COPD may experience exercise limitation because of breathlessness. Pulmonary rehabilitation programmes improve a person's exercise capacity, quality of life, symptoms and levels of anxiety and depression.

Process

- a) Proportion of people with stable COPD and a score of 3 or above on the MRC dyspnoea scale who are referred to a pulmonary rehabilitation programme.
- b) Proportion of attendances of people with stable COPD and a score of 3 or above on the MRC dyspnoea scale that result in the person completing a pulmonary rehabilitation programme.

What the quality statement means for different audiences

Service providers (secondary care and community services) ensure that systems are in place for people with stable COPD and a score of 3 or above on the MRC dyspnoea scale to be referred to a pulmonary rehabilitation programme. Healthcare professionals refer people with stable COPD and a score of 3 or above on the MRC dyspnoea scale to a pulmonary rehabilitation programme. Commissioners ensure that they commission services in which people with stable COPD and a score of 3 or above on the

MRC dyspnoea scale are referred to a pulmonary rehabilitation programme.

People with COPD that is stable who have difficulty walking, have to walk slowly, and stop often or soon become breathless are referred to a pulmonary rehabilitation programme. This includes exercises, information about COPD, diet advice and support depending on the person's needs.

Pulmonary rehabilitation programme

A multidisciplinary programme of care for people with chronic respiratory impairment that is individually tailored and designed to optimise each person's physical and social performance and autonomy.

Pulmonary rehabilitation programmes should be held at times that suit people with COPD and in locations that are easy for people with COPD to get to, and have good access for people with disabilities. Programmes should be available within a reasonable time from referral. Programmes comprise individualised exercise programmes and education, and:

- are at least 6 weeks in duration and include a minimum of twice-weekly supervised sessions
- include supervised, individually tailored and prescribed, progressive exercise training including both aerobic and resistance training
- include a defined, structured education programme.

© NICE 2025 *Chronic obstructive pulmonary disease in adults [QS10]*
Available from All <https://www.nice.org.uk/guidance/qs10> rights reserved.
Subject to [Notice of rights](#).

Idiopathic pulmonary fibrosis in adults Quality standard [QS79]

Published: 29 January 2015

Quality statement 4: Pulmonary rehabilitation

Quality statement

Pulmonary rehabilitation programmes provide services that are designed specifically for idiopathic pulmonary fibrosis.

Rationale

Pulmonary rehabilitation is often tailored to chronic obstructive pulmonary disease and not to idiopathic pulmonary fibrosis. For people with idiopathic pulmonary fibrosis, pulmonary rehabilitation is more likely to contribute to improved health-related quality of life and exercise capacity if it is tailored to their condition.

Quality measures

Structure

Evidence of local arrangements to ensure that pulmonary rehabilitation programmes are tailored to the needs of people with idiopathic pulmonary fibrosis.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (hospitals and regional specialist centres) ensure that pulmonary rehabilitation programmes provide services designed specifically for idiopathic pulmonary fibrosis.

Healthcare professionals ensure that people with idiopathic pulmonary fibrosis receive pulmonary rehabilitation designed specifically for idiopathic pulmonary fibrosis.

Commissioners (NHS England through specialised services area teams and clinical commissioning groups) use collaborative commissioning to ensure that the services they commission provide pulmonary rehabilitation programmes that are designed specifically for idiopathic pulmonary fibrosis.

People with idiopathic pulmonary fibrosis who could benefit from pulmonary rehabilitation (sessions that teach people about how their lungs work and how to cope with symptoms such as breathlessness) are offered a programme that is specially designed for idiopathic pulmonary fibrosis.

Definitions of terms used in this quality statement

Pulmonary rehabilitation

A multidisciplinary programme of care for people with a chronic respiratory condition. It is tailored and designed to optimise each person's physical performance and their independence. Pulmonary rehabilitation includes education, exercise training, psychosocial support and advice on nutrition. [Adapted from NICE's full guideline on idiopathic pulmonary fibrosis in adults]

© NICE 2024 *Idiopathic pulmonary fibrosis in adults [QS79]* Available from All <https://www.nice.org.uk/guidance/qs79> rights reserved. Subject to [Notice of rights](#).

Dementia

Dementia Quality standard [QS184] Published: 28 June 2019

Quality statement 5: Activities to promote wellbeing

Quality statement

People with dementia are supported to choose from a range of activities to promote wellbeing that are tailored to their preferences. [2013, updated 2019]

Rationale

The symptoms of dementia make it harder for a person to take part in activities, to engage socially, to maintain their independence, to communicate effectively, to feel in control and to care for themselves. Providing enjoyable and health-enhancing activities that are suitable for the stage of dementia can help with this. Understanding the activities that a person prefers, and thinks are suitable and helpful, with the input of family and carers if needed, and adapting them to their strengths and needs, will make a person more likely to engage with the activities offered.

Activities to promote wellbeing = Activities such as exercise, aromatherapy, art, gardening, baking, reminiscence therapy, music therapy, mindfulness and animal-assisted therapy

Quality measures

Structure

- a) Evidence of local arrangements to ensure that a range of activities are available that promote wellbeing for people with dementia.
- b)) Evidence of local arrangements to ensure that people offering activities to promote wellbeing to people with dementia discuss the person's preferences with them and tailor the activities to these.
- c) Evidence of local arrangements to support access to a range of activities that promote wellbeing for people with dementia, such as transport options.

What the quality statement means for different audiences

Service providers (such as local authorities, community care providers, dementia adviser services, community old age psychiatry services and memory clinics) ensure that systems are in place for people with dementia to discuss their preferences and needs, to choose activities to promote wellbeing that are tailored to these, and to access the activities they have chosen.

Health and social care practitioners (such as occupational therapists, community psychiatric nurses, psychologists, care home nurses, healthcare assistants, activities coordinators, dementia advisers, wellbeing advisers and social workers) have a discussion with the person with dementia, and their families and carers if appropriate, about life experiences, circumstances, preferences, interests, strengths and needs. They are aware of the activities to promote wellbeing that are available locally and, based on this discussion, they help the person with dementia to choose activities that suit their preferences and needs.

Commissioners (such as local authorities and clinical commissioning groups) ensure that activities to promote wellbeing are available for people with dementia. They specify that providers offer people with dementia these activities based on a discussion of their preferences and needs.

People with dementia talk about their life experiences, circumstances, preferences, interests, strengths and needs with a professional and people involved in their care. They are told about suitable activities for improving their wellbeing, such as joining a local choir or walking group, and are supported to access the activities they choose.

Fertility, maternity, postnatal and menopause

Postnatal care Quality standard [QS37] Published: 16 July 2013 Last updated: 27 September 2022

Quality statement 6: GP postnatal check for women

Quality statement

Women have a GP assessment 6 to 8 weeks after giving birth. [new 2022]

Rationale

Carrying out an assessment of women's physical and psychological health and wellbeing 6 to 8 weeks after giving birth will prevent delays in diagnosing and treating any problems and improve health outcomes.

There should be enough time allowed to focus on the woman's mental and physical health needs and respond to any concerns she may have. GPs will be able to refer women to other healthcare services including specialist services for ongoing investigation, management and support if needed.

Outcome

Proportion of women who had a GP assessment 6 to 8 weeks after giving birth who are satisfied that the GP spent enough time talking to them about their physical and mental health.

NICE's guideline on postnatal care states that the assessment carried out by a GP should include the following areas, taking into account the time since the birth. The GP should respond to any concerns, which may include further investigation and referral to specialist services in either secondary care or other healthcare services such as physiotherapy:

- asking about their general health and whether there are any concerns and assessing their general wellbeing, which may include:
 - symptoms and signs of potential postnatal mental health problems and how to seek help
 - symptoms and signs of potential postnatal physical problems and how to seek help

- the importance of pelvic floor exercises, how to do them and when to seek help
- fatigue
- factors such as nutrition and diet, physical activity, smoking, alcohol consumption and recreational drug use
- contraception
- sexual intercourse
- safeguarding concerns, including domestic abuse

Other

Lower urinary tract symptoms in men Quality standard [QS45]

Published: 18 September 2013

Quality statement 3: Initial assessment – advice on lifestyle interventions

Quality statement

Men with lower urinary tract symptoms (LUTS) whose symptoms are not bothersome or complicated are given written advice on lifestyle interventions, as part of their initial assessment.

Rationale

It is important to offer advice on lifestyle interventions as soon as possible so that the man is aware of all the options that might help to manage his condition. The content of this advice should be holistic and cover the benefits of attaining and maintaining a healthy weight, exercise and healthy eating. Also, the man should be given advice on specific health interventions, such as altering the type, quantity and timing of fluid and food intake, pelvic floor exercises and bladder training.

Process

Proportion of men with LUTS whose symptoms are not bothersome or complicated who are given written advice on lifestyle interventions, as part of their initial assessment.

What the quality statement means for different audiences

Service providers ensure that local arrangements are in place to provide men with LUTS whose symptoms are not bothersome or complicated written advice on lifestyle interventions, as part of their initial assessment.

Healthcare professionals provide men with LUTS whose symptoms are not bothersome or complicated written advice on lifestyle interventions, as part of their initial assessment.

Commissioners ensure that they commission services with local arrangements to provide men with LUTS whose symptoms are not

bothersome or complicated written advice on lifestyle interventions, as part of their initial assessment.

Men with LUTS whose symptoms are not bothersome or complicated are given written advice, as part of their initial assessment, on diet and fluid intake and avoiding things that can irritate the bladder (for example, certain foods, caffeine and smoking). They are also given information about special exercises to improve their symptoms.

Definitions of terms used in this quality statement

Advice on lifestyle interventions

Advice on lifestyle interventions should be holistic and cover the benefits of attaining and maintaining a healthy weight, exercise and healthy eating. Also, the man should be advised on specific health interventions, such as altering the type, quantity and timing of fluid and food intake and avoiding bladder irritants (for example, certain foods, caffeine and smoking). Advice should also include information about pelvic floor exercises and bladder training.

© NICE 2024 Lower urinary tract symptoms in men [QS45] Available from <https://www.nice.org.uk/guidance/qs45> rights reserved. Subject to [Notice of rights](#).

Physical activity: for NHS staff, patients and carers Quality standard [QS84] Published: 25 March 2015

[Statement 1](#) Adults having their NHS Health Check are given brief advice about how to be more physically active.

[Statement 2](#) Parents or carers of children are given advice about physical activity during their child's Healthy Child Programme 2-year review.

[Statement 3](#) Parents or carers of children are given advice about physical activity as part of the National Child Measurement Programme (NCMP).

[Statement 4](#) NHS organisations have an organisation wide, multicomponent programme to encourage and support employees to be more physically active

© NICE 2024 *Physical activity: for NHS staff, patients and carers [QS84]*

Available from

<https://www.nice.org.uk/guidance/qs84#:~:text=This%20quality%20standard%20covers%20encouraging,in%20people%20with%20specific%20conditions>

. rights reserved. Subject to [Notice of rights](#).

Quality statement 1: Advice on physical activity, diet and alcohol

Quality statement

People with non-alcoholic fatty liver disease (NAFLD) are given advice on physical activity, diet and alcohol.

Rationale

Adopting a healthy lifestyle can help to reduce the rate of progression of NAFLD. Providing lifestyle advice to people with NAFLD can encourage them to consider changes they can make that might help them avoid more serious liver disease.

Process

a) Proportion of people with NAFLD who are given advice on physical activity.

Numerator – the number in the denominator who are given advice on physical activity.

What the quality statement means for different audiences

Service providers (general practices, community healthcare providers, hospitals and specialist liver units) ensure that they give advice on physical activity, diet and alcohol to people with NAFLD. Providers ensure that their staff know where people with NAFLD can get support if they want to make lifestyle changes, such as lifestyle weight management programmes.

Healthcare professionals (such as GPs, practice nurses, hepatologists, gastroenterologists and specialist nurses) give advice on physical activity, diet and alcohol to people with NAFLD and ensure that they know where they can get support to make lifestyle changes, such as lifestyle weight management programmes.

Commissioners commission services that provide advice on physical activity, diet and alcohol to people with NAFLD. Commissioners ensure that information is available to healthcare professionals on the support

available locally to help people with NAFLD to make lifestyle changes, such as lifestyle weight management programmes.

People with NAFLD, and their parents or carers if appropriate, are given advice on diet (if they need to lose weight), physical activity and alcohol consumption (if they drink alcohol), and are told where they can get support to make lifestyle changes. Following this advice can help to improve NAFLD or stop it from getting worse.

© NICE 2025 Liver disease [QS152] Available from <https://www.nice.org.uk/guidance/qs152> rights reserved. Subject to [Notice of rights](#).

Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups Quality standard [QS167]

Published 11 May 2018

Quality statement 3: Referring people at high risk of type 2 diabetes

Quality statement

People from Black, Asian and other minority ethnic groups at high risk of type 2 diabetes are referred to an intensive lifestyle change programme.

Rationale

People from certain ethnic communities have a higher risk of developing type 2 diabetes than those in the white European population. This includes people of South Asian, Chinese, Black African and African-Caribbean family origin. In these populations, the risk of type 2 diabetes increases at an earlier age and at a lower body mass index (BMI) level. Many cases of type 2 diabetes are preventable through changes to a person's diet and physical activity levels. Evidence-based intensive lifestyle change programmes can significantly reduce the risk of developing type 2 diabetes for those at high risk.

Definitions of terms used in this quality statement

Intensive lifestyle change programme

A structured and coordinated range of interventions provided in different venues for people identified as being at high risk of developing type 2 diabetes. It should be local, evidence-based and quality-assured. The aim is to help people to become more physically active and improve their diet. If the person is overweight or obese, the programme should result in weight loss. Programmes may be delivered to individuals or groups (or involve a mix of both) depending on the resources available. They can be provided by primary care teams and public, private or community organisations with expertise in dietary advice, weight management and physical activity.

Physical health assessment

A comprehensive health check focused on physical health problems such as cardiovascular disease, diabetes, obesity and respiratory disease. The annual check should include:

- weight or body mass index (BMI), diet, nutritional status and level of physical activity
- cardiovascular status, including pulse and blood pressure
- metabolic status, including fasting blood glucose or glycosylated haemoglobin (HbA1c), and blood lipid profile
- liver function
- renal and thyroid function, and calcium levels, for people taking long-term lithium.

Quality statement 4: Cardiac rehabilitation

Quality statement

People from Black, Asian and other minority ethnic groups referred to a cardiac rehabilitation programme are given a choice of times and settings for the sessions and are followed up if they do not attend.

Cardiac rehabilitation programmes improve clinical outcomes for people who have had a cardiac event. However, uptake among people from Black, Asian and other ethnic minority groups is lower than in the general population. Providing programmes that are culturally appropriate and sensitive, at settings and times that are convenient can increase uptake. Following up people who do not attend allows for a discussion about potential barriers to attendance and how to overcome them. It also gives the opportunity to motivate people to start or to continue with the programme.

What the quality statement means for different audiences

Service providers (secondary and tertiary care services) ensure they provide individualised support for people from Black, Asian and other minority ethnic groups to attend and continue with cardiac rehabilitation programmes. This may include working on overcoming barriers with

people who are not willing to engage with services due to poor past experiences or ensuring that the programmes are run on different days, at different times and at venues that are culturally appropriate and convenient. Providers also ensure that a varied range of acceptable and culturally sensitive exercise is available, and people are followed up to continue with the programme.

Healthcare professionals (such as cardiologists and cardiac nurses) identify barriers to attending a cardiac rehabilitation programme and offer individualised support to people from Black, Asian and other minority ethnic groups. They offer cardiac rehabilitation programmes on different days, at different times and venues (such as community centres or places of worship) and ensure that they are culturally appropriate and suitable. Healthcare professionals also follow-up people to motivate them to continue with the programme or understand the obstacles that may prevent people from using the service.

Definitions of terms used in this quality statement

Cardiac rehabilitation

A coordinated and structured programme designed to remove or reduce the underlying causes of cardiovascular disease, as well as to provide the best possible physical, mental and social conditions, so that people can, by their own efforts, continue to play a full part in their community and through improved health behaviour, slow or reverse progression of the disease. Cardiac rehabilitation should consist of a multidisciplinary, integrated approach delivering care in lifestyle risk factor management, psychosocial health, medical risk factor management and the optimal use of cardioprotective therapies, underpinned by psychologically informed methods of health behaviour change and education. Cardiac rehabilitation programmes should include a range of interventions with health education, lifestyle advice, stress management and physical exercise components. [NICE's guideline on acute coronary syndromes, full guideline and recommendations 1.8.1 and 1.8.19]

© NICE 2025 Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups [QS167] Available from

<https://www.nice.org.uk/guidance/qs167> rights reserved. Subject to [Notice of rights](#).

Physical activity: encouraging activity in the community Quality standard [QS183] Published: 06 June 2019

Statement 1 Local authorities and healthcare commissioning groups have senior level physical activity champions who are responsible for developing and implementing local strategies, policies and plans.

Statement 2 Local authorities prioritise pedestrians, cyclists and people who use public transport when developing and maintaining connected travel routes.

Statement 3 Local authorities involve community members in designing and managing public open spaces.

Statement 4 Workplaces have a physical activity programme to encourage employees to move more and be more physically active.

Statement 5 Schools and early years settings have active travel plans that are monitored and updated annually.

© NICE 2025 *Physical activity: encouraging activity in the community [QS183]* Available from <https://www.nice.org.uk/guidance/qs183#:~:text=This%20quality%20standard%20covers%20how,physically%20active%20and%20move%20more.> rights reserved. Subject to [Notice of rights](#).

Quality statement 4: Annual health check

Quality statement

People growing older with a learning disability have an annual health check, which is used to update their health action plan.

Rationale

People with a learning disability have poorer health and a lower life expectancy than the general population. They may not recognise that they are unwell or may be unable to communicate how they feel. They may also develop conditions or face challenges that are associated with the learning disability. The annual health checks for people with a learning disability differ from NHS health checks and include a more specific and detailed examination of a person's physical and mental health. Carrying out these checks ensures that health issues are identified early, support can be provided promptly, and the person's health action plan is up to date.

Structure

a) Evidence of local arrangements to ensure that GP practices have an up-to-date register of people growing older with a learning disability.

Data source: NHS Quality and outcomes framework LD004.

- c) Evidence of local arrangements to ensure that GP practices offer annual health checks for people growing older with a learning disability.
- d) Evidence of local processes to ensure that health action plans for people growing older with a learning disability are updated after the annual health checks are carried out.

Data source: Local data collection, for example, review of GP records.

Definition

Health action plan

A personal plan for people with a learning disability about how to stay healthy. It should detail what help and support the person needs to look after their health. This might include support to manage physical or mental health conditions, or actions to improve their lifestyle, such as changes to diet and exercise.

© NICE 2025 *Learning disability: care and support of people growing older [QS187]* Available from <https://www.nice.org.uk/guidance/qs183#:~:text=This%20quality%20standard%20covers%20how,physically%20active%20and%20move%20more>. rights reserved. Subject to [Notice of rights](#).

NICE Guidelines

Cardiovascular Disease

Diabetes (type 1 and type 2) in children and young people: diagnosis and management NICE guideline [NG18] Published: 01 August 2015 Last updated: 11 May 2023

1.2 Type 1 diabetes

Exercise

1.2.48 Encourage children and young people with type 1 diabetes to exercise on a regular basis, and explain that this reduces their long-term risk of developing cardiovascular disease. **[2004, amended 2015]**

1.2.49 Explain to children and young people with type 1 diabetes and their families or carers that they can take part in all forms of exercise, provided that appropriate attention is given to changes in insulin and dietary management. **[2004]**

1.2.50 Explain to children and young people with type 1 diabetes and their families or carers about:

- the effects of exercise on blood glucose levels and
- how to avoid hypo- or hyperglycaemia during or after physical activity. **[2004, amended 2015]**

1.2.51 Encourage children and young people with type 1 diabetes and their families or carers to monitor blood glucose levels before and after exercise so that they can:

- d) identify when changes in insulin or food intake are needed
- e) learn how their blood glucose responds to different levels of exercise
- f) watch out for exercise-induced hypoglycaemia
- g) see how hypoglycaemia can occur several hours after prolonged exercise. **[2004, amended 2015]**

1.2.52 Explain to children and young people with type 1 diabetes and their families or carers that:

- they should have extra carbohydrates as needed to avoid hypoglycaemia and
- they should have carbohydrate based- foods available during and after exercise. **[2004]**

1.2.53 Explain to children and young people with type 1 diabetes and their families or carers that they should have extra carbohydrates if their plasma glucose levels are less than 7 mmol/litre before they exercise. **[2004, amended 2015]**

1.2.54 Explain to children and young people with type 1 diabetes and their families or carers that they may need to alter their insulin dose or carbohydrate intake if they change their daily exercise patterns. **[2004]**

1.3 Type 2 diabetes

1.3.2 Offer children and young people with type 2 diabetes and their families or carers a continuing programme of education from diagnosis. Include the following core topics:

- how diet, increasing physical activity and reducing body weight can reduce the symptoms of type 2 diabetes and lead to remission.

© NICE 2025 *Diabetes (type 1 and type 2) in children and young people: diagnosis and management [NG18]* Available from <https://www.nice.org.uk/guidance/ng18> rights reserved. Subject to [Notice of rights](#).

1.5 Physical activity

1.5.1 Advise adults with type 1 diabetes that physical activity can reduce their enhanced cardiovascular risk in the medium and long term. **[2004]**

1.5.2 For adults with type 1 diabetes who choose to increase their level of physical activity as part of a healthier lifestyle, provide information about:

- appropriate intensity and frequency of physical activity
- self-monitoring their changed insulin and or nutritional needs
- the effect of physical activity on blood glucose levels (which are likely to fall) when insulin levels are adequate
- the effect of physical activity on blood glucose levels when hyperglycaemic and hypoinsulinaemic (there is a risk of worsening hyperglycaemia and ketonaemia)
- appropriate adjustments of insulin dosage and or nutritional intake for periods during and immediately after physical activity, and the 24 hours after this
- interactions of physical activity and alcohol
- further contacts and sources of information. **[2004]**

Type 2 diabetes in adults: management NICE guideline [NG28]

Published: 02 December 2015 Last updated: 29 June 2022 Last reviewed: 23 December 2024

1.3 Dietary advice and bariatric surgery

1.3.4 Integrate dietary advice with a personalised diabetes management plan, including other aspects of lifestyle modification such as increasing physical activity and losing weight. [2009]

1.3.10 For recommendations on lifestyle advice, see the NICE guidelines on preventing excess weight gain, weight management, obesity, physical activity and tobacco. [2015]

© NICE 2025 Type 2 diabetes in adults: management [NG28] Available from <https://www.nice.org.uk/guidance/ng28> rights reserved. Subject to [Notice of rights](#).

1.9 Cardiac rehabilitation

1.9.1 Offer people with heart failure a personalised, exercise-based cardiac rehabilitation programme, unless their condition is unstable. The programme:

- should be preceded by an assessment to ensure that it is suitable for the person
- should be provided in a format and setting (at home, in the community or in the hospital) that is easily accessible for the person
- should include a psychological and educational component
- may be incorporated within an existing cardiac rehabilitation programme
- should be accompanied by information about support available from healthcare professionals when the person is doing the programme. **[2018]**

Hypertension in adults: diagnosis and management NICE guideline [NG136] Published: 28 August 2019 Last updated: 18 March 2022 Last reviewed: 27 November 2024

1.4 Treating and monitoring hypertension

Lifestyle interventions

For guidance on the prevention of obesity and cardiovascular disease, see [NICE's guidelines on obesity prevention](#) and [cardiovascular disease prevention](#).

1.4.1 Offer lifestyle advice to people with suspected or diagnosed hypertension, and continue to offer it periodically. **[2004]**

1.4.2 Ask about people's diet and exercise patterns because a healthy diet and regular exercise can reduce blood pressure. Offer appropriate guidance and written or audiovisual materials to promote lifestyle changes. **[2004]**

1.4.8 Inform people about local initiatives by, for example, healthcare teams or patient organisations that provide support and promote healthy lifestyle change, especially those that include group work for motivating lifestyle change. **[2004]**

© NICE 2025 Hypertension in adults: diagnosis and management [NG136]
Available from <https://www.nice.org.uk/guidance/ng136> rights reserved.
Subject to [Notice of rights](#).

Abdominal aortic aneurysm: diagnosis and management NICE guideline [NG156] Published: 19 March 2020

1.4 Predicting and improving surgical outcomes

Predicting surgical outcomes for unruptured aneurysms

1.4.1 Consider cardiopulmonary exercise testing when assessing people for elective repair of an asymptomatic abdominal aortic aneurysm (AAA), if it will assist in shared decision making.

Improving surgical outcomes

1.4.6 Offer people with an AAA information, support and interventions for secondary prevention of cardiovascular disease. For more information refer to the NICE guidance on:

- [tobacco: preventing uptake, promoting quitting and treating dependence](#)
- [diet, nutrition and obesity](#) and [exercise](#)
- [medicines optimisation](#)
- [lipid modification and statin therapy](#)
- [diabetes management](#)
- [hypertension diagnosis and management](#).

© NICE 2025 Abdominal aortic aneurysm: diagnosis and management [NG156] Available from <https://www.nice.org.uk/guidance/ng156> rights reserved. Subject to [Notice of rights](#).

Advice and ongoing monitoring for people with hyperglycaemia after acute coronary syndrome and without known diabetes

1.3.5 Offer people with hyperglycaemia after acute coronary syndrome and without known diabetes lifestyle advice on the following:

- healthy eating
- physical exercise
- weight management
- smoking cessation
- alcohol consumption.

1.8 Cardiac rehabilitation after an MI

1.8.1 All people (regardless of their age) should be given advice about and offered a cardiac rehabilitation programme with an exercise component.

[2007]

1.8.2 Cardiac rehabilitation programmes should provide a range of options, and people should be encouraged to attend all those appropriate to their clinical needs. People should not be excluded from the entire programme if they choose not to attend certain components. [2007]

1.8.3 If a person has cardiac or other clinical conditions that may worsen during exercise, these should be treated if possible before they are offered the exercise component of cardiac rehabilitation. For some people, the exercise component may be adapted by an appropriately qualified healthcare professional. [2007]

1.8.4 People with reduced left ventricular ejection fraction who are stable can safely be offered the exercise component of cardiac rehabilitation.

[2007]

Encouraging People to attend

1.8.10 Provide a range of different types of exercise, as part of the cardiac rehabilitation programme, to meet the needs of people of all ages, or those with significant comorbidity. Do not exclude people from the whole programme if they choose not to attend specific components. [2013]

Health education and information needs

1.8.20 A home-based programme validated for people who have had an MI (such as NHS Lothian's heart manual) that incorporates education, exercise and stress management components with follow ups by a trained facilitator may be used to provide comprehensive cardiac rehabilitation. [2007]

1.9 Lifestyle changes after an MI

Regular physical activity

1.9.10 Advise people to undertake regular physical activity sufficient to increase exercise capacity. [2007]

1.9.11 Advise people to be physically active for 20 to 30 minutes a day to the point of slight breathlessness. Advise people who are not active to this level to increase their activity in a gradual, step-by-step way, aiming to increase their exercise capacity. They should start at a level that is comfortable, and increase the duration and intensity of activity as they gain fitness. [2007]

1.9.12 Advice on physical activity should involve a discussion about current and past activity levels and preferences. The benefit of exercise may be enhanced by tailored advice from a suitably qualified professional. [2007]

1.13 Movement

1.13.1 Provide physiotherapy for people after stroke who have weakness in their trunk or upper or lower limbs, sensory disturbance or balance difficulties that affect their movement. [2013]

1.13.2 People with movement difficulties after stroke should be treated by physiotherapists with the relevant skills and training in diagnosis, assessment and management. [2013]

1.13.3 Continue to treat people with movement difficulties until they are able to maintain or progress function either independently or with assistance from others (for example, rehabilitation assistants, family members, carers or fitness instructors). [2013]

Strength training

1.13.4 Consider strength training for people with muscle weakness after stroke. This could include progressive strength building through increasing repetitions of body weight activities (for example, sit-to-stand repetitions), weights (for example, progressive resistance exercise), or resistance exercise on machines such as stationary cycles. [2013]

Fitness training

1.13.5 Encourage people to participate in physical activity after stroke. [2013]

1.13.6 Assess people who are able to walk and are medically stable after stroke for cardiorespiratory and resistance training that is appropriate to their individual goals. [2013]

1.13.7 Cardiorespiratory and resistance training for people after stroke should be started by a physiotherapist who can give them instructions on how to continue the programme independently. [2013]

1.13.8 If people after stroke choose to continue with an exercise programme independently, ensure physiotherapists supply any necessary information

about interventions and adaptations to the provider so they can make sure the programme is:

- safe for the person and
- tailored to their needs and goals.

This information may be given through written instructions, telephone conversations or a joint visit with the exercise provider and the person, depending on the needs and abilities of both. [2013]

1.13.9 Tell people who are participating in fitness activities after stroke about common, potential problems, such as shoulder pain, and advise them to seek advice from their GP or therapist if these occur. [2013]

Cardiovascular disease: risk assessment and reduction, including lipid modification NICE guideline [NG238] Published: 14 December 2023 Last reviewed 2 September 2025

1.1 Identifying and assessing cardiovascular disease risk for people without established cardiovascular disease

Communication about risk assessment, lifestyle changes and treatment

1.1.17 To encourage the person to participate in reducing their CVD risk:

- find out what, if anything, the person has already been told about their CVD risk and how they feel about it
- explore the person's beliefs about what determines future health (this may affect their attitude to changing risk)
- assess their readiness to make changes to their lifestyle (diet, physical activity, smoking and alcohol consumption), to undergo investigations and to take long-term medication
- assess their confidence to make changes to their lifestyle, undergo investigations and take medication
- inform them of potential future management options based on current evidence and best practice
- involve them in developing a shared management plan
- check that they have understood what has been discussed. [2008, amended 2014]

1.3 Lifestyle changes for the primary and secondary prevention of cardiovascular disease

Physical activity

1.3.5 Advise people at high risk of or with CVD to do aerobic and muscle-strengthening activities in line with the UK Chief Medical Officers' physical activity guidelines. [2008, amended 2014]

1.3.6 Encourage people who are unable to perform moderate intensity physical activity because of comorbidity, medical conditions or personal

circumstances to exercise at their maximum safe capacity. [2008, amended 2014]

1.3.7 Advice about physical activity should take into account the person's needs, preferences and circumstances. Agree goals and provide the person with written information about the benefits of activity and local opportunities to be active, in line with recommendation 2 of NICE's guideline on physical activity: brief advice for adults. [2008]

1.3.8 Follow recommendation 8 of NICE's guideline on walking and cycling, and recommendation 2 of NICE's guideline on exercise referral schemes. [2008]

© NICE 2025 *Cardiovascular disease: risk assessment and reduction, including lipid modification [NG238]* Available from <https://www.nice.org.uk/guidance/ng238> rights reserved. Subject to [Notice of rights](#).

Weight management/Obesity

Overweight and obesity management NICE guideline [NG246] Published: 14 January 2025

Read this guideline alongside:

- the UK Chief Medical Officers' physical activity guidelines

1.3 Information and support to help people maintain a healthier weight

1.3.1 Advise people to avoid extreme physical activity or dietary behaviours (such as obsessively exercising or cutting out all carbohydrates in the long term) that are difficult to sustain and may not be accompanied by wider health benefits. [2015]

1.3.2 Encourage everyone to identify perceptions, behaviours or situations that may undermine their efforts to maintain a healthier weight or prevent excess weight gain in the long term. These may include:

- drinking sugary or alcoholic drinks
- limiting fruit and vegetable intake
- underestimating how much food is consumed
- overestimating how much physical activity is being done
- overeating after being physically active
- planning and taking part in social events that focus on food
- using 'sweet treats' as a reward or emotional comfort or giving them regularly as gifts
- difficulties with consistently following physical activity and healthy eating plans during weekends and holidays, or after illness. [2015, amended 2025]

1.3.3 Encourage behaviours that may help people to keep an eye on their weight or associated behaviours, but be aware of risks for people who have or might develop disordered eating. For adults, behaviours may include:

- Checking their physical activity level (for example, by making a note of

activities, or using an activity tracker or an app to track physical activity). (See recommendation 7 on walking: individual support, in NICE's guideline on walking and cycling.)

Communicating the benefits of healthy behaviours and gradual improvements

1.3.5 Explain that the physical and mental health benefits of being more physically active and improving dietary behaviours are not limited to maintaining a healthier weight. They also include, for example:

- improved mental wellbeing
- enjoyment from physical activities, including the social aspects of shared activities
- reduced risk of developing diseases associated with excess weight such as heart disease, hypertension, liver disease, osteoarthritis, stroke, type 2 diabetes, some cancers, and reduced risk of poor COVID-19 outcomes
- the health benefits of losing weight before pregnancy
- reduced breathlessness, improved fitness and other benefits from increased physical activity that are independent of weight
- lower blood cholesterol, improved oral health and other benefits from improved dietary behaviours that are independent of weight. [2015]

1.3.6 Explain that even small, gradual improvements to physical activity and dietary intake are likely to be helpful. Emphasise that:

- Improving dietary intake and being physically active are as important for people who are currently a healthy weight as for people who are living with overweight.
- Weight gain in adulthood is not inevitable. It is possible to avoid gaining weight with age by being physically active and eating a diet based on foods and drinks with a lower energy density.
- No single physical activity, food or drink will maintain a healthy weight – a

combination of actions is needed. [2015]

Advice for family and carers of children and young people

1.3.7 Encourage family, carers and others regularly caring for children and young people to:

- Encourage and support them to be active at every opportunity (such as active play, travel, sport or leisure activities).

1.4 Healthcare professionals All settings

1.4.1 Focus interventions to increase physical activity on activities that:

- fit easily into people's everyday life (such as walking)
- are tailored to people's individual preferences and circumstances
- aim to improve people's belief in their ability to change (for example, by motivational interviewing and discussing positive effects).

Give ongoing support (including appropriate written materials) in person or by phone, letter, email or online and social media resources. [2006]

1.4.2 Offer individually tailored, multicomponent interventions and ongoing support to improve diet (and reduce energy intake). For example, interventions that include dietary modification, targeted advice, family involvement and goal setting. [2006]

1.4.3 Ensure that interventions to prevent obesity, including promotional, awareness raising activities, are part of a long-term, multicomponent intervention rather than one-off activities, and are accompanied by targeted follow up with different population groups. [2006]

1.4.4 At times when weight gain is more likely, such as after pregnancy, around menopause and when stopping smoking, ask permission to discuss weight, dietary intake and activity. If they agree, give them:

- information on services that provide advice on prevention and management of overweight and obesity
- general advice on long-term overweight and obesity management, in particular encouraging increased physical activity. [2006]

1.4.5 Actively involve family and carers in all actions aimed at preventing excess weight gain, optimising nutritional intake and increasing activity levels in children and young people. [2006]

Community settings

1.4.6 Support and promote community schemes and facilities that improve access to physical activity, such as walking or cycling routes, combined with tailored information, based on an audit of local needs. [2006]

1.4.7 Support and promote behavioural change programmes along with tailored advice to help people become more active, for example by walking or cycling instead of driving or taking the bus. [2006]

Preschool, childcare and family settings

1.4.9 Ensure that any programme offered to prevent obesity in preschool, childcare or family settings includes a range of components (rather than focusing on parental education alone) to promote healthy eating and physical activity. These could include:

- interactive cookery demonstrations
- videos and group discussions on practical issues such as meal planning and shopping for food and drink
- interactive physical activity sessions
- videos and group discussions on practical issues such as ideas for physical activities opportunities for active play, safety and local facilities. [2006]

1.4.10 Ensure that family programmes offered to prevent obesity, improve dietary intake or increase physical activity levels provide ongoing, tailored support, incorporate a range of behaviour-change techniques and use non-stigmatising language and images (see NICE's guidance on behaviour change: individual approaches), and have a clear aim to improve health. [2006, amended 2025]

1.5 Local or regional strategic partnerships

Managers and budget holders in local or regional strategic partnerships

1.5.1 Ensure a whole-systems approach to preventing and managing obesity is a priority at both strategic and delivery levels in all health and social care and community settings. Facilitate links between organisations to ensure that local public policies improve access to healthy foods and opportunities for physical activity and allocate dedicated resources for action to activities that:

- address both physical activity and diet
- use effective methods for encouraging and enabling behaviour change
- be targeted and tailored, using local knowledge (such as the Joint Strategic Needs Assessment or local surveys) to meet the needs of the population, recognising that some groups may need more support than others. [2006 and 2015]

1.5.2 Set an example as employers by developing policies to prevent and manage obesity in line with existing guidance and (in England) the local overweight and obesity strategy. In particular:

- promote healthy food and drink choices in on-site catering (for example by signs, posters, pricing and positioning of products)
- establish policies, facilities and information to promote physical activity, for example, through travel plans, by providing showers and secure cycle parking and by using signposting and improved décor to encourage stair use. [2006]

1.5.5 Engage with the local community to identify environmental barriers to physical activity and healthy eating. This includes planning, transport and leisure services and should involve:

- an audit, with the full range of partners including local or regional strategic partnerships, residents, businesses and institutions
- assessing (ideally by doing a health impact assessment):
 - how policies affect local people's opportunities to be physically active and eat a healthy diet
 - any barriers that may affect some groups of people differently, for example, because of their age, sex, socioeconomic status, ethnicity, religion, disability or weight stigma. Address any barriers identified in this way. [2006, amended 2025]

1.5.6 Work with all parts of local or regional strategic partnerships to create and manage more safe spaces for incidental and planned physical activity. Address as a priority any concerns about safety, crime and inclusion, by:

- providing facilities such as cycling and walking routes, cycle parking, area maps and safe play areas
- making streets safer and reducing pollution, through measures such as traffic calming, congestion charging, pedestrian crossings, cycle routes, lighting and walking schemes
- ensuring buildings and spaces are designed to encourage people to be more physically active (for example, through positioning and signing of stairs, entrances and walkways)
- considering in particular people who need tailored information and support, especially groups who are vulnerable, or less likely to be active (this could include people with neurodevelopmental conditions or learning disabilities). [2006]

1.5.7 Provide tailored advice from local and transport authorities, such as personalised travel plans, to increase active travel. [2006]

1.5.8 Encourage, through the whole-systems approach, all local shops, supermarkets and caterers to promote healthy food and drink choices, for example by signs, posters, pricing and positioning of products, in line with existing good practice guidance and (in England) with the local overweight and obesity strategy. [2006]

1.5.9 Ensure that all community programmes to prevent overweight and obesity, increase activity levels and improve diet (and reduce energy intake) address the concerns of participants from the outset. These might include the availability of services and the cost of changing behaviour, an expectation that healthier foods do not taste as good, dangers associated with walking and cycling and confusion over mixed messages in the media about weight, diet and activity. Tailor messages to any local concerns and involve those with lived experience of overweight or obesity in developing and updating programmes. [2006, amended 2025]

1.5.10 Include awareness-raising promotional activities in community-based interventions, but ensure they are part of a longer-term, multicomponent intervention rather than one-off activities. [2006]

1.6 Schools, nurseries and childcare facilities

All early-years settings, nurseries, other childcare facilities and schools

1.6.1 Ensure that improving the nutrition and activity levels of children and young people is a priority for action in all early-years settings, nurseries, other childcare facilities and schools to help prevent excess weight gain. Use a whole-school approach to develop lifelong healthy eating, physical activity practices, emotional wellbeing, self-esteem and positive body image. [2025]

1.6.2 Involve families and carers in any action aimed at preventing excess weight gain, optimising nutritional intake or increasing activity levels in children in early-years settings, nurseries, other childcare facilities and schools. For example, through newsletters, and information about lunch menus and after-school activities. [2025]

1.6.3 Nurseries and other childcare facilities should:

- minimise sedentary activities during play time and provide regular opportunities for enjoyable active play and structured physical activity sessions
- adapt activities for children with special educational needs and disabilities (SEND)

1.6.8 Staff delivering physical education, sport and other physical activity in schools should:

- promote a range of activities that children and young people enjoy and can take part in outside school and into adulthood
- give children and young people the motivation and confidence to take part in physical activities and understand their value (sometimes called physical literacy)

- follow the UK Chief Medical Officers' physical activity guidelines and the Department of Health and Social Care's physical activity guidelines for disabled children and disabled young people
- adapt activities for children and young people with SEND. [2025]

Headteachers and chairs of governors of schools

1.6.9 In collaboration with parents and pupils, assess the whole school environment and ensure that the ethos of all school policies helps children and young people to maintain a healthier weight, eat a healthy diet and be physically active, in line with existing standards and guidance. This includes policies relating to:

- building layout and recreational spaces
- catering (including vending machines) and the food and drink pupils bring into school for themselves or others
- rewards or incentives (policies should cover avoiding ones based on food) • the taught curriculum (including PE)
- school travel plans and provision for cycling
- bullying (including addressing bullying related to weight). [2006]

1.6.11 Ensure interventions are sustained, multicomponent and address the whole school, including after-school clubs and other activities. Short-term interventions and one-off events are insufficient on their own and should be part of a longterm integrated programme. [2006]

1.7 Workplaces

1.7.3 Provide opportunities for staff to eat a healthy diet and be more physically active, through:

- active and continuous promotion of healthy choices in restaurants, hospitality, vending machines and shops for staff and clients, in line with Public Health England guidance on healthier and more sustainable catering; use tailored educational and promotional programmes to support this, which could include behavioural intervention or

environmental changes (for example, food labelling or changes to availability)

- working practices and policies, such as active travel policies for staff and visitors
- a supportive physical environment, such as improvements to stairwells and providing showers and secure cycle parking
- recreational opportunities, such as supporting out-of-hours social activities, lunchtime walks and use of local leisure facilities. [2006]

1.7.4 Ensure incentive schemes (such as policies on travel expenses, the price of food and drinks sold in the workplace and contributions to gym membership) that are used in a workplace are sustained and part of a wider programme to support staff in managing weight, improving dietary intake and increasing activity levels. [2006]

1.7.5 Ensure that any health checks provided for staff offer an opportunity to discuss weight, dietary intake and activity, and provide appropriate ongoing support. [2006]

1.11 Discussing results and referral for adults

1.11.4 Discuss and agree realistic, personalised health goals (and any other related goals such as clothes fitting better, taking part in active play with children or grandchildren, finding it easier to breathe when walking or climbing stairs, being able to tie shoelaces or fasten a standard-length seatbelt). Include the importance and wider benefits of making sustainable, long-term changes to dietary behaviours and increasing physical activity levels. [2025]

If an adult declines referral

1.11.14 If the person declines a referral to an intervention:

- acknowledge and respect their choice, being aware that a person's decision to accept referral may be temporarily or permanently influenced by many factors, including the wider determinants of overweight and obesity

- either explore the reason sensitively or delay discussion until an appropriate time
- ensure they have the opportunity to discuss referral again in future
- give them information about other ways to make sustainable, long-term changes to their dietary behaviours and physical activity levels. [2025]

Discussing the results with children and young people, and their families and carers

1.12.4 Discuss personalised goals and the importance and wider potential benefits of making sustainable, long-term changes to dietary behaviours and physical activity levels with children and young people (and their families and carers).

Changes or goals could include:

- for children who are growing taller, avoidance of further weight gain and maintenance of weight whilst continuing to grow to reduce BMI centile is a realistic and appropriate goal
- for young people who have reached their near-final height, long-term behavioural changes that can help them reduce their weight (and explain that this can be a way to sustain a lower BMI)
- changes to diet and physical activity that can have positive health benefits, independent of any effect on weight or BMI
- improvements in psychosocial outcomes (such as sense of wellbeing, self-efficacy, self-esteem and self-perception) which are important health benefits
- personal goals such as feeling less breathless when playing with friends. [2025]

If a child or young person declines referral

1.12.16 If the child or young person and their family or carer are not ready or able to accept referral to a behavioural overweight and obesity management intervention:

- either explore the reason sensitively or delay discussion until an appropriate time ensure they have opportunities to discuss referral in the future and offer a follow-up appointment to monitor the child or young person's weight and reassess readiness and other options
- give them sources of information about how to make sustainable, long-term changes to their dietary behaviours and physical activity levels outside an intervention (see NHS Better Health advice)
- offer alternative interventions that include opportunities to be involved in healthy eating and physical activities such as walking or cycling groups, youth groups, cooking sessions and other children's and young people's activities (these may be delivered by community organisations or other local support). [2025]

1.14 Behavioural overweight and obesity management interventions for children and young people

Core components of behavioural overweight and obesity management interventions for children and young people

These recommendations are for providers of overweight and obesity management interventions.

1.14.4 Consider including a physical activity component in interventions.

This can focus on:

- reducing the amount of time spent being sedentary
- increasing physical activity, for example by taking part in active games, dancing and exercise (see the section on physical activity approaches). [2025]

1.14.5 Ensure behavioural overweight and obesity management interventions encourage all family members to eat healthily and to be physically active, regardless of their weight. [2025]

Developing a tailored plan to meet individual needs

1.14.15 Consider increasing the amount and types of moderate-to-vigorous-intensity physical activity during the intervention. [2025]

Ongoing support from providers of overweight and obesity management interventions

These recommendations are for providers of overweight and obesity management interventions.

1.14.33 Discuss with the child or young person, their family and carers any local services and activities that can provide further long-term support to help them manage their weight, for example, local leisure services and walking, cycling or youth groups. [2025]

Physical activity and diet

1.15 Physical activity approaches

See also the recommendations on physical activity in the section on behavioural overweight and obesity management interventions.

Staff qualifications

1.15.1 Ensure staff leading supervised physical activity sessions are qualified and insured, for example, a physiotherapist or a practitioner member of the CIMSPA (Chartered Institute for the Management of Sport and Physical Activity). Ensure that people running children's sessions have a paediatric CPR qualification. [2014, amended 2025]

Physical activity approaches for adults

1.15.2 Encourage adults to increase their physical activity even if they do not lose weight as a result, because of the other health benefits it can bring. Encourage them to meet the recommendations in the UK Chief Medical Officers' physical activity guidelines for weekly activity. See NHS advice on treating obesity [2006]

1.15.3 Advise that to prevent obesity, most people may need to do 45 to 60 minutes of moderate-intensity physical activity a day, particularly if they do not reduce their energy intake. Advise people who have lived with obesity and have lost weight that they may need to do 60 to 90 minutes of activity a day to avoid regaining weight. (See NHS advice on treating obesity.) [2006]

1.15.4 Encourage adults to build up to the recommended activity levels for weight maintenance, using a managed approach with agreed goals.

Recommend:

- activities as part of everyday life, such as brisk walking, gardening or cycling (see 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 leisure-based screen time. [2006]

Physical activity approaches for children and young people

1.15.5 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 physical activity can bring. Encourage them to meet the recommendations in the UK Chief Medical Officers' physical activity guidelines for daily activity, NHS physical activity guidelines for children and young people and the Department of Health and Social Care's physical activity guidelines for disabled children and disabled young people. [2006, amended 2025]

1.15.6 Be aware that children who are already living with overweight or obesity may need to do more than the standard recommended amount of activity. [2006, amended 2014]

1.15.7 Give children the opportunity and support to both include more physical activity in their daily lives (for example, walking, cycling, using the stairs and active play; see also NICE's guideline on walking and cycling) and to do more regular, structured physical activity (for example football, swimming or dancing). Agree the choice of activity with the child, and ensure it is appropriate to the child's interests, ability and confidence and is affordable for the family (see the UK Chief Medical Officers' physical activity guidelines for ideas of free activities). [2006, amended 2025]

Low-energy and very-low-energy diets for adults

1.16.12 Before starting someone on a low-energy or very-low-energy diet as part of a multicomponent overweight and obesity management strategy:

- Explain that this is a restrictive diet with a specific health goal (such as improvement in diabetes) and risks (such as weight cycling, weight regain and potential adverse events, and for very-low-energy diets also the risk of constipation, fatigue and hair loss).
- Explain that this is not a long-term overweight and obesity management strategy in its own right as it must be followed by lifelong dietary energy intake control and appropriate physical activity levels.
- Discuss:
 - that weight regain is likely to happen, and if it does it is not because they or their healthcare professional have 'failed'
 - reintroducing a wider range of foods after a low-energy or very-low energy diet
 - the options for long-term weight loss maintenance support or therapies (including nutritional advice, physical activity, medicines or surgery) if weight regain happens.
- Offer assessment and counselling if they may have eating disorders or other mental health issues, to ensure the diet is appropriate for them.
- Review any medicines they are taking and discuss any changes that may need to be made. [2025]

1.17 Medicines for overweight and obesity

Medicines for adults

1.17.3 Make the decision to start medicines after discussing them with the person, and discussing the potential impact on their motivation. Arrange information, support and counselling on additional diet, physical activity and behavioural strategies when medicines are prescribed, and give information on patient support programmes. [2006, amended 2014]

Medicines for children and young people

1.17.8 Weight management medicines are not generally recommended for children younger than 12 years. [2006]

1.17.10 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, and if started in a specialist

paediatric setting by a multidisciplinary team with expertise in:

- prescribing in this age group
- monitoring medicines
- psychological support
- behavioural interventions
- interventions to increase physical activity
- interventions to improve dietary intake. [2006, amended 2014]

In June 2023, this was an off-label use of orlistat.

1.18 Surgical interventions

Postoperative and longer-term follow-up care

1.18.17 Offer people who have had bariatric surgery a follow-up care package for a minimum of 2 years within the bariatric service. Include:

- monitoring nutritional intake, (including protein and vitamins) and mineral deficiencies
- monitoring for comorbidities
- medications review
- individualised dietary and nutritional assessment, advice and support
- advice and support on physical activity
- psychological support tailored to the person
- information about professionally led or peer-support groups. [2014]

Planning and delivering overweight and obesity services and interventions

Key components of interventions

1.19.3 Commission or recommend overweight and obesity management interventions for adults that focus on effective overweight and obesity management and:

- are multicomponent, covering dietary intake, physical activity and behaviour change
- adopt a respectful, non-judgemental approach
- monitor weight and participants' personal goals throughout the programme
- monitor indicators that people are engaged and meeting their goals (for example for fruit and vegetable intake or amount of physical activity) and use a variety of methods to encourage behaviour change in relation to:
 - problem solving
 - goal setting
 - how to carry out a particular task or activity
 - helping the person identify sources of support (such as friends and family or workplace programmes)
 - self-monitoring of weight and behaviours that can affect weight
 - feedback from participants on their own progress and their views of the overall programme. [2014]

1.19.5 Ensure interventions:

- include sustainable ways the person can reduce sedentary behaviour and fit more physical activity into everyday life over the long term (for example, walking)
- take any medical conditions the person may have into account when planning

any physical activity sessions

- have a qualified physical activity instructor leading any supervised activity sessions; for example, a physiotherapist or a practitioner member of the CIMSPA (Chartered Institute for the Management of Sport and Physical Activity)
- last at least 3 months, with weekly or fortnightly sessions
- monitor and review progress toward individual goals throughout the intervention
- are developed by a multidisciplinary team that includes healthcare professionals with expertise in overweight and obesity management, nutrition, psychology or physical activity
- are run by staff who are trained in delivering overweight and obesity management interventions and take part in regular professional development sessions. [2014]

Working together on local approaches to prevent overweight and obesity Involving local businesses and social enterprises

1.19.8 Engage local businesses in the wider approach to preventing overweight and obesity, and encourage them to promote health and wellbeing. For example:

- workplace health initiatives that support and encourage employees (and their families) to adopt a healthy diet
- developing and implementing active travel plans to encourage employees and their families to walk and cycle

1.20 Planning and commissioning interventions for children and young people Involving a multidisciplinary team for children and young people

1.20.4 The multidisciplinary team should comprise professionals who specialise in children, young people and overweight and obesity management, including:

- a Registered dietitian or registered nutritionist
- a physical activity specialist
- a behaviour-change expert, such as a health promotion specialist

- a health or clinical psychologist, or a child or adolescent psychiatrist, to provide expertise in mental wellbeing
- a paediatrician or paediatric nurse
- a community-based health professional (such as a public health nurse). [2013]

Monitoring and evaluating services and interventions

1.21 Data to collect

1.21.1 Measure a broad range of outcomes and use validated tools to capture the full benefits of a sustainable, integrated health and wellbeing strategy. These include:

- anthropometric measures such as BMI or waist-to-height ratio
- indicators of dietary intake (for example intake of fruit and vegetables or sugar-sweetened drinks), physical activity (for example time spent in moderately vigorous activities such as brisk walking) or sedentary behaviour (for example leisure-based screen time or car use)
- prevalence of obesity-related diseases
- wider health outcomes such as indicators of mental health and wellbeing, improvements in self-esteem and quality of life
- process outcomes such as service use, engagement of groups subject to health inequalities groups, establishment or expansion of community groups
- indicators of structural changes (such as changes to procurement contracts).

Maternal and child nutrition: nutrition and weight management in pregnancy, and nutrition in children up to 5 years [NG247] Published: 15 January 2025

1.2 Healthy eating, physical activity and weight management during pregnancy

Unless otherwise stated, these recommendations are for all healthcare professionals who discuss maternal health during pregnancy, in particular, midwives, dietitians and health visitors.

1.2.1 Commissioners and service providers should ensure that healthcare professionals provide independent and non-commercial, evidence-based, consistent information about healthy eating, physical activity and weight management during pregnancy, in line with UK government advice, whether it is a person's first or a subsequent pregnancy. [2025]

Physical activity in pregnancy

1.2.5 Discuss the importance of physical activity with anyone who is pregnant (see the UK Chief Medical Officers' guidance on physical activity in pregnancy and the NHS Start for Life advice on exercising in pregnancy). Ask people about their usual physical activity and exercise habits and preferences, and provide information on the following that is in the person's preferred format and relevant to their individual circumstances:

- How to safely continue with physical activity.
- How to gradually increase physical activity during pregnancy if they are not already physically active.
- The importance of minimising sedentary time, such as sitting for long periods. [2025]

Weight management in pregnancy

1.2.11 Because there are uncertainties around optimal weight change in pregnancy, focus advice on starting or maintaining a healthy diet and physical activity during the pregnancy. This is because of the following:

- There are different factors that can affect weight change during pregnancy, for example, weight of the baby, weight of the placenta, maternal increase in blood volume, amniotic fluid, breast tissue expansion and body fat, and how these (especially the weight of the baby) vary between individuals and affect weight differently.
- There is a lack of evidence about what the optimal total weight change in pregnancy or weight change in each trimester should be.
- There is not enough evidence to suggest that any particular nutritionally balanced diet is better than another in helping to achieve optimal weight change in pregnancy. [2025]

1.2.12 Give people advice on how they can monitor their diet and physical activity levels (see the sections on healthy eating in pregnancy and physical activity in pregnancy) as well as local and online sources of information and support, including self-management tools and materials (particularly those that are free or low cost). [2025]

Low weight gain in pregnancy

1.2.16 If concerns about low weight gain during the pregnancy are raised by anyone who is pregnant, or by a healthcare professional as part of weight monitoring for a clinical reason (also see recommendation 1.2.13):

- ask for further details, for example, ask about the person's physical and psychological wellbeing, and any clinical interventions that have been offered
- discuss healthy eating and physical activity in pregnancy (see the sections on healthy eating in pregnancy and physical activity in pregnancy)
- ensure routine monitoring of the baby to check whether they are potentially small for their gestational age (see the section on monitoring fetal growth and wellbeing in NICE's guideline on antenatal care). [2025]

Excessive weight gain in pregnancy

1.2.17 If concerns about excessive weight gain during the pregnancy raised by anyone who is pregnant, or by a healthcare professional as part of weight monitoring for a clinical reason (also see recommendation 1.2.13):

- ask for further details, for example, ask about the person's physical and psychological wellbeing
- discuss healthy eating and physical activity in pregnancy (see the sections on healthy eating in pregnancy and physical activity in pregnancy)
- ensure routine monitoring of the baby to check whether they are potentially large for their gestational age (see the section on monitoring fetal growth and wellbeing in NICE's guideline on antenatal care)
- consider a test for gestational diabetes. [2025]

Gestational diabetes

The recommendations in this section should be read in conjunction with NICE's guideline on diabetes in pregnancy.

1.2.18 When a person is diagnosed with gestational diabetes, ask about their usual diet and physical activity in order to provide individualised advice. [2025]

© NICE 2025 *Maternal and child nutrition: nutrition and weight management in pregnancy, and nutrition in children up to 5 years [NG247]* Available from <https://www.nice.org.uk/guidance/ng247> rights reserved. Subject to [Notice of rights](#).

Respiratory

Cystic fibrosis: diagnosis and management NICE guideline [NG78]

Published: 25 October 2017 Last reviewed: 19 December 2024

Multidisciplinary team

1.3.13 Specialist physiotherapists should assess and advise people with cystic fibrosis at clinic, at inpatient admissions, during pulmonary exacerbations and at their annual review. Assessment and advice could cover airway clearance, nebuliser use, musculoskeletal disorders, exercise, physical activity and urinary incontinence.

1.7 Other monitoring, assessment and management

Exercise

1.7.30 Advise people with cystic fibrosis and their family members or carers (as appropriate) that regular exercise improves both lung function and overall fitness.

1.7.31 Offer people with cystic fibrosis an individualised exercise programme, taking into account their capability and preferences.

1.7.32 Regularly review exercise programmes to monitor the person's progress and ensure that the programme continues to be appropriate for their needs.

1.7.33 Provide people with cystic fibrosis who are having inpatient care with:

- an assessment of their exercise capacity
- the facilities and support to continue their exercise programme (as appropriate), taking into account the need to prevent cross-infection (see preventing cross-infection) and local infection control guidelines.

© NICE 2025 Cystic fibrosis: diagnosis and management [NG78] Available from <https://www.nice.org.uk/guidance/ng78> rights reserved. Subject to [Notice of rights](#).

Chronic obstructive pulmonary disease in over 16s: diagnosis and management NICE guideline [NG115] Published: 05 December 2018 Last updated: 26 July 2019 Last reviewed: 12 January 2022

1.1 Diagnosing COPD

1.1.2 When thinking about a diagnosis of COPD, ask the person if they have:

- weight loss
- reduced exercise tolerance
- waking at night with breathlessness
- ankle swelling
- fatigue
- occupational hazards
- chest pain
- haemoptysis (coughing up blood).

1.1.3 One of the primary symptoms of COPD is breathlessness. The Medical Research Council (MRC) dyspnoea scale (see table 1) should be used to grade the breathlessness according to the level of exertion required to elicit it. [2004]

Table 1 MRC dyspnoea scale

Grade	Degree of breathlessness related to activities
1	Not troubled by breathlessness except on strenuous exercise
2	Short of breath when hurrying or walking up a slight hill
3	Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace
4	Stops for breath after walking about 100 metres or after a few minutes on level ground
5	Too breathless to leave the house, or breathless when dressing or undressing

Adapted from Fletcher CM, Elmes PC, Fairbairn MB et al. (1959) The significance of respiratory symptoms and the diagnosis of chronic bronchitis in a working population. British Medical Journal 2: 257–66.

1.1.25 From diagnosis onwards, when discussing prognosis and treatment decisions with people with stable COPD, think about the following factors that are individually associated with prognosis:

- FEV1
- smoking status • breathlessness (MRC scale)
- chronic hypoxia and/or cor pulmonale
- low BMI • severity and frequency of exacerbations
- hospital admissions
- symptom burden (for example, COPD Assessment Test [CAT] score)
- exercise capacity (for example, 6-minute walk test)

1.2 Managing stable COPD

Short-acting beta2 agonists (SABA) and short-acting muscarinic antagonists (SAMA)

1.2.7 Use short-acting bronchodilators, as necessary, as the initial empirical treatment to relieve breathlessness and exercise limitation. [2004]

Inhaled combination therapy

1.2.10 Do not assess the effectiveness of bronchodilator therapy using lung

function alone. Include a variety of other measures such as improvement in symptoms, activities of daily living, exercise capacity, and rapidity of symptom relief. [2004]

Nebulisers

1.2.30 Do not continue nebulised therapy without assessing and confirming that 1 or more of the following occurs:

- a reduction in symptoms
- an increase in the ability to undertake activities of daily living
- an increase in exercise capacity
- an improvement in lung function. [2004]

Oral theophylline

1.2.38 Assess the effectiveness of theophylline by improvements in symptoms, activities of daily living, exercise capacity and lung function. [2004]

Ambulatory oxygen therapy

1.2.68 Consider ambulatory oxygen in people with COPD who have exercise desaturation and are shown to have an improvement in exercise capacity with oxygen, and have the motivation to use oxygen. [2004, amended 2018]

1.2.70 Only prescribe ambulatory oxygen therapy after an appropriate assessment has been performed by a specialist. The purpose of the assessment is to assess the extent of desaturation, the improvement in exercise capacity with supplemental oxygen, and the oxygen flow rate needed to correct desaturation. [2004]

Multidisciplinary management

1.2.97 When defining the activity of the multidisciplinary team, think about the following functions:

- assessment (including performing spirometry, assessing which delivery systems to use for inhaled therapy, the need for aids for daily living and assessing the need for oxygen)
- care and treatment, including:
 - pulmonary rehabilitation
 - identifying and managing anxiety and depression
 - advising people on relaxation techniques
 - dietary issues
 - exercise
 - social security benefits and travel
 - hospital-at-home/early discharge schemes
 - non-invasive ventilation and palliative care

Nutritional factors

1.2.103 Calculate BMI for people with COPD:

- the normal range for BMI is 20 to less than 25 kg/m²
- refer people for dietetic advice if they have a BMI that is abnormal (high or low) or changing over time
- for people with a low BMI, give nutritional supplements to increase their total calorific intake and encourage them to exercise to augment the effects of nutritional supplementation. [2004]

NB. Exercise tolerance is part of follow up testing.

© NICE 2025 *Chronic obstructive pulmonary disease in over 16s: diagnosis and management [NG115]* Available from <https://www.nice.org.uk/guidance/ng115> rights reserved. Subject to [Notice of rights](#)

Dementia

Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset NICE guideline [NG16] Published: 20 October 2015

6 Improving the environment to promote physical activity

Local government, local enterprise partnerships, transport professionals and other organisations involved with the built and natural environment or with road safety (see who should take action?), should improve environments where people live and work to encourage and enable everyone to build physical activity into their daily lives. This should include:

- Using new and existing traffic management and highway schemes to make walking and cycling safe and attractive options (see NICE's guidelines on physical activity and the environment and physical activity: walking and cycling).
- Improving the existing built environment, and designing new developments, to promote physical activity (see NICE's guideline on physical activity and the environment).

12 Providing physical activity opportunities

Local authorities and third-sector organisations with a responsibility for, or who support, public health services should:

- Encourage both recreational activities and active travel (for example, walking, cycling) for local journeys.

Provide supervised activities and exercise classes and an infrastructure to support walking and cycling. They should also maintain parks and open green spaces. The aim is to help people in mid-life to be physically active in different ways, and at different levels of intensity (see NICE's guidelines on physical activity and the environment and physical activity: walking and cycling).

- Ensure that venues provide easily accessible information for visitors using forms of active travel, such as cycle parking locations and links to local online journey planners and mapping (See NICE's guideline on walking and cycling).

- Publicise these opportunities, including where they can be found and who to contact for more information (see NICE's guidelines on physical activity: brief advice for adults in primary care, behaviour change: individual approaches and the sections on risk identification in NICE's guideline on type 2 diabetes: prevention in people at high risk).

15 Providing support in the workplace

All employers should:

- Develop policies and provide information and support in the workplace to help employees:
 - Stop smoking (see the sections on promoting stop-smoking support, stopping smoking in secondary care services and reducing harm in NICE's guideline on tobacco).
 - Be more physically active (see NICE's guideline on physical activity in the workplace). – Improve their mental wellbeing (see NICE's guideline on mental wellbeing at work).
 - Return to work after long-term sick leave (see NICE's guideline on workplace health: long-term sickness absence and capability to work).
 - Eat healthily (see the recommendation on public sector catering in NICE's guideline on cardiovascular disease prevention).
 - Reduce alcohol consumption (see NICE's guideline on alcohol-use disorders: prevention).

© NICE 2025 *Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset [NG16]* Available from <https://www.nice.org.uk/guidance/ng16> rights reserved. Subject to [Notice of rights](#)

1.7 Managing non-cognitive symptoms

Sleep problems

1.7.13 Do not offer melatonin to manage insomnia in people living with Alzheimer's disease.

1.7.14 For people living with dementia who have sleep problems, consider a personalised multicomponent sleep management approach that includes sleep hygiene education, exposure to daylight, exercise and personalised activities

Musculoskeletal Conditions and MSK health

**Low back pain and sciatica in over 16s: assessment and management
NICE guideline [NG59] Published: 30 November 2016 Last updated: 11
December 2020**

1.10 Non-invasive treatments for low back pain and sciatica

Non-pharmacological interventions Self-management

Exercise

1.2.2 Consider a group exercise programme (biomechanical, aerobic, mind–body or a combination of approaches) within the NHS for people with a specific episode or flare-up of low back pain with or without sciatica. Take people’s specific needs, preferences and capabilities into account when choosing the type of exercise. [2016]

Manual therapies

1.2.7 Consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy. [2016]

Psychological therapy

1.2.13 Consider psychological therapies using a cognitive behavioural approach for managing low back pain with or without sciatica but only as part of a treatment package including exercise, with or without manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage). [2016]

© NICE 2025 *Low back pain and sciatica in over 16s: assessment and management [NG59]* Available from <https://www.nice.org.uk/guidance/ng59> rights reserved. Subject to [Notice of rights](#)

Spondyloarthritis in over 16s: diagnosis and management NICE guideline [NG65] Published: 28 February 2017 Last updated: 02 June 2017 Last reviewed: 4 March 2025

1.3 Information and support

Information about disease flares

1.3.5 When discussing any flare management plan, provide information on:

- access to care during flares (including details of a named person to contact [for example, a specialist rheumatology nurse])
- self-care (for example, exercises, stretching and joint protection)
- pain and fatigue management
- potential changes to medicines
- managing the impact on daily life and ability to work.

1.5 Non-pharmacological management of spondyloarthritis

1.5.1 Refer people with axial spondyloarthritis to a specialist physiotherapist to start an individualised, structured exercise programme, which should include:

- stretching, strengthening and postural exercises
- deep breathing
- spinal extension
- range of motion exercises for the lumbar, thoracic and cervical sections of the spine
- aerobic exercise.

© NICE 2025 *Spondyloarthritis in over 16s: diagnosis and management NICE guideline [NG65]* Available from <https://www.nice.org.uk/guidance/ng65> rights reserved. Subject to [Notice of rights](#)

1.8 Non-pharmacological management

Physiotherapy

1.8.1 Adults with RA should have access to specialist physiotherapy, with periodic review (see 1.9.2 and 1.9.3), to:

- improve general fitness and encourage regular exercise
- learn exercises for enhancing joint flexibility, muscle strength and managing other functional impairments

Hand exercise programmes

1.8.3 Consider a tailored strengthening and stretching hand exercise programme for adults with RA with pain and dysfunction of the hands or wrists if:

- they are not on a drug regimen for RA, or
- they have been on a stable drug regimen for RA for at least 3 months. [2015]

1.8.4 The tailored hand exercise programme for adults with RA should be delivered by a practitioner with training and skills in this area. [2015]

1.2 Preoperative rehabilitation

Preoperative rehabilitation for hip or knee replacement

1.2.1 Give people having hip or knee replacement advice on preoperative rehabilitation. Include advice on:

- exercises to do before and after surgery that will aid recovery
- lifestyle, including weight management, diet and smoking cessation (see [NICE's guidance on lifestyle and wellbeing](#))
- maximising functional independence and quality of life before and after surgery.

1.10 Postoperative rehabilitation

Inpatient rehabilitation

1.10.1 A physiotherapist or occupational therapist should offer rehabilitation, on the day of surgery if possible and no more than 24 hours after surgery, to people who have had a primary elective hip, knee or shoulder replacement. Rehabilitation should include:

- advice on managing activities of daily living **and**
- home exercise programmes **and**
- mobilisation for people who have had knee or hip replacement **or**
- ambulation for people who have had shoulder replacement.

Outpatient rehabilitation

1.10.4 Ensure that people who are undertaking self-directed rehabilitation have:

- a clear understanding of their rehabilitation goals and the importance of doing the exercises prescribed to achieve these goals
- a point of contact for advice and support.

© NICE 2025 Joint replacement (primary): hip, knee and shoulder [NG157]
Available from <https://www.nice.org.uk/guidance/ng157> rights reserved.
Subject to [Notice of rights](#)

Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain NICE guideline
Published: 7 April 2021

Non-pharmacological management of chronic primary pain

Exercise programmes and physical activity for chronic primary pain

1.2.1 Offer a supervised group exercise programme to people aged 16 years and over to manage [chronic primary pain](#). Take people's specific needs, preferences and abilities into account.

1.2.2 Encourage people with chronic primary pain to remain physically active for longer-term general health benefits (also see [NICE guidelines on physical activity](#) and [behaviour change: individual approaches](#)).

© NICE 2024 *Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain [NG193]* Available from <https://www.nice.org.uk/guidance/ng193> rights reserved. Subject to [Notice of rights](#)

Guided self-managed rehabilitation

1.5.6 Consider guided self-managed rehabilitation to allow the person to engage in rehabilitation in their own time and by their own schedule, working with rehabilitation healthcare professionals and practitioners, with regular reviews to check on progress, provide ongoing reassurance and answer queries.

1.5.7 As part of a self-management rehabilitation programme, consider providing a tailored package of online education and learning materials for people after a [traumatic injury](#), which could include information on:

- movement and physical activity
- 1.11 Physical rehabilitation
- Physical rehabilitation – early interventions and principles
- 1.11.1 Provide personalised exercises as soon as possible after a [traumatic injury](#) to maintain and improve muscle function, strength and range of movement.

1.11.5 Use clinical judgement and expertise to determine the frequency and dose of the prescribed exercises because this is vital to the success of the interventions, and will differ depending on the individual needs and goals.

Aerobic and strengthening exercises

1.11.13 As soon as possible after a traumatic injury, start a tailored exercise programme to help with reconditioning, fitness, strengthening, balance, proprioception and vestibular function, irrespective of the person's age, stage of rehabilitation or combination of injuries. The exercise programme:

- could be self-directed and/or delivered as one-to-one sessions or in a group
- should include resistance training, core strengthening exercises and general aerobic fitness
- should include task-specific balance training if needed
- should be incorporated into the usual play activities for children

- should be tailored to the person's needs and goals (for example, the frequency of the sessions and the exercises involved).

1.11.14 Consider a continued programme of aerobic exercise when agreeing a [rehabilitation plan](#) and at appropriate points along the rehabilitation pathway.

1.11.15 For people with limited lower limb mobility or immobility after a traumatic injury, consider a programme of upper body aerobic training or seated exercises.

1.11.16 Tailor the aerobic exercise programme to the person's interests to help with personal commitment and adherence, and depending on the nature of their traumatic injuries.

1.11.17 Do not withhold aerobic exercise programmes from older people after a traumatic injury.

1.11.18 After discharge from hospital after a traumatic injury, offer people a home exercise programme that includes aerobic and strengthening exercises, and review their progress at outpatient clinics or [key worker](#) appointments.

Gait training and re-education

1.11.19 For people who are unable to weight-bear (because of clinical restrictions or pre-existing conditions), start an exercise programme as soon as possible after the traumatic injury to reduce the impact of non-weight-bearing and to optimise the transition to gait training when possible.

1.11.20 As soon as possible after a traumatic injury and once weight-bearing can begin, start a gait re-education programme that:

- aims to restore gait patterns
- includes passive stretches and range of movement exercises
- reduces the impact of non-weight-bearing on joints and muscles.

1.11.21 For people who need a non-weight-bearing period after a traumatic injury:

- assess muscle weakness and joint range of movement as soon as possible after the non-weight-bearing period ends **and**
- start an exercise programme aimed at muscle strengthening and gait progression.

Range of movement and strengthening after limb loss or amputation

1.14.16 Maintain and improve range of movement and strength after limb loss or amputation (particularly in hip flexors, hip abductors and knee flexors) by starting rehabilitation therapy that includes:

- exercise
- mobility, including early walking aids (for example, amputee-specific early walking aids) after surgery when the wound has settled
- positioning.

Continuing rehabilitation after limb reconstruction, limb loss or amputation and after discharge

1.14.23 When completing a [rehabilitation plan](#) (see the [section on developing a rehabilitation plan and making referrals](#)) for people after limb reconstruction, limb loss or amputation, ensure that the following are always included in the person's rehabilitation programme:

- exercise and mobility
- psychological and emotional support
- referral and signposting to support groups
- pin-site review (for limb reconstruction)
- frame adjustment (for limb reconstruction)
- prosthetics team review, if relevant.

1.4 Information and support

1.2.2 Explain to people with osteoarthritis that:

- it is diagnosed clinically and usually does not need imaging to confirm the diagnosis and
- management should be guided by symptoms and physical function and
- the core treatments for the condition are therapeutic exercise and weight management (if appropriate), along with information and support.

1.2.3 Advise people with osteoarthritis where they can find further information on:

- osteoarthritis and how it develops (including flares and progression over time), and information that challenges common misconceptions about the condition
- specific types of exercise
- managing their symptoms
- how to access additional sources of information and support after consultations, such as peer-to-peer support and support groups
- benefits and limitations of treatment.

1.10 Non-pharmacological management

Therapeutic exercise

1.3.1 For all people with osteoarthritis, offer therapeutic exercise tailored to their needs (for example, local muscle strengthening, general aerobic fitness).

1.3.2 Consider supervised therapeutic exercise sessions for people with osteoarthritis.

1.3.3 Advise people with osteoarthritis that joint pain may increase when they start therapeutic exercise. Explain that:

- doing regular and consistent exercise, even though this may initially cause pain or discomfort, will be beneficial for their joints
- long-term adherence to an exercise plan increases its benefits by reducing pain and increasing functioning and quality of life.

1.3.4 Consider combining therapeutic exercise with an education programme or behaviour change approaches in a structured treatment package.

Manual therapy

1.3.6 Only consider manual therapy (such as manipulation, mobilisation or soft tissue techniques):

- for people with hip or knee osteoarthritis and
- alongside therapeutic exercise.

1.3.7 If discussing manual therapy, explain to people with osteoarthritis that there is not enough evidence to support its use alone for managing osteoarthritis.

1.4 Pharmacological management

Topical, oral and transdermal medicines

1.10.18 If pharmacological treatments are needed to manage osteoarthritis, use them:

- alongside non-pharmacological treatments and to support therapeutic exercise
- at the lowest effective dose for the shortest possible time.

Intra-articular injections

1.4.9 Do not offer intra-articular hyaluronan injections to manage osteoarthritis.

1.4.10 Consider intra-articular corticosteroid injections when other pharmacological treatments are ineffective or unsuitable, or to support therapeutic exercise. Explain to the person that these only provide short-term relief (2 to 10 weeks).

1.6 Referral for joint replacement

1.6.1 Consider referring people with hip, knee or shoulder osteoarthritis for joint replacement if:

- their joint symptoms (such as pain, stiffness, reduced function or progressive joint deformity) are substantially impacting their quality of life and
- non-surgical management (for example, therapeutic exercise, weight loss, pain relief) is ineffective or unsuitable.

Falls Prevention

Falls: assessment and prevention in older people and in people 50 and over at higher risk [NG249] Published: 29 April 2025

1.1 Identifying people at risk of falls for further assessment

Identifying the risk of falls in community settings

1.1.5 For people who have fallen in the last year who have a gait or balance impairment:

- offer a falls prevention exercise programme and
- consider a home hazard assessment. These can be carried out in the same service or involve an appropriate referral. See the section on community settings – people who have fallen once in the last year and have a gait or balance impairment.

1.1.6 Offer health and wellbeing information, and advice on physical activity in line with the Chief Medical Officer's physical activity guidelines for people who:

- have not fallen in the last year or
- have had a single fall in the last year and do not have a gait or balance impairment.

Also see the section on information and education for people receiving falls assessment or interventions.

1.3 Interventions to reduce the risk of falls

Falls prevention exercise programmes

1.3.9 Consider a falls prevention exercise programme for people who need comprehensive assessment and management.

1.3.10 Falls prevention exercise programmes should:

- be delivered by appropriately trained professionals
- be progressive and tailored to the person's specific needs, preferences, goals and abilities

- focus on functional components related to the person's risk of falls, such as balance, coordination, strength and power
- include regular exercise progress reviews
- be delivered in such a way, including duration of programme, to bring about behaviour change related to physical activity and sedentary habits.

1.3.11 Consider cognitive behavioural interventions for people who have concerns about falling that is not helped by strength and balance exercises

Community settings –

people who have fallen once in the last year and have a gait or balance impairment These recommendations are for people in community settings who do not need comprehensive falls management (see the section on identifying people at risk of falls for further assessment), but may benefit from specific interventions to reduce their risk of falling.

Falls prevention exercise programmes

1.3.12 Offer a falls prevention exercise programme (see recommendations 1.3.9 and 1.3.10).

Hospital inpatient settings – comprehensive falls management

These recommendations are for people in hospital inpatient settings.

Physical activity and exercises

1.3.19 Encourage people to remain active during their hospital stay by:

- reassuring them that they can still get up and do not need to restrict their activity (unless they have been advised not to) and
- helping them to be less sedentary and more active, for example, encouraging them to get out of bed, get dressed and regularly stand up and walk around and
- for people able to exercise, look for opportunities to encourage physical activity that addresses the person's risk of falls, such as balance, coordination, strength and power.

Residential care settings – comprehensive falls management

Physical activity and exercise

1.3.24 Encourage people to remain active by:

- reassuring them that they should not avoid getting up and moving around and
- helping them to be less sedentary and more active by having a structured daily routine to ensure that they have opportunities to regularly stand up and walk around, as appropriate.

1.3.25 For people able to exercise, consider a programme that addresses the person's risk of falls, such as balance, coordination, strength and power. Programmes should be tailored to the person's abilities and preferences, and could be delivered on an individual or group basis.

1.4 Maximising ongoing participation in falls prevention interventions

1.4.1 In all settings, maximise the likelihood of people participating in falls prevention exercise programmes as follows:

- Discuss and agree with the person what changes they are willing and able to make to reduce their risk of falls.
- Encourage change and address potential barriers, for example, if a person doubts that they can complete the exercises or has concerns about falling.
- Ensure the interventions are flexible enough to accommodate each person's individual needs and preferences.
- Consider supervised exercises and, if these are provided, offer people a choice in how exercises are delivered, for example, individual or group exercise.
- Where possible, enabling social contact and support.

1.5 Information and education for people receiving falls assessment or interventions In all settings

1.5.1 In all settings (community, hospital inpatient and residential care), discuss ways that people can reduce their risk of falls as well as improving their overall wellbeing, and provide information that they can take away.

Involve the person's family and carers as appropriate. Topics to discuss include the following:

- That a person's risk of having a fall depends on their individual risk factors (for example, increasing age, taking certain medicines, or having low blood pressure or cataracts), and that some risk factors can be modified (for example, by undertaking appropriate exercise interventions, having a medication review, or having cataract surgery).
- That some falls are preventable, with suggestions and ideas to reduce the risk of falling, tailored to their individual risk and circumstances.
- How interventions to prevent falls (for example, those focusing on exercise and staying active) can help, and how to stay motivated (for example, by participating in a group programme).
- What to do if they have a fall, including how to get up, and when and how to seek help.
- Sources of further information, for example, local and national organisations and support groups.

© NICE 2025 Falls: assessment and prevention in older people and in people 50 and over at higher risk [NG249] Available from <https://www.nice.org.uk/guidance/ng249> rights reserved. Subject to [Notice of rights](#)

Neurological Conditions

Motor neurone disease: assessment and management [NG42]

Published: 24 February 2016 Last updated: 23 July 2019 Last reviewed: 27 November 2024

1.8 Managing symptoms

Exercise programmes

1.8.5 Consider an exercise programme for people with MND to:

- maintain joint range of movement
- prevent contractures
- reduce stiffness and discomfort
- optimise function and quality of life. [2016]

1.8.6 Choose a programme that is appropriate to the person's level of function and tailored to their needs, abilities and preferences. Take into account factors such as postural needs and fatigue. The programme might be a resistance programme, an active-assisted programme or a passive programme. [2016]

1.8.7 Check that family members and/or carers (as appropriate) are willing and able to help with exercise programmes. [2016]

1.8.8 Give advice to the person and their family members and/or carers (as appropriate) about safe manual handling. [2016]

1.8.9 If a person needs orthoses to help with muscle problems, they should be referred to orthotics services without delay, and the orthoses should be provided without delay. [2016]

© NICE 2025 Motor neurone disease: assessment and management [NG42] from <https://www.nice.org.uk/guidance/ng42> rights reserved. Subject to [Notice of rights](#)

1.7 Non-pharmacological management of motor and non-motor symptoms

Physiotherapy and physical activity

1.7.2 Consider referring people who are in the early stages of Parkinson's disease to a physiotherapist with experience of Parkinson's disease for assessment, education and advice, including information about physical activity. [2017]

Physical activity

1.2.18 Discuss with adults with cerebral palsy (and their families or carers, if agreed) the importance of physical activity in maintaining general fitness and physical and mental health.

1.2.19 Provide information on accessible local services that support people with cerebral palsy to take part in physical activity.

1.2.20 Consider referring people with cerebral palsy to services with experience and expertise in neurological impairments that can provide support with physical activities (including sport) and tasks of daily living. Depending on local service provision and the person's needs, this may be to any of the following services:

- physiotherapy
- occupational therapy
- orthotic and functional electronic stimulation services
- rehabilitation engineering services
- wheelchair services.

Difficulties with eating and nutritional problems

1.4.18 Discuss if any of the following factors might be affecting the person's appetite, eating habits or weight:

- changes in carer support
- depression
- pain
- reduced physical activity
- side effects of medications.

Respiratory disorders

Prophylactic treatments for respiratory infections

1.4.28 If an adult with cerebral palsy is at high risk of lower respiratory tract infection, consider a prophylactic physiotherapy chest care review. This may include:

- postural management
- advice on exercise
- advice on training and care for family members and carers.

1.10 Modifiable risk factors for relapse or progression of MS

Exercise

1.4.1 Encourage people with MS to exercise. Advise them that regular exercise may have beneficial effects on their MS and does not have any harmful effects on their MS. **[2014]**

MS symptom management and rehabilitation

1.5.7 Advise people that aerobic, resistive and balance exercises, including yoga and pilates, may be helpful in treating MS related fatigue. **[2022]**

Rehabilitation for chronic neurological disorders including acquired brain injury [NG252] Published: 15 October 2025

1.1 Commissioning rehabilitation services and service specifications

1.2.2 Produce service specifications for integrated rehabilitation care for people with a chronic neurological disorder that include the following:

- practitioners to lead and coordinate holistic rehabilitation needs assessments, and agree and oversee delivery of rehabilitation plans
- advocacy services (for people who need them)
- information, advice, education and training to support all aspects of rehabilitation
- play interventions that facilitate the delivery of rehabilitation for children
- environmental adaptations
- equipment, assistive devices and compensatory aids
- pain and fatigue management interventions
- exercise and physical activity programmes for muscle strength, exercise capacity and physical functioning, and other interventions for general physical health
- gait training, exercises and equipment for stability, mobility and limb function
- interventions for:
 - emotional health and mental wellbeing
 - cognitive function
 - speech, language and communication
 - eating, drinking and swallowing
- occupational therapy and skills-based learning
- interventions to enable supported self-management

· interventions to support engagement in education, employment, social and leisure activities, parenting, family life, friendships, intimate and sexual relationships, and sex.

1.9 Holistic rehabilitation needs assessment

What to cover

1.8.16 Assess the person's functioning, symptoms and impairment in the following areas:

- pain (see the section on pain management)
- fatigue (see the section on fatigue)
- physical activity and exercise (see the section on physical activity and exercise).....

1.14 Fatigue

Interventions

1.14.7 Offer a fatigue management approach, if needed, that prioritises what is important to the person, meets their goals and is integrated within their overall rehabilitation plan. This could include:

- pacing and other energy-conservation strategies
- cognitive behavioural therapy
- appropriate physical activity.

1.14.8 Encourage appropriate physical activity for longer-term general health benefits, even in the presence of fatigue.

1.15 Physical activity and exercise

Follow the recommendations about physical activity and exercise for specific chronic neurological disorders or traumatic injury, as appropriate, in the sections on:

- exercise programmes in NICE's guideline on motor neurone disease: assessment and management (recommendations 1.8.5 to 1.8.9)
- physiotherapy and physical activity in NICE's guideline on Parkinson's disease in adults (recommendations 1.7.2 to 1.7.4)

- exercise in NICE's guideline on multiple sclerosis in adults: management (recommendation 1.4.1)
- physical rehabilitation in NICE's guideline on rehabilitation after traumatic injury.

1.15.1 Develop an exercise and physical activity programme with the person to optimise their muscle strength, exercise capacity and physical functioning, if needed, and:

- take into account their executive function and levels of fatigue and pain
- think about risks and potential harmful consequences of exercise and physical activity
- think about what level of support and supervision will best meet their needs
- consider supervised and unsupervised exercises (for example, online resources or local subsidised programmes)
- agree a clinically relevant exercise dose (frequency, duration and intensity).

1.15.2 For people with a functional neurological disorder offer activities that encourage and enable recovery of movement and function. These should:

- focus on planned and purposeful movement to achieve a specific outcome (goal-oriented movement) and
- acknowledge the presence and impact of symptoms while redirecting attention away from them and focus on the potential for recovery.

1.15.3 A registered practitioner with expertise in exercise programmes and physical health (for example, a physiotherapist or occupational therapist), and an understanding of the person and the effects of their condition or injury, should develop and oversee the exercise and physical activity programme.

1.15.4 Discuss and agree outdoor or indoor activities that the person could do to maintain or improve their general physical health, led by the person's preferences.

1.15.5 Help the person to participate in, and sustain engagement with, physical activity using behaviour change strategies, if needed. This may require a family-centred approach.

1.15.6 Consider the following approaches to encourage lifelong behaviour change around physical activity:

- cognitive behavioural therapy
- self-determination theory
- social context theory
- motivational interviewing or coaching techniques.

1.15.7 Discuss any barriers preventing the person from achieving their physical activity goals and work together to overcome these. Barriers could relate to:

- the need for support, which may be practical, physical or cognitive
- cultural, social or socioeconomic factors
- availability of suitable facilities to undertake physical activity.

1.18 Cognitive function

Interventions

1.18.15 Offer advice and support to help the person minimise risk factors for cognitive decline and help maintain existing cognitive function. For example, advice about physical activity, smoking cessation, blood pressure control

© NICE 2025 Rehabilitation for chronic neurological disorders including acquired brain injury [NG252] Available from <https://www.nice.org.uk/guidance/ng252> rights reserved. Subject to Notice of rights

Cancer

Bladder cancer: diagnosis and management NICE guideline [NG2]

Published: 25 February 2015 Last reviewed: 17 September 2025

1.1 Information and support for people with bladder cancer

1.1.5 When carrying out a holistic needs assessment, recognise that many of the symptoms, investigations and treatments for bladder cancer affect the urogenital organs and may be distressing and intrusive. Discuss with the person:

- the type, stage and grade of their cancer and likely prognosis
- treatment and follow-up options
- the potential complications of intrusive procedures, including urinary retention, urinary infection, pain, bleeding or need for a catheter
- the impact of treatment on their sexual health and body image, including how to find support and information relevant to their gender
- diet and lifestyle, including physical activity
- smoking cessation for people who smoke
- how to find information about bladder cancer, for example through information prescriptions, sources of written information, websites or DVDs
- how to find support groups and survivorship programmes
- how to find information about returning to work after treatment for cancer
- how to find information about financial support (such as free prescriptions and industrial compensation schemes).

© NICE 2025 *Bladder cancer: diagnosis and management [NG2]* Available from <https://www.nice.org.uk/guidance/ng2> rights reserved. Subject to [Notice of rights](#)

Non-Hodgkin's lymphoma: diagnosis and management NICE guideline [NG52] Published: 20 July 2016

1.9 Information and support

1.9.6 Discuss exercise and lifestyle with people with non-Hodgkin's lymphoma from diagnosis onwards.

© NICE 2024 Non-Hodgkin's lymphoma: diagnosis and management
[NG52] Available from <https://www.nice.org.uk/guidance/ng52> rights
reserved. Subject to [Notice of rights](#)

Brain tumours (primary) and brain metastases in over 16s NICE guideline [NG99] Published: 11 July 2018 Last updated: 29 January 2021

1.11 Surveillance for the late-onset side effects of treatment

1.11.3 Encourage people who have had cranial radiotherapy to follow a healthy lifestyle, including exercise, a healthy diet and stopping smoking (if applicable), to decrease their risk of stroke. See the NICE guidelines on obesity prevention, physical activity and tobacco: preventing uptake, promoting quitting and treating dependence.

1.14 Management of treatment side effects and menopausal symptoms

Lymphoedema: early identification and risk reduction

1.14.1 Inform people having breast cancer treatment about their risk of developing lymphoedema after treatment. Before treatment starts, give them information in a suitable format to take away and refer to. This should include:

- information on:
 - risk reduction strategies, such as maintaining a healthy body weight, ways to reduce their risk of infection, and advice on skincare (for example, use of moisturiser and sunscreen) and physical activity.

1.14.3 Ensure people who are at risk of, breast-cancer-related lymphoedema are aware that

- physical activity may improve their overall quality of life, and
- there is no indication that physical activity causes, or worsens, Lymphoedema

Lymphoedema management

1.14.11 Reassure people that there is no evidence that physical activity (including upper limb exercise) will worsen their lymphoedema and explain that it may improve their overall quality of life. [2025]

1.16 Lifestyle

1.16.1 Advise people who have had or are being treated for breast cancer that a healthy lifestyle is associated with a lower risk of recurrence, and that this should include:

- achieving and maintaining a healthy weight (see the [NICE guidelines on preventing excess weight gain](#) and [obesity](#))
- limiting alcohol intake to below 5 units per week

- regular physical activity (see the [NICE guideline on physical activity for adults](#)). [2018]

© NICE 2025 *Early and locally advanced breast cancer: diagnosis and management [NG101]* Available from <https://www.nice.org.uk/guidance/ng101> rights reserved. Subject to [Notice of rights](#)

1.2 Information for people with colorectal cancer

1.2.7 Help people prepare for discharge after treatment for colorectal cancer by giving them advice on:

- adapting physical activity to maintain their quality of life
- diet, including advice on foods that can cause or contribute to bowel problems such as diarrhoea, flatulence, incontinence and difficulty in emptying the bowels
- stopping smoking (see the NICE guideline on tobacco: preventing uptake, promoting quitting and treating dependence)
- how long their recovery might take
- how, when and where to seek help if side effects become problematic.

Mental Health (Adults)

Preventing suicide in community and custodial settings NICE guideline [NG105] Published: 10 September 2018

1.1 Suicide prevention strategies

1.2.1 Develop a multi-agency strategy based on the principles of the Department of Health and Social Care's suicide prevention strategy for England and other relevant strategies. It should emphasise that suicide is preventable, and it is safe to talk about it.

1.2.2 Identify clear leadership for the multi-agency strategy.

1.2.3 Consider how to measure activities to prevent suicide. Include the introduction of constructive, meaningful preventive activities (for example, education and physical activity) rather than focusing on suicide numbers alone.

© NICE 2025 Preventing suicide in community and custodial settings [NG105] Available from <https://www.nice.org.uk/guidance/ng105> rights reserved. Subject to [Notice of rights](#)

1.7 Person-centred care planning through assessment and formulation

1.7.3 The initial physical health check in the comprehensive assessment by the rehabilitation service should include:

- body mass index
- waist circumference
- full blood count
- pulse and blood pressure
- glycosylated haemoglobin (HbA1c), blood lipid profile, liver function tests, renal function tests and thyroid function
- prolactin levels (for people on medicines that raise prolactin levels).
- renal function tests and calcium levels (for people on lithium)
- drug levels where appropriate, for example mood stabilising or anti-epileptic medicines, lithium and clozapine; do not offer valproate to women of childbearing potential, unless other options are unsuitable and the pregnancy prevention programme is in place (follow the Medicines and Healthcare Products Regulatory Agency [MHRA] safety advice on valproate use by women and girls)
- electrocardiogram (ECG)
- smoking, alcohol and illicit substance use
- nutritional status, diet and level of physical activity
- continence and constipation (particularly if the person is on clozapine)
- any movement disorders
- sexual health
- vision, hearing and podiatry
- oral inspection of general dental health

- any difficulties with swallowing.

1.10 Physical healthcare

Healthy living

1.10.8 Offer people a combined healthy eating and physical activity programme and support them to take part in it.

1.10.9 Give people clear and accessible information about any health risks related to their:

- medicines (side effects)
- lifestyle, including:
 - diet and physical activity
 - smoking, alcohol or illicit substance use
 - oral hygiene
 - bone health
 - sexual and reproductive health.

Monitoring physical health

1.10.14 Offer people in rehabilitation services a routine physical health check at least annually. The annual physical health check should include:

- body mass index
- waist circumference
- pulse and blood pressure
- full blood count, HbA1c, blood lipid profile, renal function tests, liver function tests and thyroid function
- smoking, alcohol or drug use
- nutritional status, diet and level of physical activity
- any movement disorders
- sexual health

- vision, hearing and podiatry
- oral inspection of general dental health.

Care and treatment for physical health conditions

1.10.17 Use the annual physical health check in recommendation 1.10.15 to identify at the earliest opportunity people who:

- have or are at high risk of cardiovascular disease (see the NICE guideline on cardiovascular disease)
- have hypertension (see the NICE guideline on hypertension)
- are obese or at risk of obesity (see the NICE guideline on obesity prevention)
- have diabetes or are at high risk of diabetes (see the NICE guidelines on preventing type 2 diabetes, type 1 diabetes in adults: diagnosis and management and type 2 diabetes in adults: management)
- are physically inactive (see the NICE guideline on physical activity)
- have COPD (see the NICE guideline on chronic obstructive pulmonary disease).

© NICE 2025 *Rehabilitation for adults with complex psychosis [NG181]*
Available from <https://www.nice.org.uk/guidance/ng181> rights reserved.
Subject to [Notice of rights](#)

Mental wellbeing at work NICE guideline [NG212] Published: 02 March 2022

1.6 Individual-level approaches

1.6.4 Offer all employees (or help them to access) mindfulness, yoga or meditation on an ongoing basis. This can be delivered in a group or online, or using a combination of both. See also the section on supporting employers in NICE's guideline on physical activity in the workplace.

© NICE 2025 *Mental wellbeing at work [NG212]* Available from <https://www.nice.org.uk/guidance/ng212> rights reserved. Subject to [Notice of rights](#)

Activities to help wellbeing

1.4.42 Advise people that doing any form of physical activity on a regular basis (for example, walking, jogging, swimming, dance, gardening) could help enhance their sense of wellbeing. The benefits can be greater if this activity is outdoors. **[2022]**

Mental Health (Children and Young People)

Depression in children and young people: identification and management NICE guideline [NG134] Published: 25 June 2019

Treatment and considerations in all settings

1.1.34 A child or young person with depression should be offered advice on the benefits of regular exercise and encouraged to consider following a structured and supervised exercise programme of typically up to 3 sessions per week of moderate duration (45 minutes to 1 hour) for between 10 and 12 weeks. [2005]

© NICE 2025 Depression in children and young people: identification and management [NG134] Available from <https://www.nice.org.uk/guidance/ng134> rights reserved. Subject to [Notice of rights](#)

Fertility, maternity, postnatal and menopause

Diabetes in pregnancy: management from preconception to the postnatal period [NG3] Published: 25 February 2015: Last updated: 16 December 2020 Last reviewed: 30 April 2025

1.1 Preconception planning and care

1.1.3 When women with diabetes are planning a pregnancy, provide them and their families with information about how diabetes affects pregnancy and how pregnancy affects diabetes. The information should cover:

- the role of diet, body weight and exercise
- the risks of hypoglycaemia and impaired awareness of hypoglycaemia during pregnancy
- how nausea and vomiting in pregnancy can affect blood glucose control
- the increased risk of having a baby who is large for gestational age, which increases the likelihood of birth trauma, induction of labour, and instrumental and caesarean section deliveries
- the need for diabetic retinopathy assessment before and during pregnancy
- the need for diabetic nephropathy assessment before pregnancy
- the importance of maternal blood glucose control during labour and birth, and the need for early feeding of the baby, in order to reduce the risk of neonatal hypoglycaemia
- the possibility of that the baby may have health problems in the first 28 days, and may need admitting to a neonatal unit
- the risk of the baby developing obesity, diabetes and/or other health problems in later life. [2008]

1.2 Gestational diabetes Risk assessment, testing and diagnosis Risk assessment

1.2.1 To help women make an informed decision about risk assessment and testing for gestational diabetes, explain that:

- some women find that gestational diabetes can be controlled with changes in diet and exercise
- most women with gestational diabetes will need oral blood glucose-lowering agents or insulin

Interventions

1.2.10 Explain to women with gestational diabetes:

- the implications (both short and long term) of the diagnosis for her and her baby (including UK government advice on driving with diabetes)
- that good blood glucose control throughout pregnancy will reduce the risk of fetal macrosomia, trauma during birth (for her and her baby), induction of labour and/or caesarean section, neonatal hypoglycaemia, and perinatal death
- that treatment includes changes in diet and exercise, and could involve medicines. [2015]

1.2.14 When women are diagnosed with gestational diabetes, offer advice about changes in diet and exercise (see the section on gestational diabetes in NICE's guideline on maternal and child nutrition). [2015]

1.2.17 Advise women with gestational diabetes to exercise regularly (for example, walking for 30 minutes after a meal). [2015]

1.2.18 For women with gestational diabetes who have a fasting plasma glucose level below 7 mmol/litre at diagnosis, offer a trial of diet and exercise changes. [2015]

1.2.19 If blood glucose targets are not met with diet and exercise changes within 1 to 2 weeks, offer metformin. [2015]

1.2.21 If blood glucose targets are not met with diet and exercise changes plus metformin, offer insulin as well. [2015]

1.2.22 For women with gestational diabetes who have a fasting plasma glucose level of 7.0 mmol/litre or above at diagnosis, offer:

- immediate treatment with insulin, with or without metformin and
- diet and exercise changes. [2015]

1.2.23 For women with gestational diabetes who have a fasting plasma glucose level of between 6.0 and 6.9 mmol/litre and complications such as macrosomia or hydramnios, consider:

- immediate treatment with insulin, with or without metformin and
- diet and exercise changes. [2015]

1.3 Antenatal care for women with diabetes

1.3.3 Advise pregnant women with type 2 diabetes or gestational diabetes to test their fasting and 1-hour post-meal blood glucose levels daily if they are:

- managing their diabetes with diet and exercise changes alone or
- taking oral therapy (with or without diet and exercise changes) or single-dose intermediate-acting or long-acting insulin. [2015]

1.6 Postnatal care

Women diagnosed with gestational diabetes

1.6.11 For women who were diagnosed with gestational diabetes and whose blood glucose levels returned to normal after the birth:

- offer lifestyle advice (including weight control, diet and exercise)
- offer a fasting plasma glucose test 6 to 13 weeks after the birth to exclude diabetes (for practical reasons this might take place at the 6-week postnatal check)
- after 13 weeks offer a fasting plasma glucose test if this has not been done earlier, or an HbA1c test if a fasting plasma glucose test is not possible
- do not routinely offer a 75-g 2-hour OGTT
- offer a referral into the NHS Diabetes Prevention Programme if eligible based

on the results of the fasting plasma glucose test or HbA1c test. [2015, amended 2020]

1.6.12 For women having a fasting plasma glucose test as the postnatal test:

- Advise women with a fasting plasma glucose level below 6.0 mmol/litre that:

- they have a low probability of having diabetes at the moment
- they should continue to follow the lifestyle advice (including weight control, diet and exercise) given after the birth
- they will need an annual test to check that their blood glucose levels are normal
- they have a moderate risk of developing type 2 diabetes, and offer them advice and guidance in line with the NICE guideline on preventing type 2 diabetes (note that this guideline uses different risk thresholds, because it covers a different population).

1.6.13 For women having an HbA1c test as the postnatal test:

- Advise women with an HbA1c level below 39 mmol/mol (5.7%) that:

- they have a low probability of having diabetes at the moment
- they should continue to follow the lifestyle advice (including weight control, diet and exercise) given after the birth
- they will need an annual test to check that their blood glucose levels are normal
- they have a moderate risk of developing type 2 diabetes, and offer them advice and guidance in line with the NICE guideline on preventing type 2 diabetes (note that this guideline uses different risk thresholds, because it covers a different population).

© NICE 2025 *Diabetes in pregnancy: management from preconception to the postnatal period [NG3]* from <https://www.nice.org.uk/guidance/ng3> rights reserved. Subject to [Notice of rights](#)

Menopause: identification and management NICE guideline [NG23]

Published: 12 November 2015 Last updated: 07 November 2024

1.2 Information and support

1.2.5 Explain to people experiencing menopause the importance of maintaining muscle mass and strength through physical activity. [2015, amended 2024]

© NICE 2025 Menopause: identification and management NICE guideline [NG23]] from <https://www.nice.org.uk/guidance/ng23> rights reserved.
Subject to Notice of rights

1.1 Organisation and delivery of postnatal care

Transfer to community care

1.1.13 Before transfer from the maternity unit to community care, or before the midwife leaves after a home birth, give women information about:

- the postnatal period and what to expect
- the importance of pelvic floor exercises (see the NICE guideline on pelvic floor dysfunction)
- what support is available (statutory and voluntary services)
- who to contact if any concerns arise at different stages.

1.2 Postnatal care of the woman

Assessment and care of the woman

1.2.1 At each postnatal contact, ask the woman about her general health and whether she has any concerns, and assess her general wellbeing. Discuss topics that may be affecting her daily life, and provide information, reassurance and further care as appropriate.

Topics to discuss may include:

- the postnatal period and what to expect
- symptoms and signs of potential postnatal mental health problems and how to seek help
- symptoms and signs of potential postnatal physical problems and how to seek help
- the importance of pelvic floor exercises, how to do them and when to seek help (see the NICE guideline on pelvic floor dysfunction)
- fatigue
- factors such as nutrition and diet, physical activity, smoking, alcohol consumption and recreational drug use (also see the NICE guidelines on maternal and child nutrition, weight management before, during and after pregnancy, tobacco and the UK Chief Medical Officer's physical activity guidelines for women after birth)

- contraception (see the Faculty of Sexual & Reproductive Healthcare (FSRH) guideline on contraception after pregnancy)
 - sexual intercourse
- safeguarding concerns, including domestic abuse (see the NICE guideline on domestic violence and abuse and the NICE guideline on child abuse and neglect).

1.2 Routine antenatal clinical care

Taking and recording the woman's history

1.2.1 At the first antenatal (booking) appointment, ask the woman about:

- factors such as nutrition and diet, physical activity, smoking and tobacco use, alcohol consumption and recreational drug use (see also [recommendations 1.3.8 and 1.3.9](#)).

1.3 Information and support for pregnant women and their partners

Information about antenatal care

1.3.9 At the first antenatal (booking) appointment, and later if appropriate, discuss and give information about nutrition and diet, physical activity, smoking cessation and recreational drug use in a non-judgemental, compassionate and personalised way.

Other

Workplace health: management practices NICE guideline [NG13]

Published: 24 June 2015 Last updated: 24 March 2016

1.10 Job design

1.10.4 Take into account the effect on physical health when designing jobs. This could include, for example, ergonomic reviews, and giving advice on posture and on moving and handling physical loads. Design jobs to promote and improve the physical health of employees by, for example, helping people to be physically active in their working day. See NICE's guideline on physical activity in the workplace. [2015]

1.10.7 Consider delivering a workplace health promotion programme incorporating both physical activity and diet. See our topic pages on diet, nutrition and obesity and physical activity. [new 2016]

© NICE 2024 Workplace health: management practices [NG13] Available from <https://www.nice.org.uk/guidance/ng13> rights reserved. Subject to [Notice of rights](#)

1.5 Delivering care

Providing support and information

1.5.5 Health and social care practitioners should offer older people with social care needs and multiple long-term conditions:

- opportunities to interact with other people with similar conditions
- help to access one-to-one or group support, social media and other activities, such as dementia cafés, walking groups and specialist support groups, exercise and dance.

1.2 Group-based activities

1.2.1 Provide a range of group activities, including multicomponent activities, combining 1 or more of the following:

- Singing programmes, in particular, those involving a professionally led community choir.
- Arts and crafts and other creative activities.
- Tailored, community-based physical activity programmes including walking schemes (see recommendations 2 and 3 in NICE's public health guideline on mental wellbeing in over 65s: occupational therapy and physical activity interventions).

**Non-alcoholic fatty liver disease (NAFLD): assessment and management
NICE guideline [NG49] Published: 06 July 2016 Last reviewed: 24 October
2024 and update underway**

1.2 Assessment for advanced liver fibrosis in people with NAFLD

Lifestyle modifications for NAFLD

1.2.12 Offer advice on physical activity and diet to people with NAFLD who are overweight or obese in line with NICE's guidelines on obesity and preventing excess weight gain.

1.2.13 Explain to people with NAFLD that there is some evidence that exercise reduces liver fat content.

© NICE 2025 *Non-alcoholic fatty liver disease (NAFLD): assessment and management [NG49]* Available from <https://www.nice.org.uk/guidance/ng49> rights reserved. Subject to [Notice of rights](#)

Hospital outpatient settings

1.4.5 When assessing frailty in hospital outpatient settings, consider using 1 of the following:

- self-reported health status (that is, 'how would you rate your health status on a scale from 0 to 10?', with scores of 6 or less indicating frailty)
- the 'Timed Up and Go' test, with times of more than 12 seconds indicating frailty
- a formal assessment of gait speed, with more than 5 seconds to walk 4 metres indicating frailty
- the PRISMA-7 questionnaire, with scores of 3 and above indicating frailty
- self-reported physical activity, with frailty indicated by scores of 56 or less for men and 59 or less for women using the Physical Activity Scale for the Elderly.

Establishing disease and treatment burden

1.6.4 Establish treatment burden by talking to people about how treatments for their health problems affect their day-to-day life. Include in the discussion:

- the number and type of healthcare appointments a person has and where these take place
- the number and type of medicines a person is taking and how often
- any harms from medicines
- non-pharmacological treatments such as diets, exercise programmes and psychological treatments

any effects of treatment on their mental health or wellbeing.

© NICE 2025 Multimorbidity: clinical assessment and management [NG56]
Available from <https://www.nice.org.uk/guidance/ng56> rights reserved.
Subject to Notice of rights

Second-stage health assessment within 7 days

1.1.18 Offer people tailored health advice based on their responses to the assessment questions. This should be in a variety of formats (including face-to-face). It should include advice on:

- alcohol (see NICE's guideline on alcohol-use disorders)
- substance misuse (see NICE's guideline on drug misuse in over 16s)
- exercise (see recommendations on exercise in the section on promoting health and wellbeing)
- diet (see recommendation 1.3.5 on diet in the section on promoting health and wellbeing)

General health advice 1.3.1

Consider using peer support and mentoring to help promote a healthy lifestyle while in prison.

1.3.2 Offer people in prison tailored health information in a variety of formats, to including face-to-face. Include advice about:

- exercise
- diet
- stopping smoking
- sexual health
- personal hygiene, including oral hygiene.

Exercise

1.3.3 Encourage people to be physically active. Offer them information about:

- the benefits of exercise
- what exercise facilities are provided, where they are and how they can use them, for example:

- going to the gym
- using the exercise yard

- exercises that can be done in the cell.

1.3.4 Offer people information and advice in line with recommendations in the NICE guidelines on:

- physical activity: brief advice for adults in primary care
- physical activity: exercise referral schemes
- preventing excess weight gain
- obesity: identification, assessment and management (section 1.6 on physical activity).

1.5 Managing ADHD Planning treatment

1.5.4 Before starting any treatment for ADHD, discuss the following with the person, and their family or carers as appropriate, encouraging children and young people to give their own account of how they feel: • the benefits and harms of non-pharmacological and pharmacological treatments (for example, the efficacy of medication compared with no treatment or non-pharmacological treatments, potential adverse effects and non-response rates) • the benefits of a healthy lifestyle, including exercise

1.6 Dietary advice

1.6.1 Healthcare professionals should stress the value of a balanced diet, good nutrition and regular exercise for children, young people and adults with ADHD. [2008]

1.4 Organising and delivering care and support

1.2.12 Commissioners and service providers should ensure there is a wide range of community-based physical activity programmes available and encourage people to take part to promote their health and wellbeing. Examples include dancing, swimming, bowls, using the gym, organised walks and chair-based exercise classes.

Health checks and screening

1.5.11 Recognise that people with learning disabilities may need additional Care and support of people growing older with learning disabilities health surveillance to help them identify and communicate symptoms of age-related conditions.

1.5.12 Offer annual health checks to older people with learning disabilities as long as these are followed by prompt referral to specialist services wherever needed. Explain what annual health checks involve and how to arrange them. Record any actions identified by the annual health check in the person's health action plan.

Health action plan

A personal plan for people with learning disabilities about how to stay healthy. It should detail what help and support they need to look after their health. This might include support to manage physical or mental health conditions, or actions in relation to lifestyle issues such as diet and exercise.

Diverticular disease: diagnosis and management NICE guideline [NG147]

Published: 27 November 2019

1.1 Diverticulosis

Management and advice

1.1.5 Tell people about the benefits of exercise, and weight loss if they are overweight or obese, and stopping smoking, in reducing the risk of developing acute diverticulitis and symptomatic disease.

1.2 Diverticular disease

Management and advice

1.2.6 For advice on diet, fluid intake, stopping smoking, weight loss and exercise, follow the recommendations in section 1.1 on diverticulosis.

© NICE 2025 *Diverticular disease: diagnosis and management [NG147]*
Available from <https://www.nice.org.uk/guidance/ng147> rights reserved.
Subject to [Notice of rights](#)

1.4 Diet and physical activity

1.4.1 Consider digital and mobile health interventions as an option for people who would benefit from improving their diet or increasing their physical activity levels as an adjunct to existing services. Be aware that their effectiveness is variable.

1.4.2 Advise people to use digital and mobile health interventions that include self-monitoring, such as recording by activity trackers, or food or physical activity diaries. This can help the person to review their own progress towards their diet or physical activity goals.

1.4.3 If you are aware that the person is at risk of developing or resuming an eating disorder or another unhealthy behaviour such as excessive exercise, consider interventions that do not include self-monitoring.

1.4 Information and education for people with CKD

Lifestyle advice

1.4.6 Encourage adults with CKD to take exercise, achieve a healthy weight and stop smoking. [2008]

Self-management

1.4.10 Ensure that systems are in place to:

- inform adults with CKD (and their family members or carers, as appropriate) of their diagnosis
- enable adults with CKD (and their family members or carers, as appropriate) to share in decision making about their care
- support self-management (this includes providing information about blood pressure, smoking cessation, exercise, diet and medicines) and enable adults with CKD to make informed choices. [2014]

1.8 Managing anaemia

Patient education programmes

1.8.20 Offer culturally and age-appropriate patient education programmes to all adults, children and young people diagnosed with anaemia of CKD (and their families and carers). These should be repeated as requested, and according to the person's changing circumstances. They should include the following key areas:

- Practical information about how anaemia of CKD is managed.
- Knowledge (for example, about symptoms, iron management, causes of anaemia, associated medications, phases of treatment).
- Professional support (for example, contact information, community services, continuity of care, monitoring, feedback on progress of results).

- Lifestyle (for example, diet, physical exercise, maintaining normality, meeting other people with the condition).
- Adaptation to chronic disease (for example, previous information and expectations, resolution of symptoms). [2006]

Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management NICE guideline [NG206]

Published: 29 October 2021 Last reviewed: 24 January 2025

1.11 Managing ME/CFS

Energy management

1.11.2 Discuss with people with ME/CFS the principles of energy management, the potential benefits and risks and what they should expect. Explain that it:

- is not curative
- is a self-management strategy led by the person themselves with support from a healthcare professional in an ME/CFS specialist team
- includes all types of activity (cognitive, physical, emotional and social) and takes into account overall level of activity
- helps people learn to use the amount of energy they have while reducing their risk of post-exertional malaise or worsening their symptoms by exceeding their limits
- recognises that each person has a different and fluctuating energy limit and they are experts in judging their own limits
- can include help from a healthcare professional to recognise when they are approaching their limit (children and young people in particular may find it harder to judge their limits and can overreach them)
- uses a flexible, tailored approach so that activity is never automatically increased but is maintained or adjusted (upwards after a period of stability or downwards when symptoms are worse)
- is a long-term approach – it can take weeks, months or sometimes even years to reach stabilisation or to increase tolerance or activity.

1.11.3 Help people with ME/CFS develop a plan for energy management as part of their care and support plan. Support them to establish realistic expectations and develop goals that are meaningful to them. Discuss and

record the following in the plan along with anything else that is important to the person:

- cognitive activity
- mobility and other physical activity
- ability to undertake activities of daily living
- psychological, emotional and social demands, including family and sexual relationships
- rest and relaxation (both quality and duration)
- sleep quality and duration
- effect of environmental factors, including sensory stimulation.

1.11.4 Work with the person to establish an individual activity pattern within their current energy limits that minimises their symptoms. For example:

- agree a sustainable level of activity as the first step, which may mean reducing activity
- plan periods of rest and activity, and incorporate the need for pre-emptive rest
- alternate and vary between different types of activity and break activities into small chunks.

1.11.5 Agree how often to review the person's energy management plan with them and revise it if needed.

1.11.6 Advise people with ME/CFS how to manage flare-ups and relapses (see the section on managing flare-ups in symptoms and relapse).

1.11.7 Make self-monitoring of activity as easy as possible by taking advantage of any tools the person already uses, such as an activity tracker, phone heart-rate monitor or diary.

1.11.8 Refer people with ME/CFS to a physiotherapist or occupational therapist working in an ME/CFS specialist team if they:

- have difficulties caused by reduced physical activity or mobility (also see the sections on physical functioning and mobility and care for people with severe or very severe ME/CFS) or
- feel ready to progress their physical activity beyond their current activities of daily living (see the section on physical activity and exercise) or
- would like to incorporate a physical activity or exercise programme into managing their ME/CFS (see the section on incorporating physical activity and exercise).

Incorporating physical activity and exercise

1.11.9 Do not advise people with ME/CFS to undertake exercise that is not part of a programme overseen by an ME/CFS specialist team, such as telling them to go to the gym or exercise more, because this may worsen their symptoms.

1.11.10 Only consider a personalised physical activity or exercise programme for people with ME/CFS who:

- feel ready to progress their physical activity beyond their current activities of daily living or
- would like to incorporate physical activity or exercise into managing their ME/CFS.

1.11.11 Tell people about the risks and benefits of physical activity and exercise programmes. Explain that some people with ME/CFS have found that they can make their symptoms worse, for some people it makes no difference and others find them helpful.

1.11.12 If a physical activity or exercise programme is offered, it should be overseen by a physiotherapist in an ME/CFS specialist team.

1.11.13 If a person with ME/CFS takes up the offer of a personalised physical activity or exercise programme, agree a programme with them that involves the following and review it regularly:

- establishing their physical activity baseline at a level that does not worsen their symptoms

- initially reducing physical activity to be below their baseline level
- maintaining this successfully for a period of time before attempting to increase it
- making flexible adjustments to their physical activity (up or down as needed) to help them gradually improve their physical abilities while staying within their energy limits
- recognising a flare-up or relapse early and outlining how to manage it.

1.11.14 Do not offer people with ME/CFS:

- any therapy based on physical activity or exercise as a cure for ME/CFS
- generalised physical activity or exercise programmes – this includes programmes developed for healthy people or people with other illnesses
- any programme that does not follow the approach in recommendation 1.11.13 or that uses fixed incremental increases in physical activity or exercise, for example, graded exercise therapy (see box 4)
- physical activity or exercise programmes that are based on deconditioning and exercise avoidance theories as perpetuating ME/CFS.

Box 4 Graded exercise therapy definition

Graded exercise therapy is a term used in varying ways by different services supporting people with ME/CFS. In this guideline, graded exercise therapy is defined as first establishing an individual's baseline of achievable exercise or physical activity, then making fixed incremental increases in the time spent being physically active. This definition of graded exercise therapy reflects the descriptions given in the evidence that was reviewed, and it is this approach that the guideline says should not be undertaken.

An individualised approach that should be taken for people with ME/CFS who choose to undertake a physical activity or exercise programme is described in recommendations 1.11.10 to 1.11.13.

Flare-ups and relapse

1.11.15 Agree with the person how to adjust their physical activity during a flare-up or relapse. This should include:

- providing access to review and support from a physiotherapist in an ME/CFS specialist team
- stabilising their symptoms by reducing physical activity to within their current energy limits
- only once symptoms stabilise and the person feels able to resume physical activity, establishing a new physical activity baseline.

1.11.16 Advise people with ME/CFS after a flare-up that the time it takes to return to the level of physical activity they had before varies from person to person.

Physical functioning and mobility

1.12.5 Include strategies to maintain and prevent deterioration of physical functioning and mobility in the care and support plans of people with ME/CFS. These strategies may need to be carried out in small amounts and spread out throughout the day. Think about including the following:

- joint mobility
- muscle flexibility
- balance
- postural and positional support
- muscle function
- bone health
- cardiovascular health.

1.12.8 Give families and carers information, advice and support on how to help people with ME/CFS follow their care and support plan in relation to physical functioning and mobility. This may include:

- bed mobility
- moving from lying to sitting to standing
- transferring from bed to chair

- using mobility aids
- walking
- joint mobility
- muscle stretching
- muscle strength
- balance
- going up and down stairs.

1.14 Managing flare-ups in symptoms and relapse

- For a flare-up:
 - identifying possible triggers, such as acute illness or overexertion (in some cases, there may be no clear trigger)
 - temporarily reducing their activity levels
 - monitoring symptoms, recognising that although flare-ups are transient, some will develop into a relapse
 - not returning to usual activity levels until the flare-up has resolved.
- For a relapse:
 - reducing, or even stopping, some activities
 - increasing the frequency or duration of rest periods
 - reassessing energy limits to stabilise symptoms.

After a flare-up or relapse

1.14.8 Once a flare-up or relapse has resolved or stabilised, discuss with the person:

- whether their care and support plan needs to be reviewed and adjusted to reflect their current symptoms and energy limit if this is different from before the flare-up or relapse (for people participating in physical activity or exercise programmes, see recommendations 1.11.15 and 1.11.16)

- their experience of the flare-up or relapse to determine whether strategies can be put in place to manage potential triggers in the future.

1.15 Review in primary care

1.15.1 Offer adults with ME/CFS a review of their care and support plan in primary care at least once a year.

1.15.2 Offer children and young people with ME/CFS a review of their care and support plan at least every 6 months.

1.15.5 As part of the review, discuss with the person with ME/CFS (and their family or carers, as appropriate) and record as a minimum:

- their condition, including any changes in their illness and the impact of this
- symptoms, including whether they have experienced new symptoms
- self-management – ask about their energy management plan and (if relevant) their physical activity or exercise programme
- who is helping them and how they provide support
- psychological, emotional and social wellbeing
- any future plans – ask if the person is considering any changes or if they have any challenges ahead.

1.17 Care for people with severe or very severe ME/CFS

Energy management

Also see the main section on energy management.

1.17.8 Refer people with severe or very severe ME/CFS to a physiotherapist or occupational therapist working in an ME/CFS specialist team for support on developing energy management plans.

1.17.9 When agreeing energy management plans with people with severe or very severe ME/CFS (and their family or carers, as appropriate), take into account the need to make any changes in activity smaller and any increases (if possible) much slower.

© NICE 2025 Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management [NG206] Available from <https://www.nice.org.uk/guidance/ng206> rights reserved. Subject to [Notice of rights](#)

1.3 Preventing pelvic floor dysfunction Physical activity and diet

1.3.1 Advise women that physical activity and a healthy diet can help prevent pelvic floor dysfunction.

1.3.2 On levels of physical activity, advise women to follow the standard advice, as covered by:

- the UK Chief Medical Officers' physical activity guidelines
- the NICE guideline on physical activity: brief advice for adults in primary care
- the NICE guideline on physical activity: walking and cycling.

1.3.4 For guidance on training to help health and social care practitioners recognise and respond to diet, physical activity and hydration needs in older people with social care needs and multiple long-term conditions, see the section on training health and social care practitioners in the NICE guideline on older people with social care needs and multiple long-term conditions.

Non-surgical management of pelvic floor dysfunction

Lifestyle changes

Physical activity

1.6.11 For women who are doing supervised pelvic floor muscle training and want to be physically active, advise them that supervised exercise (for example, yoga) may help with their symptoms.

1.6.12 Advise women with pelvic floor dysfunction that there is no evidence to say that unsupervised physical activity (such as walking or swimming) will improve or worsen their symptoms.

© NICE 2025 *Pelvic floor dysfunction: prevention and non-surgical management [NG210]* Available from <https://www.nice.org.uk/guidance/ng210> rights reserved. Subject to [Notice of rights](#)

1.5 Information and support

During the hospital stay

1.5.9 Give the person advice on returning to their usual activities including work, exercise, driving and sexual activity.

NICE Public Health Guidelines

Cardiovascular Disease

Cardiovascular disease prevention Public health guideline [PH25]

Published: 22 June 2010

Recommendation 19 Children and young people

Who should take action?

- Parents and carers of children and young people under the age of 16.
- Local authorities (providers of cultural and leisure services).
- Schools (governors and teachers).
- Catering staff.
- Nursery nurses and workers in pre-school day care settings such as nurseries.
- Managers of children's centres.

What action should they take?

- Help children and young people to have a healthy diet and lifestyle. This includes helping them to develop positive, life-long habits in relation to food. This can be achieved by ensuring the messages conveyed about food, the food and drink available – and where it is consumed – is conducive to a healthy diet. (For more details see 'Maternal and child nutrition' [NICE public health guidance 11] and 'Physical activity and children' [NICE public health guidance 17].)

Recommendation 21 Physical activity

What action should they take?

- Ensure the physical environment encourages people to be physically active (see 'Physical activity and the environment' [NICE public health guidance 8]). Implement changes where necessary. This includes prioritising the needs of pedestrians and cyclists over motorists when developing or redeveloping highways. It also includes developing and implementing public sector workplace travel plans that incorporate

physical activity (see 'Promoting physical activity in the workplace' [NICE public health guidance 13]). Encourage and support employers in other sectors to do the same.

- Ensure the need for children and young people to be physically active is addressed (see 'Promoting physical activity for children and young people' [NICE public health guidance 17]). This includes providing adequate play spaces and opportunities for formal and informal physical activity.
- Audit bye-laws and amend those that prohibit physical activity in public spaces (such as those that prohibit ball games).
- Consider offering free swimming to parents and carers who accompany children aged under 5 years to swimming facilities.
- Apportion part of the local transport plan (LTP) block allocation to promote walking, cycling and other forms of travel that involve physical activity. The proportion allocated should be in line with growth targets for the use of these modes of transport.
- Ensure cycle tracks created under the Cycle Tracks Act 1984 are part of the definitive map (the legal record of public rights of way).
- Align all 'planning gain' agreements with the promotion of heart health to ensure there is funding to support physically active travel. (For example, Section 106 agreements are sometimes used to bring development in line with sustainable development objectives.)

Type 2 diabetes prevention: population and community-level interventions Public health guideline [PH35] Published: 10 May 2011 Last reviewed: 28 March 2018

Recommendation 1 Integrating national strategy on non-communicable diseases

Who should take action?

Commissioners and providers of national public health services working in partnership with:

- government departments
- the commercial sector
- local commissioners and providers of public health services
- the voluntary sector, not-for-profit and non-governmental organisations.

What action could they take?

- When developing national strategy to target non-communicable diseases with a major link to diet, physical activity and obesity (for example, type 2 diabetes, cardiovascular disease, certain cancers), consider:
 - integrating the strategy with other relevant national actions to prevent related non-communicable diseases
 - addressing the key risk factors (for example, being overweight or obese, a sedentary lifestyle and an unhealthy diet)
 - highlighting the contribution that partners in national and local government, industry, healthcare and the voluntary sector can make by working together to reduce the risk of non-communicable diseases for the population as a whole
 - taking account of variations in different population subgroups (for example, by ethnicity, age or gender)
 - linking to targets and outcomes for reducing the key risk factors for type 2 diabetes and other non-communicable diseases.

Recommendation 2 Local joint strategic needs assessments

Who should take action?

Commissioners and providers of local public health services in partnership with other local authority departments including:

- adult social care
- education
- environmental health
- planning
- public transport.

What action should they take?

- Identify local resources and existing community groups that could help promote healthy eating, physical activity and weight management, particularly within local communities at high risk of developing type 2 diabetes.

Recommendation 3 Developing a local strategy

Who should take action?

Commissioners and providers of local public health services in partnership with other local authority departments including:

- adult social care
- education
- environmental health
- planning
- public transport.

What action should they take?

- The plan should aim to increase physical activity levels and improve people's diet and

weight management by:

- identifying and assessing the effectiveness and cost effectiveness of existing local interventions
- making recommendations for future investment and disinvestment
- including action to raise awareness of type 2 diabetes and the risk factors for diabetes and other non-communicable diseases
- creating local environments that encourage people to be more physically active and to adopt a healthier diet (for example, by ensuring local shops stock good quality, affordable fruit and vegetables)
- targeting specific communities at high risk of developing type 2 diabetes, including people of South Asian, African-Caribbean or black African family origin, and those from lower socioeconomic groups
- including interventions for individuals who are deemed at particular risk (based on clear criteria about the level of absolute risk that would trigger this provision, see also NICE's guideline on preventing type 2 diabetes in people at high risk).

Recommendation 4 Interventions for communities at high risk of type 2 diabetes

Who should take action?

Commissioners and providers of local public health services in partnership with:

- other local authority departments including: children's services, education, environmental health, leisure, planning, public transport, social housing and social services
- the NHS including: GPs, practice and community nurses, dietitians, public health nutritionists, doctors and nurses working in acute and emergency care, and occupational therapists
- the voluntary sector, not-for-profit and non-governmental organisations (include community leaders and trained lay workers).

What action should they take?

- Ensure lay and peer workers are part of a wider team led by health professionals. They should be involved in the planning, design and delivery of credible and culturally appropriate messages. This includes helping people to develop the practical skills they need to adopt a healthier lifestyle. For example, they should be able to run nutrition education sessions (theory and practice) or physical activity sessions. Management and supervision of these activities should be provided by the health professionals leading these teams.

Recommendation 6 Conveying messages to the local population

Who should take action?

Commissioners and providers of local public health services in partnership with:

- other local authority departments including education and leisure
- the NHS including: GPs, practice and community nurses, dietitians, public health nutritionists, doctors and nurses working in acute and emergency care, and occupational therapists
- the voluntary sector, not-for-profit and non-governmental organisations (including community leaders).

What action should they take?

- Offer communities support to improve their diet and physical activity levels, and ensure they are aware of the importance of both.

Recommendation 9 Promoting physical activity: national action

Who should take action?

Commissioners and providers of national public health services working in partnership with:

- other government departments
- organisations with a remit for town planning
 - organisations with a remit for increasing physical activity levels

- commissioners and providers of local public health services
- the voluntary sector, not-for-profit and non-governmental organisations.

What action could they take?

- Ensure the benefits of physical activity – and the national recommendations for physical activity – are made clear to encourage people to be more physically active.
- Support a shift in the population towards being more physically active by encouraging even small changes.
- Use planning regulations to maximise the opportunities available to be physically active.
- Encourage the use of national and local planning guidance to ensure physical activity is a primary objective of transport policy, and when designing new buildings and the wider built environment.
- Monitor the population's overall physical activity levels to determine the success of national interventions. Assess the health impact of all initiatives and interventions to encourage physical activity.

Recommendation 10 Promoting physical activity: local action

Who should take action?

Commissioners and providers of local public health services in partnership with:

- other local authority departments including: planning, regeneration, public transport, leisure, sports and parks
- schools with community recreation facilities (for example, as part of the extended schools programme)

the NHS including: GPs, practice and community nurses, community pharmacists and occupational therapists

- voluntary sector, not-for-profit and non-governmental organisations (include community leaders and trained lay workers)
- the fitness industry

- large and medium-sized employers.

What action should they take?

Ensure local planning departments use existing mechanisms (for example, national planning guides) to:

- prioritise the need for people (including those whose mobility is impaired) to be physically active as a routine part of their daily life (for example, when developing the local infrastructure and when dealing with planning applications for new developments)
 - provide open or green spaces to give people local opportunities for walking and cycling
 - make sure local facilities and services are easily and safely accessible on foot, by bicycle and by other modes of transport involving physical activity (they should consider providing safe cycling routes and secure parking facilities for bikes)
 - provide for physical activities in safe locations that are accessible locally either on foot or via public transport
 - encourage people to be physically active inside buildings, for example, by using the internal infrastructure of buildings to encourage people to take the stairs rather than the lift (also see NICE's guideline on physical activity and the environment).
- Enable and encourage people to achieve the national recommended levels of physical activity by including activities such as walking, cycling or climbing stairs as part of their everyday life.
 - Assess the type of physical activity opportunities needed locally and at what times and where. Consider social norms, family practices and any fears people may have about the safety of areas where physical activities take place (this includes fears about how safe it is to travel there and back).
 - Map physical activity opportunities against local needs and address any gaps in provision.

- Ensure commissioned leisure services are affordable and acceptable to those at high risk of developing type 2 diabetes. This means providing affordable childcare facilities. It also means public transport links should be affordable and the environment should be culturally acceptable. For example, local authorities should consider the appropriateness of any videos and music played. They should also consider providing single-gender facilities, exercise classes, swimming sessions and walking groups – for both men and women.
- Provide information on local, affordable, practical and culturally acceptable opportunities to be more active. If cultural issues affect people's ability to participate, work with them to identify activities which may be acceptable. (This may include, for example, single-gender exercise and dance classes, or swimming sessions with same gender lifeguards.)
- Encourage local employers to develop policies to encourage employees to be more physically active, for example, by using healthier modes of transport to and from work. Walking and cycling can be encouraged by providing showers and secure cycle parking. Signposting and improved decor could encourage employees to use the stairs rather than the lift. In addition, people could be encouraged to be active in lunch breaks and at other times through organised walks and subsidies for local leisure facilities Flexible working policies and incentives that promote physical activity in the workplace should be considered. (This is an extract from NICE's guidelines on obesity and promoting physical activity in the workplace; see the latter for further guidance on developing programmes and policies to encourage and support employees to be more physically active).
- Ensure the basic training for professional fitness instructors covers: the role of physical activity in improving people's health, how to get marginalised groups involved and cultural issues that may prevent them from participating.

Recommendation 11 Training those involved in promoting healthy lifestyles

Who should take action?

Commissioners and providers of national and local public health services in partnership with:

- royal colleges and professional associations, further and higher education training institutions, and other organisations responsible for competencies and continuing professional development programmes for health professionals
- other local authority departments including education and leisure services
- voluntary sector, not-for-profit and non-governmental practitioners
- the commercial sector.

What action should they take?

- Ensure training programmes for those responsible for, or involved in, promoting a healthy lifestyle cover:
 - diversity, including cultural, religious and economic issues, delivering health promotion interventions in a non-judgemental way, and meeting age, gender, language and literacy needs
 - how to identify communities at increased risk of developing type 2 diabetes
 - strategies for changing behaviour (for those devising health promotion interventions)
 - how to provide advice on healthy eating, physical activity and weight management in relation to the prevention of type 2 diabetes and related non-communicable diseases
 - how to challenge stigma and dispel myths around type 2 diabetes.
- Ensure training programmes for all health professionals (including undergraduate, continuing professional development and, where appropriate, post-graduate training):
 - incorporate the knowledge and skills needed to ensure health promotion interventions are culturally sensitive

- cover nutrition, physical activity and weight management in relation to the prevention of type 2 diabetes
- are focused, structured and based on proven models and evaluation techniques
- offer opportunities to practice new skills in the community
- encourage the sharing of knowledge among colleagues – provide up-to-date information on topics such as nutrition advice and physical activity (information should be updated regularly).

© NICE 2025 *Type 2 diabetes prevention: population and community-level interventions [PH35]* Available from <https://www.nice.org.uk/guidance/ph35> rights reserved. Subject to [Notice of rights](#)

1.5 Matching interventions to risk

1.5.2 As part of brief advice:

- Discuss people's risk factors and how they could improve their lifestyle to reduce overall risk.
- Offer encouragement and reassurance.
- Offer verbal and written information about culturally appropriate local services and facilities that could help them change their lifestyle.

Examples could include information or support to: improve their diet (including details of any local markets offering cheap fruit and vegetables); increase their physical activity and reduce the amount of time spent being sedentary (including details about walking or other local physical activity groups and low-cost recreation facilities). The information should be provided in a range of formats and languages. [2012]

1.5.3 For people with a moderate risk (a high risk score, but with a fasting plasma glucose less than 5.5 mmol/l or HbA1c of less than 42 mmol/mol [6.0%]):

- Tell the person that they are currently at moderate risk, and their risks could increase in the future. Explain that it is possible to reduce the risk. Briefly discuss their particular risk factors, identify which ones can be modified and discuss how they can achieve this by changing their lifestyle.
- Offer them a brief intervention to help them change their lifestyle: give information about services that use evidence-based behaviour-change techniques that could help them change, bearing in mind their risk profile. Services cited could include walking programmes, slimming clubs or structured weight-loss programmes. (See recommendations 1.11.1 to 1.14.3.)
- Discuss whether they would like to join a structured weight-loss programme. Explain that this would involve an individual assessment and tailored advice about diet, physical activity and behaviour change. Let

them know which local programmes offer this support – and where to find them. [2012]

1.6 Reassessing risk

1.6.6 At least once a year, review the lifestyle changes people at high risk have made. Use the review to help reinforce their dietary and physical activity goals, as well as checking their risk factors. The review could also provide an opportunity to help people 'restart', if lifestyle changes have not been maintained. [2012]

1.7 Commissioning risk identification and intensive lifestyle-change programmes

1.7.1 Health and wellbeing boards and public health commissioners should make type 2 diabetes prevention a priority in the joint health and wellbeing strategy. They should identify local needs by:

- Using anonymised, regional and local health data and routinely collected surveillance data on specific population groups or geographical areas to inform the joint strategic needs assessment.
- Mapping local diet, weight management and physical activity services and interventions (for example, slimming clubs). This should include details about locations, opening times and accessibility, staffing levels and the range of professional skills available. It should also include details of any tailored support provided by trained personnel. [2012]

1.7.6 Health and wellbeing boards and public health commissioners should evaluate or compare the different service options and make the findings publicly available. Assessments should focus on changes in participants' physical activity levels, weight and dietary intake (of fat, saturated fat and fibre) over 12 to 24 months. [2012]

1.9 Quality-assured, intensive lifestyle-change programmes content

1.9.1 Intensive lifestyle-change programmes should offer ongoing tailored advice, support and encouragement to help people:

- undertake at least a level of physical activity that is in line with government recommendations

(see the UK Chief Medical Officers' physical activity guidelines for more information)

1.9.2 Established behaviour-change techniques should be used (see NICE's guideline on behaviour change: general approaches), including at least all of the following:

- Information provision: to raise awareness of the benefits of and types of lifestyle changes needed to achieve and maintain a healthy weight, building on what participants already know.
- Exploration and reinforcement of participants' reasons for wanting to change and their confidence about making changes. This may include using motivational interviewing or similar techniques suitably adapted for use in groups.
- Goal setting: prompting participants to set achievable and personally relevant short- and long-term goals (for example, to lose 5–10% of their weight in 1 year is a realistic initial target, or to be more physically active).
- Action planning: prompting participants to produce action plans detailing what specific physical activity or eating behaviour they intend to change – and when, where and how this will happen. They should start with achievable and sustainable short-term goals and set graded tasks (starting with an easy task and gradually increasing the difficulty as they progress towards their goal). The aim is to move over time towards long-term, lifestyle change.

1.10 Quality-assured, intensive lifestyle-change programmes: evaluation

1.10.1 Evaluate intensive lifestyle-change programmes by recording people's health outcomes at 12 months, or more frequently, if appropriate (for example, every 6 months). As a minimum, include the following measures:

- number and demographics of adults registered
- level of attendance
- changes in the amount of moderate to vigorous physical activity undertaken each week

1.11 Raising awareness of the importance of physical activity

1.11.1 Find out what people already know about the benefits of physical activity and the problems associated with a sedentary lifestyle. Where necessary, provide this information. In addition, explain that being more physically active can help reduce their risk of type 2 diabetes, even when that is the only lifestyle change they make. [2012]

1.11.2 Explain the government recommendations for weekly physical activity (see the UK Chief Medical Officers' physical activity guidelines for more information). [2012]

1.11.3 In cases where it is unrealistic to expect someone to meet the recommended minimum, explain that even small increases in physical activity will be beneficial – and can act as a basis for future improvements. [2012]

1.11.4 Explain that people should also reduce the amount of time they spend sitting at a computer or watching TV. Encourage them to be more active during work breaks, for example, by going for a walk at lunchtime. [2012]

1.11.5 Explain that some people may need to be more physically active to help lose weight or maintain weight loss (see NICE's guideline on obesity). [2012]

1.12 Providing tailored advice on physical activity

1.12.1 Help people to identify which of their activities involve 'moderate' or 'vigorous' physical activity and the extent to which they are meeting the national minimum recommendation on physical activity. Use a validated tool such as the Department of Health's general practitioner physical activity questionnaire or the international physical activity questionnaire (IPAQ). [2012]

1.12.2 Encourage people to choose physical activities they enjoy or that fit easily within their daily lives. For example, they may choose to do specific activities such as walking, cycling, swimming, dancing or aerobics. Or they could build physical activity into their daily life – for example, by walking or cycling instead of using a car for short journeys, and by taking the stairs instead of the lift. [2012]

1.12.3 Encourage people to set short and long-term goals for example, on how far they walk or cycle, or the number or length of activities undertaken every week. In addition, encourage them to keep a record of their activity for example, by using a pedometer, and to record the things that make it easier or harder. Help them to find other ways to identify and overcome any barriers to physical activity. [2012]

1.12.4 Consider referring people who want structured or supervised exercise to an exercise referral scheme or supervised exercise sessions, as part of an intensive lifestyle-change programme. [2012]

1.12.5 Provide information on local opportunities for physical activity. [2012]

1.16 Vulnerable groups: supporting lifestyle change

1.16.2 Make all staff aware of the benefits of physical activity and reducing the time spent being sedentary. Where possible, encourage them to increase the opportunities for those in their care to be physically active. [2012]

1.18 Training and professional development

In recommendations 1.18.1 to 1.18.3 the people and organisations who should work with the national accreditation body are commissioners and providers of public health services; managers of type 2 diabetes risk-assessment and prevention services; schools of medicine, healthcare faculties, royal colleges and professional associations offering professional healthcare qualifications such as dietetics, nursing, physiotherapy, podiatry and occupational health; voluntary organisations; commercial training organisations. 1.18.1 The national accreditation body for type 2 diabetes prevention (see recommendation 1.17.1) should work with others to:

- ensure training about risk factors for type 2 diabetes and how to prevent or delay it, is part of the core curriculum for healthcare undergraduates and postgraduates
- provide training for health professionals and community practitioners on how to provide brief advice and brief interventions

- provide accredited training which meets nationally defined criteria for health professionals and community practitioners who are delivering risk assessments and intensive lifestyle-change programmes, and for other providers of advice on diet and physical activity who may wish to develop a type 2 diabetes prevention programme.

1.18.2 The national accreditation body for type 2 diabetes prevention and others should ensure training on delivering risk assessments, intensive lifestyle-change programmes, dietary and physical activity advice increases participants' understanding of type 2 diabetes and its complications. It should also cover: behaviour-change theories and techniques, awareness-raising, how to communicate risk and how to tailor interventions to meet individual need. In addition, participants should learn how to assess, audit and evaluate type 2 diabetes prevention programmes. [2012]

1.19 Metformin

1.19.2 Discuss with the person the potential benefits and limitations of taking metformin, taking into account their risk and the amount of effort needed to change their lifestyle to reduce that risk. Explain that long-term lifestyle change can be more effective than drugs in preventing or delaying type 2 diabetes. Encourage them to adopt a healthy diet and be as active as possible. Where appropriate, stress the added health and social benefits of physical activity (for example, point out that it helps reduce the risk of heart disease, improves mental health and can be a good way of making friends). Advise them that they might need to take metformin for the rest of their lives and inform them about possible side effects. [2012]

1.19.3 Continue to offer advice on diet and physical activity along with support to achieve their lifestyle and weight-loss goals. [2012]

© NICE 2025 *Type 2 diabetes: prevention in people at high risk [PH38]*
Available from <https://www.nice.org.uk/guidance/ph38> rights reserved.
Subject to [Notice of rights](#)

Children & Young People

Unintentional injuries: prevention strategies for under 15s Public health guideline [PH29] Published: 24 November 2010 Last reviewed 10 October 2019

Recommendation 12 Developing policies for public outdoor play and leisure

Who should take action?

- Head teachers and school governors.
- Local strategic partnerships.
- Play and leisure providers in the public, private, voluntary and community sector. This includes representatives of the leisure industry, parish and town councils and early years services. It also includes private providers of outdoor play facilities that are open to the public, such as pubs and hotels.
- Public, private, voluntary and community sector managers and decision makers responsible for play and leisure policies.

What action should they take?

- Ensure a policy is in place which:
 - takes a balanced approach to assessing the risks and benefits of play and leisure environments and activities (see NICE's guideline on physical activity for children and young people)
 - counters excessive risk aversion
 - promotes the need for children and young people to develop skills to assess and manage risks, according to their age and ability
 - takes into account children and young people's preferences about the types of outdoor play and leisure activities they want to participate in
 - is inclusive, taking into account the needs of all children and young people, including those from lower socioeconomic groups, those from minority ethnic groups with specific cultural requirements and those who have a disability.

- Use local information and data on environments, equipment and behaviour that pose a risk of serious unintentional injury to help plan prevention initiatives. Include information and data provided by practitioners, play and leisure providers, children, young people, their parents and carers.
- Focus prevention initiatives on groups most at risk of an unintentional injury. Initiatives could include modification of equipment and the environment, and the provision of information, education and safety equipment.
- Take into account the principles of British and European standards covering equipment and the environment (where they exist) as part of a risk-benefit assessment of outdoor play and leisure environments. This includes standards covering playgrounds, fairgrounds, toy safety and swimming pools, as well as those for inspection and maintenance.
- Where equipment and the environment cannot be modified, provide information, advice and education about risk management and the use of any appropriate safety equipment.

Cancer Service Guidelines

Surgery A. Recommendations

Post-operative care

After surgery, women should be given information on wound care, advice on exercise, and information on dealing with the after-effects of surgery. Support and counselling should be available and women should be given opportunities to talk over their feelings and fears with an experienced breast care nurse.

Follow-up after treatment for early breast cancer

Recommendations

Process

- Evidence that non-hormonal treatments for hot flushes (including non-drug methods such as relaxation and exercise) are discussed with sufferers.

NICE Indicators

Hypertension: assessment of physical activity NICE indicator IND95

Published: 1 August 2011 Last updated: 4 November 2020

Indicator

The percentage of patients with hypertension aged 16 to 74 years in whom there is an annual assessment of physical activity, using GPPAQ, in the preceding 15 months.

Indicator type

General practice indicator suitable for use in the Quality and Outcomes Framework.

© NICE 2024 Hypertension: assessment of physical activity [IND95]

Available from [https://www.nice.org.uk/indicators/ind95-](https://www.nice.org.uk/indicators/ind95-hypertension-assessment-of-physical-activity)

[hypertension-assessment-of-physical-activity](https://www.nice.org.uk/indicators/ind95-hypertension-assessment-of-physical-activity) rights reserved.

Subject to [Notice of rights](#)

**Hypertension: brief intervention to increase physical activity NICE
indicator IND96 Published: 1 August 2011 Last updated: 4 November 2020**

Indicator

The percentage of patients with hypertension aged 16 to 74 years who score 'less than active' on GPPAQ in the preceding 15 months, who also have a record of a brief intervention in the preceding 15 months.

Indicator type

General practice indicator suitable for use in the Quality and Outcomes Framework.

© NICE 2024 Hypertension: brief intervention to increase physical activity [IND96] Available from <https://www.nice.org.uk/indicators/ind96-hypertension-brief-intervention-to-increase-physical-activity> rights reserved. Subject to [Notice of rights](#)

Cardiovascular disease prevention: primary prevention with lifestyle changes NICE indicator IND228 Published: 23 August 2022 Last updated: 5 June 2023

Indicator

The percentage of patients with a cardiovascular disease risk assessment score of 10% or more identified in the preceding 12 months who are offered advice and support for smoking cessation, safe alcohol consumption, healthy diet and exercise within 3 months of the score being recorded.

Indicator type

General practice indicator suitable for use in the Quality and Outcomes Framework.

© NICE 2024 Cardiovascular disease prevention: primary prevention with lifestyle changes [IND228] Available from <https://www.nice.org.uk/indicators/ind228-cardiovascular-disease-prevention-primary-prevention-with-lifestyle-changes> rights reserved. Subject to [Notice of rights](#)