CLINICAL GUIDELINE **Subject:** Care of Women with a raised BMI during the childbearing process (BMI 30 and over) **LOCAL**	Bedford Hospital NHS NHS Trust
Reviewed by: Gill Shinkwin – Chief Dietitian, Bedford Hospital NHS Trust Carol Leverkus: Public Health Dietitian M Moore – Midwifery Team Manager	**Key Reference:** CEMACH/RCOG 2010 NICE 2010
Date of Approval: August 2012	**Review Date:** August 2015

Purpose

The aim of this guideline is to ensure evidence based effective care is provided for women with an increased BMI in line with recommendations from CMACE/RCOG 2010. This will in turn help in reducing the morbidity and mortality Women with a BMI of equal or greater than 30, or who weigh greater than 100kgs are the target population for which this guideline should be used

Objectives

To Identify pregnant women with BMI > 30 at booking in order to provide appropriate care thereby reducing clinical risks to the women with high BMI and occupational health and safety for staff.

For Use By

Obstetricians, Anaesthetists, Other Medical Staff, Midwives, Nurses and Maternity care assistants

Related Policies

Any policies or guidelines that directly impact or are impacted by this Guideline

- Anaesthetic management of obese parturient
- Moving and Handling of Patients and Loads
- Safe Handling of bariatric patients (person weighing over 25 stones)
- Prevention and treatment of Venous thromboembolism in pregnancy and puerperium
- Antenatal care
- Care of Women in labour in all care settings
- Routine postnatal care of women and her baby
- Newborn Feeding

Definitions

Any Acronyms or Abbreviations used in Guideline

Obesity is measured by calculating the body mass index (BMI) using the formula:

BMI=weight(kg)/ height(m)]²	**Classification**	
<18.5	Underweight	
18.5-24.9	Normal Weight	
25 - 29.9	Overweight	
30-34.9	Obese	CLASS 1
35 – 39.9	Obese	CLASS 2
40 or more	Morbidly obese	CLASS 3

VTE – Venous thromboembolism
LMWH – Low molecular weight heparin

Status / Version Control

	Guideline	Date Passed
1	Care of women with a raised BMI during the childbearing process	Oct-2009
2	Care of women with a raised BMI during the childbearing process (BMI 30 and over)	Nov-2010

Contents

INTRODUCTION

Women with a BMI of equal or greater than 30, or who weigh greater than 100kgs are the target population for which this guideline should be used.

Recommended weight gain during pregnancy (based on weight at booking)

- Women of normal weight: 9-11.5kg
- Women with Low BMI (under 18.5): 11.5 -14kg
- Women with high BMI (25 and over): 5-11.5kg, see Appendix 1 page 11

1. BACKGROUND

1.1 Obesity in pregnancy has been selected as CEMACH's principal project with a maternal health focus for 2008-2011.

Maternal obesity has become one of the most commonly occurring risk factors in obstetric practice. Obesity in pregnancy is usually defined as a Body Mass Index (BMI) of 30 kg/m² or more at the first antenatal consultation (CMACE/RCOG 2010).

Obesity in pregnancy is a growing problem and contributes to increased maternal as well as fetal mortality and morbidity.

1.2 The CEMACH Maternal Death Enquiry (*Why Mothers Die) (*2007) found that approximately 35% of women who died (who had a recordable Body Mass Index) in the 2000-2003 triennia were obese (i.e. had a BMI of 30 or greater).

1.3 The CEMACH (2005) *Perinatal Mortality Report* found that approximately 30% of the mothers who had a stillbirth or a neonatal death were obese. Recent CEMACH (2007) report indicated that more than half of the women who died from direct / indirect causes were obese and highlighted the need for National Guideline for management of obesity in pregnancy.

1.4 NICE guidance (2008) recommends that all pregnant women have their BMI calculated at booking. It also recommends that pregnant women with raised BMI should be under Consultant care.

1.5 13.5% of pregnant women during 2007/8 at Bedford Hospital were obese (Audit 2009). 10% of women booked for delivery at Bedford Hospital had a BMI of 35 and over. In 2011. As expected there was an increase in instrumental delivery rate in these women. Increasing BMI may be contributing to the increase in Caesarean section rate (more so with BMI >50 Bedford Hospital local Audit 2009).

1.6 Key risks for women with BMI over 30 (Dr Penelope Law NOF Conference 2010)

- Obesity is one of the most common obstetric risk factors
- 4 to 7 fold ↑ of gestational diabetes
- 4.4 fold ↑ of pre-eclampsia
- 2 fold ↑ of still birth and intra uterine death
- Background rate nationally of LSCS 25-30% but around 50% in obese women
- Increase in wound infections and a longer hospital stay of 4-5 day
- 3.8 fold ↑ in ITU admissions
- Difficulty in breast feeding with lower rates initiating

2. INCREASED RISKS FOR WOMEN WHO HAVE BMI GREATER THAN 30

2.1 Antenatal:

- Miscarriage
- Gestational Diabetes
- Hypertension / pre-eclampsia
- Venous thromboembolism
- Sleep apnoea
- Abnormal fetal growth :macrosomia or intra uterine growth restriction
- Urinary Tract Infections
- Fetal congenital anomaly (neural tube defects)

2.2 Intra partum and post partum

- Induced labour
- Dysfunctional labour
- Thromboembolism
- Difficulty monitoring the fetus during ante and intrapartum period
- Operative delivery
- Surgical difficulties
- Fetal macrosomia
- Shoulder dystocia
- Post Partum Haemorrhage
- Post Caesarean wound infection
- Intrauterine death / Stillbirth
- Increased incidence of perineal trauma
- Increased incidence of genital and urinary tract infection
- Reduced breast feeding rate

2.3 Neonatal problems:

- Stillbirth
- Congenital abnormalities
- Prematurity
- Macrosomia
- Neonatal death
- Increased risk of obesity and metabolic disorders in childhood

2.4 Inter-pregnancy weight gain (Villamor et al 2006)
A Swedish study demonstrated a linear relationship between inter-pregnancy weight gain and the risk of pre-eclampsia, gestational diabetes, large for gestational age babies, LSCS and stillbirths.

3. PRE CONCEPTIONAL ADVICE mainly offered in the primary care setting e.g. by GP's

3.1 Women with a raised BMI should receive information and advice about the risks of obesity during pregnancy and childbirth and be supported by primary care to lose weight before conception. The information leaflet produced by the hospital can be used for this purpose and supported by interventions and advice from primary care.

3.2 Women with a BMI of 30 and above wishing to become pregnant should be advised to take **5mgs per day folic acid** supplementation, starting at least one month before conception and continuing during the first trimester of pregnancy due to the increased risk of neural tube defects.

4. ANTENATAL CARE

4.1 Booking and referral criteria - Please also see Healthy Weight Pathway Appendix 1

- **At booking**, the woman should have her weight, height and BMI accurately recorded and documented in the hand held notes and the clinic summary sheet. This is then transferred to maternity administration where it is uploaded onto the electronic patient information system.

- **The BMI is calculated by** dividing the booking weight in kg by the height of the woman in metres squared e.g. 58.5kg / (1.62m x 1.62m) = 22.3. Tables for this calculation are available.

- Women with a **BMI ≥30** should be booked for **Consultant led care** and a management plan made by the Consultant in the first trimester. Give information leaflet, Appendix 2. Refer to an accessible healthy weight pregnancy group i.e. Kickstart

- Women with a BMI 35 (NICE 2007) or more will be advised to have a consultant led hospital birth. Women should be advised to take an increased supplement of **folic acid** (5mg/day) ideally from preconception to end of the first trimester in view of the increased risk of Neural tube defect

- Women should be encouraged to take 10micrograms **Vitamin D** supplementation daily during pregnancy and whilst breast feeding.

- Women with a **BMI ≥30** will have an open discussion on obesity including associated problems and risks to both the woman and the baby. Written information will be provided in the **hospital leaflet** which includes:

    - the increased risk of pre-eclampsia, gestational diabetes and fetal macrosomia requiring an increased level of maternal and fetal monitoring;
    - the potential for poor ultrasound visualisation of the baby and consequent difficulties in fetal surveillance and screening for anomalies;
    - the potential for difficulty with intrapartum fetal monitoring, anaesthesia and caesarean section which would require senior obstetric and anaesthetic involvement and an antenatal anaesthetic assessment;
    - The need to prioritise the safety of the mother at all times. Women should be made aware of the importance of healthy eating and appropriate exercise during pregnancy in order to prevent excessive weight gain and gestational diabetes.
    - Limiting weight gain to the levels stated on appendix 1 page 11 will reduce risk; a greater weight gain will further increase the risks.
    - Dietetic advice by an appropriately trained professional should be offered early in the pregnancy

- A **written plan of care** for pregnancy, labour and delivery will be agreed and documented in the Green Pregnancy notes.

- **Diet** should be discussed in detail and exercise advice given and documented. Offer appropriate information leaflets e.g. *'Healthy eating in pregnancy'* or highlight the section on eating in pregnancy in the Department of Health *'Pregnancy Book'* (p8-12).

- **Refer women to the dietitian** (See appendix 3) for referral form when **BMI over 40** or if concerns are raised about eating habits. Dieting and weight reduction in pregnancy is not advised but sensible eating patterns, normal portion size and approximately 200 calories extra in the third trimester if the woman has not reduced her activity. For women who have a BMI of 30 or more and there are concerns, or whose weight is increasing above the desired rate, offer referral to the Dietitian or Kickstart programme.

4.2 Risk Assessment

- **A full risk assessment** will be made at every visit and every stage of the pregnancy, labour and postnatal period and any changes agreed in the management plan will be documented. A hospital antenatal clinic appointment after 30 weeks is necessary to weigh the woman and ensure that appropriate delivery beds and ward beds will be available

- **Weight, blood pressure and urine analysis** should be recorded at every visit.

  When measuring blood pressure, an appropriately sized cuff must be used as follows:

Cuff	Arm circumference at mid point (cm)
Adult	27-34 cm
Large Adult	35-44 cm
Adult thigh cuff	45-52 cm

- **Thromboprophylaxis:** Women with a booking **BMI 30** and over will be risk assessed at booking and at every antenatal admission. Antenatal and post-delivery thrombo-prophylaxis will be considered in line with RCOG (2009) guidance by the Obstetricians

  - A woman with a **BMI 30** and over who also has 2 additional risk factors for VTE should be considered for low molecular weight heparin (LMWH) antenatally as early as practicable and continued until delivery.
  - All women receiving LMWH antenatally should continue prophylactic doses of LMWH until 6 weeks postpartum with a risk assessment being made at delivery. Doses are weight dependant (RCOG 2009).
  - Women with a booking BMI 30 and over requiring antenatal thromboprophylaxis should be prescribed doses appropriate for maternal weight in accordance with RCOG Green Top 37 guidance:

Weight	Dose
50 – 90Kg	3,500 units Tinzaparin daily Or 20mg Enoxaparin daily
91 – 130Kg	7,000 units Tinzaparin daily or Enoxaparin 60mg daily
131 – 170	9,000 units Tinzaparin daily or Enoxaparin 80mg daily
>170	75 units/kg/day Tinzaparin or Enoxaparin 0.6mg/kg/day

- **The need for Ultrasound scans for fetal growth** in the 3rd trimester will be established in the hospital ante natal clinic at 32 weeks).

- **Gestational Diabetes:** Test for gestational diabetes by performing a Glucose Tolerance Test at 28 wks (NICE 2008, CEMACH 2007).

- **Pre-eclampsia risks (NICE 2010):**
  - A woman with a BMI of 30 or more will be under consultant led care. Women with a BMI 35 and over with one additional risk factor for pre-eclampsia are at an increased risk of developing the condition. Additional risk factors include:
    - Primigravida
    - Age over 40yrs
    - Pregnancy interval over 10 years
    - Family history of pre-eclampsia
    - Multiple pregnancy

- A woman with a BMI of 35 and over with no additional risk factors will be monitored by the community midwife at antenatal clinics 3 weekly between 24 – 32 weeks and fortnightly from 32 weeks to delivery.

- NICE 2010 suggest that where there are additional risk factors for pre-eclampsia (as above) that women may benefit from 75mg aspirin daily from 12 weeks gestation

- **Women who have had a previous LSCS:** Women with a BMI 30 and over will have an individualised decision for vaginal birth after LSCS **(VBAC)** following an informed decision of all the risk factors.

4.3 Antenatal Anaesthetic Review

- Pregnant women with a booking BMI of 40 and over will be offered an antenatal consultation with an obstetric anaesthetist in the obstetric anaesthetic clinic, so that potential difficulties with venous access and endotracheal intubation, regional or general anaesthesia can be identified.

- An anaesthetic management plan for labour and delivery should be discussed and documented on the Anaesthetic Assessment Chart and a summary placed in the Green Pregnancy notes on page 13 – Management Plan.

4.4 Antenatal admission:

- **Thromboprophylaxis** must be considered in accordance with the *'Prevention and treatment of venous thromboembolism in pregnancy and puerperium' (RCOG 2004).*

4.5 Manual handling / Tissue viability issues

- Women with a **BMI over 40** at booking should have a documented assessment in the third trimester of pregnancy to determine manual handling requirements for childbirth and to consider tissue viability issues. This will include re weighing to calculate drug doses & assess the need for any additional equipment

- Women with a **BMI over 30** should have a Manual handling and Tissue Viability assessment performed on any admission using the Maternity Manual Handling Tissue viability form

4.6 Equipment

- A full list of available equipment and maximum loads is available in the Safe Handling of Bariatric Patients. The delivery beds all have a maximum weight bearing capacity of 180kgs and the Delivery Suite theatre bed has a maximum weight bearing capacity of 200kgs

- When booking an induction or Caesarean section the delivery suite and obstetric theatre should be informed of the latest weight so that appropriate bariatric equipment, such as a wheelchair, theatre table, armchair, commode and hoist can be checked and in place at the time of admission

- All departments involved in the care of the woman (i.e. Scan, porters) should be informed in time to make necessary arrangements (see Trust Policy on Moving and Handling of patients).

5. INTRAPARTUM CARE

5.1 Risk assessment and referral

- Have a written plan of care for labour and delivery documented in case notes by the obstetric team so that it is available to all staff. Document the discussion about possible intrapartum complications and management strategies appropriate
- Ideally continuous midwifery care is recommended for women in this high risk category
- The duty **Anaesthetic consultant and Obstetric consultant** should be informed of all women with a **BMI of 40 and over** as soon as is reasonable if labour is progressing normally. They should be kept informed of any changes in clinical condition. This communication should be documented in the labour notes. The Anaesthetist also has a responsibility to familiarise him or herself with the women on Delivery Suite.
- Ensure that correct large size BP pressure cuff is available and used.
- There should be a low threshold for the use of the fetal scalp clip as abdominal monitoring is likely to be technically more difficult and less reliable.
- Anticipate shoulder dystocia, difficult spinal/epidural, difficult intubation, and difficulty during LSCS and post partum haemorrhage and make necessary preparations in anticipation of such events.
- Assess pressure areas and maintain skin integrity; check pressure areas two hourly and document.
- Manual handling assessment to ensure correct equipment is available and used.
- Adequate analgesia should be provided; if regional analgesia is the preferred choice of pain relief, epidural catheter should be sited early.

5.2 Mode of delivery

- In the absence of other obstetric or medical complications obesity is **not an indication for induction of labour** and a vaginal birth should be encouraged.
- In view of the higher rate of operative delivery and caesarean section, intravenous access should be considered when labour is established if BMI>40 (RCOG 2010).
- Inform theatre staff of any woman booked for an operative procedure whose weight exceeds 120kg to ensure appropriate equipment is available.
- Anaesthetic & Obstetric medical staff of grade St 3 or higher should be available on the Delivery Suite at time of delivery in case difficulties occur. Active management of the third stage of labour is recommended.

6. POSTNATAL CARE

- Give advice on signs of Deep Vein Thrombosis and Pulmonary Embolism
- Early mobilisation to reduce the risk of VTE
- Risk assess for thromboprophylaxis after delivery:
  - All women with a **BMI 40** and over at delivery should be offered postnatal thromboprophylaxis for 7 days following a normal delivery or longer in the case of a complex delivery
  - Women with a **BMI of 30** and who have 1 or more additional risk factors for VTE should be considered for LMWH for seven days following delivery

- Women with a **BMI of 30** and over who have 2 or more risk factors for VTE should be given graduated compression stockings in addition to LMWH for 7 days

- Consider referral for postnatal physiotherapy where appropriate e.g. if a third/fourth degree tear or incontinence
- Assess wound and observe for signs of skin breakdown and infection more rarely dehiscence, advise the women to ensure that the wound is kept dry.
- Vigilance regarding signs of secondary postpartum haemorrhage

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- Advise on life style modification
  - **Lose weight after pregnancy**: encourage breast feeding, explore community initiatives that may include referral to Weight Watchers or the dietitian
  - **Women with pre pregnant BMI of 25 – 29.9** should also be made aware that returning to a normal BMI is recommended.
  - **Encourage exercise**; refer to the Kickstart postnatal exercise programme in Bedford Borough or physiotherapist as required. The aim of care is to return to their pre pregnant weight or lower and preferably to reduce weight before the next pregnancy to within the normal ranges i.e. BMI 25 or less.
- Contraception –avoid Combined Oral Contraceptive Pill if the BMI is >30
- Women with a booking BMI of 30 and over and gestational diabetes should be followed up by the GP with a fasting plasma glucose at approximately 6 weeks after birth and then be followed up as appropriate to screen for development of Type 2 Diabetes Mellitus.

7. FACILITIES AND EQUIPMENT

The Safe Handling of Bariatric Patients policy contains a list of all available Trust manual handling equipment for obese women including the weight limits and location of each item.

8. TRAINING

Staff should have yearly manual handling training and training on the use of specialist equipment for obese people.

9. DISSEMINATION

The guideline has been reviewed and discussed at the Labour ward Forum by the obstetric, anaesthetic and midwifery staff. It has been circulated and commented on by the dietetic department and agreed at Clinical risk and governance meeting. A copy of this guideline will be posted on the hospital intranet. It is the responsibility of all staff working within the maternity and neonatal units to be aware and familiarise the guidelines. It will be published through the Chief executive's bulletin, at ward handovers and through the community midwives network.

Appendix 1 - Healthy Weight Pathway of Care for Pregnant Women with a BMI over 30

ANTENATAL CARE: over and above routine care offered to all women

At Booking (10-12 weeks)

- Height, weight, BMI recorded in hand held notes and CMIS

If BMI over 30:

- Give information leaflet, discuss risks and ways to minimise risks
- Discuss Eat Well Plate, reducing crisps, sweets, fizzy drinks
- Discuss exercise
- Discuss weight management in pregnancy
- Refer to an accessible healthy weight in pregnancy group (KickStart), or signpost to other support in discussion with mother
- Document all the above
- Give Your Pregnancy booklet

- Book for consultant led care – refer to ANC
- Ensure taking 5mg folic acid till 12 weeks gestation
- Taking Vit D 10 micrograms daily
- Assess VTE risk
- Document Management Plan in Green Pregnancy Notes
- Reweigh at 28 and 36 weeks

If BMI over 35:

- All above and
- Discourage home birth
- Recommend hospital birth under consultant care
- Discourage water birth
- Refer to dietitian e.g. 1:1 clinic or KickStart if any concerns for weight management and support

If BMI over 40:

- Offer referral to Dietitian explaining support available, if declined this should be documented
- Refer to Obstetric Anaesthetic Clinic in 3rd trimester

First Antenatal Appointment with Consultant obstetrician:

- Discuss with mother and complete management plan in Green Pregnancy Notes
- Plan repeat visits on individual need

Each Antenatal Visit:

- Full risk assessment documented in the Green Pregnancy Notes
- Individual plan of care for those VBAC

28 weeks:

- GTT to screen for gestational diabetes
- Weigh
- Refer to accessible healthy weight in pregnancy group or signpost to other support in discussion with Mother. **This can include women with excess weight gain and BMI below 30 at booking**

32 weeks:

Consider growth scans may be required at 28, 32, 36 weeks

36-38 weeks:

- Weigh
- All women with BMI 40 and over to attend Obstetric Anaesthetic clinic
- Manual handling risk assessment and any extra equipment identified

- Encourage skin to skin contact and breast feeding
- Refer for additional support after discharged from midwifery care to Baby Brasseries

- Encourage to mobilise as soon as possible to reduce DVT, recommend thromboprophylaxis for women with a **BMI** of **40** & over
- Pelvic floor exercises as soon as possible
- Inform of signs of pulmonary embolism and what to do if signs occur
- Consider referral to dietitian or activity sessions run by Bedford Borough

- Continue to reinforce healthy eating advice
- Recommend gentle exercise as soon as possible (if appropriate refer to Care after caesarean section and wait 6 weeks before lifting, driving or exercise involving abdominal muscles)

- Follow up by GP at 6-8 weeks if gestational diabetes in pregnancy
- Appropriate contraception prescribed

Guidance on Weight milestones in pregnancy

	BMI 18.5 -24.9	**BMI 25-29.9**	**BMI 30 and over**
Total weight gain anticipated	11.5 – 16kg (25-30lbs)	7-11.5kg (15-25 lbs)	5-7kg (11-15lbs)
0-20 weeks	0.5kg per month =2.5kg (5½ lbs)	1.8kg (4 lbs)	1.25 kg (3lbs)
20 – 40 weeks	0.5kg per week = 10kg (22lbs)	0.425kg per week 8.5kg (19lbs)	0.237kg per week 4.75kg (10½ lbs)
At 28 weeks approx	6.5kg	5.2kg	3 - 4kg
At 36 weeks approx	10.5kg	8.6kg	4 - 6kg

(Adapted from Institute of Medicine (May 2009)

Updated 19 June 2012

Appendix 2 - Healthy Weight in Pregnancy – Contacting a Dietitian

Are you pregnant or planning to start a family and have concerns about your weight management?

If you are unable to attend a KickStart group or a Dietetic Clinic or want to know more about the options for support then we can email or telephone you.

We can:

- tell you more about the KickStart groups and clinics or when we are available at early parent education classes in your area.
- have a conversation over the phone about your diet and any particular issues that concern you.
- discuss referral to a free postnatal activity programme for women with a raised BMI.

Please contact the public health Dietitian on: **dietetics@bedfordhospital.nhs.uk or on 01234 792171** and inform us when you can be contacted on a Tuesday, Wednesday and Thursday. Please note Carol Leverkus, Public Health Dietitian is only available 2 days per week

Nutrition and Dietetic Department and Maternity Services 7/6/12

Appendix 3 - Referral for Dietetic Treatment In North and Mid-Bedfordshire

NUTRITION & DIETETIC DEPARTMENT
Bedford Hospital NHS Trust
South Wing

Please return this referral form to the Dietetic Department
completed with the Mother's signed consent
I wish to refer:-

Surname:		**Sex:**	F
First name:		**NHS no:**	
Date of birth:		**Hospital no**	
Address:			
Post code:		**Tel no:** **Mobile:**	
E mail:	***Please include whenever possible***		
Reason for referral:	**Pregnant /BMI 30 and over/Postnatal**		
Medication:			
Relevant background / information:(Including recent weight, height, BMI, weight history, biochemistry. If new to diabetes or IGT please give diagnosis blood results)	**Gestation:** **Preconception** **or Days postnatal:** **BMI:** **Ht:** **Weight:**		
General practitioner:			
Address:		**Tel no:**	
Referred by (PRINT NAME):		**Signed:**	
Designation (e.g. MW/Dr):			
Date of referral:			
Is GP aware of referral:	***Yes/No/to be informed***		
Obstetric consultant			

If the referrer is not a GP or Consultant, the relevant medical practitioner, i.e. GP or consultant, **MUST** be made aware of this referral. The letter following the intervention by the dietician will be sent to the referrer and a copy to the GP/Consultant.

Please tick one of the following,:

- **The Mother wishes to be referred to KickStart - Healthy Weight in Pregnancy Group** ☐

Please state the date and venue preferred:

Sessions starting week beginning:	
Venue:	

- *The Mother wishes to be referred to Dietetics Clinic:1 to1,* ***waiting time about 2 months*** ☐
- *Mother given Contacting Dietitian handout (A5 size) to request support regarding weight management by email or telephone call* ☐

I wish to be referred to the above:

Signature of Mother to be	***Date***

Version 30/8/2012

To be circulated to Midwifery team leaders and Obstetrics as courses are booked

Appendix 4 - Healthy Weight in Pregnancy Course-Information for Midwives

The dates for the next courses are:

1. **Bedford at…….. From……. for 6 weeks……**
2. **Sandy Community Children's Centre** Laburnum Road, Sandy SG19 1HQ (behind Laburnum School: **No parking** on South Road) Tel 01767 699019, 7-9pm
   From …… for 6 weeks
3. **Flitwick/Ampthill at …… From ……. for 6 weeks**

The Flitwick/Ampthill and Sandy /Biggleswade courses will be available for antenatal and postnatal women and those planning to start a family in order to accommodate the infrequency of the groups in their area.

Who is eligible?

All pregnant women with a BMI of 30 or more (booking/pre-pregnancy weight) who can access courses run at the venues above.

Booking a mother onto a course

1. Discuss the options with the mother to be. Inform them that everyone is respected as an individual with their own needs. There is no pressure in the groups and they are based on the group member's own priorities.
2. For women consenting to a referral complete a referral for the nutrition and dietetic department, add an email address where available and ask her to sign the form.
3. On the form state whether you are referring for the group sessions and state which course or for one to one dietetic support if they are unable to attend a group. (Alternatively they can be given the contact details for Public Health Dietetics to contact us for advice or to discuss options.)
4. Fax the referral form to dietetics on 01234 795855 or by internal post via Debbie /Paola on maternity reception.
5. For women, attending a group, provide a copy of the course outline and insert the chosen venue, time and date where known. Explain she would be expected to attend each week or inform us if something unexpected occurs.

How will the women be informed that they have a place?

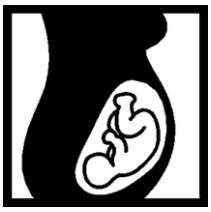
They will be sent a welcome letter confirming their place or they will receive a phone call or email if there is a tight turn round.

For more information please contact Carol Leverkus RD, Public Health Dietitian for the Pregnancy Project at dietetics@bedfordhospital.nhs.uk or carol.leverkus@bedfordhospital.nhs.uk

Tel 01234 792171

P. And CL WB, all maternity, standard letters, information for midwives 30/8/12

Appendix 5 - Referral to Postnatal Activity Programme for Women Unable to Attend Antenatal Dietetic Intervention



Bedford Hospital NHS
NHS Trust

*Kick*start Healthy weight in pregnancy and physical activity programme

Personal Details Form

In order to meet the requirements of the Data Protection Act, we require your consent to pass your contact details onto Bedford Borough Council for the physical activity part of the *Kick*start programme.

Please complete this form so that Bedford Borough Council's Sports Development Unit can provide you with information on the exciting exercise programme, involving 12 free postnatal activity sessions. These are part of the Healthy Weight in Pregnancy *Kick*start programme.

Clinic Attended ……..Unable to attend antenatal dietetic support ……..…

Name: ……..…

Address:……...……

……

…….Postcode: _____

Email Address: ……..

Phone Number (Home): ……

Phone Number (Mobile): ……

EDD or when was your baby born? ……

GP and Practice……

I understand that these details will be given to Bedford Borough Council's Sports Development Unit, for use during the *Kick*start programme

The project has been explained to me and I have had an opportunity to ask questions. I understand I may withdraw at any time. I give my consent for the above information to be passed onto Bedford Borough Council's Sports Development Unit and stored in accordance with the data protection act.

Mother's signature……. Date ……

Thank you for you participation in this project

Also Bedford Hospital may keep a copy of this form for the life of the *Kick*start *project*

Please pass this form to Nutrition and Dietetics Bedford Hospital 30/8/12

References *i.e. NICE guidance, externally recognised reports or research*	Confidential Enquiry into Maternity and Child Health (2007) Saving mother's lives *2003 -2005 (p42-46)* London: RCOG Press Available at: www.cemach.org.uk CMACE/RCOG (2010) *Joint guideline: Management of Women with Obesity in Pregnancy* CMACE/RCOG London Department of Health (2007). *Maternity Matters: Choice, access and continuity of care in a safe service*. London: COI. Available at: www.dh.gov.uk National Institute for Health and Clinical Excellence (2010) *Weight Management in pregnancy and after childbirth* London: NICE. Available at: www.nice.org.uk National Institute for Health and Clinical Excellence (2007) *Intrapartum care: Care of healthy women and their babies during childbirth*. London: NICE. www.nice.org.uk National Institute for Health and Clinical Excellence (2008) *Diabetes in pregnancy Clinical guideline No 63*. London: NICE. Available at: www.nice.org.uk National Institute for Health and Clinical Excellence (2008) *Antenatal care: Routine care for the healthy pregnant woman*. London: NICE. Available at: www.nice.org.uk Royal College of Obstetricians and Gynaecologists, Royal College of Anaesthetists, Royal College of Midwives, Royal College of Paediatrics and Child Health. (2008). *Standards for Maternity Care: Report of a Working Party.* London: RCOG Press. Available at: www.rcog.org.uk Royal College of Obstetricians and Gynaecologists (2009) *Thromboprophylaxis during pregnancy, labour and after vaginal delivery* London: RCOG www.rcog.org.uk Royal College of Obstetricians and Gynaecologists (2001) The use of electronic fetal monitoring (2001) RCOG London Royal College of Obstetricians and Gynaecologists (2004) Confidential Enquiries into Maternal Death, Sixth Report, Why Mothers Die (2002-2003) RCOG London. The Association of Anaesthetists of Great Britain and Ireland, and the Obstetric Anaesthetists' Association (2005) *OAA/AAGBI Guidelines for Obstetric Anaesthetic Services (Revised edition)* London: AAGBI/OAA. Available at: www.aagbi.org.uk and www.oaa-anaes.ac.uk Villamor E, Cnattingius S, (2006) Interpregnancy weight change and risk of adverse pregnancy outcomes: a population based study Lancet 2006:368 (9542): 1164-1170 Yu, C.K., Teoh, T.G. and Robinson, S (2006) Obesity in Pregnancy *BJOG* 2006 Oct., 113(10):1117-25.

Staff Involved In Development	S Reynolds: Lead Obstetrician for Delivery Suite V Babbur: Specialist Registrar Obstetrics and Gynaecology L Fitzgerald: Assistant General Manager/CNST lead Gill Shinkwin – Chief Dietician, Bedford Hospital NHS Trust Carol Leverkus: Public Health Dietician Marion Moore – Team Manager Midwifery

Monitoring / Audit Criteria

Aspect	Method	Frequency	Responsibility	Reporting Arrangements
All women will have their BMI calculated and recorded in the green antenatal notes	Case note review	Annually	Via department clinical audit meetings	Via department clinical audit meetings
All women with a BMI over 30 will be booked for consultant led care	Case note review	Annually	Via department clinical audit meetings	Via department clinical audit meetings
All women with a BMI over 35 will booked for a hospital birth	Case note review	Annually	Via department clinical audit meetings	Via department clinical audit meetings
The maternity department will have a list of the availability of suitable equipment to care for women with a BMI over 35	Case note review	Annually	Via department clinical audit meetings	Via department clinical audit meetings

Approving Signatories

Maternity/Gynaecology & Sexual Health Sub Committee Approving this Guideline: _____

Date: 5/9/2012	**Date:**
Signature: 	**Signature:**
Print Name: J. MCMAHON	**Print Name:**
(Chairperson of Board or Committee indicated above)	**(Chairperson of Board or Committee indicated above)**

Name of Other Sub-Committee / Business Unit involved in Approval of Guideline: _____

Date:	**Date:**
Signature:	**Signature:**
Print Name:	**Print Name:**
(Chairperson of Board or Committee indicated above)	**(Chairperson of Board or Committee indicated above)**

Ratification Signature
Approved by Deputy Director of Clinical Governance

Date:	14.9.12.
Signature:	SBlackley
Print Name	**Sue Blackley**

Consultation List

A completed list should accompany **every** guideline/policy
(This gives evidence on who has seen this Guideline and any comments made)

Bedford Hospital NHS
NHS Trust

Name of Person	Department or Committee	Comments
Rachel Morris	Midwife/Team Lead	No Comments
Anand Jetti	Consultant Obstetrician	No Comments
Angela Esposito	Midwife/Team Lead	No Comments
Suzy Adacen	Acting Ward Manager- Orchard	No Comments
Miss Babbur	Consultant Obstetrician	No Comments
Sarah Reynolds	Consultant Obstetrician	**Comments added**
Carla Ball	Midwife/Team Lead	No Comments
Jess Carlyle	Midwife	No Comments
Carol Leverkus	Public Health Dietitian	**Comments added**
Mr Patil	Consultant Obstetrician	No Comments
Deborah Sharp	Infant Feeding Co-ordinator SoM	**Comments added**
Mr Neale	Medical Director/Consultant Obstetrician	No Comments
Emily Murugiah	Midwife Team Lead- Delivery Suite	No Comments
Elizabeth Carlyle	Midwife- Orchard Ward	No Comments
Naomi Gallagher	Head of Midwifery/SoM	No Comments
Helen Leonard	Midwife/SoM	No Comments
Hema Nosib	Consultant Obstetrician	No Comments
Jullien Brady	Consultant Obstetrician	No Comments
Karen Nelson	Community Midwife SoM	No Comments
Lynda Fitzgerald	CBU Manager W&C	No Comments
Mandi Reid	Midwife/SoM	No Comments
Wendy Newell	Antenatal Clinic Co-ordinator	No Comments
Oonagh Purdy	Clinical Midwifery Manager/SoM	No Comments
Ruth Steward	Midwife Team Lead/SoM	No Comments

Name of Person	Department or Committee	Comments
Sarah Reynolds	Consultant Obstetrician	No Comments
Samantha Hunt	Midwife Team Lead	No Comments
Sarah Walker	Midwife/SoM	No Comments
Dr Liu	Consultant Anaesthetist Obstetric Lead	**Comments added**
Gill Shinkwin	Nutrition and Dietetic Manager	**Comments added**