CLINICAL PROCEDURAL DOCUMENTS

Document Title: Antenatal, Intrapartum and Postpartum Care of the Obese Pregnant women/ birthing people

This document is relevant for staff at: *(please indicate)*	Luton Hospital site	Bedford Hospital site	Both Hospital sites
			X

Document Type: *(please indicate)*	Clinical Guideline

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Document Developed in consultation with:
Circulated to all Obstetricians and Midwives

Is this document new or revised / or has minor amendments?
Revised - merging CG539B and CG260L

Reason for minor amendments? Please highlight all amendments in your document.
Appendix 4 more clear- better organised

Document Number	Version Number
CG539T	1 – New merged CG
Target Audience/Scope:	Obstetricians, midwives, anaesthetists, dietician

Associated Trust Documents:
Safe Handling of Bariatric Patients MH2B policy at Bedford and MH2L at Luton
CG335T Risk assessment and prevention of VTE during pregnancy and puerperium
CG371T Growth Related Optimal Weight (GROW) and Growth assessment Protocol (GAP) pathway
CG443T Large for gestational age
CG114T Care of the woman/ birthing people in labour (Intrapartum Care)
CG563T Intrapartum physiological Fetal Monitoring CTG
CG283T Induction of labour
CG432T Choice of place of birth- Homebirth, MLBU, Labour Ward and use of birth options clinic
Risk assessment for Low dose Aspirin in pregnancy SOP
Antenatal MDT meeting pathway SOP for Bedford site.
CG292T Hypertension and pre-eclampsia
CG10T Caesarean section (birth)

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Signature of Chair of Clinical Guidelines Committee: [redacted]	**Date:** 6th November 2024

Contents

Glossary

ANC antenatal clinic

BMI body mass index

CTG cardiotocography

GDM Gestational diabetes

GROW Growth Related Optimal Weight

GAP Growth assessment Protocol

FBC Full blood count

FGR Fetal growth restriction

MDT multidisciplinary team

MLBU Midwifery led birth unit

OGTT Oral Glucose Tolerance Test

OSA Obstructive Sleep Apnoea

PPH post-partum haemorrhage

RCOG Royal College of Obstetrics and Gynaecology

SGA Amall for gestational age

VBAC vaginal birth after caesarean section

VTE venous thromboembolism

1. Introduction

Obesity has become the most commonly occurring risk factor in obstetric practice, impacting on the health of both the mother and unborn child.

The BMI at the time of booking has a greater influence on her health and that of her unborn child than the amount of weight that she puts on during pregnancy. Obesity in pregnancy is usually defined as body mass index (BMI) of 30kg/m^2 or above at the first antenatal consultation.

There are three different classes of obesity:

- BMI 30.0–34.99 (Class I)
- BMI 35.0–39.99 (Class 2)
- BMI 40 and over (Class 3)

Obese pregnant women have an increased risk of:

- Miscarriage
- Fetal congenital anomaly, especially neural tube defect
- Urinary tract infections
- Gestational diabetes (GDM)
- Hypertension, pre-eclampsia and eclampsia
- Fetal macrosomia
- Stillbirth and early neonatal death
- Poor fetal outcomes
- Risk of childhood and adult obesity & metabolic disorders
- FGR
- Pre-term labour
- Dysfunctional labour
- Higher caesarean section rate
- Postpartum haemorrhage
- Lower breastfeeding rate
- Thrombophlebitis
- Thromboembolism
- Pulmonary embolus
- Postnatal infections / wound infection
- Anaesthetic complications
- Difficulty in CTG monitoring

There is also evidence that obesity may be a risk factor for maternal death.

According to MBRRACE-UK 2023 maternal death review 34% of women who died were obese and 24% were overweight. The same percentages were reported by MBRRACE- UK in 2019.

2. Aims & Objectives

To provide evidence -based recommendations for midwifery and medical staff involved in antenatal, intrapartum and postpartum care of obese pregnant people.

There are no evidence-based UK guidelines on recommended weight-gain ranges during pregnancy.

3. Preconception Care in primary care

In a primary care setting, people of a childbearing age wishing to conceive with BMI ≥30 kg/m2 should:

- receive information and advice about the risks of obesity during pregnancy and childbirth, and be supported to lose weight before conception.
- be advised to take **5 mg** folic acid supplementation daily, starting at least one month before conception and continuing during the first trimester of pregnancy.
- should have their weight and BMI measured before conception to be encouraged to optimize their weight.
- be informed that weight loss between pregnancies reduces the risk of stillbirth, hypertensive complications and fetal macrosomia, and increases the chances of successful vaginal birth after caesarean section (VBAC).
- Screening for Obstructive Sleep Apnoea (OSA)

4. Antenatal

4.1 At the booking appointment the midwifery staff should:

- Measure the weight and height and calculate the BMI for pregnant people. Measurements should be recorded in the handheld notes, the hospital maternity notes and the maternity computer system, CMIS. These measurements will have to be recorded only on Badger Net, when the Bedfordshire hospital will start using Badger Net for all documentation in maternity.

- Undertake a full risk and equipment need assessment. An assessment/equipment sheet should be commenced if the BMI is 35 or more or the weight is above 120 kg at booking. See Appendix 1.

- Offer a referral to an appropriate programme for assessment and advice on healthy eating such as Slimming World/ in Bedford: Healthy Lifestyle in Pregnancy Support- see referral on Appendix 2.

- Advise Vitamin D 10 micrograms (400 iu cholecalciferol) per day during pregnancy.

- Undertake antenatal risk assessment for venous thromboembolism (VTE).

- Inform women that anti-obesity or weight loss drugs are not recommended for use in pregnancy.

- Offer mental health screening to all pregnant people and be aware that people with BMI of 30 kg/m^2 or greater are at increased risk of mental health problems. There is insufficient evidence to recommend a specific lifestyle intervention to prevent depression and anxiety in obese pregnant women.

4.2 During antenatal care, the midwifery and obstetric staff should:

- Women/birthing people with sleep apnoea problems should be referred to their GP
- Ensure women/birthing people are provided with information about obesity and the associated risks and weight management in pregnancy. Inform them they have an increased risk of stillbirth. Provide them the RCOG leaflet: Being overweight in pregnancy and after birth: https://www.rcog.org.uk/media/aggdhd3g/being-overweight-in-pregnancy-patient-information-leaflet.pdf
- Complete VTE risk assessment at each clinical encounter in ANC and community
- Reweigh pregnant people in the third trimester to allow appropriate plans to be made for equipment and personnel required during labour and delivery.
- Offer an Oral Glucose Tolerance Test (OGTT) to all obese women between 24-28 weeks gestation.
- Sonographers may consider the use of transvaginal ultrasound in women in whom it is difficult to obtain nuchal translucency measurements transabdominally.
- An appropriately sized blood pressure cuff must be used on all obese pregnant people in all settings. The cuff size to be used should be documented in notes. (large 32-43 cm). In case they develop hypertension or pre-eclampsia manage as per guideline CG292T.
- **Ensure that pregnant people with a BMI>30 are aware of the symptoms and signs of heart disease (e.g. chest pain, dyspnoea, orthopnoea) as well as those of venous thromboembolism (e.g. sudden painful and swollen leg, dypnoea, chest pain)**

Be aware that for Bedford site 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. 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

For available equipment for Luton site- see Appendix 3

Extra care for women/ birthing people with BMI 35 or more:

- Refer to consultant led antenatal clinic

- Women / birthing people with **BMI ≥ 40** should have an antenatal consultation with an obstetric anaesthetist, so that potential difficulties with venous access, regional or general anaesthesia can be identified. An anaesthetic management plan for labour and delivery should be discussed and documented in the maternity records. An anaesthetic referral proforma should be used for referral
- Women / birthing people with **BMI ≥50** should be referred to the departmental antenatal multidisciplinary team (MDT) meeting- see the Antenatal MDT meeting pathway SOP for Bedford site.
- **Discuss choice of place of birth:**
  Women / birthing people with BMI ≥ 35 or who weigh more than 120kg should be booked for Consultant Led Care and be advised to have birth in a Consultant Led Obstetric Unit with appropriate neonatal services **and should not be booked for MLBU or homebirth. If they request delivery in MLBU or homebirth, then an individualised plan should be made involving a multidisciplinary discussion.**

- **Organise Fetal growth scans (BMI 35 and more):**

1. Offer serial fetal growth scans every 4 weeks from 32 weeks gestation (as per Saving Babies Lives version 3 guidance). Standardised fundal height (SFH) should be measured by Community Midwife at 28 weeks gestation and a referral for fetal growth scan at 28 weeks is only required if SFH plot on personalized GROW chart suggests small for gestational age (<10th centile).

2. In case the SFH at 28 weeks gestation suggests large for gestational age (> 90th centile), **and** routine 28 week OGTT is normal (or the result is not back but has been taken), routine serial fetal growth scans can start from 32 weeks as above and additional scan at 28 weeks is not required. If OGTT is abnormal, these patients will be identified and seen within Gestational Diabetes ANC.
3. In case there are any other risk factors for small gestational age baby (SGA) or fetal growth restriction (FGR) the serial fetal growth scans may need to start from 28 weeks gestation- see CG371T Guideline for Growth Related Optimal Weight (GROW) and Growth assessment Protocol (GAP) pathway.

   The sonographers should document the estimated fetal weight (EFW) on the customized growth charts. Staff should be aware that scans in obese women are difficult to perform and are more likely to be inaccurate.

For summary of care see appendix 4: Pre-pregnancy, antenatal and Postnatal care pathway for women with obesity

5.1 Induction of Labour

Although not routinely offered, elective induction of labour at term in obese women may reduce the chance of caesarean birth without increasing the risk of adverse outcomes; the option of induction should be discussed with each woman on an individual basis depending on obstetric and fetal indications (as per Induction of Labour guideline).

The benefits of induction of labour include a lower Caesarean sections rate, but the risks are medicalization of the labour, higher use of epidural and longer time spent in hospital, when time for induction as well as delivery and postnatal care is included.

Where macrosomia is suspected, induction of labour may be considered (as per Large for Gestational Age guideline). Pregnant people should have a discussion about the options of induction of labour and expectant management.

5.2 Mode of delivery

There are no significant differences in anaesthetic, postnatal or neonatal complications between women/birthing people with planned vaginal delivery and planned caesarean delivery, with the exception of shoulder dystocia (3% versus 0%, P=0.019).

The decision for morbid obese pregnant people (BMI >50 at booking) to give birth by planned caesarean section or by early induction of labour should involve a multidisciplinary approach, taking into consideration the individual comorbidities, antenatal complications and their wishes.

6. Intrapartum

- A risk assessment for VTE should be completed for all pregnant people on admission in accordance with local guidance.
- Women/ birthing people with a BMI ≥ 35 should have venous access established in early labour, and FBC and Group and save sent. Consideration should be given to the siting of a second cannula if BMI≥40.
- Consider ultrasound to confirm presentation and consider early epidural
- Consider Omeprazole 40mg orally once daily during labour
- Active management of the 3rd stage of labour is advised if BMI≥30, as obesity is associated with increased risk of PPH.
- Women/birthing people with BMI>35 at booking, **should not be booked for MLBU or home birth- see page 6 in case woman request this type of delivery.**
- Women with BMI<35 who are otherwise low risk can be offered choice of setting for planning their birth in MLBU, with clear referral pathways for early recourse to consultant-led units if complications arise.

- For women with a BMI ≥ 35 at booking, offer continuous electronic fetal monitoring CTG, after explaining the risks and benefits of monitoring. Fetal scalp electrode should be used early if external monitoring is not satisfactory.

- On admission to Delivery Suite women/ birthing people with a BMI ≥ 40 or ≥120kg should be assessed by midwives, a senior obstetrician and anaesthetist covering delivery suite to ensure that appropriate staff, equipment and facilities are available. These requirements need to be prepared in anticipation of the need for emergency operative delivery.

- Assess pressure areas and maintain skin integrity; check pressure areas within 2 hours of admission to consider tissue viability issues and complete the Waterlow risk assessment tool –available on intranet.

7. Operative Procedures

- If a caesarean section (CS) is required, the consultant obstetrician must be involved in the decision making and will make an individualised assessment as to whether they need to be present for the caesarean section. The consultant Obstetrician must attend for CS when BMI>50. For pregnant people with BMI>40 but <50 the consultant Obstetrician must attend unless the senior trainee present on site has documented evidence as being signed off as competent for this specific case.

- Consider skin incision over the abdominal panniculus.

- If surgery is anticipated the consultant anaesthetists must be informed.

- Operating theatre staff should be alerted regarding any women whose weight exceeds 120kgs and who is due to have an operative intervention in theatre.

- Women undergoing caesarean section should have suturing of the subcutaneous tissue space if more than 2 cm in order to reduce the risk of wound infection and wound separation.

- The Alexis retractor can be used to aid this. The use of this should be guided by the distribution of weight and the abdominal panniculus, but is not normally needed unless the BMI is ≥50. When using the Alexis, the pink maternity specific version should be used (kept in Obstetric theatres).

- Do not routinely use superficial wound drains in caesarean birth as they do not decrease the incidence of wound infection or wound haematoma. Consider negative pressure wound therapy after caesarean birth for women with a BMI of 35 kg/m2 or more to reduce the risk of wound infections.

- For operative vaginal delivery be aware that women/ birthing people with BMI>30 have higher rates of failure. They may need to have delivery performed in theatre depending on the clinical judgment of the clinical circumstance.

8. Postnatal Care

- Encourage early mobilisation and hydration following birth.
- Postnatal risk assessment for VTE should be undertaken in accordance with local guidance.
- Correctly sized anti-embolism stockings should be offered and worn for the duration of in-patient stay irrespective of mode of delivery.
- During antenatal and postnatal periods give advice to women on the benefits of breast feeding and offer support to initiate and maintain breast feeding.
- Women with booking BMI>30 should ideally receive nutritional advice and it is recommended that support should be offered postnatal from a trained professional with a view to weight reduction.
- Inform women about contraception: Combined hormonal contraception (CHC) use is UKMEC 2 for use by women with BMI ≥30–34 kg/m2 and UKMEC 3 for women with BMI ≥35 kg/m2.

9. Facilities and equipment

Ensure there is consideration of the following when a high BMI patient is admitted as an inpatient:

- Ensure adequate space around bed area to provide care to the woman
- Accessibility within clinical areas including doorways widths and thresholds
- Check the safe working loads of all equipment to be used and floors
- Availability of appropriate moving and handling equipment should be checked prior to admission and again at admission

Auditable standards

Standards to be audited	Lead for the audit	Frequency, audit Tool and Methodology	Reporting arrangements	Acting on recommendations and Lead (s)	Dissemination of results/ action plans
1.Percentage of women with BMI ≥30 at booking 2. All women with BMI of 35: advised to deliver in hospital 3. All women with BMI of 40 offered Appointment with an obstetric anaesthetist 4. Maternal and infant outcomes	Will be nominated by the maternity audit leads (Consultant or Midwife) according to the Maternity Governance Audit Plan.	This will be Performed according to audit Plan The auditors will analyse the data and develop recommendations and action plans from the audit results.	The audit results, recommendations and action plans will be circulated, and presented either at an audit meeting, a Clinical Governance day or at a Risk and Audit meeting.	The O & G Risk and Governance Committee will approve recommendations and action plans to be implemented within a specific time frame. The auditors will implement and monitor action plans with support from the clinical leads, senior midwives and pertinent groups.	The audit results and approved action plans will be disseminated by the maternity audit team to all relevant staff groups, pertinent meetings and through the newsletters, the Senior Staff meetings, the Delivery Suite Forum and by email.

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   https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/j.1471-0528.2010.02832.x

9. Weight management before, during and after pregnancy NICE Public Health Guidance 27 July 2010 https://www.nice.org.uk/guidance/ph27

Appendix 1 Risk Assessment of Equipment Needs for Bariatric Women

Form started in community/ ANC if women weigh 120kgs /20 stone or more

Patient's details

Consultant.....
...

Referral to Anaesthetist
Date.....
.

EDD .....

DATE	GESTATION	WEIGHT	HEIGHT	BMI
	1st visit in ANC			
	Third trimester			

1. **Bed/Mattress**: Assess depending on woman's weight in third trimester or on admission

Type needed	Date ordered or on Ward	If ordered Huntleigh HX number	By whom
Mattress			
Mattress			
Bed			

When ordered equipment is delivered put delivery form into woman's notes.

2. **Other Equipment:**

EQUIPMENT	OBTAINED	WHERE FROM
Bedside chair		
Commode		
Hoist		
Sling for hoist		
Flowtron Boots		Maternity theatre store room
Gown		Maternity theatre store room

Appendix 2 - Referral for Healthy Lifestyle in Pregnancy Support

NHS
Bedfordshire Hospitals
NHS Foundation Trust

Nutrition & Dietetics, Beeden House, Bedford Hospital
Please return this form for healthy lifestyle in pregnancy support, to the address above.

Name:			
Date of birth:		**NHS no:**	
Address:	**Post code:**		
Landline Tel:		**Mobile:**	
Email address:			
Reason for referral:	**Pregnant + BMI 30 and over (or 28.5 if of Asian origin) / Postnatal support**		
Medication:			
Relevant background / information: **Including recent weight, height, BMI, weight history.**	**Gestation:** **or Days postnatal:** **BMI:** **Height:** **Weight:** **Gestational Diabetes / IGT?** **Yes / No**		
GP:	**Dr**	**Is GP aware of referral?**	**Yes / to be informed**
Referred by: (Please print name):		**Job title (e.g. MW/Dr):**	
Signature of referrer:		**Date of referral:**	

☐ **BMI 30 – 34.9: I wish to be referred to a Beezee Bumps Group**

I am happy for my details to be shared with Beezee Bumps for the purposes of being referred to one of their Healthy Lifestyle programmes. I understand that Beezee Bumps will contact me regarding my chosen service, and will keep a record of my progress to share with Nutrition & Dietetics.

☐ **BMI 35 and up: I wish to be referred to the Trust approved Weight Management**

Program.
This will be a1:1 appointment in Bedford, with a Healthy Lifestyle in Pregnancy Advisor.
This service is overseen by a registered dietitian.

☐ **Referral Declined**

ıealth benefits of weight management in pregnancy have been explained.
I do not wish to be referred for healthy lifestyle in pregnancy support.

Signature of mother to be: **Date:**

Appendix 3: Each piece of equipment needs to be selected dependant on the woman's weight

Luton site:

Equipment	Weight Capacity Limit	Location
Scales	200 kg /31 stone 250 kg / 39 stone	**ANC Digital** **Ward 31**
Couches	160 kg / 25 stone	Ultrasound
	180 kg / 28 stone	**Day assessment**
	150 kg / 23 stone	ANC
Bed		
Hill Rom Bed and Hill Rom Mattress	227 kg / 35 stone	Delivery Suite
Profile Bed Electric 560	267 kg / 42 stone	Currently used on wards
Beds	180kg / 28stone	Ward 31
Mattress		
Pentaflex 120 mattress	120kg / 20 stone	Currently used on wards
Pentaflex 250 mattress	250kg / 39 stone	Available from porters
Contoura 1000 Foam Pressure Reducing Mattress	450 kg / 71 stone	May need to be ordered from Huntleigh if required. Enables more movement for woman.
Theatre Table		
Eschmann Table RX 500, electric	250 kg / 39 stone	Normally in Theatre A
Maquet Table	450kg / 70 stone	Normally in Theatre B
Theatre Trolley	160 kg / 25 stone	Anaesthetic Room Maternity
Bariatric Table		Theatre 4, if available
Hoist		
Heavy weight 12, Theatres A-D, A&E, CCU, Occ.Therapy	250 kg / 39 stone	Contact area regarding availability
Hoist	175 kg / 28 stone	Ward 34
Slings for Hoist	"Heavyweight" sling	Located on wards need to contact Wards 12/15
Miscellaneous Equipment		
Commode	381 kg / 59 stone	Ward 33
Bedside Chair	318 kg / 50 stone	Ward 33
TED stockings		Maximum available 42 cm calf measurement
BP extra-large cuff		Delivery Suite Community midwives to ensure use of extra-large cuff
Wheel Chair	317 kg/ 50stone	Available via the porters
Shower seat in delivery suite showers	146kg / 23 stone	

Appendix 4: Pre-pregnancy, antenatal and Postnatal care pathway for women with obesity

NHS
Bedfordshire Hospitals
NHS Foundation Trust

	BMI	>30	>35	>40	>50
Preconception care	Folic acid 5mg daily Discuss risks Refer to lose weight programme	☐	☐	☐	☐
Antenatal care	Referral for Healthy Lifestyle in Pregnancy Support	☐	☐	☐	☐
	Vitamin D 10micrograms daily	☐	☐	☐	☐
	Moving and handling assessment	No	☐	☐	☐
	OGTT 24-28 weeks	☐	☐	☐	☐
	Reweigh in third trimester	☐	☐	☐	☐
	Aspirin score	No	Score 1- Moderate risk factor BMI 35 or more		
	VTE score	Score 1 for BMI	Score 2 for BMI		
	Referral for Consultant led care	No	☐	☐	☐
	Referral for obstetric anaesthetist review	No	☐	☐	☐
	Serial fetal growth scans	No	☐	☐	☐
	Referral for Antenatal MDT meeting	No	No	No	☐
	Screen for Obstructive sleep apnoea	☐	☐	☐	☐
Intrapartum care	Can chose MLBU/ homebirth if no contraindications	☐	No	No	No
	Inform on call Obstetrician (registrar) and Anaesthetist	No	No	☐	☐
	Early epidural in labour				
	Consider presentation scan in labour	No	☐	☐	☐
	IV Access+ FBC+G&S	No	☐	☐	☐
	Omeprazole 40 mg once a day during labour	☐	☐	☐	☐
	Active Management 3rd stage	☐	☐	☐	☐
Postpartum care	Early mobilisation and hydration	☐	☐	☐	☐
	VTE risk score Anti- embolism stockings Remember – all emergency CS need Tinzaparin for at least 10 days regardless their BMI	Score 1: will need Tinzaparin if any extra risk factors giving a score of 2 or more		Score 2: Tinzaparin a minimum of 10 days regardless of mode of delivery	