REF: CTMObs 150

Guideline for the care of women with a BMI of 30kg/m² or over during pregnancy, labour and the postnatal period

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CHANGE HISTORY

Version	Date	Author Job Title	Reasoning
2	August 24	As below	Update to existing obesity in pregnancy guideline
3	June 2025	As below	New Nice guidance on folic acid (January 2025)

AUTHORSHIP, RESPONSIBILITY AND REVIEW

Authors	Sharon Webber Elinore Macgillivray Bryany Tweedale	Ratification Date	August 2024
Job Title	Public Health Specialist Midwife Consultant Midwife Consultant Midwife	Review Date	August 2027

Disclaimer

Equality Impact Assessment Statement

This Procedure has been subject to a full equality assessment and no impact has been identified.

Throughout this guideline, the term 'women' and 'mothers' will be used. It is recognised that maternity services also provide care to gender diverse individuals and people whose gender identity does not align with the sex they were assigned at birth.

Contents

1. Rationale

Approximately 74 women a month receiving maternity care in CTM have a booking BMI of ≥ 30 (obesity class I). Around 40 women per month have a BMI in the range 35 – 39.9 (obesity class II) and approximately 27 women per month have a BMI of 40 or over (obesity class III)

Overall, around 37% of women receiving maternity care in CTM have BMI of 30 or over. Having a BMI of 30 or over in pregnancy is associated with an increased risk of a number of serious adverse outcomes, so care planning that provides additional support is required to reduce the associated risks.

Babies born to women with raised BMI (≥30kg/m^2) also face several health risks. Maternal obesity and excess weight gain in pregnancy are associated with an increased incidence of obesity in children at 2-4 years old. There is a higher caesarean section rate and lower breastfeeding rate in this group of women compared to women with a Body Mass Index (BMI) of 25 or less. The risk of the following outcomes are increased for women with a BMI of ≥30 during pregnancy, birth and the postnatal period:

Pregnancy	Labour and Birth	Anaesthetic	Postnatal
Impaired fasting glucose and impaired glucose tolerance and gestational diabetes	Induction of labour, slow progress in labour, prolonged labour and labour dystocia	Difficulty with positioning	Delayed wound healing
Miscarriage and stillbirth	Birth assisted by forceps/ventouse Unplanned/in-labour caesarean birth	Difficulty siting an epidural catheter with increased risk of dislodgement, and difficulty siting spinal anaesthetic.	Increased rates of wound infection
Pre-eclampsia Pregnancy induced hypertension/hypertensive disorders	Postpartum haemorrhage	Increased risk of difficult intubation (siting an endotracheal tube), increased difficulties maintaining adequate ventilation (breathing).	Greater likelihood of needing support with breastfeeding establishment and continuation
Venous Thromboembolism	Shoulder dystocia	Increased risk of need for ICU care post operatively	Postnatal depression
Obstructive Sleep apnoea	Difficulties with fetal heart rate monitoring		Long term neonatal consequences: neonatal body composition, infant weight gain, obesity

Maternal death	Difficulties with labour analgesia		
Abnormalities in fetal growth and development	Use of general anaesthesia		

2. Definitions

Obesity in pregnancy is defined as a Body Mass Index (BMI) of 30 kg/m^2 or more at the first antenatal consultation. BMI is a simple index of weightto-height and is calculated by dividing a person's weight in kilograms by the square of their height in metres (kg/m^2). Maternal BMI is categorized by the World Health Organization (WHO) as follows:

- Underweight (BMI <18.5kg/m^2)
- Normal (BMI 18.5-24.99 kg/m^2)
- Overweight/pre-obese (BMI 25-29.99kg/m^2)
- Obese class 1 (BMI 30-34.99 kg/m^2)
- Obese class 2 (BMI 35-39.99 kg/m^2)
- Obese class 3 (BMI ≥40 kg/m^2)

While the majority of the recommendations within this guideline pertain to women with a BMI ≥ 30 kg/m^2, some recommendations are specific to women in the higher BMI categories only.

3. Women's Experience of Pregnancy with raised BMI

Women with BMI ≥30kg/m^2 have described experiences of humiliation, stigmatisation, discomfort, increased stress and low self-esteem as a result of discussing their weight with a healthcare professional (Furber & McGowan, 2011). Smith & Lavendar (2011) also describe women feeling misunderstood with their needs for individualised care is not met and when interventions become increasingly medicalised. Women are particularly vulnerable when pregnant with a raised BMI as their larger size becomes more visible, and this can elicit negative feelings for some women, who many experience constant awareness of their body due to frequent checkups and extensive observation by healthcare professionals (Nyman et al, 2010).

A number of qualitative studies also suggests that women with raised BMI who access maternity care perceive discrimination on the basis of their weight, reporting instances of negative interactions with maternity care providers, including perceptions that care providers were rude, abrupt and did not take them seriously. Women also report feeling embarrassed, isolated, receiving insufficient and/or inconsistent information about appropriate engagement in health behaviours in pregnancy, and attributed

their perceived negative providers to their body treatment from care size and weight.

The word 'obese' was considered unacceptable by almost all women, with a number of women describing it as feeling it as feeling 'personal' and 'degrading' (Cunningham, Endacott & Gibbons, 2018). The RCM Re:Birth Project explored the language used by maternity care professionals, and women, and the impact that this can have upon good outcomes and experience, emphasising that pregnancy and birth are extraordinarily personal, with negative language contributing significantly to feelings of failure and trauma.

The emphasis for health care professionals should be upon supporting sensitive and respectful conversations with women, particularly around weight, using sensitive language and terminology, engaging in a positive relationship with the woman that is laid on a foundation of partnership and empowerment.

4. Informed Decision Making

The following principles around informed decision making Shared decision making (nice.org.uk) should be used during any counselling, including:

- Encouraging people to talk about what is important to them
- Communicating with people in a way they can understand
- Using clear language, avoiding jargon and explaining technical terms
- Sharing and discussing the information needed to make informed decisions
- Making sure that the woman understands the choices available to her (including the choice of doing nothing or not changing her current plan)
- Accept and acknowledge that people may vary in their views about the balance of risks, benefits and consequences of treatments, and that they may differ from those of their healthcare professionals.
- Explore risks/benefits/alternatives using the B.R.A.I.N pneumonic:

Benefits - What are the benefits of the proposed plan?

Risks - What are the risks of the proposed plan?

Alternatives - What are the alternatives to the proposed plan? **I**ntuition - What does the woman feel about what is right for her, knowing her body and any previous birth experience?

Nothing - What could happen if the woman does nothing, or says 'not now' and takes some time to think?

5. Preconception Care

It is important that women are aware of the increased risk of maternal and fetal complications associated with having a BMI $\geq$30 during pregnancy. They should have factual, sensitive, accessible information and support to reduce the risk of these complications prior to pregnancy.

- All women who are planning pregnancy should have accurate height and weight measurement and BMI calculation. They should be encouraged to maintain BMI in the range of 20 kg/m^2 to 25 kg/m^2. Women with BMI ≥30 kg/m^2 should be advised and supported to optimise their weight before conception to reduce the risk of pregnancy complications.

- Women should be advised and supported to adopt healthy lifestyle choices by improving diet quality and physical activity.

- Consideration should be given to screening for type 2 diabetes prior to conception.

- All women to take the standard 400mcg folic acid supplementation unless they have any other risk factors requiring the higher 5mgs dose.

- Women should receive information about the reduced risk of hypertensive complications, fetal macrosomia and stillbirth associated with weight loss between pregnancies. Weight loss also increases the chances of successful vaginal birth after caesarean section (VBAC).

6. Pregnancy Following Bariatric Surgery

- It is recommended that women should wait a minimum 18 months following any bariatric surgery before becoming pregnant to allow body weight stabilisation and also to identify and treat any nutritional deficiencies that may present.

- All women who become pregnant following bariatric surgery should be recommended to have consultant-led care. Screening for nutritional

deficiencies including a full blood count, ferritin, calcium, and vitamin D should be carried out during pregnancy and women should be referred to a dietician for advice on their specialised dietary needs.

For further guidance on the care of women pregnant post bariatric surgery, please refer to the Welsh Institute of Metabolic and Obesity Surgery 'Management of Patients Becoming Pregnant After MetabolicBariatric Surgery: A Guide for Health Care Professionals' (June 2024).

Pregnant Postop MBS WIMOS Guidance 2024.pdf

7. Antenatal Care

7.1. Early antenatal care

- BMI is entered on to the digital self-referral system if known by the woman. Height and weight may also be entered if BMI is unknown. If these have not been entered on the system, the community midwife should ask about this during the first phone call and provide the appropriate advice about Folic Acid dosage (see below).

- Women with a booking BMI ≥30 kg/m2 should be advised to take 10 micrograms Vitamin D supplementation daily during pregnancy and while breastfeeding. The standard 400mcgs Folic Acid dose should also be advised in the first trimester.

- Maternal weight and height should be measured at the dating scan appointment for all women, and the BMI should be re-calculated for accuracy and documented in the hand-held notes, and on MITS/WPAS. NB. Self-reported weights and heights should not be used as a substitute for accurate BMI assessment at booking.

- All women with a BMI 30-34.9 kg/m2 should be provided with accurate, sensitive and accessible information about the risks associated with having a BMI of ≥30 in pregnancy and what changes they can be supported to make to reduce those risks. Women should be given the opportunity to discuss this information with their community midwife, who should document all advice and recommendations within the handheld maternity records.

- All women should be given information at the booking appointment on healthy eating (based on the Eatwell Guide provided at booking) and taking regular activity based on the Department of Health recommendations of minimum of 150 minutes per week. The importance

of not exceeding the recommended weight gain and the associated risks with excessive weight gain should also be discussed and documented.

- If a woman has booking BMI of 45 kg/m2 or over, an early consultant obstetric appointment should be arranged prior to the first Bump Start appointment at 16 weeks to discuss thromboprophylaxis in pregnancy and consideration of an early Oral Glucose Tolerance Test (OGTT). The manual handling risk assessment should be completed at the earliest opportunity in case of any unplanned antenatal admission to the maternity unit. The checklist for the care of women with BMI ≥45 should be printed, commenced and filed in the notes (see Appendix 2).

- All women with a BMI of ≥35-39.9 kg/m2 will be supported by the "Community Bump start" weight management service provided by their named community midwife and supported by the Public Health Midwives.

- All Women with BMI ≥ 40 should be referred on an opt-out basis to the 'Bump Start' weight management service with the Public Health Midwives for additional support.

- Women should be advised to avoid dieting during pregnancy as it may cause harm to unborn/developing baby. However, for women with a BMI of 40 kg/m2 or greater, a modest weight loss during pregnancy may be acceptable. The weight loss should be individualised for each woman, and should be done only under a health care professional's close supervision. If there is a weight loss of 5% or more by 24 weeks gestation, a referral should be made to a Consultant Obstetrician.

- An appropriate size of arm cuff should be used for blood pressure measurements taken at the booking visit and all subsequent antenatal consultations.

7.2. Assessing fetal growth

- All women with BMI ≥ 35 kg/m2 should be offered serial ultrasound scans for fetal growth carried out at 28 weeks, 32 weeks, 36 weeks and 39 weeks as per "Fetal Growth Assessment Guideline" and "GAP and GROW" guideline. Ultrasound measurements may not be as accurate in women with high BMI. Women should be informed of the error margins with estimations of fetal weight by ultrasound scan.

  NB. Fundal height measurement should NOT be carried out as it is an unreliable means of assessing fetal growth and may contradict scan measurements.

7.3. Oral Glucose Tolerance Testing

- A Glucose Tolerance Test (GTT) should be recommended at 28 weeks gestation for all women with a BMI $\geq$ 30 kg/m2.

- Women with BMI ≥ 40 kg/m2 who test positive for Gestational Diabetes Mellitus at any stage of pregnancy will be transferred from Bump Start to the pregnancy diabetes service and the Diabetes Specialist Midwife for ongoing care and support.

- Women with a booking BMI $\geq$ 35 kg/m2 have an increased risk of preeclampsia and should be monitored for pre-eclampsia every 3 weeks between 24-32 weeks, and every 2 weeks from 32 weeks to birth.

- Prophylactic aspirin is recommended where women have a booking BMI $\geq$ 35 kg/m2 and should be prescribed as per policy.

- Maternal weight should be recorded (regardless of booking BMI) at the end of pregnancy (after 36 weeks), documented in the All Wales handheld records and inputted into MITS via GridViewer or WPAS.

7.4. Thromboprophylaxis

- Women should be advised regarding the risk of thrombosis during pregnancy. Physical activity and the importance of hydration should be advised.

- If admitted antenatally, thromboprophylaxis should be considered in accordance with VTE guidelines. Thromboprophylaxis should be withheld if the woman is in labour or there are signs of imminent labour.

8. Birth Planning

- In the absence of co-morbidities, women with BMI 30-34.9 kg/m^2 who have a negative gestational diabetes screen, uncomplicated abdominal palpation and ease in fetal auscultation with handheld doppler device or Pinnards stethoscope, should be supported to plan to birth in a midwifery-led setting (All Wales Midwife Led Guideline, 2022).

- Women with BMI 35-39.9 kg/m^2 will be recommended to follow an obstetric led antenatal pathway, however evidence suggests that BMI 30-34.9 kg/m^2 or 35-39.9 kg/m^2 is not a reason, in itself, for advising birth within an obstetric unit, but indicates that further consideration of birth setting may be required (All Wales Midwife Led Guideline, 2022).

- Multiparous women with a previous vaginal birth are suitable for a midwifery-led setting for birth and have the same chance of transfer and obstetric complication as a nulliparous woman with a BMI <30. Birth counselling in this population should occur in line with nulliparous women suitable for midwifery-led care (All Wales Midwife Led Guideline, 2022).

- In nulliparous women the possibility of additional intrapartum complication linked to a maternal BMI 35-39.9 kg/m^2 should be discussed during the antenatal period UKMidSS Infographic Dec 2018 v1.1.pdf (ox.ac.uk), along with models of care, so that an informed choice about planned place of birth can be made. Parity is the most important factor in women with BMI 35-39.9 kg/m^2, and nulliparous women in this cohort should be recommended to plan to birth on the obstetric unit (All Wales Midwife Led Guideline, 2022).

- Where possible, and in line with local health and safety risk assessments, women with BMI 30-34.9 kg/m^2 and 35-39.9 kg/m^2 should be supported to use water immersion for analgesia during labour.

- BMI of ≥30kg/m^2 alone is **not** an indication for induction of labour.

- An anaesthetic alert should be completed for all pregnant women with BMI ≥ 45 kg/m^2. These women should be offered and recommended an antenatal consultation with an obstetric anaesthetist at approximately 32 weeks gestation. An obstetric anaesthetic management plan for labour and birth should be discussed and clearly documented on the Welsh Clinical Portal (WCP). If any woman has not been seen in antenatal clinic, they should be reviewed by the duty anaesthetist when they are admitted to the maternity unit. Any potential difficulties with venous access, regional and general anaesthesia should be assessed, discussed and documented.

- Women with BMI ≥45kg/m^2 should be counselled regarding fetal heart rate monitoring and surveillance;
- During the induction of labour process. Counselling should include the options if adequate fetal monitoring cannot be achieved, which may include recommending a caesarean section;
- During labour, in particular the practical difficulties that may arise in achieving effective fetal heart rate monitoring, and indications for internal monitoring with a fetal scalp electrode (FSE) to support informed decision making. It should also be discussed that FSE application may not be possible. If adequate monitoring of the fetal heart cannot be achieved either antenatally, during induction, review by a senior obstetrician must be sought. Options offered should include caesarean birth.

- The checklist for the care of women with a BMI ≥45 should be completed (see Appendix 2).

- All women admitted to the maternity unit should have a Purpose T score documented within 2 hours of admission to identify any additional requirements.

- Where women have a maternal weight of ≥120 kg, when booking for induction of labour or planned caesarean birth, the operational lead midwife should be informed of the woman's latest weight, so that any additional weight bearing equipment can ordered and in place prior to admission. Theatre staff should be informed in sufficient time to make suitable arrangements.

9. Intrapartum Care

- On every admission to the maternity unit, a current weight should be measured and documented on the medication chart. Where there is no end pregnancy weight documented within the antenatal handheld records, this admission weight can be used to update the MITS/WPAS system to reflect an end of pregnancy weight.

- All equipment should be checked to ensure that it meets the woman's weight requirements. The operating theatre staff should be alerted regarding any woman admitted whose weight exceeds 120 kg.

- The senior on call obstetrician and the duty anaesthetist on-call should be informed of the admission of any woman with BMI ≥45 kg/m^2.

- When active labour is established, external fetal monitoring may be difficult to achieve in women with raised BMI. Internal monitoring with a fetal scalp electrode (FSE) is indicated when there is difficulty in external monitoring. Informed consent should be sought by discussing this with the woman prior to applying.

- Women with BMI ≥ 40 kg/m^2 should be recommended to have intravenous access established early in labour.

- An 'early' epidural may be recommended for some women with raised BMI. Maternal choice is paramount, and the woman's choices around analgesia should always be respected.

- If the woman has been seen by an anaesthetist and has accepted and planned to have an epidural, it is recommended that it should be sited as soon as it is requested.

- In those women for whom regional anaesthesia has been predicted to be difficult, consideration should be given to offering an epidural before active labour has commenced. In this situation, the epidural may be sited but not fully topped up so as to preserve mobility.

- Should be recommended to have active management of third stage of labour due to the increased chance of postpartum haemorrhage.

- An active 3rd stage is a reasonable recommendation for all women with BMI ≥30 kg/m^2 due to the increased likelihood of postpartum haemorrhage (PPH). Consider administering a uterotonic via deltoid if the woman is in the pool for birth or have disproportionate weight in their lower body.

- Women with a BMI of ≥ 30 kg/m2 who undergo caesarean section, and who have subcutaneous fat layer > 2cm, should have suturing of the subcutaneous tissue space in order to reduce the risk of wound infection and dehiscence. Please note, there is a lack of evidence to recommend routine use of subcutaneous drain and interrupted skin sutures to reduce the risk of wound infection.

10. Postnatal Care

- Encourage early mobilisation irrespective of mode of birth.

- TED stockings are recommended for the duration of the hospital stay, irrespective of mode of birth. In the event of TEDS not fitting correctly, Flowtrons DVT compression garments should be advised.

- BMI $\geq$ 30 kg/m^2, or body weight greater than 90 kg are independent risk factors for venous thromboembolism (VTE). A postnatal risk assessment should be completed and signed using the VTE risk assessment form. Please refer to the VTE Guideline.

- Women with a booking BMI $\geq$30 kg/m^2 should receive appropriate advice and support antenatally and postnatally regarding the benefits, initiation and maintenance of breastfeeding.

- Contraception should be discussed before discharge. Advice should reflect the increased risk of thromboembolism with combined oral contraceptive pills.

- Advice should be given regarding weight loss prior to the next pregnancy.

- All women with a booking BMI $\geq$30 kg/m^2 who have been diagnosed with gestational diabetes should have a test of glucose tolerance approximately 6 weeks after giving birth, organised via their General Practitioner (GP).

- Women with a booking BMI $\geq$30 kg/m^2 with gestational diabetes who have a normal test of glucose tolerance in the postnatal period, should be advised to have regular follow up with their General Practitioner (GP) to screen for the development of type 2 diabetes.

- All women with a booking BMI $\geq$30kg/m^2 who have been diagnosed with gestational diabetes should be advised to have annual screening for cardio-metabolic risk factors, and lifestyle and weight management advice.

- All women at home in the post-natal period should be given advice about achieving a healthy weight, in particular if planning future pregnancies with signposting to support services provided (This may be supported by the Public Health midwives).

11. Manual Handling

All health professionals involved in maternity care should receive training in manual handling techniques and the use of specialist equipment which may be required for pregnant and postnatal women with a booking BMI $\geq$ 30 kg/m^2.

12. Auditable Standards

- BMI documented at booking appointment (100%)
- Women with a BMI $\geq$30 kg/m^2 offered routine screening for gestational diabetes at 28 weeks gestation (100%)
- Outcomes for women with a BMI ≥30-34.0 kg/m^2 and a BMI ≥3539.9 kg/m^2 who commence labour and give birth within a midwifeled setting.
- Women with BMI $\geq$45 kg/m^2 reviewed by an obstetric anaesthetist in the third trimester and plan documented for birth (100%)

- End pregnancy weight documented in notes and inputted onto the maternity electronic record (100%)
- Checklist for women with BMI ≥45kg/m^2 completed (100%)

13. References

All Wales Midwife Led Guideline (2022)

Cunningham, Endacott & Gibbons, 2018, *Communication with health professionals: The views of pregnant women with a raised BMI,* British Journal of Midwifery, Vol. 26, No. 9.

National Institute for Health and Clinical Excellence (2011) Weight management Before, During and After Pregnancy.

RCOG Green-top Guideline 37a (2015). Reducing the risk of thrombosis and embolism during pregnancy and the puerperium

RCOG Green-top Guideline 72 (2018). Care of Women with Obesity in Pregnancy.

Furber & McGowan (2011), *A qualitative study of the experiences of women who are obese and pregnant in the UK,* Midwifery, Volume 27, Issue 4, Pages 437-444

Nyman et al, (2010). *Obese women's experiences of encounters with midwives and physicians during pregnancy and childbirth,* Midwifery Volume 26, Issue 4, August 2010, Pages 424-429.

Smith & Lavendar (2011, *The maternity experience for women with a body mass index ≥ 30 kg/m2: a meta-synthesis,* BJOG, 9the March 2011

BMI over 35 and thinking about birth in an Alongside Midwifery Unit?

UKMidSS
UK Midwifery Study System

Information from a national research study

An Alongside Midwifery Unit (AMU) might be called a birth centre where you live. AMUs are in a hospital where there is also a labour ward or delivery suite

Talk to your midwife and make a care plan that suits you. An AMU birth might not be best for everyone. If your BMI is over 40 these results might not apply to you.

Had a baby before?

For women with a BMI over 35 who have given birth before and are otherwise healthy, planning birth in an **Alongside Midwifery Unit (AMU)** can be just as safe as for women with a lower BMI

Having your first baby?

Women with a BMI over 35 having their first baby are **more likely** than women with a lower BMI in the AMU to have:

- an urgent Caesarean birth

12 out of 100 women with a **BMI over 35** had an urgent Caesarean

7 out of 100 women with a **lower BMI** had an urgent Caesarean

- a severe bleed after birth

5 out of 100 women with a **BMI over 35** had a severe bleed after birth

2 out of 100 women with a **lower BMI** had a severe bleed after birth

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Your Body Mass Index, or BMI, is one of the things your health care team will take into account when they give you advice about where to have your baby

This information is based on a national research study carried out in all 122 Alongside Midwifery Units (AMUs) in the UK, over 12 months, by the UKMidSS team at the University of Oxford

What we did?

- We collected information about all women with a BMI over 35 who received labour in these AMUs (1122 women in total)
- We compared what happened to these women and their babies with a group of 1949 women with a lower BMI in the same AMUs
- The **main outcome** we looked at was whether the women experienced one or more of the following:
  - Needing labour to be speeded up with a drip
  - Birth with forceps or ventouse, or a Caesarean
  - A severe tear after birth
  - A blood transfusion after birth
  - Needing intensive care after birth
- We also looked at whether women needed an *urgent* Caesarean or had a severe bleed after birth

What we found?

Almost all of the women with a BMI over 35 in our study had a BMI between 35 and 40. This means that our results can't be used to advise women with a BMI over 40

For women with a BMI over 35 who had given birth before, there were **no differences** in our main outcome or any of the other outcomes we looked at compared with women with a lower BMI who had given birth before

6 out of 100 women with a **BMI over 35** had one or more of the features of our main outcome

8 out 100 women with a **lower BMI** had one or more of the features of our main outcome

Very few women who had given birth before had a Caesarean:

Just over **1** out of 100 women with a **BMI over 35** had a Caesarean

Just less than **1** out of 100 women with a **lower BMI** had a Caesarean

More women with BMI over 35 who were having their first baby had one or more of the features of our main outcome, compared with women with lower BMI. Because of the small numbers of women with BMI over 35 who were having their first baby in our study we can't be certain if this is a true difference or just due to chance

38 out of 100 women with a **BMI over 35** had one or more of the features of our main outcome

35 out of 100 with a **lower BMI** had one or more of the features of our main outcome

Overall, women with BMI over 35 were more likely to have a Caesarean birth, but the chances of this happening were low

5 out of 100 women with a **BMI over 35** had a Caesarean

4 out of 100 women with a **lower BMI** had a Caesarean

Rowe R, Knight M, Kurinczuk JJ, and on behalf of the UK Midwifery Study System (UKMidSS). Outcomes for women with BMI>35kg/m² admitted for labour care to alongside midwifery units in the UK: a national prospective cohort study using the UK Midwifery Study System (UKMidSS). PloxOne https://doi.org/10.1371/journal.pone.0208041

UKMidSS UK Midwifery Study System

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Appendix Two: Checklist for the Care of Women with a BMI ≥ 45

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Attach addressograph here

Please file in notes at dating scan.

Checklist for the Antenatal Care of Women with a BMI ≥45

BMI at dating scan:	Weight at Dating scan (in kg):

Checklist Item	Who	Sign when completed	Comments
Referred to Bump Start Specialist Midwifery Clinic	Antenatal Clinic Midwife		
Potential Difficulty with ultrasound scanning discussed	Community Midwife (at booking)		
Oral Glucose Tolerance Test appointment made	Antenatal Clinic		
Serial growth scans recommended	Community midwife/ Obstetrician		
VTE assessment completed at booking. Thromboprophylaxis recommended/prescribed	Community midwife		
Aspirin assessment completed at dating scan appointment	Community midwife		
Other risk factors identified: Smoker/ Diabetes/ GDM/ Drug or alcohol use/ Other	Comments:		
Anaesthetic review	Anaesthetist	Date of completion:	Comments
Birth recommendations by Obstetrician	Obstetrician	Date of completion:	Comments
Fetal monitoring limitations discussed	Community midwife/ Obstetrician	Date of completion:	Comments
Birth plan/discussion completed by named Midwife	Community midwife	Date of completion:	Comments
Manual handling risk assessment completed	Community midwife	Date of completion:	Comments
End of pregnancy weight	Community midwife	Weight gain	

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Attach addressograph here

Please use the space below to add any further relevant information, which may include:

- Anaesthetic recommendations
- Manual handling considerations
- Considerations for admission to theatre
- Obstetric recommendations
- Fetal heart rate discussion/considerations
- Birth plan preferences/discussions/woman's choices