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Fieldwork on weight management during pregnancy and after childbirth

Report to the National Institute for Health and Clinical Excellence

GSB Reference: CR2294/97

Disclaimer

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- Leicester Royal Infirmary, Leicester;
- Doncaster PCT, Ten Pound Walk, Doncaster;
- Smethwick Uplands and Londonderry Children's Centre, Sandwell;
- Stoneycroft Children's Centre, Liverpool;
- Chapeltown Children's Centre, Leeds; and
- Grassroots Children's Centre, Newham.

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Abstract

This final report summarises a fieldwork evaluation of the draft recommendations developed on weight management during pregnancy and after childbirth. The report summarises the findings from a series of workshops, focus groups and interviews with professionals and practitioners. It draws out key findings for the recommendations as a whole and for each individual recommendation. The fieldwork focussed on the content of the draft recommendations such as whether they were thought useful and relevant, factors affecting the feasibility in practice and the potential impact of the recommendations.

Overall, the findings suggested that the recommendations were received well and were relevant. They were well written, easy to read and clearly structured. Some areas already carry out these actions, resulting in the recommendations adding 'nothing new' to practice. However, others do not adopt these actions and so their resources and policies would have an impact if these recommendations were to be implemented. Resources, funding, staff and workload were reported as other important issues that would affect the recommendations being implemented and would determine their impact. Professionals would have preferred more specific detail in the recommendations to help them be put in to practice. This included instructions on how to carry them out and specific roles and responsibilities assigned for individual practitioners. Clearer care pathways were also needed to help professionals know which services and organisations they can refer women to in order to receive appropriate support. Prevention and education were other issues that needed to be covered by the recommendations to increase awareness of obesity by all women, before becoming pregnant.

E. Executive Summary

E.1 Introduction

The aim of the fieldwork was to get practitioners views on the content, feasibility and potential impact of the draft recommendations on weight management during pregnancy and after childbirth, including:

1. What were practitioner's views of the relevance and usefulness of the content and the wording of the draft recommendations?
2. What factors might affect the feasibility of the implementation of the draft recommendations?
3. What impact might the draft recommendations have on service provision and practice?
4. How well did the draft recommendations match with practitioner's experience?

E.2 Method

The fieldwork comprised of five main activities:

1. Three full day workshops with practitioners such as Consultants of Public Health, midwives, Obstetricians, dietitians, etc;
2. Three, two hour focus groups with midwives (Consultant Midwives), Obstetricians (Obstetric Consultant)and dietitians, etc;
3. Four, two hour focus groups with health visitors, Children's Centre managers and Breastfeeding co-ordinators;
4. Twenty-eight telephone interviews – carried out with GPs, practice nurses, leisure services and Children's Centres;
5. A content analysis of summaries to identify and summarise key themes of feedback.

The fieldwork took place from 18th February – 18th March 2010.

E.3 Findings and conclusions

E.3.1 Overall findings

General findings

The overall findings from the fieldwork include:

- The draft recommendations were overall well received and reported to be well written;
- The recommendations were found to be relevant and necessary to raise awareness of the issue of weight management;
- They were suggested as being particularly useful for non health care professionals to use and help raise awareness amongst this group;
- Resources and funding were required in order to implement the recommendations fully and to a high quality;
- There were several groups of hard to reach women that were not covered by the recommendations;

- More detail was needed in order to enable health professionals to carry out some of the actions;
- The recommendations should focus on more pro-active actions rather than focusing on the more negative aspects of what women should not do;
- The remit of the guidance should be broadened.

Content and wording

The findings from the fieldwork on the content and wording of the recommendations include:

- Wording and language of the recommendations to be very clear, well set out and easy to read;
- Thought to be relevant and would raise awareness amongst non-healthcare professionals;
- Too vague and general for professionals to put into practice. More specific detail was needed;
- The remit of the guidance was reported as very narrow, often missing or lacking sufficient detail on important issues. These included:
    - A greater deal of information was needed on the importance of breastfeeding, highlighting the health benefits and impact it has on weight management;
    - The focus of the guidance was on women who were overweight. However, great health risks are also posed to pregnant women who are underweight;
    - The holistic approach was an issue reported that needed to be covered. This would include focusing more on the psychological and emotional wellbeing issues that surround weight management; focusing on behaviour change and maintaining a healthy weight rather than weight loss; and focusing on changing the behaviour of the whole family and not just that of the mother.
- The practitioners reported that there were some groups of women that would not be covered by the recommendations. These included:
    - Women of low socioeconomic status (SES);
    - Women of different cultures and religions;
    - Pregnant teenagers;
    - Women of a childbearing age are a wide cohort of women.
- It was recommended that the guidance need to *'go back a step'* to include guidance on prevention of obesity and education of the risks of obesity. This would then help to reach all women and ensure they were aware of the risks before pregnancy.

Feasibility of the recommendations

The findings from the fieldwork on the feasibility of the draft recommendations include:

- Mixed feedback was gained regarding the feasibility of the recommendations. Some practitioners reported that these actions were already being carried out within areas and therefore are feasible; however other areas would have difficulty carrying out the recommendations. For example,

  - There is inconsistency in carrying out the six to eight week postnatal check across areas, with many areas not conducting this in practice;
  - The use and availability of dietitians is limited in some areas.
- The credibility of the recommendations may be questioned as obesity is not necessarily high on all services' agendas. All services would need to be 'on board' for the recommendations to be put into practice;
- It was reported that these recommendations would be more effectively implemented if there was a National Quality Outcome Framework developed by the Department of Health in weight management during pregnancy and after childbirth. It was noted that this would help to engage primary care more with the issue;
- The inconsistencies between services will affect the implementation of the recommendations in other ways. For example, mixed responses were provided regarding the range of BMI that services work to;
- The recommendations may not be effective with hard to reach groups such as:
  - Women of low SES;
  - Non- English speaking women; and
  - Transient populations;
  - It was suggested that a social marketing campaign would enable the recommendations to be implemented more effectively. The absence of mass media within the guidance was recognised as a weakness by the practitioners. Comparisons were made with the Change4Life campaign.
- Funding, resources and workload were suggested as important factors that would affect the recommendations from being implemented;
- Feedback from the practitioners emphasised that the issue of weight management is a sensitive subject area and can often be avoided by many health professionals. Approaching the issue would need to be done over time when a professional feels comfortable to do so, which is often not feasible in the limited appointments they have with women. Training should also cover communication skills.

Impact of the recommendations

The findings from the fieldwork on the impact of the recommendations include:

- Impact would differ across different areas, due to the inconsistencies between areas. The resources, staff, workload and clients of each service would affect the impact the recommendations would have;
- Large cost and resources implications. This was mainly due to the vast amount of women that these recommendations covered;
- The way in which these recommendations would be evaluated and monitored was questioned. It was suggested that roles and responsibilities need to be assigned to ensure that all services are working to these recommendations to a high quality standard;

- Impact of the guidance would be greater if actions and services were tailored to the preferences of women.

E.3.2 Recommendation specific findings

Recommendation 1 – preparing for pregnancy

The feedback on this recommendation was that it was both relevant and useful. Common themes from the fieldwork were that:

- The remit of this recommendation should be changed to "*all women of child bearing age*" (Manchester workshop Floor 24) and
- It should link into the Change4Life campaign.

One of the main factors reported as affecting feasibility was the need for a National Quality Outcome Framework (QOF) to be developed in weight management during pregnancy and after childbirth as without this it was thought that primary care would not be as involved.

Several other key findings included:

- The potential impact of this recommendation would vary depending on area and the current level of service provision;
- Clarification needed on 'community and commercial organisations', 'Health Trainers' and whether this recommendation was aimed at those with a BMI over 30;
- Include actions for leisure services and voluntary sector;
- Include use of media in raising people's awareness of weight management;
- Include sensitivity issues such as how to approach weight management issues appropriately; and
- Include the following groups under 'who should take action', wider community, women, local clubs, schools, mother/toddler groups, Children's Centres and commissions and managers outside of PCT/NHS Trusts.

Recommendation 2 – women who may become pregnant - with BMI over 30

Overall, this recommendation was thought to be relevant. However, consistent feedback suggested the title was too vague. As with recommendation one, the feedback suggested that the remit of this recommendation be extended to include all women of child bearing age. A common theme raised throughout the fieldwork suggested that there was no recognition within the recommendation of differing BMI obesity thresholds for different ethnicities, such as South Asian woman.

Several factors were identified that would impact on the feasibility of implementation. These included a lack of funding for current and new staff, a lack of services in place to signpost people to, GPs do not currently weigh and measure women (usually midwife), sufficient resources to be able to record BMI of women.

Other key findings included:

- More staff would be required to implement the recommendation;
- Considered unrealistic with current capacity and availability of services;
- Would increase knowledge and awareness of staff;

- Clarity needed of who 'health trainers' were;
- Include advice to tackle psychological issues associated with weight;
- Dietitians should be removed from the recommendation;
- Include dietary advice and assessment of current eating behaviours;
- Include practical advice to health professionals on how to raise the issue of weight with women;
- Risk factors detailed should be more specific and clearer; and
- Include the following groups under 'who should take action', commissioners, partners, families and friends, preconception advice and care services and school nurses.

Recommendation 3 – pregnant women

This recommendation was received well, was thought to be relevant and useful as it dispels common myths around weight and pregnancy. One common theme that was raised by many practitioners was the need to weigh women at every visit.

There were concerns raised over the use of BMI and the potential inaccuracies due to differences in calculations. As with recommendation one, practitioners noted that this recommendation should acknowledge the different BMI obesity thresholds for different ethnicities.

Suggested amendments to the recommendation included:

- Midwives or health professionals should replace GPs in the first bullet point;
- Should detail clear care pathways;
- More information sources should be provided on explaining the positive benefits of weight management;
- More specific details should be provided on exactly what women can and cannot eat during pregnancy;
- Information on advice to provide on a healthy weight gain during pregnancy (as in the IOM guidelines on weight gain during pregnancy 2009)[1];
- Include advice on breastfeeding and the benefits associated with weight management;
- Amend remit to include woman with a BMI between 25 – 30; and
- Include information to provide advice on the benefits of weight management.

Recommendation 4 – supporting women following childbirth

[1] Some delegates reference the Institute of Medicine's guidelines on weight gain during pregnancy. Rasmussen KM, Yaktine AL, editors. Committee to Reexamine Institute of Medicine Pregnancy Weight Guidelines (2009) Weight gain during pregnancy: re-examining the guidelines [online]. Available from http://books.nap.edu/openbook.php?record_id=12584

There was support for this recommendation. Overall, practitioners said that there needed to be more detail and direction within the recommendation. The six – eight week postnatal check was the subject of debate as was the motivation of individuals as a barrier to accessing services and successfully implementing actions in the recommendations.

Suggested amendments to the recommendation included:

- Rewording;
- Link to a national quality outcome framework;
- Link with national campaigns e.g. Change4Life;
- Clarity on existing care pathways; and
- Possibly merge with Recommendations 5 and 6.

Recommendation 5 – women with a BMI over 30 following pregnancy and after childbirth

This recommendation was thought to be very similar to recommendation four.

Practitioners said that the recommendation should include all BMI such as those with a low BMI and normal BMI. There were major concerns about the availability of dietitians.

Suggested amendments to the recommendation included:

- Rewording;
- Link with existing guidance e.g. obesity guidance;
- Clarity on the provision of services to different cultural and socio economic groups;
- Promotion of the benefits of weight loss;
- Emphasis on better utilisation of existing services; and
- Possibly merge with recommendations four and six.

Recommendation 6 – supporting women after childbirth

This recommendation was thought to be very similar to recommendation 5. It was seen as being quite vague and would benefit from a greater level of detail.

Practitioners said that implementation may be difficult if it is not known what services women access in the first place. Similarly it was essential to ensure that health professionals know what existing services are and how to signpost women to these services.

Suggested amendments to the recommendation included:

- Rewording;
- Inclusion of commissioners;
- Clarity on what is meant by ‘recently had a baby’?
- Definition of what is meant by ‘community’?
- Emphasis on strengthening existing services;
- Some form of monitoring and evaluation of existing services; and
- Possibly merge with Recommendations 4 and 6.

Recommendation 7 – professional skills

This recommendation was thought could benefit from being more specific as at present it is too vague.

The main concern was how the recommendation would be measured so as to ensure successful implementation. There also needs to be some form of assessment to determine what professional skills are required and by whom. Practitioners were also concerned about the time and funding implications.

Suggested amendments to the recommendation included:

- Rewording;
- Inclusion of professional bodies;
- Clarity on who would be responsible for monitoring the training required;
- Training that considers weight management advice for different cultural and socio-economic groups;
- Clarity on skills needed to advise women who suffer from a complicated pregnancy; and
- Some reference to the 'softer skills' needed when talking about weight management.

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1 INTRODUCTION

Greenstreet Berman Limited was commissioned by the National Institute for Health and Clinical Excellence to carryout fieldwork with practitioners to test draft recommendations on weight management during pregnancy and after childbirth.

The aim of the fieldwork was to get practitioners views on the content, feasibility and potential impact of the draft recommendations on weight management during pregnancy and after childbirth, including:

1. What were practitioner's views of the relevance and usefulness of the content and the wording of the draft recommendations?
2. What factors might affect the feasibility of the implementation of the draft recommendations?
3. What impact might the draft recommendations have on service provision and practice (by health and other agencies, for example schools)?
4. How well do the draft recommendations match with practitioner's experience?

1.1 A request for guidance from the Department of Health

The scope of the initial guidance came from two requests by the Department of Health to *"develop joint guidance on public health interventions for weight management in pregnancy"* and to *"develop guidance on public health interventions aimed at helping mothers to achieve and maintain a healthy weight after childbirth."*

The NICE guidance on weight management during pregnancy and after childbirth was originally to be two sets of guidance as specified by the DoH's two requests. However, PHIAC felt that the same types of stakeholders would need to be consulted during the fieldwork and there would potentially be a lot of overlap. Therefore, PHIAC advised that the two sets of guidance be combined into one set of guidance. The guidance has been developed through a series of six phases, these included:

1. Drafting of a scope to identify the remit of the work.
2. Consultation to ensure relevance and usefulness of the scope.
3. Reviews of the relevant literature.
4. Consultation on the review to identify any missing evidence.
5. Public Health Interventions Advisory Committee (PHIAC) review of the evidence and drafting of the recommendations.
6. Practitioner consultation to evaluate the relevance, usefulness and implementability of the recommendations.

This fieldwork formed part of phase six. The findings from this fieldwork act as a source of evidence on the relevance, utility and implementability of the recommendations. Findings from the fieldwork are considered by NICE to be an important source of evidence on the feasibility of implementation of the recommendations, and the conditions required for uptake and delivery.

The findings of the fieldwork reported in this document will be considered by NICE's Public Health Interventions Advisory Committee (PHIAC) in April 2010 and inform the final guidance, due to be issued in July 2010.

NICE guidance is developed using the best available evidence and the expertise of the NHS and the wider public health community including NHS staff, healthcare professionals, parents and carers, industry and the academic world. Once NICE publishes public health guidance, health professionals and practitioners within the NHS, local authorities and the wider public, private and voluntary sectors are expected to take guidance recommendations into account.

NICE will provide tools to support implementation of the recommendations.

1.2 Target audience and populations covered

The recommendations are aimed at professionals, commissioners, managers and practitioners within the NHS, local authorities and the wider public, private, voluntary and community sectors. More specifically, the guidance is aimed at:

- GPs;
- Obstetricians;
- Midwives;
- Those working within the antenatal and postnatal care services;
- Those working in fertility services;
- Community pharmacists;
- Dietitians and Public Health Nutritionists;
- Leisure services managers in local authorities and the private sector;
- Organisers of relevant community groups and services including slimming clubs, health trainers and fitness advisers;
- Those working in Children's Centres.

1.3 The draft recommendations

Seven draft recommendations were developed as a result of the research. The draft recommendations covered seven main areas including:

1. Preparing for pregnancy;
2. Woman who may become pregnant – with BMI over 30;
3. Pregnant women;
4. Supporting women following childbirth;
5. Woman with BMI over 30 following childbirth and after pregnancy;
6. Community based services for women before pregnancy and following childbirth; and
7. Professional skills.

A copy of each draft recommendation is included in section 3.7 of this report.

2 METHOD

2.1 Overview

The fieldwork comprised five main activities:

1. Three one-day workshops with 66 practitioners such as hospital and community midwives, Consultants in Public Health, food and nutrition advisors, Obstetricians, commissioners, , Public Health Co-ordinators, Health Improvement Specialists;
2. Three focus groups – with practitioners such as obesity co-ordinators, Obstetric Registrars, dietitians (NHS based), public health dietitians, nurses and consultant midwives;
3. Four focus groups – With practitioners such as commissioning managers, community nutritionists, Children's Centre managers breastfeeding Co-ordinators, health visitors and community dietitians;
4. Twenty – eight telephone interviews – carried out with GPs, practice nurses, local authority leisure services and Children's Centres;
5. A content analysis of summaries to identify and summarise key themes of feedback. Section 3 of this report provides a synthesis of feedback from all parts of the fieldwork. The summaries of the workshops and focus groups are provided in the appendices. The summaries of the telephone interviews are not available publicly in order to preserve the anonymity of the interview respondents.

All practitioners received briefing materials and questions prior to the fieldwork sessions, and were provided with summaries of their sessions for approval. All fieldwork was scheduled for February/March 2010 in order to meet the project timeline.

The workshop, focus group topic guides and telephone interview proformas were developed through close liaison with the team at NICE, to ensure that the key research questions were addressed. During the development of the questions for the topic guides and telephone interview proformas reference and adherence was made to '*Methods for development of NICE public health guidance'* (2006).

The topic guides (available in the separate Appendix document) were structured to ensure that practitioners had a comprehensive understanding of the background, aims and outcomes of the fieldwork. The topic guides were split into two main sections. The first section raised questions on the recommendations as a whole, and included questions in five main categories pre-agreed with the research team at NICE:

1. Content and wording of the recommendations;
2. Feasibility;
3. Barriers;
4. Impact of the recommendations; and
5. Inclusivity of the recommendations.

Each question under these main categories included prompts to give the facilitator the means to explore the subject in more detail.

The second section raised questions to be addressed for each recommendation in turn. This included questions on the wording (relevance and usefulness), factors affecting feasibility, barriers, impact and any other comments for each of the recommendations.

The telephone interview proforma was developed using the workshop topic guide as a basis.

2.2 Workshops

2.2.1 Workshop recruitment

All recruitment for the workshops was performed by Greenstreet Berman Limited. Key practitioners for the direct email were identified from an internet search of organisations using key terms such as PCT Directors of Public Health, antenatal services, post-natal care services, midwives, health visitors, GPs, practice nurses, Sure Start, Consultants in Public Health, dietitians etc..

A list of 1430 individuals was developed covering London and the North West of England, with their names, organisations and email addresses, these included:

1. GPs;
2. Practice nurses;
3. Directors of Public Health;
4. Consultants in Public Health;
5. Sure Start;
6. Dietitians;
7. Leisure services;
8. Midwives;
9. Obstetricians ;
10. Slimming clubs;
11. Breastfeeding counsellors;
12. Community pharmacists;
13. Those working in Antenatal care;
14. Those work in Postnatal care;
15. Representatives from Children's Centres;
16. Strategic Health Authority Directors of Public Health;
17. Physiotherapists specialising in women's health; and
18. Health visitors.

They were contacted via an email to request the attendance of a representative of their organisation at one of the scheduled workshops. The invitation outlined the purpose of the workshops, the scope of recommendations and who they were aimed at.

All individuals that booked onto a workshop were sent a copy of the draft recommendations as part of the delegate's topic guide in advance of the workshops.

As detailed in Table 1, a total of 66 delegates attended the workshops, which is 83% of those that agreed to attend. Initially only a one day long workshop was scheduled for Manchester. However, an additional session was run in order to accommodate all the delegates that wished to attend the workshops.

Table 1: Number of delegates per workshop

Workshop	Number of delegates that agreed to attend	Number of delegates that attended
London 26th February 2010	30	**25**
Manchester (NICE offices) 2nd March 2010	30	**26**
Manchester (Floor 24) 2nd March 2010	20	**15**
Total	80	**66**

2.2.2 Conducting the workshops

There was one main facilitator running the workshop with two other facilitators that acted as scribes in the plenary sessions, and facilitators in the recommendation-specific reviews. All workshops sessions were recorded, consent for which was obtained from all delegates at the beginning of the workshop. The session agenda is shown below:

Timing	Activity
09.30 – 10:00	Welcome and coffee
10:00 – 10:15	Introduction
10:15 – 11:15	Plenary session – discussing all draft recommendations as a whole
11:15 – 11:30	Coffee break
11:30 – 12:30	Small group work – to discuss recommendations 1, 2, 3 and 7
12:30 – 13:30	Lunch provided
13:30 – 14:00	Plenary session – discussion recommendations 1, 2, 3 and 7

Timing	Activity
14:00 – 15:00	Small group work – to discuss recommendations 4, 5 and 6
15:00 – 15:15	Coffee break
15:15 – 15:45	Plenary session – discussion on recommendations 4, 5 and 6
15:45 – 16:00	Close and evaluation of day

In total 66 delegates attended the three workshops. The disciplines of delegates were all relevant and appropriate to the subject matter. On completion of the workshops a summary was written up by the facilitators. This summary (provided in a separate appendix document) was then sent to the delegates for any additional comments and approval.

Listed below is a summary of the evaluation worksheets that were received on completion of the three workshops. Delegates were asked to answer each question on a 10 point scale (1 = not at all/poor, 10 = definitely/excellent).

Table 2 Average evaluation score for workshops

Questions posed to the delegates included the following	Average score (max score 10)
Were the key points covered?	8
Did the workshop satisfy its objectives?	8
Was the length of the workshop adequate?	8
Please rate the standard of facilitation	8
Please rate the quality of written materials/visual aids	7

2.3 Focus groups

2.3.1 Focus group recruitment

A different method was used to recruit the focus groups. It was agreed with NICE to run the sessions in Newham (London), Doncaster, Leeds, Liverpool, Leicester, Harlow and Sandwell. Due to recommendations being split between ‘before and during’ pregnancy and ‘following’ childbirth it was agreed that the focus groups should also be split. It was agreed that three focus groups would concentrate on those stakeholders involved in all stages related to ‘before and during’ pregnancy and four focus groups would focus on those stakeholders involved in all stages of post-natal care following childbirth.

During pregnancy focus groups

A Greenstreet Berman consultant contacted the Primary Care Trusts (PCTs) in Harlow, Doncaster and Leicester directly to identify the Maternity/Obesity Co-ordinator.

Once an appropriate contact within the PCT had been identified, an email was sent with the background information and what would be required:

- To book a room for two hours on the PCT premises;
- To invite colleagues such as GPs, midwives, Obstetricians, commissioners and dietitians etc…
- To let Greenstreet Berman know who had been invited.

These PCTs were very willing and able to assist with organising the focus groups.

Following childbirth focus groups

A Greenstreet Berman consultant contacted Children's Centres in Leeds, Newham, Liverpool and Sandwell.

Once an appropriate contact within the Children's Centre had been identified, an email was sent with the background information and what would be required:

- To book a room for two hours on the Children's Centre premises;
- To invite colleagues such as managers of Children's Centres, GPs, health visitors, commissioners and dietitians etc…
- To let Greenstreet Berman know who had been invited.

The majority of contacts within the Children's Centres were able to book a room and invite appropriate attendees to the focus groups. However, in a couple of instances the contact was able to book a room for the focus group to be held but was unable to invite appropriate delegates. In these instances a Greenstreet Berman consultant recruited relevant stakeholders to the focus groups.

Attendance

Once delegates had been confirmed, Greenstreet Berman sent background information including the proforma and draft guidance to the delegates (or via the contact at the PCT where delegate emails had not been provided).

Attendance at the focus groups was very good as detailed in Table 3, a total of 47 delegates attended the workshops which is more than those who initially agreed to attend.

Table 3: Number of delegates per focus group

Focus group	Number of delegates that agreed to attend	Number of delegates that attended
Liverpool	6	**7**
Newham	4	**4**
Leeds	7	**5**
Sandwell	5	**5**
Leicester	8	**10**
Doncaster	7	**10**
Harlow	5	**6**
Total	42	**47**

2.3.2 Conducting focus groups

The focus groups were generally attended by between four - ten delegates each and were usually attended by those from the host PCT and those who worked within the PCT area. They aimed to look more at local practice and how the recommendations might impact on their practice. Delegates invited to the focus groups tended to be from professions that would struggle to attend a half day workshop geographically distant from the location of their work.

One facilitator attended each focus group, as well as (usually) the person responsible for organising the group within the PCT and the delegates. The facilitator acted as a lead facilitator, as well as, taking notes. All sessions were digitally recorded to ensure accuracy of note taking throughout the session. Recordings were not used to identify any delegate – all sessions were anonymous and confidential.

Overview of recommendations

The groups started with a plenary session that looked at the recommendations as a whole and sought feedback on perceived:

- Content and relevance;
- Factors affecting feasibility;
- Barriers;
- Impact; and
- Inclusiveness.

Recommendation-specific sessions

Following the focus group plenary session, one or more specific recommendations were discussed individually by the focus group. Where the focus groups were quite large, delegates were split into smaller groups. For smaller focus groups, a plenary format was continued. Specific issues, in addition to those listed above, included:

- Content and wording of the recommendation in terms of its relevance and usefulness;
- Feasibility and practicality of the recommendation;
- Barriers and facilitators for applying the recommendation; and
- The impact on current practice.

Write ups of all sessions were drafted and circulated amongst all delegates to allow any additional comments and clarification. The write ups of the session were finalised once comments had been received, or the deadline for comment had passed.

Listed below is a summary of the evaluation worksheets that were received on completion of the seven focus groups. Delegates were asked to answer each question on a 10 point scale (1 = not at all/poor, 10 = definitely/excellent).

Table 2 Average evaluation score for focus groups

Questions posed to the delegates included the following	Average score (max score 10)
Were the key points covered?	8
Did the workshop satisfy its objectives?	8
Was the length of the workshop adequate?	8
Please rate the standard of facilitation	8
Please rate the quality of written materials/visual aids	8

2.4 Telephone interviews

2.4.1 Recruitment and sampling of telephone interviews

A list of contacts was developed by an internet search of pertinent practitioners. In each case a name and telephone number was identified. The contacts were telephoned for the sake of explaining the purpose of the fieldwork, the scope of the recommendations and to request an interview. In total, 28 telephone interviews were completed. The aim was to interview seven of each of the four different types of practitioners:

- GPs;
- Children's Centres;
- Practice nurses; and
- Leisure services.

However, GPs, practice nurses and leisure services were more difficult to recruit to carryout telephone interviews. Therefore, more interviews were carried out with Children's Centres. Table 3 presents the number of telephone interviews by each type of practitioner.

Table 3: Number of telephone interview carried out

Practitioner	Number of telephone interviews
GPs	5
Practice nurses	5
Leisure services	5
Children's Centre	12

2.4.2 Conducting the telephone interviews

Practitioners were sent the interview proforma and a copy of the recommendations to read prior to the interview. Each interview lasted approximately 30 minutes. Respondents were required to comment on those recommendations that were relevant to them. Therefore, four main telephone proformas were developed, these included:

- One for GPs and practice nurses;
- One for leisure services; and
- One for Children's Centres.

On completion of the interviews a summary was written up by the interviewer and sent to the interviewee for any additional comments and for their approval.

2.5 Analysis and reporting of results

There was one summary per fieldwork session, written so as to provide anonymised and confidential feedback on the recommendations. These are provided in the separate appendices to this report.

These summaries, along with additional thoughts and recollection of discussions were used in the analysis. All facilitators and interviewers attended a thematic analysis session whereby the recommendations as a whole and each recommendation, one by one, were discussed in turn.

The results from the focus groups, workshops and telephone interviews were compared and any differences and similarities were discussed. Issues specific to different types of health professionals were also discussed.

Discussion of the recommendations as a whole and then the recommendations one by one, included:

- Key themes surrounding:
    - Content and relevance;

  - Feasibility;
  - Impact;
  - Inclusiveness e.g. any concerns with increasing health inequalities;
  - Suggested support for implementation including links with other initiatives or other professional groups.
- Any issues particular to professional groups, for example midwives, commissioners and GPs.

3 MAIN FINDINGS

3.1 Introduction

This section of the report provides the feedback on the recommendations as a whole, specifically:

- General reactions to the recommendations;
- Content and relevance of the recommendations;
- Feasibility of the recommendations;
- Impact of the recommendations.

The findings from the three workshops, six regional focus groups and 28 telephone interviews with practitioners and professionals have been analysed and the key themes are highlighted in the following section. Overall, the content analysis revealed that the findings from all types of practitioners were quite consistent and there were no major differences between the findings from the workshops, focus groups and telephone interviews.

3.2 General reactions to the recommendations

Most professionals were positive about the recommendations, citing that they were relevant and would help to raise awareness of the issues regarding weight management during pregnancy and after childbirth. This was particularly the case for non-healthcare professionals, as it was suggested that they may have little information on the issues. However, GPs were less positive about the recommendations, stating that there are too many actions and responsibilities for GPs to carry out effectively. Limited feedback from GPs also highlighted that GPs do not see the relevance of the recommendations to them. This is supported in findings from other practitioners that reported GPs are less involved in weight management for women during pregnancy and after childbirth and that this task is the responsibility of other health professionals such as midwives.

Feedback also suggested that the recommendations were general and vague and would be open to interpretation. Practitioners said that many services would be able to report carrying out the actions; however, this may not be to the quality and standard required. More detailed information was required in order to advise how these actions can be put into practice and clear pathways that professionals can work to.

3.3 Content and relevance of the recommendations

3.3.1 Content

Overall, practitioners reported the recommendations to be relevant. However, they also reported the recommendations to be too vague and lack direction, particularly information on how the actions can be carried out. Important issues such as breast feeding were missed out, leaving the remit of the guidance as very narrow. Prevention methods such as education also needed to be addressed.

Easy to read but too general

The recommendations were reported to be relevant, clearly set out and easy to read. Practitioners suggested that they would raise awareness of the issues amongst non-health professionals and these professionals would be able to follow them without difficulty. However, for health professionals these recommendations were reported to be too general and the guidance document would be open to interpretation.

Should be more directive and clearer role allocation

Professionals wanted the actions to be more directive. For example, stronger language was preferred, with less use of words such as *'should'*. Inclusion of clear information on how the actions can be put into practice was also reported as important. Roles and responsibilities need to be allocated more clearly, such as stating who is responsible for carrying out the six to eight week check.

Guidelines on weight loss targets and goals

Targets and goals were cited as important to include helping health professionals understand exactly what they were aiming for. Standards of safe weight to lose (per week for example) and the time periods in which weight should be lost were reported as information that should be included in the recommendations. Some delegates suggested the IOM guidelines (2009) on weight gain during pregnancy[2] should be referenced in the recommendation.

Care pathways need to be outlined

Clear pathways for individual professionals were another important issue that practitioners cited for inclusion in the recommendations. This was suggested to ensure consistency takes place across services and would increase awareness of the services available that professionals should be referring women to. It was suggested that managers and commissioners should set these pathways and GPs should be aware of the pathways in order to signpost women to appropriate services.

There was no reference to existing pathways such as bariatric clinics and diabetics clinics. These were found to be useful resources and needed to be promoted within the guidance.

Actions for Commissioners

As commissioners have contact with multiple services, it was reported that more actions for commissioners should be included in the recommendations. Benefits of carrying out the recommendations should be highlighted to encourage commissioners to commission the work.

Positive vs negative health messages

Practitioners commonly reported that they thought the recommendations would benefit from more positive incentives of weight management, such as better conception rates, rather than focusing more on the negative aspects of weight management.

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[2] Some delegates reference the Institute of Medicine's guidelines on weight gain during pregnancy. Rasmussen KM, Yaktine AL, editors. Committee to Reexamine Institute of Medicine Pregnancy Weight Guidelines (2009) Weight gain during pregnancy: re-examining the guidelines [online]. Available from http://books.nap.edu/openbook.php?record_id=12584

General Practitioners and Practice Nurses

GPs and practice nurses generally did not think that the recommendations were relevant for them. Indeed they reported that they would not have much contact with pregnant women and would refer them onto a midwife. They therefore said that these recommendations were relevant for midwives but not for them.

Dietitians

There was consistent feedback that referring women to dietitians would not be appropriate. There were a few reasons for this in many areas they simply do not have dietitians available to refer people on to. Other areas that did have dietitians thought that it would create long waiting lists by referring women on to them. Suggestions were made to refer women on to an appropriate weight management programme.

3.3.2 Remit of guidance

The remit of the guidance was reported as narrow by the practitioners, with many important issues missing or lacking detail.

Breastfeeding

One of the main issues that were suggested as having been overlooked was breastfeeding. Although this was mentioned within the recommendations, many practitioners described how more importance needs to be placed on breastfeeding. For example, it needed to be promoted more within the recommendations with the health benefits cited. Practitioners highlighted that the guidance does not emphasise the importance of and that breastfeeding can have a positive impact on weight management, often helping women to lose weight.

Holistic approach

The practitioners reported a holistic approach is needed when addressing weight management in these women, as many issues need to be considered. For example, the issue of achieving a healthy weight needed to be promoted, rather than focussing on weight loss.

It was suggested that a ‘whole family approach’ was needed to address the issues covered by the recommendations. In order for women to improve their health behaviours, it was found that it is important to extend this to ensure that behaviour change was taking place by the whole family. Although the recommendations include people such as partners, friends and family within ‘those who should take action’; however, practitioners highlighted that there were no specific actions cited for these groups of people. These people can be a great support mechanism for women and should be detailed to a greater extent within the guidance.

Practitioners discussed that the main focus of the recommendations was on women who were overweight and with a high BMI. However, many highlighted that women who were underweight were not covered within the recommendations. It was suggested that these women also had health risks that needed to be addressed.

Psychological and emotional impact of weight gain

The psychological and emotional impact of weight gain was reported as missing from the guidance. These were found to be very important issues that were often linked with weight management difficulties. For example, conditions such as depression can prevent women from taking part in physical activity and behaviour change. It was also suggested that gaining weight during and after pregnancy can be a very sensitive issue for a women and can affect their emotional wellbeing. This also needed to be recognised by the guidance.

Other missing issues

The practitioners reported many other issues that were missing from the recommendations that should be considered and addressed. These included:

- Women with health conditions such as diabetes and other co-morbidity issues. These can often affect weight and would need to be considered during pregnancy;
- Childhood obesity. It was suggested that overweight mothers can have a *'knock on effect'* on childhood obesity. Many found that highlighting the impact on the child can motivate women to change their health behaviours. There is room for this guidance to link with the Childhood Obesity Strategy;
- Women experiencing fertility issues and the health issues surrounding them were not covered;
- Women with certain diets, such as vegetarians and vegans were not addressed. More guidance is needed for professionals on how to work with these women.

3.3.3 Inclusivity

Practitioners cited that certain groups had not been covered by the guidance. These are detailed below.

Socioeconomic status

The practitioners reported that the guidance does not offer anything new on how to reach certain groups and issues relating to culture and socioeconomic status needed to be addressed. For example, it was suggested that women of low socioeconomic status would have little knowledge on issues such as BMI and healthy diets. Promoting the use of weight management and slimming clubs was also found to be inappropriate as many of these are privately run and expensive. This would prevent women from attending.

Professionals also reported that many women of low socioeconomic status often only attend one appointment with a Health Professional during their pregnancy. Therefore, they are harder to engage with. It can also be difficult to provide all the information they need during a single appointment. As weight management may not be a high priority, it would often get overlooked.

Different cultures

Cultural factors were also highlighted by the practitioners as being overlooked. Many practitioners suggested that weight management is not an issue in some cultures, with certain groups preferring a woman to gain weight during pregnancy. In contrast, some practitioners suggested that South Asian women have a lower BMI threshold, where a BMI of 25 can be considered as obese. Differences such as these need to be considered by the recommendations and guidance.

Teenage pregnancies

It was suggested that insufficient detail was provided on young girls and the specific advice and support they would need. Weight was also reported to be an important issue for this group with mixed experiences highlighted. For example, some practitioners reported that this group are often underweight, presenting a need to gain weight in order to be healthy. However, other practitioners reported that these girls often gain weight to hide their pregnancy.

3.3.4 Prevention and education

It was suggested that the guidance needs to *'go back a step'* and consider prevention and education issues. Practitioners highlighted that many women do not plan a pregnancy and would not access services or health professionals before becoming pregnant. Therefore, there is a need to provide all women with education on obesity and the dangers it can pose when pregnant to prevent obesity and encourage women to maintain a healthy weight.

Women of a childbearing age are a large cohort of women with a wide age range. For example, they can include girls of 14 years old. Therefore, it was suggested that it is important to educate all women on the risks of obesity and how to manage weight at a young age in order to be inclusive.

In order to address this, it was suggested that schools and teachers should be included in 'those who should take action' and specific actions should be laid out for them.

3.4 Feasibility of the recommendations

3.4.1 Introduction

The feasibility of implementing the recommendations was considered to be varied depending on local service provision. Some would already be carrying out these recommendations, whereas others would not. Resources, skills and workload, as well as the sensitive nature of the topic were some of the barriers cited that would prevent these recommendations from being implemented. More promotion of the issues and local services would be needed to help the recommendations be implemented. See below for details on the feasibility of implementing the recommendations.

3.4.2 Differences between areas

Mixed feedback was gained regarding the feasibility of the recommendations. For example, some practitioners reported that these actions were already being carried out within areas and therefore are feasible. However, other areas were reported as not carrying out these actions and many issues would affect their ability to implement them.

The credibility of the recommendations may be questioned as obesity is not necessarily high on all areas' agendas. It often does not carry the same importance as other public health issues such as smoking. Therefore, there is a need to ensure all services are 'on board' for the recommendations to be put into practice.

The inconsistencies between services will affect the implementation of the recommendations in other ways. For example, mixed responses were provided regarding the range of BMI that services in different areas work to. Some areas class obesity as a BMI over 35, as resources would be limited to treat those with a BMI over 30 as obese. However, some professionals reported that women with a BMI of 28 and 29 should not be excluded as these women would also have serious health risks and may be more likely to change their behaviour.

Postnatal check

There were inconsistencies between areas offering the six to eight week postnatal check. Delegates reported that this check often does not take place in some areas, with some delegates reporting never having heard of this check. It was also reported that six to eight weeks after birth is a very busy period for a mother. For example, it was suggested this is period that the child's immunisations takes place and there is a heavy focus on the baby rather than the mother. This leaves limited time to focus on health checks for the mother. This may affect whether the recommendations are implemented in all areas.

Quality Outcome Framework

It was reported that primary care would be more likely to be fully engaged in these actions if the Department of Health developed a National Quality Outcome Framework in weight management during pregnancy and after childbirth. At present it was noted that GPs would not fully engage until there was a QOF set up on this.

Hard to reach groups

The socioeconomic status of women was reported to be an issue that would affect feasibility. For example, women of low SES do not access health services on a regular basis. Many of these women only come into contact with professionals during a single appointment. Therefore, there can be so much information for the professional to deliver in one appointment that weight management may not be *'top of the list'*.

Language barriers are often faced by professionals when working with non-English speaking women. It was reported that it can be difficult explaining issues such as BMI and weight management.

Practitioners also reported that transient populations such as travellers and asylum seekers can be difficult to engage with. Consistency of care is difficult to achieve with this population.

Promotion

It was suggested that a social marketing campaign would enable the recommendations to be implemented more effectively. The absence of mass media within the guidance was recognised as a weakness by practitioners. A national campaign was reported to help raise public awareness of the key issues and would help to ensure the guidance is high on professionals' agendas. Comparisons were made with the Change4Life campaign, with suggestions of a similar campaign for the guidance. It was also suggested that the guidance could be marketed as a branch of the Change4Life campaign.

In addition to this, it was cited that local initiatives are lost within the guidance. Delegates suggested that a forum to share best practice of these local initiatives was needed. This would avoid *'reinventing the wheel'*, as producing new initiatives without assessing what is already carried out was reported to not be good practice.

3.4.3 Barriers

Resources

A lack of funding, resources and skills were major concerns that could affect the recommendations being implemented. It was suggested that funding would have to be 'ring-fenced' in order to ensure that resources would be dedicated to services and available to allow the actions to be carried out.

Training

Training issues were also an important issue that would affect the feasibility of implementing the recommendations. The level of knowledge and key skills of staff were thought to be pertinent to ensure these recommendations are implemented effectively. It was reported that the levels of training and skills held by professionals can often be inappropriate, resulting in inaccurate information being provided.

To ensure consistency across services, delegates suggested that universal training should take place for all health professionals to ensure that everyone is at the same level and any common myths could be expelled. It is also important to ensure that training is kept up to date and monitored. All staff would need to be appropriately trained in the relevant health issues, but also trained in effective communication skills.

However, ensuring that staff were released for training would be difficult. It was reported that many professionals do not have the time to undergo training and could not attend courses. In addition to this, training courses can be costly, resulting in managers only sending a few members of staff on courses that the whole workforce should attend. Therefore, delegates suggested that these issues and training on communication skills and behaviour change should be included in basic training when qualifying.

Dietitians

The use and availability of dietitians is limited in many areas. Referrals to these professionals do not often take place. Some delegates suggested that dietitians would have limited interest in public health issues such as weight management during pregnancy and after childbirth, as they would focus more on issues such as diabetes. Therefore, accessing dietitians, as recommended in the guidance may be difficult in some areas.

Litigation fears

Litigation issues were cited as an issue that may affect implementation of the recommendations. For example, it was reported that many health professionals would be cautious of referring women to commercial weight management programmes. Professionals reported that these programmes need to be accredited and monitored in order for them to feel comfortable to offer referrals.

Workload

Midwives were identified as a group who with capacity issues that may prevent them from addressing the actions in the recommendations. It was suggested that they would not have the time to carry out the recommendations or attend training. Therefore, the use of health visitors was considered important to include in the recommendations as these could have regular contact with many women. The use of signposting women to other services such as Children's Centres was also found to be a useful way of relieving the responsibility placed on midwives.

Sensitivity

Feedback from the delegates emphasised that the issue of weight management is a sensitive subject area and can often be avoided by many health professionals. For example, GPs and midwives would not want to damage the relationship they held with their client by approaching the issue of weight. It was reported that approaching an issue would need to be done over time when a professional feels comfortable to do so, which is often not feasible in the limited appointments they have with women.

Delegates cited that it is important that staff, are able to approach the subject with women appropriately and offer effective support. Therefore, appropriate training should be provided that covers communication skills, motivational interviewing and behaviour change.

3.5 Impact of the recommendations

Overall, the impact of the recommendations was cited as differing across services, due to the inconsistencies between services. The impact was suggested to be greater for those services that did not already carry out these actions, as services and routines would have to be altered. The resources, staff, workload and clients of each service would affect the impact the recommendations would have.

The recommendations were reported to have significant cost and resources implications. This was mainly due to the large number of women that these recommendations cover. Women of a childbearing age cover a wide age range. Information, advice and support would have to reflect this as younger girls would need different support than older women.

The way in which these recommendations would be evaluated and monitored was questioned. It was suggested that roles and responsibilities need to be assigned to ensure that all services are working to these recommendations to a high quality standard. Delegates suggested that it would be relatively easy for many services to report complying with these actions; however this could be of a low standard, limiting the effectiveness of the recommendations.

Feedback suggested that the impact of the guidance would be greater if actions and services were tailored to the preferences of women. It was reported that more research should be conducted with women to gain an understanding of what services and support they would want.

3.6 Individual stakeholder groups

The following provides a summary of the specific views on the recommendations from the individual stakeholder groups.

Commissioners

Practitioners noted that there was very little of relevance in the recommendations for commissioners. Practitioners suggested that having an action for commissioners to develop clear care pathways was important and that these should be effectively communicated with GPs and midwives so they are confident on where to signpost women to.

Practice Nurses

Practice nurses generally viewed the recommendations as well written and easy to follow. However, they questioned the relevance of the recommendations based on preconception and during pregnancy due to the limited contact they have with pregnant women. It was suggested that these women do not visit practice nurses, with only a small percent of women visiting practice nurses prior to conception.

GPs

GPs did not give very positive feedback regarding the recommendations. They suggested that too many responsibilities are placed on GPs which is unrealistic and would be ineffective. It was reported that there were so many responsibilities placed on them that they would be forgotten and that other professionals such as midwives and health visitors have much greater contact with these women and more actions should be directed at these roles.

Midwives

One of the main concerns that midwives reported regarding the recommendations was the ability to approach the sensitive subject of weight management with women. This was suggested as very difficult and many midwives would be concerned with disaffecting the relationship they had with their clients by approaching the subject of their weight. They believed that some of the actions would be inappropriate, such as asking women to check the fit of their clothes, and would not be received well by their clients. More information and guidance was needed on how midwives can approach this sensitive subject in a tactful and effective way.

Children's Centres

Those from Children's Centres suggested that their role could be expanded and emphasised within the recommendations. They reported these centres as a very useful resource to offer support and appropriate programmes to women, as well as having the ability to signpost women to other relevant services. Offering referrals to Children's Centres was reported as an important exercise that should take place more often and should be recommended more strongly within the guidance.

Leisure Centres

Leisure centre representatives questioned the relevance of the recommendations to their service. It was reported that these recommendations were focussed towards health professionals such as GPs. Training was also suggested as something that would need to be offered to staff within leisure centres, as they currently would not have the appropriate skills or training on these issues.

3.7 Recommendation specific feedback

3.7.1 Recommendation 1: Preparing for pregnancy

Recommendation 1: preparing for pregnancy

Who is the target population?

- Women who may become pregnant, including those who have had a baby.
- Their partners, families and friends.

Who should take action?

- Commissioners and managers in primary care trusts (PCTs) and NHS trusts.
- Directors of public health, planners and organisers of public health campaigns and occupational health advisers.
- GPs, health visitors, midwives, practice nurses, pharmacists and other health professionals working in weight management, fertility, pre-conceptual advice and care services, gynaecology and contraceptive services.
- Dietitians and public health nutritionists working in NHS and non-NHS settings.
- Health trainers and health and fitness advisers working in local authority leisure services and voluntary, community and commercial organisations. This includes slimming clubs and other weight management programmes.

What action should they take?

- PCTs, directors of public health and planners and organisers of public health campaigns should ensure health professionals understand the importance of achieving a healthy weight before pregnancy. Local education initiatives should also stress the health risks of being overweight, including during pregnancy.
- Health trainers and health and fitness advisers should encourage women to check their weight and waist measurement periodically or, as a simple alternative, check the fit of their clothes. They should also encourage women to take the stairs rather than the lift, and to walk, cycle or use another mode of transport involving physical activity for part or all of any journey[3].
- Health trainers and health and fitness advisers should advise women, their partners and family to seek information and advice on healthy eating from a reputable source (such as www.eatwell.gov.uk). They should also encourage those who have weight concerns to talk to a health professional such as a GP, practice nurse, dietitian, health visitor or pharmacist[4].
- Health professionals should use any opportunity, as appropriate, to provide women, their partners and immediate family members with information on the health risks of being overweight and obese during pregnancy. This is particularly important if women have gained weight since a previous pregnancy.
- Health professionals should offer practical advice on how to eat healthily, how to be physically active and, if they are overweight, how to lose weight safely, as outlined in the introduction to this section (see 'Achieving a healthy weight' and 'Effective weight management programmes'). Advice should be tailored to women's circumstances (for example, childcare support may be needed to allow them to participate in organised physical activity sessions).

[3] This is an extract from a recommendation that appears in both NICE public health guidance 13 on physical activity in the workplace and NICE clinical guideline 43 on obesity.

[4] This is an extract from a recommendation that appears in NICE clinical guideline 43 on obesity.

Key summary for recommendation 1 preparing for pregnancy

The feedback on this recommendation was that it was both relevant and useful. However, there was feedback to suggest that this was quite an "*idealistic*" (Manchester workshop, NICE offices) recommendation and that more information needed to be provided within the recommendation on how to implement this. Common themes from the fieldwork were that the remit of this recommendation should be changed to "*all women of child bearing age*" (Manchester workshop Floor 24) and that this recommendation should link into the Change4Life campaign. The potential impact of this recommendation would vary depending on area and the current level of service provision. One of the main factors affecting feasibility was the need for a Quality Outcome Framework to be developed in weight management during pregnancy and after childbirth as without this it was thought that primary care would not be as involved.

GPs and practice nurses did not think this recommendation would be relevant to them.

Several key suggestions were made by practitioners on how to amend the recommendation, these included:

- Provide clarification on 'community and commercial organisations', 'Health Trainers' and whether this recommendation was aimed at those with a BMI over 30;
- Consistent terminology needed between 'weight management' and 'weight loss';
- Include actions for leisure services and voluntary sector;
- Include use of media in raising people's awareness of weight management;
- Include sensitivity issues such as how to approach weight management issues appropriately;
- Include the following groups under 'who should take action' , wider community, women, local clubs, schools, mother/toddler groups, Children's Centres and commissions and managers outside of PCT/NHS Trusts;

Content and wording

Findings suggest that this recommendation was relevant particularly the first bullet point under 'What action should they take'. However, overall practitioners said that it was too vague and needed more details about setting targets. Practitioners said that people are motivated by having goals by which to work towards.

Findings from the fieldwork suggest that clarification is required on several parts of the content of this recommendation, these include:

- The term 'community and commercial organisations' should be made clearer as there was confusion over what these were;
- The term 'health trainers' was said to be unclear and at present open to interpretation if left as it is;
- Practitioners were unclear if this recommendation was for women with a BMI of over 30 therefore further clarification is needed.

Findings suggest that there needs to be more consistent terminology used throughout the recommendation, for example practitioners said that the recommendation uses the phrase 'weight management' and 'weight loss' throughout this recommendation. Instead one should be used for consistency purposes.

Practitioners said that there were several aspects omitted from the 'What action should they take' section of this recommendation, these included:

- A link to health education;
- Use of the media in raising people's awareness of the issue of weight management;
- Actions for leisure services and the voluntary sector;
- Sensitivity issues – advice for health professionals on how to approach weight management issues appropriately.

There were mixed views over the inclusion of partners, family and friends within this recommendation. Some practitioners said that if they were included under 'Who should take action' then there should be specific recommendations for them within the main body of the recommendation. However, there were concerns raised by others that involving these groups may place unnecessary pressure on women to lose weight and there was a suggestion to include these groups in the recommendations for weight management after pregnancy instead.

Practitioners said that there were several groups omitted from the 'Who should take action' section of this recommendation, these included:

- Wider community – this is to try to encourage more healthy communities and environments;
- Women should be included as it was thought they should take responsibility for their weight;
- Local clubs;
- Schools;
- Mother/toddler groups;
- Children's Centres; and
- Commissioners and managers outside of PCT and NHS trusts.

GPs and practice nurses did not think this recommendation was very relevant to them. They often do not see women if they are planning a pregnancy and generally when they are pregnant they are referred onto a Midwife and therefore do not have contact with them.

Feasibility and implementation

Several common themes emerged on factors that would affect feasibility of the implementation of this recommendation, these included:

- The need to carry out a consultation with women to find out what they want and what services they would use;
- Training provided to everyone within the health service and that this training should form part of people's core skills;

- Services would need to be clearly signposted within the recommendations;
- Training would need to be provided to leisure services;
- Recommendation would need to be more targeted on specific groups to make this recommendation more feasible to implement.

One main factor that would affect the feasibility of this recommendation being implemented was the need for a National Quality Outcome Framework (QOF) in weight management during pregnancy and after childbirth. The findings from the fieldwork suggested that without this, this recommendation would not be feasible to implement. Without the QOF in weight management practitioners said that primary care would not take action on this issue.

More advice should be provided on meal preparation and what food items are 200 calories. Practitioners requested more advice on nutrition and portion size to be included within the recommendation.

Barriers

The recommendation should include information on providing advice to women on benefits of losing weight especially if they are planning a pregnancy as losing weight could increase the likelihood of conception. Practitioners stated that the health of the male in planning a pregnancy was also an important factor to consider therefore, this recommendation should include the role of the partner on

Another method of overcoming any barriers to implementing this recommendation would be to inform mothers of the specific risks involved in pregnancy if you are overweight, such as diabetes. Therefore, practitioners said that this recommendation should be aimed specifically at those women already over weight and planning a pregnancy.

Practitioners said that lessons can be learnt from groups such as Weight Watchers that weigh women regularly. It was noted that when women are in a health setting they feel more judged at being weighed, however, if they were in a community group they would feel less judged. Practitioners said that a Health Professional badge alone can act as a barrier to women. Therefore, more use of community settings should be used and this should be reflected within the recommendation.

Advice on healthy eating was welcomed by practitioners, however, it was noted that more detail was needed on what comprised a healthy diet. Practitioners ideally wanted a standard document produced that would illustrate this and include advice on how to provide advice and at what stage.

Accessing people was raised as a major barriers especially those that may not see health professionals. Questions were raised over how these individuals would be accessed and did not feel that this was covered in sufficient detail in this recommendation. Suggestions were made of linking this recommendation to community centres and NHS Direct and having one practitioner with overall responsibility for weight management during pregnancy and after childbirth.

Other potential barriers that were noted by practitioners included:

- Currently there is no cohesive ‘care pathway’ as there is too much fragmentation in the service. If there was a cohesive care pathway then it was noted that this recommendation would be implemented more effectively;

- Time and resources were identified as barriers and practitioners suggested using existing services as a way of overcoming this barrier;
- Health practitioners need to be aware of different cultures and some of the barriers that may be associated with these – for example some cultures will not access leisure centres;
- Access to services such as GPs and fitness instructors and this could vary depending on the area;
- Some areas do not have dietitians to refer people on to;
- Commissioning was seem as a major barrier especially with the current economic downturn; and
- Midwives with a raised BMI may find it difficult to raise the issues of weight management plus this questions the message they are giving out.

Impact

Practitioners noted the following potential impacts of the recommendation:

- Improve the service;
- Lead to services being more community based;
- Would reduce obesity and morbidity.

Findings suggest that the impact of this recommendation would vary depending on the area. The impact of this recommendation would depend on the current service provision in each area and it was noted that this can vary greatly from area to area. Practitioners noted that with increased pressure and increasingly stretched resources this recommendation may be difficult to implement.

3.7.2 Recommendation 2: Pregnant women with BMI >30

Recommendation 2: women who may become pregnant – with a BMI over 30

Who is the target population?

Women with a BMI over 30 who may become pregnant and their partners, families and friends.

Who should take action?

- GPs, health visitors, midwives, practice nurses, pharmacists and other health professionals working in weight management, fertility, pre-conceptual advice and care services, gynaecology and contraceptive services and services for teenage parents.
- Dietitians and public health nutritionists.
- Health trainers and health and fitness advisers working in local authority leisure services and voluntary, community and commercial organisations. This includes slimming clubs and other weight management programmes.

What action should they take?

- Explain to women who have a BMI over 30 about the increased health risks this poses to

themselves and their babies. Encourage them to lose weight before becoming pregnant again.

- GPs, dietitians and other health professionals should advise, encourage and help women to reduce their weight before becoming pregnant, ideally to a BMI between 24.9 and 18.5 kg/m2. They should recognise that reducing weight to within this healthy BMI range may be difficult and should be supportive.
- Offer women the opportunity to join a weight-loss support programme involving diet and physical activity. The programme should follow the principles of good practice as outlined in the introduction to this section (see 'Effective weight management programmes').

Key summary points for recommendation 2: Pregnant women with BMI >30

Overall this recommendation was thought to be relevant. However, consistent feedback during the fieldwork suggested that the title of this recommendation was too vague and should be amended to include "...and may be planning to become pregnant". As with recommendation one feedback suggested that the remit of this recommendation be extended to include all women of child bearing age. A common theme raised throughout the fieldwork suggested that there was no recognition within the recommendation of differing BMI obesity thresholds for different ethnicities, such as South Asian woman.

GPs and practice nurses did not think this recommendation would be relevant to them.

Several suggested amendments were made by practitioners, these included:

- Clarity of who 'Health Trainers' were;
- Include advice to tackle psychological issues associated with weight;
- Dietitians were not common in all areas, the majority of practitioners said dietitians should be removed from the recommendation;
- Include dietary advice and assessment of current eating behaviours;
- Include practical advice to health professionals on how to raise the issue of weight with women;
- Risk factors detailed should be more specific and clearer;
- Include the following groups under 'who should take action, commissioners, partners, families and friends, preconception advice and care services and school nurses.

Content and wording

Whilst the feedback suggested that this recommendation was useful, several suggestions were made regarding the content of the recommendation. Feedback indicated that there was no recognition of differing BMI thresholds of obesity for different ethnicities. Practitioners said that for South Asians the BMI level for obesity will be 28 not 30. There was no recognition of this within the recommendations.

Other amendments that practitioners suggested should be applied to recommendation two included:

- The risk factors detailed under the first bullet point under 'what action should they take' to be clearer and more specific;
- More clarification was needed on who health trainers were;
- The recommendation should include dietary advice and assessment of current eating behaviours;
- The recommendations should include advice on how to raise the issue of weight;
- Use consistent and less formal terminology throughout the recommendation such as 'weight loss support programme';
- The recommendations should detail what the risks are at various BMI stages (for example, 20, 25, 30, 35 etc…).

Suggestions were made to include the following stakeholders under 'who should take action' section:

- Commissioners – particularly those involved in the wider obesity management arrangement panels;
- Partners, families and friends;
- Pre-conceptual advice and care services;
- School nurses.

Practitioners had concerns over the recommendations stating 'BMI over 30'. Some practitioners noted that they currently adhere to national guidelines and use a BMI of 35. There was confusion over why the BMI was different in this recommendation to these National guidelines[5].

Practitioners thought there was potential for there to be confusion over the phrase 'over weight'. There was a suggestion that this was open to interpretation as it was too vague.

A suggestion was made to use the word 'encourage' throughout this recommendation rather than 'offer'. Using the word offer was thought to have huge resource implications as 'offer' implies that it is free or compulsory.

Feasibility and implementation

Practitioners identified several factors which would impact on the feasibility of this recommendation being implemented, these included:

- Lack of services/recommended services in place and which to signpost women to;
- Lack of funding for current and new services and staff;
- Would be dependent on how GPs are addressing the issue of weight;
- Lack of commissioner insight and funding; and

[5] Practitioners did not name which National guidelines they were referring to.

- Lack of training for all staff.

Practitioners said there was no way of identifying women with a BMI of over 30. This recommendation assumes that health professional have weighed all women and know who they are, when in reality they do not. There were also concerns raised over the use of BMI over 30 as it was thought this would have huge implications on resources. There were also concerns that there would not even be enough resources to establish BMI in the first place.

Practitioners suggested that guidance needs to be provided on commissioning pre-conception care before this recommendation can be implemented.

The role of GPs was raised as a barrier. At present some practitioners noted that GPs do not weigh and measure women and that this is usually left to the Midwife. However, practitioners did not think that onus should be with the midwives alone and should start with the GP. Therefore, this should be made clearer within the recommendations.

As with recommendation one GPS and practice nurses did not think this recommendation was very relevant to them as they do not have as much contact with pregnant women as midwives.

Barriers

There were concerns raised over funding. Practitioners said that more funding was needed nationally to tackle obesity and that services should be tailored to fit each area. Practitioners also stated that this was a real opportunity to be innovative and more proactive in the way people work together. Practitioners suggested PCT/Local Authorities conducting a gap analysis of existing services and look at how best to use existing services with the funds available to them.

One of the major barriers identified was psychological issues and motivation of women to change. Questions were raised over the extent to which this recommendation addresses these underlying issues. Practitioners said there are often underlying issues related to weight management and therefore these women should be referred to professional counselling services. A suggestion was that this should be reflected within the recommendation.

There were mixed feedback on the reference of 'dietitians' within the recommendation. Generally practitioners said that practitioners were a "*scare commodity*" (Harlow focus group).and that only women with clinical issues maybe referred to them. Practitioners either suggested that dietitians should be removed from the recommendation or that more dietitians be employed in hospitals and GP surgeries.

Cultural issues should be taken into consideration in this recommendation. Some ethnic groups do not see obesity as an issue and therefore there will be additional barriers in communicating effectively with these communities.

As with recommendation one practitioners said that there needs to be a properly designed national QOF for weight management during pregnancy and after childbirth. This would be one way of properly engaging GPs on the issue. However, others said that there should not need to be a QOF that it should come under a GPs duty of care.

Some practitioners were not able to make suggestions on how barriers to implementing this recommendation may be overcome as they did not think the recommendation was specific enough.

Impact

There were mixed views regarding the potential impact of this recommendation. Some practitioners did not think it would have an impact due to availability and capacity of services. Others said that if this is implemented then it will have a positive impact on the more, longer term issues with weight and pregnancy.

Other potential impacts identified by practitioners were:

- More staff would be required;
- It will improve the knowledge and awareness of different staff groups;
- Training will be required which would have further impacts on staffing levels and timescales.

The role of GPs and midwives was said to be crucial and often for them, time is a factor affecting delivery. Therefore, the recommendation needs to outline how to provide specific services and links to existing care pathways.

There were concerns raised over the remit of this recommendation. Practitioners said that the title was too vague and may potentially have a huge impact on resources.

3.7.3 Recommendation 3: Advising pregnant women

Recommendation 3: pregnant women

Who is the target population?

- All pregnant women but, in particular, those with a BMI greater than 30.
- Their partners, families and friends.

Who should take action?

- Obstetricians, midwives, GPs and practice nurses.
- Dietitians and public health nutritionists.
- Midwifery assistants, support workers and other healthcare practitioners.
- Health trainers and health and fitness advisers working in local authority leisure services and voluntary, community and commercial organisations.

What action should they take?

- At the earliest opportunity, for example, during a pregnant woman's first visit to the GP, discuss her eating habits and how physically active she is. Find out if she has any concerns about diet and the amount of physical activity she does and try to address them.
- Advise her that a healthy diet and being physically active will benefit both her and her baby during pregnancy and will also help achieve a healthy weight after giving birth.

Advise her to seek information and advice from a reputable source such as the 'The pregnancy book'[6] or the 'Eat well' website (www.eatwell.gov.uk).

- Offer those who are eligible for the Healthy Start scheme practical, tailored information, support and advice on healthy eating and how to use Healthy Start vouchers to increase their fruit and vegetable intake[7].
- Dispel any myths about what and how much to eat during pregnancy. For example, advise that there is no need to 'eat for two' or to drink full-fat milk. Explain that energy needs do not change in the first 6 months and increase only slightly in the last 3 months (and then only by around 200 calories).
- GPs and midwives should measure weight and height at the first antenatal appointment, being sensitive to any concerns women may have about their weight. Why this information is needed and how it will be used should be clearly explained. Calculate BMI by dividing their weight (kg) by the square of their height (m^2), or use the BMI calculator[8] after measuring and weighing them.
- Do not weigh women repeatedly during pregnancy as a matter of routine. Only weigh those who have a clinical problem that needs to be managed[9].
- Health professionals should explain to women with a BMI over 30 how this poses a risk, both to their health and the health of the unborn baby. Do not recommend weight-loss during pregnancy. Offer a referral to a dietitian for assessment and personalised advice on healthy eating and how to be physically active. Encourage them to lose weight after pregnancy.
- Advise women that a moderate amount of physical activity will not harm them or their baby.
- Give them advice from the Royal College of Obstetrics and Gynaecology (RCOG)[10]. In summary this states that during pregnancy:
  - aerobic (recreational exercise such as swimming or running) and strength conditioning exercise is safe and beneficial
  - the aim of recreational exercise is to stay fit, rather than to reach peak fitness
  - if women have not exercised routinely and are starting an aerobic exercise programme, they should begin with no more than 15 minutes continuous exercise, three times per week, increasing gradually to 30-minute sessions, four

[6] Department of Health (2009) The pregnancy book. London: Department of Health.

[7] This is an extract from a recommendation that appears in NICE public health guidance 11 on maternal and child nutrition.

[8] Visit www.eatwell.gov.uk/healthydiet/healthyweight/bmicalculator/

[9] This is an extract from a recommendation that appears in NICE clinical guideline 62 on antenatal care.

[10] Visit www.rcog.org.uk/womens-health/clinical-guidance/exercise-pregnancy

times a week to daily

- if women did exercise regularly before pregnancy, they should be able to participate in the same, higher intensity exercise programmes, such as running and aerobics, with no adverse effects.

Key summary points for recommendation 3

This recommendation was well received, was thought relevant and useful as it dispels common myths around weight and pregnancy. However, several suggestions were made by practitioners on the content and wording of the recommendation and suggestions on how to overcome potential barriers. One common theme that was raised by many practitioners was the need to weigh women at every visit. At present the recommendation states 'Do not weigh women repeatedly…". Practitioners said this was based on old out of date guidance and should be changed to 'Weigh all women repeatedly…'

There were concerns raised over the use of BMI and the potential inaccuracies due to differences in calculations. As with recommendation one, practitioners noted that this recommendation should acknowledge the different BMI obesity thresholds for different ethnicities.

GPs and practice nurses did not think this recommendation would be relevant to them.

Suggested amendments to the recommendation included:

- Midwives or health professionals should replace GPs in the first bullet point;
- Should detail clear care pathways;
- More advice on common myths;
- Use the term 'physical activity' rather than 'exercise';
- More information sources should be provided on explaining the positive benefits of weight management;
- More specific details should be provided on exactly what women can and cannot eat during pregnancy;
- Information on advice to provide on a healthy weight gain during pregnancy;
- Include advice on breastfeeding and the benefits associated with weight management;
- Amend remit to include woman with a BMI between 25 – 30;
- Include information to provide advice on the benefits of weight management.

Content and wording

Practitioners really liked that this recommendation as it referred to eating habits as this was thought to be very important. There were several aspects of this recommendation's content and wording that needed to be amended, these included:

- Midwives should replace GPs in the first bullet point as it was not realistic that this would be the GP and in most cases is the midwife,- suggested re-wording was 'during a women's first visit to a health professional';
- Whilst practitioners were pleased that the recommendation talked about dispelling myths – they wanted more advice on what these myths were;

- Practitioners suggested that sections of the recommendations that refer to risks should be bought forward to the start of the recommendation;
- Practitioners suggested using the word physical activity instead of exercise as it is currently used within the recommendation;
- More detail should be included in the recommendation on explaining the positive benefits of weight management;
- The second bullet point under 'what action should they take' should provide more information sources and be more specific on what women can and cannot eat during pregnancy;
- Advice should be provided within the recommendation on what is a healthy amount of weight to put on during pregnancy. Some delegates suggested the IOM guidelines 2009 on weight gain during pregnancy[11] should be referenced in the recommendation;
- The recommendation does not include any details of food which cannot be eaten during pregnancy (such as soft cheese);
- The recommendation should include breastfeeding – suggestions were made to include providing advice on breastfeeding including the benefits associated with weight loss;
- This recommendation should detail clear care pathways;
- Women with a BMI up to 30 are excluded from this recommendation. Practitioners thought that those women with a BMI of 25 – 30 were just as relevant;
- The benefits of weight management should be highlighted within the recommendation;
- There was no mention in the recommendation of the importance of sleep in weight loss/management;

Practitioners suggested that the recommendation should include other opportunities to impart advice to women during pregnancy. Suggestions included women visiting anaesthetic clinics and active birth advice for labour sessions. It was noted that both of these were impacted by weight and provide a good opportunity to raise the issue of weight with pregnant women.

There were concerns raised over using 'BMI over 30'. Firstly there was a concern over the accuracy of using BMI and that there may be differences in BMI calculations. There were also concerns over differences in populations and BMI indicators, for example, South Asian woman require a different BMI cut off (25) and this is not included within the recommendation.

There were concerns raised over exercise recommended within the recommendation. Practitioners raised concerns that health professionals would have had no training on this and therefore, clear guidance should be produced on the appropriate levels and types of physical activity for pregnant women. Health professionals should also receive training on what to advise pregnant women.

[11] Some delegates reference the Institute of Medicine's guidelines on weight gain during pregnancy. Rasmussen KM, Yaktine AL, editors. Committee to Reexamine Institute of Medicine Pregnancy Weight Guidelines (2009) Weight gain during pregnancy: re-examining the guidelines [online]. Available from http://books.nap.edu/openbook.php?record_id=12584

Practitioners recognised the importance of addressing eating habits with women, but noted that this recommendation should also cover general exercise and physical activity such as, walking and doing housework which burns a lot of calories. Suggestions were made to include more references to websites within the recommendation on physical activity and healthy diets and that this information should be available in other languages.

This recommendation needs to provide specific advice on nutrition such as providing examples of what 200 calories means. Many women and practitioners will not know this and may assume incorrectly.

Practitioners did not think that giving advice in the form of leaflets was very effective. They thought that this recommendation needs to consider potential language barriers and rates of illiteracy within the population.

Practitioners made several suggestions on who should be included within the 'who should take action' section of this recommendation, these included:

- All health workers women come into contact with;
- PCT and Trust managers; and
- Commissioners;
- Surestart;
- Health visitors;
- Skilled nurses;
- Teenage pregnancy midwives.

As with recommendation one and two GPs and practice nurses did not think this recommendation would be very relevant to them as this would mainly be applicable to midwives.

Feasibility and implementation

One of the major factors affecting the feasibility of this recommendation is the need for training so that all health professionals are able to provide the necessary advice to pregnant women. A common theme that was raised throughout the fieldwork was that referring women on to a dietitian was not thought to be practical or realistic. Practitioners suggested removing or referring women instead to a weight loss programme.

There were concerns noted about bookings taking place at home. Practitioners noted that quite often bookings take place in the home and therefore BMI may not be calculated.

Practitioners had many suggestions on what factors might affect the feasibility of implementation. These included:

- The clinical pathway is not covered by the recommendations. For example, Obstetrics should refer to weight management programmes and clinical services should be encouraged to link with public health;
- More resources are needed to be able to deliver this recommendation;
- Time – being able to provide enough time to people to be able to properly discuss everything;

- Proper equipment – practitioners suggested that proper scales were needed for women to be weighed accurately;
- Location – having a private location that women can be weigh privately;
- Communication – communicating the risks in a sensitive manor.

Barriers

The barriers identified by practitioners as part of the fieldwork included:

- Money;
- Resources;
- Training;
- Barriers within PCTs – some do not allow pregnant women to access certain services;
- Psychological issues around pregnant women and their weight. Practitioners suggested that this recommendation address this issue.

Practitioners suggested the recommendation should address how to reach lower socio-economic groups and access the most 'hard to reach'. Suggestions were also made to encourage service providers to provide out of hours services, as well as child care facilities.

Practitioners noted that this recommendation includes the promotion of a healthier diet. It was suggested that this assumes women have basic cooking skills which in many cases they do not. Therefore, suggestions were made to acknowledge this within the recommendation.

Impact

There was mixed feedback on the potential impact of this recommendation. Some practitioners said that it would not have an impact as much of the recommendation is already being carried out. However, others disagreed and thought that this recommendation would have a huge impact.

One of the main concerns raised over the potential impact of this recommendation was midwives capacity to be able to implement it. Practitioners noted that they were already over stretched and there would be capacity issues around not only delivering the advice but also being released to attend any training. Other feedback indicated that midwives have a statutory framework that they work towards and cannot undertake tasks that fall outside of this.

Other potential impacts of this recommendation included:

- There would need to be training for staff;
- Concerns that women with a BMI over 30 would not attend general group sessions as they would feel self conscious;
- If this recommendation is to cover all pregnant women then there would be commissioning issues and capacity issues of existing services.

3.7.4 Recommendation 4: Supporting women following childbirth

Recommendation 4 – supporting women following childbirth

Who is the target population?

- Women who have recently had a baby.
- Their partners, families and friends.

Who should take action?

- Commissioners and managers in PCTs and NHS trusts.
- GPs, health visitors, midwives, practice nurses, pharmacists and other health professionals working in weight management.
- Dietitians and public health nutritionists working in NHS and non-NHS settings.

What action should they take?

- GPs or practice nurses should measure women's weight and height during the 6–8-week postnatal check. The weighing process should be sensitive to any concerns women may have about their weight or body size. Why this information is needed and how it will be used should be clearly explained. Women should be encouraged to lose any excess weight.
- GPs or practice nurses should calculate women's BMI by dividing their weight (kg) by the square of their height (m^2). Or they could use the BMI calculator[12] after measuring and weighing them.
- GPs or practice nurses should ask women who are overweight, obese (or have concerns about their weight) if they would like to be weighed again 6 months after the birth of their baby.
- Health professionals should provide women with clear, tailored, consistent, up-to-date and timely advice about weight, diet and physical activity after childbirth. Women, their partners and family should also be advised to seek information and advice from a reputable source such as the 'Birth to five' book[13] or the 'Eat well' website (www.eatwell.gov.uk).
- Health professionals should discuss the benefits of a healthy diet and regular physical activity with women after childbirth. They should also offer practical advice on how to eat healthily, how to be physically active and how to lose weight safely. (See introduction to this section, 'Achieving a healthy weight' and 'Effective weight management programmes'.)
- Advice on healthy eating and physical activity should be tailored to women's circumstances. For example, it should take into account a range of issues including the demands of caring for a baby, how tired the women are and any health problems they may have (such as pelvic floor muscle weakness or backache). It should also take into account

[12] Visit www.eatwell.gov.uk/healthydiet/healthyweight/bmicalculator/

[13] Department of Health (2009) Birth to five. London: Department of Health.

the need to look after any other children in the family.

- Midwives, health visitors, GPs and health professionals should provide reassurance that a healthy diet and regular, moderate physical activity will not adversely affect a woman's ability to breastfeed. Similarly, they should explain that gradual weight loss will not have an adverse effect – and that none of these actions will affect the quantity or quality of breast milk.[14].
- Ensure women have a realistic expectation of the time it will take to lose weight. In addition, ensure they are aware of the importance of giving themselves time to achieve a healthy weight.
- Give advice from the Royal College of Obstetrics and Gynaecology [15]. In summary, this states that:
  - if pregnancy and delivery are uncomplicated, a mild exercise programme consisting of walking, pelvic floor exercises and stretching may begin immediately. But women should not resume high-impact activity too soon
  - after complicated deliveries, or lower segment caesareans, a medical care-giver should be consulted before resuming pre-pregnancy levels of physical activity, usually after the first check-up at 6–8 weeks after giving birth.

Key Summary: Supporting women after childbirth

There was support for this recommendation. Overall practitioners said that there needed to be more detail and direction.

The 6-8 week postnatal check was the subject of debate as was the motivation of individuals as a barrier to accessing services and successfully implementing actions in the recommendation.

Implementation suggestions included:

- Rewording;
- Link to a national quality outcome framework;
- Link with national campaigns e.g. Change4Life;
- Clarity on existing care pathways; and
- Possibly merge with Recommendations 5 and 6.

[14] This is an extract from a recommendation that appears in NICE public health guidance 11 on maternal and child nutrition.

[15] Visit www.rcog.org.uk/womens-health/clinical-guidance/exercise-pregnancy

Content and Wording

Overall, there was a positive reaction to the content and wording of this recommendation and most feedback revolved around providing more detail. Positive references were made to the inclusion of the 'Eatwell' website and reference to the recommendations of the Royal College of Obstetrics and Gynaecology.

Under who should take action, most practitioners said all other health providers, not just professionals should be included as well as the local health authority and family planning clinics.

The recommendation needs to promote local referral pathways as some practitioners said that rather than specialist advice given by the GP, referral to specialist services would be more beneficial. This would mean GPs would need to be made aware of what specialist services are available to them. Similarly, there needs to be a much clearer care pathways outlined for commissioners so that they can then direct funding towards such specialist services.

There was a general view that the recommendation should include more goal setting, and ensure that all other healthcare workers are aware of the existing care pathways.

The recommendation also needs to promote a more 'joined-up' working approach across relevant agencies as practitioners thought the draft guidance appeared disjointed. This could potentially cause a loss of resources amongst community healthcare professionals.

There were specific issues raised about the 6-8 week post natal checks and measuring a women's height and weight during this period. Practitioners said the recommendation may be setting a standard that does not currently exist. Many also stated that the 6-8 week check does not always happen in practice. This may be because it coincides with a busy time for the mother and baby such as immunisations.

Although practitioners said this would be a good time to refer women, they also said the recommendation needs to be more prescriptive about what should be done and when. Some questioned whether the GP was in fact the correct and only professional to be involved and suggested extending this to 'appropriate health professional'.

Some practitioners suggested the word 'height' should be taken out whilst others suggested re-phrasing the recommendation to read '6 to 8 week post natal discharge...' The word 'ask' should be replaced by 'encourage' when talking about weighing women. The term 'any excess weight' was seen as unspecific and the recommendation needs to clarify this term. This could also be received negatively by women who already have low confidence about their weight and therefore needs to be worded tactfully.

It needs to be made clear in the recommendation that as well as gradual weight loss, 'rapid' weight loss does not adversely affect breastfeeding.

Being 'weighed 6 months after the birth of your baby' was seen as too late and there was a suggestion this should happen at 3 to 4 months whilst the baby is being fed milk (either breast or formula).

Feasibility and implementation

It was thought that the recommendation was not feasible because the 6-8 week check does not take place.

Successful implementation would depend on the motivation of health professionals and there are obvious time and resource constraints. This could be made easier by introducing an accreditation of weight management programmes that professionals can refer to.

GPs felt that the motivation of individuals would also affect feasibility and proper implementation:

"The majority of patients who come in and want to lose weight ask, 'what can I eat to lose weight?' success rates are very low, approx 1 in 10 will actually lose the weight despite the advice given, so a lot of the time it is out of our hands and down to personal motivation." (GP)

Overall feedback was that the recommendation would not be feasible unless linked to a national quality outcome framework. Practitioners describe it as being too easy for services to say they are following the actions of this recommendation but stress that quality is imperative. More information is needed on how to audit this recommendation; to ensure services are following a quality standard.

Barriers

Not having a quality outcome framework as part of the recommendation was seen as a major barrier. More funding is needed for commissioners to be able to overcome obvious resource barriers.

Not imparting advice at the right time was seen to be a major barrier and waste of resources. Practitioners would like to see the recommendation state the right time to give weight management advice and this should be integrated with existing services and appointments.

Practitioners describe a lack of knowledge of existing information and services e available. A centralised collation of this information available to all practitioners was suggested. There could also be better links with national campaigns such as 'Change4Life'.

The recommendation does not draw upon the sensitivity of the subject of weight management and that there are barriers if practitioners do not approach the subject in a way that does not intimidate women. More training is needed on how best to do this such as the benefits of motivational interviewing.

Impact

It was thought the recommendation may encourage more imaginative and outside the box thinking.

There will be an impact on the training needs of healthcare professionals and services would need to identify who needs training and then deliver it. This would have a knock on effect on resources.

With the emphasis on provision of information there would need to be a support element for those giving out the advice and information. There could potentially be a more positive impact if existing services are accessed more, and professionals are able to signpost patients more effectively.

There was a strong view that linking this guidance with national campaigns such as Change4Life would have a great impact and at the moment this is a missed opportunity.

Similarly, it was suggested the recommendation could have a greater impact if the following elements were part of the recommendation: educate children in schools; allow mental health professionals input into the recommendation; and explore the benefits of promoting self nurturing.

3.7.5 Recommendation 5: Women with BMI >30 after childbirth

Recommendation 5 – women with a BMI over 30 following pregnancy and after childbirth

Who is the target population?

- Women who had a pre-pregnancy BMI over 30.
- Women with a BMI over 30 who have recently had a baby.

Who should take action?

- Commissioners and managers in PCTs and NHS trusts.
- GPs, health visitors, practice nurses, pharmacists and health professionals working in weight management.
- Dietitians and public health nutritionists working in NHS and non-NHS settings.

What action should they take?

- GPs and other health professionals should explain the increased risks that being overweight poses to women and, if they are pregnant, their babies. They should encourage them to lose weight before becoming pregnant again.
- GPs and other health professionals should offer them the opportunity to join a structured weight-loss programme that:
  - addresses the reasons why women may find it difficult to lose weight, particularly after pregnancy
  - is tailored to the needs of an individual or group
  - combines advice on healthy eating and physical exercise
  - identifies and addresses individual barriers to change
  - provides ongoing support over a sufficient period of time to allow for sustained lifestyle changes[16].
- If more appropriate, offer a referral to a dietitian for a personalised assessment and advice about diet and physical activity. Dietitians should use behaviour change strategies, such as goal setting, to help women lose weight[13].

[16] This is an extract from a recommendation that appears in NICE public health guidance 11 on maternal and child nutrition.

- GPs and health professionals should advise women who are breastfeeding that losing weight by eating healthily and taking regular exercise will not affect the quantity or quality of their milk[13].
- Provide women who are not yet ready to lose weight with information about where they can get support.

Key summary for recommendation 5 Women with BMI over 30 after childbirth

This recommendation was thought to be very similar to recommendation four.

Practitioners said the recommendation should be relevant to all women including those with a low and healthy range BMI. There were major concerns about the availability of dieticians.

Implementation suggestions included:

- Rewording;
- Link with existing guidance e.g. obesity guidance;
- Clarity on the provision of services to different cultural and socio-economic groups;
- Promotion of the benefits of weight loss;
- Emphasis on better utilisation of existing services;
- Possibly merge with Recommendations four and six.

Content and Wording

This recommendation was thought to be very similar to recommendation four and practitioners suggested the two should be merged. It should address all pregnant women with subsections for overweight or higher BMI women, women with a low BMI and women with a healthy range BMI.

There was a suggestion that friends, partners and families need to be included in the target population and the local authority, specific community and commercial organisations, leisure services and any other practitioner working in weight management be included in the list of people who should take action. This would ensure more of a holistic approach, where the focus is on the whole family.

The recommendation was described as being ‘an afterthought’ and as it stands and did not fit with the other recommendations. Practitioners found the first action confusing and suggested removing the phrase ‘if pregnant’. Similarly, they suggested removing ‘after childbirth’ from the title of the recommendation. The phrase ‘when they are ready to lose weight’ was felt to be too vague and ambiguous. There was also confusion about how long after a woman has given birth, the actions should begin, this needs to be specified.

There were major concerns regarding the availability of dietitians. They are seen as very difficult to access, especially for public health issues, and it may be better to state ‘appropriate Health Professional’ in their place, or refer patients onto a specific ‘behaviour change strategy’ as opposed to relying to the dietitian to deliver this.

Practitioners said the recommendation was good in stressing that services need to be tailored and ongoing and this should already be taking place. Although there does need to be a link back to the obesity guidance.

"If we are trying to normalize pregnancy why are the recommendations separate and not part of an obesity strategy?"

Some wanted the health risks to be outlined within the recommendation. In particular the impact on the health of the baby; this is often a strong motivator mothers to lose weight.

Feasibility and implementation

There was a suggestion that this recommendation should not specify referral to a dietitian, as every area does not have access to one.

The recommendation may not be feasible when delivering advice to different socio-economic and cultural and BME groups, practitioners felt there should be more information and awareness about providing specialist services to hard to reach and vulnerable groups, particularly how to deliver that advice e.g. outreach work and home visits.

There was strong concern that the recommendation had high cost implications for services and practitioners were worried about funding. Importantly, they said that the lack of pre-conceptual services increases the burden on post natal services.

The lack of detailed information for health professionals could result in poor quality and inconsistent weight management advice and so the recommendation needs to look to a central source of information.

Practitioners stressed the importance of delivering a healthy lifestyle message to all women, and felt there is nothing in the recommendation that promotes the benefits of weight loss. This was considered essential because it is a good motivator for women to lose weight.

Barriers

There was a view that private slimming clubs can be quite costly and so there may be a need for accredited and subsidised weight management programmes.

Some women may find the idea of physical exercise intimidating and so the recommendation should highlight everyday activities such as walking to encourage participation.

Poor use of existing services was seen to be a barrier, so better utilisation of existing services such as Children's Centres is important.

The recommendation implies a greater level of service provision and with this come training and cost barriers. Suggested ways of combating these barriers would be to: use volunteers to deliver some of the services, particularly advice and support roles; encourage dietitians to train the trainers; provide better access to information and resources.

There was a suggestion that there was a lack of awareness of who should deliver information and how. Fellow practitioners may also be unaware of what each other should be doing. This could be overcome by producing a national framework that outlines simply who does what, when they deliver and how.

A major barrier was how to get people to attend specialist services, particularly women with a high BMI. Some practitioners suggested there may need to be incentives to encourage them. Similarly, women who return to work after 6 months may not be able to access services, especially those offered in the day time. This needs to be considered in the recommendation, for example, reference to out of hours services and home visits.

There was reference to depression/mental health issues and how they can prevent people from exercising but in the long term exercise can help their condition. Some thought is needed on how to break this cycle.

Impact

Overall, practitioners said that if the barriers were overcome the recommendation would have a positive impact. Issues around time, staffing and money dominate any discussion of impact particularly when the consensus is that there is very little funding available for obesity, particularly when competing with acute service funding. It is therefore imperative that the case for funding be made at the PCT level and kept high on the agenda of commissioners.

There was a concern that there may not be enough staff to deliver the recommendation. This could have a positive impact in building the business case for more staff and resources.

"We want a business class service but with an economy class budget".

3.7.6 Recommendation 6: Supporting women after childbirth

Recommendation 6 – support women after childbirth

Who is the target population?

- Women who have recently had a baby.
- Their partners, families and friends.

Who should take action?

- Commissioners and managers in PCTs and NHS trusts.
- Managers of local authority leisure and community services including swimming pools, and parks.
- Slimming and weight management clubs.
- Children's centres.

What action should they take?

- Local authority leisure and community services should offer women with babies and children a range of opportunities to take part in physical or recreational activities, for example, swimming, organised walks, cycling or dancing. These need to be affordable and

available at times that are suitable for those with older children as well as babies. Where possible, affordable childcare (for example, a crèche) should be provided.

- Managers in PCTs, local authority leisure services and slimming clubs should work together to offer women who wish to lose weight after childbirth the opportunity to join a weight management group or slimming club.
- Weight management groups and slimming clubs should adhere to the principles outlined in the introduction to this section (see 'Effective weight management programmes'). This includes giving advice about healthy eating and the importance of physical activity.

Key Summary points for recommendation 6 – supporting women after childbirth

This recommendation was thought to be very similar to recommendation 5. It was seen as being quite vague and would benefit from a greater level of detail.

Practitioners said that implementation may be difficult if it is not known what services women access in the first place. Similarly it was essential to ensure that health professionals know what existing services are and how to signpost women to these services.

Implementation suggestions included:

- Rewording;
- Inclusion of commissioners;
- Clarity what is meant by 'recently had a baby'?
- Definition of what is meant by 'community';
- Emphasis on strengthening existing services;
- Some form of monitoring and evaluation of existing services;
- Possibly merge with Recommendations 4 and 6.

Content and Wording

As with the previous recommendation it was thought to be very similar, and practitioners suggested the Recommendations 5 & 6 should be merged.

It was suggested that commissioners and managers from voluntary services, Local Authorities and joint commissioning avenues be included, as well as schools, youth clubs, family planning clinics and GPs.

Midwives said the following wording should be included in the recommendation,

"Community based services to promote and educate in healthy eating for themselves, their family and their baby".

Practitioners wanted more clarification of the target population, 'women who have recently had a baby', such as how recent? They also suggested there needs to be a definition of 'community based'. 'Slimming clubs' was thought to be an unpopular phrase and could be re worded, for example to 'healthy weight clubs or groups'. Furthermore there was some debate around what 'weight management groups' actually are and does this actually mean 'weight loss groups'. There was also some confusion over the term 'Health Trainers', primarily who they are and what they do?

This recommendation should focus on enabling clearer links with leisure services; in particular they could capitalise on the build up to the Olympics as a means of promoting good weight management and increased funding for provision of services within the community.

Feasibility and implementation

Although the recommendation suggest signposting women to community services this may not be feasible when it is not known who accesses the various types of services. There was a perception that certain low socio-economic groups may not for example be accessing Children's Centres, where services are described to be 'white, middle class'. Similarly there is no discussion in the recommendation of specific cultural issues and how they may impact on proper provision of community based services, such as Muslim women not being able to access mainstream, mixed gender classes.

There was a strong feeling that the services outlined in the recommendation are available to women, including specialist services. The issue is how to encourage women to access them. The recommendation does not focus enough on the motivation to change, particularly as the majority of women will not attend a club through a health professional referral.

In order to be able to effectively promote community based services health professionals need to know what is available; practitioners said that this was not the case. In order for successful implementation there needs to be a centralised source that enables practitioners to know what is available and how to access that information.

Some practitioners were concerned that it may be difficult to monitor some community based services, particularly weight management clubs; this is important to ensure good standards of provision. This may also help with the evidence base for commissioning further services.

There was some suggestion from leisure service practitioners that it may be difficult to get private sector leisure services and slimming clubs with their own contracts and targets to implement the recommendation.

Barriers

A major barrier to the provision of community based services is not knowing what services women access in the first place. Practitioners suggested market research may be needed to identify this and tailor services accordingly.

Healthcare professionals not knowing what is available to their community, and what other professionals are doing, is also a major barrier.

The lack of proper facilities for pregnant women, and women who have recently given birth may act as barrier, for example there should be a promotion of breastfeeding friendly facilities, child friendly premises and women only provision.

There should be some awareness of the cultural differences in sport participation and in the take-up of services. Practitioners suggested in some areas, women from BME groups are underrepresented in groups/clubs; white women from lower socio economic groups may have difficulty accessing information i.e. on the internet.

As the lack of funding is a major theme throughout the recommendations, practitioners said it was important to focus on strengthening existing pathways and improve sign posting to these pathways. Similarly there should be a focus on improving existing community services, such as effective monitoring and evaluation.

Impact

The target population 'women who have recently had a baby...their family and friends' implies a huge case load and practitioners remarked that this would have an huge impact, implying the need for extra investment into services, strengthening training, and developing a new workforce.

There was a positive view of the longer term impact of women accessing services before pregnancy and following childbirth as this will foster improvements in healthy eating for them and their families. Information and learning at this point is crucial because it captures women during a life changing event and is likely to stay with her beyond her pregnancy and early childcare years. Leisure service managers felt that such provision may also encourage new users through focusing on delivery to a sub-group of women.

"Women remember what they have been told in pregnancy for a long long time, it's a life changing period… women want to make changes and therefore this is a good opportunity to capture them"

3.7.7 Recommendation 7: Professionals skills

Recommendation 7 – professional skills

Who is the target population?

Health professionals and support workers who care for women who may become pregnant, are pregnant or who have recently had a baby.

Who should take action?

- Professional bodies and others responsible for setting competencies and developing continuing professional development programmes for health professionals, healthcare assistants and support staff.
- Skills councils and training boards responsible for the training of health and fitness advisers and health trainers.

What action should they take?

- Ensure health professionals, healthcare assistants and support workers have the skills to advise on the health risks of being overweight or obese during pregnancy, after childbirth or after successive pregnancies. They should understand – and be able to explain – why women need their BMI calculated during pregnancy and after childbirth. This includes

knowing how this information will be used.

- Ensure they can advise women on their nutritional needs before, during and after pregnancy. They should also be able to explain why it is important to have a balanced diet and to be moderately physically active before, during and after pregnancy.
- Ensure they can broach the subject of weight management in a sensitive manner and can give practical advice on how to make positive changes to improve their diet and become more physically active. They should be able to tailor this advice to the woman's circumstances. They should also know when to refer them for specialist care and support.
- Ensure they have appropriate knowledge and skills to help dispel common myths about keeping healthy and what to eat and what not to eat in pregnancy, and weight loss in relation to breastfeeding.

Key summary for recommendation 7 professional skills

This recommendation was thought to be too vague.

The main concern was how the recommendation would be measured so as to ensure successful implementation. There also needs to be some form of assessment to determine what professional skills are required and by whom. Practitioners were also concerned about the time and funding implications.

Implementation suggestions included:

- Rewording;
- Inclusion of professional bodies;
- Clarity on who would be responsible for monitoring the training required
- Training that considers weight management advice for different cultural and socio-economic groups;
- Clarity on skills needed to advise women who suffer from a complicated pregnancy;
- Some reference to the 'soft skills' needed when talking about weight management.

Content and Wording

This recommendation was perceived as being too vague but useful because it aims to ensure uniformity and a standard level of information provision. However, there needs to be more detail on whose responsibility it is for maintaining minimum competency skills across the professions.

Practitioners thought it would be useful to include a comprehensive list of who should be included in the training e.g. obstetricians and that this training should be mandatory.

The section 'who should take action' should be inclusive of bodies that provide advice on the standards that commercial services should work such as, The British Heart Foundation.

Under ‘what action should they take’, there was a feeling that the following themes should be emphasised in training: raising the issue of weight management and how to do this effectively for women with varying BMI; weight management advice for different cultural and socio-economic groups; soft-skills to help professionals deal with the sensitivity of issues surrounding weight management; and better sign posting to existing services.

Midwives said that the attention given to breastfeeding and weight loss was insufficient and needed to be given a much higher profile in this and all other recommendations.

A few practitioners suggested this recommendation should be combined with recommendation one.

Feasibility and implementation

The main concern was how the recommendation would be measured so as to ensure successful implementation. This could potentially be a huge task bearing in mind the different groups and the different skills needed to engage each of those groups.

The recommendation is not feasible until certain gaps are filled. Practitioners questioned who would undertake the training and who is responsible for updating professionals on any new research and skills. They also felt there was no reference to workforce planning and the logistics of enabling professionals to attend training (especially GPs). There is no mention of a joined-up training approach and how this could help project a consistent message across the healthcare professions.

Leisure service managers would not be happy for their staff to impart advice on nutrition and other elements not related to physical exercise.

Any discussion of professional skills should be within a structure of a quality care framework. The recommendation may not be feasible until this is made explicit.

Before the recommendation can be successfully implemented there needs to be an assessment of what training is required and for whom. Again the practitioners questioned who would take responsibility for this.

Whatever training is provided should be done within existing frameworks, rather than being seen as ‘yet another training day’. GPs and practice nurses suggested this could be incorporated into their PCTs ‘protected learning time’.

Barriers

One of the barriers cited by practitioners was the motivation of professionals to attend training. This could be made easier by offering accredited training days, making training mandatory or incorporating weight management within professional skills qualifications such a Midwifery courses and undergraduate degrees.

Another major barrier could be the lack of a national campaign to help promote issues around weight management and pregnancy, this includes a national website. Some practitioners said there could be more advice made available to women through such a campaign and could ease the workload of healthcare professionals. It could also help both parties to access centralised, up to date information.

The practitioners noted that the recommendation does not make any reference to women who may suffer from a complicated pregnancy and the specialist advice that would be needed for them.

Impact

The most obvious impact would be the training implications and the increased cost and time it would take to successfully implement the recommendation.

Those practitioners who worked in hospitals said this recommendation would have little impact on hospitals because it would not be seen as a priority.

In an ideal world, practitioners felt the recommendation would have a positive impact. For example, the recommendation would be useful and beneficial if it was well received by practitioners, if training was offered jointly, if networking opportunities resulted in partnerships, if there was increased funding and if there was better signposting to existing service. However, in reality practitioners said it was nothing new, there were no measurable outcomes and not enough emphasis on the quality of standards.

4 CONCLUSIONS

4.1 General reaction to draft recommendations

The following provides the general reaction to the recommendations:

- The draft recommendations were overall well received and reported to be well written;
- The recommendations were found to be relevant to most of the named professions and necessary to raise awareness of the issue of weight management during pregnancy and after childbirth;
- They were thought to be particularly useful for non health care professionals to use and help raise awareness amongst this group;
- Resources and funding were required in order to implement the recommendations fully and to a high quality;
- There were several groups of 'hard to reach' women that were not covered by the recommendations and more guidance regarding reducing health inequalities in this area;
- More detail was needed in order to enable health professionals to carry out some of the actions;
- The recommendations should focus on more pro-active actions rather than focusing on the more negative aspects of what women should not do;
- The remit of the guidance should be broadened with care pathways outlined.

4.2 Content of the recommendations

Overall, the majority of the feedback gained related to the content of the recommendations. The recommendations were found to be well written, clearly set out and easy to follow. However, they were also reported to be too general for health professionals to carry out to a high quality standard and a greater level of detail and instruction was needed on how to put these actions into practice.

The remit of the guidance was cited as being very narrow, overlooking some important issues. These included:

- Care pathways should be set out in the recommendations to inform health professionals of the services available for women to be referred to. Allocation of roles and responsibilities need to be more clearly defined;
- The content of health promotion advice was limited. For example, breastfeeding was an issue discussed by many practitioners that needed a greater emphasis, particularly around the health benefits and weight management associated with breastfeeding;
- The guidance is only focussed on women who are overweight. However, feedback suggested that many pregnant women are underweight, which also poses significant risks to the woman and the child;
- There was very little guidance provided on inclusiveness and how to address health inequalities;

- Insufficient information was provided on the role of commissioners and the importance of joined up commissioning. As commissioners were reported as being a vital role in ensuring services were able to carry out these actions;
- The guidance is heavily biased towards weight loss, rather than maintaining a healthy weight and behaviour change;
- There is no mention of the use of mass media marketing to raise awareness;
- The recommendations assume that women plan pregnancies. However, many women do not plan and do not access services or health professionals. Therefore, more guidance is needed on how to reach all women;
- The importance of education on the risks of obesity within schools as a preventative measure should be drawn on. This would help to reach all women of a childbearing age and reduce the prevalence of obesity. Those who should take action needs to be expanded to schools and teachers.

4.3 Feasibility of the recommendations

Overall, it was suggested that the recommendations were feasible to implement if there were sufficient resources, staff and funding, such as ring-fenced funding dedicated to the area of obesity. Therefore, greater actions should be placed on commissioners of services.

Training would be needed to ensure the recommendations were followed. This would need to cover communication skills to deal with the sensitive nature of weight management, as well as behaviour change knowledge.

Promotion was suggested as a method of helping the recommendations to be implemented. This could be through a mass media campaign or linking with other campaigns such as Change4Life.

4.4 Impact of the recommendations

Mixed feedback was provided on the potential impact of the recommendations. On one hand feedback suggested that the recommendations did not add anything new. They were just presenting good practice and would not have a great impact on current practice. However, on the other hand, some services would not be adhering to these actions and a great deal of service restructuring would be needed to implement them.

Additional funding, resources, training and staff would be needed to implement these recommendations.

4.5 Related guidance

Feedback suggested that the recommendations would benefit from linking and referencing other sets of guidance. These included:

- Change4Life;
- Start 4 Life;

- Institute of Medicine Pregnancy Weight Guidelines
- Healthy Child Programme;
- Childhood Obesity Strategy; and
- NICE obesity guidance.