Liverpool Women's NHS Foundation Trust

OBSTETRIC ANAESTHETIC STAFFING IN LABOUR WARD

THIS IS A CONTROLLED DOCUMENT
The only Valid Version is stored in the Policies, Procedures and Guidelines Intranet Site

Version	4.2
Grade of Change	Major Revision
Summary of Changes	Removal of Role of the Consultant anaesthetist on labour ward Detailed duties Anaesthetic procedures

Document Type	Clinical Guideline
Coverage	Anaesthetic

Designation of Guideline Sponsor	Consultant Anaesthetist
Responsible Committee	Anaesthetic Business Meeting

Date ratified	10/07/2024
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1. Summary

A weekly rota of anaesthetic duties is produced and monitored
A weekly rota of anaesthetic duties is produced and monitored by the department of anaesthesia.
Digital copies can be accessed via clw.rota and allocate.
Guest access can be arranged and will be made available to all partners, including switchboard.

Anaesthetic Staff
Consultant anaesthetic presence is prioritised over any other elective care in the trust.
Two consultant anaesthetists are available 50 hours a week.
They will cover elective and emergency obstetric care from 8am-6pm Monday to Friday.
Enhanced on site consultant presence is available until 10pm on Monday to Thursday evening.
Consultant anaesthetists are non-resident on call over and above the described 70 hours of elective and enhanced on site presence.

Two trainees who have been assessed as competent as per Royal College of Anaesthetist competency framework guidance will cover emergency care 24/7.
.Entrustable Professional Activities 3&4 UNAPPROVED_2.pdf

GPAS guidance states that busier units require 2 duty anaesthetists.

Chapter 5: Guidelines for the Provision of Emergency Anaesthesia Services 2024 | The Royal College of Anaesthetists (rcoa.ac.uk)
GPAS-2020-09-OBSTETRICS.pdf (rcoa.ac.uk)

Urgent treatment of gynaecological emergencies and critically ill patients have highlighted the requirement for a resident third on call anaesthetist.

The above care provides comprehensive labour analgesia and anaesthesia to parturients.

A fortnightly triage clinic populates the 4 high-risk anaesthetic ANC session. This activity is consultant led.

2. Introduction

Successive reports, including MMBRACE MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | MBRRACE-UK | NPEU (ox.ac.uk)
and the recent Ockenden report , Ockenden review: summary of findings, conclusions and essential actions - GOV.UK (www.gov.uk) have emphasized the importance of anaesthetists as an integral part of the multi-disciplinary team managing obstetric patients, including mothers who become seriously ill. RCOA GPAS documents indicate that approximately 60% of women require anaesthetic intervention around the time of delivery of their baby, but the total anaesthetic involvement is higher.
EMC-Guidelines2018.pdf (rcoa.ac.uk)
24832 RCoA_NAP7_Book_updated.pdf
NAP7_Chapter 34_FINAL.pdf (rcoa.ac.uk)

3. Background

The mainstay of the obstetric anaesthesia service is the provision of analgesia and anaesthesia on the labour ward. In order to ensure a safe and co-ordinated service there is a designated lead obstetric anaesthetist responsible for all aspects of the clinical service. This includes the production and updating of protocols and guidelines, as well as attendance at divisional meetings and dissemination of information across the department.

Guidelines should be available to obstetricians and midwives indicating those conditions which require antenatal referral to the anaesthetic team. A system is in place to ensure these referrals occur in a timely fashion.

Obstetric anaesthesia is a core component of the curriculum for a Certificate of Completion of Training (CCT) in anaesthesia. It therefore follows that training of anaesthetic trainees forms an important component of activity on the labour ward. Trainees attend at various stages of training and the supervision of trainees should reflect this.

A 24/7 neuraxial analgesia service is provided by the anaesthetic team. Where a woman in labour requests neuraxial analgesia (and the circumstances are suitable for this type of analgesia) the duty anaesthetist should be informed. The anaesthetist should normally attend within 30 minutes of being informed. Only in exceptional circumstances should this period be longer and should be within 1 hour. This forms part of the trusts Key Performance Indicators and is regularly reviewed.

Neuraxial anaesthesia is now the expected norm in obstetric anaesthesia practice. It allows the mother to be awake, and the birthing partner to be present, at the time of delivery. Regional anaesthesia is associated with decreased overall maternal analgesia requirements.
Unlocking maternal health: labour epidurals and severe morbidity
BMJ 2024; 385 doi: https://doi.org/10.1136/bmj.q1053 (Published 22 May 2024)

Cite this as: *BMJ* 2024;385:q1053

Regional anaesthesia is generally safe but carries risks of complications including failure which may results in general anaesthesia. There is a significantly increased morbidity and mortality associated with general anaesthesia. NAP7_Chapter 34_FINAL.pdf (rcoa.ac.uk)

Risks of general anaesthesia include difficult and failed intubation. Each woman admitted to labour ward, especially those requiring surgery, should have a detailed airway assessment to determine risk and assess whether additional assistance is required.
Guidelines for the management of difficult and failed tracheal intubation in obstetrics - 2015 | Difficult Airway Society (das.uk.com)
NAP4 Full Report.pdf (nationalauditprojects.org.uk)

Enhanced maternal care should be available on or near the labour ward, with appropriately trained staff. If this is unavailable women should be transferred to a general high-dependency unit in the same hospital.

	8am-6pm	6pm-8pm	8pm-10pm	10pm-8am
Monday	2 consultants: Bleep 156 157 2 trainees: Bleep 301 504	2 consultants on site 2 on call trainees Bleep 301 504	1 consultant on site Non-resident on call consultant 2 on call trainees Bleep 301 504	2 on call trainees Bleep 301 504 Non-resident on call consultant Contact via switchboard
Tuesday	2 consultants: Bleep 156 157 2 trainees: Bleep 301 504	2 consultants on site 2 on call trainees Bleep 301 504	1 consultant on site Non-resident on call consultant 2 on call trainees Bleep 301 504	2 on call trainees Bleep 301 504 Non-resident on call consultant Contact via switchboard
Wednesday	2 consultants: Bleep 156 157 2 trainees: Bleep 301 504	2 consultants on site 2 on call trainees Bleep 301 504	1 consultant on site Non-resident on call consultant 2 on call trainees Bleep 301 504	2 on call trainees Bleep 301 504 Non-resident on call consultant Contact via switchboard
Thursday	2 consultants: Bleep 156 157 2 trainees: Bleep 301 504	2 consultants on site 2 on call trainees Bleep 301 504	1 consultant on site Non-resident on call consultant 2 on call trainees Bleep 301 504	2 on call trainees Bleep 301 504 Non-resident on call consultant Contact via switchboard
Friday	2 consultants: Bleep 156 157 2 trainees: Bleep 301 504		1 consultant on site Non-resident on call consultant 2 on call trainees Bleep 301 504	2 on call trainees Bleep 301 504 Non-resident on call consultant Contact via switchboard
Saturday	Non-resident on call consultant Contact via switchboard 2 trainees Bleep 301 504	Non-resident on call consultant Contact via switchboard 2 trainees Bleep 301 504	Non-resident on call consultant Contact via switchboard 2 trainees Bleep 301 504	Non-resident on call consultant Contact via switchboard 2 trainees Bleep 301 504
Sunday	Non-resident on call consultant 2 trainees 8am-8:30pm 8pm to 8:30am	Non-resident on call consultant 2 trainees 8am-8:30pm 8pm to 8:30am	Non-resident on call consultant 2 trainees 8am-8:30pm 8pm to 8:30am	Non-resident on call consultant 2 trainees 8am-8:30pm 8pm to 8:30am

4. Performance Management of the Guideline:

The clinical director of anaesthesia is responsible for developing:

- business plan(s) which reflect the results of the annual audit to address staffing shortfalls, if any
- contingency plan(s) to address ongoing staffing shortfalls, if any
- contingency plan(s) to address short term staffing shortfalls, e.g., due to increased workload or sickness

Who is responsible for performance management of this Maternity Guideline (i.e., who (person or group) will develop an action plan to address areas of non-compliance?)	Clinical Director Anaesthesia
Where will performance against this action plan be monitored	Operational Board
How often will this occur	Annually

5. References

RCOA Guidelines for the Provision of Anaesthesia Services for an Obstetric Population 2020. Available at https://rcoa.ac.uk/gpas/chapter-9#section-3.1

Department of Health (2007). Maternity Matters: Choice, access and continuity of care in a safe service. London: COI. Available at:www.dh.gov.uk

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. London: RCOG Press. Available at: www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists, Royal College of Anaesthetists, Royal College of Midwives, Royal College of Paediatrics and Child Health. (2008). Standards for Maternity Care: Report of a Working Party. London: RCOG Press. Available at: www.rcog.org.uk

The Association of Anaesthetists of Great Britain and Ireland, and the Obstetric Anaesthetists' Association. (2013). OAA/AAGBI Guidelines for Obstetric Anaesthetic Services (Revised edition). London: AAGBI/OAA. Available at: www.aagbi.org.uk and www.oaa-anaes.ac.uk

http://www.oaaanaes.ac.uk/assets/_managed/editor/File/PDF/Publications/obstetric-guidelines.pdf

6. Associated Guidelines

- Transfer of the critically ill patient
- Care of the patient in obstetric recovery ward
- Admission and discharge criteria to obstetric HDU
- Guidelines for management of primary post-partum haemorrhage
- Management of Severe Pregnancy Induced Hypertension
- Procedural guidance for the Management of Women Refusing Blood Transfusion.

7. Auditable Standards

- an annual audit to establish whether obstetric anaesthetist staffing levels are in line with *Safer Childbirth* (RCOG 2007)
- an annual audit to establish whether assistant staffing levels are in line with the maternity service's required staffing levels

8. Consultation and Ratification Process

Describe the implementation plan for the guideline	New staff will be made aware of this policy at local induction. Existing staff will be made aware of the guideline through the, anaesthetic meetings and Postgraduate Manager. It will be available on the Trust intranet.
By whom will this be delivered:	Clinical Director of Anaesthesia and lead nurse/ODP for theatres

9. Monitoring Compliance with the Guideline:

How will compliance with this guideline be assessed	An annual audit to establish whether obstetric anaesthetist staffing levels are in line with *Safer Childbirth* (RCOG 2007)
Who holds responsibility for this assessment	**Clinical Director Anaesthesia**

How will results be reviewed	Presented at Obstetric Theatre group and labour Ward Forum Written report submitted to the Medical Director to present in his regular report to the Trust Board
How often will this occur	Annually

Performance Management of the Guideline:
The Clinical Director Anaesthesia is responsible for developing:

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Who is responsible for performance management of this Maternity Guideline (i.e., who (person or group) will develop an action plan to address areas of non-compliance?)	Clinical Director Anaesthesia
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How often will this occur	Annually

10. Intranet Classification

Tags (separated by ;)	[Keywords]

11. Version Control Sheet

Version	Date	Author	Status	Comment
3	Oct 15	Consultant Anaesthetist	Archived	Reviewed and Updated
4	Nov 17	Consultant Anaesthetist	Archived	Reviewed and Updated
4.1	May 21	Consultant Anaesthetist	Archived	Reviewed and Updated
4.2	June 24	Charlene Grassman – Clinical Lead	Current	Removal of Role of the Consultant anaesthetist on labour ward Detailed duties Anaesthetic procedures