Obstetric High Risk Anaesthetic Clinic Referrals SOP

Applicable to (please mark with an X)							
Group-wide		**LUHFT-wide**				**Liverpool Women's**	**x**
Aintree Hospital		**Broadgreen Hospital**		**LCL**		**Royal Liverpool Hospital**	

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What is new in this version?

Latest Version	Page	Changes Made	Date
1.0		**New Document**	**31/12/2025**

1.0 Executive Summary/Flowchart

This SOP is to ensure clarity and consistency in the referral and triage process for women to the high-risk anaesthetic clinic.

2.0 Introduction and Purpose

The purpose of referral to High Risk Anaesthetic Clinic (HRANC) is to book an appointment with a consultant obstetric anaesthetist. Twenty-one 30-minute slots are available per week, excluding midweek Bank Holidays.

3.0 Procedure

3.1. Referrals

- Succinct clear reason for referral
  - Referrals that lack referral reason will be rejected
- Please avoid duplicates
- Please refer to referral guidelines (appendix A)
- If referral at later gestation, ensure that patient does not have an appointment or has already been seen in the anaesthetic high-risk clinic
- Acute referrals by consultant obstetricians should be made to anaesthetic consultant covering delivery suite (bleep 157, 8am - 10pm)
- Late referrals on triage, accept as urgent
- 37+ weeks referrals may need to be escalated as an acute referral to consultant anaesthetist covering delivery suite if no urgent clinic slots available
- Check rejections: rejections will be referred to community midwives if referral criteria not met or more information is required

3.2. Processing/triage

- Once weekly triage session by consultant anaesthetist
- Triage consultant will specify the details of the appointment booking on K2:
  - Use 'urgency of care' acceptance and specify in *'clinic requested dates'*
  - Urgent: *ASAP or less than 2 weeks*
  - High: *Gestation period to be seen, e.g. 28-32 weeks*
  - High: *Gestation period to be seen AND after joint obstetric/specialist clinic*
- Triage consultant should request a double slot in 'clinic requirements' for:
  - Complex patients
  - Postnatal Debrief patients
  - Non-English-Speaking patients
- Triage consultant will process all referrals who have completed their first trimester of pregnancy
- The triage consultant will check the archive to ascertain whether multiparous patient with pre-existing condition has been seen in HRANC in a previous pregnancy and whether a further visit is required
- Rota team will highlight to Tuesday HRANC that all third trimester referrals need to be managed (2 urgent/late booking appointments held per week: if not filled, clinic consultant anaesthetist to triage third trimester referrals)

- Document any rejections in referral
    - If rejection based on BMI, state not for re-referral if BMI reaches threshold during pregnancy (as this results in late referrals)
    - Consider adding links to information on high BMI in pregnancy to K2 (LWH website or LabourPains website)

3.3. Streamlining

- Ensure patient has not been seen in HRANC this pregnancy
- Allocate two clinic slots a week to allow for late/urgent referrals

3.4. DNAs

- Attempt to contact patient and conduct a telephonic review if applicable
- Record non-attendance in K2 if unable to contact
- Complete outcome documentation on Digicare
- Review the need to see patient and inform booking team of follow up visit using above triage guidance.

3.5. Clinics

Three weekly clinics, consisting of twenty-one 30-minute clinic slots. All day Tuesday clinic, alternating week Wednesday morning and Thursday afternoon clinic. Aligning clinic appointments with other clinic appointments at patient's convenience may therefore not be achievable.

3.6. Postnatal follow-up and Debriefs

Referral for anaesthetic postnatal follow-up or debrief should be done in usual manner via K2 referral system for anaesthetic clinic (same as antenatal referrals). In addition please email AntenatalApptTeam4@lwh.nhs.uk with patient details and time frame for clinic appointment booking to ensure patients are booked into clinic. Request double slot on triage (as above) and in email.

4.0 Roles and responsibilities

Consultant Anaesthetist triaging referrals to clinic to adhere to guidance set out above (section 3.2).

5.0 Equality, Diversity and Human Rights Statement

The Trust is committed to an environment that promotes equality and embraces diversity in its performance both as a service provider and employer. It will adhere to legal and performance requirements and will mainstream Equality, Diversity and Human Rights principles through its policies, procedures, service development and engagement processes. This document should be implemented with due regard to the commitment.

Appendix A: Referral Criteria for HRANC

Anticipated anaesthesia related problems:

- History of difficult / failed intubation
- Anticipated difficult airways, previous oral or facial surgery affecting mouth opening or neck movement, oral, neck, facial swelling (including enlarged thyroid), limited neck movement or mouth opening
- Previous awareness under anaesthesia
- Anaphylaxis to anaesthetic drugs.

Please do not refer women who are allergic to antibiotics, latex or any food allergies.

- Suxamethonium apnoea
- Malignant Hyperthermia
- Porphyria
- Previous traumatic anaesthetic experience
- Complications after neuraxial blockade (Spinal/Epidural), including previous failed Spinal or Epidural
- Severe needle phobia
- Women who refuse blood transfusion
- Known difficult venous access requiring previous mid/longline or central access, e.g. ex/current intravenous drug users with damaged veins.

Obstetric causes:

- Known placenta praevia/placenta accreta spectrum
- Large Fibroid uterus
- Anticipated difficult surgery or surgery requiring surgical support by different surgical specialty
- Triplets/quadruplets

Cardiac disease including:

Cardiology diagnosis should have been made before referral to an anaesthetist after joint obstetric cardiac clinic.

Where patients have a past medical history of cardiac disease, documentation should be available in the maternity notes and the patient's cardiologist should have been made aware of the pregnancy.

- Congenital heart disease, surgically corrected or uncorrected, structural heart defects
- Acquired heart disease: valvular lesions, ischemic heart disease (angina, previous myocardial infarction: STEMI or Non-STEMI)
- Cardiomyopathy
- Heart Arrhythmias: congenital or acquired complete AV-block, Prolonged Q-T Syndrome, WPW Syndrome
  - Diseases of the aorta (e.g. Marfan's Syndrome)
  - Permanent pacemaker or implantable cardioverter defibrillator (ICD)

Haematological problems including:

Only once referral has been accepted by joint obstetric/haematology clinic team

- Hypercoagulability with anticoagulation therapy during pregnancy (e.g. Protein S/C/ATIII deficiency)
- Congenital Coagulopathies (e.g. von Willebrand disease)

- Thrombocytopenic Coagulopathies
- Haemoglobinopathy (e.g. Thalassaemia, Sickle-Cell disease)
  - Woman with Stable and Constant Thrombocytopenia with a platelet count consistently below 100

Respiratory disease-causing impairment of daily activities

- Severe obstructive/ restrictive lung disease (e.g. severe asthma, Cystic fibrosis, pulmonary fibrosis, COPD, bronchiectasis, restrictive lung disease) which require special care during pregnancy and childbirth, causing impairment of daily activities.
- Any active treatment or chemotherapy, which combined with high concentrated Oxygen, may be dangerous or cause internal organs complications.

Neurological disease including:

- Conditions which may interfere with neuraxial (Spinal/Epidural) anaesthesia and analgesia
- Neuromuscular disease which may affect breathing (Myasthenia gravis, Muscular dystrophy, myotonic dystrophy)
- Other intracranial pathologies (e.g. AV-malformations, Neoplasm/Tumours), surgically corrected or not.
- Previous history of stroke or intracranial bleeding
- Multiple sclerosis
- Benign or idiopathic intracranial hypertension
- Hydrocephalus

Musculoskeletal

- Spine problems, e.g. congenital abnormalities, previous operations, trauma, scoliosis, spina bifida etc.
- Vascular Ehlers Danlos

BMI

Any woman with BMI 45 or above at booking should be referred

BMI 40-45 without additional co-morbidity will be rejected

Renal Disease

- End stage renal failure/ regular dialysis
- Renal Transplant

Endocrinological Disorders

- Acromegaly, Addison's disease and similar disorders
- Poorly controlled or uncontrolled Diabetes mellitus and evidence of end organ failure
- Phaeochromocytoma
- Goitre

Autoimmune Disorders

- Rheumatoid arthritis
- Ankylosing spondylitis
- Systemic Lupus erythematosus
- Systemic Sclerosis (Scleroderma)
- Myasthenia gravis
- Myotonic dystrophy

Post natal complications of Regional Anaesthesia

Women with Post Dural Puncture Headache, brain/spine haemorrhage, severe paraesthesia and signs of severe nerve damage, new severe back pain other than previous pain prior to Regional Anaesthesia procedure must be seen in the clinic within 2 weeks to 3 months in post-natal period for anaesthetic review.

Women with post puncture headache followed by blood patch procedure must be seen in the clinic within 3 months after the blood patch procedure is completed.

Referral should be made whilst still inpatient for postnatal review. If identified in the community postnatally the on-call resident anaesthetist should be contacted via MAU for review.

Debrief requests

Appendix B: Equality Impact Assessment

- The below tool must be completed at the start of any new or existing policy, procedure, or guideline development or review. **N.B.** For ease, all documents will be referred to as 'Policy*'. The EIA should be used to inform the design of the new policy and reviewed right up until the policy is approved and not completed simply as an audit of the final Policy itself.
- EIAs must be sent for review prior to the policy* being sent to committee for approval. Any changes made at committee after an EIA has been sign off must result in the EIA being updated to reflect these changes. Policies will not be published without a completed and quality reviewed EIA.

1. Possible Opportunity for Negative Impacts		
Protected Characteristic	**Possible Impact**	**Action/Mitigation**
Age	Neutral	SOP only applies to pregnant patients.
Disability	Neutral	
Ethnicity	Neutral	
Gender	Yes	
Marriage/Civil Partnership	Neutral	
Pregnancy/Maternity	Yes	
Religion and Belief	Neutral	
Sexual Orientation	Neutral	
Trans	Neutral	
Other Under Served Communities (Including Carers, Low Income, Veterans)	Neutral	

2. Possible Opportunity for Positive Impacts		
Protected Characteristic	**Possible Impact**	**Action/Mitigation**
Age	Neutral	SOP only applies to pregnant patients.
Disability	Neutral	
Ethnicity	Neutral	
Gender	Yes	
Marriage/Civil Partnership	Neutral	
Pregnancy/Maternity	Yes	
Religion and Belief	Neutral	
Sexual Orientation	Neutral	
Trans	Neutral	
Other Under Served Communities (Including Carers, Low Income, Veterans)	Neutral	

3. Combined Action Plan

Action (List all actions and mitigation below)	**Due Date**	**Lead** (Name and Job Role)	**From Negative or Positive Impact?**

4. Information Consulted and Evidence Base (Including any consultation)			
Protected Characteristic	**Name of Source**	**Summary of Areas Covered**	**Web link/contact info**
Age			
Disability			
Ethnicity			
Gender			
Marriage/Civil Partnership			
Pregnancy/Maternity			
Religion & Belief			
Sexual Orientation			
Trans			
Other Under Served Communities (Including Carers, Low Income, Veterans)			

5. EIA Update Log (Detail any changes made to EIA as policy has developed and any additional impacts included)		
Date of Update	**Author of Update**	**Change Made**

6. Have all of the negative impacts you have considered been fully mitigated or resolved?
7. Please explain how you have considered the duties under the accessible information standard if your document relates to patients?
8. Equality Impact ~~A~~ssessment completed and signed off **Name: C. Grassman, L. Wilson** **Date: 31/12/25**

Appendix C: Document History and Version Control

Version	**Date**	**Comments**	**Author/ Job Title**
1.0	31/12/2025	New SOP	Charlene Grassman, Consultant Anaesthetist Laura Wilson, Consultant Anaesthetist