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| Guideline: Obstetric Anaesthesia staffing |
| **Scope:** Annual review of obstetric anaesthesia staffing  |
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| Version 6 | Valid from Nov 2023 | Review due Nov 2024 | Authors: Dr Ben Ballisat, Dr Nicky Weale |

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| **Maternity Services Anaesthetic Staffing Strategy**  | **Version** | **Reason for review** |
| Christina Laxton Consultant AnaesthetistSharyn McKenna Clinical Risk Manager | V 1 |  |
| Christina Laxton Consultant Anaesthetist | V 2  | Annual review |
| Nicola WealeConsultant anaesthetist | V 3  | GPAS guideline 2019Change in CNST training requirements |
| Nicola WealeConsultant Anaesthetist | V 4 | GPAS 2020Review of anaesthetic activity and recommendationsEscalation of care pathway |
| Ben BallisatConsultant Anaesthetist | V 5  | Annual review GPAS 2022, Final report of the Ockenden reviewRecovery staffing |
| Ben BallisatConsultant Anaesthetist  | V 6 | Annual review Weekend staffing  |
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Version history

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| Responsibility | Name | Division / Specialty | Job Title |
| Authorised by | Version 6 | Choose an item. |  |
| Author | Ben Ballisat | Anaesthesia | Lead for obstetric anaesthesia |
| Reviewer | Clinton Lobo | Anaesthesia | Lead consultant for anaesthesia  |
| Reviewer | Maternity Speciality governance group | WCH |  |

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**1. Introduction**

Requirements for anaesthetic staff involved in the provision of safe anaesthetic care to women and their babies are detailed in the 2022 RCoA Guidelines for the Provision of Anaesthesia Services for the Obstetric Population1. This document details the obstetric anaesthetic staffing levels required for safe care on the delivery suite at Southmead Hospital.

2. Anaesthetists

2.1 Role of the anaesthetist

The role of anaesthetist in obstetrics has developed greatly over the last decade and the importance of the obstetric anaesthetist as an integral part of the multidisciplinary labour ward team is highlighted in the Ockenden Report2. Over 60% of women attending for delivery of their baby require anaesthetic intervention and many more receive anaesthetic care in the antenatal and postnatal periods.

The role of the anaesthetist includes:

* Provision of epidural analgesia for labour or consideration of alternatives where appropriate (including remifentanil PCA).
* Provision of anaesthesia for operative interventions
* Multidisciplinary team involvement in CDS ward rounds
* Antenatal assessment of high risk women
* Follow up of women who have received any anaesthetic intervention during labour and delivery
* Multidisciplinary team management of women requiring level 2 obstetric critical care on CDS

2.2 Lead Obstetric Anaesthetist

The lead obstetric anaesthetist role includes responsibility for:

* organisation and delivery of the clinical service
* provision of guidelines and protocols
* monitoring staff training
* service risk management
* ensuring national specifications are met
* auditing the service against agreed standards

The education lead for obstetric anaesthesia is responsible for:

* coordination of training and assessment of postgraduate doctors in training
* provision of educational resources for the obstetric anaesthetic doctors

Dr Ben Ballisat is the currentlead obstetric anaesthetist.

Dr Helen Johnston is the current education lead for obstetric anaesthesia.

2.3 Minimum Staffing Levels

The recommended minimum staffing is an anaesthetic consultant or associate specialist (AS) cover for the labour ward for at least 40 hours a week. This equates to ten consultant ‘sessions’ per week, to allow full ‘working hours’ consultant cover1. In addition, elective caesarean sections should be delivered by a consultant led service where the team has no additional responsibility for emergency work1.

A resident anaesthetist must be immediately available for the delivery suite 24 hours a day. A clear plan for escalation of concern and availability of additional assistance should be in place, Additional assistance with access to prompt advice and when required out-of-hours should be in place. The duty anaesthetists should not, in addition, be responsible for the intensive care unit or other anaesthetic duties. All sickness / compassionate leave must be covered internally from Trust resources or with appropriate locum doctors such that there is always a resident anaesthetist available.

2.4 Current Anaesthetist presence on Maternity Unit

Resident anaesthetic cover for the delivery suite is provided by: anaesthetic trainees (CT2 or above) or speciality grade doctors who have the required competencies to enable them to undertake the full range of obstetric procedures. The duty anaesthetist should have a minimum of 1 years’ experience in anaesthesia, and have completed the Initial Competencies for Obstetric Anaesthesia3 and been assessed as competent to undertake these duties.

In addition to 24 hour resident anaesthetic cover, we have 10 weekday consultant/AS sessions and Saturday 8am-6pm senior cover (the latter being staffed by a mix of Consultant/AS grade Anaesthetists and an experienced Specialty Doctor). The designated consultant/AS covering delivery suite is shown on the CLW rota system and this detail is written on the contact board on CDS. Consultant sessions on CDS should be covered during periods of leave by other anaesthetic consultants.Additional anaesthetic support out of hours can be provided by a senior anaesthetic trainee based in the Brunel building and two on call anaesthetic consultants.

GPAS recommendations 20221: *‘In busier units, increased levels of consultant or other autonomously practising anaesthetist cover may be necessary and should reflect the level of consultant obstetrician staffing in the unit.’* Consideration of evening and weekend sessions has been discussed at a trust level, currently, Saturday daytime senior resident cover has been achieved and there is a plan to provide Sunday daytime senior resident cover in 2024. There is no plan currently to extend weekday resident senior cover past 6pm, however, this situation will be reviewed on a regular basis.

Elective operating should not normally be interrupted by emergencies – a formal elective Caesarean with dedicated obstetric, anaesthetic, theatre and midwifery staff is necessary. A separate consultant anaesthetist (or associate specialist) is available for this list.

Out of hours, a named supervising consultant will always be available (details available from the CLW rota system or via switchboard) and must be able to attend within 30 minutes when required. The procedure for escalation of concern via senior trainees and the consultant is in place. Indications for escalation are documented in Appendix 1.

Southmead offers a 24-hour epidural service. The time from the anaesthetist being informed about an epidural until being able to attend the mother should not normally exceed 30 minutes, and must be within one hour, except in exceptional circumstances. Adequate staffing is required to provide this service in a timely fashion.

Training and supervision is an essential role of the more experienced Obstetric Anaesthetists and staffing levels must reflect this requirement. Anaesthetists who are new to Obstetric Anaesthesia require between 4 and 6 weeks of supervised sessions on delivery suite to complete their initial assessment of competence in obstetric anaesthesia. This must be completed prior to working with distant supervision out of hours.

2.5 Action to be taken in the event of unexpected shortfall during office hours

In the case of unexpected shortfall during office hours a consultant anaesthetist or speciality doctor qualified to cover Obstetrics would be asked to take over obstetric cover.

This is co-ordinated by the anaesthetic co-ordinating consultant (bleep 9030).

2.6 Action to be taken in the event of unexpected shortfall outside office hours

The on-call consultant anaesthetist (contact via switch) would allocate another qualified member of the resident anaesthetic team to cover the obstetric unit. The on-call consultant may need to provide additional resident cover in the Brunel building to facilitate this.

3. Anaesthetic Assistants and recovery care

An anaesthetic assistant (AA) is available 24 hours a day to provide anaesthetic assistance for obstetric theatres. Assistants must be trained to a recognised standard and work on the delivery suite on a regular basis to maintain competence, including the use of cell salvage, TEG and rapid transfusion devices. An additional AA is required to cover the planned Caesarean section list.

Out of hours, in an emergency requiring a second operating theatre, the coordinating AA in the Brunel building should be contacted (bleep 9666 or phone 46545) to arrange for an additional AA to attend delivery suite theatres.

All staff looking after women in recovery should be trained to the level recommended for general recovery facilities. Maintenance of standards requires continuous update and ideally staff should spend time in a general theatre recovery on a regular basis to ensure maintenance of competence1.

Women who receive a GA in the delivery suite theatres should be recovered by a trained recovery nurse. Their key responsibilities are to monitor the patient’s airway and breathing following extubation, carry out maternal observations and administer initial pain relief if required. The recovery nurse will not be responsible for midwifery duties such as wound observations or infant care. A midwife/recovery MCA will remain with the mother and baby at all times. A request for a recovery nurse can be made via the level 2 medirooms coordinator (phone 45689) and an SBAR has been written which outlines expected duties and how to escalate concerns.

4. Mandatory training

All anaesthetic staff regularly covering the obstetric unit should participate in the multidisciplinary team training (Intrapartum study day) annually4.

All staff must undertake annual level 2 safeguarding training1.

All staff must undertake annual resuscitation training1.

At least one anaesthetist in the anaesthetic department, should take the lead in safeguarding/child protection and undertake training to maintain core level 3 competencies. This person should liaise with the lead obstetric anaesthetist1. The current anaesthetic lead for safeguarding is Dr Aidan Marsh.

Out of hours, the consultant anaesthetist responsible for the obstetric unit (1st on-call consultant) may not have a regular session in obstetrics. The final report of the Ockenden review states that guidance must be provided on ‘the competency required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments’5.

As a minimum, Consultants must:

* be familiar with the layout of the delivery suite and obstetric theatres including the provision and location of emergency equipment
* understand the processes required to transfer a patient from the obstetric unit to the Brunel building
* understand the clinical management of common or serious maternal emergencies (see appendix 1)

It is recommended that consultants who are responsible for the obstetric unit attend the clinical emergency part of the multidisciplinary intrapartum study day annually and spend a ½ day on the obstetric unit in a supernumerary capacity.

5. Audit

The lead obstetric anaesthetist will provide details of workforce rota gaps and other staffing concerns as a part of the monthly Perinatal Quality Surveillance Matrix. This is reviewed at the Perinatal Quality Governance (PQG) meeting (attended by lead anaesthetist for Obstetrics).

Periodically, additional audits may be conducted to measure other aspects of the service such as delays to providing epidural analgesia and the duty anaesthetist’s workload.

6. Monitoring Compliance

Action plans as a result of the annual audit, contingency plans and the progress of business plans, will be monitored by the Directorate Clinical Governance/Risk Management group.

7. References

1. RCoA Guidelines for the provision of anaesthetic services (2022). *Chapter 9: Guidelines for the provision of anaesthesia service for the obstetric population.* Accessed at: <https://www.rcoa.ac.uk/gpas/chapter-9>

2. Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust. Accessed at <https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust>

3. RCOA curriculum in anaesthetics. Accessed at: https://rcoa.ac.uk/training-careers/training-hub/2021-anaesthetics-curriculum

4. Clinical negligence scheme for trusts: NHS Resolution 2022.

5. Final findings, conclusions and essential actions from the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust, 2022. Accessed at: <https://www.gov.uk/government/publications/final-report-of-the-ockenden-review>

**8. Appendix 1**

**Escalation of care in Obstetric Anaesthesia (extract from CDS Obstetric and Anaesthetic staffing guideline 2021):**

**Anaesthetic cover**

A consultant anaesthetist/associate specialist is present on delivery suite between 8am and 6pm on weekdays and 8am-6pm on Saturdays. In addition, there is a labour ward anaesthetist (anaesthetic trainee, clinical fellow or specialty doctor) present at all times on delivery suite.

Additionally, a senior anaesthetic trainee (3rd on call trainee, resident) and consultant anaesthetist (non-resident) are accessible 24 hours a day. If the coordinating midwife or senior members of the obstetric team have any specific concerns regarding an obstetric patient that cannot be addressed by the labour ward anaesthetist, they can contact the 3rd on call trainee (bleep 9033) or the consultant anaesthetist directly via switchboard.

**The labour ward anaesthetist would be expected to contact the 3rd on call senior trainee to discuss:**

* BMI >40 requiring operative intervention
* BMI > 50 in labour
* Any woman receiving Obstetric Critical Care on CDS
* Any high-risk labouring women
* Any other clinical concerns

*It is acceptable for specialty doctors with extensive obstetric anaesthetic experience to manage the above patients without discussing with the 3rd on call senior trainee.*

**The labour ward anaesthetist would be expected to contact the third on call senior anaesthetic trainee to attend in the following situations:**

* A second theatre is required out of hours for emergency case
* PPH with rapid ongoing blood loss and/or blood loss >1500ml
* A woman requiring return to theatre for further surgical intervention
* Placenta previa requiring CS
* Known or predicted difficult airway
* Any woman with significant pre-existing cardiac or respiratory disease
* A woman with severe sepsis requiring an anaesthetic for delivery
* A pregnant patient with non-obstetric pathology that requires an anaesthetic
* The refusal of blood products by a patient in labour or who requires a Caesarean delivery
* A failure of epidural analgesia that has not been resolved by re-siting of the epidural
* BMI > 50 requiring operative intervention
* A patient with severe pre-eclampsia, HELLP or eclampsia

**A consultant anaesthetist must be informed in the following situations:**

* A pregnant woman admitted to ED Resus
* Deterioration of woman receiving Obstetric Critical Care and requiring referral to ICU
* A patient with an intrauterine death that is complicated by an abruption

**A consultant anaesthetist is required to attend in the following situations:**

* Maternal cardiac arrest or maternal collapse
* A women with placenta accreta requiring delivery
* PPH > 2.5L

**Attendance of additional anaesthetists to provide epidural analgesia**

It is expected that once an epidural request is made, or an existing epidural fails to provide adequate analgesia, an anaesthetist will attend the patient within 30 minutes of being notified. Only in exceptional circumstances will an anaesthetist be unable to attend within 60 minutes.

If the epidural request is not able to be fulfilled within 30 mins this should be escalated to the 3rd on call anaesthetic trainee, and if no one is able to attend within 60 mins this must be escalated to the consultant on call.