



Obstetric
Anaesthetists'
Association



THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

OAA/AAGBI Survey of Obstetric Anaesthetic Workload

Introduction

This survey was undertaken to assess changes in the workload for obstetric anaesthetist throughout the country. There is much anecdotal evidence to suggest that this workload has increased significantly in the last few years; not just in the numbers of women who deliver and receive anaesthetic intervention but also in the demand for an extension of traditional obstetric anaesthesia services, e.g. the development of anaesthesia antenatal clinics. There is some concern that the demands on these services have increased without a corresponding increase in consultant sessions. The current joint OAA/AAGBI Guidelines for Obstetric Anaesthesia Services were published in 2005 and are due for review. We are keen that any new guidelines reflect and support the changes in workload. Prior to reviewing these guidelines, therefore, we were interested in collecting information about how the workload for Consultant Anaesthetists in obstetric units has changed in the last five years.

We are grateful to all the lead obstetric anaesthetists who contributed to the survey.

David Bogod

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September 2011

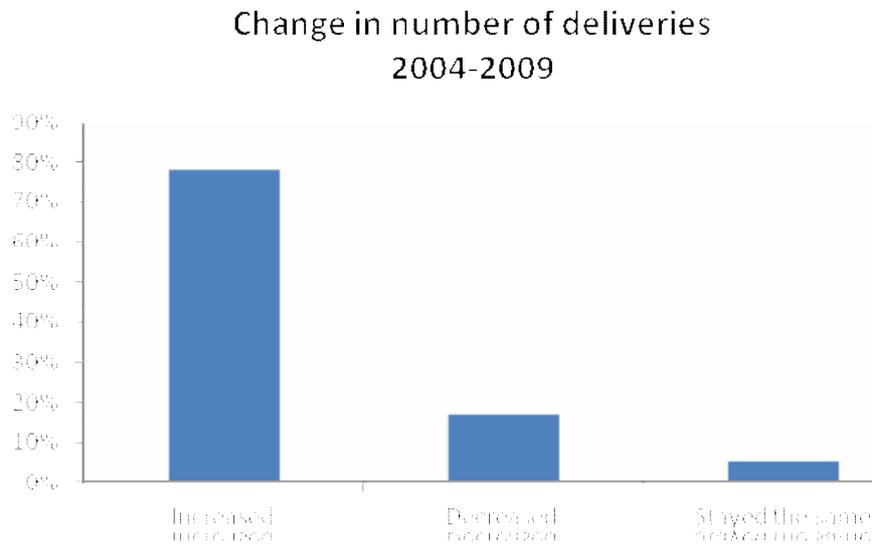
Response rate

The survey was sent to 214 lead obstetric anaesthetists throughout the UK in September 2010. The number of responses received was 162 giving an acceptable response rate of 75.7%. However for specific questions relating to 2004 the number of responses was often less than for comparative questions for 2009.

Results

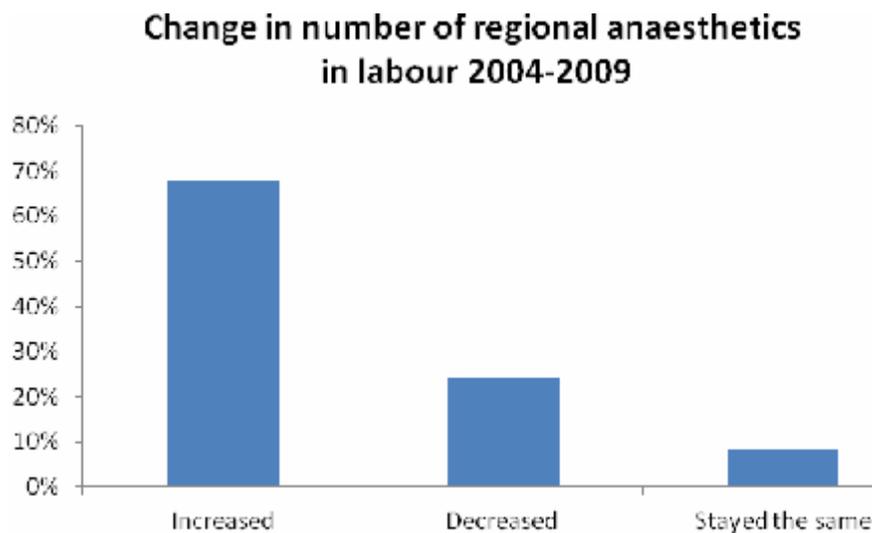
Q1 Compared to 2004 have the number of deliveries in your unit in 2009...?

This question aimed to identify whether the number of deliveries in individual units have increased from 2004 to 2009. The results show that the vast majority of units have experienced an increase in the number of deliveries.



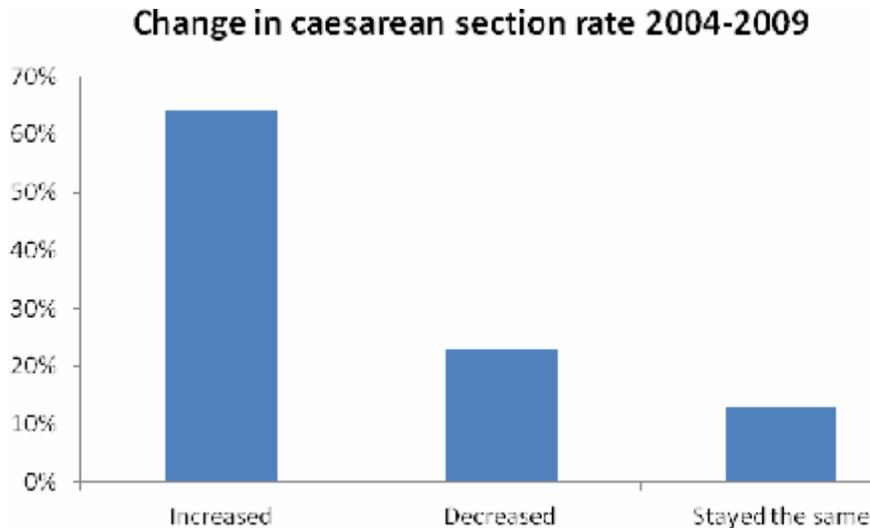
Q2 Compared to 2004, have the number of regional anaesthetics in labour in 2009...?

This question aimed to assess any change in the number regional anaesthetics in labour administered. Consistent with the results of question one the majority of units have experienced an increase in the number of regional anaesthetics in labour.



Q3 Has the caesarean section rate in 2009, in your unit, changed from 2004

This question aimed to look at the change in caesarean section rate from 2004 to 2009. The results show that majority of units have experienced an increase in the caesarean section rate consistent with the findings of other national reports.



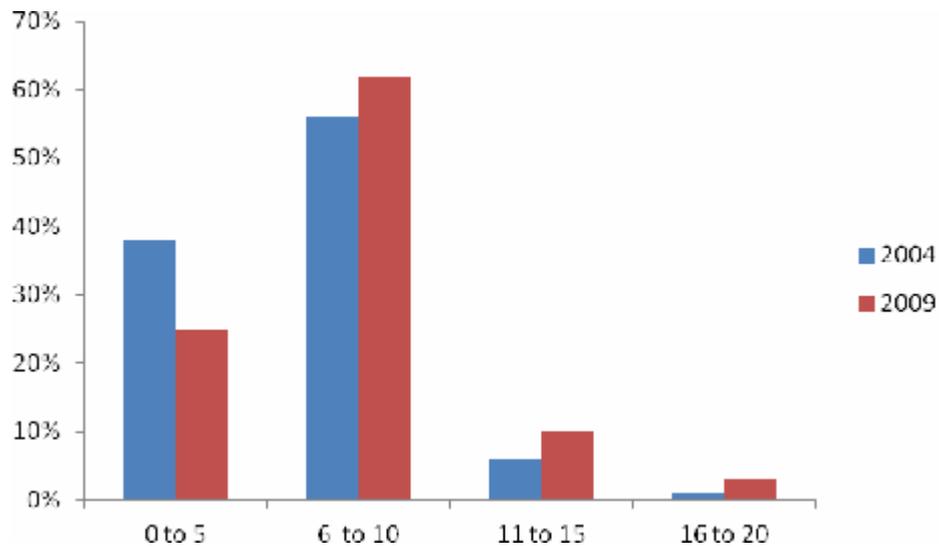
Q4 & 5

Q4 For 2009 please give the total number of Consultant Anaesthetist sessions per week covering JUST labour ward. NB 1 'session' equivalent to 0800-1300 or 1300-1800. If a different consultant working pattern is used please explain in additional comments.

Q5 For 2004 please give the total number of Consultant Anaesthetist sessions per week covering JUST labour ward. NB 1 'session' equivalent to 0800-1300 or 1300-1800. If a different consultant working pattern was used please explain in additional comments.

This question aimed to compare the number of consultant anaesthetists' sessions on the labour ward in 2004 and 2009. The definition of a session is potentially difficult since the introduction of the new consultant contract and the switch from notional half days to professional activities. For the purposes of the survey one session was counted as a five hour period (0800-1300 or 1300-1800).

No of consultant sessions for labour ward only 2004-2009

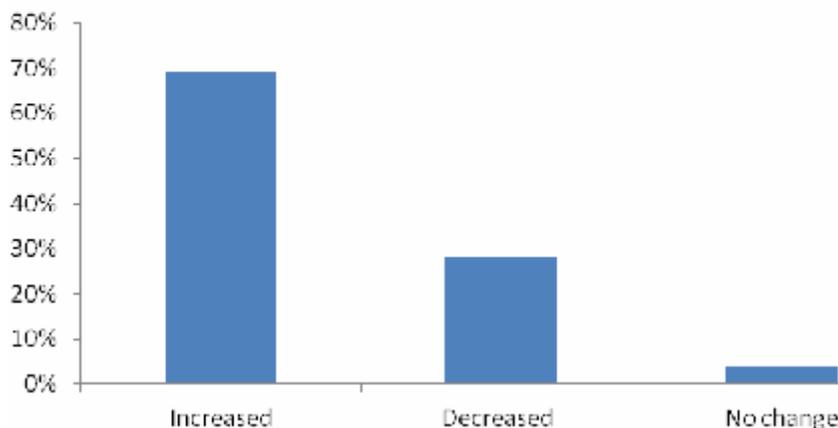


The OAA/AAGBI 2005 guidelines state that ‘the increasing workload in the modern obstetric unit requires an increase in anaesthetic staffing above currently accepted levels. As a basic minimum, there should be 10 consultant anaesthetic PAs/sessions for every maternity unit.’

Q6 Compared to 2004, has the level of Consultant Obstetrician cover on labour ward in 2009...?

This question aimed to look at the change in the level of **consultant obstetrician** cover on labour ward since 2004 as a comparison with consultant anaesthetist cover.

Level of consultant obstetrician cover on labour ward 2004-2009

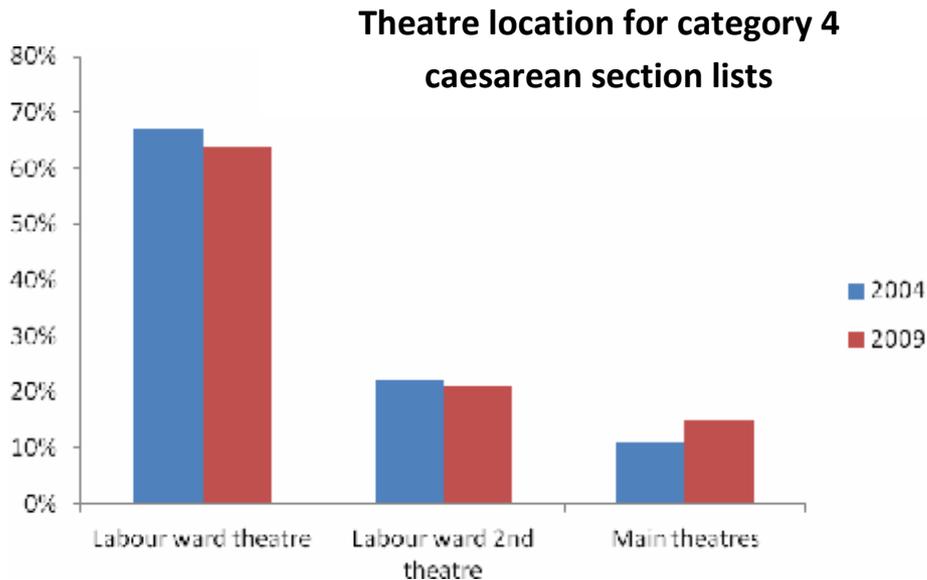


It is difficult to precisely compare these two types of consultant cover, as obstetric cover for labour wards is measured in hours per week. However the amount of consultant obstetric cover does appear to have increased more significantly than consultant anaesthetist cover. Several

respondents made additional comments about 'increased obstetric consultants' presence out of hours without corresponding increase in anaesthetic consultant sessions.'

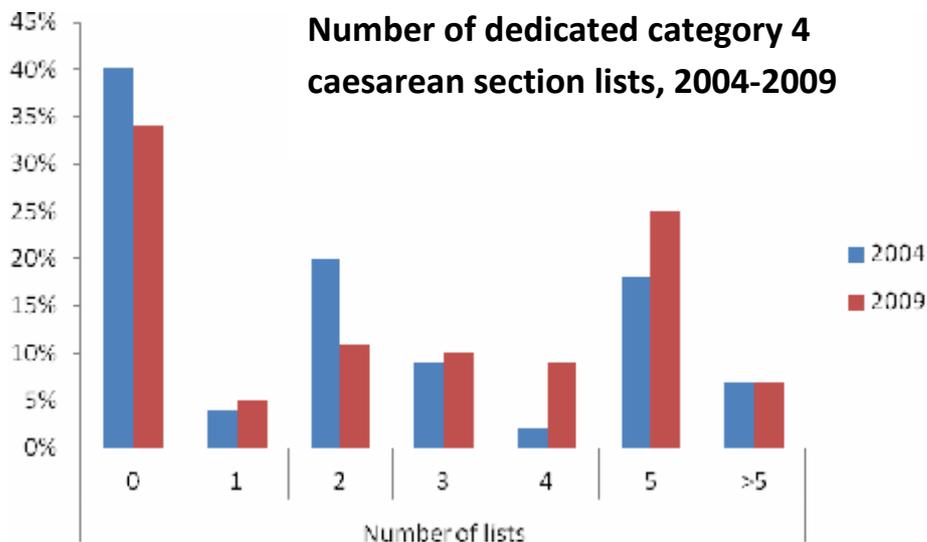
Q7 In 2004 & 2009 where were elective (category 4) caesarean section lists done?

This question aimed to identify where category 4 caesarean section lists take place and whether this has changed in the last few years. The results indicate that there has been a small increase in the number of lists now allocated a specific timing in the main theatre schedule.



Q8 In 2004 & 2009 how many dedicated elective (category 4) CS lists (in a separate theatre) were there per week? (NB 1 elective list = 1 half day operating)

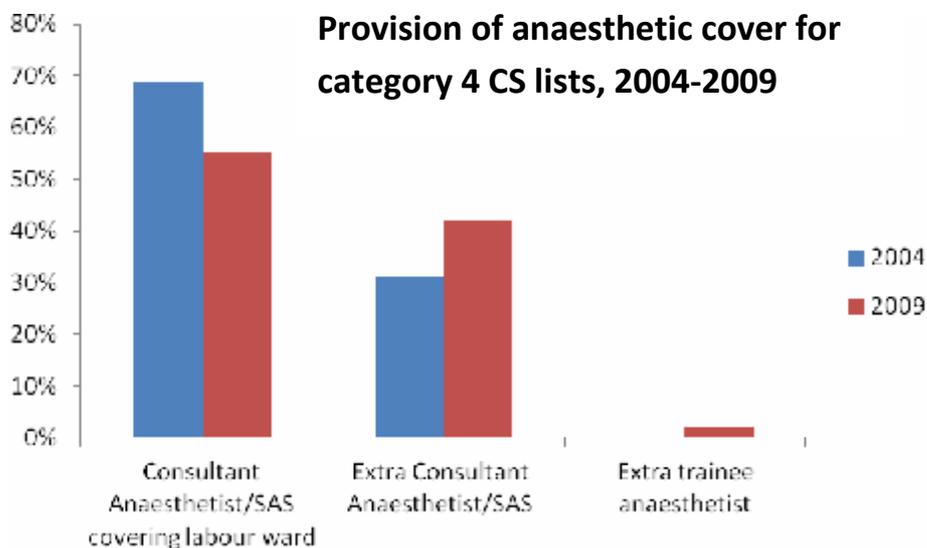
This question aimed to look at the change in provision of dedicated lists for category 4 caesarean sections between 2004 and 2009. There has been an overall increase in the number of 'elective' lists.



Q9 Who staffed these elective CS lists?

This question looked at who provided anaesthesia for category 4 caesarean section lists. There has been some improvement with an increased number of lists in 2009 being covered by an additional consultant/SAS anaesthetist. However over 50% of lists are still covered by the same anaesthetist working on labour ward. The current AAGBI/OAA guidelines state that *'separate staffing and resources should be allocated to elective Caesarean section lists to prevent delays due to emergency procedures and provision of regional analgesia in labour...The duty anaesthetist should not be primarily responsible for elective obstetric work, which should be able to continue in an uninterrupted.'*

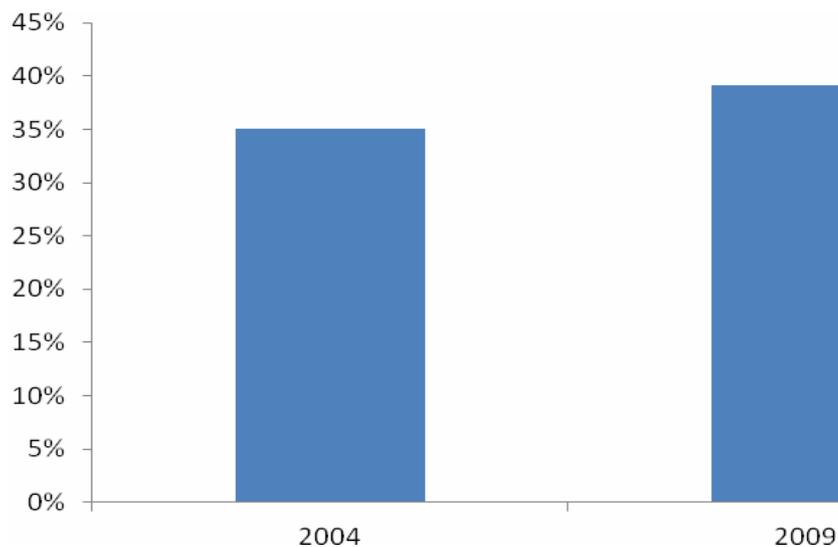
Some units reported that they had an extra (usually trainee or SAS) anaesthetist along with the consultant, although one unit reported that the second anaesthetist was at times a novice trainee. One unit reported poor support from their own department in providing a second anaesthetist for maternity at the same time as elective LSCS list.



Q10 Does your unit have a dedicated maternity high dependency unit?

This question looked at the provision of maternity high dependency care (HDU). The development of maternity HDU care has been a national recommendation for some years. However there remain many barriers to the development of this particular service (in particular funding of the service, and training of obstetric and midwifery staff). This service is likely to significantly increase the workload for obstetric anaesthetists. Results of the survey show a small increase in the provision of this service between 2004 and 2009. The majority of units (61%) still do not have dedicated maternity HDUs. Seven units use the recovery ward as an HDU and 11 units use a delivery room.

Proportion of units with maternity HDU facilities



Q's 11, 12 and 13

Does your unit have an anaesthetic obstetric clinic?

If your department has a dedicated anaesthetic obstetric clinic, how frequently is it run?

If your department has a dedicated anaesthetic obstetric clinic - who runs it?

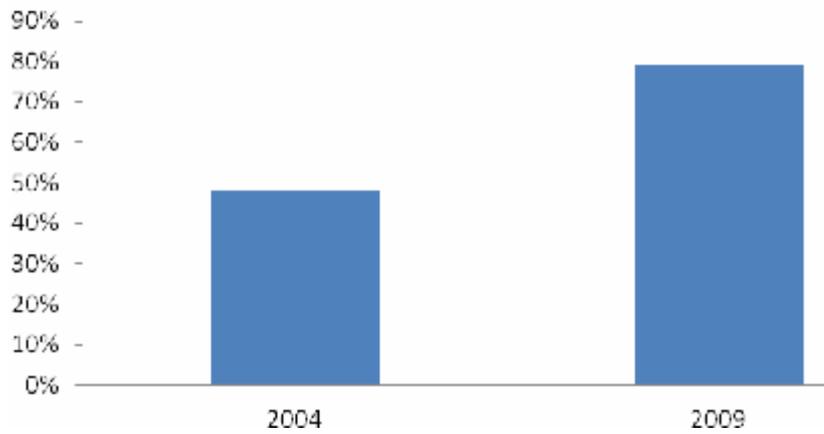
Obstetric Anaesthesia Clinics

These questions looked at the provision, frequency and staffing of obstetric anaesthesia antenatal clinics. It is well established that within the obstetric population there are increasing numbers of medically complex women and women with significantly elevated BMI's. National recommendations are that these women are reviewed in anaesthesia antenatal clinics. The results of the survey clearly reflect this increased demand with over 70% of units now offering this service compared to just fewer than 50% five years ago. In 42.7% of these, the clinic is held once a week. However some units admitted to seeing more patients on an ad hoc basis because of insufficient capacity of the regular clinics to accommodate the extra demand. Two units saw patients every day.

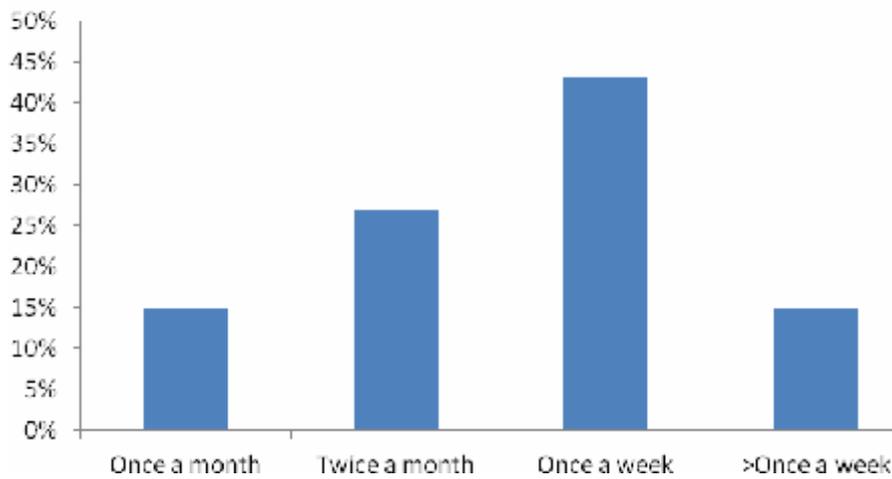
The OAA/AAGBI guidelines state that '*extra clinical time should be made available per week for antenatal referrals, especially where a formal clinic is provided.*' Question 13 assessed whether this recommendation was being achieved. In 65.6% of the units the clinic was staffed by a consultant anaesthetist with no other duties while the rest (34.3%) of the time the consultant was also covering labour ward. All the clinics were staffed by consultant anaesthetists except in four units where the

responsibility was shared with NCCG anaesthetists.

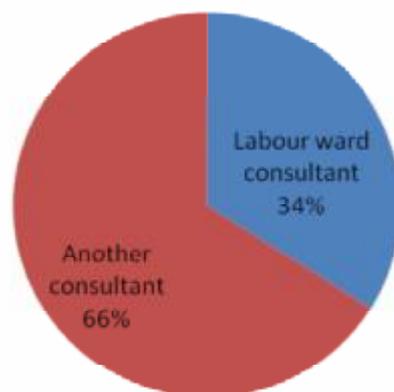
Proportion of units with obstetric anaesthetic clinics



Frequency of anaesthesia antenatal clinics

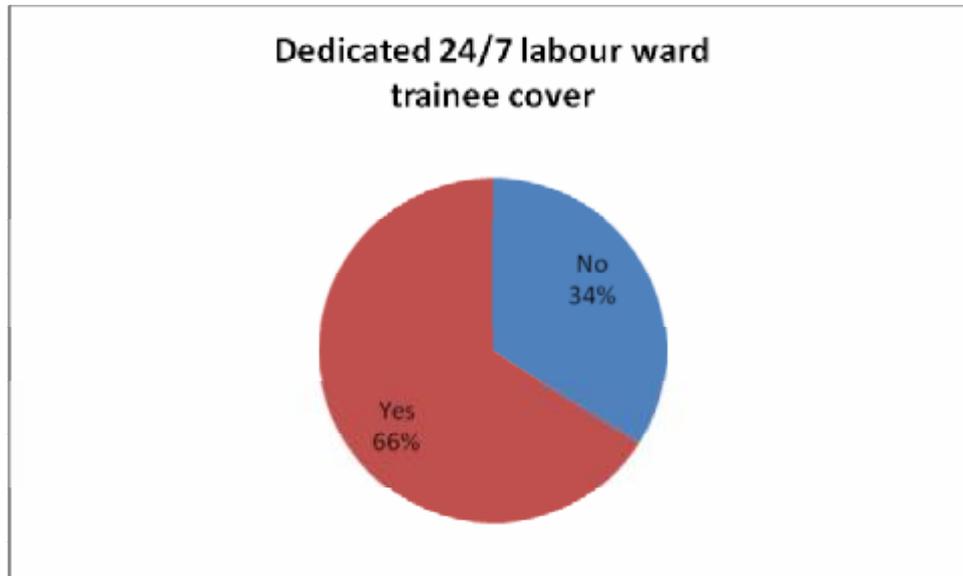


Who runs the anaesthetic antenatal clinic?



Q15 In your unit is there 24/7 resident anaesthetic cover dedicated only to obstetrics? (i.e. covering obstetrics but not general theatres/ITU etc)

Question 15 aimed to assess the proportion of units that have continuous trainee cover.



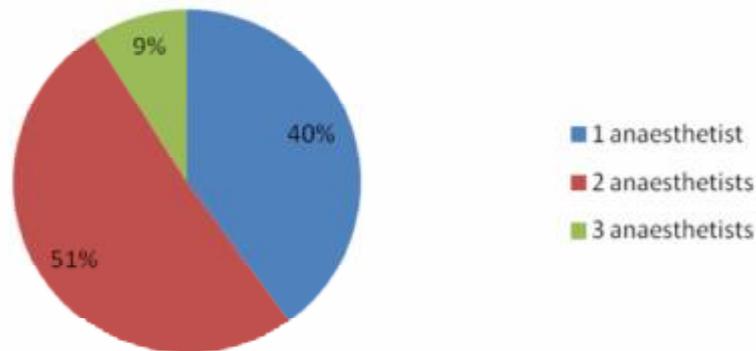
Q16 and Q17

Q16 How many anaesthetist(s) cover/supervise the labour ward during weekdays 08.00-13.00 hours (i.e. no other clinical responsibility and in the hospital)? If a different working pattern is used please state in additional comments.

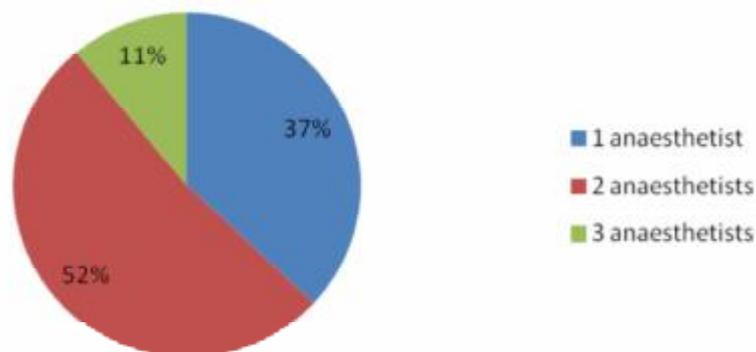
Q17 How many anaesthetist(s) cover/supervise the labour ward during weekdays 13.00-18.00 hours (i.e. no other clinical responsibility and in the hospital)? If a different working pattern is used please state in additional comments.

Question's 16 and 17 looked at the strength of daytime anaesthetic staffing on labour wards, i.e. how many anaesthetist(s) cover/supervise the labour ward with no other clinical responsibility in the hospital.

**Number of anaesthetists covering labour ward
8am-1pm**



**Number of anaesthetists covering labour ward
1pm to 6pm**



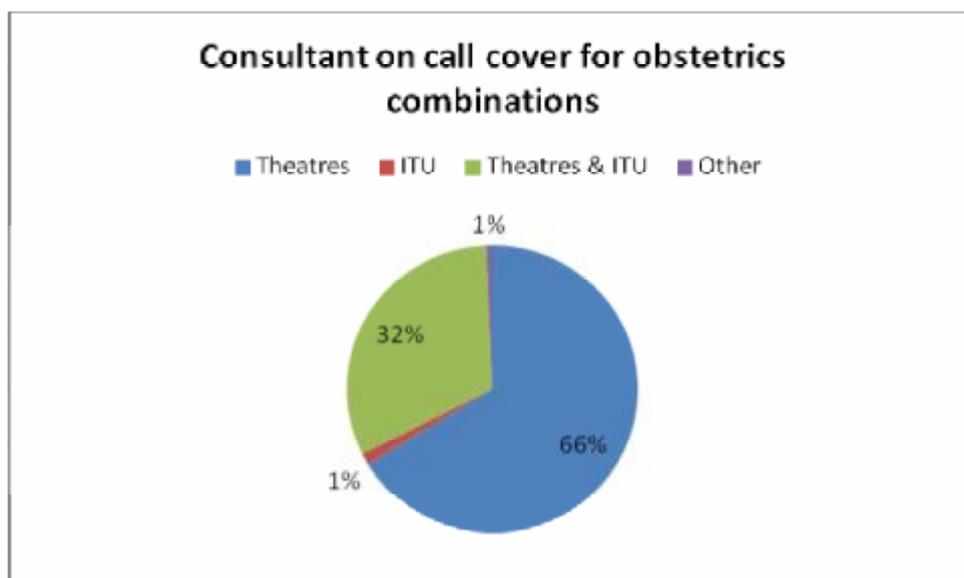
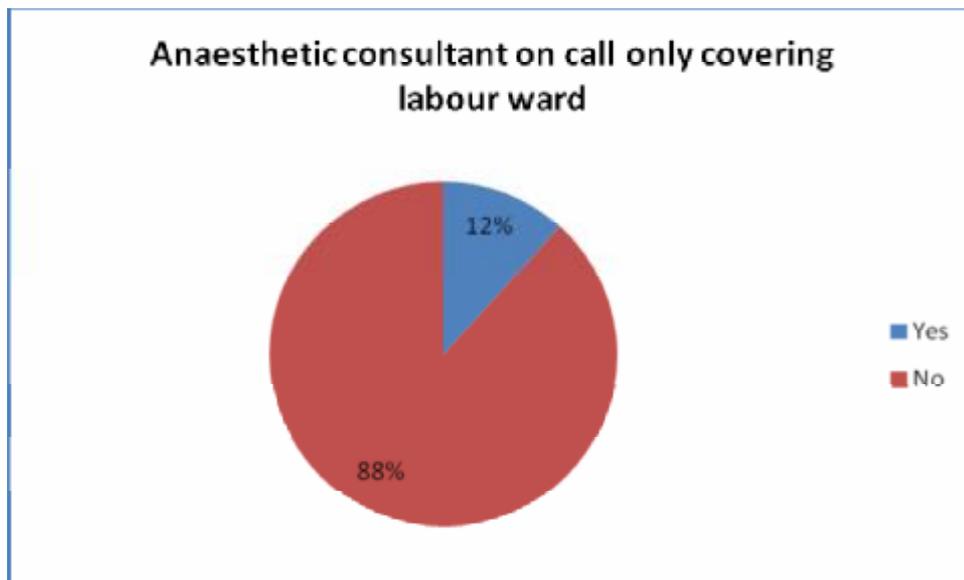
Anaesthetic staffing between 8am and 1pm was very similar to that between 1pm and 6pm in most units. More than 50% of units had 2 anaesthetists during these periods. Very few units had 3 anaesthetists despite the increase in anaesthetic workload. In some units the anaesthetic consultant in the afternoon also covered the anaesthetic clinic and in one unit the consultant was the sole resident anaesthetist between 4pm and 8pm.

Q18 & 19

Q18 Do you have a separate consultant anaesthetist on-call only for obstetrics (covering evenings/nights and weekends)?

Q19 Is the consultant on call cover for obstetrics combined with..?

Questions 18 & 19 looked at out of hours consultant anaesthetist cover for maternity units. Only a small proportion of units had a dedicated on call obstetric anaesthetic consultant. The majority shared their duties between maternity, theatres and/or ITU. A few respondents commented that they *'were unkeen to relinquish general on call duties.'*



General comments

There were many general comments about the current challenges facing the delivery of obstetric anaesthesia services in individual units. These can be broadly divided into three categories.

Service development issues

- Increased delivery rates, increase number of epidurals, instrumental deliveries and C/S (all leading to increased of 'follow ups' further impacting on daytime workload)
- Mergers with other hospitals
- Alternative types of labour analgesia. E.g. remifentanyl PCA requiring initiation and ongoing training
- Impact of changing obstetric population in all areas of maternity
 - Increased maternal co-morbidities
 - Increased maternal age
 - Increased assisted conception
- All of the above leading to increased clinic work e.g. women with elevated BMI and increased ad hoc referrals
- Increased requirement for consultant to act as physician on the labour ward for the critically ill mother
- For some hospitals, acting as referral centres, increased workload resulting from tertiary referrals for, e.g. placenta previa without concomitant increase in resources
- Introduction of interventional radiology

Trainee/training issues

- Impact of European Working Time directive on training. Widespread perception that trainees need greater supervision than in the past.

Typical comment *'Becoming more difficult to Train CT1/2's in Obstetrics while still covering emergency LW duties - with EWTD; ST3+'s also get little further training once basically competent -thus much of the ST3+ experience is gained on call.'*

- Increased trainee paperwork
- Reduced trainee numbers
- Increased requirement for training of midwives as part of multidisciplinary training (PROMPT), HDU nursing care
- Reduced numbers of obstetric trainees causing increased overflow of ward work to anaesthetists for work often outside the remit of the anaesthetic service

Organisational & miscellaneous issues

- Need for office space to carry out increasing trainee paper workload
- 'Desperately need separate consultant to cover elective C/S'
- Lack of midwives
- Increased requirement for medical knowledge to deal with sicker patients

Acknowledgements

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