

From Variation to Consistency: Regional Collaboration to Develop Standardised Referral Criteria for Anaesthetic High-Risk Clinics

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1 INTRODUCTION

High-risk anaesthetic clinics (HRAC) are well established within obstetric services, with timely review of referrals from the multidisciplinary team (MDT) essential for optimal antenatal care [1]. Variation in referral criteria may cause unnecessary clinic visits for some women or fail to identify others who would benefit from anaesthetic counselling. This is compounded by frequent rotation of staff across the region, creating uncertainty around appropriate referral criteria. This service review **aimed to develop standardised referral criteria for HRACs across a regional network.**

2 METHODS

Anaesthetic clinic service leads from all five hospital Trusts in our region formed a focus group to identify and explore areas of inconsistency in HRAC referral practice. Discussions were formally documented and analysed to determine areas of agreement and recurring themes of variation.

Three key areas were identified where there was disparity and consensus referral criteria were agreed (See Figure 1). The final criteria were categorised and summarised in a tabulated format to create a poster which could be disseminated to local departments and displayed in antenatal clinic rooms across the region. (See Figure 2).



3 RESULTS

Variations in practice for referral to anaesthetic clinics were identified for women with high BMI, epilepsy and of Jehovah’s Witness faith. **BMI >45 was agreed as the standard threshold for referral** to HRAC. Jehovah’s Witness patients were included for referral only where there was an **increased risk of needing blood product transfusion**. Epilepsy was **removed as a standalone indication for referral**. The MDT could continue to refer any patient to HRAC, with the agreed criteria representing the minimum referral standard.

Patient characteristic	Previous Practice	New Standard
Body Mass Index	≥40-45	≥45
Jehovah’s Witness Faith	Sporadic referral	Risk based referral
Epilepsy	Common referral	Not standalone

4 DISCUSSION

Regional collaboration between obstetric anaesthetic departments promotes **equity of care**. Although our standardised criteria are not aligned with national guidance [1], evidence suggests there is a **national need to improve efficiency where safe** and 42% of units already report a referral threshold of BMI ≥45 [2]. This approach **targets clinic capacity towards women most likely to benefit from antenatal anaesthetic assessment**.

1.Royal College of Anaesthetists. *Guidelines for the Provision of Anaesthesia Services for an Obstetric Population: Chapter 9. RCOA*; 2025. <https://www.rcoa.ac.uk/gpas/chapter-9>
2.Williams C, Jones M. *Survey: Method of Antenatal Anaesthetic Review of Women with Morbid Obesity*. Obstetric Anaesthetists’ Association; 2025. <https://www.oaa-anaes.ac.uk/downloads/surveys/survey--method-of-antenatal-anaesthetic-review-of-women-with-morbid-obesity-v3.pdf>

Figure 2.

Referral to High Risk Obstetric Anaesthetic Clinic North West London Guidance	
- The patient should be informed they have been referred for anaesthetic assessment and the reason for their referral - Please book the appointment for around 32 weeks gestation - If the patient has previously seen an Anaesthetist for the same condition and it has not changed since the previous pregnancy, it does not necessarily require a repeat assessment in clinic - Patients with chronic back pain who have not had surgical intervention should not be referred to anaesthetic clinic - If you are unsure if the patient needs a referral, please contact the on-call Anaesthetist (bleep 9404)	
Indications for direct referral to High-Risk Anaesthetic Clinic	
Anaesthetic	Previous failed intubation or known difficult airway Complications following general, spinal or epidural anaesthesia Previous failure of spinal or epidural anaesthesia History or family history of malignant hyperpyrexia or suxamethonium apnoea Anaphylaxis during anaesthesia Severe needle phobia Previous difficult venous access requiring central venous access Previous neck surgery or radiotherapy BMI >45 Jehovah’s Witness; <i>only</i> if at increased risk of requiring blood product transfusion (e.g. placenta praevia, anaemia, coagulopathy)
Obstetric	Placenta praevia major/accreta/percreta Other potential risk of major haemorrhage (e.g. large fibroids)
Musculoskeletal	Congenital abnormalities of the spine including spinal bifida occulta Previous spinal surgery Previous spinal cord injury Moderate/severe scoliosis (e.g. under surveillance by spinal surgeon), <i>unless previous successful spinal/epidural anaesthesia</i>
Neurological	Myasthenia Gravis / Multiple Sclerosis / Previous neurosurgery / Muscular dystrophy and myopathies / Idiopathic intracranial hypertension / Previous stroke or TIA / Chiari malformation / Neurofibromatosis
Cardiac	All cardiac conditions (excluding heart murmurs with a normal echocardiogram), including arrhythmias, ischaemic heart disease and surgically corrected congenital heart disease
Respiratory	Home CPAP or NIV / Asthma (severe enough to be managed by Respiratory physicians) Bronchiectasis / Cystic Fibrosis
Endocrine	All endocrine tumours (including adrenal, pituitary and thyroid glands), or known over- or under activity of the endocrine system (e.g. Addison’s disease, Cushing’s disease)
Autoimmune	Rheumatoid arthritis / Ankylosing spondylitis / Scleroderma / Systemic Lupus Erythematosus Connective tissue disease e.g. Marfan’s syndrome, Ehlers-Danlos syndrome
Haematological	Thrombocytopaenia / Inherited coagulation disorders / Anticoagulation therapy (including <i>treatment dose</i> LMWH and clopidogrel) / Porphyria / Sickle cell disease - <i>only</i> if recurrent exchange transfusions or cardiac involvement
Oncological	Any ongoing malignancy or previous malignancy treated with chemo- and/or radiotherapy