Responsibilities of the On Call Consultant

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Target Audience:

People who need to know about this document in detail	All medical and midwifery staff working in maternity and gynaecology services
People who need to have a broad understanding of this document	*As above*
People who need to know that this document exists	*As above*

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**March 2025** **Outcome: no negative impact**
Welsh Language Standard	Choose an item.
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Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.

Disclaimer:
If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Guidelines Definition

Clinical guidelines are systematically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Minor Amendments

If a minor change is required to the document, which does not require a full review please identify the change below and update the version number.

Type of change	Why change made	Page number	Date of change	Version 1 to 1.1	Name of responsible person
Review of existing guideline	Reviewed as existing guidance out of date		March 2025	1 to 2	Caleb Igbenehi

Introduction

The consultant's role starts with demonstrating leadership; ensuring safe and effective patient care while facilitating teaching and support of junior doctors, midwives and nurses at all times. It encompasses providing direct clinical care for those patients who require senior medical assistance while at the same time undertaking simpler procedures when there is a need to do so. The consultant should therefore be present on the labour ward when they are job-planned to be there.

Resident consultant on-call

The consultant on-call is responsible for the care of all patients on the labour, antenatal, postnatal and gynaecology wards. They should maintain an overview of the workload in the unit by regularly checking with the on-call middle grade doctor and the LW coordinator. Women in the Birth Centre will be the on-call team's responsibility in case of emergency.

Occasionally, there will be a different resident consultant covering gynaecology. See below.

The consultant on-call is expected to carry their own individual bleep during the daytime with this number clearly identified on the Labour ward white board. For non-resident cover consultants are expected to provide their mobile contact number or alternative in case of difficulties with signal and be contactable at all times.

Handover

The on-call consultant leads the MDT handover including the obstetric and gynaecology on-call teams, the anaesthetic team, the neonatal team and the labour ward coordinator. Both the incoming and outgoing teams are involved and the handover takes place on labour ward. All women on Labour ward are handed over along with any on-going concerns regarding women on the wards. Handover of gynaecology patients or any outliers should be ensured, and women booked on the CEPOD list should be handed over.

All handovers should be documented in the SBAR proforma and names of multidisciplinary team present are recorded. Electronic version of handover record is updated and saved.

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While resident

- Lead handover in the morning.

- Discuss clinical prioritisation and division of tasks with the incoming team, including ensuring opportunities for teaching and training are utilised.

- At the main doctor handover times, carry out a ward round on the labour ward, the antenatal ward, and of all gynaecology patients admitted as an emergency. Ensure discussion and where necessary review of all women on the postnatal and gynaecology wards. The handover SBAR should be completed and filed.

- Women who had an assisted birth or a complicated vaginal birth should be debriefed by the operating surgeon within 24 hours, but if this is not possible or appropriate this should be by the on-call team. Debriefing should be documented in the woman's records.

- Oversee collection of cases for discussion at Clinical Reflections meetings.

- Prioritise USC and urgent gynaecology referrals where there is time to do this during the day or at the latest by the following day.

- Take part in rapid reviews of moderate and severe incidents (Datix) in order to determine if they are Serious Incidents (SIs), and if any immediate make-safes are needed. Ideally this would NOT be the consultant involved in the incident.

- Provide immediate support for the wider team after unexpected adverse events or serious emergencies.

- Carry out a regular board review, or labour ward co-ordinator discussion of women throughout the resident on call period.

Gynaecology

Occasionally, there will be a different resident consultant covering gynaecology.

In this case, they will be responsible for all gynaecology patients and issues, including in-patients, outliers, and CEPOD cases. They will carry out a ward round of all gynaecology patients that have been admitted as an emergency, ensure all gynaecology patients are discussed and planned daily with review if clinically necessary, prioritise USC and urgent referrals and take responsibility for CEPOD cases.

At 5pm, any unresolved emergency gynaecology problems should be handed over to the non-resident gynaecology consultant on call, if it is a different person.

While non-resident for obstetrics

If the Consultant Obstetrician has not been resident until 20.00hrs a telephone ward round at around 22:00hrs is expected. The middle grade doctor on-call should normally initiate that call when they are free to do so and document this on the handover SBAR.

Week-ends

Handover on labour ward takes place between the resident teams at the same time as week day handovers.
The consultant(s) on-call for obstetrics and gynaecology will undertake ward rounds on both Saturday and Sunday, reviewing patients as described above while resident.

Obstetrics and Gynaecology Assessment Services

These are nurse- or midwifery-led with medical input when required.

Women suspected of having an ectopic pregnancy are admitted to the gynaecology ward and should be discussed with the middle grade doctor and consultant on-call.

Review by a doctor can usually safely be provided in the first instance by the middle grade doctor on-call, but when workload becomes heavy the consultant should expect to be contacted by the middle grade to ask for support and assistance. This will allow the consultant to oversee, triage and manage case load within the department when the unit is busy.

CEPOD list

Gynaecology emergencies are booked on the CEPOD or emergency lists and the consultant on-call for gynaecology should be informed before the case is booked. It is good practice to avoid operating after 22:00hrs unless the patient is haemodynamically compromised or otherwise critically unwell.

In-utero transfers

http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/All%20Wales%20In-Utero%20Guideline%20PDF.pdf

Accepting or requesting in-utero transfers may be done by the middle grade doctor on-call, but should only be done after discussion with the obstetric consultant on-call. When women need to be transferred it is usually the labour ward coordinator's responsibility to identify and liaise with the relevant labour ward and SCBU. The obstetric middle grade doctor on-call should discuss the case with the obstetric middle grade doctor on-call in the transferring unit. The all Wales transfer document should be completed in all cases, including those within the same Health board. If there are any concerns about transfer, this should be escalated to the consultant on call.

Education and training

Obstetrics and gynaecology is an apprenticeship-based specialty and the consultant must be present to ensure that the trainee is taught and supervised properly; ultimately, the consultant is responsible for their trainees. There comes a time when trainees need to learn to work alone but this should never be at the expense of their confidence or, importantly, the safety of patients. The consultant must be nearby at all times until the trainee has been assessed within their portfolio as fit for independent practice.

Escalation

Doctors at every level have a duty to escalate and ask for help if they feel that a clinical situation outside the list below requires the direct input of a consultant. Effective clinical escalation requires clear, succinct communication with the right person at the right time (see A.I.D guidance on P 18 of escalation guideline in hyperlink below). The request should be documented in the notes.

Midwifery, nursing or other medical staff should contact the consultant or senior middle grade doctor directly if it is considered that the clinical situation requires senior medical input (known as clinical escalation) as highlighted in escalation guideline. If there is a disagreement between Registrar, Consultant/band 7 that cannot be resolved advice should be sought from on call Consultant at the other site in CTM UHB.
wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/escalation/

Consultants should be aware that there are some situations where they must attend in person as patient safety is priority. Where consultants feel that they are being inappropriately called they should be able to raise this formally and the issued reviewed and addressed.

Attendance in person at all times

In the following situations, the consultant should attend in person, whatever the level of the middle grade doctor:

- Eclampsia
- Maternal collapse (such as massive abruption, septic shock)
- Caesarean section for major placenta praevia
- Postpartum haemorrhage of more than 1.5 litres where the haemorrhage is continuing and a massive obstetric haemorrhage protocol has been instigated.
- Return to theatre – obstetrics or gynaecology
- Critically unwell patient – obstetrics or gynaecology
- Laparotomy for ruptured ectopic pregnancy
- Whenever appropriately requested
- Repair of fourth degree or buttonhole tear

Attendance in person while resident

In the following situations, the consultant should attend in person, when a trainee at ST5 or below is involved, in order to provide training and direct supervision. For specialty doctors and more senior trainees, the level of supervision can be determined by their known competencies:

Obstetrics

- Vaginal breech birth
- Trial of instrumental birth in theatre
- Repair of third degree tear
- PPH > 1000mls with ongoing bleeding and/ or clinical concern
- Shoulder Dystocia
- Twin birth
- Caesarean birth at full dilatation
- Caesarean birth in women with body mass index greater than 40
- Caesarean birth for transverse lie
- Caesarean birth at less than 32 weeks gestation

Gynaecology

- Any intra-abdominal surgery

Both

- Any deviation from the usual clinical pathway, with unexpected or unexplained symptoms.

Attendance in person or immediately available when non-resident

The consultant should attend in person or should be immediately available if the middle grade doctor on duty has not been assessed and signed-off, by OSATS where these are available, as competent for the procedure in question:

Obstetrics

- Vaginal breech birth
- Trial of instrumental birth in theatre
- Repair of a third or fourth degree tear **if doctor in attendance not signed off to undertake repair**
- Twin birth
- Caesarean birth at full dilatation
- Caesarean birth in women with body mass index greater than 40
- Caesarean birth for transverse lie
- Caesarean birth at less than 32 weeks gestation

Gynaecology

- Any intra-abdominal surgery
- If requested

Both

- Any deviation from the usual clinical pathway, with unexpected or unexplained symptoms

Consultant's decision to attend

When a senior trainee (ST6/7) is on call with a more junior doctor or when the labour ward and emergency gynaecology clinics are being covered directly by a senior trainee, it is the consultant's decision whether to attend.

Doctors in non-training grades and Locums

Doctors in the non-training grades should have their capabilities and experience assessed by their individual units and a clear decision should be made as to the level at which they should be working. The doctor should then be provided the same level of supervision as a trainee with the same competencies.

Consultant duty hours by site and speciality

Princess of Wales Hospital

- All consultants cover both obstetrics and gynaecology.
- Most consultants are resident Monday – Friday 9am – 8pm, Saturday and Sunday 9am – 11.30am. It should be clear from the weekly rota when there is a resident consultant.
- The consultant is non-resident but within 30 minutes travel time at all other times.

Prince Charles Hospital/Royal Glamorgan Hospital

- Consultants cover obstetrics, gynaecology or both depending on the time of day, the site, and the individual concerned. It should be clear from the weekly rota who is covering which elements of the service at all times.
- PCH obstetric cover resident Monday – Friday 8.30am – 8.30pm.
- PCH obstetric cover non-resident but within 30 minutes travel time at all other times.
- Resident gynaecology cover for PCH, Monday – Friday 8.30am – 5pm. In PCH, this is mostly provided by the same consultant as the obstetric cover.
- Resident gynaecology cover in RGH by consultant, or resident middle grade with consultant cover from PCH, Monday – Friday 8.30am – 5pm.
- Gynaecology cover non-resident by one consultant for both PCH and RGH at all other times. This is provided by a different consultant than the obstetric cover.