Consultant presence in the maternity unit

Target audience	Maternity staff
Patient group	Maternity patients. The term 'women/birthing people' is used within this document to include women, girls, trans men, and non-binary and intersex people, who are pregnant or have recently been pregnant.

In the following situations, the on-call obstetric consultant should attend in person, whatever the level of the trainee:

1. Eclampsia.
2. Maternal collapse (such as massive abruption, septic shock, cardiorespiratory arrest).
3. Caesarean birth for major placenta praevia or placenta accreta spectrum.
4. Postpartum haemorrhage of 1500 millilitres or more where the haemorrhage is continuing or any postpartum haemorrhage when the massive obstetric haemorrhage protocol has been instigated.
5. Confirmed ruptured uterus.
6. Any return to theatre for laparotomy.
7. Trial of instrumental birth in theatre and/or caesarean birth at full dilatation:
    a. during resident hours, and only in the absence of fetal or maternal compromise, the on-call obstetric consultant should assess the patient in the labour room prior to the decision to proceed to theatre.
    b. the consultant obstetrician should not only be present for all trials of instrumental birth in theatre to support the obstetric resident doctor on-call, but should also confirm themselves that the forceps blades cannot be locked before abandoning the procedure.
    c. In the event of a trial of instrumental for an intrauterine fetal death, all attempts should be made to deliver the patient vaginally, providing there is no immediate maternal compromise necessitating urgent caesarean birth. If the on-call consultant experiences difficulty with this, then attempts should be made to obtain assistance from other consultants not on-call, on a "grace and favour" basis.

d. the consultant is not required if the patient is taken to theatre purely for regional anaesthesia and the registrar is confident that they will achieve an instrumental birth.

8. Fourth degree perineal tear repairs.
9. Third degree perineal tear repair when the duty resident doctor has not been signed off for this competency.
10. If requested by the duty resident doctor or maternity unit co-ordinator – in this circumstance the relevant person should directly contact the on-call consultant and clearly state the reason for consultant presence .

For the procedures listed below, the on-call obstetric consultant should attend in person:

1. Vaginal breech birth.
2. Vaginal birth of twins/higher order pregnancies.
3. Caesarean birth in women/birthing people with a body mass index of 45 or more.
4. Caesarean birth for transverse lie.
5. Caesarean birth at less than 32 weeks of gestation.

The following situations should be routinely discussed with the obstetric consultant on-call:

1. Any management plan involving delivery of a patient by emergency caesarean birth.
2. Any management plan involving the referral of a patient to a different specialty.
3. When concern arises about a patient deviating from the usual clinical pathway with unexpected or unexplained symptoms (eg. severe pain requiring opiates).
4. Any situation where disagreement arises between the obstetric resident doctor and senior midwifery staff regarding an assessment of or a management plan for a patient.

When the duty resident doctor is very senior (ST7 and within 6 months of achieving their certificate of completion of training (CCT) or equivalent or post-CCT), it should be the on-call obstetric consultant's decision whether or not to attend, ideally with the experience and competency of the resident doctor in question having been discussed at the monthly departmental senior staff meeting.

Consultants are contracted to be resident whilst on-call Monday – Friday 9am until 9pm (excluding public holidays) and 9am-12pm on Saturdays, Sundays and public holidays. During these hours, the consultant on-call should be informed if patients are waiting longer than two hours for medical review in maternity triage.

Clinical governance

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