



Royal College of  
Obstetricians &  
Gynaecologists

# Maternity Triage

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## Maternity Triage

This is the first edition of this guidance. This guidance is for healthcare professionals who care for women, non-binary and trans people who are pregnant.

Within this document we use the terms woman and women's health. However, it is important to acknowledge that it is not only women for whom it is necessary to access women's health and reproductive services in order to maintain their maternal health and reproductive wellbeing. Obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

### 1. Purpose

This document highlights the challenges in maternity triage departments\* and defines their role as emergency portals into maternity units. It has been produced in response to a UK Government and Parliament petition in 2021, which requested a national review of triage procedures used by NHS maternity wards,<sup>1</sup> and proposed to mandate the implementation of a standardised risk assessment-based system for maternity triage; assessing every woman within 15 minutes and prioritising care based on urgency.

The paper is aimed at stakeholders responsible for developing and improving maternity services. It presents the recommendations for the operational structure and pathways within maternity triage to improve safety and experience for both women and staff, by recommending implementation of the Birmingham Symptom-specific Obstetric Triage System (BSOTS), while recognising opportunities for future research and evaluation.

### 2. Introduction and background

Beyond scheduled antenatal clinic and ultrasound appointments, most attendances to maternity services are unscheduled (emergency). Unscheduled attendances can occur because of conditions ranging from physiological labour or concerns related to pregnancy (such as pain, vaginal bleeding or reduced fetal movements) to acute obstetric or medical emergencies.

Prior to earlier published confidential enquiries,<sup>2,3</sup> all emergency attendances to maternity units were assessed by the duty team on labour ward. This resulted in high numbers of women attending with pregnancy-related problems that did not necessarily require urgent action, and diverted midwifery and obstetric staff from caring for those in active labour. In response, national recommendations directed pregnant women attending with unscheduled visits to be seen in areas separate from the labour ward. These recommendations have now been accepted throughout the UK, and new standalone maternity triage departments have developed in other physical spaces, such as day assessment units and labour induction bays.

Maternity triage departments function as emergency portals to access maternity services for pregnant or newly postnatal women and people who have unexpected complications or concerns. Unlike general emergency departments, they have developed without appropriate organisational and clinical systems in place to prioritise the clinical urgency of the women presenting. On average, the number of triage attendances are double or treble the number of births in an individual maternity unit, although accurate reporting and routine data collection are not common.

\* In different Trusts/organisations, maternity triage departments are variously described as Maternity Triage Service, Maternity Assessment Suite, Maternity Assessment Unit, or Maternity Triage Unit.

Maternity triage departments have local guidelines, as national standardised pathways have not previously existed. Women are often seen in the order in which they arrive, rather than following a standardised assessment and clinical prioritisation, as happens in general emergency departments. Space limitation can further hinder the process, leading to women with relatively non-urgent issues being reviewed ahead of emergencies that require urgent action, thus contributing to increased maternal and perinatal morbidity.

The need for national standardised maternity triage systems has been highlighted in UK confidential enquiries,<sup>2–4</sup> as well as in many local Care Quality Commission and Healthcare Safety Investigation Branch<sup>5</sup> reviews. A 2021 UK Government and Parliament petition<sup>1</sup> also recognised that, unlike mainstream emergency medicine, there was no nationally standardised triage system within maternity for women who attend for unscheduled appointments.

The need to develop guidelines for the triage of pregnant women and people has also been recommended by the American College of Obstetricians and Gynecologists,<sup>6</sup> which advocates the use of standardised tools to improve quality and efficiency.

### 3. Existing standards

In emergency medicine, the Australian Triage System (ATS) was developed more than 20 years ago and formed the basis for the Manchester Triage System (MTS),<sup>7</sup> which was initiated in the UK in 1997 by the Manchester Triage Group. It was jointly developed by the then Royal College of Nursing, Accident and Emergency Association and the British Association for Accident and Emergency Medicine, and differs from the other systems in that it is an algorithm-based approach to decision making. The system aimed to standardise assessment and increase reproducibility and validity, and has been mandated for use in UK emergency departments.

No national standards currently exist for staffing numbers in maternity triage departments, other than within the overall standards for midwifery staffing levels, summarised in the National Institute for Health and Care Excellence (NICE) guideline [NG4] *Safe Midwifery Staffing for Maternity Settings*.<sup>8</sup> This guideline used evidence from numerous national reports to provide regulated targets for midwifery staffing, including the core standard of one-to-one care for pregnant women in labour.

### 4. Principles of triage

Triage is a process of standardised clinical assessment, prioritisation, and delivery of emergency care when workload exceeds capacity. It is particularly useful in areas of high-flow patient care with diverse clinical needs. Triage systems are designed to ensure the patient receives the level and quality of care appropriate to their clinical needs and the resources available are used most effectively. It involves a systemic prioritisation of the order in which patients receive medical attention on arrival, guiding treatment according to clinical need.

The clinical triage process results in a clinical priority being assigned and involves:

- a) identification of the presenting problem; and,
- b) undertaking a standardised assessment including vital signs.

### 5. Triage in maternity

The generic parameters of standard triage tools cannot be extrapolated to pregnancy as the physiological changes of pregnancy are associated with a higher resting heart rate, lower blood pressure and increased respiratory rate. This together with the underlying good health of the maternity population may mask the severity of maternal illness, unless a specific assessment is undertaken by appropriately trained healthcare professionals. Triage of pregnant women has been identified as being less reliable when using mainstream triage systems,<sup>9,10</sup> and therefore this area has

been highlighted as requiring development of specific guidelines and education packages.<sup>11</sup> There is also no means of assessing the condition of the unborn baby using existing emergency medicine triage tools.

In Australia, triage algorithms for pre-eclampsia and antepartum haemorrhage for use by midwives were re-evaluated and showed marked improvements in consistency of assessment and documentation.<sup>12</sup>

Within the UK setting, BSOTS has been co-developed by clinicians from Birmingham Women's Hospital and researchers from the University of Birmingham. It was developed in response to the need for a standardised process to identify those women who required more urgent attention in a busy clinical setting. Initial evaluation showed an increase in the numbers of women assessed within 15 minutes of attendance (from 39% to 54%) (RR 1.4, 95% CI 1.2–1.7;  $P < 0.0001$ ), and that women identified as having greater urgency were seen more quickly by a doctor. The system had excellent inter-operator reliability (intraclass correlation 0.961, 95% CI 0.91–0.99). Healthcare professionals felt the system improved the management of the department and increased patient safety. BSOTS has been widely adopted throughout the UK and is the recommended triage system in England.<sup>13</sup>

### 5.1 Pathways in maternity triage

In maternity services, the pre-hospital contact for women may be through:

- a) their primary care team (GP or community midwife),
- b) verbal, telephone or online advice from friends or family, calling 999 or NHS 111, charity websites (see the Tommy's symptom checker in Appendix I, with further information available from [Tommy's](#) and the [Mama Academy](#)), or
- c) direct contact with their maternity triage department.

Advice on when to contact maternity services is often included in scheduled antenatal consultations or can be accessed from handheld or electronic patient records (EPRs). Details of how to contact maternity services or where to attend with concerns related to their pregnancy should also be made available from the same sources. However, it is vital to recognise the confusion and additional challenges for people from ethnic minorities, those without English as their primary language or from areas of social deprivation.<sup>14,15</sup> Minimum standards for telephone triage are included in section 6.2.1.

BSOTS<sup>14</sup> includes a standardised initial assessment of all women and their babies within 15 minutes of arrival and the use of symptom-specific algorithms to determine the clinical urgency of further investigations and seniority of review.

## 6. Recommendations for maternity services

### 6.1 Learning from emergency medicine

Evidence from the Royal College of Emergency Medicine<sup>16</sup> has shown that patient harm is associated with crowding in emergency departments, and that this harm increases with increasing length of stay.

The model of core emergency care should form the foundations for maternity triage departments. Maternity services need to define their core emergency 24/7 triage service (both telephone-based and in-person), with appropriately senior midwifery and medical decision makers, and adequate physical and equipment facilities. The service should have 24/7 access to prompt clinical investigations and additional administrative space and support in those departments.

This model of multidisciplinary care with senior decision makers available for high quality, time-critical clinical plans and treatment enables the management of short-term issues, and visible clinical leadership with training for all staff, which will improve experience and safety for women and their babies.

## 6.2 Recommendations and key principles for maternity triage

Maternity triage should be recognised as the emergency portal of maternity units, for pregnant or newly postnatal women (up to 6 weeks) with unscheduled related concerns or problems. Women and people should be provided with clear information on how and when to contact maternity services and where to attend with concerns related to their pregnancy, in a format and language that they can readily access and understand.

Maternity triage should include appropriately trained midwifery staff whose primary responsibility is to assess women both by telephone and in-person. This role should be seen as an essential part of operating a safe maternity service, therefore these midwives should only be moved out of triage in exceptional circumstances. Accurate and contemporaneous recording of both phone calls to triage and triage attendances will ensure identification of women who call or attend on multiple occasions.

It is the responsibility of NHS service providers to ensure interpreting and translation services are made available to their patients, and are free at the point of delivery.<sup>17</sup> Advice and guidance on language interpreting and translation can be found in the [migrant health guide](#).

### 6.2.1 Recommendations for maternity telephone triage

1. Ensure there are well-defined pathways and clearly signposted telephone numbers to call depending on the woman's concerns.
2. Ensure there is a dedicated telephone line for women and people with unscheduled pregnancy or postnatal concerns and that calls are answered promptly.
3. Ensure calls are taken outside the clinical area in a dedicated and protected quiet space – to ensure confidentiality – by a midwife who is clinically active and familiar with maternity triage, but whose duties at that time are solely for telephone triage. Calls should ideally be audio recorded with consent.
4. Ensure all such consultations are documented using a standardised telephone triage template (see Appendix II) so that there is a reliable and accurate record of the conversation and the paperwork is integrated into EPRs if used.
5. Ensure there is a contemporaneous documentation of the call and advice given. If handwritten, ensure robust systems are in place to add the documentation to the maternity records.
6. Midwives should have access to the EPRs if in place.
7. Ensure requests to attend hospital are documented and the woman is clearly informed of the urgency and timeframe for attendance.
8. Do not assign a clinical priority or use an appointment system based on telephone triage. Where a time-critical emergency is identified, the woman/caller is directed to dial 999 for an ambulance and a system is in place within each integrated care system, to ensure that any time-critical emergencies are clearly managed to safeguard the woman, and ensure they are taken to the most appropriate maternity services, dependent upon the location and condition of the woman at the point of arrival of the emergency services.
9. Continuity of telephone triage assessment process is important. For example, if the telephone triage midwife is absent, local escalation policies should be in place so this absence can be covered.

### 6.2.2 Recommendations for in-person maternity triage

1. Ensure a prompt and brief assessment (triage) of the woman is undertaken by a midwife within 15 minutes of attendance, and the clinical urgency in which they need to be seen is determined in a standardised way, using a system that has been evaluated (e.g. BSOTS<sup>14</sup>). This system should have minimal variation in the assessment of urgency between midwives, and include physiological assessment with use of a modified early obstetric/maternal early warning score (e.g. MEOWS or MEWS).
2. Ensure triage assessment and clinical prioritisation is performed by clinical staff who have been trained in the specific method of triage and demonstrate their competency to do this. The initial triage assessment is in-person and should normally take 5–10 minutes.

3. Ensure there is a seated waiting area where women can wait as they may require further assessment, investigations, and ongoing management (see the triage pathway in Appendix III).
4. Ensure the seated area is in an adequately sized space, ideally visible to the clinical staff.
5. Ensure further assessment, investigations and ongoing management are standardised in line with local guidance and are led by a midwife with obstetric input when required. It may include continuous risk assessment and safeguarding.
6. Ensure triage attendances/episodes are clearly recorded, either in maternity notes using a standard template (see Appendix II for an example triage assessment card) or in EPRs.
7. Ensure there is a centralised overview of the department showing workload and location of women in the department and their progress (e.g. waiting for initial triage assessment, triaged and clinical priority). This should include the ability to record time of arrival, initial time of assessment, clinical priority assigned and time of further tests and investigations.
8. The most senior obstetrician on call for the labour ward (consultant/specialist) and midwifery coordinator on labour ward must have an overview of triage activity and any escalation. To ensure this occurs, review of triage activity should be included in the consultant-led labour ward rounds twice daily (over 24 hours), 7 days a week.<sup>18</sup>
9. Ensure that if the department becomes very busy, with either many women attending at the same time (and triage within 15 minutes is not possible) or a number of women and people requiring ongoing care, there are local escalation policies in place to call for additional staff.

## 7. Recommendations for facilities and space

### 7.1 Access to maternity triage

Pre-hospital information should be clear for women and people who are pregnant about where the maternity triage unit is, the reasons for contacting the unit, and when to call and when to attend. Systems need to be in place to ensure women are directed to the correct department if maternity triage is not appropriate (i.e. Early Pregnancy Assessment Unit), and that those with administrative queries (such as appointment changes) are redirected.

### 7.2 Maternity triage

There should be:

- A dedicated telephone line for women with queries or concerns, with calls ideally taken outside the clinical area by appropriately trained midwives.
- 24/7 access to maternity triage for women, and they need to be informed what the local arrangements are. Dedicated triage areas should be clearly signposted throughout the hospital. They should be situated onsite, ideally alongside the labour ward to facilitate easy transfer.
- A reception area (ideally with receptionists who can inform midwifery staff of the woman's attendance) and a waiting area for those waiting to be triaged or awaiting further investigation/review. There should be easy access to clinical staff should the women require more urgent attention than anticipated.
- Constant access to a space where the initial triage can be undertaken by a midwife is key. Within this space there needs to be a trolley to facilitate transfer as required and the equipment to carry out a physical assessment.

There are two options:

- The first is to have a single room where all women are triaged. In this instance all women would be transferred out of that room following the triage, either directly to labour ward (if it is an emergency), to a bay for further assessment (requiring urgent care), or – for those deemed to be less urgent – to a seated waiting area to await further assessment in a timely manner.
- The second option is to rotate the initial triage room. This means several single rooms need to be available and once the initial triage assessment has been undertaken, the woman either remains in that room if she is deemed to require more urgent care, or sits back outside to await further assessment. If the room is occupied following the initial triage, further triages take place in another single room.

- Sufficient space to enable timely, ongoing assessment of the women in attendance. Any available space should adequately accommodate healthcare staff, women and their families and provide safety, privacy and confidentiality.
- An office space within the clinical area to facilitate clear handover between the triage midwife and midwife undertaking ongoing assessments. This space should include a centralised overview of the department showing the present workload. This facilitates efficient management of the department by enabling staff to:
  - Establish how many women have not yet had their initial triage assessment to determine level of clinical urgency.
  - Know the level of clinical urgency assigned to each woman who has received initial assessment.
  - Know when further assessments are due for each woman.
  - Provide easy handover between shifts.
- Access to electronic fetal monitoring with computerised cardiotocography (cCTG), and to diagnostic tests such as blood tests, urine samples and ultrasound scanning when required.

### *7.3 Recommendations likely to require additional planning, resources and finance*

Additional resources may be required:

- For extra medical, midwifery and maternity support worker (MSW) staffing to ensure the safe functioning of both telephone triage and the department; to allow midwifery staff to have primary responsibility to assess and care for those women in triage.
- To identify a protected quiet space away from the clinical area for telephone triage to be carried out by a midwife.
- For changes to be made to the physical space to provide an available room/bay for the initial triage to be undertaken in a timely way. This space may be flexible and rotate its function, but there must always be dedicated space to assess and triage new arrivals.
- To provide additional trolley space for women, where ongoing tests, fetal monitoring and maternal investigations can be undertaken in a timely way.

Midwifery-led units (either standalone or alongside) cannot meet the standards required outlined above to provide maternity triage and should not be undertaking this work.

## **8. Recommendations for staffing and workforce**

Women who attend maternity triage with unscheduled pregnancy-related concerns should be seen in a single place, whatever the reason, without any appointment system, but should be asked to attend promptly. Women who require ad-hoc medical review or are booked/scheduled for tests/investigations/scan reviews/treatments should be seen by different staff to avoid potential delay in triage and assessment of those women presenting with unscheduled pregnancy-related concerns.

Local midwifery and medical staffing numbers and skill mix will depend on how busy the triage department is, and may vary with different shift times. The priority must be to undertake the initial triage assessment (5–10 minutes) within 15 minutes of arrival, and numbers of staff will therefore depend on the numbers of women who attend. It is advisable to undertake an audit within each individual maternity unit to assess the numbers of women attending, times of attendance and the waiting time for initial triage. This can be used to inform staffing models/business cases for additional staff, e.g. extra midwives may be required at certain times of the day/night.

It is recommended that one midwife is responsible for the initial triage assessment and at least one other midwife carries out the subsequent care and investigations. In smaller units, such as those with fewer than 3000 births, one midwife may assume both roles (along with a MSW), but will need to remain responsive to new attendees and interrupt the ongoing care of women to triage each arrival.

An MSW can be an integral part of the multidisciplinary team and can undertake tasks in their sphere of practice, but initial triage assessment, including maternal observations, should be carried out by a midwife.

This separation of roles so that one midwife undertakes the initial triage assessment and another carries out subsequent care and investigations is a different way of working and staff may require support to make this change. It should be emphasised that this change ensures that women and people are prioritised based on clinical need and improves safety. Training in this way of working should be mandatory, both before implementation and for new staff.

Defined thresholds for escalation (for both midwifery and medical staffing) for when a department exceeds capacity, and the need for additional staffing, should be based on numbers of women attending the department and their clinical categories of urgency. For example, there needs to be an escalation policy for when Tier 2 medical staff review of women categorised as orange cannot take place within 15 minutes because of workload. Careful consideration should be given to the workload within triage before reducing staffing in response to acuity elsewhere, but this needs to be done considering the acuity of other areas of the maternity unit to maintain minimal safe staffing levels across the whole service.

Within these operational policies, both midwifery and medical staffing escalation are required to maintain safe and timely initial triage assessment, and ongoing review and medical assessment. This may also include locally agreed thresholds for consultant/senior attendance beyond the twice daily ward rounds.

Further distractions in the clinical area, such as answering the telephone to external queries or reviewing ad-hoc queries from other departments, should be removed from the maternity triage area.

### 8.1 Models of care

Table 1 details the minimum staffing recommendations for maternity triage departments. However, flexibility in staffing is required in response to increased workload and to maintain the standard for initial assessment within 15 minutes of arrival. Following initial triage assessment, women should be seen in the order of their clinical need and should be informed when they are likely to be seen, or if there are any anticipated delays. The key to successful triage is to be able to assess patients rapidly and to accurately prioritise their clinical need.

Safety is improved by excellent inter-rater reliability of the triage system, which means the accuracy of the initial triage assessment should vary minimally between midwives. This will be further enhanced by standardisation of subsequent care and investigations and a shared language between professionals.

Maternity units have a number of midwifery models for staffing, with some having a team who work permanently in triage, other staff triage from labour ward staffing, and others use a mixture of the two with a smaller core team and midwives co-opted from the labour ward rota. All models are feasible, but all staff who work in triage need training and regular experience. For any system to work effectively there needs to be some continuity to ensure familiarity and consistency, as well as consideration given to size in terms of provision of staff who are adequately trained. Escalation policies should be in place with plans to manage peak activity.

### 8.2 Midwifery staffing

Midwifery staff should be available 24/7 to respond to telephone calls regarding unscheduled pregnancy or newly postnatal concerns or problems. These calls should not be dedicated/diverted to clerical staff.

There may be benefit in pooling midwifery staffing resources across maternity systems and basing the midwives within the ambulance service – as is already in place in some local maternity and neonatal systems.



**Table 1.** Recommendations for minimum staffing levels for maternity triage departments.

<b>Maternity unit (births/year)</b>	<b>Midwifery staffing (Bands 6 and 7)</b>	<b>Medical staffing (seniority equivalents)</b>
< 3000	<ul style="list-style-type: none"> <li>One midwife 24/7</li> <li>One MSW 24/7</li> </ul>	<ul style="list-style-type: none"> <li>FY2/GP VTS/ST1–2/LED (usually on-call LW team)</li> <li>ST3–7 or specialty doctor or LED available (usually on-call LW team)</li> <li>Obstetric consultant/specialist* available</li> </ul>
3000–4500	<ul style="list-style-type: none"> <li>One midwife 24/7</li> <li>One additional midwife for peak time of workload (usually 1–9pm)</li> </ul>	<ul style="list-style-type: none"> <li>FY2/GP VTS/ST1–2/LED in maternity triage department 'in hours'</li> <li>FY2/GP VTS/ST1–2/LED available (usually on-call LW team) ST3–7 or specialty doctor/LED available (usually on-call LW team)</li> <li>Obstetric consultant/specialist available</li> </ul>
4500–6000	<ul style="list-style-type: none"> <li>Two midwives 24/7</li> <li>Consider one additional midwife for peak time of workload (usually 1–9pm)</li> </ul>	<ul style="list-style-type: none"> <li>FY2/GP VTS/ST1–2/LED in maternity triage department 'in hours'</li> <li>Additional FY2/GP VTS/ST1–2/LED available (usually on-call LW team)</li> <li>ST3–7, specialty doctor or LED available (usually on-call LW team)</li> <li>Obstetric consultant/specialist available</li> </ul>
6000–8000	<ul style="list-style-type: none"> <li>Two midwives 24/7</li> <li>One additional midwife for peak time of workload (usually 1–9pm)</li> </ul>	<ul style="list-style-type: none"> <li>FY2/GP VTS/ST1–2/LED in maternity triage department 'in hours'</li> <li>Additional FY2/GP VTS/ST1–2/LED or ST3–7/specialty doctor available for peak workload period (usually 1–9pm)</li> <li>ST3–7, specialty doctor or LED available (usually on-call LW team)</li> <li>Obstetric consultant/specialist available</li> </ul>
> 8000	<ul style="list-style-type: none"> <li>Two midwives 24/7</li> <li>One additional midwife for peak time of workload (usually 1–9pm)</li> <li>One MSW 24/7</li> </ul>	<ul style="list-style-type: none"> <li>FY2/GP VTS/ST1–2/LED in maternity triage department 24/7</li> <li>ST3–7, specialty doctor or LED in maternity triage department for peak workload period (usually 1–9pm)</li> <li>Additional FY2/GP VTS/ST1–2/LED and ST3–7/specialty doctor available (usually on-call LW team)</li> <li>Obstetric consultant/specialist available</li> </ul>

FY2, foundation year two; GP VTS, General Practice Vocational Training Scheme; LED, locally employed doctor; MSW, maternity support worker; LW, labour ward; ST, specialty trainee.

\*Specialist doctors [are senior SAS doctors who are able to practice autonomously](#) in a defined area of obstetrics and gynaecology.

### 8.3 Medical staffing

Those women who require more urgent clinical assessment (red/orange) should be seen by a ST3–7, specialty doctor or equivalent level of Locally Employed Doctors (LED) obstetrician from labour ward with more senior expertise, to ensure prompt assessment and planned care. Women allocated the red category of urgency should be transferred to the labour ward for assessment. For those women allocated the orange category of urgency, review within 15 minutes is required if there is abnormal MEOWS or MEWS, abnormal cCTG, or urgent maternal/fetal concern (guided by individual algorithms). This is likely to represent 15–20% of women attending triage. Those women prioritised as less urgent (yellow/green) can be seen by a FY2/GP VTS/ST1–2/LED in a timely way. One of the principles in BSOTS is that those assigned red/orange priority are seen and assessed by ST3–7, specialty doctor or equivalent level of LED because they represent the most unwell requiring urgent clinical attention. However, if the ST3–7, specialty doctor or

LED is not available within the timeframe, that initial assessment can be made by the FY2/GP VTS/STI–2/LED, with escalation to ST3–7, specialty doctor, equivalent level LED or consultant/specialist to ensure timely review by medical staff.

## 9. Assessment of performance

The ability to assess the performance of an individual maternity triage department requires appropriate metrics and high-quality data. Measurement of arrival and waiting times in maternity triage is rarely collected routinely and, without the assistance of EPRs, often inaccurate and incomplete. In emergency medicine, the introduction of the 4-hour standard effectively drove change, but performance of a single area needs to consider the whole maternity unit and avoid undermining quality of care in other areas.

Maternity units should regularly review their own data. This should include the baseline characteristics of the women who attend (including ethnicity). Data should be collected for a 24-hour period to enable identification of the times breaches may occur, and might include:

- Time of arrival
- Time of triage
- Time triage completed
- Reason for attendance
- Category of urgency
- Time ongoing care commenced
- Time ongoing care completed
- Time medical review requested
- Time of medical review
- Time of transfer/admission or discharge.

However, audit data may not always capture the length of time the triage took, whether the women categorised as less urgent (yellow/green) were seated back outside, or whether the triage and ongoing care was undertaken by different midwives (in units with more than 3000 births) – and these features are key to successful implementation.

Auditable standards of wait for initial assessment and triage after arrival can provide evidence of workload, times of peak activity, delays and staffing levels. These data, together with accuracy of the triage undertaken, how long women waited for further assessment and potentially medical review, will enable maternity units to plan their midwifery and medical staffing models more effectively. If problems are identified, further work will be required to explore the reasons, such as was the midwife responding to telephone calls that took them away from the women in front of them, or were women attending for ad-hoc reviews or scheduled attendances causing similar issues. This information should then be used to improve services. These data should be triangulated with clinical incidents, episodes of escalation for staffing, as well as feedback from women and staff from the maternity triage department and the whole service.

## 10. Conclusion

Maternity triage should be recognised as the emergency portal of maternity units, for pregnant or newly postnatal women and people who are pregnant with unscheduled related concerns or problems. A dedicated telephone advice line should be made available to women, which should be answered by a midwife using a standardised telephone triage template. Clear pre-hospital information should be provided to women with the location of the maternity triage unit, the reasons for contacting the unit, and when to call and when to attend.

Maternity units should make sure a standardised system is in place to provide prompt assessment of all women and people who attend with unscheduled pregnancy-related issues or concerns within a designated area, which should be accessible 24/7.

The recommended standardised maternity triage system is BSOTS, which has been evaluated and shown to have minimal variation in the assessment of urgency between midwives. A prompt and brief (5–10 minutes) initial triage assessment of the women is carried out by a midwife within 15 minutes of attendance, with clinical urgency determined in a standardised way, including physiological assessment with use of a modified early obstetric/maternal early warning score. Standardisation of immediate tests and investigations using evidence-based clinical guidance and pathways further supports timely and appropriate review.

Implementation of BSOTS can help address some of the safety issues identified from inspections of maternity units:

- Lack of dedicated triage department (triage staff also covering Day Assessment Unit).
- Poor telephone triage (lack of dedicated phone line, poor record of phone calls, triage phone answered by clinical staff within the clinical area).
- Lack of robust, consistent systems to triage women and prioritise care in a timely manner.
- Poor record keeping and inconsistent documentation.
- Insufficient or inconsistent staffing by midwives and doctors.
- No clear guidance for escalation.

Successful implementation can require significant system level change and investment and is dependent on:

- Recognition that maternity triage is the emergency portal for maternity services.
- A multidisciplinary desire to improve the pathway to enable timely identification of women (and their babies) who require more urgent care.
- A designated area dedicated to triage of women with suitable space to undertake ongoing care. This should include both a waiting area and space for ongoing management.
- Sufficient numbers of adequately trained midwifery and medical staff.
- A centralised overview of the department showing workload and location of women within the department.
- Development of escalation plans for both midwifery and medical staff to ensure timely response to capacity.

Following implementation:

- Continuous audit should be undertaken to maintain compliance, as well as identify and respond to issues arising.
- Local leadership and ongoing training of midwifery and medical staff is required.

## 11. Tools for implementation

More information about BSOTS is available on the [BSOTS Public Page](#). Once permissions have been obtained, successful implementation is supported by online training and support materials available within the resources area of this website.

## 12. Future considerations

An agreed national standard and reporting tool for maternity triage, similar to that used in emergency medicine, is essential. This should include staffing requirements, agreed audit standards reported nationally and frameworks for improvement.

The role of advanced midwifery practitioners has potential within maternity triage and could be considered when exploring staffing models.

Telephone triage is inherently complex as it does not include clinical assessment, but relies on individual account and is impacted by the expertise of the person answering the telephone. It is therefore important to adopt a standardised approach to what questions are asked depending on the reason for the call, and to who is asked to attend (and who is

not asked). Additional training for healthcare professionals and further evaluation of a more standardised approach to telephone triage is required.

## References

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# Call the midwife

if you experience any of the following...



Spotting or  
light bleeding



Constant vomiting



Leaking fluid



Painful urination



Persistent severe  
headache



Swelling in face,  
hands or legs



Contractions  
or cramps



Itching, especially  
on hands and feet



Sharp or continuing  
abdominal pain



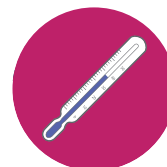
Pelvic pain



Blurred vision,  
seeing spots



Baby's movements  
slow down or pattern  
changes



High temperature

## Getting help



You will find the number  
for your midwife and local  
labour ward on the front  
of your pregnancy notes



You can also contact your  
doctor about any of the  
above symptoms



If your symptoms are  
severe, or if you have  
noticed any change or  
reduction in your baby's  
movements, contact  
your local labour ward  
immediately



Trust your instincts;  
if you feel something  
is wrong, even if it's not  
in this list, contact your  
midwife or doctor



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## Appendix II: Example of telephone triage assessment card.

TELEPHONE TRIAGE ASSESSMENT CARD										1 <sup>st</sup> Call				
Telephone call taken by			Print Name						PIN					
			Signature											
			Date		Time		Location							
Woman's name									Woman's Telephone number					
Registration no. or DOB									Lead Professional					
Gravida		Parity		EDD or Date of delivery	D	D	-	M	M	-	Y	Y	Gestation	Days PN
Primary reason for calling Triage		Abdominal pain				Antenatal bleeding				Hypertension				
		Postnatal concern				Ruptured membranes				Suspected labour				
		Unwell/other				Fetal movements -Reduced / absent (circle as required)								
Relevant medical & obstetric history														
Current pregnancy														
All women to be asked following questions as appropriate (tick box)		Antenatal						Postnatal						
		Reduced fetal movements						Mode of birth						
		Ruptured membranes						Complications						
		Abdominal pain						Feeling unwell/ feverish						
		PV bleeding												
Additional information		(including social & lifestyle history)												
Advice given including time-frame if you ask woman to attend triage														
		If asked to attend; COVID-19 questions completed (tick)												
Plan (please circle)		Phone ambulance; attend triage immediately		Attend triage (use own transport)		Referred to CMW		Referred to GP		Advised with no further action				
Actions if woman advised to attend		Timeframe for woman to attend		Inform LW and medics if <b>urgent</b> attendance		Request hospital notes (ward clerk)		Inform ward clerk of urgency & to alert you when notes are received						
Specific early labour advice		Mobilise		Paracetamol		To call back if:								
		Rest		Regular fluids		Any changes				PV Bleed				
		Regular snacks		Warm bath		Change in FMs				SROM				
						Increase in strength and/or frequency of contractions				Worried about anything				

**PLEASE ATTACH TO HOSPITAL NOTES AND FILE ON ADMISSION**

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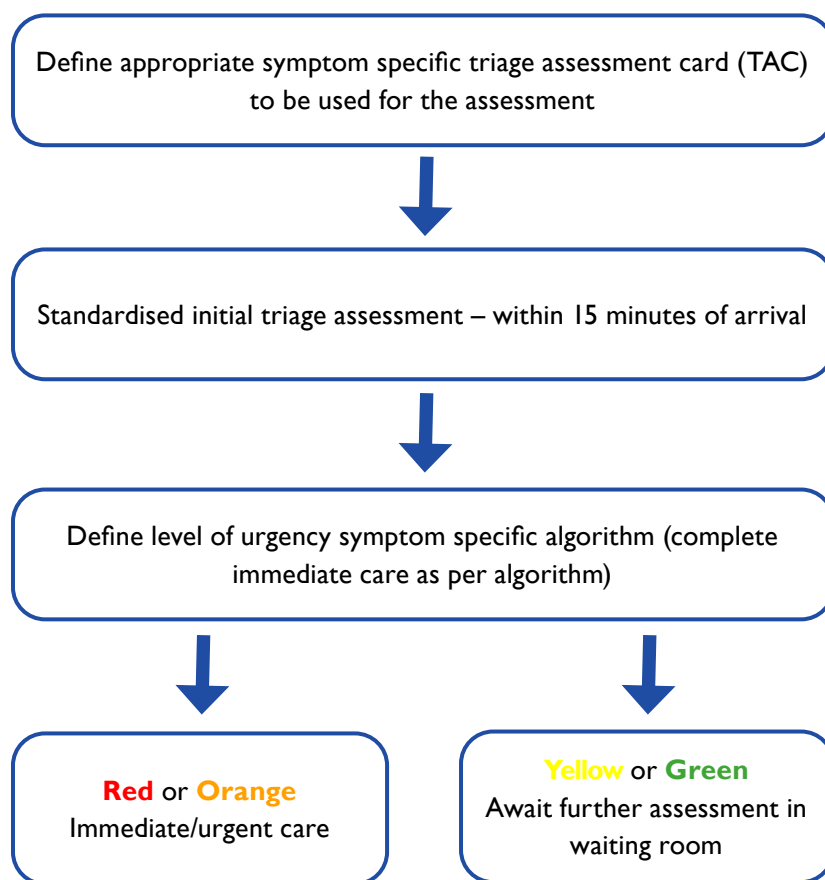
TELEPHONE TRIAGE ASSESSMENT CARD			2 <sup>nd</sup> Call		Consider Triage attendance	
Primary reason for calling Triage	Abdominal pain		Antenatal bleeding		Hypertension	
	Postnatal concern		Ruptured membranes		Suspected labour	
	Unwell/other		Reduced fetal movements			
Relevant medical & obstetric history						
Current pregnancy						
Changes since last call						
Advice given including <u>time-frame if asked to attend triage</u>						
Plan (please circle)	Phone ambulance; attend triage immediately	Attend triage (use own transport)	Referred to CMW	Referred to GP	Advised with no further action	
Actions if woman advised to attend	Timeframe for woman to attend	Inform LW and medics if <b>urgent</b> attendance	Request hospital notes (ward clerk)	Inform ward clerk of urgency & to alert you when notes are received		
Print Name & PIN		Signature			Date & time call completed	

TELEPHONE TRIAGE ASSESSMENT			3 <sup>rd</sup> Call		Recommend Triage attendance	
Primary reason for calling Triage	Abdominal pain		Antenatal bleeding		Hypertension	
	Postnatal concern		Ruptured membranes		Suspected labour	
	Unwell/other		Reduced fetal movements			
Relevant medical & obstetric history						
Current pregnancy						
Changes since last call						
Advice given including <u>time-frame if asked to attend triage</u>						
Plan (please circle)	Phone ambulance; attend triage immediately	Attend triage (use own transport)	Referred to CMW	Referred to GP	Advised with no further action	
Actions if woman advised to attend	Timeframe for woman to attend	Inform LW and medics if <b>urgent</b> attendance	Request hospital notes (ward clerk)	Inform ward clerk of urgency & to alert you when notes are received		
Print Name & PIN		Signature			Date & time call completed	

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### Appendix III: The triage pathway.





This guideline was produced on behalf of the Royal College of Obstetricians and Gynaecologists by:  
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The following organisations and individuals submitted comments at peer review:

Association for Improvement in Maternity Services (AIMS); H Allmond, Consultant Midwife, United Lincolnshire Hospitals NHS Trust; A Anderson, Midwife and Head of Early Notification Clinical Team, NHS Resolution; Birthrights; K Brintworth, Regional Chief Midwife NHS England, London; British Association of Perinatal Medicine; British Maternal & Fetal Medicine Society; Dr KA Edey MRCOG, Exeter; C Foulds, Maternity Triage Ward Manager and Registered Midwife, Manchester Foundation Trust Saint Mary's Hospital; Dr A Gorry MRCOG, London; Dr ED Johnstone MRCOG, Manchester; Dr SJ Mountfield FRCOG, Southampton; Royal College of Midwives; Dr F Siddiqui FRCOG, Leicester; and M Upton, Head of Maternity and Neonatal Safety, NHS England.

The Committee lead reviewers were: Mr W Yoong FRCOG, London; and Dr E Khan MRCOG, Milton Keynes.

The chair of the RCOG Patient Safety Committee was: Dr SL Cunningham MRCOG, Stoke-on-Trent.

The final version is the responsibility of the Patient Safety Committee of the RCOG.

The review process will commence in 2026, unless otherwise indicated.

## DISCLAIMER

The Royal College of Obstetricians and Gynaecologists produces Good Practice Papers as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant healthcare professionals. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in light of the clinical data presented by the patient and the diagnostic and treatment options available.

This means that RCOG guidance is unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.