Triage

Maternity triage is an important first step for women who have an emergency or concern during their pregnancy (including early labour) or post-birth, offering advice, assessment and prioritisation.

On contacting the service, midwifery staff will carry out a preliminary assessment of their condition to determine the urgency of the situation and decide what further action is needed. In maternity services, the first assessment is often carried out over the telephone and includes:

- advising when women should make their way to their chosen birthing unit because they are in labour
- suggesting they should call back for further review
- making sure women are seen urgently if they have an obstetric issue that needs assessment, such as bleeding or if they have reduced fetal movements.

Despite being the first point of call when women have concerns, research by the Sands and Tommy's Joint Policy Unit found that guidance about how and when to contact triage is not consistent between services. It found “concerning levels of variation” about key topics including bleeding, waters breaking and reduced fetal movements.

Issues around assessments and the prioritisation of clinical risk have been highlighted in previous national reports, dating back several years. With no national targets or standards for operating maternity triage services, our inspection programme found significant variation. While a 'one size fits all' approach may not be appropriate across all services, we are concerned that not everyone received a safe and timely assessment, as many services developed their own tools, processes, and standard operating procedures. We found a lack of consistency across services and many were not able to audit the effectiveness of their triage system.

Consistency in this area would provide frontline staff with clarity when caring for women and babies.

Issues with triage emerged as an early finding from the programme. Following the first 20 inspections, we highlighted concerns around:

- patient prioritisation
- timeliness for initial assessment
- oversight of those waiting
- staff training and competence.

Unsafe practice in maternity triage went on to form the basis of 81% of enforcement actions issued to providers and was recognised as a safety concern in around a third of our inspections overall. Through our Give feedback on care service, we heard that women and babies were exposed to potential harm by delays in triage. Many women told us they had experienced significant delays in triage, even when they had been told they would need an urgent medical review because they had presented with high-risk scenarios.

All the obstetric services we inspected offered a form of triage service. Standalone midwifery-led units offer a limited dedicated triage service, with phone numbers to the main units. One service that did not offer a triage service provided a maternity helpline for women who needed advice.

Triage services also varied in terms of opening hours, with some services open 24 hours a day, 7 days a week , and others operating between a given time, often during daytime hours. Where the dedicated triage service was closed through the night, most services offered telephone triage and/or a triage system operated by a different department within the maternity service, such as the delivery suite.

As there was no national mandate during the programme, we did not apply a single criterion for assessing triage across inspections. Instead, we judged safety against the trust's own declared criteria for time to first triage and best practice guidelines. For example, we expected to see a rapid review by a midwife for a woman attending the service in an unscheduled way. Proactive services had introduced an electronic safety in triage system to enable consistent professional assessment and recording of the assessment to determine the immediate action needed according to clinical urgency.

Many of our inspections were carried out before the Royal College of Obstetricians and Gynaecologists (RCOG) released its Good Practice Paper on Maternity Triage in December 2023. The paper acknowledges that implementing the recommendations will require significant system-level change and investment, and a commitment to multidisciplinary working to improve local pathways.

As RCOG's good practice paper points out, maternity triage systems evolved to mitigate against urgent attendances diverting intrapartum teams from caring for people in labour. It highlights, that "unlike general emergency departments, they have developed without appropriate organisational and clinical systems in place to prioritise the clinical urgency of the women presenting". We found this to still be the case.

Triage attendance is not monitored nationally but trusts have told us, using their own data, that they have seen an increase in the number of women who attend the maternity unit with concerns about their pregnancy. While there are many contributory factors, such as access to primary care, or the increase in women with multiple morbidities who become pregnant , a knock-on effect is the additional pressure on triage in maternity services. Sometimes this means services struggle to keep pace with demand and assess people in a timely way.

There is a need for national data collection and analysis about the number of women attending maternity units for triage to monitor themes and trends.

Telephone triage

In the same way that people use NHS 111 when they need general medical help, the first step for women who have a concern or emergency linked to their pregnancy is often to call a triage phone line. RCOG's Good Practice Paper on Maternity Triage recommends that services should have well-defined pathways and dedicated telephone lines where calls are answered promptly. It highlights that telephone triage is complex as there is no clinical assessment, instead it relies on a person's individual account, which can be affected by the person answering the telephone.

Most services inspected operated a dedicated telephone triage service monitored by midwives. We saw pockets of good practice, such as staff trained in telephone triage and measures to ensure lines were monitored. The improvement resource published along with this report provides more information on the areas of good practice in telephone triage that we identified.

However, as highlighted in the Staffing section, low levels of staffing prevented some services from implementing measures like this. We saw instances where the telephone triage midwife was moved to a busier department, leaving telephone triage unmonitored. This puts women and babies at risk of harm if calls are not answered and means vital early warning signs could be missed. One service did not have a dedicated telephone triage line, which led to a congested main hospital telephone line and delayed women getting through to the telephone triage midwife. On this inspection, we also observed the midwife leaving the phone line unattended and a call was not answered.

We also found services did not always monitor their triage telephone line in terms of the number of calls waiting and call drop-offs to understand the levels of activity. This information could have helped services to gauge the volume of calls to provide enough staff to manage the phone lines accordingly.

At one service that did monitor call numbers and waiting times, we were encouraged to see that data on abandoned calls was reviewed on a weekly basis. More information on this can be found in our improvement resource.

We also saw some services using a paper-based triage prioritisation tool. This was far less reliable, resulting in inconsistencies and confusion between staff while increasing the risk of poor outcomes for women.

Through our Give feedback on care service we heard how issues with the telephone triage line can affect women:

> "The triage phone line was not working properly, but it was not clear whether any staff were available to talk to. Because of this I was delayed in going to the hospital in person. When I arrived at the hospital (I went as I had concerns about my baby) I waited 107 minutes before I was seen. It turned out my baby was in distress so I had to have a cat 1 emergency c section delivering my baby at 34 weeks."

> "The initial phone call was helpful and provided advice and told to ring when contractions closer together. Tried to call at this point when I was scared, worried and also bleeding and not knowing what I was doing. Unable to get through for over 30mins. When I did get through I was told that despite having close together contractions that they didn't sound bad enough and that I needed to wait until they were toe-curling and couldn't talk through them (again as a first time mum you don't know what to expect)."

We know that calls to triage are often time-sensitive and calls going unanswered, or lines being frequently engaged could present a real risk to the safety of mothers and their babies.

In-person triage

On arrival at a maternity unit, face-to-face triage is carried out according to a trust's own policy. RCOG's Good Practice Paper on Maternity Triage recommends that a brief assessment is performed by a midwife within 15 minutes of arrival. Then, staff should determine the urgency in which people need to be seen in a standardised way. This assessment should ensure consistency in the way different midwives assess risk and should include physiological assessment using a modified early obstetric or maternal early warning score.

There are a number of tools available for identifying and monitoring risk including:

- BSOTS – Birmingham Symptom-Specific Obstetric Triage System (recommended in the RCOG's Good Practice Paper)
- MEOWS - Modified Early Obstetric Warning Score
- RAG - Red Amber Green
- SBAR - Situation, Background, Assessment, Recommendation.

Like telephone triage, we found similar variation in how services operated in-person triage services. Some services had effective processes and were able to triage a high rate of women within the RCOG-recommended 15-minute guideline. This usually involved staff using a recognised tool for evaluating risk and prioritisation of women, which was reviewed regularly. As we discuss in the sections on staffing and estates,, services with effective triage systems had adequate staffing levels and space to manage flow of people into the service.

Several services did not routinely complete risk assessments on arrival and did not use formal tools or processes to effectively triage women. In one service, it was not clear how long people had been waiting, and in others, ineffective tools and processes led to delays in accessing care. We frequently found gaps in risk assessments and examples of poor record-keeping, which could pose risks for women.

Another service had a chaotic environment, where triage systems and processes were not well managed, which led to long delays. It was also concerning to visit services where staff had access to a risk assessment tool but did not always use it. On one inspection, staff did not always record a priority score , meaning the service could not be assured that all staff had enough information on high risk women and babies.

In a couple of services a RAG system was used to understand women's immediate needs, but the tool did not give target timescales for medical staff to review. At one of these services, there were no processes or guidelines in place to aid prioritisation and ensure women were seen and treated in a timely way, meaning staff had to use their clinical judgement to do this.

Triage environment

The environment is an important factor in the safe and effective running of a triage service. Health Technical Memorandum guidance outlines that maternity units should be designed to ensure a clear flow of women through triage and onto the labour ward. The location of the triage area should enable quick transfers in an emergency. Good maternity triage areas provide space for people to discuss concerns in private, as well as allowing birthing partners and families to stay while assessments are carried out.

We found that many maternity triage areas had dedicated rooms and areas that gave people privacy for initial assessments, but not all triage environments were designed in a way that kept women safe. While we found one example of a service improving its triage area to ensure safer assessments and improve patient flow (see our improvement resource for more information) , others continued to triage women in areas that were cramped, crowded, and lacked privacy.

At one service, inspectors could hear all information requested and shared during telephone calls. This included identifiable information such as the caller's name and date of birth, and perhaps most worryingly, meant that sensitive information such as safeguarding concerns could not be discussed in confidence. Small triage areas can also cause issues with patient flow. A lack of space for triage had been identified as a risk by many services and was included on their service risk register.

The location of the triage area in the hospital itself was another important factor in being able to provide women with safe, high-quality care . For example, having the triage area close to the labour ward enabled quick transfers in an emergency at one service , which helped reduce the risk of poor outcomes related to deterioration. Another trust relocated its triage service closer to the midwifery unit (see our improvement resource for further information).

We were concerned that in some services, the location of waiting areas posed increased risks to women. Waiting areas out of the direct line of sight of clinical triage staff, for example in a corridor outside a triage unit, meant staff could not carry out continuous observation to identify any deteriorations in condition. We heard how this negatively affected one woman's experience:

> "We were left on the corridor in between triage and the delivery suites for 2 hours with no pain relief and nobody checked on us during this time."

Where women were not in the direct line of sight of clinical staff, we were also concerned about how clinical staff could be summoned in the event of deterioration. At one service, this was compounded by a lack of information for women on how to seek support if their health deteriorated. In another service, while triage was located on the delivery suite, the rapid assessment room was in the midwife-led unit, in a separate area of the maternity unit. This meant the triage midwife would need to leave to go to rapid assessment, leaving other women unattended and increasing their workload.

In some cases, it was extremely concerning to hear about women going into labour and giving birth in maternity triage because of delays in transfer from maternity triage to the delivery suite. As well as putting women in a frightening situation, this poses a safety risk as triage areas may lack appropriate equipment, such as neonatal resuscitation and emergency obstetric equipment. This can be vital if people give birth quickly and experience complications.

Where our inspectors raised concerns about the physical environment and the impact it had on women, leaders in some services acted by submitting improvement plans to try to combat risk and improve the physical triage environment . However, we were also told in some cases there was little more that could be done because of the physical constraints of the estate.

Triage staffing

During our inspections we saw how the availability of staff played a significant role in how well services were able to triage women. The Royal College of Obstetricians and Gynaecologists (RCOG) states that maternity triage should be staffed by "appropriately trained midwifery staff whose primary responsibility is to assess women both by telephone and in-person". In many services, we found a dedicated team of suitably trained and competent midwives. However, issues with workforce management and staffing numbers contributed to delays in women's assessment and treatment, which could put them at risk of harm.

When women arrived at triage, many services did not have enough midwives to carry out initial assessments, which led to an increase in the length of time people waited to be triaged. In some services, this affected the flow of women coming through the triage service, as well as increasing the risk of deterioration.

In some cases, delays in triage were so severe that women discharged themselves before being seen by a midwife or doctor. This is unacceptable – these women clearly had concerns that prompted them to go to hospital, so waiting for long periods (in some cases 6 hours) and leaving before a medical review presents safety risks for both the mother and baby. Concerningly, one service did not have systems and processes in place to follow up women who left the triage unit without a review to ensure they were safe.

We also found that midwives were often re-allocated to different maternity departments during quieter triage periods, which frequently led to delays when triage became busier and they were then a midwife short. At one service, the labour ward co-ordinator was tasked with allocating staff from the delivery suite to work in triage. This meant staffing in triage depended on the activity and acuity on the labour ward. At busy times, the triage service would then be under-staffed, posing a risk to women.

We also found that staffing issues meant that staff who had not received sufficient training in triage filled the roles of experienced and trained staff. For example, at one service staff told us they worked in triage but had not received training on the triage system. We found particular concerns around the availability of appropriately trained doctors. In some cases, the required number of doctors had not been allocated to triage in line with the acuity of patients, and in others, the skills and experience of the doctor on duty did not meet the women's needs (see the staffing section for other examples where staff were covering for roles that are outside of their training).

We found some positive examples where leaders were supportive of triage-specific training. Triage wait times, as well as compliance with national and local guidelines, were better in these services (see our improvement resource for further details.)

Staffing levels also meant that the quality of care in triage varied between day and night. There were often fewer members of staff on shift during the night, meaning those working had higher workloads. Concerningly, this could mean that women receiving care in triage during the night did not always receive the same level of care and attention as those being treated during the day. In some services during the night, delivery suite staff who did not have access to the same training as triage midwives were expected to cover the triage telephone. Staff at one service told us there were times when they were alone during night shifts and their duties included answering the telephone, initial triage assessments and providing ongoing care to women.

Issues with triage are unlikely to be overcome by frontline staff alone and there is also a role for national policy to support trust boards and integrated care systems to address inconsistencies in prioritisation and escalation by implementing standardised systems.

We recommend NHS England oversees the performance of maternity triage services to enable trusts to benchmark and improve. This is in line with the Royal College of Obstetricians and Gynaecologists (RCOG) recommendation to introduce "an agreed national standard and reporting tool for maternity triage, similar to that used in emergency medicine." As outlined by RCOG, metrics should include "staffing requirements, agreed audit standards reported nationally, and frameworks for improvement."