NHS England

National Maternity Triage Specification

Contents

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Introduction

Purpose

As outlined in NHS England's 10 Point Plan for maternity and neonatal services, all trusts must commit to delivering safe and effective maternity triage. Within three months, each trust should complete a board-level audit to identify any gaps and ensure services are consistently safe, responsive and appropriately resourced.

This national maternity triage specification will support local services in achieving this urgent action. It sets out what good maternity triage services should look like, recognising maternity triage as a safety-critical clinical environment, as the emergency front door for urgent and unscheduled maternity care. It establishes consistent national principles to strengthen, protect and sustain this core part of maternity services, closing gaps in current provision and supporting seamless pathways from early pregnancy services into maternity triage, so that women and families receive safe, timely urgent care when they need it.

This specification aims to:

- Set a high-level framework for what good maternity triage services should look like.
- Improve safety and experience for women by reducing variation.
- Reduce inequalities through consistent access and care.
- Support accountability through a clear measurement strategy.
- Provide a practical approach to implementation.

As outlined in the Medium Term Planning Framework, ICBs and providers are expected to take immediate action on maternity triage, and this document sets a clear vision for best practice that services should work towards.

There is an expectation that organisations will have fully implemented the specification within 12 months of publication. Additionally, within 3 months of publication, organisations will have audited their current maternity triage services, completed a gap analysis against this specification, and developed an implementation plan, with progress reported through a public Trust Board meeting and shared with regional NHS England teams.

The 10 core principles, introduced below, describe the essential features of effective maternity triage services – including access, staffing, facilities, estates and models of care – and the standards required to deliver safe, timely and responsive care.

Who is this for?

This specification is for:

- Women using maternity services, ensuring they receive safe, timely, support and care, and that they feel heard and respected when accessing services.
- Clinical and non-clinical staff involved in maternity services, including midwives, maternity support workers, obstetricians and operational managers who deliver or oversee triage.
- Maternity service leaders responsible for planning, improving or redesigning services to ensure national standards are met.
- Trust boards with responsibility for the safety, quality, governance and oversight of maternity triage services.
- Commissioners, regulators and system partners responsible for monitoring what good maternity services look like and ensuring consistency how they should be measured.

Who is responsible for delivery and oversight?

NHS trust boards are responsible for the delivery and trust-level oversight of maternity triage services. In the same way that boards are expected to understand and be accountable for performance in urgent and emergency care, they should have clear visibility of maternity triage performance and be accountable for ensuring safe, timely and effective services. This includes routine monitoring of key performance data, including time to initial assessment, waiting times, review times, frequency of staff redeployment from triage, outcomes for women who experience delays, and evidence that actions to improve the service are implemented where issues are identified. These metrics should be included in routine reporting and form part of ongoing Board oversight of maternity services.

To strengthen accountability, key metrics from the specification will also be incorporated into the refreshed maternity and neonatal model board report. Model board report templates are available on the Maternity and Neonatal FutureNHS Hub.

Oversight should be supported by system partners and relevant assurance bodies to ensure a coordinated and comprehensive approach to quality and safety. This specification is intended as a supportive framework to drive continuous improvement and strengthen services.

Background

The case for change

Multiple reviews have identified consistent challenges in maternity triage, including delays in assessment, inconsistent prioritisation, variable advice, poor documentation, and gaps in staffing, training and oversight. They also highlight widespread variation in access, processes and quality, with risks associated with telephone triage and care for women with complex needs.

A note about language

This specification sets standards for the care of everybody using maternity and perinatal services. Some people do not identify with the gender that matches their sex registered at birth and our reference to women and mothers in this specification should be read as inclusive of all service users. Services should use inclusive and respectful language in practice, tailored to the needs and preferences of the individuals they care for.

Equity and Equality

Designing maternity triage services that proactively consider and address inequalities is essential to improving safety and experience. This specification must form part of a coordinated, system-wide effort to tackle the complex drivers of healthcare inequalities, as outlined in national frameworks such as Core20PLUS5.

All services should routinely monitor access, experience and outcomes by key demographic factors. Where data highlight disparities, services should develop, implement and track targeted improvement actions, aligned with local equity and equality action plans and with wider national initiatives, including the Maternity and Neonatal Inequalities Dashboard.

These approaches will help Trusts understand local population needs, identify where inequalities are most pronounced, and target improvement where it will have the greatest and most sustained impact.

Existing guidance and standards

The Royal College of Obstetricians & Gynaecologists (RCOG) Good Practice Paper on Maternity Triage provides key clinical recommendations for maternity triage services. This specification builds on this guidance by setting out the wider service, operational and governance expectations required to support consistent, high-quality triage across all maternity services.

Services should use the Birmingham Symptom-Specific Obstetric Triage System (BSOTS) as described in the RCOG Good Practice Paper No. 17 (above). If services choose not to use BSOTS, they must ensure that any alternative approach is evidence-based, clinically validated, meets local needs and the standards of this specification, and delivers safe, timely care. Any such variation must be formally approved by the Trust Board.

National principles for maternity triage services

The principles in this section set out what a good maternity triage looks like. The maternity triage specification has 10 principles:

Principle	**Key message**
1 Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.
2 Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.
3 Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.
4 Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.
5 Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.
6 Service user voice and experience	Women's feedback must shape service design, improvement and experience.
7 Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.
8 Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is

Principle	Key message
	needed.
9 Equity and equality	Services must use data and targeted action to identify and reduce inequalities.
10 Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.

Each principle sets out its purpose, assigned delivery responsibilities where appropriate, and the key metrics required to monitor progress and support continuous improvement. These principles must be locally interpreted, tested and implemented to reflect the specific context, needs and configuration of each maternity service and local women – regardless of service size, geography, population characteristics, or local models of care. Implementation and subsequent improvement should be co-designed with service users and local Maternity and Neonatal Voices Partnerships (MNVPs).

Principle 1: Access and integration

All women should be able to access maternity triage services 24/7. Maternity triage services should work closely with Emergency Departments, Primary Care, Early Pregnancy, Gynaecology and wider maternity services, so women can easily access the right care from early pregnancy to six weeks postnatal.

These pathways of care should include clearly defined:

- 24/7 access routes, so women always know where to go with urgent concerns.
- Agreement on the most appropriate place of care for women at differing stages of pregnancy, and with different clinical needs. These should be shared with women, staff and partner services, including primary care, ambulance services and NHS 111, and support seamless care from early pregnancy to six weeks postnatal.
- Inclusive access arrangements that ensure all women can use maternity triage services safely and equitably, regardless of language, disability, race, ethnicity, socioeconomic status, digital literacy or GP registration. Pathways should be clear and accessible to women with no prior knowledge of the system.
- Access routes, such as telephone, walk-in, and community referral, and maintain an open-door policy for anyone who attends with concerns or needing urgent care (e.g.,

latent phase of labour, pain, bleeding, reduced fetal movements, mental health concerns). Initial assessment should be equitable regardless of route of access or previous attendance.

- Accessible and consistent guidance and signposting for staff and service users, with responsibility for onward referral and coordinated handover resting with healthcare professionals within the presenting service. Women should be supported to navigate between services.

- Referral criteria across local maternity services including community midwifery, antenatal clinics and day assessment services.

- Communication and referral pathways between triage, primary care, emergency departments, ambulance services, perinatal mental health and safeguarding teams.

- Plans for ongoing care, including sufficient bed capacity to support timely and safe admission for women who require inpatient care from maternity triage services.

- Timely sharing of information and discharge summaries with relevant care partners including primary care and community midwifery. To ensure safe follow-up, and include clear accountability for communicating outcomes, actions, and next steps to the woman's usual care provider.

- Postnatal pathway to six weeks postnatal, including guidance on care of the baby if required. Where the baby does not require separate neonatal or paediatric care, they should not be separated from their mother wherever possible.

Key measurement metrics

- Rate of triage presentations per 1,000 births.
    - Why: This helps services understand demand, helping services plan capacity.
- Frequency of unplanned maternity triage service closures per month.
    - Why: Tracks service resilience and identifies risks to 24/7 access, informing contingency planning and capacity improvements.
- Ethnicity, deprivation and language (incl. English as a first language and need for interpretation services) data for each woman presenting.

    - Why: To identify patterns across women who are more likely to face barriers in access and experience worse outcomes, to target interventions and reduce inequalities.

- Proportion of women who attend without prior telephone triage.

    - Why: Understand use of different access routes and ensure open-door policies are working as intended.

Principle 2: Recognition as urgent care

Maternity triage services must be recognised across the whole system as a safety-critical environment and the primary access point for urgent and emergency care and advice for pregnant women, and those up to six weeks postnatal, experiencing unexpected or urgent concerns or problems.

Maternity Triage services should be:

- Designed to provide rapid assessment and care. Including ensuring that every woman receives an initial triage assessment within 15 minutes of arrival, regardless of time of day or service pressures.

- Accessible for all women presenting with unscheduled pregnancy, labour or postpartum concerns, without requiring an appointment or referral.

- Underpinned by a culture that validates and responds to women's concerns. Staff should actively reinforce that seeking care was the right decision and that accessing triage services (either telephone or in-person) is always appropriate when women have concerns, even when symptoms are later assessed as not requiring further care or action.

- Able to provide information on expected waiting times (based on risk categorisation) communicated on arrival. This should include real time updates where feasible.

- Operating as a safety net with an 'open door' approach. An open-door approach means that women can attend the in person maternity triage service without needing to make contact beforehand. Attendance should be accepted without judgement, and presenting concerns should be assessed promptly and without assumptions including in the latent stages of labour. This includes situations where the presenting issue may not appear urgent or emergent to a healthcare professional but requires timely

attention or escalation to prevent harm. This open-door approach is critical, particularly for those who have struggled to have their concerns listened to or resolved elsewhere and those who may struggle to navigate complex care systems.

- Distinct from scheduled or day assessment activity and, where possible, physically separate.
- Defined by a Standard Operating Procedure that clearly distinguishes maternity triage services from day assessment, including scope, exclusions and navigation between services. Scheduled reviews, tests and treatments should be managed separately by separate staff, in a separate location, to support safe prioritisation, escalation and appropriate allocation of staff and resources.
- Clearly signposted throughout the hospital with information and maps accessible electronically and/or in paper form.
- Recognised as a core part of the urgent and emergency care system, working with ambulance and emergency services to support appropriate escalation, conveyance decisions, structured handover, and assessment in the safest setting.
- Part of a system-wide network that supports neighbouring Trusts during periods of high demand, enhancing safety for women across the wider geography.

Key measurement metrics

- Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns.
    - Why: Helps to identify common urgent issues and monitor whether triage is being used appropriately as the first point of urgent care.

Principle 3: Assessment and care of women

The clinical model for maternity triage should align with existing RCOG Good Practice guidance and result in a clinical priority being assigned for every woman attending to ensure they receive timely, structured clinical assessment that takes into account their physical, mental and social wellbeing. The triage assessment and clinical prioritisation must be carried out by staff who are trained in the specific triage method.

The RCOG Good Practice Paper recommends the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), which delivers these principles, and organisations should aim to adopt this approach. If services choose not to use BSOTS, they must ensure that any adaptation or alternative model is evidence-based, clinically evaluated or piloted, and demonstrates equivalent outcomes through audit. Any such variation must be formally agreed by the Trust Board.

Triage models and staff training must address unconscious bias and support equitable escalation. Services should recognise that Black and Asian women are more likely to present with higher risk factors, often later in their progression, and ensure triage systems and associated escalation pathways deliver timely, appropriate and equitable assessment and care based on clinical need.

Key measurement metrics

- Proportion of women triaged in each category of urgency.
    - Why: Shows the spread of urgency levels, helping services understand case mix and plan staffing and escalation capacity.
- Proportion of women for whom expected timeframes are met for initial assessment, waiting time to clinical review, and clinical review, based on their category of urgency.
    - Why: Measures time to initial assessment, waiting times and review times, and whether urgent cases are escalated in line with triage standards, reducing the risk of harm.
- Proportion of women who experience a delay in assessment, review or onward care, with outcome recorded.
    - Why: Monitors the impact of delays on women’s care and outcomes, supporting timely review, learning and targeted improvement where harm or increased risk is identified.
- Proportion of women who leave without further reviews or care following initial triage, despite an identified need for further review or care.
    - Why: To understand patterns of incomplete assessment and address barriers that cause women to leave early, improving experience and outcomes.

Principle 4: Clear information for women

All pregnant women must have clear, accessible information about maternity triage services throughout their pregnancy continuum and up to six weeks postnatal.

Services must:

- Provide clear, consistent guidance on how and when to contact maternity services and where to attend with concerns related to their pregnancy or postnatal concerns.

- Offer information and advice in accessible formats, including plain language, easy-read materials, and culturally appropriate messaging. Information should clearly explain how to access care and reassure women of their entitlement to support.

- Provide timely access to effective interpretation services where women require them. Do not rely on family members or accompanying individuals to interpret. Services should allow adequate time to support accurate information exchange and decision-making, whilst reducing communication related bias and assumptions. See the RCOG Cross-Cultural Communication and Language Support standards for additional guidance.

- Provide consistent and personalised discharge information, including asking women if they are happy to be discharged, checking their understanding of next steps, and clearly outlining when and how to re-attend or seek further advice if symptoms or concerns change, in line with local guidance.

- Ensure effective signposting and provision of discharge information through direct referral to the appropriate service, avoiding situations where women are directed elsewhere without coordinated handover or support.

Key measurement metrics

- Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns.

    - Why: Understand why women seek care and ensure information provided addresses common concerns, improving early help-seeking.

Principle 5: Telephone maternity triage

All maternity triage services should provide a dedicated telephone triage service alongside an open-door policy, as set out in Principles 2 and 4. Maternity telephone triage services need to provide a safe, responsive and consistent first point of contact for pregnant women or those who have been pregnant in the last six weeks experiencing unexpected / urgent concerns or problems.

Every maternity triage service should:

- Provide a well-publicised, 24/7 single contact number, answered promptly by clinically active midwives trained and experienced in maternity triage. Telephone maternity triage should not be diverted to labour wards where there is a risk of prompt response not being possible.

- Encourage use of telephone triage where appropriate but never make it the only route to care.

- Ensure all women have open access to face-to-face maternity triage services. Where a woman remains anxious or concerned following telephone triage, they should be invited to attend for in-person assessment.

- Operate telephone triage from a protected, quiet, confidential space, away from the main clinical area and clinical office space. Ensure that the midwife's sole responsibility during this time is telephone triage.

- Ensure in-person attendance is not deferred to manage service workload, and that women are given clear information about the clinical urgency of attending. Operate a low threshold for attendance, recognising the assessment of clinical conditions over the phone is difficult and prone to subjective assessments.

- Not allow their telephone triage to provide a definitive diagnosis over the phone, determine clinical priority prior to in-person assessment, make appointments for in-person triage services, or manage or limit the number or timing of women attending the service.

- Have clear pathways to ensure that where threatened preterm or extreme preterm birth is suspected via telephone triage services, women are appropriately signposted to attend an in-person maternity triage service without delay, advise in-person maternity triage attendance without delay, where this is the safest and most appropriate setting, to enable timely clinical assessment.

- Document all calls in real time, using a standardised template, within the woman's electronic patient record, where available, ensuring all calls are audio-recorded with consent to support accuracy and safety. Document any request for hospital attendance, including the urgency and expected timeframe.

Key measurement metrics

- Rate of calls to telephone triage per 1,000 births.
    - Why: Understand demand for telephone triage and plan staffing and resources effectively.
- Proportion of women who call telephone triage but do not attend in person.
    - Why: To monitor effectiveness of telephone triage in identifying urgent care needs or if there are barriers preventing attendance when needed.
- Proportion of dropped or unanswered calls to telephone triage.
    - Why: To identify service capacity issues and ensure timely access for urgent concerns, reducing risk of harm.

Principle 6: Service User Voice (SUV) and experience

Triage services must actively seek and use feedback from women to improve care and ensure services meet the needs of local populations. As set out in NHS England's 10 Point Plan for maternity and neonatal services, all trusts should review patient outcome and experience data from their maternity and neonatal services at their public board meetings every month, using locally meaningful measures. Alongside wider maternity services, maternity triage services should:

- Develop a deeper understanding of their local populations, including social, cultural, and geographical contexts. To do this, maternity services should proactively engage and seek feedback from service users on their experiences of triage services and care, including telephone triage.
- Gather feedback regularly through multiple channels (e.g., surveys, focus groups, real-time tools) and review this regularly to inform continuous service improvement.

- Present monthly data and quality improvement work in accessible patient-facing and staff-facing formats, using this information to improve the quality of the service.

- Ensure women are clearly informed about how to raise concerns or seek further review if they are not satisfied with the outcome of a triage review, including access to local escalation routes and relevant safety processes. This should include awareness of Martha's Rule as it is implemented across maternity services, including maternity triage.

- Adopt the national maternity and neonatal Patient Reported Experience Measure (PREM), when available.

- Value qualitative lived experience alongside quantitative data, recognising that even small numbers of serious concerns can reveal underlying system issues that may not be visible in aggregated metrics. Feedback from service users should be treated as a critical source of insight for improving safety, quality, and experience.

- Work in partnership with their local Maternity and Neonatal Voices Partnership (MNVP) to co-produce improvements and ensure service user voice is embedded in decision-making and service design. Closing the feedback loop by sharing "you said, we did" updates is essential to building trust and demonstrating accountability, particularly with communities who have historically feel unheard.

Key measurement metrics

- Qualitative and quantitative data on the experience of women using maternity triage services should be collected using existing local feedback methods, with transition to the national maternity and neonatal Patient Reported Experience Measure when it becomes available.

    - Why: To understand the experience of women, including whether they feel informed, respected and involved in their care, helping to target actions to improve experience.

- Frequency and diversity of feedback collected.

    - Why: Ensures timely, representative feedback to support continuous improvement based on service user feedback This can be achieved through the gathering of

feedback from all women and reviewing this by ethnicity to ensure it is reflective of the service population.

- Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback, and the associated impact of these improvements.

    - Why: Monitors whether identified issues lead to timely, measurable improvement actions, supporting continuous service improvement and accountability.

Principle 7: Facilities and estates

Maternity triage services should provide a safe, accessible and purpose-designed estate and environment that supports early recognition of deterioration, efficient clinical care and compassionate care for women.

Triage services should:

- Where possible be co-located with, or positioned as close as possible to, the central delivery suite/labour ward to support timely escalation and care and minimise transfer risks.

- Provide a suitably sized seated waiting area that is easily visible to clinical staff.

- Include a reception area where staff are notified of women's arrival and women can access help quickly if they require more urgent attention.

- Maintain a dedicated space protected for initial triage, ensuring that a midwife can undertake assessments promptly and safely whilst maintaining privacy. This space should have appropriate equipment.

- Ensure appropriate facilities for timely, ongoing care, ensuring sufficient space for healthcare staff, women and their families while safeguarding privacy and confidentiality.

- Include a well-equipped office space within the clinical area to support clear and confidential handover and centralised oversight of the service workload.

- Ensure access to essential diagnostics, including electronic fetal monitoring, blood tests, urine samples and ultrasound.

- Meet accessibility standards, including provision of accessible WCs and clear signage, in line with the Department of Health's Health Building Note 09-02: Maternity Care Facilities. Designing spaces that provide quiet or private areas wherever possible, offering clear explanations of waiting processes, and ensuring systems to demonstrate that women have been seen and are awaiting care.

- Be physically separate from scheduled or day assessment activity to maintain focus on urgent and unscheduled care.

- Design the physical environment to promote women's sense of safety and comfort.

- Ensure maternity triage services are supported by modern, interoperable digital solutions, including real-time documentation, escalation and timely information sharing across maternity and neonatal services.

Key measurement metrics

- Clinical area where the woman was admitted following triage (where relevant). For example, Antenatal Ward, Labour Ward, Intensive Treatment Unit etc.

    - Why: Supports estates planning by showing demand for specific areas and informing capacity requirements, inpatient flow and service user experience.

Principle 8: Staffing

Maternity triage services must maintain safe and responsive staffing levels, with midwifery and medical skill mix adjusted according to demand and peak times. The priority is to ensure that every woman receives an initial triage assessment within 15 minutes of arrival, regardless of time of day or service pressures.

To achieve this:

- Staffing models should be dynamic, informed by local activity data and align to the system of triage used. Units should also consider their size and activity levels when planning staffing, ensuring sufficient trained personnel are available to meet demand.

- Maternity triage services must ensure appropriate, dedicated midwifery, medical and support staffing (e.g., Maternity Support Workers), in line with the recommended minimum standards for number, seniority and responsibilities of staff outlined in RCOG Good Practice Paper No. 17. The recommended minimum staffing levels include

minimum numbers and seniority of both appropriate midwifery and medical staffing. Staffing models must provide appropriate clinical capacity and escalation pathways at all times of day and night, including weekends, to maintain patient flow and ensure timely access to senior clinical decision makers. Staffing models should be reviewed regularly against local attendance data to ensure the service remains appropriately resourced, safe and responsive to demand.

- Services should have dedicated triage staffing structurally independent of labour ward midwifery staffing. Any redeployment of staff from maternity triage to other service areas, including labour ward, must be treated as a formal escalation event and documented, reviewed and monitored through local governance processes.

- Where possible, services should have minimum of one midwife who is responsible for the initial triage assessment and a minimum of one other midwife who carries out the subsequent care. This requirement should be informed by local demand, service need and the RCOG Good Practice Paper No. 17 birth-rate modelling.

- Maternity services must ensure that initial triage assessment and telephone triage is undertaken by appropriately trained and experienced staff, to ensure safe and timely decisions. These roles require clinical judgement to provide advice, assess clinical urgency, escalate concerns and initiate urgent interventions where necessary.

- Consideration should be given to defining competency requirements for these functions to ensure staff are well supported and supervised.

- Staff working in triage must receive appropriate training including in rapid assessment with clear competency frameworks and governance and maintain regular experience in this setting.

- There should be defined escalation protocols and thresholds for managing peak activity and escalating both midwifery and medical staffing when the department exceeds capacity. Thresholds should be based on the number of women attending and their clinical urgency categories. These protocols should be embedded in operational policies and local governance processes and supported by real-time monitoring of activity to trigger additional staffing to meet demand as required. Examples are included in the RCOG Good Practice Paper No. 17.

- Where staffing needs to be adjusted in response to critical workload and demand in maternity triage, decisions should be carefully considered and actioned promptly. Any

adjustments should balance acuity and safety requirements across the wider maternity service to maintain minimum safe staffing levels.

- Escalation should incorporate locally agreed thresholds for senior or consultant attendance beyond twice-daily ward rounds, ensuring timely access to senior input when required.

- The most senior obstetrician on call for the labour ward and the midwifery coordinator must jointly maintain oversight of maternity triage activity and escalation, supported by clear and timely lines of communication with neonatal teams where required. Triage activity should be reviewed as part of consultant-led labour ward rounds, conducted twice daily, seven days a week.

- Midwifery-led units should restrict their triage type activity to low-risk term labour assessment. Where women present to midwifery-led units with concerns requiring triage care, they must be promptly transferred to the appropriate obstetric unit with a designated maternity triage service.

Key measurement metrics

- Proportion of women assessed (initial triage and medical clinical review) within expected timeframes based on the category of urgency.

    - Why: Monitors whether triage standards are met and flags delays linked to staffing or capacity, guiding targeted improvements.

- Frequency of staff being redeployed to other maternity care areas within the unit from maternity triage.

    - Why: Monitors how often triage staffing is compromised, supporting improvements to staffing plans.

Principle 9: Equity and equality

A deliberate and targeted approach is required to identify and reduce inequalities in maternity triage access, experience and outcomes—particularly for women from ethnic minority backgrounds, socially deprived areas, and those with additional needs such as language support, disabilities, or low digital literacy.

Maternity triage services should:

- Acknowledge and understand the existence of inequalities experienced by their service users as a crucial first step.
- Understand local population needs and service demand, including social, cultural and geographical factors, and align improvements with wider system work such as ICB-led population mapping and blueprints.
- Use demographic and outcome data to identify where poor outcomes are concentrated and use this to inform service design and improvements. Mapping inequalities, for example by postcode, can help visualise areas of greatest need and guide targeted interventions.
- Work with local improvement initiatives and community-led organisations, so that lived experience meaningfully informs service improvements.
- Ensure all staff involved in maternity triage undertake training to support culturally safe care, including recognised programmes on cultural competence and cultural safety, as well as training that develops cultural intelligence and addresses unconscious bias.

Key measurement principles:

- Refer to Principle 1 where these metrics align to Principle 9 of Equity and Equality.
    - Equity and equality data should be captured as a defined subset of each primary dependent (outcome) measure, and reported both overall and stratified by ethnicity, deprivation (IMD) and spoken language to identify variation and potential inequality.

Principle 10: Data and measurement

Maternity triage services must adopt a structured, improvement-focused data collection and audit approach in line with the measurement strategy, supporting safe, effective and equitable care. Services should:

- Collect and review all data as outlined in the measurement strategy wherever feasible, ensuring a robust and representative sample is collected. At a minimum, this includes attendance patterns, peak times and waiting times and examined for inequalities for initial triage.

- Where a service is unable to capture a specific metric outlined in the measurement strategy, services should consider what improvements can be made to enable this data capture in the future. This should include timescales and whether it is a manual or automated process.

- Review data at appropriate intervals (daily, weekly, monthly and quarterly) to identify trends, patterns and areas for improvement.

- Establish processes that enable teams to frequently review their data, reflect on insights or changes, and react appropriately to support continuous improvement.

- Embed maternity triage within robust governance arrangements, including routine safety event review through the Patient Safety Incident Response Framework (PSIRF).

- Include demographic variables (e.g. ethnicity, language, deprivation, disability), as outlined in the measurement strategy, to ensure services understands the needs of its local population and addresses inequalities in access and outcomes.

- Be transparent with women about why data is collected and how it will be used to improve care. This is particularly important in communities with lower trust in the healthcare system.

Measurement Strategy

The measurement strategy, as described by the key measurement metrics, sets out a nationally recommended approach for services to measure, use and track key local metrics to understand how their maternity triage service is performing, identify variation, and drive improvement.

The table below summarises the key metrics aligned to each principle, and a suggested frequency of review for each of these metrics. The expectation is that these metrics support service development, improvement and reporting to Trust boards.

Where digital systems are not yet in place, services should still monitor safety, quality and experience using available local processes.

Principle	Metric	Frequency of review
1 Access and integration	Rate of triage presentations	Weekly/monthly*

Principle	Metric	Frequency of review
	per 1,000 births	
	Frequency of unplanned service closures per month	Monthly
	Ethnicity, deprivation and language data for each woman presenting	Monthly
	Proportion of women who attend without prior telephone triage	Monthly
2 Recognition as urgent care	Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns	Monthly
3 Assessment and care of women	Proportion of women triaged in each category of urgency	Weekly/monthly*
	Proportion of women for whom expected timeframes are met for initial assessment, waiting time to clinical review, and clinical review, based on their category of urgency.	Weekly/monthly*
	Proportion of women who experience a delay in assessment, review or onward care, with outcome recorded.	Weekly/monthly*
	Proportion of women who leave without further reviews following initial triage, despite an identified need for further review or care.	Weekly/monthly*
4 Clear information for women	Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns	Weekly/monthly*
5 Telephone maternity	Rate of calls to telephone	Weekly/monthly*

Principle	Metric	Frequency of review
triage	triage per 1,000 births	
	Proportion of women who call telephone triage but do not attend in person	Monthly
	Proportion of dropped or unanswered calls to telephone triage	Monthly
6 Service user voice and experience	Qualitative and quantitative data on the experience of women using triage services	Quarterly/half year*
	Frequency and diversity of feedback collected	Quarterly/half year*
	Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback, and the associated impact of these improvements.	Quarterly/half year*
7 Facilities and estates	Clinical area where the woman was admitted following triage	Monthly
8 Staffing	Proportion of women assessed within expected timeframes based on the category of urgency	Weekly/monthly*
	Frequency of staff being redeployed to other maternity care areas within the unit from maternity triage	Weekly/monthly*

Principle	Metric	Frequency of review
9 Equity and equality	Refer to Principle 1 where these metrics align to Principle 9 of Equity and Equality.	As described for the corresponding metrics in Principle 4.
Footnote: *may indicate a change in frequency depending on the size of the organisation and the rate of live births. This frequency of review should be agreed and determined locally.		

Baselining your service and undertaking a gap analysis

Before implementing the specification, services should undertake a baseline assessment and structured gap analysis, to understand their current triage provision, performance, strengths and areas for improvement. A maternity triage diagnostic tool will be published by NHS England on the NHS Futures Maternity and Neonatal Hub to support this process.

This assessment should include reviewing demand, existing pathways and provision, staffing models, facilities and estates, and current performance before changes or interventions are made. A structured gap analysis will support teams to identify where their service aligns with the national specification and where improvements are needed. This exercise will form the basis of initial local action planning, ensuring that implementation is grounded in local needs.

Within 3 months of publication of this specification, organisations should have audited their current maternity triage services, completed a gap analysis against this specification, and developed a local implementation plan. The outcome of this baseline assessment, including identified gaps and proposed actions, should be reported to a public Trust Board meeting to support transparency, accountability and oversight of progress towards full implementation.

Implementation

Implementation of this specification will require a coordinated and phased approach, supported by local Trust leadership, maternity service operational and clinical leaders, and the entire maternity triage staff. Implementation should be iterative and improvement-focused, with services using data and audit to monitor progress, identify variation, and refine approaches over time.

Services should develop a clear local implementation plan, setting out defined actions, timelines, and ownership, aligned to this specification. This should be supported by strong governance arrangements, regular oversight, and clear lines of accountability to ensure delivery is prioritised and sustained.

Crucially, implementation and service improvement must be informed by the voices of women. Services should work with local Maternity and Neonatal Voices Partnerships (MNVPs) and service users to co-design and refine triage services, ensuring they are responsive, accessible, and meet the needs of the populations they serve.

Collaboration and shared learning across systems, regions and providers is encouraged, enabling services to adopt best practice, address common challenges, and accelerate improvement at pace and scale.

Organisations are expected to fully implement this specification within 12 months of publication. Local implementation plans should therefore set out the actions, milestones, ownership and governance required to achieve full implementation within this timeframe.

Where any change in service name is being considered, this should be undertaken in meaningful partnership with women and families, including those who have experienced poor outcomes, to understand potential unintended consequences of proposed terminology and to ensure the chosen name supports safe, timely access to care.

Appendix

Acknowledgements

The national maternity triage task and finish group played a major role in developing this specification, bringing together clinical, operational, regulatory, improvement, regional and service user expertise.

We would particularly like to thank representatives from the following organisations and programmes for their contributions:

- Birmingham and Solihull Local Maternity and Neonatal System
- Birmingham Symptom-specific Obstetric Triage System / The Royal Wolverhampton NHS Trust
- British Association of Perinatal Medicine (BAPM)

- Care Quality Commission (CQC)
- East Midlands Ambulance Service NHS Trust
- GPs Championing Perinatal Care (GPCPC)
- Greater Manchester Local Maternity and Neonatal System
- Health Innovation Oxford and Thames Valley
- Health Innovation Wessex
- Humber Teaching NHS Foundation Trust
- London North West University Healthcare NHS Trust
- Maternity and Newborn Safety Investigations (MNSI)
- Sands
- West Midlands Ambulance Service University NHS Foundation Trust

Definitions used throughout this document

What is maternity triage?

Maternity triage services are the front-door for urgent and emergency care for pregnant or newly postnatal women with unexpected complications or concerns. For example, pain, vaginal bleeding, concerns about fetal movements, or acute obstetric or medical emergencies. Maternity triage services include both telephone and face-to-face contacts.

Maternity triage is different from the more common use of “triage” as a process in emergency care, which focuses on standardised clinical assessment and prioritisation. While maternity triage services also use structured approaches to assess, prioritise and escalate care, their scope is broader. Maternity triage should be understood as distinct, formal departments or clinical areas within maternity services, providing comprehensive assessment, decision-making, and coordination of care for women presenting with concerns at any point during pregnancy and up to six weeks postnatal.

Maternity triage, as a distinct service, is relatively new in its current form. While elements of triage have long existed within maternity care, this activity was historically absorbed

within labour ward functions and delivered in varying capacities across organisations. In recent years, maternity triage services have evolved rapidly in response to national safety and quality recommendations, increasing population complexity and rising demand – often without the corresponding structure, investment, or oversight seen in other urgent and emergency care pathways. This specification recognises both the relative newness of maternity triage as a standalone service and the significant transformation that has occurred, and seeks to provide the clarity, consistency, and support required to strengthen and standardise this critical area of care.

What is maternity telephone triage?

Maternity telephone triage refers to the initial remote contact point where pregnant or newly postnatal women can seek urgent advice or support regarding unexpected complications or concerns.

Telephone triage services provide timely guidance, signposting and escalation to face-to-face care when necessary. Phone-based assessment is limited and should not replace in-person clinical assessment. Telephone triage services must not be used to provide a definitive diagnosis, determine clinical priority prior to in-person assessment, make appointments for in-person triage services, or manage or limit the number or timing of women attending the service. While they play an important role in helping women access urgent maternity services quickly and safely, they should never be the sole route to in-person maternity triage care.

An alternative point of contact should be available for women to discuss routine and non-urgent enquiries.

What is a maternity day assessment unit or service?

A Maternity Day Assessment Unit (MDAU) differs from Maternity Triage in that their primary function is to provide planned or scheduled care for women with pregnancies that require enhanced monitoring. This may include regular blood pressure checks, CTGs, blood tests or treatment for specific clinical conditions, and other forms of ongoing antenatal surveillance.

Unlike Maternity Triage, which provides urgent and unscheduled assessment, MDAUs operate strictly through pre-arranged appointments, offering a structured and predictable model of care for women with known or ongoing clinical needs.

While their core function is planned care, many MDAUs can also support urgent but non-emergency assessments when clinically appropriate for example such as administering iron infusions or repeat fetal monitoring.