

## LTHT Review of National NHSE Triage Tool, and Implementation Plan

**Trust Board**  
**24<sup>th</sup> of September 2026**

|                             |                                             |
|-----------------------------|---------------------------------------------|
| <b>Presented for:</b>       | Information and Assurance                   |
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| <b>Previous Committees:</b> | WQAG                                        |

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|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Freedom of Information Act (FOIA) Exemption</b> | <input type="checkbox"/> <b>YES</b> (restricted from the FOIA) <input checked="" type="checkbox"/> <b>NO</b> (available to the public under the FOIA) |
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|-----------------------------------------------|-------------------------------------------------------------|
| <b>Link to Strategic Objective</b>            | Focus on care quality, effectiveness and patient experience |
| <b>Link to Provider Capability Assessment</b> | Quality of care                                             |
| <b>Link to CQC Well-led Statement</b>         | Governance, Management and Sustainability                   |
| <a href="#"><u>Regulatory Impact</u></a>      | Regulation 17: Good governance                              |

| <b>Key points</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <b>Purpose</b>                   |
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| 1. Overall assurance is partial: core services and safety controls are in place, but consistent, measurable compliance is not yet fully evidenced. Separate assessments were completed for each site; however, LTHT operates a single maternity service with minimal variation in provision or clinical effectiveness. The main estates difference is at SJUH, where the waiting area is not directly visible to staff; this is mitigated by CCTV and call bells. All calls are managed through the dedicated SJUH telephone-triage service and directed to the appropriate site; LGI therefore has no separate on-site telephone service. | <i>Information and Assurance</i> |
| 2. The principal assurance gap is, validated data and measurement are not consistently sufficient to demonstrate the 15-minute standard and pathway metrics. This is due to digital systems not currently having the capability to                                                                                                                                                                                                                                                                                                                                                                                                         | <i>Information and Assurance</i> |

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| support audit requirements. However, a solution is in progress which will support service improvement and ability to provide assurance of standards.                                                                                                                                                                                                                                                                                                                                  |                           |
| 3. Clinical priority areas for development include early pregnancy care, sustained embedding of the Birmingham Symptom Specific Obstetric Triage System (BSOTS), competency assessments, medical staffing and consultant oversight.                                                                                                                                                                                                                                                   | Information and Assurance |
| 4. Equity and integration require further development. Triage-specific equity reporting is not yet established, and formal pathways with Primary Care, NHS 111, neighbouring providers and mutual-aid partners require clearer discharge, handover and escalation arrangements.                                                                                                                                                                                                       | Information and Assurance |
| 5. The principal costs relate to dedicated obstetric and specialist midwifery staffing. Obstetric provision is included in the approved medical workforce plan, and 2.0 WTE specialist triage midwives were approved through the Phase 3 workforce paper to support service improvement, education and clinical effectiveness. Focused health-equity work will be delivered within existing resources. Training and minor estates requirements remain subject to scoping and costing. | Information and Assurance |
| 6. Note the partial assurance position; endorse delivery of the integrated improvement programme through the perinatal improvement plan; and receive regular progress reports against agreed milestones, measures, risks and resource requirements.                                                                                                                                                                                                                                   | Decision                  |

| <b><u>Risk Appetite Framework</u></b> |                                                                                                                                                                                                          |                              |                  |
|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------|
| <b>Level 1 Risk</b>                   | <b>Level 2 Risks</b>                                                                                                                                                                                     | <b>(Risk Appetite Scale)</b> | <b>Impact</b>    |
| Workforce Risk                        | Workforce Supply Risk - We will deliver safe and effective patient care through having adequate systems and processes in place to ensure the Trust has access to appropriate levels of workforce supply. | Cautious                     | Operating within |
| Operational Risk                      | Business Continuity Risk - We will develop and maintain stable and resilient services, operating to consistently high levels of performance.                                                             | Cautious                     | Choose an item.  |
| Clinical Risk                         | Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.                    | Minimal                      | Operating within |
| Financial Risk                        | Choose an item.                                                                                                                                                                                          | Choose an item               | Choose an item.  |

|               |                                                                                                                                 |        |                   |
|---------------|---------------------------------------------------------------------------------------------------------------------------------|--------|-------------------|
| External Risk | Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law. | Averse | Operating outside |
|---------------|---------------------------------------------------------------------------------------------------------------------------------|--------|-------------------|

## 1. Summary

National maternity reviews identify maternity triage as a safety-critical front door where delays, inconsistent assessment, failures to listen or escalate, and poor continuity of information can contribute to avoidable harm. The 2026 Ockenden report and the Amos review collectively emphasise compassionate listening, reliable urgent assessment and escalation, staffing and capacity aligned to demand and acuity, integrated pathways, and active use of performance, incident and outcome data. The current review therefore assesses whether LTHT's triage model is clinically safe, compassionate, equitable, adequately resourced and supported by escalation arrangements that respond to both clinical need and operational pressure.

NHS England's Maternity and Neonatal 10 Point Plan translates the urgent learning from the Amos and Nottingham reviews into immediate provider action. Its maternity triage element requires every Trust to commit to safe and effective triage, complete a Board level audit and gap analysis within three months, develop an implementation plan, report progress through a public Trust Board meeting and implement the national maternity triage specification within 12 months of publication.

## 2. Discussion

Assessment against the ten principles presents a mixed but broadly consistent picture. The full assessment can be viewed in the NHSE Triage tool in Appendix 1 A&B. LTHT has established many of the fundamental components expected of a maternity urgent care model: women can access services through several routes; dedicated assessment centres operate within maternity units; 24/7 midwifery staffing and telephone triage are in place; escalation arrangements are documented; and service-user engagement through the MNVP is well established. Telephone triage provides the strongest assurance because there are dedicated contact numbers, clinical guidance and protected accommodation. These arrangements demonstrate a credible operational platform from which full compliance can be achieved within the required timescale.

Despite these strengths, the assessment is predominantly rated as partial assurance, with limited assurance for equity and equality and for data and measurement. The principal gap is not service provision, but the absence of consistent evidence that the model is fully implemented, effective and equitable. As several standards combine multiple outcomes, full compliance can be recorded only when every component is evidenced; consequently, standards with some fully evidenced elements remain partially compliant overall. To support transparent monitoring, the team has developed a detailed local tool that separates each component into individual actions. These individual actions will be incorporated into the perinatal improvement plan and reconciled with the national tool for Board reporting.

Clinical pathway assurance is incomplete in several areas. BSOTS implementation is underway, but a formally approved implementation and sustainability plan, current competency records and

routine audit of triage performance are required. Women presenting under 14 weeks are managed through the early pregnancy unit within Gynaecology services (EPAU); however, the assessment does not demonstrate that this pathway uses an equivalent urgent triage model or achieves comparable access, escalation and outcome standards. There are also gaps in standardised discharge, safety netting and coordinated handover, particularly when care interfaces with Primary Care, NHS 111, community teams or neighbouring providers.

Workforce arrangements provide partial assurance. Dedicated funded midwifery staffing is a strength, but the model requires further analysis against activity and acuity data to identify peaks and troughs in demand, confirm establishment requirements and determine whether staffing should expand and flex. The inpatient areas of the service can evidence acuity through the Birthrate Plus acuity tool, but unfortunately there isn't a tool available for Triage services and therefore this requires a different approach by critically analysing other acuity and workforce data which will be enhanced by the digital solutions in progress. Assurance is further limited by the absence of a consistent dedicated medical establishment for triage. However, this has been built into the approved medical workforce plans which are in the process of being transacted.

Estates and equipment arrangements similarly offer a sound base but require further assurance. Both assessment centres are co-located with maternity services and have dedicated waiting and initial assessment areas. Residual concerns include limited direct visibility of the JMAC waiting area, this is partially mitigated through monitored CCTV. Accessibility, wayfinding and pressure on ongoing care space during periods of high activity and site specific environmental assessments are needed to establish any further risks and the required mitigation.

Although the wider maternity service has a wealth of health equity expertise, mandatory training and established community relationships, the specific impact on maternity triage cannot currently be demonstrated. Access, timeliness, experience and outcomes for women attending the assessment centres are not routinely stratified by ethnicity, deprivation, spoken language, interpreter need or accessibility requirements. Accessible information is available in some formats, but translated print, easy read and non-digital materials are inconsistent. A defined equity dataset, targeted engagement and routine review are therefore essential to establish whether all groups receive timely and appropriate care.

Overall, LTHT has a credible operational foundation, but the current position remains partial assurance because implementation, effectiveness and equity are not yet consistently evidenced. Progression to full assurance depends on validated data, standardised pathways, reliable audit, clear escalation arrangements and evidence of sustained improvement. These actions will be managed as one integrated workstream within the perinatal improvement plan, with executive sponsorship and named Women's CSU leads, timebound milestones, measurable KPI's, clear resource requirements and defined daily, weekly, monthly and quarterly assurance processes.

### **3. Quality and Performance Implications and strategies to support phased implementation over 12 months.**

The absence of a validated maternity triage dataset and agreed reporting architecture limits assurance over the 15 minute assessment standard, BSOTS categorisation, time to clinical

review, delays, escalation response, destination, incomplete care, reattendance and clinical outcomes. This constrains operational oversight, prevents meaningful trend analysis and limits the ability to distinguish isolated concerns from sustained performance deterioration. It also limits the service's ability to identify variation between sites or shifts, align staffing and capacity with demand, and detect emerging safety concerns before they become evident through incidents or complaints. A solution has been identified and is under development and will be implemented in the next 3 months.

Reliable triage is essential to ensure that women and babies with urgent or time critical needs are prioritised, assessed and escalated without avoidable delay. Incomplete assurance over BSOTS implementation, staff competency, senior clinical review and early pregnancy pathways reduces assurance that risk is consistently identified and managed. The maternity service has recognised the need to prioritise triage standards, experience and outcomes and have recently appointed 2 WTE Specialist Triage midwives to support improvements to education, experience, outcomes and effectiveness of the service. A key element of the role will be the identification, standardisation and implementation of audits to provide the required intelligence on which to base further improvements to service delivery. They will initially prioritise testing of category allocation, observations, documentation, escalation, time to obstetric review, adherence to clinical pathways, safety netting, transfer, admission and outcomes.

Maternity triage escalation requires live information on activity, acuity, staffing, waiting times, clinical space and equipment, supported by clear surge, mutual aid and executive escalation triggers. Delays in initial assessment or onward review may increase clinical risk, prolong length of stay, reduce privacy and dignity, contribute to crowding, and place additional pressure on labour ward, antenatal and emergency pathways. An OPEL aligned escalation tool is progressing through governance approval and once implemented, should support earlier intervention and more consistent management of operational pressure.

Telephone analytics will be triangulated with clinical records, incidents, complaints, reattendance and outcomes to identify delays, communication failures and demand patterns to identify opportunities for service development and improvement. The service has a telephone system which collects this information to support audit.

The improvement programme leads will define measurable trajectories for the proportion assessed within 15 minutes, category accuracy, time to clinical review, telephone answer and abandonment rates, completion of observations and documentation, escalation response, staffing and competency compliance, delays attributable to capacity or equipment, discharge and safety netting completeness, reattendance, patient experience and equity gaps. Sustained improvement needs to be evidenced over time and supported by audit, incident learning and service user feedback rather than by process completion alone.

The under 14-week EPAU pathway will be reviewed to determine whether an evidence based urgent triage model is required or whether the current pathway can demonstrate equivalent standards through audit. The review will assess access, assessment, escalation, handover and outcomes.

Named obstetric and midwifery leads are accountable for maternity triage equity, supported by the consultant midwife for Health Equity and clinical, digital, analytical and service user partners. A quarterly equity dashboard will be developed to monitor access, waiting times, interpreter use, experience and outcomes, with any significant variation escalated through Women's CSU governance structures. Actions will have named owners, timescales and measurable outcomes, including reduced access and waiting time gaps, improved interpreter access and evidence of comparable experience and clinical outcomes.

Quality will be assessed not only through clinical outcomes but also through whether women feel listened to understand the advice given, can access face to face assessment when concerned and receive consistent discharge and safety-netting information. Triage specific feedback, complaints, incidents, patient stories and PREM measures will be reviewed together, with demographic representativeness monitored and improvement actions tracked

Cultural competence, unconscious bias, maternal inequalities and equitable communication are included in wider training, but compliance needs to be reconciled against all staff delivering telephone and face to face triage. Education will be supported by competency assessment, reflective learning from incidents and feedback, and clear expectations for professional interpretation, personalised communication, reasonable adjustments and escalation when a woman's concerns persist.

Progression to full assurance requires coordinated delivery across digital and analytical capability, early pregnancy pathways, BSOTS implementation, and consultant oversight, OPEL escalation, telephone access, discharge and handover, health equity, estates and equipment. These dependencies will be managed through the perinatal improvement plan with executive sponsorship, named owners, costed and time-bound actions, measurable benefits, formal risk controls and a defined reporting cycle.

## **7. Financial Implications**

Required improvements depend on digital and analytical capacity, interpretation services, accessible information, equipment replacement and estates mitigation. The full costs are not yet known until a full financial review is undertaken. Without prioritised resources and coordinated programme management, delivery may be delayed or fragmented. Conversely, failure to act may increase the costs associated with avoidable harm, inefficient flow, repeated attendance, incident response, claims and regulatory intervention.

## **8. Risk**

The principal potential risks are associated with the absence of validated data which could impact on delayed detection of clinical deterioration, inconsistent assessment and escalation, inequitable access or outcomes, and insufficient evidence of compliance with the national maternity triage specification. Mitigation will be delivered through the integrated improvement programme, with formal risk controls, named owners, milestones and regular reporting through Women's CSU and perinatal governance structures.

Failure to evidence implementation of the national maternity triage specification may result in insufficient Board assurance, external scrutiny and loss of confidence among women, families,

staff and partners. Weak triangulation of performance, incidents, complaints, feedback and outcomes may also reduce the Trust's ability to demonstrate learning and sustained improvement.

## **9. Communication and Involvement**

Communication is central to safe maternity triage because women must know how and when to seek help, be able to access advice promptly, understand the outcome of assessment and receive clear information about further care. LTHT has a dedicated maternity contact number, 24/7 access arrangements and digital information, but assurance is reduced by inconsistent accessible formats, incomplete evidence of telephone performance, variable discharge processes and gaps in communication across organisational boundaries.

MNVP involvement needs a specific focus on co-producing triage access information, waiting time messages, discharge materials and feedback methods. Feedback should include both telephone and face to face experiences and should actively involve communities underrepresented in existing data. Regular "You Said, We Did" reporting should demonstrate how feedback, complaints, incidents and patient stories have changed the service.

Professional interpretation should be reliably available and used whenever required, with monitoring of access, delays and inappropriate reliance on family members. Priority information should be available in translated, easy read, large print and non-digital formats, with reasonable adjustments for hearing, visual, cognitive and communication needs. Patient understanding should be checked rather than assumed, particularly where advice is complex or urgent.

Development of a standardised discharge process will confirm the assessment outcome, agreed plan, treatment or follow-up, warning signs, when and where to seek further help and that the woman has understood the advice. Written information needs to be consistent with verbal communication and provided in an accessible format. Completion of discharge communication and safety netting will be audited, with reattendance, incidents and complaints used to test effectiveness.

The maternity triage SOP, BSOTS implementation plan, escalation criteria, OPEL status and mutual aid arrangements need to be communicated consistently to all relevant staff. Shift handovers and safety huddles should include activity, acuity, waiting times, staffing, capacity, high risk women, delayed reviews and equipment constraints. Changes to pathways, guidance or contact information must be supported by briefings, accessible reference materials and confirmation that affected teams understand their responsibilities.

## **10. Impact on Equality & Health Inequalities**

LTHT has relevant foundations, including a Health Equity Team, specialist midwifery expertise, mandatory training and established links with community partners. However, the service cannot yet demonstrate whether women from different communities experience equivalent access, timeliness, communication, escalation, clinical review, experience or outcomes within the triage pathway. The absence of triage specific analysis means inequalities may be present but remain hidden within aggregate performance.

Triage demand and outcomes will be considered alongside local population health intelligence from the Trust, ICB and public health partners. This will help identify communities with higher need, lower use, repeated attendance, later presentation or poorer experience. Targeted interventions may include revised access information, community based engagement, improved interpretation, alternative contact routes, staff education and stronger links with voluntary and community organisations.

#### **11. Publication Under Freedom of Information Act**

The paper is available under the Freedom of Information act.

#### **12. Recommendation**

The Trust Board is asked to accept the current partial assurance position; endorse delivery of the integrated triage improvement programme through the overarching perinatal improvement plan; appoint a named executive sponsor to provide oversight, scrutiny and constructive challenge; and receive regular progress reports against agreed milestones, measures, risks and resource requirements. Progression to full assurance should occur only when validated data, audit, workforce and competency evidence, service-user feedback and equity analysis demonstrate that improvements are embedded, sustained and delivering safer, more timely and equitable care.

#### **13. Supporting Information**

**Appendix 1A** NHSE Triage benchmarking Tool SJUH

Appendix 1B NHSE Triage benchmarking Tool LGI