Health and Adult Social Care Overview and Scrutiny Committee

Report subject	**Care Quality Commission (CQC) Maternity assessment September 2025 and actions taken for improvement**
Meeting date	22nd of September 2026
Status	Public Report
Executive summary	The report is to provide an update on maternity improvements since the CQC inspection in September 2025. The maternity services were rated as overall requires improvement. Good practice was seen and women reported kindness compassion and benefits from the new building and facilities. Staff were committed and working well together. Areas that required improvement were security, workforce, triage induction of labour processes, theatre capacity services and leadership. All areas have been improved with continual plans for ongoing improvements as per new national maternity guidance.
Recommendations	**It is RECOMMENDED:** To note the report and assurances provided of UHD commitment to continued maternity improvements
Reason for recommendations	Public assurance of maternity services at UHD
Report Authors	Lorraine Tonge Director of Midwifery and Neonatal Services
Wards	Maternity services at Royal Bournemouth Hospital

1.0 Background

1.1 The Care Quality Commission (CQC) assessed the UHD maternity services in Royal Bournemouth Hospital on the 16th and 27th of September in 2025

1.2 This was the first assessment in the new build after the move of the service from Poole to Bournemouth on the 31st of March 2025.

1.3 The previous assessment in Poole in 2022 rated the service as inadequate. The assessors recognised many aspects of improvements however further work was required as the service is rated at **requires improvement** (2025 assessment.)

1.4 There were several areas of **good practice** recognised by the CQC

Catherine Campbell, CQC deputy director of hospitals, secondary and specialist care for the South-West, said:

- "We found committed staff
- Women told us staff treated them with kindness and compassion, and we saw this during our visit.
- We saw midwives and doctors working well together.
- Staff enabled 79% of women to book their first appointment by 10 weeks, exceeding national targets and helping women begin pregnancy care earlier.
- Women reported positive experiences of person-centred care, saying staff involved them in decisions, supported them, and listened to their concerns.
- Women said they liked having their own room and that their partners could stay with them.
- The service had specialist midwives to support vulnerable women and consultant obstetricians were present for difficult births

Catherine Campbell also said that Inspectors identified areas for **improvement were**:

- "The maternity service frequently left the advice line unstaffed, diverting calls to triage or the labour ward and delaying urgent advice for women.
- Staff often delayed the induction of labour process, leaving some women waiting many hours or days and increasing distress and the likelihood of intervention.
- Staffing shortages and limited theatre capacity led staff to cancel some elective caesarean sections, creating uncertainty and increasing anxiety for women."
- Staff felt there was a disconnect between managers and staff working clinically to the senior leadership team.
- The inspectors also found the newborn security policy hadn't been updated for the new building, and recovery bay CCTV cameras compromised women's privacy and dignity. The team acted promptly to remove the cameras and update the security policy.

2.0 Immediate actions taken during inspection

2.1-CCTV cameras were reviewed and removed from theatre recovery immediately

2.2 Baby abduction exercise completed in the new build.

Improvements made Sept 2025 – Sept 2026

Theme	Key milestones achieved	Next steps or in progress
Security	✓ Baby abduction standard operated policy completed. ✓ Implementation and staff awareness of policy. ✓ Staff education on security at yearly updates implemented ✓ Repeated baby abduction exercise in June 2026 ✓ Tailgating posters on every entry door ✓ Tailgating exercises weekly ✓ CCTV cameras were reviewed at the time of inspection and removed from the recovery bay in theatre.	➢ Further learning identified in the lockdown of the building in the event of an abduction. Work in progress to improve building security further. (Security guards will be in place until work is completed.)
Workforce ▪ Overall staffing ▪ Midwifery sickness ▪ Improvement of roster management	✓ We over recruited above birthrate plus staffing levels in September 2025 ✓ Commencement of new birthrate plus assessment in new build ✓ Continuous support of overrecruiting by trust Board in September 2026 ✓ Supportive management of sickness training by Human resources to senior staff completed and midwifery sickness less than 5% from February 2026 to date. National rate for midwifery sickness between 5-7%. ✓ Annual plan for support for junior staff in place.	➢ Recruit Newly Qualified Midwives (NQM) in September 2026 ➢ Supporting the birthrate plus assessors to complete assessment over next 3 months ➢ Continuous monitoring of sickness to sustain and reduce rates further to trust target of 4% ➢ Continue to support junior staff with lead midwife in

▪ Wellbeing of staff	✓ Maternity triage line recruited and to vacant posts now fully staffed ✓ We have strengthened daily oversight of staffing by Matrons leading on safety huddles supporting the allocation of staff to ensure staff are allocated to the most needed areas as acuity changes within a shift. Making early decisions and forward planning if temporary staff is needed ✓ Daily monitoring of staffing through trust workforce governance ✓ Senior team and professional midwifery advocate are supporting staff to take breaks.	place to feedback to senior team. ➢ We will recruit any vacant Maternity triage line posts immediately as they arise. ➢ Continue to receive feedback from staff at listening events and work together on improvements ➢ Ongoing monitoring by Matrons of break relief
Triage ▪ Staffing training on maternity advice line ▪ Staffing gaps and vacancy on maternity advice line ▪ Triage response times	➢ Refresher training has been completed with all staff on the maternity advice line. ➢ Guidebook and pathways updated and in place for staff to follow ➢ Staff recruited and to advice line and roster prioritised to prevent staffing gaps. ➢ Due to reduction in sickness and staffing improvements response times in unit is above 80% target since May 2026	Further improvements expected in maternity advice line **-** ➢ Introducing Healthy Start app in October to aid women in finding advice for minor enquires and setting line up as a triage service for emergencies. ➢ Review and assessing service with new NHS Maternity Triage guidance August 2026 on maternity triage services.

Leadership ▪ Increase visibility of senior leaders ▪ Seniors staff working in clinical areas ▪ Communication of changes ▪ Celebrating success	➢ Senior leaders are now working part of the week in allocated areas for example the labour ward matron will work in the labour ward setting to support staff as issue arise. ➢ We have introduced a back to the floor shift and senior staff work clinically alongside their colleagues ➢ We have increased communication with staff on changes within the unit and the communication policy has been updated ➢ We have increased our celebrating of success with weekly thank you from senior staff.	➢ We will continue to listen to our staff and engage in national programme of maternity staff survey which is expected later in this year.
Induction	➢ Review of induction process and information given to women updated. ➢ Delays of more than 2 hours post admission reported and monitored overall reduction seen to now 2 per month. ➢ Senior Clinician/Matron communicating with family if there is a delay	➢ Continued monitoring of any delays
Theatre capacity	➢ Review of theatre capacity completed ➢ Increased staffing for theatre, and postnatal care. ➢ All day lists introduced for planned Caesarean sections	➢ Ongoing monitoring system in place of any delays as Caesarean section are increasing and current rate at 50%

4.0 Conclusion

4.1 Maternity has made improvements since 2025 with all teams working together on managing and supporting workforce, improving security and leadership systems and processes which have improved patient care.

4.2 The service is committed to continue improvements and work with the regional and national team as the overall guidance are given to improve maternity service nationally.

Appendices

CQC Maternity report 2025
The Royal Bournemouth Hospital HTML report for assessment LAP-02683 - Maternity - Care Quality Commission

Maternity Triage Guidance August 2026
NHS England » National maternity triage specification